

# COVID-19 and Refugees in Malaysia: An NGO Response

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## Abstract

COVID-19, a watershed moment in global health, has brought health inequalities into sharp focus exposing structural disadvantage and institutional discrimination experienced by disenfranchised populations. Focusing on urban refugees and asylum seekers in Malaysia who are deemed of irregular status under the law, this field report outlines the legal and policy responses of the government and the impact of COVID-19 on refugees. It also highlights the organisational response of an organisation working with refugees in the greater Kuala Lumpur area. As pandemics become a reality of our times, it is imperative that pandemic preparedness and mitigation strategies adopt inclusive and universal approaches that include migrant populations such as refugees and asylum seekers.

**Keywords:** asylum seekers, COVID-19, Malaysia, mental health, refugees

## Introduction

It has been acknowledged that while refugees pose a low risk to the transmission of infectious diseases, they are typically at likely increased risk of contracting diseases, including COVID-19 (Kluge et al., 2020). The pandemic has been found to lead to stigma and isolation, livelihood insecurity and lack of access to accurate health information among refugees (Bukuluki et al., 2020).

Malaysia receives a significant number of asylum seekers each year who are fleeing conflict and repressive regimes throughout the region. As of end October 2020, there were some 178,450 urban refugees and asylum seekers registered with the United Nations High Commissioner for Refugees (UNHCR) in Malaysia (UNHCR, 2020).

Malaysia is neither a signatory to the 1951 Convention Relating to the Status of Refugees, nor its 1967 Protocol. It has not enacted legislation recognising the legal status of asylum seekers and refugees who are considered "illegal immigrants" under the Immigration Act 1959/63 (Act 155). While Malaysia provides a 50% discount off the foreigner's rate for medical fees incurred by UNHCR recognised refugees and asylum seekers, this is also unaffordable because they lack the formal right to work. Those who do find employment tend to work in occupations that are unprotected and highly vulnerable to exploitation and forced labour. This structural marginalisation shapes their exposure to physical harms and health risks.

Refugees are also susceptible to violence in various forms, including robbery, extortion and personal injury perpetrated by local gangsters. Psychosocial stressors like financial difficulties (including lack of employment), legality of status (nonrecognition of refugees), worrying thoughts about the future of their children (especially with regard to education/higher education) and lack of access to health-care exacerbate the symptoms of common mental disorders (Health Equity Initiatives [HEI], 2010).

The violence that refugees are subject to in Malaysia, as well as deep uncertainty about their future arising from protracted exile, exacerbates the mental/psychological symptoms trauma faced in their country of origin, often related to conflict and including systematic and institutional violence in the form of sexual violence, rape, torture, forced labour and trafficking for forced prostitution. Pre-migration trauma often exhibits as posttraumatic stress disorder (PTSD), depressive disorders and anxiety disorders in the country of asylum. The case of Afghan refugees in Malaysia reveals some of the psychosocial aspects of protracted exile (HEI, 2010).

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Against this backdrop, the first COVID-19 case in Malaysia was detected at the end of January 2020. The detection of COVID-19 among refugees began with the first major cluster where a number of refugees had joined an estimated 16,000 strong Tabligh (religious gathering) in Sri Petaling from 27 February to 01 March 2020 (Babulal & Othman, 2020).

Since then, the impact of the pandemic on refugees and asylum seekers was driven by the Movement Control Order imposed by the government to control the transmission of the disease, the policies on access to testing and arrest of undocumented migrants including asylum seekers, and the rise in hate speech against migrants and negative portrayal of migrants in the media. Thus, pre-existing stressors have been compounded with the COVID-related stressors for the refugee community.

This paper discusses the impact of the pandemic and the measures taken by the authorities to control the pandemic on refugees and asylum seekers. It also details the interventions undertaken by Health Equity Initiatives (HEI).

## About Health Equity Initiatives

HEI is a Malaysian nonprofit, community-based organisation which runs an integrated mental health programme covering prevention, treatment and rehabilitation services and using the mental health and psychosocial support (MHPSS) approach (IASC, 2007), with activities comprising of (1) a community-based mental health programme including an annual training of refugees as community health workers (CHWs) in mental health, advanced professional development of CHWs on mental health, community-based mental health screening and mental health promotion; (2) psychiatric and psychological interventions; (3) psychiatric treatment adherence support; (4) mental health rehabilitation; (5) facilitated support groups (6) psychosocial support services and (7) research-driven advocacy. It also hosts a health and human rights internship programme, and refugee mental health elective programme for medical students.

## The Movement Control Order

On 16 March 2020, pursuant to Section 11 of the Prevention and Control of Infectious Diseases 1988 [Act 342] and the Police Act 1987, the Prime Minister announced the Prevention and Control of Infectious Diseases (Declaration of Infected Local Areas) Order 2020 (ZICO Law, 2020). The predominant measure in this regard was the Movement Control Order (MCO) which was imposed in several phases:

- Phases 1 to 4: Movement Control Order (MCO) from 18 April – May 3 2020
- Phases 5 and 6: Conditional Movement Control Order (CMCO) from 4 May – 9 June 2020
- Phase 7: Recovery Movement Control Order (RMCO) from 10 June – 31 August 2020

In the initial phase of the MCO, a total lockdown was imposed with only essential services being able to operate.

Among other restrictions, people were disallowed from travelling beyond a 10km radius from their place of residence, even for daily necessities and healthcare, and police-controlled road blocks enforced these movement restrictions (Bernama, 2020b).

## Lockdowns and Food and Housing Insecurity

These measures had far reaching implications for refugees and asylum seekers. With the majority of the refugee population working in informal, unprotected work sectors, these measures led to them losing their jobs as businesses closed during the lockdown. In a Community Feedback Survey (HEI, 2020) conducted by HEI to rapidly gather information to adapt the organisation's services, almost 95% of the 100 Rohingya refugees interviewed reported that they were not paid for the month of March, 2020, while 30% were assured that they would get their old jobs back when the MCO was lifted, and about 90% of Afghan workers in Afghan refugee families lost their jobs. During this time, many refugees were also evicted from their homes or were threatened with eviction (Teoh, 2020, Welsh and Cheng, 2020) and hunger was extensive in the refugee community (FMT Reporters, 2020, HEI, 2020). Although, the government rolled out a generous stimulus package which included financial assistance to low-income households, noncitizens were excluded from these benefits (Ating, 2020). Noncitizen populations had to rely on food banks and aid organised by nongovernmental organisations (NGOs).

In response to these problems, limited organisational resources, and HEI's primary focus on delivering mental health services for refugees, the organisation strengthened its networking and partnership building with about 20 partner NGOs to facilitate material support for its refugee patients. Such complementarity with other NGOs, coalitions and government agencies allowed for the distribution of skills and knowledge, and widening of community impact. Between 18 March 2020 and 18 June 2020, a total of 505 families and 25 individuals residing in shelters received donations of food and nonfood provisions. While there was positive feedback to this support from the patients and their families, there were some families who experienced delays in receiving food aid. Understandably, they also expressed annoyance when HEI called them to remind them about their follow up appointments. They stated that they did not want to be contacted for mental health services if the organisation did not understand their material predicament. Although, ultimately, these families did receive the support they required, such instances simultaneously reflect the limitations of under-resourced organisations in urban refugee settings to respond to a pandemic, but importantly, it validates the indivisibility of needs and integration of services posited by the MHPSS operational framework (IASC, 2007).

HEI continues to carry out psychosocial support interventions for community members, both patients and nonpatients, in relation to health, livelihood and arrest and

detention. It also maintains close communication with UNHCR Malaysia on their strategy with regard to refugees and asylum seekers.

## Arrest and Detention

Although the government initially assured undocumented migrants that they would not be arrested if they came forward for testing for COVID-19 (Bernama, 2020a, Razak, 2020), the later mass targeted testing of migrants in certain Enhanced Movement Control Order areas led to crackdowns on undocumented migrants via mass arrests and immigration raids (CodeBlue, 2020), which included asylum seekers pending registration by UNHCR and UNHCR cardholders whose registration had expired and could not be renewed because of the lockdown. These individuals were detained in immigration detention centres, to be deported to their country of origin. The mass arrests and raids increased feelings of fear in the refugee community. New clusters of COVID-19 cases were detected in three of these immigration centres. Based on available information, it is likely that the infection source might have been from the newer detainees mixing with the detainees who had been in detention prior to the MCO (People's Health Forum, 2020).

As a convening member of the People's Health Forum (PHF), HEI coreleased a press statement on 1 May 2020 and a letter on 24 May 2020, calling on the government to impose a moratorium on arrests to ensure that all migrants come forward for screening. The press statement and the letter were hand delivered to the office of the Prime Minister, the Minister of Communications and Multimedia and the Director General of Health. On 20 March 2020, PHF had submitted a memorandum to the Prime Minister highlighting the special needs of refugees and asylum seekers, due to, among others, having insufficient food, supplies and being unable to pay bills.

## Hate Speech and Racism

In the meantime, on 16 April 2020, a boat of about 200 Rohingya refugees tried to dock in Malaysian waters before being turned away and escorted by two Navy vessels after giving food to those on board (Ong, 2020). Prior to that, about 60 Rohingya refugees died aboard a cramped vessel carrying 400 people, as Thailand and Malaysia refused the boat entry (Parekh, 2020). The government position was that these measures were intended to keep COVID-19 out of their countries (Ong, 2020). This was followed by a growing online anti-immigrant and anti-Rohingya sentiment and old videos of a Rohingya activist demanding equal rights and full citizenship in Malaysia albeit with fabricated captions surfaced. These fictitious captions were refuted and debunked by several media websites (Ong, 2020). Nevertheless, it triggered a wave of hate speech and a series of newly created accounts such as "Malaysians Against Illegal Immigrants", with such online xenophobic hate speech also targeting human rights defenders of Rohingya refugees (Ong, 2020). All these

developments greatly increased fear in the refugee community, particularly among the Rohingyas.

## Mental Health Consequences of the Lockdown and Access to Mental Health Care

With regard to the refugees being supported by HEI's psychiatric and psychological services, a high number reported experiencing flashbacks and most reported feeling intense fear and anxiety because of the increased presence of enforcement personnel and roadblocks. These fears were intensified when the government backpedalled from its initial assurances to come forward for testing for COVID-19 without fear of arrest (Razak, 2020), to conduct raids and arrests of undocumented migrants. Refugees who had lost their jobs because of the lockdown reported experiencing feelings of helplessness and stress about how they would feed their families. Those working in essential services such as restaurants providing takeaway services during the MCO were concerned about the risks associated with working during this period, although many were afraid that to stop work might lead to loss of jobs.

In order to continue its services, HEI liaised with the Ministry of Health and secured permission to ensure the mobility of both patients and team members. A Letter of Permission was given by the Ministry of Health. The Movement Control Order necessitated the prioritising of some mental health services while rescheduling others and adapting work processes to provide care to patients on a virtual scale, as most HEI team members had to work remotely from home. The range of mental health interventions provided by HEI during this period is given in Box 1. The psychiatric consultations revealed that many of the refugee patients that were being treated were experiencing stress and exacerbation of anxiety and depressive symptoms during the MCO. This exacerbation of anxiety and depressive symptoms were captured by the increase of the Beck's Anxiety Inventory (BAI; Beck and Steer, 1993) and Beck's Depression Inventory (BDI; Beck et al., 1996) scores which are utilised to monitor the progress of treatment of refugee patients diagnosed with anxiety and depressive disorders respectively. These instruments were chosen in 2010 after a review of literature and a discussion between the treating clinicians who found these validated tools most suitable for the local context. Translations and back translation of the BAI and BDI have been done in the languages of the refugee communities with the assistance of HEI's refugee CHWs, UNHCR translators and bilingual medical practitioners and/or clinical psychologists from the countries of origin of the refugees. In this regard, the refugee CHWs in the organisation play a big role in the development of culturally sensitive assessments, psychoeducation strategies and interventions implemented for their community members. Frequent discussions on these topics are held in the CHWs' training on mental health conducted annually, weekly case discussions and supervisions, and discussions in the clinics.

**Box 1: Mental health services and psychological and behavioural interventions provided by HEI since the imposition of the Movement Control Order**

- Providing pharmacological treatment for patients by maintaining a skeleton team on clinic days.
- Conducting psychiatric consultations with patients via phone calls, as well as face-to-face sessions with the Consultant Psychiatrists starting from May when the MCO restrictions were eased.
- Providing treatment adherence support via follow-up phone calls, which includes psychoeducation and monitoring of the medication refill process.
- Providing transport subsidies and door-to-door transportation services for all patients to attend clinics
- Psychological therapy and counselling sessions have been conducted with patients via phone, or video consultations where possible.
- Support group sessions with Afghan, Sri Lankan and Rohingya communities are also continuing via online social platforms such as Telegram and Viber.

With regard to the BAI and BDI which are administered just before the psychiatric consultations, a review of HEI case files from the period 18 March to 18 June 2020 of patients with psychiatric problems showed deterioration in mental health status in 48.1% of patients with anxiety disorders and 46.8% of patients with mood disorders. For more stable patients, the BAI and BDI are administered every 3 months when they come for their psychiatric review. For patients with acute symptoms, the review is more frequent. The deterioration in score in this instance was measured by comparing the score from the previous consultation with the score from the consultation during the period of review.

During this same period, physical symptoms of stress, anxiety and depression were extensively explored with refugee patients and further addressed in individual and group psychoeducation, and by the psychiatrist in clinic sessions. HEI developed information, education and communication (IEC) materials on COVID-19 and the diagnosis of COVID-19 based on it being a syndrome. The difference in respiratory symptoms due to a physical ailment and due to stress and anxiety were repeatedly addressed as outlined above. Additionally, informed consent was taken to use the data in anonymised and aggregated form for policy advocacy and publication purposes and patients were advised by CHWs that they could decline the request for data use without consequences.

The most common reasons shared by refugee patients for the associated symptoms of anxiety and depression were the following:

- (1) Loss of employment
- (2) Inability to pay rent for rented premises
- (3) Lack of money to buy essential items like food
- (4) Fear of arrest and detention
- (5) Fear of deportation

- (6) Fear of being infected by the SARS-CoV-19 virus
- (7) Uncertainty of their refugee status and resettlement.

HEI was able to adapt its operations to an online mode, conducting 148 psychological and behavioural intervention sessions and 20 support group meetings between 18 March and 18 June 2020. However, the challenges in conducting virtual sessions related to counselling, psychotherapy and support groups included external distractions from the patients' home environment, poor internet connectivity and a lack of privacy. Although many patients conveyed a preference for face-to-face sessions, others reported that the virtual sessions were helpful, and some requested more sessions during this period. The participants of the online support groups were mostly women who shared positive feedback. They appreciated the benefit of connecting with others outside their home and having someone to talk to about their problems.

## Access to COVID-19 Screening, Testing and Treatment

To encourage Tabligh attendees to approach testing facilities, the Ministry of Health issued statements assuring undocumented migrants that they would not be arrested. It also declared an exemption of treatment fees for those who had been infected or had been in close contact with other COVID-19 patients, although those who tested negative would have to pay USD 10 for the test. This was different from citizens who had access to free screening, testing and treatment. Nevertheless, owing to the crackdown on undocumented migrants that ensued and the sharp rise in online hate speech and xenophobia (Ong, 2020), particularly against the country's large Rohingya refugee population, refugee communities were unsurprisingly afraid to come forward for screening as they feared arrests. Moreover, because those noncitizens who obtain a negative result would incur a cost of USD 10 per head for COVID-19 screening at public healthcare facilities, many refugees who were at the Tabligh refrained from coming forward for testing.

The additional cost of transportation was another barrier to accessing screening. As NGOs such as Mercy Malaysia and IMARET (IMAM Response & Relief Team) began to provide subsidies to refugees to access screening and testing, HEI worked with them to expand the access of refugees to COVID-19 test services. It also liaised directly with the National Crisis Preparedness and Response Centre (CPRC) to facilitate access to testing and provide information to CPRC about Tabligh attendees, areas they reside in, and the number of people they may have interacted with. Additionally, between 18 March and 18 June 2020, HEI also conducted 615 screening calls for COVID-19 symptoms for patients and community members, for the purpose of early case detection and intervention.

However, the major challenge to supporting refugees and help them protect themselves against the disease was related to their overcrowded housing conditions which prevented the practice of social distancing and the absence

of running water in many refugee homes which made hand hygiene difficult (HEI, 2020). Additionally, the infodemic generated in the wake of the pandemic and information asymmetries created by refugees being sequestered from mainstream society and not having access to accurate and timely information on COVID-19 also led to many misconceptions about the disease (HEI, 2020). The misconceptions are detailed in Box 2.

### **Box 2: Misconceptions on the part of refugees with regard to COVID-19**

Only Chinese people are vulnerable to COVID-19.

- Onion, garlic and turmeric can kill the novel coronavirus.
- Since the disease originated in China, Chinese traditional medicine is the best treatment for COVID-19.
- You can protect yourself from COVID-19 by gargling or swallowing ethanol or bleach.
- The new coronavirus, SARS-CoV-2, was created by people.
- Applying body oil can prevent the virus from getting to the skin.

Addressing these problems, HEI's response included:

- Producing and curating 21 IEC materials in seven languages for dissemination. These materials focused on the themes of COVID-19, government updates and maintaining psychological wellbeing. The seven languages that they are translated into were Arabic, Burmese, English, Farsi, Malay, Tamil and Urdu. These materials were distributed as infographics, videos, audio notes and text messages, and were disseminated on platforms such as WhatsApp and social media.
- Providing health education about disease prevention and control, as well as advice to individuals at risk on the next steps to take based on instructions given by the Ministry of Health.
- Communicating with community based organisations and community leaders to ensure the dissemination of accurate information to the wider community.

## **Discussion and Conclusion**

As in many countries, in Malaysia too, COVID-19 has disproportionately affected disadvantaged populations and has exposed racial and citizen-noncitizen fault lines in the social landscape. While countries like South Korea expanded access to testing and treatment even for undocumented migrants (Kim, 2020) and other countries regularised migrants, extended social protection and released migrants from immigration detention into community based alternatives (UNDP, 2020), in Malaysia the pandemic excessively impacted refugees and asylum seekers who could not return to their country of origin durably nor draw upon the support of the embassy of their home country. Increase in mass arrests and immigration raids, hate speech, racial discrimination and xenophobia, housing

and food insecurity, and differential access to COVID-19 testing and treatment vis-à-vis citizens exacerbated fear, hunger, homelessness, low access to healthcare, and importantly increased stress, anxiety and depression among refugees. The pandemic also exposed the limitations of the NGO response, unprecedented as it was in scale, to sustainably address the needs of this population during a crisis.

HEI was able to continue providing mental health services and psychosocial support services during these unprecedented times, for example online consultations, prescription and distribution of medication, online counselling and psychotherapy and facilitating online support groups. Critically, engaging in policy advocacy helped to draw attention to the problems of an otherwise forgotten and hidden population.

While organisations like HEI were able to switch to an online mode of operations with significant resource constraints, the existing digital divide created differential opportunities in the refugee community to be able to make use of such support. Strengthening organisational pandemic preparedness in the context of COVID-19 highlights the salience of four important things: flexibility of organisational systems to adapt to the crisis; partnering with other organisations to create complementarity of services; having strong links with community networks and organisations to reach deep into the community quickly; and capacity and competency related to digital and online communication. Public-private partnerships should be optimised for humanitarian assistance. Prominently, the capacity of front liners, nonspecialists and refugee community members needs to be strengthened to foster pandemic preparedness especially in resource constrained settings.

With the likelihood of global epidemics becoming more frequent, it is imperative that migrant populations including refugees and asylum seekers are included in pandemic responses with equal entitlements to health care and social protection via universal approaches to testing and treatment. In preparing for recovery, it is also critical that governments educate their citizens on the contributions of migrant populations and take action against xenophobic hate speech against migrant communities to preserve the rule of law. Pandemics cannot become an excuse to securitise migrant communities. Fulfilling the promise of the 2030 Agenda for Sustainable Development to leave no one behind requires the inclusion and participation of all people.

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We declare no competing interests.

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