International Cancer Patient Coalition

Mexico

Colorectal Cancer Factsheet: Insights & Key Developments

Key Insights on Colorectal 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. Colorectal Cancer Screening

Colorectal 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 colorectal cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Among the top 5 cancers in men.
- Incidence rate: Approximately 19 per 100,000 men per year.
- Total new cases (2022): Around 9,000 men.
- Daily diagnoses (2022): About 25 men per day.
- Deaths (2022): Approximately 5,500 men.
- 5-year survival rate: Estimated 50–55%.
- Most affected age group: Primarily men aged 55 and older.
- Screening participation: Limited organized screening, with most screening occurring in urban areas.

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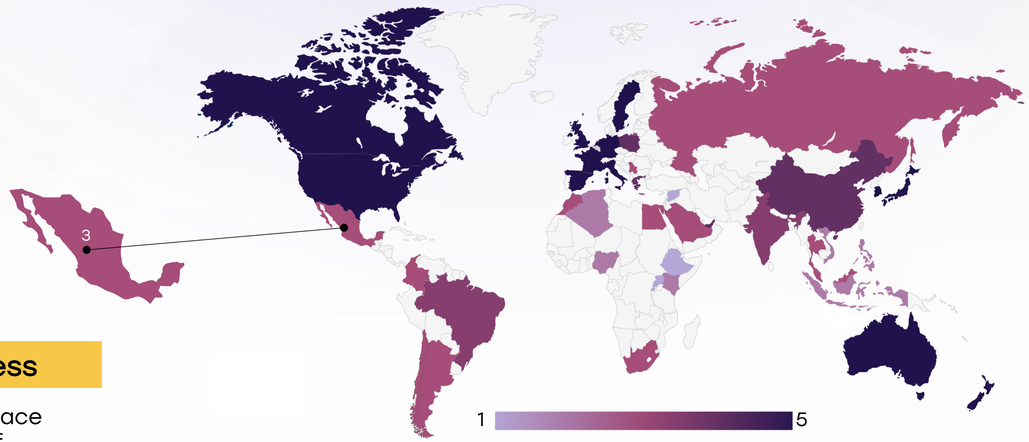
Infrastructure



Strengths

- Major cancer hospitals like Instituto Nacional de Cancerología (INCan) and private centers (e.g., Médica Sur) offer comprehensive colorectal cancer care.
- Integration of cancer care within the national health system (IMSS, ISSSTE) ensures service coverage for a significant population.

Weakness

- Rural areas face shortages of oncologists, endoscopists, and diagnostic equipment.
- Centralized cancer services lead to overcrowding at urban centers, increasing wait times.

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Opportunity

- Development of regional cancer centers could decentralize services.
- Partnerships with international agencies can boost training in oncology care delivery.

Threats

- Unequal distribution of resources and workforce worsens rural-urban disparities.
- Infrastructure gaps limit access to high-quality diagnostics and surgery outside metropolitan zones

5. Advanced nationwide infrastructure, widespread availability in public and private sectors, integration with clinical practice.

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

3. Moderate infrastructure, primarily in private settings or research institutions.

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

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

Country	Specialized Centers	Genetic & Molecular Testing Infrastructure
South Africa	3	3
Kenya	1	2
Nigeria	1	2
Egypt	2	3
Morocco	2	2
Algeria	2	2
Ethiopia	1	1
India	3	4
Japan	4	4
South Korea	4	4
China	4	4
Thailand	3	3
Singapore	4	4
United Kingdom	4	4
Germany	5	4
France	4	4
Netherlands	5	4
Sweden	5	4
Italy	4	3
Spain	4	3
Poland	4	3
Mexico	2	3
Brazil	3	3
Argentina	3	3
Chile	3	3
Colombia	2	3
United States	5	5
Canada	5	4
Australia	4	4
New Zealand	4	4
Greece	4	3
Rwanda	1	1
Uganda	1	1
Serbia	3	3
Saudi Arabia	4	4
UAE	4	3
Syria	1	1
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	3	3
Malaysia	3	3

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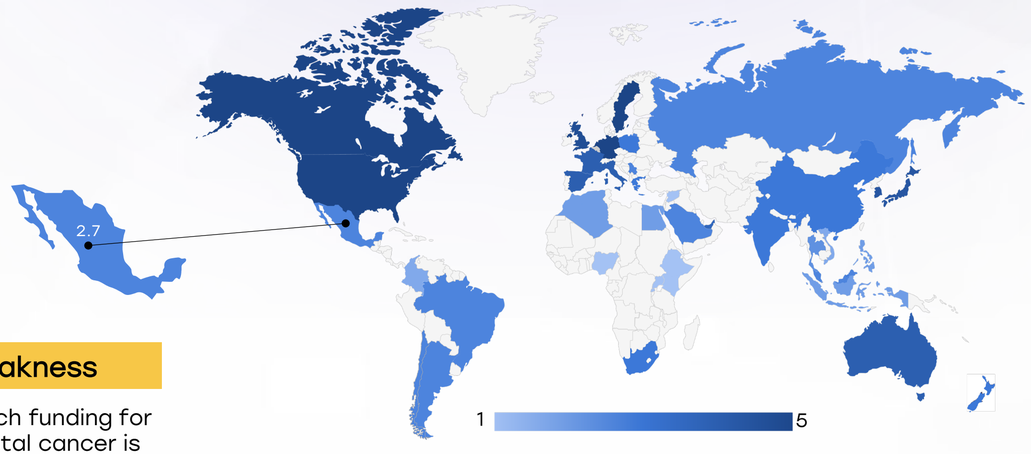
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Public programs such as Seguro Popular (previously) and INSABI now attempt to guarantee cancer treatment access for uninsured patients.
- National campaigns during Cancer Awareness Month target lifestyle risks and prevention.

Weakness

- Research funding for colorectal cancer is limited compared to breast and cervical cancer.
- Awareness efforts are intermittent and not sustained year-round.

S W O T

Opportunity

- Collaboration between universities and public hospitals could boost clinical research and biomarker studies.
- Increased media campaigns in indigenous languages could enhance outreach.

Threats

- Changes in healthcare policy and funding priorities risk destabilizing cancer programs.
- Economic limitations and bureaucracy hinder rapid scaling of education and research projects.

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 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.

Country	Treatment Access	Research Funding	Awareness Campaigns
South Africa	3	3	3
Kenya	1	1	1
Nigeria	1	1	1
Egypt	2	2	2
Morocco	2	2	2
Algeria	2	2	2
Ethiopia	1	1	1
India	3	3	3
Japan	4	4	5
South Korea	4	4	5
China	3	3	3
Thailand	2	3	2
Singapore	4	5	5
United Kingdom	4	5	5
Germany	5	5	5
France	4	4	4
Netherlands	5	5	5
Sweden	5	5	5
Italy	4	4	4
Spain	4	4	4
Poland	3	3	3
Mexico	2	3	3
Brazil	2	3	3
Argentina	2	3	3
Chile	2	3	3
Colombia	1	2	2
United States	5	5	5
Canada	5	5	5
Australia	4	4	4
New Zealand	3	3	3
Greece	3	3	3
Rwanda	1	1	1
Uganda	1	1	1
Serbia	2	3	3
Saudi Arabia	3	2	3
UAE	4	3	4
Syria	1	1	1
Indonesia	2	2	2
Vietnam	2	1	2
Philippines	3	2	2
Russia	3	3	2
Malaysia	3	3	3

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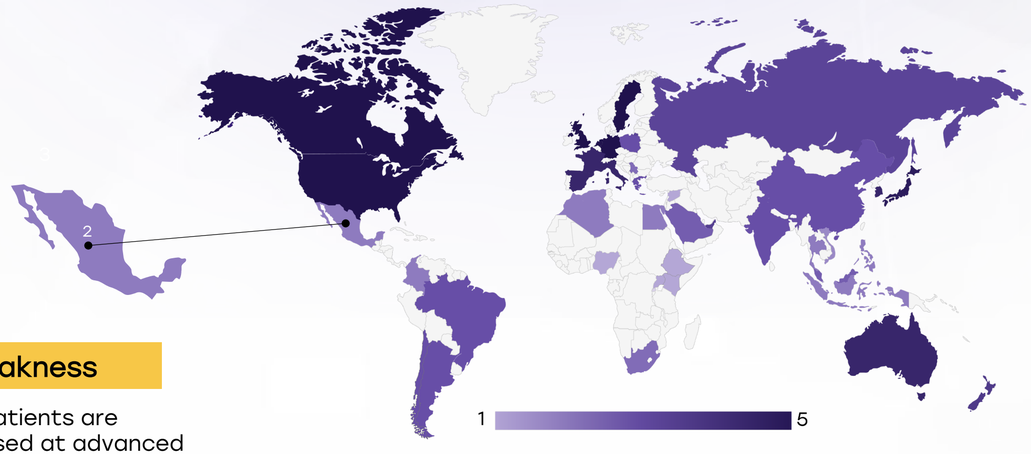
Survival Rates, Early Detection and Palliative Care



Strengths

- Multidisciplinary treatment approaches in INCan and other major centers have improved outcomes for early-stage cases.
- Palliative care services are expanding in major cities, especially in academic hospitals.

Weakness

- Most patients are diagnosed at advanced stages due to low screening uptake and late symptom recognition.
- Palliative care services are underutilized and remain scarce outside major cities.

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Opportunity

- National expansion of early detection programs with community health workers and FIT screening could improve early-stage diagnoses.
- Greater integration of palliative care into oncology guidelines.

Threats

- Stigma around cancer and limited access to primary care delay help-seeking behavior.
- Growing cancer burden strains limited healthcare workforce, especially for chronic care.

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	2	3	2
Kenya	1	1	1
Nigeria	1	1	1
Egypt	2	2	2
Morocco	2	2	2
Algeria	2	2	2
Ethiopia	1	1	1
India	3	3	3
Japan	5	4	5
South Korea	5	4	5
China	3	3	4
Thailand	2	2	2
Singapore	5	5	5
United Kingdom	5	5	5
Germany	5	5	5
France	5	4	4
Netherlands	5	5	5
Sweden	5	5	5
Italy	5	4	5
Spain	5	4	5
Poland	3	3	4
Mexico	2	2	2
Brazil	3	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	2	2	2
United States	5	5	5
Canada	5	5	5
Australia	5	4	4
New Zealand	4	4	3
Greece	3	3	3
Rwanda	1	1	1
Uganda	1	1	1
Serbia	2	3	2
Saudi Arabia	3	2	3
UAE	4	3	4
Syria	1	1	1
Indonesia	2	2	2
Vietnam	2	1	2
Philippines	2	3	2
Russia	4	3	3
Malaysia	3	2	3

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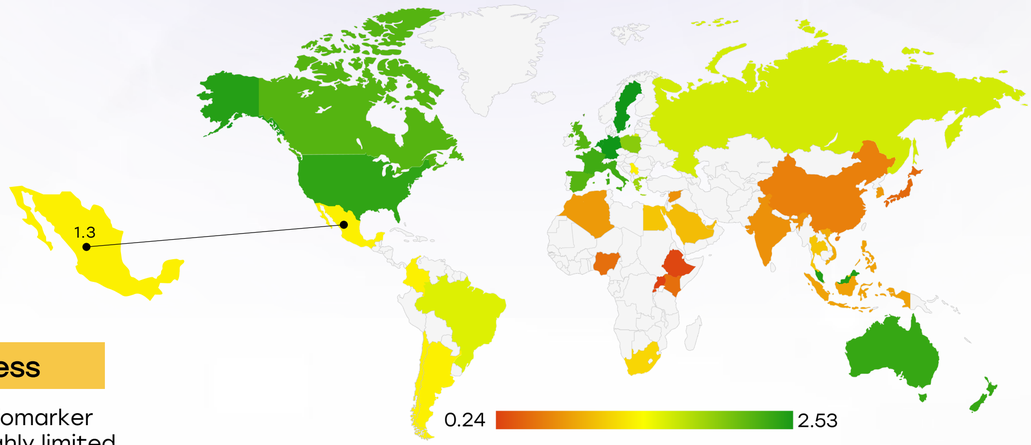
Utilization of Biomarkers



Strengths

- Private hospitals and academic labs offer testing for KRAS, NRAS, and MSI/dMMR, guiding treatment decisions for anti-EGFR and immunotherapy.
- INCan runs molecular oncology programs that include biomarker analysis in clinical trials.

Weakness

- Access to biomarker testing is highly limited in public hospitals due to cost and resource constraints.
- PIK3CA and BRAF V600E testing are still not part of standard care protocols for all patients.

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Opportunity

- National guidelines can include biomarker testing as a requirement for advanced colorectal cancer care.
- International research collaboration could lower test costs and improve technology transfer.

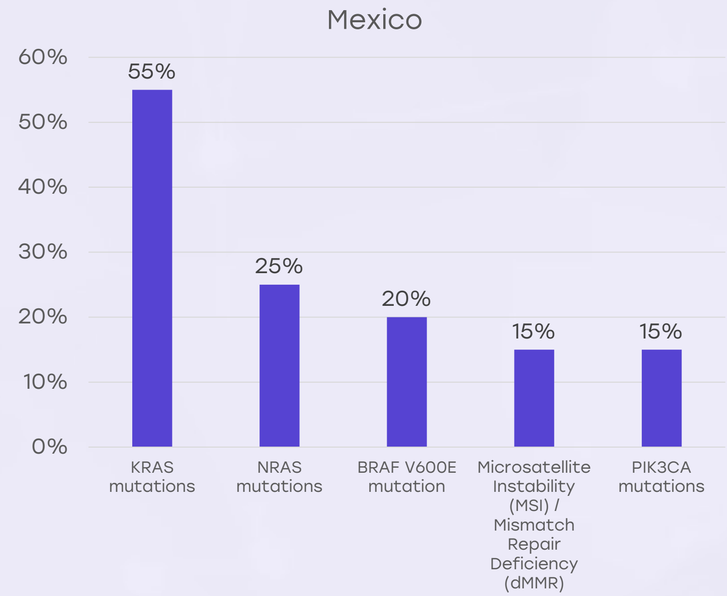
Threats

- Out-of-pocket costs for biomarker testing exclude many patients from precision medicine benefits.
- Lack of standardization across labs may affect test accuracy and utility.

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.

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.

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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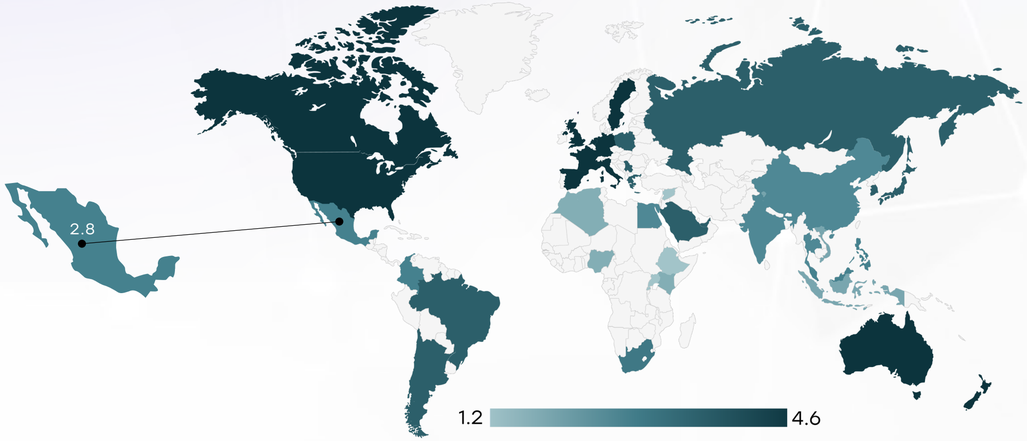
Clinical Guidelines



Strengths

- Mexico has national cancer management guidelines that align with international standards like ESMO and NCCN.
- Guidelines are updated periodically by INCan and government health agencies.

Weakness

- Adherence to guidelines is inconsistent in peripheral and rural hospitals due to lack of training or support infrastructure.
- Some guidelines do not incorporate the latest biomarker and immunotherapy recommendations.

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Opportunity

- Mandatory CME training on national guidelines could improve consistency in practice.
- Digitization of clinical protocols can improve access for remote clinicians.

Threats

- Rapid innovation in therapies may outpace guideline updates, leading to treatment lags.
- Fragmented public-private systems lead to disparities in implementation.

	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	✖	✖	O	✖	✖
Feasibility of Integration	✖	✖	O	✖	✖
Adoption of International Guidelines	✖	✖	O	✖	✖
Engagement with Updates	✖	✖	O	✖	✖
ESMO Guidelines Implementation	✖	✖	O	✖	✖

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Reimbursement

Strengths

- Public health schemes (INSABI, IMSS) cover basic cancer treatment, including surgery and chemotherapy.
- Some reimbursement available for diagnostic tests and follow-up care.

Weakness

- Targeted therapies and biomarker tests are rarely covered and often require out-of-pocket payment or private insurance.
- Lack of transparency and delays in reimbursement discourage innovation adoption.

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Opportunity

- Expansion of reimbursement packages to include molecular diagnostics and biologics.
- Reforms in national procurement can reduce drug costs and improve affordability.

Threats

- Budget limitations and healthcare reforms have created uncertainty around long-term funding for cancer care.
- Patients falling outside the system (e.g., informal workers) remain vulnerable to catastrophic expenses.

● 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.

● 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 formal reimbursement system exists, meaning patients must fully cover the cost of biomarker testing out-of-pocket.

Country	Reimbursement Framework	No-cost Access
United States	●	○
United Kingdom	●	●
Canada	●	●
Australia	●	●
Germany	●	●
France	●	●
Netherlands	●	●
Sweden	●	●
Italy	●	●
Spain	●	●
Poland	●	●
Japan	●	●
South Korea	●	●
China	●	●
India	○	○
Singapore	●	●
Thailand	●	●
South Africa	○	○
Kenya	○	○
Nigeria	○	○
Egypt	○	○
Morocco	○	○
Algeria	●	●
Ethiopia	○	○
Mexico	●	●
Brazil	●	●
Argentina	●	●
Chile	●	●
Colombia	●	●
New Zealand	●	●
Greece	●	●
Rwanda	○	○
Uganda	○	○
Serbia	●	●
Saudi Arabia	●	●
UAE	●	●
Syria	○	○
Indonesia	●	○
Vietnam	●	○
Philippines	○	○
Russia	●	●
Malaysia	●	●

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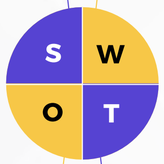
Colorectal Cancer Screening

Strengths

- Pilot screening programs using FIT tests are active in some states and among higher-risk groups.
- Primary care clinics under IMSS have started incorporating screening guidelines for patients over 50.

Weakness

- National screening coverage remains below 20%, with poor follow-up colonoscopy rates.
- Public awareness of screening options is limited, especially in rural and indigenous populations.



Opportunity

- Nationwide rollout of FIT-based screening with centralized data collection can improve impact.
- Leveraging mobile health units and pharmacies can reach underserved communities.

Threats

- Cultural barriers and fear of diagnosis reduce willingness to undergo screening.
- Inadequate endoscopy capacity and long waitlists undermine the effectiveness of early detection programs.

Country	Colorectal Cancer Screening
United States	Annual LDCT (50-80 years, high-risk smokers)
United Kingdom	LDCT for high-risk individuals (55-74 years)
Canada	LDCT for high-risk individuals (55-74 years)
Australia	No national program, high-risk groups advised LDCT
Germany	No national program, under evaluation
France	No national LDCT screening
Netherlands	Participating in European screening studies
Sweden	No national LDCT screening
Italy	Regional pilot LDCT screening
Spain	No national LDCT program
Poland	No national program
Japan	No national LDCT program
South Korea	LDCT for high-risk individuals (50-74 years)
China	No national LDCT program
India	No national LDCT program
Singapore	No national LDCT program
Saudi Arabia	No national LDCT program; some hospital-based opportunistic screening
UAE	No national LDCT program; early-stage pilot studies ongoing in select hospitals
Syria	No national LDCT program; screening not prioritized due to conflict
Malaysia	No program; high-risk CT pilots

Country	Colorectal Cancer Screening
Thailand	No national LDCT program
South Africa	No national LDCT program
Kenya	No national LDCT program
Nigeria	No national LDCT program
Egypt	No national LDCT program
Morocco	No national LDCT program
Algeria	No national LDCT program
Ethiopia	No national LDCT program
Mexico	No national LDCT program
Brazil	No national LDCT program
Argentina	No national LDCT program
Chile	No national LDCT program
Colombia	No national LDCT program
New Zealand	No national LDCT program
Greece	No national LDCT program
Rwanda	No national LDCT program
Uganda	No national LDCT program
Serbia	No national LDCT program
Indonesia	No national LDCT program; opportunistic screening in private sector
Vietnam	No national LDCT program; early pilot screening studies in Hanoi and Ho Chi Minh
Philippines	No national LDCT program; feasibility and awareness programs under discussion
Russia	No formal national LDCT program; regional pilot screening programs in large cities