



**UiT**

THE ARCTIC  
UNIVERSITY  
OF NORWAY

Centre for Peace Studies

**Maternal Care of Undocumented Pregnant Women under  
The Fees Act (Medical) for Foreigners 1951:  
Perspectives of Health and Non-health Actors**

**Pei Shan Loo**

Master's thesis in Peace and Conflict Transformation

May 2017





Maternal Care of Undocumented Pregnant Women under  
The Fees Act (Medical) for Foreigners 1951: Perspectives of Health and Non-health Actors

By

Pei Shan Loo

A Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of

MASTER OF PHILOSOPHY

in the Peace and Conflict Transformation Program

Centre for Peace Studies

The Arctic University of Norway

May 2017

Supervisor

Dr. philos. Professor emerita Randi Rønning Balsvik

(Institute of History and Religious Studies)



## Abstract

With the unprecedented international migration around the world, policies that restrict immigrants' health care access have become prevailing. In 2014, the amendment to The Fees Act (Medical) for Foreigners 1951 had further hindered the health care access of undocumented pregnant women. This qualitative study aimed to obtain perspectives of health and non-health actors regarding the implications of the amendment to the undocumented pregnant women. Ten semi-structured interviews were conducted in Kuala Lumpur, Malaysia. The findings show that Malaysians perceive as a threat when the competition for public health care access rises with the growing number of immigrants. The amendment was used to save the health care budget and to control the immigrant population. Scapegoating immigrants has nonetheless masked the weak governance and poor development of the health care system that has stretched the health care budget. The amendment is likely to show immediate cost saving. However, women are highly prone to various pregnancy complications without adequate maternal care, and may eventually result in increased hospital fees. The high medical cost will increase the difficulty in public health control as any outbreak of infectious disease can cost the government massive amounts of money. Also, provision of family planning services among the immigrants can directly improve maternal and child survival and extend women's work productivity from unwanted pregnancy. Stemming the undocumented immigrant pool not only can reduce job competition for Malaysia's bottom 50%, the collected levy among the newly documented immigrants can in turn subsidize the health care services for immigrant group themselves. The presented findings are based on the perspectives from health and non-health actors in Malaysia. To conclude, this study shows a profound need for health and immigration policy reform. The effort is not just for the health of undocumented pregnant women, but most importantly for the economic and health benefit of Malaysians in general.

*Keywords:* undocumented women; maternal health; health policy

## Table of Contents

Abstract .....	i
Table of Contents .....	ii
List of Figures .....	v
List of Tables.....	vi
List of Acronyms.....	vii
Acknowledgement.....	viii
<b>Chapter 1: Introduction.....</b>	<b>1</b>
Background .....	1
The Focus of This Dissertation .....	3
Research Objectives and Questions .....	3
Dissertation Outline.....	4
<b>Chapter 2: Literature Review .....</b>	<b>5</b>
Introduction .....	5
Notes on Terminology.....	5
Migration in Southeast Asia.....	7
Malaysia .....	8
Challenges .....	10
Gendered Dimensions of International Migration .....	11
Maternal Health Care .....	12
Malaysia Health Care System and Health Care Access of Immigrants .....	14
Maternal Health Development in Malaysia .....	15
Maternal Health of Undocumented Immigrant .....	15
The Turning Point, the Amendment on The Fees Act (Medical) for Foreigners 1951 .....	17
Cost effectiveness of Maternal Care .....	18

Conclusion.....	19
<b>Chapter 3 Theoretical Framework.....</b>	<b>21</b>
Introduction .....	21
Social Threat Theory .....	21
Development of the concept and the Critics .....	23
Structural Violence.....	26
The Debates.....	28
Conclusion.....	30
<b>Chapter 4: Methodology.....</b>	<b>31</b>
Introduction .....	31
Research Design.....	31
Data Collection Techniques .....	31
Document Review .....	32
Selection of participants/sources .....	33
Data Analysis .....	35
Researcher Positionality.....	36
Conclusion.....	43
<b>Chapter 5: Interview Results .....</b>	<b>44</b>
Introduction .....	44
General Perception on The Fees Act Amendment.....	44
Plausible Factors Contributing to the Amendment .....	45
Outcomes and Possible Impacts.....	48
Cost Effectiveness .....	51
Current Response or Resources in Assisting the Undocumented .....	52
Challenges Faced by Undocumented Pregnant Mothers.....	53
Alternatives Approaches .....	55
Human Rights Perspective .....	58

Conclusion.....	59
<b>Chapter 6: Discussion and Conclusion.....</b>	<b>63</b>
Introduction .....	63
Social Threat Theory .....	63
Structural Violence.....	66
Structural Violence – Health Policy and Medical Ethics.....	66
Cost Effectiveness .....	68
Family Planning and Contraceptive Care.....	70
Structural Violence - Legal Status and Poverty .....	73
Structural Violence - Neoliberalism and Migration.....	76
Structural Violence - Gendered Migration.....	80
Structural Violence - Human Rights .....	82
New Research Agendas and the Hurdles .....	85
Conclusion.....	87
References .....	93
Appendix .....	102



## List of Figures

Figure 1. Principal labour migration flows in Southeast Asia.....	8
Figure 2. Causal Chain Proposed by Social Threat Theory.....	23

List of Tables

Table 1. Treatment Charges for Foreigners - Outpatient Charges.....18

## List of Acronyms

ASEAN	Association of Southeast Asian Nations
CEDAW	Convention on the Elimination of Discrimination Against Women
CDC	Centers for Disease Control and Prevention
CRC	Convention on the Rights of the Child
GST	The Goods and Services Tax
IOM	International Organization for Migration
MOH	Ministry of Health
NHS	National Health Service
NGO	Non-governmental organisation
OHCHR	The Office of the United Nations High Commissioner for Human Rights
RELA	Pasukan Sukarelawan Malaysia/The People's Volunteer Corps
SARS	Severe acute respiratory syndrome
SPIKPA	Hospitalisation and Surgical Scheme for Foreign Workers
SRHR	Sexual and reproductive health and rights
UiT	The Arctic University of Norway
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees

## Acknowledgement

I would like to express my gratitude to all those who supported and encouraged me throughout the process of this research. Many of you whom I have met are truly committed to the humanitarian work and has an immense impact towards the lives of many other you serve.

I sincerely appreciate the effort my supervisor, Dr Philos. Professor emerita Randi Rønning Balsvik who has provided academic guidance, timely feedback for me in accomplishing this project. Also, I am grateful for the financial support from Centre for Peace Studies on my travel expenses as well as other field learning opportunities during my master study here in Tromsø.

Dr Mary, my mentor who has taught me the lesson in maternal and child health, and continuing through the present, I am always grateful for your guidance.

To all the participants, I cannot thank you enough for taking the time out of your busy schedule for the interviews and your meaningful contribution to the present study.

No words can express my gratitude for my family, thank you for your patient and the endless support for what I believe in.

Nathanael, your constant encouragement has meant a lot to me, merci.

Most importantly, thanks to all the readers for taking the time to read the dissertation.

## Chapter 1: Introduction

### **Background**

Neoliberal economic policies have constructed new international guest worker systems leading the flow of migrants to fulfil corporate labour needs. International migration has become a crucial global issue that influences the lives of hundreds of millions of people in this contemporary world (Benach, Muntaner, Chung, & Benavides, 2010). Benach et al. (2010) further describe that if all international immigrants recorded were to gather as a single political entity (a state), they would represent the world's fifth most populous country. Even if migration had only a modest impact on immigrants' health, given the increasing number of immigrants, the potential impact on the population's health would be significant (Carballo & Mboup, 2005). The complexities of the health issues that are emerging due to this accelerating pace and scope are relatively new and not utterly understood, but call for much more attention than they have received to date.

The delivery of social services to improve people's quality of life is the obligation of the government, although large parts of the society in developing countries are lacking basic rights such as access to basic health care. In this globalised world, the resources of this type of service are not solely utilised by the citizens, but also covering the immigrants. Public funding of health care for immigrants has become a matter of intense debate, and the debates continue today. Such debates have led to various policy changes to health care, and immigrant eligibility for public benefits.

This research focuses on the undocumented immigrants in Malaysia, a vulnerable group where the criminalisation of immigrants increase their marginalised social status, which further helps to ensure their limited bargaining power when it comes to negotiating wage and labour conditions. Due to their immigration status, they are ineligible for neither health insurance nor any social benefit programs. Thus, undocumented immigrants face major barriers to obtaining health care services, including a lack of access to maternal care.

One of the society's especially vulnerable groups, undocumented pregnant women, has found themselves in the political crossfire surrounding this debate. In 2014, Malaysia Health Minister Datuk Seri Dr S. Subramaniam claimed that immigrants were taking about 30 to 40 percent of the country's entire allocation for medical treatment meant for Malaysians (Zuhrin, 2014). The Fees Act (Medical) for Foreigners 1951 was amended in 2014, and the new order

comes into operation on 31 December 2014 to tackle such budgeting issue (Zuhrin, 2014). Public health facilities provide health treatment to immigrants according to the Fees Act (Medical) 1951 for Foreigners. Under the amendment\*, health treatment costs for immigrants will no longer be subsidised. Undocumented immigrants who cannot afford the high medical cost are ineligible for health treatment, except when receiving emergency medical care such as child labour with complications.

Pregnancy is a period of increased vulnerability for immigrant women. Access to health care, use and quality of care provided during this period are essential aspects to identify the support given to this marginalised population (Almeida, Caldas, Ayres-de-Campos, Salcedo-Barrientos, & Dias, 2013). Regardless of the legal status of a woman, maternal care is extremely crucial for the health of both pregnant women and their babies. Antenatal testing can discover if mothers and babies are experiencing any complications, and antenatal visits enable health care personnel the opportunity to empower mothers and to prepare them for pregnancy (World Health Organization [WHO], 2009).

Compared to mothers who receive antenatal care, mothers who do not access that care is three times more likely to give birth to babies with low birth weight, and infant mortality is five times greater (Health Resources and Services Administration, 2011). Improving access to maternal care for immigrants has been shown to reduce aggregate health care costs associated with complications of labour and relatively costly, yet preventable, perinatal health problems (Lu, Lin, Prietto, & Garite, 2000; Lee, 2015).

As former World Health Organization (WHO) director Lee Jong-Wook emphasised,

“There is a sense that science has not done enough, especially for public health, and there is a gap between today’s scientific advances and their application: between what we know and what is actually being done”

(as cited in Liverani, Hawkins, & Parkhurst, 2013)

While evidence shows the cost benefits of antenatal care, concerns persist that the best

---

\* Note: The term ‘The amendment’ represents The Fees Act (Medical) for Foreigners 1951

available evidence does not sufficiently inform health policy and practice, perhaps those research findings may take too long to be incorporated into policy processes or perhaps other factors are determining the policy making.

### **The Focus of This Dissertation**

Health policy changes regarding immigrants is a national, regional and global issue where it can be reflected from social, economic, political, legal, and human rights standpoints. In general, there is substantial academic literature related to undocumented immigrants, yet there is a paucity of academically sound, publicly available information pertaining to undocumented immigrants in Malaysia, especially concerning health policy. The purpose of this research is to obtain perspectives of health actors and non-health actors (including academics, politicians, Non-governmental organisations (NGOs), activists and others) in Malaysia on the amendment of The Fees Act (Medical) for Foreigners 1951, with an emphasis on maternal health care of the undocumented pregnant women.

While the narrowed topic limits the extent to which other significant issues can be explored (such as how regional economics and politics affect the migration, the abuse and violence on the immigrants and others), this enables a particular attention, in detail, how the health policy changes in Malaysia affects the health and wellbeing of undocumented pregnant women. Qualitative studies such as this can provide a more nuanced understanding of how current health policy changes are expected to impact the marginalised groups as well as economic, health, and moral policy of the country. This research will contribute to the literature in Malaysia, and be a voice to speak out for the invisible group.

### **Research Objectives and Questions**

The present study employed a qualitative research design. The primary method used for data collection was semi-structured interviews, and a review of documents (specifically from academic journals, media sources and others) provided additional background and current information. A critical discussion and triangulation within the data provided an unique insight to assess vulnerability among undocumented pregnant women in the context and stands to make a particular contribution to the literature. The inductive and deductive analysis approach were used to identify themes from the semi-structured interviews.

## **Research objectives**

This research aimed to comprehend the implications of dramatic increment of medical fees on maternal health care of the undocumented pregnant women through the insight of health and non-health actors.

## **The research questions:**

- 1) To learn the response from different actors regarding the amendment on The Fees Act (Medical) for Foreigners 1951
  - i. Why is The Fees Act (Medical) for Foreigners 1951 amended in 2014?
  - ii. What has changed since the increase of medical cost?
  - iii. What are the impacts of the amendment on The Fees Act (Medical) for Foreigners 1951?
  - iv. Elimination of publicly subsidised maternal care for undocumented women saves the state in direct maternal care costs. What are the long-term impacts?
  
- 2) To consider applications of the knowledge generated in this study in the context of interventions related to undocumented immigrant pregnant women's maternal health.
  - i. How can information that provides a foundation for effective planning on issues related to immigrant women's health be created and advocated?
  - ii. What resources and existing response can be used as the core for such efforts?

## **Dissertation Outline**

In the following chapter, Chapter 2, illustrates the reviewed literature on undocumented immigrants, antenatal care and health policy in Malaysia. In Chapter 3, the theoretical framework of this study is outlined. Chapter 4 contains the methodology employed in this study. In Chapter 5, the data from the semi-structured interviews are analysed and presented. The findings are then critically discussed and triangulated with document review in Chapter 6. The last chapter, Chapter 7 is the conclusion of the current study.



## Chapter 2: Literature Review

### **Introduction**

This chapter provides an overview of migration in Malaysia and the change of health policy that is affecting immigrants, specifically, the maternal health of undocumented pregnant women. These three distinct subject areas are reviewed in three different parts in the chapter.

The first part begins with the justification of the terminology focused in this study. It is essential to understand the different terminology used in the literature to describe the status of immigrants who enter countries on an irregular or undocumented basis. This section continues with a brief description of migration in Southeast Asia and followed by the historical and present-day situation of immigrants in the Malaysia context. This provides the general understanding of who, how, why immigrants are in Malaysia, which is then narrowed to a concise overview of the challenges the female immigrants face in Malaysia.

The second part starts with a review of maternal health care in general that includes clarification on terminology regarding maternal health care services. Next, the section overviews the Malaysia health care system and health care access of immigrants. Maternal health development in Malaysia is then described. The section continues to focus on maternal health of undocumented immigrants by outlining issues encountered by immigrant women. The Fees Act (Medical) for Foreigners 1951 and its amendment sections are explained, followed by literature regarding cost effectiveness of maternal care.

### **Notes on Terminology**

At the very beginning, it is useful to clarify some terms currently used in the literature on the status of migrants who enter countries on an irregular or unlawful basis: illegal, unauthorised undocumented or irregular, and immigrants, migrants, and foreigners.

Illegal migrants, illegal foreigners, illegal workers are commonly appearing in the discussion on labour migrants. Elie Wiesel, the Nobel Peace Prize winner, once claimed that human being cannot be illegal (as cited in Wickramasekara, 2002). The term 'illegal' signifies negativity that disregards the contributions made by the migrant workers to the host economy. It seems that labour migrants are put to blame solely while ignoring the illegal roles of others, such as illegal local employers and intermediaries. In some cases, the migrant may simply be

a victim only forced into an irregular situation by traffickers and recruitment agents (Wickramasekara, 2002).

In April 1999, "International Symposium on Migration: Towards Regional 2 Cooperation on Irregular/Undocumented Migration" hosted by Thailand has opted and defined the term 'irregular' migration, as it can accommodate various diverse situations.

An irregular (im)migrant worker is a person who,

- (a) has not been granted an authorization of the State on whose territory he or she is present that is required by law in respect of entry, stay or employment, or
- (b) has failed to comply with the conditions to which his or her entry, stay or employment is subject

(As cited in Wickramasekara, 2002)

In Malaysia, irregular or undocumented migrants are often referred to as '*illegal immigrants*' (Pendatang Asing Tanpa Izin or PATI) or '*illegal workers*' (Pekerja Asing Tanpa Izin). Generally, undocumented immigrants involve overstayers on the tourist visa or engaged in work; students involved in employment; regular migrants extending the stay beyond the contract period; regular migrants running away from their designated companies before termination of the contracts; and persons trafficked into the country.

In the International Migration Paper from Wickramasekara (2002) regarding Asian Labour Migration Issues, he argues that despite the terms 'documented/undocumented' are frequently used about migration, undocumented migration does not include all irregular cases. United Nations (1998) states that some documented persons who are tourists, for instance, may work in the host country and thus violating requirements of entry. Likewise, labour migrants who are trafficked may have valid documentation contributed by a thriving fake documentation industry (as cited in Wickramasekara, 2002).

Although the term irregular immigrants comprise of all irregular cases, this study focuses on immigrants who do not possess relevant documents in Malaysia, leading to their inability to access any form of social, health, legal, economic benefits, and under constant fear of deportation. Irregular migrants who own fake documents as explained above are not part of the study focus. Undocumented immigrants in this study include irregular immigrants, stateless people, and asylum seekers (have yet to register with United Nations High Commissioner for Refugees [UNHCR]).

## **Migration in Southeast Asia**

Migration has emerged as an integral part of economic and social development globally and is unlikely to change in the near future (Benach et al., 2010). In addition, new forms of displacements occur such as environmental refugees (in addition to political refugees and migrant trauma survivors) due to growing conflicts, environmental degradation and declining land fertility. According to Professor Kaur (2010) who is expert in migration issues in Southeast Asia, states that the Southeast Asia region has experienced high levels of migration, predominantly intraregional migration since the 1980s. The forming of Association of Southeast Asian Nations (ASEAN) in 1976 comprising Philippines, Cambodia, Burma, Lao PDR, Viet Nam, Indonesia, Singapore, Malaysia and Thailand (with Brunei joining later) initially aimed to promote common political and, later, economic interests. Some countries have undergone rapid economic growth, along with 'push' factors in others has led to a surge in labour migration, both skilled and low-skilled workers, from neighbouring economically disadvantaged countries.

With the increased involvement of states in the political regulation of economic activities, policies are organised and coordinated for immigrants recruitment that shaped (and continue to shape) the 'new' migration geography in the region (Kaur, 2010). Of the ASEAN countries, Brunei, Malaysia, Singapore and Thailand are destination countries for labour migrants, and they comprise between 15 to 30 percent of the labour force, and their share is growing. Less-skilled guest workers are usually employed from ASEAN countries such as Indonesia, Philippines, Burma, Lao PDR, Cambodia and Viet Nam and South Asia countries such as India, Bangladesh, Nepal, Pakistan and Sri Lanka (Kaur 2010).

Undocumented migration has emerged as a key issue influencing the management of migration not just in Southeast Asia, but also globally. While Southeast Asian states are determined to govern their frontiers through developing border strategies, the combination of extensive land and sea borders under the limited capacity of states to effectively control borders render the region to undocumented migration (Larsen, 2010). International Organization for Migration (IOM) (2008) states that approximately 30 to 40 percent of all migration in Southeast Asia is through irregular channels, with destination countries (particularly Malaysia and Thailand), hosting somewhere proximity of three million or more undocumented immigrants (as cited in Larsen, 2010)

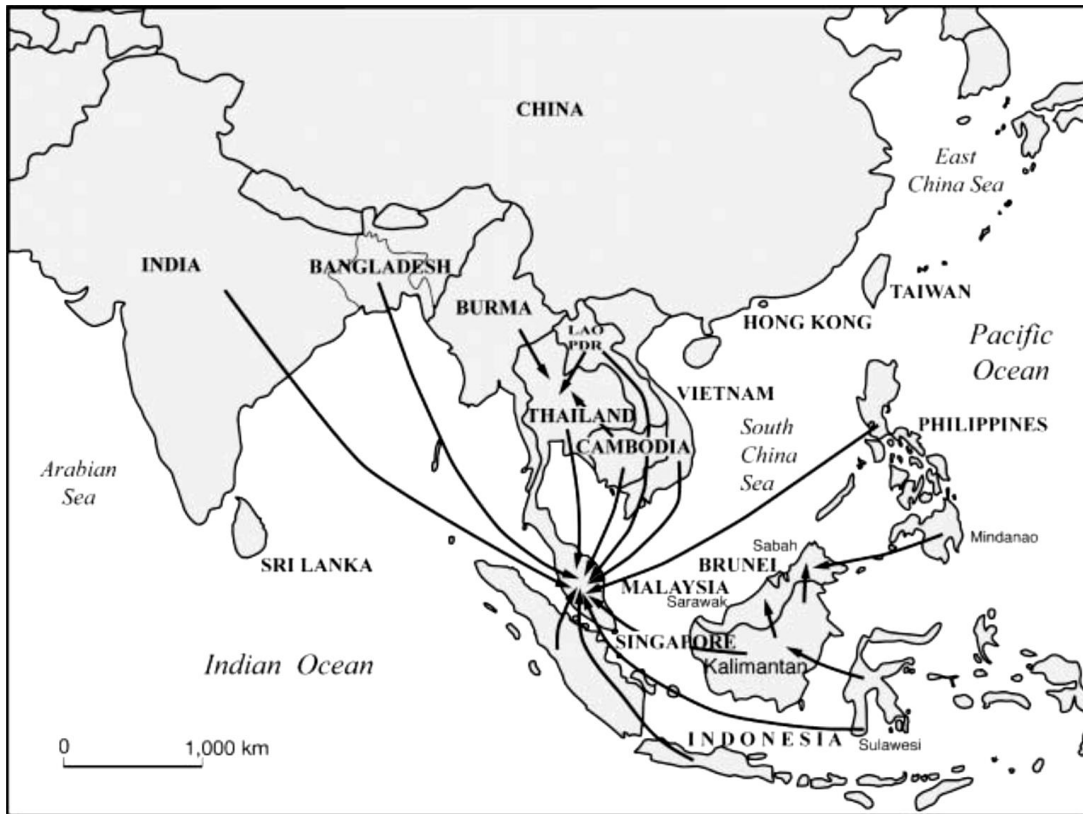


Figure 1. Principal labour migration flows in Southeast Asia.

Source: Kaur (2010).

### Malaysia

Malaysia has witnessed a prompt increase in its immigrant population in the past three decades. Department of Statistics 1983 shows a figure of 63,700 non-citizens making up 0.49 percent of a total population of about 13 million (as cited in Kassim, 2014). By 2016, the percentage of non-Malaysian citizens was 3.3 million (10.3 percent) out of a total population of 28.4 million in Malaysia (Department of Statistics, 2016). However, this number was an underestimation due to inability to capture migrants who enter without proper documentation or overstay their visas and remain to reside illegally. Kassim (2014) who studied regarding transnational population inflows into Malaysia, states that the official sources put the number of undocumented immigrants now between 1.3 million and 3 million, which means that for every one labour migrant, there is another undocumented one.

While the dependence on labour migrants began in the early 1970s and through the 1980s to upkeep Malaysia's growth strategy, formal guidelines pertaining to labour migrants were only introduced in the early 1990s (World Bank, 2013). It was to permit labour migrants as an interim strategy to meet the escalating demand for low-skilled labour in plantations and later

in low-skill-intensive construction and domestic services. The immigrant population can be divided into two categories depending on the state response that significantly varies as reflected in the different rules and regulations that govern their entry and stay in the country. First, the desirable inflow, comprising expatriates, foreign spouses, international students, foreign retirees who relocated to Malaysia through international residency scheme (Malaysia My Second Home Programme). Secondly, the unwelcome but needed inflow, containing low to medium-skilled foreign workers (approximately more than 90.0 % of the entire immigrant population), asylum seekers and refugees (Kassim, 2014; Ab Rahman, Sivasampu, Mohamad Noh, & Khoo, 2016).

Abella (1999) explains that rigid immigration laws and policies in a country that has labour shortage but refuse to permit less skilled workers are the leading cause of undocumented immigration (as cited in Wickramasekara, 2002). Likewise, World Bank (2013) reports on several reasons that lead to the situation where labour immigrants are becoming irregular. They include financial burdens, length of time, the cumbersome nature of the approval procedures, rigidity of the system, working conditions and employer behaviour. Firstly, Malaysian immigration laws assign the labour migrants with specific employers. While the regular immigration channels are usually safer, the irregular channels are more favourable, having greater freedom both for themselves and the employers, as they are faster, less expensive, and thus more practical.

Secondly, in cases where a documented migrant encounters improper working conditions, physical and psychological abuse or non-payment of wages leave the worker with little choice but to leave that particular employer. In addition, certain regulations allow the labour immigrants' travel documents to be kept by the employers. Hence, the regular labour immigrant is forced to lose the permit or both permit and travel documents, as they are tied to the employers. Thirdly, lack of information or illiteracy among the immigrants increases their vulnerability to deception and potential trafficking by parties in both labour sending countries and Malaysia. In addition, Kassim (2000) has highlighted the burden of the labour immigrants levy in Malaysia, which is acting as an incentive to undocumented recruitment (as cited in Wickramasekara, 2002).

Another reason is that political suppression and armed conflict in neighbouring countries have caused forced migration through undocumented channels to Malaysia. As of February 2016, there are over 158,510 asylum seekers and refugees registered with UNHCR in Malaysia, and

approximately 35,000 unregistered asylum-seekers still (UNHCR, 2016). Although Malaysia is not a signatory to the Geneva Convention on the Status of Refugees 1952, asylum-seekers and refugees are permitted to stay temporarily on humanitarian grounds. UNHCR is responsible for finding one of the three durable solutions for them: repatriate them once their country of origin is in peace and accepts them, transfer them to a third country for resettlement, or integrate them into the host country (if possible). For most asylum-seekers and refugees, the process takes a long time.

### **Challenges**

Not all immigrants are opposed by Malaysians, and not all Malaysians oppose immigrants. In other words, Malaysians generally have a positive attitude towards immigrants from the “desirable inflow”. As for the “unwelcome but needed inflow”, some who benefited from their presence such as employers, traders and landlords welcome them. However, as their number escalates, and their presence in urban areas increase their visibility, public resentment towards them begins to rise. Particularly because of the competition they pose to the local urban poor and the lower income group for the limited supply of low-cost housing, public and social amenities and petty trading opportunities (Kassim, 2014).

Misleading media in exaggerating negative news about immigrants results in locals believe or over generalise that all immigrants are prone to commit crimes. Ramachelvam (2008) notes that immigrants comprise 33 percent of the prison population, despite the fact that they commit only 2 percent of the crimes (as cited in Kaur, 2010). The high percentage of them in prison population is due to immigration-related offences instead of the common misleading perception that the rise of immigrants causes the increase of burglaries, fraud, sexual assaults and other crime rates. Moreover, since immigration violations are considered civil matters, these immigrants may be imprisoned without any rights and no guarantee of a speedy trial.

The resentment among the locals soon turned up in the public debate and found its way into Malaysia’s national political agenda. They began to be viewed as a threat to border security and internal order where more and more unpopular measures are used against the immigrants (Kassim, 2014). The weak governance structure has led to the marginalisation and vulnerability of labour immigrants, specifically undocumented immigrants. They lack basic human rights such as lack of access to basic health, justice and education services. A key flaw is the complication of jurisdictions and poor inter-ministerial and departmental coordination that make it almost impossible for workers to seek redress and justice (Kaur, 2010). Many

employers are concerned and afraid to employ undocumented immigrants due to their anomalous status that might cause them to be arrested for employing and harbouring undocumented immigrants under the Immigration Act 1959/63. Yet, those who hire them tend to exploit and abuse them knowing that undocumented immigrants have no recourse to justice in the case of non-payment of wages by employers; or in any other event of employer-employee disputes (Kassim, 2014).

Malaysia's management of its urban areas for migrant workers is seen as the worst in the region (Kaur, 2010). NGOs and human rights groups have been strongly criticising the canning of immigrants who violated the immigration law and sending them to jails and then deportation (Amnesty International, 2010). The report, *Trafficking and Extortion of Burmese Migrants in Malaysia and Southern Thailand* (US Committee on Foreign Relations 2009), not only proved the trafficking and human rights violations but also asserted that Malaysian immigration officials, the police and The People's Volunteer Corps (RELA) personnel were part of the trafficking trade. Such reports contribute significantly to Malaysia's poor rating in the annual *Trafficking in Persons Report* issued by the State Department of the United States. In 2009, Malaysia was placed on Tier 3, on the same rank with countries with horrendous human rights records. In the following year, the rating improved to Tier 2 (Watch list), a placing that runs for four years in a row until 2013.

### **Gendered Dimensions of International Migration**

The rise of the feminisation of migration in general and in this region in particular has spurred new concerns and poses new challenges relating to institutions, processes and outcomes associated with female migration. Labour migration in Southeast Asia is undeniably a gendered process and interlinked closely with changes in the age, economic status and position of women in this region. It is related to the gender-selective policies of labour-importing countries and the emergence of gender-specific employment niches (Kaur, 2009).

This feminisation of the new migrant labour may be attributed to a few reasons. The rise of formal education rate among Malaysian results in changing job preferences from services and construction to formal and better-remunerated employment in the public and private sectors. These increased specific labour needs gravitate toward the informal services, housekeeping and childcare services, which has been met by female labour migrants from the lower income Southeast Asian countries (Kaur, 2009). However, female labour immigrants are explicitly vulnerable due to the difficulty or failure to secure decent work.

Trafficking results in different kinds of undocumented migration through cooperation among recruiters, immigration personnel, traffickers and job placement agencies. The conventional approach of criminalising and deporting victims of trafficking usually seen as a ‘green light’ to traffickers to perpetuate these systems. Trafficking includes severe breaches of basic human rights of victims. Their work gravitates towards the “entertainment” sector that is amounting to virtual slavery with constant debt-bondage in brothels to pay back exorbitant costs claimed by traffickers (Wickramasekara, 2002).

Moreover, both commercial sex and the domestic immigrant workers are at risk of unwanted pregnancy, unsafe abortion, unsafe child labour, sexually transmitted diseases and issues relating to their sexual reproductive health that severely impairs their health (Wickramasekara, 2002; Lasimbang, Tong, & Low, 2015). In Malaysia, documented immigrants have to undergo mandatory pregnancy tests, and they are deported if they become pregnant. They may, however, choose to have an abortion to avoid deportation, mostly unsafe abortion due to abortion is illegal in Malaysia (unless high-risk pregnancy with a specific medical condition).

Sexual and reproductive health and rights (SRHRs) of migrants is one of the aspects that truly lacks attention (Lasimbang et al., 2015). Female immigrant’s contribution to the host country labour force has been mostly overlooked since the immigration systems in both sending and receiving countries of the Southeast Asia prone to be gender-blind (Bharathi, & Mitra, n.d.).

### **Maternal Health Care**

The recent waves of immigration indicate the increasing feminisation where migrant women frequently initiate the mobility process at an active reproductive age, regardless of individual motivations for leaving their countries (Almeida et al., 2013). While women and men share many similar health challenges, the disparities are such that the health of women deserves particular attention as there are conditions that only women experience and whose likely negative impact only they suffer (WHO, 2009).

The Office of the United Nations High Commissioner for Human Rights (OHCHR) justifies that International human rights law comprises fundamental commitments of states to enable women to survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health, rights and living a life of dignity regardless of their socioeconomic status (as cited in WHO, 2016). Yet, nearly 303,000 women and adolescent girls died as a result of



pregnancy and childbirth-related complications in 2015 (United Nations Population Fund [UNFPA], 2016). This suggests that near to 800 women continue to die every day, and almost 99% of maternal deaths happen in limited-resource settings which mostly could have been prevented (WHO, 2016). Similarly, approximately 2.6 million babies were stillborn in 2015, also primarily in limited-resource settings.

Maternal mortality has long been debated as one of the most profound indicators of development and of functioning health systems of a country. The key direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour (WHO, 2016). The crucial hurdle is that pregnant women's lack of access to quality care before, during and postpartum period. (UNFPA, 2016). The health of women during these three stages is defined as maternal health (WHO, 2016). Motherhood is often a positive and fulfilling life experience, yet, it is related to suffering, ill-health and even death for too many women.

The basic maternal care comprises four vital elements to prevent maternal death (UNFPA, 2016). It begins with antenatal care, also known as prenatal care. WHO (2016) defines antenatal care as the care services received by pregnant women from skilled health-care professionals to ensure the optimum health condition for both mother and child during pregnancy. Antenatal care includes risk identification, pregnancy-related or concurrent diseases prevention and management, and health education. WHO introduced the basic antenatal care guideline in 2002 that expectant mothers shall receive at least four antenatal visits as soon as first 12 weeks' gestation (WHO, 2016).

The second element defined by UNFPA (2016) is skilled birth attendance with emergency backup such as doctors, nurses and midwives who have the skills and equipment to conduct normal deliveries and recognise the onset of complications. This is considered the most crucial intervention for safeguarding safe motherhood during intrapartum period (labour and delivery) (UNFPA, 2016). Third, emergency obstetric care is critical to prevent the major causes of maternal death. In the case of complications, all women and newborns should have prompt access to emergency obstetric facilities.

The last element is in the in the postpartum period (after delivery) which is the postnatal care. It is given within the first 24 hours of delivery, on the third day afterwards, then in the second and sixth weeks (UNFPA, 2016). Bleeding, sepsis and hypertensive disorders can occur to the

mother during this period, and newborns are especially weak in the immediate aftermath of birth. Therefore, postnatal care is as necessary as antenatal care. All elements of basic maternal health care aim to put women at the centre of care, enhancing their motherhood experience, and ensuring that babies have the best possible start in life.

### **Malaysia Health Care System and Health Care Access of Immigrants**

The Ministry of Health is responsible for the functioning of health care in Malaysia. Malaysia has a two-tier health care system consisting of the government-run health care system and coexisting private health care system (Noh, Wahab, Bakar Ah, & Islam, 2016). The public health care system is heavily financed by the government through general taxation, with an annual health budget designated by Ministry of Finance to the Ministry of Health with the obligation of delivering affordable health care. The government-run health care facilities are available to immigrants, though at a higher fees compared to Malaysians because of the lower funded rate imposed on immigrants. Up until 2014, immigrants were charged RM 15 (NOK 30) for primary care consultation and RM 60 (NOK 120) for consultation with the specialists while Malaysians spend RM 1 (NOK 2) and RM 5 (NOK 10), respectively (Ab Rahman et al., 2016).

Hospitalisation and Surgical Scheme for Foreign Workers (SPIKPA) was introduced as a mandatory medical coverage for labour immigrants that came into effect on 1 January 2011 (as cited in Guinto, Curran, Suphanchaimat, & Pocock, 2015). Although most immigrants are under insurance coverage on entering the country, it does not cover care related to pregnancy since they are subjected to deportation if they are pregnant. On the other hand, refugees who hold UNHCR cards are eligible to get 50% discount for treatment in public hospitals at the foreigner rates (UNHCR, 2016). Undocumented immigrants have been profoundly sidelined since they are neither eligible for 50% discount for treatment in public hospitals nor any other social security benefits.

The study by Noh et al. (2016) present the findings on the status of the foreign workers' access to the public health services in Malaysia. The result shows that the labour immigrants' access to public health services is low. Most immigrants seldom used public health services when they were ill due to the costly health care services. They only attempt to seek health treatment when their illness turns critical. These findings are in line with the study by Lasimbang et al. (2015) where the Ministry of Health reported the access of outpatient public health care services by immigrant population was lower in comparison to Malaysians.

## **Maternal Health Development in Malaysia**

There has been a notable decline in maternal mortality in Malaysia from 1950 to 2010. It has dropped from 540 per 100,000 live births to 28 per 100,000. The decline in maternal death has been contributed by the introduction of the new programmes from the Ministry of Health (Yadav, 2012). The remarkable improvement of maternal health in Malaysia was flagged as a model for other countries to follow.

A keynote addressed from the Director-General of Health Malaysia at The International Conference on Maternal and Child Health (2016) states that the Ministry of Health is committed to the right to health and the right to the highest attainable standard of health care. This commitment has been extended to include all individuals. He further described that eliminating discrimination is core to human rights approach, where strategies include delivery services to the marginalised groups. Furthermore, Malaysia has ratified international treaties such as Convention on the Rights of the Child (CRC) and Convention on the Elimination of Discrimination Against Women (CEDAW).

The efforts to promote maternal and child health initiated since the 1960s, and continue until the present time, include increased number of health centres, the coverage of antenatal, postnatal care and access to deliveries attended by trained skilled personnel; prevent delays and assuring the availability of emergency obstetric care (Kaur & Singh, 2011). Besides, Ministry of Health began a termination of pregnancy guideline in September 2012 to allow abortion if the pregnancy would jeopardise the woman's physical or mental health (Karim & Ali, 2013).

The significance of adequate maternal health care is not just maximising the opportunity for health gains for both mothers and children; it is also being seen as a fundamental element in the development agenda of the country in the new millennium.

## **Maternal Health of Undocumented Immigrant**

Maternal mortality and morbidity are indicators for poor maternal health and remains a concern for undocumented immigrants who are vulnerable by virtue of who they are. Thousands of those who undertake their journey through pregnancy and childbirth outside the health system are left behind from the current medical progress.

According to the Malaysia Millennium Development Goals Report by (United Nations Malaysia [UNM] 2015), as of 2012 in Malaysia, all ethnic groups had maternal mortality rate under 30 per 100,000 live births except the “Others” category (immigrants) whose rate was 65.9 per 100,000 live births. Throughout the period of 2000 to 2012, “Others” had higher maternal mortality rate than other ethnic groups with the medians being 56.7 per 100,000 live births. Contrary, the medians for Malays, Indians and Chinese in Malaysia were 28.0, 23.6 and 12.9 respectively per 100,000 live births. The data implies the existing barriers that limit immigrants in obtaining adequate maternal care in Malaysia (UNM, 2015).

Several studies have indicated that immigrants have late initiation of antenatal care and fewer visits (Almeida et al., 2013; Almeida, Santos, Caldas, Ayres-de-Campos, & Dias, 2014; Korinek & Smith, 2011; Lasimbang et al., 2015; Zulkifli, Yusof, & Lin, 1994). The study conducted among local citizens and migrant women in Sabah (East Malaysia) by Zulkifli et al. (1994) found that migrant workers who attended to their antenatal care only did so in their last term of pregnancy, in comparison to local natives who initiated antenatal care in the first three months of pregnancy. The study also indicates a significant number of labour immigrants reporting not practising any contraception, and never visiting antenatal care in comparison to locals.

Another study by Ab Rahman et al (2016) aimed to examine access to health services for immigrants in Malaysia. The results show that the most common condition sought in public hospitals among immigrants were obstetric cases (37.7 %). Of this total, high-risk pregnancies comprise of 7.5 percent. These findings highlight the prevalence of obstetric cases and suggest the need for maternal health services among immigrants. According to Almeida et al., (2013), migrant women were frequently exposed to physical and psychosocial risks when faced with new environments and vulnerable lifestyles. A study by Eastwood, Phung, & Barnett, (as cited in Almeida et al., 2013) has shown that social and physical environmental difficulty have been associated with maternal stress, prematurity, low birth weight and infant death.

There is a paucity of empirical data regarding undocumented immigrants mainly due to the difficulties of identifying such an elusive population, has a limited understanding of their health status and health care seeking behaviour (Korinek & Smith, 2011). The issue of vulnerability accentuates with the barriers that limit the access of immigrant populations to health systems. The reasons for the persistent disparity in maternal care utilisation includes

structural restrictions that impair efforts to locate health care providers, psychosocial barriers when there is a lack of trust in health care professionals or hospitals, language barrier and cultural differences (Almeida et al., 2013).

Besides, fear of being detained is one of the main factors causing undocumented immigrants to be hesitant in seeking health care services. A Malaysian non-profit organisation, Health Equity Initiatives has released a press statement on 3 April 2014 to describe the asylum seeking women who were admitted to hospital childbirth, were sent to immigration detention centres after delivering their babies. Both mothers and babies human rights are severely infringed under this immigration policy of detaining such vulnerable women, particularly at the time of childbirth

### **The Turning Point, the Amendment on The Fees Act (Medical) for Foreigners 1951**

The public health system has not kept pace with population growth, especially in urban areas. The increase in demand for health services over the years has reportedly placed strains on the public health care system (Lee, 2015). Safurah, et.al. (2013) points out the lack of health professionals, and a scarcity of health clinics in highly populated areas, such as Kuala Lumpur, is the main issues as people are enduring long waiting times (as cited in Lee, 2015). There is a great need for health care reform but receives little attention.

In 2014, Health Minister Datuk Seri Dr S. Subramaniam claimed that immigrants are taking about 30 to 40 percent of the country's entire allocation for medical treatment meant for Malaysians (Zuhrin, 2014). The Fees Act (Medical) for Foreigners 1951 was revised in 2014, and this order came into operation on 31 December 2014 with the goal to tackle such budgeting issue (Zuhrin, 2014). The Fees Act (Medical) 1951 for Foreigners is a guide for health treatment charges apply to non-citizens at government health facilities. On the 29th December 2014, a circular “(17)d/m.KKM-58/300/1-5” (Appendix D) was released by the Deputy Secretary General of the Ministry of Health. This circular instructs all State Health Directors, Hospital Directors and District Health Officers to implement the new fees structure for immigrants starting from 1st January 2015. Several groups of noncitizens such as red identity card holders, the children of red identity card holders, the foreign spouses of Malaysian citizens, and the children of a foreign spouse are not included. Nevertheless, labour immigrants and asylum seekers are required to pay up for treatment.

Under the amended act, health treatment costs for immigrants will no longer be subsidised. Undocumented immigrants who cannot afford the high hospital cost are ineligible for health treatment, except receiving emergency medical care. Health Minister Datuk Seri Dr S. Subramaniam stated that medical fees of immigrants on health care services would be increased phase by phase such as the rise of 30% in 2015, and in 2016, it will be increased by 50% and subsequently be raised by 70% in 2017 (Zuhrin, 2014). In 2018, health treatment costs for immigrants will no longer be subsidised.

The main concern of the amendment is that the elimination of health treatment costs for foreigners that should come into operation in 2018 is already (2016) being enforced in hospitals instead. The following table shows the comparison hospital treatment charges related to maternal care services before and after the amendment of the Fee Act.

Types of Facility	Charges per day (RM)	
	Before Amendment	After Amendment
<b>General treatment :</b>		
i. Obstetrics & Gynaecology treatment	15	40
ii. Postnatal services	15	40
iii. Ultrasound	100	100
<b>Specialist treatment :</b>		
i. First visit	60	120
ii. Follow-up visit	60	120
<b>Delivery Charges :</b>		
i. Normal delivery	500	2593
ii. Caesarean	1000	3021
iii. Twins	800	2593
iv. Forceps, vacuum or breech	600	2593

Table 1. Treatment Charges for Foreigners - Outpatient Charges

Source: Adapted from MOH, 2013; MOH, 2016

### Cost effectiveness of Maternal Care

Numerous studies have determined that the acquiring adequate antenatal care is related to positive pregnancy outcome, especially a decline in the risk of low birth weight. Since medical expenses for low birth weight infants are numerous times more than normal birth

weight infants, it is assumed that medical expenses for newborns would be cheaper for babies whose mothers have had sufficient antenatal care than those with inadequate antenatal care.

According to the study by Henderson (1994) on the cost effectiveness of antenatal care, for mothers who did not obtain antenatal care, the medical costs for low birth weight infants had nearly six times the costs of normal birth weight infants, and very low birth weight infants had costs of higher than 70 times normal. He explains that prematurity is the significant contributing factor of complications that result in increased hospital fees. He claims a higher incidence of prematurity among females who lack antenatal care. His study concluded that hospital costs for infants with antenatal care are on average USD 1,198.42 less than those without antenatal care (USD 1,045.69 versus USD 2,244.11).

Another study by Lu et al., (2000) regarding a cost and benefit analysis on the removal of state funding for antenatal care for undocumented immigrants in California is in line with the study from Henderson (1994). Comparing the medical cost of postnatal care for an infant without antenatal care to an infant with antenatal care, USD 2341 more was needed initially, and USD 3247 more when additional long-term morbidity cost was combined. Elimination of state-funded antenatal care for undocumented women could save the state USD 58 million in immediate antenatal care costs but could cost taxpayers as much as USD 194 million extra in postnatal care, following with a net cost of USD 136 million initially and USD 211 million in long-term costs.

There is empirical data confirms that practical interventions exist at a fair cost for the prevention of essentially all life-threatening pregnancy complications. Fisk, McKee, and Atun (2011) claim that almost two-thirds of the world maternal and infant disease burden could be relieved through uptake of present empirical findings (as cited in WHO, 2016). Malaysia having implemented comprehensive strategies in improving maternal health care has marked a new chapter in the country by commitment to the rights to health and the right to highest attainable standard of health care. The recent amended Fees Act has drawn attention among Malaysian and started a huge debate among different actors in Malaysia. Will the maternal health in the country move into a different chapter now?

### **Conclusion**

Given that three distinct subject areas (immigrants, maternal health, and health policy) are reviewed in this chapter, a concise overview of them is attempted by focusing mainly on the

literature that exists at the nexus between them. The literature review enables a general understanding of the migration in Southeast Asia and mostly in the context of Malaysia. It is essential to know who, how, why immigrants are in Malaysia. The chapter then outlines an overview of maternal health in general and in Malaysia. The maternal health status of undocumented immigrants and the barriers they encounter in accessing health care are shown. Next, The Fees Act (Medical) for Foreigners 1951 is explained, followed by literature regarding the cost effectiveness of maternal care. The following chapter proceeds to illustrate the theoretical framework employed in the present study to help comprehend how the amendment come into a place and the implications towards the undocumented pregnant women in Malaysia.



## Chapter 3 Theoretical Framework

### Introduction

In public health research, social determinants of health models have improved the conceptualization of how particular circumstances shape an individual's ability to make healthy decisions. This development has entailed a wider conceptualization of factors determining health status. Nonetheless, seldom does investigation attempt to go beyond recognising *barriers* and *promoters* of illness to address problems of origin involved and the unjust power dynamics. Page-Reeves et al. (2013) see public health frameworks likely to be under-theorised. Hence, they think that extending theoretical repertoire to incorporate conceptual frameworks from social science perspective can not only interpret dynamics underlying the creation of health inequality that is poorly understood in the public health discussion but can contribute new perspectives to enhance the effort to restrict and lessen health inequality.

This chapter introduces and illustrates how different theories and concepts interlink with each other to provide a comprehensive understanding of the change of health policy and the implications on undocumented pregnant women to yield constructive responses. The chapter is arranged into two main parts. The former part introduces social threat theory to explain the possible causes that led to the amendment of health policy towards immigrants. The latter part then reviews the role played by structural violence as an effective tool in reshaping the understanding of the marginalisation experience of undocumented pregnant women. Although the framework may not immediately appear related to the health of undocumented pregnant women, recognising multidimensional structural violence can help to answer the second research question that aimed to develop practical and efficient responses to improve undocumented pregnant women's access to maternal health care services in Malaysia.

### Social Threat Theory

Several theories and concepts including social threat theory, nationalism, anti-foreigner sentiment, globalisation, economic insecurity and others have been used to justify increased restrictive immigration policy posed by states in managing immigrants to the countries (Billiet, Meuleman, Witte, 2014; Blalock, 1967; Blumer, 1958; Bohman, 2011; Mavroudi, 2010; Zamora-Kapoor, Kovincic, & Causey, 2013). In this study, social threat theory (also known as group threat theory) is adopted as a useful framework, particularly the economy

threat derivative, in comprehending the leading cause of the government's social control practices. Blumer (1958) and Blalock (1967) originally worked on the theory of prejudice and discrimination mainly on the minority group of African Americans. The threat hypothesis informs a wealth of studies on formal social control and more recently on criminal punishment (King & Wheelock, 2007). In the present study, social threat theory is adapted towards the context of the undocumented immigrants in Malaysia, while the social control practices are expected to take the form of restrictive immigrant policy in Malaysia. In this case, it is emphasising on the change of health policy towards immigrants in Malaysia.

Prejudice and discrimination rise as the relative size of the minority group increases has been a theory among sociologists for a long time. Blalock (1967) attempts to show the disparity in power and status between the majority and the minority. He justifies that, while the size of the minority population, African American expands, it leads to the perception of threat by the majority American Whites, which resulted in "discrimination" against the minority. He outlines two reasons associating intergroup threat and prejudice. First, the competition for scarce resources increases with the relative size of the minority group to the majority group increases. Second, group size can increase the potential for political mobilisation and lead to a larger threat to the majority group as numbers are a potential resource for political mobilisation.

"Economic self-interest" is the key factor of minority discrimination, according to Blalock (1967). Members of the majority groups who sense the economic threat were more inclined to endorse a policy of diminishing benefits to the minority groups. The majority groups view this as problematic as competition for insufficient social resources, such as access to health care, jobs, housing and education rise with the greater numbers of minority group members. For instance, immigrants are considered the minority while native-born Malaysian are considered the majority in the present study. The increase in the number of immigrants in Malaysia has been perceived as a threat harming the country economy by increasing unemployment among citizens, lowering wages, and increasing the demand for health care services in Malaysia. In 2014, Health Minister stated that immigrants in Malaysia were taking about 30 to 40 percent of the country's entire allocation for medical treatment meant for Malaysians (refer to chapter 2 page 17). He further claimed that the situation has led to a huge burden on taxpayers. Thus, the government has sorted to eliminate subsidy (health benefits) towards immigrants' use of public health services starting in 2015.

Blalock underlines the power threat, also known as a political threat as the second type of threat grounded on the core idea that discrimination grows with the potential increased political strength through the expanded minority group size (1967). The majority group perceive that the minority increase would strengthen their capability to push their own agendas in political areas. Previous studies on political threat have mainly focused on the perceived threat posed by African Americans. For instance, Myers’s study concluded that the threat posed by the developing political power of African American has been linked to the rise of incarceration of African Americans in 1990 (as cited in Stupi, 2013). Having said that, this power threat is mostly generated by minority groups who have the voting rights in the national election. Undocumented immigrants in Malaysia have no eligibility to vote may not be considered as a political threat towards the majority Malaysians.

**Development of the concept and the Critics**

Social threat theory proposed a causal chain, which is as outlined in Figure 2 below. These additional links illustrate how the context impacts the perception of threats, which in turn generates support for social or punitive control and eventually result in macro-level control efforts in the country. While Blalock emphasises his core ideas on minority size and threat, it is crucial to be aware that these objective contextual circumstances may only lead to mobilising support for social controls if individuals positioned in such circumstances are truly threatened by the minority groups (Stupi, 2013). Nonetheless, Blalock does not outline extensive detail on the in individual-level part.



Figure 2. Causal Chain Proposed by Social Threat Theory

King & Wheelock (2007) criticise the social threat theory’s lack of study empirically examining if individual perceptions of the minorities as intimidating are associated with punitiveness or if such perceptions support the relationship between aggregate demographic structure and punitive results. They claim the present research mostly operationalises “threat” following aggregate level standards and depends profoundly on judgments and assumptions about individual perceptions of the minorities as threatening. Nonetheless, their study summarises that individual perceptions of African Americans as threatening to economic resources are a strong predictor of punitive controls in the United States.

Besides Blalock, other theorists have contributed to the development of social threat theory. Group position and its consequence on racial prejudice are outlined by Herbert Blumer (1958). He underlines four different feelings that usually exist with the presence of prejudice. First, he points out that the majority group must feel superior to the minority group, whereas the minority group is seen as inherently strange alien (Blumer, 1958). These two markers enable those in the majority group to point out that not only is the minority not comparable to them but also not alike them in unappealing ways. For example, Wong (2016) describes the love-hate relationship between Malaysian and labour immigrants the Malaysian media. While Malaysians complain ceaselessly about the rising presence of immigrants, Malaysians are also the first to surrender and object shortly after a freeze is enforced on these immigrants.

Nonetheless, one may question how many immigrants exactly need to be considered as many enough or too many to cause the perception of threat. Lawrence Bobo (1983) expanded the social threat theory beyond Blalock's by the original relative size of a minority group. He argues that while objective matters may affect perceptions of threat, the subjective or personal perception that minority members pose a threat to scarce resources must be reflected (1983). Hence, an individual's view of the size of the minority groups may be just as crucial as the actual relative group size. Specifically, in the case of immigration, some other sources of information affect individuals' opinions. Sides and Citrin (2007) articulates that perhaps individuals depend on vivid events, or messages from media and politicians while less on the demographic and economic situations (as cited in Stupi, 2013).

In addition, Bobo (1983) highlighted group membership as a strong influential on the perception of threat. That is to say, threats may not directly perceived by an individual, rather to group status or position (Bobo, 1983). As such, original contextual indicators of threat, such as increases in the size of the minority population, may not precisely predict support for the mobilisation of social controls towards the minority. This is because individuals in that area may be responding to a perceived threat to a broader set of collective interests than one's own. For example, a Malaysian may perceive the undocumented immigrants to be an economic threat even when he or her own economic well-being is secure.

The development of social threat theory has come to include other types of threat, criminal threat. This proposed threat emerges from the perception that a minority group commits more crime than the majority group. Chiricos, McEntire and Gertz (2001) explain that this threat is often known as racial or ethnic threat, as their study has connected the presence of minorities,

typically African Americans, to the fear of crime and perceived level of crime in an area (as cited in Stupi, 2013). Castle (1998) claims that there is a new trend in scapegoating labour migrants throughout Asia. Besides being accused of diseases, there is emergence view on “criminal immigrants” in Malaysia. Moreover, there are openly xenophobic voices opposing immigrants committing crimes in Malaysia. This misconception of over generalisation all immigrants are prone to commit crimes is mostly due to the misleading media in exaggerating negative news about immigrants.

The study by Filindra (n.d.) examines theoretical and methodologic issues in the way threat indicators (social threat theory) are used in the literature on state-level immigration policy outcomes. He points out the related issues and urges others to reconsider the conceptualization and methodological confusion of Blalock’s theory in policy models. For instance, he criticises the social threat theory as the analyses have formed inconsistent results which add on to the theoretical confusion. Some scholars found positive and statistically significant correlations between measures of the minority group (Latino or foreign-born) with restrictive immigration policy outcomes; conversely, the same number of studies report null effects (Filindra, n.d.).

For instance, research that focuses on integration policies also indicates a positive and statistically significant correlation between measures of minority size and pro-immigrant policy outcomes (Chavez and Provine 2009; Boushey and Luedtke 2011). The conflicted issue emerges when these analyses that include the identical demographic proxies have indicated two diverse theoretical constructs. It seems to propose that in one case (anti-immigrant policy), the size of the Latino or foreign-born population is a potential for threat, but in the other circumstances (pro-immigrant), it is a potential for Latino electoral strength. The plausible justification is that Asians and Latinos have appeared as politically significant and influential groups that are capable of advocating for their own cause. Hence, political parties who intend to draw voters from these minority groups are prone to have a pro-immigrant policy.

In the case above, the American law of *jus soli* and the principle of naturalisation allow individual from minority immigrant groups to acquire citizenship and along with it political rights. By contrast, undocumented immigrants in Malaysia are not allowed to gain citizenship. Not only they have no rights to vote in the election, but they are also criminalised under the immigration policy and subjected to be deported if they are identified undocumented by the

authorities. The above literature reviewing social threat theory predominates the context in the United States. However, this theory is plausible adapted to this study through justification and understanding the strength and limitation of the theory.

Doing fairness to the theoretical confusion, a separate, thorough review grounded in recent methodological discussions within the relevant context of the studies is the key. There is a chance for other scholars to jointly reconsider the theory and methods in strengthening the practice for clear hypothesis and the generation of new knowledge. Having said that, testing the correlations between measures of perceived threats and restrictive immigration policy outcomes is beyond the scope of this study. However, review of the theory development and recent debate among scholars sheds light on comprehending the restrictive immigration policy in Malaysia.

Next, the chapter proceeds to analyse the structural violence literature in understanding the implications caused by the restrictive immigrant policy.

### **Structural Violence**

While direct violence and human rights violations may invoke images of the genocide on Jews, war in Syria, or challenges to free speech at Tiananmen Square, structural violence invoke a different nature of images on extreme poverty, famine, or denial of services. Strong distinction between the two is that the former examples, violators can be easily marked. For Jews genocide, there is Hitler and his followers who are mainly held accountable, while in Syria war, soldiers and rebel groups are blamed for the death of the civilian, and tanks are visible at the Tiananmen incident. On the other hand, can one easily point fingers at who are accountable for the extreme poverty, famine, or denial of services? How can one identify starvation and illness as human rights violations? Because one does not see the murderer, this violence goes unregistered.

Johan Galtung (1969) defines violence as,

“Avoidable impairment of fundamental human needs or, to put it in more general terms, the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible.”

He further illustrates that,

“When the potential is higher than the actual [it] is by definition avoidable and when it is avoidable, then violence is present.”

For instance, if a pregnant mother died of maternal hypertensive disorder in the eighteenth century, it would be difficult to perceive of this as violence since it might have been quite unavoidable. Nevertheless, if she dies from the same condition today, with all the medical knowledge and resources in the world where maternal hypertensive disorder can be easily prevented through antenatal care, then violence is present according to the definition.

Galtung (1969) underlines that structural violence is indirect, preventable violence constructed into structures where there is imbalanced power and as a result unequal life opportunities. That is to say, structural violence emerges as an unjust and repressive framework that functions through dominant associations and institutions that promise prerogative among its leaders, prioritisation of their individual political agenda through the implementation of their approaches and beliefs. This power inequality ultimately leads to harming others through exclusion and exploitation.

Structural violence is usually rooted in longstanding “ubiquitous social structures, normalised by stable institutions and regular experience” (Farmer, Nizeye, Stulac, & Keshavjee, 2006). They seem almost invisible because they appear so normal in our ways of seeing the world. The frameworks are structural as they are embedded in the political and economic arrangement of the social world. They are violent as they cause harm to people either physically or mentally (Farmer et al., 2006). Paul Farmer is an anthropologist and physician who focuses his work on providing health care to the vulnerable in under-resourced areas. He has further elaborated on Galtung’s concern of structural violence. He explains that it is not the consequences of an accident, they are the result either directly or indirectly of human agency (an agency is a capacity and ability to make choices and act in the world). This human agency is associated with structures that reveal an unequal distribution of power that lead to unequal distribution of resources (Farmer, 2005).

Anthropologist Nancy Scheper-Hughes (as cited in Salvage, Rowson, Melf, & Sandøy, 2012) describes that,

“Structural violence erases the history and consciousness of the social origins of poverty, sickness, hunger, and premature death, so that they are simply taken for granted and naturalised so that no one is held accountable except, perhaps, the poor themselves”.

In this field, the killing does not appear as murder because it seems “natural” because it is a violation of “omission” rather than of “commission.” Let the poor themselves be blamed as the unlucky ones as the easy way out for the invisible murderers.

### **The Debates**

Galtung’s theory of structural violence has brought virtue in discovering the types of violence that include poverty, famine, gender discrimination, subordination, and marginalisation. It enables the possibility to theorise disparity in access to power and resources as a kind of violence. This is especially helpful to understand health disparities in the marginalised groups and the underlying causes in Malaysia because the concept has helped to shift the types of violence from surface phenomena to a wide-ranging set of social relations. Nonetheless, the breadth of Galtung’s concept has marked its boundaries. The idea of structural violence has regularly been argued as too broad and elusive, emphasising mainly on the illusive character of suffering (Winter, 2012).

One of the criticisms among scholars is the lack of analytic methodology in measuring structural violence. Alcock and Köhler (1979) recommend that one should be able to construct a comprehensive, empirically validated theory of structural violence to clarify differences and changes in the magnitudes of structural violence eventually. Conversely, they foresee such a theory is a long way off. Traditionally, scholars decreased the concept of structural violence by assessing it through comparisons of national average life expectancy rates. For example, Alcock and Köhler (1979) measure structural violence according to the basis that a country with high life expectancy rate, like Norway, is exposed to less structural violence than a country with a low life expectancy rate, like South Sudan.

Farmer (1996) questions and demands a well-grained, systemic analyses of power and prerogative that is geographically extensive and historically profound in debates of structural violence and suffering. “Human suffering index” was generated by experts in 1991 to extend the initial approach proposed by Alcock and Köhler (1979). The index aims to analyse human welfare measures including political freedom and life expectancy. Moreover, it is a more advanced and improved method of quantifying the symptoms of structural violence. The index has categorised 27 out of 141 countries as facing “extreme human suffering”. Having said that, it is challenging to quantify suffering due to uniqueness and subjectivity of each’s experience. Farmer (1996) argues that the experience of suffering is not all equal, and



statistics or graphs do not effectively convey suffering. Rather, he stresses the importance to engage studies in human experiences to understand structural violence.

In the feedbacks of Farmer's study (2004), Wacquant criticised that the concept of structural violence has disregarded the historical distinctions of injustice, their intersections, and the way they are compound. Slavery, sexism, class domination, prejudice, and other social exclusions are placed into a single category. Parson (2007) agrees with this argument, and notes on Galtung's oversimplification of structural violence by relating it as an "umbrella concept". This concept may potentially neglect the significant opportunities and possibilities for conflict transformation. Having said that, Parson underlines a multi-faceted analysis and approach not only to understand but also to reduce structural violence, and this can contribute to legitimate the concept in the international sphere.

Stiles (2011) has a different view on Galtung (1969) statement below,

"...if people are starving when this is objectively avoidable, then violence is committed, regardless of whether there is clear subject-action-object relations... as in the way world economic arrangements are organized today."

He highlights the lack of clear subject-action-object relations is problematic while elaborating the theory of structural violence. He uses an example of starvation to justifying his statement. Starvation can be categorised as direct violence, cultural violence or nonviolent resistance; for instance, in the forms of capital punishment, anorexia or hunger strikes respectively. He stresses the significance to draw a complex and dynamic picture of the circumstances to transform structural violence.

Sen (2005) presents an easy and explicit example of a lethal chaos of food politics (as cited in Stiles, 2011). He shows the startling fact that India suffers worse hunger and malnutrition than sub-Saharan Africa while the government held an enormous amount of available food stock. He urges a comprehensive articulation and an analysed examination when explaining this case of injustice. He justifies that the identification of redressable injustice is not just motivating one to think about justice or injustice, but it is also fundamental to the theory of justice. In other words, it is crucial to articulate, scrutinise and clarify a subject-action-object relation in order to position as a case of injustice as structural violence.

The core of various social movements hinges on tracing structural violence back to a cause and tackling those root causes accountable through efficient and practical ways. It is not that

structural violence happens when things are puzzling and indescribable, rather where there is intricateness of social forces. This has to be presented understandable for constructive conflict transformation to alleviate structural violence. Moreover, scholars and conflict transformation practitioners comprehend better on the subject-action-object relations can form the space essential for constructive dialogue and response. Refining the theory requires a system designed for accountability through analysed evidence rather than merely accepting the illusive character of suffering. That is to say, a great collective and social responsibility are needed instead of attributing human suffering to convenient scapegoats such as bad luck.

The articulation of the subject-action-object relation through contextualising the multidimensional structural violence to the suffering of undocumented pregnant women in Malaysia is discussed in chapter 6. This comprehensive analysis is aimed as a guide in answering the second research question to form practical recommendations for the current issues.

### **Conclusion**

The chapter outlines the two social frameworks, social threat theory and structural violence theory. The review of the theory development and recent debate among scholars creates awareness for the researcher in adapting the theories into Malaysian context. Though the frameworks may not immediately appear related to the health of undocumented pregnant women, the frameworks help in comprehending the development of restrictive immigrant policy in the country, and the understanding of the marginalisation experience of undocumented pregnant women. Through locating the root causes of their suffering, practical and efficient responses to improve their maternal health can be constructed.

## Chapter 4: Methodology

### **Introduction**

This chapter describes the methodology strategies and provides the rationale for the chosen strategies. Overall, it discusses the planning and execution of this study as well as reflections on the researcher's positionality. The chapter begins with the justification for the chosen qualitative research design. Following this, logistics of data collection, data analysis and writing processes are outlined. Next, issues pertaining to research and how they are addressed are described. The chapter ends with the reflections of the researcher role and limitations encountered in this study.

### **Research Design**

The research design for this study is employing qualitative methods. They are frequently used in health services and health policy evaluations to present feedbacks concerning outcomes and effectiveness of something such as intervention, policy shift, practice or service (Robson, 2002; Sofaer, 1999). Through 'thick description' supported by Geertz, the descriptive data illustrates not simply the behaviour, but the context also. Hence, the behaviour becomes meaningful to an outsider (as cited in Bryman, 2012). On the other hand, Bryman (2012) asserts that researchers should be conscious of the risk of being over entangled in descriptive part (descriptive excess), as some of the detail may be unnecessary. Hence, it is crucial for a researcher to be aware of limiting lengthy and description excess dissertation. Steps in 'sieving' data to a controllable length and describe an essence rather than accumulating pages in writing is challenging but is important for qualitative research (Wolcott, 2009).

### **Data Collection Techniques**

The semi-structured interview is selected as the primary method of data collection for the present research as it is a suitable method that enables in-depth, narrative answers from the participants (Bryman, 2012; Robson, 1999). This approach requires asking participants a series of pre-determined but open-ended questions. It also opens for additional questions. By applying this approach, information needed to address the research objective can be obtained. Also, with the flexibility of this method, interviewees will be given an opportunity to discuss issues that are relevant to them. Respondents were asked if they consented to potential follow-up interview when there is a need of information or particular explanation.

An interview guide (Appendix C) was used during the interviews as it is flexible to allow it to evolve as the interviews progressed. The interview guide was developed following the literature review. Given the context of the policy change, the questions flow chronologically on the past, the present and the future context directing on outcomes/impacts of the policy change. Open and neutral questions were asked regarding experiences and perceptions of participants towards why the policy is altered, various existing responses and future recommendations were asked. The data collection was carried out between July and August 2016. However, due to complications in scheduling interviews, two participants were interviewed in February 2017 during the researcher's visit in Malaysia.

Individual interviews lasted between 20 to 60 minutes. They were conducted in English language since all participants understood and spoke fluent English. English is the second language in Malaysia. Hence, translation from Malay language to English in data analysis is not needed. Interviews were recorded digitally, transcribed and anonymised to protect confidentiality. Transcripts were the main source for analyses.

### **Document Review**

Additional sources of information was used to contribute insight into the study context, although not formal study data. For example, documents relevant to the studied subject such as media review, reports, scientific articles, policy briefs, advocacy documentation were also gathered to enhance understanding of the study's context. The literature search was conducted to capture the three core themes: undocumented immigrants, maternal care, and health policy. The search was performed on Oria Search. It is the UiT library search that includes multiple databases such as Maternity & Infant Care (Ovid), MEDLINE (Ovid), Scopus, JSTOR, Science Direct (Elsevier), Cochrane Library, PubMed, ProQuest Research Library and others. Besides, the search was conducted on Google and the websites of the following organizations/institutions/projects/networks: World Health Organization (WHO), United Nations Population Fund (UNFPA), All Women's Action Society, Malaysia (AWAM), Ministry of Health (MOH), Federation of Reproductive Health Associations, Malaysia (FRHAM) and others.

The limitation of the literature search is mainly due to the scarce literature regarding the amendment of The Fees Act (Medical) for Foreigners 1951. Most of the relevant information was gathered from reports of news articles and some essential information from the

parliament statement was found on the website of the Socialist Party of Malaysia. There is a lack of information from the official government websites such as Parliament Library, The Public Sector Open Data Portal and the Ministry of Health. Nonetheless, the collected data from other sources presented possibilities for triangulating data sources, thereby improving the validity of the study result.

### **Selection of participants/sources**

Recruitment for individual interviews followed purposeful sampling strategies. Patton (2005) explains purposeful sampling is a method commonly practised in qualitative research for the identification and determination of information-rich samples for the most efficient use of inadequate resources (as cited in Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015). In other words, this approach is employed to recognise individuals or groups that are particularly informed or experienced with a phenomenon of concern, in this case, the change of health policy focusing on undocumented pregnant women.

Two purposeful sampling strategies are applied to enhance validity and reliability of the study. In the first strategy, key informants with experience in aid work of migration issues were asked to recommend actors that potentially met the two criteria. They include knowing the change of policy since 2014 and well informed on immigrants issues especially maternal health. The intensity sampling (targeting persons intensely experienced or knowledgeable of the studied phenomenon) was used. Participants who were successfully interviewed were asked to suggest other information-rich respondents as in the snowball sampling strategy. Purposive sampling is frequently coupled with "snowball" sampling, in which new informants are identified as the research goes along (Sofaer, 1999).

In the second purposive sampling strategy, hospitals and other actors were contacted directly by the researcher without going through key informants. Potential participants were searched within the areas of Kuala Lumpur that are known for highly populated immigrant groups. Thereafter, the snowball sampling strategy was used. This intentional effort was done to curb the dangers of 'enclavage' (a French term defining the risk that the researcher would be absorbed into a given clique and alienated from the larger society as a whole) (as cited in D'Ostie-Racine, Dagenais, & Ridde, 2016). This second strategy was developed after the researcher reflection on the potential bias from solely depending on the first purposive sampling strategy.

The targeted participants are from both health care sector (public and private sectors), and non-health actors. Potential participants who are from the health care sectors are mainly health personnel from the Ministry of Health, health professionals involved in obstetrics and gynaecology or a general maternal and child health care. While potential participants the non-health actors that include academicians, politician, lawyer associate, journalist/media especially health journalist (columnist), economist, people working in NGOs, insurance companies, corporate companies. The undocumented women who have had birth experience after the amendment started 2015 are not recruited as part of the study because this study does not involve all the relevant stakeholders due to the resource limitation and a concern of the ethical issue. However, an attempt was made to recruit various participants with a distinct background to accomplish data triangulation. Such intra-group diversification was a purposive attempt to obtain varied perspectives for an extensive appreciation of individual and collective experiences.

All potential participants were initially contacted via phone call, SMS text or email. Objectives and procedures of the present study were explained to participants upon soliciting their participation. The potential participants were followed up through email with information sheets and consent form (Appendix B). When participants responded positively, interviews were scheduled at a time and place of their convenience. A total of 29 potential participants were contacted. 10 participants responded positively. Eight interviews were carried out through face to face interviews, and two participants were conducted through phone calls due to the time limitation. The participants recruited were health professionals in obstetrics and gynaecology and family medicine (part of maternal care), academician, politician, and people working in NGOs and insurance companies. A list of recruited participants is attached at Appendix A.

In the course of selecting participants, an assessment of three questions were asked to determine whether we can proceed to the next interview session. This assessment is also part of the information sheet that was sent to participants before the interviews were scheduled. This approach helps to assure that the study has the right set of participants overall. This can also avoid draining time interviewing people who did not view themselves as knowledgeable.

1. Are you aware of the difference between refugees, documented and undocumented immigrants?

2. Are you aware of the amendment to the Fees Act (Medical) for Foreigners 1951 in 2014 and the medical fees for foreigner has been increased since 2015?
3. Are you aware of the 100% increase in the foreigners' medical fees since January 2016 instead of the phased removal of subsidies that was planned?

All participants except one answered yes to all three questions. One participant was not aware of the third question, however, the participant was confident to answer information related to the research. Hence, the participant was included in this study.

Moreover, participants were requested to sign the consent form after the briefing of the study by the researcher. Confidentiality and anonymity were assured to participants who refused to be recognised by the public. The research was initially planned to be sent to the participants for their review before being submitted and published. However, only drafted chapters of the research were sent to the participants for review due to the time constraint.

The research was approved by the Centre of Peace Studies, Tromsø. The travel expenses for data collection of the present study were financially supported by Centre of Peace Studies, Tromsø. The ethical approval for the study was granted by Data Protection Official for Research, NSD - Norwegian Centre for Research Data.

### **Data Analysis**

There are no precise rules for analysing and interpreting qualitative data. Unquestionably, data analysis is the most complicated and puzzling of all the stages of qualitative research. However, Burnard and Morrison describe the purpose is to creative and rigorous order, discover patterns, and extract themes from the data (as cited in Houghton, Murphy, Shaw, & Casey, 2015). While Miles and Huberman (1994) defines a case as a phenomenon that occurs within a context. The present study which aimed to answer 'why', 'what' and 'how' questions regarding the amendment in Malaysia follows the analytic strategies developed by Miles and Huberman (1994). These strategies have been influential in case study research and they include data reduction, data display and drawing conclusion.

After all interviews were transcribed, it is inductively coded line-by-line by the researcher manually. Computer-assisted qualitative data analysis software has been developed to assist in the handling, storage and manipulation of the data which allows for quick and easy retrieval of data. However, the present study does not utilise such software due to the rather small number of participants. Primary codes were brought from the question themes, with

additional emergent codes joined when they are judged to be relevant. Such process decontextualizes the data because information is detached from its context. This gave a general accounting design that was not content specific but identified general domains in which codes could be developed inductively (Miles and Huberman 1994).

When new codes were developed, all transcripts were reviewed to see whether the new codes were also relevant. Some codes were developed to group shared perspectives on the amendment and related matters. When completed, codes were examined for meaning and relevance to the research question, which led to the classification of key themes displayed in the findings. According to Miles and Huberman (1994), this involves organising and coding the data, and can be achieved by a process known as 'pattern coding'. The purpose of this type of coding is to reunite data that were split during data decontextualization. Codes and themes were displayed in a matrix form on Excel sheets. Memos are summaries of key information derived from the coding system; they lay the foundation for further development of propositions regarding the data (Miles and Huberman 1994). Memos were written as summary statements on each theme in analysis process to help in drawing the conclusion.

Rather than undertaking deductive data analysis based on an existing social threat theory and structural violence framework, the present study uses a mix of deductive and inductive methods. Since a variety of frameworks was reviewed in developing this research we included some themes identified from the literature, for example cost effectiveness and health care access. However, there were other potential themes that emerged from the data besides themes from such frameworks. Through inductive analysis of the open interpretation of the data and logical categorization of topics, additional themes were recognised. The data analysed is shown in Chapter 5, and it is then triangulated and critically discussed in Chapter 6 as a means to draw the conclusion.

### **Researcher Positionality**

The positioning of researchers as an insider or an outsider have long been theorised and debated upon participation in a research process. It is a crucial issue in qualitative research. The debate includes a specific aspect of identity relating to, for example, ethnicity, socio-economic class, power and gender and how these interactions form the identities of the researchers' insider and outsider. Banks (as cited in Abbas, 2013) said, "the biographical journeys of researchers greatly influence their values, their research questions, and the



knowledge they construct”. Through comprehending the dichotomies of the insider and outsider debate, researchers are or enabled to be more conscious of the implications of being in either, both or in between positions and how these interactions influence the perspective in the research process.

In the work of sociologists such as Merton (1972), he illustrates insider as a researcher who has former intimate knowledge of the researched society due to the previous and ongoing relation with that society. The common presumption is that this intimate knowledge contributes to privileged access of the insider to the researched society that otherwise is difficult or impossible to be accessed by an outsider (Merton, 1972). Nonetheless, an insider does not guarantee the validity of what is learned, as Labaree (2002) states that insiders may have ‘a near obsession with seeking an unseen “reality” in virtually every corner’.

Some researchers (Hellawel, 2006; Naples 1996; Merriam et al., 2001) have debated the established dichotomous notions of insider and outsider because it does not take into account of individuals’ agency concerning the structures they interact with, as well as the varied identities individuals have. Hellawell (2006) says that individual changing experiences and the knowledge of particular context add to different gradients of outsidership or insidership of the researcher, where it is neither fully on the outside looking in nor on the inside taking part. Merriam et al (2001) explain positionality as the researcher ability to change according to socio-cultural factors that form the positionality sub-continuums, such as age, race, religion, gender, language, education, and marital status, and how these interact to form feelings of insidership and outsidership.

The key is to recognise that qualitative researchers are never completely insiders nor outsiders. By identifying these positionality factors, can improve the identities of insiders and outsiders to be seen, and create awareness of the cultural norms of the participants, as well as the researchers own norms, biases, prejudices, positions, and fears regarding this factors (Savvides et al., 2014). According to Hellawell (2006), a series of insider-outsider continua is one way of guiding students in developing the skill to be reflexive about their qualitative research as they become alert and questioning themselves throughout the research process. Moreover, in assuring what researchers reflect on, and are transparent about, the methodological challenges they encounter throughout every research journey have become a significant part of conducting qualitative research. For instance, an ethical issue is an essential element of a study’s internal validity (Abbas, 2013).

Engagement in critical reflexivity on researcher's positionality throughout the research process can contribute in generating ethical and credible research. Next section proceeds to illustrate the concept through the examples of the present researcher's background and experiences (writing in the first person) as both an insider and an outsider in the following section.

The insider-outsider circumstances affected my study even before the study topic was formed. My academic background and my past working experience significantly influence my choice of the research topic. I am a 27 years old Malaysian Chinese female with a bachelor degree in Health Sciences of Community Health and Nutrition. My great interest in aid work has given me the opportunity to be an intern at the health unit of United Nations High Commissioners for Refugees (UNHCR) Malaysia in 2011. I have been affiliating with the health unit in different capacities (Researcher, Research Assistant, Programme Assistant) between 2011 and 2015.

Coming across the injustice and hardship that asylum seekers and refugees are enduring, I have developed a strong concern for maternal and child health of refugees in Malaysia. Hesse-Bieber (2014) explains that feminist researchers often start with a problem that disturbs them individually, and hence, employs different methods to research the concerned social phenomenon. My bachelor thesis was conducted at UNHCR Malaysia regarding maternal care practices of refugees in Klang Valley. Shortly after graduating, I engaged with the National Study on Nutritional Status of Refugee Children in Malaysia as a research assistant under both UNHCR and the Universiti Putra Malaysia. Throughout these years, my affiliation with the health unit in UNHCR gave me an extensive insider's knowledge in the field of forced migration issues. As described by Deutsch (as cited in Labaree, 2002), researchers' positionality of insiderness is a process of achievement.

The current master program of Peace and Conflict Transformation at the Arctic University of Norway has provided me insights into social science research, which have driven me to unite both my health science perspectives with social science perspectives on the present qualitative research. After consulting my research supervisor and my previous colleagues in migration work, I have determined a topic related to migration, gender, and health policy. One of the reasons is the lack of public health research that use the social science perspective lens. Social science theories are ways of understanding that recognise and attempt to disentangle the complicated interplay between politics, economy, social and individual factors over time.

Thus, such approach allows us to understand health policy change, the amended Fees Act (Medical) 1951 for Foreigners in a bigger picture.

My insiderness related to forced migration and my concern on the marginalised groups are both the impetus and foundation for this research. Undeniably, there are advantages to possessing the insider knowledge (Merton, 1972). However, Biber-Hesse (2014) states that some researchers who are conducting projects on social justice are at risk to be prejudiced because of the personal empathy of injustice for others. The challenge of the researchers must be to always negotiate as an insider with the objectivity and precision (Labaree, 2002). Hellowell (2006) illustrates how an individual's changing experiences and the knowledge of particular circumstances can add to certain levels of outsidership or insiderness. Can my identity as a Norwegian student returning to carry out a research in Malaysia construct the outsidership in me, and allow me 'stepping back' to gain objectivity?

Regarding Oriola and Haagerty's study (2012), they describe how scholars who are educated in the global North will face various challenges and opportunities when they return home to conduct research. For instance, they may discover themselves culturally estranged even in societies they assume to know very well. I am unquestionably a different person than I was before studying in Norway. I see myself different in the aspect of gaining new perspectives and experience which can have an impact on the outsidership of me. Nevertheless, I do not find myself alienated from the social and political context of Malaysia. Possibly, I have not left the country for too long (since 2015).

In Ohnuki-Tierney study, she highlights the benefits of individual distancing from the researched community as it enables her to retrieve clarity, and bring objectivity to her research (as cited in Labaree, 2002). Nevertheless, Bulmer argues that 'stepping back' or personal distancing from the researched phenomenon does not promise the capacity to achieve objectivity of the insider's community (as cited in Labaree, 2002). There are indeed complex challenges concerning the matter of objectivity and subjectivity. I perceive the key to being ethical and objective in the research process is through constant awareness and reflexivity on positionality. With the approach that all sides must be represented as well as the use of written documents, newspapers, and government directives may enhance the quest for objectivity.

As a returning researcher with both insider and outsider understanding, I could capitalise on my concurrent inside outsider status methodologically. The participants involve health personnel from the public and private health care sector, politicians, academicians, insurance company, and NGOs from non-health actors. A purposive sampling method is applied to identify suitable participants that are considered insider towards migration and health in Malaysia. They are approached using information obtained from key informants (previous colleagues in UNHCR), and the participants then introduce me to potential participants known to them. The participants were found much more quickly and agreed to participate more readily which implies their perception of me as an insider due to the connection between the key informants and myself. Identifying potential participants through informants who may be considered 'linkages' between the participants and me is helpful to addressing the implications of insider-outsider perceptions in the data collection process (Edmonds-Cady, 2011). This is because they can serve as valuable bridges between outsiders (my position as Norwegian student) and insiders (the participants) in the research process.

Nevertheless, it is dangerous to solely relying on key informants to recruit the initial sample, specifically with the small sample size. Sampling bias may occur when only a particular network of potential participants are being recruited (Atkinson & Flint, 2001). In this research, the key informants are working in humanitarian aid organisations where there is a risk that the sampling chain participants are mostly working in this field. It is also crucial to obtain insiders that are not working actively on humanitarian ground. Through reflexivity on this issue, I have used purposive sampling method in searching for potential participants without key informants. This strategy was aimed at initiating another sampling chain to reach the wider population that has no shared characteristic but still an insider towards the researched topic. The response rates was relatively low compared to sampling that has been done through key informants. The difficulty in getting participants to agree to an interview is partly an implication of their perception of me as an outsider.

The research topic is related to government policy on immigrants' health that is mainly influenced by political and economic factors. This is considered a sensitive topic that has potential consequences or implications, either directly for the participants in the research or the class of individuals represented by the research (McCosker, Barnard, & Gerber, 2001). Such concern may cause participants to withhold information and thus influence the genuinity of their response during interviews. Potential participants may even reject the interview request due to this concern. In the very early stage of recruiting participants, I did not

emphasise on their option of being anonymous participants during my first contact with the potential participants (through emails, SMS and phone calls). Through their answer, I could sense their concern on the sensitivity issue. They may think of the possibility of being misunderstood or misrepresented by a Norwegian student, an outsider (Labaree, 2002). It was the subsequent contacts with the potential participants that built up the relationship, especially when they recognised me as a Malaysian.

In another example, a female human right activist participant expressed her gratitude towards my initiative to study issues concerning gender and migration, especially when I returned to Malaysia to conduct such research. Also, two participants have requested to have a picture together at the end of the interview. This has shown that being Malaysian has enabled me to gain access and contributed to levels of trust. On the other hand, this development of trust may have been influenced by my outsider status as a Norwegian student. It is interesting that although I have a particular shared background between participants and me, as Malaysian, my ability to gain access and build the relationship with them may also have been influenced by my perceived professional 'stranger' identity. My multiple identities have shaped a different positionality (Hellowel, 2006; Naples 1996; Merriam et al, 2001). This positioning can lead to a shifting relationships with the participants (McNess, Arthur, and Crossley, 2013), and thus create unexpected outcomes.

The study by Hsiung (as cited in Merriam et al., 2001) presents evidence that power relations in the field are complicated. It comprises multidimensional variables in the circumstances not only the uneven relationship between the researchers and the participants. My attempt in requesting personnel from the Ministry of Health (MOH) regarding this policy amendment has been challenging and unsuccessful even though I have emphasised the choice of anonymity. One of the personnel (that was proposed by the key informant) mentioned that if I was able to interview his senior colleague in MOH, then he will be willing to accept my interview request as an anonymous. Through contact with the senior personnel, I was advised on the formal process of application for conducting research with MOH. The application process may take as long as six months. Hence, I have decided not to apply due to time limitation for the study.

This case has shown a different situation than Hsiung's study. She was very cautious in not showing alligation with any of the actors (different power level) in the factory in order to gain trust from the factory workers. Whereas, I have encountered the situation where I should

gain support from the senior personnel in MOH in order to have the trust from the others. Through reflection of my positionality, the rejection from MOH may present the implication of unequal power relationships in the social structures. In a social structure that discourages active participation from the citizen in public policy formation and implementation may be partly due to the 'ruling authorities' concern with the research outcomes challenge their power. In this example, my positioning within the unequal social structure is complicated further by my outsidership as a citizen and a Norwegian student.

Reflecting on my positionality in sampling has helped me to understand the various response rates from the participants. It is significant to note implications of insider-outsider status perceptions at the initial and perhaps most crucial stage of the research project (Edmonds-Cady, 2011). Regarding McNess, Arthur, and Crossley (2013), it is necessary for researchers to reflect both the ways in which participants view them before and during interviews. Also, how active decisions in planning research and such positioning can lead to shifting relationships. My return to Malaysia for data collection has lasted six weeks. However, if I was aware of the challenge on being perceived as an outsider or an insider ahead of time, I may acknowledge the need for additional time for the data collection stage. This can help to build rapport with potential participants through phone calls or written communication before the face to face interview occur. It may also assist me in taking more time for the referral process through snowballing and aiming for a larger number of participants in the sampling frame.

Besides sampling strategies, my varied identities of insider-outsider status as researcher led to a different rate of participants' engagement during the interview session. The ways where the participants framed their oral histories and how this information was understood within the study are different from each participant, especially when they have a distinct background from each other. Thus, reflexivity is critical in all phases of the research process, as well as continuing the process of research ethically (Pillow, 2003). Nevertheless, Pillow (2003) states the risk when reflexivity may become oddly non-reflexive. With the emphasis excessively on researcher self-examination can turn into "self-indulgent, narcissistic and tiresome of data". She suggested a "more 'messy' examples like the examples that may not always be successful are important as well.

Besides, triangulation by using more than one method or source of data in the study of social phenomena can check and establish validity in their studies (Bryman, 2012). Bryman (2012)

further illustrates triangulation and thick description contributes to the credibility of the qualitative research. The use of semi-structured interviews, literature review and document review, as well as my own positionality, were reflected in the data, and hence contributing to a stronger reliability of the research. In a study involving multiple participants and many interviews, there is much analytic work to be done. One cannot be navel-gazing at every detail, or the work would never get done. However, it is essential to maintain a kind of methodological alertness as to how interview knowledge is co-produced.

### **Conclusion**

The chapter started with justifying qualitative research as the research design of the present study. Next, the chapter outlined the methodology framework of data collection, participant recruitment and data analysis together with the rationale for the chosen strategies respectively. Following this, decisions made by the researcher throughout the planning and execution of this research were examined through research positionality concept. The chapter ended with showing limitations pertaining to research, and how they were reflected and addressed.

## Chapter 5: Interview Results

### Introduction

In this chapter, the findings are reviewed from the qualitative interviews with health and non-health actors in Malaysia. The chapter has been structured to clearly answer the main questions set out at the beginning of this research. The findings discussed in this chapter presents a comprehensive overview of the data generated by this study and establish the basis for the in-depth discussion contained in the following chapter.

### General Perception on The Fees Act Amendment

Overall, a majority of the participants expressed their firm opposition towards the amendment. For instance, one of the participants (P3) believed this amendment is short-sighted, counterproductive and unfair despite the constraint on the government financial resources. There are three main reasons why this group disagree to the amendment. Firstly, immigrants pay tax; secondly, adverse impacts on the health of immigrants and locals; thirdly, the medical ethic of health care providers. On the other hand, one of the participants (P2) thought that this amendment should be made due to the depleting country resources.

Regarding the first reason, four participants (P1, P3, P7 & P8) affirmed the immigrants' tax paying role in Malaysia. They explained the levy paid by documented immigrants is a labour tax comparable to how the citizens are paying tax. Another two participants (P1 & P3) said that the undocumented immigrants are paying The Goods and Services Tax (GST) that is a value added tax in Malaysia. In explaining the levy generated from immigrants, one of the participants (P7) said,

“If you look at the levy we are collecting, 2 billion over from documented. In fact, the documented can subsidies the undocumented. Is more than enough to cover for them. Our whole health budget is only about 16 billion for a population of 30 million. And health care is mainly for antenatal care, neonatal delivery care, end of life care, older people. Most of the immigrants coming to work are healthy

---

Note: To preserve the anonymity of participants, quotations are credited in this chapter to participants by citing the individual numeric codes they were designated.



young people, age between 20 to 45. That age group don't require very high health care services, accidents and infectious diseases are basically what they get.”

He believed that RM 2 billion is capable of financing the necessity health care budget for the immigrant population of either documented or undocumented.

For the second reason, a majority participants asserted the amendment would induce health problems towards the undocumented pregnant women. For example, the concern about the rise of maternal mortality rate said one participant (P5). In contrast, another four participants (P1, P3, P7 & P8) worried such amendment might rather influence the health of Malaysian themselves. They reflected a higher risk of spreading infectious diseases such as Tuberculosis from the immigrants (who are reluctant to seek health care due to the high cost) towards the locals.

The last reason stated by half of the participants is the obligation of health care providers to treat the sick. The values embracing the right to health, equality care and women rights are fundamental of health care deliveries. For example, one participant said (P7) that Malaysia is a country where the majority if practising moderate Islamic values, yet, fail to look after the poor that are working here. Taking their labour but not appreciating them with basic rights.

### **Plausible Factors Contributing to the Amendment**

Among all the different factors contributing to the amendment, five factors are frequently mentioned by the participants:

- the increased finance burden on public health care services which the amendment is used as a means to release some of the burden
- the health care finance budget are from the Malaysian taxpayers, and hence, should be used for Malaysians themselves
- the expanding number of immigrants lead to difficulties for locals in accessing public health care services
- the amendment is used as restrictive immigration approach to discourage the immigrant from coming to the country
- the privatisation health care approach from the government

The majority of the participants perceived that heightened financial constraint in providing health care services in the country was one of the main reasons motivating the amendment. The expanded health care demand has been shrinking the health care resources. One of them (P4) said,

“Because the government can’t afford to take care of its own citizen. They can’t take care the average 33% extra.”

Moreover, two participants (P2 & P9) related health care to the increased expenses globally where advanced technology in the medical field has driven the surge in medical cost. Half of the participants viewed this amendment, therefore, as a means to reduce or to recover as much as possible the cost of service delivery. Besides the amendment approach, one participant (P2) said that even medical fees applied to Malaysians had been raised. Another participant (P5) also mentioned a budget cut of 10% at the health care facilities where she is working due to the current economic crisis.

Furthermore, more than half of the participants thought individually (or on behalf of friends' or colleagues' comments) that the health care budget should be used to deliver health care services to the country’s own citizens. This mostly due to Malaysian taxpayers’ contribution to the budget. Two participants (P1 & P9) noted that Malaysia health care services are nearly free of charge for citizens as it is very much funded by the government. Besides, the immigrants' medical fees were partly subsidised by the government before the amendment. Close to half of the participants pointed out the increased amount of immigrants in utilising the health care facilities has led to some Malaysians are unable to gain access to the services. One of them (P4) said there is estimated 10 million immigrants where most of them are undocumented. The current health infrastructure is only designed for the locals, and it is incapable of taking care of such an influx of immigrants. Another participant (P10) told the comments that she usually heard from Malaysians and hearsay from doctors respectively,

“Why we pay taxes and all kind of thing, but we have to get services from the private hospitals. Because when we go to the public hospitals, we have to queue quite long, the beds are occupied by non-Malaysian.”

“I have patients in the government hospital, most of them are non-Malaysian. Where are Malaysian? We want to treat Malaysian because we are from Malaysia, we want to treat Malaysian, and this is Malaysian money.”

Although these are the common feedbacks, she doubted the accuracy of the hearsay since there is no other research or evidence to prove this illustrated situation.

Also, one participant (P5) presented an example,

“TB clinic in Hospital Kuala Lumpur sees Indonesian where they will just come by boats across the sea, just to get treatment. After getting treatment, off they go

back. So the government is thinking that some are these foreigners (no doubt some are refugees) using our facilities.”

Therefore, she considered the government is attempting to restrict immigrants from abusing the health system.

The amendment is also used as an approach to restricting the undocumented pool of immigrants. Half of the participants imagined that the amendment aimed to curb the influx of undocumented immigrants to Malaysia by creating a challenging living condition for them. For instance, one participant (P7) pointed out that part of the amendment declared that if anybody does not have proper documents while seeking health care, he or she should be referred to the immigration offices for public release. Another participant (P8) considered the racially polarised structure of Malaysia would be further dynamized with the increased number of immigrants, hence, a restrictive measure is placed to regulate the population.

Besides, the potential reason is that the government is trying to support the health industry such as the private sector to lessen the huge patient load on government health care facilities, according to three of the participants (P5, P7 & P9). One of them (P9) said the government intends to shift all the responsibility to the insurance companies. Another participant (P7) pointed out that the government believes in the neoliberal paradigm where the market can address everything. He went on to explain,

“The government has the concept of staying out of everything. Let the market works. If the government taxing the levy and cost subsidise health care, that’s wrong, that’s government getting involve in the market. The market is god will solve everything if you just take out of it.....So, this price mechanism can solve the problem. Charge them.”

Besides that, a minority of the participants (P5 & P7) presumed that it is the Ministry of Finance, the Economy Planning Unit, and policy makers at the higher level that are accountable for the amendment instead of the Ministry of Health. They argued that the public health sector is not happy with the amendment, notably because they are responsible for looking towards the patients’ health. One of them (P5) said it is likely that the Fees Act is amended by the Ministry of Finance without proper communication with the Ministry of Health.

Additionally, health care is taken as part of the political issues by some politicians, according to one participant (P1). The health care budget is also seen as a political budget to draw votes

for certain politicians. For example, if they raise the medical fees for citizen instead, citizens may not vote for them eventually.

### **Outcomes and Possible Impacts**

The outcomes and possible impacts from the amendment are presented in two directions, the positive and the negative. The main sub-theme in the negative outcomes are; worse maternal and child health; worse security issue while seeking health care; increased health care seeking in the private sector; and doctors are requested to pay the medical treatment fees for those who cannot afford treatment. Whereas the positive outcomes comprised of increased hospital income, hospital productivity and quality of health care.

The overwhelming majority of the participants expressed their profound concern towards worsening maternal and child health of the undocumented immigrant population. Due to the spike in health care cost at the public health care facilities, most of the participants said undocumented pregnant women are seeking late or even no antenatal care at all. Nearly half of the participants said undocumented pregnant women deliver their children without the assistance of skilled health practitioners, and oftentimes, only seeking help when the condition turns urgent. For instance, they most probably give birth at home or with the help of informal medical service providers (traditional treatment), or they deliver at hospitals with pregnancy complications.

Half of the participants said this amendment eventually cause more pregnancy complications, morbidity, higher maternal and infant mortality rate, and children without vaccination. For example, one of the participants (P2) claimed that maternal mortality rate increased tremendously in 2016 by almost 200%. 90% of this increase is from the immigrants. Another participant (P5) worried that undocumented pregnant women who develop complications such as diabetics might transfer it to the babies.

Moreover, denied health care access under critical condition due to lack of money (either for the treatment or hospital deposit) has further undermined the health of both mother and child. One participant (P1) described three incidents where undocumented pregnant women were rejected for hospital admission and hospital deliveries (with a dangerous condition) because they had no money to pay the deposit. In one of the incidents,

“I have got 2 patients from Penang (a city in Malaysia) who are undocumented. They were sent to public hospital for delivery. Public hospital refused their admission, which then they went to seek help at private hospital. And private hospital also refuse to admit them. At last, they delivered the child in the taxi.”

He was disappointed with the different reality from the health care sector that is morally obliged to provide health care towards emergency cases at once. He continued saying,

“So actually, according to the guideline, hypertension patients, if your pregnancy blood pressure is more than 180 systolic you should be admitted to hospital. I have referred this kind of cases to hospitals where I thought they would be admitted. They were not admitted but they were given some medication and then being discharged from the hospital at the same day. The patient then come to me again the next day. There are a few similar cases, so what should I do?”

He expressed his frustration by telling that more and more cases are refused since the stricter enforcement of the ‘black and white’ in the amendment. Another participant (P4) said patients usually do not reach the doctors before going through the administration or registration. If patients cannot afford the treatment, they are not allowed to see doctors, which is unfortunately beyond the control of the health care professional. Two other participants (P1 & P3) noticed some doctors were asked to guarantee payment for the patients who were unable to pay if the doctors wanted to treat them.

Moreover, the risen security concern among undocumented pregnant women while seeking health care is another adverse outcome. Half of the participants said the amendment states anybody who is seeking health care without proper document will be either asked to leave the facilities or will be reported to the immigration. One participant (P8) described incidents where mother and child were sent to a detention centre after delivery at the hospital. This worsens security problem has created more reluctance among the undocumented pregnant mother to seek health care at public facilities.

Moreover, the workload has been reduced to nearly half at the public health care facilities, according to two participants (P2 & P5). One of them (P2) estimated a drop of about 400 to 500 deliveries at the hospital from immigrant pregnant women in 2016. Another participant (P5) said she previously sent two doctors to examine pregnant mothers at the clinic, but she only sends one doctor in 2016. On the other hand, there is a growing access to private health care services among undocumented population mainly due to lower cost than the public sector, more secured from government authorities, and the perceive of better medicine,

according to four participants (P3, P4, P7 & P8). One participant (P1) reviewed the need for extra NGO budget for the high medical cost; another participant (P9) has the related rising insurance cost to pay for more expensive hospital bills.

Additionally, a minority of the participants (6 & P8) said that Malaysia is heavily depending on labour migrants (as cheap labour) in developing the national economy. The stressful situation may seem less attractive for immigrants to work in Malaysia. This may prompt them to either ‘tighten their belt’, or begin to look for other countries. Nonetheless, they are doubting whether this amendment is powerful enough to dissuade or deter them from working in Malaysia or even prompting a labour shortage.

When participants were asked about the possible impacts from the amendment towards the locals, almost half of them said Malaysian would not be affected much. One participant (P4) thought Malaysian are getting health care services as usual, in fact, with a faster rate. However, four participants (P1, P3, P7 & P8) mentioned the concern of the spread of infectious diseases and an increase of non-vaccinated children in the country might affect the locals. One of them (P6) expressed the immense worry on infectious disease control in the country,

“One specific incident can dramatise what could emerge as a problem. For example, SARS pandemic\* 2002, it erupted and subsided again in the period of six months. No medicine. Public health community has resolved to quarantine, and contact tracing. Can you imagine doing this among one to two million undocumented immigrants? We were lucky during SARS pandemic. ... We got it during the subsequent wave, secondary transmission. We have only five cases. If we have gotten it in the first wave, there will be more cases. If it leaks into the large pool of undocumented immigrants and start circulating.”

On the other hand, three participants (P2, P5 & P10) outlined some of the positive outcomes from the amendment. For example, one of them (P2) said more income is generated at the hospitals. This can contribute and improve the productivity of the hospitals. Another participant (P10) said the possible better quality health care services are provided with the

---

\* Note: Severe acute respiratory syndrome (SARS) was a new human disease in the autumn of 2002. It first occurred in Southern China in November 2002 and the global outbreak started in February 2003 (Centers for Disease Control and Prevention [CDC], 2013)

charged treatment, and the patients will not take free treatment for granted. One of the neutral outcomes stated by a participant (P5) is that the undocumented pregnant women still prefer to go to public health care facilities even though the fees is higher now. She guessed that they might see public hospitals as a safer option for deliveries, and some positive experience from friends. She said that some of them manage to pay the hospital fees, as it is not necessary for them to pay one big sum, but paying later.

### **Cost Effectiveness**

Regarding cost effectiveness of the amendment, participants were asked if removal of publicly subsidised health care for immigrants can lessen the government health care budget now and also in the long run. As public hospitals do not withhold emergency cases, it is not cost effective for undocumented pregnant women to have inadequate maternal care. This may burden the country financially in the long run due to the likely additional illness and increased emergency cases, according to three participants (P6, P7 & P8). One of them (P7) explained the cost for treating infectious diseases such as tuberculosis is remarkably high. If the immigrant population is not seeking health care due to high hospital bills, diseases may spread not only among immigrants but also among locals. Ultimately, the government may require a tremendous expense in treating the diseases in the whole country when it becomes uncontrollable.

Furthermore, one participant (P1) related cost effectiveness to the pregnant women knowledge and quality of life. For example, antenatal care is cost effective in preventing complications only for pregnant women with knowledge and money to afford maternal care services. On the contrary, he thought many of the undocumented immigrants in Malaysia might see pregnancy as increasing workforce in the household, probably due to their knowledge and belief from their home countries. However, the perception of having more children may burden those who are undocumented in Malaysia. The need to work for survival is prioritised over nurturing their children. For instance, he (P1) explained,

“I have many patients, they came to our clinic for the first antenatal visit, with pregnancy already in the third trimester. When we asked, why you didn’t come early, they would then say they have got no money, they have to survive, they have to work. I questioned what if they baby has something wrong, they would answer ‘tuhan bagi punya’ (given by God). So religion part, individual education part are all related. For those educated, with money, of course antenatal care is the best.”

He believed the cost effective way for them is through education, especially education on family planning. Another participant (P2) perceived likewise, suggesting that if finance is an issue for the population, they should either not be pregnant or come for antenatal care earlier to ensure the pregnancy is proceeding well as a cost effective approach. One participant (P5) also mentioned that a combined care with General Practitioners (private health care) would be cost effective for maternal health care for this undocumented group. However, almost half of the participants did not answer this question as they were not sure and not an expert in this field.

### **Current Response or Resources in Assisting the Undocumented**

Participants were asked regarding the current response towards the amendment, either from their experience or other actors. Half of the participants said the civil society such as NGOs is helping the undocumented group in various ways. Some NGO clinics are providing free health care services, as well as family planning services to give out contraceptives. One of the participants (P1) determined to join NGO clinic because of the amendment as he foresees the adverse impact on marginalised group.

Another participant (P7) said his team and himself were bridging different NGOs to develop a statement on how this new fee structure is detrimental towards Malaysian public health. Additionally, he was against this amendment by filing a judicial review. Yet, it is rejected by High Court due to the government's decision is a policy decision and as such is not amenable to judicial review procedures.

Moreover, two participants (P5 & P6) said that hospitals still provide treatment in the emergency situation. One of them (P6) said the hospitals would probably deal with some of the needed patients in a quiet way without coming out with exclusive policy. The other participant (P5) spoke of her different way of work in assisting those who cannot bear the consultation services (RM75 each time). Although her workload in seeing the pregnant mothers has lessened, she is giving consultation indirectly through Medical Officers. Also, she mentioned her clinic is co-managing patients with other NGO clinics, local pharmacies or general practitioners (private sector). For instance, she encouraged diabetic undocumented pregnant women to monitor their blood sugar level at local pharmacies which is less expensive than her clinic services and later follow up with the clinic.



## Challenges Faced by Undocumented Pregnant Mothers

Participants were not questioned directly about the present challenges endured by undocumented pregnant women, but the key theme emerged from the interviews through the induction data analysis approach. This theme is essential as a foundation to explore efficient strategies and further support the recommendations given by the participants (they will be outlined in the next section).

Throughout interviews with many of the participants, sub-themes such as security, infectious diseases burden, worse health outcome are regularly mentioned (these three sub-themes were outlined in the previous section). Additionally, another primary difficulty that was assumed by most of the participants is the weak governance regarding the immigration issue in Malaysia. Half of them said there is a lack of communication and collaboration from the government with other actors in Malaysia in improving the situation. Also, another participant (P3) underlined an absence of transparent information from the government. For example, some organisations are advising and engaging the ministry on a broad-based policy level. Although the ministry is attending to given advice, this may not lead to any change. Additionally, government policy is said to be quite selective and inconsistent according to one participant (P6). One example for poorly planned policy from the government was described by a participant (P3) as follow,

“A lot of changes in the health care sector taken place without rational thought, poorly planned development of health care sector, expanding the number of doctors, now is about 5000 doctors joining every year. But there is no increased amount of government hospitals and health centres proportionately. And they are not increasing the health budget proportionately. Huge amount of health care budget is going to the payment to the staffs, instead of being used for development and treatment.”

He further said that this poorly planned development is now being reflected at a shortcut measure such as charging the immigrants, unfortunately.

Both documented and undocumented labour immigrants are highly vulnerable. They are highly susceptible to exploitation by different actors such as government agency, employers, and brokers according to three participants (P6, P7 & P8). Besides, practically every angle of Malaysian policy indirectly promotes undocumented workers (as many as 5 million) according to two participants (P7 & P8). It is systemic structure issue both through corruption

and some shadow policy. One participant (P8) illustrated situations when labour immigrants are abused or mistreated,

“When it comes to domestic work, in private entities is very hard for anyone to check, unless neighbour complaint, normally, they are like in prison. Most of them are not really allowed to go out to interact with people. So that’s where the cases happen. Rape, sexual assault, all kind of violation like no food, or violence..... Besides, female immigrant workers are working in other sector such as garment sector, textile sector. They get very low pay. Lots of unpaid wages, even sexual offends happened. But they are so scared, because they come here by paying a lot of money to the agency. If they complain, they will be sent back. They hardly get out to tell what their problem is.”

He proceeded saying that some of the labour migrants are pregnant either from sexual abuse or of their own will, they are nevertheless subjected to be sent back to home countries. They may decide to risky abortion to remain documented, or they become part of the undocumented immigrant category by continuing the pregnancy.

Nonetheless, two participants (P7 & P8) emphasised what would happen if the labour immigrants reported against the employers such as,

“Once this happen, employer will cancel the working permit, they (labour immigrants) can’t stay in Malaysia legally. They have to go back. They can get special one month pass for RM100, but if the case is going to take 6 month to 2 years to process, they can’t even work in other places or with other employer. How can one sustains life without work and just waiting for such long time?”

Both participants said such system eventually leads to increased undocumented immigrants.

Moreover, one participant (P6) described an article from the World Bank stating one of the chief reason for the rise of undocumented immigrants in this region is the fee structure for immigrants to obtain the working permit. Application to work in Malaysia through the legal channel is very costly (between RM9000 to RM14000). For those who cannot bear the cost and still intend to come to Malaysia may favour an illegal channel such as smuggling. He further explained that trafficking is also another driving force for increasing the pool of undocumented immigrants.

According to three participants (P3, P7 & P8), the policy on criminalising undocumented immigrants has forced them to work long hours and take very low-paid jobs for survival. One participant (P8) saying,

“When it comes to undocumented immigrants, is more difficult. Their pay is always lesser. Minimum wage from this month (July 2016) onward is RM1000, earlier was RM 900. But they don’t get RM 900 neither they are going to get RM 1000. RM 700 or RM 500 are usually what they get. Even if they get RM 1000, they work very very long hours 16 hours.”

The long hour work demand will undermine their health both physically and emotionally.

### **Alternatives Approaches**

In this section, participants were invited to propose an alternative approach, if any, for the amendment. More than half the participants urged for more flexibility from health care providers towards the undocumented pregnant women, specifically the cost of treatment. One of them (P6) said if the need for maternal health care is not too high, the services should be provided for them based on humanitarian reasons. Another three participants (P5, P8 & P10) mentioned that even if the hospitals refuse to provide free treatment, at least it should not be too expensive, perhaps 50% of the current medical cost. One participant (P3) stated that doctors should not be requested to get guarantee payment for patients who cannot afford. Instead, doctors should be permitted to decide whether to waive the payment for particular patients. Also, health care facilities should be a safe place where health is the principal concern. One participant (P7) said hospitals should ignore the legal status of patients, notably not to involve immigration policies within the health care facilities.

Another approach is that equality health care should be given for all. For instance, two participants (P3 & P10) suggested that the government should implement comprehensive national health care financing and corporate social responsibility. Nevertheless, one of the participants (P3) indicated concern over the fact that the national health care financing scheme is politically unpopular as it requires tax paying. Malaysians are not confident that the government administers the fund in a transparent, efficient and honest manner. Another participant (P8) expressed the same concern regarding corruption. He suggested that Malaysia as a developing country should have access to other global bodies and donors for financial aid to immigrants. However, he recommended a mechanism to monitor that the fund is also spent for this purpose.

Besides, half the participants advised an approach to enhance communication either from civil society to government, or communication within government ministries. They explained that two ways communication is the key to forming effective policy concerning all the

stakeholders. Furthermore, three participants (P1, P5 & P9) said cooperation among sectors or actors could improve health and quality of life of the immigrants. At the local level, one participant (P1) suggested undocumented pregnant women can perform blood test at NGO clinics with a reasonable price and then follow-up at government facilities. He mentioned the reduced co-managing cases with government health clinics since the amendment, and he would like to communicate more with health clinics for more co-managing patients. At the national level, a participant (P3) was suggesting,

“We don’t have national health care financing scheme then you have to integrate the two sectors. If to integrate both sectors, have to understand how they both work, but the government just doing all the studies, not engaging private sector to know how the sector work. How do you employ staff; see patients; get paid; order drug; treatment. All these things are very different in the private sector. I’d say they are far more efficient. If you want to integrate 2 such different systems, you have to have internal knowledge of both. But they are not engaging private.”

He considered this as silo intellectual, where one sits in the silo, and sees what is going around without going out to investigate.

At the regional level, one participant (P7) advised on more cooperation among ASEAN countries. ASEAN is essential to act as a society to look after solutions that impact positively towards the regional migration.

One participant (P1) was glad that NGOs are helping the undocumented population, yet, he thought that the assistance is usually challenging to cover non-emergency cases due to insufficient funding. Hence, he hoped that the NGO clinic could ultimately turn into a hospital that delivers free health care services to the needed. Three participants (P1, P2 & P3) said the importance of family planning outreach education and distributing contraceptive to the immigrant population. However, a participant (P2) was concerned that the family planning education cannot reach the target population efficiently because of their precarious status. He repeated that a streamlined system to register the undocumented immigrants is indispensable. He (P2) justified,

“The first thing should done is, the whole system must be streamlined, you see a lot of people coming here (hospital). Not all of them are registered with UN. Of course we have people coming here from so many alternate parts to which they have come. You don’t have a system in place, to know who is here, who is not. Whatever you want to do, you must first organise that, and then think about the insurance for this people, because right now, if someone were to come here, they

ask you how many immigrants you have, and then you don't know, which insurance company willing to blanket covering them. You have to get a system in place.”

He suggested a system in which international organisations or foundations should offer immigrants family planning advice and children immunisation. Another participant (P1) acknowledged that lack of document is causing troubles in identifying them. This is particularly challenging during complicated follow-up treatment if they are using their friends' identity cards or other fake cards with a different medical record in hospitals.

Additionally, he (P2) mentioned a system which might help to look into insurance coverage possibility to improve immigrant health. On the contrary, a participant (P9) said it is not possible for an insurance company to cover purely on maternity. This is because expenses for maternal care can be predicted and saved before pregnancy. This is different to accident insurance coverage that one cannot predict when the accident is going to occur.

Furthermore, the system described above can be a broad-based means to reduce the undocumented pool of immigrants. Half of the participants also stressed the significance of decreasing the number of this profoundly vulnerable group. Two of them (P1 & P4) urged the government in tightening the border crossing. Another suggestion by a participant (P8) is that,

“Should start with the sending country, because they can come undocumented, is also the corruption at their side, sending their workers and getting remittance. We call this modern day slavery.”

Moreover, one participant (P7) said the government should be firm with employers that misuse undocumented immigrants. Strategies centering on reducing undocumented immigrants will ultimately profit the population itself, and most significantly the Malaysian citizens. A sub-theme that surfaced directly and indirectly often during the interview is, “Through helping immigrants, is actually helping ourselves (Malaysian)” or in other words “if we do not assist them, then the outcome will backfire on all of us (Malaysian).” For an indirect example, a participant (P7) mentioned,

“Undocumented immigrants who work below minimum wage, reflects badly on our bottom 40%, because they have similar factory job. To improve the quality of life for Malaysian bottom 40%, we have to improve the life of the immigrants without becoming undocumented immigrants.”

When there are more documented immigrants instead of undocumented immigrants, the levy collection grows further. For instance, one participant (P8) said,

“Migrant pay tax, is more than RM100 per month. Some of the sectors are about RM3000 per year. So much money, should be more than enough to subsidising their own health services.”

This approach was emphasised by two participants (P7 & P8) involves immigrants themselves subsidising health care for the group of immigrants (regardless of legal status) through their own contribution of levy.

### **Human Rights Perspective**

Many of the participants recognised and supported human rights as everyone should be treated equally. For example, one of them (P6) said there is a responsibility of the government towards upholding human rights, which is in line with international obligation. Another participant (P10) claimed this amendment as discrimination against women; she continued saying,

“Getting pregnant for women, we consider it as a general human rights, is not specific. It will be happening to every women in the world. Women need treatment in each and every part in the world, wherever they go, they need justice. And fairness. In that sense. We can’t constraint the treatment for rights.”

She highlighted the need for women to be treated and protected equally, disregarding locals or immigrants. One participant (P3) pointed out that not only is maternal care a human right, but it is also one's right to obtain contraceptive care.

On the other hand, half of the participants discussed the hurdles of human rights in the Malaysian context. Two of them (P6 & P7) considered it inefficient to advocate human rights as a way to improve the amendment in the Malaysian context under the existing unsatisfactory situation. One of them (P8) said,

“If you allow them to enter this country, you should treat them humanly, that should be the position. That is a difficult position to tell the Malaysian public. They have a negative thinking. The other thing that underlying is, you will get the money from them. I defended the case. First, we came out with the human right position, and a lot of people were scolding us. We met a lot of people basically saying we are stupid fellows, should be Malaysian first, and all that.”

Similarly, one participant (P1) said human rights are solely for one that is documented as citizen. He is disappointed with the reality of the government pretending undocumented immigrants do not exist. Furthermore, the rectification is rather seen as a number, according to a participant (P10). She explained there are many reservations in the ratification process. Even if there is no reservation, she is not sure whether the government is committed to the signed ratification. As she said, many people do not recognise human rights still, including some government players. This might be due to human rights is somewhat new in Malaysia. It was only introduced in Malaysia Law study in 2008 for instance.

On the other hand, the general public does not understand human rights as well. She described,

“They don’t know what are rights in specific. How to ensure that public make complaint because they don’t know whether their rights is denied or not. They just accept everything. Especially women. Because we live in the culture of male bias, patriarchal. Sexist. In Malaysia, women usually looking into their violated rights as consented it is alright. There is a possibility of an element they will consent to be treated like that.”

She stressed the importance to make sure what they choose not to discriminate themselves.

### **Conclusion**

In this chapter, the qualitative data are outlined in four main parts. The first part describes the general perspective from the participants regarding the amendment and the plausible reasons contributing to the amendment. The amendment drew a general firm disagreement among the participants. Their argument involves tax paying from immigrants, negative influence on the health of immigrants and locals, and humanity of health care providers. Contrarily, a different perspective on the amendment should be made due to the depleting resources in health care was mentioned.

Most of the participants explained the increased financial constraint in delivering health care services as the main motivation behind the change. This is contributed by increased number of immigrants in utilising the health care facilities. Moreover, this situation has also led to some Malaysian unable to access to the health care services. The resentment among the locals has risen because they perceive the health care budget which is coming from the taxpayers should be used for the citizen themselves. On the other hand, two other different reasons were

mentioned. Firstly, the amendment is used as a means to control the undocumented pool of immigrants, and secondly, to support privatisation of health care industry in Malaysia.

Next, the chapter shows the outcomes and possible impacts from the amendment, and the current response and assistance towards the undocumented pregnant women. The outcomes and potential impacts from the amendment are in the positive and negative categories. Most of the participant underlined the negative outcomes and impacts that include worsening maternal and child health; worse security issue while seeking health care; increased health care seeking at private sector; and doctors are requested to absorb fees for those who cannot afford treatment. Whereas the positive outcomes comprised of increased hospital income, hospital productivity and quality of health care.

For the current response and assistance for the undocumented pregnant women, the civil society such as NGOs is playing a central role. They are helping the undocumented group in various ways. For example, some NGO clinics are providing free health care services, as well as family planning services to give out contraceptives. Besides, some NGOs are advocating for the rights of the undocumented immigrants in Malaysia. Moreover, increased co-managing patients between government health facilities with NGO clinics or local pharmacy was mentioned.

Regarding cost effectiveness, close to half of the participants said it is not cost effective for undocumented pregnant women to have inadequate maternal care as public hospitals do not withhold emergency cases. This may burden the country financially in the long term due to the possible additional illness. Three strategies were mentioned to improve cost effectiveness. They include education for family planning, access to antenatal care earlier, and a combined care (such as co-managing patients) with the local General Practitioners (private health care).

The subsequent part of the chapter illustrates the problems arising from the amendment and the alternative approaches. Throughout the interviews with many of the participants, sub-themes such as security, infectious diseases burden, worse health outcome were regularly mentioned. Another difficulty mentioned by the majority is the weak governance regarding immigration issue in Malaysia and poorly planned development of the health care system.

The chapter then continues with alternative approaches to the amendment. Firstly, a more flexibility from health care providers towards the undocumented pregnant women, specifically a more affordable cost of treatment. Secondly, the significance to decrease the



number of the profoundly vulnerable group of undocumented immigrants through different means such as developing a system to register undocumented immigrants; holding employers accountable for employing undocumented immigrants instead of solely criminalising the undocumented group; tightening the border; curb corruption from the labour immigrant-sending countries. Thirdly, the approach to enhance communication either from civil society to government, or communication within government ministries as well as dialogue with other ASEAN countries to form practical policy concerning all the stakeholders.

The last part of the chapter shows the human rights perspective regarding both the amendment and the undocumented pregnant women. Although many of the participants recognised and supported human rights as everyone should be treated equally, using human rights as an approach to advocate for the undocumented pregnant women might not be effective.

Some of the themes emerged from the majority responses. However, there are many responses often expressed by single or minority participants. These responses were included and not seen as outliers of the study because the participant's groups are from a variety of background. A pattern of different perspectives was observed between individual responses. This is part of the objective of the study to explore perspectives of various actors in obtaining a different point of views. Also, the participants are classified into health actors (such as health practitioners) and non-health actors (such as politician, academician, NGOs and insurance company). However, no distinct pattern of responses was noticed from these two groups in general (besides within the theme of challenges encountered by undocumented immigrants.)

One of the reasons is an overlapping background of some non-health actors with health knowledge or background. For example, the politician was previously a health physician, and the academician has the background in public health. Therefore, a majority of the participants are part of the health sectors. Although the NGOs' participants have no distinct health background, they are working indirectly with the health aspects of the undocumented immigrant group which may be the reason contributing to no explicit difference between these two categories. Another potential reason is that none of the participants is from the policymaking authority or the most affected group of undocumented pregnant women. If these two groups have been part of the participants in the present study, it is assumed that a distinct pattern would have been found.

In the theme of challenges encountered by undocumented immigrants, a difference was observed between health and non-health actors. Non-health actors expressed more issues faced by undocumented immigrants compared to health actors. This pattern may be contributed by the nature of work among non-health actors that have a broader range besides focusing on health care aspect. For example, NGOs who work mainly with immigrants may come across and be more aware of the different problems faced by them.

In addition, a pattern of connection between the various themes was recognised. For instance, the sub-themes of the weak governance and the poorly planned health policy which is under the theme 'challenges faced by undocumented immigrants' can be part of the theme on 'why the policy is amended'. This is an example of interrelated factors that is not easy to be reorder (sequential following the questions asked) or desegregated from each other.

To conclude, the comprehensive overview of the data generated by this study provides the fundamental to incorporate social threat theory and structural violence to enable further in-depth discussion in the next chapter

## Chapter 6: Discussion and Conclusion

### **Introduction**

This chapter begins with connecting results from the qualitative interviews with the theoretical concepts underpinning this study. The first part locates the study findings in the context of the social threat theory, and various factors that are driving restrictive immigrant policies are discussed. The next section explores linkages between the themes identified to structural violence. Structural violence is used to reshape and understand the actual causes of the very circumstances that make pregnancy among undocumented women riskier. It argues a more efficient practical response by avoiding oversimplification of the underlining complex social and economic factors.

### **Social Threat Theory**

According to Blalock (1967), the social threat theory asserts that prejudice and inter-group resentment are principally reactions to perceived threats that are posed by minority groups. The majority groups regard this as problematic or a threat because the competition for limited social resources (such as access to health care, jobs, housing and education) aggravated by increasingly larger numbers of the minority group members. The political threat arises from the majority groups' fear of declining political domination. Also, the symbolic threat appears when the majorities, regardless of social class, perceive minorities as being associated with crime or other "deviant" acts. The expansion of the social threat theory has thus extended to this new types of threat including criminal threat. The theory predicts that each type of threat provokes the majority to support for state-sanctioned social control practices as a means to maintain the majority hegemonic power.

In the present findings, the overburdened health care budget is the chief reason driving a shift in the amendment. Majority of the participants claimed that Malaysians perceive a growing competition in accessing public health care services when some Malaysian are unable to access the services due to the increased number of immigrants in the hospitals. Consequently, the resentment towards immigrants arises. Nearly half of the participants said that some Malaysians demand that citizens should be given priority in the health care services since they are the taxpayers who contribute to the government funded health care. Both studies by Noh et al. (2016) and Lasimbang et al. (2015) summarise that the labour immigrants' access to public health services is low, yet, the increased number of immigrants in the country is seen

as the chief factor straining the health budget. Hence, the government reacted towards the perceived economic threat by eliminating the publicly subsidised health care that was previously available to the immigrants. This main finding is in accordance with the principal economic threat postulated under the social threat theory.

Besides, economic crisis or financial uncertainty can further exacerbate the economic intimidation and thus cause governments to react with stringent immigration laws. Frequently, undocumented immigrants are invoked as the scapegoats for financial crises. In times of a downward economic shift, economic competition escalates since the resources needed for both majority and minority become scarcer, ultimately heading to greater levels of perceived threat (Blalock 1967). According to the study by Evelyn and Chan (2014), numerous import bans were inflicted to lower the admission of migrants to Malaysia, particularly during economic downturns. These measures were regularly short-lived, not persisting longer than a year. This is because retrenchments and evictions of labour immigrants following any economic slowdown were usually reversed soon after employers back paddle due to the labour shortages.

Speaking at a press conference, Dr Mahathir Mohamad (ex-prime minister) has called the government “confused” and says,

“We see flip-flops happening all the time. They introduce a policy then they reverse it and then they reintroduce it. I think there is some confusion about what they have to do which has forced them to reverse policies every time.”

(Chen, 2016)

Moreover, one of the participants (P5) mentioned that beside the imposed amendment; there is a budget cut of 10% (2015) at the health care facilities where she is working. She thinks the current economic crisis might be one of the factors leading to such revision of policy. The devaluation of the Malaysian ringgit (RM) started in the second half of 2014 when global prices for oil began to weaken from a peak of RM 3.16 per USD on 22 August 2014. Malaysia’s ringgit reached its weakest level since the Asian financial crisis in 1998 when the currency depreciated to a low of RM 4.5002 per USD in January 2017 (Liao & Teso, 2017; CNBC, 2017).

On the other hand, a minority (P3 & P7) of participants thought that it was poor governance and poor development of the health care system that has stretched the health care budget instead of the increased immigrant population. This finding is in line with the news article by

Tilford (2015) about BREXIT. He highlighted the growing number of immigrants in the United Kingdom was blamed for putting pressure on the National Health Service (NHS). Nevertheless, he states that the real culprit is instead the health policy failure, such as the supply of public services is too slow to respond to increased demand. Besides, some participants (P5, P7 & P9) mentioned the intention of the government in shifting towards privatisation and corporatisation to lessen the huge patient load at government health care facilities is one of the reasons motivating the amendment.

Through the induction data analysis approach, these two sub-themes (poor governance and privatisation) were identified from the participant's responses. A deductive data analysis approach solely based on the social threat theory may neglect these two plausible factors of the amendment. Although the present main finding is in line with social threat framework, this framework is insufficient to explain other underlying factors that contribute to the government's immigrant restrictive policy.

Regarding political threat from the social threat theory, none of the participants mentioned the potential for increased political threat. This power threat is mostly generated by minority groups who have the voting rights in the national election. Undocumented immigrants in Malaysia having no eligibility to vote may not be considered as a political threat. However, symbolic threat (similar to criminal threat) that links criminal incidents or other “deviant” behaviour to immigrant population is mentioned by minority participants. The threat underlines Malaysians’ perception of immigrants as people who committed crimes, although, Ramachelvam (2008) points out that immigrants committed only 2 percent of the total crimes in Malaysia (as cited in Kaur, 2010). On the contrary, some immigrants were regularly beaten and robbed by Malaysians, according to a report from The Guardian (Pattison, 2017). The report states that the Nepalese labour immigrants in Malaysia do not go out individually or in small groups due to fear of being assaulted or robbed by the locals. Besides, immigrants, especially those who are undocumented are frightened of the police, whom one worker called “robbers in a uniform” (Pattison, 2017).

To conclude, social threat theory is a practical framework which critically considers threats of immigrants perceived by Malaysians; however, it should not be used as the chief framework to examine the forming of restrictive immigrant policy. Next, the thesis then articulates the subject-action-object relation through contextualizing the multidimensional structural violence to the suffering of undocumented pregnant women in Malaysia. This comprehensive

analysis is aimed as a guide in answering the second research question, and to develop practical and effective responses to improve undocumented pregnant women's access to maternal health care services in Malaysia.

### **Structural Violence**

Galtung (1969) illustrates structural violence draws the preventable impairment of basic human needs and exposes how the way habits, norms, and policies embedded in everyday activities are harmful. A deep history of prejudice of immigrant groups leads to norms that hinder them from venturing outside of their comfort zone, for instance, avoiding seeking help from physicians. This causes impairment, not in a general physical sense, but possibly more precariously, because it is accepted as a societal norm. Violence is not confined to a direct action; instead, 'passivity can also be violent'. Dr. Martin Luther King (1991) once said,

“It may well be that we will have to repent in this generation. Not merely for the vitriolic words and the violent actions of the bad people, but for the appalling silence and indifference of the good people who sit around and say, ‘Wait on time.’”

Considering that violence in a restricted context blinds and mislead one to passive violence in a world where one is at risk of being 'perpetrators and not just innocent bystander'. The next section proceeds to how health policy and the underlined structural violence impact the marginalised.

### **Structural Violence – Health Policy and Medical Ethics**

WHO (2015) defines health policy as decisions, plans, and actions that are engaged to attain specific health care goals within a society. Respecting and protecting human rights upholds the health sectors' obligation in caring for everyone's health (WHO, 2015). Health programmes and policies can both enhance or breach human rights depending to their design and implementation. In Malaysia, the Ministry of health states that the health policy follows the core value of right to health and the right to the highest attainable standard of health care (refer to chapter 2 page 15). Malaysia has historically proposed universal access to health care and has made maternal health a priority.

Structural violence happens when it is born of policies within the structural system itself. For example, the one that concurrently limits direct access to prevention and essential health care services, and ultimately leads to health inequalities among particular groups, primarily the

undocumented pregnant women. Denying health care access is a way of strengthening immigrants' subservient position. Societies profit from the economic role played by immigrants, either documented and undocumented. However, the immigrants are discouraged by various barriers in accessing the mainstream health care system. In other words, the people who are cleaning the hospital beds are not allowed to use them.

The traditional measurement of structural violence is based on the evidence of high life expectancy rate, this study, however, proposes to use maternal mortality rate as the indicator. As of 2012 in Malaysia, all ethnic groups had maternal mortality rate below 30 per 100,000 live births except the "Others" category, which is non-citizens (65.9 per 100,000 live births) (UNM, 2015). Although there is no other study showing or measuring the correlations between structural violence and maternal mortality, the statistical difference is obvious to illustrate a huge inequality between pregnant Malaysian and immigrant women.

The present findings show that this amendment leads to a decline in attendance of the immigrant women seeking maternal health care. It is thus inevitable that most of the participants worried about increased of pregnancy complications, morbidity, higher maternal and infant mortality as well as children without vaccination. For example, one of the participants (P2) claimed that maternal mortality rate increased tremendously in 2016, almost 200% in the hospital where he worked. 90% of this rise of maternal death was from the immigrant population. Although this is an estimation from the participant, the huge contrast of percentage has indicated a high level of structural violence faced by the immigrant pregnant women.

In addition, it is also crucial to recognise medical ethical principles that associated to health care providers. Medical ethics illustrate a complicated set of rules outlining the health care providers' obligations to their patients (Biswas, Toebes, Hjern, Ascher, & Nørredam, 2012). Bureaucratic setbacks plaguing the health care delivery can be considered to induce injury by withholding vital, sometimes life-saving care for the needed. For instance, when delivering care to undocumented immigrants, health care professionals may encounter complex ethical dilemmas. In the present study, two participants (P1 & P3) reported incidents of disagreement between doctors and hospital restriction on treating patients who are unable to pay the hospital fees. There are cases where doctors were requested to pay for the patients who cannot afford the medical expenses if the doctors insist on treating them.

Eventually, doctors may compromise their professional values when they choose to give restricted health care to undocumented immigrants. Biswas et al. (2012) describe such dilemmas are often comprehended as “dual loyalty”. These dilemmas are intensified especially when doctors’ professional commitment to providing the greatest possible care is prevented from doing so by policies limiting undocumented immigrants access to health care. A participant (P2) argued that health care professionals should not be directed to be payment guarantor for patients who cannot afford the payment. Instead, doctors should be authorised to determine whether to waive the payment for particular patients. Furthermore, the government should not involve immigration enforcement within hospital facilities, according to a participant (P7). According to medical ethical principles, health care facilities should be a safe place for anyone to seek health care without the fear of being arrested.

### **Cost Effectiveness**

Half of the participants mentioned that many undocumented pregnant women sought health care only when their condition turned critical. According to Malaysia health care ethical codes and guidelines, health care facilities do not reject emergency cases. Some participants (P2, P6, P7 & P8) believed that it is not cost effective for undocumented pregnant women to have inadequate maternal care, and only seeking care when they are in critical situations. The participants perceived an increase in the potential burden towards the country’s finances in the long term due to the likely additional illness or pregnant complications. Additionally, some participants (P1, P3, P7 & P8) also related cost effectiveness to other public health issues such as infectious diseases. Focusing on the preventive measures of infectious diseases control not only improves the health of the general population, but it can also directly save an enormous amount of money from managing an outbreak of infectious diseases.

The study of Lu et al (2000) in the United States summarises that removal of publicly financed antenatal care for undocumented women could save the government USD 58 million in direct maternal care expenses. However, it could require taxpayers as much as USD 194 million more in postnatal care, following in a net cost of USD 136 million in the beginning, and USD 211 million in long-term costs. Hence, providing government subsidised antenatal care to undocumented immigrants will not be a financial burden for the governments. On the contrary, it would eventually save the state's money as antenatal care can prevent the increase of pregnancy-related health conditions that thus incurring higher medical cost. Additionally, it



lessens the long-term medical care costs for the hospitals by ensuring both mothers and newborns are healthy.

The present findings are in line with Lu et al.'s study that argues the plausible immediate financial cost saving from the amendment but fails to recognise the future economic consequences of limiting undocumented women's access to maternal care. For instance, the public hospitals' unsettled bills have sharply increased since the amendment. In a responding statement toward inquiry of unpaid bill by immigrants in 2015, the health minister reported that a total of RM 32.9 million was owed by immigrants at government hospitals and clinics (PSM, 2016). This amount represents 75% of the total unpaid bill of RM 43.8 million in 2015. Compared to 2014, a total of RM 16.4 million comprise bills unpaid by immigrants, the amount of unpaid bill doubled in 2015 due to the increased hospital fees of the amendment. Health minister announced the total unpaid bill by immigrants in 2016 is RM50 million which represents 84.17% of the total unpaid bill at government hospitals and clinics (Free Malaysia Today, 2017). The goal of the amendment is to save taxpayers' money, but can the government truly save more money in the long run?

According to Kassim (2005), the main reason for the unpaid bills incurred by immigrants was their inability to pay for the treatment. This has caused some immigrants who were hospitalised to abscond before being discharged (as cited in Lasimbang et al., 2015). Some employers abandon their immigrant employees when the bill exceeds the insured limit. Moreover, with such high cost of treatment after the amendment, it is predicted that the trend of increasing unpaid bill will persist if no effective alternatives are introduced. Therefore, the present study argues\* that increasing medical cost for the immigrant population is not an appropriate or justifiable means to improve the situation of government financial constraint on delivering health care services.

Furthermore, providing affordable maternal health care will not significantly raise the number of undocumented immigrants in the country. A participant (P6) was concerned that temporary staying immigrants might establish a family unit in the country through pregnancy, and

---

\* Note: The term 'the present study argues' represents the researcher's individual argument.

consequently other long-term migration and citizenship issues from this population emerge. This is a common worry of creating pulling factors for more immigrants to the country if the health care services are affordable. For instance, another participant (P5) mentioned that Indonesians (who are not immigrants in Malaysia) would arrive in Malaysia by boats just to get health care treatment, and go back to their country after the treatment. Nonetheless, there is no other report or research data to support this statement. It is recommended that further research be carried out to support or refute this theory.

On the other hand, empirical data strongly suggest that immigrants' chief reason for coming to Malaysia is clearly not to access health care. They come to Malaysia primarily for greater economic opportunities for a better living and a minority of them are seeking protection as asylum seekers and refugees (Kaur, 2010; IOM, 2008). Besides, immigrants access medical services less often than Malaysian citizens (Lasimbang et al., 2015; Noh et al., 2016). In the present study, half of the participants perceived the amendment by the government is also intended to curb the influx of undocumented immigrants to Malaysia. The government may think that creating a challenging living condition for them could potentially discourage and lower the number of immigrants in the country.

Nevertheless, the present study argues that the complete exclusion of undocumented immigrants from all benefits under the Medical Fees Act is not an appropriate or justifiable means to reduce illegal immigrants mostly because health care is not currently the main reason for migrating to Malaysia.

### **Family Planning and Contraceptive Care**

There is an overarching inclination within public health to emphasise the individual agency and role of patients in caring for their own health. Maternal care, for example, eating sufficient food, seeking antenatal care, seeking timely help in case of an obstetric emergency and accessing skilled delivery are the responsibility of the individual agency. It is essential to highlight the structural violence concept where individual agency is restrained within the choices that are realistically attainable. Farmer (1999) further explains that the degree to which the patients are capable of adhering to therapy or utilising health care services is critically restricted by structural forces that are utterly beyond their control.

For example, participant (P1) explained that undocumented immigrants' late antenatal care visit (as late as the third trimester) is due to financial barriers. They prioritise working to

survive in the country instead of making time to seek antenatal care. Poverty has been one of the key barriers preventing undocumented pregnant women from seeking health care. Consequently, health-promoting choices are not an option in many cases, or they may not be the most practical strategy for an individual in the context of other restraining circumstances. What approaches are effective in improving the health of undocumented women besides providing affordable maternal health care services to them? Three participants (P1, P2 & P3) urged that family planning education including contraceptive services as an alternative approach for the immigrant population.

Since 1960, programmes to encourage family planning in response to large improvements in maternal and child survival are a fundamental factor in reducing poverty (UNPFA, 2005). The poorest, who are the least capable of obtaining maternal care services, will benefit the most from investments in reproductive health care. The advantages of family planning for immigrant women include preventing unwanted or early births, unsafe abortions, high medical costs for pregnancy-related disabilities, the cost of providing for an additional child in the family, as well as indirect costs that include lost productivity at work. With family planning, immigrant women are expected to stay healthier, continue to be productive, and have more opportunities for employment. This, in turn, increased participation in the labour force will also produce macroeconomic gains, and hence, improve Malaysia's productivity and development prospects.

A study by National Population and Family Development Board conducted in Sabah, East Malaysia showed almost 60% of Indonesian female labour immigrants who were married and were living with their spouses in Sabah. However, less than half of that proportion practised any form of contraception (as cited in Lasimbang et al., 2015). In the present findings, a participant (P1) pointed out religion, cultural background and lacks knowledge of family planning are factors influencing the contraceptive use among immigrants. Most of the female immigrants who practise either Islam or Christianity are not encouraged to utilise contraceptive. Additionally, the participant (P1) highlighted that NGOs in Malaysia who provide health care aid to immigrant population are mostly faith-based groups which are not providing family planning services.

The lack of family planning service providers for the immigrant population in Malaysia can be one of the factors contributing to low usage of contraceptive measures. In the present finding, the participant (P1) illustrated the NGO clinic that is Buddhist faith-based is one of

the very few family planning service providers to the immigrant population in Malaysia. This clinic has also invited Muslim religion teachers to understand the situation where asylum seekers or refugees who are seeking protection in another country be allowed to utilise contraceptives due to their vulnerable status. The cooperative approach with the religion teachers in family planning education programs has improved the use of contraceptive among the immigrant population at the NGO clinic. Although there is an improvement of utilisation of contraceptives, the participant also raised the issue of husband's objection towards contraceptive use due to the misunderstanding of that contraceptive would prevent sex with their spouse. Therefore, it is essential to involve men in promoting family planning as some immigrants come from societies that are predominantly patriarchal.

Historically, leadership for family planning has originated from the United States government, and more than half of all international support for family planning still comes from that country. Most developing countries already have population policies in place, however, there is a strong need to assess the barriers to contraceptive use among immigrants, as well as to address adaptation of the knowledge to the local context. This, in turn, can provide a holistic approach to suit the immigrants' societal values, cultures and the religious aspect, and can ensure the use of knowledge effectively.

Another recommendation from the present study is through providing family planning services when documented immigrants undergo health screening each year in Malaysia. To obtain or renew working permit among immigrant women, they must undergo obligatory pregnancy tests. Under the immigration policy, only single women are permitted to work in Malaysia, and they will be deported if the test turns out positive (this policy does not apply to high-skilled immigrants). Those who tested pregnant often undergo abortion, which in some instances may be unsafe to avoid deportation. Otherwise, they tend to escape from the authorities and eventually becoming undocumented pregnant women. Providing family planning services during immigrant compulsory health screening (including both male and female immigrants) can improve the sexual reproductive health of the immigrant population. Most importantly, higher work productivity among immigrants can contribute to Malaysia's economic development.

Very little has been written about violence among undocumented pregnant immigrants from the standpoint for structural violence. Maternal health is constantly impaired by a range of structural violence which put undocumented pregnant women, especially in harm's way. This

concept offers a unique perspective, in seeking to explain the barriers to these problems that are beyond individual agency. Next section attempts to explore the intersection between structural violence, legal status and poverty.

### **Structural Violence - Legal Status and Poverty**

Laws are part of structural violence when they normalise the exclusion of many immigrants who suffer indefinite family separation, work abuse, and limited access to education, health care, social services and poverty. Menjivar and Abrego (2012) clarifies “legal violence” as the “accumulative and injurious” outcomes of immigrant illegality among Central American immigrants in the United States. “Legal violence” apprehends how the range of structural and symbolic violence are systematised in laws. They are creating not only direct social distress but also capable of long-term harm with direct consequences for major aspects of immigrant inclusion (Menjivar & Abrego, 2012).

Structural violence is applied to theorise the rendering of “illegality” leading to diverse forms of violence toward undocumented immigrants. Malaysia, in this case, has labour shortage but rigid immigration laws and policies in the country in approving the working permit for immigrants remains the leading cause of undocumented immigration. A participant (P6) explained that costly working permit application makes immigrants sort to the irregular channel to reach Malaysia while two participants (P7 & P8) pointed out that many of the documented immigrants often result in part of the undocumented pool of immigrants due to work or sexual exploitations as well as pregnancy. One official at Nepal’s embassy in Kuala Lumpur stated labour immigrants are not illegal, they are made illegal by their employers (Pattison, 2017). The poor policy has produced a flood of unskilled migrant workers into Malaysia, encouraged irregular migration and exposed migrants to abuse and exploitation.

According to Schiller (2009), without legal status, both skilled and low-skilled immigrants are subjected to wages difference according to their precarious circumstances, forming a productive, but also flexible and low-wage workforce. The vilification and criminalization of immigrants marginalise their social status further. This threatens their limited bargaining power when it comes to negotiating labour conditions and causing them remain in the cycle of poverty. Farmer (2005) highlights that the world's poor are the chief victims of structural violence. They are subjected to suffering, and more probable to have their suffering silenced.

Besides, WHO has declared that poverty is the world's greatest killer where it is destructive at virtually every stage of human experience, beginning from conception to the grave.

The poor are severely rejected their very right to health and livelihood by a paucity of economic and social opportunities. Deprivation produces persistent barriers to health when people are denied from access to right-to-life commodities such as residing in conditions that make them ill, without a basic shelter, clean water, necessity sanitation or adequate food (WHO, 2003). In addition, people who suffer constant structural violence are also considered as being impoverished of their right to productive and meaningful lives. The poor have poorer health and short life expectancy because they have poor access to health care services, social protection, and in addition, women and girls face gender inequality.

Health is a vital economic asset for the poor since their livelihoods rely on it (WHO, 2003). Average monthly income of a labour immigrant in Malaysia ranges between RM 501 to RM 1000 (NOK 1000 to NOK 2000). With the recent spikes in health care cost, when immigrants become ill or pregnant, they are most inclined to be trapped in a double burden situation of lost income and high health care cost. This is a chain reaction that may involve averting time from earning an income to seeking care for their health. They may even be forced to sell off assets required for livelihoods and sometimes relying on loans just to survive. For instance, one participant (P3) described that,

“For the doctors especially who work in government hospitals, who have to turn away patients, they told me about Sabah and Sarawak especially, they have a big group of immigrants, talking about young people who come with fractures. Young people fractures, they usually affect the whole career of the person and the whole household, if you don't treat it immediately, the leg is going to be stunted. Then the person will not be able to work, and will become the burden of the family and their people.”

From this example, the poor will remain in cycle poverty, if not, even poorer. Those who are desperately in need of work to survive will, therefore, remain in the pool of cheap labour source. One participant (P7) highlighted that this situation would negatively affect the Malaysian bottom 40% or the vulnerable citizens. This is because both vulnerable citizens and the immigrants are seeking similar low-skilled jobs. However, employers are more apt to rely on undocumented immigrants by offering them low pay and deplorable conditions, instead of the required minimum wages for the locals or documented immigrants.

A report by Federation For American Immigration Reform (2011) supported the present findings. The report summarises the presence of a large undocumented labour source continues a vicious cycle because devalued work conditions deter Americans from searching these jobs, and employers became more dependent on undocumented labour immigrants. The report urged for a reformation in stopping the job competition for America's vulnerable locals by halting undocumented immigration and unskilled legal immigration. The report emphasises on holding employers accountable for hiring illegal workers, and this recommendation is comparable to the present study findings.

Nonetheless, the report disagrees with the proposal of amnesty for the undocumented immigrants that is part of the suggestions from the current study. This is because documented immigrants who usually have low income, contribute little or no tax to the government of United States. They are available for tax credits that may exceed their tax contribution and be utilised of various government services. On the other hand, a participant (P7) in the present study urge for both the approaches of amnesty and holding employers accountable for using undocumented immigrants. This is mainly because documented immigrants in Malaysia are not entitled to any other social welfare programs.

Furthermore, the participant (P7) said the annual levy collected is as high as RM 2 billion. A recorded statement from Ministry of Home Affairs at the House of Representatives shows that the levy collected from documented immigrants in 2015 was RM 2.5 billion (PSM, 2016). The participant (P7) argued that the collected levy is more than enough to subsidise the immigrants' own health care services. For instance, the statistic provided by the Ministry of Health shows that the 2015 revenue collected in the public hospitals from immigrants was RM 173.7 million, and the unpaid bill by immigrants was RM 32.9 million. Therefore, the levy collected in 2015 can be used to fund the immigrants' health care services. Overall, stemming the undocumented immigrant pool through amnesty can reduce job competition for Malaysia's most vulnerable citizens and can increase levy collection among new documented. According to two participants (P7 & P8), the levy can in turn subsidise the health care services for immigrants, and thus improves the quality of life among immigrants. This effective cycle can further benefit the economy development of the country.

Living in poverty can be the reason for migration, as well as a result of migration. Next, the section examines the bigger picture of poverty among immigrants as the social inequality that emerges from the structural violence at the global level.

## **Structural Violence - Neoliberalism and Migration**

The range of today's widespread structural violence mirrors longstanding histories, albeit they also arise from more contemporary shifts in global political economies, notably the turn toward neoliberalism. Harvey (2005) postulates that neoliberalism is known for today's predominant model of business-friendly and market-based states. This model commands an approach to states that are founded on the notion that capitalist social relations operate efficiently when they are liberalised from regulation to an establishment of the fundamental so-called free-market forces.

Harvey further outlines the consequences embedding the concept into states functioning as the developing set of neoliberal policies which are presently prevalent around the world. Such policies introduce privatisation, free trade, business deregulation, financial deregulation, diminishment in government services, and cutback of welfare. People are systematically shredded from support systems and resources that were previously openly accessible and publicly provided without the mediation of neoliberalism. For example, one participant (P7) pointed out that the government believes in the neoliberal paradigm where the market can address everything. He further claimed,

“This is all over the world. Immigrants are blamed for threatening the bottom 50%. But those pressure are coming because the austerity. The IMF, World Bank, blue chip coming. Not sure how much is planned. But definitely you are pressuring your own working people, the bottom 50%, by bring more and more cost saving measures, rationalisation. Basically, to cut down the safety net. Then you point to the foreigners, bluff it all and say, is because of them using the economy, they coming for the maternity care and all that, they are getting your jobs.”

(Note: “you” represents the government in this quotation)

The participant (P7) believes this as a kind of right wing propaganda that is connected to shielding up what the government has been attempting to do. For instance, the top 1% gets all the money out of such system.

Moreover, privatisation of health care is a specifically clear example of the impact of neoliberalism. Various problems surface in such ‘market-based health care’, or Farmer (2005) sees it as ‘market-based medicine’. He highlights a few concerns that include: the formulation of the fee-based health sector attendant with the vulnerabilities of the poor getting little or



only intermittency care; an overall focus on individual patients as solely responsible for their individual care; as well as over-charging of the pharmaceutical industry and its reformation of scientific innovations into an alleged intellectual property.

Majority of the participants think the increase in the number of people in need for health care services over the years has overwhelmed the public health care system in Malaysia.

Policymakers have been shifting towards privatisation and corporatization as plausible answers to relieve the difficulty in health care provision (Lee, 2015). For instance, a minority of the participants (P5, P7 & P9) assumed the government is attempting to support health industry such as the private sector to lessen the huge patient load on government health care facilities. One of them (P9) said the government intends to shift all the responsibility to the insurance companies. Using rhetoric of privatisation to address shrinking resources and improve efficiency has however turned out to be a contrary reality.

According to Lee's (2015) study on health economic Malaysia, he argues that privatisation headed by political elites with ties to the states has led to a less desired outcome manifested by elevated costs. Rightly or wrongly, the public health care has been regarded to be for the poor and marginalised, while private health care is meant for the wealthy. Public health care in Malaysia has been seen as inefficient, especially long waiting hours for accessing services (Lee, 2015). For instance, a participant (P10) reflected the common criticism from Malaysians regarding services at public hospitals requires a long waiting time due to high demand for the services. Two participants (P3 & P7) perceived this situation as a result of the poorly planned policy. They think there are too many health professionals in hospitals but inadequate health care facilities. One of them (P3) continued to explain,

“A lot of changes in the health care sector taken place without rational thought, poorly planned development of health care sector, expanding the number of doctors, now is about 5000 doctors joining every year. But there is no increased amount of government hospitals and health centres proportionately. And they are not increasing the health budget proportionately. Huge amount of health care budget is going to the payment to the staffs, instead of being used for development and treatment.”

He claimed the poorly planned development of health care has resulted in the government's health care expenditure to rise, and hence, sorting to a shortcut measure such as charging the immigrants.

In the 1980s, the government began implementing its privatisation policy with the national electricity board (NEB) (Augustin, 2017). The former prime minister, Dr Mahathir Mohamad stated the cut down on civil service through the privatisation of government agencies in the 80s was adopted as a means for the government to spend less on the wages. He explained that some of the civil service staff have sinecure jobs, where they do not work and nonetheless getting paid. Moreover, it was reported (in February 2015) that the Malaysian civil service is the biggest in the world by ratio to the number of the people in the country, with one civil servant for every 19.37 people (Augustin, 2017).

The second Finance Minister Johari Abdul Ghani was quoted that the bloated civil servants of 1.6 million is causing the government's expense to increase drastically every year. However, he said Putrajaya (the government) would not be taking any action to reduce the number of civil servants (Augustin, 2017). Half the participants argued that communication either from civil society to government, or communication within government ministries must be changed. They explained that two ways communication is the key to forming effective policy concerning all the stakeholders. Long term positive impacts should be emphasised instead of cringing to short sighted positive outcome.

On the other hand, the study by Wise, Covarrubias and Puentes (2010) regarding migration, development and human rights, has critiqued the means of capitalist reorganisation that is presently leading under neoliberalism has very little to deal with a liberal market philosophy. Instead, it involves the spreading monopolisation of economics, global production, services, and trade with rising labour exploitation and environmental depravity. They further illustrate the unequal growth that sums up this prevailing trend that produce economic, political, and social processes of divisions (between regions, countries, and social classes). The manipulation of the workforce, particularly through labour migration (that has been built-in poorer peripheral nations) have ultimately reshaped the scope of current human mobility. For instance, some countries including Malaysia in ASEAN, have undergone rapid economic growth since the 1980s. Such development along with 'push' factors in other nations has led to a surge in labour migration, especially low-skilled workers as a cheap labour source, predominantly coming from neighbouring economically disadvantaged countries.

The coupling of structural violence (with its impacts) and migration can be identified in cases where the structural and subsequent direct violence serves a purpose for migration. Delgado Wise and Márquez (2013) demonstrate that unequal progress in the neoliberal circumstances

creates a separate nature of migration that can be distinguished as forced. Although the notion of forced migration does not refer to all migrants in such circumstances, it does portray largely on the present migration flows. Forced migration primarily refers to asylum seekers, refugees, or internally displaced persons in the humanitarian field. Through this principal, most migrants cannot fall in this category considering these migrant group movements are assumedly undertaken willingly and freely. Castles (2003) argument is in accordance to Delgado Wise and Márquez (2013) study. Although it is relatively effortless to recognise the impact of neoliberalism on economic driven migration, it is harder to recognise its impact on forced migration.

Migration is a global level challenge, a national level solution that neglect the root causes (such as inequality and poverty) of such challenge will simply not work. The present study urges more effort from the government in rethinking and revising the existing national immigrant policies. Additionally, supporting more dialogues and cooperation among ASEAN countries regarding migration in this region should be emphasised. A participant (P8) mentioned the importance of labour-sending countries in reducing irregular emigration. He said,

“Unless the sending countries do the best in sending their workers, doing the measurement on their side, not everyone can go illegally. Because they (immigrants) can come undocumented, is also the corruption at their (sending countries) side. We are like fighting fire here alone. If you want to resolve, should start with the sending countries. They themselves nicely sending their workers and getting remittance. We call this modern day slavery.”

Both sending and receiving countries are benefiting from the labour migration. For example, sending countries usually have a great economic advantage in emigration, in particular due to remittances from emigrants that can relieve the need for social welfare that the governments are incapable of providing. Reported remittances solely received by developing countries in 2010 notably surplus the amount of official fund flows and composed ‘over than 10 percent of Gross Domestic Product (GDP) in numerous developing countries’ (World Bank, 2011). Therefore, effort should be made in both Malaysia and labour-sending countries in reducing irregular immigration.

Despite the determinants that underlie migration in the present world are diverse, international or individual debt and the neoliberal policy measures creates part of the background context under which many people choose to migrate. The dominance of neoliberalism is not gender-

neutral, and the forces have unevenly affected women. One of the consequences of neoliberal economy structure is the feminisation of labour. This is reflected in the growing number of women in the global labour markets is the effect of systematised gender positions and work that is depreciated (Ruiz, n.d.). The next section attempts to discuss the gendered experience of structural violence in female migration, present the specific position of gender inequality in the commission and protraction of structural violence.

### **Structural Violence - Gendered Migration**

Research into the influence of a gendered experience of migration on female migrants is not new. However, the discussion is dominated by the scope of capital flows that draws women from the global south into labour in the global north, mainly about lives of migrant domestic workers and migrants engaging in sexual labour (Stepnitz, 2013). The paucity of research on gendered migration experiences in the context of structural violence may potentially neglect the underlying circumstances of female migrants who are in fact more precarious. Hence, perpetrating the continuance of gender inequality in sending and receiving countries.

Donato (2000) illustrates that migrants are usually conscious of the relative nature their gender takes on since their migration forces them to react to who and what they should be instead of who and what they want to be (as cited in Stepnitz, 2013). Sylvia Walby (1997) divides 'gender regimes' into public/private. The 'domestic gender regime' is related to the household context as the central arrangement of women's work, where the abuse of women's labour and gender is based upon the exclusion of women from the public. For instance, a participant (P8) explained,

“When it comes to domestic work, in private entities is very hard for anyone to check, unless neighbour complaint, normally, they are like in prison. Most of them are not really allowed to go out to interact with people. So that's where the cases happen. Rape, sexual assault. All kind of violation. No food, or violence.”

On the other hand, 'public gender regime' reflects the similar principle. It includes women in public, however, based on the discrimination and subjection of women in the structures of paid work, as well as within culture, sexuality and violence. Individuals who are driven by certain conditions where their options are predetermined for them by a structure instead of their individual choice are the victims of structural violence. In Malaysia, rising specific labour needs gravitates toward the informal services, housekeeping and childcare services,

and the "entertainment" sectors. Such structured paid work have been met by female labour migrants from the lower income Southeast and East Asian countries.

For example, the participant (P8) further described that most of the immigrants coming from Cambodia are female where they usually work in the garment or textile sector besides domestic labour. Their salary is very low or they are even often not paid for their work. When sexual offences happen, the cases tend to go unreported due to fear of being sent back by the agency. Due to the high fees or cost in applying working permit to come to Malaysia, labour immigrants may be in direct debt to the agency or indirect debt with third parties such as family and friends back in their home countries. Hence, many of the immigrants who are abused remain quiet and seldom report their problems.

The emanation of gender-specific employment niches has indirectly led to a range of migratory violence towards female migrants. Women's migration, primarily from less economically developed countries, is portrayed as low skilled with strong stereotyping of women earning less wage than men, desperate for the work and willing to accommodate work with poor conditions has positioned both women and men into differing work-related tasks and expectations. This gendered migratory violence spreads from complex structural abuse of the high cost of work visas compared to women's wages, to the most outrageous accounts of trafficking women in sex exploitation. It includes low-skilled female migrants who are exposed to sexual harassment at work or smuggled women who are raped in order to pay for their passage.

Upon arrival in the destiny country such as Malaysia, their precarious status often lead them to be undocumented female immigrants, which will then be criminalised under the immigration policy. This population who is often overlooked and deemed invisible continue to be suppressed under such structural violence. Structural violence framework enables the recognition of female migrants is not only spatially excluded in a private work place, but they are also then doubly marginalised because of social and economic presumptions about women's place. As such, gender inequality runs through and amplifies marginalisation as a result of structural violence in preventing women to triumph of advancement and access to resources. Next section further discusses human rights aspect regarding the marginalised group, particularly violation of rights on gender-specific health of migrants.

## **Structural Violence - Human Rights**

Human rights acknowledge the birthright of each and every human being. Human rights strive to defend the fundamental dignity and just value of all. States assume commitments following international law to uphold and safeguard human rights (IOM, 2013). International human rights law provides that all persons, without discrimination, must have access to all fundamental human rights presented in the international bill of human rights (IOM, 2013). Migrants, regardless of their status, are protected by international human rights law. However, governments often use legal status as a foundation to draw a line between individuals who may and may not enjoy access to health-care facilities, or other social services. Different forms of discrimination create obstacles for the realisation of the right to health and other rights of immigrants especially that of undocumented pregnant women.

The health policy in Malaysia is formed on the core value of rights to health and the right to the highest attainable standard of health care. Also, on 5th July 1995, Malaysia reaffirmed its pledge to provide basic human rights to women and children in complying with the Convention by the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC) (Ean, 2003). Although Malaysia had declared some reservations and did not acknowledge the provisions of several articles, the key provisions grant all women and children a right to health, without concern for legal status.

The CEDAW Committee has affirmed the obligation of states' parties to assure women's right to secure motherhood and emergency obstetric treatment, as well as designating a maximum limit of accessible resources to such services. In 2008, CEDAW focused its attention on the circumstances of female labour immigrants, including their sexual and reproductive health. As noted in its General Recommendation No. 26 (CEDAW, 2008) on female labour immigrants,

“Discrimination may be especially acute in relation to pregnancy. Women migrant workers may face mandatory pregnancy tests followed by deportation if the test is positive; sometimes resulting in irregular immigration status and deportation; coercive abortion or lack of access to safe reproductive health and abortion services, when the health of the mother is at risk, or even following sexual assault; absence of, or inadequate, maternity leave and benefits and absence of affordable obstetric care, resulting in serious health risks.”

In Malaysia, where undocumented women hardly have access to emergency medical treatment, this commitment is not met. Besides, their reproductive rights are infringed upon the mandatory pregnancy examinations followed by deportation if the test is positive. Furthermore, lack of legal assistance for physical exploitation and sexual assault among undocumented women is hugely problematic. According to the CRC who acknowledges all children have the right to health, Malaysia undermines the right to health by not delivering adequate health care services to undocumented children.

States that decline to provide adequate health care can be held accountable for not meeting their obligation to human rights standards. In a case study in Sweden, the Right to Health Initiative expresses that accountability is not merely serving legal cases to court. It can involve a broader legislative process where health professionals coordinate with human rights lawyers and civil societies to draw awareness to disparities between international human rights law, state policies, and enforcement in the system (Biswas et al., 2012). Consequently, numerous hospitals together with 19 out of the 21 Swedish councils have approved a less restrictive policy towards undocumented immigrants. The indications for treatment are expanded, and flexibility on demand for payment is raised. The report pointed out the argumentation for the policy reformed was largely based on human rights legislations (Biswas et al., 2012).

Nevertheless, half of the participants in the present study argued the hurdles of human rights in the Malaysian context where the gap between ideal human rights concept and the reality is wide. They considered it inefficient to advocate human rights as a way to improve the amendment in the Malaysian context under the existing unsatisfactory situation. The field of health and human rights, most would agree, is in its infancy in Malaysia compared to human rights awareness in European or Western countries. This might be due to the fact that human rights is somewhat new in Malaysia. Human rights were only introduced into Malaysia Law educational system in 2008, according to one of the participants (P10) in the present study.

The participant (P10) continued to explain that many people including some of the government staff still do not recognise human rights. Additionally, the clear connections between health and human rights is not recognised. Different factors have contributed to the acceptability and priority of human rights in Malaysia context. One should be aware that the development of human rights is chiefly originated from Western countries. However, O'Connor (2014) argued that diminishing human rights with the claim that they are

“Western” and therefore incompatible with other cultures is problematic. He explained that the human rights declaration might not be perfect, and unquestionably there are debates regarding the implementation of such rights. Nonetheless, the essential of human rights is not due to their origins, but the knowledge to defend the individual concerns of the powerless, in any culture. Further analysing of such debate is beyond the capacity of the present study, yet, some of the current study findings shed light on the human rights situation in Malaysia.

According to the participant (P10), the government’ rectification to the various convention is rather viewed as just a matter of signature in Malaysia. She explained different reservations had been made in the ratification process. Even if there is no reservation, she is not confident whether the government is seriously committed to the signed ratification and implementing the principles as well as reforming existing regulations. This can be perceived as the government’s unwillingness to prioritise human rights protection. Besides, Farmer (2005) questions the concept of human rights. He highlights that social inequalities have always been used to deny some people status as fully human. He critiques health care that considers human rights accorded only to citizens of a certain nation. He commented,

“If access to health care is considered human rights, who is considered human enough to have that right?”

In the present study, one participant (P1) said human rights are solely for one that is documented as a citizen. He is disappointed with the reality of the government pretends undocumented immigrants do not exist. A few participants (P6, P7 & P8) pointed out that some Malaysians tend to be selfish in their resentment towards immigrants accessing the country’s resources. They think that human rights for locals should be prioritised first before talking about human rights for immigrants.

On the other hand, Farmer (2005) stressed that everybody is part of the socioeconomic arrangement and thus part of the global problems. He said that, “we profit from a social and economic order that promises a body count” (2005). Even some people who are conscious of this connection, may react by saying that this socioeconomic arrangement is impossible to re-arrange, especially with the individual power. This kind of reaction causes apathy, yet it concurrently underlines the persistence of human rights violation. Farmer argues that comprehending violence as being constructed by a socioeconomic arrangement should encourage the idea of system restructuring is possible. Something that is socially and economically organised in a way can be reorganised in another more fair and humane way.



An individual might ponder on how one individual can make a change in this globalised and deep-rooted socioeconomic structure. Change always begins with an individual. One individual may seem powerless in making a change, but everyone has the power to appoint the leader in today's majority democratic world. For example, although public policy in Malaysia is mainly top down and to a great extent made behind closed doors (Hunter, 2013), one of the participants (P7) in present study argued that the government is likely to respond to the demand from the public in the long term. He explained that Malaysians do have the ability to affect the government policy decision through their ability to elect politicians in or out of their services according to the adequacy of their policy representation. One of the participants (P1) said the government would not raise the medical fees for citizens but on the immigrants. This is part of the political games where the politicians are afraid that Malaysians will not vote for them.

Therefore, a participant (P7) strongly urged for more awareness among the locals. To set things in the right direction, education is central of all recommendations. A more comprehensive education on human rights can create awareness. A participant (P7) stated that civil societies which care about the undocumented immigrants should go to the public to educate the locals and to correct the misconceptions against immigrants. Nonetheless, it is crucial to recognise human rights education should not be limited in teaching a select group of students or Malaysians with an avowed concern in health and human rights.

The argument of undocumented immigrants' rights and right to health care is undeniable a controversial political topic. The intense debate is not only in Malaysia, but it is also debated worldwide, especially in light of the present global economy recession. What measures can be taken to improve health and human rights for the vulnerable immigrant group?

### **New Research Agendas and the Hurdles**

New research agendas that focus on the complicated dynamics of health and human rights, on the health effects of political-economic disruption, and on the pathogenic effects of health and social inequalities, including prejudice, gender bias, and the expanding gap between rich and poor need to be in place. Clancy, Glied, and Lurie (2012) point out that the role of research in advocating policy change starts with defining the contours of an issue which is aimed at showing the need to address the issue. This is crucial towards matters that are not obvious, especially the rooted structural violence that seems invisible to many. For example, accessing

to HIV antiretroviral medication but having no money for food is similar to washing hands and drying them in the dirt. Moreover, health policy is firmly linked to political and economic factors in the country. A new level of cooperation between disciplines extending from social anthropology to epidemiology must be put in place. Such research must stress on social and economic rights as the central of health and human rights agenda.

Advocacy research is often used to influence the formal and informal policies constructed or amended by policymakers and others in power (Clancy et al., 2012). On the other hand, it is not clear to what extent this can impact policy making in Malaysia. Public policy in Malaysia is mainly top down and to a great extent made behind closed doors. The Malaysian public service has been the leading policy maker for years through the Economic Planning Unit (EPU) within the Prime Minister's Department. One of the participants from the present study highlighted that policymakers in government involve relevant consultants in the process of policy decision making. As such, the policy is probably designed within government, influenced by non-government actors, and by organisations external to the national health system.

With the lack of transparency regarding policy making from the government, the present study recommends that research in understanding this aspect so that advocacy research targeting the right actors may have a bigger impact for health policy change. Nonetheless, one should note the multiple barriers to reach the many different actors, individuals, groups and networks involved in policy processes. Therefore, a study should explore the possible network of this policy communities to learn whether the policy communities are tight-knit networks with few participants who share core values and resources.

Another huge hurdle is that researchers can barely influence policy or implementation decisions by publishing research papers. Clancy et al., (2012) claim that researchers are seldom successful alone, but can benefit from cooperation with advocates and related parties to help make their case stand out with the language for public and policy makers to comprehend. The present study emphasises on the links between universities, medical providers, and NGOs to advocate effectively in improving the health of undocumented pregnant women.

To sum up the argument up to now: there is a long way to go in the fight for health and human rights. It is not really plausible to solely examine the topic without essential and

realistic programs; and the health angle allows a critical new perception to understand the interlink of politic, economy, health and human rights violation

### **Conclusion**

In this study, a wide range of issues such as migration, neoliberalism, governance, gender, immigrant regulations, poverty and human rights were discussed through examining the implications of the recent amendment made to health policy that affects the maternal health of the undocumented immigrants. In a traditional public health research, these broad perspectives that purview different disciplines might be seen as too far afield from health-related matters, or ‘too political, too economical’ (Page-Reeves et al., 2013). However, the present study argues that developing an effective intervention in reducing health disparities among undocumented pregnant women requires moving beyond the focus on *barriers* and *promoters* that are commonly emphasised in public health research, and address factors previously considered to be beyond the focus of public health (Page-Reeves et al., 2013).

By extending the theoretical repertoire to embrace frameworks from social theory, dynamics underlying health inequality in an immigrant population that are not usually the centre of attention in public health research can be revealed. Further theorising allows formulation of how the social and economy factors interact with health rather than solely accepting that they exist. The invisible forces or invisible violence makes health inequality seem like an inevitable result of the natural order of things. It indicates risk factors within individuals and enables the silo-ing of health from other aspects of individuals' life. The structural violence framework helps to incorporate the comprehending of health by explaining the extent to which the dynamics of inequality are structured by larger political, economic and social forces. Furthermore, the review on the social threat theory has shed light on understanding the shift of health policy in forming the amendment in Malaysia. The findings of the present study were located within the social science framework to make sense of the bigger picture behind the amendment.

## Chapter 7: Conclusion

The amendment on The Fees Act (Medical) for Foreigners 1951 which has come into order in 2015 has cut out the subsidy on the health treatment costs for immigrants. Health care cost has risen almost triple for a labour immigrant in Malaysia that earns RM 1000 (NOK 2000) monthly or often less than that. The purpose of this research was to understand the on the amendment on The Fees Act (Medical) for Foreigners 1951 and its implications on maternal health care of the undocumented pregnant women through perspectives of health actors and non-health actors in Malaysia. Specifically to answer the research questions on why the amendment was put in place; what are the outcomes and impacts in aspects such as public health and economically; as well as the existing help and alternative approaches to improve the maternal health of the undocumented pregnant women. The findings gathered were used to explore the root causes of the existing issues in order to develop practical recommendations or interventions. This chapter briefly summarises the implications of the findings and the potential aspect of future research.

The uneven growth in neoliberalist economy structure has driven people from poorer countries to more developed countries that have demand for the labour force, such as Malaysia. Additionally, forced migration has contributed to asylum seekers and refugees population in Malaysia. However, Malaysia, who has a labour shortage and concurrently rigid immigration policies has indirectly encouraged the undocumented migration. The present findings are in line with the social threat theory, especially the economy threat. A majority of the participants stated that the strained health care budget situation has led to the amendment, and the increased number of immigrants in Malaysia was perceived as the chief factor straining the health budget.

Close to half of the participants pointed out that Malaysians perceive a growing competition in accessing public health care services when some of them are unable access the services due to the increased number of immigrants in the hospitals. Consequently, the resentment towards immigrants arises. More than half of the participants expressed that some Malaysians demand that citizens should be prioritised in the public services since they are the taxpayers of the government funded health care provision. Therefore, such restrictive policy is formed (especially during economy crisis) to reserve the health budget to Malaysians and to control the immigrant population. Half of the participants imagined that the amendment is aimed to

create a challenging living condition for immigrants, and hence, could potentially curb the influx of undocumented immigrants. Nevertheless, the present study argues that the complete exclusion of undocumented immigrants from all health care support is not a justifiable means to reduce illegal immigrants because health care is currently not the main reason for migrating to Malaysia.

Although the main finding is in accordance to the social threat framework, the framework is insufficient to reveal other factors that possibly lead to the forming of restrictive policy. Through inductive analysis approach, the present findings also unveil other underlying factors. A minority (P3 & P7) of participants unveiled that the poor governance and poor development of health care system that have actually stretched the health care budget were masked by scapegoating the immigrants. Studies have shown the low access of labour immigrants to public health services in Malaysia, but the immigrant population is often cited as the main cause of the limited health care provisions (Lasimbang et al., 2015; Noh et al., 2016). Besides, some participants (P5, P7 & P9) mentioned the intention of the government to support private health care sector in the country.

With the drastic increase of hospital fees structure, immigrants are most inclined to be trapped in a double burden situation of lost income and high health care cost when they become ill or pregnant. The main impact of the amendment is the declined in maternal health care-seeking among the immigrant population. All participants worried about the possible increase pregnancy complications, morbidity, higher maternal and infant mortality rate, and children without vaccination. These circumstances will further widen the health disparity among the undocumented pregnant women. Half of the participants said the civil society such as NGOs are helping the undocumented group in providing free health care and family planning services. A participant (P1) said the available scarce resources in the NGO clinic often limit to primary cases.

Moreover, three participants (P6, P7 & P8) said that inadequate maternal care among undocumented pregnant women is not cost effective as this forces them to only seek care when faced with life and death situations, leading to further complications. This is perceived by participants as a latent burden to the country's resources due to additional illnesses or pregnancy complications. This impact has been shown with the current (2016) unpaid hospital bill from the immigrants. The total unpaid bill by immigrants in 2016 was RM50 million compared to RM 32.9 million and RM 16.4 million (before the amendment) in 2015 and 2014

respectively. Therefore, the present study argues that increasing medical cost for the immigrant population is not an appropriate or justifiable means to improve the situation of government financial constraint on delivering health care services.

Another impact of the amendment pointed out by four participants (P1, P3, P7 & P8) is the increased challenge in public health control. Especially, infectious diseases such as tuberculosis or SARS among the undocumented immigrant population. Any outbreak of infectious diseases can cost the government massive amounts of money. Two participants (P2 & P10) have commented the positive outcomes such as increased hospital income, hospital productivity and quality of health care. However, the present study argued that adverse outcomes with negative long-term impacts can outweigh the positive outcomes.

Regarding the structural violence framework, it should not be solely illustrating the suffering of the vulnerable, but to also tracing structural violence back to a source and undertaking those causes accountable through effective strategies. One of the themes emerged from data analysis is the challenges encountered by the undocumented pregnant women. “Illegality” has caused diverse forms of violence toward undocumented immigrants, especially the most vulnerable undocumented pregnant women. Two participants (P7 & P8) mentioned that many of the documented immigrants often become undocumented immigrants due to exploitations from employers and pregnancy. Three of the participants (P6, P7 & P8) described that without legal status, low-skilled individuals are subjected to wages according to their precarious status. The vilification and criminalization of immigrants further marginalised their social status. The poor will remain in the poverty cycle, if not, even poorer. Moreover, poverty is directly associated with adverse health through complicated means, in this case, poor maternal and child health.

Alternative approaches and recommendations in improving the maternal health of undocumented pregnant women were discussed in the present study:

Firstly, almost half of the participants stated that affordable hospital care coverage should be given to undocumented women as well as other immigrants. The present study argues that the amendment may provide an immediate cost saving to the government, but it fails to recognise the future economic consequences of limiting undocumented women’s access to maternal care. Therefore, affordable maternal care services can save the health care budget in the long run. Additionally, a participant (P3) stressed that health care professionals should not be

directed to be payment guarantor for patients who cannot afford the payment. Instead, doctors should be authorised to determine whether to waive the payment for particular patients. Furthermore, the participant (P7) urged that the government should not involve immigration enforcement within hospital facilities. According to medical ethical principles, health care facilities should be a safe place for anyone to seek health care without the fear of being arrested.

Secondly, a participant (P7) said that stemming the undocumented immigrant pool through amnesty and holding employers accountable for using undocumented immigrants can reduce job competition for Malaysia's most vulnerable citizens and can increase levy collection among the newly documented. Two participants (P7 & P8) emphasised that the levy can, in turn, subsidise the health care services for immigrants, and thus improve the quality of life among immigrants. In the long run it will benefit the economy development of the country.

Thirdly, three participants (P1, P2 & P3) claimed that family planning and contraceptives should be used to improve maternal and child survival and reduce poverty. The present study argues that civil society and government should commit to promote and provide family planning services. Poverty has been one of the key barriers preventing undocumented pregnant women from seeking health care. Thus, all efforts must be tried to reduce poverty. Most importantly, a higher work productivity among immigrants who are not pregnant can further contribute to Malaysia economic development.

Fourth, the present study urges for a more comprehensive education on human rights to create awareness among Malaysians and policy makers. Malaysia has been succeeded in promoting maternal and child health for all and should not neglect the undocumented pregnant women. Labour immigrants have been essential to the Malaysian economy. Human rights education can correct the misperception and resentment of Malaysians towards the immigrants. A participant (P7) said that the government is likely to respond to the demand from the public in the long term, Malaysians do have the ability to affect the government policy decision to be less anti-immigrant.

Fifth, half the participants advised an approach to enhance communication either from civil society to government, or communication within government ministries as well as dialogue with other ASEAN countries. Two ways communication is the key to forming effective policy concerning all the stakeholders. A participant (P8) mentioned that effort should be

made in both Malaysia and labour-sending countries in reducing irregular immigration. Long term positive impacts should be emphasised instead of cringing to short sighted positive outcome.

Sixth, the present study urges the need of new research agendas to be placed to focus on the complicated dynamics of health by cooperation between disciplines extending from social anthropology to epidemiology. However, researchers can barely influence policy or implementation decisions by publishing research papers. Therefore, the present study must be linked to universities, medical providers, NGOs and other advocates in order to make this case stand out using a language that public and policy makers can comprehend.

Incorporating social theory (such as the social threat theory and structural violence framework utilised in the analysis presented here) into conceptualising public health contexts and the way where the purpose and focus of the current study are viewed can shift towards a new research paradigm challenging the status quo. This change was aimed to improve the contribution of the study in reducing health disparities among undocumented pregnant women and immigrants in general.



## References

- Ab Rahman, N., Sivasampu, S., Mohamad Noh, K., & Khoo, E. (2016). Health profiles of foreigners attending primary care clinics in Malaysia. *BMC Health Services Research*, *16*(1). Retrieved from <http://dx.doi.org/10.1186/s12913-016-1444-0>
- Abbas, R. (2013). Whose Interview Is It, Anyway? Methodological and Ethical Challenges of Insider–Outsider Research, Multiple Languages, and Dual-Researcher Cooperation. *Qualitative Inquiry*, *19*(6), 480-488.
- Alcock, N., & Köhler, G. (1979). Structural violence at the world level: diachronic findings. *Journal of Peace Research*, *16*(3), 255-262. Retrieved from <http://journals.sagepub.com/doi/abs/10.1177/002234337901600305>
- Almeida, L. M., Caldas, J., Ayres-de-Campos, D., Salcedo-Barrientos, D., & Dias, S. (2013). Maternal health care in migrants: a systematic review. *Maternal and child health journal*, *17*(8), 1346-1354.
- Almeida, L., Santos, C., Caldas, J., Ayres-de-Campos, D., & Dias, S. (2014). Obstetric care in a migrant population with free access to health care. *International Journal Of Gynecology & Obstetrics*, *126*(3), 244-247. Retrieved from <http://dx.doi.org/10.1016/j.ijgo.2014.03.023>
- Amnesty International. (2010). *Trapped: The exploitation of migrant workers in Malaysia*. United Kingdom: Amnesty International. Retrieved from <https://www.amnesty.org/en/documents/ASA28/002/2010/en/>
- Ariely, G. (2012). Globalization, immigration and national identity: How the level of globalization affects the relations between nationalism, constructive patriotism and attitudes toward immigrants?. *Group Processes & Intergroup Relations*, *15*(4), 539-557. Retrieved from <http://dx.doi.org/10.1177/1368430211430518>
- Atkinson, R., & Flint, J. (2001). Accessing hidden and hard-to-reach populations: Snowball research strategies. *Social research update*, *33*(1), 1-4.
- Augustin, R. (2017). Hard to collect hospital dues from foreigners. *Free Malaysia Today*. Retrieved from <http://www.freemalaysiatoday.com/category/nation/2017/03/22/hard-to-collect-hospital-dues-from-foreigners/>
- Augustin, S. (2017). Dr Mahathir: Privatise like I did to reduce civil service. *Free Malaysia Today*. Retrieved from <http://www.freemalaysiatoday.com/category/nation/2017/04/08/dr-mahathir-privatise-like-i-did-to-reduce-civil-service/>
- Benach, J., Muntaner, C., Chung, H., & Benavides, F. G. (2010). Immigration, employment relations, and health: Developing a research agenda. *American Journal of Industrial Medicine*, *53*(4), 338-343.
- Bharathi, D., & Mitra, S. *Gender and international migration | Situation Report*. UNESCAP. Retrieved 11 May 2017, from <http://sitreport.unescapsdd.org/gender-and-international-migration>
- Biber-Hesse, S. (2014) *A Re-Invitation to Feminist Research*. Feminist Research Practice: A Primer (pp.1-13). London: Sage Publications Ltd.
- Billiet, J., Meuleman, B., Witte, H. D. (2014) The relationship between ethnic threat and economic insecurity in times of economic crisis: Analysis of European Social Survey data. *Migr Stud*, *2* (2): 135-161. Retrieved from doi: 10.1093/migration/mnu023

- Biswas, D., Toebes, B., Hjern, A., Ascher, H., & Norredam, M. (2012). Access to health care for undocumented migrants from a human rights perspective: A comparative study of Denmark, Sweden, and the Netherlands. *Health And Human Rights, 14*(2), 49-60.
- Blalock, Hubert M. 1967. *Toward a Theory of Minority-Group Relations*. New York: Wiley & Sons.
- Blumer, H. (1958). Race Prejudice as a Sense of Group Position. *The Pacific Sociological Review, 1*(1), 3-7. <http://dx.doi.org/10.2307/1388607>
- Bobo, L. (1983). Whites' Opposition to Busing: Symbolic racism or realistic group conflict? *Journal of Personality and Social Psychology, 45*(6), 1196-1210. Retrieved from <https://scholar.harvard.edu/bobo/files/whitesop.pdf>
- Bohman, A. (2011). Articulated antipathies: Political influence on anti-immigrant attitudes. *International Journal Of Comparative Sociology, 52*(6), 457-477. Retrieved from <http://dx.doi.org/10.1177/0020715211428182>
- Boushey, G., & Luedtke, A. (2011). Immigrants across the US federal laboratory: Explaining state-level innovation in immigration policy. *State Politics & Policy Quarterly, 11*(4), 390-414. Retrieved from <http://journals.sagepub.com/doi/abs/10.1177/1532440011419286>
- Bryman, A. (2012). *Social research methods* (4th ed.). New York: Oxford University Press.
- Carballo, M., & Mboup, M. (2005). International migration and health. *Paper submitted to the Global Commission on International Migration*. Retrieved from [http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/policy\\_and\\_research/gcim/tp/TP13.pdf](http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/policy_and_research/gcim/tp/TP13.pdf)
- Castles, S. (1998). New migrations in the Asia-Pacific region: a force for social and political change. *International Social Science Journal, 50*(156), 215-227. <http://dx.doi.org/10.1111/1468-2451.00125>
- Castles, S. (2003). Towards a sociology of forced migration and social transformation. *Sociology, 37*(1), 13-34. Retrieved from <http://journals.sagepub.com/doi/pdf/10.1177/0038038503037001384>
- Centers for Disease Control and Prevention. (2013). *Severe Acute Respiratory Syndrome*. Retrieved 14 May 2017, from <https://www.cdc.gov/sars/>
- Chan, B. (2016, February 20). Dr M: Gov't is confused, flip-flops all the time. *Free Malaysia Today*. Retrieved from <http://www.freemalaysiatoday.com/category/nation/2016/02/20/dr-m-govt-is-confused-flip-flops-all-the-time/>
- Chavez, J. M., & Provine, D. M. (2009). Race and the response of state legislatures to unauthorized immigrants. *Annals of the American Academy of Political and Social Science, 623*, 78-92. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3821545/>
- Chen, B. (2016). 261 13 1 281 Dr M: Gov't is confused, flip-flops all the time. *Free Malaysia Today*. Retrieved from <http://www.freemalaysiatoday.com/category/nation/2016/02/20/dr-m-govt-is-confused-flip-flops-all-the-time/>
- Clancy, C. M., Glied, S. A., & Lurie, N. (2012). From Research to Health Policy Impact. *Health Services Research, 47*(1 Pt 2), 337-343. <http://doi.org/10.1111/j.1475-6773.2011.01374.x>
- Committee on the Elimination of Discrimination Against Women. (2008). *General recommendation No. 26 on women migrant workers*, Retrieved from <http://www.refworld.org/docid/4a54bc33d.html>

- D'Ostie-Racine, L., Dagenais, C., & Ridde, V. (2016). A qualitative case study of evaluation use in the context of a collaborative program evaluation strategy in Burkina Faso. *Health Research Policy and Systems, 14*, 37. <http://doi.org/10.1186/s12961-016-0109-0>
- Davis, W. (2017, January 04). Things will get worse for the Malaysian Ringgit: BMI research. *Bloomberg*. Retrieved from <https://www.bloomberg.com/news/articles/2017-01-04/things-will-get-worse-for-the-malaysian-ringgit-bmi-research>
- Department of Statistics. (2016). *Current Population Estimates, Malaysia, 2014 – 2016*. Retrieved from [https://www.statistics.gov.my/index.php?r=column/cthemByCat&cat=155&bul\\_id=OWlxdEVoYlJCS0hUZzJyRUcvZEYxZz09&menu\\_id=L0pheU43NWJwRWVVSZklWdzQ4TlhUUT09](https://www.statistics.gov.my/index.php?r=column/cthemByCat&cat=155&bul_id=OWlxdEVoYlJCS0hUZzJyRUcvZEYxZz09&menu_id=L0pheU43NWJwRWVVSZklWdzQ4TlhUUT09)
- Devadason, E. S., & Meng, C. W. (2011). A critical appraisal of policies and laws regulating migrant workers in Malaysia. In *World Business Institute Australia, World Business and Social Science Research Conference. Hotel Istana, Kuala Lumpur, Malaysia*.
- Devadason, E., & Chan, W. (2014). Policies and Laws Regulating Migrant Workers in Malaysia: A Critical Appraisal. *Journal Of Contemporary Asia, 44*(1), 19-35. <http://dx.doi.org/10.1080/00472336.2013.826420>
- Donato, K. M. (2006). A glass half full: gender in migration studies. *International Migration Review, 40*(1), 3-26.
- Ean, H. T. L. (2003). Measuring up to CEDAW: how far short are Malaysian laws and policies. *Women's Center for Change Penang*. Retrieved from <http://www.wccpenang.org/files/docs/honey-measuring-up-to-cedaw.pdf>
- Edmonds-Cady, C. (2011). A view from the bridge: Insider/Outsider perspective in a study of the Welfare Rights Movement. *Qualitative Social Work, 14*(3), 147-167.
- Farmer, P. (1996). On suffering and structural violence: a view from below. *Daedalus, 261*- 283.
- Farmer, P. (2004). An Anthropology of Structural Violence. *Current Anthropology, 45*(3), 305-325. Retrieved from <http://dx.doi.org/10.1086/382250>
- Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2005). Structural violence and clinical medicine. *PLoS Med, 3*(10), e449.
- Farmer, P., & Sen, A. (2005). *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. University of California Press.
- Filindra, A. (n. d.). Is Threat in the Eye of the Researcher? Theory, Definition, and Measurement in the Study of State-Level Immigration Policymaking. Retrieved from [http://s3.amazonaws.com/academia.edu.documents/46180849/Filindra-Is\\_threat\\_in\\_the\\_eye\\_of\\_the\\_researcher\\_.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1494515263&Signature=X19HstThkDHcNCvhxUHSpW8NGIE%3D&response-content-disposition=inline%3B%20filename%3DIs\\_Threat\\_in\\_the\\_Eye\\_of\\_the\\_Researcher\\_T.pdf](http://s3.amazonaws.com/academia.edu.documents/46180849/Filindra-Is_threat_in_the_eye_of_the_researcher_.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1494515263&Signature=X19HstThkDHcNCvhxUHSpW8NGIE%3D&response-content-disposition=inline%3B%20filename%3DIs_Threat_in_the_Eye_of_the_Researcher_T.pdf)
- Free Malaysia Today. (2017). Subra: RM60 million in unpaid medical bills in 2016. Retrieved from <http://www.freemalaysiatoday.com/category/nation/2017/03/20/subra-rm60-million-in-unpaid-medical-bills-in-2016/>
- Galtung, J. (1969). Violence, peace, and peace research. *Journal of peace research, 6*(3), 167-191.

- Guinto, R. L. L. R., Curran, U. Z., Suphanchaimat, R., & Pocock, N. S. (2015). Universal health coverage in “One ASEAN”: are migrants included? *Global Health Action*, 8, 10.3402/gha.v8.25749. <http://doi.org/10.3402/gha.v8.25749>
- Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. *Risk Management and Health care Policy*, 8, 175–183. <http://doi.org/10.2147/RMHP.S70173>
- Harvey, D. (2005). *A brief history of neoliberalism*. Oxford: Oxford Univ. Press.
- Health Equity Initiatives. (2012). *Stop The Arrest and Detention of Asylum Seeking Women Accessing Maternal Health Care* [Press release]. Retrieved from <http://www.healthequityinitiatives.com/our-work/core-program/research-and-evidence-based-advocacy/statements>
- Health Resources and Services Administration. (2012). Prenatal services. Retrieved from <http://www.mchb.hrsa.gov/programs/womeninfants/prenatal.html>
- Hellawell, D. (2006). Inside–out: analysis of the insider–outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. *Teaching in higher education*, 11(4), 483-494.
- Henderson, J. W. (1994). The Cost Effectiveness of Prenatal Care. *Health Care Financing Review*, 15(4), 21–32. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193436/>
- Ho, K. (2007). *Structural violence as a human rights violation* (p. 3). University of Essex.
- Hospital Sungai Buloh. (2016). *Kenaikan Caj Baru Warga Asing Bagi Tahun 2016*. Hospital Sungai Buloh, Malaysia: Author.
- Houghton, C., Murphy, K., Shaw, D., & Casey, D. (2015). Qualitative case study data analysis: an example from practice. *Nurse Researcher*, 22(5), 8-12. Retrieved from <http://dx.doi.org/10.7748/nr.22.5.8.e1307>
- Hunter, M. (2013). Who makes public policy in Malaysia? *The Nordic Page*. Retrieved from <http://www.tnp.no/norway/global/3540-who-makes-public-policy-in-malaysiaiaj>
- International Organization for Migration. (2008). *Situation Report on International Migration in East and South-East Asia*. Bangkok: International Organization for Migration, Regional Office for Southeast Asia. Retrieved from [http://publications.iom.int/system/files/pdf/situation\\_report.pdf](http://publications.iom.int/system/files/pdf/situation_report.pdf)
- International Organization for Migration. (2013). *International Migration, Health and Human Rights*. Retrieved from <http://publications.iom.int/books/international-migration-health-and-human-rights>
- Karim, R., & Ali, S. (2013). Maternal health in Malaysia: progress and potential. *The Lancet*, 381(9879), 1690-1691. Retrieved from [http://dx.doi.org/10.1016/s0140-6736\(13\)60904-6](http://dx.doi.org/10.1016/s0140-6736(13)60904-6)
- Kassim, A. (2014). Recent trends in transnational population inflows into Malaysia: policy, issues and challenges. *Malaysian Journal of Economic Studies*, 51(1), 9.
- Kaur J, Singh H. Maternal Health in Malaysia: A Review. *WebmedCentral PUBLIC HEALTH*, 2(12) :WMC002599 doi: 10.9754/journal.wmc.2011.002599
- Kaur, A. (2004). The Global Factory: Cross-border production networks and women workers in Asia. *Women Workers in Industrialising Asia: Costed, Not Valued*, 99-128.

- Kaur, A. (2006). Order (and disorder) at the border: Mobility, international labour migration and border controls in Southeast Asia. In *Mobility, labour migration and border controls in Asia* (pp. 23-51). Palgrave Macmillan
- Kaur, A. (2009). Labor Crossings In Southeast Asia: Linking Historical and Contemporary Labor Migration. *New Zealand Journal of Asian Studies*, 11(1), 276-303.
- Kaur, A. (2010). Labour migration in Southeast Asia: migration policies, labour exploitation and regulation. *Journal of the Asia Pacific Economy*, 15(1), 6-19.
- Keynote Address for the International Conference on Maternal and Child Health – Attaining the Highest Standard of Health for Women and Children: Human Rights Approach. (2016). From the *Desk of the Director-General of Health Malaysia*. Retrieved from <https://kpkkesihatan.com/2016/03/04/keynote-address-for-the-international-conference-on-maternal-and-child-health-attaining-the-highest-standard-of-health-for-women-and-children-human-rights-approach/>
- King, M., & Washington, J. (1991). *A testament of hope* (1st ed.). San Francisco: HarperSanFrancisco.
- King, R., & Wheelock, D. (2007). Group Threat and Social Control: Race, Perceptions of Minorities and the Desire to Punish. *Social Forces*, 85(3), 1255-1280. <https://muse.jhu.edu/article/215361/pdf>
- Korinek, K., & Smith, K. R. (2011). Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: Exploring the impact of immigrant legal status. *Social science & medicine*, 72(10), 1695-1703.
- Kuiper, H., Richwald, G.A., Rotblatt, H., Steven, A. (1999). The Communicable Disease Impact of Eliminating Publicly Funded Prenatal Care for Undocumented Immigrants *Matern Child Health J*, 3(39). Retrived from doi:10.1023/A:1021862113241
- Labaree, R. V. (2002). The risk of ‘going observationalist’: negotiating the hidden dilemmas of being an insider participant observer. *Qualitative Research*, 2(1), 97-122.
- Larsen, J. J. (2010). Migration and people trafficking in southeast Asia. *Trends and issues in crime and criminal justice*, (401), 1.
- Lasimbang, H., Tong, W., & Low, W. (2015). Migrant workers in Sabah, East Malaysia: The importance of legislation and policy to uphold equity on sexual and reproductive health and rights. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 32, 113-123. Retrieved from [https://umexpert.um.edu.my/file/publication/00000399\\_135570.pdf](https://umexpert.um.edu.my/file/publication/00000399_135570.pdf)
- Lee, C. (2015). Unjust barriers: Prenatal care and undocumented immigrants. *Journal of Contemporary Health Law & Policy*, 31(1), 96-119.
- Lee, P. O. (2015). *What lies ahead for Malaysian health care?* Singapore: Yusof Ishak Institute. Retrieved from [https://www.iseas.edu.sg/images/pdf/ISEAS\\_Economics\\_Working\\_Paper\\_2015-04-01.pdf](https://www.iseas.edu.sg/images/pdf/ISEAS_Economics_Working_Paper_2015-04-01.pdf)
- Liao, Y., & Teso, Y. (2017). Malaysia's Ringgit crackdown spooks overseas investors. *Bloomberg*. Retrieved from <https://www.bloomberg.com/news/articles/2017-02-06/malaysia-s-ringgit-crackdown-saps-volatility-deters-investors>
- Liverani, M., Hawkins, B., Parkhurst, J. O. (2013) Political and Institutional Influences on the Use of Evidence in Public Health Policy. A Systematic Review. *PLoS ONE*, 8(10): e77404. <https://doi.org/10.1371/journal.pone.0077404>

- Lu, M. C., Lin, Y. G., Prietto, N. M., & Garite, T. J. (2000). Elimination of public funding of prenatal care for undocumented immigrants in California: A cost/benefit analysis. *American Journal of Obstetrics and Gynecology*, 182(1), 233-239. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0002937800705187>
- Malaysiandigest. (2014). *Illegal Immigrants: Are They A Threat To Our Health?* Retrieved from <http://www.malaysiandigest.com/features/528742-illegal-immigrants-are-they-a-threat-to-our-health.html>
- Mavroudi, E. (2010) Nationalism, the Nation and Migration: Searching for Purity and Diversity. *Space and Polity*, 14(3), 219-233. Retrieved from DOI: 10.1080/13562576.2010.532951
- McCosker, H., Barnard, A., & Gerber, R. (2001). Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All Participants. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 2(1). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/983>
- McNess, E., Arthur, L., & Crossley, M. (2015). ‘Ethnographic dazzle’ and the construction of the ‘Other’: revisiting dimensions of insider and outsider research for international and comparative education. *Compare: A Journal of Comparative and International Education*, 45(2), 295-316.
- Menjívar, C., & Abrego, L. (2012). Legal Violence: Immigration Law and the Lives of Central American Immigrants. *American Journal of Sociology*, 117(5). Retrieved from <http://www.jstor.org/stable/pdf/10.1086/663575.pdf>
- Merriam, S. B., Johnson-Bailey, J., Lee, M. Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, 20(5), 405-416.
- Merton, R. K. (1972). Insiders and outsiders: A chapter in the sociology of knowledge. *American journal of sociology*, 9-47.
- Miles, M., & Huberman, A. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks: Sage.
- Ministry of Health. (2013). *Government Hospitals’ Treatment Charges for Foreigners*. Official Portal for Ministry of Health Malaysia. Retrieved 11 May 2017, from <http://www.moh.gov.my/english.php/pages/view/153>
- Ministry of Health Malaysia. (2014). *Surat Pekeliling Bil. 1 Tahun 2014 - Garis Panduan Pelaksanaan Perintah Fi (Perubatan) (Kos Perkhidmatan) 2014*. Retrieved 13 May 2017, from [http://www.moh.gov.my/index.php/database\\_stores/store\\_view\\_page/31/257](http://www.moh.gov.my/index.php/database_stores/store_view_page/31/257)
- Ministry of Health. (2016). *Government Hospitals’ Treatment Charges for Foreigners*. Official Portal for Ministry of Health Malaysia. Retrieved 11 May 2017, from <http://www.moh.gov.my/index.php/pages/view/163>
- Naples, N. A. (1996). A feminist revisiting of the insider/outsider debate: The “outsider phenomenon” in rural Iowa. *Qualitative Sociology*, 19(1), 83-106.
- Noh, N., Wahab, H., Bakar Ah, S., & Islam, M. (2016). Public Health Services for Foreign Workers in Malaysia. *Social Work In Public Health*, 31(5), 419-430. <http://dx.doi.org/10.1080/19371918.2015.1125321>
- O'Connor, T. (2014). Debating Human Rights – universal or relative to culture?. *Development Education*. Retrieved from <http://developmenteducation.ie/blog/2014/02/debating-human-rights-universal-or-relative-to-culture/>

- Oriola, T., & Haggerty, K. D. (2012). The ambivalent insider/outsider status of academic 'homecomers': Observations on identity and field research in the Nigerian Delta. *Sociology*, 0038038511425559.
- Page-Reeves, J., Niforatos, J., Mishra, S., Regino, L., Gingrich, A., & Bulten, R. (2013). Health Disparity and Structural Violence: How Fear Undermines Health Among Immigrants at Risk for Diabetes. *Journal of Health Disparities Research and Practice*, 6(2), 30–47.
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, 42(5), 533–544. Retrieved from <http://doi.org/10.1007/s10488-013-0528-y>
- Parsons, K. (2007). Structural Violence and Power. *Peace Review*, 19(2), 173-181. <http://dx.doi.org/10.1080/10402650701353612>
- Pattison, P. (2017, February 02). Violence, prejudice, low pay: all in a day's work for migrants in Malaysia. *The Guardian*. Retrieved from <https://www.theguardian.com/global-development/2017/feb/02/violence-prejudice-low-pay-migrant-workers-malaysia>
- Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International journal of qualitative studies in education*, 16(2), 175-196.
- Risso-Gill, I., McKee, M., Coker, R., Piot, P., & Legido-Quigley, H. (2013). Health system strengthening in Myanmar during political reforms: perspectives from international agencies. *Health Policy And Planning*, 29(4), 466-474. <http://dx.doi.org/10.1093/heapol/czt037>
- Robson, C. (2002). *Real world research* (2nd ed.). Malden: Blackwell.
- Ruark, E., & Graham, M. (2011). *Immigration, Poverty and Low-Wage Earners: The Harmful Effects of Unskilled Immigrants on American Workers*. Retrieved from Federation for American Immigration Reform Website. [http://www.fairus.org/docs/poverty\\_rev.pdf](http://www.fairus.org/docs/poverty_rev.pdf)
- Ruiz, P. (n.d.). *Is globalisation good for women?*. Academia.edu. Retrieved 11 May 2017, from [https://www.academia.edu/29231704/Is\\_globalisation\\_good\\_for\\_women](https://www.academia.edu/29231704/Is_globalisation_good_for_women)
- Saheli, R. C. (2017, January 02). Malaysian ringgit could push past 4.55 by end of Q1: Westpac. *CNBC*. Retrieved from <http://www.cnbc.com/2017/01/02/malaysian-ringgit-could-weaken-further-against-the-dollar-by-end-of-first-quarter-2017.html>
- Salvage, J., Rowson, M., Melf, K., & Sandøy, I. (2012). *The Medical Peace Work*. In (Eds.), *The Medical Peace Work textbook*, 2nd edition, Course 4 Structural violence and the underlying causes of violent conflict. London, Medact.
- Savvides, N., Al-Youssef, J., Colin, M., & Garrido, C. (2014). Journeys into Inner/Outer Space: reflections on the methodological challenges of negotiating insider/outsider status in international educational research. *Research in Comparative and International Education*, 9(4), 412-425.
- Schiller, N. G. (2009). A global perspective on migration and development. *Social Analysis*, 53(3), 14-37. Retrieved from <http://www.berghahnjournals.com/view/journals/social-analysis/53/3/sa530302.xml>
- Socialist Party of Malaysia. (2016, October 01). *Tunggakan Bayaran Hospital Warga Asing 2015* [160309]. Retrieved from <https://partisosialis.org/en/node/3638>

- Socialist Party of Malaysia. (2016, October 18). Levy Pekerja Asing 2010-2015 [160408 BT]. Retrieved from <https://partisosialis.org/en/node/3665>
- Sofaer, S. (1999). Qualitative methods: what are they and why use them?. *Health services research*, 34(5 Pt 2), 1101. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089055/>
- Sparke, M. How Research on Globalization Explains Structural Violence | Office of Minority Affairs & Diversity. *University of Washington*. Retrieved 11 May 2017, from <http://www.washington.edu/omad/ctcenter/projects-common-book/mountains-beyond-mountains/how-research-on-globalization/>
- Stiles, C. E. (2011). *Countering Structural Violence: Cultivating an Experience of Positive Peace*. (Published dissertation). Portland State University: United States. Retrieved from [http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1209&context=open\\_access\\_etds](http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1209&context=open_access_etds)
- Tilford, S. (2015). The policy failures masked by scapegoating immigrants. *Financial Times*. Retrieved from <https://www.ft.com/content/044b85ec-9dd7-11e5-8ce1-f6219b685d74>
- Tunon, M., & Baruah, N. (2012). Public attitudes towards migrant workers in Asia. *Migration And Development*, 1(1), 149-162. <http://dx.doi.org/10.1080/21632324.2012.718524>
- U.S. Senate Committee on Foreign Relations. (2009). *Trafficking and Extortion of Burmese Migrants in Malaysia and Southern Thailand*. Human Trafficking: Data and Documents. Paper. Retrieved from <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1018&context=humtraffdata>
- United Nations High Commissioner for Refugees-Malaysia. (2016). *Figures at A Glance*. Retrieved from [http://www.unhcr.org.my/about\\_us-@-figures\\_at\\_a\\_glance.aspx](http://www.unhcr.org.my/about_us-@-figures_at_a_glance.aspx)
- United Nations High Commissioner for Refugees-Malaysia. (2016). *Figures at A Glance*. Retrieved from [http://www.unhcr.org.my/about\\_us-@-figures\\_at\\_a\\_glance.aspx](http://www.unhcr.org.my/about_us-@-figures_at_a_glance.aspx)
- United Nations Malaysia. (2017). *Malaysia Millennium Development Goals Report 2015*. Malaysia: United Nations Malaysia. Retrieved from [http://un.org.my/upload/undp\\_mdg\\_report\\_2015.pdf](http://un.org.my/upload/undp_mdg_report_2015.pdf)
- United Nations Population Fund. (2017). *Maternal health*. Retrieved 11 May 2017, from <http://www.unfpa.org/maternal-health>
- Wake, C. (2014). *Forced Migration, urbanization and health: Exploring social determinants of health among refugee women in Malaysia* (Published doctoral dissertation). University of Victoria, Canada.
- Walby, S. (1997). *Gender transformations*. Psychology Press.
- Weiss, C. H. (1991). Policy research as advocacy: Pro and con. *Knowledge, Technology & Policy*, 4(1), 37-55.
- Wickramasekara, P. (2002). *Asian labour migration: Issues and challenges in an era of globalization*. Geneva: International Migration Programme, International Labour Office.
- Winter, Y. (2012). Violence and Visibility. *New Political Science*, 34(2), 195-202. <http://dx.doi.org/10.1080/07393148.2012.676397>
- Wise, R. D., Covarrubias, H. M., & Puentes, R. (2010). Reframing the Debate on Migration, Development and Human Rights. *Population, Space And Place*, 19(4), 430-443. <http://dx.doi.org/10.1002/psp.1783>
- Wise, R., & Márquez, H. (2013). Neoliberal globalization and migration. *The Encyclopedia Of Global Human Migration*. Retrieved from <http://dx.doi.org/10.1002/9781444351071.wbeghm389>



- Wolcott, H. (2009). *Writing up qualitative research* (1st ed., pp. 14-16). Thousand Oaks, Calif.: Sage Publications.
- Wong, C. (2016). The migrant dilemma. *The Star*. Retrieved from <http://www.thestar.com.my/opinion/columnists/on-the-beat/2016/02/21/the-migrant-dilemma-it-may-not-be-possible-to-stop-having-foreign-workers-in-malaysia-but-we-do-need/>
- World Bank. (2011). *Migration and Remittances Factbook 2011*. (2nd ed.). Washington: World Bank Publications.
- World Bank. (2013). *Immigration in Malaysia: Assessment of its economic effects, and a review of the policy and system*. Retrieved from <http://psu.um.edu.my/images/psu/doc/Recommended%20Reading/Immigration%20in%20Malaysia.pdf>
- World Health Organization. (2009). *Women and health: today's evidence tomorrow's agenda*. World Health Organization. Retrieved from <http://www.who.int/gender-equity-rights/knowledge/9789241563857/en/>
- World Health Organization. (2016). *WHO recommendations on antenatal care for a positive pregnancy experience*. (1st ed.). Geneva: World Health Organization. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK409110/>
- Yadav, H. (2012). A review of maternal mortality in Malaysia. *IeJSME*, 6(1), 142-151. Retrieved from [http://web.imu.edu.my/ejournal/approved/19.Review\\_Hematram\\_s142-s151.pdf](http://web.imu.edu.my/ejournal/approved/19.Review_Hematram_s142-s151.pdf)
- Zamora-Kapoor, A., Kovincic, P., & Causey, C. (2013). Anti-foreigner Sentiment: State of the Art. *Sociology Compass*, 7(4), 303–313. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4350658/#R48>
- Zuhrin, A. A. (2014, February 25). Foreigners taking up big share of Malaysia's medical subsidy. *The Star*. Retrieved from <http://yourhealth.asiaone.com/content/foreigners-taking-big-share-malaysias-medical-subsidy>
- Zulkifli, S., U, K., Yusof, K., & Lin, W. (1994). Maternal and Child Health in Urban Sabah, Malaysia: A Comparison of Citizens and Migrants. *Asia Pacific Journal Of Public Health*, 7(3), 151-158. Retrieved from <http://search.proquest.com/docview/1468448660/fulltextPDF/8BE58228C0EA4270PQ/1?accountid=17260>

## Appendix

### Appendix A: List of Participants

Location of interviews: Kuala Lumpur, Malaysia

	Name/Date of Interview	Background
<b>Health Actors</b>		
P1	Anonymous 07-02-2017	Health professional (General Physician) in NGO clinic
P2	Anonymous 07-02-2017	Health Professional (Specialist in Obstetrics and Gynaecology)
P3	Dr. Ashok Zachariah Philip 31-07-2016	Health professional (General Physician) Former president of Malaysian Medical Association
P4	Anonymous 15-08-2016 (Phone)	Health professional (Specialist in Obstetrics and Gynaecology)
P5	Dr. Nurul Aida Salleh 12-07-2016	Health professional (Specialist in Family Medicine)
<b>Non-health Actors</b>		
P6	Prof. Chan Chee Khoon 09-07-2016	Epidemiologist, Health and social policy analyst Academic consultant in the field of health care financing policy, and environmental health and development
P7	Dr. Michael Jeyakumar Devaraj 23-07-2016	Malaysian politician who serves as a Member of Parliament Former chest physician
P8	Mr Adrian Pereira & Ms Anne Beatrice 26-07-2016	Directors and founders of North South Initiative Activist of human rights, social justice and development for the marginalised groups
P9	Anonymous 08-08-2016 (Phone)	Insurance company personnel
P10	Dr. Nik Salida Suhaila 27-07-2016	Senior lecturer specialises in international, domestic and Islamic laws on human rights and gender issues

Note: Participants in Non-health actors group may/may not have health background. It is not a rigid categorisation for the participants.



**Request for Participation in Research Project:**

**Maternal Care Services for Undocumented Immigrants in Malaysia**

**Background and Purpose**

This is a master research project of the “Centre for Peace Studies (CPS)” which is part of the Arctic University of Norway (UiT). The purpose of the project is to capture perspectives of health actors and non-health actors in Malaysia on the amendment to the Fees Act (Medical) for Foreigners 1951, with an emphasis on maternal health care of undocumented immigrants (comprising of asylum seekers, stateless people and irregular migrants such as undocumented workers or trafficked persons with a potentially long stay in the country), thus capturing an understanding of how current changes can impact the economics and health of the vulnerable and marginalized group in the country and whether or not it is morally acceptable.

**What does participation in the project imply?**

A purposive sampling will be used to identify potential participants, and assisted by respondent driven sampling beginning with contacts known to the participants. You are being invited to take part in this research as your knowledge and your experience can contribute significantly to the research.

The potential participants will be asked the following questions, to which you can answer “yes” or “no” to determine whether we can proceed to the next interview session.

1. Are you aware of the difference between refugees, documented and undocumented immigrants?
2. Are you aware of the amendment to the Fees Act (Medical) for Foreigners 1951 in 2014 and the medical fees for foreigner has been increased since 2015?
3. Are you aware of the 100% increase in the foreigners' medical fees since January 2016 instead of the phased removal of subsidies that was planned?

Semi-structured interviews will be carried out if the potential participants are aware of the situation mentioned above. Semi-structured interviews is a suited and strong method that enable in-depth, narrative responses from the participants. This approach involves asking participants a series of pre-determined but open-ended questions, as well as open for additional questions. The approximate duration of the interview is between 40 to 60 minutes, and data will be collected through audio recordings.

### **What will happen to the information about you?**

All personal data will be treated confidentially. Only the project group, student and supervisor will have access to personal data. Personal data will be saved with password to ensure confidentiality. Participants will be recognizable in the publication; however, it will be unrecognizable for those who want to stay anonymous.

### **Voluntary participation**

Your participation in this research is entirely voluntary. You can at any time choose to withdraw your consent without stating any reason. If you decide to withdraw, all your personal data will be made anonymous.

### **Sharing the Results**

The knowledge that we get from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results.

### **Who to Contact**

If you would like to participate or if you have any questions concerning the project, please contact:

Pei Shan (Researcher) email: [plo008@post.uit.no](mailto:plo008@post.uit.no) phone: +601114307321/+4747223683

Randi Balsvik (Research supervisor) email: [randi.balsvik@uit.no](mailto:randi.balsvik@uit.no) phone: +4777645790

The research project has been notified to the Data Protection Official for Research, NSD - Norwegian Centre for Research Data.

**Consent for Participation in the Research Project**

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research project.

I agree / disagree that my personal information may be published and saved in this project.

Name of Participant\_\_\_\_\_

Signature of Participant \_\_\_\_\_

Date \_\_\_\_\_

Day/month/year

I have accurately read out the information sheet to the potential participant. I confirm that the participant was given an opportunity to ask questions about the research project, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Name of Researcher/person taking the consent\_\_\_\_\_

Signature of Researcher /person taking the consent\_\_\_\_\_

Date \_\_\_\_\_

Day/month/year

## Appendix C: Interview Guide

Can you tell me about your background and your related work to immigrants (if there is)

### 1. Economy perspective

- i. What is your thought on this amendment?
- ii. In your opinion, why did the government implement this amendment to the fee structure?
- iii. How do you think this amendment will impact the Malaysia economy, currently and in long term?
- iv. What are your thoughts on the level of cost-effectiveness of such strategies?

### 2. Public health perspective

- i. What has changed in the local hospitals/clinics since the increase of medical cost?
- ii. How do you think this amendment will impact hospitals in long term?
- iii. How do you think this amendment will impact maternal health of the undocumented immigrants?
- iv. Do you think this amendment will affect the local population?
- v. What are the existing response or resources in helping the undocumented immigrants? / What changes, if any, did your organization make in response to the amendment?
- vi. The news on 4th of July shows that a proposal to provide free vaccination for all children under five, including migrants and refugees, is being discussed by the Health Ministry.
- vii. Do you think whether MOH will propose to reform the policy to provide affordable maternal care services for all?
- viii. Is there any other alternative approach?
- ix. In what ways can one advocate for this?

### 3. Human rights/moral perspective

- i. How is this amendment or changes affecting your work or your colleagues (directly or indirectly)?
- ii. What is the impact of the amendment on undocumented immigrants' health rights?
- iii. In relation to the amendment, what are your thoughts on the government meeting its obligations to respect, protect and fulfil health rights?

**Appendix D: The Fees Act (Medical) for Foreigners 1951 (MOH, 2014)**

## AKTA FI 1951

## PERINTAH FI (PERUBATAN) (PINDAAN) 2014

PADA menjalankan kuasa yang diberikan oleh seksyen 3 Akta Fi 1951 [*Akta 209*], Yang di-Pertuan Agong membuat perintah yang berikut:

**Nama dan permulaan kuat kuasa**

1. (1) Perintah ini bolehlah dinamakan **Perintah Fi (Perubatan) (Pindaan) 2014**.
- (2) Perintah ini mula berkuat kuasa pada 31 Disember 2014.

**Pindaan perenggan 1**

2. Perintah Fi (Perubatan) 1982 [*P.U. (A) 359/1982*], yang disebut “Perintah ibu” dalam Perintah ini, dipinda dalam subperenggan 1(3)—

- (a) dalam subsubperenggan (b), dengan memotong perkataan “dan” yang terdapat di hujung subsubperenggan itu;
- (b) dalam subsubperenggan (c), dengan menggantikan noktah di hujung subsubperenggan itu dengan perkataan “; dan”; dan
- (c) dengan memasukkan selepas subsubperenggan (c) subsubperenggan yang berikut:  
  
“(d) orang asing.”.

**Pindaan perenggan 2**

3. Perintah ibu dipinda dalam subperenggan 2(1) dengan memasukkan selepas takrif “pengamal persendirian” takrif yang berikut:

“penjagaan harian” ertinya penjagaan pesakit yang dimasukkan ke unit rawatan harian di hospital atau pusat rawatan khas, bagi tempoh kurang daripada dua puluh empat jam atas rujukan oleh pegawai perubatan bagi prosedur perubatan termasuk bagi tujuan pencegahan, penyiasatan, terapi dan rehabilitasi;’

**Pemotongan perenggan 8A**

4. Perintah ibu dipinda dengan memotong perenggan 8A.

**Perenggan baru 11A**

5. Perintah ibu dipinda dengan memasukkan selepas perenggan 11 perenggan yang berikut:

“Fi untuk 11A. Fi bagi penjagaan harian pesakit adalah seperti yang dinyatakan penjagaan dalam Jadual C hingga H dan fi bagi wad adalah berdasarkan kadar wad harian pesakit kelas tiga dalam Jadual B.”.

**Pindaan perenggan 16**

6. Perintah ibu dipinda dalam perenggan 16 dengan memotong subperenggan 6A.

**Pindaan perenggan 17**

7. Perintah ibu dipinda dalam perenggan 17—

(a) dengan memotong proviso; dan

(b) dengan menggantikan noktah bertindih di hujung perenggan dengan noktah.

**Pemotongan Jadual FA, FB dan FC**

8. Perintah ibu dipinda dengan memotong Jadual FA, FB dan FC.



Dibuat 27 Disember 2014  
[KK(S)-280(32/41); PN(PU2)86/XVII]

Dengan Titah Perintah,

DATUK SERI DR. S. SUBRAMANIAM  
*Menteri Kesihatan*

*[Akan dibentangkan dalam Dewan Rakyat menurut seksyen 4 Akta Fi 1951]*

FEES ACT 1951

FEES (MEDICAL) (AMENDMENT) ORDER 2014

IN exercise of the powers conferred by section 3 of the Fees Act 1951 [*Act 209*], the Yang di-Pertuan Agong makes the following order:

**Citation and commencement**

1. (1) This order may be cited as the **Fees (Medical) (Amendment) Order 2014**.

(2) This Order comes into operation on 31 December 2014.

**Amendment of paragraph 1**

2. The Fees (Medical) Order 1982 [*P.U. (A) 359/1982*], which is referred to as the “principal Order” in this Order, is amended in subparagraph 1(3)—

(a) in subparagraph (b), by deleting the word “and” at the end of that subparagraph ;

(b) in subparagraph (c), by substituting for the full stop at the end of that subparagraph with the word “; and”; and

(c) by inserting after subparagraph (c) the following subparagraph:

“(d) foreign persons.”.

**Amendment of paragraph 2**

3. The principal Order is amended in subparagraph 2(1) by inserting after the definition of “child” the following definition:

“day care” means care of a patient admitted to a day treatment unit at a hospital or special treatment centre, for a period of less than twenty four hours on a referral by a medical officer for medical procedures including for the purposes of prevention, investigation, therapy and rehabilitation;’.

**Deletion of paragraph 8A**

4. The principal Order is amended by deleting paragraph 8A.

**New paragraph 11A**

5. The principal Order is amended by inserting after paragraph 11 the following paragraph:

“ Daycare patient fee            11A. The fee for daycare patient shall be as specified in Schedules C to H, and the fees for ward is based on the third class ward in Schedule B.”.

**Amendment of paragraph 16**

6. The principal Order is amended in paragraph 16 by deleting subparagraph 6A.

**Amendment of paragraph 17**

7. The principal Order is amended in paragraph 17—

(a) by deleting the proviso; and

(b) by substituting for the colon at the end of that paragraph a full stop.

**Deletion of Schedules FA, FB and FC**

8. The principal Order is amended by deleting Schedules FA, FB and FC.

Made 27 December 2014  
[KK(S)-280(32/41); PN(PU2)86/XVII]

By Command,

DATUK SERI DR. S.  
SUBRAMANIAM  
*Minister of Health*

*[To be laid before the Dewan Rakyat pursuant to section 4 of the Fees Act 1951]*

**JADUAL PERTAMA**  
**[Perenggan 3]**  
**FI PESAKIT LUAR**

	<b>Fi bagi satu lawatan  (RM)</b>
<b>(a) Hospital</b>	
Pesakit luar am	40
Pesakit luar pakar	120
Jabatan Kecemasan	100
<b>(b) Klinik kesihatan</b>	
Pesakit luar am	40
Pesakit luar pakar	120
<b>(c) Klinik 1 Malaysia</b>	
	40
<b>(d) Klinik Desa</b>	
	40
<b>(e) Lain-lain</b>	
Perkhidmatan kesihatan kanak-kanak	40
Rawatan obstetrik dan ginekologi	40
Perkhidmatan postnatum	40

Calitan pap	45
Perkhidmatan bersalin (termasuk di Pusat Bersalin Alternatif dan di rumah)	200
Perkhidmatan perubatan di luar hospital	300 untuk setiap lawatan selain dari apa-apa tuntutan bagi perjalanan, sara hidup dan penginapan mengikut kadar yang ditentukan oleh Kerajaan

*\*Fi dalam Jadual ini tidak termasuk apa-apa fi lain yang dinyatakan dalam Perintah ini.*

**JADUAL KEDUA**  
**[Subperenggan 4(1)]**  
**FI WAD**

	<b>Fi bagi sehari (RM)</b>
<b>(a) Eksekutif</b>	
Bilik 1 katil (VIP)	500
Bilik 1 katil	400
Bilik 2 katil	340
<b>(b) Kelas satu</b>	
Bilik 1 katil	320
Bilik 2 katil	240
Bilik 3 katil atau lebih	200
<b>(c) Kelas dua</b>	180
<b>(d) Kelas tiga</b>	160
<b>(e) Bilik bersalin</b>	300
<b>(f) Unit Rawatan Intensif atau Unit Rawatan Koronari (dewasa)</b>	360
<b>(g) Unit Rawatan Intensif atau Unit Rawatan Koronari (kanak-kanak)</b>	300

<b>(h) Nurseri</b>	60
<b>(i) Nurseri rawatan khas</b>	140
<b>(j) Nurseri dengan rawatan <i>incubator</i></b>	170
<b>(k) Wad psikiatri</b>	Berdasarkan kelas wad dan mengikut bilangan katil



**JADUAL KETIGA****[Perenggan 5]****FI RAWATAN****BAHAGIAN 1****RAWATAN PESAKIT DALAM**

	<b>Fi (RM)</b>
Rawatan pesakit dalam	100 sehari

**BAHAGIAN 2****RAWATAN PSIKIATRI**

	<b>Fi (RM)</b>
Rawatan psikitrik	1,500 setiap kali dimasukkan ke hospital

**BAHAGIAN 3****RAWATAN BERSALIN**

	<b>Fi (RM)</b>
<i>Caesarean</i>	3,021
Bersalin dengan bantuan : <i>forsep/breech/vakum/bersalin kembar/bersalin normal</i>	2,593

**BAHAGIAN 4****LAIN-LAIN RAWATAN**

	<b>Fi (RM)</b>
Kardiotokograf	120

