International Cancer Patient Coalition

# Nigeria

# 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 increasing, now among top 5 digestive cancers in men.
- Incidence rate: Around 5 per 100,000 men per year.
- Total new cases (2022): Approximately 2,300 men.
- Daily diagnoses (2022): About 6 men per day.
- Deaths (2022): Around 2,000 men.
- 5-year survival rate: Likely under 30%, due to late diagnosis and limited treatment.
- Most affected age group: Mostly men aged 60 and older.
- Screening participation: No national program; screening is virtually absent.

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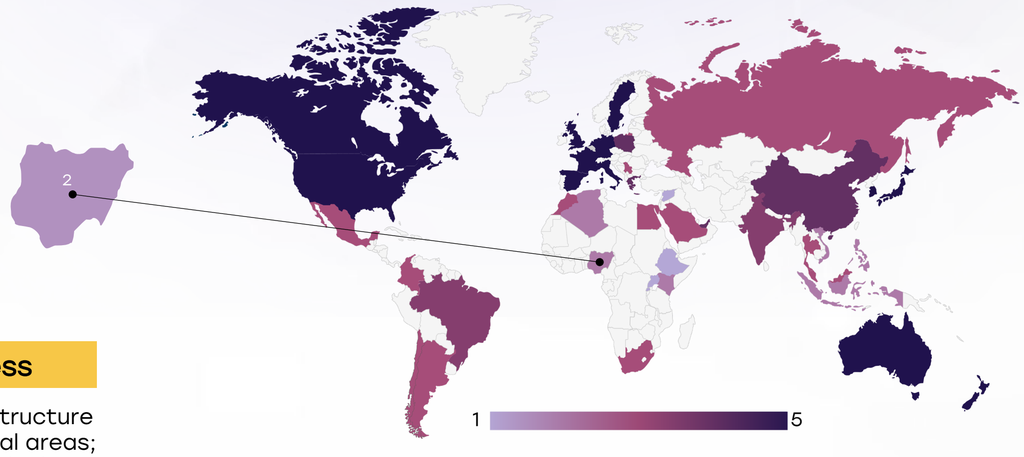
## Infrastructure




### Strengths

- Major cancer centers like the **Lagos University Teaching Hospital** and **National Hospital Abuja** provide CRC care with surgery and limited oncology services.
- Growing adoption of digital health platforms for patient monitoring and referrals in urban centers.

### Weakness

- Severe infrastructure deficits in rural areas; many regions lack CT, MRI, or endoscopy equipment.
- Frequent power outages, understaffing, and lack of multidisciplinary tumor boards impair care quality.

S W O T

### Opportunity

- Public-private infrastructure partnerships can upgrade diagnostic facilities and regional oncology hubs.
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- Investment in mobile endoscopy and telepathology services for remote outreach.

### Threats

- Continued reliance on external donors for major upgrades poses sustainability risks.
- Brain drain of trained oncologists and surgeons to higher-income countries.

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 | 4 |
| Spain | 4 | 4 |
| 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 | 4 |
| Syria | 1 | 1 |
| Indonesia | 2 | 2 |
| Vietnam | 3 | 3 |
| Philippines | 2 | 2 |
| Russia | 4 | 3 |
| Malaysia | 4 | 4 |

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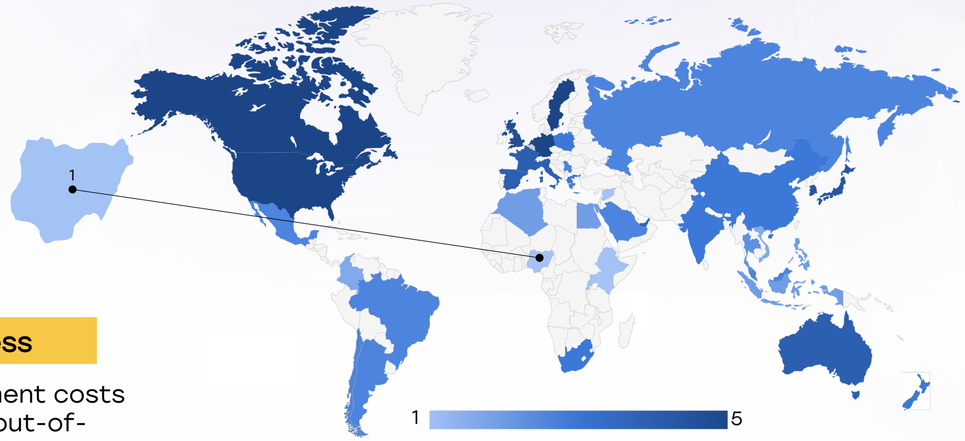
## Treatment Access, Research Funding and Awareness Campaigns




### Strengths

- NGOs like **Project PINK BLUE** and **Breast Without Spot** engage in awareness campaigns for various cancers, including CRC.
- Pilot partnerships with global agencies support training of oncology nurses and pathologists.

### Weakness

- CRC treatment costs are largely out-of-pocket; public hospitals often face drug and equipment shortages.
- Extremely limited CRC-specific research funding and clinical trials within Nigeria.

### Opportunity

- Increased domestic philanthropy and diaspora investments could fund awareness and access programs.
- Regional collaboration (e.g., West African Health Organization) may help secure pooled research grants.

### Threats

- Rising CRC incidence, especially among younger adults, without corresponding national investment.
- Misinformation and cancer stigma hinder early 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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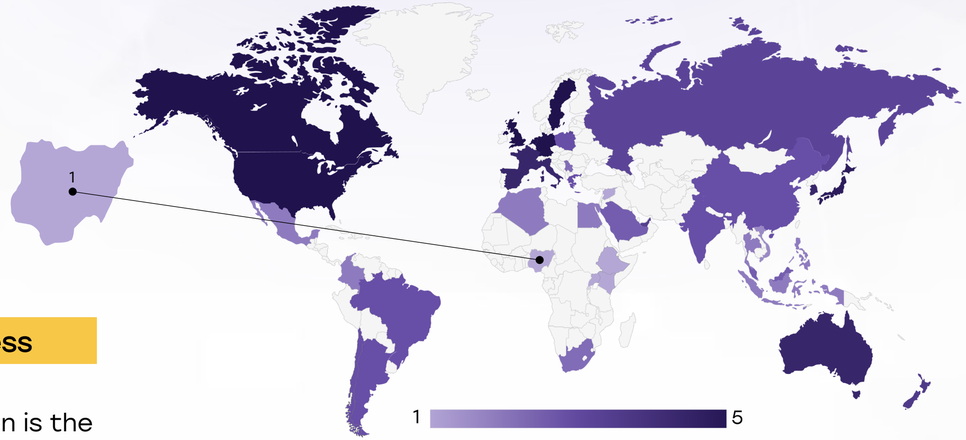
## Survival Rates, Early Detection and Palliative Care




### Strengths

- Urban centers like Ibadan and Abuja have established histopathology labs supporting earlier-stage diagnosis.
- Traditional and community health systems are increasingly engaged for early symptom referral.

### Weakness

- Late-stage presentation is the norm; **>70%** of CRC cases are diagnosed at advanced stages.
- Very few structured palliative care services outside capital cities, with morphine availability being inconsistent.

### Opportunity

- Education of primary care providers on CRC red-flag symptoms can boost early referral rates.
- Incorporation of home-based palliative models to reach underserved populations.

### Threats

- Delayed diagnosis due to long waiting times, diagnostic bottlenecks, and lack of cancer awareness.
- Poverty and poor transportation limit follow-up after initial consultations.

S W O T

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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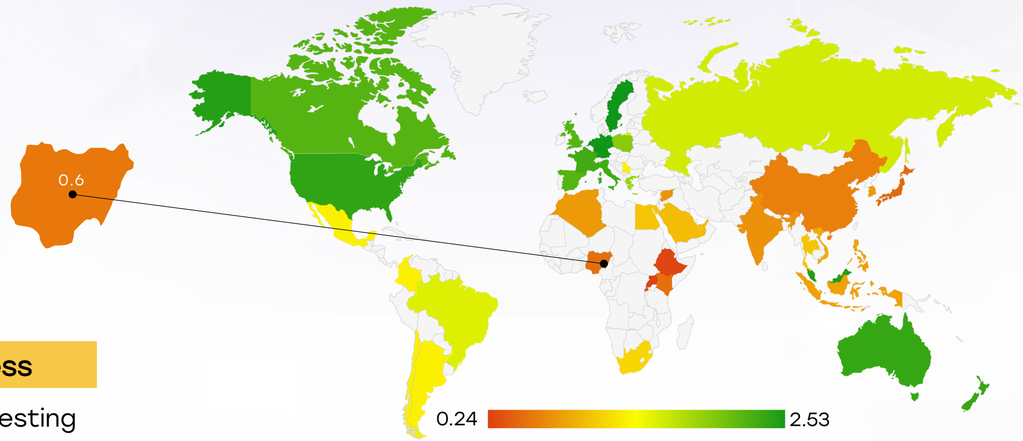
## Utilization of Biomarkers




### Strengths

- Some tertiary centers have begun offering **KRAS and BRAF mutation** testing via research collaborations.
- Pathology labs in Lagos, Ibadan, and Port Harcourt are slowly incorporating IHC testing for MSI/dMMR.

### Weakness

- Biomarker testing remains rare, expensive, and mostly research-driven; not standard in clinical pathways.
- No national mandate or reimbursement for molecular profiling in CRC.

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### Opportunity

- Regional lab networks or centralized genomic testing could reduce biomarker testing costs.
- Partnering with universities and private labs for biomarker-driven drug trials.

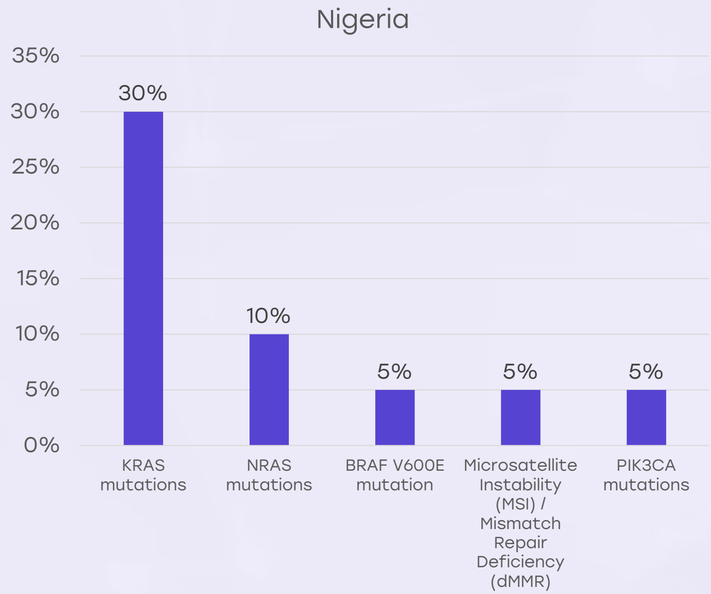
### Threats

- High costs of test kits and reagents due to currency instability and import dependency.
- Risk of outdated treatment decisions due to unavailable molecular data.

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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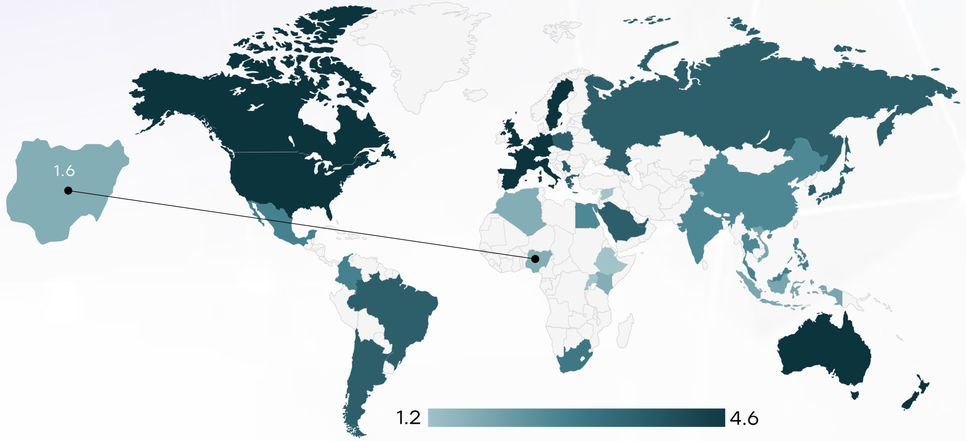
## Clinical Guidelines




### Strengths

- Nigeria's **National Cancer Control Plan (2018–2022)** acknowledges the need for early CRC detection and treatment scale-up.
- Some teaching hospitals follow international guidelines (e.g., NCCN) for advanced CRC.

### Weakness

- No CRC-specific national guidelines customized to Nigerian patient populations and healthcare realities.
- Disparity in protocol adherence across facilities, especially between public and private sectors.

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### Opportunity

- Development of **context-appropriate CRC protocols**, including when to test for biomarkers, could standardize care.
- Training programs to institutionalize tumor boards and case review structures.

### Threats

- Fragmentation in policy implementation and low accountability can delay national guideline adoption.
- Confusion from inconsistent practices undermines clinician confidence in guideline use.

| | 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

- CRC surgery and select chemotherapy are included under **NHIS (National Health Insurance Scheme)** in certain pilot states.
- Faith-based and NGO hospitals sometimes subsidize cancer treatment.

### Weakness

- Limited NHIS penetration (~10% of the population); most cancer care remains paid out-of-pocket.
- No reimbursement for diagnostics like colonoscopy, CT scan, or biomarker tests.

S W O T

### Opportunity

- Advocacy for cancer-specific funding within **NHIS expansion reforms** can broaden reimbursement scope.
- Emerging microinsurance and community-based health schemes could cover diagnostic costs.

### Threats

- Unstable insurance funding mechanisms and delays in provider reimbursements reduce effectiveness.
- Economic constraints may further delay inclusion of new treatments or tests.

● 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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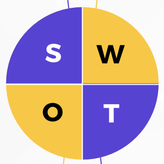
## Colorectal Cancer Screening

### Strengths

- Pilot screening initiatives in Lagos and Enugu have tested FIT and colonoscopy referral approaches.
- Some employer-led health plans incorporate CRC screening for executives or older employees.

### Weakness

- No national CRC screening program; opportunistic screening is rare and not subsidized.
- Low health literacy and fear of colonoscopy contribute to poor uptake.




### Opportunity

- Task-shifting to nurses and community health workers to distribute and interpret FIT can expand reach.
- Combining CRC awareness with existing campaigns for breast or cervical cancer could reduce costs.

### Threats

- Diagnostic follow-up infrastructure (colonoscopy, pathology) is under-resourced and overwhelmed.
- Without policy backing, small-scale screening efforts may not be sustainable.

| 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 |