International Cancer Patient Coalition

Colombia

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 is among the top 10 cancers in men.
- Incidence rate: Around 11 per 100,000 men per year.
- Total new cases (2022): Approximately 8,938 men.
- Daily diagnoses (2022): About 24 men per day.
- Deaths (2022): Roughly 2,591 men.
- 5-year survival rate: Estimated below 40–45%.
- Most affected age group: Typically men aged 60–75.
- Screening participation: No formal screening; diagnosis usually occurs at symptomatic stages.

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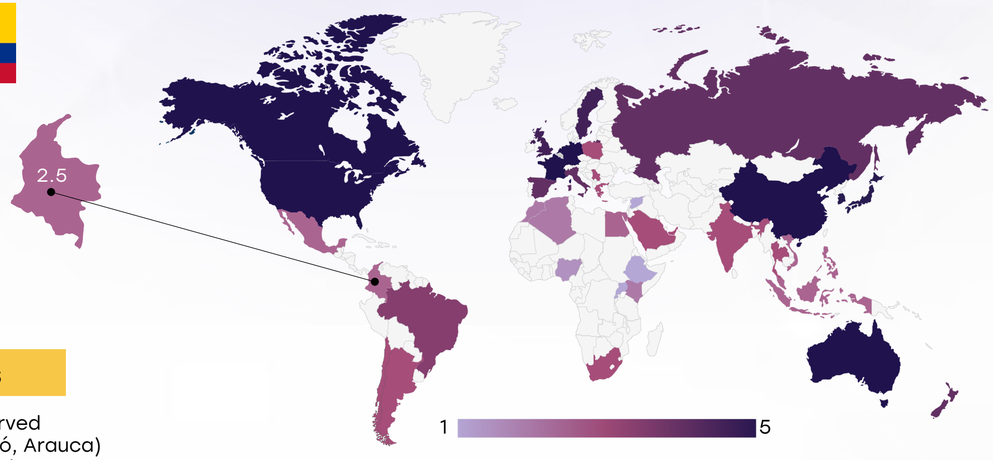
Infrastructure



Strengths

- Urban cancer centers in Bogotá (Instituto Nacional de Cancerología) and Medellín (Clínica Antioquia) provide advanced endoscopy, surgery, imaging, and pathology, including molecular diagnostics.
- National cancer registry and regional oncology networks support quality monitoring and patient referrals.

Weakness

- Rural and underserved regions (e.g. Chocó, Arauca) lack endoscopic units, pathology services, and oncology specialists.
- Referral systems from primary to tertiary care are inefficient, leading to diagnostic and treatment delays.

S W O T

Opportunity

- Expansion of regional cancer infrastructure through public funding or partnership with academic institutions.
- Implementation of telepathology and mobile endoscopy units to serve geographically remote populations.

Threats

- Urban facility overcrowding, particularly in Bogotá and Medellín, causes long wait times and diagnostic bottlenecks.
- Healthcare provider migration from public to private sector and abroad drains talent from public institutions.

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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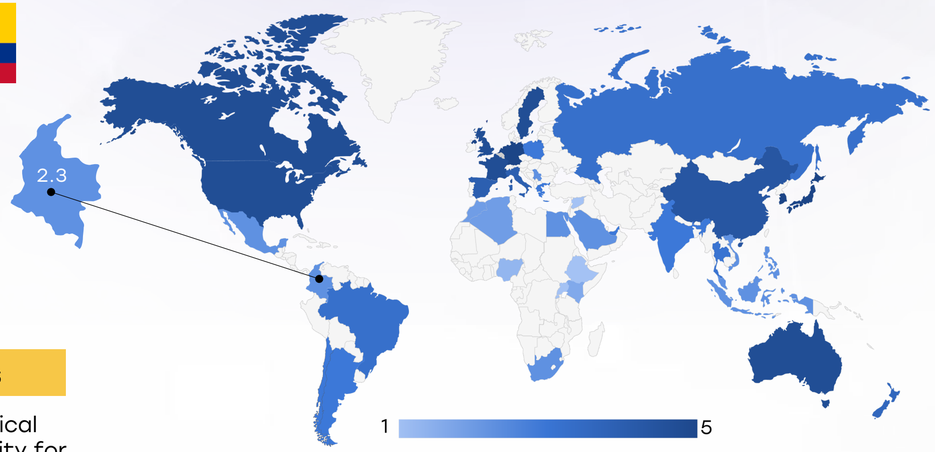
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Public insurance systems (SISBEN/SGSSS) cover standard gastric cancer treatments including surgery and chemotherapy.
- Participation in international GC clinical trials provides patients with access to biomarker-driven therapies (e.g., HER2-targeted agents, immunotherapy in MSI-H or PD-L1-positive cases).

Weakness

- Funding and clinical research capacity for gastric cancer remain limited; few nationally led biomarker-specific trials.
- Low public awareness of gastric cancer risk factors (high-salt diet, H. pylori, smoking) results in late presentation.

S W O T

Opportunity

- Collaborate with academic and NGO partners to increase funding into nationwide research and awareness campaigns.
- Leverage media and community health worker networks for culturally adapted education about prevention and early symptoms.

Threats

- Budget competition with more high-profile cancers (breast, prostate, cervical) can result in underinvestment in GC initiatives.
- Socioeconomic barriers may limit uptake of awareness campaigns among marginalized groups.

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	2	2
Kenya	2	1	1
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	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	2	2
Brazil	4	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	2	2
United States	5	5	4
Canada	5	5	4
Australia	5	5	4
New Zealand	4	4	4
Greece	3	3	3
Rwanda	1	1	1
Uganda	1	1	1
Serbia	3	2	2
Saudi Arabia	3	2	2
UAE	3	3	3
Syria	1	1	1
Indonesia	3	2	2
Vietnam	3	2	2
Philippines	2	2	2
Russia	4	3	3
Malaysia	3	2	2

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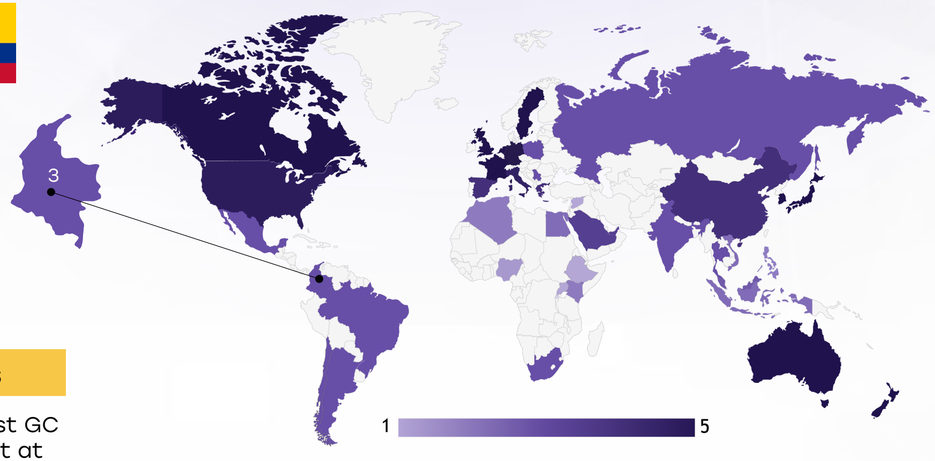
Survival Rates, Early Detection and Palliative Care



Strengths

- In regional cancer centers offering early diagnosis and multidisciplinary care, 5-year survival for localized GC exceeds 40%.
- Palliative care integration is increasing in major hospitals, improving symptom control and quality of life for advanced GC patients.

Weakness

- Nationwide, most GC patients present at advanced stage III–IV; overall 5-year survival remains below 30%.
- Palliative care is poorly available in non-urban areas, with limited hospices or home-care programs.

S W O T

Opportunity

- Deploy early detection programs using symptom screening and risk stratification in primary care settings.
- Train rural and district-level providers in palliative best practices and pain management

Threats

- Cultural stigma around cancer may discourage early symptom presentation.
- Fragmented follow-up systems delay post-surgical care or palliative referrals.

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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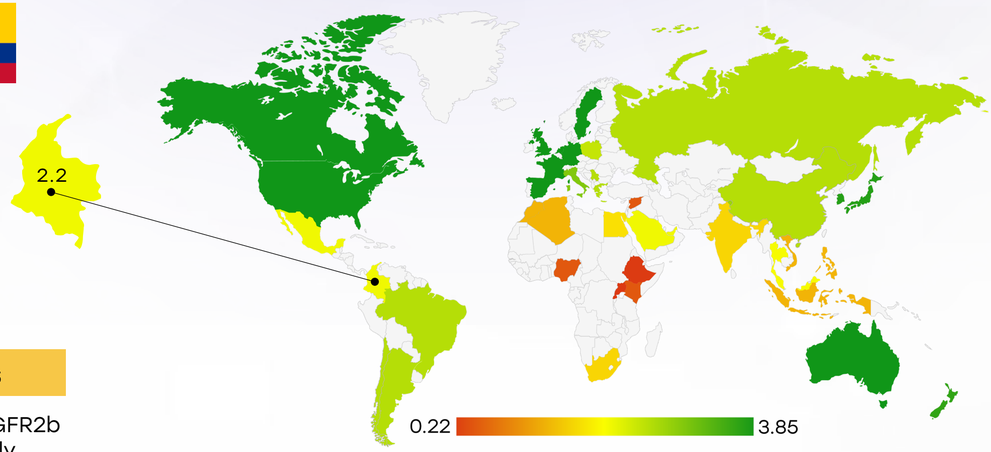
Utilization of Biomarkers



Strengths

- HER2 testing is available and guiding trastuzumab use in public and private tertiary centers for advanced GC.
- MSI-H/dMMR and PD-L1 (CPS ≥ 1) profiling is performed at academic institutions to select for immunotherapy.

Weakness

- CLDN18.2 and FGFR2b testing are rarely available outside trial settings—even where clinical utility is emerging.
- Variability in lab accreditation and biomarker reporting contributes to inconsistent test quality across regions.

S W O T

Opportunity

- CLDN18.2 and FGFR2b testing are rarely available outside trial settings—even where clinical utility is emerging.
- Variability in lab accreditation and biomarker reporting contributes to inconsistent test quality across regions.

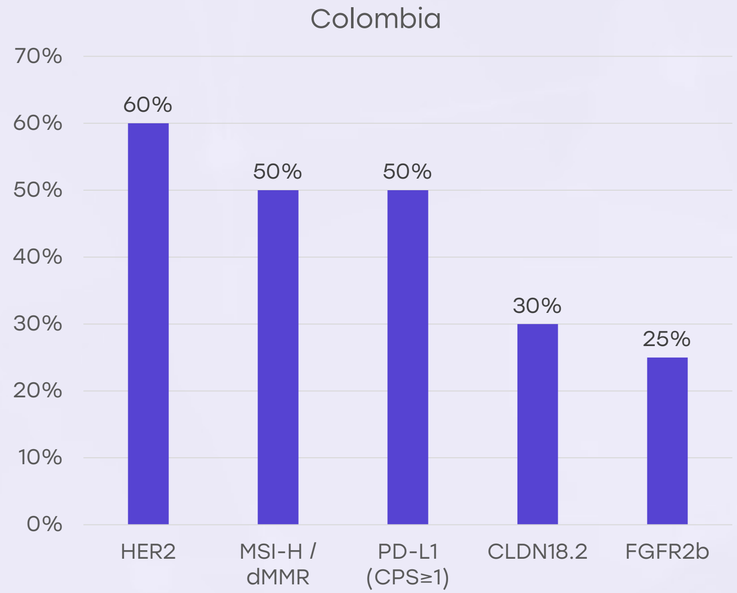
Threats

- High costs and low insurance coverage for less common biomarkers hinder equitable access.
- Delay in reimbursement policy for biomarker assays leads to underutilization by clinicians.

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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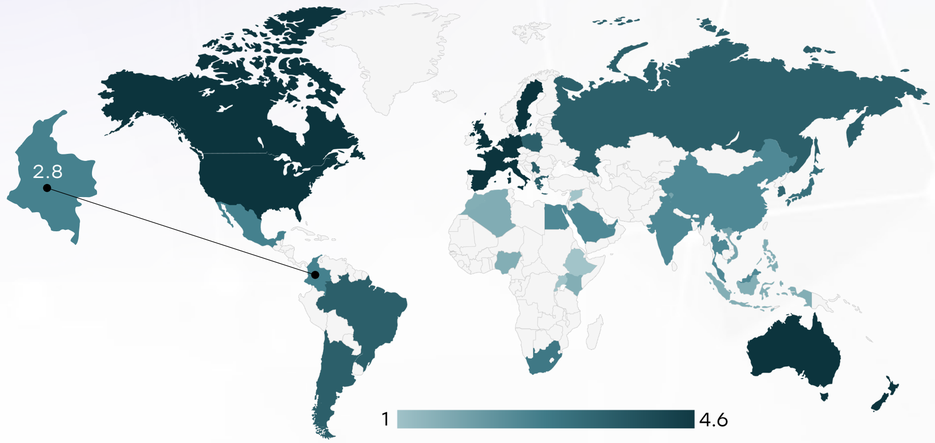
Clinical Guidelines



Strengths

- National treatment protocols include HER2 testing and recommend trastuzumab for eligible metastatic GC cases.
- Colombian oncologists generally follow international guidelines (e.g., ESMO/ASCO) adapted for local care conditions.

Weakness

- Guidelines lack updates for emerging biomarkers such as CLDN18.2 and FGFR2b-based therapies.
- Variable implementation of protocols across regions due to differences in hospital capacity and training

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Opportunity

- Establish expert working groups to incorporate novel biomarker-based therapies into national guidelines.
- Promote multidisciplinary tumor boards and CME to reinforce guideline compliance in provincial hospitals.

Threats

- Slow bureaucratic processes delay formal updates to national guidelines.
- Uneven application of protocols creates disparities in treatment quality and outcomes.

	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 schemes cover essential treatments, including surgery, chemotherapy, and trastuzumab for HER2+ GC.
- Clinical trial participation provides alternative routes for access to advanced therapies not yet reimbursed officially.

Weakness

- Newer agents (e.g., immune checkpoint inhibitors in PD-L1 positive patients, CLDN18.2 or FGFR2b therapies) are not well-reimbursed.
- Diagnostic testing for biomarkers such as MSI, PD-L1, CLDN18.2 is rarely covered and often requires out-of-pocket payment.

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Opportunity

- Advocate for inclusion of critical biomarker tests and immunotherapy agents in public reimbursement frameworks.
- Pilot outcome-based payment or managed access schemes to accelerate coverage for effective therapies.

Threats

- Budget constraints and rising pharmaceutical costs limit the expansion of public coverage.
- Fragmentation among health insurers and regional systems creates inequitable access pathways.

● 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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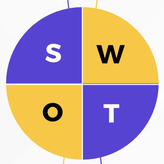
Gastric Cancer Screening

Strengths

- Opportunistic endoscopic evaluation is available for symptomatic individuals or those with family history in urban centers.
- H. pylori testing and eradication policies are included in some GI care protocols and PP programs.

Weakness

- No population-wide gastric cancer screening program exists—even in moderate–high incidence regions.
- Endoscopy capacity is limited outside major cities; many symptomatic or high-risk individuals remain undiagnosed.



Opportunity

- Develop risk-based screening guidelines for higher-risk populations (e.g., older adults, family history, H. pylori-infected).
- Integrate H. pylori eradication into community health initiatives and primary care screenings.

Threats

- Low awareness and mistrust of invasive procedures, like gastroscopy, reduce screening uptake.
- Health system priorities focused elsewhere (e.g., infectious diseases) may delay policy action on GC screening.

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