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Syria crisis

The authors of the four articles in this FMR mini-feature discuss some of the challenges faced by those who have been displaced and those who are trying to assist them, and some of the limitations of current humanitarian practice in and around Syria.

This mini-feature is online at **www.fmreview.org/detention/syria.pdf** Please feel free to circulate it, print it out, link to it, etc; unfortunately we are unable to supply the mini-feature separately in print ourselves. If you would like print copies of the full issue in which the mini-feature appears, please email the Editors at **fmr@qeh.ox.ac.uk**

The four articles are available individually in html, pdf and mp3 format at **www.fmreview.org/detention**

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Articles

Syrian refugees crossing to Jordan. UNHCR/Jared Kohler

Humanitarian and medical challenges of assisting new refugees in Lebanon and Iraq

Caroline Abu Sa'Da and Micaela Serafini

The massive and continuing flows of Syrian and Palestinian refugees to Syria's neighbours have shown the limitations of humanitarian practice and present new challenges for medical and humanitarian interventions.

As the crisis in Syria continues, humanitarian needs inside and outside the country are escalating rapidly. Since the crisis began in March 2011, the ability of international organisations to provide aid inside Syria has been severely restricted. Most international agencies have therefore focused attention on the situation of those refugees who have crossed the border into Turkey, Lebanon, Jordan and Iraq. UNHCR estimates the total number of refugees – including further afield in Egypt and elsewhere – at two million people as of late August 2013.[1]

The substantial impact that these two years of mass influx has had on neighbouring countries has not been addressed appropriately by the international community. Most of the present priorities and practices for health-care provision in conflict settings are still, unfortunately, based on those decades where conflict was usually synonymous with overcrowded refugee camps sheltering young populations from developing countries. Most contemporary wars, however, are taking place in higher income settings with better baseline health indicators and they are of protracted duration. These facts are profoundly changing the demography and disease profile of conflict-affected populations.

Northern Iraq

During 2012, many Syrian Kurds fled to neighbouring Iraq, to the region in the north governed by the Kurdish Regional Government (KRG). Doomiz Camp, near the Iraqi city of Dohuk, was opened in April 2012 while the central government in Baghdad opened two other camps in the southwestern part of Iraq. Eighteen months later the assistance provided in Doomiz camp is far from acceptable. The investment in water and sanitation has never been enough, the different phases of the camp were not properly planned, very few international actors are present and there is a dramatic lack of mid- to long-term vision in anticipation of new arrivals in the camp. While the Kurdish authorities initially had a welcoming policy towards refugees, the lack of support from the international community eventually pushed them to restrict assistance in various ways, including, for example, closing the border in May 2013. The KRG has permitted refugees to access public services free of charge but these services are beginning to come under strain.

More recent clashes in eastern Syria caused the KRG authorities to reopen the border on 15 August 2013. More than 30,000 people poured into Iraqi Kurdistan over a few days, filling the newly-opened camp at Kawargost in Erbil to capacity. Two other camps are due to be opened in the area but they will only have the capacity to absorb the new influx, offering nothing to the overwhelming majority of refugees scattered in urban areas.

Lebanon

The influx of refugees to Lebanon has been in several phases. While in May 2012 there were 20,000 Syrian refugees mainly in the northern part of Lebanon, by early August 2013 there were 570,000 according to UNHCR – and around 1.3 million according to the government. In addition to the 425,000 Palestine refugees registered in Lebanon before the war, UNRWA estimates that 50,000 more have arrived from Palestinian refugee camps in Syria since the beginning

of the war. With a total Lebanese population of an estimated 4.2 million, refugees in Lebanon now represent almost 25% of the total population. The Lebanese government, following an official policy of 'dissociation' from the Syrian conflict, has left its borders open and has refused to open camps to host refugees. Therefore, people are scattered all over the country, mainly in impoverished areas where services are already under severe strain. The response to their needs has been massively underfunded.

Health systems

Although its hospitals have been destroyed and its pharmaceutical industry damaged, Syria used to have one of the best health systems in the region before the crisis. The epidemiological profile of the population and its needs therefore differ substantially from the refugee settings which may be more familiar to humanitarian actors.

Iraq's health system was severely depleted by years of embargo followed by the US-led occupation and civil war. The Lebanese health system is based on private practice and is therefore difficult to access for the most vulnerable people. For example, a survey conducted by MSF found that almost 15% of the refugees interviewed could not access hospitals because they were unable to pay the fees (up to 25% of the costs, the rest being covered by UNHCR). Nine out of ten interviewees said that the price of prescribed drugs was the main barrier to their accessing medical care.[2] The continuing influx of refugees has put both health systems under severe strain. Health structures are overstretched and cannot cope with more patients. These difficulties also raise tensions between the host communities and the refugee populations and therefore need to be tackled urgently and effectively.

Middle-income 'disease burden'

Refugees from middle-income countries present a different demographic profile and disease burden than the classical refugee profile that humanitarians across the world are used to working with. In the past in mass influx situations there was a high mortality rate during the acute phase of emergencies, mainly fuelled by epidemics, the exacerbation of endemic infectious diseases and acute malnutrition. In this situation today, however, much of the excess morbidity and mortality result from the exacerbation of existing chronic diseases (such as cardio-vascular, hypertension, diabetes, tuberculosis and HIV). In these cases, treatment continuation becomes essential. The complexity and long-term duration of chronic diseases call for different thinking and new strategies.

Most of the primary health-care consultations done by MSF in Lebanon and Iraq since early 2012 can be attributed to chronic diseases. Continuation of treatment – not just access to it – becomes essential. But when interviewing Syrian refugees in the Bekaa Valley and Saida in Lebanon, more than half of the respondents (52%) said that they could not afford treatment for chronic diseases, and nearly one-third (30%) had to suspend treatment because it was too expensive to continue. In Iraq, access to treatment is supposedly free but in reality, due to frequent breakdowns in supply, refugees have to buy their medicines in private pharmacies.

Outbreak-prone diseases too are still a threat to conflict-affected populations in middle-income countries. Iraq has experienced a measles outbreak that had to be controlled by mass vaccination in the refugee camp. Lebanon too suffers from outbreaks that, even though of lesser magnitude, are much more difficult to control due to the widespread distribution of the refugee population. The incidence of infectious diseases – even though lower than in other settings – is still considerable. In view of these realities, preventive and curative responses involving not only primary but also secondary and tertiary level health care with free service provision need to evolve substantially.

Health challenges in open settings and camps

One of the main issues is the link between the registration of people and access

to services, including health services.[3] 41% of interviewees said they were not registered, mainly because they lacked information on how and where to register, because registration points were too far away, because of delays at registration facilities or because they were worried about not having the proper legal papers and therefore being sent back to Syria.

In Lebanon, and specifically in the Bekaa Valley, refugees are so scattered that access to hospitals is extremely difficult. Moreover, even though UNHCR is covering some of the hospital costs for refugees, they are not covering them all. Most of the refugees will ultimately have to pay to access secondary or tertiary health care.

The fact that the largest proportion of Syrian refugees is currently residing in urban environments rather than in camps poses major challenges for health interventions. According to UNHCR, 65% of refugees in the region are living outside camps. While Syrian refugees in Lebanon are scattered over 1,000 municipalities, mostly in impoverished urban areas, in Iraq they live both in camps and cities. This diversity of settings is a challenge for medical and health interventions.

In a camp a comprehensive and centralised system can be designed to ensure access to health, and a simple surveillance system for major outbreak-prone diseases might be enough. Unfortunately outbreaks are occurring among the refugees scattered in Lebanon and the surveillance system in place is incapable of predicting them early enough. Refugees in urban settings anyway face intermittent access to health services due to overstretched public systems in the hosting countries, which are unable to cope even with the demands of their own population. Urban refugees often live informally alongside residents. The fact that both have similar needs and vulnerabilities and that they share the same under-resourced health system will inevitably have an impact on local residents' attitude towards refugees, which will in turn ultimately generate exclusion and inequities in the provision of services.

In Iraq, the majority of refugees are residing in urban settings. Access to primary and secondary health care seems to be free but the system appears to be facing an influx of consultations that is overwhelming their capacity. In Lebanon, as in Iraq, the unpredictable distribution of aid to Syrian refugees is leading to increased competition for scarce resources. The economic disparity created by this unequal distribution is generating resentment and ambivalence towards Syrian refugees. The living conditions of refugees in open settings remain inappropriate; the payment of rent represents an additional burden on their budget, and most of them live in inappropriate shelters such as schools, mosques and dilapidated buildings. Overall, assistance to Syrian refugees still falls short of their needs.

Conclusions

Health policies and interventions have not kept up with the profound global changes in conflict settings, and the Syrian conflict has been no exception. Humanitarian actors need to adapt their strategies to the reality of refugees today and their specific disease burdens. As the disease burden has shifted to chronic diseases, there is also a need for more complex interventions that take into consideration the continuation of care. Nevertheless, outbreak-prone diseases are still present, and this demands good surveillance systems that can anticipate and take action.

Barriers to access to secondary and tertiary health care – such as the cost of services, short opening hours and long distances – have to be taken into account when assisting Syrian refugees. There is a need for a systematic integration of affordable non-communicable diseases treatment in the health-care system. Moreover, all vulnerable refugees suffering from acute medical conditions should gain full and fast access to hospital care.

Urban refugees scattered all over Iraqi Kurdistan and Lebanon face huge difficulties in accessing aid. This again raises the issue of how to best address the needs of people displaced in open settings.

In August 2013 UN High Commissioner for Refugees António Guterres talked of the urgent need to adopt a more generous and consistent approach to Syrians seeking shelter and asylum in Europe. Germany and Sweden have accepted nearly two-thirds of Syrians seeking protection in the EU; more countries need to help Syria's neighbours shoulder the burden by offering asylum or resettlement. The Syrian crisis has shown a huge gap between the need for assistance and actual response. This type of long-term crisis also needs long-term planning and commitment from donors, states and agencies. Syria's neighbours have most of the time welcomed, hosted and assisted refugees; without proper support for local authorities and structures, however, mass influxes will eventually only provoke rejection when local capacities falter and fail.

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1. http://data.unhcr.org/syrianrefugees/regional.php

2. MSF survey conducted in Lebanon in December 2012 www.doctorswithoutborders.org/publications/article.cfm?id=6627

3. Randomised surveys on households in Saida, Ein Al Helweh camp, the Bekaa Valley and Tripoli, conducted by MSF in May 2012, December 2012 and June 2013.

"What is the most important thing you brought from home?"

Ahmed holds his cane without which, he says, he could not have made the two-hour crossing on foot to the Iraqi border. (Domiz refugee camp in the Kurdistan Region of Iraq)

Tamara brought her diploma so that she can continue her education. (Adiyaman refugee camp, Turkey)

Abdul holds the keys to his home in Damascus. "God willing, I will see you this time next year in Damascus," he told the photographer. (Bekaa Valley, Lebanon)

(Names changed for protection purposes.) UNHCR/Brian Sokol

Failure to adapt: aid in Jordan and Lebanon

Jon Bennett

Many aid agencies in Lebanon and Jordan find themselves stuck in a wholly inappropriate paradigm of assistance from which they cannot extricate themselves.

As the whole edifice of aid machinery descended on the world's latest emergency, it soon became apparent that it was ill-equipped to adequately address the needs of a displaced population from a middle-income country.

Although a majority of the refugees are either hosted or in rented accommodation, Za'atari camp in Jordan (now the world's largest refugee camp) stands out as the most visibly 'managed' Syrian population. It encompasses everything that is wrong about camps. The Jordanian government confines the population, taking possession of their identity papers, and disallowing free movement to other parts of the country. The aid agencies collude by containing the crisis through provision of aid. Both parties are bewildered when stones are thrown at them by frustrated camp residents. This is a predominantly educated population with resources and a history of regional migration and ties across the Middle East. They are finding it difficult to be 'grateful' for having to queue for a loaf of bread and a food parcel while trapped in a dusty field on the Jordan/Syria border.

There are some stark examples of organisations with solutions looking for problems. In Lebanon the population's biggest burden is spiralling rents, made worse by reducing work opportunities. They are not generally food insecure, yet they receive cash vouchers ($27 a month) from the World Food Programme (WFP) which cover only a part of the actual food consumption of people who are used to spending far more per month on essentials. Far from being a life-saving intervention, the voucher is just one of several 'coping strategies' – resources they can draw on – and it is hardly surprising that up to 40% of these vouchers are sold rather than redeemed. The depletion of household resources is, at this stage in the crisis, a financial, not nutritional or food-related, crisis. To say that the $27 per month voucher offsets other costs is a truism that does not justify such a costly venture, the administration of which drains both financial and human resources.

At least twice a month people queue up for their vouchers at warehouses or football stadiums in urban centres where a combination of 'non-food items' (from UNHCR), food vouchers (from WFP) and ad hoc gifts from Gulf states and philanthropic individuals are distributed. The registration process is meticulously designed to avoid fraud at an enormous cost of time and expense. The recipient then takes the voucher to a designated shop where agency staff 'monitor' the counter to ensure that the voucher is spent only on nutritious food items – no toothpaste, shampoo or chocolate.


UNHCR/ Salah Malkawi

Syrian refugees queue for relief items at Za'atari camp, Jordan.

If the shop too often contravenes the rules, it is penalised or dropped from what shopkeepers acknowledge as a quite lucrative scheme.

Inevitably, the paper voucher has attracted its own micro-economy. The arithmetic is simple. The voucher is sold by the recipient for $20 to the middle men (usually immediately outside the gate of the distribution site) who then sell it to the shopkeeper for $23, who then redeems it for its face value of $27. This is big business, representing about $20 million dollars per month changing hands. In an effort to curtail nefarious transactions of this kind, the voucher will soon be replaced by an electronic e-card that will include a proportional contribution for non-food items. It is not yet known how the middle men will capitalise on this aid credit card but they will.

Meanwhile, the UN is preparing for a shift from general to targeted distribution in which they identify the 'most vulnerable' families. This is a shifting target, changing almost daily as more people are evicted from rented accommodation that they did not anticipate staying in for more than a couple of months before returning home. Middle-class families who arrived in comfortable cars find that their savings are rapidly depleting, hence the seeming paradox of a family arriving for a food box or voucher in a Mercedes.

It is surely not necessary to go through the rigmarole and huge expense of itemised vouchers, food and non-food parcels, and distribution logistics in a country where supplies are plentiful. There seems to be as wilful blindness on the part of donors and aid agencies caught in a repetitive stereotype of refugee assistance. Without the redundant modalities of the aid 'industry' on the ground, Syrian refugees could probably have received at least twice as much money in a simple cash hand-out.

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Dimensions of gender-based violence against Syrian refugees in Lebanon

Ghida Anani

Assessments of the impact of the Syrian crisis indicate high levels of sexual and gender-based violence, with rape, assault, intimate partner violence and survival sex appearing increasingly common. Humanitarian agencies urgently need to work together to address this trend.

In times of conflict everyone is affected by violence; however, women and girls in particular are more at risk of facing different forms of violence including sexual and gender-based violence (SGBV) due to the lack of social protection and lack of safe access to services. There is wide recognition of sexual violence as a weapon of war but other forms of violence against women during conflict also exist, including domestic violence, sexual exploitation and early marriage.

In early September 2013 UNHCR estimated the number of Syrian refugees in Lebanon at 720,003 and the number of the displaced is still rising. Several local and international organisations have conducted rapid assessments to better understand the magnitude and impact of the crisis on displaced Syrians in Lebanon. Some of the main issues identified by these assessments include overcrowding, inadequate access to basic services, rising rent and food prices, and competition for the limited work opportunities. The assessments also helped to identify women and children as among the most vulnerable groups, solely by virtue of belonging to a particular gender, a certain age group or social status. This in turn shed light on the increase in SGBV among the

refugees and the need for humanitarian agencies urgently to develop a tailored response to reduce this form of violence.

There is no quantitative data in respect to violence against women but many displaced Syrian women and girls report having experienced violence, in particular rape. A rapid assessment conducted in 2012 by the International Rescue Committee in collaboration with ABAAD-Resource Center for Gender Equality assessed the vulnerabilities of Syrian women and girls to increased exposure to GBV both prior to crossing the borders and in their new host communities, and concluded the following:

- Rape and sexual violence were identified by focus groups and key informants alike as the most extensive form of violence faced by women and girls while in Syria.
- Intimate partner violence (IPV), early marriage and survival sex were identified by adult women and adolescent girls as other forms of violence experienced since arriving in Lebanon. Adult female participants in several focus groups reported that IPV has increased since their arrival in Lebanon, while adolescent girls stated that early marriages have increased, most frequently framed as efforts by families to 'protect' girls from being raped or to ensure that they are 'under the protection of a man'. Survival sex, typically linked to women's and girls' desperate need to earn money to cover the cost of living since arriving in Lebanon, was also identified as a type of violence frequently experienced by Syrian women and girls.
- Many newly arrived women and girls are living in unplanned and overcrowded refugee settlements, with minimal privacy and compromised safety, particularly among those refugee populations inhabiting abandoned public buildings.
- Survivors are reluctant to report SGBV or seek support due to the shame, fear and 'dishonour' to their families. Women risk further physical and sexual violence, including death, often from their own families, when reporting GBV, a pattern that exists in many contexts
- Minimal coordination and lack of adherence to international standards of humanitarian assistance have hindered women's and girls' ability to access services. Discrimination and mistreatment are key barriers to accessing services.
- Women and girls have restricted access to information about the availability of services and support, particularly those that are relevant to survivors of GBV. Key informants strongly agreed that there are few services currently in place specifically designed to meet the needs of survivors of GBV or that are accessible to Syrian refugees.[1]

Sexual exploitation or non-consensual 'survival' sex occurs when women and girls exchange sexual favours for food or other goods, or money to help pay the rent, especially in Lebanon. *"And if you want other help from other NGOs you should send your daughter or your sister or sometimes your wife… with full make-up so you can get anything… I think you understand me."* (participant in focus group discussion)

Although early marriage of daughters was common practice in Syria before the conflict began, this is reportedly being resorted to more commonly as a new coping strategy, either as a way of protecting young women or of easing pressures on family finances.

Lower self-esteem among men because of what being a refugee means, in some cases, leads to a negative expression of masculinity. Violence towards women and children has increased as some men vent their frustration and abuse their power within the household. *"I don't feel that I am a real man after what has happened to me now, and to be honest, I can't handle it anymore." … "When my wife asks me for vegetables or meat to prepare food, I hit her. She does not know why she was hit, neither do I."*

Outside the household, there are also examples of women and girls who are vulnerable to physical and verbal harassment, including sexual harassment, and in many areas they fear kidnap, robbery and attacks. Widowed or other women on their own are particularly vulnerable, with some hiding the fact that their husbands have been killed or kidnapped and even pretending in public to receive phone calls from their former husbands to protect themselves from male harassment.

Information on the prevalence of GBV among men and boys – and its impact – has been markedly lacking but recent research conducted by ABAAD with the support of UNICEF[2] confirms that men and boys also have faced and/or are likely to face GBV and SGBV in Syria or in their new host communities. Interviews with displaced male youth and boys revealed they did not know the term 'Gender-Based Violence' but almost all the interviewees identified different forms of GBV – including domestic violence and harassment based on gender – as present within their communities after fleeing Syria, and had either witnessed such violence or were survivors of it. 10.8% of them had been exposed to sexual harm/harassment in the previous three months but tended to associate the forms of GBV they were exposed to with being Syrian and/or Palestinian/Syrian; thus racism and discrimination masked their ability to identify violence as GBV.

When interviewees were asked specifically about the impact of sexual harm/harassment on them, the majority reported ignoring it and trying to forget it; some thought it was their fault that it happened. Moreover, the very few who had told someone about it stated that nothing was done as a result. It was clear that the behaviour of the majority of those surveyed had changed drastically due to their displacement and what they had witnessed, resulting in constant conflict within households; they expressed feelings of insecurity, sadness, doubt, anger and loneliness, and were sometimes violent themselves. They have had little access to the resources and social support necessary to help them. Young males and boys in particular are also highly susceptible to forced and early labour because they are seen from childhood as the economic provider for the family, which in itself is a form of GBV.

Response

Many national and international organisations have been working on reducing GBV against Syrian refugee women, focusing on prevention and protection programmes using a holistic multi-sectoral approach incorporating a range of services such as legal services, information provision and awareness raising, medical and psychological health services, etc. However, these services are decentralised and scattered throughout the different regions and are provided by different providers. Having to go to different access points to obtain services hinders – either because of financial or cultural restrictions – people's ability to access all the services they need.

Some new initiatives are addressing this problem of scattered service-provision points by creating a clear referral system among providers to facilitate access by beneficiaries. One example is the opening (by ABAAD in collaboration with UNHCR, UNICEF and the Danish Refugee Council) of three Safe Shelters in three different areas within Lebanon where there are large concentrations of Syrian refugees. These houses provide a secure and confidential place for Syrian refugee women who are survivors of or are at high risk of being exposed to GBV, and their children. In addition to providing housing for up to 60 days, the centres also provide – in one venue – case management and crisis counselling, psychosocial and legal support, forensic and medical care and referrals for provision of social services (economic opportunities, longer-term shelter, medical services, etc).

Recommendations

The following recommendations are drawn from our recent study published with Oxfam which assesses the impact of the Syrian crisis from a gendered perspective, including an examination of the prevalence and impact of GBV:[3]

- Increase the number of safe spaces for women, men, boys and girls.
- Organise mass distribution of educational protection messages for women and men.
- Build the capacity of care providers in clinical care for survivors of sexual assault, gender-based violence case management, and caring for child survivors.
- Conduct community safety audits to further assess the security situation in relevant areas. Establish community protection mechanisms on the basis of regular community safety audits, including support for women's groups and capacity-building protection programmes for women.
- Sensitise and engage relevant community stakeholders and actors in the security sector to install appropriate gender-sensitive security measures, including mechanisms to control the proliferation of small-arms.
- Work to ensure all actors engaged in the delivery of aid receive training on gender equity, the elimination of violence against women and minimum ethical standards in aid delivery, and aim to meet standard operating principles. All actors should systematically track sexual violence in conflict, and build their GBV documentation capacities.
- Ensure all aid agencies adhere to the principle of zero tolerance of sexual violence and exploitation, establish mechanisms for reporting such incidents, and act accordingly when incidents are observed or reported.
- Establish confidential and trusted mechanisms for tracking and reporting incidents of sexual exploitation and abuse during aid delivery, and inform Syrian women and girls about the existence of such mechanisms.
- Provide awareness sessions on GBV affecting male youth to staff of aid organisations and start support group sessions for male youth and boys.

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1. See Executive Summary, *Syrian Women & Girls: Fleeing death, facing ongoing threats and humiliation*, International Rescue Committee, August 2012 http://tinyurl.com/IRC-Lebanon-August2012

2. *Assessment of the Impact of GBV on Male Youth and Boys among Syrian and Syrian/Palestinian Refugees in Lebanon*, ABAAD-UNICEF, forthcoming September 2013.

3. Roula El Masri, Clare Harvey and Rosa Garwood, *Shifting Sands: Changing gender roles among refugees in Lebanon*, ABAAD-Resource Center for Gender Equality and OXFAM, September 2013 http://tinyurl.com/Oxfam-ABAAD-ShiftingSands-2013 Arabic: http://tinyurl.com/Oxfam-ABAAD-ShiftingSands-ar

Real-time evaluation of UNHCR's response to the Syrian refugee emergency

Earlier in 2013 UNHCR commissioned a real-time review of its response to the emergency, focusing on Jordan, Lebanon and Northern Iraq. The report was published in July and highlighted:

- the need to address the situation of refugees in urban contexts and in out-of-camp areas, while at the same time highlighting the risks associated with conventional camp responses
- a yawning gap in emergency response arrangements in terms of support for host communities
- that emergency response in middle income countries is expensive and complex
- the emergence of many new actors, working outside the established humanitarian coordination framework
- that the international refugee protection regime continues to function, even in countries which have not formally adhered to the basic instruments of international refugee law.

See 'From slow boil to breaking point: A real-time evaluation of UNHCR's response to the Syrian refugee emergency' online at http://tinyurl.com/UNHCR-SyriaRTE-2013

Conflict in Syria compounds vulnerability of Palestine refugees

Gavin David White

Palestine refugees in Syria find themselves once more engulfed in a cycle of conflict and displacement that exacerbates their underlying vulnerability and highlights the ongoing need for durable solutions.

Before the outbreak of conflict, Syria was generally seen to afford the best conditions for Palestine refugees among the nations of the Middle East. Palestinians benefited from relative freedoms, including access to social services provided by the government. Nonetheless, development indicators reflect a socioeconomic frailty compared with the wider Syrian population.

Of the 12 long-established Palestine refugee camps in Syria supported by UNRWA (the UN Relief and Works Agency for Palestine Refugees in the Near East), seven of the camps – largely in and around Damascus in the south and Aleppo in the north – are now caught up in the conflict. The vast majority of the some 529,000 Palestine refugees registered in the country have been directly affected by the unfolding violence. Armed clashes and the use of heavy weapons in and around these camps have resulted in extensive damage to homes, schools, health centres and the administrative infrastructure, and scores of Palestine refugees, together with eight UNRWA staff, have lost their lives.

Internally displaced Palestine refugees, Jaramana refugee camp, Damascus Governorate, May 2013.

In response, UNRWA is providing cash assistance, food aid, non-food items, water and sanitation services, emergency health and education, shelter and protection for Palestine refugees, safety and security for UNRWA staff, and emergency repair of existing infrastructure. Seeking to ensure continuity of education for the 67,000 students enrolled in UNRWA's school system in Syria, the Agency has designated alternative safe learning zones including the temporary use of state schools on a second-shift basis; employed distance learning materials; developed virtual classes for its digital television channel; and integrated students fleeing Syria within its wider school system in neighbouring countries. And with the temporary closure of a number of its 23 primary health-care centres due to their proximity to conflict, UNRWA has established new health points, relocating health services to newly displaced Palestine refugee populations.

Displaced again

Palestine refugees in Syria have been widely displaced. One of the most serious single incidents occurred in late April 2013 in Ein el Tal Camp in Aleppo, with the forced displacement of all 6,000 camp residents in a single day following months of sporadic armed engagements. The population of Yarmouk Camp in southern Damascus, which once numbered some 160,000, has dwindled to a mere 30,000 inhabitants following mass displacements in December 2012.

A total of 235,000 Palestine refugees are now internally displaced within Syria. Of those, 18,000 have sought refuge in other Palestinian refugee camps that for now afford a greater level of safety. But here, as around the world, UNRWA and other agencies such as UNHCR are not able to provide physical security and are reliant on the state (and other actors) to ensure the security of refugee camps. Homs Camp in central Syria, with an original camp population of 22,000 and now hosting 6,500 Palestinian IDPs from Aleppo, Damascus and the Homs countryside, finds itself on an emerging frontline between government and opposition forces, making further mass displacement likely. Of those displaced beyond Syria's borders, of 93,000 Palestine refugees from Syria who made themselves known to UNRWA in Lebanon, over 45,000 were consistently relying on the Agency's humanitarian services. Meanwhile, some 8,500 individuals have reached Jordan. In addition, around 1,000 Palestine refugees have reached Gaza via Egypt while small numbers have fled as far afield as Malaysia, Indonesia and Thailand.

The majority of Palestinians from Syria in Lebanon have sought refuge within one of the 12 existing Palestine camps. Overcrowded, with ageing infrastructure and challenging environmental health issues, these camps and services in them are being stretched beyond capacity, while UNRWA remains chronically under-funded. The new refugees compete for both limited and unsuitable accommodation options, with families of up to ten persons sharing a single room at a monthly cost of US$200-400. With the start of the 2013-14 academic year, an existing Palestine refugee student population of 32,213 pupils has been joined by over 5,000 additional students from Syria.

Newly arrived Palestine refugees find themselves competing not only with the existing Palestinian population for limited income-generation opportunities but also with some 677,000 newly arrived Syrian refugees. Unlike Syrian citizens, Palestine refugees from Syria do not have the right to employment in Lebanon, nor do they have the decades-old experience of working as labour migrants, as many Syrian citizens do. With 40% of the Palestine refugee population having been engaged as unskilled labourers in Syria, they also lack transferable skills.

In Jordan, the government's public confirmation, in January 2013, of its decision to close Jordan's borders to Palestinians fleeing violence in Syria has limited the flow of arrivals to some 8,500 individuals. A few thousand Palestinians currently reside within communities in border areas in southern Syria, where conflict is still raging. Their precarious legal status means they face difficulties in relation to civil processes such as registration of births and in access to services, are often unable to work and are left extremely vulnerable to high-risk survival strategies, and are at constant risk of *refoulement*. Palestinians are entitled to equality of treatment and non-discrimination in the application of international law, including protection from *refoulement*. UNRWA continues to engage key stakeholders to intercede with authorities on individual cases and to appeal to the government to provide the same humanitarian consideration it has provided to other refugees and allow them to enter Jordan without discrimination.

This secondary forced displacement of Palestine refugees is a painful reminder of what they have endured for 65 years. While this remains the most protracted of displacement situations, the vulnerability of Palestine refugees within an increasingly unstable Middle East charges the international community more than ever with the duty to ensure their care and protection, and the responsibility to reach a just and durable solution to their plight.

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