

# Expanding breast cancer care through partnerships and innovation: experience from a South African public hospital

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The number of breast cancer cases at Groote Schuur Hospital (GSH) has almost doubled over the last 18 years. The GSH breast cancer team has developed new strategies to manage increasing demands on clinical resources at the hospital.

The annual number of newly diagnosed breast cancer patients utilising the Groote Schuur Hospital breast cancer service increased from 320 in 1999 to 608 in 2017. However, breast cancer resources did not improve over the period to offset this, thus there were increasing delays in diagnosis and treatment. Concerned breast clinicians have developed a multi-pronged strategy to increase capacity for breast cancer care by decreasing mammographic and surgical waiting times and streamlining patient visits to the clinic.

The entry point to the breast cancer service is through the Breast Clinic. In the absence of a same-day radiological service, large numbers of patients had to return for a second visit after their mammogram to discuss their results. To streamline visits, a virtual telephone clinic has been established that formally contacts women on a set day and time, improving efficiency for patients and the clinic. The mammographic waiting time has been improved from 20 - 24 weeks to 6 - 8 weeks through partnering with PinkDrive, a non-profit NGO that provides an additional 100 on-site mammograms per month. Project Flamingo, a non-profit

NGO and breast cancer advocacy group has assisted in reducing breast surgery waiting times from 14 weeks to 10 weeks by providing extra theatre lists on Saturdays and public holidays. Through this project, timely cancer surgery has been provided to over 400 women.

While there are still significant delays in this service, these strategies have prevented the potential collapse of an essential clinical service. Longer-term strategies include advocating for increased funding for public health facilities, and (as exemplified in these partnerships) harnessing breast cancer campaign resources to serve populations most in need. The recent focus on cancer care by the National Department of Health, and development of the Clinical Guidelines for Breast Cancer Control and Management, represent an opportunity to plan comprehensively for sustainable and coordinated breast cancer care.

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## Introduction

Breast cancer is the most common cancer affecting women in the Western Cape, and a significant cause of morbidity and mortality in South Africa. It is estimated that one in 33 women in South Africa will develop breast cancer in her lifetime.<sup>1</sup> Few preventive measures significantly decrease the risk of breast cancer, as modifiable risk factors such as smoking, alcohol use and obesity are minor contributors to overall breast cancer risk.<sup>2</sup> However, early stage of presentation has been linked to improved survival, making early detection and appropriate treatment the most effective strategies for improving outcomes.<sup>3</sup> In South Africa, limited breast symptom awareness<sup>4</sup> and inconsistent access to good-quality efficient breast diagnostic services<sup>5</sup> contribute to late-stage presentation. Delays in accessing treatment contribute further to breast cancer morbidity and mortality.

## Breast cancer care pathway

Breast cancer care begins with symptom awareness and presentation to primary-level health facilities. This first step is influenced by breast cancer knowledge and the effectiveness of public-awareness campaigns. Following awareness, effective breast cancer care requires access to efficient and reliable diagnostic services involving triple assessment, namely clinical evaluation, radiological evaluation, and tissue biopsy. Surgical, radiology and pathology teams staff these aspects respectively. After diagnosis, patients require staging investigations involving radiological, biochemical and nuclear medicine investigations. A multidisciplinary team (MDT) should discuss all aspects of care, including at least radiology, surgery, oncology and pathology, and present the agreed-on treatment plan to patients. Initial treatment is usually surgery or chemotherapy,<sup>6</sup> followed by radiotherapy,

endocrine therapy,<sup>7</sup> and where available, targeted biological therapy. Follow up, survivorship support and palliative care involve breast care nurses, advocacy groups, breast cancer survivor networks and palliative care specialists, as shown in Figure 1.

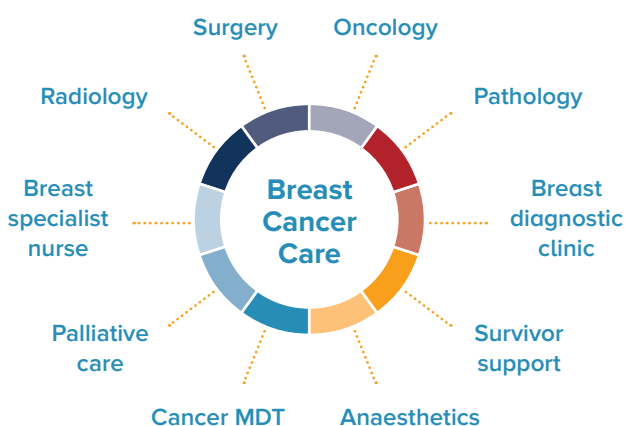
Treatment of women with breast cancer therefore involves a range of health workers engaged at different levels within the health system, from primary clinic symptom detection to tertiary hospital oncological services. Successful treatment relies on collaboration and co-ordination between all these role players. Conversely, backlogs and resource constraints at any one of these points will result in delays in the entire care pathway, with the potential to impact negatively on patient outcomes.

## Groote Schuur Hospital breast cancer service

Groote Schuur Hospital (GSH) is one of two tertiary hospitals providing breast cancer care in the city of Cape Town. It serves a population of approximately two million and offers the full spectrum of breast cancer care from diagnosis to oncological and palliative care. As shown in Figure 2, over the past 18 years new breast cancer cases at GSH have almost doubled, from 320 in 1999 to 608 in 2017. This rate of increase has been most significant in the last five years, with a 25% increase between 2013 and 2017. The reasons for this rapid increase may include population growth, greater breast cancer awareness, and health migration from other parts of the country and the continent. This doubling of the clinical workload has not been matched by an increase in resources at any of the points of service delivery, resulting in significant delays in diagnosis and treatment.

The aim of this chapter is to outline some of the strategies employed by the GSH breast cancer team to manage these increasing demands in the context of fixed clinical resources, and then to consider some of the longer-term and more sustainable interventions needed to resource breast cancer care nationally.

Figure 1: Role players in Groote Schuur Hospital breast cancer care



## Maintaining the service despite increasing patient numbers

Groote Schuur Hospital runs an open-access breast diagnostic clinic, the Breast Clinic (BC). This clinic sees between 120 and 150 patients weekly, of which 80 - 100 are new referrals and 40 - 50 are follow-up bookings. On average, 10 - 15 patients are diagnosed with breast cancer per clinic. The clinic is considered open access because although patients need a referral letter from a doctor or clinical nurse practitioner in the GSH catchment area, the

referring health worker does not need to follow the standard primary-secondary-tertiary referral pathway, no clinic bookings are required, and there is no restriction on access dependent on the contents of the referral letter. This system substantially decreases the time to access the clinic but also permits some filtering of patient symptoms at primary level. A trained specialist breast nurse monitors patient numbers at the clinic. Beyond a set point (usually 120 patients), the nurse assesses the urgency of referrals and either ensures that patients are seen immediately or that they get an appointment within three weeks. A team of clinicians then performs a clinical evaluation and refers patients for appropriate investigations.

At the index BC visit, breast biopsies are performed for all women aged over 25 years who have a clinically palpable breast lump, and mammography is requested for symptomatic women over 40 years. Fine needle aspiration biopsy is done in addition to core biopsies for women with suspicious breast lumps. The reason for cytology in addition to histology is to allow immediate onsite cytological assessment by a cytotechnologist. Provisional cytology results enable clinic staff to refer patients with positive cytology to an oncologist at the same clinic visit, thus reducing multiple hospital visits and permitting triaging of investigations into urgent and non-urgent streams.

In 2017, 7 536 patients were evaluated through the BC, and 608 were diagnosed with breast cancer. Figure 3 shows a snapshot of three months at the BC from January to March 2019 to provide a perspective on the resources required to run such a diagnostic clinic. Twenty-one per cent and 32% of patients needed ultrasonography and mammography respectively, and 31% required a core needle biopsy.

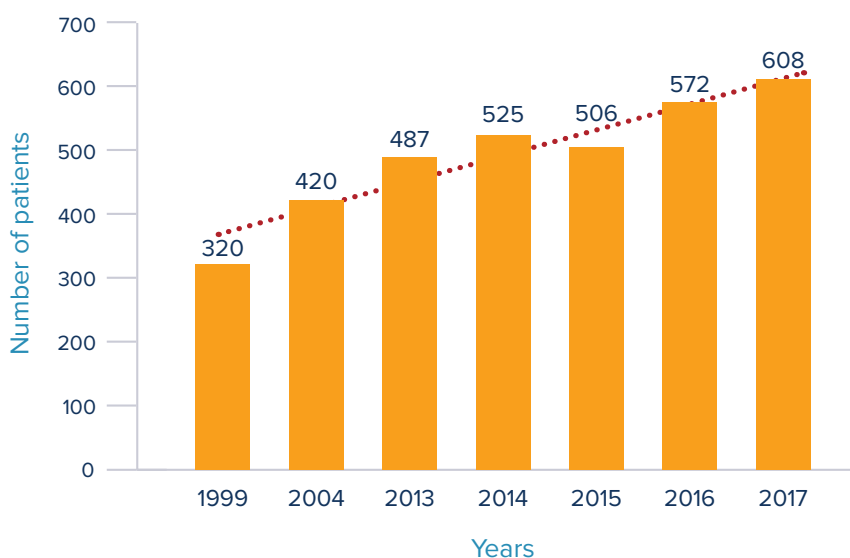
While the GSH BC runs an effective diagnostic service, it is a very busy clinic, as historically all breast diagnostic work was centralised at the tertiary hospital. The referral of women with breast symptoms to a one-stop breast-diagnostic clinic staffed by breast-trained health professionals is the international standard of care.<sup>8</sup> The advantages of this model are many, particularly if the clinic also presents few barriers to access. A focused BC means that women with benign disease can be confidently evaluated and discharged by experienced staff without unnecessary investigation. Clinicians who have been trained to do breast biopsies and who perform a high volume of these procedures have an improved accuracy rate, which results in fewer repeat biopsies.<sup>9</sup> On-site cytology permits same-day diagnosis for many women.

There are, however, some disadvantages to the current system. The centralisation of breast diagnostics to one hospital within the catchment area for GSH means long travel distances to the BC. There is also tremendous pressure on both the physical space and the staff at the clinic, particularly during peak attendance (October - January), following October Breast Awareness month. This fluctuation makes resource planning challenging in an open-access clinic. Finally, centralising diagnostic services may decapacitate peripheral clinics in terms of the diagnosis and management of breast conditions.

To maintain the advantages of an open-access, one-stop clinic in the face of increasing numbers and static resources, clinicians have employed the following three strategies in the service:

- A satellite BC was established at Mitchells Plain Hospital (MPH).

Figure 2 : Number of new breast cancer cases managed at GSH, 1999 - 2017



Source: Annual GSH Breast Clinic Reports, 1999 - 2017.

- The number of follow-up patients was reduced and emphasis was placed on new referrals.
- A virtual telephone clinic (TC) was established.

### Establishment of a satellite breast clinic

Mitchell's Plain Hospital is a relatively newly built district hospital that refers to GSH. As a new service located 30 km away, MPH was an ideal site for the establishment of a satellite BC. The aim was to establish a similar one-stop diagnostic clinic, with radiology and pathology services available on site. The clinic was started in May 2014, with the support of GSH management, National Health Laboratory Service cytotechnologists, and an NGO, PinkDrive, which provided on-site mammography. By 2017, the MPH BC had attended to 666 women with breast symptoms and diagnosed 35 women with breast cancer. The clinic continues to see between 600 and 800 patients per year.

Two key challenges were encountered in establishing a 'satellite' clinic. First was establishing a service in a facility lacking the required radiological infrastructure, primarily mammography, to complete a comprehensive patient assessment. This was circumvented by partnering with PinkDrive. While this partnership is very valuable, it remains intrinsically vulnerable to potential lack of funding or sudden loss of service and is not an ideal solution in the long term. The second challenge was 'psychological ownership' on the part of the receiving hospital with regard to the satellite clinic services.

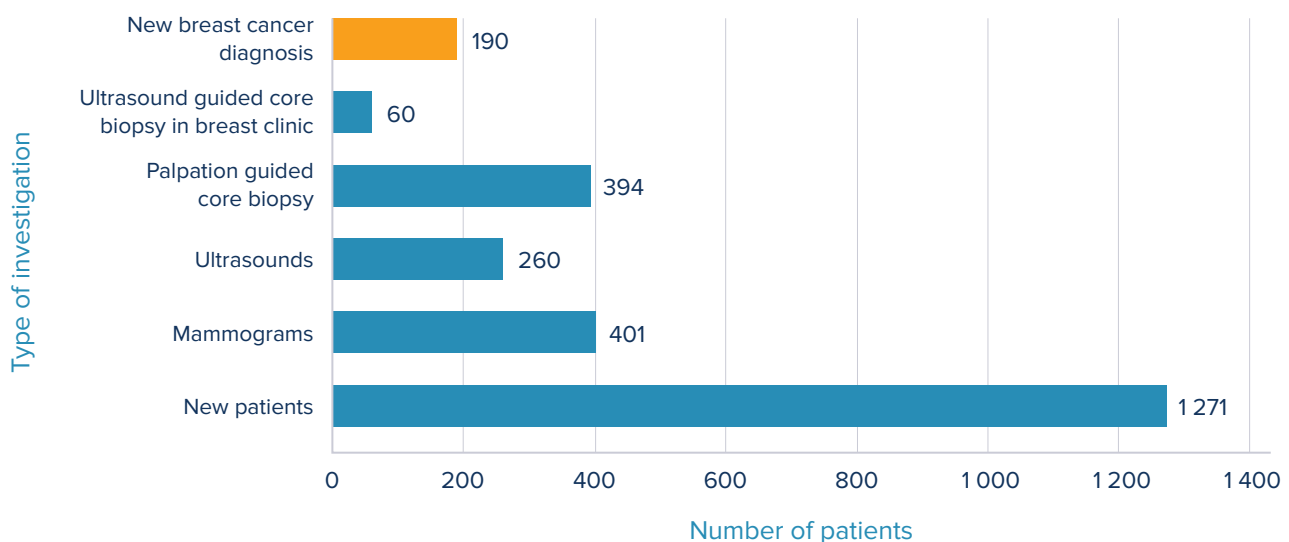
In the beginning, breast diagnosis was seen primarily as a service that GSH staff would deliver, and the resident clinical staff at GSH showed little engagement with the satellite clinic service. Over time, this attitude has shifted, and there has been much greater acceptance of the new BC clinic, with MPH staff taking pride in their clinic and ownership of HR requirements from within the hospital management structures.

### Reduced follow-up visits and emphasis on new referrals

An evaluation of BC attendance statistics revealed that many low-risk women were brought for regular follow-up visits for benign disease or mammography for mastalgia. To address this, new protocols were developed to risk-stratify women and allocate resources more appropriately. A published, validated risk-evaluation calculator (IBIS-score)<sup>10</sup> is used when special investigations are requested. In addition, patients returning for results of investigations are reviewed by surgical consultants in the BC who have at least six months' experience and who are able to evaluate confidently and discharge patients with benign disease.

As a result of these interventions, follow-up patient bookings decreased from 3 138 in 2015 to 2 419 in 2017, a 22% reduction. Total clinic numbers did not change (as shown in Figures 3 and 4) as there was a simultaneous increase in new patient numbers; however, this relative increase in new patient numbers was matched by an increase in the diagnosis of new breast cancers, validating the strategy to adjust the focus of the BC.

Figure 3 : Investigations and new cancer diagnoses at the GSH Breast Clinic, January - March 2019



Source: Annual GSH Breast Clinic Report, 2019.

### Introduction of the breast telephone clinic

Despite attempts to run a same-day diagnostic service, patients with clinically benign disease often receive a later date for mammogram and ultrasound, and a follow-up clinic appointment for results. As most patients at a symptomatic BC have benign disease, these results are often normal or reassuring. Drawing on the experience of other health systems,<sup>11,12</sup> a TC was established for selected patients to receive the results of their investigations.

Phoning patients with results or for appointments is usually fraught with problems. Clinicians may misplace folders or forget to call patients, and patient phone numbers are often captured incorrectly on the hospital record system. Also, many patients do not answer a random call from an unknown number or do not have access to their phones at the time they are called. To address these problems, the TC was established as a formally booked clinic on the hospital appointment system. A designated clerk was appointed by GSH to manage the TC by making all appointments and ensuring that a working phone number and correct contact details were available. The appointment is recorded on the standard hospital clinic card as a visual patient reminder and for workplaces with telephone restrictions. Two hospital telephones with direct outside lines were allocated to circumvent waiting for an outside line via the busy hospital exchange system.

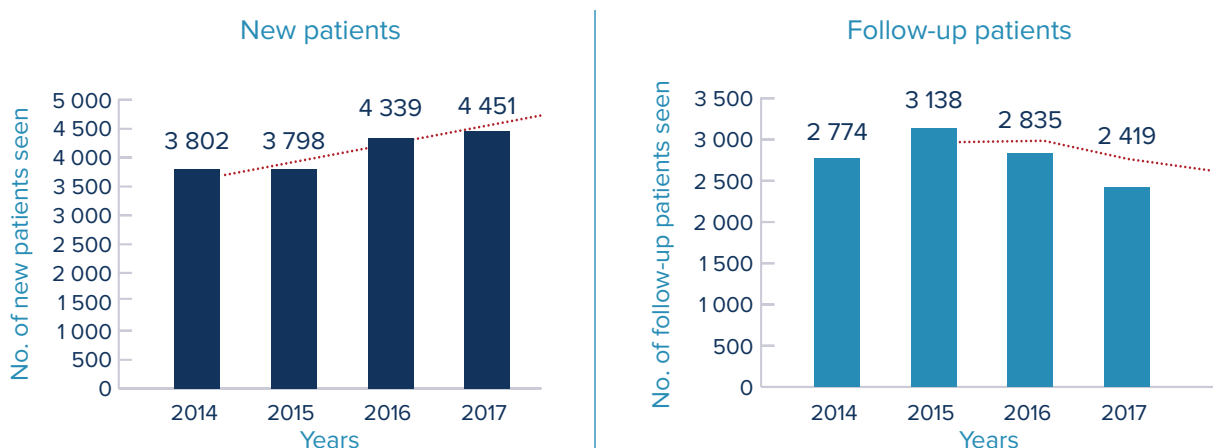
Only low-risk patients are selected for the TC as the aim is to convey anticipated benign or normal results. Clinical eligibility criteria for this category of patients is clearly documented and includes a normal clinical examination or clinically benign disease. Any patients undergoing a biopsy for suspected malignancy are excluded from the TC. The TC clerk collates folders and relevant reports for review

by a breast surgical consultant who makes an action plan to either discharge, follow up or recall patients. Surgical registrars are responsible for phoning patients at a set time and for recording each interaction in the patient's file.

The GSH TC was established in May 2018, with weekly bookings of 40 - 50 patients; with two registrars, the TC takes between 60 and 90 minutes to complete. A total of 1 857 patients have been booked into the TC since its establishment, and of these, 1 543 (83%) were contacted successfully. Patients not contactable on the first attempt are automatically booked into the next TC for a repeat call. If still not contactable, an SMS will be sent if the result is benign or normal. If follow up or further investigation is required, the breast nurse practitioner will be contacted. As a comparator, from September 2018 to March 2019, a total of 1 265 patients were booked for a physical BC clinic follow-up appointment. Of these, 309 (22.9%) did not attend.

However, aspects of this new system need to be improved. There is a high turnover of registrars through the BC and formal telephonic communication training has not been provided. In addition, not all GSH registrars are proficient in the three languages of the Western Cape: English, isiXhosa and Afrikaans. This raises the potential for miscommunication during a telephonic consultation. A quality-improvement study has not been done yet to evaluate how the TC is experienced by patients, and the accuracy of the information transmitted. This is necessary to assess whether the concept is safe and reproducible for other hospitals/clinical environments. In the longer term, phoning of patients could be shifted to trained nurse practitioners, a further motivation for training and recognition of this category of health workers.

Figure 4: Number of new and follow-up patients at the GSH Breast Clinic, 2014 - 2017



Source: Annual GSH Breast Clinic Report, 2019.

## Breast radiology – partnerships and new ultrasound skills

Mammography and ultrasound are critical to both the diagnosis and exclusion of breast cancer. At GSH, the radiology department is under tremendous pressure to support not only the diagnostic breast service but also the follow-up mammogram investigations for breast cancer patients. With finite human and technical resources, a backlog in mammography and ultrasound became inevitable as patient numbers increased. In response to this, the BC team, with support from GSH management, entered into partnership with two non-profit health companies: PinkDrive and Project Flamingo.

### PinkDrive mammography at GSH

PinkDrive is a health-sector NGO founded in 2009 to improve early detection of breast, cervical, prostate and testicular cancers. In 2011, mammogram waiting times at the GSH BC fluctuated between 16 and 24 weeks, depending on how busy the BC service was in the preceding months. PinkDrive was known in the province but was mainly engaged in providing mammograms to the public outside of a structured clinical service. The GSH clinical team engaged with PinkDrive to support the BC by providing mammograms on the hospital premises on clinic days. The number of mammograms done weekly has fluctuated over the years, but currently, PinkDrive provides approximately 100 mammogram bookings per month to support the GSH and MPH breast clinics. The total number of mammograms done in this partnership since 2011 is now 2 225, which by October 2018 brought the mammographic waiting time down to six weeks. Similar support for ultrasound at the hospital has been provided by PinkDrive since April 2019.

While this has been an extremely valuable partnership that has enabled timely diagnosis for hundreds of women, there are challenges to providing services through an NGO. Significant time and energy was spent setting up and maintaining the project. This included developing a memorandum of understanding to ensure that clinical records and mammographic images were integrated into the hospital system. Technical production of mammograms did not initially include a report on the findings. Thus, in the early years, these mammograms were reported on by GSH radiology staff who were already overburdened with their standard workload. Only in the latter years of the partnership was PinkDrive able to source funds to have mammogram reports done by contracted radiologists. This has been a great improvement but it has also introduced some complexities as the reporting is done off site and reports often take longer than in-house reports.

Although PinkDrive is in partnership with other public health facilities, it is unlikely that this model can be replicated throughout every breast service in the country, and an NGO-provided service will always be dependent on external

funding, making long-term sustainability a concern. In addition, provision of the mammogram machine does not necessarily include human resource capacity for reporting or for the ultrasounds that are often needed to complete the radiology report. Long-term solutions to the breast radiology crisis in the public sector must include capital investment in mammogram and ultrasound equipment as well as in human resources to perform and report on the investigations. If PinkDrive support should terminate for any reason, it will result in a major gap in our health service, which the public health system is unlikely to be able to fill.

Perhaps the most valuable contribution of PinkDrive has been to show that mobile breast imaging is a feasible option for taking breast diagnostic services to communities where they are most needed. If owned and serviced by the public health system, mobile diagnostic trucks could make breast diagnostic clinics a real possibility in district and secondary hospitals.

### Surgeon-performed breast ultrasound enabled by Project Flamingo fundraising

Clinician-performed ultrasound is becoming an essential adjunct to clinical breast examination. Surgeons and breast clinicians trained in ultrasound are enabled to provide a more comprehensive evaluation, and in the case of young women, there can be potential same-day assessment and often discharge. While most breast biopsies in the GSH BC are done by palpation, a proportion are referred for ultrasound-guided biopsy in the radiology department. Because of the potential advantages to having an ultrasound in the BC, two clinicians in the BC team underwent breast ultrasound training. After that, the only barrier to implementing this service was lack of an ultrasound machine.

Project Flamingo was founded in 2010 to support public hospitals in providing holistic and timely breast cancer care. The Project has two key strategies: enabling extra cancer surgical lists and providing 'pamper packs' (packs of essential toiletries and donated cosmetics) to women with breast cancer. In 2017, through close collaboration with the surgical team at GSH, Project Flamingo launched a successful campaign to raise funds for an ultrasound machine for the BC. Approximately 20 clinician-performed ultrasounds are now done weekly, and since April 2017, 963 point-of-care ultrasounds and 149 ultrasound-guided biopsies have been performed. Radiology biopsy slots are now reserved for more challenging cases involving either impalpable breast lesions or micro-calcifications requiring stereotactic biopsies.

Point-of-care ultrasound required ultrasound training of the surgeons in the clinic. While performing these ultrasounds has improved same-day diagnosis for women and decreased the wait for ultrasound-guided biopsies, it has meant that the surgeon performing these ultrasounds has not been able to evaluate patients in the clinic. To utilise the human resources in the clinic more effectively, breast



nurses and medical officers should also be trained in breast ultrasound, particularly as point-of-care ultrasound is rapidly becoming an adjunct to the clinical examination.

## Surgical services for breast cancer – the challenge of waiting times

Surgical operating lists are a scarce resource in most public health facilities. Groote Schuur only has capacity for four breast cancer operations per week, and fewer than this if breast reconstruction is undertaken. Over the last 15 years, the Breast Cancer MDT has increasingly referred patients to secondary hospitals for breast cancer surgery (after evaluation and treatment decision-making). Currently, 50% of all breast cancer surgery is booked at the three associated secondary hospitals, namely New Somerset Hospital, Mitchells Plain Hospital, and Victoria Hospital. However, capacity at the secondary hospitals to take on these operations is limited as breast-conserving surgery, breast reconstruction, and until recently, sentinel lymph node biopsy, cannot be performed outside the tertiary hospital.

### Project Flamingo breast cancer lists

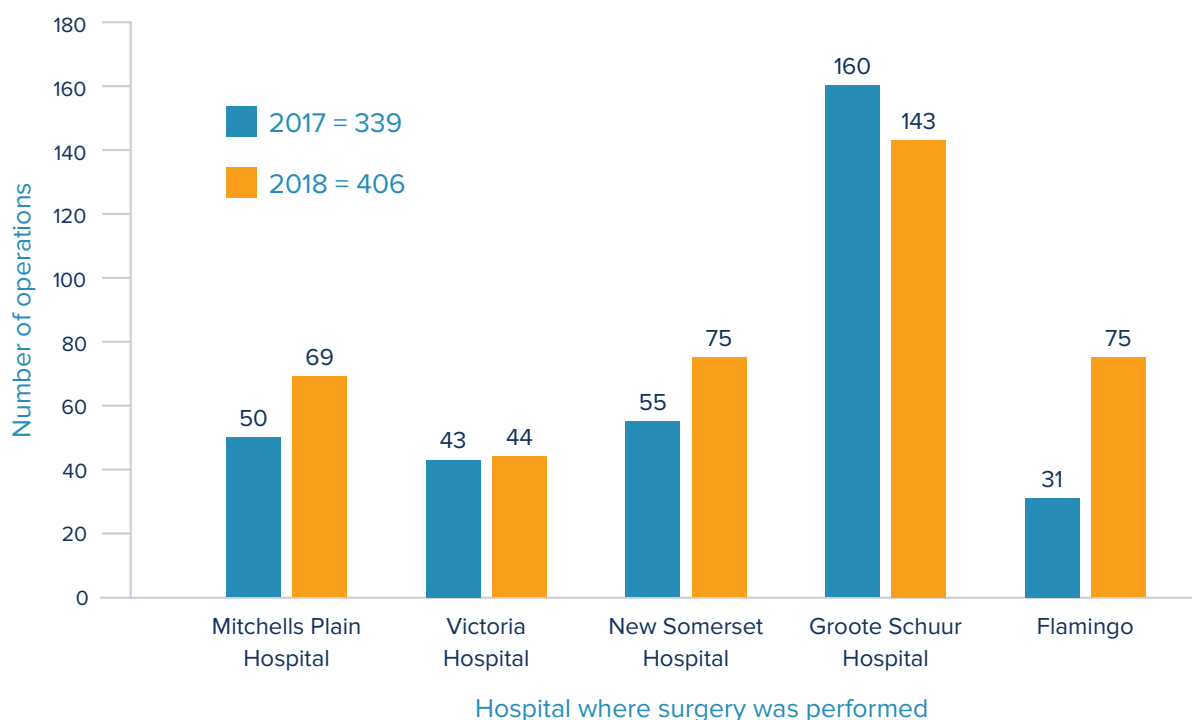
A summary of breast cancer surgeries performed at GSH and surrounding secondary hospitals is provided in Figure 5.

With the support of GSH management, the Breast Surgical Unit partnered with Project Flamingo to establish additional theatre lists. These were initially on public holidays or during hospital de-escalation periods in theatres not utilised on those days. For the first list in 2010, GSH provided the theatre space and consumables, Project Flamingo paid for a nursing theatre team for the day, and surgeons and anaesthetists volunteered their expertise and time. This model from the first list has been replicated, with minor modifications, over the last eight years.

When the Project Flamingo breast cancer lists were first initiated, the waiting time for surgery was 14 weeks. Currently a Project Flamingo list is performed on one Saturday of every month. In 2018, a total of 75 patients were operated on, and over the full period, 401 additional breast cancer surgeries have been done. This translates to approximately 100 additional full-day theatre lists. The current surgical waiting time is 10 weeks, still longer than the ideal time of 4 - 6 weeks, but without these lists the waits would now be 22 weeks, at which point the cancer in many women would be inoperable.

While the partnership with Project Flamingo has permitted us to improve our waiting times, arranging operating lists outside of the normal clinical work week has negative aspects. There is a significant additional administrative burden on clinical staff to bring patients in for these extra lists; nursing staff in the wards experience an additional load on what would normally be relatively quiet weekends or public holidays; and sourcing volunteer anaesthetists and

Figure 5 : Breast surgeries performed at GSH and secondary hospitals, 2017 - 2018



Source: Surgical Operative Database GSH.

surgeons requires constant attention. The clinical planning, risk and responsibility continue to lie with the surgeons and hospital staff. The partnership with Project Flamingo is valuable but it is potentially unsustainable as the work is primarily driven by volunteer surgeons and anaesthetists who already carry a heavy clinical workload.

## Conclusions

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This chapter has focused mainly on delays and resource constraints in the diagnosis and surgical care of breast cancer patients and the strategies that have been used to manage these in one particular service. It has not addressed the significant challenges faced in other aspects of treatment, such as chemotherapy and radiotherapy. These areas are also sites of ongoing work, including campaigning for better chemotherapeutic agents and decreasing radiotherapy waiting times through the appropriate use of hypofractionation schedules. Other innovative oncology strategies have been to revise staging investigation protocols to reduce unnecessary tests, and using the radiotherapy planning computed tomography (CT) scanner for breast cancer staging. A GSH Breast Cancer Working Group consisting of radiologists, pathologists, surgeons and oncologists has been established; this group meets regularly to discuss strategies to improve the systemic barriers to quality patient care at all levels of the system.

Improving efficiencies within the BC has prevented a collapse of the service under the increasing clinical load. Strategies such as ensuring standardised protocols for investigation and follow up and establishment of a satellite clinic have been necessary and timely interventions. Introduction of the TC has reduced multiple clinic visits for patients and allowed increased access to patients with new breast symptoms for evaluation. These strategies could potentially be implemented across a wide range of healthcare facilities. If properly implemented and quality assured, the TC in particular could impact positively on patient care in remote rural areas where transport and distance pose a barrier to follow-up but cellphone access is widespread.

Collaboration with various NPOs such as PinkDrive and Project Flamingo has assisted in supporting and maintaining the service in the face of a 5% annual increase in new cancers. These collaborations have also channelled some of the significant public and private resources raised for breast cancer directly into the public health system, with substantial benefits for patients most in need. The BC has also been fortunate in being actively supported by GSH leadership in the pursuit of these collaborations and in ensuring that appropriate oversight is maintained throughout.

While clinician-initiated strategies to cope with the burden of disease, and good-Samaritan efforts to support these strategies, should be applauded and supported, they should not replace a critical analysis of what is needed to deliver equitable and quality care throughout South Africa. The specific partnerships and relationships the BC has built in this one hospital may not be available to clinical services in rural communities or provinces with poor health system infrastructure. It should also be noted that despite these numerous efforts and collaborations, the GSH BC is still not delivering breast cancer care within the quality parameters set out both internationally and nationally.

The strategy of forming partnerships and the improved efficiencies described here can only hold the service for a limited time. Globally, cancer incidence continues to rise,<sup>13</sup> and cancer in the developing world is set to become the next major health crisis. Whereas in prior decades breast cancer was considered primarily a problem in affluent countries, in 2012 the majority of new breast cancer cases (53%) were among women in low- and middle-income countries.<sup>13</sup> South Africa is therefore set for a significant increase in cancer burden, for which we need to plan, as these patients will flow into breast cancer care systems such as the one at GSH that are already stretched beyond capacity.

## Recommendations

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In his inaugural State of the Nation Address on 16 February 2018, President Cyril Ramaphosa recognised the importance of the growing cancer epidemic and announced the initiation of strategies such as the National Cancer Campaign to address this. Importantly, the National Department of Health has recently completed the Clinical Guidelines for Breast Cancer Control and Management.<sup>14</sup> Clinicians need to engage actively with provincial and national Departments of Health to ensure that these excellent policies take concrete and practical form.

More specifically, at the diagnostic level, symptomatic, one-stop BCs should be established at all district and secondary hospitals to ensure that women with breast symptoms can be seen within the two-week timeframe suggested by the new South African breast cancer guidelines.<sup>14</sup> For treatment after diagnosis, a breast cancer care plan is needed that is not hospital or specialty based. A seamless flow is needed between district diagnostic services, regional surgical services, and tertiary oncology and multidisciplinary team services. This means approaching funding and resourcing of breast cancer care outside of the traditional silos of hospital and department funding to global costing based on the full pathway from diagnosis to palliative care. Critical to this co-ordination of care between the district/secondary diagnostic centres and tertiary hospital MDTs is the Breast Nurse Practitioner, whose training and employment is promoted by the new national breast cancer guidelines.<sup>14</sup>



Breast cancer care in South Africa receives significant support from the NGO sector and the broader public. These projects and fundraising initiatives have the potential to support the essential work of the public health system but need to be channelled into meaningful and sustainable partnerships. The NGO partnerships at GSH have undoubtedly had a meaningful impact on improving quality healthcare access. The next step is to integrate these resources systematically into our national health system to ensure equity and sustainability.

Hopefully the momentum created by the national focus on cancer will stimulate a vital collaboration between community organisations, primary, secondary and tertiary hospital leadership, the NGO sector, breast cancer survivor organisations and role players in provincial and national Departments of Health to ensure that breast cancer care is planned, coordinated, and appropriately resourced.

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