IDEAS
INSTITUTE FOR DEMOCRACY AND ECONOMIC AFFAIRS

Left Far Behind:

The Impact of COVID-19 on Access to Education and Healthcare for Refugee and Asylum-Seeking Children in Peninsular Malaysia Report Launch

Presentation of Findings on Access to Healthcare

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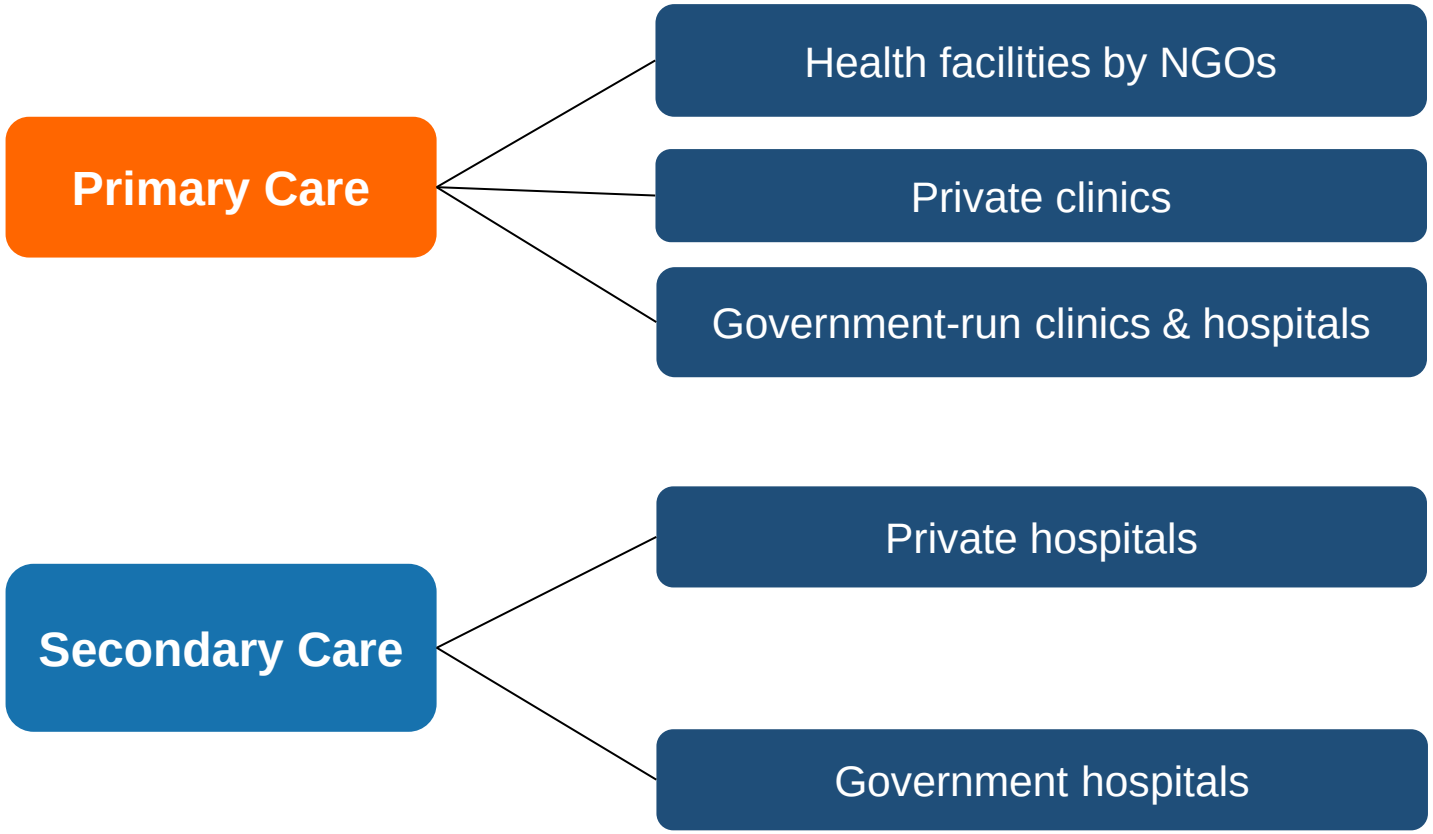
DIODE

Introduction

Healthcare Access for Refugees and Asylum-seekers



Introduction

Healthcare Access for Refugees and Asylum-seekers

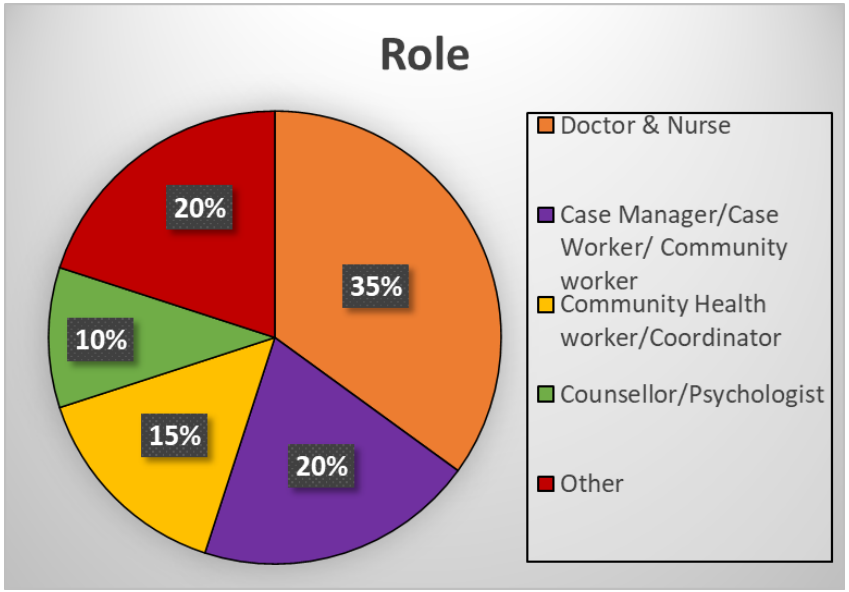
- The **process of migration** exposes refugee and asylum-seeking children to greater health risks, resulting in poorer health outcomes

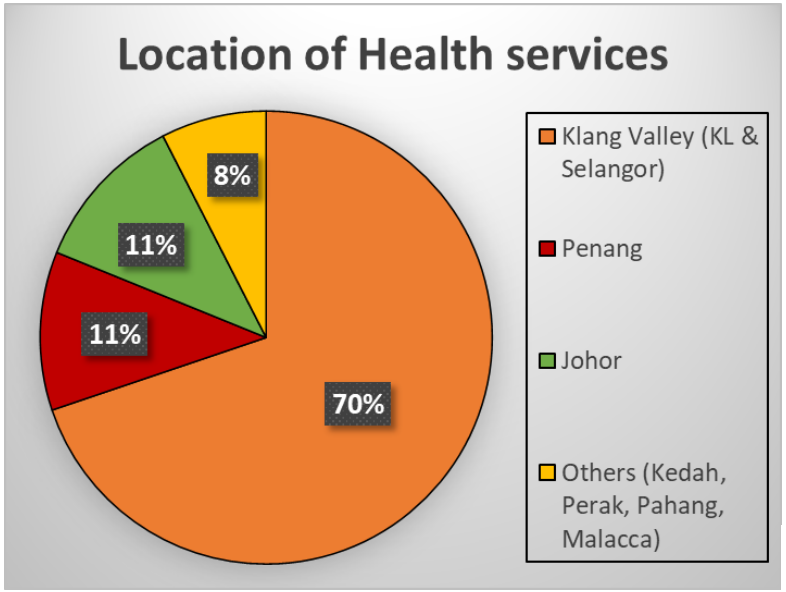
- **Several barriers** already identified in previous research:

Poor health literacy and general lack of health information	Language barriers	Fear due to lack of legal status
Cost-related barriers	Lack of appropriate services that can cater to the trauma and needs	Stigma and harassment

Participants Profile

- **30 HCWs** completed the online survey, **10 HCWs** participated in the in-depth interviews





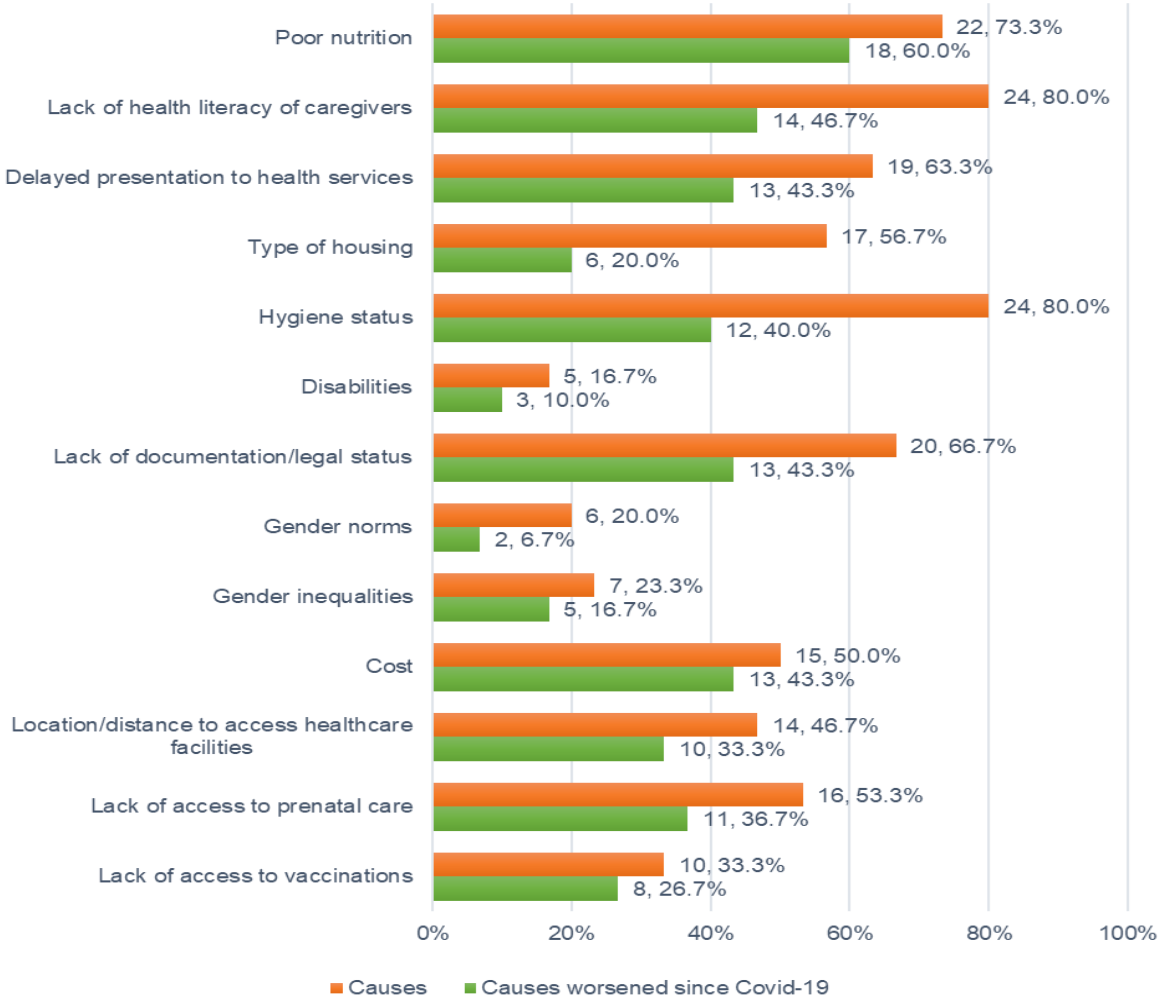
Key Findings: Health needs

- Nature of presentations **remained unchanged** since the beginning of the pandemic.
- Common primary care presentations → fever, upper respiratory tract symptoms, and worms.
- Main health conditions that affected **girls specifically** → issues arising from child marriage, teenage pregnancy, child abuse and sexual and gender-based violence.
- Main health conditions that affected **boys specifically** → Skin issues
- **Children with disabilities** → malnutrition was reported as one of the top three presentations

Key Findings: Causes of morbidity

- **Main causes of morbidity** → Lack of health literacy, hygiene status, poor nutrition, and lack of documentation.
- Participants perceived **causes of morbidity worsened** during the pandemic. *(See diagram in the next slide)*
- Participants reported increase demand for **mental health services**, **child protection and care services** for survivors of SGBV, particularly post-MCO.
- **Social determinants of health**, such as socioeconomic conditions, safe living and working conditions, access to livelihoods perceived to have been negatively impacted since the beginning of the pandemic.

Respondents' perceived major causes of morbidity among refugee and asylum-seeking children



Key Findings: Barrier 1 – Cost-related

- **All existing barriers to access worsened** during the pandemic
- **Barrier 1: Cost-related barriers**
  - Described by participants as a **major and primary barrier to access (97%).**
  - Cost for care includes transportation, interpretation, testing and investigations, treatment and admission, multiple follow-ups and visits.
  - Access to antenatal care, secondary care, and childhood vaccinations is limited due to prohibitively high costs.
  - Policy - Fee increase for foreign patients in 2016 further increased this barrier.
  - The COVID-19 and MCO led to a **worsened and unstable financial situation** → Evictions, a lack of access to food, raids and arrests exacerbated this barrier.

Key Findings: Barrier 2 – Sociocultural

- **Barrier 2: Sociocultural barriers**
  - Cultural (60%) and Language (70%) barriers.
  - No legal options to hire interpreters from refugee communities, so no interpretation services in government services.
  - Lack of sociocultural sensitization in NGO and Government facilities.
  - 63% reported no appropriate child friendly language in health promotion activities.
  - Without case management services or interpretation support, children struggle to access government healthcare systems.
  - Worsened during the pandemic due to the one-person per consultation policy.

Key Findings: Barrier 3 – Fear of arrest

- **Barrier 3: Fear of arrest and detention (lack of legal status)**
  - 90% of surveyed participants reported a lack of documentation and fear of arrest and detention as a **major barrier**.
  - Causative factors → xenophobia and health policies such as Circular 10/2001 from the Ministry of Health (MOH).
  - Being undocumented often led to **mistreatment and discrimination** at health facilities and **delays in seeking healthcare**.
  - Compounding barrier – cost (unable to access the 50% discount).

"They arrested him as soon as they saw him discharged. He was detained more than one year in immigration detention until he could be released by UNHCR. Because of this news, phobia and fear exist in the community." [P09]

Key Findings: Barrier 4 – Harmful policies

- **Barrier 4: Harmful and inconsistent application of healthcare policies**
  - **MOH Circular No 10:**
    - Increases fear and acts as a deterrent for many to seek healthcare unless absolutely necessary.
    - Ethical implications for physicians – “Do no harm”
  - **Fee increase policy in 2016** and **policy on limiting medication** to 5 days **-** exacerbated cost barriers and impeded quality of treatment.
  - **Inconsistent application** - policy on free treatment and investigations for infectious diseases.

“We need to sensitise everyone about the common struggles we face and the moral distress we face… When we talk about policy makers, they need to understand that this is curtailing what we are supposed to do – which is to provide the best care for our patients.” [P10]

Key Findings: Barrier 5 – Discrimination

- **Barrier 5: Discrimination, xenophobia, and a lack of empathy among HCWs**
  - Apparent in both government and NGO healthcare facilities.
  - Participants reported cases of refugees being denied treatment or rejected at hospitals due to their status.
  - Discrimination and xenophobia are presented in the forms of refusing to provide treatment, suggesting they attend private facilities instead, and practices that result in humiliation.
  - **Barrier worsened** by the pandemic where rising hate speech and targeted xenophobia against refugee communities occurred.

Key Findings: Barrier 6 – Knowledge gaps

- **Barrier 6: Knowledge gaps among parents and caregivers**
  - Limited health literacy, a lack of information on health services, and inadequate parenting skills.
  - 80% of survey respondents reported **poor health literacy** as a barrier to access.
  - Causative factors - sociocultural barriers (language), migration experience of displacement and separation from families, prevalence of child marriages and young mothers being unable to absorb and understand health knowledge.
  - Knowledge gaps have directly contributed to some of the common health conditions (accidents and trauma cases, neglect, and primary healthcare issues).

Key Findings: Barrier 7 – Availability of services

- **Barrier 7: Lack of state support for child protection issues and availability of refugee-specific health services**
  - Participants reported that in many cases, the **Social Welfare Department did not intervene** in child abuse/neglect, child marriage and child/teenage pregnancy cases involving foreign children.
    - Causative factors - incorrect understanding and application of the Child Act 2001, limited number of child protection personnel and shelters, limited understanding of the consequences of child marriage and its relation to child protection.

  - Too few NGO clinics catering to the refugee population, a lack of support for services beyond basic healthcare services) and a lack of available services for complex medical cases.

Key Findings: Gender and access to healthcare

	DIFFERENCES IN BARRIERS	IDENTIFIED GAPS
GENDER	Girls are disproportionately affected due to the disproportionate effects of SGBV and early pregnancy. Teenage sons of mothers who were survivors of domestic violence or SGBV face a lack of protective placement.	Gender-transformative, family-friendly, and family-centered approach in protection policies, which include protection of teenage boys and girls.
	Harmful gender roles and norms have created barriers for girls to access information and care.	Programs specifically for newly-arrived adolescents to improve health literacy and access to healthcare.
	Refugee girls who have newly-entered Malaysia and are fully dependent on their husbands' face disempowerment, which further compounds all stated barriers.	Empowered, safe reporting and safe spaces for girls within child marriages. Gender-transformative parenting skills and practice.

Key Findings: Disability and access to healthcare

	DIFFERENCES IN BARRIERS	IDENTIFIED GAPS
DISABILITY	Most NGO refugee health clinics reported not being able to provide assistance for children outside of referrals to government facilities.	Increasing the capacity of personnel at health facilities to identify and address the needs.
	The costs of long-term disability care are often beyond the limits of NGO support.	Best practice guidelines and checklist for all health services providing care.
	Access for children with disabilities to NGO clinics was found to be severely limited.	Comprehensive outreach services for families with children with disabilities.
	A lack of parenting knowledge for parents of children with disabilities could often lead to punitive parenting or disciplinary measures that may result in harm.	Parenting education and support networks for parents of children with disabilities.

Key Findings: Opportunities to increase access

Recommendations

R1: Legal & Policy

- Remove or reduce non-citizen fees at government hospitals
- Implement a health insurance or a healthcare financing
- Remove MOH Circular 10
- Establish a policy of firewalls between service providers and immigration authorities
- Provide free access to essential childhood vaccinations for ALL children in the country.
- Ensure that health policies which apply to all are applied consistently and fairly across all hospitals.
- Develop child protection policies to address the specific needs collaboratively with the communities, NGOs, government facilities, and the Department of Social Welfare
- Apply the Child Act and the UNCRC, UNCRPD, and CEDAW to ALL children

Recommendations

R2: Quality of healthcare services and capacity building

- Provide capacity building for HCWs, particularly in the areas of child marriage, child protection, SGBV, and mental health so that they can identify and refer cases.
- Establish networks and referral pathways for available services and adequately disseminate this information among HCWs.
- Conduct sensitization workshops with HCWs to combat the stigmatization and discrimination.
- Conduct health promotion for communities.
- Establish guidelines and best practices for NGO refugee clinics to meet gender and disability needs.

Recommendations

R3: Targeted health programmes for specific needs

- Establish case management programs within healthcare facilities, open to all children and supported by interpreting services.
- Provide comprehensive care for all survivors of SGBV to ensure that protection needs are addressed alongside health needs.
- Expand and deepen existing multi-sectoral outreach services
- Ensure that all healthcare services and programs are inclusive of children with disabilities, with child-friendly language, access to resources, and appropriate support.
- Provide tailored programs for newly arrived unaccompanied or separated children to improve health literacy and access to care.
- Ensure refugees are involved through all phases of design, implementation and evaluation of services, so that the capacity, agency, rights, and dignity of refugees are at the center of programming

Recommendations

R4: Networking, coordination, and partnerships

- Continue to strengthen partnerships and coordination between refugee-specific healthcare service providers and HCWs in the public and private spheres; share educational resources, referral options, and establish a support network.
- Establish referral pathways from organizations offering health care for refugees to services offered by the Department of Social Welfare, particularly for children with disabilities.

Conclusion

- This study identified a significant number of barriers. These barriers were clearly exacerbated since the beginning of the COVID-19 pandemic.
- The pandemic and civil society response allowed the NGO sector to attempt to utilise some opportunities to enable improved access, but many of these had limitations and may not be sustainable to fully realize the right to healthcare.
- We encourage looking into implementing proposed recommendations that arose from the study to fully realize refugee and asylum-seeking children's basic right to access adequate and affordable healthcare.

Conclusion

“I think the impact is very negative. When you’re not well and you don’t have access to the service that you need…you’re not going to get better without getting the help – whether it's mental health or physical health. And when you add [lack of] documentation of course, makes it even harder. And also, when you think about the financial or the cost issue. So, it's like you're adding one problem to another problem. At the end of the day, it's too difficult for the person. So, the impact is, instead of getting lighter, it's getting more and more deeper, and more and more serious for people. I don't think it's just one community's problem. I think it's the whole refugee community problem, that they don't have enough access to all these services.” [P06]

Conclusion

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