



Symposium on the Access to Healthcare for Refugees and Asylum-Seekers in Malaysia

3 December 2018 | Impiana Hotel, Kuala Lumpur

Executive Summary: Key Issues and Recommendations

Objectives of the Symposium

1. To provide a platform where policyholders, frontline healthcare providers, civil society, UNHCR, and refugee communities exchange perspectives on access to healthcare services for refugees and asylum-seekers in Malaysia.
2. To present rigorous research conducted at national academic institutions on the challenges in access to healthcare for refugees and asylum-seekers and on the policies affecting refugee health.
3. To discuss the impact of limited access to healthcare on refugee and public health through case studies and medical expertise.
4. To propose possible solutions based on ideas and recommendations from stakeholders, as well as references of best practices in the international and regional community.

Speakers

The speaker list for the Symposium included Beatrice Lau (Head of Mission, MSF - Malaysia), Dato' Dr. Ahmad Faizal (President, MERCY Malaysia) YB Charles Santiago (MP for Klang), Dr. Susheela (UNHCR Health Unit), Sharifah Shakirah (Rohingya Women Development Network), Mohd Ayas Hashim (community health worker), Dr. Veena Pillai (MSF), Dr. Lilyany Farhana (University Malaya), Prof. Melati Nungsari (Asia School of Business), Kate Sheill (OHCHR consultant), Dr. Hathairat Kosyoporn (IHPP – Thai Ministry of Public Health), Au Yong Wai Nyan (Bar Council), and Lilianne Fan (APRRN and Geutanyoe Foundation).

Participants

The Symposium welcomed more than 70 participants, including representatives of the Malaysian Ministry of Health and Immigration Department, ICRC, UNHCR, IOM, International Detention Coalition, SUKA Society, Malaysian Medical Association (MMA), Medico-Legal Society of Malaysia, DNDi, HOPE Worldwide Malaysia, IMARET, USIM, International Medical University, United Nations University, representatives of the Canadian, French and US Embassies, representatives from the Rohingya, Afghan, Iranian and Somali refugee communities, and others.



Key Issues

Since 2006, the Ministry of Health has delineated various avenues for improved access to healthcare for refugees registered with UNHCR. For example, holders of UNHCR card and Under-Consideration Letter are accorded to a reduction of 50% in relation to the foreigner rate for medical treatment charges. Refugees registered with UNHCR can also benefit from the programme “One Clinic, One Community, Qualitas Refugee Health Programme”, which provides subsidized and flat rate primary healthcare in 69 Qualitas clinics nationwide.

Notwithstanding these positive measures, refugees and asylum-seekers continue to face on a day-to-day basis certain difficulties in accessing healthcare. The various barriers in access to healthcare have detrimental impact on refugee and public health.

For example, documentation, language and financial barriers can complicate regular access to primary care and the necessary medication for refugee patients with non-communicable diseases, such as diabetes and hypertension. This leads not only to poorer health outcomes and increased morbidity and mortality among the refugee and asylum seeker population, but also limits efforts in communicable diseases control and prevention among the general population. The incapacity to afford treatment can also lead to a delay in seeking care for refugee populations, which leads to poorer health and treatment options. The above barriers and cost of deliveries also can lead to a higher number of unsupervised home births, which increases risk to both mother and child.

Furthermore, threats and reports of arrests of undocumented patients in health facilities have increased fear among asylum seekers and refugees. Those without documentation, in particular, are more likely to wait until a later stage of disease progression, or even a life-threatening situation, before seeking medical assistance.

Despite the fact that the Malaysian’s government has taken steps to make treatment of tuberculosis (TB) accessible to non-Malaysians by providing first-line TB treatment for free, difficulties in transportation, lack of understanding of the disease, financial incapacity and lack of documentation can also cause an interruption in the treatment of patients with communicable diseases.

Main barriers in access to healthcare

- Lack of documentation
- Financial incapacity
- Language barriers
- Insufficient health literacy
- Stigma and discrimination

Key recommendations for improving the access to healthcare for refugees and asylum-seekers

1. *Identification and documentation*: **allow and encourage unfettered access for asylum-seekers to be registered with UNHCR** and obtain valid documentation. This enables the asylum-seekers and refugees to make use of the provision on access to healthcare accorded by the Ministry of Health; it also promotes better public health management as patients in need of treatment will not be deterred from seeking healthcare due to lack of documentation or fear of arrest.
2. *Financial capacity*:
 - **Grant work rights to refugees and asylum-seekers**, thereby ensuring their access to legal and sustainable livelihoods, which in turn will contribute positively to the country's economy and enhancing their ability to afford the medical charges for treatment at healthcare facilities, cost of medications, transport to medical appointments, and health insurance plans.
 - Initiate a **sustainable mandatory health-financing scheme** for refugees and asylum-seekers, linked to the documentation and work rights, with the aim to reduce cost barrier and promote self-reliance with regards to healthcare. The health financing scheme, apart from primary and secondary health care should include:
 - ❖ Reproductive health and ante-natal care
 - ❖ Psychiatric treatment
 - ❖ The coverage of implants for corrective orthopedic surgeries following trauma
 - ❖ Medical screening, including for communicable diseases.
3. *Language barrier*: increase healthcare facilities' **capacity to provide translation and interpretation** services to refugee populations by allowing registered refugees to legally work as interpreters for their communities and working with NGOs and community-based organizations to find the necessary interpretation resources while at the same time encouraging and working with civil society to increase language proficiency in the refugee community.



4. *Health literacy*: In cooperation with civil society and community-based organisations (CBOs), take steps to provide **health education** to refugees and asylum-seekers in order to increase their health literacy, understanding of symptoms and treatment options.
5. Cultural competency and sensitivity: collaborate with civil society and CBOs to provide training to healthcare staff in public facilities in enhancing their understanding of the vulnerabilities and healthcare needs of refugees.
6. Establish binding and effective **firewalls** between public health service providers on one hand and immigration enforcement authorities and other security actors on the other, and take necessary steps to ensure that firewalls are respected. Consider a **moratorium on the implementation of Directive 10** and conduct efficacy studies on the impact of its implementation, thus releasing the obligation for staff at healthcare facilities to report to Immigration on undocumented patients.
7. Take concrete steps to close the gap in social **protection coverage** for migrant workers, including refugees, and enhance their ability to afford healthcare following workplace accidents, as per the Equality of Treatment (Accident Compensation) Convention, 1925, through which Malaysia has committed to providing the same treatment to migrant workers who suffer personal injury due to industrial accidents as received by nationals.