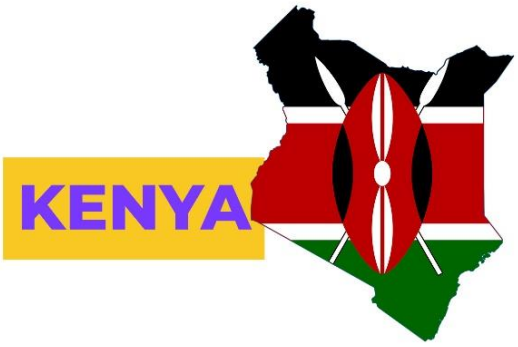


International Cancer Patient Coalition

BRIDGING THE GAP

Enhancing Equitable Access & Innovation in **Gastric Cancer Care** in Kenya

EXECUTIVE SUMMARY

Kenya faces a meaningful burden from gastric cancer (GC) with many patients diagnosed at advanced stages, resulting in high mortality and limited cure rates. Key obstacles include lack of population screening, constrained endoscopy capacity outside tertiary urban centres, inconsistent access to molecular testing (HER2) and targeted therapies, and uneven palliative and survivorship services. Financial barriers and geographic inequities — with much stronger care available in some Nairobi and coastal tertiary centres compared with rural counties — further limit outcomes.

This policy brief adapts the Morocco paper's structure to outline pragmatic, Kenya-focused actions to raise national GC maturity from fragmented care toward an integrated, equitable system.

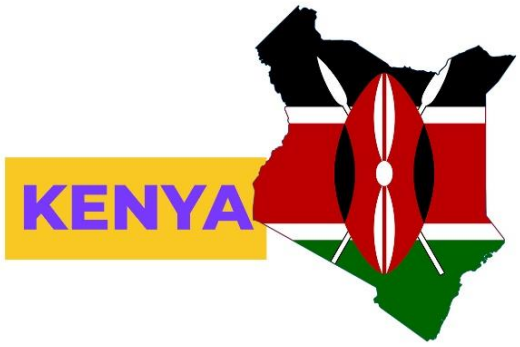
INTRODUCTION

Building on Awareness Gains Amid Structural Gaps

While awareness of cancer in Kenya has grown through NGO, professional and government activity, this has not translated consistently into early detection or comprehensive GC care.

With a **Level 3 maturity**, Kenya has functioning diagnostic, surgical and oncology services in tertiary hospitals but they are unevenly distributed, and national guidance and financing do not yet guarantee timely, standardized care across the country. Strategic policy interventions can leverage existing strengths to close key gaps in prevention, diagnosis, treatment and palliation.

Kenya Ranks at Level 3 – Gastric Cancer Care Maturity Framework



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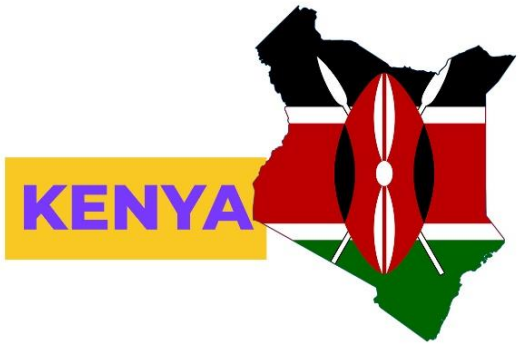
GASTRIC CANCER IN KENYA

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No population screening; most GC cases diagnosed after symptoms lead to late-stage presentation. Endoscopy services concentrated in urban tertiary hospitals; rural access is limited.	Tertiary hospitals have endoscopy and pathology services able to diagnose GC.	Define a national GC pathway with alarm-symptom triage and targets for time-to-endoscopy; expand endoscopy capacity via sessional lists, mobile outreach and task-shifting where appropriate.
Biomarker & Molecular Testing	HER2 and other molecular testing are limited and mainly available in private or tertiary reference labs; results turnaround can delay therapy decisions.	Reference labs in major urban centres can provide testing if samples are routed appropriately.	Operationalize hub-and-spoke molecular testing networks so HER2 status is routinely available for advanced disease; set turnaround targets and subsidize testing for public patients.
Treatment Access	Curative gastrectomy and peri-operative chemotherapy are available in select tertiary centres; access to targeted therapies and newer systemic agents is largely confined to private care or out-of-pocket payers.	Surgical and oncology expertise exists in teaching hospitals and private centres.	Ensure peri-operative chemotherapy protocols are available publicly; create procurement/funding routes (e.g., through NHIF or pooled procurement) to secure affordable HER2-targeted agents for eligible patients.
Clinical Guidelines	Fragmented practice with facilities following a mix of international and local guidance; no single, uniformly implemented national GC pathway.	Multidisciplinary practice in referral centres provides a basis for standardization.	Develop and disseminate a national GC clinical pathway including diagnostic algorithms, staging, peri-operative treatment, metastatic algorithms and referral SLAs; embed MDT review and audit.
Palliative & Survivorship Care	Palliative care availability is expanding but remains unequal; timely access to palliative radiotherapy and opioids can be constrained in some regions.	Growing palliative networks and community programmes provide a foundation for scale-up.	Expand community-based palliative teams, protect palliative radiotherapy capacity, ensure consistent opioid availability and integrate nutritional and psychosocial support into the GC pathway.



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CONCLUSION & Call to Action

Kenya's gastric cancer system has core technical strengths housed in tertiary centres but remains fragmented by geography, financing and diagnostic gaps. By adopting a national GC pathway, scaling H. pylori control and endoscopy access, mainstreaming HER2 testing and financing for indicated targeted therapies, protecting palliative capacity, and improving data transparency, Kenya can make measurable improvements in survival and quality of life for people with GC within a 3–5 year timeframe.

KEY POLICY PRIORITIES

1. **National GC Pathway:** Standardize triage, diagnostics, MDT review, peri-operative protocols, referrals, and monitor timelines.
2. **H. pylori Test-and-Treat:** Integrate into primary care for high-risk groups with resistance surveillance.
3. **Molecular Testing:** Establish hub-and-spoke labs for routine HER2 testing with public funding and defined turnaround.
4. **Targeted Therapy Access**: Ensure affordable HER2 therapies via NHIF/procurement or pooled-buying mechanisms.
5. **Endoscopy & Diagnostics:** Invest in training, equipment, maintenance, and mobile outreach to reduce delays.

CONCLUSION

With targeted, practical policy moves that align financing, diagnostics, workforce and data, Kenya can transition from a system where outcomes depend heavily on location and ability to pay toward a more equitable, effective gastric cancer care pathway. Prioritising these actions within the health sector reform agenda will deliver measurable benefits for patients across counties.