ETHIOPIA

International Cancer Patient Coalition

BRIDGING THE GAP

Enhancing Equitable Access & Innovation in **Colorectal Cancer Care** in Ethiopia

EXECUTIVE SUMMARY

Ethiopia is in the earliest stages of developing a response to colorectal cancer (CRC). While there are centres of oncology and surgical expertise in Addis Ababa and a few regional hospitals, CRC care remains extremely limited in reach, with most patients diagnosed at advanced stages. Public awareness is low, organised screening is absent, and diagnostic and treatment services are heavily centralised. High out-of-pocket costs, limited infrastructure, and scarce palliative services hinder equitable access.

This policy brief examines current conditions and proposes foundational reforms to initiate a pathway from **Level 1** toward structured national CRC care.

INTRODUCTION

Addressing Foundational Gaps Amid Rising Burden

Ethiopia faces a growing cancer burden, but CRC has not been a priority within existing health strategies. Most cases present late, reflecting low awareness and weak referral pathways. Existing oncology capacity in Addis Ababa's tertiary centres is overstretched and inaccessible for many rural patients.

With Maturity **Level 1 – Nascent** CRC care, Ethiopia's immediate priority is to establish basic public awareness, essential diagnostic capacity, and decentralised access to core treatments, alongside the development of a national CRC strategy.

Ethiopia at Level 1 – Colorectal Cancer Maturity Framework

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COLORECTAL CANCER IN ETHIOPIA

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No organised CRC screening; diagnosis almost always occurs at symptomatic, late stages; minimal public awareness.	Existing primary health care network can be leveraged for awareness campaigns.	Implement targeted awareness and education programmes; pilot FIT/FOBT screening in selected high-capacity urban centres; create basic referral pathways to regional hospitals with endoscopy.
Biomarker & Molecular Testing	No routine public-sector molecular testing (MSI/MMR, RAS/BRAF); histopathology access is limited and slow.	National pathology laboratory in Addis Ababa could act as a hub for capacity development.	Prioritise strengthening histopathology services; plan phased introduction of essential molecular testing through central labs; partner with academic institutions for training.
Treatment Access	Surgery and basic chemotherapy are only available at a handful of tertiary hospitals; radiotherapy is extremely limited; no access to targeted therapies in the public sector.	Surgical oncology capacity in major referral hospitals.	Expand essential surgery and chemotherapy services to regional hospitals; train surgical teams; ensure procurement of essential chemotherapy drugs.
Clinical Guidelines & Quality Standards	No national CRC treatment guidelines; clinical practice varies widely.	National Cancer Control Plan framework could integrate CRC-specific guidance.	Develop concise, resource-appropriate national CRC guidelines and distribute them to all referral hospitals; train clinicians in guideline use.
Palliative & Survivorship Care	Palliative services limited to a few NGOs and faith-based organisations; survivorship care virtually absent.	Community health extension workers provide a potential delivery channel for basic palliative care.	Integrate palliative care into primary health care; train providers in pain management and stoma care; ensure access to essential opioids for pain relief.

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CONCLUSION & Call to Action

Ethiopia's CRC care is in its early stages and needs low-cost, high-impact interventions to prevent late diagnoses and unequal access. A coordinated, phased approach—starting with awareness, diagnostics, and regional treatment—is urgent and achievable. The Ministry of Health, regional bureaus, hospitals, NGOs, and global partners should work together on a roadmap for affordable, accessible care.

KEY POLICY PRIORITIES

1. **Launch Awareness and Education Campaigns —** target high-risk populations and primary care providers to recognise CRC symptoms early.
2. **Pilot Screening in Urban Centres —** start small-scale FIT/FOBT pilots in high-capacity hospitals with clear referral pathways.
3. **Strengthen Diagnostics —** improve histopathology turnaround; prepare central labs for eventual MSI/MMR and RAS/BRAF testing.
4. **Expand Essential Treatment —** decentralise surgical and chemotherapy services to regional hospitals; ensure availability of core medicines.
5. **Create National CRC Guidelines —** develop and disseminate resource-appropriate protocols with provider training.
6. **Integrate Palliative Care —** train providers in basic palliative care and ensure opioid availability.

CONCLUSION

With targeted investment in awareness, diagnostic capability, and essential treatment services, Ethiopia can begin to move from Level 1 toward structured national CRC care. Early wins in awareness, screening pilots, and decentralised treatment will establish the foundation for future expansion into advanced diagnostics, guideline standardisation, and comprehensive palliative and survivorship programmes.