



Struggling against COVID-19 and Suffering from Despair: Time for Inclusive Protection of Migrant Workers

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How can governments protect and improve the health and safety of migrant workers as the pandemic continues? To answer the question, we first need to define what measures and indicators we should use to evaluate the government response to the pandemic. In infectious disease control, precautionary measures are found to be effective (perhaps, the only option to choose) when the epidemiological evidence is unavailable or inconclusive, and a vaccine is not available. During the COVID-19 pandemic, various forms of precautionary measures of social distancing have been used across countries to control the spread of the disease, including lockdowns, border controls, travel restrictions and bans, extensive contact tracing and screening, quarantine, confinement, isolation, closure of public places, and restriction of private gatherings (while adding the individual responsibility of wearing a face mask and hand sanitization). From the early epidemic, the policy of mobility restriction (or more commonly known as social distancing), which aims to reduce contact with those infected or “at-risk,” has been supported by mathematical modeling on the effects of non-pharmaceutical interventions on the reduction of COVID-19 transmission, mortality rates, and healthcare burden.¹ Accordingly, these medical outcomes in the modeling are known to be the objective indicators of the success of the pandemic control; therefore, they are used in the country comparison, which will influence local policymaking.

However, potential harms and negative consequences from mobility restriction are well known in the context of socio-economic impact and health inequity, particularly among those mobile and transient workers who are excluded from the state policy for the health and social care of local citizens.² (The discourse of citizenship in migrant workers is yet another point of debate from the ethics of reciprocity in the pandemic control.) For low-wage migrant workers, mobility restriction is incompatible with meeting their essential needs; therefore, they could be more vulnerable to COVID-19-related adversities by exclusionary health policies and health risks due to living conditions under mobility restrictions.³ Measures for COVID-19 containment should include protecting “at-risk” populations, paired with equivalent support in their rights. In egalitarian concerns of global health policy, the state has an obligation to protect low-wage migrant workers who are more exposed to COVID-19 due to the structural causes listed above.⁴ Including measures of protection in addition to reducing COVID-19 are crucial in the discussion of global and local health policy and governance.

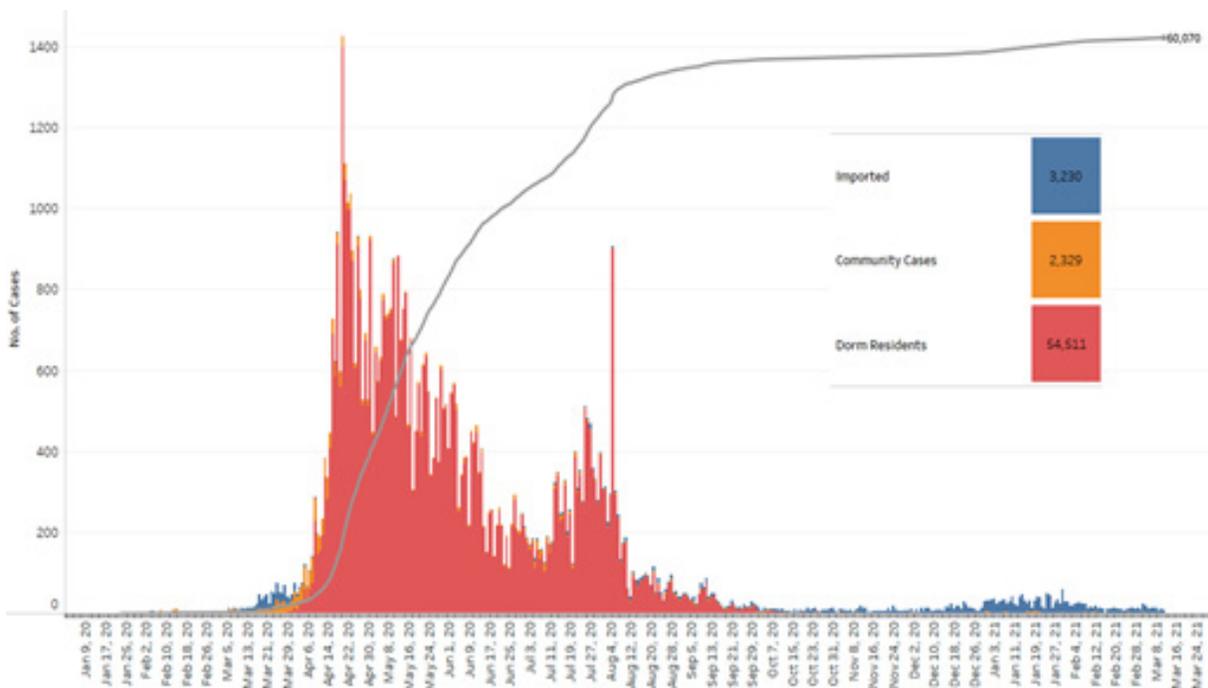
Below, I discuss the impact of COVID-19 on low-wage, dormitory-dwelling migrant workers in Singapore as a case study. As of March 11, 2021, the country reported 60,070 laboratory-confirmed cases of COVID-19 in a total of 5.704 million population, 1053.8 cases per 100,000, which was the highest incidence rate in Asia, compared to 813.9 in India, 509.5 in

Indonesia, 334.2 in Bangladeshi, 351.0 in Japan, 184.7 in South Korea, and 148.7 in Hong Kong.⁵ However, in the nation-level data of Singapore, migrant workers consisted of 90.7% (n=54,511) of the total cases with a prevalence rate of 16.88% (n=54,511/323,000 workers), compared to 0.04% in the local population (n=5.381 million) (Ministry of Health Singapore).⁶ As addressed by the literature, such a sharp disparity in COVID-19 infection resulted from the high-density and unhygienic living conditions of migrant workers and a lack of an inclusive protection system of equal access to healthcare.⁷

From the very early stages of the pandemic (possibly due to geopolitical proximity to China), Singapore’s government has undertaken a whole-of-government, multi-ministry taskforce approach to control the outbreak.⁸ Under the strict border control, the taskforce has augmented active case finding, extensive contact tracing,

quarantine, testing, isolation, and treatment. Yet, expectedly, migrant workers were not a priority group in prevention, and soon the risk of this population became evident. Immediately after the first case in migrant workers on February 9, 2020, four workers were infected from the index case from all different dormitories. Since then, cluster dormitory infections have escalated exponentially across the country.⁹ Twenty-five out of 43 dormitories were declared isolation areas within one month of the first case.

The country implemented a “circuit breaker” phase (a local term for lockdown) for two months from April 7 to June 1, 2020, and the following three phases to exit lockdown: “safe reopening, transition, and nation.” However, this timeline of mobility restriction was not applied to migrant workers. Once circuit breaker started, all the dormitories’ residents—regardless of the cases—were confined to



their dormitory room. Many migrant workers were not informed about it. They were not allowed to leave their room, in order to reduce any contacts within a dormitory, while meals were delivered to them. In confinement, extensive swab operations and serological testing were undertaken in all dormitories. Infected workers were transferred to “community care facilities” and recovered workers to “community recovery facilities” before they transitioned back to work. From June 9, all workers recovered from COVID-19 resumed work, while COVID-19 tests of all migrant workers were completed on August 11, 2020.

It took eight months of confinement to control the spread of the disease in 323,000 migrant workers, but eventually extensive and prolonged confinement effectively reduced infections among migrant workers living in dormitories with unhealthy conditions. As shown in the figure below, no more than one case in migrant workers has been reported daily since October 9, 2020. The grassroots migrant workers communities were concerned about an almost year-long confinement and raised a critical question: “COVID-19 has been under control. So, now what for them?”

On the other side of the mobility restrictions, migrant workers suffered from exclusion and despair caused by confinement, with no social safety net provided. While confined, they lacked the ability to meet essential needs, such as earning money for family support, proper meals, cooking, haircuts, religious activities, and phone and wi-fi access; importantly, they lost social ties over the course of quarantine, isolation, and relocation of room arrangement by

workplace. Confinement has been gradually lifted among migrant workers since December 2020. However, as of this piece’s writing, migrant workers are still confined to their dormitories except for the time of work and legal and medical appointments with government agencies.

Implementing mobility restrictions as a measure to reduce transmission is only possible when their needs can be met without mobility; social-economic marginality increases suffering from the pandemic. Distributive justice for living necessities, in addition to healthcare, must be addressed.¹⁰ Overall, the efficacy of the government response was proven by the elimination of infection. But, to answer the question, “how can governments protect and improve the health and safety of migrant workers as the pandemic continues?”, the government will need to include the measures of an inclusive protection system and the indicator of security under the policy of disease control and prevention.

Endnotes

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