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ABSTRACT

Colorectal cancer (CRC) is a major and growing global health challenge, marked by stark disparities in incidence, mortality, and access to care between high-income countries (HICs) and low- and middle-income countries (LMICs). The "Global Cancer Movement: Challenging the Status Quo in Colorectal Cancer" Congress, a three-day virtual event, brought together international experts to examine these disparities and develop strategies to improve CRC outcomes worldwide. This paper synthesizes the congress's key insights, assessing challenges in CRC prevention, diagnosis, and treatment across diverse settings and highlighting priority areas for action.

The rising incidence of early-age onset CRC (EAOCRC) adds further complexity, demanding urgent research and tailored approaches. Addressing the global CRC burden requires investment in data systems, equitable access to screening and early diagnosis, context-specific therapeutic innovation, workforce and infrastructure development, and targeted EAOCRC strategies. Civil-society actors, particularly national NGOs, are instrumental in co-leading early detection and navigation initiatives with primary care and in ensuring uptake and follow-up at the community level. Strengthened global partnerships and cohesive policies are essential to closing the care gap and reducing the toll of this preventable and treatable disease.

INTRODUCTION

Colorectal cancer (CRC) is a major global health challenge, ranking among the most commonly diagnosed cancers and leading causes of cancer-related death[1]. If current trends persist, annual cases may exceed 2.2 million by 2030 and reach 3.2 million by 2040, with deaths projected to rise to 1.1 million and 1.6 million, respectively[2]. These figures underscore the urgent need for strengthened global efforts in prevention, early detection, and treatment[3,4].

Table 1. Current Estimates and Future Projections of Global Colorectal Cancer (CRC) Burden According to GLOBOCAN 2020–2040

Metric/Year	GLOBOCAN 2022 [1]	Projected 2030 [2]	Projected 2040 [2]
Global New Cases	~1.9 million	>2.2 million	~3.2 million
Global Deaths	~930,000	~1.1 million	~1.6 million
Highest Incidence Regions (ASIR)	Europe, Australia/New Zealand	High HDI countries	Predominantly High/Very High HDI countries
Lowest Incidence Regions (ASIR)	African regions, Southern Asia	Low HDI countries	-
Highest Mortality Regions (ASMR)	Eastern Europe	Countries in transition	-
Lowest Mortality Regions (ASMR)	Southern Asia	-	-
Early-Age Onset CRC (<50 years) Trend	Increasing	Expected to increase by >140% by 2030 (US data)[8]	Continued increase predicted

The "Global Cancer Movement—Challenging the Status Quo in Colorectal Cancer" Congress was convened to address this escalating burden. This three-day virtual event brought together 72 international experts from 36 countries—spanning clinicians, researchers, public health leaders, and patient advocates—to examine the drivers of global disparities in incidence and outcomes and to propose actionable strategies that advance equity in prevention, diagnosis, and treatment.

This report synthesizes the Congress's key insights, situating them within current scientific and policy contexts. It outlines priority areas to guide research, inform policy, and mobilize coordinated global efforts to reduce CRC's impact and narrow disparities in care delivery across diverse socioeconomic settings.

NAVIGATING THE GLOBAL LANDSCAPE OF COLORECTAL CANCER

The "Global Cancer Movement: Challenging the Status Quo in Colorectal Cancer" Congress highlighted critical aspects shaping the global colorectal cancer (CRC) landscape, including disparities in burden and outcomes, barriers to screening and early detection, innovations in diagnostics, evolving treatments, the rise of early-age onset CRC, and the role of advocacy.

Disparities in CRC Burden and Outcomes

CRC is the third most commonly diagnosed cancer and the second leading cause of cancer-related mortality globally. In 2022, CRC accounted for 1.93 million new cases and 935,000 deaths, representing 9.6% of the global cancer incidence and 9.3% of cancer-related mortality. By comparison, lung cancer remained the top cause of cancer death (18.7%), followed by CRC (9.3%), liver (7.8%), breast (6.9%), and stomach (6.8%) cancers. Today, one in every 10 cancer deaths globally is attributable to CRC.

Marked disparities in CRC incidence and mortality persist, driven by differences in development, health infrastructure, and resource allocation. Global cancer incidence varied fivefold in 2022 from 507.9 per 100,000 in Australia/New Zealand to 97.1 per 100,000 in Western Africa among men, and from 410.5 to 103.3 per 100,000 among women. Similarly, age-standardised CRC mortality rates in Africa in 2022 were 5.6 per 100,000, compared to much higher rates in Eastern Europe[1,3,5,6].

While mortality rates from CRC are decreasing in many high-income settings due to screening and specialized care, age-period-cohort modelling projects a sharp increase in deaths from rectal cancer in several countries.

Between 2020 and 2035, the total number of deaths due to rectal cancer is expected to rise by 73.6% in Costa Rica, 59.2% in Australia, 27.8% in the United States, 24.2% in Ireland, and 24.1% in Canada[7]. Overall, the number of deaths from colon and rectal cancers is projected to increase by 60.0% and 71.5%, respectively, by 2035, primarily due to population growth and aging.

These inequities are further compounded by weak cancer registries, limited oncology workforce capacity, insufficient infrastructure, and restricted access to diagnostics and essential therapies. In many low- and middle-income countries (LMICs), including Armenia, survival rates remain substantially lower than in high-income countries (HICs)[8,9,10]. Closing these gaps requires robust, tailored national cancer control plans that integrate cost strategies for diagnostics and treatment strategies, in alignment with the Lancet Oncology Commission on Medical Imaging and Nuclear Medicine[11].

Finally, "data deserts" in LMICs and parts of the Eastern Mediterranean Region remain a critical barrier to both, early detection and timely treatment. Strengthening population-based cancer registries and improving follow-up colonoscopy tracking are essential to accurately assess screening effectiveness, report equity outcomes, and optimize return on investment.

THE DUAL CHALLENGE OF SCREENING AND EARLY DETECTION

Screening remains central to CRC control, enabling early detection and prevention through removal of precancerous polyps. The Congress reaffirmed the efficacy of fecal immunochemical testing (FIT) and colonoscopy, while underscoring persistent global barriers to access, coverage, and follow-up.

FIT demonstrates pooled sensitivity of 93% and specificity of 91% for high-risk individuals, respectively[12]. Population-based programs using annual FIT have reduced CRC mortality by up to 40%[13]. Colonoscopy decreases CRC incidence by approximately 31% and mortality by up to 68%[14]. Ten-yearly colonoscopy has proven cost-effective in both high- and middle-income settings[15]. In the United States, initiating screening at age 40 with FIT or flexible sigmoidoscopy is cost-effective given the rising incidence of early-age onset CRC (EAOCRC)[16].

Despite these proven benefits, participation rates vary considerably. In HICs, screening uptake often exceeds 60%, whereas in many LMICs, rates fall below 20%. Completion of follow-up colonoscopy ranges from just 13% to 50%. Contributing factors include inadequate infrastructure, limited endoscopic capacity, workforce shortages, and weak referral systems[3]. Evidence-based strategies can mitigate these gaps: mailed FIT kits with automated reminders increase participation by 20–30%[17], though for highly mobile and urbanized populations, such as in the Gulf Cooperation Council, primary care–anchored distribution with SMS reminders and e-referrals may be a more effective delivery model.

Knowledge, attitudes, and practices of healthcare professionals can also hinder CRC screening. A web-based survey (Dec 2018–Mar 2019) among internal medicine physicians at Hamad Medical Corporation found that 90.6% recommend screening for asymptomatic patients, with residents more likely than consultants to choose the correct modality (86.2% vs 40.7%). Yet only 43.4% routinely recommend screening in clinics and 29.4% for inpatients. The main barrier cited was an unclear screening pathway (30.2%), while 54% noted that clear, streamlined pathways would facilitate uptake[18].

Community health worker engagement can further improve adherence by up to 42%, particularly in underserved populations[19]. Experts emphasized that improved outcomes require not only test availability but also an integrated continuum of care—from public awareness and test distribution to diagnostic evaluation and linkage to treatment[20]. Without coordinated delivery and sustained investment, even the most effective tools cannot achieve population-level impact.

Innovations in Diagnostics

Recent advances in CRC detection are reshaping the diagnostic landscape, offering greater precision in tumor visualization, characterization, and treatment planning. While colonoscopy with AI-based computer-aided detection (CADe)[21] and standard PET-CT imaging are becoming routine in high-resource settings, emerging modalities are pushing the frontier further– though global access remains uneven.

In molecular imaging, gallium-68 fibroblast activation protein inhibitors (68Ga-FAPI) and zirconium-89 labeled monoclonal antibodies such as 89Zr-cetuximab[22] for colorectal cancers and 89Zr-trastuzumab[23] GI cancers have demonstrated superior lesion detectability and target specificity than 18F-FDG, particularly in fibrotic or mucinous tumors. ImmunoPET now enables in vivo receptor profiling of EGFR, HER2, and CEA, allowing for patient-specific treatment selection[24]. Tumor-targeted fluorescent probes like SGM-101 have demonstrated >95% specificity in intraoperative detection of CEA-expressing lesions, highlighting their theranostic potential[25].

Novel imaging modalities such as multispectral optoacoustic tomography (MSOT) and endoscopic photoacoustic microscopy provide label-free visualization of vascular and metabolic features, especially in rectal tumors[26]. Meanwhile, deep learning and radiomics are being integrated into imaging pipelines to enhance lesion detection, margin assessment, and response prediction, leveraging multi-institutional, multimodal datasets[27].

However, these high-cost, high-complexity tools remain inaccessible in most LMICs. During the conference,

participants stressed the importance of an "equity test": prioritizing scalable solutions such as (AI-assisted) interpretation on standard scopes, regional production of novel radiotracers, and deployment of mobile imaging units—before investing in high-cost novel platforms. Expanding access to advanced diagnostics, supported by appropriately applied AI in low-resource settings, is essential to balance innovation with global health equity[28].

Bridging the gap between advanced technologies in HICs and the fundamental diagnostic needs of LMICs remains essential to achieving true global equity. Each delayed or missed diagnosis – occurring disproportionately in LMICs – represents preventable harm and reinforces inequities that extend across individuals, families, and communities. Achieving diagnostic equity requires systematic approaches tailored to the realities of LMICs, addressing infrastructure, workforce capacity, financing, and regulatory frameworks in a coordinated manner.

EXPANDING MOLECULARLY TARGETED OPTIONS IN COLORECTAL CANCER

The therapeutic landscape of colorectal cancer has rapidly shifted toward biology-driven, molecularly stratified approaches. Immune checkpoint inhibitors have redefined the treatment of mismatch repair-deficient (dMMR)/microsatellite instability-high (MSI-H) tumors, which account for ~5% of mCRC cases. In the pivotal KEYNOTE-177 trial, pembrolizumab significantly improved progression-free survival (PFS) versus chemotherapy in first-line MSI-H mCRC (median PFS 16.5 vs. 8.2 months; HR 0.60, p = 0.0002) with a more favorable safety profile, however OS did not reach statistical significance (HR 0.74), yet with > 60% crossover[29]. Building on this, the CheckMate-8HW trial reported an unprecedented hazard ratio for PFS of 0.21 (p < 0.0001) with first-line nivolumab–ipilimumab versus chemotherapy in the same population, reinforcing dual checkpoint blockade as a preferred strategy[30].

A recent phase 2 trial by Cercek et al. demonstrated that neoadjuvant PD-1 blockade with dostarlimab can eliminate the need for surgery in patients with early-stage dMMR rectal and nonrectal tumors. Among 117 patients, 84 (72%) achieved clinical complete response following six months of dostarlimab, and 82 (70%) elected nonoperative management. In rectal cancer specifically, all 49 patients who completed therapy achieved a complete clinical response, with 2-year recurrence-free survival reaching 96%. Across all tumor types, recurrence-free survival at 2 years was 92%. No patients lost the opportunity for curative surgery[31].

In parallel, Total Neoadjuvant Therapy (TNT) has emerged as standard in locally advanced rectal cancer irrespective of MSI status. The RAPIDO trial showed that TNT (short-course radiotherapy + chemotherapy before surgery) improved disease-related treatment failure (23.7% vs. 30.4%; HR 0.75, p = 0.019), and reduced distant metastases, though at the cost of higher locoregional recurrence. TNT also increased rates of pathologic complete response, enabling watch-and-wait strategies and potential avoidance of permanent colostomy in selected patients[32].

Despite these advances, the majority of CRCs (~95%) are microsatellite stable (MSS) and immunologically "cold," continuing to rely on cytotoxic backbones. Molecular targeting has improved outcomes, as in RAS wild-type, left-sided mCRC, anti-EGFR therapy with chemotherapy remains standard. For BRAF V600E-mutated mCRC (~10% of cases), the BEACON CRC trial established encorafenib plus cetuximab as the global standard (median OS 9.3 vs. 5.9 months; HR 0.60, p<0.001)[33]. The SEAMARK trial is now testing the addition of pembrolizumab to encorafenib–cetuximab in MSI-H, BRAF-mutant disease[34].

Novel immunotherapy combinations are making inroads into MSS CRC. In a phase I/II trial botensilimab (anti–CTLA-4) plus balstilimab (anti–PD-1) achieved an objective response rate of 24% and disease control rate of 74% in refractory MSS CRC[35]. Median OS exceeded 14.1 months, with a 12-month OS rate of 61% — substantially better than historical controls with regorafenib or trifluridine–tipiracil (~7 months).

In parallel to immunomodulatory strategies, molecularly targeted therapies are reshaping treatment for biomarker-defined MSS subsets. KRAS G12C-targeted therapy is advancing with sotorasib plus panitumumab, which in the phase III CodeBreaK 300 trial showed an ORR of 30.2% and an OS HR of 0.70 vs. investigator's choice, supporting its role in chemorefractory mCRC[36]. In parallel, the SUNLIGHT trial confirmed FTD/TPI plus bevacizumab as a third-line standard, improving median OS to 10.8 months (HR 0.61; p < 0.001) across molecular subtypes[37]. These data highlight continued gains in precision and late-line management.

Emerging modalities such as adoptive cell therapies, CAR-T cells, and cancer vaccines – are under active investigation, though none are yet approved, underscoring the persistent global burden and therapeutic unmet need in advanced colorectal cancer. The benefits of these novel therapies remain concentrated in HICs, highlighting the urgent need to scale molecular diagnostics, access to biosimilars, and trial infrastructure in LMICs.

Data show that biologics and their biosimilars perform equally across regions when available, with cost savings of up to 20–40% in HICs and up to 92% in LMICs when biosimilars are implemented[38]. GCC/EMR case studies of pooled procurement and structured formularies can accelerate equitable access to biologics/biosimilars; we need to flag civil-society roles in payer dialogues and patient-reported barriers.

As molecular classification deepens and therapeutics become increasingly personalized, the next era of CRC care must balance innovation with global inclusion. Expanding access to clinical trials, molecular diagnostics,

and targeted therapies is essential to narrow disparities and deliver equitable improvements in outcomes worldwide[39].

Precision oncology is accelerating—immunotherapy, EGFR/BRAF targeting, and emerging cell/vaccine strategies—but access remains the rate-limiting step in LMICs. The principal gap is not efficacy, but infrastructure and affordability: limited biomarker testing, fragmented procurement, and out-of-pocket payment models interrupt therapy despite clinical benefit.

Real-world nationwide data from Armenia illustrate this signal—patients with biomarker-selected tumors derive meaningful survival, yet many discontinue early for financial reasons; among documented causes, financial hardship was the leading non-progression driver of interruption, implying underestimation given missing data[40]. Equity requires a pragmatic sequence: scale essential biomarkers, adopt pooled procurement/price negotiation and biosimilars, and align coverage with high-benefit regimens—so that novel, biology-driven advances narrow rather than widen global outcome gaps.

BEYOND MOLECULAR TARGETS: THE ROLE OF INTEGRATIVE MEDICINE

As colorectal cancer (CRC) management advances through molecular stratification and precision therapeutics, there is increasing recognition that optimal care must also address host resilience. Integrative oncology—merging conventional treatments with evidence-based complementary approaches—has gained momentum globally as a strategy to improve treatment tolerance, quality of life, and possibly survival.

China has emerged as a global leader in advancing this approach. The China Anti-Cancer Association (CACA), in collaboration with the World Association for Integrative Oncology (WAIO), has institutionalized integrative oncology within its national cancer framework. The 2024 Chinese Congress on Holistic Integrative Oncology drew over 60,000 onsite participants and 72 million virtual attendees, reflecting wide-scale clinical and scientific engagement. Chinese integrative protocols incorporate Traditional Chinese Medicine (TCM), individualized nutrition, mind-body practices, and exercise-based rehabilitation alongside chemotherapy and surgery[41].

In CRC, this approach targets chemotherapy-induced gastrointestinal toxicity, supports immune modulation, and promotes gut microbiota balance— an emerging determinant of treatment response. TCM is now offered in over 60% of tertiary oncology centers in China, with select herbal formulations under active investigation in randomized trials for symptom relief and adjunctive efficacy[42].

Exercise has gained recognition as a therapeutic modality in its own right. At the 2025 ASCO Annual Meeting, the CHALLENGE phase 3 trial (n = 889) demonstrated that a 3-year structured aerobic exercise program initiated after adjuvant chemotherapy for colon cancer significantly improved disease-free and overall survival. At a median follow-up of 7.9 years, the exercise group showed a 28% reduction in recurrence or death (HR = 0.72, 95% CI 0.55–0.94) and a 37% reduction in overall mortality (HR = 0.63, 95% CI 0.43–0.94) compared to controls. Five-year disease-free survival was 80.3% versus 73.9%, and 8-year overall survival reached 90.3% versus 83.2% compared with controls[43].

These survival gains are comparable in magnitude to certain systemic therapies, underscoring the biological relevance of physical conditioning in oncologic outcomes. Mechanistically, exercise is thought to modulate inflammation, immune surveillance, insulin signaling, and tumor microenvironment composition. Notably, patients in the CHALLENGE trial achieved a sustained increase of 5–7 MET-hours/week in moderate-to-vigorous physical activity, equivalent to 1.5 to 2 hours of brisk walking per week.

China's national efforts in exercise oncology parallels these findings. Major cancer centers report >80% adherence to structured rehabilitation during chemotherapy, with associated improvements in fatigue, treatment completion, and physical functioning[44]. As China continues to produce high-quality clinical evidence and expand standardized integrative oncology pathways, its model offers a replicable framework for improving supportive care, particularly in low- and middle-income countries where symptom burden is high and palliative resources are limited.

The evidence now positions integrative modalities not as adjunctive measures but as essential components of modern CRC care, reinforcing the need for their integration into global cancer control strategies.

In resource-constrained settings, community- and primary-care–delivered programmes—often co-implemented with civil-society partners—that pair brief exercise prescriptions with group physical activity and culturally tailored nutrition counselling offer low-cost, scalable interventions to improve treatment tolerance, quality of life, and survivorship outcomes in the near term.

THE RISING TREND OF EARLY-AGE ONSET COLORECTAL CANCER

A significant global concern is the rising incidence of early-onset colorectal cancer (EAOCRC), defined as diagnosis before age 50. EAOCRC now accounts for nearly 10% of all new CRC cases worldwide. In the United States, CRC is the leading cause of cancer death in men under 50 and the second in women, with incidence rates increasing by 1.4–4.4% annually since the 1990s, depending on age group[45]. Projections suggest that by 2030, EAOCRC will comprise

11% of colon cancers and 23% of rectal cancers, with the steepest increases in the 20–34 age group, where rates are expected to rise by 90–124%[46].

This pattern is mirrored globally. Rates have more than doubled in South Korea[47] and Japan[48] over two decades, risen ~50% in Canada49 and the UK[49], and grown in Australia[50] from 6% to over 12% of all CRC cases within 15 years. In Canada, the current incidence is 13.5 per 100,000 person-years.

Despite rising incidence, early diagnosis remains rare. More than 55–61% of EAOCRC cases are diagnosed at stage III or IV, compared to 40–45% in older adults, largely due to diagnostic delays and lack of screening[51]. Symptoms such as rectal bleeding and abdominal pain are often misattributed to benign causes, contributing to late-stage presentation. While younger patients have slightly better stage-specific outcomes (5-year CRC-specific survival 74–80%)[52,53,54], the psychosocial and economic burdens are profound, affecting fertility, employment, caregiving, and long-term quality of life. Survivors frequently face chronic toxicities, including neuropathy, bowel dysfunction, and mental health challenges.

Most EAOCRC cases are sporadic, not linked to hereditary syndromes. Lifestyle factors, such as obesity, sedentary behavior, processed/Western diets, sugary drinks, and microbiome disruption, are implicated, though etiology remains unclear[55]. Genomic and epigenetic profiling reveals EAOCRC as a biologically distinct subtype with unique mutational and methylation signatures. International consortia, such as PROSPECT, and advocacy groups are prioritizing research into risk factors, biomarkers, and interventions[56]. Major cancer centers—including Memorial Sloan Kettering[57], MD Anderson, Dana-Farber[58], and Cleveland Clinic[59]—have now established dedicated EAOCRC programs to address the unique clinical and psychosocial needs of younger patients.

Recent genomic profiling studies indicate that, among microsatellite stable (MSS) tumors, EAOCRC is broadly similar to average-onset CRC in histopathology, chemotherapy response, and survival, once tumor sidedness and molecular alterations are accounted for. However, germline pathogenic variants are more common in younger patients: 23.3% in those ≤35 years versus 14.1% in older adults (P = .01), supporting the case for routine germline testing even without family history[60].

This epidemiological shift challenges age-based screening. Current guidelines now recommend initiating average-risk screening at age 45, but a risk-adapted, personalized model incorporating family history, germline testing, lifestyle, and potentially microbiome/molecular markers is urgently needed[61].

In patients diagnosed under age 50, care pathways should explicitly integrate pre-treatment fertility-preservation counselling, structured return-to-work support, and mental-health navigation, co-delivered by multidisciplinary oncology services and national NGOs to enhance access, adherence, and survivorship outcomes.

Co-implementation of community 'red-flag' symptom campaigns, such as persistent rectal bleeding, unexplained change in bowel habit with expedited, protocolized primary-care referral pathways to colonoscopy; civil-society organizations, working with ministries of health and PHC, can operationalize these measures to shorten diagnostic delays and downstage presentation.

Palliative Care Considerations

Despite the fact that palliative care is an essential part of universal health coverage (UHC), between 80% and 90% of the world's palliative care needs are still unmet. Around the world, 32% of nations provide isolated hospice and palliative care services, whereas 32% do not. Globally, fewer than 10% of nations offer sophisticated, integrated palliative care. Surprisingly, low- and middle-income countries (LMIC) account for the bulk of unmet palliative care needs[62].

Premature death and decreased productivity resulting from EOCRC have higher indirect costs than direct ones. Delays in diagnosis caused by patient awareness, the system, and physicians should be strategically reduced. Younger cancer patients have different survivorship issues than older patients[63]. This indicates that these patients need a personalized care plan tailored to meet their needs.

Despite growing awareness, the term "palliative care" is perceived as a lack of hope and causing suffering to patients and their families, it may act as a barrier to early referral. Introduction of palliative care in this context is aimed to improve quality of life and is somewhat warranted that physicians discuss the introduction of palliative care for younger patients in the early phase of the disease trajectory. More work is required to incorporate palliative care in young cancer patients' treatment plans at an early stage[64].

THE ROLE OF PATIENT ADVOCACY AND GLOBAL ALLIANCES IN DRIVING CHANGE

Patient advocacy organizations and global alliances are essential to advancing CRC care. By connecting patients, clinicians, and policymakers, they ensure that lived experiences shape policy, research, and care delivery. Their work has accelerated screening implementation, expanded biomarker access, and advanced equity-driven reform across diverse settings.

In the United States, Fight Colorectal Cancer (Fight CRC)[65] has advanced national policies through initiatives like Call-on Congress, United in Blue, and the Colorectal

Cancer Care Initiative. Their advocacy efforts helped to lower the CRC screening age to 45, set national goals to improve care for CRC patients, and boost federal investment in prevention. The Colorectal Cancer Alliance[66] serves over 1.5 million individuals annually via BlueHQ, offering navigation, psychosocial support, and biomarker education. The GI Cancer Alliance[67], a coalition of over 40 groups, and COLONTOWN[68], a digital patient community with 9,000+ members, provide disease-specific education and peer mentorship.

Globally, the Global Colon Cancer Association (GCCA)[69] connects over 100 member organizations across 56 countries, serving more than 6 million patients. Its #KnowYourBiomarker campaign and Health Equity Grants support testing access and advocacy in LMICs including Kenya, Mexico, and Brazil. In Europe, Digestive Cancers Europe (DiCE)[70] unites 40+ national groups across 30 countries. Its public campaigns (Screening Saves Lives, My Survival Story) and engagement with the EU's Beating Cancer Plan have shaped CRC policy across the continent.

In the Asia-Pacific region, the Asia-Pacific Colorectal Cancer Alliance (APCRC)[71] and national societies in Japan, South Korea, India, and China drive culturally tailored awareness and screening programs. Japan's national fecal occult blood testing program now achieves >60% participation among eligible adults. The UICC Patient Group Mentoring Program supports advocacy development across 11 South and Southeast Asian countries[72]. Across Africa, the African Organization for Research and Training in Cancer (AORTIC) developed the African Cancer Advocates Consortium (ACAC)[73], with 51 member groups, to advance policy, research, and education.

An AORTIC advocacy special interest group has now emerged from this that is training civil societies to engage in political and research advocacy. In Kenya, partnerships between GCCA and the national oncology society. KESHO, have expanded patient-centered quality initiatives. Partnerships between AORTIC, KESHO and the local surgical society, SSK has led to expansion of surgical training and multidisciplinary approaches to cancer management In Latin America, GCCA-backed mentorship programs are growing, while Colorectal Cancer Canada continues to lead public awareness and policy engagement nationally.

Multilateral platforms further amplify these efforts. The IAEA–Lancet Oncology Commission convenes global stakeholders to address disparities in imaging access, while ASCO's Global Oncology, NCCP National Control Plans[74] and WHO-led frameworks increasingly embed patient voices in guideline development. Grassroots leadership remains vital: in Armenia, civil society has driven early detection efforts, while in Ghana, regional initiatives have expanded awareness and screening in rural areas. These examples demonstrate a shared imperative of equity in CRC care that needs to be both locally led and globally reinforced[75].

In Europe, the EU Cancer Mission takes a comprehensive, multidisciplinary approach to cancer control, aiming to improve prevention, early detection, treatment, and quality of life for people affected by cancer, including those with CRC. This approach envisions saving more than 3 million lives by 2030 through better public health interventions, innovation, and patient-centered care[76,77]. It emphasizes personalized and risk-based screening strategies, advancing the use of novel, non-invasive technologies and artificial intelligence for improved accuracy and efficiency, specifically in CRC. The mission supports multi-country projects like ONCOSCREEN and DIOPTRA that develop risk models, awareness campaigns, and digital solutions to increase screening uptake and empower citizens[78].

There's a strong focus on primary prevention through lifestyle interventions, education, and structured follow-up to reduce cancer incidence, supported by research consortia like ONCODIR that apply AI and social science to prevention programs[79]. Although this approach stems from the European Union (EU), its benefits extend beyond the Union's member states given that neighboring countries associated with the Horizon Europe funding framework can participate in the development and implementation of relevant proposals. Overall, the EU Cancer Mission sets a tangible paradigm of institutions defining cancer policy in direct communication and exchange with all involved parties to ensure that the entire trajectory from research question to practice is aligned with real-world needs.

LMICs can pragmatically adapt the EU model by implementing risk-stratified screening protocols, embedding low-cost digital reminder/recall systems, such as SMS/WhatsApp, and deploying community-based navigation through primary care and NGOs—achieving measurable gains without replicating full EU-level infrastructure.

As a MENA/GCC exemplar, the Qatar Cancer Society partners with primary-care clinics and tertiary hospitals to co-deliver population awareness campaigns, screening navigation, and psychosocial/financial support—illustrating a civil-society–health-system model that improves screening uptake and timeliness of diagnosis in resource-diverse settings[80].

As colorectal cancer becomes more biologically stratified and demographically diverse, partnerships with advocacy groups are essential to ensuring that innovations reach all populations, and that care remains inclusive, responsive, and humane.

CONCLUSION AND STRATEGIC PRIORITIES

The Global Cancer Movement: Challenging the Status Quo in Colorectal Cancer Congress underscored the

widening global divide in CRC outcomes. The escalating burden—particularly the alarming rise of EAOCRC—alongside persistent disparities in prevention, diagnosis, and treatment demands urgent, coordinated global action. To move beyond incremental progress and truly challenge the status quo, the congress emphasized that progress must be grounded in equity, patient partnership, and shared accountability. This requires embedding patient expertise not only in advocacy but in research design, policy development, and program implementation, ensuring that those most affected are co-creators of solutions, not end-users of them.

The following interconnected priorities form the foundation for a patient-centered, globally inclusive CRC movement:

1. Strengthening global data systems and research equity – Expanding cancer registries, building data infrastructure (particularly in LMICs), and ensuring equitable participation in international research.
2. Expanding equitable screening and early detection – Scaling cost-effective, population-based screening programs; guaranteeing diagnostic follow-up; and leveraging AI-assisted tools and outreach innovations.
3. Ensuring broader access to essential medicines and trials – Facilitating pooled procurement and local production of biosimilars and immunotherapies, adapting multidisciplinary models for LMICs, and increasing clinical trial availability to generate regionally relevant evidence.
4. Accelerating innovation through regulatory pathways – Advancing global regulatory convergence, adaptive trial designs, conditional approvals, and real-world data integration to enable earlier access to therapies targeting molecular subtypes and immunologically distinct CRC populations.
5. Building workforce and infrastructure capacity – Investing in oncology training, diagnostics, treatment facilities, and palliative care services.
6. Addressing early-age onset CRC – Expanding research, increasing awareness to reduce diagnostic delays, considering earlier screening, and creating tailored survivorship pathways.
7. Embedding patient advocacy and alliances –Elevate grassroots and coalition leadership by embedding patient seats with real power in every decision-making forum.
8. Integrating CRC control into health agendas – Embedding CRC within NCD strategies, UHC benefit packages, and policies targeting modifiable risks.
9. Prioritizing integrative approaches – Recognizing exercise, nutrition, mind-body practices, and supportive care as essential components of modern CRC management.
10. Expanding early access to palliative care – Ensuring holistic, quality-of-life–focused care for patients and caregivers across the disease trajectory.
11. Sustaining the Global CRC Movement – Establishing ongoing platforms for accountability, annual convenings, and shared learning to track progress and maintain momentum.
12. Tracking implementation and accountability – Establishing country-level KPIs on screening participation, diagnostic follow-up, stage-at-diagnosis, biomarker testing, time-to-treatment, and patient-reported outcomes, co-owned by ministries, primary care, and civil society.

Above all, achieving equity in CRC care requires more than scientific knowledge—it demands collective commitment and global solidarity. The lived experiences of patients and survivors must remain at the center of every policy and innovation.

The next decade represents a pivotal window: by acting now, we can prevent more disease, detect it earlier, and ensure that every individual—regardless of birthplace or income—benefits from the promise of modern science, integrative care, and coordinated global action.

This report reflects the urgency and vision captured during the Global Cancer Movement: Challenging the Status Quo in Colorectal Cancer, convened by OncoDaily. The Congress marked not an endpoint, but the beginning of a sustained global effort. Through cross-sector partnerships, country-level implementation, and annual collaboration, the momentum generated here must translate into measurable progress. By continuing to challenge the status quo—boldly and collectively—we can transform the future of colorectal cancer worldwide.

CONTRIBUTORS

This report reflects an independent synthesis of Global Cancer Movement: Challenging the Status Quo in Colorectal Cancer Congress proceedings and does not represent formal recommendations or guidelines. All authors contributed to interpreting the proceedings, drafting the manuscript, and critically revising it for accuracy and clarity. All authors approved the final version for publication.

CONFLICT OF INTEREST DISCLOSURES

Pogacian A is the Founder of INCKA Psycho-Oncology Center.

Aggarwal A reports institutional funding from the National Institute for Health and Care Research (NIHR) and the National Institutes of Health (NIH).

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Tamamyan G is the Chief Executive Officer of the Immune Oncology Research Institute (IMMONC) and reports ownership interest in p53.

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40. **Michael Sapienza**
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41. **Mila Ogalla Toledo**
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42. **Miriam Mutebi**
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