International Cancer Patient Coalition

Kenya

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.

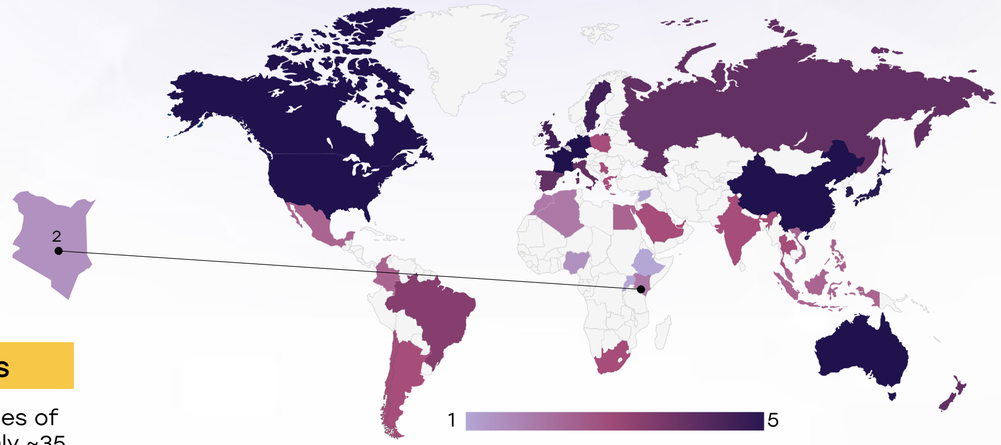
This factsheet provides a comprehensive overview of key pillars shaping Gastric cancer care, including specialized infrastructure, treatment accessibility, research funding, early detection, and palliative care.

- Incidence share: Gastric cancer is not among the top digestive cancers in Kenyan men.
- Incidence rate: Approximately 4 per 100,000 men per year.
- Total new cases (2022): Around 600–700 men.
- Daily diagnoses: Roughly 2 men per day.
- Deaths (2022): About 500–600 men.
- 5-year survival rate: Likely < 40%, with many late-stage presentations.
- Most affected age group: Men aged 60 and older.
- Screening participation: None; diagnosis usually occurs at advanced stages.

International Cancer Patient Coalition

Kenya

Infrastructure



Strengths

- Existence of referral hospitals such as Kenyatta National Hospital and Moi Teaching & Referral Hospital offering oncology services.
- Public-private partnerships (e.g., Aga Khan University Hospital) provide access to diagnostics and surgery in major cities.

Weakness

- Severe shortages of oncologists (only ~35 medical oncologists in the country).
- Rural infrastructure gaps: Most cancer services centralized in Nairobi, Kisumu, Eldoret—limiting reach to 75%+ of the population.

S W O T

Opportunity

- Expansion of County Cancer Centres as part of Universal Health Coverage (UHC) agenda.
- Telemedicine and mobile diagnostic vans for early detection in rural counties.

Threats

- Equipment breakdowns (e.g., radiotherapy machines), electricity outages, and lack of maintenance limit service delivery.
- Growing cancer burden may overwhelm under-resourced infrastructure.

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.

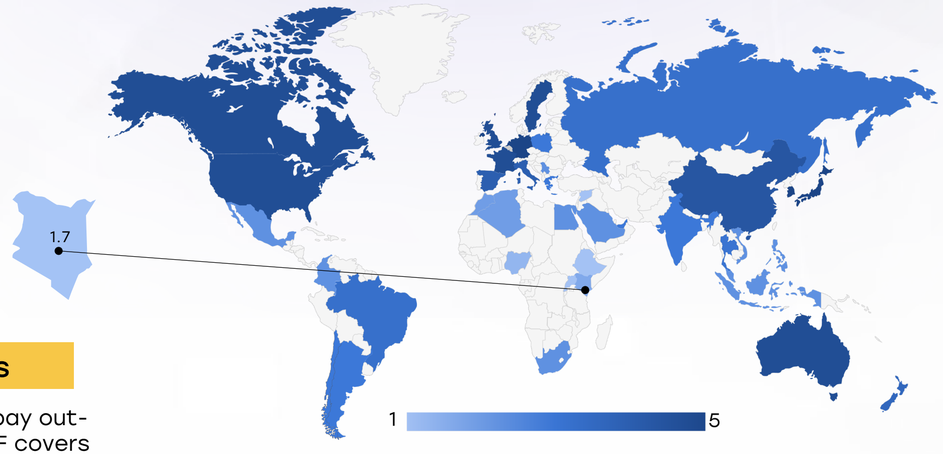
1. Minimal or no infrastructure, testing mostly unavailable or sent abroad.

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

International Cancer Patient Coalition

Kenya

Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Recent National Cancer Control Strategy (2023–2027) emphasizes access, affordability, and awareness.
- Civil society and NGOs (e.g., Faraja Cancer Support, Hope for Cancer Kids) lead local awareness and patient support

Weakness

- Most Kenyans pay out-of-pocket; NHIF covers some treatments but excludes high-cost drugs and biomarker testing.
- Minimal local gastric cancer research or funding from national institutions.

S W O T

Opportunity

- Increased global funding (e.g., WHO, IAEA) for oncology scale-up can support early detection and training.
- Public education on risk factors like H. pylori, tobacco, diet could reduce incidence.

Threats

- Cultural stigma and late health-seeking behavior hinder awareness efforts.
- Economic instability reduces donor and government cancer funding.

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.

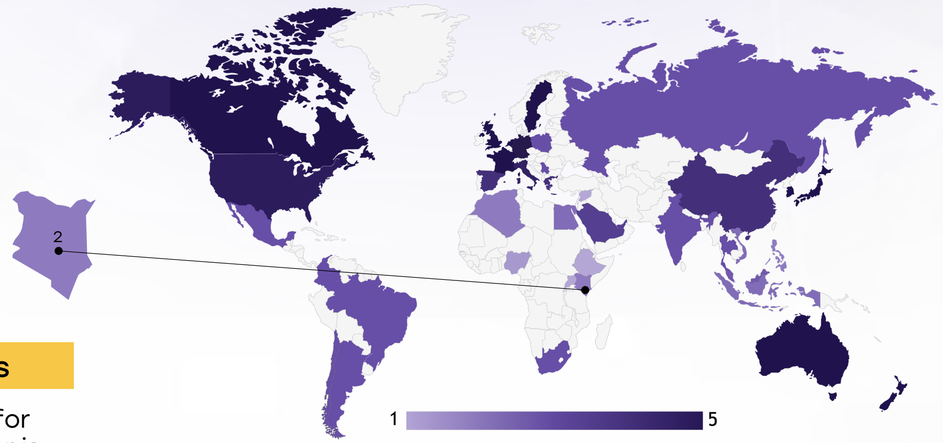
1. Poor infrastructure with severe barriers to treatment, little to no research funding, and lack of structured awareness campaigns. Cancer care is largely inaccessible, with many patients relying on out-of-pocket expenses or external aid.

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

International Cancer Patient Coalition

Kenya

Survival Rates, Early Detection and Palliative Care



Strengths

- Growing focus on palliative care, supported by Kenya Hospices and Palliative Care Association (KEHPCA).
- Increasing training of palliative nurses and counselors through national programs.

Weakness

- Survival rate for gastric cancer is <15%, largely due to late diagnosis.
- No national screening program, and most cases are detected at Stage III or IV.

S W O T

Opportunity

- Scale-up of early H. pylori screening and treatment in high-incidence counties (e.g., Rift Valley, Central).
- Train community health workers in basic symptom screening and referral.

Threats

- Poor diagnostic access, especially pathology turnaround times (2–4 weeks), delays staging and treatment.
- Low availability of pain medications and poor palliation in remote regions.

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.

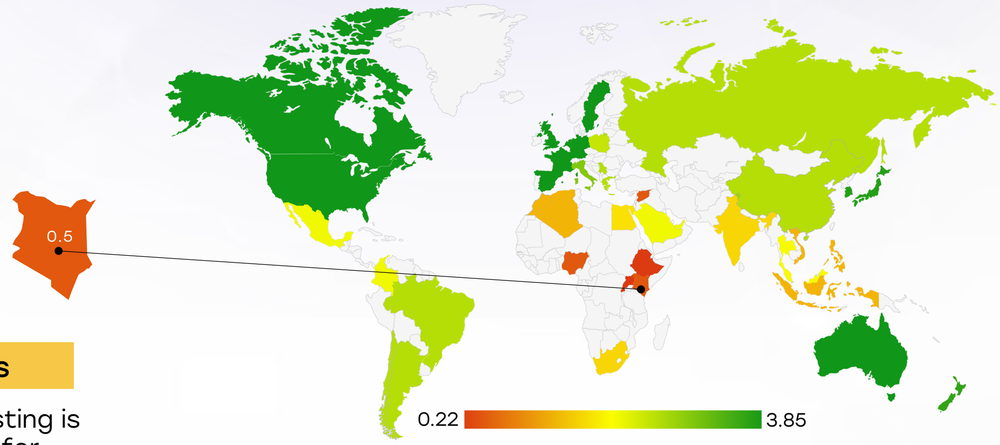
1. Very low survival rates, poor early detection infrastructure, and almost no palliative care services. Many patients are diagnosed late and lack proper support for pain management and end-of-life care.

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

International Cancer Patient Coalition

Kenya

Utilization of Biomarkers



Strengths

- HER2 testing occasionally available in private labs (e.g., Lancet Labs, Pathologists Lancet Kenya).
- Global clinical trials (especially HER2+) increasingly enrolling from sub-Saharan Africa, including Kenya.

Weakness

- Biomarker testing is unaffordable for most patients and not available in public hospitals.
- Lack of national laboratory capacity for advanced genomic profiling (e.g., NGS).

S W O T

Opportunity

- Collaboration with international biopharma and NGOs to improve access to testing and targeted therapy.
- Inclusion of HER2 and PD-L1 testing in NHIF-covered diagnostic packages.

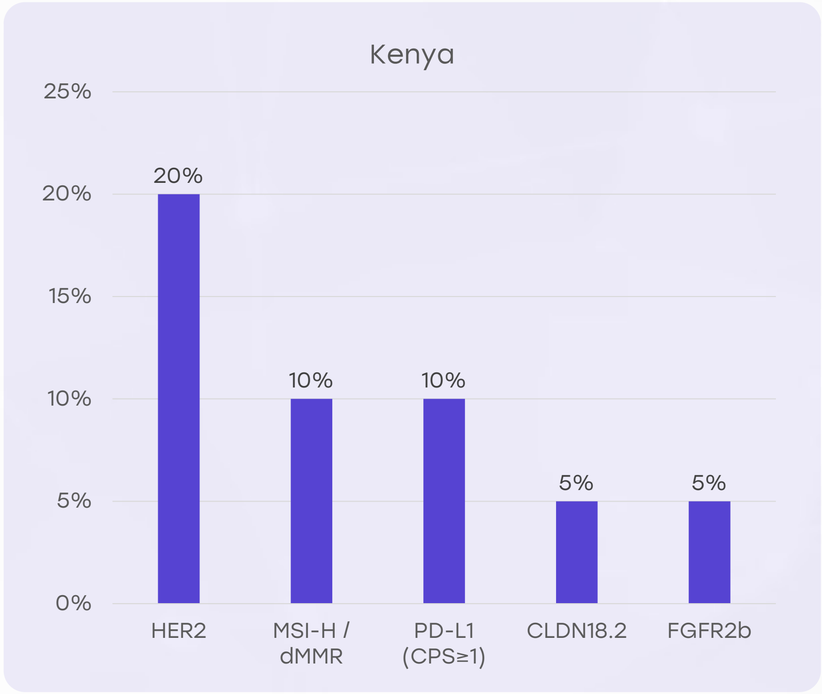
Threats

- Delayed diagnosis and inability to perform timely biomarker testing makes targeted therapy ineffective.
- Dependence on imported reagents and supply chain delays.

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.

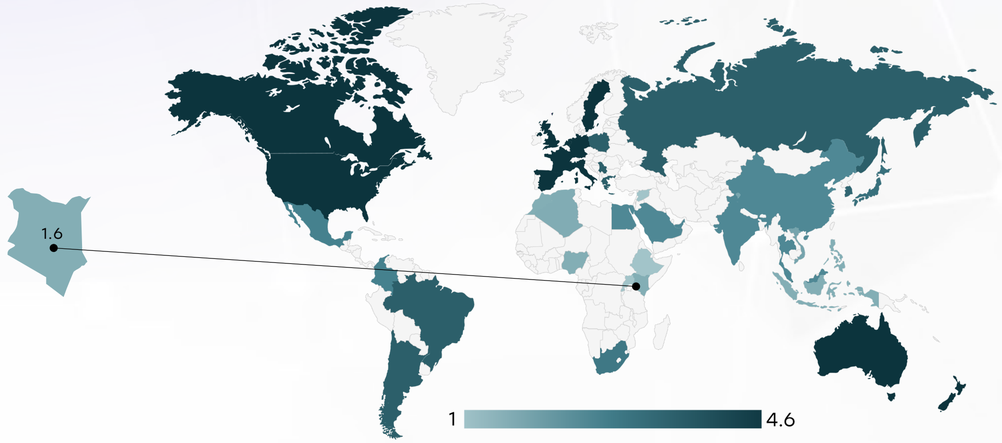
Biomarker testing is rarely performed, often due to lack of infrastructure, awareness, or financial barriers. Patients typically do not receive targeted therapies based on biomarker status.



International Cancer Patient Coalition

Kenya

Clinical Guidelines



Strengths

- National Cancer Treatment Protocols (2021) provide basic clinical pathways for gastric and GI cancers.
- Kenyan doctors trained with NCCN and ESMO-based approaches in referral hospitals

Weakness

- Gastric cancer-specific protocols lack depth and biomarker integration.
- Limited adherence outside major centers due to training and capacity gaps.

S W O T

Opportunity

- Periodic updates incorporating global evidence (e.g., HER2, immunotherapy).
- Develop simplified algorithms for tiered health centers using WHO cancer toolkit.

Threats

- Poor implementation and monitoring lead to guideline non-compliance in public facilities.
- Lack of training in molecular oncology among general practitioners

	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

International Cancer Patient Coalition

Kenya

Reimbursement

Strengths

- NHIF offers basic oncology care, including chemotherapy, surgery, and radiotherapy at designated centers.
- Recent NHIF reforms are increasing outpatient cancer care packages.

Weakness

- NHIF does not reimburse biomarker testing or targeted therapies (e.g., trastuzumab, nivolumab).
- Private insurance is unaffordable for most Kenyans; many patients go without full treatment.

S W O T

Opportunity

- NHIF strategic purchasing from private labs and treatment centers can broaden access.
- Pilot outcomes-based reimbursement models for select targeted therapies.

Threats

- Rising cancer treatment costs may lead to benefit package cuts.
- Informal sector populations often not enrolled in NHIF, limiting their cancer coverage

● 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	●	●

International Cancer Patient Coalition

Kenya

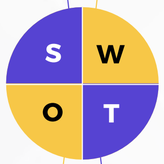
Gastric Cancer Screening

Strengths

- Research initiatives (e.g., AMPATH, Moi University) piloting H. pylori screening and eradication programs.
- Basic gastroscopy services available in tertiary centers like Kenyatta and Aga Khan.

Weakness

- No national gastric cancer screening program in place.
- Limited endoscopy availability in public hospitals; long wait times and low diagnostic quality.



Opportunity

- Develop risk-based screening guidelines in high-incidence areas using community health workers.
- Public-private partnerships to train more endoscopists and upgrade equipment.

Threats

- Competing health priorities (e.g., TB, HIV, maternal health) may delay implementation.
- Cultural barriers and fear of diagnosis reduce patient acceptance of 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