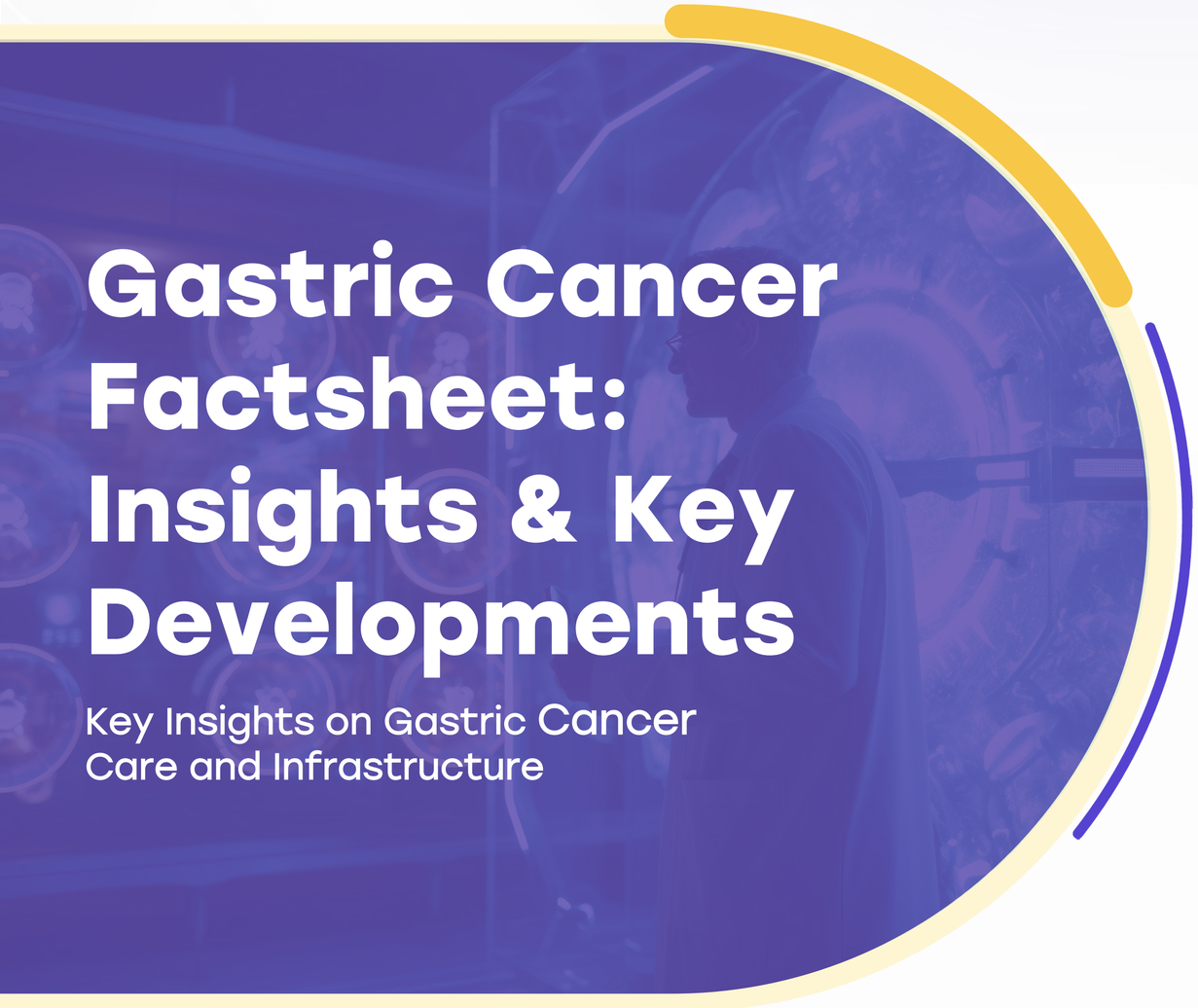
International Cancer Patient Coalition

Nigeria



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 cancers in men, but incidence is increasing.
- Incidence rate: Around 3 per 100,000 men per year.
- Total new cases (2022): Estimated 1,000–1,200 men.
- Daily diagnoses: Around 3–4 men per day.
- Deaths (2022): Roughly 1,000 men.
- 5-year survival rate: Likely under 30%, due to late detection and limited access to care.
- Most affected age group: Mostly 60+.
- Screening participation: No screening program; diagnosis is often delayed until advanced stages.

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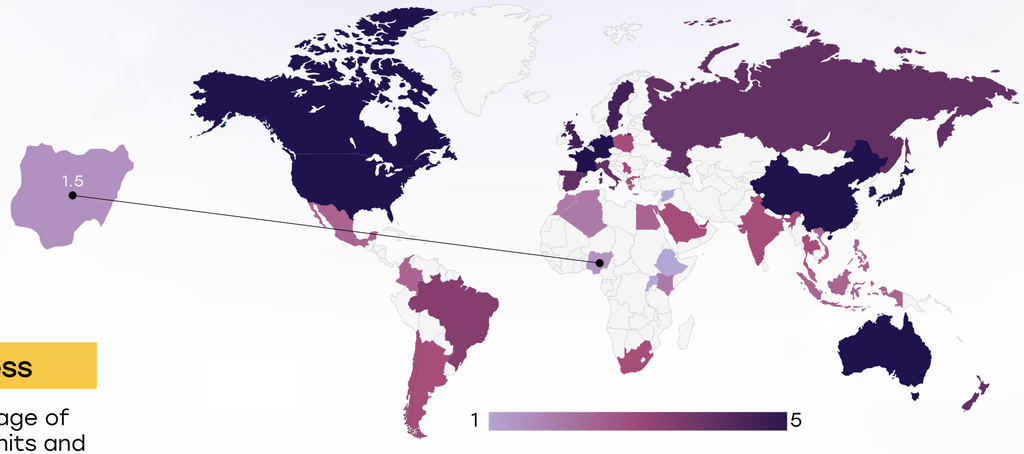
Infrastructure



Strengths

- Presence of major tertiary hospitals like University College Hospital (Ibadan) and LUTH (Lagos) with surgical and oncology units.
- Some public hospitals offer diagnostic services like gastroscopy and basic cancer treatment.

Weakness

- Severe shortage of endoscopy units and advanced imaging infrastructure in rural and secondary facilities.
- Poor maintenance of medical equipment leads to frequent service interruptions.

S W O T

Opportunity

- Public-private partnerships and diaspora-led investment can boost cancer infrastructure.
- Decentralization of oncology services could improve accessibility in underserved states.

Threats

- Chronic underfunding of healthcare and political instability slow infrastructure development.
- Inadequate electricity and logistics systems hamper reliable operation of diagnostic equipment.

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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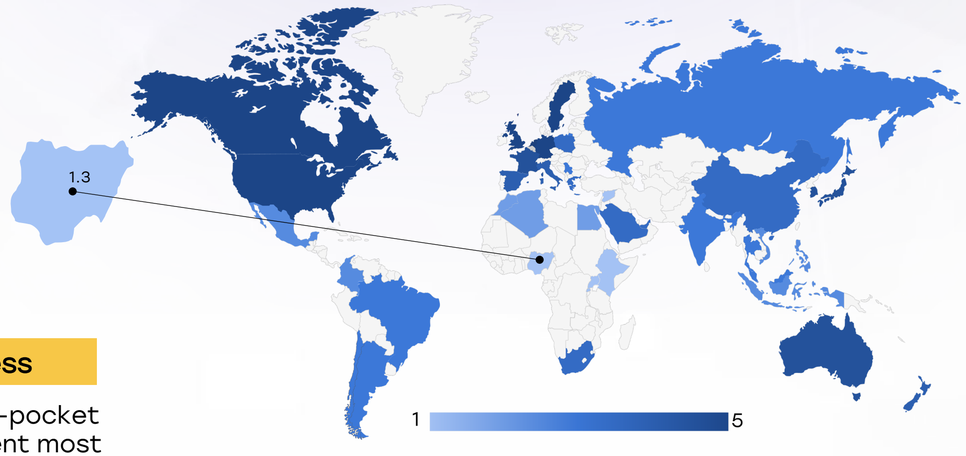
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Some teaching hospitals offer subsidized cancer care and chemotherapy under tertiary funding schemes.
- Nigeria is participating in global and regional cancer research collaborations.

Weakness

- High out-of-pocket costs prevent most patients from accessing timely treatment.
- Very limited public awareness campaigns targeting gastric cancer or gastrointestinal symptoms.

Opportunity

- Awareness programs through radio and local health workers can reach rural populations.
- Increasing global interest in African cancer research may bring new funding to local gastric cancer studies.

Threats

- Donor fatigue and low government research investment make sustained progress uncertain.
- Poor cancer literacy contributes to late-stage presentations and worsens treatment outcomes.

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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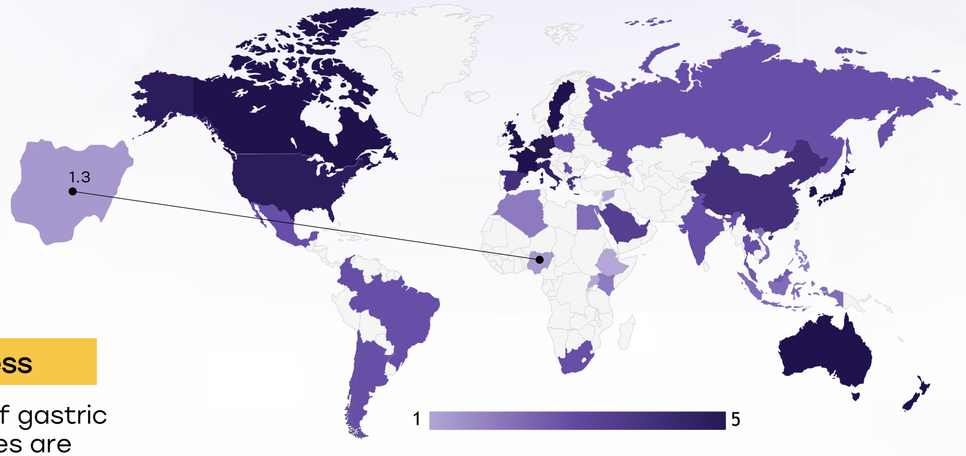
Survival Rates, Early Detection and Palliative Care



Strengths

- Some hospitals have functional pathology labs and multidisciplinary teams for advanced cancer care.
- Community-based palliative care initiatives exist in certain urban and semi-urban areas.

Weakness

- Over 80% of gastric cancer cases are diagnosed at late stages due to nonspecific symptoms and late help-seeking.
- Lack of organized referral systems delays diagnosis and continuity of care.

Opportunity

- Training community health extension workers (CHEWs) in cancer symptom awareness could improve early detection.
- Scaling mobile health initiatives could improve rural access to palliative care and diagnosis.

Threats

- Cultural beliefs and stigma around cancer discourage early medical attention.
- Weak death registry and cancer surveillance systems make it difficult to track survival outcomes.

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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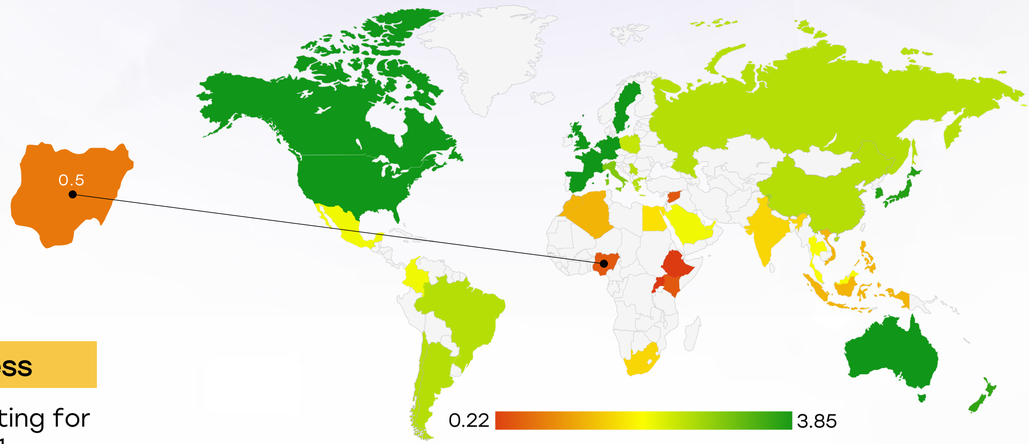
Utilization of Biomarkers



Strengths

- Select reference labs (in Lagos and Abuja) provide HER2 testing for gastric cancer cases.
- Research institutions are beginning to explore molecular diagnostics in collaboration with international partners.

Weakness

- Routine testing for MSI-H, PD-L1, CLDN18.2, and FGFR2b is almost non-existent.
- High cost and lack of lab personnel trained in molecular pathology limit expansion.

Opportunity

- Centralized biomarker testing hubs could serve multiple hospitals across zones.
- Academic and pharmaceutical partnerships can fund capacity-building and pilot testing programs.

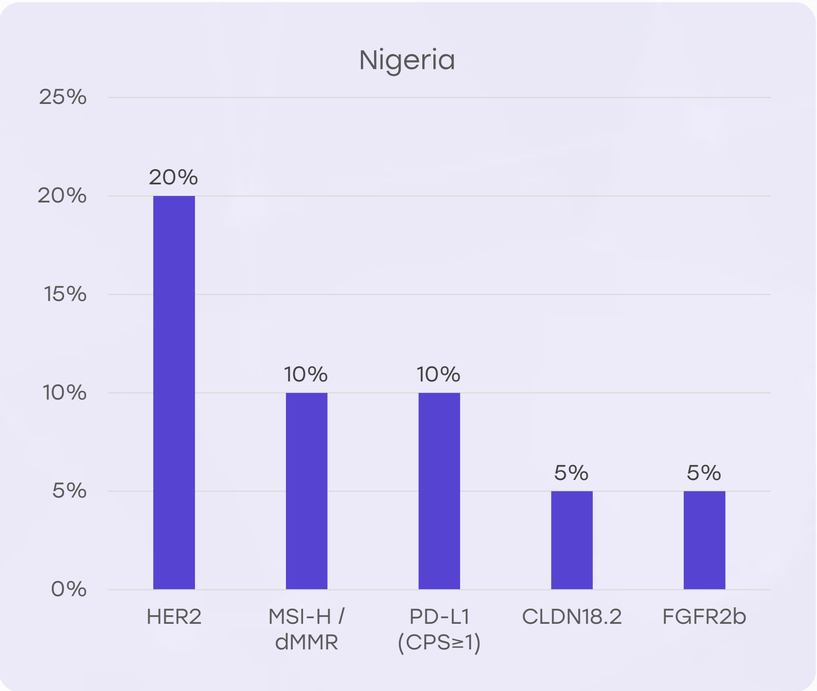
Threats

- Without reimbursement or policy support, biomarker adoption remains low.
- Rapid technological advancement globally may widen Nigeria's diagnostic gap without targeted investment.

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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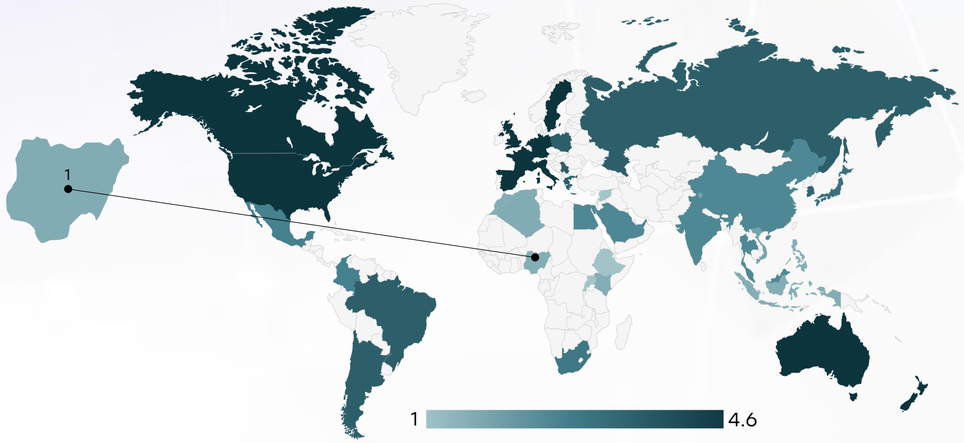
Clinical Guidelines



Strengths

- Nigeria's National Cancer Control Plan (2018–2022) includes broad standards for cancer management and referral.
- Teaching hospitals follow adapted international protocols for cancer treatment.

Weakness

- No gastric cancer-specific national clinical guidelines have been developed.
- Low awareness and poor dissemination of protocols among general practitioners.

Opportunity

- Adaptation of WHO and ESMO guidelines to local contexts can create national protocols.
- Use of mobile apps and CME webinars can improve knowledge of guidelines across the country.

Threats

- Overworked physicians in under-resourced hospitals may not follow standard protocols.
- Lack of implementation oversight leads to wide practice variation and suboptimal care.

	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

- National Health Insurance Authority (NHIA) is expanding its cancer care coverage in phases.
- Some pilot programs provide partial funding for chemotherapy and surgery.

Weakness

- Most cancer diagnostics and therapies are not reimbursed under NHIA.
- Only a small fraction of the population is covered by insurance; the majority rely on out-of-pocket payments.

S W O T

Opportunity

- NHIA reforms could include more cancer-specific coverage packages, especially for low-income groups.
- Civil society pressure can push for budget increases in cancer financing.

Threats

- Inflation and currency instability affect the affordability of cancer medications and diagnostics.
- Regional inequalities in health budgets worsen financial barriers to cancer care.

● 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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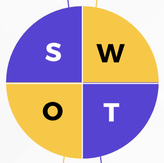
Colorectal Cancer Screening

Strengths

- Hospitals can conduct endoscopic screening for high-risk or symptomatic patients.
- Pilot **H. pylori** eradication and awareness studies have been done in select research sites.

Weakness

- No organized national screening program for gastric cancer exists.
- Public health system prioritizes other cancers like cervical and breast, leaving gastric cancer under-recognized.



Opportunity

- Screening initiatives targeting high-risk populations (e.g., men >50, chronic gastritis patients) can be cost-effective.
- Integration of **H. pylori** test-and-treat in routine GI care can reduce gastric cancer risk long-term.

Threats

- Logistical and financial barriers prevent scale-up of any population-based endoscopy program.
- Poor documentation and follow-up limit continuity after initial 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