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FACTSHEET

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Disability Inclusion in Syria: Bridging Promise and Practice

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Summary

In Syria, disability is not a marginal issue; it is rather a defining feature of the humanitarian and recovery context. 14 years of conflict, widespread use of explosive weapons, natural disasters, and the collapse of essential services have significantly increased the number of persons living with disabilities across Syria, while simultaneously eroding the systems meant to support them.

Syria ratified the Convention on the Rights of Persons with Disabilities in 2009. Yet, the gap between formal commitment and the lived reality of persons with disabilities remains profound, further deepened by years of conflict. As governance structures are rebuilt, as reconstruction plans are drawn, as return conditions are negotiated, and as international partners decide where to direct resources for Syria, **persons with disabilities must be at the center of every one of those conversations.**

The report draws on secondary data from trusted humanitarian and academic sources, as well as first-hand accounts from persons directly affected by the crisis, and consultations with humanitarian workers operating in the Syria response and national public and private actors. The findings of this factsheet point to several urgent priorities to ensure that persons with disabilities are not left behind as Syria moves toward recovery. Syria's Transitional Government must translate existing legal commitments into practice by operationalizing disability legislation, developing a disability-inclusive recovery framework, and ensuring that persons with disabilities and their representative organizations play a meaningful role in decision-making processes. Donors and UN agencies must treat disability inclusion as a cross-sectoral requirement embedded across humanitarian, recovery, and development programming, while providing sustained and flexible support to disability-focused services and organizations.

Across all sectors, the ongoing impact of explosive ordnance contamination, which continues to cause new disabilities and exacerbate existing vulnerabilities, must be addressed as a core component of recovery efforts, alongside increased investment in victim assistance, including physical rehabilitation, mental health and psychosocial support, and other services that support the recovery and inclusion of survivors. Ultimately, recovery in Syria will only be sustainable if the policies, systems, and services that shape it are designed with the meaningful participation of persons with disabilities and respond to their rights, needs, and priorities.

Disability in Syria: High Prevalence, Limited Data

Legal & Policy Framework

Syria is a State Party to the Convention on the Rights of Persons with Disabilities, signed in 2007 and ratified in 2009[1]. Syrian Persons with Disabilities Law No. 34 was adopted in 2004, establishing a foundational framework for the care, rehabilitation, and employment of persons with disabilities[2]. A more recent development is the Legislative Decree No. 19 of 2024 related to the rights of persons with disabilities and the obligations of public and private entities towards them[3].

15.6M	28%	37–48%
people — nearly two-thirds of the population require urgent humanitarian assistance in 2026 (OCHA, HNRP, 2026)	of persons in need are estimated to have disabilities — likely underrepresented due to data gaps	disability prevalence in Northeast Syria — one in every two or three people (HI data)

Understanding the true scale of disability in Syria is itself a challenge, and the inconsistency in the figures most commonly cited reflects a deeper structural problem. Estimates of disability prevalence in Syria vary significantly: some sources cite 28%[4], while older reports referenced 17%. Rather than indicating a settled picture, this discrepancy reveals the need to consolidate existing data into a reliable, updated, and nationally representative perspective.

Syria's last national population census was conducted in 2004, over two decades ago, and no census has been carried out since due to the conflict. Additionally, no dedicated national disability survey has been conducted, largely due to funding shortfalls and the absence of technical support[5].

Administrative records remain fragmented across ministries and capture only a portion of persons with disabilities, particularly those registered with social service centers, resulting in significant underestimation due to access barriers, displacement, stigma, and institutional distrust[6].

A 2023 report from northern Syria found that 52% of people aged two and above live with a disability or experience difficulties in daily activities[7] (ACU, 2023). This is more than three times the global average of 16%[8] [9].

The conflict in Syria has both increased the prevalence of disability, through injuries, explosive ordnance contamination, trauma, and the erosion of healthcare, and systematically deepened the barriers that persons with disabilities face in accessing basic services, protection, and recovery.

Photo Caption: Rama, 10 years old, during a physical rehabilitation session| at Ma'arat Misrin Hospital, Idlib. ©HI/ Syria Team

Photo Caption: Abdullah, 35 years old, during a physical rehabilitation session at Raqqa National Hospital, Raqqa. ©HI/ Syria Team

Systematic Gaps in Inclusive Recovery

1. Multiple Displacements Deepen Vulnerability for Persons with Disabilities

Persons with disabilities face compounded barriers throughout displacement and return. Due to physical and communication barriers, social stigma, and exclusion from planning processes, they often struggle to access assistance and protection. These challenges persist and often intensify during return. Information on return processes is rarely accessible; transportation systems do not accommodate diverse needs, and return locations are often difficult to reach. Many individuals return to environments that are less supportive than displacement settings, particularly when essential services such as rehabilitation are unavailable, creating a significant deterrent to sustainable return[10].

According to the 3RP Regional Strategic Overview 2026, around 11 million Syrians remain forcibly displaced, with nearly four million taking refuge in neighboring countries[11]. Ongoing conflicts, natural disasters, climate-related shocks, and worsening economic and humanitarian conditions continue to drive vulnerability, with as many as nine in ten Syrian refugees unable to adequately meet their basic needs, while host communities face growing pressure for support[12]. Within Syria, there are over 5.5 million internally displaced persons (IDPs), alongside 1.5 million who had returned to their areas of origin[13].

While the significant changes in December 2024 have opened new prospects for voluntary return and recovery, protection risks and humanitarian needs persist and require sustained attention. According to the Enhanced Refugee Perceptions and Intentions Survey (eRPIS), 80% of refugees hope to return one day, with 18% expressing the intention to do so within the next year[14]. By the end of 2025, over 1.3 million Syrians had already returned[15].

Since December 2024, approximately 1.86 million internally displaced persons (IDPs) have returned to their areas of origin; however, only around 987,000 departures from IDP sites were recorded. This suggests that many returns involved people leaving host communities or experiencing secondary displacement rather than achieving durable solutions[16].

While return figures continue to rise, they risk masking the reality that conditions for safe, dignified, and sustainable return remain absent for many Syrians. More than one million people remain in IDP camps across Syria, and assessments indicate that most camp residents do not foresee conditions that would enable them to return safely in the near future[17]. Structural barriers continue to significantly limit refugees' intentions to return. In addition to 77% of refugees citing safety and security concerns, the most frequently cited barriers also include housing availability and property damage (36%), limited employment opportunities (28%), and lack of financial resources to support the journey (7%).

Photo Caption: Two girls coloring in Khasham village, Deir Ezzor, after returning home following years of displacement. © HI

These concerns are compounded by the reality on the ground: 87% of refugee-owned properties in Syria are destroyed or severely damaged, while 58% of property owners lack the documentation needed to legally reclaim their homes[18].
While these structural barriers affect the broader refugee population, they are acutely compounded for persons with disabilities. Destroyed housing is not merely a logistical obstacle but an accessibility crisis; limited employment disproportionately excludes those with physical or psychosocial impairments; and safety concerns, including explosive ordnance contamination, carry heightened consequences for those with limited mobility.

These challenges fall with particular severity on displaced women, female-headed households, and mothers of children with disabilities. HI consultations emphasize the reality of unmet needs that

remain largely invisible in aggregate return statistics. In rural and village settings, families of up to 15-20 members are crowded into partially destroyed homes with little more than mattresses on bare floors. Conditions are wholly inadequate for persons with disabilities, and girls with disabilities are frequently confined to the home with no access to rehabilitation, education, or social participation. The burden of caregiving falls overwhelmingly on women: mothers of children with disabilities are often left to navigate all medical follow-up, therapy appointments, and consultations on their own, while fathers are absent for work or in search of employment. This gendered distribution of care, compounded by destroyed infrastructure, lack of adaptive equipment, and the near-total absence of disability-inclusive services in return areas, leaves women simultaneously managing household survival and the complex needs of family members with disabilities.

IDP Camps and Informal Settlements

Photo Caption: Children near temporary shelters in Mari'yeh village during an HI field visit in May 2026. © HI/Syria Team

IDP camps and informal settlements in Syria have been characterized by overcrowding, poor shelter conditions, and limited basic services even for the general population. For persons with disabilities, these settings present additional structural barriers[19]. Tents, unfinished buildings, and collective centers are the predominant shelter typologies for Syria's 1.2 million IDPs still in camps.

They are typically inaccessible: no ramps, narrow doorways, uneven surfaces, and communal sanitation facilities that cannot be used by persons with mobility impairments[20]. These forces persons with disabilities into a state of near-constant dependence on others for basic daily functions including hygiene, which carries serious dignity and protection implications, particularly for women and girls with disabilities.

Given that nearly 70% of sites are overcrowded, retrofitting for accessibility remains financially difficult, resulting in persistent exclusion from assistance and services[21].

These structural barriers are further compounded by the breakdown of traditional care systems within displacement settings. The 2025 Multi-Sector Needs Assessment (MSNA) data notes that women serve as primary caregivers in over 95% of Syrian households; when caregivers are themselves displaced, injured, or killed, persons with disabilities can be left entirely without support[22].

Areas of Return and Secondary Displacement

"We are originally from Al Hasakeh, but we were displaced again after the escalation in January 2026. This is the second time we have lost our home. My grandchild, Abdul Rahman, has hearing and speech disabilities. We only discovered it after saving enough money to take him to a doctor, who told us he needs a hearing device. As a family, we keep trying to save and borrow money to help him, but everything takes time when you are displaced and struggling to survive. The second displacement made everything harder for him. In a new place, surrounded by unfamiliar people and dangers, he cannot understand what is happening around him." - Fathila Hamadi, 52, Mari'yeh Village

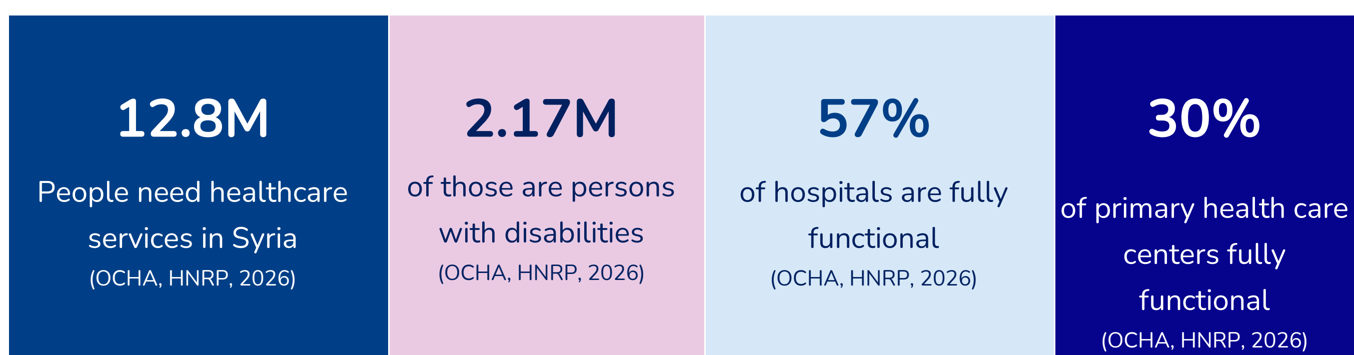
Photo Caption: Abdul Rahman, six years old, Mari'yeh Village. © HI/Syria Team

Areas of return are among the most heavily damaged in Syria. The Nationwide Housing Damage Assessment confirms that at least 6.2 million Syrians need shelter repair, with destroyed homes, missing roofs, rubble-filled access paths, and non-functional basic infrastructure[23]. For persons with disabilities, and especially persons with mobility impairments, returning to a structurally damaged home is not simply uncomfortable; it can render independent living entirely difficult.

A particularly concerning pattern highlighted in the 2026 HNRP is that of secondary displacement; returnees who, having returned to their areas of origin, are subsequently displaced again because conditions do not support reintegration[24].

This cycle disproportionately affects persons with disabilities. When a person with a disability arrives in an area with no functional health infrastructure, no rehabilitation services, no accessible shelter, and no livelihood pathway suited to their capacity, the conditions for sustainable return are absent. Faced with these barriers, some return to displacement sites or move to urban centers in search of services, creating a cycle of repeated displacement that deepens vulnerability and erodes resilience. Persons with disabilities who experience secondary displacement are also likely to lose whatever fragile support networks: family, community, and informal care arrangements they had managed to rebuild, compounding their isolation and protection risk.

2. Healthcare Access and the Cost of Exclusion



The protracted conflict in Syria has left a fragmented and collapsed health system that is actively deepening disability in Syria. The health system is also now chronically underfunded and struggling to meet the needs of millions.

Decades of underinvestment and 14 years of conflict have led to the near collapse of Syria's primary health care system. Health infrastructure has been widely damaged, including hospitals targeted in airstrikes, and over 50– 70% of the health workforce has left the country, putting immense pressure on those who remain[25].

Structural underfunding is now driving service-suspension risks across the country. With only half of planned budgetary support realized in 2025, and with funding beyond April 2026 uncertain for critical primary healthcare centers, the continuity of essential health services cannot be guaranteed. At risk are 23 hospitals, 150 primary healthcare centers, and 53 mobile or other health units, many

of them dependent on short-term funding cycles that create service gaps and delays in care[26].In areas hosting IDP camps, where health service provision is almost entirely donor-dependent, any reduction in funding translates directly and rapidly into deteriorating service availability. Without sustained investment, preventable maternal and child deaths, untreated injuries, and uncontrolled disease outbreaks become inevitable.

Even where services remain operational, access to them is far from guaranteed. Health facilities are often located far from displacement sites and areas of return, require transportation that is unaffordable or unavailable, and are frequently housed in damaged or makeshift structures that present significant physical barriers.

These constraints disproportionately affect persons with disabilities. Transportation barriers, financial limitations, and inaccessible infrastructure restrict their ability to seek care, resulting in delayed rehabilitation sessions, missed vaccinations, unmanaged chronic conditions, and preventable complications. As a result, the health system increasingly relies on costly emergency interventions rather than preventive care, further weakening overall public health outcomes[27]. For instance, field-level data from HI's January 2026 rapid assessment in Aleppo corroborates this: nearly one in three individuals (31.8%) reported unmet medical needs, and 23.2% required physical rehabilitation[28].

The 2025 MSNA found that 91% of respondents reported paying for health services, rising to 95% among returnees, with high medicine costs, transportation expenses, and long waiting times cited as the primary barriers[29]. For persons with disabilities, transportation is not merely a financial burden but a functional barrier. Standard minibuses, shared taxis, and informal transport; the dominant modes of movement in Syria are not adapted for wheelchair users, persons with mobility impairments, or those who require assistance to travel.

This burden is further compounded for women and girls with disabilities, who face intersecting layers of discrimination based on both gender and disability. In northern Syria, such intersection restricts access to education, employment, and essential services, with women and girls with disabilities reporting higher rates of feeling unsafe in their communities compared to women without disabilities[30]. The UN Committee on the Rights of Persons with Disabilities has noted that persons with disabilities who fled the armed conflict in Syria were "disproportionately at risk of being neglected, excluded or even abused," with women and children with disabilities identified as particularly at risk[31].

Access to maternal and child healthcare is especially precarious for women with disabilities. In northwestern Syria, women with disabilities navigating reproductive healthcare encounter financial, social, and psychological barriers, while maternal and newborn health materials are not regularly available in accessible formats, and facilities are often physically ill-equipped for their needs[32]. More broadly, women requiring maternal care across Syria face dwindling access to specialized services, while children experience disrupted vaccination schedules and severe shortages of pediatric care[33].

Moreover, the systematic attacks on healthcare facilities throughout the 14-year-conflict have reduced women and girls' access to reproductive health services across many areas of Syria[34]. Vital reproductive healthcare facilities offering life-saving services are on the brink of closure, while safe spaces for women and girls, essential for survivors of gender-based violence, are being shut down, leaving them without refuge or support[35]. In Syria, women and girls with disabilities already experience multiple forms of discrimination and stigma that severely limit their access to services and resources — layers of exclusion that are superimposed on a broader crisis of gender-based violence affecting the general population[36]. At the end of 2024, 93% of the approximately 8.5 million people in need of gender-based violence assistance in Syria are women and girls, while support services for survivors are increasingly limited due to funding shortfalls. These gaps fall most heavily on those least able to navigate an already inaccessible system[37].

Field Testimony-a Child's Long Road to Recovery

Amer Mathloul, 11 - Khasham Village, Deir Ezzor, Syria, 2025–2026

When HI met Amer in August 2025, he was already using a wheelchair after losing his leg in a landmine accident — shortly after his family returned home following seven years of displacement. Today, nearly a year later, he has a prosthesis.

The journey has not been easy. First a wheelchair, then crutches, and now a prosthetic leg. After the amputation, Amer spent nearly a year waiting for a prosthesis while attending consultations and follow-up appointments. The family regularly travelled to Al-Kasra to access services — a journey that was both exhausting and costly.

Yet, when asked what he usually does during the day, Amer smiles. **"Most of the time, I'm outside with the other children. We play together, and I also spend time with my doves. I have around ten of them."** — he says proudly.

While receiving the prosthesis marked an important step forward, the need for rehabilitation support continues. Follow-up appointments have recently been suspended, leaving the family uncertain about when Amer will be assessed again.

Many challenges also remain beyond rehabilitation. Amer and his siblings are still out of school. The nearest school remains damaged, while the closest functioning school is too far for him to reach.

Photo Caption: Amer during an HI visit in Khasham Village, Deir Ezzor, August 2025 © HI/ N.Bimbashi

Photo Caption: Amer after receiving a prosthesis nearly a year after a landmine injury. Khasham Village, Deir Ezzor, May 2026. ©HI N.Bimbashi

> **"If there was a school nearby, I would go. But the other school is far away. I can't walk for long distances, and we don't have a car."** — Amer

For Amer, the prosthesis marks an important step toward regaining mobility and independence. Additionally, continued rehabilitation, follow-up care, and access to education remain essential for children like Amer as they rebuild their lives after years of displacement and conflict.

Physical Rehabilitation: unmet needs and lack of access

In low- and middle-income countries, more than 50% of people do not receive the rehabilitation services they require. In emergencies, needs surge dramatically while services are disrupted or deprioritized[38]. Despite its recognized importance, rehabilitation is rarely integrated into preparedness and early response, widening existing gaps and increasing the risk of long-term disability[39].

Persons with disabilities, who represented 24.4% of the assessed population in HI's January 2026 rapid assessment in Aleppo, accounted for 90.9% of all rehabilitation needs and 94.7% of all MHPSS needs identified — a concentration of need that reflects both their heightened vulnerability and their systematic exclusion from mainstream services[40].

This global pattern is reflected and intensified in Syria. Against this scale of need, Syria's rehabilitation infrastructure is inadequate. The number of trained physiotherapists, occupational therapists, prosthetists, and orthotists falls far below what is required. Many skilled rehabilitation professionals left Syria during the conflict. Those who remain are concentrated in urban centers, leaving many people in rural areas, camps, and other areas across Syria with little or no access to services. The 2026 HNRP notes continued out-migration of trained health professionals as an ongoing concern[41].

Post-surgical care and long-term rehabilitation following trauma, which is essential to prevent secondary complications, chronic pain, and permanent functional loss are frequently unavailable or interrupted. The 2026 HNRP explicitly identifies trauma care, post-operative rehabilitation, and long-term post-surgical care as areas that must expand as part of wider systematic investments, yet funding for these services remains far below what is needed[42].

“When Hadi was around one and a half years old, I began noticing that he could not balance himself like other children. He could not walk properly and kept falling. After a year and a half, he underwent tendon surgery. Since then, his life has revolved around physical rehabilitation, exercises, medications, and hospital visits. Hadi needs a walker because he cannot keep his balance on his own. HI will provide one for him once he progresses further with walking and balance.

Photo Caption: Hadi during a physical rehabilitation session supported by HI, Hamdanyah Public Health Center (PHC), Ma’arrat Misrin. © HI/ Syria team

I think a lot about sending him to school. I want him to have a normal childhood, friends, and an education like any other child. But I am deeply afraid that other children will bully him. Hadi is extremely sensitive, and I try to protect him from feeling hurt or different. What hurts the most is not only his condition, but the feeling that families like ours are left alone trying to figure everything out by themselves.” – Nadia, mother of eight-year-old Hadi, Ma'arrat Misrin, Idlib Governorate.

Child Disability, Nutrition and Health

The 2026 HNRP reports that 557,175 children under five are living with disabilities in Syria, facing substantially heightened risks of malnutrition. Children with disabilities are 34% more likely to be stunted and 53% more likely to experience acute respiratory infections than Syrian children without disabilities— compounding vulnerabilities that, without intervention, create a cycle of worsening health outcomes and deepening the risk of long-term impairment[43].

Acute malnutrition among children under five reached 5.5% in 2025, up from 1.7% in 2019[44]. For children with disabilities, malnutrition is not simply a consequence of food insecurity, it is also driven by disability-specific factors, including feeding difficulties, swallowing disorders, increased metabolic demands, and the absence of therapeutic feeding support adapted to children with physical or developmental disabilities.

The Invisible Wounds of Years of Conflict

In Syria, an estimated one in 10 people live with a mild to moderate mental health condition, while one in 30 are likely to experience more severe conditions that significantly affect their ability to function in daily life. Mental health needs have intensified further in areas directly affected by recent conflicts, including the coast and southern regions[45].

The scale of mental health needs in Syria is enormous and deeply intertwined with disability. The 2026 HNRP notes that depression, anxiety, and post-traumatic stress disorder are among the most common conditions, with the 2025 MSNA indicating that 56% of communities report limited availability of mental health services[46].

The 2025 MSNA highlights increasing substance use as a coping mechanism across the Syrian population, further straining available mental health services and creating new patterns of complex need among persons with psychosocial disabilities[47].

Persons who acquired disabilities during the conflict through explosive ordnance injuries, conflict-related trauma, or medical complications face a distinct mental health challenge: the psychological adjustment to a newly acquired disability in a context of extreme adversity, with no access to psychosocial support, peer support networks, or disability-positive communities[48]. The grief, loss of identity, and social stigma associated with disability acquisition in the Syrian context are well documented, yet psychosocial support services specific to this experience are almost entirely absent.

Photo Caption: Children playing outdoors during an HI field visit. © HI/ Filippo Mancini

Specialized mental health services (psychiatrists, clinical psychologists, and trained mental health counsellors) are severely depleted in Syria. The integration of mental health into primary health care, while recommended and partially implemented, remains uneven and inadequately resourced, particularly outside major urban centres[49].

The mental health burden falls with particular severity on women, children, and displaced persons with disabilities. A 2025 cross-sectional study found that 63% of women in Syria reported daily anxiety, rising to 71% among displaced women, who also reported significantly lower mental health scores than their non-displaced counterparts (Çakır-Mete et al., BMC Women's Health, 2025)[50]. In Raqqa Governorate specifically, partner violence, severe food insecurity, and perceived deprivation of basic needs were each independently associated with higher depressive symptom scores among women — a combination of stressors borne disproportionately by women with disabilities, who face additional layers of social exclusion and economic dependency[51].

For persons with disabilities in Syria, a key driver of psychosocial distress is the inability to find work and the resulting dependency on family savings, which in the context of prolonged conflict leaves women with disabilities particularly exposed[52]. Among children, studies on Syrian war-affected populations document a pooled post-traumatic stress disorder prevalence of 36%, with internally displaced children bearing a higher burden of mental health problems than non-displaced children, and approximately one in five reported to have been exposed to violence[53].

For children with disabilities in displacement settings, this is compounded by the loss of assistive devices, disrupted therapy, and the near-total absence of disability-specific psychosocial support in camp environments.

The intersection of disability and mental health in Syria is one of the most acute dimensions of the broader crisis, and one that carries long-term consequences extending well beyond the current emergency.

"After Layan was born, she was not moving her hands, she could not even crawl, and she cried constantly as if she was always in pain.

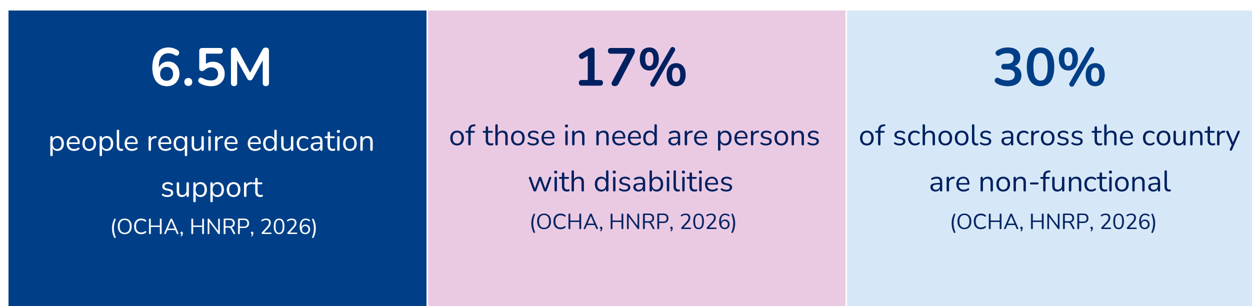
For months, I lived with confusion and fear, watching my daughter suffer without understanding why. It is one of the hardest feelings for a mother, seeing your child in pain while having no answers.

Now Layan is two years old. After receiving physical rehabilitation through HI, she is slowly improving. She has started making small progress, even with walking, and every tiny step feels huge to me. But reaching these services was not easy at all. Having a child with a disability is already difficult, but displacement makes everything heavier. My whole family is displaced, so I am mostly alone.

Photo Caption: Layan, two years old, during a physical rehabilitation session at Ma'arat Misrin Hospital. © HI/ Syria Team

Still, when I see Layan slowly improving, it gives me the strength to continue. I just hope there can be more support for families like ours, because sometimes what people need most is not only treatment, but also someone to stand beside them."— Fatima, Layan's Mother, Ma'arrat Misrin.

3. The Right to Education: Structural Exclusion and Lost Generations



"I fear that I will never achieve my dream of getting an education and that I will remain without schooling. My dream is to become a teacher so that I can teach other children with disabilities." – Radwan, 13 years old, Deir Ezzor.

In 2026, an estimated 6.5 million people in Syria require education support, with persons with disabilities accounting for approximately 17% of those in need[54]. Over 8,000 schools, approximately 30% of the country's total, are non-functional. An estimated 2.5 to 2.7 million children are out of school, and a further one million are at risk of dropping out[55]. In HI's January 2026 Rapid Needs Assessment conducted in Afrin and Jebel Saman districts following the escalation of violence in Aleppo, only 29.5% of children in the assessed population were currently enrolled in school, a figure that reflects the broader national pattern of severe educational disruption[56]. Additionally, 50% of assessed schools reported disruptions in 2025, with students missing an average of 25.5 instructional days due to insecurity, natural hazards, teacher absence, and the continued use of schools as displacement shelters[57]. The education system in Syria is operating at the edge of its capacity for the general population. The highest numbers of non-functional schools are recorded in Aleppo, Al-Hasakeh, Ar-Raqqa, Deir Ezzor, Hama, Idleb, and Homs[58]. Over 60% of school-aged children with severe mental or physical disabilities are estimated to have never attended school or any other form of education[59]. Even when enrolled, children with disabilities face higher risks of violence and exclusion and encounter significant barriers to accessing education and other basic services that meet their needs.

"I am a father of seven; five boys and two girls and none of them are in school anymore. This is one of the hardest things for me. Education used to feel within reach, but today, it's simply too expensive for us." — Mohammad Mousa, 64-year-old, Raqqa

The barriers keeping children with disabilities out of school in Syria are multiple and intersecting. Physical inaccessibility of schools, the absence of trained teachers, family decisions to keep children with disabilities at home due to safety concerns or stigma, the cost of transport and

materials, and the perception that education is not relevant or achievable for children with disabilities all contribute to a pattern of exclusion that begins early and compounds over time.

Education is not a peripheral concern for children with disabilities in Syria. It is a protection mechanism, a developmental necessity, and a determinant of lifelong outcomes. When children with disabilities are excluded from education, the consequences extend far beyond missed schooling. They include heightened exposure to abuse and exploitation, deepening social isolation, loss of developmental milestones that cannot be recovered, and entrenchment of a cycle of poverty and exclusion that will persist into adulthood and across generations.

Physical Inaccessibility of Schools and Learning Environments

The most visible barrier to education for children with disabilities in Syria is the physical inaccessibility of school infrastructure. Syria's schools were largely built without accessibility standards, and years of conflict damage have rendered even basic physical access impossible for many children with mobility impairments[60].

The 2025 Joint Education Needs Assessment found that 17% of classrooms in functional schools are non-operational, 41% of latrines are unsafe, 46% of sanitation facilities are not gender-segregated, and 36% of schools have irregular water access[61]. These figures describe conditions for the general school population. For children with disabilities, these conditions are compounded by the near-universal absence of ramps, accessible toilets, wide doorways, appropriate seating, and other minimum accessibility standards that would make the physical environment navigable.

Recent findings by Humanity & Inclusion (HI) from Northeast Syria highlight both progress and persistent gaps. An assessment conducted across 11 Child Development Centers (CDCs) in Raqqa and Deir Ezzor, using accessibility audits, key informant interviews, and focus group discussions with 100 children, caregivers, and education staff found that learning spaces average only 41% compliance with minimum accessibility standards. The most critical barriers were identified in WASH facilities and signage and orientation, with 10 out of 11 centers lacking adapted toilets.

Radwan lives in a rural area of western Deir Ezzor. He has a physical disability and faces difficulties with self-care. Despite being 13 years old, he has never attended school. Like many children with disabilities in the area, Radwan faces multiple barriers to accessing education. There are no nearby inclusive schools, infrastructure remains inadequate, and support services are limited. Yet Radwan's ambition remains simple.

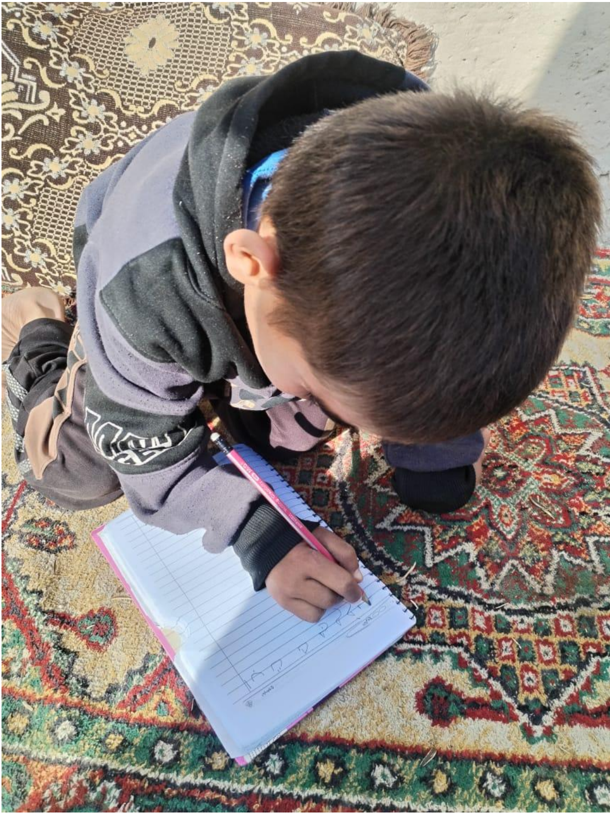


Photo Caption: Radwan, 13 years old, learning the alphabetics. © H/ Syria Team

"My dream is to learn like any other child," **he says.** ***"It is one of my most basic rights, and it will help me in my life."*** **-** Radwan, 13 years old, Deir Ezzor

Radwan's father says: **"As the parent of a child with a disability, I see that my son has a strong desire to learn. However, there are no schools willing or able to accommodate him, or other children with disabilities. I also work full-time, which makes it difficult for me to commit to transporting him, even if there was a nearby school that was accessible and adequately equipped. These challenges prevent my child from accessing education and from participating in society like other children. Education and inclusion are among the most basic rights needed to live with dignity."** – Ahmad, Radwan's Father, Deir Ezzor.

Absence of Inclusive Education Approaches

Teacher capacity across Syria's education system is severely constrained. The 2026 HNRP notes that many teachers require introductory induction, subject-specific training, inclusive education skills, and access to teaching materials. Teacher shortages and absenteeism linked to insecurity, low pay, and long commutes further affect quality[62]. In this context, the specialized knowledge and skills required to teach children with diverse learning needs, including children with visual, hearing, physical, intellectual, and psychosocial disabilities are almost entirely unavailable in most schools.

The situation is further compounded by deeply entrenched attitudinal barriers. In many Syrian communities, disability carries a significant social stigma. Beyond schools and learning centers, social stigma, gender norms, poverty, and safety concerns remain powerful drivers of exclusion, particularly for girls with disabilities and displaced families. Compared to other households, those headed by a person with a disability were twice as likely to report safety and security concerns related to discrimination based on personal characteristics, including disability[63]. Women with disabilities are two to three times more likely than other women to experience violence, including violence perpetrated by family members, partners, caregivers, and within institutional settings. Women and girls with intellectual and psychosocial disabilities face particularly heightened risks, experiencing violence at rates two to four times higher than women without disabilities[64].

For families living in displacement, particularly in camps and informal settlements, the decision not to enroll a child with a disability in school is often not a choice but a practical response to the absence of any viable option. If the nearest school is physically inaccessible, if there is no transport, if the child would be placed in a classroom where no one is equipped to support them, and if the journey exposes the child to safety risks including explosive ordnance contamination, the rational decision for a family under extreme stress is to keep the child at home.

Photo Caption: An Abandoned Classroom, Deir Ezzor.
© HI/ Syria Team

4. Explosive Ordnance Contamination and the Disproportionate Impact on Persons with Disabilities

Explosive ordnance contamination constitutes one of the most severe and enduring protection threats facing civilians in Syria. More than a decade of conflict has produced a complex and evolving contamination landscape across residential areas, agricultural land, infrastructure, and essential service locations. According to the Landmine Monitor, Syria recorded the second highest number of explosive ordnance casualties globally in 2024, with 1,015 casualties, surpassed only by Myanmar, and ahead of Afghanistan and Ukraine[65]. Casualties have risen steadily each year since 2022, from 834 in 2022 to 933 in 2023 and 1,015 in 2024, with a major spike reported from late 2024 into 2025 as people returned from displacement following the political transition of December 2024. One-third of all recorded casualties were children[66]. In 2025, casualties tripled compared to 2022.

Since December 8, 2024 through May 2026, 1,261 incidents have been recorded across Syria, resulting in 2,288 casualties; 808 killed and 1,477 injured, among them 246 children killed and 588 children injured[67]. The scale of ongoing contamination is further underscored by UNMAS reporting from June 2025, which noted that since January 2025, operators had identified 141 minefields and 450 contaminated hazard areas in Northwest Syria alone. Nonetheless, survey remained ongoing in Central and South Syria and emergency Explosive Ordnance Disposal (EOD) spot tasks constituted the primary response modality in the Northeast[68].

Explosive ordnance is both a direct cause and a compounding factor of disability in Syria. Blast injuries from landmines, unexploded ordnance, and improvised explosive devices are among the leading causes of acquired physical impairments in the country, due to traumatic amputations, vision and hearing loss, spinal injuries, and severe burns. Psychological trauma, including post-traumatic stress disorder, anxiety, and depression, constitutes an additional and frequently under-documented dimension of EO-related disability.

For persons with disabilities, the consequences of explosive ordnance incidents are often more severe, and recovery pathways considerably more limited, given existing barriers to healthcare, rehabilitation services, and assistive devices, all of which remain unevenly available across governorates.

Photo Caption: Explosive ordnance in a field in Deir Ezzor. © HI/ Syria Team

Mobility impairments restrict the ability to identify, avoid, or evacuate contaminated areas. Sensory and cognitive disabilities limit access to risk education and early warning information, particularly where outreach methods are not adapted to diverse needs. Dependency on caregivers, reduced economic agency, and social marginalization further constrain the capacity of persons with disabilities to make informed, protective decisions about the hazards around them[69].

Livelihood-driven exposure intensifies these vulnerabilities. Sustained economic pressure compels many households, including those with members with disabilities, to access contaminated farmland, collect scrap metal, clear rubble, or engage in informal construction despite known risks. The hardest-hit areas are predominantly rural, agricultural, or communities depopulated and destroyed during the war.

For example, the annual truffle harvest season running from February to April draws rural households into desert areas heavily contaminated with landmines and explosive remnants of war. This year's season was among the most abundant in recent years, bringing more people into contaminated lands, driving a corresponding rise in casualties and newly acquired disabilities among those with no alternative source of income.

As for displaced populations, they are the most at risk of encountering landscapes riddled with EO, with poverty driving many to disregard safety warnings in pursuit of basic livelihoods. According to the Mine Action Area of Responsibility in Syria, since December 8, 2024 through May 2026, 817 incidents occurred in farmland or grazing areas alone. Recent data illustrate the continued lethal nature of this exposure. Over a single reporting week, 18 explosive ordnance-related accidents and incidents were recorded across Syria, resulting in 24 casualties: 6 people killed (4 men and 2 children) and 18 injured (8 men, 1 woman, and 9 children). The incidents spanned nine governorates, with Aleppo recording the highest concentration at five incidents, followed by Deir Ezzor with four and Rural Damascus with three. On April 29 alone, five incidents were recorded across five different governorates, while May 2 and 4 together accounted for eight incidents across five governorates[70].

The geographic scope of contamination compounds these risks for persons with disabilities. Deir Ezzor, Aleppo, and Idlib remain the three most affected governorates. Protection monitoring indicates that more than 30% of key informants reported explosive ordnance contamination within 10 kilometers of their community, with 80% of those areas also reporting EO-related civilian incidents[71].

“When we returned to our village, Al Mari’yeh, after years of displacement, we thought the hardest part was over. One day, while we were clearing the debris from our damaged house, a landmine exploded beside me. I got injured last year. My family heard the explosion immediately and rushed to save me before taking me to the hospital.

It has now been a year since my injury, and there are still no proper services available for me. I was only given crutches, but I do not like using them. People my age look at me differently when I walk with them, and it makes me feel ashamed. Sometimes I prefer not to leave the house at all.
When I was in the hospital, the doctors promised that after treatment, I would be able to return to school. Before the injury, I was known for doing very well in school. Mathematics was my favorite subject, and I dreamed of becoming a math teacher one day. But when the time came, I could not bring myself to go back.

Photo Caption: Hamza, 16 years old, injured by a landmine, Deir Ezzor. © HI/ Syria Team

I felt embarrassed to walk into school with crutches, so I stayed home instead. I try every day to feel stronger, and my family supports me as much as they can. But it is not an easy journey.” – Hamza Al Sheik, 16, Al Mari'yeh village, Deir Ezzor.

Recommendations: The Path Forward

1-	To the Syria Transitional Government
01	**Move from policy commitments to implementation** by operationalizing Legislative Decree No. 19 of 2024 and Law No. 34 of 2004, aligning both with UNCRPD obligations through enforceable regulations, designated ministerial accountability, and dedicated budget lines. Operationalization must include independent monitoring, with meaningful participation of organizations of persons with disabilities (OPDs) in oversight mechanisms.
02	**Develop a national disability-inclusive recovery plan** in coordination with local civil society organizations, organizations of persons with disabilities, national and international non-governmental organizations, and service providers. This plan must consolidate and operationalize all aspects of disability inclusion across recovery sectors — health, rehabilitation, education, shelter, livelihoods, protection, and mine action — into a single, time-bound, costed framework with designated ministerial accountability. Critically, the plan must establish independent accountability and citizen-led monitoring mechanisms, with meaningful and ongoing participation of organizations of persons with disabilities at every stage of design, implementation, and review. A plan developed without the people it concerns is not a disability-inclusive plan.
03	**Integrate disability inclusion across all recovery planning** — health, education, shelter, livelihoods, mine action, and return, by establishing a national multisectoral coordination committee led by the Ministry of Social Affairs and including the Ministries of Health, Education, Public Works, and Economy, formalizing accountability along ministerial lines. This requires designated disability focal points within each relevant ministry, disability impact assessments for all recovery programs, and accessibility as a prerequisite in reconstruction.
04	**Ensure that victim assistance is embedded within disability-inclusive programming.** Victim assistance carries distinct obligations that extend beyond disability inclusion, including preventative elements, dedicated rehabilitation pathways, and psychosocial support. Survivors of explosive ordnance, the families of those killed or injured, and affected communities must have their basic needs met in a timely manner, safe access to mainstream and disability-specific services, and assistance to compensate for loss of homes and livelihoods resulting from explosive weapons contamination.

05	**Prioritize rehabilitation as a core component of health system recovery**. Expand physiotherapy, occupational therapy, prosthetics, and orthotics services to all affected governorates, addressing the documented shortages of trained rehabilitation personnel and materials that leave persons with disabilities, particularly in rural areas, camps, and areas of return without any access to services. Post-surgical rehabilitation must be treated as clinically essential, not optional: its absence leads directly to preventable secondary complications, chronic pain, and permanent functional loss.
06	**Enforce and expand accessibility provisions through revised implementing decrees,** prioritizing damaged and reconstructed public service facilities; schools, hospitals, and primary healthcare centers as the immediate entry point for mandatory accessibility compliance. Minimum standards must include ramps, adapted toilets, wide doorways, non-slip surfaces, and appropriate signage, and must be developed in consultation with international and local organizations with expertise in accessible construction. Compliance audits should be built into reconstruction approval processes, and accessibility must be embedded as a mandatory module in engineering curricula to shift practice at the professional formation level.
07	**Establish a national disability-disaggregated data system** using the Washington Group Questions as the standard identification tool across all government-managed data collection including population registers, service enrollment systems, and the planned national census.
08	**Develop and fund mental health services** tailored to people who have acquired disabilities, addressing grief, loss of identity, stigma, and the psychological impact of conflict-related injuries. These needs are well documented in Syria but remain largely unmet. Peer support and community-based psychosocial support should be treated as essential services.
09	**Strengthen protection and safeguarding frameworks** with explicit provisions for women and girls with disabilities, who are two to three times more likely than other women to experience violence, and women and girls with intellectual and psychosocial disabilities face rates two to four times higher.[72] Protection systems must use accessible referral pathways, train staff on disability-specific vulnerability, and ensure that women with disabilities can report violence safely and receive appropriate follow-up.
10	**Design return and re-integration programs** that assess and guarantee the preconditions for sustainable return for persons with disabilities. A person with a disability returning to an

	area with no functional health infrastructure, no rehabilitation services, inaccessible shelter, and no adapted livelihood pathway cannot sustainably reintegrate. The documented pattern of secondary displacement, returnees displaced again because conditions do not support reintegration disproportionately affects persons with disabilities.

2- To Member States, UN Agencies and Donors	
01	**Fund disability inclusion** as a cross-sectoral requirement, not a standalone budget line. All humanitarian, development and early recovery funding mechanisms for Syria, including pooled funds, bilateral allocations, and sectoral appeals, should include explicit disability inclusion requirements, minimum accessibility standards, and disability-disaggregated reporting obligations as conditions of funding approval.
02	**Apply the twin-track approach** across all disability-related programming in Syria. This means ensuring all sector responses: health, education, shelter, WASH, and livelihoods are accessible and inclusive, while also funding targeted services such as rehabilitation, assistive devices, peer support, and home-based care.
03	**Shift toward multi-year, flexible funding** for disability programming in Syria, recognizing that rehabilitation, inclusive education, psychosocial recovery, and community reintegration are inherently long-term processes that cannot be achieved through annual project cycles.
04	**Invest in a comprehensive national system** to measure disability prevalence and needs, going beyond one-off studies. This should combine census data, regular surveys, and sectoral data (health, education, social protection), using tools such as the Washington Group Questions. The aim is to generate reliable, updated, and actionable data to guide planning, funding, and service delivery across Syria.
05	**Ensure that return is voluntary and together with recovery programming is conditional on minimum accessible service availability**, including functional healthcare with rehabilitation capacity, accessible schools, and safe infrastructure to prevent the reinforcement of secondary displacement cycles that disproportionately affect persons with disabilities.

06	**Provide direct, flexible, and sustained funding to Syrian OPDs, disability-led organizations, and civil society organizations working with and for persons with disabilities,** both inside the country and in diaspora, as rights-holders with irreplaceable expertise on the barriers their communities face. OPD participation must go beyond consultations; it must include meaningful roles in program design, decision-making, and accountability processes, consistent with the CRPD principle of "nothing about us without us" and the commitments of the 2025 Amman-Berlin Declaration.
07	**Invest specifically in inclusive education**, including teacher training on inclusive pedagogy, adapted curricula, transport support for children with disabilities, and accessibility retrofitting of schools. The fact that over 60% of school-aged children with severe disabilities in Syria have never attended any form of education represents a rights failure at scale.
08	**Address child disability and nutrition as an intersecting and underfunded emergency**: 557,175 children under five with disabilities face heightened malnutrition risk and are 34% more likely to be stunted. Therapeutic feeding programs must be adapted to include children with feeding difficulties, swallowing disorders, and increased metabolic demands, and nutrition funding must explicitly cover this population.
09	**Recognize caregivers** — women in over 95% of Syrian households — as a distinct group requiring support, protection, and recognition within disability-related programming, and prioritize grants and funding mechanisms for women-led initiatives and households with members with disabilities. When caregivers are displaced, injured, or killed, persons with disabilities can be left entirely without support. Caregiver wellbeing is inseparable from the wellbeing of persons with disabilities and must be funded and addressed accordingly, including through dedicated economic empowerment pathways for caregiver households.
10	**Fund victim assistance as a sustained pillar of mine action programming in Syria** and as a prerequisite of any recovery investment, ensuring sustained investment in trauma care, emergency and continuing medical care, rehabilitation, prosthetics and orthotics, and psychosocial support for survivors, their families, and affected communities. Funding horizons must match the duration of need, not the duration of the emergency.

3- To Humanitarian Actors	
01	**Engage persons with disabilities and their representative organizations genuinely** and systematically in program design and implementation, not as a box-checking exercise but as a technical and ethical requirement. This includes adapted consultation formats, accessible venues, and genuine decision-making influence.
02	**Adopt the twin-track approach consistently across all sectoral programming**: mainstream accessibility and disability inclusion into every intervention while simultaneously providing targeted support for persons with disabilities whose needs cannot be met through mainstream channels. This means, concretely, that a health program should both ensure its facilities are physically accessible to all and provide home-based or mobile rehabilitation to those who cannot travel. An education program should both train all teachers in basic inclusive pedagogy and provide specialist support for children with complex needs.
03	**Integrate Washington Group Short Set Questions** into all household assessments, registration processes, and monitoring tools, placing them in the demographic section, and investing in structured enumerator training before any data collection begins. Use WG data actively to reshape program targeting and design: if disability data is collected but does not change how services are delivered, the collection serves reporting rather than inclusion.
04	**Strengthen case management and referral systems** with the specific architecture needed to serve persons with disabilities in Syria: cross-sector referral pathways linking health, rehabilitation, MHPSS, protection, education, and livelihoods; follow-up mechanisms that track whether persons with disabilities actually access referred services; and outreach to persons with disabilities who are homebound, isolated, or living in areas with low service coverage.
05	**Ensure services are physically and financially accessible in practice.** Flexible delivery, mobile outreach, home-based services, and community-based service points must be scaled in areas where persons with disabilities cannot travel to central facilities.

06	**Use accessible communication formats across all information and risk communication,** including audio materials, visual guides, simplified messaging in Arabic, and community-based outreach through trusted intermediaries. Communication must be adapted for persons with sensory, cognitive, and intellectual disabilities, and accessibility of information must be treated as a technical verified standard.
07	**Address social stigma and attitudinal barriers as a structural driver of exclusion,** not as a soft component. Evidence consistently shows that challenging staff and community attitudes is the essential first step to meaningful inclusion. Invest in disability awareness among humanitarian staff, community leaders, and service providers, including on the heightened protection risks facing women with disabilities, and integrate disability-positive messaging into community engagement.

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