RELIEF INTERNATIONAL

Diagnosing return

Health conditions and experiences of returnees in Syria

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"THE MOMENT I CAME BACK FROM IDLIB, I CRIED. THIS IS NOT THE HOME WE LEFT BEHIND. THERE ARE NO PROPER HEALTH SERVICES. EVEN SEEING A DOCTOR COSTS MORE THAN WHAT PEOPLE CAN AFFORD. WE CAME BACK TO REBUILD OUR LIVES. EVEN IF WE START FROM ZERO, WE WILL TRY AGAIN."

– Sawsan, 51, in Rural Damascus governorate

Front cover: An infant is weighed by a nutritionist during an acute malnutrition check-up at Al-Jazrat Health Center in Deir-ez-Zor. Project delivered by Relief International and funded by the Syrian Humanitarian Fund (SHF) (Frontline in Focus, 2025).

Acknowledgements

This paper draws on a combination of primary and secondary research. Primary research includes mixed-methods fieldwork commissioned by Relief International (RI) and conducted by Middle East Consulting Solutions (MECS) between November 2025 and January 2026, comprising surveys with 705 returnees across Aleppo, Deir-ez-Zor, and Rural Damascus governorates. The report also draws extensively on an European Union (EU)-funded Multi-Sectoral Needs Assessment (MSNA) designed and implemented by RI between November and December 2025, capturing the evolving humanitarian situation among 2,109 Syrians in Northeast (Deir-ez-Zor, Al-Hassakeh, and Raqqa governorates), Northwest (Aleppo, Idlib, and Hama governorates), and Southern Syria (Dara'a governorate). Secondary sources, including published reports and studies, are cited throughout and listed in full as endnotes. The analysis is further grounded in RI's direct experience in Syria across the health and nutrition, protection, and water, sanitation, and hygiene (WASH) sectors, as well as in the operational knowledge of RI's partners.

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Relief International in Syria

Relief International is an international humanitarian and development organization that partners with communities in the world's most fragile and complex settings to save lives and support resilience, dignity, and long-term wellbeing. RI has operated in Syria since 2012, since it began programs in Northwest Syria in response to the escalating conflict. Over the intervening years, RI has delivered integrated services to people in need across the country. Its teams and partners provide emergency, free-of-charge healthcare, protection, and nutrition services, and deliver clean water and solar power to health facilities and communities affected by displacement. The organization is committed to strengthening Syria's health system as the country embarks on large-scale recovery, including through evidence-based advocacy. It echoes RI's conviction that efforts to advance durable solutions must be shaped by the experiences and voices of Syrians themselves.

Executive summary

The December 2024 collapse of the Assad-led government transformed the trajectory of Syrian displacement virtually overnight, rekindling long-suppressed hope among many that returning home might finally be possible. Syrians continue to face significant barriers to returning safely and rebuilding their lives, despite ongoing stabilization efforts. This is particularly evident in the health sector.

Access to healthcare is a crucial consideration in return decision-making and realities. Quality, distance, and affordability of care reflect stark discrepancies between what Syrians require and what is available in large swathes of the country. Just over half of hospitals and one third of primary healthcare facilities were fully operational as of late 2024. More than 15,000 physicians – approximately half of Syria's pre-war medical workforce – fled the country. In rural Deir-ez-Zor, 78% of returnees report healthcare as unavailable. Up to 51% of returnees describe the quality of health services as low or unreliable. Healthcare costs are effectively excluding most of the population from treatment in certain areas.

Many Syrians are coping with trauma, chronic disease, malnutrition, and untreated injury – conditions that displacement has all too often failed to resolve. In fact, as the Ministry of Health's Strategic Plan argues, "displacement and overcrowding have intensified psychosocial stress while limiting the continuity of care."[1] Returning to areas where health infrastructure is devastated, expertise is depleted, and treatment is prohibitively costly, poses significant health risks for returnees.

Particular and acute health vulnerabilities demand urgent attention in this context. Female returnees exhibit the highest rates of anxiety and psychological distress documented in this study, driven by compounded exposure to conflict, displacement, and return-related stressors. These issues are further exacerbated by the near absence of maternal, reproductive, and gender-based violence-responsive health services, alongside a critical nationwide gap in mental healthcare provision.[2]

An estimated 28% of Syrians – nearly double the global average – now live with some form of disability, a figure that continues to rise amid widespread landmine and unexploded ordnance (UXO) contamination. Yet rehabilitation services, such as prosthetics, physiotherapy, and assistive device maintenance, are among the most severely under-resourced components of an already fragile system.[3] For persons with disabilities (PWDs) and those managing chronic conditions, returning to areas lacking specialized care risks reversing functional gains made during displacement.

A vaccination team conducts immunizations in a damaged neighborhood in Idlib. Project delivered by RI and funded by the WHO (Frontline in Focus, 2025).

This report is based on primary research commissioned by Relief International and conducted by Middle East Consulting Solutions surveying 705 returnees across Aleppo, Deir-ez-Zor, and Rural Damascus governorates. It also draws on RI's EU-funded Multi-Sectoral Needs Assessment involving 2,109 Syrians in Deir-ez-Zor, Al-Hassakeh, Raqqa, Aleppo, Idlib, Hama, and Dara'a governorates. It reveals that the speed and scale of return have dramatically outpaced the health infrastructure, capacity, and resources required to receive returnees safely and support their health and wellbeing.

Addressing these challenges requires coordinated action across three sets of actors. Commitment to resolving displacement and honoring Syrians' return intentions – shared by the Syrian government and humanitarian community – must translate into reasonable timeframes for improving conditions in areas of return and calibrating service delivery accordingly. The international community must continue to substantially increase support to the humanitarian response and reconstruction in a manner that enables conditions for safe, voluntary return and resist pressure to accelerate movements prematurely. Health actors must invest in integrating health considerations into return assistance and support Syrian health organizations as the foundation of any durable recovery. Taken together, these actions can help to stave off a looming public health challenge and lay the groundwork for durable solutions to displacement, including improved health and wellbeing for all.

Introduction

The fall of Bashar al-Assad's government on 8 December 2024 marked a watershed moment in the politics of Syrian displacement, and, for millions of Syrians, the first credible prospect of return since 2011. Under the previous government, return to many parts of Syria had been rendered effectively impossible, as civilians faced an entrenched system of violence and repression, including persistent hostilities, collective punishment, arbitrary detention, enforced disappearance, torture, and violence against women and girls.[4] The government's collapse precipitated a profound psychological reckoning, restoring the possibility of finally returning home.

What followed was unprecedented in scale. 76% of returns documented by MECS/RI occurred in 2025. Between December 2024 and April 2025 alone, an estimated 372,550 Syrians crossed back to Syria via neighboring countries and an additional 1.05 million internally displaced persons (IDPs) made the journey back to their areas of origin.[5] Whether they stayed put or settled elsewhere depended on conditions of physical, legal, and material safety. In Aleppo, most returns were from abroad (71%) and from Türkiye specifically (93%). In Rural Damascus and Deir-ez-Zor, the majority of returns documented occurred within Syria (60% and 81% respectively). Throughout 2025, the demographics of return evolved: what had begun as predominantly male 'go-and-see' visits shifted into full family reunification. UNHCR data reinforces this, with children under 18 comprising approximately 40% of all returnees from Jordan.[6]

Upon returning to Al-Tibni, a father and daughter found their local health center shuttered. Project supported by the EU (Frontline in Focus, 2026).

The speed and scale of this movement have far outpaced the restoration of the conditions that make return sustainable, especially in the health sector. Returnees across the surveyed governorates have encountered a heavily damaged environment in which between 40% and 70% of housing stock is destroyed or structurally unsafe;[7] electricity reaches most households for fewer than six hours a day; water networks have been systematically degraded; and health facilities are destroyed, closed, or functioning at minimal capacity.

International standards for safe, voluntary return require that individuals can make free and informed decisions, unconstrained by coercion or by conditions of hardship in displacement that effectively foreclose alternatives. The reality of Syria's 2025 return movement – documented in both the secondary data review and the primary household surveys underpinning this report – is considerably more complex. Positive intentions are real and well-evidenced: 95% to 98% of returnees cited family reunification, property recovery, and the end of active hostilities as primary motivations. Yet negative push factors are equally present and cannot be dissociated from the decision to return.

In Lebanon, for example, a breakdown in state functions has produced hyperinflation exceeding 250% and widespread unemployment,[8] fueled hostile attitudes towards Syrian refugees, and triggered evictions that leave families with no viable alternative to return.[9] An uptick in cross-border movements precipitated by active hostilities in March 2026 deepens these concerns.

In Türkiye, escalating restrictions on refugee residency, mounting documentation pressures, and other factors have created conditions in which return to Syria appears to many marginally preferable to continued displacement.[10] This explains in part why 41% of Aleppo returnees surveyed cite negative push factors as a primary driver of their return.

Within Syria, a drawdown in humanitarian assistance linked to donor funding cuts, coinciding with the closure and consolidation of displacement sites in northern governorates, constitute stressors for IDPs as camp management actors withdraw and basic services deteriorate.[11] Declining international financial support for the Syrian health sector in early 2025 forced at least 77 health facilities, including 17 hospitals, in Northwest Syria to suspend activities, leaving 1.5 million people without access to lifesaving and emergency healthcare, with knock-on effects rippling across society.[12] The resulting service vacuum has proven impossible for the Ministry of Health and local actors to absorb, entrenching critical gaps in care and further undermining the conditions required for safe and sustainable return.

> "People began to think about returning directly after the fall of the regime... We felt that the difficult stage had ended and a real chance for stability had begun."
>
> — Alia in Douma, Rural Damascus governorate

This combination of push and pull constitutes a fluid demographic dynamic. Returnees are exercising agency, but often within severely constrained choice sets, and under circumstances where genuine voluntariness is difficult to establish. This distinction carries direct consequences for how Syrian authorities and the international community characterize, monitor, and respond to these movements, including through health and its broader social determinants in water, energy, and food systems.

Recovery in Syria is inseparable from the health of those returning. 14 years of conflict have left communities carrying the compounded weight of undetected illness, untreated disease, malnutrition, and trauma – conditions that displacement has all too often masked, if not exacerbated. Returning to areas where health infrastructure is destroyed, health workers have fled or cannot be paid, and medicines are unaffordable means that the act of return is itself a health risk. Women face particular and acute vulnerabilities in this context. Maternal and reproductive health services are among the most consistently absent facets of an already impaired system.

As RI/MECS research demonstrates, rates of anxiety and psychological distress, already severe across displaced populations, are highest among female returnees (86%), who navigate the stresses of return alongside the structural absence of services and persistent protection risks such as civil documentation gaps, unpaid care responsibilities, and freedom of movement restrictions.[13] In Rural Damascus, 81% of women reported feeling overwhelmed by daily living and 58% suffered from frequent anxiety, compared with 21% and 15% of men respectively. As the Ministry of Health's Strategic Plan reinforces, "untreated mental health conditions further contribute to the progression of chronic illnesses."[14]These concerns are central to whether return constitutes a durable solution.

The Government of the Syrian Arab Republic has voiced intention to expedite the closure of displacement camps as a step towards normalization, and its Ministry of Health has published a strategic plan for rebuilding the national health system. Both signal a necessary orientation toward recovery and durable solutions. Yet the pace at which camp closures are being pursued risks accelerating movements absent the conditions that make return sustainable. The lack of adequate preparation, reliable information, and functioning services in return destinations means that camp closures risk manufacturing the appearance of voluntary return while delivering distress and additional displacement. Healthcare in this context is a crucial factor.

This report examines the reality of return among communities – who is returning, to what conditions, with what access to services, and at what risk – with particular focus on intersections with health and interrelated needs. Its findings are unambiguous: the speed and scale of return have outpaced the infrastructure, institutions, and resources required to receive returnees safely and provide adequate care. That gap represents an urgent protection and public health challenge, one that demands concerted and commensurate response from the Syrian government and the support of the international community.

"No matter how hard the conditions are, your country remains precious. It's your birthplace, your memories.

You cannot erase that."

– Ghassan, 67, in rural Dara'a governorate

The dangers of data in isolation

Data on returns to Syria is both methodologically contested and politically charged. At least four parallel counting systems operate, producing figures that are partially incompatible and, in some cases, irreconcilable.

UNHCR verified return figures capture only individuals whose return has been directly monitored by its operations and therefore may underrepresent total return movements. Its methodology does not specify a fixed temporal threshold for determining durability, making it difficult to capture circular or onward movements. These figures are further constrained by limited monitoring access in insecure or remote areas.

Syrian government figures put returns about 15% to 20% above UNHCR's total. The likely sources of this divergence are multiple and reinforcing: the inclusion of temporary or 'go and see' visits as permanent; double counting of individuals passing through multiple crossings or checkpoints; and institutional incentives to maximize tallies as evidence of stabilization and progress.[15]

Turkish statistics have not always aligned with UNHCR's verified count of returns from the country. The characterization of these movements as voluntary has raised concern among human rights groups which have documented instances of coercion affecting the conditions under which return decisions were made.[16]

IOM's Displacement Tracking Matrix (DTM) utilizes a community-level baseline assessment methodology of key informant interviews to generate local level estimates of IDP displacement and return. Reactivated in February 2025, it does not provide a directly comparable baseline for movements associated with the late-2024 developments. While the approach enables rapid, wide geographic coverage, informant-based reporting and aggregated estimates can be open to interpretation and may complicate comparability with other data sources using different methodologies.

A father of 12 examines the remains of his family home in a town in central Idlib whose primary health center has yet to resume functioning. Project delivered by RI and funded by the WHO (Frontline in Focus, 2025).

Primary research corroborates these discrepancies within communities. Interviewees in Deir-ez-Zor and Rural Damascus voiced concern that official figures underestimate actual return volumes because of the informal routes traversed, ambiguous registration procedures, and frequent lack of legal civil documentation among those returning from remote areas. The cumulative effect is a data environment in which the scope, trajectory, and character of Syria's return picture cannot be accurately established with coherence and ease. This contributes to a misreading of conditions and challenges the degree to which international standards determination for voluntary, safe, and dignified movement are made. It also makes it difficult for actors across the humanitarian response as well as local authorities to anticipate and prepare for population influxes, including in hospitals and primary healthcare centers which have experienced shifting demand as a result.

Research findings

"Health cannot wait. Education is important, but when someone is sick, there is no delay. Without healthcare, people cannot rebuild their lives."

- Aref, 56, rural Deir-ez-Zor governorate

1. The return journey and decision-making

The decision to return is rarely taken in conditions of complete information. For most Syrians, it is made based on secondhand accounts, social media posts, and the word of relatives who made earlier exploratory visits – filtered through years of absence and a hope that home will be livable again. The degree to which that information proved accurate upon arrival is a key variable shaping whether the current wave of return becomes durable or tips into secondary displacement.

According to RI/MECS research, two distinct information ecosystems shaped how returnees prepared for the journey home. IDP returnees – who maintained active tribal and family networks inside Syria throughout their displacement – tended to arrive with relatively accurate pictures of both the security environment and service conditions. Refugee returnees, particularly those coming from Türkiye or Europe, depended more heavily on social media and 'go and see' visits. These trips tend to show observable, immediate circumstances effectively; they rarely capture structural and granular details affecting longer-term reintegration.

Across all three governorates, primary research found a consistent pattern that cuts across both IDP and refugee groups: information about the security environment was broadly reliable, while information about services, infrastructure, and market conditions was frequently incomplete, inaccurate, or overly optimistic. In Aleppo, a high degree of alignment was reported between what returnees had heard and what they found, such as the cessation of arbitrary detention and improved freedom of movement. Yet, the economic reality was harsher than most had anticipated. In rural Shamarin, for instance, the combination of low income and absent work drove some returnees back to their areas of displacement. In Deir-ez-Zor and Rural Damascus, where most returnees were IDPs, the divergence was not in economic expectations but in service coverage. Optimism about service availability clashed sharply with the reality of infrastructure devastated, lacking, or overstretched. Service conditions in Deir-ez-Zor were worse than even the most pessimistic accounts had suggested. In Rural Damascus, returnees who had been told electricity was resuming arrived to discover there were hardly a few hours of power per day.

This pattern – reliable security information, inaccurate service information – is not incidental. It illustrates how information travels and what is visible to those who carry it. Security conditions are observable, noticeable when they change quickly, and often the subject of proactive government communication and media commentary. Service conditions meanwhile are precise, variable, and frequently only visible at the point of need. A returnee can learn whether checkpoints have been removed from a phone call with a

relative. Whether the nearest clinic stocks insulin requires consultation with a professional.

In the context of health, this information deficit can be a matter of life or death. The question facing a returnee is not simply, "Is it safe enough to return?" but a series of condition-specific questions that existing information channels struggle to answer: Will my medication be stocked at the local pharmacy? Is a specialist within reach of my community? Can I afford the treatment required? Returnees described arriving to find a stark gap between expectation and reality, gleaning answers to these questions only upon arrival, if at all. This shapes not only the decision about whether to stay, but how effectively aid agencies can support recovery in the critical period that follows.

The dynamics described by Syrians should directly inform both humanitarian programming and policy responses. Generic assurances that "it is safe to return" risk being actively misleading when tailored, condition-specific information is absent. Safe and voluntary return is contingent on individuals' ability to make informed decisions rooted in their specific circumstances – a standard that is especially high given that wellbeing often hinges on access to health services. For people with health dependencies, this means timely, accurate information on service availability spanning expertise, facilities, and medications, delivered through channels that are both accessible and trusted.

Salem's story: Restoring hope and home in Idlib

When it became possible to return to his village in Idlib countryside, Salem, 53, did not hesitate. "This is my village. My land. My roots," he said. "No one can replace the place where you were born."

After a decade fleeing from one place to another without stable income or a sense of permanence, Salem first made the journey back to assess the situation and found that his house had been heavily damaged. His hometown of Jobas was situated along a frontline of the conflict, changing hands multiple times and enduring years of ground fighting and aerial bombardment, most fiercely between 2019 and 2020.[17] His home bore the scars.

Salem and his mother in their home in Jobas in Idlib countryside. Project delivered by RI (Frontline in Focus, 2025)

10 days later, he returned to begin repairs. Within a month, his family moved back in. "We rebuilt the house and reopened our lives," he said. "We finally closed the chapter of displacement. In displacement, no matter how comfortable you are, you are still called a displaced person," he explained. "Here, I am free. This is my village. This is where I belong."

For families like Salem's, access to quality healthcare is a condition for safe, durable return. Soon after they returned, Salem's elderly mother suffered a fall and required an urgent hip replacement. Nearby Saraqib Hospital provided comprehensive medical care, including diagnostic tests, surgery, medications, and post-operative care. Today, she is able to walk again.

"You can rebuild a house. But without healthcare, you cannot rebuild life," Salem noted. "We have our house. We have our work. And we have a hospital that treats us with dignity. That is enough to start again."

Saraqib Hospital is the only general hospital in the region providing free, around-the-clock healthcare services, including inpatient care, intensive care, life-saving surgery, and specialized ophthalmology and neurology consultations. Having relocated in 2020 amidst attacks, the facility and its staff reconstituted near its original location in December 2025. [18] It currently serves around 13,000 patients each month, alongside a growing number of emergency cases as families return to the area.

2. Conditions upon return

The decision to return to Syria is often made in the hope of restoring a dignified life. Yet for the hundreds of thousands who have made the journey, the reality upon arrival is one of profound loss and deprivation. The infrastructure of daily existence – electricity, water, markets – is functionally absent in many parts of the country. Understanding the quality of and access to services that returnees face is crucial to supporting their integration and recovery, alongside the rest of the Syrian population already bearing the costs of years of neglect.

Mobile immunization teams reach children in Kafr Jalis in northern Idlib. Project delivered by Relief International and funded by the WHO (Frontline in Focus, 2025).

Material safety and standards of living

Access to electricity and water is critically and unevenly degraded, exposing a system that cannot absorb the populations now depending on it. In Deir-ez-Zor, surveyed returnee households receive an average of five and a half hours of electricity per day, with none reporting access exceeding eight hours. In Rural Damascus, the situation is nearly identical. While Aleppo benefits from a higher average of 15.2 hours, this masks sharp intra-governorate disparities as 10% of rural households reported zero hours and 31% reported critically low access.

Water access inverts this picture and exposes an even deeper crisis. Aleppo, despite its relative electricity advantage, faces a critical water failure: 99% of urban and 90% of rural returnee households receive public running water for fewer than four hours a day. In urban centers in Rural Damascus governorate, the situation is the most extreme as 28% of households reported a complete absence of running water. Only Deir-ez-Zor, benefiting from proximity to the Euphrates River, records frequent water connectivity – averaging 14.2 hours daily in urban areas – though this does little to offset the electricity deficit that cripples water pumping, sanitation systems, cold-chain medicine storage, health facility functionality, and basic household food safety.

These figures are signs of the precarity of basic services amidst an increasing caseload of return. Local authorities confirm that increased consumption linked to returnee influxes has caused interruptions in water networks, with solid waste volumes doubling in some municipalities without any corresponding increase in capacity to manage them. The funding context is inseparable from this deterioration. The suspension of USD 117 million in foreign assistance specifically targeting Northeast Syria led directly to the closure of water treatment plants and health facilities at the precise moment returnee numbers were peaking, eroding conditions for recovery overnight.[19]

> "Water rationing has increased. And electricity cuts are deeper compared to neighboring areas."

– Hisham, municipal employee in Qudsaya, Rural Damascus governorate

Fissures exposed in Northeast Syria's health system

Returns across rural Deir-ez-Zor governorate have laid bare the severe structural constraints facing the health system in Northeast Syria and a concerning rural-urban divide. 14 years of conflict, chronic underinvestment, and infrastructural neglect have left a system ill-equipped to meet the needs of existing residents, let alone absorb the additional demands induced by waves of return. RI's MSNA confirmed that nearly all 10 sub-districts have experienced significant demographic variation in the past six to 12 months, driven overwhelmingly by the return of displaced families, with populations in locations including Al-Tibni having doubled or tripled as a result. Without urgent and sustained support, the conditions necessary for safe, voluntary, and dignified return cannot be guaranteed.

In Al-Tibni, a town situated on the western bank of the Euphrates River, both returnees and host community members face serious and overlapping gaps in healthcare access. A confluence of armed conflict, forced displacement, and prolonged deprivation has left local health infrastructure damaged, inactive, or critically under-equipped. The town lacks laboratory, paramedic, and radiography services entirely. The nearest facilities capable of providing specialized or emergency care are located up to 65 kilometers away, accessible only via unreliable road networks and at prohibitive cost for households with limited income. RI's MSNA found that 81% of households in Al-Tibni rely on private, paid transport to reach health facilities in serious or life-threatening situations – among the highest rates recorded across all assessed locations, and reflective of the complete absence of emergency medical services. Some 41% of households in the sub-district reported that at least one family member had been unable to access emergency care in the previous six months, exceeding the regional average of 35%. For individuals facing chronic illness, obstetric emergencies, or acute childhood disease, this distance has life-threatening consequences.

The situation among young children is especially concerning. Malnutrition screening coverage for children under five in Al-Tibni stands at a mere 10%, among the lowest recorded. Among the small proportion of children who were screened, all demonstrated moderate acute malnutrition (MAM). A 100% MAM rate among screened children, set against low screening coverage, points to a nutrition crisis whose true scale almost certainly far exceeds what current data can capture. The assessment also confirmed significant service gaps in antenatal and postnatal care. Such risks are further compounded by intersecting vulnerabilities: widespread poverty, acute food insecurity, and limited connectivity to referral and specialist services disproportionately affect at-risk groups, including young children, pregnant and lactating women, PWDs, and the elderly.

A nutritionist conducts an acute malnutrition screening at Al-Jazrat Health Center in Deir ez-Zor. Project delivered by Relief International and funded by the SHF (Frontline in Focus, 2025)

Healthcare costs exacerbate these access failures to a degree that is effectively excluding most of Al-Tibni's population from care. 93% of households in the sub-district reported needing medical care in the past six months but being unable to afford it – the highest rate of unmet financial need recorded across all assessed areas, placing it far above the governorate average. Across the sub-district, only 17% of households managed to access services without financial difficulty. In cases where residents reached a facility, dissatisfaction was widespread, with only 34% of respondents across Northeast Syria considering the quality of care at their nearest health facility adequate. In Al-Tibni and neighboring Maadan, residents cited the absence of medicines and poor quality of care as the dominant concerns, reinforced by financial constraints and a critical shortage of female medical staff, particularly affecting protection services. The RI/MECS research found that residents consistently characterized healthcare access as "very bad or non-existent," citing the near-total absence of functioning local medical facilities.

Faced with these barriers, communities have been largely left to manage communicable diseases at home and without clinical support – an approach that accelerates transmission, defers deteriorating conditions until they become critical, and places burden on women as caregivers. Supported by the EU, RI mobile clinic teams operating in the area have documented a pattern of health outcomes consistent with prolonged service absence, including advanced and poorly controlled chronic diseases such as diabetes and hypertension, and delayed care-seeking, resulting in patients facing complications. Health-seeking behavior in Al-Tibni is notably low at 45%, suggesting that the barriers to care are not only structural and financial but indicate medical mistrust and hesitancy. Expressed in the context of postnatal care and immunization services, for example, these trends highlight the value of active outreach and engagement among returnee and host communities alike.

What makes Al-Tibni's situation complex is that return is ongoing and community confidence, by regional standards, is relatively strong. Perceptions of safety are among the highest recorded across assessed locations, with 84% of residents reporting a sense of relative stability and stronger social cohesion – a finding shaped in part by the community's own experience having endured heavy militarization by non-state armed groups and armed attacks by the Islamic State group. That returnees are choosing to return despite documented deficiencies in health, water, and other basic services indicates both a depth of commitment to place and, in many cases, the absence of viable alternatives, rather than an endorsement of current conditions as adequate or sustainable. It is a signal that the population is ready to return even if the systems to provide for their needs are not.

"SOMETIMES, BY THE TIME AN AMBULANCE ARRIVES, IT'S ALREADY TOO LATE."

– Aref, 56, in rural Deir-ez-Zor governorate

Basic needs and livelihoods

Across the three governorates surveyed by RI/MECS, between 50% and 72% of returnees described that their capacity to meet basic household needs was insufficient, indicative of a population that has returned but not yet stabilized. The divergence between actual income and perceived needs ranges from 82% to 120%, with the most extreme shortfall reported in Rural Damascus. The primary challenge in this context is not a lack of jobs, but an issue of wages. Between 71% and 93% of rural respondents and 75% and 88% of urban respondents identified low wages, not job scarcity, as the dominant barrier. This signals an economy whose productive base has not yet recovered, presenting risks that returnees turn to exploitative labor and other harmful measures to address basic needs.

A 10-year-old is examined for anemia at Al-Muhimida Health Center in Deir-ez-Zor. Project delivered by Relief International and funded by the SHF (Frontline in Focus, 2025).

A midwife applies training to detect potential birth complications and make rapid, life-saving referral decisions at Al-Jazrat Health Center in Deir-ez-Zor. Project delivered by Relief International and funded by the SHF (Frontline in Focus, 2025).

In Aleppo – Syria's industrial center and the location with the highest livelihood availability in the research – main constraints to meeting basic needs are high competition for available positions and the few female employment opportunities being concentrated in low-paying agricultural work. The structural collapse of the oil and gas sector in Deir-ez-Zor, which historically absorbed a significant share of the male workforce, generated a labor market with few diversified industries. Refugee returnees in the governorate face a compounding disadvantage: 50% reported that livelihoods were not readily available, against 28% of IDP returnees – a gap that likely indicates the greater economic precarity of those who spent displacement abroad without the networks and local knowledge that can aid integration. In Rural Damascus, extreme poverty coupled with high competition and social unrest yields an especially difficult economic environment, as indicated by the highest rate of returnees unable to meet basic needs (72% compared with 50-51% in other areas).

Against this backdrop, women face distinct and compounding barriers that aggregate figures obscure. Social norms, the absence of childcare, and, crucially, the fear of harassment during transit inhibit women from pursuing work outside their immediate neighborhoods. For female-headed households, including widows and wives of the missing, these barriers intersect with a wider crisis of legal identity in which securing legal civil documentation presents added administrative hurdles, especially in Rural Damascus.

Without proof of property ownership or marriage or birth registration, for instance, they are blocked from receiving humanitarian assistance and legal protection, resulting in economic exclusion, exploitation, and other protection risks.[20]

"Many people lived for years without proper medical care during displacement or exile. The overall health situation requires much more support due to poor infrastructure and limited services, especially during winter when needs increase dramatically."

– Dr. Mohammad Wfaa Hammoud Alhusin, RI Medical Officer in Saraqib, Idlib governorate

3. Access to healthcare examined

No sector demonstrates the gap between the pace of return and the adequacy of reception more starkly than health. Returnees arriving to devastated communities carry the compounded burden of untreated chronic disease, trauma, undetected pathologies, interrupted care, and, in significant numbers, disability. Yet the health system they return to is structurally incapable of meeting those needs. Just over half of hospitals and one third of primary healthcare facilities were fully operational as of early 2025. More than 15,000 physicians – around half of Syria's pre-war medical workforce – fled the country during the conflict, resulting in about 2.2 doctors per 10,000 population.[21] Hundreds of thousands of pregnant women face a health system unable to guarantee emergency obstetric care,[22] with humanitarian actors reporting that access to lifesaving services is "practically impossible" in areas heavily marred by conflict.[23] In the absence of sufficient investment, these cracks in a fragmented system are likely to widen as return continues.

A system on life support

The speed of return has outpaced the health system's ability to recover. RI and partners witnessed new arrivals inundating health facilities calibrated to smaller, stable populations. Al-Nur Hospital in Taftanaz, a town in northeast Idlib governorate, saw a 35% rise in consultations of women and children between December 2024 and December 2025. Consultations at Qatmeh Primary Healthcare Center fell by 43% between May 2025 and February 2026 as families left the area's patchwork of IDP sites to return to their places of origin elsewhere in Idlib. Just weeks after opening, an International Rescue Committee (IRC) women's protection center in Homs reached full capacity as other clinics and hospitals saw a significant influx.[24] Médecins Sans Frontières (MSF), which provides outpatient consultations, mental health support, and sexual and reproductive healthcare services in 15 health facilities in areas such as Daraya[25] found that returnees had gone years without reliable medical care, managing illness, pregnancy, and emergencies on their own.[26]

Availability of healthcare ranges from constrained to functionally absent. RI's MSNA across Northeast Syria found that 59% of households reported illness or injury within the six months preceding RI's assessment, including elevated rates of non-communicable diseases (NCDs). NCDs are particularly prevalent among a population that has spent years in displacement without consistent access to treatment or monitoring. Addressing them requires a continuity of care that local systems are struggling to offer in the region. The situation is particularly dire in Deir-ez-Zor, with a striking 78% of respondents reporting healthcare as not available in rural areas. These figures illustrate a health system absent in the places where return is often highest and need significant.

The quality of care is as poor as its availability. Up to 51% of returnees in Deir-ez-Zor describe healthcare quality as low or unreliable. Across the country, diagnostic tools are absent and facilities lack the equipment for surgery, maternal health assessment, or specialist care. Nine in 10 medical devices are more than five years old and shortages of spare parts, oxygen, and laboratory supplies inhibit continuity of care.[27] Understaffing, the disruption of training programs, and inconsistent accreditation, means that clinical capacity cannot be reconstituted along the timescale of return.

Efforts to rehabilitate centers and establish referral pathways, while vital, underscore the scale of the void national and international organizations are attempting to fill, with Syrian organizations facing added precarity amidst reduced funding levels. As the Danish Refugee Council (DRC) has warned, pushing returns on a population that finds "barely survivable" conditions risks simply creating new displacement, as people are forced to move again in search of safety and care.[28] For instance, returnees may be compelled to move from rural areas lacking primary healthcare to already overwhelmed urban centers, leading to overcrowding and other impacts.

"In recent months, we have seen a significant increase in returnees not only to Saraqib, but also to surrounding villages and even southern rural Aleppo. To respond to this demand, our medical teams operate 24 hours a day, seven days a week, across all hospital departments."

– Dr. Mohammad Hammoud, Medical Officer with Relief International in Saraqib, Idlib governorate

A workforce and diagnostic void

As the research demonstrates, the quality of healthcare is as consequential as availability and cost. Up to 51% of urban returnees in Deir-ez-Zor described healthcare quality as low or unreliable. Women in Douma and other towns in Rural Damascus recalled waiting hours to see a doctor who, under patient volume pressure, had insufficient time for thorough examinations. In Shamarin, a village in northern Aleppo, the local hospital prioritized orthopedic and cardiac surgery, leaving gaps in gynecological, obstetric, and pediatrics care. The shortage of qualified staff was cited as a major barrier by 62% of urban Deir-ez-Zor respondents (48% rural), 60% of urban respondents in Rural Damascus governorate (53% rural), and 38–39% of Aleppo respondents. These figures point to a structural challenge facing Syria's health system. A critical shortage of female medical staff also persists, affecting access to protection services in particular. This includes gender-based violence (GBV) clinical care and case management, psychosocial support, sexual and reproductive healthcare, and monitoring of child protection cases. Clinical capacity

built over years of training and experience cannot be easily reconstituted in the current context, especially given that many experienced teaching staff have emigrated, universities and training programs have been damaged or disrupted, and standardization of qualifications is patchy. As the Ministry of Health acknowledges, these factors weaken the pipeline of new professional talent and perpetuate the shortage of skilled staff across the health system.[29]

Reviving health in Syria's south

When Syrians began returning to the south, the family health center in Saida, Dara'a was barely functional. Beyond routine childhood vaccinations, it had little to offer. Basic services had deteriorated sharply across the town: water reached households only once every 15 to 20 days, electricity outages were chronic, and sanitation infrastructure had largely broken down. These conditions contributed to acute public health risks, elevating the likelihood of water-borne disease outbreaks – including hepatitis and acute watery diarrhea – among a population already made vulnerable by years of displacement and its humanitarian side effects.

Saida's family health center has witnessed a surge in demand for its services as return movement accelerates in the region. RI responded by drilling new wells and installing a solar-powered pumping system that unlocked both electricity access and the reliable supply of safe, clean water to the health center and surrounding neighborhoods. It also invested heavily in the capacity of the health center to diversify its services. These interventions addressed a disconnect between return movements and local absorptive capacity, which, if left unaddressed, risked undermining the conditions for durable, dignified return in Dara'a and beyond.

Today, the center delivers a significantly expanded package of care, including pediatric services, internal medicine, reproductive and maternal health, nutrition consultations, and emergency treatment, supported by a fully operational pharmacy. According to a local council member, the facility now serves between 25,000 and 30,000 people, a catchment that extends well beyond the town. "Patients come not only from Saida, but from surrounding villages and displacement camps. Every day we receive nearly 100 patients. In just three months, more than 3,300 consultations were recorded," he confirmed. As Saida's population continues to grow with the return of displaced families, medical staff have identified laboratory services, dental care, and diabetes management as areas warranting urgent investment.

The center's strengthened capacity has had a tangible effect on families weighing return. For Amjad, 42, who came back after two decades abroad, accessible healthcare was more than a practical concern; it instilled confidence in return itself. The family sought care at the center when his son fell ill within days of their arrival. "The reception and care were equal to what I experienced abroad. Within a few days, he recovered. That gave us confidence that returning home was the right decision."

"For many people, this is their only access to healthcare. They cannot afford private clinics. Without this support, they would have nowhere to go."

– Hassan, nurse and local council member in Saida, Dara'a governorate

Saida Family Health Center has become a lifeline for primary healthcare in the town and surrounding areas. Project delivered by Relief International and funded by International Relief Teams (IRT) (Frontline in Focus, 2026).

A fractured system's response

The health system in areas of return is adapting – relocating primary healthcare centers, deploying mobile clinics, consolidating services – yet in ways that reflect the constraints of available resources rather than a planned or adequately resourced response to return-driven demand. Facilities such as Ras Al-Hisn Primary Healthcare Center and Al-Rahman Hospital in Idlib relocated in March and April 2025 respectively to keep pace with return movements in their original locations. Today, each responds to between 3,000 and 4,000 consultations a month. This adaptation holds significant value, and it warrants recognition and support. Equally, it should not be mistaken for a long-term solution. Mobile clinics can extend geographic reach; they cannot provide the continuity of care required for patients managing chronic conditions, cannot perform surgery, and cannot replace the specialist capacity that has atrophied over years.

The Ministry of Health's strategic plan offers a vision for moving towards "an integrated and resilience health system that provides equitable, high-quality healthcare that is accessible, affordable and available to reach for all."[30] Its emphasis on strengthening primary healthcare systems integration, rehabilitation, and workforce capacity speak to core priorities for rebuilding and modernizing the national health system over the longer-term. The work of national and international NGOs in partnership with the Ministry of Health is crucial to these efforts. Last year, Syrian NGO HiHFAD, with the support of the Aid Fund for Syria, rehabilitated five primary health centers in former frontline areas in southern Idlib and reconstructed 60% of Ma'arrat al-Numan National Hospital, establishing a dedicated and fully equipped outpatient department and installing sewage, ventilation, heating, and lighting systems throughout.[31] Intersos is rehabilitating PHCs and other basic infrastructure coupled with protection monitoring and assistance to ensure the safety and dignity of those reintegrating into their communities.

Furthermore, restoring access to essential healthcare services cannot occur in isolation. As area-based approaches utilized by Un Ponte Per and RI partner Action for Humanity indicate, enabling communities to lead healthy and safe lives and achieve durable solutions hinges on the restoration of a suite of basic services holistically at the district level, including WASH, school, and infrastructure rehabilitation. This includes efforts to reduce the public health impacts of climate change, as the International Federation of Red Cross and Red Crescent Societies (IFRC) Network Country Plan reinforces.

Aref and his daughter collect his prescribed medication from staff at RI's mobile clinic in Al-Tibni. Project supported by the EU (Frontline in Focus, 2026).

Disability in return: What's the prognosis?

The decision to return for Syrians living with disabilities or chronic health conditions goes beyond weighing security and shelter – it is also a determination as to whether quality of care and of life are possible. An estimated three million Syrians have been injured over the course of the conflict with approximately half living with permanent impairments, including some 86,000 who have undergone amputations.[32] Today, 28% of Syrians now live with some form of disability, making disability not a marginal concern but a central dimension of the return reality.[33]

Significant protection risks, accessibility barriers, and gaps in essential services constrain safe, dignified, and independent living during displacement. These conditions are particularly acute across much of Syria, where deliberate attacks on health infrastructure and personnel have left the system structurally unable to meet the needs of people with complex or ongoing care requirements. Rehabilitation services such as prosthetics, physiotherapy, and assistive device maintenance are among the most severely lacking and least consistently available facets of an already fragile system.[34] In Northwest Syria, nearly half of PWDs reported only partial access to assistive devices in 2024, while 41% had no access at all.[35] In the Northeast, 86% of RI MSNA respondents emphasized the absence of specialized services for PWDs, with notable gaps in Saffia, Muhasan, and Al-Mayadin sub-districts.

A young girl receives physical therapy through gaming; an initiative delivered by RI partner NSPPL in Türkiye (Ramzy Shrayyef, 2025).

For many with chronic conditions, years of displacement have been both a period of hardship and of carefully constructed healthcare relationships: a physician who knows their medical history, an accessible pharmacy that stocks their prescription, a hospital equipped with their devices, and a non-governmental organization (NGO)-run program covering their treatment costs. Despite the profound and well-documented gaps in health provision in displacement settings, those who have managed to establish access to care have often invested considerable effort to do so. Syrian organizations operating within the country and in neighboring Jordan, Türkiye, and Lebanon have played a crucial role in this regard. Return to Syria risks severing those relationships entirely, and potentially irreversibly, and requires constructing new care pathways in a health system that is both disjointed and under-resourced. For patients requiring regular monitoring, dosage adjustment, prosthesis refitting, or frequent therapy, this transition carries acute clinical risk. Rehabilitation services for people with physical disabilities – prosthetics, physiotherapy, assistive device maintenance – are lacking across the country. Returning to an area without access to the specialist care that has maintained one's functional independence in displacement is not a return to normal life; in many cases, it is a deterioration of health status.

The consequences of inadequate rehabilitation support and other components of care extend well beyond health, shaping access to education, employment, and social participation in ways that compound across a lifetime. One fifth of returnees with disabilities between the ages of 12 and 23 are attending school against substantially higher rates among their peers without disabilities. Nearly two-thirds of returnees aged 16 to 26 with disabilities are neither engaged in learning or employment, setting them profoundly behind at a critical stage of development.[36] PWDs are disproportionately excluded from economic opportunities due to discriminatory attitudes, a lack of tailored job opportunities, and inaccessible infrastructure. These barriers are especially high for women, who face intersecting restrictions. They are of growing relevance in the context of Syria's economic recovery and reconstruction.[37]

The erosion of services in displacement settings deepens these challenges. In Lebanon – home to an estimated 716,000 Syrian refugees registered with UNHCR[38] and the point of origin for a substantial share of current return movements – five rehabilitation centers have ceased providing services, 10 specialized schools for children with disabilities have shut down, and 113,000 PWDs are no longer benefitting from subsidized access to healthcare.[39] Strained asylum space in regional refugee hosting countries, coupled with the dismantling of services due to cuts in international development assistance, risk playing up pressures to return.[40]

In addition, widespread explosive ordnance contamination presents a perilous physical threat – one that falls with severity on those with disabilities and mobility impairments. Former frontline and agricultural areas, including communities in Deir-ez-Zor, Aleppo, Idlib, and Hama, are heavily contaminated. In January and February 2025 alone, 136 UXO incidents were recorded, resulting in 61 deaths and 93 injuries among farmers and shepherds. In the year since the collapse of the Assad-led government, 1,600 civilians faced unexploded ordinance casualties; 165 of those killed were children.[41] Returning to areas laced with explosive remnants of war is dangerous and risks generating new and additional disability cases if adequate demining and mine risk education are not urgently scaled up.

Against this backdrop, RI and its partners are working to bridge the gap between displacement and durable return for Syrians with disabilities in Türkiye. The EU-supported program restores and improves daily functioning through a continuum of specialized rehabilitation and assistive technology services, including psychosocial support for PWDs and their caregivers; physiotherapy and rehabilitation, with tele-rehabilitation extending coverage to rural and hard-to-reach patients; provision of prosthetics and orthotics; and assistive technology support, such as mobility aids, hearing aids, and spectacles. Among the few specialized organizations, the National Syrian Project for Prosthetic Limbs (NSPPL) is actively working to link refugee patients in Türkiye with service providers inside Syria, ensuring that integrated rehabilitation and case management can be sustained along the return journey. This cross-border model represents a crucial proof of concept for the kind of continuity-of-care infrastructure that must be built at scale if return is to be safe, dignified, and durable for the most vulnerable.

"With my prosthesis and rehabilitation, I regained my independence and returned to my studies and work."

– Hisham, 24, who received specialized rehabilitation at an NSPPL-supported center in Reyhanli, Türkiye

Conclusion

Taken together, these findings produce a snapshot of Syria's health system across governorates, methodologies, and analytical layers. A population with high and, in many cases, urgent health needs is returning to a system that is present only in partial, variable, and largely unaffordable forms. The barriers – cost, distance, equipment shortages, workforce absences, diagnostic gaps, rehabilitation deficits – are not independent challenges. They build on each other. A patient who can reach a facility but cannot afford the consultation, or who can afford the consultation but cannot purchase the medication, is a patient who risks going untreated. A person with a physical disability who can reach Syria safely but cannot access the prosthetics or physiotherapy that maintained their functional independence in displacement has not achieved a durable solution.

The coercive forces driving premature return – camp closures, erosion of protections in host countries, cuts to health programming in displacement settings – press on precisely this population. When a person with a chronic condition can no longer access the care that has kept them resilient in displacement, returning to an unknown health environment is an impossible choice between two forms of medical risk. International standards require that return be voluntary, safe, and dignified. For the hundreds of thousands managing life-threatening chronic conditions and millions more with basic health needs, those standards are not being met.

In the absence of improved conditions in areas of return, the risks of onward displacement must be taken seriously. IDPs who have returned from camps in northern Syria may not always have the option of moving back to these camps again, as camps are being closed gradually. Refugees returning from countries including Türkiye, Egypt, and Lebanon may inadvertently lose legal protection status in the host country, limiting options for the future. With more families returning to their homes and villages, the need for continued investment in healthcare becomes increasingly consequential for recovery and wellbeing. The future of the response depends on strengthening medical staff capacity, expanding training, upgrading equipment, and improving surrounding infrastructure.

Hadi and his family benefit from the restoration of healthcare at their local primary health center in Hazano, Idlib. Project delivered by Relief International through partners (Frontline in Focus, 2025).

Recommendations

The findings of this report point to emerging, urgent challenges of financing, governance, and operational delivery that have consequence for health and protection outcomes across Syria. Bridging the gap between what the current return environment offers and what Syrians require, particularly in terms of healthcare, demands a concerted and well-resourced response from the international community, health actors, and the Syrian government.

To international and national health actors operating in Syria:

- **Integrate health needs screening into facilitated return processes, strengthening linkages between referral pathways, case management, and continuity-of-care arrangements and public facilities at arrival destinations.** Current return counselling processes do not systematically screen for health dependencies before supporting movements. Health actors should develop and deploy standardized screening tools – covering chronic conditions, disability and rehabilitation needs, mental health status, and reproductive health – that can be administered in displacement settings and used to generate condition-specific return guidance. Where no viable care pathway exists at destination, actors should clearly communicate this to returnees and resist facilitating movements that impose clinical risk. Return-area planning should also integrate disease surveillance, vaccination, and outbreak preparedness, given large-scale population movements, weak WASH, overcrowding, and disrupted vaccination.

- **Strengthen linkages between return patterns and health service readiness by expanding and sustaining mobile health outreach while investing in the restoration of fixed PHC and hospital services, including diagnostics, essential medicines, referral capacity, and reliable water and power systems.** Mobile clinic models represent a vital form of immediate geographic coverage, particularly when linked to static healthcare facilities. At the same time, mobile provision cannot substitute for the continuity, specialist capacity, and diagnostic infrastructure that a functioning primary and secondary health system requires. Health actors should use mobile outreach data, including health-seeking behavior patterns, to build the evidence base for targeted facility rehabilitation, and invest concurrently in emergency coverage and durable health system capacity. Mental health and psychosocial support should be integrated as a core pillar of these services, and accountability and community engagement mechanisms established to help inform communities of service gaps, triage needs, and exchange reliable information to address mistrust and hesitancy.

- **Support and invest in Syrian health organizations as the backbone of any durable health system.** National and local Syrian NGOs are delivering critical services under conditions of reduced international funding and administrative fragility. Sustainable recovery requires meaningful capacity-sharing, direct funding where feasible, technical assistance, and progressive leadership of implementation in coordination with the Ministry of Health. International health actors should prioritize partnership arrangements that build Syrian organizational capacity, exchange specialized knowledge, and progressively shift implementation leadership to these organizations.

- **Prioritize gender-responsive health programming in areas of high return.** Female returnees experience the highest rates of anxiety and psychological distress documented in this research, and face the greatest structural barriers to accessing care, including the critical shortage of female medical staff and the absence of sexual and reproductive health services. Health actors should ensure that staffing, facility design, and essential package of primary health services in areas of return include dedicated capacity for maternal health, reproductive health, and mental health and psychosocial support for women and girls. Women's health needs must be systematically assessed and explicitly funded.

To the Syrian government:

- **Align camp closure and return facilitation to verified improvements in essential services in communities of origin, using clear, measurable health readiness benchmarks.** The current pace of camp closures risks separating people from their only available source of healthcare and basic services before viable alternatives exist in return areas. To avoid additional pressures on existing services, the government should align the Ministry of Health's Strategic Plan with minimum service provision in primary healthcare facilities in return areas as prerequisites for any camp closure process. Progress in restoring functioning public PHC points, essential medicines, referral pathways, emergency care access, workforce presence, and continuity of services in return areas coupled with facility and workforce mapping and governance mechanisms should be monitored at the sub-district level.

- **Accelerate implementation of the Ministry of Health Strategic Plan with a clear prioritization of areas of high return.** The Ministry of Health's 2026-2028 Strategic Plan articulates a sound vision for an integrated national health system. The gap between that vision and present conditions is most acute in high-return, under-resourced areas including rural Deir-ez-Zor and Rural Damascus. The government should continue to coordinate planned primary health facility restoration and investments in workforce retention, supply chains, data systems, and coordination with considerations of return movements and needs and ensure that national and international NGOs take advantage of the access and regulatory clarity required to operate in these areas.

To international donor governments:

- **Uphold the principles of voluntary, safe, and dignified return and resist pressure for premature returns.** Donor governments must not leverage aid conditions, refugee status reviews, or bilateral political arrangements to accelerate return movements before conditions are conducive, especially in the health sector. The international community must continue to support regional host country governments in sustaining asylum space and services for Syrians who are not yet prepared to return and simultaneously provide predictable, multi-year funding for continuity of care, public service reactivation, workforce support, and preparedness in underserved sub-districts of Syria.

- **Ensure early recovery support incorporates protection and health as foundational conditions.** Early recovery and reconstruction financing that does not account for health system functionality, displacement-linked demand, and the care needs of the most vulnerable will fail to produce durable outcomes. Donor governments should require that all recovery and reconstruction investments include baseline health access assessments and protection safeguards as conditions of disbursement and ensure alignment with MoH priorities, use existing coordination platforms, and support the transition

from fragmented humanitarian substitution toward complementary support to public system.

- **Fund continuity-of-care mechanisms for those managing chronic conditions and persons with disabilities, including linkages between assistance in refugee-hosting settings and communities of destination inside Syria.** RI's research documents the acute risk of care discontinuity for returnees who have established rehabilitation, prosthetics, and NCD management pathways in displacement settings, particularly given service erosion in regional refugee hosting contexts. The international community should invest in cross-border coordination models that link displacement-country service providers with care structures inside Syria, building on emerging models. UNHCR and the health cluster should be resourced to map and maintain continuity-of-care registries for medically dependent returnees.

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