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# BMJ Open

## Healthcare for migrant workers in destination countries: a comparative qualitative study of China and Malaysia

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2020-039800
Article Type:	Original research
Date Submitted by the Author:	29-Apr-2020
Complete List of Authors:	Loganathan, Tharani; University of Malaya Faculty of Medicine, Centre for Epidemiology and Evidence-based Practice, Social and Preventive Medicine Rui, Deng; Kunming Medical University, School of Public Health Pocock, Nicola S.; London School of Hygiene & Tropical Medicine, Gender Violence & Health Centre; United Nations University International Institute for Global Health
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, PUBLIC HEALTH, QUALITATIVE RESEARCH

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4 **1 Healthcare for migrant workers in destination**  
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7 **2 countries: a comparative qualitative study of China**  
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22 Word Count: 6439

## 23 ABSTRACT

24 **Objectives:** To explore policies addressing migrant worker's health and barriers to healthcare  
25 access in two middle-income, destination countries in Asia with cross-border migration to  
26 Yunnan province, China and international migration to Malaysia.

27 **Design:** Qualitative interviews were conducted in Rui Li City and Tenchong County in  
28 Yunnan Province, China (n=23) and Kuala Lumpur, Malaysia (n=44), along with review of  
29 policy documents. Data were thematically analysed.

30 **Participants:** Participants were migrant workers and key stakeholders with expertise in  
31 migrant issues including representatives from international organisations, local civil society  
32 organisations, government agencies, medical professionals, academia and trade unions.

33 **Results:** Migrant health policies at destination countries were predominantly protectionist,  
34 concerned with preventing transmission of communicable disease and the excessive burden  
35 on health systems. In China, foreign wives were entitled to state-provided maternal health  
36 services while female migrant workers had to pay out-of-pocket, and often returned to  
37 Myanmar for deliveries. In Malaysia, immigration policies prohibit migrant workers from  
38 pregnancy, however, women do deliver at healthcare facilities. Mandatory HIV testing was  
39 imposed on migrants in both countries, where it was unclear whether and how informed  
40 consent was obtained from migrants. Migrants who did not pass mandatory health screenings  
41 in Malaysia would runaway rather than be deported and become undocumented in the  
42 process. Excessive attention on migrant workers with communicable disease control  
43 campaigns in China resulted in inadvertent stigmatisation. Language and financial barriers  
44 frustrated access to care in both countries. Reported conditions of overcrowding and  
45 inadequate healthcare access at immigration detention centres raise public health concern.

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3 46 **Conclusions:** This study's findings inform suggestions to mainstream the protection of  
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5 47 migrant workers' health within national health policies in two middle-income destination  
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7 48 countries, to ensure that health systems are responsive to migrants' needs, as well as to  
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9 49 strengthen bilateral and regional cooperation towards ensuring better migration management.  
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12 50 **Word count: 296**  
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## 15 51 **Article Summary**

### 16 52 Strengths and limitations of this study

- 17 53 • We have made suggestions to mainstream the protection of migrant workers' health  
18 54 within national health policies to ensure that health systems are responsive to migrants'  
19 55 needs, as well as to strengthen bilateral and regional cooperation towards ensuring better  
20 56 migration management.
- 21 57 • Although the qualitative nature of this study precludes the generalisation of findings, the  
22 58 experience gained by examining different perspectives provides insights into health  
23 59 policy and barriers accessing healthcare in different settings.
- 24 60 • Healthcare in origin countries and during the travel and return phase of migration may  
25 61 impact migrant health and we have given some policy suggestions.  
26 62

### 27 63 **Key Words**

28 64 Migration, migrant health, access to health, the right to health, LMIC, ASEAN, China  
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## 65 INTRODUCTION

66 International migration is an inevitable feature of today's globalized world and is critical for  
67 the economic development of many nations. In 2017, 258 million international migrants were  
68 estimated worldwide, with 80 million residing in Asia<sup>1</sup>.

69 This massive movement of people highlights the inevitability of economic growth and  
70 exchange, and yet international migrants are often considered a liability by destination  
71 countries. Potential health security and migrant control concerns have become essential  
72 policy drivers in many destination countries<sup>2</sup>.

73 In contrast, the right to the highest attainable standard of health, regardless of citizenship or  
74 immigration status, is enshrined in the World Health Organization (WHO) constitution and  
75 numerous human rights instruments<sup>3 4</sup>. The rights-based commitment to the health of migrant  
76 populations is reiterated in the 2030 Agenda for Sustainable Development and the 2018  
77 Global Compact for Safe, Orderly and Regular Migration<sup>5-7</sup>. Among the Association of  
78 Southeast Asian Nations (ASEAN) countries and China, the ratification of international  
79 human rights treaties protecting the Right to Health is inconsistent, with only the Philippines  
80 and Indonesia, predominantly migrant-sending countries, ratifying the International  
81 Convention on the Protection of the Rights of All Migrant Workers and Members of their  
82 Families<sup>8</sup> (Table 1).

83 Yunnan province, an important border province located in the southwest frontier area of  
84 China, shares substantial land borders (4,060 km) with Myanmar, Laos and Vietnam<sup>9</sup>.

85 Through kinship networks, there are longstanding relationships of trade and ethnic  
86 interchange between local peoples along the four countries border lines<sup>10 11</sup>. More recently,  
87 cross-border migration is enhanced by economic reform and the 'opening up' policies,  
88 especially with the China-Myanmar Economic Corridor, integral to the Belt and Road

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3 89 Initiative <sup>9 12 13</sup>. Largely due to economic disparities between the two countries, an increasing  
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5 90 number of Myanmar citizens cross national boundaries primarily in search of employment in  
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7 91 China and others for marriage. Myanmar migrants are the fourth largest migrant community  
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9 92 in China, and most reside in Yunnan province <sup>14</sup>.

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13 93 Malaysia, a vibrant Southeast Asian economy with relative political stability, is a magnet for  
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15 94 low-skill, low-wage labour migrants from across the region and increasingly Asia. Between  
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17 95 2008 and 2018, the official numbers of documented migrant workers doubled from 1.1 to 2.2  
18  
19 96 million, or 15% of the labour workforce in Malaysia <sup>15</sup>. The number of undocumented  
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21 97 workers in Malaysia is less certain, with estimates of all migrant workers ranging from 3.9 to  
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23 98 5.5 million, including undocumented workers <sup>16</sup>. Of the 15 source countries, Indonesia  
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25 99 (35%), Bangladesh (28%), Nepal (15%), and Myanmar (6%) are the largest contributors of  
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27 100 migrant workers to Malaysia <sup>17</sup>.

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32 101 Increasingly, migration is circular with health outcomes influenced by the cumulative social  
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34 102 determinants and health risks aggregated over the various phases of the migration cycle <sup>18</sup>  
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36 103 <sup>19</sup>.In destination countries, migrant workers often fill undesirable low-skill, labour-intensive  
37  
38 104 jobs in potentially health-damaging work environments, with restricted healthcare access <sup>20</sup>.  
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40 105 This paper explores policies that address migrant workers' health and the barriers to  
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42 106 healthcare access in two middle-income, destination countries in Asia with cross-border  
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44 107 migration to Yunnan province, China and international migration to Malaysia (Figure 1).  
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109 **Table 1. Ratification of international treaties protecting the Right to Health within ASEAN and China**

Country	International Covenant on Economic, Social and Cultural Rights (ICESCR)	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	International Covenant on Civil and Political Rights (ICCPR)	International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	Convention on the Rights of the Child (CRC)	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW)
<b><u>Migrant-sending countries*</u></b>						
Cambodia	✓	✓	✓	✓	✓	✗
Indonesia	✓	✓	✓	✓	✓	✓
Lao PDR	✓	✓	✓	✓	✓	✗
Myanmar	✓	✓	✗	✗	✓	✗
Philippines	✓	✓	✓	✓	✓	✓
Vietnam	✓	✓	✓	✓	✓	✗
<b><u>Migrant-receiving countries*</u></b>						
Brunei Darussalam	✗	✓	✗	✗	✓	✗
Malaysia	✗	✓	✗	✗	✓	✗
Singapore	✗	✓	✗	✓	✓	✗
Thailand	✓	✓	✓	✓	✓	✗
China	✓	✓	✗	✓	✓	✗

110 \*predominantly; ASEAN - Association of Southeast Asian Nations

111 Source: <sup>21</sup>

## 112 **MATERIALS AND METHODS**

### 113 **Study design**

114 We conducted a mixed methods study combining policy document review with exploratory  
115 qualitative analysis to describe and compare available healthcare policies and determine  
116 barriers in accessing healthcare experienced by migrant workers in Yunnan province, China  
117 and Malaysia.

### 118 **Definition of terms**

119 “Migrant” is a broad term. Here we focus on international labour migrants or migrant  
120 workers, both documented and undocumented, in Malaysia and Yunnan Province in China.  
121 Refugees, asylum seekers, victims of trafficking, people moving for marriage and expatriates  
122 are not included in this study.

123 A migrant worker or a foreign worker is defined here as a person who crosses international  
124 borders for the purpose of employment. Documented or regular migrants are authorised to  
125 enter, stay and partake in employment in a country and are in possession of legal documents  
126 such as passports and work permits. Undocumented or irregular migrants do not have the  
127 required documentation or authorisation to enter, reside or carry out remunerated activities in  
128 a country<sup>22 23</sup>.

### 129 **Patient and public involvement**

130 The topic guides for Malaysia and China were informed by review of literature and cross-  
131 country meetings to discuss research priorities. In Malaysia, purposive sampling of participants  
132 from a previous migration health workshop in November 2017<sup>24</sup> was conducted, with further  
133 snowball sampling until no new participants were identified. In China, purposive sampling was

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3 134 also used to select key informants in two study sites. Topic guides were slightly adapted  
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5 135 throughout the study to account for participant's priorities identified during interviews.  
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8 136 Malaysia results were shared with research participants at a workshop in Kuala Lumpur in  
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10 137 December 2019. In China, results were disseminated at the 10<sup>th</sup> International Conference on  
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12 138 Public Health among Greater Mekong Sub-Regional Countries in November 2018.  
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## 15 16 139 **Data collection and analysis**

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19 140 Two broad categories of participants were involved in our qualitative study: (1) migrant  
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21 141 workers and (2) key stakeholders with expertise in migrant issues including representatives  
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23 142 from international organisations (IOs), local civil society organisations (CSOs), government  
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25 143 agencies, medical professionals, academia, trade unions and others. We conducted a series of  
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27 144 in-depth interviews in China and Malaysia.

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30 145 Semi-structured interview guides were developed to seek participants' perspective on barriers  
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32 146 to healthcare access for migrant workers. These guides were further customised to suit the  
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34 147 organisational background of participants and were applied to both countries.

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37 148 Data collection was conducted between July and September 2018 in China and from July  
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39 149 2018 to July 2019 in Malaysia. Researchers purposefully recruited and interviewed migrant  
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41 150 workers and key informants working closely with migrant workers. Individual interviews  
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43 151 were conducted in local languages. Further snowball sampling was conducted in each study  
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45 152 site until the research teams agreed that additional interviews would not yield new  
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47 153 information, as theoretical saturation was reached.

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51 154 In China, interviews were conducted with 23 participants in two border counties, Rui Li City  
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53 155 and Tenchong County in Yunnan Province. While, interviews of 44 individuals were  
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55 156 conducted in Kuala Lumpur, Malaysia. Table 2 describes the main characteristics of the study  
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57 157 participants.  
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159 **Table 2. Characteristics of study participants**

	China	Malaysia
<b><u>Organisation type</u></b>		
Local civil society organisations	2	10
International organisations	0	4
Trade unions	0	3
Medical doctors	2	13
Academia	0	3
Government officials	4	2
<b><u>Migrant workers</u></b>		
Male	4	2
Female	11	2
<b>Total</b>	<b>23</b>	<b>44</b>

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161 The audio-recordings were transcribed verbatim into local languages. Data were analysed  
 162 using thematic analysis<sup>25</sup>. Data analysis was conducted in an immersive, exploratory and  
 163 inductive manner, initially separately in each country. Transcripts were coded into emerging  
 164 themes using NVivo 12 Pro software and Microsoft Excel across research teams. Following  
 165 initial analysis in both countries, selected quotations were extracted and were translated into  
 166 English. Subsequently, the authors examined codes to identify the broader pattern of themes  
 167 and subthemes across both countries. Desk review of policy documents including circulars,  
 168 legal documents and memos, served to contextualise and triangulate qualitative findings.

## 169 **Reflexivity**

170 Interviews in both countries were conducted by teams of academic researchers and medical  
 171 doctors, that could be perceived as trusted authority figures. To balance potential power  
 172 imbalances, especially for interviews with migrant workers, interviews were conducted at  
 173 locations and times of the participants' choosing.

## 174 **Ethics**

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3 175 We sought to minimise harm to study participants by assuring anonymity and confidentiality.  
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5 176 Written informed consent was obtained at recruitment. All participants agreed to be audio  
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8 177 recorded and quoted anonymously in publications. Given the sensitive nature of this research,  
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10 178 patients were not asked to divulge personal identification information. Data was anonymised  
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12 179 using pseudonyms and general descriptors without any identifying information. Study  
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15 180 participation was entirely voluntary, and participants were informed that they could refuse to  
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17 181 answer questions or terminate interviews at any point. Electronic data such as audio files and  
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19 182 transcripts were stored in secure servers, while other material was secured in locked  
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21 183 cupboards at researcher's offices.  
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24 184 Ethical approval was obtained from Institutional Review Boards at University Malaya,  
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26 185 Malaysia (UM.TNC2/UMREC-238) and Kunming Medical University, China  
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28 186 (kmu42018049), as well as the Medical Research and Ethics Committee, Ministry of Health,  
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30 187 Malaysia (NMRR-18-1309-42043).  
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## 188 RESULTS

### 189 China

#### 190 Policy setting

191 Over the past two decades, the Chinese health system has undergone significant reform with  
192 the aim of providing safe, effective, and affordable health care for citizens. Currently,  
193 Chinese citizens enjoy comprehensive medical services through government subsidised  
194 health insurance packages that are broadly location-based and designed specifically for social  
195 groups, such as urban employees, urban residents and rural residents. The policy for medical  
196 insurance as well as the household registry system, known as *hukou*, whereby citizens are  
197 registered by location of residence, have created ‘geographical barriers’ for internal migrants  
198 due to difficulties claiming health insurance across provinces<sup>26 27</sup>. Despite growing numbers  
199 of international migrants, China lacks a cohesive national policy on the provision of  
200 healthcare for international migrant workers, who are not included in national health  
201 insurance schemes.

202 In contrast, Yunnan province has initiated several programmes to better facilitate the  
203 management of migrant workers. International Migrant Service and Management Centres  
204 have been established at border towns, such as Ruili city, the largest Sino-Burmese border  
205 port in Yunnan province. This centre established in June 2013, provides migrants with one-  
206 stop services to obtain the following documents: (1) health certificate, (2) work permit, (3)  
207 trading certificate and (4) temporary residential permit<sup>28</sup>. According to local regulations,  
208 migrant workers who intend to temporarily reside in China for over a month are required to  
209 apply for these documents within three days of crossing the border and must have either a  
210 passport or a China-Myanmar border pass, and an employment contract with a Chinese

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3 211 company for applications <sup>29</sup>. China does not have mandatory pre-departure health  
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5 212 requirements for low-wage migrant workers.  
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8 213 According to officials interviewed, undocumented migrants are not allowed to work in China.  
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10 214 The Chinese government conducts random inspections at border areas and those identified  
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12 215 without the necessary documents are placed under temporary placement under the local  
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14 216 police station before being repatriated to host countries within a few days. At the time of this  
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16 217 study, there were no immigration detention centres in Yunnan province, China.  
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18 218 Specific health programmes for migrants in Yunnan province include maternal and child  
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20 219 health services for non-citizen women and infectious disease prevention programmes at  
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22 220 border areas.  
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27 221 **Maternal and child health services**  
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29 222 In border areas of Yunnan province, local health authorities provide a safe motherhood  
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31 223 package for migrant women with legal identity certificates. Foreign spouses with legal  
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33 224 marriage certificates are eligible for national health insurance with equal benefits as Chinese  
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35 225 citizens. For example, the Health and Family Planning Commission of Whenshan prefecture,  
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37 226 Yunnan issued guidelines for migrant maternal and child health services in January 2018. All  
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39 227 migrant mothers, including foreigners who have stayed in Whenshan for more than six  
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41 228 months, are eligible to obtain similar maternal and child health services as citizens <sup>30</sup>.  
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45 229 However, compared with foreign spouses, female migrant workers would have to pay out-of-  
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47 230 pocket for these services, since she has no Chinese citizenship or household registration.  
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49 231 If a migrant worker is pregnant, she can visit any local hospital for maternity care. She would  
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51 232 be eligible for hospital delivery, conditional on having antenatal records at that particular  
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53 233 hospital. Owing to rigid guidelines, many foreign women were denied admission for delivery  
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55 234 on account of their lacking antenatal records at specific hospitals.  
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3 235 *“My friend went to three hospitals before she was finally admitted for delivery. In the past, it*  
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5 236 *was convenient to have children in X town. But now the government is strict on standardized*  
6  
7 237 *medical management. Because she did not have an antenatal check-up at this hospital, there*  
8  
9 238 *was no way to be admitted. Finally, we went to Y hospital. At that time her condition was*  
10  
11 239 *very bad, very painful, as the baby was about to be born. So, the doctor let her stay, and*  
12  
13 240 *finally, the child was born safely. Myanmar migrants used to choose to have children in X*  
14  
15 241 *town. But now they must have tests and other records before they can be hospitalized. Many*  
16  
17 242 *women have to go back to Myanmar to deliver a baby.”* Mei, female, migrant school  
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19 243 administrator.

## 24 244 Infectious disease and migrant workers

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26 245 According to government officials interviewed, Myanmar migrants, were perceived as a  
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28 246 source of infectious diseases transmission, such as HIV and dengue fever due to their  
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30 247 mobility and convoluted social relationships. Consequently, targeted infectious disease  
31  
32 248 surveillance of non-citizens has become common practice at border townships.  
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34 249 HIV testing is compulsory for migrant workers entering China. To obtain a Health Certificate  
35  
36 250 for International Travel, migrant workers must complete a post-arrival medical screening,  
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38 251 which includes mandatory HIV testing, within three days of arrival into China. Since the  
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40 252 health certificate is only valid for a year, migrant workers must be screened annually for  
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42 253 infectious diseases including HIV.

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44 254 Local health authorities also implement health intervention projects, including community-  
45  
46 255 based health promotion campaigns targeting migrants at their settlements, for example, health  
47  
48 256 education for landlords of migrants, distribution of free condoms and HIV screening. These  
49  
50 257 activities are in addition to the mandatory screenings conducted by the immigration office to  
51  
52 258 obtain health certificates. Although well-intended, the excessive attention given to migrant  
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3 259 workers with regards to infectious disease has inadvertently caused prejudice and  
4  
5 260 stigmatization. One community worker described the following:  
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7  
8 261 *“We have a lot of Myanmar migrants here and it’s very difficult to do our work. We don’t*  
9  
10 262 *know their language. We don’t have their phone number. Some people don’t even have a cell*  
11  
12 263 *phone. Many of them have come to X town, so they must have a temporary residence permit,*  
13  
14 264 *and those in the factory have had to apply for a health card. They [government authorities]*  
15  
16 265 *have already drawn blood and tested it. When we [health workers] go to the community, they*  
17  
18 266 *don’t want to do the blood test [migrants refuse]. They look for various excuses not to draw*  
19  
20 267 *blood. When they see us in the community, they start running, and they don’t come at all. It is*  
21  
22 268 *perceived [by migrants] that we are drawing blood over and over again. They are disgusted*  
23  
24 269 *and repelled.”* Chen, male, community health worker.

25  
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29  
30 270 Although informed consent is obtained prior to screenings by the immigration office, our  
31  
32 271 findings suggest that migrants understanding of health activities that they are consenting to, is  
33  
34 272 lacking. Language barriers and the lack of cultural sensitivity have likely exacerbated  
35  
36 273 migrants’ distrust of healthcare providers.

37  
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39  
40 274 The local government conditionally provides free anti-retroviral treatment to HIV infected  
41  
42 275 Myanmar citizens. Two groups of Myanmar migrants are eligible, these are long-time  
43  
44 276 residents who have stayed in China for at least six months with valid identity documents, and  
45  
46 277 migrant wives with valid marriage documents (which may consist of a marriage certificate or  
47  
48 278 a letter from the village office)<sup>31</sup>. To discourage foreign patients from coming to China to  
49  
50 279 obtain free medical services, non-citizens are not provided with free investigations or  
51  
52 280 hospitalisations for HIV infections.

53  
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55  
56 281 *‘Free services for all are not feasible since policies related to HIV treatment and health care*  
57  
58 282 *are not consistent between the two countries. If we are the only ones offering free services,*  
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3 283 *the patients from the Myanmar side would flood into China. We are not capable to deal with*  
4  
5 284 *this situation due to limited financial and human resources which are allocated according to*  
6  
7 285 *domestic population rather than international migrants.* ' Yang, female, government official.

9  
10 286 Resource constraints meant that policies were deliberately designed to discourage care-  
11  
12 287 seeking for HIV treatment among cross-border migrants in China.

## 16 288 Financial and language barriers to healthcare

17  
18 289 Those interviewed revealed that Myanmar migrants rarely seek medical services in China,  
19  
20 290 mainly due to financial and language barriers.

21  
22 291 Medical treatment at public hospitals is expensive and unaffordable to low-wage migrant  
23  
24 292 workers. Since they are not covered by health insurance, migrant workers are subject to high  
25  
26 293 out-of-pocket payments when seeking care. Also, most employers will not pay for medical  
27  
28 294 expenses or purchase medical insurance for employees. As such, most migrant workers resort  
29  
30 295 to self-treatment or return to Myanmar border towns for healthcare.

31  
32 296 *“People who come out to work are generally in good health. Most of us are young people.*  
33  
34 297 *Old people [migrants] do not come out to work, because the cost of medicine is very*  
35  
36 298 *expensive in China. It is not worth the money to see a doctor when you are sick. We will buy*  
37  
38 299 *medicine for ourselves if we are ill [self-medicate]. If we have a slightly more serious illness,*  
39  
40 300 *almost all of us will go back to Myanmar for treatment. Because seeing a doctor in China is*  
41  
42 301 *too expensive. We usually go back to Myanmar to see a doctor for about 50 yuan (less than*  
43  
44 302 *10 USD), but in China, 50 yuan is not enough. If we must be hospitalized, we must pay a*  
45  
46 303 *deposit of 5000 yuan (about 800 USD). That is impossible for us, Myanmar[workers] to get*  
47  
48 304 *so much money all at once. We don't have to pay deposit in Myanmar, we pay the bill when*  
49  
50 305 *we leave the hospital.”* Tok, male, migrant worker.

51  
52 306 This participant implied that high healthcare costs in China deterred older workers from  
53  
54 307 Myanmar from migrating.

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3 308 One interviewee suggested that given the opportunity, Myanmar migrants would opt-in to  
4  
5 309 Chinese health insurance scheme, as that would lessen their financial burden while providing  
6  
7 310 healthcare access.  
8  
9  
10 311 *“China has good medical facilities. Rich Myanmar people will choose to see a doctor in*  
11  
12 312 *China, but for the average Myanmar people, they cannot do the same. People have heard that*  
13  
14 313 *China has health insurance, but Myanmar migrants can't buy it. For Myanmar migrants like*  
15  
16 314 *us who live in China for a long time, we really want to be able to buy Chinese health*  
17  
18 315 *insurance, and the grade of insurance can be divided into different amounts. Everyone can*  
19  
20 316 *buy health insurance according to their own ability. There are many Myanmar laborers in*  
21  
22 317 *China, it will be much more for them, if they have health insurance, they can also reduce the*  
23  
24 318 *economic burden.”* Yang, female, migrant worker  
25  
26  
27  
28 319 Migrant workers tend to avoid public hospitals because of language barriers. Very few  
29  
30 320 healthcare workers speak Myanmar languages, and migrants face difficulties in  
31  
32 321 communicating and navigating the health system. Migrant workers often need to find a  
33  
34 322 Chinese language interpreter, either a colleague or friend, to accompany them when seeking  
35  
36 323 care at hospitals. This migrant worker expressed frustration at the lack of language-friendly  
37  
38 324 services in China and suggested improvements.  
39  
40  
41  
42 325 *“Myanmar friends who come to work will usually go back to Myanmar to see the doctor,*  
43  
44 326 *mainly because of the lack of language and the cost of Chinese hospitals. My friends have*  
45  
46 327 *told me that when they go to see a doctor, because the patients do not understand what the*  
47  
48 328 *doctor says, and the doctors will be angry [with them] after asking many times [questions*  
49  
50 329 *repeatedly].I hope there is a Chinese-Myanmar contrast (bilingual information) at every*  
51  
52 330 *window of the hospital, so that we can know which department we should go to. The staff of*  
53  
54 331 *the guidance desk should speak Burmese. If possible, I hope they can recruit Burmese-*  
55  
56 332 *speaking doctors, so that it be much easier [for us]. I hope that doctors will be more patient,*  
57  
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3 333 *communicate with us with simple words and speak slowly, so we can understand.*” Nuinui,  
4

5 334 female, migrant worker.  
6

7  
8 335 While this participant described Burmese doctors as a possible solution to language barriers,  
9

10 336 we did not come across any instances of this occurring within two border counties studied.  
11

12 337 Foreign doctors must pass the Chinese medical exams and have a valid medical diploma,  
13

14 338 making it very difficult to practise in China. Furthermore, there are no formal interpreter  
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16 339 provisions in the Chinese health system, which is also the case in Malaysia <sup>24</sup>.  
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## 341 **Malaysia**

### 342 Policy setting

343 Being a net migrant-receiving country, Malaysia has several health policies in place for  
344 migrant workers. It is mandatory for foreign nationals seeking employment in Malaysia to  
345 have undergone a pre-departure medical examination prior to entry into Malaysia. The  
346 Ministry of Health, Malaysia with the cooperation of migrant-sending countries selects  
347 clinics to conduct pre-departure medical examinations of prospective workers. Pre-departure  
348 medical examination generally consists of infectious disease screening for HIV and  
349 tuberculosis<sup>32</sup>.

350 In addition, the Malaysian government established the Foreign Workers Medical  
351 Examination and Monitoring Agency (FOMEMA) to carry out pre-employment medical  
352 examinations, within the first month of arrival into Malaysia and subsequently annual  
353 medical examinations when renewing work permits, at private clinics approved by the  
354 FOMEMA. All documented migrant workers are mandatorily tested for tuberculosis, HIV,  
355 syphilis, hepatitis B, malaria, leprosy, pregnancy (for women), drug abuse, hypertension,  
356 diabetes mellitus, cancer, epilepsy and psychiatric illness<sup>33 34</sup>.

357 Malaysia has a mixed public-private healthcare system. The public healthcare system is  
358 subsidized for citizens, but non-citizen fees are much higher<sup>35</sup>. At the same time, a  
359 government-mandated compulsory insurance scheme, the Hospitalisation and Surgical  
360 Scheme for Foreign Workers (SPIKPA) provides documented workers with a maximum of  
361 RM 20,000 (4,800 USD) annually for in-patient care and surgery in public hospitals<sup>36</sup>. Some  
362 employers pay for workers treatment at private clinics, but this is not a legal obligation, as  
363 such it is not standard practice<sup>37</sup>.

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3 365 Maternal and child health services  
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6 366 Female migrant workers are prohibited from marrying or becoming pregnant in Malaysia.  
7

8 367 Those testing positive for pregnancy will not be granted work permits and are subject to  
9

10 368 deportation<sup>38</sup>. While there are no specific public antenatal or delivery services offered for  
11

12 369 migrant workers in Malaysia, in practice women do give birth in healthcare facilities, often  
13

14 370 private, at high cost. While public healthcare facilities will not deny patients necessary  
15

16 371 medical care, healthcare providers are obliged to report undocumented workers to the police  
17

18 372 and immigration authorities.  
19

20 373 *“It is very sad for refugees or illegal migrants who do not have any passport or documents*  
21

22 374 *[UNHCR cards or valid work permit], they will [need documents to] register at the counter.*  
23

24 375 *If they need to see the Family Medicine Specialist [FMS], foreigners, they have to pay extra –*  
25

26 376 *maybe RM 30 [8 USD] or something like that. They will register and pay the money, while*  
27

28 377 *she is inside seeing the doctor, the police are already outside, waiting for her. Once she is*  
29

30 378 *out, she will be caught by the police. This has happened many times at the ‘Klinik Ibu dan*  
31

32 379 *Anak’ [public Maternal and Child Health Clinic].” Dr Lucy, female, physician*  
33

34 380 Mainly due to the expense of antenatal care at private facilities, non-citizens tend to present  
35

36 381 late for booking and default follow-up. Some migrants prefer to deliver at home, assisted by  
37

38 382 traditional midwives. This doctor expressed concern that non-citizens often present late at  
39

40 383 hospitals for delivery, without prior antenatal follow-up.  
41

42 384 *“They usually come in emergency, like ectopic[pregnancy] with abdominal pain. My*  
43

44 385 *colleagues, they will say, ‘Bila dah almost deliver baru datang?’ (Sarcastic: You only come*  
45

46 386 *to hospital when you’re about to deliver?). Because they didn’t follow up during the*  
47

48 387 *antenatal stage. Because of financial and other reasons, they only come at the late stage*  
49

50 388 *[...]” Dr Nazirah, female, physician*  
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3 389 Participants shared that the inadequate antenatal care, late presentation for hospital delivery  
4  
5 390 and home deliveries may result in poor obstetric outcomes.  
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### 8 391 Infectious disease and migrant workers

9  
10  
11 392 The Malaysian government requires a pre-departure medical examination to be conducted at  
12  
13 393 designated clinics in migrant-sending countries. Some interviewed questioned the quality of  
14  
15 394 medical screenings conducted in migrant-sending countries, due to the lack of regulation and  
16  
17  
18 395 potential corruption.

19  
20  
21 396 *“The medical tests done in the country of origin is not audited. So, there is a lot of instances*  
22  
23 397 *where people do not pass the medical test, but they obtain a certificate and then they come*  
24  
25 398 *here. When they come here, the requirement is that the medical test [pre-employment*  
26  
27 399 *screening done on arrival in Malaysia] results must be submitted with the application to do*  
28  
29 400 *your work permit. Only then will your work permit will be approved. What we see is, when*  
30  
31 401 *they come here, they fail the medical test.”* Priya, female, civil society organisation.  
32  
33

34  
35 402 In order to obtain a work permit, migrant workers are required to undergo a mandatory pre-  
36  
37 403 employment medical examination within the first month of arrival. Mandatory annual  
38  
39 404 medical examinations are conducted annually for the first 3 years, and subsequently every  
40  
41 405 alternate year for a maximum of ten years of employment in Malaysia. The consequence of  
42  
43 406 failing these mandatory medical examinations is severe, as workers are denied work permits  
44  
45 407 and are subject to deportation. This interviewee informed that failing medical examinations is  
46  
47 408 a possible reason for migrant workers to become undocumented.  
48  
49

50  
51 409 *“Once they have got leprosy or mental health disease or... [failed medical examination],*  
52  
53 410 *they are deemed 'unfit' or unsuitable [for employment]. So, once you deem them unsuitable*  
54  
55 411 *[unfit] in your medical examination, the employer has to send them back. And THAT is where*  
56  
57 412 *a lot of problems arise. Because when they [migrant workers] come to know that they have to*  
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3 413 *be sent back, they disappear. And they become 'undocumented'. This is a huge problem.*” Dr  
4  
5 414 Amir, male, a doctor in private practice.

7  
8 415 Some interviewed shared that screenings were for medically treatable conditions and should  
9  
10 416 not preclude employment. This interviewee felt that infectious diseases, like tuberculosis  
11  
12 417 (TB) is of public health concern and should be treated upon detection.

13  
14 418 *“Yes, TB also, to some extent, it can be contained, right? And it is medically treatable. He*  
15  
16 419 *[the migrant worker] is not incapable of working. The moment he has TB, what they do is,*  
17  
18 420 *they pack him and send him back home. And (if) this guy doesn't get back home and get*  
19  
20 421 *treatment- he's going to spread it to others. You've got to treat the disease before you*  
21  
22 422 *actually send him back home.*” Rosa, female, country coordinator of an international  
23  
24 423 organisation.

25  
26 424 Medical doctors interviewed explained that while general consent is obtained for medical  
27  
28 425 screenings, the consent obtained is not specific for HIV testing. There was also concern  
29  
30 426 expressed on patient confidentiality, as employers are informed of investigation results.

31  
32 427 *“We obtain a general consent for blood STD (sexually transmitted disease) investigation as*  
33  
34 428 *our regulations, but not specifically for HIV. If found positive, we need to call the worker and*  
35  
36 429 *the employer, as we need to explain to the employer the reason the worker needs to be sent*  
37  
38 430 *back. So, confidentiality is affected there.*” Dr Sashi, male, a doctor in private practice.

39  
40 431 Others expressed concern that migrant workers are not properly informed of test results and  
41  
42 432 are uncertain of their infectious disease status even though testing is mandatory.

43  
44 433 *“A lot of them just do not know [their status]. I think once they go through FOMEMA*  
45  
46 434 *screening, the least they can do is be made aware of the HIV status. Of course, they wouldn't*  
47  
48 435 *be able to come in [to the country]. But it would be good for them to know, even if they are*  
49  
50 436 *being sent back - to know their HIV status.*” John, male, an academic.



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3 437 The implication is that workers were only informed of HIV test results in terms of pass or  
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5 438 fail, and are not given detailed results, or post-test counselling.  
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### 8 439 Financial and language barriers to healthcare

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11 440 Healthcare costs are a major barrier for migrant workers accessing healthcare in Malaysia.

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13 441 Participants felt that the coverage by the SPIKPA insurance is inadequate in compensating  
14  
15 442 the considerably higher fees charged to non-citizens at public hospitals and clinics.

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17 443 Furthermore, SPIKPA does not cover outpatient treatment. Consequently, migrant workers  
18  
19 444 are likely to pay out-of-pocket for healthcare.

20  
21  
22 445 *“We migrants only have insurance for hospitalisation. When we are ill, our employers say, ‘I*  
23  
24 446 *can’t give you medicine. I won’t send you for treatment.’ Why? It costs a lot! If you want*  
25  
26 447 *medication, it’s up to you. You buy yourself.”* Yat, male, migrant worker and union organiser

27  
28 448 Migrant workers prioritise sending money home to families and are less willing to spend  
29  
30 449 money on healthcare. Participants described healthcare avoidance and the use of traditional  
31  
32 450 medicine as a common practice among migrant workers.

33  
34 451 As there are no formal interpreters in the Malaysian healthcare system, we found that the  
35  
36 452 common expectation is for migrant workers to learn the Malay language or to bring a  
37  
38 453 companion to act as an informal translator. Healthcare providers also use various methods to  
39  
40 454 communicate with patients including sign language, gestures, Google translate and others.

41  
42 455 Doctors interviewed express frustration as language barriers hinder communication and  
43  
44 456 patient management.

45  
46 457 *“Those from Myanmar [have a] major barrier when it comes to communication.*

47  
48 458 *Bangladeshis pickup Malay very, very fast. They only need to work here about a year and*  
49  
50 459 *then they will be able to have a full conversation with you. Whereas the Burmese, they are*  
51  
52 460 *still very backward with the language. Nepalese, some of them can speak English quite well.*  
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3 461 *The Myanmar group is very difficult. Very, very difficult. It's literally sign language and*  
4  
5 462 *acting out the illness, and all sorts of things.*" Dr Ram, male, a doctor in private practice  
6  
7 463 This medical practitioner explained that there were notable differences faced by different  
8  
9 464 migrant populations and their ability to communicate in the Malay language.  
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## 12 465 Health in detention

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15 466 Immigration offences like illegal entry and stay are criminal offences in Malaysia. Many  
16  
17 467 undocumented workers are arrested and imprisoned, before being sent to immigration  
18  
19 468 detention centres (immigration depots) to await deportation. To facilitate the process of  
20  
21 469 deportation, embassies are contacted to issue travel documents. The duration of detention is  
22  
23 470 often lengthy and dependant on the detainee's ability to finance repatriation costs, including  
24  
25 471 the purchasing of flight tickets.  
26  
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28  
29 472 *"[Some] embassies have allocations to help finance repatriation of their citizens in detention,*  
30  
31 473 *but in a limited manner and [based] on the severity of the case. From my observation, most*  
32  
33 474 *migrants have to get families to pay for tickets [...]"* Ryan, male, member of a local civil  
34  
35 475 society organisation.  
36  
37

38 476 Interviewees describe conditions at immigration detention camps as overcrowded and  
39  
40 477 uncomfortable.  
41

42  
43 478 *"[...] and what food you are giving? Just that small thing. And the hygiene was bad. And they*  
44  
45 479 *have to sleep on the floor. 3 persons in one room. Hardly they can turn, they can only sleep*  
46  
47 480 *like that."* Cheah, female, member of a local civil society organisation.  
48

49  
50 481 *"I have experience of visiting a Filipino who overstayed here, in XXX [immigration detention*  
51  
52 482 *centre]. I think it's not easy. They didn't have anything. They [the authorities] didn't provide*  
53  
54 483 *bedding, even a sleeping mat. They [inmates are] just sleeping on the floor, on the cement.*  
55  
56 484 *And they didn't have a toothbrush [...]. Food is okay. It is limited, but still they can eat. But*  
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3 485 *they had bad experience. They just sleep on the cement.*" Beth, female, a migrant worker  
4  
5 486 representative at a local civil society organisation.

7  
8 487 Others explained that healthcare services available at the camps were minimal, with only a  
9  
10 488 paramedic stationed on-site. Detainees found to be ill are sent to public hospitals for further  
11  
12 489 clinical management. Dr Goh, a physician who investigated conditions at an immigration  
13  
14 490 detention centre following a major typhoid outbreak commented:

16  
17 491 *"This lockup (depot) was designed for 750 people, however, from our investigation, we found*  
18  
19 492 *out that there were almost 1,500 people are staying in that centre. There was overcrowding.*  
20  
21 493 *The conditions were not at all sanitary. The initial plans for the lockup were designed for a*  
22  
23 494 *cook- someone who cooks for all the inmates. But we discovered that the inmates cook for*  
24  
25 495 *each other. And the food that is provided there is mostly carbohydrate-based. And a lot of*  
26  
27 496 *them [detainees] do not have proper supervision in terms of medication. For example, TB*  
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29 497 *medication. DOTS (Directly observed treatment) is not carried out as per plan. Because*  
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31 498 *there is a lack of manpower."* Dr Goh, female, physician.  
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## DISCUSSION

We found that migrant health policies at destination countries were largely protectionist in nature, concerned with preventing the spread of communicable disease and the perceived excessive burden on national health systems due to in-migration.

Generally, migrants are considered at particular risk for infectious diseases like HIV, tuberculosis and malaria, due to the relatively high disease prevalence, poor socio-economic conditions and weak health systems at origin countries<sup>19 39-42</sup>. Both Malaysia and China have mandatory medical screenings for migrant workers, with pre-departure screenings at origin countries required by Malaysia, and post-arrival screenings enforced by Malaysia and Yunnan province, China<sup>32 43</sup>. Contrary to narratives about migrants being infectious disease carriers, the reality may not be so dramatic. FOMEMA reported that just 3 in 100 migrant workers tested positive for infectious diseases in recent years<sup>44</sup>. Mandatory medical screenings are part of labour migration policies that determines health status as an eligibility criterion for entry into a country and stay for employment<sup>45</sup>. This is problematic from the human rights and ethical standpoints, as mandatory testing is conducted merely for immigration selection and not to improve the individuals' health. Also, mandatory HIV testing of migrant workers contravenes with international standards for informed consent, confidentiality, counselling and referral to treatment and care services<sup>46-49</sup>. Our findings from both Yunnan province and Malaysia suggest that informed consent for HIV testing may be inadequate, as migrants were unsure of tests conducted, without access to pre- and post-test counselling.

Our findings also suggest that communicable disease control programmes in Yunnan province, China are poorly received by migrants. Linguistic and culturally appropriate public health interventions are key to acceptance and cooperation among non-citizen populations<sup>50-</sup>

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3 523 <sup>52</sup>. We caution against the inadvertent negative stereotyping and stigmatisation of migrants  
4  
5 524 and suggest that public health interventions be guided by epidemiological evidence and  
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7 525 conducted with sensitivity. Furthermore, the lack of medical services for individuals  
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10 526 diagnosed with infectious disease both in China and Malaysia, combined with the fear of  
11  
12 527 deportation may hinder initiatives promoting testing of migrants <sup>53</sup>. A more pragmatic  
13  
14 528 approach towards disease control is needed without neglecting the provision of high quality  
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16 529 preventive and curative care, to ensure early detection and treatment of infections for the  
17  
18 530 benefit of the individual migrant and society <sup>45 54 55</sup>.  
19  
20  
21 531 All countries in ASEAN and China have ratified the Convention on the Elimination of All  
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23 532 Forms of Discrimination against Women (CEDAW), which recognises the right to sexual and  
24  
25 533 reproductive health as fundamental to women's health <sup>56</sup>. A core minimum state obligation in  
26  
27 534 fulfilling these international human rights agreements are the provision of access to quality,  
28  
29 535 affordable maternal health services that would prevent maternal mortality. Unlike Yunnan  
30  
31 536 province where maternal health services are available for non-citizens with certain  
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33 537 administrative requirements, immigration policies in Malaysia are a barrier to the access of  
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35 538 services at public facilities. The imposition of mandatory testing for pregnancy and HIV, has  
36  
37 539 been likened to a violation of the right to privacy and bodily integrity, and is an example of  
38  
39 540 conflict between immigration policy, human rights and public health <sup>57</sup>.  
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42 541 Highlighted in this paper are the financial, language and legal barriers to healthcare access in  
43  
44 542 destination countries. Due to escalating healthcare costs and the revelation that foreigners  
45  
46 543 were consuming a sizable portion of the national health allocation, the Malaysian government  
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48 544 substantially revised medical fees for non-citizens at public hospitals and clinics in 2014 <sup>35 58</sup>.  
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50 545 Our findings suggest that the government-mandated SPIKPA insurance for documented  
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52 546 migrants is easily breached due to high treatment costs <sup>36 37 59 60</sup>.  
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3 547 Previous studies support our findings that low-skilled international migrants in China are  
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5 548 without health insurance<sup>61</sup>. Although maternal and child health services are available for  
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7 549 non-citizens in Yunnan province, the utilisation of this service is questionable as stringent  
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9  
10 550 administrative requirements and out-of-pocket payments needed to finance care make  
11  
12 551 hospital delivery inaccessible. Our findings in Malaysia and China suggest that high out-of-  
13  
14 552 pocket payments and inadequate health insurance coverage are significant financial barriers  
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16 553 to access, resulting in healthcare avoidance amongst migrants.  
17  
18 554 Language discrepancies may induce psychological stress, misunderstanding of health risks  
19  
20 555 and medically significant communication errors impacting the quality and effectiveness of  
21  
22 556 healthcare delivery<sup>62-66</sup>. Countries like Malaysia receive migrant workers from a multitude of  
23  
24 557 countries. Such diverse backgrounds pose a challenge to health systems in coping with  
25  
26 558 distinctive languages and cultures<sup>24</sup>. Not surprisingly, the implicit expectation of destination  
27  
28 559 country health systems, seen here with examples from Malaysia and China, is for non-  
29  
30 560 citizens to develop local language proficiency. We suggest that destination countries actively  
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32 561 invest in developing migrant-sensitive health systems, engaging migrant communities as  
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34 562 patient navigators and intercultural mediators, hiring professional interpreters and training  
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36 563 culturally competent health professionals<sup>67-69</sup>.  
37  
38 564 Undocumented migrants are an especially vulnerable group, as they lack the legal and social  
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40 565 protections given to their documented counterparts. Denying healthcare to undocumented  
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42 566 migrants increases disparities among this already vulnerable group<sup>70</sup>. Unlike Malaysia,  
43  
44 567 China does not impose mandatory reporting between health facilities and immigration when  
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46 568 undocumented migrants try to use services. The requirement for health workers in Malaysia  
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48 569 to report non-citizens without appropriate documents<sup>71 72</sup>, is likely to have far-reaching  
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50 570 implications on public health, healthcare expenditure and clinical practice<sup>70 73</sup>.  
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3 571 Malaysia has 14 immigration centres nationwide <sup>74</sup>, while there are none in Yunnan province,  
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5 572 China. Determining who enters or stays in a country is a matter of state sovereignty.  
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8 573 However, the threat of detention as a means of deterring irregular migration is problematic <sup>75</sup>  
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10 574 <sup>76</sup>. While states have the authority to regulate migration through immigration enforcement,  
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12 575 guarantees against arbitrary detention migrants are enshrined in international human rights  
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14 576 instruments <sup>77-79</sup>. The adverse health effects of detention on the mental and physical health of  
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16 577 migrants are well catalogued <sup>80-82</sup>. Conditions in immigration detention in Malaysia, are  
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18 578 reported here and elsewhere, as overcrowded, unsanitary and with insufficient medical care  
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20 579 <sup>83-86</sup>, representing a major public health challenge. The Mandela Rules, or the revised UN  
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22 580 Standard Minimum Rules for the Treatment of Prisoners, which states the minimum  
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24 581 standards for detention in prisons, are also applicable to immigration detention centres <sup>87</sup> and  
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26 582 Malaysia should open their immigration detention centres for an independent audit to ensure  
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28 583 compliance with these minimum standards.  
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31 584 Low-wage migrants may return to home countries in poor health, requiring healthcare that is  
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33 585 unavailable or unaffordable in countries of origin. With this in mind, there are concerns  
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35 586 about the transferability of destination countries' social protection policies when migrants  
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37 587 return to countries of origin. One such scheme that will test the portability of benefits is the  
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39 588 recently introduced Employment Injury Scheme for Foreign Workers under the Malaysian  
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41 589 Social Security Organization (EI-SOCSO) which provides life-long cash payments for  
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43 590 permanent disablement from injury or illness arising during the course of employment <sup>88</sup>.  
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45 591 We suggest that origin countries consider providing health insurance for the benefit of  
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47 592 returning workers. One such example is the mandatory insurance coverage provided for  
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49 593 overseas Filipino workers by employment agencies at no cost to the worker, as legislated by  
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51 594 Philippines law <sup>89</sup>.  
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3 595 Improving migrant health requires commitment from both migrant-sending and receiving  
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5 596 countries, as well as bilateral and regional partnerships. Memorandum of Understandings  
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7 597 between migrant-sending and receiving countries could improve referral mechanisms to  
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9 598 ensure proper treatment of returnees with an infectious disease or occupational injuries.  
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11 599 Thailand has successful bilateral agreements with neighbouring Myanmar, allowing for  
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13 600 cooperation via the Nationality Verification and One Stop Service Centre regularisation  
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15 601 processes for migrants arriving in Thailand through irregular channels <sup>90</sup>. The example of  
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17 602 cross-border coordination mechanisms for migration and health as demonstrated by Thailand  
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19 603 and Myanmar would benefit other strategic border areas with health concerns associated with  
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21 604 population movement. Countries should also build on commitments made on regional  
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23 605 platforms like the 2007 ASEAN Declaration on the Protection of the Rights of Migrant  
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25 606 Workers to protect and promote the rights of migrant workers in the region <sup>91 92</sup>.  
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27 607 Malaysia and China are both upper-middle-income countries with advanced health systems.  
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29 608 However, protectionist policies lead to unequal treatment of migrant workers resulting in  
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31 609 poorer availability of healthcare services compared to citizens. We hope that national efforts  
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33 610 towards achieving Universal Health Coverage (UHC) include migrant workers, following the  
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35 611 concept of ‘leave no-one behind’ envisioned in the 2030 Agenda for Sustainable  
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37 612 Development <sup>7</sup>.  
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39 613 Our study has several limitations. While the qualitative nature of this study precludes the  
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41 614 generalisation of findings, the experience gained by examining different perspectives gives us  
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43 615 insights into health policy and barriers accessing healthcare in different settings. Also, while  
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45 616 our study focuses on health in destination countries, we acknowledge that health and  
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47 617 healthcare in origin countries and during the travel and return phase of migration may impact  
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49 618 migrant well-being, thus have given some policy suggestions.  
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## 619 **CONCLUSION**

620 This study has unique contributions, as a comparative study of healthcare access and migrant  
621 health policy between China and Malaysia, two middle-income destination countries. We  
622 suggest options to mainstream the protection of migrant workers' health within national  
623 health policies to ensure that health systems are responsive to migrants' needs, as well as to  
624 strengthen bilateral and regional cooperation towards ensuring better migration management.  
625 Migration brings great benefits, fuelling socio-economic growth in migrant-sending and  
626 receiving countries. Yet, insufficient attention is paid to the health of migrant workers. The  
627 intersectional nature of healthcare and immigration policy in destination countries  
628 commodify human life, contradicting with public health needs and ethical norms. We appeal  
629 to governments to use human rights principles and national commitment towards Universal  
630 Health Coverage to guide the provision of migrant inclusive and sensitive healthcare  
631 accessible to all, for the betterment of individual and population health.

## 632 **CONTRIBUTORSHIP STATEMENTS**

633 Contributors: Both TL and DR conceptualised the study, analysed the data, managed the overall  
634 design of the study and wrote the draft. NP provided comments on the draft and critically  
635 revised content. All authors contributed to the final version of the manuscript.

## 636 **COMPETING INTERESTS**

637 The authors have declared that no competing interests exist.

## 638 **ACKNOWLEDGEMENTS**

639 This work is supported by The Atlantic Fellows for Health Equity in South East Asia based at  
640 The Equity Initiative, a program of The CMB Foundation

## 641 **FUNDING STATEMENT**

642 We are grateful for funding to conduct this research from the China Medical Board's Equity  
643 Initiative [IF055-2018]. The funders had no role in study design, data collection and analysis,  
644 decision to publish, or preparation of the manuscript.

## 645 **DATA SHARING STATEMENT**

646 All data relevant to the study are included in the article or uploaded as supplementary  
647 information.

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648 **FIGURE LEGENDS**

649 **Figure 1. Migration phases framework**

650 Adapted from <sup>18</sup>

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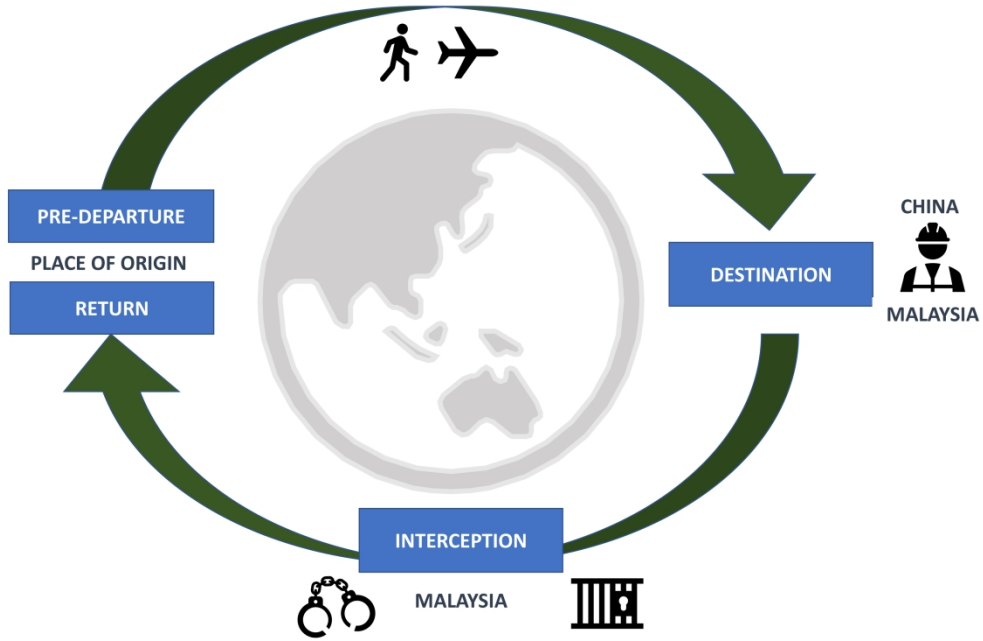


Figure 1

292x189mm (300 x 300 DPI)

# Reporting checklist for qualitative study.

Based on the SRQR guidelines.

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Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

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	Reporting Item	Page Number
<b>Title</b>		
	<a href="#">#1</a> Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	1
<b>Abstract</b>		
	<a href="#">#2</a> Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	2
<b>Introduction</b>		
Problem formulation	<a href="#">#3</a> Description and significance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement	5,9

1	Purpose or research	<a href="#">#4</a>	Purpose of the study and specific objectives or	5,9
2	question		questions	
3				
4	<b>Methods</b>			
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7	Qualitative approach and	<a href="#">#5</a>	Qualitative approach (e.g. ethnography, grounded	8
8	research paradigm		theory, case study, phenomenology, narrative research)	
9			and guiding theory if appropriate; identifying the	
10			research paradigm (e.g. postpositivist, constructivist /	
11			interpretivist) is also recommended; rationale. The	
12			rationale should briefly discuss the justification for	
13			choosing that theory, approach, method or technique	
14			rather than other options available; the assumptions	
15			and limitations implicit in those choices and how those	
16			choices influence study conclusions and transferability.	
17			As appropriate the rationale for several items might be	
18			discussed together.	
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26	Researcher characteristics	<a href="#">#6</a>	Researchers' characteristics that may influence the	9
27	and reflexivity		research, including personal attributes, qualifications /	
28			experience, relationship with participants, assumptions	
29			and / or presuppositions; potential or actual interaction	
30			between researchers' characteristics and the research	
31			questions, approach, methods, results and / or	
32			transferability	
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37	Context	<a href="#">#7</a>	Setting / site and salient contextual factors; rationale	8,9
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40	Sampling strategy	<a href="#">#8</a>	How and why research participants, documents, or	8
41			events were selected; criteria for deciding when no	
42			further sampling was necessary (e.g. sampling	
43			saturation); rationale	
44				
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46	Ethical issues pertaining to	<a href="#">#9</a>	Documentation of approval by an appropriate ethics	10
47	human subjects		review board and participant consent, or explanation for	
48			lack thereof; other confidentiality and data security	
49			issues	
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53	Data collection methods	<a href="#">#10</a>	Types of data collected; details of data collection	8,9
54			procedures including (as appropriate) start and stop	
55			dates of data collection and analysis, iterative process,	
56			triangulation of sources / methods, and modification of	
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1		procedures in response to evolving study findings;	
2		rationale	
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4	Data collection	<a href="#">#11</a> Description of instruments (e.g. interview guides,	8,9
5	instruments and	questionnaires) and devices (e.g. audio recorders)	
6	technologies	used for data collection; if / how the instruments(s)	
7		changed over the course of the study	
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10	Units of study	<a href="#">#12</a> Number and relevant characteristics of participants,	8,9
11		documents, or events included in the study; level of	
12		participation (could be reported in results)	
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16	Data processing	<a href="#">#13</a> Methods for processing data prior to and during	9,10
17		analysis, including transcription, data entry, data	
18		management and security, verification of data integrity,	
19		data coding, and anonymisation / deidentification of	
20		excerpts	
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24	Data analysis	<a href="#">#14</a> Process by which inferences, themes, etc. were	9
25		identified and developed, including the researchers	
26		involved in data analysis; usually references a specific	
27		paradigm or approach; rationale	
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31	Techniques to enhance	<a href="#">#15</a> Techniques to enhance trustworthiness and credibility	9
32	trustworthiness	of data analysis (e.g. member checking, audit trail,	
33		triangulation); rationale	
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36	<b>Results/findings</b>		
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39	Syntheses and	<a href="#">#16</a> Main findings (e.g. interpretations, inferences, and	11-24
40	interpretation	themes); might include development of a theory or	
41		model, or integration with prior research or theory	
42			
43			
44	Links to empirical data	<a href="#">#17</a> Evidence (e.g. quotes, field notes, text excerpts,	11-24
45		photographs) to substantiate analytic findings	
46			
47			
48	<b>Discussion</b>		
49			
50	Intergration with prior	<a href="#">#18</a> Short summary of main findings; explanation of how	25-28
51	work, implications,	findings and conclusions connect to, support, elaborate	
52	transferability and	on, or challenge conclusions of earlier scholarship;	
53	contribution(s) to the field	discussion of scope of application / generalizability;	
54		identification of unique contributions(s) to scholarship in	
55		a discipline or field	
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1	Limitations	<a href="#">#19</a>	Trustworthiness and limitations of findings	29
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3	<b>Other</b>			
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6	Conflicts of interest	<a href="#">#20</a>	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	31
7				
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10				
11	Funding	<a href="#">#21</a>	Sources of funding and other support; role of funders in data collection, interpretation and reporting	31
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# BMJ Open

## Healthcare for migrant workers in destination countries: a comparative qualitative study of China and Malaysia

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2020-039800.R1
Article Type:	Original research
Date Submitted by the Author:	01-Oct-2020
Complete List of Authors:	Loganathan, Tharani; University of Malaya Faculty of Medicine, Centre for Epidemiology and Evidence-based Practice, Social and Preventive Medicine Rui, Deng; Kunming Medical University, School of Public Health Pocock, Nicola S.; London School of Hygiene & Tropical Medicine, Gender Violence & Health Centre; United Nations University International Institute for Global Health
<b>Primary Subject Heading</b>:	Global health
Secondary Subject Heading:	Qualitative research, Health policy, Public health
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, PUBLIC HEALTH, QUALITATIVE RESEARCH

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4 **1 Healthcare for migrant workers in destination**  
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7 **2 countries: a comparative qualitative study of China**  
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11 **3 and Malaysia**  
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14 Tharani Loganathan<sup>1\*#a¶</sup>, Deng Rui<sup>2¶</sup>, Nicola Suyin Pocock<sup>3,4</sup>

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20 <sup>¶</sup>These authors contributed equally to this work.

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22 Word Count: 7410



## 23 ABSTRACT

24 **Objectives:** This paper explores policies addressing migrant worker's health and barriers to  
25 healthcare access in two middle-income, destination countries in Asia with cross-border  
26 migration to Yunnan province, China and international migration to Malaysia.

27 **Design:** Qualitative interviews were conducted in Rui Li City and Tenchong County in  
28 Yunnan Province, China (n=23) and Kuala Lumpur, Malaysia (n=44), along with review of  
29 policy documents. Data were thematically analysed.

30 **Participants:** Participants were migrant workers and key stakeholders with expertise in  
31 migrant issues including representatives from international organisations, local civil society  
32 organisations, government agencies, medical professionals, academia and trade unions.

33 **Results:** Migrant health policies at destination countries were predominantly protectionist,  
34 concerned with preventing transmission of communicable disease and the excessive burden  
35 on health systems. In China, foreign wives were entitled to state-provided maternal health  
36 services while female migrant workers had to pay out-of-pocket, and often returned to  
37 Myanmar for deliveries. In Malaysia, immigration policies prohibit migrant workers from  
38 pregnancy, however, women do deliver at healthcare facilities. Mandatory HIV testing was  
39 imposed on migrants in both countries, where it was unclear whether and how informed  
40 consent was obtained from migrants. Migrants who did not pass mandatory health screenings  
41 in Malaysia would runaway rather than be deported and become undocumented in the  
42 process. Excessive attention on migrant workers with communicable disease control  
43 campaigns in China resulted in inadvertent stigmatisation. Language and financial barriers  
44 frustrated access to care in both countries. Reported conditions of overcrowding and  
45 inadequate healthcare access at immigration detention centres raise public health concern.

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3 46 **Conclusions:** This study's findings inform suggestions to mainstream the protection of  
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5 47 migrant workers' health within national health policies in two middle-income destination  
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7 48 countries, to ensure that health systems are responsive to migrants' needs, as well as to  
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9 49 strengthen bilateral and regional cooperation towards ensuring better migration management.  
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12 50 **Word count: 296**  
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## 15 51 **Article Summary**

16 52 Strengths and limitations of this study

- 17  
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19 53 • This is the first comparative qualitative study on health policies for migrant workers in two  
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21 54 middle-income countries in Asia.  
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23 55 • We offer practice and policy suggestions to mainstream migrant workers within national  
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25 56 health policies.  
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27 57 • Multiple stakeholders (health workers, civil society, government officials) insights were  
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29 58 triangulated to identify cross-cutting themes.  
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31 59 • Limitations included difficulties sampling migrant workers, and lack of generalisable  
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33 60 findings due to the qualitative nature of the study.  
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## 43 62 **Key Words**

44 63 Migration, migrant health, access to health, the right to health, LMIC, ASEAN, China  
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## 64 INTRODUCTION

65 International migration is an inevitable feature of today's globalized world and is critical for  
66 the economic development of many nations. In 2017, 258 million international migrants were  
67 estimated worldwide, with 80 million residing in Asia<sup>1</sup>. There are an estimated 164 million  
68 international migrant workers globally<sup>2</sup>, many of whom face significant health risks from  
69 workplace accidents and poor working conditions, leading to physical and psychological  
70 morbidities<sup>3</sup>. Despite these risks, just 6% of the global migration health literature focusses on  
71 migrant workers, relative to 25% on refugees and asylum seekers<sup>4</sup>. By recent estimates, there  
72 will be close to 1.4 billion new working-age people in developing countries by 2050, of  
73 whom around 40% are unlikely to find meaningful employment in their home countries<sup>5</sup>.  
74 This massive movement of people for work highlights the inevitability of economic growth  
75 and exchange, and yet international migrant workers are often considered a liability by  
76 destination countries despite their contributions to the economy. Potential health security and  
77 migrant control concerns have become essential policy drivers in many destination countries<sup>6</sup>.  
78 In contrast, the right to the highest attainable standard of health, regardless of citizenship or  
79 immigration status, is enshrined in the World Health Organization (WHO) constitution and  
80 numerous human rights instruments<sup>7 8</sup>. The rights-based commitment to the health of migrant  
81 populations is reiterated in the 2030 Agenda for Sustainable Development and the 2018  
82 Global Compact for Safe, Orderly and Regular Migration<sup>9-11</sup>. Among the Association of  
83 Southeast Asian Nations (ASEAN) countries and China, the ratification of international  
84 human rights treaties protecting the Right to Health is inconsistent, with only the Philippines  
85 and Indonesia, predominantly migrant-sending countries, ratifying the International  
86 Convention on the Protection of the Rights of All Migrant Workers and Members of their  
87 Families<sup>12</sup> (Table 1).

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3 88 Yunnan province, an important border province located in the southwest frontier area of  
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5 89 China, shares substantial land borders (4,060 km) with Myanmar, Laos and Vietnam <sup>13</sup>.  
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7 90 Through kinship networks, there are longstanding relationships of trade and ethnic  
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9 91 interchange between local peoples along the four countries border lines <sup>14 15</sup>. More recently,  
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11 92 cross-border migration is enhanced by economic reform and the ‘opening up’ policies,  
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13 93 especially with the China-Myanmar Economic Corridor, integral to the Belt and Road  
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15 94 Initiative <sup>13 16 17</sup>. Largely due to economic disparities between the two countries, an increasing  
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17 95 number of Myanmar citizens cross national boundaries primarily in search of employment in  
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19 96 China and others for marriage. Myanmar migrants are the fourth largest migrant community  
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21 97 in China, and most reside in Yunnan province <sup>18</sup>.  
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26 98 Malaysia, a vibrant Southeast Asian economy with relative political stability, is a magnet for  
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28 99 low-skill, low-wage labour migrants from across the region and increasingly Asia. Between  
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30 100 2008 and 2018, the official numbers of documented migrant workers doubled from 1.1 to 2.2  
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32 101 million, or 15% of the labour workforce in Malaysia <sup>19</sup>. The number of undocumented  
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34 102 workers in Malaysia is less certain, with estimates of all migrant workers ranging from 3.9 to  
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36 103 5.5 million, including undocumented workers <sup>20</sup>. Of the 15 source countries, Indonesia  
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38 104 (35%), Bangladesh (28%), Nepal (15%), and Myanmar (6%) are the largest contributors of  
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40 105 migrant workers to Malaysia <sup>21</sup>.  
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45 106 Increasingly, migration is circular with health outcomes influenced by the cumulative social  
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47 107 determinants and health risks aggregated over the various phases of the migration cycle <sup>22 23</sup>.  
48  
49 108 In destination countries, migrant workers often fill undesirable low-skill, labour-intensive  
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51 109 jobs in potentially health-damaging work environments and face numerous challenges  
52  
53 110 including poor housing, discrimination, violence and exploitation, with restricted healthcare  
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55 111 access <sup>24-26</sup>. This paper explores policies that address migrant workers’ health and the barriers  
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112 to healthcare access in two middle-income, destination countries in Asia with cross-border  
113 migration to Yunnan province, China and international migration to Malaysia (Figure 1).  
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115 **Table 1. Ratification of international treaties protecting the Right to Health within ASEAN and China**

Country	International Covenant on Economic, Social and Cultural Rights (ICESCR)	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	International Covenant on Civil and Political Rights (ICCPR)	International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	Convention on the Rights of the Child (CRC)	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW)
<b><u>Migrant-sending countries*</u></b>						
Cambodia	✓	✓	✓	✓	✓	✗
Indonesia	✓	✓	✓	✓	✓	✓
Lao PDR	✓	✓	✓	✓	✓	✗
Myanmar	✓	✓	✗	✗	✓	✗
Philippines	✓	✓	✓	✓	✓	✓
Vietnam	✓	✓	✓	✓	✓	✗
<b><u>Migrant-receiving countries*</u></b>						
Brunei Darussalam	✗	✓	✗	✗	✓	✗
Malaysia	✗	✓	✗	✗	✓	✗
Singapore	✗	✓	✗	✓	✓	✗
Thailand	✓	✓	✓	✓	✓	✗
China	✓	✓	✗	✓	✓	✗

116 \*predominantly; ASEAN - Association of Southeast Asian Nations

117 Source: <sup>27</sup>

## 118 **MATERIALS AND METHODS**

### 119 **Study design**

120 Qualitative methods were used in an exploratory, iterative design to describe and compare  
121 available healthcare policies and determine barriers in accessing healthcare experienced by  
122 migrant workers in Yunnan province, China and Malaysia.

### 123 **Definition of terms**

124 “Migrant” is a broad term. Here we focus on international labour migrants or migrant  
125 workers, both documented and undocumented, in Malaysia and Yunnan Province in China.  
126 Refugees, asylum seekers, victims of trafficking, people moving for marriage and expatriates  
127 are not included in this study.

128 A migrant worker or a foreign worker is defined here as a person who crosses international  
129 borders for the purpose of employment. Documented or regular migrants are authorised to  
130 enter, stay and partake in employment in a country and are in possession of legal documents  
131 such as passports and work permits. Undocumented or irregular migrants do not have the  
132 required documentation or authorisation to enter, reside or carry out remunerated activities in  
133 a country<sup>28 29</sup>.

### 134 **Patient and public involvement**

135 The topic guides for Malaysia and China were informed by review of literature and cross-  
136 country meetings to discuss research priorities. In Malaysia, purposive sampling of participants  
137 from a previous migration health workshop in November 2017<sup>30</sup> was conducted, with further  
138 snowball sampling until no new participants were identified. In China, purposive sampling was  
139 also used to select key informants in two study sites. Topic guides were slightly adapted

1  
2  
3 140 throughout the study to account for participant's priorities identified during interviews.  
4  
5 141 Malaysia results were shared with research participants at a workshop in Kuala Lumpur in  
6  
7 142 December 2019. In China, results were disseminated at the 10<sup>th</sup> International Conference on  
8  
9 143 Public Health among Greater Mekong Sub-Regional Countries in November 2018.

## 14 144 **Data collection**

15  
16 145 The health and welfare of migrant workers are contentious, with issues concerning  
17  
18 146 immigration status being particularly sensitive. As such, we did not specifically target  
19  
20 147 migrant workers only for interviews. We aimed to capture viewpoints of different  
21  
22 148 stakeholders with expertise in migrant issues to obtain a broader understanding different  
23  
24 149 policies and access to healthcare for this population. We conducted in-depth interviews with  
25  
26 150 stakeholders including representatives from international organisations (IOs), local civil  
27  
28 151 society organisations (CSOs), government agencies, medical professionals, academia, trade  
29  
30 152 unions and others, in China and Malaysia.  
31  
32 153 Semi-structured interview guides were developed to seek participants' perspective on barriers  
33  
34 154 to healthcare access for migrant workers. These guides were further customised to suit the  
35  
36 155 organisational background of participants and were applied to both countries. Please see the  
37  
38 156 interview guide in the Supplementary File.

39  
40 157 Data collection was conducted between July and September 2018 in China and from July  
41  
42 158 2018 to July 2019 in Malaysia. Researchers purposefully recruited and interviewed migrant  
43  
44 159 workers and key informants working closely with migrant workers. Further snowball  
45  
46 160 sampling was conducted in each study site until the research teams agreed that additional  
47  
48 161 interviews would not yield new information, as thematic saturation was reached.  
49  
50 162 In China, interviews were conducted with 23 participants in two border counties, Rui Li City  
51  
52 163 and Tenchong County in Yunnan Province. While, interviews of 44 individuals were  
53  
54 164 conducted in Kuala Lumpur, Malaysia. In China, individual interviews were conducted either



1  
2  
3 165 in Mandarin or Myanmar language by two researchers (one researcher was able to speak the  
4  
5 166 Myanmar language.) In Malaysia, individual interviews were conducted either in English or  
6  
7 167 Bahasa Malaysia (Malay language) depending on the participants' preference, by the multi-  
8  
9 168 lingual research team. No interpreters were used. Table 2 describes the main characteristics  
10  
11 169 of the study participants.  
12  
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14

15 170 **Table 2. Characteristics of study participants**

	China	Malaysia
<b><u>Organisation type</u></b>		
Local civil society organisations	2	10
International organisations	0	4
Trade unions	0	3
Medical doctors	2	13
Academia	0	3
Government officials	4	2
Industry	0	5
<b><u>Migrant workers</u></b>		
Male	4	2
Female	11	2
<b>Total</b>	<b>23</b>	<b>44</b>

171

## 172 **Data Analysis**

173 The audio-recordings were transcribed verbatim into local languages. We conducted thematic  
174 analysis as described by Braun and Clarke, where themes or patterns of meaning within data  
175 were identified and reported using six phases: becoming familiar with the data, generating  
176 initial codes, searching for themes, reviewing themes, defining themes and producing the  
177 report<sup>31</sup>.

178 Data analysis was conducted in an immersive, exploratory, iterative and inductive manner,  
179 initially separately in each country. Researchers in country teams reviewed and analysed  
180 transcripts independently, with regular discussions between researchers to refine codes and  
181 identify new themes. Transcripts were coded into emerging themes using NVivo 12 Pro

1  
2  
3 182 software and Microsoft Excel across research teams. Following initial analysis in both  
4  
5 183 countries, selected quotations were extracted and were translated into English. Subsequently,  
6  
7 184 the authors examined codes to identify the broader pattern of themes and subthemes across  
8  
9 185 both countries. Desk review of policy documents including circulars, legal documents and  
10  
11 186 memos, served to contextualise and triangulate qualitative findings.  
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## 16 187 **Reflexivity**

17  
18 188 Interviews in both countries were conducted by teams of academic researchers and medical  
19  
20 189 doctors, that could be perceived as trusted authority figures. To minimize potential effects of  
21  
22 190 social distance and power imbalances between researchers and participants, most interviews  
23  
24 191 were conducted locations of the participants' choosing, in a space they were comfortable in  
25  
26 192 and at a time convenient to them. Migrant participants, in particular, were assured that they  
27  
28 193 could refuse to answer questions or could choose to end the interview at any time. In doing  
29  
30 194 so, we hoped that participants felt that they could exert a degree of control over the interview  
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33 195 process.  
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## 38 196 **Ethics**

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41 197 We sought to minimise harm to study participants by assuring anonymity and confidentiality.  
42  
43 198 Written informed consent was obtained at recruitment. All participants agreed to be audio  
44  
45 199 recorded and quoted anonymously in publications. Given the sensitive nature of this research,  
46  
47 200 patients were not asked to divulge personal identification information. Data was anonymised  
48  
49 201 using pseudonyms and general descriptors without any identifying information. Study  
50  
51 202 participation was entirely voluntary, and participants were informed that they could refuse to  
52  
53 203 answer questions or terminate interviews at any point. We gave small gifts costing less than 5  
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55 204 USD as tokens of appreciation for interviewees at both study sites. Electronic data such as  
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3 205 audio files and transcripts were stored in secure servers, while other material was secured in  
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5 206 locked cupboards at researcher's offices.  
6  
7  
8 207 Ethical approval was obtained from Institutional Review Boards at University Malaya,  
9  
10 208 Malaysia (UM.TNC2/UMREC-238) and Kunming Medical University, China  
11  
12 209 (kmu42018049), as well as the Medical Research and Ethics Committee, Ministry of Health,  
13  
14 210 Malaysia (NMRR-18-1309-42043).  
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5 211 **RESULTS**  
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8 212 Study findings are presented by country and organised into major themes: policy setting,  
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10 213 maternal and child health services, infectious disease and migrant workers, financial and  
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12 214 language barriers to healthcare, and health in detention. Table 3 summarises major study  
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15 215 findings.  
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216 **Table 3. Main findings of the study**

<b>CHINA</b>	<b>MALAYSIA</b>
<p><b>Policy setting</b></p> <ul style="list-style-type: none"> <li>China lacks a cohesive national healthcare policy for international migrant workers, however Yunnan province, a major border province, has several programmes for the management of cross-border migrants.</li> </ul> <p><b>Maternal and child health services</b></p> <ul style="list-style-type: none"> <li>Safe motherhood packages are provided for migrant women and foreign spouses with legal documents</li> <li>Rigid administrative requirements including requirements for antenatal records at the facility are a barrier to hospital delivery</li> </ul> <p><b>Infectious diseases and migrant workers</b></p> <ul style="list-style-type: none"> <li>In addition to mandatory medical screenings by the immigration office, targeted infectious disease surveillance of non-citizens is common</li> <li>Excessive attention on infectious disease control programmes targeted at migrant workers has resulted in stigmatisation</li> <li>Language barriers and the lack of cultural sensitivity may have exacerbated migrants’ distrust of healthcare providers</li> <li>Free anti-retroviral treatment is provided conditionally to HIV infected non-citizens; however, these policies were designed to discourage cross-border travel specifically for HIV treatment</li> </ul> <p><b>Financial and language barriers to healthcare</b></p> <ul style="list-style-type: none"> <li>Medical treatment is unaffordable to migrant workers, since they are not covered by the Chinese health insurance</li> <li>Migrants face difficulties in communicating and navigating the healthcare system and often bring informal interpreters to accompany them to hospital</li> </ul>	<p><b>Policy setting</b></p> <ul style="list-style-type: none"> <li>Malaysia has several national healthcare policies for documented migrant workers including predeparture, pre-employment and annual medical examinations, and a government-mandated insurance scheme</li> </ul> <p><b>Maternal and child health services</b></p> <ul style="list-style-type: none"> <li>Migrant workers found pregnant are subject to termination from employment and deportation</li> <li>Pregnant migrant workers tend to avoid healthcare due to financial barriers and immigration restrictions, possibly resulting in poor obstetric outcomes</li> </ul> <p><b>Infectious diseases and migrant workers</b></p> <ul style="list-style-type: none"> <li>Migrant workers are obliged to undergo mandatory infectious disease screenings several times as an immigration requirement</li> <li>Migrant workers failing medical examinations are denied work permits and are subject to deportation. Failing medical examinations is a possible reason for ‘undocumented’ status.</li> <li>Concerns were raised on the quality of informed consent for HIV testing, proper explanation and confidentiality of infectious disease test results</li> </ul> <p><b>Financial and language barriers to healthcare</b></p> <ul style="list-style-type: none"> <li>SPIKPA insurance is inadequate in compensating the high fees charged to non-citizens at public hospitals, and does not cover outpatient care</li> <li>As there are no interpreter service in the healthcare system, the common expectation is for migrant workers to learn the Malay language or to bring a companion to act as an informal interpreter</li> </ul> <p><b>Health in detention</b></p> <ul style="list-style-type: none"> <li>Undocumented workers are sent to immigration detention centres, often for lengthy periods, to await deportation</li> <li>Conditions at immigration detention camps have been described as overcrowded, with limited available healthcare facilities</li> </ul>

217 SPIKPA - Hospitalisation and Surgical Scheme for Foreign Workers

## 218 **China**

### 219 **Policy setting**

220 Over the past two decades, the Chinese health system has undergone significant reform with  
221 the aim of providing safe, effective, and affordable health care for citizens. Currently,  
222 Chinese citizens enjoy comprehensive medical services through government subsidised  
223 health insurance packages that are broadly location-based and designed specifically for social  
224 groups, such as urban employees, urban residents and rural residents. The policy for medical  
225 insurance as well as the household registry system, known as *hukou*, whereby citizens are  
226 registered by location of residence, have created ‘geographical barriers’ for internal migrants  
227 due to difficulties claiming health insurance across provinces<sup>32 33</sup>. Despite growing numbers  
228 of international migrants, China lacks a cohesive national policy on the provision of  
229 healthcare for international migrant workers, who are not included in national health  
230 insurance schemes.

231 In contrast, Yunnan province has initiated several programmes to better facilitate the  
232 management of migrant workers. International Migrant Service and Management Centres  
233 have been established at border towns, such as Ruili city, the largest Sino-Burmese border  
234 port in Yunnan province. This centre established in June 2013, provides migrants with one-  
235 stop services to obtain the following documents: (1) health certificate, (2) work permit, (3)  
236 trading certificate and (4) temporary residential permit<sup>34</sup>. According to local regulations,  
237 migrant workers who intend to temporarily reside in China for over a month are required to  
238 apply for these documents within three days of crossing the border and must have either a  
239 passport or a China-Myanmar border pass, and an employment contract with a Chinese  
240 company for applications<sup>35</sup>. China does not have mandatory pre-departure health  
241 requirements for low-wage migrant workers.

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3 242 According to officials interviewed, undocumented migrants are not allowed to work in China.  
4  
5 243 The Chinese government conducts random inspections at border areas and those identified  
6  
7 244 without the necessary documents are placed under temporary placement under the local  
8  
9 245 police station before being repatriated to host countries within a few days. At the time of this  
10  
11 246 study, there were no immigration detention centres in Yunnan province, China.  
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14 247 Specific health programmes for documented migrants in Yunnan province include maternal  
15  
16 248 and child health services for non-citizen women and infectious disease prevention  
17  
18 249 programmes at border areas.  
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20

## 21 250 Maternal and child health services

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24 251 In border areas of Yunnan province, local health authorities provide a safe motherhood  
25  
26 252 package for migrant women with legal identity certificates. Foreign spouses with legal  
27  
28 253 marriage certificates are eligible for national health insurance with equal benefits as Chinese  
29  
30 254 citizens. For example, the Health and Family Planning Commission of Whenshan prefecture,  
31  
32 255 Yunnan issued guidelines for migrant maternal and child health services in January 2018. All  
33  
34 256 migrant mothers, including foreigners who have stayed in Whenshan for more than six  
35  
36 257 months, are eligible to obtain similar maternal and child health services as citizens <sup>36</sup>.  
37  
38 258 However, compared with foreign spouses, female migrant workers would have to pay out-of-  
39  
40 259 pocket for these services, since she has no Chinese citizenship or household registration.  
41  
42 260 If a migrant worker is pregnant, she can visit any local hospital for maternity care. She would  
43  
44 261 be eligible for hospital delivery, conditional on having antenatal records at that particular  
45  
46 262 hospital. Owing to rigid guidelines, many foreign women were denied admission for delivery  
47  
48 263 on account of their lacking antenatal records at specific hospitals.  
49  
50 264 *“My friend went to three hospitals before she was finally admitted for delivery. In the past, it*  
51  
52 265 *was convenient to have children in X town. But now the government is strict on standardized*  
53  
54 266 *medical management. Because she did not have an antenatal check-up at this hospital, there*  
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3 267 *was no way to be admitted. Finally, we went to Y hospital. At that time her condition was*  
4  
5 268 *very bad, very painful, as the baby was about to be born. So, the doctor let her stay, and*  
6  
7 269 *finally, the child was born safely. Myanmar migrants used to choose to have children in X*  
8  
9 270 *town. But now they must have tests and other records before they can be hospitalized. Many*  
10  
11 271 *women have to go back to Myanmar to deliver a baby.” Mei, female, migrant school*  
12  
13 272 *administrator.*  
14  
15

### 17 273 **Infectious disease and migrant workers**

18  
19 274 According to government officials interviewed, Myanmar migrants, were perceived as a  
20  
21 275 source of infectious diseases transmission, such as HIV and dengue fever due to their  
22  
23 276 mobility and convoluted social relationships. Consequently, targeted infectious disease  
24  
25 277 surveillance of non-citizens has become common practice at border townships.  
26  
27 278 HIV testing is compulsory for migrant workers entering China. To obtain a Health Certificate  
28  
29 279 for International Travel, migrant workers must complete a post-arrival medical screening,  
30  
31 280 which includes blood tests, urine tests, chest X-rays and mandatory HIV testing, within three  
32  
33 281 days of arrival into China. Since the health certificate is only valid for a year, migrant  
34  
35 282 workers must be screened annually for infectious diseases including HIV. These tests cost  
36  
37 283 around 20 USD and are paid for by the migrant worker.  
38  
39 284 Local health authorities also implement health intervention projects, including community-  
40  
41 285 based health promotion campaigns targeting migrants at their settlements, for example, health  
42  
43 286 education for landlords of migrants, distribution of free condoms and HIV screening. These  
44  
45 287 activities are in addition to the mandatory screenings conducted by the immigration office to  
46  
47 288 obtain health certificates. Although well-intended, the excessive attention given to migrant  
48  
49 289 workers with regards to infectious disease has inadvertently caused prejudice and  
50  
51 290 stigmatization. One community worker described the following:  
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3 291 *“We have a lot of Myanmar migrants here and it’s very difficult to do our work. We don’t*  
4  
5 292 *know their language. We don’t have their phone number. Some people don’t even have a cell*  
6  
7 293 *phone. Many of them have come to X town, so they must have a temporary residence permit,*  
8  
9 294 *and those in the factory have had to apply for a health card. They [government authorities]*  
10  
11 295 *have already drawn blood and tested it. When we [health workers] go to the community, they*  
12  
13 296 *don’t want to do the blood test [migrants refuse]. They look for various excuses not to draw*  
14  
15 297 *blood. When they see us in the community, they start running, and they don’t come at all. It is*  
16  
17 298 *perceived [by migrants] that we are drawing blood over and over again. They are disgusted*  
18  
19 299 *and repelled.”* Chen, male, community health worker.

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24 300 Although informed consent is obtained prior to screenings by the immigration office, our  
25  
26 301 findings suggest that migrants understanding of health activities that they are consenting to, is  
27  
28 302 lacking. Language barriers and the lack of cultural sensitivity have likely exacerbated  
29  
30 303 migrants’ distrust of healthcare providers.

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33  
34 304 The local government conditionally provides free anti-retroviral treatment to HIV infected  
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36 305 Myanmar citizens. Two groups of Myanmar migrants are eligible, these are long-time  
37  
38 306 residents who have stayed in China for at least six months with valid identity documents, and  
39  
40 307 migrant wives with valid marriage documents (which may consist of a marriage certificate or  
41  
42 308 a letter from the village office)<sup>37</sup>. To discourage foreign patients from coming to China to  
43  
44 309 obtain free medical services, non-citizens are not provided with free investigations or  
45  
46 310 hospitalisations for HIV infections.

47  
48  
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50  
51 311 *‘Free services for all are not feasible since policies related to HIV treatment and health care*  
52  
53 312 *are not consistent between the two countries. If we are the only ones offering free services,*  
54  
55 313 *the patients from the Myanmar side would flood into China. We are not capable to deal with*  
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3 314 *this situation due to limited financial and human resources which are allocated according to*  
4  
5 315 *domestic population rather than international migrants.* ' Yang, female, government official.

7  
8 316 Resource constraints meant that policies were deliberately designed to discourage care-  
9  
10 317 seeking for HIV treatment among cross-border migrants in China.

### 13 318 Financial and language barriers to healthcare

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15  
16 319 Those interviewed revealed that Myanmar migrants rarely seek medical services in China,  
17  
18 320 mainly due to financial and language barriers.

19  
20 321 Medical treatment at public hospitals is expensive and unaffordable to low-wage migrant  
21  
22 322 workers. Since they are not covered by health insurance, migrant workers are subject to high  
23  
24 323 out-of-pocket payments when seeking care. Also, most employers will not pay for medical  
25  
26 324 expenses or purchase medical insurance for employees. As such, most migrant workers resort  
27  
28 325 to self-treatment or return to Myanmar border towns for healthcare.

29  
30 326 *“People who come out to work are generally in good health. Most of us are young people.*  
31  
32 327 *Old people [migrants] do not come out to work, because the cost of medicine is very*  
33  
34 328 *expensive in China. It is not worth the money to see a doctor when you are sick. We will buy*  
35  
36 329 *medicine for ourselves if we are ill [self-medicate]. If we have a slightly more serious illness,*  
37  
38 330 *almost all of us will go back to Myanmar for treatment. Because seeing a doctor in China is*  
39  
40 331 *too expensive. We usually go back to Myanmar to see a doctor for about 50 yuan (less than*  
41  
42 332 *10 USD), but in China, 50 yuan is not enough. If we must be hospitalized, we must pay a*  
43  
44 333 *deposit of 5000 yuan (about 800 USD). That is impossible for us, Myanmar[workers] to get*  
45  
46 334 *so much money all at once. We don't have to pay deposit in Myanmar, we pay the bill when*  
47  
48 335 *we leave the hospital.”* Tok, male, migrant worker.

49  
50 336 This participant implied that high healthcare costs in China deterred older workers from  
51  
52 337 Myanmar from migrating.

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3 338 One interviewee suggested that given the opportunity, Myanmar migrants would opt-in to  
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5 339 Chinese health insurance scheme, as that would lessen their financial burden while providing  
6  
7 340 healthcare access.  
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10 341 *“China has good medical facilities. Rich Myanmar people will choose to see a doctor in*  
11  
12 342 *China, but for the average Myanmar people, they cannot do the same. People have heard that*  
13  
14 343 *China has health insurance, but Myanmar migrants can't buy it. For Myanmar migrants like*  
15  
16 344 *us who live in China for a long time, we really want to be able to buy Chinese health*  
17  
18 345 *insurance, and the grade of insurance can be divided into different amounts. Everyone can*  
19  
20 346 *buy health insurance according to their own ability. There are many Myanmar laborers in*  
21  
22 347 *China, it will be much more for them, if they have health insurance, they can also reduce the*  
23  
24 348 *economic burden.”* Yang, female, migrant worker  
25  
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27  
28 349 Migrant workers tend to avoid public hospitals because of language barriers. Very few  
29  
30 350 healthcare workers speak Myanmar languages, and migrants face difficulties in  
31  
32 351 communicating and navigating the health system. Migrant workers often need to find a  
33  
34 352 Chinese language interpreter, either a colleague or friend, to accompany them when seeking  
35  
36 353 care at hospitals. This migrant worker expressed frustration at the lack of language-friendly  
37  
38 354 services in China and suggested improvements.  
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41  
42 355 *“My friends have told me that when they go to see a doctor, because the patients do not*  
43  
44 356 *understand what the doctor says, and the doctors will be angry [with them] after asking*  
45  
46 357 *many times [questions repeatedly]. I hope there is a Chinese-Myanmar contrast (bilingual*  
47  
48 358 *information) at every window of the hospital, so that we can know which department we*  
49  
50 359 *should go to. The staff of the guidance desk should speak Burmese. If possible, I hope they*  
51  
52 360 *can recruit Burmese-speaking doctors, so that it be much easier [for us]. I hope that doctors*  
53  
54 361 *will be more patient, communicate with us with simple words and speak slowly, so we can*  
55  
56 362 *understand.”* Nuinui, female, migrant worker.  
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3 363 While this participant described Burmese doctors as a possible solution to language barriers,  
4  
5 364 we did not come across any instances of this occurring within two border counties studied.  
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7 365 Foreign doctors must pass the Chinese medical exams and have a valid medical diploma,  
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9 366 making it very difficult to practise in China. Furthermore, there are no formal interpreter  
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11 367 provisions in the Chinese health system, which is also the case in Malaysia <sup>30</sup>.  
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## 369 **Malaysia**

### 370 **Policy setting**

371 Being a net migrant-receiving country, Malaysia has several health policies in place for  
372 migrant workers. It is mandatory for foreign nationals seeking employment in Malaysia to  
373 have undergone a pre-departure medical examination prior to entry into Malaysia. The  
374 Ministry of Health, Malaysia with the cooperation of migrant-sending countries selects  
375 clinics to conduct pre-departure medical examinations of prospective workers. Pre-departure  
376 medical examination generally consists of infectious disease screening for HIV and  
377 tuberculosis<sup>38</sup>.

378 In addition, the Malaysian government established the Foreign Workers Medical  
379 Examination and Monitoring Agency (FOMEMA) to carry out pre-employment medical  
380 examinations, within the first month of arrival into Malaysia and subsequently annual  
381 medical examinations when renewing work permits, at private clinics approved by the  
382 FOMEMA. These medical examinations are paid for by employers, and all documented  
383 migrant workers are mandatorily tested for tuberculosis, HIV, syphilis, hepatitis B, malaria,  
384 leprosy, pregnancy (for women), drug abuse, hypertension, diabetes mellitus, cancer, epilepsy  
385 and psychiatric illness <sup>39 40</sup>.

386 Malaysia has a mixed public-private healthcare system. The public healthcare system is  
387 subsidized for citizens, but non-citizen fees are much higher <sup>41</sup>. At the same time, a  
388 government-mandated compulsory insurance scheme, the Hospitalisation and Surgical  
389 Scheme for Foreign Workers (SPIKPA) provides documented workers with a maximum of  
390 RM 20,000 (4,800 USD) annually for in-patient care and surgery in public hospitals<sup>42</sup>. Some  
391 employers pay for workers treatment at private clinics, but this is not a legal obligation, as  
392 such it is not standard practice <sup>43</sup>.

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3 393 Maternal and child health services  
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6 394 Due to immigration requirements, female migrant workers are prohibited from marrying or  
7  
8 395 becoming pregnant in Malaysia. Those testing positive for pregnancy will not be granted  
9  
10 396 work permits and are subject to deportation<sup>44 45</sup>. While there are no specific public antenatal  
11  
12 397 or delivery services offered for migrant workers in Malaysia, in practice women do give birth  
13  
14 398 in healthcare facilities, often at private facilities and at high cost. While public healthcare  
15  
16 399 facilities will not deny patients necessary medical care, healthcare providers are obliged to  
17  
18 400 report undocumented workers to the police and immigration authorities. This physician  
19  
20  
21 401 explains the situation at public Maternal and Child Health Clinics.

22  
23  
24 402 *“It is very sad for refugees or illegal migrants who do not have any passport or documents*  
25  
26 403 *[UNHCR cards or valid work permit], they will [need documents to] register at the counter.*  
27  
28 404 *If they need to see the Family Medicine Specialist [FMS], foreigners, they have to pay extra –*  
29  
30 405 *maybe RM 30 [8 USD] or something like that. They will register and pay the money, while*  
31  
32 406 *she is inside seeing the doctor, the police are already outside, waiting for her. Once she is*  
33  
34 407 *out, she will be caught by the police. This has happened many times at the ‘Klinik Ibu dan*  
35  
36 408 *Anak’ [public Maternal and Child Health Clinic].” Dr Lucy, female, physician*

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41 409 Other CSO interviewees informed of incidents of undocumented migrant women being taken  
42  
43 410 to immigration detention centres immediately after delivery at public hospitals.

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45  
46 411 Due to immigration restrictions at public facilities and the expense of antenatal care at  
47  
48 412 private facilities, non-citizens tend to present late for booking and default follow-up. Some  
49  
50 413 migrants prefer to deliver at home, assisted by traditional midwives. This doctor expressed  
51  
52 414 concern that non-citizens often present late at hospitals for delivery, without prior antenatal  
53  
54 415 follow-up.  
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3 416 *“They usually come in emergency, like ectopic[pregnancy] with abdominal pain. My*  
4  
5 417 *colleagues, they will say, ‘Bila dah almost deliver baru datang?’ (Sarcastic: You only come*  
6  
7 418 *to hospital when you’re about to deliver?). Because they didn’t follow up during the*  
8  
9 419 *antenatal stage. Because of financial and other reasons, they only come at the late stage*  
10  
11 420 *[...]”* Dr Nazirah, female, physician

12  
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14  
15 421 Participants shared that the inadequate antenatal care, late presentation for hospital delivery  
16  
17 422 and home deliveries may result in poor obstetric outcomes.

### 20 423 Infectious disease and migrant workers

21  
22  
23 424 The Malaysian government requires a pre-departure medical examination to be conducted at  
24  
25 425 designated clinics in migrant-sending countries. Some interviewed questioned the quality of  
26  
27 426 medical screenings conducted in migrant-sending countries, due to the lack of regulation and  
28  
29 427 potential corruption.

30  
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32  
33 428 *“The medical tests done in the country of origin is not audited. So, there is a lot of instances*  
34  
35 429 *where people do not pass the medical test, but they obtain a certificate and then they come*  
36  
37 430 *here. When they come here, the requirement is that the medical test [pre-employment*  
38  
39 431 *screening done on arrival in Malaysia] results must be submitted with the application to do*  
40  
41 432 *your work permit. Only then will your work permit will be approved. What we see is, when*  
42  
43 433 *they come here, they fail the medical test.”* Priya, female, civil society organisation.

44  
45  
46  
47 434 In order to obtain a work permit, migrant workers are required to undergo a mandatory pre-  
48  
49 435 employment medical examination within the first month of arrival. Mandatory annual  
50  
51 436 medical examinations are conducted annually for the first 3 years, and subsequently every  
52  
53 437 alternate year for a maximum of ten years of employment in Malaysia. The consequence of  
54  
55 438 failing these mandatory medical examinations is severe, as workers are denied work permits  
56  
57 439 and are subject to deportation. This interviewee informed that failing medical examinations is

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2  
3 440 a possible reason for migrant workers to become undocumented.  
4

5 441 *“Once they have got leprosy or mental health disease or... [failed medical examination],*  
6  
7 442 *they are deemed 'unfit' or unsuitable [for employment]. So, once you deem them unsuitable*  
8  
9 443 *[unfit] in your medical examination, the employer has to send them back. And THAT is where*  
10  
11 444 *a lot of problems arise. Because when they [migrant workers] come to know that they have to*  
12  
13 445 *be sent back, they disappear. And they become 'undocumented'. This is a huge problem.”* Dr  
14  
15  
16 446 Amir, male, a doctor in private practice.

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19  
20 447 Some interviewed shared that screenings were for medically treatable conditions and should  
21  
22 448 not preclude employment. This interviewee felt that infectious diseases, like tuberculosis  
23  
24 449 (TB) is of public health concern and should be treated upon detection.

25  
26 450 *“Yes, TB also, to some extent, it can be contained, right? And it is medically treatable. He*  
27  
28 451 *[the migrant worker] is not incapable of working. The moment he has TB, what they do is,*  
29  
30 452 *they pack him and send him back home. And (if) this guy doesn't get back home and get*  
31  
32 453 *treatment- he's going to spread it to others. You've got to treat the disease before you*  
33  
34 454 *actually send him back home.”* Rosa, female, country coordinator of an international  
35  
36 455 organisation.

37  
38 456 Medical doctors interviewed explained that while general consent is obtained for medical  
39  
40 457 screenings, the consent obtained is not specific for HIV testing. There was also concern  
41  
42 458 expressed on patient confidentiality, as employers are informed of investigation results.

43  
44 459 *“We obtain a general consent for blood STD (sexually transmitted disease) investigation as*  
45  
46 460 *our regulations, but not specifically for HIV. If found positive, we need to call the worker and*  
47  
48 461 *the employer, as we need to explain to the employer the reason the worker needs to be sent*  
49  
50 462 *back. So, confidentiality is affected there.”* Dr Sashi, male, a doctor in private practice.  
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3 463 Others expressed concern that migrant workers are not properly informed of test results and  
4  
5 464 are uncertain of their infectious disease status even though testing is mandatory.  
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7

8 465 *“A lot of them just do not know [their status]. I think once they go through FOMEMA*  
9  
10 466 *screening, the least they can do is be made aware of the HIV status. Of course, they wouldn’t*  
11  
12 467 *be able to come in [to the country]. But it would be good for them to know, even if they are*  
13  
14 468 *being sent back - to know their HIV status.”* John, male, an academic.  
15  
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17

18 469 The implication is that workers were only informed of HIV test results in terms of pass or  
19  
20 470 fail, and are not given detailed results, or post-test counselling.  
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### 23 471 Financial and language barriers to healthcare

24 472 Healthcare costs are a major barrier for migrant workers accessing healthcare in Malaysia.

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26 473 Participants felt that the coverage by the SPIKPA insurance is inadequate in compensating  
27  
28 474 the considerably higher fees charged to non-citizens at public hospitals and clinics.  
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31 475 Furthermore, SPIKPA does not cover outpatient treatment. Consequently, migrant workers  
32  
33 476 are likely to pay out-of-pocket for healthcare.  
34  
35

36 477 *“We migrants only have insurance for hospitalisation. When we are ill, our employers say, ‘I*  
37  
38 478 *can’t give you medicine. I won’t send you for treatment.’ Why? It costs a lot! If you want*  
39  
40 479 *medication, it’s up to you. You buy yourself.”* Yat, male, migrant worker and union organiser  
41  
42

43 480 Migrant workers prioritise sending money home to families and are less willing to spend  
44  
45 481 money on healthcare. Participants described healthcare avoidance and the use of traditional  
46  
47 482 medicine as a common practice among migrant workers.  
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49

50 483 As there are no formal interpreters in the Malaysian healthcare system, we found that the  
51  
52 484 common expectation is for migrant workers to learn the Malay language or to bring a  
53  
54 485 companion to act as an informal translator. Healthcare providers also use various methods to  
55  
56 486 communicate with patients including sign language, gestures, Google translate and others.  
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3 487 Doctors interviewed express frustration as language barriers hinder communication and  
4  
5 488 patient management.

6  
7 489 *"Those from Myanmar [have a] major barrier when it comes to communication.*

8  
9 490 *Bangladeshis pickup Malay very, very fast. They only need to work here about a year and*

10  
11 491 *then they will be able to have a full conversation with you. Whereas the Burmese, they are*

12  
13 492 *still very backward with the language. Nepalese, some of them can speak English quite well.*

14  
15 493 *The Myanmar group is very difficult. Very, very difficult. It's literally sign language and*

16  
17 494 *acting out the illness, and all sorts of things."* Dr Ram, male, a doctor in private practice

18  
19 495 This medical practitioner explained that there were notable differences faced by different

20  
21 496 migrant populations and their ability to communicate in the Malay language.

## 22 497 Health in detention

23  
24 498 Immigration offences like illegal entry and stay are criminal offences in Malaysia. Many

25  
26 499 undocumented workers are arrested and imprisoned, before being sent to immigration

27  
28 500 detention centres (immigration depots) to await deportation. To facilitate the process of

29  
30 501 deportation, embassies are contacted to issue travel documents. The duration of detention is

31  
32 502 often lengthy and dependant on the detainee's ability to finance repatriation costs, including

33  
34 503 the purchasing of flight tickets.

35  
36 504 *"[Some] embassies have allocations to help finance repatriation of their citizens in detention,*

37  
38 505 *but in a limited manner and [based] on the severity of the case. From my observation, most*

39  
40 506 *migrants have to get families to pay for tickets [...]"* Ryan, male, member of a local civil

41  
42 507 society organisation.

43  
44 508 Interviewees describe conditions at immigration detention camps as overcrowded and

45  
46 509 uncomfortable.

47  
48 510 *"I have experience of visiting a Filipino who overstayed here, in X [immigration detention*

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50 511 *centre]. I think it's not easy. They didn't have anything. They [the authorities] didn't provide*

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3 512 *bedding, even a sleeping mat. They [inmates are] just sleeping on the floor, on the cement.*

4  
5 513 *And they didn't have a toothbrush [...]. Food is okay. It is limited, but still they can eat. But*

6  
7 514 *they had bad experience. They just sleep on the cement."* Beth, female, a migrant worker

8  
9 515 *representative at a local civil society organisation.*

10  
11 516 *Others explained that healthcare services available at the camps were minimal, with only a*

12  
13 517 *paramedic stationed on-site. Detainees found to be ill are sent to public hospitals for further*

14  
15 518 *clinical management. Dr Goh, a physician who investigated conditions at an immigration*

16  
17 519 *detention centre following a major typhoid outbreak commented:*

18  
19 520 *"This lockup (depot) was designed for 750 people, however, from our investigation, we found*

20  
21 521 *out that there were almost 1,500 people are staying in that centre. There was overcrowding.*

22  
23 522 *The conditions were not at all sanitary. The initial plans for the lockup were designed for a*

24  
25 523 *cook- someone who cooks for all the inmates. But we discovered that the inmates cook for*

26  
27 524 *each other. And the food that is provided there is mostly carbohydrate-based. And a lot of*

28  
29 525 *them [detainees] do not have proper supervision in terms of medication. For example, TB*

30  
31 526 *medication. DOTS (Directly observed treatment) is not carried out as per plan. Because*

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33 527 *there is a lack of manpower."* Dr Goh, female, physician.  
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## DISCUSSION

We found that migrant health policies at destination countries were largely protectionist in nature, concerned with preventing the spread of communicable disease and the perceived excessive burden on national health systems due to in-migration.

Generally, migrants are considered at particular risk for infectious diseases like HIV, tuberculosis and malaria, due to the relatively high disease prevalence, poor socio-economic conditions and weak health systems at origin countries<sup>23 46-49</sup>. Both Malaysia and China have mandatory medical screenings for migrant workers, with pre-departure screenings at origin countries required by Malaysia, and post-arrival screenings enforced by Malaysia and Yunnan province, China<sup>38 50</sup>. Contrary to narratives about migrants being infectious disease carriers, the reality may not be so dramatic. FOMEMA reported that just 3 in 100 migrant workers tested positive for infectious diseases in recent years<sup>51</sup>. Mandatory medical screenings are part of labour migration policies that determines health status as an eligibility criterion for entry into a country and stay for employment<sup>52</sup>. This is problematic from the human rights and ethical standpoints, as mandatory testing is conducted merely for immigration selection and not to improve the individuals' health. Also, mandatory HIV testing of migrant workers contravenes with international standards for informed consent, confidentiality, counselling and referral to treatment and care services<sup>53-56</sup>. Our findings from both Yunnan province and Malaysia suggest that informed consent for HIV testing may be inadequate, as migrants were unsure of tests conducted, without access to pre- and post-test counselling.

Our findings also suggest that communicable disease control programmes in Yunnan province, China are poorly received by migrants. Linguistic and culturally appropriate public health interventions are key to acceptance and cooperation among non-citizen populations<sup>57-</sup>

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2  
3 552 <sup>59</sup>. We caution against the inadvertent negative stereotyping and stigmatisation of migrants  
4  
5 553 and suggest that public health interventions be guided by epidemiological evidence and  
6  
7 554 conducted with sensitivity. Furthermore, the lack of medical services for individuals  
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9  
10 555 diagnosed with infectious disease both in China and Malaysia, combined with the fear of  
11  
12 556 deportation may hinder initiatives promoting testing of migrants <sup>60</sup>. A more pragmatic  
13  
14 557 approach towards disease control is needed without neglecting the provision of high quality  
15  
16 558 preventive and curative care, to ensure early detection and treatment of infections for the  
17  
18 559 benefit of the individual migrant and society <sup>52 61 62</sup>.

21 560 All countries in ASEAN and China have ratified the Convention on the Elimination of All  
22  
23 561 Forms of Discrimination against Women (CEDAW), which recognises the right to sexual and  
24  
25 562 reproductive health as fundamental to women's health <sup>63</sup>. A core minimum state obligation in  
26  
27 563 fulfilling these international human rights agreements are the provision of access to quality,  
28  
29 564 affordable maternal health services that would prevent maternal mortality. Unlike Yunnan  
30  
31 565 province where maternal health services are available for non-citizens with certain  
32  
33 566 administrative requirements, immigration policies in Malaysia are a barrier to the access of  
34  
35 567 services at public facilities. The imposition of mandatory testing for pregnancy and HIV, has  
36  
37 568 been likened to a violation of the right to privacy and bodily integrity, and is an example of  
38  
39 569 conflict between immigration policy, human rights and public health <sup>64</sup>.

44 570 Highlighted in this paper are the financial, language and legal barriers to healthcare access in  
45  
46 571 destination countries. Due to escalating healthcare costs and the revelation that foreigners  
47  
48 572 were consuming a sizable portion of the national health allocation, the Malaysian government  
49  
50 573 substantially revised medical fees for non-citizens at public hospitals and clinics in 2014 <sup>41 65</sup>.

54 574 Our findings suggest that the government-mandated SPIKPA insurance for documented  
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56 575 migrants is easily breached due to high treatment costs <sup>42 43 66 67</sup>.

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3 576 Previous studies support our findings that low-skilled international migrants in China are  
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5 577 without health insurance<sup>68</sup>. Although maternal and child health services are available for  
6  
7 578 non-citizens in Yunnan province, the utilisation of this service is questionable as stringent  
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10 579 administrative requirements and out-of-pocket payments needed to finance care make  
11  
12 580 hospital delivery inaccessible. Our findings in Malaysia and China suggest that high out-of-  
13  
14 581 pocket payments and inadequate health insurance coverage are significant financial barriers  
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17 582 to access, resulting in healthcare avoidance amongst migrants.  
18  
19 583 Language discrepancies may induce psychological stress, misunderstanding of health risks  
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21 584 and medically significant communication errors impacting the quality and effectiveness of  
22  
23 585 healthcare delivery<sup>69-73</sup>. Countries like Malaysia receive migrant workers from a multitude of  
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25  
26 586 countries. Such diverse backgrounds pose a challenge to health systems in coping with  
27  
28 587 distinctive languages and cultures<sup>30</sup>. Not surprisingly, the implicit expectation of destination  
29  
30 588 country health systems, seen here with examples from Malaysia and China, is for non-  
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33 589 citizens to develop local language proficiency. We suggest that destination countries actively  
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35 590 invest in developing migrant-sensitive health systems, engaging migrant communities as  
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37 591 patient navigators and intercultural mediators, hiring professional interpreters and training  
38  
39 592 culturally competent health professionals<sup>74-76</sup>.  
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41  
42 593 Undocumented migrants are an especially vulnerable group, as they lack the legal and social  
43  
44 594 protections given to their documented counterparts. Denying healthcare to undocumented  
45  
46 595 migrants increases disparities among this already vulnerable group<sup>77</sup>. Unlike Malaysia,  
47  
48 596 China does not impose mandatory reporting between health facilities and immigration when  
49  
50 597 undocumented migrants try to use services. The requirement for health workers in Malaysia  
51  
52 598 to report non-citizens without appropriate documents<sup>78 79</sup>, is likely to have far-reaching  
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54 599 implications on public health, healthcare expenditure and clinical practice<sup>77 80</sup>.  
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3 600 Malaysia has 14 immigration centres nationwide <sup>81</sup>, while there are none in Yunnan province,  
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5 601 China. Determining who enters or stays in a country is a matter of state sovereignty.  
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7 602 However, the threat of detention as a means of deterring irregular migration is problematic <sup>82</sup>  
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10 603 <sup>83</sup>. While states have the authority to regulate migration through immigration enforcement,  
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12 604 guarantees against arbitrary detention migrants are enshrined in international human rights  
13  
14 605 instruments <sup>84-86</sup>. The adverse health effects of detention on the mental and physical health of  
15  
16 606 migrants are well catalogued <sup>87-89</sup>. Conditions in immigration detention in Malaysia, are  
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18 607 reported here and elsewhere, as overcrowded, unsanitary and with insufficient medical care  
19  
20 608 <sup>90-93</sup>, representing a major public health challenge. The Mandela Rules, or the revised UN  
21  
22 609 Standard Minimum Rules for the Treatment of Prisoners, which states the minimum  
23  
24 610 standards for detention in prisons, are also applicable to immigration detention centres <sup>94</sup> and  
25  
26 611 Malaysia should open their immigration detention centres for an independent audit to ensure  
27  
28 612 compliance with these minimum standards.  
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31 613 Low-wage migrants may return to home countries in poor health, requiring healthcare that is  
32  
33 614 unavailable or unaffordable in countries of origin. With this in mind, there are concerns  
34  
35 615 about the transferability of destination countries' social protection policies when migrants  
36  
37 616 return to countries of origin. One such scheme that will test the portability of benefits is the  
38  
39 617 recently introduced Employment Injury Scheme for Foreign Workers under the Malaysian  
40  
41 618 Social Security Organization (EI-SOCSO) which provides life-long cash payments for  
42  
43 619 permanent disablement from injury or illness arising during the course of employment <sup>95</sup>.  
44  
45 620 We suggest that origin countries consider providing health insurance for the benefit of  
46  
47 621 returning workers. One such example is the mandatory insurance coverage provided for  
48  
49 622 overseas Filipino workers by employment agencies at no cost to the worker, as legislated by  
50  
51 623 Philippines law <sup>96</sup>.  
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3 624 Improving migrant health requires commitment from both migrant-sending and receiving  
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5 625 countries, as well as bilateral and regional partnerships. Memorandum of Understandings  
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7 626 between migrant-sending and receiving countries could improve referral mechanisms to  
8  
9 627 ensure proper treatment of returnees with an infectious disease or occupational injuries.  
10  
11 628 Thailand has successful bilateral agreements with neighbouring Myanmar, allowing for  
12  
13 629 cooperation via the Nationality Verification and One Stop Service Centre regularisation  
14  
15 630 processes for migrants arriving in Thailand through irregular channels<sup>97</sup>. The example of  
16  
17 631 cross-border coordination mechanisms for migration and health as demonstrated by Thailand  
18  
19 632 and Myanmar would benefit other strategic border areas with health concerns associated with  
20  
21 633 population movement. Countries should also build on commitments made on regional  
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23 634 platforms like the 2007 ASEAN Declaration on the Protection of the Rights of Migrant  
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25 635 Workers to protect and promote the rights of migrant workers in the region<sup>98 99</sup>.  
26  
27 636 Malaysia and China are both upper-middle-income countries with advanced health systems.  
28  
29 637 However, protectionist policies lead to unequal treatment of migrant workers resulting in  
30  
31 638 poorer availability of healthcare services compared to citizens. We hope that national efforts  
32  
33 639 towards achieving Universal Health Coverage (UHC) include migrant workers, following the  
34  
35 640 concept of ‘leave no-one behind’ envisioned in the 2030 Agenda for Sustainable  
36  
37 641 Development<sup>11</sup>.  
38  
39 642 Our study has several limitations. Due to the sensitive nature of this study, we had difficulties  
40  
41 643 obtaining interviews with migrant workers. Nevertheless, we were able to triangulate study  
42  
43 644 findings by interviewing diverse key informants including representatives of civil society and  
44  
45 645 international organisations, trade unions and academia, medical doctors and government  
46  
47 646 officials. As qualitative approaches were used in this study, findings are grounded to specific  
48  
49 647 contexts and populations, and this precludes generalisation of findings. Nevertheless, the  
50  
51 648 experience gained by examining different perspectives gives us insights into health policy  
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3 649 and barriers accessing healthcare in different settings. Also, while our study focuses on health  
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5 650 in destination countries, we acknowledge that health and healthcare in origin countries and  
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7 651 during the travel and return phase of migration may impact migrant well-being, thus have  
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10 652 given some policy suggestions.  
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For peer review only

## 653 CONCLUSION

654 This study has unique contributions, as a comparative study of healthcare access and migrant  
655 health policy between China and Malaysia, two middle-income destination countries. We  
656 suggest options to mainstream the protection of migrant workers' health within national  
657 health policies to ensure that health systems are responsive to migrants' needs, as well as to  
658 strengthen bilateral and regional cooperation towards ensuring better migration management.  
659 Migration brings great benefits, fuelling socio-economic growth in migrant-sending and  
660 receiving countries. Yet, insufficient attention is paid to the health of migrant workers. The  
661 intersectional nature of healthcare and immigration policy in destination countries  
662 commodify human life, contradicting with public health needs and ethical norms. We appeal  
663 to governments to use human rights principles and national commitment towards Universal  
664 Health Coverage to guide the provision of migrant inclusive and sensitive healthcare  
665 accessible to all, for the betterment of individual and population health.

## 666 **CONTRIBUTORSHIP STATEMENTS**

667 Contributors: Both TL and DR conceptualised the study, analysed the data, managed the overall  
668 design of the study and wrote the draft. NP provided comments on the draft and critically  
669 revised content. All authors contributed to the final version of the manuscript.

## 670 **COMPETING INTERESTS**

671 The authors have declared that no competing interests exist.

## 672 **ACKNOWLEDGEMENTS**

673 This work is supported by The Atlantic Fellows for Health Equity in South East Asia based at  
674 The Equity Initiative, a program of The CMB Foundation

## 675 **FUNDING STATEMENT**

676 We are grateful for funding to conduct this research from the China Medical Board's Equity  
677 Initiative [IF055-2018]. The funders had no role in study design, data collection and analysis,  
678 decision to publish, or preparation of the manuscript.

## 679 **DATA SHARING STATEMENT**

680 All data relevant to the study are included in the article or uploaded as supplementary  
681 information.

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4 **682** **FIGURE LEGENDS**

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7 **683** **Figure 1. Migration phases framework**

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9 **684** Adapted from <sup>22</sup>

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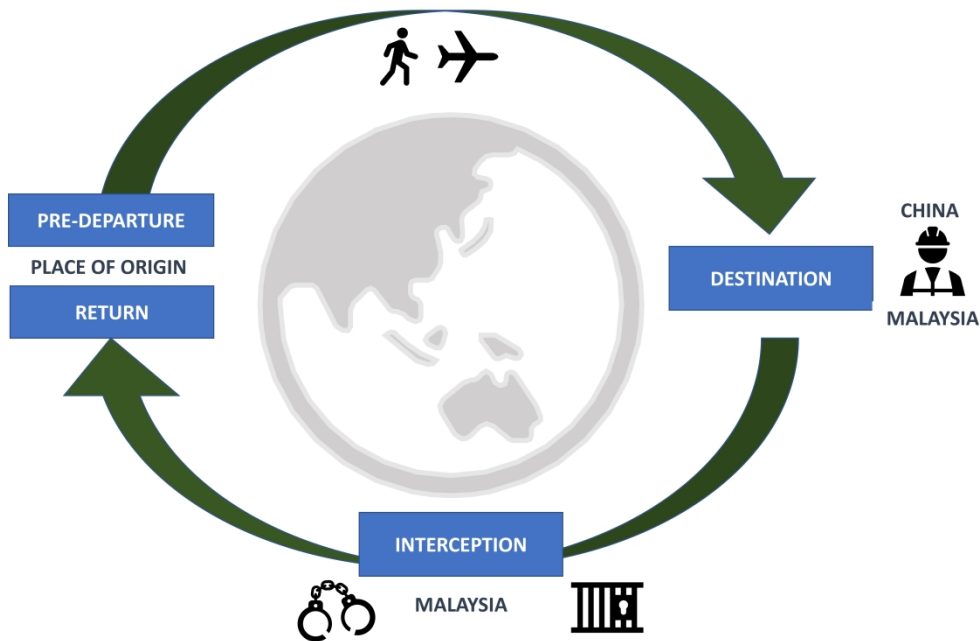


Figure 1

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**SUPPLEMENTARY FILE****Interview Guide****A. Migrant workers**

Interview topics and questions that form the broad framework of discussion with migrant workers will include:

**Topics:**

- Knowledge and perception of healthcare services available
- Experience with access to healthcare in Malaysia/China
- Experience with barriers to access to healthcare in Malaysia/China
- Experiences with employers in relation to illness or injury
- Experience with healthcare workers in regard to healthcare treatment
- Suggestion for improvement in health policy or services available for migrants

**Introductory questions:**

1. Sex (M/F)
2. Date of Birth
3. Nationality
4. Years in Malaysia/China
5. Which country did you leave to come here?
6. What do you work as? Are you employed by an individual or a company?

**Open questions:**

1. What are the most common health problems that you or your friends have faced during your stay in Malaysia/China? (examples)
2. Can you tell me where you or your friends will go for healthcare services when you are ill in Malaysia/China?
3. Can you share with me what is the healthcare experience like for migrant workers in Malaysia/China?

Prompts: How? Availability? Experience? Case studies?

4. What do you think regarding healthcare services in Malaysia/China?  
Prompts: awareness of services available for migrants, insurance schemes, and injury compensation schemes
5. What are the difficulties you or your friends have faced in accessing care?  
What are the key barriers for migrant workers in accessing care in Malaysia/China?  
Prompts: Barriers from an individual, health system, community/cultural, stigma, geographical, financial, immigration status, fear of deportation? Case studies?

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6. How do you pay for healthcare services?  
What are the financial barriers for migrant workers in accessing healthcare in Malaysia/China?  
Prompts: Are you covered by any insurance scheme? Does your employer pay your medical bills? Can you afford to seek treatment? Does seeking healthcare cause you financial hardship? Case studies?
  7. What are your experiences with your employer/employers in relation to access to healthcare for illness or injury?  
What is the experience of migrant workers with employers with regards to healthcare treatment?  
Prompts: Are employers supportive? Will pay be docked for non-attendance? Will the worker be fired? Will employer pay for healthcare? Case studies?
  8. What is your experience with healthcare workers with regards to healthcare treatment?  
Prompts: positive/negative? Are they friendly? Communication barrier? Cultural appropriateness? Stigma? Case studies?
  9. What are your suggestions for the improvement in health policy or services available for migrants in Malaysia/China?

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## B. Key Informant interviews: NGOs, representatives from government, trade unions, academia etc.

Interview topics and questions that form the broad framework of the discussion on policy protecting the health of migrants will include:

10 Topics:

- 11 • Knowledge of healthcare policy and services available in Malaysia/China
- 12 • Experience with migrant access to healthcare in Malaysia/China
- 13 • Perceptions or experience of barriers to migrant access to healthcare in
- 14 Malaysia/China
- 15 • Experiences with employers of migrants in relation to work-related illness or
- 16 injury
- 17 • Experience of migrants with healthcare workers
- 18 • Suggestion for improvement in health policy or services available for
- 19 migrants
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### 25 **Introductory questions**

26 For representatives of migrant workers communities:

- 27 1. What is your role in your community/organisation?
- 28 2. What communities or nationalities does your organisation represent?
- 29 3. What is the demographic profile of migrants in your community? (age, sex,
- 30 occupation, marital status)
- 31 4. What is immigration status of the communities that your organisation
- 32 represents? (documented/undocumented, economic migrants, refugees,
- 33 stateless people)
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### 38 **Open questions**

- 39 1. Can you tell me about healthcare policy and services available for migrant
- 40 workers in Malaysia/China?

41 Prompts: awareness of services available for migrants, insurance schemes, and

42 injury compensation schemes

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- 45 2. Could you please share the experience of migrant access to healthcare in
- 46 Malaysia/China?

47 What is the healthcare experience like for migrant workers in Malaysia/China?

48 Prompts: Where? How? Availability? Experience? Case studies?

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- 52 3. Could you please share the experience of barriers to access to healthcare of
- 53 migrant workers in Malaysia/China?

54 What are the key barriers for migrant workers in accessing care in

55 Malaysia/China?

56 Prompts: Barriers from an individual, health system, community/cultural, stigma,

57 geographical, financial, immigration status, fear of deportation? Case studies?

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4. What are the perceived barriers to access to healthcare for migrant workers in Malaysia/China  
What are the key barriers for migrant workers in accessing care in Malaysia/China?  
Prompts: Barriers from an individual, health system, community/cultural, stigma, geographical, financial, immigration status, fear of deportation? Case studies?
  5. What kind of healthcare facilities do migrants go to when they are ill?  
Prompts: Public or private? And why? Do many opt not to seek care?
  6. How do migrants pay for healthcare?  
What are the financial barriers for migrant workers in accessing healthcare in Malaysia/China?  
Prompts: Do you know migrants covered by insurance schemes? Do employers pay for medical bills? Can migrants afford to seek treatment? Does seeking healthcare cause financial hardship? Case studies?
  7. What is the migrants experience with employers when they are ill?  
What is the experience of migrant workers with employers with regards to healthcare treatment?  
Prompts: Are employers supportive? Will pay be docked for non-attendance? Will the worker be fired? Will employer pay for healthcare? Case studies?
  8. What is migrants experience with healthcare workers?  
Prompts: positive/negative? Are they friendly? Communication barrier? Cultural appropriateness? Stigma? Case studies?
  9. What are your suggestions to improve health policy and services for migrants in Malaysia/China?

# Reporting checklist for qualitative study.

Based on the SRQR guidelines.

## Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med.* 2014;89(9):1245-1251.

	Reporting Item	Page Number
<b>Title</b>		
	<a href="#">#1</a> Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	1
<b>Abstract</b>		
	<a href="#">#2</a> Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	2
<b>Introduction</b>		
Problem formulation	<a href="#">#3</a> Description and significance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement	5,9

1	Purpose or research	<a href="#">#4</a>	Purpose of the study and specific objectives or	5,9
2	question		questions	
3				
4	<b>Methods</b>			
5				
6				
7	Qualitative approach and	<a href="#">#5</a>	Qualitative approach (e.g. ethnography, grounded	8
8	research paradigm		theory, case study, phenomenology, narrative research)	
9			and guiding theory if appropriate; identifying the	
10			research paradigm (e.g. postpositivist, constructivist /	
11			interpretivist) is also recommended; rationale. The	
12			rationale should briefly discuss the justification for	
13			choosing that theory, approach, method or technique	
14			rather than other options available; the assumptions	
15			and limitations implicit in those choices and how those	
16			choices influence study conclusions and transferability.	
17			As appropriate the rationale for several items might be	
18			discussed together.	
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25				
26	Researcher characteristics	<a href="#">#6</a>	Researchers' characteristics that may influence the	9
27	and reflexivity		research, including personal attributes, qualifications /	
28			experience, relationship with participants, assumptions	
29			and / or presuppositions; potential or actual interaction	
30			between researchers' characteristics and the research	
31			questions, approach, methods, results and / or	
32			transferability	
33				
34				
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36				
37	Context	<a href="#">#7</a>	Setting / site and salient contextual factors; rationale	8,9
38				
39				
40	Sampling strategy	<a href="#">#8</a>	How and why research participants, documents, or	8
41			events were selected; criteria for deciding when no	
42			further sampling was necessary (e.g. sampling	
43			saturation); rationale	
44				
45				
46	Ethical issues pertaining to	<a href="#">#9</a>	Documentation of approval by an appropriate ethics	10
47	human subjects		review board and participant consent, or explanation for	
48			lack thereof; other confidentiality and data security	
49			issues	
50				
51				
52				
53	Data collection methods	<a href="#">#10</a>	Types of data collected; details of data collection	8,9
54			procedures including (as appropriate) start and stop	
55			dates of data collection and analysis, iterative process,	
56			triangulation of sources / methods, and modification of	
57				
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1		procedures in response to evolving study findings;	
2		rationale	
3			
4	Data collection	<a href="#">#11</a> Description of instruments (e.g. interview guides,	8,9
5	instruments and	questionnaires) and devices (e.g. audio recorders)	
6	technologies	used for data collection; if / how the instruments(s)	
7		changed over the course of the study	
8			
9			
10	Units of study	<a href="#">#12</a> Number and relevant characteristics of participants,	8,9
11		documents, or events included in the study; level of	
12		participation (could be reported in results)	
13			
14			
15			
16	Data processing	<a href="#">#13</a> Methods for processing data prior to and during	9,10
17		analysis, including transcription, data entry, data	
18		management and security, verification of data integrity,	
19		data coding, and anonymisation / deidentification of	
20		excerpts	
21			
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23			
24	Data analysis	<a href="#">#14</a> Process by which inferences, themes, etc. were	9
25		identified and developed, including the researchers	
26		involved in data analysis; usually references a specific	
27		paradigm or approach; rationale	
28			
29			
30			
31	Techniques to enhance	<a href="#">#15</a> Techniques to enhance trustworthiness and credibility	9
32	trustworthiness	of data analysis (e.g. member checking, audit trail,	
33		triangulation); rationale	
34			
35			
36	<b>Results/findings</b>		
37			
38			
39	Syntheses and	<a href="#">#16</a> Main findings (e.g. interpretations, inferences, and	11-24
40	interpretation	themes); might include development of a theory or	
41		model, or integration with prior research or theory	
42			
43			
44	Links to empirical data	<a href="#">#17</a> Evidence (e.g. quotes, field notes, text excerpts,	11-24
45		photographs) to substantiate analytic findings	
46			
47			
48	<b>Discussion</b>		
49			
50	Intergration with prior	<a href="#">#18</a> Short summary of main findings; explanation of how	25-28
51	work, implications,	findings and conclusions connect to, support, elaborate	
52	transferability and	on, or challenge conclusions of earlier scholarship;	
53	contribution(s) to the field	discussion of scope of application / generalizability;	
54		identification of unique contributions(s) to scholarship in	
55		a discipline or field	
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1	Limitations	<a href="#">#19</a>	Trustworthiness and limitations of findings	29
2				
3	<b>Other</b>			
4				
5				
6	Conflicts of interest	<a href="#">#20</a>	Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	31
7				
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10				
11	Funding	<a href="#">#21</a>	Sources of funding and other support; role of funders in data collection, interpretation and reporting	31
12				
13				

14  
15 None The SRQR checklist is distributed with permission of Wolters Kluwer © 2014 by the Association  
16 of American Medical Colleges. This checklist can be completed online using  
17 <https://www.goodreports.org/>, a tool made by the [EQUATOR Network](#) in collaboration with  
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