MARCH 2026

MULTI-SECTORAL NEEDS ASSESSMENT

Deir Ezzor Governorate

Northeast Syria

Disclaimer: The findings in this report are indicative of conditions in the assessed locations and should not be interpreted as statistically representative of all households in Deir Ezzor governorate. They are intended to inform prioritisation, programme design, and donor decision-making.

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Executive Summary

To understand current humanitarian needs following major political and security shifts in Northeast Syria, DDD conducted a household-based multisectoral needs assessment (MSNA) in March 2026 across five locations in Deir Ezzor governorate: Al-Mayadin, Deir Ezzor city, Al-Bukamal, Al-Husseiniya and Hajin, composed of urban, rural and semi-rural areas.

The survey covered 200 households and 1,246 household members. The average household size was 6.2, and 62.% of respondents were female. The caseload is heavily shaped by return dynamics: 58% of households were returnees from internal displacement, while 3% reported return from abroad and 6% identified as internally displaced persons (IDPs).

The assessment shows a severe convergence of health, economic, and psychosocial vulnerability. Two-thirds of households reported illness in the previous three months. Yet only 28.5% said they could access health care all the time; 60% said access was only partial and 11.5% reported no access at all. Barriers are driven less by physical closure of facilities than by the cost and availability of medicines, diagnostics, and transport to clinics.

Food insecurity is acute even in households with labor participation. Although 81.5% of households reported at least one employed member, 42% did not have enough food or money to buy food during the previous seven days, 57.5% relied on buying food on credit, and only 10% reported regular food kits or cash assistance. This points to an erosion of purchasing power rather than simple joblessness.

Maternal, infant, and child health indicators are also alarming. One-third of surveyed households included pregnant or lactating women, but fewer than half of those households reported antenatal consultations. Among women who had already delivered, only 27.9% reported postnatal care. Pregnancy loss was reported by 18% of households surveyed. This data includes miscarriage, stillbirth, and other pregnancy losses based on the dataset, not only spontaneous miscarriage illustrates a broad reproductive health concern requiring urgent maternal health outreach).

Households with infants and young children reported recurrent feeding difficulties and limited access to specialized nutrition products.

Mental health needs are widespread, and formal services are almost absent. Nearly half of households reported anxiety, depression, nervousness, insomnia or related distress within the last three months, while 93% had not attended any psychosocial information session and support-seeking was overwhelmingly informal. The assessment also indicates low exposure to protection information, very limited humanitarian coverage, and persistent public-health risks related to water, hygiene and solid waste conditions.

Return intentions among the small subset of IDP households suggest conditional willingness to return rather than durable confidence. Of 12 assessed IDP households, 41.7% said they planned to return immediately, 25% preferred gradual return, another 25% were waiting for fuller stability, and 8.3% were undecided.

The main barriers to return were lack of basic services (91.7%), destruction of homes (75%), lack of financial resources (75%), security concerns (66.7%) and legal/property issues (58.3%). This reinforces a central message of the assessment: service restoration and economic support are prerequisites for dignified and sustainable return.

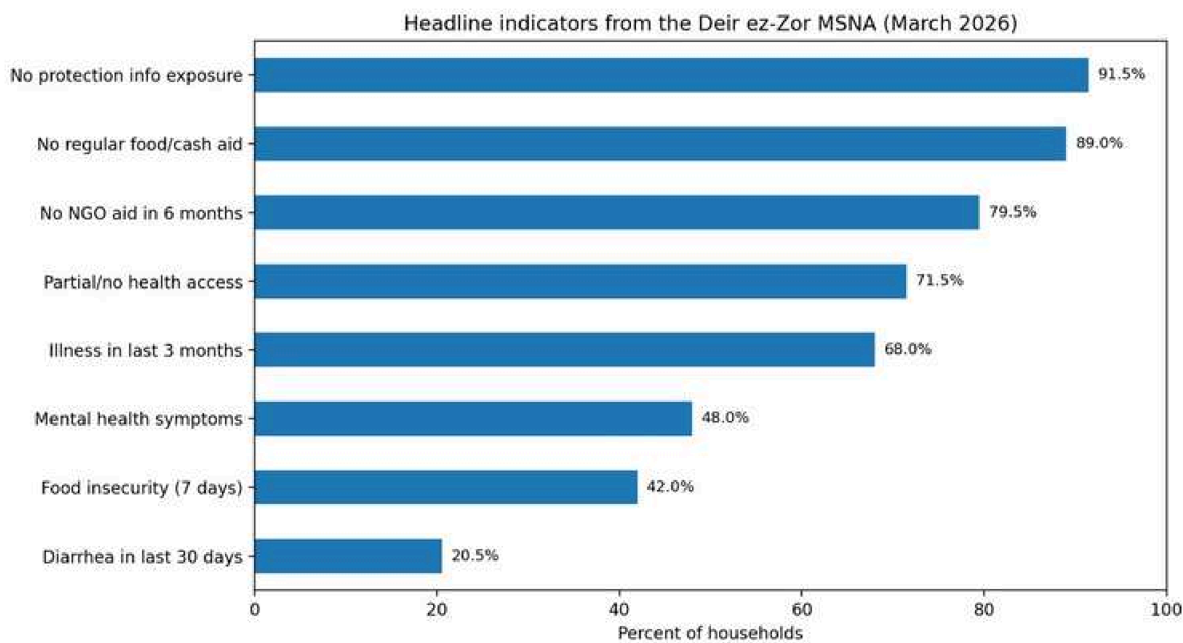

Figure 1. Headline indicators from the Deir Ezzor MSNA (March 2026).

Key Messages for Donors

- The most significant humanitarian needs identified in the surveyed areas of Deir Ezzor are in the following sectors: health, multipurpose cash, food security, MHPSS, WASH, and protection mainstreaming.
- Returns are increasing pressure on already fragile local systems. The governorate cannot absorb large return movements without support to services, improvement of household purchasing power, and early recovery.
- Health needs are not only about increasing the number of health facilities; they are about affordability. Funding should cover medicines, diagnostics, referrals, and transport subsidies alongside service delivery.
- Employment alone is not sufficient for people to meet their basic needs and cannot be used as a reliable indicator for self-reliance. Livelihoods support must be paired with cash and food assistance during the recovery period.
- While there are many common gaps across locations, interventions must be tailored to each area's specific needs. For example, Deir Ezzor city and Al-Husseiniya show high needs across multiple sectors, while Hajin stands out specifically for poor access to safe water.

1. Context and Operating Environment

Deir Ezzor entered 2026 in a volatile operating environment. In mid-January 2026, clashes between the Syrian Democratic Forces (SDF) and the Syrian Transitional Government, were reported along the eastern bank of the Euphrates. Parts of Deir-ez-Zor, and public services and key transport routes in Deir-ez-Zor city in particular were temporarily suspended, interrupting access to schools and other basic services [1][2]. UNICEF later reported that humanitarian needs across Aleppo, Ar-Raqqa, Al-Hasakeh and Deir-ez-Zor remained high despite the January ceasefire, with water, sanitation, basic services, child protection and winterization among the priority concerns [3].

At the same time, the governorate is facing major demographic pressure. UNHCR estimated in March 2026 that more than 1.52 million Syrians had returned to Syria from neighboring countries since the political transition of December 2024, adding strain to governorates with already weak systems and limited absorption capacity [4]. The survey findings suggest that return from internal displacement is already a defining feature of the Deir Ezzor caseload. Some public health facilities in rural areas such as Hajin and Al-Bukamal remain closed or only partially functional, as reflected in observations and the health access data. As such significant barriers in accessing health care persists in these areas despite the absence of active front-line conflict in assessed locations.

Recent humanitarian reporting also points to high unexploded ordnance (UXO) contamination across Syria, with Deir Ezzor consistently among the governorates of concern. UNICEF and other humanitarian sources note that explosive ordnance continues to endanger children and constrain safe access to services and livelihoods [5][6]. In Northeast Syria more broadly, IOM reported in March 2026 that the most frequently cited needs were multipurpose cash assistance, non-food items, food assistance and health services [7].

Against this backdrop, DDD's March 2026 MSNA provides a location-specific snapshot of household conditions and helps identify priority sectors for support in Deir Ezzor.

2. Methodology

DDD surveyed 200 households in March 2026 using a structured multisector questionnaire covering health, nutrition, reproductive health, WASH, education, livelihoods, MHPSS, protection and return intentions. The sample was evenly distributed across five assessed areas: Al-Mayadin, Deir Ezzor, Al-Bukamal, Al-Husseiniya and Hajin (40 interviews each).

Women represented 62.5% of respondents. The average household size was 6.2 people. Based on household profiling, the assessed caseload is diverse but returnee-heavy: 58% of households identified as returnees from internal displacement, 74% as host community, 6% as IDPs and 3% as returnees from abroad. Because some questions were only applicable to relevant subgroups, denominators vary across sector-specific indicators.

The results should be interpreted as indicative for the assessed communities rather than statistically representative for the entire governorate. Nonetheless, the findings are strong enough to inform geographic and sectoral prioritization.

Sample Profile

Indicator	Value	Indicator	Value
Households	200	**Female respondents**	62.5%
Household members represented	1,246	**Average HH size**	6.2
Assessed locations	5	**Returnees from internal displacement**	58% of HHs
IDP households	6%	**Returnees from abroad**	3%
Host community	74%		

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3. Key Findings by Sector

3.1 Health Access and Service Functionality

Healthcare access is the clearest and most urgent need in the surveyed locations. Overall, 68% of households reported illness during the previous three months. Yet only 28.5% said they could access health care whenever needed. The remaining households faced either partial access (60%) or complete lack of access (11.5%).

Affordability is the core constraint. Among respondents who answered the medication-access question, 52% said medicines were not available free of charge at all and only 1.7% said they were always free. The main reasons for incomplete or absent health access were medication costs (62.2% of affected households), transportation costs (61.5%), lack of medicines (60.8%), lack of specialised services (37.8%), and absence of services altogether (34.3%).

Diagnostics and basic clinical services are major gaps. The most frequently reported unmet health needs were X-ray (50% of all households), primary health care (48.5%), laboratory services (45.5%), dental care (43.5%), and mental health services (27%). Among households reporting disability-related barriers to care, 69% said a home visit by a health professional was needed.

Geographic disparities are marked. Deir Ezzor city recorded the highest burden in the sample, with 90% of households reporting recent illness and 32.5% reporting complete inability to access care. This suggests that urban demand pressure and cost barriers may be especially acute in the governorate center.

3.2 Maternal, Reproductive, Infant and Young Child Health

Thirty-four percent of households included pregnant or lactating women. However, only 47.1% of those households reported that the woman received antenatal care consultations. Receipt of micronutrient support during pregnancy was also inconsistent: 57.4% reported receiving multi-nutrients, while 41.2% did not.

Postnatal care is a major gap. Among women who had already given birth, only 27.9% reported receiving a postnatal consultation, while 72.1% did not. Pregnancy loss was reported by 18% of all surveyed households, this includes miscarriage, stillbirth, and other pregnancy losses compared to the global average of 15% of miscarriage only for recognized pregnancies.[1] Standard maternal health reporting often distinguishes between different types of pregnancy loss, but this composite indicator signals a major reproductive health concern requiring urgent follow-up and strengthened maternal health outreach.

Among households with infants aged 0-12 months, 71.8% reported breastfeeding; however, two-thirds also reported that feeding the infant was sometimes difficult. The most common issues were insufficient breastmilk, unaffordability of milk or other products, and unavailability of infant feeding items. Among households with children aged 12-36 months, 26.9% reported feeding difficulties.

Access to specialized child nutrition support is extremely limited. Only 25% of relevant households reported regular access to special baby food, and only 7.7% reported access to RUTF (Ready-to-Use Therapeutic Food) or RUSF (Ready-to-Use Supplementary Food). These findings suggest elevated risk of poor infant and young child feeding practices, especially where household purchasing power is weak.

[1] This 15% usually refers to miscarriage before 20 weeks and excludes stillbirths.

3.3 Livelihoods, Food Security and Basic Needs

Economic stress is severeand widespread. While81.5% of households reported at least one currently employed member, 42% said they had not had enough food or money to buy food for their family during the last seven days. This confirms that income generation alone is not protecting households from deprivation.

Households are financing consumption through negative coping and fragile informal systems. Eighty per cent reported buying food from personal resources, but 57.5% also reported purchasing food on credit or by borrowing. Smaller but still important shares reported depending on relatives or neighbours (13.5%), barter (11.5%), work-based in-kind payment (12.5%) and humanitarian food aid (7.5%).

Regular assistance coverage is inadequate. Only 10% of households reported regular receipt of food kits or cash assistance, and 79.5% reported receiving no humanitarian assistance across any sector (food, cash, health, WASH, protection) from NGOs during the previous six months. This coverage gap stands in stark contrast with the breadth of needs identified in the survey.

Food insecurity is especially acute in Deir Ezzor city and Al-Husseiniya, where 72.5% and 52.5% of households respectively reported not having enough food or money to buy food during the previous week.

3.4 Education and Child Protection

Seventy-two per centof surveyedhouseholds had school-aged children. Among those households, 91.7% reported that all school-aged children were attending school, while 8.3% reported that at least one child was not attending. Although the out-of-school rate is not the most alarming headline in the dataset, it remains significant in a returnee-heavy and economically stressed environment.

The most frequently cited reason for non-attendance was economic difficulty (58.3% of affected households). Other barriers included distance, transport issues, and engagement in income-generating activities. The pattern indicates that school access is being constrained less by formal availability than by household poverty and related coping pressures.

Protection exposure is very limited. Only 4% of respondents had attended a protection information session explaining available services and eligibility criteria. This low awareness reduces the likelihood that vulnerable households will access existing services, even where they do exist.

3.5 Mental Health and Psychosocial Support

Mental health needs are substantial. Forty-eightper cent of households reported that a household member had experienced anxiety, depression, nervousness, insomnia or related emotional or behavioural problems during the previous three months. A further 33.5% reported visible stress symptoms within the family.

Despite this burden, service uptake and awareness are extremely low. Ninety-three per cent of households had not attended any psychosocial information or coping-skills session. Support-seeking is overwhelmingly informal: 60.5% of households said they would turn to relatives, friends or neighbours, while 30% said they did not receive any support at all. Only isolated households mentioned a mental health worker, general practitioner or community safe space.

Deir Ezzor city appears to be the most affected location in the sample, with 72.5% of households reporting recent emotional or behavioural symptoms, followed by Hajin (60%) and Al-Mayadin (52.5%). This points to a clear need for area-based MHPSS expansion.

3.6 Water, Sanitation and Public Health

WASH indicators show a mixed picture. Onthe one hand, 90.5% of households reported access to a protected drinking water source and 88.5% said they had enough clean water for their needs. On the other hand, the system appears fragile, highly dependent on trucked water, and insufficient to prevent public-health risks.

Sterilised water trucks were the dominant water source in the sample, far exceeding piped networks. This signals continued dependence on costly and potentially unstable supply chains rather than durable service restoration.

Twenty-point-five per cent of households reported diarrhea during the previous 30 days. Reported causes included weather, poor hygiene of drinking water and food poisoning. Hajin had the weakest access to protected water in the sample, while Al-Husseiniya and Deir Ezzor recorded the highest diarrhoea prevalence. The relationship between water source type and diarrhea outcomes is influenced by hygiene practices and solid waste management, not only by source protection. Al-Husseiniya and Deir Ezzor city recorded higher diarrhea prevalence despite relatively better water access, suggesting that WASH programming should address hygiene behaviors and waste management alongside water supply.

These findings support continued WASH investment, especially where return pressure and weak municipal services coincide.

3.7 Substance Use, Social Stress and Return Dynamics

Substance useemergedas an under-addressed concern. Thirty-four-point-five per cent of respondents believed substance addiction is prevalent in their community or social circle, while all respondents reported that no rehabilitation center or specialized service for addiction exists in the location. Given likely stigma and under-reporting, this issue warrants cautious but proactive programming through awareness, referral pathways and youth engagement.

Return intentions among the small subset of IDP households suggest conditional willingness to return rather than durable confidence. Of 12 assessed IDP households, 41.7% said they planned to return immediately, 25% preferred gradual return, another 25% were waiting for fuller stability, and 8.3% were undecided.

The main barriers to return were lack of basic services (91.7%), destruction of homes (75%), lack of financial resources (75%), security concerns (66.7%) and legal/property issues (58.3%). This reinforces a central message of the assessment: service restoration and economic support are prerequisites for dignified and sustainable return.

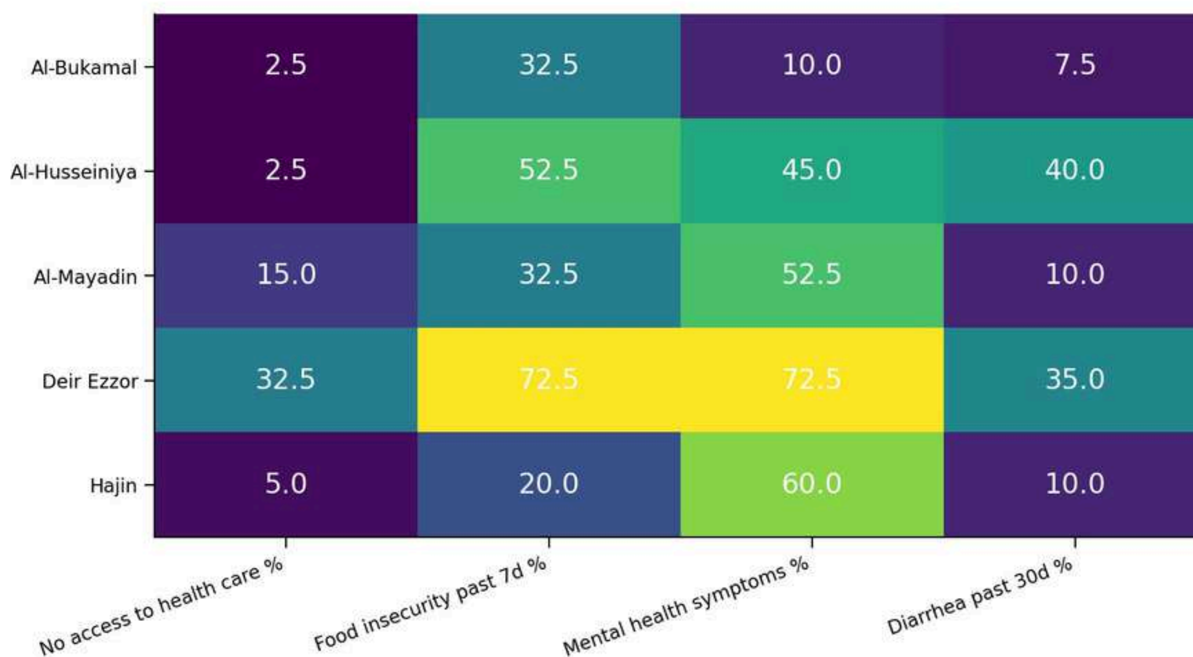

Figure 2. Geographic variation in selected needs across the five assessed locations.

4. Priority Recommendations

Priority Area	Operational Recommendation
Maternal and child health	Fund integrated Primary Health Care Centers (PHCC) and mobile outreach with an emphasis on subsidized medicines, laboratory tests, imaging, transport support and referral pathways. Support should prioritize Deir Ezzor city and other high-burden locations.
Cash and food security	Expand antenatal, postnatal and reproductive health outreach through mobile teams, women-friendly referral pathways and home visits for mothers with mobility or disability-related constraints. Nutrition counselling and infant feeding support should be embedded in the package.
MHPSS and protection	Scale up multipurpose cash and food assistance immediately for the most vulnerable households, including returnees, female-headed households, and households with disability, chronic illness or high dependency ratios.
Education and child protection	Support school retention through cash-for-education, transportation support, learning materials, and case management for children at risk of dropout or economic exploitation.
Livelihoods and early recovery	Pair humanitarian assistance with early recovery support for agriculture and small livelihoods, especially where return pressure is high. Recovery programming should reduce reliance on debt and credit for food purchases.

Durable solutions	Do not treat returns as proof of recovery. Ongoing clearance of unexploded ordnance (UXO) and explosive ordnance risk education are perquisites for safe return. Support to local services, shelter rehabilitation, legal assistance and basic infrastructure is necessary if returns are to be safe, voluntary and sustainable.

5. Conclusion

The March 2026 Deir Ezzor MSNA shows a governorate under severe humanitarian pressure despite the absence of large-scale active front-line warfare in all assessed locations. Households face a compound crisis shaped by return movements, unaffordable health care, food insecurity, psychosocial distress, and thin humanitarian coverage.

For donors and policymakers, the central implication is straightforward: Deir Ezzor requires a combined humanitarian and early recovery response. Investments limited to single sectors will underperform unless they address the interaction between health costs, household purchasing power, protection risks and weak local services. The evidence from this assessment supports flexible, area-based and multi-sector funding that can protect households now while stabilizing conditions for sustainable recovery.

References

[1] UN OCHA, Recent Developments in Ar-Raqqa, Deir-ez-Zor and Al-Hasakeh, 19 January 2026.

[2] UN OCHA, Today's top news: Syria update, 19 January 2026.

[3] UNICEF, Humanitarian Flash Updates: Escalation of Violence in Aleppo and Northeast, 2026.

[4] UNHCR, Regional Flash Update #68 Syria Situation, 13 March 2026.

[5] UNICEF Syria Humanitarian Situation Report, January 2026.

[6] UNICEF Syria Humanitarian Action for Children (HAC) 2026 appeal.

[7] IOM DTM, North East Syria (NES) Conflict, March 2026.

[8] DDD internal survey dataset: Deir Ezzor MSNA, March 2026.

[9] DDD MSNA example report used for structural templating: Tartous-Latakia Syria Multisectoral Needs Assessment, November 2025.

Appendix: Selected Indicator Table

Indicator	Result	Interpretation
Households reporting illness in last 3 months	68.0%	High recent disease burden
Households with partial or no health access	71.5%	Serious service and affordability barriers
Households reporting pregnant/lactating women	34.0%	Large maternal health caseload
PLW households reporting ANC consultations	47.1%	Suboptimal maternal care coverage
Postpartum women receiving PNC	27.9%	Critical postnatal care gap
Households reporting pregnancy loss	18.0%	Major reproductive health concern
Households with food insecurity in previous 7 days	42.0%	Acute purchasing-power crisis
Households with at least one employed member	81.5%	Employment does not prevent vulnerability
Households reporting mental health symptoms	48.0%	Substantial MHPSS needs
Households with no NGO assistance across any sector, in the previous 6 months	79.5%	Humanitarian coverage gap