Lives in Limbo

Findings from a Mixed-Methods Study of Zomi Refugee Experiences, Wellbeing, and Community in Urban Malaysia

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Acknowledgments

A study of this magnitude is never the work of one person. It took a whole village. People gave their time, shared their knowledge, trusted us with their experiences, and supported the work in ways both visible and unseen. I am deeply grateful to each of them.

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To every person who participated in this study, thank you for trusting us with your experiences. Speaking openly about personal struggles, hopes, and uncertainties is not always easy, and we deeply appreciate the courage it took to share those parts of your lives with us. We do not take that trust lightly. I hope this report treats your experiences with the care and dignity they deserve and that, in some meaningful way, it contributes to something better for our community.

Finally, I am grateful to Zomi people around the world. Despite the many struggles our people have faced, we continue to care for one another, hold on to who we are, and find ways to move forward. That strength has carried our community across borders and generations. It gives me hope that this work will help our people be more clearly seen, more carefully heard, and better supported.

Report Outline

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Abbreviations and Key Terms

Chin: An administrative and institutional category (used, for example, in UNHCR reporting) that overlaps with but is distinct from Zomi; UNHCR publishes a Chin category and no separate Zomi count.

Documents held: The specific evidence a person possesses, each issued for a stated purpose, such as a passport, an expired identity card, a community card, a registration reference, an appointment card, or a UNHCR identity document, kept distinct in the report from protection, registration, and Malaysian legal authorization.

GAD-7: The seven-item Generalized Anxiety Disorder scale, an anxiety-symptom screen scored from 0 to 21 on which a score of 10 or higher is counted as a positive screen; it is a screening measure, not a diagnosis.

Interview corpus: The report's separate qualitative sample of 36 distinct one-on-one interview records, a nonprobability sample with no recorded participant-level overlap with the survey sample.

Legal authorization in Malaysia: What a person is permitted to do under Malaysian domestic law; the report emphasizes that a UNHCR document does not by itself grant Malaysian immigration or work authorization.

PHQ-8: The eight-item Patient Health Questionnaire, a depressive-symptom screen scored from 0 to 24 on which a score of 10 or higher is counted as a positive screen; it is a screening measure, not a diagnosis.

Positive screen: A score of 10 or higher on the PHQ-8 or GAD-7, indicating elevated symptoms on that measure rather than a clinical diagnosis.

Protection (international protection): The need for protection and any determination made under a relevant mandate or procedure, kept distinct in the report from registration, documents held, and Malaysian legal authorization.

Registration: The recording of a person's information within an institutional process, specifically UNHCR registration, kept distinct from protection, documents held, and Malaysian legal authorization.

Survey sample: The report's quantitative sample of 90 analytical survey records, a nonprobability sample separate from and not linked to the interview corpus.

UNHCR: The Office of the United Nations High Commissioner for Refugees.

Zolai: The written Zomi language, the language a person reads and writes, distinguished in the report from Zopau, the spoken language.

Zomi: The report's principal community identifier for the people whose lives it documents (adults who identified as Zomi through community-network recruitment); the term carries cultural, historical, and often political meaning, coexists with related terms such as Zo and Chin, and is not used to fix territorial boundaries or to decide who is or is not Zomi.

Zopau: The spoken Zomi language, the language a person speaks, distinguished in the report from Zolai, the written language.

Executive Summary

Purpose and contribution

Zomi families, churches, educators, community leaders, and mutual-aid networks already hold substantial knowledge about displacement and everyday life in Malaysia. Much of that knowledge has remained dispersed across personal experience, local-language materials, and organizational records. This report brings a defined body of Zomi-specific survey and interview evidence into a form that can be cited, examined, challenged, and extended. It complements community knowledge and earlier documentation; it does not claim to speak for every Zomi person in Malaysia.

The study's overall objective was to describe and interpret the conditions shaping daily life for Zomi adults living in urban Malaysia. It examined documentation, enforcement and movement, work, housing, healthcare, children's learning, emotional wellbeing, support, information, trust, participant priorities, and future planning. Considering these domains together made it possible to show how practical conditions, household responsibilities, relationships, and institutional decisions interacted without forcing a single narrative or treating hardship as the whole of any participant's life.

Study design and evidence base

1. **Survey.** A one-time online survey was administered in written Zopau using Zolai from 11 February through 27 June 2026. Community-network recruitment produced 92 submissions; two no-consent records were excluded, leaving 90 consenting adults in the locked analytical workbook.
2. **Interviews.** A separate qualitative corpus comprised 36 adults interviewed in person in Zopau during February 2026. Oral consent and separate recording permission were obtained. English analytical records were examined case by case and across cases to identify meaning, reported sequence, institutional encounters, variation, and counterexamples.
3. **Integration.** The survey and interview components were analyzed as separate nonprobability samples. No participant-level linkage was attempted, and any overlap was not recorded. Survey counts and percentages describe the 90 records or smaller eligible bases; interview recurrence is not a population frequency. Integration was used for complementarity and interpretation, not participant-level confirmation or causal inference.
4. **Ethics and protection.** Although the study did not undergo formal review by an institutional review board or research ethics committee, it incorporated a range of safeguards to protect participants and their information. These measures included voluntary informed consent, data minimization, restricted access to study materials, neutral interview identifiers, quotation verification, disclosure review, and a planned deletion of study data and confidential source materials six months after publication. Together, these practices were designed to reduce privacy and confidentiality risks while recognizing the additional value that independent ethics review can provide, particularly in close-knit communities where participants may remain identifiable through context.

Key findings

Documentation changed some encounters without eliminating fear

Thirty of 90 survey participants reported UNHCR-related documentation, 26 pending documentation circumstances, 32 no documents, and two other circumstances. Fifty-six of 90 participants (62%) reported high fear of being stopped or checked. Seventy-nine (88%) said they at least sometimes avoided places because of documentation concerns, and 46 (51%) said fear changed normal routines sometimes or more often. Interviews showed that documents could lower a hospital charge, support verification, or assist after detention, while community-issued cards could identify whom to call.

Work sustained households while concentrating risk

Sixty-three of 90 participants (70%) were working. Among current workers with available data, 42 of 61 (69%) reported typical days of at least nine hours; 18 of 62 (29%) reported late or missing pay at least once in the previous three months; and 17 of 62 (27%) reported unsafe conditions or injury risk. Twenty-nine of 62 workers (47%) met the exploratory work-risk definition. Interviews showed that employers could also provide housing, meals, transport, or medical help. These supports could be generous and stabilizing while making job loss consequential across several parts of household life.

Housing stability depended on affordability, control, and alternatives

Seventy-five of 90 participants (83%) agreed that rent was difficult to pay, 45 (50%) reported that three or more people shared their sleeping room, and 28 (31%) had moved at least twice in the previous 12 months. Eighty participants (89%) met at least one condition in the broad post hoc housing indicator. Shared and employer-linked arrangements often made shelter affordable and enabled care, but they could also limit privacy, negotiating power, or the ability to leave. A stable address did not necessarily mean that the arrangement was affordable, freely chosen, or easy to replace.

Healthcare access was a pathway, not a doorway

A pharmacy was the usual first response to illness for 41 of 90 participants (46%), and home care for 38 (42%). Twenty participants (22%) reported needing healthcare but not going in the previous three months, while 49 (54%) disagreed that healthcare felt safe for people like them. Fifty-seven (63%) met the exploratory healthcare access-and-safety definition. Interviews located breakdowns before and after the visible point of care: travel, documentation, registration, language, cost, work time, caregiving, medicine, and follow-up. A relative, employer, interpreter, or community worker could make care possible without resolving every later step.

A learning place did not guarantee a continuous educational pathway

Forty-eight survey participants reported children under 18 in their household. Of those household reports, 26 indicated church- or community-based learning, five formal learning, one home schooling, one a mixed arrangement, and 15 no current school or learning arrangement; six of the 15 cited children being below school age. Twenty-four of 48 participants (50%) disagreed that children could learn safely and consistently. Interviews identified fees, transport, language, placement, household time, additional learning needs, and uncertain progression as distinct links. These are adult household reports, not child-level enrollment, attendance, dropout, or learning estimates.

Elevated symptom screens for both depression and anxiety were common

All 90 survey participants completed the PHQ-8 and GAD-7. Forty-two (47%) had a PHQ-8 score of 10 or higher, 48 (53%) had a GAD-7 score of 10 or higher, and 56 (62%) screened positive on at least one; 34 screened positive on both. The measures do not establish diagnosis, cause, treatment need, or current safety, and the PHQ-8 contains no self-harm or death item. Interview participants more often described worry, pressure, fear, exhaustion, sleeplessness, and uncertainty in everyday language. Faith, family, work, study, and service could provide purpose and calm while material pressures remained.

Community support was consequential and finite

Sixty-nine of 90 survey participants (77%) reported having someone to rely on no more than sometimes during the previous month. Friends and family were the most frequently selected information source at 62 of 90 (69%), followed by church leaders at 31 (34%) and WhatsApp or Facebook groups at 25 (28%). Church leaders and friends or family received the two higher mean trust ratings, but trust, use, capacity, and authority did not align. Relatives, churches, community organizations, employers, teachers, and interpreters often made systems usable; they could not guarantee money, continuity, legal authorization, or an institution's final decision.

Participants identified connected priorities rather than one mandate

Job protections and safer access to healthcare were each selected among the top priorities by 48 of 90 participants (53%), and safe transportation by 45 (50%). Legal information, housing stability, emergency cash, education support, language support, protection from raids or extortion, and mental health or community support also appeared. In the separate forced-choice item, no category received more than 20% of responses. The survey fields contained irregular selection counts and mismatches, so they are evidence of participant-entered priorities, not a validated ranking or a mandate from the whole community.

Hardships frequently overlapped

The post hoc four-domain count combined documentation insecurity, enforcement and mobility, healthcare access and safety, and housing risk. Sixty-six of 90 participants met at least three definitions, including 28 who met all four. A positive PHQ-8 or GAD-7 screen occurred in 24 of 28 participants in the all-four group, compared with 32 of 61 among those meeting one to three definitions. Percentages at one, two, and three were nearly identical. The concentration at four is descriptive, unadjusted, and noncausal; it is not a dose-response pattern, threshold, severity score, or validated risk classification.

Integrated interpretation

1. **Access depended on a chain of conditions.** Availability did not ensure usable access. Movement, information, language, money, time, care, registration, and follow-up determined whether a job, clinic, learning place, document, or referral could produce a repeatable outcome.
2. **Protection was bounded, situational, and relational.** Documents and trusted contacts could improve a specific encounter without conferring Malaysian authorization or controlling how another officer, employer, provider, landlord, or institution would respond.

3. **Households absorbed costs that institutions did not.** Shared earnings, housing, debt, care, remittances, and unpaid coordination kept services and daily life functioning, but adaptation could reduce privacy, autonomy, financial margin, or future options.
4. **Community bridging work made systems usable.** Families, churches, organizations, employers, teachers, and interpreters explained, referred, accompanied, translated, transported, lent, and advocated. Their value was real; their resources, coverage, and formal authority were limited.
5. **Agency did not remove constraint.** Participants changed routes, jobs, housing, care strategies, and budgets; sought documents and accompaniment; studied, prayed, saved, and served others. These actions changed outcomes without making all available choices safe, affordable, or sustainable.

Priority actions

The report presents 11 author recommendations. They are evidence-grounded but provisional: none was tested, costed, legally evaluated, or assessed for feasibility. The tiers describe implementation routes, not importance. Each action requires a responsible actor, current verification, minimum data, clear role limits, confidential feedback, harm monitoring, and a correction or stopping rule.

Priority 1: Immediate and high-confidence actions

1. **Create a verified multilingual information and referral pathway.** Provide dated, correctable guidance in accessible formats, distinguish documents from legal authorization, name the next contact, and connect information to a usable referral.
2. **Pair priority referrals with transport, interpretation, and accompaniment.** Coordinate these supports for urgent or recurring healthcare and time-sensitive education visits, with consent, safe scheduling, reimbursement, and backup coverage.
3. **Pilot flexible emergency assistance that prevents cascading loss.** Use rapid, low-burden grants for short gaps involving transport, medicine, required health payments, rent, temporary accommodation, or learning continuity; avoid unnecessary disclosure and dependency-producing debt.
4. **Adopt practical employer standards and independent referral routes.** Clarify wages, hours, urgent leave, safety, injury response, accommodation, and language access while ensuring workers can seek confidential advice outside the employment relationship.

Priority 2: Strengthen systems and continuity

5. **Fund community navigators, interpreters, and referral agreements.** Pay for recurring navigation and language work, define role boundaries and caseloads, and use closed-loop referrals without building centralized sensitive profiles.
6. **Build a healthcare pathway from first contact through follow-up.** Connect registration, communication, cost, transport, treatment, medicine, and follow-up while providers retain clinical responsibility and feedback remains confidential.

7. **Protect housing continuity during illness, job loss, and household crisis.** Offer short-term rent support, temporary accommodation, housing referral, and transition planning from employer housing without presuming that sharing is harmful or contacting others without consent.
8. **Strengthen continuity and progression in community-based learning.** Address fees, transport, language, placement, additional learning needs, household schedules, staff capacity, funding gaps, and the next step beyond available levels.
9. **Pair psychosocial support with practical problem solving and safe referral.** Offer confidential, participant-chosen faith-based, community, clinical, or combined routes; do not diagnose informally or make screening a condition for practical help.

Priority 3: Structural action requiring formal authority

10. **Review documentation, protection, and enforcement-related pathways.** Relevant Malaysian institutions, UNHCR, and qualified legal and protection actors should clarify current roles, verification, escalation, decision ownership, and correction without promising externally controlled outcomes.
11. **Reduce dependence on informal gatekeepers through institutional access and accountability.** Each sector should identify who owns eligibility and service decisions, provide language-accessible procedures, and offer confidential review and feedback routes that do not depend on work, housing, or organizational membership.

How the evidence should and should not be used

The study is strongest as a bounded description of 90 survey records and a transparent interpretation of a separate 36-person interview corpus. Exact item distributions, eligible denominators, screening scores, traceable pathways, variation, counterexamples, and participant-entered priorities remain useful within those two groups. Together, they provide a documented basis for attention, dialogue, carefully bounded pilots, institutional review, and more rigorous future research.

1. **Do not generalize the findings to all Zomi adults in Malaysia.** Community-network recruitment, online access, written-language requirements, unknown refusals, and the lack of verified city coverage prevent population prevalence or statistical representativeness claims.
2. **Do not infer cause, change over time, or participant-level confirmation.** The evidence is cross-sectional and self-reported; survey and interview participants were not linked.
3. **Do not convert analytical categories into legal, clinical, or child-level findings.** Documentation groups were self-reported; derived indicators were post hoc and unvalidated; PHQ-8 and GAD-7 were screens; and education findings were adult household reports.
4. **Do not treat the recommendations as proven interventions.** They require bounded design, current legal and institutional verification, feasibility and cost assessment, formal responsibility, and monitoring for disclosure, retaliation, debt, gatekeeper power, stigma, unsafe screening, and transfer of institutional duties to community organizations.

Next research and publication safeguards

Legal and institutional context in the report was checked against sources current through publication date. Relevant rules, procedures, fees, service arrangements, and responsible actors must be reverified before publication or operational use. The next research phase should strengthen the evidence without delaying bounded, low-risk improvements already supported by the report.

1. **Establish independent ethics review and compensated community governance.** Future protocols should make consent, disclosure risk, data access, retention, and responsibility for difficult decisions explicit; governance should include people beyond the organizations that provide easiest access.
2. **Improve measurement, translation, and recruitment.** Document the path between oral Zopau, written Zolai, and English analysis; test key items; recruit across multiple urban settings; and reach people with weaker organizational, digital, or language access.
3. **Add child, institutional, longitudinal, and intervention evidence only with appropriate safeguards.** Direct child participation requires a dedicated safeguarding protocol; legal and institutional studies require specialist review; and selected recommendations should be evaluated for reach, continuity, equity, cost, burden, and unintended harm before expansion.

> **What the report ultimately establishes.** Material strain, restricted institutional access, documentation-related uncertainty, uneven support, psychological distress, and persistent household and community effort were visible across the two participant groups. Better evidence and present action are complementary obligations: organizations can strengthen verified information, navigation, referral, and accountability now within their authority, while future research builds the designs needed for population, longitudinal, legal, clinical, and intervention claims.

Chapter 1. Introduction

1.1 Why this study was undertaken

Zomi families, churches, educators, community leaders, and mutual-aid networks already hold substantial knowledge about displacement and everyday life in Malaysia. Their work includes helping people find housing and employment, supporting children's learning, raising money for medical care, sharing information about documents, and sustaining relationships across countries.

Some of that knowledge had been written down. A 2022 community report addressed identity, displacement, documentation, healthcare, education, employment, protection, and resettlement in Malaysia, India, and Thailand. A 2023 Mission of Hope report drew on a fact-finding visit, public meetings, interviews and discussions, and engagement with churches, educators, community organizations, nongovernmental organizations, and UNHCR representatives. These reports preserve community priorities and institutional knowledge that are not readily available in academic or administrative sources.[1]

Knowledge nonetheless remained dispersed across personal experience, local-language materials, churches, learning centers, and organizations. Official statistics posed a different problem because they often placed Zomi people in broader categories such as Chin or people from Myanmar. The present report brings a defined body of Zomi-specific survey and interview evidence into a form that can be cited, examined, and extended. It does not claim ownership over community knowledge or speak for every Zomi person in Malaysia.

Fragmentation of information affected who could use the available knowledge. People already connected to community networks might know whom to ask or where to look, while students, healthcare providers, journalists, donors, researchers, and policymakers often could not locate the same material. Even when a source was available, an outside reader might not know how the information had been gathered, whose experience it reflected, or how far a conclusion could travel beyond its original purpose.

Community reports and institutional statistics answer useful but different questions. The reports record priorities, observations, and organizational work; the statistics record people within specified administrative categories. Neither source alone supplies a representative account of displaced Zomi people in Malaysia.

1.2 What systematic documentation adds

A teacher, worker, family member, or community leader may recognize a recurring problem through direct experience. A structured record can place that observation beside other accounts, show where experiences recur or diverge, and make clear when a conclusion rests on limited evidence.

Research does not make community experience valid for the first time. Its value here is to preserve part of that experience while stating whose accounts are represented, how information was gathered, and what the evidence cannot establish. Those boundaries reduce the risk that one account, one organization's observations, or one administrative statistic will be treated as a complete account of Zomi life.

A structured record can also preserve disagreement and variation. Experiences that recur across several accounts may warrant attention, but a counterexample can be equally important when it

shows that an institution, relationship, or household arrangement did not operate in the same way for everyone. Documentation makes these differences easier to revisit. It does not resolve the conditions described or remove the need for community judgment.

1.3 What the study contributes

This cross-sectional mixed-methods study was conducted through community-network recruitment. It combines an online survey of 90 consenting adults with a separate qualitative analytical corpus of 36 adults interviewed in person. No participant-level linkage was attempted, and any overlap between the two components was not recorded.[2]

The survey provides a structured account of responses within its nonprobability participant group. The interviews add detail about how participants understood events, decisions, relationships, and institutional encounters. The study does not estimate conditions among all Zomi adults in Malaysia, and recurrence in the interviews is not population prevalence.

The two components answer different questions. Survey counts and percentages describe patterns within 90 analytical records. Interview material shows sequences, explanations, variation, and counterexamples within the separate corpus. The report does not combine the denominators or assign a survey response to an interview participant. External and community-authored sources provide context but remain distinct from both forms of study evidence.

The contribution is therefore bounded: the report brings together a methodologically documented body of Zomi-specific evidence across domains often considered separately. It complements earlier community documentation and direct consultation rather than replacing either.

1.4 How the evidence should be read

The survey is descriptive, exploratory, cross-sectional, and based on self-report. It can describe the 90 analytical records and limited associations within them, but it cannot support population prevalence, causal inference, or change over time. Interviews can explain sequences and variation within the separate 36-person corpus, but they cannot show how common an experience is beyond that corpus.

Accounts of documents, work, healthcare, safety, and institutions are participants' reports, not independent legal or administrative determinations. PHQ-8 and GAD-7 results are screening findings, not diagnoses. Chapter 4 provides the controlling methods account, and Chapter 17 consolidates the study's limitations.

Later chapters retain the denominator relevant to each question, treat small subgroups cautiously, and separate description from interpretation. Education evidence comes from adults reporting about their households. Documentation groups are self-reported analytical categories, and the derived indicators and four-hardship count are post hoc and unvalidated. These measures help organize the participant data but do not establish legal status, clinical need, or causal risk.

1.5 Who the report is for

The report is written first for Zomi community members, community organizations, churches, educators, students, researchers, and people who may carry this work forward. It is a record that community members can question, revise, and expand.

It also serves service providers, nongovernmental and humanitarian organizations, healthcare and education providers, donors, journalists, policymakers, and researchers. Readers may use it to locate prior work, inform planning, identify questions, or examine service gaps. It cannot replace direct consultation with affected communities.

Different audiences carry different responsibilities. A community organization may use the report to compare its own observations with the participant evidence; a service provider may review where procedures appear difficult to complete; a researcher may identify a question that requires a different sample or design. None should treat the report as a mandate from the whole community.

1.6 How the report is organized

Chapter 2 supplies the historical, identity, legal, and institutional context. Chapter 3 states the study objectives and research questions; Chapter 4 describes the methods; and Chapter 5 describes the survey participants and the separate interview corpus. Chapters 6 through 13 present domain findings.

Chapter 14 examines overlapping hardship, Chapter 15 provides the integrated interpretation, and Chapter 16 presents author recommendations that were not tested, costed, or evaluated. Chapter 17 addresses study limitations, and Chapter 18 identifies priorities for future research. The next chapter provides the context needed to understand why identity, protection, documents, and Malaysian legal authorization must be kept distinct.

Chapter 2. Zomi Displacement and the Malaysia Context

This chapter provides the historical, political, legal, social, and institutional context for the study. It does not offer a complete history of the Zomi, resolve contested identity questions, determine any participant's legal position, or present the study's findings.

The chapter separates historical interpretation, current law, stated institutional procedure, community documentation, and wider refugee research. Later chapters remain the only source for results from the 90 survey records and 36 interview participants.

Where a source uses Chin, refugee, asylum seeker, or another institutional term, the wording is preserved and its limits are stated rather than silently converted into a Zomi-specific claim.

2.1 Identity, language, and institutional categories

Zomi is not a simple demographic label. It carries cultural and historical meaning and, for many people, political meaning. It also exists alongside terms such as Zo, Chin, and Chin–Kuki–Mizo that overlap in some settings but are not automatically interchangeable. Scholarship on the Indo-Burma borderlands and Northeast India describes identities shaped by colonial boundaries, administrative classification, language, political mobilization, and changing forms of self-identification.[3]

The meaning and preferred use of these terms vary by period, place, institution, and speaker. Chin can function as a geographic, ethnic, political, humanitarian, or administrative category. Zo may be used as a wider cultural or linguistic reference, while Zomi may express a specific collective identification. The chapter records those distinctions without deciding a political or historical debate that lies beyond the study.

A person may identify as Zomi, come from Myanmar, speak Zopau, read and write Zolai, and be recorded as Chin in an institutional database. Each description answers a different question. This report uses Zomi as its principal community identifier while preserving the terminology of a historical source, public institution, or dataset when discussing that source.

The study targeted adults who identified as Zomi through community-network recruitment. The research team did not independently adjudicate or verify identity through a formal eligibility procedure. The report does not define fixed territorial boundaries or decide who is or is not Zomi.

This recruitment description is narrower than a claim that every participant completed an independently verified identity screen. It also keeps the study's community identifier separate from categories assigned for registration, service delivery, or administrative reporting.

Administrative categories require the same care. UNHCR publishes a Chin category in its Malaysia statistics but no separate Zomi count. The category records an administrative classification; it does not show how everyone included identifies, how many Zomi people fall elsewhere in the data, or how many people remain outside UNHCR registration.[4]

Identity and origin must also be distinguished from international protection, UNHCR registration, documents, and Malaysian authorization. A person may require international protection without completing UNHCR registration. A UNHCR document does not itself grant Malaysian immigration or

work authorization. A passport, expired identity document, community card, registration reference, appointment card, and UNHCR identity document serve different purposes.

International protection concerns the need for protection and any determination made under a relevant mandate or procedure. Registration records information within an institutional process. A document is evidence issued for a stated purpose. Malaysian authorization concerns what domestic law permits. Collapsing these questions can overstate what a document proves or understate a person's protection needs.

Four questions therefore remain separate:

- Does the person require international protection, and has a determination been made?
- Has the person requested or completed UNHCR registration?
- What documents does the person hold?
- What is the person authorized to do under Malaysian law?

No single label or document answers all four questions. Keeping them separate is necessary when interpreting an administrative statistic, document, or participant account.

2.2 Historical and political context

Zomi-authored histories describe communities connected across an upland region now divided among Myanmar, India, and neighboring areas. Academic histories show how colonial conquest, boundary-making, and administrative classification changed this borderland and standardized categories that later entered censuses, political institutions, and research.[3]

Present borders do not reproduce older relationships of kinship, language, settlement, exchange, and political organization. A shared regional history does not mean that all Zomi and related communities used the same name, spoke the same language variety, or pursued the same political aims. Community-authored histories remain important because they preserve viewpoints that state records and outside scholarship may not contain.

Colonial administration separated communities into different jurisdictions and produced labels for governing a varied upland region. Those labels outlived the administrative systems that created them. They later appeared in censuses, electoral arrangements, school systems, humanitarian databases, and scholarship, sometimes alongside and sometimes in tension with community names.

2.2.1 Independence, military rule, and exclusion

The 1947 Panglong Agreement became an important reference in later debates about federalism, equality, and ethnic rights. Its use in this report is limited to that historical role; the chapter does not resolve competing claims about representation at Panglong. Burma became independent in January 1948, while armed conflict and disputes over political authority continued.[5]

The military takeover of 2 March 1962 expanded centralized rule. Historical scholarship, human-rights reporting, and community accounts describe restrictions on political participation and cultural or religious life, as well as coercion and violence in ethnic minority regions. These conditions interacted with economic hardship and restricted opportunity; no single event explains every later movement.[6]

Community accounts often connect this history to political recognition, language and literature, religious life, education, and local authority. These are attributed perspectives, not claims that every Zomi community experienced state power in the same way or adopted the same political response.

2.2.2 Coercion, conflict, and community institutions

Human Rights Watch documented forced labor, arbitrary arrest, torture, religious discrimination, and other abuses reported by Chin communities before 2009. A 2010 population-based survey in all nine townships of Chin State interviewed heads of 621 households about the preceding year. Ninety-one point nine percent reported forced labor affecting at least one household member, alongside reports of food and livestock theft, forced displacement, detention, violence, disappearance, and religious or ethnic persecution.[7]

Those findings are neither Zomi-specific nor current. They document a particular region and period and help explain a longer history of insecurity. Churches and community organizations also developed as sites of worship, education, language preservation, leadership, information, and mutual assistance. Their histories and capacity vary, and they do not reach every person or possess authority to resolve the conditions that create need.

The distinction between regional evidence and Zomi-specific evidence is essential. A study of Chin State can document conditions in a place where Zomi and related communities have lived, yet it cannot identify the experience of every ethnic or language group within that place. The same rule applies when administrative data use a broad Chin or Myanmar category.

2.3 Conflict since 2021 and continuing displacement

The military takeover in February 2021, the suppression of opposition, and the growth of armed conflict deepened Myanmar's humanitarian and human-rights crisis. OHCHR's February 2026 review described worsening violence, repression, arbitrary arrest, conscription, displacement, and constraints on humanitarian access during 2025. OCHA's 13 July 2026 update estimated that nearly 3.8 million people were displaced and more than 16 million needed humanitarian assistance nationwide. It also reported intensified military activity in Falam Township and related shortages of food, medicine, and other essentials.[8]

National totals do not identify Zomi people separately. Community reports describe movement within Myanmar, across the border into northeastern India, and onward to Malaysia and other countries, but no comprehensive Zomi-specific displacement count is available. People may move more than once, and family members may be separated across several countries. Time living in Malaysia therefore does not by itself show when displacement began or what routes preceded arrival.

Movement may respond to several conditions at once, including immediate security, political pressure, military recruitment, family separation, loss of livelihood, education, or the availability of a relative who can receive someone elsewhere. These possibilities describe a regional context, not a single Zomi migration pathway. The study interviews contain individual accounts, which are reported later without being turned into one narrative for the whole community.

The 2023 Mission of Hope report arose in this setting. Its authors described a six-person delegation to Malaysia and India, public meetings, interviews and discussions, and engagement with community and external institutions. The report is evidence of community documentation and priorities, not a representative population study.[1]

2.4 Urban displacement in Malaysia

Refugees and asylum seekers in Malaysia generally live in towns and cities rather than a national camp system. As of the end of February 2026, UNHCR reported about 215,600 registered refugees and asylum seekers in Malaysia. It classified 193,824 as from Myanmar, including 15,774 in its Chin category. These are administrative registration figures, not an estimate of everyone needing protection and not a Zomi population count.[4]

The 2022 Zomi community report estimated about 12,400 Zomi refugees in Malaysia, while the 2023 report cited about 30,000. The reports do not document reproducible national estimation methods, so their figures should not be averaged or treated as definitive. They remain records of what community organizations reported at two points in time.[1]

Urban location matters because work, housing, healthcare, education, worship, transportation, and assistance are obtained through institutions and relationships dispersed across a city. Geographic proximity alone does not establish eligibility, affordability, safe travel, language access, or time away from work. The later chapters examine how study participants experienced those conditions.

Urban residence also complicates counting. People may move within or between metropolitan areas, share accommodation, stay temporarily with relatives, or remain absent from formal registration. UNHCR cautions that changes in its totals reflect registration capacity as well as arrivals and departures. Registered figures should not be read as a complete migration-flow series.[4]

2.5 International protection, UNHCR, and Malaysian law

Malaysia is not a party to the 1951 Refugee Convention or the 1967 Protocol and does not operate a national asylum system. UNHCR conducts registration and refugee-status determination under its mandate. UNHCR recognition or registration does not confer Malaysian immigration status. Section 6 of the Immigration Act 1959/63 requires a noncitizen to hold a valid entry permit or pass, or to fall within an exemption, to enter Malaysia lawfully.[9]

This position should not be summarized by calling a person “illegal” or by saying that refugees have no rights. It means that UNHCR protection processes and Malaysian immigration authorization have different legal bases. Other Malaysian criminal, civil, labor, and family-law rules may still apply, while the outcome of any case depends on the facts, governing law, and competent authorities.

Current UNHCR guidance distinguishes a request for registration from an appointment, completed registration, and refugee-status determination. People in Malaysia submit a request through UNHCR’s My Services portal and receive a reference number, but guidance warns that the wait for an interview may be long. Procedures can change, so the source date matters when describing an individual record.[10]

A reference number can show that a request was submitted, but it is not the same as a completed registration record or identity document. A registration interview may lead to documentation, while refugee-status determination is a separate protection procedure. The report uses the most specific stage supported by the evidence rather than describing all pending circumstances as registered.

UNHCR documentation includes identity cards, Certified Copy Letters, Under Consideration Letters, and appointment cards. An appointment card is not an identity document. UNHCR documents can verify a record and may support access to specified services, but they are not passports, residence permits, or work permits and do not give immunity from Malaysian law.[10,11]

The practical effect of a document can vary by setting. A service provider may accept it for identity verification or a stated fee arrangement, and an authority may use it to contact UNHCR. Neither practice changes the document into a Malaysian pass or guarantees that another institution will respond in the same way.

UNHCR and partner organizations may receive arrest reports, verify a record, engage authorities, and provide legal assistance in immigration matters. UNHCR states that it may be unable to assist during the initial remand period unless authorities request verification, and that release decisions rest entirely with Malaysian authorities. Registration therefore does not prevent arrest, detention, prosecution, or removal, and it does not guarantee release.[12]

These statements describe public law and current institutional guidance; they are not legal advice or a determination of any participant's circumstances. Proposed registration, education, or work initiatives are not treated here as established rights unless implemented through a verifiable rule or procedure.

Law, announced policy, institutional procedure, and reported practice are cited separately. A public webpage can verify what an institution says its procedure is; it cannot prove that every person can complete that procedure or predict the decision in an individual case. Legal conclusions in the final publication still require specialist review.

2.6 Everyday institutions and practical access

The legal distinctions above shape, but do not by themselves determine, everyday options. Refugees may encounter government agencies, UNHCR, nongovernmental organizations, community organizations, churches, employers, relatives, friends, and digital networks for different purposes. These actors hold different information, resources, and authority; their roles should not be treated as interchangeable.

Public agencies determine immigration enforcement and rules for public services. UNHCR acts under its protection mandate and may register, refer, or assist people, but it cannot grant Malaysian immigration status. Nongovernmental organizations and community institutions work within their own mandates, eligibility rules, funding, staffing, and geographic reach.

2.6.1 Movement and work

Immigration enforcement and uncertainty about documents can influence travel, service use, and willingness to approach institutions. A document may help establish identity or a UNHCR record without supplying immigration authorization. Current UNHCR guidance also states that refugees and asylum seekers are not able to work formally in Malaysia and that UNHCR identity documents are not work permits.[11,12]

The effect of enforcement risk cannot be inferred from a document label alone. It may depend on the document held, the reason for an encounter, the agency involved, the ability to verify a record, and access to legal or community assistance. Chapters 6 and 15 examine participant reports and later interpretation without converting those reports into legal findings.

Informal employment may supply essential income while leaving workers without reliable contracts, insurance, or accessible dispute resolution. This is general context, not a claim about how often any experience occurred among Zomi participants. Chapters 6 and 7 report the study's documentation, movement, and employment evidence.

Work can also affect where a person lives, how they travel, when they can seek care, and whether they can support relatives. Those are plausible contextual connections rather than assumed study results. Their form and frequency must be established from participant evidence in the relevant findings chapters.

2.6.2 Healthcare and education

UNHCR's current guidance states that registered refugees and asylum seekers receive a 50 percent discount from the foreigner fee at Malaysian government hospitals and clinics, but payment is still required. Research with several refugee communities has also documented cost, language, transport, information, and documentation barriers. Those studies provide context and do not supply Zomi-specific estimates.[13]

A discount is not equivalent to free care or proof that treatment can be completed. Fees, deposits, referral requirements, transport, working hours, language, and knowledge of services may still matter. The chapter states these as documented features of the wider environment and leaves the study's healthcare results to Chapter 9.

The same current guidance states that refugee and asylum-seeking children and youth do not have access to Malaysian public schools. Education is provided mainly through community learning centers, whose capacity, fees, curriculum, location, language, and age coverage vary. UNHCR recognition of a center does not mean that UNHCR funds it.[14]

An available learning center may not offer a place for every child or a recognized pathway through later levels of education. Household cost, transport, placement, language, age, and continuity can affect access. Chapter 10 relies on adult household reports, not interviews with children or a national inventory of learning centers.

Zomi churches and organizations have helped sustain learning and raise funds for medical care. Their work can be essential without guaranteeing coverage or replacing public authority. Chapters 9 and 10 examine adult participants' reports of healthcare and children's education.

2.6.3 Housing, services, and community relationships

Housing may be found through landlords, employers, relatives, friends, or community contacts. Nongovernmental organizations and community groups may provide legal information, healthcare, education, emergency assistance, translation, referral, or accompaniment. Availability does not establish that everyone knows about a service, can reach it, meets its criteria, or feels safe using it.

Shared housing can lower costs and support childcare or information exchange, while employer-linked or relationship-based arrangements may also create dependence. Neither shared housing nor a move should be classified automatically as preference, instability, or forced displacement. Chapter 8 applies the study's defined measures and evidence boundaries.

Community institutions differ in resources, reach, and authority. People who are newly arrived, live farther away, work long hours, or are less connected may have different access to them. This neutral institutional context is not a model of how access works; that interpretation belongs to Chapter 15.

Families, friends, coworkers, employers, and digital channels may also provide information, transport, money, translation, or referrals. Such relationships can help, fail, or create new obligations. This chapter does not assume that support is uniformly available or that an informal contact has the resources or authority of a public institution.

2.7 Prior evidence and the bounded study contribution

Research on refugees in Malaysia documents recurring concerns involving legal status, work, health, education, housing, safety, and services. Much of it concerns Rohingya communities, mixed-nationality samples, service users, or broad policy questions. It can identify wider conditions but cannot be assumed to describe Zomi communities directly. The same caution applies to administrative or research categories using Chin.[13,14]

Differences in language, religion, migration history, location, household structure, and community institutions may influence how a wider policy environment is encountered. General refugee research can frame a question or identify a possible mechanism; only evidence with a clear Zomi-specific basis can support a Zomi-specific claim.

Zomi-authored and community-authored reports answer different questions. Their principal value lies in preserving community priorities, direct observations, organizational knowledge, and earlier responses to displacement. Their documented methods do not support representative population estimates, but that limit does not erase their evidentiary value.[1]

They also document the prior work of churches, educators, organizations, and community leaders. Their limits should be stated rather than used to dismiss them: they were created for community response, fact-finding, or advocacy, not to estimate national prevalence. Academic, administrative, community, survey, and interview evidence are each used for the questions their methods can answer.

Publicly accessible, methodologically transparent Zomi-specific evidence remains limited, and no reproducible national population estimate is available. The present study adds a bounded survey and interview record without claiming to replace community knowledge or wider refugee research. Chapter 3 defines the objectives and research questions that govern that inquiry.

The evidence gap is therefore a gap in accessible and documented evidence, not proof that community knowledge was absent. Much remains in local-language material, organizational records, and personal experience. The report contributes one transparent record and states its limits so later work can confirm, challenge, or extend it.

Chapter 3. Study Objectives and Research Questions

Chapter 1 explained why a new body of Zomi-specific evidence was needed, and Chapter 2 placed the study within the histories, institutions, and legal distinctions that shape displacement and urban life in Malaysia. This chapter defines the inquiry that connects that rationale and context to the methods, participant description, findings, interpretation, and recommendations that follow.

The objectives and questions below reflect the study as it was completed. The survey and interview components were treated as separate samples: 90 adults completed the survey, and 36 adults formed the final qualitative analytical corpus. No participant-level linkage was attempted, and any overlap between them was not recorded. The questions distinguish what the survey can describe from what interviews can explain and place the report's recommendations in a separate applied objective. They do not assume the findings in advance.

3.1 Overall study objective

The overall objective was to describe and interpret the conditions shaping daily life for Zomi adults living in urban Malaysia, including how practical conditions, household responsibilities, relationships, and institutional encounters affected access to work, housing, healthcare, children's learning, information, support, and future options.

The inquiry covered documentation, enforcement and mobility, employment and economic security, housing, healthcare, children's learning arrangements, mental-health symptoms, social support, information, trust, participant priorities, and future planning. It also examined how selected practical hardships co-occurred within survey records and how interview accounts clarified the varied pathways through which difficulties were managed. The report then used the completed findings and participant priorities to develop recommendations that remain bounded by the evidence and by the authority of the actors to whom they are addressed.

Considering these domains together permits analysis of their relationships without assuming that every participant experienced the same connections. It keeps variation between participants visible rather than forcing a single narrative. Stable and positive experiences remain visible alongside hardship. The study therefore extends beyond a list of isolated service barriers without claiming to offer a complete account of Zomi life in Malaysia.

3.2 Specific objectives

1. **Describe major reported conditions.** Document the distributions reported by survey participants across documentation, enforcement and mobility, employment, housing, healthcare, children's learning arrangements, mental-health screening, support, information, and trust.
2. **Understand daily experience and household response.** Examine how interview participants described movement, work, care, household responsibility, coping, support, and planning, including the sequences through which a need became manageable, remained unresolved, or changed another part of daily life.

3. **Preserve variation in experience.** Identify differences in how similar circumstances were understood and managed, including counterexamples, stable or positive experiences, changes participants described retrospectively within their own accounts, and situations in which an expected difficulty was absent.
4. **Examine overlapping practical hardship.** Explore how four broadly defined domains, documentation insecurity, enforcement and mobility, healthcare access and safety, and housing risk, co-occurred within the 90 survey records. The resulting composite was constructed after data collection and was used only as a descriptive, exploratory count.
5. **Interpret access pathways and relational support.** Consider how money, movement, documents, language, transport, time, care responsibilities, and relationships with households, employers, churches, community organizations, teachers, interpreters, and service providers shaped whether opportunities and services were usable in practice. This objective concerned reported pathways and variation, not a proven causal model.
6. **Document priorities and future orientations.** Describe participant-selected priorities and distinguish immediate needs from hopes, conditional intentions, concrete plans, and uncertainty. Participant priorities were treated as evidence from the study, not as a single community mandate.
7. **Inform evidence-bounded recommendations.** Use the integrated findings, participant priorities, and author interpretation to develop recommendations for relevant community, service, employer, funding, and institutional actors. The study did not test the effectiveness, cost, feasibility, or legal sufficiency of those recommendations.

3.3 Levels of inquiry

Descriptive inquiry asks what survey participants reported, how responses were distributed, and which selected conditions appeared within the same records. Claims remain tied to item wording, denominators, and timeframes. Comparisons describe variation within the survey group; they do not explain its cause or establish patterns beyond the sample.

Interpretive inquiry asks how interview participants understood and managed their circumstances. It considers how participants moved from recognizing a need to seeking help, which household or institutional relationships entered that process, where a pathway stopped, and why similar measured circumstances could carry different meanings. Counterexamples and stable experiences remain part of the analysis.

Applied work begins after the empirical findings and adds author judgment about what actions the evidence can reasonably inform, which actors have the needed authority or resources, and what cautions should govern implementation. Recommendation development therefore remains a report objective, not a question the study tested directly.

3.4 Research questions

The study was organized around six main research questions. The first concerns structured description, the next four combine domain-specific and cross-domain interpretation, and the final question guides the integrated discussion. Recommendation development remains an applied report objective rather than a research question.

1. **What documentation, enforcement and mobility, employment, housing, healthcare, children's learning, mental-health, support, information, and trust conditions did survey participants report?**

It concerns distributions and selected descriptive or exploratory comparisons within the survey participant group, not population prevalence, legal determinations, clinical diagnoses, or child-level outcomes.

2. **How did interview participants describe the ways these conditions entered daily decisions, household responsibilities, coping, and access to work, housing, healthcare, education, information, and institutional assistance, and how did their accounts vary?**

The focus is meaning, reported sequence, household context, institutional encounters, practical response, and counterexamples. Recurrence in the interviews is not treated as frequency in a wider population.

3. **How did the four exploratory practical-hardship domains co-occur within survey records, and how did positive PHQ-8 or GAD-7 screening vary across the resulting hardship count?**

The analysis is descriptive and post hoc. The composite is not a validated scale, severity measure, or predictor. Separate interview accounts provide context but cannot be linked to survey records or used to explain an individual response.

4. **What different roles did family and friends, employers, community institutions, and service providers play in making information, services, and opportunities usable, and where did their assistance reach its limits?**

The categories encompass different actors and functions. Trust and practical help are distinct from formal authority, and relational assistance is not assumed to replace institutional resources or decisions.

5. **What priorities, hopes, conditional intentions, concrete plans, and uncertainties did participants identify for themselves, their households, and the wider community?**

Survey priority selections remain separate from interview accounts of the future. Participants' priorities and proposals are also distinct from the recommendations developed by the report's authors.

6. **What cross-domain patterns emerged when the findings on practical conditions, household responses, relational support, and institutional encounters were interpreted together?**

The integrated discussion does not presume a single pathway, treat the exploratory composite as causal, or assume that similar measured circumstances carried the same meaning.

3.5 How the mixed-methods design addresses the questions

The survey provided structured distributions, item-specific descriptive or exploratory comparisons, participant-selected priorities, exploratory indicators, and a post hoc analysis of co-occurrence within the same 90 records. Its cross-sectional, community-network sample describes the participant group rather than all Zomi people in Malaysia or other refugee communities.

The interviews examined meaning, variation, household responsibilities, institutional encounters, and reported sequences. They also showed the practical strategies people used when approaching work, housing, healthcare, education, or assistance. The components were analyzed as separate samples without participant-level linkage. Interview accounts can therefore clarify how a pattern might arise or differ in practice, but they cannot validate a survey response or identify the circumstances of a particular survey participant.

Chapters 6 through 14 present the empirical findings, and Chapter 15 interprets them together. Chapter 16 adds author judgment about authority, feasibility, equity, sustainability, and possible harm. Its recommendations are applied proposals, not intervention findings.

3.6 How the questions organize the report

Table 3.1. Research questions, applied objective, evidence sources, and report chapters

Inquiry	Primary evidence	Principal chapters
Research Question 1	Survey items and descriptive or exploratory distributions	Chapters 6 through 12
Research Question 2	Interview accounts and qualitative analysis across domains	Chapters 6 through 13
Research Question 3	Four-domain survey composite, hardship-count distribution, and descriptive screening comparison; separate interviews for contextual interpretation	Chapter 14, supported by Chapters 6 through 13
Research Question 4	Survey support, information, and trust measures; interview accounts of the roles and limits of relational and institutional assistance	Chapters 7, 9, 10, 12, 14, and 15
Research Question 5	Survey priority selections and interview accounts of needs, hopes, intentions, plans, and uncertainty	Chapter 13
Research Question 6	Integrated interpretation of finalized domain and overlap findings	Chapter 15
Applied report objective	Findings, participant priorities, actor authority, and author assessment of feasibility and possible harm	Chapter 16

3.7 Scope of the inquiry

The study was descriptive, exploratory, and cross-sectional. Survey findings describe 90 adults reached through community networks; interview findings describe a separate 36-person corpus with no participant-level linkage. Screening results are not diagnoses, education evidence is based on adult household reports, documentation categories are self-reported rather than legal determinations, and derived indicators are post hoc and unvalidated. The design does not support population prevalence, causal or longitudinal inference, or claims that recommendations were evaluated. Chapter 4 specifies the methods and Chapter 17 addresses their limitations.

Within those boundaries, the study examines the practical steps between a service or opportunity and its use, without treating household or community assistance as formal authority, stable funding, or institutional accountability.

3.8 Chapter synthesis

The six research questions move from survey description and interview accounts through exploratory overlap, assistance, participant priorities, and integrated interpretation. Recommendation development remains a separate applied objective, not a tested question. Chapter 4 explains the

recruitment, consent, measurement, interviewing, analysis, and ethical safeguards used to address the inquiry.

Chapter 4. Methods

This report draws on two samples of Zomi adults living in Malaysia: 90 people who completed an online survey and 36 people whose interviews formed the final qualitative analytical corpus. The survey supplied structured descriptions of participant characteristics and reported conditions. The interviews supplied accounts of meaning, sequence, household response, institutional encounters, variation, and counterexamples. The survey and interview components were treated as separate samples. No participant-level linkage was attempted, and any overlap between them was not recorded.

The study was descriptive and exploratory. Each component was analyzed within its own evidentiary limits before findings were brought together by domain and later across the report. Integration examined complementarity, explanation, and variation. It did not turn a nonprobability survey into a population estimate, interview recurrence into prevalence, or cross-sectional association into causation.

4.1 Study design

The project was a cross-sectional mixed-methods study conducted through community-network recruitment. The quantitative component was a one-time online survey. The qualitative component was a bounded corpus of one-on-one interviews. Community networks were central to recruitment and implementation, but the study was not conducted as community-based participatory research. The records do not support a more specific mixed-methods subtype.

The components followed a common substantive framework covering documentation, enforcement and movement, work, housing, healthcare, children's learning, emotional wellbeing, support, information, trust, priorities, and future plans. Their analytical roles remained different. Survey responses were summarized as distributions, selected unadjusted comparisons, and post hoc exploratory indicators. Interviews were examined case by case and across cases to understand how participants described daily decisions, relationships, institutional pathways, and differences in experience.

Integration followed component-level preparation and analysis. Chapters 6 through 13 align survey distributions with interview accounts in the same domain. Chapter 14 describes co-occurrence across four universal survey domains, while separate interview accounts illustrate pathways and variation without being assigned to survey categories. Chapter 15 interprets the established findings together. Chapter 16 develops author recommendations from those findings and participant priorities; the recommendations were not tested, costed, or evaluated as interventions.

4.2 Setting, population of interest, and eligibility

The study focused on Zomi adults living in urban Malaysia. No complete list of displaced Zomi residents was available, and the analytical records contain no location variable that could verify city-level residence or geographic coverage. The urban focus came from the project's recruitment scope and framing, not from a retained city screen. No city defines the analytical sample.

Recruitment targeted adults who identified as Zomi, were living in Malaysia, and understood themselves to be refugees, asylum seekers, people without documentation, or in another displacement-related documentation circumstance. The survey directly screened only age and

consent. It did not independently verify Zomi identity, residence, urban location, or documentation circumstance as eligibility conditions; community recruitment targeted the intended population, and substantive items described participants' circumstances. Participation required access to written Zopau presented using Zolai, but no separate language-proficiency criterion was documented.

The interview guide similarly defined invitees as adult members of the Zomi community in Malaysia. No standardized case-level eligibility checklist, invitation denominator, or refusal count was retained. All 36 people in the analytical interview corpus were treated as adults. Children were not interviewed directly; education evidence came from adult household and community accounts.

Table 4.1. Study components, participants, evidence, and analytical roles

Component	Study group	Recruitment and flow	Evidence collected	Analytical role
Online survey	90 consenting adults	Community-network nonprobability recruitment; 92 submissions; two excluded for no consent	Structured items across demographic, practical, household, support, priority, and screening domains	Descriptive distributions, selected unadjusted comparisons, and post hoc indicators
One-on-one interviews	Separate final corpus of 36 adults	Community-network recruitment; in person during February 2026; invitation and refusal totals not retained	Zopau interviews with oral consent, audio recording, interviewer notes, and retained English translated or edited analytical records	Case-based and cross-case interpretation of meaning, pathways, variation, and counterexamples
Report-level integration	No combined participant sample	No participant-level linkage; any overlap was not recorded	Findings established separately within each component	Domain-level complementarity in Chapters 6-13, cross-domain analysis in Chapters 14 and 15, and recommendation in Chapter 16

4.3 Survey recruitment and participant flow

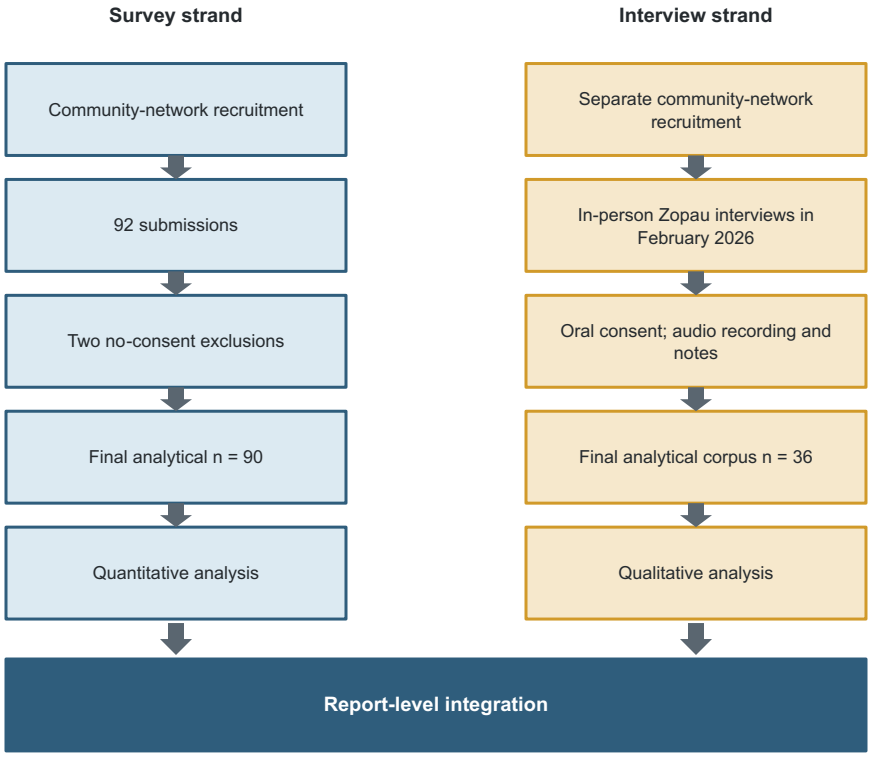
Survey recruitment used churches, Zomi organizations, community leaders, WhatsApp, personal networks, and related community channels. Research-team members and community contacts circulated the questionnaire through available networks. The records do not distinguish all direct invitations from group links, identify everyone reached, or count eligible nonparticipants, so a response rate cannot be calculated.

This was a community-network convenience sample, not a probability sample. Participation depended on connection to circulation channels, digital access, willingness to take part, and ability to use the written Zopau questionnaire presented in Zolai. People with weaker organizational ties, limited digital access, greater participation concerns, or less contact with the research team may have been less likely to enter the sample.

The consent screen came before the substantive survey. Ninety-two submissions were recorded. Two were excluded because consent was not provided, leaving 90 records in the final analytical workbook. The workbook begins after these exclusions, so the 92 submissions and two exclusions come from the participant-flow record. The final file contains sequential analytical IDs and no duplicate IDs.

Survey participants were not compensated. The methods record says the form was configured to limit one submission, but the final Google Forms settings were not archived. The absence of duplicate analytical IDs does not verify every platform-level submission control.

Figure 4.1. Study components and analytical flow



4.4 Survey administration and translation

The survey was administered online through Google Forms from 11 February through 27 June 2026. It was presented in written Zopau using Zolai. Participants were told that the survey was anonymous, and the analytical export contained no names, email addresses, exact addresses, account fields, device identifiers, or other direct participant identifiers. It also contained no response timestamp or city field. The final Google Forms metadata settings were not archived, so platform-level metadata collection, required-item settings, and post-submission editing cannot be verified.

The methods record attributes translation of the questionnaire and participant-provided responses to Zopau-speaking research-team members working collaboratively to resolve wording and culturally specific expressions. No item-level translation ledger, translator-role record, pilot or cognitive-interviewing record, formal linguistic validation, or back-translation was preserved. Whether another person assisted a participant with online completion was not systematically recorded. A paper instrument allowed self-completion or read-aloud administration, but it does not establish the mode used for any online response.

Open-text and text-labeled analytical responses were available in English. Limited normalization joined clearly equivalent categories without changing meaning, including capitalization variants and numeric recoding of text-labeled trust endpoints. No free-text narrative was treated as independently linguistically validated.

4.5 Survey measures

The questionnaire used single-choice, multi-select, numeric, and ordered response items. Recall periods were stated where relevant. Participant characteristics covered age group, gender, marital status, household size, children under 18 in the household, and time living in Malaysia. These items describe the survey participants and households, not the wider Zomi population.

Documentation was self-reported through selected document circumstances. Public reporting grouped responses into UNHCR-related documentation, pending documentation circumstances, reported no documents, and a residual other category. The groups do not establish legal status, immigration authorization, work authorization, or the stage or validity of an administrative process.

Enforcement and mobility items asked how often participants avoided places because of documentation concerns, their fear of being stopped or checked on the study's 0-to-5 scale, and how often fear of police or immigration changed daily routines. Avoidance and routine items used ordered frequency categories. A detailed multi-select follow-up asked what changes occurred, but that follow-up was not used for public estimates because its response pattern conflicted with the preceding frequency item.

Employment measures distinguished working at the survey date, not working but looking, and not working and not looking. Conditional items for current workers covered main work type, typical daily hours, late or missing pay in the previous three months, and unsafe conditions or injury risk during that period. Work-condition denominators were restricted to eligible workers with nonmissing data.

Housing items covered current housing arrangement, the number of people sharing a sleeping room, agreement that rent was hard to pay, and the number of residential moves in the previous 12 months. These are participant reports. Sleeping-room sharing was not treated as a legal overcrowding determination, and residential moves were not assumed to have a single cause.

Healthcare measures asked what participants usually did first when sick, whether they needed healthcare but did not go in the previous three months, and whether healthcare felt safe for people like them. The unmet-need follow-up was unusable for estimating reasons because its stored responses appeared in the wrong skip group. It was excluded from public analysis.

Education items applied to the 48 survey participants who reported children under 18 in the household. They asked about the household's current formal, community, home-based, mixed, or absent learning arrangement; the main reason where no arrangement was reported; and agreement that children could learn safely and consistently. These were adult household reports. The survey did not enumerate children, collect direct accounts from children, or establish individual enrollment, attendance, dropout, educational quality, or formal recognition.

Support was measured by how often, during the previous month, the participant had someone to rely on for help. Information sources were a multi-select item covering friends and family, church leaders, digital groups, organizations, and employers or agents. Five source-specific trust ratings used a numeric 1-to-5 scale. Because the English anchors for the final written Zopau trust item in Zolai could not be independently verified, public reporting uses numeric means without applying unverified verbal labels.

Participants also selected issues in a field described as their top three priorities, then named the most important. The multi-select distribution was retained despite irregular selection counts, while the separate most-important field was treated as internally imperfect. Interview accounts, rather than

a structured survey field, supplied the report's fuller qualitative distinctions among hopes, conditional intentions, concrete plans, and uncertainty.

4.6 PHQ-8 and GAD-7 scoring

The survey included the eight-item Patient Health Questionnaire and the seven-item Generalized Anxiety Disorder scale. Each item asked about symptom frequency during the previous two weeks and was scored from 0, not at all, to 3, nearly every day. PHQ-8 items were summed from 0 to 24. GAD-7 items were summed from 0 to 21. All 90 analytical records contained complete item responses for both measures, and row-level checks reproduced every stored total.

PHQ-8 severity bands were 0 to 4 minimal, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe, and 20 to 24 severe. GAD-7 bands were 0 to 4 minimal, 5 to 9 mild, 10 to 14 moderate, and 15 to 21 severe. A score of 10 or higher was treated as a positive screen on the named measure. The combined categories identified a positive PHQ-8 screen, a positive GAD-7 screen, either positive screen, or both.

These instruments are symptom screens, not diagnostic interviews. They do not establish a depressive or anxiety disorder, clinical need, cause, prognosis, or service eligibility. PHQ-8 omits the ninth Patient Health Questionnaire item concerning self-harm or thoughts of death. The survey therefore included no self-harm or suicide-risk item, and no clinical assessment or urgent-risk determination was conducted from the screening data.

4.7 Quantitative data preparation and data-quality decisions

Google Forms responses were exported to a spreadsheet, translated and recoded, and retained in a locked worksheet. That 90-row workbook controls the final analysis. It contains source items, screening totals, publication groupings, and derived indicators.

The two no-consent submissions had already been removed. Missing values were not imputed, and a blank conditional response was not treated automatically as a negative answer. Percentages used eligible, available-case denominators. Universal items generally used 90; key worker measures used 61 or 62 current workers with data; and education items used the 48 adults reporting children in the household. Multi-select percentages could exceed 100 percent.

Faulty or inconsistent fields were narrowed rather than repaired speculatively. The healthcare-barrier follow-up and detailed routine-change follow-up were excluded from public estimates. Education reasons were restricted to the intended group. The priority fields contained inconsistent selection counts and mismatches between the multi-select and forced-choice responses, so they were reported separately and were not treated as a validated ranking. Text-labeled trust endpoints were recoded to their leading numeric values, while interpretation remained numeric because the English verbal anchors were uncertain. The audit preserves the complete irregularity counts and row-level dispositions.

4.8 Quantitative analysis

Quantitative work used Python with pandas for cleaning, recoding, tabulation, cross-tabulation, and derived variables; openpyxl for workbook access and checks; and matplotlib for figures. Software versions were not retained. Final tables and figures were built from the locked workbook and checked against row-level recalculations and the cross-chapter ledger.

Analysis used counts, percentages, means, medians where useful, full distributions, severity bands, selected cross-tabulations, and unadjusted descriptive comparisons. Numerators and denominators were reported together when eligibility or missingness changed the base. Subgroup comparisons were selective and cautious, especially for small cells; small differences were not treated as stable population patterns.

No missing value was imputed. No p-value, confidence interval, regression model, hypothesis test, or claim of statistical significance was used. The design cannot establish temporal order or causal effect. All comparisons describe this participant group at one period of data collection.

4.9 Post hoc indicators and the four-hardship composite

Several binary indicators were constructed after data collection to summarize combinations of source items. They were post hoc, exploratory, unvalidated, and secondary to their components. They are not legal, clinical, severity, deprivation, trauma, vulnerability, or predictive classifications.

Table 4.2. Exploratory derived indicators used in the report

Indicator	Component definition	Eligible base	Interpretation boundary
Documentation insecurity	No documents, or pending documentation circumstances	All 90 survey records	Self-report, not a legal determination
Enforcement and mobility	Fear score 4 or 5 on the 0-to-5 item, avoidance often or very often, or routine change sometimes or more often	All 90 survey records	Broad post hoc indicator, not objective exposure
Housing risk	Rent difficulty, three or more people sharing a sleeping room, or two or more moves in the previous 12 months	All 90 survey records	Rent strongly influences the indicator; not homelessness or legal overcrowding
Healthcare access and safety	Needed care but did not go in the previous three months, disagreed that healthcare felt safe, or both	All 90 survey records	Participant-assessed access and safety
Work risk	Late or unpaid wages, unsafe conditions or injury risk, or both	Current workers with both fields	Conditional worker indicator, not a universal domain
No current school or learning arrangement	Adult reported no current arrangement for children in the household	Households with children under 18	Household category, not a child-level rate
Low or inconsistent support	Never, rarely, or sometimes had someone to rely on in the previous month	All 90 survey records	“Sometimes” does not mean no support
Positive mental-health screen	PHQ-8 or GAD-7 score of 10 or higher, as specified	All 90 survey records	Screen, not diagnosis or clinical assessment

The four-hardship composite counted documentation insecurity, enforcement and mobility, healthcare access and safety, and housing risk. Each universal domain contributed zero or one point, producing a count from zero to four for every survey participant. Domains were equally weighted. The count records co-occurrence, not severity, timing, duration, mechanism, or importance.

Work was excluded because work-condition items applied only to current workers. Education was excluded because its items applied only to households with children. Positive mental-health screening was excluded because screening was treated as the descriptive outcome in the comparison. Support was retained as a separate contextual domain. These exclusions allowed the

four components to be defined for all 90 survey records and avoided placing an outcome inside the count used to compare that outcome.

The relationship between the count and a positive PHQ-8 or GAD-7 screen was examined descriptively and without adjustment. No trend test, dose-response model, threshold analysis, prediction model, or causal analysis was conducted. The composite remained a report-specific construct developed after review of the data.

4.10 Interview recruitment and analytical corpus

Interview participation was voluntary following circulation of study information through community networks. The evidence does not support purposive, maximum-variation, theoretical, respondent-driven, or formal snowball sampling. Invitation and refusal totals, a full screening log, and any overlap with the survey were not retained. The components were therefore analyzed as separate nonprobability samples without participant-level linkage; actual overlap remains unknown and unrecorded.

Zopau-speaking members of the research team conducted the interviews in person during February 2026. Interviews were audio-recorded, and interviewers also prepared notes. The methods review did not verify that the current archive contains every audio file.

The final analytical corpus contains 36 distinct one-on-one interview records. All were readable and sufficiently complete for case-based thematic analysis, although length, question coverage, guide version, and detail varied. Several records marked questions as not asked, and silence was not coded as proof that an experience was absent. No analytical exclusion count beyond the final corpus can be reconstructed.

4.11 Interview procedures and consent record

The final English-language guide contains 20 open questions with optional probes across participant and household context, documentation, work, finances, housing, enforcement, education, healthcare, stress, coping, and priorities. The retained records share these domains but vary in guide length, wording, and follow-up. The guide therefore documents the planned structure, not identical delivery.

Participants could decline a question or stop, and each received 50 Malaysian ringgit in compensation for time. Separate permission was obtained for audio recording. Consent was obtained orally before each interview. These procedures were confirmed by the study lead after the initial methods review. No separate payment ledger or case-level written consent log was located in the reviewed archive.

The guide directed interviewers to choose a private setting, use participant codes rather than names in notes, avoid exact addresses, employer names, and official identification numbers, and limit unnecessary incident detail. The guide proposed an interview of about 60 minutes, but actual duration was not logged. For distress, it instructed interviewers to offer a pause, skip a question, change topic, or end the interview. No separate clinical, suicide-risk, urgent-referral, or incident-response protocol is documented.

4.12 Interview transcription and translation

All interviews were conducted orally in Zopau. English analytical text was retained for every case, but the records varied among translated question-and-answer text, edited translations, summaries, partial translations, and note-style accounts. Each English text was translated directly from the Zolai transcript. Published quotations reproduce the English analytical translations, with minor punctuation changes where needed for readability and no substantive wording change. Each quotation was checked against the supplied English record and page. This verifies the published English wording against the available analytical source, not against the participant's original Zopau speech. The absence of original-speech verification limits claims about exact phrasing, emphasis, and culturally specific nuance even when the English analytical source is clear.

4.13 Qualitative analysis

The primary qualitative analysis was conducted using a case-first, framework-based thematic process that combined domain-led and inductive coding. Each interview was reviewed individually before cross-case synthesis. Case memos recorded the central account, context, consequences, coping, priorities, tensions, ambiguity, candidate codes, and possible quotations, preserving within-case sequence and contradiction.

Codes drew from interview domains and from distinctions that emerged during close reading. The codebook documented definitions, inclusion and exclusion rules, related-code boundaries, supporting interview IDs, examples, and analytical notes. Codes were grouped, separated, and refined as review progressed. An interview-by-theme matrix linked candidate themes to cases and source pages and distinguished explicit, interpretive, ambiguous, and contradictory material. It also noted whether a topic appeared mainly because it was directly elicited or recurred elsewhere in an account. Theme summaries were checked against the matrix and supporting-ID lists. Recurrence counts described only the 36-record corpus and were not treated as population frequencies.

Analysis retained negative and counterexamples, including supportive employers, effective care, stable shared housing, educational progress, and accounts in which an expected relationship did not appear. Interpretation considered guide prompts, record depth, translation quality, and silence. More detailed records naturally offered more opportunities for coding and quotation. Quotations required analytical relevance, readable translated wording, a traceable source page, and an acceptable disclosure profile; each was checked against the English source record.

No independent second coding, intercoder agreement, member checking, respondent validation, formal saturation assessment, reflexive journal, grounded-theory procedure, or qualitative software record is documented. Naming the primary analyst does not remove the need to consider the limits of a single-analyst workflow and incomplete reflexivity documentation.

4.14 Mixed-methods integration

The components shared substantive domains but retained separate analytical bases. In Chapters 6 through 13, survey distributions establish what participants selected within defined items and denominators. Interview accounts show how a similar issue could enter daily decisions, acquire different meanings, involve several relationships, or be absent in a particular case. An interview never explains the response of a named or assumed survey participant.

Chapter 14 describes co-occurrence across four post hoc survey domains and uses qualitative cases separately to examine pathways, timing, household responsibility, assistance, and counterexamples. Interview participants are not assigned a hardship count. Chapter 15 interprets established findings across domains. Chapter 16 combines findings, participant priorities, actor authority, and author judgment to propose actions that were not evaluated.

Integration emphasized complementarity, explanation, and variation. Agreement did not automatically validate a measure or inference, and divergence remained visible. Survey percentages did not estimate interview-theme frequency, and interview recurrence did not strengthen a survey estimate statistically.

4.15 Consent, ethics-review status, and participant protection

Survey participants received electronic consent information and had to select agreement before continuing. Participation was voluntary, questions could be skipped, and the two no-consent submissions were excluded. The analytical survey records contain no direct participant identifiers, while the platform-metadata limitation described in Section 4.4 remains.

Interview participants gave oral consent before the interview and separate permission for audio recording. Participation was voluntary, and participants could skip a question or stop. Each received 50 Malaysian ringgit in compensation for time. Interview analysis used neutral IDs, but the source files remained confidential rather than anonymous. No child was interviewed directly.

The study did not undergo formal review by an institutional review board or research ethics committee. Protections included consent, voluntary participation, data minimization, restricted research-team access, analytical survey records without direct identifiers, de-identified interview analysis, source verification, and disclosure review. The team also adopted prospective deletion of study data and confidential source materials six months after publication.

4.16 Data management, quotation review, and disclosure protection

Study files were stored in a restricted-access Google Drive folder protected through the research team's account credentials. Access was limited to research-team members. The locked survey workbook contains an analytical ID and no direct participant identifier. Interview sources remained confidential because some included participant codes or distinctive details about residence, work, health, family, detention, or migration. Analysis assigned neutral IDs from Interview participant 01 through Interview participant 36 and kept public labels separate from confidential source naming. The records do not establish an encryption standard, formal access log, or certified security framework.

The research team will retain the study files until six months after publication of the report, after which retained study data and confidential source materials will be deleted. This is a prospective policy, not a completed procedure. The deletion plan should cover unnecessary duplicates, confidential source files, analytical copies, quotation banks, and internal audit materials containing sensitive data, subject to any final author-approved archival exceptions. Responsibility for carrying out and documenting deletion must be settled before publication.

Public quotations were verified against source text and page. Names, precise locations, employers, exact incident dates, and unnecessary medical or family details were omitted or generalized. Paragraph-level review considered whether ordinary details could combine into a recognizable

profile. The integrated manuscript retained 34 quotations from 26 participants, with no participant quoted more than twice. Sensitive death-related quotations and high-risk contextual detail were excluded.

These protections reduced direct and deductive identification risk but could not eliminate recognition within a close community. Publication retains only the context needed to understand a claim and avoids reconstructing detailed participant profiles across chapters.

4.17 Methodological boundaries carried forward

Community-network nonprobability recruitment, analytically separate survey and interview samples without participant-level linkage, available-case and conditional denominators, translation uncertainty, and the exclusion or narrowing of faulty fields define the study's principal methodological boundaries. The derived indicators and four-hardship composite were post hoc and exploratory; quantitative analysis was descriptive and unadjusted; and the study did not evaluate interventions. Chapter 17 examines the implications of these limits in full.

4.18 Chapter synthesis

The survey provides structured responses from 90 adults, while a separate corpus of 36 interviews supports case-based and cross-case interpretation. The two forms of evidence meet only through domain-level and report-level integration, without participant linkage. Chapter 5 next describes the two participant groups before the report turns to substantive findings.

Chapter 5. Participant Characteristics

Before the report turns to findings, this chapter describes the 90 adults in the survey and the separate 36-person interview corpus. The components were treated as separate samples: no participant-level linkage was attempted, and any overlap was not recorded. Survey percentages apply only to the 90 analytical records; qualitative descriptions apply only to the interview corpus.

5.1 Survey participant flow

Community-network nonprobability recruitment produced 92 survey submissions between 11 February and 27 June 2026. Two were excluded because consent was not provided, leaving 90 adults in the locked analytical workbook. The survey was presented in written Zopau using Zolai. The records describe the people who participated, not a representative sample of Zomi adults in Malaysia.

All 90 records contained the eight characteristics reported here. One participant preferred not to state a gender category. A separate prefer-not-to-say documentation response is retained within the verified residual group rather than treated as missing.

5.2 Demographic characteristics

The two youngest recorded groups contained 32 participants aged 18–24 and 41 aged 25–34. The remaining participants were distributed across three older bands. Because age was collected in groups, the data do not support an exact mean or individual age profile.

Fifty-two participants identified as male, 37 as female, and one preferred not to say. Fifty-seven reported being single, 30 married, and three widowed. These recorded categories do not establish wider community patterns.

Table 5.1. Survey participant demographic characteristics

Characteristic	Category	n	%
Age group	18–24 years	32	36
Age group	25–34 years	41	46
Age group	35–44 years	10	11
Age group	45–54 years	3	3
Age group	55 years or older	4	4
Gender	Male	52	58
Gender	Female	37	41
Gender	Prefer not to say	1	1
Marital status	Single	57	63
Marital status	Married	30	33
Marital status	Widowed	3	3

5.3 Household and residence characteristics

Household size was collected in grouped categories. Twenty participants reported living alone, while the other records were distributed across households of 2–3 people, 4–5 people, and 6 or more people. The largest single category was 4–5 people, reported by 25 participants. These bands

cannot be converted into an exact mean, and they do not by themselves indicate crowding or housing pressure.

Forty-eight of 90 participants (53%) said that children under 18 lived in their household. This is an adult household report, not a count of children, parents, or guardians. No children participated directly in the study. The survey's separate education items are examined later and are not part of this participant profile.

Reported time in Malaysia ranged from less than one year to eight years or longer. Forty-six participants were in the 1–3 year category, eight had lived in Malaysia for less than a year, and 18 participants were recorded in each of the 4–7 year and 8 years or longer categories. These categories refer only to reported time living in Malaysia. They do not establish the duration of displacement, continuity of residence, immigration authorization, or the timing of any documentation process.

Table 5.2. Survey household and selected contextual characteristics

Characteristic	Category	n	%
Household size	1 person	20	22
Household size	2–3 people	21	23
Household size	4–5 people	25	28
Household size	6 or more people	24	27
Children under 18 in household	Yes	48	53
Children under 18 in household	No	42	47
Time living in Malaysia	Less than 1 year	8	9
Time living in Malaysia	1–3 years	46	51
Time living in Malaysia	4–7 years	18	20
Time living in Malaysia	8 years or longer	18	20
Current work status	Currently working	63	70
Current work status	Not working but looking	19	21
Current work status	Not working and not looking	8	9
Reported documentation circumstance	UNHCR-related documentation	30	33
Reported documentation circumstance	Pending documentation circumstances	26	29
Reported documentation circumstance	Reported no documents	32	36
Reported documentation circumstance	Other	2	2

5.4 Selected contextual characteristics

Current work status is included as a short point of orientation. Sixty-three participants were working at the time of the survey, 19 were not working but looking, and eight were neither working nor looking. The categories do not describe work type, hours, pay, safety, or dependence on an employer. Those subjects are examined in Chapter 7.

Documentation circumstances are also introduced only at group level. Thirty participants were placed in the verified UNHCR-related group, 26 in the pending group, 32 reported no documents, and two were retained as other. The residual group contains one passport or permit response and

one prefer-not-to-say response. These categories organize self-reported answers for analysis; they are not legal determinations. Chapter 6 examines documentation and movement-related evidence in detail.

5.5 Interview participant corpus

The qualitative component contained 36 adults interviewed in person in Zopau during February 2026. Participants gave oral consent, with separate permission for audio recording. Interviews were audio-recorded and accompanied by interviewer notes, and each participant received 50 Malaysian ringgit. The component was analyzed separately from the survey.

The interview records were designed to capture accounts of daily life rather than a standardized demographic profile. They did not use a uniform demographic questionnaire, and the amount of background information varied from one interview to another. Some records included substantial household or work context, while others moved quickly to the experiences covered by the interview guide. A characteristic that was not mentioned cannot be treated as absent.

Within those limits, the corpus included adults at different life stages and with differing household, work, caregiving, health, residence-duration, and documentation circumstances.

Participants also described varied contact with churches, community organizations, employers, schools, healthcare providers, and other services. These references help locate later qualitative findings, but they were not collected as a complete institutional-contact inventory. The corpus therefore supports a broad narrative description of participant circumstances, not percentages, subgroup comparisons, or a parallel demographic table.

5.6 Interpretation boundaries

The characteristics in this chapter describe two nonrepresentative components that were analyzed separately and cannot be combined into one sample. Survey values apply to the 90 analytical records; interview descriptions apply to the 36-person corpus. Documentation responses are not legal findings, and child-related data are adult reports about households. Grouped age, household-size, and residence-duration responses should not be converted into exact individual values. Substantive results are presented in later chapters.

5.7 Chapter synthesis

These two nonrepresentative profiles establish the evidence base without combining the samples. Chapter 6 moves from the documentation categories introduced here to enforcement and freedom of movement.

Chapter 6. Documentation, Enforcement, and Freedom of Movement

Interview participants described UNHCR cards helping with hospital fees, police checks, or release after detention. They also described cardholders who remained cautious about roadblocks, work, and taking children outside. Community-issued cards carried a different kind of value: they could identify an organization to contact and give relatives or community leaders a way to respond, even when the card itself did not prevent an arrest.

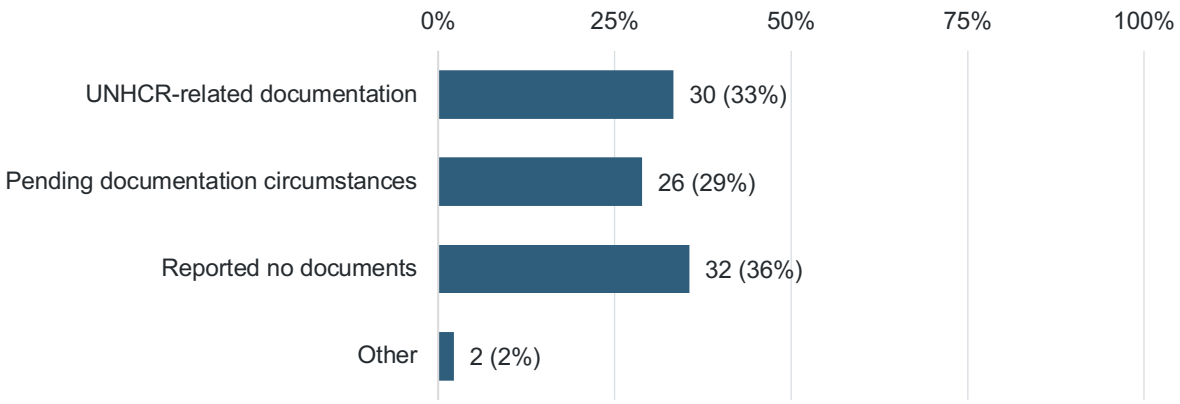
The same tension appears in the structured results. Among the 30 survey participants with UNHCR-related documentation, 17 reported high fear of being stopped or checked, defined as 4 or 5 on the study's 0-to-5 scale. Fifteen said they often or very often avoided places because of documentation concerns. Possessing a document did not divide this participant group into people who felt secure and people who did not.

Documentation and freedom of movement therefore have to be examined together. The formal meaning of a document, the practical assistance it could unlock, the way an officer or service provider responded to it, and the holder's own history all entered decisions about leaving home. For some participants, a card made an ordinary journey more manageable. For others, a prior arrest, an operation nearby, or the undocumented circumstances of a spouse or parent kept fear present. Among people still waiting, papers and reference records sometimes provided proof of an application but not the certainty they wanted.

6.1 Documentation circumstances among participants

Survey participants reported several documentation circumstances. Thirty of 90 were grouped as having UNHCR-related documentation (33 percent). Twenty-six were grouped as having pending documentation circumstances (29 percent), covering verified asylum-seeking, registration-request, appointment, or related pending responses. Thirty-two reported having no documents (36 percent). The remaining two reported other circumstances: one selected passport or permit, and one preferred not to say.

Figure 6.1. Documentation circumstances among survey participants



These groupings summarize what participants selected; they do not determine legal status. In particular, the pending category does not show that UNHCR registration had been completed, that an appointment had been received, or that refugee status had been determined. The UNHCR-related category likewise does not imply Malaysian immigration or work authorization. The two responses outside the three principal groups were retained separately rather than assigned to a category they did not fit.

Interview accounts described current UNHCR cards, community-issued cards, application or registration papers, a passport, a medical referral memo, an expired temporary document, and no completed document. The transcripts sometimes used “UN card” as shorthand. Analysis treated a participant as a current cardholder only when the interview clearly established present possession.

Some participants had a registration document but no card, while others reported an application without a reference number or repeated contact without a completed document. A medical referral reportedly helped one family move its registration forward. These accounts reflect participants' understandings; the study did not inspect administrative records or determine any formal procedural stage.

Documentation also varied within households. One cardholder described a spouse and child who had arrived more recently and did not share the same circumstances. Another said a card improved personal travel and hospital access while a parent remained in a pending circumstance. A document held by one person could reduce some risks without resolving the household's wider uncertainty.

6.2 Recognition, reassurance, and the limits of paper

Participants did not describe documents as meaningless. UNHCR-related documents were associated in the interviews with several concrete forms of assistance: reduced hospital charges, greater confidence during travel, verification during a police check, contact with UNHCR after detention, and in some cases release. A few participants also believed employers preferred workers who held a UNHCR card. These were reported practical effects, not a claim that the document conferred Malaysian residence or work authorization.

Community-issued cards operated differently. Their value often lay in identification and connection. They named an organization that might answer a call, verify community membership, contact relatives, communicate with a hospital, or try to assist after an arrest. Interview participant 28 stated the distinction directly:

> *"Having a community card does not provide legal protection. However, it gives me some peace of mind because if something happens to me, my family and community leaders will know where I am and can assist me."*
> Interview participant 28

The reassurance in this account did not come from an expectation that the card would compel an officer to release its holder. It came from the possibility that someone else would know whom to contact and what to do next. Other participants described community representatives negotiating during police encounters, helping to prepare documents for hospital visits, supporting applications, or accompanying people who lacked language confidence. A community card could thus function as contact infrastructure even when participants believed authorities might reject it.

Across the interviews, community documents mattered most when an organization could be reached. Participants described help with hospital registration, applications, translation, or contact during an enforcement encounter, while also recognizing that the document itself did not guarantee protection.

UNHCR cardholders also distinguished practical help from complete security. Interview participant 08 described the balance in one account:

> *"Having a UNHCR card gives me greater peace of mind when traveling or going out. During police checks or roadblocks, officers usually allow me to continue after verifying my card. However, having a UNHCR card does not make much difference in terms of employment or living conditions."*
> Interview participant 08

This participant later described release after a workplace detention while coworkers without UNHCR cards were deported. The card was consequential. Yet it did not settle the participant's employment circumstances, the documentation of family members, or a broader sense of security. Across the interviews, cardholders spoke of similar partial gains: a lower hospital bill that remained difficult to pay, a check that ended without detention, or greater peace of mind that stopped short of confidence.

Participants' expectations also differed. Some understood the document mainly through hospital discounts. Some focused on what might happen if police stopped them. Some hoped it would improve access to work. Others saw it as a record that made them less anonymous during an emergency. These meanings were shaped by what participants had experienced or heard. A person whose card had been accepted at a roadblock could view it differently from someone whose relative had been detained while holding one.

Pending and expired circumstances produced their own uncertainty. An application paper could show that a person had begun a process, but participants did not necessarily know when the next step would occur or whether the paper would be recognized outside that process. Interview participant 15 described a temporary card that had expired after an application produced no reference number. Interview participant 31 described repeated efforts without receiving a UNHCR card and continued fear while traveling. The interviews do not permit an administrative assessment

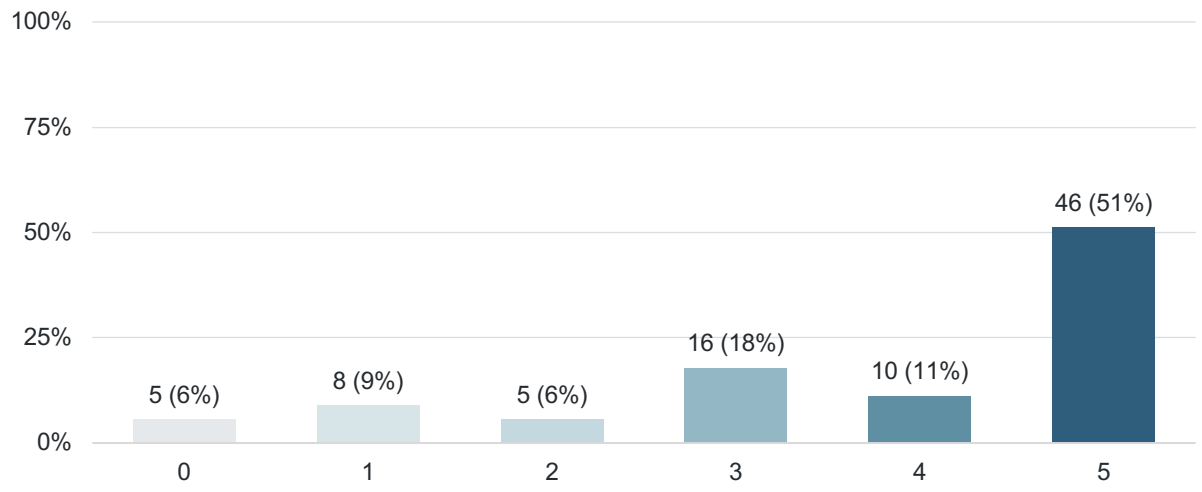
of either case. They show what prolonged procedural uncertainty meant in daily life: the person continued to carry whatever paper was available while planning movement as if it might not be enough.

The central qualitative pattern was therefore not that documents failed to matter. It was that their value was graded, situational, and often relational. A document could verify identity, reduce a fee, improve the chance of assistance, or shorten a stop. It could not guarantee how every officer, employer, hospital, or landlord would respond. Nor could it make all members of a household share the same circumstances.

6.3 Fear of being stopped

Fear of being stopped or checked was measured on a 0-to-5 scale. All 90 survey participants answered the item. The mean was 3.7, but the distribution is more informative than the average. Forty-six of 90 participants selected the maximum response of 5 (51 percent), and another 10 selected 4 (11 percent). Under the locked definition, 56 of 90 therefore reported high fear (62 percent). Twenty-one selected 2 or 3 (23 percent), while 13 selected 0 or 1 (14 percent). The median response was 5.

Figure 6.2. Fear of being stopped or checked on the 0-to-5 scale



N = 90. High fear is defined as 4 or 5; the item records perceived fear, not objective enforcement probability.

The concentration at the top of the scale shows that a mean alone would understate the pattern. At the same time, the 34 participants who did not meet the high-fear definition should not be collapsed into a single low-fear group. Sixteen selected 3, while five selected 0. The survey contained substantial variation even within a distribution weighted toward high fear.

The descriptive pattern also differed across documentation groups, although not in a simple stepwise manner. High fear was reported by 17 of 30 participants with UNHCR-related documentation (57 percent), 18 of 26 participants in pending documentation circumstances (69 percent), and 21 of 32 participants with no documents (66 percent). The two participants in other circumstances are not emphasized because the subgroup is too small to interpret. Within the three

principal groups, high fear was somewhat less common among those with UNHCR-related documentation, but it remained the majority response in each group. The survey cannot establish why these differences occurred.

Table 6.1. Documentation circumstances and selected enforcement and mobility measures

Documentation circumstance	High fear (4 or 5), n (%)	Avoided places often or very often, n (%)	Routine changed sometimes or more often, n (%)
UNHCR-related documentation	17 (57%)	15 (50%)	14 (47%)
Pending documentation circumstances	18 (69%)	12 (46%)	15 (58%)
Reported no documents	21 (66%)	16 (50%)	17 (53%)

Fear developed through several paths. Some participants linked it to a personal stop, search, arrest, detention, reported demand for money, or near-arrest. Others had no direct encounter but changed behavior after events involving relatives, coworkers, or nearby operations. The study did not verify official records; it records what participants reported and how those events shaped later choices.

Some cardholders felt safer after receiving a card without feeling fully secure. Earlier encounters continued to shape where they went and how they managed later checks.

One participant contrasted an earlier stop that reportedly ended after a payment with a later check in which officers accepted the card. The document changed the encounter, but not the participant's sense that information had to be managed carefully.

Reported encounters ranged from questioning and demands for money to detention and near-arrest. Their importance here lies in how earlier events remained part of later decisions.

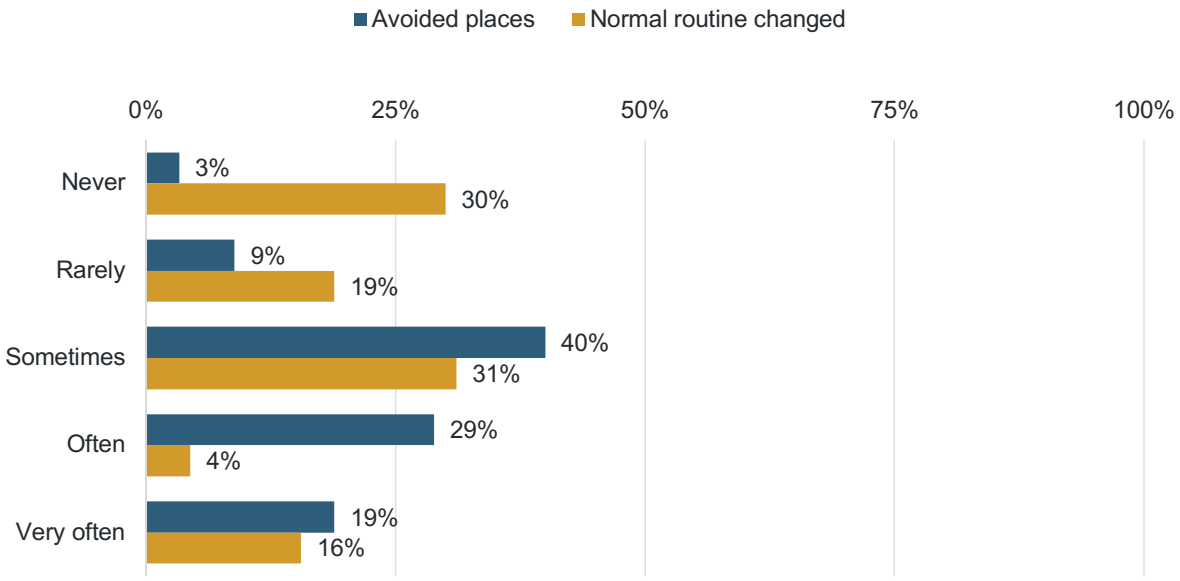
Fear also developed without a personal stop. Relatives, workplaces, churches, group chats, and nearby buildings circulated warnings about operations. Such messages could help people avoid a location while extending anticipatory fear into homes and routines. Incident counts and fear measures therefore answer different questions: perceived risk could be high without a direct encounter, and a past encounter did not produce the same lasting response in every case.

6.4 How fear reshaped movement and routine

Avoidance was common within the survey participant group. When asked how often they avoided going somewhere because of documentation concerns, 43 of 90 participants said often or very often (48 percent), and 36 said sometimes (40 percent). Eight said rarely and three said never. Thus, 79 of 90 reported at least sometimes avoiding a place for this reason (88 percent), although the study's more conservative threshold for this item counted only often or very often.

A separate question asked how often fear of police or immigration changed normal routines. Forty-six of 90 participants answered sometimes, often, or very often (51 percent). This included 28 who said sometimes, four who said often, and 14 who said very often. Seventeen said rarely and 27 said never. The two items therefore captured related but nonidentical experiences. Some participants avoided particular places without describing their overall routine as frequently changed.

Figure 6.3. Avoidance of places and changes to normal routines



The exploratory enforcement/mobility indicator combined three conditions: high fear, avoiding places often or very often, or reporting that enforcement concerns changed normal routines sometimes or more frequently. Seventy-one of 90 survey participants met at least one condition (79 percent). This is a post hoc summary flag, not a validated scale or a legal measure. Its breadth is useful for identifying whether at least one substantial concern was reported, but it should not be interpreted as a single level of severity. A participant who met one condition and a participant who met all three received the same flag.

Interviews supplied the behavioral detail that the survey categories could not. Participants described staying close to home, going out only for appointments or essential errands, avoiding particular transit areas, choosing a longer walking route, temporarily leaving an apartment during an operation, hiding in another home or church, reducing attendance at worship, and limiting trips with children. These were not interchangeable behaviors. Some changed a single route. Others reorganized much of the day.

For Interview participant 01, caution followed several reported arrests before receiving a UNHCR card:

> *"Whether we have legal documents or not, it is important to be careful whenever we go outside and avoid encounters with the police whenever possible."*
> Interview participant 01

The participant stayed near the neighborhood and reserved travel for important appointments. The card had previously been accepted during a later stop, but experience had produced a rule that extended beyond document possession. Movement became a repeated judgment about necessity.

Work created one of the hardest judgments because staying home could also mean losing income. Interview participant 25 described leaving home during warnings about operations and being anxious when traveling, yet still needing to keep a job. Interview participant 29 said a spouse left a workplace after coworkers were arrested, then later found different work through a friend. Interview participant 30 described an acquaintance who stopped going to work after a reported money

demand at a roadblock. These accounts do not show how often enforcement caused job loss across the wider community. They show how the possibility of a stop could enter employment decisions before a person reached the workplace.

Family responsibilities sometimes narrowed the option to avoid travel. Parents still had to bring children to school, obtain food, or seek medical care. Interview participant 18, despite holding a UNHCR card, connected fear to going outside with children and sending them to school. Interview participant 24 rarely went out except to take a child to school or complete an essential task and depended on other people for language and hospital accompaniment. Interview participant 29 limited outings while caring for young children with recurring health needs. For these participants, freedom of movement was not simply an individual preference. It determined whether care work could be done without recruiting someone else into the journey.

Age, health, and disability also shaped what avoidance meant. Interview participant 11 said that being unable to run or hide during operations made them especially afraid and described repeated household moves. Interview participant 03 rarely left home because serious illness limited physical movement; the absence of a personal police encounter in that account should not be interpreted as evidence that documentation concerns were unimportant. Interview participant 36 described being nearly arrested during hospital travel when application papers had been forgotten, with community contacts intervening. A medical trip could not always be postponed, even when it felt risky.

Participants also described different forms of accompaniment. A relative might travel with someone who did not speak Malay. An employer might provide transport to a clinic. A teacher or community worker might accompany a hospital visit. A community leader might answer a call during a police encounter. Accompaniment reduced practical and emotional barriers for some participants, but it could be unavailable, expensive, or dependent on another person's schedule.

The relationship between information and mobility was similarly mixed. Warnings helped participants avoid an operation or prepare contact details. Yet repeated reports could also interrupt sleep and widen the set of places perceived as risky. The interviews do not establish whether every warning was accurate. They show that participants acted on information circulating through networks they relied upon, often because the cost of ignoring a true warning seemed high.

Approaching institutions could carry a separate calculation. Interview participant 08 worried that refugees reporting robbery or other harm would not be treated as a priority. Others described uncertainty about government offices, hospitals, or police checks on the way to an appointment. Some therefore relied first on churches, employers, relatives, or community organizations. This was not necessarily a rejection of formal services. It was often an attempt to approach them with identification, translation, transport, or a person who could intervene if difficulties arose.

6.5 Documentation did not create a simple boundary between safety and insecurity

The subgroup comparisons make the limits of a binary interpretation especially clear. The exploratory enforcement/mobility indicator was met by 23 of 30 participants with UNHCR-related documentation (77 percent), 22 of 26 in pending documentation circumstances (85 percent), and 26 of 32 with no documents (81 percent). Avoiding places often or very often was reported by exactly half of both the UNHCR-related group (15 of 30) and the no-documents group (16 of 32), compared with 12 of 26 participants in pending documentation circumstances (46 percent). These differences

are descriptive, based on small nonprobability subgroups, and not evidence that one documentation circumstance produced more or less avoidance.

The figures do not mean documentation was irrelevant. High fear was lower in the UNHCR-related group than in the two larger insecure-documentation groups, and interviews supplied examples in which a card changed an encounter. The important point is narrower: the relationship was not complete or uniform. Documentation circumstance was one part of a larger practical setting.

Previous encounters were one source of variation. Some participants continued to organize travel around what had happened; others said that receiving a card reduced constant fear. A serious earlier encounter and a later sense of relative safety could coexist.

Family composition was another source of variation. A survey category assigned to one adult cannot capture whether a spouse, child, or parent has different documentation circumstances. Interviews show why cardholders could still answer questions about fear with other household members in mind.

Location, work, and exposure mattered as well. A participant who lived at a workplace and rarely traveled encountered a different set of risks from someone commuting through transport hubs, taking children to school, or visiting hospitals. Interview participant 32 had no completed document and reported no personal enforcement incident or significant stress. The account also described living at the workplace and going out infrequently:

> *“With the grace of God I haven’t faced any inconvenience so far. I have not been going out, that's why I haven’t faced any.”*
> Interview participant 32

The interview does not justify inferring hidden distress that the participant denied. It does show that low reported exposure and restricted movement could occur together. "No encounter" could describe a genuinely stable period, a narrow daily geography, or both.

The inverse pattern also appeared. Interview participant 27 had no personal stop but took a longer route to avoid a heavily policed area and sometimes lost sleep after reports of operations. Interview participant 06 reacted strongly to sirens and enforcement vehicles without reporting personal detention. Direct experience was therefore neither necessary nor sufficient for high fear. Information, proximity, and the experiences of close others could shape behavior.

Support altered the practical meaning of documents. Participants who could call a community office, employer, relative, pastor, teacher, or interpreter had more options during an encounter or urgent journey. The evidence does not show that such help was always available or successful.

The interview variation also guards against an opposite overstatement: not every participant described daily fear. Interview participant 07 felt relatively safe despite a close relative's detention. Interview participant 34 emphasized the benefits of a UNHCR card and reported no personal encounter. Interview participant 03's illness, rather than an enforcement strategy, was the main reason for rarely leaving home. These accounts belong in the central finding because they show that documentation, fear, and movement were connected without being interchangeable.

6.6 Consequences beyond movement

Restrictions on movement entered other areas of life, but they did so in different ways. The later thematic chapters examine those areas in full. Here, their importance is that access to work,

healthcare, education, housing, and institutional help often required a journey through spaces participants did not always experience as secure.

Work, healthcare, education, and institutional help all required movement through public space. Participants described stops during commutes, concern on the way to appointments, and reliance on transport or accompaniment for school and healthcare. A document might help at registration or during a check without resolving the journey, cost, or need for another person's time.

Movement was therefore a cross-cutting condition. Knowing where work, a clinic, a school, or an office was located did not guarantee usable access when the route, entrance, lost wages, or need for accompaniment introduced another barrier.

6.7 Chapter synthesis

Documentation changed some encounters without eliminating fear or restricted movement. Chapter 7 examines what happened when earning income required travel, visibility, and continued access to work.

Chapter 7. Employment and Economic Security

A job could keep a household afloat without making its finances secure. Survey participants who were working described long days, late or unpaid wages, and risks of injury. Interview participants described a wider set of arrangements around the job itself: relatives who made an introduction, employers who provided a room or a ride to a clinic, salaries divided among rent and relatives, and workers who stayed through difficult conditions because leaving would interrupt several forms of support at once. Work was indispensable. Its value could not be judged by employment status alone.

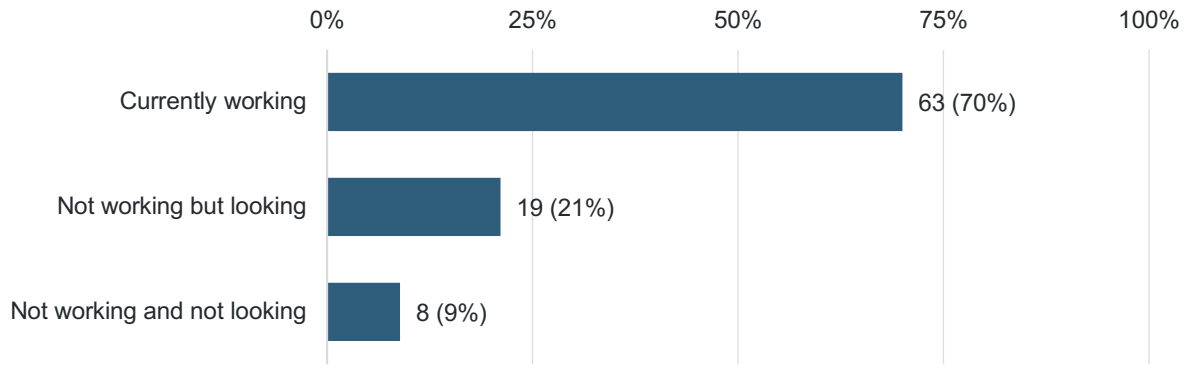
Within the survey sample, 63 of 90 participants reported that they were working at the time of the study. Among current workers who answered the relevant questions, 42 of 61 reported working nine or more hours on a typical day. Eighteen of 62 said they had been paid late or not paid at least once in the previous three months, and 17 of 62 reported unsafe conditions or a risk of injury at least once. Twenty-nine of 62 met the study's exploratory work-risk definition by reporting one or both concerns. These results describe conditions within a community-network-recruited participant group; they are not estimates for Zomi adults in Malaysia as a whole.

Interviews show how work was obtained and what could depend on it. Relatives, friends, community contacts, group messages, and employer referrals frequently opened routes into work. Employers sometimes influenced housing, meals, transport, healthcare, schedules, and contact with authorities in addition to pay. Family obligations shaped the other side of the relationship: one wage might support children, parents, siblings, or relatives abroad. Accounts still varied, from low wages and limited leave to stable work and decisive employer help.

7.1 Who was working, and in what jobs

All 90 survey participants answered the employment-status question. Sixty-three reported that they were working at the time of the survey (70 percent). Nineteen were not working but looking for work (21 percent), and eight were not working and not looking (9 percent).

Figure 7.1. Current employment status among survey participants

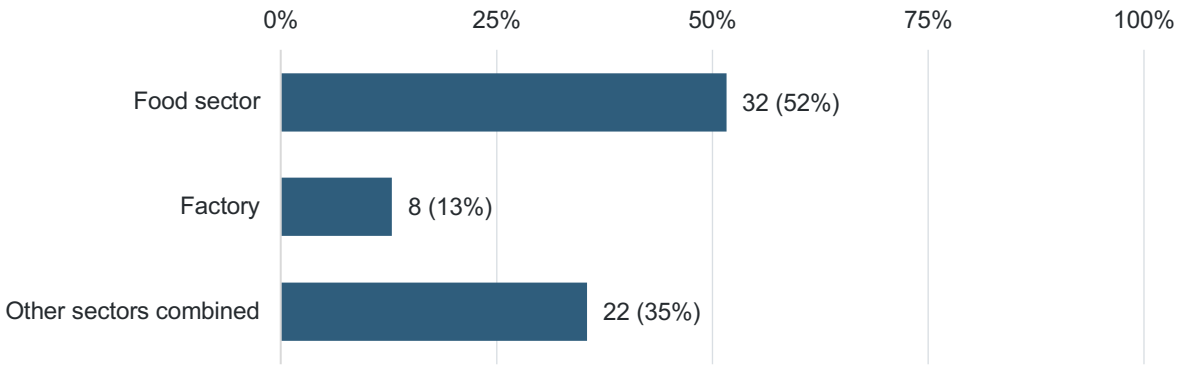


These are the only employment-status categories in the locked workbook. The survey does not show whether the eight participants who were not working and not looking were studying, caring for family members, unable to work because of health or disability, discouraged from searching, retired, or outside work for another reason. Those circumstances should not be assigned after the fact. The

distinction the survey supports is narrower: current work, active job search, and neither current work nor active search.

Sector information was available for 62 of the 63 current workers. Thirty-two of 62 worked in the food sector (52 percent), using the locked grouping of restaurant or food work, bakeries, cafés, and a pet-food market. Eight worked in factories (13 percent). The remaining 22 reported 16 different categories, including hair or beauty work, education, offices, workshops, construction, cleaning, childcare, warehousing, printing, church or NGO work, and other individual occupations. Because each of those raw categories contained fewer than five participants, they are combined rather than emphasized separately in the main figure.

Figure 7.2. Main work sector among current workers



The sector distribution describes where participants worked, not the conditions of every job. Food-sector accounts included long schedules and physical hazards, but the survey did not compare pay, safety, or stability by sector.

The interview corpus included regularly employed workers, people doing occasional or part-time work, caregivers and students who were not employed, and participants who could no longer work because of illness, disability, age, or language barriers. Some interview participants described another household member's work because that person supported the family. The interview and survey samples were recruited separately and are not directly comparable. Their value here is complementary: the survey gives a structured distribution, while the interviews show the different circumstances that can sit behind a short employment-status label.

7.2 Relationships as routes into work

Personal relationships functioned as labor-market infrastructure in the interviews. Participants described jobs introduced by siblings, aunts and uncles, fellow villagers, neighbors, church members, community leaders, coworkers, and friends. Zomi WhatsApp groups carried job announcements. Community offices connected workers to employers. One manager transferred a worker among restaurant branches; another employer referred a worker onward when a restaurant closed.

The sequence described by Interview participant 28 shows how several kinds of connection could operate over time:

> *“My first job in Malaysia was through my uncle, who had already been living here. My second job came through a friend who invited me to work at his restaurant. When that restaurant closed, my employer referred me to another restaurant, where I currently work.”*
> Interview participant 28

The account is not simply about receiving help from relatives. An uncle provided an initial entry point, a friend opened a later opportunity, and an employer became the next link. Each relationship carried information and credibility that the participant could not easily supply through formal documentation.

Other interviews described similar functions in different forms. A fellow villager introduced a participant to an employer. A church member helped a daughter obtain salon work. A community leader circulated factory openings. A young person's English ability made a WhatsApp advertisement usable, after which a manager offered more responsibility. A participant in community mental-health work found a position through a group chat. These routes reduced the cost of searching, helped bridge language barriers, and told an employer that someone known to the network stood behind the applicant.

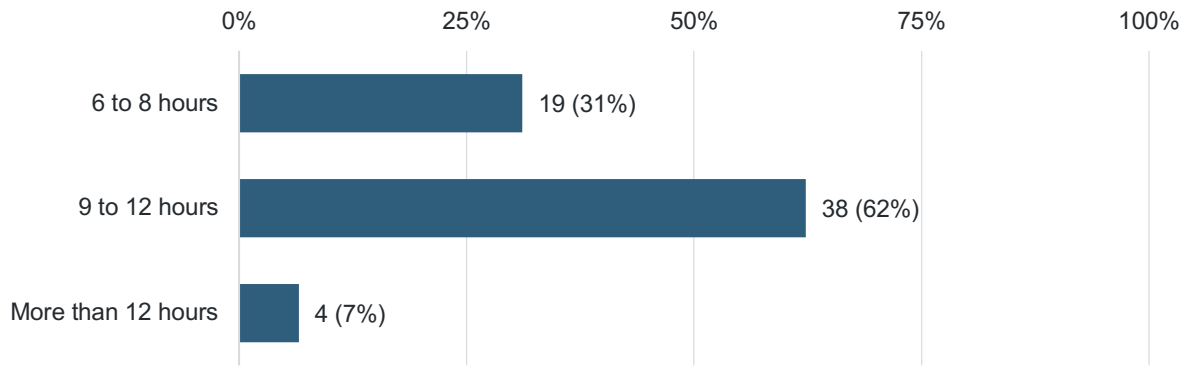
Networks did not guarantee a good job. A referral could lead to stable work, but it could also lead to low pay, long hours, harassment, or employment that ended quickly. One participant's daughter left a job after threats and intimidation. Another participant moved through several occupations before finding work that felt more stable. The same network that created access could become a source of dependency if the worker had few alternatives or feared damaging a relationship by objecting.

The interviews also contain a useful contrast between formal and relational search. Interview participant 28 described applying through an online employment platform and being rejected because the applications did not include the documents employers requested. A friend later connected the participant to restaurant work. This one account cannot establish the relative success of formal and informal job search across the participant group. It does show why a personal introduction could do more than pass along an opening: it could make employment possible when an impersonal screening process stopped at documentation.

7.3 Hours, schedules, and the shape of the workday

Typical daily working hours were reported by 61 of the 63 current workers. Nineteen of 61 reported six to eight hours (31 percent), 38 reported nine to 12 hours (62 percent), and four reported more than 12 hours (7 percent). Thus, 42 of 61 current workers with available data reported a typical day of at least nine hours (69 percent).

Figure 7.3. Typical working hours per day among current workers



The item records hours per day, not days per week, break time, split shifts, commuting time, control over the schedule, or whether additional hours were paid. It cannot establish total weekly hours. Still, the distribution shows that the typical workday extended beyond eight hours for most survey workers who answered.

Interview accounts gave those categories a daily rhythm. Several participants described very long restaurant or factory shifts, while others emphasized narrow control over leave rather than the physical difficulty of the work. One cook explained the scheduling constraint directly:

> *"If there is an emergency, it is difficult to take leave because I must follow my employer's schedule."*
> Interview participant 31

What mattered in this account was not physical intensity alone. The schedule determined whether a worker could respond to an urgent family need, attend an appointment, or recover from illness. Limited leave could convert a manageable job into a fragile arrangement when something outside work demanded time.

Physical demands varied by occupation. Participants described standing throughout the day, construction and farm labor, cleaning, carpentry, factory work, kitchen heat, and lifting or repetitive tasks. Older participants and those with chronic illness described a shrinking range of work they could perform. A job that had once been manageable became irregular after illness or age reduced stamina. Some continued with part-time work because food and rent still had to be paid.

This pattern was not universal. Several participants said the work itself was not especially difficult once they learned it. One carpenter described language in technical drawings as the main obstacle, while the machine-based tasks became manageable after the instructions were understood. Other participants emphasized ordinary adjustment to coworkers and different workplace cultures rather than danger or abuse. Hours and job title therefore provide only part of the employment experience. Skill, health, language, schedule control, and treatment at work changed what those hours meant.

7.4 Payment insecurity and the distance from wages to security

Among 62 current workers who answered the wage question, 18 reported at least one episode of late payment or nonpayment during the previous three months (29 percent). Twelve reported this once and six more than once. One current worker did not answer the item.

The question combines being paid late with not being paid, and the response options do not separate them. It therefore supports a combined statement only. The study cannot determine the amount, duration, cause, or legal significance of the reported payment problem.

The interviews did not mirror the survey item closely. They more often described low wages, perceived unequal pay, unpaid overtime, lack of advancement, unpredictable work, or fear that employment would end than they described a recent payment arriving late. One participant said refugees were sometimes paid less for the same effort. Another described extra factory hours without overtime pay. Several linked low or uncertain income to rent, food, transport, school fees, or medical care. This is a point of expansion rather than direct confirmation: the survey measured recent lateness or nonpayment, while interview accounts described a wider field of payment and income insecurity.

For Interview participant 25, the threat lay in how quickly instability would enter the household budget:

> *"Whenever work becomes unstable, I worry because I don't know how I'll cover my expenses."*
> Interview participant 25

The sentence explains why a worker might tolerate poor communication, limited leave, or an uncertain future. A wage was rarely described as spare income. It had already been assigned to rent, food, transport, healthcare, school, debt, or relatives. When payment or employment became uncertain, the consequences did not remain inside the workplace.

7.5 Safety, injury, and the reach of employer power

The workplace-safety question was answered by 62 current workers. Forty-five said they had not experienced unsafe conditions or a risk of injury during the previous three months (73 percent). Sixteen reported this once (26 percent), and one reported it more than once (2 percent). The combined result was 17 of 62 (27 percent). The item does not distinguish an unsafe condition from perceived injury risk, nor does it show that an injury occurred.

The exploratory work-risk indicator combines the wage and safety items. A current worker met the indicator by reporting late or unpaid wages, unsafe conditions or injury risk, or both. Twenty-nine of the 62 workers with complete responses met this definition (47 percent). The indicator is post hoc and unvalidated. It is not a legal finding of exploitation, a measure of forced labor, or a severity scale; it is a transparent summary of two reported concerns.

Interview participants described burns, gas and fire hazards, lifting, falls, hand injuries, and difficulty obtaining time to recover. One restaurant worker believed foreign workers were steered toward undesirable and physically demanding tasks. These accounts differed in whose experience was described and cannot be counted as equivalent incidents.

Employers sometimes reduced those consequences. Some paid or advanced medical costs, provided accommodation or meals, arranged transport, or helped during an enforcement encounter. In one account, an employer provided both accommodation and transport to routine clinic care.

This broader role gave the employment relationship practical power even when an employer acted generously. Leaving a job could mean losing housing, meals, transport, or access to assistance along with wages. The interviews do not establish that employers used every benefit as leverage. They show that a worker's independence depended partly on whether those supports could be

replaced. Employer provision could be both valuable and difficult to separate from the worker's limited alternatives.

7.6 Documentation, enforcement, and limited room to seek help

Chapter 6 showed that documentation could have practical value without producing a simple boundary between security and insecurity. Employment followed the same pattern. UNHCR documents do not provide Malaysian work authorization, as Chapter 2 explains, but some interview participants believed that employers preferred applicants with a UNHCR card. Others said the card changed little about work conditions. Participants without a card sometimes found jobs through personal referrals, while formal applications could stop when an employer requested a passport or other documentation.

Employment appeared in all three principal documentation groups without a defensible causal pattern. The unadjusted differences could reflect age, health, caregiving, time in Malaysia, job-search pressure, or other measured and unmeasured circumstances.

Interviews help explain why documentation categories did not determine one employment outcome. A participant without a passport described being rejected in online applications and then finding restaurant work through a friend. Another was hired without completed documents after a brother made an introduction and remained with the employer. Cardholders described both stable jobs and poor conditions. Some participants believed a card reassured an employer; others emphasized that it did not change their lack of work authorization or bargaining power.

Enforcement concerns entered the workplace through commuting, operations, and decisions about whether to remain in a job. Participants described arrests at workplaces, coworkers taken during operations, stops while traveling to work, and a worker leaving after colleagues were arrested. An older participant explained that transport costs alone could absorb much of a short job:

> *“For part-time work, transportation is one of the biggest problems because travel costs can take up nearly half of my daily wages. Even so, I still have to work because I need money to pay for food and rent.”*
> Interview participant 30

The cost in this account was financial, but the interview also connected travel to fear of arrest. Work required visibility outside the home. Staying home reduced one form of exposure while removing the income needed for rent and food.

Participants did not describe a clear institutional pathway for resolving employment disputes. Several relied on an employer, community leader, relative, or organization during police or medical emergencies. When a job became intolerable, leaving and finding another job through the same network was often more visible in the interviews than challenging the employer through a formal authority. The evidence does not establish whether formal remedies were unavailable, unsafe, unknown, or simply outside the interview discussion. It does show that documentation and enforcement concerns could narrow the practical room in which a worker considered seeking help.

7.7 Work inside the household economy

Employment became economic security only after a wage passed through the household's obligations. Interview participants repeatedly described rent, food, transport, healthcare, school fees, debt, and support for relatives. Some sent money to parents, children, or siblings in Myanmar.

Others supported dependents living with them in Malaysia. The direction and destination of support varied, but the underlying point was consistent: earnings were shared.

Employer-provided housing and meals changed the calculation. For some workers, these benefits reduced the cash needed each month and made saving or remitting possible. They could also make job loss a housing event. A household living in employer accommodation could be grateful for the arrangement and still have limited control over crowding, cleanliness, or whether the housing would continue after employment ended. Chapter 8 examines those housing circumstances in detail.

Health was one of the clearest routes by which income stopped. Illness, disability, recovery, and caregiving reduced work in several households while medical needs increased expenses. Employer support sometimes prevented an immediate crisis, but could also leave the household dependent on continued work or repayment.

The study did not collect a validated income, consumption, or poverty measure, and interview amounts were not recorded consistently enough to construct one. It therefore cannot classify households by poverty status or compare earnings across sectors. What the interviews establish is relational: a modest but predictable income could support a household; a higher burden could make even regular employment insufficient; and the loss of one wage could move rent, healthcare, and schooling into crisis at the same time.

7.8 Employment was not one story

The chapter's central pattern is insecurity, not uniform exploitation. Twenty-nine of 62 survey workers met the exploratory work-risk indicator, which also means 33 did not. Forty-four of 62 reported being paid on time, and 45 of 62 reported no unsafe condition or injury risk in the preceding three months. These responses should remain visible alongside the accounts of hardship.

Participants also evaluated work through different horizons. For some, the immediate question was whether wages could cover rent. For others, work made it possible to support relatives or save for a future home. One participant, reflecting on employment before serious illness, offered a perspective that resists reducing Malaysia only to hardship:

> *“Malaysia provides many opportunities for healthy people who are willing to work hard. It is possible to save money and support family members back in Myanmar.”*
> Interview participant 34

The phrase "for healthy people" is essential. The same participant later became unable to work, and the household's financial position changed sharply. Opportunity and exclusion could occur in the same life at different times.

Other differences had little to do with documentation alone. Age narrowed job opportunities for some older participants. Illness and disability prevented others from working. Caregiving kept several people at home. A student relied on a sibling's wage. Language limited both job search and task performance. Some workers changed jobs successfully; others remained because they feared that another position would be difficult to find. A person with no completed document could have a supportive employer, while a cardholder could work long hours with little leave.

The interviews therefore support neither a celebratory account of work as straightforward independence nor a single account of employers as exploiters. Work offered income, purpose, skill,

and a way to support others. It could also expose a worker to long schedules, physical risk, uncertain pay, limited leave, and relationships that carried power far beyond the wage.

7.9 Chapter synthesis

Work supplied income and, in some cases, housing, meals, transport, or healthcare, while concentrating risk when those supports were hard to replace. Chapter 8 follows that concentration into housing stability.

Chapter 8. Housing and Household Stability

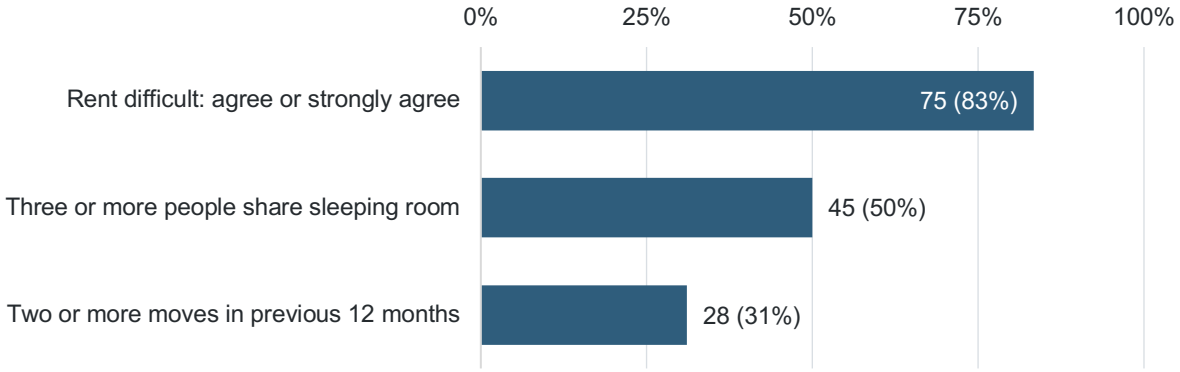
A household could remain under one roof without being certain that it could stay there. Within the survey participant group, almost half had not moved during the previous 12 months, yet most agreed that rent was difficult to pay. Half reported that at least three people shared their sleeping room. Interviews supplied the missing terms of that apparent contradiction: a family might keep its current address by dividing rent with other households, accepting a room connected to employment, relying on relatives, or continuing in a place it would have preferred to leave.

Housing stability therefore involved more than the presence of shelter or the number of recent moves. It also depended on whether a household could meet the next payment, absorb a lost wage or medical bill, maintain tolerable relationships in shared space, and exercise some control over where and how it lived. Participants described homes that were crowded but cooperative, stable but expensive, rent-free but tied to a job, physically adequate but difficult to inhabit because of a neighbor, or peaceful while still exposed to enforcement fears. The same arrangement could provide support and create dependency at once.

All 90 survey participants answered the core housing items used in this chapter. Seventy-five agreed or strongly agreed that rent was difficult to pay (83 percent). Forty-five reported that three or more people shared their sleeping room (50 percent), and 28 reported moving at least twice during the previous 12 months (31 percent).

The exploratory housing-risk indicator records whether a participant reported at least one of those three conditions. Eighty of 90 participants met it (89 percent). This broad flag is strongly influenced by the rent item and does not measure tenure, habitability, eviction risk, homelessness, or severity. The component findings remain more informative than the combined value.

Figure 8.1. Components of the exploratory housing-risk indicator

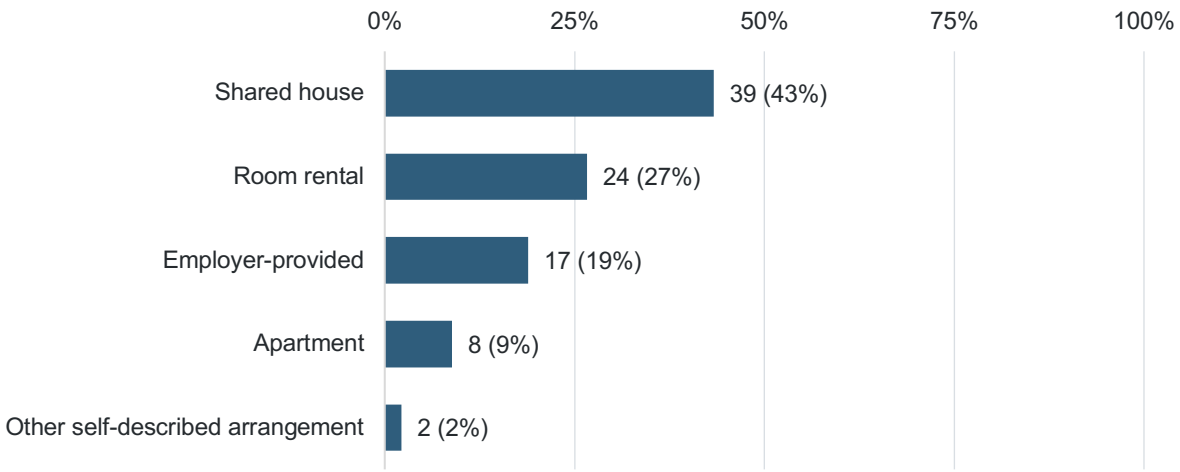


Interviews broadened the analysis beyond the survey items. Participants described rent pressure, crowded or uncomfortable space, repeated movement, employer dependence, landlord rejection, neighborhood conflict, and limited authority within a household. Others described shared or relative housing as comfortable, secure, or free of interpersonal problems.

8.1 Housing and household arrangements among participants

The most frequently reported survey category was a shared house, selected by 39 of 90 participants (43 percent). Twenty-four reported renting a room (27 percent), 17 reported employer-provided housing (19 percent), and eight reported living in an apartment (9 percent). Two participants used other self-described categories. Those two categories are combined in the publication figure because each contained one person, and the workbook's misspelling of "employer-provided" is corrected for presentation.

Figure 8.2. Current housing arrangements reported by survey participants



These categories describe the type of current arrangement as participants understood it. They do not form a complete tenure classification. A "shared house" might involve relatives, unrelated tenants, or several families. A "room rental" could sit within a house or apartment. Employer-provided accommodation could be free, subsidized, deducted from wages, or governed by another arrangement; the survey did not ask. The categories therefore should not be translated into assumptions about ownership, lease rights, rent payment, or control over the dwelling.

Household size and sleeping-room sharing measured different things. The questionnaire materials do not define whether “household” included unrelated co-tenants or whether the sleeping-room count included the participant. The report therefore preserves both measures as recorded rather than inferring total dwelling occupancy.

Interview accounts revealed the range concealed by a single housing-type label. Some participants rented one room within a larger apartment. Others lived with adult children, siblings, in-laws, grandchildren, unrelated tenants, coworkers, or several family units. A few lived at or near a workplace. Some children or young people stayed in school hostels because daily travel was difficult. Housing could therefore organize caregiving, schooling, work, and social support as much as sleeping space.

The interview and survey samples are separate and should not be treated as if they describe the same households. Their patterns are nevertheless complementary. Shared houses and room rentals were common categories in the survey, while the interviews show that sharing could mean mutual

financial support, care across generations, limited privacy, conflict over common space, or several of these at once.

8.2 Finding a place to live

Housing was often reached through a person or institution already connected to the participant. Relatives offered an initial place to stay, helped search for a room, or incorporated a new arrival into an existing household. Friends hosted participants while they looked for work. Employers arranged accommodation for workers. In a smaller number of accounts, a school or hostel became an alternate residence for a child or young person.

These relationships lowered immediate barriers. A new arrival did not necessarily have to identify a landlord alone, communicate in an unfamiliar language, or pay for an entire dwelling. Relatives could explain an area and make introductions. An employer could place a worker near the job. Sharing with people already known to the household could reduce both rent and uncertainty.

The interviews also show the limits of relying on access through relationships. Interview participant 03 became seriously ill, temporarily stayed with an aunt, and then asked other relatives to help locate a room. Several landlords reportedly refused after learning about the illness. The participant eventually found lower-cost housing, but only after repeated rejection. In this account, family connections made continued searching possible; they did not guarantee that a landlord would agree.

Other participants remained in arrangements established by family or work because alternatives were difficult to afford. One participant stayed with in-laws after illness and unemployment narrowed the household's options. Another initially stayed with a friend until the same social network secured a job and transport to the workplace, where employer accommodation was available. The path into housing was intertwined with the path into work.

8.3 Rent and the household budget

Rent difficulty was the most frequently met component of the exploratory indicator. Twenty-nine of 90 participants strongly agreed that rent was difficult to pay, and 46 agreed. Eleven were neutral, one disagreed, and three strongly disagreed. The combined result was 75 of 90 participants agreeing or strongly agreeing (83 percent).

The item records agreement with a statement, not a formal affordability measure. It does not provide the rent amount, household income, income-to-rent ratio, arrears, debt, lease terms, or risk of eviction. It was also answered by everyone, including participants who reported employer-provided housing, and it did not ask who personally paid rent. The result should therefore be read narrowly: rent was reported as difficult within most of this participant group.

In other interviews, rent competed with a more variable or fragile income. Participants described one wage supporting several people, older adults unable to find work, illness reducing earning capacity, childbirth interrupting employment, or an employer closing a business. Rent then became part of a sequence of household decisions rather than an isolated bill. A late wage, medical payment, school fee, or period without work could narrow what remained for housing.

Some participants responded by renting a room rather than an entire dwelling, bringing relatives into the household, or sharing with another family. Others relied on employer accommodation. These strategies could make housing possible without making the budget comfortable. Chapter 7 showed

how wages were often already committed to several people and expenses. Housing was the place where that financial concentration became most visible.

The interviews do not support a single threshold at which rent difficulty became a housing crisis. Some participants described pressure but no move or conflict. Others connected lack of money to staying in a crowded home, remaining near a difficult neighbor, or depending on relatives. The survey cannot identify which of those circumstances applied to any particular response.

8.4 Shared space, privacy, and household life

Twenty-seven survey participants reported one person sharing their sleeping room, 18 reported two, 25 reported three to four, and 20 reported five or more. The study's exploratory indicator treats the last two categories as three or more people sharing the room: 45 of 90 participants (50 percent).

The survey does not record room size, total dwelling size, ventilation, the age or sex of occupants, whether occupants belonged to one family, or how participants felt about the arrangement. It therefore cannot determine whether a room met a legal or international overcrowding standard. The measure is best understood as reported sleeping-room sharing.

Interviews show why numerical density did not have one meaning. Interview participant 05 linked sharing directly to affordability:

> *“We cannot afford to rent an entire apartment by ourselves. We share a three-bedroom apartment with two other families. Living together requires cooperation, mutual respect, and understanding so that everyone can live peacefully.”*
> Interview participant 05

The arrangement reduced cost, but it also required work: coordination, patience, and a shared understanding of how common space would be used. Cooperation was part of the housing system.

Privacy and authority mattered alongside space. Some participants could negotiate cleaning, noise, or shared areas with coworkers. Others felt less able to speak. In an in-law household, Interview participant 36 described the constraint in relational terms:

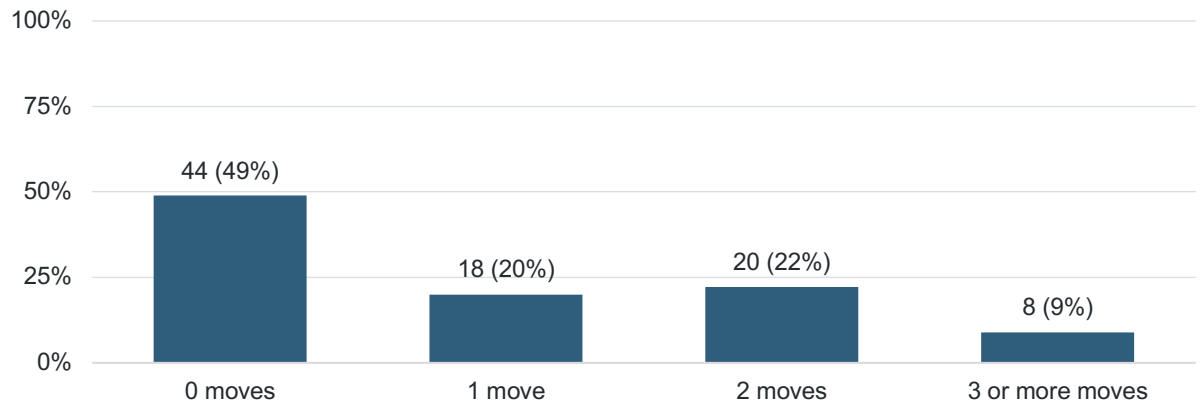
> *“Even if I want to say something, I am also just the daughter in law. So I haven’t said anything and have just been living like this.”*
> Interview participant 36

The problem was not only the room's size. Economic dependence and family position limited the participant's ability to ask for a different arrangement. The interviews thus point to control over household terms as a dimension of stability that the room-sharing count cannot capture.

8.5 Moving, staying, and residential stability

Twenty-eight of 90 participants reported moving at least twice during the previous 12 months (31 percent), including eight who moved three or more times. Eighteen reported one move, and the remainder reported no move.

Figure 8.3. Residential moves reported in the previous 12 months



The item records a count, not the reason, distance, or consequences of a move. It does not show whether a move was voluntary, constrained, temporary, connected to a job, made to join family, caused by rent, or forced by a landlord or enforcement event. Moving once and moving repeatedly are visible in the distribution, but the survey cannot classify either as residential instability by itself.

Interview accounts described several pathways. A participant moved after an injury ended work in one area and another job became available elsewhere. A seriously ill participant left one residence, stayed temporarily with family, and then searched for a room. One household moved from a relative's room into its own place. Other participants described repeated relocation during immigration operations. These experiences should not be collapsed into one category.

Staying could also be constrained. One household reported conflict with a neighbor, could not afford another place, and began spending time away from home. A stable address can therefore conceal reduced use of the dwelling.

Other households stayed because the arrangement worked. Relatives divided expenses, cared for children, or provided companionship. A landlord's understanding made a residence with water problems more tolerable. A participant with expensive rent still called the housing stable. These cases show why stability should not be equated either with immobility or with the absence of material problems.

8.6 When housing depended on employment or institutions

Seventeen of 90 survey participants selected employer-provided housing. The survey did not ask whether the arrangement was tied to the participant's current job, what it cost, who else lived there, or what would happen if employment ended. The label establishes that an employer was understood to provide the accommodation, but not the terms.

Several interviews show the immediate benefit. Employer housing reduced or removed a cash expense, located workers near their jobs, and sometimes included meals. One employer allowed a family to remain in a hostel after pregnancy and childbirth interrupted the participant's work. Another arrangement enabled a worker to send more of the wage to family abroad. For someone newly arrived or unable to rent a full dwelling, the room could be decisive.

Another participant lived alone in employer-arranged accommodation and described isolation rather than crowding. A different worker reported dirty shared quarters and unequal expectations around cleaning, while also benefiting from not paying rent and from employer transport to a clinic. These accounts resist a simple judgment. Employer provision could be humane, stabilizing, uncomfortable, dependent, or several at once.

What made the arrangement structurally important was the number of needs attached to the employment relationship. If a job ended, a participant might lose wages, accommodation, meals, proximity to work, or access to an employer who helped during illness. The interviews do not establish that employers threatened to withdraw housing or used it deliberately as leverage. They do show that replacing a job could require replacing a home at the same time.

Institutions played smaller but related roles. School hostels allowed some children or young people to attend when travel was difficult, but they also separated them from ordinary household life. Churches and relatives offered temporary shelter during enforcement warnings or personal crisis. These arrangements widened access without necessarily giving the household long-term control over residence.

8.7 Documentation, enforcement, and the use of home

Chapter 6 documented how enforcement concerns changed routes, travel, and daily routines. In the housing accounts, those concerns sometimes changed where participants slept or whether they remained at home.

Interview participant 11 linked repeated movement to an operation in the neighborhood:

> *“There was an immigration operation in our neighborhood before, and because of that many families, including ours, had to move from place to place constantly to stay safe.”*
> Interview participant 11

Another participant described a family moving frequently for the same reason. Others reported leaving home temporarily after warnings, going to a church or another person's house, or avoiding their residence for several days. These are different events: repeated relocation, a temporary place to hide, and short-term absence from home should not be described as though they were the same kind of move.

The interviews also include participants who did not move but restricted their use of the surrounding area. Some stayed close to work, rarely left employer accommodation, or remained indoors when reports circulated. One participant described a current home as secure while still losing sleep when news of an operation spread. Home could operate as protection from exposure and as a boundary around daily life.

Documentation circumstances did not create a simple housing division. Survey participants in all three principal documentation groups reported rent difficulty, shared sleeping rooms, and recent moves. Because the housing subgroup patterns were broadly high and the two-person "other documentation" category was too small to interpret, no documentation-by-housing table is emphasized here. The survey cannot establish whether documentation affected access to a landlord or caused a move. Interviews indicate that enforcement fear shaped some residential decisions, but not all of them.

8.8 Housing, health, caregiving, and children

Housing needs changed with children, caregiving, and health, but those relationships are not interpreted as causal. The detailed household subgroup comparisons are reserved for the cross-domain analysis.

Family needs entered housing decisions through shared costs, childcare, school location, and access to work or healthcare. Grandparents sometimes provided care while a parent worked, and hostels or moves altered how often children were at home.

Health could change both housing need and access. Serious illness stopped work in some households, reduced rent capacity, or narrowed the set of landlords and arrangements available. In other cases, continued employer or family housing prevented immediate displacement.

These connections are developed in later chapters. Chapter 9 examines healthcare costs, safety, and access; Chapter 10 addresses schooling and educational continuity. The purpose here is narrower: illness, caregiving, and children changed what kind of space a household needed, where it could live, and how much disruption it could absorb.

8.9 Housing was not one experience

The survey's high combined indicator should not erase the differences within it. Ten of 90 participants met none of the three selected conditions. Twenty-seven met one, 38 met two, and 15 met all three. Because the indicator is binary, those distinctions disappear in the headline 80 of 90 result. Nor does the absence of an indicator condition prove that a home was safe, adequate, or under the participant's control.

The interviews provide equally important counterexamples to a uniform account of hardship. Interview participant 19 described shared family housing as a source of support:

> *“I currently live with relatives, and overall I feel comfortable staying with them. Living together helps us support each other emotionally and financially.”*
> Interview participant 19

Other participants said that living with renters, relatives, or several people in one house caused no particular problem. One described a relatively safe neighborhood despite being homebound for other reasons. Another described housing as stable even while rent was burdensome. A participant with unreliable water also described an understanding landlord. These accounts do not negate the reports of pressure; they show which features made an arrangement more workable: trusted relationships, shared costs, practical care, tolerance, and some continuity.

Conditions could also change over time. A participant might begin with a friend, move into employer housing, and later view the arrangement as acceptable but limiting. A family could remain comfortably with relatives until a job loss or illness changed the budget. A stable address could become difficult after conflict with a neighbor or an enforcement warning. Conversely, a participant could find lower-cost housing after rejection or move from a relative's room into a more independent place.

The relevant distinction was therefore not "shared" versus "private," "moved" versus "stayed," or "employer-provided" versus "rented." Stability depended on whether the household could sustain the arrangement and exercise meaningful control within it. Sharing sometimes expanded that control by pooling money and care. In other cases, dependence narrowed the ability to object, leave, or plan.

8.10 Chapter synthesis

Housing stability depended on affordability, control, and the replaceability of shared or employer-linked arrangements, not simply on whether a household moved. Chapter 9 traces the same distinction between available care and care that could be completed.

Chapter 9. Healthcare Access and Safety

Reaching a clinic or hospital did not necessarily mean that care was usable. Participants also had to decide that an illness could no longer be managed at home, travel without feeling exposed, present documents, communicate with staff, find the money for fees and medicine, miss work or arrange care for children, and return for follow-up. A problem at any point could delay or interrupt the sequence. The interviews also show the reverse: a relative who translated, an employer who provided transport, a community worker who prepared papers, or a clinic known to serve refugees could turn an available service into care that a household could actually use.

Within the survey participant group, the usual first response to illness was most often a pharmacy or home care. Forty-one of 90 participants selected a pharmacy (46 percent), and 38 selected home care (42 percent). In the previous three months, 20 of 90 said they had needed healthcare but had not gone: 16 reported this once and four more than once. Forty-nine of 90 disagreed or strongly disagreed that healthcare felt safe for people like them (54 percent).

The study combines the unmet-need and safety items in an **exploratory healthcare access/safety indicator**. A participant met the indicator by reporting an unmet healthcare need, disagreeing or strongly disagreeing that healthcare felt safe, or reporting both. Fifty-seven of 90 participants met at least one condition (63 percent). Of the 90, 12 reported both conditions, eight reported unmet need without feeling unsafe, 37 felt unsafe without reporting unmet need, and 33 reported neither.

The indicator is post hoc, unvalidated, and deliberately simple. It is not a measure of clinical need, quality of care, discrimination, affordability, legal entitlement, or severity. A participant reporting unmet need, a participant feeling unsafe, and a participant reporting both receive the same binary value. The separate components are therefore more informative than the combined percentage alone.

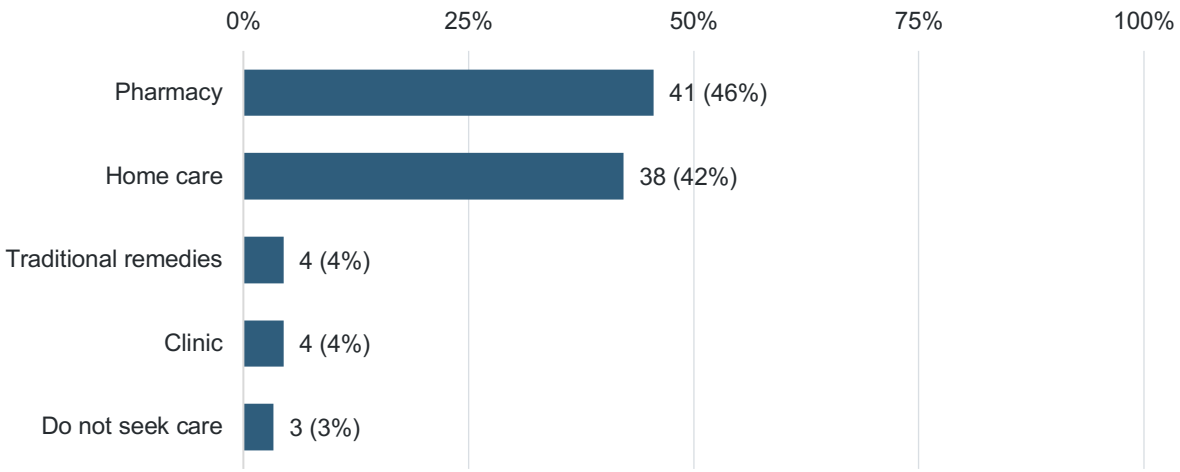
The interviews explain what those components could contain. Cost was the most recurrent healthcare concern. Home treatment, over-the-counter medicine, informal advice, or delayed professional care appeared across many accounts, while several participants described language or interpretation problems. These patterns are used to explain pathways, not to estimate prevalence.

Chapters 6 through 8 established the conditions surrounding care: documentation and movement, employment and wages, and housing and household stability. This chapter focuses on the point at which those conditions met illness. Access depended on a chain. It also varied: several participants obtained routine or urgent care, some described respectful treatment or practical support, and others reached care only after several problems had been solved at once.

9.1 What participants usually did first

The survey asked, "When you are sick, what do you usually do first?" All 90 participants answered. A pharmacy was the most common response, reported by 41 participants, followed closely by home care, reported by 38. Four selected traditional remedies, four selected a clinic, and three selected the response recorded in the workbook as "Do not seek car," treated here as the typographical error "Do not seek care."

Figure 9.1. Usual first response when sick



The question concerned the participant's usual first action, not every episode of illness and not necessarily the behavior of the entire household. It did not define home care, ask what was purchased at a pharmacy, distinguish minor from serious symptoms, or record what happened next. A first response of home care or pharmacy use therefore should not be read automatically as rejection of formal medicine or proof that needed treatment was delayed.

The interviews supplied the sequence missing from the single-choice item. Participants described taking paracetamol or another over-the-counter medicine, asking a relative or community member for advice, monitoring symptoms, and then moving to a clinic if the illness did not improve. A clinic might provide a prescription or refer the patient to a hospital. Some households already knew which community or charitable clinics they considered affordable. Others searched for the lowest-cost option each time.

This stepped approach often functioned as household triage. For minor coughs or fevers, participants described medicine at home as sufficient. A participant who had experienced only a cold and cough went to a clinic with employer transport and reported no serious access problem. Another participant contacted a Zomi clinician for advice and used scheduled clinic care for a child's recurring condition. These were not accounts of abandoning care; they were ways of matching the response to the perceived severity and available resources.

Severity could also collapse the sequence. Interview participant 03, describing serious recurring illness in the household, said:

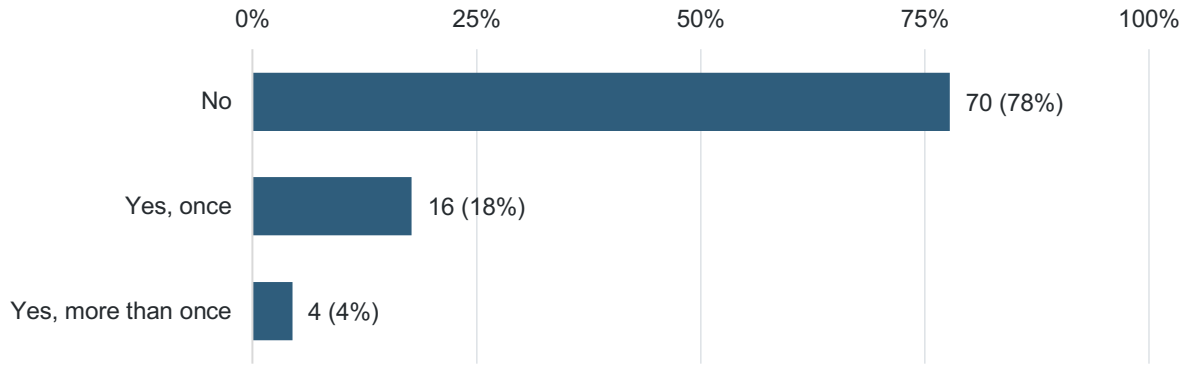
> *"Even though treatment is expensive, we still have to go because our illnesses are serious and we want to recover."*
> Interview participant 03

In that account, the problem was not recognizing the need or valuing treatment. Serious symptoms made hospital care unavoidable even when the household could not meet the cost without help. Across the interviews, the point at which people sought formal care differed with the illness, prior experience, cash available that day, work obligations, and whether someone could accompany them.

9.2 Needing care but not going

The survey's unmet-need item asked whether, in the previous three months, the participant had needed healthcare but not gone. Seventy of 90 answered no (78 percent), 16 reported one occasion (18 percent), and four reported more than one (4 percent). The combined unmet-need result was 20 of 90 participants (22 percent).

Figure 9.2. Reported unmet healthcare need in the previous three months



The wording captures the participant's own assessment of need. It does not establish that a clinician considered care medically necessary, identify the illness, or distinguish never beginning treatment from delaying it beyond the three-month window. It also does not show whether the participant was refused, received partial treatment elsewhere, could not complete follow-up, or decided that the symptoms had improved. "Needed healthcare but not go" should therefore be read narrowly as a reported unmet healthcare need.

The interviews contained several different pathways that could produce an incomplete course of care. Some participants postponed a clinic or hospital visit while trying medicine at home. Some attended an initial visit but described difficulty paying for tests, admission, prescriptions, or later appointments. A participant with recurring medication and scheduled checkups said financial constraints sometimes made it impossible to attend on time. Another household received a recommendation for hospital treatment but went only when enough money was available. Interview participant 07 described that limit in one sentence:

> *“We can only visit the hospital when we have enough money.”*
> Interview participant 07

This did not mean that cost was the only reason care was delayed. Work schedules, transport, language, caregiving, long waits, uncertainty about documents, and fear during travel appeared in other accounts. Nor did every participant wait. Several used clinics directly, and some went to a hospital when symptoms were severe.

A follow-up barrier item did not align with the unmet-need response pattern: responses were present for participants reporting no unmet need and blank for those reporting an unmet need. Because the skip logic cannot be interpreted securely, its selections are excluded from the chapter's estimates.

9.3 Cost extended beyond the bill

Cost was the most recurrent healthcare issue in the interviews. Participants referred to registration charges, clinic visits, hospital deposits, tests, medicine, transport, and recurring prescriptions. Individual amounts differed by reported illness and setting and are not treated as typical prices.

The interviews show why the meaning of cost was wider than a fee. Paying for care could require losing wages, asking an employer for an advance, borrowing from relatives, delaying rent, using savings, or relying on a church collection. A household with chronic medical needs described the hospital as affordable only on some days. Another participant could obtain monthly medicine but not always keep a six-month checkup schedule. In a household with serious illness, treatment continued because a pastor paid costs that the family had not been able to repay.

Illness also changed the income side of the calculation. Several participants or family members could no longer work because of pain, disability, pregnancy, recovery, or recurring symptoms. Medical spending then rose while earnings fell. In one household, savings that had supported daily life were exhausted during treatment. In another, an employer paid for surgery, but the payment became debt owed back to the employer. Community assistance could make care possible without restoring the household's financial margin.

Interview participant 03 presented the other side of delay: when illness was serious, the household continued despite the cost. That distinction matters. Financial strain did not always result in no care. It could instead produce debt, dependence, incomplete follow-up, or sacrifice elsewhere in the household. The interviews cannot quantify those consequences, but they show that "received care" and "could afford care" were not equivalent.

The survey did not collect income-to-medical-spending ratios, total healthcare expenditure, borrowing, or a validated affordability threshold. It therefore cannot determine catastrophic health expenditure or compare the financial burden across households. The interviews support a narrower conclusion: participants often understood healthcare as a cost that had to be absorbed through work, debt, savings, or relationships before treatment could continue.

9.4 Documents at registration and the limits of financial relief

Chapter 6 distinguished UNHCR-related documentation, pending documentation circumstances, community-issued cards, passports, and the Malaysian authorizations those documents did not create. In healthcare accounts, participants discussed documents mainly in relation to registration, fee reductions, identity verification, referral, or contact with an organization.

Several participants reported that a UNHCR card reduced fees at a government hospital, often describing the reduction as 50 percent. Others said that community cards or referral papers helped them register at a clinic or hospital. One participant without a UNHCR card used a passport when the hospital requested identification. A different household described a community-issued document as enabling a medical check while its UNHCR application remained pending. These are participant reports about specific encounters, not verification of a uniform policy across institutions or time.

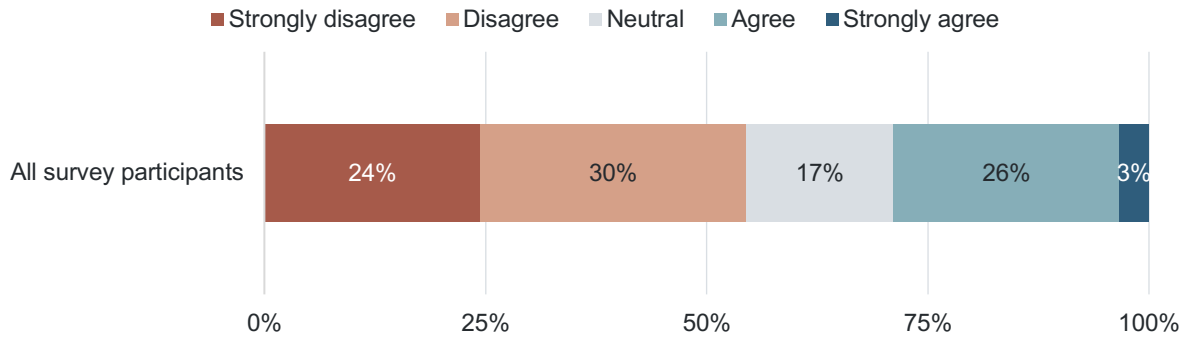
Survey participants in each principal documentation group reported unmet need, lack of perceived safety, or both. The small, unadjusted subgroup differences did not form a clear protective gradient and are not emphasized in this chapter.

Interview accounts explain why a clean gradient was unlikely: a document could help at registration or reduce a charge while leaving travel, language, waiting, medicine, lost wages, follow-up, and the remaining bill unresolved.

9.5 Feeling safe enough to seek care

All 90 survey participants responded to the statement, "Healthcare feels safe for people like me." Twenty-two strongly disagreed (24 percent) and 27 disagreed (30 percent). Fifteen were neutral (17 percent), 23 agreed (26 percent), and three strongly agreed (3 percent). In grouped terms, 49 felt unsafe, 26 felt safe, and 15 selected the middle response.

Figure 9.3. Agreement that healthcare feels safe for people like the participant



The statement did not specify where safety began or ended. It could refer to the journey, registration, the interaction with staff, the possibility of a documentation check, the ability to communicate, being alone while ill, anticipated cost, or a prior experience. The survey cannot separate those meanings. Disagreement should not be translated into a claim that a healthcare worker threatened the participant or that a particular facility was objectively dangerous.

The interviews nevertheless show why safety belonged in an access chapter. For some participants, the trip itself required planning because of police or immigration concerns described in Chapter 6. One participant reported nearly being arrested while traveling to a hospital after leaving application papers behind. Others connected documentation to greater peace of mind during medical appointments. A participant with children went out only when necessary, although illness and caregiving also limited movement.

Safety inside care settings varied. Some participants reported feeling deprioritized or treated differently as foreigners. One participant described a difficult emergency and maternity experience that created lasting stress about appointments. Another reported that a private hospital did not treat the participant without recognized documentation. These are specific accounts and should remain attributed; they do not establish the conduct of hospitals generally.

Counterexamples are equally important. Interview participant 21 explicitly reported no experience of discrimination by a doctor. Interview participant 34 also said the household had not experienced healthcare discrimination, while still describing language and cost problems. Others used clinics routinely, received referrals, or said treatment improved a child's health. A participant who usually went to a refugee-supporting clinic described the care pathway as manageable even though expenses could strain the family.

The survey's 26 positive and 15 neutral responses are consistent with that variation. Feeling unsafe was common within the participant group, but not universal. The interviews suggest that a person could feel safer because of a card, a familiar clinic, prior successful treatment, or another person's presence without believing that every part of the process was secure.

9.6 Language, transport, and accompaniment

Several interview participants described healthcare-specific language or interpretation problems. The consequences ranged from inconvenience to uncertainty about symptoms, forms, diagnoses, or appointments.

Interview participant 29 described repeated hospital use for a child without receiving an explanation the participant could understand:

> *“For my daughter we often go to the hospital, I'm not sure what's wrong with her as I'm not able to ask due to language barrier, and the interpreter doesn't give the details either.”*
> Interview participant 29

The barrier here was not simply reaching the hospital. Treatment occurred, but information did not travel back to the parent in a usable form. Access without comprehension left uncertainty about the child's condition and future decisions.

Accompaniment could solve several problems at once. A companion might arrange a ride, speak with staff, carry documents, complete forms, provide money, watch a child, or reassure someone who feared traveling alone. For Interview participant 24, money by itself would not have resolved the difficulty:

> *“Even if we were to have the money for it, it's still a lot of stress when you don't know the language and you're sick, needing to consistently find someone to go with you.”*
> Interview participant 24

That account shows why language and accompaniment should not be treated as secondary conveniences. A person could know that a hospital existed and still need another person's time before using it.

Transport added another condition. Participants referred to fares, distance, routes perceived as risky, and the difficulty of traveling while weak or caring for a child. Employer transport made one routine clinic visit straightforward; elsewhere, the journey required another person's time and money.

Accompaniment was not always evidence of dependence. Family members ordinarily care for one another, and several participants described accompanying a parent or child as a normal household responsibility. The structural issue arose when care depended on finding someone who could leave work, speak the necessary language, travel safely, and remain available. When that person was unavailable, several links in the chain failed together.

9.7 Work, caregiving, and the timing of care

The interviews explain the practical tension. Some workers had long or inflexible shifts. A spouse could not take leave except for an emergency. A household member with a work injury reportedly wanted time to recover but did not receive approval. Participants also described working while in pain or becoming too tired to manage recurring symptoms. Even when permission was available, an appointment could remove a day's wages.

One worker described illness as an immediate loss of income. When one wage supported several people, a missed shift could affect rent, food, school fees, medicine, or remittances.

Caregiving shaped timing as well. Parents had to bring children, remain during admission, arrange care for siblings, or travel while recovering themselves. Older adults relied on adult children who were also working. Participants caring for relatives with disability or chronic illness described repeated appointments rather than a single encounter. An appointment therefore required coordinating the patient's condition with the schedules and responsibilities of the people around them.

Employer behavior varied. Some employers paid injury costs, advanced money, granted continued housing, or drove a worker to a clinic. Other accounts described limited leave or no help. The study cannot determine how common either practice was, but the difference could decide whether care happened promptly and whether the resulting cost became assistance, debt, or lost income.

9.8 The people and institutions that made care possible

Healthcare was often reached through relationships. Families and friends gave advice, translated, arranged rides, loaned money, accompanied patients, and cared for children. Churches and community organizations raised funds, prepared documents, contacted hospitals, connected participants with clinicians, and intervened when someone did not know where to go. Employers sometimes provided transport or paid part of a bill. Community and charitable clinics offered a familiar entry point for routine care.

The range of functions matters. "Support" could mean information, a physical journey, communication at registration, direct payment, a loan, or the presence of another person. These forms were not interchangeable. A participant might have someone who could translate but no one who could pay. A community office might prepare paperwork but not control whether a hospital accepted it. Fundraising could cover one visit without sustaining recurring treatment.

Employer behavior varied. Some provided transport, paid or advanced part of a bill, or granted leave; others offered little flexibility. One participant described a simple route to routine clinic care through an employer, without reporting a serious recent health problem.

The interviews also show the limits of celebrating these arrangements. Employer payment could become debt. A relative who accompanied a patient lost time of their own. Pastors and church members absorbed costs that institutions did not. Community staff carried translation, documentation, and emergency-navigation work. Support made care possible in many accounts; it did not make the need for improvised coordination disappear.

9.9 Healthcare was not one experience

The headline results are substantial: 20 of 90 survey participants reported an unmet need, 49 of 90 felt healthcare was unsafe, and 57 of 90 met the exploratory indicator. They should not erase the 33 participants who reported neither condition, the 26 who agreed healthcare felt safe, or the different first responses reported across the sample.

The interviews show variation at every stage. Some participants used medicine at home and recovered. Some contacted a clinician they trusted. Some went first to a clinic; others went directly to a hospital when pain became severe. Several reported that documentation reduced a fee, while others described a community card, passport, referral paper, or companion as the document-related

help that mattered in a particular encounter. A lower charge could be manageable for one household and still impossible for another.

Experiences with providers also differed. Some participants perceived delayed or unequal treatment, while others said they had not experienced discrimination. Some were uncertain whether a problem reflected language, cost, status, waiting procedures, or staff conduct. A positive encounter did not remove other burdens: a participant could receive effective treatment and still incur debt, lose wages, or depend on a translator.

Nor did home treatment carry one meaning. For some, it was an ordinary first response to a minor illness. For others, it was a bridge while waiting to see whether symptoms improved. In a smaller number of accounts, it replaced recommended or desired care because admission, follow-up, or transport was unaffordable. The evidence does not support treating all self-care as unsafe or all hospital use as complete access.

The strongest cross-cutting distinction was between knowing that care existed and being able to complete the pathway. Documents, money, language, transport, work time, caregiving, and support affected different stages. No single factor explains all accounts, and no participant necessarily faced every barrier.

9.10 Chapter synthesis

Healthcare became usable only when participants could complete the steps from illness recognition through travel, communication, payment, treatment, and follow-up. Chapter 10 examines a similar continuity problem in children's learning.

Chapter 10. Children’s Education

A place to learn was not the same as a continuous path through education. A child or young person could obtain a place in a community program yet still face fees, a long or unsafe journey, instruction in an unfamiliar language, placement below the expected level, limited support, or no clear next step. Families sometimes solved one part of that sequence through a church sponsor, a teacher’s exception, a hostel, or the earnings of another household member. Those arrangements could be meaningful and stable. They could also remain dependent on resources that were difficult to sustain.

Of the 90 adults surveyed, 48 reported children under 18 in their household. Among those 48 household reports, 26 indicated church- or community-based learning, labeled "informal" in the survey, five formal learning, one home schooling, one a mixture of participating and non-participating children, and 15 no current school or learning arrangement. Twenty-four of 48 participants (50 percent) disagreed or strongly disagreed that children could learn safely and consistently.

These are household reports from adults, not child-level data. The survey does not establish the number or circumstances of individual children, regular attendance, or recognized progression. The “Both” response confirms that children within one household could have different arrangements. Results cannot be converted into enrollment, attendance, dropout, or out-of-school rates.

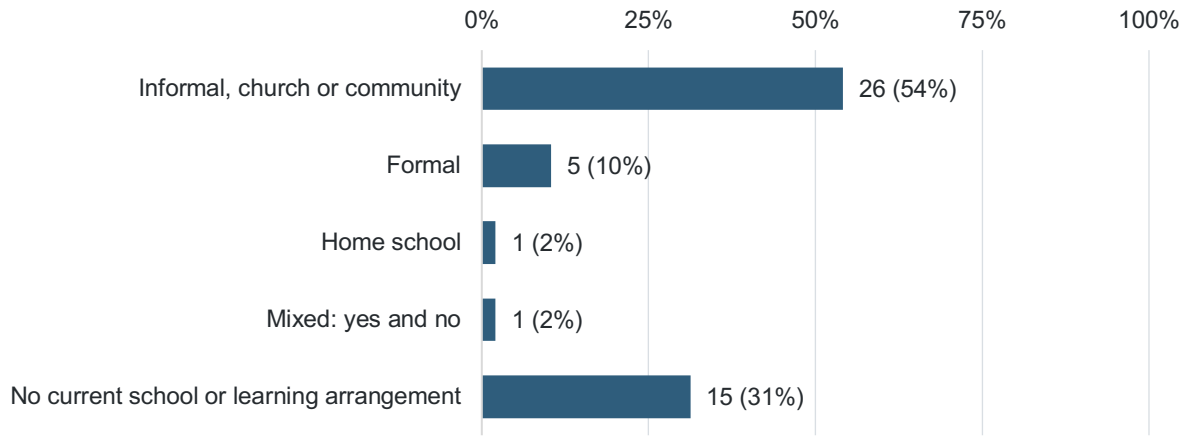
Interviews add the stages the survey could not capture: finding an option, securing a place, covering fees and transport, reaching the site, managing the language of instruction, entering at a workable level, attending over time, and identifying a next step. Accounts came from parents, caregivers, students, relatives, and people who knew little about education; they remain adult reports.

10.1 Learning arrangements reported by participant households

All 90 survey participants answered whether children under 18 lived in their household. Forty-eight said yes (53 percent), and 42 said no (47 percent). The 48 participants reporting children under 18 all answered the two follow-up education items.

The learning-arrangement item asked, “Are the children currently attending school or learning?” Its recorded categories were household-level and mutually exclusive in the workbook. Twenty-six of 48 participants selected “Yes, informal (church/community)” (54 percent). Five selected “Yes, formal” (10 percent), one selected “Home School” (2 percent), and one selected “Both (Yes and No)” (2 percent). Fifteen selected “No” (31 percent).

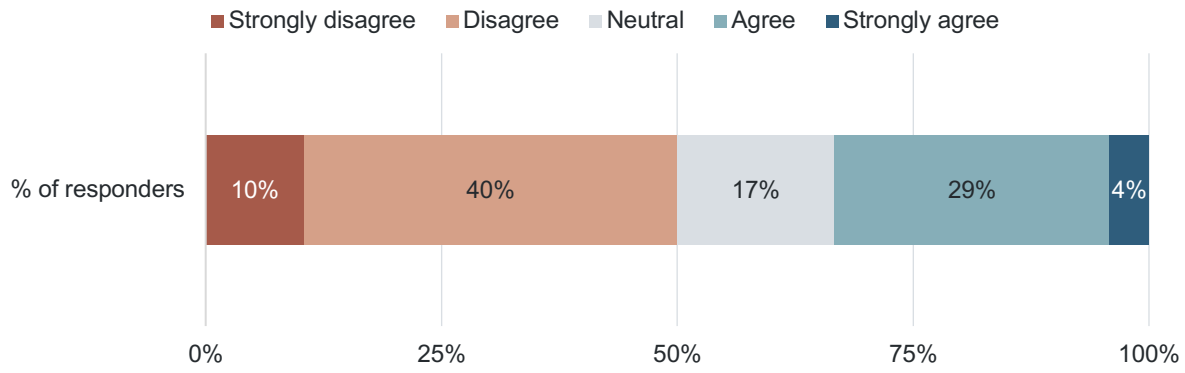
Figure 10.1. Current school or learning arrangements reported by participants with children under 18 in the household



The study materials do not supply an operational definition that would allow the survey labels “formal” and “informal” to be mapped reliably onto recognition, curriculum, teaching quality, or legal status. They are therefore retained as participant-selected categories. “Informal (church/community)” should not be interpreted as unstructured learning, and “formal” should not be assumed to mean government-recognized schooling.

The second item asked participants to respond to the statement, “Children can learn safely and consistently here.” Five strongly disagreed and 19 disagreed, for a combined 24 of 48 participants (50 percent). Eight were neutral (17 percent). Fourteen agreed and two strongly agreed, for a combined 16 of 48 (33 percent).

Figure 10.2. Agreement that children can learn safely and consistently



The statement joins safety and consistency in one response, so the survey cannot show which concern drove disagreement. Nor does the item identify a particular child or learning site. Still, its distribution complicates a simple division between households with and without a learning arrangement. Of the 33 participants reporting at least some learning, 17 disagreed or strongly disagreed that children could learn safely and consistently, eight were neutral, and eight agreed or

strongly agreed. A place to learn could coexist with concern about whether participation was safe or sustainable.

The 15 reports of no current school or learning arrangement should not be treated as a single form of educational exclusion. Six participants said the children were below school age. The other reported reasons were cost or fees, transport safety, the need to work, documentation, or the absence of a community school nearby. The survey therefore supports a household-level arrangement measure, not a child-level out-of-school rate.

Four participants supplied a reason even though they also selected a current learning arrangement. Those responses are not used to explain the 15 households without an arrangement and remain a data-quality issue for internal review.

10.2 Finding a place to learn

The interviews show that families did not search within one unified school system. Participants referred to refugee and community schools, church-supported programmes, a Chinese school, an international school, preschool, home-based learning, and school hostels. These labels came from the participants and were not independently verified. What mattered in their accounts was often how an option was found and whether someone could help the family enter it.

Relatives, churches, community organizations, teachers, and prior school connections served as entry points. One student came to Malaysia partly because a relative knew of a community education center described as affordable. Another parent found a nearby class through a teacher who was also connected to a church. A different family moved a child from a refugee school into an international school. These routes were not interchangeable, but they show that access frequently began with a relationship rather than a public enrollment pathway.

> *“Education is very important to us, especially literacy in Burmese and other languages.”*
> Interview participant 18

The value placed on language and literacy also cautions against judging a programme only by its formal label. Families could value community learning because it offered continuity, familiar language, trusted adults, or a feasible route into study. At the same time, finding an option did not guarantee a place at the appropriate level, long-term funding, or a route onward. One participant raised uncertainty about what children could do after completing the levels available at a refugee school. Another described donor-supported schooling that ended, after which a grandchild began part-time work.

10.3 Fees and the household budget

The survey asked only for one main reason among households reporting no learning arrangement. It did not collect tuition, transport, uniform, food, hostel, device, or supply costs. Cost or fees were selected by three of the 15 “No” households, and one additional participant reporting a formal arrangement also entered cost or fees in the follow-up field. These small counts cannot rank the importance of cost across all households with children.

The interviews show why fees could matter even when a child was attending. Participants placed school costs beside rent, food, utilities, medicine, transport, diapers, remittances, and debt. The question was rarely whether education mattered. It was what else had to be covered from the same income, and which person’s work made continued attendance possible.

Some households were able to sustain the expense. Interview participant 05 reported that a younger child attended a community school and that the family could currently pay the fees. Interview participant 20 described a child progressing from a refugee school to an international school. These accounts show that stable or expanding participation existed within the interview corpus.

In other households, the margin was much narrower. A parent described a single modest wage being divided among rent, tuition, utilities, childcare supplies, and recurring illness. Another participant said rent, electricity, and school fees left little for food. Grandparents described school payments as one of several bills carried by an adult child's earnings. A student's fees and personal supplies were supported by a working sibling who also sent money to another sibling studying outside Malaysia.

Community help and financial constraint could appear in the same account. One family that could not afford the next educational level found teachers willing to admit a child to a lower-cost program. The exception preserved learning while leaving the parent concerned about age-appropriate placement.

10.4 Distance, transport, safety, and hostels

Education had to be reached. Among the 15 survey participants reporting no current arrangement, two selected transport safety as the main reason and one selected the absence of a community school in the area. These are household reports from small cells, but the interviews show several ways that location and travel entered decisions.

A nearby program could make attendance feasible. Its absence could require paid transport, a long journey, or an adult able to accompany the child. Participants described fares, limited language confidence, and the difficulty of combining school travel with work or care. One account involving specialized support required paid transport for every trip; identifying details are omitted.

Movement concerns discussed in Chapter 6 also entered school travel, although they were not the explanation in every transport account. Some parents described fear when taking children out, while others focused on distance, fare, or work schedules. One parent said that having a UNHCR card brought greater comfort when dropping off children but did not eliminate concern created by reports of enforcement operations.

For two interview participants, a school hostel solved the daily-travel problem. One student said hostel residence reduced ordinary movement and therefore reduced contact with police or immigration officers. The arrangement also meant returning to the household only periodically. In another family, a parent described choosing a hostel because the school was far away and taking younger children on each trip was difficult. The parent understood the tradeoff as both access and separation:

> *"That's why he is staying in the hostel. With other schools, they don't want foreigners. For him, what he finds hard is that he can't stay as he would at home since it's a hostel."*
> Interview participant 35

The final sentence is the parent's interpretation, not the child's direct account. The case shows why hostel residence should not be treated simply as evidence of either success or hardship. It made attendance possible when daily travel was not workable. It also changed where family life took place and how often the child returned home.

Chapter 8 documented repeated residential moves, crowded housing, and employer-linked accommodation. The education interviews did not consistently connect every move to a school interruption, so such a relationship should not be assumed. The clearer finding here is that residential location shaped distance and available options, while some families used a hostel or a different type of school to bridge that gap.

10.5 Language, placement, progression, and inclusion

Entering a learning program did not ensure that its instruction, level, or support fit the learner. Participants described unfamiliar languages, interruptions before arrival, placement below the expected grade, uncertainty about what followed the available school level, and needs that ordinary classroom arrangements did not meet.

Language could be a barrier and a route to progress. One parent described early difficulty helping with homework in unfamiliar languages and no money for tutoring, followed by some improvement. A student in another program said volunteer-led instruction was helping in a difficult subject.

A student participant offered a more positive account. English was described as the weakest subject, but English-medium classes and volunteer teachers were helping the participant improve. This was meaningful progress inside a community institution, even though school fees and personal expenses remained difficult. The example resists the assumption that language difference necessarily produced continuing failure.

Age placement raised a separate issue. Interview participant 36 described a child attending preschool when the parent believed the child should have entered kindergarten, because the higher-cost option was not manageable. Another caregiver reported an older grandchild attending a pre-kindergarten program. The interviews do not allow an independent assessment of placement decisions, prior learning, or academic ability. They show how participants themselves understood a mismatch between age, level, and available resources.

Attendance did not always mean inclusion. One account described a learner who needed continuing specialized assistance that relatives and teachers could not always provide. The case is retained only to show that obtaining a place may leave support needs unresolved.

Progression beyond the available program remained uncertain in several accounts. Participants asked for scholarships and higher education, or worried about what followed completion of a refugee-school level. The interviews do not verify credential recognition or compare curricula. They support a narrower conclusion: some participants judged education partly by whether it opened a next step, not simply whether a learner occupied a place that year.

10.6 When work and household responsibilities interrupted study

“Need to work” appeared as the main reason in two of the 15 household reports with no current learning arrangement. It also appeared in three of the four anomalous follow-up responses from households that reported some learning. Because the survey cannot identify the child, age, or employment arrangement involved, it does not establish child labor or show whether work replaced all study.

The interviews preserve several distinct pathways. An adult participant said personal education in Malaysia ended because work and financial survival took priority. Another young worker supported younger siblings’ school fees while worrying about the worker’s own education and future. A

grandparent described donor-supported study ending before a grandchild began part-time work, although the transcript did not establish the grandchild's age. A different participant paid for a younger brother's schooling until the cost could no longer be sustained.

Some accounts concerned observations beyond the household. Interview participant 30 described adolescents arriving after the 2021 military coup and beginning work as family migration debt came due. Interview participant 33, an adult student, described what happened among peers:

> *"Many of my friends, who are around 15 or 16 years old, leave school and begin working to earn money instead."*
> Interview participant 33

The quotation reports the participant's observation of friends; it does not establish the circumstances of all young people or allow the study to determine how often schooling and work overlapped. Its analytical value lies in the substitution it describes. Education depended on paying a fee and on whether a young person's time and earnings were needed elsewhere.

Care responsibilities shaped the adult side of the equation as well. Parents described being unable to take paid work because young children were at home, arranging employment around a child's school, or relying on one wage while another adult provided care. In these cases, schooling could free time for work, while nonattendance could make employment less feasible. The study contains too little direct evidence to characterize children caring for siblings as a recurring cause of nonattendance. It more clearly documents adults reorganizing work around children's care and education.

Illness added another layer. One parent described a child missing preschool because of fever on the day discussed, while the household lacked money for medical care. Other accounts placed recurring medical bills beside school expenses or described disability changing the kind of educational support required. As Chapter 9 showed, illness could remove an earner and increase spending at the same time. The education consequences were household-specific and should not be assumed where participants did not make the connection.

10.7 Education was not one experience

The survey categories are useful because they show that participant households reported several arrangements, with informal church or community learning the most common. They cannot show whether two households selecting the same category had similar experiences. The interviews make that variation visible.

For some families, a community school was affordable and stable. For another, a child moved from a refugee school to an international school. A student described enjoying volunteer-led English instruction and improving in a difficult subject. A child in a financially constrained household enjoyed preschool and was described by the parent as doing well. Church sponsorship and teachers' flexibility enabled other children to attend.

Other households used the same kinds of institutions under less stable conditions. Fees could be paid only while sponsorship lasted. A programme could be available but far from home. A child could attend at a level the parent considered too low. A learner could be physically present without adequate disability support. Hostel residence could solve transport while separating the child from daily family life. Similar arrangement labels therefore concealed different degrees of continuity, inclusion, and choice.

Documentation was one part of this variation, not a complete explanation. Among the 15 survey households reporting no arrangement, only one selected documentation as the main reason. Interview participants sometimes linked documents or enforcement fear to school travel or acceptance, but they also emphasized fees, distance, language, age, disability, work, and the availability of support. Chapter 6 remains essential context, but the education evidence does not support making documentation the cause of every educational difficulty.

Nor do the interviews support dismissing community education as an inferior substitute. Participants valued teachers, volunteers, familiar languages, affordability, sponsorship, and the chance to continue studying. Community systems filled an essential gap in the accounts. Their limits were visible in the same narratives: staff could not provide continuous individualized assistance, donor funding could end, places could be distant, and progression beyond the available levels could be uncertain. Recognizing both sides is more accurate than either romanticizing community labor or treating it as educational failure.

10.8 Education and hopes for the future

Education appeared in the interviews as a present expense and a future claim. Participants asked for fee assistance, inclusive teaching, scholarships, language learning, and broader access, while also describing children already progressing in workable arrangements.

For some participants, education was also a reason to endure present hardship. The adult student living in a hostel described continuing to study in order to support family later. A parent managing illness and unemployment said thinking about a daughter’s future provided motivation. Another participant hoped that children would have access to higher education and scholarships rather than reaching the end of the pathways available locally.

10.9 Chapter synthesis

Adult household reports showed varied learning arrangements and substantial concern about safety and continuity. Interviews located continuity in fees, transport, language, placement, household time, and progression. Chapter 11 turns to emotional wellbeing under these and other pressures.

Chapter 11. Mental Health and Wellbeing

Participants often described distress without naming a disorder. They spoke of lying awake after hearing that an immigration operation might be near, feeling pressure when one wage had to support relatives in more than one country, losing appetite when overwhelmed, or being unable to rest while a family member was ill. They also described prayer that made sleep possible, work that gave the day structure, children who gave hardship a purpose, and service to others that restored a sense of usefulness. Emotional wellbeing was present in ordinary responsibilities and routines, not set apart from them.

The survey shows that elevated depressive and anxiety symptoms were common within the participant group. All 90 survey participants completed all eight PHQ-8 items and all seven GAD-7 items. Forty-two of 90 had a PHQ-8 score of 10 or higher (47 percent), 48 of 90 had a GAD-7 score of 10 or higher (53 percent), and 56 of 90 screened positive on at least one of the two measures (62 percent). Thirty-four participants screened positive on both.

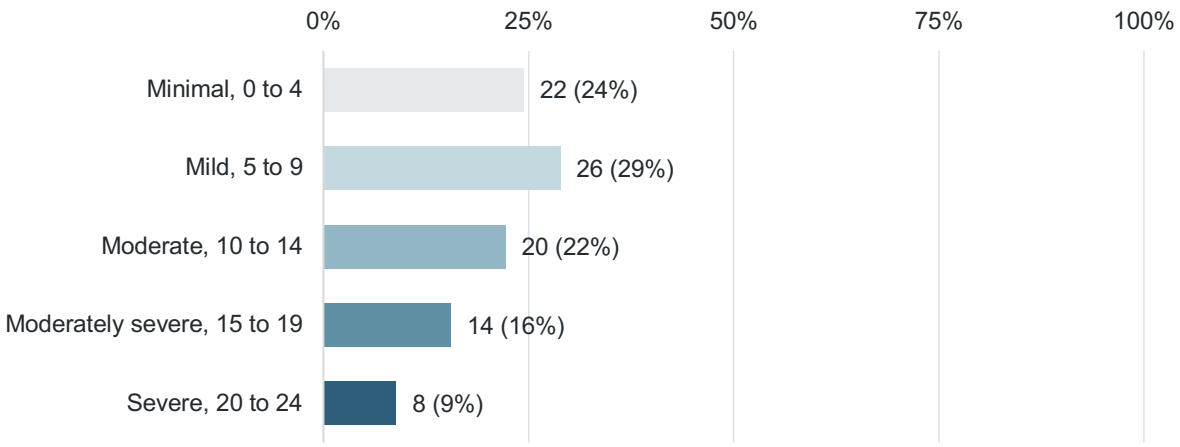
These are screening results, not diagnoses. The PHQ-8 records depressive symptoms on a 0-to-24 scale, and the GAD-7 records anxiety symptoms on a 0-to-21 scale. Under the study's rules, a score of 10 or higher is a positive screen on either measure. The instruments do not determine whether a participant had a depressive or anxiety disorder, establish the cause or duration of symptoms beyond the scale timeframe, or substitute for a clinical assessment. The PHQ-8 also does not contain the PHQ-9 item concerning thoughts of self-harm or death. It therefore provides no survey measure of suicidal thoughts.

11.1 Depressive-symptom patterns in the survey

PHQ-8 scores were available for all 90 survey participants. Scores ranged from 0 to 24, with a mean of 9.7 and a median of 8. The full distribution matters because the average sat just below the positive-screen threshold while individual scores covered the scale's entire possible range.

Twenty-two of 90 participants were in the minimal band, with scores from 0 to 4 (24 percent). Twenty-six were in the mild band, with scores from 5 to 9 (29 percent). Twenty were in the moderate band (22 percent), 14 in the moderately severe band (16 percent), and eight in the severe band (9 percent). The last three groups total 42 participants, the 47 percent with PHQ-8 scores of 10 or higher.

Figure 11.1. PHQ-8 depressive-symptom severity bands among survey participants



The positive-screen threshold is the study's screening cutoff; it does not show that all 42 participants had the same condition or need.

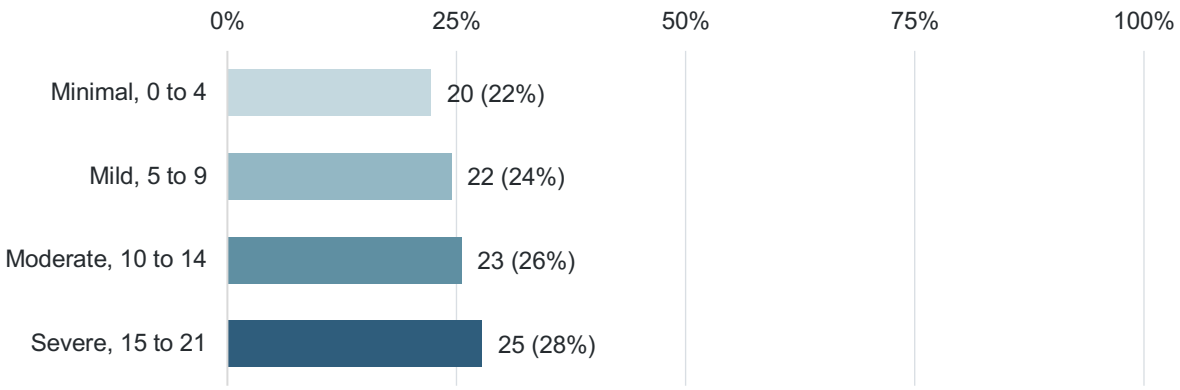
Item responses show that participants reached similar PHQ-8 totals through different symptom patterns. At the two highest frequency categories, low energy was reported by nearly half of the sample, sleep difficulty by 41 of 90 participants (46 percent), and low mood or hopelessness by 35 of 90 (39 percent). Loss of interest or pleasure was reported at that frequency by 28 of 90 participants (31 percent), while 23 of 90 (26 percent) reported slowed movement or speech, or unusual restlessness. These are item descriptions rather than separate clinical thresholds. The same total could arise through several moderately frequent problems, a smaller number reported nearly every day, or another combination.

The responses should not be assigned one explanation. Sleep difficulty, fatigue, appetite, concentration, and movement can be shaped by physical health, shift work, caregiving, enforcement fear, or circumstances not measured in the survey. The interviews show some of those meanings, but they cannot explain the score of an individual survey participant.

11.2 Anxiety-symptom patterns in the survey

GAD-7 scores were also complete for all 90 participants and ranged from 0 to 21. The mean was 10.5 and the median was 10, placing the middle of the survey distribution at the study's positive-screen threshold. Twenty participants were in the minimal band (22 percent), 22 in the mild band (24 percent), 23 in the moderate band (26 percent), and 25 in the severe band (28 percent).

Figure 11.2. GAD-7 anxiety-symptom severity bands among survey participants



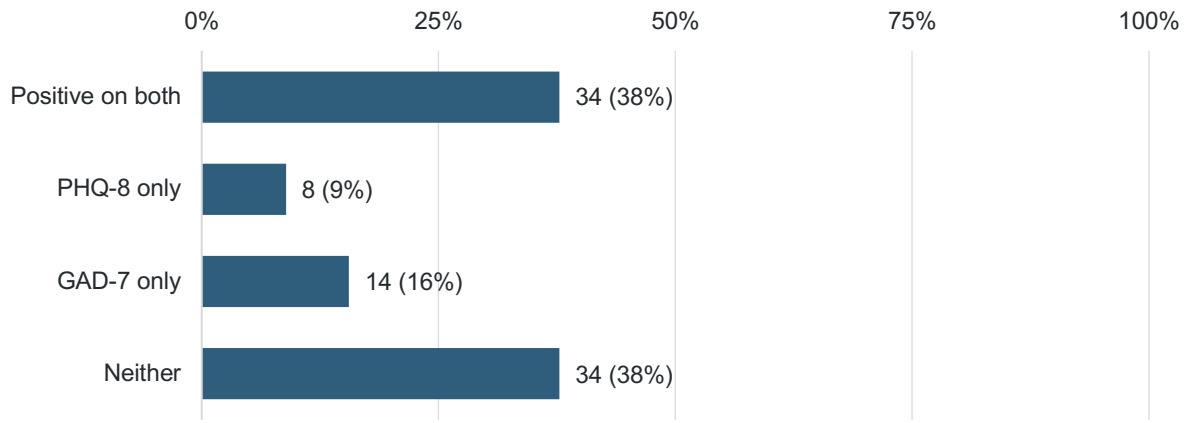
Forty-eight of 90 participants had GAD-7 scores of 10 or higher (53 percent). Twenty-five had scores of 15 or higher (28 percent), the severe anxiety-symptom band. "Severe" describes the score band. It is not a diagnosis of an anxiety disorder and does not show what circumstance, if any, a participant believed was driving the symptoms.

Anticipatory worry was prominent in the GAD-7 items. Fifty-four of 90 participants (60 percent) reported feeling afraid that something awful might happen more than half the days or nearly every day, and 46 of 90 (51 percent) reported difficulty relaxing at that frequency. No item identifies the object of worry.

11.3 Overlap between depressive and anxiety symptoms

The two screens overlapped substantially without being interchangeable. Thirty-four of 90 participants screened positive on both the PHQ-8 and GAD-7 (38 percent). Eight screened positive on the PHQ-8 only (9 percent), 14 on the GAD-7 only (16 percent), and 34 on neither (38 percent). The combined result of 56 of 90 is the sum of the three positive categories. It is a descriptive indicator of a positive screen on at least one measure, not a third scale or a measure of overall mental illness.

Figure 11.3. Overlap in positive PHQ-8 and GAD-7 screens



11.4 Distress in participants' own language

Most interview participants described some form of stress or emotional burden, although the wording and depth of the questions varied. This recurrence reflects a directly elicited topic and is not a prevalence estimate.

Participants used words such as worry, pressure, fear, discouragement, exhaustion, and uncertainty more often than clinical terms. One participant described family responsibility as a felt weight:

> *“In my heart, it's a burden when I am alone; it feels like I am carrying a heavy load. It’s hard.”*
> Interview participant 35

The metaphor joins emotion to responsibility without supplying a diagnosis. The quotation is retained without the adjacent family and reunification details that could increase identification risk.

Sleep and bodily functioning were often intertwined. One participant described the effect of working nights:

> *“If I do not get enough sleep, I feel numb, lose my appetite, and become dizzy. Sometimes I work night shifts, and then I cannot sleep well during the daytime.”*
> Interview participant 30

The same account later placed exhaustion alongside continuing fear of arrest. Shift work and fear appeared together, but the transcript does not establish how much each contributed to the reported symptoms. Nor should numbness, appetite loss, or dizziness be treated as "just psychological." The participant described bodily experiences within a demanding routine, and the study did not clinically assess their cause.

Accounts also differed in timing. Some participants described worry that returned when work became unstable, an operation was rumored, or a medical bill arrived. Others described fear remaining active long after a detention or continuing across years. A few emphasized that life had become more manageable or that distress was not overwhelming. The interviews therefore do not support one progression from hardship to illness. They show distress that could be chronic, episodic, situational, muted, or held alongside ordinary functioning.

Translation and question wording also shape what can be concluded. Several transcripts used terms such as "anxiety," "mental health," or "psychological stress," while others recorded everyday language such as a heavy load, no peace, or being unable to sleep. In some interviews, clinical-sounding terms appeared first in the interviewer's question. The analysis therefore gives greater weight to the participant's description than to the label used in the prompt. A translated word may identify serious suffering without supplying a diagnosis, and a short denial may reflect either relative wellbeing or the limited depth of that exchange.

11.5 Enforcement, uncertainty, and the fear of what might happen

Chapter 6 showed how enforcement concerns altered routes, outings, and routines. In the mental-health accounts, the possibility of an encounter mattered even when no recent encounter had occurred. Participants described reacting to sirens, unfamiliar uniforms, vehicles, roadblocks, social-media posts, or reports of an operation. The feared event could remain outside the home while still interrupting sleep inside it.

Several participants linked enforcement uncertainty to sleep and bodily tension. One described lying awake because arrest felt possible at any time; another said fear associated with an earlier detention remained active even after receiving a UNHCR card. Other participants reported less persistent fear or no personal encounter. These accounts show how remembered and anticipatory risk could affect wellbeing without establishing that enforcement concerns caused any survey score.

Documentation sometimes changed the emotional meaning of movement. Participants said a UNHCR card or community card could provide peace of mind, a way to identify them, or a contact point if something happened. Some felt safer after receiving a card. Others continued to expect questioning, detention, or unequal treatment. As in the survey comparison, documents mattered without producing a simple line between fear and calm.

11.6 Work, money, and responsibility for others

Work and family responsibility were among the clearest explanations participants gave for worry. A job could provide income, routine, dignity, and a reason to persist. It could also be the single point on which rent, food, medicine, school fees, remittances, and relatives' survival depended. The prospect of missing wages or losing employment therefore carried more than an individual career consequence.

Interview participant 02, living apart from a spouse and children, explained the connection directly:

> *“If I lose my job, I worry about how I will continue supporting them. Financial hardship is my greatest source of stress.”*
> Interview participant 02

Other participants described being the only worker supporting a large family, combining long shifts with school expenses, or continuing undesirable work because there was no safe margin for unemployment. One said the pressure of difficult work sometimes kept the participant awake. Another worried about becoming unemployed even while describing the current job as stable. Past instability changed how present stability was interpreted.

Responsibility was not described only as burden. It also supplied purpose. A student said thinking about family members' hardship created motivation to continue studying and support them in the future. Parents described children as the reason to keep working, seek care, or imagine a different

future. A participant with serious illness continued because a parent also needed care. The same relationship could intensify pressure and make endurance meaningful.

11.7 Illness, family separation, and daily functioning

Illness often changed both what a household had to spend and what its members could do. Participants described serious health conditions, disability, recurring treatment, medical debt, and dependence on another person for transport or interpretation. Emotional distress entered these accounts through uncertainty about recovery, fear of failing to provide, isolation at home, and the possibility that no one would be available to accompany a sick parent or child.

One participant receiving serious treatment described crying after landlords refused to rent to the household and identified a child's illness as the greatest source of stress. Another described living apart from an adult child who worked far away; illness, financial hardship, and separation were presented together. A participant whose health prevented paid work spoke of regret and diminished self-worth while relying on a spouse and others for medical navigation. These were distinct accounts, and the chapter does not combine them into one trajectory.

Family separation extended beyond the household. Participants worried about spouses, children, parents, or siblings elsewhere and sometimes carried responsibility for people they could not reach directly. Uncertainty about return, resettlement, documentation, or reunification made planning difficult.

A small number of interviews contained past death-related language during periods of severe overlapping strain. The material is not quoted. The transcripts do not support an inference about current risk, intent, plan, diagnosis, or a relationship to PHQ-8, which contains no self-harm or death item.

Sleep was the most recurrent bridge between emotional pressure and daily functioning. Participants described difficulty falling asleep after hearing bad news, staying awake because of operation rumors, sleeping poorly because of work schedules, and finding it hard to rest while worried about money or family. Some also mentioned appetite loss, dizziness, fatigue, or reduced ability to work. The accounts warrant attention without establishing that any physical symptom had a psychological cause.

11.8 Coping, faith, and sources of meaning

Many participants described faith-based coping, partly in response to a direct question about what helped them continue. The pattern is not a population estimate and did not have the same meaning for everyone.

Prayer was often described in terms of an immediate effect: feeling calmer, being able to sleep, regaining hope, or finding strength to continue. Interview participant 07 said:

> *“Prayer gives me strength. When I cannot sleep because of worry, I pray to God. I believe God reminds me to keep praying and trust Him. After I pray, I feel more peaceful and am able to sleep better.”*
> Interview participant 07

Other participants referred to reading Scripture, listening to sermons, worshipping, asking a pastor to pray, or trusting that hardship would not last forever. These practices created a way to interpret uncertainty and continue through it. They did not pay a medical bill, create work authorization, or

guarantee safety. In several accounts, prayer and practical help from relatives, churches, employers, clinicians, or community organizations worked together.

Family relationships offered both obligation and support. Participants drew motivation from children, parents, spouses, siblings, and the hope of helping them later. Friends gave encouragement, found jobs, shared housing, accompanied patients, or provided information. Routine also mattered. Work, study, saving, and caring for others could keep the day organized even when the wider future remained uncertain.

Service to others was another source of meaning. Participants described translating, sharing information, assisting with documents, or responding to people in crisis. Helping could provide purpose while also exposing the helper to repeated accounts of detention, deportation, illness, or family strain. Purpose and emotional cost could coexist.

Coping resources were uneven. Support depended on another person's time, money, knowledge, and willingness to help. Some participants had an employer who provided transport to a clinic or accommodation; others had no one consistently available to accompany them. Some spoke readily about faith; others named family, friends, work, or deliberate optimism. The evidence supports several sources of meaning, not one community-wide coping style.

11.9 Talking about distress and seeking help

When participants discussed distress, they usually named relatives, friends, pastors, church leaders, or community members as people they spoke with. No transcript clearly documented a participant's own use of professional counseling, psychiatric treatment, or medication for emotional distress. That absence is not evidence of rejection or nonuse: the guide did not systematically ask every participant about counseling, medication, stigma, service knowledge, or prior treatment.

Informal support also varied in purpose. A pastor might pray with someone, a sibling might listen, and a friend might help with the bill or journey producing the immediate pressure. The interview did not always distinguish emotional support from practical assistance, and receiving help once did not establish that it was available consistently.

General healthcare barriers also cannot be assigned directly to mental-health care. Cost, language, transport, documentation, and trust are important questions for future study, but participants did not consistently identify them as reasons for not obtaining counseling.

11.10 Wellbeing was not one experience

The interview accounts complicate a division between people who were well and people who were unwell. Some participants described persistent fear, sleeplessness, or emotional exhaustion while continuing to work, care for children, worship, study, and help others. Continued functioning did not mean distress was absent. At the same time, hardship did not produce the same account from everyone.

Interview participant 26 resisted the strongest description while leaving wellbeing unsettled:

> *“I wouldn't say I carry an overwhelming burden, but I also can't say that I truly feel happy.”*
> Interview participant 26

The same participant said life could be enjoyed to some extent, did not regret coming to Malaysia, and found peace through prayer, while also saying genuine freedom remained absent. Satisfaction, gratitude, constraint, and unhappiness coexisted in one account.

Other participants described relative improvement after receiving documentation, comfort in living with relatives, manageable routine care, supportive employers, progress in education, or hope attached to future plans. Such accounts do not cancel the elevated survey scores or the severe interview disclosures. They show why neither a positive screen nor a hardship category can stand in for a complete account of wellbeing.

Wellbeing also changed within individual narratives. A participant could describe being safer than before while remaining fearful, grateful for employment while dreading its loss, or hopeful about a child's future while unable to meet current school costs. Some spoke of Malaysia as a place of opportunity for people healthy enough to work and, in the same account, described what happened when illness removed that ability. These tensions are not inconsistencies to be corrected. They show that safety, purpose, distress, gratitude, and constraint could be present at the same time.

11.11 Chapter synthesis

Elevated PHQ-8 and GAD-7 screens were common, but neither measure established diagnosis or cause. Interviews connected wellbeing to ordinary routines, responsibilities, relationships, and sources of meaning. Chapter 12 examines how support and information became usable.

Chapter 12. Social Support, Information, and Trust

A person who knew whom to call could turn a difficult-to-use institution into a sequence of practical steps. Friends found jobs and accompanied new arrivals. Relatives translated, shared rooms, or lent money. Church and community contacts raised funds, prepared documents, and connected people with services. Employers and teachers sometimes supplied transport, accommodation, payment, or flexibility.

Having someone to call was not the same as having someone able to solve the problem. Within the 90-person survey sample, 69 participants reported that, during the previous month, someone they could rely on for help was available no more than sometimes (77 percent). Friends and family were the most commonly selected source in a separate question about information for jobs, housing, healthcare, or school, and they received one of the higher mean trust ratings. Yet the interviews repeatedly showed relatives and friends facing the same rent, work, documentation, and healthcare pressures as the person asking for help. A trusted relationship could provide a contact, translation, reassurance, or a small loan without supplying the money or formal authority required for the next step.

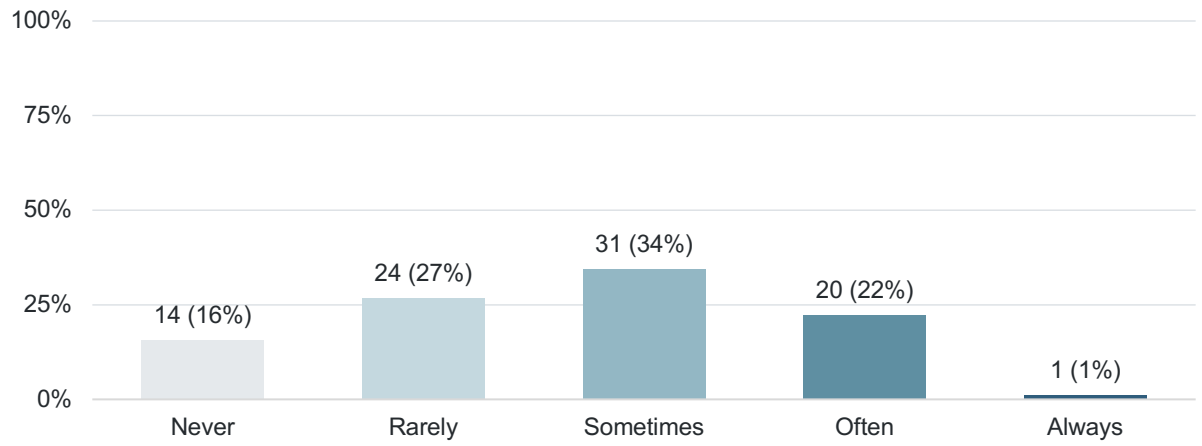
This chapter therefore keeps three related ideas separate. **Support frequency** concerns how often survey participants felt they had someone they could rely on. **Information use** concerns the sources they selected for a combined question about jobs, housing, healthcare, or school. **Trust** concerns ratings of five types of people or institutions on a common five-point scale. A source could be used without being highly trusted, trusted without being used often, or relied upon for one task but not another.

The 36 interviews show how these distinctions worked in practice. They also connect relationships documented in earlier chapters: the friend who found a job, the leader who responded during an enforcement encounter, the relative who accompanied someone to a clinic, the church that helped with school fees, and the person who listened or prayed during a period of distress. This chapter examines the relational structure across those encounters rather than repeating the employment, housing, healthcare, education, or mental-health findings themselves.

12.1 Support was present, but often not consistently available

The survey asked participants to respond to the statement, “In the past month, I had someone I could rely on for help.” All 90 participants answered. Fourteen selected “Never” (16 percent), 24 “Rarely” (27 percent), 31 “Sometimes” (34 percent), 20 “Often” (22 percent), and one “Always” (1 percent).

Figure 12.1. Frequency of having someone to rely on for help during the previous month



Under the study's exploratory rule, “Never,” “Rarely,” and “Sometimes” form a **low or inconsistent support** group. Sixty-nine of 90 participants met that definition (77 percent), while 21 reported support “Often” or “Always” (23 percent). The grouping is not a validated social-isolation scale. It does not measure network size, loneliness, relationship quality, or whether a specific need was met. In particular, “Sometimes” does not mean that a participant had no support. It means that support was available with limited frequency or consistency under this single item.

Interviews clarify why a frequency item cannot capture the whole value of help. A friend could find a job and accompany a newcomer to the workplace, or a community contact could intervene during one urgent encounter, while neither remained available for every later need. Consequential assistance at one moment and inconsistent support across a month could both be true.

The 14 participants who selected “Never” form a narrower group reporting no such person during the reference period. Their answers warrant attention, but they should not be treated as proof of complete social isolation. The question did not ask about occasional contact outside the month, remote family relationships, spiritual support, or assistance that the participant did not regard as dependable.

12.2 What help did in practice

Support in the interviews was best understood by what it enabled. The same relationship could provide several kinds of help at once, and a single need often required more than one person.

For employment, assistance included hearing about a vacancy, recommending the participant, speaking with an employer, explaining the work, or accompanying the person on the first day. Housing help included sharing a room, locating a landlord willing to rent, negotiating an arrangement, or providing accommodation through work. Healthcare assistance combined transport, translation, clinic selection, document preparation, fundraising, fee payment, and childcare. Educational help included locating a community school, allowing delayed or reduced fees, arranging a hostel, sponsoring a child, or interpreting enrollment requirements.

These were not interchangeable forms of support. A friend with a job contact might not know how to prepare a hospital document. A community leader might understand a registration process but lack money for treatment. An employer could arrange transport but not provide independent advice about a workplace dispute. The most useful intermediary was often the person with a particular combination of language, contacts, documents, experience, and time.

Some support chains crossed several settings. During an enforcement encounter, a participant might first call a spouse, who contacted a community office, whose representative then spoke with an authority. During illness, a relative might identify a clinic, a community member translate, a church raise money, and an employer grant leave. The practical result came from coordination rather than from one generalized “community” response.

The interviews also contained emotional and spiritual help that did not depend on an institution. Participants described relatives who listened, friends who encouraged them, pastors who prayed, church members who visited, and children whose presence gave them a reason to continue. Such support could change how a person experienced an immediate burden even when no bill was paid or procedure completed.

The boundaries among practical, financial, informational, emotional, and spiritual support were porous. A hospital visit with a church member could provide transport, language help, reassurance, and a witness to how the participant was treated. A loan was financial assistance, but it also expressed confidence that the borrower would repay. A job referral conveyed information and activated a relationship with an employer. What mattered was not merely that a contact existed. It was whether that contact could perform the task needed at that moment.

12.3 Family and friends: first contacts with shared limits

Friends and family were the most prominent personal sources in the survey. Sixty-two of 90 participants selected “Friends/family” in the combined multi-select information question (69 percent). In the separate trust item, friends and family received a mean rating of 3.80 out of 5 across all 90 participants and a median of 4. Fifty-four participants gave a rating of 4 or 5 (60 percent), while 14 gave a rating of 1 or 2 (16 percent). The distribution shows generally favorable ratings with meaningful variation.

Interview accounts gave substance to these numbers. Relatives and friends helped people enter Malaysia, find a first room, obtain work, learn a route, translate, borrow money, reach a clinic, and care for children. They also offered information through ordinary conversation: which workplace was hiring, which school might accept a child, which clinic charged less, or whom to contact after a stop. Personal knowledge often made information actionable because the source could explain it in a familiar language and remain involved in the next step.

Trust among relatives and friends was often tied to a specific task or relationship. Participants described borrowing, lending, sharing rooms, finding jobs, translating, or caring for children with people whose reliability they knew. This did not imply that every family member or friend was trusted equally, or that willingness to help guaranteed enough money or time.

Family responsibility could also intensify pressure. Participants supported parents, children, spouses, siblings, and relatives in Myanmar while trying to meet expenses in Malaysia. A person with more income, stronger language skills, or greater institutional experience could become the

family intermediary. That role brought purpose for some participants, but it also concentrated demands on the person best able to respond.

Capacity was the clearest limit. Interview participant 33 explained why asking relatives was difficult even where family ties remained important:

> *"In Malaysia, most of our relatives are facing the same financial struggles. Everyone has to work to survive, so without a job or income, we become a burden not only to ourselves but also to our relatives."*
> Interview participant 33

The account does not show a withdrawal of care. It shows that willingness and capacity were different. A relative working long hours might be unable to accompany someone to a hospital. A sibling paying rent and remittances might be unable to lend more. A family network could know that help was needed while having no member with the necessary time, money, language, or documents.

Accounts also differed. Some participants described dependable family accommodation, regular financial support, or a spouse who handled institutional tasks. Others lived apart from close relatives, hesitated to ask again, or relied on one person whose absence left no obvious substitute. Friends and family were an important first layer of assistance, but they were not a uniform or unlimited resource.

12.4 Churches and community institutions as trusted bridges

Church leaders received a mean trust rating of 3.87 out of 5, the highest of the five means, with a median of 4. The difference from friends and family, at 3.80, was small and should not be treated as a substantive ranking between the two. Fifty-seven of 90 participants rated trust in church leaders at 4 or 5 (63 percent), while 16 rated it at 1 or 2 (18 percent). Thirty-one participants selected church leaders as a source of information about jobs, housing, healthcare, or school (34 percent).

The interviews described churches as places of worship, gathering, information exchange, emergency assistance, and practical referral. Pastors and church members prayed with participants, visited during illness, collected money, shared food, helped locate work, assisted with school fees, and connected families to other people. The material and spiritual roles were often present in the same account, but neither should be assumed in every case.

During one severe period, a participant credited church members and nearby contacts with providing food and medical help that the household could not have managed alone. The account shows consequential support without establishing that every church or participant received the same response.

Community organizations and leaders played a related but distinct role. Participants described offices or representatives that explained documentation, issued community records, contacted authorities, found interpreters, connected people to work, accompanied patients, or helped communicate with schools and hospitals. In several accounts, the organization's principal value was as a recognizable contact point: a participant who could not explain a situation in Malay could call someone who could.

Trust in NGOs and community-based organizations averaged 3.28 out of 5 across all 90 survey participants, with a median of 3. The distribution included both high and low ratings, reinforcing that one mean should not be treated as a uniform view.

Community institutions could bridge a gap without controlling the institution on the other side. A leader might call a hospital but not determine the fee. An organization might prepare documents but not decide whether an authority recognized them. A pastor might organize a collection but not finance long-term treatment. These limits do not make the help symbolic. They show the difference between making a system more usable and having authority over its outcome.

12.5 Help linked to work, schools, and services

Employers, agents, teachers, clinicians, and school staff occupied a different position because they could control or unlock resources that participants needed. Their help could be decisive, but the relationship often contained practical dependence.

Employers provided jobs and, in some accounts, rooms, transport, clinic visits, medical payment, wage advances, food, or leave. One participant reported that an employer paid hospital expenses after a workplace injury. Other arrangements involved advances to be repaid or housing tied to continued work.

That distinction is visible in the survey. Only eight of 90 participants selected employers or agents as a source in the combined information item (9 percent). Trust in employers and agents averaged 2.71 out of 5, with a median of 3. Twenty-four participants gave a rating of 4 or 5 (27 percent), while 43 gave a rating of 1 or 2 (48 percent). The item combines employers and agents, which may have carried different meanings, and it asked all 90 participants, not only those currently working or using an agent.

Teachers and schools sometimes exercised discretion in ways that changed access: accepting a child when fees could not be paid immediately, finding sponsorship, sharing school information, arranging a hostel, or allowing a different level of study. Clinicians and clinic staff could explain a referral, identify lower-cost care, or communicate in a language the participant understood. These relationships were not included as separate trust items, so the survey cannot rank them against the five rated sources.

Participants' accounts also show why intermediaries could become overextended. A person with language skills might translate for relatives, coworkers, or community members in addition to paid work. A teacher might waive a fee without being able to cover transport or books. A community worker could receive calls concerning documents, detention, healthcare, and employment from many households. Assistance depended partly on labor that was not always visible in the final outcome.

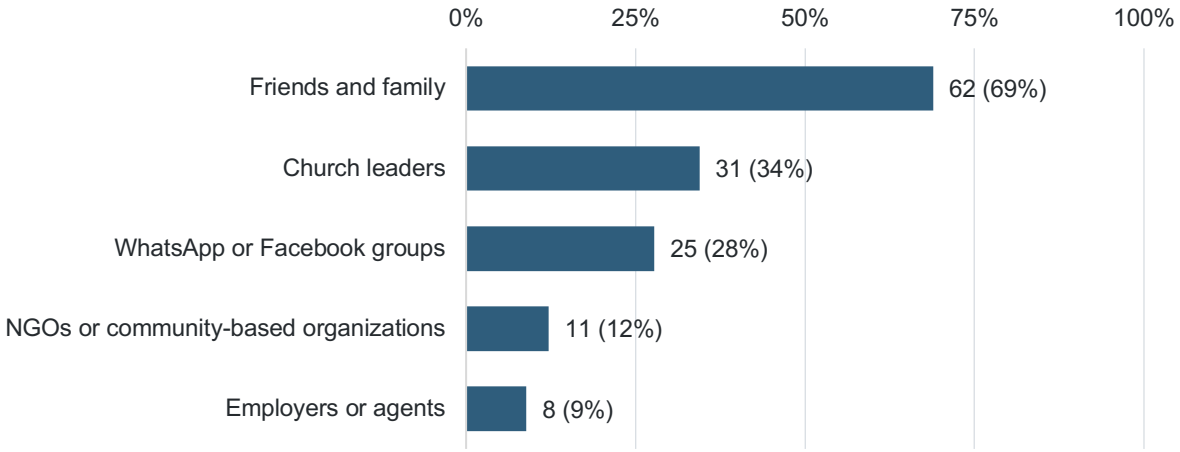
12.6 Information moved through personal and digital networks

The survey asked, “Where do you usually get information about jobs, housing, healthcare, or school? (Select all that apply).” All 90 participants answered. Because the question combined four domains and allowed several selections, its results cannot show which source was used for a particular need, how often it was used, whether it was preferred, whether the information was accurate, or whether the participant acted on it. Percentages may sum to more than 100 percent.

Friends and family were selected by 62 of 90 participants (69 percent), followed by church leaders at 31 (34 percent), WhatsApp or Facebook groups at 25 (28 percent), NGOs or community-based organizations at 11 (12 percent), and employers or agents at eight (9 percent). Four participants

supplied other routes; those one-off or very small categories are not displayed separately in the figure.

Figure 12.2. Sources selected for information about jobs, housing, healthcare, or school



The order reflects selection in this combined item, not a hierarchy of reliability. Interviews showed information travelling through conversation, calls, group messages, church announcements, community offices, workplaces, schools, clinics, and social-media posts. Personal and digital routes often overlapped. A friend might forward a WhatsApp notice, a church leader might announce information received from an organization, or a community office might be contacted after a relative saw a post.

Digital channels were valued for speed and reach. Participants described part-time work announcements, warnings, school information, and community notices circulating through WhatsApp or Facebook groups. Use did not establish that every post was current, accurate, or successful.

The survey included a separate statement: “I know where to go for safe information when problems happen.” Thirty-six of 90 participants agreed or strongly agreed (40 percent), 27 were neutral (30 percent), and 27 disagreed or strongly disagreed (30 percent). The even division between neutral and disagreement is important. Many participants selected at least one information source in the combined item, but having a source was not equivalent to confidence about where to obtain safe information during a problem.

The interviews did not systematically ask participants to describe a verification routine. Some accounts identified a known person or office whose experience made a message more actionable. Others described acting on reports that could not be confirmed, especially when the possible cost of ignoring an enforcement warning felt high. The study cannot determine whether a warning was true merely because it changed behavior.

12.7 Trust, use, and authority did not align

All five trust items had valid responses from all 90 survey participants. They used a 1-to-5 numeric scale, with higher values indicating more trust. The workbook does not contain a complete verified set of English endpoint labels for every item, so this chapter does not assign verbal meanings to

individual scale points. Means are shown to two decimal places, and the full numeric scale should remain visible in any figure.

Church leaders and friends or family received the two higher mean ratings, at 3.87 and 3.80 respectively. NGOs and community-based organizations averaged 3.28. WhatsApp or Facebook averaged 2.74, and employers or agents 2.71. The small difference between the last two does not support a meaningful ranking, just as the small difference between church leaders and friends or family does not establish that one was substantively more trusted.

Figure 12.3. Mean trust ratings across people and institutions

The distributions show more than the means. Ratings of 4 or 5 were most common for church leaders and friends or family, while ratings of 1 or 2 were more common for WhatsApp or Facebook and employers or agents. These groupings show variation; they are not validated trust thresholds, and the survey did not specify which aspect of trust participants were rating.

An employer could be trusted to provide transport while remaining the person who controlled wages and housing. A pastor could be trusted for prayer and emergency fundraising without possessing legal expertise. A community organization could be the best available source for a document process while lacking authority over the final decision. WhatsApp could be useful for rapid notices even when a participant was cautious about acting on an unconfirmed post.

Interview participant 26 described the effect of uncertain enforcement information:

> *“Other than that, we often hear rumors about immigration operations, which make everyone panic and run.”*
> Interview participant 26

“Rumors” is the participant's characterization. The study did not verify the reports as true or false. The account shows why use may persist despite uncertainty: when the feared consequence is detention, people may act before certainty is available.

Table 12.1. Information-source selection and mean trust

Information source	Selected as a source, n (%)	Mean trust rating for corresponding item (1 to 5)
Friends and family	62 (69%)	3.80
Church leaders	31 (34%)	3.87
WhatsApp or Facebook groups	25 (28%)	2.74
NGOs or community-based organizations	11 (12%)	3.28
Employers or agents	8 (9%)	2.71

The survey illustrates the same conceptual separation. Friends and family were selected as information sources by 69 percent of participants and received a mean trust rating of 3.80. Church leaders were selected by 34 percent and averaged 3.87. WhatsApp or Facebook groups were selected by 28 percent while the broader trust item averaged 2.74. These percentages and means should be placed beside one another only to show that use and trust are different measures. They do not identify how often a source was used, whether a particular user trusted it, or what happened after information was received.

12.8 Where relational support reached its limits

The interviews contained strong examples of assistance, but they did not describe a system able to meet every need. Support most often changed one part of a problem. It might supply a first month's rent but not continuing income, a clinic ride but not the hospital bill, a school place but not transport, or contact with an authority but not protection from detention.

Financial limits were especially clear. Loans from relatives, friends, employers, or community members could bridge an emergency while creating another obligation. One participant described using paracetamol at home because borrowing from siblings for a hospital visit felt untenable. The account links a healthcare decision to limited family capacity without implying a lack of care.

Time was another scarce resource. Participants described circumstances in which everyone nearby was working, leaving no one to accompany a patient, translate, watch children, or visit someone in hospital. A person could have many contacts and still lack the one form of help needed at a particular hour. Solo parents and people with serious illness were especially dependent on reliable accompaniment, though the interview sample cannot establish how common that circumstance was.

Language and institutional knowledge were unevenly distributed. A participant who depended on one relative or community worker for translation could be left without a substitute. The intermediary also carried risk: an incomplete explanation, missed message, or unavailable phone could delay the next step. Some participants became intermediaries themselves after learning English or Malay or gaining experience with a school, clinic, employer, or community office. Their accounts show reciprocity and community knowledge being built over time. They also show how much coordination could rest on a small number of people.

Support was sometimes tied to another dependency. Employer accommodation was helpful while employment continued. A wage advance paid an urgent cost while deepening debt to the workplace. Living with relatives reduced rent while limiting privacy or the ability to negotiate household arrangements. These relationships should not be presumed coercive. Nor should their practical value obscure the difficulty of losing the same relationship.

Several interviews included stable or positive arrangements: relatives who provided a workable home, employers who responded generously, churches that sustained assistance through a severe period, and community leaders who successfully resolved an immediate encounter. Others described no organizational aid, uncertainty about whom to call, or help that arrived only in crisis. The variation resists both a celebration of community support and a conclusion that relational systems failed. Their capacity was real and finite.

12.9 Chapter synthesis

Relationships helped people explain, translate, refer, accompany, lend, advocate, and comfort, but a trusted contact did not guarantee capacity or authority. Chapter 13 turns to the changes participants prioritized and the futures they described.

Chapter 13. Community Priorities, Hopes, and Future Plans

Participants could usually describe what needed to change more clearly than how or when change would happen. In the survey, job protections and safer access to healthcare were each selected among the top priorities by 48 of 90 participants (53 percent), and safe transportation by 45 (50 percent). Yet when participants were asked to name one most important priority, no category was selected by more than one fifth of the sample. Job protections led at 18 of 90 (20 percent), followed closely by safer access to healthcare at 17 (19 percent), legal information at 14 (16 percent), and safe transportation at 14 (16 percent).

The difference between the two questions matters. The first item asked participants to "Choose your top 3 priorities." It did not ask them to rank those selections, and the order stored in the workbook should not be read as first, second, or third. The second item required a single answer. It therefore asked people to separate needs that earlier chapters have shown to be connected: safe travel to work, income for rent and school fees, documentation for greater reassurance during movement, and affordable healthcare when illness threatened the ability to earn.

The workbook also preserves imperfections. Eighty-four records contain three top-priority selections, four contain one, and two contain four. Eight single-priority answers do not appear in the participant's recorded multi-select set. The two items are therefore reported separately and are not treated as validated rankings.

The 36 interviews extend the evidence beyond a list of issues. Participants explained what protection, work, transport, healthcare, education, and support were expected to make possible. They also described futures in several directions: improving life in Malaysia, resettling or reuniting with family elsewhere, returning if conditions changed, continuing education or work, serving other Zomi people, or simply waiting without knowing what would come next.

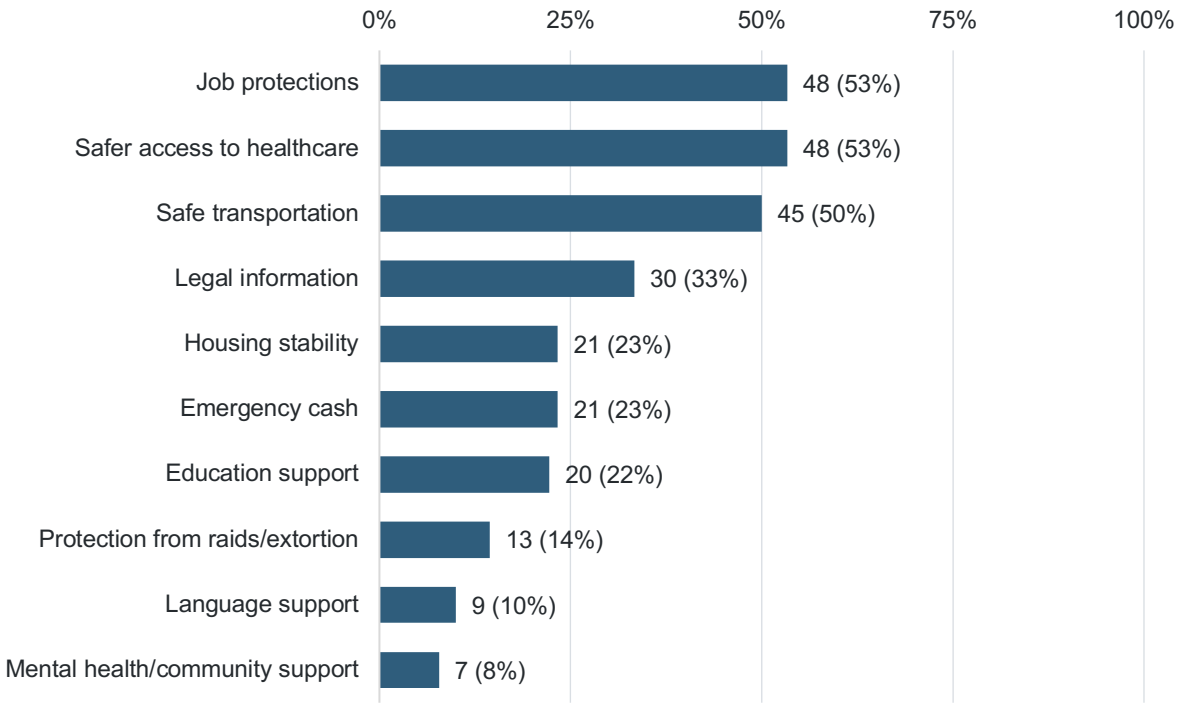
This chapter distinguishes an immediate priority from a hope and a plan. A priority was a condition participants wanted addressed. A hope was a desired future that might have no identified pathway. A conditional intention depended on an event outside the participant's control. A plan involved an action the participant expected or intended to pursue, often one already underway. The interviews were not designed to test whether any future course was feasible, and the direct prompt asking what participants would change likely increased discussion of recommendations. Recurrence within the 36 accounts is not a population estimate or a formal community agenda.

13.1 Several priorities at once

The full top-three distribution was broad. Alongside job protections, safer access to healthcare, and safe transportation, 30 of 90 participants selected legal information (33 percent). Housing stability and emergency cash were each selected by 21 (23 percent), and education support by 20 (22 percent). Protection from raids or extortion was selected by 13 after normalization of one capitalization variant (14 percent). Language support was selected by nine (10 percent), and mental health/community support by seven (8 percent).

Two one-off entries could not be normalized securely and are not displayed separately in the main figure. Because the item allowed multiple selections, percentages exceed 100 percent, and nonselection does not mean an issue was unimportant.

Figure 13.1. Issues selected among participants' top priorities



The three most frequently selected categories describe access in practical terms. "Job protections" is not the same as employment alone. "Safer access to healthcare" combines a service with the conditions under which participants believed it could be approached. "Safe transportation" concerns the journey linking home to work, clinics, schools, worship, and community life. None of the three can be interpreted as a stand-alone solution.

Interview recommendations were similarly overlapping. Participants frequently discussed healthcare, documentation or legal protection, work or skills, and education, often naming more than one. These directly elicited recommendations are not rankings of the wider Zomi population.

The interviews also expanded the categories. Participants described interpreters, job matching, practical language instruction, help with hospital bills, inclusive teaching, emergency accompaniment, assistance for people unable to work, and stronger community organizations. Some proposals concerned a service. Others concerned the ability to use a service without fear, unaffordable cost, or dependence on one intermediary.

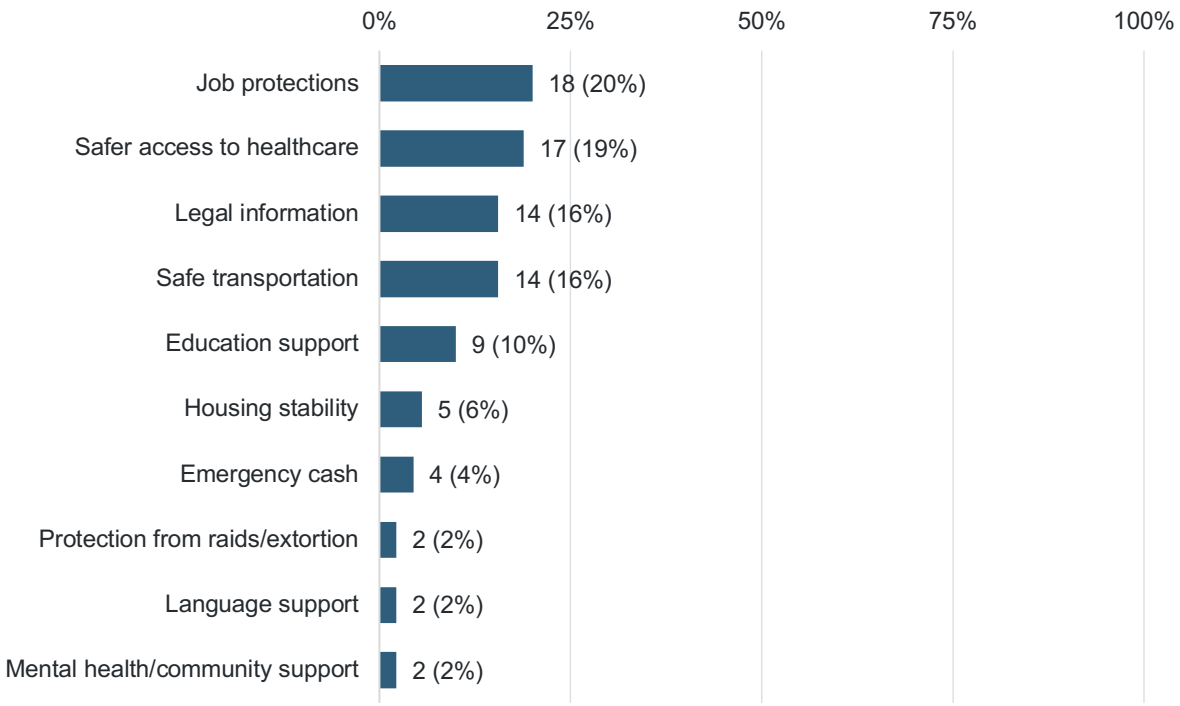
13.2 One most important priority did not create consensus

The single-priority item produced a more concentrated display but not a single dominant answer. Job protections were selected by 18 of 90 participants (20 percent), safer access to healthcare by 17 (19 percent), legal information by 14 (16 percent), and safe transportation by 14 (16 percent). Education

support followed at nine (10 percent), housing stability at five (6 percent), and emergency cash at four (4 percent). Protection from raids or extortion, language support, and mental health/community support were each selected by two participants (2 percent).

Three single responses were recorded once each: “To be UNHCR Card holder,” “All,” and “None.” They are reported in the prose but omitted from the main figure because their meanings differ and the cells are too small for useful visual comparison.

Figure 13.2. Priority selected as most important



The leading four categories accounted for 63 of the 90 single selections, but their proximity is more informative than their order. A difference of one participant separates job protections from safer healthcare. Legal information and safe transportation are tied. The survey design does not support declaring one of them "the community's top demand."

Eight records contain a most-important answer outside the stored multi-select set. The survey did not ask why. The distribution remains useful as a record of what participants entered, but it should not be interpreted as a validated ranking.

13.3 Practical priorities were valued for what they enabled

The interviews explain why the survey categories sit close together. Documentation and legal protection were commonly valued as means to move with less fear, reach a hospital, reduce some costs, work more securely, or know whom to contact after an encounter. Participants did not describe a document as making every setting safe. They described specific differences they hoped it would make.

Work-related proposals concerned more than obtaining any job. Participants asked for fairer treatment, stable employment, vocational training, job placement, and skills that could produce income. One participant proposed teaching an existing practical skill so that other refugees could earn income. The idea was grounded in a current capacity, but no organized training program was described.

Safe transportation and language support were similarly enabling priorities. Transport was connected to the cost and perceived risk of reaching work, school, and healthcare. Language could determine whether someone understood a route, explained a symptom, completed an application, or acted without paying another person to accompany them. Interview participant 27 proposed functional Malay rather than full fluency:

> *"Same concept but we teach Malay to them, even if not 100% fluent, at least just enough for them to get from one place to another, take their kids to school, go to hospital, go to the store, etc."*
> Interview participant 27

The account brings several survey categories into one ordinary sequence. Language was valued because it could make transport, school, healthcare, and shopping more manageable. It was not merely an educational preference.

Table 13.1. Distinguishing priorities, hopes, conditional intentions, and concrete plans in the interviews

Category	Working definition	Illustrative interview pattern	Interpretation boundary
Priority	A condition or practical change the participant wanted addressed.	Fairer or more stable work, safer healthcare, reliable documentation or legal information, and safer transport.	Identifies importance, not a rank, consensus, implementation plan, or tested solution.
Hope	A desired future that might have no identified pathway or next step.	Greater stability, safety, opportunity, family unity, education, peace, or resettlement without a stated course of action.	Shows future orientation, not feasibility, eligibility, timing, or a plan.
Conditional intention	A possible course of action that depended on an event outside the participant's control.	Returning to Myanmar if conditions improved, or helping others if a future pathway became available.	The condition had not necessarily occurred; the account did not establish a current plan or controllable timeline.
Concrete plan	An action the participant expected or intended to pursue, often one already underway.	Continuing study, remaining in work, saving for an emergency or education, learning a skill, or continuing an existing community role.	An intention or present practice can still be disrupted and does not guarantee completion or outcome.

13.4 Children made the future immediate

Adults often described children's futures through present household decisions. School fees, transport, books, language, disability support, and the availability of a suitable level of study were immediate concerns. The longer horizon included literacy, qualifications, higher education, stable employment, family support, and choices beyond the work participants currently saw around them.

These were adult accounts. They should not be attributed directly to children unless the participant clearly reported the child's view. Some adults said a child wanted to attend school or enjoyed it;

others inferred how hostel life or interrupted study might feel. The interviews do not provide a child sample.

Education also organized family labor. One person worked while a sibling studied. A parent stayed home to care for younger children while another household member earned. Some adults paid school fees for children or siblings in Malaysia and Myanmar. Present sacrifice was often justified by a future in which the learner could later support the family.

Other children's futures were described less concretely. Participants wanted children to be safe, receive scholarships, progress beyond the level available, avoid entering work early, or reunite with a parent. Serious illness, unstable income, and enforcement fear could narrow attention to the next fee, appointment, or trip. The long-term aspiration remained, but the next action was not always under the household's control.

13.5 Resettlement was one future, not the only future

Third-country resettlement or reunification appeared in several interviews, with different meanings: a safer country, family reunification, lawful work, education, or simply an alternative to uncertainty. These accounts do not establish an active application, eligibility, a confirmed destination, or a likely timeline.

For some participants, resettlement was the clearest image of long-term safety. Illness, separation, insecure work, and fear of detention made an alternative country seem like the only route out of a suspended life. Others treated it as one possibility while continuing to work, study, parent, or build community ties in Malaysia.

Family reunification carried a different urgency. One participant living apart from a spouse described reunification as the greatest desire but did not know how to proceed from Malaysia or how a child's documents might affect the process. The account is paraphrased because the combination of family structure, destination, and documentation details creates a greater identification risk. The study cannot establish the procedural status or feasibility of the case.

Return to Myanmar was also present, usually conditionally. Some participants missed home and wanted to return if conflict and political conditions improved. Others said return did not feel safer, or used conditions in Myanmar to make continued hardship in Malaysia more bearable. Interview participant 23 expressed the condition simply:

> *“If the country gets better I would love to go back home.”*
> Interview participant 23

This is an attachment and a conditional aspiration. It is not a current return plan, and the interview does not establish what change would make return safe or possible.

Staying in Malaysia could reflect preference, comparative safety, family or community ties, work, or lack of another option. Several participants acknowledged opportunity in Malaysia, especially for people healthy enough to work. Some described supportive employers, workable housing, education in progress, or skills gained through work. Others focused on making life in Malaysia safer while waiting. Remaining should not automatically be read as choosing Malaysia over resettlement or return.

13.6 Hope often remained broader than a pathway

Many interview accounts were future-oriented without specifying a course of action. Participants hoped for health, safety, documentation, a stable job, family unity, education, peace, or the ability to help others. Faith often sustained the belief that circumstances could change. Family responsibility provided another reason to continue. Neither produced control over documents, health, conflict, or resettlement.

Interview participant 19 resisted the request for a specific program:

> *“I do not have specific suggestions, but I hope refugees can live with more stability, safety, and opportunities in the future.”*
> Interview participant 19

The absence of a detailed proposal should not be interpreted as lack of concern or ambition. Other participants used similarly broad language because illness, unemployment, caregiving, debt, or family separation made long-term planning difficult.

Uncertainty was sometimes explicit. Participants said they did not know when documents would arrive, whether a family could reunite, whether work would continue, or what would happen next. Some described life in Malaysia as temporary without naming the next destination. Some focused on the present: medication, a child's fee, the next rent payment, or avoiding an enforcement operation.

Planning requires more than a desired outcome. It requires some control over timing, information, money, health, documents, or institutional decisions. The interviews show that those conditions were unevenly available. Inability to name a plan was therefore evidence about constrained agency, not evidence that a participant lacked a future orientation.

13.7 Plans were most visible in actions already underway

Concrete plans were less common than hopes. The clearest examples were attached to current behavior: continuing study, remaining in work, saving, supporting relatives, learning a skill, caring for a family member, or serving through an existing community role. Even these plans could be disrupted.

Several participants described saving for emergencies, a future home, children's education, or relatives abroad. These plans remained vulnerable to illness, lost work, and other shocks.

Work plans were often nearer-term. Participants sought a stable job, stayed with a familiar employer, learned restaurant or carpentry skills, or tried to save from part-time income. Some hoped to open a service, teach a skill, or assist other refugees later. Those later activities usually remained aspirations unless the participant was already doing related work.

The strict distinction prevents a positive narrative from outrunning the evidence. "I hope to resettle" is not a plan to move. "I would like to open a clinic" is a participant proposal, not a funded project. "I will continue studying" has a clearer action, especially when study is already occurring. "I am saving for an emergency" describes an active practice, even if the amount or outcome is uncertain.

13.8 Service, faith, and responsibility extended the horizon

Some participants imagined their futures through service to others. They wanted to teach practical skills, assist new arrivals, translate, improve healthcare or education, connect people to organizations, share information, or help Zomi refugees apply if a future pathway became available.

One hoped to preserve personal experience in writing for younger generations. These were individual aspirations, not a shared program endorsed by all participants.

For some, service was already part of daily life. Interview participant 20 was helping people during documentation and enforcement problems and described what that work meant:

> *“Helping the refugee community and supporting people in difficult situations gives me purpose and motivation.”*
> Interview participant 20

The quotation describes present activity as well as future orientation. Service gave meaning, but it also exposed the participant to repeated accounts of detention, deportation, financial need, and fear. Collective responsibility could sustain a person and increase the burden carried.

Faith appeared in similar ways. Participants described prayer as bringing calm, endurance, or confidence that a way would emerge. Some connected a hoped-for future to reciprocal obligation: if they became safer or more established, they wanted to help those still struggling. Faith did not remove the need for money, documents, healthcare, or information. It helped some participants continue while those needs remained unresolved.

Family responsibility was even more widespread. Provision, remittances, childcare, and caregiving shaped work, saving, study, and the desire to remain healthy. A future was often judged by whether it would allow a participant to protect or support someone else. The unit of aspiration was not always the individual.

13.9 Priorities and futures were not one experience

Participants identified a cluster of connected practical priorities rather than a single mandate. Their futures ranged from work, study, saving, care, and service to conditional hopes of reunification, resettlement, or return. Chapter 14 examines how the main hardship domains overlapped.

Chapter 14. Overlapping Hardships

Practical hardships often appeared in the same survey record, while interviews showed how one disruption could affect several parts of household life. To describe co-occurrence without treating the domains as equivalent, this chapter uses a post hoc count of documentation insecurity, enforcement and mobility, healthcare access and safety, and housing risk.

Twenty-eight of 90 met all four definitions, 38 met three, 17 met two, six met one, and one met none; the mean was 2.96. A positive PHQ-8 or GAD-7 screen occurred in 24 of 28 participants meeting all four definitions, compared with 32 of 61 meeting one to three. Similar percentages at one, two, and three make the comparison descriptive, unadjusted, noncausal, and neither a dose-response nor a validated threshold. Separate interviews show pathways and variation but cannot be linked to survey records.

14.1 Defining overlapping practical hardship

The four domains applied to all 90 survey participants. Documentation insecurity included participants reporting no documents or pending documentation circumstances; 58 met this definition. It describes reported circumstances, not legal status, immigration authorization, work authorization, or safety.

The enforcement and mobility component identified participants reporting at least one of three conditions: fear rated 4 or 5 on the 0-to-5 scale, avoiding places often or very often because of documentation concerns, or routine change sometimes or more often because of fear. Seventy-one participants met this broad definition. It is not a scale of enforcement exposure.

The healthcare access and safety component combined needing care in the previous three months but not going with disagreeing that healthcare felt safe for people like the participant. Fifty-seven reported at least one. The measure does not make unmet need and perceived safety equivalent. The healthcare-barrier follow-up was excluded because its reversed response pattern could not be interpreted securely.

Housing risk included difficulty paying rent, three or more people sharing the sleeping room, or two or more moves in the previous 12 months. Eighty participants met at least one condition, a total strongly influenced by rent difficulty. The indicator does not measure homelessness, eviction, legal overcrowding, habitability, or severity.

Table 14.1. Definitions of the exploratory four practical hardships

Practical hardship domain	Operational definition	Participants meeting definition, n/N (%)	Principal caution
Documentation insecurity	Reported no documents or pending documentation circumstances.	58/90 (64%)	Describes reported circumstances, not legal status, immigration authorization, work authorization, or safety.
Enforcement and mobility	Met at least one condition: fear rated 4 or 5; avoided places often or very often because of documentation concerns; or routine changed sometimes, often, or very often because of fear.	71/90 (79%)	A broad post hoc indicator, not a scale or objective measure of enforcement exposure.

Practical hardship domain	Operational definition	Participants meeting definition, n/N (%)	Principal caution
Healthcare access and safety	Needed care in the previous three months but did not go, or disagreed that healthcare felt safe for people like the participant.	57/90 (63%)	Does not make unmet need and perceived safety equivalent; the reversed healthcare-barrier follow-up was excluded.
Housing risk	Reported difficulty paying rent, three or more people sharing the sleeping room, or two or more moves in the previous 12 months.	80/90 (89%)	Strongly influenced by rent difficulty; does not measure homelessness, eviction, legal overcrowding, habitability, or severity.

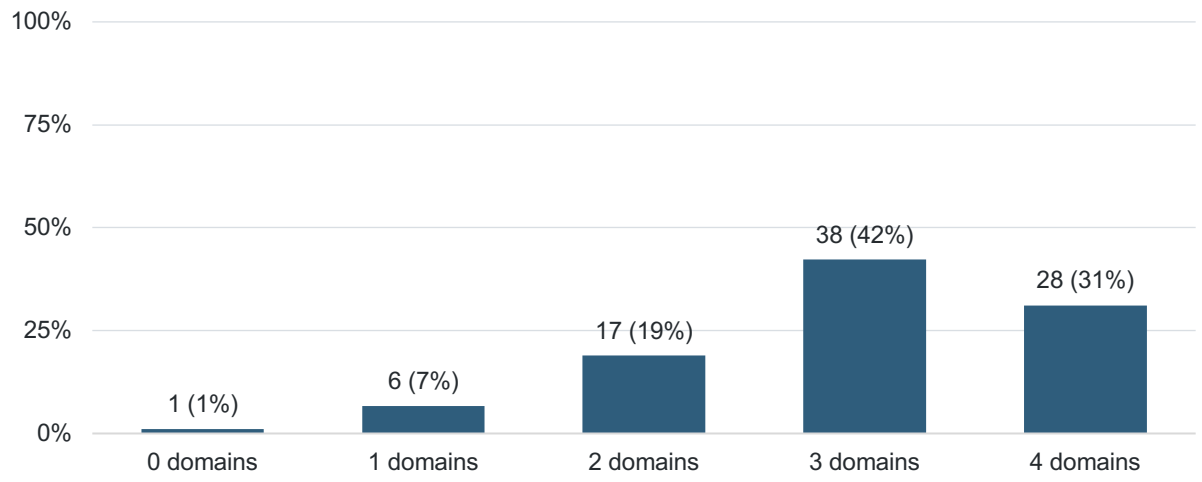
Mental-health screening remained an outcome for comparison rather than a fifth hardship. Support remained a resource and relationship. Employment and education were excluded because they applied conditionally to workers and households with children. The composite therefore offers one consistent count across the survey sample while leaving the domain findings intact.

This selection rule matters. Adding work would have changed the meaning of a score for people who were working, seeking work, or outside the current labor force. Adding education would have made the score depend on whether children were present in the household. Excluding those domains does not make them less important. It preserves a common denominator and keeps conditional findings available for separate interpretation.

14.2 Most participants met several broad definitions

One participant met none of the four definitions, six met one, 17 met two, 38 met three, and 28 met all four. Sixty-six of 90 met at least three. The complete distribution is more informative than the mean alone.

Figure 14.1. Number of practical hardships reported by survey participants



Overlap was common, but equal totals could contain different domains and different experiences within a domain. One housing point could reflect rent difficulty alone or rent difficulty together with frequent moves and a crowded sleeping room. The count cannot show whether a condition was brief or persistent, manageable or overwhelming, or dominant in a household decision.

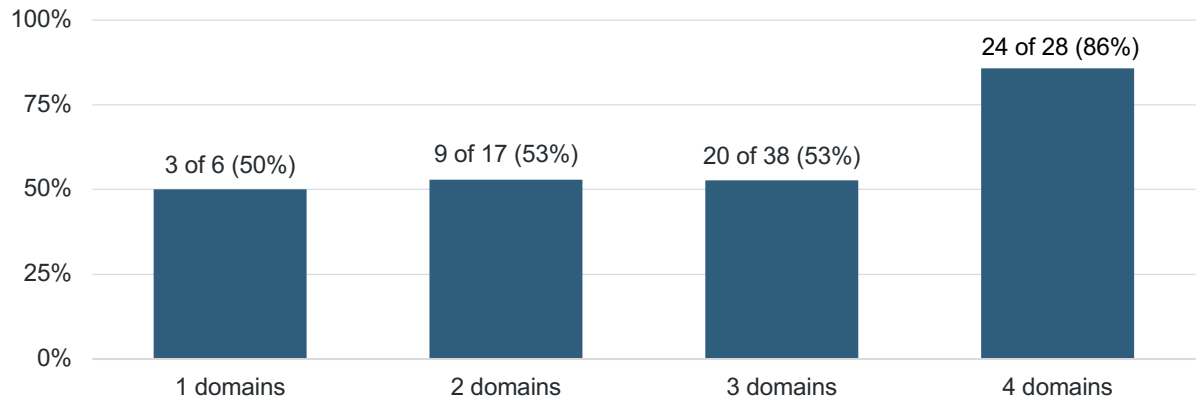
Nor can it identify the combination from the total alone. A score of three might join documentation insecurity, enforcement or mobility, and housing, or enforcement or mobility, healthcare, and housing. The distribution establishes frequent overlap, while the component matrix and domain chapters remain necessary to understand what overlapped.

14.3 Positive screens were concentrated in the all-four group

Across the survey sample, 42 of 90 participants had PHQ-8 scores of 10 or higher, 48 had GAD-7 scores of 10 or higher, and 56 screened positive on either or both measures. These are symptom screens rather than diagnoses, and the PHQ-8 contained no self-harm or death item.

Three of six participants with one hardship screened positive, as did nine of 17 with two and 20 of 38 with three. The corresponding percentages were 50, 53, and 53 percent. In the all-four group, 24 of 28 screened positive, or 86 percent. The descriptive difference between the all-four group and the combined one-to-three group was 34 percentage points.

Figure 14.2. Positive PHQ-8 or GAD-7 screen by number of practical hardships



The result establishes only that a positive screen was more common among survey participants meeting every broad definition. The analysis did not adjust for age, health, work, household composition, earlier experiences, or other factors. It cannot establish which condition came first or that a fourth domain caused symptoms.

The four measured domains may also co-occur with circumstances outside the composite. Chronic illness, earlier experiences, family separation, disability, caregiving, income, and work conditions could shape both reported hardship and symptom scores. The separate interview sample can make such connections intelligible, but it cannot identify the circumstances of the 28 survey participants in the all-four group.

14.4 Documentation and enforcement entered other domains through movement

Documentation and enforcement concerns entered work, healthcare, education, worship, and institutional contact through decisions about routes, timing, accompaniment, and whether to travel. Anticipation could affect behavior even when no encounter occurred that day.

Documents could still improve a specific interaction. One participant described that bounded practical protection:

> *“Although I now have a UNHCR card and feel safer than before, I still do not feel completely safe.”*
> Interview participant 10

Earlier encounters, warnings, household documentation differences, location, and reachable help altered the practical meaning of similar papers. Some participants without completed documents described stable routines arranged through work or family, while some document holders continued to restrict movement. Documentation insecurity and enforcement or mobility were therefore related but not interchangeable.

Movement was the connecting mechanism. A clinic visit, work opportunity, school journey, worship service, or institutional appointment required travel through spaces that participants did not always experience as secure. Concern about that route could enter another domain before any direct encounter occurred, while transport or accompaniment could make the same journey more workable.

14.5 Work, housing, and healthcare could turn one disruption into several

Employment was outside the universal composite but shaped its domains. Sixty-three of 90 survey participants were working. Among workers with available data, 42 of 61 reported days of at least nine hours and 29 of 62 met the exploratory work-risk definition. These worker-only results do not apply to participants outside current employment.

Employers sometimes provided accommodation, meals, transport, interpretation, or medical payment. One participant described direct help:

> *“I go to a clinic first. My employers bring me to a clinic.”*
> Interview participant 32

The assistance was valuable, yet it also shows how access could depend on a relationship. When one job supplied income, housing, transport, and healthcare help, illness or job loss could affect several needs. Continuing to work might protect food and rent while reducing time for treatment; leaving might protect health while threatening income or shelter.

Illness could raise costs while reducing earnings. Treatment might require fees, travel, interpretation, time away from work, and another person's care. A relative, church, employer, or community contact could make one stage possible while debt, lost wages, rent, or follow-up remained unresolved.

Housing could either pool resources or narrow control. Shared arrangements sometimes reduced costs and enabled care. In other accounts, crowding, limited privacy, household authority, or employer dependence made the arrangement harder to leave. The single housing point cannot distinguish these meanings.

The interviews also show why a single disruption need not follow one fixed sequence. Medical treatment could reduce savings, missed work could delay rent, and a rent shortfall could increase reliance on relatives or an employer. In another household, employer transport or family help could interrupt that chain. These are observed routes through participants' accounts, not a claim that every domain caused the next.

14.6 Household responsibility connected work, health, and learning

A missed wage could affect several adults and children. One participant stated the responsibility plainly:

> *“I am the only worker supporting seven family members.”*
> Interview participant 17

Across interviews, adults weighed work, illness, rent, food, transport, fees, accompaniment, and care. One person's employment could depend on another remaining at home. When care needs changed, work options changed.

Education remained outside the composite because it applied only to households with children under 18. Among 48 such household reports, 15 indicated no current school or learning arrangement, including six in which children were below school age, and 24 disagreed that children could learn safely and consistently. These are adult household reports, not child-level rates.

Learning could depend on fees, transport, language, location, community provision, and an adult's schedule. Adults also linked present work, saving, and study to younger family members. Household responsibility could create both purpose and pressure without giving every family the same experience.

This household lens changes the meaning of individual indicators. A participant's work hours could determine another person's access to care or learning. A caregiver's absence from paid work could enable someone else to earn. A move could alter transport, school continuity, and the availability of relatives at once. The composite records the adult respondent's four domains, while the interviews show how consequences were distributed within and beyond the household.

14.7 Support changed what was possible without replacing resources or authority

Relatives, friends, churches, community representatives, employers, teachers, interpreters, and service providers explained, translated, lent, transported, accompanied, referred, called, cared, and reassured. In many accounts, another person connected knowledge of a service to its actual use.

The limits were concrete. A relative could know whom to call but lack money. A church could contribute to a bill without replacing lost wages. An employer could arrange care while controlling available time. An interpreter could enable a conversation without determining the institution's decision. Help in one crisis might not be available for the next rent payment or follow-up visit.

The support-frequency item cannot measure the type, adequacy, timing, or obligation attached to help. The exploratory support-by-screen comparison did not show a simple protective gradient and is therefore retained in the audit rather than the public chapter. The supported public finding is narrower: relational help could change an immediate outcome, but it did not replace recurring resources or formal authority.

Frequency also cannot reveal whether help was sufficient, arrived in time, created an obligation, or required the helper to lose wages. Participants with greater need may have mobilized assistance more often. Faith, conversation, work, family, and service could sustain functioning alongside distress. Neither receiving help nor continuing responsibility demonstrates that hardship had ended.

14.8 The same hardship count did not mean the same life

The composite deliberately compresses variation. A participant could meet all four definitions and still describe supportive work, successful care, cooperative housing, or meaningful community roles. Another could meet fewer domains while a severe illness, family separation, disability, caregiving demand, or income loss dominated daily life.

Timing also mattered. A current document did not erase an earlier encounter. Stable housing at the survey date could follow repeated moves. A person might have received care yet remain in debt or uncertain about follow-up. Cross-sectional responses place domains in the same record, not necessarily in the same sequence.

Participants' strategies further changed practical consequences. They changed routes, shared costs, borrowed, sought accompaniment, moved, changed jobs, used pharmacies or home care, studied, prayed, and served others. Such actions were neither evidence that constraints had disappeared nor proof that the participant lacked agency. The same count could therefore coexist with different levels of control, support, responsibility, and replaceability.

The interview cases make that variation concrete. Some people described stable work or housing while limiting movement. Others obtained respectful care but incurred costs or remained uncertain about follow-up. Shared housing could increase companionship and pooled resources, or it could narrow privacy and decision-making. A current document could improve confidence while a spouse, parent, or child remained in a different documentation circumstance. The count identifies co-occurrence, not a uniform life.

14.9 What the overlap can and cannot establish

The composite shows that four broad definitions often co-occurred and that positive screens were more common in the all-four group. It does not measure severity, vulnerability, trauma, deprivation, legal status, or causal risk; establish a threshold; rank individual lives; or identify an intervention target.

Convenience recruitment, broad components, small groups at zero and one, the unadjusted cross-sectional comparison, and the absence of survey-interview linkage limit inference. Domain findings and qualitative variation remain necessary.

14.10 Chapter synthesis

Most survey participants met several broad definitions, and positive screens were concentrated in the all-four group without a steady rise across one to three. Interviews showed why the same count could reflect different sequences, responsibilities, supports, and degrees of control. Chapter 15 interprets those connections without extending the composite.

Chapter 15. Integrated Discussion

Across the findings chapters, a resource could exist without participants controlling the steps needed to use it. Work, a clinic, a learning place, a document, or a trusted contact might still depend on money, movement, language, time, care, follow-up, and an institution's decision.

This chapter interprets the established findings without adding evidence or recommendations. Survey and interview samples remain separate, the four-hardship composite remains post hoc and descriptive, and the measurement boundaries set out in Chapter 4 continue to govern the discussion.

15.1 Access depended on a chain of conditions

An access chain is the sequence between a need and a usable outcome. For healthcare, it could include recognizing that care was needed, finding information, arranging travel, entering registration, communicating with staff, paying, receiving treatment, and returning. Education could require a place, fees, transport, language support, workable placement, regular attendance, and a next level. Employment could depend on a referral, safe travel, understood terms, payment, leave, injury response, and a viable alternative if the job ended.

Breakdown at one link could make an existing service unusable. Forty-nine of 90 survey participants disagreed that healthcare felt safe, while interviews described cost, travel, documents, language, work time, accompaniment, and continuity. Half of adults in households with children disagreed that learning was safe and consistent, while interviews described fees, distance, placement, and progression. These measures do not identify one universal barrier. They show why availability alone was an incomplete test of access.

The chain was also social. A relative located a job, a community member interpreted, an employer arranged transport, or a church helped with a bill. Such help could convert formal availability into practical use. Its success depended on another person's knowledge, resources, and availability, and the final decision often remained with an institution.

Repeatability is therefore central. One completed appointment or rent payment matters, but durable access also requires a route that can be used again, a substitute when one helper is absent, a way to correct information, and clarity about who controls the next decision.

A pathway could fail before or after the visible point of service. A person might know where to go but not travel, complete registration but not afford medicine, obtain a school place but not sustain transport, or receive an employer advance that deepened dependence. Access is therefore better understood as control over a sequence than as simple availability.

15.2 Protection was bounded, situational, and relational

Documents and relationships sometimes produced bounded practical protection: a concrete improvement in a particular encounter without control over the person's wider circumstances. A UNHCR-related document might lower a hospital charge, support verification, or assist after detention. A community-issued card might identify whom to call. A companion might make a journey or registration possible.

These benefits were substantial but situational. The same document could be interpreted differently across settings, and household members could hold different papers. Earlier encounters, work location, health, family obligations, and access to help shaped whether a person felt able to travel. The term is not a legal category and does not imply immigration authorization, work authorization, release, resettlement, reunification, or complete safety.

Protection was also relational because practical outcomes often depended on someone willing and able to act. That relationship could improve the immediate outcome while leaving a power difference intact. Recognizing the benefit without overstating its reach is more accurate than treating informal assistance as either meaningless or sufficient.

The distinction also applies within households. One person's document, employment, language skill, or institutional relationship could expand options for others without being shared equally. Assistance could make a journey possible while another household member remained unable to travel. Bounded practical protection describes that uneven improvement; it does not describe a stable status held by a person.

15.3 Work concentrated resources, responsibility, and risk

Employment supplied income, routine, skill, purpose, and support for relatives. It could also involve long days, delayed pay, injury risk, limited leave, or concern during travel. For some participants, employers added housing, meals, transport, interpretation, medical payment, or help during an encounter.

Bundling several resources in one relationship increased the consequences of exit. Losing a job could mean replacing a wage, room, clinic route, meals, and an institutional contact at the same time. This does not establish coercion or make employer help suspect. Several participants described supportive employers. The interpretive point is unequal replaceability: the worker might have fewer alternatives and more resources to replace.

Wages also carried household obligations. Rent, food, healthcare, school fees, debt, and support for relatives competed within one budget. Illness could increase spending while reducing earnings, and inflexible work could delay care. These connections explain how participants could value employment, appreciate an employer, and still identify job protections as a priority.

They also explain why changing jobs appeared as a practical response. Where a complaint or remedy felt inaccessible, replacing the employment relationship could be more feasible than changing its terms. That strategy demonstrated judgment and agency, but it placed the work of adjustment on the worker and could interrupt every resource attached to the job.

15.4 Households absorbed costs that institutions did not

Households pooled earnings, shared housing, borrowed, provided care, sent money, postponed spending, and divided paid and unpaid work. These actions kept rent paid, enabled treatment, and allowed another person to work or study.

Adaptation could create its own costs. Sharing might reduce rent and provide companionship while limiting privacy. Unpaid care could support one person's work while narrowing another's options. Borrowing might complete a medical visit while transferring the cost into debt. Employer accommodation or a school hostel could solve one problem while reducing control elsewhere.

The findings do not support a single judgment about sharing or dependence. Cooperative arrangements produced genuine stability for some participants. The broader interpretation is that households supplied time, money, care, and coordination when formal pathways were difficult to use, and their capacity to absorb the next disruption depended on the margin that remained.

These allocations could extend across borders as well as across rooms. Remittances and responsibilities to relatives elsewhere shaped what remained for rent, treatment, or school fees in Malaysia. The study was not designed to estimate gendered divisions of paid and unpaid labor, so it cannot assign these costs to one household member or model.

15.5 Community relationships made systems usable

Friends, relatives, churches, community organizations, teachers, interpreters, employers, and service providers carried out community bridging work. They passed information, confirmed identity, referred people, interpreted, accompanied, raised money, negotiated, and provided shelter or transport. The term describes practical connecting work, not a formal or coordinated system.

The distinction between trust, use, and authority matters. Friends and family were the most selected information source, and church leaders and friends or family had the higher mean trust ratings. Yet 69 of 90 participants reported someone to rely on no more than sometimes. A person may trust a relative who lacks money, use a digital group cautiously, or call an organization that can explain a process but cannot decide the outcome.

Community bridging work could change an urgent encounter, but it could not guarantee income, continuing treatment, educational progression, or an institutional decision. Helpers also faced financial, time, and emotional limits. When a small number of people became the default contacts for interpretation or crisis response, access depended on labor that was difficult to replace.

A referral chain was often assembled for one problem rather than supplied by a coordinated system. A relative could locate a clinic, a community member interpret, a church contribute funds, and an employer permit leave. A different need required a different combination. This flexibility was a strength, while the absence of stable coverage made continuity uncertain.

The support-frequency item adds no simple protective gradient for positive screens. That exploratory comparison remains in the audit. The stronger interpretation comes from the combined evidence: relational help could be decisive at a specific moment while leaving the source of pressure unresolved.

15.6 Accumulated hardship and emotional wellbeing

Twenty-four of 28 survey participants meeting all four exploratory hardship definitions screened positive on the PHQ-8, GAD-7, or both, compared with 32 of 61 participants meeting one to three. Percentages at one, two, and three domains were nearly identical. The observed concentration therefore does not establish a dose-response pattern or causal threshold.

The four binary components do not record severity, timing, or duration, and the comparison was unadjusted. Health, earlier experiences, household composition, work, caregiving, and other unmeasured factors may relate to both hardship and symptoms. PHQ-8 and GAD-7 results are screens, not diagnoses or evidence of treatment need.

Interview accounts make plausible connections visible without proving the survey association. Work pressure could interrupt sleep when one income supported several people. Illness could increase costs while reducing earnings. Enforcement reports could alter travel and rest. Delayed care could extend uncertainty and require money or accompaniment.

Participants also found purpose in family, faith, work, study, and service. Continued functioning did not prove that distress was absent, and a positive screen did not describe the whole person. Physical symptoms in interviews cannot be assigned psychological causes. The all-four result is a descriptive concentration that warrants attention, not a new clinical or social classification.

The shape of the comparison is as important as its size. Positive-screen percentages at one, two, and three domains were 50, 53, and 53 percent, then 86 percent at four. Calling this a smooth gradient would misstate the data. Calling it a threshold would give a post hoc count a status the design cannot support. The literal all-four comparison is both clearer and stronger.

15.7 Agency did not remove constraint

Participants sought documents, changed routes, found accompaniment, moved, changed jobs, learned skills, saved, studied, cared, shared information, prayed, and served. These actions altered outcomes and sometimes produced real stability.

Agency is not the same as unconstrained choice. Avoiding travel could reduce exposure while limiting work or services. Borrowing could protect health while increasing debt. Employer housing could stabilize shelter while tying it to work. Home care could be ordinary treatment for a minor illness, a temporary step, or a response to cost.

Accounts of opportunity, supportive employers, effective care, stable shared housing, and educational progress are part of the findings. Recognizing those gains does not transfer responsibility for institutional limits onto participants. It also keeps hope separate from planning: a desired future became a plan only when a feasible action or pathway was identified.

Future orientations included improving life in Malaysia, resettlement or reunification, return under safer conditions, and uncertainty. Some participants focused on medicine, rent, or the next work decision rather than a distant destination. Concrete plans were most visible in study, work, saving, care, and service already under way, and even those plans remained open to disruption.

Variation is essential to this interpretation. Some participants described stable work, effective treatment, supportive shared housing, educational progress, or little personal difficulty in a domain. Others faced severe constraints concentrated in one part of life. Keeping these counterexamples in view prevents hardship from becoming an identity and prevents a cross-domain explanation from flattening individual accounts.

15.8 Children extended the time horizon

Adults connected school fees, transport, language, placement, and safety to literacy, progression, future work, and family support. Current allocations therefore carried consequences beyond the immediate household budget.

The evidence remains adult household reporting. Among 48 participants reporting children under 18, half disagreed that children could learn safely and consistently. Six households with no current

arrangement cited children being below school age. These findings are not child-level rates or direct accounts from children.

Education entered other domains through the adult time and income needed to sustain it. Work could pay fees, care could limit employment, a hostel could resolve travel, and illness or rent could narrow continuity. Adults described sacrifice for younger relatives as both pressure and purpose, but households differed in their arrangements and aspirations.

Community learning should therefore be interpreted neither as automatic exclusion nor as proof of a complete pathway. Families valued teachers, familiar language, sponsorship, and continuity while also describing uncertain progression, transport, fees, and limited specialist support. The study did not collect children's own views, so their interests cannot be inferred from adult accounts alone.

15.9 Participant priorities identified cross-domain leverage points

Job protections and safer healthcare were each selected by 48 of 90 survey participants, and safe transportation by 45. The multi-select item was not a rank, six records did not contain exactly three selections, and the separate most-important item had eight mismatches. No category received more than one fifth of forced-choice responses.

Even with those limits, the selections illuminate cross-domain leverage points. Work conditions could affect income, leave, housing, healthcare, and family support. Transportation connected homes to jobs, clinics, learning, worship, and community institutions. Legal information, language support, housing, education, and emergency assistance addressed other links.

Participant priorities, interview proposals, hopes, plans, and author recommendations remain different forms of evidence. Chapter 16 makes the author judgment about action, authority, feasibility, equity, and possible harm.

This separation protects both forms of evidence. It prevents a survey selection from becoming an unevaluated programme and prevents author recommendations from being presented as participant consensus. It also allows a prominent priority to be modified when the proposed actor lacks authority or the foreseeable harm requires safeguards.

15.10 What this study contributes

The study provides a bounded Zomi-specific account within two participant groups. The survey describes distributions and limited overlap within 90 records; 36 separate interviews show sequences, institutional encounters, household responses, variation, and counterexamples.

Community bridging work is also visible. Families, churches, organizations, employers, teachers, and other contacts supplied information, translation, transport, money, referrals, accompaniment, and communication; the evidence records both their value and limits.

The four-hardship composite shows frequent co-occurrence and a sharper positive-screen percentage in the all-four group, but it cannot classify people, measure severity, or replace domain evidence. The report complements rather than replaces community knowledge and direct consultation.

15.11 Integrated interpretation

Daily security depended on control over the sequence connecting a need to an outcome. Participants, households, and community institutions often supplied missing links, sometimes decisively, but repeated improvisation exposed gaps in resources, replaceability, and decision authority.

Immediate assistance and durable access are therefore complementary. Chapter 16 converts that distinction into recommendations that assign responsibility to actors with relevant authority while keeping participant priorities separate from author judgment.

Chapter 16. Recommendations

The 11 recommendations are author judgments based on the findings, participant priorities, authority, feasibility, equity, sustainability, and possible harm. Priority 1 covers immediate action, Priority 2 recurring system-building, and Priority 3 structural action requiring formal authority. The tiers describe implementation routes, not importance. The study did not test effects, costs, or legal obligations; each action requires bounded design, current verification, and harm review.

16.1 Principles for action

Strengthen the whole pathway. Each action should name the link it improves, the next contact, and what must happen after referral. Emergency help should protect continuity rather than close a case after one payment.

Match responsibility to authority. Community actors can explain, interpret, accompany, and connect. They cannot grant legal authorization, determine a UNHCR or enforcement outcome, set institutional eligibility, or guarantee release, resettlement, reunification, or return. The actor controlling a decision must own it.

Build repeatable access. A usable pathway needs continuity, backup when one helper is unavailable, correction of inaccurate information, and escalation when the first contact cannot resolve the problem.

Support agency without transferring system failure. Participants already changed routes, jobs, housing, care strategies, and budgets. Actions should expand options and reduce repeated improvisation rather than treat households as passive or make better individual choices the answer to institutional limits.

Protect confidentiality and reach. Collect only information needed for a stated purpose, use clear consent, restrict access, and avoid centralized sensitive profiles. Delivery through several channels should include people outside established churches, organizations, and digital groups.

Fund community bridging work and define roles. Interpretation, navigation, coordination, and accompaniment require pay or reimbursement, supervision, caseload limits, backup, and clear boundaries. A community navigator is a trained person who provides verified practical information, prepares a participant for a referral, coordinates language or travel support, and follows up with consent. The role is not the same as an interpreter, legal adviser, case manager, clinician, community representative, or general volunteer, although one qualified person may perform more than one role under explicit safeguards.

The working title and translated terminology for this role should be confirmed with Zomi organizations before recruitment. Whatever title is chosen, participants need to know the person's training, confidentiality duties, decision limits, supervision, and route for correcting advice or raising a concern.

16.2 Priority 1: Immediate and high-confidence actions

16.2.1 Establish a verified multilingual information and referral pathway

Zomi organizations, churches, refugee-serving organizations, and relevant providers should maintain a small dependable pathway that explains the next step, named contact, likely information requests,

known costs or waits, and escalation route for healthcare, education, housing emergencies, work problems, documentation questions, and urgent assistance.

Guidance should distinguish community-issued records, UNHCR-related documents, pending papers, passports or permits, and Malaysian legal authorization. Navigators may explain verified distinctions and refer to qualified providers, but must not give unqualified legal advice or imply that a document guarantees safety or an outcome.

Use several language-accessible channels, including print, phone, in-person explanation, voice messages, and carefully managed digital updates. Every item needs a review date and owner for corrections. A referral should also flag likely needs for interpretation, accompaniment, transport, financial help, or follow-up. Begin with a limited set of high-use pathways that can be kept current.

Urgent warnings require a verification and correction protocol so that speed does not turn uncertain information into panic. Materials should state when the responsible institution, policy, fee, or contact was last checked. People without smartphones, high literacy, or regular church attendance need an equivalent route to the same information.

16.2.2 Pair priority referrals with transport, interpretation, and accompaniment

Community organizations, clinics, learning providers, and funders should coordinate transport, interpretation, and accompaniment for priority healthcare and education visits. A companion may arrange travel, carry papers, interpret, assist with registration, care for a child, and remain present if a problem arises.

A model could combine transport vouchers, safe and lawful reimbursed drivers, paid interpreters, trained navigators, and an urgent-contact procedure. Receiving providers should identify visits likely to need language or registration help and coordinate in advance. Backup coverage should prevent dependence on one pastor, relative, teacher, or worker.

Participants should disclose only what is necessary and consented to. Routes, pickup practices, and contact records require review for visibility and enforcement exposure. No one should promise that transport or accompaniment determines an authority's response. Initial use should prioritize urgent or recurring care, time-sensitive education visits, and households affected by illness, disability, care, language, or distance.

Eligibility and scheduling should be understandable before a crisis. Providers and community partners should agree who authorizes transport, who books interpretation, what happens after hours, and how a participant can decline accompaniment. Costs should include waiting time and backup coverage, not only the outward journey.

16.2.3 Create flexible emergency assistance that prevents cascading loss

Funders, refugee-serving organizations, and Zomi organizations should pilot rapid grants for short gaps such as transport, medicine, a required health payment, temporary rent shortfall, brief accommodation, or a fee needed to maintain a learning arrangement. Flexibility reflects evidence that illness, interrupted wages, rent, and fees could affect several domains at once.

The study did not evaluate cash assistance or identify a best transfer model. A pilot should use proportionate eligibility, a rapid decision window, a second-review route, and transparent limits. It should test whether assistance solved the stated problem, what remained, and whether payment introduced new risk.

Basic help should not require extensive disclosure of documentation, diagnoses, family history, or church membership. Direct payment to a provider may be offered with consent but should not be the only option when it causes delay or disclosure. Grants are preferable to debt for basic emergency needs.

The mechanism should record only the minimum needed to authorize and review a payment. Monitoring should examine processing time, unmet portions of need, repeat emergencies, privacy, and whether direct payment exposed a participant to a landlord, employer, provider, or community gatekeeper. Emergency aid should create time for a next step, not become a substitute for stable income or affordable services.

16.2.4 Adopt practical employer standards and independent referral routes

Willing employers recruiting through Zomi or refugee-serving networks should pilot a concise good-practice package developed with workers, community organizations, and qualified employment specialists. It should state wages and timing, ordinary hours, urgent leave, safety and injury response, accommodation terms, and how information will be provided in a language the worker understands.

The recommendation responds to job-protection priorities and the 29 of 62 workers who met the exploratory work-risk definition, while preserving evidence of supportive employers. Employer help should not make the employer the only route to healthcare, housing, interpretation, or dispute advice. Workers need a confidential external referral, and employer housing should include clear terms and a transition contact if work ends.

The package must distinguish voluntary practice from enforceable obligation. Malaysian law and the authority of any complaint or referral body require specialist review. Community organizations should refer rather than adjudicate disputes. Independent worker feedback should guide whether the pilot changes or expands.

Feedback must be available without the employer present and should ask about payment, hours, leave, safety, injury response, accommodation, debt or advances, and access to outside advice. A referral body needs independence sufficient to avoid exposing a worker to the same actor whose conduct is in question. Any data reported publicly should be aggregated and disclosure-reviewed.

16.3 Priority 2: Strengthen systems and continuity

16.3.1 Fund community navigators, interpreters, and referral agreements

Funders and service organizations should support paid navigator and interpreter roles within trusted Zomi organizations or accountable partners. Budgets should include pay, transport, phones, supervision, training, secure minimal records, coordination time, and backup coverage.

Navigators may provide verified information, prepare a participant, arrange language or travel support, and follow up with consent. They should not diagnose, provide unqualified legal representation, determine recognition, promise outcomes, or remain personally responsible for every unresolved case.

Documented agreements with clinics, learning programmes, housing and legal services, and emergency providers should name a receiving contact, required information, expected response, confidentiality rules, and the next step when help is unavailable. Closed-loop referral means

checking, with permission, whether the next step occurred, not building a centralized case history. Outreach must include people outside established organizations.

Referral agreements should also define what happens when a receiving service declines, delays, or cannot complete the referral. The navigator should not become the owner of an institutional decision. Caseload and waiting-time review can identify when funded coverage is too small, while participant feedback can identify misinformation, coercion, or a breach of confidence.

16.3.2 Build a healthcare pathway from first contact through follow-up

Healthcare providers serving refugee communities, together with community organizations and funders, should cover entry, registration, communication, cost, treatment, medicine, referral, and follow-up. The 20 participants reporting unmet need and 49 reporting that care felt unsafe support attention to the whole route, not one presumed barrier.

Providers should publish current plain-language registration, fee, document, language-support, appointment, and emergency information, with a staff contact for uncertain administrative questions. Any document statement needs current institutional verification and must not imply legal status or entitlement.

The pathway should connect interpretation, transport, accompaniment, cost discussion, medicine, and follow-up while providers retain clinical authority. Confidential feedback should not depend on an employer or community leader. PHQ-8 and GAD-7 screens do not support universal screening; screening should occur only where consent, language access, referral capacity, confidentiality, and specialist urgent-risk procedures are established.

Care continuity should include the practical steps after the first visit: obtaining medicine, understanding instructions, arranging another appointment, and knowing whom to contact if symptoms change. Community partners may assist with those steps only with consent, while the provider remains responsible for clinical communication and decisions.

16.3.3 Protect housing continuity during illness, job loss, and household crisis

Community organizations, housing partners, employers providing accommodation, and funders should create a continuity route for households facing loss after illness, injury, childbirth, interrupted wages, or job loss. Options may include short-term rent grants, temporary accommodation, consent-based landlord communication, housing referral, and transition planning from employer housing.

Shared and employer-linked housing was sometimes supportive. The concern is control and replaceability when one job supplies both wage and shelter. Clear terms, feasible transition time, and an independent referral can reduce the chance that employment loss becomes an immediate housing crisis.

Mediation should never presume that sharing is harmful, expose documentation circumstances, or pressure a household to remain unsafe. Legal claims about tenancy, eviction, accommodation, or remedies require specialist verification. Monitoring should focus on continuity, participant choice, privacy, and whether assistance creates landlord or employer leverage.

A continuity route should distinguish a temporary financial gap from a dispute, unsafe condition, or need for longer-term relocation. Consent-based landlord communication may be useful in one case and risky in another. Participants should retain the choice not to involve an employer, landlord, relative, church, or community representative.

16.3.4 Strengthen continuity and progression in community-based learning

Community learning programmes, churches, education partners, and funders should plan for fees, transport, language, placement, progression, additional learning needs, household schedules, and funding gaps. Among 48 adult household reports, 15 indicated no current school or learning arrangement, including six with children below school age, and 24 disagreed that children could learn safely and consistently. These are not child-level rates.

Providers should communicate costs and attendance, review placement with families, identify a next step beyond available levels, and coordinate transport and fee support. Teacher and volunteer capacity requires funding, training, supervision, and continuity planning.

The survey label “informal” does not establish quality or recognition. Claims about credential recognition, eligibility, or official progression require current verification by the responsible authority or provider. Family communication should be language-accessible and workable around care, employment, distance, and disability. Direct research with children requires a future age-appropriate protocol.

Programmes should track whether a secured place leads to workable attendance and progression, not only admission. Funding plans need to cover teachers, learning materials, transport coordination, and predictable gaps in donor support. Additional learning needs require referral to appropriately qualified providers rather than unsupported promises from volunteers.

16.3.5 Pair psychosocial support with practical problem solving and safe referral

Zomi churches and organizations, qualified mental-health and primary-care providers, and funders should develop a layered pathway from confidential listening and practical help to qualified care when chosen or indicated. Fifty-six of 90 participants screened positive on at least one measure, but the screens did not establish diagnosis or treatment need.

Trusted first contacts can listen without diagnosing, explain choices, seek consent, protect confidentiality, and recognize role limits. Pastors, volunteers, employers, and community workers should not provide therapy or manage clinical risk without qualification. Urgent-risk procedures require specialist design and current service mapping.

Emotional support should connect with help for the immediate pressure, such as transport, interpretation, a missed wage, rent, or a medical bill. Participants should be able to choose faith-based, community, clinical, or combined routes. Screening must not be an entry condition for practical assistance. Pilots should assess stigma, unequal reach, language, cost, privacy, and continuity.

Confidentiality requires special care in a small community. Records should be minimal, access limited, and referral options explained before sensitive disclosure. Practical assistance must remain available to people who decline screening, counseling, prayer, or disclosure to a community leader. No informal helper should be left to improvise a crisis protocol alone.

16.4 Priority 3: Structural actions requiring formal authority

16.4.1 Review documentation, protection, and enforcement-related pathways

Relevant Malaysian institutions, UNHCR, qualified legal and protection organizations, and UNHCR-facing community partners should review current documentation, verification, contact, and escalation

pathways. The review should state what each recorded circumstance can and cannot do, who controls the next decision, appropriate urgent contacts, and how incorrect information is corrected.

Community organizations can explain, refer, record reported problems, and support communication. They cannot guarantee registration, status determination, release, work authorization, resettlement, reunification, or another externally controlled outcome.

Current legal and policy verification is required. The study did not evaluate enforcement, remedies, or individual procedural status. Review should minimize disclosure and avoid a central list of people with insecure documentation. The appropriate goal is bounded public guidance and tested institutional contacts, not promised outcomes.

The review should distinguish international protection, UNHCR registration, documents held, and authorization under Malaysian law. It should also identify which statements are current legal claims, which are institutional procedures, and which are reported practices requiring further evidence. Public materials need dates and a correction route because both rules and procedures can change.

16.4.2 Reduce dependence on informal gatekeepers through institutional access and accountability

Relevant institutions and sector partners should review the procedures through which refugees and asylum seekers seek healthcare, education, workplace assistance, and complaints. Each sector should identify who owns eligibility decisions, what information is required, how language support is obtained, where stalled decisions can be reviewed, and how confidential feedback can be given without risking work, housing, service, or community relationships.

This is not one centralized system. Institutions hold different powers and must own decisions and corrections within those powers. Community navigators should remain available as chosen support, but church or organizational membership should not determine access to information or referral.

The study did not establish legal duties, cost, or feasibility. Sector-specific legal, policy, and operational review is required. Monitoring should examine reach beyond established networks, retaliation, visibility, and whether institutions are shifting their duties onto community organizations.

Each sector needs a named decision owner and an independent or escalated review route where feasible. Participation in a church or established organization should never be the condition for basic information. Community navigators may support a participant's chosen route, but the institution must explain and correct its own decisions.

16.5 Recommendation matrices

Table 16.1. Recommendation priorities, evidence, actors, timing, and safeguards

Priority	Recommended action	Principal evidence	Relevant actors	Time horizon	Primary safeguard
Priority 1	1. Verified multilingual information and referral pathway	Information, trust, documentation, and access-chain findings; participant interest in legal information	Zomi organizations and churches; refugee-serving organizations; service providers	Immediate	Separate navigation from legal advice; dated corrections; minimum data
Priority 1	2. Transport, interpretation, and accompaniment for priority visits	Safe transport priority; movement, healthcare, and education pathways	Community organizations; clinics; learning programmes; funders; trained navigators	Immediate	Consent, confidentiality, safe scheduling, and backup coverage
Priority 1	3. Flexible emergency assistance	Rent pressure; healthcare costs; interruption across work, housing, and learning	Funders; refugee-serving organizations; Zomi organizations	Immediate pilot	Low-burden eligibility; grants rather than dependency-producing debt
Priority 1	4. Employer good-practice package and independent referral route	Job-protection priority; worker hours and risk; supportive and dependent employer arrangements	Participating employers and associations; worker-support and community partners	Immediate pilot	Independent advice; clear housing and advance terms; legal review
Priority 2	5. Paid navigator and interpreter roles with referral agreements	Interviews on community bridging work; inconsistent support availability	Funders; Zomi organizations; NGOs; receiving service providers	Medium-term	Caseload limits, supervision, role boundaries, secure minimal records
Priority 2	6. Healthcare pathway through follow-up	Unmet need, perceived safety, cost, language, transport, and continuity findings	Clinics and hospitals; healthcare NGOs; community organizations; funders	Medium-term	Provider ownership of clinical decisions; no screening without response capacity
Priority 2	7. Housing continuity after illness or job disruption	Rent difficulty; employer housing; illness and job-loss pathways	Housing partners; community organizations; employers; funders	Medium-term	Consent before contact; no assumption that sharing is harmful
Priority 2	8. Learning continuity and progression	Household learning and safety/consistency findings; fee and transport pathways	Community learning programmes; churches; education NGOs; funders	Medium-term	Household-level interpretation; current verification of recognition claims
Priority 2	9. Psychosocial support linked to practical assistance	Positive screens and interview accounts of pressure, coping, and support	Community and faith organizations; qualified providers; primary care; funders	Medium-term pilot	Consent, confidentiality, referral capacity, and specialist urgent-risk design
Priority 3	10. Documentation, protection, and enforcement-pathway review	Bounded practical document protection; high fear and movement findings; Chapter 2 distinctions	Relevant Malaysian institutions; UNHCR; qualified legal and protection actors	Structural	Current legal verification; no outcome promises; no sensitive central registry
Priority 3	11. Sector-specific institutional access and accountability	Repeated dependence on informal intermediaries across services	Relevant institutions; healthcare and education providers; employment specialists; civil society	Structural	Named authority, confidential feedback, anti-retaliation review, equitable reach

Table 16.2. Access pathways, decision authority, community roles, and risks

Access pathway	Common point of breakdown	Proposed response	Actor with decision authority	Community-support role	Risk to monitor
Information to action	Outdated advice, unclear document meaning, or no named contact	Verified multilingual guidance linked to a referral and correction process	The institution responsible for the procedure or service	Explain, translate, refer, and report errors	False expectations, unqualified advice, digital exclusion
Journey to service	Fare, perceived exposure, language, caregiving, or no companion	Coordinated transport, interpretation, and accompaniment	Service provider for appointment and registration; relevant authority for public rules	Schedule, accompany, interpret, and arrange backup	Visibility, unnecessary disclosure, volunteer overload
Work to household stability	Late pay, injury, limited leave, or one employer controlling several resources	Good-practice package, independent referral, housing transition contact	Employer for workplace practice; qualified body for formal remedies	Provide information and independent referral	Retaliation, debt, employer control, loss of housing
Illness to continuing care	Registration, cost, communication, medicine, or follow-up	Provider-led care pathway with navigation and practical support	Healthcare provider for clinical and administrative decisions	Prepare, interpret, transport, and follow up with consent	Debt, stigma, confidentiality breach, incomplete referral
Learning place to continuity	Fees, travel, placement, language, care schedule, or no next level	Fee and transport support, placement review, progression and continuity planning	Education provider for admission and programme decisions	Communicate with families and coordinate support	Exclusion, overclaiming recognition, unsustainable volunteer labor
Distress to appropriate support	Stigma, no confidential contact, or practical crisis left unresolved	Layered listening, practical help, and qualified referral	Qualified provider for clinical assessment and urgent-risk response	Offer trusted first contact and chosen practical support	Informal diagnosis, unsafe screening, privacy loss

16.6 Implementation principles

Co-design around real decisions. Participants and Zomi organizations should shape language, timing, information, and contact methods. Include people outside leadership and frequent-service roles, as well as those constrained by work, care, distance, illness, disability, literacy, or digital access.

Start with bounded pilots. Specify the access link, safe reach, minimum resources, success and harm indicators, and conditions for stopping or changing. Expansion should follow evidence of usability and safety, not referral volume alone.

Use consent and data minimization. Explain why information is needed, who can see it, retention, and the effect of declining optional disclosure. Separate service records from public reporting and collect no detail merely for a dashboard.

Compensate labor and define escalation. Pay or reimburse recurring navigation, interpretation, coordination, and accompaniment. State what the first contact can decide, what requires a qualified actor, and what happens when no option is available.

Monitor unequal reach and harm. Review who is missing, who waits longer, and who depends on one intermediary. Track incomplete access, debt, retaliation, stigma, privacy loss, enforcement visibility, employer or landlord control, unsafe screening, and burnout.

Plan for sustainability and exit. Budgets should cover administration, phones, transport, secure storage, supervision, and relief coverage. A pilot should state how participants will be informed if funding ends, how active referrals will be transferred, and which records will be retained or destroyed.

16.7 From recommendations to accountability

Each partner should name the role responsible for its part of a pathway, the resources committed, and the institution owning the final decision. A refusal, delay, or failed referral should come with an understandable explanation, the limit of the decision maker's authority, and any available next step.

Monitoring can remain focused: whether information was reviewed on time, a receiving contact responded, requested interpretation or transport was available, the participant understood the next step, and follow-up occurred with consent. Repeated dead ends should be treated as pathway failures rather than completed referrals.

Participants need a confidential route to report cost, delay, discrimination, coercion, misinformation, retaliation, or an inaccessible complaint process. Review should be independent when the organization receiving the complaint also controls a job, home, service, or essential referral. Programmes should report back in usable language about changes made and limits that remain.

Process measures should be disaggregated only when the data can be collected safely and the groups are large enough to avoid disclosure. Referral volume is not an access outcome. A high count may coexist with delay, debt, incomplete treatment, retaliation, or a burden transferred to unpaid community workers.

16.8 Chapter synthesis

The three tiers move from immediate pathway support to funded continuity and structural accountability. Community knowledge and relationships remain essential, but not as substitutes for institutional responsibility. None of the 11 actions was evaluated; implementation must remain bounded by the methodological and ethical limits addressed in Chapter 17.

Chapter 17. Study Limitations

A limitation matters through the claim it changes. Some features of this study prevent population, causal, clinical, legal, or intervention-effect conclusions. Others narrow the people, setting, or measure to which a finding applies. Still others require careful interpretation without erasing the experience that was actually reported. This chapter consolidates those boundaries so that the findings and recommendations can be read at their proper strength.

The study remains useful within those boundaries. The survey gives exact descriptions of 90 consenting adults reached through community networks. A separate corpus of 36 interviews gives traceable accounts of meaning, sequence as remembered, institutional encounters, variation, and counterexamples. The methods support report-level complementarity, not participant-level confirmation. The safeguards used in analysis and publication reduce some risks, but each leaves residual uncertainty that must remain visible.

Table 17.1. Major study limitations and their implications

Limitation	Evidence affected	What remains supportable	What cannot be concluded	Safeguard used
Community-network recruitment	All survey and interview findings	Distributions and accounts within the two participant groups	Population prevalence or statistical representativeness	Exact denominators; bounded participant-group wording
Geographic and eligibility verification	Urban framing and documentation groups	Study scope as recruited and self-reported circumstances	Verified city coverage, legal status, or case-level eligibility	No city claims; self-report and legal boundaries stated
Cross-sectional self-report	Relationships among hardship, support, and screening	Co-occurrence, recalled sequence, and participant perception	Causal order, change over time, or independent institutional facts	Descriptive language; no causal analysis
Survey translation and item design	Fear, trust, and translated survey measures	Observed numeric responses and clearly defined item distributions	Formal linguistic equivalence or unrecorded English anchors	Observed scales retained; uncertain labels not assigned
Data-quality exclusions	Healthcare, routine-change, education-reason, and priority fields	Unaffected source items and narrowed conditional results	Specific unmet-care reasons or repaired responses	Unusable fields excluded; blanks not treated as negatives
Post hoc indicators	Binary domains and four-hardship composite	Transparent exploratory description of co-occurrence	Validated risk, severity, vulnerability, or prediction	Component measures preserved; rules applied row by row
Mental-health screening	PHQ-8 and GAD-7 findings	Substantial depressive and anxiety symptom burden in the survey group	Diagnosis, cause, treatment need, or current suicide risk	Screening language; PHQ-8 self-harm limit stated
Household education reporting	Learning arrangements and safety or consistency	Adult household reports, practical pathways, and concerns	Child-level enrollment, attendance, dropout, or direct child experience	Household denominator and below-school-age cases retained
Qualitative sampling and source variation	Theme recurrence, detail, and exact translated phrasing	Traceable accounts, variation, counterexamples, and possible pathways	Population frequency, saturation, or original-language verbatim wording	Case-first review, source-page checks, disclosure review
Single-analyst interpretation	Coding and cross-case synthesis	Transparent interpretations linked to cases and negative evidence	Analyst-independent coding agreement	Memos, code definitions, matrices, and counterexample review
Separate mixed-methods samples	Report-level integration	Complementarity across forms of evidence	Participant-level confirmation or linked explanation	Methods analyzed separately; overlap left unknown
Ethics and disclosure	Consent, protection, quotation, and data handling	Documented consent procedures and risk-reduction practices	Independent ethics review or elimination of recognition risk	Data minimization, restricted access, neutral IDs, disclosure review
Recommendation feasibility	All Chapter 16 actions	Evidence-grounded provisional directions for bounded pilots and review	Effectiveness, cost, legal sufficiency, demand, or feasibility	Authority limits, safeguards, and pilot language

17.1 Sampling, recruitment, and study scope

Neither study component used a population sampling frame. Survey recruitment moved through churches, Zomi organizations, community leaders, WhatsApp, personal networks, and related community channels. Interview recruitment also relied on voluntary community-network participation. These routes made it possible to reach participants through trusted channels, but they did not give every Zomi adult in Malaysia a known or equal chance of participation. People with strong community ties may have encountered the study more readily. People with limited digital access, less written-language confidence, little privacy, demanding work or care schedules, weaker organizational ties, or greater concern about disclosure may have been less likely to take part. People facing the greatest insecurity could have been either especially motivated to participate or especially difficult to reach. The direction of selection bias cannot be established.

No complete invitation denominator, refusal total, or record of everyone who saw a survey link was retained. A response rate cannot be calculated. Of 92 submitted survey forms, two were excluded because consent was not given, leaving 90 analytical records. Survey percentages therefore describe those 90 consenting adults, not all Zomi adults in Malaysia. Interview recurrence describes the 36-person corpus and does not estimate how common an experience is in the wider community. These limits prevent claims of prevalence and representativeness, but they do not invalidate exact distributions within the survey records or traceable recurring and contrasting accounts within the interviews.

Geographic precision is also limited. The project was framed around Zomi adults living in urban Malaysia, but the survey retained no city variable and no formal case-level urban screen. Age and consent were screened directly. Zomi identity, residence in Malaysia, urban residence, and displacement-related documentation circumstance were reached through targeted recruitment and substantive questions rather than independent verification. The study did not adjudicate identity or legal status. The resulting evidence supports an urban recruitment frame and participant-reported circumstances, not verified city coverage or a legal classification of every case.

Online survey administration introduced an additional participation filter. Completion required a device, connectivity, time, privacy, and the ability to use written Zopau presented using Zolai, possibly with assistance that was not systematically recorded. The final Google Forms configuration was not archived, so required-item settings, account restrictions, platform metadata, and post-submission editing cannot be fully reconstructed. The analytical export contained no direct participant identifiers. That evidence supports a narrow statement about the analytical file, not a broad technical guarantee that the platform was fully anonymous.

17.2 Cross-sectional and self-reported evidence

The survey captured conditions during one fieldwork period, from 11 February through 27 June 2026. The analysis was descriptive and exploratory: it used no p-values, confidence intervals, regression, or other inferential tests. It can show that circumstances appeared in the same record and that descriptive differences existed between groups. It cannot determine which condition came first, whether one condition changed another, or whether a pattern endured. Retrospective interview accounts can describe sequence as participants remembered it, but they do not turn the study into a longitudinal design.

Temporal limits are especially important when interpreting documentation, enforcement concerns, work, housing, healthcare, support, and mental-health symptoms. A hardship may have contributed to distress, distress may have changed how a condition was experienced or reported, and a third circumstance may have shaped both. Support may have preceded a crisis, been mobilized in response to it, or changed after need intensified. The study therefore reports co-occurrence and participant-described pathways without assigning causal order. The Chapter 14 comparison is not a dose-response finding, a natural threshold, or evidence that a fourth hardship caused a positive screen.

Most practical evidence was self-reported. Participants described documentation, fear, avoidance, enforcement encounters, work, payment, safety, housing, healthcare, children's learning, symptoms, support, trust, priorities, and future intentions. The study did not inspect immigration files, UNHCR records, employment contracts, payroll records, medical files, school records, housing agreements, or enforcement records. It did not determine legal status, verify wages, adjudicate treatment quality, or confirm institutional decisions.

Self-report does not have one known direction of bias. Recall, perceived risk, social desirability, privacy, and willingness to disclose may have influenced answers, but participant perception is itself central evidence for fear, safety, trust, burden, and decision-making. A report that healthcare felt unsafe cannot establish that a facility was objectively dangerous. It can still show that the participant experienced enough concern for safety to shape the meaning of access. The report preserves this distinction rather than treating perception as either objective proof or unusable evidence.

17.3 Survey measurement, translation, and data quality

The survey was presented in written Zopau using Zolai. Zopau-speaking members of the research team translated the questionnaire collaboratively, which supported access in the intended language. The archive does not contain an item-level translation ledger, formal back-translation, cognitive interviews, linguistic validation, or a complete record of how ambiguous wording was resolved. Semantic equivalence between the written Zopau items and the English labels used for analysis was therefore not formally tested. Missingness and conditional eligibility also change the base of some estimates. No value was imputed, and a blank conditional field was not treated as a negative response.

17.4 Exploratory indicators and the four-hardship composite

The report constructed several binary indicators after data collection, including documentation insecurity, enforcement and mobility, housing risk, healthcare access and safety, work risk, low or inconsistent support, positive mental-health screening, and the household category of no current school or learning arrangement. Thresholds were selected after review of the study items and data structure. The indicators are transparent, consistently applied, and row-level verified. They are also exploratory and unvalidated.

Binary classification compresses information. A person meeting one component and a person meeting several components can receive the same value. Duration, timing, intensity, and the combination of source items disappear. Indicators remain secondary to their component measures and should not be used for individual eligibility, legal decisions, clinical decisions, or prediction.

The four-hardship composite gives one point for each of four universal domains: documentation insecurity, enforcement and mobility, healthcare access and safety, and housing risk. Work was

excluded because its measures applied only to current workers, and education was excluded because its measures applied only to households with children. Mental health was retained as the screening outcome in the comparison, while support remained a separate context. Equal weighting does not mean the domains have equal severity or consequence. Housing is especially influenced by the common report of rent difficulty. Different domain combinations and very different within-domain experiences can produce the same total.

The composite has no external validation, validated threshold, predictive model, or causal interpretation. Only one participant met none of the four definitions, so that person cannot serve as a stable comparison group. The principal Chapter 14 contrast is literal: 24 of 28 participants in the all-four group screened positive on the PHQ-8, GAD-7, or both, compared with 32 of 61 in the combined one-through-three group. Percentages at one, two, and three domains were similar. The concentration in the all-four group is an exploratory descriptive finding, not a severity score, risk score, vulnerability index, deprivation measure, trauma score, dose-response pattern, or proven threshold.

17.5 Mental-health screening

PHQ-8 and GAD-7 scores describe depressive and anxiety symptom burden during the measures' reference period. A score of 10 or higher was treated as a positive screen. No diagnostic interview or clinician assessment was conducted. The results do not determine diagnosis, cause, prognosis, treatment need, service eligibility, or current safety.

The PHQ-8 omits the PHQ-9 item concerning self-harm or thoughts of death, and the survey included no separate suicide-risk item. No conclusion about suicidal thoughts or present risk can be drawn. Interview language concerning hopelessness, exhaustion, burden, or death cannot supply that missing assessment. Sensitive death-related interview material was not quoted.

Formal linguistic and cultural validation of the translated scales was not conducted. Sleep difficulty, fatigue, appetite change, concentration problems, and restlessness may also overlap with shift work, physical illness, caregiving, material strain, or other conditions. These limits prevent diagnostic and causal claims. They do not erase the finding that elevated symptom scores were common and that the survey participant group carried substantial reported symptom burden.

17.6 Household education evidence

Education results came from 48 adults reporting on households with children under 18. The survey did not enumerate individual children, and no child participated directly. The study cannot calculate enrollment, attendance, dropout, progression, or out-of-school rates. Adult interpretations of a child's experience, including hostel life, safety, or learning difficulty, are not direct child testimony.

The survey's formal and informal categories were participant-selected and were not independently validated for recognition, curriculum, or quality. The item on learning safely and consistently combined two concepts. Among 15 household reports of no current arrangement, six cited children being below school age, so the group does not represent one form of educational exclusion. Within these boundaries, the evidence remains useful for describing household-level arrangements, adult concerns, and reported pathways involving fees, transport, language, placement, continuity, and progression.

17.7 Qualitative recruitment, interviewing, and translation

The final qualitative analytical corpus contains 36 adults recruited voluntarily through community networks. Invitation and refusal totals, a complete case-level screening log, and any overlap with the survey were not retained. Interviews varied in length, guide version, question coverage, detail, and analytical source format. Some topics were directly prompted, while others emerged elsewhere in an account. Not every topic was discussed in every interview, and silence cannot be coded as evidence that an experience was absent. More detailed records created more opportunities for coding and quotation. Recurrence belongs to this corpus and is not population prevalence. The study does not claim formal thematic saturation or complete coverage of Zomi experience.

Zopau-speaking research team members conducted the interviews in person during February 2026. The archive does not preserve a detailed interviewer roster, training record, or systematic account of prior interviewer-participant relationships. Community and language familiarity may have supported access, trust, and comprehension. Interviewer identity, expectations, position, and relationships may also have influenced disclosure and follow-up. No misconduct is implied, and the available record does not support more specific claims about interviewer characteristics.

Participants gave oral consent, provided separate permission for recording, could skip questions or stop, and received 50 Malaysian ringgit. Interviews were audio-recorded and accompanied by notes. The methods review did not confirm that every audio file remains in the archive, and it did not review a complete original-language transcript collection. English analytical records range from translated question-and-answer text to edited translations, summaries, partial translations, and note-style records. The translation chain for each case cannot always be reconstructed. Formal back-translation, independent checking, standardized reconciliation, and linguistic validation were not documented.

Published quotations elsewhere in the report were verified against the available English analytical record, with only minor punctuation changes for readability. That procedure supports the accuracy of the published English wording against its retained source. It does not verify exact original Zopau speech. Translation and source variation affect confidence in exact phrasing, emphasis, and culturally specific nuance more than they affect the existence of a broader reported account.

17.8 Qualitative coding and interpretation

The primary qualitative analysis was conducted using a case-first, framework-based thematic process that combined domain-led and inductive coding. Case memos, code definitions, interview-by-theme matrices, supporting interview IDs, source-page checks, and explicit review of negative cases and counterexamples strengthened traceability. Quotations were verified against the available English sources, and unclear material was treated as uncertain.

No independent second coding, intercoder agreement calculation, member checking, respondent validation, formal saturation assessment, or formal reflexive journal was documented. These procedures are not universal requirements for valid qualitative inquiry, but their absence matters here because interpretation depended substantially on one primary analyst and because interviewer and analyst positionality were not systematically recorded.

The audit trail allows a reader or reviewer to see how a claim was supported and where variation was retained. It does not eliminate interpretive subjectivity, unequal record depth, or the effect of prompts and translation. Qualitative conclusions are strongest when they identify a traceable

pathway, contrast, or recurring account and weakest when read as a count of the wider population or as the only possible interpretation.

17.9 Mixed-methods integration

The survey and interview groups were separate, no participant-level linkage was attempted, and any actual overlap was unknown and unrecorded. An interview cannot explain the survey response of a particular person. Interview recurrence cannot estimate survey prevalence, and survey percentages cannot establish how common an interview theme was. Similarity between methods does not automatically validate either measure, especially when wording, timeframes, and constructs differ.

Integration instead supported complementarity. The survey supplied structured distributions and co-occurrence within 90 records. Interviews supplied possible pathways, sequence as remembered, institutional encounters, variation, and counterexamples within a separate 36-person corpus. The methods supplied complementary forms of evidence rather than participant-level confirmation. Report-level interpretation is credible when that distinction remains visible.

17.10 Ethics, consent, privacy, and disclosure

The study did not undergo formal review by an institutional review board or research ethics committee. No formal exemption, waiver, university review, or organizational ethics review is documented. Community involvement, internal discussion, consent, and data protections were not equivalent to independent ethics review.

The absence of formal review matters because no independent body assessed the consent language, participant vulnerability, power relationships in community-network recruitment, interview compensation, distress procedures, handling of immigration and enforcement information, publication of quotations, data retention, or the risk of recognition in a small community. No separate clinical or urgent-risk protocol was documented. The study also lacked an external review of whether direct child research should be included and what protections it would require. These gaps are ethical limitations. They do not automatically invalidate the evidence, and the report does not invent a retroactive approval, waiver, or exemption.

Procedures used in the study still matter. Survey participants received electronic consent information, and two submissions without consent were excluded. Interview participants gave oral consent and separate recording permission, could skip questions or stop, and were assigned participant codes. Oral consent is consent; the limitation is that no case-level written consent log or independent review of the process was retained. Participant-facing guidance emphasized voluntary participation and data minimization. No direct child interviews were conducted.

Study files were stored in a restricted-access Google Drive folder with access limited to the research team. The analytical survey file contains no direct participant identifiers. Interview sources remained confidential, while analysis used neutral IDs and removed or generalized names, locations, employers, dates, medical details, family details, and migration information. Paragraph-level disclosure review considered mosaic identification. The integrated manuscript retained 34 quotations from 26 participants, with no participant quoted more than twice, and high-risk quotations were excluded.

These safeguards reduced direct and deductive identification risk but could not eliminate it. The Zomi community is interconnected, and combinations of ordinary details may allow participants,

relatives, employers, church members, or community leaders to recognize an account. Removing a name does not guarantee anonymity. Study data and confidential sources are scheduled for deletion six months after report publication, but deletion has not occurred. Responsibility for completing and documenting deletion, together with any approved archival exceptions, remains to be assigned.

17.11 Limits on contextual claims and recommendations

Legal and institutional context changes over time. Chapter 2 claims were checked against authoritative sources current to publication date, but laws, policies, fees, registration procedures, education access, service rules, and institutional responsibilities may change. Specialist Malaysian legal review was not performed as the study was not a legal analysis, and participant accounts do not determine status, authorization, entitlement, duty, or remedy. Any Chapter 16 action involving legal or institutional authority requires current verification before implementation.

The recommendations are evidence-grounded but provisional. The study did not test an intervention, estimate demand, compare alternatives, conduct a service-capacity inventory, calculate costs, establish institutional willingness, or evaluate feasibility. It did not complete a legal review of each recommendation. Possible harms include disclosure, visibility, retaliation, debt, gatekeeper power, stigma, unsafe screening, dependency on a single helper, and transfer of institutional duties to community organizations.

These limits do not require abandoning the 11 recommendations. They determine how the recommendations should be used. Immediate actions should begin as bounded pilots with consent, minimum necessary data, clear role limits, independent feedback, and stopping or correction rules. System-strengthening actions require recurring resources, supervision, and receiving partners. Structural actions require decision makers with formal authority. Community organizations can explain, interpret, accompany, and refer; they should not be assigned powers or obligations they do not hold.

17.12 What remains credible within these limits

The study is strongest as a bounded description of 90 survey records and a transparent interpretation of a separate 36-person interview corpus. Exact distributions, item-specific denominators, full screening scores, and clearly defined component measures remain credible within the survey group. Interview findings remain credible as traceable accounts of pathways, variation, counterexamples, and institutional encounters within the corpus. Participant-selected priorities are evidence of what participants entered, provided they are not converted into a population mandate or a validated rank.

The mixed-methods contribution lies in comparison across complementary forms of evidence. It identifies how practical access could depend on movement, money, language, time, care, documents, relationships, and institutional decisions. It shows how household, employer, church, and community assistance could make a pathway usable while remaining finite and without formal authority. The post hoc composite adds an exploratory description of co-occurrence, and the all-four comparison identifies a concentration that warrants attention within this participant group.

The report does not support population prevalence, representativeness, causal conclusions, clinical diagnosis, suicide-risk determination, legal status, direct child-level estimates, validated individual risk classification, or intervention effectiveness. Those are excluded conclusions, not reasons to

discard the evidence the study actually produced. Within its stated scope, the report provides a documented basis for attention, dialogue, bounded implementation, and more rigorous inquiry.

17.13 Chapter synthesis

The study's strongest claims are descriptive and interpretive within the two participant groups. Its limitations do not apply equally to every finding: some prevent a conclusion, some narrow its scope, and others require careful wording without erasing the measured experience. The safeguards used in analysis and publication reduce overinterpretation and disclosure risk, but they do not remove selection, measurement, translation, ethics, or implementation uncertainty.

Chapter 18. Future Research

Chapters 6 through 16 identify recurring barriers that already justify bounded, careful action: clearer information, safer referral, practical navigation, and accountable institutional engagement. Future research should make those responses more precise, more equitable, and more testable. It should not turn uncertainty into a reason to postpone low-risk improvements.

The agenda begins from the study's actual reach. The survey describes 90 consenting adults recruited through community networks, and the separate qualitative corpus contains 36 interviews. The two groups were not linked at participant level, and actual overlap is unknown and unrecorded. The evidence is cross-sectional, descriptive, and exploratory. It therefore supports questions for the next stage, not population estimates, causal claims, clinical or legal determinations, or claims that the recommendations have already been proved effective.

18.1 Principles for the next research phase

The next phase should be question-led rather than instrument-led. Each study should name the decision it is meant to improve, the people whose experience is missing, the inference the design can support, and the harm that could follow from collecting or linking the data. A broader survey is appropriate when the question concerns distribution or variation. Repeated observation is needed when the question concerns change. Direct child participation is needed for child-level experience, but only when independent safeguards make that participation defensible. Programme evaluation is appropriate only after an intervention, responsible actor, and theory of change are sufficiently clear.

Five principles should govern the portfolio. First, preserve the distinction between what is described, what is associated, and what may be causal. Second, treat Zopau and written Zolai as related but distinct communication contexts. Third, build community governance into question selection, interpretation, dissemination, and decisions about access to data. Fourth, include people who are less visible to established networks rather than treating network reach as community coverage. Fifth, stage the work so that later studies depend on validated measures, feasible recruitment, legal review, referral capacity, and credible data protection.

The portfolio should use a small common core of definitions and outcomes so that results can be compared across studies, while allowing modules to change with the question and setting. Common measures should not freeze weak items into permanent use. Each protocol should specify which findings would change an operational decision, which result would be insufficient to do so, and when a null or mixed finding would lead to revision rather than abandonment. This makes learning cumulative without pretending that every study has the same purpose.

18.2 Who is represented, and where

The first population question is not simply whether a larger sample can be recruited. It is who remains outside the routes used in this study, where those people live, and how their circumstances differ. Future mapping should document the reach and blind spots of community organizations, faith networks, workplaces, housing clusters, service providers, and informal referral routes without publishing information that exposes households or brokers. Recruitment can then combine several sources, test the degree of network dependence, and report how each source changes the sample.

A multisite survey should cover more than one urban setting and should consider purposeful oversampling of women, young adults, older adults, people with disabilities, gender-diverse people, residents with weak organizational ties, recent arrivals, long-term residents, and Zomi subgroups whose language or migration pathways differ. Sampling options may include community-site lists, time-location recruitment where it is safe, and peer-referral methods whose assumptions are tested rather than presumed. A defensible probability design would be preferable if a suitable frame becomes available. Until then, studies should report recruitment-source profiles, refusal and ineligibility where they can be observed, and sensitivity analyses rather than implying representativeness.

Geographic work should distinguish place of residence, place of work, service catchment, and mobility between them. Comparative work outside urban Malaysia may later examine how different host-country institutions shape Zomi lives, but cross-country comparison should follow common measurement development and local ethical review. It should not assume that a shared identity produces comparable legal, linguistic, or service environments.

Every future sample should carry an explicit denominator plan. Eligibility, contact, consent, item nonresponse, conditional follow-up, and analysis exclusions should be recorded separately. Weighting should be used only when inclusion probabilities or defensible calibration information exist. Otherwise, subgroup counts and uncertainty should be presented as properties of the achieved sample. This is especially important when outreach succeeds in bringing previously less visible participants into the study, because a changed distribution may reflect better coverage rather than a changed community condition.

18.3 Change, sequence, and household pathways

Cross-sectional accounts cannot establish whether housing, work, health, documentation concerns, and psychological distress precede or reinforce one another. A longitudinal panel could follow adults and households through job changes, moves, illnesses, education transitions, policy shifts, and periods of greater or lesser enforcement pressure. Short repeated modules, event histories, and scheduled qualitative follow-ups would allow change to be examined without requiring a long interview at every wave.

The design should expect mobility and attrition. Participants must be able to choose safe contact methods, update those choices, pause participation, and remain in a study without disclosing unnecessary location or legal information. Reasons for loss to follow-up should be described without treating missing participants as unchanged. Repeated measures can establish temporal order and within-person change, but causal interpretation would still require a plausible comparison strategy, clear assumptions, and attention to events occurring outside the study.

A panel should establish a clear baseline and record major contextual events at each wave, including policy changes, service openings or closures, enforcement episodes, and large economic disruptions. When an external change occurs, the study may support an interrupted time-series, difference-in-differences, or other quasi-experimental analysis if the timing, comparison, and assumptions are credible. Such opportunities should be analyzed from a pre-specified plan where possible and should not be manufactured by denying access or delaying assistance.

18.4 Measures, language, and culturally grounded wellbeing

Measurement development is a near-term priority. Survey items should be reviewed through Zopau discussion, written Zolai testing, cognitive interviewing, community and specialist review, and documented reconciliation of disputed wording. Testing should ask not only whether a translation is understandable, but whether response options, time periods, and concepts carry the intended meaning across age, gender, education, and language-use groups.

The fear, trust, support, and healthcare-safety items need explicit construct definitions and item-level testing before they are treated as scales. Participant priorities should be elicited with methods that distinguish first choices, tied choices, forced rankings, and priorities formed after group discussion. The post hoc hardship count and documentation-related composite should be examined for content validity, dimensionality, reliability, and sensitivity to alternative definitions. Validation may lead to revision or retirement rather than preservation of the current indicators.

PHQ-8 and GAD-7 can remain screening tools, with the PHQ-8 clearly identified as excluding the self-harm or death item. Future work should test comprehension, measurement equivalence, functional correlates, and appropriate thresholds in this context. Where clinical validation is proposed, it requires qualified professionals, a defensible reference assessment, and referral capacity. The portfolio should also develop culturally grounded measures of wellbeing, social connection, dignity, agency, sleep, functioning, and locally meaningful distress rather than defining mental health only through symptom scores.

Instrument development should preserve an audit trail from concept to reported variable. That record should include the original wording, oral prompts, written form, response choices, translation decisions, cognitive findings, field changes, scoring rule, missing-data rule, and reasons for any threshold. Mode testing should examine whether oral administration, self-completion, or interviewer presence changes response patterns. A measure should enter the shared research core only after its intended use, uncertainty, and limits can be stated plainly.

18.5 Children, youth, and education pathways

The present education findings are adult household reports. They do not establish child-level rates, children's own priorities, learning outcomes, or how children experience interrupted schooling. No children were interviewed. Future studies should distinguish access, attendance, continuity, progression, language support, learning, safety, and transition into work or further study. Administrative or provider records may help describe pathways, but they should not be linked to household data without specific authorization and consent.

Direct research with children or adolescents should begin only after a dedicated safeguarding review. Age-appropriate assent, caregiver permission when safe and appropriate, confidential participation options, trained researchers, referral arrangements, and a clear response to disclosures are minimum conditions. No child should be asked to establish household legal status, identify an employer or landlord, or carry information between researchers and adults. Youth advisory input can help define relevant questions and acceptable methods, but advisory roles must be voluntary, supported, and compensated.

A staged approach could begin with service and curriculum mapping, adult and provider interviews, and adolescent co-design before any broader child survey. Younger children may require observational, creative, or caregiver-supported methods, each with its own limits. If direct

participation cannot be made safe, researchers should say so and retain the distinction between household reports and child evidence.

Sampling must include children and young people who are not connected to a learning centre as well as those who are enrolled, while avoiding recruitment methods that identify them publicly. Studies should attend to gender, age, disability, care responsibilities, work, language, and household mobility. Outcomes should include more than enrollment or attendance: learning opportunity, continuity, progression, belonging, safety, time use, and realistic transition options all require separate questions and age-appropriate interpretation.

18.6 Work, household economy, and housing

Work and housing research should examine pathways rather than isolated conditions. Useful questions include how people enter and leave jobs, how income volatility changes food, transport, healthcare, and rent decisions, what happens after wage withholding or injury, and how job loss relates to moves, crowding, debt, and household separation. Repeated household diaries and panel interviews can capture short shocks that a single survey misses. Employer, landlord, and service-provider studies should be separate from participant recruitment so that access to research does not depend on a person with power over work or housing.

Economic modules should record hours, pay arrangements, payment reliability, occupational risk, work-related costs, unpaid care, remittances, debt, and informal support with response options that do not demand documentation participants may not have. Housing modules should distinguish tenure arrangements, mobility, eviction pressure, repair and utility problems, crowding, and continuity after a shock. Research should assess differences within households and avoid assuming that one adult can report every member's control over resources.

Analysis should test whether the same shock has different effects by gender, age, disability, household role, network reach, residence duration, and access to support. It should distinguish an individual's earnings from resources the person can actually use, and household totals from the distribution of food, care work, debt, and decision-making. Any question about wage disputes, unsafe work, eviction, or informal tenancy should be reviewed for legal sensitivity and for the possibility that disclosure could harm employment or housing.

18.7 Healthcare access and mental health pathways

Healthcare research should follow the full pathway from a perceived need to a decision to seek care, transport, registration, interpretation, payment, treatment, follow-up, and recovery. This would clarify where delay or discontinuity occurs and how documentation concerns, cost, language, work schedules, information, and prior encounters influence each step. Participant reports can be combined with facility workflow studies and provider interviews, but only through consented linkage or clearly separate analyses.

Mental health work should connect symptoms with functioning, social conditions, coping, and help-seeking. Longitudinal follow-up is needed to examine whether changes in work, housing, safety, family circumstances, or service access accompany changes in distress. Clinical assessment, if included, should be conducted by qualified personnel and should never be inferred from a screen alone. Every study asking about severe distress should have a practical, language-accessible referral plan, trained staff, and a response protocol that does not promise services that are unavailable.

18.8 Documentation, enforcement, and institutional practice

Documentation research must keep self-reported categories separate from legal determinations. It should examine what people believe a document permits, what frontline institutions request, how practice varies, and how uncertainty affects work, movement, healthcare, housing, education, and help-seeking. Prospective policy monitoring can pair dated legal review with structured observation of implementation. All legal and institutional claims in this report were checked through publication date; future work must recheck them and obtain specialist Malaysian legal review before publication or operational use.

Institutional studies should include health facilities, employers, education providers, community organizations, humanitarian actors, and relevant public agencies. Questions should address staff authority, referral practice, records requested, language capacity, complaint routes, discretion, and resource limits. Researchers must not collect names, locations, or encounter details merely because they may be analytically interesting. Reporting should aggregate or mask details when disclosure could increase enforcement, employment, housing, or reputational risk.

A dated policy tracker should record the legal source, issuing authority, effective date, implementation guidance, later amendment, and the institution responsible for practice. Where a policy changes during data collection, researchers can compare implementation before and after the change, but they must document concurrent events and variation in exposure. Community reports of practice and institutional records should be analyzed as different evidence streams, with disagreement treated as a finding to investigate rather than an error to erase.

18.9 Support, information, trust, and community capacity

Future work should distinguish the availability of support from its reliability, reach, burden, and authority. Information studies can trace how guidance changes as it moves among community groups, service providers, employers, digital channels, and households. They should test whether recipients can identify the source, date, scope, and limits of a message, and whether correction reaches people who received an earlier version. Trust should be examined by institution and task rather than treated as a single community trait.

Network analysis may help identify bottlenecks and overburdened connectors, but published network maps could expose precisely the people who make access possible. Safer approaches include participant-controlled mapping, role-based rather than name-based data, minimum reporting thresholds, and community review before release. Repeated priority-setting exercises should include less visible groups and record how priorities vary by circumstances. Community capacity studies should also measure the time, emotional labor, language work, and opportunity costs carried by volunteers and navigators.

Priority setting should recur at defined points in the programme, including before funding decisions and after early findings. Individual ranking can reduce pressure to conform, while facilitated deliberation can reveal tradeoffs and shared constraints; using both can show how preferences change with information and discussion. Reports should state who participated, which options were excluded, how disagreement was handled, and whether decision-makers accepted, modified, or declined the resulting priorities.

18.10 Evaluating the recommendations

Chapter 16 presents 11 provisional recommendations. They were not tested, costed, legally evaluated, or subjected to formal feasibility assessment. Evaluation should therefore begin with design clarification: the responsible actor, intended users, resources, pathway of change, foreseeable harms, and outcomes that matter to participants. Information and navigation initiatives can first be assessed for accuracy, reach, comprehension, referral completion, and correction of outdated advice. Emergency, transport, interpretation, housing, education, health, employment, and psychosocial initiatives require additional measures of timeliness, fairness, continuity, burden, and unintended exclusion.

Small pilots should use mixed process and outcome evaluation before expansion. Comparison designs may include phased introduction, matched sites, interrupted time series, or other quasi-experimental approaches when allocation cannot ethically or practically be randomized. Randomization is not a default proof standard and should not be used to withhold an established essential service. Cost, staff burden, participant time, language access, and distributional effects should be recorded alongside average outcomes.

Every evaluation needs independent referral routes, incident monitoring, and predefined stopping or revision rules. Institutional and employer pilots require particular protection against retaliation, loss of work, coercive recruitment, and misinterpretation of a programme as legal protection. Legal review must precede claims about documentation, work authorization, detention, or institutional duties. A result should be reported as effective only for the population, setting, outcome, and follow-up period actually studied.

Implementation outcomes should be defined before effect outcomes are interpreted. Reach, fidelity, adaptation, dose, timeliness, staff competence, referral completion, participant burden, and institutional follow-through help distinguish a weak theory from a weak delivery system. Equity analysis should ask who is offered the response, who can use it, who drops out, and who bears new work. Negative, mixed, and unintended results should be retained in the record so that later expansion is not built only on favorable cases.

18.11 Community governance, ethics, and research infrastructure

A standing community governance arrangement should review priorities, recruitment, language, burden, interpretation, disclosure risk, and dissemination. Its members should include people beyond the organizations that provide easiest access, and participation should be compensated. Governance is not the same as independent ethics review. Prospective studies should also undergo formal review by an appropriate research ethics body, with additional specialist review for child participation, mental health risk, legal sensitivity, or institutional linkage.

Consent should be modular. Participation in a survey, recontact, audio recording, data linkage, quotation, archiving, and future reuse should be separate choices. Linked mixed-methods work should use a prospectively designed consent process and a coded linkage key held apart from research data. Refusal of linkage must not prevent participation in either component. Contact and identity data should be minimized, encrypted, access-controlled, and deleted on a stated schedule. Protocols should cover withdrawal, data breach, mandatory reporting, distress, coercion, and requests from authorities or institutions.

Reproducible research infrastructure should include versioned instruments in Zopau and Zolai, translation and decision logs, a data dictionary, denominator rules, quality checks, analysis code, a record of exclusions, and dated legal sources. Analytic plans should be registered or time-stamped where feasible, while exploratory work remains clearly labeled. Multilingual qualitative analysis should use more than one trained analyst for at least a structured subset, document disagreements, and retain the path from source language to reported interpretation. Public data release is not an automatic good: controlled access, community-held governance, or no release may be appropriate when re-identification risk cannot be acceptably reduced.

18.12 A staged research agenda

Near-term work should establish the conditions for credible expansion: community governance, formal ethics pathways, safer recruitment mapping, measure and translation development, data-protection protocols, and dated legal and policy monitoring. These activities can proceed alongside low-risk implementation learning for information, referral, and navigation responses already justified by the report.

Intermediate work should broaden the evidence base through multisite sampling, child and youth safeguards and pilot studies, provider and institutional research, healthcare-pathway studies, and focused work on employment, household economy, housing, support, information, and trust. Prospectively linked mixed methods can be introduced where consent and linkage protections have been tested. Longer-term work should follow change over time, compare settings using common measures, and evaluate selected recommendations whose responsible actors, legal boundaries, resources, and harm controls are sufficiently defined. Table 18.1 summarizes the sequence.

Table 18.1. Prioritized agenda for future research

Priority	Unanswered question	Suggested approach	Participants or data	Essential safeguard	Stage
Governance and research infrastructure	Who should set priorities, control access, and judge acceptable disclosure risk?	Standing community governance group, formal ethics pathway, versioned protocols, and secure data systems	Community members, researchers, ethics reviewers, and data stewards	Compensated participation, independence, conflict rules, and breach response	Near term
Recruitment and geographic mapping	Who is missed by existing networks, and how do residence, work, and service catchments differ?	Safe service and network mapping, recruitment-source testing, and multisite feasibility work	Urban residents with strong and weak network ties; organizations and service sites	No public household or broker maps; minimum disclosure thresholds	Near term
Language and measure development	Do key items carry consistent meaning in oral Zopau, written Zolai, and different participant groups?	Cognitive interviews, reconciliation panels, psychometric testing, and construct validation	Diverse adults and, only with safeguards, older adolescents	Document disagreements; validate or retire post hoc indicators	Near term
Broader population description	How do conditions and priorities vary across urban settings and less visible groups?	Multisite survey using several recruitment sources, oversampling, and sensitivity analysis	Women, youth, older adults, disabled and gender-diverse people, recent and long-term residents, Zomi subgroups	Do not imply representativeness without a valid frame and design	Intermediate
Consented mixed-methods linkage	How do measured conditions relate to a participant's own account, sequence, and interpretation?	Prospectively linked survey and interview components with optional linkage	Adults who separately consent to each component and linkage	Coded key, separate storage, linkage refusal without penalty	Intermediate
Children, youth, and education	How do children and young people experience access, continuity, learning, safety, and transitions?	Service mapping, youth co-design, then age-appropriate direct and longitudinal studies	Children, adolescents, caregivers, educators, and providers	Independent safeguarding, assent, safe permission, referral, and no legal-status elicitation from children	Intermediate
Work, household economy, and housing	How do job shocks, income volatility, care work, debt, and housing instability interact?	Household panel, short diaries, event histories, and separate employer or landlord studies	Workers, nonworkers, household members, employers, landlords, and service providers	No recruitment through a person controlling work or housing; protect against retaliation	Intermediate
Healthcare and mental health pathways	Where do need, delay, treatment, follow-up, functioning, and distress diverge?	Care-pathway studies, facility workflow research, repeated screens, functioning measures, and qualified validation	Care seekers and nonseekers, providers, interpreters, and facilities	Language-accessible referral and no clinical inference from screens alone	Intermediate
Documentation, policy, and institutions	How do current rules, frontline practice, discretion, and information affect access and safety?	Dated legal review, policy monitoring, institutional case studies, and provider surveys	Community members, institutions, providers, and specialists	Specialist Malaysian legal review; minimize identifying encounter data	Near term and continuing
Support, information, trust, and priority setting	Which channels are accurate, trusted, reachable, and sustainable, and whose priorities remain unheard?	Message tracing, role-based network study, repeated inclusive priority exercises, and capacity costing	People with varied network ties, information providers, volunteers, and navigators	Participant-controlled mapping and community review before disclosure	Intermediate and repeated

Priority	Unanswered question	Suggested approach	Participants or data	Essential safeguard	Stage
Longitudinal and intervention evidence	What changes over time, and which selected responses improve outcomes without creating new harms?	Panel follow-up, natural or policy experiments where defensible, and staged mixed-methods evaluation	Cohorts and programme participants in settings with defined actors and resources	Attrition protection, legal review, incident monitoring, and stopping rules	Longer term

18.13 Conclusion

This study does not end with a claim to have measured all Zomi lives in urban Malaysia. It ends with a disciplined account of what 90 survey participants and a separate 36-person interview corpus make visible: material strain, restricted institutional access, documentation-related uncertainty, uneven support, psychological distress, and persistent household and community effort. The report's contribution lies in bringing those domains into one evidence structure while keeping the limits of each claim explicit.

The next research phase should widen participation, follow change, improve language and measurement, include children only through defensible safeguards, study institutions as well as households, and test selected responses under real conditions. It should also make its own infrastructure visible: who governs the questions, who carries the burden, how consent and linkage work, what legal advice supports an interpretation, and which data should never be released.

Better evidence and present action are complementary obligations. Organizations can improve verified information, navigation, referral, and accountability now within their authority, while researchers build the stronger designs needed for population, longitudinal, institutional, and intervention claims. If that work remains community-led, ethically reviewed, legally careful, and transparent about uncertainty, future research can do more than extend this report. It can make the next decisions safer, fairer, and more answerable to the people whose lives those decisions affect.

Notes

Website and policy sources were through publication date. Dynamic figures and procedures should be rechecked if publication occurs after that date.

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