International Cancer Patient Coalition

Algeria

Gastric Cancer Factsheet: Insights & Key Developments

Key Insights on Gastric 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. Gastric Cancer Screening

Gastric 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 Gastric cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Gastric cancer ranks lower in frequency compared to other digestive cancers; not among top 5 male cancers.
- Incidence rate: Approximately 2.6 per 100,000 men per year (based on broader regional data).
- Total new cases (2022): Estimated around 2,400–2,600 cases (both sexes).
- Daily diagnoses: ≈ 6–7 cases per day.
- Deaths (2022): Likely ~1,200–1,400 deaths.
- 5-year survival rate: Likely below 50%, given late diagnosis and limited treatment access.
- Most affected age group: Primarily men aged 60 and older.
- Screening participation: No organized screening; few early screenings, primarily symptom-triggered detection.

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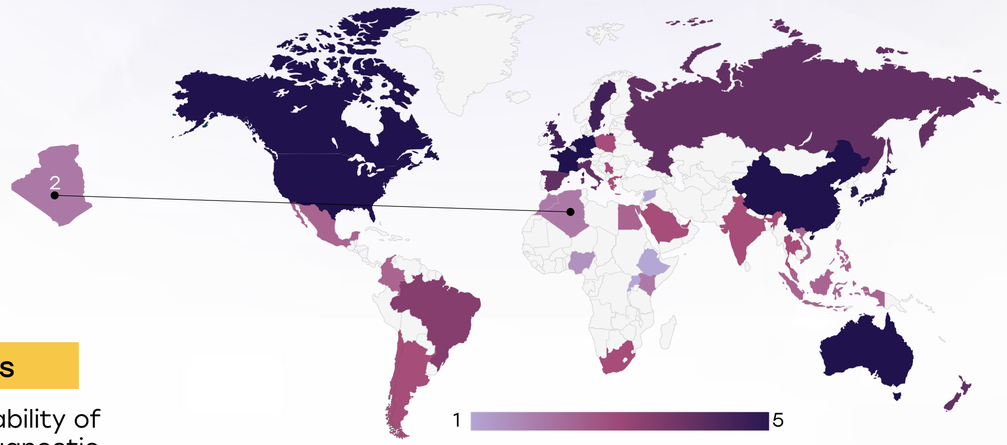
Infrastructure



Strengths

- Major cancer centers in Algiers (e.g., Centre Pierre et Marie Curie) offer surgical oncology and chemotherapy.
- Expansion of oncology departments in regional hospitals such as Oran and Constantine.

Weakness

- Limited availability of advanced diagnostic tools like PET-CT and endoscopic ultrasound in secondary hospitals.
- Inadequate pathology infrastructure for molecular and immunohistochemical testing.

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Opportunity

- Government prioritization of cancer care under national health development programs.
- Partnerships with private diagnostic companies to upgrade imaging and surgical capacity.

Threats

- Urban-rural health divide persists, with poor cancer infrastructure in southern and rural provinces.
- Heavy patient burden leads to long waiting times and delayed diagnosis.

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	1	2
Nigeria	1	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	3
Spain	4	3
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	3
Greece	4	3
Rwanda	1	1
Uganda	1	1
Serbia	3	3
Saudi Arabia	4	4
UAE	4	3
Syria	1	1
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	3	3
Malaysia	3	3

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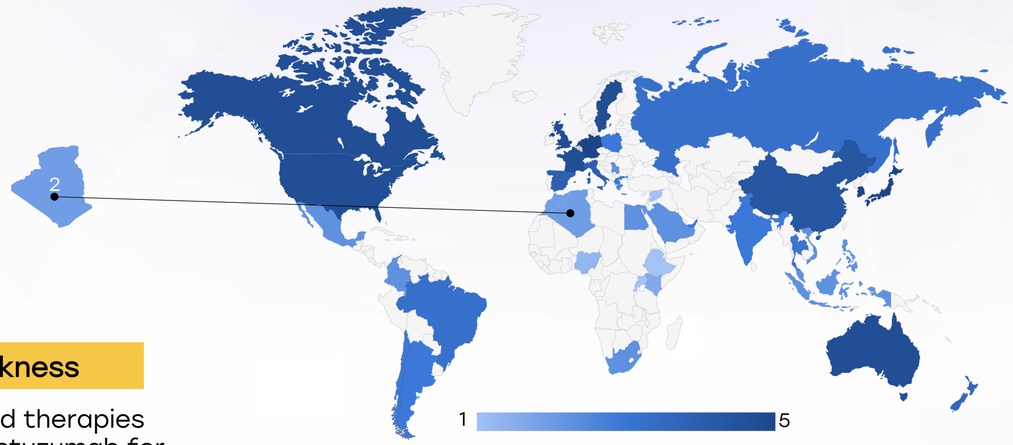
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Access to chemotherapy (e.g., cisplatin, 5-FU) is supported by national procurement for essential medicines.
- Existing oncology networks and training programs through university hospitals.

Weakness

- Targeted therapies (like trastuzumab for HER2-positive gastric cancer) are not widely accessible.
- Very limited gastric cancer-specific public awareness or education programs.

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Opportunity

- Expansion of partnerships with international research consortia for gastric cancer trials.
- Launch of nationwide awareness programs leveraging local NGOs and TV/radio platforms.

Threats

- Lack of dedicated national funding lines for gastric cancer research.
- Cultural stigma and fear reduce participation in cancer education or early checkups.

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	4	4
Kenya	4	2	2
Nigeria	4	2	2
Egypt	3	4	4
Morocco	4	4	4
Algeria	4	4	4
Ethiopia	2	2	2
India	3	3	3
Japan	5	5	5
South Korea	5	5	5
China	4	5	4
Thailand	3	3	3
Singapore	5	4	4
United Kingdom	5	5	4
Germany	5	5	5
France	5	4	4
Netherlands	5	5	4
Sweden	5	5	4
Italy	5	4	4
Spain	5	4	4
Poland	3	3	3
Mexico	3	4	4
Brazil	4	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	4	4
United States	5	5	4
Canada	5	5	4
Australia	5	5	4
New Zealand	4	4	4
Greece	3	3	3
Rwanda	2	2	2
Uganda	2	2	2
Serbia	3	4	4
Saudi Arabia	3	4	4
UAE	3	3	3
Syria	2	2	2
Indonesia	3	4	4
Vietnam	3	4	4
Philippines	4	4	4
Russia	4	3	3
Malaysia	3	4	4

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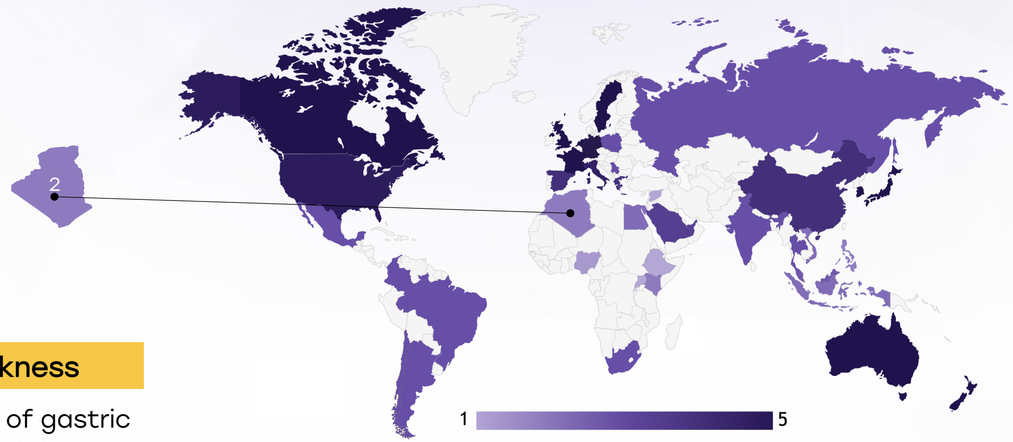
Survival Rates, Early Detection and Palliative Care



Strengths

- Multidisciplinary cancer boards in major hospitals improve coordinated treatment plans.
- Some palliative care training incorporated into oncology residency programs.

Weakness

- Majority of gastric cancer cases diagnosed at Stage III or IV due to nonspecific symptoms and lack of screening.
- Palliative care units remain scarce, with limited availability of opioids and trained personnel.

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Opportunity

- Integrate symptom-based early detection algorithms at primary care level.
- National scale-up of palliative care services through WHO-endorsed frameworks.

Threats

- Delayed referrals from primary health centers due to lack of GP training.
- Limited palliative home-care models or hospice facilities in most provinces.

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	3	3	3
Kenya	2	2	2
Nigeria	2	1	1
Egypt	3	2	2
Morocco	2	2	2
Algeria	2	2	2
Ethiopia	1	1	1
India	3	3	3
Japan	5	5	5
South Korea	5	5	5
China	4	4	4
Thailand	3	3	3
Singapore	5	5	5
United Kingdom	5	5	5
Germany	5	5	5
France	5	5	5
Netherlands	5	5	5
Sweden	5	5	5
Italy	4	4	4
Spain	4	4	4
Poland	3	3	3
Mexico	3	3	3
Brazil	3	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	3	3
United States	5	5	4
Canada	5	5	5
Australia	5	5	5
New Zealand	5	5	5
Greece	4	4	4
Rwanda	1	1	1
Uganda	1	1	1
Serbia	3	3	3
Saudi Arabia	3	3	3
UAE	3	3	3
Syria	1	1	1
Indonesia	3	2	2
Vietnam	3	2	2
Philippines	3	2	2
Russia	3	3	3
Malaysia	3	2	3

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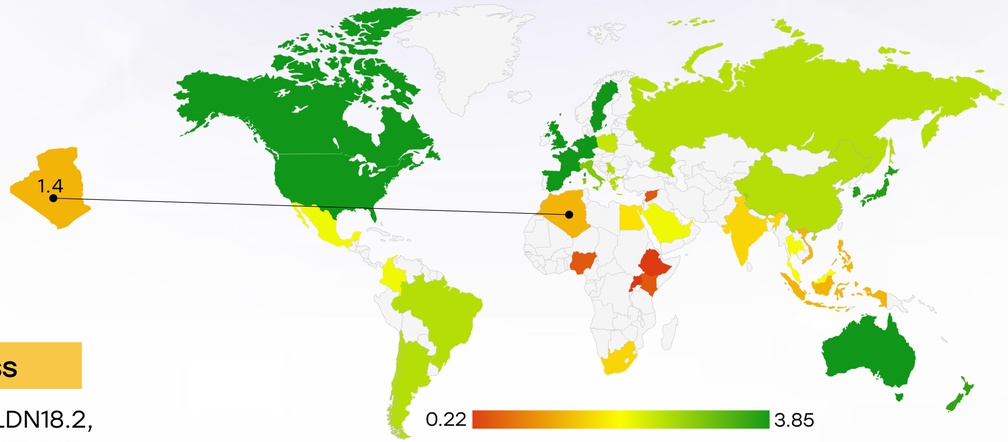
Utilization of Biomarkers



Strengths

- HER2 testing is available in reference pathology labs, guiding trastuzumab use for HER2+ advanced GC.
- Limited PD-L1 CPS testing has started in a few academic hospitals for immunotherapy eligibility.

Weakness

- MSI/dMMR, CLDN18.2, FGFR2b testing are not routinely done due to cost and lab capacity limitations.
- Lack of centralized tumor boards delays biomarker-integrated treatment decisions.

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Opportunity

- Introduction of centralized biomarker testing services across northern Algeria.
- Public-private partnerships for expanding NGS and immunohistochemistry platforms.

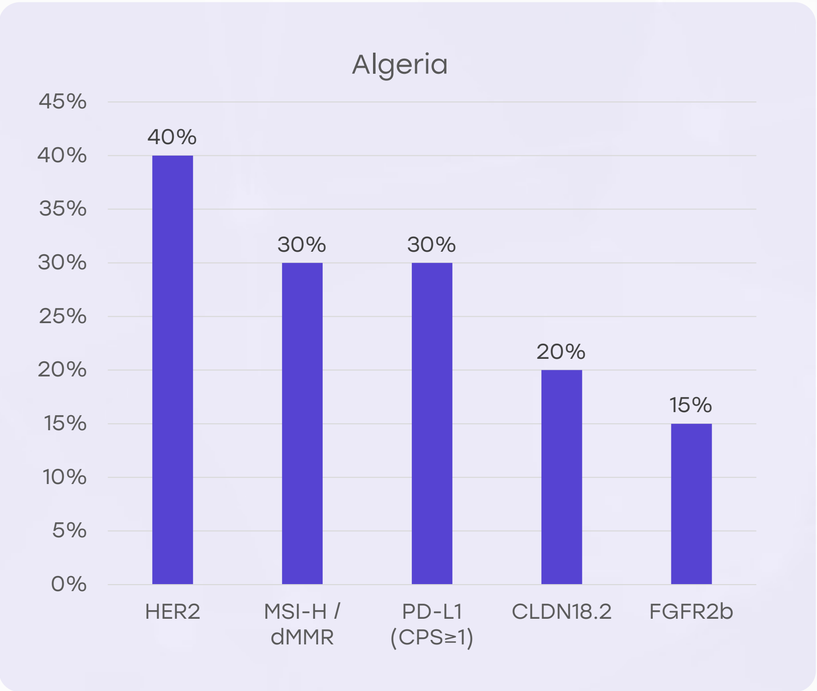
Threats

- High cost and lack of reimbursement limit widespread biomarker utilization.
- Fragmented data collection hampers evidence-based biomarker adoption policies.

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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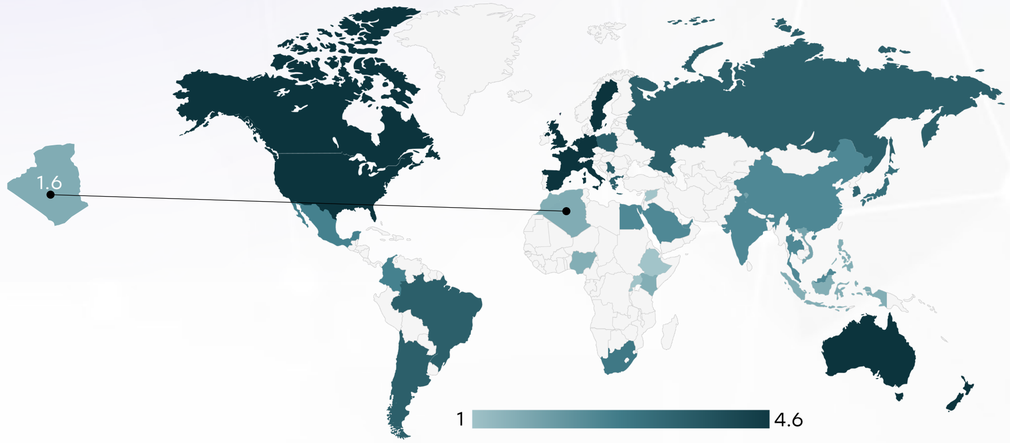
Clinical Guidelines



Strengths

- National oncology centers follow modified international guidelines (e.g., ESMO, NCCN).
- Standard regimens for chemotherapy in advanced gastric cancer are defined.

Weakness

- No gastric cancer-specific national clinical guidelines tailored to local context.
- Inconsistent adherence to protocols in lower-tier hospitals due to training gaps.

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Opportunity

- Develop national gastric cancer guidelines in Arabic and French for broader clinician access.
- Use tele-education to train provincial doctors in evidence-based management.

Threats

- Guideline implementation is hindered by resource disparity across regions.
- Lack of regulatory mechanisms to enforce treatment standards.

	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

- Public healthcare covers standard chemotherapy and surgery for gastric cancer.
- National health insurance subsidizes hospitalization and diagnostic imaging in government facilities.

Weakness

- High out-of-pocket costs for advanced diagnostics and targeted therapies.
- Private insurance coverage is limited and fragmented, creating inequity.

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Opportunity

- Expand reimbursement for biomarker testing under national insurance.
- Pilot programs for cost-effective bundled treatment packages in public hospitals.

Threats

- Inflation and economic pressures may lead to reduced health budget allocations.
- Delays in claim processing discourage patients from accessing full treatment.

● 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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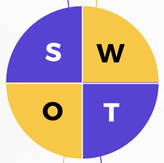
Colorectal Cancer Screening

Strengths

- Some opportunistic endoscopic screening occurs in high-risk patients with chronic gastritis or H. pylori infection.
- Growing awareness among gastroenterologists of the need for earlier risk assessment

Weakness

- No organized population-based gastric cancer screening program.
- Endoscopy access is limited and mostly reserved for symptomatic patients.



Opportunity

- Implement risk-based screening in adults over 40 with H. pylori, anemia, or chronic dyspepsia.
- Train general practitioners to identify high-risk cases for referral.

Threats

- Low public understanding of gastric cancer symptoms limits participation.
- Competing health priorities such as cardiovascular disease and diabetes divert focus

Country	Gastric 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	Gastric 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