International Cancer Patient Coalition

Syria

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 among top cancers, but data are limited due to ongoing conflict.
- Incidence rate: Estimated 3–4 per 100,000 men per year.
- Total new cases (2022): Around 400–500 men.
- Daily diagnoses: About 1–2 men per day.
- Deaths (2022): Likely ~350–450 men.
- 5-year survival rate: Likely under 30%, due to late detection and health system limitations.
- Most affected age group: Men aged 60+.
- Screening participation: None; diagnosis typically at advanced stage.

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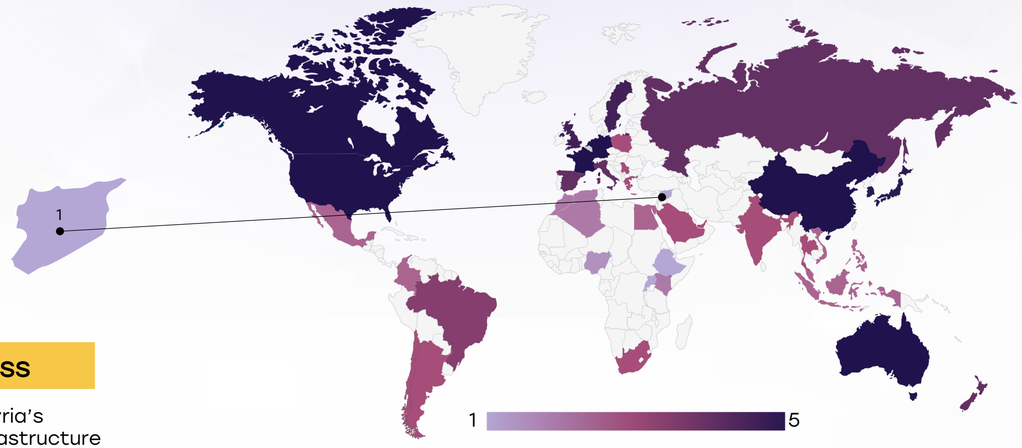
Infrastructure



Strengths

- The Al-Bairouni University Hospital in Damascus acts as the main national cancer center, managing over 60% of all cancer cases, with 550 beds, alongside ~11 regional oncology departments
- University-affiliated hospitals (e.g. Al Mouwasat and National University Hospital) maintain essential imaging and oncology labs (MRI, CT, gamma camera, tumor markers) and continue limited cancer research activities

Weakness

- Over 50% of Syria's healthcare infrastructure has been damaged or destroyed; only ~47–60% of facilities remain partially functional
- Oncology services are concentrated in Damascus, with no comprehensive facilities in northeast Syria and only one oncology center in northwest

S W O T

Opportunity

- The 2025–2030 National Cancer Control Program, developed with WHO and IAEA support, provides a roadmap to rebuild diagnostic infrastructure, radiotherapy programs, and establish a national cancer registry
- International support (e.g. IAEA technical cooperation, WHO support from Kuwait) can help restore radiology, nuclear medicine, and oncology diagnostics

Threats

- Continued conflict, economic sanctions, and fragmentation limit rebuilding and equitable infrastructure expansion across the country.
- Region-based disparities: besieged or opposition-held areas have severely limited or no oncology infrastructure

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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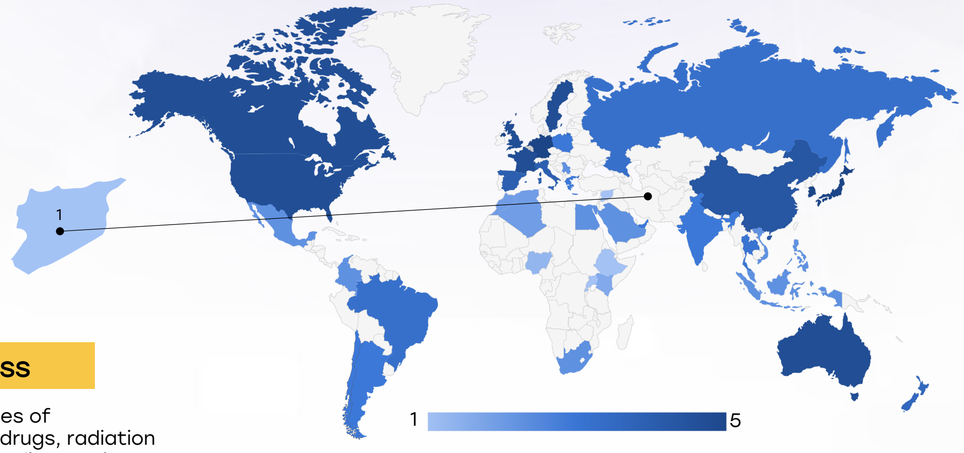
Treatment Access, Research Funding and Awareness Campaigns



Strengths

- Specialized oncology care remains free in public hospitals (in government-held areas), with training through Syrian Association of Oncology (circa ~170 active specialists)
- Emerging national awareness and prevention campaigns (mostly targeting breast and cervical cancers starting 2019/2021) signal the beginning of systematic attention to non-communicable diseases

Weakness

- Severe shortages of chemotherapy drugs, radiation therapy access, diagnostic imaging, and targeted agents, especially outside Damascus; in many areas only basic blood tests and biopsies are available
- Cancer care is largely self-funded in private facilities; public insurance covers less than 3% of cancer costs, meaning most patients face prohibitive drug and treatment expenses (~$100–1,000/month)

Opportunity

- Integration into international aid frameworks could channel resources for diagnostic supplies, clinical training, and awareness campaigns beyond breast/cervical cancer.
- Telemedicine and mobile outreach services to support screening and symptom recognition training, especially in conflict-affected zones.

Threats

- Persistent underfunding of oncology within humanitarian aid frameworks means cancer care remains overlooked.
- Staff attrition and brain drain exacerbate capability gaps in regional and rural health systems.

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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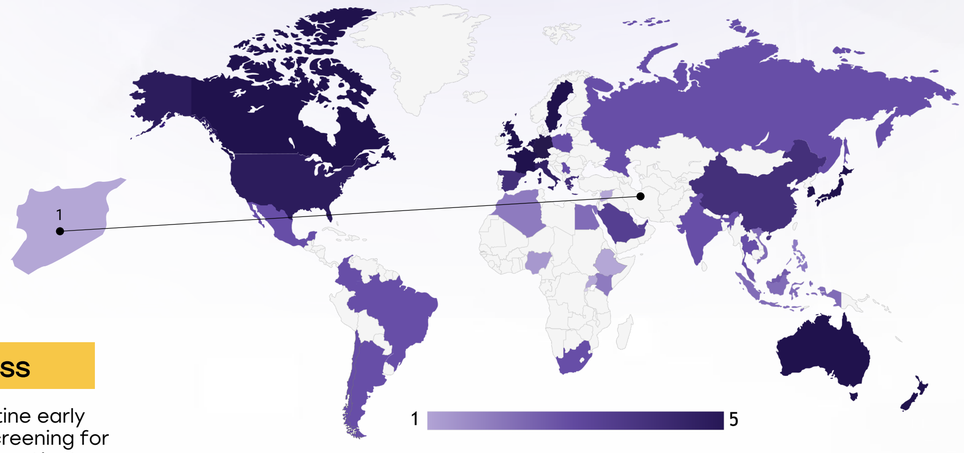
Survival Rates, Early Detection and Palliative Care



Strengths

- Public-sector care in Damascus remains free, and select tertiary centers manage advanced thyroid and breast cancers, implying some capabilities for aggressive gastric cancer treatments when available.
- Oncologist training continues through university hospitals despite war, preserving pockets of expertise

Weakness

- There is no routine early detection or screening for gastric cancer; patients typically present at late stages when prognosis is very poor.
- Palliative care is severely limited, with poor access to pain relief, hospice services, or supportive care—especially outside government-controlled zones

S W O T

Opportunity

- Rebuilding of the National Cancer Control Program could prioritize early detection pathways, symptom awareness, and basic palliative training.
- Partnerships with NGOs and international health bodies to provide mobile or refugee-focused palliative units.

Threats

- Continued late-stage presentation due to absent screening and delays from conflict-related disruptions.
- Worsening outcomes from untreated metastases and invasive symptoms without palliative support.

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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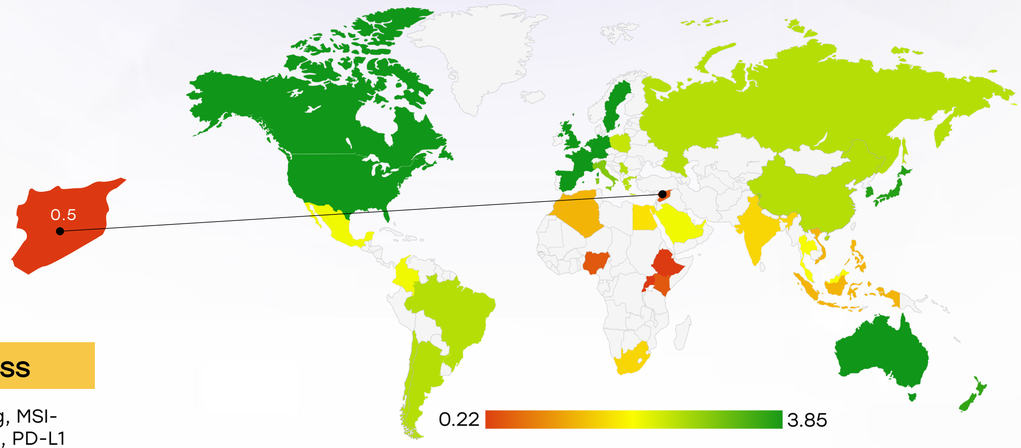
Utilization of Biomarkers



Strengths

- A small cadre of trained oncologists in Damascus and Aleppo understands the value of molecular diagnostics and precision therapies.
- Teaching hospitals retain laboratory capacity to perform basic tumor marker analyses (e.g., immunohistochemistry in pathology labs).

Weakness

- Genetic testing, MSI-H/dMMR assays, PD-L1 staining, and advanced biomarker diagnostics are not available nationally; infrastructure remains rudimentary or absent in most regions
- There is no access to targeted therapies aligned with biomarker status due to cost and lack of reimbursement.

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Opportunity

- Partnerships via WHO, IAEA or NGOs could support gradual re-establishment of molecular pathology labs in Damascus.
- Later inclusion of HER2 or PD-L1 testing in guideline updates under the national cancer plan could improve access.

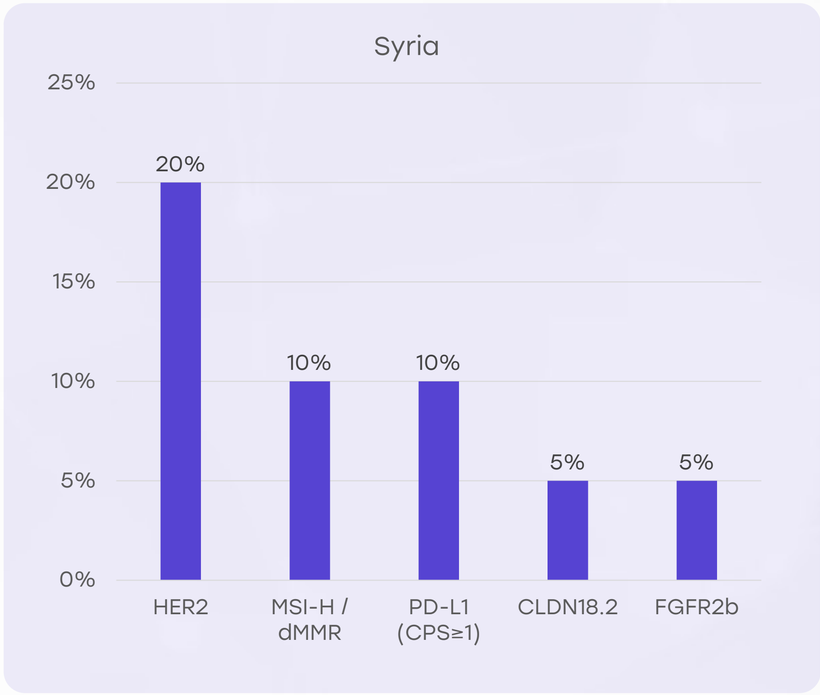
Threats

- High cost and international import restrictions make advanced diagnostics unaffordable.
- Even if infrastructure is rebuilt, lack of medication availability limits utility of biomarker results.

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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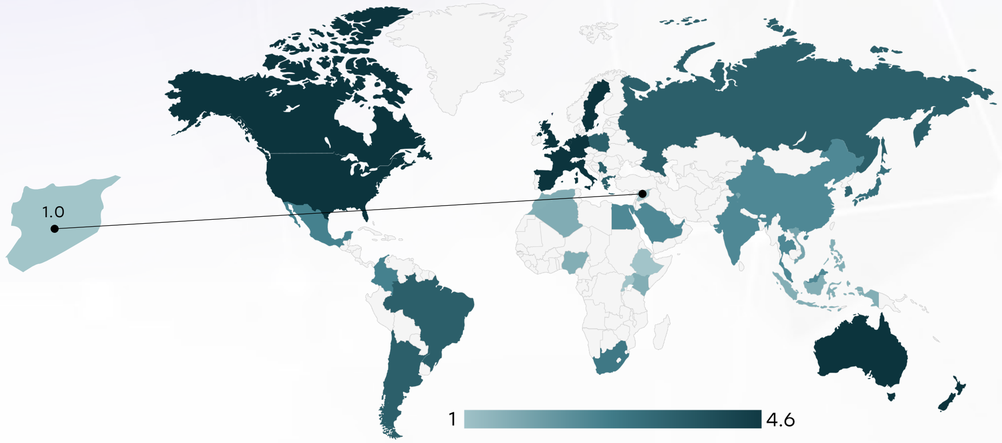
Clinical Guidelines



Strengths

- The newly drafted National Cancer Control Program (2025–2030) includes plans to develop standardized treatment guidelines across cancer types
- Syrian oncologists maintain links with regional associations and international oncology bodies to stay current on protocols

Weakness

- No existing national guidelines for gastric cancer, staging, biomarker-led therapy or screening; practice remains fragmented and inconsistent across regions.
- War-related fragmentation prevents nationwide guideline dissemination or enforcement.

S W O T

Opportunity

- The 2025–2030 initiative provides a platform for publishing gastric cancer–specific guidance tailored to available infrastructure.
- Digital kits and e-learning can deliver protocols to regional centers and refugee health clinics.

Threats

- Without political stability or ministry coordination across regions, adoption of guidelines could remain limited.
- Resource constraints may delay key policy implementation across sectors needed for guideline rollout.

	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

- Oncology care in public tertiary centers (Damascus) historically was free under legislative decree and still remains so for government-controlled areas

Weakness

- For most Syrians, cancer care is paid out-of-pocket; only ~3% of costs are reimbursed, and many treatments are unaffordable to those living below the poverty line (≈90% of population)
- Private care costs ($100–1000/month) are unsustainable; health insurance mechanisms are fragmented or nonexistent outside Damascus and Aleppo.

S W O T

Opportunity

- Inclusion of cancer treatment subsidies in humanitarian response, or emergency health financing schemes for refugees and internally displaced persons.
- Adoption of international donor funding or local solidarity funds for essential cancer medicines.

Threats

- Economic instability, sanctions, and budget shortages may prevent extension of reimbursement beyond basic hospital care.
- Without reimbursement for diagnostics or targeted drugs, the expansion of biomarker-based treatment remains unlikely.

● 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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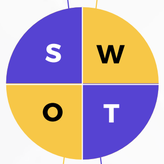
Colorectal Cancer Screening

Strengths

- None—no organized gastric cancer screening exists.

Weakness

- Syria has no screening programs for gastric cancer; even breast and cervical screening began only in 2019/2021 and remain limited to Damascus
- Public awareness of cancer signs and preventive services is very low, particularly for non-breast cancers.



Opportunity

- Future national strategies may include expansion of awareness campaigns to gastric cancer along with integration into general education and primary care.
- Partnerships with NGOs or telehealth platforms could provide symptom-based referral guidance for high-risk individuals

Threats

- Focus remains on more visible cancers (breast, cervical), further marginalizing gastric cancer.
- Resource constraints and competing health needs may delay the development of screening expansion.

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