Towards a *Resilient* Care Workforce

THE RE:CARE PROJECT

Lessons from COVID-19 in Malaysia

Towards a Resilient Care Workforce:

Lessons from COVID-19 in Malaysia

by

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About RE:CARE

This report is a part of the **RE:CARE** Project (Endemicity, Care, and Gender: Towards Developing Resilience in Malaysia's Essential Care Workforce and Infrastructure), an initiative led by researchers and personnel from Women's Aid Organisation, University of Alberta, and University of Malaya, in collaboration with representatives of Talent Corporation Malaysia Berhad (TalentCorp) and the Ministry of Health, Malaysia. RE:CARE is funded under the **Women RISE Initiative** - Women's health and economic empowerment for a COVID-19 Recovery that is Inclusive, Sustainable and Equitable. Women RISE is an initiative to address the gendered impacts of COVID-19 and is co-funded by Canada's International Development Research Centre (IDRC), the Canadian Institutes of Health Research (CIHR), and the Social Sciences and Humanities Research Council (SSHRC).

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Foreword I

Care is the quiet foundation of every society. In Malaysia, however, this responsibility has long fallen disproportionately on women, spanning childcare to eldercare, often without recognition or adequate support. The COVID-19 pandemic exposed the fragility of our care system while also revealing the extraordinary resilience of those who sustain it.

This report brings to light the lived experiences of essential care workers in Malaysia, who during the crisis carried multiple responsibilities at work and at home. Too often their voices are absent from policy debates, yet they offer vital insights into how care shapes families, communities, and the nation. I commend the RE:CARE Project team for making visible what has remained invisible, and for reframing care as a shared social responsibility rather than a private burden.

As a researcher of ageing and the care economy, I see the issues raised here as central not only to the wellbeing of care workers but also to the dignity of the elderly and vulnerable populations who rely on them. As Malaysia advances under the 13th Malaysia Plan, we must recognise care as a developmental priority and place care workers at the centre of this ecosystem.

This report's focus on "care loads" provides a powerful lens for understanding the struggle for work–life balance, while also exposing the gender norms that tie care almost exclusively to women. Valuing care means recognising it as essential work—deserving dignity, fair compensation, and institutional support.

The RE:CARE Project's participatory approach—bringing together communities, policymakers, academia, and civil society—offers an inspiring model for change. My hope is that the insights here not only shape stronger policies but also spark a cultural shift: one that uplifts care workers and reimagines care as the foundation of a compassionate and resilient Malaysia. Caring for those who care for us is the true measure of a just society.

Dato' Dr Tengku Aizan Hamid
Fellow of Academy of Science Malaysia and The Third World Academy of Science
President of the Gerontological Association of Malaysia (2018-2021)

Foreword II

The COVID-19 pandemic was more than just a health crisis; it was a magnifying glass that exposed deep-seated vulnerabilities and inequalities in our society, particularly within Malaysia's care infrastructure. As this extensive and critical research initiative reveals, the pandemic's impact has been profoundly gendered, significantly affecting women who constitute the backbone of our essential care workforce.

The RE:CARE report presents a timely and unprecedented exploration into the lived experiences of care workers - spanning healthcare, social care, and domestic sectors - through a large-scale nationwide mixed-methods study. This study stands out due to its comprehensive approach, incorporating both qualitative narratives and quantitative data from diverse groups of care workers across Malaysia. By amplifying voices often sidelined in public discourse, the report provides invaluable insights into the complex realities faced by those who sustained our communities during the most challenging periods of the pandemic and into the ongoing transition to endemicity.

Care workers in Malaysia grapple with a "double burden", balancing demanding paid responsibilities at work and extensive unpaid caregiving duties at home, both of which can demand significant emotional and community labour. This multifaceted demand has led to considerable strains on their physical and mental well-being, a troubling increase in burnout rates, and alarming rates of intended departure from the care sector. As Malaysia confronts simultaneous demographic shifts, climate-induced crises, and an escalating demand for care, the resilience of our care ecosystem has never been more crucial.

As you engage with this report, I invite you to reflect deeply on the narratives and data presented within it. Consider not only the stark challenges but also the policy pathways suggested to transform care work into decent, dignified employment. The recommendations call for comprehensive reform - from improved working conditions, fairer remuneration, and robust job security to enhanced governance and family-friendly policies.

It is my sincere hope that this report not only informs but inspires decisive action. By addressing these underlying vulnerabilities, we can build a care infrastructure that is resilient, equitable, and capable of withstanding future crises. Let us collectively commit to recognising, valuing, and supporting those who have tirelessly cared for us all.

Nazreen Nizam
Executive Director
Women's Aid Organisation (WAO)

Foreword III

Care Worker Community Forewords

For us Filipino Domestic Workers, we were enthusiastic and grateful for participating in the RE:CARE Project as it helped us share what we were grateful for, but also our grievances. The project allowed us to feel safe while sharing these stories, and we also learned about the importance of expressing our needs and what our host government, Malaysia, needs to focus on to better support us. We also were able to reflect on the support given to us by our home government, as well as the benefits that the Malaysian government gave, especially during the pandemic years. This project is so important to me because it gave me the freedom to speak and write what is truly on my mind and helps me to fully understand how important my work is. I am a domestic worker, but sometimes to others, we are perceived as very low, as just "maids." We hope through this project, Malaysia will understand the importance of care workers to their country and household.

Donna Mae
AMMPO Chairperson
Research Associate

Care work is the backbone of and underpins our healthcare system, yet too often exacts a personal toll on those who provide it. This report sets out why prioritising care workers' wellbeing is both a moral imperative and an operational necessity for safe and high quality sustainable care. Fair pay, secure contracts, safe staffing, supportive supervision, psychological safety, and protected time for rest and learning have been demonstrated to improve retention and outcomes.

As research associates on this project, we listened to care workers across diverse settings. Their insights illuminate both the pressures they face and the practical recommendations including ensure manageable workloads, foster inclusive leadership and measure wellbeing alongside quality.

We invite policymakers, providers, and partners to act. By consolidating the wellbeing of care workers, we strengthen the foundation of care itself and honour the dignity of those who give so much to others.

Indiranee, Yohgasundary, and Vani
Nurses and Research Associates

It was a pleasure to be part of the RE:CARE Project, which explored care workers' perspectives and experiences during the COVID-19 pandemic. Through this project, I gained a deeper understanding of the care work often undertaken by women—work that is sometimes overlooked or taken for granted.

I particularly remember one brainstorming session where we discussed potential recommendations to stakeholders on how to better support women as care workers. During the discussion, someone pointed out that when we put on the "stakeholder hat," we sometimes forget that we are women ourselves—women who should be advocating for support, recognition, and benefits for those who take on caregiving roles.

This reflection made me realize how deeply these roles are often culturally assigned to women, who are expected to provide care for their families. Women have long been the "iron ladies," independently multitasking and fulfilling countless responsibilities. Yet, in this strength and resilience, their own needs for support and care as care workers are too often overlooked or forgotten.

Dr. Munirah Ismail
Research Associate

As a respondent in this meaningful research on child care workers in Malaysia, I am honoured to contribute to a project that highlights the often-overlooked wellbeing of those who care for our youngest generation. Every day, we care for children with patience, love, and dedication—often without recognition or adequate support. This project gave us a voice and reminded us that our wellbeing matters just as much as the care we provide.

Being part of this initiative opened my eyes to the resilience and quiet sacrifices made daily by care workers. Their emotional, physical, and financial wellbeing must be prioritised—not only for their dignity, but for the quality of care children receive. This report is more than data; it is a call to action. I hope its findings inspire policymakers, employers, and communities to invest in better support, fair compensation, and recognition. Let this be the moment care work is truly valued.

Puan Anisa Ahmad
Research Associate and Child Care Advocate

The Malaysian Association of Social Workers welcomes this timely report of an extensive nationwide study on female care workers. It highlights that an effective social welfare system depends on care workers whose key efforts—frequently underrecognized—support the needs of the most vulnerable. Though distinct, the roles of social workers and care workers often intersect in caring for children, older persons, and people with disabilities. Without skilled, well-supported care workers, social work interventions cannot achieve their aims.

This study informs policymakers and stakeholders with evidence to recognize care workers' indispensable role in community well-being. It calls for greater investment in their training, protection, and welfare, alongside broader efforts to strengthen the social service workforce and infrastructure. I hope it will guide policy that elevates the care sector and ensures a resilient, inclusive support system for all.

Dr. Teoh Ai Hua
President, Malaysian Association of Social Workers

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Most importantly, thank you to the care workers who, with compassion and resilience, carried us through moments of crisis and generously shared their time and stories with the RE:CARE Project. We hope the findings and recommendations in this report will continue to shed light on the important contributions of care workers in Malaysia.

Abbreviations

B40	Referring to the bottom 40% socioeconomically
BRS	Brief Resilience Scale
COVID-19	Coronavirus disease 2019
EPF	Employment Provident Fund
HRMIS	Human Resource Management Information System
ILO	International Labour Organization
JKM	Social Welfare Department or *Jabatan Kebajikan Masyarakat*
KPWKM	Ministry of Women, Family and Community Development or *Kementerian Pembangunan Wanita, Keluarga dan Masyarakat*
KPKT	Ministry of Housing and Local Government or *Kementerian Perumahan dan Kerajaan Tempatan*
LHDN	Inland Revenue Board of Malaysia or *Lembaga Hasil Dalam Negeri*
M40	Referring to the middle 40% or middle class socioeconomically
MCO	Movement Control Order
MDW	Migrant Domestic Worker
MOH	Ministry of Health Malaysia
PBT	Local Authorities or *Pihak Berkuasa Tempatan*
PDPR	Home-based Learning Programme
PPE	Personal Protective Equipment
PWD	Person(s) with disabilities (in Bahasa Malaysia: OKU)
SOCSO	Social Security Organisation, also known as PERKESO
SOP	Standard Operating Procedure
TABIKA	Kindergarten or preschool or *taman bimbingan kanak-kanak*
TASKA	Nursery or *taman asuhan kanak-kanak*
T20	Referring to the top 20% or upper class socioeconomically
WHO	World Health Organization

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Executive Summary

The primary purpose of this research is to examine underlying care ecosystem vulnerabilities by focusing on the gendered impact of the pandemic. The crisis exacerbated pre-existing inequalities, which were disproportionately experienced by women, including into the post-pandemic period.

Our research scope, thus, focuses on paid essential care workers, their paid and unpaid care responsibilities, and the impact this has had on their wellbeing, from pre-pandemic to post-pandemic. Through an examination of the impact of the pandemic on care workers' wellbeing, our goal is to enhance the resilience of Malaysia's care ecosystem and bolster care workforce retention.

The large-scale, nationwide study undertook a mixed-methods approach, influenced by participatory principles. This study involved 144 women care workers across 24 focus group discussions, complemented by a quantitative survey with 1,534 men and women care worker respondents, and 20 key informant interviews with policy-adjacent stakeholders across government and civil society.

Our findings revealed:

1. ***Care workers experience overlapping forms of inequality,*** including unpaid care burdens, income disparities, and broader financial strain. These challenges disproportionately affect women. Together, these intersecting inequalities compound women's vulnerabilities across both paid and unpaid care roles.

2. ***Wellbeing among care workers declined during the COVID-19 pandemic and has not fully recovered.*** Burnout also remains elevated post-pandemic in over half the care worker population surveyed. Most importantly, Malaysian women's recovery lags behind their Malaysian men and migrant women. The gap between Malaysian men and women is especially telling: Despite similar contexts, women reported poorer wellbeing outcomes, reflecting persistent gender norms and structural inequalities that shift how unpaid care work is experienced.

3. ***The data indicates a high prevalence of intent to leave their positions within the next five years amongst care workers*** (34.5% amongst Malaysian care workers; 56.5% amongst migrant domestic workers), which is concerning for the long-term sustainability of Malaysia's care ecosystem.

4. ***Strengthening resilience is crucial for care workforce retention,*** as modest improvements in individual resilience increases the odds of a care worker staying in their current position by 33%, whereas improved organisational resilience increases the odds by 112%. Resilience is also crucial for buffering negative impacts such as burnout, leading to improved overall wellbeing for care workers.

These findings demonstrate the importance of gender-transformative initiatives to improve the wellbeing and resilience of the care workforce. In this, we recommend:

1 ***Enhance the working conditions of care workers by ensuring care work is decent work.*** Strengthen the foundations of care professions in Malaysia by ensuring fair employment standards, improved mental health support, protection from violence both in the workplace and home. Promote spaces that enable care workers to organise, establish effective feedback loops and ensure stronger representation of care workers in decision-making processes. Additionally, build an ecosystem that supports clear career pathways and opportunities to sustain and professionalise the care workforce.

2 ***Strengthen family-friendly policies and support for care workers.*** At the organisational level, tailor family-friendly workplace policies and initiatives to care worker contexts and foster workplace cultures that value work-life balance, rather than penalising workers for accessing family-friendly benefits. At the societal level, invest in and improve community-based care services to expand the avenues of support for care workers. At the same time, shifting norms and values around care using the 5R framework through public service messaging and programmes Care should be valued and seen as a collective responsibility, not as a responsibility that falls solely on individuals, families or women. It should be regarded as a public good and its cost and responsibilities should be fairly shared across society and among all stakeholders (e.g. men within households, state, private actors, community). Additionally, recognise that domestic workers are not 'maids' or 'helpers' but workers.

3 ***Integrate care workers and care work within crisis-preparedness and response plans.*** Designate care workers as essential workers, so they may be protected with resources, access unrestricted mobility while in service, receive adequate hazard-related compensation (e.g. special allowances) and access crisis-specific facilities and services (e.g. transportation, childcare or elderly care services, temporary housing). Strengthen standard operating procedures (SOPs) within national crisis-preparedness and response plans and ensure that it includes all care sectors (healthcare, social care and domestic care). Upgrade crisis-training modules to ensure relevance of content and enhance predictability for care workers (e.g. clear activation triggers).

4 ***Bolster investments in the care ecosystem, to ensure sustainable financing of care policies including crisis preparedness.*** None of the recommendations put forward in this report is possible without sustained, strategic investments. Care must be an economic priority, with investments across the short, medium, and long term to strengthen the care workforce and build resilience across individual, organisational, and national levels. We recommend investing at least 1% of GDP (RM39.6 billion) to secure a resilient and sustainable care ecosystem. This investment could be one-off or year-on-year, as both have been demonstrated through economic modelling to yield returns. Modelling by economists Onaran and Oyvat (2023) suggests even a one-off investment of 1% GDP could offer returns of 2.2% GDP. This means that investing RM39.6 billion could potentially lead to an increase in GDP by RM87 billion in five years.

5 ***Strengthen governance and coordination for a coherent care ecosystem,*** by institutionalising a national multi-sectoral coordinating entity such as a national care commission, a special select committee or an inter-ministerial taskforce which could oversee the development and implementation of a national care strategy and plan. Given the growing attention to care as a social infrastructure and as a burgeoning economic sector there is a need to strengthen the care ecosystem and the care workforce. This entity could potentially lead national care workforce planning, develop an integrated data system to link care demand and workforce supply, address gendered dimensions of care (and its undervaluation), increase state and local authority roles in planning, monitoring and identifying care infrastructure needs, as well as promote better integration of our health and social care systems. This entity could also play a critical role in resolving long-standing coordination issues within care sectors that require closer multi-sectoral collaboration.

01
Situating the Report

CHAPTER 1

Situating the Report

In the intricate mosaic of societal structures, care work stands as the often invisible thread weaving through the fabric of our communities. As highly gendered labour, care work, divided into paid and unpaid, remains underappreciated and undervalued in its varied forms (United Nations Economic and Social Commission et al. 2022). *Care work encompasses the myriad of daily activities undertaken to meet the social, emotional, and physical needs of others.* It can be understood as direct, personal, and relational, wherein one undertakes the tending of another person, for example by feeding and bathing a care recipient (Lim 2022). Care work can also be indirect, through activities such as cooking, cleaning, and ensuring a household is in order. Sometimes the recipient of care is unclear, however, typically everyone in a household benefits from activities and outcomes of care work (Antonopoulos 2008).

This chapter introduces the research, its objectives, as well as provide brief context and motivation for our research.

1.1 Background

This research delves into the care ecosystem vulnerabilities exposed by the COVID-19 pandemic, and its ongoing, gendered impacts. While the pandemic serves as our starting point to understand the crucial support needed by the essential care workforce and infrastructure, our ultimate goal is clear:

To enhance the resilience of Malaysia's care ecosystem.

Therefore, the specific objectives of this research are:

1. *To explore knowledge, attitudes, practices and experiences of women health, social, and domestic care essential workers in performing paid and unpaid care work during the pandemic and in transition to endemicity and its impacts on their wellbeing;*

2. *To assess the effectiveness and relevance of existing paid and unpaid care sector policies that govern working conditions of the essential care workforce in Malaysia in collaboration with diverse stakeholders; and*

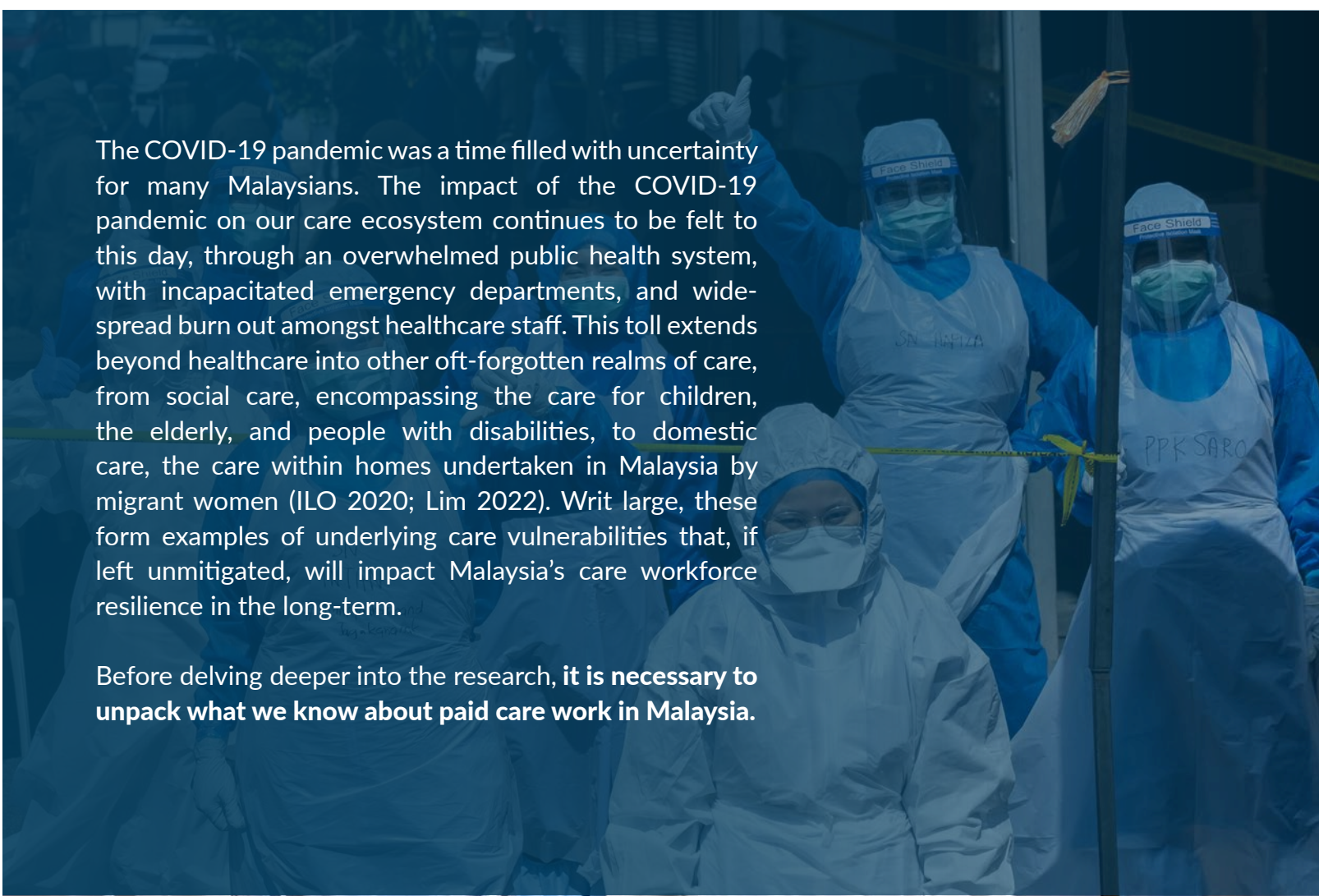
3. *To recommend equitable and gender-responsive policies and practices for a more resilient care workforce and infrastructure that can effectively respond to future crises.*

Thus, in examining these objectives, we primarily draw our focus to the care responsibilities, both paid and unpaid, of those we define as essential care workers who fall into the following categories:

TABLE 1.1

Categories of Essential Care Workers Included in the RE:CARE Study by Sector

Healthcare	Social Care	Domestic Care
Doctors	*Social workers*	*Domestic workers from Indonesia*
Nurses	*Childcare providers*	*Domestic workers from Philippines*
Hospital cleaners	*Specialised care providers* (those providing care for the elderly or people with disabilities)	



The COVID-19 pandemic was a time filled with uncertainty for many Malaysians. The impact of the COVID-19 pandemic on our care ecosystem continues to be felt to this day, through an overwhelmed public health system, with incapacitated emergency departments, and wide-spread burn out amongst healthcare staff. This toll extends beyond healthcare into other oft-forgotten realms of care, from social care, encompassing the care for children, the elderly, and people with disabilities, to domestic care, the care within homes undertaken in Malaysia by migrant women (ILO 2020; Lim 2022). Writ large, these form examples of underlying care vulnerabilities that, if left unmitigated, will impact Malaysia's care workforce resilience in the long-term.

Before delving deeper into the research, **it is necessary to unpack what we know about paid care work in Malaysia.**

1.2

Understanding the Care Ecosystem

The care ecosystem refers to the interconnected system of people, services, and institutions that support the provision, accessibility, and sustainability of care work. Crucially, the care ecosystem encompasses both paid and unpaid care work. This concept is further elaborated in the next chapter.

Paid care work is typically delivered through formal care infrastructure, such as childcare centres, eldercare services, and home and community-based services, including through institutionalised services that enable care provision, and conditions of employment for care workers (Collins 1993; Levy and Palley 2021; Li and Laughlin 2023; Small and van der Meulen Rodgers 2023).

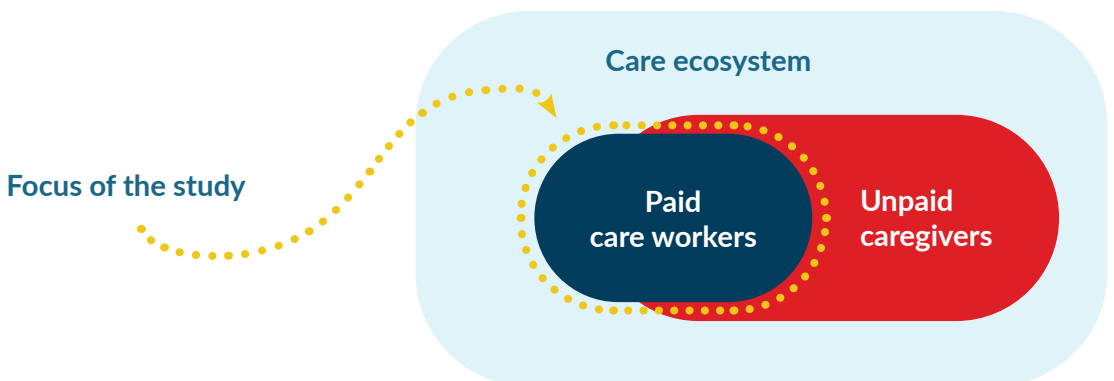
While some care is delivered through paid services, a significant portion of care work remains unpaid—provided informally and also within households and families, primarily by women. This represents the largest dimension of the care ecosystem. We will unpack this more in Chapter 2, when examining our conceptual framework.

Importantly, we emphasise the interrelations between healthcare, social care, and domestic care—these systems rely on and support each other. Formal employment of some segments of Malaysian women, for example, would not be possible without the availability of domestic care; care workers themselves rely on other care workers who provide care for their children, elderly, or disabled relatives to enable their own engagement with formal employment. The care ecosystem, then, is an entanglement of the diversity of ways care is provided in our country.

Ultimately, the COVID-19 pandemic led to a crisis of care, observed in the way our healthcare system was strained, coupled with increased personal caregiving for many Malaysians, ranging from childcare, eldercare, to care for people with disabilities. The scope of this study, thus, turns to how paid care workers, as a locus of stress, within systems that were stretched thin; particularly, we examine how they managed their paid care responsibilities at work and their personal unpaid caregiving responsibilities at home, within their families and households, especially during a crisis.

FIGURE 1.1

Situating Paid Care Workers Within the Care Ecosystem.



1.3

Paid Care Work

In Malaysia, the phrase "paid care work" is typically associated with social care, namely provision of care services for children, the elderly, and people with disabilities. Recent studies have primarily focused on social care because of the growing demand for social care services, which has outpaced supply, in light of Malaysia's demographic shifts (see Lee et al. 2024; Ilyana Mukriz et al. 2024; Hafiz Hafizi Suhaimi and Hawati Abdul Hamid 2024). Paid care work is, in fact, broader, encompassing those involved in care-providing roles across healthcare, social care, and domestic care sectors who are remunerated.

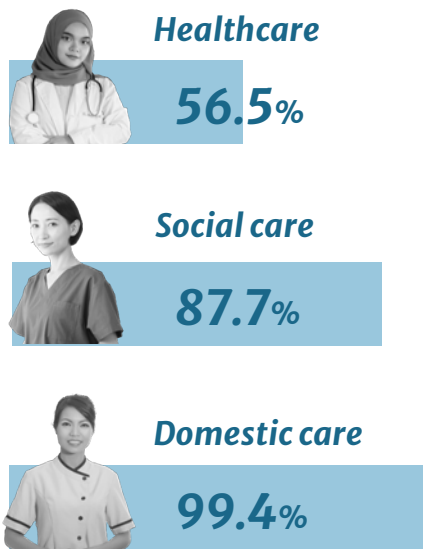
Prior research in Malaysia has noted that there is heavy reliance on informal care arrangements, with the bulk of this care being provided by women aged 36-59 (Lee et al. 2024). While we acknowledge a great portion of paid care is likely done informally, our research focus turns to paid, formal care workers.

The paid care workforce in Malaysia is primarily made up of women, echoing global trends where feminised labour is concentrated across care systems. This has also been pointed out by Wong et al. (2021), who state the care economy is largely run by women and often gravely underestimated and undervalued in social terms.

Although women's economic role has expanded in Malaysia, gender roles in the family have not changed substantially. Studies on childcare in Malaysia commonly found that mothers spend significantly more time on childcare compared to fathers (Boo 2021; Juhari et al. 2013). Women in Malaysia also undertake more domestic or household work compared to men (Malaysian Population Research Hub 2017). This means that Malaysia's paid care workforce are disproportionately saddled with what Hochschild (1989) refers to as the "second shift", wherein they need to juggle both paid work and unpaid care responsibilities.

TABLE 1.2

Estimated Share of Women across Various Care Sectors.[1]



As there is such a wide variety of paid care work, the palette of tasks looks different across occupations, though the primary function is provision of care services to care recipients from children to elderly, people with disabilities and from sick to healthy individuals. This provision usually supports physical, emotional, psychological, and developmental wellbeing.

The paid care workforce in Malaysia is primarily made up of women, echoing global trends.

1 Figures are from 2021. For healthcare, refer to Hafiz Hafizi Suhaimi and Hawati Abdul Hamid, 2024. Figure for social care and domestic care are the authors' own calculation, based on data from the Ministry of Education, JKM, and the Ministry of Economy.

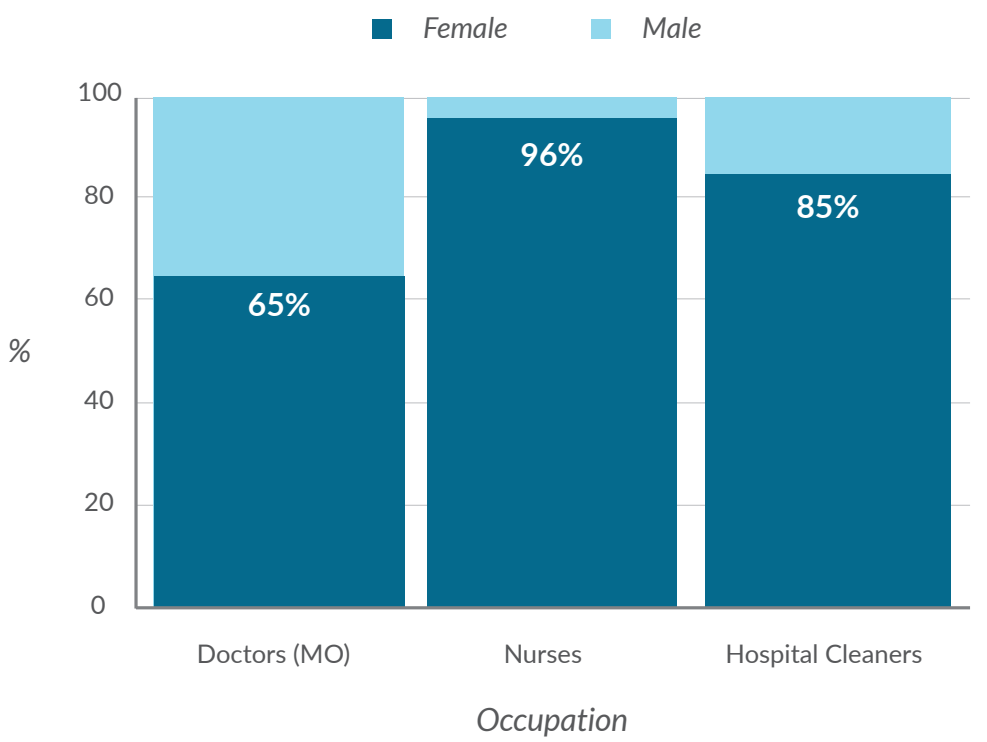
1.3.1
Healthcare

The healthcare workforce, at a glance, appears more gender-balanced as shown in Table 1.2, but when disaggregated by profession, women outnumber men across all categories except specialists and assistant medical officers (Azizan Abdul Aziz 2024). Most relevant to this study, however, are doctors and nurses. It is important to note that most data on healthcare workers excludes hospital cleaners.

Based on data shared by HRMIS from 2022, 65% of medical officers were women, whereas 96% of the nurses were women. Meanwhile, according to a testimony from the Women's Tribunal in 2021, 85% of hospital cleaners are women.

FIGURE 1.2

Share of Female Healthcare Workers Across Three Occupations



SOURCE: Doctors - Ministry of Health (2022). HRMIS data shared to the research team; Nurses - Ministry of Health (2022). HRMIS data shared to the research team; Hospital Cleaners - Women's Tribunal Malaysia on X on 6 December, 2021 at 11:30AM

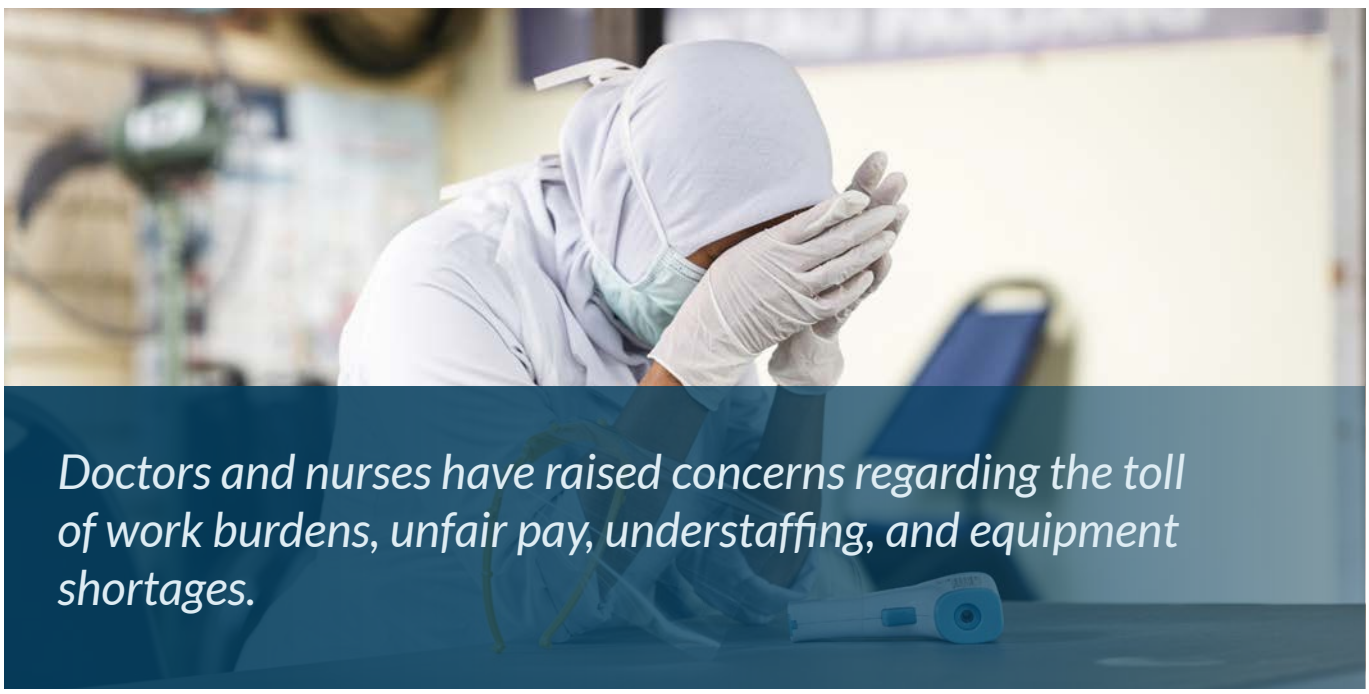
These data substantiate the feminised nature of the healthcare occupations included within our study, indicating a slightly more feminised composition than the national estimate of 56.5%. Amongst the healthcare occupations we are examining, approximately 81.4% are women.[2] Notably, salary data from DOSM (2023) demonstrates that, despite women outnumbering men in healthcare, men out-earn women by 17.4% (around RM787 a month). This gender pay gap is likely due to the disproportionate presence of men in higher paying

2 Authors' own calculations.

positions and the over-representation of women in lower paying jobs in the healthcare sector.

During the COVID-19 pandemic, studies in Malaysia demonstrated that healthcare personnel, especially nurses, were at high risk of burnout (Zakaria et al. 2021). Some research has attributed this to the long working hours expected of those in this field (Marzo et al. 2022). The transition into endemicity, however, has not mitigated the issues faced by doctors and nurses. Instead, the public healthcare system seems to still be reeling from the underlying vulnerabilities that the pandemic exposed.

Doctors and Nurses



Doctors and nurses have raised concerns regarding the toll of work burdens, unfair pay, understaffing, and equipment shortages.

A survey by CodeBlue (2023) indicated that 95% of healthcare workers say that Malaysia's public healthcare system is in crisis, with 73% of respondents stating they are thinking about quitting the public health service. Codeblue (2023) highlighted that most of the issues raised in the survey by respondents focused on the toll of work burdens, unfair pay, understaffing, and equipment shortages. All of this, undoubtedly, has an impact on the wellbeing of healthcare workers.

Doctors within the public sector appear to be moving to the private sector or abroad, as shared by the Health Minister in 2024 (NST 2024). The issue of the doctor shortage in Malaysia is compounded by constraints in the production of medical graduates (CodeBlue 2024), leading to concerns about the long-term sustainability of the public healthcare system.

In 2024, the World Health Organization (WHO) estimated there would be a global shortage of 4.5 million nurses by the year 2030 (WHO 2024a). The Malaysian Deputy Minister of Health has also shared that the COVID-19 pandemic hampered nursing recruitment (Iskandar 2025). With demand for nurses outpacing the availability, coupled with issues such as Malaysian nurses opting to work abroad (CodeBlue 2024), Malaysia has a shortfall of 43,243 nurses (Iskandar 2025).

ii Hospital Cleaners

The case of hospital cleaners merits closer inspection, given their exclusion from the public healthcare system. In conjunction with the privatisation efforts undertaken during Dr Mahathir Mohamad's prime ministership in his first tenure to ostensibly provide financial relief and upgrade standards of those services, under the Seventh Malaysia Plan (1996-2000), government support services, such as cleaning, have been outsourced to private contractors (Devi 2021; Jaringan Pekerja Kontrak Kerajaan 2020; Rasiah et al. 2009).

Consequently, the Ministry of Health became directly responsible for tendering and procuring services, including hospital cleaners designated under healthcare allied services. Ever since, healthcare allied services workers' employment status has been converted from government employees to contract workers of private companies. This change has resulted in the loss of the privileges and benefits they previously enjoyed as government employees, leading to job insecurity, precarious employment, and unfair working conditions (Jaringan Pekerja Kontrak Kerajaan 2020).

As per Figure 1.3, tenders are awarded to companies (the main concessionaire or the parent company), who usually sub-contract the service to companies that are sometimes subsidiaries of the parent companies, (Jaringan Pekerja Kontrak Kerajaan 2020). Often the process involves layers of sub-contraction. The sub-contractors who can recruit both local and foreign workers hire cleaners on a minimum one-year contract.

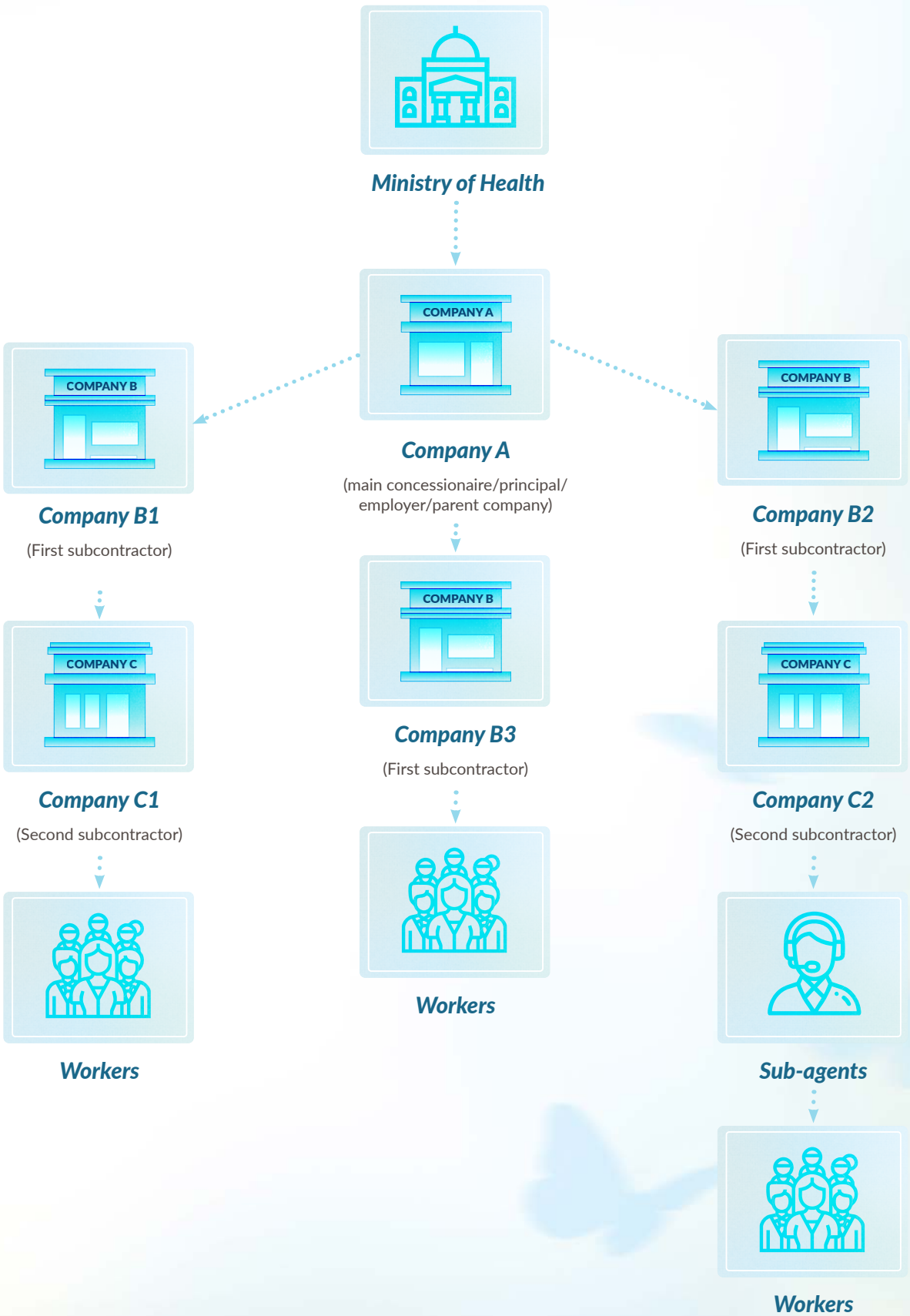
Hospital cleaners' scopes of work vary depending on the departments they are assigned to, but their general role is to maintain sanitation and hygiene in public healthcare facilities. The pandemic has since highlighted the crucial role of hospital cleaners in the healthcare ecosystem in curtailing the spread of viruses and outbreaks (Lim 2022).

Since the pandemic, hospital cleaners in Peninsular Malaysia have mobilised to demand better treatment, highlighting the challenges they have faced including a lack of recognition as frontliners, long working hours, arbitrary dismissal, delayed wages, lack of career growth, highlighting how some cleaners have been paid RM1,200 for 15 years, and general lack of support (FMT Reporters 2022; Jaringan Pekerja Kontrak Kerajaan 2020).

Healthcare allied services workers' employment status has been converted from government employees to contract workers of private companies.

FIGURE 1.3

The Employment/Contract Structure for Hospital Cleaners



1.3.2
Social Care

The social care sector encompasses occupations ranging from social work to care providers for children, the elderly, and people with disabilities—the key feature of their roles is a focus on the social aspects of care. Notably, in conceptualising care as an ecosystem, we view all those engaged in paid care work as care workers. Social care may contain the greatest diversity of care workers, as it captures various industries. We recognise that each of these care workers, especially within social care, require different qualifications and criteria for professionalisation, with separate domains of expertise. Nonetheless, in our view, social workers, childcare providers, eldercare providers, and PWD care providers all function within the same care ecosystem.

Social care appears highly feminised in Table 1.2 because of the sheer scale of women engaged in childcare. When examining other occupations within social care, the share of women in these services is less clear. Social work, eldercare, and PWD care appear to be far more underdeveloped compared to other care occupations; within the Malaysian Labour Force Survey, health and social care occupations are grouped together under "Human Health and Social Work." However, as noted by the United Nations Development Program (UNDP 2020), the percentage of social care workers, which includes *those who provide residential, home, and community care, never exceeds twenty per cent of the human health and social workforce, signalling a persistent underinvestment in social care roles.* In the following sections some brief background information on the four social care occupations covered in this study is provided.

Childcare Providers

Childcare provision is a highly feminised sector. 92.2% of public childcare providers are women.[3] Though there is no exact figure for how many women are involved in private childcare provision, we assume the trend is similar.

Overall provision of childcare in Malaysia is quite fragmented. While childcare can be thought of as under the umbrella of "early childhood care and education" (ECCE), in Malaysia, care in early childhood and early childhood education are placed under two different ministries (Qin and Md Nor 2018). Care for children under four years of age is governed by the Ministry of Women, Family and Community Development. For children aged five to six, care is governed by the Ministry of Education. Simultaneously, government childcare is also provided through various agencies and ministries. Refer to the table below:

TABLE 1.3
List of Government TASKAs Available in Malaysia

TASKA	Ministry or Body	Community served
TASKA KEMAS (Department of Societal Development)	Ministry of Rural and Regional Development	Children aged two to four years old. KEMAS also has TABIKAs, for children aged four to six. Curriculum follows the Ministry of Education; regulations comply with JKM.
TASKA PERMATA	Ministry of Education	Part of the national PERMATA programme, aimed at children under the age of four.
TASKA Perpaduan	National Unity and Integration Department (Jabatan Perpaduan Negara dan Integrasi Nasional, JPNIN)	Utilises the same curriculum as TASKA PERMATA, aimed at children under the age of four.
TASKA Permata Keluarga	Family Development Foundation of Terengganu (Yayasan Pembangunan Keluarga Terengganu, YPKT)	Children under the age of four in Terengganu, especially for families struggling to secure childcare.

Source: Adapted from Ilyana Mukhriz, Hafiz Hafizi Suhaimi and Hawati Abdul Hamid. 2024..

3 Authors' own calculations from data available from the Ministry of Education, as well as data shared by KEMAS

Broadly, there are four types of non-government or private childcare available in Malaysia:

TABLE 1.3

List of Government TASKAs Available in Malaysia

Type of childcare centre	Description	Number of children
Community childcare centres	"Established based on initiatives by the community" and "receive assistance from the Government."	10 or more children
Workplace childcare centre	Facilities established by employers	Depends on employers
Institution-based childcare centres	Can be sponsored by the private sector or NGOs	10 or more children
Home-based childcare centres	Operate in an owner's residence	If three children or less, no registration needed[4] If four to nine children, must be registered

Source: Child Care Act 1984, Child Care Centre Regulations 2012, MyGOV (n.d)

In general, there is consensus that Malaysia lacks an adequate amount of childcare facilities, in line with the population of children. This gap is especially apparent in rural settings (Ilyana Mukriz et al. 2024). Of the 4,571 TASKAs for children aged four and below, only 16.6% are provided by the government (Ilyana Mukriz et al. 2024).

Over the past few years, there have been increased efforts to encourage the private sector to set up workplace childcare centres through allocations within the national budget. Uptake, however, remains unclear as many employers cite cost constraints (Bernama 2022).

While steps to expand child care facilities are important, we should be mindful that workplace-based childcare is often only available to middle-class women and poorer women often rely on informal sources of childcare. As such, the availability of state-provided child care remains important.

Increasingly, technology-facilitated childcare is also gaining popularity in urban areas of Malaysia. These typically take the form of apps that parents can use to find a babysitter. While this is a growing field, much like workplace-based childcare, technology-facilitated childcare is often only available to those middle class and above and often co-opt women of lower classes to provide the service (UN Women 2023a).

During COVID-19's most acute phases, childcare centres were closed down, which meant care that was typically provided was channeled back to the household (Lim and ILO 2022). This demonstrated the centrality of childcare, as parents depended on childcare centres in order to enable certain commitments, such as work, and so forth. Childcare centres, throughout the different phases of the pandemic, operated across different modes, from online to in-person, but with less capacity (ILO 2020c).

Despite the large, feminised workforce, limited studies have been conducted on the experiences of those

providing childcare, especially during the COVID-19 pandemic. A recurring issue is the need to bridge the childcare training gap, as qualifications remain unstandardised, complicating career development pathways (Ramakrishnan 2024). Studies available during the pandemic focus on service provision, highlighting the economic, logistical, and financial constraints of childcare providers (Aziz et al. 2021), as well as the overall fragility of the childcare ecosystem, which was considerably weakened by lockdown orders (Nik Hussin et al. 2021).

Malaysia lacks an adequate amount of childcare facilities and this gap is especially apparent in rural settings.

ii Specialised Care Providers

Malaysia is an ageing nation—a label assigned to countries where 7% of the population is over 65 years old (WHO 2020b). There are several types of eldercare centres available in Malaysia operated by private, public, and nongovernmental organisations; however, generally, eldercare provision remains underdeveloped (Md Isa et al. 2020). Eldercare is provided, to a minor extent, by the government through homes under the Social Welfare Department (JKM); however, most elderly Malaysians prefer to age in place in their own homes and communities (Awang et al. 2024; Lee et al. 2024). To facilitate this, much like childcare, there is a rise in technology-facilitated elder care provision, where eldercare providers can be hired through apps.

According to data from the Social Welfare Department (JKM), the bulk of their staff involved in residential care are men. This is supported by findings from Hafiz Hafizi Suhaimi and Hawati Abdul Hamid (2024), who revealed that men comprised 56.5% of those employed in public sector residential care in 2023. The proportion of women working within private care settings remains unclear. Public provision of eldercare and PWD care is limited, with only 11 eldercare facilities (Rumah Seri Kenangan) and seven PWD care facilities (Taman Sinar Harapan) available across the country, with limited to no availability in Sabah and Sarawak (East Malaysia).[4] Private provision, though more widespread than public provision, can be expensive and typically concentrated in urban settings, leaving a large provision gap for those in rural areas.

4 There are two Rumah Seri Kenangan in East Malaysia, both in Sarawak and none in Sabah. There are no Taman Sinar Harapan facilities in either Sarawak or Sabah.

During the COVID-19 pandemic, residents of live-in eldercare centres were at high-risk for contracting the virus.

Worrying news stories emerged of aged care centres as cluster events indicating that these centres lacked the resources to safeguard clients (Jafri et al. 2022; Kaos 2021).

Studies on the experiences of those involved in eldercare and PWD care are limited, though Ilyana Mukriz et al. (2024) demonstrated that the carer to patient ratio in these facilities across Malaysia are typically below the ideal ratio. This likely means that carers bear a heavy workload, as they may potentially need to look after more patients.

One key issue related to eldercare and PWD care is the lack of professionalisation, which may limit the number of those who want to take up the career, and may compromise quality of care.

Eldercare is still largely a personalised obligation, and also a gendered one (Noor and Mahudin 2016). Thus, eldercare is occasionally also undertaken by migrant domestic workers or other personal hired help in private households. However, this practice has been called into question because taking care of sick, elderly people requires skills that those who enter the country as migrant domestic workers may not possess nor are trained to do, especially as caregivers must assume more complex medical and health-related tasks (Ang et al. 2022).

iii Social Workers

Social work is not yet a legally recognised profession in Malaysia. The Malaysian Association of Social Workers (MASW, n.d.) defines social work as a profession which is "guided by a body of knowledge, values and skills, utilizing a bio-psycho-social approach, to facilitate optimal social functioning of individuals, families, groups and communities." They view social work as a "helping profession", wherein social workers "undertake assessment to address client's concerns to improve their quality of life." In Malaysia, social workers exist across governmental and non-governmental bodies, supporting vulnerable groups with access to health, education, housing, and the justice system.

In light of this, social workers, within this study, refer to those within the Social Welfare Department (JKM), undertaking the role of Welfare Officers. Welfare Officers typically handle cases, working to support children, the elderly, PWD, women who have experienced domestic violence, and a wide range of other clients. Despite the complexity of the work undertaken by social workers, the Social Work Profession Bill, which was approved by the Cabinet in 2010, is yet to be tabled in Parliament, as of publication. The anticipated legislation will establish standards for qualifications, training, and ethical practice, positioning Malaysia with neighbouring countries like the Philippines, Singapore, Thailand, and Indonesia, which have formal legislation regulating the social work profession (UNICEF 2025). Many civil society actors, including MASW and UNICEF, have been advocating for the enactment of the Bill. The delay in enactment means that social work continues to be unregulated. Consequently, the absence of legal recognition for social work in Malaysia hinders the development of the profession and the provision of effective services to those in need.

During the COVID-19 pandemic, social workers were not initially recognised as frontliners, despite the fact that they were involved in key pandemic response, including monitoring quarantined Malaysians returning from abroad and handing out food baskets.

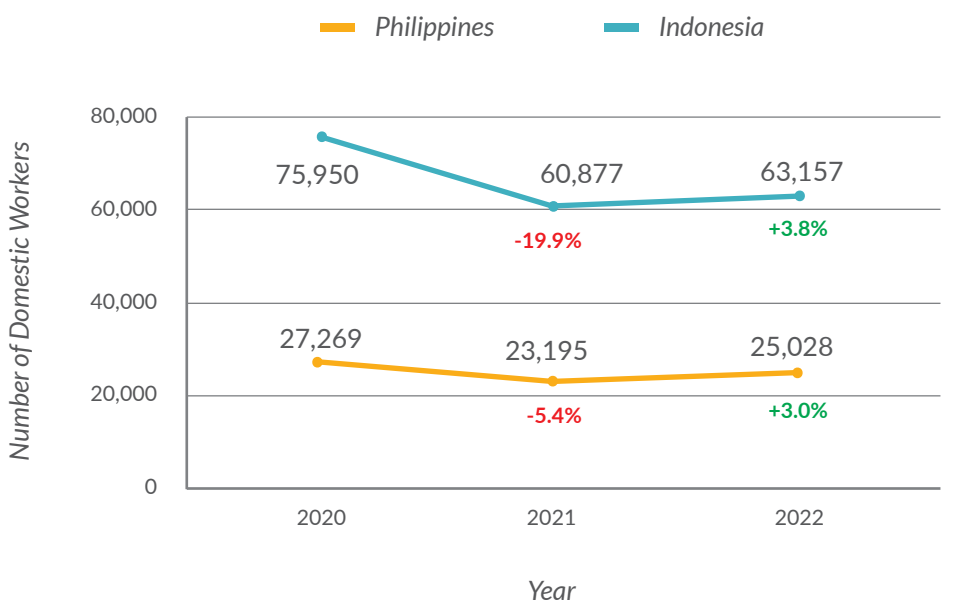
There have been several studies on social workers in Malaysia (see Shuhaimi et al. 2025; Salim and Anuar 2023), though none highlight their experiences during the COVID-19 pandemic.

1.3.3
Migrant Domestic Workers

There were 88,173 registered migrant domestic workers in Malaysia in 2021:[5] 69.4% of them were from Indonesia (61,183) and another 26.4% were from the Philippines (23,267), with the remainder from other South and Southeast Asian countries. There was a substantial decline of migrant domestic workers from both Indonesia and the Philippines following the COVID-19 pandemic.

FIGURE 1.4

Number of Migrant Domestic Workers from Indonesia and the Philippines in Malaysia (2020-2022).



SOURCE: Home Ministry

The feminisation of the migrant domestic workforce, according to Tenaganita (2023), is an example of institutional engineering that stems from the Malaysian Immigration Department's regulation that stipulates migrant domestic workers must be female. Moreover, there are additional age restrictions, health requirements, and bureaucratic obligations that are applied even though they are not explicitly outlined in the Immigration Act 1959.

Typically, migrant domestic workers are employed to undertake household chores, including childcare and eldercare, though a portion of them are also enlisted for duties beyond domestic help. The tasks performed by migrant domestic workers in Malaysia primarily fall under Skill Level 2 of the International Standard Classification of Occupations (ISO-8) for domestic housekeepers, childcare workers, and home-based care workers (ILO 2023). These activities include, but are not limited to: supervising staff, purchasing and controlling supplies, providing first aid for minor injuries, assisting children in their daily needs, preparing for children's activities, disciplining and managing children's behaviour and social development, assisting elderly clients and/or those with disabilities with personal and therapeutic needs, preparing nutritional meals per their requirements, maintaining records of client care, and scheduling appointments (ILO 2023). In addition, migrant

5 According to data shared by the Ministry of Home Affairs with the research team

domestic workers are compelled to engage in extensive emotional labour as they manage their own deportment and demeanour to align with their employers' and care recipients' expectations, efforts that can be considerable for workers who reside in their workplace (Spitzer et al. 2023).

Migrant domestic workers also usually have care duties in their home countries, which they have, for the time being, entrusted to others. This embeds them in an international chain of care, both because they have care work in their home countries and because they have been brought to Malaysia to undertake care work (Anderson 2016; ILO 2023; Spitzer et al. 2023). Tenaganita (2023) affirms and explicitly highlights the crucial role of migrant domestic workers in enabling parents and caregivers of the elderly to engage in employment outside their homes. Their absence would impede economic growth and bring about financial burdens on individual households for the cost of care is much higher if provided by the private sector compared to if it is done by migrant domestic workers.

In our view, domestic workers must be viewed as essential care workers because of the dependence of Malaysian families on them for their care needs. During COVID-19, it was these migrant domestic workers who took on the bulk of cleaning and disinfecting that needed to be done at the home (ILO 2020a). Despite their critical need in Malaysian households and the national economy, their welfare and rights are often neglected on various fronts, primarily because the Employment Act of 1955 only partially covers domestic workers (Malaysian Employers Federation 2022). This partial coverage denies entitlement as an employee to certain rights including overtime pay, annual leave, right to mobility, and right to a decent wage. Memorandums of Understanding (MOUs) do exist between Malaysia and sending countries like the Philippines and Indonesia, which are meant to govern the working conditions of migrant domestic workers.[6] However, enforcement and implementation of the MOUs vary, leading to differential enjoyment of rights between migrant domestic workers—an issue which is further complicated in Sabah and Sarawak. In fact, migrant domestic workers in Sabah and Sarawak appear understudied compared to their counterparts in Peninsular Malaysia (ILO 2023).

Migrant domestic workers in Malaysia, as elsewhere, are vulnerable to manifold forms of emotional, physical, sexual, and financial abuse by employers due in large part both to their precarious migration, housing, and employment statuses that tie them to their employers, and to the bounded and private nature of their work within the household (ILO 2021; Spitzer 2020; Spitzer et al. 2023; Tayah 2016; Tenaganita 2023). As migrant domestic workers in Malaysia are tied to one employer through their work contracts, they are unable to request for a change of employment situation, thus, alongside their low wages and lack of job security, they may be anchored to a precarious and potentially exploitative living and working environment (Dawood and Seedat-Khan 2023).

Domestic workers must be viewed as essential care workers as well because Malaysian families depend on them for their care needs.

6 For example, migrant domestic workers have a right to minimum wage and one day off through Memorandum of Understanding (MOUs).

1.4

COVID-19 and the Impact on Unpaid Care Work

Prior to the pandemic, women and girls in Asia and the Pacific spent on average up to 11 hours a day on unpaid care and domestic work, a figure four times more than the amount of time men spent (United Nations Economic and Social Commission for Asia and the Pacific 2021). While the pandemic likely had a bigger impact on women, the exact impact on women essential care workers in Malaysia who shouldered the increased demand of the second shift is less known.

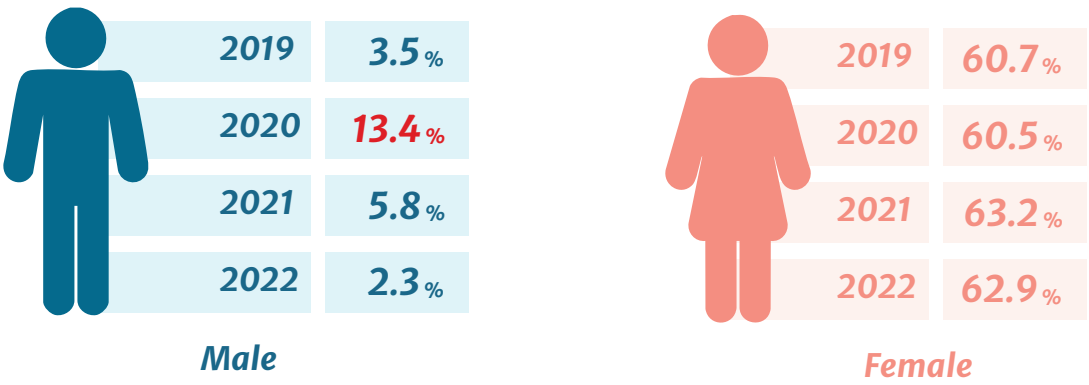
In Malaysia, women most commonly cite the reason they are out of the labour force as housework and family responsibilities (see Table 1.5). This trend has held steady, with over 60% of women year on year reporting as such. Less than 5% of men cite the same reason, with the exception of during the COVID-19 pandemic, when this figure increased to 13.4%. This figure, however, has steadily declined since then, indicating this trend was short-lived and did not bring about a gender transformative outcome.

According to Choong (2021), it is difficult to analyse the profile of those outside the labour force further without more granular data. His reading of these data is that there is a possibility that "essential work" is feminised. This, on some level, supports a recent LPPKN (National Population and Family Development Board) public opinion survey of Malaysians that revealed that during the pandemic, housework in two-parent families was more likely to be done by both husband and wife (as opposed to one spouse). In other words, men did more housework during the pandemic (though only by a few percentage points), although this was still comparatively less compared to women (Omar et al. 2022).

Following the pandemic (see Table 1.5), there was an increase in the number of women after 2020 who left the labour force due to housework and family responsibilities. In Malaysia, the pandemic worsened in 2021, coinciding with the delta variant—the most severe COVID-19 outbreak (Nadzri et al. 2024). In the same period, men departing the workforce for housework and family responsibilities decreased, suggesting that the brunt of unpaid care responsibilities amidst a worsening crisis was shifting to women in private spheres.

TABLE 1.5

Percentage of Men and Women who Stated Housework and Family Responsibilities as Reason for Being Outside the Labour Force



SOURCE: Labour Force Survey 2019, 2020, 2021,2022

1.5

COVID-19, Paid Care Work, and Wellbeing Impact

The documentation of healthcare workers' mental health throughout different phases of the pandemic helps to make sense of the impact of the pandemic on their wellbeing. For example, research in Malaysia reveals high levels of anxiety and burnout amongst healthcare staff, with some even noting suicidal ideation (Sahimi et al. 2021).

As mentioned, little data are available in the Malaysian context on the impacts of the pandemic on other types of care workers, such as social workers, care providers, and domestic workers. There are some studies examining aspects such as anxiety, burnout, and depression amongst healthcare workers during COVID-19 in Malaysia (see Tabur et al. 2022; Marzo et al. 2022; Ching et al. 2024), but the broader considerations of wellbeing impacts on care workers across various sectors during the pandemic appears understudied.

Care worker wellbeing is important because it influences care workforce resilience.

In this, it is critical to examine paid care workers and their wellbeing. Understanding the impact of a crisis like COVID-19 on the wellbeing of the care workforce is important as it has an influence on workforce resilience—concepts which will be further explored in Chapter 2. Additionally, experiences of paid and unpaid care work are intertwined, and personal unpaid care responsibilities are an important component of wellbeing that is typically overlooked. Thus, this key gap is one the current research hopes to address, extending the understanding of wellbeing to encapsulate aspects beyond mental health, but also the impact of managing the balance of paid and unpaid care work on care workers. We are guided by the belief that a holistic approach is needed to understand how to best support care workers in times of crisis and beyond.

1.5.1
Towards Resilient Care Ecosystems

While, for many, the COVID-19 pandemic has passed, it still remains a relevant starting point to begin tracing the experiences of essential care workers.

The care ecosystem is vulnerable to many crises. The first of which is the demographic shift, especially as Malaysia is ageing rapidly, there are implications potentially for women's labour force participation. Women's increased labour force participation, especially amongst the middle class (M40) and the upper class (T20) families, historically, were encouraged by policies assisting families to access foreign domestic workers. However, these policies have yet to address the magnitude of the impending epidemiological shifts of a rapidly ageing population. These issues are intensified by the state's hardline stance on reducing reliance on foreign labour, as many care sectors remain unattractive to Malaysians and many Malaysians in care sectors are dropping out. As Malaysia faces polycrises, it is important to ensure the resilience of Malaysia's care ecosystems—looking beyond just physical infrastructure for care and provision of services.

In this, this report aims to strengthen the data available on the perspective of care workers to policy discussions around the care ecosystem, a perspective that is sorely missing from the landscape of prior studies. This report, thus, is unique in positioning care workers as essential. Paid care work is not possible without care workers.

Our goal is to provide evidence from the experience of essential care workers to ensure that care ecosystem policies are not just inclusive of their needs, but prioritise their wellbeing.

As the demands on Malaysia's care ecosystem grows, driven by demographic, economic, and political changes, ensuring our care workers are cared for is absolutely crucial for national resilience.

The following chapters will introduce the conceptual framework and outline the study, its findings, and policy recommendations. Chapter 2 details the conceptual framework that guides the research, including key ideas central to the formulation of data collection tools. In Chapter 3, we outline the methodology. The participatory approach we take in our research is also further elaborated in this chapter, highlighting the efforts we took to ensure the active involvement of essential care workers by centering their voices and perspectives through participatory data collection, data analysis, and recommendation formulation. In Chapter 4, we share findings from our data collection, arising from 24 focus group discussions across Malaysia and a quantitative survey with over 1,500 survey respondents. Finally, care worker perspectives and inputs guide the policy recommendations we put forward in Chapter 5.

02

Care Workers' Wellbeing & Care Sector Resilience:

A Conceptual & Policy Landscaping

CHAPTER 2

Care Worker's Wellbeing and Care Sector Resilience: A Conceptual and Policy Landscaping

This chapter elaborates on the analytical lens through which our research examines the Malaysian care workforce and care ecosystem. In Section 2.1, we define key concepts—care work, care workforce, essential work, well-being, and resilience—and explain the relationships between them. Crucially, in Section 2.2., we also identify the critical policy gaps that must be urgently addressed to foster a robust and supportive environment for Malaysia's care workforce.

2.1 *Conceptual Framework*

2.1.1 *Conceptualising Care Work*

Understanding care work necessitates distinguishing between its direct and indirect care manifestations, a foundational categorisation provided by the International Labour Organization (ILO 2018). Direct care refers to "face-to-face, personal or relational care activities" such as feeding and bathing, and is what most of us think about when we hear the term 'care'. In contrast, Indirect care refers to "non-relational care activities", such as cooking and cleaning, and involves activities that often sets up the space for personal caregiving activities, or direct care (ILO 2018, 6).

Direct and indirect care work should not be thought of as separately occurring activities, nor should one be considered more important than the other, as they often happen simultaneously and are both important in ensuring adequate provision of care. For example, in providing quality care for patients in hospitals, sanitation of equipment or space, which is indirect care must also be prioritised. In caring for an elderly parent, apart from administering medication, one must manage a host of medical and non-medical appointments, synthesize advice from the various consultations, and ensure that appropriate documentation and records are maintained. Direct and indirect care are thus both crucial in ensuring quality care.

TABLE 2.1
Definitions of Care Work

Direct care work	Personal or relational care activities that involve face-to-face contact such as feeding a baby or nursing an elderly patient.
Indirect care work	Non-relational care activities or household tasks that "provide the preconditions for personal caregiving" (ILO 2018, 6). Examples include cooking and cleaning, managing finances/ paperwork or coordinating appointments.

Source: ILO 2018

In exploring types of care work, we also highlight an often obscured or invisible aspect of care namely the intense emotional labour that comes with care work (Hochschild 1983). Emotional labour often requires one to utilise diverse skills which may include emotional intelligence, relational strategies and psychological resilience—all of which can take a significant toll on a caregiver (Hochschild 1983). Yet, because the emotional aspects of care work is invisible, it often leads many to assume that care work is 'unskilled' or 'easy' labour, when in fact it is emotions that make care work highly complex and demanding, often requiring high levels of personalisation on the part of the care provider to ensure the unique needs of each care recipient is met.

From an economic perspective, care can be demarcated as paid care work and unpaid care work, either within homes or institutions. Paid care work occurs when financial remuneration is provided in exchange for care services, while unpaid care work typically occurs within the home for loved ones, and provided freely without any direct material or financial obligation. While some may view efforts to identify and define unpaid care work as futile, doing so is, in fact, intentional given that unpaid care work is often invisible, unacknowledged and yet profoundly shapes women's lives.

The environment within which care work, its actors, network and structures occur has often been referred to as either the care economy, care sector or care ecosystem. While these terms are often used interchangeably, in Table 2.2 below we highlight some differences between these interconnected concepts.

TABLE 2.2

Definitions of the Care Economy, Care Sector and Care Ecosystem

Care economy

Encompasses all activities related to the provision of care, including paid and unpaid care work for present and future populations. This term emphasises the valuable contributions of caregiving activities to the economy and is underpinned by an economic lens of productivity.

Care sector

Refers to formal care services (e.g. within healthcare or social care) in both public and private sectors. This term is often used to focus more narrowly on policies, regulations and frameworks that govern the care sector.

Care ecosystem

Refers to an interconnected network of individuals, organisations and systems involved in paid and unpaid care work. The term is often used to highlight the importance of approaching care from an integrated and collaborative approach (e.g. social care, healthcare, domestic care, community-based care services), leveraging the multiple levels of resources and networks within a care context (e.g. family, community, service providers, government) to meet the needs of care recipients and support those who undertake paid or unpaid care work.

Source: The Asia Foundation 2022; UN Women and International Labour Organisation 2021; Peng 2019; UN 2024; The Centre for Care 2025.

In this report, we have chosen to prioritise the term 'care ecosystem' to emphasise the importance of recognising the myriad of interconnected components that simultaneously work together to affect the provision of care within a particular context. In this, we emphasise the diverse sectors that comprise a care ecosystem (e.g. healthcare, social care, general care, domestic care),[1] and the unique and important contributions of each sector towards sustaining our collective wellbeing. Simultaneously, we also recognise that definitions of care ecosystem often centre care recipients. In this, our approach differs as we acknowledge the multiplicity of roles that paid care workers have, in managing both their paid and unpaid care responsibilities. Crucially, we also interrogate how care workers themselves navigate their own personal care responsibilities within the care ecosystem that they exist in (e.g. family support, domestic workers, child care centres, workplace support), and how both professional and personal lives of care workers may overlap. Our analysis, thus, centres care workers, as an actor within the care ecosystem.

Because the emotional aspects of care work is invisible, it often leads many to assume that care work is 'unskilled' or 'easy' labour.

2.1.2
Revaluing Care: From Gendered Labour to Public Good

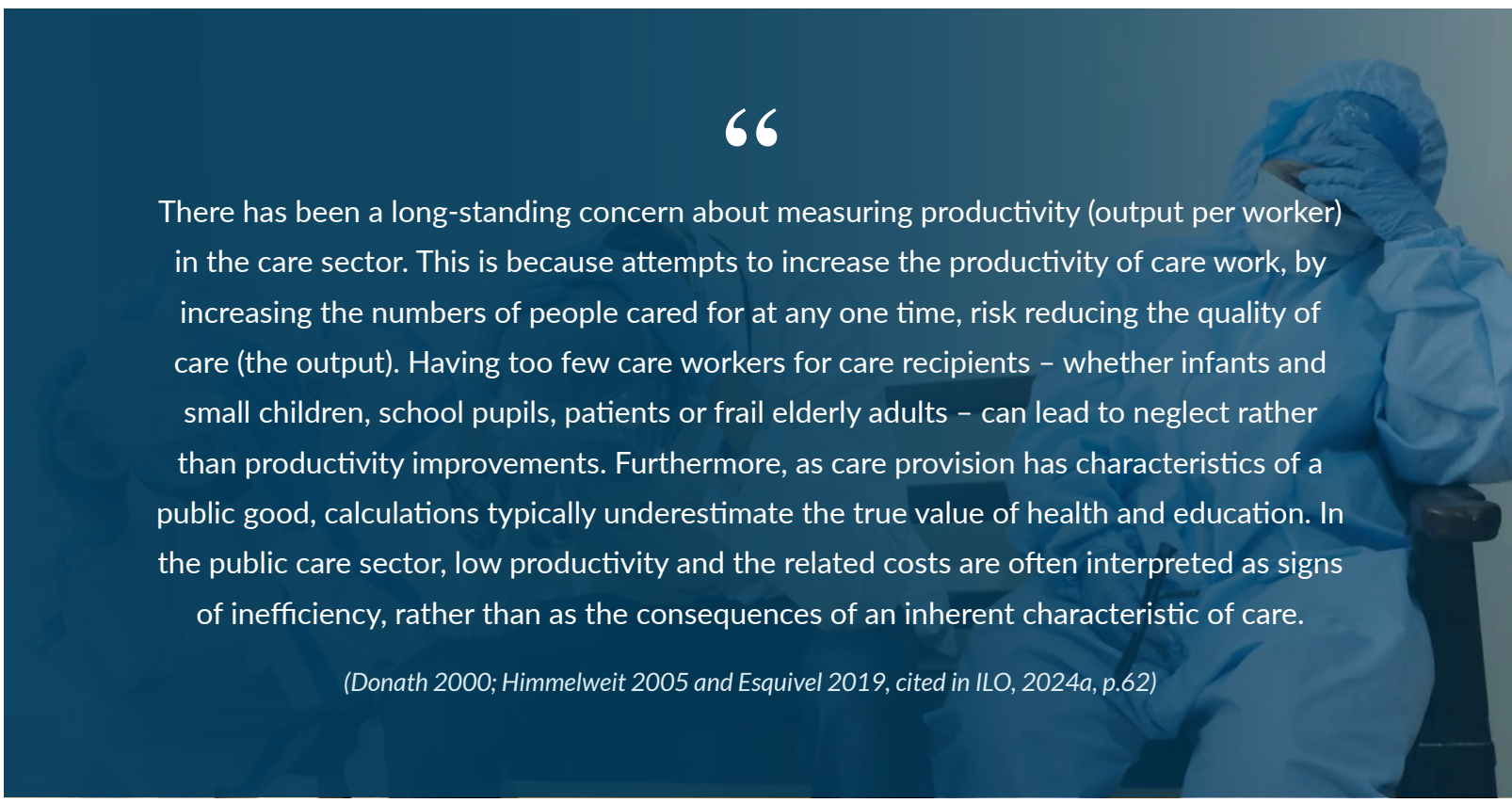
Care work is highly gendered. Deeply ingrained social norms and expectations of women as the primary bearers of care responsibilities within the home have reinforced the idea of care work as 'women's work' (Bauhardt 2019). This historical bias has led to a gendered division of labour, where men tend to engage in remunerative employment, while women tend to shoulder the majority of unpaid care work within homes. The benefits of unpaid care work to homes and communities can be thought of as an 'in-kind' income that directly fosters wellbeing (Folbre 2009). Fundamentally, unpaid care work is a systemic transmission of unseen subsidies to the rest of the economy - subsidies that are invisible and unrecognised. This unacknowledged transfer implies a methodical time-tax on women throughout their lives, revealing unequal power relations between men and women and the exploitative links between the "private" domain of the households and families, with the "public" domain of markets and the state (Folbre 2009; Antonopoulos 2008).

Gender norms, however, have not only influenced broader societal attitudes towards care work, but also occupational choices. Within the sphere of paid work, women tend to take on roles that are seen to be more 'feminine' and this explains why the care workforce is highly feminised. Ultimately, gender is not merely a descriptive characteristic of the care workforce, but a fundamental determinant of who takes up care work, how responsibilities are shared or divided and whose labour is recognised, rewarded or devalued (Budlender 2002). Entrenched social norms thus shape and perpetuate the idea of care work as 'natural' to women leading to the feminisation of both paid and unpaid care work (Bauhardt 2019).

1 In line with the priorities of this research, we have conceptualised 'care workers' to encompass workers across three different sectors—healthcare, social care and domestic care. This broad conceptual definition is not intended to conflate or diminish the important roles and unique contributions of each occupational group. We recognise that for the purposes of advocacy, or practical implementation within the care industry, the use of narrower and more operational definitions, such as 'care workers' to denote personal support workers within care centres or institutions, may be more suitable.

The feminisation of care work has contributed to its undervaluation. The undervaluation of care work is rooted in neoclassical economic assumptions that viewed 'productive labour' as activities that occur within formal markets and measured through instruments such as the Gross Domestic Product (GDP). Thus, work typically associated with men was considered productive labour, whereas women's vital unpaid reproductive labour, primarily confined to domestic spheres, remained unremunerated, excluded from economic measure and socially dismissed as 'unproductive' (Folbre 2001).

For these reasons, and in line with experts, this research calls for a re-evaluation of how we view and value care work. Recognising and valuing care requires us to move beyond market-based measures, (underpinned by neoliberal economic frameworks) and to take into consideration care's unique, intensely relational and time-consuming nature (Benería et al. 2015; Heintz et al. 2021). Fundamentally, *care cannot be easily commodified.* As such, experts caution against applying standard productivity measures to care work, and recognising that so doing, fails to capture the broad social benefits that it provides (ILO 2024a).



> "There has been a long-standing concern about measuring productivity (output per worker) in the care sector. This is because attempts to increase the productivity of care work, by increasing the numbers of people cared for at any one time, risk reducing the quality of care (the output). Having too few care workers for care recipients – whether infants and small children, school pupils, patients or frail elderly adults – can lead to neglect rather than productivity improvements. Furthermore, as care provision has characteristics of a public good, calculations typically underestimate the true value of health and education. In the public care sector, low productivity and the related costs are often interpreted as signs of inefficiency, rather than as the consequences of an inherent characteristic of care.
>
> *(Donath 2000; Himmelweit 2005 and Esquivel 2019, cited in ILO, 2024a, p.62)*

The complexities around valuing and measuring care work within conventional economic models underscore the need to reconceptualise care as a public good (Folbre 2001; Chopra and Sweetman 2014). As Chopra and Sweetman (2014, as cited in Withers and Hill 2023, 2) argue, care is "a social good" as "it not only sustains and reproduces society, but underpins all developmental progress." Fundamentally, care work constitutes a critical form of social reproduction wherein the physical, emotional, and social needs of individuals are addressed by the paid and unpaid labour, provided predominantly by women, which enable and sustain the population (Fielder 2020; Glover 2021). Taking care of people means contributing to collective capabilities, work that must be recognised and valued (Fielder 2020; Folbre 2001).

2.1.3
Care Workers as 'Essential'

While we acknowledge that a large portion of care work is often unpaid and done within private households, our focus in this research turns to paid care workers—individuals who receive financial compensation for delivering care services. As there is currently no national or international consensus on the components of a care workforce, this research has chosen to focus on select occupations across three sectors: Healthcare, social care and domestic care. This framing aligns with the approach taken by several international organisations in viewing all three sectors as integral components of the complex ecosystem of care (as outlined in Chapter 1). For purposes of this research, we conceptualise workers within all three sectors as comprising the 'care workforce'.

The COVID-19 pandemic revealed to us the importance of strong care systems and comprehensive disaster preparedness plans. At the heart of these systems are care workers, predominantly women who carry the responsibility of ensuring the continuity of care, despite high levels of uncertainty or instability. A truly resilient workforce, however, is able to ensure the continuity of care without severely affecting workers' well-being. Unless Malaysia begins to rethink its support for care workers, and review how care is addressed and prioritised within the nation, future crises will potentially result in negative impacts on the care workforce and strain our already fragile care ecosystems. As a starting point, we assert that, in order to be prepared for future crises, it is critical for care workers across all three sectors—healthcare, social care and domestic care—to be recognised as essential workers (Berry and Stuart 2021; Guerrero et al. 2020).

An 'essential worker' is defined as a worker engaged in sectors or services thought of as critical to the functioning of society. Granting care workers with this recognition will not only underscore their important role in sustaining societal wellbeing in times of crisis, but also elevate their status, and thereby justifying increased investment in the care workforce. Such a recognition would bolster care workers' access to improved labour and workplace protections and ensure their prioritisation within, and inclusion into, national disaster preparedness plans (ILO 2023c). Importantly, it would also establish robust and resilient care systems as a collective societal need and a priority for the country.

Unless Malaysia begins to rethink its support for care workers, future crisis will potentially result in negative impacts on the care workforce and strain our already fragile care ecosystems.

Throughout the different phases of the pandemic, countries worldwide developed and revised their own 'essential services' list, in accordance with evolving national needs (ILO 2023c). Governments' focus on the acute response to the COVID-19 pandemic and delivery of basic goods and services, however, has meant that a limited number of occupations (e.g. healthcare workers such as doctors, nurses, and paramedics) receive the recognition of being an essential worker. In the context of Malaysia, the initial classifications of 'essential services' emphasised the continued functioning of health and economic sectors and excluded social services (Parliament of Malaysia 2021; Lim 2022). For example, child care centres (TASKA) and care centres were only included and recognised as essential services during later iterations of the Movement Control Order (MCO) regulations (Government of Malaysia 2020). This created confusion for care recipients and their families over the availability of care support and services. Care workers were also uncertain about their roles and function within the context of the pandemic.

2 ILO, UN Women, OECD

This study, calls for a reevaluation of occupations considered as part of the 'essential workforce' and argues for the inclusion of under-studied categories of care workers such as social workers, child care workers, care workers for the elderly and people with disabilities, hospital cleaners, and domestic workers.

Recognition of all care workers as essential workers is an acknowledgement of the important role of care workers in times of crisis, their contributions to national resilience and thus the importance of safeguarding their well-being as workers.

2.1.4
Conceptualising Wellbeing of Care Workers

Care workers form the backbone of our care systems. As such, their wellbeing is central to discussion of a thriving and resilient care ecosystem. At the height of the pandemic, the World Health Organization (WHO) Director-General declared that "no country, hospital or clinic can keep its patients safe unless it keeps its health workers safe" (WHO 2020a). Echoing this critical statement, *this study contends that Malaysia's care ecosystem will not be able to deliver quality services and ensure the wellbeing of the nation unless the wellbeing of care workers are prioritised.*

In this research, we focus on care workers' subjective assessment of their well-being to understand how well-supported they perceive themselves to be in their personal and professional lives across three time points—pre-pandemic, during the COVID-19 pandemic crisis, and post-pandemic. Within public health research, subjective well-being is "a valid population outcome measure beyond morbidity, mortality, and economic status that tells us how people perceive their life is going from their own perspective" (Lamu and Jan Abel Olsen 2016, 177). In fact, subjective appraisals of wellbeing have become increasingly recognised as a more accurate predictor of life-changing actions (e.g., as changing jobs, leaving a partner, etc.) and are now routinely used alongside objective measures in prominent wellbeing measurement frameworks such as the OECD Better Life Index and the European Quality of Life Survey (Gammarano 2025; Kaiser and Oswald 2022).

'Wellbeing' is a multi-dimensional concept (Tov 2018). A review of existing literature reveals that wellbeing has been defined and operationalised in multiple ways, confirming that there is no universal definition of wellbeing. In this study, we align with the approach taken by the World Health Organization (WHO) in defining wellbeing as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO 2021). This definition is valuable for two reasons. First, it positions wellbeing as something positive to be pursued and not

just the absence of suffering or disease. This perspective encourages us to reflect on aspects of life that could contribute to improved wellbeing or a 'flourishing of life' (Seligman, 2011). Second, it makes clear that wellbeing extends beyond physical and mental health, to include social wellbeing, emphasising that there are many social factors that can influence overall health and wellbeing. As this study is focused on exploring how care workers navigate their paid and unpaid care work, we have chosen to view the experience of social wellbeing as being shaped by care workers' satisfaction with their work, personal life, work-life balance and social support (Greenhaus et al. 2003; Wilkinson et al. 2003). Further to this, as care work does not occur in isolation, and is often impacted by broader contextual factors, we have chosen to conceptualise wellbeing as a layered construct, shaped by key wellbeing elements and contextual factors (See Figure 2.1 for details). By adopting a multi-dimensional perspective to wellbeing, we hope to be able to explore and highlight the nuances of care workers' lived experiences.

Key Elements

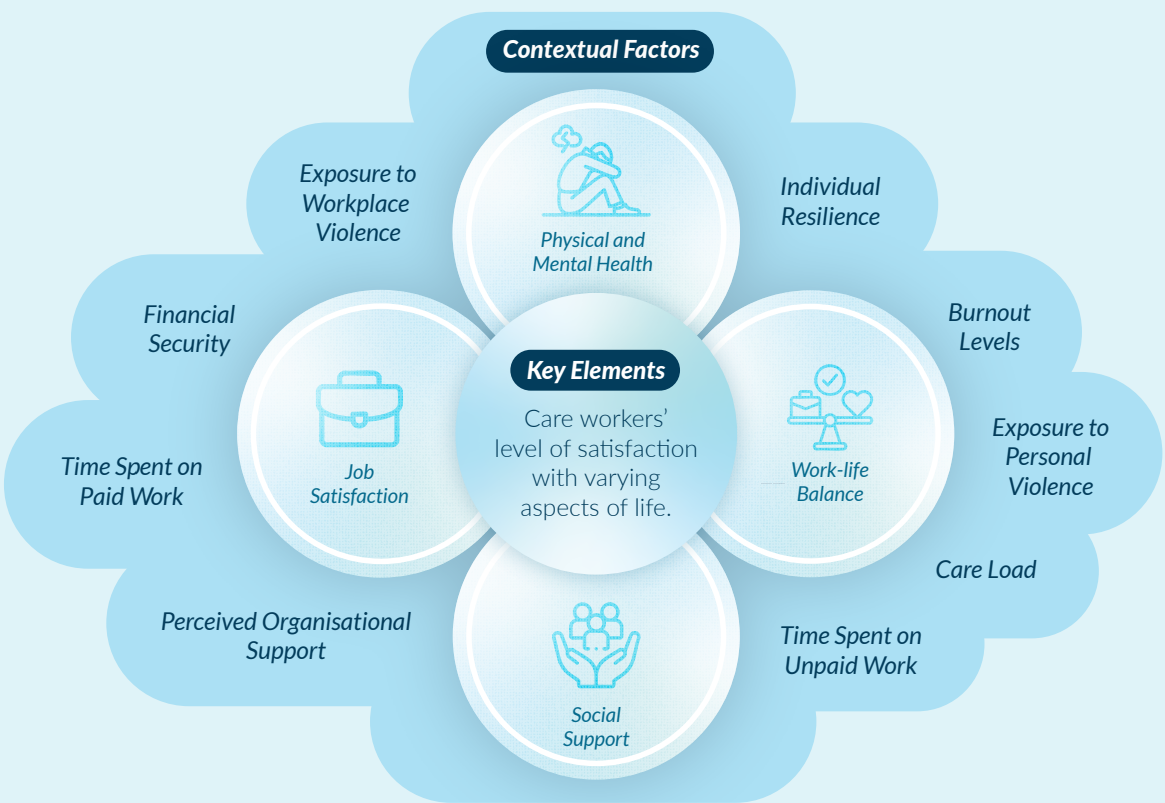
Care workers' satisfaction with their physical and mental health, job/work conditions, work-life balance, and perceived social support.

Contextual Factors

Individual resilience, burnout levels, exposure to violence in the workplace and/or the home, unpaid care loads, the interplay between paid and unpaid care work, perceived organisational resilience and support, and financial security.

FIGURE 2.1

The Subjective Wellbeing of Care Workers: Key Elements and Contextual Factors



In exploring the various intersections, this study underscores the need to consider an under-examined dimension: That of the cumulative impact of paid work and unpaid care work on wellbeing. Commonly referred to as the 'double burden', this phenomenon is particularly relevant for a workforce, predominantly composed of women. As previously mentioned, social norms require women to perform unpaid care work at home, even as they engage in paid work (Antonopoulos 2008; Duffy 2011). Similar to paid care work, unpaid care demands intense physical and emotional labour from caregivers, and when both worlds intersect, the resulting cumulative effect can profoundly affect care workers' wellbeing. Therefore, we emphasise that recognising this intersectionality and other contextual factors is critical to fully understanding the complexities of care worker wellbeing. The following boxes describe each key element and selected contextual factors in more detail.

KEY ELEMENT
Physical and Mental Health

Physical and mental health are both important aspects of wellbeing and are interrelated. Physical wellbeing refers to "the ability to maintain a healthy quality of life that allows us to get the most out of our daily activities without undue fatigue or physical stress" (National Health Services, n.d.). Mental wellbeing is defined as a "dynamic state of internal equilibrium", that includes "[empathising] with others, flexibility and ability to cope with adverse life events and function in social roles" (Galderisi et al. 2015, 231-232).

The impact of COVID-19 pandemic on the physical and mental health of healthcare workers has been well documented (Aymerich et al. 2022; Salazar de Pablo et al., 2020); however, there are fewer studies documenting impacts on social care workers. Notably, a study in the United States found higher than national estimates of Post Traumatic Syndrome Disorder (PTSD) among social workers during the pandemic, while another study found that non-healthcare essential workers were more vulnerable than healthcare workers to negative psychosocial outcomes (Garfin et al., 2022; Holmes et al, 2021).

The benefits of being physically and mentally healthy accrues in supporting interactions across domains of life. Care workers engaged in care work may be required to perform physically strenuous activities (e.g., lifting clients, standing/walking/working for long hours) and/or respond to the emotional demands of care recipients and their families. This can cause physical or mental fatigue/stress, lead to illness or disease and significantly impact care workers' wellbeing.

KEY ELEMENT
Job Satisfaction

Job satisfaction refers to satisfaction with work conditions, including aspects such as recognition, pay, job security, and opportunities for career growth. Studies show that work environment or conditions have been shown to impact not only workers job satisfaction and psychological/emotional health but also their

retention rates (Aazami et al. 2015; Wei et al. 2018; Park et al. 2018). As such, many studies have explored the relationship between work environment and workers' intention to leave, and vice versa, suggesting a strong link between job satisfaction and worker retention (Wei et al. 2018). For example, a study on the healthcare workforce in the United Kingdom, showed that income levels influences job satisfaction, and affects retention of workers. (Bimpong et al. 2020) Another study on critical nurses found that the organisational factors of having sufficient staff, and good teamwork improved nurses job satisfaction (Dilig-Ruiz et al. 2018). In essence, there are many factors that may influence job satisfaction, but importantly job satisfaction is closely linked with worker retention.

KEY ELEMENT
Social Support

Social support, broadly conceived of as a "social 'fund' from which people may draw when handling stressors" (Thoits 1995, 64), may involve the engagement of various actors within a care ecosystem, spanning from individual social networks (e.g., family, friends, community) to formal workplace support (e.g., flexible work arrangements, paternity leave) and state-level interventions (e.g., childcare subsidies). Perceived social support is often a protective factor against life stressors and can improve wellbeing (Gülaçtı 2010). All three are assessed in this study, however, in conceptualising wellbeing, we focus on care workers' satisfaction with the social support received from their personal networks in managing their unpaid care work.

The perceived presence of support in managing unpaid care work can significantly reduce care workers' stress levels. When care workers feel supported, they are able to better manage both their paid and unpaid care work, and this enhances their wellbeing. Satisfaction with this support is a likely indication that unpaid care responsibilities are being shared more equitably within the household (e.g. with spouses, mothers, daughters, sons, domestic workers) or larger community (e.g. with friends, relatives, neighbours, paid care worker/centres).

KEY ELEMENT
Work-life Balance

Work-life balance is the ability to manage both work and non-work activities in line with individual priorities (Kalliath and Brough 2008). Non-work activities may include family responsibilities or unpaid care work and other non-family related demands, such as self-care or self-development. Greenhaus et al. (2003) defines work–life balance as "the extent to which an individual is engaged in and equally satisfied with his or her work role and family role" (513). This definition focuses on aspects such as "equal time, involvement, and satisfaction across an individual's work and non-work roles" (Brough et al. 2020, 2). In line with this study's objectives, we have chosen to focus on care workers' satisfaction with how they navigate the demands of unpaid care work and self care, alongside their paid work.

Work-life balance is an important aspect of wellbeing. Studies consistently show that individuals with better work-life balance are more likely to report higher job satisfaction, improved mental health and better quality of life (Haar et al. 2014). In contrast, prolonged disruptions to work-life balance have been linked to negative mental health outcomes, resulting in increased stress and burnout (Putri et al. 2023). This study positions work-life balance as an essential part of care workers' wellbeing, as their ability to manage the competing demands of their work and non-work responsibilities can impact their overall wellbeing.

Furthermore, evidence suggests that work-life balance policies in organisations can support employees in managing the demands of their multiple roles (Brough & O'Driscoll 2010). Importantly, the provision of such policies within a workplace must be accompanied with an organisational culture that supports and encourages its use (Brough et al 2009; Waters & Bardoel 2006). In their investigation of poor utilisation of work-life balance policies by workers, Waters and Bardoel (2006) identified several key barriers which include poor communication of policies, high workloads, fear of negative career repercussions, attitudes and expectations of supervisors/managers, influence of peers, and administrative processes. Other researchers have highlighted the crucial role of supervisors/managers and co-workers in determining employee use of work-family policies (Blair-Loy and Wharton 2002; Weale et al. 2020). Scarce resources and elevated workloads are also likely to affect workers' ability to use work-family policies (Kropf 1999).

CONTEXTUAL FACTOR
Burnout

Burnout is a state of emotional, physical and mental exhaustion, typically a result of consistent and long-term exposure to stress. In this study, we focus on work-related burnout, defined by Kristensen et al. (2005, 197) as "the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work." Burnout can drastically affect an individual's wellbeing, and can manifest as emotional exhaustion, cognitive impairment (e.g., fogginess, feeling overwhelmed, anxiety), chronic fatigue, social withdrawal and can ultimately undermine job performance and satisfaction. Importantly, studies have identified that burnout is most common in occupations that have humanitarian and social contribution, suggesting that care workers are at a higher risk of experiencing burnout (Papathanasiou 2015).

CONTEXTUAL FACTOR
Exposure to Violence

In its various forms, exposure to violence, can result in serious and long-lasting physical and mental health consequences for care workers, severely impacting their wellbeing. Violence has many forms - verbal, non-verbal, physical, psychological, social, sexual - and can occur within professional or personal spheres (Chung

et al. 2021). In Malaysia, workplace violence has been documented within healthcare settings, as evidenced by recent reports of suicides within the public health sector that have illuminated the intensity of workplace bullying (Bedi 2024). Less is known about the prevalence of workplace violence towards care workers within social care settings.

While experiences of workplace violence amongst specific segments of paid care workers have received more public attention, a lesser and equally important aspect is care workers' exposure to violence within their personal lives. Care workers are commonly perceived as providers, or 'givers' of care, and as a result, the challenges they face in their personal lives receive less attention or are often neglected. As the majority of care workers are women, care workers are more vulnerable to gender-based violence. Structural barriers that perpetuate gender norms, coupled with the fear of humiliation and poor reporting mechanisms can often hinder care workers from seeking protection and accessing the support they need.

In conclusion, this section has outlined key elements that we believe fundamentally shape the wellbeing of care workers including care workers' subjective assessments of their physical and mental health, job satisfaction, social support for unpaid care responsibilities and work-life balance. Importantly, these elements are never experienced in isolation, but are interactive and must be analysed against the backdrop of social structures and contextual factors that affect care workers wellbeing, including the gendered nature of care and the predominantly female care workforce. The overlapping demands of paid care work, unpaid care work, combined with gaps in support (explored further in Section 2.2), create a unique set of pressures that disproportionately impact women care workers' well-being. In the subsequent section, we introduce a resilience capacities framework that will enable a more robust analysis of how care workers presently navigate these pressures. In doing so, we highlight the importance of addressing structural barriers to ensure that the sustainable wellbeing of the care workforce is over time.

2.1.5 *Defining Resilience*

Resilience is defined as systematic agility or resourcefulness to "anticipate, adapt and reorganise itself" and "retain control over its structure and functions" (e.g. continue delivering critical services, maintaining the wellbeing of its workers) while facing shocks or crises (Blanchet et al. 2016, 432; Ungar 2018, 1). How systems, networks or actors respond to adversity or shocks is often described through three levels of resilience capacities or strategies—absorptive, adaptive and transformative (Barasa et al. 2017; Blanchet et al. 2017; Haider and Cleaver 2023). These capacities may occur at the individual, organisational/ employer or systemic level.

While absorptive capacity refers to the capacity to absorb and bounce back from shocks in the short term, adaptive capacity refers to the ability to adapt to a range of environmental and social contingencies (Haider and Cleaver 2023). Transformative capacity is described as the highest level of change where root causes of fragility are addressed so that capacities of actors within systems are enhanced (Haider and Cleaver 2023; Jeans et al. 2016). In other words, transformative capacities refers to structural shifts (e.g., policy, institutional, infrastructural changes, social norms change) that bring about change and enable individuals or communities to respond more effectively to a changing environment (Jeans et al. 2016). See Table 2.2 for a more detailed definition of the varying resilience capacities.

TABLE 2.2

Definitions of the Types of Resilience Capacities

Absorptive capacity	The ability to absorb and bounce back from shocks in the short term; typically thought of as the ability to withstand or absorb stresses and shocks.
Adaptive capacity	The ability to learn from and adapt to "a range of environmental and social contingencies."
Transformative capacity	The ability to "shift to a substantively new system, often intentionally, and involving priorities different to the status quo, leading to changes across multiple scales."

Source: Haider and Cleaver 2023

This framework of resilience capacities helps us analyse how care workers respond individually to crises like the pandemic, and to identify points at which systems, organisations, and employers must evolve to support care workers' capacities in a more sustainable and equitable manner, while taking into consideration specific vulnerabilities arising from care workers' social identities (e.g., women, migrant workers, persons with disabilities and those with significant unpaid care work loads). Understanding the care work experience from an intersectional perspective is important, as closely examining specific vulnerabilities of particular groups, for example, single mothers, migrant domestic workers, and so forth, can lead to better outcomes for everyone.

During the COVID-19 pandemic, care workers demonstrated individual resilience in their ability to absorb and adapt to the shocks that occurred, for example, healthcare workers making their own personal protective equipment (PPE) to address a lack of supply at the beginning of the pandemic (CodeBlue 2020a), or rapidly converting other wards into COVID-19 wards to address the demand for hospital beds (Boo and Low 2022), and eldercare providers scaling their services by working longer hours to ensure they could support their clients during the pandemic (Tan 2021). This, however, often occurred at personal cost, leading to burnout, mental health issues, and increased dropout rates across sectors. In this, we argue that the task of building resilience should not rest solely on the individual shoulders of care workers.

Organisations and national systems must bear the responsibility of fostering a transformative environment and putting in place policies, processes and protections that enables care workers to absorb and adapt to shocks without sacrificing their wellbeing.

2.1.6
Wellbeing, Individual Resilience, and Organisational Resilience

To strengthen the care workforce, our focus should move towards improving both the wellbeing and resilience of care workers. Wellbeing and resilience should be viewed as elements that are mutually reinforcing. Studies have shown that the more resilient workers are, the more likely they are to have higher levels of wellbeing (Smith and Hollinger-Smith 2015). Similarly, workplace interventions focused on improving workers' wellbeing resulted in workers' improved ability to cope with stress and manage crises, thus improving both their individual resilience and organisational adaptability in the context of crises (Pacheco et al. 2020; Tonkin et al. 2020). Thus, *we posit that investing in the well-being and individual resilience of care workers will lead to more resilient organisations/institutions and national care systems.*

Individual resilience is often positioned as a stable and fixed trait. In this study, we challenge this conception and frame individual resilience as a dynamic trait that can be influenced and facilitated by an enabling environment (Luthar et al. 2000; Windle 2011; Rahim et al. 1999). The creation of such an environment should be intentional on the part of organisations and systems, as when organisational resources and support are directed to ensure the wellbeing of care workers, even individuals who struggle in times of adversity can become more resilient.

As such, we adopt the view that organisational resilience and individual resilience have a bidirectional relationship in that individual resilience can be shaped by the organisation's responsiveness to their needs; an organisation's resilience is also determined by individual resilience and wellbeing. We assert that, *on some level, organisations bear the responsibility of addressing aspects within their purview that can support individual resilience,* including supporting their employees, to an extent, with their unpaid care responsibilities.

During the COVID-19 pandemic, for instance, perceived organisational support by healthcare workers in China was reported to have reduced fear and psychological distress among them (De Kock et al. 2021). Perceived organisational resilience in this case emanated from an adequate supply of personal protective equipment, adequate training and organisational communication about COVID-19. Similarly, Wong et al. (2022) found that improved organisational management of the COVID-19 pandemic was positively associated with resilience of the health care workers. Healthcare workers who were satisfied with infection control and prevention guidelines in the workplace exhibited a high resilience level, whereas healthcare workers who were concerned over inadequate protective equipment and infecting family members tended to have lower resilience (Wong et al. 2022). Another study observed that organisational investment in the personal health of employees (physical and mental health) as well as employee capabilities (communication, resilience and work capabilities) were the most important areas of investment to improve employee resilience (Danaeefard et al. 2022).

When organisations invest in and support the wellbeing of care workers, this fosters individual resilience. In turn, care workers who have higher levels of individual resilience, contribute towards organisational resilience, thereby strengthening the resilience of our national care systems.

Investing in the wellbeing and individual resilience of care workers will lead to more resilient organisations/institutions and national care systems.

FIGURE 2.2

Relationships Between Resilience Across Individual, Organisational and Systemic Levels

Individual resilience and organisational resilience are thus key components of national care systems resilience. The ability of our national care systems to be resilient in the face of another calamity or crises, hinges on its ability to adequately prepare organisations to better support care workers. In chapter four, we showcase the interrelations between these three components through detailed explanation of our findings. In chapter 5, we expand further on how care systems can support organisational structures to foster individual resilience and wellbeing of care workers. But first, in the next section, we briefly review Malaysia's policy landscape to identify specific factors that shape care workers' wellbeing in Malaysia.

2.2

Factors Impacting Wellbeing of Care Workers

While the previous section has unpacked the theories and concepts relevant to understanding the study at hand, it is also important to examine how the context is shaped by structural and gendered inequalities.

Care work is not inherently or naturally gendered. Rather, we have culturally associated care work with feminine values. Over time, these associations become deeply ingrained gender norms that often position women as natural carers and perceive care work as women's work that requires little skill. This can lead to structural and gendered inequalities, such as the following:

1. *Perception of unpaid care work as private matter and personal responsibility,* particularly to be shouldered by women. Consequently, structural support to manage unpaid care work can be limited or inaccessible, leading women to take on a disproportionate amount of unpaid caregiving which can have impacts on their economic and overall wellbeing.

2. *Systems and societal norms that feminise and undervalue care work.* When care work is thought of as "natural" and requiring less skill, especially for women, it is treated as less valuable than other types of work. Consequently, care workers are often underpaid.

3. *Policy frameworks that overlook the important contributions of the care workforce.* Aside from being underpaid, there are asymmetries in the working conditions of care workers, as some sectors and industries have limited regulations and policies. Additionally, care workers may lack social protection and representation in decision-making.

4. *A lack of gender responsiveness and intersectional approaches into policy and planning for the care workforce.* As the care workforce is predominantly women, there are gendered elements that embody the experiences of care workers that are not adequately recognised. The lack of intersectionality in policy approaches make invisible the varying levels of vulnerabilities that care workers may face, for example arising from their age, gender, or geographic location, amongst other factors.

The following sections will zero into the policy landscape of care work in Malaysia, identifying the ways structural and gendered inequalities play a role in influencing the wellbeing of care workers.

2.2.1

Gendered Occupational Segregation

Gender-based occupational segregation in the care workforce refers to the concentration of women in care work, such as in childcare, eldercare, healthcare, social work and domestic work. These jobs are mainly held by women due to societal norms and expectations that caregiving is a "natural" feminine role, creating an environment that perceives caregiving as "women's work," reinforcing gender inequalities in this sector (Joshi et al. 2024) As care work is gendered, this, in turn, then impacts wellbeing.

In Malaysia, the feminisation of the human health and social work workforce has been particularly pronounced.

TABLE 2.3

Employed Persons in Human Health and Social Work Activities by Gender, 2012-2022

Year	Total ('000)	Male ('000)	Male (%)	Female ('000)	Female (%)
2012	414.8	94.9	22.9%	319.8	77.1%
2013	489.9	95.9	19.5%	394.4	80.5%
2014	531.1	100.2	18.8%	431.3	81.1%
2015	573.1	110.0	19.2%	463.0	80.8%
2016	570.3	115.8	20.3%	454.0	79.6%
2019	527.7	114.6	21.7%	413.1	78.3%
2020	559.6	157.9	28.2%	401.7	71.8%
2021	582.2	256.6	44.1%	325.6	55.9%
2022	599.0	226.6	37.8%	372.4	62.2%

Source: DOSM Labour Force Survey 2012-2016, 2019-2022

When examining available data, it is clear that women outnumber men in domains such as healthcare and aspects of social care, such as childcare. However, there is a lack of data for other aspects of social care, including for private sector eldercare and disability care providers.

Broadly, though, women overwhelmingly dominate caregiving roles. Cultural norms, economic conditions, and limited policies supporting diversity in caregiving roles have reinforced gendered occupational segregation.

The apparent drop in the share of women as compared to men in care related work—bottoming out at 71.8% in 2020 to 55.9% in 2021 as illustrated in Table 2.3 above—during the COVID-19 pandemic likely reflects women disproportionately exiting the workforce due to increased domestic and caregiving responsibilities (e.g., from school closures, lack of childcare), rather than a genuine shift away from the feminisation of the care sector itself.

Based on an analysis of 104 countries conducted by the WHO, approximately 70% of the global healthcare workforce is made up of women (Boniol et al. 2019).

Despite the feminised nature of the workforce, women remain significantly underrepresented in decision-making roles, as during the COVID-19 pandemic, globally, only 30% of leaders in medicine and science were women (Wenham et al. 2020). This gender disparity highlights a critical gap—though women were at the frontlines, very few women were involved in spaces where they were able to influence policies and priorities for the pandemic response (Rajan et. al. 2020). This trend was present in Malaysia, as well, as in 2021, in the midst of the pandemic, the five highest posts in the Ministry of Health, that is the Minister, the two Deputy Ministers, Secretary General, and the Director General of Health, were all held by men. Both Deputy Chief Secretaries were men and three of the six Deputy Chief Directors were men as well. These patterns of underrepresentation of women in leadership is visible throughout civil service, likely within the departments of the public sector care workforce as well. The number of female employees in the Malaysian civil service exceeded that of males (DOSM 2022); however, as of 2021, in top management positions, notably, Premier Grade C (JUSA C) and above, only 38.8% are women, a modest increase of 0.6% compared to the figure from 2020 (DOSM 2022). This reflects the status quo because the grade increase for female employees seems to be much slower compared to male employees.

Despite the feminised nature of the workforce, women remain significantly underrepresented in decision-making roles.

2.2.2 *Access to Social Protection*

Malaysia, like many countries, has implemented social protection floors. These, according to ILO (2012a), are "nationally-defined sets of basic social security guarantees, which secure protection aimed at preventing or alleviating poverty, vulnerability, and social exclusion." In principle, social protection floors should ensure that, over the life cycle, all have access to essential healthcare and basic income security.

Part of Malaysia's social protection floors include social assistance programmes. These, up until 2021, were largely considered to be ad hoc, fragmented, and short term buffers that did not aid long term financial sustainability and protection for workers in Malaysia. In short, despite efforts towards a social protection floor, as noted by KRI (2021), there are still gaps. This is, in part, due to charity-driven welfare structures, focused on targeting poverty, as opposed to longer lasting life-cycle approaches.[3] Bank Negara Malaysia (2020, 46) highlighted that the pandemic "unearthed deep structural issues surrounding the prevailing social protection framework in the country."

3 Refer to KRI 2021 for further reading.

While gender gaps in social protection remain understudied in Malaysia, there is global evidence that women are disadvantaged in social protection systems, suggesting a lack of a gender-responsive approach to these types of policies.[4]

As the study at hand focuses on care workers, it is necessary to examine current social protection measures in place to support care workers and the management of unpaid care work. Care workers, however, typically lack specific social protection measures, and are instead covered by broader measures. A review of these measures reveal that care workers are not adequately supported for retirement, unemployment, family care, and other areas.

Paid care workers, who are often precariously employed and underpaid, are vulnerable to shocks which may impact long-term stability and wellbeing. As social protection functions to mitigate risks and shocks, a life cycle approach is necessary to the wellbeing of care workers to bridge critical life stages, considering the potential impact of parenthood, crises (such as the pandemic), and retirement, amongst others. Malaysia also does not have a universal social protection structure that would protect migrant domestic workers and other vulnerable workers in the country (ILO 2021). Current social protection provisions are largely for employees in the formal sector.

Diagram 2.1 highlights current available social protections, particularly focusing on how they support care workers and the management of unpaid care work.

BOX 2.1

Available Social Protection for Care

Health protection and sickness benefits

There are no policies that make health insurance compulsory or legally mandatory for Malaysian employers except for those required for documented migrant workers (SKHPPA) including domestic workers. Malaysians, however, do receive tax incentives to purchase private medical insurance.

However, Malaysian citizens are entitled to low-cost government medical coverage at public hospitals, as Malaysia has a nearly universal healthcare system with highly subsidised fees. Foreigners, such as foreign domestic workers, will need to pay additional fees and do not qualify for these subsidised rates (Loganathan et al., 2019).

As of 2011, all foreign workers are required to be insured under the Foreign Workers Hospitalisation and Surgical (SKHPPA) insurance scheme (MOH 2011). For an annual premium of RM120, the policy will cover them annually for RM20,000 (Loganathan 2020). The SKHPPA is sold by 25 private insurers and is paid for by employers (Loganathan 2020).

Despite how medical coverage is mandated by the Malaysian government for foreign workers, some domestic workers may lack access to healthcare because the extent of their coverage can vary depending on their employers.

4 See ITUC 2018.

Old age income security (pensions)

Cash aid through the Bantuan Warga Emas scheme of RM600 per month is available to those above 60 (JKM 2024). These are means tested (JKM n.d.).

Prior to January 2024, civil servants were offered a pension scheme from the government which provided, in addition to a percentage of the last drawn monthly salary dependent on years of service, lifetime medical coverage for themselves and eligible dependents (Kumpulan Wang Persaraan, KWAP, 2024). Additionally, derivative pensions can be claimed by the spouse or children below the age of 21 after the pensioner's death or children.

In January 2024, it was announced that new employees would not be entitled to the pension scheme and, instead, the government would contribute to the Employees' Provident Fund (EPF) and the Social Security Organisation (SOCSO) on their behalf (The Edge 2024).

Private sector employees are expected to contribute to EPF. Employers are required to provide statutory contributions. Self-employed can voluntarily contribute.

The government has introduced various small incentives to promote EPF contributions for family caregivers—for example the i-Saraan and i-Sayang programmes, as well as income tax incentives for voluntary contributions.

A separate Private Retirement Schemes (PRS) programme, which both Malaysians and foreigners are eligible for, was created in 2012 to further promote private retirement savings (LHDN 2021). The government offers small financial incentives to contribute (Ministry of Finance 2024).

Recently, it was announced that employers of migrant workers must also contribute, but the contribution rate was set at a low 2% (The Edge 2025). Employers of migrant domestic workers are allowed to contribute.

Employment injury benefits

Malaysia has two social security schemes, the Employment Injury Scheme that covers occupational diseases and accidents, and the Invalidity Scheme that provides 24 hours coverage against invalidity and death, administered by SOCSO (Talenox 2023).

These are not extended to informal or unpaid workers, with the exception of the Housewives Social Security Scheme that minimally covers any woman, single or unmarried, that undertakes care responsibilities at home (PERKESO 2023).

Unemployment protection

Under SOCSO, the Employment Insurance System (EIS) was established recently in 2018. EIS provides temporary financial aid and other assistance to eligible private sector employees who lose their jobs, with compensation typically starting at 80% of their assumed monthly wage in the first month and decreasing over a maximum of six months.

For care workers, their coverage under EIS largely depends on their employment status and sector. This potentially creates precarity, further explored later on in this chapter, for certain categories of care workers, including foreign domestic workers. Government care workers (such as nurses, childcare workers, or eldercare workers employed by public institutions) are not covered under EIS. Contract workers may be covered during their contract term, but the expiry of their fixed-term contract is typically not considered a loss of employment eligible for EIS benefits.

Family and child benefits

The government runs several early childhood care initiatives, through departments like KEMAS, JKM, and others–where fees are highly subsidised. Some states have initiatives, most notably Terengganu, which runs centres through the Yayasan Pembangunan Keluarga Terengganu (YPKY). Nonetheless, overall enrolment rates (of children 6 and below in early childhood care and education) are low nationwide.

Malaysia provides Bantuan Kanak-Kanak (BKK), means-tested monthly support for families earning below RM3,000 per month, with the total aid not exceeding RM1,000 per year.

Childcare exists at worksites, though there is likely a mismatch between supply and demand.

As of January 2020, 241 childcare centres have been set up in government offices (Bernama, 2020).

In 2015, only 11% of Malaysian public listed companies provided childcare facilities, while almost half had no plans to implement or improve their family-friendly facilities (TalentCorp and PwC, 2015).

- Typically, private sector cite cost, health, and safety as primary constraints for opening onsite childcare centres (Bunyan, 2018).

Under Budget 2026, the RM3,000 tax relief for childcare (for children ages 6 and under) has been expanded to registered day care or transit centres for children aged up to 12 (Ministry of Finance 2025).

Maternity and paternity benefits

Maternity leave in the private sector is 98 days, regardless of length of employment. Maternity leave in the public sector is slightly lower, at up to 90 days.

Paternity leave in the private sector is seven days, so long as a father has been employed for the past year (Wong and Partners 2022). Paternity leave is also 7 days for public sector employees. These leaves apply to Peninsular Malaysia, as well as to Sabah and Sarawak.

Disability benefits

Cash transfer support exists for those who provide care to family members with a disability, but is means-tested (JKM n.d.).

The government issues OKU cards–registration cards for persons with disabilities–giving holders access to some services and benefits. Some tax incentives are also provided to persons with disabilities.

Disability resulting from work is covered by SOCSO schemes, as described above.

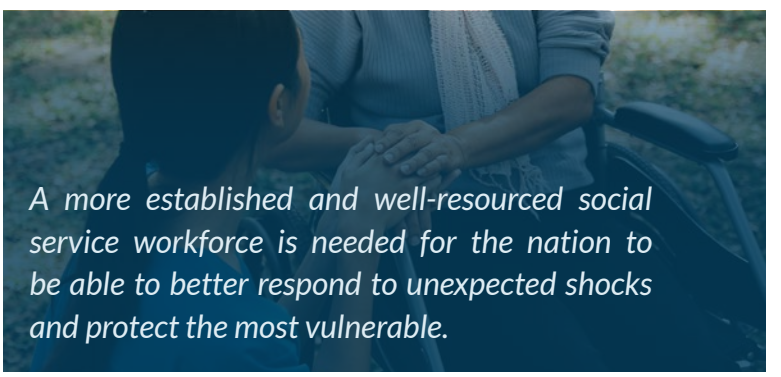
Notes: Thematic areas are adapted from ILO (2012b). List may be non-exhaustive.

While Box 2.1 details social protection available in Malaysia, as they are applicable to care workers included within this study, we must also acknowledge that the care workers themselves are also part of the delivery system of some of these social protection measures.

The COVID-19 crisis and the government's response to the shocks of the pandemic have exposed both the strengths and weaknesses of Malaysia's social protection system. Increased social protection expenditure during the pandemic has important implications for the role and mandates of social workers and the wider social service workforce in social protection.

Malaysia introduced ad hoc social protection measures and strengthened existing measures during the pandemic. The workforce, though, was not expanded accordingly with the increased expenditure. These measures were delivered mainly through existing channels, and this extended coverage stretched the capacities of the social service workforce, especially at the local level, as they continued ensuring the social protection responses reached the most vulnerable, for example, in the form of food baskets (food security) in addition to doing their primary job tasks.

The social service workforce played an important role in supporting access to additional COVID-19 social protection measures during the pandemic. Despite this, there were still gaps in service delivery. For example, there was recognition that many target beneficiaries did not have access to digital methods, especially in remote areas or for those who have no e-access due to poverty, disability, age or gender divides (ASEAN 2023a). Simultaneously, the White Flag campaign, a grassroots movement emerging as a response to slow aid delivery systems, signalled frustrations with bureaucracy beyond digital divides (Rodzi 2021).



A Mampu report highlighted how Malaysia had a social worker to population ratio of 1: 8,576 (Bernama 2019). However, more recent estimates of the social worker workforce are lacking. These issues raise the importance of increasing the numbers of social workers and the wider social service workforce, whose workload increased during the pandemic. A more established, well-resourced social service workforce is better able to respond to unexpected shocks and protect the most vulnerable (ASEAN 2023b), which will contribute towards the country's preparedness for future crises.

2.2.3
Poor and/or Unfair Wages

To situate our discussion of poor and/or unfair wages, we review some relevant context. Income in itself is a well recognised determinant of health that intersects with other determinants and can affect wellbeing along different pathways (WHO 2008). For men, education, occupation, and income are generally co-determined, such that higher education tends to lead to higher job status and better income; however, this relationship does not always hold for women, migrants, and members of minoritised communities. Importantly, mismatch between education and occupation can result in chronic stress that has an impact on overall health and wellbeing and has been linked with specific conditions including hypertension and Type 2 diabetes (Haan 2008; Spitzer 2011). Furthermore, downward mobility, wherein one's socioeconomic status declines over time, has also been shown to have deleterious health effects (Krieger et al. 2001).

In Malaysia, there is evidence suggesting a stagnation in income irrespective of education. Tertiary education holders are now 33% of the labour market, but almost 90% of diploma graduates and half of degree graduates reported wages of RM2,000 or less in 2021 (Lee 2023). According to the Government of Malaysia's salary and wage survey (2023); however, the mean monthly salary for workers with tertiary education was RM4,703, compared to those with secondary education (RM2,536), primary education (RM2,026), and no formal education (RM1,810). In the first quarter of 2024, median monthly wages for women workers was RM2,800 compared to RM2,900 for men. Mean monthly salaries for men in 2023 were RM3,532 as compared to RM3311 for women workers (Government of Malaysia, 2023).

Salaries are hierarchically linked to skill level; average monthly salaries for skilled workers was RM4,878 more than twice that of semi-skilled workers who earned on average RM2,475, and RM1,982 for low-skilled workers. Foreign workers earn on average RM1,834 per month as compared to Malaysian citizens who garner an average of RM3,441. Monthly salaries for workers engaged in human health and social work in 2023 averaged RM4,654. Despite this, however, starting salaries for doctors and nurses in the public sector can be as low as RM2,947 (Chee 2024) and RM1,797 (Pillai 2024) respectively. Falling within the same range, public sector social workers can anticipate making around RM2,250 when starting (Suruhanjaya Perkhidmatan Awam 2016). For these roles, however, there exists wage progression schemes.

There is limited data available on the salaries of those working in social care professions, such as those who provide care for children, the elderly, and PWD. Aggregate salary websites like Indeed suggest the average base salary for caregivers is approximately RM2,611 per month (Indeed 2025a), while for childcare providers, they quote a figure of RM2,174 (Indeed 2025b). For those outside the public sector, it is unclear whether there exists wage progression with cumulative years of experience.

Migrant domestic workers, on the other hand, are not only poorly remunerated for numbers of hours worked that exceed the standard workweek, they are also often indebted for their migratory journey and repayment of levies and loans erode their financial status (ASEAN 2024; ILO 2023b). A study of returned migrant domestic workers noted that more than half had the same or fewer savings compared to what they held pre-migration (ASEAN 2024).

Whilst demands from hospital cleaners for a minimum monthly salary of RM2,000 and standard wage increases have yet to be met, the contracting out of these services has meant that workers lose their seniority and fail to be remunerated for their years of experience as their employment status begins anew with each contract and subcontract (NUWHSAS 2025).

2.2.4
Precarity

Uncertainty, instability, and the absence of or limited social benefits and economic protection are problematic characteristics of precarious employment that fosters “a condition of perennial insecurity” (Barbier 2004; Millar 2017). Precarious work is prevalent amongst marginalised and vulnerable populations (e.g., the poor, women, migrant workers, elderly people, and minority ethnic groups) (Shin et al. 2023). In the Global South, precarious employment is predominantly observed in the informal economy (Breman and van der Linder 2014; Hammer and Ness 2021; Zhang 2021). However, the Malaysian case illustrates a relatively broadened definition of precarious employment, regardless of industry.

When Mahathir Mohammad was prime minister in the 1980s, Malaysia intensified its economic liberalisation, rationalised by a necessity to reduce government expenditures (Liu 2023; Fong-Woon, et al. 2018; Nambiar 2009). Privatisation, outsourcing, and contract hiring were emphasised, marking the transition towards a more market-oriented approach (Fong-Woon et al. 2018; Jomo 2014). Consequently, Malaysia’s labour force has become increasingly precarious, affecting the country’s care system, and the well-being of care workers.

Privatisation and casualisation of workers led to the creation of precarious employment with the ‘contract system’ and subcontract system where outsourcing certain tasks became the norm - which eliminated most employment benefits and job security. Under Malaysian law, the contract system is divided into contract of service and contract for labour (service).

This issue is prevalent across the care ecosystem– stretching from healthcare to social care to domestic care. The table below highlights the specific issues per sector.

BOX 2.2

Issues of Precarity Across the Three Care Sectors

SECTOR

Healthcare

ISSUES

Contract employment within the public healthcare sector was introduced as a means to manage government expenditure and the overproduction of medical graduates (MOH 2023).

However, discrepancies in benefits and opportunities between permanent and contract healthcare workers have emerged, resulting in precarity through undermined job security, wage structure, and career progression (Jinah et al., 2023). In the case of doctors, this precludes them from time-based increments (automatic salary increases), government scholarships for specialisation, and eligibility for government loans.

Meanwhile, in the case of hospital cleaners, opportunities for wage increments are nearly nonexistent, despite their tenure and accumulated expertise, resulting from the "contract for service" terms through which they are hired. "Contract for service" involves a hierarchical subcontracting system with multiple tiers of exploitation and complications in establishing a clear employer-employee relationship, allowing the principal employer to distance themselves from accountability. Each time a new employer is contracted, these workers are absorbed as new workers, disallowing them from retaining accumulated benefits such as annual leave, bonus or medical allowances. Thus, their employment is restarted from a state of blank slate (Devi 2021; Yap 2020).

SECTOR

Social Care

ISSUES

In Malaysia, social work is a skilled and complex profession, yet it remains legally unregulated and unrecognised, as highlighted in the first chapter on the issues surrounding the Social Work Profession Bill. This lack of recognition contributes to the severe shortage of social workers in Malaysia; as noted by former Deputy Prime Minister KPKWM in 2019, there is only one social worker for every 8,576 people (Mampu 2019).

On the other hand, in the case of residential or institutional care, care workers for children, the elderly, and people with disabilities (PWD) still do not have cohesive guidelines for qualifications (Asalal and Wahab 2024; Hua Teoh and Fuziah 2017). This creates disparate provision of services by the market. Here too there is a shortage of caregivers compared to the demand for these services.

Additionally, excessive bureaucratic obstacles in establishing and operating care centres contribute to the rise of private informal centres. Employees/caregivers attached to these informal centres are exposed to precarity. In times of crisis, such as the COVID-19 pandemic, unlicensed centres were ineligible to receive socio-economic aid like wage subsidies to alleviate their financial burden. In effect, the workers risk retrenchment, wage deduction, or unpaid salary.

Further, social care is supported by an extensive network of volunteer programmes, which cater to a variety of care recipients, including the elderly, PWDs, and children. The sustainability of this volunteer-based structure is questionable due to its precarious nature, driven by an allowance payment model instead of wages and insecure contract hiring instead of permanent employment (Jabatan Kebajikan Masyarakat 2023).

SECTOR

Domestic Care

ISSUES

In Malaysia, care work, particularly within private and domestic settings, is dependent on migrant domestic workers (MDWs). Factors such as low wages and long working hours make domestic workspaces increasingly unattractive to Malaysian workers. Consequently, this gap is filled by MDWs from Indonesia, the Philippines, Cambodia, and Nepal (Viajar 2017). However, MDWs are in a precarious position because of their exclusion from certain domestic labour laws as well as the government's reluctance to ratify the ILO Convention on Domestic Workers (C189).

Recently, improvements have been made in social security and welfare for MDWs, including their inclusion in SOCSO provisions as well as the Employment Provident Fund (EPF). Although registration and contributions to SOCSO are mandatory, the implementation of the two percent EPF deduction remains vague in implementation for MDWs and adds to the growing number of challenges. Additionally, the Minimum Wage Order omits MDWs, leaving them reliant on non-binding intergovernmental MOUs for wage thresholds (Labour Law Reform Coalition 2022). Contract breaches and violations, passport confiscation, restrictive work permits, overworking (without one day off), and mobility restrictions persist (Association of Nationalist Overseas Filipino Workers in Malaysia, Indonesian Migrant Domestic Workers Association, International Domestic Workers Federation, Project Liber8 and Ratio:Cause 2024; Low and Tarissa 2023). Furthermore, the private nature of domestic work blurs work-life boundaries, which has been linked to excessive working hours, isolation, and unfair salary deductions (Low and Tarissa 2023).

2.2.5.
Vulnerability to Violence and Harassment

Existing academic and policy literature have estimated the scale of some forms of violence and harassment in Malaysia. Estimates of the prevalence rate for intimate partner violence against women ranges between 5% and 36% (Shahar et al. 2020). A study by Women's Aid Organisation and Vase.ai (2020) estimate that 39% of women have experienced stalking which caused them fear. A YouGov (2019) survey estimates that 36% of women have experienced sexual harassment. These more general figures, which are fairly high, give us a starting point (and perhaps a benchmark) to assess violence and harassment faced by care workers specifically.

When examining care workers—that is, healthcare workers, social care workers, and domestic care workers—where evidence exists, it shows a large problem, even perhaps suggesting that care workers face higher amounts of violence and harassment compared to the broader Malaysian society.

Box 2.6 summarises sector specific incidences of violence and harassment, as well as sector-specific policies.

In addition to these sector-specific policies, there are also broad policies (that apply to the broader population, including care workers).

At the broadest level, there are national policies on violence and harassment, which cover all persons. This includes the Domestic Violence Act 1994, the Anti-Sexual Harassment Act 2021, and anti-stalking provisions in the Penal Code and Criminal Procedure Code–which cover those specific (often gender-based) forms of violence and harassment. This also includes various provisions in the Penal Code, the Communications and Multimedia Act 1998, and other laws–that criminalise general types of violence and harassment. These policies provide anyone–including care workers–with some protection and redress if faced with harassment or violence (whether experienced as part of their care work, or in their private lives).

Care workers face higher amounts of violence and harssment compared to the broader Malaysian society.

Next, there are public policies on violence and harassment, which are specific to the workplace. Workplace sexual harassment is covered, for the private sector workers, in the Employment Act 1955, the Sabah Labour Ordinance, and Sarawak Labour Ordinance. For public sector workers, sexual harassment is covered in the Public Officers (Conduct and Discipline) Regulations 1993. Additionally, the Occupational Safety and Health Act 1994 (which applies to both private and public sectors) covers health, safety, and wellbeing generally—though without specifying harassment or violence specifically.

Related to this act is the Guidance for the Prevention of Stress and Violence at the Workplace 200—a non-binding guideline to address workplace abuse, harassment, bullying, and other issues. These policies provide care workers the same redress as for workers more generally.

TABLE 2.6

Existing Reports of Violence and Harassment and Existing Policies Available by Care Sector

SECTOR

Healthcare

REPORTS OF VIOLENCE AND HARASSMENT

Various forms of data exist. Firstly, looking at government data (reported cases), CodeBlue (2023) reports that workplace violence against Ministry of Health Staff were recorded as 167 cases in 2017, 494 cases in 2019, 321 cases in 2020, and 260 cases in 2021. However, these figures only capture reported cases, and appear quite low.

Next, there are studies on violence and harassment faced by healthcare workers. These studies suggest that violence and harassment faced by healthcare workers—of various professions, in various geographic locations, and in various types of facilities—are high.

Across the studies workplace violence (WPV)—which includes actions like verbal abuse, bullying, sexual harassment, physical violence, and other acts—prevalence ranged from 38% (Sahiran et al., 2021)[7] to 98% (Jetly et al. 2023).[8] Verbal abuse was the most common form of WPV across the studies. Some evidence suggests nurses (compared to say, doctors) and women face higher rates of WPV (Jetly et al. 2023; Rajakrishnan et al. 2022[9]). Studies were conducted in various locations and types of facilities.[10]

There are also anecdotes and specific cases that have been highlighted in the media and other platforms—for example Pillai (2023).

EXISTING POLICIES

The Ministry of Health has produced the Guidelines on Preventing and Dealing with Violence Against Members at the Facilities of the Ministry of Health Malaysia (2016)—which was updated in 2023.

These guidelines are meant to help prevent and respond to verbal or physical abuse committed by patients or the public against staff in public hospitals, clinics, and other facilities. Private sector facilities potentially have their own guidelines.

6 Sahiran (2021) surveyed 231 healthcare workers including "doctors, nurses, medical assistants, ambulance drivers, health attendants and administrative/clerical workers" in emergency departments in three public hospitals in Melaka, finding the prevalence of WPV was 38%—of which 88.9% were psychological violence experiences.
7 Jetly et al. (2023) surveyed 316 doctors in 14 Malaysian state-tertiary government emergency departments finding a "majority (98.7%) experienced some kind of bullying" including "98.1% who faced verbal abuse", and that women "had 2.69 times the odds to be mentally abused" and "5.50 times the odds to be sexually abused" compared to men.
8 Rajakrishnan et al. (2022) surveyed 838 primary healthcare workers from the nine district health offices in Selangor, finding the prevalence of WPV to be 68.5%—including verbal abuse (65%), bullying (27%), physical violence (6%), and sexual harassment (2%)—and that "nurses (29.7%) were the most affected by WPV".
9 Other studies include for example: Zainal (2018), which surveyed 136 doctors and nurses in a public hospital in Kuala Lumpur, finding that WPV to be 71.3%—including verbal abuse (70.6%), bullying/mobbing (29.4%), physical violence (11.0%), and sexual harassment (6.6%); and Ismail et al. (2022) surveyed 393 nurses in a Penang Hospital, finding the prevalence of workplace violence to be 43.9%—including verbal abuse (82.2% of the 43.9%), psychological violence (8.9%), physical violence (8.3%), and sexual violence (0.6%).

SECTOR

Social Care

REPORTS OF VIOLENCE AND HARASSMENT

There seems to be little to no studies or reports on violence or harassment faced by social care workers in Malaysia specifically.

Existing studies tend to focus on issues like quality of services, accessibility, qualifications, regulations, and other industry-level issues. The perspective and challenges of workers is less of a focus.

EXISTING POLICIES

There do not appear to be policies relating to violence and harassment against social care workers specifically.

SECTOR

Domestic Care

REPORTS OF VIOLENCE AND HARASSMENT

There are few studies that give us a broad picture of violence and harassment faced by domestic care workers.

There is however, ample evidence on instances and the nature of violence and harassment against domestic care workers.

Policy reports documenting various forms of violence and harassment include:

1. An AMMPO report surveyed 108 migrant domestic workers in Malaysia, finding that "Sixteen migrant domestic workers (15%) were subject to physical violence, threats and/or verbal abuse by their employer because they asked for a rest day" (AMMPO et al. 2024, 4)
2. An ILO (2023b) report surveying 400 migrant women domestic workers in Malaysia found that 29% were in conditions meeting the ILO's statistical definition of forced labour. A lower share of domestic workers said they experienced more explicit forms of violence or harassment—like sexual abuse, harassment, and threats of violence—but the relatively high 29% figure suggests high vulnerability.

EXISTING POLICIES

The Ministry of Human Resources has produced the Guidelines and Tips for Employers of Foreign Domestic Helpers (2017). There have been moves to produce specific regulations for domestic workers, though no concrete policies have been finalised.

It is also worth noting that domestic violence involving domestic workers and their employers are not covered by the Domestic Violence Act (though domestic workers would be covered by the Act if they experience domestic violence by a spouse or their own family members) though domestic workers now are covered by workplace sexual harassment provisions in the Employment Act following a legal amendment in 2022.

Another form of policy relating specifically to domestic workers are agreements between the Malaysian government and domestic workers' country of origin. The memorandum of understanding between Malaysia and Indonesia (2022) states that domestic workers can terminate their contract in the event of misconduct by the employer—including physical or verbal abuse or mistreatment—and that the employer would bear repatriation cost. The 2011 memorandum between Malaysia and the Philippines has similar provisions though (based on a standard contract template produced by the Philippines government) cost of repatriation may be borne by the domestic worker herself (source).

Broadly, it appears that there is much left to be done that can improve the support provided to care workers facing violence and harassment–in particular for health and domestic care workers. For social care workers, we additionally need to better understand the specific challenges faced.

2.2.6
Representation of Care Workers

Often grounded in human rights discourse, labour movements and their variations have been significantly instrumental in advocating for workers' social and economic rights and interests (Elias, 2008). Unions are able to collectively negotiate salaries, better working conditions, and provide a venue for raising workplace complaints and concerns without fear of reprisal (Goh et al. 2023; ILO 2002).

In support of these efforts, the International Labour Organization (ILO) has established two Conventions that are directly related to unionising and organising—the Freedom of Association and Protection of the Right to Organise Convention No. 87, adopted in 1948 and entered into force in 1950, and the Right to Organise and Collective Bargaining Convention No. 98, that was introduced in 1949 and implemented in 1951. Although Malaysia remains a non-signatory to these Conventions, with impetus from the labour provisions of the Trans-Pacific Partnership and the UN's Sustainable Development Goals, in 2019 the Malaysian government, the Malaysian Employers' Federation, and the Malaysian Trades Union Congress (MTUC), signed a Memorandum of Understanding to effect, with support of the ILO, a Decent Work Country Program (Lee 2023; Lee and Zhang 2023). Notably, workers in countries with robust

and organised labour forces benefit from improved working conditions and employment benefits, better wages, and greater workplace gender equality, which align with Malaysia's aspirations for a well-remunerated, socially protected, and productive workforce and generative economy (Lee and Zhang 2023).

Emerging 100 years ago, Malaysia's organised labour movement was also engaged in the struggle for independence (Goh et al. 2023); over the past four decades, rates of unionisation have declined. As of 2022, less than 6% of Malaysia's total workforce were members of one of 767 registered trade unions, including an estimated 3% of private sector Malaysian workers and 1% of migrant workers (Goh et al. 2023; Lee 2023). Only 0.4% of the Malaysian workforce have access to collective bargaining (the world's lowest rate) compared to the global average of 34% (Cheng 2023). To wit, most public sector unions serve primarily as advocates rather than engage in contract negotiations (Lee 2023; Lee and Zhang 2023). As a result, the ecosystem for representation of the needs of care workers is weakened.

As evidenced by low membership rates and weak state of collective bargaining, unionisation in Malaysia remains fraught. Women workers in particular are less likely to be union members and are more often the focus of efforts by employers to convince them that human resource departments and not unions are the appropriate sites to lodge complaints (Ariffin 2004). Furthermore, amendments to labour laws are not uniformly implemented across East and peninsular Malaysia (MTUC Database 2024).

In the case of hospital cleaners, the subcontracting system indirectly discourages unionisation efforts since employers can arbitrarily decline contract renewal of those involved or associated with the union. Union busting, however, is a violation of the Industrial Relations Act (1967). Consequently, hospital cleaners hesitate to organise and participate in union activities, for fear of threat to employment and livelihood.

Migrant domestic workers are, on the other hand, exceedingly difficult to unionise given their long work hours, high rates of turnover, and local laws that prohibit their involvement in unions or leadership positions (ILO 2021; Tayah 2016). There are, however, migrant advocacy organisations, for example, the Asosasyon ng mga Makabayang Manggagawang Pilipino Overseas (AMMPO) and the Persatuan Pekerja Rumah Tangga Indonesia Migran (PERTIMIG), who are affiliates of the International Domestic Workers' Federation (IDWF). These organisations have have collaborated with local trade unions and civil society organisations to successfully ensure that migrant domestic workers have access to partial social security benefits (UN Network on Migration 2024). However, membership and organisation remains focused on the Klang Valley, limited also only to those who are able to receive one day off per week by their employers.

Representation for care workers leads to improved working conditions, enhanced employment benefits, higher wages, and greater workplace gender equality.

TABLE 2.7

Current List of Unions and Associations of Care Workers

Healthcare

Care Sector	Union / Association	Locality (Regional / National)
Doctor	Malaysian Medical Association	National
	Hartal Doktor Kontrak	National
Nurses	Malayan Nurses Union (Peninsular)	Regional but with branches in Sabah and Sarawak
	Sabah Nurses Association	Sabah-based
	Sarawak Nurses Association	Sarawak-based
	Sabah Medical Services Union	Sabah-based
Hospital Support and Allied Services	National Union of Workers in Hospital Support and Allied Services (NUWHSAS)	Peninsular

Social Care

Care Sector	Union / Association	Locality (Regional / National)
Childcare (Private)	Persatuan Pengasuh Berdaftar Malaysia (PPBM)	National
Eldercare (Private)	AGECOPE	National

Domestic Care

Care Sector	Union / Association	Locality (Regional / National)
Domestic Workers	Indonesian Migrant Domestic Workers Association (PERTIMIG)	Regional
	Association of Nationalist Overseas Filipino Workers in Malaysia (AMMPO)	Regional

Public & Civil Services (Related)

Care Sector	Union / Association	Locality (Regional / National)
Civil Services	Congress of Unions of Employees in the Public and Civil Services (CUEPACS)	National

Private Sector (Related)

Care Sector	Union / Association	Locality (Regional / National)
Private	Malaysian Trade Union Congress (MTUC)	National
	Union Network International-Malaysia Labour Centre (UNI-MLC)	National

Note: Table is not exhaustive.

In the previous section, we detailed aspects of subjective wellbeing, which includes work-life balance, job satisfaction, social support, and physical and mental health. As such, we assert that securing the wellbeing of care workers necessitates addressing issues which may directly impact their wellbeing, such as the ones covered here. While there are measures addressing certain issues faced by care workers, there are still gaps which must be reconciled as many policies lack gender-responsive approaches. Policies and legislation which secure the rights and protect care workers, extending recognition and value to the work, can, thus, enhance care worker wellbeing.

2.3

Key Policy Gaps

In outlining the issues, eight key policy gaps emerge, highly relevant to the wellbeing of care workers. We briefly explore these gaps here, which we will further investigate in the following chapters.

1

Lack of adequate compensation and recognition, leading to the undervaluation of care work

The care sector in Malaysia is largely undervalued, with care work often seen as an extension of unpaid domestic labour traditionally performed by women. This perception results in lower wages and limited benefits for care workers. Current policies lack provisions to standardise fair pay and benefits for care roles, perpetuating the view that care work is "secondary" labour that does not warrant the same remuneration as other sectors. Since these roles are seen as "women's work," they tend to be compensated less than male-dominated professions, even when they require similar skill levels. This is driven by societal beliefs that caregiving aligns with women's "natural" nurturing qualities, which can limit male participation and perpetuate gender stereotypes in the workforce. This reinforces gendered economic inequalities.

Consequently, those in caregiving roles often have minimal benefits and a lack of opportunities for career advancement and growth, leading to poor job security.

2

Lack of professional development opportunities and inadequate career progression pathways

The care workforce often have limited access to training and career advancement opportunities. This affects their ability to progress within the sector or to transition to other, higher-paying fields. As care sectors are often feminised, women bear the brunt of this inequality, facing difficulties moving to higher positions, reflected in how spaces such as the medical faculty, or even the boards of early childhood care and education, often have a lack of female leadership. This contributes to economic insecurity and restricts overall workforce mobility.

The lack of formal structures for career advancement is underpinned by structures which fail to support and standardise training, certification, and professional growth, leading to "dead-end" roles. Without clear career pathways, workers—primarily women—often remain in lower-wage positions without opportunities to progress to higher-paying roles. Consequently, there are high turnover rates within the paid care sectors, constricting the growth of the care workforce.

3

High emotional and physical demands and insufficient family-friendly policies

Care work is emotionally and physically demanding, with high levels of stress and burnout. The societal expectation that women should handle this "labour of love" without complaint makes it challenging to advocate for better working conditions and support. Further complicating this issue is Malaysia's limited family-friendly policies, which could help balance caregiving responsibilities between genders and enable women to remain in the workforce. For example, childcare and eldercare services are often costly and lack government subsidies, placing a disproportionate burden on women to take on informal caregiving roles. Although parental leave exists, it is primarily focused on maternity leave, with minimal paternity leave provisions. This imbalance reinforces gender stereotypes by framing caregiving as a female responsibility.

4

Limited male representation and male inclusion initiatives

The low number of men in caregiving roles restricts the diversity and inclusivity of care teams. This can reinforce stereotypes that caregiving is solely "women's work" and may discourage men from entering the field, even if they have an interest in it. Men are significantly underrepresented in Malaysia's caregiving roles, partly due to the gendered nature of care work and partly due to cultural beliefs that these roles are less "appropriate" for men. The exception to this, of course, is within leadership, as men who enter the care workforce may be promoted at higher rates, compared to their female counterparts. Nonetheless, men are needed within the care workforce because of the growing demand, as in certain settings, male carers may be preferred over female carers. The issue of a lack of male carers is compounded by the absence of policies or initiatives aimed at encouraging men to enter care-related fields. Men, thus, are not incentivised to consider caregiving roles as viable career options.

Inadequate care provision

5

Gendered occupational segregation can lead to broader social issues, such as a shortage of trained workers, which can compound and lead to inadequate care provision, as the demand for care increases in tandem with Malaysia's life expectancy and growing ageing population. While Malaysia has made strides in improving labour protections, policies specifically targeting the care workforce and gender segregation within it are limited. The lack of a robust support system to elevate the care workforce, combined with insufficient public or government-funded care services, places additional pressure on women to fill these roles, often informally and without adequate support. This will contribute to increased difficulty in retaining care workers..

Malaysia has a limited network of public childcare and eldercare facilities, which are essential for supporting people in the workforce, especially women. Without access to affordable care facilities, women are often required to reduce their working hours or exit the workforce to manage caregiving responsibilities. Additionally, Malaysia's community-based care, which may be a viable alternative to institutional care, remains underdeveloped. More government support in this area could help alleviate the burden on women and reduce the gender gap in caregiving roles.

Women's representation in leadership roles within care sectors remains limited

6

Traditional gender roles often cast men as primary breadwinners and position women as family nurturers. Despite some progress, these gender biases persist, often steering men toward higher-paying, managerial roles and women toward caregiving roles, regardless of qualifications or experience. The care sector in Malaysia is still defined by these traditional values, which can further discourage men from entering caregiving professions. The presence of fewer female mentors and role models in senior positions within care-related fields also limits women's professional growth and restricts networks critical for career advancement. In the Malaysian workplace, women generally face limited opportunities for career growth, where they are less likely to be promoted compared to their male counterparts (Moorthy et al 2022). Gregor and O'Brien (2016) stated that women remain underrepresented in management positions,

even in fields which have been historically dominated by women, such as in "feminine" professions within the care sectors (cited in Moorthy et. al 2022).

7

Lack of social safety nets for care workers, especially in old age

With Malaysia already classified as an ageing nation and set to become an aged nation by 2040, a gender-responsive approach is necessary to address the future of ageing as women generally live longer than men, but have different patterns of labour force engagement compared to men. For example, women typically take longer career breaks and are commonly segregated into underpaid sectors, such as those within the care ecosystem. Consequently, women typically have lesser savings or pensions compared to men, even more so if they are in precarious employment, which may be typical of certain segments of those within care sectors, such as hospital cleaners or domestic workers.

As it is, over 90% of EPF members under the age of 30 do not have enough savings to meet the basic retirement savings target of RM240,000 by age 55, in part due to the COVID-19 pandemic (KRI 2024). Meanwhile, informal workers with lower average income may face more dire consequences, as they have little to no safety net for retirement in comparison to those in formal employment (Business Times 2024). Additionally, there is a growing trend of poverty in old age in Malaysia (Awang 2023). Given the undervaluation of formal care work, women engaged in this sector face financial vulnerability as they age, even if they are long-tenured.

8

Care remains under financed

The persistent underfinancing of care systems, identified by the World Health Organization (WHO) (2024b), "results in a vicious cycle of unpaid health and care work, lowering women's participation in paid labour markets, harming women's economic empowerment and hampering gender equality." In Malaysia, the

underfinancing of the care workforce and infrastructure is a critical issue, with compounding impacts. As it stands, Malaysia's investments towards the care infrastructure is heavily reliant on individual ministry related financing and budgetary needs. With Malaysia's current prioritisation of the care economy, there needs to be increased investments in healthcare, childcare as well as eldercare infrastructure—a large part of which would be investments in critical, long-term development of infrastructure and labour.

For example, despite how over 53% of the Budget 2025 allocation for the Ministry of Health is channelled towards emoluments, the healthcare workforce remains underpaid (CodeBlue 2024b). This contributes to a severe shortage of specialist doctors, medical officers as well as nurses. In social care, it is less transparent how much of allocations are put towards salaries. In the 2021 Voluntary National Review, it was noted that many implementing agencies are underfunded (Economic Planning Unit 2021). Undoubtedly, this underfunding impacts social care services, including those available through public provision. Further, while availability of public services is important, little work is done to look into the welfare of care workers, who are likely also impacted by strained resources.

Underfunded public resources, unable to keep pace with public demands, effectively transfers the responsibility to private households, reinforcing gender inequalities perpetuating informal care as women's responsibility.

2.4 *Conclusion*

This chapter has thus outlined the conceptual framework which guides the research, as well as offered insight into the policy landscape governing care work in Malaysia, with particular attention paid to its impacts on care workers. In the next chapters, we delve deeper into the methodology as well as findings on the wellbeing of care workers, and the lived experiences contending with the key issues highlighted in this chapter.

03
Methodology

CHAPTER 3

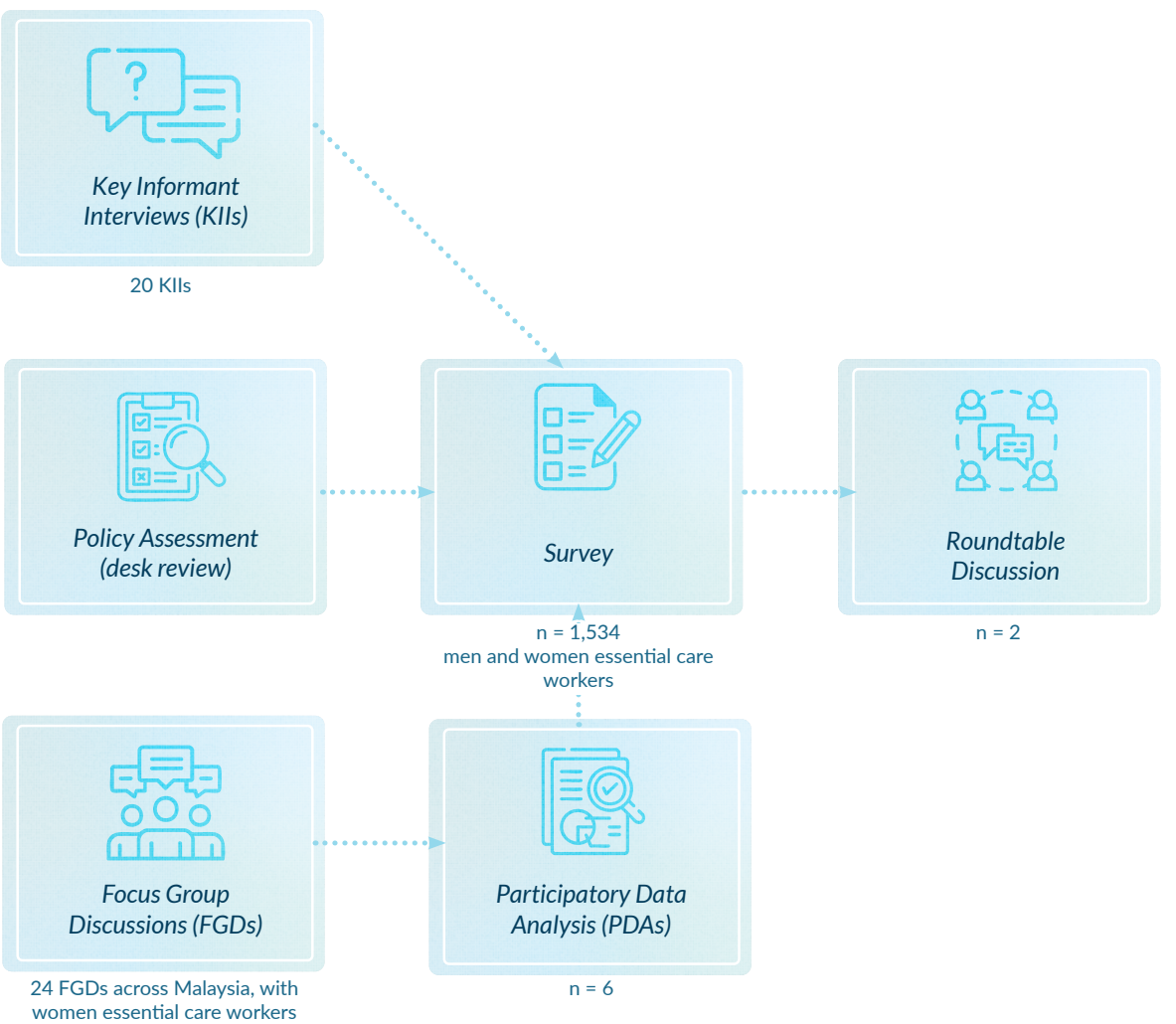
Methodology

3.1 Overview of Study Design

This study employs a sequential mixed-methods approach, primarily utilising focus group discussions (FGDs), key informant interviews, and a quantitative survey complemented by participatory data analysis sessions and roundtable discussions. The research adopts the principles of a participatory approach, ensuring the active involvement of community interlocutors in the formulation, data collection, and analysis stages. Ethical approval was received from both the Medical Research and Ethics Committee (MREC) of the Ministry of Health, as well as the Research Ethics Board of the University of Alberta. To ensure the safety of our participants and the quality of our data, we followed strict confidentiality procedures and obtained informed consent for each aspect of data collection.

FIGURE 3.1

The Sequential Mixed-Methods Approach Utilised by the RE:CARE Study



The sectors and occupations involved in the study, as outlined in Chapter 1, are as follows and are listed in Table 3.1.

TABLE 3.1
Occupations Involved in the RE:CARE Study.

Healthcare	
	**Occupation:** • Doctors • Nurses • Hospital cleaners
Social Care	

	**Occupation:**
	• Public social workers[1]
	• Childcare workers
	  • Public sector[2]
	  • Private sector
	  • Home-based
	• Specialised care (for the elderly and PWD)
	  • Public sector[3]
	  • Private sector

Domestic Care	
	**Occupation:** • Indonesian domestic workers • Filipina domestic workers

3.1.1. *Focus Group Discussions*

Focus group discussions (FGDs) were conducted to explore the issues faced by women care workers, focused particularly on their experiences during the COVID-19 pandemic and if or how these aspects may have changed for them during the shift to endemicity. The FGDs also functioned to develop a preliminary understanding of the types of support care workers felt they needed in order to better manage their paid and unpaid care responsibilities.

i *Sampling*

Participant selection followed a flexible, purposive, and convenience-based sampling strategy, balancing community input with diversity and contextual relevance. We also prioritised locations that reported high intensity of COVID-19 cases, allowing for more relevant exploration of the pandemic's impact on care workers in different sectors. Practical factors like availability, bureaucracy, and logistics also shaped the process. Participants were selected based on the following criteria:

- Women aged 18 and above
- Employed in a paid care work sector during the COVID-19 pandemic (March 2020 - April 2022), in occupations listed in Table 3.1.

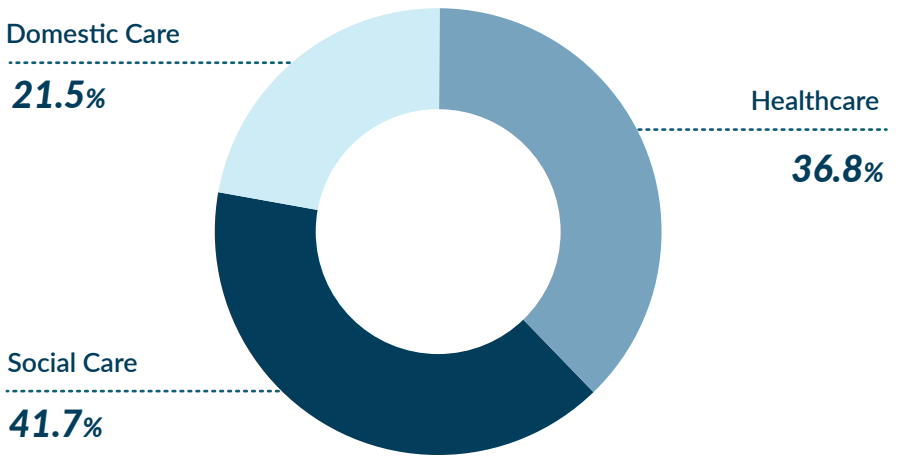
ii *Engaging care workers through FGDs*

A total of 24 FGDs with 144 participants, facilitated by 32 community research associates (RAs), were held across Malaysia. FGDs were designed to be small, with five to seven participants per group led by two RAs. These FGDs were conducted in multiple and mixed languages,

1 This refers to Welfare Officers from the Social Welfare Department (JKM).
2 This refers to childcare workers in TASKAs run by the Community Development Department (KEMAS).
3 This refers to officers under JKM who work within institutional care settings, such as Rumah Seri Kenangan or Taman Sinar Harapan.

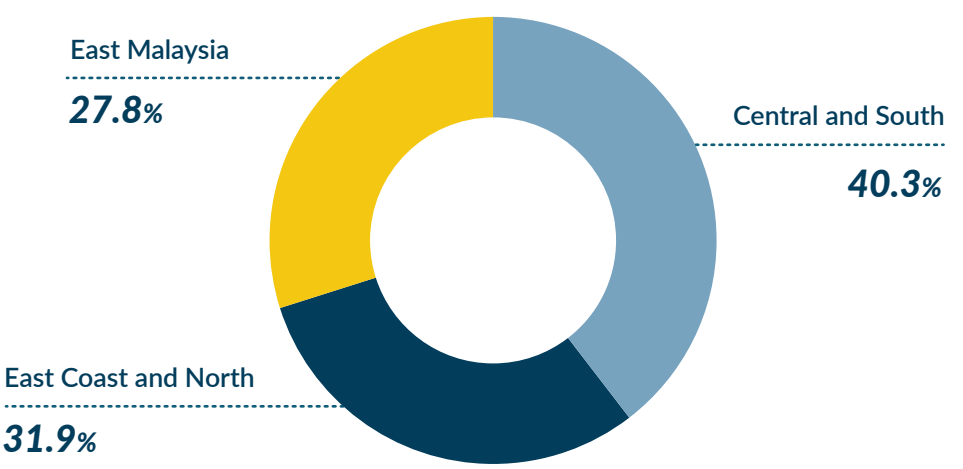
to accommodate comprehension and participation, with mixtures including languages such as Bahasa Malaysia, English, Bahasa Iban, Tagalog, Bahasa Indonesia, and Tamil. Malaysia was divided into three regions to ease fieldwork.

FIGURE 3.2
Share of FGD Care Sectors



The majority of respondents were from the social care segment, followed by healthcare, then domestic care (Figure 3.2). In terms of occupations, there was high representation of respondents from childcare, as three types of childcare workers were included.

FIGURE 3.3
Share of FGDs by Region



For all occupations, an FGD was conducted in each region, with the exception of private specialised care, home-based childcare, and private taska childcare, whose FGDs were conducted exclusively in the central region. As such, there is higher representation within the central and southern regions, followed by east coast and north Malaysia, and East Malaysia.

Respondents ranged in age from 23 to 73 years old, demonstrating the diversity of those involved in paid care work, though the majority were between 30 to 49 years of age. Most were married and were also mothers.

iii *Research Associates and the Participatory Approach*

In undertaking a participatory approach, the team worked closely with a group of Research Associates (RAs), who were community interlocutors. This involved a systematic process of identifying, recruiting, and engaging potential RAs, with the overarching goal of ensuring care worker perspectives were represented and included in the research process. This strategic engagement ensured that the research process remained inclusive, collaborative, and reflective of diverse perspectives within the research context.

TABLE 3.2

Specific Responsibilities of Research Associates by Aspect of Research

Aspect	Role of Research Associates (RAs)
Pre-FGDs	Attend a training session with RE:CARE Team and provide feedback on FGD interview guide to ensure relevance to occupation group. Identify and recruit participants.
During FGD	Conduct the FGDs
Post FGDs	Debrief with RE:CARE Team and, if interested and available, attend participatory data analysis sessions to support analysis and interpretation of data.

The rationale of working with RAs was to reduce power imbalances and promote inclusion. Their involvement enhanced transparency and participation, as their insider knowledge guided more nuanced and contextually relevant discussions.

While the approach had clear advantages, its full implementation was challenged by time and resource constraints. To adapt, the team involved professionals, academics, community organisers with sector-expertise, or RE:CARE members as co-moderators when community practitioners were unavailable, ensuring the participatory process remained both rigorous and practical.

3.1.2
Survey

Drawing from the experiences of care workers from the FGDs, a quantitative survey was designed, aligning with our research objectives.

Purpose of the Survey

The questionnaire includes the following sections:

TABLE 3.3

Survey Sections and Purpose

Section	Purpose
Introduction and consent	This section introduces the survey, covers the objectives, how the data will be used, and includes acknowledgment of consent.
Screening questions	We screened for nationality, gender, and occupation during COVID-19 to ensure only relevant respondents took the survey.
Sociodemographic and Household arrangements	This section aims to capture relevant socio-demographic details of the respondent, including marital status, educational attainment, and household composition, amongst other aspects that would be relevant to the paid and unpaid care work undertaken by the respondents.
Wellbeing of respondents before, during, and after the COVID-19 pandemic	This covers aspects such as satisfaction with: • Physical and Mental Health • Job and Working Conditions • Work-life Balance • Social Support for Unpaid Care Work It also includes questions on burnout, individual resilience, and experience of violence and safety in personal and professional lives.
Gender Role Attitudes	This section assesses perception of respondents towards traditional gender roles.
Work setting resilience	This section allows the respondent to assess work setting resilience. For all occupation groups except domestic workers, this refers to organisational resilience. For domestic workers, they assess their experiences with their employer.
Policy Preferences	This final section assesses the policy preferences of care workers, as well as allows them to identify key issues within their sector that must be addressed to promote long-term resilience.

ii Survey Design and Sampling

The survey covers essential care workers, both women and men, who worked during the COVID-19 pandemic in Malaysia. Inclusion criteria varied based on the occupation.[5] While men were not initially included in the FGDs, they were included in the survey for meaningful statistical comparison.

The FGDs were intentionally focused on women to enable a deeper understanding of their specific experiences and challenges during the pandemic. As women are overrepresented in care roles and were disproportionately impacted by the pandemic, this qualitative emphasis allowed a better understanding of these issues while aligning with the study's broader objectives on exploring gendered impacts.

Generally, all respondents had to be aged 18 and above and working during the COVID-19 pandemic in one of the eight occupations relevant to the study (see Table 3.1).

The sample design employed a three-stage stratified purposive (non-random) sampling method. We intentionally avoided using Labour Force Survey data due to its inconsistency with our research objectives. This means that while the stratification aligns with national composition up to Stage 2, Stage 3 reflects administrative data. Consequently, these findings might not be generalisable to the entire Malaysian population but may be applicable to populations similar to the sample. Importantly, we focused on credibility of the results to our sample population by following ethics and rigorous research methods.

Although the sample is not statistically generalisable, it is analytically generalisable, yielding valid insights into structural patterns, sectoral disparities, and gendered experiences among essential care workers. Despite its non-random nature, the sampling strategy enhances reliability by:

- Anchoring the sample in real-world workforce proportions using authoritative administrative data;
- Deliberately stratifying for gendered occupational dynamics, central to our research; and
- Grounding minimum sample proportions using the expected prevalence of low individual resilience for each occupation, where data was available, drawing from published studies and grey literature, to ensure sufficient statistical power to detect vulnerability trends.

5 Specific inclusion criteria can be found in the companion appendix.

Thus, the sample selected is the most relevant to our research objectives, emphasising women's voices and experiences in care work, as well as sufficiently capturing specific groups we are studying. As our study focuses on eight specific groups of care workers, the sample is not and does not need to be nationally representative.[6] We did not include a strata for location, as it would further complicate the sampling, but we took efforts to ensure respondents were captured from across Malaysia. Notably, migrant domestic workers and hospital cleaners took an enumerated survey, whereas all other respondents took the survey through an online portal. This difference in data collection was necessary to ease understanding of survey questions. That said, it may have also led to varying degrees of respondent openness for disclosure on sensitive topics, due to potential enumerator effect or social desirability biases. Nonetheless, the consistency of key patterns in the findings suggests the robustness of data collected.

iii Validation Processes

We undertook face, content, and construct validation for the survey.[7] The survey was initially designed in English and extensive back- and forward-translation processes were undertaken to ensure validity of the survey in Bahasa Malaysia, Bahasa Indonesia, Tamil, and Tagalog—the main languages of the groups with which we worked.

iv Respondent Profile

The quantitative data was collected from November 2024 to February 2025. Thus, when the term "post-pandemic" is used in relation to quantitative data, it is in reference to this time period. There were a total of 1,534 survey respondents:[8] 1,238 women and 296 men.

FIGURE 3.4

Breakdown of Survey Respondents by Gender

Men

19.3%

Women

80.7%

6 Further information on the sampling frame is available in Appendix A.
7 Further details of this can be found in the appendix.
8 Based on the stratified sampling frame, our initial target was 1,489 respondents across the three care sectors, thus our final sample exceeded our required sample size.

In terms of geographic distribution across Malaysia's six zones during the COVID-19 pandemic, our respondents were concentrated in the following zones:

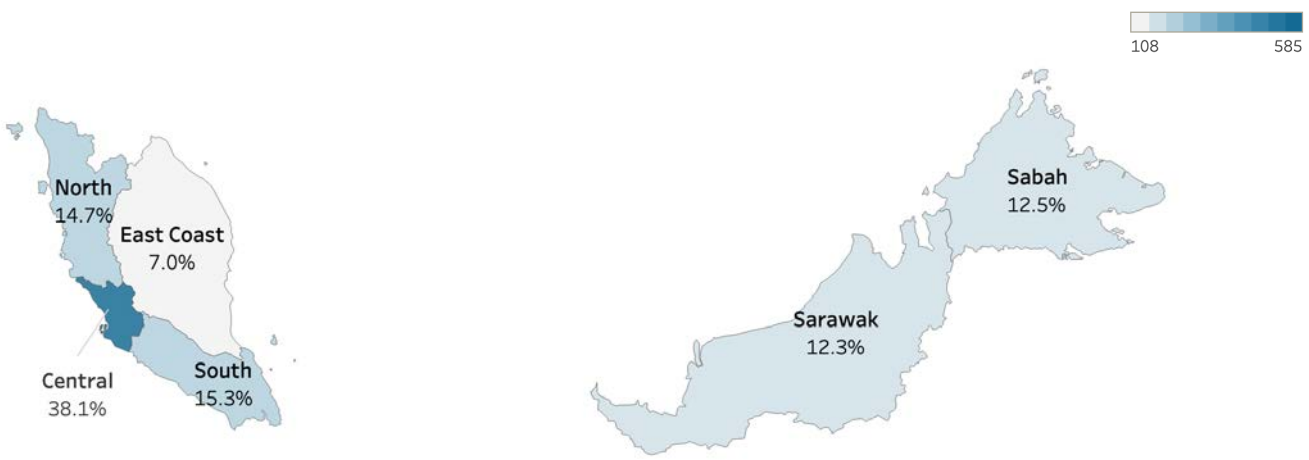
TABLE 3.4

Breakdown of Survey Respondents by Gender

Zone	Number of respondents	Respondents (%)
Central (Selangor, W.P. Kuala Lumpur, Putrajaya)	585	38.1
South (Negeri Sembilan, Melaka, Johor)	234	15.3
North (Perlis, Pulau Pinang, Kedah, Perak)	226	14.7
Sabah and W.P. Labuan	192	12.5
Sarawak	189	12.3
East Coast (Kelantan, Terengganu, Pahang)	108	7.0

FIGURE 3.5

Distribution of Respondents Across Regions (%)

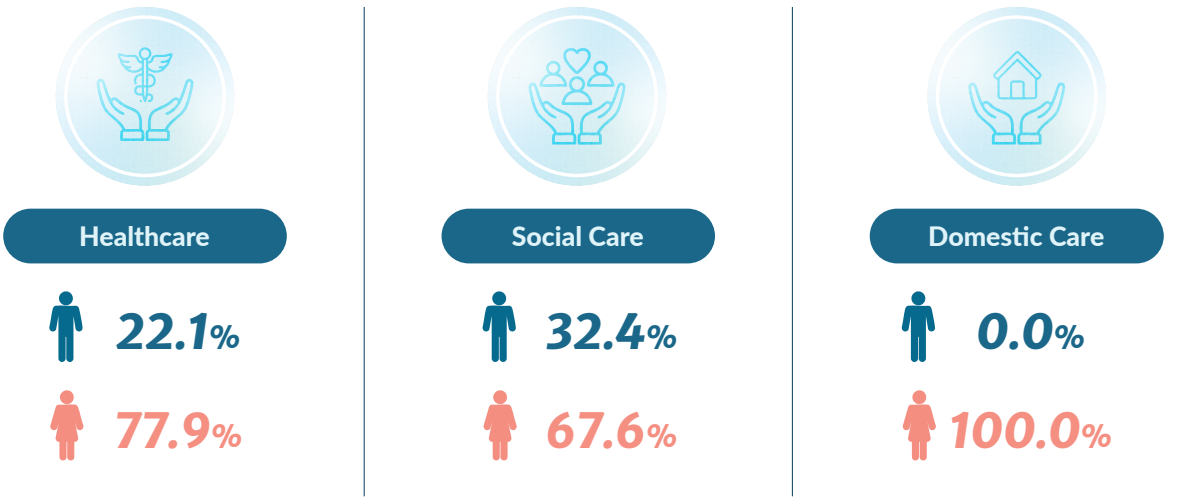


Regarding place of residence, most respondents (92.2%) lived in urban areas during the pandemic, while a smaller portion (7.8%) resided in rural areas.

The gender distribution highlights the highly feminised nature of care work in Malaysia: Women made up 80.7% of the sample, while men accounted for 19.3%. This gender imbalance was evident across sectors, with a female-to-male ratio of approximately 4:1 in healthcare, 3:1 in social care, and 100% female representation in the domestic care sector (Figure 3.5). This distribution, however, aligns well with the composition initially highlighted in Chapter 1.

FIGURE 3.6

Breakdown of Sector by Gender (%)



Nearly two-thirds (63.1%) of respondents worked in healthcare, while another 20.4% in domestic care, and 16.5% in social care. Social care, within our sample, appears to be the smallest sector. While acknowledging potential constraints in reaching larger amounts of social care workers, we also believe social care may also be underdeveloped compared to healthcare and domestic care.

By occupation, the sample covered a wide spectrum of care-related roles. Nurses made up the largest group of respondents (32.0%), followed by domestic workers (20.4%), and doctors (17.9%). Among domestic workers, 68.7% were live-in (residing with their employers), while 31.3% were live-out (living independently).

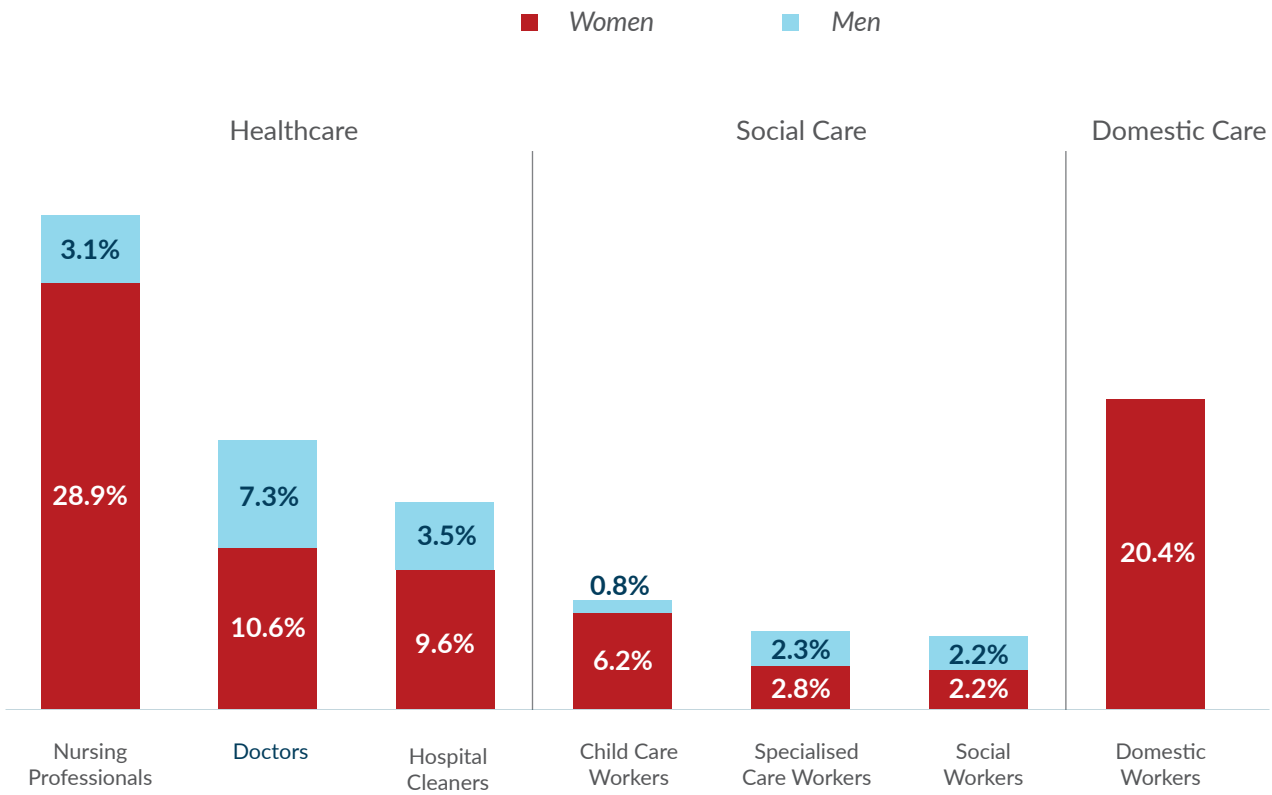
TABLE 3.5

Percentage of Respondents by Occupation.

Sector	Occupation	Respondents (%)
Healthcare	Nurses	32.0
	Doctors	17.9
	Hospital cleaners	13.2
Social care	Childcare providers	7.0
	Specialised care workers (those providing eldercare or PWD care)	5.1
	Social workers	4.4
Domestic care	Live-in domestic workers (residing with their employer)	14.0
	Live-out domestic workers (residing independently)	6.4
	Total	**100.0**

FIGURE 3.7

Breakdown of Occupation by Gender (%)



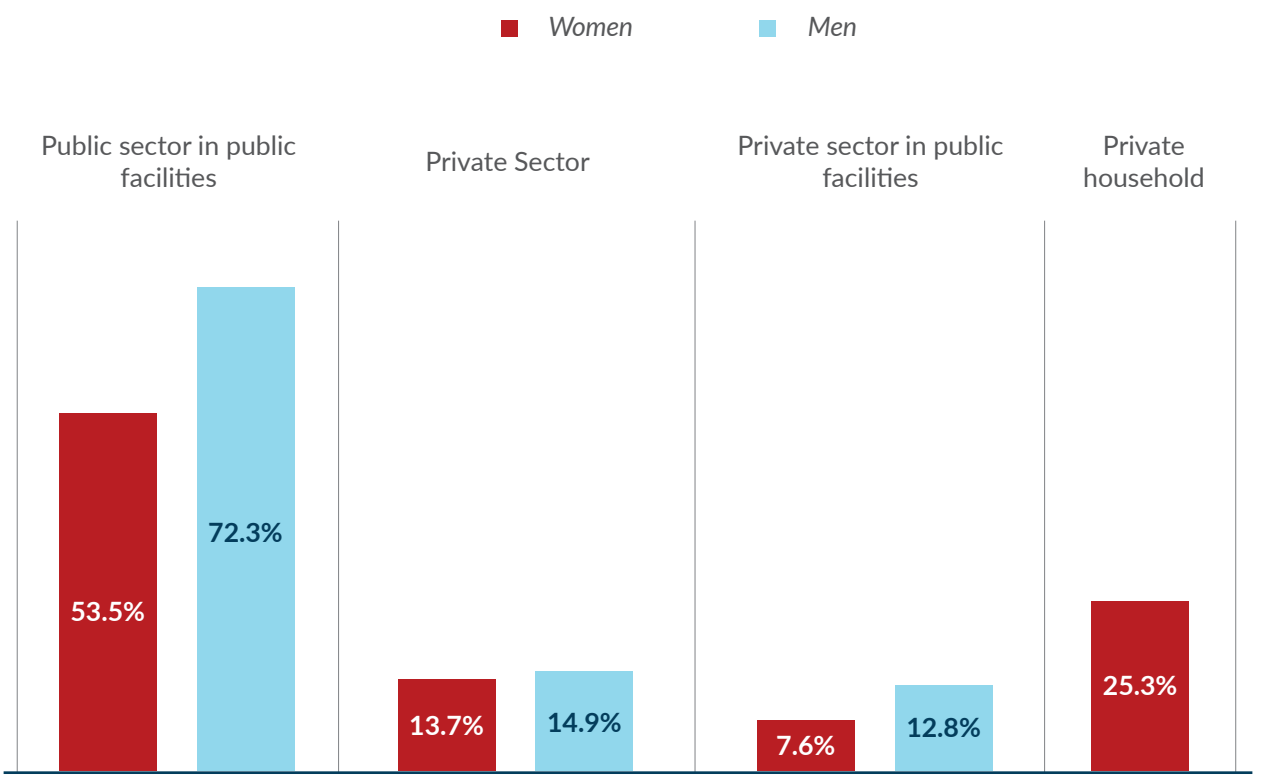
Women made up the majority of respondents across nearly all occupational categories (Figure 3.7). In the healthcare sector, 90.2% of nurses, 59.3% of doctors, and 73.3% of hospital cleaners were women. In social care, women comprised 88.8% of childcare workers, 54.4% of specialised care workers, and 49.3% of social workers. In domestic care, all respondents were women. These figures, again, align well with initial estimations outlined in Chapter 1.

The majority of respondents were employed in the public sector—53.5% of women and 72.3% of men. In comparison, 13.7% of women and 14.9% of men worked in the private sector, while an additional 7.6% of women and 12.8% of men were employed by private providers operating within public facilities, for a combined total of 49.0% working for private companies (21.3% women, 27.7% men). All the migrant domestic workers (25.3%) were employed in private households.

Women made up the majority of respondents across nearly all occupational categories, as care sectors in Malaysia are predominantly feminised.

FIGURE 3.8

Breakdown of Type of Employment Sector by Gender (%)



In terms of ethnicity, the majority of Malaysian respondents were Malay, followed by Chinese, Orang Asal and Orang Asli, Indian, and then others, as shown in Table 3.6.

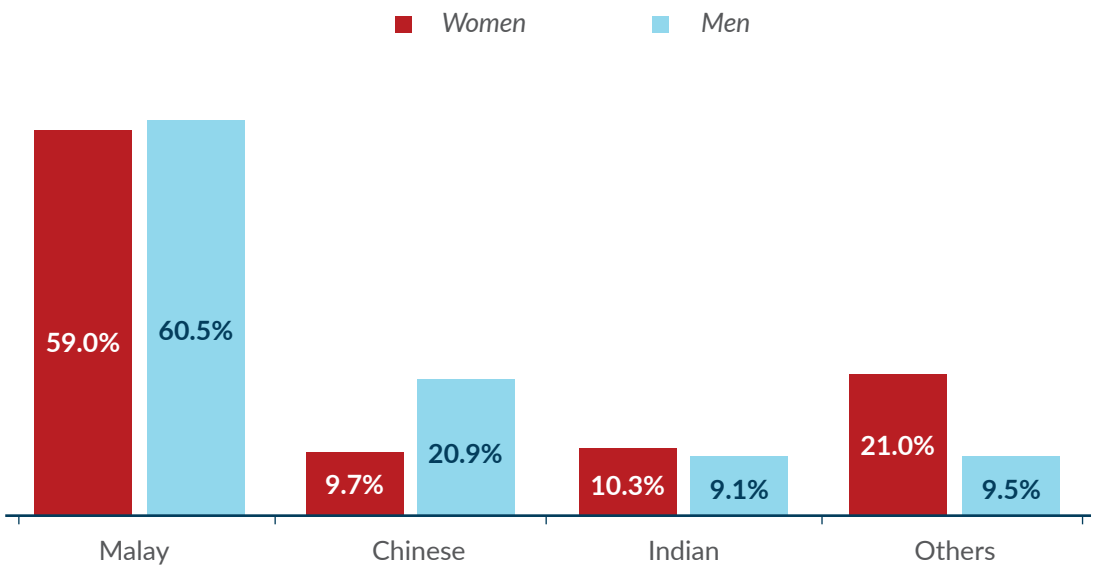
TABLE 3.6

Breakdown of Respondents by Ethnicity, in Percent (%)

Ethnicity	Women (%)	Men (%)
Malay	59.0	60.5
Chinese	9.7	20.9
Indian	10.3	9.1
Orang Asal and Orang Asli	19.8	8.1
Others	1.2	1.4

FIGURE 3.9

Breakdown of Malaysian Respondents by Ethnicity and Gender (%)

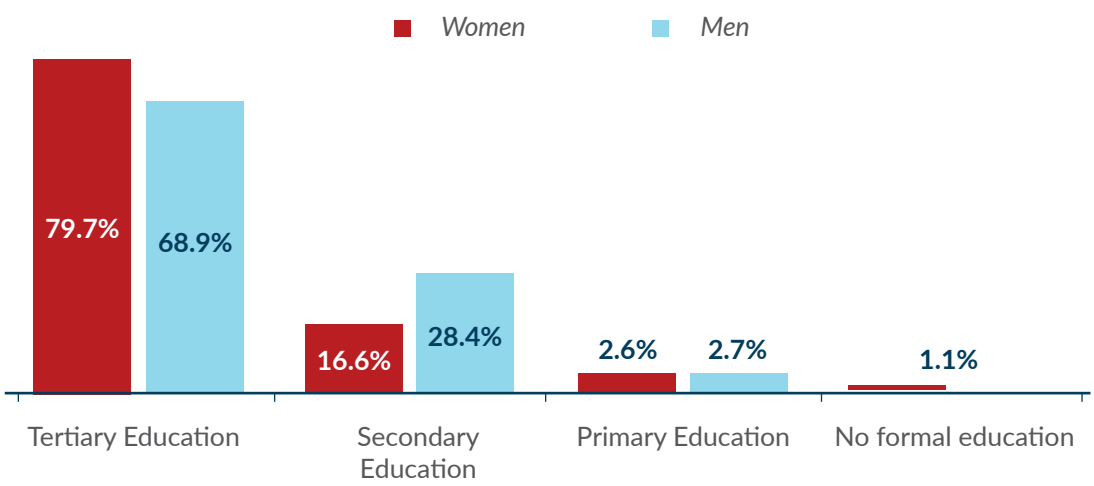


Most Malaysian respondents had completed tertiary education, comprising 79.7% of women and 68.9% of men. Among domestic workers, the majority of Indonesians had secondary education (57.7%), while 32.4% had completed primary education. For Filipina domestic workers, most had completed secondary education (59.3%), and 16.5% had attained tertiary education.

Most of the sample was partnered (63.8%), while the remaining (36.2%) were not. Overall, across the whole sample, most respondents were in monogamous marriages. This accounts for 57.1% of the women and 68.2% of the men. The next largest group was those who have never been married, including 23.5% of women and 26.4% of men (Figure 3.11).

FIGURE 3.10

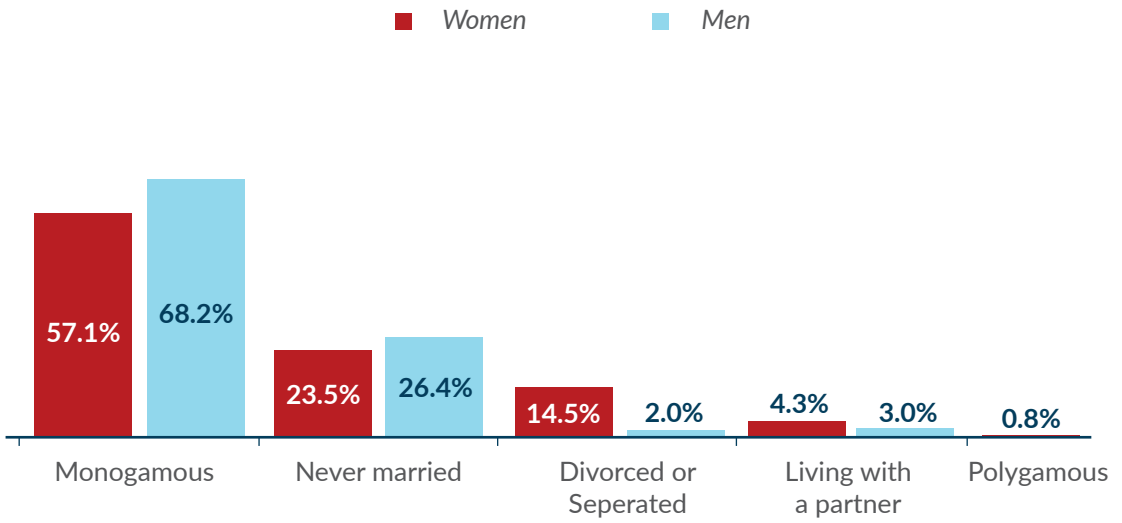
Breakdown of Malaysian Respondents by Highest Level of Education and Gender (%)



9 Partnered includes those who are in monogamous marriages, polygamous marriages, or living with a partner. Unpartnered includes those who have never been married, or are divorced/separated, or widowed.

FIGURE 3.11

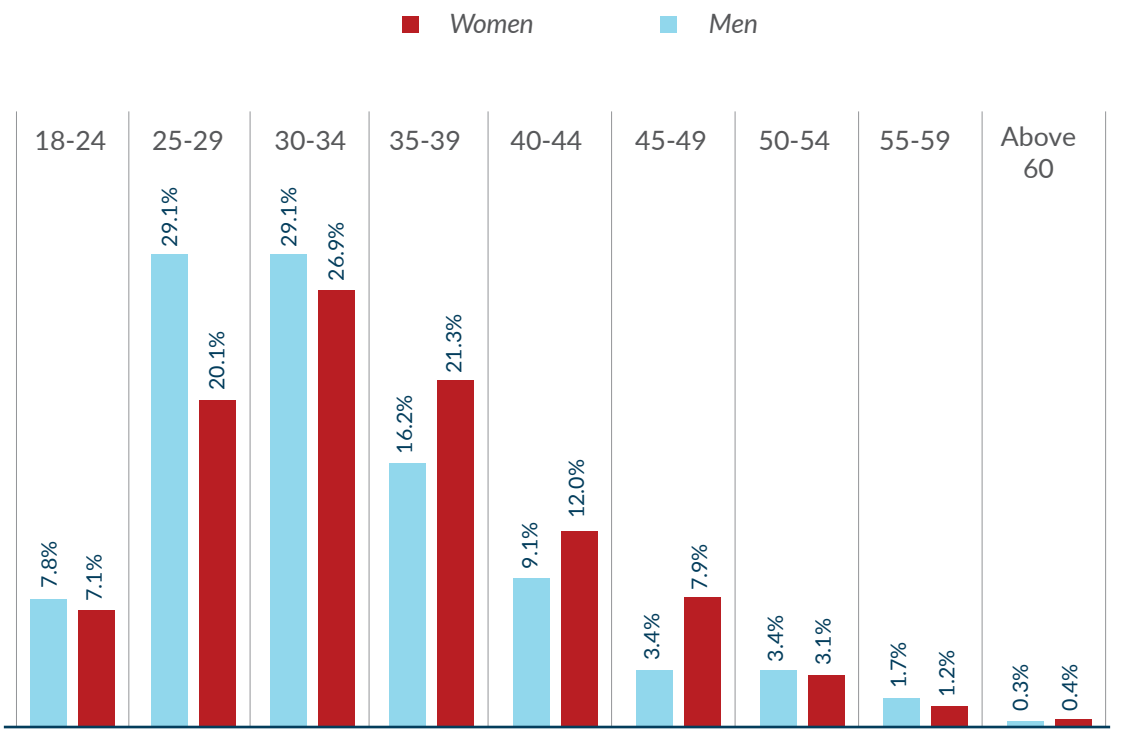
Breakdown of Respondents by Marital Status and Gender (%)



Based on age group distribution, a majority of male respondents (66.0%) were aged 18-34, indicating a higher representation in this age group. In contrast, women care workers were concentrated in the 30-49 age group, accounting for 60.2% of female respondents (Figure 3.12). This pattern suggests that women survey respondents appear to be more likely within prime working age.

FIGURE 3.12

Age Distribution of Respondents by Gender (%)



3.1.3.

Key Informant Interviews (KIIs)

i *Purpose of KIIs*

Finally, to complement the perspectives of the care workers, gathered from both FGDs and the quantitative survey, we employed a total of 20 key informant interviews (KIIs) with representatives from civil society organisations as well as government institutions. These interviews aimed to understand the policies from the perspectives of those involved in or adjacent to policy making.

ii *Interview Guide Design*

Questions were broken down into five sections:

TABLE 3.7

Sections of Key Informant Interview Guide and Purpose

Section	Purpose
Introduction	Allows the key informant to introduce themselves and the work they do
Background—Understanding of care	Probes the key informant's understanding of care, care workers, and care policies
Context—COVID-19 and beyond	Allows the key informant to further explain policies relevant to care workers in the context of COVID-19 and now
Recommendations	Recommendations from the key informant on how to better support care workers and the care ecosystem in Malaysia
Conclusion	Allows the key informant to share any final thoughts they may have on the topics and issues discussed

As semi-structured interviews, the KIIs allowed for a high degree of flexibility and variability in the questions asked, depending on the key informant responses and their area of expertise.

TABLE 3.8

Summary of Research Tools within the RE:CARE Study

	Focus group discussions (FGDs)	Participatory data analysis	Questionnaire	Key informant interviews (KIIs)	Roundtable discussions
Purpose and relevant research objectives	To understand the knowledge, attitudes, practices, and experiences of essential care workers during the COVID-19 pandemic.	To understand the knowledge, attitudes, practices, and experiences of essential care workers during the COVID-19 pandemic. To synthesise recommendations from care workers.	To measure the wellbeing of care workers before, during, and after the pandemic to better understand the supports needed by care workers in times of crisis. To allow care workers to assess organisational resilience as well as key issues within their sector, for the purpose of formulating policy recommendations.	To assess existing care sector policies through the perspectives of stakeholders within civil society and government, who have policymaking insights.	To finalise recommendations with care workers, ensuring the recommendations being put forward reflect their needs.
Participants	Women essential care workers from the eight occupations identified.	Six groups of women essential care workers, involving doctors, nurses, private childcare providers, specialised care providers, Indonesian domestic	Women and men essential care workers from the eight occupations identified, stratified by proportion of population.	Mid-level and high-level policy stakeholders, including representatives from government and civil society.	Women and men essential care workers from the eight occupations identified.

		workers, and Filipina domestic workers. Mostly involved the Research Associates, though some sessions also involved participants.			
Number of participants	144, with an average of six participants per session	32	1,534	20	68
Locations covered	Eight states in Malaysia–all regions covered (north, south, east coast, central, and East Malaysia)	Focus on Klang Valley; out of state Research Associates were invited to attend	All of Malaysia	Mostly Klang Valley. Interviews were also conducted online for those who were unable to meet in person.	Focused on Klang Valley; participation from out of state participants was also facilitated.
Conducted by	Community Research Associates	RE:CARE Team with guidance from Community Research Associates	Hybrid online and face-to-face. Face-to-face surveys were enumerated by RE:CARE team and/or trained enumerators.	RE:CARE Team	RE:CARE Team

3.2

Data Analysis

The participatory approach taken in this study has meant that analysis of the data has been an iterative process, with care worker perspectives being a key element. For qualitative FGD data, care workers were engaged through debriefing sessions and participatory data analysis sessions. In particular, through the participatory data analysis sessions, care workers actively contributed to the development of the coding frame used by the researchers in analysis of the data through inductive coding processes.

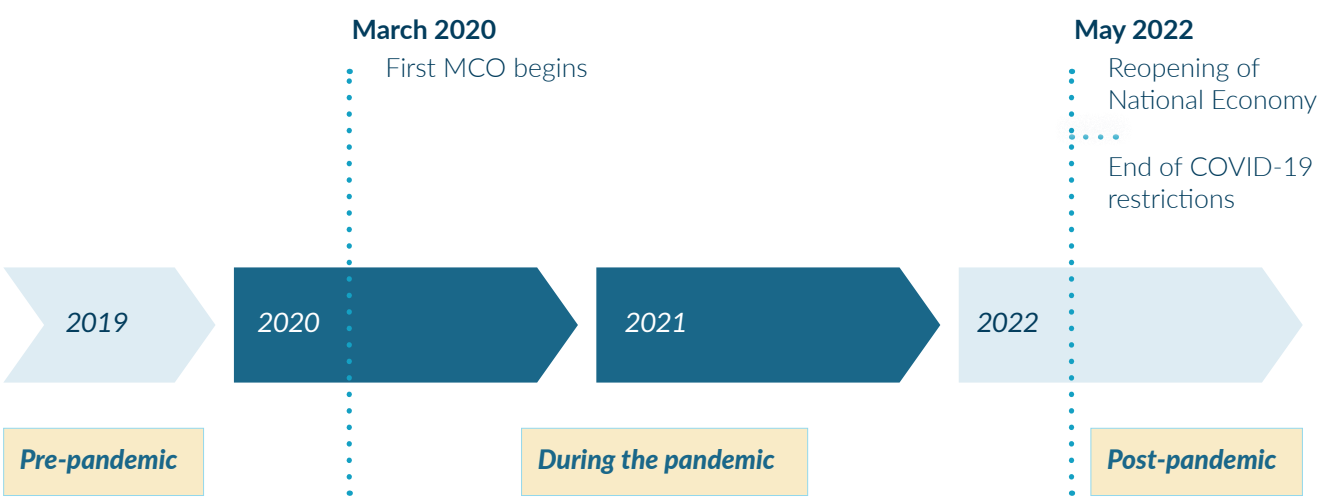
The themes that emerged from the qualitative analysis served as the basis for questions developed in the survey. Qualitative data from the focus group discussion were analysed using the software NVIVO whilst data from KIIs were analysed thematically. Quantitative survey data were analysed with Excel, Stata, Jamovi and Tableau.

Quotes featured from qualitative data have been anonymised and focus group discussion participants have been assigned pseudonyms.

Notably, data from focus group discussions was collected from May to December 2023, whereas data collection for the quantitative survey occurred between November 2024 to February 2025. Thus, we will refer to the pre-pandemic period as the time before March 2020, wherein the first lockdown was instituted. The pandemic period, which will be referred to as "during the pandemic" within this report, refers to the period of time between March 2020 and April 2022, wherein there were several restrictions on movement and economic activities. Finally, post-pandemic refers broadly to the time after May 2022, when restrictions on movement and economic activities were fully lifted. As data were collected at different periods, post-pandemic refers to a large time period. Most important for this report is to note that, with regards to qualitative data, this will largely refer to experiences within 2023, whereas for quantitative data, this refers to information gathered in late 2024 to early 2025. Key informant interviews began in July 2023 and finished in February 2025.

FIGURE 3.13

Demarcation of Relevant Time Periods



3.2.1
Survey Analysis

The outcome measure used was subjective wellbeing, composed of four aspects explored within the previous chapter. Table 3.9 details each measure.

TABLE 3.9

Aspects of Wellbeing Measured in the Survey

Aspect	Matter
Satisfaction with physical and mental health	Examines how satisfied respondents are with aspects of their physical and mental health, with a focus on presence of feelings of anxiety and depression
Job satisfaction	Examines how satisfied respondents are with aspects of their job, including salary, recognition and appreciation, as well as career growth and development
Satisfaction with work-life balance	Examines how satisfied respondents are with the amount of time spent on paid care work, unpaid care work, and self-care.
Satisfaction with social support	Examines how satisfied respondents are with the support received from those within their household, as well as global community support, with particular emphasis on unpaid care work

Each of these domains contained a range of three to five questions that were scored on a five-point Likert scale. These scores were tallied up for a total score per domain. The sum of all the subcomponent scores comprised the composite wellbeing measure.

Our findings will be presented by first highlighting the quantitative finding, followed by emerging qualitative narratives, where relevant.

In our analysis, we use sector, occupation, gender, age group, income, education level, marital status, and migrant status, where relevant, as key variables to examine care worker profiles. We further analyse household composition—household income, household size, the presence of spouse, children, elderly, and the household's care dependency score—to understand how care workers' experiences and challenges differed across demographic groups during the pandemic and transition into endemicity.

To assess economic sufficiency more accurately, we adopt household income per capita as an alternative to total household income bracket. This approach better captures the financial realities of care workers, who often live in larger or multigenerational households with children, elderly, or dependents requiring additional care. This will be further explored in Finding 1.

In the next chapter, we will delve deeper into the six key findings of this report.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04
Findings

CHAPTER 4

Findings

There are six key findings:

Finding 1

Women care workers are disproportionately impacted by multiple structural inequalities.

Finding 2

Wellbeing among care workers declined during the COVID-19 pandemic and has not recovered to pre-pandemic levels.

Although the overall decline was similar for men and women, the experience differed by gender.

Finding 3

Malaysian women had the slowest post-pandemic wellbeing recovery, relative to migrant women and Malaysian men.

The gap between Malaysian men and women, however, reflects more than just a difference in wellbeing recovery—it points to a persistent, structural disadvantage rooted in gender norms impacting women's overall wellbeing.

Finding 4

Preventing burnout and supporting resilience are key to supporting care workers.

While burnout was experienced equally by men and women, there appears to be gender gaps in individual resilience that must be bridged.

Finding 5

One in three Malaysian care workers want to leave their current position within the next five years, while over half of migrant domestic workers want to do the same.

Care workforce retention can be supported by improving job satisfaction, individual resilience, organisational resilience, and addressing experiences of violence.

Finding 6

The double burden of paid and unpaid care work more negatively impacts women's wellbeing compared to men.

Both structural and individual supports are crucial in protecting care workers and bridging gender disparities in wellbeing.

Relevant statistical analyses are available in the companion Appendix booklet.

Finding 1:

Women care workers are disproportionately impacted by multiple structural inequalities.

FINDING HIGHLIGHTS

This first finding in this report sheds light on deep-rooted inequalities within Malaysia's care sector, revealing intersecting dimensions of gender, care load, wage injustice, and economic disparity.

1

Care Inequality

- Care inequality is profoundly gendered: Women disproportionately shoulder greater unpaid caregiving responsibilities compared to men, especially within households classified under the highest care-load quartile.
- The highest care-load households experience a pronounced double burden, combining extensive unpaid caregiving with significant paid employment, heightening risks of overwork and burnout.
- Household composition plays a major role, with larger, multigenerational households concentrated in the highest care-load quartile, indicating that care responsibilities and economic burdens are both intensified and shared. As more women are found in these types of households, women appear to shoulder more of this load, suggesting an uneven distribution of unpaid care work across household members.
- While the presence of a spouse significantly increases the number of hours of unpaid care work for both men and women, married women still undertake more hours of unpaid care work.
- Interestingly, elderly household members appear to slightly alleviate unpaid care work, rather than solely receiving care, suggesting a trend of intergenerational care sharing.

2

Wage Disparity among Care Workers

- Care workers, especially hospital cleaners, face significant wage stagnation despite their experience, highlighting structural undervaluation of care roles perceived as lower-skilled.
- Domestic workers' wages remain consistently low and stagnant, with earnings largely influenced by regional location rather than years of experience or living arrangement, reinforcing economic vulnerability.
- Hospital cleaners, predominantly older women, earn minimal wages (median RM1,500 per month) irrespective of tenure, reflecting broader systemic inequities in the care sector.

- Nurses, despite structured pay scales and high educational qualifications, still face limited income progression and modest wages, disproportionate to their professional responsibilities.

3

Economic Inequality

- Household income per capita sharply decreases as care responsibilities and household size increase, creating hidden economic vulnerability that headline income figures typically mask.
- Higher-care-load households have more income earners but significantly lower per capita income due to increased dependency ratios, highlighting a "care-finance squeeze."
- Economic sufficiency perceptions vary significantly by gender; women consistently report living closer to the economic margin ("just enough"), despite objectively lower household income per capita across nearly all quartiles.
- Men, while generally reporting greater sufficiency in lower care-load quartiles, experience higher financial strain as care load increases, highlighting complex gendered dynamics around financial stress and household roles.

4.1

Inequalities Faced by Care Workers

As established in Chapters 1 and 2, there are clear inequalities faced by care workers, which disproportionately impact women. From this finding, three inequalities faced by care workers were further examined: Care inequalities, income inequalities, and economic inequalities.

4.1.1

Inequality 1: Care inequalities

Mapping the Distribution of Unpaid Care Load by Quartile

Insights from our qualitative data reveal that women care workers disproportionately did more unpaid care work during the pandemic, while shouldering a heavier load of paid labour. Capturing this often taken for granted care load is critical to our analysis. To better reflect this intra-household care intensity, we adapted the Montano and Rico (2007) care unit methodology, applying weighted care scores based on age and care needs for each household. Each type of dependent is assigned a weight based on the level of care they typically require (Table 4.1.1):

TABLE 4.1.1

Weights Based on Age and Additional Care Needs

Group	Weights	Justification
Child aged 0-2	2.0	This age group requires constant, high-intensity care, including feeding, diapering, carrying, and supervision. Often needs round-the-clock care.
Child aged 3-4	1.5	Still highly dependent—requires help with toileting, feeding, dressing, and close supervision—but beginning to develop some autonomy.
Child aged 5-6	1.2	Moderate dependency; may attend preschool/ kindergarten part-time, but still needs adult help with meals, hygiene, transport, and routines.
Child aged 7-17	1.0	Lower daily care intensity but still dependent for meals, transport, schooling needs, and emotional support. Intensity varies by age.
Adult aged 18-65	0.5	Assumed to be independent unless otherwise stated. Acts as a reference point for baseline (low care burden, as all adults still require some degree of care, whether through shared household responsibilities, emotional support, or basic maintenance of daily life).
Adult aged 65+	0.8	Increasing likelihood of functional limitations, illness, or mobility issues. Care needs may range from light assistance to intensive support.
Any person with additional care and support needs (count)	+2.0	Higher care needs, including but not exclusive to family members with disabilities; dependent on health and mobility limitations.

1. Highest weights were assigned to those who require more intensive care, primarily young children, based on age bracket (0-7 years).

2. Elderly individuals (65+) were assigned a lower baseline weight than children because not all older adults require constant care. However, where an elderly person does have disabilities, chronic illness, or long-term care needs, this additional demand is explicitly captured through the "additional care needs" multiplier. In this way, the model avoids underestimating care intensity while not assuming all elderly require the same level of care as young children.

3 Greater weights were also assigned for individuals with additional care needs, such as persons with disabilities, chronic illnesses, or those requiring long-term care.

4 We refer to this as the weighted household composition score, which we believe better reflects the intensity required to provide care to household members by age and additional care needs.

Once all care scores are calculated, we divide the household's care load into four quartiles (Table 4.1.2):

TABLE 4.1.2
Care Load by Quartiles

Quartile	Meaning
Q1	Households with low care responsibilities
Q2	Households with moderate-low care responsibilities
Q3	Households with moderate-high care responsibilities
Q4	Households with the most intensive or multiple care responsibilities

ii *Limitations of Care Load Quartiles*

While stratifying households by care load quartiles is useful for illustrating broad patterns and gradients of care responsibility, this approach inevitably simplifies a much more complex reality. Quartile boundaries are statistical constructs, as households on either side of a cut-off may have nearly identical care burdens, yet fall into different analytical categories.

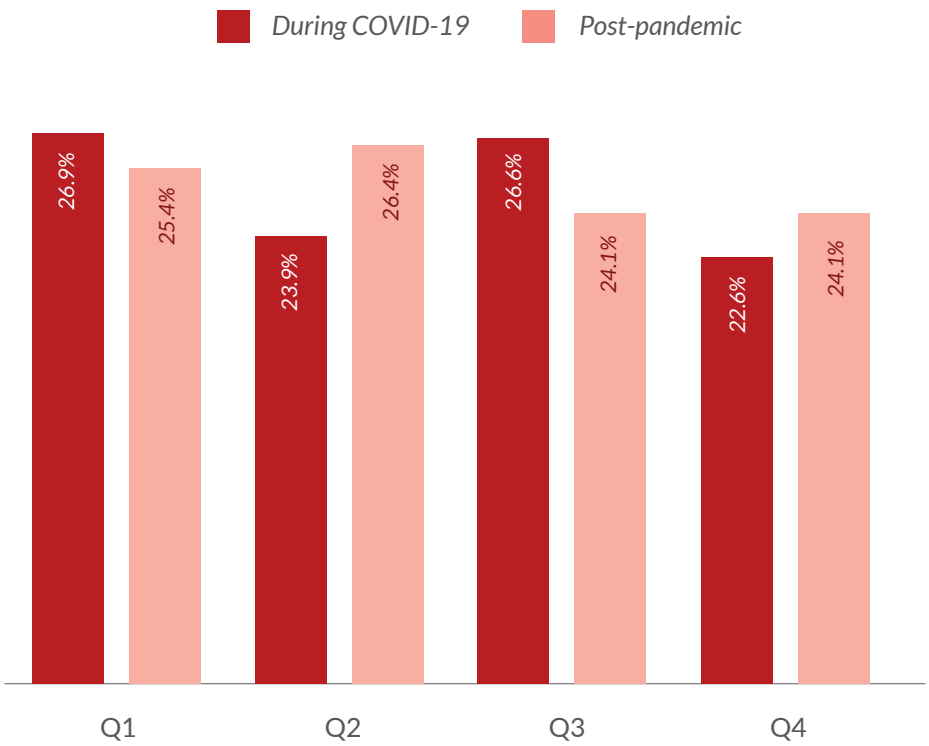
In practice, the lived experience of care work is highly nuanced and fluid. Many households sit precariously close to these boundaries, and small differences in reported care responsibilities can shift a household from one quartile to another, even though their actual circumstances are remarkably similar. As such, while quartile analysis helps identify trends, it does not fully capture the spectrum or the shifting nature of care work experienced by households in our sample.

iii Household and Care Worker Characteristics Across Care Quartiles

Based on this weighted scoring system, accounting for the presence of children, adults, elderly members, and individuals with additional care needs, the analysis revealed that the distribution of household care load quartiles is now more evenly distributed across all quartiles compared to the pandemic period. The proportion of households in the highest care burden group (Q4) is marginally higher now (24.1% vs. 22.6%). A slight shift might reflect some post-pandemic recovery or adaptation, but this also highlights that care responsibilities are deeply embedded and not easily altered by changing external conditions (Figure 4.1.1).

FIGURE 4.1.1

Care Load by Quartile During the COVID-19 Pandemic and Post-Pandemic



To better understand the implications of a high care load, we examined the specific characteristics and household profiles of respondents across the care load quartile. This analysis extends beyond the overall distribution by examining gender and other relevant demographic factors closely. By exploring these profiles, we can identify which groups are disproportionately represented among households with the most intensive care responsibilities. Such scrutiny not only reveals potential patterns of vulnerability but also highlights the gendered nature of care work, providing a more nuanced picture of how high care burdens are distributed within our sample.

Findings revealed that, during the pandemic, men and women are distributed unevenly across the four care-load categories.[1] *Men were disproportionately concentrated in the lowest care load group, with 34.1% falling into this category, compared to only 25.2% of women.* In contrast, women had a larger share in the highest

1 Statistical significance was determined using a chi-square test, with significance set at **P** < 0.05. The test revealed a significant association between gender and care-load quartile. See Appendix 4.1.1 in the companion appendix for further details.

care load quartile, Q4, 24.0% compared to just 16.9% of men (Figure 4.1.2). This confirms that women in the sample shouldered a disproportionately heavier share of household caregiving responsibilities, as they were significantly more likely to be concentrated in households with the highest care burden during the pandemic. *Post-pandemic, there remains a persistent burden on women, with their share slightly increasing to 25.5% in the highest quartile, Q4, compared to only 18.2% of men* (Figure 4.1.3). While women are still more likely to be found in higher care-load quartiles than men, the gender gap in care burden has narrowed since the pandemic.[2]

FIGURE 4.1.2

Breakdown of Respondents across Care Load Quartile by Gender during the COVID-19 Pandemic (%)

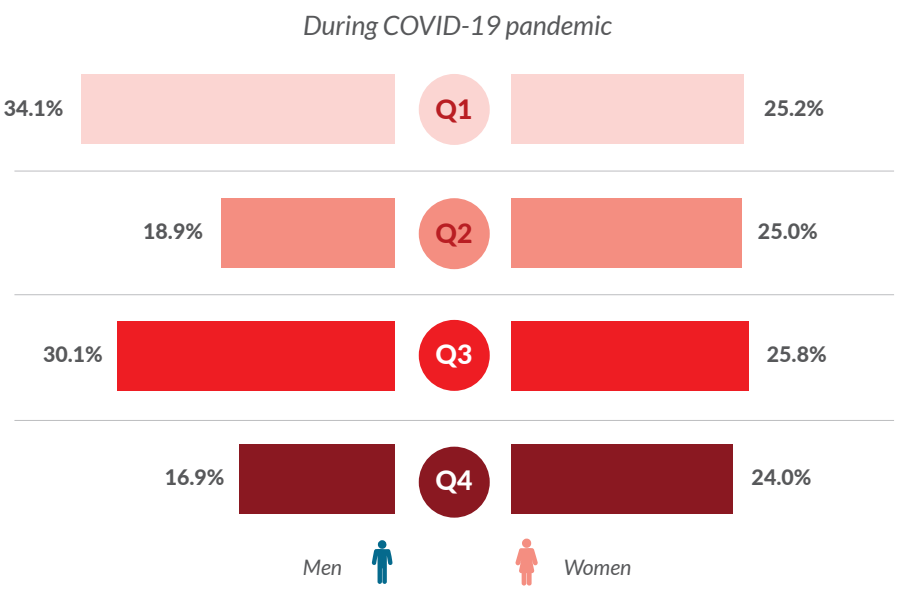
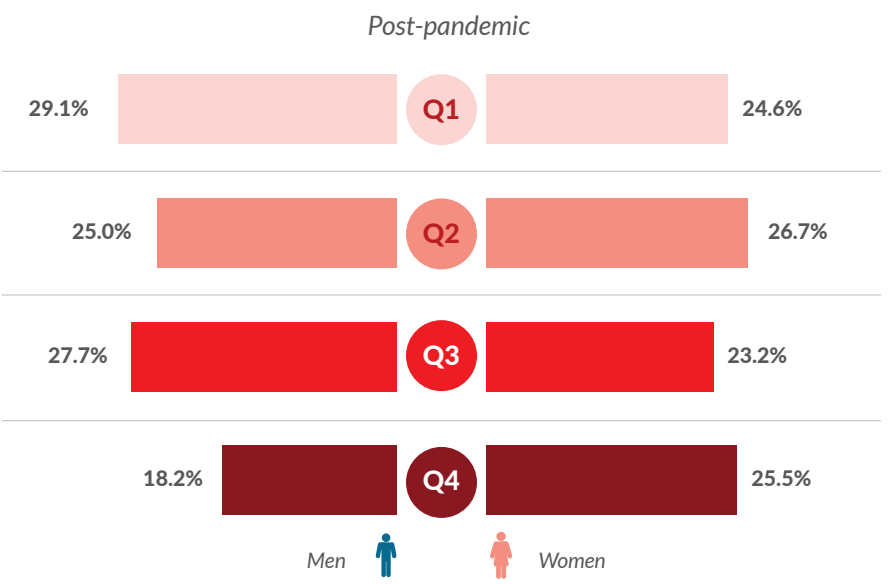


FIGURE 4.1.3

Breakdown of Respondents across Care Load Quartile by Gender in Post-pandemic (%)



2 Statistical significance was determined using a chi-square test, with significance set at **P** < 0.05. See Appendix 4.1.2 in the companion appendix for further details.

Household-level analysis across care load quartiles during the pandemic[3] demonstrates a clear upward trend: As care responsibilities intensify from Q1 to Q4, households exhibit larger sizes, greater dependency ratios, and increased time allocated to caregiving. The average household size increases from 2.3 persons in Q1 to 7.0 in Q4, reflecting a threefold rise as the care load intensified. The average number of dependents rises from 0.5 in Q1 to 4.2 in Q4. Children are nearly absent from Q1 households, with an average of only 0.1 people under 18 years of age, whereas Q4 households report an average of 2.4 household members under 18 years old.

Households in Q4 additionally have a larger number of working-age adults (18-65), suggesting multigenerational living arrangements. There are more older adults (65+) present in Q4 households compared to other quartile households (Table 4.1.3), further suggesting that households with the highest care loads are likely sites of intergenerational caregiving. When considering whether households require additional care (e.g., if there is a household member with an illness or disability present that requires more support), there is a massive increase in Q4, with 2.8 people per household, on average, suggesting that household members with additional care needs are highly concentrated in the upper care load quartile.

TABLE 4.1.3

Average Household Characteristics Across Care Load Quartiles during the pandemic

Quartile	Household Size	Number of dependents	Number of people <18	Number of people >65	Number of people requiring additional care
Q1	2.3	0.5	0.1	0.0	0.0
Q2	4.3	1.9	1.0	0.2	0.1
Q3	5.4	3.0	1.7	0.4	0.5
Q4	7.0	4.2	2.4	0.7	2.8

The presence of domestic workers is slightly more common in Q4 but remains low overall, even in high-care-load households. Although Q4 households report a greater variety of family members participating in caregiving and household responsibilities during the pandemic,[4] this increase is not proportional to the rise in care demands. This implies that care work may still fall disproportionately on one or two individuals within the household. Given that women respondents are more present in these high care load households, it is likely they are the ones shouldering this load. Thus, women appear to tend to undertake care responsibilities, even in settings where more household members are present.

Thus, when looking at household size, *while larger households are typically associated with higher care needs, they do not necessarily indicate greater support or a more even distribution of care responsibilities.* The next section will delve deeper into gender disparities.

3 Descriptive Statistics of Household Characteristics by Care-Load Quartile during the pandemic. See Appendix 4.1.3 in the companion appendix for further details.
4 Distribution of reported caregiver relationships by care load quartile during the pandemic. Descriptive table in Appendix 4.1.4 in the companion appendix.

iv The Impact of Care Load on Unpaid and Paid Care Work Hours Across Quartiles

To examine how care load shapes work patterns, we analysed both unpaid and paid care work hours across the four care load quartiles, at two time points: During the pandemic and post-pandemic. This approach allows us to observe not only the distribution of work hours but also to identify shifts over time.

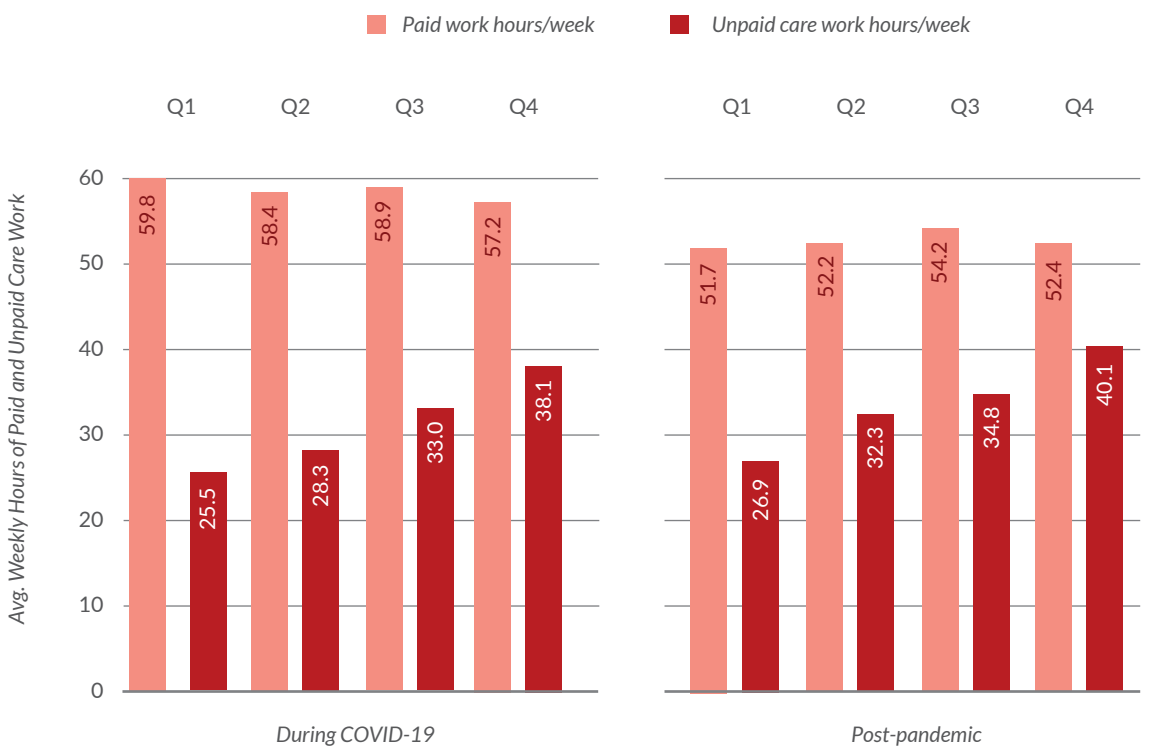
Our analysis specifically considers the double burden, which, as described in the conceptual framework, is the phenomenon where individuals juggle both paid employment and an extensive share of unpaid caregiving responsibilities. By associating work hours with care load quartiles, gender, and the presence of other family members in the household, we can better understand who bears the brunt of this double burden.

A consistent pattern emerged upon further analysis: Unpaid work hours differed significantly across care-load quartiles, with higher quartiles reporting substantially more hours.[5]

In contrast, paid work hours did not differ significantly across quartiles at either time point[6], remaining relatively stable at 51.6 to 54.2 hours per week, regardless of care load (Figure 4.1.4). As a result, respondents in Q4 experienced the longest total weekly workload when combining paid and unpaid care work hours, highlighting a pronounced double burden, which potentially heightens risk of overwork or burnout. This pattern aligns with household composition data, where Q4 households had the most dependents and the highest care intensity.

FIGURE 4.1.4

Average Hours of Paid and Unpaid Care Work per week across Care Load Quartile (During COVID-19 and Post-pandemic) (n = 1,534)



5 Welch's ANOVA showed there is statistically significant difference in unpaid care hours among the four care-load quartiles during the pandemic. As care load increases, so do unpaid hours. Full analysis in Appendix 4.1.5 of the companion appendix.
6 Welch's ANOVA showed there is no significant difference in paid care hours among the four care-load quartiles during the pandemic. Full analysis in Appendix 4.1.6 of the companion appendix.

When examining Malaysians more closely by gender, both unpaid and paid work hours varied across care-load quartiles. *Across all quartiles, women consistently spent more time on unpaid care work than men* (Table 4.1.4), with women averaging an additional 4.4 hours per week during the pandemic and 4.0 hours per week post-pandemic. Particularly, post-pandemic, the gender gap in unpaid care work amongst Q4 respondents was especially pronounced, with women reporting an average of 42.9 hours per week, about six hours more per week than their male counterparts.

TABLE 4.1.4

Average Unpaid Care Work Hours Per Week by Gender amongst Malaysians Across Care Load Quartile (During COVID-19 and Post-Pandemic) (n = 1,221)

	During COVID-19	During Post-pandemic
Q1	22.9	25.7
	26.7	28.9
Q2	23.6	28.8
	30.3	31.1
Q3	33.3	36.0
	35.1	39.8
Q4	35.1	36.2
	40.4	42.9

TABLE 4.1.5

Average Paid Work Hours Per Week by Gender amongst Malaysians Across Care Load Quartile (During COVID-19 and Post-Pandemic) (n = 1,221)

	During COVID-19	During Post-pandemic
Q1	63.4	51.8
	58.0	49.2
Q2	59.9	49.9
	56.9	49.5
Q3	60.0	53.6
	57.3	50.6
Q4	56.3	50.3
	56.5	49.4

Meanwhile, paid work hours declined slightly for both genders post-pandemic, but remained relatively stable across quartiles (Table 4.1.5). This likely reflects the increased demands of paid care work during the COVID-19 pandemic. Notably, men in lower care load households (Q1) reported the highest average paid work hours during COVID-19 at 63.4 hours per week. The decrease in paid work hours to 56.3 hours per week amongst men in the highest care-load households (Q4) appears to suggest that those within lower care loads households are able to prioritise undertaking more paid care work. Women's paid work hours were more stable, averaging around 57.2 hours per week during the pandemic and 49.7 hours per week post-pandemic. *Overall women consistently experienced a dual burden, maintaining similar paid work hours while shouldering more unpaid care responsibilities, particularly in high care load households.*

The time burden in Q4 is especially acute for women, who consistently reported higher unpaid care work hours than men. Notably, during the pandemic, ***Malaysian women in Q4 reported an average of 40.2 hours of unpaid care work per week, which has, post-pandemic, increased to 42.9 hours per week—equivalent to a full-time job.*** *More broadly, unpaid care hours increased across all quartiles and for both genders in the post-pandemic period, highlighting a persistent intensification of household responsibilities.*

When looking at migrant domestic workers, it is clear that despite how demanding their paid care work was, especially for live-in domestic workers, they were managing high unpaid care work demands as well. For migrant domestic workers, undertaking transnational unpaid care typically takes the form of calling and checking in with family, as well as managing family affairs from afar, especially financially. The amount of time reportedly spent on unpaid care work for migrant domestic workers remained consistent across the three key timepoints (before, during, and post-COVID-19 pandemic), averaging approximately 28.3 hours per week, or roughly 4.0 hours a day across time.

TABLE 4.1.6

Number of Hours of Unpaid Care Work Reported by Migrant Domestic Workers Across Timepoints

Migrant domestic workers	Before COVID-19	During COVID-19	After COVID-19
	28.3 hrs	27.6 hrs	29.1 hrs

Spousal Presence: Impacts on Paid and Unpaid Care Work Hours

To understand how having a spouse in the household influenced unpaid and paid care work hours during the pandemic, separate analyses were conducted for Malaysian men[7] and women.[8] Results showed statistically significant differences in both domains by gender:

- ***Unpaid care work:*** Women with a spouse performed significantly more unpaid care work hours per week (35.8 hours) than those without a spouse (25.7 hours), representing a 10-hour increase in unpaid care work when a spouse is present. Interestingly, men with a spouse performed an additional 12 hours more unpaid care work hours per week (32.9 hours per week) than those without a spouse (20.9 hours per week).

  While marriage appears to redistribute unpaid care work towards men, reflected in the higher increase in hours for them, it also seems to have a similar effect on women. The gendered division of labour, however, is not equal within marriages as women still perform significantly more hours than men. This reorganisation of labour, while encouraging men to undertake more, simultaneously imposes greater unpaid care load on women as well.

- ***Paid work***: Women with a spouse reported fewer paid care work hours per week (56.1 hours per week) than those without a spouse (61.2 hours per week), suggesting marriage may constrain the amount of time women are able to allocate to paid work. No significant difference was observed in men's paid work hours, indicating a contrast with the gendered pattern seen among women, suggesting marriage does not meaningfully alter men's paid work commitments, but it does for women.

These findings affirm the experiences of Malaysian women, wherein the presence of a spouse typically leads to an increased care burden. Interestingly, though, both men and women took on significantly more unpaid care work when living with a spouse during the pandemic. *However, the overall unpaid care burden remained heavier for women than for men (35.8 vs. 32.9 hours), regardless of spousal presence.* This may reflect households with greater care needs, such as those with more dependents or intergenerational living arrangements, where the total time spent on unpaid care work increased. Even in settings where more household members are present, women appear to continue to shoulder a disproportionately higher share. Findings 3 and 6 will further delve deeper into the impact of paid and unpaid care work on wellbeing.

The overall unpaid care burden remained heavier for women than for men (35.8 vs. 32.9 hours), regardless of spousal presence.

7 Statistical significance was determined in weekly unpaid work hours (during COVID-19) among men, by presence of spouse in the household, with significance set at $P < 0.05$. See Appendix 4.1.7 of the companion appendix for full results.
8 Statistically significant was determined in weekly unpaid and paid work hours (during COVID-19) among women, by presence of spouse in the household, with significance set at $P < 0.05$. See Appendix 4.1.8 of the companion appendix for full results.

Elderly Persons Presence Impacts on Unpaid Care Work Hours

To assess whether the presence of elderly members within a household contributes to higher unpaid care work hours, and potentially signals intergenerational caregiving, further analysis was conducted for both the COVID-19 period and the post-pandemic period.[9] Interestingly, *during the pandemic households with elderly members reported slightly lower average unpaid care work hours than those without (29.4 vs. 31.4 hours per week, respectively).* Similarly post-pandemic, households with elderly members reported lower average unpaid care hours (31.3 hours) compared to those without (34.0 hours).

Linda, Doctor, East Malaysia

Partly because I always have my mom. They are just around and it's easy for me to just pop in and see if she's alright. And I've got my siblings who's [sic] around as well who could always come by. Even if we had COVID, they could come in and give us some daily requirements if we need it.

While the differences are not statistically significant, the direction of the results is notable as households with elderly members tend to report slightly lower unpaid care hours than those without. This contradicts the common assumption that elderly presence uniformly increases care burden. One plausible interpretation is *intergenerational care sharing,* where older household members may be contributing to, rather than solely requiring, care.

This finding aligns with our qualitative data in many multigenerational households, where grandparents often assist with child-rearing, cooking, or daily chores, especially during times of stress like the pandemic. Rather than being passive recipients of care, the elderly may be active participants in maintaining household functioning (Scott et al. 2020).

Kaina, Social Care Worker, Central Malaysia

As long as I was on duty, it was my mother-in-law who helped me look after my children.

The data suggest a more nuanced view of multigenerational living, not merely as a source of increased care demands for women, but as a potential structure of mutual support, where care flows both ways. This trend points to intergenerational reciprocity, with elderly members possibly helping to ease care burdens—an important insight for policies on aging and family-based care.

4.1.2

Inequality 2: Wage Disparity Among Care Workers

Unequal Returns to Experience in Care Work

Hospital cleaners form an essential, yet persistently undervalued segment of Malaysia's healthcare workforce. While their roles are critical to maintaining hygiene, infection control, and day-to-day operations within hospitals, their compensation and working conditions reflect structural inequalities in the healthcare sector.

This type of labour is typically taken up by older workers, often due to barriers in accessing other forms of formal employment. These barriers, such as lower levels of education and structural barriers in the labour market, disproportionately affect older women. Nationally, according to Women's Tribunal Malaysia (2021), it is estimated that around 85% of hospital cleaners are

women, demonstrating a clear gendered segregation in this undervalued form of work. As highlighted in KRI (2020), the increase in women's labour force participation rate coincided with higher educational attainment among women. However, the report also highlights that women, particularly those residing in urban areas and holding post-secondary education were more likely to experience unemployment. This trend is reflected in our sample: Hospital cleaners averaged 39.5 years of age, with a median age of 41, and 15.4% of them were in their 50s and 60s.[10] The data suggest that their presence in these roles is not merely by choice, but shaped by systemic exclusion from other economic opportunities.

Despite having an average of 9.3 years of experience, hospital cleaners earned a median monthly income of just RM1,500, with negligible variation across experience bands (Figure 4.1.5). This reflects reports emerging, for example, from CodeBlue (2022), where a hospital cleaner with 15 years of service earned RM1,200, nearly the same as a new entrant. Their wages appear to track minimum wage levels rather than tenure, skills, or contribution, indicating a stagnant wage structure that fails to recognise or reward long-term commitment. This unfair wage structure is further maintained and reinforced by the system of contracting and subcontracting, wherein workers relinquish their seniority with each new arrangement. The implications are especially severe for women hospital cleaners, many of whom are sole income earners, a phenomena further explored later in this Finding when we examine marital status and household income level by gender. Their dual role as breadwinners and caregivers magnifies the impact of stagnant wages and insecure employment, leaving them disproportionately vulnerable despite years of experience in frontline work.

However, the presence of a progressive wage scale does not necessarily imply fairer returns to experience. For example, nursing professionals have more structured pay scales that provide gradual increases in income over time. However, even this progression remains modest. In our sample, *98% of nurses held tertiary-level qualifications,* yet their monthly earnings typically ranged from RM3,000 to RM5,000 after more than a decade of service. These pay scales remain low relative to their education, responsibilities, and work experience.

The result is a clear picture of *unequal income progression within the health sector.* While nurses face undervaluation despite their qualifications and workload, hospital cleaners experience near-total wage stagnation over time. Both care worker groups face structural limitations, but the severity is most acute for those who are perceived to be undertaking lower-skilled jobs (in this case, the hospital cleaners).

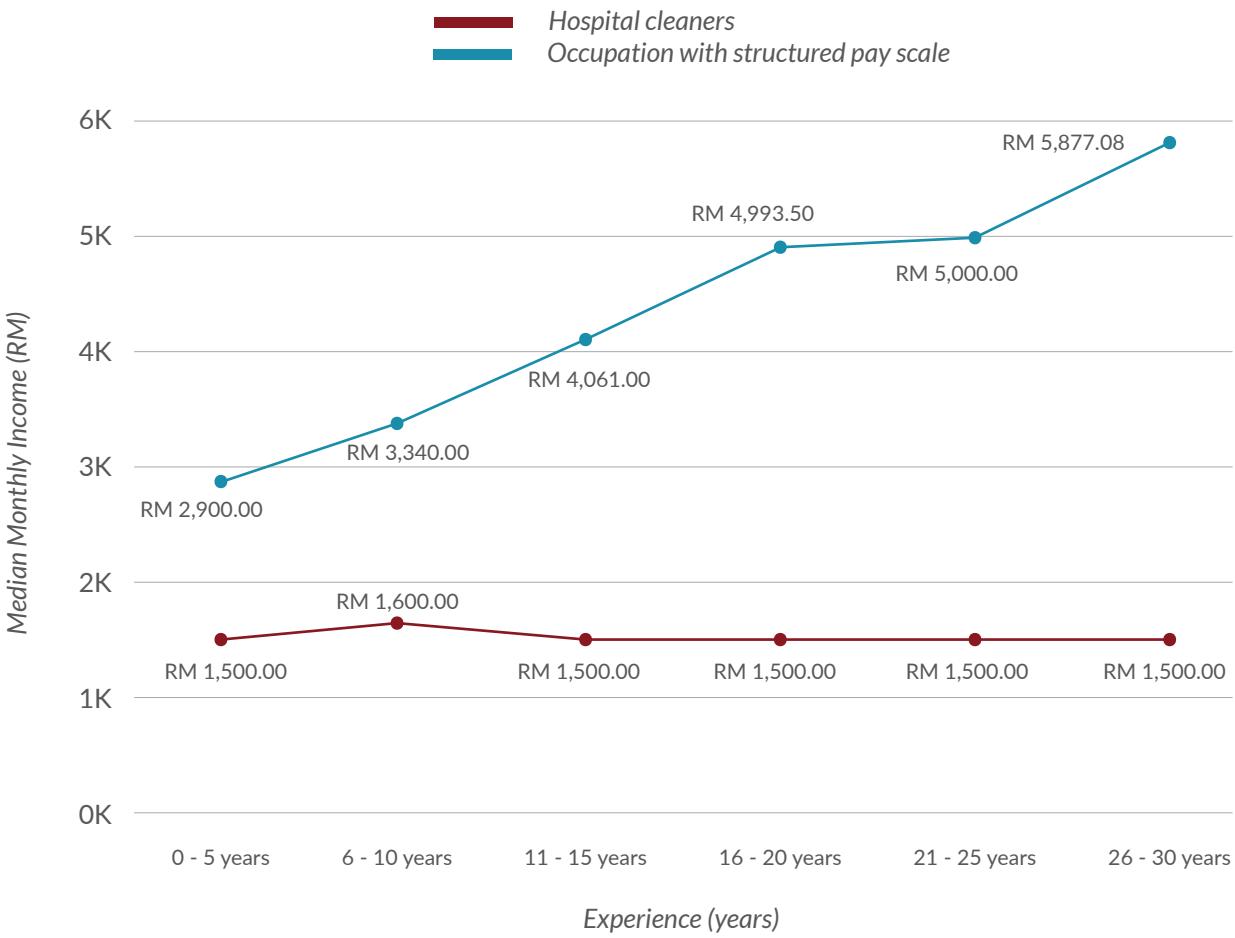
Hospital cleaners do not earn more by staying longer in their jobs, as they are ***excluded from time-based wage progression systems.***

As cleaners themselves often articulate, *working for a longer period does not mean earning more,* a reflection of how deeply wage inequality is embedded within the care economy. Compounding this, *hospital cleaners in our study worked an average of 55.2 hours per week—nearly equivalent to the hours logged by doctors and nurses and, in many cases, exceeding formal full-time thresholds.* Yet this intensive labour continues to be undervalued, underpaid, and excluded from institutional pathways to wage growth.

10 Descriptive Statistics in Appendix 4.1.10 in the companion appendix.

FIGURE 4.1.5

Median Monthly Wages by Years of Experience: Hospital Cleaners vs. Structured Pay Occupations



While those in structured pay scales benefit from consistent, seniority-based wage progression, others, particularly hospital cleaners and domestic workers, are trapped in static wage bands, with median incomes that remain stagnant regardless of years of experience (Figure 4.1.5). This is not only unjust, but economically marginalises care workers who play critical roles in hospital sanitation, safety, and pandemic response. This issue also carries long-term economic costs, as these workers may have less savings for old age. Given that there is no comprehensive social protection floor, these gaps exacerbate their vulnerabilities.

ii Gendered and Regional Disparities in Care Workers Wages

Domestic work remains a highly feminised sector in Malaysia, with the vast majority of workers being migrant women. Descriptive analysis of our survey data highlights ongoing and substantial wage disparities within Malaysia's domestic care sector.[11] Personal incomes among domestic workers consistently reflect low wages, insufficient to support their own needs or provide for family members, whether in Malaysia or in their home countries (ILO 2020). Median incomes across various regions remain notably low, emphasising a persistent undervaluation of domestic labour.

11 Descriptive Statistics in Appendix 4.1.11 in the companion appendix.

Migrant domestic workers in our sample averaged 35 to 36 years of age, and most had worked in Malaysia for an average of seven to eight years. Despite substantial tenure among domestic workers, our analysis shows that region was the strongest predictor of income disparities. Work arrangement (live-in vs. live-out) had no significant effect on earnings. At the same time, experience was positively associated with income, though the effect was modest, with only slight increases per additional year of experience.[12]

During the pandemic, the majority of migrant domestic workers in our sample (68.8%) were employed in live-in arrangements. Such roles are typically associated with longer working hours and greater responsibilities, as migrant domestic workers are viewed as at the disposal of employers' whims and demands (Galen Centre 2022). *Live-in domestic workers reported significantly extended work hours, averaging between 68 to 70 hours per week, substantially exceeding standard full-time working hours.* In contrast, live-out domestic workers reported hours closer to standard full-time working hours, averaging between 44 to 46 hours per week during the pandemic.

Sephia, Indonesian Domestic Worker, East Malaysia

Kerja lebih masa tapi gaji tidak naik. Lebih kurang begitu lah gaji tidak ada naik time-time COVID lah.

English translation

Working overtime but salary not increasing. More or less, the salary has not increased in the COVID time.

Despite the substantially longer working hours during the COVID-19 pandemic for those in live-in positions, increased working hours did not equate to significantly higher wages. Filipino live-in workers reported a median monthly personal income of RM1,700, only slightly higher than their live-out counterparts' median income of RM1,600. Indonesian live-in workers reported even lower median monthly incomes of RM1,200, compared to RM1,500 for live-out workers.

This discrepancy demonstrates that live-in roles, despite longer working hours, are associated with significantly lower and inconsistent hourly wages.[13] Though live-in roles are underpaid given their longer working hours, it is also important to note that live-out migrant domestic workers must also manage finances associated with cost of living, from rent to food and other necessities. Broadly, then, under both circumstances, migrant domestic workers face systemic undervaluation and inadequacy of their financial compensation (Table 4.1.7).

TABLE 4.1.7.
Work Hours and Income Per Hours by Living Arrangement for Domestic Workers During the Pandemic

Living arrangement	Average work hours per week	Average wage per hour
Live-in	10.97	RM5.92
Live-out	7.95	RM9.81

12 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.1.12 of the companion appendix.
13 Statistical significance was determined using independent samples t-test. Variables were considered significant at **P** < 0.05. See Appendix 4.1.13 in the companion appendix for full results.

This trend extends to East Malaysia, where domestic workers' earnings remain below the national minimum wage. (Table 4.1.8) These regional disparities reveal ongoing structural economic inequalities faced by migrant domestic workers in Malaysia, with the especially pronounced penalty in East Malaysia concerningly suggesting possible differences in enforcement of labour protections.

Workers with extended tenure, often exceeding 15 years, typically do not experience wage increments that reflect their years of dedicated service. This scenario reflects structural challenges, including a lack of bargaining power and inadequate regulatory protections, further reinforcing the economic precarity of domestic workers.

TABLE 4.1.8

Wage Gaps by Living Arrangement for Domestic Workers during the Pandemic

Region (number of domestic workers)	Median wage for Live-in domestic worker	Median wage for Live-out domestic worker
Central (99)	RM1,500	RM1,500
East Malaysia (73)	**RM1,000**	**RM1,000**
North (50)	RM1,500	RM1,500
South (91)	RM1,200	RM1,200

Note: During the COVID-19 pandemic, minimum wage was RM1,200. East Malaysia comprises Sabah and Sarawak and WP Labuan. North Malaysia includes Perak, Penang, Kedah, and Perlis. South Malaysia includes Negeri Sembilan, Johor, and Melaka. Central Malaysia comprises WP Putrajaya, WP Kuala Lumpur, and Selangor. No domestic workers from the East Coast, which includes Kelantan, Terengganu, and Pahang, were represented in our survey.

This is also in line with what was initially highlighted in Chapters 1 and 2, where, despite how domestic workers have a minimum wage set by Memorandums of Understanding (MOUs) between countries, enforcement can be weak or poor, leading to differential enjoyment of rights. These MOUs also appear much harder to enforce in East Malaysia, given the large disparity between migrant domestic workers in East Malaysia and Peninsular Malaysia. In roundtable discussions with East Malaysian domestic worker representatives, we were informed that states like Sabah, for example, lack agents or agencies for recruitment. In Peninsular Malaysia, agents and agencies appear to be most responsible for ensuring migrant domestic workers have contracts documenting the appropriate minimum wage.

4.1.3. *Inequality 3: Economic Inequality*

Economic and Care Burden in Low-Income Level Household

Understanding household dynamics is crucial for uncovering how families allocate both time and resources between unpaid care and paid work, and, just as importantly, for exposing the economic vulnerability faced by care workers. This analysis moves beyond simple counts of unpaid care hours, focusing also on

each household's capacity to financially support its members. Relying on national income brackets alone fails to capture critical differences in household size and composition, particularly the ratio of dependents to income earners.

For example, under Malaysia's national income classification, a household earning RM6,000 per month is labeled "M40." Yet this label is meaningless without knowing whether that income supports one adult or a single breadwinner with five dependents (including an elderly parent and three children). Two households with the same income may experience vastly different economic realities, depending on how many people rely on that income.

Similarly, a single-person household earning RM3,000 and a three-person household earning RM9,000 are assigned to different income brackets, despite comparable per-capita resources and living standards. To address these blind spots, we calculate household income per capita by summing all reported sources—salaries, wages, remittances, and informal income—and dividing by the total number of household members. While this per capita approach facilitates comparisons across diverse household structures, it relies on the simplifying assumption that each member has similar needs and consumption patterns and does not account for economies of scale that arise when individuals share housing, utilities, or other resources (Table 4.1.9).

TABLE 4.1.9

Household Income Level Classification

Income Level	Category	Meaning
Income Level 1 (IL1)	The bottom 25% of per-capita incomes	Households facing the greatest economic constraints.
Income Level 2 (IL2)	The 25th-50th percentile	Households with low to moderate per-capita income.
Income Level 3 (IL3)	The 50th-75th percentile-households with moderate to upper-middle per-capita income.	Households with moderate to upper-middle per-capita income.
Income Level 4 (IL4)	The top 25% of per-capita incomes	Households with the highest per-capita income.

ii *Household Income Level during COVID-19*

To examine economic inequality and hardship among household income groups during COVID-19, we conducted cross-tabulations by key demographics (gender, education, marital status) and occupational characteristics to identify which groups are most at risk.

To note, domestic care workers were excluded from the main analysis of household income per capita due to the distinct nature of their employment and household arrangements. In our sample, all of the domestic workers were women, and most (68.7%) were employed as live-in workers. Unlike other respondents, domestic workers were also migrants, and their households are their families back in their home countries. Their income is often sent abroad as remittances, meaning their household economic context is shaped by cross-border family dynamics and dependency patterns, rather than local cost of living and co-resident dependents.

The geographical distribution of household income among our survey respondents reveals stark regional disparities. In Sabah, Sarawak, and the east coast, nearly half of respondents (40.3% to 48.1%) fall into the two lowest income groups, IL1 and IL2. In contrast, a greater proportion of households in the south, central, and north regions are concentrated in the higher income groups (IL3 and IL4), ranging from 61.4% to 62.9%. These figures reflect the composition of our survey sample and may not represent the population-level distribution due to differences in sample sizes across regions, but suggest regional disparities within our survey sample.

iii *Economic Vulnerability and Gender Disparities Across Household Income Levels*

When we divide income per capita into quartiles, households in the lowest quartile (IL1) have a median household income of RM375.00 per capita. In 2019, the Department of Statistics Malaysia (DOSM) set the national poverty line income (PLI) at RM2,208.00 per household. With an average household size of 3.9 persons (DOSM 2020), this translates to a per capita poverty threshold of about RM566.15. This means that *IL1 households fall well below the national poverty line, highlighting their acute economic vulnerability.* Even amongst IL2, the median per capita income remains low, at RM700.00, underscoring persistent hardship among a significant segment of the population (Table 4.1.10).

TABLE 4.1.10

Household Income Level, by Percentage of Respondents Across Gender

Income Level	Per Capity Mean Household Income (RM)	Per Capita Median Household Income (RM)	Number of respondents, n	Women (%)	Men (%)
Income Level 1 (IL1)	356.23	375.00	470	20.4	18.2
Income Level 2 (IL2)	698.54	700.00	299	20.9	17.2
Income Level 3 (IL3)	1,265.21	1,250.00	390	31.2	24.3
Income Level 4 (IL4)	3,712.28	3,000.00	375	27.5	40.2

The gender distribution across household income levels reveals significant disparities in economic status. Among men, the largest proportion is concentrated in the highest level (IL4), with 40.2% of male respondents falling into this group, while only 18.2% are in the lowest level (IL1). In contrast, women are more evenly distributed across income levels, with the highest concentration in the third level (IL3) at 31.2%, and only 27.5% reaching the highest level (IL4).

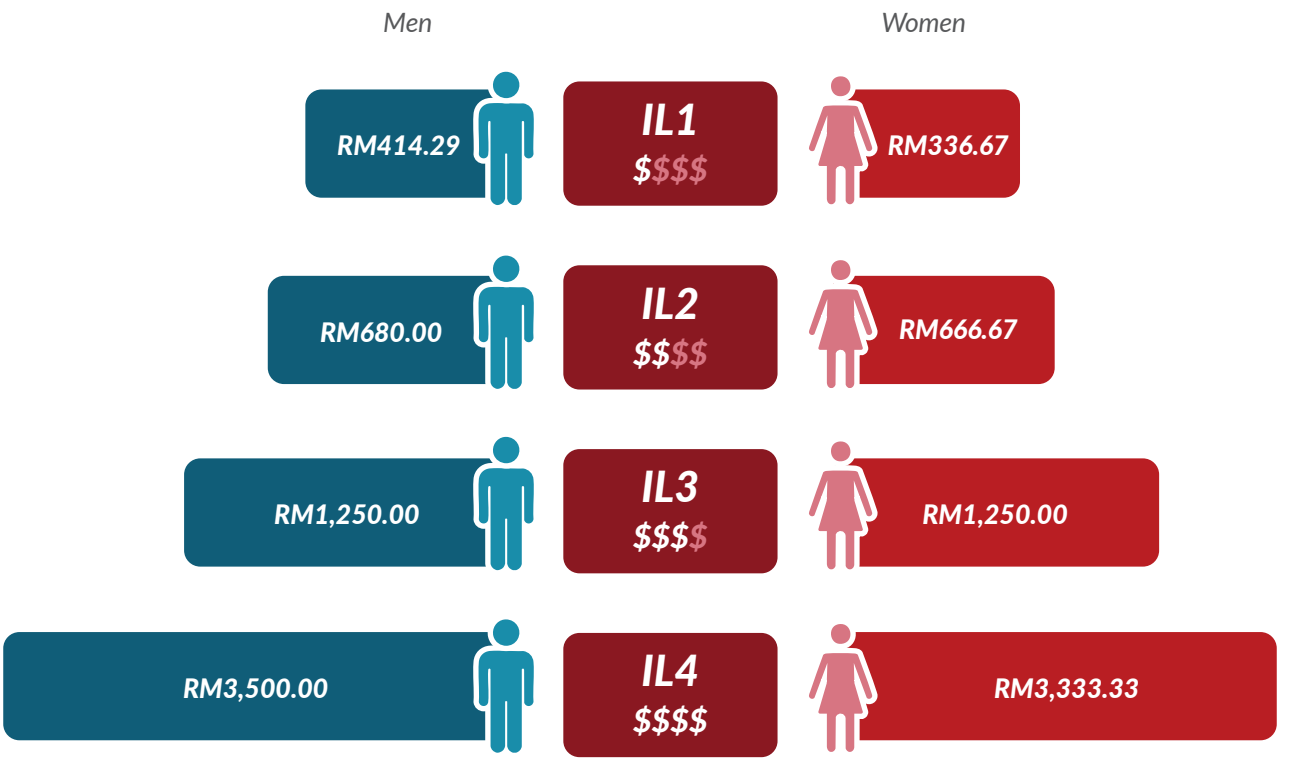
Across all household income levels, men's reported income is consistently higher than women's, with the disparity most pronounced in IL4: Men report a median of RM3,500.00, while women report RM3,333.33 (Figure 4.1.6). At IL1, the difference is narrower but still evident. This consistent gap across all levels reflects a persistent gender income disparity. Notably, a greater proportion of women than men are found in both the lowest (20.4% vs 18.2%) and second lowest income levels (20.9% and 17.2%) (Table 4.1.10).

In sum, men are more likely to be found in the highest income households, while women are overrepresented in the lower and middle income levels. This suggests that household financial strain is potentially gendered. This appears to be a reflection of structural inequalities, including the aforementioned lower wages earned by women, as their educational attainment does not obtain the same earning potential as men (Haan 2008), as well as how they are more likely to engage in precarious work (for example, as hospital cleaners).

Women are overrepresented in the lower and middle income levels. This is appears to be a reflection of structural inequalities, including the lower wages typically earned by women.

FIGURE 4.1.6

Median Household Income by Gender and Income Level



Analysis of household income levels by gender and occupation reveals persistent disparities and occupational patterns that reinforce income inequality within the care sectors. In our sample, among women in the lowest household income level, 45.0% are nursing professionals and 28.3% are hospital cleaners. For men, the lowest income group is dominated by hospital cleaners and those in specialised care roles. These occupational trends highlight how gendered and job-based segmentation continues to contribute to unequal income distribution and economic vulnerability within care work, reaffirming issues highlighted in Chapter 2.

Education is a strong predictor of household economic status. In the highest quartile, IL4, half of the respondents (50.1%) have attained tertiary education, while the proportion with lower education levels is minimal. By contrast, households in the lowest quartile (IL1) are more diverse where 41.9% have secondary education, 40.6% primary education, and 70.0% of those with no formal

education fall into this group. Strikingly, a small but notable share (11.8%) of tertiary-educated individuals are also found in IL1, suggesting that higher education does not uniformly guarantee economic security.

Generally, education is associated with improved economic outcomes, with tertiary graduates typically enjoying higher earnings and greater resilience against poverty (Psacharopoulos and Patrinos 2018; UNESCO 2022). Yet, the presence of highly educated households within the lowest income group suggests that education alone does not shield care worker families from economic vulnerability. This is potentially linked to the undervaluation of paid care roles, stemming from issues highlighted in Chapter 2. These findings emphasise the need to move beyond education as the sole explanatory factor and to examine the intersecting social and economic conditions that shape household precarity for care workers.

iv *Marital Status and Household Income Level by Gender*

A comparison of marital status across household income per capita reveals distinct gendered patterns of economic vulnerability and advantage. Among women in our sample, those in IL1 are disproportionately divorced or separated (14.8%), while the shares of never married (21.2%) and married or partnered (64.0%) are much lower compared to other household income levels. This pattern indicates that women who are divorced or separated are more likely to be concentrated in the lowest income level, reflecting the well-documented financial precarity associated with marital dissolution for women. In recalling the profiles of hospital cleaners, it is notable that a majority of women in this group tend to be the sole income earners in their households. This dual role as breadwinner and caregiver compounds their economic vulnerability.

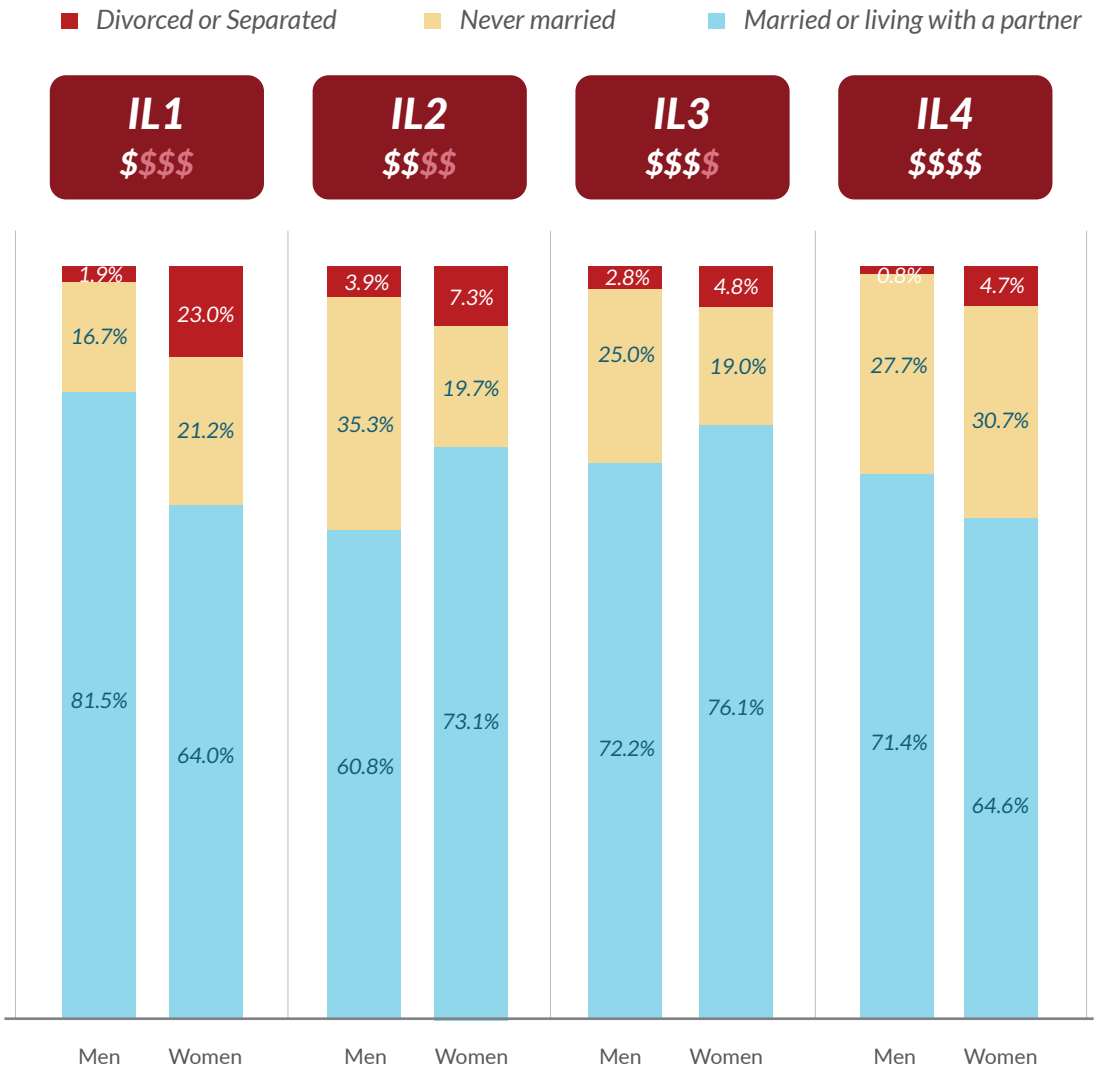
As income rises, the share of divorced or separated women declines, dropping to just 4.7% in IL4. Notably, among women, single-person households make up the largest proportion within IL4, reflecting their high concentration among higher household income groups. This is consistent with the idea that per capita income can appear higher in single-person households since it is not divided among multiple members.

For men, the distribution looks very different. Across all income levels, divorced or separated men make up only a small proportion, ranging from 1.9% in IL1 to only 3.9% in IL2. In contrast, the overwhelming majority of male care workers remain married or partnered, with consistently high proportions between 60.8% and 81.5% (Figure 4.1.7). This indicates that divorce or separation does not carry the same economic penalty for men as it does for women. This gendered asymmetry extends beyond care workers, aligning with a wide body of evidence, both internationally and in Malaysia, showing that divorce disproportionately undermines women's economic security (Smock et al. 1999; Avellar and Smock 2005; Hogendoorn et al. 2020; Women's Aid Organisation 2024; SIS Forum 2025).

Women who are divorced or separated are more likely to be concentrated in the lowest income level, whereas across all income levels, divorced or separated men make up only a small portion. This reflects the well-documented financial precarity associated with marital dissolution for women.

FIGURE 4.1.7

Breakdown of Malaysian Respondents across All Income Levels by Gender and Marital Status During the COVID-19 Pandemic (%) (n = 1,221)



v Unpaid and Paid Work Hours Across Household Income Level

To examine how household income level shaped time use, we analysed weekly unpaid and paid care work hours across household income levels (IL1-IL4) at two time points: During the COVID-19 pandemic and post-pandemic.

During the pandemic, there are statistically significant disparities in both unpaid and paid care work hours.[14] Households in IL1 and IL2 consistently performed more unpaid care work, averaging 36.5 to 37.1 per week, respectively, compared to just 24.9 hours per week among households in IL4. Post-pandemic, rather than declining, unpaid care hours increased for most groups, with IL1 and IL2 households reporting 37.8 and 39.0 hours per week; only IL4 households saw a modest increase to 27.0 hours per week.

These patterns suggest that the inequality appears entrenched, as these households still undertake more unpaid care work than their counterparts in higher

14 Welch's ANOVA shows there is significant difference in unpaid and paid care work hours across household income levels during the pandemic, where significance was set at $P < 0.05$. Full analysis in Appendix 4.1.14 in the companion appendix.

household income levels. This may reflect the limited capacity of lower-income households to redistribute, outsource, or delegate caregiving responsibilities, particularly in times of crisis, potentially owing to facing financial strain, thus having less resources to hire additional assistance for the household. As highlighted in an earlier analysis of unpaid care work across care load quartiles, the post-pandemic period saw how the gap in unpaid care hours widened.

In contrast, paid work hours followed the opposite trend, with households in IL4 reporting the highest average paid work hours (61.8 hours per week) during the pandemic, while those in IL1 and IL2 worked fewer hours (55.3 and 54.8 hours, respectively). These differences were also statistically significant, suggesting that higher-income households not only assumed less unpaid care responsibility but also maintained greater access to paid employment. We must note that while there is a very weak correlation between number of hours of paid care work and per capita household income, the relationship between the two is more complicated and there are likely more factors at play. For example, there may be underlying occupational segregation with wage structures where simply working more paid hours would not result in significant increases in earnings. Nonetheless, taken together, this highlights a dual inequality faced by lower-income households: Greater unpaid care burdens coupled with reduced paid work hours, underscoring structural constraints faced by lower income households.

After the pandemic, a statistically significant difference remained in unpaid care hours across income quartiles.[15] IL1 and IL2 households continued to report the highest number of unpaid care hours (37.8 and 39.0 hours per week, respectively), while IL4 reported the lowest (27.0 hours per week), reinforcing the persistence of income-based unpaid care load inequalities. In contrast, differences in paid work hours across income levels were no longer significant, suggesting a levelling effect in paid labour participation post-pandemic. While unpaid care work remains unequally distributed, access to paid work may have become more equal across income groups in the recovery period. This trend is likely because certain care occupations, such as childcare workers and live-out domestic workers, were less able to take on regular hours of work during the pandemic, due to childcare centres being shut down or employers who wanted to maintain social distancing. Post-pandemic, these occupations may have been able to return to more regular hours. Simultaneously, occupations which saw high increases in paid work hours during the COVID-19 pandemic, such as those in healthcare, as well as social workers, also saw a return to more regular hours post-pandemic. Consequently, the gaps in hours spent on paid care work appear to have closed between respondents.

vi *Income, Care Load, and Household Composition: Exploring the Care–Finance Squeeze*

Economic inequality among care worker households is often masked by headline income numbers. Our income per capita data, segmented by care load quartiles, exposes a hidden crisis: As household size and care responsibilities increase, per capita income decreases. This means families with the highest care demands are left with the least to go around, even if they technically have more income earners.

Using this income level measure, we examine how household income interacts with care load quartiles to examine how economic sufficiency, household composition, and the distribution of unpaid care responsibilities intersect with patterns of paid employment and demographic characteristics.

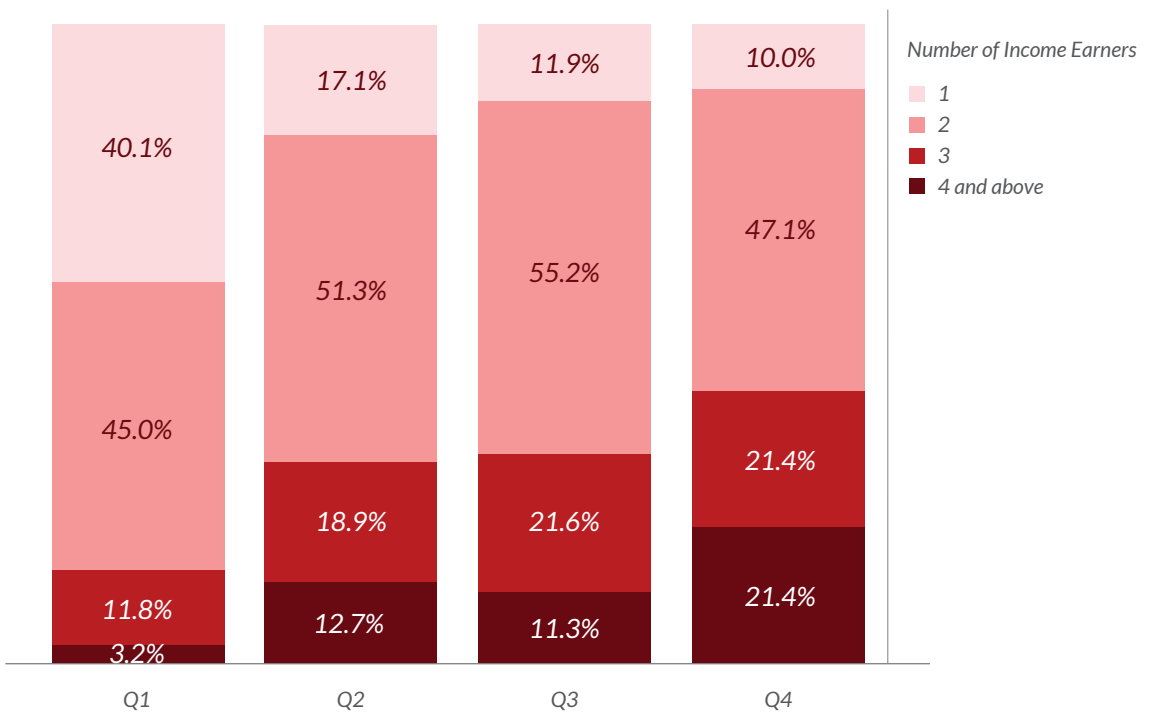
Analysis of household characteristics across care load quartiles reveals a clear pattern: As care load increases,

15 Welch's ANOVA shows there is significant difference in unpaid work hours across household income levels post-pandemic, where significance is set at $P < 0.05$. Full analysis in Appendix 4.1.15 in the companion appendix.

so does the number of people contributing income within the household. About half of households in Q1 (lowest care load) had just one income earner, and only 3.2% had four or more. As care demands increase, the proportion of households with multiple income earners rises sharply. In Q4 (the highest care load quartile), the share of households with three or more earners is significantly higher. This trend suggests that higher-care-load households tend to have more members engaged in income-earning activities. One plausible explanation is that these households are larger, requiring both more caregiving and financial contributions. Alternatively, the need to balance intense care responsibilities may necessitate distributing both paid and unpaid work across more adults in the household (Figure 4.1.8).

FIGURE 4.1.8

Distribution of Income Earners Across Care Load Quartile (%)



This points to a *care-finance squeeze,* where families in the highest care load quartile (Q4) face both intensive caregiving responsibilities and financial strain. The analysis reveals a clear pattern of double burden among Q4 households, where respondents reported the longest total weekly workload when combining unpaid and paid work hours, as shown in subsection iv. The Impact of Care Load on Unpaid and Paid Care Work Hours. There is, thus, heightened risk of overwork and burnout among high-care load households.

These patterns indicate that as care demands intensify, households tend to increase their economic participation, that is, more members of the household undertake paid work, to buffer financial stress. However, this does not necessarily reduce unpaid caregiving workload. Instead, families absorb the combined pressures of caregiving and labour market engagement, stretching their time and energy, with impacts on their wellbeing, as will be explored in further findings. In essence, Q4 households exemplify the "double burden": They provide the most unpaid care and, collectively, contribute the most paid work. *Recalling how there are more women within these households,* this points to a structural pressure borne disproportionately by women, whereby care-heavy households are expected to sustain both care and income roles with limited structural support.

TABLE 4.1.11

Income Per Capita During the Pandemic Across Care Load Quartiles

Quartile	Mean income per capita (RM)	Median income per capita (RM)	Average income earners	% Large Households (≥4)	% Small Households (≤3)
Q1	RM 3,030.19	RM 2,500.00	1.8	5.8	71.0
Q2	RM 1,601.65	RM 1,250.00	2.4	25.0	17.9
Q3	RM 1,167.30	RM 979.64	2.6	34.4	10.6
Q4	RM 836.19	RM 685.00	2.8	34.9	0.5

This paradox is further illustrated by examining household composition across care load quartiles (Table 4.1.11). Households in Q1 (lowest care load) are predominantly small, with 71.0% comprising three or fewer members. In contrast, Q4 (highest care load) is overwhelmingly made up of large households; a striking 34.9% of households in Q4 are large households (≥4 persons), while just 0.5% are classified as small. Larger households bring more income earners, but also more dependents and a much higher care load, which dilutes the benefit of additional income. This is evident in Q4's median household per capita income of just RM685.00, despite more working adults. Policy frameworks that ignore household size and dependency risk perpetuate this invisible poverty among care workers. In reality, they are navigating invisible poverty, overburdened by caregiving demands, stretched financial resources, and insufficient support.

vii *Perceived Economic Sufficiency by Gender Across Care Load Quartiles*

By analysing household income per capita across care load quartiles and cross-referencing these figures with responses to the subjective income sufficiency question ("During the COVID-19 pandemic, did you feel your household income was enough to support yourself and the people you care for?"), we were able to empirically calibrate per capita income thresholds that most accurately reflect actual experiences of sufficiency. This approach provides a more robust and grounded basis for identifying economic vulnerability among our respondents.

Analysis of household income sufficiency across care load quartiles during the pandemic reveals clear gender disparities. Median household income for women is consistently and substantially lower than for men at every care load quartile, with the gap especially pronounced at the top (Q1: men RM3,000.00 vs. women RM2,000.00) and persisting at the lowest quartile (Q4: men RM750.00 vs. women RM667.00) (Table 4.1.12).

Women, especially those with higher care loads, are doubly disadvantaged: They carry more unpaid care responsibilities and have fewer economic resources.

TABLE 4.1.12

Gender Differences in Income Sufficiency and Median Income Across Care Load Quartiles during the COVID-19 pandemic

Quartile	Median income per capita (in RM)		Household income is insufficient (%)		Household income is just enough (%)		Household income is sufficient (%)	
	Women	Men	Women	Men	Women	Men	Women	Men
Q1	2,000.00	3,000.00	18.3	14.9	43.5	39.6	38.2	45.5
Q2	1,200.00	1,542.00	23.3	23.2	42.9	35.7	33.8	41.1
Q3	1,000.00	929.00	20.4	27.0	39.1	29.2	40.4	43.8
Q4	667.00	750.00	23.9	34.0	30.4	22.0	45.7	44.0

Note: Findings on gender differences in income sufficiency do not include domestic workers.

While women report slightly higher income insufficiency at lower care loads. In Q1, 18.3% of women reported their household income as insufficient, compared to 14.9% of men. In Q2, the gender gap narrows and men and women report nearly similar rates of income insufficiency.

However in Q3, the pattern flips where men reported both lower household income per capita (RM929.00 vs. women's RM1,000.00) and higher insufficiency rates (27.0% vs women's 20.4%). At first glance, this might suggest women are doing better than men, but disaggregation by occupation and household structure tells a different story. *Men in Q3 are more likely to be sole or primary earners in households with larger numbers of dependents* (eg., nurses and social workers with one income earner with three dependents). By contrast, *women in Q3 are more likely to be in multi-earner households*, which lifts per capita income even when their individual earnings are lower.

The apparent inversion in Q3 therefore does not reflect women out-earning men, but rather the unequal gender pressures of household composition where men bear the strain of being sole providers in households with multiple dependents. In Q4, the sufficiency gap widens further with 34.0% of men compared to 23.9% of women report their household income as insufficient, despite both genders experiencing extremely low income per capita. This trajectory indicates that while women face persistent economic disadvantage across care quartiles, men in higher care load households become more vulnerable under increasing economic demands when they are sole income earners.

*Men in moderate-high care-load households are more likely to be **sole income earners**, compared to women in similar households. These men are also **more likely to report their household income is not sufficient.***

TABLE 4.1.13

Median Household Income Per Capita, Income Earners, and Dependents by Gender and Occupation (Q3)

Occupation	Median income per capita (in RM)		Average number of income earner(s)		Average number of dependent(s)	
	Women	Men	Women	Men	Women	Men
Doctors	1,667.00	1,800.00	2	3	2	3
Nurses	1,000.00	1,100.00	1	1	3	3
Hospital Cleaners	375.00	500.00	1	2	3	3
Child Care Workers	600.00	**540.00**	2	**1**	2	3
Social Workers	1,200.00	**750.00**	1	**1**	3	3
Specialised Care Workers	1,050.00	**730.00**	2	**1**	2	3

FIGURE 4.1.9

Men's Reported Income Sufficiency during COVID-19, Across Care Load Quartile (%)

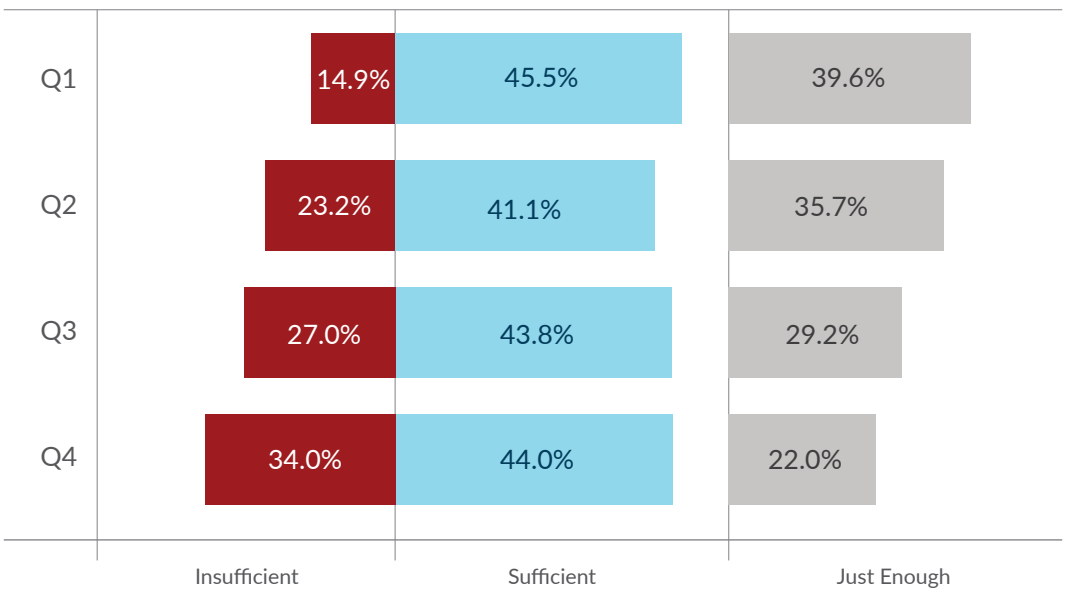
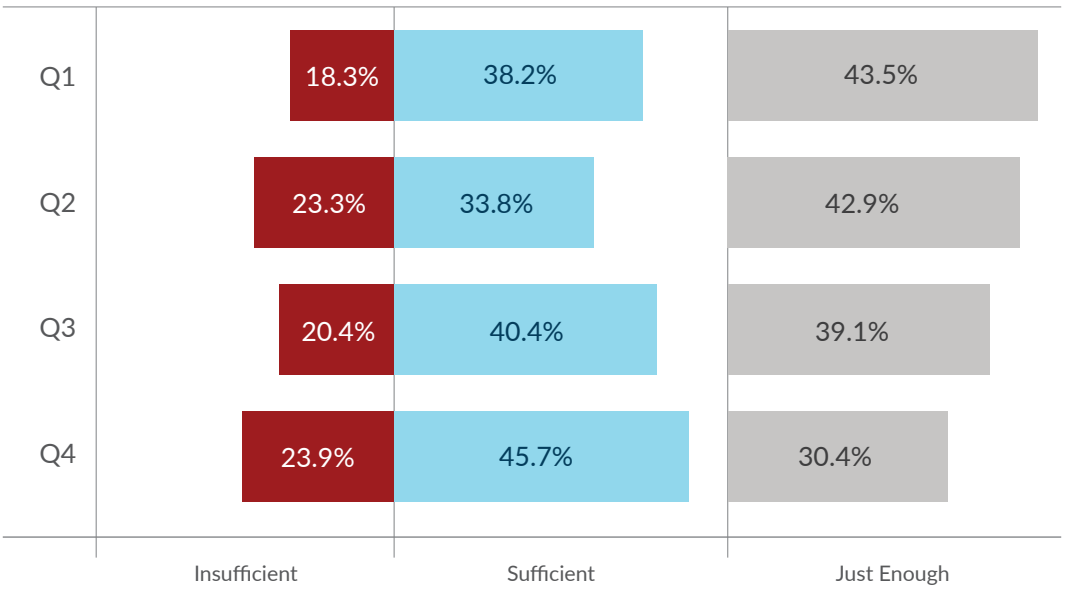


FIGURE 4.1.10

Women's Reported Income Sufficiency during COVID-19, Across Care Load Quartile (%)



A larger proportion of women than men report income as "just enough" across all care load quartiles. Among women, this sentiment declines from 43.5% in Q1 to 30.4% in Q4; for men, it drops more sharply from 39.6% to 22.0%. The tendency for women to report their income as "just enough" more often than men may suggest they are likelier to live on the economic margin, neither outright sufficient nor insufficient. However, it may also reflect the internalised expectation for women to manage within limited means; while men are more likely to expect a certain standard of income or comfort, women are often socialised to adapt and adjust. This shows in the data when women tend to have lower median household income per capita than men across most care load quartiles. Men are more likely to report their income as sufficient in lower care load quartiles (Q1-Q3), but in Q4, women slightly surpass men in reporting their income as sufficient with 45.7% compared to 44.0% (Figure 4.1.9). These findings highlight a complex gendered experience of economic adequacy, where women, despite earning less, are more likely to perceive their household income as marginally or barely sufficient (Figure 4.1.10).

Overall, gender disparities in economic security are not uniform across the care burden spectrum. While women face persistent economic disadvantage at all levels, men appear especially vulnerable as care loads intensify. This finding may seem counterintuitive, as we have established that women are more impacted by income

Women, despite earning less, are more likely to perceive their household income as marginally sufficient. Men in higher care load households are more likely to feel their household income is insufficient.

and economic inequality. We would, thus, presume that women would also explicitly agree they experience more economic vulnerability; however, we suspect that deeper gendered experiences may be at play. Money management within households is gendered. Typically, men are positioned as breadwinners, who are largely responsible for ensuring the household has enough money to support everyone's needs, whereas women undertake expenditure management, that is how the money is spent (Codod 2015; Lauer and Yodanis 2014).

In Malaysia, Yusof (2014) found that when children are present in the household, women are more likely to be the ones tasked with financial management. All of this suggests that men and women, when partnered, play different roles in terms of financial management within their households. In this, men may be more able to disclose the economic vulnerability they feel as an extension of the male breadwinner role they are expected to play. Women, on the other hand, in being tasked with managing how money is spent, are positioned to essentially make do with the money they have. This, in turn, may lead them to feel as though the income, subjectively, is enough even though, objectively, based on our analysis of the data, it may not be.

This dynamic points to a gendered tension that requires further study. Nonetheless, it is clear there is a need for gender- and care-responsive interventions to address economic inequalities within households.

Finding 2:

Wellbeing among care workers declined during the COVID-19 pandemic and has not recovered to pre-pandemic levels.

FINDING HIGHLIGHTS

This finding addresses the decline in wellbeing experienced during the pandemic and what was driving it.

1

Three-fourths of care workers (75.7%) experienced a decline in wellbeing during the COVID-19 pandemic, compared to their pre-pandemic levels of wellbeing. Most concerningly, however, is the fact that *two-thirds of care workers (67.2%) who experienced this decline have not yet recovered to pre-pandemic levels of wellbeing.*

a. These experiences of wellbeing decline are narrated where care workers detailed how the stress during the pandemic led to an impact on their physical and mental health.

b. Additionally, there was a strong theme of self-sacrifice emerging from the FGDs, as care workers shared how it felt as though they were expected to put their health and wellbeing on the line in order to ensure they could meet the increased demand for services.

c. Undoubtedly these experiences not only shaped wellbeing outcomes during the pandemic, but may potentially continue to have an impact on care workers, who often did not have much of a break between experiencing the pandemic to transitioning to endemicity.

2

Men had a slightly stronger decline in wellbeing compared to women, but when this was examined sector by sector, the gender difference disappears suggesting that there were sector-level stressors.

3

The decline in wellbeing was *shaped by a decline across all four key aspects measured:* Satisfaction with physical and mental health, job satisfaction, satisfaction with work-life balance, and satisfaction with social support.

a. *For women, the decline is strongest in satisfaction with their physical and mental health* during the pandemic.
    a. When taking into consideration perceived organisational

resilience and social support, however, women's decline in mental and physical health did not significantly differ from men's, suggesting these two aspects may be important to support women's health outcomes in times of crisis.

b. While *men experienced a steep decline in physical and mental health as well, they experienced greater decline in job satisfaction* compared to women.
c. For both men and women, the decline in satisfaction with work-life balance was strong, driven by a dissatisfaction in spending too much time on paid work and too little time on personal caregiving.
d. Finally, there was a modest decline in satisfaction with social support that was equally felt by men and women.

4.2
The Impact of COVID-19: Understanding the Decline in Wellbeing

Wellbeing within this research, as mentioned in previous chapters, comprises four aspects:

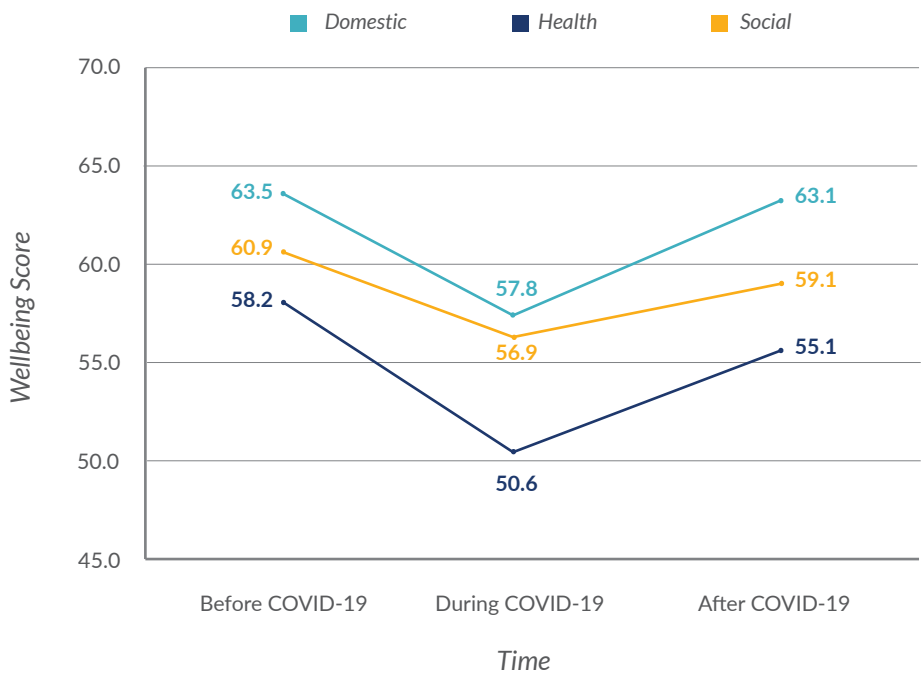
TABLE 4.2.1

Components of Wellbeing and Aspects Examined within the Component.

Component	Aspects Examined
Satisfaction with physical and mental health	Examines how satisfied respondents are with aspects of their physical and mental health, with a focus on presence of feelings of anxiety and depression
Job satisfaction	Examines how satisfied respondents are with aspects of their job, including salary, recognition and appreciation, as well as career growth and development
Satisfaction with work-life balance	Examines how satisfied respondents are with the amount of time spent on paid care work, unpaid care work, and self-care.
Satisfaction with social support	Examines how satisfied respondents are with the support received from those within their household, as well as global community support, with particular emphasis on unpaid care work

FIGURE 4.2.1

Average Wellbeing Scores across Time across Three Sectors (n=1,534)



In Figure 4.2.1, it appears that those in domestic care had the highest wellbeing across timepoints, followed by those in social care, and finally those in healthcare. However, when examining the average wellbeing scores across the three care sectors, it is clear that individuals in all three sectors experienced a significant decline in overall wellbeing during the COVID-19 pandemic.[1]

Further, while post-pandemic wellbeing levels appear to suggest recovery, it is important to note that these averages mask larger disparities, elaborated further in the next section.

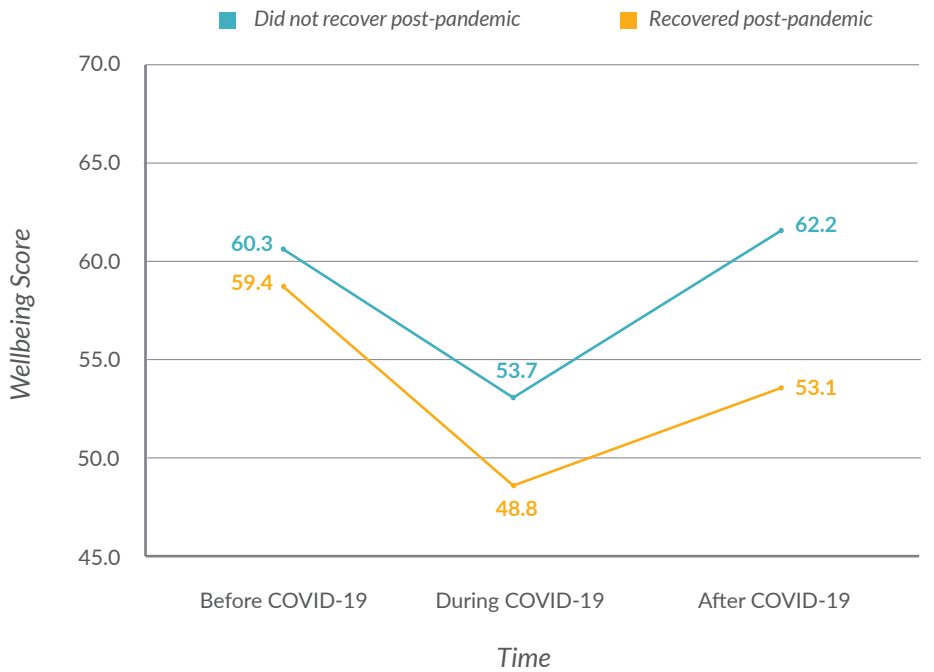
4.2.1 *Decline in Overall Wellbeing*

Broadly, *this decline in wellbeing was felt by three-fourths (75.7%) of the care workers surveyed.* Most importantly, however, is that *two-thirds (67.2%) of those who experienced this decline in wellbeing still have not recovered* to pre-pandemic levels of wellbeing[2], While Figure 4.2.1 suggests that post-pandemic, there has been recovery, when we examine those who experienced a decline in wellbeing during COVID-19 and their wellbeing post-pandemic, it becomes clear that those who did not recover have significantly lower wellbeing scores (Figure 4.2.2).[3] This suggests that a large portion of our care workers may still be feeling the impact of COVID-19 pandemic on their wellbeing.

1 Statistical significance was determined using paired t-test, at **P** < 0.05. See Appendix 4.2.1 for further details.
2 Statistical significance was determined using paired t-test, at **P** < 0.05. See Appendix 4.2.2 for further details
3 Statistical significance was determined using paired t-test, at **P** < 0.05. See Appendix 4.2.2 in the companion appendix for further details

FIGURE 4.2.2

Average Wellbeing Scores across Time by Wellbeing Recovery (n = 1,144)



This decline was impacted by the amount of paid care work and unpaid care work that was done.[4] Essentially, *the more paid care work that a care worker engaged in, the greater the decline in wellbeing.* However, *the more unpaid caregiving that a care worker engaged in, the lower the decline in wellbeing.* This suggests that, during the pandemic, having enough time for personal care responsibilities was important to supporting wellbeing. This was equally true for both men and women.

The gender difference arises when individual resilience and burnout are considered. The higher the level of individual resilience, the lower the decline in wellbeing for the care worker. On the other hand, the higher the level of burnout experienced by the care worker, the greater the decline in wellbeing. *When individual resilience and burnout were taken into consideration, it appears that men had a more significant decline in wellbeing than women*. Burnout and individual resilience will be discussed in depth in Finding 4.

When examining sector by sector, however, there is no significant gender difference.[5] This may suggest there are sector-specific stressors that had a more dominant influence on wellbeing decline than gender alone.

For example, within healthcare, the decline in wellbeing was not about how much time was spent on paid work or caregiving. Rather, their wellbeing decline was associated more with aspects such as their level of burnout and their level of individual resilience. Thus, it appears for healthcare workers, *the impact of the pandemic on their wellbeing decline was largely associated with how they were coping psychologically.* In social care, on the other hand, spending more time on paid work and experiencing burnout was most significantly associated with a decline in wellbeing, whereas individual resilience did not play a significant role in buffering this decline.

Generally, the largest decline in wellbeing occurred for those within the healthcare sector, followed by domestic care. Social care sectors appeared to have had the lowest decline.

4 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in the companion appendix, Appendix 4.2.3.
5 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. See Appendix 4.2.4 for gender difference results.

FIGURE 4.2.3

Decline in Wellbeing During the COVID-19 Pandemic, in Percent, by Sector

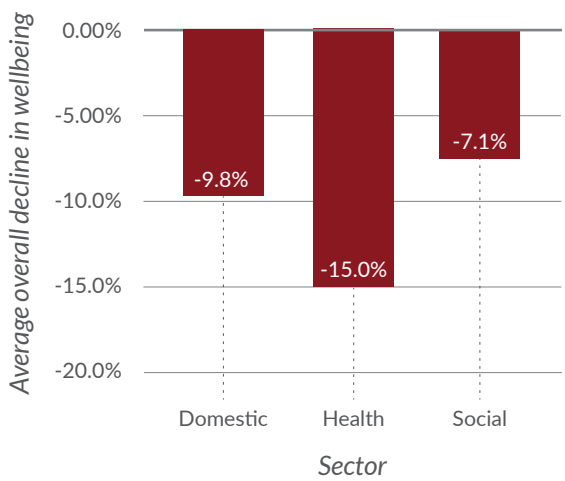
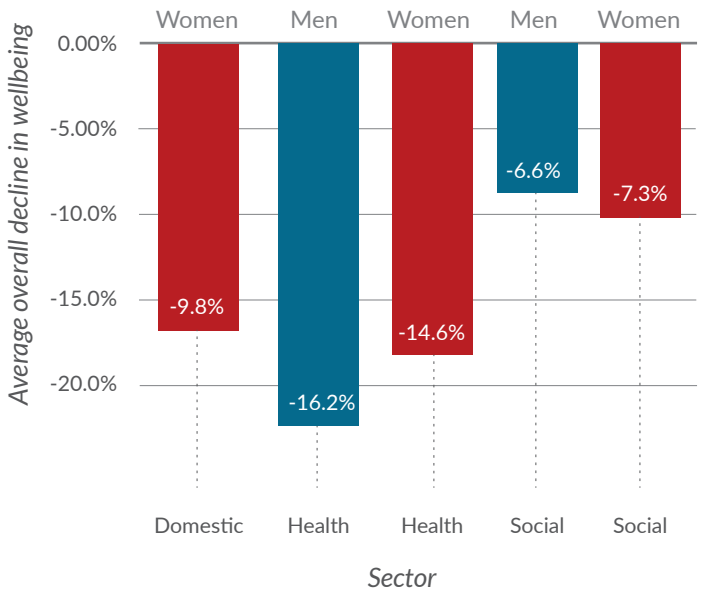


FIGURE 4.2.4

Decline in Wellbeing During the COVID-19 Pandemic, in Percent, by Sector and Gender



Disaggregating by gender across sectors, it appears men in healthcare experienced a slightly larger decline than women, whereas women in social care experienced a slightly bigger decline than men in that sector. As mentioned, there was no statistically significant gender difference within sectors.

Stress and the Deterioration of Health and Wellbeing

When examining the narratives emerging from the FGDs, it becomes clear why this impact on wellbeing was felt. Numerous respondents opined that their employers and the structure of the workplace were non-supportive, resulting in deleterious impacts on their health and wellbeing. For example, some employers failed to acknowledge the personal and emotional needs of care workers and their families, some expecting their employees to sever themselves from unpaid care concerns and attendant worry work at the workplace. In addition, some care workers were worried about working in unsafe conditions that could lead to COVID-19 infection. For example, some hospital cleaners complained that they were not provided with adequate personal protective equipment (PPE). As so many colleagues were on sick leave, units were short-staffed, further increasing the workload of remaining staff who had little time to eat, rest, or even use the toilet. When on break or even at home, some were called back to work resulting in high rates of stress and exhaustion. Murni, a hospital cleaner from north Malaysia, recounted how she succumbed to the effects of stress at work and the response of her employer to her predicament:

Murni, Hospital Cleaner, North Malaysia

Ha, nak datang balik tengah buat kerja, tiba-tiba call (panggil), "Hei, ada kes COVID lagi lah. Bolehkah masuk?" Lepas tu, aiyo—saya, kadang-kadang saya duduk, duduk bawah lah. Saya nangis sahaja lah. "Aiyo, saya tak mahu pergi lah, pergi lah you (awak) orang buat." Saya marah sahaja lah, sebab stres. Sekarang sudah buat satu kali COVID, lagi sekali call (panggil) diorang suruh dia pergi buat tempat situ pula. Lepas itu pun saya pergi buat lah, saya taknak marah sama dia lah. Pakai PPE semua, tengah buat, tengah buat kes COVID, susah nafas pula. Tak boleh nafas. Lepas tu, mata semua keluar air. Tak boleh nafas. Lepas tu buka mask (penutup muka) pula. Tiba-tiba buka mask (penutup muka). Lepas tu diorang marah, "Hei, jangan buka mask (penutup muka), jangan buka mask (penutup muka)!" Habis tu? Saya tak boleh nafas. Macam mana saya nak buat kes COVID? Lepas tu duduk sekejap pula, rehat sekejap. Diorang cakap, "Tak boleh rehat lah, cepat-cepat habis lah." Itu nak kena cepat-cepat habis ke? Lama nak kena buat, tiga kali nak kena buat.

English translation

Ha, just as I was about to come back to work, suddenly they called, "Hey, there's another COVID case. Can you go in?" And I was like, aiyo—sometimes I just sat down, sat on the floor. I just cried. "Aiyo, I don't want to go. You guys go instead." I was just so angry because of the stress. I have already handled one COVID case, and then they called again, asking me to go to another place. After that, I still went because I didn't want to be mad at them. Wearing PPE, handling COVID cases, it's hard to breathe. I couldn't breathe. After that, my eyes started tearing up. I couldn't breathe. After that, I took off my mask as well. Suddenly, [I] took off the mask. After that, they started shouting, "Hey, don't take off the mask, don't take off the mask!" Then what? I couldn't breathe. How was I supposed to handle COVID cases like that? Then I had to sit down for a while to rest. Then they said, "No time to rest, hurry up and finish it." Finish it fast? It wasn't that simple. I had to do it three times.

Furthermore, the movement between workplace and home became more problematic as workers were placed in quarantine or effected informal physical separation at home along with repeated showers and laundering of work clothes—all of which required time and additional resources—to avoid passing along the COVID-19 virus on to household members. Those who were compelled, or were by choice able, to work from home were not exempt from the challenges of conflicting demands between paid and unpaid care work. As working from home was new for many employment contexts, some managers were suspicious that their employees were not carrying out their duties, which engendered stress amongst home-based workers who were concomitantly facing often incessant care requests from children and other family members.

Some care workers reported a deterioration of their health and wellbeing during the pandemic that they attributed to the stress induced by the demands of paid care work and the impact it had on unpaid care work. Many did not recover their health status and attributed an increase in stress-related conditions such as stroke to this period. One anecdote embodies the intersections of guilt and compromised family care, worry work and workplace tensions, and stress, and its long-term impacts on the self quite tragically. Yun, a doctor from east coast Malaysia, related how, exhausted after a long stretch in hospital, she had returned home from work where she was caring for her mother who contracted COVID-19.

Yun, Doctor, East Coast Malaysia

So, in the end, it was actually quite sad because on the day my mum passed away, her [oxygen] saturation dropped. But since my dad wasn't medically trained, he didn't realise the severity of it. It happened on my post-call day. I had gone to sleep and when I woke up, she . . . was in very bad condition. And yeah, that was the day she passed away. I felt really guilty about it.

ii *Care Workers Sacrifice Themselves to Serve*

The impact of the COVID-19 pandemic on care workers arises from several factors and one key finding from the focus group discussion that contextualises the experiences of care workers is an emerging theme around the self-sacrifice of care workers. Sacrifice, on some level, is typically associated with the work undertaken by care workers and is an extension of the gendered socialisation wherein women are taught to place family priorities ahead of themselves. Just as women are socially rewarded by enacting these behaviours, self-sacrifice is thought of as a noble, sometimes even required, element of care work.

Across the pandemic and across the various FGDs, care workers spoke about what they had sacrificed in order to continue showing up to work. For many in healthcare contexts, during the harshest periods of the pandemic, they would give up mealtimes and breaks, spending upwards of ten hours in personal protective equipment (PPE) to attend to patients. Across care sectors, many also had to sacrifice rest days. For example, for public sector social workers, many undertook *tugas hakiki* (core work) Mondays through Fridays, and then were expected to take on additional pandemic response tasks during the weekend—effectively a freeze of weekends. In this, self-sacrifice is closely linked with experiences of extended workload.

Examining sacrifice, without contextualising the circumstances of the sacrifice, however, fails to accurately capture the experiences of the care workers during the pandemic. The care workers in the FGDs occupied a spectrum of roles, many of these intrinsically subject to power dynamics between themselves, their occupation, and their employer. Within this context, then, acts previously framed as self-sacrifice are reframed, better understood as necessary decisions for self-preservation. It is debatable, then, whether these are genuine instances of self-sacrifice or instances where care workers' wellbeing was instead compromised in order to continue providing services.

One social care worker shared how shared how, in undertaking her service, she contracted COVID-19, Category 4, and had to be hospitalised, explaining that they nearly induced her into a coma.

Hospital cleaners across the three FGDs spoke of how they sacrificed their own wellbeing, narrating instances where they went into shifts without any time to eat, had their breaks cut short, and worked extended hours. While these were spoken as though they were sacrifices,

the power imbalance between hospital cleaners and the system they function under means these are not instances of self-sacrifice, but rather instances of being sacrificed.

Ani, Hospital Cleaner, East Malaysia

Already on rest [break], but then, like, your colleagues weren't enough for the ward [short-staffed]. I was pulled in to go there. So, my leave had to be cut short to go manage [the new] ward. I [was] force[d] to go to the ward, for example the ward that [has] more severe [cases]. Indeed, everything is severe; it seems we don't have enough staff. [We did not] have [a] choice [cough].

Staff are not disposable—but it appears the circumstances of the pandemic made it necessary for management to take calculated risks. In light of needing to manage scarce resources, coupled with an overwhelming demand for services from overstretched systems, care workers were simply expected to sacrifice themselves.

Even for other healthcare workers, the overwhelming demands of COVID-19 meant the sacrifice of self was normalised. As a doctor from the east coast explains:

Musu, Doctor, East Coast Malaysia

So, I think dari segi penjagaan, dari segi nak jaga emotional patient tu memang tak sempat lah [ketawa]. Dengan kita sendiri pun, limited resources. Kita pun tak terjaga. [ketawa]

English translation

So, I think in terms of being cared for, in terms of emotionally caring for the patients, we really didn't have time [laugh]. Even for ourselves, we had limited resources. We were also not cared for [laughs].

The above touches on the way healthcare staff might have felt their needs were sidelined, under the expectation of serving others. In recognising the sacrifices that needed to be made, it appears, then, that the price was their own wellbeing.

4.2.2. *Unpacking Decline in Wellbeing*

There was a decline in all four aspects of wellbeing during the pandemic, which is what led to the overall decline across respondents.[6]

6 Statistical significance was determined by using paired t-test, at **P** < 0.05. See Appendix 4.2.5 for full results.

FIGURE 4.2.5

Percentage Decline Across the Four Aspects of Wellbeing in Total Population (n = 1,534).

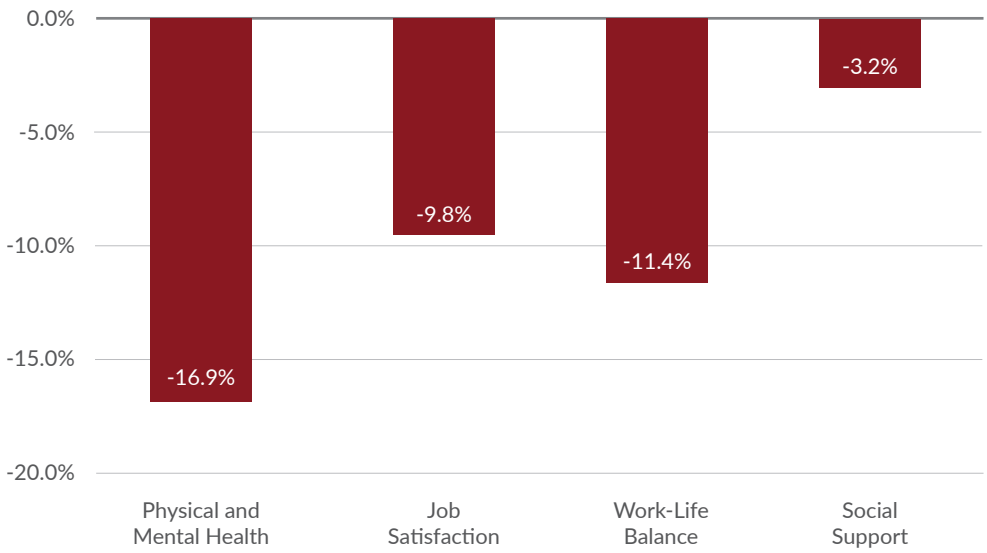


Figure 4.2.5 shows the average scores across all four aspects as a percentage.

Overall, the largest decline occurred in satisfaction with physical and mental health, as well as work-life balance.

Men appear slightly more impacted by decline in job satisfaction compared to women, whereas women seem slightly more impacted by decline in physical and mental health.

FIGURE 4.2.6

Bar Chart of Percentage Decline Across the Four Aspects of Wellbeing by Gender

Notes: (n = 1,534)

Decline in Satisfaction with Physical and Mental Health

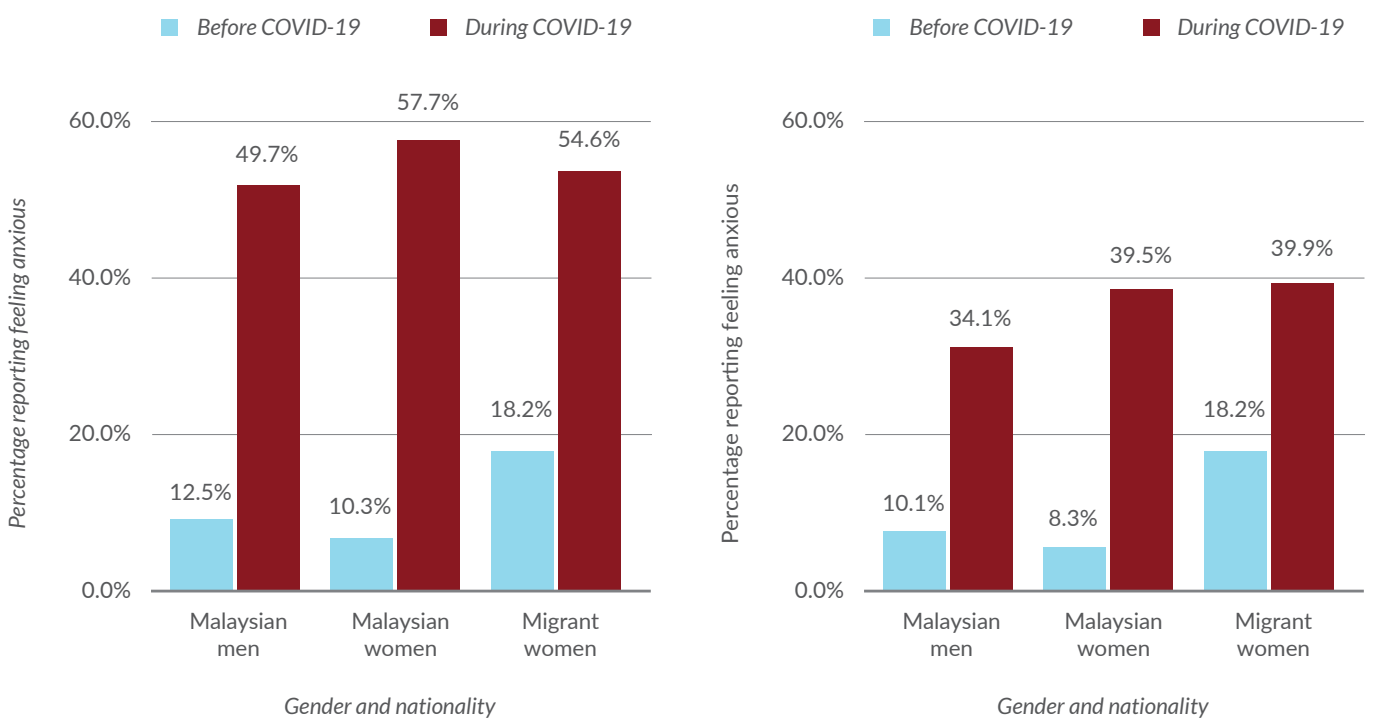
The domain of physical and mental health included questions on satisfaction with overall physical health and overall mental health. Additionally, respondents were asked if they felt anxious or depressed before, during, and after the COVID-19 pandemic. These questions helped understand how respondents perceived their mental health as changing over time. While the nature of the questions dealt with mental health issues, they are not meant to be diagnostic, but rather an indicator of the mental state of respondents at points in time across the pandemic.

Before the pandemic, 77.3% of respondents were satisfied with their physical health. During the pandemic, only 52.3% were satisfied, suggesting that the pandemic had an impact on physical wellbeing. With mental health, before the pandemic, 75.4% of respondents were satisfied with their mental health. During the pandemic, this declined to 52.0%, with slightly more men satisfied than women (55.1% of men were satisfied, compared to 51.3% of women).

The sharp decline in physical and mental health during the COVID-19 pandemic appears to arise from increased reports of feeling anxious and depressed during the pandemic.

FIGURE 4.2.7

Reported Rates of Anxiety (left) and Depression (right) Before and During the COVID-19 Pandemic Across Different Groups.



Notes: (n = 1,534)

Women's physical and mental health satisfaction was more negatively impacted by the pandemic compared to men's.[7] This disparity appears driven by gendered patterns of exposure to pandemic-related stressors.

One important factor in this decline is satisfaction with the amount of time spent on paid care work: Those who were dissatisfied with the amount of time they spent on paid care work experienced more of a decline in satisfaction with physical and mental health than those who were satisfied and those who felt neutral about how much time they spent on paid care work. Satisfaction with the amount of time spent on caregiving was similarly important. Compared to dissatisfied individuals, those who were satisfied with the amount of time they spent on caregiving experienced less steep declines in physical and mental health satisfaction, and those who felt neutral also reported less decline. In summary, *dissatisfaction with the amount of time spent on paid and unpaid care work led to a stronger decline in physical and mental health satisfaction.*

Interestingly, when we considered satisfaction with social support and perceived organisational resilience, that is, how supported care workers felt by their workplaces, there was no significant gender difference, suggesting both play crucial roles in supporting physical and mental health for women. While satisfaction with social support and perceived organisational resilience did not individually appear to be associated with wellbeing decline, both were necessary to close the gender gap. This suggests that *women's decline in physical and mental health is not due to their gender alone, but the unequal gendered experiences of support* in both their personal and professional lives.

Essentially, the pandemic had a greater impact on women's mental and physical health compared to men. Importantly, this gender gap disappeared when both social support and perceived organisational resilience were accounted for, suggesting that these potentially play a crucial role in buffering negative health outcomes. In short, *when women are adequately supported—both at home and at work—their mental and physical health outcomes are not significantly worse than men's, underscoring the importance of strengthening both personal and institutional support systems to protect women's mental and physical health,* especially in times of crisis.

ii Decline in Satisfaction with Work-Life Balance

Khas, Nurse, Central Malaysia

Bukan kita nak cari duit je, kita kena ada spend time dekat family juga.

English translation

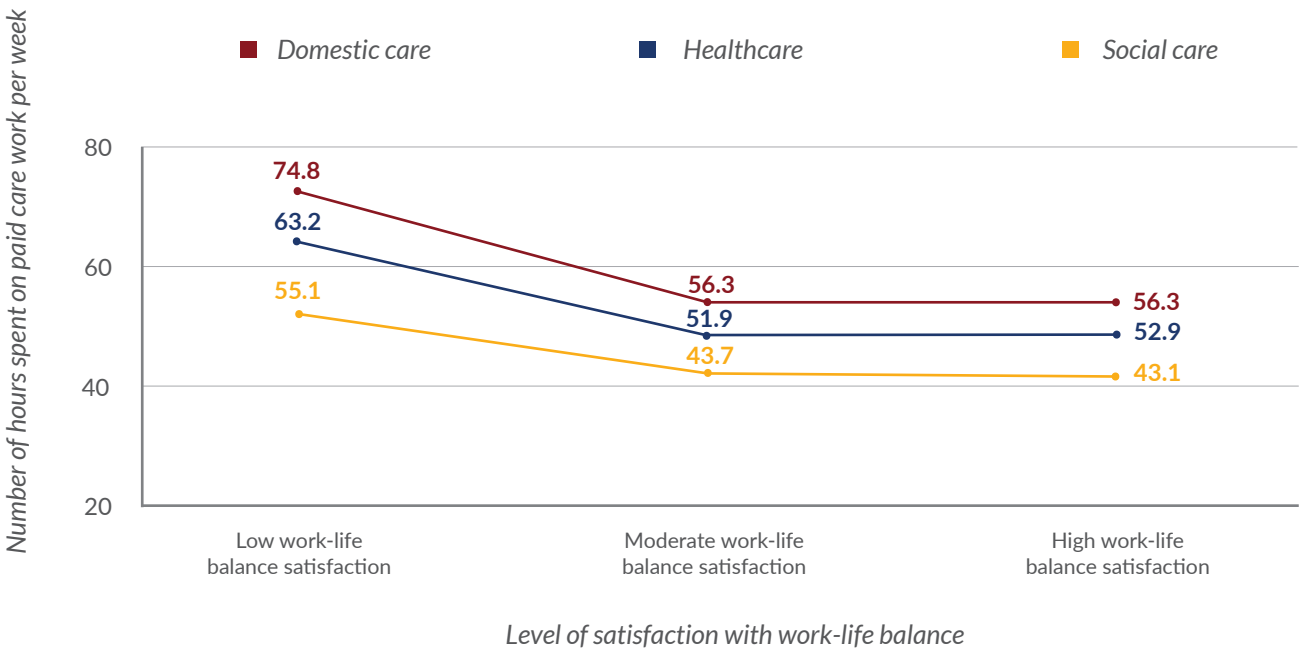
It's not just that we're looking to make money, we also need to spend time with our families.

The decline in work-life balance satisfaction appears to be driven by an increase in paid work hours simultaneous to a decrease in unpaid care work hours.[8] Thus, **the more time spent on paid work, the less satisfied respondents are with work-life balance.**

7 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.2.6.
8 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.2.7.

FIGURE 4.2.8

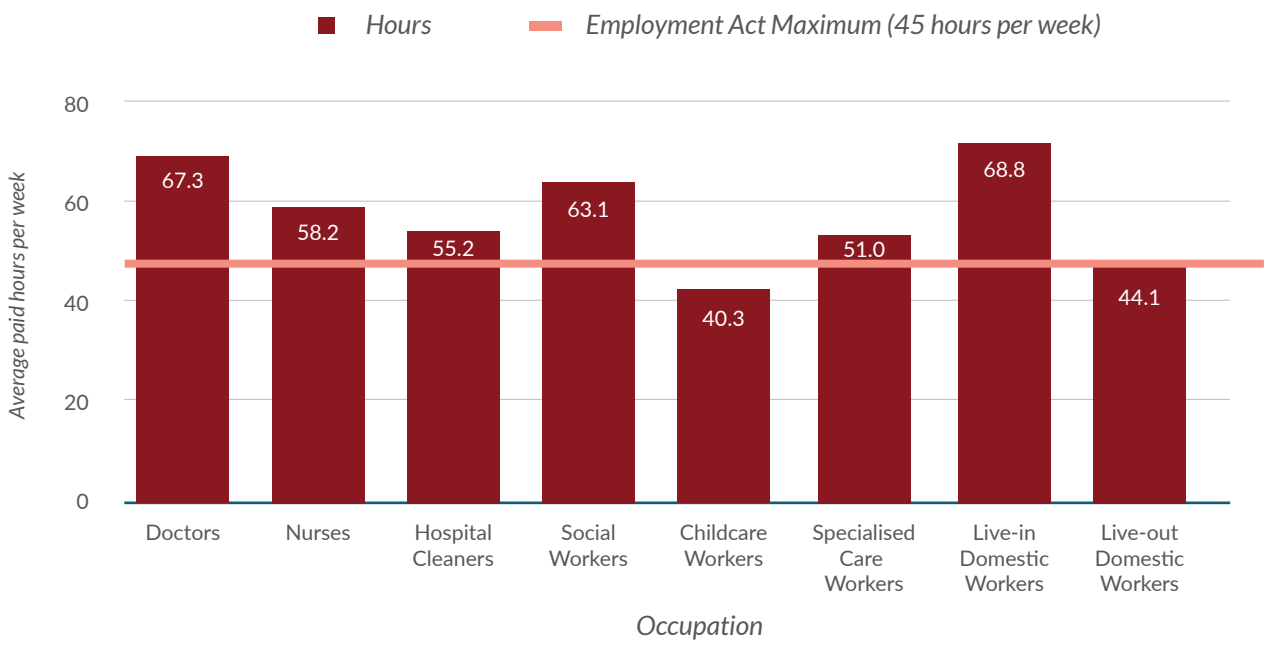
Average Number of Hours of Paid Care Work Per Week by Work-Life Balance Satisfaction



Across the board, it is clear that care workers were spending extensive hours on paid care work during the COVID-19 pandemic, with many occupations clocking in over forty-five hours per week on average (Figure 4.2.9). Work hours increased, on average, by nearly four hours a week compared to pre-pandemic, with some occupations, for example, social workers, reporting an average increase of over 15 hours per week. These increased hours, consequently, clearly had a toll on care workers' satisfaction with work-life balance, in part explaining the sharp decline experienced by both men and women and influencing the care workers' overall reported wellbeing.

FIGURE 4.2.9

Number of Hours of Paid Care Work Per Week during the COVID-19 Pandemic across Care Occupations

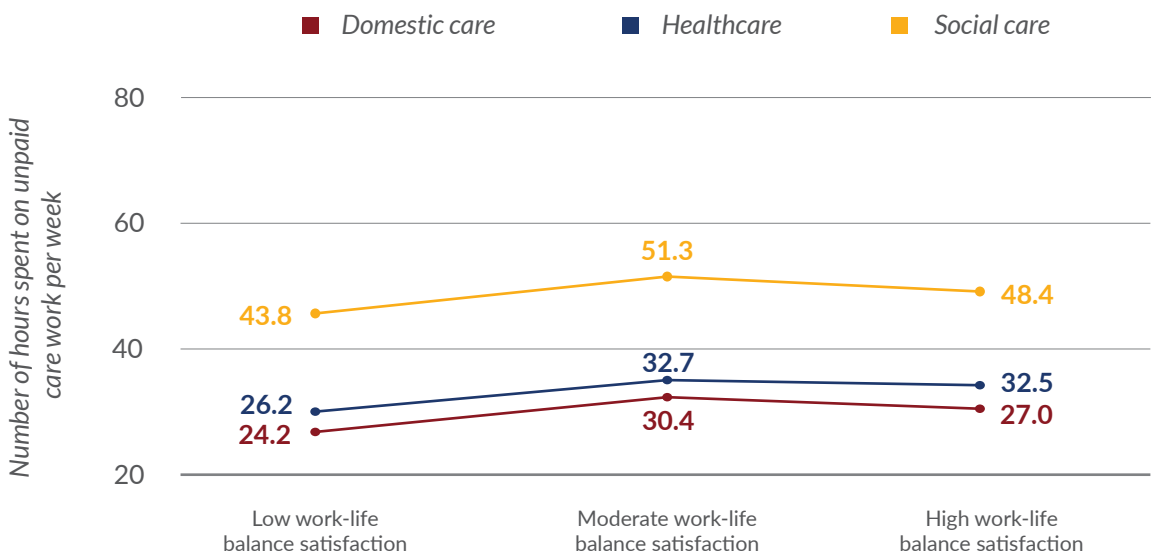


The increased paid work hours during the COVID-19 pandemic had a toll on care workers' satisfaction with work-life balance.

Conversely, *the more time spent on unpaid care work, the more satisfied with work-life balance respondents appear to be.* Interestingly, when care workers spend too much time on unpaid care work, they are only moderately satisfied, which is why the line graph in Figure 4.2.10 peaks at moderate work-life balance satisfaction.

FIGURE 4.2.10

Average Number of Hours of Unpaid Care Work by Level of Satisfaction with Work-Life Balance



It is important here to note that, in recognising the toll that unpaid care work can take on people, it appears in the context of this survey that caregiving, during the pandemic especially, may be positively associated with being able to spend time with family. During the COVID-19 pandemic, as a result of the increased demands of paid work, care workers often had to sacrifice time with their families in order to undertake their work demands.

Further statistical analysis revealed no gender difference in decline in satisfaction with work-life balance, indicating both men and women experienced similar declines. However, the analysis did reveal the following:[9]

1. The amount of time spent on paid work had a significant impact on decline in work-life balance satisfaction, that is, *the more time spent on paid work, the more work-life balance satisfaction declined.* Additionally, those who reported difficulty managing caregiving responsibilities during the COVID-19 pandemic were more likely to experience a decline in work-life balance satisfaction.
    a. These two appear to be related, in that an increased amount of time spent at work meant balancing caregiving became more difficult—those who struggled the most with managing their caregiving appeared to, on average, spend nearly six hours more

9 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in the companion appendix, Appendix 4.2.7.

on paid care work than those who did not struggle. As time is finite, it may be that the additional demands of work meant more strain was felt managing personal caregiving.

2. The amount of time spent on caregiving also had a significant impact on the decline in work-life balance, that is, *the more time spent on caregiving, the less work-life balance satisfaction decline.* Despite this, taking on more unpaid care work does not necessarily mean high satisfaction with work-life balance (peak at moderate).

3. Initially, perceived organisational or employer resilience appeared to be positively associated with less decline in work-life balance. However, after satisfaction with social support was taken into account, perceived organisational resilience was less relevant. *Those who were more satisfied with the social support they received appeared to experience less of a decline in work-life balance satisfaction.* It is possible that for care workers during the pandemic, *home-based support systems played a more critical role than organisational-level factors* in buffering work-life balance satisfaction decline.

These findings highlight how *care workers value spending time with their families, and having enough time to spend with their families is central to their wellbeing.* These sentiments emerged in narratives during the FGDs as well, where care workers shared the guilt and irresponsibility they felt, in not being able to be as present for their families.

Far, Doctor, East Coast Malaysia

So, cuma ni yang saya rasa yang kesan masa itu, saya rasa banyak rasa bersalah. Rasa bersalah for both my family and, at the same time, for work. Kenapa kepada family—sebab ni banyak saya kena bekerja dekat hospital. Saya jaga anak orang, tapi anak sendiri tak terjaga.

English translation

So, the impact I felt the most that time, I felt a lot of guilt. I felt guilty for both my family and, at the same time, for work. Why, for my family—because I felt I had to do so much work at the hospital. I was taking care of people's kids, but my own kids were neglected.

Pauline, Specialised Care Provider, Central Malaysia

They now are 13. During that time, [my child was] ten [years old] ah because three years ago, right? So my younger one will be three years old during that time. Six years old now. So during that time, actually, we are quite suffer [sic]. Because during the pandemic, I need to work, you know. So less time. And then they cannot go to school, online class and really, really rule my whole family. Because we have to buy computers, we have to buy laptops because they need to go for the class. And then my younger ones, supposingly, I already signed up for the daycare and also kiddy. Also have to cancel. No class, [laughs] nothing for him. Then I got no time to teach him as well because I'm so busy in my work.

Nana, Hospital Cleaner, East Malaysia

Even during Raya, I had to say I was celebrating in the ward. It's not true to say it wasn't hard; my child even asked, "Mom, aren't you celebrating Raya?" At that time, how do I explain, it must…I'm sorry [crying]. As a single mother, it does feel heavy, because my children are at home. There is no one else to take care of them. In that situation, people say that various feelings are running through the mind. The child has to celebrate alone, while the mother has to continue working at the hospital, urmm, with heavy responsibilities and frozen leave.

The COVID-19 pandemic put care workers in a position where, oftentimes, they had to choose between being with their families or meeting their obligations and commitments to work. This clearly took a toll on the care workers, reflected in a decrease in work-life balance satisfaction.

iii Decline in Job Satisfaction

There is a significant gender difference in terms of decline in job satisfaction, with *men more impacted by a decline in job satisfaction than women.*[10] This seems to be largely driven by dissatisfaction arising from men in healthcare, who experienced a much steeper decline than women in healthcare.[11] In social care, men and women appeared to have experienced similar declines.[12]

10 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.2.8, Table 4.2.10.
11 Statistical significance was determined using Welch's t test. Variables were considered significant at **P** < 0.05. Full model details are provided in Appendix 4.2.6, Table 4.2.10.
12 Statistical significance was determined using Welch's t test. Variables were considered significant at **P** < 0.05. Full model details are provided in Appendix 4.2.6, Table 4.2.10.

During the pandemic, women were more likely to report feeling worried about job loss compared to men (46.3% of women compared to 40.9% of men). However, across all other aspects of job satisfaction during the COVID-19 pandemic, men were more likely to report:

01

A lack of satisfaction with remuneration (50.0% of men felt they were being paid unfairly for the work they were doing, compared to 41.9% of women);

02

Limited opportunities for career development (44.3% of men reported feeling this, compared to 40.2% of women)

03

A lack of satisfaction with the recognition and appreciation they received for the work they did (40.9% of men reported feeling unsatisfied with the recognition and appreciation received, compared to 30.2% of women)

04

A lack of job satisfaction overall (25.7% of men reported explicitly feeling unsatisfied with their jobs, compared to 15.4% of women).

It is also possible that the aspects of job satisfaction which were chosen for study within the survey were capturing dimensions of job satisfaction that were more important to men.

Broadly, besides gender, the following predicted decline on job satisfaction:[13]

01

Satisfaction with the amount of time spent on paid work—generally, **those who were dissatisfied with the amount of time they spent on paid work were more likely to experience a decline in job satisfaction** compared to those who were satisfied and those who felt neutral.

02

Those who **were more satisfied with their work-life balance experienced less of a decline in job satisfaction.**

03

Those who had higher income per capita were more likely to experience less of a decline in job satisfaction.

13 Full analysis available in the companion appendix, Appendix 4.2.9.

iv *Decline in Satisfaction with Social Support*

Social support had the most modest decline (on average, 3.2%) amongst the components of wellbeing, potentially suggesting it may have been the most stable, even through a crisis. This could be because satisfaction with social support measures aspects such as satisfaction with support received at home for unpaid care work, satisfaction with how care responsibilities are divided at home, and feeling like one could rely on their community. As individuals are embedded within their families and communities, perhaps, then, social support remained consistent during the pandemic. There were no significant gender differences in the decline in satisfaction with social support—it appears both men and women felt similar declines, even when other factors, such as amount of time spent on unpaid care work and satisfaction with amount of time spent, were accounted for.

Decline was mainly driven by a lack of satisfaction with the amount of unpaid care work. Generally, the more unpaid care work someone performed, the more their satisfaction with social support declined; however, the most important aspect was how satisfied they were with the amount of caregiving they did. *Those who were dissatisfied with the amount of caregiving they did were more likely to experience a decline in satisfaction* with social support compared to those who were satisfied and those who felt neutral. More specifically, this dissatisfaction arose amongst those who spent less time on unpaid care work, indicating that *being able to support their family's caregiving needs during the pandemic was important to careworkers.* Individual resilience also appeared important, as *the more resilient an individual was, the less likely they experienced a decline in satisfaction with social support.* Those who did not access formal support, such as government aid or community support, were more likely to have experienced a decline in satisfaction with social support.

Dissatisfaction with social support arose amongst those who spent less time on unpaid care work, indicating that being able to support their family's caregiving needs during the pandemic was important to careworkers.

Finding 3:

Malaysian women had the slowest post-pandemic wellbeing recovery, relative to migrant women and Malaysian men.

The gap between Malaysian men and women, however, reflects more than just a difference in wellbeing recovery—it points to a persistent, structural disadvantage rooted in gender norms impacting women's overall wellbeing.

FINDING HIGHLIGHTS

This finding highlights gaps in wellbeing recovery between Malaysian women, migrant women, and Malaysian men, as well as gender gaps in overall wellbeing between Malaysian men and women.

1. *Malaysian women appear to lag behind Malaysian men and migrant women in wellbeing recovery.*

2. Wellbeing recovery post-pandemic appears supported by doing more paid care work, having higher individual resilience, and experiencing lower burnout.
    a. This may be because a different meaning is ascribed to what the work means post-crisis—perhaps doing more paid work post-pandemic signals the return of normalcy, especially for those who were less able to work during the pandemic such as childcare providers and live-out domestic workers. Potentially, the intensity of the work is also different.

3. While it appears that migrant women have nearly recovered from the wellbeing impacts of the COVID-19 pandemic, this does not discount the deep toll the COVID-19 pandemic had on their wellbeing, especially through narratives emerging from the FGDs.
    a. It is highly likely that there is greater variation in migrant domestic worker recovery, which is masked by the average recovery, and this could arise from differences in how data was collected.

4. When examining just Malaysians, *women lag slightly behind men in overall wellbeing recovery,* and the difference is nearly statistically significant.

5

The potential gap in wellbeing is affirmed by themes emerging from the FGDs, where women narrated how the pandemic impacted their unpaid care responsibilities. There was a strong theme emerging around the *internalisation of gendered responsibilities as mothers and wives, with women sharing how the demands of paid and unpaid care work during the pandemic led them to sacrificing time for self-care* in order to meet their families' unpaid care needs. This, in turn, took a toll on women, with an emerging theme around *guilt and feeling irresponsible for feeling as though they were unable to meet their paid and unpaid care responsibilities.*

6

This *prompts us to consider how there may be an overall gender difference across aspects of wellbeing, reflecting structural inequalities rooted in sociocultural norms that place women as primary caregivers*. Our analysis revealed that *women's wellbeing was never equal with men's to begin with.*

a. Across time, women have had significantly lower levels of satisfaction with social support, physical and mental health, and work-life balance compared to men, when aspects such as number of paid care work hours, unpaid care work hours, weighted household composition, number of caregivers present in the household, and perceived organisational resilience are controlled for. This persistent satisfaction gap cannot be attributed to gender alone, but rather reflects how structural gender inequalities shape women's lived experiences. In other words, *it is not simply that women are less satisfied, but that the systems surrounding care and work are not designed to support them equally.*

b. This is a reflection of gendered structural inequalities that position women as natural caregivers. In doing so, caregiving is thought to be effortless and intrinsic, rather than labour-intensive and socially structured. Consequently, *support structures do not adequately address women's need for support across private and public spheres, perpetuated by gender-blind policies that, in turn, create workplaces insensitive to the care needs of its workers.*

4.3
The Recovery of Wellbeing Amongst Care Workers

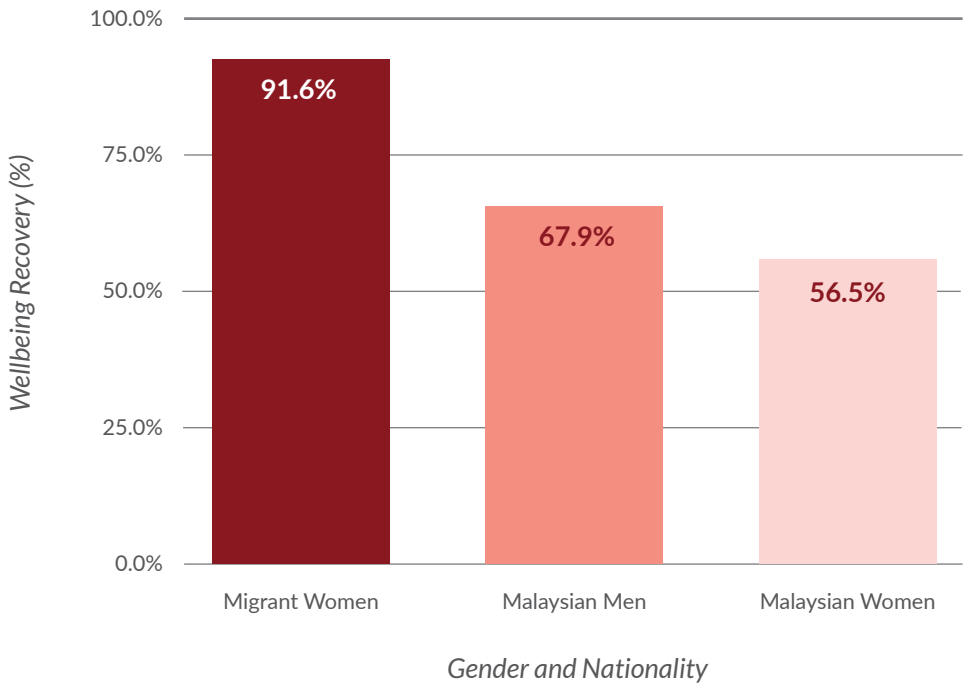
As mentioned in Finding 2, there was a drop in wellbeing experienced during the COVID-19 pandemic and nearly two-thirds of care workers had not recovered to pre-pandemic levels of wellbeing. In order to better understand this, it is necessary to examine the recovery of wellbeing more closely.

Figure 4.3.1 shows the proportion of recovery, relative to the decline that was experienced per group, demonstrating an uneven recovery across groups, with

Malaysian women making a lower recovery, on average. Further analysis revealed that, while Malaysian women lagged behind both groups, there was only a meaningful difference between them and migrant women.[1]

FIGURE 4.3.1

Wellbeing Recovery by Group



Before delving into these differences, it is necessary to understand what generally supported wellbeing recovery. Notably, wellbeing recovery is complex and these variables explain only a portion of stronger wellbeing recovery. That said, our analysis revealed:[2]

1. *Undertaking more paid care work appeared positively associated with wellbeing recovery.* This is potentially for a few reasons:
    a. First, the additional hours for certain care worker groups might symbolise a return to normal. For example, for some childcare workers, their hours were reduced during the COVID-19 pandemic because childcare centres were closed. Similar with live-out domestic workers, who had reduced work hours. This may be positively influencing the regression.
    b. Secondly, the additional hours might not carry the same intensity as during the pandemic, hence why wellbeing is improving as opposed to declinging with the additional hours.
2. *Individual resilience is positively associated with wellbeing recovery,* in that the more resilient a care worker is, the stronger their with wellbeing recovery.
3. *Burnout negatively is negatively associated with wellbeing recovery,* in that the more burnt out a care worker is, the poorer their wellbeing recovery is.

1 Statistical significance was determined using one-way ANOVA, with significance set at $P < 0.05$. Assumptions of normality and homogeneity of variances were tested; details are provided in Appendix 4.3.1 of the companion appendix.
2 Statistical significance was determined using multiple linear regression. Variables were considered significant at $P < 0.05$. Full model details, including diagnostics and assumptions, are provided in Appendix 4.3.2 of the companion appendix.

4.3.1

The Wellbeing Recovery of Migrant Domestic Workers

Findings from the survey appear to suggest that the impact of the COVID-19 pandemic on migrant workers was not as severe as it was on Malaysians, as migrant women nearly achieved 100% recovery. In reality, these groups are not comparable because their situations are vastly different. To understand the extent the pandemic impacted the wellbeing of migrant domestic workers, it becomes important to examine the narratives that emerged during the FGDs for domestic workers to reconcile the impact of the COVID-19 pandemic and the apparent recovery the women have made.

The impact of pandemic on emotional wellbeing were grounded in both proximate and distal factors. Moreover, constraints to travel precluded care workers from providing onsite social support to loved ones who were ill or grieving, generating further distress. This was acutely felt by many migrant domestic workers.

Patricia, Migrant Domestic Worker, Central Malaysia

For my family, it was also challenging, especially for my two siblings who have depression. They couldn't go out, which made things worse for them, and it stressed my mom out, causing her to have high blood pressure. Since my husband was far away at the house we were building, I had to rely on neighbours to assist my mom when my siblings were having episodes.

This distress worsened particularly for domestic workers who had strict employers. For example, Maria describes the physical toll the stress of the pandemic had taken on her, as her employers did not allow her to contact her family back home.

Maria, Migrant Domestic Worker, Central Malaysia

I couldn't sleep, I was extremely thin. I really struggled to keep track of my meal times, so I was really stressed during the pandemic. So [I had to keep myself distracted]. If I didn't fight against myself, I would just keep crying. I would cry and cry. So, I didn't have anyone to talk to, friends or family. Because sometimes you only get to communicate with your family once a month. You only get 10 to 15 minutes. So I was really stressed during the pandemic. Because I also remembered my parents, my siblings. I wonder how they were doing. And then, I would also find out about how high the cases were [back home]. So that's what you worry about for your family.

Candelaria, another domestic worker, also details the impact on her wellbeing after finding out her mother passed away.

Candelaria, Migrant Domestic Worker, Central Malaysia

The pandemic had a huge impact. Mentally, I was extremely stressed. Depressed. I couldn't sleep because of what's called? Insomnia. Because I was so worried. At first, my mom got sick. So, I was extremely stressed because I was far from her until she passed away during the pandemic. I couldn't even go home. Because of the lockdown. So, I was very stressed. Maybe that's also why I was stressed with my employer. So, it's a big impact. And also, I was stressed because... I couldn't accept it. [crying] That I was hurt by my mom's death... and I couldn't go home. So... after that... I got sick... from stress because I couldn't sleep.

The position of migrant domestic workers in Malaysia has always been unique, shaped by precarity arising from their migration status and the work itself (Spitzer et al. 2023). This may be why it appears that they have higher individual resilience than Malaysian women. In participatory data analysis sessions, migrant domestic workers tended to refer to stressors, including strained relationships with employers and difficult working conditions, as things to be "endured." Thus, migrant domestic workers may also feel they need to be strong, not just for their families, but for their own survival in Malaysia. Additionally, it may be possible that there is greater variation in migrant domestic worker recovery that is masked by the average, and this could be an artefact of differences of data collection methods, as mentioned in Chapter 3.

Migrant domestic workers, in part, do introduce a great deal of heterogeneity to the survey. Hence, the following analyses on recovery consider particularly the gender differences amongst Malaysian care workers.

4.3.2
The sociocultural and structural inequalities of Malaysian women's uneven recovery

The pandemic was inherently a gendered experience, especially in terms of the intensity, expectations, and emotional load associated with the care work undertaken. More specifically, women are typically expected to contribute more of themselves to unpaid care work compared to men. There was a near statistically significant difference between men and women in wellbeing recovery, when number of paid care work hours, unpaid care work hours, number of those partaking in shared caregiving within the household, and the weighted household composition are accounted for, with men showing slightly greater improvements. This suggests there is a potential difference in wellbeing between men and women that is linked to care-related factors, which warrants deeper consideration.

In earlier chapters, we highlight how sociocultural expectations position women as primary caregivers, even when they undertake paid work. In placing this gendered expectation on women, the way care is distributed and experienced becomes qualitatively different. These are the invisible burdens they carry, ranging from extended emotional labour to worry work to the mental load of care management within their households.

These experiences suggest deeper inequalities which, then, appear to influence women's wellbeing, especially in times of crisis. This was clear from the themes emerging in the FGDs, as women detailed how pandemic impacted their unpaid care work responsibilities, as well as themselves.

The Impact of the Pandemic on Unpaid Care Work

In effect, care workers from various sectors were socially, economically, and culturally compelled to juggle dual responsibilities—paid and unpaid care work—amid the compounded pressures of poverty: Time, income, and assistance.

> ***Ai Ye, Private Childcare Provider, Central Malaysia***
>
> *To care for my baby, manage work, housework, being a daughter, being a daughter-in-law, all this right—I never rested. And then plus breastfeeding, I haven't had a full eight hours of sleep for so many days already.*

3 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.3.3.

The COVID-19 pandemic rendered social spaces perilous. These domains, which previously afforded a respite from unpaid care work, became either non-operational or inaccessible. Additionally, nationwide lockdowns prompted the return of dispersed family members, significantly increasing household size and further intensifying domestic responsibilities.

Two key consequences emerged to address evolving contingencies. First, an accentuation in caregiving activities, including but certainly not limited to childcare, eldercare, cooking, and decontamination efforts within domestic settings. Second, domestic responsibilities were diffused among the household members, though the extent of their participation varied due to differing capacities, willingness, and circumstances.

In this, one key theme emerging from the FGDs was the internalisation and perpetuation of entrenched sociocultural norms that position care at the home as a woman's responsibility.

Gayu, Hospital Cleaner, North Malaysia

Anak-anak empat orang. Masa tu sekolah semua cuti. Tanggungjawab sebagai seorang ibu dengan isteri menjaga diorang. Sebelum kerja saya siapkan untuk makanan semua sebab anak saya semua masa tu kecil lah. Sebab tiga sekolah, satu tu kecil lagi, tak sekolah. Terpaksa saya sediakan makanan sebab tak mampu, nak beli pun tak boleh. Saya siapkan makanan apa yang ada untuk anak, sebab kita pergi kerja kan masa tu.

English translation

Four children. Schools were on leave then. It was my responsibility as a mother and wife to take care of them. Before work, I had to prepare meals because they are all young. I had to prepare food as we can't afford to buy food. I cook with what was available for my children because I have to go [to] work at that time.

The internalisation of this sentiment, that women, as mothers and wives, are natural caregivers, reinforces the assumption that they do not need support, strengthened by the belief that care within families is a personal responsibility rather than a shared one. This sentiment carried a range of impacts, where women described sacrificing their time for self-care with the duties they needed to undertake as mothers and wives. A doctor located in the East Coast shared that her "me time" and "family time" were entirely replaced by "cooking time," turning her into a "reluctant but consistent cook" to meet her family's needs.

Similarly, care workers reported an increase in both the frequency and volume of cooking. For many, this adjustment was driven by the need to ensure family members had access to food while occupied at their workplaces.

When women are assumed to be natural caregivers, it reinforces the idea that they do not need support, especially when care within families is viewed as a personal responsibility rather than a shared one.

Juna, Nurse, North Malaysia

Tapi macam time kalau nak makan tu masak kalau kerja pagi memang kita akan kena bangun awal lah. Dalam 4.30 tu untuk sediakan makanan depa untuk breakfast dengan lunch. Kalau macam kerja syif petang tak ada masalah lah. Kalau malam pun cuma kerja pagi je terpaksa bangun awal untuk sediakan makanan.

English translation

But it's like when we want to eat and cook, if we work in the morning we will have to get up early. [We need to wake up at] 4.30 am to prepare food for breakfast and lunch. If it's like evening shift, there's no problem. Only when it's morning shift, you have to get up early to prepare food.

It can thus be inferred that resting and personal time, particularly for those caring for family members with additional needs, such as those with disabilities, are significantly compromised, as they are predominantly consumed by extended care work that extends far beyond cooking.

Lydia, Nurse, East Malaysia

Untuk kita balik penat, daripada balik kita terpaksa masak lagi di rumah. Sudahlah kita bekerja 12-24 jam. Di rumah kena masak lagi untuk family.

English translation

For us, we come back tired, and then when we go home, we have to cook again at home. We are already working 12-24 hours. At home we have to cook again for the family.

ii *The Impact of the Pandemic on the Self*

The increasing intensity of unpaid care work for women care workers, coupled with internalised sociocultural norms and pandemic restrictions that compelled the women to primarily shoulder this burden themselves, created a toll on care workers. As observed through the FGDs, care workers often felt as though they could not escape competing demands from work and from home. Although respondents both desired and felt obliged to address needed familial care responsibilities, paid care work was often prioritised. In a sense, care workers were stretched thin—burning their candles at both ends.

In addition to financial need and contractual obligations, as Fas, a doctor in south Malaysia, shared, there was a sense of contribution and accomplishment: "You are part of the family, but you are also [institution name] family." The primacy of paid care work, however, did not prevent the bleeding of unpaid care work into the workplace—nor was the home environment free from the pressures of work—often resulting in feelings of guilt pertaining to comprised family care and familial relationships; increased worry work and workplace tensions; and stress and the deterioration of health and wellbeing.

Expectations of family members that women care workers would be able to fulfil all their needs during this stressful time weighed heavily. Children, particularly those of mothers engaged in child and social care, found it particularly difficult to adjust to changes in mothers' physical and emotional availability. According to their mothers, some children believed that their mothers were attending to the needs of other children and neglecting them, resulting in increased resentment, behavioural problems, and poor mental health.

Expressions of guilt permeated respondents' stories of compromised familial care and relationships. They felt guilt about going to work, guilt about leaving their children, guilt about potentially infecting family members with COVID-19 and then not being present to care for them if they fall ill, and guilt about being physically distant due to travel restrictions and even when at home. These sentiments were borne by care workers throughout their daily lives and had an impact on their selves in the workplace.

Murni, Hospital Cleaner, North Malaysia

Masa COVID tu, penjagaan family (keluarga) kan, sangat teruk lah. Sebab saya habis kerja, datang penjagaan family (keluarga). Saya punya family (keluarga), adik beradik semua enam orang. Dua kakak, satu abang, satu adik lelaki, adik perempuan ada lah. Tinggalkan kita punya family (keluarga), ada abang, kakak dua orang, mak saya lah. Sebab itu jam sangat susah lah. Nak dapat barang, nak beli barang kedai runcit, banyak susah. Tiba-tiba itu jam masa COVID tu, abang saya sudah kena COVID. Saya pun balik kerja, pada, pada pukul tiga macam itu, saya pun letih lah sebab kita buat kes COVID sebelum datang. Mak saya cakap, tiba-tiba nak pergi barang- beli barang lah itu lah, tak ada barang lah. Dia cakap macam tu. Saya cakap, "Lah, tak payah lah. Hari ini kita buat bubur sahaja lah,". Macam itu cakap lah. Mak saya marah, "Kenapa buat macam itu,". Sebab kita nak jaga family (keluarga), itu banyak sangat susah. Kita tak ada duit pula, makan pun susah, keluar pun tak boleh. Memang sangat susah lah penjagaan family (keluarga). Lepas tu, saya pun tinggal dengan- tinggal dengan asing. Lepas tu saya pun ada pergi rumah mak lah, saya tinggal dengan rumah mak lah. Memang sangat susah lah nak jaga family (keluarga) masa COVID tu. Itu je. Memang sangat teruk.

English translation

During COVID, taking care of family was really hard. After work, I had to come home and take care of my family. In my family, there are six siblings. Two older sisters, one older brother, one younger brother, and a younger sister. But at home, it was just my older brother, my two older sisters, and my mother. At that time, everything was tough. Getting supplies, buying groceries at the convenience store, everything was a struggle. Then suddenly, during the pandemic, my older brother got COVID. I came home from work around three o'clock, completely exhausted after dealing with COVID cases. Then my mother suddenly said, "We needed to go out and buy groceries because there was nothing left." I told her, "It's okay, let's just make porridge today." But she got angry, "Why are we doing this?" Taking care of my family during that time was incredibly hard. We had no money, even getting food was difficult, and we weren't allowed to go out. It was really tough. I was living separately, but I would go to my mother's house and stay there. Taking care of my family during COVID was one of the hardest things. That's it. It was really terrible.

4.3.3

The Gendered Gap Across Aspects of Wellbeing: An Analysis Between Malaysian Men and Women

These narratives then prompt us to further examine the experiences of wellbeing and potential gender gaps—not just during the pandemic, but across time. In this, our analysis revealed that, despite marginally similar wellbeing recoveries, *women's wellbeing was never equal with men's to begin with.*[4] This becomes clear when we examine satisfaction with social support, physical and mental health, and work-life balance.[5]

Gendered Differences in Social Support Satisfaction

Satisfaction with social support, as previously mentioned, is measured by satisfaction with how care work is divided at home, satisfaction with support received at home, and feeling as though the respondent could rely on the community for support. In Finding 2, men and women experienced similar declines in satisfaction with social support.

Notably, despite the fact that they experienced similar declines, men and women did not start with similar levels of satisfaction with social support. To determine this, we considered satisfaction with social support across three timepoints, that is before, during, and after the COVID-19 pandemic. Our findings revealed that men have consistently been more satisfied with the social support they received. When time spent on unpaid care work per week, weighted household size, number of caregivers present within the household, and perceived organisational resilience were accounted for, there is a clear gender difference between men and women's satisfaction with social support across time.

Accounting for caregiving and work-related factors allowed for closer inspection of how gender influences satisfaction with social support. Perceived organisational resilience was considered as well because it appears to buffer the impact of paid work demands, demonstrating that even when individuals worked longer hours, perceiving their workplace as resilient and supportive of their needs lessens the negative effect on their experience of social support. Essentially, organisations do appear able to support care workers with their paid work in some capacity. However, this does not reduce the gender difference in satisfaction with social support.

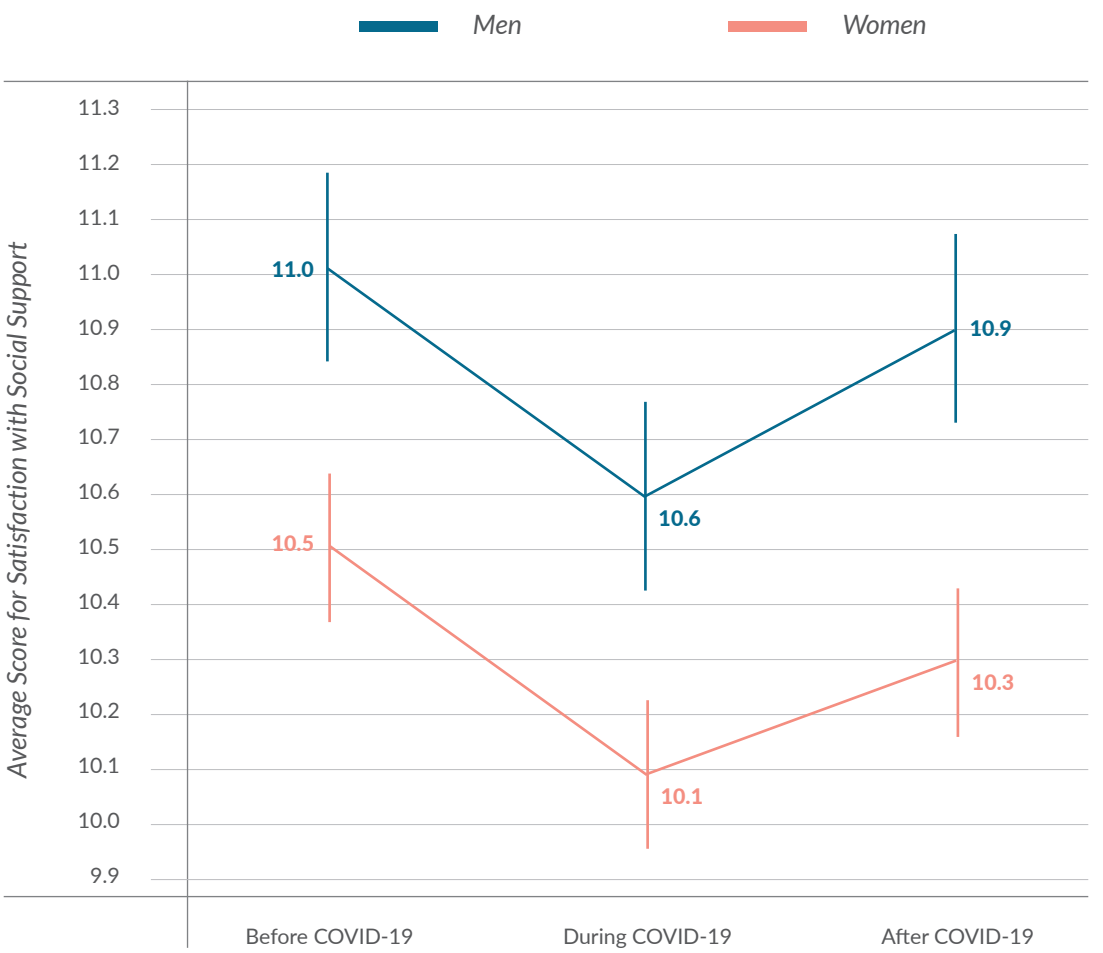
Women appear to experience social support very differently, regardless of caregiving hours or paid work hours, evidenced by how none of these variables predict satisfaction with social support. While the presence of more support helps to an extent, as demonstrated by how having more caregivers post-pandemic significantly improves satisfaction with social support, it does not diminish the gender difference in satisfaction with social support. It appears that *how support is felt and experienced is what shapes satisfaction; gender norms shape who takes on care responsibilities which, in turn, shapes how those responsibilities are distributed, ultimately affecting the quality of support women have.*

Satisfaction with social support is influenced by how that support is felt and experienced; gender norms shapes who takes on care responsibilities and how these responsibilities are distributed, ultimately affecting the quality of support available to women.

4 Statistical significance was determined using repeated measures ANOVA with Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at $P < 0.05$. The full analyses are available in the companion appendix, Appendix 4.3.4.
5 Job satisfaction is the only aspect of wellbeing where, across time, it appears men have less satisfaction. This, again, may be because the aspects of job satisfaction assessed were more relevant to men, or it could be that men are more sensitive to certain work-related factors compared to women.

FIGURE 4.3.2

Profile Plot Comparing Malaysian Men and Women's Satisfaction with Social Support Across Three Time Points (Before, During, and After the COVID-19 Pandemic)



These gaps in satisfaction with social support emerged in findings within the FGDs as well, as women shared instances where they felt they were unable to rely on their family, more specifically their spouses, for support.

One care worker, who was stationed away from her home, shared how, whenever she was away, her husband never supported the household responsibilities. As a result, when she returned home, she described the state of their home as a trash can. In order to ensure her child was fed, she returned home every weekend to cook enough meals to last the child for the week.

Aliya, Care worker, North Malaysia

Jadi, last kali saya balik rumah bulan tujuh tu rumah macam tong sampah. Jadi, buat saya lagi tertekan. Saya tiap-tiap minggu balik saya kena masak untuk stok anak saya makan seminggu.

English translation

So, the last time I went home, back in July, the house was like a trash can. It made me even more stressed. Each week I had to go back to cook enough food to last my child for the week.

A nurse shared how she experienced anxieties around whether her husband was feeding their child, based on how she perceived her husband as being unwilling to cook.

Asmah, Nurse, North Malaysia

Sebab masa tu [anak masih] kecil kan, kadang-kadang takut husband tak bagi makan [laughter]. Takut, takut, takut nanti anak mengadu, "Ibu lapar lah hari ni, tak makan lagi." Tak betul, [tapi takut] tiba-tiba [anak] tak makan lagi.

English translation

Because, that time, my child was still young, so sometimes I was worried my husband wasn't feeding her [laughing]. I was scared, scared that my child was complaining, "Mum, I'm hungry today, I haven't eaten yet." It wasn't really happening, but I was still quite worried, like suddenly thinking my child was not eating.

While, at first glance, this may read as her mistrusting her husband, this actually demonstrates the mental load women take on, an often invisible aspect of care coordination that women disproportionately shoulder. This mental load is defined by planning, anticipation, monitoring, and worrying about the needs of others. A recent study demonstrated that women take on 71% of the mental load of care management, compared to men, who take on 45% (Weeks and Ruppanner 2024).

Thus, even when unpaid care tasks are shared between spouses, women may still feel it is their responsibility to oversee and double-check that these aspects of care are being carried out properly. In the long run, this can lead to feeling less satisfaction with social support simply because support that requires micromanagement may not feel like support at all.

ii Gendered Differences in Physical and Mental Health Satisfaction

In the previous finding, women experienced a greater decline in satisfaction with physical and mental health during the pandemic. When perceived organisational resilience and social support were taken into consideration, men and women appeared to experience similar declines, suggesting that organisational and personal support were critical for women's physical and mental health.

As with satisfaction with social support, however, further analysis revealed that women's satisfaction with these aspects of their wellbeing have always been lower than men's. This finding emerges after accounting for caregiving hours, paid work hours, weighted household size, number of caregivers within the household, perceived organisational resilience, and satisfaction with social support.

Similar to social support, *the physical and mental health impact of the demands of paid and unpaid care work takes a different toll on women,* even when they have similar supports or spend a similar number of hours on their

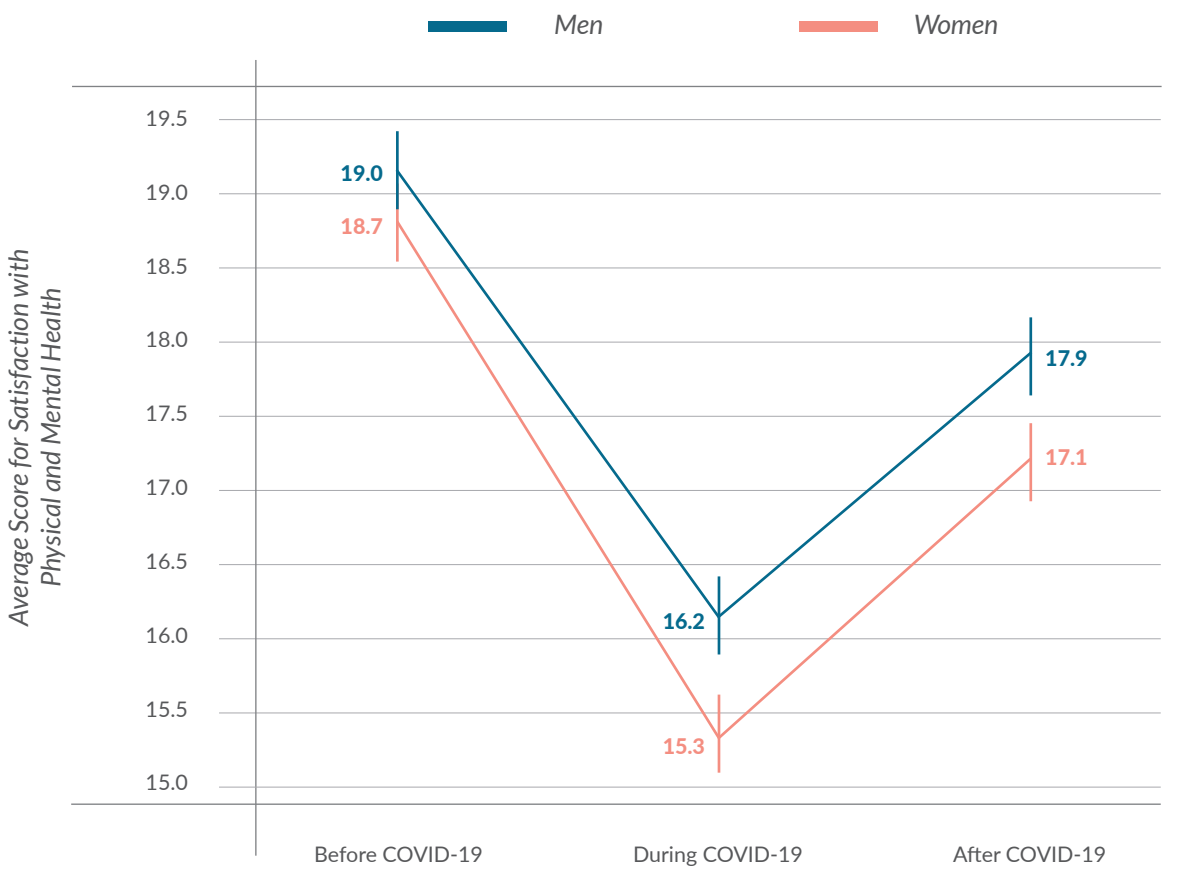
paid and unpaid care work. While both social support and organisational resilience were positively associated with better satisfaction with physical and mental health, they were insufficient in mitigating the gendered satisfaction gap in physical and mental health.[6] This suggests that *existing support structures, though valuable, do not adequately address the unique pressures women face in their caregiving roles and the impact this has on their physical and mental health.*

This is critical because, during a crisis, as per the previous finding, it appears that both social support and perceived organisational resilience, are able to buffer severity of the decline in satisfaction with physical and mental health. However, the absence of a buffering effect when satisfaction with physical and mental health is examined across time implies that *women's caregiving responsibilities are taking and have taken a different toll on women—a toll that predates the pandemic.* In other words, *while structural and social supports can help in the short term, they are not currently designed to sufficiently protect women's long-term physical and mental health in the context of compounding demands at work and at home.*

The physical and mental health impact of the demands of paid an unpaid care work takes a different toll on women, even when they have similar support or spend a similar number of hours on their paid and unpaid care work.

FIGURE 4.3.3

Profile Plot Comparing Malaysian Men and Women's Satisfaction with Social Support Across Three Time Points (Before, During, and After the COVID-19 Pandemic)



6 Statistical significance was determined using repeated measures ANOVA with Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at **P** < 0.05. The full analyses are available in Appendix 4.3.5 in the companion appendix.

iii *Gendered Differences in Work-Life Balance Satisfaction*

Satisfaction with work-life balance, as mentioned, is measured by satisfaction with how much time is spent on paid care work, unpaid care work, and self-care, in addition to general assessment of satisfaction with overall work-life balance. During the pandemic, there was no significant gender difference between men and women in the decline experienced in satisfaction with work-life balance.

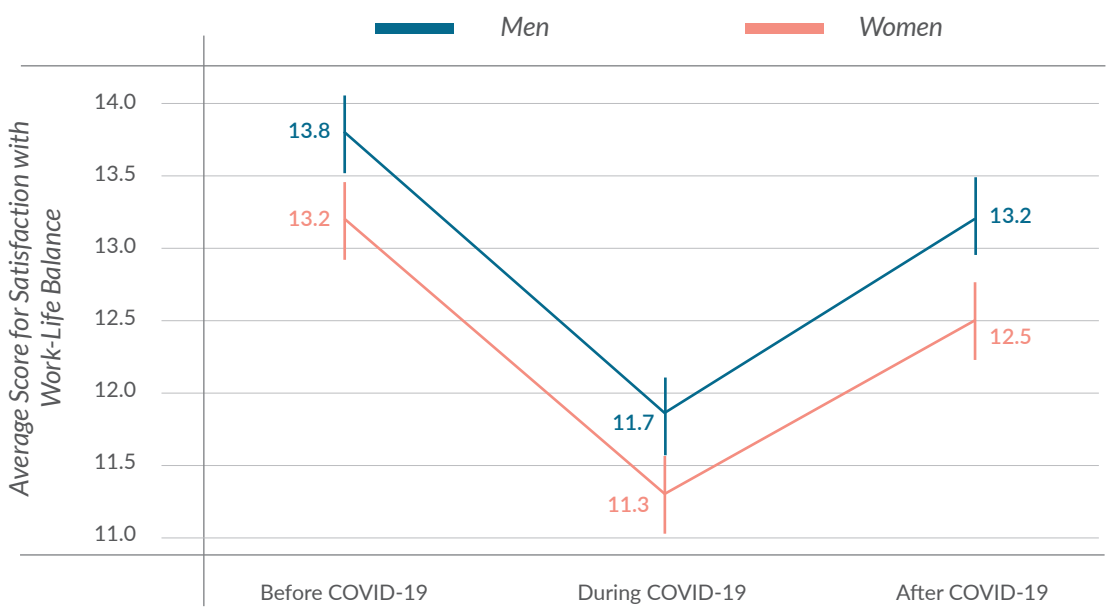
However, despite similar pandemic-era declines, *men have consistently been more satisfied with their work-life balance compared to women.* Across time, when we accounted for the number of hours spent on unpaid care work, number of hours spent on paid care work, weighted household composition, and perceived organisational resilience, women have always had significantly lower levels of work-life balance satisfaction than men.

Work-life satisfaction balance appears to be meaningfully linked to the number of hours spent on paid care work, both during the pandemic and now.[7] Specifically, higher paid care work hours is associated with lower work-life balance satisfaction. While this trend holds across the Malaysian sample, the gender difference in *work-life balance satisfaction across time remains, suggesting existing structures make it harder for women to enjoy work-life balance satisfaction even when paid work hours are accounted for.* This may very well be because women are performing more unpaid care work than men.

It is important to note that while women have less work-life balance satisfaction than men, it does not mean that men are satisfied with their work-life balance. Most care workers report low work-life balance satisfaction. *This widespread dissatisfaction likely reflects workplaces that lack adequate policies to better support care workers to sufficiently manage their personal care responsibilities. This gap appears to impact women more, reflected by their lower satisfaction with work-life balance, likely due to sociocultural expectations positioning women as primary caregivers.*

FIGURE 4.3.4

Profile Plot Comparing Malaysian Men and Women's Satisfaction with Work-Life Balance across Three Time Points (Before, During, and After the COVID-19 Pandemic)



7 Statistical significance was determined using repeated measures ANOVA with Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at **P** < 0.05. The full analyses are available in Appendix 4.3.6 in the companion appendix.

Finding 4:

Preventing burnout and supporting resilience are key to supporting care workers wellbeing.

While burnout was experienced equally by men and women, there appears to be gender gaps in individual resilience, which must be bridged.

FINDING HIGHLIGHTS

There are two measures of resilience: Individual resilience and perceived organisational or employer resilience, both of which have an impact on care workers.

1

Resilience trends across time:

a. Overall, care workers experienced a drop in resilience levels during COVID-19, and their resilience levels have yet to recover to pre-pandemic levels. *Both men and women care workers had a similar pattern of change in resilience levels.* However, *women care workers consistently had lower levels of resilience at each time point compared to men care workers.*

b. This gap reflects the deeper structural gendered inequities that shape women's experiences in care work, which were evident through both our quantitative and qualitative findings in this report. Urgent attention must be drawn to *developing and implementing resilience-building strategies that are both targeted and gender-transformative* to bridge this gendered gap and ensure sustainability of the care ecosystem in the long run.

2

Resilience as a dynamic process:

a. In our study, *resilience fluctuated in response to an external crisis* (i.e., the COVID-19 pandemic), where resilience levels dipped during the pandemic but partially rebounded after. It suggests that *care workers were experiencing possible common environment stressors,* including volume of workload, uncertainty, lack of social and/or organisational support, as well as lack of resources.

b. We contend that resilience has not fully recovered or strengthened post-pandemic because *current institutional and societal measures are misaligned with the realities of care work today.* While the notion of a "new normal" has been widely circulated, many policies and practices continue to aim for a return to the "old normal"—restoring pre-pandemic routines rather than reimagining new, adaptive ways of

working.

c. *Resilience is not a fixed trait or a one-time achievement. It is a dynamic and ongoing process, shaped by context, support systems, and the capacity for adaptation.* When systems fail to change in response to crises like the COVID-19 pandemic, they risk undermining the very conditions that enable resilience to grow.

d. By not addressing the structural and cultural shifts needed in the aftermath of the pandemic, current efforts may inadvertently stall or suppress the resilience of the care workforce. Instead, *resilience-building must be seen as a continuous, collective process*—one that demands new frameworks for care work that are flexible, future oriented, and attuned to the lived realities and needs of care workers.

3

Individual and organisational resilience:

a. Care workers who perceived their organisations as more resilient were more likely to have greater individual resilience. This finding underscores the importance of *organisational resilience as a protective factor for individual wellbeing.*

b. Our findings also highlight a critical limitation—*organisational support alone is not enough to bridge the gender gap in resilience.* Even when women care workers felt supported by their organisation, they continued to report lower individual resilience compared to men care workers.

c. This reinforces the urgent need for organisations to move beyond a one-size-fits-all approach. Instead, *organisations must adopt gender-transformative strategies that explicitly recognise and address the unique challenges faced by women in the care workforce to build a truly resilient and equitable care ecosystem.*

FINDING HIGHLIGHTS

Burnout faced by care workers varied across time, based on occupation, and also impacts satisfaction with paid and unpaid care work.

1

Burnout trends across time:

a. Overall, care workers experienced an increase in burnout levels during COVID-19, and their burnout levels have yet to recover to pre-pandemic levels. Men and women care workers experienced burnout similarly.

b. These findings indicate that the *pandemic had a long-term impact on care workers' wellbeing, and existing efforts to address burnout have been ineffective.* Future crisis preparedness plans must *integrate and institutionalise mental health and emotional support systems* to better support care workers, particularly during and post-crisis.

2

Influence of paid and unpaid care work hours:

a. Burnout was strongly associated with the intensity of paid work, especially in occupations with extreme working hours. Unpaid care work, on the other hand, seems to slightly buffer the negative effects of paid care work on burnout—suggesting that *care workers with a healthier work-life balance experienced less burnout.*

b. Care workers who were working reasonable hours while having the capacity to spend more time with family or on caregiving reported lower burnout than those overwhelmed in both areas or burdened by extreme paid workloads. This suggests that *many care workers may desire to spend more time away from formal work but lack the capacity to do so due to the demands of their jobs.*

c. These findings highlight the need to *regulate excessive working hours and invest in strategies that support work-life balance* of care workers. Without addressing the structural intensity of paid care work, especially in essential but overburdened roles, *efforts to reduce burnout and sustain the care workforce will remain limited.*

3

Burnout varies across different types of care work:

a. Healthcare workers reported the highest burnout levels compared to both domestic care and social care workers. Notably some occupations (e.g., live-in domestic workers, hospital cleaners) experienced high burnout despite fewer paid work hours—suggesting *emotional burden and working conditions are also critical.*

b. *Targeted, occupation-specific strategies* need to be developed in order *to address the distinct emotional and operational stressors faced in each role.* This includes ensuring that those in precarious work, like domestic workers and hospital cleaners, would be able to access mental health services where formal pathways are limited.

4

Satisfaction with time spent on paid and unpaid care work:

a. Satisfaction with time spent on paid and unpaid care work emerged as a stronger predictor of burnout among care workers, where *higher satisfaction was significantly associated with lower burnout.* Thus, quality of work experiences and the ability to maintain work-life balance are crucial for care workers' wellbeing.

b. Besides addressing structural intensity and volume of paid care work, strategies to mitigate burnout must also *prioritise factors that shape care workers' satisfaction with their care responsibilities.* This includes *institutional policies and practices that support work-life balance, recognising and valuing their contributions in both paid and unpaid care work,* as well as *cultivating supportive work environments.*

4.4.1

Resilience Amongst Care Workers

i *Measuring Individual Resilience of Care Workers*

The survey used the Brief Resilience Scale (BRS), which measures an "individual's capacity to rebound from stress despite significant adversity" (Rosner et al. 2024, 2).[1] This scale was particularly relevant due to this study's focus on the impacts of COVID-19 (a stressor) on the care workforce in Malaysia.

Table 4.4.1 shows the cut-off points for the three levels of resilience, as indicated by the BRS (Smith et al 2008). This scale was asked at three time points—before, during, and after the COVID-19 pandemic—to examine whether individual resilience is a static trait or dynamic process, and to assess its susceptibility to change in response to adverse events (e.g., the COVID-19 pandemic).

TABLE 4.4.1

Resilience Levels of Participants Based on Their BRS Scores

Resilience Scores Range	Level of Resilience
1.00 - 2.99	Low resilience
3.00 - 4.30	Normal resilience
4.31 - 5.00	High resilience

Note: The ranges above are based on the established cut-off points by Smith et al. (2008).

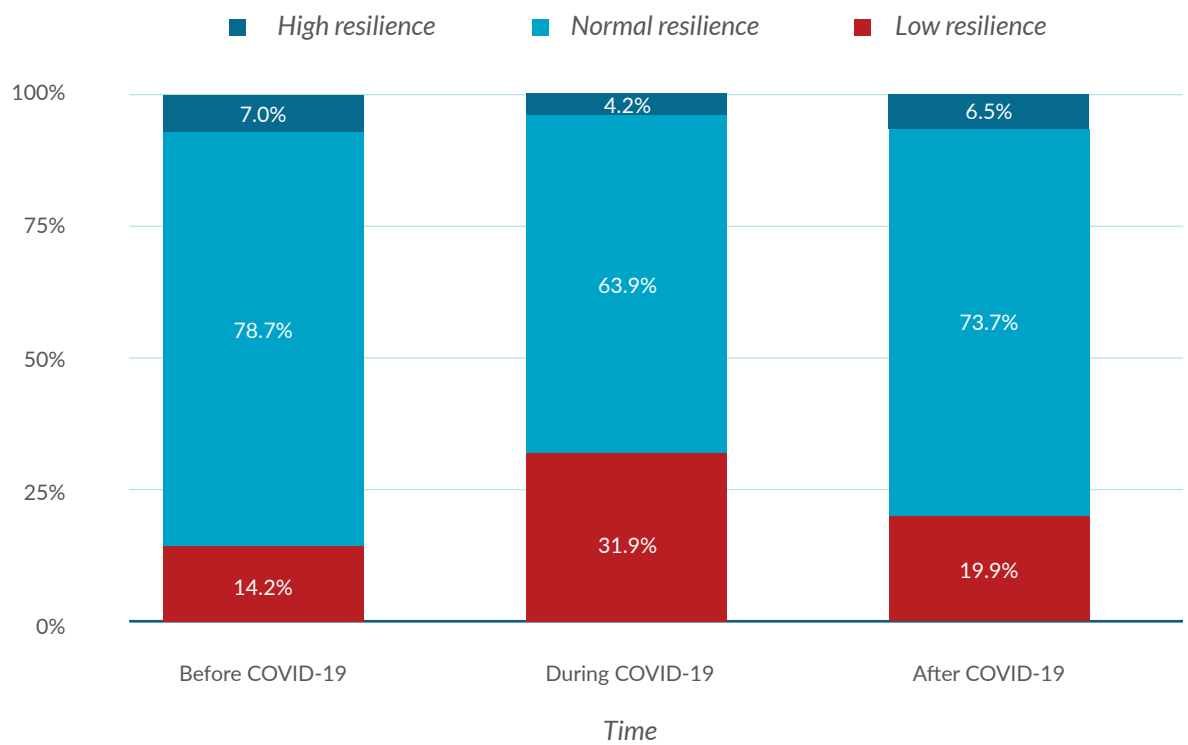
ii *Individual Resilience of Care Workers Across Time*

Based on Figure 4.4.1, the majority of care workers from our study reported normal levels of resilience across time. However, the proportion of care workers with low resilience increased by 17.7% during the pandemic compared to before the pandemic. This suggests that some care workers with either normal or high resilience may have *fallen into the low resilience category during the pandemic. Current resilience levels have yet to recover to pre-pandemic levels* as well.[2]

1 See the companion appendix, Appendix 4.4.1, for the BRS items.
2 See the companion appendix, Appendix 4.4.2, for descriptive statistics on resilience.

FIGURE 4.4.1

Bar Chart on Percentage of Care Workers with Low, Normal, and High Resilience Across Time (%)



Some care workers with either normal or high resilience may have fallen into the low resilience category during the pandemic. Current resilience levels have yet to recover to pre-pandemic levels.

Further analysis indicated that *resilience levels of care workers significantly changed across time, that is before, during, and after the COVID-19 pandemic.*[3]

Importantly, there was a significant difference between genders—with men reporting higher resilience overall.

When we looked at how resilience changed over time, it appears that *both genders experienced similar changes in resilience across time.*

3 Statistical significance was determined using mixed ANOVA with Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at **P** < 0.05. The full analyses are available in Appendix 4.4.3 in the companion appendix.

FIGURE 4.4.2

Profile Plot of Individual Resilience by Gender Across Three Time Points (Before, During, and After the COVID-19 Pandemic)

These findings suggest that *resilience functioned as a dynamic process* rather than a static trait, affirming our initial assertions in Chapter 2. Notably, both genders showed the *same trajectory of change* in resilience levels, which dropped during COVID-19 and partially recovered post-pandemic. This suggests that *resilience levels vary according to shared external circumstances or events*, like being impacted by a global pandemic, illustrating how individual *resilience naturally shifts and adapts in response to societal-level disruptions* (i.e., during COVID-19). This observation is in line with existing literature which posits resilience as a dynamic process rather than a static trait (Luthar et al. 2000; Windle 2011).

What the data make clear, though, is that care workers entered the pandemic with a certain level of individual resilience. *As the crisis hit and worsened, care workers adapted, often by taking on more work, managing health risks, and navigating uncertainty.* Narratives from the FGDs highlight exactly the circumstances under which care workers were forced to adapt, including the *cost of adaptation:*

Far, Doctor, East Coast Malaysia

Tapi, saya rasa mungkin agak kurang lah support daripada jabatan. Saya rasa mungkin dari segi dia orang pun ada dia orang punya demand. Maksudnya dia orang, they see what we don't see. I think we as MO see differently from how specialist see. But, and we don't communicate well during that time. I think work was too demanding and everybody is too busy doing their own work to check up on others, other people, okay. So, it was quite difficult because during the roster-making time, the demand was very great, from down and from up… Tapi, masa tu memang, I think sebab situasi ni tak pernah ada orang alami so, our superior pun macam tak tahu what is our burden. Dia pun tak panggil kita, talk to us, apa tu, apa yang kita nak, perlu, baiki, semua. So, masa tu, I think I was belittled lah bila saya demand for more people tu. So, sebab dia rasa case tak banyak, so tak perlu ramai orang……So, I think very unfair lah for me. So, bila kita demand for more people pun orang macam belittle macam tu.

English translation

But, I think maybe there is a little support from the department. I think maybe from their perspective, they also have their demands. Meaning, they see what we don't see. I think we as MO see differently from how specialists see. But, and we don't communicate well during that time. I think work was too demanding and everybody is too busy doing their own work to check up on others, other people, okay. So, it was quite difficult because during the roster-making time, the demand was very great, from down and from up… But, at that time, I think because no one had ever experienced this situation before, so our superiors didn't know what our burden was. They didn't even call us, talk to us, what we wanted, needed, fixed, everything. So, at that time, I think I was belittled when I demanded for more people. So, because they felt that there weren't many cases, so there was no need for more people……So, I think it was very unfair for me. So, when we demanded more people, people kind of belittled us like that.

Eliza, Nurse, East Malaysia

Masa itu tak cukup staf, manpower, no experience. Jadi bila masuk dalam ICU, di sana kita stres dengan patient, struggle dengan patient. Struggle dengan staff baru itu. Jadi mereka tidak boleh macam, kita tidak boleh biarkan mereka sendiri. Dan mereka pun tidak boleh buat sendiri. Jadi dalam masa yang sama, kita jaga patient, kita jaga dia juga.

English translation

At that time there was not enough staff, manpower, no experience. So when we entered the ICU, we were stressed with the patient[s], struggling with the patient[s]. Struggling with the new staff. So they couldn't like, we couldn't leave them alone. And they couldn't do it themselves either. So at the same time, we took care of the patient, we took care of them [new staff] too.

Tara, Hospital Cleaner, North Malaysia

Kalau kita tak cukup staff, kita gotong-royong ada gotong-royong. Kalau kawan-kawan kita pergi masuk sekali gotong-royong ada. Ada pernah buat…..Satu orang satu satu tempat. Kalau takde orang, tak cukup staff kita tiga, empat orang masuk sekali.

English translation

If we don't have enough staff, we help each other out. If our friends go in together, there is mutual support. We have done this before... One person at one place. If there is nobody, if we don't have enough staff, all three of us, four people, will go in together.

Thus, *while resilience levels have somewhat rebounded post-pandemic, they have not returned to pre-pandemic levels—likely because stressors impacting overall wellbeing have not gone away.* In this sense, resilience operates like a finite pool: It can support workers through crises, but it gets depleted. Without intentional recovery and support, individual resilience does not replenish sufficiently. This, in part, is why we assert there must be a shift away from absorptive and adaptive capacities of resilience—as these carry costs on the wellbeing of care workers. Transformative resilience capacities would rely less on care workers responding as and when crises happen, offering structural relief.

Notably, *men care workers consistently reported higher levels of resilience across all time points than women care workers.*[4] Further analysis using post hoc comparisons confirmed this, where these differences between men and women were statistically significant at each time point. In other words, the gap in resilience levels between men and women care workers remained present before, during, and after the pandemic.

Although studies on gender differences in resilience often yield mixed findings due to varying contextual factors, some evidence suggests that gendered patterns do exist, with women frequently reporting lower levels of resilience. For example, studies by Naseem and Munaf (2020) on resilience and aggression, and Rösner et al.'s (2024) on the reliability of the BRS within the German population, both identified gender-based differences. These findings align with *the gendered differences observed in the present study* which, crucially, we assert *are a reflection of broader structural inequalities that disproportionately impact women.* As our previous findings have shown, *women shoulder more unpaid care responsibilities, often with limited support, constrained by precarity and economic uncertainty.* These stressors compound, impacting resilience as well as its recovery. In these previous findings, individual resilience appears to play a buffering role, improving wellbeing outcomes. Thus, lower resilience in women is not only concerning because of how it reflects existing gender inequalities, but by how it may also reinforce them. Therefore, there is a clear need to better understand what can contribute to strengthening the resilience of women in the care workforce.

4 See Appendix 4.4.3 in the companion appendix for full statistical output of mixed ANOVA measuring resilience, time, and gender.

iii *Women and Men Care Workers' Individual Resilience: Exploring the Gender Disparities*

To explore the possible factors contributing to lower resilience levels among women care workers, we focused on whether *differences in perceived organisational support*[5] *could account for this gender disparity.* This particular analysis focuses on the post-pandemic period.[6,7]

Our findings showed that care workers who had *higher perceptions of their organisation's ability to support its workers during a crisis were more likely to have greater individual resilience.* Although *organisational resilience has a positive influence across genders, it does not fully eliminate gender disparities* in individual resilience. That is, *women care workers still consistently reported lower levels of resilience compared to men care workers,* even after accounting for organisational resilience, underscoring how *even robust organisational support cannot fully offset the structural and gendered barriers that undermine women's resilience.*[8]

In Chapter 2, we asserted that when organisations invest in the wellbeing of care workers, their individual resilience improves. Care workers with higher individual resilience, in turn, then contribute to stronger organisational resilience—a necessary component to ensuring the sustainability of care systems resilience. Thus, it is also necessary for us to look into the relationship between wellbeing and individual resilience. When wellbeing is accounted for, the relationship between individual resilience and perceived organisational support considerably weakened, suggesting that *wellbeing plays a more direct and meaningful role in fostering individual resilience.*[9] *However, the resilience gender gap still remains.*

This highlights an *urgent need for more targeted, gender-transformative strategies* in supporting the wellbeing of care workers, as a means to building their individual resilience. This, in the long-term, can support organisational resilience, though further study is needed to understand the exact relationship between the three factors.

Care workers with higher individual resilience, in turn, then contribute to stronger organisational resilience—a necessary component to ensuring the sustainability of care systems resilience.

5 The perceived organisational resilience or support in this section was collapsed to be one variable for ease of analysis, as items for this domain were different for domestic workers. Items answered by domestic workers were adapted due to the nature of their work, which exists within the structures where they have a direct relationship with their employer, as opposed to an organisation like other care workers within healthcare and social care sectors.
6 For the measure of perceived organisational resilience or support, care workers answered based on how they generally felt, indicating that they were likely answering based on how they currently felt (after COVID-19) or how they have felt thus far. Aligning the variables to focus on those post-pandemic helps ensure temporal and conceptual consistency across predictors, and allows for a more accurate comparison.
7 Statistical significance was determined using multiple linear regression. Variables were considered significant at $P < 0.05$. Full model details, including diagnostics and assumptions, are provided in Appendix 4.4.4 in the copmanion appendix.
8 Refer to Table (2) in Appendix 4.4.4 for estimated marginal means of individual resilience by gender and perceived organisational resilience levels.
9 Statistical significance was determined using multiple linear regression. Variables were considered significant at $P < 0.05$. Full model details, including diagnostics and assumptions, are provided in Appendix 4.4.5 in the companion appendix.

4.4.2.

Burnout Amongst Care Workers

Measuring Burnout of Care Workers

Six questions were adapted from the original Copenhagen Burnout Inventory (CBI) under the work-related burnout subscale. The survey items under the work-related burnout subscale were selected as the survey focuses on paid care work, thus making work-related burnout the most relevant. The selection of the work-related burnout section was also due to the increased demands of paid work, especially during COVID-19, making it an important domain to assess.

The authors define work-related burnout as "the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work" (Kristensen et al. 2005). Notably, this is not a comprehensive measure of burnout, as it is only assessing work-related burnout. Rather than diagnosing, these questions are intended to assess potential experience of burnout.

The selected questions were rephrased to be statements to ensure they aligned with other scales and questions used throughout the survey.[10] The adapted CBI in the survey consists of six items, and was asked at three time points: Before, during, and after the pandemic. The adapted scale demonstrated strong internal consistency.[11,12] Respondents' burnout score is scaled from 0 to 100, using the cut offs provided in Table 4.4.2.

TABLE 4.4.2:

Levels of Burnout Experienced by Participants Based on Their Burnout Score

Burnout Score Range	Level of Burnout
0 - 49	No to low burnout
50 - 74	Moderate burnout
75 - 99	High burnout
100	Severe burnout

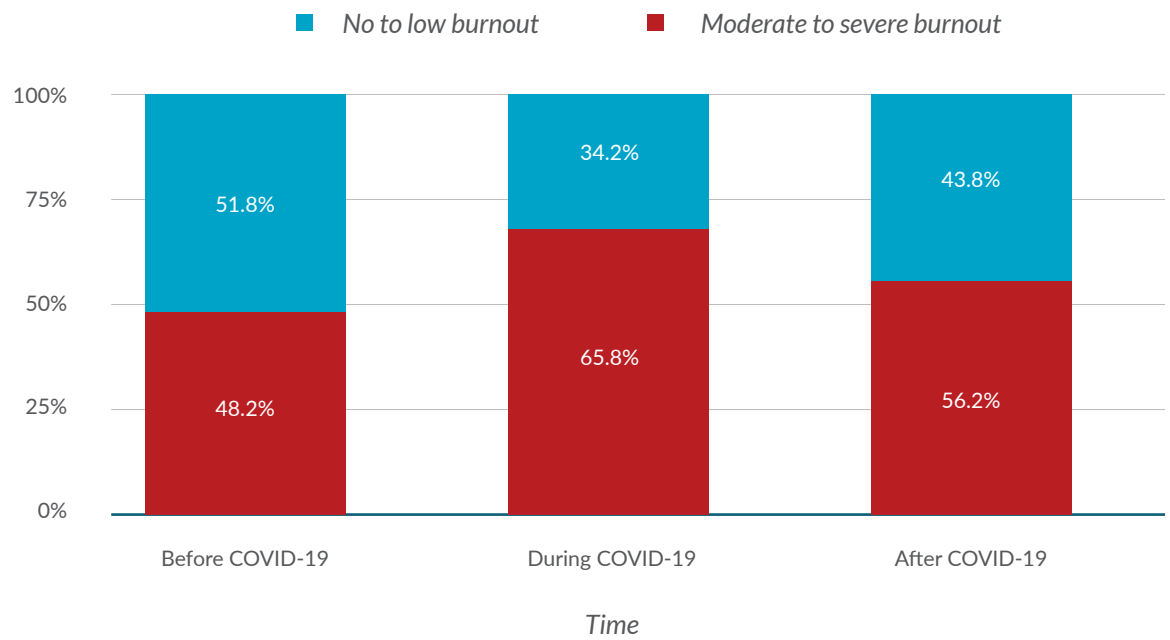
10 See Appendix 4.4.6 in the companion appendix for selected and rephrased items of the adapted CBI scale.
11 Cronbach's alpha scores for the adapted CBI scale across the three time points—before, during, and after the pandemic—are provided in Appendix 4.4.7 in the companion appendix.
12 Cronbach's alpha was conducted for the adapted CBI in English with the overall sample (n = 1534).

ii *Experiences of Burnout by Care Workers Across Time*

Care workers across the three sectors reported *greater intensity of burnout during and after the COVID-19 pandemic. Nearly two-thirds (65.8%) of care workers experienced moderate to severe burnout* levels—an increase of 17.6% from pre-pandemic levels. These numbers did not significantly drop after the pandemic, with 56.2% of care workers still reporting moderate to severe levels of burnout.[13] This suggests that care *workers may still be feeling the impact of the pandemic, reflected in how these rates remain elevated.*

FIGURE 4.4.3

Bar Chart on Proportion of Care Workers Who Experienced Moderate to Severe Levels of Burnout Across Time



Our analysis indicated that the *burnout levels of care workers significantly changed across time* (i.e., before, during, and after the COVID-19 pandemic).[14] *Burnout peaked during COVID-19 for both men and women,* significantly exceeding levels before and after the pandemic. Specifically, *burnout during COVID-19 was significantly higher than both before and after COVID-19.*[15] While burnout declined after COVID-19, it remained higher compared to pre-pandemic levels.

These patterns were consistent for men and women, as no significant gender differences were found at any time point. Despite detecting no gender difference between men and women in the experience of burnout, it is still worth situating this finding in context of gender differences in individual resilience. More precisely, this may suggest that burnout is a *response* to a stressor within a shared environment. Men and women across care sectors experienced the COVID-19 pandemic together and similarly felt burnout. However, individual resilience, as a *resource*—a finite pool that care workers can draw on to support coping mechanisms—is shaped by structural factors, such as the support available to them. Consequently, as mentioned previously, women's individual resilience is constrained by the structural inequalities they routinely face.

13 See Appendix 4.4.2 in the companion for descriptive statistics on burnout.
14 Statistical significance was determined using mixed ANOVA with Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at **P** < 0.05. The full analyses are available in Appendix 4.4.8 in the companion appendix.
15 Determined through pairwise post-hoc analysis **P** < 0.05. View full results in Appendix 4.4.8 in the companion appendix.

iii *Influence of Paid and Unpaid Care Work Hours on Care Workers' Experiences with Burnout*

This section aims to explore the possible influence of paid and unpaid care work on care workers' experiences with burnout during COVID-19. We felt it was important to focus on this time period due to the increased stress, uncertainty, and amount of paid and unpaid work during the pandemic, which could potentially impact the intensity of burnout experienced by care workers. Cross-tabulations of care workers' average paid (Figure 4.4.4) and unpaid (Figure 4.4.5) care work hours per week and their levels of burnout during COVID-19 were conducted to provide a preliminary overview of these relationships.

In Figure 4.4.4, care workers with *higher average paid work hours per week were more likely to experience a greater intensity of burnout.* For example, doctors who worked an average of 79.4 hours per week experienced severe burnout, while those who worked an average of 57.1 hours per week experienced lower burnout during COVID-19. A similar pattern was observed for specialised care workers too; those who worked an average of 46.1 hours per week experienced no to low burnout, whereas those who worked an average of 61.9 hours per week experienced high burnout.

Notably, *certain occupations* in Figure 4.4.4 *experienced severe burnout despite working fewer hours in relative to those with low, moderate, or high burnout.* Namely, amongst live-in domestic workers and hospital cleaners, a higher number of hours of paid care work was reported by those who experienced high burnout, whereas those who experienced severe burnout reported less paid care work hours. This may seem counterintuitive, but may potentially reflect individual differences in how care workers respond to and experience stress.

Figure 4.4.4

Heatmap of Average Paid Care Work Hours per Week According to Burnout Levels of Care Workers During COVID-19

Occupation	No to Low Burnout	Moderate Burnout	High Burnout	Severe Burnout
Doctors	57.1	65.5	70.2	79.4
Nurses	50.6	57.1	62.5	73.3
Hospital cleaners	51.5	55.4	63.6	60.8
Child care workers	38.6	41.2	52.8	
Social workers	66.1	55.3	66.0	**105.0**
Specialised care workers	46.1	53.9	61.9	
Live-in domestic workers	64.8	68.6	83.2	68.0
Live-out domestic workers	41.2	46.5	47.3	

Note: The redder the column, the higher the average paid work hours per week during COVID-19.

The greater intensity of burnout experienced by certain care workers—despite reporting fewer average paid care work hours per week—could also be due to other factors. For example, the *emotional burden of providing care while simultaneously worrying about the wellbeing of their own families during the pandemic may have significantly contributed to this disconnect between working hours and burnout.* These experiences were best captured in our qualitative findings.

In focus group discussions, care workers shared that they *struggled to manage their emotions in the face of morbidity and mortality of care recipients and their own family members*—often forced to *compartmentalise their feelings and de-prioritise their wellbeing* in order to keep working during the pandemic.

For *migrant domestic workers,* the challenge of *managing transnational care while being physically distant from their families added another layer of emotional complexity* during COVID-19. Trista and Anisa are two migrant domestic workers who reflected on their worries about their family back home, including Trista's child's health condition during the pandemic:

Trista, Migrant Domestic Worker, Central Malaysia

I was also ***worried because the youngest child had asthma,*** *right, so COVID is the most sensitive to asthma.* ***I kept crying, my boss said "If you want to go back, it's okay to go back, it's okay to go back…***

Merely examining the average amount of paid care work done by care workers is not sufficient to comprehensively capture factors that influence experiences of burnout. Based on Figure 4.4.5, we observed that *the intensity of burnout is not solely dependent on the amount of time spent on paid care work.* Rather, it also *depends on the amount of time spent on unpaid care work concurrently.*

Care workers are often forced to compartmentalise their feelings and de-prioritise their welling in order to keep working during the pandemic.

Social workers and hospital cleaners who experienced high burnout during COVID-19 had higher average unpaid work hours per week (i.e., 56.6 hours and 32.6 hours respectively). On average, these two groups also had more than 60 hours of paid work per week.[16]

Anisa, Migrant Domestic Worker, North Malaysia

But what was more emotional was towards our own family in the village. We couldn't even share because it was far away. It was just anxiety that sometimes made us emotional. *What was more emotional, like that. If here, to the boss, no. Because there were grandparents, we could love them. Give them herbs so they would be healthy. Don't get COVID while I'm here. If I'm not there, what COVID I'll get, I don't know [laughs].*

Child care workers who experienced no to low burnout during COVID-19 spent the most time on unpaid care work (an average of 58.9 hours per week) compared to other child care workers with moderate and high burnout. They were also spending, on average, the least paid care work hours per week (38.6 hours)—suggesting that the intensity of burnout may be influenced by one's capacity to balance paid care work and unpaid care responsibilities.

16 Refer to Figure 4.4.4 for comparisons of average paid work hours per week by occupation during COVID-19 and Figure 4.4.5 for comparison of average unpaid work hours per week by occupation during COVID-19.

Figure 4.4.5

Heatmap of Average Unpaid Work Hours per Week According to Burnout Levels of Care Workers During COVID-19

Occupation	No to Low Burnout	Moderate Burnout	High Burnout	Severe Burnout
Doctors	22.5	15.8	14.5	13.4
Nurses	37.8	33.1	34.6	20.6
Hospital cleaners	29.4	29.1	32.6	20.2
Child care workers	58.9	56.7	36.8	
Social workers	38.7	39.0	56.6	63.0
Specialised care workers	39.4	37.4	40.6	
Live-in domestic workers	29.4	28.9	17.7	20.0
Live-out domestic workers	26.6	29.2	37.0	

Note: The redder the column, the higher the average unpaid work hours per week during COVID-19.

To understand these relationships further, *we conducted three analyses.* In our first analysis,[17] we examined paid and unpaid care work hours, as well as *their combined effect on burnout.* Results showed that paid care work hours were significantly and positively associated with burnout, indicating that *more hours spent on paid care work resulted in higher burnout levels.* Unpaid care work hours did not seem to significantly influence burnout outcomes. This model accounted for *approximately 9% of the variation in burnout* across individuals, suggesting that *burnout is complex and is influenced by other factors beyond the amount of time spent on paid care work.*

Thus, in our *second analysis,*[18] we considered how *care worker groups* (healthcare, social care, and domestic care) might shape differences in patterns by sector during the pandemic. Paid care work hours remained a significant predictor of burnout, reinforcing that *longer working hours are a key driver for higher burnout levels.* Unpaid care work hours also remained non-significant. However, we found a *significant negative interaction between paid and unpaid care work hours, suggesting that the relationship between paid care work hours and burnout may be buffered by unpaid care work hours.* This indicates a complex dynamic, where unpaid care work could potentially alter how the demands of paid care work impact burnout. It does not imply that greater time spent on unpaid care work is inherently protective. Rather, these findings highlight that *excessive cumulative workload, especially in paid care work, is the primary factor contributing to the intensity of burnout experienced,* and that *managing multiple care responsibilities and roles may influence—but does not necessarily eliminate—the risk of burnout among care workers.* In essence, having enough time to manage personal care responsibilities is critical for care workers in times of crisis, when there is a significant increase in paid care work intensity and demand.

Notably, when care worker groups were taken into account, this significantly improved the model's

17 Statistical significance was determined using hierarchical regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.4.9.
18 Statistical significance was determined using hierarchical regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.4.9.

explanatory power, accounting for nearly 19% of the variation in burnout. These results suggest that hours worked are only part of the picture; *the type of care work also plays a crucial role in shaping burnout outcomes.* Healthcare workers reported higher burnout levels than social care and domestic workers,[19] illustrating that there are *occupational differences in burnout which potentially reflect the varying intensity and emotional demands across the care sectors*—especially during the pandemic, which was primarily a healthcare crisis.

Collectively, these findings highlight the *dominant role that paid care work has in contributing to burnout* and suggest that *unpaid care work, while not directly predictive, may change this relationship.* In other words, *unpaid care work may slightly buffer the impact of paid care work on burnout during times of crises,* particularly in *occupations with extreme working hours.* However, we assert that the buffering effect of unpaid care work may be limited, as care workers with both extreme paid and unpaid care work hours tend to experience more severe burnout than others—a clear and unsustainable double burden especially for women care workers. These statistical findings support the interpretations drawn from the cross-tabulated data above, suggesting that *care workers' capacity to manage their paid and unpaid care responsibilities during crises matters in supporting their wellbeing and sustaining the care workforce in the long run.*

Finally, in our *third analysis,*[20] we included care workers' *satisfaction with their time spent on paid and unpaid care work* during COVID-19. Once satisfaction was accounted for, the amount of time spent on paid and unpaid care work—as well as their interaction—during COVID-19 *no longer significantly predicted burnout.* Significant differences in burnout remained between care worker groups, even after accounting for paid and unpaid care work hours and satisfaction—reinforcing that the type of care work matters in burnout experiences. On the other hand, satisfaction with time spent on paid and unpaid care work were significant negative predictors;

If another large-scale crisis were to occur, it is unclear how many care workers would be able to recover from the burnout they already experienced.

care workers who have greater satisfaction with their care responsibilities are less likely to experience burnout. As satisfaction is a subjective measure, two care workers with the same number of paid and unpaid care work hours can have vastly different experiences. A care worker who feels less satisfied with their care responsibilities is more likely to experience burnout, underscoring that the *quality of work experiences and ability to have work-life balance are key factors in supporting the overall wellbeing of care workers.*

This final model *explained 43% of the variance in burnout,* highlighting that experiences of burnout are not solely driven by the amount of time spent on care work and type of care work. Rather, *how satisfied care workers feel about their care responsibilities—both paid and unpaid—may play a more important role in shaping the intensity of one's burnout.* Given that satisfaction with the amount of time spent on paid and unpaid care work is closely tied to broader satisfaction with work-life balance (as discussed in Finding 2), these findings suggest that *burnout may be influenced not only by how well care workers feel they are managing and balancing their care roles and demands, but also by the structural conditions that shape those experiences.* Essentially, it is not just about individual perceptions of managing care responsibilities, but more importantly, about *how much space and support care workers are afforded by organisations to concretely achieve work-life balance.* The *structural intensity and demanding nature of care responsibilities,* especially when *compounded by lack of institutional support, can limit care*

19 Specifically, domestic workers reported burnout scores approximately 14.41 points lower, and social care workers approximately 16.70 points lower than healthcare workers (both were **P** < 0.001).
20 Statistical significance was determined using hierarchical regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.4.9.

workers' ability to manage their care demands, significantly contributing to their experiences of burnout.

Nonetheless, a massive crisis—like the COVID-19 pandemic—has had clear implications on the continued experience of burnout by care workers within our study. *In the event of another major adverse event comparable to the COVID-19 pandemic, how many care workers would possess the capacity to recover?* More critically, *how many would have the resources necessary to survive another crisis?* Thus, effective crisis preparedness plans—both on the national and sector-specific level—requiring systemic and cultural shifts within Malaysia's care ecosystem are critical to circumvent the long-term effects of burnout among care workers and to ensure the sustainability of Malaysia's care workforce and ecosystem.

Our findings point to a dynamic and interdependent relationship, where the wellbeing of care workers is closely tied with their individual resilience and the resilience of their organisations. *Investing in the wellbeing of care workers as a pathway to resilience means not only mitigating burnout, but also cultivating a care ecosystem where recovery and sustainability are embedded in institutional frameworks and policies.* Without such measures, Malaysia's care infrastructure will remain ill-equipped to withstand future crises, with lasting consequences for care workers, the communities they support, and the broader care ecosystem.

Finding 5:

1 in 3 Malaysian care workers want to leave their current position within the next five years, while over half of domestic workers want to do the same.

Care workforce retention can be supported by improving job satisfaction, individual resilience, organisational resilience, and addressing experiences of violence.

FINDING HIGHLIGHTS

1

Overall, **one in three Malaysian care workers plan to leave their current position** within the next five years.

There appear to be gendered reasons for this.

a. Women's decision-making around staying in their current position appears to be tied to their unpaid care responsibilities, as they are more likely to cite wanting to spend more time with family or retirement. Many of those who are intending to leave their current position appear to be in their prime working years, that is under 50, but also are nestled within households with higher care loads, with little support or redistribution.
    i. This appears to echo current trends around women's labour force participation rate and the pressure women are under to choose between their careers and their families, within structures that do not adequately support their care needs.
b. Men's decision-making appears focused on career stability, growth, and economic security. These considerations are prevalent even amongst men with lower care loads, suggesting men's concerns are future-oriented, in efforts to meet the pressure of fulfilling the gendered ideal of a provider or breadwinner role.
c. In sum, these patterns highlight how *structural gaps around care, income security, and career growth continue to reinforce traditional gender roles,* placing women under pressure to exit the workforce prematurely while men prioritise financial advancement.

2

One in two migrant domestic workers intend to leave their current position within the next five years.

Beyond gender-specific cited reasons, job stress and burnout was highly cited by Malaysians as a reason for looking to leave their current position, with those intending to leave reporting higher levels of burnout than those intending to stay.

While most were citing wanting to spend more time with their family, there is a similarity in profiles between domestic workers intending to stay and those intending to leave. Uncertainty largely defines the role of migrant domestic workers: Contracts typically last two years, while the visa needs to be

renewed yearly. Many also have limited alternative options for employment. This defines the structural precarity faced by migrant domestic workers. It is, thus, possible that the question around intention to stay functions less as a forecast and more as an expression of desire or preference for workers under circumstances where they had greater control. Consequently, there is a similarity in profiles because the decision to disclose this desire may have been shaped by external factors, such as how comfortable the respondent felt in truthfully sharing the information. That said, as more than half intend to leave their current position within five years, more must be done to better support domestic workers and understand their issues, especially since they play a vital role in enabling the labour force participation of women in M40 and T20 households.

Overall retention of the care workforce can be supported by improving job satisfaction, individual resilience, and organisational resilience, in addition to addressing violence faced by care workers both at work and in their personal lives

3

When looking at the retention of the overall care workforce, the following emerged:

a. Those who intend to stay in their current position appear to have *higher levels of job satisfaction.*
    i. In trying to predict what supports job satisfaction, it was revealed that burnout is the strongest predictor of low job satisfaction.
    ii. Individual resilience helps boost job satisfaction to an extent, but it does not fully protect workers from the negative effects of burnout.
b. Investment into individual resilience is still crucial, as even *modest improvements in care workers' individual resilience are associated with a 33% greater likelihood of them wanting to stay* in their jobs.
c. Importantly, perceived organisational resilience is a critical factor as *care workers who perceived their organisations as more resilient were 112% more likely to intend to stay,* essentially more than twice as likely compared to those who did not.
d. *Those intending to leave appear to face more violence in the workplace* regardless of gender, than those who are intending to stay, suggesting the need for strengthened protection mechanisms. These protection mechanisms must also consider the needs of domestic workers, who typically work in isolated conditions in private homes.
e. Finally, *Malaysian women who intend to leave their current position appear to report higher instances of personal violence* than those who intend to stay in their current position. There was no significant difference in the reported levels of personal violence for Malaysian men or migrant women. This underscores the importance of considerations around how *domestic and personal violence can shape women's labour force trajectories,* highlighting the need for meaningful protections or reporting mechanisms for those experiencing violence at home.

4.5

Intention to Leave Current Position Amongst Care Workers

Amongst Malaysian care workers, one in three care workers want to leave their current position within the next five years (34.5%). This is roughly 35.8% of the women in our sample and 30.4% of the men.[1] The intention to leave question was structured to determine two things:[2]

1 If there was intention to drop out of the workforce altogether;

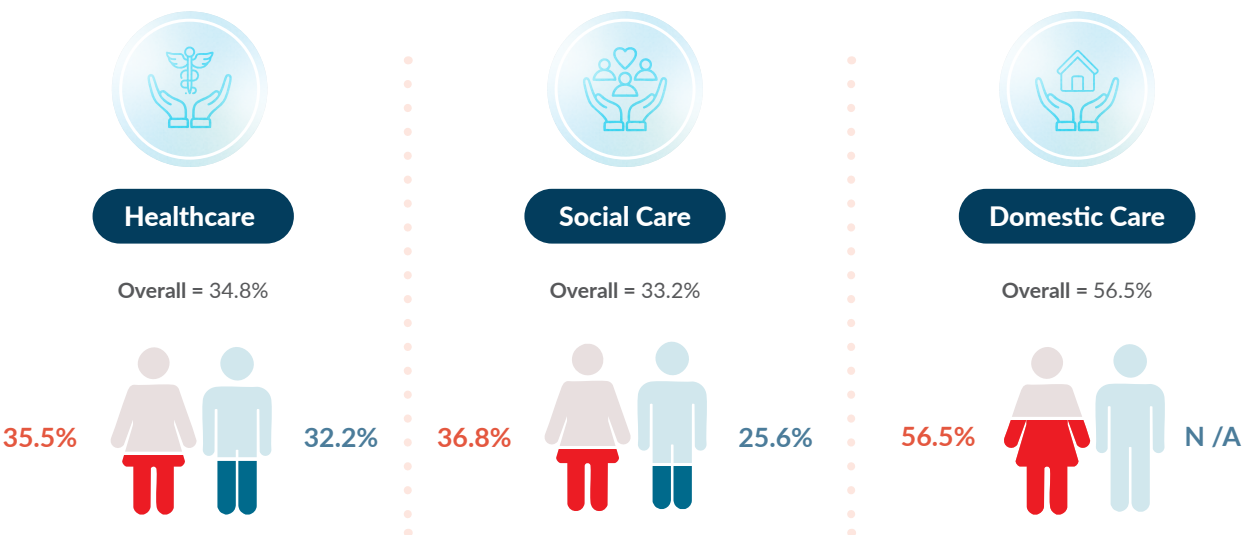
2 If there was intention to remain in the care workforce, but under different circumstances (for example, by shifting to the private sector or moving to another country).

Both of these options would present challenges to the resilience and sustainability of Malaysia's care workforce and infrastructure, as the intention to drop out or move to another country signals a reduced workforce. Meanwhile, public sector care workers intending to shift to the private sector risks undermining the affordability of care for Malaysians, which would further strain public care systems.

The breakdown per sector, by gender, of care workers stating an intention to leave within the next five years is displayed in Figure 4.5.1.

Figure 4.5.1

Percentage of Care Workers by Sector and Gender Stating They are Intending to Leave Their Current Position within the Next Five Years.3



Notes: n = 1,534

1 There is no significant gender difference within sectors, where significance is **P** < 0.05. View Appendix 4.5.1 in the companion appendix for full statistical output.
2 The initial question allowed respondents to select the length of time they intend to stay in their current position, ranging from less than six months to six or more years. For the purposes of this analysis, those who selected answers less than six years or more have been combined as a group intending to leave within the next five years. This was done to ease analysis, while also recognising that those intending to leave within five years likely presents, at the very least, a concern in the medium-term sustainability of the care ecosystem in Malaysia.
3 There is no significant gender difference within sectors, where significance is **P** < 0.05. View Appendix 4.5.2 for full statistical output in the companion appendix.

By sector, there is a higher intention to leave their current position amongst domestic care. This result may be because, as migrant domestic workers employed under two-year contracts, respondents are potentially expressing a desire to change employers, or are temporary migrants and may have plans to return to their homeland. This may also explain differences between Malaysians and migrant domestic workers expressing their intention to leave; for example, Malaysians intending to leave their current position within the next five years report lower levels of overall wellbeing compared to those who do not intend to leave, whereas there is no statistically significant difference between the wellbeing scores of those intending to leave their current position amongst migrant domestic workers.[4]

That said, migrant domestic workers are still important to the care ecosystem in Malaysia. As such, for Finding 5, we will first delve deeper into the reasons Malaysians intend to leave their current position and then explore why migrant domestic workers intend to leave. This finding will also consider how to support workforce retention, examining the role of job satisfaction, burnout, individual resilience, and organisational resilience.

4.5.1
Intention to Leave Amongst Malaysians

The highest intention to leave current position amongst Malaysian care workers is in specialised care workers, followed by doctors and nurses.

TABLE 4.5.1

Percentage of Care Workers Intending to Leave Their Current Position within the Next Five Years by Occupation.

Occupation	Percentage intending to leave position within next five years
Doctors	35.3
Nurses	35.0
Hospital Cleaners	33.7
Childcare Workers	33.6
Specialised care (eldercare and PWD care)	40.5
Social Workers	23.9

4 Malaysians intending to leave their position within the next five years have significantly lower overall wellbeing scores compared to those who do not intend to leave within the next five years. However, for migrant domestic workers, those intending to leave their position within the next five years do not have significantly different overall wellbeing scores compared to those intending to stay six or more years. This was determined through independent samples t-test, with further information available in Appendix 4.5.3 in the companion appendix.

Based on Table 4.5.2, there is a slightly higher intention to leave the current position amongst those who are in the private sector, as opposed to those in the public sector. However, when further disaggregating the data by gender, it appears that an equal rate of men intend to leave their current positions within the next five years from the public and private sectors, whereas amongst women, there is higher intention to leave amongst those who are in the private sector.[5]

TABLE 4.5.2

Percentage of Care Workers Intending to Leave their Current Position within the Next Five Years by Sector and Gender.

Sector	Overall	Women	Men
Public sector	31.4%	31.7%	30.4%
Private sector	42.3%	46.0%	30.5%

Examining into the reasons for why Malaysians intend to leave their *current position might better explain gender differences emerging from the responses.*

Reasons for Leaving

Overall, the top three reasons for leaving appear to be job stress and burnout, wanting more time with family, and retirement. When further disaggregated by gender, it appears that these reasons were most commonly cited by women; for men, in addition to job stress and burnout, wanting to move to the private sector and financial concerns were more likely to be cited over wanting to spend more time with family and retirement.

Top three reasons for leaving appear to be ***job stress and burnout, wanting more time with family,*** and ***retirement.***

TABLE 4.5.3

Percentage of Care Workers Intending to Leave their Current Position ithin the Next Five Years by Top Three Reasons by Gender.

	Primary reason	Secondary reason	Tertiary reason
Overall	Job stress and burnout (41.8%)	Wanting more time with family (29.9%)	Retiring (27.6%)
Women	Job stress and burnout (41.7%)	Wanting more time with family (32.6%)	Retiring (29.3%)
Men	Job stress and burnout (42.2%)	Wanting to move to private sector (35.6%)	Financial concerns (31.1%)

Notes: n = 421

5 Statistical significance was determined through an independent sample t-test, at **P** < 0.05. View Appendix 4.5.4 in the companion appendix for further details.

Table 4.5.4

Percentage of Care Workers Intending to Leave their Current Position within the Next Five Years by Top Three Most Commonly Cited Reasons by Occupation.

	Primary reason	Secondary reason	Tertiary reason
Doctors	Stress and burnout (58.8%)	Financial concerns (40.2%)	Wanting to move to private sector (39.2%)
Nurses	Stress and burnout (52.9%)	Better opportunities in another country (34.9%)	Wanting to spend more time with family (32.0%)
Hospital Cleaners	Retirement (44.1%)	Wanting to spend more time with family (32.4%)	Financial concerns (17.6%) Wanting to move to another sector (17.6%)
Childcare Workers	Concerns about mental health (41.7%)	Retirement (36.1%)	Wanting to spend more time with family (30.6%)
Specialised care (eldercare and PWD care)	Retirement (43.8%)	Wanting to spend more time with family (31.1%)	Concerns about mental health (28.1%)
Social Workers[6]	Retirement (68.8%)		

When disaggregated by occupation, there is slight variation amongst the occupations. It becomes clear that intentions to leave their employment for social care workers appears most impacted by retirement, whereas healthcare, with the exception of hospital cleaners, appears more impacted by stress and burnout. For those who have financial concerns or are actively seeking other opportunities either in the private sector or abroad, it is likely they do not intend to drop out of the care workforce but perhaps leave their current position within the public sector. On the other hand, those citing retirement and wanting to spend more time with family may be seeking to leave the workforce entirely.

It is important to note here certain reasons for leaving their current positions amongst doctors and nurses mirror current trends in Malaysia. For example, in 2022, 54 percent of medical officers in the public sector had left for the private sector (NST 2025). Our data suggest that nearly 40 percent of doctors are thinking of shifting to the private sector.

In 2023, the Ministry of Health also reported that over 2,400 nurses had applied to work abroad, a number amounting to two percent of the workforce (CodeBlue 2024a). While the actual number of nurses who have left to work abroad may not seem alarming, the real issue, as pointed out during our roundtable discussions with nurses, is that Malaysian nursing graduates are opting to begin their careers abroad. As a result, the number

6 For social workers, their primary reason for leaving was retirement. Four other reasons tied for second, that is stress and burnout, concerns about physical health, concerns about mental health, and wanting to spend more time with family. These four reasons were cited by 18.8% of social workers each.

of vacancies for nurses per year has been steadily increasing, from around 2,100 vacancies in 2020 to nearly 7,000 vacancies in 2023 (MalayMail 2024).

Finally, when disaggregated by the public and private sector, retirement appears to be the main reason cited by those in the private sector, whereas for the public sector, job stress and burnout is the main reason.

TABLE 4.5.5

Percentage of Care Workers Intending to Leave their Current Position within the Next Five Years by Top Three Most Commonly Cited Reasons by Sector.

Sector	Primary reason	Secondary reason	Women
Private	Retirement (29.5%)	Stress and burnout (27.4%) Financial concerns (27.4%)	Wanting to spend more time with family (26.0%)
Public	Stress and burnout (49.5%)	Wanting to spend more time with family (32.7%)	Retirement (26.5%) Financial concerns (26.5%)

Notes: n = 421

Recognising the gendered nature of care work, we will now examine the reasons cited by Malaysian men and women more closely.

ii *Reasons Cited by Malaysian Women*

A *Wanting More Family Time*

32.6% of women who are intending to leave their current position say they are considering it because they want to spend more time with their family.

Two-thirds of women citing this reason have at least one child in their household (65.5%), compared to men who cite this, where only 44.4% of them have a child in their household. This suggests the presence of a child may weigh more heavily on women's decision to leave their current position.

TABLE 4.5.6

Percentage of Women Citing "Wanting More Family Time" by Presence of Household Members Under the Age of Eighteen.

34.5%
No children under 18

65.5%
Have children under 18 present

Most of these women are in prime working age (81.8% are under the age of 50) and two thirds (66.4%) of them have only one to two caregivers present in the household. On average, they also have 17.9% less in household income per capita (RM349.78) than women who did not cite this reason. These women were also more likely to support benefits such as a monthly allowance or stipend for those who are unable to work because they are family care providers (66.4%), compared to women who did not cite this reason (only 52.9% agreed) and even men who cited this reason (only 55.6% agreed). This possibly reflects how measures like this could offer the women tangible relief. Additionally, 70.0% of these women feel as though they could be doing more to support their families with household responsibilities, compared to 55.6% of men who cited this reason, suggesting a stronger internalised expectation to fulfil caregiving roles.

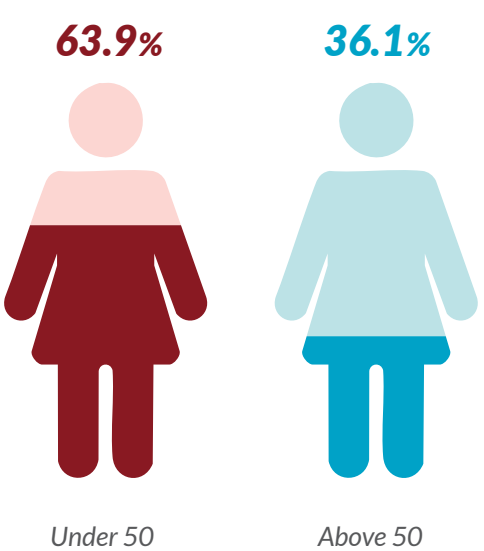
Taken together, these patterns potentially indicate that *women who want more time with their family may also face structural challenges,* such as unmet childcare needs, limited care support at home, and financial strain. While further inferential analysis is needed, these findings point to the importance of care-supportive policies, not just to address the unpaid care load that women disproportionately carry, but to better support their retention in the care workforce too.

B Retirement

This was cited by 29.3% of women who are intending to leave their current position. Interestingly, nearly two-thirds (63.9%) of the women citing retirement are below the age of 50, indicating that many are thinking of early retirement or of dropping out, compared to men where less than half are over the age of 50 (47.4%). This reflects current trends in female labour force participation rate, where labour force participation rate gaps between men and women begin increasing after age 35 (Hawati and Puteri Marjan 2024; KRI 2024).

FIGURE 4.5.2

Percentage of Women Citing Intention to Retire within the Next Five Years by Age.



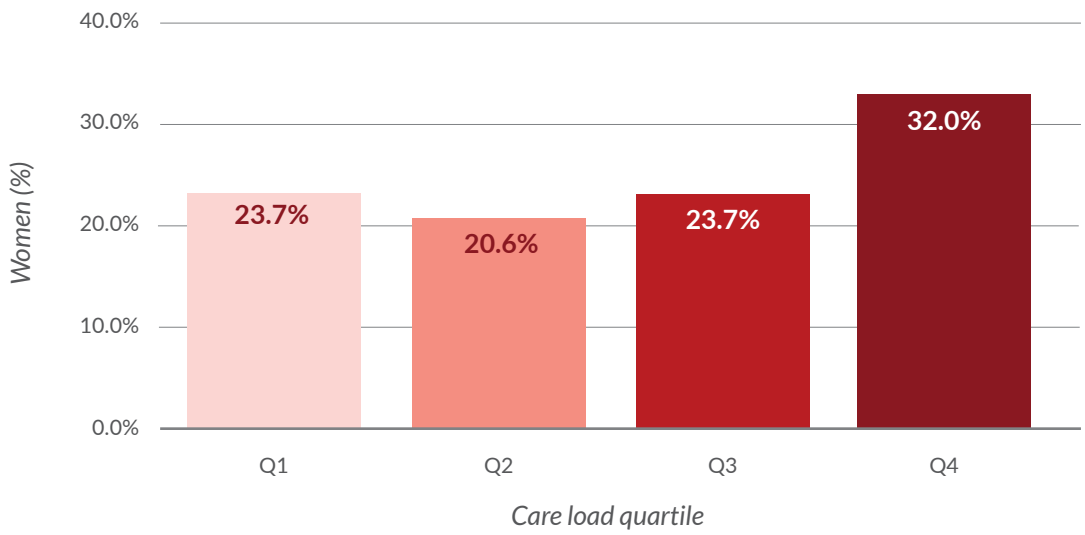
Over half of the women (55.7%) who want to retire fall into the highest care-load quartiles, Q3 and Q4. Of this group, an even higher proportion are below the age of 50 (70.4%), suggesting a link between having higher care responsibilities and wanting to pursue early retirement. As mentioned in Finding 1, those in these care quartiles are typically living within intergenerational household arrangements and women in these care quartiles also typically report undertaking around 40 hours of unpaid care work each week. Additionally, even though these women are in intergenerational households, care responsibilities may be unevenly distributed to them, as 64.8% of the women in Q3 and Q4 citing retirement have either only one or two caregivers in their households. Despite this, two-thirds of these women (68.0%) felt as though they could be doing more to support their families with household and caregiving responsibilities (compared to only 52.6% of men citing retirement).

While it is important to acknowledge the autonomy of women–the freedom to be able to choose whether they want to work or be homemakers–this autonomy depends on women having sufficient support structures. That 41.2% of these women fall into the low satisfaction with social support for unpaid care work bracket (compared to only 26.3% of men citing this reason) suggests that there are deeper, gendered inequalities potentially influencing these decisions.

This points to a concerning implication for female workforce retention, where, possibly, *the cumulative burden of intensive unpaid care work coupled with minimal redistribution of care within the household, may drive women in prime working age to consider early retirement.*

FIGURE 4.5.3

Percentage of Women Citing an Intention to Retire within the Next Five Years by Care Load Quartile



iii Reasons Cited by Malaysian Men

A Better Opportunities in the Private Sector

Around a third of men (35.6%) said they are looking for better opportunities in the private sector, hence why they are intending to leave their current positions within the next five years.[7]

Nearly three-quarters of these men (71.9%) report low satisfaction with their work-life balance, slightly higher than women who cite the same reason (64.4%) and men who are not looking to the private sector (48.3%). 43.8% of men looking to the private sector also cited job stress and burnout as another reason for why they are thinking of leaving their current positions. This suggests the desire for improved work-life balance is a key factor behind their intention for seeking opportunities in the private sector.

Financial dissatisfaction also appears to be a major driver, though it is not explicitly mentioned; only 25.0% of men looking to the private sector for better opportunities explicitly cited financial concerns as a reason for leaving. A much larger share of men seeking opportunities in the private sector (65.6%) believe they are not being paid fairly (Figure 4.5.4). This is almost double the rate among men who are not considering the private sector (34.5%). Even amongst women looking to the private sector for better opportunities, less than half believe they are not fairly paid (49.3%). This gap suggests that, even when not directly stated, *perceived unfair compensation may be an underlying factor that is influencing men's desire to seek opportunities in the private sector,* potentially tied to the belief that the pay is better.

7 This difference is also statistically significant, as determined by an independent sample t-test, where significance is determined by **P** < 0.05. Full statistical output is available in Appendix 4.5.5 in the companion appendix.

FIGURE 4.5.4

Comparison of Those who Feel they are Being Paid Unfairly Amongst a Selected Group of Respondents Seeking to Leave their Current Position within Five Years for Better Opportunities in the Private Sector.

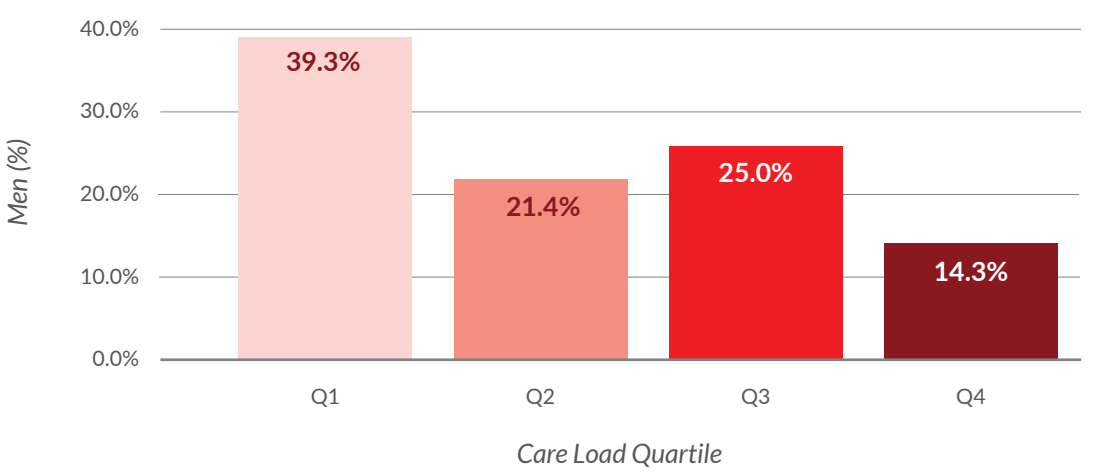
B Financial Concerns

Related to the previous, financial concerns appear to be more salient for men, as 31.1% cited this as one of the reasons they are considering leaving their current position in the next five years, compared to only 25.7% of women.[8]

Amongst those citing financial concerns, a slightly higher number of women believe they are not being paid fairly (58.8%), compared to 57.1% of men. This suggests that there are other factors for men citing financial concerns beyond just explicitly feeling they are being paid unfairly. Most interestingly, only 28.6% of men citing this reason fall into the B40 household bracket, which means this reason was most cited by those in M40 and T20 households (71.4%). When examining household income per capita, men who cite this reason are only earning approximately RM10 less than men who did not. Thus, it appears men who are concerned about their remuneration may not necessarily be doing so due to financial hardship, but potentially because they face other pressures such as expectations for financial provision or concerns about long-term economic security.

FIGURE 4.5.5

Percentage of Men Citing Financial Concerns as a Reason for Leaving their Current Position within the Next Five Years by Care Load Quartile



8 That said, there is no statistical difference, as men do not appear to be citing this more significantly than women. Full statistical output is available in Appendix 4.5.6 in the companion appendix.

Notably, 42.9% of men who cite financial concerns feel they have limited opportunities for growth at work (compared to 38.7% of men who did not cite financial concerns), and many of them fall into Q1 (39.3%), indicating they currently have few or no care dependents in their household. In totality, this suggests that men who want to leave *their current position for financial concerns may be less worried about immediate financial strain, but more about anticipated future responsibilities,* such as starting a family and stepping into a gendered breadwinner role, where limited opportunities for growth in their career may have negative implications. Thus, financial concerns may serve as a proxy for men's worries around whether their current job can offer sufficient income security or career progression for the future.

iv Other Reasons Cited by Malaysians for Intending to Leave Current Position

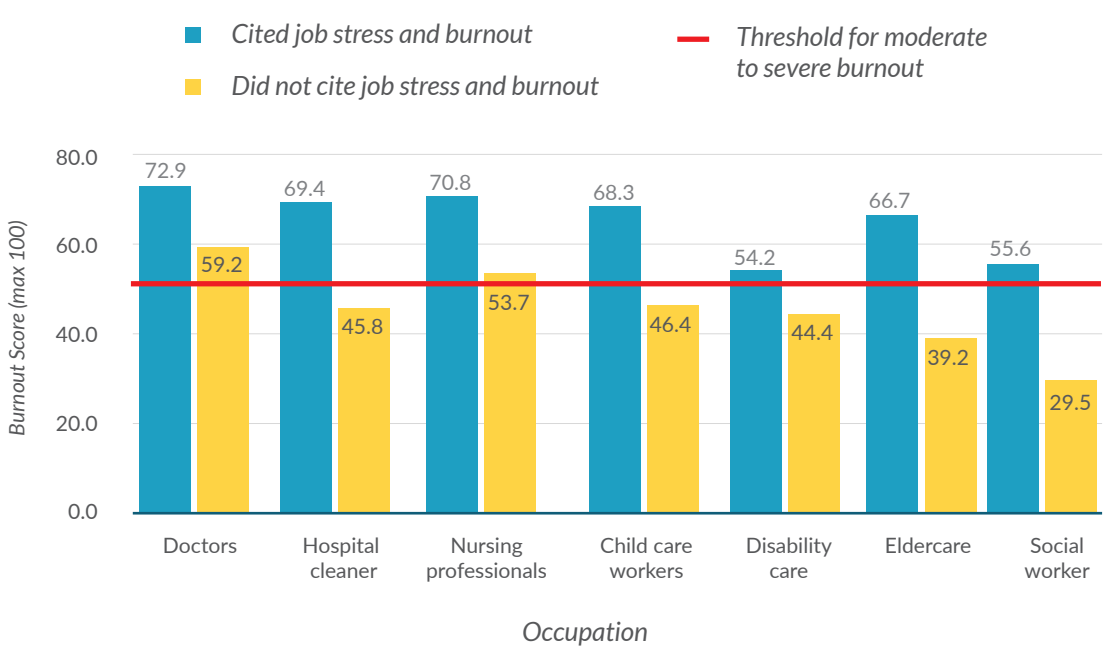
Job stress and burnout

Job stress and burnout was the top reason given by those intending to leave their positions within the next five years, totalling 41.8% and equally cited by men and women. Unsurprisingly, those who cited job stress and burnout as the reason for their desire to leave had higher levels of burnout than those who did not cite the same reason (Figure 4.5.6).[9]

The implications of this is further discussed when examining how to support care worker retention.

FIGURE 4.5.6

Average Burnout Scores based on whether Respondent Cited Job Stress and Burnout as a Reason for Wanting to Leave in the next Five Years, by Occupation (n = 421).



9 There is a statistically significant difference in burnout scores of those not citing job stress and burnout, compared to those who did cite job stress and burnout as determined by an independent sample t-test, where significance is determined by **P** < 0.05. The full output available in Appendix 4.5.7.

4.5.2

Intention to Leave Amongst Migrant Domestic Workers

56.5% of migrant domestic workers within the sample want to leave their current position within the next five years, with 70.1% of them being live-in domestic workers, while another 29.9% were live-out domestic workers.[10] The top three most cited reasons by migrant domestic workers for intending to leave are:

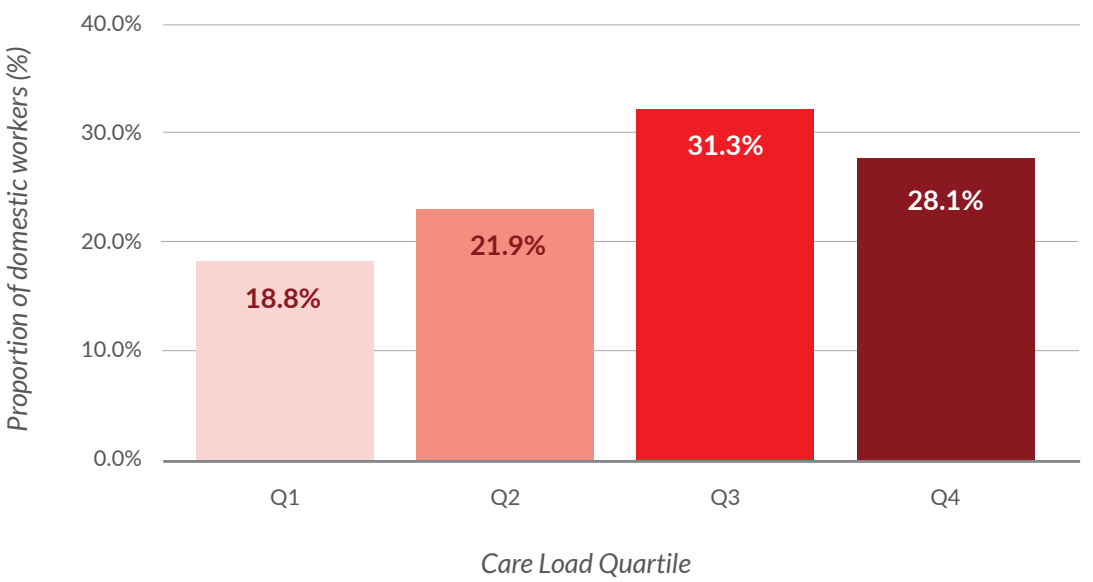
54.2%
Wanting to spend more time with family

21.5%
Retirement

15.3%
Better opportunities in another sector

FIGURE 4.5.7

Care Load Quartiles of Migrant Domestic Workers Citing Wanting to Spend More Time with Family as a Reason for Leaving Current Position in Next Five Years



Most domestic workers saying they want to spend more time with family have high care loads, with 59.4% of them in either Q3 or Q4. That said, across other aspects, they do not differ much from those not citing wanting more time with family in terms of work-life balance satisfaction, age, years of experience, or household income per capita. This suggests then returning to their family is likely their main motivation.

On the other hand, those who said they want to retire have nearly four years more experience than those who did not wish to retire, having worked an average of nearly

10 There is no significant difference between the amount of live-in and live-out domestic workers stating that they intend to leave, as per independent t-test, with significance set at **P** < 0.05. Full statistical output is available in Appendix 4.5.8 in the companion appendix.

11 years. Moreover, they were, on average, around 45 years of age and six years older than those who did not cite retirement as a reason to leave their job. This, to an extent, demonstrates that working as a domestic worker may not be a sustainable long term career, likely because of the pressures faced in such roles including long-term familial separation (Spitzer and Torres 2023).

The context under which migrant domestic workers find themselves in Malaysia is catalysed by a myriad of factors. Spitzer et al. (2023) note that "gendered, cultural, and religious values and ideologies" shape decisions that push women to undertake "filial duty and sacrifice for the family." Hence, it is unsurprising that there is a strong desire amongst migrant domestic workers to return home and spend more time with family.

While those who want to leave appear to spend more time on paid care work than those who intend to stay,[11] this does not seem to have any impact on their work-life balance satisfaction[12]—as both groups who intend to stay and who intend to leave are comparable across these factors. Thus, for migrant domestic workers, *the decision to leave their current position does not seem to arise from dissatisfaction in surrounding factors, but potentially an obligation to return home once they feel the job is done.*

There are, however, important implications, as most migrant domestic workers intending to leave their current position are quite similar to those intending to stay. That is, they report similar levels of overall wellbeing across multiple indicators including job satisfaction and work-life balance. Given the structural precarity that many migrant domestic workers face—as contracts typically last two years, visas must be renewed yearly, and alternative options for employment are limited—it is possible the question may not be capturing intention to stay as an accurate assessment of staying. Rather, *given the constraints migrant domestic workers face, it may instead be capturing desire or preference for either staying or leaving under circumstances where they have greater say over these decisions.* Consequently, there is a similarity in profiles because the *decision to disclose this desire may have been shaped by external factors, such as how comfortable the respondent felt in truthfully sharing the information.* Additionally, it may also be that the tool could not capture the full breadth complexities of staying or leaving for migrant domestic workers, consequently resulting in similar profiles between either option.

Given the importance of migrant domestic workers to Malaysia's care ecosystem, especially in supporting the labour force participation of women in upper and middle income households, their retention in the care workforce warrants further investigation.

In fulfiling their financial and filial responsibilities, migrant domestic workers are pushed to make sacrifices for their family. Given the prolonged separation, most of them want to return home within the next five years.

4.5.3
Care Workers' Retention

This section explores how the care workforce's retention can better be supported, by examining factors such as job satisfaction, burnout, individual resilience, and perceived organisational resilience.

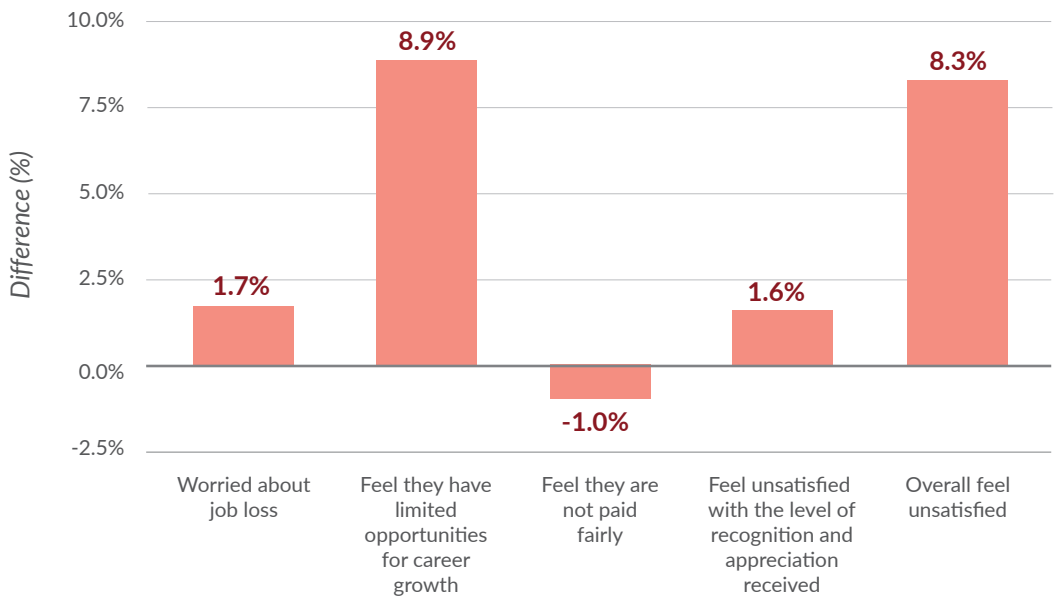
11 Those who intend to leave their current position reported significantly higher hours of paid care work per week compared to those who intend to stay, as determined by an independent sample t-test with significance set at **P** < 0.05. The full output available in Appendix 4.5.9 in the companion appendix.
12 Those who intend to leave their current position compared to those who intend to stay did not differ significantly in levels of work-life balance satisfaction, as indicated by an independent sample t-test with significance set at **P** < 0.05. The full output is available in Appendix 4.5.10. of the companion appendix.

Job Satisfaction, Burnout, and Individual Resilience

While only 16.4% explicitly mentioned that their lack of job satisfaction is one of the reasons why they are leaving, given that job satisfaction is an aspect of wellbeing, it likely plays a role in care worker retention. Generally, there is a significant difference in job satisfaction between those who intend to stay in their current position and those who do not.[13] Across the aspects of job satisfaction measured, those who do not intend to stay are more likely to feel they have limited opportunities for career growth, as well as generally overall feeling more dissatisfied with their jobs (Figure 4.5.8).

FIGURE 4.5.8

Difference Between Those Intending to Leave Within Five Years and Those Intending to Stay 6 Years or More Across Various Aspects of Job Satisfaction.



Note: Maximum score for the scale is out of 25 points; n = 1,534.

Based on previous findings, burnout and individual resilience play a crucial role in wellbeing warranting further examination in relation to job satisfaction. An analysis was conducted to examine factors predicting job satisfaction among care workers after COVID-19, considering aspects such as burnout and individual resilience.

Burnout emerged was most strongly associated with lower job satisfaction: *Care workers experiencing moderate to severe burnout reported lower job satisfaction* than those who had no to little burnout.[14] Moreover, *resilience was positively associated with job satisfaction,* where greater individual resilience meant greater job satisfaction. When comparing among the three different sectors, after accounting for resilience and burnout, *social care workers and domestic workers reported significantly higher job satisfaction than healthcare workers.*

13 Those who intend to leave within five years have significantly lower scores than those who intend to stay, as measured by independent t-test, with significance set at **P** < 0.05. Full statistical output available in Appendix 4.5.11 in the companion appendix.
14 Statistical significance was determined using multiple linear regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.5.12 in the companion appendix.

When assessing the *combined effects of burnout and care worker groups on job satisfaction,* we found a significant interaction among domestic workers only. While burnout reduced job satisfaction across all groups, the *negative impact was less severe for domestic workers compared to healthcare workers.* In other words, domestic workers appeared more buffered against the effects of burnout on job satisfaction. However, *this does not mean that they are less burned out*—only that *burnout does not reduce their job satisfaction as sharply as in other sectors.* No similar buffering effect was observed among social care workers, who experienced similar burnout-related declines in job satisfaction as healthcare workers. This difference may be attributed to the nature of domestic work, which often takes place in private households and under different employment arrangements compared to healthcare and social care workers. Unlike institutional care settings such as hospitals or eldercare centres, *domestic workers may define and evaluate job satisfaction through different expectations and relationships with employers.* Their work environments may shape how burnout is experienced or expressed, resulting in differing impacts on job satisfaction—even when burnout levels are high.

After accounting for differences in *burnout, resilience, and worker type,* the analysis showed how these factors together were linked to differences in care workers' job satisfaction. *It appears that while resilience helps boost job satisfaction, it does not fully protect workers from the negative effects of burnout.* For example, even among highly resilient domestic workers, those who experienced moderate to severe burnout were less satisfied with their jobs. Their average job satisfaction score was 12.8% less than those with little to no burnout. Recalling that burnout was highly cited as a reason for care workers wanting to leave their current position, it appears that supporting care worker retention necessitates considering factors impacting job satisfaction. Thus, there is a need for a dual approach: Strengthening individual resilience while also addressing the workplace factors that contribute to burnout, in order to improve job satisfaction among care workers.

ii *Individual Resilience, Perceived Organisational Resilience, and Intention to Stay*

Previous findings from this study highlighted that individual resilience appears to buffer the impact of care work, both paid and unpaid, on wellbeing, while perceived organisational resilience is positively associated with both individual outcomes and satisfaction across several wellbeing domains. Thus, we assume that individual resilience and perceived organisational resilience has a role to play in workforce retention as well. To better understand the relationships between individual resilience, organisational resilience, and care workers' intention to stay in their current positions, a binomial logistic regression was conducted.

We began first considering the role that individual resilience plays, noting that this analysis is meant to be exploratory, as opposed to predictive. Findings demonstrate that *individual resilience alone was a significant predictor of care workers' intention to stay,* where even *modest improvements in care workers' individual resilience are associated with a 33% greater likelihood of them wanting to stay* in their jobs.[15]

When both individual and organisational resilience were accounted for, each remained significant.[16] While the influence of individual resilience reduced slightly, compared to when it was considered on its own,

15 Statistical significance was determined using binomial regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.5.13 in the companion appendix.
16 Statistical significance was determined using binomial regression. Variables were considered significant at **P** < 0.05. Full model details, including diagnostics and assumptions, are provided in Appendix 4.5.13 in the companion appendix.

there was still a clear impact: Care workers with *higher individual resilience were 25% more likely to want to stay,* even after accounting for how resilient they perceived their organisations to be. *Organisational resilience, however, had a stronger effect:*

Care workers who perceived their organisations as more resilient were 112% more likely to intend to stay, essentially more than twice as likely compared to those who did not.

While this analysis was not designed to evaluate predictive performance, the results highlight that both individual and organisational-level resilience appear to be linked to care workers' decision to remain in their roles. Broadly, while supporting individual coping capacity is crucial, *creating resilient and supportive organisational environments potentially plays an even bigger role in supporting retention.*

iii Experiences of Violence

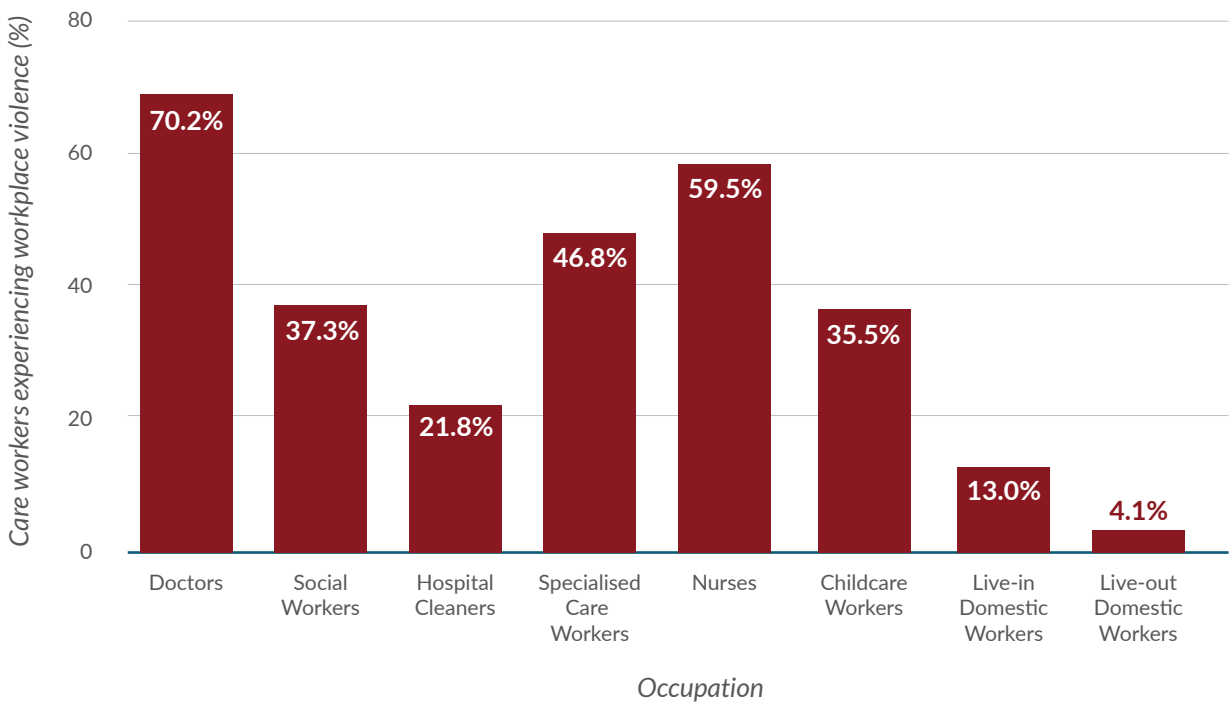
Finally, whilst we did not explicitly ask about experiences of violence in relation to workers' intentions to stay, analysis revealed that those who intended to leave their current position within the next five years were more likely to have experienced more violence in the workplace compared to those who intend to stay.[17] This finding holds for both men and women.[18] This suggests that *violence and safety in the workplace may be important but under-recognised factors in retention, with current workplace protections potentially insufficient.* These considerations must also extend to protections for migrant domestic workers, whose workplace settings, in the private homes of employers, makes safety much harder to regulate. Figure 4.5.9 demonstrates the rates of care workers reporting they had experienced violence in the workplace, where workplace violence was assessed by the frequency of which respondents reported experiencing prejudice, spontaneous anger, threats of or actual abuse, and/or sexual harassment.

Violence and safety in the workplace may be important, but under-recognised factors in retention.

17 Statistical significance was determined with Welch's t-test, at **P** < 0.05. See Appendix 4.5.14, Table 4.5.16 in the companion appendix for further details.
18 Statistical significance was determined with Welch's t-test, at **P** < 0.05. See Appendix 4.5.14, Tables 4.5.17 and 4.5.18 in the companion appendix for further details.

FIGURE 4.5.9

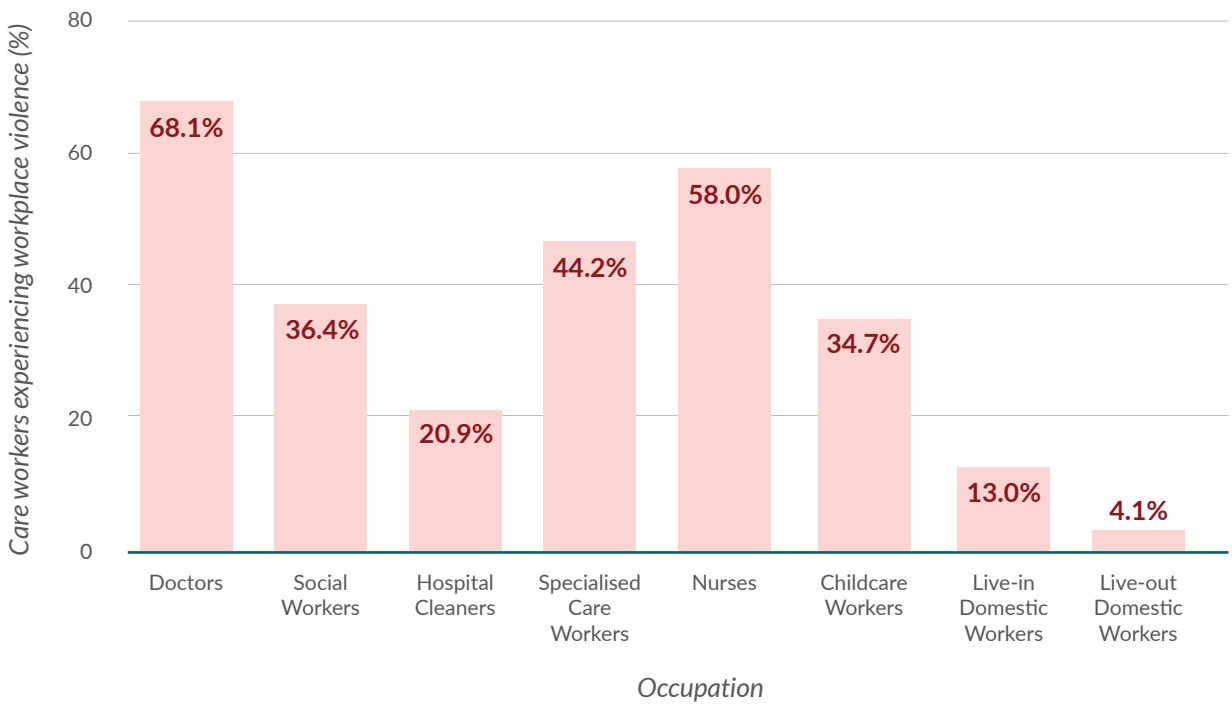
Percentage of Care Workers Reporting that They Experienced a Form of Violence in the Workplace by Occupation



Notes: n = 1,534

FIGURE 4.5.10

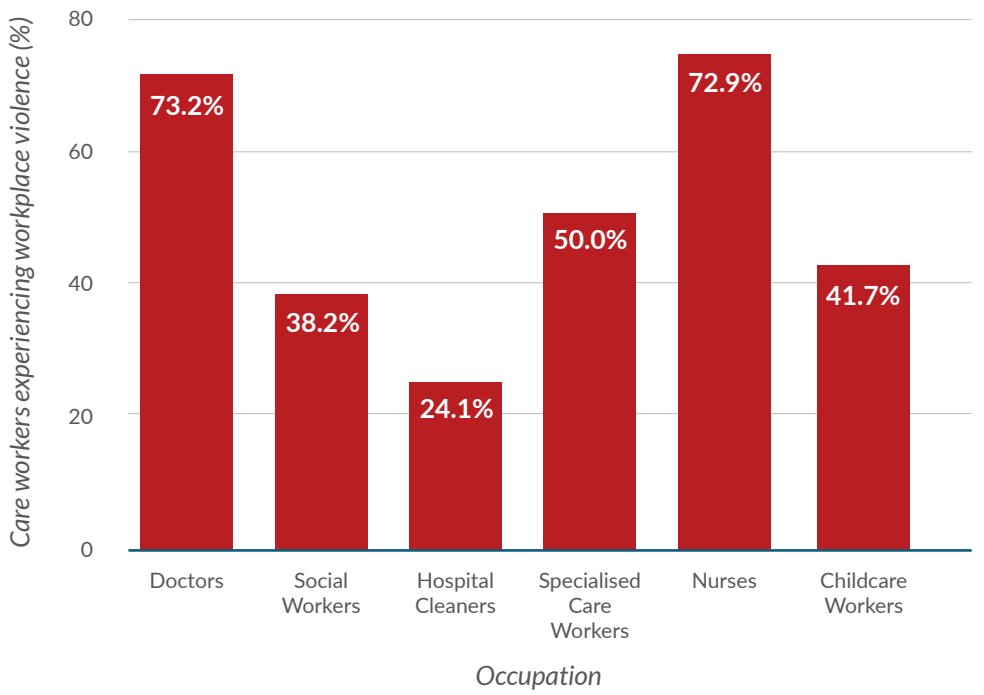
Percentage of Women Care Workers Reporting that They Experienced a Form of Violence in the Workplace by Occupation



Notes: n = 1,221

FIGURE 4.5.11

Percentage of Men Care Workers Reporting that they Experienced a Form of Violence in the Workplace by Occupation



Notes: n = 296

More concerningly, when examining instances of personal violence, Malaysian women who intended to leave their position within the next five years reported experiencing higher levels of personal violence compared to those who did not intend to leave their position.[19] Personal violence was assessed through a battery which included experiencing excessive arguments, physical violence, social isolation, sexual violence, financial abuse, and vaccine control. Amongst Malaysian men and migrant domestic workers, however, those intending to leave within five years did not report any significantly different levels of violence from those who were intending to stay in their position for six or more years.[20] Further analysis and study is needed to understand the relationship between experiences of personal violence and employment retention for Malaysian women, but this finding underscores the importance of considering how *domestic and personal violence can shape women's labour force trajectories.* This, additionally, shows how critical meaningful protections are, not just for workplace violence, but support for workers facing violence at home too. *Safety beyond the workplace is crucial to sustaining the care workforce.*

19 Statistical significance was determined with Welch's t-test, at **P** < 0.05. See Appendix 4.5.10, Table 4.5.20 in the companion appendix for further details.
20 Statistical significance was determined with an independent sample t-test, at **P** < 0.05. See Appendix 4.5.15, Table 4.5.21 and Table 4.5.22 in the companion appendix for further details. Notably, the figure is nearly significant for migrant domestic workers.

FIGURE 4.5.12

Percentage of Malaysian Women Care Workers Reporting that They Experienced a Form of Personal Violence, by Occupation.

Finding 6:

The double burden of paid and unpaid care work more negatively impacts women's wellbeing compared to men.

Care workforce retention can be supported by improving job satisfaction, individual resilience, organisational resilience, and addressing experiences of violence.

FINDING HIGHLIGHTS

1

Wellbeing is shaped by stressors experienced both at work and at home, and their interactions, underscoring how interconnected the spheres of care are.

a. Stressors in the paid care work realm include the number of hours of paid care work and experiencing burnout and violence in the workplace.

b. At home, stressors include the number of hours spent on unpaid care work, how many people contribute to caregiving in the household, how many people there are to look after in the household, financial strain, and experiencing violence.

c. *The compounding effect of these stressors is linked to poorer wellbeing outcomes across time, with women most significantly impacted,* as demonstrated by their significantly lower levels of wellbeing when these stressors are taken into account.

d. Narratives emerging from FGDs affirm this interwoven nature of paid and unpaid care work, and the compounded impact this has on women's wellbeing, as women, during the pandemic, felt torn between their personal and professional care duties. As a consequence, many women compromised their self-care, especially during the COVID-19 pandemic, to ensure they were able to fulfil both duties. This highlights the *unsustainable double burden* women often have to manage.

2

Having higher levels of wellbeing is associated with an intention to stay within their current position or role in the care workforce, meaning that those who intend to leave appear to have lower levels of wellbeing. When we consider intention to stay, gender differences become less pronounced, that is, regardless of gender, those with lower wellbeing are more likely to report wanting to leave their current position. Nonetheless, given that women have lower levels of wellbeing, compounded by structural inequalities that do not adequately take into consideration the demands of managing simultaneous paid and unpaid care work responsibilities, this places them at higher risk of potentially wanting to leave their current positions.

3

Finally, individual resilience and perceived organisational resilience are both crucial to supporting retention in the care workforce.

a. When we account for perceived organisational resilience, differences in wellbeing amongst those who intend to stay in their current position and those who intend to leave disappear, suggesting that *feeling supported at work may buffer negative experiences which may lead to a decline in wellbeing and are associated with a desire to leave their current position.*

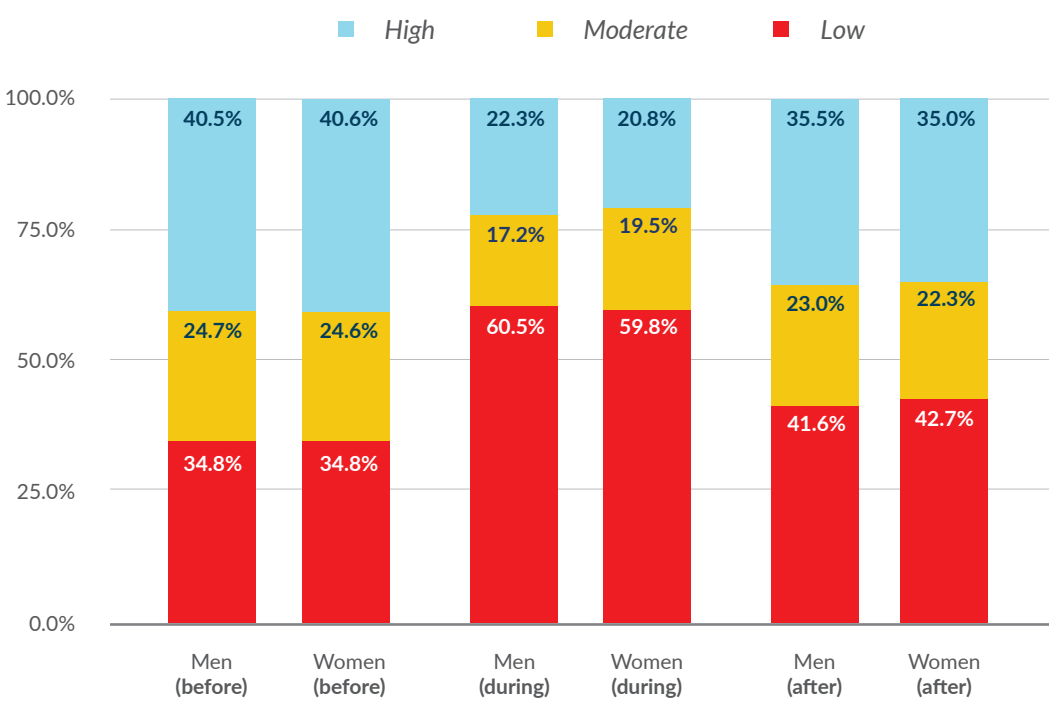
b. When we account for *individual resilience,* gender differences in wellbeing disappear completely, highlighting its *crucial role in bridging the gendered wellbeing gap.*

c. Thus, *strategies for supporting the retention of our care workforce and addressing gender gaps in wellbeing outcomes would potentially benefit from strengthening both individual resilience and perceived organisational resilience.*

4.5
Wellbeing Impacts Across Time

FIGURE 4.6.1

Proportion of Wellbeing Levels across Time (n=1,534)



Incidence of low wellbeing skyrocketed in both genders during the COVID-19 pandemic, across the total population of care workers surveyed. Concomitantly, the proportion of those who had high wellbeing declined. When examining the total population, wellbeing changed over time, with many care workers reporting a

decline during a pandemic and an incomplete recovery post-pandemic, as mentioned in Finding 2. Furthermore, both genders were similarly impacted across time.[1]

From Finding 3, there were gender gaps in satisfaction in aspects of wellbeing, with women much less satisfied than men with the social support they received, work-life balance, and physical and mental health. This persistent satisfaction gap appears to reflect structural gender inequalities experienced by women, wherein support structures may lack gender sensitivities to be equally beneficial to women. While those analyses examined wellbeing in its components, it is also critical to understand the effect on overall wellbeing, as well as what can potentially support better wellbeing outcomes.

4.6.1
Care-Related Stressors: An Unequal Impact on Women Care Workers

One key theme emerging from our findings has been that paid and unpaid care work are intertwined and their interactions impact wellbeing. To unpack this relationship using a gender lens, we look to the following factors that may contribute to stress and consequently wellbeing:

1. *Hours of paid care work*
2. *Burnout experienced at work*
3. *Violence experienced at work*
4. *Weighted household composition, that is how many people are in the household, weighted by the intensity of care required, as explained in Finding 1*
5. *Number of those supporting caregiving in the household*
6. *Personal violence experienced at home*
7. *Household income per capita*

1 Statistical significance was determined using repeated measures ANOVA with Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at **P** < 0.05. The full analyses are available in Appendix 4.6.1 of the companion appendix.

When looking at workplace stressors, we considered each aspect sequentially, adding them to our analysis and examining how each sequential factor affects gender differences.[2] Our step-by-step analysis allows us to see the ways stressors compound and its gendered effect. To note, if a stressor is significant in the model, it means that, regardless of gender, the stressor will have an effect on wellbeing in some way. If a stressor is added to the model and the result is that gender differences appear or become more pronounced, as shown by a more significant p-value, it means that the factor carries a gendered impact. Importantly, a factor may have a gendered impact but not be significant on its own—which means that, in and of itself, men and women may have similar measures for the stressor, but if the gender difference becomes clearer, there exists a differential impact on wellbeing by gender. Thus, if we want to understand which stressors contribute lower wellbeing outcomes in women, *what is most crucial is not necessarily that the stressor is significant on its own, but if it is making the gender difference in the model more pronounced.*

With this in mind, the following picture emerges from the analysis:

1 *Paid work hours can negatively impact wellbeing*

As we have previously established, paid work hours impact wellbeing. This is the first stressor we add to the model. Across time, working more hours is linked to lower wellbeing regardless of gender.

2 *Burnout, however, more negatively impacts wellbeing than paid work hours*

Next, we looked at the toll of paid care work by considering the impact of burnout on wellbeing. When burnout was included in the analysis, the link between hours worked and wellbeing weakened, demonstrating that the emotional toll and exhaustion from work matters more to wellbeing than the length of the work-week. Simply stated, the greater the burnout, the more likely one will report poor overall wellbeing. This pattern was true across genders.

3 *Burnout, however, more negatively impacts wellbeing than paid work hours*

Lastly, we considered whether experiencing workplace violence might also shape care workers' wellbeing. Our analysis revealed that experiences of workplace violence strongly affects wellbeing, and also attenuates gender differences. While men reported experiencing more violence at work than women, it appears that experiences of violence more negatively impacts women's wellbeing. This could be for a variety of factors, including that support structures may not necessarily respond well when women raise complaints, perpetuating a cyclical issue which may lead women to underreport the violence they experience. Broadly, though, this reinforces the idea that how care workers are treated and how exhausting their work is matters far more to their wellbeing than how many hours they spend working.

2 We conducted a repeated measures ANOVA, which considers how variables impact wellbeing by comparing respondents, as well as considering the effect on wellbeing over time. Analyses used Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at $P < 0.05$. The full analyses are available in Appendix 4.6.1 of the companion appendix.

After considering workplace stressors, we then began adding stressors arising from the home. The logic of adding home stressors after workplace stressors is because, particularly during COVID-19, care workers were expected to prioritise work over personal care responsibilities, in essence being told: Work comes first, then home. In reality, the two are heavily intertwined, but this order helps demonstrate how stressors at home compound workplace stressors. After considering these factors, the following emerges from our analysis:

4 *Unpaid care work has a minor effect on overall wellbeing*

When we consider how many hours care workers spend on their unpaid caregiving, while the number of hours itself was not a significant predictor of wellbeing, there remains a gender difference. This gender difference suggests unpaid care hours may contribute to a broader gendered experience that results in lower wellbeing amongst women compared to men. Burnout and experiences of violence at work continue to have the most direct impact on wellbeing, regardless of gender.

5 *Household size does not matter as much as how care is distributed, and care appears unevenly distributed towards women*

Personal care responsibilities are not just defined by the number of hours, but also by the nature, number, and status of care recipients (e.g., age, disability, number of individuals dependent on care) and how many other caregivers are present in the household. The next aspect we considered is who is in the care worker's household. As mentioned in Finding 1, we have calculated the weighted household composition, which considers the age of other members of the household in relation to how much care they may require, with those who are younger, older, and requiring additional care weighted as heavier compared to adults and those who do not have additional care needs.

While accounting for weighted household composition and number of caregivers in the household did not show a strong standalone impact on wellbeing, the gender difference became more pronounced. More specifically, this suggests care workers who have similar household compositions experience the intensity of that care work differently, and this difference is, in some part, explained by gender. The care load is felt differently by genders, likely because even in similar household sizes, care is still disproportionately shouldered by women. This is also reflected in earlier findings, where women, across Care Quartiles, undertook more hours of unpaid care work than their male counterparts. It is also highly likely that women are taking on more high-intensity caregiving compared to men, which further impacts their wellbeing.

6 *Experiencing violence at home is linked to poorer wellbeing outcomes, especially for women*

The next factor we considered is whether care workers experienced violence at home, and if this produces an effect on wellbeing. Experiences of violence at home were linked to poorer wellbeing outcomes, and amplified gender differences in wellbeing. Similar to workplace violence, experiences of violence at home contributed to poorer wellbeing outcomes, especially for women.

5 Financial strain worsens the wellbeing toll on women

Finally, we looked at the role of financial strain by considering household income per capita. While lower household income per capita was not directly associated with poorer wellbeing outcomes, gender differences became even more significant when this variable was considered. This suggests that financial pressure, in combination with stressors from the workplace and home, disproportionately impacts women. Per Finding 1, women care workers face both income and economic inequality. Our FGDs also revealed how many women became sole income earners as their family lost jobs amidst the pandemic. This added financial and emotional stress likely contributed to women's reports of worse wellbeing across time.

Tara, Hospital Cleaner, Central Malaysia

Kalau mak tak ada kerja, macam mana kita makan, belanja? Bapa pun tak ada kerja, susah. Banyak sedih hati juga. Hari-hari kita nampak [kat] hospital [banyak orang] meninggal. Masa time kita balik, banyak susah risau.

English translation

If I don't have a job, how would we eat, what would we have to spend? Dad also doesn't have a job, it's hard. There's a lot of sadnesss also. Everyday, we see death at the hospital. When we go back home, there's a lot of worrying about our hardships.

Mei, Nurse, East Malaysia

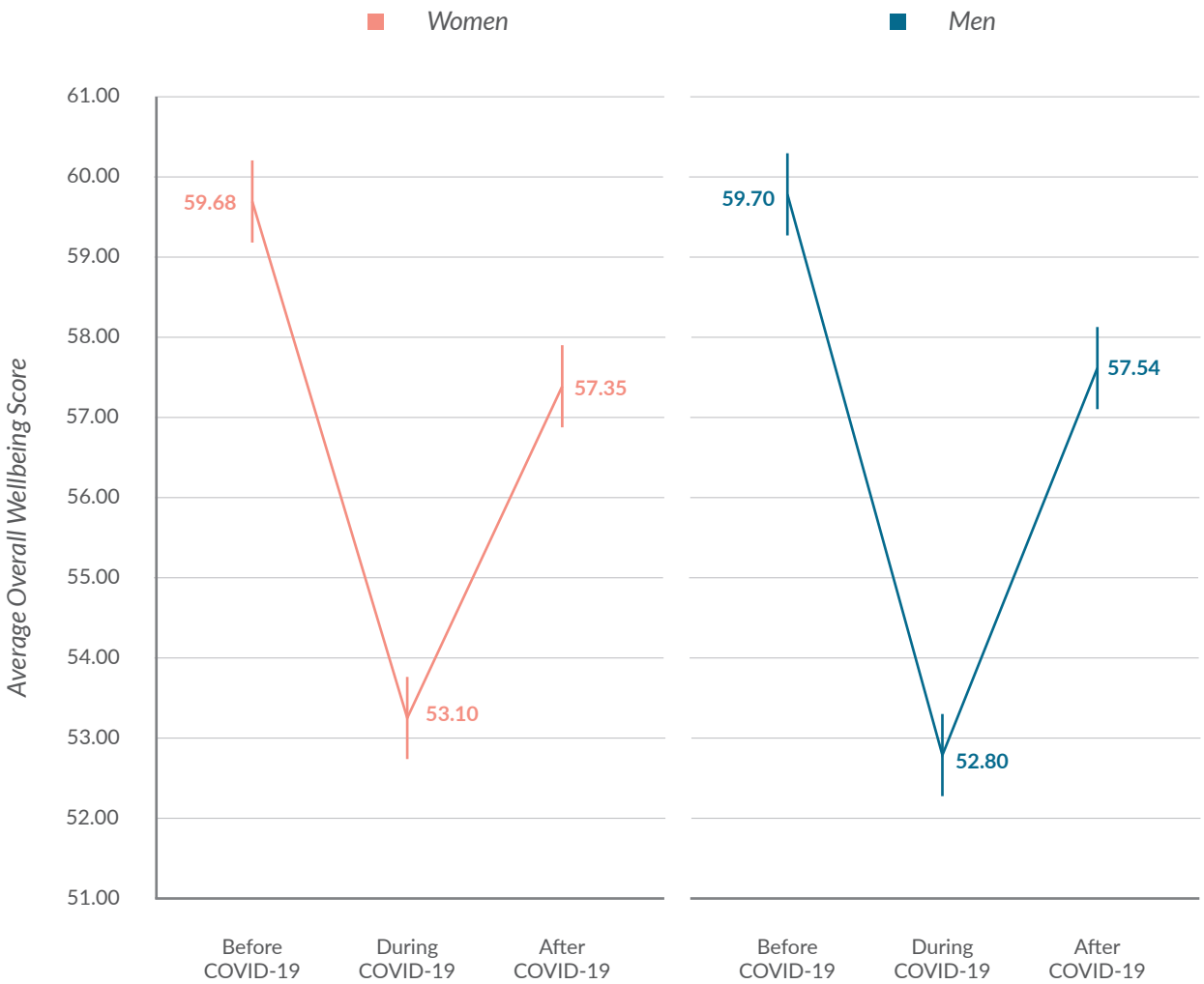
Kalau saya masalah kewangan, ada lah sebab anak sayalah kerja, [tapi] semasa pandemik dia kena [balik ke sini], cuti berhenti tanpa ganti. Selama 2 tahun dia tidak bergaji, saya kena support dia. So saya kena balik, nasib jugalah kita dapat elaun RM600. Saya kena bayar kereta, kena bayar rumah—semua itu.

English translation

For me, financial problems, I do have them because my child was working, but during the pandemic, she had to come back home—she was furloughed (put on leave without salary replacement). For two years, she didn't have a salary, so I had to support her. So I had to go return to work, and it's a good thing we got the allowance of RM600. I had to pay for the car, the house—all of that.

FIGURE 4.6.2

Profile Plot of Wellbeing across Time by Gender[3]



Summary of Care-Related Stressors

Wellbeing is shaped by the interconnectedness of work and personal life, where stressors experienced at work—from the number of hours, to the experience of burnout and violence—interact with stressors at home—ranging from the number of hours of unpaid care work to financial strain. When we consider these care-related stressors across the two spheres of life, it becomes clear that they compound, and that gender continues to play a significant role in who is most affected as evidenced by women reporting poorer wellbeing outcomes than men.

3 Note: While visual inspection of the error bars may not show obvious differences, the statistical model (repeated measures ANOVA) pools information across timepoints. This allows us to detect overall differences in average wellbeing, wherein there is a demonstrated significant difference in wellbeing between men and women. The statistical output can be found in Appendix 4.6.1 in the companion appendix.

ii "Kita Tak Memikirkan Diri Sendiri": Care Workers Torn between Responsibilities

The impact of the compounded stressors on women care workers, in how their paid care work and their unpaid care work was interwoven, was clearest through narratives emerging during the FGDs. Oftentimes, women described feeling torn between their professional and personal care obligations.

Belle, a domestic worker, describes how she sometimes feels she is not mentally present at work because she is thinking about where her child back home in Indonesia wants to go, and how this sometimes affects her work.

Belle, Migrant Domestic Worker, Central Malaysia

For example, my child wants to go somewhere like that, out of town. I feel like I'm more dreamy. Then sometimes the work here seems to be abandoned. So I can't focus. And if it's wrong, it's not until later if you've ever been angry with your employer, right? If something goes wrong, you have to be reprimanded. So we feel like that's how it is. So indeed stress is a must.

She is not the only care worker to experience this, as others also shared similar experiences:

Radiya, Social Worker, Malaysia

Kesan pada saya ni memang banyaklah. Kesan tu kan maknanya kita terpaksa fokus pada kerja, pada tanggungjawab, dan pada masa yang sama, kita risau tentang pasal keluarga kita.

English translation

There are a lot of impacts on myself. It means we are forced to focus on work, on our responsibilities [at work] and, at the same time, we are worried about our families.

Kahee, Private Childcare Provider, Central Malaysia

Kena fokus dengan kerja kita. So agak macam terabai sikit dekat anak lah.

English translation

We need to focus on our jobs. So it's a bit like our children are neglected.

As a consequence of feeling torn between their responsibilities, care workers compromise their own self-care, to ensure that they are able to fulfil their duties at work and at home. For many, this meant sacrificing time to eat.

Mel, Hospital Cleaner, Central Malaysia

The place was full of people, in the wards and rooms, there were many people, and they also got COVID. They would ask for some help. I would help by bringing food, water, or taking orders if anything was needed. We would do other work during COVID time. Even if it was late to eat, we would finish the work first and then eat. We have to finish our meal in a rush. If the boss calls us when no one is around, we would rush over immediately, no matter the time.

When a research associate asked care workers in north Malaysia, "Macam mana waktu makan puan-puan sendiri?", the women in the group responded, "Jarang."[4] They went on to share that the amount of time they had for eating was uncertain—they ate when they could. One care worker even went on to say:

Fiza, Specialised Care Worker, North Malaysia

Memang [masa] sangat terhad, terhad sangat-sangat. Kadang-kadang sanggup saya ni kurang tidur. Kurang tidur sebab, walaupun saya dah rela, saya terpaksa kurang tidur untuk hantar anak-anak.

English translation

The time is really limited, really really limited. Sometimes I'm willing to sleep less. Sleep less… even though I'm willing to do it, I [still feel] forced to sacrifice my sleep to send my kids.

This took a clear toll on the women, with one describing how, as a consequence, she consistently felt sick and unhealthy post-COVID, culminating in a diagnosis of high blood pressure.

Fas, Specialised Care Worker, North Malaysia

Kesan kat tadi sendiri terutamanya kesihatan lah. Sebab saya perasan, saya selepas daripada COVID itu memang saya tak berapa sihat. Kena COVID tu kan dah beberapa kali. Dan lepas tu, yang terbaru, di diagnose darah tinggi pulak.

English translation

The biggest impact on myself is to my health lah. Because what I noticed, after I had COVID, I haven't been well. I had COVID a few times. And after that, more recently, I was diagnosed with high blood pressure.

4 Translates to: "How was the time you all had for self-care?" The women in the group responded, "We rarely had the time."

These narratives reflect the *unsustainable double burden* faced by women care workers, where the care work they undertake, both personally and professionally, is prioritised at the expense of their own wellbeing. This affirms our findings from the overall wellbeing analysis examining the stressors alone—gender disparities in wellbeing are not incidental, but arise from inequalities, shaped by the interwoven nature of personal and professional care work.

Manda, a care worker from central Malaysia, describes the impact succinctly, "Tak ada apa-apa aktiviti yang boleh saya buat bagi nak release stress during the pandemik sebab kita [...] tidak memikirkan diri kita, kita tak memikirkan diri sendiri, *kita hanya memikirkan kerja rumah sahaja."*[5]

The double burden faced by women is unsustainable, because the care work they undertake, both personally and professionally, is prioritised at the expense of their own wellbeing.

4.6.2 *Care-related Stressors and Intention to Stay*

As previously noted we found, amongst care workers, there was a high intention to leave their current position, a rate of around one in three amongst Malaysians and one in two amongst migrant domestic workers. Thus, in this section, we explore if there is a potential relationship between care-related stressors and intention to stay in their current position.

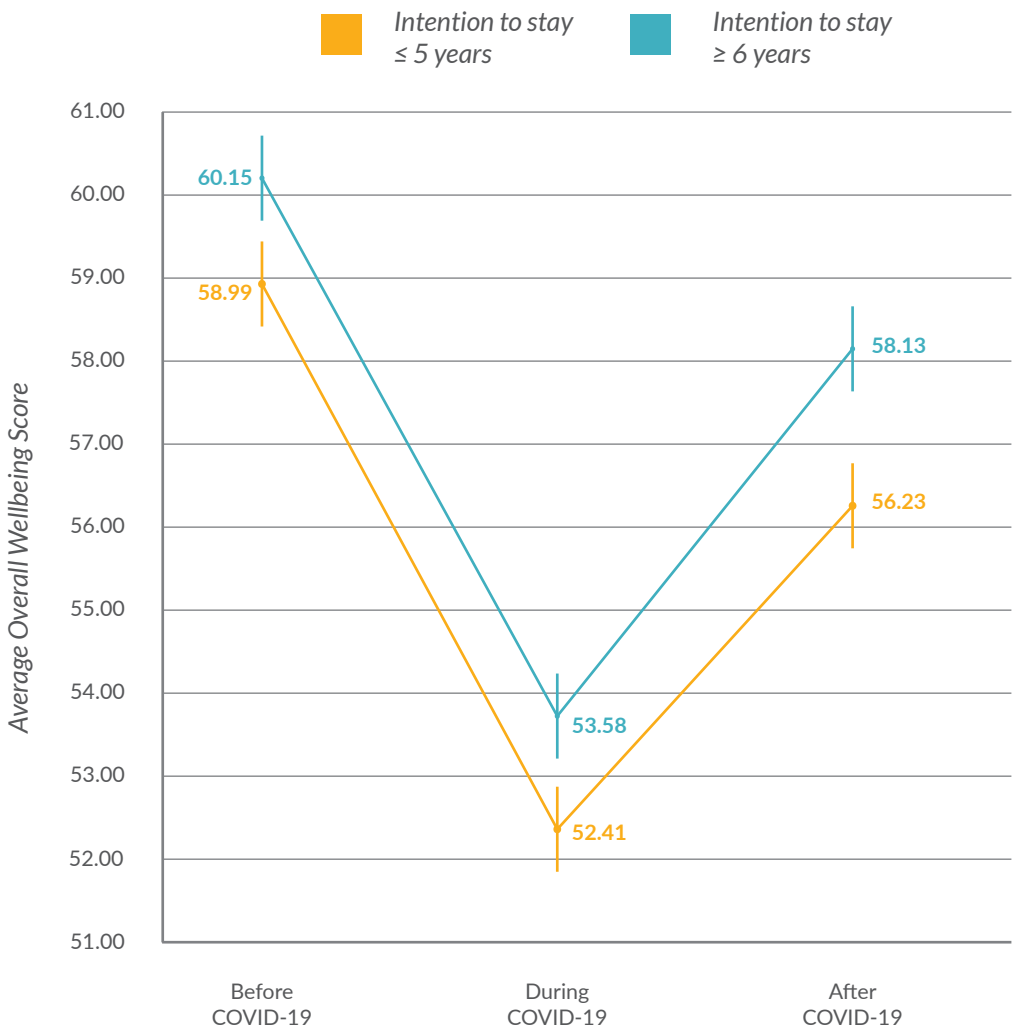
Wellbeing levels were different between those who intended to stay in their jobs in the next five years and those who were thinking about leaving in that time frame. In short, care workers who plan to leave their jobs tend to report lower levels of wellbeing.

Interestingly, when we account for intention to stay in their current position, there is no clear gender difference in wellbeing. What the data show is that there are similar levels of wellbeing for those who intend to stay and similar, albeit lower, levels of wellbeing amongst those who are intending to leave their current position. This means the gender differences we saw when looking only at stressors may be linked to how secure or supported care workers feel in their jobs, rather than gender alone. Thus, while men and women are equally likely to want to leave their current position when they experience lower wellbeing, it is important to recognise that, as women have, on average, lower wellbeing levels compared to men, they face a higher risk of reaching the threshold where leaving becomes more likely. Consequently, the structural inequalities faced by women must be meaningfully taken into consideration when targeting policy interventions to strengthen care workforce retention.

5 Translates to: There was no activity that I could do to release stress during the pandemic because we [...] didn't think about ourselves, we were not thinking about ourselves, we were only thinking about all the work we had to do at home."

FIGURE 4.6.3

Profile Plot of Overall Wellbeing across Time by Intention to Stay[6]



As explored in Finding 3, it appears that structural supports do not sufficiently consider the needs of women. While this does not necessarily lead to women leaving their positions at higher rates, there is still a possibility that staying in the care workforce is harder for women to sustain over time. As such, especially for women, the decision to remain in their current positions in the care workforce may not always be a matter of personal choice; rather, these decisions reflect the ongoing demands of balancing paid and unpaid care work.

Supporting the wellbeing of care workers therefore matters for two key reasons: Firstly, this improves their quality of life, through addressing key issues faced related to work-life balance, mental and physical health, as well as support for unpaid care work amongst other aspects. Secondly, these aspects crucially underpin workforce retention. Given women's lower average wellbeing, coupled with gendered pressures, failing to address these issues risks disproportionately weakening the sustainability of women's participation in the workforce. As per Finding 5, the main reasons cited by Malaysian women for leaving their current position does

6 Note: While visual inspection of the error bars may not show obvious differences, the statistical model (repeated measures ANOVA) pools information across timepoints. This allows us to detect overall differences in average wellbeing, wherein there is a demonstrated significant difference in wellbeing between those who are intending to stay in their current position for less than five years, and those who intend to stay for six years or more. The statistical output can be found in Appendix 4.6.2 in the companion appendix.

not just reflect wanting a career change, but a desire to leave the workforce altogether. If the overarching goal is better retention across the care workforce, attention must be paid to women, who form the backbone of the ecosystem. In our final analysis, we consider the impact of individual resilience and organisational resilience.

4.6.3
Care-Related Stressors, Intention to Stay, and Resilience: Enhancing Support for Care Workers

In Finding 5, we showed how having strong individual resilience improved the odds of a care worker staying in their current position by 33%, whereas perceived organisational resilience improved the odds of a care worker staying in their current position by 112%. Thus, when looking at overall wellbeing and intention to stay, we want to account for these aspects as well.

Perceived organisational resilience, or how supported care workers feel by their organisations, when accounted for, is linked to better outcomes in overall wellbeing. Essentially, care workers who feel their organisations or workplaces can respond to challenges and support them report higher levels of wellbeing compared to those who feel less supported. Once we account for perceived organisational resilience, there is no longer a significant difference in wellbeing between those who intend to stay and those who intend to leave. This suggests that feeling supported at work may buffer negative experiences which often are associated with declines in wellbeing as well as a desire to leave their current position.[7] Thus, it appears that perceived organisational resilience has a role in supporting wellbeing. This points to a possible link: Improving care workers' wellbeing could potentially better support retention. Nonetheless, more research is needed to better define this relationship.

Despite this, gender differences in wellbeing did not completely disappear. Women still appeared to be slightly worse off, though it was not significantly different from men. This may mean other aspects need to be considered to fully bridge gender disparities.

This prompts us to consider the role of individual wellbeing which, in previous findings, appears to be able to buffer gender differences. When individual resilience is accounted for in the statistical model, gender differences in wellbeing disappeared completely. This suggests that when both workplace and personal support were in place, men and women showed similar outcomes in wellbeing across time. Interestingly, when individual resilience is accounted for, financial strain, as observed through household income per capita, has a more visible impact on wellbeing. While perceived organisational resilience buffers the potential negative effect of financial strain, it was not enough to eliminate it completely. This suggests there is potentially some interaction between resilience and financial strain, which should be further explored.

While individual resilience can help improve retention, it is the combination of individual resilience and perceived organisational support that most effectively strengthens retention and addresses gender gaps in wellbeing.

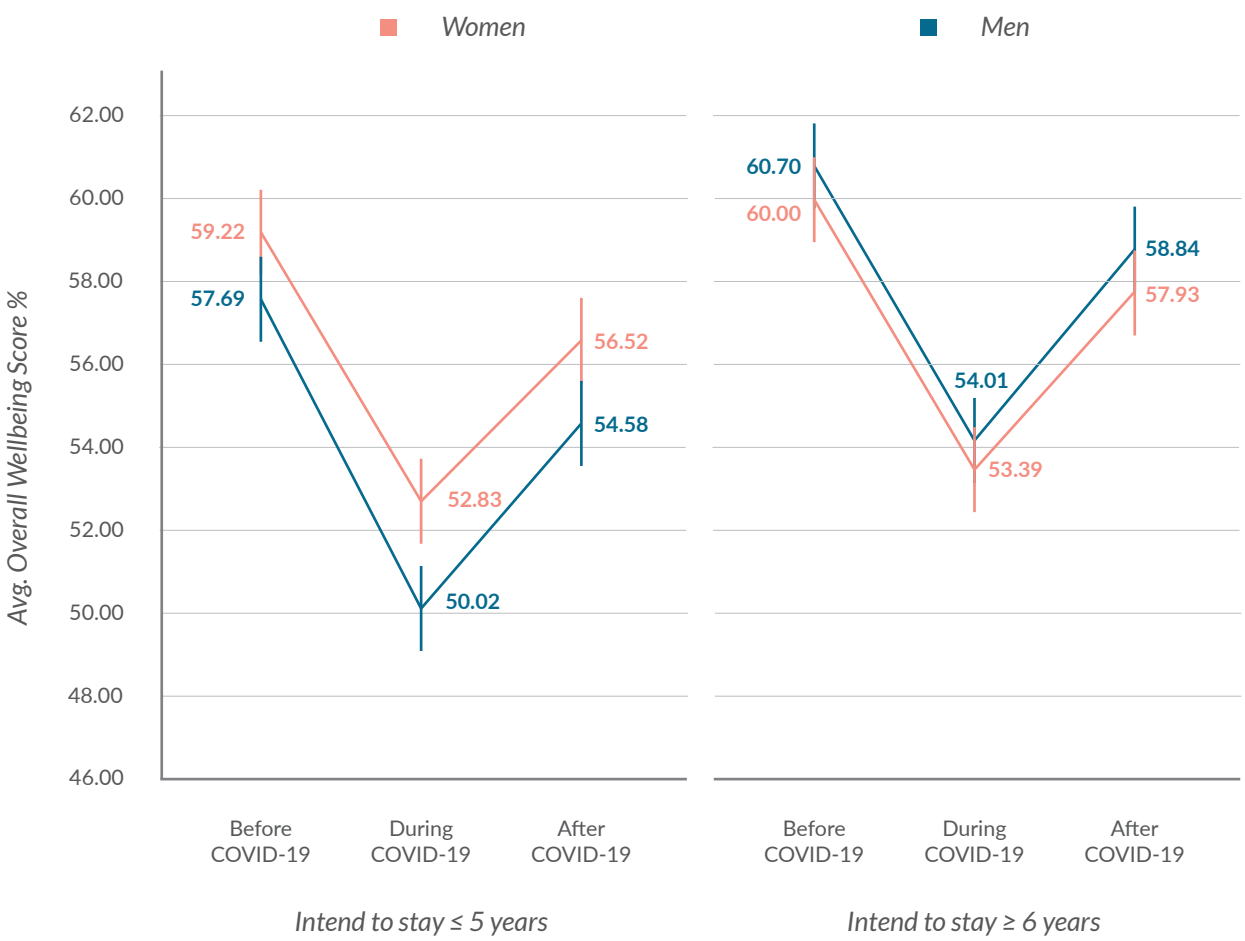
In conclusion, experiences of burnout, violence at work and at home, per capita household income, individual resilience, and perceived organisational resilience appear

7 We conducted a repeated measures ANOVA, which considers how variables impact wellbeing by comparing respondents, as well as considering the effect on wellbeing over time. Analyses used Type III sums of squares and Greenhouse-Geisser correction as needed. Significance was set at $P < 0.05$. The full analyses are available in Appendix 4.6.3 in the companion appendix.

to be crucial in shaping the wellbeing of care workers. Stressors such as burnout, experiences of violence, and financial strain have significant negative impacts on wellbeing, as experiencing higher levels of these stressors is associated with poorer wellbeing outcomes. The compounding impact of these stressors can lead care workers to considering dropping out from the workforce. Conversely, resilience is key in supporting care workers. While individual resilience alone can improve retention, it is the combination of individual resilience with perceived organisational support that strengthens retention and addresses gender gaps in wellbeing. In short, both are important for the retention of the care workforce and addressing gender disparities arising from the unequal impact of care-related stressors, arising from workplace conditions and personal care contexts.

FIGURE 4.6.4

Profile Plot of Overall Wellbeing across TIme by Intention to Stay[8]



8 Note: While visual inspection of the error bars may not show obvious differences, the statistical model (repeated measures ANOVA) pools information across timepoints. In this particular model, the statistical differences in wellbeing disappear between genders and those who intend to stay more than six years and those who intend to leave their current positions within the next five years. The statistical output can be found in Appendix 4.6.3 in the companion appendix.

05

Recommendations and Conclusion

CHAPTER 5

Recommendations and Conclusion

During the pandemic, care workers in Malaysia, across healthcare, social care and domestic care sectors shouldered a bulk of the nation's care and played a critical role in sustaining our collective wellbeing. The onset of the pandemic was sudden and nations globally were unprepared in responding to a crisis of this magnitude, simultaneously revealing foundational gaps within care systems worldwide. Despite these challenges, Malaysia was recognised internationally for its early action and coordinated efforts (Lo 2020), which in large part, was due to the unwavering commitment and dedication of its care workforce.

Farah, Nurse, North Malaysia

Macam pengajaran yang saya dapat, bila saya dah kerja dekat wad COVID tu... kita kena kerja bersatu. Kalau macam kita tak bersatu, kita tak bekerja bersatu dengan keadaan equipment yang tak cukup staff tak cukup kan kita tak bersatu, wad tu tak boleh nak, nak go on tahu

English translation

The lesson I got, now that I have worked in the COVID wards... we have to be united. If we are not united, if we are not working as one, with the state of a lack of equipment, lack of staff, and if we were not united, the wards would not have been able to go on.

While care workers in Malaysia may have responded to the pandemic through their remarkable resourcefulness, including through the use of various absorptive and adaptive strategies, it certainly took a toll on them. Our study findings reveal that about three-fourths (75.7%) of the care workers surveyed experienced a decline in wellbeing during the COVID-19 pandemic, and that the wellbeing of two-thirds (67.5%) of care workers have not recovered to pre-pandemic levels. Concerningly, one in three Malaysian care workers want to leave their current position within the next five years, while over half of migrant domestic workers want to do the same. In order for Malaysia to foster a more inclusive, sustainable and equitable care ecosystem, *we must prioritise the wellbeing and resilience of the care workforce, and we must do this by addressing the root causes i.e. the structural and systemic gaps that hinder a resilient and stable care workforce.* These structural and systemic gaps are explored more thoroughly in the subsequent sections of this chapter.

Positively, our study reveals that *change is possible.* When care workers perceive *improvements in organisational support or resilience, their likelihood of staying in their current role increases significantly.* In fact, our findings show that the *odds of retention increase by 112%.* This suggests that improving workplace conditions for care workers and fostering a positive care ecosystem is key to improving care worker retention.

To guide the formulation of recommendations in this chapter, we draw on two key conceptual frameworks. Firstly, we draw on the Resilience Capacities Framework expounded on in section 2.1.5 of Chapter 2. The Resilience Capacities Framework emphasises the importance of ensuring that actors, organisations and systems are able to effectively draw on a range of resilience capacities - absorptive, adaptive and transformative - when facing shocks or periods of instability like the pandemic. In applying this framework,

we assert that Malaysia needs to move beyond solely relying on the absorptive and adaptive capacities of care workers, and to prioritise enabling transformative capacities, where organisations/institutions and systems engage in meaningful reforms and change to create a conducive ecosystem for care workers to thrive despite the circumstances. The resilience capacities framework is thus useful as an analytical framework and helps us understand that resilience and wellbeing are not fixed personality traits, but dynamic features that can be shaped and molded by strong and supportive structures, policies and environments.

Secondly, we draw on the *5R Framework for Decent Care Work* (see Figure 5.1.1) to ensure that our recommendations meaningfully address the structured and gendered inequalities that shape care workers' professional and personal lives. Conceptualised by the International Labour Organization (ILO), the 5Rs represent a framework of policy outcomes that provides a roadmap for ensuring that care work is decent work. It also highlights the importance of ensuring that various social and economic policy areas (e.g. care, labour, migrant, macroeconomic, social protection policies) are in alignment and work cohesively to create a strong care ecosystem (United Nations 2024).

Figure 5.1.1

Policy outcomes of the 5R Framework for Decent Care Work

Recognise	***Recognise*** *the value of care work and the rights of care recipients, caregivers and care workers*
Reduce	***Reduce*** *labour-intensive unpaid care work through investments in infrastructure, technology, and services*
Redistribute	***Redistribute*** *unpaid care work more equitably between genders, and between households and the state, businesses and community*
Reward	***Reward*** *paid care workers with decent wages, fair allowances and social protection*
Representation	***Representation*** *and meaningful participation of care workers, care givers and care recipients in decision-making*

Source: ILO 2018; United Nations 2024

Ultimately, our findings demonstrate that the gendered elements which embody the experiences of the care workers must be reconciled. The care workforce is predominantly women, and thus, policymakers must integrate a gender transformative approach into the planning for the care workforce. This includes "removing harmful gender norms, roles and relations" that may hinder the capacities and progress of women care workers, while "redistributing power, resources, and services" in a manner that takes into account gendered inequalities (UNFPA 2023, 6).

5.1
Challenges and Recommendations from the Perspective of Care Workers

The development of resilient care systems must be grounded in local knowledge, local context and informed by local communities, particularly that of care workers. To gain a better understanding of both sector-specific and pandemic-related challenges, we asked care workers to identify areas of improvement within their sector that they consider important for their wellbeing. Feedback was gathered through focus group discussions and participatory data analysis sessions. The issues that were predominantly raised were subsequently included in the survey questionnaire and distributed to care workers nationwide. Figures 5.1.2, 5.1.3 and 5.1.4 showcase the top 10 pressing concerns highlighted by care workers according to sector, while Figures 5.1.5 and 5.1.6, highlight the top five crisis-response recommendations by care workers.

5.1.1
Sector-Specific Concerns

Survey results from healthcare (Figure 5.1.2) and social care (Figure 5.1.3) reveal that inadequate salary levels are a consistent challenge for care workers in both sectors. This also reflects broader concerns about being underpaid, i.e. highlighting a mismatch between salary levels and the demands of their roles. Furthermore, the limited size of the care workforce was also identified as a major concern, suggesting that care workers are facing high workload pressures, a challenge that should be addressed through the expansion of the care workforce. Beyond pay and workload, workers articulated concerns about their wellbeing. Almost half of the healthcare workers (45.5%) and a third (36%) of social care workers called for better mental health support, while about a third of social care workers (35.6%) requested for better wellbeing infrastructure (e.g. resting spaces).

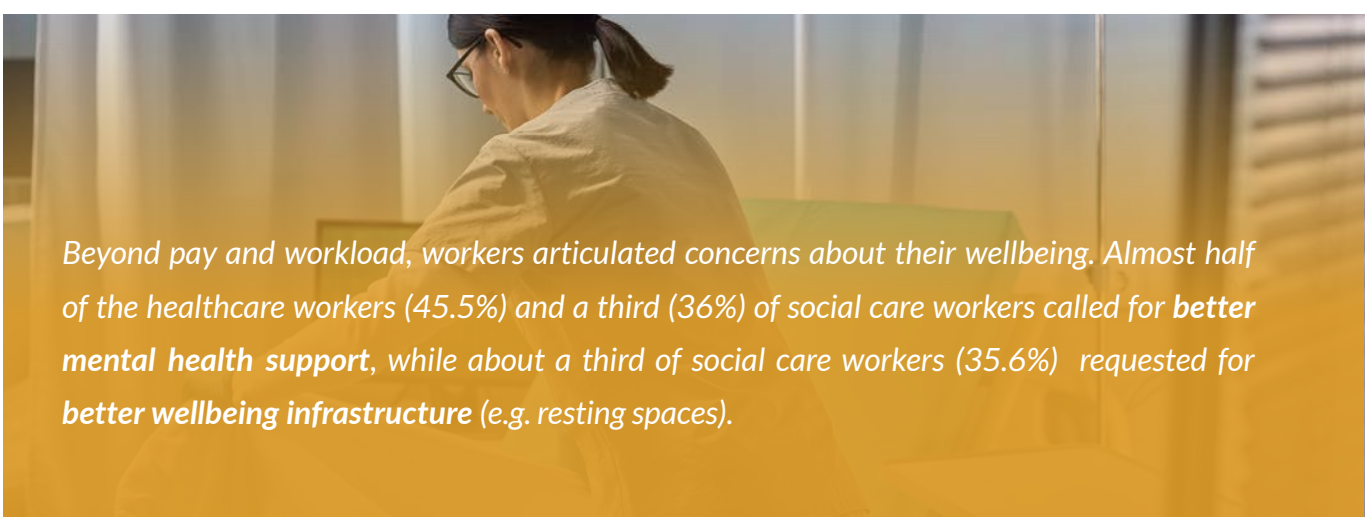
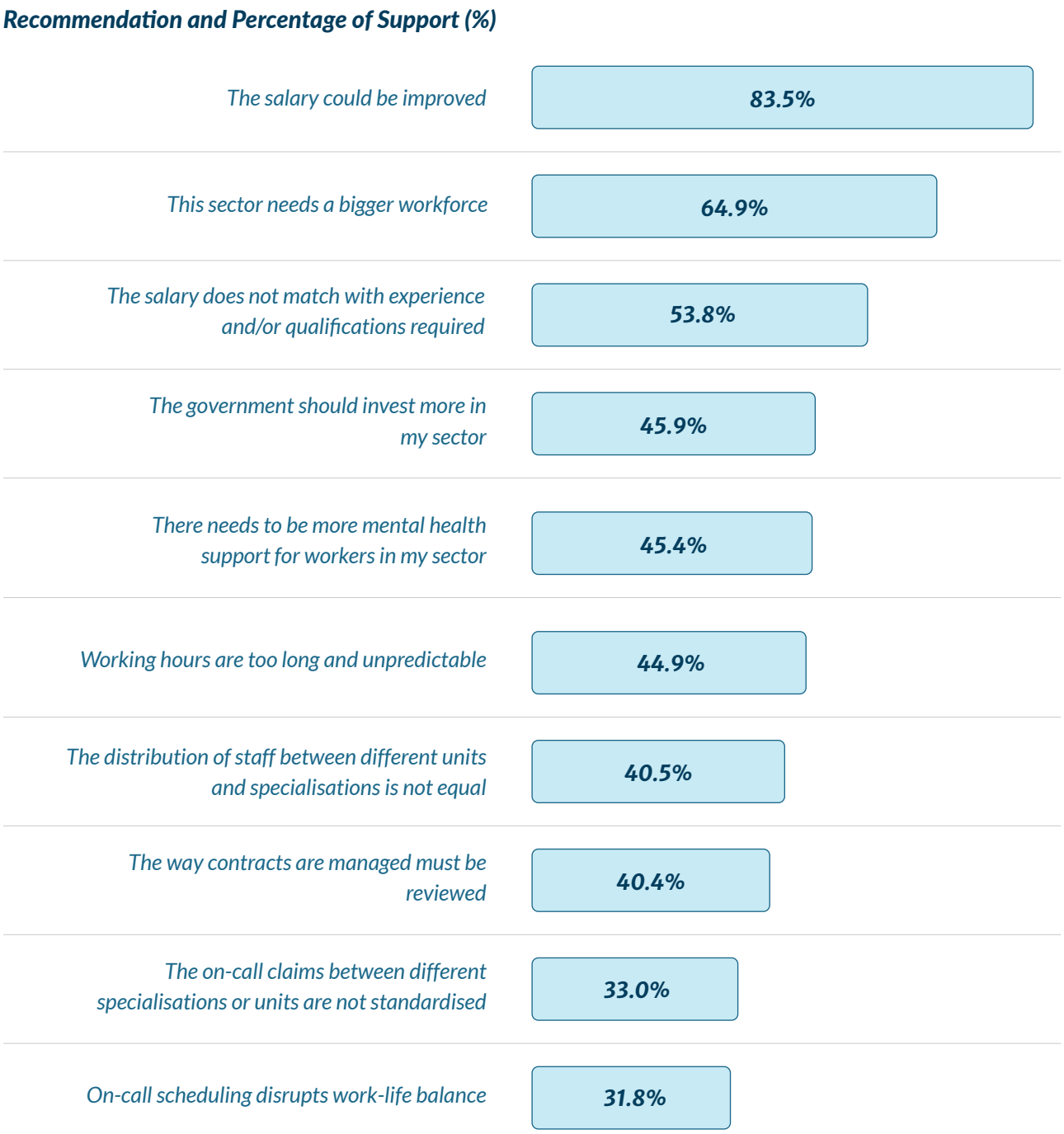


FIGURE 5.1.2

Top 10 Concerns in the Healthcare Sector (Doctors, Nurses, Hospital Cleaners)

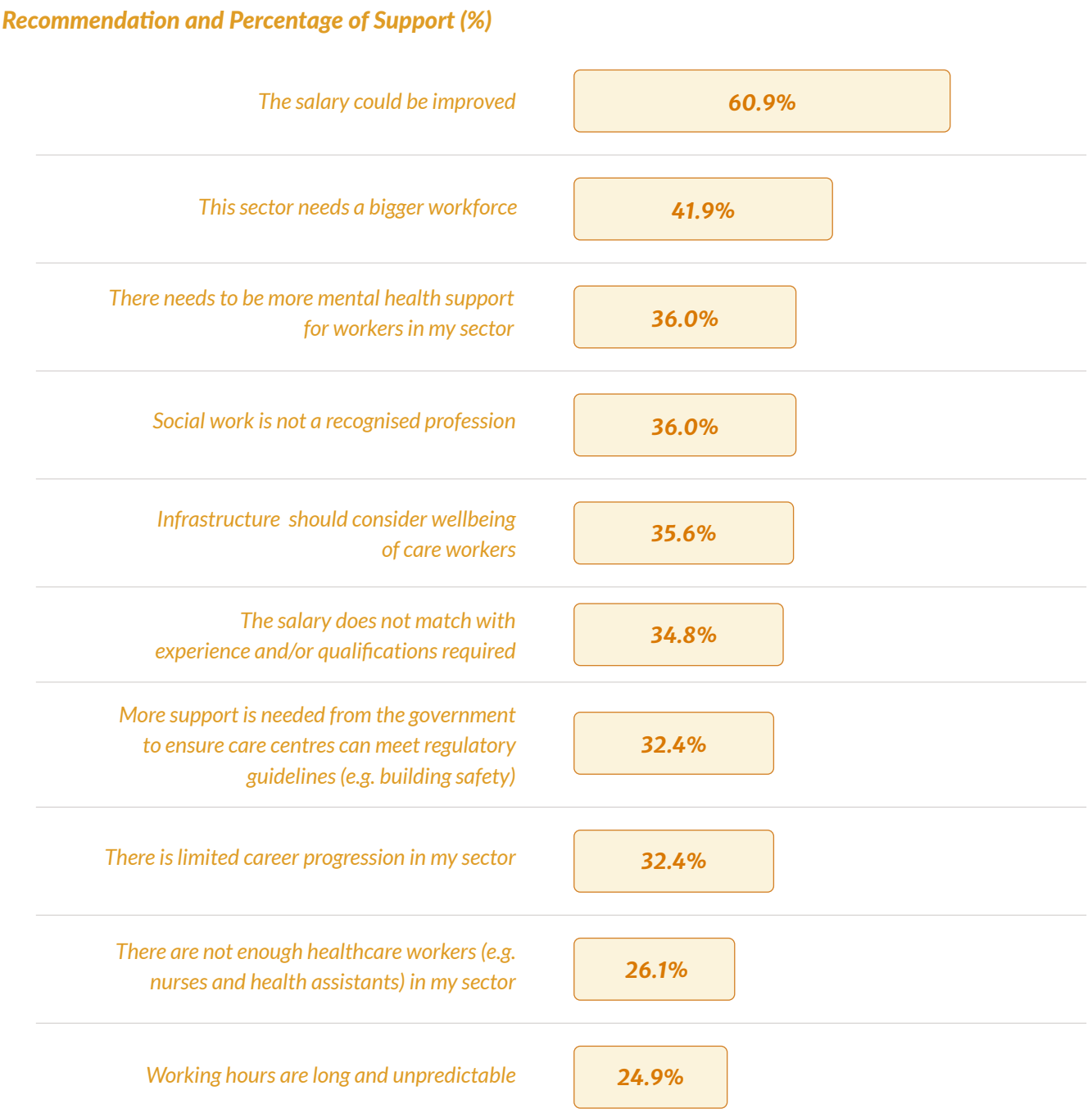


Note: n = 968

Within the healthcare sector, concerns related to contract terms and resource distribution issues come to fore, highlighting bureaucratic as well as resource allocation challenges. In the social care sector (see figure 5.1.3), workers highlighted several structural barriers, such as inconsistent licensing requirements across local authorities (32.4%), the lack of clear career progression pathways (32.4%) and the lack of professional recognition for social work (36%). These represent deeper structural issues, indicating that the social care sector in Malaysia is significantly less developed, compared to the health care sector. Interestingly, about a quarter (26.1%) of social care workers noted a shortage of healthcare workers within their sector, suggesting a need for better integration between social and health care systems.

FIGURE 5.1.3

Top 10 Concerns in the Social Care Sector (Social Workers, Elderly Care, PWD and Child Care Workers)



Note: n = 253

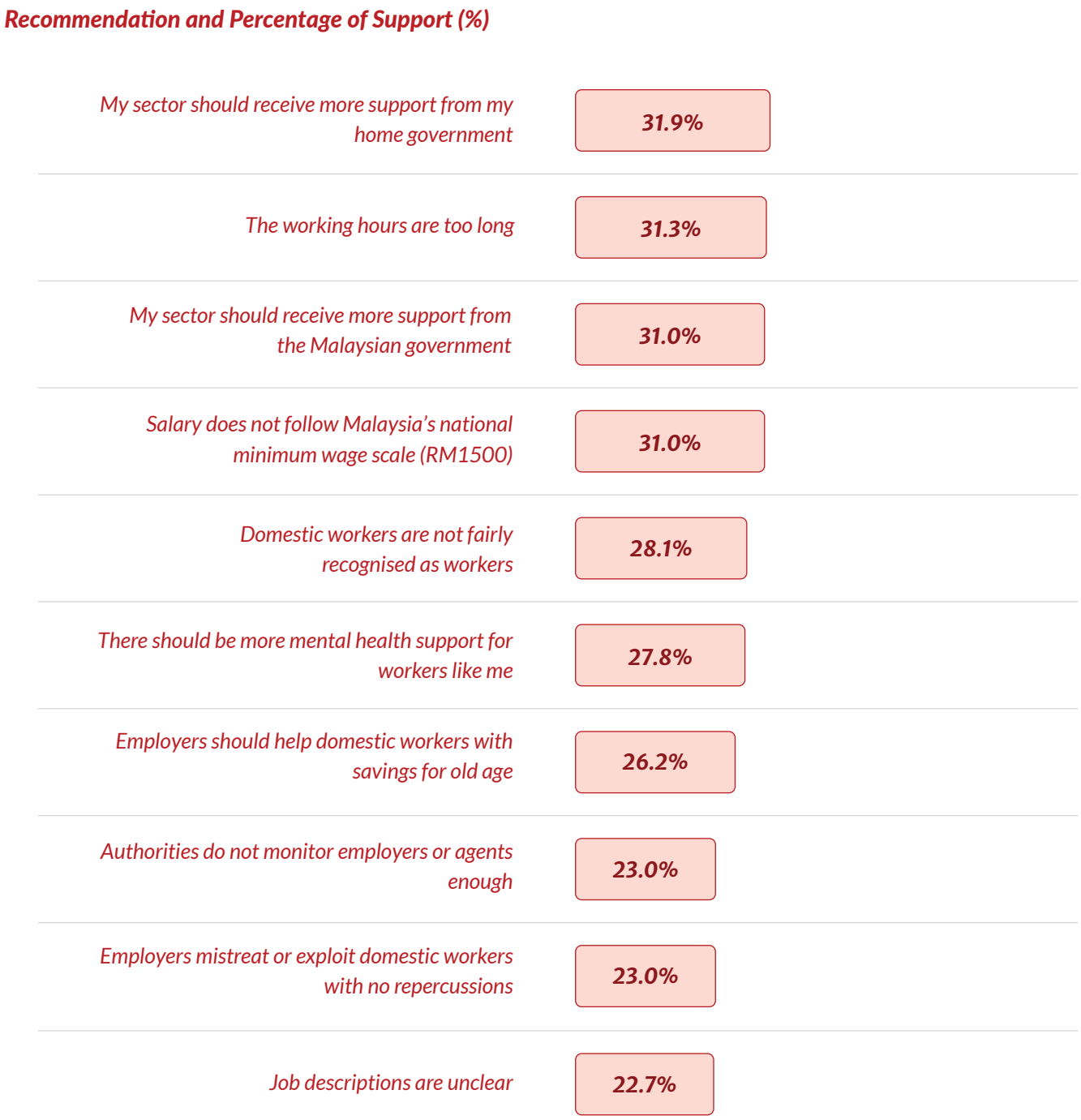
Overall, domestic workers showed lower response levels compared to those in healthcare and social care. This likely demonstrates the unbalanced power dynamics that shape employer-domestic worker relationships and relatedly, the constraints they may face. Domestic workers, especially those who are live-in, are often isolated from their communities, and many have few places to turn to for information or may fear speaking openly about their needs, for fear of repercussions. Thus, given these circumstances, it may have been more difficult for them to raise concerns during survey engagements.

Nevertheless, among those who were able to articulate their concerns, the concerns that stood out are salary levels not aligning with the national minimum wage scale (31%) and weaker protections from labour rights violations by employers or agencies. A third of domestic

workers expressed concerns over long working hours (31.3%) and our survey findings affirm this: 61.7 % of domestic workers worked more than 50 hours per week, while 21.7 % worked more than 80 hours per week. Domestic workers also felt that both their respective governments, and the Malaysian government could do more to improve their support for domestic workers' wellbeing.

FIGURE 5.1.4

Top 10 Concerns in the Domestic Care Sector (Domestic Workers)



Note: n = 313

5.1.2
Recommendations for Crisis Response

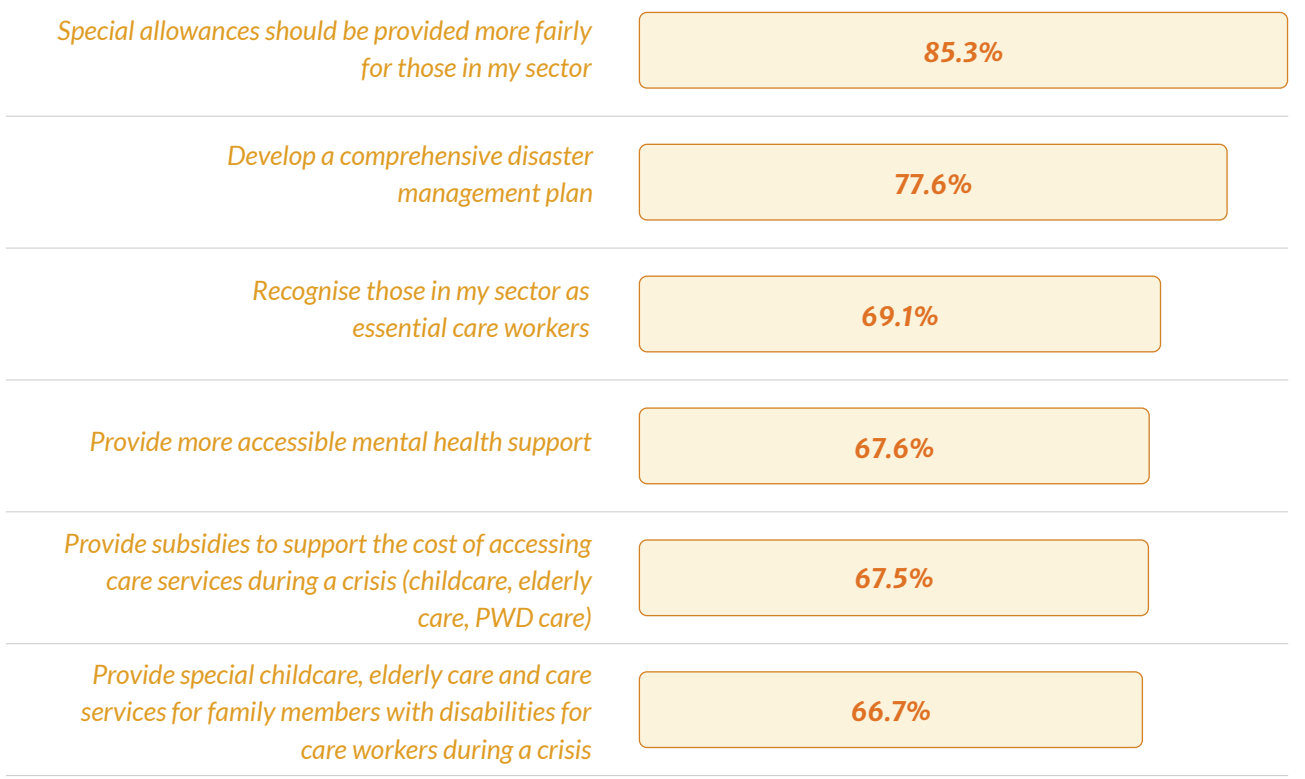
When asked what should be done to ensure care workers are better prepared for future crises, care workers emphasised the need for greater recognition, improved wellbeing and systemic reform as key recommendations. Among the health and social care workers, the most widely supported recommendation was for special allowances to be distributed more fairly (85.3%), indicating that the current method and approach of allocation does not adequately reflect the diverse contributions of care workers during crises. Addressing this perceived unfairness in recognition is essential, as it affects care workers' general morale and motivation, especially in times of crisis.

In addition to financial recognition, care workers were also strongly in favour of recommendations that focus on their personal wellbeing. In particular, they have called for more accessible mental health support (67.6%) and support for managing their own unpaid care responsibilities in the form of services (66.7%) or subsidies (67.5%). These results highlight that the double burden is a significant area of concern for care workers.

FIGURE 5.1.5

Crisis-Specific Recommendations by Care Workers in Health and Social Care Sector

Recommendation and Percentage of Support (%)



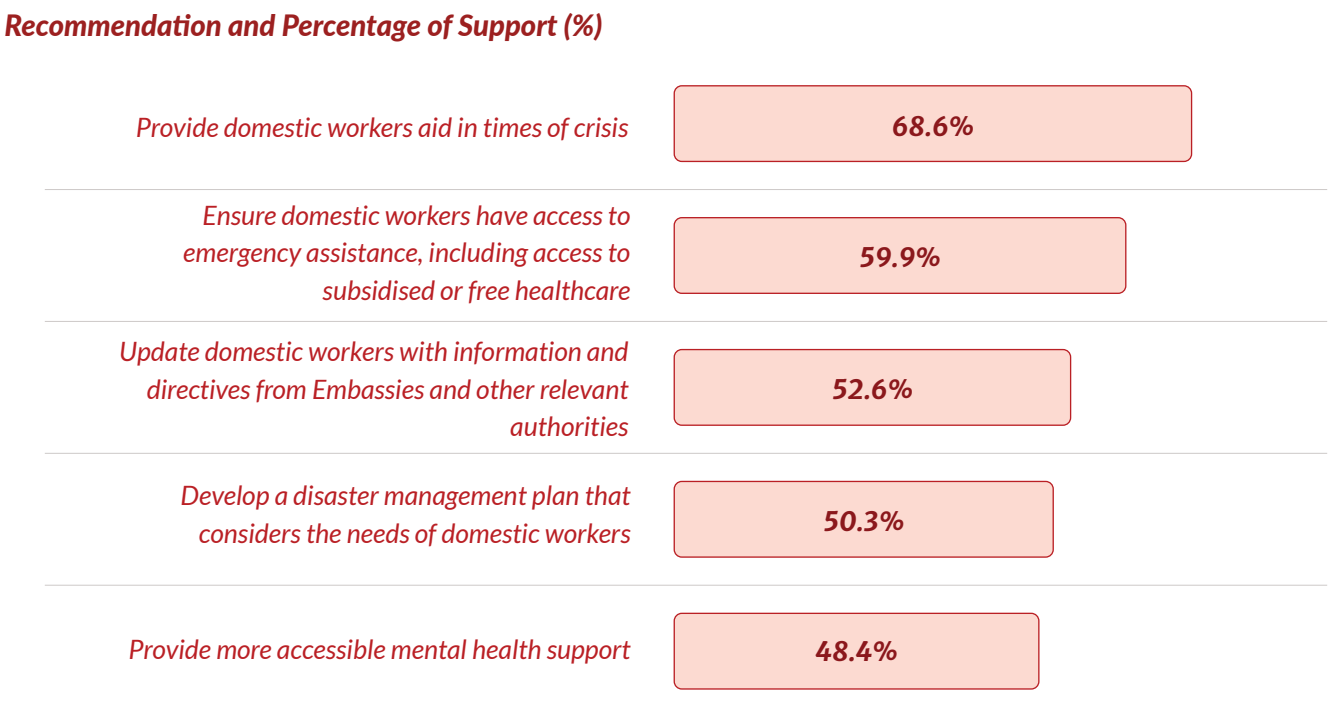
Note: n = 1221

With regard to systemic reforms, care workers emphasised the importance of stronger crisis preparedness, with a majority (77.6%) supporting the development of a comprehensive disaster management plan, and the formal recognition of care workers as essential. Understandably, both measures are seen as critical to easing the pressures faced by care workers during crises. Both these recommendations highlight key lessons from COVID-19, where gaps in planning and recognition left many care workers feeling unsupported. Importantly, recognition of care workers as 'essential' is not merely symbolic but has practical implications in terms of care workers' access to resources, protections and special provisions in future emergencies.

In general, domestic workers emphasised the need for greater recognition and inclusion, reflecting a general perception of being excluded from official communication channels and national crisis management efforts, despite their crucial role in sustaining households that were otherwise cut off from other care services. More than half expressed wanting to receive regular information and updates from embassies or relevant authorities (52.6%), while half want to be included in crisis preparedness plans (50.3%). For domestic workers, separation from their home countries, families and communities heightens the uncertainty they experience, making government support (both from Malaysia and their home countries) especially critical. Ensuring the protection of their rights, along with access to health services, mental health support, emergency assistance such as food or financial aid (including to their families in home countries), would offer much needed assurance and help alleviate the emotional and psychological strain they endure in times of crisis.

FIGURE 5.1.6

Crisis-Specific Recommendations by Domestic Workers



Note: n = 313

In summary, findings across all three sectors demonstrate that *care workers want both individual-level wellbeing support as well as broader systemic changes.* Ultimately, this aligns with the broader idea of resilience as multi-layered, requiring interventions at the individual, organisational and systemic levels. While strengthening absorptive capacities (e.g. through measures such as special allowances, or improving mental health services) is important for supporting workers' wellbeing and individual resilience, what is crucial for Malaysia at this juncture, is a focus on strengthening adaptive/transformative capacities i.e. a focus on structural and systemic reforms (e.g. improved crisis preparedness plans, recognition of workers as essential workers, support for workers' own personal care responsibilities, changes in attitudes) that will help address the foundational gaps within our care systems and steer us towards the development of a more resilient care workforce.

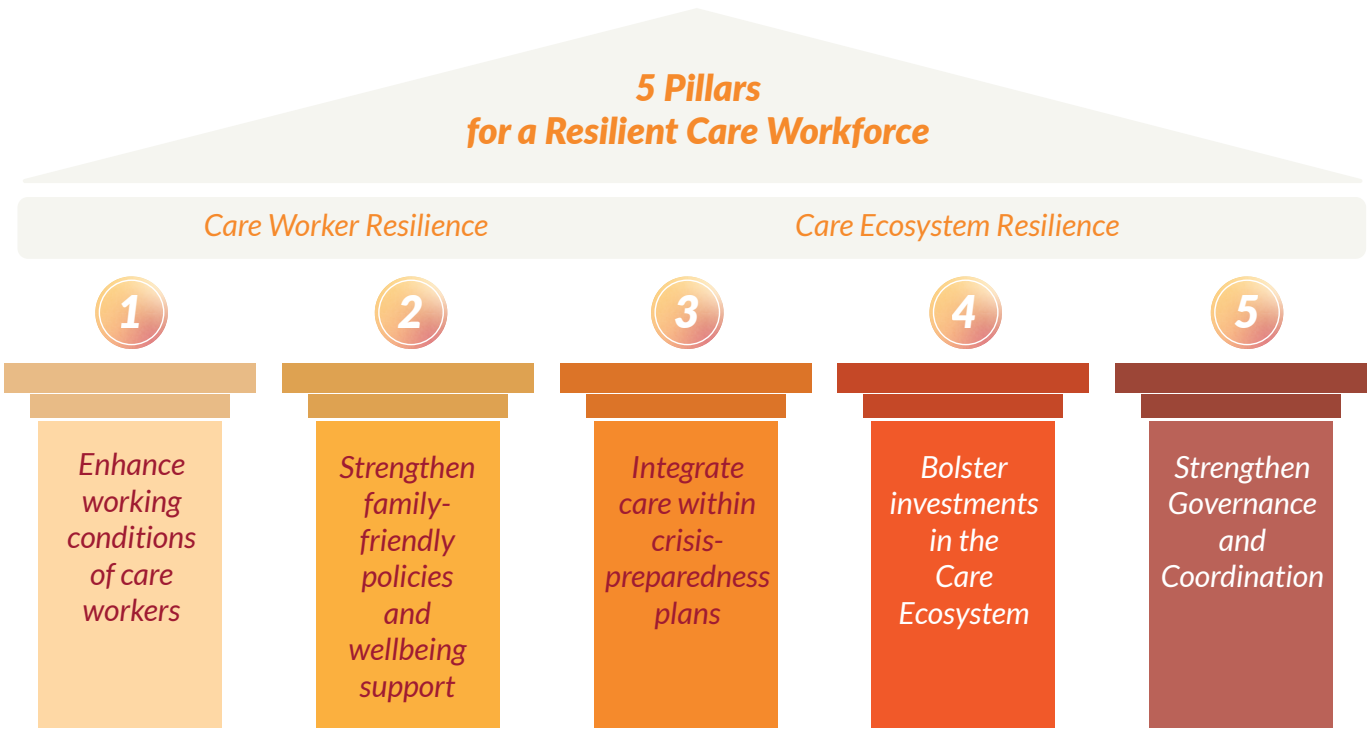
5.2
Five Pillars of Recommendations to Achieve a Resilient Care Workforce

Drawing on the relevant conceptual frameworks and the evidence presented in Chapter 4, this section puts forward five broad pillars of recommendations that will lead to structural and systemic reforms needed to achieve a more resilient care workforce in Malaysia (see Figure 5.2.1). Ultimately, the wellbeing of the care workforce is intricately linked with the health of the broader care ecosystem, and thus the pillars of recommendations include wider ecosystem-related suggestions.

For each pillar of recommendation, we highlight sub-recommendations arising from our engagements with care workers and key informants within healthcare, social care, and domestic care sectors. We present these sub-recommendations not as an exhaustive list, but as indicators (highlighted by care workers themselves) of where attention and investment are urgently needed. The following pages provides a summary of recommendations and key actions.

FIGURE 5.2.1

Five Pillars of Recommendations for a Resilient Care Workforce



The five pillars of recommendations are as follows:

Pillar 1

Enhance the working conditions of care workers by ensuring care work is decent work

Strengthen the foundations of care professions in Malaysia by ensuring fair employment standards, improved mental health support, protection from violence both in the workplace and home. Promote spaces that enable care workers to organise, establish effective feedback loops and ensure stronger representation of care workers in decision-making processes. Additionally, build an ecosystem that supports clear career pathways and opportunities to sustain and professionalise the care workforce.

Pillar 2

Strengthen family-friendly policies and support for care workers

At the organisational level, family-friendly workplace policies and initiatives should be tailored to the specific context of the care workers. Relatedly, foster workplace cultures that value work-life balance, rather than penalising workers for accessing family-friendly benefits. At the societal level, invest in and improve community-based care services to provide broader support for care workers. In addition, public messaging and programmes should be used to shift social norms and values around care, guided by the 5R framework - recognising, reducing, redistributing, rewarding and representing care work. Care should be valued and seen as a collective responsibility, not as a responsibility that falls solely on individuals, families or women. It should be regarded as a public good and its cost and responsibilities should be fairly shared across society and among all stakeholders (e.g. men within households, state, private actors, community). Additionally, recognise that domestic workers are not 'maids' or 'helpers' but workers with rights.

Pillar 3

Integrate care workers and care work within crisis-preparedness and response plans.

Designate care workers as essential workers, so they may be protected with resources, access unrestricted mobility while in service, receive adequate hazard-related compensation (e.g. special allowances) and access crisis-specific facilities and services (e.g. transportation, childcare or elderly care services, temporary housing). Strengthen SOPS within national crisis-preparedness and response plans and ensure that it includes all care sectors (healthcare, social care and domestic care). Upgrade crisis-training modules to ensure relevance of content and enhance predictability for care workers (e.g. clear activation triggers).

Pillar 4

Bolster investments in the care ecosystem

Bolster investments in the care ecosystem to ensure sustainable financing of care policies including crisis preparedness. None of the recommendations put forward in this report is possible without sustained, strategic investments. Care must be an economic priority, with investments across the short, medium, and long term to strengthen the care workforce and build resilience across individual, organisational, and national levels. We recommend investing at least 1% of GDP (RM39.6 billion) to secure a resilient and sustainable care ecosystem. This investment could be one-off or year-on-year, as both have been demonstrated through economic modelling to yield returns. According to Onaran and Oyvat (2023), even a one-off investment of 1% GDP could offer returns of 2.2% GDP. This means that investing RM39.6 billion could potentially lead to an increase in GDP by RM87 billion in five years.

Pillar 5

Strengthen governance and coordination for a coherent care ecosystem

Institutionalise a national multi-sectoral coordinating entity such as a national care commission, a special select committee which could oversee the development and implementation of a national care strategy and plan. Given the growing attention to care as a social infrastructure and as a burgeoning economic sector there is a need to strengthen the care ecosystem and the care workforce. This entity could potentially lead national care workforce planning, develop an integrated data system to link care demand and workforce supply, address gendered dimensions of care (and its undervaluation), as well as promote better integration of our health and social care systems. This entity could also play a critical role in resolving long-standing coordination issues within care sectors that require closer multi-sectoral collaboration.

Summary of Pillars, Focus Areas and Recommendations

Pillar 1 Ensure Care Work is Decent Work

Focus Area: Employment standards and protections

Rationale: Raise employment standards, ensure fair reward, protections, job security and wellbeing across the care workforce.

RECOMMENDATIONS

- Review salary structures and ensure wages are aligned with care worker qualifications, workload and years of experience
- Review contracting systems for hospital cleaners, doctors, nurses to address concerns over fair wages and job security
- Introduce a maximum 40-hour work week and mandatory rest periods for all care workers
- Expand Employment Act protections to migrant domestic workers (e.g. rest days, paid leave, minimum wage, possession of passport)
- Pass the Social Work Profession Bill and ensure coverage for both public and private social workers
- Develop standardised national training and competency frameworks for care workers; introduce career progression pathways across childcare, disability care, and elderly care

Focus Area: Mental health support

Rationale: Reduce burnout and psychological distress, creating safer and inclusive workplaces for care workers

RECOMMENDATIONS

- **Ensure mental health support services are provided by independent providers to ensure confidentiality and encourage uptake**
- **Ensure issues raised by care workers during mental health support sessions are meaningfully addressed**
- **Introduce respite leave where care workers can periodically rest and recover after a period of work**
- **Train supervisors/managers to identify and support care workers facing burnout and stress**
- **Foster a workplace culture where mental health is a system-wide priority**
- **Connect migrant domestic workers with psychosocial support through Post-Arrival Orientation Seminars (PAOS); Complement this with mandated pre-employment orientation briefings for employers**

Focus Area: Protections against violence at the workplace and home

Rationale: Prevent and protect against violence, creating safer and inclusive workplaces for care workers

RECOMMENDATIONS

- Strengthen SOPs for addressing workplace violence through comprehensive definitions, survivor-centric procedures, and assured access to counselling or psychosocial support
- Develop national standards and guidelines for workplaces to respond to personal violence, understanding the critical role employers can play in supporting survivors of gender-based violence.
- Develop a formal grievance mechanism for migrant domestic workers to improve monitoring and enforcement of contract terms

Focus Area: Worker representation and participation

Rationale: Ensure systemic changes and reforms represent workers experiences on the ground

RECOMMENDATIONS

- Strengthen institutional processes for feedback to facilitate opportunities for care workers to voice out concerns (e.g. anonymous staff surveys, regular consultations)
- Strengthen institutional processes for care workers, especially women, to participate in decision-making processes (e.g. formation of worker advisory councils or invitations to participate in policy drafting committees)
- Strengthen care workers' capacities to self-organise and advocate for their rights and wellbeing

Pillar 2 Strengthen Family-friendly Policies and Supports for Care Workers

Focus Area: Family-friendly workplace policies

Rationale: Support care workers in balancing paid and unpaid care responsibilities, including during times of crisis. A care-supportive culture encourages uptake and utilisation of family-friendly policies

RECOMMENDATIONS

- Tailor family-friendly workplace policies to care worker realities (parental leave for dual-care-worker couples especially from the healthcare sector, predictable rostering, onsite care services, flexible work arrangements)
- Review deployment/placement policies for care workers to allow flexible postings during crises; Consider workers' personal and familial contexts (e.g. where they reside, personal care responsibilities)

Focus Area: Care-supportive infrastructure and culture

Rationale: Support care workers in balancing paid and unpaid care responsibilities, including during times of crisis. A care-supportive culture encourages uptake and utilisation of family-friendly policies

RECOMMENDATIONS

- Establish care-supportive workplace infrastructure (childcare, eldercare, maternal-health facilities, well-being spaces)
- Foster workplace cultures that promote work-life balance

Focus Area: Community-based care services

Rationale: Strengthen the wider care ecosystem to support redistribution of care responsibilities, while reducing care loads on women care workers

RECOMMENDATIONS

- Invest in and improve community-based care infrastructure and service models;
- Shift towards outcome-based metrics that focus on the benefits gained by care recipients
- Explore innovative service models e.g. (respite leave for caregivers, inter-generational hubs that can be adapted and scaled for the Malaysian context
- Develop sustainable financing models for community-based care centres

Focus Area: Social norms and attitudes

Rationale: Actively challenge unsupportive social norms and attitudes that hinder perceptions of care as collective responsibility and care work as valuable and skilled work.

RECOMMENDATIONS

- Transform gendered social norms and public attitudes towards care through awareness programmes and public-service messaging; Normalise shared caregiving and the valuing of care work
- Promote the recognition of domestic workers as workers; Normalise the use of the term ‘domestic worker’ in everyday speech, official documents and public communications

Pillar 3 *Integrate care workers and care work in crisis-preparedness and response plans*

Focus Area: Integration of care work and care workers into national crises frameworks

Rationale: Prevent care workers from absorbing disproportionate stress, ensuring a crisis-ready care workforce

RECOMMENDATIONS

- Integrate care workers from across public and private healthcare, social care and domestic care sectors in national crisis preparedness and response plans
- Strengthen SOPs, guidelines and communication protocols within national crises preparedness plans to ensure smoother processes and clearer scope of work for care workers
- Ensure fair and transparent distribution of risk/hazard (special allowances)
- Institutionalise regular crises preparedness and emergency response training for care workers across public and private sector (e.g. joint inter-agency trainings)
- Upgrade training modules to ensure relevance of content (e.g. include pandemic preparedness) and enhance predictability for care workers (e.g. clear activation triggers)
- Ensure fair and transparent distribution of risk/hazard (special) allowances

Focus Area: Crisis preparedness and response at the instituional/organisational level

Rationale: Improve crisis-preparedness, through training and clear institution-specific crisis SOPs.

RECOMMENDATIONS

- Strengthen institution-specific (e.g. hospital, care centre) crises plans and ensure alignment with national frameworks; co-design with experienced care workers
- Leadership training for managers and supervisors on managing teams during crises.

Focus Area: Access to crisis-specific supports

Rationale: Accessible crisis-specific supports to enable care workers to balance their paid and unpaid care responsibilities during a crisis, preventing burnout and increased stress. Reduce inequities in support between formal and informal service providers.

RECOMMENDATIONS

- Provide crisis-specific support services for care workers to execute their paid work (e.g. temporary housing arrangements, transportation services/subsidies, special passes for navigating roadblocks
- Establish temporary care arrangements to support care workers with their personal care responsibilities during crises (e.g. 24-hour childcare and eldercare for frontline workers)
- Ensure government emergency support (e.g. financial aid, sanitation supplies, vaccination outreach) reaches all social care providers and migrant domestic care workers

Pillar 4 Bolster Investment in the Care Ecosystem

Focus Area: Strategic care financing

Rationale: Secure sustained financing for the care ecosystem to ensure care services and workforce resilience. According to economic modelling by Onaran and Oyvat (2023), a one-off investment of 1% GDP could increase GDP by 2.2% in five years, a potential gain of approximately RM87 million. This will also lead to gains in GDP and employment.

RECOMMENDATIONS

- Invest at least 1% of GDP (RM39.6 billion) to secure a resilient and sustainable care ecosystem
- Finance increased staffing, improved salary structure and benefits, enhanced job security, and expanded training/upskilling and professional pathways.
- Long-term investments and goals towards universal pension to ensure care workers are supported into old age, especially those within B40 households
- Fund programmes that offset unpaid care loads (e.g.expanding size of workforce, introducing respite care, on-site care services, community-based care services)
- Finance wellbeing initiatives (e.g. rest spaces, training managers, measures to strengthen mental health support and protect against violence)

Pillar 5 Strengthen governance and coordination for a coherent care ecosystem

Focus Area: Leadership and multi-sectoral coordination

Rationale: Establish clear leadership and whole-of-government alignment for coherence in policies, standards and leadership across sectors

RECOMMENDATIONS

- Institutionalise a national coordinating entity (e.g. a national care commission or a Special Select Committee) to strengthen governance and coordination; This entity could be supported by an inter-ministerial taskforce.
- The entity's scope of work could include the following:
    - Develop and oversee implementation of a National Care Strategy and Plan for a long-term, gender-responsive care ecosystem
    - Lead national care workforce planning, premised on a forecast of Malaysia's care needs
    - Resolve and oversee long-standing coordination issues that require multi-sectoral coordination and agreement
    - Address systemic gaps and structural barriers to ensure retention of a skilled workforce
    - Develop an integrated and gender-disaggregated data system linking care demand and supply
    - Promote better integration between of health and social care systems
    - Recognise and address gendered dimensions of care work (e.g. undervaluation of care)
    - Recognise the domestic care sector and strengthen protection of domestic workers
    - Involve care workers in decision-making processes

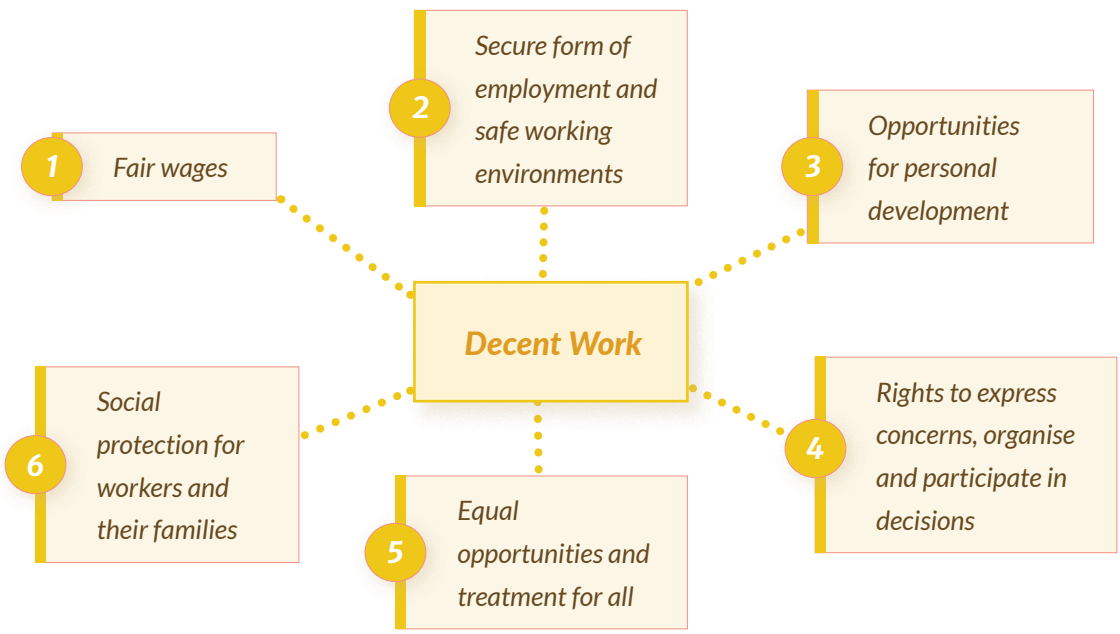
Pillar 1:

Enhance working conditions of care workers by ensuring care work is decent work

Care workers are essential to the nation's resilience and wellbeing, yet many are underpaid, overworked, and unrecognised. While this study calls for increased recognition of care workers and for care workers to be considered as a part of the essential workforce, we contend that this is not possible without first ensuring that care work is 'decent work' (Ghai 2003). According to ILO (2018) and the European Commission (n.d.), a job is considered to be decent work when several characteristics are fulfilled (See Figure 5.2.2).

FIGURE 5.2.2

Characteristics of 'Decent Work'



Source: ILO 2018; European Commision n.d.

As our findings indicate, a significant number of care workers in Malaysia tend to have low wages, work long hours, and some with limited pathways for career advancement. In the long run, this is a recipe for burnout. Some workers are also not protected or supported through current legislation. Without intentional effort to improve the work conditions of care workers, Malaysia risks losing the very workforce it depends on to execute national strategy and action plans such as the National Aging Blueprint, Health White Paper, and the 13th Malaysia Plan.

A Ensure fair employment standards for care workers

Summary of Relevant Findings

01

Over two-thirds (70.7%) of care workers believe their salary could be improved.

02

Care worker households with higher care loads typically have less income per capita compared to households with smaller care loads, indicating a *care-finance squeeze.* Essentially, families with higher care loads face both intensive caregiving responsibilities and financial strain.

03

Certain care occupations are categorised as low-skilled labour and *excluded from progressive wage scales.* This means these care workers often do not progress beyond minimum wage levels, regardless of performance or years of experience. For example, despite having accumulated over 15 years of experience, hospital cleaners and domestic workers still typically earn around minimum wage, ranging from RM1,300 to RM1,700, on average.

04

Care workers undertake an extensive amount of time on paid care work, with many working well over the 45 hour maximum work week mandated by the Employment Act. Long working hours takes a toll on workers' wellbeing and it also leads to burnout. *Two-thirds of care workers surveyed experienced moderate to severe burnout during the pandemic and over half of the care workers continue to experience high rates of burnout post-pandemic.* Furthermore, our analyses demonstrates that total paid work hours is significantly associated with burnout, where *more time spent on paid care work results in higher levels of burnout.*

05

One in three care workers (35.7%) feel they have limited opportunities for growth in their career. Many care workers do not have clear career development pathways. This includes private sector care providers for children, the elderly, and people with disabilities, as well as hospital cleaners and domestic workers. These issues compound, emblematic of a lack of recognition for the skills required for these roles, further evidenced by their persistently low wages despite years of work experience.

06

When jobs are viewed as unskilled, they may also be viewed as easily replaceable, which may be why *one-third of care workers (34.2%) are currently worried about losing their jobs*. The recognition and valuation of care workers is a prerequisite to ensuring decent employment.

07

While working conditions can be improved for all care workers, *migrant domestic workers in particular face further challenges arising from being partially excluded from many of the protections under the Employment Act 1955* in Malaysia. They remain excluded from provisions related to set working hours (including maximum working hours), overtime pay, annual leave, and rest day pay provisions (under Section 60 and its subsections) and maternity protection (Part IX) (Malaysian Employers Federation 2022). Despite Malaysian employment contracts mandating a weekly day off for migrant domestic workers, over a quarter of respondents (28%) reported working seven days a week, highlighting a significant gap between contractual obligations and enforcement in practice.

Recommendations

i Review and improve current salary structures to ensure fair remuneration for care workers

While there have been recent efforts by the government to address the issue of the rising cost of living, the desire for equal pay for work of equal value is a consistent demand across the paid care sectors. In their responses, care workers have explained that receiving fair pay means receiving remuneration that is commensurate with qualifications (recognising the value of their qualifications versus warrants), years of experience (including years of service while under contract), and demands required for the roles (intensity and scope of work). As shared by a childcare worker, wages are often insufficient to meet even basic living needs.

Saf, Private Child Care Worker, Central Malaysia

Macam saya kan, rasa macam lama dah [kerja], tapi gaji macam bawah lagi RM2,000 [ketawa]. Macam tak boleh survive.

English translation

Like for myself, I feel like I have been [working] for long, but my wages are under RM2000 [laughs]. Like I can't survive.

ii Review the management of contracts for hospital cleaners

Some of the hospital cleaners we spoke to shared their dissatisfaction with the sub-contracting system used by public hospitals in outsourcing cleaning services. While hospital cleaners are integral to infection control and daily hospital operations, subcontracting places them under the purview of private companies, and excludes them from protections and benefits enjoyed by other hospital staff. For instance, without a progressive wage scheme, hospital cleaners are trapped at entry-level earnings, despite their years of service. Over one-third of hospital cleaners surveyed (38.1%) believe that the management of their contracts should be reviewed. A hospital cleaner union has even called for the end of contract systems, which have systematically exploited and disadvantaged them. Clearly, there is a need to meaningfully engage with hospital cleaners to resolve grievances.

Representative, National Union of Workers in Hospital Support and Allied Services (NUWHSAS)

A worker may be working for more than 20 years in the same hospital…they do the same job over the 20 years. But then when the contractor changes, they lose everything…[years of work experience]

Aside from contracts, hospital cleaners also reported unfair or inconsistent compensation for working over-time (OT) during COVID-19. In East Malaysia, some received a one-off company-provided COVID-19 allowance instead of OT pay, while in central Malaysia cleaners described working up to 20 hours with minimal rest and months away from family, without proper allowances. Hospital cleaners, therefore, bore heavier workloads than usual, but without fair remuneration. Overall, there is an urgent need to improve monitoring of the employment practices by subcontracted companies, to ensure the wellbeing and labour rights of hospital cleaners are not being violated.

Hospital cleaners are integral to infection control and daily hospital operations. Subcontracting places them [hospital cleaners] under the purview of private companies, and excludes them from protections and benefits enjoyed by other hospital staff.

iii Review the management of contracts for doctors and nurses

Over one-third of doctors and nurses surveyed (38.1%) believe the way contracts are managed should be reviewed. Contracts of service were initially introduced in public healthcare to manage the overproduction of doctors back in 2016 (The Star, 2025). Since then, contract positions have expanded to include nurses as well, as has been shared by nurses throughout the study. These contract positions, as discussed in Chapter 2, create precarity among the healthcare staff, impacting job security and limiting access to key employment benefits. These conditions, coupled with low wages, intense workload demands, and impacts on wellbeing, lead doctors and nurses within the public sector to seek opportunities elsewhere. Among those intending to leave, over one third of doctors (39.2%) cited wanting to move to the private sector, while one third of nurses (34.9%) indicated plans to work abroad. In Budget 2026, it was announced that 12,600 doctors have been absorbed into permanent positions since 2023, with an additional 4,500 to be offered permanent positions (Ministry of Finance 2025). These commendable efforts should be continued and should extend further to nurses as well to ensure the resilience of the healthcare workforce.[1]

iv Expand labour protections for migrant domestic workers by amending the Employment Act

Domestic workers carry out crucial responsibilities that allow many Malaysian families to manage unpaid care work. By caring for children and the elderly, and performing household tasks, they enable more Malaysian women to remain in the labour force. Findings from our survey illustrate this clearly: during the pandemic, nearly two-thirds of domestic workers (62.0%) reported the presence of either an elderly person, a child under six, or both in their employers' home. Yet, despite their central role, domestic workers are not recognised as part of the care workforce, and are only partially covered under the Employment Act of 1955. At the same time, domestic workers have called for the terms of their contracts to be more closely monitored by authorities to address labour violations by both employers and agencies (ILO 2023b). These include domestic workers' access to one-day-off per week, to hold their own passports and to receive wages that are in line with amounts stipulated in the contracts.

1 In Budget 2026, it was announced that 935 graduates from MOH training institutes would also be offered permanent positions (Ministry of Finance 2025). However, it is unclear if these are nursing graduates, though some news outlets have reported it as such (see Hakim Mahari 2025).

v *Introduce a maximum 40-hour work week and mandatory rest periods for care workers*

Findings from this research show that long work hours are one of the main concerns raised by care workers across sectors. Around 40% of healthcare workers, 31% of domestic workers, and 24.9% of social care workers pointed to long work hours as an issue within their respective sectors.

Recently, the directive to increase the 42 hour work week for nurses to 45 hours, to align with the work week hours of others in civil service, was the subject of debate and protest. In fact, data from our study reveals that most care workers, including nurses, are already working beyond a 45 hour work week (refer to Findings 1 and 2 for more data on the paid work hours of care workers). The decision to reverse the directive marked a crucial turning point and a growing recognition that care work should not be benchmarked against standard productivity measures (Bernama, 2025).

In essence, care work should not be regarded in the same way as office-based jobs or work in other sectors that are often driven by the logic of productivity and profit maximisation. As elaborated in Chapter 2, the intensity of care work and the emotional labour involved make care work different from most other jobs. Thus, the ILO recommendation for a 40-hour work week and a 12-hour rest time in between shifts for nurses provides a useful benchmark, and a strong case for extending this to the wider care workforce (International Labour Organization 1977, s. 32 (2)).

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The intensity of care work and the emotional labour involved make care work different from most other jobs. Thus, the ILO recommendation for a 40-hour work week and a 12-hour rest time in between shifts for nurses provides a useful benchmark, and a strong case for extending this to the wider care workforce (International Labour Organization 1977, s. 32 (2)).

vi Pass the social work profession bill and ensure it applies to all social workers in both the public and private sector

Currently, anyone can claim the title of 'social worker' without appropriate qualifications. This has been seen to result in a conflation of roles, with social workers often treated as administrative staff rather than professionals with specialised training. Furthermore, there is a likelihood that it exposes vulnerable clients to practices that are harmful or unprofessional.

Recently, the draft Social Work Profession Bill was reportedly amended to exclude public sector social workers, making it only applicable to social workers in the private and NGO sectors (HSS et al. 2025). While the implementation of this potential Act may need to be gradual to accommodate for the harmonising of regulations governing civil service, the ultimate aim of the bill should be to strengthen the profession and ensure professional standards of social work practice are upheld across the board, in both the private and public sector. By passing this Bill, social work will finally be recognised as a profession, creating an impetus for clearer career pathways, improved work conditions, greater retention of social workers and overall sustainability for the profession.

Social workers are often treated as administrative staff rather than professionals with specialised training

vii Professionalise and raise the status of the childcare, eldercare, and disability care workforce

Care workers should be valued and recognised as skilled professionals. The lack of standardised training, accreditation, and clear career pathways continues to constrain their growth and keeps the profession undervalued. As one private childcare worker shared:

Kahee, Private Child Care Worker, Central Malaysia

Taska ni dia orang tak pandang sangat. Kerja taska? Ah lah setakat kerja mengasuh budak je, macam tu kan. So dia orang tak pandang sangat kita punya skop kerja, kira macam underground lah… So, kalau boleh macam kita nak taska ni dipandang tinggi, sebab kalau tak de taska, mak bapa yang kerja, dia orang tak boleh nak, nak buat kerja dia orang. Kita lah yang banyak membantu dia orang, menjaga anak dia orang dari pagi sampai ke petang.

English translation

Childcare [workers], they don't regard us highly. Childcare work? Ah lah it's just about taking care of children, like that. They don't really look at our job scope, like we're just underground [workers]... If it's possible, we would like childcare work to be regarded highly, because if there is no childcare, parents who are working, they can't possibly work. We are the ones who help them a lot, taking care of their children from morning to evening.

Her words echo the experiences of many other care workers employed in formal care institutions (e.g. child care, elderly care, disability care) and who desire greater recognition of their highly skilled work. As she highlights in the excerpt, child care workers' extensive scope of work is often overlooked and undervalued. This view is shared by another disability care worker in a roundtable discussion, who notes that with seven categories of disability, the needs of their clients vary widely and each care recipient requires distinct and tailored forms of care. Unfortunately, many disability care workers do not receive adequate training needed for quality care of persons with disabilities (PWDs).

The elevation and recognition of institution-based care workers, particularly those providing specialised care services, hinges on structural changes within the care ecosystem, in particular the professionalisation of care worker roles through development of regulations, standards and accreditation. This requires the development of a national care competency framework and accreditation for childcare, elderly care and disability care. As such, we commend the recent Budget 2026 announcement of firstly, a RM5 million allocation to strengthen the long-term care (LTC) sector through professional Technical and Vocational Educational Training (TVET) training and secondly, to double tax deductions for companies who sponsor the training of care workers (Ministry of Finance 2025). These are important steps forward for the industry and a recognition of the importance of investing in a skilled care workforce. Sustained improvements will depend largely on how training and accreditation are integrted with other components of decent work such as fairer wages, sustainable workloads, and clear career pathways.

B Strengthen mental health support for care workers

Summary of Relevant Findings

01

Physical and mental health saw *the largest decline* during the COVID-19 pandemic; care workers *reported over a fourfold increase in feeling anxious and over a threefold increase in feeling depressed.*

02

Post-pandemic, one in four care workers *still report feeling anxious,* while *one in six* report *still feeling depressed.*

03

Women experienced a greater decline in satisfaction with physical and mental health during the pandemic compared to men. However, when women perceived organisational and social support to be adequate, their decline was similar to men's, suggesting that these supports are important for women's health outcomes in times of crisis.

04

Two in five care workers surveyed (40.2%) believe there needs to be more mental health support for workers in their sector, while findings from FGDs reveal that care workers believe there is room for improvement in the mental health support that is available to them at work.

05

Within the public healthcare sector, while mental health assessments are administered, *follow-ups are one-off or inconsistent,* leading to fractured support for healthcare personnel facing mental health issues.

06

Non-clinical care workers noted a *lack of access to mental health support.* Within FGDs, many of these care workers described the mental health toll of the extended work hours and workloads on their wellbeing. For example, one key informant highlighted that hospital cleaners did not receive adequate mental health support during the COVID-19 pandemic to manage the trauma they faced working in high risk wards, sharing, "So many workers called us and cried. I'm scared to go into the ward, yesterday a worker died or [yesterday] the patient died. So trauma. So they need counseling."

Care work can be emotionally intense, and physically draining. When mental health needs are neglected, it can compromise care workers' wellbeing and impact on quality of service. Mental health support should be treated as integral to the wellbeing of care workers, and institutions/organisations across care sectors should proactively take measures to ensure it is prioritised.

Findings from our FGDs indicate that the awareness of mental health initiatives within the public sector were uneven. While some care workers acknowledged the availability of such services, some said there were none specifically for workers. Doctors, nurses and social workers also noted that the stigma towards mental health was prevalent within their sectors. For example, a doctor shared that although she knew about the availability of a dedicated hotline for healthcare workers during the pandemic, she was hesitant to access it due to the fear of being stigmatised. In particular, she feared that accessing mental health services would result in negative perceptions about herself and her credibility as a professional.

Mada, Doctor, Northern Malaysia

Macam kita kadang-kadang, Nak ke call? Orang kena label. Stigma. Depress dah ke? Takkan, adjustment disorder dah ke? Takkan yang ni pun tak boleh nak handle. So saya rasa benda tu kena, kena, mental health ni kena di-bring up as a main thing among, I mean, our KKM staff ni lah. Sebabnya saya rasa at all levels. Jangan cakap just doctor. PPK [pembantu perawatan kesihatan] pun dia ada stress dia kan. Sebab demands tu at every level. So benda tu sepatutnya kena di-improve dan dibawa ke hadapan.

English translation

Like sometimes [we think] should we call [the hotline]? People will label [you]. Stigma. You're already depressed? Don't tell me, you're having an adjustment disorder already? Don't tell me you can't even handle this. So I feel that mental health should be raised as a main thing among our KKM staff. Because at all levels, not just doctors, PPK [healthcare assistants] also have their stresses. Because there are demands at every level. So, that should be improved and raised.

Among social workers, there were concerns around the confidentiality breaches that occur when these counselling services were accessed. As these services are provided by counsellors employed within the agency, many social workers felt uncomfortable seeking support, and this has discouraged uptake. Thus, social workers have highlighted the importance of having independent mental health support services, as this would encourage more social workers to access it.

Radiya, Social Worker, Malaysia

Sebab itu kaunselor dia kena berdiri sendiri. Dia tidak boleh ada kaitan apa-apa pun. So, dia tak boleh dilibatkan dengan tugas-tugas pentadbiran. Supaya dia stand dia sendiri dan dia boleh simpan itu sebagai rahsia lah.

English translation

That is why counsellors need to be independent. They shouldn't be linked to the administration, so that they can standalone, and they can then maintain confidentiality.

Some doctors, nurses, hospital cleaners and social workers felt that management could play a bigger role in supporting and monitoring care workers' wellbeing through regular check-ins. One doctor suggested implementing either a quota on continuous working hours or mandatory rest periods to prevent exhaustion and burnout. Some workers also suggested setting up peer support teams, to provide a safe space for colleagues to share experiences and support each other, especially during stressful periods.

Ifra, Doctor, North Malaysia

Saya rasa kita, kenapa, bila kita letih, kita tend untuk buat mistakes. So all our mistakes are not the simple mistakes because our mistakes as doctors, we can cause patients' lives. So we need to prevent that. … So mungkin ada orang boleh pantau dan juga boleh implement. Kita tak boleh bekerja lebih daripada masa ni dan masa ni. sama ada kita letakkan limit bekerja ataupun kita bagi waktu cuti. That would be very, very beneficial already. Small things matters.

English translation

I think that when we are tired, we tend to make mistakes. And our mistakes are not simple mistakes because, as doctors, we can affect people's lives. So we need to prevent that… so maybe there is someone who should monitor [us] and implement [a rule] that we shouldn't be working more than a certain number of hours. Either we set clear limits on working time or we ensure workers are given leave. That would be very, very beneficial already. Small things matters.

Based on the findings, we assert the importance of strengthening institutional/organisational mechanisms for monitoring wellbeing and providing accessible mental health support for care workers.

Recommendations

i Equip supervisors and managers with adequate training to support care workers facing burnout and stress

Supervisors and managers should receive adequate training to monitor care worker well-being (e.g. through enforced limits on working hours), to recognise signs of burnout and stress and if an intervention is needed, connect them with relevant support services or make adjustments to their work schedules. These adjustments could range from short breaks to respite leave, allowing workers the space and time to recover and prevent burnout. As care workers are known to experience compassion fatigue especially after an intense period of service, institutions/organisations within the care sector should consider introducing respite leave. Respite leave is sometimes referred to by other terms such as mental health leave, or provided through managerial discretion. Essentially, the way respite leave is framed is an important consideration in avoiding stigmatisation and encouraging uptake.

ii Ensure mental health support services are provided by independent providers to ensure confidentiality and encourage uptake

For care workers within the public sector, mental health support should be provided by independent mental health service providers who operate outside ministries and agencies. Based on our findings, this is necessary to build care worker trust in available support services and ensure that confidentiality is maintained.

iii Ensure mental health support is consistent and meaningful

With consent of the care worker, issues raised within sessions should be appropriately addressed either through referrals to specialised services, managerial adjustments to workload and working conditions. This would not only demonstrate institutional/organisational commitment to staff wellbeing but would also result in tangible outcomes and improvements for care workers.

iv Foster a workplace culture where mental health is a system-wide priority

In order to support the resilience of the care workforce, workplace cultures within care sectors should build a culture that values and prioritises mental health wellbeing. While the mental health needs across care workers may vary across care settings, all workplaces should cultivate a culture that centres wellbeing and psychological safety. Building such a culture could include the following:

- Value rest and recovery, ensuring that care workers can utilise leave entitlements without stigma or guilt.
- Normalise help-seeking behaviours to challenge stigma associated with accessing mental health support
- Encourage peer-support groups that could provide safe spaces for shared experiences and mutual encouragement
- Raise awareness on policies and measures in place to address harassment and bullying
- Design workspace infrastructure with wellbeing spaces for workers (e.g., resting rooms with privacy, quiet spaces, showering facilities)

v Ensure migrant domestic workers are connected with psychosocial support

Domestic workers also require accessible and culturally appropriate mental health support. As highlighted in Findings 2 and 3, the COVID-19 pandemic took a toll on the mental health of migrant domestic workers, who were worried about their families back in their home countries. Beyond times of crises, psychosocial support can also help migrant domestic workers manage homesickness, isolation, workplace stress, and the emotional impact of family separation. This support is crucial for ensuring their holistic wellbeing.

The following measures should be taken to strengthen mental health support for migrant domestic workers:

- *Integrate a mental health component in Post-Arrival Orientation Seminars (PAOS) for domestic workers by* including briefings on mental health awareness, stress management, workers' rights, and available support services. These initiatives should be led by embassies (instead of agencies), in partnership with local domestic worker organisations such as PERTIMIG (Indonesian Migrant Domestic Workers Association) or AMMPO (Association of Nationalist Overseas Filipino Workers), to ensure that materials and mental health support are relevant and culturally appropriate.
- *Mandate pre-employment orientation briefings for employers* on fair labour practices, respectful communication, and available mental health support *for domestic workers.* Civil society organisations that have had experience in documenting domestic workers' challenges and abuse should be consulted in this initiative. This would ensure the content of modules addresses common challenges affecting domestic workers' wellbeing in Malaysia.

In conclusion, while larger and more formal care institutions may have the capacity to implement robust measures, smaller private and community-based providers could take a gradual approach to normalising mental health support for care workers. In achieving this, they should be supported through practical guidance, simplified tools, and capacity-building initiatives to ensure that mental health of care workers remains a priority across all care settings.

Relatedly, we commend the efforts of the Department of Occupational Safety and Health (DOSH) in setting up the Guidelines on Psychosocial Risk Assessment and Management at the Workplace 2024 (Malaysiakini. 2024). We urge for a further review of available guidelines and their practical application to small and medium-sized care operators, ensuring that mental health wellbeing becomes a core component in operations across the care sectors.

C Strengthen Protections Against Violence in the Workplace and t Home

Summary of Relevant Findings

01

Over two in five care workers surveyed *(43.1%) experienced violence in the workplace,* while nearly one third of care workers surveyed *(30.4%) reported experiencing violence at home.*

02

Those intending to leave their current position within the next five years appear to face more violence in the workplace, regardless of gender, than those who are intending to stay.

03

Malaysian women who intend to leave their current position appear to *report higher instances of personal violence* than those who intend to stay in their current position.

04

There was *no significant difference* in the reported levels of personal violence *for Malaysian men or migrant women* intending to stay or leave their current position in the next five years.

Recommendations

Develop or strengthen organisational/institutional SOPs for addressing workplace violence

In July 2025, amendments to the Penal Code to criminalise bullying came into effect. The Occupational Safety and Health Act (OSHA) also places a legal duty on employers to ensure the safety, health, and welfare of all employees, and this includes psychological wellbeing (Singh Toor & Azman, 2025). Employers must, therefore, take reasonable steps to prevent and respond to workplace violence. While some institutions/organisations may already have in place or codes of conduct or standard operating procedures (SOPs) for handling workplace violence, these should be reviewed and updated in accordance with Malaysia's legal framework and international standards. Box 5.2.1 highlights key considerations when reviewing SOPs on handling workplace violence.

BOX 5.2.1

Key considerations for standard operatong procedures on handling workplace violence

Ensure clear and comprehensive definitions of workplace violence including physical, verbal, sexual, psychosocial forms of violence and harassment perpetrated by both staff and non-staff. A brief review of existing guidelines within the healthcare sector has revealed a tendency to focus on violence perpetrated by external parties (e.g. patients, patients' families, contractors). These SOPs should be expanded to address violence and harassment occurring between supervisor and staff or between peers, as this would also be an acknowledgment that such incidents do occur within workplaces. There are currently no known guidelines for responding to workplace violence within the social care and domestic care sectors.

Ensure the procedures for reporting are accessible, confidential, and non-retaliatory to organisation staff. The first point for staff to report workplace violence is usually the supervisor or department head. Alternative reporting channels should be developed and introduced to ensure staff are able to bypass normal chains of command when necessary (e.g. if the perpetration of violence involves the supervisor).

Ensure the procedures are survivor-centric in that they ensure those experiencing violence feel safe to utilise the procedure and feel confident that no harm or retaliation can be done to them. For example, interviews should be carried out in a safe and secure location. After disclosure, survivors should be given information about all possible options and should be given the choice to decide if they want to proceed with a formal complaint.

Ensure victim/survivors' access to psychosocial support and counselling services. The act of disclosing violence to another or engaging in formal reporting processes can be overwhelming and highly stressful for survivors, and can result in intense fear, shame, guilt, or mental breakdowns. Where necessary, ensure that the survivors have access to psychosocial support or counselling services.

ii Develop national standards and guidelines for employers and workplaces to respond to personal violence

As our findings indicate, nearly a third of the care workers surveyed (30.4%) report experiencing violence at home. Personal violence, such as domestic violence, stalking, and rape, has long been regarded as a private matter, to be separated from the workplace. However, this study demonstrates that there is an undeniable link between personal violence and worker wellbeing, with such experiences potentially contributing to lower wellbeing, especially among women. Workplaces should acknowledge personal violence as a workplace concern and implement measures to mitigate its effects on employees. This is especially so since a majority of the care workforce comprises women who are more vulnerable to risks of gender-based violence.

Currently, Malaysia does not have national standards on how employers should respond to employees experiencing personal violence. Thus, the recommendation is to develop national standards and guidelines for the workplace detailing procedures and steps that can be taken to support survivors experiencing personal violence at home. Having this overarching set of guidelines in place could raise awareness among employers on the importance of responding to personal violence and encourage the provision of adequate support for victims/survivors. Examples of workplace support measures include providing access to mental health support, creating referral pathways that can be used to connect survivors with available support services, introducing flexible working arrangements, and offering temporary relocation to ensure safety.

iii Develop a grievance mechanism for domestic workers

Domestic workers within private homes often face various forms of mistreatment, including violation of contract terms (e.g., unpaid salaries, withholding of passports, no one-day off a week) and abuse (e.g., physical, emotional, and sexual abuse). Yet, these violations rarely come to light due to the unequal power relations between employers and domestic workers and the often subordinate position occupied by domestic workers.

Findings from this study support these concerns, as *40.6%* of migrant domestic workers *agreed* that they were *afraid to raise concerns* or share their opinions with employers, and 42.5% said that complaints made to employers or agents were *not properly addressed.* When there are few channels to raise issues safely and little accountability placed on employers, exploitation and abuse can easily be perpetrated.

Jennie, Migrant Domestic Worker, North Malaysia

Beginning with my first employer, who was elderly. [crying] I endured nine months of not being fed, only given water even on occasions, and not provided with any food. They would give me a little rice, but no viand [protein or vegetables]. I suggested buying my own food since I had a salary with them, but they didn't allow me to use my earnings for myself. I endured this because of my children; they go to school.

We recommend that a formal grievance mechanism be developed and implemented to monitor and ensure enforcement of contract terms, standards, and regulations, while ensuring migrant workers are protected from abuse and exploitation. This should be a multi-stakeholder effort, involving collaboration between embassies, civil society organisations, and other key stakeholders.

D Strengthen feedback loops, representation of care workers at decision-making levels, and spaces for organising

Summary of Relevant Findings

Our findings indicate the following within the healthcare and social care sectors:

01

Three in four care workers surveyed (75.1%) want more opportunities and spaces to voice their concerns to decision-makers

02

More than a third (43.1%) feel that more women in decision-making positions can better represent issues faced by care workers

03

Almost half (45.7%) feel that complaints and issues raised with management are not addressed properly

04

About half (55.3%) feel that their workplace expects more from them than what they can reasonably handle

05

Three in four care workers (75.1%) feel supported by their peers at work, while more than half (60.1%) feel supported by their supervisor

06

Two-thirds (67.9%) want more associations and unions that better represent their voice, values, and goals.

Within the healthcare and social care sectors, care workers have demonstrated a clear desire for better communication with decision-makers. A distinct concern that emerged from the FGDs was around how *care workers felt excluded from decisions impacting them and their work conditions,* especially during the COVID-19 pandemic, when new SOPs had implications on them in managing their daily tasks and workloads. This exposes gaps in participatory governance within care institutions and highlights the need for more inclusive decision-making that considers care workers' perspectives.

Enhancing care workers' ability to voice their concerns and strengthening the representation of care workers can help bridge these gaps, ensuring their needs and perspectives are meaningfully centred in decisions that affect their working lives.

Recommendations

i Strengthen institutional processes for care workers to provide feedback

Strengthen institutional processes for care worker's to provide feedback and raise greviences as this would create clearer avenues for care workers to voice out concerns to decision-makers within institutions/ organisation. As our FGDs indicate, due to the limited avenues for providing feedback or raising greviences, care workers' sometimes rely on mental health support services for this purpose. Mental health support services, however, are primarily meant to address individual stress or coping, rather than resolving workplace or structural issues. Measures to strengthen feedback loops could include institutionalising regular consultations between management and care workers, with insights used to inform policy and operational changes. Alternatively, introduce anonymous staff surveys that could address fears of speaking out. Most importantly, ensure concerns and issues raised are meaningfully addressed as this in critical in building workers' continued trust and confidence in such mechanisms.

ii Increase representation of care workers, especially women, at decision-making levels

Care workers are experts in their own right, possessing important insights into how policies, processes, and systems operate on the ground. Including them at decision-making levels would ensure the relevance and practical application of policies and SOPs drafted. For example, include care workers in policy drafting committees, set up care worker consultation councils, or invite them to co-design relevant protocols and frameworks. As the care workforce is predominantly composed of women, women care workers (and not managers) are better positioned to provide insights on the gendered challenges faced by care workers, and thus should be represented in decision-making spaces.

iii Strengthen care workers' capacities to self-organise and advocate more effectively

Employers must recognise the important role that worker associations and unions play in consolidating and channeling workers' perspectives and improving working conditions for care workers. We note the active role of Malaysian Nurses Association (MNA) and Malaysian Nurses Union (MNU) in recent policy decisions on nurses' work hours. However, not all unions representing care workers groups are allowed the space to self-organise. Among the unions/worker associations consulted for this research, at least one of them reported ongoing union-busting activities by employers that have served to undermine their efforts in collective bargaining and improving worker conditions. A thriving space for care worker representation should not be seen as a threat, but a space for constructive dialogue, shared problem-solving, and the betterment of the care sectors.

Pillar 2:

Strengthen Family-Friendly Policies and Support for Care Workers

Summary of Relevant Findings

01

Gendered norms still shape participation trends in both paid and unpaid care work. Across different household types, *women still undertake more hours of unpaid care work* compared to men in similar household types.

02

Marriage increases the disparity in paid and unpaid care between genders. While men undertake more unpaid care work when they are married (an additional 12 hours of unpaid care work per week compared to men without a spouse), women with a spouse still performed more unpaid care work hours per week (undertaking nearly three hours more a week than married men). Importantly, women with spouses reported five hours less of paid care work a week compared to women without a spouse, suggesting that marriage may constrain the amount of time women are able to allocate to paid work. This trend was not found in men, suggesting marriage does not meaningfully alter men's paid work commitments as compared to women.

03

Work-life balance satisfaction had the second steepest decline during the COVID-19 pandemic, as care workers had to accommodate for increased work demands, with 61.3% of care workers reporting low satisfaction with work-life balance. *Post-pandemic, 49.0% of care workers report feeling low satisfaction with work-life balance.*

a. Generally, satisfaction with work-life balance is more meaningfully associated with the number of hours spent on paid care work, that is, the more time spent on paid care work, the less satisfied care workers are with their work-life balance.

04

Malaysian women's work-life balance satisfaction has always been lower compared to Malaysian men, suggesting *existing support structures at work and in their personal lives may make it harder for women to enjoy work-life balance satisfaction.* This is potentially because women do perform more unpaid care work than men, even across different household types.

05

Though women have lower work-life balance satisfaction, *men are not satisfied with their work-life balance either.*

a. This widespread dissatisfaction may arise from *inadequate policies within workplaces to better support care workers* to sufficiently manage their personal care responsibilities with their paid care workload.
b. A third of Malaysian care workers (34.5%) want to leave their current position within the next five years, citing stress or burnout, wanting to spend more time with family, and retirement as top reasons. Notably, many women who want to retire (63.9%) are also younger than 50 years old, in their prime working years, pointing to the potential toll on women within these care sectors.

06

There is widespread support for enhanced family-friendly workplace policies and initiatives to better support care workers manage their unpaid care work:

a. Nearly three-fourths of care workers surveyed (72.2%) want family leave[1] to be introduced
b. Over two-thirds of care workers surveyed (69.3%) want longer paternity leave
c. Nearly two-thirds of care workers surveyed (60.2%) believe all families with young children should be given child benefits
d. Nearly two-thirds of care workers surveyed (61.3%) believe all families caring for a sick or disabled relative should be given care allowance.

07

Care workers show *strong support for initiatives supporting care as a co-responsibility:*

a. 65.1% of care workers believe there should be adequate infrastructure for community-based care
b. 70.4% of care workers believe daycare facilities for children, the elderly, and people with disabilities should be available in workplaces

Over the past decade, Malaysia has introduced a range of family-friendly policies such as paternity leave, extended maternity leave, flexible working arrangements, tax incentives for hiring women returning to work, as well as caregiving leave in the private sector (Nor Ain, 2022). However, there are still gaps in support for unpaid care work, indicated by low labour force participation rates of women and high proportion of women citing housework and family responsibilities as the reason why they are outside of the labour force, as mentioned in Chapter 2. Furthermore, care workers who are a part of the public sector do not have assured access to these entitlements. For example, a relatively recent report of women doctors in Hulu Langat whose maternity leave was reduced from 90 to 60 days due to a shortage of staff, highlighted how fragile and uneven protections can be (Free Malaysia Today, 2024). While the issue was quickly resolved through the intervention of the Minister of Health, this case illustrates the need for more standardised protections to prevent such inconsistencies in the future.

1 Family leave is a type of leave that allows employees to handle urgent family responsibilities, for example caring for a sick child, or taking an elderly parent to the hospital for a medical emergency. Introducing family leave would mean that employees would not need to use annual leaves for pressing familial obligations

Care workers' ability to manage their personal care responsibilities is shaped by the broader family-friendly policy environment in Malaysia. In fact, their struggles are symptomatic of the gaps in care supports and infrastructure in Malaysia. Given this, recommendations under this pillar comprise measures at both organisational and national levels.

Recommendations

i Tailor family-friendly workplace policies to care worker realities

Care workers face unique challenges in managing their personal care responsibilities, and this requires existing family-friendly policies to be reviewed and tailored to their realities. This would ensure existing interventions are responsive to care worker needs and effective in redistributing their care loads. For example, in the healthcare sector, many workers are married or partnered to each other, which often leads to challenges in managing care responsibilities, especially when both are required to be on duty. Within the context of a pandemic or national crises, such pressures are exacerbated when the demand for services increases and staff shortages are most acute, as was reported by many women in the FGDs. A targeted response could include *introducing a special parental leave scheme* for healthcare worker couples, with non-transferable leave days for each partner This could ease workers' care loads while encouraging men to participate and share in caregiving duties. Other such examples of targeted responses include *predictable rostering, on-site childcare or eldercare with 24/7 services, or pathways to part-time or flexible work arrangements.*

Additionally, deployment procedures, particularly for social workers, should be reviewed and adapted to allow for greater flexibility during crises. JKM officers suggested that placement practices during crises should consider workers' personal familial contexts (e.g. where they reside, their personal care responsibilities). In times of crisis, allow officers to serve closer to their homes, as it would make it easier for social workers to provide critical social welfare services while attending to their own personal care responsibilities, especially if mobility is restricted (e.g. movement control orders). Additionally, where possible, allow for flexible work arrangements.

Nazmin, Social Worker, Malaysia

Jadi beban tu agak terasa dan saya ada buat permohonan pertukaran ... Tapi tengok-tengok. orang dekat-dekat juga yang dapat. Itu yang saya kata tu, kadang kadang... yang berkeperluan tu dihantar jauh-jauh... yang kurang berkeperluan tu sebelah daerah aje kan.

English translation

So I kind of feel the burden and so I made a transfer request... but it appears that those who live nearby are the ones who got it [approved]. That is what I meant, sometimes... the one who needs it most is sent further away... and those who don't need it as much, [get deployed] to a nearby district.

ii Establish care-supportive workplace infrastructure

Develop care-supportive workplace infrastructure near hospitals and major workplaces of care workers - *childcare, eldercare, disability care facilities.* Ensure they are subsidised and affordable. This would enable care workers to better manage and redistribute personal care responsibilities while reducing care-related anxieties or concerns when at work. The lack of accessible, affordable, and quality childcare has long been an issue in Malaysia and with an increasing ageing population, elder day care facilities should also be included. Another important infrastructural consideration are *consistent and private maternal health facilities,* as current disparities in the availability of such services across institutions can have a negative impact on women care workers' ability to balance work and life. In one FGD, a doctor shared that she resorted to pumping breast milk in her car because the available facilities in the hospital lacked privacy.

Nasha, Doctor, East Malaysia

I mean some of us, we don't even have a designated place to breastfeed. I'm in a specialist room, in front is doctors, all is surrounded by males. I can't turn anywhere [laughs]. So most of it I actually have to go to my car and pump actually to have some privacy.

Workplace infrastructure should also incorporate *wellbeing spaces for workers such as resting rooms with privacy, or showering facilities.* This recommendation came out strongly among social workers, who observed that care institutions often prioritise the comfort of care recipients, but overlook the wellbeing needs of care workers themselves. Care workers also require safe, private spaces to rest and decompress from sometimes emotionally demanding, client-facing work.

Care institutions often prioritise the comfort of care recipients, but overlook the wellbeing needs of care workers themselves.

iii *Foster workplace cultures that promote work-life balance, rather than penalising workers for using family-friendly benefits*

While family-friendly policies are important to institute, they are only effective if accompanied by a workplace culture that values and prioritises work-life balance. Unsupportive supervisors or co-workers, high workloads, fear of career repercussions, poor communication are among key barriers to the utilisation of such policies by workers (Waters & Bardoel 2006; Blair-Loy and Wharton 2002; Weale et al. 2020).

Concerningly, these barriers mirror some of the reflections made by the care workers in our study about their work context. For example, one key informant from the healthcare sector observed a tendency for their workplace to be punitive towards workers, especially women, who needed to attend to their care responsibilities. In an adequately care-supportive environment, workers should be able to prioritise family care responsibilities over work responsibilities when necessary, without fearing penalty or discrimination.

In our participatory data analysis sessions, doctors highlighted the structural expectation of constantly putting "service first" above all else, which also meant that personal responsibilities often had to be sacrificed. While a doctor was reviewing her own ranking of recommendations, she slowly realised that her choices reflected an unconscious prioritisation of healthcare service delivery over care worker wellbeing, and in doing so, quietly exclaimed, "I forgot that I am also a woman [with caregiving responsibilities and self-care needs]."

This embedded culture of overwork and constant service provision can have devastating consequences. In one extreme case, a Malaysian parent doctor, while rushing to work and potentially overwhelmed with competing priorities, had forgotten that she left her child in the car. Disturbingly, this incident resulted in the death of the child (The New Straits Times, 2023). This tragic case underscores the urgent need to shift away from a workplace culture that normalises or rewards workaholism, and deprioritises work-life balance and personal care responsibilities. We must begin to foster genuine care-supportive workplace cultures and this effort must be led by employers and management of organisations/institutions.

iv *Invest in and improve community-based care infrastructure and service models*

Interestingly, 65.1% of the care workers surveyed support the need for more community-based care services. With the low uptake of government incentives for workplace childcare, long wait lists for existing workplace care services (World Bank 2025), and gaps in care facilities for low-income and rural communities (Ilyana Mukriz et al. 2024), strengthening community-based care services may be a more practical and accessible option for families and care workers in Malaysia, especially since our study indicates that a significant number of care workers are likely to be from the B40 community. This recommendation also closely aligns with Malaysia's policy direction of strengthening social protection policies under the 13th Malaysia Plan (RMK13).

Community-based care refers to an array of care services (e.g. daycare centres for children, the elderly, PWD, home care services) provided within the community and that brings support for care closer to home. Central to this is the active involvement of families, community members, local organisations and local authorities in the planning and development of the initiatives. In Japan and Singapore, community-based services are planned for at the district/precinct level, to ensure implementation is effective and relevant to community needs (Singapore Ministry of Health, 2025; Szczepura et al. 2023).

Malaysia has foundations of such community-based care services but ***the quality of the infrastructure, programmes and services offered need to be improved and strengthened.*** The Community Development Department (KEMAS) runs affordable nurseries (Taska) and preschools (Tabika) in rural areas and B40 communities, while Jabatan Kebajikan Masyarakat (JKM) runs Pusat Aktiviti Warga Emas or senior citizen activity centres (PAWE) and Pusat Pemulihan Dalam Komuniti or Community-Based Rehabilitation centres (PDK) for PWD. Additionally, JKM provides Home Help Services or Khidmat Bantu Di Rumah (KBDR), a volunteer- led service for the elderly and persons with disability that offers support such as helping to clean, eat, cleaning of residence, and so forth. Table 5.2.1 showcases the number of centres that have been set up and the number of clients that have thus far received services, suggesting that there has already been government investment in community-based care infrastructure.

TABLE 5.2.1

Community-based Care Initiatives under the Ministry of Women, Family and Community Development

Centre	Description	Primary clientele	Number of centres	Number of clients served up until 2024
PAWE - Pusat Aktiviti Warga Emas (Senior citizen activity centres)	Community-based activity centres that offers social activities, caregiver support, health promotion and referrals	Older persons	192	77, 378
PDK - Program Pemulihan Dalam Komuniti (Community-Based Rehabilitation) Programme	Community-based development for the rehabilitation, training, education, economic empowerment, and social integration of Persons with Disabilities (PWD)	Persons with Disabilities (PWD)	568	21,160
KBDR - Khidmat Bantu Di Rumah (Home Help Service)	Home-based, community-supported assistance for elderly persons and persons with disabilities (PWD), delivered by trained volunteers	Older persons and Persons with Disabilities (PWD)	Volunteer network (2170 trained volunteers)	8, 686

Source: Social Welfare Department (JKM), personal communication, June 25, 2025

However, these efforts should be reviewed for quality of service and where effective, scaled to widen coverage. For example, performance measures should move beyond the number of centres or clients engaged, towards *outcome-based metrics that focus on the benefits gained by care recipients* because of the service or programme, such as improved daily functioning, reduced caregiver stress, number of women staying at work, continued participation of those enrolled, percentage of B40 or rural communities reached. *Introduce respite care* for families with high care strain, where caregivers are given 'respite' or a break from their care responsibilities through temporary care services for their loved ones (e.g. for 4-6 hours). Explore intergenerational care hubs, where eldercare and childcare are combined into one setting (Samsudin et al. 2022).

These efforts must be accompanied with *sustainable public financing.* Communities should not be left to shoulder the operation of community-based centres alone. The government should either fully fund core services, or develop clear partnership frameworks so other stakeholders can co-finance and contribute under transparent rules and safeguards.

For policy-makers, *investing in community-based care will have a multiplier effect* in that it will support women labour force participation by reducing the double burden

of care, while alleviating pressure on hospitals and care institutions by *redistributing some portion of care work into the community.* It also promotes aging-in-place or a caring-in-place concept, which appears to be a preferred approach in Malaysia compared to institutionalisation, and where the elderly and persons with disabilities are able to remain near their homes and communities while accessing quality care.

v *Transform gendered social norms and attitudes towards care through awareness programmes and public service messaging*

Women care workers often had little imagination of what workplace support for unpaid care could look like, and tended to internalise societal expectations of women bearing these responsibilities on their own.

The successful implementation and utilisation of family-friendly policies and community-based care is not possible without also reconciling the tendency, in Malaysia, to view care as a responsibility to be managed by individuals, oftentimes and largely women. *Care must shift from being thought of as an individual responsibility to collective responsibility*—not just between genders, but also between the household and members of the community, state and the workplace (Razavi, 2007). In our FGDs, it was apparent that women care workers often had little imagination of what workplace support for unpaid care could look like, and tended to internalise societal expectations of women bearing these responsibilities on their own.

Targeted public service messaging can play a critical role in shifting these norms and challenging gendered stereotypes around care, especially in promoting the idea that *care is a shared responsibility, men should share in caregiving, and that care work is highly valuable and skilled work*. These value-change initiatives should run in parallel with systemic reforms such as strengthening community-based care, improving on-site workplace care facilities, encouraging private sector involvement, and implementing national family-friendly policies. A shift in values and norms is key in ensuring that investment in strong policies, programmes and infrastructure translate into shared caregiving and more sustainable outcomes for Malaysian families.

Mus, Social Worker, Malaysia

Tapi masa Covid tu memang betul-betul. Sebab saya pun masa tu pening kepala juga sebab dekat rumah pun nak masak, nak beli barang, dah tak ada makanan apa semua, dia orang nak makan apa? By that time, kita nak bertugas kat situ. Kita time nak balik, kedai nak tutup. The next day, nak pergi pasar memang tak sempat. So, banyak lah kekangan kita nak dapat barang basah pun. That's why masa tu minta tolong bila dia kata dia boleh pergi, ok lah, dia pergi. Tapi bila cakap tu, kita dengar tu, "This is the first time saya beli ayam tau", lepas tu sentuh ayam macam tu. Ok fine, takpe lah, belajar je lah.

English translation

During COVID, I was really stressed because I had to cook at home, had to buy groceries, and there was no food. What were they going to eat? And I had to go for my duties. When I return [from work], the shops are closed. The next day, I didn't get to go to the market. That's why during that time, I asked [him] for help, and he said he could go, so ok lah, he went. But then when he passes comments, we hear it, "This is the first time I am buying chicken you know", and then [he asks] "How do I handle the chicken? " Okay fine, it's okay [I said], just learn.

The revaluation of care work should extend to all who perform it, including domestic workers, whose labour remains among the most invisibilised. Domestic workers play a critical role in sustaining Malaysian families and households. Despite their essential contributions, domestic workers are not recognised as 'workers' with full labour rights, and therefore remain undervalued and overlooked. This undervaluation creates conditions for the exploitation and abuse of domestic workers often seen reported in the media (Jo Ann Mool, 2025; Ragu, 2023).

Recognise that domestic workers are workers and *normalise the use of the term 'domestic worker' in everyday speech, official documents and public communications,* instead of reductive terms such as 'servants, maids or helpers', as they strip away recognition of their skills, dignity and rights as workers. In 2022, the term 'domestic servant' in the Employment Act 1955 was amended to 'domestic employee', and reflects a positive move towards this goal.[2] Yet the ultimate goal is the adoption of the term 'domestic worker' in all public discourse. As a society, we must shift in our norms, attitudes and the way we value domestic workers in Malaysian society.

2 Malaysia, Employment (Amendment) Act 2022, sec. 2.

Pillar 3:

Integrate care workers and care work within crisis preparedness and response plans

The COVID-19 pandemic was sudden and disrupted normal routines and processes, forcing institutions, workplaces and workers to navigate high levels of uncertainty. For care workers, who had to work during the lockdown, this pressure was two fold—they faced heightened stress as they sought to respond to shifting demands of their paid work, while having to ensure personal care arrangements for their families and loved ones.

To support care workers in future crises, integrate care workers and care work into crisis preparedness and response plans.

*Governments must **recognise the importance of care work, especially in times of crises, and consider classifying all care workers** (not just clinical workers) **as essential workers.***

In this, we emphasise that national crisis preparedness and response plans should not focus merely on the provision of emergency services to the nation but also on securing the wellbeing and needs of the care workforce, tasked to deliver such critical services.

Summary of Relevant Findings

01

Three-fourths of health and social care workers surveyed (77.7%) emphasised the *importance of a comprehensive disaster management plan.* In our FGDs, care workers share that having a comprehensive disaster management plan not only includes the SOPs for how to handle certain disasters, but also a clear method of disseminating and communicating directives across relevant sectors and entire chains of command.

02

Two-thirds of health and social care workers surveyed *(69.2%) want formal recognition of care workers as essential workers.*

03

Over *85%* of health and social care workers surveyed agreed that *special allowances during crises should be more fairly distributed.* From FGD findings, unequal or one-off disbursement of allowances was a point of frustration.

05

One-third of social care workers surveyed (35.6%) feel that *infrastructure should consider wellbeing of care workers* (e.g. rest and recovery spaces for decompressing during long shifts).

06

A *lack of equipment, training on crisis-preparedness, and support from management/ authorities* made it difficult for staff, to handle COVID-19 protocols and cases, as shared by care workers in FGDs.

Recommendations

In line with concerns identified by the care workers we engaged with, we propose the following sub-recommendations:

i Strengthen SOPs, guidelines and communication protocols within national crisis-preparedness plans and integrate care workers

In our FGDs, care workers reported that unclear SOPs and directives, a lack of resources, and poor inter-sectoral understanding led to confusion and stress over how to manage care recipients within their specific care contexts. Private elder care operators described the multiple hurdles faced in accessing much needed health services and support while migrant workers received little to no information about the potential impact of the pandemic on their livelihoods, mobility, and access to health services. Private disability care workers felt that PWDs were excluded altogether from crisis response plans and protocols, especially since critical information such as SOPS and public messaging were either inaccessible to them or failed to take into consideration the needs of PWDs. Public sector child care providers shared that they were not recognised by the communities nor the law enforcement officers at roadblocks although they were attempting to carry out their duties. Meanwhile, social workers shared that they had to take on additional duties (e.g. packing of food items) which were not within their scope of work.

Anna, Nurse, East Malaysia

Kalau dari segi organisasi, apa yang saya cadangkan... Siapa saja yang jadi ketua, kena ada satu panduan untuk, bagaimana arrangement sekiranya berlaku pandemik. Contohnya kalau ada sudah step. Kalau ada pandemik lagi, kita buat dengan ini. Sebab dia baru, jadi kucar kacir.

English translation

If from an organisational lens, what I recommend is... whoever is head, they need to have a guide for what the arrangements are should a pandemic happen. For example, if there are steps, and if there is a pandemic again, we could just use it [the guide]. Because it [the pandemic] was new, things were haphazard.

Given these findings, existing national crises preparedness guidelines and standards should be reviewed and strengthened to ensure smoother processes and clearer scopes of work for care workers. Since the pandemic, Malaysia has embarked on a process of consolidating earlier guidelines on disaster management to ensure a more coordinated, whole-of-government and whole-of society approach to future crises. These ongoing efforts have resulted in the NADMA Strategic Plan 2024-2028, as well as Arahan NADMA No.1 published in 2024, signalling government attempts to address coordination gaps exposed during the pandemic (National Disaster Management Agency, 2024a; National Disaster Management Agency, 2024b).

In supporting ongoing efforts, we recommend that policy-makers move beyond focusing on preparedness of government agencies alone, and *integrate a care ecosystems approach.* This would require line ministries and implementing agencies to develop SOPs and response plans *encompassing care workers from across public and private healthcare, social care and the domestic care sectors,* including those in less formal care settings (e.g. private care homes, community-based care, migrant domestic workers within private homes). The presence of unregulated and less formal providers of social care makes this task complex, but it also offers an opportunity for authorities to better understand this under-documented sector. This move would be consistent with NADMA's whole-of-society approach and Malaysia's commitment to the Sendai Framework for Disaster Risk Reduction.

ii *Develop institutional/organisational crisis preparedness plans and ground them in the experiences of frontline workers*

At the institutional and organisational level, crisis preparedness plans should be developed and aligned with revised national guidelines and standards, while also adapted to the specific needs and risks unique to the institution/organisation or care setting (e.g. hospital-specific crises plans, childcare centres crises plans). In doing so, engage and consult frontline care workers who served during the pandemic to ensure that guidelines are grounded in real operational experience. During the FGD, many of the frontline workers shared interesting insights about pandemic measures that worked and those that could be improved. For instance, one public sector childcare worker highlighted the limitations of the Home-based Teaching and Learning (PDPR) programme for children with autism or Attention Deficit Hyperactivity Disorder (ADHD), while doctors and nurses shared ideas on how the increased workload during the pandemic could be managed better. These examples demonstrate the importance of systematic feedback loops so that frontline lessons can be integrated within future crisis preparedness plans.

iii Provide leadership training for managers and supervisors on managing teams

Findings from our FGDs indicate that stronger crisis leadership is needed at the management and supervisory levels. Many care workers reported feeling unsupported, citing communication gaps between management and frontline workers. Although some praised their immediate supervisors for support, there was a clear sentiment that middle managers could do more to support care workers in times of crisis.

Managers and supervisors should be provided with targeted leadership training focused on crisis management, staff wellbeing and communication during crisis. This would equip them with the skills to effectively communicate decisions and support their teams, while under pressure. Building this capacity among middle management is critical to ensuring that frontline workers receive timely guidance, emotional support, and fair workload distribution during future crises.

> ***Far, Doctor, North Malaysia***
>
> *It was quite difficult because during the roster-making time, the demand was very great, from down and from up.....Tapi, masa tu memang, I think sebab situasi ni tak pernah ada orang alami so, our superior pun macam tak tahu what is our burden. Dia pun tak panggil kita, talk to us, apa tu, apa yang kita nak, perlu, baiki, semua.*

iv Institutionalise crises preparedness and emergency response training for all care workers

Institutionalise crises preparedness and emergency response training for all care workers across public and private sectors. Crisis preparedness training modules should be upgraded to ensure relevance of content. For example, in our FGDs, one social worker shared the importance of integrating health perspectives within their training programmes. Junior or contract nurses who were inexperienced but brought in to serve at the frontlines were struggling and required more preparation and training especially in handling patients and operating wards/equipment. One nurse asserted the importance of regular crisis preparedness training for all hospital staff.

Ram, Social Worker, Malaysia

Memang kita ni membantu rakyat, kita menyampaikan bantuan dan sewaktu dengannya tapi at the same time juga haruslah kita mempunyai salah satu pengukuhan ilmu kemahiran yang bersesuaian dengan apa yang kita nak perform benda ni... So, kita-kita ni... saya nampak kita dah tak boleh nak berada dalam taraf sosial sahaja tau, kita ni sepatutnya pun kena ada sedikit ilmu berkenaan dengan perubatan sedikit, benda-benda macam tu. So, saya tak tahulah apa yang boleh di-di-dirangka pada yang masa akan datang, oleh apa kita punya kerajaan dalam nak memperkasakan lagi kita punya social worker ni, but hopefully kita dah ke arah situ lah. Sebab kita tak dapat nak jangka apa yang berlaku pada akan datang.

English translation

We are definitely tasked to help the people, we deliver the aid and do all necessary but at the same time we should have enhancement of skills and knowledge that is relevant to what we are expected to perform [during the pandemic]. So, for us... I see that we cannot just be knowledgeable at the social level [on social issues] alone you know, we should also have knowledge about the changes that are happening, things like that. So I don't know what is being planned for the future, by our government, in the goal of empowering our social workers, but hopefully we are already headed in that direction lah. Because we cannot predict what will happen in the future.

Rameen, Nurse, Central Malaysia

Saya rasa lah bagi saya kan... kita kena keep training diorang [staff] untuk handle outbreak. Sebab kalau, bila berlaku outbreak , kita tak perlu lagi nak, nak cari apa- orang kata, nak ajar during masa tu. On the spot tu susah, biar diorang kita, kita maksudnya, 16 kali kita buat awareness, kita buat training, PPE ke kat diorang. Untuk semua staf, bukan kata untuk "Oh, untuk medical je tak boleh,". Sebab bila outbreak , dia tak kira lah kau kerja Ortho ke, kerja Neuro ke, still kena handle outbreak tu, betul tak? Jadi biar diorang, kena sama rata lah untuk proses training ni.

English translation

I think for me... we should keep training staff to handle outbreaks. Because, if an outbreak happens, we shouldn't have to be teaching [others] during that time. On the spot [learning] is hard, we should create awareness 16 times, training them how to wear the PPE. And [it should be] for all staff, don't exclude [other] medical staff. Because during an outbreak, it doesn't matter if you work in Ortho, Neuro, you still have to handle the outbreak, isn't that right? So let them also be a part of this training process.

Additionally, modules should also work towards the goal of enhancing predictability. Develop automatic triggers or indicators and corresponding protocols as a way of ensuring care workers understand when a new set of SOPs should apply (Institute of Medicine, 2013). Standardising indicators and protocols (e.g. when X happens, Y protocol begins) helps create predictability, reduces ad hoc decision-making and the confusion that often ensues during crises. These trainings should be embedded within national training frameworks and complemented with regular drills and refreshers, and potentially tied to accreditation.

v Ensure fair distribution of risk/hazard (special) allowances

During the pandemic, the government introduced special monthly allowances to recognise the exposure to risk and increased burden of work of frontline workers. Doctors and nurses received monthly allowances of RM400 (later increased to RM600), while personnel from the police, customs, immigration, civil defence force and RELA received RM200 (Sabapatthy, 2020). However, social workers, who were responsible for the distribution of food baskets, and actively supported quarantine efforts, while responding to escalation of domestic violence and child abuse cases, were inconsistently given allowances. Social workers who did receive the allowance noted that it was often only one-off. Hospital cleaners, although under the purview of the private sector, worked alongside other healthcare staff to maintain sterile environments and were directly exposed to biohazards. One hospital cleaner shared that, during the pandemic, she would work up to 20 hours a day with minimal rest. Despite carrying out equally high-risk responsibilities and shouldering an increased burden of work, many did not receive special allowances. In contrary, some hospital cleaners reported receiving a one-off allowance.

Ram, Social Worker, Malaysia

Memang kita bantu rakyat ya, memanglah itu one of the tanggungjawab kita kan, tapi biarlah setimpal. Sekurang-kurangnya, kalau dapat elaun kritikal dalam RM 300 sebulan, sepanjang tempoh pandemik tu berlaku pun, satu bulan RM 300 tu pun kami rasa dah macam, "eh at least ada lah juga orang top up sikit", kan? Kita pun rasa eh, people pun appreciative kita….

Orang memandang kepada contoh, saya mengambil senario orang memandang kepada polis, memandang kepada hospital dan kerana mereka ni adalah merupakan salah satu golongan kumpulan professional. Yang kita yang [social worker] ni tadi tu sipi-sipi, terpinggir. Walhal, yang on the ground betul-betul, mereka ni lah tadi tu yang duduk dekat apa hotel PUS, nak kena hadap rakyat kita….

English translation

It's true that [it is our duty] to help the people, ya, and that is certainly one of our responsibilities, but let it [the compensation] be proportional. At least, if we get critical allowances of RM300 a month, throughout the duration of the pandemic, one month [just] RM300, that would make us feel "eh there is at least some top up" right? We would feel that people are appreciative of us too.

People look up at, for example, the police, the hospital because they are from the professional grouping. We who are [social workers] are sidelined. When the people who are really on the ground, they are the ones who sit at the hotel PUS [hotels used as quarantine centres], we have to face the people…

Vijahah, Hospital Cleaner, Central Malaysia

Yes, everyone should be treated equally. We are cleaners. The hospital is clean because we, the cleaners, are doing our job. If we weren't there, would the hospital be clean? So, whatever benefits they get, we should get too. But if we ask, they'll say they are government employees, and we are contract staff

The government and the private sector must ensure that special allowances are distributed fairly across all frontline sectors, guided by clear criteria of exposure and risk for times of crisis. This includes for clinical workers within the healthcare sector, who shared that calculations felt unfair, as those who worked up to 15 days received RM300, whereas those who worked 16 or more days received RM600. In the future, fairer prorated allowances, for example a rate per day, could alleviate these gaps. Additionally, it was also shared with us that for certain healthcare workers, their allowance depended on where they worked, for example those working in intensive care units (ICU) received higher allowances, whereas those who were working in general wards received RM400 less. Nonetheless, given the criticality of some patients even in the general ward, tasks undertaken to care for the patients were more similar to ICU tasks.

vi *Ensure government emergency support (e.g. financial aid, sanitation supplies, vaccination outreach) reaches all social care and domestic care providers*

During COVID-19, access to government aid was uneven across social care providers and this was made complicated by the large informal and under-regulated landscape of care centres in Malaysia. For instance, many taska and elderly centre operators could not meet the Inland Revenue Board LHDN tax filing requirements (often because they were not profitable or operated informally) and were therefore excluded. Following this, the taska operators have suggested that other forms of documentation apart from tax filings, such as by Employees Provident Fund (EPF) or Social Security Organisation (SOCSO) should be accepted as criteria for eligibility.

At the same time, the government's quick decision to extend vaccination to unlicensed eldercare centres was seen setting a new and constructive precedent. This was highlighted as a positive move by care providers that should be repeated, if needed. for future crises. Moving forward, emergency support in the form of financial aid, sanitation supplies, PPE, and vaccination outreach should be designed to reach all care providers, including those in the informal sector.

Domestic workers in the country should also continue to be included in future vaccinations programs and assured access to healthcare during a crisis. This is crucial as domestic workers are also exposed to health risks. Our findings revealed that 35% of domestic workers surveyed were caring for those who had contracted the virus and concerningly, 20.4% felt that their employers did not provide sufficient health coverage – meaning that their health needs went unaddressed.

vii Provide crises-specific support services for care workers, such as temporary housing/ shelter arrangements during crises and transportation services/subsidies

for workers who work late night shifts. During the pandemic, some healthcare preferred staying away from their families, to avoid risk of spreading the virus to their own families. In our FGDs, this was a great source of stress for healthcare workers, who often felt conflicted in their roles as healthcare workers and as individuals expected to bear unpaid care responsibilities within their households. Transportation was another major challenge, especially for workers who rely on public transportation. During the pandemic, transportation services were reduced, and this impacted healthcare workers who worked late-night or early morning shifts, who were already exhausted from extended work hours. Some workers described the roads as scary as they were dark and empty. Hospital cleaners, social workers, and private care centre operators faced problems at roadblocks because their frontline status was not recognised—even some nurses, who despite having frontline status, shared that they sometimes faced blockages at roadblocks.

Sue, Public Sector Childcare Worker, Malaysia

Semasa pandemik... kita buat kerja apa-apa daripada rumah, jadi kalau benda nak access, nak pass up, kalau jabatan minta apa-apa banyak maklumat tu di tabika, so kita kena pergi tabika, bawak balik. Melalui sekatan apa semua, sebenarnya sekatan ni walaupun dia tanya kita dia kenal dah kita pun dia akan tanya, jadi benda tu jadi macam stress juga...

English translation

During the pandemic... we would work from home, so if there is something we need to access, need to pass up, if the department asks for anything, and the information is at the tabika, and so we have to go to the tabika, and bring it back. Going through the road blocks, actually [those at the] roadblock, although they have asked us before, and they know us, they would still ask [pursue their questioning] so that was stressful...

Thus we recommend the following provisions be considered for future crises:

a

Dedicated vehicle service, especially for those who work late night or early morning shifts

b

Transportation support in the form of subsidies

c

Special passes or formal documentation for all care workers to navigate roadblocks or cross-state travel

viii *Establish temporary care arrangements to support care workers with their personal care responsibilities during crises*

During the initial phases of the COVID-19 pandemic, childcare centres were closed and frontline workers (including many government care workers) experienced great uncertainty about potential childcare arrangements. Some care workers disclosed the creative but potentially dangerous solutions taken to adapt to the circumstances. This includes monitoring their children who were left home alone via Closed-Circuit Television (CCTV) or relying on the informal permission of supervisors to bring their children to work, and garnering the support of colleagues to co-participate in childcare efforts at work. Thus, for future crises when childcare may pose a concern for parents needed for work, particular care centres should be designated as temporary child care centres. Setting up temporary child care services would enable care workers to redistribute their mounting care loads. Notably, during the COVID-19 pandemic, the Selangor government initiated a programme called the Frontier Child Care Initiative (iPAF) aimed at offering child care services for medical workers on the frontlines (Farah Solhi, 2020). This should be institutionalised as a good practice and should automatically be made available for all care workers to enable a redistribution of personal care responsibilities to state-led programmes, especially during crises.

Elize, Nurse, East Malaysia

Masa COVID melanda, sekolah semua cuti, tutup, dan anak-anak semua berada di rumah. Disitu lagi lah mengganggu - orang kata, kita punya, jiwa kita agak tertekan sikit. Masalah kerja, tempat kerja. Masalah tempat kerja. Masa itu saya dengan anak saya saja. Anak saya sebenarnya sebelum itu saya tinggalkan di Taska. Kami hanya berdua tinggal di sana so masa pandemik itu, taska tutup, saya sangat risaulah sebab saya terpaksa biar dia di rumah satu orang. Masa itu dia tahun 4 kan... saya mulai berfikir yang macam bekerja pun tidak tenang, sebab teringat-ingat dia. Jadi lama-lama terbiasalah dia di rumah, trained dia macam mana, siapkan makan.

English translation

During that time, I was alone with my children. Before that, I would leave my child at the Taska. During the pandemic, there were only two of us, the taska closed, it was worrying for me as I had to leave her alone at home. At that time she was in year 4 [10 years old]... I would constantly think [about her] and I wouldn't be at peace at work, because I would keep thinking of her. But after a while, she became used to being at home, trained her how to prepare food.

Farah, Public Sector Childcare Worker, Malaysia

Saya ceritakan sikit lah pengalaman pada waktu tu memang saya tak dapat kebenaran untuk kerja dari rumah jadi memang kena datang ke tempat kerja dengan surat kebenaran yang suami sendiri buat... jadi kat situ memang satu saya rasa sukarlah kat situ. Emosi pun mungkin agak sedikit terganggu sebab anak tiga orang nak kena bawa hari-hari pergi dan balik jadi. Tak ada orang nak jaga pada waktu tu pun, taska banyak yang tutup jadi memang tak boleh nak hantar jadi terpaksa bawa [mereka ke tempat kerja].

English translation

I can share a little bit lah about my experience, at that time I did not get permission to work-from-home [disappointed tone] so I had to come in to work with a permission, letter issued by my own husband... so firstly I definitely felt that that was challenging. My emotions were also disturbed because I had to bring my three children back and forth [to work] everyday. There wasn't anyone to take care [of them] at that time, taska's were all closed, so I definitely couldn't send them anywhere, so I had to bring them along [to work].

Eli, Hospital Cleaner, Central Malaysia

Masalah di rumah, sebab kita takut apa yang kita buat kat hospital akan balik. Akan memudaratkan keluarga kita sebab anak-anak ada rumah masa tu. Dan juga kedai kebanyakannya tutup dan terpaksa sediakan makanan sendiri. Masak. Saya, walaupun saya masuk kerja pukul 8, saya pukul 4 pagi dah bangun sedia makanan untuk 3 ka- 3 kali untuk anak-anak. Sebab diorang pun tak boleh keluar, tak boleh order (buat pesanan), tak boleh apa. Jadi saya bangun pukul 4 pagi, masak sarapan pagi, masak untuk makan tengah hari.

English translation

When COVID came, all schools were on holiday, closed and the children were all at home. That's where it was distressing, we were a bit stressed. Problems at the workplace, problems at home, we were scared that what we did at the hospitals would come home with us. That it would bring harm to our families, because our children were at home at that time. And most shops were closed, so we had to prepare our own food. Cook. Even though I start work at 8am, I was up at 4am to prepare food for 3 meals for the children. Because they couldn't go out, they couldn't order [food], they couldn't do anything. So I had to wake up at 4am, cook breakfast, cook for lunch.

Manda, Social Worker, Malaysia

"Tak ada apa-apa aktiviti yang boleh saya buat bagi nak release stress during the pandemik sebab kita [...] tidak memikirkan diri kita, kita tak memikirkan diri sendiri, kita hanya memikirkan kerja rumah sahaja."

English translation

There were no other activities that I could do that would help me release stress during the pandemic because we [...] were not thinking of ourselves, we were not thinking of ourselves, we were only thinking of our house work.

Ika, Nurse, North Malaysia

So, macam kita dah prepare lah. Okay kalau contoh, wabak tu datang lagi sekali, family kita duduk mana, kita dah tetapkan, tak de lah kucar-kacir anak duduk mana. Kita dah prepare lah, anak duduk dengan mak, okay saya bekerja. macam ni macam ni. Macam tu kita prepare siap-siap, bahagi siap-siap, anak-anak tu duduk kat mana. Ah macam tu tak ada workload [kurang beban].

English translation

So, we should be prepared lah. Okay for example, if the pandemic happens again, where should my family stay, we should already know this, so we wouldn't be so scattered about where to place our children. We should have in mind lah, the children stay with my mother, and I will go to work. So on, and so forth. Like that, if we prepare in advance, divide in advance, where the children should be placed, then there is no workload [less to worry about].

Pillar 4:

Bolster investments in the care ecosystem to improve the wellbeing and resilience of the care workforce.

Summary of Relevant Findings

01

There must be stronger investments into the care workforce to improve care workforce retention, as currently one in three Malaysian care workers (34.5%) intend on leaving their current positions within the next five years.

02

The care workforce requires sustained financing as 49.6% of care workers feel there must be more government support and/or investment in their sector. Futher to this, 60.1% of care workers feel their workforce must be bigger.

03

Simultaneously, initiatives shifting unpaid care work to a co-responsibility are highly supported by care workers:

a. Nearly two-thirds of care workers surveyed (60.2%) believe all families with young children should be given child benefits
b. Nearly two-thirds of care workers surveyed (61.3%) believe all families caring for a sick or disabled relative should be given care allowance.
c. Two thirds of care workers (65.1%) believe there should be adequate infrastructure for community-based care
d. Nearly three-fourths of care workers (70.1%) believe daycare facilities for children, the elderly, and people with disabilities should be available in workplaces

Care must be seen as an economic and financial priority, worth investing into for the future-proofing and crisis-preparedness of our country. Our findings demonstrate the importance of investing in organisational resilience, ensuring that workplaces are not only able to meet the needs of its clients, but also its workforce, as this can help improve retention of the care workforce. Care financing must go beyond infrastructure and service delivery to explicitly include the needs of care workers. Investment in the care ecosystem must be strategic and sustained, recognising that *workforce wellbeing is a prerequisite for care system resilience.*

Recalling that one in three Malaysian care workers surveyed (34.5%) stated an intention to leave their current position within the next five years, supporting the wellbeing and resilience of the care workforce through sustained investment is important. Largely, key gaps need to be bridged in order to better support the care workforce in Malaysia.

In the short and medium term, investments must be made to ensure the following:

1. *Increased human resource*
2. *Improved salary structure and benefits*
3. *Upskilling of care workers*
4. *Enhanced support for care workers' unpaid care work, including investments into community-based care*

The above reflect key concerns of care workers, namely in expanding the care workforce, ensuring fairer remuneration, and receiving adequate support for unpaid care responsibilities. Based on our findings, investing in these aspects can improve the wellbeing of care workers, potentially leading to higher intention to stay.

Simultaneously, these investments align with stated goals in the 13th Malaysia Plan (Ministry of Economy 2025), namely with its focus on ensuring uniformity in care-related policies and regulations, providing incentives and social protection benefits to caregivers and long-term care service workers, as well as introducing training efforts for care-related careers to raise women's labour force participation rates. Nonetheless, accomplishing these goals require significant investments.

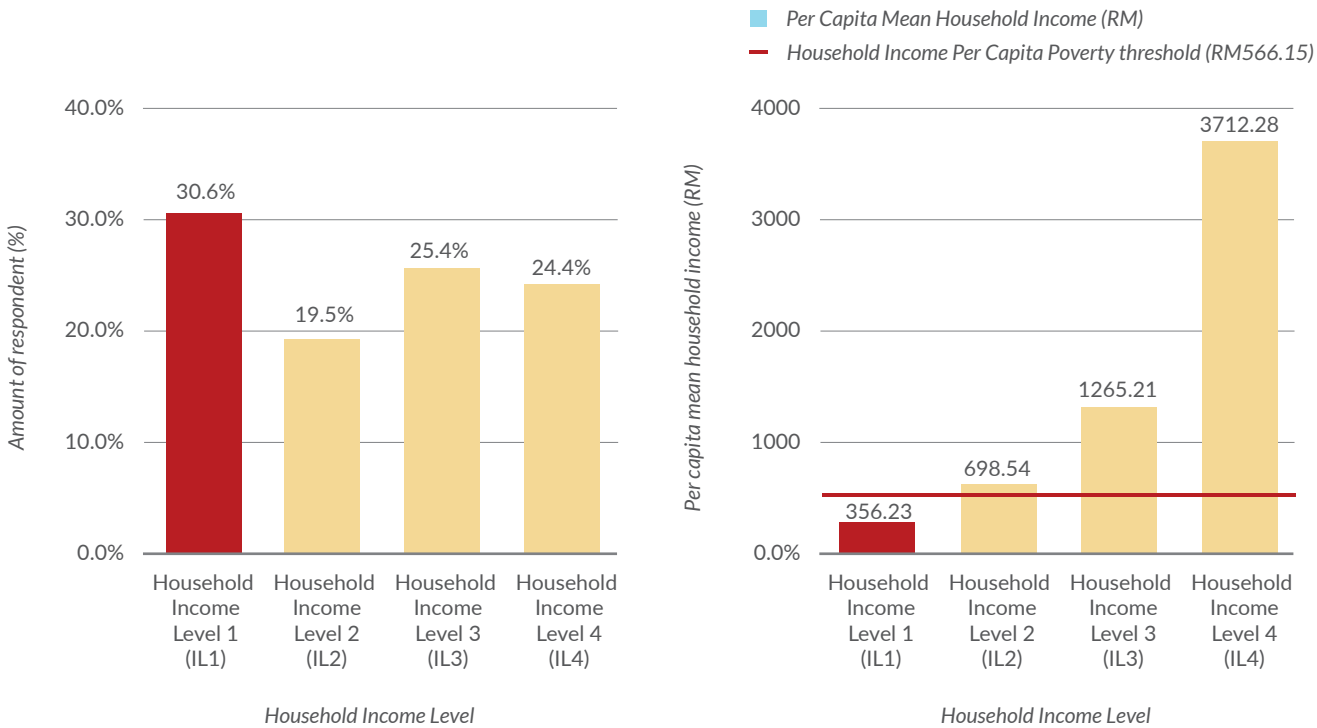
While short and medium term investments are crucial to strengthen the care workforce and infrastructure, long-term investments must also be strategised simultaneously. In the long term, it should be a priority to finance old-age pensions, as many care workers remain in lower socioeconomic classes, with 59.3% of care worker households explicitly falling into the B40 category. Closer inspection of care worker households reveals larger disparities when examining per capita household income, with nearly one-third of care worker households surveyed (30.6%) having an average of RM356.23 to spend per person, far below the per capita household income poverty threshold of RM566.15.[1] In this, *we believe investing at least 1% of Malaysia's national Gross Domestic Product (GDP), or RM39.6 billion, into the care ecosystem is a crucial first step.* Box 5.2.2 delves deeper on the potential returns of such an investment.

Invest at least 1% of Malaysia's national GDP, or RM39.6 billion, into the care ecosystem.

1 Refer to Finding 1 for further details.

FIGURE 5.2.3

Share of Care Worker Households by Per Capita Income Bracket (right). Average Per Capita Income by Household Income Level (left)



Box 5.2.1: What could returns on investments into the care ecosystem look like?

While there are no clear benchmarks for how much to invest into the care ecosystem, there are models which give a potential indication for returns on investment. Onaran and Oyvat (2023) have undertaken models to simulate the impact of a 1% GDP increase in investment across six emerging economies, including Southeast Asian counterparts Indonesia and the Philippines. Generally, what is understood is that investments into care ecosystems will lead to an increase in GDP and increased employment, through job creation within care services as well as by enabling people to enter the workforce once they have adequate support for care. Specifically, Onaran and Oyvat's models estimate:

- A one-off investment of 1% of GDP leads to an average 2.2% increase in GDP after five years and a 1.2% increase in employment;
- A year-on-year investment of 1% of GDP each year leads to an increase, in average, of 11.1% in GDP and employment by 6.3%.

In Malaysia, 1% of GDP is approximately RM39.6 billion. This means that investing RM39.6 billion could potentially lead to an increase in GDP by RM87 billion in five years. A sustained year-on-year investment of RM39.6 billion, on the other hand, could potentially generate nearly RM440 billion in returns. Thus, investments into care ecosystems can possibly yield strong returns.

Further, recent studies in Malaysia have estimated that the unpaid care and domestic work sector, if valued, stands at RM379 billion (Lee et al. 2024). However, this RM379 billion remains invisible, as it places a value on care work that is not remunerated, often undertaken in familial and household contexts. What investments into care ecosystems would do is potentially make visible some of these valuations. Though public investment into the care ecosystem would not automatically monetise unpaid care work, it lends visibility to the hidden value of unpaid care by shifting what was previously done in the private sphere to the public sphere. In practice, investing into the care ecosystem might mean better pay for care workers as well as increasing the availability and affordability of care services. This, in turn, may enable care workers greater access to paid care services and reduce their personal unpaid care workloads. This may also support bridging gaps in gender equality for women, who face gender pay gaps and disproportionately shoulder unpaid care work at home.

Though estimates provide insight into the economic value that care work can provide to a country, it is also important to note that care is intrinsically valuable because it sustains and connects communities. Investments into the care ecosystem are more than just an economic investment, but an investment into the resilience of the nation.

Concerted efforts to finance crisis-preparedness must also occur across the short, medium, and long terms. For example, in the short-term, immediate investments in training and contingency planning can ensure the care workforce and infrastructure are able to respond if a crisis were to happen soon. In the medium-term, organisational resilience can be strengthened through key investments in, for example, programmes supporting care workers' unpaid care work. Finally, long-term investments into strategies to scale resilience and improve workforce wellbeing will also be necessary for crisis-preparedness.

Pillar 5:

Strengthen Governance and Coordination for a Coherent Care Ecosystem

Malaysia faces multiple pressures: an ageing population, rising living costs, increase in climate-related disasters, and increasing geopolitical tensions. It is clear that for Malaysia to remain resilient, care must be at the centre of economic and social policy discussions. This also means planning for, investing in, and sustaining a skilled care workforce. While it is critical to support care workers at the individual level, our findings suggests that the highest impact will come from structural reforms and systemic change, enabling better retention of a skilled care workforce, equipped to face future challenges.

A strong care workforce, however, cannot exist without a coordinated and well-resourced care ecosystem. Building that ecosystem requires clear leadership and coordination across ministries and other stakeholders. While there have been many recent initiatives to promote the development of the care economy, these efforts are fragmented, lacking a whole-of-government approach and a consideration of long-term planning for the care workforce, and often in ways that have prioritised the commodification of care (Choong 2025). Hence, we reassert our approach, outlined in Chapter 2, of conceptualising care as an ecosystem working to meet the needs of care recipients and support those who undertake paid or unpaid care work.

We recommend *establishing a national coordinating entity,* such as a National Care Commission or a Special Select Committee on Care that would report to Parliament, and be supported through an inter-ministerial taskforce. This national coordinating entity could provide oversight and leadership on care-related policies and initiatives, ensuring policy coherence across sectors and alignment with Malaysia's national priorities. Its potential scope of work is described in more detail in the next section.

Recommendations for the national coordinating entity

i *Develop and oversee implementation of a national care strategy and plan*

A national care strategy and action plan is critical to provide coherence, direction, and accountability across Malaysia's fragmented care landscape. Currently, care-related policies and programmes are dispersed across various ministries, agencies and other actors with limited coordination or shared outcomes. Developing and implementing a unified strategy and policy framework would help align existing efforts, establish common standards, and clarify roles and responsibilities of ministries, agencies and other actors (e.g., KPWKM, MOH, KESUMA, Ministry of Economy, state governments, local governments, NGOs). This would ensure Malaysia's care ecosystem develops in a systematic, integrated, and gender-responsive manner, while ensuring the continuity of efforts beyond electoral cycles.

A national coordinating entity could provide oversight and leadership on care-related policies and initiatves, ensuring policy coherence across sectors and alignment with national priorities.

ii Resolve long-standing coordination and alignment issues

Resolve long-standing coordination and alignment issues within the care ecosystem that requires closer multi-sectoral collaboration, including between federal, state and local authority levels. Following are some examples:

- *Streamline and harmonise the registration and licensing processes for care centres nationwide* through closer collaboration between relevant ministries and agencies (e.g. KPWKM, KPT, MOH, JKM and local authorities). This could potentially reduce what has been described by some private care operators as the current 'bureaucratic maze', (BIGTREE 2025), and encourage unlicensed centres to be registered and brought under the fold of regulation.

- *Unify the governance of early childhood care for children ages 0-6* According to a key informant interview with an early childhood care expert, "there are about five or six ministries handling [children aged] zero to six and different standards apply to government versus private operators." This fragmented governance structure causes many operational challenges for providers. For example, the different regulations around what age groups pusat jagaan, taska, and tadika may cater to are difficult to comply with and do not always reflect families needs' within communities, especially when siblings belong to different age groups. In practice, some centres accept older children for a few hours as they transit between school and home.

- *Ensuring greater equity of patient-healthcare worker ratio at state levels.* As pointed out by doctors and nurses in participatory data analysis sessions, while Malaysia has achieved the recommended WHO ratios at a national level, there are disparities at state-levels which impacts the quality of care received, especially in more rural areas. Simultaneously, when patient-healthcare worker ratios are high, the workload is likely more demanding and intense for healthcare professionals, leading to wellbeing impacts in the long run.

- *Develop a formal grievance mechanism to monitor and ensure enforcement* of standards, regulations and contract terms in domestic workers' employment. As noted in Pillar 1, the lack of a formal grievance mechanism for domestic workers has meant that many incidents of abuse and exploitation involving domestic workers often go unreported, leaving domestic workers without any avenues for recourse. This should be a multi-stakeholder effort, involving collaboration between embassies, civil society organisations and other government stakeholders.

- *Strengthen the legal protection framework for Persons with Disabilities (PWDs).* Care workers have noted that while the current Persons with Disabilities Act 2008 outlines broad principles of equality and inclusion, it lacks provisions for comprehensive monitoring, enforcement mechanisms, penalties and remedies against individuals, organisations/businesses who violate the Act or the rights of PWDs (SUHAKAM 2017). The Federal Constitution also does not provide explicit prohibition of discrimination against disability (Malaysian Bar 2024).

  This is concerning, as care workers have pointed to cases of mistreatment and abuse of PWDs within care settings, highlighting that without clear legal standards, accountability

or reporting mechanisms, care provision for PWDs becomes highly dependent on individual care worker commitment rather than institutionalised legal standards. "You can take a case to court, but beyond that there's little protection under current law," said one disability expert. Furthermore, as Malaysia increasingly becomes an aged society, the number of PWDs is likely to increase as aging can impact mobility, eyesight, and other bodily functions, resulting in disability. These gaps in protection and support must urgently be addressed through stronger coordination between stakeholders, including Malaysian disability groups and care operators.

iii *Lead national care workforce planning, premised on a forecast of Malaysia's care needs*

As this research shows, care workers are calling for less ad hoc responses and more systematic, forward-looking planning. The national coordinating entity should ensure effective workforce planning using evidence-based projections of Malaysia's demographic, social, and economic trends. Planning would ease systematic planning for a care workforce that can support Malaysia's care needs without becoming overstretched or at risk of burnout.

iv *Address systemic gaps and structural barriers to ensure retention of a skilled workforce*

As outlined in Pillar 1, this includes developing standardised training and competency frameworks, formal certification and professional recognition, ensuring fair wages, better management of contract workers, creating structured pathways for career progression—all of which would elevate care work, making it a stable and respected profession.

v *Develop an integrated data system and monitoring framework across ministries to enhance evidence-based decision making*

A key measure would be the development of a national care data registry that would track service coverage, workforce deployment, and care outcomes, enabling more efficient planning and resource allocation. When these projections are mapped against existing numbers of care workers and infrastructure, policy-makers can anticipate future care demands, identify gaps in care service provision, resources, and infrastructure. All data should be gender-disaggregated to ensure inequities in care responsibilities and access to programmes, training, and promotions are captured. This effort would require close collaboration between ministries, agencies and stakeholders at state and district level (e.g. MOH, KPWKM, DOSM, PBTs).

vi Promote better integration of health and social care systems

Malaysia's care ecosystem has evolved in silos, with health and social care systems operating largely independently under different ministries, mandates, and funding streams. For example, the MOH oversees healthcare delivery, while KPWKM manages and regulates social welfare, childcare, eldercare, and disability support services. This institutional separation often leads to fragmented service delivery, duplication of efforts, and gaps in continuity of care, particularly for older persons, persons with disabilities, and individuals with chronic conditions who require long-term, integrated support.

An example are private nursing homes for the elderly, for which oversight is currently split between MOH and KPWKM, resulting in much ambiguity for eldercare providers. Findings from our FGDs reveal that during the pandemic, this separation resulted in significant challenges for eldercare centres who did not have in-house clinical services and yet required timely medical support and referrals to healthcare services. Survey findings also support this recommendation, as about a quarter (26.1%) of social care workers felt that there are not enough healthcare workers within the social care sector (refer to Chart 5.1.3)

Integrated care requires a multidisciplinary workforce—healthcare professionals, social workers, community carers, and case coordinators—who are trained to work collaboratively. Joint training programmes, inter-agency placements, and competency frameworks that bridge both sectors can help foster shared understanding and collaborative practice. Thus, integrated models of care delivery, adapted to the Malaysian context, has the potential to ensure that individuals receive holistic, person-centred support that addresses both medical and social needs. For care workers, better integration of health and social care systems can make workloads more manageable, enabling further clarity of roles, reducing bureaucratic inefficiencies, improving coordination across teams and enhancing multidisciplinary support. In other words, it prevents care workers from having to navigate unclear responsibilities or compensate for gaps in service delivery, thus reducing additional strains on them.

Better integration of health and social care systems can make workloads more manageable, enabling further clarity of roles, reducing bureaucratic inefficiencies, improving coordination across teams and enhancing multidisciplinary support.

vii Recognise the domestic care sector and strengthen the protections for domestic workers

Recognise the domestic care sector as an essential component of the care system, rather than a private household matter. In nations where public care systems are still developing, care work is likely to be borne by migrant domestic workers (ILO 2018). In Malaysia, this holds true as many upper and middle income households still rely on migrant domestic workers for childcare, eldercare, disability care, household responsibilities, or a combination of these.

As Malaysia's population ages, and while the country works to strengthen its health and social care systems, the domestic care workforce will remain an important provider of care. Declining fertility rates and a shrinking working-age population are creating new pressures on households and the labour market. Amidst this, the demand for care increases. In this landscape, migrant domestic workers have become important providers of care, stepping in where public care systems are unable to meet care demands.

In recognition of this, countries like Japan and South Korea are increasingly offering more structured migration pathways to attract and retain migrant talents for care work (Nakagawa 2025; Ming 2023). Based on our survey, over half of MDWs (56.5%) want to leave their current position within the next five years. In our FGDs, those who could afford the support emphasised how important migrant domestic workers were in helping them manage their unpaid care responsibilities, suggesting that efforts for retention are crucial. Recognise the valuable contributions of domestic workers to the Malaysian economy, and ensure their rights and wellbeing.

Box 5.2.3

Key measures to imrove recognition of domestic workers

- *Integrate domestic care work into national care strategies and workforce planning*
- *Ensure rights to minimum wage, rest days, paid leave, protection against workplace violence and harassment*
- *Strengthen monitoring mechanisms for migrant domestic workers to prevent exploitation by employers and agencies*
- *Ensure access to grievance mechanism, followed by access to protections for domestic workers facing abuse or contract violations*
- *Facilitate access to health care and mental health support*
- *Facilitate pathways for skill recognition and training*

viii Recognise and address gendered dimensions of care

(and its undervaluation). The care ecosystem in Malaysia is highly gendered. Women continue to shoulder the majority of unpaid care work within households while also dominating paid care sectors such as nursing, childcare, eldercare, and domestic work. The association of care work with femininity, whether paid or unpaid, continues to contribute to the undervaluation of these sectors, as outlined in Chapter 2. Unsurprisingly, then, these sectors often tend to be low-paid, underrecognised, and informal.

Furthermore, the nature of care work is easily misunderstood, as evidenced by a recent proposal to standardise nurses' working hours from 42 to 45 hours a week, in line with other areas of civil service. Although the decision was eventually reversed, the underlying

principle was not fully explored. Care work, unlike office-based work, requires continuous physical and emotional labour with people who are often in vulnerable states. This makes care work intense, unpredictable, emotionally demanding, and far more taxing when compared to office-based work that follows fixed schedules or measurable outputs. For this reason, labour policies for the care sector must take into account the particular nature of care work, or risk undermining the factors that contribute to quality care.

Addressing structural inequalities (examples of which are described above), requires intentional governance measures that recognise the nature of care work, its inherent value and the importance of placing a gendered lens at the centre of care policy design, implementation, and monitoring.

ix *Involve care workers in decision-making processes*

Beyond government coordination, care governance should include the participation of non-governmental actors such as care workers, employers, unions, associations, volunteer bodies, and civil society organisations in policy dialogues and decision-making processes. Their involvement can ensure that care policies reflect the realities on the ground. This could be done through consultations or mutli-stakeholder advisory bodies.

Their involvement can ensure that care policies reflect the realities on the ground. This could be done through consultations or multi-stakeholder advisory bodies.

To conclude, many countries have or are shifting towards a more systematic and coordinated approach to care. For instance, Australia, the United Kingdom, Scotland, and Uruguay are already implementing their national or integrated care plans. Concurrently, many low and upper middle-income countries such as Nepal, Indonesia, Brazil, Colombia, Bangladesh, and India are engaging in ongoing efforts to strengthen their care coordination systems and develop national care strategies.

In most of these strategies or plans, the care workforce is consistently identified as a priority area (See Table 5.2.1 for more information), demonstrating a clear recognition that a well-supported care workforce is central to advancing national care agendas.

While these examples provide useful reference points, further analysis should be undertaken to understand how these examples of coordination efforts differ in approach and which aspects have contributed to a strengthened workforce and improved care outcomes. For Malaysia, such insights could inform the development of a coordination model adapted to our local governance structures and responsive to local community needs.

Care work, unlike office-based work, requires continuous physical and emotional labour with people who are often in vulnerable states. This makes care work intense, unpredictable, emotionally demanding, and far more taxing when compared to office-based work that follows fixed schedules or measurable outputs.

TABLE 5.2.2

National-Level Care Coordination: Best Practices from Other Countries

Country	Policy Initiatives	Lead Ministry/Entity	How the care workforce features
Australia	The National Strategy for the Care and Support Economy 2023 is a whole-of-government plan to integrate aged care, disability care, early childhood care and other sectors. Currently, a national roadmap and sector-specific action plans are being formulated in collaboration with state governments.	Department of Prime Minister & Cabinet (PM & C), through the Care and Support Economy Reform Unit (cross-ministerial collaboration)	The national strategy prioritises workforce strengthening and addressing workforce shortages by improving job security, ensuring fair wages, inclusive workplaces, clearer training pathways and professional recognition of care workers
England	Since 2014, England has set out on a vision for better integrating health and social care. The Health and Social Care Act 2022 contains provisions for integrated care systems (ICS) and strengthened structural integration of the National Health Systems (NHS) and Social Care. Accompanying these reforms are policy initiatives to strengthen the care workforce. The most recent initiative for social care is the Adult Social Care Workforce Strategy 2024 which was updated in 2025. For healthcare, it is the NHS Long-Term Workforce Plan 2023 Both share a shift towards community-based integrated models of care	Department of Health and Social Care, NHS England, ICS Partnerships. Leading the implementation of the social care workforce strategy is Skills for Care, with support from the Care Quality Commission (CQC), Oversight Executive Group, and other groups and bodies.	The NHS Long-Term Workforce Plan 2023 seeks to ensure the sustainable growth of the healthcare workforce for the next15 years. It has identified the priority areas of 'train', 'retain' and 'reform'. Its main focus is to increase the size of the workforce, improve the retention of staff and improve productivity through innovative ways including through technology. Similarly, the Adult Social Care Workforce Strategy 2024 sets out the country's direction and plans to address social care workforce shortages (including through management of international recruitment). Its priority areas for the next 15 years are to 'attract and retain', 'train' and 'transform', recognising that reversing the decline in the social care workforce requires proactive measures.

Uruguay	Sistema Nacional Integrado de Cuidados (SNIC) or the National Integrated Care System was established in 2015 to set up a co-responsible model of care. Its implementation is ongoing with the latest plan being the Plan Nacional de Cuidados 2021–2025. Uruguay's integrated care system has been regarded as a regional model though it faces coverage and sustainability challenges. The plan also emphasises strengthening community/territorial based care initiatives	The National Board of Care is an inter-ministerial board responsible for defining guidelines, objectives and policies, and is advised by an Advisory Committee (AC) comprising 16 representatives of civil society organisations, academia, workers and the private sector The National Care Secretariat (Secretaría Nacional de Cuidados) under the Ministry of Social Development (MIDES) coordinates activities across several ministries and reports to the National Board of Care.	The strategy focuses on making care work visible and valued, professionalising paid care roles, formalising informal caregivers, addressing gender and labour inequalities
Singapore	Singapore positions care within the health and aging agenda. In 2015, Singapore launched the Action Plan for Successful Ageing, a national blueprint to integrate health, social and community initiatives for aging. This plan was updated in 2023 and comprises over 70 initiatives across various domains. Childcare, disability care and family support are not included in this plan, and are addressed through other initiatives. Active Aging Centres (AACs) are community-based care centres that serve as entry points for senior citizens to access the suite of integrated services.	Ministry of Health (MOH) oversees aged care, long term care and community care; Ministerial Committee on Aging formed under MOH is an inter-ministerial coordinating body that oversees Singapore's aging and care strategy The Agency for Integrated Care (AIC), is a statutory body under MOH that leads coordination and supports the delivery of aged and community care services across health and social domains. Ministry of Social and Family Development (MSF) oversees childcare, disability services and family support	Through accompanying policy documents and programmes, Singapore has made efforts towards strengthening the community care workforce, ensuring appropriate training and upskilling. For example, the SkillsFuture programs provides upskilling for healthcare and eldercare workers

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National-Level Care Coordination: Best Practices from Other Countries

Country	Policy Initiatives	Lead Ministry/Entity	How the care workforce features
Indonesia	National Care Economy Roadmap and Action Plan 2025-2045, which addresses seven strategic areas of care, has been adopted and is currently being operationalised. A Care Economy Working Group has been established to coordinate action across ministries	Ministry of Women's Empowerment and Child Protection (KPPA) and National Planning Ministry (Bappenas)	Recognition and professionalisation of care workers, improving training and certification, elevating status and protections for care workers
Thailand	Thailand's Long-Term Care (LTC) policy approach was adopted in 2016 and integrated within community health and volunteer systems. The country has successfully extended LTC access through local government and village networks, although it continues to face challenges in workforce stability, system adequacy and financial sustainability.	Ministry of Public Health with National Commission on the Elderly; Ministry of Social Development and Human Security and local government.	Thailand's post-COVID capacity-building agenda explicitly targets expanding the number of certified care workers through standardised national curricula, establishing continuous professional development pathways for community caregivers, and enhancing inter-professional collaboration between health and social-care workers at the district level. Following the pandemic, attention is being given to ensuring that infection prevention and control standards are implemented in all long-term care settings, providing support for family and voluntary caregivers, and prioritising the psychosocial well-being of people receiving and providing long-term care services.

			To address labour shortages especially in rural areas, Thailand is is also considering migrant care labour as part of a long-term solution
Nepal	A National Care Working Group (CWG) has been established under the the National Planning Commission to draft a Care Roadmap	National Planning Commission (NPC) in collaboration with Ministry of Women, Children and Senior Citizens, with support from International Organisations such as UN Women, ILO and others	Ongoing commitments to ensure care work is decent, strengthening training and recognition of care workers, and promoting integration of care roles within the labour market

Sources: Australia (Department of the Prime Minister and Cabinet 2024), United Kingdom (NHS England 2023; Skills for Care 2024; The King's Fund 2022), Singapore (Ministry of Health Singapore 2023; Ministry of Health Singapore 2022; AIC n.d.; AIC 2024; The Straits Times 2024; SkillsFuture Singapore 2024a; SkillsFuture Singapore 2024b), Uruguay (UN Women 2019; UN Women 2023b; Sternkopf 2024), Indonesia (ILO 2024b; ILO 2023a; World Bank 2024), Thailand (Department of Older Persons 2024; ERIA 2023; World Bank 2021; ADB 2021) Nepal (UN Women 2024; Nikore et al. 2025; Fernández-Pacheco 2024)

5.3.

Conclusion

This study set out to better understand the experience of essential care workers, especially women, in navigating their paid and unpaid care work during the COVID-19 pandemic. Women make up a majority of the care workforce and yet we know so little about them and their experiences.

During the pandemic, care workers across healthcare, social care and domestic care sectors in Malaysia carried the nation through crisis, and as this research demonstrates, it was at a great personal cost. Many care workers' wellbeing has still not recovered post-pandemic, worsened by elevated experiences of burnout post-pandemic.

More importantly, the gendered differences that emerged from this study emphasise the structural inequalities women care workers still face as they manage their personal and professional lives. Women face an unsustainable double burden from compounding stressors across both professional and personal lives and this negatively impacts their wellbeing. In high care load households, women are undertaking up to 40 hours of unpaid care work per week, equivalent to a full-time job. In the highest care load household, Q4, women are undertaking over six hours of additional unpaid care work a week compared to men in similar households. Consequently, especially amongst Malaysian women, we observed a significantly lower satisfaction with social support for unpaid care work, work-life balance, and physical and mental health compared to men.

Given Malaysia's resilience as a nation rests on the strength of its care ecosystem and workforce, it is concerning that there is such high intention to leave current positions in the care workforce within five years, risking the long-term sustainability of Malaysia's care ecosystem. Most alarming is that, while men appear to be seeking opportunities for enhanced career growth and financial stability, women intending to leave their current positions appear to be contemplating dropping out of the care workforce altogether. Considerations for early retirement as well as wanting to spend more time with family amongst women intending to leave their current positions may reflect unmet care needs and insufficient structural support. Our findings suggest that high care burdens, limited household support, and stronger internalised caregiving expectations appear to constrain women's ability to remain in the care workforce.

Women face an unsustainable double burden from compounding stressors across both professional and personal lives and this negatively impacts their wellbeing.

By gaining a better perspective of care worker experiences and by taking an intersectional approach this study has uncovered crucial gendered realities and identified important lessons of what would better support women care workers for future crises. In light of the high intention of care worker's to leave their current position within the next five years, strategies for care workforce retention become central to bolstering the resilience of the care ecosystem. Through our study, we highlighted the importance of improving job satisfaction and reducing rates of burnout as one strategy. Simultaneously, there is a need to enhance both individual and organisational resilience, as worker-perceived improvements in these aspects appear to increase the likelihood of retention Violence experienced by care workers, both in the workplace and at home, must also be addressed through measures that are , survivor-centric and non-retaliatory. Finally, these strategies must be complemented by care-supportive policies to enable care workers, especially women, to better manage and redistribute their unpaid care work. Unpaid care should not just be distributed and shared by household members, but supported through community and state initiatives as well. Given the compounding effects of paid and unpaid work, these are important measures that can reduce strain on care workers and improve wellbeing outcomes and care workforce retention.

We were caught unprepared once, but we should not allow ourselves to be caught unprepared again. Now is the time to address the underlying issues and challenges that limit our care systems and workforce.

At its core, our study is a call for collective responsibility and investment into care work, both paid and unpaid. Building a care system that can withstand future challenges and carry us forward requires leadership across sectors, coherence in our policies, and equitable financing of our care systems. And in all of this, when we centre the wellbeing of care workers, recognise the realities they face, and ensure that policies reflect those realities, we lay the foundation for a care system that is not only more resilient, but inclusive and more sustainable for everyone.

References

Aazami, Sanaz, Khadijah Shamsuddin, Syaqirah Akmal, and Golnaz Azami. 2015. "The Relationship Between Job Satisfaction and Psychological/Physical Health among Malaysian Working Women." The Malaysian Journal of Medical Sciences: MJMS 22 (4): 40–46.

Agency for Integrated Care (AIC). n.d. "About Us." Accessed September 30, 2025. https://www.aic.sg/about-us/.

Agency for Integrated Care (AIC). 2024 "Community Care Career Track Rolled Out for Eldercare Sector." October 2. Singapore: Agency for Integrated Care. https://www.aic.sg/partners/community-care-career-track.

Aloisio, Laura D., Mary Coughlin, and Janet E. Squires. 2021. "Individual and Organizational Factors of Nurses' Job Satisfaction in Long-Term Care: A Systematic Review." International Journal of Nursing Studies 123. https://doi.org/10.1016/j.ijnurstu.2021.104073.

Anderson, B. 2016. Worker, Helper, Auntie, Maid? Working Conditions and Attitudes Experienced by Migrant Domestic Workers in Thailand and Malaysia. Bangkok: UN Women Regional Office for Asia and the Pacific.

Ang, Kim Wai, Yi Ling Eileen Koh, Xue Fei Wang, Azizah Mohd Yusoff, Ai Meng Tan, Xin Yi Cindy Poh, Ning Zhang, and Ngiap Chuan Tan. 2022. "Pilot Cross-Sectional Study of Foreign Domestic Workers Supporting the Basic Healthcare Needs of Older Persons in the Community." BMJ Open 12 (3): e051877. https://doi.org/10.1136/bmjopen-2021-051877.

Antonopoulos, Rania. 2008. "The Unpaid Care Work-Paid Work Connection." Working Paper, The Levy Economics Institute of Bard College. Annandale-on-Hudson, NY. https://ssrn.com/abstract=1176661.

Ariffin, Rohana. 2004. "Globalization and its impact on women workers in Malaysia." Women and globalization. Amherst, NY: Humanity Books: 25-51.

ASEAN. 2023a. ASEAN Guidelines on Disaster-Responsive Social Protection to Increase Resilience. Jakarta: ASEAN Secretariat. https://asean.org/book/asean-guidelines-on-disaster-responsive-social-protection-to-increase-resilience/.

ASEAN. 2023b. Regional Guidance on Strengthening the Role of Social Workers and the Wider Social Service Workforce in Social Protection. Jakarta: ASEAN Secretariat. https://asean.org/wp-content/uploads/2023/11/Strengthening-the-Role-of-Social-Workers-and-the-Wider-Social-Service-Workforce-in-Social-Protection_FINAL.pdf.

ASEAN. 2024. Research on Migrant Workers' Rights-Based Standard Employment Contract for Domestic Work in ASEAN. https://asean.org/book/research-on-migrant-workers-rights-based-standard-employment-contract-for-domestic-work-in-asean/.

Asian Development Bank (ADB). 2021. Lessons from Thailand's National Community-Based Long-Term Care Programme for Older Persons. Manila: ADB. https://www.adb.org/publications/thailand-long-term-care-older-persons

Australian Aid, & International Labour Organization. 2016. TRIANGLE II Quarterly Briefing Note | Malaysia. https://www.ilo.org/resource/brief/triangle-ii-quarterly-briefing-note-malaysia-january-march-2016

Avellar, Sarah, and Pamela J. Smock. 2005. "The Economic Consequences of the Dissolution of Cohabiting Unions." Journal of Marriage and Family 67 (2): 315–27. https://doi.org/10.1111/j.0022-2445.2005.00118.x.

Awang, Balkish. 2023. "Address Poverty Issues Besetting Elderly Population – Experts." Bernama, October 13, 2023. https://www.bernama.com/en/bfokus/news.php?social&id=2234386.

Awang, Halimah, Tan Chin Lung, Nur Fakhrina Ab Rashid, Norma Mansor, Tan Lih Yoong, and Kama Firdaus Subbahi. 2024. "Preparedness to Age in Place Among Older Adults in Malaysia." Ageing International 49 (3): 720–35. https://doi.org/10.1007/s12126-024-09558-9.

Aymerich, Claudia, Borja Pedruzo, Jose Luís Pérez, Maria Laborda, Jon Herrero, Jorge Blanco, Gonzalo Mancebo, et al. 2022. "COVID-19 Pandemic Effects on Health Worker's Mental Health: Systematic Review and Meta-Analysis." European Psychiatry 65 (1). https://doi.org/10.1192/j.eurpsy.2022.1.

Aziz, Nor Azah Abdul, Nur Hanani Zakaria, Emilda Hashim, Roznim Mohamad Rasli, Erni Marlina Saari, Mazlina Che Mustafa, and Sopia Md Yassin. 2021. "Issues in Operating Childcare Centers in Malaysia." International Journal of Evaluation and Research in Education 10 (3): 993–1000. https://doi.org/10.11591/ijere.v10i3.20881.

Aziz, Azizan Abdul. 2024. "Women: The Driving Force of Healthcare." Paper presented at 38th CMAAO General Assembly and 59th Council Meeting, Manila, Philippines. Symposium Report, Malaysia, August 24. https://www.cmaao.org/wp-content/uploads/2024/10/2024_Malaysia-Symposium.pdf.

Barasa, Edwine W., Keith Cloete, and Lucy Gilson. 2017. "From Bouncing Back, to Nurturing Emergence: Reframing the Concept of Resilience in Health Systems Strengthening." Health Policy and Planning 32, no. Suppl 3: iii91–94. https://doi.org/10.1093/heapol/czx118.

Barbier, J.-C. 2004. "A Comparative Analysis of 'Employment Precariousness' in Europe." In Learning from Employment and Welfare Policies in Europe, European Cross-National Research Papers, Seventh Series, 7–18.

Bauhardt, Christine, and Wendy Harcourt, eds. 2019. Feminist Political Ecology and the Economics of Care : In Search of Economic Alternatives. London and New York: Routledge.

Bedi, Rashvinjeet S. 2024. "In Malaysia, Doctor's Death Shines Spotlight on Long-Standing Workplace Bullying in Public Health Sector." Channel NewsAsia, September 28. https://www.channelnewsasia.com/asia/malaysia-doctors-workplace-bullying-healthcare-hospitals-4641766.

Benería, Lourdes, Günseli Berik, and Maria S. Floro. 2015. "Paid and Unpaid Work: Meanings and Debates." In Gender, Development and Globalization: Economics as If All People Mattered, 2nd ed., edited by Lourdes Benería, Günseli Berik, and Maria S. Floro, 48–66. New York: Routledge.

Bernama. 2022. "Challenges Remain Despite Support for Childcare and Working Women Policies." Astro Awani, July 14. https://international.astroawani.com/malaysia-news/challenges-remain-despite-support-childcare-and-working-women-policies-371163.

Berry, L. L., and Stuart, B. 2021. "An 'essential services' workforce for crisis response". Journal of Public Policy & Marketing 40(1), 92-93.

BIGTREE Medicare & Nursing Home. 2025. "RMK13 and the Future of Malaysian Eldercare: Our Industry's Greatest Opportunity." BIGTREE Medicare & Nursing Home. https://www.bigtree.care/rmk13-eldercare-malaysia-industry-hopes/.

Bimpong, K. A. A., Khan, A., Slight, R., Tolley, C. L., and Slight, S. P. 2020. "Relationship between labour force satisfaction, wages and retention within the UK National Health Service: a systematic review of the literature". BMJ open 10(7), e034919.

Blair-Loy, M. and A.S. Wharton. 2002. "Employees' use of work–family policies and the workplace social context". Social Forces 80(3): 813–45.

Blanchet, Karl, Sara L. Nam, Ben Ramalingam, and Francisco Pozo-Martin. 2017. "Governance and Capacity to Manage Resilience of Health Systems: Towards a New Conceptual Framework". International Journal of Health Policy and Management 6 (8): 431–35. https://doi.org/10.15171/ijhpm.2017.36.

Boniol, Mathieu, Michelle McIsaac, Lihui Xu, Tana Wuliji, Khassoum Diallo, and Jim Campbell. 2019. Gender Equity in the Health Workforce: Analysis of 104 Countries (Working Paper 1). Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf

Boo, H. S. 2021. "Gender Norms and Gender Inequality in Unpaid Domestic Work among Malay Couples in Malaysia". Pertanika Journal of Social Sciences and Humanities 29(4), 2353–2369. https://doi.org/10.47836/pjssh.29.4.14

Boo, Su-Lyn, and Nie Yen Low. 2022. "Sabah Coping Despite Record High Covid-19 Hospital Admissions." CodeBlue, February 15. https://vgh.pth.mybluehost.me/2022/02/sabah-coping-despite-record-high-covid-19-hospital-admissions/.

Brough, P., and O'Driscoll, M. P. 2010. "Organizational interventions for balancing work and home demands: An overview. Work & Stress", 24(3), 280-297. https://doi.org/10.1080/02678373.2010.506808

Brough, Paula, Carolyn Timms, Xi Wen Chan, Amy Hawkes, and Laura Rasmussen. 2020. "Work–Life Balance: Definitions, Causes, and Consequences". In Handbook of Socioeconomic Determinants of Occupational Health, 1–15. Cham: Springer International Publishing. https://doi.org/10.1007/978-3-030-05031-3_20-1.

Budlender, D. 2002. Why Should We Care About Unpaid Care Work? A Guidebook Prepared for the UNIFEM Southern African Region Office.

Bunyan, J. 2018. "Why aren't childcare centres common in the workplace? Bosses explain" Malay Mail July 18. https://www.malaymail.com/news/malaysia/2018/07/08/why-arent-childcare-centres-common-in-the-workplace-bosses-explain/1649924

Business Times. 2024. “90 Pct of EPF Members under 30 Will Not Have RM240K to Retire – KRI Report.” New Straits Times, September 26. https://www.nst.com.my/business/corporate/2024/09/1110974/90pct-epf-members-under-30-will-not-have-rm240k-retire-kri-report.

The Centre for Care. 2025. “Care as a Complex, Adaptive Ecosystem”. https://centreforcare.ac.uk/topics/care-as-a-complex-adaptive-ecosystem/.

Chee, Jo-Ey. 2024. “Salary Guide for Public Hospital Doctors in Malaysia.” Dollars and Sense Malaysia, May 2. https://dollarsandsense.my/salary-guide-for-public-hospitals-doctors-in-malaysia/.

Child Care Centre Act 1984 (Act 308). https://unicefeaproecdtoolkit.wordpress.com/wp-content/uploads/2017/08/act-308-child-care-center-act-1984.pdf

Child Care Centre Regulations 2012 P.U. (A) 223/2012. https://www.jkm.gov.my/jkm/uploads/files/peraturan-peraturan%20TASKA%20edit%2003082016.pdf.

Cheng, Calvin. 2023. “Post-Covid-19 Recovery and Quest for ‘Good Jobs.’” In Where Do We Go Workwise? Malaysia’s Labour Landscape, edited by A. Mahadi and M.H. Lee. Institute of Strategic and International Studies (ISIS) Malaysia. https://www.isis.org.my/2023/11/01/post-covid-19-recovery-and-quest-for-good-jobs/.

Ching, S. M., Cheong, A. T., Yee, A., Thurasamy, R., Lim, P. Y., Zarina, I. I., Lee, K. W., Taher, S. W., and Ramachandran, V. 2024. “Prevalence and factors associated with burnout among healthcare providers in Malaysia: a web-based cross-sectional study”. Irish journal of medical science, 193(2), 851–863. https://doi.org/10.1007/s11845-023-03483-7

Choong, Christopher Weng Wai, A. M. M. Firouz, A. F. Jasmin, Nazihah Muhamad Noor, and R. Gong. 2019. Time to Care: Gender Inequality, Unpaid Care Work and Time Use Survey. Kuala Lumpur: Khazana Research Institute. https://doi.org/10.13140/RG.2.2.22350.61764

Choong, Christopher Weng Wai. 2021. “More Men Citing Housework as Reason for Staying Outside the Labour Force During the Pandemic? Some Data from Malaysia.” LinkedIn, September 20. Accessed August 26, 2025. https://www.linkedin.com/pulse/more-men-citing-housework-reason-staying-outside-some-christopher/.

Choong, Christopher Weng Wai. 2025. “Unpaid Care Labour under Care-Pitalism: Critical Policy Perspectives.” Khazanah Research Institute Publications. https://www.krinstitute.org/publications/unpaid-care-labour-under-care-pitalism-critical-policy-perspectives.

Chung, Isabel, Anis Farid, and Shazana Agha. 2021. “A Study on Malaysian Public Attitudes and Perceptions towards Violence Against Women (VAW)”. Women’s Aid Organisation. https://wao.org.my/wp-content/uploads/2021/12/PRINT-WAO_VAW-REPORT_30-NOV.pdf.

CodeBlue. 2020a. “Private Clinics Shutter, Health Workers Recycle And Tailor Protective Gear Amid Shortages”. CodeBlue, July 7. https://codeblue.galencentre.org/2020/03/private-clinics-shutter-health-workers-recycle-and-tailor-protective-gear-amid-shortages/.

CodeBlue. 2020b. “Building A Resilient Health Care System For The Future—Mark Cheong”. CodeBlue. https://codeblue.galencentre.org/2020/10/21/building-a-resilient-health-care-system-for-the-future-mark-cheong/

CodeBlue. 2023. “HUKM Emergency Department Overwhelmed, Only Critical Cases Accepted For Now”. CodeBlue. https://codeblue.galencentre.org/2023/05/09/hukm-emergency-department-overwhelmed-only-critical-cases-accepted-for-now/

CodeBlue. 2024a. “Quitting For Jobs Abroad: 2,400 Nurses Last Year, 20 Specialist Doctors In Past Decade.” CodeBlue https://codeblue.galencentre.org/2024/07/quitting-for-jobs-abroad-2400-nurses-last-year-20-specialist-doctors-in-past-decade/

CodeBlue. 2024b. “Budget 2025: Health Ministry Gets RM 45.3 Billion, Most of Increased Allocation Goes to Emoluments.” CodeBlue, October 18. https://codeblue.galencentre.org/2024/10/budget-2025-health-ministry-gets-rm45-3-billion-most-of-increased-allocation-goes-to-emoluments/

CodeBlue. 2024c. “Malaysia’s Doctor Shortage: Causes And Solutions: Part 1 — Dr Sean Thum.” https://codeblue.galencentre.org/2024/12/malaysias-doctor-shortage-causes-and-solutions-part-1-dr-sean-thum/

Codod, C. L. 2015. “Gender role of married couples in financial management”. International Journal of Management and Commerce Innovations 3(1), 21-29.

Collins, P. H. 1993. “Toward a New Vision: Race, Class, and Gender as Categories of Analysis and Connection”. Race, Sex & Class 1(1), 25–45.

Crinis, Vicki, and Aisha Bandali, A. 2017. “Malaysia: Balancing paid and unpaid work”. Faculty of Law, Humanities and the Arts - Papers (Archive) 41–54.

Dawood, Q., and Seedat-Khan, M. 2023. "The unforgiving work environment of black African women domestic workers in a post-apartheid South Africa". Development in Practice 33(2), 168-179.

De Kock, Johannes H., Helen Ann Latham, Stephen J. Leslie, Mark Grindle, Sarah-Anne Munoz, Liz Ellis, Rob Polson, and Christopher M. O'Malley. 2021. "A Rapid Review of the Impact of COVID-19 on the Mental Health of Healthcare Workers: Implications for Supporting Psychological Well-Being". BMC Public Health 21 (1): 104. https://doi.org/10.1186/s12889-020-10070-3.

Department of Older Persons. 2024. Situation of the Thai Older Persons 2023. Bangkok: Ministry of Social Development and Human Security. https://www.dop.go.th/download/statistics/th1738230377-2563_1.pdf

Department of Statistics Malaysia (DOSM). 2017. Labour Force Survey Report, 2012–2016. Putrajaya: Department of Statistics Malaysia.

Department of Statistics Malaysia. 2020. Household income and basic amenities survey report 2019. Putrajaya: Department of Statistics Malaysia.

Department of Statistics Malaysia. 2023. Labour Force Survey Report, 2019–2022. Putrajaya: Department of Statistics Malaysia.

Department of Statistics Malaysia. 2022. Number of Civil Servants by Grade and Sex, Malaysia. Putrajaya: DOSM. https://archive.data.gov.my/data/en_US/dataset/number-of-civil-servants-by-grade-and-sex-malaysia

Department of the Prime Minister and Cabinet. 2024. "Care and Support Economy – State of Play." May 28. https://www.pmc.gov.au/resources/care-and-support-economy-state-play.

Devi, L. 2021. Case Study on the Situation of Government Hospital Cleaners in Southeast Asia. Accessed May 20, 2025. https://jpkk.org/wp-content/uploads/2021/05/Case-Study-on-Situation-of-Government-Hospital-Cleaners-in-SEA_08052021.pdf

Dilig-Ruiz A, MacDonald I, Demery Varin M, Vandyk A, Graham ID and Squires JE. 2018. "Job satisfaction among critical care nurses: A systematic review". Int J Nurs Stud 88:123-134. doi: 10.1016/j.ijnurstu.2018.08.014.

Duffy, M. 2011. Making care count: A century of gender, race, and paid care work. Rutgers University Press.

Economic Planning Unit. 2021. Malaysia Voluntary National Review 2021: Voluntary National Review of Progress towards the Sustainable Development Goals. Putrajaya: Economic Planning Unit, Prime Minister's Department. https://ekonomi.gov.my/sites/default/files/2021-07/Malaysia_Voluntary_National_Review_%28VNR%29_2021.pdf

Economic Research Institute for ASEAN and East Asia (ERIA). 2023. "Capacity Building for Resilient Long-Term Care in Thailand." In Research Project Report RPR-2023-08, Chapter 6. https://www.eria.org/uploads/media/Research-Project-Report/RPR-2023-08/13_Chapter-6-Capacity-Building-for-Resilient-Long-term-Care-in-Thailand.pdf

Elias, Juanita. 2008. "Struggles over the Rights of Foreign Domestic Workers in Malaysia: The Possibilities and Limitations of 'Rights Talk.'" Economy and Society 37, no. 2, 282–303. https://doi.org/10.1080/03085140801933330.

Endut, N., Bagheri, R., Azmawati, A. A., Hashim, I. H. M., Selamat, N. H., and Mohajer, L. 2020. "Factors Influencing Malaysian Men's Perceptions of Gender Equity in Family Planning". Malaysian Family Physician : The Official Journal of the Academy of Family Physicians of Malaysia 15(3), 43–53.

European Commission. n.d. Employment and Decent Work. Accessed August 25, 2025. https://international-partnerships.ec.europa.eu/policies/sustainable-growth-and-jobs/employment-and-decent-work_en.

Faragher, E, M Cass, and C Cooper. 2005. "The Relationship between Job Satisfaction and Health: A Meta-Analysis." Occupational and Environmental Medicine 62 (2): 105–12. https://doi.org/10.1136/oem.2002.006734.

Farah Solhi. 2020. "Selangor Gov't Launches Childcare Assistance for Frontliners." NST Online. https://www.nst.com.my/news/nation/2020/10/632781/selangor-govt-launches-childcare-assistance-frontliners.

Fernández-Pacheco, Patricia. 2024. "Investing in the Care Economy: A Shared Responsibility for Sustainable Growth and Gender Equality." Nepal Economic Forum, December 30. https://nepaleconomicforum.org/investing-in-the-care-economy-a-shared-responsibility-for-sustainable-growth-and-gender-equality/.

Ferrant, G., Pesando, L. M., and Nowacka, K. 2014. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes.

Fielder, Ann. 2020. Women and the Future of Care Work in Asia. Friederich-Ebert Stiftung.

Folbre, N. 2001. The Invisible Heart: Economics and Family Values. New York: New Press.

Folbre, Nancy. 2009. "Inequality and time use in the household." in Wiemer Salverda, Brian Nolan, and Timothy M. Smeeding (Eds.) Handbook of Economic Inequality, 342–363, New York: Oxford University Press

FMT Reporters. 2022. "Contract hospital cleaners deserve frontline treatment, says MMA". Free Malaysia Today. February 10 https://www.freemalaysiatoday.com//category/nation/2022/02/10/hospital-cleaners-deserve-better-treatment-being-frontliners-says-mma/.

Free Malaysia Today. 2024. "Review Order on Maternity Leave for Civil Servants, MMA Urges JPA." Free Malaysia Today, August 7. https://www.freemalaysiatoday.com/category/nation/2024/08/07/review-order-on-maternity-leave-for-civil-servants-mma-urges-jpa/.

Gammarano, Rosina. 2025. "Happiness: A Key Metric to Understanding Decent Work." ILOSTAT (blog). March 20. https://ilostat.ilo.org/blog/happiness-a-key-metric-to-understanding-decent-work/.

Galderisi S, Heinz A, Kastrup M, Beezhold J, and Sartorius N. 2015. "Toward a new definition of mental health". World Psychiatry 14(2):231-3. doi: 10.1002/wps.20231. PMID: 26043341; PMCID: PMC4471980.

Ganesan, R. R. 2022. "Care Infrastructure Needed to Get Women into the Workforce, Govt Told." Free Malaysia Today, December 15. https://www.freemalaysiatoday.com/category/nation/2022/12/15/care-infrastructure-needed-to-get-women-into-workforce-govt-told.

Garfin, Dana Rose, Lindita Djokovic, Roxane Cohen Silver, and E. Alison Holman. 2022. 'Acute Stress, Worry, and Impairment in Health Care and Non-Health Care Essential Workers during the COVID-19 Pandemic'. Psychological Trauma: Theory, Research, Practice, and Policy 14 (8): 1304–13. https://doi.org/10.1037/tra0001224.

Ghai, Dharam. 2003. "Decent Work: Concept and Indicators." International Labour Review 142, no. 2, 113–45. https://doi.org/10.1111/j.1564-913X.2003.tb00256.x.

Glover, Lydia. 2021. "Social Reproduction Theory: On Regulating Reproduction, Understanding Oppression as a Lens on Forced Sterilization." Journal of International Women's Studies 22 (2): 32-48.

Goh, Edwin, Kok Hin Ooi, and Khairil Ahmad. 2023. "What You Need to Know About Unionisation in Malaysia." The Centre. https://www.centre.my/post/what-you-need-to-know-about-unionisation-in-malaysia.

Gopal, S., & Musa, M. 2022. Migration of Indian Women to Malaya: Socio-Economic Status and Sense of Nationalism, 1900–1957. In A Kaleidoscope of Malaysian Indian Women's Lived Experiences. https://link.springer.com/book/10.1007/978-981-19-5876-2

Government of Malaysia. 2020. SOP Perintah Kawalan Pergerakan Pemulihan (PKPP) - Sektor Penjagaan Sosial (Taska & Pusat Jagaan Warga Emas). Accessible at: https://covid-19.moh.gov.my/faqsop/sop-pkp-pemulihan/17-PenjagaanSosialKPWKM_10JUN2020V2.pdf.

Government of Malaysia. 2023. Laporan Survei Gaji & Upah: Malaysia 2023. Putrajaya: Jabatan Perangkaan Malaysia.

Greenhaus, J. H., Collins, K. M., and Shaw, J. D. 2003. "The relation between work–family balance and quality of life". Journal of Vocational Behavior 63(3), 510-531.

Gülaçtı, Fikret. 2010. "The Effect of Perceived Social Support on Subjective Well-Being". Procedia - Social and Behavioral Sciences, Innovation and Creativity in Education 2 (2): 3844–49. https://doi.org/10.1016/j.sbspro.2010.03.602.

Guerrero, L. R., Avgar, A. C., Phillips, E., and Sterling, M. R. 2020. "They are essential workers now, and should continue to be: Social workers and home health care workers during COVID-19 and beyond". Journal of Gerontological Social Work, 63(6-7), 574-576.

Haan M. 2008. "The Place of Place: Location and Immigrant Economic Well-Being in Canada". Population Research and Policy Review 27: 751-771.

Haar, Jarrod M., Marcello Russo, Albert Suñe, and Ariane Ollier-Malaterre. 2014. "Outcomes of Work–Life Balance on Job Satisfaction, Life Satisfaction and Mental Health: A Study across Seven Cultures." Journal of Vocational Behavior 85 (3): 361–73. https://doi.org/10.1016/j.jvb.2014.08.010.

Hafiz Hafizi Suhaimi and Hawati Abdul Hamid. 2024. Recognising and Rewarding Care Workers. Khazanah Research Institute. https://new.krinstitute.org/publications/Recognising_and_Rewarding_Care_Workers.

Haider, L. Jamila, and Frances Cleaver. 2023. “Capacities for Resilience: Persisting, Adapting and Transforming through Bricolage.” Ecosystems and People 19 (1). doi:10.1080/26395916.2023.2240434.

Hakim Mahari. 2025. “2026 Budget: More Permanent Posts for Doctors, Nurses Will Strengthen Public Healthcare.” New Straits Times, October 11. https://www.nst.com.my/news/nation/2025/10/1292293/2026-budget-more-permanent-posts-doctors-nurses-will-strengthen-public.

Heintz, J., Staab, S. and Turquet, L. 2021. “Don’t Let Another Crisis Go to Waste: The COVID19 Pandemic and the Imperative for a Paradigm shift”. Feminist economics 27(1-2): 179-226, http://dx.doi.org/10.1080/13545701.2020.1867762.

Hochschild, Arlie Russel. 1983. The managed heart: Commercialization of human feeling. Berkeley: University of California Press.

Hochschild, Arlie Russel, with Anne Manchung. 1989. The Second Shift: Working Parents and the Revolution at Home. New York: Viking.

Hogendoorn, B., T. Leopold, and T. Bol. 2020. “Divorce and Diverging Poverty Rates: A Risk-and-vulnerability Approach.” Journal of Marriage and the Family 82 (3): 1089-1109. https://doi.org/10.1111/jomf.12629.

Holmes, Megan R., C. Robin Rentrope, Amy Korsch-Williams, and Jennifer A. King. 2021. “Impact of COVID-19 Pandemic on Posttraumatic Stress, Grief, Burnout, and Secondary Trauma of Social Workers in the United States”. Clinical Social Work Journal 49 (4): 495–504. https://doi.org/10.1007/s10615-021-00795-y.

HSS, Amar Singh et al. 2025. “Please Fix the Flawed Social Work Profession Bill.” The Borneo Post (Online), July 9. https://www.theborneopost.com/2025/07/09/please-fix-the-flawed-social-work-profession-bill/.

Ilyana Mukhriz, Hafiz Hafizi Suhaimi and Hawati Abdul Hamid. 2024. Care in Malaysia: Emerging Trends, Challenges and Opportunities. Kuala Lumpur: Khazanah Research Institute. https://www.krinstitute.org/publications/care-in-malaysia-emerging-trends-challenges-and-opportunities.

Indramalar, S. 2023. “Women’s Minister Wants Government to Prioritise Care Economy.” The Star, October 9. https://www.thestar.com.my/lifestyle/family/2023/10/09/women039s-minister-wants-government-to-prioritise-care-economy.

Indeed. 2025a. “Caregiver Salaries in Malaysia.” Indeed. July 8. https://malaysia.indeed.com/career/caregiver/salaries.

Indeed. 2025b. “Childcare Provider Salaries in Malaysia.” Indeed. July 8 https://malaysia.indeed.com/career/childcare-provider/salaries?from=top_sb.

Institute of Medicine. 2013. Crisis standards of care: A toolkit for indicators and triggers. Washington, DC: The National Academies Press.

International Labour Organization (ILO). 1977. Recommendation on Nursing Personnel, 1977 (No. 157). Geneva: International Labour Office.

International Labour Organization. 2002. The International Labour Organization’s Fundamental Conventions. ILO.

International Labour Organization. 2012a. Social Protection Floors Recommendation. Recommendation 202. Geneva: International Labour Organization.

International Labour Organization. 2012b. “Convention C102 - Social Security (Minimum Standards) Convention, 1952 (No. 102).” https://normlex.ilo.org/dyn/nrmlx_en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312247.

International Labour Organization. 2018. Care Work and Care Jobs for the Future of Decent Work. Geneva: International Labour Organization.

International Labour Organization. 2020a. Protecting the rights of domestic workers in Malaysia during the COVID-19 pandemic and beyond. Geneva: International Labour Organization

International Labour Organization. 2020b. COVID-19: Impact on migrant workers and country response in Malaysia. International Labour Organization.

International Labour Organization. 2020c. Migration cost survey among Indonesian and Filipina domestic workers in Malaysia [Research Brief]. International Labour Organization

International Labour Organization. 2020d. Workers in Malaysia during the COVID-19 pandemic and beyond. International Labour Organization.

International Labour Organization. 2021. Making Decent Work a Reality for Domestic Workers: Progress and Prospects Ten Years After the Adoption of the Domestic Workers Convention, 2011. Geneva: International Labour Organization.

International Labour Organization. 2023a. “Launch of Indonesia’s Care Economy Roadmap and Action Plan 2025–2045.” ILO. https://www.ilo.org/resource/news/ministry-women%E2%80%99s-empowerment-and-child-protection-and-ilo-launch-care.

International Labour Organization. 2023b. Skilled to care, forced to work? Recognizing the skills profiles of migrant domestic workers in ASEAN amid forced labour and exploitation.

International Labour Organization. 2023c. World Employment and Social Outlook 2023: The Value of Essential Work. Geneva: ILO. https://doi.org/10.54394/OQVF7543.

International Labour Organization. 2024a. Decent work and the care economy. Geneva: International Labour Organization.

International Labour Organization. 2024b. “Indonesia Launches Its Roadmap on the Care Economy for a More Gender-Equal World of Work.” Jakarta: ILO Regional Office for Asia and the Pacific. https://www.ilo.org/resource/news/indonesia-launches-its-road-map-care-economy-more-gender-equal-world-work.

Ipsos. 2021. “Singapore Women Are Doing More Unpaid Domestic & Care Work than the Men Think They Are.” Ipsos. https://www.ipsos.com/en-sg/singapore-women-are-doing-more-unpaid-domestic-care-work-men-think-they-are.

Iskandar, I. M. 2025. “MOH: 1,754 nurses quit in past 5 years, Malaysia short by 43,243.” New Straits Times. https://www.nst.com.my/news/nation/2025/03/1182947/moh-1754-nurses-quit-past-5-years-malaysia-short-43243

Jabatan Kebajikan Masyarakat Malaysia (JKM). n.d. “Bantuan Warga Emas Perlis.” Portal Rasmi JKM Malaysia, Accessed May 11, 2025. https://www.jkm.gov.my/negeri/article/PLS/bantuan-warga-emas-perlis.

Jabatan Kebajikan Masyarakat Malaysia. 2024. “Kadar bantuan untuk warga emas kini dinaikkan kepada RM600 sebulan berbanding RM350 sebelum ini...” Facebook, 21 October, 2024. https://www.facebook.com/myjkmhq/posts/970201988468026/.

Jabatan Kebajikan Masyarakat Malaysia. 2025. “Bantuan Bulanan.” Portal Rasmi JKM Malaysia, May 11 May. https://www.jkm.gov.my/main/article/bantuan-bulanan

Jafri, F., Omar, M., Kusnin, F., and Mohamed, M. 2022. “COVID-19 outbreak at an aged-care facility in Selangor, Malaysia, March-April 2020”. Western Pacific Surveillance and Response Journal: WPSAR,13(1), 1–5. https://doi.org/10.5365/wpsar.2022.13.1.839

Jaringan Pekerja Kontrak Kerajaan. 2020. Study on Direct Employment of Contract Workers in Government Agencies. https://jpkk.org/penyelidikan/

Jeans, Helen, Sebastien Thomas, and Gina Castillo. n.d. “The Future Is a Choice: The Oxfam Framework and Guidance for Resilient Development.” Oxfam Policy & Practice. Accessed October 9, 2025. https://policy-practice.oxfam.org/resources/the-oxfam-framework-and-guidance-for-resilient-development-604990/.

Jinah N, Lee KY, Zakaria NH, Zakaria N, Ismail M and Mohmad S. 2023. “Contract doctors’ strike in Malaysia: A content analysis of the perception of medical fraternity and stakeholders on Facebook”. PLoS One 18(9):e0292213. doi: 10.1371/journal.pone.0292213. PMID: 37768943; PMCID: PMC10538735.

Jo Ann Mool. 2025. “Duo Jailed for Killing Maid: Even Recorded Her Torture.” Daily Express (Kota Kinabalu), June 21. https://www.dailyexpress.com.my/news/260862/duo-jailed-for-killing-maid-even-recorded-her-torture/.

Joshi, D., Abhishek, S., Nandi, S., and Sinha, D. 2024. “Feminization of the Health and Care Workforce in India and South Asia: Implications for Women’s Labor and Decent Work”. In Handbook on Sex, Gender and Health: Perspectives from South Asia (pp. 1-31). Singapore: Springer Nature Singapore.

Juhari, R., Yaacob, S. N., & Talib, M. A. 2013. “Father Involvement Among Malay Muslims in Malaysia”. Journal of Family Issues 34(2), 208–227. https://doi.org/10.1177/0192513X12461339

Kaiser, C., and A.J. Oswald. 2022. “The scientific value of numerical measures of human feelings”. Proc. Natl. Acad. Sci. U.S.A. 119 (42) e2210412119, https://doi.org/10.1073/pnas.2210412119 (2022).

Kadoya Y, Khan MSR. 2020. “Financial Literacy in Japan: New Evidence Using Financial Knowledge, Behavior, and Attitude”. Sustainability 12(9):3683. https://doi.org/10.3390/su12093683

Kaos, J. 2021. "Covid-19 clusters in nursing homes have claimed nine lives, says Health DG". The Star. https://www.thestar.com.my/news/nation/2021/03/04/covid-19-clusters-in-nursing-homes-have-claimed-nine-lives-says-health-dg

Kementerian Kesihatan Malaysia (KKM). 2020. Laporan Pasukan Petugas Khas bagi Penambahbaikan Budaya Kerja Perkhidmatan Kesihatan.

Khazanah Research Institute (KRI). 2024. "The State of Households 2024: Households and the Pandemic 2019–2022". Khazanah Research Institute. https://www.krinstitute.org/assets/contentMS/img/template/editor/[WEBSITE]%20SoH%202024%20Report%20FINAL%20v2.pdf

Krieger N, J. Chen, J. Selby. 2001. "Class Inequalities in Women's Health: Combined Impact of Childhood and Adult Social Class—A Study of 630 US Women". Public Health 115: 175-185.

Kristensen, Tage S., Marianne Borritz, Ebbe Villadsen, and Karl B. Christensen. 2005. "The Copenhagen Burnout Inventory: A New Tool for the Assessment of Burnout." Work & Stress 19, no. 3: 192–207. https://doi.org/10.1080/02678370500297720.

Kropf, Marcia B. 1999. "A Research Perspective on Work-Family Issues." In Work and Family: Challenges and Choices for a Changing World, edited by S. Parasuraman and J. Greenhaus, 2nd ed. (69-76). Westport: Praeger.

Kumpulan Wang Persaraan (KWAP). 2024. FAQs on Pension Services Malaysia. Kumpulan Wang Persaraan. https://www.kwap.gov.my/pension-services/faqs-on-pension-services/

Lamu, Admassu N., and Jan Abel Olsen. 2016. "The Relative Importance of Health, Income and Social Relations for Subjective Well-Being: An Integrative Analysis." Social Science & Medicine 152 (March):176–85. https://doi.org/10.1016/j.socscimed.2016.01.046.

Lauer, S. R., & Yodanis, C. 2014. "Money Management, Gender, and Households". The Wiley Blackwell Companion to the Sociology of Families, 344–360.

Lee, Hwok-Aun. 2023. "Labour Policy in Post-Covid-19 Malaysia: Crisis Responses, Structural Reform." Japan Labor Issues, vol. 7, no. 45, Special Issue: 76–88.

Lee, Hwok-Aun, and Kevin Zhang. 2023. "Decent Work, Wage Growth as National Objective." In Where Do We Go Workwise? Malaysia's Labour Landscape, edited by A. Mahadi and M.H. Lee. Institute of Strategic and International Studies (ISIS) Malaysia. https://www.isis.org.my/2023/11/01/decent-work-wage-growth-as-national-objective/.

Lee, Min Hui, Calvin Kah Weng Cheng, Shazana Agha, and Anis Farid. 2024. Building a Cradle-to-Grave Care Economy for Malaysia. Policy Brief. Institute of Strategic and International Studies. https://www.isis.org.my/2024/06/12/building-a-cradle-to-grave-care-economy-for-malaysia/.

Lembaga Hasil Dalam Negeri Malaysia (Inland Revenue Board of Malaysia, LHDN). 2021. Panduan Ringkas 09/2021 – Pelanjutan Pelaburan dalam Skim Persaraan Swasta (PRS). Kuala Lumpur: Lembaga Hasil Dalam Negeri Malaysia. https://phl.hasil.gov.my/pdf/pdfam/PR_09_2021.pdf

Levy, T., & Palley, E. 2021. "Yes, Care Is Infrastructure". RealClearPolicy. May 11 https://www.realclearpolicy.com/articles/2021/05/11/yes_care_is_infrastructure_776526.html

Labrague, Leodoro J., and Janet Alexis A. De los Santos. 2020. "COVID-19 Anxiety among Front-line Nurses: Predictive Role of Organisational Support, Personal Resilience and Social Support." Journal of Nursing Management 28, no. 7: 1653–61. https://doi.org/10.1111/jonm.13121.

Li, M., & Laughlin, C. 2023. "Care as infrastructure: Rethinking working mothers' childcare crisis during the COVID-19 pandemic". Gender, Work & Organization. https://doi.org/10.1111/gwao.13107

Lim, B. F. Y. 2022. "Impact of the COVID-19 Pandemic on Malaysian Labour Market and Policy Responses". Japan Labor Issues 6, no. 40 (November). https://www.jil.go.jp/english/jli/documents/2022/40-04.pdf

Lim, Lin Lean. 2022. Key Workers in Malaysia during the Pandemic. ILO Working Paper 81. Geneva: International Labour Organization. https://doi.org/10.54394/SXSA4174.

Litt, J. S., and Zimmerman, M. K. 2003. "Guest Editors' Introduction: Global Perspectives on Gender and Carework: An Introduction". Gender and Society, 17(2), 156–165.

Lo, Ying-Ru Jacqueline. 2020. "A Country United in the Face of the Pandemic." World Health Organization. https://www.who.int/malaysia/news/commentaries/detail/a-country-united-in-the-face-of-the-pandemic

Loganathan, T., Rui, D., Ng, C.-W., and Pocock, N. S. 2019. "Breaking down the barriers: Understanding migrant workers' access to healthcare in Malaysia". PLOS ONE, 14(7), e0218669. https://doi.org/10.1371/journal.pone.0218669

Luthar, Suniya S., Dante Cicchetti, and Bronwyn Becker. 2000. "The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work." Child Development 71(3): 543–62. https://doi.org/10.1111/1467-8624.00164

Malay Mail. 2023. "Malaysians Should Have EPF Savings of at Least RM240,000 to Retire Comfortably, Says Ahmad Maslan." Malay Mail, July 24. https://www.malaymail.com/news/malaysia/2023/07/24/malaysians-should-have-epf-savings-of-at-least-rm240000-to-retire-comfortably-says-ahmad-maslan/81441.

Malay Mail. 2024. "MMA President Says Malaysia Losing Its Nurses to Overseas Offers, Urges Govt to Improve Welfare to Reclaim Brain Drain." Malay Mail, April 15. https://www.malaymail.com/news/malaysia/2024/04/15/mma-president-says-malaysia-losing-its-nurses-to-overseas-offers-urges-govt-to-improve-welfare-to-reclaim-brain-drain/128859.

Malaysiakini. 2019. "Shortage of Social Workers Among Social Problem Challenges – Wan Azizah." Malaysiakini, October 9. https://www.malaysiakini.com/news/495037.

Malaysiakini. 2024. "DOSH Malaysia Launches New Guidelines for Managing Psychosocial Risks in the Workplace." Malaysiakini, October 18. https://www.malaysiakini.com/announcement/723131.

Malaysian Association of Social Workers. n.d. "What Is Social Work." https://www.masw.org.my/what-is-social-work.

Malaysian Bar. 2024. "Press Release | Rights Unseen: The Urgent Need to Include 'Disability' in Malaysia's Federal Constitution." Malaysian Bar, 8 May. https://www.malaysianbar.org.my/article/news/press-statements/press-statements/press-release-rights-unseen-the-urgent-need-to-include-disability-in-malaysia-s-federal-constitution

Malaysian Employers Federation. 2022. Circular No: AG 16/2022 - Employment (Amendment of First Schedule) Order 2022. https://www.mpma.org.my/upload/CirAG2022_16.pdf.

Malaysian Population Research Hub. 2017. The Evolution of Gender Roles in Malaysia – Malaysia Population Research Hub. https://mprh.lppkn.gov.my/the-evolution-of-gender-roles-in-malaysia/

Malaysia. Employment (Amendment) Act 2022. Act A1651. Kuala Lumpur: Percetakan Nasional Malaysia Berhad, 2022.

Marzo, Roy Rillera, Mohamed ElSherif, Muhd Siv Azhar Merican Bin Abdullah, et al. 2022. "Demographic and Work-Related Factors Associated with Burnout, Resilience, and Quality of Life among Healthcare Workers during the COVID-19 Pandemic: A Cross Sectional Study from Malaysia." Frontiers in Public Health 10 (December). https://doi.org/10.3389/fpubh.2022.1021495.

Md Isa, F., Noor, S., Wei Wei, G., Syed Hussain, S. D. B., Mohamad Ibrahim, H., and Ahmdon, M. A. S. 2020. "Exploring the facet of elderly care centre in multiethnic Malaysia". PSU Research Review, 6(1), 17–38. https://doi.org/10.1108/PRR-05-2020-0013

Md Nadzri MN, Md Zamri ASS, Singh S, Sumarni MG, Lai CH, Tan CV, Aris T, Mohd Ibrahim H, Gill BS, Mohd Ghazali N, Md Iderus NH, Lim MC, Ahmad LCRQ, Kamarudin MK, Ahmad NAR, Tee KK, and Zulkifli AA. 2024. "Description of the COVID-19 epidemiology in Malaysia". Front Public Health: 10.3389/fpubh.2024.1289622. PMID: 38544725; PMCID: PMC10968133.

Millar, K. M. 2017. "Toward a critical politics of precarity". Sociology compass 11(6), e12483. https://doi.org/10.1111/soc4.12483

Ministry of Economy. 2025. RMK13 Buku Utama – Rancangan Malaysia Ketiga Belas (RMK13). https://rmk13.ekonomi.gov.my/rmk13-buku-utama/.

Ministry of Finance Malaysia. 2025. Budget 2026 Touchpoints. https://belanjawan.mof.gov.my/pdf/belanjawan2026/ucapan/touchpoint-budget-en.pdf.

Ministry of Finance Malaysia. 2024. Tax Measures in Budget 2025. Putrajaya: Ministry of Finance Malaysia, 2024. https://belanjawan.mof.gov.my/pdf/belanjawan2025/ucapan/tax-measure.pdf

Ministry of Health Malaysia. 2011. Kaedah Pelaksanaan Skim Perlindungan Insurans Kesihatan Pekerja Asing. Portal Rasmi Kementerian Kesihatan Malaysia, January 27. https://www.moh.gov.my/index.php/pages/view/369

Ministry of Health Malaysia. 2023. Human Resources for Health (HRH) Country Profiles: 2019 - 2021 Malaysia. Malaysia https://www.moh.gov.my/moh/resources/Penerbitan/HRH/HRH_COUNTRY_PROFILES_2019-2021_FINAL.pdf.

Ministry of Health (MOH) Singapore. 2023. Action Plan for Successful Ageing. Singapore: Ministry of Health. https://www.moh.gov.sg/others/resources-and-statistics/action-plan-for-successful-ageing/.

Ministry of Health (MOH) Singapore. 2022. Healthier SG White Paper. Singapore: Ministry of Health. https://www.moh.gov.sg/healthiersg.

Ministry of Women, Family and Community Development (MWFCD) and United Nations Development Programme (UNDP). 2014. Study to support the development of national policies and programmes to increase and retain the participation of women in the Malaysian Labour Force.

Ming, Toh Ee. 2023. "In Singapore and Hong Kong, Korean Dream Tempts Domestic Helpers." Al Jazeera, 5 July. https://www.aljazeera.com/economy/2023/7/5/singapore-and-hong-kongs-domestic-helpers-eye-korean-dream.

Moorthy, K., Salleh, N. M. Z. N., T'ing, L. C., Ling, L. P., Min Yeng, D., Jia Ning, L., and Pui Mun, L. 2022. "Gender inequality affecting women's career progression in Malaysia". Journal of International Women's Studies 23(1), 310-332.

Morikawa, Mie. 2014. "Towards Community-Based Integrated Care: Trends and Issues in Japan's Long-Term Care Policy." International Journal of Integrated Care 14: e005. https://doi.org/10.5334/ijic.1066.

Malaysia Trades Union Database. 2024. No More Excuse! LLRC & MTUC Sabah Demands Amendments of Sabah & Sarawak Labour Ordinance. 28 April. https://tradeunion.org.my/no-more-excuse-llrc-mtuc-sabah-demands-amendments-of-sabah-sarawak-labour-ordinance/.

MyGOV. n.d. "Registered Child Care Center." The Government of Malaysia's Official Portal. Accessed October 10, 2025. https://www.malaysia.gov.my/portal/content/31020.

National Disaster Management Agency. 2024a "NADMA Directive to Guide Disaster Management and Risk Reduction - Ahmad Zahid." October 4. https://www.nadma.gov.my/bi/media-en/news/1294-nadma-directive-to-guide-disaster-management-and-risk-reduction-ahmad-zahid.

National Disaster Management Agency. 2024b. Pelan Strategik NADMA 2024-2028. Putrajaya: NADMA. https://www.nadma.gov.my/images/2025/TerbitanDalaman/PELAN_STRATEGIK_NADMA_2024-2028.pdf.

National Union of Workers in Hospital Support and Allied Services (2025). 2022-2024: An Overview. Kuala Lumpur, Malaysia National Union of Workers in Hospital Support and Allied Services. Author.

Nakagawa, Takemi. 2025. "Japan to Let More Foreigners Provide In-Home Nursing Care - Nikkei Asia." Nikkei Asia, 14 March. https://asia.nikkei.com/spotlight/japan-immigration/japan-to-let-more-foreigners-provide-in-home-nursing-care.

Naseem, Sabahat, and Seema Munaf. 2020. "Resilience and Aggression of Adolescents, Early and Middle-Aged Adults: Analyzing Gender Differences." Pakistan Journal of Gender Studies 20, no. 1: 155–72. https://doi.org/10.46568/pjgs.v20i1.107.

New Straits Times (NST). 2024. "54 per cent of medical officers who left government service in 2022 joined private sector, statutory bodies - Dr Dzulkefly." New Straits Times, February 28. https://www.nst.com.my/news/nation/2024/02/1018847/54-cent-medical-officers-who-left-government-service-2022-joined-private

New Straits Times (NST). 2025. "Health: Strong Medicine Needed in Doctor Crisis." New Straits Times, April 2025. https://www.nst.com.my/lifestyle/heal/2025/04/1205495/health-strong-medicine-needed-doctor-crisis.

NHS England. 2023. NHS Long Term Workforce Plan. https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/.

NHS Forth Valley. n.d. "Physical Wellbeing." https://nhsforthvalley.com/health-services/az-of-services/mental-health-wellbeing/staff-support-and-wellbeing/physical-wellbeing/.

Nikore, Mitali, Vandhana Ramesh, and Brinda Juneja. 2025. "Building Nepal's Care Economy: Regional Insights and Strategic Framework for Development." Nepal Economic Forum, January 14. https://nepaleconomicforum.org/building-nepals-care-economy-regional-insights-and-strategic-framework-for-development/.

Nik Syuhailah Nik Hussin, Zuraimi Abdul Aziz, and Nurul Ashykin Abd Aziz. 2021. "The Childcare Centre Survival Covid 19 Pandemic." Paper presented at 4th International Virtual Conference on Economics, Entrepreneurship and Management. https://www.researchgate.net/publication/353428526_The_Childcare_Centre_Survival_Covid_19_Pandemic.

Noor, N. M., and Mahudin, N. D. M. 2016. "Work, family and women's well-being in Malaysia". In Handbook on well-being of working women, 717-734.

Nor Ain Mohamed Radhi. 2022. “Amendments to Employment Act Comes into Force Jan 1.” NST Online, 21 December. https://www.nst.com.my/news/nation/2022/12/863117/amendments-employment-act-comes-force-jan-1.

Ng, R., and Indran, N. 2021. “Societal Narratives on Caregivers in Asia”. International Journal of Environmental Research and Public Health, 15.

OECD. 2019a. “Enabling Women’s Economic Empowerment: New Approaches to Unpaid Care Work in Developing Countries”. OECD. https://doi.org/10.1787/ec90d1b1-en

OECD. 2019b. “How can social protection address women’s unpaid care work?” In OECD, Enabling Women’s Economic Empowerment. OECD. https://doi.org/10.1787/c8eb9246-en

Onaran, Özlem, and Cem Oyvat. 2023. The Employment Effects of Public Spending in Infrastructure, the Care Economy and the Green Economy: The Case of Emerging Economies. https://www.ituc-csi.org/IMG/pdf/public_spending_infrastructure_en_v2.pdf?29413/c59b2627ea94f5fabd65e3998cc93123a94caef9712af1cb2a8ca612726e6880.

Pacheco, Tyler, Simon Coulombe, Christine Khalil, Sophie Meunier, Marina Doucerain, Émilie Auger, and Emily Cox. 2020. “Job Security and the Promotion of Workers’ Wellbeing in the Midst of the COVID-19 Pandemic: A Study with Canadian Workers One to Two Weeks after the Initiation of Social Distancing Measures”. International Journal of Wellbeing 10 (3). https://internationaljournalofwellbeing.org/index.php/ijow/article/view/1321.

Papathanasiou IV. 2015. Work-related Mental Consequences: Implications of Burnout on Mental Health Status Among Health Care Providers. Acta Inform Med. 2015 Feb;23(1):22-8. doi: 10.5455/aim.2015.23.22-28. Epub 2015 Feb 22. PMID: 25870487; PMCID: PMC4384854.

Parliament of Malaysia. 2021. Prevention and Control of Infectious Diseases (Amendment) Act 2021. https://www.cljlaw.com/files/bills/pdf/2021/MY_FS_BIL_2021_20.pdf.

Park, Jungsun, Boyoung Han, and Yangho Kim. 2018. “Association of Job Satisfaction and Security With Subjective Health and Well-Being in Korean Employees.” Journal of Occupational & Environmental Medicine 60 (10). https://doi.org/10.1097/jom.0000000000001418.

Peng, Ito. 2019. The Care Economy: A New Research Framework. (LIEPP Working paper No. 89) Sciences Po.

Pertubuhan Keselamatan Sosial (PERKESO). 2023. Housewives’ Social Security Scheme (SKSSR). https://www.perkeso.gov.my/en/our-services/protection/housewife.html

Pillay, Sharayu. 2024. “After 14 Years as a Nurse, My Basic Salary Is Still RM2,600.” CodeBlue, January 15. https://codeblue.galencentre.org/2024/01/after-14-years-as-a-nurse-my-basic-salary-is-still-rm2600/..

Putri, N.K., Melania, M.K.N., Fatmawati, S.M.Y. et al. 2023. “How does the work-life balance impact stress on primary healthcare workers during the COVID-19 pandemic?”. BMC Health Serv Res 23, 730 (2023). https://doi.org/10.1186/s12913-023-09677-0

Qin, T. Y., & Md Nor, M. 2018. “Exploring Issues on Teaching and Learning in Malaysian Private Preschools.” 6(2), 67–82. https://doi.org/10.22452/mojem.vol6no2.4.

Rahim, N. B., Osman, I., & Arumugam, P. V. 2019. “Evaluating Work-Life Balance and Individual Well-Being with the Moderating Role of Organisational Climate”. Pertanika Journal of Social Sciences and Humanities, 27, 2731-2752.

Ragananthini Vethasalam. 2025. “Dzulkefly Hints at Ending Contract Doctor System.” The Star, August 8. https://www.thestar.com.my/news/nation/2025/08/08/dzulkefly-hints-at-ending-contract-doctor-system.

Ragu, Dineskumar. 2023. “Indonesian Maids in the Dark over Their Rights, Says Advocacy Group.” Free Malaysia Today | FMT, 21 January. https://www.freemalaysiatoday.com/category/nation/2023/01/21/indonesian-maids-in-the-dark-over-their-rights-says-advocacy-group.

Rajan D, Koch K, Rohrer K, Bajnoczki C, Socha A, Voss M, et al. 2020. “Governance of the Covid-19 response: a call for more inclusive and transparent decision-making”. BMJ Global Health.

Ramakrishnan. 2024. “Bridging childcare training gap”. New Straits Times, 14 August. https://www.nst.com.my/opinion/letters/2024/08/1091662/bridging-childcare-training-gap

Rasiah, R., Noh, A., and Tumin, M. 2009. "Privatising healthcare in Malaysia: Power, policy and profits". Journal of Contemporary Asia, 39, 50–62. https://doi.org/10.1080/00472330802506790

Rodzi, Nadirah H. 2021. "Malaysians Launch White Flag Campaign to Signal Distress without Begging." The Straits Times, June 30. https://www.straitstimes.com/asia/se-asia/malaysians-launch-white-flag-campaign-to-signal-distress-without-begging.

Rösner, Christoph, Elmar Brähler, Cedric Sachser, Vera Clemens, and Katja Petrowski. 2024. "New Norm Values of the Brief Resilience Scale (BRS) from the German General Population with New Post-Covid-19 Data." BMC Psychology 12, no. 1 (September 27, 2024): 1–11. https://doi.org/10.1186/s40359-024-01995-0.

Sabapatty, Kumara. 2020. "Wan Azizah Mahu Warga Kerja JKM Juga Diberikan Elaun Khas Prihatin." MalaysiaGazette, 28 March. https://malaysiagazette.com/2020/03/28/wan-azizah-mahu-warga-kerja-jkm-juga-diberikan-elaun-khas-prihatin/.

Safeek Affendy Razali. 2023. "Baby Dies after Doctor Mum Leaves Her in Hospital Car Park for 10 Hours." New Straits Times, October 6. https://www.nst.com.my/news/nation/2023/10/963670/baby-dies-after-doctor-mum-leaves-her-hospital-car-park-10-hours.

Samsudin, I. L., Ariffin, S. I., & Sapri, M. 2022. Intergenerational Program And Care: Analysis Of Malaysia Intergenerational Modules, Policies And Guidelines. International Journal of Law, Government and Communication, 7 (27), 13-25.

Sahimi, H. M. S., Mohd Daud, T. I., Chan, L. F., Shah, S. A., Rahman, F. H. A., and Nik Jaafar, N. R. 2021. "Depression and Suicidal Ideation in a Sample of Malaysian Healthcare Workers: A Preliminary Study During the COVID-19 Pandemic". Frontiers in Psychiatry, 12, 658174. https://doi.org/10.3389/fpsyt.2021.658174

Salazar de Pablo, Gonzalo, Julio Vaquerizo-Serrano, Ana Catalan, Celso Arango, Carmen Moreno, Francisco Ferre, Jae Il Shin, et al. 2020. "Impact of Coronavirus Syndromes on Physical and Mental Health of Health Care Workers: Systematic Review and Meta-Analysis". Journal of Affective Disorders 275 (October):48–57. https://doi.org/10.1016/j.jad.2020.06.022.

Salim, Norsalina & Anuar, Herman. 2023. "Exploring the Role of the Department of Social Welfare Malaysia in Enhancing the Efficiency of Productive Welfare". International Journal of Entrepreneurship and Management Practices. Vol. 6 (23). https://gaexcellence.com/ijemp/article/view/3935

Salleh, S. N. S., and Mansor, N. 2022. Women and Labour Force Participation in Malaysia 7(7), 9.

Scott, H., Fokkens, T., Ray, M., and Roe, L. 2020. "Young and young adult caregivers of older relatives: a systematic review". BMC Geriatrics 20(1), 169. https://doi.org/10.1186/s12877-020-01976-z

Seedat, S., & Rondon, M. 2021. "Women's wellbeing and the burden of unpaid work". BMJ, n1972. https://doi.org/10.1136/bmj.n1972

Senreich, Evan, Straussner, Shulamith Lala Ashenberg, and Jeffrey and Steen. 2020. "The Work Experiences of Social Workers: Factors Impacting Compassion Satisfaction and Workplace Stress". Journal of Social Service Research 46 (1): 93–109. https://doi.org/10.1080/01488376.2018.1528491.

Seligman, Martin E. P. 2011. Flourish: A Visionary New Understanding of Happiness and Well-Being. Simon and Schuster.

Shin, K.Y., A. L. Kalleberg, and K. Hewison. 2023. "Precarious Work: A Global Perspective," Sociology Compass 17, no. 12 (2023): e13136.

Shuhaimi, Noorhaizah Ahmad, Amna Md Noor, Wan Munira Wan Jaafar, and Azlina Mohd Khir. 2025. "The Influence of Trust and Job Satisfaction on Structural Empowerment and Social Work Competency." Journal of Human Behavior in the Social Environment, January, 1–23. doi:10.1080/10911359.2025.2457963.

Skills for Care. 2024. A Workforce Strategy for Adult Social Care in England. Leeds: Skills for Care. https://www.skillsforcare.org.uk/Workforce-Strategy/resources/Supporting-resources/A-Workforce-Strategy-for-Adult-Social-Care-in-England.pdf.

SkillsFuture Singapore (SSG). 2024a. Skills Framework for Healthcare. Singapore: SkillsFuture Singapore. https://www.skillsfuture.gov.sg/skills-framework/healthcare.

SkillsFuture Singapore (SSG). 2024b. Skills Framework for Social Service. Singapore: SkillsFuture Singapore. https://www.skillsfuture.gov.sg/skills-framework/socialservice.

Silvey, R., and Parreñas, R. 2020. "Precarity chains: Cycles of domestic worker migration from Southeast Asia to the Middle East". Journal of Ethnic and Migration Studies, 46(16), 3457–3471. https://doi.org/10.1080/1369183X.2019.1592398

Singh Toor, Amardeep, and Jihan Azman. 2025. "Malaysia's Approach to Bully-Proofing the Workplace with Employer Duties and Legal Risks." Wolters Kluwer, July 25. https://www.wolterskluwer.com/en-my/expert-insights/malaysias-approach-to-bully-proofing-the-workplace-with-employer-duties-and-legal-risks.

SIS Forum. 2025. Hak Kewangan Wanita Muslim Berpendapatan Rendah Dalam Sistem Perundangan Keluarga Islam Di Selangor Dan Wilayah Persekutuan. Petaling Jaya: Sisters in Islam. https://sistersinislam.org/wp-content/uploads/2025/02/Hak-Kewangan-Wanita-Muslim-Berpendapatan-Rendah-Dalam-Sistem-Perundangan-Keluarga-Islam-di-Selangor-dan-Wilayah-Persekutuan.pdf.

Small, S. F., and van der Meulen Rodgers, Y. 2023. "The gendered effects of investing in physical and social infrastructure". World Development, 171, 106347. https://doi.org/10.1016/j.worlddev.2023.106347

Smith, Bruce W., Jeanne Dalen, Kathryn Wiggins, Erin Tooley, Paulette Christopher, and John Bernard. 2008. "The Brief Resilience Scale: Assessing the Ability to Bounce Back." International Journal of Behavioral Medicine 15, no. 3 (2008): 194–200. https://doi.org/10.1080/10705500802222972.

Smith JL, Hollinger-Smith L. 2015. "Savoring, resilience, and psychological well-being in older adults". Aging Ment Health 19(3):192-200. doi: 10.1080/13607863.2014.986647. Epub 2014 Dec 4. PMID: 25471325.

Smock, Pamela J., Wendy D. Manning, and Sanjiv Gupta. 1999. "The Effect of Marriage and Divorce on Women's Economic Well-Being." American Sociological Review 64, no. 6: 794–812. https://doi.org/10.1177/000312249906400602.

Spitzer, D. L. 2005. "Engendering health disparities". Canadian Journal of Public Health = Revue Canadienne De Sante Publique, 96 Suppl 2(Suppl 2), S78-96. https://doi.org/10.1007/BF03403704

Spitzer D.L. 2011. "Work, Worries, and Weariness: Towards an Embodied and Engendered Migrant Health". In Engendering Migrant Health: Canadian Perspectives. Edited by DL Spitzer. University of Toronto Press.

Spitzer, D. L. 2020. "Precarious Lives, Fertile Resistance: Migrant Domestic Workers, Gender, Citizenship, and Well-Being". In Gendering Globalization, Globalizing Gender. Edited by G. Çalışkan. Oxford: Oxford University Press.

Spitzer, D. L., Thambiah, S., Wong, Y. L., and Kaundan, M. K. 2023. "Globalization and the health and well-being of migrant domestic workers in Malaysia". Globalization and Health, 19(1), 29. https://doi.org/10.1186/s12992-023-00925-w

Spitzer D.L., and Torres, S. 2023. "Migrant Family Separation, Reunification, and Recalibration." In Handbook of Migration and the Family, edited by J. Waters and B. Yeoh. London: Edward Elgar. Pp. 366-384.

Sternkopf, Mette. 2024. "The Introduction of the National Care System in Uruguay: A Case of Policy Innovation and Institutionalization." Policy Sciences 57, no. 3: 421–40. https://link.springer.com/article/10.1007/s11077-024-09543-8.

Suruhanjaya Hak Asasi Manusia Malaysia (SUHAKAM). 2017. "Fix Shortcomings in Person With Disabilities Act Immediately." Letters. Malaysiakini, 3 December. https://www.malaysiakini.com/letters/404198.

Suruhanjaya Perkhidmatan Awam Malaysia (Public Service Commission Malaysia). 2016. "Syarat Permohonan Ijazah Sarjana Muda, Sarjana, Doktor Falsafah – Pegawai Pembangunan Masyarakat Gred S9." SPA Malaysia. https://www.spa.gov.my/informasi/syarat-permohonan/ijazah-sarjana-muda-sarjana-doktor-falsafah/pegawai-pembangunan-masyarakat-gred-s9

Szczepura, Ala, Harue Masaki, Deidre Wild, Toshio Nomura, Mark Collinson, and Rosie Kneafsey. 2023. "Integrated Long-Term Care 'Neighbourhoods' to Support Older Populations: Evolving Strategies in Japan and England." International Journal of Environmental Research and Public Health 20(14), 6352. https://doi.org/10.3390/ijerph20146352.

Tabur, Ayhan, Safa Elkefi, Abdurrahim Emhan, Cengiz Mengenci, Yasin Bez, and Onur Asan. 2022. "Anxiety, Burnout and Depression, Psychological Well-Being as Predictor of Healthcare Professionals' Turnover during the COVID-19 Pandemic: Study in a Pandemic Hospital" Healthcare 10, no. 3: 525. https://doi.org/10.3390/healthcare10030525

Talenox. 2023. "What is SOCSO?" Talenox Knowledge Centre. https://help.talenox.com/en/articles/2488112-what-is-socso

Tan, Joycelyn. 2021. "COVID-19 Made Elderly Care a Whole Lot Harder, but Caregivers in M'sia Are Persisting." Vulcan Post, June 9. https://vulcanpost.com/748467/elderly-care-services-malaysia-business-covid-19/.

Tayah, M.J. 2016. Decent Work for Migrant Domestic Workers: Moving the Agenda Forward. Geneva: ILO.

Thambiah, S., and Tan, B. 2018. “Globalization and Increased Informalization of Labor: Women in the Informal Economy in Malaysia”. Women of Asia. Routledge.

The Asia Foundation. 2022. Towards A Resilient Care Ecosystem In Asia And The Pacific: Promising Practices, Lessons Learned, And Pathways For Action On Decent Care Work. San Francisco: The Asia Foundation. https://asiafoundation.org/wp-content/uploads/2024/08/Towards-A-Resilient-Care-Ecosystem-in-Asia-and-the-Pacific.pdf.

The Edge. 2024. “Frankly Speaking: Pensions Are Not Sustainable and That Is the Truth.” The Edge Malaysia. https://theedgemalaysia.com/node/698866.

The Edge Communications. 2025. “Parliament Approves Mandatory EPF Contribution for Foreign Workers.” The Edge Malaysia. https://theedgemalaysia.com/node/747048.

The King’s Fund. 2022. “The Health And Care Act: Six Key Questions.” May 16. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-and-care-act-key-questions.

The Straits Times. 2024. “Community Care Career Track Rolled Out for Singapore Eldercare Sector.” October 2. Singapore. https://www.straitstimes.com/singapore/community-care-career-track-rolled-out-for-eldercare-sector.

Thoits, P. 1995. “Stress, Coping and Social Support Processes: Where Are We? What Next?” Journal of Health and Social Behaviour 35(extra): 53-79

TENAGANITA. 2023. “The Unrecognised: Realities of Domestic Workers in Malaysia”. Subang Jaya: PIE Bersatu Maju.

Tonkin, K., Malinen, S., Näswall, K., and Kuntz, J. C. 2018. “Building employee resilience through wellbeing in organisations”. Human Resource Development Quarterly, 29(2), 107–124. doi:10.1002/hrdq.21306

Tov, W. 2018. “Well-being concepts and components”. In the Handbook of well-being edited by E. Diener, S. Oishi, and L. Tay. Salt Lake City, UT: DEF Publishers.

Ungar, M. 2018. “Systemic resilience: principles and processes for a science of change in contexts of adversity”. Ecology and Society 23(4):34. https://doi.org/10.5751/ES-10385-230434

United Nations (UN). 2024. Transforming Care Systems in the Context of the Sustainable Development Goals and Our Common Agenda. UN System Policy Paper. https://unsdg.un.org/sites/default/files/2024-07/FINAL_UN%20System%20Care%20Policy%20Paper_24June2024.pdf

United Nations Children’s Fund Malaysia and the United Nations Population Fund (UNICEF). 2021. Families on the Edge.

United Nations Development Programme (UNDP). 2020. “Care Work in the Time of COVID-19: Women’s Unpaid Care Burden in Four Charts.” https://www.undp.org/malaysia/blog/care-work-time-covid-19-womens-unpaid-care-burden-four-charts.

United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP). 2021. COVID-19 and the Unpaid Care Economy in Asia and the Pacific.

United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP). 2022. How to Invest in the Care Economy: A Primer.

United Nations Network on Migration. 2024. “Social Security Extended for Migrant Domestic Workers in Malaysia.” United Nations Network on Migration. https://migrationnetwork.un.org/practice/social-security-extended-migrant-domestic-workers-malaysia.

United Nations Population Fund (UNFPA). 2023. Gender-Transformative Approaches to Achieve Gender Equality and Sexual and Reproductive Health and Rights: Technical Note. Mexico City: UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_GTA-2023.pdf

UN Women. 2019. National Integrated Care System in Uruguay (SNIC): Towards a Society of Care. Latin America and the Caribbean Regional Office. https://lac.unwomen.org/sites/default/files/Field%20Office%20Americas/Documentos/Publicaciones/2019/10/SNIC%20web%20INGLES.pdf.

UN Women. 2023a. Pathways Towards Decent Work in the Digitally Enabled Care Economy in Southeast Asia. https://asiapacific.unwomen.org/en/digital-library/publications/2023/09/pathways-towards-decent-work.

UN Women. 2023b. Toolkit – Recognizing, Reducing and Redistributing Unpaid Care Work: Selected Case Studies to Support Reform in West and Central Africa. https://africa.unwomen.org/en/digital-library/publications/2023/08/toolkit-recognizing-reducing-and-redistributing-unpaid-care-work-selected-case-studies-to-support-reform-in-west-and-central-africa.

UN Women. 2024. “Nepal Establishes a ‘Care Working Group’ to Advance the Care Economy.” January 29. https://asiapacific.unwomen.org/en/stories/news/2024/02/nepal-estalishes-a-care-working-group.

UN Women and International Labour Organization. 2021. A guide to public investments in the care economy: Policy support tool for estimating care deficits, investment costs, and economic returns. New York: UN Women and ILO. https://www.unwomen.org/en/digital-library/publications/2021/04/ policy-tool-care-economy

Waters, M. A., and Bardoel, E. A. 2006. “Work–family policies in the context of higher education: Useful or symbolic?” Asia Pacific Journal of Human Resources, 44(1): 67-82.https://doi.org/10.1177/1038411106061510

Wang, H., Jin, Y., Wang, D., Zhao, S., Sang, X., and Yuan, B. 2020. “Job satisfaction, burnout, and turnover intention among primary care providers in rural China: results from structural equation modeling”. BMC family practice 21, 1-10.

Weale, Victoria, Jodi Oakman, and Yvonne Wells. 2020. “Can Organisational Work–Life Policies Improve Work–Life Interaction? A Scoping Review”. Australian Psychologist 55 (5): 425–39.

Wei, H., Sewell, K. A., Woody, G., and Rose, M. A. 2018. “The state of the science of nurse work environments in the United States: A systematic review”. International Journal of Nursing Sciences 5(3), 287–300.

Wenham, Clare, Julia Smith, and Rosemary Morgan. 2020. “COVID-19: The Gendered Impacts of the Outbreak.” The Lancet 395 (2020): 846–848. https://doi.org/10.1016/S0140-6736(20)30526-2

Wilkinson, Richard G., Michael G. Marmot, and Weltgesundheitsorganisation. 2023. Social Determinants of Health: The Solid Facts. 2nd. ed. Copenhagen: WHO Regional Office for Europe.

Windle, Gill. 2011 “What Is Resilience? A Review and Concept Analysis.” Reviews in Clinical Gerontology 21(2): 152–69. https://doi.org/10.1017/S0959259810000420.

Withers, Matt, and Elizabeth Hill. 2023. “Migration and Development Without Care? Locating Transnational Care Practices in the Migration-Development Nexus.” Population, Space, and Place 29 (e2648): 1-12. https://doi.org/10.1002/psp.2648

Women’s Aid Organisation. 2024. Single Mothers’ Experiences during COVID-19 in Malaysia: A Data Snapshot. Data Snapshot. Women’s Aid Organisation. https://wao.org.my/wp-content/uploads/2024/12/Single-Mothers-Data-Snapshot-FINAL.pdf.

Wong, A., Yoong, R., and Kheng, S. K. 2021. Stethoscope: Making the care economy equitable, sustainable and visible. The Edge Malaysia. https://theedgemalaysia.com/article/stethoscope-making-care-economy-equitable-sustainable-and-visible

Wong, Eliza Lai-yi, Hong Qiu, Wai Tong Chien, Cho Lee Wong, Hom Nath Chalise, Huong Thi Xuan Hoang, Hong Trang Nguyen, et al. 2022. “Comparison of Resilience Among Healthcare Workers During the COVID-19 Pandemics: A Multinational Cross-Sectional Survey in Southeast Asian Jurisdictions”. International Journal of Public Health 67 (December):1605505. https://doi.org/10.3389/ijph.2022.1605505.

Wong and Partners. 2022. Employment (Amendment) Bill 2021: Key amendments to the Employment Act 1955. Accessed June 10, 2025 https://insightplus.bakermckenzie.com/bm/attachment_

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