

Syria

Acute Needs Analysis | November 2025 - March 2026

WHAT IS THE ACUTE NEEDS ANALYSIS?

The **2026 Acute Needs Analysis (ANA)** seeks to support needs-based prioritisation by **identifying populations facing the most acute, life-threatening needs**. The analysis uses a standardised framework to consolidate a wide range of evidence and develops findings that are **comparable within and across crises**.

The ANA focuses on **intersectoral drivers of mortality to assess the risk of emergency mortality**. The ANA considers the impact of violence and insecurity on (access to) critical services. However, due to the complexity of anticipating conflict dynamics and impacts, **it does not include risk of direct trauma deaths**, nor does it provide a full picture of all needs or community priorities.

More information on definitions, methods, and limitations can be found on page 7.

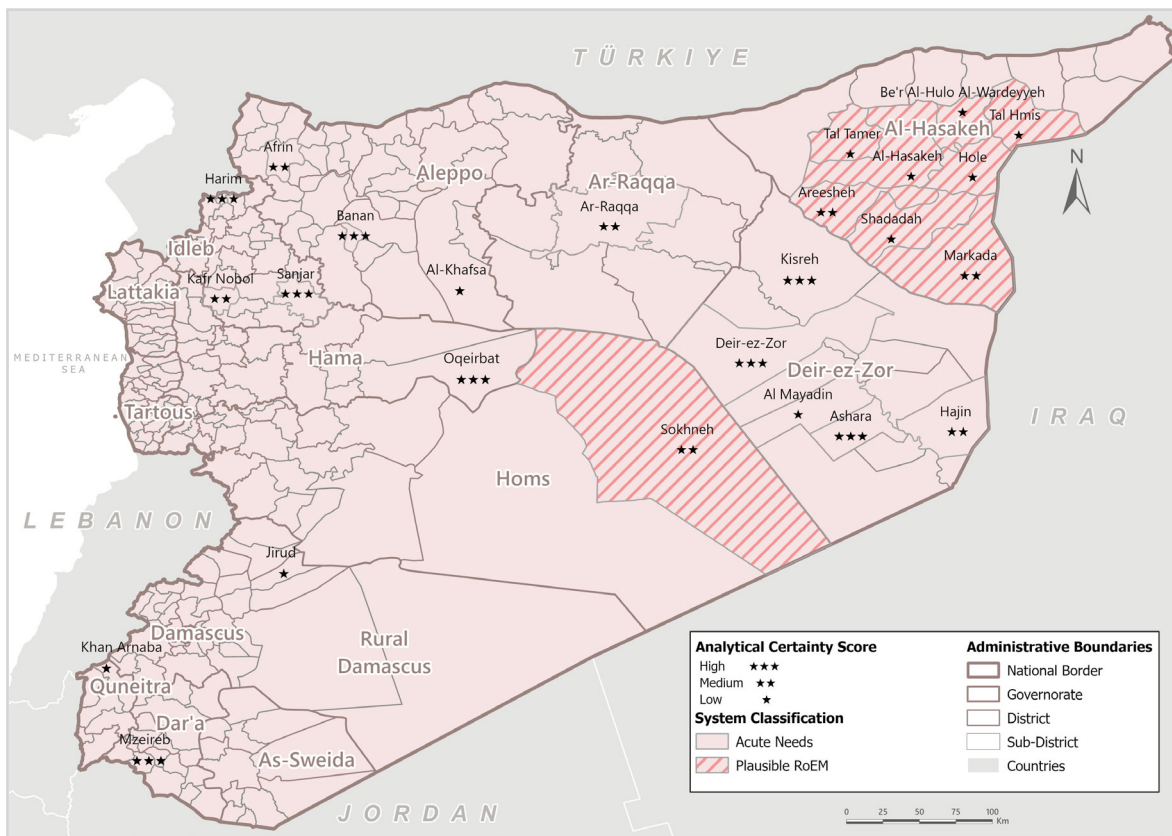
WHERE ARE THE MOST ACUTE NEEDS?

More than a decade of conflict in Syria has caused widespread damage to infrastructure and basic services, as well as large-scale and protracted displacement. While overall levels of hostilities have declined and recovery efforts are underway, economic hardship, population movements, recurrent shocks, and localised insecurity continue to drive needs. **An Acute Needs Analysis (ANA) was conducted** to identify where these needs are most acute, **covering all 270 sub-districts** (Admin 3) in Syria. In this analysis, Acute Needs (AN) refer to high-severity gaps across key drivers of mortality, while Risk of Excess Mortality (RoEM) refers to a convergence of these conditions to the point that available evidence suggests mortality has likely exceeded the emergency threshold.

The ANA classified **9 sub-districts as Plausible RoEM** and the remaining **261 as AN**. The Plausible RoEM classification indicates that the analysis identified severe conditions and a plausible pathway towards emergency-level mortality; however, specific evidence gaps prevented a final judgement on whether this represents the most likely scenario.

Notably, none of the 270 assessed sub-districts were classified as having No evidence of Acute Needs or Insufficient Data. In addition, several sub-districts that were not classified as Plausible RoEM nevertheless exhibited concerning conditions

Map 1: Area-level analytical conclusions and corresponding level of certainty, ranging from low (*) to high (***). More detailed findings per administrative unit can be found in Annex 2 (pages 8 - 13).



that could indicate heightened vulnerability to further deterioration.

The sub-districts classified as Plausible RoEM were concentrated in Al-Hasakeh governorate (Tal Tamer, Al-Hasakeh, Tal Hmis, Be'r Al-Hulo Al-Wardeyyeh, Areesheh, Shadadah, Hole, and Markada), as well as **Sokhneh sub-district** in Homs governorate, within the Syrian Desert (Badia). These areas were characterised by severe financial strain, widespread inadequate shelter, poor sewage and sanitation coverage, and limited water availability, with compounding system failures further exacerbated by economic deterioration, displacement, and the legacy effects of conflict and drought.¹

ACUTE NEED DRIVERS IN SYRIA

Converging gaps in living conditions and water systems were commonly identified alongside acute and potentially life-threatening conditions across the ANA. These gaps frequently coincided with concerning health outcomes, reflected in many cases by **high levels of morbidity among the under-five (U5) population** reported through the household survey and/or the WHO Early Warning, Alert and Response System (EWARS). Findings further suggested that, within these contexts, **financial barriers to care and strained healthcare services** appeared to limit the capacity to address emerging health needs. Together, these overlapping vulnerabilities were, in the most severe cases, indicative of conditions with a heightened risk of preventable loss of life.

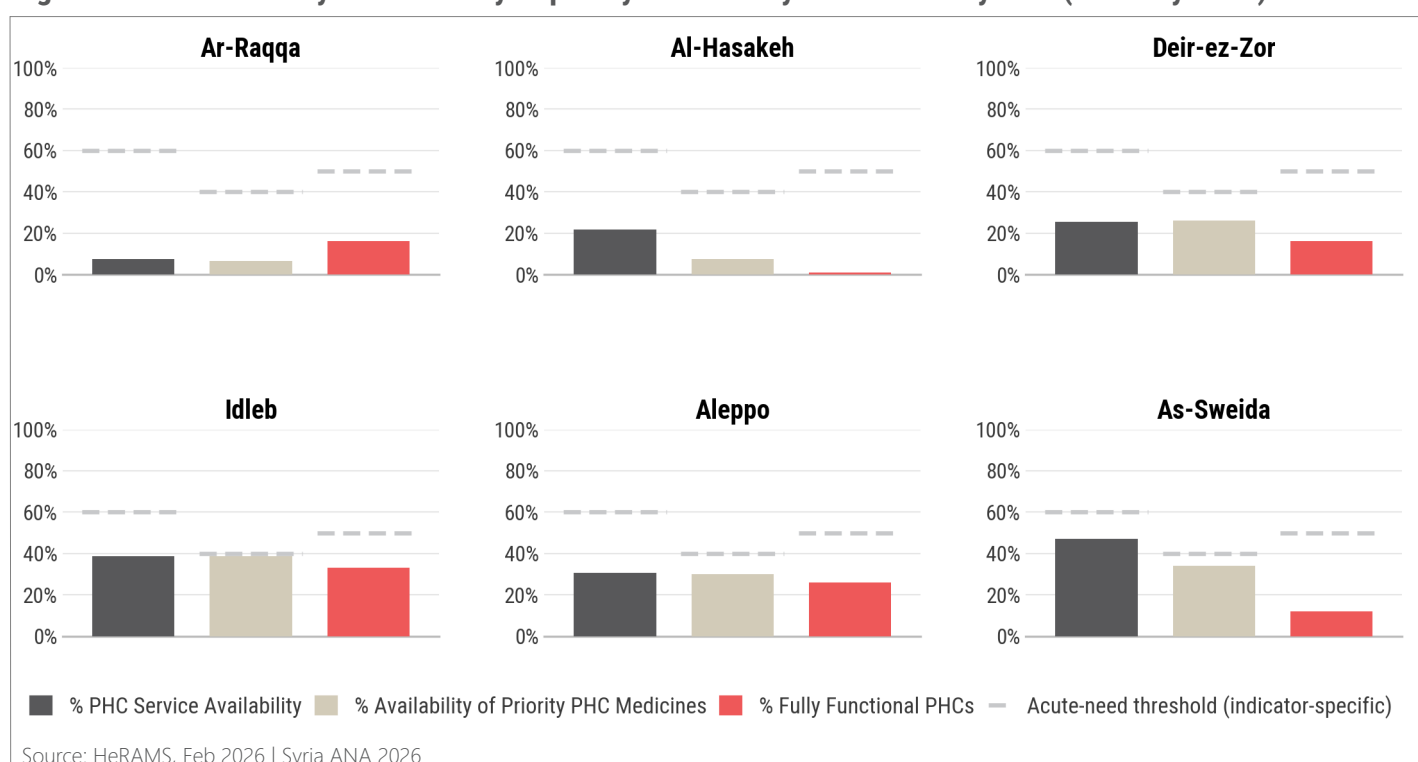
Evidence indicated that living condition systems across much of the country remained compromised, with inadequate shelter, limited sewage and waste management service coverage, ongoing conflict shocks, and damaged

critical infrastructure affecting significant pockets of the population. Water systems showed similarly concerning patterns in many areas, highlighted by **high water-related expenditures** and, in some locations, **limited availability** at the main water source. Reliance on unimproved water sources remained localised rather than widespread; however, dependence on costly and potentially unsustainable, although predominantly improved, alternatives such as water trucking underscored the **fragility of access to water**. These exposure gaps were particularly concerning where they coincided with elevated morbidity and broader constraints in access to healthcare. Evidence suggested that, within these contexts, public hospitals and primary healthcare centres (PHCs) faced limitations in functionality, alongside constrained availability of essential medicines and services. At the household level, catastrophic health expenditures were widely reported. In combination, these factors indicated limited capacity to detect and treat illnesses and prevent deterioration in severe cases.

When looking at food systems and overall levels of **food security, concerns were comparatively less severe**. Key consumption indicators, such as levels of poor Food Consumption Score (FCS) and CARI Phase 4, were not widespread and did not emerge as a primary contributor to mortality risk in most analysed areas.

However, evidence suggested that **economic pressures and livelihood constraints remained significant**. Sub-districts of concern frequently reported restricted access to agricultural land, crop failure or reduced production, high food expenditures, rising food prices, reliance on atypical or unstable income sources, and the adoption of crisis- or emergency-level livelihood coping strategies. While these pressures did not seem to have translated into widespread food consumption gaps, they can drastically

Figure 1: The Availability-Functionality Gap in Syria's Primary Health Care System (February 2026)



weaken household resilience, increase barriers to accessing healthcare and other essential services, and have the potential, in the event of further deterioration, to contribute to worsening nutrition outcomes and heightened mortality risk.

AREAS OF CONCERN

The analysis identified the **most fragile and acute conditions in Al-Hasakeh governorate and Sokhneh sub-district** (Syrian Desert/Badia). In these locations, the convergence of poor water and sanitation conditions, widespread infrastructure damage, high reported morbidity, and limited healthcare access signaled a plausible pathway towards excess mortality that could not be ruled out, although available evidence was insufficient to confirm a RoEM conclusion.

Water System Gaps

Severe water system constraints were not widespread across Syria, yet they could compound other acute needs and increase public health risks. Where such constraints were observed, conditions were commonly characterised by reliance on insecure (even if largely protected) water sources, **high rates of water expenditure, damaged critical infrastructure, and localised challenges in water availability and quality.**

In Al-Hasakeh governorate, areas of concern were **characterised by high water expenditure**, with at least 78% of households in each sub-district of concern reporting that water costs exceeded 5% of their income. This was largely linked to a heavy reliance on water trucking, reported as the primary water source by at least 93% of households. In Al-Hasakeh, Areesheh, Tal Hmis, Tal Tamer, and Be'r Al-Hulo Al-Wardeyyeh sub-districts, households also reported that their main **water source was available, on average, for fewer than four days per week.** This pointed to constrained supply as well as financial barriers to water access.

As for **Sokhneh**, the sub-district recorded one of the highest rates of reliance on unimproved water sources in Syria (45% of households). This coincided with reported damage to water infrastructure and long water collection times, with 71% of households reporting collection times of more than 30 minutes. In addition, 48% of households reported high water-related expenditure (spending more than 5% of their income on water).² Taken together, these **conditions suggested limited access to sufficient and safe water, additional economic pressure on households, and a potential environment conducive to waterborne disease transmission.**

Poor Living Conditions

The most severe and widespread gaps identified in the analysis related to people's living conditions.

These included widespread shelter inadequacies, protection and safety concerns related to latrine access, and gaps in the coverage and quality of sewage and waste collection systems. **Such conditions may be associated with increased exposure to disease vectors and other envi-**

ronmental health risks, particularly where sanitation and waste management systems are weak. Where these risks coincided with poor health outcomes and limited access to care, they may have been linked to more severe health consequences.

Areas of concern exhibited some of the most severe living condition gaps in the country. In Al-Hasakeh governorate, **inadequate shelter** was reported by 89% of households in Areesheh sub-district and 75% in Al-Hasakeh sub-district, with the most commonly reported shelter issues including a lack of privacy, overcrowding, and limited ventilation. In Sokhneh sub-district, a high proportion of households reported inadequate shelter, with the vast majority living in unfinished enclosed buildings.²

Infrastructure damage was also quite prevalent.

In Sokhneh, sewage network coverage was reported as absent, while waste management services were reported as limited or largely absent. Across Plausible RoEM sub-districts in Al-Hasakeh governorate, an average of 74% of households per sub-district reported that their waste was not collected.³ These conditions coincided with reports of solid waste and sewage accumulation, most notably in Tal Tamer, where 45% of households reported frequent sewage flooding and 85% reported waste accumulation.³

Elevated Under-Five (U5) Illness

Across the areas of concern, high reported morbidity among children U5 was one of the most common signals of negative health outcomes identified in the analysis.

While global acute malnutrition (GAM) and forgone healthcare rates were generally below ANA thresholds, reported childhood illness was high, a trend also reflected in health surveillance data.^{4,5}

In Al-Hasakeh governorate, 40% and 67% of **children U5 were reportedly experiencing acute watery diarrhoea** in Areesheh and Markada sub-districts, respectively.² These figures coincided with limited water availability and sanitation gaps reported in these areas. A similar pattern was observed for **acute respiratory illness (ARI):** approximately 40% and 55% of children U5 were reported to be experiencing ARI symptoms in Al-Hasakeh and Tal Tamer sub-districts, respectively.² These figures were consistent with increasing caseload trends in surveillance data and may point to a sustained burden of childhood illness.⁴

Suspected measles cases also increased in Al-Hasakeh governorate, reaching 17 cases across Al-Hasakeh and Ash-Shaddadeh health districts in epidemiological week 12 of 2026. EWARS data indicated that cases continued to rise in subsequent weeks, reaching 34 cases.⁴ Measles vaccination coverage in the governorate was reported as being among the lowest in Syria and below international benchmarks.⁵ This raised concerns about the potential for transmission and severe health outcomes among children.

Sokhneh sub-district showed a similar profile to Al-Hasakeh, with **morbidity reported for 69% of children U5**. Unlike most areas of concern, Sokhneh also recorded **high levels of forgone healthcare**, reported for 58% of individuals.²

Similar patterns in health outcomes were also observed in parts of Idleb and Deir-ez-Zor governorates. In Deir-ez-Zor, respiratory and influenza-like illness among children U5 was reported at high levels in Hajin (55%) and Deir-ez-Zor (49%) sub-districts. In Idleb, forgone healthcare was reported by 81% of individuals in Kafr Nobol, while child morbidity was reported by 58% in Harim and 53% in Sanjar.² These outcomes were observed alongside a reported influx of returnees, which may have placed additional pressure on already strained services and conditions.⁶

Healthcare Functionality & Accessibility Gaps

The health risks described above occurred in the context of **constrained healthcare services, marked by medicine shortages, limited service availability, and financial barriers to care.**

In Sokhneh, an isolated and remote sub-district in the Syrian Desert (Badia), **healthcare capacity appeared particularly limited.** The sub-district was served by one partially functioning PHC and one partially functioning public hospital, both of which reported low availability of essential health services (12% in the PHC and 47% in the hospital).^{7,8}

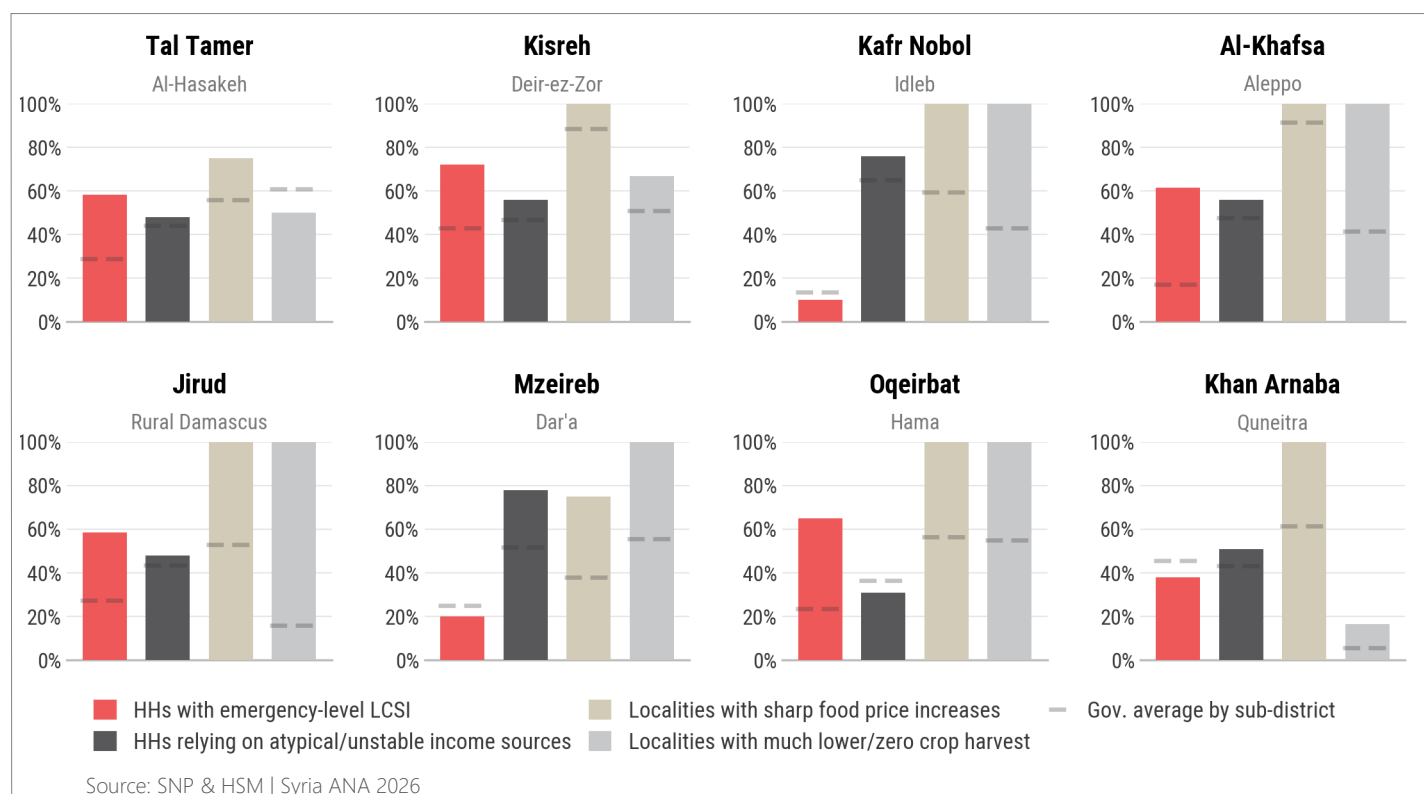
Across Al-Hasakeh governorate, healthcare provision appeared highly constrained. In Al-Hasakeh and Ash-Shaddadeh health districts, where most of the governorate's areas of concern were located, essential services were delivered largely through partially functioning PHCs, with a limited number of functioning public hospitals. Essential health service availability was reported at 22%, while priority medicine availability was reported at 4% in PHCs and 12% in hospitals.^{7,8} In addition, an average of 74% of households per sub-district across Al-Hasakeh reported catastrophic health expenditure, representing a persistent barrier to access.²

Economic Strain

The analysis found that **economic strain was a prominent cross-cutting underlying driver of need across the crisis.** This was reflected in **high rates of emergency-level coping LCSi** (Livelihood Coping Strategies Index), frequently reported **food price increases**, heavy **reliance on unstable sources of income**, and a **reduced ability to generate income from traditional means** such as agriculture and livestock. These financial pressures were observed across multiple systems, limiting households' ability to access safe water and healthcare while reducing their capacity to absorb additional shocks. In areas already affected by high healthcare costs, poor water access, and elevated levels of child illness, financial vulnerability may further compound humanitarian needs and increase the risk that deteriorating conditions may translate into more severe outcomes.

The increasing prevalence of economic stressors was reflected in the rising cost of the Survival Minimum Expenditure Basket (SMEB), which increased by over 12% across Al-Hasakeh governorate between October 2025 and February 2026.¹⁰

Figure 2: Mapping Economic Vulnerability in Syria



Reliance on unstable or atypical income sources was widespread, reported by 63% of households in Sokhneh, 61% in Areesheh, and 67% in Shadadah. Emergency-level coping strategies were also prevalent in sub-districts with the most acute needs, reported by 67% of households in Tal Hmis and 69% in Hole.²

SHOCKS AND STRESSORS

Beyond service gaps and deteriorating living conditions, the **convergence of ongoing shocks — including economic hardship and displacement — alongside the legacy effects of conflict, drought and flooding, has left populations in many sub-districts increasingly vulnerable.**

In Deir-ez-Zor, severe flooding was reported in May 2026. As this occurred outside the ANA analysis window, its effects were not captured in the analysis. However, qualitative sources indicated that the flooding damaged large areas of cropland, destroyed homes, and compromised water points.¹² This may have further increased the vulnerability of a population already facing concerning exposure pathways. **In addition, widespread explosive ordnance (EO) contamination and other after effects of over 14 years of conflict shocks** remained defining features of the crisis.¹³ These hazards cause deaths and injuries among civilians, particularly children, who accounted for 45% of EO-related trauma patients at Deir-ez-Zor National Hospital.¹³ They may also be reflected in the high proportion of households reporting restricted access to farmland and markets, indicating constraints on livelihoods and additional financial pressures. Protection concerns were similarly reported, with households frequently citing safety concerns when accessing latrines and sanitation facilities, pointing to heightened exposure risks.²

The **influx of returnees** may also have contributed to deteriorating conditions in some areas. **In Ar-Raqqa and Rural Damascus**, large numbers of returnees settled in sub-districts already facing service gaps and infrastructure limitations, likely straining healthcare, water, sanitation, and other basic services, and further increasing vulnerability in communities where needs were already elevated. **This was also observed as a significant issue in Idleb**, where years of conflict and displacement continue to shape migration patterns, currently characterised by large numbers of returnees. The sub-district of Kafr Nobol, for example, was the most commonly cited area of intended return for IDP returnees as of late 2025. According to these trends, its population is projected to increase by 175%, from 38,000 to 104,000 people,⁶ which may place additional strain on services and infrastructure that already exhibited severe gaps (98% of households reporting inadequate shelter).²

EMERGING AREAS OF CONCERN

In addition to the highlighted areas of concern, **several areas** classified as Acute Needs also **showed concurrent gaps in critical systems that warranted attention.** These areas showed similar patterns in exposure and mitigation gaps as areas classified as Plausible RoEM, but the evidence suggested the impact on health outcomes

remained relatively contained during the analysis window.

In Idleb governorate, gaps in living conditions, water systems, and healthcare services were widespread and often reached critical levels. Across the governorate, an average of 68% of households resided in inadequate shelter,² while only 34% were covered by sewage networks, with frequent reports of flooding and waste accumulation.³ In addition, stressors related to water security remained prevalent, with a concerning proportion of residents reporting high water costs and frequent damage to water system infrastructure. Health service capacity appeared particularly constrained. The governorate relied on a single functioning public hospital in Idleb City, and average PHC service availability was 38%. Priority medicine availability was 39% in PHCs and 26% in public hospitals.^{7,8}

In Deir-ez-Zor governorate, water system gaps were among the most prominent observed. This was reflected in the low average proximity of populations to their main water points, while 56% of households reported damage to critical water infrastructure. This figure reached 100% in higher-vulnerability sub-districts such as Ashara, Al Mayadin, and Hajin.³ Critical needs related to living conditions were also reported, with over 50% of localities reporting movement restrictions attributed to conflict-related shocks.¹⁴ Deir-ez-Zor was also identified as the largest EO contamination hotspot in the country,¹³ which may be linked to the reported movement restrictions. In addition, 48% of households reported waste accumulation occurring 2-3 days per week.³ Healthcare services appeared constrained, with average service availability of 25% in PHCs and 49% in public hospitals.^{7,8} In addition, 84% of households reported catastrophic health expenditure.²

Taken together, these findings highlight the fragility of conditions in many areas of Syria, even where negative health outcomes are not widespread. Years of conflict, displacement, and economic hardship have left many people and essential services with little capacity to absorb future shocks and stressors. Particularly where severe gaps in water systems, living conditions, and access to healthcare converge, such as in Idleb and Deir-ez-Zor, any deterioration could have considerable consequences and increase the risk of preventable loss of life.

MITIGATION CAPACITY

Humanitarian programming remains an important part of the response in many areas facing Acute Needs, but current resource constraints mean that **available assistance is often unable to meet the scale and severity of needs.** In areas such as Afrin and Ar-Raqqa, health programming was present alongside persistent constraints in service functionality, medicine availability, and access to care. Similarly, Banan in As-Safira recorded some of the most concerning food-consumption outcomes in the analysis, with 27% of households with poor FCS and 13% classified in CARI Phase 4,¹¹ alongside comparatively limited FSL coverage.¹⁵ Conversely, several areas facing substantial livelihood pressures but less severe food-consumption outcomes had greater FSL programming coverage.¹⁵ These patterns do not demonstrate that assistance caused better

outcomes, but they suggest that **current levels of need should be understood in relation to the support available to crisis-affected communities.**

This is particularly relevant given the mortality pathways observed in Plausible RoEM areas, where heavy reliance on water trucking, high water-related expenditure, limited water availability, and gaps in sewage and waste management services were observed alongside constrained healthcare capacity and elevated morbidity. These findings point to the **need for both sustained humanitarian assistance and longer-term recovery and development investment in infrastructure and essential services.** Where these weaknesses persist, gaps in humanitarian coverage, reductions in support, or additional shocks could exacerbate existing vulnerabilities, place further pressure on already fragile systems, and increase the risk of more severe, potentially life-threatening needs.

ESTIMATES OF MAGNITUDE

In addition to the geography of acute needs, the ANA sought to capture an estimate of the magnitude of needs to **help identify where the risk of loss of life is greatest** and ensure that small pockets of the population with very severe needs living outside of areas categorised with RoEM **are not overlooked.**

The estimate of magnitude provides **an indicative range of the number of people at risk of preventable loss of life** due to public health causes. It combines data on overlapping deprivations in food, water, and living conditions with information on health-related vulnerabilities and the mitigating capacity of health systems. The calculation method requires household-level data.

The ANA estimates that between 711,000 and 1.59 million people in Syria faced conditions of potentially life-threatening need during the November 2025 to March 2026 analysis period. **These figures should not be interpreted as caseload figures or targeting numbers;** rather, they should be read as an analytical approximation of the scale and geography of risk — not a precise number — produced using a pilot methodology.

The “Acute Needs” category is often applied where available evidence identifies significant gaps in at least one critical system, but is insufficient to determine whether vulnerabilities converge across sectors in a manner consistent with RoEM conditions. As such, the absence of a RoEM or Plausible RoEM classification should not be interpreted as evidence that severe or life-threatening needs are absent. Rather, an Acute Needs classification may reflect a critical severity gap in at least one key mortality driver, based on the available evidence, while information might be insufficient to assess the broader convergence of mortality risks.

ABOUT REACH

REACH Initiative facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery, and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED, and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR - UNOSAT).

ANNEX 1: METHODOLOGY OVERVIEW

HOW WAS THE ANALYSIS CONDUCTED?

The ANA is a structured analysis designed to identify populations facing the most acute, life-threatening conditions resulting from a breakdown of critical systems in contexts in which mortality data is unavailable. It aims to inform big-picture humanitarian prioritisation decisions.

The analysis assesses the functionality of critical systems (health, nutrition, food, water, and living conditions), triangulated with immediate mortality drivers (acute malnutrition and morbidity). Severe deprivations in any or multiple of these public health systems are investigated further to determine whether they are severe enough to result in a Risk of Excess Mortality (RoEM).

The analysis consists of two critical phases. During the quantitative phase, preliminary “flags” are raised when emergency thresholds are exceeded across multiple indicators, based on global reference frameworks (SPHERE, WHO, IPC, etc.). Analysts then verify, triangulate, and interpret these flags with contextual evidence during the Deep-dive phase, using structured analysis techniques, to reach a final ANA category for each area or group:

- **Excess Mortality:** Timely evidence confirms mortality rates exceed the World Health Organisation (WHO) Emergency Threshold (>1 death/10,000 people/day, >2 for children under 5 years old).
- **Risk of Excess Mortality (RoEM):** Very severe gaps in multiple mortality drivers are interacting in a way that suggests excess mortality is likely occurring within the analysis timeframe, or is imminent.
- **Plausible Risk of Excess Mortality (Plausible RoEM):** Available evidence suggests a potential risk of excess mortality due to failures across multiple systems; however, a critical data gap prevents confirmation of RoEM.
- **Acute Needs (AN):** Evidence confirms very severe gaps in at least one mortality driver, but not to the extent that there is immediate concern for excess mortality.
- **No Evidence of AN:** There is no evidence of very severe gaps in mortality drivers.
- **Insufficient Evidence:** There is insufficient evidence to analyse acute needs.

WHO IS NOT INCLUDED IN THE ANALYSIS?

For Syria, the ANA assessed all 270 sub-districts (Admin 3). Data were drawn from multi-sector household surveys, sectoral assessments, health and nutrition surveillance, and key informant reporting, complemented by contextual information. The ANA is an area-level analysis: findings reflected conditions at the sub-district level rather than for specific population groups. As a result, differences between population groups within the same area, such as women and girls, IDPs, and returnees, may not have been visible in the outcomes. A sub-district's overall findings may therefore have masked more severe conditions experienced by specific groups. Efforts were made to explore and contextualise some population-specific dynamics through the Deep-dive analysis. However, data limitations did not allow a systematic assessment of the distinct mortality pathways and vulnerabilities of these groups.

DISCLAIMER

While the analysis framework and process are standardised to promote consistency and reduce cognitive biases, conclusions depend on the availability, reliability, and timeliness of data, as well as the quality of contextual interpretation. Each area is assigned an **analytical certainty score**, reflecting the degree of confidence in the conclusion (★/★★/★★★) based on the type and quality of the data and the strength of triangulation.

The ANA does not speak to community priorities and should not replace sectoral assessments, nor does it provide a comprehensive view of the full breadth and depth of intersectoral humanitarian needs.

The ANA considers the impact of violence and insecurity on access to and functionality of critical systems, and its possible cascading impacts on public health. However, due to limitations in nowcasting and anticipating conflict dynamics, **the ANA does not assess the risk of direct trauma deaths.**

The ANA in Syria assesses the situation in the period **November 2025 - March 2026. Contextual changes after this time window have not been reflected in the results.**

More detailed information on the methodology and its limitations can be accessed [here](#).

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Abu Kamal	Acute Needs	*
Abu Qalqal	Acute Needs	*
Abul Thohur	Acute Needs	*
Afrin	Acute Needs	**
Aghtrin	Acute Needs	*
Ain al Arab	Acute Needs	*
Al Bab	Acute Needs	*
Al Makhrim	Acute Needs	*
Al Mayadin	Acute Needs	*
Al Qutayfah	Acute Needs	*
Al-Haffa	Acute Needs	*
Al-Hasakeh	Plausible RoEM	*
Al-Khafsa	Acute Needs	*
Al-Khashniyyeh	Acute Needs	*
Al-Malikeyyeh	Acute Needs	*
Al-Qardaha	Acute Needs	*
Al-Qusayr	Acute Needs	*
Al-Thawrah	Acute Needs	*
Amuda	Acute Needs	*
An Nabk	Acute Needs	*
Anaza	Acute Needs	*
Arbin	Acute Needs	*
Areeshesh	Plausible RoEM	**
Ariha	Acute Needs	*
Arima	Acute Needs	*
Ariqa	Acute Needs	*
Armanaz	Acute Needs	*
Ar-Ra'ee	Acute Needs	*
Ar-Raqqa	Acute Needs	**
Ar-Rastan	Acute Needs	*
Arwad	Acute Needs	*
Ashara	Acute Needs	***
Ash-Shajara	Acute Needs	*
As-Saan	Acute Needs	*
As-Safira	Acute Needs	*
As-Salamiyyeh	Acute Needs	*
As-Sanamayn	Acute Needs	*
As-Suqaylabiyah	Acute Needs	*
As-Sweida	Acute Needs	***
At Tall	Acute Needs	*
Atareb	Acute Needs	*
Azaz	Acute Needs	*
Az-Zabdani	Acute Needs	*
Babella	Acute Needs	***
Badama	Acute Needs	*
Bahlolieh	Acute Needs	*
Bait Jan	Acute Needs	*
Banan	Acute Needs	***

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Banyas	Acute Needs	*
Baramanet Elmashayekh	Acute Needs	*
Bariqiyeh	Acute Needs	*
Basira	Acute Needs	*
Beit Yashout	Acute Needs	*
Bennsh	Acute Needs	*
Be'r Al-Hulo Al-Wardeyyeh	Plausible RoEM	*
Bulbul	Acute Needs	*
Busra Esh-Sham	Acute Needs	*
Da'el	Acute Needs	*
Dalyeh	Acute Needs	*
Damascus	Acute Needs	*
Dana	Acute Needs	*
Dar'a	Acute Needs	*
Darbasiyah	Acute Needs	**
Daret Azza	Acute Needs	*
Darkosh	Acute Needs	*
Dayr Hafir	Acute Needs	*
Deir Attiyeh	Acute Needs	*
Deir-ez-Zor	Acute Needs	***
Dhameer	Acute Needs	*
Dimas	Acute Needs	*
Dreikish	Acute Needs	*
Duma	Acute Needs	*
Dweir Raslan	Acute Needs	*
Eastern Bari	Acute Needs	*
Eastern Kwaives	Acute Needs	*
Ehsem	Acute Needs	*
Ein El-Bayda	Acute Needs	*
Ein Elfijeh	Acute Needs	*
Ein Elniser	Acute Needs	*
Ein Elsharqiyeh	Acute Needs	**
Ein Et-teeneh	Acute Needs	*
Ein Halaqim	Acute Needs	*
Ein Issa	Acute Needs	*
Ein Shaqaq	Acute Needs	*
Esal El-Ward	Acute Needs	*
Fakhura	Acute Needs	*
Farqalas	Acute Needs	*
Fiq	Acute Needs	***
Ghabagheb	Acute Needs	*
Ghandorah	Acute Needs	***
Gharyeh	Acute Needs	***
Ghizlaniyyeh	Acute Needs	*
Hadher	Acute Needs	*
Hadideh	Acute Needs	*
Hajar Aswad	Acute Needs	*
Hajeb	Acute Needs	*

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Hajin	Acute Needs	**
Hama	Acute Needs	*
Hamam Wasil	Acute Needs	*
Hameidiyyeh	Acute Needs	*
Hamin	Acute Needs	*
Hamra	Acute Needs	*
Hanadi	Acute Needs	*
Haran Al'awameed	Acute Needs	*
Harasta	Acute Needs	*
Harbanifse	Acute Needs	*
Harf Elmseitra	Acute Needs	*
Harim	Acute Needs	***
Haritan	Acute Needs	*
Hasyaa	Acute Needs	**
Hawash	Acute Needs	*
Heish	Acute Needs	*
Hole	Plausible RoEM	*
Homs	Acute Needs	*
Hrak	Acute Needs	*
Idleb	Acute Needs	*
Izra'	Acute Needs	*
Jablah	Acute Needs	*
Jalaa	Acute Needs	*
Jandairis	Acute Needs	*
Janudiyeh	Acute Needs	*
Jarablus	Acute Needs	*
Jaramana	Acute Needs	*
Jasim	Acute Needs	*
Jawadiyah	Acute Needs	*
Jeb Ej-Jarrah	Acute Needs	*
Jeb Ramleh	Acute Needs	*
Jebel Saman	Acute Needs	*
Jirud	Acute Needs	*
Jisr-Ash-Shugur	Acute Needs	*
Jizeh	Acute Needs	*
Jneinet Raslan	Acute Needs	*
Jobet Berghal	Acute Needs	*
Jurneyyeh	Acute Needs	*
Kafr Batna	Acute Needs	*
Kafr Nobol	Acute Needs	**
Kafr Takharim	Acute Needs	*
Kafr Zeita	Acute Needs	*
Kansaba	Acute Needs	*
Karama	Acute Needs	*
Kareemeh	Acute Needs	*
Karnaz	Acute Needs	*
Kasab	Acute Needs	*
Khan Arnaba	Acute Needs	*

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Khan Shaykun	Acute Needs	*
Khanaser	Acute Needs	*
Khasham	Acute Needs	*
Kherbet Elma'aza	Acute Needs	*
Kherbet Ghazala	Acute Needs	*
Kherbet Tin Noor	Acute Needs	*
Kisreh	Acute Needs	***
Kisweh	Acute Needs	***
Lattakia	Acute Needs	*
Little Sura	Acute Needs	*
Lower Shyookh	Acute Needs	**
Maadan	Acute Needs	*
Maaret Tamsrin	Acute Needs	*
Ma'arrat An Nu'man	Acute Needs	*
Ma'btali	Acute Needs	*
Madaya	Acute Needs	*
Madiq Castle	Acute Needs	**
Mahin	Acute Needs	*
Maliha	Acute Needs	*
Ma'loula	Acute Needs	*
Mansura	Acute Needs	*
Mare'	Acute Needs	*
Markada	Plausible RoEM	**
Markaz Darayya	Acute Needs	*
Mashnaf	Acute Needs	*
Mashta Elhiu	Acute Needs	*
Maskana	Acute Needs	**
Masmiyyeh	Acute Needs	*
Masyaf	Acute Needs	*
Mazra'a	Acute Needs	*
Menbij	Acute Needs	**
Mhambal	Acute Needs	*
Milh	Acute Needs	*
Mseifra	Acute Needs	*
Muhasan	Acute Needs	*
Muhradah	Acute Needs	*
Mzair'a	Acute Needs	*
Mzeireb	Acute Needs	***
Nabul	Acute Needs	*
Nashabiyeh	Acute Needs	**
Nasra	Acute Needs	*
Nawa	Acute Needs	*
Oj	Acute Needs	*
Oqeirbat	Acute Needs	***
Qabu	Acute Needs	*
Qadmous	Acute Needs	*
Qahtaniyyeh	Acute Needs	*
Qarayya	Acute Needs	*

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Qaryatein	Acute Needs	*
Qastal Maaf	Acute Needs	*
Qatana	Acute Needs	*
Qourqeena	Acute Needs	*
Qteilbiyyeh	Acute Needs	*
Quamishli	Acute Needs	**
Qudsiya	Acute Needs	*
Qumseyyeh	Acute Needs	*
Quneitra	Acute Needs	***
Rabee'a	Acute Needs	*
Raheiba	Acute Needs	*
Raju	Acute Needs	*
Rankus	Acute Needs	*
Raqama	Acute Needs	**
Ras Al Ain	Acute Needs	**
Ras El-Khashufeh	Acute Needs	*
Rasm Haram El-Imam	Acute Needs	*
Rawda	Acute Needs	*
Sabe Byar	Acute Needs	**
Sabka	Acute Needs	*
Saboura	Acute Needs	***
Sadad	Acute Needs	*
Safita	Acute Needs	*
Safsafa	Acute Needs	*
Sahnaya	Acute Needs	***
Salanfa	Acute Needs	*
Salkhad	Acute Needs	*
Salqin	Acute Needs	*
Sanjar	Acute Needs	***
Saraqab	Acute Needs	*
Sarghaya	Acute Needs	*
Sarin	Acute Needs	***
Sarmin	Acute Needs	*
Sa'sa'	Acute Needs	*
Shadadah	Plausible RoEM	*
Shahba	Acute Needs	*
Shaqa	Acute Needs	*
Sharan	Acute Needs	*
Shat-ha	Acute Needs	*
Sheikh Badr	Acute Needs	*
Sheikh El-Hadid	Acute Needs	*
Sheikh Miskine	Acute Needs	*
Shin	Acute Needs	***
Sibbeh	Acute Needs	*
Sidnaya	Acute Needs	*
Sisniyyeh	Acute Needs	*
Soda Khawabi	Acute Needs	*
Sokhneh	Plausible RoEM	**

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Suluk	Acute Needs	***
Sur	Acute Needs	***
Suran (Aleppo)	Acute Needs	*
Suran (Hama)	Acute Needs	*
Susat	Acute Needs	*
Tabni	Acute Needs	*
Tadaf	Acute Needs	*
Tadmor	Acute Needs	*
Tal Hmis	Plausible RoEM	*
Tal Tamer	Plausible RoEM	*
Talbiseh	Acute Needs	**
Taldu	Acute Needs	*
Taleen	Acute Needs	*
Tall Ed-daman	Acute Needs	*
Tall Kalakh	Acute Needs	*
Tall Refaat	Acute Needs	*
Tamanaah	Acute Needs	*
Tartous	Acute Needs	*
Tassil	Acute Needs	*
Tawahin	Acute Needs	*
Teftnaz	Acute Needs	*
Tell Abiad	Acute Needs	*
Tell Salhib	Acute Needs	*
Thiban	Acute Needs	*
Thibeen	Acute Needs	*
Wadi El-oyoun	Acute Needs	*
Yabroud	Acute Needs	*
Ya'robiyah	Acute Needs	*
Zarbah	Acute Needs	*
Ziyara	Acute Needs	*

ANNEX 3: LIST OF SOURCES

The 2026 ANA in Syria draws on data from the following sources:

1. [FEWS NET. \(2026\). Syria food security outlook: Insecurity, drought, and economic constraints drive outcomes aligned with Crisis \(February-September 2026\).](#)
2. REACH. (2025). Syria Needs Profile [Internal assessment].
3. Syria WASH Sector. (2025). Vulnerability Mapping Assessment [Available from Sector upon request].
4. [WHO & Syrian Ministry of Health. \(2026\). Early Warning, Alert and Response System \(EWARS\), Syria \[Dashboard\].](#)
5. Syria Nutrition Sector. (2026). SMART survey [Available from Sector upon request].
6. [CCCM Cluster, International Organization for Migration \(IOM\), United Nations High Commissioner for Refugees \(UNHCR\), & REACH. \(2025, November 18\). IDP movement intentions survey - Syria.](#)
7. [WHO EMRO. \(2026\). Health Resources and Services Availability Monitoring System \(HeRAMS\): Primary health care centres \(2021-2026\) \[Dashboard\].](#)
8. [WHO EMRO. \(2026\). Health Resources and Services Availability Monitoring System \(HeRAMS\): Public hospitals \(2021-2026\) \[Dashboard\].](#)
9. [OCHA. \(2026, April 2\). Syrian Arab Republic: 2026 Humanitarian Needs and Response Plan \(April 2026\).](#)
10. REACH. (2026, February). Joint Market Monitoring Initiative (JMMI), Syria. REACH Initiative.
11. [GOAL & ICS. \(2026, April 15\). Multi-Sector Needs Assessment: Full Report 2026.](#)
12. [UNFPA. \(2026, June 8\). UNFPA Syria Flash Update: Euphrates Floods in Raqqa and Deir-ez-Zor \(25 May-6 June 2026\).](#)
13. [MSF. \(2026, June 25\). Explosive Remnants of War: Lasting Harm in Deir Ez-Zor, Syria.](#)
14. REACH. (2026). Humanitarian Situation Monitoring (HSM), Syria. REACH Initiative.
15. [Food Security and Agriculture Sector \(FSAS\). \(2025\). Syria Food Security and Agriculture Sector interactive response dashboard 2025 \[Dashboard\].](#)
16. REACH. (2025). Joint Market Monitoring Initiative (JMMI), Syria. REACH Initiative.
17. United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2025, August). Population data. OCHA.
18. International Medical Corps (IMC). (2025, December). Multi-Sector Needs Assessment (MSNA) [Available from IMC upon request].
19. [ONSUR. \(2025, December\). Multi-sector needs assessment in Deir-ez-Zor Governorate \(December 2025\). ReliefWeb.](#)
20. [ONSUR. \(2026, February\). Multi-sector needs assessment in As-Sweida Governorate \(December 2025\). ReliefWeb.](#)
21. [Syria WASH Sector. \(2025\). Syria WASH response dashboard \[Dashboard\].](#)
22. [Health Sector Syria. \(2025\). 4Ws dashboard \(Who does What, Where, and When\) \[Dashboard\].](#)