

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 a leading cancer in men.
- Incidence rate: Approximately 9 per 100,000 men per year.
- Total new cases (2022): Estimated ~1,400 men.
- Daily diagnoses (2022): Around 4 men per day.
- Deaths (2022): About 1,700 men.
- 5-year survival rate: Likely under 40%, reflecting late-stage diagnosis.
- Most affected age group: Primarily 60 years and older.
- Screening participation: No screening; diagnosis typically happens after symptom onset.

Ethiopia



Infrastructure

Strengths

- Major referral hospitals in Addis Ababa (e.g., Black Lion Hospital) provide endoscopy, surgical treatment, and basic pathology services.
- Emerging oncology units in regional centers (e.g., Bahir Dar, Hawassa) enhance access to GI cancer care.

Opportunity

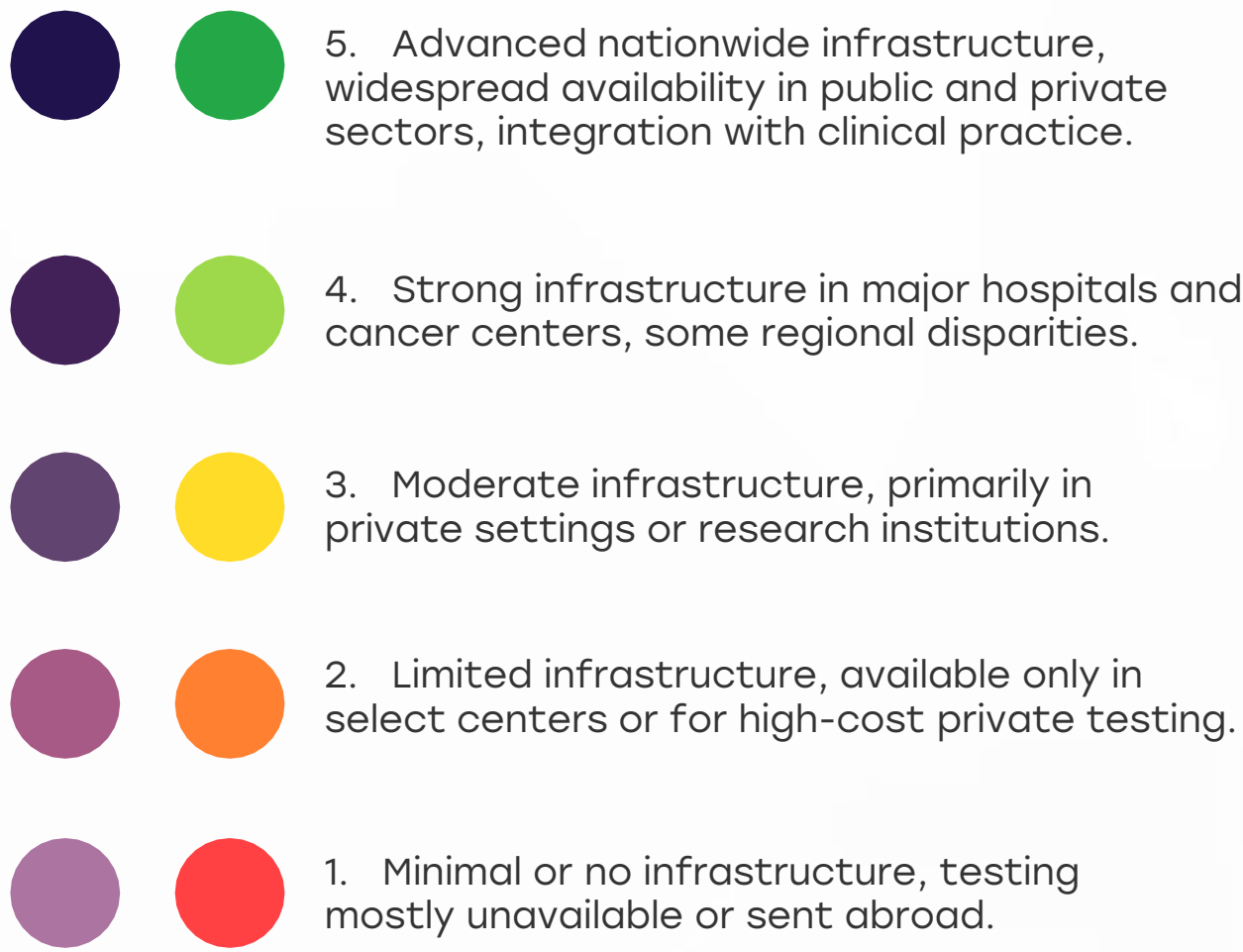
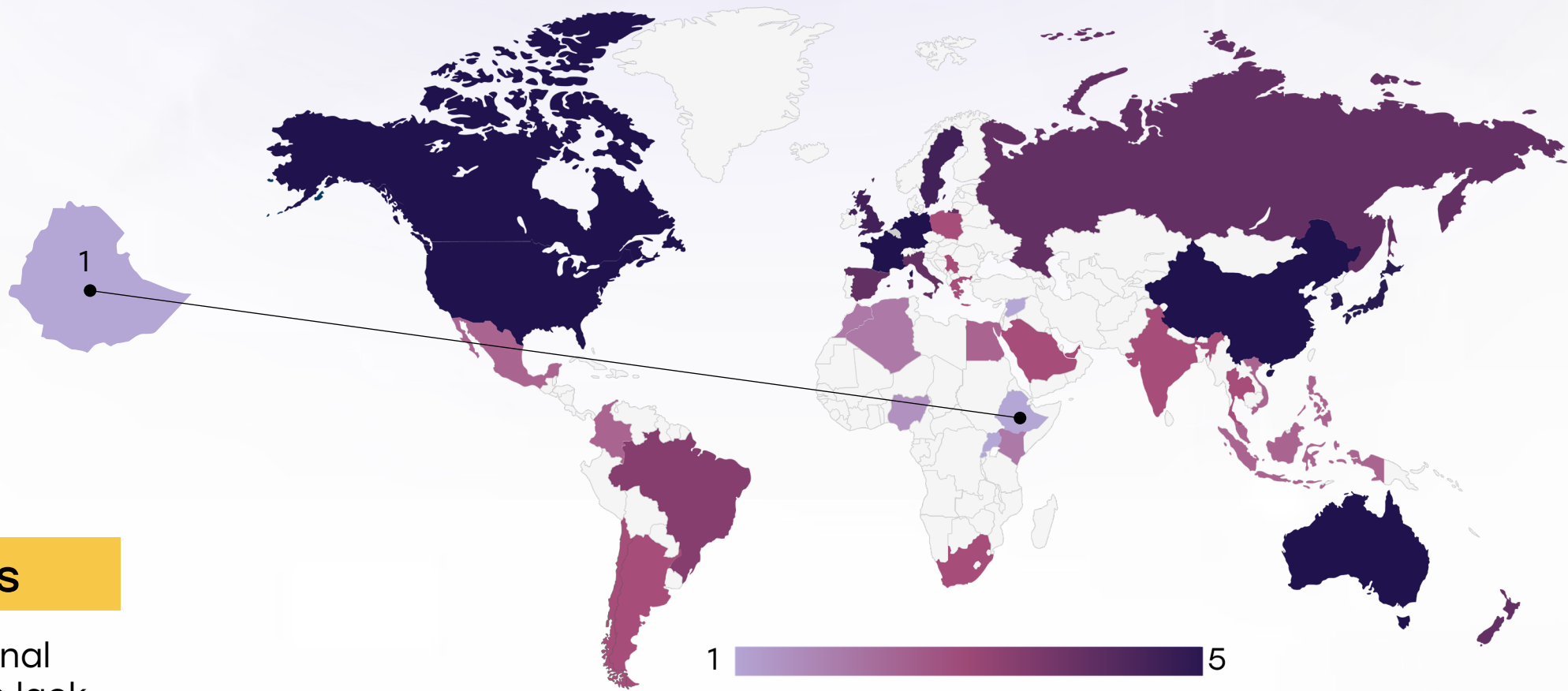
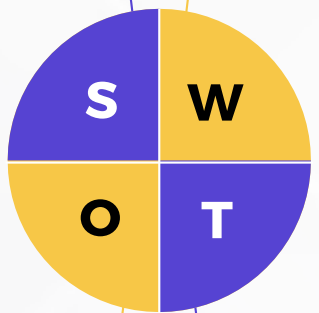
- Establish mobile diagnostic clinics and tele-endoscopy units to reach remote and underserved areas.
- Develop regional labs or collaborate with external partners to support molecular testing for biomarkers.











Weakness

- Rural and regional hospitals often lack endoscopy equipment and molecular pathology labs, hampering GC diagnosis.
- Inadequate referral networks lead to delays in staging and treatment at central oncology facilities.

Threats

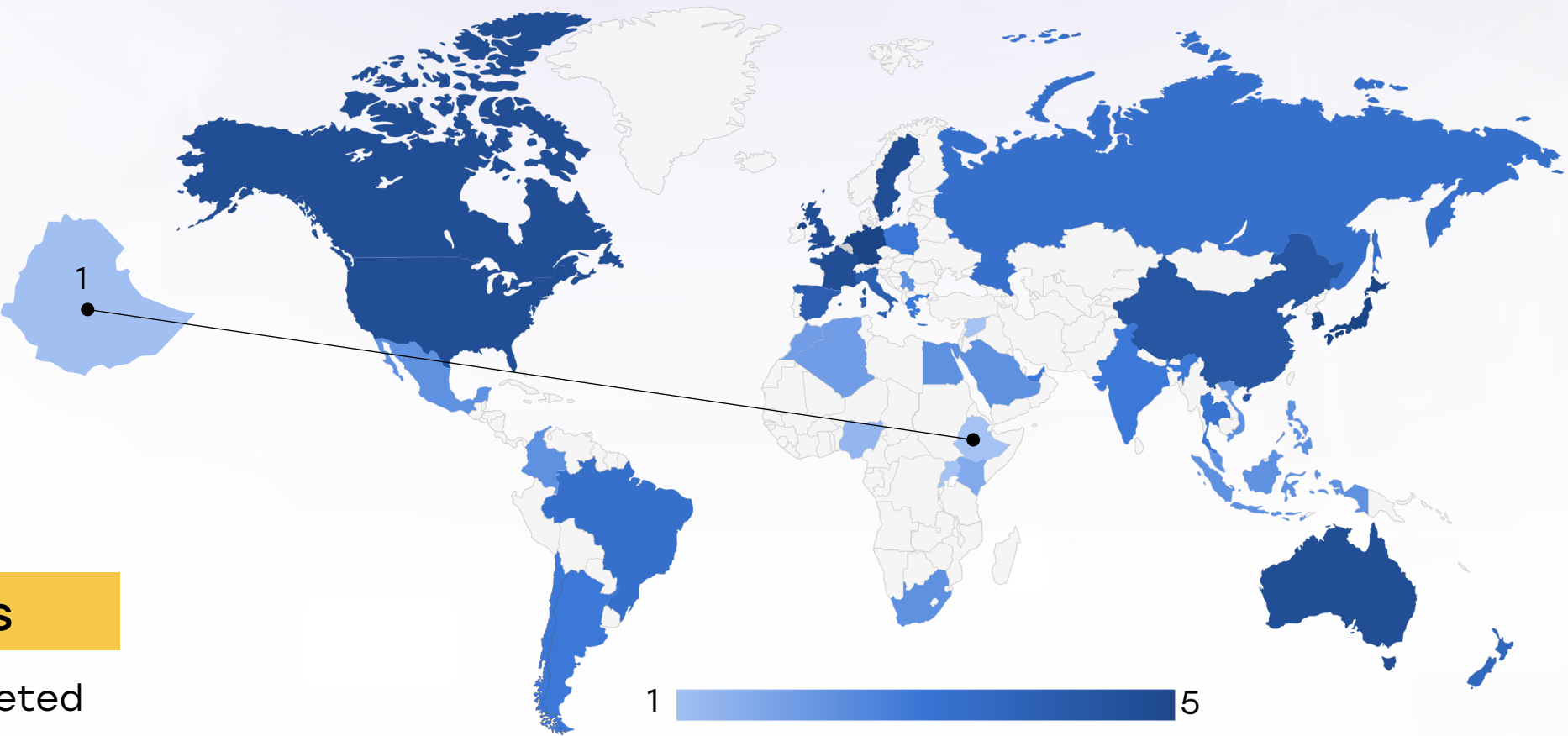
- Overwhelmed tertiary centers struggle with high patient loads due to population growth and limited infrastructure.
- Health professional migration to better-resourced countries undermines local program capacity.



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		

Ethiopia

Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Basic GC care—including surgery and chemotherapy—is subsidized by the national health system and donor support.
- Growing engagement with international health agencies and NGOs provides scope for clinical education and pilot research.

Weakness

- Access to targeted therapies (e.g., trastuzumab, immunotherapy) is very limited and often unavailable in public hospitals.
- General public knowledge about gastric cancer risk factors (such as H. pylori) and early symptoms remains extremely low.

Opportunity

- Partner with NGOs, academic institutions, and international consortia for pilot awareness programs and early detection campaigns.
- Launch community education initiatives through health extension workers at the grassroots level to increase awareness.

Threats

- Persistent funding gaps and competing health priorities (e.g. infectious disease) make sustained GC funding challenging.
- Cultural stigma around cancer discourages early care and participation in prevention programs.



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.



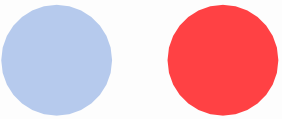
4. Well-developed system with good treatment availability, strong research funding, and effective but regionally focused awareness campaigns. Some disparities may exist in rural areas or between public and private sectors.



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.



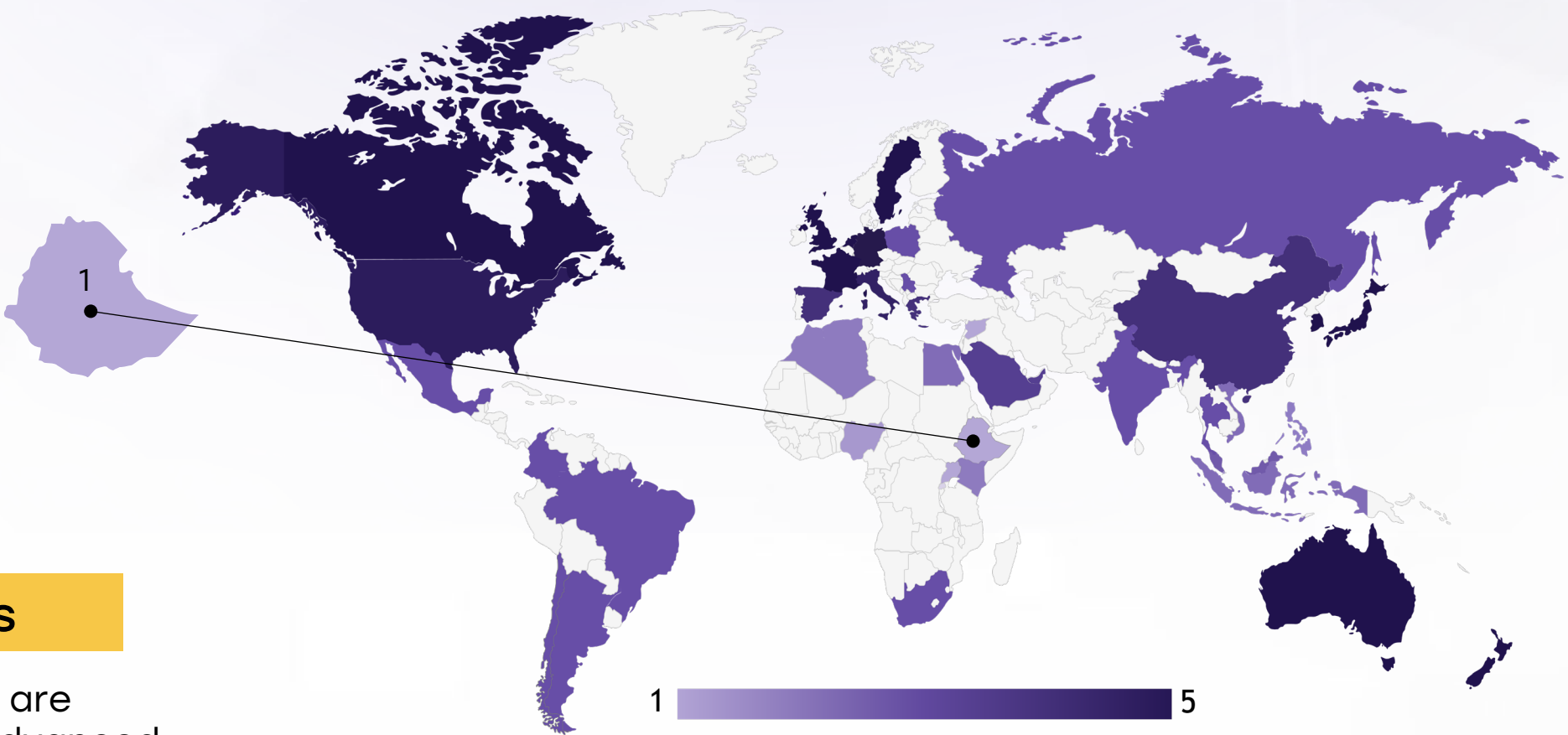
1. Poor infrastructure with severe barriers to treatment, little to no research funding, and lack of structured awareness campaigns. Cancer care is largely inaccessible, with many patients relying on out-of-pocket expenses or external aid.

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			

Ethiopia



Survival Rates, Early Detection and Palliative Care



Strengths

- Early GC detection in Addis Ababa and other urban centers enables higher survival rates among a minority of patients.
- Integration of basic palliative care services—including pain relief—exists at oncology units and hospices.

Weakness

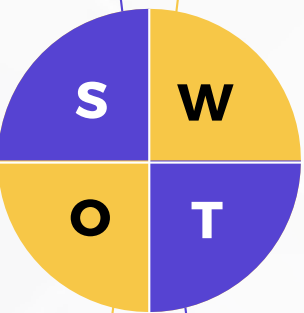
- Most GC cases are diagnosed at advanced stage III/IV; national 5-year survival is very low (around 15–20%).
- Palliative care infrastructure is sparse, especially outside Addis Ababa, and lacks standard protocols.

Opportunity

- Train primary care and community health workers to identify warning symptoms and refer high-risk patients earlier.
- Expand community-based palliative care and home-support programs in partnership with NGOs.

Threats

- Delayed patient presentation due to poor symptom recognition and misattribution to benign conditions.
- Weak health systems lead to loss to follow-up after initial diagnosis, reducing continuity of care.



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.

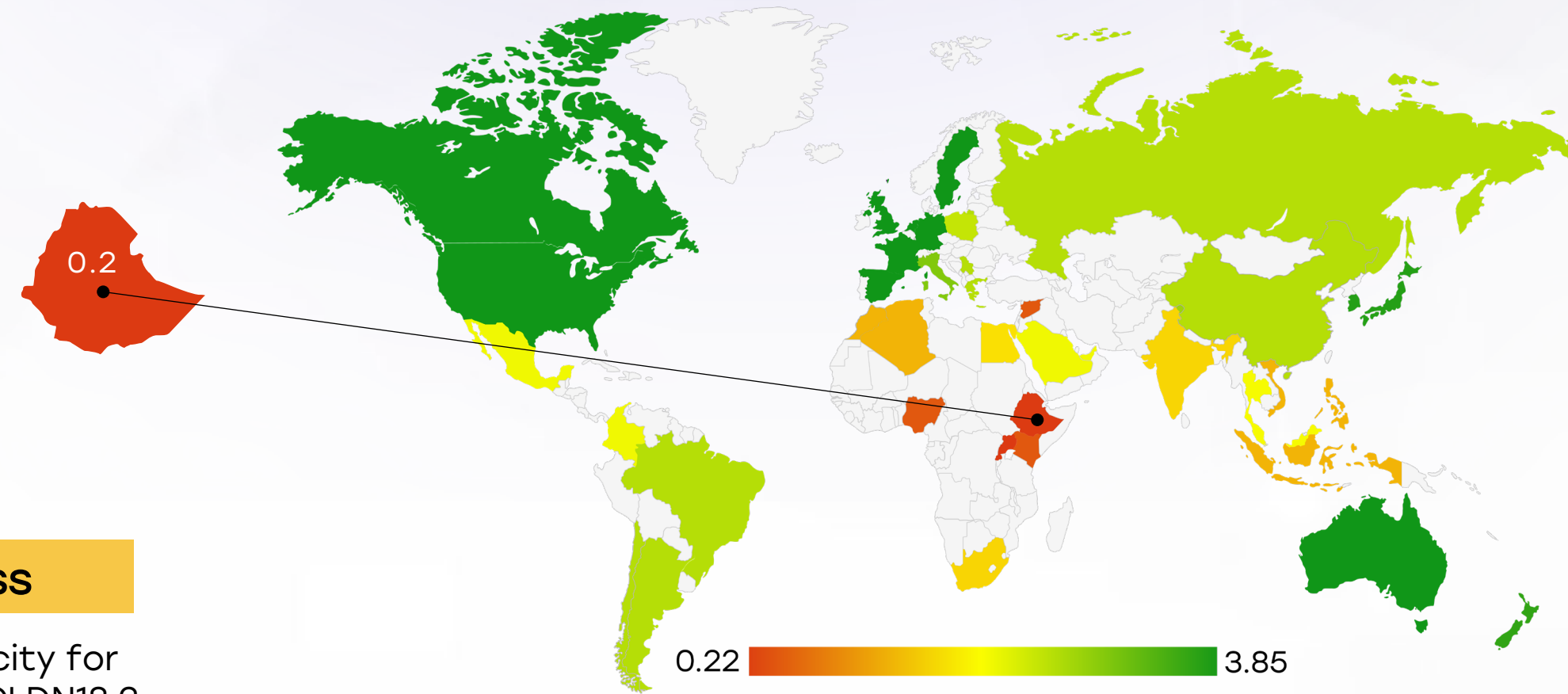
1. Very low survival rates, poor early detection infrastructure, and almost no palliative care services. Many patients are diagnosed late and lack proper support for pain management and end-of-life care.

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			

Ethiopia



Utilization of Biomarkers



Strengths

- Awareness of HER2 and PD-L1 testing in top-tier hospitals in Addis Ababa is emerging, laying groundwork for future evaluation.
- Limited pilot molecular profiling initiatives in collaboration with international labs generate initial data.

Weakness

- No local capacity for MSI-H/dMMR, CLDN18.2, or FGFR2b testing—all assays require sending samples abroad.
- Absence of standardized biomarker protocols; testing is sporadic, delayed, and financially prohibitive for most patients.

Opportunity

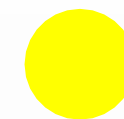
- Establish centralized molecular pathology hubs in urban centers that serve the broader country.
- Advocate for inclusion of core biomarker testing (HER2, MSI, PD-L1) in simplified national guidelines.

Threats

- High import costs, lack of reimbursement, and unstable supply chains prevent sustainable biomarker testing.
- Delays in policy adoption or integration may leave Ethiopia trailing in precision oncology.



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.

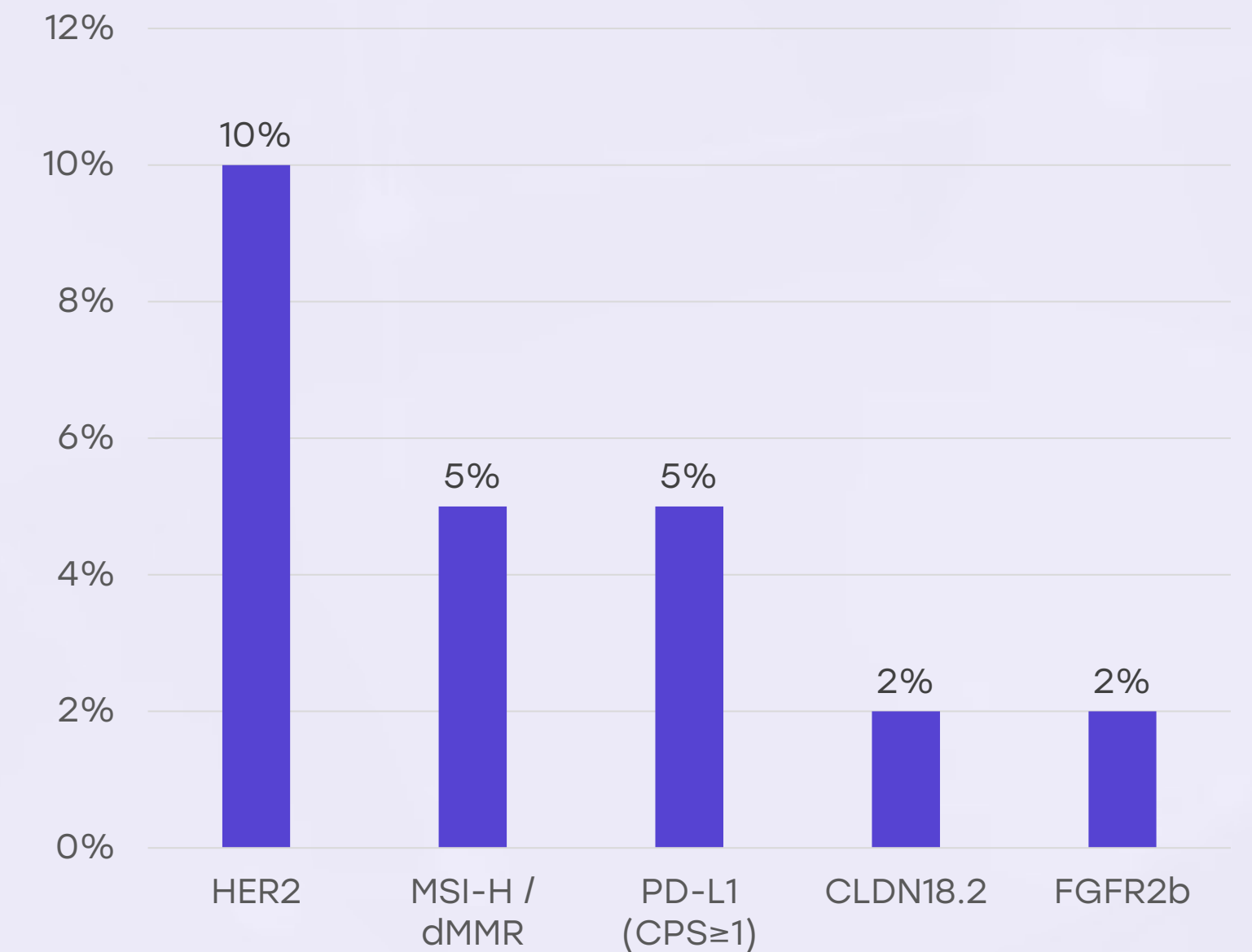


Biomarker testing is available but underutilized, with significant barriers such as high costs, lack of awareness, or limited infrastructure. Many patients may not receive recommended biomarker assessments.



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.

Ethiopia



Ethiopia



Clinical Guidelines

Strengths

- National cancer control strategies include GC management frameworks aligned with WHO recommendations.
- Oncologists in teaching hospitals often adopt international guidelines (e.g. NCCN/ESMO) adapted for local resources.

Weakness

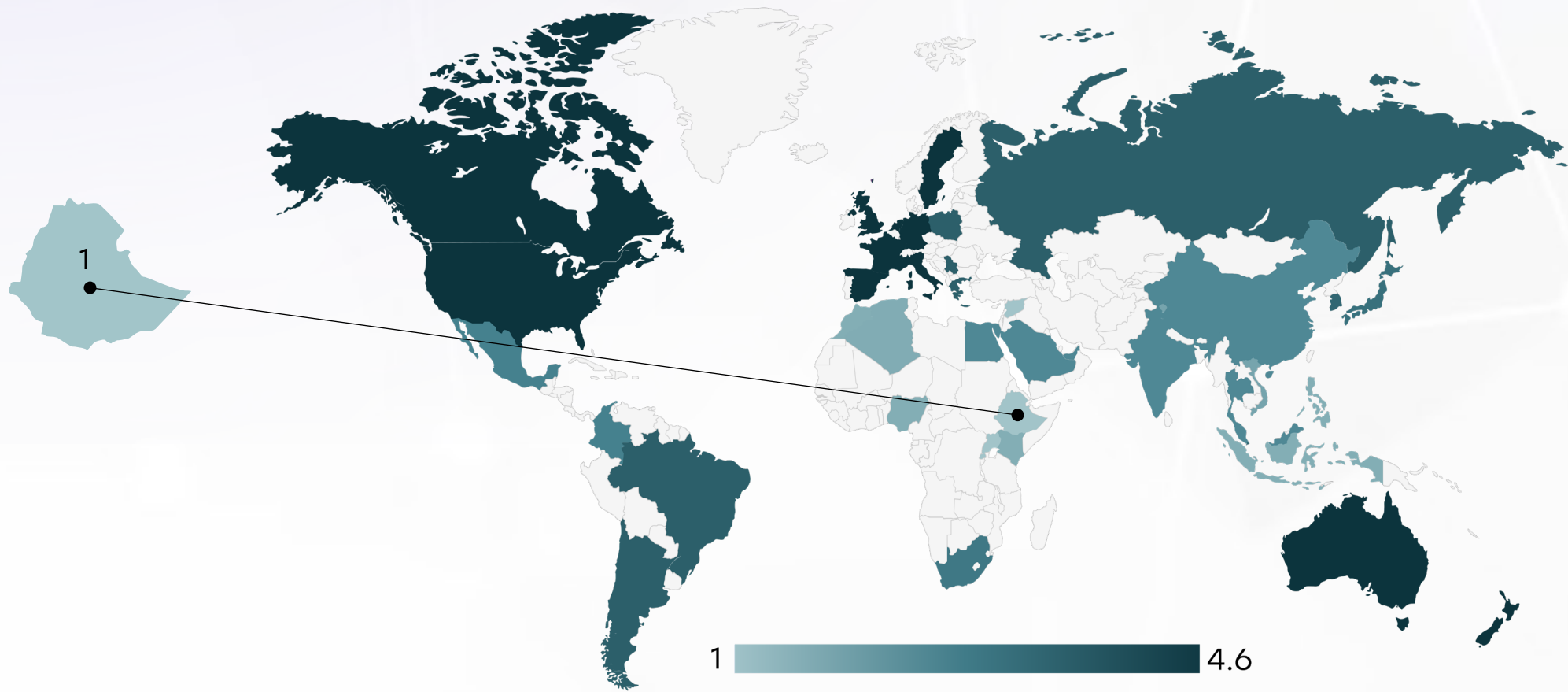
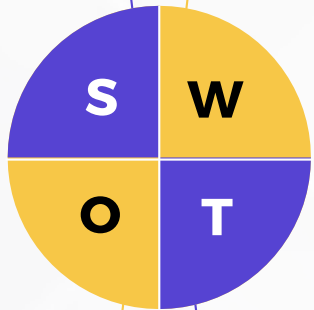
- National guidelines lack updates for emerging biomarker-driven therapies and companion diagnostics.
- There is a gap in dissemination and uptake of guidelines in regional and rural healthcare settings.

Opportunity

- Form a cross-sector task force to adapt global GC guidelines to Ethiopia-specific resource contexts.
- Roll out CME and training modules for guideline awareness and implementation across regional facilities.

Threats

- Bureaucratic obstacles delay guideline standardization and formal adoption nationwide.
- Lack of policy coordination across health regions may result in fragmented care pathways.



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

Ethiopia



Reimbursement



Strengths

- Basic GC treatments—including surgery, chemotherapy, and supportive care—are largely covered or subsidized for low-income patients.
- NGO and philanthropic hospital support supplement access to medications for underserved patients

Weakness

- Biomarker tests and targeted agents (trastuzumab, immune checkpoint inhibitors) are not formally reimbursed.
- Patients bear high out-of-pocket costs if treatments go beyond basic public care, leading to financial strain.

Opportunity

- Pilot managed-access or outcomes-based support models for key therapies linked to biomarker results in urban centers.
- Engage policymakers to include essential biomarker tests and therapies in national benefit packages.

Threats

- Budget constraints and competing priorities jeopardize sustained funding of advanced cancer services.
- Unregulated high-cost private care threatens equity and may exacerbate disparities.



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		

Ethiopia



Gastric 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