UGANDA

International Cancer Patient Coalition

BRIDGING THE GAP

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

EXECUTIVE SUMMARY

Uganda's response to colorectal cancer is at an early, formative stage. CRC services are highly centralised in a few tertiary hospitals; public awareness and organised screening are essentially absent; diagnostic pathology and endoscopy capacity are limited and slow; and access to systemic therapies and palliative care is patchy outside urban centres.

Immediate, low-cost, high-impact actions are needed to build basic detection, diagnosis and treatment capacity and to create the governance, data and financing platforms required for later-scale improvements.

INTRODUCTION

Foundational gaps and the opportunity to begin

Uganda faces competing health priorities and constrained resources, so CRC has not yet been systematically addressed. Nonetheless, existing referral hospitals, primary-care networks and active civil-society partners provide a starting platform.

With targeted, sequenced investments in awareness, referral pathways, basic diagnostics (histopathology), core surgical and chemotherapy capacity, and palliative care, Uganda can establish the essential building blocks for a future, more advanced CRC system.

Uganda at Level 1 – Colorectal Cancer Maturity Framework

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COLORECTAL CANCER IN UGANDA

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No organised screening; most CRC cases present symptomatically and late; low public awareness.	National primary-care network and community health workers offer outreach channels.	Start public awareness campaigns on CRC symptoms and risk factors; pilot FIT/FOBT screening in 1–2 districts with clear referral pathways to regional hospitals.
Biomarker & Molecular Testing	Virtually no routine molecular testing; histopathology capacity is limited and turnaround times are long.	Teaching hospital laboratories can serve as initial hubs for diagnostics strengthening.	Prioritise reliable histopathology first (reduce turnaround); plan phased introduction of essential molecular tests via referral labs only after histopathology is robust.
Treatment Access	Surgery and basic chemotherapy available at few tertiary centres only; radiotherapy very limited; targeted agents unavailable to most.	Surgical oncology skills exist in referral hospitals.	Ensure safe basic colorectal surgery and essential chemotherapy at selected regional referral hospitals; create referral protocols to tertiary centres for complex cases.
Clinical Guidelines & Quality Standards	No widely implemented CRC clinical pathway; practice varies between facilities.	Existing national NCD/cancer frameworks can incorporate CRC guidance.	Develop simple, resource-appropriate national CRC guidelines (diagnosis → referral → basic treatment → palliative care) and train clinicians at district/regional levels.
Palliative & Survivorship Care	Palliative care is limited, mostly NGO-driven; survivorship services and stoma care are uncommon outside tertiary centres.	Community health workers and faith-based organisations can support basic palliative outreach.	Integrate basic palliative care into primary and regional hospitals; train clinicians in pain management and basic stoma care; improve access to essential analgesics.

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CONCLUSION & Call to Action

Uganda's CRC care is still developing. The priority is to strengthen basics—awareness, referrals, pathology, surgery, chemotherapy, and palliative care—before expanding to advanced treatments. A focused national effort now will enable future growth. The Ministry of Health, regional bodies, hospitals, NGOs, and partners must collaborate on a targeted, actionable plan to quickly improve access and outcomes.

KEY POLICY PRIORITIES

1. **Raise awareness & pilot detection :** community education and FIT/FOBT pilots in 1–2 districts with clear referral links.
2. **Secure basic diagnostic capacity :** strengthen histopathology turnaround at national/regional labs before adding molecular tests.
3. **Expand essential treatment services :** enable safe colorectal surgery & basic chemotherapy at selected regional hospitals; formalise referral pathways.
4. **Create simple national clinical guidance :** resource-adapted protocols and targeted clinician training.
5. **Integrate basic palliative care :** train primary & district-level providers in pain management & stoma basics; ensure opioid policy allows appropriate access.

CONCLUSION

At **Maturity Level 1**, Uganda should prioritise foundational, feasible actions that deliver immediate value: awareness, diagnostic strengthening (histopathology), decentralised basic surgery/chemotherapy and palliative care. These steps will improve early detection and equity and create the "plumbing" needed for phased introduction of organised screening and advanced diagnostics in later maturity stages.