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REVIEW ARTICLE

Barriers limiting access to healthcare among refugees or asylum seekers in Asia in the recent years: a scoping review

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ABSTRACT

Over the years, the number of refugees that reside in Asian countries has been increasing. Many refugees that arrive are at risk of many diseases and comorbidities, for example, mental health diseases, trauma, malnutrition and many more. This scoping review aimed to explore the barriers faced by refugees or asylum seekers that limit their access to healthcare services in their host countries. Systematic searching was performed in PubMed and Science Direct databases to search for the relevant studies published in English from the year 2017 to the year 2020. Arksey and O'Malley's methodology framework was adopted in this scoping review. Ten studies that addressed this topic were included. We found that lack of awareness of one's rights to healthcare, communication, cultural differences and financial difficulties were reported as the key barriers faced by the refugees in accessing healthcare in the Asian host countries. Improvements in health promotion, communication, cultural support and financial support for the refugees settling in Asia must be urgently addressed.

Key words: refugees, health access, barriers

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INTRODUCTION

The United Nations High Commissioners for Refugees (UNHCR) defines 'refugees' as persons who have a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it'.[1,2] Globally, there are 79.5 million forcibly displaced people, with total of 26.0 million refugees at the end of 2019.[3]

The vulnerability and poverty experienced by refugees often compromise their health. Several factors that affect the health of refugees include social and cultural barriers to integration, low socioeconomic status, discrimination, changes in lifestyle and diet, and loss of family and friendship networks.[4,5] It was reported that the percentage of refugees that was admitted to the hospital emergency department is higher than the local population.[6] Most refugees were food insecure, which led them to malnutrition, obesity and many other medical complications.[7] Besides that, refugees and asylum seekers are susceptible to mental health disorders.[8] This could be due to their traumatic experience in their own country such as being forced to leave their country and being exposed to war, violence and many more.[9] Racism, discrimination and trying to fit themselves into a new environment also contribute to their traumatic experiences.[10] These in turn expose them to high risk of developing post-traumatic stress disorder (PTSD).[11]

Asia has become a major refugee-hosting region in recent years. It hosted 9.4 million people of concern, including 4.2 million refugees, 2.6 million internally displaced persons (IDPs) and 2.2 million stateless people as of mid-2018.[12] The growing number of refugees in the Asian countries has led to the need to address the problem of health access in this region. Thus, a scoping review was done to compile the studies published in recent years on the barriers faced by refugees in accessing healthcare in Asian host countries.

METHODS

Arksey and O'Malley's methodology framework was adopted in this scoping review through the following five stages: 1) Research question identification; 2) Identify relevant studies; 3) Study selection; 4) Data charting; and 5) Collating, summarising and reporting results.[13]

Step 1: Research question identification

The research question identified is, "What are the barriers that limit the access to healthcare among refugees or asylum seekers in Asia?" This includes overall health and the accessibility of primary, secondary and tertiary medical care for refugees and asylum seekers as our target focus. Even though there are a few reviews on the barriers that limit the access to healthcare among refugees and asylum seekers, no review to our knowledge has been broadly captured and summarised the accessibility of healthcare among refugees in Asia.

Step 2: Identifying relevant studies

PubMed and ScienceDirect databases were used for the literature search to identify the relevant studies with the use of the following keywords: "barriers", "healthcare", "refugees", and "asylum seekers". Medical Subject Headings

(MeSH) and search terms were identified (Table 1). A systematic search was conducted to search for the studies published in English from the years 2017 to 2020.

Table 1 Literature Search Strategy

Concept	Keywords	MeSH
Refugee	Refugee*	Refuge
Barrier	Barrier* Challenges* Obstacle*	Barrier
Healthcare system	Healthcare system*	Healthcare
Asylum seeker	Asylum seeker*	Refugee Asylum seeker

*Note: Truncation symbol * (asterisk) to search for multiple variants of a word*

Step 3: Studies selection

A total of 619 articles were found from the two databases. The title and the abstract of the articles were screened for the elimination of duplicates. Out of 619 articles, four articles were duplicated studies, 465 titles appeared to be irrelevant to our research question, and 86 of them were published before the year 2017. Hence, after the first screening, 64 articles remained for further screening. In the full text reviews of the remaining 64 articles, we included studies published in English between 2017 and 2020, which focused on the needs, accessibilities and barriers that limit the refugees or asylum seekers to general healthcare services in Asian countries. Studies that focused on the needs, accessibility and barriers that limit the refugees or asylum seekers to healthcare services that targeted specific medical conditions were excluded. Studies that involved refugees or asylum seekers residing outside of Asia were also excluded. After a thorough full text screening, we included 10 articles that fulfilled the inclusion criteria of our review.

Step 4: Data charting

The data obtained from the finalised articles were categorised and tabulated with the following information: authors, publication year, aim, origin country of the study, number of participants and results (Table 2).

Step 5: Collating and summarising the results

In order to collate and summarise the results, the evidence from the respective articles were extracted and interpreted repeatedly. A qualitative analysis was performed to summarise the relevant evidence of the barriers to access healthcare among refugees according to the theme.

RESULTS

With the use of two databases, the literature search yielded 615 articles, however only 10 articles were eligible for the review (Figure 1). The characteristics of the studies included in the review are summarised in Table 1. Various types of studies were included which consisted of: qualitative interviews,[14-17] workshops,[18] qualitative surveys,[19] retrospective evaluations,[6] cross-sectional studies,[20-21] and mix-method studies.[22] The geographical distributions among the studies were also examined. The outcomes of the review were based on the 10 eligible studies from the following countries: Malaysia (n= 2), Jordan (n= 3), Turkey (n= 3) and South Korea (n= 2).

From these studies, refugees' access to healthcare and its barriers were explored. The findings from the studies were categorised into four themes which included lack of awareness of one's rights to healthcare, communication, cultural differences and financial constraints as the key barriers to access healthcare.

Lack of awareness on one's rights to healthcare as a barrier to access healthcare

In a study that was conducted among Syrian refugees in Jordan,[20] it was stated that 20.6% of refugees reported the lack of awareness towards the healthcare system in the host country as a barrier. In another study, close to half of the Syrian women who were interviewed were not aware about their rights to free access to healthcare.[17] The majority of the refugees or asylum seekers felt that they were not provided with sufficient information regarding the services available in the host country, which thus led to difficulty in navigating the healthcare system upon arrival.[14] This, coupled with the lack of legal status undermined their ability to seek formal recourse for any problems faced regarding healthcare.[14] When further interviewed regarding the access to the information among those who knew, the source of information was mainly from close contacts (57.8%).[17]

Communication as barrier to access healthcare

Among the 10 studies that were being reviewed, most of the studies reported language as one of the barriers to access healthcare. In a study conducted by Kim et al., African refugees in South Korea reported that the language barrier impeded their access to healthcare. Participants felt that the care received was not attentive due to the unwillingness of the health professionals or incompetency to provide an explanation in their mother tongue.[15] The findings by Torun et al. confirmed the findings from Kim et al. as the participants from the study also experienced language barriers during their medical visits, specifically in understanding the health assessment results and the paperwork.[17] Thus, many refugees or asylum seekers relied heavily on their community leaders as translators when seeking healthcare services.[14] Duzkoylu et al. stated that qualified translators were essential for the care of refugee patients in each camp and hospital in Turkey, so that the refugees can explain their medical history and complaints accordingly.[6] On the other hand, Torun et al. reported the lack of interpreters as one of the barriers.[17]

Cultural differences as barrier to access healthcare

Beyond addressing communication as one of the barriers, the delivery of culturally appropriate care must also be addressed. According to the findings conducted by Chuah et al., participants from the study stated that the healthcare services provided did not take into account their

cultural beliefs or traditional practices.[14] For instance, many refugees and asylum-seekers usually sought complementary medicines that are based on their ethics and traditional practices but these forms or treatments are unavailable in the host country. Apart from this, in the study by Kim et al., cultural differences relating to religion was reported by the Muslim participants.[15] This matter is also reported in the findings from Torun et al. where women participants expressed their unhappiness with the healthcare service provided because they were not able to choose female doctors.[17] Besides that, in a study performed by Han et al., some refugees from North Korea stated that cultural differences in healthcare seeking-behaviour in South Korea also acted as a barrier for the participants to access the healthcare system.[19]

Financial constraints as a barrier to access healthcare

The majority of participants faced financial problems. Chuah et al. reported that the inability to afford the cost of healthcare is one of the key barriers among the refugees and asylum seekers to access the healthcare services that were highlighted by most of the participants.[14] This was further supported by the study conducted by Dator et al. In the study, financial issues were reported with a prevalence of 66%. The cost included medical services, medicines and transportation.[20] The problem was further exacerbated with the lack of livelihood, healthcare insurance or refugee status which allowed them to obtain healthcare services at discounted rates.[14] However, this discounted rate is only true if the refugees lived in the camps where healthcare services are subsidised by the government. However, asylum seekers or refugees who do not live in the camp are non-insured and are burdened by out-of-pocket payments to cover the medical fees. This is further explained by Al- Rousan et al. in their findings. The study reported that refugees who live outside the camp opt for care from pharmacies and made pharmacies their primary healthcare service.[22] However, these medical facilities are far from their homes which led to an increase in the cost due to transportation.

Financial stress is also shown to be the main challenge that limits the access to maternal health services among the refugees who live outside the camp in Jordan and Lebanon.[21] In a report prepared by Pocock et al., limited income for the migrant workers caused them to rely on fast food and thus their diet lacked micro-nutrients and eventually led to health problems.[18] Financial constraints and insufficient healthcare insurance also limited the migrants from accessing the healthcare system.[18] Apart from that, the study from McNatt et al. also showed that financial burden is one of the major challenges for Syrian refugees to access healthcare. The participants stated that the high cost of government setting for basic healthcare needs and the limited services available in NGO facilities forced refugees to make dangerous health decisions to reduce their financial burden, such as in borrowing medications from neighbours, reducing the dosage of the medications and more.[16]

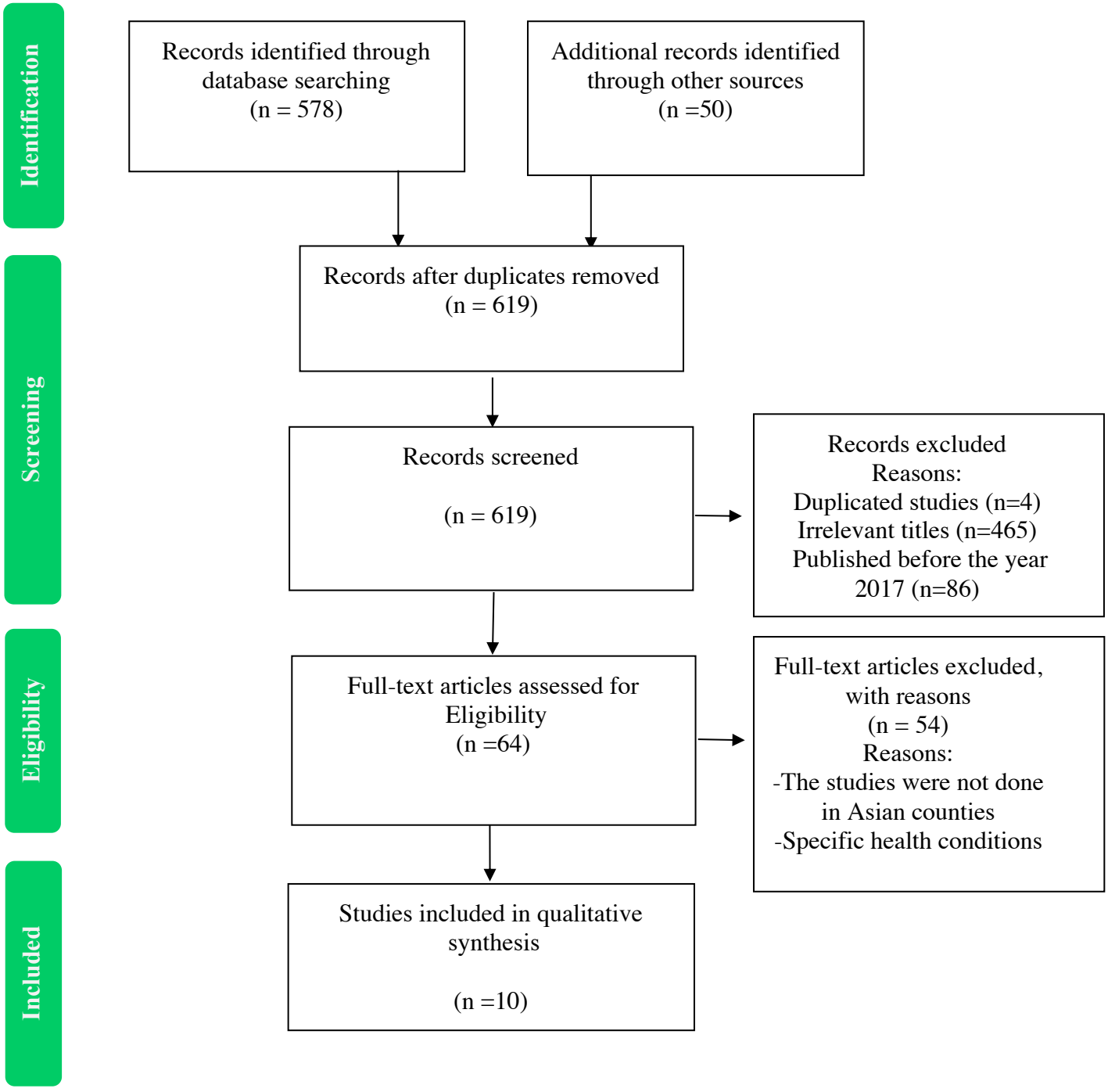

Figure 1 PRISMA flow diagram

Table 2 Summary of reviewed studies

Author and year of publication	Aim	Country of the study	Number of participants	Design, Methodology	Results
Al-Rousan T, et al.2018[22]	To determine the perspectives of Syrian refugees in Jordan, Jordanian health care providers and other stakeholders in addressing the public health issues of the refugee crisis.	Jordan	230 Syrian refugees	Qualitative interview and Focus group	Syrian refugees reported financial problems as their main barrier to healthcare access. Jordanian health care providers reported that understaffed and under-resourced issues, they are overworked, and are facing difficulties to care for the increasing number of Syrian refugee patients.
Chuah FLH, et al.2018[14]	To examine the key health concerns and barriers to healthcare access among refugees and asylum-seekers in Malaysia through the lens of healthcare professionals, program staff and experts on refugee and migrant health.	Malaysia	20 professional expertise working in the field of refugee health	Qualitative interview	Most of the participants reported that barriers in language lead to poor communication between healthcare providers and patients in both administrative and treatment processes. Besides, cultural differences; legal and protection issues; and financial difficulties are also the main concerns of the participants.
Dator W, et al. 2018[20]	To look at the health conditions and barriers to accessing healthcare in Syrian refugees settled in Jordan.	Jordan	Syrian refugees	Cross-sectional study	The communicable diseases have the highest prevalence among the Syrian refugees and followed by mental and emotional health problems, chronic diseases and physical impairment. Most of the Syrian refugees reported that financial issues are the main barrier to access healthcare including cost of the medical services, medicines and transportation. Unavailability of medicines and medical equipment as well as lack of knowledge about the healthcare also reported as barriers for them to access healthcare.
Duzkoylu Y, et al 2017[6]	To evaluate refugee admissions to emergency department because of trauma in means of demographics of patients and mechanism of trauma and compare the results with the local population	Turkey	Refugee camp's patient >10,000 patient	Retrospective evaluation	The ratio of emergency admission of refugee patients because of trauma was significantly higher than the emergency admission of the local population for any trauma combined.

Author and year of publication	Aim	Country of the study	Number of participants	Design, Methodology	Results
H.R.Han, et al. 2017[19]	To examine the extent and pattern of healthcare utilization among NK refugees prior to leaving North Korea and after they arrived in South Korea; and 2) to conduct in- depth individual qualitative interviews to explore facilitators of and barriers to NK refugees' healthcare service utilization	South Korea	329 North Korea refugees	Qualitative survey	Almost one third of the refugees reported that they became ill or injured before leaving NK. Cold, gastritis and arthritis are the most common conditions. About 40% of the refugees reported that they were in need of healthcare but unable to access healthcare due to the common reason such as not being able to access medication or treatment, unaffordability, or other such as legal issues. However, North Korea refugees were unable to determine a barrier to healthcare services after arriving in South Korea.
Kim MS, et al. 2017[15]	To understand refugee mothers of young children regarding their health needs and barriers to access maternal child health services.	South Korea	6 African refugee mothers	Qualitative interview	Based on the report, cultural barrier, socioeconomic factors such as unstable social identity, unable to obtain health insurance and low economic status, language barriers because of difficulty in accessing translation services and lack of healthcare knowledge Most of the participants reported to have economic problems due to the non-stable social identity and results in difficulty in obtaining health insurance. Language and cultural barriers are the most common barriers for the refugees to access maternal child health services.
McNatt ZZ, et al. 2019[16]	To understand the depth and nuances of Syrian refugees' experiences accessing non-communicable disease services in urban and semi-urban settings in Jordan	Jordan	68 Syrian refugees age between 18-59	Qualitative interview	Emotional distress and physical health of the refugees are the major concern that directly link to the trigger of non-communicable disease and the refugee reported that only limited specialized mental health services are available. In addition, the participants reported that the healthcare costs in government settings are relatively high and only a few selection of services are funded and available in NGO settings, so the refugees need to visit various healthcare settings in order to have a better healthcare experience. Next, financial constraints were reported as one of the concerns among the refugees, the participants reported that harmful decisions were made in order to minimise their financial burden.

Author and year of publication	Aim	Country of the study	Number of participants	Design, Methodology	Results
Pocock NS, et al. 2018[18]	To identify gaps in knowledge and promising interventions or policies to improve migrant and refugee health in Malaysia	Malaysia	40 participants from industry, medical professions, civil society and academia in Malaysia	Workshop	The workshop aim to address health injustice due to power differentials, unfair policies and inequity economic conditions and opportunities among migrants and refugees in Malaysia
Tappis et al. 2017[21]	To assess the utilisation of maternal health services among Syrian refugees in Lebanon and Jordan.	Lebanon and Jordan	1634 households in Jordan and 2165 in Lebanon	Cross-sectional survey	Cost is the main factor in care-seeking location and decision for Syrian refugees in both Jordan and Lebanon.
Torun P, et al. 2018[17]	To assess the health needs of urban refugees living in İstanbul.	Turkey	734 Syrian women	Qualitative interview	Most participants faced a challenge in accessing health care because of a lack of knowledge towards the Turkish healthcare system and also the language barrier. Besides that, negative attitudes of healthcare staff and long waiting time also led to the reduced satisfaction in these services.

DISCUSSION

Lack of awareness on one's rights to healthcare as barrier to access healthcare

From the review, we found that most refugees in Asia were not aware of their rights to receive healthcare. This could be due to the limited provision of information about the healthcare system and services available as well as the lack of knowledge of their rights to access healthcare services.[23] Saurman emphasised the importance of a healthcare service that is aware of the local context and the population's need to provide more appropriate and effective care, where patients could access such services if they were simply aware of them in the first place.[24] Refugees have faced difficulties in accessing specialist treatment services and participating in health promotion and disease prevention programmes.[25-26] The unfamiliar and lengthy procedures that are required to obtain exemption from medical fees can also prevent them from accessing healthcare.[27] There is also lack of data on refugee health in general and little evaluation on the effectiveness of the health intervention strategies.[28] It was reported that acculturation to the host country's values and help-seeking practices through integration and assimilation could lead to increased use of health services among refugees.[29] Health promotion plays an important role to raise the awareness of refugees pertaining to their rights, the available healthcare support and resources, as well as to raise awareness to promote health and to prevent disease and injury.[29]

Communication as barrier to access healthcare

In several studies that were included in this review, it was concluded by the authors that there is a need to bridge the language gap of the refugees and asylum seekers residing in Asia.[14-15,17] The language gap among the refugees is further explained in a study conducted by Gordan,[30] where trauma was highlighted as a factor in language learning. This factor was investigated by Söndergaard and

Theorell in a nine-month longitudinal study of Iraqi refugees in Sweden.[31] It was concluded in the study that refugees with more severe PTSD learned the second language at a slower pace. Due to this barrier, many were not able to fully understand the given information regarding their rights to healthcare and on the healthcare system itself. This is mentioned in the study conducted by Torun et al., where the main issue faced by the Syrian refugees in Turkey was found to be related indirectly to health as they had rights to access healthcare services but many had difficulties understanding that.[17] This barrier must be rapidly addressed so that proper and effective communication between the healthcare segments can be carried out, especially with the increasing number of refugees or asylum seekers that are suffering from poor mental and physical health to prevent the spike in the number of morbidity and mortality rates. The main solution to this barrier is still education.[6,32] A pilot study that was conducted on young refugees where physical education was combined with second language learning activities, such as games has been seen to be effective.[33]

Cultural differences as barrier to access healthcare

Some of the studies that were included also showed that there is a need for a more culturally appropriate healthcare for refugees and asylum seekers in Asia.[6,14-15,17] These studies found that this factor is important to increase the understanding of the health examination process and to develop culturally appropriate health interventions or lifestyle changes.[14-15,17] Previous studies have reported reluctance among refugees to seek Western healthcare services because of a mismatch of beliefs about the sources of illness and correspondingly appropriate treatments with the Western models of medical care. Besides that, healthcare providers need to be aware of the types of food generally consumed by the refugees to provide culturally relevant nutritional counselling.[34] It was reported that some refugees prioritised basic needs over health issues, such as issues in finding a job or overcoming housing problems.[35] Even though cultural appropriateness does not have a significant impact in reducing the health problems faced by the refugees and asylum seekers, it nevertheless helps in addressing the society's health disparities. However, it can be a challenging effort to bridge the cultural understanding. Cultural competence of the healthcare practitioners has been linked to patient satisfaction.[36] Therefore, education and training on the relevant knowledge, attitudes, and skills needed to effectively respond to sociocultural issues should be provided for healthcare workers who deal with refugees.[37]

Financial constraints as a barrier to access healthcare

A number of the included studies expressed that financial difficulty is a barrier among the refugees to access health services in Asia.[14, 16, 20, 21, 22, 32] Unemployment is common among newly arrived refugees, and refugees are often employed in low paying jobs or casual employment.[38] Perceived high cost of health care also limits access to healthcare among refugees and migrant patients.[39] High transportation cost to the healthcare centre was also identified as a barrier among refugees to access to healthcare services, regardless of the host country.[40-42] With increasing medical fees, McNatt et al. found that participants make rash or harmful decisions that can further worsen their health status as a solution to reduce their financial burden. El Arab and Sagbakken et al. suggested increased flexibility with regards to documentation for those who do not have access to healthcare as an effort to solve this major

problem.[43] Host countries can also look into health insurance schemes for refugees. Thailand's public health ministry provides health insurance card schemes that cover over 1.5million registered and unregistered migrants[44] whereas in Malaysia, the United Nations High Commissioner for Refugees Malaysia has partnered with RHB Bank Berhad to create an innovative private health insurance scheme (REMEDI) to help cover the hospital charges. [45-46] Reimbursement of transportation costs can also be provided to the refugees who need to travel to healthcare centres. Relocation or decentralisation of healthcare centres can also reduce the distance and transportation costs for refugees.

CONCLUSION

The review concludes that communication, lack of awareness of one's rights to healthcare, cultural differences and financial difficulties are perceived as the key barriers that limit access to healthcare among refugees and asylum seekers in Asia. With these ongoing barriers, the prevalence of non-communicable and communicable diseases in the host countries will increase, therefore, mortality and morbidity rates will be elevated in comparison to the population of the host countries. Hence, improvements in health promotion, communication, cultural support and financial support for the refugees must be urgently addressed.

REFERENCES

1. UN Refugee Agency. What is a refugee? UNHCR [Internet]. [cited 2021 Aug 10]. Available from: https://www.unhcr.org/what-is-a-refugee.html.
2. UN Refugee Agency. Asylum and Migration. UNHCR [Internet]. [cited 2021 Aug 10]. Available from: https://www.unhcr.org/asylum-and-migration.html.
3. Nations U. Refugees. Peace, dignity and equality on a healthy planet. United Nations [Internet]. [cited 2021 Aug 10]. Available from: https://www.un.org/en/global-issues/refugees.
4. Davies A, Basten A, Frattini C. Migration: A Social Determinant of the Health of Migrants | Migration Health Research Portal [Internet]. [cited 2021 Sept 4]. Available from: https://migrationhealthresearch.iom.int/migration-social-determinant-health-migrants.
5. WHO Regional Office for Europe. Health of refugees and migrants: Regional situational analysis, practices, experiences, lessons learned and ways forward [Internet]. 2018 [Cited 2021 Aug 10]. Available from: https://www.who.int/migrants/publications/PAHO-report.pdf?ua=1.
6. Duzkoylu Y, Basceken SI, Kesilmez EC. Physical trauma among refugees: comparison between refugees and local population who were admitted to emergency department-experience of a state hospital in syrian border district. J Environ Public Health. 2017;2017:8626275.
7. Mei C, Xiao Chuan L, Faller E, Pereira A. Household Income, Household Food Insecurity And Weight Status Of Migrant Workers In Klang Valley, Selangor, Malaysia. In: 6th Medical & Health Sciences Symposium, Management And Science University; 2016.
8. Hameed S, Sadiq A, Din AU. The Increased Vulnerability of Refugee Population to Mental Health Disorders. Kans J Med. 2018;11(1):20–3.
9. Traumatic Experiences of Refugees. Refugee Health TA [Internet]. Refugee Health Technical Assistance Center (RHTAC). 2011 [cited 2021 Aug 31]. Available from: https://refugeehealthta.org/physical-mental-health/mental-health/adult-mental-health/traumatic-experiences-of-refugees/

10. Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J, et al. Common mental health problems in immigrants and refugees: general approach in primary care. CMAJ. 2011;183(12):E959-67.
11. Knipscheer JW, Sleijpen M, Mooren T, Ter Heide FJJ, Van der Aa N. Trauma exposure and refugee status as predictors of mental health outcomes in treatment-seeking refugees. BJPsych Bull. 2015;39(4)178–82.
12. UN Refugee Agency. Global Trends: Forced Displacement in 2018. Geneva [Internet]. UNHCR. [cited 2021 Aug 31]. Available from: https://www.unhcr.org/5d08d7ee7.pdf
13. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Methodol. 2005;8:19-32.
14. Chuah FLH, Tan ST, Yeo J, Legido-Quigley H. The health needs and access barriers among refugees and asylum-seekers in Malaysia: a qualitative study. Int J Equity Health. 2018;17(1):120.
15. Kim MS, Song IG, An AR, Kim KH, Sohn JH, Yang SW. Healthcare access challenges facing six African refugee mothers in South Korea: a qualitative multiple-case study. Korean J Pediatr. 2017;60(5):138–44.
16. McNatt ZZ, Freels PE, Chandler H, Fawad M, Qarmout S, Al-Oraibi AS, et al. "What's happening in Syria even affects the rocks": a qualitative study of the Syrian refugee experience accessing noncommunicable disease services in Jordan. Confl Health. 2019;13(1):26.17.
17. Torun P, Mücaz Karaaslan M, Sandıklı B, Acar C, Shurtleff E, Dhrolia S, et al. Health and health care access for Syrian refugees living in İstanbul. Int J Public Health. 2018;63(5):601–8.
18. Pocock NS, Suphanchaimat R, Chan CK, Faller EM, Harrigan N, Pillai V, et al. Reflections on migrant and refugee health in Malaysia and the ASEAN region. In: BMC Proceedings. BioMed Central Ltd.; 2018. p. 4.
19. Han HR, Lee JE, Kim K, Chung Y, Kim MT, Robinson C, et al. Healthcare utilization among North Korean refugees in South Korea: a mixed methods study. Public Health. 2017;142:116–20.
20. Dator W, Abunab H, Dao-Ayen N. Health challenges and access to health care among Syrian refugees in Jordan: a review. East Mediterr Health J. 2018;24(7):680–6.
21. Tappis H, Lyles E, Burton A, Jordan Health Access Study Team, Lebanon Health Access Study Team, Doocy S. Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan. Matern Child Health J. 2017;21(9):1798–807.
22. Al-Rousan T, Schwabkey Z, Jirmanus L, Nelson BD. Health needs and priorities of Syrian refugees in camps and urban settings in Jordan: perspectives of refugees and health care providers. East Mediterr Health J. 2018;24(3):243–53.
23. Dias S, Gama A, Silva AC, Cargaleiro H, Martins MO. [Barriers in access and utilization of health services among immigrants: the perspective of health professionals]. Acta Med Port. 2011;24(4):511–6.
24. Saurman E. Improving access: modifying penchansky and thomas's theory of access. J Health Serv Res Policy. 2016;21(1):36–9.
25. Shaw SJ, Huebner C, Armin J, Orzech K, Orzech K, Vivian J. The role of culture in health literacy and chronic disease screening and management. J Immigr Minor Health. 2009;11(6): 460–7.
26. Lee SK, Sulaiman-Hill CMR, Thompson SC. Providing health information for culturally and

linguistically diverse women: priorities and preferences of new migrants and refugees. Health Promot J Austr. 2013;24(2):98–103.
27. Joels C. Impact of national policy on the health of people seeking asylum. Nurs Stand. 2008;22(31):35–40.
28. Diaz E, Ortiz-Barreda G, Ben-Shlomo Y, Holdsworth M, Salami B, Rammohan A, et al. Interventions to improve immigrant health. A scoping review. Eur J Public Health. 2017;27(3):433–9.
29. Powell TM, Li S-J, Hsiao Y, Thompson M, Farraj A, Abdoh M, et al. An integrated physical and mental health awareness education intervention to reduce non-communicable diseases among Syrian refugees and Jordanians in host communities: A natural experiment study. Prev Med Rep. 2021;21:101310.
30. Gordon D. Trauma and Second Language Learning among Laotian Refugees. Journal of Southeast Asian American Education and Advancement. 2015;6.
31. Söndergaard HP, Theorell T. Language Acquisition in Relation to Cumulative Posttraumatic Stress Disorder Symptom Load over Time in a Sample of Resettled Refugees. PPS. 2004;73(5):320–3.
32. Assi R, Özger-İlhan S, İlhan MN. Health needs and access to health care: the case of Syrian refugees in Turkey. Public Health. 2019;172:146–52.
33. Krüger M. Second language acquisition effects of a primary physical education intervention: A pilot study with young refugees. PLOS ONE. 2018;13(9):e0203664.
34. Uba L. Cultural barriers to health care for southeast Asian refugees. Public Health Rep. 1992;107
35. Kiselev N, Pfaltz M, Haas F, Schick M, Kappen M, Sijbrandij M, et al. Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland. Eur J Psychotraumatol. 2020;11(1):1717825.(5):544–8.
36. Castro A, Ruiz E. The effects of nurse practitioner cultural competence on Latina patient satisfaction. J Am Acad Nurse Pract. 2009;21(5):278–86.
37. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003;118(4):293–302.
38. Saunders P. The immigrant poverty profile. Migration Action. 1998;20(3)
39. Harris MF, Telfer BL. The health needs of asylum seekers living in the community. Med J Aust. 2001;175: 589-92.
40. UNHCR and JHAS. Health Access and Utilisation survey among non-camp Syrian Refugees [Internet]. 2014 [cited 2021 Oct 28]. Available from: data.unhcr.org/syrianrefugees/admin/download.php?id=6029.
41. Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC. Healthcare barriers of refugees post-resettlement. J Community Health. 2009;34(6):529–38.
42. Riggs E, Davis E, Gibbs L, Block K, Szwarc J, Casey S, et al. Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. BMC Health Serv Res. 2012;12(1):117.
43. El Arab R, Sagbakken M. Healthcare services for Syrian refugees in Jordan: a systematic review. European Journal of Public Health. 2018;28(6):1079–87.
44. Tangcharoensathien V, Thwin AA, Patcharanarumol W. Implementing health insurance for migrants, Thailand. Bull World Health Organ. 2017;95(2):146–51.
45. RHB Bank Malaysia. RHB Insurance In Collaboration With UNHCR To

Support Refugees In Malaysia [Internet]. 2016 [cited 2021 Aug 31]. Available from: https://www.rhbgroup.com/~/media/files/malaysia/news-room/2016/june/160607.ashx

46. Hamdan N. Policy to address medical issues faced by migrants in Malaysia, says UNHCR rep [Internet]. 2016 [cited 2021 Aug 31]. Available from: https://www.thestar.com.my/news/nation/2016/06/08/insurance-for-refugees-launched-policy-to-address-medical-issues-faced-by-migrants-in-malaysia-says