Concerns regarding the health and well-being of populations of low- and middle-income countries (LMICs), particularly those of sub-Saharan Africa (SSA), have typically focused on problems that many in the U.S. and other high-income countries (HICs) consider diseases of the past. For many countries in sub-Saharan Africa, infectious diseases like HIV, tuberculosis, and malaria, along with the consequences of malnutrition and challenges in maternal and child health, whereas for HICs, chronic noncommunicable diseases of middle and older ages—cancer, coronary artery and cerebrovascular disease, diabetes, and dementia—pose major threats to the health of their populations. However, in SSA, the picture is slowly but surely evolving, with the threat of noncommunicable diseases, including cancers, now looming large [1].

This transformation is attributable to two parallel phenomena observed in that part of the world. The first is the impact of the scale-up of effective antiretroviral therapy for HIV, resulting in a truly remarkable transformation of HIV from “a death sentence” to a chronic, manageable condition, as well as substantial progress in malaria control and in decreases in maternal and child mortality. Advances in the management of HIV have resulted in a substantial increase in life expectancy among people living with HIV in SSA, with such individuals now surviving into middle and older ages. The aging of this population is a critical factor in their increased susceptibility to noncommunicable diseases [2, 3].

At the same time, many LMICs, including those in SSA, are experiencing economic growth. Although profound disparities in wealth remain, this economic growth, which is welcomed, has resulted in fundamental changes in lifestyles, with increase in caloric intake, tobacco smoking, and sedentary status. These realities put sub-Saharan African populations at increased risk for diseases that are associated with the Western lifestyle, notably certain cancers, coronary heart disease, stroke, and diabetes. Tobacco use has been on the rise, partially caused by tobacco companies targeting LMICs because of loss of sales in HICs, as has obesity, due to increased caloric intake combined with a more sedentary lifestyle. As urbanization has accelerated, many have left behind more active lifestyles in rural areas, and have adopted more meat rich “fatty” diets associated with depletion of fresh vegetable/fruit “high fiber” diets [4]. All these lifestyle and health access changes have contributed toward an increased risk of chronic noncommunicable diseases [5].

Mayosi and colleagues have reported that in South Africa, home to the largest population of people living with HIV in the world (approximately 23%), the recent decades have seen a rise in chronic noncommunicable disease rates attributable to the changes in risk factors noted above. In particular, they reported that between 1999 and 2006, the mortality rate from prostate cancer increased by 12%, whereas breast cancer mortality increased by 21% [5]. More recent studies have suggested that these increases in cancer rates have continued and have been observed for other malignancies as well [6]. Increases have also been noted throughout SSA for incidence for various major cancers, including breast, colorectal, lung, and prostate cancers. Recent increases in colorectal cancer incidence rates in South Africa, especially in younger patients, have paralleled increases in socioeconomic changes among ethnic groups [7]. Others have recently suggested that as countries develop economically, the types of cancers observed also evolve from those that are infection-related to those that are not infection-related [1].

These recent trends in cancer epidemiology compel the need for urgent action. There is an urgent need to put measures in place to address the risk factors for various cancers in order to stem the rise in cancer rates. Unfortunately, tobacco use is increasing in SSA as it stands more than 30% in that region as compared with <15% in the U.S., where lung cancer incidence and mortality rates are falling dramatically. A serious effort to stem the use of tobacco, particularly given the reported increased susceptibility of persons living with HIV to its carcinogenic effects, is called for [8]. The high rates of cervical cancer and other squamous cell malignancies must motivate the urgent necessity to expand vaccination programs for human papillomavirus as well as for hepatitis B
## Table 1. Illustrative supportive interventions by health system building block

| Health System Building Blocks | Possible interventions |
|-----------------------------|------------------------|
| **Financing**               | Investment from bilateral and multilateral sources  
|                             | Prioritization of cancer programming in national health funding decisions  
|                             | Subsidizing of cost of cancer treatments |
| **Governance and policy**   | Establishment of Cancer Task Force at Ministries of Health  
|                             | Development of national cancer strategic plans  
|                             | Engagement of community representatives in shaping cancer policy and programs  
|                             | Support for research initiatives to address knowledge gaps |
| **Information systems**     | Development of national cancer registries/surveillance systems in line with the International Agency for Research on Cancer  
|                             | Establishment of case-based management systems for cancer cases |
| **Laboratory**              | Increased availability of pathology diagnostic services  
|                             | Establishment of virtual pathology consultation networks |
| **Commodities**             | Increased availability of newer chemotherapeutic drugs and analgesics for pain relief in line with the latest WHO Essential Medicines List |
| **Service delivery**        | Development of regional networks and agreements between countries to establish pathways of care  
|                             | Establishment of comprehensive cancer centers of excellence at national and provincial levels  
|                             | Establishment of adequate radiotherapy and chemotherapy services  
|                             | Support for comprehensive case management models of care |
| **Human resources**         | Training and mentorship of health care workers (e.g., physicians, nurses, pharmacists) in cancer prevention, diagnosis, and care  
|                             | Use of virtual learning platforms  
|                             | Development of a cadre of peer support workers for patients with cancer  
|                             | Linkage of facility and community care systems |
| **Community**               | Development of cancer sensitization and prevention campaigns  
|                             | Support for community-based organization that support cancer patients and their families |

**Abbreviation:** WHO, World Health Organization.
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