**OBJECTIVES**

THE PAST:
- Awareness of and access to comprehensive breast health care was limited and fragmented as was supportive care.

THE PRESENT:
- Twenty years post democracy health care in South Africa has seen increased awareness, access, treatment guidelines, supportive care, and service delivery.

THE FUTURE:
- Improving availability of the Big 5 in cancer care (awareness; access; treatment guidelines; supportive care, and service delivery) will improve comprehensive patient care.

**PATIENT DEMOGRAPHICS**

The majority of projects present in SA with advanced breast cancer (LABC) and are referred for palliative chemotherapy, LMC decreasing from 80-85% to the last 4 yrs.

- 61% stage 3 and 4
- 28% under age 45
- 8% under 35
- 12% over 75
- The units mirror the population demographics of urban Johannesburg
- 65% black patients; 10% white, 20% Asian (PAF, ITA)

The units see an average of 1500 cancer patients per year, 390-500 being non-urban patients in the government sector per year.

**BACKGROUND**

**Breast Reconstructive Unit (BRU)**

- 2008-2012
  - 500-700 pts per month
  - 3800 new pts per year
  - 40% consultation for free, or treatment for less than $4
  - 1555 cancer patients

**Navana Breast Centre (NBC)**

- 2009-2012
  - 14000 patients
  - 4000 Cancer patients (patients with medical insurance)

**METHODS**

- These multidisciplinary units (MDU) in Johannesburg, South Africa, are clinical delivery clones with different financial models.
- NOSCO caters for patients of higher income with medical funding, (HJBC) for low-income non-insured patients.
- The symbiotic relationship between the two units is an example of how a partnership between funded private healthcare and non-funded government service, can deliver quality multidisciplinary care for all.
- The units work closely with national and regional government, as well as with health departments of other Southern African countries.

**LONG WAVE OF HEALTH ADVOCACY**

- In South Africa surmounting physical barriers of affordability allows access to specialised units, whilst addressing the barriers of culturally based health beliefs.
- Higher unrest (including socio-economic disparities) at the start of the cancer journey translates to greater needs along the road.
- Government sector success needs honest management, dedicated clinicians and stringent evaluation of resource allocation.

**NAVIGATION FOCUS**

- Tolerable model of cross-cultural communication by our breast care navigators traverses cultural barriers.
- Breast navigators in today’s multi-cultural global villages should be versed in the clinical nuances of care.
- They should readily travel any cultural and language barriers allowing a better dialogue between patient, community and specialist.

**NOTES**

The units on an average of 1500 cancer patients per year, 390-500 being non-urban patients in the government sector per year.

**CONCLUSIONS**

**True Vegetable Soup**

- Partnerships should be initiated
- Public/private; local/international; academic/service oriented (medical learning) programs are more effective than vertical (lets show you best):
- Multi-disciplinary care should be a right for all patients.

**“Best breast practice is possible”**

This is what the NCBC collaboration ensures

- NCBC provides the opportunity to intense work done, collaborate with JH and learn as professionals who realize the need to improve health care systems in environments with daily challenges.
- Embrace the Big 3 of breast care.