SOUTH AFRICA

International Cancer Patient Coalition

BRIDGING THE GAP

Enhancing Equitable Access & Innovation in **Gastric Cancer Care** in South Africa

EXECUTIVE SUMMARY

South Africa's gastric cancer (GC) burden is moderate but carries high mortality driven by late presentation and uneven access to timely endoscopy, pathology (including HER2 testing), curative surgery, systemic therapy, radiotherapy for palliation, and survivorship services. There is no population screening for GC; Helicobacter pylori prevalence remains significant in many communities. Access differs markedly between public and private sectors. The

National Health Insurance (NHI) reforms create an opportunity to standardize benefits and reduce inequity as roll-out proceeds. Priority actions include scaling H. pylori test-and-treat, expanding public endoscopy capacity and triage, ensuring routine HER2 testing with funding pathways for indicated therapies, addressing radiotherapy backlogs for palliation, and improving registry completeness and timeliness.

INTRODUCTION

Building on Awareness Gains Amid Structural Gaps

South Africa operates a two-tier health system with strong tertiary centres but variable provincial capacity. With gastric cancer maturity assessed at **Level 3**, core services exist but remain inconsistent in coverage and timeliness.

Ongoing health financing reforms offer a policy window to codify a national GC pathway, but near-term improvements will rely on targeted investments in diagnostics, molecular pathology, oncology services, and palliative care within existing provincial systems.

South Africa Ranks at Level 3 – Gastric Cancer Care Maturity Framework

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GASTRIC CANCER IN SOUTH AFRICA

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No population screening; diagnosis is symptom-driven and many cases present late. Public-sector endoscopy often has long waits.	Endoscopy and histopathology services are well-established in tertiary centres.	Implement a national GC pathway with alarm-symptom triage and time-to-endoscopy targets; expand sessional endoscopy lists and mobile outreach in underserved districts.
Biomarker & Molecular Testing	HER2 testing for advanced GC is available in academic/reference labs but not consistently across all public hospitals; turnaround times vary.	Urban academic pathology capacity that can act as reference hubs.	Mandate HER2 IHC/ISH for unresectable /metastatic GC with defined turnaround targets (e.g., ≤10 working days) and network smaller labs to reference centres.
Treatment Access	Curative gastrectomy and peri-operative chemotherapy are available in tertiary hubs; targeted therapy access for HER2+ GC is limited in the public sector.	Strong surgical and oncology expertise concentrated in tertiary centres and private sector.	Ensure equitable access to peri-operative chemotherapy nationally; plan procurement and funding pathways for trastuzumab biosimilars or equivalent HER2-targeted options for HER2+ metastatic GC within the NHI benefits package.
Clinical Guidelines	Many centres follow international protocols, but there is no single, uniformly implemented national GC pathway.	Established multidisciplinary team (MDT) practice in major hospitals supports standardisation.	Publish and implement a national GC pathway covering diagnostics, staging (including CT and diagnostic laparoscopy where indicated), peri-operative chemotherapy, metastatic care, and palliation; set referral SLAs and audit mechanisms.
Palliative & Survivorship Care	Palliative services exist but are uneven; radiotherapy backlogs challenge timely palliation in some provinces.	Growing palliative care networks and increasing attention to survivorship.	Ring-fence palliative radiotherapy slots, strengthen equipment maintenance and planning workflows, expand community-based palliative teams, and integrate nutrition and psychosocial support into the GC pathway.

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CONCLUSION & Call to Action

South Africa's GC system is at an inflection point: core clinical capabilities exist, but outcomes are hampered by inequitable access and delays. By embedding a national GC pathway into health system planning, scaling H. pylori prevention, strengthening molecular diagnostics, ensuring equitable access to evidence-based systemic and palliative therapies, and improving data transparency, South Africa can markedly improve survival and quality of life for people with gastric cancer within a 3–5 year horizon.

KEY POLICY PRIORITIES

1. **National GC Pathway:** Standardize triage, diagnostics, MDT review, protocols, and referral timelines with monitoring.
2. **H. pylori Test-and-Treat:** Integrate into primary care with recommended regimens and resistance surveillance.
3. **Molecular Pathology:** Fund HER2 testing nationwid with fast reporting through hub-and-spoke labs
4. **Targeted Therapy Access:** Establish procurement and funding for HER2 therapies via national insurance.
5. **Radiotherapy Solutions:** Reduce backlogs with maintenance, workflow improvements, and outsourcing while safeguarding palliative care.
6. **Data & QA:** Use registries for dashboards, audits, and tracking endoscopy, HER2, and treatment timelines.

CONCLUSION

With focused policy action, South Africa can transition from fragmented services to a cohesive, patient-centred gastric cancer care system. Prioritising equitable access to diagnosis, molecular testing, evidence-based treatment, and palliative care—while using the NHI reform process to secure financing and accountability—offers the clearest route to improved survival and quality of life for all patients, regardless of province or income.