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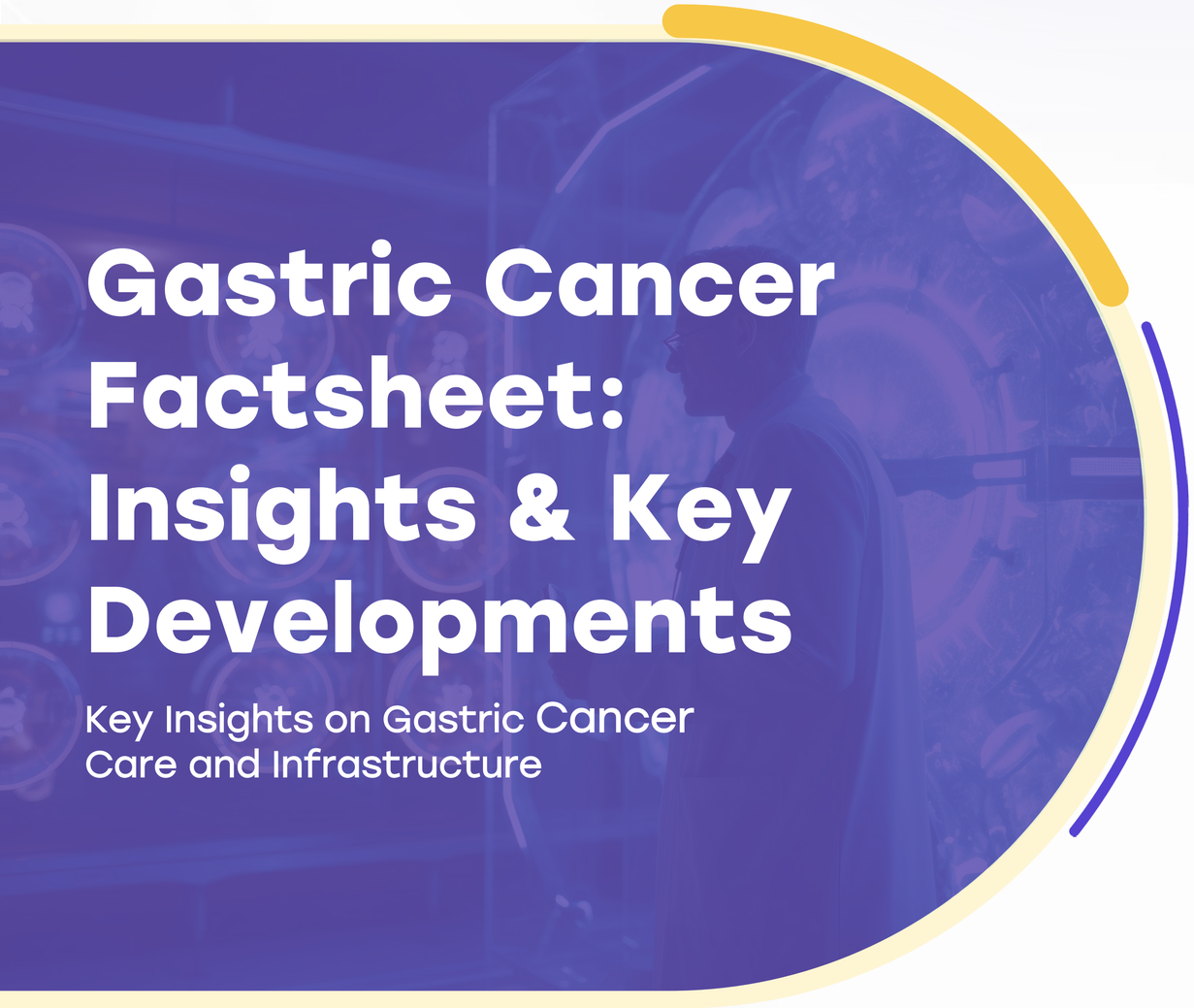

Gastric Cancer Factsheet: Insights & Key Developments

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 falls outside the top 10 cancers in men.
- Incidence rate: Approximately 3–4 per 100,000 men per year.
- Total new cases (2022): Around 3,200 men.
- Daily diagnoses: Approximately 9 men per day.
- Deaths (2022): About 2,400–2,600 men.
- 5-year survival rate: Likely < 40%, due to late-stage diagnosis.
- Most affected age group: Men aged 60 and above.
- Screening participation: None; detection usually occurs after symptoms appear.

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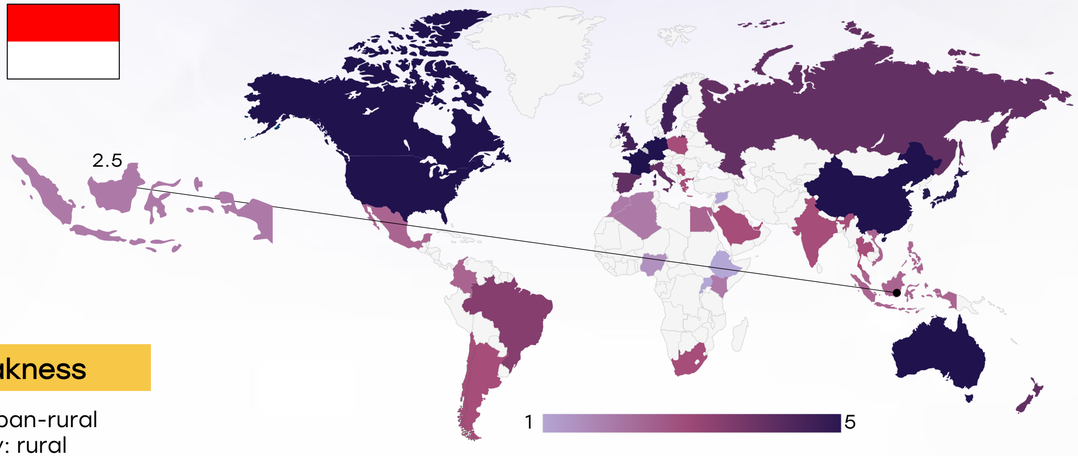
Infrastructure



Strengths

- National referral hospitals like RSUPN Dr. Cipto Mangunkusumo and Dharmais Cancer Hospital provide specialized cancer care with endoscopy and surgical services.
- Growing number of regional cancer centers equipped with diagnostic and treatment capabilities

Weakness

- Major urban-rural disparity: rural populations lack access to basic oncology infrastructure.
- Shortage of trained oncologists, surgical oncologists, and oncology nurses in secondary hospitals.

S W O T

Opportunity

- Investment under Indonesia's Universal Health Coverage (JKN) scheme to expand cancer care infrastructure.
- Government incentives for telemedicine and mobile cancer care units to reach underserved areas.

Threats

- Natural disasters (earthquakes, floods) periodically disrupt access to care in multiple regions.
- Overburdened public health infrastructure with competing disease burdens like TB and diabetes.

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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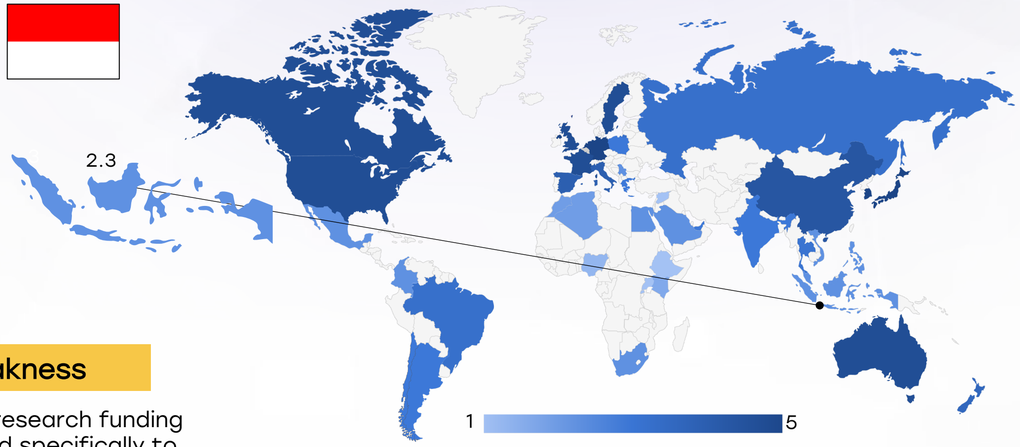
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- BPJS (national insurance scheme) covers basic gastric cancer treatment, including surgery and chemotherapy.
- Public-private partnerships driving some awareness programs on digestive cancers.

Weakness

- Minimal research funding allocated specifically to gastric cancer.
- Awareness about symptoms like early satiety, indigestion, and anemia is extremely low in rural areas.

S W O T

Opportunity

- Collaborate with academic institutions for regional studies and targeted awareness drives in high-incidence zones.
- Use of mosques, community health posts (Posyandu), and digital campaigns for culturally relevant outreach.

Threats

- Cultural reliance on traditional medicine delays diagnosis and formal treatment.
- Geographic fragmentation limits uniform implementation of awareness 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	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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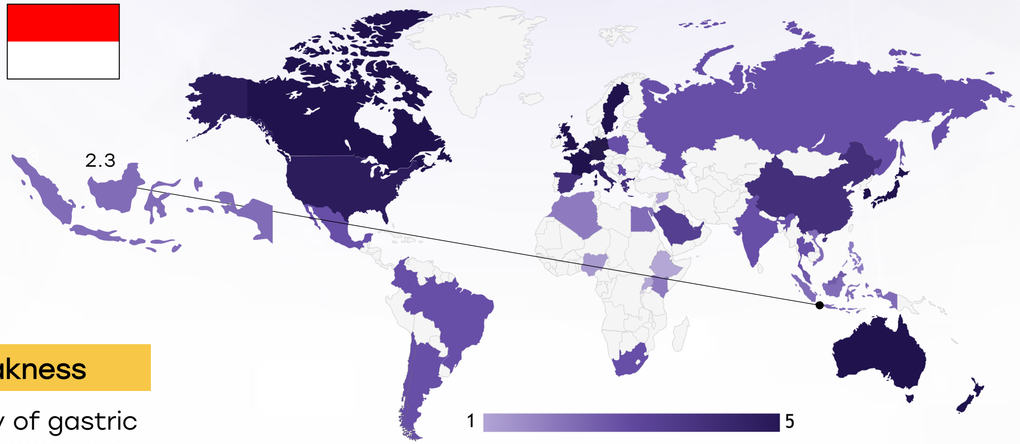
Survival Rates, Early Detection and Palliative Care



Strengths

- Tertiary centers have capability for curative gastrectomy and palliative chemo-radiotherapy.
- Government support for building palliative care units in provincial hospitals.

Weakness

- Majority of gastric cancer cases are diagnosed at Stage III/IV, resulting in <15% 5-year survival.
- Limited palliative care access outside Jakarta, Surabaya, and Bandung.

S W O T

Opportunity

- Train general practitioners in early symptom triage and palliative pain management.
- Community-based palliative programs supported by NGOs and religious foundations.

Threats

- Poor symptom recognition and late presentation, especially in eastern Indonesia.
- Social stigma around cancer still affects disclosure and treatment continuation.

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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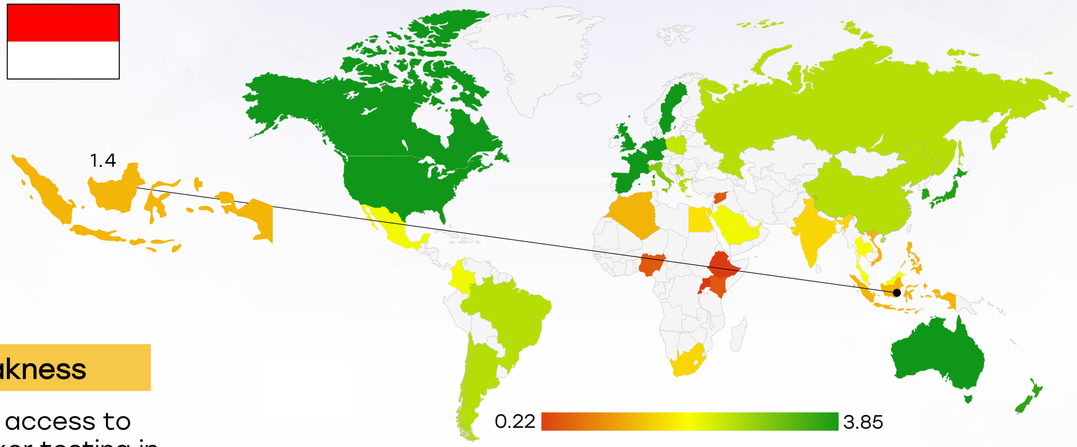
Utilization of Biomarkers



Strengths

- HER2 testing available in selected tertiary centers (e.g., Dharmais).
- PD-L1 testing offered in private labs for immunotherapy eligibility in select advanced cases.

Weakness

- Limited access to biomarker testing in public hospitals; often requires out-of-pocket payment.
- Biomarkers like CLDN18.2 and FGFR2b are not yet in standard practice.

S W O T

Opportunity

- Partnership with international labs or pharma companies to subsidize biomarker testing.
- Create national biomarker registry to build local evidence and guide future protocols.

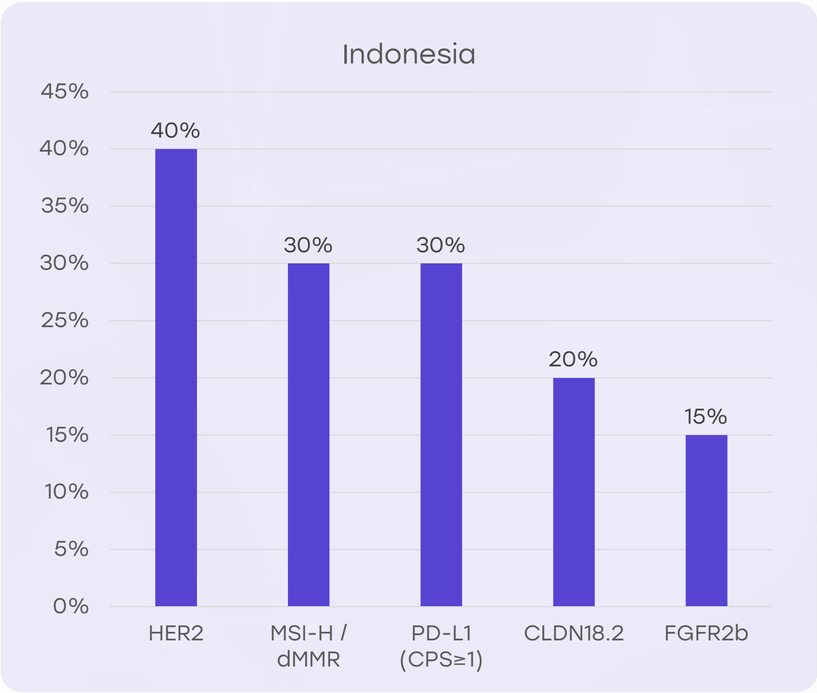
Threats

- High cost and low insurance coverage for advanced diagnostics may lead to treatment ineligibility.
- Lack of trained pathologists and lab infrastructure in tier-2 cities.

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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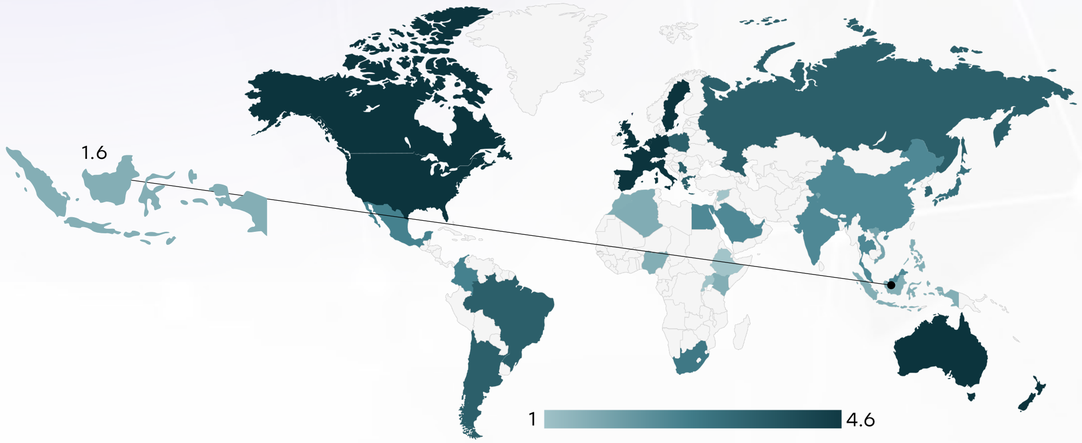
Clinical Guidelines



Strengths

- Indonesian Society of Surgical Oncology and Gastroenterology issue general guidelines referencing international best practices.
- Major hospitals follow NCCN/ESMO-aligned protocols.

Weakness

- No national gastric cancer-specific guidelines tailored to Indonesia's population.
- General practitioners rarely trained in cancer-specific referral pathways.

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Opportunity

- Develop simplified national guidelines using Bahasa Indonesia for broad healthcare worker dissemination.
- Use National Cancer Control Plan (NCCP) platform to standardize care.

Threats

- Inconsistent adoption of protocols across islands and hospital levels.
- Rapid updates in international guidelines may not be quickly localized or implemented.

	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

- BPJS covers basic treatment: diagnostics, surgery, chemotherapy, and limited targeted therapy.
- Efforts to improve digital claim processing have reduced delay in reimbursements.

Weakness

- High-cost treatments (e.g., Trastuzumab for HER2+) are often only partially reimbursed or excluded.
- Delays in insurance approval can lead to treatment interruption.

S W O T

Opportunity

- Negotiate bulk procurement or tiered pricing for targeted therapies through government channels.
- Expand coverage to include biomarker testing and immunotherapy under JKN

Threats

- Rising cancer care costs could strain BPJS, leading to future coverage limitations.
- Patients may drop out due to indirect costs (travel, lodging, unpaid time off).

● 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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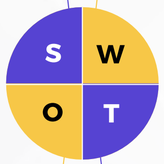
Gastric Cancer Screening

Strengths

- Opportunistic screening using endoscopy for high-risk patients (chronic gastritis, peptic ulcer history) in some hospitals.
- Pilot community screening programs in Java and Sumatra.

Weakness

- No national screening program for gastric cancer or H. pylori eradication.
- Endoscopy availability low in many public hospitals and not part of routine checks.



Opportunity

- Initiate population-based screening pilots in high-risk regions (e.g., North Sumatra, Jakarta).
- Combine H. pylori breath tests and serology with broader digestive health programs.

Threats

- Competing focus on infectious disease screening (TB, hepatitis) dilutes cancer prioritization.
- Lack of public understanding and fear of endoscopy reduces participation.

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