

Comparative Country Studies

Volume 4, Number 1 2021

Moving towards culturally competent, migrant-inclusive health systems: a comparative study of Malaysia and Thailand

Editors: Nicola Pocock, Rapeepong Suphanchaimat



Asia Pacific Observatory
on Health Systems and Policies

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World Health Organization Regional Office for South-East Asia
Moving towards culturally competent, migrant-inclusive health systems: a comparative study of Malaysia and Thailand
Comparative Country Studies. Vol-4, Number 1
ISBN 978-92-9022-830-1

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Suggested citation: Pocock N, Suphanchaimat R, editors. Moving towards culturally competent, migrant-inclusive health systems: a comparative study of Malaysia and Thailand. New Delhi: World Health Organization Regional Office for South-East Asia; 2021.

Cataloguing-in-publication (CIP) data. CIP data are available at <http://apps.who.int/iris/>.

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Acknowledgements

We gratefully acknowledge funding support from the Asia Pacific Observatory on Health Systems Research and Policies (all chapters), China Medical Board's Equity Initiative (Chapter 3), and the Health System Research Institute, Ministry of Public Health, Thailand, Raks Thai Foundation and the World Vision Foundation in Thailand (Chapter 5).

We are thankful for advice and comments from Dr Nima Asgari-Jirhandeh, APO's Director; Dr Anns Isaac, APO's Technical Officer; and Professors Shenglan Tang and Lijing Yan of Duke Kunshan University, China, on the draft version of this report. We would also like to thank the two anonymous peer-reviewers for their feedback on the draft report.

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Abbreviations

B4G	Back for Good
CSMBS	Civil Servant Medical Benefit Scheme
CSO	civil society organization
GP	general practitioner
HICS	Health Insurance Card Scheme
IHPP	International Health Policy Programme
LC	migrant language coordinator
LMICs	low- and middle-income countries
MHV	migrant health volunteer
MHW	migrant health worker
MHWV	Migrant Health Workers and Volunteer programme
MoH	Ministry of Health
MoPH	Ministry of Public Health
MoU	memorandum of understanding
NGO	nongovernmental organization
NHSO	National Health Security Office
NV	nationality verification
OOP	out of pocket (payment)
OSH	occupational safety and health
OSSC	one stop service centre
PHO	provincial health office
SDGs	Sustainable Development Goals
SHI	Social Health Insurance (Scheme)
SPIKPA	Skim Perlindungan Insurans Kesihatan Pekerja Asing
SRH	sexual and reproductive health
UCS	Universal Coverage Scheme
UHC	universal health coverage
UN	United Nations
UNU-IIGH	United Nations International Institute for Global Health

Executive summary

International labour migration is set to accelerate, given the demographic trends of population ageing and inability of low- and middle-income countries (LMICs) to absorb citizens into domestic employment. Globally, there are 277 million international migrants, including 164 million labour migrants of whom around 30% are working in LMICs. The United Nations (UN) Declaration for Refugees and Migrants, and the accompanying Global Compacts on Migrants and Refugees reflect commitments to providing basic health care to migrants and countering xenophobia or racism when these affect service access. Many countries are aiming to achieve universal health coverage (UHC) by 2030 as part of the UN's Sustainable Development Goals (SDGs), and to "leave no one behind" while doing so. However, migrants are often not included when policy-makers talk about UHC. Whether health systems are equipped to deal with the increasing numbers of migrant patients is questionable, particularly in LMICs where the evidence base is lacking. Alongside how to finance migrant services, challenges include navigating language barriers and providing culturally appropriate care.

Countries belonging to the Association of Southeast Asian Nations (ASEAN) are not exempt from these global migration trends. Malaysia hosts an estimated 5.5 million documented and undocumented migrant workers, while Thailand hosts 3.9 million such workers.

This comparative study analyses the extent to which two middle-income countries, Thailand and Malaysia, have culturally competent, migrant-inclusive health systems. We focus on labour migrants as a neglected group in migration health research regionally and globally. Malaysia and Thailand were purposively selected as case studies, as they face similar challenges in providing migrant health coverage, given both countries' reliance on migrant workers and similar economic profile. However, these countries have taken different paths in their journey towards migrant-inclusive health systems. Malaysia has not implemented migrant-friendly services in policy or practice in Ministry of Health (MoH) hospitals or clinics. On the other hand, migrant-friendly services are an established

concept and practice in Thailand's Ministry of Public Health (MoPH) facilities. Thailand has created formal interpreter and migrant community educator schemes, known as the migrant health worker (MHW) and migrant health volunteer (MHV) programmes.

We use mixed methods to conduct these case studies, including qualitative interviews with key informants, systems thinking and a quantitative survey of MHWs and MHVs. In Chapter 3 of this report, we assess how service providers in Malaysia respond to migrant patients in the absence of formal institutional support in MoH facilities. In Chapter 4, we examine how Thailand's MHW and MHV programmes are being implemented, while in Chapter 5, we explore health literacy among MHWs and MHVs to inform improvements to associated training programmes for these groups. Chapter 6 offers overarching conclusions and policy options from these case studies.

Both country case studies emphasize the need to explicitly consider migrants when designing systems improvements in cultural competency. Interpreters were identified as the major cultural competency intervention in both countries. There are limits to how much informal interpreters can be relied upon in the absence of institutional health system responses, with ad-hoc service provision. Improving standards for training of interpreters, whether informal (Malaysia) or formal (Thailand), will help to prevent medical errors due to language barriers and improve care. Clarifying the roles and responsibilities of MHWs and MHVs in Thailand, as well as raising the health literacy levels of these groups are suggested, given their important roles in migrant communities. Budgetary constraints were identified in both countries, where a dedicated minimum budget line for interpreters is suggested at the central MoH level. While Thailand has some health worker guidelines and multilingual resources for health workers, MHWs and MHVs, there is an absence of such guidelines in Malaysia. For maximum relevance, cultural competency guidelines could address both the needs of migrant patients alongside domestic minority populations. Training to support health workers on how to respond to migrant patients' needs could be embedded in existing structures, either in medical and nursing school curricula or as part of continuing professional development.

Overall, we recognize that there are barriers to making health systems more migrant-inclusive, which may stem from negative public attitudes towards migrants, and policy-makers' fears of overuse of health-care services by migrants. Yet, we have no evidence from either low or middle-income countries that overuse actually occurs, and with no examples from Thailand or Malaysia identified in this report; this should be the subject of a future study.

Migrant health policies require intersectoral thinking. We hope that our findings illustrate the potential for systems thinking to be used by policy-makers as a tool to consider how the current system set-up leads to certain outcomes. Applying systems thinking in migrant health can help to identify the adverse consequences of well-intentioned policies. Overall, we hope that these findings from Thailand and Malaysia offer insights to policy-makers on how to build more culturally competent, migrant-inclusive health systems, with particular relevance for interpreter systems. By featuring two countries at different stages of development of migrant-inclusive health systems, it is clear that there is no "one size fits all" solution, and that different policy options can be considered, depending on where each country lies along the path towards truly migrant-inclusive UHC.

Chapter 1: Introduction

Nicola Poccock, Zhie Chan, Allard de Smalen, Hathairat Kosiyaporn, Rapeepong Suphanchaimat



Background

Globally, there are 277 million international migrants and 19 million refugees, including 164 million labour migrants, of whom around 30% are working in low- and middle-income countries (LMICs) (ILO, 2018). The United Nations (UN) Declaration for Refugees and Migrants, and the accompanying Global Compacts on Migrants and Refugees represent critical steps forward in countries' commitments to sharing responsibility for migrants and refugees worldwide, including basic health-care provision and countering xenophobia or racism when these affect service access (United Nations General Assembly, 2016). Achieving universal health coverage (UHC) by 2030 is an explicit target in the UN's Sustainable Development Goals (SDGs), articulated in the concept of "leaving no one behind" (Loganathan et al., 2019). While many countries claim to have achieved UHC, most do not include migrants and refugees in health coverage or reporting. Yet, evidence suggests that migrant-inclusive health systems reduce long-term health expenditure, help to tackle shortages of health- and social-care workers, boost economic growth, and promote social integration in host countries (Legido-Quigley et al., 2019). While migrants are often framed as infectious disease carriers, evidence from high-income countries suggests that the risk of transmission to host populations is generally low, and that international migrants have lower rates of mortality overall. There is much less research occurring in either low or middle-income countries on migrant health and systems responses overall (Abubakar et al., 2018).

This comparative study analyses the extent to which two middle-income countries, Thailand and Malaysia, have culturally competent, migrant-inclusive health systems. While refugees, asylum seekers and other groups of foreign citizens are resident in these countries, we focus primarily on international labour migrants, given the dearth of information available about this particular group in the regional and global evidence base (Sweileh et al., 2018).

Why Thailand and Malaysia?

Migration in countries belonging to the Association for Southeast Asian Nations (ASEAN) is set to accelerate with economic integration in the

coming years. Malaysia and Thailand, among others, are major destination countries for low-skilled migrants working mainly in construction, agriculture, manufacturing, services, and domestic work. Malaysia hosts an estimated 5.5 million documented and undocumented migrant workers, who are mostly from Indonesia, Bangladesh, Nepal and Myanmar. Thailand, on the other hand, has around 3.9 million documented and undocumented migrant workers, mainly from the neighbouring countries of Cambodia, Lao People's Democratic Republic and Myanmar (IOM, 2019; Lee and Khor, 2018). Apart from foreign labour, both countries host significant refugee populations (179 000 in Malaysia, 103 000 in Thailand), where the majority in both countries is from Myanmar (IOM, 2019; UNHCR Malaysia, 2019). In addition, Malaysia and Thailand are destination countries for human trafficking.

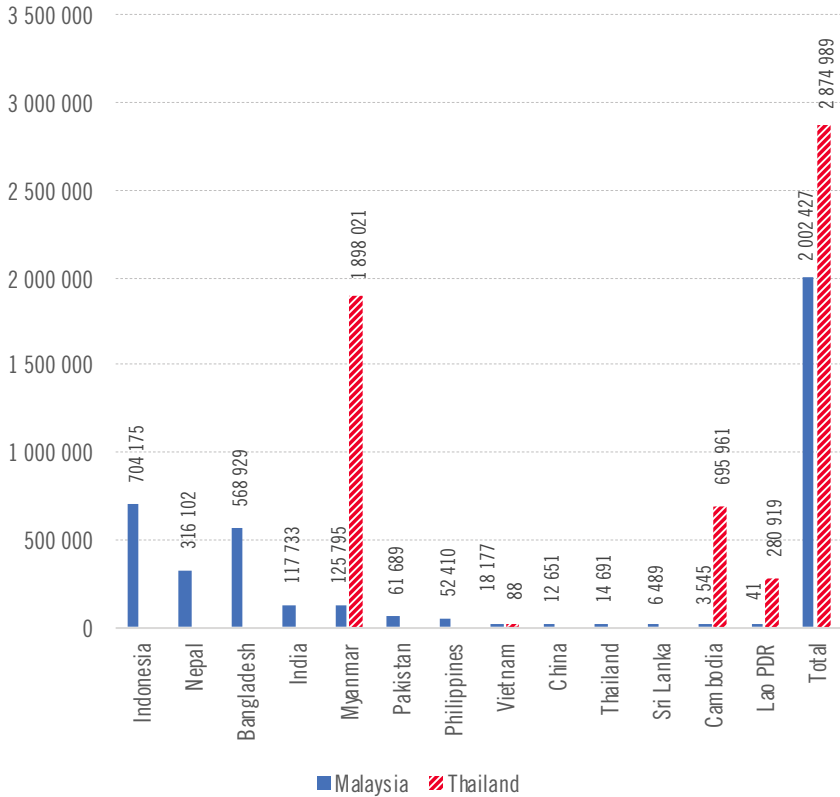
Despite large numbers of migrants in both countries, we know little about how health-care providers are responding to the challenges posed by this changing patient demographic (Suphanchaimat et al., 2015).

Documented and undocumented migrant workers: issues and trends

There were just over 2 million documented migrant workers in Thailand, and 2.8 million in Malaysia. Migrants are classified as “documented” in different ways by the destination country. Fig. 1.1 shows the numbers of documented low-skilled migrant workers in Thailand and Malaysia.

Documented workers in Thailand comprise those who have entered legally via memoranda of understanding (MoUs) with neighbouring countries, which is a fully legal channel to access job opportunities in Thailand. Migrants who have entered illegally have the option to register at one-stop service centres (OSSCs), which allows them to obtain temporary work permits and identification documents, as well as health insurance. To complete the regularization process, migrants must then undergo the nationality verification (NV) process, which involves authorization from their embassy in Thailand. While the number of migrants entering via MoUs is increasing, the number of illegal migrants who passed the NV remains relatively small, due to the complex procedures of the NV (Harkins et al., 2017). While the OSSC and NV process is the preferred

Fig. 1.1 Number of documented low-skilled migrant workers in Malaysia (2019) and Thailand (2018) by nationality



Sources: Thailand: Office of Foreign Workers Administration, Department of Employment, Ministry of Labour, Thailand (September 2019); (ILO, 2020).

Malaysia: Department of Statistics Malaysia (2020). Statistics of foreign workers in Malaysia by country of origin and industry (2019); (DOSM, 2020).

route for most migrants seeking legal status, there remain unsolved problems with the system, such as temporary work permits expiring before the NV is completed. This means that semi-regularized workers become irregular again (IOM, 2019; Suphanchaimat et al., 2017). The corresponding complication for health care is that migrants' health insurance, provided by

the Health Insurance Card Scheme (HICS) sold at OSSCs, have expiry dates and this makes some migrants risk living without insurance if they fail to repurchase the HICS (and there is no legal punishment for migrants or employers if those migrants fail to buy, or are denied the HICS). Migrants registered via the MoU (mostly engaged in the formal sector) should be enrolled in the Social Security Scheme (SSS), which includes health-care coverage that carries benefits similar to those for Thai workers.

The classification of documented workers in Malaysia is more straightforward, comprising those who have entered the country legally on official work permits. For undocumented workers in the past decade, the Malaysian government took steps to provide opportunities for regularization through the “Amnesty and Rehiring” Programme in 2011. Approximately 1.3 million undocumented workers had registered: 600 000 of whom opted to be rehired in one of the five sectors permitted under this Programme. Workers who do not want to be part of the labour force again may return home under this amnesty arrangement (Kassim, 2014).

A similar amnesty programme saw the repatriation of 840 000 undocumented migrants, between 2014 and 2018 (IOM, 2019). More recently, the Back for Good (B4G) programme introduced on July 2019 by the Home Ministry saw the repatriation of 138 901 undocumented migrants (including refugee card holders) at the end of 2019, according to the then Director-General of the Immigration Department (Kannan, 2019).

However, these efforts have not been very successful according to the Secretary-General, Ministry of Higher Education in a 2017 report (Mazlan et al., 2017). Authorities felt that they did not meet the targeted reduction in numbers of undocumented migrants living in Malaysia. Implementation issues such as the lack of effective communication between workers and employers, unreliable outsourcing of contractors, and mistrust towards the authorities have all contributed to the low registration rates of these programmes (Devadason and Meng, 2014; Harkins, 2016; Kassim, 2014). For instance, the common practice of withholding passports of migrant workers by employers or recruitment agents has led to migrants experiencing unpleasant encounters with the authorities in Malaysia (Devadason and

Meng, 2014), as they did not have the necessary documentation in their possession when they were asked to support their identity.

Health needs of migrant workers

In terms of migrant workers' health needs, research variously examines occupational health and injuries, infectious diseases, sexual and reproductive health (SRH) and mental health in both countries, with different gaps in the evidence base. A scoping review on the quality of evidence for migrant health in Malaysia found that most studies were descriptive. Over two thirds of studies focused on diseases and injuries, mainly on infectious diseases, while limited attention was paid to chronic diseases. In general, the included studies were of low quality, particularly studies with a prevalence and analytical research design (De Smalen, 2020). While a similar exercise has not been conducted for Thailand, there are a large number of studies focused on the Thai–Myanmar border, as well as on the prevalence of HIV/AIDS and infectious diseases (Suphanchaimat, 2016); however, those studies mostly focus on the clinical aspects and behavioural risks of migrants rather than addressing the health system angles in their entirety.

Malaysia and Thailand face similar challenges in providing migrant health coverage, given both countries' reliance on migrant workers and similar economic profile. However, these countries have taken different paths in their journey towards migrant-inclusive health systems, which is explored in this comparative study.

Cultural competency of health systems

Cultural competency is a broad concept that describes interventions that aim to improve the accessibility and effectiveness of health services for people from racial or ethnic minority backgrounds (Truong et al., 2014). A culturally competent health-care system is one that recognizes the importance of culture and the dynamics among stakeholders that result from cultural differences and adapt mechanisms to meet culturally unique needs (Betancourt et al., 2003).

Until now, most research on cultural competency has focused on interventions in high-income settings in western countries, with several studies conducted in the United States (US) with Hispanic, Indian and African American populations (Truong et al., 2014). Interventions have been poorly defined, with a lack of long-term outcomes, and lack of standardized assessment tools to measure cultural competency, which is partly due to the lack of consensus on the definition of cultural competency (Anderson et al., 2003; Truong et al., 2014).

In Thailand, studies conducted to date have mostly been observational and not specific to the multicultural aspect of health services for migrant populations (Noparatayaporn et al., 2017; Oatme and Kruachottikul, 2017; Songwathana and Siriphan, 2015). While one study describes the benefits and challenges of implementing a migrant health volunteer (MHV) programme in two provinces in Thailand (Sirilak et al., 2013), a more systematic evaluation of the programme is needed. In Malaysia, recent studies using clinic-based surveys examined the health profiles of migrants, but did not look into health workers' response to migrants, nor did they assess system features that encourage or discourage health-care seeking among migrants (Ab Rahman et al., 2016; Noh et al., 2016). Furthermore, only one paper examines the multicultural counselling experience in the domestic population (Jaladin, 2013). There is also a gap in research around interpreter services for migrants globally, with most research conducted in health settings (Berthold and Fischman, 2014; Sirilak et al., 2013). In Thailand and Malaysia, there are no dedicated studies on how interpreter services are being provided, despite interpretation being a core element of a culturally competent health system (Betancourt et al., 2003).

Anecdotally, migrants in both countries have reported discrimination by health-care providers (Pocock et al., 2017; Suphanchaimat, 2016). Refugees also face similar difficulties in accessing the health system. In Malaysia, for example, refugees report being charged even higher fees than the specified foreigner fees by public providers, which is linked to provider discrimination (Reynolds and Hollingsworth, 2015). It is well known that both undocumented migrants and those with work permits may avoid seeking care for fear of arrest or deportation, or they may internalize exclusionary arguments that they are "undeserving" (Mang, 2016; Willen,

2012), which usually leads to high rates of self-treatment or use of private clinics (Aung et al., 2009; Naing et al., 2012). Notably, discrimination and extortion by other authorities (e.g. police, immigration officials) is another significant source of stress for migrant workers, which further discourages them from seeking health care (Harrigan et al., 2017). In Malaysia, stress levels among migrant workers were significantly associated with discrimination (Noor and Shaker, 2017).

Positive public attitudes towards migrant workers in both countries appear to be declining. In a recent public opinion poll, 77% of Thais and 83% of Malaysians attributed crime rates to migration, despite evidence to the contrary. Furthermore, 56% of Malaysians and 51% of Thais believed that migrant workers should not receive the same pay and benefits as locals (ILO, 2019:28). Wider perceptions of migrant workers matter, as public attitudes undoubtedly inform policy-makers' decisions around health and social inclusion of migrant workers.

Language, nationality and gender, and accompanying cultural practices, are important to consider for cultural competency. As shown in Fig. 1.1, the majority of migrant workers in Thailand come from the neighbouring country of Myanmar, followed by Cambodia. Malaysia's migrant profile is much more diverse, with workers primarily hailing from Indonesia, Bangladesh and Nepal. Linguistically, Lao migrants in Thailand and Indonesian migrants in Malaysia share similar languages. Gender is another consideration for cultural competency. Among documented migrant workers in Thailand, 44% are women, compared to just 18% of documented migrants in Malaysia (DOSM, 2020; ILO, 2020).

Current status of migrant-inclusive health systems

Migrant-inclusive health systems, known as migrant-friendly services, have been implemented in many countries as a means to improve migrants' access to quality health services (Bischoff et al., 2009). Interpretation services are a key component of migrant-friendly services, as they reduce language and cultural barriers between health personnel and migrants (Integration up North, 2015; Novak-Zezula et al., 2005). Interpreters are classified into two types: formal and informal interpreters. Formal interpreters are specially trained for the job function, particularly on the

technicalities of interpretation and cultural sensitivities, and undertake ethical considerations; while informal interpreters are usually ad-hoc interpreters who are family members, relatives or friends with knowledge of the language, or bilingual health staff who have other main duties (Hadziabdic and Hjelm, 2013).

Malaysia has not implemented migrant-friendly services in policy or practice in MoH hospitals or clinics. However, migrant-friendly services are an established concept in Thailand, stemming up from collaboration between the Ministry of Public Health (MoPH) and nongovernmental organizations (NGOs) since 2003 (Jitthai, 2009).

Thailand's MoPH has tried to increase access to the health system by providing specific migrant health insurance with a comprehensive benefits package (Ministry of Public Health of Thailand, 2019). However, language barriers are key constraints in providing health services, prompting the creation of a migrant health worker (MHW) and MHV programme in Thailand (Jitthai, 2009). MHWs are formal interpreters hired by public health facilities or NGOs, while MHVs are those who do not receive remuneration and are not directly assigned for interpretation. The roles of MHWs and MHVs have expanded beyond the interpretation scope to being health assistants for health staff and health educators in health facilities or communities (Jitthai, 2009).

Health-care financing in Thailand and Malaysia

Health care is financed differently in both countries. Thailand achieved UHC in 2002 via three main insurance schemes: the Civil Servant Medical Benefit Scheme (CSMBS) for government employees and their dependents; the Social Health Insurance Scheme (SHI) for private sector employees; and the Universal Coverage Scheme (UCS) for the remaining citizens. The three insurance schemes are managed by the Ministry of Finance, Ministry of Labour and the National Health Security Office (NHSO), respectively, i.e. there is a purchaser-provider split, with services provided by the MoPH. Funding for CSMBS and SHI is premium based, while UCS is financed completely by the government. Private health insurance enrolment is very

low, paid for on a voluntary basis on top of the three main insurance schemes for citizens (Jongudomsuk et al., 2015; Patcharanarumol et al., 2018).

In contrast, Malaysia's public health-care system is financed mainly through general revenues and direct and indirect taxation collected by the federal government. Funds are allocated by the Treasury to the MoH based on past spending and any additional increments based on the Consumer Price Index, or additional funding during times of need, including disease outbreaks. Private health care is funded through private insurance and out-of-pocket (OOP) payments. Publicly provided health care is available to the entire population, with very low user charges for citizens and higher fees for foreign patients (including migrant workers). In practice, long waiting times and understaffed public facilities have increased demand for private health services and insurance in recent years (Jaafar et al., 2013).

Arguably, without full inclusion of all migrant workers in health coverage (to a much greater degree in Malaysia relative to Thailand, where migrant inclusion is more explicit in policy), countries cannot claim to have achieved UHC (Guinto et al., 2015).

Health-care financing for migrant workers

Health-care financing systems for migrants differ in both countries. In Thailand, migrants (including undocumented migrants) can enrol in migrant-specific HICS public health insurance schemes with comprehensive benefits packages operated by the MoPH (Suphanchaimat, 2016; Suphanchaimat et al., 2017). The HICS premiums are distributed to the MoPH centrally, provincial health offices and the actual hospitals where the HICS insurance is sold, which receive most of the premiums (approximately 57% of the total premium) (Prakongsai, 2017). The NHSO is not involved in the HICS. While the HICS has improved migrant workers' access to services and reduced OOP payments, outpatient utilization rates have remained low. Migrants primarily used it for inpatient services, which meant that there were high self-treatment rates and many delayed seeking care (Srithamrongsawat et al., 2009; Suphanchaimat, 2016; Tharathep et al., 2013).

In Malaysia, migrant workers are required by the MoH to enrol in a private insurance scheme; the Hospitalization and Surgical Scheme for Foreign Workers or Skim Perlindungan Insurans Kesihatan Pekerja Asing (SPIKPA). However, the total coverage amount is low (20 000 Malaysian ringgit/ US\$ 4741) relative to foreigner fees charged in public hospitals (which saw 100% increases in 2016, linked to MoH budget constraints), and only documented migrants can enrol in the scheme (Guinto et al., 2015; Hospital Kuala Lumpur, 2020). A survey of migrant workers using hospitals in Kuala Lumpur found that 79% of migrants made OOP payments for health treatments (Noh et al., 2016), with 87% of Bangladeshi migrants in another study not receiving any financial support from employers for treatment (H. M. Zehadul Karim and Mohamad Diah, 2015).

Both countries have pursued very different models of health-care financing for migrant workers. Thailand has implemented HICS- a social health insurance model, through the MoPH. Malaysia has implemented mandated private health insurance for migrant workers (SPIKPA) through 25 private insurance providers. There are some positive impacts from the HICS on migrant health service use, and a growing evidence base on migrant health financing (Suphanchaimat et al., 2017; Suphanchaimat, Kunpeuk, et al., 2019; Suphanchaimat, Pudpong, et al., 2019), including a private community-based fund endorsed by the Thai MoPH (Pudpong et al., 2019). In Malaysia, there is no similar assessment of the impact of SPIKPA on migrant health service use or other outcomes.

While there is emerging literature documenting migrant and refugee health needs in both countries (Ab Rahman et al., 2016; Chimbanrai et al., 2008; Naing et al., 2012; Pocock et al., 2017; Verghis, 2013), little is known about provider strategies to accommodate the needs of these groups. In addition, data are also lacking on whether and how policies promote communication and understanding, notably interpreter systems. Therefore, there is an urgent need for wider understanding about how to make health systems more migrant-inclusive in Asian countries, in pursuit of leaving no one behind in the UN SDGs.

The next chapter describes the objectives of this comparative study, conceptual framework that informed the study focus, and elaborates on the mixed methods used to generate the findings.

Chapter 2: Methods

Nicola Pocock, Tharani Loganathan, Hathairat Kosiyaporn, Rapeepong Suphanchaimat



Objectives

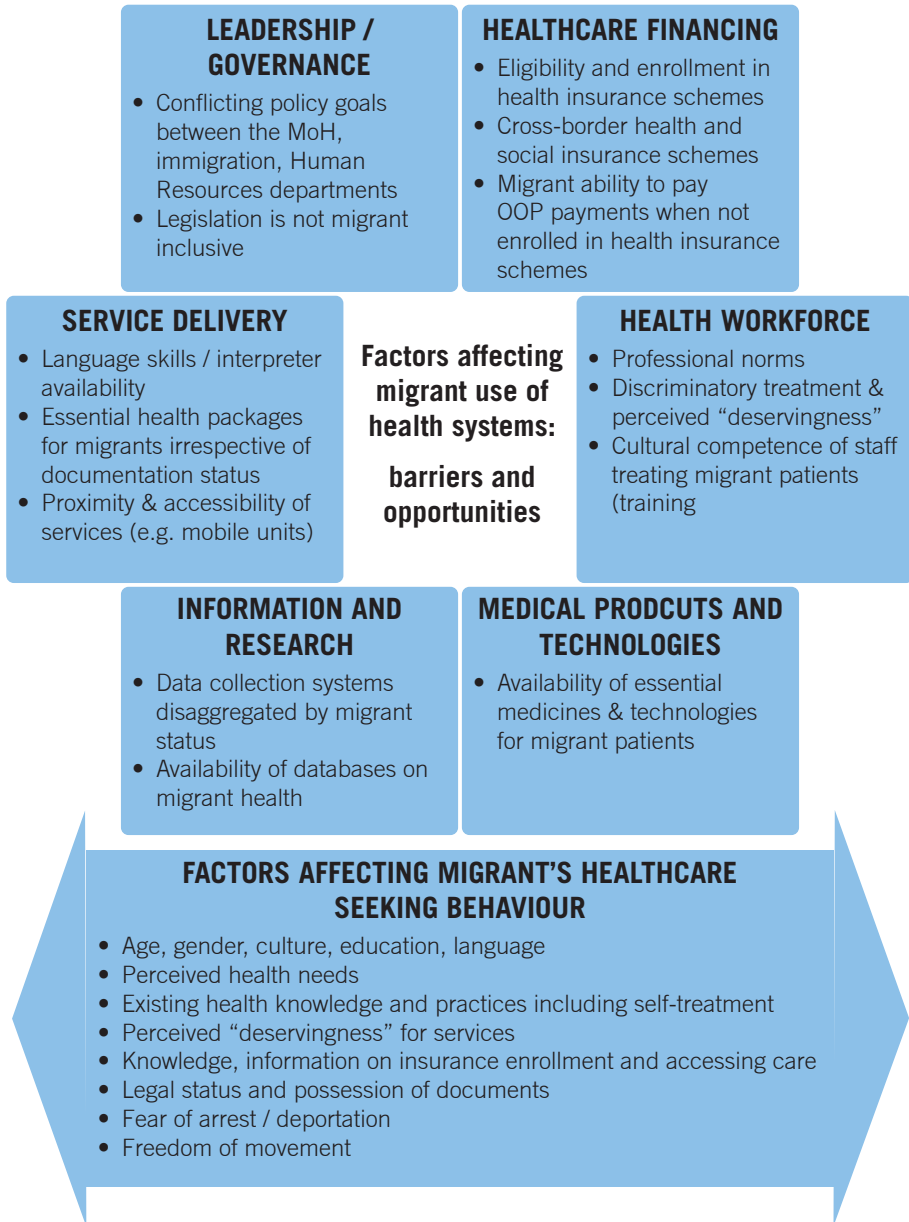
This study explored the cultural competence of health systems for migrant service use in Malaysia and Thailand. The objectives were:

- A. to describe the challenges and barriers to developing a culturally competent health system in Malaysia, using systems thinking, with reference to Thailand;
- B. to examine systems-level factors affecting implementation of interpreter services in Thailand;
- C. to analyse the determinants of health literacy among MHWs and MHVs in Thailand;
- D. to identify policy options for migrant-inclusive health systems in both countries.

Conceptual framework

Several factors inhibit or encourage the use of health systems by migrants (Fig. 2.1). For service delivery, the language skills of health workers, and availability and competency of interpreters are important. Professional norms among the health workforce, including the perception of whether or not migrant patients deserve the services, affect the propensity of migrants to use services. Migrants' health-care-seeking behaviour may be further influenced by their knowledge of how to access services, and internalized feelings of whether they deserve to use the services, which is often linked to their legal and document status, and fear of arrest among undocumented migrants (particularly when there are mandatory immigration reporting requirements in health facilities, as is the case in Malaysia).

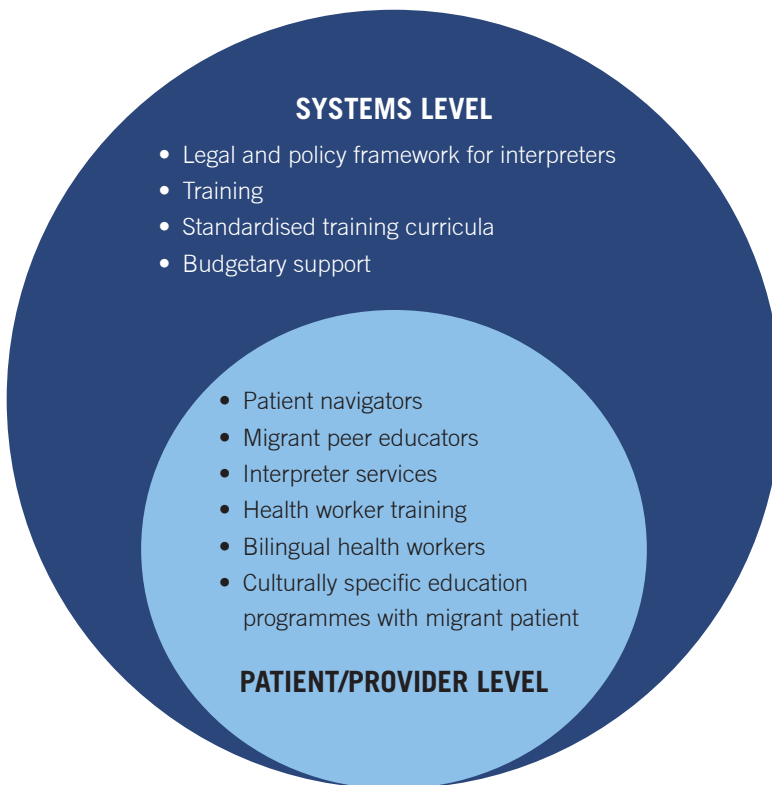
Fig. 2.1 Factors affecting migrant use of health systems: barriers and opportunities



Source: Legido-Quigley et al. 2019

This report examines cultural competency in the context of migrant-friendly services with a particular focus on interventions at the provider and patient levels (Fig. 2.2). Interventions may include interpreter services, migrant peer educators or patient navigators, health worker training on providing culturally appropriate care for migrants, and culturally specific/tailored education programmes with migrant patients.

Fig. 2.2. Conceptual framework for the cultural competency of health systems to enhance service use by migrants



Source: conceived by study authors

In qualitative work in Malaysia, we narrowed the focus to the provider and patient levels, especially how interpretation services with migrants were being conducted and how health care was financed for both documented and undocumented migrants.

In qualitative work in Thailand, we explored how the migrant health worker and volunteer (MHWV) programme was being managed in primary and secondary care facilities in selected provinces, with a focus on systems-level factors (Fig. 2.2). We included a quantitative survey component to explore specifically the determinants of MHW and MHW health literacy as the critical link between providers and patients.

For the conceptual part of this project, we used systems thinking to scope what a culturally competent, migrant-friendly health system may look like in both contexts, including systems features beyond provider/patient level to examine, for example, where cultural competence in serving migrant patients is integrated in MoH policies and hospital procedures.

Mixed methods approach

This project considered both documented and undocumented migrants who may use services in these two countries. We used mixed methods, which differed by country, given the different trajectories towards migrant-inclusive health systems in Thailand and Malaysia. Currently, the Malaysian health system has no formal provision for cultural competency compared to Thailand, whereas the latter has a semi-formalized migrant interpreter system in place. Thailand's public migrant health insurance is provided directly by MoPH hospitals, while private migrant health insurance in Malaysia is provided by 25 different insurers under the oversight of the MoH. Given these differences, we opted for separate country case studies in Chapters 3, 4 and 5 (with reference to the corresponding country), with a more comparative element in Chapter 6.

Qualitative methods

Given that the research aim and objectives were primarily geared towards describing the "how" of the functioning of migrant-inclusive health systems, including challenges and barriers, we opted for qualitative methods to attain objectives A, B and D.

In Malaysia, 37 interviews were conducted with a total of 44 policy and civil society organizations (CSOs), industry stakeholders and health workers in the Klang Valley (Table 2.1) between April 2018 and August

2019. Participants were sampled purposively from an initial sample frame obtained from a previous migrant health stakeholder workshop (Pocock et al., 2018). Further snowballing from existing participants and LinkedIn facilitated recruitment of additional stakeholders involved in migrant health.

In Thailand, a total of 50 interviews with health workers, NGOs, policy stakeholders, MHVs and MHWs were conducted in two provinces between November 2018 and April 2019. Provinces A and B were purposively selected (the real name of provinces is blinded to protect the participants' confidentiality) as they are among the topmost highly migrant-populated provinces in Thailand. In each province, the headquarters district (Amphoe Muang) was used as the study site because it was the most densely populated with migrants. Participants were recruited purposively from stakeholders involved in migrant-interpreting services in the two provinces, representing the central and border areas of Thailand, and policy stakeholders in the MoPH. For MHWs and MHVs, working areas and years of work experience were used as selection criteria. For other key informants, snowball sampling was employed. Informed consent was sought and obtained from participants in both countries to participate in interviews.

Table 2.1 Participant characteristics for qualitative interviews in Malaysia and Thailand

Code*	Participants' background	Malaysia	Thailand
		N	N
AC	Academia	3	-
CSO	Civil society organization	11	4
IND	Industry	5	-
IO	International organization	4	-
HP	Health professional	12	18
MW	Migrant worker	4	-
POL	Policy stakeholders	2	7
TU	Trade union	3	-
MHV	Migrant health volunteer	-	9
MHW	Migrant health worker	-	12
Total		44	50

*M = Malaysia, T = Thailand before codes in the results section

Semi-structured interview guides were developed by the research team. Questions were tailored according to the organizational and professional background of participants (e.g. by frontline health workers, policy-makers, CSOs, etc.). Interviews were primarily conducted by a team of medical doctors and academic researchers in both countries. Interviewers could be perceived as trusted authority figures, particularly with migrant workers, MHWs and MHVs. To lessen potential power imbalances between researchers and participants, the majority of interviews were conducted in locations and at times of the participants' choosing as well as in a space where they felt comfortable. We emphasized that anonymity and confidentiality would be maintained in reporting the study. Migrant participants especially were assured that they could refuse to answer questions or to end the interview at any time.

Interviews were transcribed verbatim and analysed in the native languages by the multilingual research team. Audio files and electronic transcripts were stored on secure servers, and transcripts were stored securely in locked cupboards in the researchers' offices. In Malaysia, all except five interviews were conducted in English, while interviews with MHWs and MHVs in Thailand were conducted in Thai. Following the analysis in both countries, selected quotes were translated to English for presentation in this manuscript and accompanying papers.

Relevant policy documents, including circulars, memos, guidelines and regulations, were collected to contextualize the interview findings in both countries. Thematic analysis of interview transcripts was conducted in Dedoose and NVivo qualitative analysis software and Microsoft Excel across the research team. Qualitative findings informed the development of systems thinking diagrams for objective A, which were conceptualized after discussions among the research team and drawn using the VennSim software. Participant diversity gave rise to different perspectives on the same issue, which were reflected in the systems-thinking diagrams in Chapters 3 and 4.

Systems-thinking diagrams

A systems-thinking approach enables understanding of interrelationships, interactions and various perspectives of a system, including reflecting on

the system's boundaries. Systems reflect dynamic, often unpredictable, interactions among diverse, constantly adapting parts that continually change in relation to each other and the collective environment (Rusoja et al., 2018). These relationships can be represented via causal loop diagrams, which use reinforcing loops (representing feedback loops that accelerate change) and balancing loops (representing feedback loops that resist change) to generate systems maps. This approach helps planners to understand possible leverage points for policy, feedback loops and adverse effects of policy change (Pocock et al., 2020).

This study used qualitative data to inform systems-thinking diagrams for each country, which are at very different stages of development of migrant-friendly health systems, with varying local contextual complexity. Therefore, systems-thinking diagrams are presented separately for Malaysia and Thailand, in Chapters 3 and 4, respectively.

Quantitative methods

Quantitative methods were more suitable for objective C, as it described the determinants of health literacy among MHWs and MHVs, and was conducted only in Thailand, given that there was no similar intervention in Malaysia. Data were collected between December 2018 and April 2019 in the same two provinces where qualitative data were collected.

Following sample size calculations, 120 MHWs/MHVs were needed, however, due to the limited number of active MHWs and MHVs in the two selected provinces, all active and reachable MHWs and MHVs, totalling 118 were recruited. Owing to the key role in operating the MHV programme, MHVs under public provision were recruited in province A while those under NGO provision were recruited in province B. We then recruited 116 general migrants, matching their living area approximately to the selected MHW/MHV (1:1 neighbourhood matching). The term "general migrants" in this study referred to all cross-border migrants regardless of their immigration status (either documented or undocumented), occupations and nationality, who were neither MHWs nor MHVs. A self-administered questionnaire was issued, with the assistance of interpreters for those who were illiterate.

Survey questions comprised demographic information, questions about how participants received health information, and a self-rated health literacy scale. The health literacy scale items (N=12) were adapted from previous validation studies, including in Thailand (Intarakamhang and Intarakamhang, 2017; Osborne et al., 2013). The survey was piloted among 24 migrant participants and Cronbach Alpha score (0.89) indicated high reliability of the health literacy scale used. Descriptive and inferential analyses of data were conducted in STATA 14. Table 2.2 shows participant characteristics for the quantitative study presented in Chapter 5, where more detailed sample information can be found.

Table 2.2 Participant characteristics of the quantitative study with MHWs, MHV and general migrants in Thailand

		Number of MHWs (%)	Number of MHVs (%)	Number of general migrants (%)	Total (%)
Province	A	22 (55.0)	41 (52.6)	47 (40.5)	110 (47.0)
	B	18 (45.0)	37 (47.4)	69 (59.5)	124 (53.0)
Total (%)		40 (17.1)	78 (33.3)	116 (49.6)	234 (100.0)

Ethics approval

Ethical approval to conduct this mixed methods comparative study was granted by the Medical Ethics Committee, University Malaya Medical Centre (UM.TNC2/UMREC-238), the Medical Research and Ethics Committee, Ministry of Health, Malaysia (NMRR-18-1309-42043) and the Institute for Human Research Protection, Thailand (IHRP 530/2561).

Report structure

The following chapters provide critical analysis on how culturally competent and migrant-inclusive health systems are in Malaysia and Thailand, using qualitative data, survey data and a policy document review in order to achieve the following objectives:

- A. to describe the challenges and barriers toward developing a culturally competent health system in Malaysia, using systems thinking, with reference to Thailand;

- B. to examine systems-level factors affecting implementation of interpreter services in Thailand;
- C. to analyse the determinants of health literacy among MHWs and MHVs in Thailand;
- D. to identify policy options for migrant-inclusive health systems in both countries.

Chapter 3 focuses on Malaysia and Chapters 4 and 5 focus on Thailand, with reference to the other country where useful for comparison. After reviewing all the available data collected for this report, Chapter 6 outlines policy options in both countries appropriate to their stage of migrant-inclusive health systems development. We hope that this comparative study will advance our understanding of how migrant-inclusive health systems are developing in middle income countries in Asia, which should be useful for policy-makers and practitioners in countries with similar challenges that are considering practical steps towards migrant inclusion as part of the UN SDGs.

Chapter 3. Applying systems thinking in a qualitative study in Malaysia

Nicola Pocock, Zhie Chan, Tharani Loganathan, Rapeepong Suphanchaimat, Hathairat Kosiyaporn, Pascale Allotey, Wei-Kay Chan, David Tan



This chapter describes the challenges and barriers to developing a culturally competent health system in Malaysia, using systems thinking, and comparing some aspects of Malaysia's system with Thailand. Malaysia is a step behind Thailand in migrant-inclusive health systems development and, as such, no previous studies have been conducted on the cultural competency of the use of migrant services in Malaysia. This chapter aims to illuminate the main challenges to developing a migrant-inclusive, culturally competent health system in Malaysia, including how migrants and health workers attempt to overcome these challenges. Findings are based on interviews with 44 key informants in Malaysia and 50 key informants in Thailand, across policy, CSO and industry stakeholders, as well as health workers and MHWs and MHVs in Thailand. In particular, this chapter focuses on navigating and overcoming language barriers between health workers and migrant patients.

The main themes and subthemes identified in the qualitative analysis are discussed below.

Perceptions of language ability, cultural differences and communication skills

Malay was considered an easy language to pick up by some interview informants. Migrants who had resided in Malaysia for a longer time with stronger social ties were considered more linguistically competent, but this varied by ethnic group (e.g. the Chin community had mixed less with the local community and did not speak Malay as well as the long-term Rohingya community). One health professional questioned whether focusing on migrants who were more adaptable, compared to the minority who did not learn the language or local customs, would be fruitful:

“Well, it depends on their social adaptability... they can eat the local food, they speak very fluent Malay, but there are some who don't. So, I guess I can't generalize for all migrants as well; but... there (are) always those outliers. And so, the question is: 'Do we actually focus on the outliers or those... general ones who are able to adapt?' Which are mostly the majority.” [M-HP-10]

Language barriers meant that migrant patients sometimes misunderstood the seriousness of the procedures required. Medical errors were also

described, although it was unclear whether these were always attributed to language barriers:

“I went to the clinic the other day because I had [a] fever. I told the doctor, ‘I had fever’. The doctor gave me an injection, after that I could not walk for 5 hours! After that, I went back to the clinic and confronted the doctor. He apologized and admitted he gave me the wrong medication!” [M-TU-2]

When there were no language barriers, it was easier for health workers to communicate with empathy and a good bedside manner, where they could use more descriptive words alongside non-verbal cues.

Employers, as essential mediators between migrant workers and health systems, faced varying cultural barriers when dealing with migrant employees. Employers may have positive intentions to solving problems, but sometimes responded with knee-jerk reactions to migrant workers’ behaviour that they did not understand, such as curfews in response to alcohol or drug addiction. Generally, employers and health worker participants felt that migrants should respect Malaysian culture and adapt accordingly.

Consequences of language barriers and a migrant-unfriendly health system

Language barriers led to delayed health-care-seeking among migrants and could lead to lack of informed consent for serious procedures when they did seek care:

“My friend from Ipoh worked in a plastic factory. He had an accident, and cut his finger. He told his employer: ‘I don’t want to amputate my finger!’ The doctor did not understand [or] maybe the employer told him differently. The worker could not understand the Malay language. So, the doctor amputated! [Below elbow amputation].” [M-TU-2] translated from Malay

As a result of medical errors, perceptions that doctors did not take their conditions seriously, and sometimes lack of informed consent, migrant workers might develop fear and mistrust of health workers.

Language barriers were amplified when doctors had to make more nuanced assessments of a migrant patient's mental health, which is required in the migrant health screening process. While the MoH Malaysia has developed a detailed mental health screening tool, this was considered impractical to administer with migrant patients because of the language barrier. Diagnosis via visual inspection of patients was considered sufficient by some doctors.

Systems constraints included low fees paid for the compulsory documented migrant health screening, which prevented doctors from conducting lengthy consultations that would only be prolonged if a formal interpreter was used. Selecting an interpreter outside of the home community was particularly important for mental health assessments due to the stigma around mental health help-seeking. It was difficult for informal interpreters when equivalent terms for mental health did not exist.

Strategies to overcome language barriers

Doctors in Malaysia had several ways of mitigating language barriers with migrant workers, ranging from encouraging migrant patients to bring an English- or Malay-speaking friend along to interpret, use of Google translate to sign language or gestures to try and bridge the language gap:

"Of course it's difficult if they don't bring someone to help communicate. But then we have Google translate. We just use Google translate and it's somehow working." [M-HP-4] translated partially from Malay

However, in public hospital outpatient departments, time constraints meant that doctors would rather resort to hand gestures than request friends to act as informal interpreters:

"Unless it's in a government hospital, [there's a] line up to 100 patients, you know, I don't have time to call 3 fellas [fellows] to come and do your interview! I already understand you, from what you are telling me, you know, maybe we can even say, you know. Yeah, [it's] cough [or] running nose." [M-HP-5] [Participant demonstrates hand gestures]

In Thailand, there was much less confidence expressed in health workers' ability to overcome language barriers without interpreters, via gestures or

otherwise. Weekend courses on the Burmese language were provided by the Provincial Health Office to health workers, but time constraints and difficulty in mastering Burmese accents did not encourage health workers to join.

Among employers, strategies to overcome language barriers included allocating less hazardous tasks to migrant workers (mitigating the need for training on occupational safety and health (OSH) risks in their language). Estate hospital assistants in plantations, mandated by law, provided some OSH training but it was unclear whether and how these were translated to migrant languages.

Challenges and barriers to improving cultural competency

Informal interpreter systems in Malaysia consisted of community members who may be refugees, asylum-seekers or migrant workers acting as interpreters in CSO clinics. Professional training of informal interpreters, including training on ethics and patient consent, as well as standard working hours, should be a priority according to the participants interviewed. However, it was difficult to hire informal interpreters, who were often paid via volunteer stipends, due to legislation prohibiting refugee- and asylum-seeker employment. The Malaysian MoH has no formal provision to finance interpreter systems in public facilities. In Thailand, a semi-formalized system was in place to directly employ MHWs as contract staff in public hospitals. MHWs interviewed were keen to expand beyond the interpreter role, to clinical skills and preventive care, but some health workers were not keen on this idea.

Real and perceived systems constraints to improve cultural competency included fears that making the system more easily accessible to migrants via interpreters would encourage further use of an already stretched health system. Existing health-care challenges in Malaysia, namely budget constraints, meant that migrants had less priority in health policy discussions nationally. In Malaysia, there were no MoH guidelines on cultural competency, while in Thailand, an MoPH-sponsored medical terminology guide for the main migrant languages was well-known among health workers.

Generally, doctor–patient interactions and cultural competency were perceived to be something that doctors learnt on the job and was not formally included in medical school curricula. Table 3.1. summarizes the main themes and subthemes from the qualitative analysis.

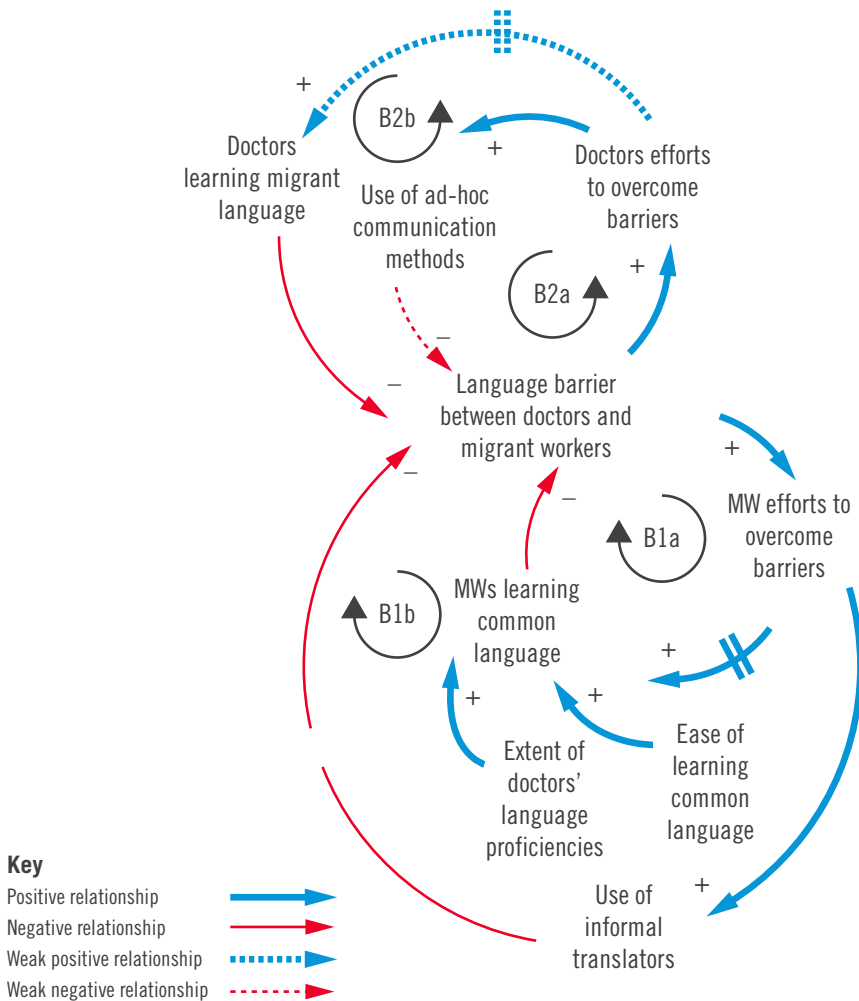
Table 3.1 Summary of findings in Malaysia

Theme/subtheme	Description of themes
Perceptions of language ability, cultural differences and communication skills	
<ul style="list-style-type: none"> • Language ability of migrant workers • Health workers' language ability and patient communication skills • Employer perceptions of cultural differences with migrant workers 	<ul style="list-style-type: none"> • Language barriers mean migrants receive suboptimal services • Doctors have low English proficiency and poor bedside manner due to language barriers • Cultural misunderstandings lead to conflict with migrant employees, affecting health
Consequences of language barriers and a migrant-unfriendly health system	
<ul style="list-style-type: none"> • Informed consent and medical errors • Mental health assessments 	<ul style="list-style-type: none"> • Language barriers can lead to lack of informed consent and medical errors • Assessing mental health is especially difficult in the face of language barriers
Strategies to overcome language barriers	
<ul style="list-style-type: none"> • Health worker strategies • Employer strategies 	<ul style="list-style-type: none"> • Use Google translate and sign language, ask migrant patients if a friend can interpret • Assign less hazardous tasks that require simpler linguistic explanation; use migrant peer liaisons in plantations
Challenges and barriers to improving cultural competency	
<ul style="list-style-type: none"> • Informal interpreter systems at CSO clinics • “Opening the floodgates” and domestic priorities • Availability of guidelines on cultural competency of health workers 	<ul style="list-style-type: none"> • Professional training of interpreters, further training in ethics and informed consent is needed • Perception that migrants will overuse services if system is migrant-friendly • MoH guidelines are not available, cultural competency is not included in medical and nursing school curricula

Visualizing interactions that surround the language barrier system in Malaysia

Based on the qualitative analysis findings from Malaysia, migrant and doctor pathways to address language barriers, which inhibit cultural competency in a health system, are presented in the causal loop diagram below:

Fig. 3.1 Interventions to mitigate language barriers between migrant patients and health workers in Malaysia

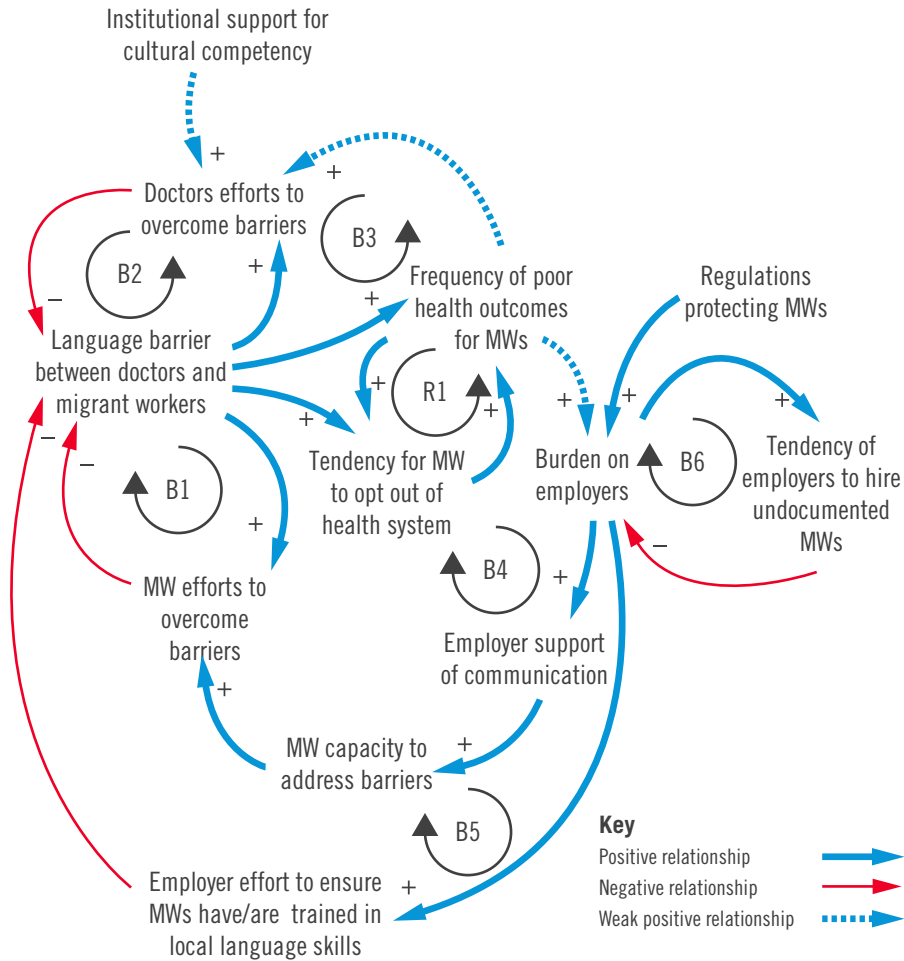


Double-barred arrows represent delays in response and dotted arrows show weak linkages. Positive relationships between variables are depicted via blue arrows, and negative relationships in red arrows. The availability of one pathway may create the perception that alternative pathways are unnecessary, as seen in perceptions that it is the responsibility of migrants to learn the local language whereas the health system should allocate limited resources to the majority. The fact that many migrants do become conversant in Malay (B1a) and that migrant workers and their employers are often able to provide informal translators (B1b) reinforces this perspective. However, this overlooks the differences between different migrant groups and the varying barriers they face in overcoming linguistic and cultural barriers (Pocock et al., 2020).

Migrants becoming conversant in Malay and the presence of informal interpreters also neglects the delays in learning a common language (B1a), which creates a period of vulnerability for migrants. Similarly, if doctors think their ad-hoc communication methods of gestures and Google translate is sufficient (B2a), they may be less motivated to learn migrant languages (B2b). Based on these findings, doctors are unlikely to learn migrant languages, and even when they attempt to, there is a delay, given the length of time required to acquire sufficient proficiency for effective clinical communication. These ad-hoc communication methods are typically all that doctors have the capacity for and are sensible adaptive behaviours at the individual level; however, reliance on these methods masks the need for systemic solutions (Pocock et al., 2020).

Fig. 3.2 shows a larger system surrounding the language barriers in medical care and includes a third group, employers. Employers may not have an incentive to support migrants with language interventions, as they may fear that fluent migrants will leave to seek better paid or more skilled work than they are currently undertaking.

Fig. 3.2 Systems interactions between health workers, migrant workers and employers in Malaysia



Migrant workers have the greatest incentive to overcome language barriers (B1), but also have the most limited agency among the three groups. While some are able to, many others are not. Some may even choose to opt out of the health system in response to real or perceived problems in health care and health outcomes (R1), to the detriment of their health and increasing the likelihood of complications in treatment when they do eventually

enter the health system. This, together with the language barriers, further undermines migrant trust in the health system (Pocock et al., 2020).

Doctors have little institutional support for cultural competency and many competing responsibilities, making B2 a largely unresponsive feedback loop. Indeed, the ad-hoc communication methods described above are typically the limit of doctors' adaptive measures in the absence of strong system incentives and supports for learning migrant languages. There is a lack of health system efforts to document evidence on language competencies and health outcomes; in the absence of data and feedback to doctors, existing poor health outcomes for migrant workers are unlikely to change doctors' efforts to acquire language competency (B3) (Pocock et al., 2020).

Overall, this chapter has described how health workers, migrants and employers overcome language and cultural barriers in a health system, focused on findings from Malaysia. In the next chapter, we explore the Thai case in further detail.

Chapter 4. Situation analysis of interpretation services under migrant-friendly service policies: a case study of Thailand

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Watinee Kunpeuk, Nareerut Pudpong, Pascale Allotey, Zhie Chan, Tharani Loganathan,
Nicola Pocock, Rapeepong Suphanchaimat



This chapter examines systems-level factors affecting implementation of interpreter services in Thailand. Previous studies examining overall migrant health services, including the MHW and MHV programmes, showed that there were various constraints: small numbers of MHWs and MHVs; limitations in interpretation skills, lack of training and supervision, and lack of budgetary support (Sirilak et al., 2013; Chungsiwapornpong W and Vanpetch Y., 2016). However, no studies have specifically examined the operational constraints and challenges of the MHW and MHV programmes in Thailand. Based on 50 key informant interviews with MHWs, MHVs, health professionals, NGO staff and policy stakeholders, this chapter aims to describe how these interpretation services are being implemented as part of migrant-friendly services in Thailand.

The main themes and subthemes identified in the qualitative analysis are summarized in Table 4.1 and further discussed below.

Table 4.1 Summary of the main themes and subthemes from the qualitative analysis in Thailand

Theme/subtheme	Description of themes
Evolving organization of interpretation services	<ul style="list-style-type: none"> From NGO pilot to MoPH support with training, guidelines for MHW/MHV programmes
Differentiation between MHW and MHV roles	<ul style="list-style-type: none"> Roles and responsibilities sometimes overlap, require clarity for planning and training purposes
Supporting systems in need <ul style="list-style-type: none"> Budget constraints Non-standardized curricula and training methods for interpreter services Lack of interagency coordination and legal mandate for interpretation 	<ul style="list-style-type: none"> Funding for MHWs/MHVs comes from varying HICS revenues at hospital level, no central budget Curricula adapted to the local context, NGOs have own curricula, no monitoring or quality assurance for MHW/MHV training Oversight of MHW/MHV programmes is unclear, poor coordination between involved agencies, MHW/MHV programmes exist only in policy, not legislation

Evolving organization of interpretation services

Interpreter services have gradually evolved in Thailand since 1995, when frontline NGO workers were primarily responsible for interpretation on an

ad-hoc basis as MHVs. Starting in 2003 with international donor support under MoPH auspices, the “Migrant Health Programme Model” was implemented in six provinces, whereby MHWs could now be employed. Following the withdrawal of donor financial support in 2008, local NGOs and the MoPH continued the programme, with MoPH support consisting of training materials, guidelines, and some limited funding to local NGOs to continue with MHV and MHW programme implementation. While MHVs were recognized as interpreters early on, their role has broadened to include being health educators in communities, whereas for MHWs in public facilities, interpretation remains the core function alongside basic medical tasks such as taking blood pressure. An MHV’s job is entirely voluntary and unpaid compared with MHWs, who receive payment from public authorities and NGOs.

The legal framework for hiring migrants in public facilities has evolved. According to the 2008 Alien Work Act, migrants could not work in health facilities, unless they were hired as cleaners or labourers by the employing hospital. In late 2016, the government amended the law, permitting migrants to be hired as migrant language coordinators (LCs) in the different government ministries. According to the legal amendment, Thais who can communicate in the Khmer, Laotian and Burmese languages can also be employed as LCs. An important selection criterion for LCs was that they participate in training programmes approved by the Department of Employment, Ministry of Labour. Priority in hiring Thai citizens means that hiring migrants as LCs is possible only if organizations are unable to recruit Thai workers (The Prime Minister’s Office of Thailand, 2017). While MHWs can be hired only in health facilities, LCs are hired primarily by the Ministry of Labour. The revised legal framework means that after 2016, MHWs were formally employed and recognized as LCs in health facilities:

“[In the past] jobs that allowed for migrant workers were [cleaners] and labourers, so in the work permit of MHWs, they [were being] hired only in those two jobs. Nowadays, [we are] allowed to hire [them] as language coordinators.”
[T-HP-9]

Differentiation between MHW and MHV roles

MHWs are hired as staff in public health facilities and with NGOs in migrant communities, while MHVs conduct only volunteer work in migrant communities. The different roles and responsibilities of MHWs and MHVs are shown in Table 4.2. Common tasks of MHWs and MHVs are to provide health education, assist health staff and coordinate interactions between health staff, migrant communities and other agencies (Wongsuwansiri et al., 2016; Arayawong et al., 2016). The responsibilities of MHWs have expanded much beyond those of MHVs and include translation of bilingual materials, joining training courses and meetings, surveying migrant demographic data in communities and follow up home health-care visits (Wongsuwansiri et al., 2016; Arayawong et al., 2016).

Table 4.2 Roles and responsibilities of MHWs and MHVs

Components	Migrant health workers	Migrant health volunteers
Workplaces	Health facilities and communities	Communities
Allowances	Yes	No
Roles and responsibilities		
<ul style="list-style-type: none"> • Interpretation 	Yes	No
<ul style="list-style-type: none"> • Providing health education, e.g. health insurance registration, health promotion and disease prevention 	Yes (including to MHVs)	Yes
<ul style="list-style-type: none"> • Coordinating among health staff, migrant communities and other agencies, e.g. reporting disease outbreaks 	Yes	Yes
<ul style="list-style-type: none"> • Assisting health staff, e.g. screening diseases 	Yes	Yes
<ul style="list-style-type: none"> • Being role models for healthy lifestyles 	Yes	Yes
<ul style="list-style-type: none"> • Translating bilingual materials 	Yes	No
<ul style="list-style-type: none"> • Joining training courses and meeting regularly 	Yes	No
<ul style="list-style-type: none"> • Surveying migrant demographic data in communities 	Yes	No
<ul style="list-style-type: none"> • Following up home health care 	Yes	No

Source: Training curriculum for migrant health workers (2016) (Wongsuwansiri et al., 2016); Training curriculum of migrant health volunteers (2016) (Arayawong et al., 2016).

In general, MHWs in public health facilities mostly conduct interpretation, while MHWs working in communities are responsible for additional duties beyond interpretation; these include being health service navigators, health coordinators and health educators. For example, MHWs in communities may assist with disease screening and measuring blood pressure; coordinating interactions with health professionals; as well as educating MHWs and migrant workers about basic measures like personal hygiene and reproductive health (Wongsuwansiri et al., 2016; Arayawong et al., 2016). MHWs were recognized as interpreters at the beginning of the programme. When the MHW programme started, the MHWs' role shifted to that of health service navigators, cultural mediators and health educators in migrant communities. Although MHWs are formally assigned as interpreters, MHWs are used as interpreters in situations where MHWs are not available. Nevertheless, not all MHWs are able to be interpreters. The roles of MHWs and MHWs vary, depending on the organizational context and the individual capacities of MHWs and MHWs (Kosiyaporn et al., 2020b). Health workers generally opined that MHW roles should be limited to interpretation and basic health checks such as taking blood pressure:

“The point is that you [MHW] cannot advise [patients] because that is the role of doctors. You should not tell patients that they have hypertension 100% – you [MHW] can only measure blood pressure and not do interpretation.” [T-HP-3]

Supporting systems in need

The programme factors in the need for support, including budget, human resource development, and interagency coordination and planning. The MHW and MHW schemes are partly financed by revenues from the migrant HICS, whereby about 13% of premiums are allocated for health promotion activities, which encompass the MHW and MHW programmes as mentioned in the MoPH announcement (Ministry of Public Health of Thailand, 2019). However, declining enrolment in the HICS has led to budget constraints. New government legislation in 2017 mandated harsher punishments for employers who do not enrol migrant workers in the formal sector into the Thai Social Security Scheme, leading to declining HICS enrolment. Although there is another budget directly allocated to hospitals (57% of the HICS premium), it is not explicitly for MHW and

MHV programmes and is also affected by the decreasing number of HICS beneficiaries.

Low salaries and lack of employment benefits for MHWs mean that there is a high turnover rate in public facilities, with the private sector offering more attractive packages for migrant workers with interpreter skills:

“The [MHW] salary was 6900 Baht (US\$ 230) then it was deducted for Social Health Insurance, approximately 300 Baht (US\$ 10). The remaining allowance was around 6500 Baht, which I had to pay for debts and living costs of the whole family, so it was not enough.” [MHW-7]

Based on the national guidelines, selection criteria for MHWs and MHVs included demonstrating a positive attitude towards health issues and volunteerism, fluency in their first language and good Thai language skills. Education and length of stay in Thailand are not mentioned.

Training manuals for the programme have been developed by the Nursing Division and Department of Health Service Support, MoPH. The material includes: an introduction to Thai culture; migration-related laws; different migrant health insurance schemes; roles and ethics for MHWs and MHVs; health communication skills; first aid; disease surveillance and health promotion for infectious and noncommunicable diseases (Wongsuwansiri et al., 2016; Arayawong et al., 2016). MHWs undergo further training specific to reproductive health, mental health, environmental health, rehabilitation and long-term care. Yet in both curricula, developing interpreter skills or professional conduct for interpreters is not explicitly mentioned, nor is medical interpretation. Only Thai health workers receive the bilingual medical dictionary.

MHWs are trained by local staff from MoPH facilities and NGOs in the Thai language, while MHVs are trained bilingually by both local staff and MHWs. There is no dedicated organization that coordinates training among MoPH hospitals, provincial health offices and NGOs, hence training depends on the area that MHWs and MHVs are in. Moreover, this training is adapted to the local context. Some MHWs and MHVs faced time

constraints in attending courses, and did not fully understand the training content due to language barriers:

“I [MHV] do not have enough time [to join training courses]. For example, they [local organizations] set up a training programme this week, but I cannot join. When I learn intermittently, it influences our understanding of course contents.” [MHV-3]

MHWs were typically supervised via observation in health facilities, while MHVs were less closely supervised owing to their more distributed role in the community.

Interagency coordination for the MHV and MHW programmes was lacking, with numerous individual collaboration agreements between public health facilities and NGOs. Accurate data on numbers and profiles of MHVs were not always available as, in some cases, MHVs were not registered in some provinces, either with the provincial health office or NGOs. There is also no legal basis for the MHV and MHW programmes, which exist only in MoPH policy announcements. The lack of legal mandate may affect continuation of these schemes in the future.

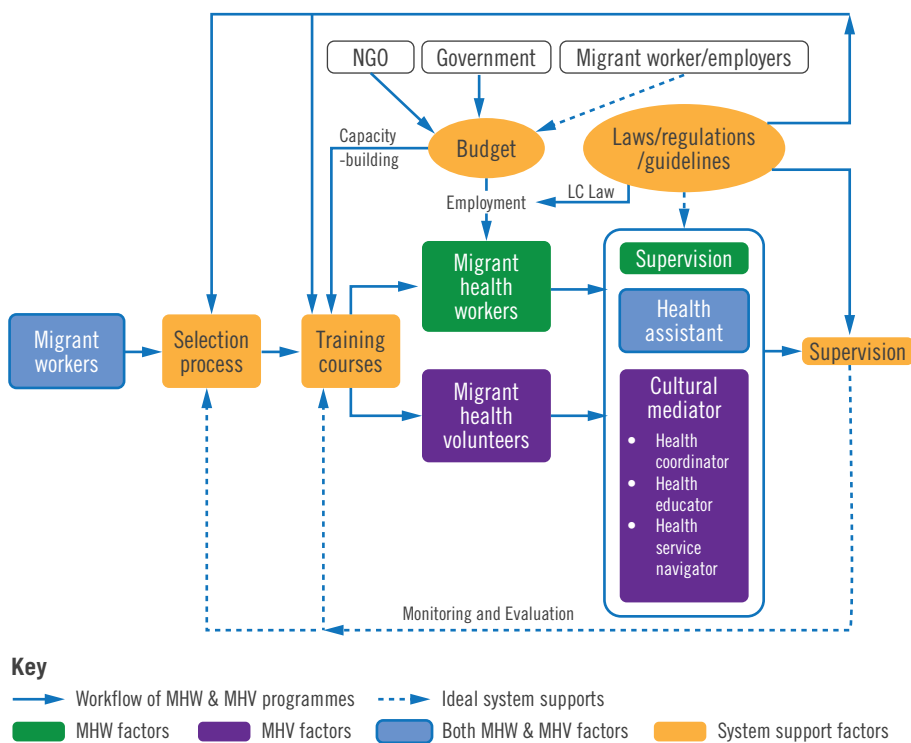
Systems support for health-care interpretation services for migrant workers in Thailand

Fig. 4.1 provides an overview of the MHW and MHV programmes in Thailand and systems support in terms of budget allocation, human resources and governing mechanisms. Budgetary resources are allocated for the training programmes and MHW employment. Human resource interventions consist of recruitment and selection processes, training courses and supervision. Finally, laws, regulations and guidelines regulate and guide service delivery (examples are the Act permitting MHWs to be hired as LCs, or the use of national guidelines for training and budget support under MoPH regulations).

The roles of MHWs and MHVs combine interpretation and cultural mediation, but primary roles are defined for each position (green boxes for MHWs and purple boxes for MHVs). However, the system faces many challenges in implementing the MHW and MHV programmes, and ideal

resolutions are shown as grey lines in Fig. 4.1. Ideally, interpretation services and cultural mediation at public facilities and with migrant communities should be supported by laws, regulations and guidelines. Moreover, this governance should ensure that an adequate and sustainable budget is allocated to support these programmes. Migrant workers and employers can also contribute to supporting these programmes. Finally, there should be a feedback loop for MHWs and MHVs from supervision to training and a selection process to guide the work processes in the right direction.

Fig. 4.1 Systems support for health-care interpretation services for migrant workers in Thailand



Source: Kosiyaporn H, Julchoo S, Phaiyarom M, Sinam P, Kunpeuk W, Allotey P, et al. (2020b).

Human resource interventions consist of recruitment and selection processes, training courses, roles and responsibilities in the interpretation

service and supervision; all of which feed back to training and selection processes. To sustain the training programmes and MHW employment, budgetary resources are important, with government, NGOs and migrant workers responsible for this. Moreover, laws, regulations and guidelines also regulate and guide interpretation services, such as following the Act permitting MHWs to be hired as LCs, using national guidelines for training and budget support under MoPH regulations. However, there are many systemic challenges in implementing the MHW and MHV programmes and ideal resolutions are shown in Fig. 4.1. The diagram implies that if there is a law or regulation that supports interpretation services in public facilities and if health staff's awareness of the benefits of interpreter services increases, then the interpretation services will be more responsive to migrants' needs. Moreover, there are no monitoring and evaluation processes for the MHW and MHV programmes, which could serve as a feedback loop from supervision processes to the content and delivery of training programmes (Kosiyaporn et al., 2020b).

There are myriad challenges in implementing the MHW and MHV programmes in terms of resources, processes and programme direction (Hogwood and Gunn, 1984). Based on interview findings and document review by the study team, Table 4.3 applies Hogwood and Gunn's (1984) framework of factors affecting policy implementation to the MHW and MHV programmes.

Major factors affecting policy implementation include differential budgets (which depend on the fluctuating funding source of the HICS premiums) leading to small numbers of workers in some areas. Current working processes are not geared towards standardization of training content and quality of interpreters, with core interpreter skills missing from existing training. Training guidelines are voluntarily implemented, which may lead to a varying quality of interpreters. Furthermore, it is unclear which agency (MoPH, other ministries or NGOs) has the authority to manage the MHV and MHW programmes, which exacerbates unclear policies in resource management and sharing of responsibilities between organizations.

Table 4.3 Factors affecting policy implementation of MHW and MHV programmes in Thailand

Factors that influence effective implementation of policies	MHW and MHV programme implementation
No impossible external constraints to overcome	Besides public authorities, NGOs follow legislation about LC employment; however, the training guidelines are voluntarily implemented by NGOs.
Adequate time and sufficient resources	There is insufficient budget in some areas and a small number of MHWs and MHVs due to high turnover rate and poor salaries compared with private sector remuneration.
Requires combinations of resources	Differential budgets are allocated to MHW and MHV programmes among public health facilities, depending on the number of registered migrant workers in the HICS and local agreements.
Valid theory underlying programmes	The training courses are not specific to the core competencies of interpreters.
Causal connections between programme components are reasonable, clear and direct	It is a good start that the MoPH and NGOs allocated resources for MHW and MHV programmes after 2003, but it is not a reasonable connection because the MHW and MHV programmes began to provide services before resources were well-organized in the programmes.
Dependency relationships are minimal	It is still unclear which agency (MoPH, other ministries or NGOs) has the authority to manage MHW and MHV national programmes.
Understanding and agreed objectives	All organizations recognize the importance of MHWs and MHVs but there are different perspectives on their remits, e.g. some expect MHWs to have only interpretation functions, while some expect them to expand their role beyond interpretation.
Correct sequence of tasks	There is a lack of standard operating procedures in the overall system.
Perfect communication and coordination	There is unclear communication about MoPH budget allocation, e.g. there is no specific budget for MHW employment.
Perfect compliance	There is no resistance from the health sector to the programmes but some resistance from national security and other ministries, e.g. employing MHWs on the same terms as Thai employees, with the same benefits, is still being debated.

Source: Hogwood BW, Gunn LA. Policy analysis for the real world. Oxford: Oxford University Press; 1984.

Overall, this chapter has described the evolution and current challenges in Thailand's MHW and MHV schemes. We have identified that both positions require providing health education in migrant communities. In the next chapter, we explore health literacy among MHWs and MHVs, given their important community roles in conveying critical health information to the wider population of migrants.

Chapter 5. Health literacy and its related determinants in migrant health workers and migrant health volunteers: a case study of Thailand

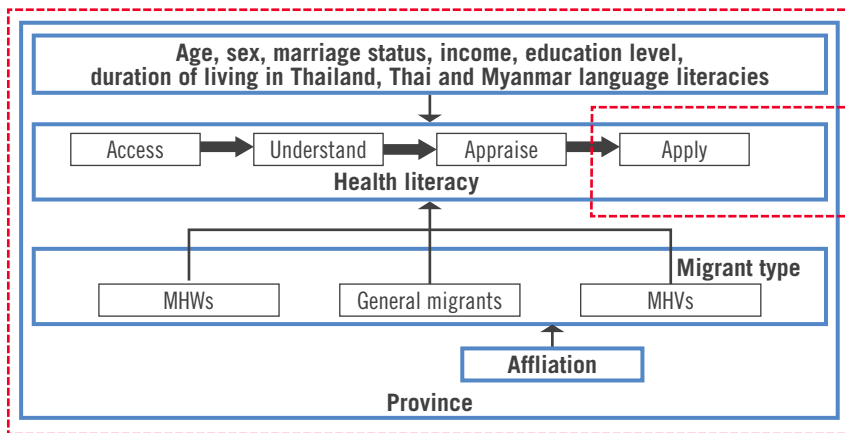
Hathairat Kosiyaporn, Sataporn Julchoo, Pigunkaew Sinam, Mathudara Phaiyaron, Watinee Kunpeuk, Nareerut Pudpong, Rapeepong Suphanchaimat



This chapter analyses the determinants of health literacy among MHVs and MHWs in Thailand. Qualitative interviews described in chapters 2 and 4 indicated that the capacities of MHVs and MHWs should be strengthened, including health literacy. Health literacy is the ability to access, understand, appraise and apply health information in order to make decisions for one’s own health, as well as the health of one’s family and community (Sørensen et al., 2012). Migrants may be more likely to have low health literacy levels, partially linked to limited health service access and poor medical compliance, which usually leads to poor health outcomes (World Health Organization Regional Office for Europe, 2013; Andrulis and Brach, 2016).

MHWs and MHVs are expected to have adequate levels of health literacy, due to their active role in health communication and promoting healthy environments in migrant communities. Health literacy is associated with individual factors (demographic, psychosocial, sociocultural) as well as health systems-level factors (Sørensen et al., 2012). This study aimed to assess levels of health literacy and associated factors among MHVs and MHWs compared with the general migrant population in Thailand. It focuses on the first three components of health literacy; namely, accessibility, understanding and appraisal of health information (Sørensen et al., 2012). The application of health literacy is excluded, given the difficulty of assessing this component within the limited time frame of this study. The scope of the study and conceptual framework is shown in Fig. 5.1.

Fig. 5.1 Conceptual framework of factors associated with health literacy



Source: conceived by study authors

Using an already validated health literacy scale for Thailand (Osborne et al. 2013 and Intarakamhang, 2017), consisting of 12 items on a Likert scale ranging from one (cannot do/disagree) to three (easy to do/agree), health literacy skills of MHWs, MHVs and general migrants were assessed. Health literacy scores could range from a minimum of 12 to a maximum of 36, with these scores serving as the main dependent variable in analysis. Associations between health literacy and demographic factors, including sex, age, marital status, education levels, income, years lived in Thailand, Myanmar and Thai language ability, as well as association of scores by migrant type (MHV, MHW or general migrant) and province, were assessed using descriptive, as well as bivariable and multivariable analysis. In addition, sensitivity analysis involved applying a random-intercept model in multivariable analysis to assess whether the findings would change if the province variable acted as a supra-individual level variable, rather than serving as an independent variable (Kosiyaporn et al., 2020a).

Health literacy findings among MHVs, MHWs and general migrants

Demographic information

The majority of participants were Burmese (94.4%) among all respondents and working in the informal sector (30%) among MHVs and general migrants. Most participants were female (64.9%) and married (69.2%), aged 21–40 years (65.5%). A larger proportion of MHWs had completed secondary school (60%), compared with MHVs and general migrants (around half, respectively). Larger proportions of MHWs had a longer duration of stay in Thailand (67.5% had spent 11 years or more), compared with MHVs and general migrants (48.7% and 32.7%, respectively) (Table 5.1).

Table 5.1 Participant characteristics of MHWs, MHVs and general migrants in Thailand (N=234)

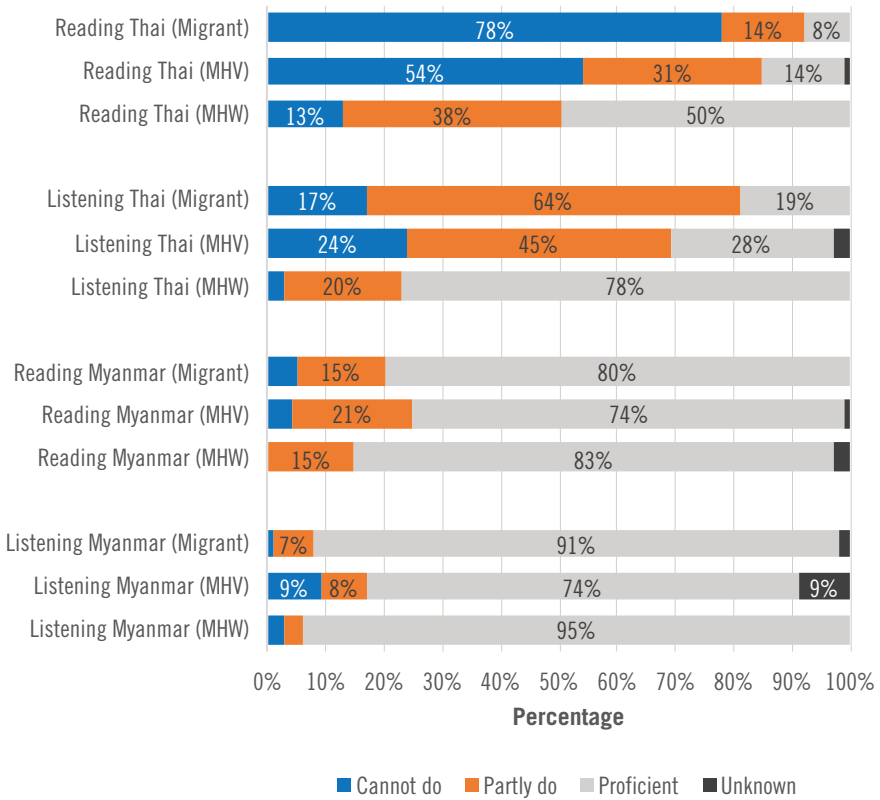
Characteristics		Number (%) of MHWs	Number (%) of MHVs	Number (%) of general migrants	Total (%)
Sex*	Male	20 (50.0)	21 (26.9)	40 (34.5)	81 (34.6)
	Female	20 (50.0)	57 (73.1)	75 (64.7)	152 (64.9)
Age (years)	<20	1 (2.5)	7 (8.9)	9 (7.8)	17 (7.3)
	21–40	30 (75.0)	37 (47.4)	86 (74.1)	153 (65.4)
	41–60	9 (22.5)	34 (43.6)	21 (18.1)	64 (27.3)
Nationality **	Myanmar	37 (92.5)	78 (100.0)	106 (91.4)	221 (94.4)
	Thai	3 (7.5)	0 (0.0)	0 (0.0)	3 (1.3)
Education level	No qualifications	1 (2.5)	1 (1.3)	4 (3.5)	6 (2.7)
	Primary school	6 (15.0)	25 (32.1)	50 (43.1)	81 (36.3)
	Secondary school	24 (60.0)	39 (50.0)	57 (49.1)	120 (53.8)
	University and above	8 (20.0)	8 (10.3)	-	16 (6.9)
	Unknown/not answer	1 (2.5)	5 (6.4)	5 (4.3)	11 (4.7)
Marital status	Single	18 (45.0)	19 (24.4)	18 (15.5)	55 (23.5)
	Married	20 (50.0)	52 (66.7)	90 (77.6)	162 (69.2)
	Divorced/widowed	2 (5.0)	6 (7.7)	5 (4.3)	13 (5.6)
	Unknown/not answer	0 (0.0)	1 (1.3)	3 (2.6)	4 (1.7)
Duration in Thailand (years) ***	≤5	1 (2.5)	13 (16.7)	39 (33.6)	53 (22.7)
	6–10	8 (20.0)	24 (30.8)	39 (33.6)	71 (30.3)
	11–15	17 (42.5)	14 (17.9)	18 (15.5)	49 (20.9)
	>15	10 (25.0)	24 (30.8)	20 (17.2)	54 (23.1)
Income / month	Lower than minimal wage [^]	17 (42.5)	43 (55.1)	69 (59.5)	129 (55.1)
	Equal to or higher than minimal wage [^]	22 (55.0)	32 (41.0)	46 (39.7)	100 (42.7)
	Unknown/not answer	1 (2.5)	3 (3.9)	1 (0.86)	5 (2.1)
Affiliation (n=118)	Public hospitals	19 (47.5)	41 (52.6)	N/A	60 (50.9)
	NGOs	21 (52.5)	37 (47.4)	N/A	58 (49.2)
	Total	40 (100.0)	78 (100.0)	116 (100.0)	234 (100.0)

*1 unknown **10 unknown ***7 unknown

[^]Minimal wage in province A is 325 Baht (US\$ 11) and province B is 310 Baht (US\$ 10.5)

Literacy skills were evaluated in the Thai and Myanmar (Burmese) languages. MHWs had better Thai-reading skills than MHVs and general migrants, with 50% being proficient compared with just 14% of MHVs and 8% of general migrants. Similar differences were observed for Thai listening skills, with MHWs being mostly proficient (78%). There were no large differences between the groups in reading or listening skills in the Myanmar language (Fig. 5.2).

Fig. 5.2 Basic literacy skills in listening and reading in the Thai and Myanmar languages among MHWs, MHVs and general migrants (N=234)*

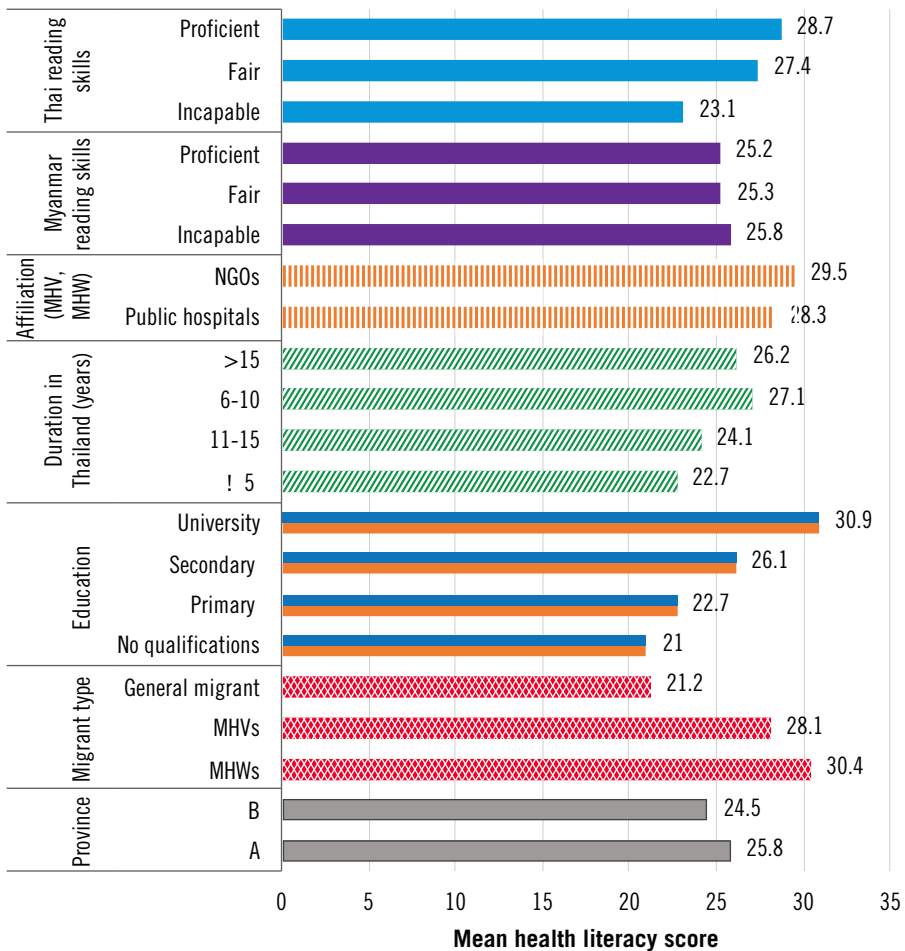


*Missing data were excluded as the number of missing records was negligibly low.

Health literacy

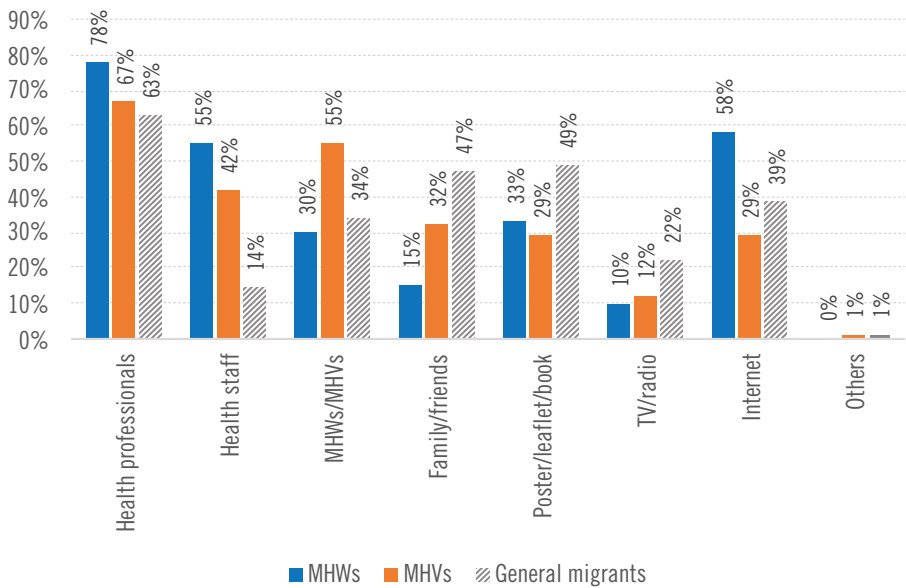
Health literacy scores did not differ by sex, age, marital status, income level (data not shown) and province. Participants who had lived in Thailand for over 10 years had higher mean health literacy scores than those who had lived in Thailand for less than 10 years (Fig. 5.3). Participants with stronger Thai reading skills had higher mean health literacy scores compared to those who had fair reading skills or could not read Thai at all.

Fig. 5.3 Mean health literacy scores by selected demographic characteristics (N=234)



Health professionals in health facilities were a major source of health information for all migrant groups, including MHVs and MHWs (Fig. 5.4). Health staff responsible for health issues in the organizations provided information for over a third of MHVs and MHWs, respectively, compared to 14% among general migrants. Nearly half (47%) of the general migrants relied on family and friends for health information, as well as posters/leaflets/books (49%). The Internet was commonly used for health information among MHWs (58%), followed by general migrants (39%) and MHVs (29%). Overall, general migrants and MHVs were more reliant on informal sources (family, friends, leaflets) while MHWs, working directly in health facilities, had access to health professionals.

Fig. 5.4 Sources of health information by migrant type (N=234)



*Participants can select up to 3 responses, total sum >100

Results from the multivariable analysis showed that general migrants had lower health literacy scores than MHWs by approximately 5.59 points (Table 5.2). Participants who had graduated from secondary school and university had higher health literacy scores compared with those with no formal education (4.24 and 5.25 points, respectively). Minor differences in health literacy scores were seen for other demographic variables. The

sensitivity analysis did not demonstrate significantly different results by province, implying that scores indeed do not differ according to location.

Table 5.2 Multivariable factors associated with health literacy scores*

	Demographic data	Number	Coefficient	P-value	95% CI
Province	A	111		Reference	
	B	124	-2.00	0.009	-3.50– (-0.51)
Migrant type	MHWs	40		Reference	
	MHVs	78	0.06	0.954	-2.14–2.27
	General migrants	116	-5.59	<0.001	-8.26– (-2.93)
Education level	No qualifications	6		Reference	
	Primary school	81	1.56	0.429	-2.32–5.44
	Secondary school	120	4.24	0.032	0.38–8.11
	University and above	16	5.25	0.033	0.42–10.08
Duration in Thailand (years)	≤5	53		Reference	
	6–10	71	-0.31	0.729	-2.07–1.45
	11–15	49	0.63	0.547	-1.43–2.69
	>15	54	0.52	0.616	-1.53–2.57
Thai listening level	Poor	40		Reference	
	Fair	117	0.97	0.311	-0.92–2.86
	Good	75	0.31	0.799	-2.06–2.67
Thai reading level	Poor	138		Reference	
	Fair	55	1.17	0.176	-0.53–2.87
	Good	40	2.16	0.071	-0.19–4.51
Affiliation	Public hospitals	60		Reference	
	NGOs	58	1.13	0.301	-1.02–3.29

*Missing data were excluded as the number of missing records were negligibly low.

This analysis contributes new information on factors that determine levels of health literacy among MHVs and MHWs compared with general migrants. In particular, MHWs, who on average had more education than MHVs, had higher health literacy scores, and education levels appear to be associated with health literacy. While health literacy did not differ much by province, a further qualitative study might examine differential training

content and programme operations (as each province has discretion over implementation of the MHV and MHW schemes) (Kosiyaporn et al., 2020a).

Overall, this chapter has identified factors associated with health literacy among MHWs and MHVs, which contribute information on potentially modifiable factors that could be considered in recruitment and training for these programmes. In the next chapter, we discuss the policy implications of the overall study, synthesizing findings across Chapters 3–5 to inform specific policy options that could be considered to improve the cultural competency of health systems for the use of migrant services.

Chapter 6. Implications of this study and policy options for migrant-inclusive health systems

Nicola Pocock, Hathairat Kosiyaporn, Rapeepong Suphanchaimat



This chapter describes the implications of this study and policy options for both Thailand and Malaysia based on the entire comparative study data and synthesis across Chapters 3–5. A summary of the study findings and related implications relevant for policy are presented in Table 6.1.

Table 6.1 Overall summary of study findings and policy implications

Study findings	Policy implications of findings	Relevant chapter
<ul style="list-style-type: none"> Differentiation between MHV and MHW roles in Thailand is not always clear 	Dual role of interpreters and health educators in communities	Chapter 4
<ul style="list-style-type: none"> Extensive use of informal interpreters in Malaysia can lead to misunderstanding and medical errors 	Limitations of informal interpreters	Chapter 3
<ul style="list-style-type: none"> Interpreter skills are not comprehensively covered in MHV and MHW training in Thailand Training programmes for CSO informal interpreters are variable in Malaysia 	Improving standards of training for interpreters	Chapters 3 & 4
<ul style="list-style-type: none"> Education significantly associated with health literacy levels among migrants, MHVs and MHWs in Thailand 	Improving health literacy among interpreters and migrants	Chapter 5
<ul style="list-style-type: none"> No clear budget source for MHWs and MHVs in Thailand No formal budget for interpreters in Malaysia besides CSOs 	Identifying funding sources for interpreter services	Chapters 3 & 4
<ul style="list-style-type: none"> No cultural competency guidelines in Malaysia Bilingual dictionaries and health worker training in Thailand, but no migrant patient guidelines 	Developing cultural competency guidelines for domestic and migrant populations	Chapters 3 & 4
<ul style="list-style-type: none"> Time pressures due to low reimbursement for migrant screenings in Malaysia discourage the use of interpreters Unclear and differential budgets by province for MHW and MHV schemes, unclear overall management authority for schemes in Thailand 	Removing structural policy constraints to a culturally competent health system	Chapters 3 & 4
<ul style="list-style-type: none"> Perceptions that migrants will overconsume health services if system is more culturally competent in Malaysia 	Barriers to making health systems migrant inclusive: fears of overuse	Chapter 3

The policy implications of the findings are discussed in more detail in the subsequent section.

Dual role of interpreters and health educators in communities

Interpreters who are more familiar with migrants' social and cultural contexts are more likely to communicate health messages effectively than those who are not. Recruiting interpreters with the dual role of interpreter and health educator may be an effective strategy to overcome communication barriers, as they are/become well-versed in culturally effective ways to translate messages in communities (Smith, 2007). This practice is consistent with some European countries, where migrants are recruited from communities to serve as "cultural mediators" between health workers and migrant patients (World Health Organization Regional Office for Europe, 2010).

In this comparative study, homogeneity in language and culture between migrants and citizens may affect health worker and employer attitudes towards migrants. In Thailand, most migrants come from neighbouring countries, with similar cultural practices and shared language in the case of Lao People's Democratic Republic. Conversely, Malaysia receives migrants and refugees from further afield, with fewer cultural and linguistic similarities (except for Indonesian workers). In Malaysia, while the health system should make an attempt to provide interpreters at public hospitals, this is unlikely to be feasible for outpatient care, especially stand-alone general practitioner (GP) clinics (Pocock et al., 2020). This is in contrast to Thailand, where cultural and linguistic similarities mean that it may be more feasible to have MHVs at the primary care level when they are already working in communities.

Limitations of informal interpreters

This study highlights some of the limitations of using informal interpreters, such as friends and family members. While some migrants may feel that trusted friends or family members are preferable, others may not feel comfortable discussing symptoms or health problems in front of them (Zendedel et al., 2018). Use of informal interpreters was commonly reported in both countries.

Doctors and migrant patients in Malaysia are forced to cope without the use of interpreters, but as findings indicate, misunderstanding of procedures, lack of informed consent and sometimes medical errors may occur as a result.

According to the systematic review findings, informal interpreters may be suitable for non-complex clinical situations (e.g. colds, fever), but not for mental health diagnoses or other serious conditions, where trained interpreters are important (Suphanchaimat et al., 2015). Formal interpreters are particularly important during emergency situations, when doctors must accurately and rapidly diagnose and treat life-threatening conditions. Formal interpreters can increase service use, improve clinical outcomes and lead to higher patient satisfaction among migrants, assuring them of heightened patient confidentiality compared with informal interpreters (Karliner et al., 2007; Zendedel et al., 2018). A contextual approach to interpreter use could be developed, in line with patient and providers' needs (Hadziabdic et al., 2009). This would mean drawing up guidelines justifying the use of formal versus informal interpreters in specific clinical situations. This measure would be particularly relevant for Thailand (where both practices occur), while for Malaysia, guidelines could inform planning as to when formal interpreters could be considered/deployed.

In future, both countries could consider making it a formal obligation for health services to deploy interpreters. Patients' rights have become central in several countries and, for this reason, the availability of interpreters in health-care settings should be encouraged when patients hail from linguistically diverse backgrounds (Phelan, 2012). For example, according to Italian legislation, health-care settings are required to use interpreters when language barriers occur (Ani et al., 2011). Although Thailand supports the employment of LCs, there is no regulation to ensure the use of these services when needed (Kosiyaporn et al., 2020b).

Improving standards of training for interpreters

To ensure that core capacities of interpreters are consistent and included in training, training standards and content for interpreters should be clearly defined and include the three main components advised by the International Medical Interpreters Association, namely: interpretation,

cultural interface and ethical behaviour (International Medical Interpreters Association and Education Development Center, 2007). For informal interpreters in Germany, Turkey and the United Kingdom (UK), improving interpreter skills through ensuring understanding of terminology, ethical and cultural issues have been suggested for inclusion in training programmes (Ani et al., 2011). Although there are training courses for MHWs and MHVs in Thailand, these courses do not comprehensively cover interpretation skills, especially on translation of medical terminology, and ethical and cultural concerns, which may arise during interpretation. This is partly because MHV and MHW functions have expanded to health educators and assistants in some cases, and training programmes have been oriented towards health knowledge and skills as a result. For Thailand, it will be important to include core interpretation skills in the existing training programme core content.

In Malaysia, CSO interpreter schemes consist of refugee, asylum-seeking and migrant worker community members who act as informal interpreters. While stakeholders described training programmes for these interpreters (including ethical codes of conduct, non-disclosure, confidentiality measures, medical terminology), these programmes vary among CSOs. Sharing information among CSOs developing training programmes will be helpful, and CSOs may wish to consult the International Medical Interpreters Association guidelines for core content as well.

Improving health literacy among interpreters and migrants

Health literacy was significantly associated with educational attainment among MHVs and MHWs, consistent with the findings from the USA on education and health literacy levels (Kutner et al., 2003). Recruitment criteria for new MHWs and MHVs could include a minimum educational requirement of secondary school completion to ensure higher levels of health literacy.

Overall, MHWs' greater health literacy relative to MHVs and general migrants suggests that the overall training process of MHWs may increase health literacy among this group. The MHW and MHV curricula could be compared and streamlined so that MHVs also receive relevant health literacy information, essential to their role as health educators in communities.

Access to health information resources as part of health literacy interventions is essential to achieve improved population health according to a recent systematic review (Fernández-Gutiérrez et al., 2018). Interactive health communication with health professionals and online sources such as social media could help to improve health literacy levels among migrant patients, who were likely to use health professionals and the Internet for health information in this study in Thailand. However, community networks remain important. In this study, almost half of the general migrants relied on family and friends for health information, consistent with findings among migrants in Europe (World Health Organization Regional Office for Europe, 2010). The policy implication is that health messages should be imbued in migrant communities, with MHVs being commissioned in this role.

Identifying funding sources for interpreter services

Financing interpreter services is a core policy consideration, as these services can add significant costs to routine care. Different budgetary sources to support interpreter services include direct government funding (e.g. “interpreter and translator service” paid for by the Netherlands government) (De Boe, 2015) while in countries such as Malaysia without formalized interpreter services, these systems are funded and implemented by CSOs (Pocock et al., 2020). While deploying trained interpreters costs more than using informal interpreters, policy-makers should consider that formal interpretation is a more cost-effective and efficient way to improve compliance with medical advice and health outcomes (Novak-Zezula et al., 2005). Such services should be free at the point of use for migrant patients, as they are in Thailand, although there is no clear dedicated funding source from the MoPH, which raises concerns about sustainability among health-care providers. Unclear budget allocation and low remuneration and benefits for MHWs and MHVs leads to brain drain from public to private sector, and high turnover of workers. The MoPH should consider a dedicated central budget line for MHW programming so that health-care providers can plan and, where needed, increase benefits to retain MHWs and MHVs.

Developing cultural competency guidelines for domestic and migrant populations

There are no cultural competency guidelines for the domestically diverse population in Malaysia, and stakeholders did not know of any guidelines for migrant patients. Addressing the needs of a linguistically and ethnically diverse domestic population is already a challenge in the Malaysian health system where, for example, spiritual concerns and family pressure to seek traditional therapies differ by ethnicity (Chang, 2010; Hani et al., 2012; Lim et al., 2015; Shoosmith et al., 2018). Equally, given previous tensions in Malaysia among the ethnically diverse domestic population, addressing prejudice against migrants and refugees will be challenging (Pocock et al., 2020). In a recent survey, 82% of Malaysians wanted to see immigration levels decrease, compared to 49% in Thailand (IOM and Gallup, 2015).

Interventions that aim to improve cultural competency among health workers should address both migrant and domestic population groups. For example, interpreters for domestic Indian Malaysian and Chinese Malaysian populations who cannot speak Malay (Pocock et al., 2020) could also facilitate doctor–patient communication for migrant workers from India and China. None of the health-care worker stakeholders in Malaysia had formally received cultural diversity training in the workplace or in medical school (Pocock et al., 2020). In Thailand, a bilingual medical dictionary in the main migrant languages is available for health workers, alongside Burmese language classes for health-care workers organized by PHOs in provinces with high migrant densities nationwide. While these strategies are encouraging, we did not find similar dedicated cultural competency guidelines for migrant patients. More attention paid to curricula and continuing professional development may help providers provide a better quality of care to migrant patients (Kosiyaporn et al., 2020b).

Removing structural policy constraints to a culturally competent health system

Structural policy constraints compound problems arising from health systems that are not culturally competent. In Malaysia, for example, doctors faced low payments (that had remained the same for 20 years) for health screening of each official documented migrant worker, and

a large number of conditions to screen for. Use of an interpreter would take time that doctors do not have, leading some to use rules of thumb (visual assessments) to diagnose mental health disorders. Findings in Malaysia raise questions about panel doctors' competencies and training for conducting proper mental health examinations and diagnoses.

In Thailand, structural policy constraints also hindered the operation of the MHW and MHV programmes. These constraints included: unclear budget allocation and differential budgets by province, depending on the numbers of official migrants enrolled in the HICS. It was also unclear which agency (MoPH, other ministries or NGOs) has the overall authority to manage MHWs and MHVs – without which setting clear directions on training in core content, selection criteria and other issues raised by this study will be difficult.

Barriers to making health systems migrant inclusive: fears of overuse

Making systems non-migrant inclusive by not ensuring cultural competency, alongside risks of high user charges as in Malaysia, may actually be a strategy to deter the use health services (Doctors of the World, 2017). The perception that migrants will overuse services if the health system becomes more migrant-friendly is real, yet there is a paucity of evidence from LMICs that overuse occurs. Medium- to low-quality evidence from high-income settings suggests that while restrictive welfare and documentation policies reduce service use by adult migrants, this is not the case for children (Guyatt et al., 2008; Juárez et al., 2019). In other high-income settings, migrant children's use of services was less than that of native populations, except for emergency care and hospitalization where they had higher use (Markkula et al., 2018), while migrants had higher service use of emergency services and hospitalizations than non-migrants (Graetz et al., 2017). Screening and outpatient services were used less often by migrants compared to the native population (Graetz et al., 2017; Pocock et al., 2020; Sarría-Santamera et al., 2016).

Overall, migrants tend to delay seeking health care until conditions are acute and costlier to treat, which raises the question of whether migrants can afford to pay high user charges even when applied (Legido-Quigley et al., 2019). Evidence from Thailand suggests that even with dedicated

migrant health insurance provided by the MoPH, migrants significantly underuse both inpatient and outpatient services compared to Thai citizens, with disease status being a stronger predictor of health-seeking behaviour compared to insurance status (Suphanchaimat, 2016). The extent to which making services more culturally competent increases service use by migrants is a question for future research from low- and middle-income countries, including Thailand and Malaysia (Pocock et al., 2020).

Policy options

To improve cultural competency for migrant-inclusive health systems in Thailand and Malaysia, the following policy options could be considered:

- **Include medical interpretation and professional ethics in interpreter training content.** Bilingualism alone is insufficient to ensure adequate interpretation skills.
- **Include educational background (secondary school completion) as part of the recruitment criteria for interpreters.** This may help to ensure that interpreters have adequate health literacy levels, which is particularly important when many perform health educator roles as well.
- **Consider interpreters acting in community-based health liaison roles as well.** This could help to increase interpreters' capacity to communicate health messages in culturally appropriate ways to different migrant groups.
- **Ministries of health could provide core content training guidelines.** In Malaysia, such content could be designed with CSOs, who currently implement their own informal systems and training. CSO content would need to be reviewed (e.g. by public health researchers) to ensure that core interpretation skills and ethics are included. In Thailand, the MoPH provides some training guidelines but these are adapted to local contexts without central oversight, and do not include core interpreter skills.
- **Ministries of health could provide budgetary support for interpreter training.** In Thailand, there are funding shortfalls

when the interpreter schemes are reliant on HICS sales, which vary by province. Both countries could consider providing budgetary support for interpreter training from the core health budget, and seek alternative sources of funding support (e.g. from the Thai Health Promotion Foundation) since some of the MHWs and MHVs' work is seen as health promotion. In Malaysia, a proportion of the migrant levy paid by employers to the State could be used to fund training.

- **Ministries of health could work with CSOs on quality assurance procedures for interpreter services.** The Thai MoPH has launched the guidelines/curricula for training of MHVs and MHWs and also allows the local authorities (such as provincial Public Health Office or local hospitals) to adapt the guidelines/curricula in a way that matches the local context. However, there is no formal quality assurance procedure (such as licensing or relicensing exams) for MHVs and MHWs in Thailand, and none in the Malaysian informal interpreter systems run by CSOs.
- **Community leaders with seniority and language proficiency could serve as patient liaisons for migrant workers.** This practice is already prevalent in Malaysian plantations, where such patient liaisons work with estates hospital assistants to coordinate OSH training in native migrant languages.
- **Embassies of sending countries in destination countries could help CSOs and destination country ministries of health to identify potential interpreters.** This was suggested in Malaysia as part of locating interpreters for OSH training among migrant workers.
- **Glossaries of medical terminology for both health workers and interpreters could be provided by ministries of health.** While there is a glossary in Thailand, it is not formally provided to interpreters, only health workers. In particular, it will be important to develop a mental health glossary of terms in migrant languages (as suggested by Malaysian participants).

- **Include provision of culturally competent care in medical and nursing school curricula, and ongoing professional development of health workers.** Study findings indicated a complete absence of cultural competency training for health workers, who stated that they learned on the job. Integrating the concept and practice of culturally competent care throughout existing modules, or creating stand-alone modules, will provide basic familiarity with the needs of an ethnically diverse migrant population.
- **Include specific mention of migrant patients in health worker standards of care.** Emphasize that professionalism and care standards are important for all patients, including migrants.

Specific recommendations for the MHV and MHW programmes in Thailand are as follows:

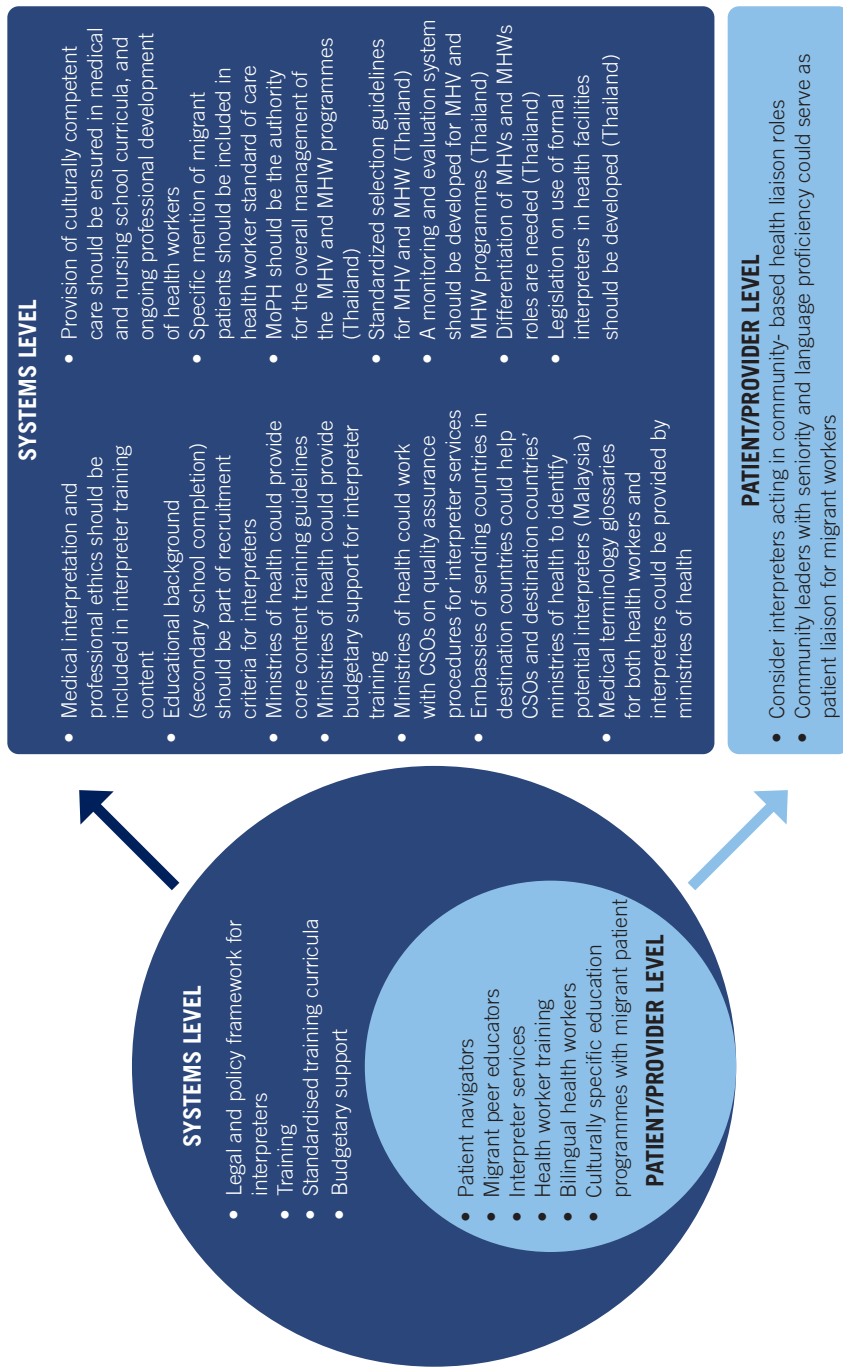
- **The MoPH has the authority for overall management of the MHV and MHW programmes.** Currently, there is no clear oversight, given the devolved nature of the MHV and MHW programmes, which is particularly important when working with non-health sector stakeholders such as the immigration department.
- **Standardized selection guidelines for MHVs and MHWs.** These should include educational background requirements (*see above*).
- **Develop a monitoring and evaluation system for the MHV and MHW programmes.** All involved stakeholders should allocate resources toward developing a monitoring and evaluation framework, including patient- and health systems-level outcomes. Monitoring and evaluating outcomes could be used to assess performance of the MHV and MHW programmes as part of quality assurance.
- **Role differentiation is needed between MHVs and MHWs.** It was not always clear what functions MHVs were expected to perform versus MHWs. For example, where MHWs are not available, MHVs tend to serve as interpreters for migrant

patients; and health professionals tend to accept this compared with using ad-hoc interpreters such as family members and friends. While MHVs have passed training courses before, these courses do not focus on interpretation skills or on guidelines and ethics related to interpretation services. The differentiation of roles and responsibilities of MHWs and MHVs should be emphasized to guide working processes (Kosiyaporn et al., 2020b).

- **Legislation on the use of formal interpreters in health facilities.** While Thailand permits the employment of LCs, there is no regulation to ensure the use of these services when they are needed. MHVs and MHWs exist in policy, not law. As we move towards migrant-inclusive health systems and, given the existing semi-formalized system in place, Thailand could consider this policy option sooner rather than later.

Integrating the policy options within the initial conceptual framework for the study (Fig. 6.1.) shows that most policy options to improve cultural competency for migrant service use are at the health systems level rather than at the patient or provider level.

Fig. 6.1 Integration of policy options with the conceptual framework for the study



Source: conceived by study authors

Limitations of the comparative study

This study has a number of limitations. For the health literacy component in Thailand, findings may not be generalizable as study sites were selected purposively. Moreover, health literacy assessments were self-reported in a questionnaire. A more objective measure of health literacy, testing actual knowledge, could be applied in future studies, as well as observation by health professionals of application of health literacy in practice. Small sample sizes for some subgroups in the regression analysis mean that findings should be interpreted cautiously. Confounders, including sociocultural factors and learning processes and methods, were not accounted for in this study, which could be included in future research.

In Malaysia, participants were heterogeneous with small subsamples for policy-makers, trade unions, industry and academics. We may have incurred selection bias from purposive sampling of known participants in both locations. Subsequent snowball sampling to collect participants beyond the researchers' known contacts aimed to mitigate against potential selection bias (Pocock et al., 2020).

As the research topic could be considered sensitive, participants may have given socially acceptable responses. We tried to lessen potential bias with open-ended questions and inclusion of indirect questions about a third party's perspective on an issue, so participants would not feel pressured to frame responses as their own opinions. However, as the focus was on understanding cultural competency in the health system, we prioritized interviewing health professionals and those with frontline experience of treating and assisting migrants, including NGOs in Malaysia serving migrant health workers and volunteers in Thailand (Pocock et al., 2020).

In Thailand, a limited number of study sites means that findings may not be representative of implementation of interpretation services across Thailand. Nonetheless, these findings provide a necessary update to the 2013 evaluation of the MHV programme at a crucial time when Thailand's migrant health policies are evolving (Kosiyaporn, et al., 2020b).

While qualitative findings cannot be generalized to other settings, they provide case studies that assess the cultural competency of health systems

for use of migrant services in middle income countries. The methodological approach, of sequential qualitative work followed by conceptualization of a systems thinking diagram, may be useful to others considering the impact of policies on migrant health in other sectors (Kosiyaporn et al., 2020b; Pocock et al., 2020).

Chapter 7: Conclusions

Nicola Pocock, Rapeepong Suphanchaimat



This comparative study aimed to explore the cultural competence of health systems for use of migrant services in Malaysia and Thailand. This report described the challenges and barriers to developing a culturally competent migrant-inclusive system in Malaysia (Chapter 3), and examined systems-levels factors affecting implementation of interpreter services in Thailand (Chapter 4). A quantitative study analysed the determinants of health literacy of interpreters in Thailand (MHVs and MHWs) as part of skills that all interpreters should have or acquire (Chapter 5). Finally, based on the research findings, this report describes policy options relevant for countries seeking to build culturally competent, migrant-inclusive health systems (Chapter 6).

Migrant health policies require intersectoral thinking. Systems thinking is a useful tool for policy-makers to consider how the current system set-up leads to certain outcomes. Even when considering the implications of improved cultural competency and reduction in language barriers in Malaysia, there were potentially negative feedback loops for migrants. The macro-level health systems perspective on cultural competency uses the Thai case of ongoing formalization of an existing interpreter- and migrant-friendly health system. Applying systems thinking in migrant health can help to identify the adverse consequences of well-intentioned policies (Pocock et al., 2020).

Alongside the HICS, the MHV and MHW schemes are among the most prominent features of migrant-inclusive health systems in Thailand. Despite the huge merits of these programmes in mitigating barriers in health-care access among migrants, challenges remain to programme implementation. These included insufficient budgetary support (Kosiyaporn et al., 2020b). In Malaysia, language interventions with migrants were the most feasible intervention point, but it is unclear who should provide or pay for language interventions – employers, the State or migrants themselves (Pocock et al., 2020). Identifying funding sources and mechanisms for cultural competency will be important, as countries move towards migrant-inclusive health systems as part of the UN SDGs.

It is hoped that these findings from Thailand and Malaysia will offer insights to policy-makers who are considering how to build more culturally

competent, migrant-inclusive health systems, with particular relevance for interpreter systems. By featuring two countries at different stages development of migrant-inclusive health systems, it is clear that there is no “one size fits all” solution, and that different policy options can be considered, depending on where each country lies along the path towards truly inclusive, rather “migrant-inclusive UHC”.

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Appendix A. Interview guide for Malaysia

A. Key Informant interviews: 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
- Experience with barriers to access to healthcare in Malaysia
- Experiences with employers in relation to illness or injury
- Experience with healthcare workers with regards 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
5. Which country did you leave to come here?
6. What do you work as?
7. Are you employed by an individual or a company?

Open questions:

- What are the most common health problems that you or your friends have faced during your stay in Malaysia? (examples)
- Can you tell me where you or your friends will go for healthcare services when you are ill in Malaysia?
- Can you share with me what is the healthcare experience like for migrant workers in Malaysia?
 - Prompts: How? Availability? Experience? Case studies?

- What do you think regarding to healthcare services in Malaysia?
 - Prompts: awareness of services available for migrants, insurance schemes, and injury compensation schemes
- 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?
 - Prompts: Barriers from individual, health system, community/cultural, stigma, geographical, financial, immigration status, fear of deportation? Case studies?
- How do you pay for health care services?
 - What are the financial barriers for migrant workers in accessing healthcare in Malaysia?
 - 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?
- 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?
- 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?
- What are your suggestions for the improvement in health policy or services available for migrants in Malaysia?

B. Key informant interviews: NGOs, migrant representatives, trade unions, academia

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

Topics:

- Knowledge of healthcare policy and services available in Malaysia
- Experience with migrant access to healthcare in Malaysia
- Cultural competency considerations for migrants
- Perceptions or experience of barriers to migrant access to healthcare in Malaysia
- Experiences with employers of migrants in relation to work related illness or injury
- Experience of migrants with healthcare workers
- Suggestion for improvement in health policy or services available for migrants

Introductory questions

For representatives of migrant workers communities:

1. What is your role in your community/organisation?
2. What communities or nationalities does your organisation represent?
3. What is the demographic profile of migrants in your community?
(age, sex, occupation, marital status)
4. What is immigration status of the communities that your organisation represents? (documented/undocumented, economic migrants, refugees, stateless people)

General open questions

- Can you tell me about healthcare policy and services available for migrant workers in Malaysia?

- Prompts: awareness of services available for migrants, insurance schemes, and injury compensation schemes
- Could you please share experience of migrant access to healthcare in Malaysia?
 - What is the healthcare experience like for migrant workers in Malaysia?
 - Prompts: Where? How? Availability? Experience? Case studies?
- Could you please share experience of barriers to access to healthcare of migrant workers in Malaysia?
 - What are the key barriers for migrant workers in accessing care in Malaysia?
 - Prompts: Barriers from individual, health system, community/cultural, stigma, geographical, financial, immigration status, fear of deportation? Case studies?
- What are the perceived barriers to access to healthcare for migrant workers in Malaysia
 - What are the key barriers for migrant workers in accessing care in Malaysia?
 - Prompts: Barriers from individual, health system, community/cultural, stigma, geographical, financial, immigration status, fear of deportation? Case studies?
- 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?
- How do migrants pay for healthcare?
 - What are the financial barriers for migrant workers in accessing healthcare in Malaysia?
 - 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?

- What are 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?
- What are migrants experience with healthcare workers?
 - Prompts: positive/negative? Are they friendly? Communication barrier? Cultural appropriateness? Stigma? Case studies?
- How the organization (you are representing) involved in migrant health issue? What is your organization's role?
 - Prompts: What are the organization's aims and activities relating migrant access to health care? What are the key success and challenges of your organization while working on migrant health issue? What is your opinion on collaboration among different sectors working on migrant health issue?
- What are your suggestions to improve health policy and services for migrants in Malaysia?

Cultural competency questions

- Are you aware of MOH or other guidelines on treatment for migrant patients, refugees? Or patients of different ethnicities (e.g. Chinese, Indian, Malay)?
 - Has your organization developed any guidelines? Uptake?
- Are you aware of training for health workers, administrators dealing with migrant patients?
 - Prompts: Hospital level? Elsewhere? What does the training involve?

Where relevant –

- How do you communicate with migrants about their health problems when they cannot speak Malay or English?

- How have you tried to overcome communication/language barriers?
- If interpreters – how is your experience of using interpreters? Can you tell me about the last time you used an interpreter?
 - Prompts: positive, negative experiences
 - Challenges in using interrupters?
- How does your organization find interpreters?
 - Agency, in-house employees, volunteers, NGO provided?
- Payment of interpreters?
- Besides language, what cultural differences have you noticed in dealing with migrant workers?
 - Prompts: by nationality? And refugees?
 - Wage disputes, OSH?
- How have you tried to overcome cultural differences in understanding, when it comes to dealing with migrant workers?
 - Prompts: besides interpreters – patient education in community? Pamphlets, physical gestures?
- What changes would you like to see in policy that could help you to do your job better?

C. Key informant interviews: health workers

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

Topics:

- Knowledge of healthcare policy and services available in Malaysia
- Experience with migrant access to healthcare in Malaysia
- Cultural competency considerations for migrants
- Perceptions or experience of barriers to migrant access to healthcare in Malaysia
- Experiences with employers of migrants in relation to work related illness or injury
- Experience of healthcare workers with migrants
- Suggestion for improvement in health policy or services available for migrants

Introductory questions

1. In what capacity do you deal with migrant workers?
2. What is immigration status of the communities that you see? (documented/undocumented, economic migrants, refugees, stateless people)
3. What are the demographic characteristics of the migrant workers you see? (male/female, occupation, country of origin)

General open questions

- What are the common conditions that migrant workers present with?
- Who pays for migrant's health services? Migrant/ employer
- Do healthcare services for migrant workers cost more than Malaysians?
- What is your opinion of migrant workers knowledge/awareness on healthcare issues?

- Can you tell me about healthcare policy and services available for migrant workers in Malaysia?
 - Prompts: awareness of services available for migrants, insurance schemes, and injury compensation schemes
- Could you tell me about FOMEMA services?
- What is your opinion of occupational health and safety measures taken by migrant workers and their employers?
- Do you provide sexual reproductive health services for migrants? E.g. contraception
- Do you have any suggestions for future improvement for migrant workers in healthcare?

Cultural competency questions

- Are you aware of MOH or other guidelines on treatment for migrant patients, refugees? Or patients of different ethnicities (e.g. Chinese, Indian, Malay)?
 - *Has your organization developed any guidelines? Uptake?*
- Are you aware of training for health workers, administrators dealing with migrant patients?
 - Prompts: Hospital level? Elsewhere? What does the training involve?

Where relevant –

- How do you communicate with migrants about their health problems when they cannot speak Malay or English?
- How have you tried to overcome communication/language barriers?
- If interpreters – how is your experience of using interpreters? Can you tell me about the last time you used an interpreter?
 - Prompts: positive, negative experiences
 - Challenges in using interrupters?
- How does your organization find interpreters?
 - Agency, in-house employees, volunteers, NGO provided?

- Payment of interpreters?
- Besides language, what cultural differences have you noticed in dealing with migrant workers?
 - Prompts: by nationality? And refugees?
 - Wage disputes, OSH?
- How have you tried to overcome cultural differences in understanding, when it comes to dealing with migrant workers?
 - Prompts: besides interpreters – patient education in community? Pamphlets, physical gestures?
- What changes would you like to see in policy that could help you to do your job better?

Appendix B. Interview guide for Thailand

A. For migrant health volunteers and migrant health workers (MHVs/MHWs):

Topics	Questions
Motivation	<ul style="list-style-type: none"> – Why do you decide to be MHVs/MHWs or quit from MHVs/MHWs?
Roles/Responsibilities	<ul style="list-style-type: none"> – What is your opinion about roles and responsibilities that you receive from organizations?
Support from organizations	<ul style="list-style-type: none"> – What is your opinion about the process of MHVs/MHWs selection? – What is your opinion about supervise from organizations such as mentoring, training? – What is your opinion about remuneration from MHV/MHW's works?
Opinions about strengths/challenges and suggestions	<ul style="list-style-type: none"> – Besides language, what are the main cultural misunderstandings between migrant patients and health workers here? – Prompts: patient understanding about diseases, traditional medicine use, treatment adherence (differences by nationality?) – What kinds of problems do you have while working as MHVs/MHWs? If yes, how do you solve these problems? – What is your opinion about MHV/MHW services? How can your work be better supported?

B. For health personnel and chief of organizations/Non-government organizations/Other supporting organizations for MHVs/MHWs services

Topics	Questions
Background and structure	<ul style="list-style-type: none"> – Does your organization have migrant-friendly services or any services for migrants? When did it start? What are the activities? – Does your organization have MHV/MHW services? When did it start? What are the activities? – What is the number of MHVs/MHWs under your organization? What is the ratio of MHVs/MHWs to migrants?
General supports from organization	<ul style="list-style-type: none"> – Does your organization have any problems about laws and regulations of employment MHVs/MHWs? Please describe in detail and what are the solutions? – Does your organization have any problems about financial support? Please describe in detail and what are the solutions? – Does your organization have process of MHV/MHW selection, training and supervision? Please describe in detail – For training, how does your organization prepare for instructors, contents and training methods? – For MHVs/MHWs services, does your organization collaborate with stakeholders?

Topics	Questions
Specific supports from organization to improve access, understand and appraise health information in MHVs/MHWs (Health literacy)	<ul style="list-style-type: none"> – What is your opinion about accessing, understanding and appraising health information among MHVs/MHWs under your supervision? Please describe in detail – What is your opinion about your organizational supports to improve accessing, understanding and appraising health information among MHVs/MHWs under your supervision? Please describe in detail
Cultural competency in Health personnel	<ul style="list-style-type: none"> – Can you please tell me about your experience of treating migrant workers overall or the last time you treated a migrant worker? – Prompt: specific illnesses, diseases? Treatment or follow-up? – Does your organization support cultural competency activities? Please specified – Does your organization provide any guidelines for treating migrant patients, or patients of different ethnicities? If Yes, please describe – Prompt: Are these MOPH guidelines, Handbooks, Policy documents – Have you received any training for dealing with migrant patients? If Yes, please describe – Prompt: Hospital level training? What did the training involve?
Opinions about strengths/ challenges and suggestions	<ul style="list-style-type: none"> – (Health professionals) Besides language, what are the main cultural misunderstandings between migrant patients and health workers here? – Prompts: patient understanding about diseases, traditional medicine use, treatment adherence (differences by nationality?) – (Health professionals) How have you tried to overcome cultural misunderstandings, when it comes to treatment? – Prompts: besides MHV – patient education in the community? Pamphlets, physical gestures? – What is your opinion about MHVs/MHWs services? What are the strengths/ challenges and suggestions? – What is your opinion about supporting for migrant-friendly services in term of accessing, understanding and appraising health information among MHVs/MHWs? What are the strengths/challenges and suggestions?

C. Policy makers

Topics	Questions
Background and structure	<ul style="list-style-type: none"> <li data-bbox="374 311 1041 396">– When did the migrant-friendly service policy or any service policies for migrants start? What are the components under this policy? And why do you support this policy? <li data-bbox="374 402 1041 469">– When did the MHV/MHW service policy start? What are the components under this policy? And why do you support this policy?
General supports from organization	<ul style="list-style-type: none"> <li data-bbox="374 475 1041 566">– What are the supports from central government to follow migrant-friendly service policy in term of laws and regulations of employment, finance and governance?
Specific supports from organization to improve access, understand and appraise health information in MHVs/ MHWs (Health literacy)	<ul style="list-style-type: none"> <li data-bbox="374 571 1041 753">– What is your opinion about central government supports to improve accessing, understanding and appraising health information in MHV/MHW services? Please describe in detail
Opinions about strengths/challenges and suggestions	<ul style="list-style-type: none"> <li data-bbox="374 758 1041 826">– What is your opinion about MHVs/MHWs services? What are the strengths/ challenges and suggestions? <li data-bbox="374 831 1041 913">– What is your opinion about supporting for migrant-friendly services in term of accessing, understanding and appraising health information among MHVs/MHWs? What are the strengths/challenges and suggestions?

Appendix C. Health literacy questionnaire

Health literacy questionnaire

	Cannot, do / Disagree (Score 1)	Difficult / Neutral (Score 2)	Easy / Agree (Score 3)
1. I can find information about health problems or concerns			
2. I can find health information from different places e.g., health personals, media, etc.			
3. I always check health information in order to keep myself in good health			
4. I have enough health information to deal with my health problems			
5. After I have read health information in my native language, I can understand all information			
6. After I have heard health information in my native language, I can understand all information			
7. After getting health information, I try to understand the information			
8. After receiving health information, I always compare health information from different sources			
9. When I see new information about health, I always check whether the sources are reliable before I believe or follow			
10. I know how to find reliable sources of health information before I believe or follow			
11. You have a competency to make a right decision after receiving health information			
12. You have a competency to share health information to others			

Source: Intarakamhang, U. *Creating and Developing of Thailand Health Literacy Scales*; Behavioural Science Research Institute, Srinakharinwirot University: Bangkok, Thailand, 2017.

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ISBN-13 978 92 9022 830 1



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