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Obstacles Faced by Palestinian Refugees in Accessing Health Services

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Abstract: Health equity is a right stipulated by United Nations charters and is a basic topic of interest in humanitarian assistance professions, including social work. The principles of health equity are based on achieving parity in the delivery and provision of human services and satisfying the health needs of disadvantaged individuals, groups, and communities. This study aims to understand the obstacles Palestinian refugees face in availing the health services provided by international relief agencies (e.g., UNRWA). Palestinian society is classified as a disadvantaged community by virtue of its political nature and humanitarian situation. This study conducts a social survey to assess the obstacles preventing the achievement of health equity among Palestinian refugee families living in Palestinian territories. The sample consisted of 600 Palestinian refugee families in Nablus, covering different geographical distributions. Furthermore, 121 social workers in a relief and social work program affiliated with UNRWA in the West Bank were surveyed. The findings suggest that Palestinian refugees face multiple disadvantages that curtail them from availing of healthcare facilities. The findings pertaining to the role of social work show that social workers have an important role in improving healthcare access.

Keywords: Obstacles; Health Equity; Disadvantaged Communities; Palestinian Refugees; Social Workers

1 Introduction

Since the early days of its inception social work has been a humanistic profession helping people improve their lives. By working with some of the most vulnerable groups in society, social work practitioners are well placed to study the impacts of disadvantages on individuals, groups, families, and societies. Social work is one of the prominent helping professions today, evolving over the years to gain a professional status (Mathiesen & Lager, 2007; Rotabi et al., 2007; Weiss-Gal & Welbourne, 2008). With its initial focus on social welfare in the early days, social work gradually evolved to advocate for better social welfare policies and services to the weak, needy, and disadvantaged communities. This vision contributes significantly to transferring experiences and effective models, understanding difficulties and obstacles, and contributing to the development of social policies and services. Moreover, as social work has become a global, increasingly interactive, and collaborative profession, it has continued to flourish. As a result, social work has gained a global appeal, as social work researchers, practitioners, and educators have begun to think globally in addition to their work at the local level, whether in the field of education or practice with individuals, groups, and communities (Lord, 2012). Social work, with its humanistic outlook, has always emphasized on the needs and rights of disadvantaged sections. Refugees and their plight, hence, has always been a top

priority for social work professionals across the globe. One of the very significant cases of refugee crisis that social work profession has always been attentive to, is that of the Palestinians.

The establishment of Israel in 1948 and the following expulsion of Palestinians from their homeland lead to an unprecedented refugee crisis in the region. This led to the transformation of many Palestinian people into refugees in the Arab countries surrounding Palestine, in addition to some of them heading toward the West Bank and the Gaza Strip, which had not yet been occupied then, where the largest number of Palestinian refugees fell within the scope of the United Nations Relief and Works Agency for Palestine Refugees in the Near East's (UNRWA) mandate. A large number of Palestinians still live in neighboring countries and other countries around the world. The State of Palestine has a population of more than 5 million and is distributed over an area of 6,020 square kilometers.

The grave humanitarian situation in Palestine prompted the United Nations General Assembly to establish the UNRWA in accordance with Resolution No. 302 (Fourth) issued on December 8, 1949. The agency began executing its duties on May 1, 1950. The agency's mandate was to respond to the needs of Palestinian refugees until a permanent and just solution was reached. The agency is currently one of the largest United Nations programs, with the number of Palestinian refugees covered by its mandate reaching 5.271 million people and the number of the agency's employees exceeding 29,500. The agency provides various services within five programs: education, health, relief and social services, microfinance, and camp infrastructure and development.

According to the United Nations Charter of 1951, a refugee is defined as someone who took refuge as a result of war or someone who was outside his/her country at the time of war and could not return due to fear. The United Nations Charter does not oblige countries hosting refugees to grant asylum. The United Nations' definition also does not include those who immigrate to their countries because of internal disturbances nor does it include internal migration (Simmelink, 2011). In addition, the 1951 Convention and its Protocol (Article 33) defines refugees as those who have a well-founded fear of being exposed to persecution based on race, religion, nationality, membership in a social group, or a particular political opinion and those who are still under examination (The UN Refugee Agency, 2006). Regarding the Palestinian concept, and according to the definition contained in the National Charter, refugees are defined as all Palestinians and their descendants who were expelled from or forced to leave their homes between November 1947 (Partition Plan) and January 1949 (Rhodes Agreement) from the area under the control of Israel.

1.1 Healthcare and Social Work

According to the Universal Declaration of Human Rights (1948), health is a fundamental human right. The Constitution of the World Health Organization (WHO, 1946) states that one of the basic human rights is to achieve the highest possible level of health. Despite global efforts to guarantee the right to health for all human beings, there have been cases of violation, abuse, and neglect of this legitimate and basic right. Since its establishment, the social work profession has been concerned with issues of social justice, eliminating the health disparities that they constitute, and legislation at the local and global levels. Owing to the importance of policies and legislation, social workers in the healthcare field work in accordance with these set boundaries, given that fair healthcare is one of the basic demands that social service specialists hope to achieve and implement with individuals, families, and communities (Martinez, 2019). Social workers also occupy a unique position across the

healthcare system in hospitals, primary healthcare, public health, community settings, nonprofit organizations, and elsewhere. They are relied upon by many agents of change alongside fellow professionals with expertise in the health field (Ashcroft et al., 2021). The professional nature of social work in the health field and the unique position of social workers in the medical field emphasize their responsibility to achieve the goals of health justice and equity.

Social work in the healthcare field is often limited by medical models based on study, diagnosis, and treatment. Individual behavioral models, often, disproportionately emphasizes the role of individual behavior in inducing adverse health outcomes (Blue, Shove, Carmona, & Kelly, 2016). Medical models often use a single-axis approach to health inequalities that addresses health inequalities from independent axes, thus reducing the impact of overlapping cross-cutting disadvantages (Holman et al., 2021; Lundberg, 2020). In the medical field, diagnosis is a crucial step in uncovering many aspects, including intersection of disadvantages and discrimination. These intersections are often a source of suffering for individuals, groups and families. These intersections are also often present before diagnosis and may persist with clients/patients even after they are discharged from the hospital. Therefore, the serious consequences of these intersections are often highlighted leaving individuals vulnerable to the condition. Hence, social work in the healthcare field is sometimes limited to providing services in hospitals, where the issue of health inequalities is often not addressed. Social workers face enormous challenges in reconciling contradictions between traditional medical models and social service values. In practice, social workers often have to work within a healthcare system that is weak in terms of recognizing the value of social work in the health field, considering that providing comprehensive healthcare is the correct perspective adopted by multiple disciplines, including social work (Mitchell, 2012).

Social work in the healthcare field has a forward-looking and critical outlook that evaluates underserved communities, uses intersectional approaches, and integrates elements of the community and profession. This is especially true for marginalized communities that are caught in a cycle of poor health and poverty, in which poverty leads to poor health outcomes, diminished income, and poverty; this cycle is repeated with negative consequences (Wagstaff, 2002).

1.2 Significance of the study

Since the occupation of 1948, the Palestinian people have become dispersed. They found themselves scattered in camps, facing multiple challenges and various difficulties, most notably access to health services. These challenges had negative effects on the health situation, it induced poor health outcomes among the Palestinian refugees. Their suffering was compounded by the harsh conditions they lived in due to the lack of infrastructure and adequate healthcare facilities. The decline in health services year after year has made matters worse. The modest health services provided in general and those provided in emergency cases remain insufficient. It is worth noting that there is a shortage of medicines in the camps' clinics affiliated with UNRWA for long periods and specific medicines, such as those for rheumatism, diabetes, and blood pressure, are unavailable. The shortage of specialized physicians and the early closure of clinics (closing at 2:30 pm) have all led to the deterioration of health conditions in the camps, the spread of chronic diseases among older adults, and malnutrition among children. Miscarriage rates among women have also increased, and the rate of vaccination against diseases has decreased. The neonatal mortality rates have reached high numbers (Ibrahim, 2016; 2012). A specialized report indicates that the health situation

in the camps has deteriorated significantly and further confirms that there is a defect in the existing health situation. On the one hand, the report indicates a decrease in basic needs and an increase in demand for health services provided by international relief agencies more than ever. On the other hand, it emphasizes the limited resources allocated, especially medical equipment (UN, 2013). Because of the poor health and political conditions, efforts to improve and organize health services in refugee camps are undermined.

Due to the greater professional practice of international social work in the relief and social services program compared with other programs, social work services are available in the region. However, there are multiple factors that limit the Palestinian refugees from receiving healthcare services provided by the UNRWA. This study aimed at understanding these obstacles and the role of social work professionals in addressing these obstacles.

1.3 Study objectives

This study seeks to achieve two objectives viz., a). identifying the obstacles that limit Palestinian refugees from availing benefits from the primary healthcare services provided by the UNRWA and b). identifying the role of social work efforts in addressing these obstacles. The first objective further seeks to understand the factors from the perspective of both the service user, i.e. the Palestinian refugee families, and the service provider, i.e. the agency. The second objective deals with the role of social workers in addressing these barriers to healthcare utilization and the difficulties in addressing these barriers.

2 Methods

2.1 Study type

In order to capture the obstacles faced by Palestinian refugees in availing primary healthcare services and understand the role of social workers to facilitate this, a cross sectional descriptive design was employed.

2.2 Sampling method

The study consists of a social survey that employs "cluster random sampling" to choose a sufficient sample of Palestinian refugees based on the geographical regions. Cluster sampling is one of the probability sampling techniques that is best consistent with the objectives of this study. The reasons behind choosing this particular sample are to a) ensure diversity as the population is vast and diverse, b) create an accurate sample from the whole population and obtain well-defined data, c) reduce sample bias derived from a population to negligible or nonexistent.

A comprehensive inventory of social workers in the West Bank was used to determine the roles of specialists in the professional practice of social services in confronting the obstacles that limit Palestinian refugees from receiving benefits from primary healthcare services.

2.3 Study tools

Based on the type of study and the method used, two tools were utilized:

- A questionnaire was administered to the Palestinian refugees (the study population). The questionnaire was designed to identify the obstacles that limited availing the benefits of primary healthcare services provided by the UNRWA.

- A scale prepared by the researchers was also applied to social workers in the health field who provide services in the Health Directorate at the West Bank level at UNRWA.

Since the participants were Arabic speakers, both tools were initially developed in the Arabic language. After data collection, the researchers reviewed, classified, and coded the data, which were then entered and analyzed using SPSS version 25.0. Drafting was the last stage of the research, in which the researchers used the English language, carefully employing appropriate research terms, phrases, and expressions. To ensure the same meaning across the two languages, the researchers met several times and then decided to translate the two tools into English. Next, the Arabic and English elements were evaluated by the research team. The evaluation took into account the integration of these translations to ensure clear meaning (i.e., comparability and equality).

2.4 Study population and sample

A proportional distribution method was used to obtain the Palestinian refugee sample. The sample size was 600 Palestinian families in the Nablus Governorate, spanning across varying geographical regions (i.e., camps). The reason behind choosing a proportional distribution method was to reach a good sample size, cover the geographical regions, and include all classes of families. Participants were approached through two procedures: a) community meetings that give a rough sense of the study population, prepare the participants for their roles in the study, and help them fill up the survey and b) door-to-door survey, especially for those that did not attend the community meetings.

Region	Number of camps	Population of refugees	Sample size
West Bank	19	206,123	600

UNRWA (2021).

The researchers applied a questionnaire among 121 social workers (i.e., complete census) practising in the health sector at the UNRWA at the West Bank level. The researchers decided to include all social workers in order to reach a reasonable sample size for answering the study questions (i.e., questions 5 & 6).

2.5 Data collection procedures

The data for this study were collected between February 2023 and June 2023. The researchers trained four graduate students from AL-Istiqlal University to collect the data from the families. The participants returned the questionnaire in a sealed envelope that was collected by the researchers.

2.6 Tool validity

Face validity is usually verified through an initial examination of the item content. By looking at the subtopics within the tool, we checked the items that comprised the tool and the extent to which they related to the topic to be measured or verified. Face validity also included presenting the tool to a group of arbitrators (n = 12), with six arbitrators for each tool (i.e., scale and questionnaire). The list of arbitrators (e.g., corrected and interrater) included educators specializing in social work at Fayoum University, Helwan University (Egypt), and Umm Al-Qura University (Saudi Arabia). The percentage of agreement on the phrases of the

tools was calculated; phrases that were not agreed upon were excluded, and the wording was modified for phrases on which 20% of the arbitrators did not agree.

Intrinsic validity is measured as the square root of the reliability coefficient. The results for both tools indicated high validity (questionnaire = 0.90, scale = 0.96).

2.7 Tool reliability

To assess the reliability of the social workers' scale, the split-half method was used. The reliability coefficient of the scale was high (0.93).

The researchers used the test-retest method to assess the reliability of the family questionnaire, following these steps:

- Apply the questionnaire to 25 randomly selected Palestinian refugees.
- Apply the questionnaire to the same refugee families with a time interval of three weeks.
- Calculate the Pearson correlation between the first and second applications of the questionnaire.

The scale was evaluated for reliability, and the overall statistic was found to be 0.81 indicating good reliability.

Table 1: Results of the family questionnaire

Axis	Correlation coefficient (reliability)	Significance (p-value)	Intrinsic validity coefficient	Level of the relationship
1	0.92	significant (0.05)	0.96	High and strong
2	0.91	significant (0.05)	0.95	High and strong
3	0.87	significant (0.05)	0.93	Strong
4	0.93	significant (0.05)	0.96	High and strong

2.8 Ethical considerations

Two consent agreements were obtained prior to conducting this study. The study proposal was first approved by the AL-Istiqlal University's Institutional Review Board (Could you please provide the IHEC approval number, if available, here) and then by the Palestinian Ministry of Health. Participation was voluntary, and the participants could drop out of the study at any time. The study guaranteed that the participants' responses to the survey were

anonymous and used only for scientific purposes. The informed consent document clearly explained the nature of the questionnaire, stating that participation was not compulsory and assuring participant confidentiality. The informed consent document was given to each participant before administering the questionnaire. Several procedures, including a pre-phone call and follow-up reminder phone call when needed, were used to increase the response rates (Dillman et al., 2014).

3 Results

The results are divided into four sections: a) obstacles pertaining to the beneficiary's background, b) obstacles attributed to the service provider, c) obstacles related to the quality of service provided by social workers and d) roles of social workers within primary healthcare services.

3.1 Obstacles related to the beneficiary's background

Table 2 illustrates the obstacles limiting Palestinian refugees from availing benefits from primary healthcare services provided by the UNRWA. Table 3 demonstrates the obstacles attributed to the service provider (the agency, UNRWA). Table 4 shows the obstacles associated with social workers. Table 5 evaluates the professional practice of social workers in confronting obstacles that limit Palestinian refugees from receiving benefits from primary healthcare services.

Table 2: Obstacles related to the beneficiary's background (Palestinian refugee families; n = 600)

N	Statement	Responses						RSI	R
		Yes		To some extent		No			
		K	%	K	%	K	%		
1	Lack of family knowledge about the nature of the agency's services	305	50.8	240	40.0	55	9.2	80.55	2
2	Inefficiency of the primary health care services provided by the agency compared to other services (such as social and economic services)	80	13.3	281	46.8	239	39.8	57.83	10
3	Lack of family cooperation with agency specialists	320	53.3	197	32.8	83	13.8	97.83	3
4	Poor family engagement with the agency's primary health care activities	297	49.5	215	35.8	88	14.7	78.27	6
5	Lack of resources of the family that can be invested in confronting its problems	327	54.5	217	36.2	56	9.3	81.72	1

6	The large size of family limits the use of the agency’s services	239	39.8	141	23.5	220	36.7	67.72	8
7	Multiple needs of family, which limits the use of the agency’s services	337	56.2	149	24.8	114	19.0	79.05	4
8	Weak family confidence in the agency’s ability to solve the family’s health problems	348	58.0	117	19.5	135	22.5	78.50	5
9	Lack of family experience in knowing the services that most satisfy their needs	219	36.5	264	44.0	117	19.5	77.33	7
10	Lack of family adherence to health directives given by agency	143	23.8	329	54.8	128	21.3	67.50	9

RSI = Relative Strength Index, R = Rank. Arithmetic mean = 1338, RSI = 74.33%

Table 2 shows that the three most prominent obstacles are “Lack of family resources that can be invested in confronting its problems,” “Lack of family knowledge about the nature of the agency’s services,” and “Lack of family cooperation with agency specialists”. Table 2 includes pivotal points that identify the most prominent obstacles facing families benefiting from the services provided by the UNRWA. Researchers may attribute these obstacles to the family’s lack of initiative and effort to learn about the importance and goals of the UNRWA. In addition, the care services provided to refugees may fail to satisfy the family’s actual needs. This may be due to the decline in trust between the UNRWA and Palestinian refugees resulting from the care policy followed by the UNRWA in recent years, which deprived many families of the benefits of some services, damaging the relationship that is based on cooperation and dialogue.

3.2 Obstacles attributed to the service provider

Table 3: Obstacles attributed to the service provider (the agency, UNRWA; n = 600)

N	Statement	Responses						RSI	R
		Yes		To some extent		No			
		K	%	K	%	K	%		
1	Decrease in the number of agency specialists compared to the increase in the number of families	422	70.3	126	21.0	52	8.7	84.27	2
2	Weak capabilities granted to specialists in primary health care services	323	53.8	195	32.5	82	13.7	80.55	4

3	Inflexibility of the laws regarding entitlement to services provided by the agency	283	47.2	262	43.7	55	9.2	79.33	6
4	Weak cooperation between the agency's administration and institutions concerned with refugee care	330	55.0	177	29.5	93	15.5	79.83	5
5	Poor level of primary health care services provided by the agency	268	44.7	247	41.2	85	14.2	76.83	7
6	The agency is not willing to develop its services and to follow up with the families to ensure that health needs are fulfilled	311	51.8	136	22.7	153	25.5	75.44	8
7	The agency declines in its response and services to family health needs	357	59.5	183	30.5	60	10.0	83.17	3
8	Weak agency capabilities in comparison to the multiplicity of family health needs	182	30.3	245	40.8	173	28.8	67.16	11
9	Weak cooperation and communication between the agency and other health institutions in the community	216	36.0	274	45.7	110	18.3	72.55	9
10	Long processes and many documents are required by the agency to provide primary health care services to the families	412	68.7	148	24.7	40	6.7	87.33	1
11	Lack of suitable places to provide health services and distribute aid	276	46.0	134	22.3	190	31.7	71.44	10

RSI = Relative Strength Index, R = Rank. Arithmetic mean = 1403.09, RSI = 77.95%

Table 3 illustrates that the Palestinian refugee families faced multiple obstacles in availing healthcare services due to factors associated with the service provider system . The three most significant obstacles were "The agency requires long processes and many documents to provide primary healthcare services to the families," "Decrease in the number of agency specialists compared with the increase in the number of families," and "The agency's decline in its response and services to family health needs." This may be due to the policy followed by the UNRWA in terminating the contracts of more than 312 service provider specialists in mid-2009 (Ibrahim, 2016; 2012), which increased the burden and responsibilities of the remaining workers. This also affected the scope of their empowerment and their ability to follow up on refugee families efficiently and effectively, assess their needs, and provide appropriate services. In addition, it appears that the eligibility criteria set by the UNRWA, the

inflexible regulations, and the adoption of certain strategies when providing services do not take into consideration the Palestinian culture, leading to a decline in services and the feeling of dissatisfaction with the UNRWA's role in covering their simplest and growing needs. Moreover, there is an indication that the policy followed by the UNRWA has contributed to restricting the freedom of specialists when making decisions concerning refugees. This, in turn, has contributed to the failure in achieving justice and equality in the provision of primary healthcare services. The agency's medium-term strategy for 2010–2015 revealed that UNRWA employees determine their eligibility for UNRWA services on a case-by-case basis, following strict eligibility criteria (Ibrahim, 2016). In addition, the limited financial resources that the UNRWA allocates to relief programs and services amount to only approximately 10% of its budget, and this percentage does not help cover the needs of refugees. Furthermore, the occurrence of new conflicts, such as in Somalia, Afghanistan, and Yemen, clearly affected the commitment of donating countries. With the continued steady increase in the number of refugees and the escalation of their needs, the UNRWA budget is not sufficient to meet the needs of Palestinians to secure quality of life.

3.3 Obstacles related to the quality of service provided by social workers

Table 4: Obstacles related to the social worker (n = 600)

N	Statement	Responses						RSI	R
		Yes		To some extent		No			
		K	%	K	%	K	%		
1	Social workers rarely treat refugees with respect	165	27.5	144	24.0	291	48.5	59.66	9
2	Social workers rarely show interest in solving refugees' health problems	146	24.3	381	63.5	73	12.2	70.72	5
3	The social worker discloses confidential information about refugees	67	11.2	141	23.5	392	65.3	48.61	10
4	The social worker's inability to establish a professional relationship with families	243	40.5	283	47.2	74	12.3	76.05	1
5	An increase in the number of refugee families with whom the social worker deals	236	39.3	280	46.7	84	14.0	75.11	2
6	The social worker is frequently preoccupied with administrative work and non-professional tasks	211	35.2	240	40.0	149	24.8	70.11	6
7	The social worker's discomfort in	202	33.	256	44.	133	22.	69.5	8

	working with refugees		7		2		2	0	
8	The social worker does not direct refugees to institutions concerned with meeting their health needs	213	35.5	248	41.3	139	23.2	70.77	4
9	Unfairness in the specialist's dealings with refugees, such as intermediation	260	43.3	171	28.5	169	28.2	71.72	3
10	The effect of the social worker's political affiliation on his/her role in serving refugees	210	35.0	236	39.3	154	25.7	69.77	7

RSI = Relative Strength Index, R = Rank. Arithmetic mean = 1227.7, RSI = 68.21%

Table 4 shows the responses of Palestinian refugee families pertaining to the quality of services provided by social workers. The three most significant factors as per the responses were, "The social worker's inability to establish a professional relationship with families", "An increase in the number of refugee families with whom the social worker deals", and "Unfairness in the specialist's dealings with refugees, such as intermediation/intercession".

This aspect of the study identified the quality of the professional practice of social services at the UNRWA. As expressed by the Palestinian families, there were deficiencies in the input to the professional practice of social work. This may be because of limited training programs to provide social workers with the required knowledge, skills, and values. Moreover, limitations associated with professional practice strategies and adherence to professional standards to avoid bias in working with refugees, might have affected the quality of service. These factors could have had a negative impact on the quality of professional practice and the ability to deal effectively with refugee problems.

3.4 Roles of social workers within primary healthcare services

Table 5: Roles of social workers within primary health care services (n = 121)

N	Statement	Responses						RSI	R
		Yes		To some extent		No			
		K	%	K	%	K	%		
1	Helping the family to cover treatment costs	69	57.0	42	34.7	10	8.3	82.92	2r
2	Providing a healthy diet to reduce malnutrition problems	56	46.3	50	41.3	15	12.4	77.96	6r
3	Helping the family to effectively confront the difficulties associated with their health problems	69	57.0	42	34.7	10	8.3	82.92	2r

4	Monitoring the health status of the family periodically to ensure that they receive health services	59	48.8	44	36.4	18	14.9	77.96	6r
5	Facilitating procedures for families to obtain health insurance services	64	52.9	43	35.5	14	11.6	80.44	4r
6	Contributing to problem solving between families and medical centers	50	41.3	53	43.8	18	14.9	75.48	10
7	Contributing to referring families to the medical clinics they need	75	62.0	36	29.8	10	8.3	84.57	1
8	Contributing to the development of health services provided to families	60	49.6	44	36.4	17	14.0	78.51	5
9	Contributing with specialists in finding the health services the family needs	50	41.3	39	32.2	32	26.4	71.63	11
10	Investing available resources in providing health services to the family	51	42.1	59	48.8	11	9.1	77.69	7
11	Educating the family about health pathogens through leaflets	60	49.6	35	28.9	26	21.5	76.30	9
12	Providing the family with preventive procedures and measures to avoid illness and infection	60	49.6	38	31.4	23	19.0	76.86	8
13	Presenting new ideas that contribute to infection prevention through seminars	62	51.2	47	38.8	12	9.9	80.44	4r
14	Providing the family with good health habits	63	52.1	50	41.3	8	6.6	81.81	3

RSI = Relative Strength Index, R = Rank. Arithmetic mean = 286.57, RSI = 78.95%

Table 5 illustrates social workers' roles in helping the community to address the barriers to availing healthcare services. The most important roles, as enumerated by the respondents were: (1) "Contributing to referring families to the medical clinics they need", (2) "Helping the family to cover treatment costs", (3) "Helping the family to effectively confront the difficulties associated with their health problems", and (4) "Advising families on good health habits".

It is also clear from the field data presented in the table that the role of social workers is important in confronting health obstacles. The problems that social workers deal with in the field can be described as diverse, complex, continuous, and transformational. Social workers

bear a professional responsibility to identify the various problems that refugee families experience, especially those related to health issues, and to help them take preventive measures. In addition, it is clear from the data that social workers play a vital role in helping families confront their health problems through referral to medical centers and clinics, whether they are health centers affiliated with the UNRWA, or through referral to governmental or private centers and hospitals.

4 Discussion and Conclusion

The most prominent obstacles to Palestinian refugee families benefiting from primary healthcare services provided by the UNRWA were (1) “Lack of family resources that can be invested in confronting its problems”, (2) “Lack of family knowledge about the nature of the agency’s services” and (3) “Lack of family cooperation with agency specialists”.

The most prominent health obstacles attributed to the UNRWA were (1) “The agency requires long processes and many documents to provide primary healthcare services to families”, (2) “Decrease in the number of agency specialists compared with an increase in the number of families”, and (3) “The agency’s decline in its response and services to family health needs”.

The obstacles related to social workers were (1) “The social worker’s inability to establish a professional relationship with families,” (2) “An increase in the number of refugee families with whom the social worker deals”, and (3) “Unfairness in the specialist’s dealings with refugees, such as intermediation/intercession”.

While the efforts of the social work profession to confront health obstacles were limited to specific roles provided by social workers (see Table 5), the most prominent were (1) “Contributing to referring families to the medical clinics they need,” (2) “Helping families cover treatment costs”, (3) “Helping families to effectively confront the difficulties associated with their health problems”, and (4) “Advising families on good health habits.”

This study’s finding regarding the lack of knowledge among migrant families about the healthcare system and the nature of the health services provided (see Table 2) resonates with studies held in other parts of the globe. A study from Vienna analyzing the reasons for the low use of professional healthcare services, focusing on migrants from Turkey, the former Yugoslavia (Bosnia and Serbia), Poland, and Iran (Reinprecht, 2024) showed that reasons ranging from structural causes (poverty, marginalization, and discrimination) to a lack of knowledge about the healthcare system can result in below-par utilisation of healthcare services. Evidence shows a heterogeneous situation in European countries with regard to health literacy among migrants and refugees (Rosano, 2015). Another study showed that the lack of information about available care options was one of the factors contributing to the poor health of refugees (Pithara et al., 2012). A Finnish study also highlighted factors such as a lack of awareness of the healthcare system among different groups of immigrants (Russians, Somalis, and Kurds) and found that they contribute to unmet needs (Koponen et al., 2014). Similarly, a survey of 455 adult refugees in Sweden revealed that most immigrants had insufficient or limited health knowledge, both functional and comprehensive (Wangdahl et al., 2014).

The findings regarding the problems of organization and coordination (see Table 3) are not far from the results of a study that focused on the health conditions of refugees in Greece (Psarros et al., 2016). Organizational issues faced by healthcare providers include problems of internal

and external communication and coordination, insufficient funding, and lack of human resources to treat large numbers of refugees (Dara et al., 2016).

Refugees across the globe appear to face the similar problems in accessing healthcare. Lack of funding, shortage of trained and stable human resources, and poor organization and coordination were mentioned as impeding access to essential health services. In addition, there is a need for qualified and trained medical personnel, including social workers. The findings emphasize the need for social and psychological support, additional financial and human resources, and training of healthcare professionals. The findings also highlight the need to improve the availability of diagnostic equipment and mental healthcare services and the need for providing integrated care for migrants that allows them to access different services easily. Hence the study recommends development work that focuses on the performance of social services at UNRWA so that it pays special attention to the issue of health equity. A second recommendation is expanding the recruitment and training of social workers as they are agents of change in the UNRWA and other health organizations that provide services to vulnerable, needy, and disadvantaged groups living in disadvantaged communities.

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