ETHIOPIA

International Cancer Patient Coalition

BRIDGING THE GAP

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

EXECUTIVE SUMMARY

Ethiopia faces major challenges in gastric cancer (GC) control. Most patients present late, diagnostic capacity (endoscopy, pathology, molecular testing) is limited and concentrated in a few urban centres, and access to curative surgery, systemic therapy and palliative services is uneven and frequently unaffordable. Health system capacity is improving slowly through national cancer planning and donor-supported programs, but major investments in workforce, diagnostics, financing and referral systems are required.

This brief outlines pragmatic, staged reforms to move Ethiopia from fragmented, reactive care toward a basic, more equitable GC pathway.

INTRODUCTION

Building on Awareness Gains Amid Structural Gaps

Ethiopia is expanding its health system reach through primary-care networks and hospital upgrades, yet specialised cancer services remain scarce outside Addis Ababa and a few regional hubs. With an overall gastric cancer maturity of **Level 2**, Ethiopia has nascent services and policy awareness but lacks widescale diagnostic, treatment and palliative capacity.

Priorities are realistic, incremental actions that create functioning referral pathways, strengthen core diagnostics, and make essential therapies available and affordable.

Ethiopia Ranks at Level 2 – Gastric Cancer Care Maturity Framework

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GASTRIC CANCER IN ETHIOPIA

Current Landscape and Strategic Gaps

Pillar	Current Status	Strength	Policy Action
Early Detection & Diagnosis	No population screening; most GC detected after symptom onset. Endoscopy services are extremely limited and largely concentrated in tertiary urban hospitals; many patients face long travel and cost barriers.	Expanding primary care and referral networks, and growing clinical awareness in urban centres.	Define simple alarm-symptom referral criteria for primary care and create clear, resourced referral pathways to regional endoscopy hubs; scale basic diagnostic endoscopy capacity at selected regional hospitals with sustainable maintenance plans.
Biomarker & Molecular Testing	Molecular testing (e.g., HER2) is largely unavailable in the public sector; histopathology capacity is limited with slow turnaround times.	A few public and private reference labs can provide biopsy diagnosis and limited molecular tests if samples are routed.	Build basic pathology capacity (training, equipment, supply chains) at regional centres; establish a hub-and-spoke sample referral network for molecular testing while subsidizing critical biomarker testing for advanced cases.
Treatment Access	Curative surgery and peri-operative chemotherapy are available in very few centres; access to modern targeted therapies is essentially absent for most patients due to cost and procurement limits.	Dedicated surgeons and oncologists exist in tertiary hospitals and teaching institutions.	Standardize realistic peri-operative chemotherapy protocols for available regimens; include core GC chemotherapy on essential medicines lists and explore pooled procurement or donor-negotiated access for key agents.
Clinical Guidelines	No widely implemented national GC pathway; clinicians rely on limited local protocols or international guidance inconsistently.	Growing engagement from academic hospitals and professional societies willing to lead guideline adaptation.	Develop a concise, resource-stratified national GC pathway that fits Ethiopia's capacity (tiered diagnostics/treatment), distribute it to all hospitals, and couple with clinician training and simple audit targets.
Palliative & Survivorship Care	Palliative services are sparse and uneven; opioid availability and trained community palliative teams are limited, particularly outside urban areas.	Community health extension workforce and nascent palliative programs offer a platform for scale-up.	Integrate basic palliative care into district hospitals and primary-care follow-up, train health extension teams in symptom recognition/referral, and improve opioid supply chains and prescriber training for pain control.

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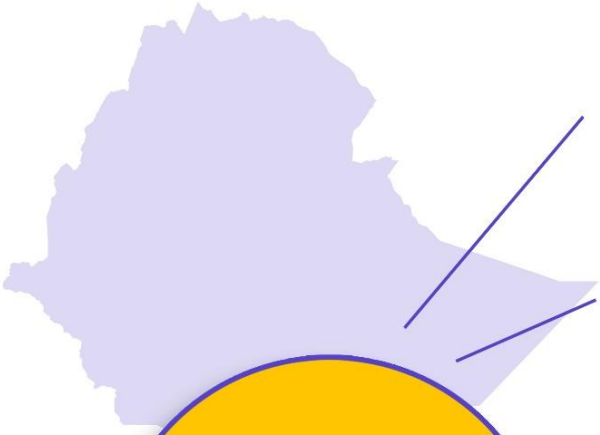
CONCLUSION & Call to Action

Ethiopia's gastric cancer system is at an early developmental stage: there is clinical will and some tertiary capacity, but widespread lack of diagnostics, trained workforce, financing and palliative coverage. Practical, sequenced interventions that prioritize referral pathways, basic diagnostics, essential therapies, and palliative integration can shift outcomes measurably. Early wins will build momentum and justify larger investments.



KEY POLICY PRIORITIES

1. **National GC Referral Pathway:** Define alarm-symptom criteria, referral routes, and time targets to regional diagnostic hubs.
2. **Diagnostic Capacity:** Invest in endoscopy kits, training, and maintenance at regional hospitals.
3. **Pathology & Sample Referral:** Upgrade regional histopathology, implement molecular testing networks, and subsidize essential biomarkers.
4. **Essential Therapies:** Ensure peri-operative and palliative chemotherapy availability via essential medicines lists and pooled procurement.
5. **Palliative Care Integration:** Train district clinicians, improve opioid access, and embed psychosocial and nutritional support.

CONCLUSION

For Ethiopia, pragmatic, resource-aware interventions that prioritize referral systems, a small number of strengthened regional diagnostic and treatment hubs, essential medicines access, and palliative integration will deliver the fastest, most equitable gains. With Level 2 maturity, the focus should be on achievable, high-impact steps that build capacity and trust — creating the foundation for broader, sustained cancer-system development over the medium term.