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'WE WOULD HAVE TO MAKE DO WITH IT': PATIENTS' LIVED QUARANTINE EXPERIENCE AT THE COVID-19 QUARANTINE CENTRE IN MALAYSIA

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Abstract

Malaysia is one of the few countries that has adopted an institutionalised quarantine approach for low-risk COVID-19 patients, as part of the various measures implemented to contain the spread and prevent the outbreaks of COVID-19. This research explored the individual lived quarantine experience at the institutionalised quarantine centre, aiming at informing the effects of such public health measures for better management of healthcare services. Using in-depth interviews, six purposively selected low-risk COVID-19 patients retrospectively provided their quarantine experience at the institutionalised quarantine centre. The interviews were conducted online, recorded, and transcribed. Interpretative phenomenological analysis (IPA) was employed in analysing the data and synthesising the initial codes, sub-themes, and main themes. Analysed data resulted in four overarching themes illustrating the quarantine experiences at the institutionalised quarantine centre: increased psychological distress, weakened physical health, poor quarantine management, and quarantine coping. The study's findings contributed to the understanding of how overflowed and poor quarantine management led to increased psychological distress, weakened physical health, and the formation of perceived unfairness. In turn, policymakers and healthcare practices outlined recommendations for better planning and implementation of institutionalised quarantine.

Keywords: COVID-19 Quarantine Centre, Institutionalised Quarantine, Interpretative Phenomenological Analysis, Malaysia, Patient Perspective

Introduction

The coronavirus disease, COVID-19, is a highly infectious disease characterised by severe acute respiratory syndrome genetically related to coronavirus known

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as the SARS-CoV-2 (World Health Organisation, 2020). The origin of COVID-19 is phylogenetically linked to bat viruses (Shereen et al., 2020), and it is unknown how the virus has intermediately been transmitted to a human. However, virologists widely confirmed that the virus is airborne and rapidly transmitted from human to human.

The COVID-19 was first detected in Wuhan City, Hubei Province, China, in December 2019. The disease swiftly amplified to other countries forcing the World Health Organisation (WHO) to declare a Public Health Emergency of International Concern in January 2020 and eventually Global Pandemic in March 2020. As of June 24, 2021, COVID-19 has infected 179,241,734 people, and 3,889,723 lives were lost to the disease (WHO, 2021). Several vaccines have been developed, although clinically proven drugs to treat COVID-19 are still unavailable.

Nevertheless, COVID-19 vaccines have been found effective in reducing deaths rates and hospital admissions (WHO, 2021). Despite this positive development, many countries, including Malaysia still being walloped by COVID-19 and are struggling to contain the spread of the virus while ramping up its vaccinations. Therefore, preventive measures such as social distancing, wearing a face mask, lockdown, travel restriction, and Quarantine are still in place even after almost two years into the pandemic.

Many past studies have focused either on the impact and the effectiveness of home quarantine (e.g., Liu et al., 2021) or mandatory institutionalised quarantine (Memon et al., 2021). Very few studies have been devoted to the individual's perspective of such policy, especially those subjected to the mandatory quarantine at the quarantine facilities. The objective of this research is to examine the lived individual experiences being quarantined at the COVID-19 institutionalised quarantine centre. Thus, the research aims to answer the following research questions:

a) How do low-risk COVID-19 patients feel about mandatory quarantine at the institutionalised quarantine centre?
b) How mandatory quarantine at the institutionalised quarantine centre affected the low-risk patients of COVID-19? and
c) How did low-risk COVID-19 patients cope with the mandatory quarantine at the institutionalised quarantine centre?

In line with these research questions, the present research is designed to meet the following research objectives:

a) To explore the low-risk COVID-19 patients' quarantine experience and how patients give meaning to their quarantine experience,
b) To discover the impact of quarantine experience at the institutionalised quarantine centre on low-risk COVID-19 patients, and
c) To delve into the coping mechanisms adopted by low-risk COVID-19 patients subjected to mandatory quarantine at the institutionalised quarantine centre.

Literature Review

Quarantine is one of the primary measures taken by many countries to contain the spread of COVID-19, especially for low-risk COVID-19 cases. For example, in Malaysia, low-risk cases accounted for 88% of the COVID-19 cases (Zainul, 2020). There are, however, various ways in how to quarantine. Some countries employed mandatory home quarantine like the United Kingdom (Shevlin et al., 2020), Ireland (Burke et al., 2020), Finland (Lohiniva et al., 2021), and Turkey (Kilincel et al., 2020), and, some specifically build quarantine hospitals and quarantine centres. Such is the case for China (Chen, 2020), Saudi Arabia (AlKhamees et al., 2020), Uganda (Ndejjo et al., 2021), Pakistan (Mansoor et al., 2020), and Malaysia.

Despite its many forms of implementation, quarantine has helped hospitals primarily tasked to cater to severe cases of COVID-19 from overflowing. Therefore, mandatory home quarantine and, to a greater extent, the total lockdown are enforced, affecting not only low-risk COVID-19 patients but also those who are not affected by COVID-19. Home quarantine then changed to centralised or institutionalised quarantine, arguably for better monitoring and better control of intra-family infection (Chen, 2020). Centralised or institutionalised quarantine, however, is not without its limits. Many have argued about its over budget economic and manpower resources (Yen et al., 2020). Others also question the effectiveness of such measures (Nussbaumer-Streit et al., 2020). Studies also have examined the effects of institutionalised Quarantine on COVID-19 patients battling the illness in isolation from their loved ones (e.g., AlKhamees et al., 2020; Mansoor et al., 2020).

Malaysia is one of the countries that have opted for mandatory institutionalised quarantine. Malaysia built its first institutionalised quarantine facility in December 2020 as part of the strategies to curb the third wave of COVID-19, seeded by the Sabah State Election held in September 2020. The biggest quarantine centre in Malaysia is built near its capital city of Kuala Lumpur and is known as COVID-19 Quarantine and Low-Risk Treatment Centre (*Pusat Kuarantin dan Rawatan* COVID-19 *Berisiko Rendah*; PKRC). Claimed to be an integrated COVID-19 hospital for low-risk patients (Malaysia Prime Minister Office, 2021), the PKRC began its operations in January 2021, catering to low-risk COVID-19 patients listed as Category 1 to Category 3 patients. It includes patients who do not exhibit symptoms of difficulty in breathing and do not require a ventilator or respirator. The PKRC was applauded for its good condition and services for low-risk COVID-19 patients (e.g., Ismail, 2021; Som, 2021).

There are, however, critical reviews on its functions and capacity when the country is hit hard by the third wave of COVID-19 with a surging of low-risks cases (Ismail, 2021; Simon, 2021). Such is the case when Malaysia first recorded over 4000 daily cases on May 7, 2021. Since then, the situation at PKRC has become more challenging (Kanyakumari, 2021) and deplorable (Mahpar, 2021). This warrants research examining the lived experience of low-risk COVID-19 patients subjected to mandatory quarantine in Malaysia's institutionalised COVID-19 quarantine centre

during the time of the alarming surge in COVID-19 cases. Research of this nature can help policymakers to understand human and social issues affected by the policy.

Method

Study design and participants

This research employed a cross-sectional research design with a retrospective qualitative approach. In this study, participants provided their accounts of being quarantined at the quarantine facility after discharge. Using the purposive sampling technique, six low-risk Malaysian COVID-19 patients subjected to mandatory quarantine at the institutionalised quarantine facility were recruited. The inclusion criteria are low-risk COVID-19 patients subjected to institutionalised quarantine at the designated quarantine centre without any underlying diseases such as cardiovascular disease, diabetes, and obesity. They were recruited from two families with three members, respectively. Below is the description of participants' background with pseudonyms:

(1) **Adam (28).** Adam was tested positive on May 14, 2021, and was transported to the quarantine centre on May 16, 2021. He was subjected to 13-day mandatory quarantine. He was a smoker and was categorised as Category 3 patient. He contracted COVID-19 from a colleague at the workplace where he worked as a business executive. His wife, his mother-in-law, and his 11-month-old baby were all tested positive and were all subjected to mandatory quarantine at the quarantine centre.

(2) **Aina (28).** Aina is the wife of Adam. She is a full-time housewife. Like Adam, she was tested positive on May 14, 2021, and was transported to the quarantine centre on May 16, 2021. Aina, however, was asymptomatic, and she is a breastfeeding mother. As a result, she and her 11-month-old baby were both categorised as Category 1 patients. As a result, Aina and her baby had to spent 9-day in quarantine and was released on May 25, 2021.

(3) **Asma (52).** Asma is the mother of Aina and the mother-in-law of Adam. Unlike her daughter, Asma exhibited positive symptoms of COVID-19, e.g., fever, headache, and cough. She was categorised as Category 3 patient and was quarantined for 10-day.

(4) **Pamilia (32).** Pamilia was tested positive on May 15, 2021. She worked as a human resource executive and contracted the virus from the workplace. It was unclear which colleagues carried the virus, but the whole department was tested positive for COVID-19. She was asymptomatic and was categorised as Category 1 patient, but her two sisters exhibited fever and cough and were tested positive, possibly infected by Pamilia. Both their parents, however, were tested negative. The parents were vaccinated two weeks before Pamilia, and her sisters were tested positive. Pamilia spent 9-day in quarantine at the quarantine centre.

(5) Pamina (27). Pamina is the younger sister of Pamilia. She has been working from home since March 2020. She was symptomatic, tested positive on May 15, 2021, and was transported to the quarantine centre on May 17, 2021, with her elder and youngest sisters. She was categorised as Category 3 patient and was in quarantine for 13-day.

(6) Pamelina (22). Pamelina is a college student and has been learning from home since March 2020. Similar to her sisters, she was tested positive on May 15, 2021. She was an asymptomatic patient and was categorised as Category 3 patient. She spent 13-day in quarantine at the quarantine centre with her sister, Pamina, and they both were released on May 30, 2021.

Research instrument and data collection

An in-depth interview was utilised for the data collection, and semi-structured interview questions were constructed for the in-depth interview. This type of interview question helps encourage participants to recount specific experiences (Howitt, 2019; Smith et al., 2009). The structured interview questions consisted of demographic questions ranging from age, gender, occupation, education, name of COVID-19 cluster to the duration of mandatory quarantine. The unstructured interview questions were divided into three areas, and the prompts to the questions were designed to explore broad domains of quarantine experiences; how the low-risk COVID-19 patients subjected to the mandatory institutionalised quarantine felt about the quarantine environment and quarantine management (e.g., what emotions that you feel during the quarantine at the quarantine centre? Did the emotions further escalate? In which situation? Can you explain more precisely what you felt?), how do they manage the challenges at the quarantine centre (e.g., what challenges did you encounter and how do you feel about them? How did you overcome?) and the coping mechanisms (e.g., how did you cope with the mandatory quarantine and the circumstances surrounding the quarantine at the quarantine centre?).

Data collection procedure and data analysis

The participants were firstly briefed on the research objectives and the nature of their participation, i.e., voluntary and merited with monetary reward. Then, they were given an information sheet to be read and an informed consent form to be signed one day before their scheduled interview. Each participant was interviewed once, and the schedule (day and time) of the interview was determined by the participants based on their availability. The interview began after participants indicated their understanding of the nature of the research, and the participants consented and signed the informed consent form. The in-depth interviewing took place individually via online interview, given the restrictions in place. The individual interview lasted for about 50 minutes up to one hour and 30 minutes, with an average of one hour. The participants were debriefed and asked if they had any questions about the study after the interview ended. They were also informed that they might withdraw their data at any time without having to provide any reason.

The data were transcribed and analysed using interpretative phenomenological analysis (IPA). IPA is a qualitative analytic approach founded in phenomenology (the study of conscious experience), hermeneutics (interpretative), and ideographic (individual experience). Hence, the analysis focuses on individual subjective experience and meaning-making (Smith et al., 2009). In the context of this research, IPA is proper because it helps the researcher explore individuals' subjective experience being subjected to mandatory quarantine at the quarantine centre and the meaning-making activities, that is, how the low risk COVID-19 patients construed, comprehend and make sense of the quarantine experience.

This data analytic procedure was guided by Smith et al., (2009) six stages of IPA. First, each interview transcript was read and re-read for initial familiarisation and understanding. Second, initial themes were identified in the first interview transcript and the participant's experience were coded. Third, main themes and sub-themes were identified and labelled. Fourth, the themes were connected, clustered and labelled tabular through abstraction and in a way that captures their essence. Fifth, step one to step four were repeated across all remaining transcripts, and sixth, patterns of themes across all interview transcripts were identified with special attention given to similarity in themes and differences in themes between participants. In this final stage of analysis, correspondingly, participants' quotations that illustrate the themes were selected, and themes that were not well-represented were abandoned.

Results

Analysed data revealed four overarching themes associated with individual subjective lived experience of being quarantined at the COVID-19 quarantine centre, namely: (a) increased psychological distress, (b) weakened physical health, (c) poor quarantine management, and (d) quarantine coping. These four themes were reported and elaborated in a cohesive narrative supported with the interview excerpts obtained from the participants.

Increased psychological distress

The first theme of increased psychological distress emerged as a combination of reported negative emotions initially manifested and resulted from tested positive for COVID-19. The negative emotions were reportedly heightened during the early days in quarantine at the quarantine centre. However, the negative emotions ranging from stress, shock, anxiety, fear, worry, guilt, anger, and frustration were more extraordinary in combinations and in a chain of reactions where one negative emotion led to the experience of another negative emotion.

Stress and worry

The patient reported increased experienced stress given the poor quarantine condition while worrying about the safety of other family members designated at the different halls of the quarantine centre.

> "My baby kept crying the first few days in quarantine. She has stranger anxiety. At times, I had no choice but had to leave her alone in the designated baby cot. I could not bring her with me to the toilet all the time. The toilet is so unhygienic. It is not good for her. She would cry her heart out, and my 'neighbours' who are mothers with toddlers, would watch and entertain my baby while I went to the toilet. I think she is traumatised by the whole experience because she has become clingy until now. They were days I cried behind the curtain because I could not help it. I was so worried for my mother and my husband because they were both in Category 3, and they both were symptomatic."

Fear and anxiety

The quarantine condition also contributed to patients feeling scared and worried for their own life and safety.

> "On the fourth day of the quarantine, I saw a video posted on social media of a COVID-19 patient receiving CPR [cardiopulmonary resuscitation] at the quarantine centre because he stopped breathing. The patient passed away. The patient was at the same quarantine centre as mine but at a different hall, and it was not clear what category of patient he was. He was definitely low-risk at first; that was why he was admitted to this quarantine centre instead of a hospital. I was shocked to the core. There were floods of emotion running through me, fear and anxiety mostly. No one should die at the quarantine centre for low-risk COVID-19 patients. That could be me. I cannot imagine how devasted the loved ones would be. It is fearful and worrisome enough that you were tested positive for COVID-19. You kept thinking, 'am I going to die?', and then you saw this? This kind of quarantine was not helpful. The quarantine situation would add more fear and anxiety that were already there since the day my family and I were tested positive for COVID-19."

Stress, worry, fear and guilt

A patient identified as the 'spreader' or the one who brought home the COVID-19 virus and infected the family members developed not only worry and fear for oneself but also the affected family members. The quarantine situation just further intensified the stress, worry, fear, and guilt.

> "Both my younger sisters were placed in a different hall because they were in Category 3. I was so worried about them because they both had fever and cough. I am grateful they were at least together, and they have each other. It is better that they were together, and I was alone. But I still feel scared if anything were to happen to both my young sisters because they were in a more severe category, and I am scared that I could not do anything to help them. I felt very guilty for bringing home the virus. Thank God both my parents were vaccinated and were tested negative. I was also worried about my parents at home, whether they had been eating well and doing okay. All our relatives live in different states from us. My whole world would collapse if

anything were to happen to them [my parents] because of me. Every single day in quarantine passed by with stress, fear, and anxiety."

Weakened physical health

In this second theme, patients reported weakened physical health while in quarantine and attributed it to the quarantine environment described as cold and very unsanitary.

> "I am asymptomatic, but I caught flu and cough at the quarantine centre. It could be due to the freezing and extremely cold air-conditioning. I lost my appetite; I could not eat any of the meals provided. I only ate biscuits and a 3-in-1 cereal drink. At times, I would buy an instant noodle from the vending machine. It is funny that they sold unhealthy foods here [the quarantine centre]. I lost 6 kg when I weighed myself after been released from the quarantine centre. I was already so thin before the COVID-19, losing a 6-kilogram has put me further underweight by my BMI [body mass index]. My mom said I looked like a walking skeleton when I arrived home after being discharged."

In another instance, one of the participants narrated:

> "My baby and I were both asymptomatic, but as days passed by, I developed a sore throat. God, it was a horrible sore throat, the one where when you drink water, it stung. My baby also developed eczema and skin infection while in quarantine. I believed due to the unhygienic condition. Anyone in this situation will become ill. If you are not sick, you will become sick, and if you are already sick, you will become sicker because of the stressful condition."

Poor quarantine management

The third theme of poor quarantine management illustrates how patients reported feeling shocked with the awful situation at the quarantine centre upon arrival and throughout the quarantine period. The quarantine centre is described as overcrowded, disorganised, deplorable, and unhygienic. Patients also highlighted the inconsistencies between the disseminated policies and the implementation of policies. Consequently, these brought about the feeling of social injustice and mistrust towards the authorities leaving the patients to feel they were unfairly treated.

Overcrowded

The patient described the quarantine situation as congested and felt that it does not comply with the COVID-19 safety guideline of social or physical distancing.

> "The situation is just so horrible. I am utterly shocked. I do not understand how this is a quarantine for COVID-19 patients. How would this situation

> [congested] help us to recover from COVID-19? The beds were double-decker beds and were placed so close to each other. There were no partitions except some white clothes being used as a curtain to shield for some privacy. There is no way to make social distance here [quarantine centre], and people were not wearing face masks. I am puzzled and confused by the lack of compliance and monitoring of COVID-19 safety measures at a place called COVID-19 Quarantine and Low-Risk Treatment Centre."

Disorganised

The patient also perceived the admission procedure as disorganised, and the arrangement of the quarantine facility was perceived as unsystematic.

> "On the day of admission, it took me two hours to search for my bed. I was walking for two hours with my luggage and while holding my baby searching for my bed. When we arrived at the bed with the given number, the bed had already been occupied. Seeing my condition, one of the patients offered her a bed, and she shared a bed with another patient. I finally crashed at around 2:30 AM. I arrived around 8:30 PM at the quarantine centre, had to face the long queue, and finally ended up sleeping on someone else's place [bed] after like 6 hours! It was a dreadful 6 hours. The toilets are so far, and the queue to enter the toilet was very long. It was tough when I had to bring my baby to the toilet to change her diaper and bathe her. This place is not mother-and-baby friendly. If the quarantine facility could not cater for mothers and small children, they [the authorities] should have allowed us [low-risk patients] for home quarantine."

Unjust procedure and policy

The involuntary nature of the institutionalised quarantine was seen as unjust healthcare procedure and policy, victimising and oppressing.

> "My family and I have medical insurance, but we could not even use it. What is the whole point of paying the thousand-ringgit monthly insurance when it could not be utilised to provide you the best healthcare when you are very ill? We are the patients, the sick ones, but we could not seek good healthcare when we had paid for it. This policy [institutionalised quarantine] is victimising and oppressing. This is tyranny. The insurance companies must be having a spree with all those money. They were lots of questions in my head on how this whole mandatory quarantine could be better managed. Why do we need this quarantine centre when we have private hospitals and pay for their medical insurance? It is just unbelievable!

Similarly, another participant expressed her concerns as follows:

> "I have family members returning from overseas, and they were subjected to a different kind of institutionalised quarantine, what they called a hotel quarantine. They were provided with good hotels and good food. Not that I felt envious of living at the hotel and eating good food. Why were they

given good quarantine conditions when they are not even tested positive for COVID-19, and why were those like me and my sisters, patients of COVID-19 battling the illness, placed in the quarantine centre? that is overcrowded, deplorable, and insanitary. Indeed, this policy of mandatory quarantine is not well-deliberated. I cannot help but feel discriminated against just because I was tested positive and infected? Neither I nor my colleagues or my family members asked for this [tested positive for COVID-19]. I had to work at the office because of the nature of my job, and I had been very careful, and my employer had adhered to the guidelines by the ministries. It could be the poor ventilation at the office, I did not know, and there could be millions of possibilities."

Poor management and communication

The inconsistencies between the policy made public, and its implementation, the lack of information on the quarantine situation, and the absence of communication between the patients and the authorities at the quarantine centre were seen as poor public relations management.

"I do not understand why we were not allowed to be home quarantined. The minister announced in the news that Category 1 and Category 2 are allowed to be home-quarantined given the increasing cases of Category 3 patients who would need to be at the quarantine centre. Every day I asked the doctor, 'can I be discharged?', and the answers were NO until the day that I would finally be allowed to go home, that is Day 9. My baby and I were both asymptomatic. We would be better off at home. It is certainly less stressful and more hygienic at home. My baby would not have developed eczema and skin infection if we were home quarantined instead of being quarantined at the overcrowded and unsanitary quarantine centre."

Another participant narrated that:

"There were inconsistencies in the information provided to the patients. Oh no, there was NO information provided to patients. We found out what to do because we asked around. I saw my 'neighbour' kept receiving food and supplements from his family members. I first asked the staff if my family members could send me clean clothes, foods, and supplements like the much-needed Vitamin C. The answer was outright NO, as if such thing [service] never exist. I decided to ask my neighbour, and he gave me the contact number of the person in charge, and I forwarded the contact number to my family member. My family member managed to send me the clean clothes that I needed, but weirdly they did not allow any foods or vitamins to be handed to me. I could not get over it till today because my neighbour managed to have his foods and supplements safely delivered to him. I ended up eating instant noodles from the vending machine and begging for medications until the day I was released from the quarantine centre. When there was no standardised procedure, and discrimination like this happened, it just shows how poorly managed the quarantine centre is."

Quarantine coping

The fourth theme centres around the coping mechanism employed by the patients while in quarantine. This theme also represents how the patients feel empathy and sympathy toward the front liners who appeared to be working under a shortage of supplies and limited workforce. They were stretched to the utmost limit. The patients felt that there were insufficient personnel and medical equipment to help the front liners work more efficiently and in a less stressful manner, as the situation at the quarantine centre itself is highly stressful.

Acceptance and perseverance

Patients illustrated how they accepted and came to terms with the quarantine condition and how they persevered with the situation.

> "I am battling not only COVID-19 symptoms but also withdrawal symptoms from smoking deprivation. I think my whole body was shocked. The first seven days at the quarantine centre were a living hell. They did not provide me any medications for my cough and fever. Whenever I asked for medication, the nurses and doctors would give me a weird look like they were angry that I asked for medication. I wondered, were there short of supplies of medications? All I needed was paracetamol and cough syrups. These are plentiful out there [outside quarantine centre]. Why were they so reluctant to provide medication? I could not be bothered anymore; I needed to sweat away from the fever and the cough syrup to tone down the cough. My chest hurts every time I coughed. I kept telling myself I needed to survive; I would consistently ask for medication regardless of the weird looks from the doctors and nurses. I would think that no hurt feelings. They must have been under much pressure, perhaps due to limited supplies and manpower."

In another instance, one of the participants mentioned that:

> "My blood pressure kept increasing while I was in the quarantine centre. It was the stress. You could not sleep because of the crowd and because of the constant announcements. Not to mention the extremely cold air-conditioning. I was sleep-deprived during the whole quarantine, the whole ten days, the ten most horrible days in my life. I experienced severe headaches because of the heightened blood pressure and lack of sleep. That place [the quarantine centre] is not a good place for patients, any patients, be it COVID-19 patients or non-COVID-19 patients. I am in my fifties, but they were those older than me. It was very stressful. I have been hospitalised before for other illnesses, but it [previous hospitalisation] was not as stressful as this one [quarantine at the quarantine centre]. I pray no one would ever have to go through what I did, especially the elderly. For many of us [the elderly] here, we took it as this is the test from God so that we remember Him and become closer to Him. I guess I survived with this thought in mind. I knew my son-in-law, my daughter, and my granddaughter were also suffering in quarantine. At that time, I thought we would have to do with this and survive this quarantine."

Sympathy and empathy

Patients attributed their sympathy and empathy to the healthcare workers who form their perspective were already at their maximum limit.

> "The nurses and doctors were nice to me. Nurses and doctors have frequently visited me. I guess because of my high blood pressure, anyone at my age with BP [blood pressure] would have high blood pressure under this kind of quarantine. They [healthcare workers] always look exhausted, you can tell they have been working around the clock, especially when you kept meeting the same nurses and doctors and they have been wearing the same clothes under that protective gear. When you think back at the whole situation now, your empathy and sympathy go to the healthcare workers. God knows how they were stretched thin by the surge of cases. Some of the healthcare provided to us [the low-risk patients] can easily be done at home. My daughter would constantly check on my blood pressure and my body temperature before. There was slight guilt in me when I saw them [healthcare workers] because I felt patients like me [low-risk COVID-19 patients] could recover better at home, and they [healthcare workers] will not be overburdened."

Support system

Supports received from family members at home, and the social support at the quarantine centre was perceived as helpful coping resources for the patients.

> "My elder sister had been my best family and social support at the quarantine centre. I was lucky. I had her with me while many were kept separated from their family members. She was supposed to be discharged earlier because I still have the cough, but she told the doctors she would like to stay with me and be discharged together. So, they allowed her to remain in quarantine for the two additional days I was held at the quarantine centre."

One of the participants narrated:

> "Constant video calls with my family members give me the strengths to stay strong. My husband and my mom would video-called me twice a day. It felt so far yet so near. It lessened my worries and anxieties. I am also indebted to the other patients who are mothers with small children. They were very, very helpful. They were my social support at the quarantine centre. I am truly thankful to God for 'sending' me these mothers with small children. They would lend their hands without you asking. One of my 'neighbours' managed to get her family member to send baby biscuits for my baby. I was so touched by the kind gesture. They were no meals specifically prepared for the babies under one year old. My baby survived by breastfeeding and the baby biscuits."

Discussion and Recommendations

This study has researched the lived experience of the low-risk COVID-19 patients subjected to mandatory quarantine at the institutionalised quarantine centre in Malaysia. The patients were tested positive for COVID-19 and were categorised in Category 1 (asymptomatic; n=2) and Category 3 (symptomatic and with pneumonia). In Malaysia, COVID-19 patients are categorised into five categories (Malaysia Ministry of Health, 2020):

(1) Category 1: Asymptomatic,
(2) Category 2: Symptomatic but without pneumonia,
(3) Category 3: Symptomatic and with pneumonia,
(4) Category 4: Symptomatic, with pneumonia, requiring supplemental oxygen, and
(5) Category 5: Critically ill with multi-organ involvement.

In addition, all the patients were listed as cases linked to the workplace cluster. It was not the intention of the present research to specifically sample patients from workplace clusters and low-risk COVID-19 patients of Category 1 and Category 3. However, workplace clusters have accounted for almost two-thirds of COVID-19 cases in Malaysia and have not shown any signs of declining ("Workplace Clusters are Increasing," 2021).

Additionally, Malaysia reported increased admissions of Category 3 patients in its third wave of COVID-19 ("More Category 3 Covid Patients", 2021). That is the time this study was conducted. It may explain the coincidence of having COVID-19 patients from Category 3 and workplace clusters.

The findings of this study illustrate four overarching themes representing the individuals' institutionalised quarantine experiences. The themes were increased psychological distress, weakened physical health, poor quarantine management, and quarantine coping. These results call for better planning and management of the institutionalised quarantine centres, such as:

(1) quarantine is an effective public health measure to control the spread of COVID-19 and prevent further outbreaks (Wilder-Smith & Freedman, 2020). However, shreds of evidence suggest that quarantine is most effective if it started earlier (Nussbaumer-Streit et al., 2020).
(2) the quarantine cannot be efficiently and effectively managed in outbreaks and the surge of COVID-19 cases.
(3) poor quarantine management can lead to adverse psychological and physical health effects. The latter can be long-term, not only to the patients but also to the healthcare workers (He et al., 2021).
(4) the patients may have survived COVID-19, but the experience may have left them with trauma. There is also growing literature demonstrating the damaging psychological effects experienced by the overburdened healthcare

workers (Chirico et al., 2021; Marvaldi et al., 2021; Moitra et al., 2021), it could leave them with a lifetime trauma. It is, therefore, essential to ensure that the institutionalised quarantine centres enable healthcare workers to deliver and the patients to recover. When the situation impedes this (e.g., outbreaks and surge of cases), mandatory institutionalised quarantine needs to be reviewed and facilitated by other public health measures and resources.

Similar to past literature, the present research contributed to the growing literature showing the detrimental effect of poorly managed institutionalised quarantine centre on health. While there is relatively abundant evidence on how institutionalised quarantine impacted the patients' mental health, findings in this present study further illustrates that the increased psychological distress experienced during the time in quarantine at the quarantine centre weakens the patients' physical health that is already weak due to the virus. Even asymptomatic patients became sick after being admitted to the quarantine centre.

It is also important to highlight how patients cope with increased psychological distress and weaken physical health with acceptance, sympathy, perseverance, and continuous family and social support. The negative emotional responses experienced during the early days in quarantine changed to positive emotions used to cope with the quarantine stress. Such transition of emotions can be explained with Lazarus and Folkman's (1987) transactional model of stress and coping. This model postulates that the stressor(s) is first appraised as either positive, negative, or irrelevant. Negative appraisal, for example, is then appraised by having either sufficient or insufficient resources to deal with the stressor. Insufficient resources will lead to stress, forcing the individual to either change the situation or change the emotion to cope. The institutionalised quarantine was indeed the stressor, and its mandatory and involuntary nature led to the perception of insufficient resources leading to stress. The patients also could not change the quarantine situation leading them to change their emotions to better cope with the quarantine stress.

Another key finding of the present research is the perceived unfairness resulting from poor communication and the inconsistencies between the policy made public and how the policy was implemented. The patients' experiences and perceptions of unfairness or injustice can be related to Greenberg's (1990) organisational justice theory. The central focus of the theory is how individuals socially construct incidence of justice and injustice. The theory posits that fair and unfair events bring about three types of justice perceptions: distributive justice, procedural justice, and interactional justice. Commonly applied in organisational management (Cropanzano et al., 2007).

The theory illustrates how individuals' fairness or unfairness perception have resulted from satisfaction with the decision (distributive justice), satisfaction with the processes and policies (procedural), and satisfaction with interpersonal communication and treatment (interactional). Such is the case of the patients' quarantine experience at the quarantine centre. The experience of social injustice

and the unfairness perception, thus, are resulted from dissatisfaction with the decision for mandatory institutionalised quarantine vs. home-quarantine (distributive justice), dissatisfaction with the mandatory institutionalised quarantine policy that excludes the usability of medical insurance for better healthcare services (procedural justice) and dissatisfaction with the lack of proper communication and fair treatment at the quarantine centre (interactional justice).

Quarantine remains the key to contain the spread and outbreaks of COVID-19. However, such public health measures shall be well-planned and well-managed, notably in the context of institutionalised quarantine. This type of quarantine is involuntary. It involves human and social issues that inevitably will impact public trust and confidence in public health policy and public policy in general. With this in mind, and based on the present findings as well as findings from past literature, the present research would suggest the following measures for better management of institutionalised quarantine facilities, especially during the outbreaks and surge of COVID-19 cases when the quarantine facility can no longer accommodate the increasing admission of low-risk patients:

(1) **Operate the quarantine centre within its capacity.** The institutionalised quarantine facilities should not be allowed to overflow. Overflow of patients beyond the facility's capacity, human resources, and medical supplies will only obstruct efficient healthcare delivery and overburden healthcare workers. This eventually will impact the patients' experience and recovery.
(2) **Proper monitoring of patients under quarantine.** The low-risk patients can drastically change to high-risk without proper monitoring. It can only be done with a sufficient workforce and medical supplies. Hence, it is essential that the quarantine facility operates within its capacity and not beyond.
(3) **Provide better access to healthcare services.** For example, when the institutionalised and publicly funded quarantine facilities can no longer accommodate overflowed low-risk COVID-19 patients, authorities must authorise mandatory home quarantine for low-risk COVID-19 patients and empower private healthcare personnel to follow up with the low-risk patients.
(4) **Provide consistent and adequate information.** Patients who tested positive with COVID-19 often reported negative emotional responses, mainly stress, fear, and anxiety. The quarantine can further escalate the emotions. Therefore, the patients need to be provided with adequate and consistent information about the disease and the need for institutionalised quarantine (e.g., the inapplicability of physical distancing at the quarantine centre). Research has shown that people in quarantine coped better when provided with adequate information on COVID-19 by public health officials (Nedjjo et al., 2021).
(5) **Quarantine needs to be facilitated with other measures.** Authorities need to think of multiple ways and act based on the latest development of the disease. In the case of outbreaks and surges of cases where vaccines have been developed, institutionalised quarantine shall be accompanied by other measures such as accelerations of vaccine distributions. Pieces of evidence

on inoculations have demonstrated that vaccinations have been supported to reduce admission and death rates (Wise, 2021). This, accordingly, can save lives and help the overburdened healthcare system.

The present study is not without its limitations. First, the participants sampled are the Malaysians residing in the capital of Malaysia, the city of Kuala Lumpur. They were then subjected to mandatory quarantine at the biggest and perhaps better-equipped quarantine centre in the country. Their experiences, therefore, may not be compatible with those quarantined at other institutionalised quarantine facilities, and their experiences are also not comparable to those subjected to other types of institutionalised quarantines (e.g., hotel quarantine, home quarantine, and hospital quarantine).

Second, the participants were from middle-class socioeconomic status. All of them hold a bachelor's degree except one currently enrolled in a bachelor's degree programme, and those employed hold a position at the executive level. It can be construed that the participants are well-educated and living in a stable household income. Therefore, their experiences and perceptions cannot represent the institutionalised quarantine experiences of those coming from different socioeconomic statuses. Despite these differences, it is possible that generally, the quarantine experiences are similar, notwithstanding the varied, detailed experiences. Third, online interviewing may have missed out on the non-verbal communication that could be valuable cues to the participants' quarantine experience. This research, nevertheless, provides important inputs on low-risk COVID-19 patients' quarantine experiences subjected to mandatory quarantine at the institutionalised quarantine centre. It was conducted when such information was very few in the literature and during its third wave of COVID-19. It could help the policymakers better understand the limitations of institutionalised quarantine during COVID-19 outbreaks and how it can be better managed. Another strength of this research is that the interviews conducted not long enough after the patients were discharged from the quarantine centre enabled the researcher to minimise the possible recall bias given the change of environment.

Conclusion

In conclusion, this study had explored and illustrated the lived experiences of low-risk COVID-19 patients subjected to mandatory quarantine at the institutionalised quarantine centre. It has detailed the patients' conceptualisation of quarantine management. The study has also elucidated how patients navigate the healthcare system by perseverance, resilience, acceptance, empathy, and sympathy. The initial negative emotions transitioned to positive ones by coming into terms with the quarantine situation, and the positive emotions helped them cope with the quarantine. Patients also sought constant emotional support, mainly from family members who shared their fear, worry, anxiety, and frustration, although they were not at the quarantine. The quarantine experiences found in this research are valuable

information for the policymakers and healthcare management to ensure that the public health interventions are acceptable to the public. Several recommendations have been outlined to safeguard public trust and confidence in public health policies. These are vital for the country's smooth exit from the pandemic and recovery post-pandemic.

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References

Alkhamees, A. A., Aljohani, M. S., Alghesen, M. A., & Alhabib, A. T. (2020). Psychological Distress in Quarantine Designated Facility During COVID-19 Pandemic in Saudi Arabia. *Risk management and Healthcare Policy, 13,* 3103-3120. https://doi.org/10.2147/RMHP.S284102

Burke, T., Berry, A., Taylor, L. K., Stafford, O., Murphy, E., Shevlin, M., ... & Carr, A. (2020). Increased psychological distress during COVID-19 and quarantine in Ireland: A national survey. *Journal of Clinical Medicine, 9*(11), 3481-3496. https://doi.org/10.3390/jcm9113481

Chen, J. (2020). Quarantine hospitals are essential for COVID-19 contention. *European Review for Medical and Pharmacological Sciences, 24,* 3442-3443. https://www.europeanreview.org/wp/wp-content/uploads/3442-3443.pdf

Chirico, F., Nucera, G., & Magnavita, N. (2021). Protecting the mental health of healthcare workers during the COVID-19 emergency. *BJPsych International, 18*(1), 1-2. https://doi.org/10.1192/bji.2020.39

COVID: Workplace clusters are increasing – Dr. Noor Hisham (2021, May 28). *Bernama.* https://www.bernama.com/en/general/news_covid-19.php?id=1965816

Cropanzano, R., Bowen, D. E., & Gilliland, S. W. (2007). The management of organizational justice. *Academy of Management Perspectives, 21*(4), 34-48. https://doi.org/10.5465/amp.2007.27895338

Greenberg, J. (1990). Organizational justice: Yesterday, today, and tomorrow. *Journal of Management, 16*(2), 399-432. https://doi.org/10.1177/014920639001600208

He, Q., Fan, B., Xie, B., Liao, Y., Han, X., Chen, Y., & McIntyre, R. S. (2021). Mental health conditions among the general population, healthcare workers and quarantined population during the coronavirus disease 2019 (COVID-19) pandemic. *Psychology, Health & Medicine,* 1-13. https://doi.org/10.1080/13548506.2020.1867320

Howitt, D. (2019). *Introduction to qualitative research methods in psychology: Putting theory into practice.* Pearson.

Ismail, S. N. (2021, January 18). An asymptomatic Covid-19 patient experience. *New Straits Times.* https://www.nst.com.my/opinion/letters/2021/01/658327/asymptomatic-covid-19-patient-experience

Kanyakumari, D. (2021, May 17). 'Increasingly challenging' situation at Selangor quarantine centre due to growing admissions: Health department. *Channel News Asia.* https://www.channelnewsasia.com/news/asia/malaysia-selangor-covid-19-quarantine-centre-maeps-challenging-14826674

Kılınçel, Ş., Kılınçel, O., Muratdağı, G., Aydın, A., & Usta, M. B. (2020). Factors affecting the anxiety levels of adolescents in home-quarantine during COVID-19 pandemic in Turkey. *Asia-Pacific Psychiatry, e12406,* 1-6. https://doi.org/10.1111/appy.12406

Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1*(3), 141-169. https://doi.org/10.1002/per.2410010304

Liu, Q., Zhou, Y., Xie, X., Xue, Q., Zhu, K., Wan, Z., ... & Song, R. (2021). The prevalence of behavioral problems among school-aged children in home quarantine during the COVID-19 pandemic in China. *Journal of Affective Disorders, 279,* 412-416. https://doi.org/10.1016/j.jad.2020.10.008

Lohiniva, A. L., Dub, T., Hagberg, L., & Nohynek, H. (2021). Learning about COVID-19-related stigma, quarantine and isolation experiences in Finland. *PloS One, 16*(4), 1-20. https://doi.org/10.1371/journal.pone.0247962

Mahpar, N. (2021, May 17) Long wait for beds, freezing temperatures and disgusting toilets at MAEPS. *Free Malaysia Today.* https://www.freemalaysiatoday.com/category/nation/2021/05/17/long-wait-for-beds-freezing-temperatures-and-disgusting-toilets-at-maeps/

Malaysia Ministry of Health (2020). *Clinical management for confirmed COVID-19 in adult and paediatric.* http://covid-19.moh.gov.my/garis-panduan/garis-panduan-kkm/Annex_2e_Clinical_Management_For_Confirmed_COVID-19_in_Adult_and_Paed.28.09.20.pdf

Malaysia Prime Minister Office (2021, January 19). MAEPS PKRC: *Extraordinary action in extraordinary situation – PM.* https://www.pmo.gov.my/2021/01/maeps-pkrc-extraordinary-action-in-extraordinary-situation-pm/

Mansoor, T., Mansoor, S., & bin Zubair, U. (2020). 'Surviving COVID-19': Illness narratives of patients and family members in Pakistan. *Annals of King Edward Medical University, 26*(Special Issue), 157-164. https://www.annalskemu.org/journal/index.php/annals/article/download/3630/2204

Memon, Z., Qureshi, S., & Memon, B. R. (2021). Assessing the role of quarantine and isolation as control strategies for COVID-19 outbreak: A case study. *Chaos, Solitons & Fractals, 144,* 110655, 1-10. https://doi.org/10.1016/j.chaos.2021.110655

Moitra, M., Rahman, M., Collins, P. Y., Gohar, F., Weaver, M., Kinuthia, J., ... & Kumar, M. (2021). Mental health consequences for healthcare workers during the COVID-19 pandemic: A scoping review to draw lessons for LMICs. *Frontiers in Psychiatry, 12*(602614), 1-10. https://doi.org/10.3389/fpsyt.2021.602614

More Category 3 Covid patients admitted at PKRC Maeps (2021, May 16). *The Malaysian Reserve.* https://themalaysianreserve.com/2021/05/16/more-category-3-covid-patients-admitted-at-pkrc-maeps/

Ndejjo, R., Naggayi, G., Tibiita, R., Mugahi, R., & Kibira, S. P. (2021). Experiences of persons in COVID-19 institutional quarantine in Uganda: A qualitative study. *BMC Public Health, 21*(1), 1-11. https://doi.org/10.1186/s12889-021-10519-z

Nussbaumer-Streit, B., Mayr, V., Dobrescu, A. I., Chapman, A., Persad, E., Klerings, I., & Gartlehner, G. (2020). Quarantine alone or in combination with other public health measures to control COVID-19: A rapid review. *Cochrane Database of Systematic Reviews,* (9), 1-78. https://doi.org/10.1002/14651858.CD013574.pub2

Shereen, M. A., Khan, S., Kazmi, A., Bashir, N., & Siddique, R. (2020). COVID-19 infection: Origin, transmission, and characteristics of human coronaviruses. *Journal of Advanced Research, 24,* 91-98. https://doi.org/10.1016/j.jare.2020.03.005

Shevlin, M., McBride, O., Murphy, J., Miller, J. G., Hartman, T. K., Levita, L., ... & Bentall, R. P. (2020). Anxiety, depression, traumatic stress and COVID-19-related anxiety in the UK general population during the COVID-19 pandemic. *BJPsych Open, 6*(e125), 1-9. https://doi.org/10.1192/bjo.2020.109

Simon (2021, May 18). My 8 days in hell at the quarantine centre. *Free Malaysia Today.* https://www.freemalaysiatoday.com/category/opinion/2021/05/18/my-eight-days-in-hell-at-the-quarantine-centre/

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

Som, Z. M. (2021, January 20). NST editor under quarantine at MAEPS 2.0 shares 'humbling' experience. *New Straits Times.* https://www.nst.com.my/opinion/columnists/2021/01/658901/nst-editor-under-quarantine-maeps-20-shares-humbling-experience

Wilder-Smith, A., & Freedman, D. O. (2020). Isolation, quarantine, social distancing and community containment: Pivotal role for old-style public health measures in the novel coronavirus (2019-nCoV) outbreak. *Journal of Travel Medicine. 27*(2), 1-4. https://doi.org/10.1093/jtm/taaa020

Wise, J. (2021). Covid-19: Is vaccination roll out reducing cases and deaths in the UK? *BMJ, 372*(n506), 1-2. http://dx.doi.org/10.1136/bmj.n506

World Health Organization (2020). *Coronavirus disease (COVID-19).* https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19

World Health Organization (2021). *Statement on the benefits of vaccines against COVID-19.* https://www.who.int/malaysia/news/detail/30-04-2021-statement-on-the-benefits-of-vaccines-against-covid-19

Yen, Y. F., Tsai, Y. F., Su, V. Y. F., Chan, S. Y., Yu, W. R., Ho, H., ... & Huang, S. J. (2020). Use and cost-effectiveness of a telehealth service at a centralized covid-19 quarantine center in Taiwan: Cohort study. *Journal of Medical Internet Research, 22*(12), e22703, 1-9. https://doi.org/10.2196/22703

Zainul, E. (2020, April 7). Covid-19: MoH found 69 sporadic cases with no clear infection source. *The Edge Markets.* https://www.theedgemarkets.com/article/covid19-moh-found-69-sporadic-cases-no-clear-infection-source