



The Breast Health Global Initiative

BCI2.5

2018 GLOBAL SUMMIT: IMPROVING BREAST HEALTH CARE THROUGH RESOURCE-STRATIFIED PHASED IMPLEMENTATION

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BREAST CANCER INITIATIVE 2.5

Making breast health a global priority

BCI 2.5 is a global campaign to reduce
disparities in breast cancer outcomes
for 2.5 million women



Initiating Partners

American Cancer Society

Susan G. Komen for the Cure

Breast Health Global Initiative

Harvard Global Equity Initiative

National Cancer Institute Center for Global Health

Norwegian Cancer Society

Pan American Health Organization (PAHO)

Union for International Cancer Control (UICC)

Women's Empowerment Cancer Advocacy Network (WE CAN)



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2018 GLOBAL SUMMIT

- Resource-Stratified Guidelines
- Guideline Adoption
- Phased Implementation



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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 2012: Supportive Care and QOL



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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.

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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 Trages patients to center 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 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 clinician, staff and breast imaging access Breast prostheses for mastectomy site
Enhanced	Education regarding survivorship Lymphedema education Education regarding home care	Organization of national volunteer network Specialized nursing oncology training Home care nursing Physiotherapy & 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 breast health groups		Satellite (non-certified 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 50-59 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 (cytology or histology) 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 type, lymph node status, histologic type and tumor grade Process to establish hormone receptor status precisely including empiric assessment of response to therapy Determination and reporting of TNM stage
Limited	US-guided FNAB of sonographically indeterminate axillary nodes Sentinel lymph node (SLN) biopsy with blue dye‡	Diagnostic breast ultrasound (US) Plain chest and skeletal radiography Lower US Breast chemistry profile† Complete blood count (CBC)†	Determination of ER status by IHC Determination of margin status, DCIS status, presence of US Frozen section or touch prep SLN analysis §
Enhanced	Image guided breast sampling Preoperative needle localization under mammogram and/or US guidance SLN biopsy using radiolabel	Diagnostic mammography Specimen radiography Bone scan, CT scan Cardiac function monitoring	Measurement of HER2/neu overexpression or gene amplification Determination of PR status by IHC
Maximal		PET scan, MRI scan, breast MRI, BRCA1/2 testing Mammographic double reading	IHC staining of sentinel nodes for cytokeratin 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 ^a	
Limited	Breast conserving surgery ^b Sentinel lymph node (SLN) biopsy with blue dye ^c		Classical CMF ^d AC, EC, or FAC ^d		e
Enhanced	SLN biopsy using radiolabel ^f Breast reconstruction surgery	Breast-conserving whole-breast irradiation as part of breast-conserving therapy ^g	Tamoxifen	Aromatase inhibitors LH-RH agonists	Trastuzumab for treating HER-2/neu positive disease ^h
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 radiolabel Breast reconstruction surgery	Breast-conserving whole-breast irradiation as part of breast-conserving therapy†	Tamoxifen	Aromatase inhibitors LHRH 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 4FAC, 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	Tamoxifen	Aromatase inhibitors LHRH agonists	Trastuzumab for treating HER2-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	Hormonal and opioid analgesics and symptom management
Limited		Palliative radiation therapy	Classical CMF† Antihormonal monotherapy or in combination		
Enhanced			Sequential single agent or combination chemotherapy Trastuzumab Lapatinib	Aromatase inhibitors	Biphosphonates
Maximal			Bevacizumab	Fulvestrant	Growth factors

9 Cancer: 113 (8 suppl), 2008

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BASIC LEVEL CARE (BHGI) TREATMENT (ALL STAGES)

- Surgical services:
 - Modified radical mastectomy
 - Breast conservation (radiation required)
- Systemic therapy (on WHO essential drug list 2011):
 - Tamoxifen (vs oophorectomy)
 - Cytotoxic therapy (CMF, AC, EC, FAC)
 - Pain management

10 Anderson, Cancer 113(8 suppl):2221, 2008

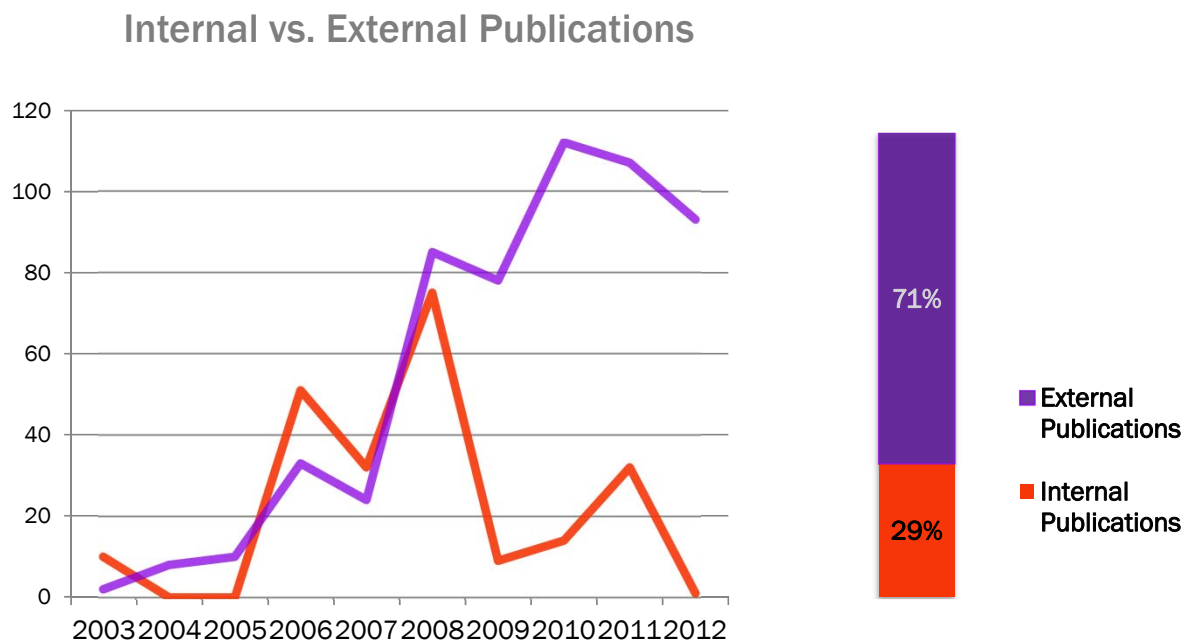
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Findings



1. Extent of citations over time

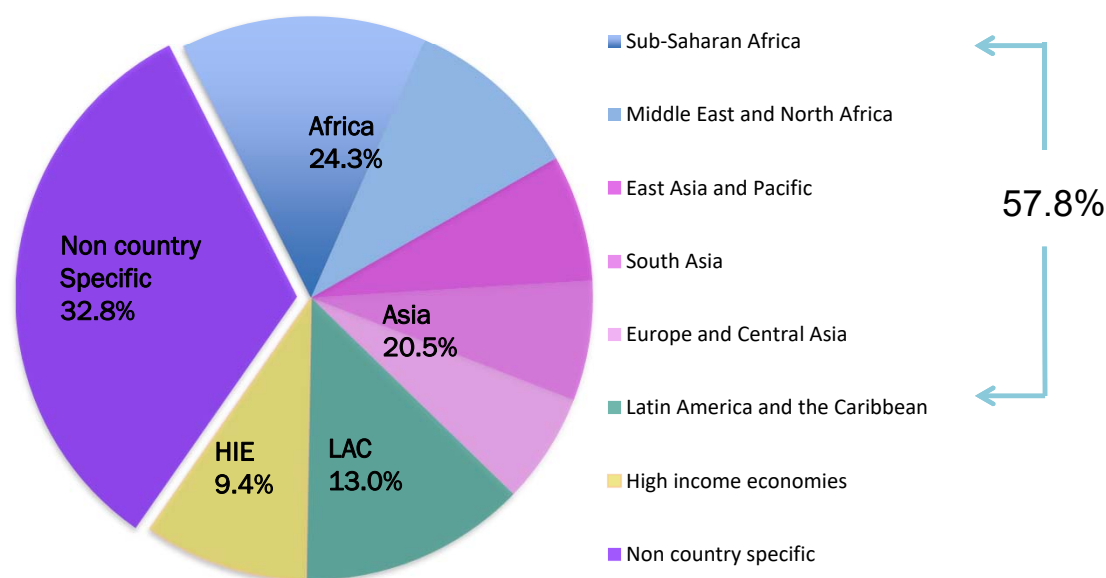


Findings



3. Uptake of the BHGI guidelines by region

Articles referencing BHGI guidelines by region
external publications only (n= 552)





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NCCN Framework for Resource Stratification of NCCN Guidelines (NCCN Framework™)



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Invasive Breast Cancer

Enhanced Resources (Preliminary)

Version 2.2017 — June 27, 2017

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NCCN Framework™

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NCCN Framework™: Visual Display of Framework


The NCCN Framework™ is represented as follows:

Black Text: Included recommendation

Gray Text: Withheld recommendation

Italicized Blue Text: Modified recommendation based on resource level

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PREOPERATIVE SYSTEMIC THERAPY FOR INOPERABLE OR LOCALLY ADVANCED BREAST CANCER (NON-INFLAMMATORY): WORKUP

CLINICAL STAGE	WORKUP
<p>Stage IIIA T0, N2, M0 T1, N2, M0 T2, N2, M0 T3, N2, M0</p> <p>Stage IIIA patients with T3, N1, M0 disease, see BINV-1</p>	<ul style="list-style-type: none"> • History and physical exam • Diagnostic bilateral mammogram; ultrasound as necessary • Pathology review^a • Determination of tumor ER/PR status and HER2 status^b • Genetic counseling if patient is high risk for hereditary breast cancer^c <ul style="list-style-type: none"> • Breast MRI^d (optional), with special consideration for mammographically occult tumors • Fertility counseling if premenopausal^e • Assess for distress^f <p>Additional studies consider:</p> <ul style="list-style-type: none"> • CBC • Comprehensive metabolic panel, including liver function tests and alkaline phosphatase • Chest diagnostic CT with contrast • Abdominal ± pelvic diagnostic CT with contrast or MRI with contrast • Bone scan or sodium fluoride PET/CT^h (category 2B) • FDG PET/CT^{i,j} (optional)
<p>Stage IIIB T4, N0, M0 T4, N1, M0 T4, N2, M0</p>	<p>• Bone scan or sodium fluoride PET/CT^h (category 2B)</p> <p>• FDG PET/CT^{i,j} (optional)</p>
<p>Stage IIIC Any T, N3, M0</p>	<p>• FDG PET/CT^{i,j} (optional)</p>

^aThe panel endorses the College of American Pathologists Protocol for pathology reporting for all invasive and noninvasive carcinomas of the breast. <http://www.cap.org>.

^bSee [Principles of HER2 Testing \(BINV-A\)](#).

^cSee [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian](#).

^dSee [Principles of Dedicated Breast MRI Testing \(BINV-B\)](#).

^eSee [Fertility and Birth Control \(BINV-C\)](#).

^fSee [NCCN Guidelines for Distress Management](#).

^hIf FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.


ⁱFDG PET/CT can be performed at the same time as diagnostic CT. The use of PET or PET/CT is not indicated in the staging of clinical stage I, II, or operable III breast cancer. FDG PET/CT is most helpful in situations where standard staging studies are equivocal or suspicious, especially in the setting of locally advanced or metastatic disease.

^jFDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.

Note: This is the NCCN Framework for Resource Stratification of NCCN Guidelines. For definitions of the NCCN Framework™, see page FR-1.
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PREOPERATIVE SYSTEMIC THERAPY FOR INOPERABLE OR LOCALLY ADVANCED BREAST CANCER (NON-INFLAMMATORY): WORKUP

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<p>Stage IIIB T4, N0, M0 T4, N1, M0 T4, N2, M0</p>	<ul style="list-style-type: none"> • Chest x-ray • Abdominal ultrasound • Plain radiograph of symptomatic bony sites
<p>Stage IIIC Any T, N3, M0</p>	<ul style="list-style-type: none"> • Chest x-ray • Abdominal ultrasound • Plain radiograph of symptomatic bony sites

[See Preoperative Systemic Therapy For Inoperable or Locally Advanced Breast Cancer \(Non-Inflammatory\) \(BINV-15\)](#)

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^bSee Principles of HER2 Testing (BINV-A).

^cSee NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian.

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^eSee Fertility and Birth Control (BINV-C).

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PREOPERATIVE SYSTEMIC THERAPY FOR INOPERABLE OR LOCALLY ADVANCED BREAST CANCER (NON-INFLAMMATORY): WORKUP

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<p>Stage IIIB T4, N0, M0 T4, N1, M0 T4, N2, M0</p>	<ul style="list-style-type: none"> • <i>Chest x-ray</i> • <i>Abdominal ultrasound</i> • <i>Plain Radiograph of symptomatic bony sites</i>
<p>Stage IIIC Any T, N3, M0</p>	<p><i>(No additional workup listed for Stage IIIC)</i></p>

^aThe panel endorses the College of American Pathologists Protocol for pathology reporting for all invasive and noninvasive carcinomas of the breast. <http://www.cap.org>.

^bSee Principles of HER2 Testing (BINV-A).

^cSee NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian.

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<p>Stage IIIB T4, N0, M0 T4, N1, M0 T4, N2, M0</p>	<div style="font-size: 2em; margin: 0;">→</div>	<div style="font-size: 2em; margin: 0;">→</div>
<p>Stage IIIC Any T, N3, M0</p>	<ul style="list-style-type: none"> Chest x-ray Abdominal ultrasound Plain Radiograph of symptomatic bony sites 	<div style="font-size: 2em; margin: 0;">→</div>

[See Preoperative Systemic Therapy For Inoperable or Locally Advanced Breast Cancer \(Non-Inflammatory\) \(BINV-15\)](#)

[See Locoregional treatment \(BINV-15\)](#)

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^bSee Principles of HER2 Testing (BINV-A).

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^fSee NCCN Guidelines for Distress Management.

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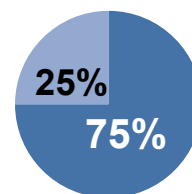
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NCCN Framework™: Cancer Frameworks 2018

- Currently online (75% of all cancers globally):
 - Adult Cancer Pain
 - Bladder Cancer
 - Breast Cancer
 - Cervical Cancer
 - Colon Cancer **NEW**
 - Esophageal and Esophagogastric Junction Cancers
 - Gastric Cancer
 - Head and Neck Cancers – Cancers of the Lip and Oral Cavity
 - Hepatobiliary Cancers
 - Kidney Cancer
 - Non-Small Cell Lung Cancer
 - Palliative Care
 - Pancreatic Cancer
 - Prostate Cancer
 - Rectal Cancer **NEW**
 - Uterine Neoplasms – Endometrial Carcinoma





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NCCN Harmonized Guidelines™ for Sub-Saharan Africa

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LOCOREGIONAL TREATMENT OF CLINICAL STAGE I, IIA, OR IIB DISEASE OR T3, N1, M0^k

Excision to negative margins with surgical axillary staging (category 1)^{l,m,n}
This pathway should only be followed if radiation therapy is available.

or

Total mastectomy^{**} with surgical axillary staging^{l,m,o} (category 1) ± reconstruction^p
or
If T2 or T3 and fulfills criteria for breast-conserving therapy except for sizeⁿ

<p>≥4 positive^q axillary nodes</p>	<p>Radiation therapy to whole breast with or without boost^r to tumor bed (category 1), infraclavicular region, supraclavicular area, internal mammary nodes, and any part of the axillary bed at risk (category 1). It is common for radiation therapy to follow chemotherapy when chemotherapy is indicated.</p>
<p>1–3 positive axillary nodes</p>	<p>Radiation therapy to whole breast with or without boost^r to tumor bed (category 1). Strongly consider radiation therapy to infraclavicular region, supraclavicular area, internal mammary nodes, and any part of the axillary bed at risk. It is common for radiation therapy to follow chemotherapy when chemotherapy is indicated.</p>
<p>Negative axillary nodes</p>	<p>Radiation therapy to whole breast with or without boost^r to tumor bed, and consider regional nodal radiation in patients with central/medial tumors or tumors >2 cm with other high-risk features (young age or extensive lymphovascular invasion [LVSI]). or Consideration of accelerated partial breast irradiation (APBI) in selected low-risk patients.^{r,s} It is common for radiation therapy to follow chemotherapy when chemotherapy is indicated.^t</p>

See BINV-4

See Locoregional Treatment (BINV-3)

Consider Preoperative Systemic Therapy Guideline (BINV-10)

^kIf axillary staging is not adequate, then follow the ration pathway for >4 positive axillary nodes.

^{**} If radiotherapy is not available then total mastectomy

^lSee NCCN Guidelines for Older Adult Oncology for special treatment considerations.

^lLevel I/II axillary dissection or See Surgical Axillary Staging (BINV-D).

^mSee Axillary Lymph Node Staging (BINV-E) and Margin Status in Infiltrating Carcinoma (BINV-F).

ⁿSee Special Considerations to Breast-Conserving Therapy Requiring Radiation Therapy (BINV-G).

^oExcept as outlined in the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian and the NCCN Guidelines for Breast Cancer Risk Reduction, prophylactic mastectomy of a breast contralateral to a known unilateral breast cancer is discouraged. When considered, the small benefits from contralateral prophylactic mastectomy for women with unilateral breast cancer must be balanced with the risk of

recurrent disease from the known ipsilateral breast cancer, psychological and social issues of bilateral mastectomy, and the risks of contralateral mastectomy. The use of a prophylactic mastectomy contralateral to a breast treated with breast-conserving therapy is very strongly discouraged.

^pSee Principles of Breast Reconstruction Following Surgery (BINV-H).

^qConsider imaging for systemic staging, including chest/abdominal ± pelvic diagnostic CT with contrast, bone scan, and optional FDG PET/CT (See BINV-1).

^rSee Principles of Radiation Therapy (BINV-I).

^sPBI may be administered prior to chemotherapy.

^tBreast irradiation may be omitted in patients ≥70 y of age with estrogen-receptor positive, clinically node-negative, T1 tumors who receive adjuvant endocrine therapy (category 1).


Note: This is the NCCN Harmonized Guidelines™ for Sub-Saharan Africa. For definitions, see page DEF-1.

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LOCOREGIONAL TREATMENT OF T1-3,N0-1,M0 DISEASE¹

Lumpectomy with surgical axillary staging (category 1)^{m,n,o}

This pathway should only be followed if radiation therapy is available.

or

Total mastectomy with surgical axillary staging^{m,n,p} (category 1) ± reconstruction^q

or

If T2 or T3 and fulfills criteria for breast-conserving therapy except for size^o

<p>≥4 positive^r axillary nodes</p>	→	<p>Radiation therapy to whole breast with or without boost^s to tumor bed (category 1), infraclavicular region, supraclavicular area, internal mammary nodes, and any part of the axillary bed at risk (category 1). It is common for radiation therapy to follow chemotherapy when chemotherapy is indicated.</p>
<p>1–3 positive axillary nodes</p>	→	<p>Radiation therapy to whole breast with or without boost^r to tumor bed (category 1). Strongly consider radiation therapy to infraclavicular region, supraclavicular area, internal mammary nodes, and any part of the axillary bed at risk. It is common for radiation therapy to follow chemotherapy when chemotherapy is indicated.</p>
<p>Negative axillary nodes</p>	→	<p>Radiation therapy to whole breast with or without boost^s to tumor bed, and consider regional nodal radiation in patients with central/medial tumors or tumors >2 cm with other high-risk features (young age or extensive lymphovascular invasion [LVI]).</p> <p>or</p> <p>Consideration of accelerated partial breast irradiation (APBI) in selected low-risk patients.^{s,t}</p> <p>It is common for radiation therapy to follow chemotherapy when chemotherapy is indicated.^u</p>

→ [See BINV-4](#)

→ [See Locoregional Treatment \(BINV-3\)](#)

→ [Consider Preoperative Systemic Therapy Guideline \(BINV-10\)](#)

¹See [NCCN Guidelines for Older Adult Oncology](#) for special treatment considerations.

^mSee [Surgical Axillary Staging \(BINV-D\)](#).

ⁿSee [Axillary Lymph Node Staging \(BINV-E\)](#) and [Margin Status Recommendations for DCIS and Invasive Disease \(BINV-F\)](#).

^oSee [Special Considerations to Breast-Conserving Therapy Requiring Radiation Therapy \(BINV-G\)](#).

^pExcept as outlined in the [NCCN Guidelines for Genetic/Familial High-Risk Assessment: Breast and Ovarian](#) and the [NCCN Guidelines for Breast Cancer Risk Reduction](#), prophylactic mastectomy of a breast contralateral to a known unilateral breast cancer is discouraged. When considered, the small benefits from contralateral prophylactic mastectomy for women with unilateral breast cancer must be balanced with the risk of recurrent disease from the known ipsilateral breast cancer, psychological and social

issues of bilateral mastectomy, and the risks of contralateral mastectomy. The use of a prophylactic mastectomy contralateral to a breast treated with breast-conserving therapy is very strongly discouraged.

^qSee [Principles of Breast Reconstruction Following Surgery \(BINV-H\)](#).

^rConsider imaging for systemic staging, including chest/abdominal ± pelvic diagnostic CT with contrast, bone scan, and optional FDG PET/CT (See [BINV-1](#)).

^sSee [Principles of Radiation Therapy \(BINV-I\)](#).

^tPBI may be administered prior to chemotherapy.

^uBreast irradiation may be omitted in patients ≥70 y of age with estrogen-receptor positive, clinically node-negative, T1 tumors who receive adjuvant endocrine therapy (category 1).

Note: This is the NCCN Harmonized Guidelines™ for the Caribbean. For definitions, see page DEF-1.

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

BINV-2

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2018 GLOBAL SUMMIT

- Resource-Stratified Guidelines
- Guideline Adoption
- Phased Implementation

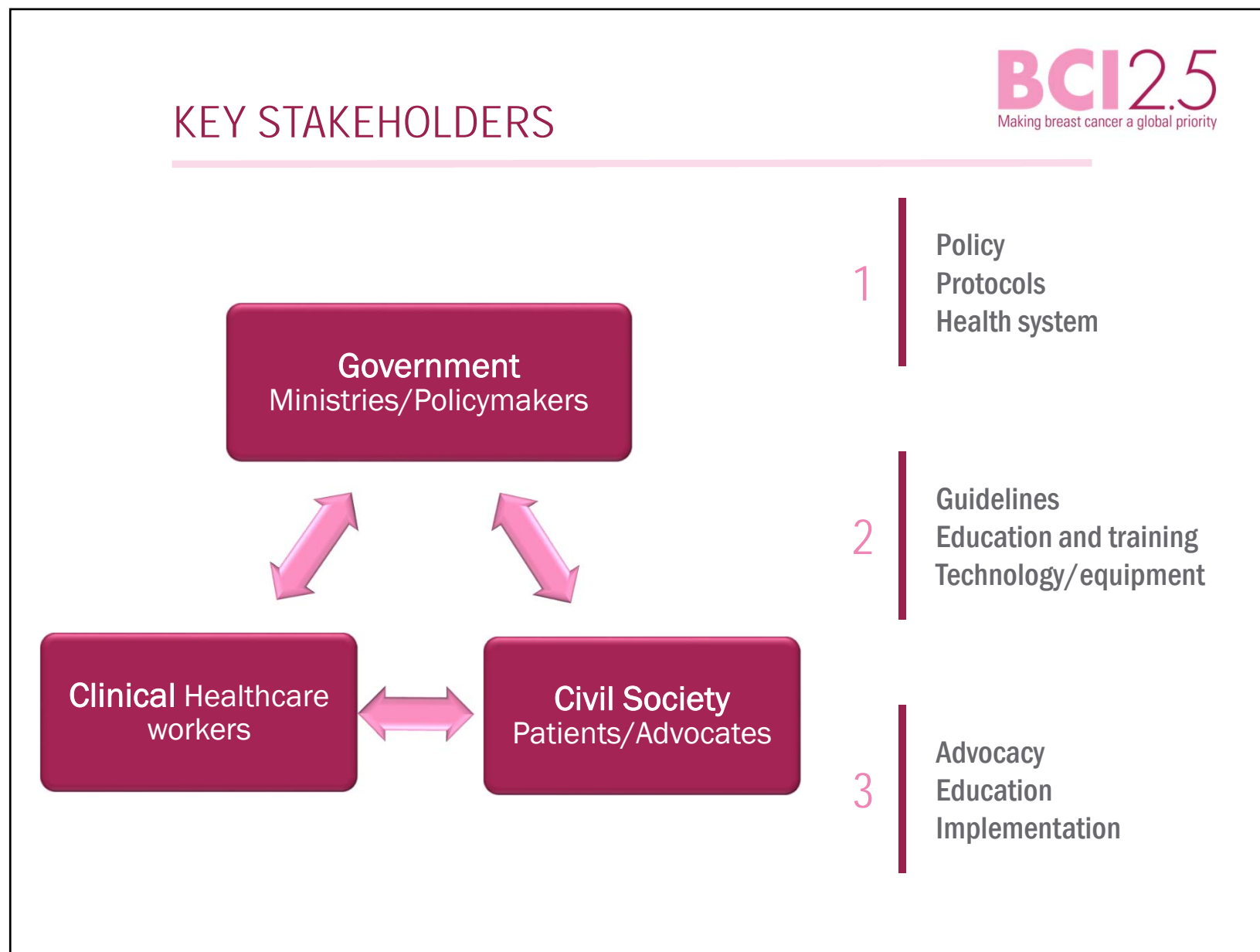


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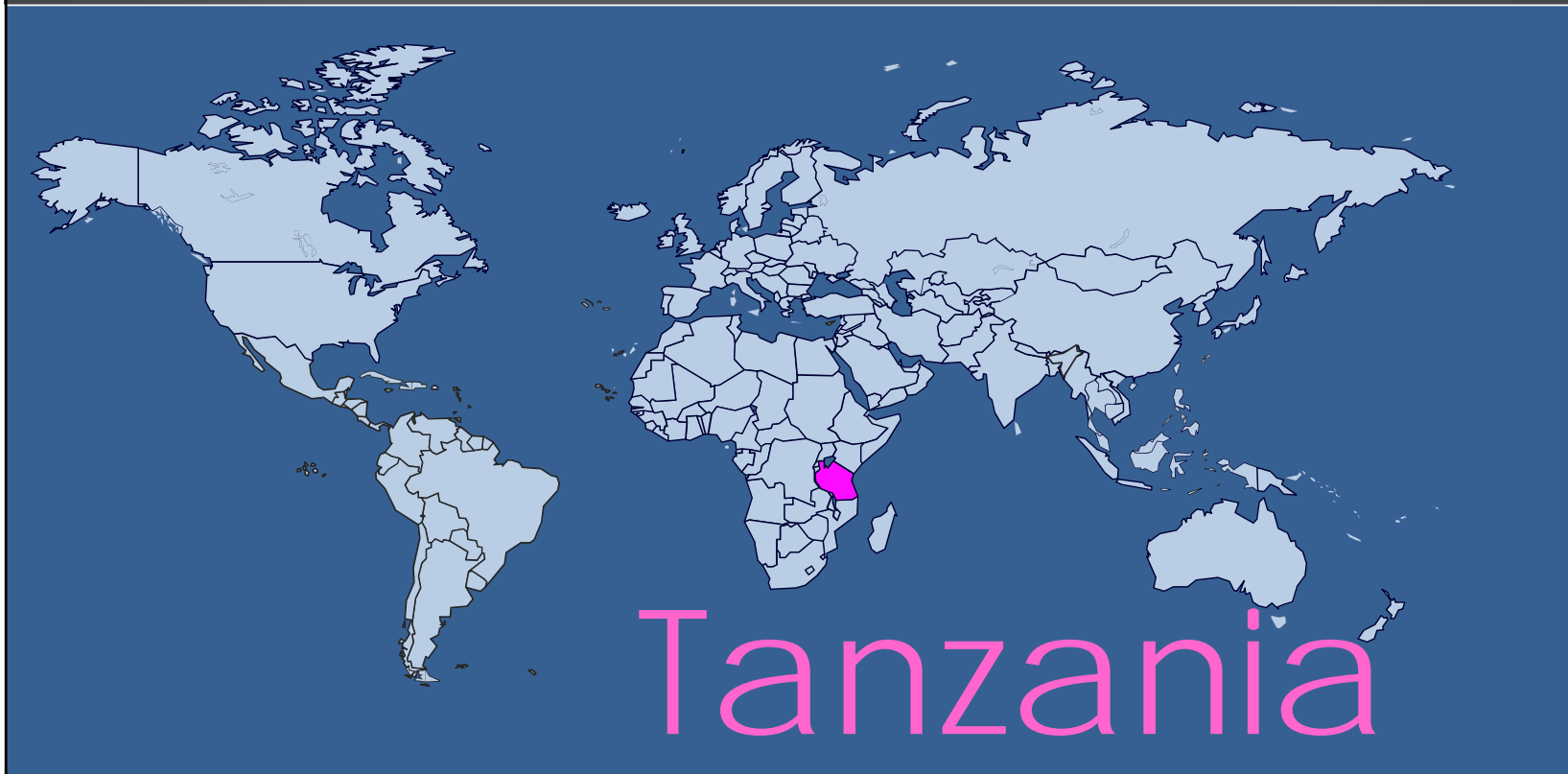
2018 GLOBAL SUMMIT

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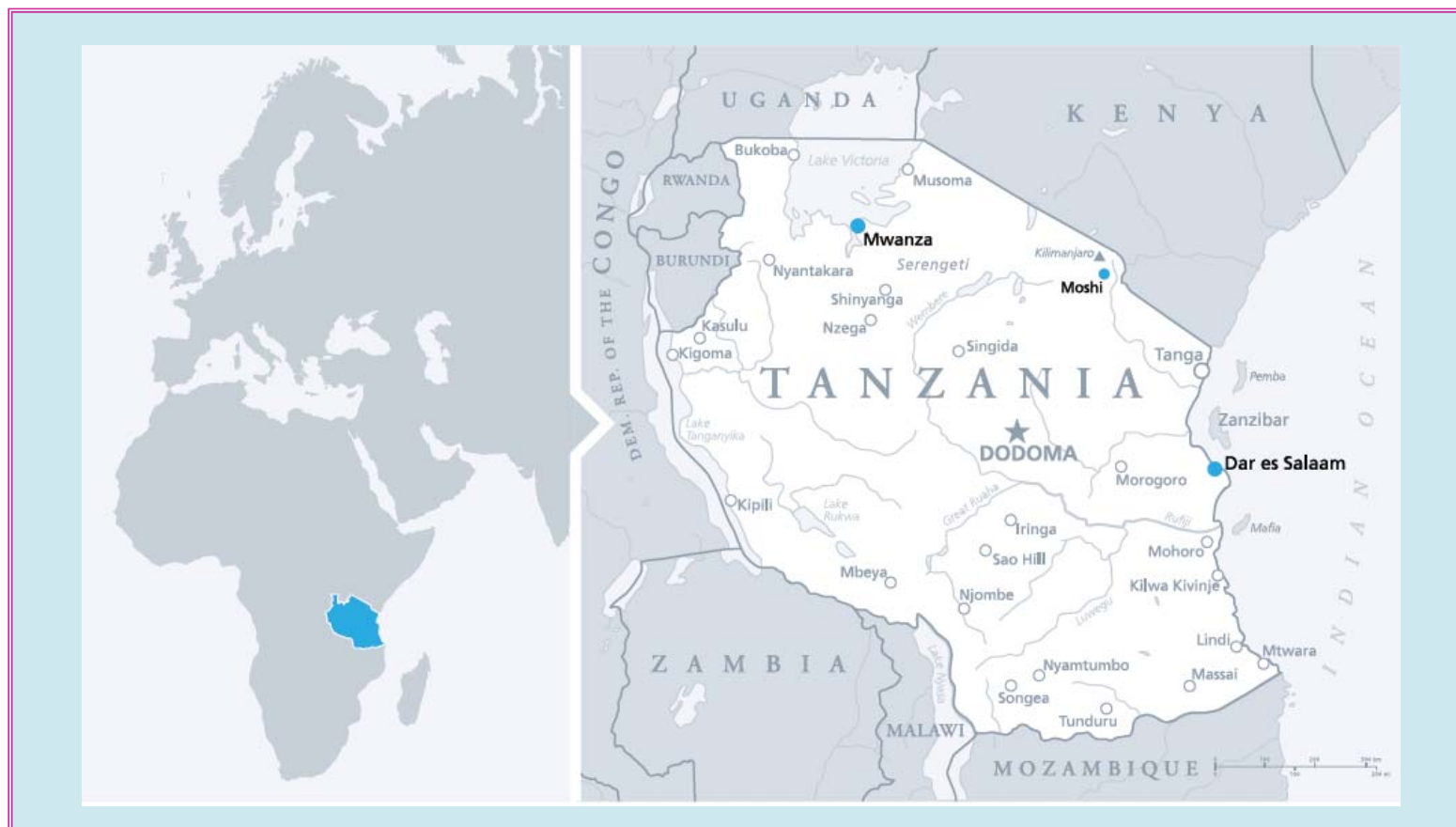
SITUATION ANALYSIS

LOW INCOME COUNTRY



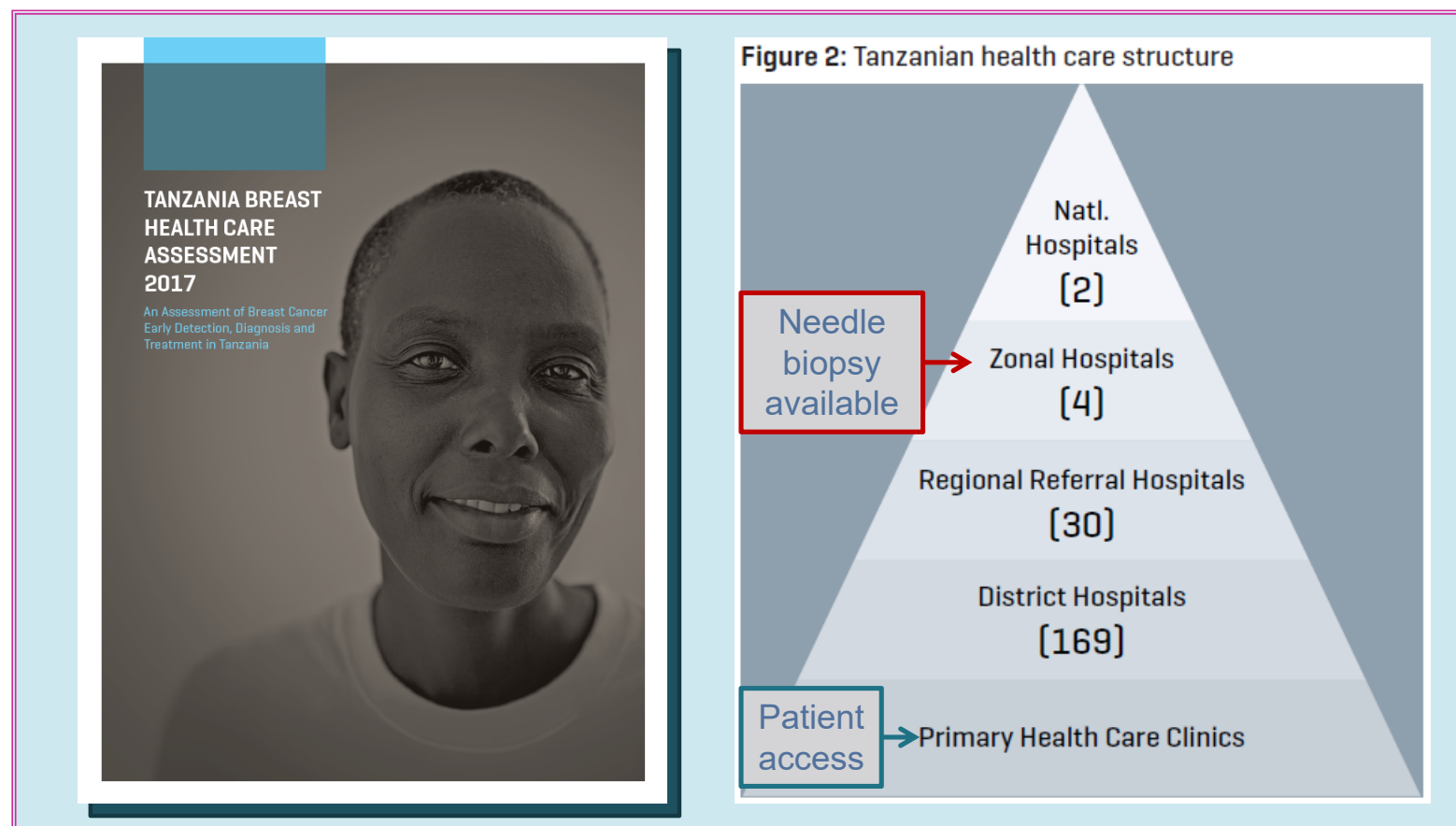
Tanzania Situation Analysis

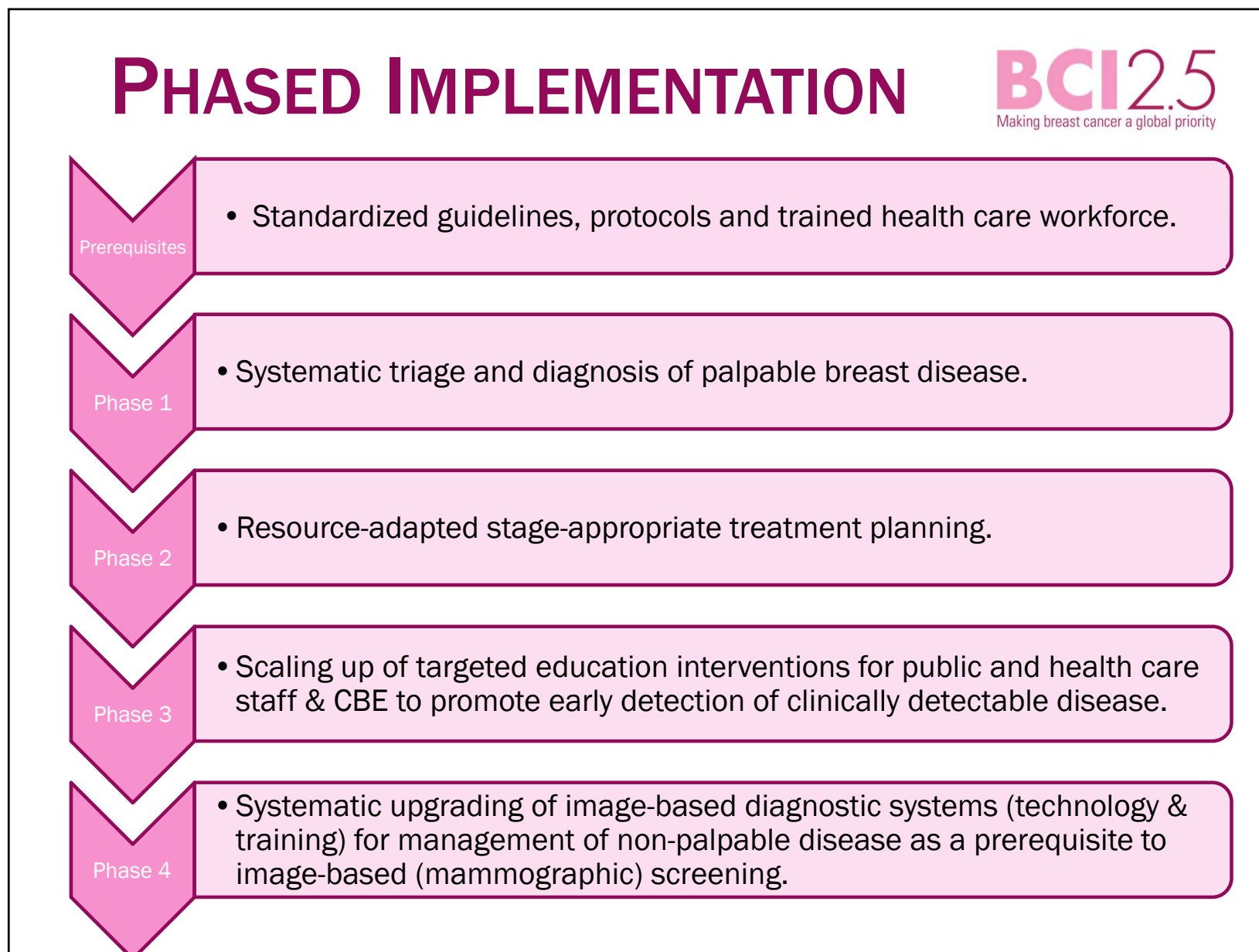
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Tanzania Situation Analysis

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LMC IMPLEMENTATION RESEARCH

LOWER-MIDDLE INCOME COUNTRY



Early Detection and Patient Triage

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Breast cancer care model



Photos courtesy of Ben Anderson

Regional Cancer Institute
(Trujillo)

- Mammography
- Pathology
- Surgery
- Chemotherapy
- Radiotherapy

La Fora Reference Hospital

- FNA

Health Centers

- Community education
- CBE

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Two phases

- **Phase 1:**
 - Pilot demonstration of the model of care.
- **Phase 2:**
 - National scale-up of the model.
 - Integration of post-treatment support for patients:
 - Clinical support at the local level for women who need follow-up care and monitoring.
 - Psychosocial support in the community.

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PHASED IMPLEMENTATION

BCI2.5
Making breast cancer a global priority



Improving Breast Health Care through Resource-Stratified Phased Implementation

A BHGI Global Summit

Seattle, Washington, USA | October 15-17, 2018

Day 1: Phased Implementation for Breast Cancer
Early Diagnosis

Day 2: Phased Implementation for Breast Cancer
Treatment and Supportive Care

Day 3: Integration of Breast Care Strategies into
Existing Health Systems



The Breast Health Global Initiative

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PHASED IMPLEMENTATION IN CANCER SUMMARY

- Early detection followed by breast cancer treatment improves breast cancer outcomes and survival.
- Resource-stratified guidelines provide a framework for prioritizing sustainable health care strategies.
- Phased implementation defines sustainable approaches that integrate into existing healthcare systems to improve outcome.



The Breast Health Global Initiative

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BCI 2.5 UW / HUTCH TEAM

- Allison Dvaladze
- Catherine Duggan
- Marisa Hartman
- Julie Gralow
- John Scheel
- Ruth Etzioni
- Ben Anderson











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