

South Africa



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.

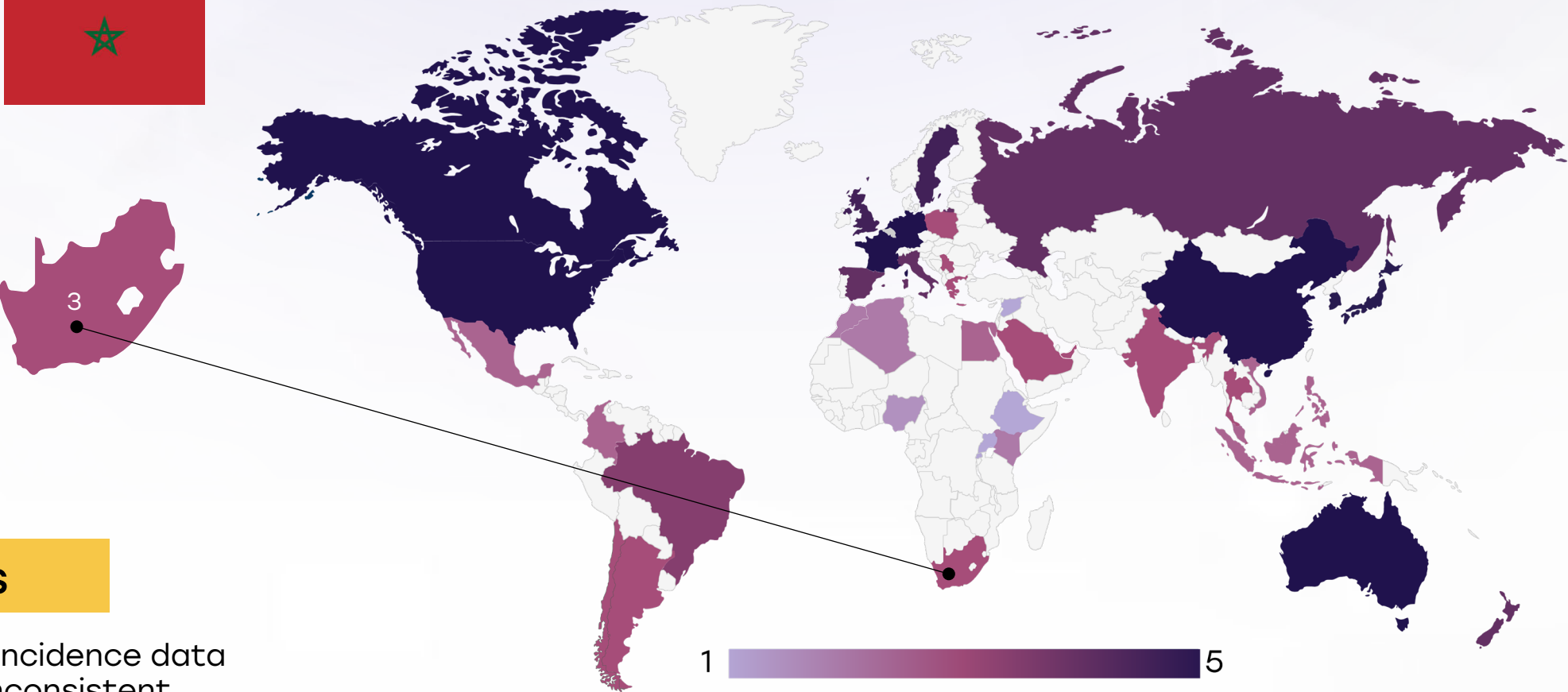
This factsheet provides a comprehensive overview of key pillars shaping Gastric cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Gastric cancer is not in the top 10 male cancers.
- Incidence rate: Approximately 3–4 per 100,000 men per year.
- Total new cases (2022): Around 1,500 men.
- Daily diagnoses: About 4 men per day.
- Deaths (2022): Roughly 1,200 men.
- 5-year survival rate: Likely below 35%, due to late presentation and limited access.
- Most affected age group: Mostly 60 years and above.
- Screening participation: No national screening; symptom-based detection only.

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Infrastructure



Strengths

- A multidisciplinary care pathway exists, with coordination among GPs, gastroenterologists, surgeons, pathologists, dietitians, and palliative specialists across both public and private sectors.
- National registries (e.g. the South African National Cancer Registry) collect data on gastric cancer incidence and mortality, supporting epidemiological tracking and resource planning

Weakness

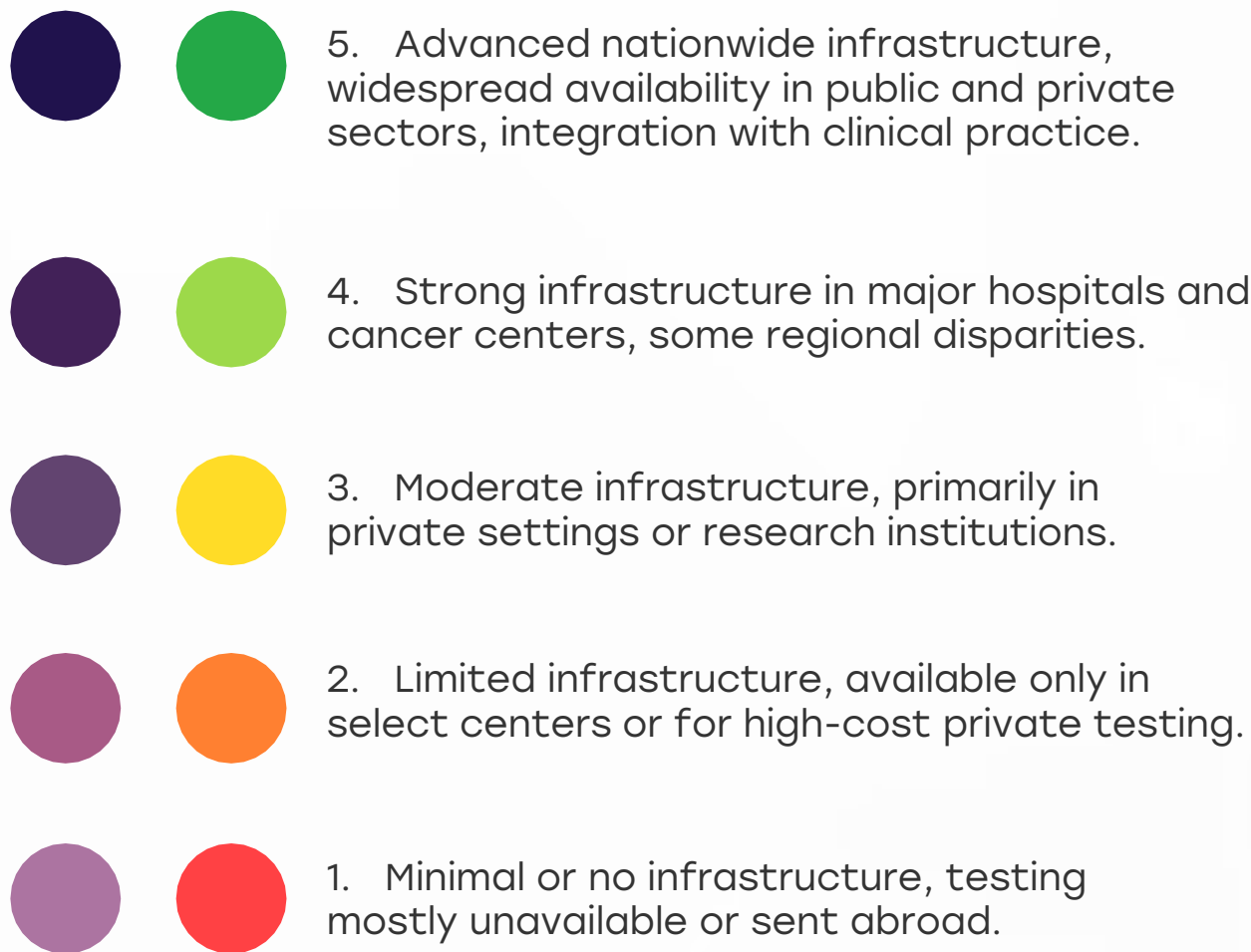
- Accurate cancer incidence data is limited due to inconsistent registry quality; incidence estimates are around ~1.9 cases per 100,000 males and ~1.1 per 100,000 females—ranking 10th and 14th most common cancers respectively.
- Many hospitals, particularly in rural settings, lack advanced endoscopic diagnostics, imaging modalities (e.g. CT scan), or surgical oncology capabilities, leading to late detection and limited curative treatment.

Opportunity

- Enhancing registry completeness and standardizing data collection can improve infrastructure allocation and disease surveillance.
- Investment in endoscopy units and training in secondary/rural hospitals can decentralize diagnostic capacity and reduce delays.

Threats

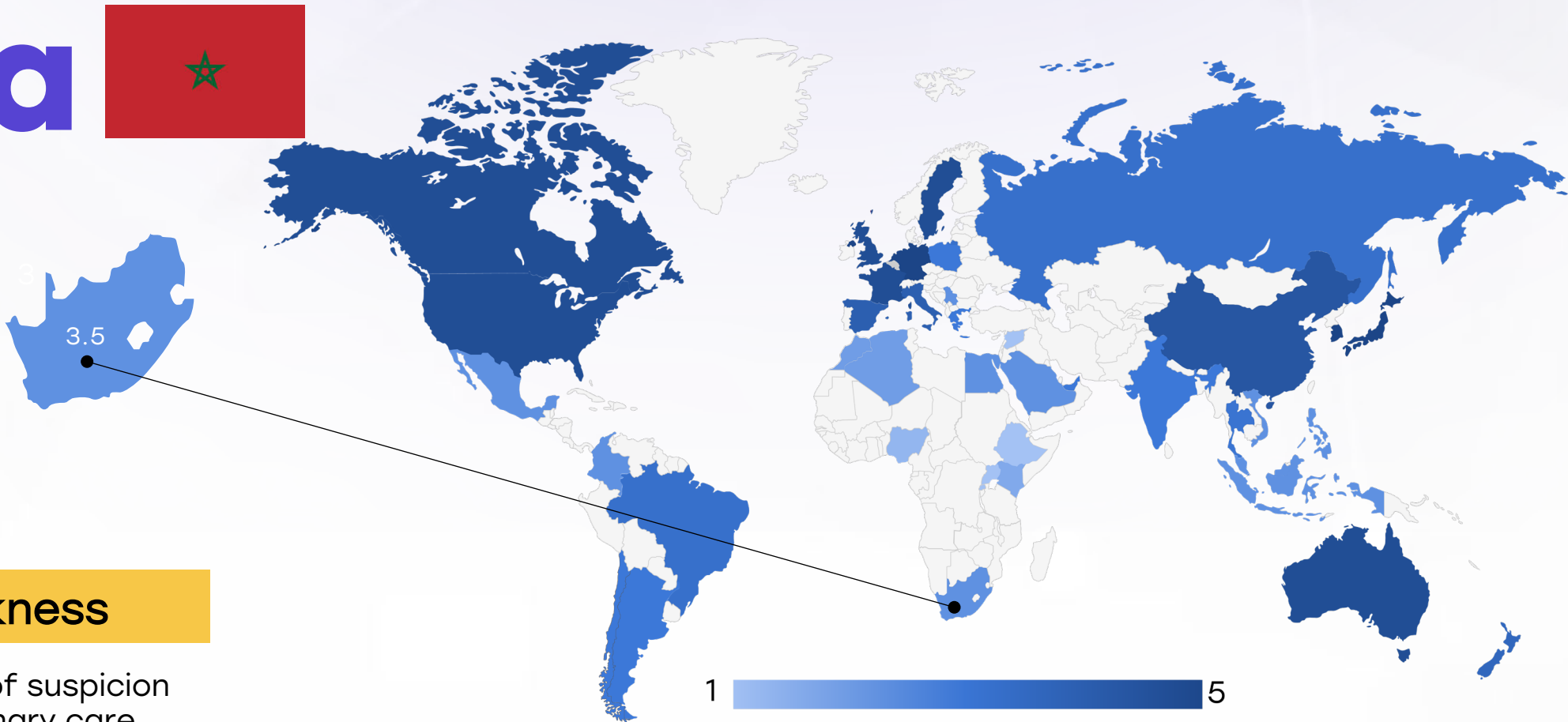
- Resource constraints and unequal distribution of specialists (e.g. pathologists, GI surgeons) across provinces limit equitable infrastructure expansion.
- Under-reporting and fragmented data sources undermine planning efforts.



Country	Specialized Centers	Genetic & Molecular Testing Infrastructure
South Africa		
Kenya		
Nigeria		
Egypt		
Morocco		
Algeria		
Ethiopia		
India		
Japan		
South Korea		
China		
Thailand		
Singapore		
United Kingdom		
Germany		
France		
Netherlands		
Sweden		
Italy		
Spain		
Poland		
Mexico		
Brazil		
Argentina		
Chile		
Colombia		
United States		
Canada		
Australia		
New Zealand		
Greece		
Rwanda		
Uganda		
Serbia		
Saudi Arabia		
UAE		
Syria		
Indonesia		
Vietnam		
Philippines		
Russia		
Malaysia		

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Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Both public and private healthcare systems practice MDT care for gastric cancer management, providing structured referral pathways from initial consultation to specialist care.
- Key stakeholders are calling for national consensus on streamlined care pathways to enhance timely diagnosis and treatment planning.

Weakness

- Low index of suspicion among primary care providers delays referrals; Helicobacter pylori detection is inconsistent due to limited resources.
- Public awareness of gastric cancer symptoms and risk factors is minimal; funding is often directed toward more common cancers (e.g. breast, cervical).

Opportunity

- Targeted training for primary care clinicians to improve early referral and H. pylori management.
- Awareness campaigns emphasizing gastric cancer risk (diet, reflux, H. pylori) could improve patient-initiated presentation.

Threats

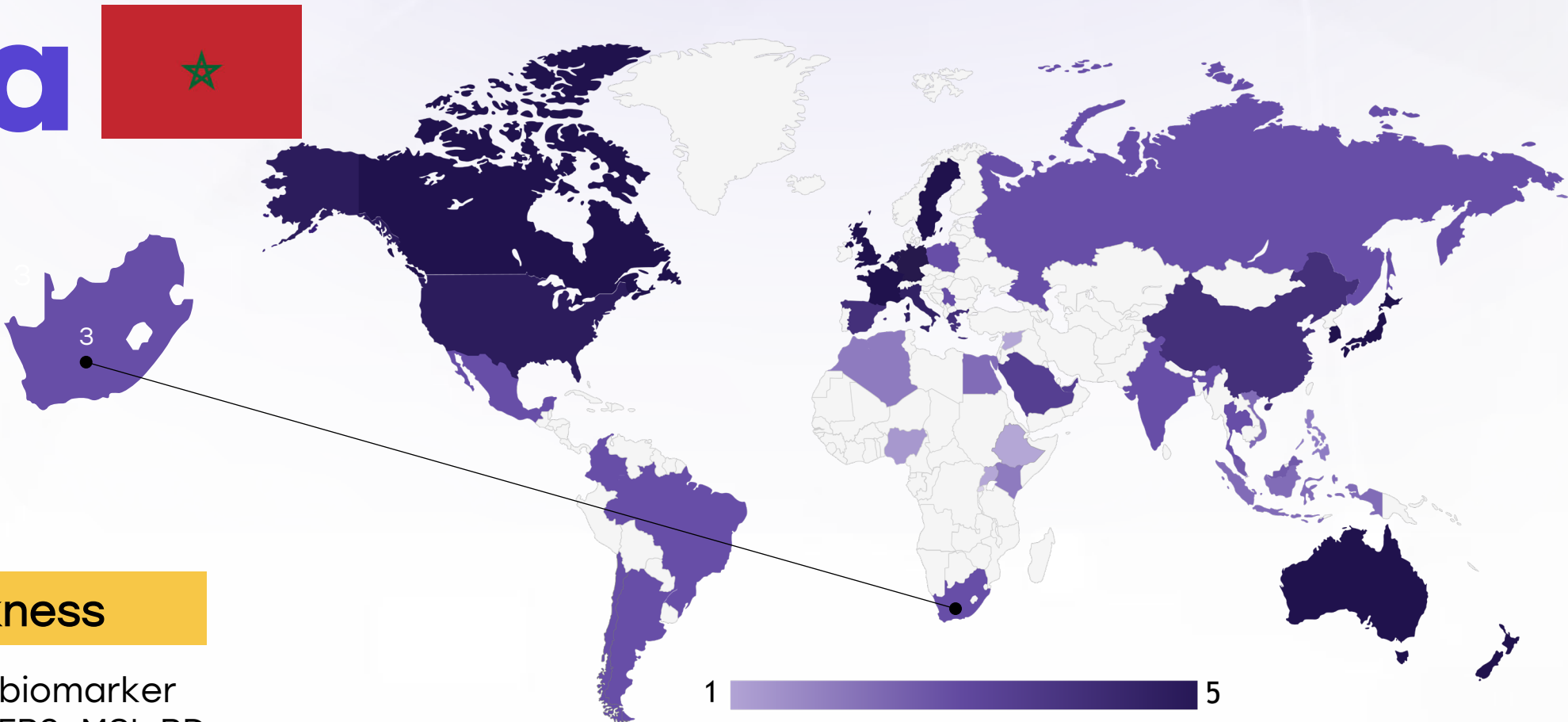
- Limited attention to gastric cancer in research grant agendas may hinder progress in prevention and diagnostics.
- Socioeconomic and geographic disparities reduce equal access to diagnostics and emerging therapies.

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

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Survival Rates, Early Detection and Palliative Care



Strengths

- Some tertiary pathology labs have the capacity to perform basic immunohistochemistry (e.g., HER2), though infrequent in routine gastric cancer workups.

Weakness

- Molecular biomarker testing (HER2, MSI, PD-L1) is rarely available; advanced markers (CLDN18.2, FGFR2b) are essentially absent from clinical practice.
- Companion diagnostics and targeted therapies are largely inaccessible and not reimbursed.




























































































































Opportunity

- Strengthening lab infrastructure at tertiary hospitals and building partnerships to pilot biomarker testing in referral centers.
- Embedding biomarker panels into cancer care guidelines nationally could incentivize their adoption.

Threats

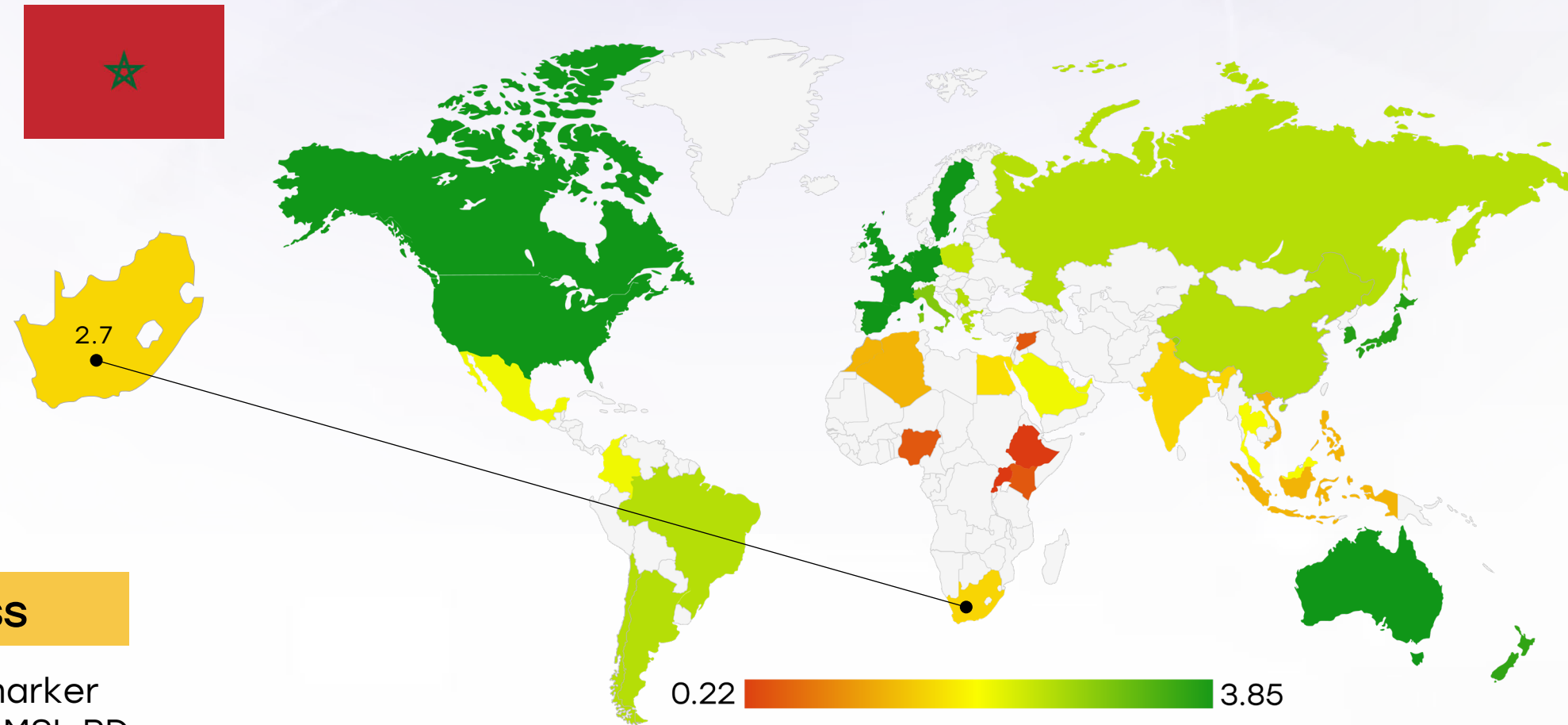
- Absence of reimbursement frameworks for diagnostics and novel therapies limits meaningful use of biomarker information.
- Technical capacity and training gaps hinder reliable testing.

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

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Utilization of Biomarkers

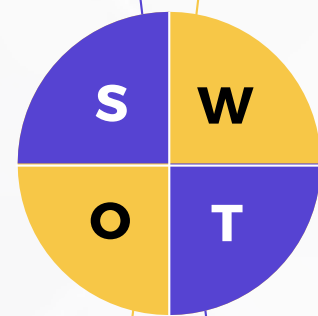


Strengths

- Some tertiary pathology labs have the capacity to perform basic immunohistochemistry (e.g., HER2), though infrequent in routine gastric cancer workups.

Weakness

- Molecular biomarker testing (HER2, MSI, PD-L1) is rarely available; advanced markers (CLDN18.2, FGFR2b) are essentially absent from clinical practice.
- Companion diagnostics and targeted therapies are largely inaccessible and not reimbursed.



Opportunity

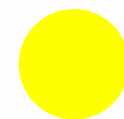
- Strengthening lab infrastructure at tertiary hospitals and building partnerships to pilot biomarker testing in referral centers.
- Embedding biomarker panels into cancer care guidelines nationally could incentivize their adoption.

Threats

- Absence of reimbursement frameworks for diagnostics and novel therapies limits meaningful use of biomarker information.
- Technical capacity and training gaps hinder reliable testing.



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.

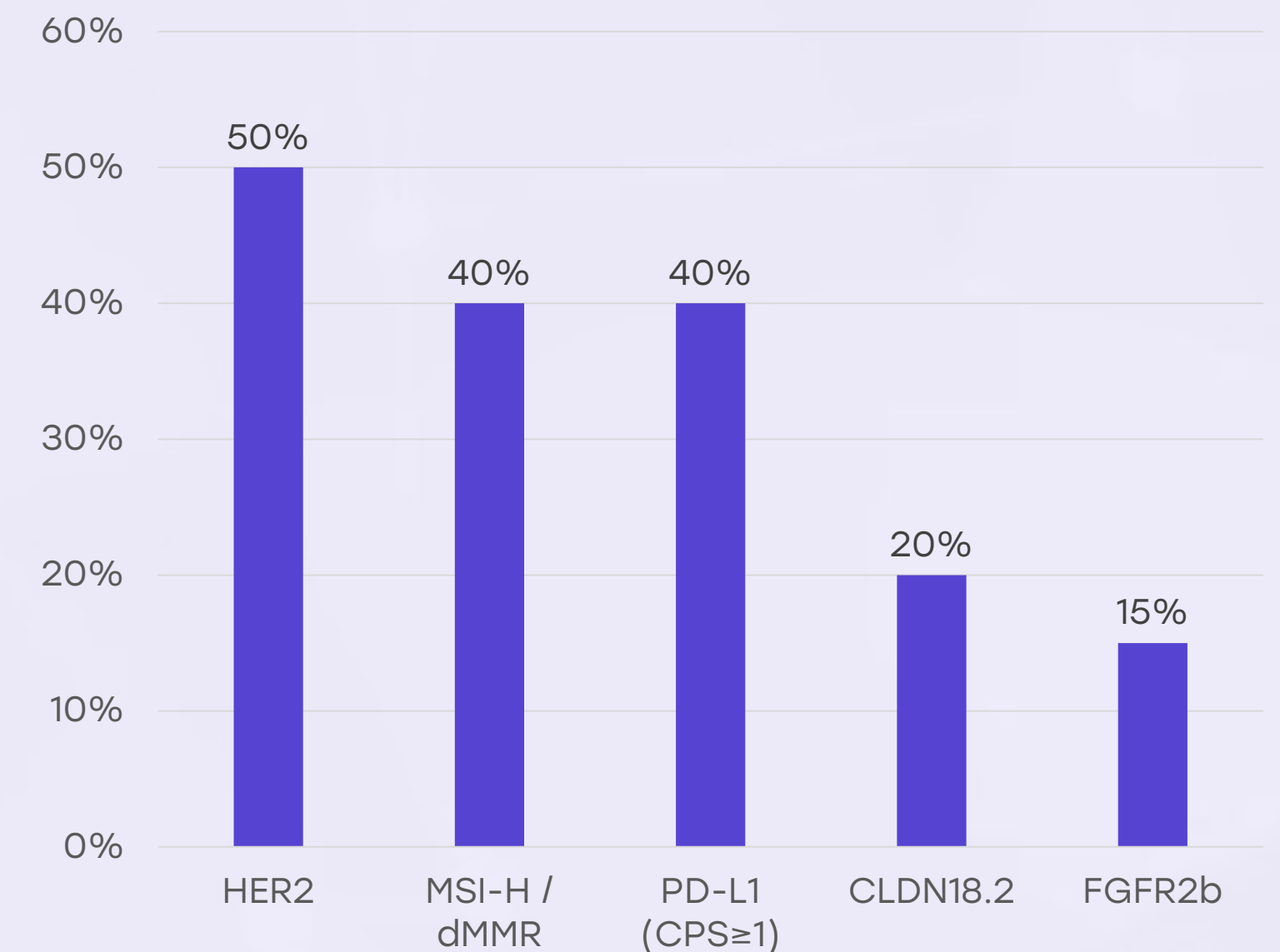


Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.



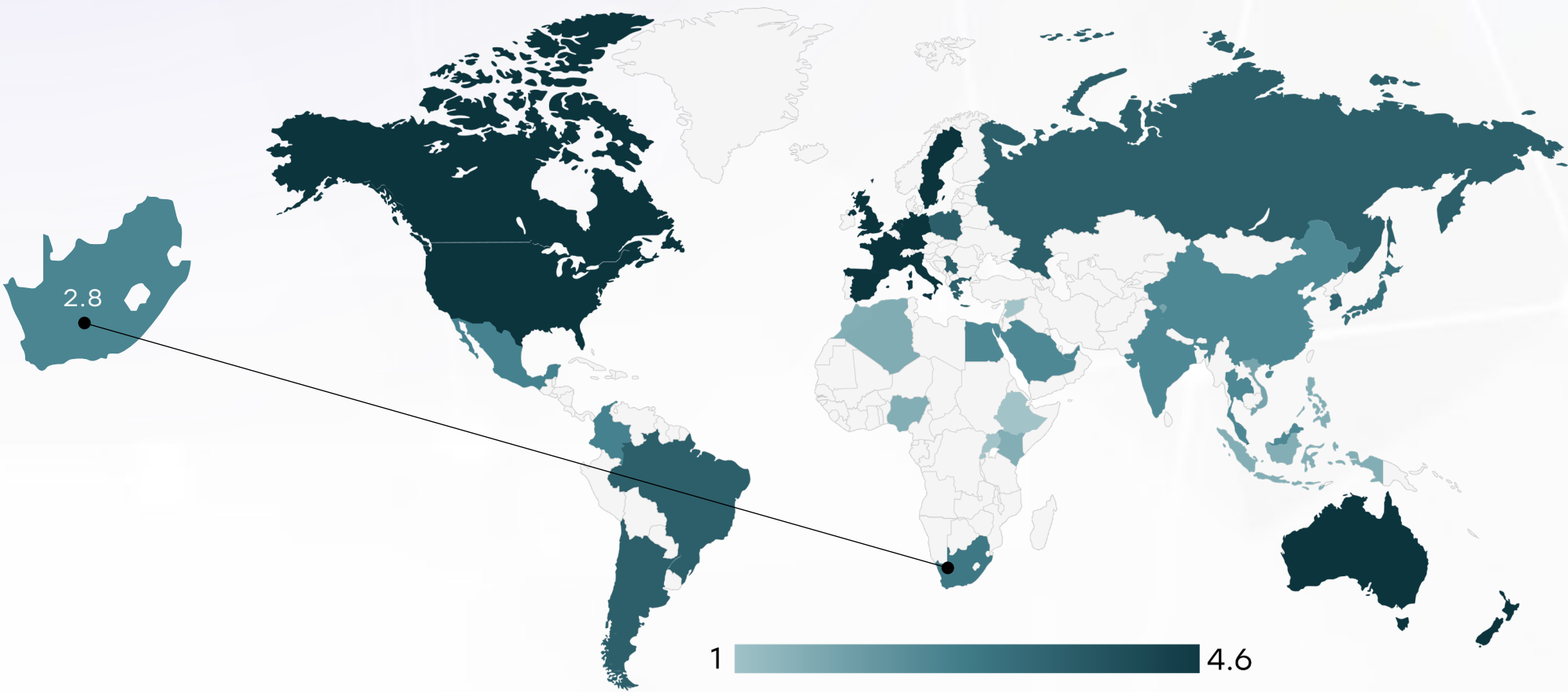
Biomarker testing is rarely performed, often due to lack of infrastructure, awareness, or financial barriers. Patients typically do not receive targeted therapies based on biomarker status.

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Clinical Guidelines



	Very High	High	Medium	Low	Very Low
Clinical Guideline Implementation	✗	○	✗	✗	✗
Feasibility of Integration	✗	✗	○	✗	✗
Adoption of International Guidelines	✗	✗	○	✗	✗
Engagement with Updates	✗	✗	✗	○	✗
ESMO Guidelines Implementation	✗	✗	○	✗	✗

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Reimbursement



Strengths

- MDT involvement includes public-sector referral mechanisms; core treatments such as surgery and chemotherapy may be covered in the public system.

Weakness

- Most diagnostic tests (e.g. endoscopy, imaging) may require out-of-pocket payment, especially in rural settings; private care is expensive.
- No reimbursement for molecular diagnostics or targeted therapies, leaving patients unable to access precision medicine.

Opportunity

- Introducing reimbursement schemes for early diagnostic services and staging investigations could reduce financial delays.
- Advocating for subsidized access to targeted therapies for eligible patients based on biomarker-driven protocols.

Threats

- Health budget limitations and unequal private-public funding create disparities.
- Patients may forgo early diagnostic workups due to cost, perpetuating delays.



















































































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.

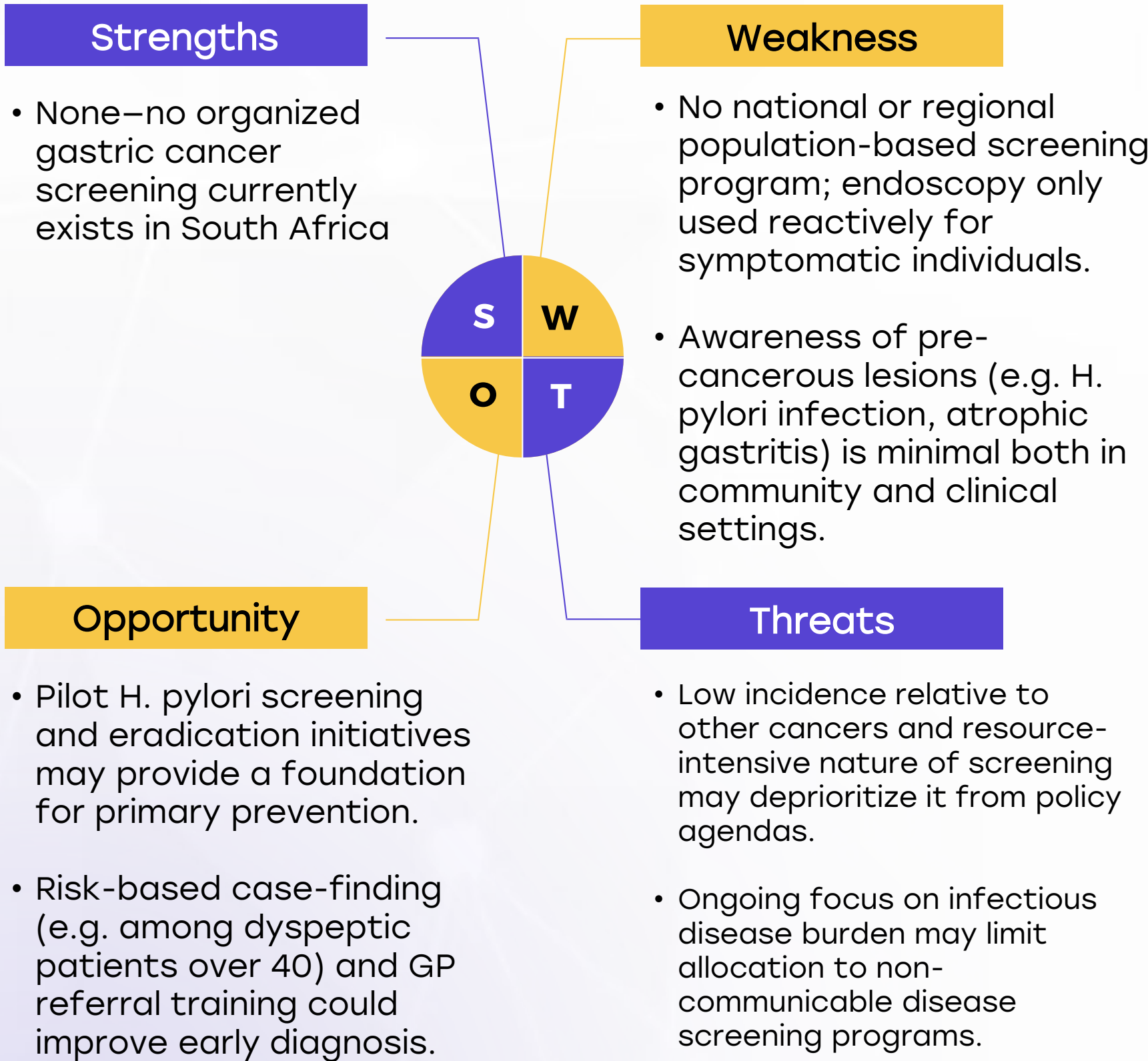


No formal reimbursement system exists, meaning patients must fully cover the cost of biomarker testing out-of-pocket.

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		
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Uganda		
Serbia		
Saudi Arabia		
UAE		
Syria		
Indonesia		
Vietnam		
Philippines		
Russia		
Malaysia		

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Colorectal Cancer 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