

# Breast Cancer Factsheet: Insights & Key Developments

Key Insights on Breast Cancer Care and Infrastructure

## **Core Pillars:**

- 1. Infrastructure
- 2. Treatment Access, Research Funding and Awareness Campaigns
- 3. Survival Rates, Early Detection and Palliative Care
- 4. Utilization of Biomarkers
- 5. Clinical Guidelines
- 6. Reimbursement
- 7. Breast Cancer Screening

Breast cancer remains one of the most prevalent cancers worldwide, affecting millions of individuals each year. Despite advancements in diagnostics, treatment, and awareness, disparities in access to care, molecular testing, and specialized centers persist.

This factsheet provides a comprehensive overview of key pillars shaping breast cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Breast cancer incidence: 22.6% of all female cancers
- Incidence rate: 52.6 per 100,000 women per year
- Total cases (2020): Approximately 15,491 new cases
- Ethnic distribution:
- White women: Lifetime risk of 1 in 13
- African women: Lifetime risk of 1 in 81
- Lifetime risk in South Africa: 1 in 26 women
- Breast cancer deaths: 16% of all cancer deaths among women
- Most affected age group: Median age at diagnosis is 59 years



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Infrastructure

# Strengths

- Molecular testing and cancer care infrastructure is strong in academic hospitals and urban private clinics.
- Private sector offers comprehensive services including HER2, BRCA, and NGS testing in major cities.

# Opportunity

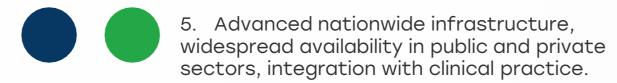
- Scale up diagnostic capabilities in the public sector through national laboratory initiatives.
- Expand public-private partnerships to extend access beyond urban centers.

#### Weakness

- Limited specialized cancer centers in rural and township areas lead to unequal access.
- Public hospitals lack consistent infrastructure for timely diagnostics and multidisciplinary care.

#### Threats

- Reliance on a dual health system risks widening disparities in cancer outcomes.
- Centralized facilities may become overburdened with rising incidence and migration from underserved areas.



4. Strong infrastructure in major hospitals and cancer centers, some regional disparities.

Moderate infrastructure, primarily in private settings or research institutions.

 Limited infrastructure, available only in select centers or for high-cost private testing.

> Minimal or no infrastructure, testing mostly unavailable or sent abroad.

Country	Specialized	Genetic & Molecular
o o di i ci y	Centers	Testing Infrastructure
South Africa		
Kenya		
Nigeria		
Egypt		
Morocco		
Algeria		
Ethiopia		
India		
Japan		
South Korea		
China		
Thailand		
Singapore		
United Kingdom		
Germany		
France		
Netherlands		
Sweden		
Italy		
Spain		
Poland	<u> </u>	0
Mexico		
Brazil	<u> </u>	0
Argentina	<u> </u>	<u> </u>
Chile	$\bigcirc$	<u> </u>
Colombia		
United States		
Canada		
Australia		
New Zealand		
Greece		0
Rwanda		
Uganda		
Serbia		<u> </u>
Saudi Arabia	<u> </u>	0
UAE		<u> </u>
Syria		
Indonesia		
Vietnam		
Philippines		
Russia		



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Treatment Access, Research Funding and Awareness Campaigns

# Strengths

- Urban private hospitals offer advanced therapies, including targeted HER2 treatments.
- Awareness campaigns by CANSA and PinkDrive support early detection and community outreach.

# Opportunity

- Strengthen local research and trial infrastructure through international collaboration.
- Increase public education efforts in rural areas and integrate awareness into primary care.

#### Weakness

- Public sector patients face delays in diagnosis and limited access to novel treatments due to cost.
- Breast cancer research funding remains low and dependent on external partnerships.

- Rising therapy costs could further restrict public sector access to modern treatments.
- Low awareness and healthcare engagement in underserved communities may delay detection.

- underfunded. Patients often face long wait times or financial barriers.
- 1. Poor infrastructure with severe barriers to treatment, little to no research funding, and lack of structured awareness campaigns. Cancer care is largely inaccessible, with many patients relying on out-of-pocket expenses or external aid.

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5. Strong healthcare infrastructure with comprehensive treatment access, high research funding, and nationwide awareness campaigns. Patients have access to advanced therapies, clinical trials, and widespread early detection programs.	
4. Well-developed system with good treatment availability, strong research funding, and effective but regionally focused awareness campaigns. Some disparities may exist in rural areas or between public and private sectors.	
3. Moderate development, with specialized treatments available in major hospitals, research funding concentrated on specific cancers, and occasional but limited awareness efforts. Healthcare access may be restricted by cost or geography.	
2. Limited system where cancer treatment is available only in select urban centers, research funding is minimal or sporadic, and awareness campaigns are rare or underfunded. Patients often face long wait times or	

Country	Treatment Access	Research Funding	Awareness Campaigns
South Africa	<u> </u>	<u> </u>	<u> </u>
Kenya			
Nigeria			
Egypt	<u> </u>	<u> </u>	0
Morocco			
Algeria			
Ethiopia			
India		<u> </u>	
Japan			
South Korea			
China			
Thailand			
Singapore			
United Kingdom			
Germany			
France			
Netherlands			
Sweden			
Italy			
Spain			
Poland	<u> </u>	<u> </u>	0
Mexico			
Brazil		$\bigcirc$	
Argentina		<u> </u>	
Chile			
Colombia			
United States			
Canada			
Australia			
New Zealand			
Greece	$\bigcirc$	<u> </u>	<u> </u>
Rwanda			
Uganda			
Serbia	<u> </u>	<u> </u>	<u> </u>
Saudi Arabia		0	0
UAE		0	0
Syria			
Indonesia	<u> </u>	•	0
Vietnam	<u> </u>	•	0
Philippines	<u> </u>	•	0
Russia			<u> </u>



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Survival Rates, Early Detection and Palliative Care

# Strengths

- Five-year survival
  >80% in private
  sector due to early
  diagnosis and
  multidisciplinary care.
- Mobile mammography programs like PinkDrive reach underserved women.

# Opportunity

- Expand integration of palliative care into primary health clinics and train more professionals.
- Scale up mobile screening and community-based education to boost earlystage diagnoses.

#### Weakness

- Survival in public hospitals can drop to ~50% due to latestage diagnosis and delayed treatment.
- Only 16% of patients needing palliative care have access, and services remain fragmented.

#### **Threats**

- Ongoing workforce shortages threaten scaling of palliative care and early detection services.
- Persistent inequality in care access may hinder national improvements in survival rates.



5. High survival rates, strong early detection programs, and well-established palliative care services. Patients have access to timely diagnosis, advanced treatments, and comprehensive end-of-life care.



4. Good survival rates, effective early detection efforts, and accessible but regionally limited palliative care. Some disparities may exist in rural areas or for specific cancer types.



3. Moderate survival rates, early detection available but not widespread, and palliative care services mainly in urban centers. Some patients experience delays in diagnosis or limited end-of-life care.



2. Low survival rates, early detection efforts are inconsistent or underfunded, and palliative care is minimal or only available in select hospitals. Cancer patients face significant access barriers.



1. Very low survival rates, poor early detection infrastructure, and almost no palliative care services. Many patients are diagnosed late and lack proper support for pain management and end-of-life care.

Country	Survival Rates	Early Detection	Palliative Care
South Africa	<u> </u>	0	0
Kenya			
Nigeria			
Egypt	<u> </u>	0	<u> </u>
Morocco	<u> </u>	0	0
Algeria			
Ethiopia			
India	<u> </u>	0	<u> </u>
Japan			
South Korea			
China	<u> </u>	0	<u> </u>
Thailand	<u> </u>	0	<u> </u>
Singapore			
United Kingdom			
Germany			
France			
Netherlands			
Sweden			
Italy			
Spain			
Poland			
Mexico			
Brazil			
Argentina			
Chile			
Colombia		<u> </u>	
United States			
Canada			
Australia		0	0
New Zealand	0	0	0
Greece	<u> </u>	0	<u> </u>
Rwanda			
Uganda			
Serbia	<u> </u>	<u> </u>	<u> </u>
Saudi Arabia			
UAE			
Syria			
Indonesia	$\bigcirc$	0	0
Vietnam	<u> </u>	0	0
Philippines			
Russia			



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Utilization of Biomarkers

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## Strengths

- HER2, ER, and PR testing widely available in tertiary and private hospitals, with ~70-80% coverage in urban centers.
- NHLS and academic institutions are investing in improving diagnostic coverage.

# Opportunity

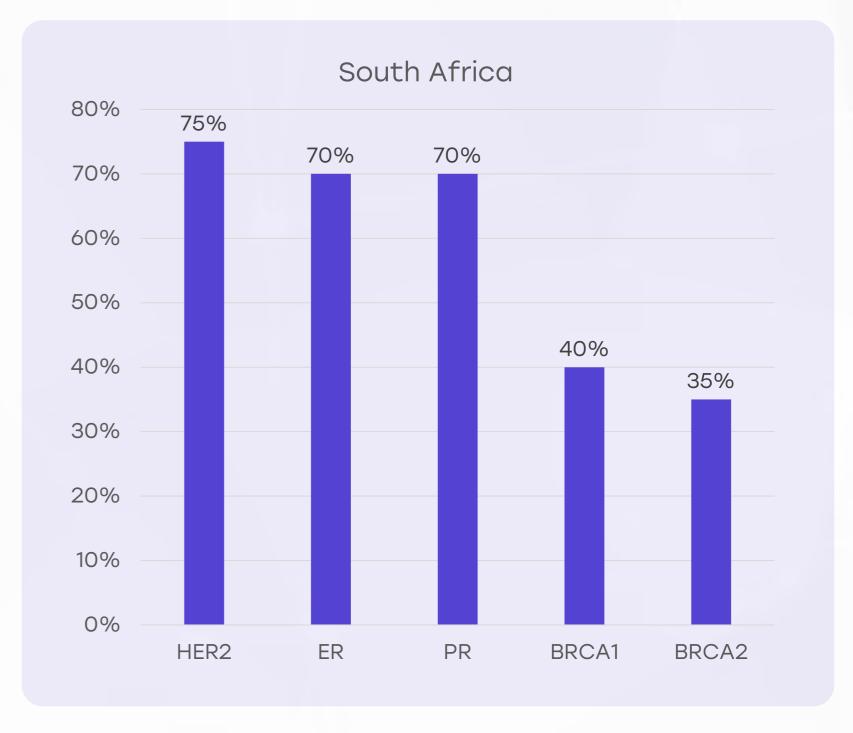
- Expand NHLS infrastructure and subsidize biomarker testing for public sector patients.
- Develop national protocols to standardize biomarker use across sectors.

## Weakness

- Biomarker testing is often delayed or inaccessible in public hospitals due to infrastructure gaps.
- BRCA testing is underutilized and geographically concentrated in large cities.

- Cost barriers and limited lab capacity may prevent full implementation of precision medicine.
- Continued urban-rural disparity in testing could entrench outcome differences.

- 5. 80% Biomarker testing is widely available and routinely performed as part of standard clinical practice. Strong integration into treatment decisions, with national coverage and reimbursement ensuring accessibility.
  - 4. 61-80%. Biomarker testing is commonly used, but access may be limited in certain regions or patient groups. Some disparities exist in coverage or affordability, but it is still a crucial part of cancer diagnostics
  - 3. 41-60% Moderate utilization, often restricted to major hospitals or private healthcare settings. Some patients may not receive biomarker testing due to cost or limited availability in public healthcare systems.
  - 2. 20-40% Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.
  - <20% Biomarker testing is rarely performed, often due to lack of infrastructure, awareness, or financial barriers. Patients typically do not receive targeted therapies based on biomarker status.





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**Clinical Guidelines** 

## Strengths

- South Africa has national guidelines aligned with ESMO/NCCN recommendations.
- Academic centers in major cities follow current protocols for HER2positive treatment.

# Opportunity

- Train primary care providers and public sector oncologists on HER2-positive protocols.
- Develop simplified, resource-stratified guidelines adapted for lower-resource settings.

#### Weakness

- Implementation is uneven; many public hospitals lack capacity for consistent application.
- Limited CME and clinical support for updating practitioners outside academic settings.

- Inconsistent application of guidelines may lead to non-standardized care pathways.
- Resource constraints may delay updates or full implementation of new treatment algorithms.



	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	*	*	0	*	*
Feasibility of Integration	×	×	0	×	*
Adoption of International Guidelines	*	*	0	*	*
Engagement with Updates	*	×	*	0	*
ESMO Guidelines Implementation	*	*	0	*	*



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Reimbursement



- Private sector offers broad coverage through medical aid schemes for HER2targeted therapies.
- Public hospitals provide free breast cancer care, including surgery and basic chemotherapy.

# Opportunity

- Negotiate national pricing and expand access to HER2 drugs via tiered reimbursement models.
- Leverage advocacy and global aid to subsidize essential HER2 therapies for low-income patients.

#### Weakness

- Trastuzumab and other targeted therapies often not available in the public sector due to cost.
- Patients in the public system face high outof-pocket costs for advanced diagnostics.

- Dual system reinforces inequity, with delayed access for uninsured or underinsured populations.
- Economic pressures may limit public health budgets for high-cost oncology medications.



- Yes A structured reimbursement system exists, ensuring biomarker testing is covered through national healthcare systems, insurance, or public-private partnerships. Patients face no direct financial burden.
- Partial A reimbursement framework is in place, but patients may still have out-of-pocket expenses such as co-pays, limited coverage, or financial caps on testing.
- No No formal reimbursement system exists, meaning patients must fully cover the cost of biomarker testing out-of-pocket.

	Country	Reimbursement	No-cost Access
	South Africa	0	×
	Kenya	×	×
	Nigeria	×	×
	Egypt	0	0
	Morocco	0	×
	Algeria	0	×
	Ethiopia	×	×
	India	0	×
	Japan	0	0
	South Korea	0	0
	China	0	0
	Thailand	0	0
	Singapore	0	0
	United Kingdom	0	0
	Germany	0	0
	France	0	0
	Netherlands	0	0
	Sweden	0	0
	Italy	0	0
	Spain	0	0
	Poland	0	0
ut uch as	Mexico	0	×
sting.	Brazil	0	×
	Argentina	0	<b>X</b>
	Chile	0	0
	Colombia	0	×
	United States	0	0
	Canada	0	0
	Australia	0	0
	New Zealand	0	0
	Greece	0	0
	Rwanda	×	×
	Uganda	×	×
	Serbia	0	0
	Saudi Arabia	0	0
	UAE	0	0
	Syria	0	0
	Indonesia	0	0
	Vietnam	×	<b>X</b>
	Philippines	×	* * * * * * * * * * * * * * * * * * *
	Russia	0	0



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**Breast Cancer Screening** 

## Strengths

- Biennial mammogram guidelines are in place; private sector offers comprehensive screening.
- Public campaigns encourage breast selfexams and clinical breast assessments in low-resource areas.

# Opportunity

- Expand mobile screening units and train nurses for breast clinical exams in primary care.
- Use culturally tailored education materials to improve participation in national screening.

## Weakness

- National screening coverage remains under 30%; access in public hospitals is inconsistent.
- Equipment shortages and staffing gaps hinder mammogram delivery in rural zones.

- Delayed or missed diagnoses due to inadequate screening infrastructure in public health.
- Digital and geographic divides limit uptake of services and follow-up diagnostics.

Country	Breast Cancer Screening
United States	Biennial mammograms (50-74 years)
United Kingdom	Triennial mammograms (50-71 years)
Canada	Mammograms every 2-3 years (50-74 years)
Australia	Biennial mammograms (50-74 years)
Germany	Mammograms every 2 years (50-69 years)
France	Biennial mammograms (50-74 years)
Netherlands	Mammograms every 2 years (50-75 years)
Sweden	Mammograms every 18-24 months (40- 74 years)
Italy	Mammograms every 2 years (50-69 years)
Spain	Mammograms every 2 years (50-69 years)
Poland	Mammograms every 2 years (50-69 years)
Japan	Mammograms every 2 years (40+ years)
South Korea	Biennial mammograms (40+ years)
China	Regional mammogram programs (40-69 years)
India	Opportunistic screening
Singapore	Biennial mammograms (50-69 years)
Saudi Arabia	Opportunistic screening; regional programs for women aged 40+
UAE	Opportunistic screening; encouraged every 2 years for 40-69 years
Syria	No national program; limited local initiatives due to conflict

Country	Breast Cancer Screening
Thailand	Biennial mammograms (50-69 years)
South Africa	Opportunistic screening
Kenya	No national program
Nigeria	No national program
Egypt	National awareness campaigns
Morocco	National program for 45-69 years
Algeria	Planned national program (50-69 years)
Ethiopia	No national program
Mexico	Biennial mammograms (40-69 years)
Brazil	Biennial mammograms (50-69 years)
Argentina	Biennial mammograms (50-69 years)
Chile	Mammograms every 3 years (50-69 years)
Colombia	Biennial mammograms (50-69 years)
New Zealand	Biennial mammograms (45-69 years)
Greece	Biennial mammograms (50-69 years)
Rwanda	No national program
Uganda	No national program
Serbia	Biennial mammograms (50-69 years)
Indonesia	Opportunistic screening; no national mammography program
Vietnam	Regional mammography programs; pilot programs in urban areas (age 45-69)
Philippines	Opportunistic screening; mammography recommended every 2 years for women 50+
Russia	National program for biennial mammograms (50-69 years)