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Commentary

Do Sub-Saharan African Countries have a Hiding Place Anymore against Gynaecologic Oncology Cancers? A Case of Uganda

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Globally, there has been a rise in life expectance at birth [1-3]. In 2021, the global average life expectancy at birth was just over 70 years. It is imperative to note that about 200 years ago in 1980, no country had a life expectancy at birth surpassing the 40th birthday mark. Whereas this is an indicator of heavy investments in public health interventions coupled with discoveries of antibiotics and advances in technology [2], man's longevity is not without challenges [2].

One of the challenges is the rise of the Noncommunicable diseases (NCDs) that will surely need serious interventions and investments now rather than waiting for 2035 [3]. Of the NCDs that threaten mankind, cancers deserve a mention. In 2020, 801,392 new cancer cases and 520,158 cancer deaths were estimated to have occurred in sub-Saharan Africa (SSA) in 2020 with breast and cervical cancer contributing 30% of cancers diagnosed in both sexes, that is cancers of the breast (129,400 female cases) and cervix (110,300 cases). Furthermore breast and cervical cancers were the most common cancers, ranking first in 28 and 19 countries, respectively. In men, prostate cancer led in terms of incidence (77,300 cases), followed by liver cancer (24,700 cases) and colorectal cancer (23,400 cases). Prostate cancer was the leading incident cancer in men in 40 sub-Saharan Africa countries. The risk of a woman in sub-Saharan Africa developing cancer by the age of 75 years was 14.1%, with breast cancer (4.1%) and cervical cancer (3.5%) responsible for half of this risk [4].

One important aspect that cannot be ignored is that over years, there has been adoption of western lifestyle and therefore, increased incidence of metabolic diseases both in rural and urban areas in SSA [5,6]. With obesity on the rise, comes the scourge of endometrial cancer-a cancer whose prevalence and mortality is expected to rise by twofold in the next two decades as per the International Agency of Research on Cancer (IARC) estimates [7]. What is more worrying is that African population carries the more aggressive and poorly differentiated histological subtypes that mirror that of the African Americans (AA) [8-10].

The impact of the rising endometrial cancer burden is expected to be more severe in East and Southern Africa, accounting for 42.4% of Africa's new endometrial cancer cases (11.5 out of 27.1 thousand) by 2040 despite the region accounting for approximately one-third of the continent's population [11]. In the United states of America, the outcome amongst African Americans is worse compared to the

Caucasian counterparts [12] but this, in SSA context, as one can envisage, will be worsened by the poor and low investments in health building blocks [13].

In Uganda cervical cancer is the most frequent cancer among women and is responsible for an estimated 6959 cases (33.8% of all cancer in women) and 4607 deaths annually. It is also the leading malignancy among women of 15 - 44 years of age [14]. One of the major challenges gynaecologic patients face in Uganda is poor access to care with Uganda having only one comprehensive gynaecologic oncology treatment centre at Uganda Cancer Institute Mulago Hill in Kampala [15].

Uganda cancer institute (UCI) through the International Gynaecologic Cancer society runs a Gynaecologic Oncology fellowship programme in a bid to improve care both at UCI, and areas beyond Kampala [16]. Even if it were to be an incomplete package of care in the peripheral tertiary centres, it would still represent a significant milestone in the right direction. It is on this background that we decided to start a Gynaecologic oncology clinic that focuses on treatment of all gynaecologic cancers. This clinic is housed by the department of Gynaecology and Obstetrics at Mbale Regional Referral and Teaching hospital (MRRTH). The description of MRRTH has been given in earlier publications [17,18]. The clinic has revolutionised management of patients including timely referral for those that need chemotherapy and radiation therapy. It has also provided a teaching avenue for students in areas of gynaecologic oncology and we hope this will have a spillover effect in the years to come. Despite the initiation of the clinic, challenges are still stiff such as high burden of patients, lack of diagnostics and other consumables. The sound of referral to UCI still sound like a "death sentence" to some clients.

In conclusion, it is a rallying call for all governments to take seriously investment in management of NCDs especially costly cancer treatments. With increasing life expectancy, the demand for such services must and will increase. It is better to act now than act tomorrow.

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