International Cancer Patient Coalition

Mexico

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 in the top 10 male cancers, but not in the top 5.
- Incidence rate: Approximately 10 per 100,000 men per year.
- Total new cases (2022): Around 8,400 men.
- Daily diagnoses: Around 23 men per day.
- Deaths (2022): Roughly 5,200 men.
- 5-year survival rate: Estimated 35–45%.
- Most affected age group: Men aged 65 and older.
- Screening participation: No formal program; detection usually happens at later stages.

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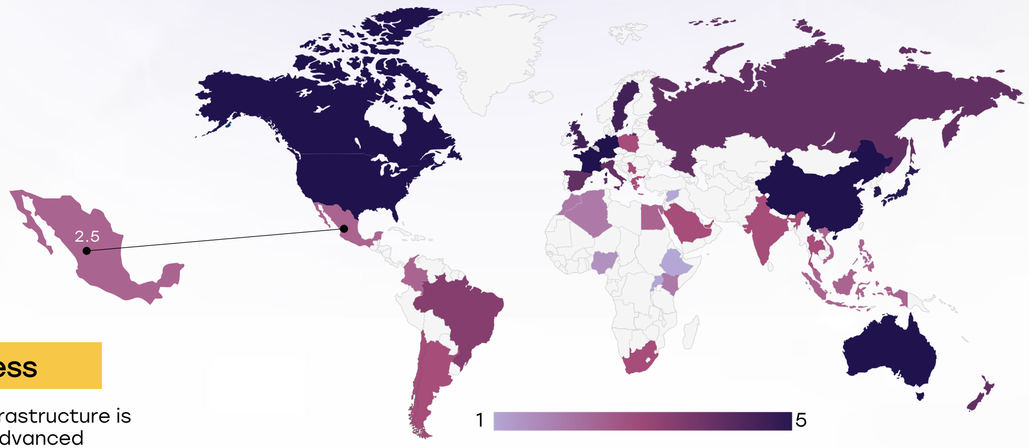
Infrastructure



Strengths

- Presence of a structured cancer care network led by the Instituto Nacional de Cancerología (INCan) in Mexico City and other public hospitals offering oncology services.
- Several tertiary care centers provide endoscopy, surgical oncology, and chemotherapy services under the national health system.

Weakness

- Healthcare infrastructure is uneven, with advanced cancer care concentrated in urban areas–rural states face significant limitations.
- Delays in diagnostic services like endoscopy and histopathology due to backlogs and lack of trained specialists.

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Opportunity

- Government initiatives like the INSABI (Instituto de Salud para el Bienestar) aim to extend cancer care to uninsured populations.
- Expansion of telemedicine and mobile endoscopy units in underserved regions

Threats

- Overburdened health system due to high NCD load and limited oncology workforce.
- Economic pressure and healthcare decentralization challenges may delay infrastructure upgrades in remote areas.

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	1	2
Nigeria	1	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	3
Spain	4	3
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	3
Syria	1	1
Indonesia	2	2
Vietnam	3	3
Philippines	2	2
Russia	3	3
Malaysia	3	3

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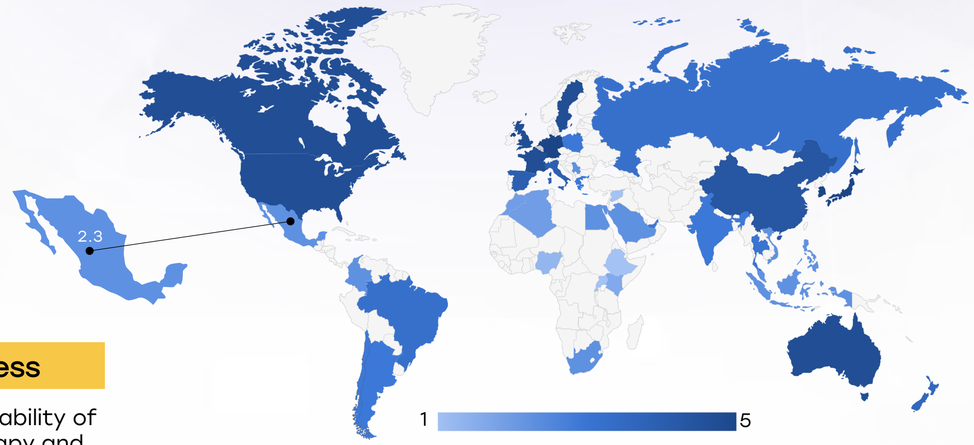
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Gastric cancer is included in the National Cancer Plan, and major public institutions (e.g., INCan, IMSS) provide chemotherapy and surgery at subsidized costs.
- Academic institutions and cancer foundations occasionally support awareness campaigns on digestive cancers.

Weakness

- Limited availability of immunotherapy and targeted treatments in public health settings.
- Low public awareness of gastric cancer symptoms and risk factors, including H. pylori infection and dietary contributors.

S W O T

Opportunity

- Expand collaboration with NGOs and international partners to fund awareness and early detection programs.
- Increase local research on gastric cancer epidemiology to support tailored policy responses.

Threats

- Political shifts and instability in public health policy (e.g., transition from Seguro Popular to INSABI) can create coverage gaps.
- Funding cuts to public research institutions may reduce clinical trial activity and academic collaboration.

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	4	4
Kenya	4	2	2
Nigeria	4	2	2
Egypt	3	4	4
Morocco	4	4	4
Algeria	4	4	4
Ethiopia	2	2	2
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	4	4
Brazil	4	3	3
Argentina	3	3	3
Chile	3	3	3
Colombia	3	4	4
United States	5	5	4
Canada	5	5	4
Australia	5	5	4
New Zealand	4	4	4
Greece	3	3	3
Rwanda	2	2	2
Uganda	2	2	2
Serbia	3	4	4
Saudi Arabia	3	4	4
UAE	3	3	3
Syria	2	2	2
Indonesia	3	4	4
Vietnam	3	4	4
Philippines	4	4	4
Russia	4	3	3
Malaysia	3	4	4

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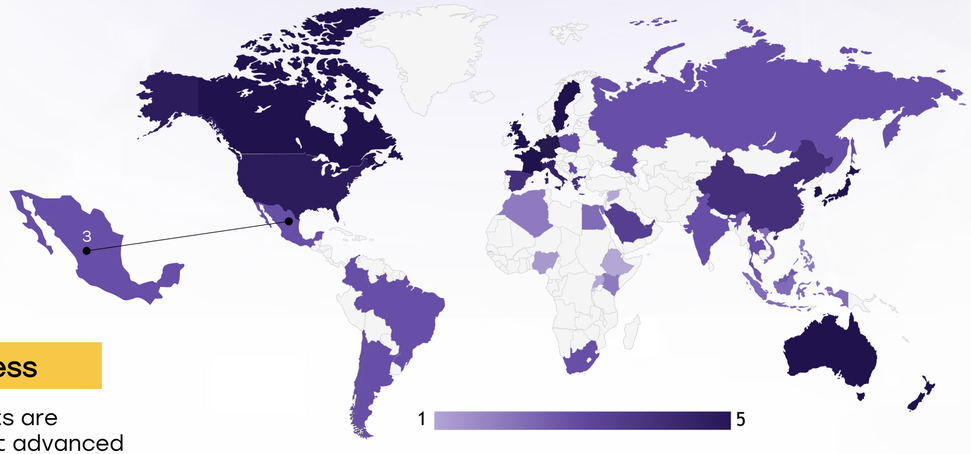
Survival Rates, Early Detection and Palliative Care



Strengths

- National reference centers provide multidisciplinary care, including surgery, chemotherapy, and palliative services.
- Palliative care programs are increasingly being included in national guidelines, with improved access in larger hospitals.

Weakness

- Most patients are diagnosed at advanced stages (III or IV), with poor 5-year survival rates (often below 25%).
- Lack of organized screening or early detection programs for high-risk populations.

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Opportunity

- Integrate non-invasive screening tools for H. pylori and chronic gastritis in primary care settings.
- Expand palliative care access at the community level through nurse training and family support models.

Threats

- High out-of-pocket costs for diagnostics and supportive care may delay timely interventions.
- Cultural stigma around cancer may lead to treatment abandonment or late presentation in rural communities.

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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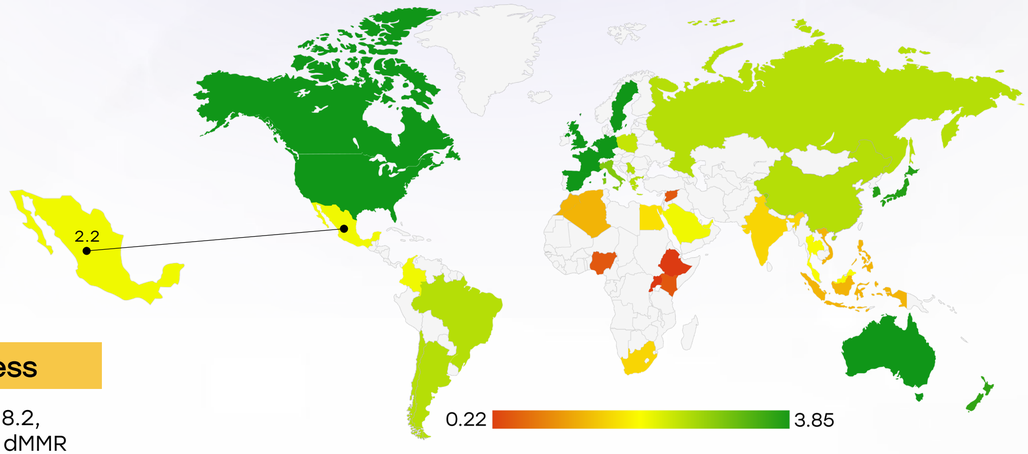
Utilization of Biomarkers



Strengths

- HER2 testing and trastuzumab use are available in select tertiary centers like INCan, especially for gastric and breast cancers.
- Some private labs and academic centers conduct PD-L1 testing for advanced gastric cancer candidates.

Weakness

- MSI-H, CLDN18.2, FGFR2b, and dMMR testing are not routinely used in standard practice due to cost and lack of training.
- Biomarker use is not standardized, and reimbursement policies for advanced testing are unclear.

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Opportunity

- Build public-private partnerships to subsidize molecular testing and provide access to targeted therapies.
- Launch national biomarker registry to guide future guideline integration and pricing policies.

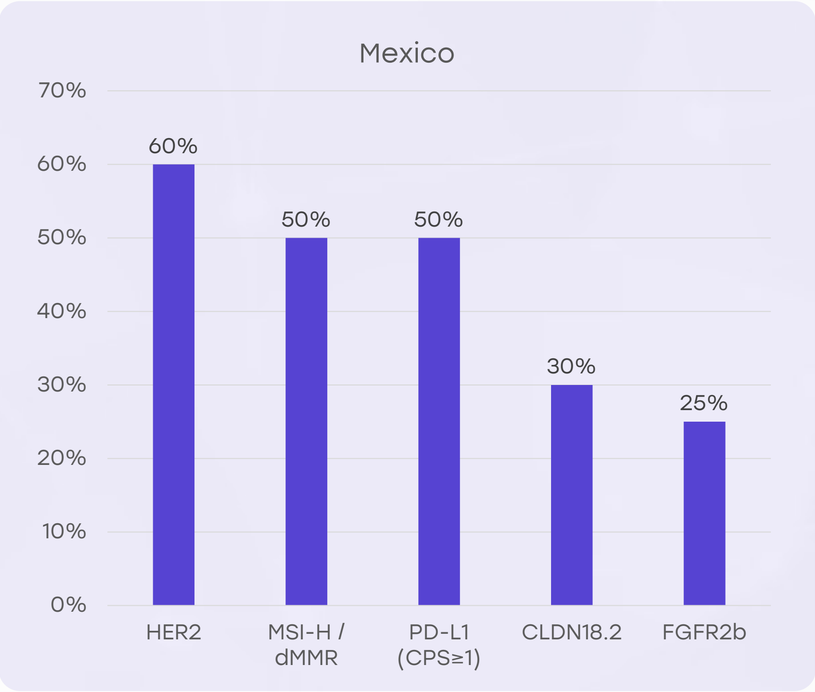
Threats

- Limited clinical infrastructure for precision oncology, particularly outside capital cities.
- Lack of insurance coverage for biomarker-based treatment decisions creates inequity in outcomes.

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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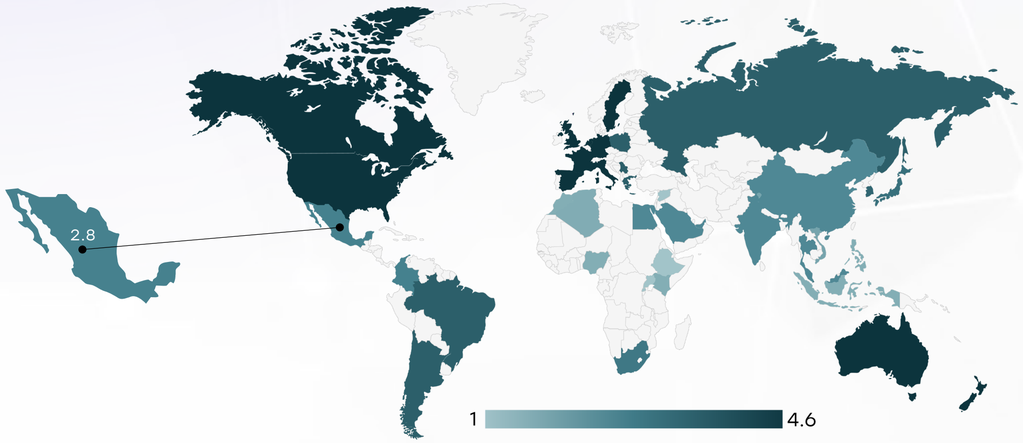
Clinical Guidelines



Strengths

- National institutions follow adapted NCCN/ESMO guidelines, and INCan publishes local recommendations for gastrointestinal cancers.
- Some institutional protocols include HER2 testing and staging-specific therapies.

Weakness

- National guidelines are often inconsistently implemented across regions and institutions.
- Delayed updates to reflect new therapies (e.g., immunotherapy, biomarker-directed therapy).

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Opportunity

- Create gastric cancer-specific national guidelines that include screening, biomarkers, and treatment pathways.
- Support continuous medical education on guideline implementation in secondary and tertiary hospitals.

Threats

- Fragmentation of the health system across IMSS, ISSSTE, and INSABI results in inconsistent adherence.
- Resistance to guideline adoption due to variability in resources between institutions.

	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

- Some chemotherapy regimens and trastuzumab are covered under INSABI and IMSS programs.
- Efforts to standardize coverage of essential cancer medicines through the National Formulary.

Weakness

- Limited reimbursement for advanced diagnostics and targeted therapies in gastric cancer.
- Out-of-pocket costs for immunotherapy or biomarker testing are often unaffordable.

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Opportunity

- Implement value-based reimbursement models tied to biomarker usage and outcomes.
- Leverage regional price negotiations to improve access to PD-1/PD-L1 therapies.

Threats

- Budget constraints and drug shortages may lead to rationing or delays in treatment.
- Disparities between public and private sector limit equitable access to advanced care.

● 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

- Some pilot projects in high-incidence states (e.g., Oaxaca, Chiapas) focus on H. pylori detection and eradication.
- Availability of endoscopy in tertiary hospitals enables symptom-based detection

Weakness

- No national gastric cancer screening program, despite high burden in certain indigenous and rural populations.
- Lack of screening infrastructure or protocols at the primary care level.

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Opportunity

- Introduce risk-stratified screening models targeting H. pylori and atrophic gastritis in high-risk communities.
- Promote H. pylori eradication campaigns linked to nutrition and public health programs.

Threats

- Competing health priorities like diabetes, maternal health, and infectious diseases may limit policy attention to gastric cancer.
- Low public awareness and fear of invasive procedures may reduce screening uptake.

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