BARRIERS TO MATERNAL AND CHILD HEALTHCARE ACCESS FOR ASYLUM SEEKERS AND MIGRANTS FROM MYANMAR IN MALAYSIA: A CASE STUDY OF SELAYANG, KUALA LUMPUR

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นางสาวสุบาตรา จะยารัตน์

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาศิลปศาสตรมหาบัณฑิต
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สุบาตรา จะยารัตน์: อุปสรรคในการเข้าถึงการดูแลสุขภาพแม่และเด็กในกลุ่มผู้ลี้ภัยและผู้ย้ายถิ่นจากพม่าในมาเลเซีย: กรณีศึกษาเขตเซลายัง กัวลาลัมเปอร์ (BARRIERS TO MATERNAL AND CHILD HEALTHCARE ACCESS FOR ASYLUM SEEKERS AND MIGRANTS FROM MYANMAR IN MALAYSIA: A CASE STUDY OF SELAYANG, KUALA LUMPUR) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: รศ.ดร.นพ.จิรุตม์ ศรีรัตนบัลล์, 101หน้า.

การศึกษาในครั้งนี้ได้วางกรอบขึ้นจากแนวคิดเรื่องสิทธิในการเข้าถึงบริการทางสาธารณสุข ตามหลักของปฏิญญาสากลว่าด้วยสิทธิมนุษยชน ฉบับปี พ .ศ. 2491 ข้อที่ 25 ซึ่งกล่าวว่า ทุกคนมีสิทธิในมาตรฐานการครองชีพอันเพียงพอสำหรับสุขภาพและความอยู่ดี ซึ่งรวมถึงการดูแลรักษาทางการแพทย์ และบริการสังคมที่จำเป็น การศึกษาในครั้งนี้มีเจตนาเพื่อบรรยายข้อมูลโดยรวมของผู้ย้ายถิ่นชาวพม่าในเขตเซลายัง กัวลาลัมเปอร์ ระบุถึงอุปสรรคในการเข้าถึงการดูแลสุขภาพแม่และเด็กของกลุ่มประชากร และวิเคราะห์อุปสรรคทางเพศในการเข้าถึงการบริการด้านสุขภาพ

การวิจัยได้จัดทำขึ้นด้วยวิธีการสัมภาษณ์เชิงคุณภาพ ในกลุ่มหญิงชาวพม่าจำนวน 15 คน บุคลากรจากกรมสาธารณสุข ตัวแทนจากสำนักงานข้าหลวงใหญ่ผู้ลี้ภัยสหประชาชาติ และผู้ประสานงานด้านการแพทย์จากองค์กรพัฒนาเอกชนซึ่งเป็นชาวพม่า โดยใช้กระบวนการสุ่มตัวอย่างด้วยการเลือกตัวอย่างที่หลากหลายในกลุ่มชาติพันธุ์ พร้อมด้วยหลักพิจารณาเพิ่มเติม คือการเป็นหญิงชาวพม่าที่กำลังตั้งครรภ์ หรือพึ่งคลอดบุตรภายในเวลา 2 ปี อาศัยในประเทศมาเลเซียอย่างน้อย 6 เดือน และได้ประสบความยากลำบากในการเข้าถึงบริการทางสุขภาพ

ตัวแปรที่ใช้วัดประกอบด้วย การตรวจสุขภาพก่อนคลอดและรับวัคซีนตามที่กำหนด ความรู้ด้านการวางแผนครอบครัว และการตื่นตัวต่อโรค HIV/AIDS อุปสรรค์หลักที่ขัดขวางการเข้าถึงบริการสุขภาพแม่และเด็กประกอบด้วย ความกลัว ประเด็นเชิงความมั่นคง ปัญหาการเตรียมเอกสารประกอบและการลงทะเบียน ค่าใช้จ่าย การขาดความรู้ถึงสถานที่และเหตุผลในการเข้ารับบริการสุขภาพแม่และเด็ก รวมถึงอุปสรรคด้านภาษา โดยไม่พิจารณาอุป สรรคด้านกายภาพเป็นปัญหาสำคัญ

ผลการศึกษาได้ชี้ให้เห็นว่า อุปสรรค์ในการเข้าถึงการดูแลสุขภาพแม่และเด็กในกลุ่มผู้ลี้ภัยและผู้ย้ายถิ่นชาวพม่าในกัวลาลัมเปอร์นั้นเกิดขึ้นก่อนการทำงานของหน่วยงานสาธารณสุข (เช่น ปัจจัยด้านความมั่นคง การเตรียมเอกสารประกอบ และด้านสังค ม-วัฒนธรรม ต่างๆ) เนื่องมาจากสถานะที่ไม่มั่นคงของชุมชนผู้ย้ายถิ่นจากพม่า ส่งผลกระทบต่อผลลัพธ์ทั้งในเชิงปัจเจกและเชิงเศรษฐกิจ-สังคม ที่กำหนดการตัดสินใจในเชิงสุขภาพ ปัจจัยเชิงระบบต่างๆ เช่นนโยบายระดับชาติต่อกลุ่มผู้ย้ายถิ่น และความต้องการทางความมั่นคงอาจส่ งอิทธิพลเป็นอย่างมากต่อการเข้าถึงบริการด้านสุขภาพเช่นกัน นอกจากนั้น ความกลัวที่มีต่อเจ้าหน้าที่ผู้บังคับใช้กฎหมายยังขัดขวางการเข้าถึงบริการอย่างมีประสิทธิภาพอีกด้วย โดยแนวทางซึ่งอาศัยหลักด้านสิทธิมนุษยชน อาจสนับสนุนการจัดการปัญหาอุปสรรคในการเข้าถึงบริการด้านสุขภาพของประชาชนได้

สาขาวิชา การพัฒนาระหว่างประเทศ ลายมือชื่อนิสิต……

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SUBATRA JAYARAJ: BARRIERS TO MATERNAL AND CHILD HEALTHCARE ACCESS FOR ASYLUM SEEKERS AND MIGRANTS FROM MYANMAR IN MALAYSIA: A CASE STUDY OF SELAYANG, KUALA LUMPUR. ADVISOR: ASSOC. PROF. JIRUTH SRIRATANABAN, Ph.D., 101 pp.

This study was framed around the concept of the right to access healthcare services. Article 25, of the Universal Declaration of Human Rights 1948, states that everyone has the right to a standard of living that is adequate for their health and well-being, including medical care and necessary social services. The studies intended to describe the Myanmar migrant profile in Selayang, Kuala Lumpur, identify barriers to maternal and child healthcare (MCH) access in the population and analyse gender obstacles in health access.

Research was via qualitative interviews with 15 Myanmar women, a health department personnel, a UNHCR representative and a Myanmar NGO Medical Coordinator. Maximum variation sampling of ethnic groups was used; with inclusion criteria comprising Myanmar migrant women who were pregnant or recently given birth in the past 2 years, been in Malaysia at least 6 months and experienced difficulty in accessing health services.

Parameters assessed included antenatal and vaccination checkups compliance, family planning knowledge and HIV/AIDS awareness. Major barriers to MCH access comprised of fear/security issues, documentation and registration problems, cost, lack of knowledge on where and why to seek MCH services, and language barriers. Physical barriers were not a major problem.

This study suggests that barriers to MCH access for Myanmar asylum seekers and migrants in Kuala Lumpur come from prior to the health service sector (security, documentation, and socio-cultural factors). This is because of the irregular status of the Myanmar migrant community affecting individual and socioeconomic outcomes in determining health decisions. System based factors such as national policy towards migrants and the need for security also may have great influence in determining healthcare access. Additionally, fear of enforcement authorities prevents effective access to services. A rights-based approach may facilitate addressing barriers in MCH access in the population.

Field of Study: International Development Studies Student's Signature .....

Academic Year: 2012 Advisor's Signature .....

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Words cannot express my deepest gratitude to my translator, Montaz of the Burma Muslim Community who has become a good friend. Her amazing determination and passion to work for a better society inspires me to continue the aspirations that drive this research. I would also like to acknowledge all the Myanmar community organizations as well as every interviewee who helped form the very core of this project. Their new perspectives on life, adversity and struggles in the region has become an eye opener, especially as we strive for better equitability for health rights in the region.

Above all I would like to thank Raj & Pasu, who believed in my passion and continue to support me throughout my transition in life. I am forever grateful for the never-ending inspiration that I have seen growing up highlighting that a better world should indeed be possible for everyone.

Last, but not least, as a sign of my heartfelt appreciation, I dedicate this thesis to all my patients who have made me smile, made me cry and made me realise why exactly I carry on.

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ABBREVIATIONS

AIDS	-	Acquired Immuno-Deficiency Syndrome
ASEAN	-	Association of South East Asian Nations
CEDAW	-	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	-	Convention on the Rights of the Child
HIV	-	Human Immunodeficiency Virus
ILO	-	International Labor Organization
MCH	-	Maternal and Child Health
MDG	-	Millennium Development Goals
MMR	-	Maternal Mortality Ratio
MOH	-	Ministry of Health, Malaysia
NGO	-	Non-Governmental Organization
RBA	-	Rights-Based Approach
RELA	-	Malaysia Volunteers Corps *(Ikatan Relawan Rakyat)*
UN	-	United Nations
UNDP	-	United Nations Development Programme
UNHCR	-	United Nations High Commissioner for Refugees
WHO	-	World Health Organization

CHAPTER I

INTRODUCTION

The nexus of migration and health is an important issue as globalisation takes the world into a community of interconnectedness and of increasing complexities. The rapid development of the countries has lead to disparities between subsets of populations and consequently inequality influences not only economic dimensions, but also affects social opportunities (Gushulak & MacPherson, 2006).

This thesis explores the topic of migrant health. The area of migrant health is an important cross-regional issue, as ramifications extend across policy and planning of multiple communities and countries. Specifically, issues of access to social services such as healthcare and education play an important role in the overall human development of a society (UNDP, 2011) .

The research focused on barriers to maternal and child healthcare access in a Myanmar migrant population in Kuala Lumpur, Malaysia. The case study population is a multi-ethnic urban population comprising a mixed flow source of Myanmar migrants. This mixed flow comprises of asylum seekers, economic migrants and environmental refugees; a bulk of which are irregular and undocumented.

1.1 Background of the Study

Malaysia has been a country that has been built on migrations of populations. It is inevitable that the country's future population will be shaped by an ever increasing ease in transmigration across borders, especially among South East Asian countries. Over the past decade there has been a rapidly increasing population of Myanmar migrants in the city of Kuala Lumpur, Malaysia. This is on a large part due to the persistent political, economic and environmental situation in Myanmar.

Large portions of Myanmar migrants to Malaysia are refugees and asylum seekers and they also currently make up around 90% of those registered with the United Nations High Commissioner for Refugees in Malaysia (UNHCR, 2011). Myanmar refugees frequently are undocumented, thus making them difficult to distinguish between migrants who leave their countries because of political persecution, conflicts, economic problems, environmental degradation or a combination of these reasons and those who do so in search of conditions of survival or well-being that does not exist in their home country.

1.2 Problem Statement

Irregular migrants however, are marginalised by most national services and do not have adequate access to health facilities (Kaur, 2007). Whilst the Myanmar migrant population contributes to the economy as part of the low-skilled services sector, they are seen as a burden by the local institutions in terms of health and society, as many are illegal or undocumented. Various obstacles thus hinder the use of health services by the community.

Basic health services that every community should be able to access, at the very least, include primary health care and basic reproductive health services. In Malaysia, migrants who have the opportunity may receive maternal and child health services with different degrees of cost from a range of places. These include medical clinics and hospitals, which may be either private or government funded. In addition to these modern medical health centres, traditional forms of healthcare may also be accessed. Government hospitals in Malaysia provide universal healthcare as a national health service. However, costs are varied depending on civil service status, citizenship, and health speciality (HKL, 2012).

Barriers in accessing these maternal and child health services can be seen as coming intrinsically from within the community, and also extrinsically by outside factors influencing the health decisions made. The irregular status of the Myanmar migrants compounds existing barriers in healthcare access, thus leading to a problem that is multifaceted in nature.

1.3 Significance of Research

Data and research on migrant populations in Malaysia have been confined to government statistics and do not give accurate impressions, especially around issues of undocumented and illegal migrants. There has been insufficient emphasis in mainstream health research or policy on the factors that affect health and socio-economic outcomes relating to the migrant experience (Jayaweera, 2010). Therefore, exploration of the issues surrounding healthcare access will lead to a better understanding of social development needs of the migrant population as well as highlight potential areas of improvement.

Additionally, the migrant population is a subset of the national population that are marginalised by mainstream health facilities (Phua, 2007). Research into the issue will also contribute to a greater understanding of equitable service provision in other sidelined communities.

Healthcare access and opportunities to vulnerable populations have extended implications to health and socio-economic wellbeing of the host country citizens (Parikh, 2010). As rapidly as migration is evolving, a multitude of diseases, such as tuberculosis and malaria now are re-emerging in a country that once had levels under control. Thus it is essential that national healthcare policies take an increasingly more regional outlook; taking into account migration demographics and population mobility into planning health budgets and services. This approach, combined with a rights based perspective to health may provide more equitable development prospects for citizens and non-citizens alike.

1.4 Operational Definition of Terms

For the purpose of this research, the term “migrant” is used in a very broad sense, referring not only to those who change their country of residence voluntarily but also to asylum seekers, refugees and victims of human trafficking. This reflects the difficulty in distinguishing between those who migrate to escape political persecution, economic difficulties or environmental degradation. Many of these groups overlap, and commonly form joint communities. Since the consequences of migration may also extend beyond the first generation, second and later generations are also included. A *migrant* from Myanmar describes any individual who has originated from the geographical unit of The Union of Myanmar (previously known as Burma) who has moved across one or more political borders and wishes to settle definitely or temporarily in a place other than their place of origin.

International law defines a *refugee* as a person who has fled from and/or cannot return to their country due to a well-founded fear of persecution, including war or civil conflict. An *asylum seeker* is a person who has left their country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on their application. Additionally, the term *Persons of Concern* (POC) used by the UNHCR includes refugees, asylum seekers, internally displaced persons, returnees and certain groups which are granted temporary protection by the UNHCR.

"Access" describes the potential and actual entry of a given individual or population group into the health care delivery system (Aday & Anderson, 1981). This view of access involves different aspects of the relationship between the service providers and clients, which determine patterns of use. The concept of access is focused on the processes that determine entry into the health care system and the opportunities that are present to make use of a particular resource.

According to the World Health Organisation (WHO) glossary guidelines, "*access*" to health care is affected by the presence or absence of barriers (WHO, 2012a). The definitions below from the guidelines will be used for the purpose of this research.

Socio-cultural barriers: those related to social or community perceptions of health services, for example perceived or actual discrimination on the part of health care providers, and language barriers.

Physical barriers: those related to the general supply of, availability of, and distance to health services.

Economic or financial barriers: those related to the cost of seeking and obtaining health care, in relation to a patient's or a household's income. An increase in the price of drugs or treatment may reduce access to health care for individuals in that household. Financial barriers also include indirect costs such as transport, time away

from work, and childcare costs. Government policies on health financing influence the impact of financial barriers.

Consequently, system-based factors in this thesis refer to policy and institutional arrangements that stem from state regulations and expression of policy in society that affect healthcare access. They include structural determinants of healthcare that are not dependent on health service delivery or price of those services.

This research focuses on barriers to maternal and child health care services for migrant communities. Maternal and child health care includes various facilities and programs organised for the purpose of providing medical and social services for mothers and children. Medical services include prenatal and postnatal services, family planning care, and paediatric care in infancy up till adolescence.

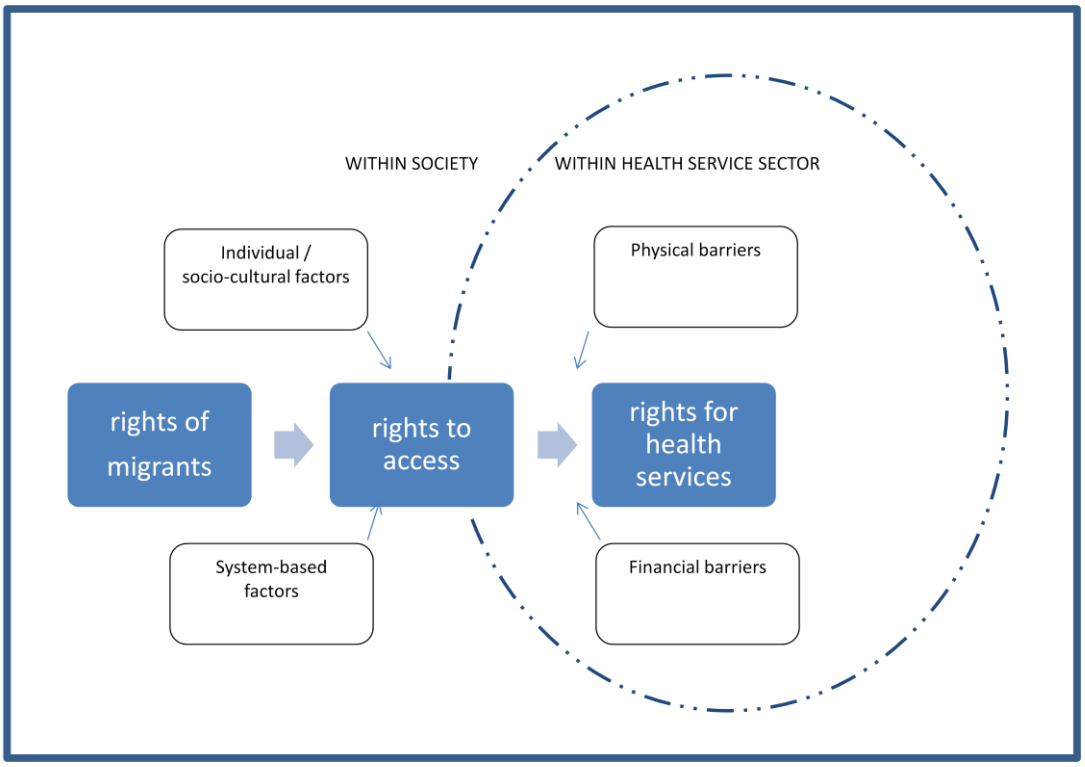
1.5 Development and Health Inclusiveness.

Health issues are closely related to socio-economic development capacities and increase the resilience of societies to intrinsically develop and thus increase standards of living and sustainability. Three of the eight Millennium Development Goals (MDGs) that nations of the world are aspiring to achieved by 2015 are directly related to health; namely to reduce child mortality, to improve maternal health and to combat HIV/AIDS, malaria and other diseases (UNDP, 2010). Other health areas, such as sanitation and non-communicable diseases, although not included in the MDGs, are also intricately linked to development and progress of communities towards better standards of living.

Marginalised groups in relation to health in Malaysia include the poor, indigenous populations, prisoners and migrants including workers and refugees.

1.6 Conceptual Framework

Figure 1 Conceptual Framework for Barriers to Maternal and Child Healthcare Access for Migrant Communities



This research is framed around the concept of the right to access healthcare services. Article 25, of the Universal Declaration of Human Rights 1948, states that everyone has the right to a standard of living that is adequate for their health and well-being, including medical care and necessary social services. The right to access medical services is further elaborated on in the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966) which necessitates the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

A Rights-Based Approach to development is a concept that encompasses the norms, principles, standards and goals of the international human rights system into the plans, policies and processes of development. One of the core aims is to promote and protect human rights.

The baseline to build on are norms and standards that are contained in international treaties and declarations agreed upon by the international community. These principles include equality and equity, accountability, empowerment and participation. This approach to development contrasts itself with a needs approach to development. It also includes expressed linkages to rights, accountability, non-discrimination and attention to vulnerable groups (UNESCAP, 2012).

Article 12 of the International Covenant on Economic, Social and Cultural Rights, outlines that State Parties should recognise the right of everyone to the enjoyment of the highest attainable standards of physical and mental health (OHCHR, 1966). The convention requires that steps taken by State Parties to achieve full realisation of this right, shall include those necessary for

a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b) The improvement of all aspects of industrial hygiene;
c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness.

Referred to in short as “the right to health” the expression of that right has been endorsed in the World Health Organisation (WHO) Constitution and a wide range of international and regional human rights instruments. In May 2000, the UN Committee on Economic, Social and Cultural Rights, which oversees the Covenant, adopted a

General Comment on the right to health with further explains the nature, scope and content of the right to health (WHO, 2012b).

With regards to health, a rights based approach (RBA) entails integrating human rights norms and principles in throughout the processes of health-related policies and programmes. These activities include the design, implementation, monitoring and evaluation. Incorporating human rights into development should empower the poor, ensuring participatory mechanisms in decisions that concern them and ensure accountability mechanisms which are accessible. These approaches should involve human dignity, pay attention to the needs and rights of vulnerable groups, and ensure that health systems are accessible to everyone.

Rights based approaches in development in the area of health care are particularly important for maternal and child health, for example in the issue of contraception and sexual and reproductive health, and in issues surrounding HIV/AIDS. Migrants also form a population of particular concern.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) attempted to improve on ILO conventions by introducing a wider definition of family, and a wider scope of protection to include the undocumented (United Nations, 1990). It also recognises the possibility of individual complaints. The ICRMW came into force in 2003, with only 40 parties to date; although the only South East Asian countries that have ratified it are the Philippines and Timor Leste.

1.7 Regional Commitments for Migrant Health in South East Asia

As the need for increased migrant health protections became more apparent, nations recognised the need for regional commitments on the issue. The 61st World Health Assembly Resolution on Health of Migrants in 2008 requested member states to "promote migrant-inclusive health policies and to promote equitable access to health promotion and care for migrants." (WHA, 2008). The Association of South East Asian Nations (ASEAN) agreed to regional strategies such as the ASEAN Declaration on the Protection & Promotion of the Rights of Migrant Workers (2007). A working group was set up in 2007 and a protection mechanism is currently still being drafted (Naito, 2011).

For example, the ASEAN Commitments on HIV & AIDS (2007) recognized that the HIV epidemic affect the vulnerable such as migrants and mobile populations. It encouraged the sharing of lessons, best practices and evidence based prevention policies. Additionally it advocates moving beyond just the health sector in prevention and education efforts especially in how migrants protect themselves. Outcomes also include improving access to pre-departure and post-arrival programs via improved legislation.

ASEAN members however, cannot agree on how to proceed with migrant worker issues because of conflict of interest between sending and receiving countries. There is no regional commitment to tackle the issue, despite the many regional meetings that took place. Each nation is protecting its own interest and ASEAN has not been able to establish an ASEAN Commission on Migrant Workers, unlike the successful ASEAN Commission on Women and Children (ACWC) or the ASEAN Intergovernmental Commission on Human Rights (AICHR).

1.8 Rights-Based Approaches to MCH for Migrants in South East Asia and Malaysia

South East Asia has many challenges, although not unique, but pertinent to this part of the world. Many countries, despite having signed many International Human Rights treaties, still have disparities between ratification and practice. Nevertheless, perhaps the signing of the Convention on the Rights of the Child (CRC) (United Nations, 1989) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (United Nations, 1979) by all ASEAN countries can be capitalised for migrant health.

Among the main concerns regarding migrant health is the right to access health care services. The barriers to accessing service are frequently institutional and expose migrants to increased risk of ill-health and injury, as well as exclude them from formal health systems.

Barriers are related to lack of information about how services are organised and delivered, cultural, language and financial barriers. Additionally, even though migrants are permitted to access government services such as in Thailand, there are still low usage of health services due to financial constraints, inability to speak Thai, illegal status, as well as cultural beliefs (Isarabhakdi, 2004). A rights-based approach to health programming will also optimise a integrated process with a focus on health promotion and disease prevention (Pace & Gushulak, 2010). Moreover, Article 28 of the ICRMW states that all migrant workers and their families are entitled to emergency medical care regardless of irregularity.

Besides access, special attention should be given to health needs of migrant women in view of the high number of women migrant workers in the region. Article 12 of CEDAW compels state parties to ensure appropriate services in connection with pregnancy, confinement and the post-natal period, granting services where necessary. Although having one of the lowest Maternal Mortality Rates in the world, 42 percent

of maternal deaths in Malaysia in 2000 were to non-citizens (UNDP, 2011). Asylum seekers and migrants, especially the undocumented, often have limited access to maternal health. Nevertheless, one positive development that can be seen is that the ratification of the Convention on the Rights of the Child has led to a Malaysian initiative to provide all children of migrant workers unrestricted access to health services (Pace & Gushulak, 2010). How this is implemented in daily practice though, remains to be seen.

In accessing maternal and child health services, many barriers are present in many forms and thus limit the expression of the right to health. Some previous publications on barriers to healthcare access to migrant communities merely state out the various obstacles, rather than conceptually categorising the social elements (Veerman & Reid, 2010). One other previous paper on the issue was done with the objective to suggest a policy framework to the government, in addressing the issues of refugees and asylum seekers used a conceptual framework on the rights based approach to health. The framework however, specifically focused on the role of the State in guaranteeing the right to health (Verghis & Pereira, 2009).

Conversely, the conceptual framework of this research suggests that barriers can be seen to come from within society and also within the health service sectors. For migrant communities, important individual and socio-cultural factors drive decisions to access health services. These may include cultural understanding, linguistic challenges, and health-seeking behaviours specific to a certain community (Aung, Pongpanich, & Robson, 2009).

Systems based or structural factors also play an important role. For example, the national migration policy and health policy and their interaction with each other determine security as well as health outcomes to migrant individuals and their families. Once an intrinsic decision has been made to seek healthcare access, many barriers exist within health service sectors as well that impede opportunity to seek medical care. These include financial factors such as high medical costs, and also

physical barriers at health centres that prevent direct access to medical care (HEI, 2009). For migrants, especially irregular migrants, these barriers that require documentation and legitimisation prevent access to the basic right to health that is required at the minimum.

1.9 Research Questions

This research strived to answer the following questions:

- What are the intrinsic barriers within the Myanmar migrant population and extrinsic challenges in the community and the national health system that dampers access to maternal and child health services in the case study population?
- Why are the reasons behind the permanent lack of encouragement to increase access to maternal and child healthcare in migrant populations?
- How can a rights-based approach facilitate increased access to maternal and child health opportunities in Myanmar migrant populations in the case study population?

1.10 Research Objectives

- To describe the community migrant profile in the Selayang area.
- To identify barriers to maternal and child healthcare access in Myanmar Inner City Migrant Populations.
- To analyse gender needs and obstacles faced by the Myanmar migrant populations in relation to health.

1.11 Hypothesis

The hypothesis of this research is that barriers to maternal and child healthcare access for the Myanmar migrant community exist within their community and also within the health service sector. Of these factors, more influence will come from prior to the level of the health service sector. This is because the irregular status of the Myanmar migrant community affecting individual and socioeconomic outcomes in determining health decisions. System based factors such as national policy towards migrants and the need for security also may have great influence in determining healthcare access. Additionally, fear of enforcement authorities prevents effective access to services.

1.12 Research Scope

This research focused on a case study area in the North Kuala Lumpur district of Selayang. It is a district about 10km away from the city centre, which has become an area of agglomeration for Myanmar migrants. This is in large part due to the fact of socio-economic and security reasons. There are many opportunities for low-skilled work, for example at the Selayang Wholesale Market and other businesses. Transport and communication also facilitates the presence of the migrants here. The Selayang Hospital is a Tertiary Government Hospital that covers the population besides functioning as the National Hepatobilliary Referal Centre. An estimated number of 1000 Myanmar migrants live in the immediate vicinity. They comprise mostly of Rohingyas, Chins, and Karens. The unit of research was the individual.

Figure 2 Maps showing the Selayang district in Kuala Lumpur, Malaysia in relation to Myanmar

Note: Modified from www.dromoz.com

1.13 Research Methodology

This Research employed the following methods of collecting data in the case study area.

Primary Research- Ethnographic Interview

- Semi-structured qualitative interviews with 15 women from different nuclear families in the case study area.
- Sampling: Maximum variation sampling of diverse ethnic groups, interview with 9 Myanmar Muslim, 2 Rohingya, 4 from other/mixed ethnic groups.
- Study site: Kuala Lumpur district of Selayang, selected due to high presence of urban irregular Myanmar migrants.
- Inclusion criteria:
    - First generation Myanmar migrant women who are currently pregnant or recently given birth in Malaysia in the past 2 years
    - who have been in Malaysia at least 6 months
    - who are living, however temporarily, in the given urban environment in Kuala Lumpur; regardless of regularity
    - who have had experienced at least once, difficulty in accessing health services.
- Exclusion criteria:
    - Children under 18 will not be included due to problems of language interpretation, although questions regarding barriers to child health will be posed to parents.

Qualitative interviews with health clinic staff in the case study area.

Expert Interview.

- Interview with an official from the health department in the district of Selayang.
- Interview with UNHCR representative.

Secondary Research

- Health clinic records from the Selayang District Health Clinic regarding patient load and demographic data. Permission would be sought from the State Health Department, Ministry of Health Malaysia.
- Malaysian Ministry of Health data

Key variables are individual/socio-economic factors, system's based factors, financial factors and physical factors that may affect healthcare access for the interviewees. Other variables include ethnicity, education level, language use and duration of stay in Malaysia.

1.14 Limitations

There were a number of limitations to this study, as the research population was diverse in irregularity, ethnicity, and of varying age groups.

Definitional issues were a challenge, especially for effective policy, advocacy and analysis surrounding forced migrants, which may be legal or irregular (Landau, 2004). This research took an expansive and inclusive view of migrants as all those coming from Myanmar, who are living, however temporarily, in a given urban environment in Kuala Lumpur. This implicitly recognised that the division between voluntary and forced migrants may not be as strict legal definitions suggests.

As the research depended on translators for qualitative interviews, some of the essence of a response may have been lost in translation. Additionally, some Rohingya did not speak fluent Burmese, and the translator may not have fully comprehended the local dialect. Limitations of time expressed itself in the number of interviews, while the quality of the interviews might have depended on the trust and relationship built

during the interview. Respondents might not have been directly forthcoming due to the short relationship during the research.

1.15 Ethical Issues

Bearing in mind the sensitivities involved in dealing with a population that may be irregular in the eyes of the law, ethical grounds guided the process of this research (Jacobsen & Landau, 2003). Compounding the situation of migrants, questions related to personal maternal and child health also required respect to the right of individuals regarding their own health.

Before any interviews were undertaken, informed consent was asked verbally to ensure all interviewees were aware on the purpose of the research and what it would entail. Migrant respondents were informed that their names would be kept confidential, and not passed on to a third party.

Security concerns in dealing with migrants that may be irregular was respected, and a neutral role played throughout the research. Of utmost importance, it was emphasised that no one involved in the research should have their safety or security compromised by any element of the study method.

CHAPTER II

LITERATURE REVIEW

2.1 Background

This literature review examines academic and legal documents that explore issues of migrant health in the context of development, human rights and inequity and the issue of obstacles to access to healthcare in Myanmar migrant populations. This area of migrant health is an important cross-regional issue, as ramifications extend across policy and planning of multiple communities and countries.

Malaysia is an attractive location for immigrants from Myanmar who seek refuge and economic opportunities away due to the persistent conflicts and policies of the current military regime. As the region of South East Asia increasingly acquires more porous borders, and as globalisation of the international economy trends towards greater population mobility, access to healthcare should be seen as a right for everyone, citizens and non-citizens alike. The provision of more equitable access to health services stands to benefit both the host country and marginalised populations such as migrants in the developing world.

2.2 Health and Development in Malaysia

Healthcare and all issues relating to the access and inclusiveness of health in society is a paramount necessity for the overall development of a community. Health issues are closely related to socio-economic development capacities and increase the resilience of societies to intrinsically develop and thus increase standards of living and sustainability.

Three of the eight Millennium Development Goals that are aspiring to be achieved by nations of the world by2015 are directly related to health; namely to reduce child mortality, to improve maternal health and to combat HIV/AIDS, malaria and other diseases (UNDP, 2010). Other health areas, such as sanitation and non-communicable diseases, although not included in the MDGs, are also intricately linked to development and progress of communities towards better standards of living.

In 2000 Malaysia achieved the aggregate MDG objective of halving poverty, although nationally, income inequality remains high. Additionally, despite Malaysia having overall achieved the MDG statistical aspirations, the data does not capture certain non-citizen populations and migrants. The MDG5 for example excludes births and deaths of non-citizens and migrants from the calculation of the maternal mortality ratio (UNDP, 2011).

The 2011 Human Development Report ranks Malaysia 61st overall, but 74th with health indicators alone.

2.3 Horizontal Inequality and the Right to Health.

Inclusiveness and equity are important areas in development as it strives to provide every individual with the freedom to make choices and increases their quality of life. Inequity may be horizontal or vertical. Horizontal inequity indicates that people with similar needs lack access to the same resources. Vertical inequity exists when individuals with greater needs are not provided with greater resources. In population surveys, similar use of services across population groups signifies inequity, because different population subgroups have differing needs (Starfield, 2011). What is usually assumed to be equitable (equal use across population subgroups) is, rather, inequity. Most developed countries have achieved both horizontal and vertical equity in the use of primary healthcare services. Consequently, in these communities, people with greater health requirements receive more primary care services.

Marginalised populations in Malaysia who are sidelined in health include the indigenous Orang Asli populations, migrants and refugees, urban poor , male to female transsexuals (mak nyah) and female prisoners (Phua, 2007). From a rights based perspective, every individual should be entitled to the right to receive the highest attainable standard of physical and mental health (Alexander, 2010). Malaysia, as a State Party to the International Covenant on Economic, Social and Cultural Rights has the responsibility to create conditions which would assure to all medical services and medical attention in the event of sickness (United Nations, 1966).

It has been recommended that Malaysia prioritise relative poverty as a major policy axis, to ensure the needs and welfare of marginalized populations. Specific policy measures have to be designed and effectively implemented because the needs of the bottom 40% will require targeted approaches to suit their needs. Although Malaysia has a well established healthcare system of detection and treatment, it needs broader socio-economic programmes that seek to decrease poverty, address the situation of migrants and reduce the gap between health services and people (UNDP, 2011).

2.4 Migration in Malaysia

Migration is a multi-dimensional issue in Malaysia. Malaysia hosts 2 million migrant workers in a population of 28 million. As a country dependent on low-skilled foreign labour, the national policy towards immigrants is biased towards the need of national economic requirement and frequently neglecting perspectives of immigrants themselves. Less-skilled migrants have been marginalised in the country and official policy is influenced also by issues of ethnicity and racism (Kaur, 2007).

In this literature review, the term “migrant” is used in a very broad sense, referring not only to those who change their country of residence voluntarily but also to asylum seekers, refugees and victims of human trafficking. This reflects the difficulty in distinguishing between those who migrate to escape political persecution, economic difficulties or environmental degradation. Many of these groups overlap, and commonly form joint communities. Since the consequences of migration may also extend beyond the first generation, second and later generations are also included.

Migrants in Malaysia comprise of a wide group of categories; differentiated mainly due to legal ramifications of their situations. Many migrants enter the country legally as economic migrants, illegally enter or overstay their visa, or seek protection as refugees and as asylum seekers.

There is currently no legislative or administrative framework for dealing with refugees. By Malaysian Law, under the Immigration act 1959/63 (Act 155), refugees are not differentiated from undocumented migrants (Malaysia, 1959). Around an estimated 1.5 million migrants are thought to be undocumented. They are therefore vulnerable to arrest for immigration offences and may be subject to detention, prosecution, whipping and deportation.

By definition by Article 1, of The 1951 UN Convention Relating to the Status of Refugees, a refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…"(United Nations, 1951)

Many States party to the 1951 Convention also have refugee status determination procedures, to determine the person's status in accordance with the domestic legal system. Malaysia, however, is not a signatory to the 1951 UN Refugee Convention. Nevertheless, the UNHCR office in Malaysia assists by offering advice to governments on refugee status determination as part of its mandate to promote refugee law and Convention.

As of the end of October 2011, there were around 95,300 refugees and asylum-seekers registered with UNHCR Malaysia (UNHCR, 2011). A large majority of those registered, around 87,300 were from Myanmar; comprising 35,000 Chins, 22,100 Rohingyas, 10,400 Myanmar Muslims, 3,800 Mon, 3,300 Kachins and other ethnicities from Myanmar.

The other remaining 8,000 refugees and asylum-seekers from other countries include some 4,300 Sri Lankans, 1,100 Somalis, 740 Iraqi and 440 Afghans. Overall, 71% of refugees and asylum-seekers are men, while 29% are women. There are some 19,500 children below the age of 18.

The statistics above only include those registered with the UNHCR. There are also a large number of persons of concern who live in Malaysia, but have not sought refuge due to multiple reasons. Refugee communities themselves estimate that the population of unregistered refugees and asylum-seekers to be some 10,000 persons.

Malaysia also hosts a population of some 60,000 Filipino Muslims in the province of Sabah for whom the Malaysian Government has assumed responsibility, and an estimated 40,000 potentially stateless people in Peninsular Malaysia(UNHCR, 2011).

2.5 The Myanmar Migrant Population and Refugee Integration in Kuala Lumpur.

Large portions of Myanmar migrants to Malaysia are refugees and asylum seekers and they also currently make up around 90% of those registered with the UNHCR in Malaysia. Myanmar refugees frequently are undocumented, thus making them difficult to distinguish between migrants who leave their countries because of political persecution, conflicts, economic problems, environmental degradation or a combination of these reasons and those who do so in search of conditions of survival or well-being that does not exist in their home country.

There are many Myanmar migrant communities scattered throughout Malaysia, living mostly in the Klang Valley, around the capital city, Kuala Lumpur. As there no longer are refugee detention camps in Malaysia, migrant populations instead share living spaces in groups of up to 20 people or more, living in low-cost flats or housing areas along side local Malaysian homes in cities and small towns. Many also form small communities near construction sites or plantations where they seek employment (UNHCR, 2011).

The situation of Myanmar migrants and refugees are difficult as they lack official status. Thus they tend to have no access to legal employment, tend to work in jobs that locals tend to shun, such as the 3Ds (dirty, dangerous and difficult) jobs. Frequently, they are exploited by employers by extremely low wages or no wages at time. Children of Myanmar migrants do not have access to formal education. However, some children are able to attend community schools, or those supported by UNHCR or other NGOs.

Nevertheless, Malaysia has taken significant steps forward in improving refugee rights. In the past year, there have been no reported attempts to deport Burmese refugees to the border with Thailand and a decrease in immigration raids and arrests of registered refugees. But these advances have not yet been codified into written government policy, leaving refugees considered “illegal migrants” and subject to arrest and detention. A recent report on the plight of Malaysian refugees by the NGO Refugee International (Yoshikawa & Teff, 2011) recommends improving access to government schools and health facilities and increase support in projects that are sensitive to women’s needs.

2.6 Malaysian Migration Policy and Practices Towards Refugees or Asylum Seekers.

Malaysia has not ratified the 1951 UN Convention Relating to the Status of Refugees (United Nations, 1951). Thus it does not have refugee status determination procedures to determine the person's status in accordance with the domestic legal system. Nevertheless, there is a UNHCR office in Malaysia that assists by offering advice to governments on refugee status determination as part of its mandate to promote refugee law and Convention (United Nations, 1951).

The absence of a guiding framework acknowledging refugees has resulted in incoherent attitudes towards refugees or what can be termed de-facto statuses of refugees in Malaysia. Malaysian immigration law does not provide special protection or procedures for asylum seekers, refugees or trafficked persons nor does it make special provisions for children or women, including pregnant women. Consequently, the status "refugee" is not recognized under Malaysian law (Malaysia, 1959) despite having been recognized as one by the UNHCR. Therefore, refugees and asylum seekers are equally subject to the Immigration Act as other undocumented migrants. As a result, if they unlawfully enter or remain in Malaysia, they are liable to being imprisoned, whipped, detained and removed. Around an estimated 1.5 million migrants are thought to be undocumented, that is without legal registration. Undocumented immigrants that are arrested are detained in Immigration Detention Centers for various periods of time; a process also seen to be inconsistent.

Increasingly, there has been a large degree of inconsistencies in practices, particularly since the Immigration Act was amended in 2002 (Somwong & Huberlant, 2008). The Immigration Act was further amended in 1997 and 2002, leading to the establishment of harsh penalties for immigration violations. The Act allows the indefinite detention of illegal migrants pending deportation.(Kaur, 2007).

Some refugees and asylum seekers acquire documentation with the UNHCR, and are able to enjoy some de-facto benefits and some limited protection from enforcement of Malaysian law. Yet, the Director of Enforcement of the Immigration Department has indicated that occasionally UNHCR documentation holders are arrested as a means of showing the public that there are no 'double standards' in relation to undocumented migrants, although it is avoided where possible (Somwong & Huberlant, 2008).

The only type of status that may be legally accorded to persons recognized as refugees or asylum seekers is through discretion by the Minister of Home Affairs under section 55 of the Immigration Act via the provision of the IMM13 temporary visas to a particular group of persons. The Acehnese from Indonesia and Rohingyas from Burma, who are Muslims, have been given these temporary protections as groups by the Malaysian government at various times. Refugees with group status are not eligible for resettlement, but are facilitated to return to their countries of origin. They however remain in the local population and form communities of refugees around Malaysia. The visas also have certain conditions attached such as work and education. It appears that Malaysia discriminates on the basis of the religion of refugees, since the Christian Chins from Burma do not have the right to work (Somwong & Huberlant, 2008). The practice of IMM13 visas however, is also erratic, when the issuance of that visa was suddenly stopped citing corruption in issuance procedures. Additionally, there is no coordination between the Immigration Department and the Education Ministry, so there are cases where schooling is still denied to refugees with no education visa.

Previously, it was policy to detain refugees in camps and on islands demarcated as transit points till the resettlement of refugees to other nations. The Malaysian government no longer practices the setting up of refugee detainment camps, and the last refugee camp was closed in 2001(UNHCR, 2001). This is not to be confused with Immigration Detention Centres, which are for holding of arrested illegal migrants, with no proper documents or permits.

Migrants and refugees thus form communities scattered throughout Malaysia, living mostly in the Klang Valley, around the capital city, Kuala Lumpur. As there no longer are refugee detention camps, migrant populations instead share living spaces in groups of up to 20 people or more, living in low-cost flats or housing areas along side local Malaysian homes in cities and small towns. Many also form small communities near construction sites or plantations where they seek employment (UNHCR, 2011). These settlement, however undergo frequent raids by the authorities.

Additionally, there has not yet been implementation of restricted movement passes, such as in Thailand to cater for the need of increased cheap labour supply in certain economic zones. This has allowed a certain amount of choice in migrant refugee population in choosing location of residence, although many change addresses frequently due to immigration crackdowns.

Nevertheless, Malaysia has taken some significant steps forward in improving refugee rights. In the past year, there have been no reported attempts to deport Burmese refugees to the Thai border and a decrease in immigration raids and arrests of registered refugees. But these advances have not yet been written into government policy, leaving some refugees still considered “illegal migrants” and subject to arrest and detention.

2.7 Maternal and Child Health Care Access and Barriers to Access.

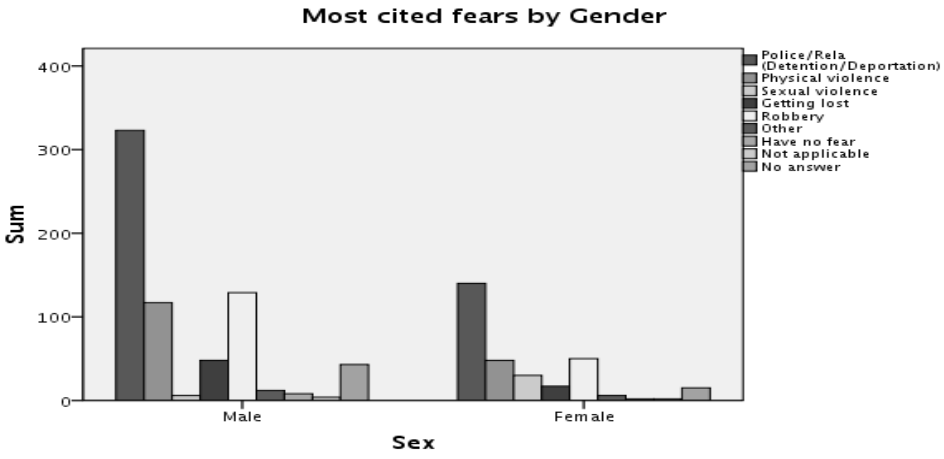
Although health services in Malaysia are well established, certain populations remain sidelined by mainstream health facilities. These barriers are common to many marginalised communities and research into these issues will lead to a greater improvement in equitable provision of services (Veerman & Reid, 2010).

In Malaysia, while asylum seekers and refugees are able to access public and private healthcare facilities, this is often hindered by a variety of factors including the cost of treatment, fear of moving in public in order to access those services, and language barriers. One study called 'A Rapid Appraisal of Needs of Afghan Refugees in the Klang Valley' in Malaysia showed that refugees struggle for access to healthcare services, including information, economic and physical accessibility. This was due to their inability to communicate effectively with the health service providers and financial difficulties. Additionally, they cited fear of enforcement authorities as their biggest fear when travelling to/from healthcare facilities (HEI, 2009).

Asylum seekers and refugees in Malaysia are also vulnerable to various other ill-treatments. Instances of human rights violations include reports of assault, sexual abuse, and lack of access to basic needs including medical treatment and education (Somwong & Huberlant, 2008). Access to basic needs is also often restricted for undocumented persons and their family members, due to inconsistent policies amongst various government institutions. For example, the Malaysian Health Ministry reportedly announced it would grant access to refugees and other persons registered by the UNHCR to healthcare at local rates. However, this policy is not practiced by enforcement agencies and local hospitals. The Malaysian Human Rights Commission (SUHAKAM) continues to receive reports of refugees being denied access to adequate and affordable treatment at government health centres (Adnan, 2007).

Several government agencies, including the RELA "volunteer corps", police, and immigration department often use punitive measures, such as crack downs to arrest, detain and deport migrants. In another Participatory Action Research with refugees in Kuala Lumpur, nearly half had been stopped en-route to a clinic (Error! Reference source not found.). Robbery and physical violence also figured prominently in the list of fears of these Afghan and Myanmar refugees surveyed (Verghis & Pereira, 2009).

Figure 3 Participatory Action Research on Access to Health Care Services with Refugees from Burma –Main Fear When Travelling to Clinic



Note: (HEI, 2009a)

Another barrier that impedes access is the status of children of refugees and stateless persons who are born in Malaysia. Since their parents are still undocumented, their children face obstacles in obtaining birth certificates and other identification documents which would facilitate their access to basic needs including medical care and education.

A UNCHR report on provision of Anti-Retroviral Therapy for documented refugees in Malaysia knowledge and awareness on HIV/AIDS prevention was also lacking. The report found that this was especially so amongst the Rohingya of Myanmar (UNHCR, 2010).

As a result of the long conflict in Myanmar and the resultant long stay in refugee camps over decades, transiting to Malaysia sometimes over multiple generations, the health wellbeing of these migrants are frequently affected. One study into migrant health has found that many Myanmar refugees into neighbouring countries such as Thailand lack sexual health education and relevant services, and concerns for their future are particular constant psychological problems which need to be addressed (Benner et al., 2010).

2.8 Increasing Research and Interest in the Field of Migrant Health

Increasingly, there has been a growing interest in the field of migrant health. As globalisation promotes the fluidity of population movements within traditional national geographical borders, international transmigration is a fact that has to be taken into account especially in planning healthcare policy. Even in a developed country like the United Kingdom for example, the changing size, diversity and needs of migrants have not yet been sufficiently address in academic research and in mainstream healthcare policy and practice. One healthcare review recommended that it was essential to progress beyond ethnic differences and inequalities in health and to consider a range of factors that may describe the experiences and needs of migrants, including populations who are most vulnerable and restricted in access to free healthcare in the UK (Jayaweera, 2010).

Closer to home in Asia, the Japanese migration policy prioritises immigration control over migrant rights and welfare. One literature review revealed that disadvantaged migrant populations have poor health, and face barriers in accessing mainstream healthcare, particularly for emergency services, HIV/AIDS and maternal and child care (Parikh, 2010).

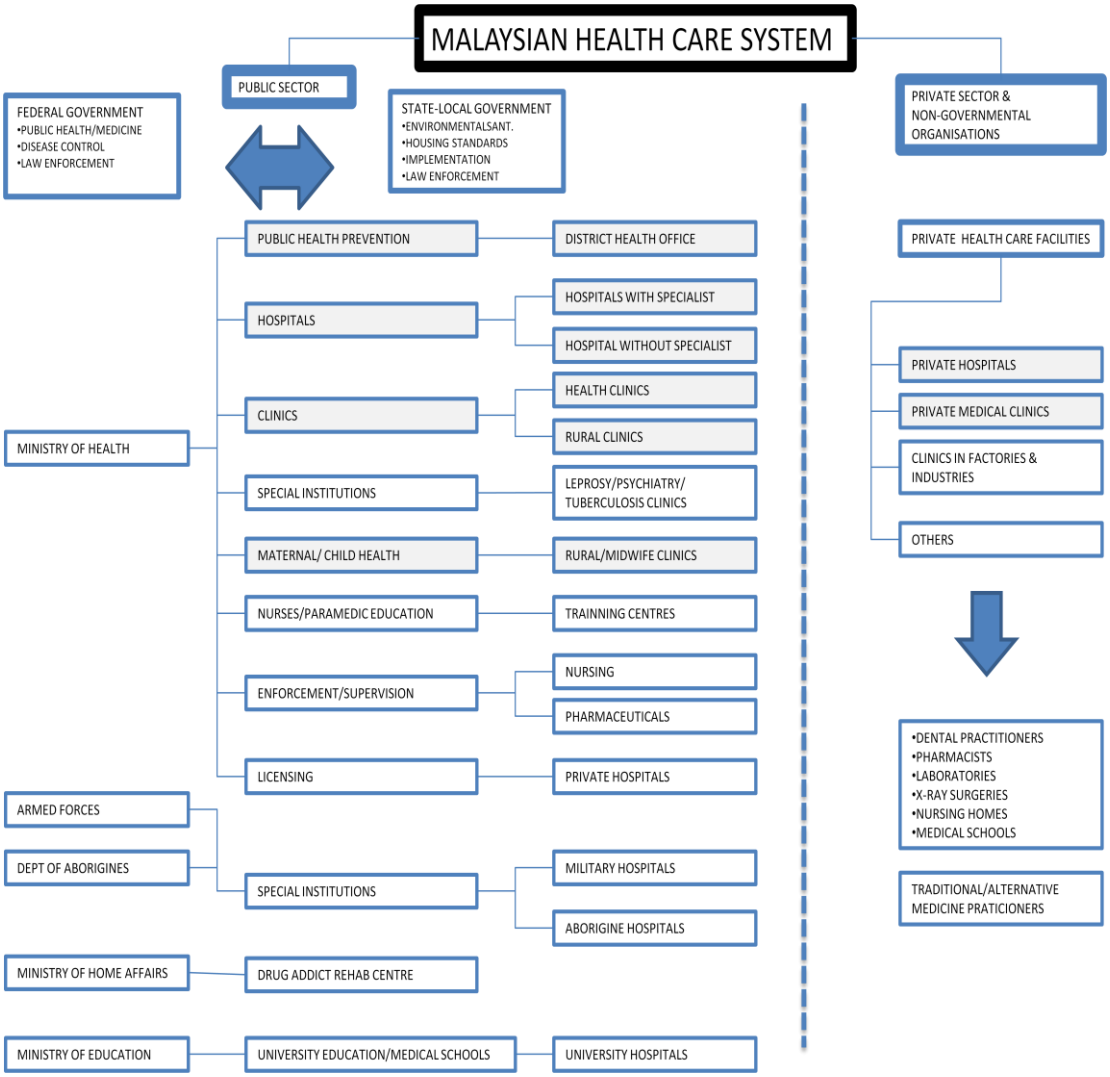
Health status of migrants and their access to healthcare are key indicators of "integration' within receiving societies (Ager & Strang, 2008). Unfortunately, there has been insufficient emphasis in mainstream health research or policy on the factors that affect health and socio-economic outcomes relating to the migrant experience (Jayaweera, 2010). Data and research on migrant populations in Malaysia have been confined to government statistics and do not give accurate impressions, especially around issues of undocumented and illegal migrants.

CHAPTER III

POLICY AND ACCESS TO HEALTHCARE SERVICES FOR MIGRANTS IN THE MALAYSIAN CONTEXT

3.1 Access to the Health Care System for Migrants in Malaysia

Figure 4 Organisation Chart of the Malaysian Health Care System



Note: Adapted from Ministry of Health, Malaysia.

The Malaysian health care system is a dual system that is split into the public sector and private sector. The delivery system can also be seen as divided into primary, secondary and tertiary care. Primary healthcare forms the backbone of health, with strong distribution of public health clinics in rural areas while private clinics are prominent in urban areas. Government Maternal and Child Health divisions are focused on small rural/midwife clinics which are staffed by trained staff nurses, community nurses and occasionally medical attendants. Doctors are stationed at all Government Health Clinics, which are first referral centres with laboratory and testing facilities.

In principle, the Malaysian public health service is open to all. Distribution of clinics is good in urban areas with most towns having at least a government health clinic. Hospitals without permanent specialist (secondary centres) are situated in larger towns while most big cities have hospitals with specialist (tertiary centres). In efforts to decentralise, tertiary centres in Kuala Lumpur have been declared sub-speciality referral centres, such as for Haematology, Hepato-Biliary and Cardio-thoracic referral hospitals. Access to these speciality hospitals are only via referrals from other government health facilities.

Government health service is heavily subsidised by Malaysian tax-payers. Hence, there are different cost schedules for citizens and non-citizens, with discounted rates for public servants, school children, and pensioners. In hospitals rooms are further split into 3 classes, with varied costs for each. Treatment and management however is the same throughout.

Private hospitals and clinics are open to everyone who is able to afford it. Generally, costs are standard irrespective of citizenship, and higher than that of the public sector. With greatly appreciating health care cost, the mainstay of payment includes insurance schemes and out-of-pocket payments.

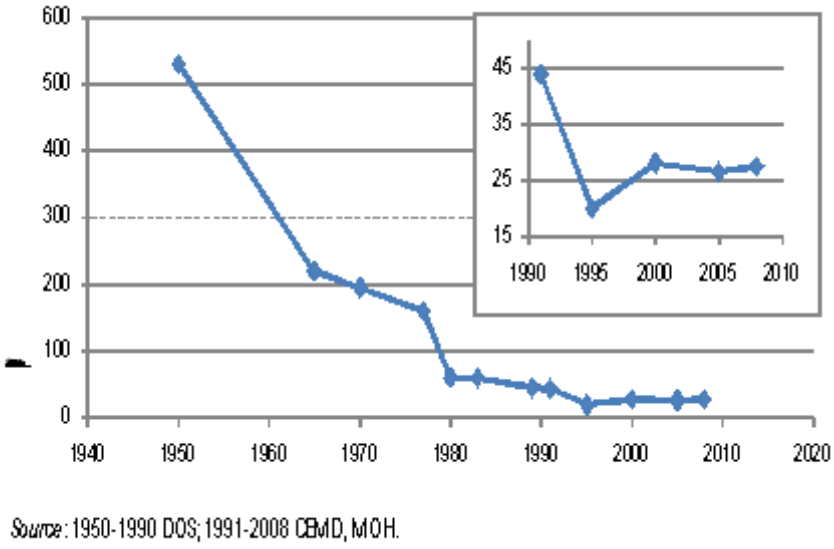
Migrant workers are required to be covered by insurance schemes, although this also depends on the regularity of the individual, renewability and conduct of the employer. There is no policy on acceptance of asylum seekers and refugees. Nevertheless, after negotiation with the Malaysian government, UNHCR card holders are able to receive a 50 percent discount on public service fees.

3.2 Maternal and Child Health Access in Malaysia

Since 2000, the Maternal Mortality Ratio (MMR) has remained relatively stagnant at around 28-30 per 100,000 live births (Figure 5). However, improvement is required in order to realize further reduction of MMR to achieve the Malaysian MDG target of 11 per 100,000 populations by 2015(Kaur J & Singh H, 2011).

Declines in MMR in Malaysia have been credited to the many improvements in MCH services. These include improvements to access to quality health services, increased professional skills of trained delivery attendants to manage pregnancy and delivery complications, investments in upgrading the quality of essential obstetric care in district hospitals, improved efficiency of referral and feedback systems to prevent delays, close engagement with communities to remove socio cultural constraints, improved acceptability of modern maternal health services and improved monitoring system (Kaur J & Singh H, 2011).

Figure 5 Maternal Mortality Ratios in Malaysia 1950-2008

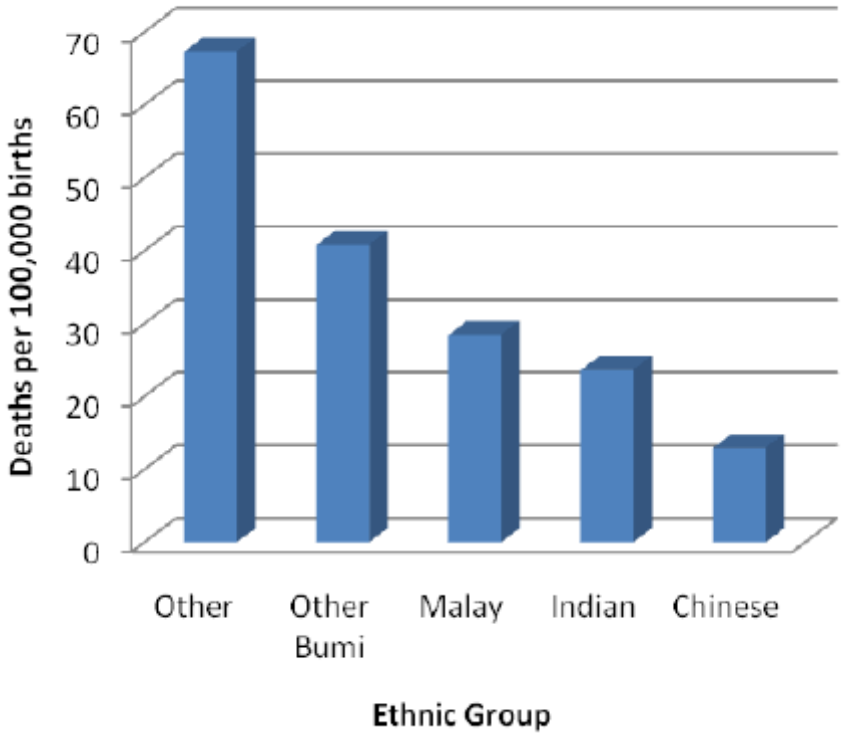


Note: Adapted from Kaur J and Singh H, 2011

Nevertheless, certain populations persistently have poor MCH use and access. One study of Orang Asli (aboriginal community) found that their knowledge on certain aspects of antenatal care were still poor, especially on the importance of early antenatal check-up, health screening and complications related to diabetes and hypertension in pregnancy (Rosliza AM & Muhamad JJ, 2011).

Although having one of the lowest Maternal Mortality Rates in the world, 42 percent of maternal deaths in Malaysia in 2000 were to non-citizens (UNDP, 2011). Migrants, especially the undocumented, often have limited access to maternal health (Figure 6).

Figure 6 Maternal Mortality Ratios by Ethnic Group 2007



Note: Adapted from Kaur J and Singh H, 2011

The Malaysian MOH provides facilities for antenatal care and follows guidelines that encourage the first antenatal visit during the first 12 weeks of pregnancy. Antenatal care allows the monitoring of the well being of mother and unborn child, as well as diagnosis and management of complications. Antenatal care is provided at rural health clinics, health clinics and government hospitals. For those who can afford it or covered by insurance, private clinics and hospitals also provide MCH service.

The WHO recommends a minimum of four antenatal visits based on a review of the effectiveness of different models of antenatal care. The WHO guidelines are specific on the content of antenatal care visits, which should include:

- blood pressure measurement;
- urine testing for bacteriuria & proteinuria;
- blood testing to detect syphilis & severe anemia; and
- weight/height measurement (optional)

Four antenatal visits will ensure that the pregnant women receive important services, such as tetanus vaccinations, screening and treatment for infections and health promotion and prevention advice on warning signs during pregnancy. Thus, antenatal visits help identify and treat illnesses which place pregnant women at high risk of maternal death due to indirect causes and is therefore considered a proxy indicator for safe deliveries.

Postnatal period is within 6 weeks after birth. Almost two thirds of all maternal deaths occurred in the postnatal period. Postpartum care is provided by primary health care staff from the health clinics. Ministry of Health Guidelines for home visits are a total of 8 visits, 1st, 2nd,3rd,4th,6th,8th,10th and 20th postnatal days and on the 42nd postnatal day for a routine examination for mother and baby which is done at the clinic by the doctor.

Regular postnatal visits are carried out by community nurses. They attempt to detect complications early and cases can be referred for further care. More than 70% of deaths occurred in hospitals or en route to hospitals. This could be due to the late referral of cases or ignorance on part of patient and family as well as weakness in the referral system (Kaur J & Singh H, 2011).

For children, the Ministry of Health recommends immunisation according to the Extended Programme for Immunisation (EPI) Schedule (Figure 7). All children should be covered by the programme.

There have been attempts for outreach programmes at health clinic levels depending on the distribution of marginalised communities such as migrants. Unfortunately, these depend on resources available, and many barriers remain in the way.

Figure 7 Extended Programme for Immunisation (EPI) Schedule. Ministry of Health Malaysia

Immunisation	Age (months)							Age (years)		
	0	1	2	3	5	6	12	18	6	12
BCG	1								if no scar	
Hep B	1	2				3			2	
DTaP[1]			1[1]	2[1]	3[1]			4[1]	DTaP[2]	DTaP[2]
IPV[1]			1[1]	2[1]	3[1]			4[1]	IPV	
Hib[1]			1[1]	2[1]	3[1]			4[1]		
Measles						Sabah				
MMR							1		2	

footnote:

1. The combination vaccine used in the primary immunisation schedule is a 5-in-1 DTaP-IPV/Hib.

2. DTaP after primary immunization: for those who had not received primary DTaP in their childhood, replace the booster with Td (adult tetanus-diphtheria) vaccine if they received their last dose of Td > 10 years earlier.

Also:

A child who has been started on DTaP must complete his immunisation with DTaP, it cannot be inter-change with DTP. However a child started on DTP can use DTaP for subsequent doses.

Abbreviations. BCG, Bacille-Calmitte-Guerin vaccine; Hep B, Hepatitis B vaccine; DTaP, Diphteria, tetanus, acellular pertussis vaccine, IPV, inactivated polio vaccine; Hib, Haemophilus influenzae b vaccine; MMR, measles, mumps, rubella vaccine.

Note: Adapted from the Malaysian Paediatric Protocol 2nd Edition

3.3 Estimated Total Population of Migrants from Myanmar in Selayang District

This research focused on a case study area in the North Kuala Lumpur district of Selayang. It is a district about 10km away from the city centre, which has become an area of agglomeration for Myanmar migrants. This is in large part due to the fact of socio-economic and security reasons. There are many opportunities for low-skilled work, for example at the Selayang Wholesale Market and other businesses. Transport and communication also facilitates the presence of the migrants here.

In this paper, the term "migrant" is used in a very broad sense, referring not only to those who change their country of residence voluntarily but also to asylum seekers, refugees and victims of human trafficking. It is difficult to distinguish between those who migrate to escape political persecution, economic difficulties or environmental degradation. Many of these groups overlap, and form the community in the case study area.

The Selayang Hospital is a Tertiary Government Hospital that covers the population besides functioning as the National Hepatobilliary Referral Centre. The Selayang District Health Office oversees the many public and private health clinics in the area.

Prior to the conduct of the research, it was estimated that the number of Myanmar migrants living in the immediate vicinity was around 1000. However, further research data gained from latest UNHCR statistics for the district showed that the total number of Persons of Concern (POC) registered with the UNHCR office in Kuala Lumpur was 3887 individuals.

Feedback from Myanmar community NGOs active in the registration of Myanmar nationalities further confirmed that only around 30-50% of the community are registered with the UNHCR with documentation. Hence it is estimated that there are around 7000-8000 Myanmar migrants (both regular and irregular) in the district of Selayang. Additionally, nearly all of the Myanmar migrants in the Selayang area are undocumented rather than legalised foreign workers, although many are able to find informal work.

Most of those unregistered had to resort to "NGO community cards" as the only form of documentation, while some had no documents at all. The quoted portion also corresponded to the small sample of interviewees where only 6 out of 15 (40%) individuals had UNHCR documentation.

3.4 Ethnic Distribution of Migrants from Myanmar in Selayang District

The Myanmar migrant profile in the Selayang district was initially thought to comprise mostly of Rohingyas, Chins, and Karens. On closer clarification, the overwhelming majority (69.56%) of the population was found to be Myanmar Muslims, followed by Rohingya (17.96), then various minority ethnic groups.

A majority of Myanmar Muslims are not registered by the UNHCR, as compared to other ethnic groups such as the Chin and Karen. This may be due to the increased NGO support of Chin and Karen communities when the registration was opened. Registration for UNHCR has since been closed.

Nevertheless, the closest statistics that are available that delineates the Myanmar migrant community in the Selayang area are the UNHCR registration statistics as described below in Table 1.

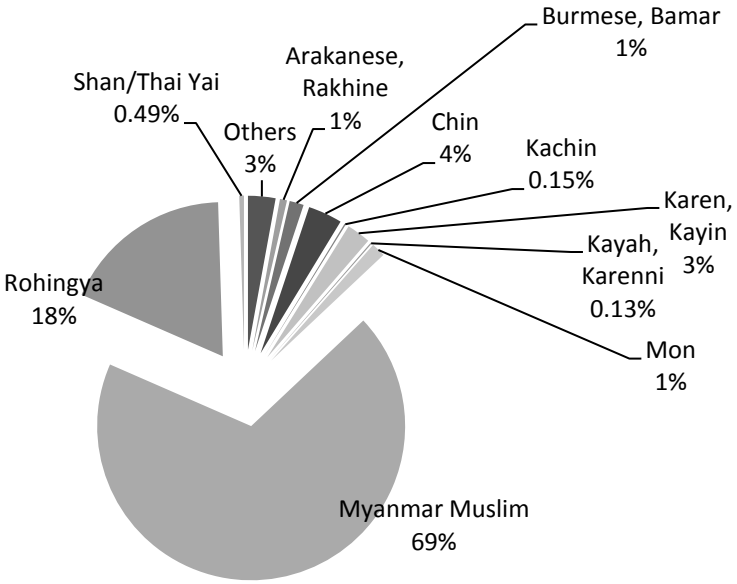
Table 1 Breakdown of UNHCR Persons of Concern (POC) from Myanmar in the Selayang District as of June 2012.

COUNTRY OF ORIGIN	ETHNICITY	MALE	FEMALE	TOTAL	% OF TOTAL POC POPULATION
MYANMAR	Others	76	36	112	2.88
MYANMAR	Arakanese, Rakhine	28	1	29	0.74
MYANMAR	Burmese, Bamar	36	22	58	1.49
MYANMAR	Chin	87	52	139	3.58
MYANMAR	Kachin	5	1	6	0.15
MYANMAR	Karen, Kayin	68	30	98	2.52
MYANMAR	Kayah, Karenni	3	2	5	0.13
MYANMAR	Mon	42	16	58	1.49
MYANMAR	Myanmar Muslim	1668	997	2665	68.56
MYANMAR	Rohingya	522	176	698	17.96
MYANMAR	Shan/Thai Yai	11	8	19	0.49
Total		**2546**	**1341**	**3887**	**100**

Note: Raw data from UNHCR Malaysia, 2012

This research focuses on barriers to maternal and child health access in the Myanmar migrant population. Hence, the breakdown of female UNHCR Persons of Concern was also determined.

Figure 8 Proportional Ethnic Representation of UNHCR Persons of Concern from Myanmar in the Selayang District as of June 2012



Note: Raw data from UNHCR Malaysia, 2012

Table 2 Breakdown of Female UNHCR Persons of Concern from Myanmar Residing in the Selayang District According to Age Groups, as of June 2012.

COUNTRY OF ORIGIN	ETHNICITY	FEMALE (age)					TOTAL
		0 - 4	5 - 12	13 - 17	18 - 59	60 +	
MYANMAR	Others	2	1	3	30	0	**36**
MYANMAR	Arakanese, Rakhine	0	0	0	1	0	**1**
MYANMAR	Burmese, Bamar	3	0	1	18	0	**22**
MYANMAR	Chin	5	3	3	40	1	**52**
MYANMAR	Kachin	0	0	0	1	0	**1**
MYANMAR	Karen, Kayin	3	1	0	26	0	**30**
MYANMAR	Kayah, Karenni	0	0	0	2	0	**2**
MYANMAR	Mon	0	2	0	14	0	**16**
MYANMAR	Myanmar Muslim	90	79	28	792	8	**997**
MYANMAR	Rohingya	22	12	6	132	4	**176**
MYANMAR	Shan/Thai Yai	0	0	1	7	0	**8**
Total		**125**	**98**	**42**	**1,063**	**13**	**1,341**

Note: Raw data from UNHCR Malaysia, 2012

3.5 Housing Conditions for Myanmar Migrants in Selayang District

The migrant housing situation in certain parts of Kuala Lumpur has evolved into a new form of informal housing. The classical perspectives of slums are of dense congregations of single or double storey simple structured or semi-wooden houses, which are devoid of the minimum requirements of basic conveniences such as piped water or sanitation facilities. In contrary, the picture of informal urban housing of migrant refugees in the Selayang district of Kuala Lumpur gives a starkly different picture.

The referred case study area for example, was initially developed as a series of commercial infrastructure complementing the Selayang Wholesale Market, a main entry point of fresh produce such as fruit and vegetables, and meat into Kuala Lumpur for more than 30 years. The district of Selayang is around only 15 km from the heart of the capital city, Kuala Lumpur. It has grown from a small suburban town area to a teeming industrial and commercial district which is a direct extension of the main city centre. Property prices have also skyrocketed.

The networks of buildings that have been converted to informal housing were actually designated for office and commercial use. The series of linear buildings are three or four storeys high. The ground floor usually provided service-oriented commercial shops such as grocery stores, mechanics, clothes and household product retailers, restaurants and banks. The upper floors were commonly offices and small companies. Each unit area is less than 1000m2. There are facilities for water piping, electricity and a toilet in each unit. The road in between the rows of buildings have adequate parking and were built wide enough for lorries that frequented the wholesale market.

Figure 9 Internal Environment of Refugee Housing in Case Study Area.

Note: Photo Credit to UNHCR Malaysia.

Over the past few years, the dozen or so rows of commercial multi-storey buildings have been increasingly rented out as residential units for Myanmar refugee and migrants, especially the third and fourth floors. These urban dwellings have overcrowded conditions, limited privacy, sub-standard housing and substandard environments. Commonly, each unit is occupied by up to 25 people and is shared between family and friends, usually of the same ethnic group. The first task refugees usually undertake on arrival in the country is to contact relatives and friends in Malaysia. Social support among refugees is more likely to be extended from those of the same ethnicity (Nah, 2010).

Features of urban poverty intensify the insecurity and life-threatening health risks while influencing the coping strategy at the community and household level. These features include environment and health risks, vulnerability and social fragmentation. Additional risks involve crime and negative contact with the police (Wratten, 1995).

High density housing is common in traditional urban slums, but this case study describes population density in a different physical infrastructure. These units were not designated as residential units originally. Thus the sub-standard housing conditions are created as a by-product of adaptation. Electricity facilities and water provision have usually been cut as a result of non-settling of bills. The sanitation systems are over-burdened and waste collection is very erratic. Fire hazards are a particular concern especially in the makeshift kitchens and ad-hoc wiring modifications.

The limited physical space also creates multiple forms of sub-standard environments. Bedrooms are limited, and some have to sleep in the balcony. Children have no place to wander, so sit along the narrow, dark stairways or play on the streets between buildings which are a main link for vehicles into the wholesale market. The irregular waste collection and irregular council maintenance of the streets also have contributed to the rundown aesthetics of the area. Dark alleys make it unsafe to walk at night, although many take advantage of the condition to evade detection from authorities.

Figure 10 External Environment of Refugee Housing (Back Alley).

Note: Photo Credit to UNHCR Malaysia.

Due to the high risk of leaving the housing units, some refugee women stay home and cook and clean for male household members, who are not generally related, but share the same ethnic group. Up to 20-25 people occupy in a single unit and share the rent for women who tend to their domestic work. While this might protect women from potential arrest while out, it puts her at risk of sexual exploitation by unrelated male household members who share overcrowded living quarters (Buscher & Heller, 2010).

These adaptations above are actually pragmatic strategies of survival and accumulation that slum-dwellers assign to their settlement space, but there are other benefits (Askew, 2002). Residents do not exist in isolation. Rather their social networks are built around cooperation in household activities, assistance in finding work, borrowing money, childcare and watching over the neighbourhood. Although this does not always mean harmonious integration as conflicts are also seen, this social bond allows a greater expression of the communities' cultural practices in a foreign land. The practice of chewing and spitting betel nut onto the street around the refugee housing has increased to the dismay of the original local community.

Some of the original commercial users of these particular buildings have preferred to relocate as a result of the effects of the conversion of these office units into rented residential quarters for refugees and migrants. As local leave the neighbourhood, the proportion of the refugees and migrants increase, and thus strengthens the establishment of this new form of urban slum in the city of Kuala Lumpur.

CHAPTER IV

FINDINGS AND ANALYSIS OF BARRIERS TO HEALTHCARE ACCESS FOR MIGRANTS IN SELAYANG

Field research was undertaken in June 2012 to achieve the research objectives of this study. Various obstacles that hindered maternal and child health access was explored in key informants that were both from the community of Myanmar migrants in the case study area, as well as with key informants from the Ministry of Health, Malaysia, the UNHCR, and a community NGO. The field research focused specifically in the district of Selayang, around the Selayang Wholesale Market, where the Myanmar migrant population had formed a dense community. Some of the most insightful research findings were found during formal interviews as well as informal group discussions.

A total of 18 formal interviews were conducted with the help of translators during a field research period of 16 days [11th-26th June 2012]. A total of 15 interviewees were Myanmar migrant women who were either expecting (8 women) or had given birth in Malaysia in the past 2 years. The women were chosen to satisfy decided inclusion and exclusion criteria. The variation of sampling was spread according to the proportionality of Myanmar migrant ethnic groups in the case study area (Table 1).

Each of the interviewees quoted remains anonymous for ethical and security reasons and is denoted by an interview code for example, M1, M2, etc. After interviewees were chosen, demographic data of the interviewees were recorded and subsequent variables determined. The demographic data of the interviewees are

presented in Table 3. Further responses to specific variables such as awareness and perceived barriers were then recorded. The translated ethnographic interviews were also subsequently transcribed for further analysis.

Table 3 Demographic Data of All Interviewees from the Case Study Area

INTERVIEW CODE	NAME	AGE	ETHNICITY	STATE OF ORIGIN	RELIGION	DURATION IN MALAYSIA (MONTHS)	DOCUMENTATION	PREGNANCY STATUS		CURRENT NUMBER OF PREGNANCIES	NO OF LIVING CHILDREN IN CURRENT HOUSEHOLD
M1	F.L.W	40	CHIN	CHIN	CHRISTIAN	5 YEARS	UNHCR CARD	5 MONTHS	ANTENATAL	4TH	2
M2	R.S	38	MON	MON	MUSLIM	10 MONTHS	COMMUNITY CARD	8 MONTHS	ANTENATAL	5TH	2
M3	F.M.T	24	MYANMAR MUSLIM	KAYIN	MUSLIM	21 MONTHS	COMMUNITY CARD	7 MONTHS	ANTENATAL	1ST	0
M4	K.N	37	MYANMAR MUSLIM	THANINTHAYI	MUSLIM	14 MONTHS	COMMUNITY CARD	8 MONTHS	ANTENATAL	5TH	4
M5	J.B	27	MYANMAR MUSLIM	MON	MUSLIM	2 YEARS	NIL	7 MONTHS	ANTENATAL	1ST	0
M6	S.P	30	MYANMAR MUSLIM	THANINTHAYI	MUSLIM	5 YEARS	NIL	4 MONTHS	ANTENATAL	1ST	0
M7	S.K	26	MYANMAR MUSLIM	KAYIN	MUSLIM	12 MONTHS	NIL	2 MONTHS	ANTENATAL	1ST	0
M8	F.B	23	ROHINGYA	RAKHINE	MUSLIM	5 YEARS	UNHCR TEMP DOC	6 MONTHS	ANTENATAL	3RD	2
M9	S.B	24	ROHINGYA	RAKHINE	MUSLIM	4 YEARS	UNHCR TEMP DOC	3 MONTHS	POSTNATAL	2ND	2
M10	S.M	20	MYANMAR MUSLIM	MON	MUSLIM	19 MONTHS	COMMUNITY CARD	9 MONTHS	POSTNATAL	1ST	1
M11	J.M.B	23	MYANMAR MUSLIM	MON	MUSLIM	3 YEARS	COMMUNITY CARD	13 MONTHS	POSTNATAL	1ST	1
M12	L.B	37	MYANMAR MUSLIM	MON	MUSLIM	3 YEARS	COMMUNITY CARD	6 MONTHS	POSTNATAL	7TH	3
M13	M.B	27	MYANMAR MUSLIM	YANGON	MUSLIM	3 YEARS	UNHCR CARD	10 MONTHS	POSTNATAL	1ST	1
M14	N.W	33	KAREN	KAREN	CHRISTIAN	23 MONTHS	UNHCR CARD	20 DAYS	POSTNATAL	1ST	1
M15	T.A	40	KAREN	IRRAWADY	BUDDHIST	23 MONTHS	UNHCR CARD	7 MONTHS	POSTNATAL	1ST	1

Additionally, 3 key informants were interviewed for a more holistic view on stakeholders in the process of access of healthcare for migrants from Myanmar. Details of the expert interviews are listed as follows:

- Interview E1: Community Health Clinic Staff Nurse, Selayang Baru Community Health Clinic.
  - The Selayang Baru Community Health Clinic is a small healthcare facility in the 1km2 of the highest density of the case study area. It is the smallest unit of maternal and child health facility in the MOH. It is staffed by 4 community nurse and 1 staff nurse. An estimated 30 percent of the patient load is from the migrant community.

- Interview E2: Dr Susheela Balasundaram, Asst. Programme Officer (Health & Assistance), UNHCR Malaysia.
  - In Malaysia, UNHCR works with Government agencies and civil society to protect refugees and assist in their welfare needs while they are seeking temporary asylum in Malaysia. Many Persons of Concern (POC) to the UNHCR are present in the case study area.
  - UNHCR cooperates with various partners including government agencies, Non-Governmental Organisations and volunteers to carry out its mandate.

- Interview E3: Medical Coordinator, Malaysian Karen Organisation (MKO).
  - The MKO have a trained medical coordinator to assist their members in health situations. He also doubles as a Community Health Worker, translator and functions as a liaison officer with the UNHCR.
  - He is a Karen refugee and has 3 years experience in the field.

Due to some of the testimonies being similar or repeated by other interviewees, not all of the interviews have been included. Nevertheless, a large portion of the key findings have been included in the overall survey data and interviews. The findings are presented and categorised into various topics and subtopics to allow a more coherent analysis.

4.1 Specific Barriers to MCH Access.

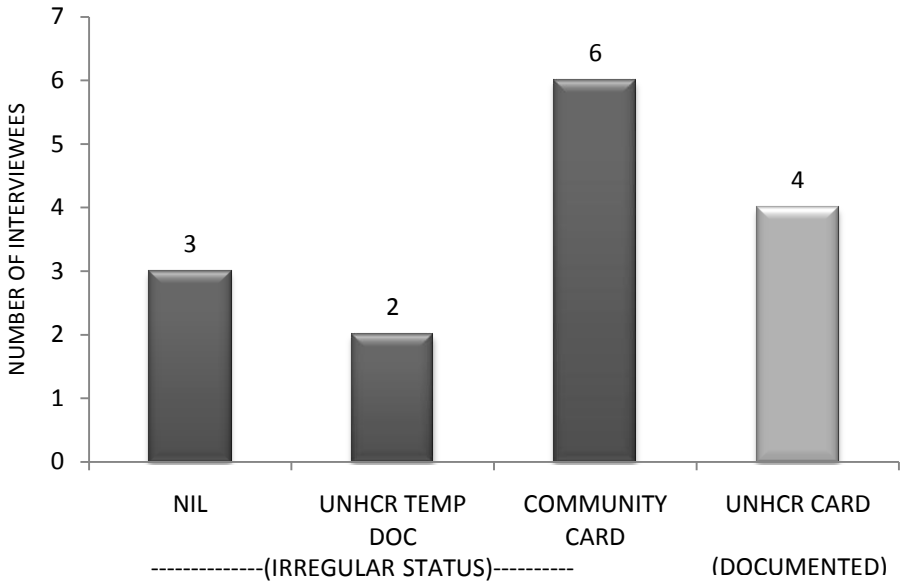
4.1.1 Systems-Based Barriers

Systems-based factors refer to policy and institutional arrangements that stem from state regulation and expression of policy in society. They include determinants in healthcare that are not dependent on health service delivery or price of those services. In the case study community, such factors included fear and lack of security from irregular documentation and the lack of child's documentation

4.1.1.1 Fear and Lack of Security from Irregular Documentation

Almost all Myanmar migrants in the community arrived in the country without passport or documentation. A majority do not have the UNHCR card (Figure 11), which is the only one recognised officially by the Malaysian government. This exposes the majority to measures that are used to detain and control illegal immigrants. In an attempt to address the problem of a total lack of documentation, some Myanmar NGOs have prepared what are termed "Community Cards" so that members of their community will at least have some form of identification, albeit not legal. These community cards are not government authorised but sometimes allow a person to negotiate with the police. Nevertheless, many still do not have any form of documentation at all.

Figure 11 Breakdown of Documentation Status of Mothers Interviewed.



Mother M7, aged 26, No documentation

"I am too scared to go out to the clinic because I fear for my security. My husband works in the market, but has been detained by the police several times although he has a UNHCR card. Each time he has to pay a bribe of at least RM50. I have no documents at all, so I really don't know where I can go or how to go to a clinic for my problem. I once went to an NGO clinic in town, but am afraid to do so again without my husband who can't take time off work now."

The lack of documents causes many mothers to fear for their security. The irregular detention and corruption with potential arrest further compounds the problem. One interviewee (Mother M3) described a situation where threatening law-enforcers were involved in a healthcare facility which subsequently increased the fear sufficiently to lead to defaulting important healthcare access.

Mother M3, aged 24, Community Card holder

"I was initially on antenatal check up, but the health clinic found some abnormality with my heart. I was sent to the big hospital for testing, where I was admitted for 3 days. The scans and tests further said it was normal. However, as I was worried that I couldn't pay, I insisted that I leave. Subsequently, an un-uniformed man who said he was a police officer was called in. As I had only my community card as documentation, he didn't accept it, as he didn't know what it was. The staff also further said that I can't use my community card as only the UNHCR card is accepted. The policeman then demanded a RM300 bribe to prevent detention. I paid him RM200 which was all I had. I was so frightened by that stay that I am too scared to go back to continue my follow-up. I am also not sure what to do."

4.1.1.2 Lack of Child's Documentation

Even though the child of a migrant from Myanmar is born in a Malaysian hospital, lack of documentation such as the birth certificate hinders further healthcare access especially for vaccination. It appears that the process of obtaining the birth certificate is frequently complicated at the Registration Office, where the birth has to be registered within 10 days. The process is incoherent, with most undocumented parents denied birth certificates for their child, even though given hospital registration.

Although most undocumented mothers were given at least some antenatal care at the government health clinics, those same clinics did not accept their offspring for paediatric healthcare services.

Mother M11, aged 23, Community Card holder

"My baby was only vaccinated when born. After that, because she has no birth certificate, even when I went to the health clinic, the staff told me to go away. The security guard shouted at me for not taking care of my baby properly. I know a lot of children in the similar situation. After going to the Registration office, because we have no UNHCR card, we were not given back the hospital registration of the baby and told that we can't register. So we are unable to get further vaccination even though we know it is important. Plus, we can't afford it in the private clinic."

Mother M12, aged 37, Community Card holder

"Even though I have no UNHCR card, there was no problem with my community card to register for my antenatal visits at the health clinic (KK) or childbirth at the Selayang Hospital. I only had problems while registering my baby's birth certificate at the Registration Office, where we were told we had to pay a bribe. We couldn't afford it, so my baby still has no birth certificate."

Policy arrangements about immigration frequently are confused with healthcare policies as many are incoherent. Additionally, there is no clear outline on the proper procedure for registration or right to treatment. The Ministry of Health has a policy for providing "Health For All". Nevertheless, it appears that some individuals are turned away and denied service due to certain conditions such as citizenship, or the lack of documents.

Interviewee E1, Community Health Clinic Staff Nurse

"The Myanmar women have many different kinds of documentation, not all legal. If there is a temporary UNHCR document we accept it. We also accept the community cards (as long as it has been confirmed by the UN).There was previously a circular in 2010 by the MOH that required us to report undocumented patients but we don't follow it, although we have never received a letter to cancel to first circular either. If they don't have any form of documentation at all, we advise them to go to private clinics. I think they do go because as you can see there are so many private clinics in this area. Sometimes, some NGOs complain, so we sometimes accept even undocumented patients. It is very irregular because we don't dare simply accept just everyone as we have not received any official order."

Interviewee E2, Asst. Programme Officer, UNHCR Malaysia

"Many front line health personnel are blind to procedures in registration of undocumented patients- no patients should be turned away. Having no documentation should not be an excuse as everyone can be registered even with only a name."

Interviewee E3, Medical Coordinator, Malaysian Karen Organisation

"Two months ago, a Chin lady gave birth at home, and only went to a clinic after 6 days and asked for vaccination. She was denied by the nurse because the baby had no birth certificate. As a medical coordinator, I asked for a referral letter and made a police report to negotiate with the UNHCR. Only after that, we could get the baby treated."

4.1.2 Socio-Cultural Barriers

Several barriers related to social or community perceptions of health services were described by in the interviewees. They included attitudes in health-seeking behaviours, discrimination and language barriers.

4.1.2.1 Lack of Knowledge and Health Seeking Behaviour

Some interviewees had a lack of awareness on where and why to seek MCH services. Many women were dependent on their spouse or immediate family to make decisions on healthcare. Health seeking behaviour varied within the group, with women who had a higher level of education having more awareness on the need for MCH services.

Mother M10, aged 20, no previous formal education

"When I was pregnant, I had no antenatal check-up at all. When I got pregnant, my father applied for a UNHCR card for me, so all I had was the temporary document. However, I was told that that UNHCR document was not accepted at the Selayang Baru Health Clinic and they only accept the UNHCR card. I was not given further instructions. I didn't know what to do and where to go."

Mother M6, aged 30, no previous formal education

"I am 4 months pregnant but do not know where to go. I have not yet seen a doctor about my pregnancy. I don't know anything about health or pregnancy. My husband doesn't care about me, and currently ignores me. I have no money to go to any clinic, and have to wait for my husband even for money to eat. I previously spent 2 years in prison after my husband was caught because he had no documents. I now stay to myself and don't go out at all."

Although some women were aware of their health condition, the procedure involved in accessing affordable health services or the locations were not known to them. Some compensated by using traditional methods which were more familiar and available to them (Mother M7).

Mother M7, aged 26, secondary level of education

"I have a heart problem diagnosed in Myanmar before, but now that I am pregnant, I am not sure how to go for treatment. I know they are private clinics around but they are expensive. I have no knowledge on what to do. My sister asked me to go to the ACTS NGO clinic, but my husband can't take time off work at the market to wait the whole day. Plus I'm scared to go by myself as I have no documents. So I am just taking a Myanmar traditional heart tonic which I buy in the local area."

Mother M4, aged 37, secondary level of education

"The rooms are very crowded and have little ventilation, but the children go play outside on the streets a lot; so I guess that helps. When some of the children in this market community are sick, they just take Myanmar medication or cough mixture they can buy from the shops. I am not sure about TB (tuberculosis) in our community."

4.1.2.2 Perceived or Actual Discrimination

Many women spoke about discrimination that was experienced. The experiences however were not negative enough to stand as a reason that they would attribute not seeking MCH services or stop accessing services. Most negative experiences were rationalised as communication failures.

Mother M11, aged 23, Myanmar Muslim

"When I go to the health clinic (KK), a neighbour who was previously UNHCR trained as a translator comes to help with translation. When I went to register for childbirth, I was shouted at initially because I couldn't understand."

Mother M14, aged 33, UNHCR card holder

"I was initially scared as I was not sure about what to do in the hospital. The nurses look down on us, as though we are second class patients and because we are foreigners, we are poor. They are afraid if we can't afford money and think we will run away. Many of the nurses don't know the UNHCR benefit if we have the card. They assume we have to pay double the charge. However, the doctors are not like the nurses, and treated me with more respect, especially for me operation for childbirth."

Mother M2, aged 38, Mon

"I don't understand Malay at all, so I bring a friend along to translate. Usually they are rude to me in the examination room because I don't understand what they are saying when I am alone."

4.1.2.3 Language Barriers

Language barriers were obstacles that were perceived frequently, but often overcome with use of the community network. The main Kuala Lumpur General Hospital provides UNHCR-sponsored translators at the maternity wing, although that is only during office hours. In other clinics, only Malay is used. The language barrier prevents knowledge of where and how to access MCH healthcare services in the community.

It was interesting to note that language barriers were present within the Myanmar community as well as with the Malaysian population (Mother M8). Not all migrants spoke Burmese, while different dialects complicated translation.

Mother M5, aged 27, Myanmar Muslim

"I only went to a private clinic antenatal check-up because a friend asked me to go. I've been only 2 times so far. I don't understand the languages spoken here, but in that private clinic, there is sometimes a Myanmar lady doctor who speaks my language. She says I need to go to the Selayang Hospital to give birth but I don't know how and am not sure of the community support here."

Mother M8, aged 23, Rohingya

"I speak very little Burmese, as I speak a Rohingya dialect. My husband can speak and understand a little Malay, but anyway, I don't go out or keep in touch with anyone else in the community. At the clinic, sometimes we get by with hand-gestures."

Many women only speak Burmese. Health personnel were unable to communicate effectively with the interviewees, and this sometimes led to the incomplete transfer of MCH health information. The language barrier also prevents outreach of information from health authorities thus also influencing health education, awareness and safety.

Interviewee E1, Community Health Clinic Staff Nurse

"Although many of our Myanmar patients can get by with their translators and with sign language, miscommunication is common. For example, they come on wrong days for their glucose testing, and we have to start again. When we refer them to the larger clinic or hospital, we write them simple notes on what to do."

4.1.3 Physical Barriers

Certain reasons for not accessing health care or defaulting MCH services were attributed to the general supply of, availability of and distance to health services.

4.1.3.1 General Supply

Although health clinics were close by to the population, there were a few instances where those who had sought services were turned away. One mother cited the excuse given as lack of supply in the government health clinics, and was subsequently told to source at private clinics. Cost limitations then prevented further access.

Mother M13, aged 27, UNHCR card holder

"After giving birth, the doctor explained that I needed to space out my pregnancies. I went to the government health clinic (KK) to seek for the 3 monthly family planning injections I was told about, but was told by the staff that there wasn't enough stock for foreigners, and was asked to go to buy at private clinics. I couldn't afford that, so I am trying to buy OCP to take every day."

4.1.3.2 Availability

Inconsistencies in registration procedures further limit the availability of healthcare to certain health centres. There does not seem to be a standard procedure for acceptance of registration. Confusion on the procedure may lead to defaulting on healthcare services. Additionally, the limited resources of health staff distribution decreases health coverage in some cases.

Interviewee E1, Community Health Clinic Staff Nurse

"My 4 other nurses and I sometimes feels overloaded as we have so many patients. One Community Clinic is supposed to cover around 2km^2 of urban area but we have to cover more than 10km^2. Nevertheless, we still try to conduct many postnatal house visits to the Myanmar community, but only if they come and register the birth with us as required."

Although the perceived availability might be wrong, some women were under the assumption that they could only seek healthcare in certain hospitals, not necessarily the closest.

Mother M13, aged 27, UNHCR card holder

"My baby was born in the main hospital in Kuala Lumpur (10km away), not the Selayang hospital because someone told me that although I have a UNHCR card, there will be no discount unless you have a letter stamped by the UNHCR office. It was too late and difficult to get the letter. In the main hospital in Kuala Lumpur, registration is no problem with a UNHCR card. I have tried to complete my child's vaccination, although I'm scared each time as once I wasn't allowed inside the hospital."

4.1.3.3 Distance to Health Facility

Distance to healthcare centres was suggested as an obstacle by one mother, although an alternative was found in the form of a private health clinic. The other limitation then became financial due to the cost involve. One woman who could afford a taxi fare as transport cited safety reasons to get to the health centre as a

reason she would rather pay more (Mother M15). Overall however, physical barriers were not seen as major factors to prevent initial access or default of services and were easily overcome.

Mother M5, aged 27, Myanmar Muslim

"I have gone for antenatal check-up at a private clinic since I was told to go by a friend. I have no documentation so am afraid to go very far to the cheaper government clinic. The private clinic is close by and there sometimes is a Myanmar lady doctor there. I can walk to the clinic. However, since it is private, the fees were expensive (RM50). I have gone for 2 check-ups up till now, at 7 months pregnancy."

Mother M15, aged 40, Karen

"I initially went to the ACTS NGO free clinic when I was pregnant because I didn't know any other government clinic, but was told to go to the government clinic for antenatal follow-up. Of course it's expensive to take the taxi (around RM6.50 each way) but I would rather go there because they have Burmese translators there. When I had high blood pressure during pregnancy I had to go every day to get my pressure checked. I could afford the taxi fare as I was working as a restaurant worker then (salary RM900). I can take the bus but choose to take the taxi because I feel safer."

Mother M4, aged 37, Myanmar Muslim

"Generally it is no problem to get to a health clinic. The bus to the government health clinic takes 15 minutes and cost RM1 each way. I have been told that I need to deliver in the Selayang Hospital which is around 3km away."

4.1.4 Economic or Financial Barriers

There has been a push by NGOs to allow refugees to work so that they may be able to support their families financially. However, legislation has not been passed, thus rendering irregular migrant labour vulnerable to economic problems. Although not legally allowed employment, many men gain informal labour work at the surrounding wholesale markets, or businesses in the immediate vicinity. Many are paid very little and are made to work for long irregular hours. Many interviewees cited financial limitations related to the cost of seek and obtaining healthcare, in relation to their household income. Many families borrowed from their community, and were subsequently in debt.

Case 1: Mother M10, aged 20, Community Card holder

"When I went to the main Kuala Lumpur hospital, the staff actually didn't want to admit me until I paid the deposit. After delivery and admission of one day, I was chased outside to wait till my husband came to pay. The total cost was RM1060. We had to borrow to pay and we are still in debt."

4.1.4.1 Hospital Fees and Admission Deposits

Health clinics charge non-citizens a standard fee of RM15 for each visit, including treatment and medication.

Case 2: Interviewee E1, Community Health Clinic Staff Nurse

"There is a standard charge for all visits for non-citizens in the government health clinics, regardless of treatment or medication. It is only RM15 per visit, even for pap smears and family planning. UNHCR card holders have a 50% discount (RM7.50)."

Most of the barrier comes in the form of hospital admission cost. A deposit is required before admission, but is 50 percent less with a UNHCR card. UNHCR card holders are able to negotiate deposits if unable to pay upfront. Other non-recognised documentation holders are charged at non-citizen rates.

Although, as mentioned earlier, state healthcare facilities are open to all, cost is a significant barrier. Non-citizens have to pay double the rates that citizens pay. Table 1 below displays ward charge deposits that contrasts differences that have to be paid up front (HKL, 2012). Although eventual cost might not be that high, deposits required are too steep for admission for non-citizens.

Table 4 Hospital Admission Deposit Rates for Kuala Lumpur General Hospital Contrasting Malaysian Citizens (top) with Non-Citizens (below).

MALAYSIAN CITIZEN			
Ward Class	Medical	Surgery	Maternity and O&G
First class	RM 700	RM 1100	RM 800
Second class	RM 200	RM 400	RM 350
Third class	RM 20	RM 30	RM 15

NON CITIZEN			
Ward Class	Medical	Surgery	Maternity and O&G
First class	RM 1400	RM 2200	RM 1400
Second class	RM 600	RM 1000	RM 1000
Third class	RM 400	RM 800	RM 800

One interviewee mentioned that she was allowed admission even though she did not have enough deposit. The high costs of maternal care also takes away from future costs such as vaccination for the children as the family is already in debt (Mother M12).

Mother M11, aged 23, Community Card holder

"Initially when I went to register, I couldn't afford the deposit fee of RM800. I only paid half which was all I had, and then had to borrow from friends later to pay. I am still paying my debt."

Mother M12, aged 37, Community Card holder

"The deposit I had to pay for childbirth was RM1400, while the final bill was RM1100. We borrowed the money from people in the community. The only vaccination my child received was at the hospital at birth. After that I didn't try to get him vaccinated at other clinics because we couldn't afford it."

4.1.4.2 Indirect Cost

Indirect cost such as transport, time away from work and corruption were also seen as a reason on potentially not continuing with health services. However, one woman who could afford private clinic check-ups had the extra burden of cost after alleged ill-service at a government clinic. Cost was overcome by re-prioritising household expenses (Mother M1).

Mother M15, aged 40, UNHCR Card holder

"During my pregnancy, I was diagnosed with high blood pressure, so I had to go everyday to check my pressure. I had to go everyday with taxi ($6.50 one way). I take the taxi because it is much safer, and that way, I'm less likely to be harassed by the police. My husband has left for the United States by UNHCR, so I had to work to support myself in a restaurant. During one check-up I had to be admitted straight away for an emergency operation, but I had no one around for me. Luckily, the hospital accepted all I had (RM300) for the deposit. My employer loaned me upfront for the hospital bill (RM1600)."

Mother M1, aged 40, UNHCR Card holder

"I only received my UNHCR card after my baby was born, so when I was pregnant it was difficult to register at the health clinic. The government health clinic didn't treat my husband and me very well, even though my husband can speak good Malay. I had high blood pressure during my pregnancy. As I was worried after I had an abortion of my second child, we used a lot of money in private clinics for antenatal follow-up. My husband and I worked in permanent jobs, so we had regular income. However, we knew we needed to put more money into health. Transport to the hospital was expensive too (RM20 each way), but we knew it was important to go. I had to undergo an emergency Caesarean section operation with my baby subsequently admitted for 7 days. The hospital bill came up to RM1500."

A social protection scheme was recently introduced to assist in covering health expenditure for migrants in Malaysia. The Hospitalisation and Surgical Scheme for Foreign Workers / Skim Perlindungan Insurans Kesihatan Pekerja Asing (SPIKPA) is a mandatory medical coverage for all new foreign workers which will take effect on 1 January 2011. Enforced by the Ministry of Health, all foreign workers are required to take up this compulsory scheme with a premium of RM120 and a total coverage of RM10, 000.

This scheme is applicable for:

- Foreign plantation workers and domestic foreign maids – premium to be paid by the employers.
- Foreign workers in other sectors – premium can either be paid by the employers or the workers. In the event that the employer decides to pay in advance on behalf of the employers, permission from Director General of Labour Department Peninsular Malaysia is required for salary deduction purpose.

However, only documented migrant workers are qualified. Since most of the Myanmar migrant women interviewed were undocumented asylum seekers they were not they are not entitled to the programme.

Interviewee E2, Asst. Programme Officer, UNHCR Malaysia

"A Migrant Health Insurance programme called SPIKPA was implemented in January 2011, but it only covers documented migrant workers. Undocumented persons of concern such as asylum seekers do not have such coverage."

4.2 Specific Maternal and Child Health Issues

4.2.1 Late Presentations for Antenatal Care

Early access to antenatal care is important for early detection and treatment of complications of pregnancy such as maternal death and adverse foetal outcomes. Early booking (within 4 months) allows fairly accurate determination of estimated delivery dates, gives certain baseline measurements such as blood pressure, and urine testing to be done to allow a fair idea of the pre-pregnancy state of the mother (Adekanle DA & Isawumi AI, 2008).

The WHO recommends that pregnant women in developing countries should seek antenatal care within the first 4 months of pregnancy (WHO, 1994). The Malaysian MOH and the NICE guidelines (NICE, 2003) recommend that the first antenatal (booking) visit should be before the completion of 12 weeks of pregnancy.

Interviewee E1, Community Health Clinic Staff Nurse

"Many Myanmar women present for booking late; after 6 or 7 months of pregnancy. This makes it difficult for us to properly manage and detect all maternal complications early."

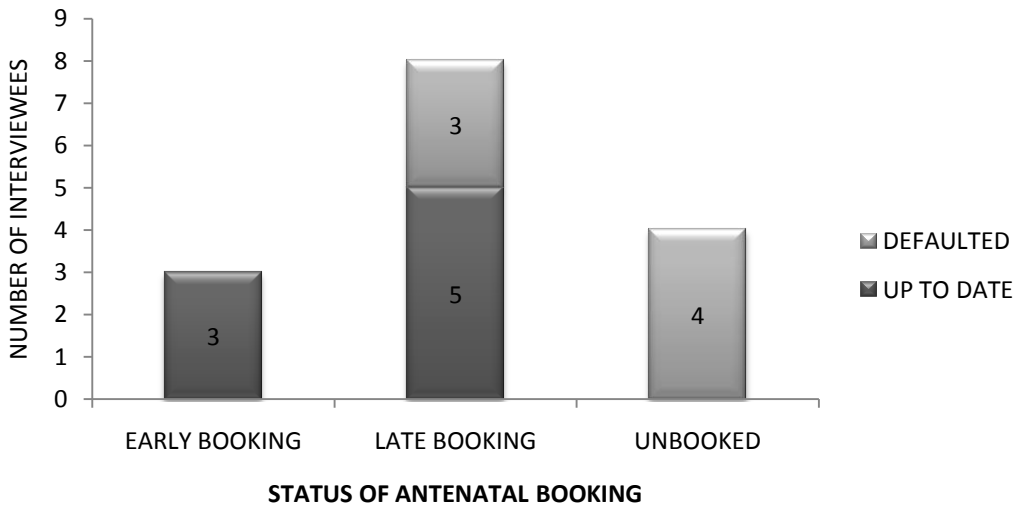
It was noted that a majority of the women interviewed presented for their first antenatal booking after the first 4 months (Table 5). Nearly a third of the interviewees (4 out of 15) did not have any antenatal check at all, with their first maternal healthcare visit being at childbirth.

Table 5 Breakdown of Status of Antenatal Booking and Compliance to Follow-Up with Comparison Data of Number of Pregnancies, Level of Education and Language Use of Interviewees.

INTERVIEW CODE	AGE	DOCUMENTATION	PREGNANCY STATUS		CURRENT NUMBER OF PREGNANCIES	EDUCATION LEVEL	LANGUAGE USE	FIRST ANTENATAL VISIT	STATUS OF ANTENATAL BOOKING	COMPLIANCE: ANTENATAL FOLLOW UP/ VACCINATION STATUS OF CHILD
M1	40	UNHCR CARD	5 MONTHS	ANTENATAL	4TH	SECONDARY	B,m	5 MONTHS	LATE BOOKING	UP TO DATE
M2	38	COMMUNITY CARD	8 MONTHS	ANTENATAL	5TH	PRIMARY	B	5 MONTHS	LATE BOOKING	UP TO DATE
M3	24	COMMUNITY CARD	7 MONTHS	ANTENATAL	1ST	PRIMARY	B	5 MONTHS	LATE BOOKING	DEFAULTED
M4	37	COMMUNITY CARD	8 MONTHS	ANTENATAL	5TH	SECONDARY	B	5 MONTHS	LATE BOOKING	UP TO DATE
M5	27	NIL	7 MONTHS	ANTENATAL	1ST	PRIMARY	B	5 MONTHS	LATE BOOKING	UP TO DATE
M6	30	NIL	4 MONTHS	ANTENATAL	1ST	NIL	B	NIL	NIL	NIL
M7	26	NIL	2 MONTHS	ANTENATAL	1ST	SECONDARY	B,m	NIL	NIL	NIL
M8	23	UNHCR TEMP DOC	6 MONTHS	ANTENATAL	3RD	SECONDARY	R	6 MONTHS	LATE BOOKING	UP TO DATE
M9	24	UNHCR TEMP DOC	3 MONTHS	POSTNATAL	2ND	NIL	R	NIL	NIL	DEFAULTED vaccination
M10	20	COMMUNITY CARD	9 MONTHS	POSTNATAL	1ST	NIL	B	NIL	NIL	NIL
M11	23	COMMUNITY CARD	13 MONTHS	POSTNATAL	1ST	PRIMARY	B	5 MONTHS	LATE BOOKING	DEFAULTED vaccination
M12	37	COMMUNITY CARD	6 MONTHS	POSTNATAL	7TH	NIL	B	5 MONTHS	LATE BOOKING	DEFAULTED vaccination
M13	27	UNHCR CARD	10 MONTHS	POSTNATAL	1ST	SECONDARY	B	2 MONTHS	1ST TRIMESTER	UP TO DATE vaccination
M14	33	UNHCR CARD	20 DAYS	POSTNATAL	1ST	SECONDARY	K,B,E,m	2 MONTHS	1ST TRIMESTER	UP TO DATE vaccination
M15	40	UNHCR CARD	7 MONTHS	POSTNATAL	1ST	PRIMARY	K,B	3 MONTHS	1ST TRIMESTER	UP TO DATE vaccination

Note: Language code B: Burmese, K: Karen, E: English, m: minimal understanding of Malay

Figure 12 Status of First Antenatal Booking of Mothers Interviewed in the Case Study Area



Cost was the most common reason cited as reasons for not presenting early, delaying or defaulting antenatal follow-ups. Household income is limited, and spending on health is sourced from borrowing from surrounding community. This situation is dealt with by presenting later as it would decrease the number of times accessing a health facility, with the assumption of paying less in the long run.

Mother M2, aged 38, fifth pregnancy, late booking

"*I only went for a check up after 5 months. I suspected I was pregnant, but didn't do anything to confirm it. Only when my baby started moving did I know I was pregnant. My main issue is cost to go for check-ups (RM15 per visit). But if I cannot afford, I try to borrow money and still go.*"

Mother M12, aged 37, seventh pregnancy, late booking

"My first antenatal visit was after 6 months. I went late because I couldn't afford the cost earlier. My husband works at the market but can't work every day because he has high blood pressure. I defaulted further check-ups because I couldn't afford it and started depending on other people for money."

One lady who was in her first pregnancy confessed she had no previous knowledge/awareness on the importance of early check-up (Mother M11). This was most probably due to the lack of social support that she had after migrating to Malaysia. Many women depend on extended community support, and if that is not reached, healthcare access information is not gained.

Mother M11, aged 23, first pregnancy, late booking

"I only went for my first antenatal visit at 5 months of pregnancy after my mother who is in Myanmar told me to go."

The lack of knowledge on where and how to seek early MCH services is compounded by the fact that many women fear for the safety and security of themselves and their family. The limited environment and social support prevents adequate outreach of these women to seek early access to proper healthcare.

Mother M9, aged 24, second pregnancy, unbooked

"I didn't know what to do for my pregnancy. When I knew I was going to give birth, my husband brought me to the hospital, but the staff was very angry at me. I didn't have any check-up previously. It is very difficult for us. I don't know what to do. I have no family here to tell me what to do. I am scared to go out and depend on my husband to take care of me."

4.2.2 Early Childhood Diseases and Vaccination

All children born in Malaysia are to be vaccinated with a comprehensive paediatric vaccination schedule prepared by the Ministry of Health. However, a majority of the children in the case study population are not vaccinated; this includes new arrivals as well as children born in Malaysia. This decreases the herd immunity in the population, and exposes the community and surrounding population to childhood disease epidemics. Overcrowded living conditions further increase the chance of spread of illnesses (Mother M10).

Interviewee E2, Asst. Programme Officer, UNHCR Malaysia

"Many health personnel in the clinics are not aware of catch-up vaccinations that are required by young children of migrants that have not been immunised previously. This failure of catch-up vaccinations may lead to the decrease in herd immunity which further exposes the general community to infectious childhood diseases"

Mother M10, aged 20, with 1 child

"My baby was able to get a birth certificate I think because his father has a UNHCR card. I was able to go the government health clinic and keep the vaccinations up to date. Nevertheless, my baby is always sick, but I used Myanmar traditional medication for him. My husband earns RM25 in the market a day, while I don't work. 8 people live in our small room in the flat."

Obstacles cited in not accessing vaccination are lack of documentation of the child, fear, and cost. Decisions for vaccinating the child were also referred to as the decision of the father (Mother M8). The small group of postnatal interviewees did not place childhood vaccination on high priority and it was seen commonly defaulted.

Mother M13, aged 27, with 1 child

"*Most children in our community are not vaccinated because they have no documents. They usually are turned away at the health clinics, and told to come back with proper documentation. Eventually, the children are not able to get vaccinated. I was also scared to go again to the clinic after not allowed inside the hospital once."*

Mother M12, aged 37, with 3 children

"The deposit I had to pay for childbirth was RM1100, while the final bill was RM1400. We borrowed the money from people in the community. The only vaccination my child received was at the hospital at birth. After that I didn't try to get him vaccinated at other clinics because we couldn't afford it."

Socio-cultural norms in the community also influence the awareness and knowledge of migrant women from Myanmar on the need to seek childhood vaccination and the importance for compliance and completion.

Mother M8, aged 23, with 2 children

"I don't know exactly why babies need vaccination, but I know it is to prevent illnesses. In the end, it will be my husband who decides if my baby needs vaccination or not."

Interviewee E3, Medical Coordinator, Malaysian Karen Organisation

"Sometimes, mothers do not know or are not told about the need for vaccination. In villages in our country (Myanmar), there is no access to vaccinations although there are midwives. Getting to hospitals are difficult as they are far from villages. So when the women come here to Malaysia, it is assumed the same. But when the nurses or doctors tell them what to do, they will comply without questions."

4.3 Gender Based Issues

4.3.1 Health-Seeking Decisions

Many women were dependent on their spouses for money, security and network. One interviewee described her health decisions as completely left to her husband (Mother M8). The power disparity between spouses affected the health-seeking behaviour of a woman. Gender roles played my migrant women from Myanmar were prominent, and were placed as maternal and domestic roles. Although a few women worked prior to their pregnancy, the exposure towards the community outside their own was very limited.

Hence, most women were not affected by national health campaigns via the media. Most health education was from other women in their community.

Mother M8, aged 23, Rohingya

"I don't know anything about how to plan a family. I also don't know if I want more children or not. Anyway, it doesn't depend on me; my husband will decide. I will just follow everything my husband says."

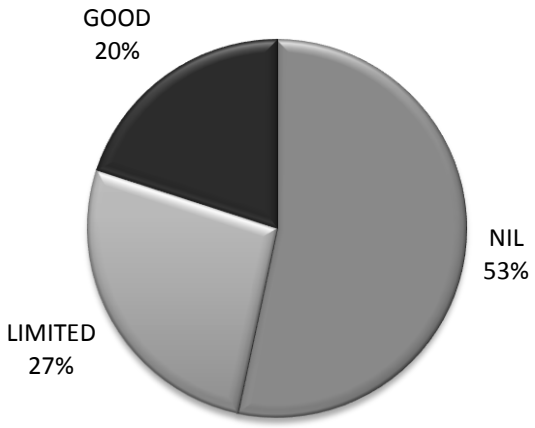
Case 3: Mother M11, aged 23, Myanmar Muslim

"Until I get a chance to be resettled with the UNHCR, I would like to stop having children because there are many problems involved. Upon discharge from childbirth, the doctor actually advised me to take regular 3 monthly injections because it is more effective. However, my husband didn't allow me to, as he was told by some people that it would prevent me from getting pregnant again forever. I am

now taking birth control pills from Myanmar shops every day. It is without prescription, and I only learnt about it from other women."

4.3.2 Family Planning

Figure 13 Knowledge of Family Planning (FP) Among Women Interviewed



Note: Good: Able to explain description and/or methods and reasons for FP,
Limited: Able to express a reason for FP only,
Nil: Not able to express description, methods or reasons for FP

A majority of the women interviewed had no knowledge about family planning issues. Although several women were familiar with the concept of family planning, they did not have access to clinically sourced birth control pills. Most bought pills off-the-counter after finding out from fellow women. They were not screened nor told of the proper procedure to use the medication. Cost was another factor that prevented the use of the optimum choice of method of family planning.

Case 4: Mother M12, aged 37, Myanmar Muslim

"I actually became pregnant while taking the birth control pills I bought from the local shops. Sometimes I couldn't afford them, so I had to stop for a few days. The injection is RM45 (once every 3 months) at the clinic, but the pills are about RM10/month."

Case 5: Mother M10, aged 20, Myanmar Muslim

"I take birth control pills from Myanmar, but I didn't know that I had to take them at a certain time each day. I just buy them from the local shop. A nurse has previously told me that I can take an injection for RM45, but I don't know much about anything else."

Family planning practices were also influenced by cultural views. Although children added to the vulnerability of undocumented migrant population, the fertility rate appears to be quite high. This may be due to the skewed age of most migrants from Myanmar being in the reproductive age group (Table 2).

Case 6: Mother M2, aged 38, Mon

"Now that I'm in my 5th pregnancy, I don't want more children. I felt I needed to get good luck, that's why I wanted another child. I don't know how to take pills for family planning. My husband and I don't sleep together, that's why I don't get pregnant otherwise. After this I may have to take medicine but I'm not sure."

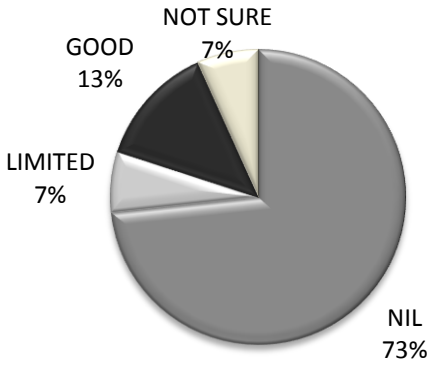
4.3.3 Knowledge on HIV/AIDS

While the subject may be taboo, the area of HIV/AIDS stands as a reflection on women's awareness towards sexual health. The lack of knowledge of the disease is an important barrier to improving the overall health of mother and child.

The interviews conducted suggest that there is a severe lack of awareness of HIV/AIDS among women in the Myanmar migrant community in the case study area. A huge majority had completely no knowledge of the disease (Figure 13). The only 2 women who had good knowledge had gained knowledge from the UNHCR and Myanmar community NGOs while in Malaysia. Many had no health information from their community, or from local media.

From the small sample of women, there was no strong connection between education level and health awareness. This may be because the main source of information would be from the own community, and not via educational material. Nevertheless, those with secondary school education tended to have more knowledge on the subject (Table 6).

Figure 14 Knowledge of HIV/AIDS Transmission/Prevention among Interviewees



Note: Good: Able to explain description of transmission and/or prevention of HIV/AIDS,
Limited: Able to express very basic description of HIV/AIDS only,
Nil: Not able to express any description, transmission or prevention,
Not Sure: Unsure of any above.

Table 6 Breakdown of Family Planning & HIV/AIDS Awareness and Ranked Healthcare Barriers with Comparisons of Documentation, Level of Education and Language Use of Interviewees.

INTERVIEW CODE	AGE	DOCUMENTATION	EDUCATION LEVEL	LANGUAGE USE	KNOWLEDGE OF FAMILY PLANNING	KNOWLEDGE OF HIV/AIDS TRANSMISSION/ PREVENTION	RANKED 1ST BARRIER THAT PREVENTS ACCESS	RANKED 2ND BARRIER THAT PREVENTS ACCESS
M1	40	UNHCR CARD	SECONDARY	B,m	NIL	NIL	COST	FEAR/SECURITY
M2	38	COMMUNITY CARD	PRIMARY	B	NIL	NIL	COST	LANGUAGE
M3	24	COMMUNITY CARD	PRIMARY	B	NIL	NIL	FEAR/SECURITY	COST
M4	37	COMMUNITY CARD	SECONDARY	B	LIMITED	NIL	FEAR/SECURITY	COST
M5	27	NIL	PRIMARY	B	NIL	LIMITED	FEAR/SECURITY	LANGUAGE
M6	30	NIL	NIL	B	NIL	NIL	KNOWLEDGE	SECURITY
M7	26	NIL	SECONDARY	B,m	NIL	GOOD	FEAR/SECURITY	KNOWLEDGE
M8	23	UNHCR TEMP DOC	SECONDARY	R	NIL	NIL	FEAR/SECURITY	COST
M9	24	UNHCR TEMP DOC	NIL	R	NIL	NIL	KNOWLEDGE	FEAR/SECURITY
M10	20	COMMUNITY CARD	NIL	B	LIMITED	NIL	KNOWLEDGE	COST
M11	23	COMMUNITY CARD	PRIMARY	B	GOOD	NIL	CHILD'S DOCUMENTATION	FEAR/SECURITY
M12	37	COMMUNITY CARD	NIL	B	LIMITED	NIL	COST	CHILD'S DOCUMENTATION
M13	27	UNHCR CARD	SECONDARY	B	GOOD	NIL	DOCUMENTATION	FEAR/SECURITY
M14	33	UNHCR CARD	SECONDARY	K,B,E,m	GOOD	GOOD	FEAR/SECURITY	COST
M15	40	UNHCR CARD	PRIMARY	K,B	LIMITED	NOT SURE	COST	FEAR/SECURITY

Note: Language code B: Burmese, K: Karen, E: English, m: minimal understanding of Malay

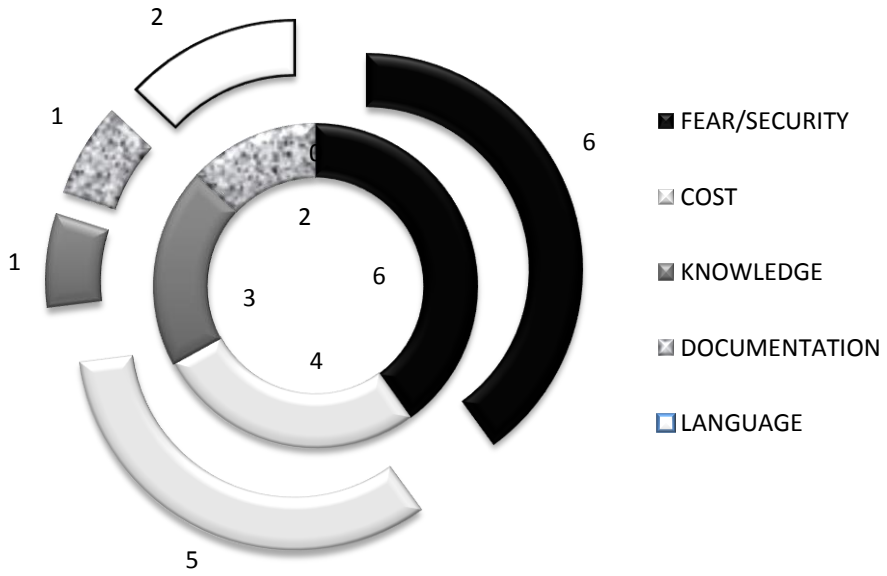
4.4 Summary of Findings

Out of all the barriers discussed during the interviews, the interviewees were asked to state the overall the 1st and 2nd obstacles they perceived to hinder MCH access in the case study area. The frequency of responses is shown below in Table 7.

Table 7 Frequency of Respondents (f) According to Barriers that are Perceived to Hinder Access to Maternal and Child Health Services in the Case Study Area of Selayang, Kuala Lumpur.

	1ST MOST IMPORTANT BARRIER	2ND MOST IMPORTANT BARRIER
	f	f
FEAR/SECURITY	6	6
COST	4	5
KNOWLEDGE	3	1
DOCUMENTATION	2	1
LANGUAGE	0	2

Figure 15 1st Barrier (Inner Circle) and 2nd Barrier (Outer Circle) Ranked by Interviewees According to Percentage of Responses.



CHAPTER V

DISCUSSION

The main thrust of the conceptual framework of this thesis is the right of every individual to access healthcare. A rights-based approach to healthcare in policy making is lacking but areas for utilisation are present, such as provisions in the UDHR, CEDAW, CRC and the 'Health For All' policy of the Malaysian Ministry of Health. A rights-based approach needs to be mainstreamed into all aspects of MCH services to ensure that access to healthcare is present for everyone, including migrant communities. This has become increasingly relevant as health provision and services are improving at significant rates, while portions of society remain sidelined.

Although Malaysia has signed women and child rights conventions such as CEDAW and the CRC, full recommendations for maternal and child health have not been fully ratified. The law still has loop holes that allow marginalised groups to fall through. This research has found that barriers to healthcare to the Myanmar migrant community in the Selayang area are prevalent and multidimensional.

5.1 Multidimensional Barriers to MCH Access in Selayang District

Out of all the factors cited by interviewees, those related to security and documentation were seen to be the greatest obstacles to accessing health services. The national immigration policy and health policy by their interaction with each other determine security as well as health outcomes of migrant individuals and their families.

A more controversial issue is the widespread corruption that is present in the system which further weakens protection of migrants in the community. This institutionalisation of threat from law enforcers with uncertain protection from legal mechanisms hinders decisions to access health services. For migrants from Myanmar in the case study area, especially irregular migrants, barriers that require documentation and legitimisation prevent access to the basic right to health that is required at the minimum. In practice, state healthcare facilities are supposed to be open to all refugees and asylum seekers regardless of their documentation status. However, system-based structural inconsistencies create a condition where health personnel are unsure of the correct procedure despite the having a "Health for All" policy in the Ministry of Health.

Once an intrinsic decision has been made to seek healthcare access, many barriers exist within health service sectors as well that impede opportunity to seek medical care. These include financial factors such as high medical costs, and also indirect costs of travel and corruption in order to gain security or access to medical care.

Although, as mentioned earlier, state healthcare facilities are open to all, cost is a significant barrier. Non-citizens have to pay double the rates that citizens pay. Although eventual cost might not be that high, deposits required are too steep for requiring admission for non-citizens.

Physical barriers were among the least mentioned by the interviewees. They were not ranked in both first and second most important barriers that were perceived to hinder access to MCH services. This is most probably as the case study community is situated in a very well connected urban area in the capital city in the country. As such, the district of Selayang would be very easily connected by various forms of transportation, ensuring proper supply and availability. Overall, physical barriers were not seen as major obstacles to initial access nor caused default of services and were easily overcome.

Several individual and socio-cultural factors were described by the interviewees. It can be seen that health-seeking behaviours of migrants play a key role in the issue of accessing health care. Other intrinsic socio-cultural factors included lack of information and difficulties in acquiring knowledge on how to access services. The health system in their home country Myanmar has not sufficiently developed; hence most migrants do not have the experience and lack familiarity with the Malaysian health system that is widely available.

Migrant communities are also often cut-off from mainstream communities. Language barriers in a foreign country compound the lack of information. Most of the signs for health services in Malaysia are in the Malay language. The language barrier prevented the knowledge of where and how to access MCH services. Linguistic barriers are also a problem, in communication with medical personnel and in accurate explaining medical problems, and understanding information provided. It also prevented the transfer of outreach of information. Health promotional activities, if available, such as pamphlets on reproductive health services are mostly in Malay and English.

Although language translators have been provided by the UNHCR in two major hospitals and a health clinic in the city, it is not sufficient for adequate coverage. Efforts to provide information in multiple relevant languages need to be instituted in order to ensure proper informed health decisions. This needs to be so in line with the right of the person to have the choice in decisions affecting their own reproductive health.

Stigma and discrimination also contribute to fear of accessing services. Discrimination results from cultural differences as well as its influence on the understanding of illnesses. Institutionalisation of “the other” that is reinforced in social and political norms based on manipulation of differences contribute to inferiority felt when accessing service and treatment. Although, discrimination was

generally seen as a minor barrier to the interviewees, it is an important socio-cultural barrier to overcome

A rights based approach emphasises that everyone is entitled to a basic level of healthcare regardless of background, or gender. This approach is an important paradigm, as two major perceptions stand in the way. The first is the assumption that only citizens should be entitled to social services. The other perception barrier is that immigrants are a burden to the health system. These perceptions further fuel the ingrained assumptions that maintain discriminatory practices.

Undeniably, these barriers may be the hardest to change. However they can be seen as an overarching driver of the inconsistent practices of immigration and health practices. A new vision free from discrimination may lead to better implementation of equitable health services.

5.2 Repercussions of Barriers that Prevent Healthcare Access

The analysis of the findings of this research proceeded to delve into specific MCH issues that were affected by the barriers to health care that were present in the case study community.

A majority of the women interviewed had their first antenatal visit after the first 4 months; which was against WHO recommendations. Malaysian MOH guidelines which are more progressive to be in line with more developed populations were not achieved due to not presenting early, delaying or defaulting follow up.

The MMR in Malaysia has stabilised but requires further improvement. Although having one of the lowest Maternal Mortality Rates in the world, 42 percent of maternal deaths in Malaysia in 2000 were to non-citizens (UNDP, 2011). Migrants, especially the undocumented, often have limited access to maternal health.

The initial booking date is an important indicator in efforts to reduce maternal mortality in the country. The barriers to health access discussed earlier, act together to contribute to the failure of achieving the proper target. These barriers prevent access to important antenatal services that assist in indentifying and treating illnesses which place pregnant women at high risk of maternal death due to indirect causes.

Article 12 of CEDAW compels state parties to ensure appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. Hence it is imperative that these barriers are overcome especially to further improve the MMR in the country.

The analysis also found that a majority of children in the case study area were not vaccinated due to barriers in the system. Obstacles cited were lack of documentation of the child, fear and cost. Children's documentation and registration are important areas to be addressed as this primarily resulted in the lack of coverage of infant immunisation. Although the Ministry of Health recommends immunisation according to the Extended Programme for Immunisation (EPI) Schedule, and that all children should be covered by the programme it is evident that many children of Myanmar migrants in the case study area are not included.

With the ratification of the Convention of the Rights of The Child (CRC), the onus is on the Government of Malaysia to ensure the progressive realisation of all the enshrined rights of a child. Article 24 of the Convention compels State Parties to pursue full implementation of this right and to take appropriate measures to diminish infant and child mortality. The State Party should also strive to ensure that no child is deprived of his or her right of access to such health care services.

Article 7 of the CRC also requires that children be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality. State Parties should ensure the implementation of these rights in accordance with national law, in particular where the child would otherwise be stateless. This requirement is clearly breached in the process of registering migrant children, especially those of undocumented parents and this situation needs to be addressed urgently to ensure the rights of all children.

There have been attempts for outreach programmes at health clinic levels depending on the distribution of marginalised communities such as migrants. Unfortunately, these depend on resources available, and many barriers remain in the way.

5.3 Gender Dimensions of Healthcare Barriers in the Myanmar Migrant Community

The ethnographic interviews in this study also provided gender insights into barriers in accessing MCH health care services in the Myanmar migrant community. Many women were dependent on their spouses for women, security and network. It was unclear if health decisions were made in cooperation with their husbands, but the power disparity between spouses certainly affected the health-seeking behaviour of the women.

A rights-based approach advocates that women be given the right to reproductive decisions that affect her health. This entails adequate education to enable informed choices in health. Cultural practices and inadequate knowledge are important barriers to be addressed in this area. The Myanmar Community NGOs, such as the Burma Muslim Community, and Malaysian Karen Organisation have a particular unique role to play in empowering women and balancing the power disparities that are present.

Knowledge of family planning issues was also very limited in the community. This deficiency is partly fuelled by lack of availability and lack of knowledge. Of the interviewees that did use family planning methods, many were off-the-counter and with no proper counselling and education on use and choice. Article 12 of CEDAW states that State Parties shall take appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health services including those related to family planning. This approach should provide for the provision of sufficient choice of the various methods of family planning so that a woman may chose the most appropriate for her situation.

Consequently, Many migrants are from countries where there have been limited HIV awareness activities, and improvements in knowledge, attitudes and practices will take some time and effort. This thesis research confirmed that HIV/AIDS knowledge is extremely low in the community and efforts should be made to increase awareness and education.

Again local Myanmar community NGOs have the potential to increase awareness and tackle stigma in the community. This may be supported with the fact that the only 2 women who had good knowledge had gained knowledge from the UNHCR and Myanmar community NGOs while in Malaysia. Many other women had no health information from their community, or from local media.

5.4 Rights-based Approach to Healthcare in Policy Making

These examples of barriers that prevent access to healthcare services stand to be addressed in the quest to provide basic opportunities of health to every person. Many of the solutions or challenges highlighted need clarification of migration policy issues that are currently to incoherent in practice (MSF, 2007). The acknowledgement of the presence and pervasiveness of these barriers is needed so as to provide basic requirements of health in a society.

Although health care provision in Malaysia is advancing at a rapid and commendable rate, many segments of society, especially in the lower income population have persistent barriers that prevent adequate access. The commercial drivers of health care such as profit and privatisation have acknowledged benefits in the overall development of a nation. However, disparities tend to remain and be reinforced when no universal social protection is in place. Marginalised communities such as migrants and urban poor in the informal economy tend to be left out of health services and the overall economic development agenda.

Article 12 of CEDAW states that State Parties should ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary. Although providing completely free healthcare might be unpractical and unsustainable, it is compounded by the fact that refugees and irregular migrants are not legally allowed to gain employment to support health and socio-economic needs. In the era of rising health care cost, financing health services are important areas of concern. Nevertheless, one option of ensuring adequate social protection is to ensure a minimum of basic MCH services to every person in the community. The next step to progressively realize other improvements in Malaysian MCH services may later be continued.

Hence a middle-income developing country such as Malaysia stands to benefit with more balanced development when rights-based practices are instituted into the overall health sector, especially with regard to access and coverage.

Since healthcare is controlled at the federal level of government, there is much opportunity for more equitable redistribution. Conversely, health is also seen as a politically sensitive topic. There is currently no proper policy that links immigration to the right to access basic health services. A rights-based approach in the Malaysian context may only be effective if it is leadership-driven.

Implementation of best practices and novel health care innovations should not be a substitute for ratification and implementation of internationally agreed conventions. The many human rights instruments stand as baseline that try to ensure universal coverage in social services in accordance with rights. As signatories of CEDAW and the CRC, the Government of Malaysia is required to institute legislation and policies that ensure the attainment of the rights stated. With regards to healthcare access, this translates to ensuring the availability, affordability, acceptability and opportunities to make use of resources for optimum health are provided to everyone.

"A Rights-based approach in the Malaysian context will only be effective if it is leadership driven, as currently there is no proper policy by Immigration procedures to provide everyone the right to basic health access. Everything is political in the end, and leaders eventually determine the direction of policy coherence. I haven't seen any contribution from the Health Ministry unless it was leadership driven. "

Dr Susheela Balasundaram, Asst. Programme Officer (Health & Assistance), UNHCR Malaysia.

5.5 Concluding Remarks

Malaysia is a diverse and vibrant nation that is continually influenced by population mobility within the region of South East Asia as well as with the rest of the world. Human rights violations occur throughout all phases of the migration cycle, from pre-departure at the countries of origin, and then on to the receiving countries. Although receiving countries such as Malaysia has not signed many International Human Rights Conventions, most other countries in ASEAN have (with the exception of ICRMW). Moreover, many other regional instruments exist that promote migrant rights with regards to non-discrimination, safety and health. Nonetheless, there are still discrepancies between practice and national policies which are mostly security and labor-market driven.

Every individual has the right to basic health care, regardless of citizenship, religion, or ethnic background. A rights-based approach emphasizes a universal right, as opposed to a perception that an individual deserves a right to services solely by virtue of citizenship or contribution to society. This is ultimately the most difficult institutional perception to be overcome.

Many areas of migrant health stand to improve by employing a rights-based approach; in design, implementation, monitoring and evaluation. These need to be sensitive to the wide range of individuals involved; from refuges and other undocumented populations, economic migrants, and their families involved. The increasing gender dimension of migrant health also has room for improvement.

One argument is that providing adequate health services decreases the cost implications involved in addressing migrant health needs in the future. Appropriate use of services, particularly preventive services when not hampered by accessibility can contain the cost of complications later. Rights-based approaches in migrant health achieve the realization of health by focusing interest on the migrant as an individual with rights rather than as mode of production.

By incorporating the approach into planning and policy development, countries such as Malaysia are able to empower the marginalized population of migrants which contribute as much to the receiving country as to their country of origin. The externality of health is frequently ignored in the market economy. Nations thus have the responsibility to ensure the incorporation of human rights into development, ensuring human dignity and freedom to choose is available to everyone.

Increased population mobility calls for new approaches for national and international health policy regardless of status of regularity. National point-of-arrival activities such as immigration medical screening for specific diseases target at airports will become less effective, more costly and more irrelevant in population health practices.

A rights based approach to provision of basic access to health care is a good force to guide policy. This should cover economic accessibility, physical accessibility, information accessibility, and as well non-discrimination principles in agenda setting. Although resource constraints and security issues may be challenges to implementation, the minimum level of rights provision is a necessary condition for ensuring human rights for all. The progressive realisation of increasing the range of services provided can then be evolved over time.

Healthcare access and opportunities to vulnerable populations have extended implications to health and socio-economic wellbeing of the host country citizens. As rapidly as migration is evolving, a multitude of diseases, such as tuberculosis and malaria now are re-emerging in a country that once had levels under control. Thus it is essential that national healthcare policies take an increasingly more regional outlook; taking into account migration demographics and population mobility into planning health budgets and services. This approach, combined with a rights based perspective to health may provide more equitable development prospects for citizens and non-citizens alike.

5.6 Conclusion

Research data in this study found that a majority of Myanmar migrant women in the Selayang area are undocumented asylum seekers and refugees. The majority ethnic group in the Myanmar population is Myanmar Muslim. Most women in the community have no legally recognised documentation such as the UNHCR card.

Further findings of this study suggests that barriers to maternal and child healthcare access for the Myanmar migrant community in Kuala Lumpur exists within their community and also within the health service sector. Of these factors, more influence comes from prior to the level of the health service sector (security, documentation, socio-cultural factors).

Fear and security concerns are the primary challenges that prevent access to healthcare in the case study population. System based factors such as national policy towards migrants and the need for security as undocumented asylum seekers have great influence in determining healthcare access. Fear of enforcement authorities prevents effective access to services.

The irregular status of the Myanmar migrant community affects individual and socioeconomic outcomes in determining health decisions. Financial concerns ranked second as barriers to healthcare access to the community. Socio-cultural barriers in the community include lack of knowledge, their inherent health-seeking behaviours, perceived or actual documentation and language barriers. Physical barriers were seen as minor obstacles in accessing healthcare services and were easily overcome.

A rights-based approach to migrant health may be useful to address the barriers in accessing maternal and child health services in the Myanmar migrant population in the Selayang area.

5.7 Recommendations

5.7.1 Short Term Recommendations

- Utilise a rights-based approach to confront the unmet needs of migrant populations and vulnerable groups recognising that everyone has a right to basic maternal and child healthcare regardless of citizenship, religion or ethnic background or contribution to society.

- Implement targeted outreach programme to encourage migrant communities to seek out healthcare services that are available.

- Re-evaluate registration procedures in health clinics to allow registration of children without documentation to access childhood vaccination programmes to increase coverage into migrant communities.

- Set clear guidelines for Ministry of Health personnel with regard to registration of undocumented individuals; every woman should be allowed to be registered for MCH services.

- Re-evaluate deposit for hospital admission procedures.
- Encourage early antenatal booking through outreach programmes which promote benefits that may offset eventual complication costs.

- Provide education material on MCH in Burmese for distribution to the Myanmar migrant women who access health clinics. Trained Community Health Volunteers can be used as translators in at least hospital settings with high migrant patient load.

5.7.2 Long Term Recommendations

- Institute a leadership driven commitment to a rights-based approach from high-level policy makers such as the Minister of Health and the Director General of Health.

- Implementation of more comprehensive strategies that specifically target undocumented and documented migrant populations aiming for a further reduction of MMR to achieve the Malaysian MDG target of 11 per 100,000 populations by 2015.

- Promote right-based approaches via medical education to instil non-discriminatory in health professionals and for effective holistic approaches to the right to health.

- Integrate at national level, policies in immigration, health and social protection to cover all level of society including migrants including asylum seekers and refugees.

- Re-evaluate avenues to legalise labour for refugees and asylum seekers so that the burden of cost for basic social services may be overcome.

- Tackle corruption, security, and arbitrary detention in line with the right of every individual to security.

- Increase qualitative research on specific target migrant groups and pockets of the population, especially in non-urban communities that have unmet needs for MCH services.

5.7.3 Recommendations for NGOs

- Increase awareness on reproductive health especially surrounding MCH services in early access to antenatal healthcare, family planning and HIV/AIDs. Community NGOs especially Myanmar NGOs have an important role in addressing the barriers to healthcare present in the community.

- Specifically focus health education and promotion activities on the negative impact of unplanned pregnancies, socio-cultural issues affecting family planning and fear of the side effects of family planning reducing their barriers to family planning practice.

- Include the role of males in utilizing family planning methods as well as joint decisions in health seeking behaviour ensuring that women are aware and uphold their right to making informed health decisions.

- To collaborate with health/humanitarian NGOs to implement childhood vaccination programmes to increase herd immunities in migrant children populations, while increasing awareness on the importance of vaccination in the community.

- Increase data collection about health indicators in Myanmar migrant communities in collaboration with academia or health authorities.

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BIOGRAPHY

Subatra Jayaraj is a qualified medical doctor who graduated with from the National University of Ireland in 2006. She spent five years working in a suburban district hospital in Malaysia mostly in intensive care and in the management of anaesthesia of patients in the surgical theatre. Her experience brought her into contact with multiple realities pertaining to difficulties in accessing healthcare in a developing country. The hospital served a vast background of patients primarily from local low to middle income socio-economic backgrounds, with a substantial growing number of foreign nationalities and refugees, from Myanmar, Indonesia, Vietnam and Bangladesh and the Indian Sub-continent.

Additionally, she has had 10 years of experience in community and social health development work, from inner city children to refugee humanitarian issues. Subatra is also passionate about women's health issues, and has implemented a Women's Health for Young People program in a few schools in Malaysia