



GLOBAL BREAST CANCER ALLIANCE – AN EQUITY IMPERATIVE

Julie Torode - Deputy CEO, UICC
7th February 2013, Paris

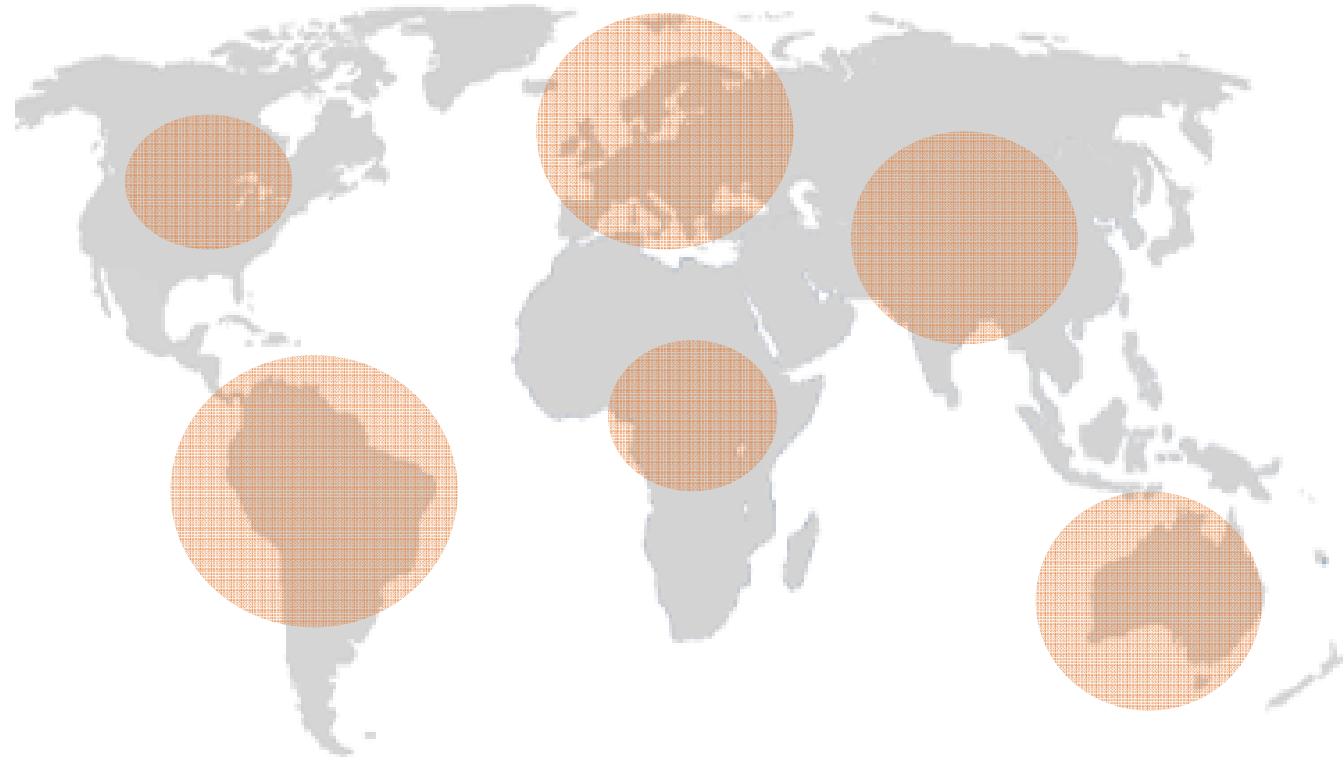
Union for International Cancer Control

www.uicc.org

OVERVIEW OF UICC

- UICC is the **largest and oldest (founded in 1933) global cancer fighting organisation** of its kind in the world
- We are at the **heart of the cancer community** and **uniquely positioned** to drive action
- Our **global membership base** includes the world's major cancer societies, treatment and research centres, patient organisations, and governmental health institutions and currently stands at 770+ organisations in over 155 countries
- We have developed important **strategic partnerships** with like-minded public and private sector organisations
- We play to our strengths, which include our ability to **advocate** on behalf of the cancer community, **convene** leaders to drive action and run **programmes** that require international coordination

Our influence has grown



Membership has increased across all continents

	# members	
	2010	2012
Africa	44	97
Australasia	15	145
Asia	110	125
Europe	109	159
North America	47	70
South America	48	165

Our membership now spans 155 countries (up 26% from 123 in 2011)

370



776

members 2010

members today

Journey to the UN High Level Meeting on Non-Communicable Diseases (NCDs)

As a founding member of the NCD Alliance, UICC was at the forefront of the civil society campaign to hold a UN High-Level Meeting (HLM) on NCDs to put cancer and the other NCDs on the global agenda.



Formed in 2009, the NCD Alliance now represents over 2,000 organisations in 170 countries. Together with NCD Alliance partners, UICC campaigned for a strong outcomes document with concrete targets and actions on NCDs to be adopted at the UN HLM from 19-20 September 2011 in New York.



General Assembly

Distr.: General
24 January 2012

Sixty-sixth session
Agenda item 117

Resolution adopted by the General Assembly

[without reference to a Main Committee (A/66/L.1)]

66/2. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

The General Assembly

Adopts the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases annexed to the present resolution.

*3rd plenary meeting
19 September 2011*



WORLD BANK COUNTRY GROUPS

WORLD BANK CLASSIFICATION (ATLAS

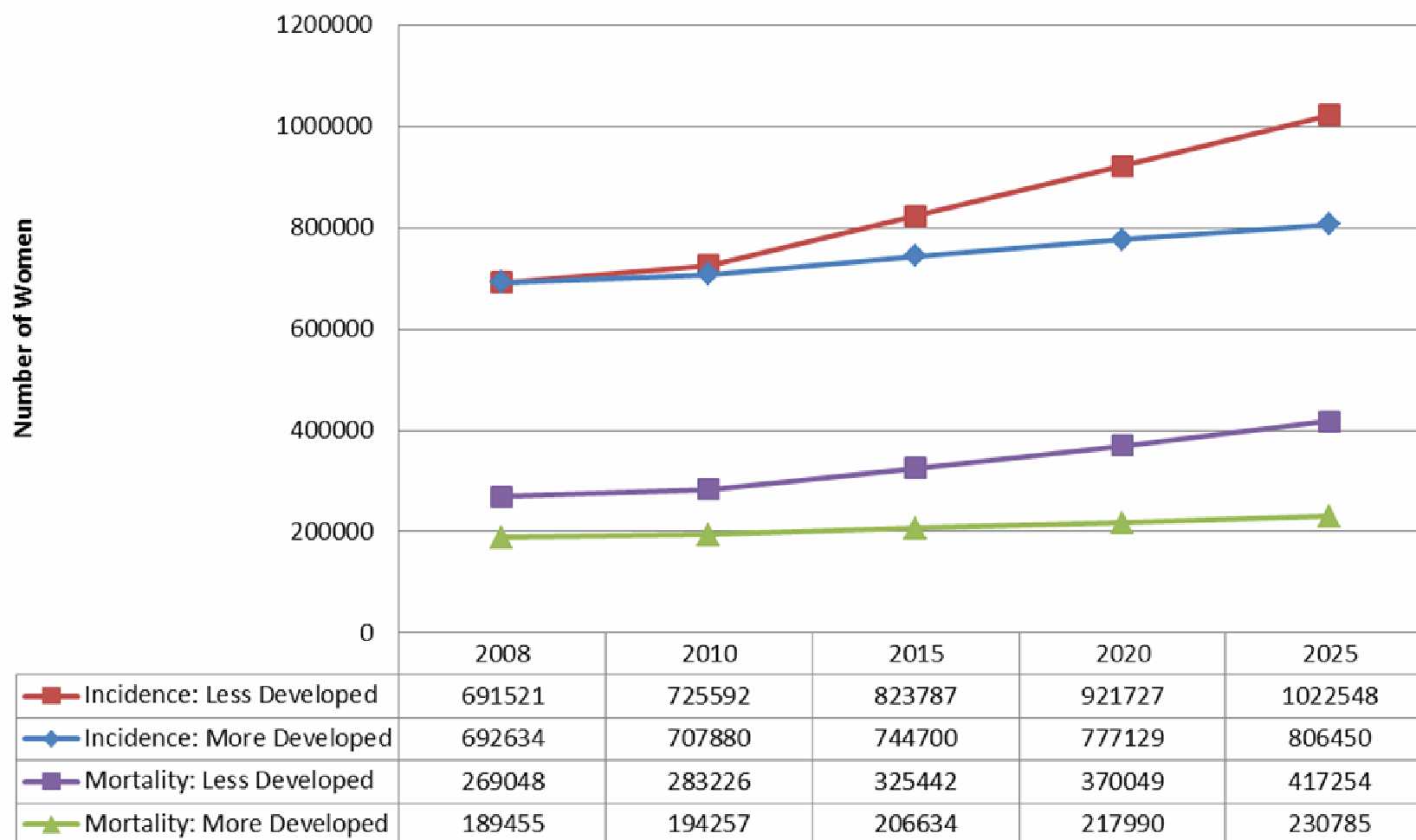
METHOD)

World Bank Country Groups (GNI per capita)	Low Income (<i>\$995 or less</i>)	Lower Middle Income (<i>\$996 - \$3,945</i>)	Upper Middle Income (<i>\$3,946 - \$12,195</i>)	High Income (<i>\$12,196 or more</i>)
Average female life expectancy at birth	57.8 yrs	69.3 yrs	74.4 yrs	82.4 yrs
Average GNI per capita (2009 US dollars)	\$403	\$1,723	\$6,314	\$36,953
Total national health expenditure per capita	\$22	\$76	\$458	\$4,266
Fraction of GDP spent on health care	5.1%	4.3%	6.4%	11.2%

Health expenditure figures 2010 for calendar year 2007; GNI = gross national income
<http://data.worldbank.org/data-catalog/health-nutrition-and-population-statistics>.



BREAST CANCER INCIDENCE AND MORTALITY More vs. Less Developed World Regions



SOURCE: Globocan 2008 (IARC)



GLOBAL BREAST CANCER BURDEN INCIDENCE AND MORTALITY: 2015-2024

- Most common cancer among women
 - ❖ 17.5 million cases in next decade
 - ❖ 9.1 million cases in less developed countries
 - ❖ By 2024, over 1 million cases per year in LMCs
- Most common cancer killer among women
 - ❖ 5 million women will die in next decade
 - ❖ 3.6 million deaths in less developed countries
 - ❖ 650,000 deaths are premature and preventable

SOURCE: Globocan 2008 (IARC)

GLOBAL CANCER BURDEN: FEMALE CANCER MORTALITY BY AGE

	Breast cancer (deaths in thousands [95% uncertainty intervals])		
	15-49 years	≥50 years	Total
Global	94.0 (87.1-102.3)	331.2 (269.9-352.8)	425.2 (358.6-453.4)
Developing	67.8 (61.6-74.2)	145.9 (125.8-160.2)	213.7 (188.6-231.2)
Developed	26.1 (24.1-29.4)	185.3 (143.2-200.4)	211.4 (169.3-228.5)

	Cervical cancer (deaths in thousands [95% uncertainty intervals])		
	15-49 years	≥50 years	Total
Global	55.9 (39.5-78.7)	144.1 (98.9-195.7)	200.1 (139.0-276.3)
Developing	46.2 (32.7-64.3)	109.2 (73.1-146.3)	155.4 (106.2-212.1)
Developed	9.7 (6.8-13.1)	35.0 (25.6-49.3)	44.7 (32.3-62.3)



**World Health
Organization**

**EXECUTIVE BOARD
132nd session
Provisional agenda item 6.2**

**EB132/7
11 January 2013**

Draft action plan for the prevention and control of noncommunicable diseases 2013–2020

Report by the Secretariat



NCD GLOBAL ACTION PLAN CANCER-RELATED GOALS

- Maintain disease registries, including for cancer incidence by type
- Reduction in modifiable risk factors (tobacco, physical activity, obesity, saturated fat, alcohol)
- Promote breast feeding (exclusive for 6 months, continue until 2 years with complementary feeding)
- No specific goals or actions relating to breast cancer early detection, diagnosis, treatment or palliation

BREAST CANCER EPIDEMIOLOGY

STAGE AT DIAGNOSIS: UNITED STATES VS.

INDIA

STAGE	EXTENT	5 year SURVIVAL	DISTRIBUTION	
			USA	INDIA
0	Noninvasive	100%	16%	----
I	Early stage disease	100%	40%	1%
II	Early stage disease	86%	34%	23%
III	Locally advanced	57%	6%	52%
IV	Metastatic disease	20%	4%	24%

USA:
90% DCIS or early staged invasive disease at diagnosis

INDIA:
76% locally advanced or metastatic at diagnosis

Sources: SEER Survival Monograph (NCI), 2007;
Chopra, Cancer Institute Chennai, 2001



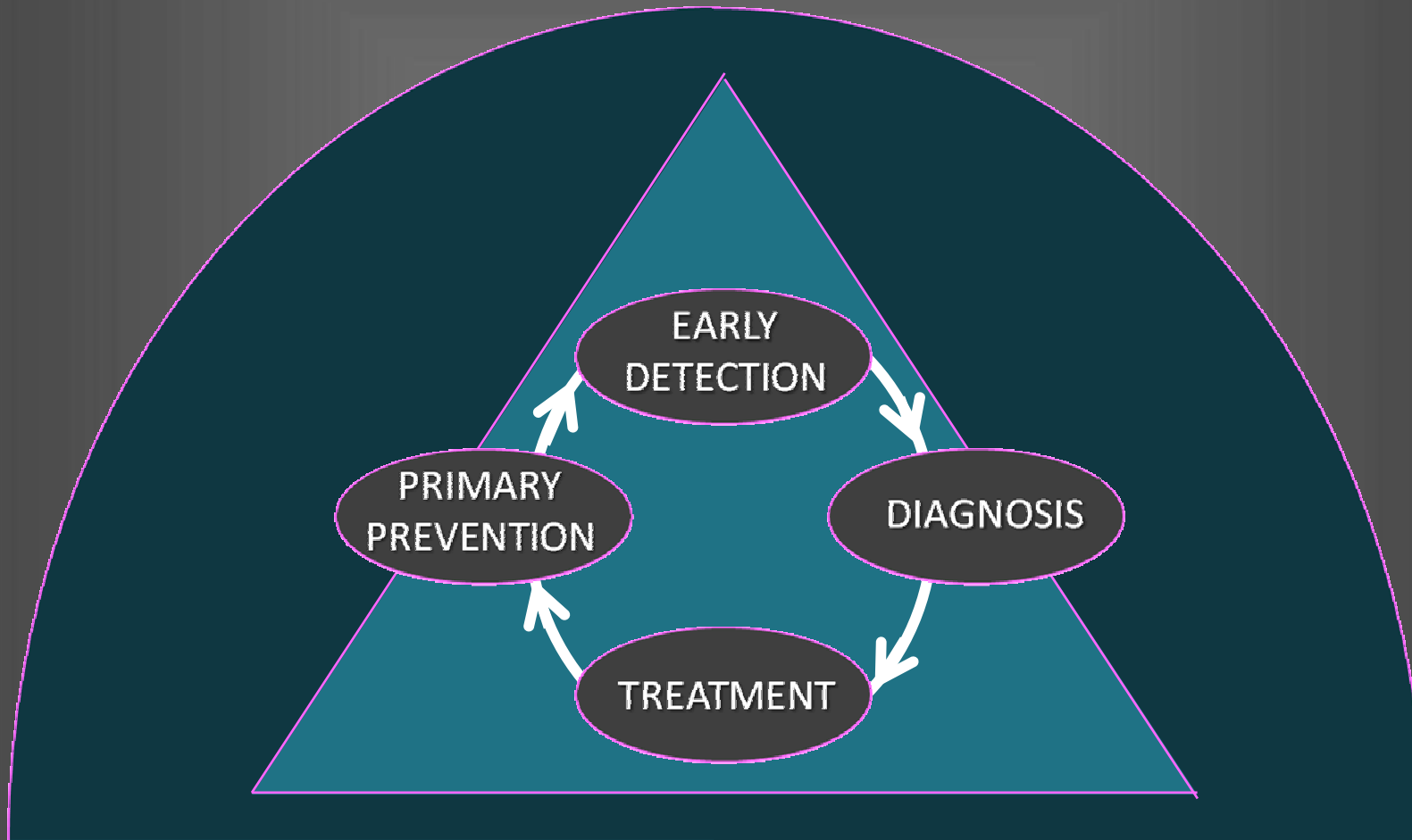
U.N. HUMAN RIGHTS LAW (1966)
INTERNATIONAL COVENANT ON

ECONOMIC, SOCIAL AND CULTURAL
RIGHTS (ICESCR), ARTICLE 12(1)

“The States Parties to the present
Covenant recognize the right of
everyone to the enjoyment of the
highest attainable standard of
physical and mental health.”



CANCER CONTROL GUIDELINES DISEASE-SPECIFIC APPROACH





BHGI GUIDELINE DEVELOPMENT

- Comprehensive guidelines by selected expert panels
- Consensus opinions based on evidence review
- Publication of a) consensus and b) individual manuscripts

GUIDELINE DEVELOPMENT SUMMITS:

Global Summit 2002: Health Care Disparities

Global Summit 2005: Resource Stratification

GUIDELINE VALIDATION SUMMITS:

Global Summit 2007: Guideline Implementation

Global Summit 2010: Healthcare Delivery



GLOBAL SUMMIT 2005 – BETHESDA

RESOURCE STRATIFICATION

- **Basic level:** Core resources or fundamental services necessary for any breast health care system to function.
- **Limited level:** Second-tier resources or services that produce major improvements in outcome such as survival.
- **Enhanced level:** Third-tier resources or services that are optional but important, because they increase the number and quality of therapeutic options and patient choice.
- **Maximal level:** Highest-level resources or services used in some high resource countries that have *lower priority* on the basis of extreme cost and/or impracticality.



BHGI GUIDELINE TABLES

HEALTH CARE SYSTEMS

Level of resources	Patient and Family Education	Human Resource Capacity Building	Patient Navigation	Cancer Care Facility	Breast Care Center
Basic	General education regarding primary prevention of cancer, early detection and self-examination Development of culturally adapted patient and family education services	Primary care provider education re breast cancer detection, diagnosis and treatment Nursing education re cancer patient management and emotional support Pathology technician education re tissue handling and specimen preparation Trained community worker	Field nurse, midwife or healthcare provider triages patients to central facility for diagnosis and treatment	Health facility Operating facility Outpatient care facility Pharmacy Home hospice support External consultation Pathology laboratory	Breast healthcare access integrated into existing healthcare infrastructure
Limited	Group or one-on-one counseling involving family and peer support Education regarding nutrition and complementary therapies	Nursing education re breast cancer diagnosis, treatment and pt management Imaging technician education re imaging technique and quality control Volunteer recruitment corp to support care	On site patient navigator (staff member or nurse) facilitates patient triage through diagnosis and treatment	Clinical information systems Health system network Imaging facility Internal pathology laboratory Radiation therapy	Breast Center with division, staff and breast imaging access Breast prostheses for mastectomy pts
Enhanced	Education regarding survivorship Lymphedema education Education regarding home care	Organization of national volunteer network Specialized nursing oncology training Home care nursing Physiotherapist & lymphedema therapist On-site cytopathologist	Patient navigation team from each discipline supports patient "handoff" during key transitions from specialist to specialist to ensure completion of therapy	Centralized referral cancer center(s) Radiation therapy: low energy linear accelerator, electrons, brachytherapy, treatment planning system	Multidisciplinary breast programs Oncology nurse specialists Physician assistants
Maximal		Organization of national medical breast health groups		Satellite (non-centralized or regional) cancer centers	

EARLY DETECTION

Level of resources	Public Education and Awareness	Detection Methods
Basic	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 + self-examination)	Clinical history and CBE
Limited	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	Diagnostic breast US +/- diagnostic mammography in women with positive CBE Mammographic screening of target group*
Enhanced	Regional awareness programs regarding breast health linked to general health and women's health programs	Mammographic screening every 2 years in women ages 50-69 [†] Consider mammographic screening every 12-18 months in women ages 40-49 [†]
Maximal	National awareness campaigns regarding breast health using media	Consider annual mammographic screening in women ages 40 and older Other imaging technologies as appropriate for high-risk groups [†]

DIAGNOSIS

Level of resources	Clinical	Imaging and Lab Tests	Pathology
Basic	History Physical examination Clinical breast examination (CBE) Tissue sampling for cancer diagnosis (cytologic or histologic) prior to initiation of treatment		Pathology diagnosis obtained for every breast lesion by any available sampling procedure Pathology report containing appropriate diagnostic and prognostic predictive information to include tumor size, lymph node status, histologic type and tumor grade Process to establish hormone receptor status possibly including genomic assessment of response to therapy Determination and reporting of TMI stage
Limited	US-guided FNAB of serologically suspicious axillary nodes Sentinel lymph node (SLN) biopsy with blue dye [†]	Diagnostic breast ultrasound (US) Plain chest and skeletal radiography Liver US Blood chemistry profile* Complete blood count (CBC)*	Determination of ER status by IHC Determination of margin status, DCIS content, presence of LVI Frozen section or touch prep SLN analysis §
Enhanced	Image guided breast sampling Preoperative needle localization under mammo and/or US guidance SLN biopsy using radiotracer [†]	Diagnostic mammography Specimen radiography Bone scan, CT scan Cardiac function monitoring	Measurement of HER-2/neu overexpression or gene amplification [†] Determination of PR status by IHC
Maximal		PET scan, MBI scan, breast MRI, BRCA1/2 testing Mammographic double reading	IHC staining of sentinel nodes for cytokeratins to detect micrometastases Pathology double reading Gene profiling tests

STAGE I

Level of resources	Local-Regional Treatment		Systemic Treatment (Adjuvant)		
	Surgery	Radiation Therapy	Chemotherapy	Endocrine Therapy	Biological Therapy
Basic	Modified radical mastectomy			Oophorectomy in premenopausal women Tamoxifen*	
Limited	Breast conserving surgery [†] Sentinel lymph node (SLN) biopsy with blue dye [†]		Classical CMF [†] AC, EC, or FAC [†]		†
Enhanced	SLN biopsy using radiotracer [†] Breast reconstruction surgery	Breast-conserving whole-breast irradiation as part of breast-conserving therapy [†]	Taxanes	Aromatase inhibitors LH-RH agonists	Trastuzumab for treating HER-2/ neu positive disease [†]
Maximal			Growth factors Dose-dense chemotherapy		

STAGE II

Level of resources	Local-Regional Treatment		Systemic Treatment (Adjuvant)		
	Surgery	Radiation Therapy	Chemotherapy	Endocrine Therapy	Biological Therapy
Basic	Modified radical mastectomy		Classical CMF [†] AC, EC, or FAC [†]	Oophorectomy in premenopausal women Tamoxifen*	
Limited	Breast conserving surgery [†] Sentinel lymph node (SLN) biopsy with blue dye [†]	Postmastectomy irradiation of chest wall and regional nodes for high-risk cases*			†
Enhanced	SLN biopsy using radiotracer [†] Breast reconstruction surgery	Breast-conserving whole-breast irradiation as part of breast-conserving therapy [†]	Taxanes	Aromatase inhibitors LH-RH agonists	Trastuzumab for treating HER-2/ neu positive disease [†]
Maximal			Growth factors Dose-dense chemotherapy		

LOCALLY ADVANCED

Level of resources	Local-Regional Treatment		Systemic Treatment (Adjuvant or Neoadjuvant)		
	Surgery	Radiation Therapy	Chemotherapy	Endocrine Therapy	Biological Therapy
Basic	Modified radical mastectomy		Preoperative chemotherapy with AC, EC, FAC or CMF [†]	Oophorectomy in premenopausal women Tamoxifen [†]	
Limited		Postmastectomy irradiation of chest wall and regional nodes*			§
Enhanced	Breast-conserving surgery Breast reconstruction surgery	Breast-conserving whole-breast irradiation as part of breast-conserving therapy	Taxanes	Aromatase inhibitors LH-RH agonists	Trastuzumab for treating HER-2/ neu positive disease [†]
Maximal			Growth factors Dose-dense chemotherapy		

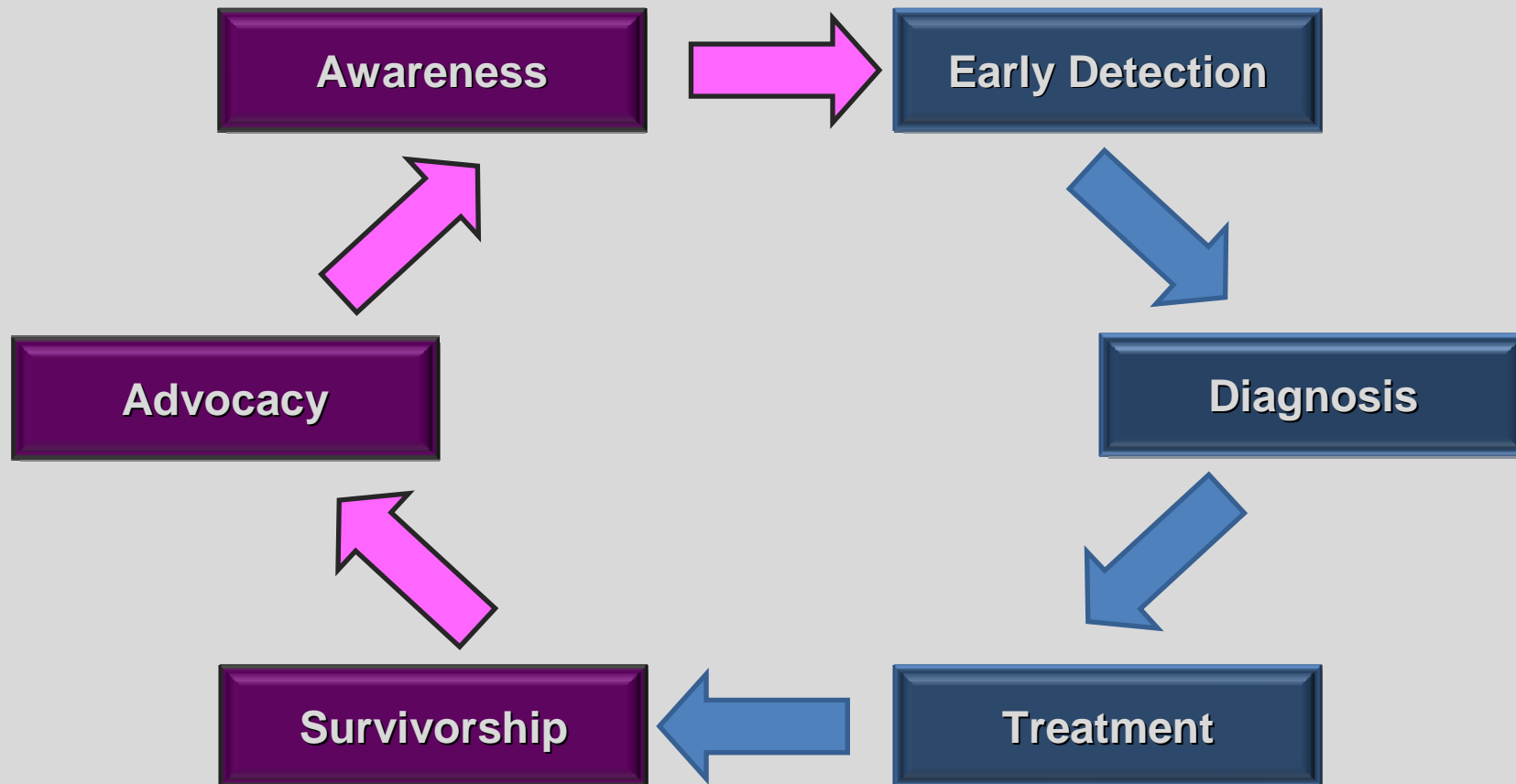
METASTATIC

Level of resources	Local-Regional Treatment		Systemic Treatment (Palliative)		
	Surgery	Radiation Therapy	Chemotherapy	Endocrine Therapy	Supportive Therapy
Basic	Total mastectomy for (ipsilateral) breast tumor recurrence after breast conserving surgery*			Oophorectomy in premenopausal women Tamoxifen [†]	Nonopioid and opioid analgesics and symptom management
Limited		Palliative radiation therapy	Classical CMF [†] Antracycline monotherapy or in combination [†]		
Enhanced			Sequential single agent or combination chemotherapy Trastuzumab Lapatinib	Aromatase inhibitors	Bisphosphonates
Maximal			Bevacizumab	Fulvestrant	Growth factors

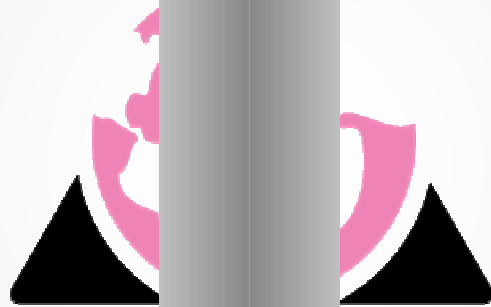


Public Participation

Health Care Delivery



THANK YOU



The Breast Health Global Initiative

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*Courtesy of Benjamin O. Anderson, M.D., Chair & Director Breast Health Global Initiative
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