

Philippines

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

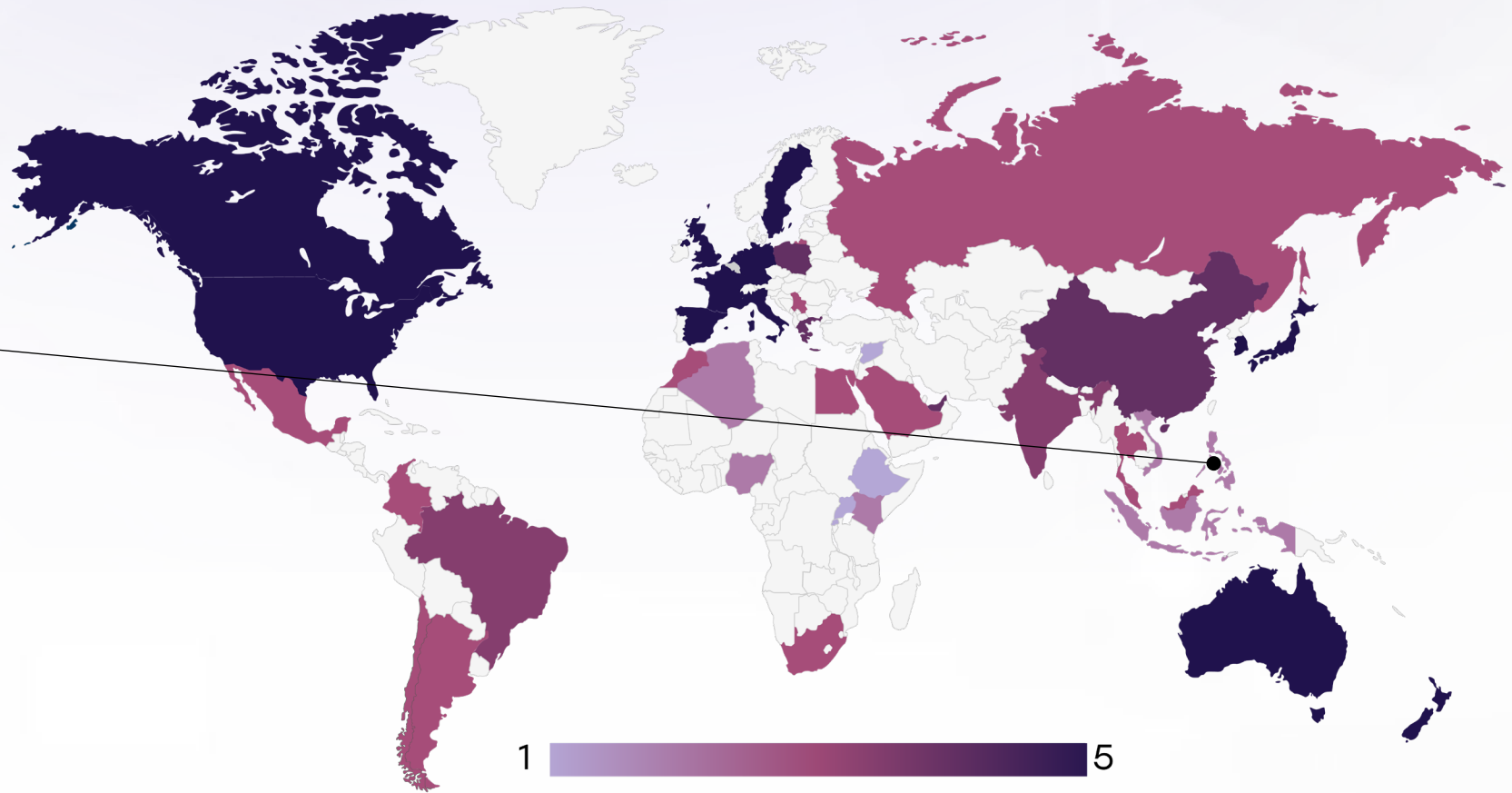
Colorectal cancer remains one of the most prevalent cancers worldwide, affecting millions of individuals each year. Despite advancements in diagnostics, treatment, and awareness, disparities in access to care, molecular testing, and specialized centers persist.

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 3 most common cancers in both Filipino men and women; fourth leading cause of cancer-related deaths
- Incidence rate: Approximately 17.6 per 100,000 people per year
- Total new cases (2022): Around 15,000 cases
- Daily diagnoses (2022): Approximately 41 people per day
- Deaths (2022): Around 8,000 deaths
- 5-year survival rate: Up to 90% for early-stage cases; overall 2-year survival around 74% (colon cancer: ~82%, rectal cancer: ~72%)
- Most affected age group: Primarily adults aged 50 and above; however, rising incidence also observed in younger adults (20s–30s)
- Screening participation: No organized national program; screening is opportunistic and includes annual stool-based tests (FIT) and colonoscopy for those aged 50+, though uptake remains low

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Infrastructure



Strengths

- Endoscopy services (sigmoidoscopy, colonoscopy) available in major tertiary hospitals.
- Pathology labs offer histopathology and immunohistochemistry (IHC) in urban centers.

Weakness

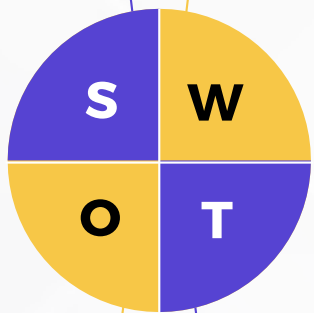
- Only ~1 colonoscopy unit per 500,000–700,000 population in several regions.
- Long wait times (~2–6 months) for colonoscopy in public hospitals.

Opportunity

- Expand regional cancer hubs under NICCA with endoscopy units and GI surgeons.
- Collaborate with medical societies to set up mobile screening endoscopy caravans.

Threats

- High equipment costs and lack of trained endoscopists limit expansion.
- Maintenance delays and power instability in rural hospitals.



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.

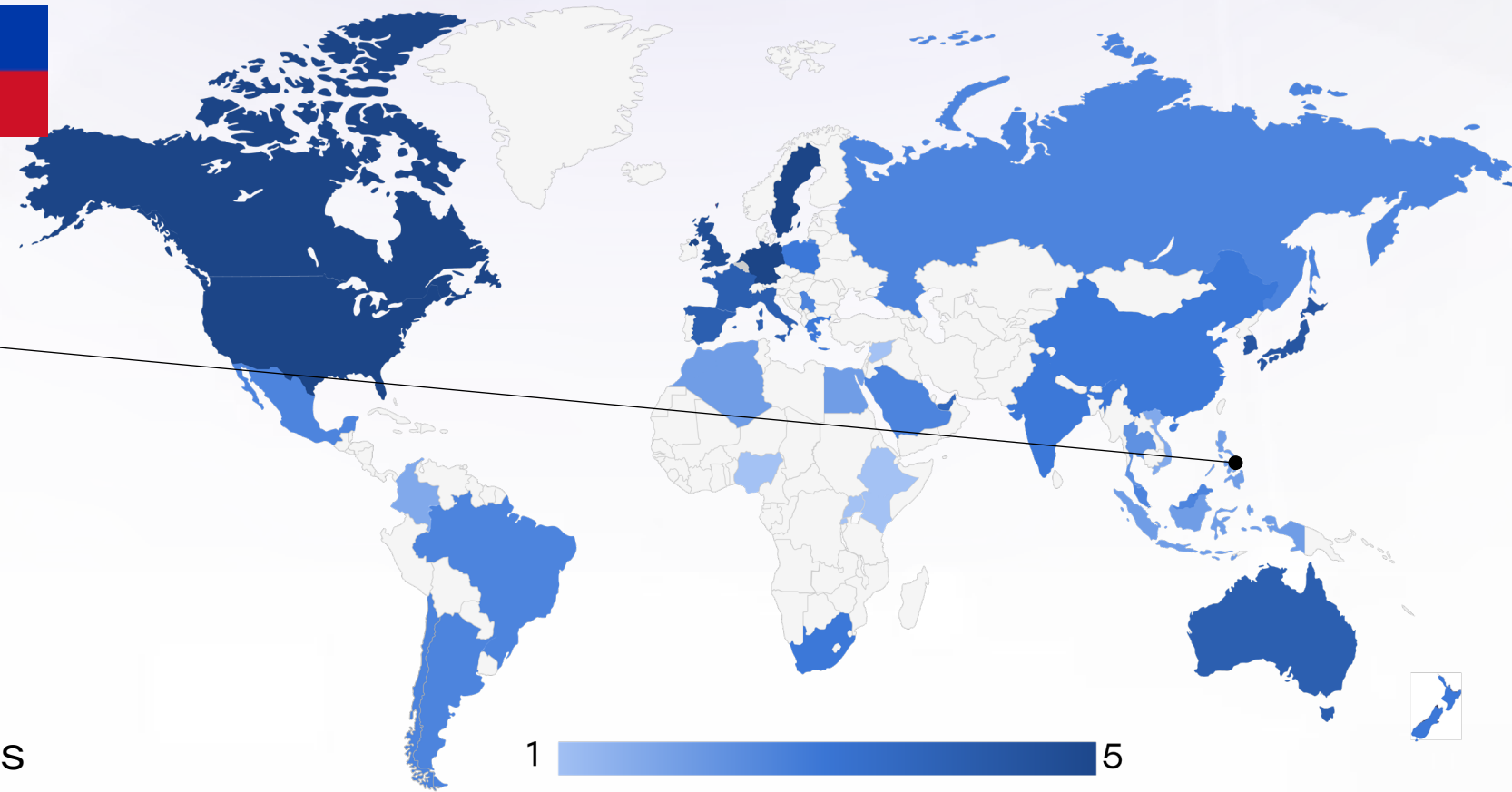


1. Minimal or no infrastructure, testing mostly unavailable or sent abroad.

| Country | Specialized Centers | Genetic & Molecular Testing Infrastructure |
|----------------|---------------------|--|
| South Africa | | |
| Kenya | | |
| Nigeria | | |
| Egypt | | |
| Morocco | | |
| Algeria | | |
| Ethiopia | | |
| India | | |
| Japan | | |
| South Korea | | |
| China | | |
| Thailand | | |
| Singapore | | |
| United Kingdom | | |
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| Rwanda | | |
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Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Surgical resection, chemotherapy (FOLFOX/FOLFIRI), and targeted therapies (bevacizumab) are available in urban centers.
- Awareness is slowly growing through cancer month campaigns and NGO efforts.

Weakness

- Access to treatments like oxaliplatin or bevacizumab limited by out-of-pocket cost (~₱30k–₱100k/month).
- Minimal locally-led research on mutation profiles, drug responsiveness, or CRC subtypes.

Opportunity

- Increase public-private partnerships to subsidize targeted therapy and chemo.
- Expand patient navigation and awareness programs in local dialects.

Threats

- Growing CRC burden (especially in younger adults) not matched by awareness or funding.
- Limited registry data restricts accurate program design



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.

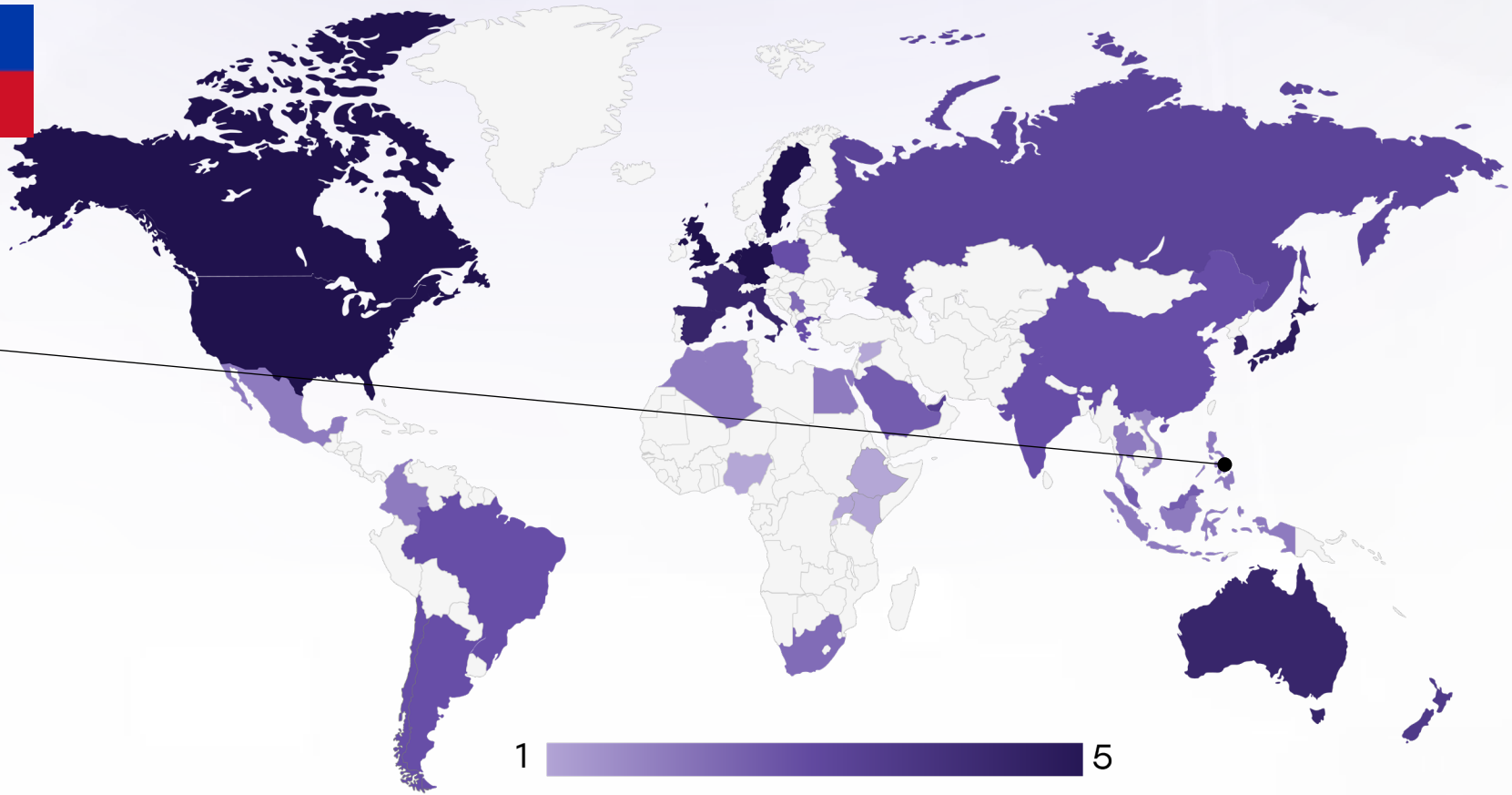
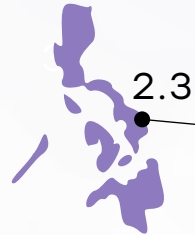


1. Poor infrastructure with severe barriers to treatment, little to no research funding, and lack of structured awareness campaigns. Cancer care is largely inaccessible, with many patients relying on out-of-pocket expenses or external aid.

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

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Survival Rates, Early Detection and Palliative Care



Strengths

Weakness

- Localized CRC has 5-year survival of ~80–90% when detected early.
- Palliative care services are integrated in tertiary cancer centers.

- Over 60% of patients diagnosed at stage III or IV due to lack of early screening.
- Limited access to pain management and home-based palliative care in provinces.

Opportunity

Threats

- Strengthen screening for ages 45+ through barangay health initiatives.
- Train nurses and rural health workers in community-based palliative care.

- Fragmented referral systems and delay in diagnosis.
- High symptom burden and cost in late-stage patients with few social supports.



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.

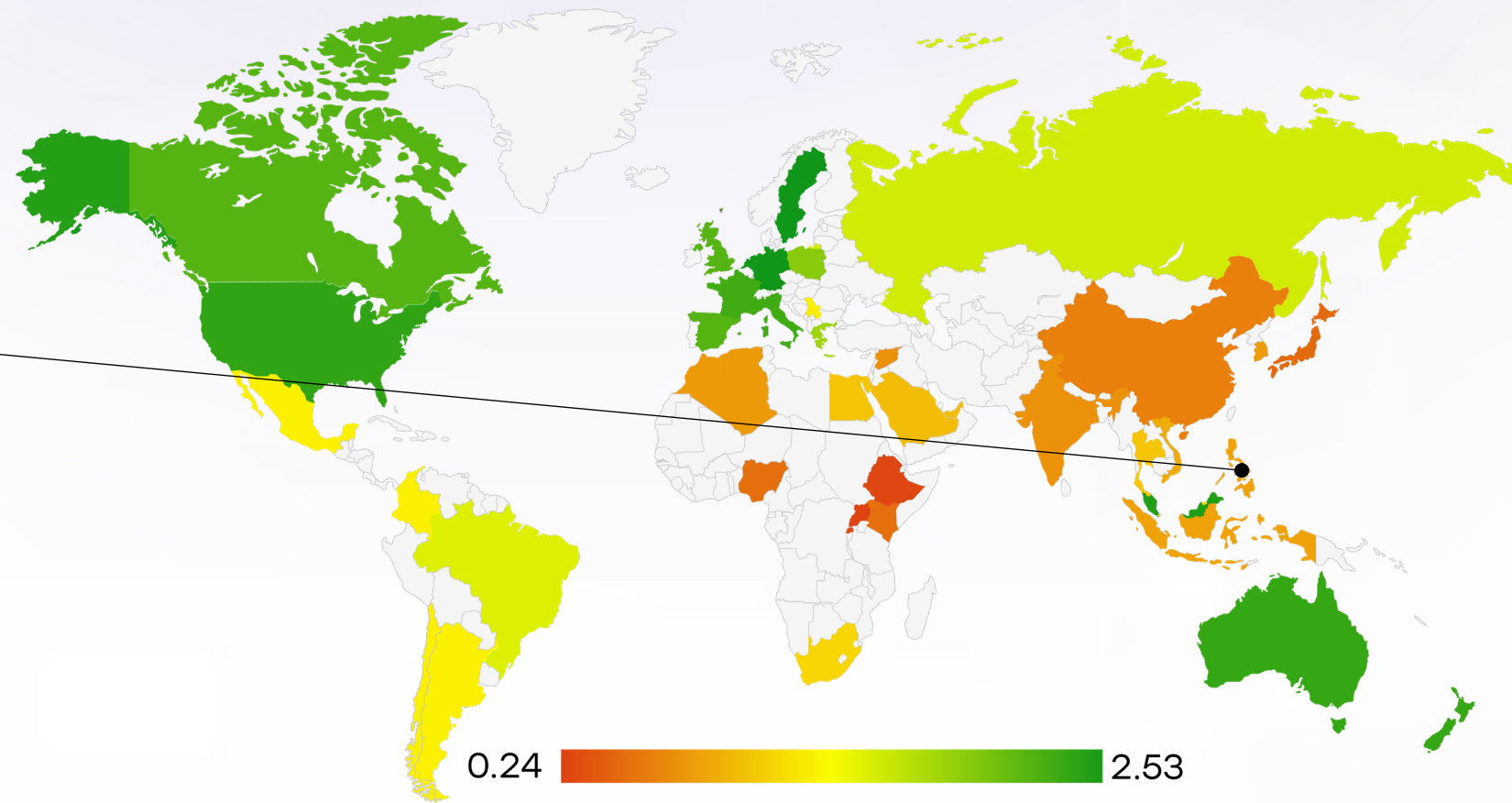
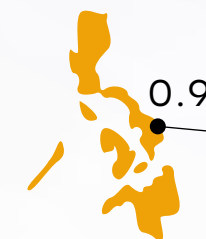
2. Low survival rates, early detection efforts are inconsistent or underfunded, and palliative care is minimal or only available in select hospitals. Cancer patients face significant access barriers.

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 | | | |
| Kenya | | | |
| Nigeria | | | |
| Egypt | | | |
| Morocco | | | |
| Algeria | | | |
| Ethiopia | | | |
| India | | | |
| Japan | | | |
| South Korea | | | |
| China | | | |
| Thailand | | | |
| Singapore | | | |
| United Kingdom | | | |
| Germany | | | |
| France | | | |
| Netherlands | | | |
| Sweden | | | |
| Italy | | | |
| Spain | | | |
| Poland | | | |
| Mexico | | | |
| Brazil | | | |
| Argentina | | | |
| Chile | | | |
| Colombia | | | |
| United States | | | |
| Canada | | | |
| Australia | | | |
| New Zealand | | | |
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Utilization of Biomarkers



Strengths

- IHC for KRAS, NRAS, BRAF mutations and MSI testing available in major diagnostic labs.
- Select hospitals participate in international genomic research collaborations.

Weakness

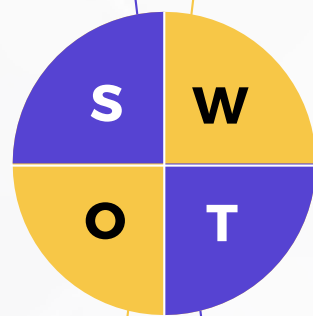
- Biomarker testing is not standardized and is paid out-of-pocket (~₱20k–₱60k).
- Lack of local labs for ctDNA or NGS panels delays personalized therapy.

Opportunity

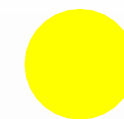
- Incorporate biomarker testing into national treatment protocols and subsidies.
- Build lab capacity for IHC, MSI, and liquid biopsy in NCR and regional centers.

Threats

- Limited clinician awareness of how to use biomarker data to guide treatment.
- Inequity in access can worsen survival gaps.



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.

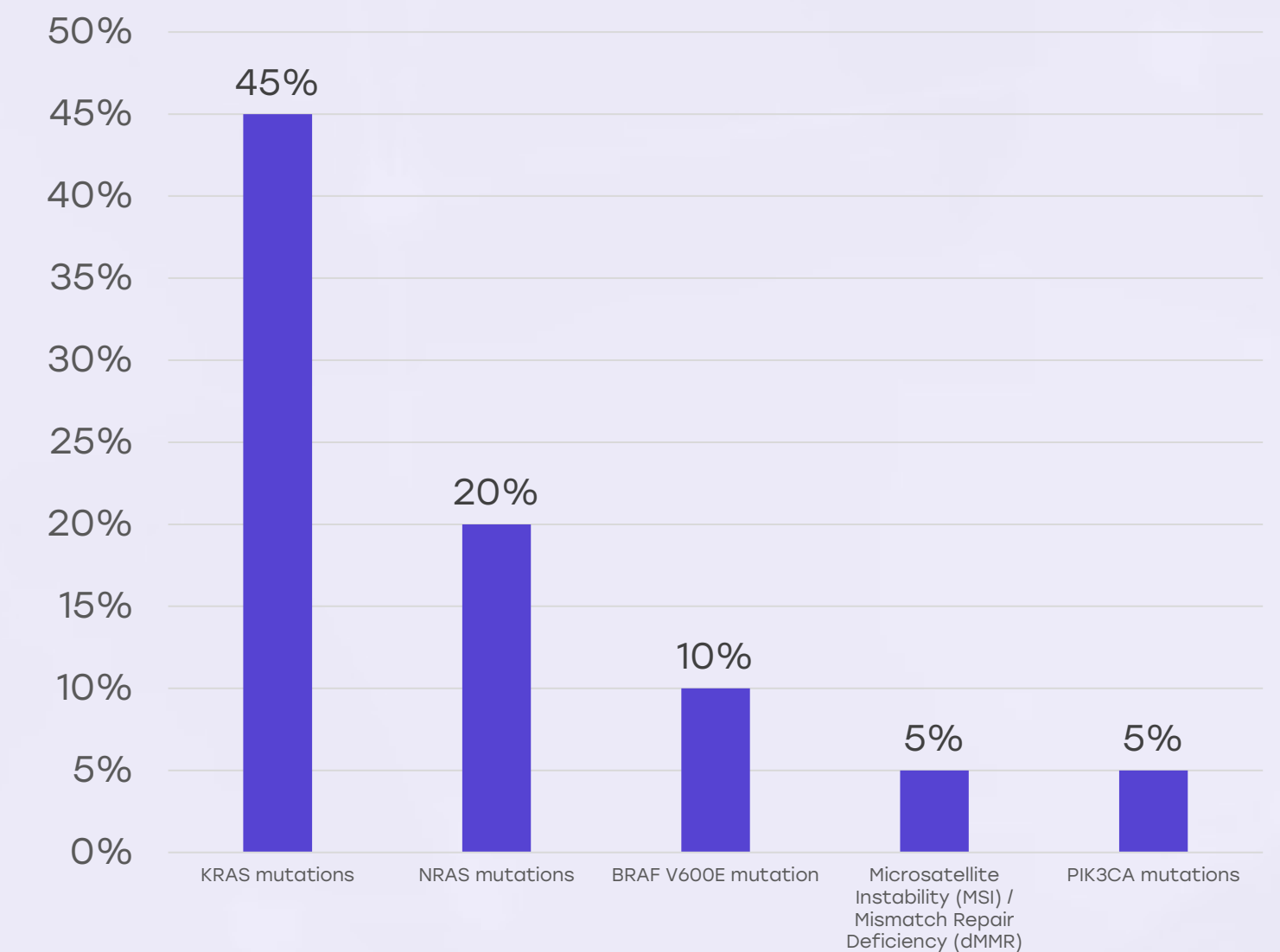


Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.



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.

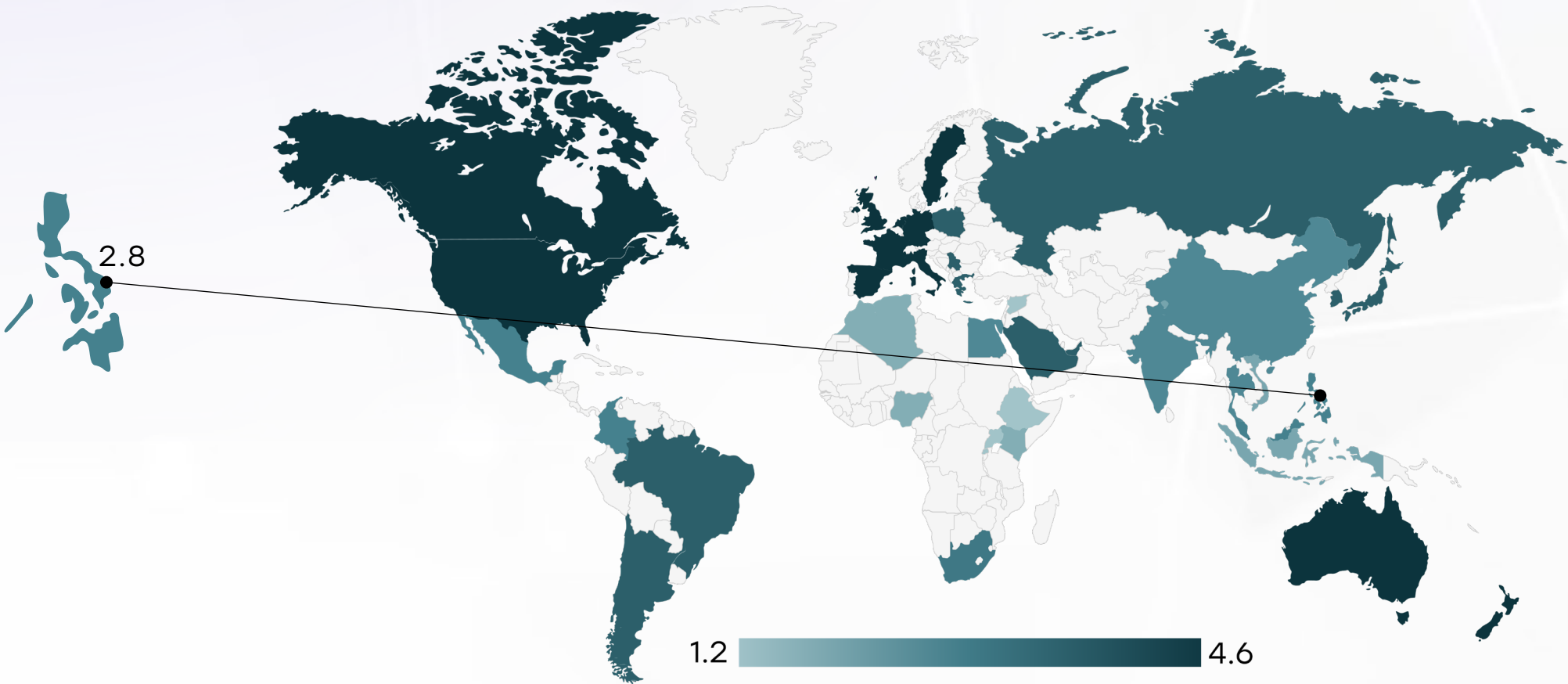
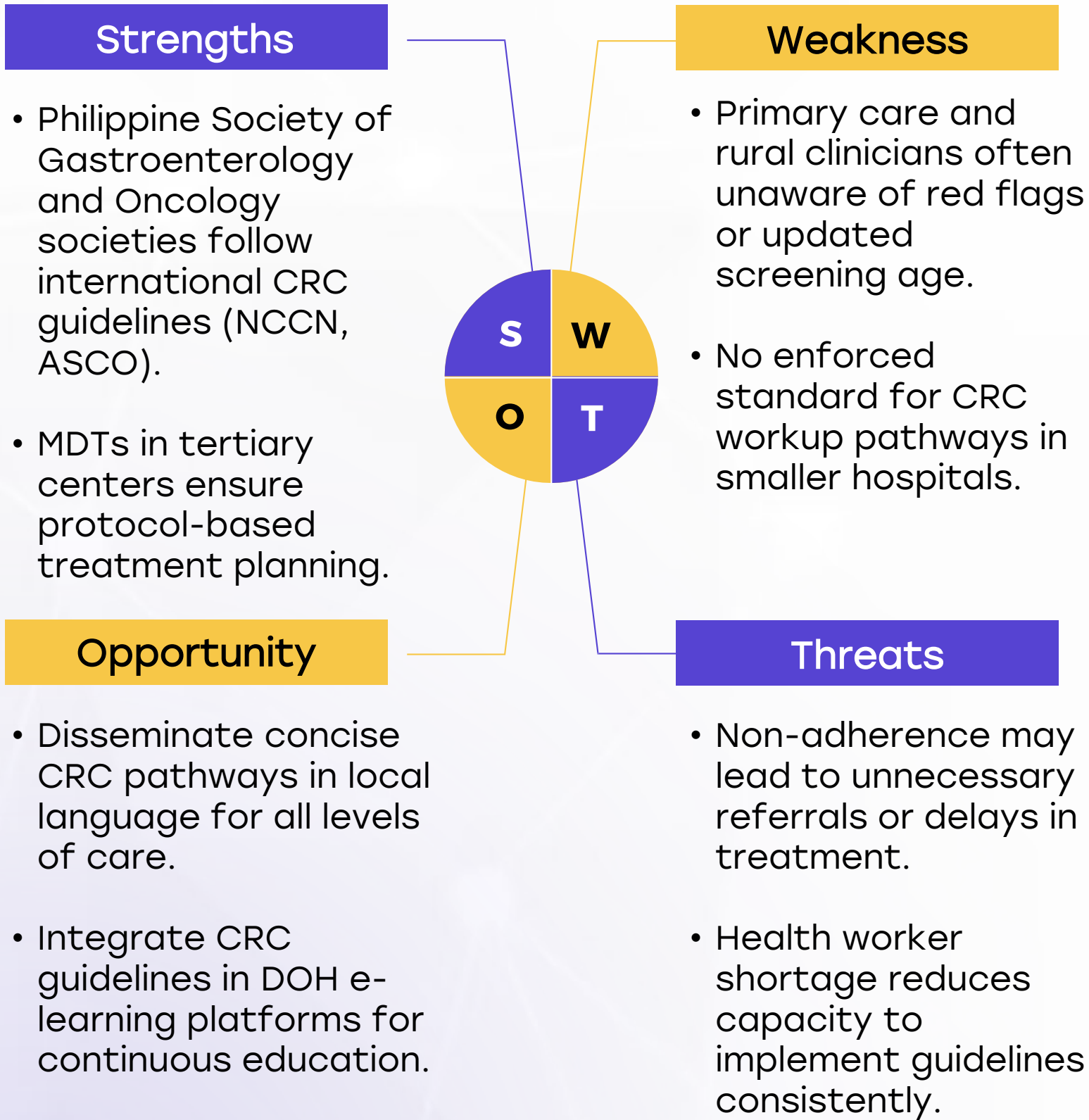
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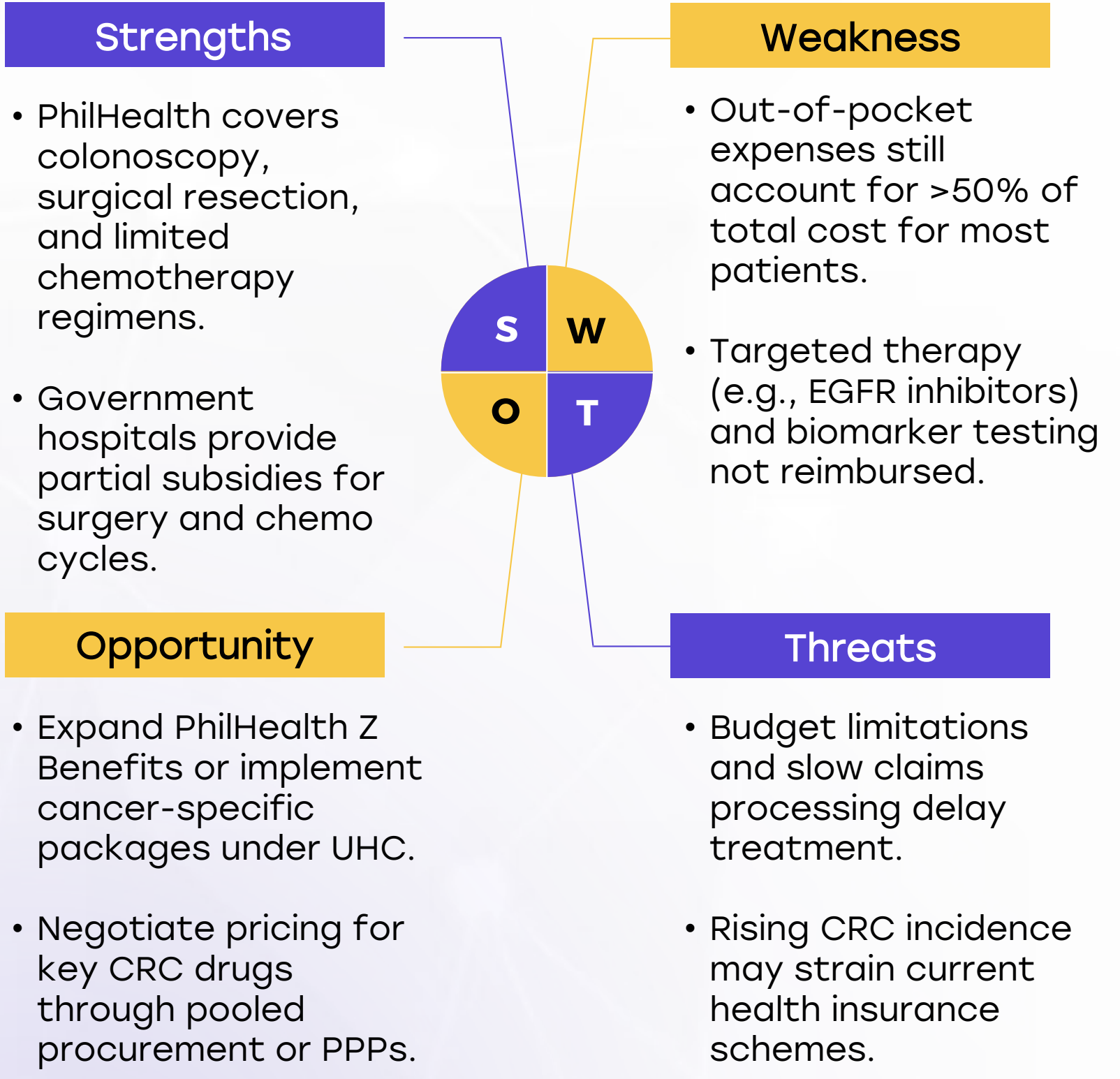
Clinical Guidelines



| | Very High | High | Medium | Low | Very Low |
|--------------------------------------|-----------|------|--------|-----|----------|
| Clinical Guideline Implementation | ✗ | ✗ | ◯ | ✗ | ✗ |
| Feasibility of Integration | ✗ | ✗ | ◯ | ✗ | ✗ |
| Adoption of International Guidelines | ✗ | ✗ | ◯ | ✗ | ✗ |
| Engagement with Updates | ✗ | ✗ | ✗ | ◯ | ✗ |
| ESMO Guidelines Implementation | ✗ | ✗ | ◯ | ✗ | ✗ |

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Reimbursement



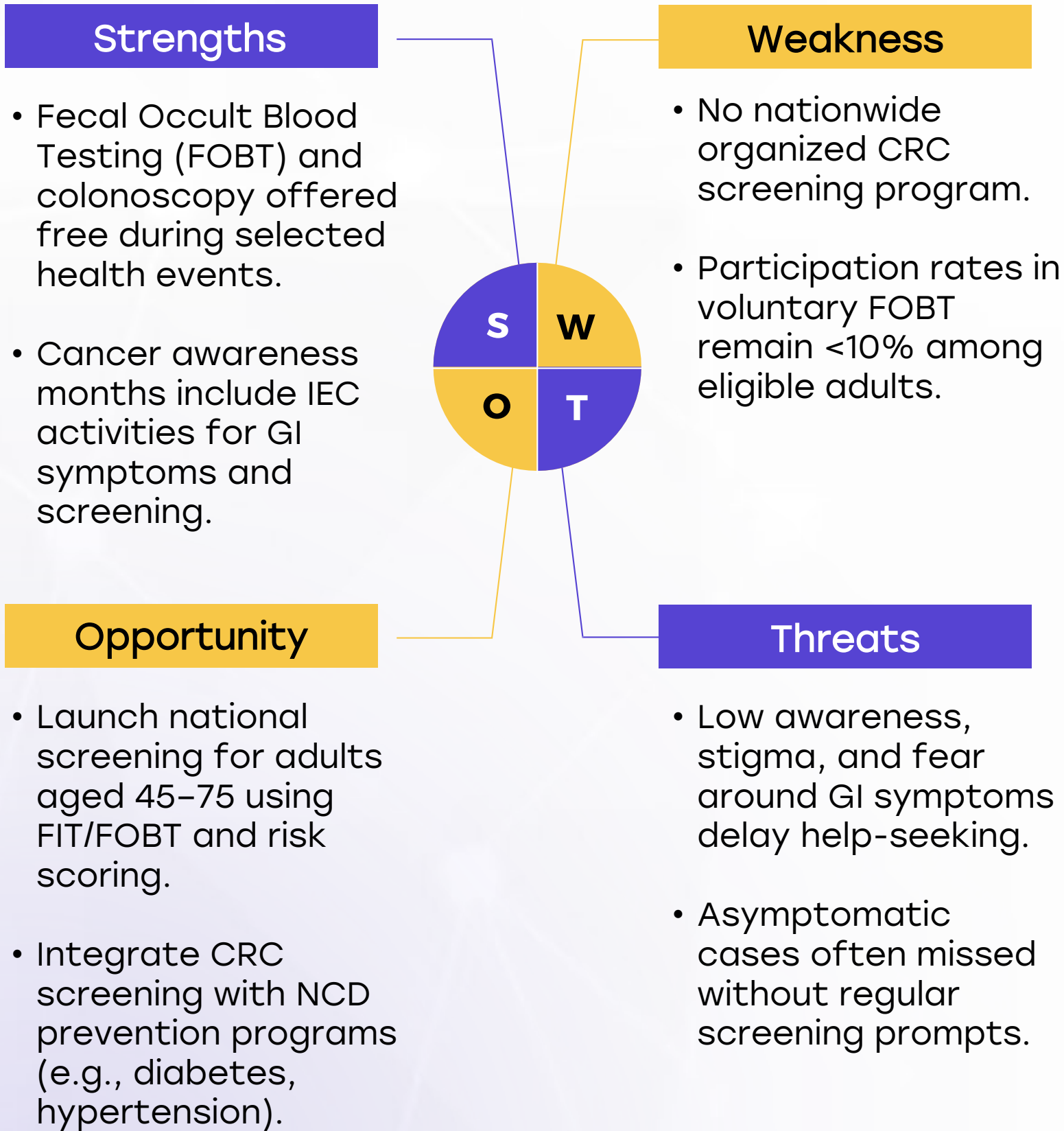
- A structured reimbursement system exists, ensuring biomarker testing is covered through national healthcare systems, insurance, or public-private partnerships. Patients face no direct financial burden.
- A reimbursement framework is in place, but patients may still have out-of-pocket expenses such 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 | | |
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| South Africa | | |
| Kenya | | |
| Nigeria | | |
| Egypt | | |
| Morocco | | |
| Algeria | | |
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| Vietnam | | |
| Philippines | | |
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Colorectal Cancer Screening



| 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 |