NIGERIA

International Cancer Patient Coalition

BRIDGING THE GAP

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

EXECUTIVE SUMMARY

Nigeria faces a significant burden from gastric cancer (GC) characterized by late-stage presentation, high mortality, and marked geographic and economic inequities in care. Key obstacles include lack of population screening, limited endoscopy access outside tertiary urban centres, constrained pathology and molecular testing (including HER2), uneven availability of curative surgery and peri-operative chemotherapy, limited access to targeted agents, and under-resourced palliative services. Financial barriers and fragmented insurance coverage exacerbate disparities.

This brief outlines pragmatic, Nigeria-specific policy actions to raise GC system maturity through improved prevention, diagnostics, treatment access and palliative support.

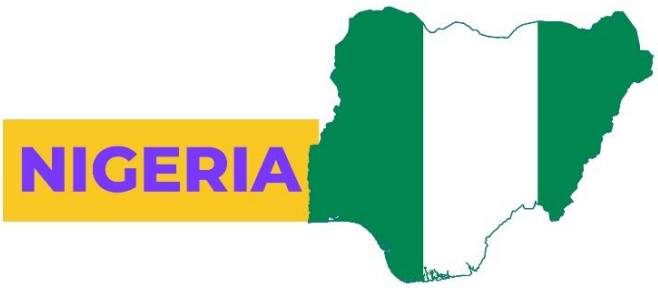
INTRODUCTION

Building on Awareness Gains Amid Structural Gaps

Despite growing cancer awareness and expanding oncology capacity in major teaching hospitals, Nigeria's gastric cancer system remains fragmented. With a **Level 3 maturity**, the country has important clinical skills and centres of excellence but lacks consistent access across states and populations.

Strategic, implementable reforms — aligned with national health financing reforms and state-level health planning — can accelerate progress toward an integrated, equitable GC care pathway.

Nigeria Ranks at Level 3 – Gastric Cancer Care Maturity Framework



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GASTRIC CANCER IN NIGERIA

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No population screening; most GC detected after symptoms, leading to late-stage diagnosis. Endoscopy services are concentrated in a few tertiary centres; rural access is poor.	Tertiary hospitals in major cities provide endoscopy and histopathology capacity.	Define a national GC pathway with alarm-symptom triage and time-to-endoscopy targets; expand sessional endoscopy lists, deploy mobile outreach to underserved states, and enable task-shifting where safe.
Biomarker & Molecular Testing	HER2 and other molecular tests are rarely available in routine public care; most testing occurs in private or academic reference labs with variable turnaround.	Reference labs and private-sector capacity exist in Lagos, Abuja and other urban centres.	Establish hub-and-spoke molecular testing networks so HER2 status is routinely available for advanced cases; set turnaround targets and subsidize testing for public patients.
Treatment Access	Curative gastrectomy and peri-operative chemotherapy are available in select tertiary centres; targeted therapies and modern systemic agents are largely inaccessible to many due to cost and limited procurement.	Strong surgical and oncology expertise in teaching hospitals and specialist centres.	Standardize peri-operative chemo protocols nationally; develop pooled procurement/NHIS pathways or public–private financing to make HER2-targeted agents (including biosimilars) affordable for eligible patients.
Clinical Guidelines	Practices vary by facility; no single, uniformly implemented national GC clinical pathway exists.	Active MDT practice in teaching hospitals provides a base for harmonization.	Publish and disseminate a national GC guideline/pathway (diagnosis, staging, peri-op therapy, metastatic algorithms, palliation), mandate MDT review for complex cases, and implement monitoring/audit mechanisms.
Palliative & Survivorship Care	Palliative care services are uneven across states; access to timely palliative radiotherapy, opioids and trained community teams is inconsistent.	Growing palliative initiatives and NGO involvement create a platform for expansion.	Expand community palliative teams, ensure consistent opioid availability by addressing regulatory barriers, protect palliative RT capacity, and integrate psychosocial and nutritional support into standard care.

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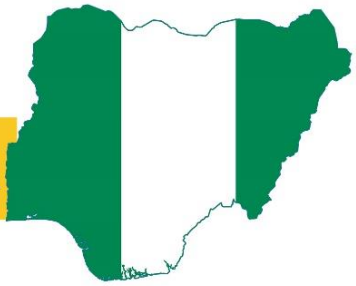

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CONCLUSION & Call to Action

Nigeria has the clinical foundations to improve gastric cancer outcomes but must address major access, diagnostic and financing gaps. By codifying a national GC pathway, scaling H. pylori prevention where relevant, expanding and regionalizing endoscopy and molecular diagnostics, ensuring equitable access to evidence-based systemic and targeted therapies, strengthening palliative care (including opioid access), and improving data systems, Nigeria can make meaningful improvements in survival and quality of life within a 3–5 year horizon.

KEY POLICY PRIORITIES

1. **National GC Pathway:** Standardize triage, diagnostics, MDT review, referrals, and monitor treatment timelines.
2. **H. pylori Test-and-Treat:** Integrate into primary care for high-risk groups with resistance monitoring.
3. **Molecular Testing:** Establish hub-and-spoke labs for routine HER2 testing with subsidized public access.
4. **Targeted Therapy Access:** Secure affordable HER2 therapies through pooled procurement and public–private mechanisms.
5. **Endoscopy & Diagnostics:** Invest in training, equipment, maintenance, and mobile outreach to reduce delays.

CONCLUSION

With pragmatic, state-aligned policy actions that align financing, diagnostics, workforce and data, Nigeria can shift from a fragmented, location-dependent GC system to a more equitable, effective national pathway. Prioritizing these actions within national and state health reform agendas will yield measurable improvements in outcomes and patient experience across the country.