International Cancer Patient Coalition

Ethiopia

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: Colorectal cancer is not among the top cancers but is rising.
- Incidence rate: Around 4 per 100,000 men per year.
- Total new cases (2022): Approximately 800 men.
- Daily diagnoses (2022): Around 2 men per day.
- Deaths (2022): Around 700 men.
- 5-year survival rate: Likely under 30%, due to advanced-stage diagnosis.
- Most affected age group: Mostly men aged 60+.
- Screening participation: No screening programs; diagnosis is delayed in most cases.

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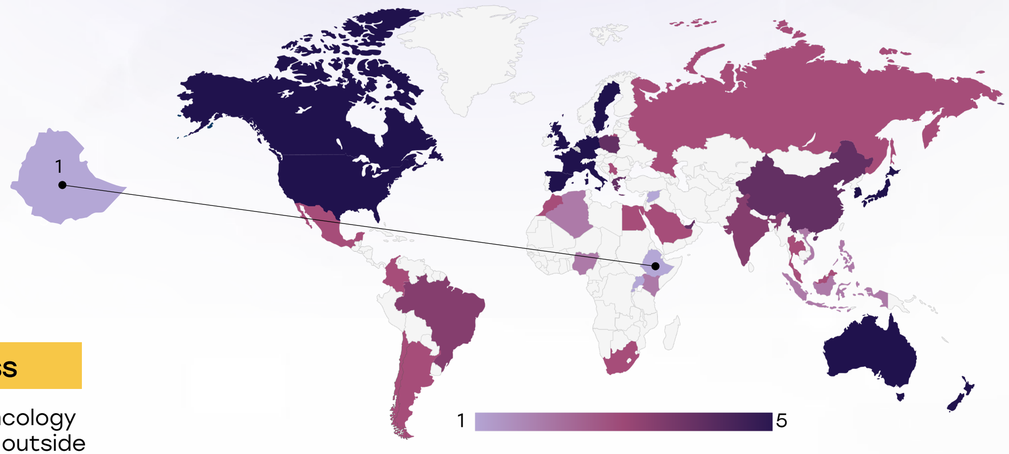
Infrastructure



Strengths

- Key public institutions like Tikur Anbessa Specialized Hospital (Addis Ababa University) offer oncology services, including surgery and limited diagnostics.
- Government support for expanding tertiary care through national cancer control efforts.

Weakness

- Very limited oncology infrastructure outside Addis Ababa, resulting in long travel distances for care.
- Lack of radiotherapy units and endoscopy services in most regional hospitals hampers early detection and treatment.

Opportunity

- Ongoing national plans to scale up cancer services and build regional centers of excellence.
- Collaboration with NGOs and international donors could help upgrade medical infrastructure.

Threats

- Chronic equipment shortages and delays in procurement.
- High burden of infectious diseases (e.g., TB, HIV) often takes precedence over cancer investments.

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	2	2
Nigeria	2	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	3
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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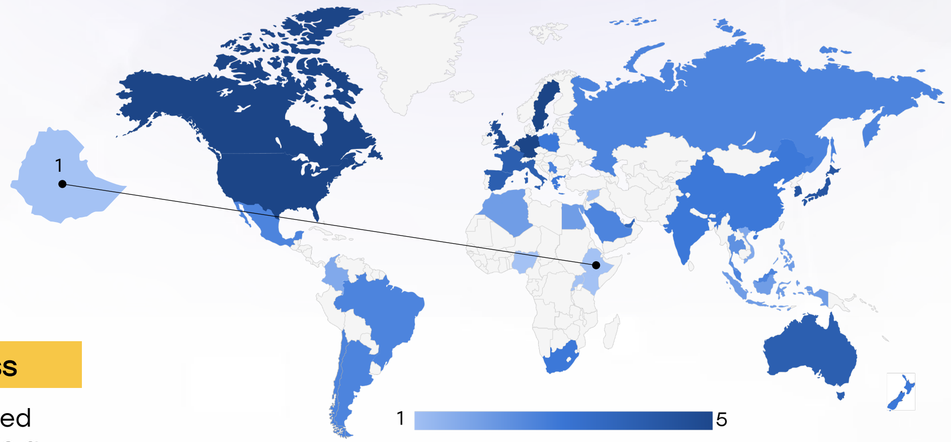
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Some chemotherapy drugs for colorectal cancer are available in public hospitals.
- Ethiopia's Ministry of Health has launched NCD campaigns that indirectly promote cancer awareness.

Weakness

- Most advanced treatments (e.g., targeted therapy, immunotherapy) are unavailable or unaffordable.
- No dedicated government-funded research program on colorectal cancer.

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Opportunity

- Training Ethiopian oncologists and nurses abroad and bringing expertise back home.
- External partnerships could drive local research, clinical trials, and targeted awareness initiatives.

Threats

- Limited cancer-specific budget within national health funding.
- Public mistrust of cancer treatment and widespread myths delay care-seeking behavior.

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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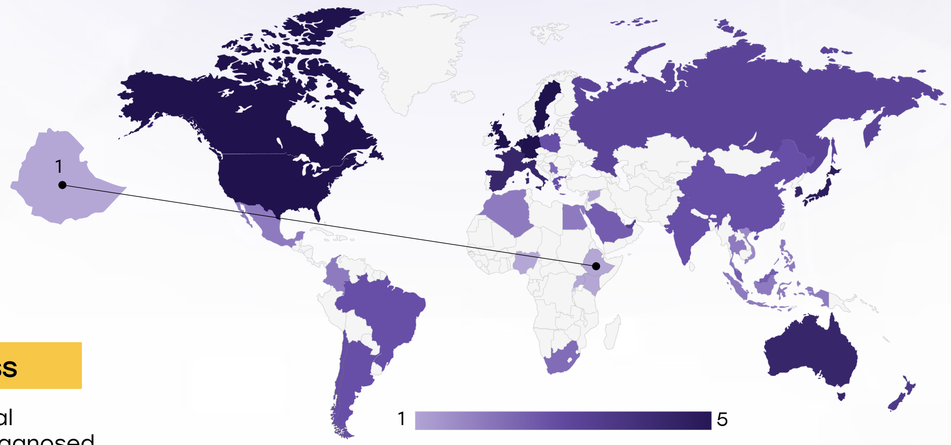
Survival Rates, Early Detection and Palliative Care



Strengths

- Pilot palliative care services are being integrated into some hospitals, with government and NGO backing.
- Community health extension workers play a role in health education, which could be adapted to cancer.

Weakness

- Most colorectal cancers are diagnosed at advanced stages, often stage III or IV, due to lack of early detection tools.
- Limited access to opioids and trained palliative care staff in rural regions.

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Opportunity

- Creating early referral systems via primary care workers can boost early detection.
- Introducing basic screening protocols could lead to stage migration and better survival.

Threats

- Late presentation leads to high mortality rates.
- Lack of national mortality and survival data makes evaluation of interventions difficult

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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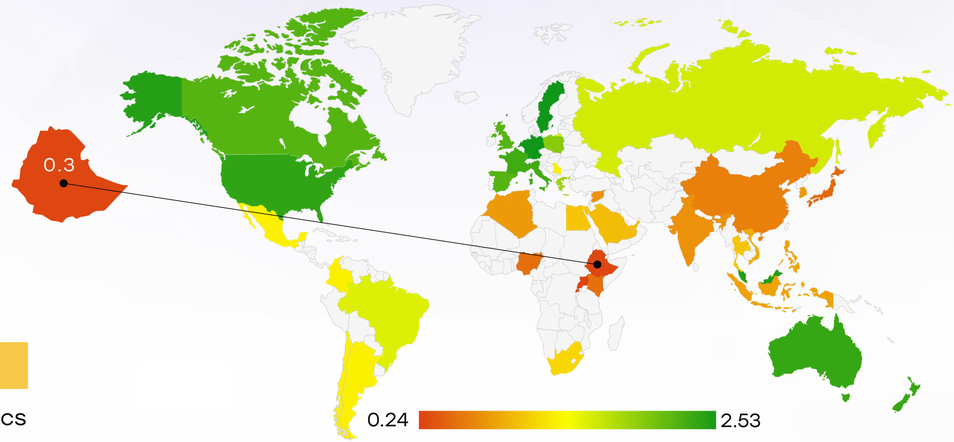
Utilization of Biomarkers



Strengths

- Some research collaborations have enabled biomarker testing (e.g., KRAS, MSI) on a case-by-case basis, mainly for academic purposes.
- National Cancer Control Plan recognizes precision oncology as a future priority.

Weakness

- Molecular diagnostics (e.g., BRAF, NRAS, PIK3CA) are almost nonexistent in routine practice.
- Most oncologists lack access to labs capable of running biomarker panels, and even KRAS is rarely ordered.

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Opportunity

- Establishing centralized pathology/molecular labs in Addis Ababa could introduce scalable testing.
- Partnering with academic or private labs in the region (e.g., Kenya, South Africa) for remote testing.

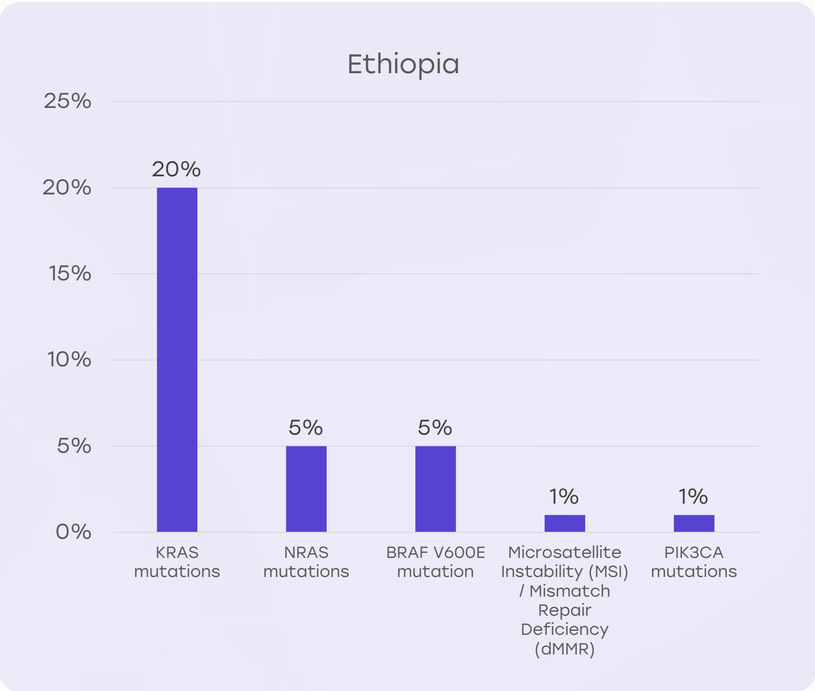
Threats

- High cost and lack of local suppliers for reagents, consumables, and machines.
- Without reimbursement or government prioritization, biomarker testing will remain unavailable to most.

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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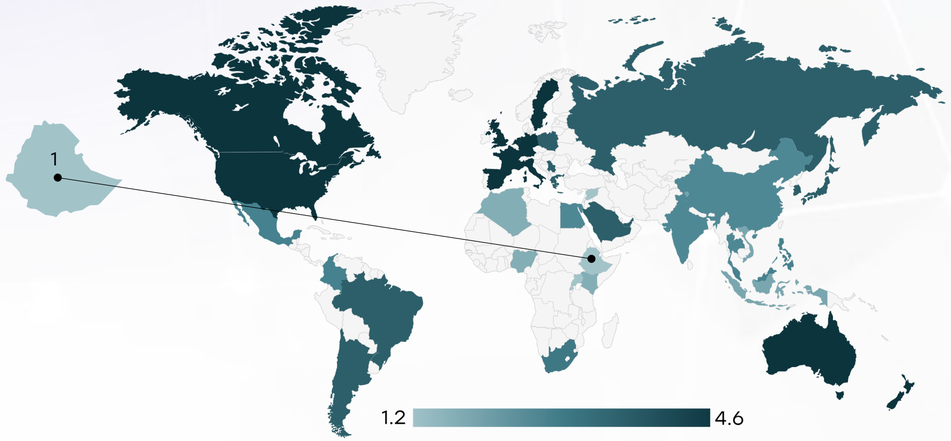
Clinical Guidelines



Strengths

- Ethiopia has started adapting WHO and NCCN guidelines into local practice where resources allow.
- Some academic hospitals use internal protocols based on international standards.

Weakness

- No national colorectal cancer-specific treatment guidelines currently in implementation.
- Lack of consistent multidisciplinary teams (MDTs) to guide decision-making.

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Opportunity

- Development of resource-stratified guidelines that fit the Ethiopian context (e.g., adapted NCCN Framework).
- Training programs to ensure guideline adoption by general practitioners and specialists.

Threats

- Inconsistent application due to resource gaps and fragmented health governance.
- Absence of oncology auditing to track adherence to clinical protocols.

	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

- Some chemotherapy drugs are subsidized or offered free in public institutions.
- New government initiatives aim to increase financial protection for NCD patients.

Weakness

- Advanced treatments, surgery, and diagnostics are often paid out-of-pocket, making care unaffordable.
- Lack of insurance coverage for diagnostics or biomarker testing.

S W O T

Opportunity

- Expanding the essential drugs list to include colorectal cancer medications.
- Implementing national health insurance (currently under pilot) can broaden coverage

Threats

- Out-of-pocket burden may prevent many from completing treatment.
- Delayed drug procurement and stockouts lead to treatment interruptions.

● 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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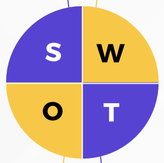
Colorectal Cancer Screening

Strengths

- Primary care structure via health extension workers can support community-level awareness and risk education.
- MoH recognizes the need for cancer screening programs under its NCD strategy.

Weakness

- No organized national colorectal cancer screening program (e.g., FIT/FOBT, colonoscopy).
- Very low public awareness of colorectal cancer symptoms and screening importance.



Opportunity

- Introduction of low-cost FIT-based screening in adults over 50 could be feasible in urban areas.
- Community education using radio, religious institutions, and local leaders could boost participation.

Threats

- Competing health priorities and limited budgets may deprioritize screening programs.
- Resistance to endoscopy due to stigma, myths, and fear of cancer diagnosis.

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