Growing the economy and meeting the care needs of the Malaysian society

REPORT

24 - 25 September 2024
ISIS Malaysia

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Agenda

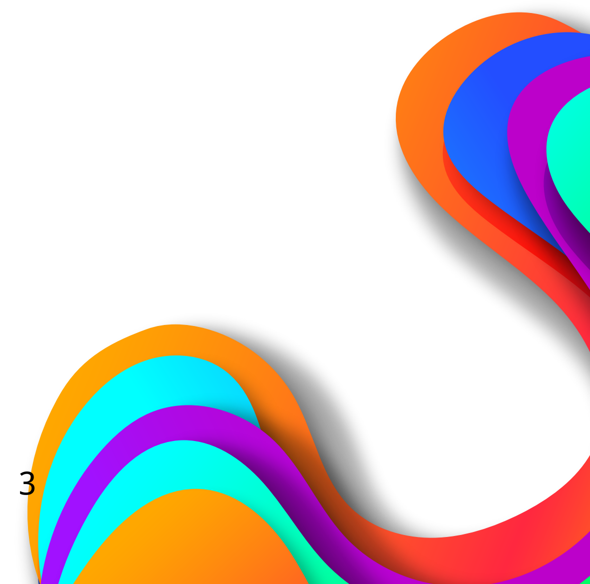
DAY ONE 24 September 2024, Tuesday

0830-0915 hrs	Registration
0915-0930 hrs	**Opening address** **Datuk Prof Dr Mohd Faiz Abdullah** Chairman ISIS Malaysia **Welcoming remarks** **Prof Datuk Dr Denison Jayasooria** Senior Visiting Fellow ISIS Malaysia
0930-1100 hrs	**SESSION 1: Policy papers, initiatives, legislations and regulations in Malaysia** Paper presenter: **Prof Datuk Dr Denison Jayasooria** (ISIS Malaysia)
1100-1230 hrs	**SESSION 2: Issues in governance: Federal-state relations, public, private and voluntary sectors, urban-rural divide and lessons from the Global South** Paper presenters: **Dr Teo Sue Ann** and **Dr Khairil Ahmad** (MySDG Centre for Social Inclusion, Society for the Promotion of SDGs)
1230-1400 hrs	LUNCH
1400-1530 hrs	**SESSION 3: Older persons** Paper presenters: **Chai Sen Tyng** and **Assoc Prof Dr Rahimah Ibrahim** (MyAgeing, UPM)
1530-1700 hrs	**SESSION 4: Persons with disabilities - Program Pemulihan Dalam Komuniti (PDK)** Paper presenters: **Sapura Arshad** (PPDK Sungai Buloh), **Haji Mohd Fouzi Haji Mohd Isa** (PPDK Kuala Klawang) and **Lydia Ann Bill** (APPGM-SDG)
1700-1715 hrs	Concluding reflections **Prof Datuk Dr Denison Jayasooria**

Agenda

DAY TWO 25 September 2024, Wednesday

0830-0915 hrs	Registration
0915-0930 hrs	**Welcoming remarks** **Prof Datuk Dr Denison Jayasooria**
0930-1100 hrs	**SESSION 5: Children in need** Paper presenters: **Anisa Ahmad** (House of Wisdom PLT) and **Debbie Ann Loh** (APPGM-SDG)
1100-1230 hrs	**SESSION 6: People with mental health concerns** Paper presenter: **Prof Dato' Dr Andrew M Chandrasekaran** (Malaysian Mental Health Association)
1230-1400 hrs	LUNCH
1400-1530 hrs	**SESSION 7: Professional standards and training for the social care industry** Paper presenter: **Dr Teoh Ai Hua** (UUM & MASW)
1530-1700 hrs	**SESSION 8: Care economy as a growth sector** Paper presenter: **Dr Teo Lee Ken** (MySDG Centre for Social Inclusion, Society for the Promotion of SDGs)
1700-1715 hrs	Concluding reflections **Prof Datuk Dr Denison Jayasooria**



SUMMARY

Growing the economy and meeting the care needs of the Malaysian society
24-25 September 2024 | ISIS Malaysia

Malaysia is faced with two critical demographic challenges – an ageing population and a declining birth rate. Amid the shifting demographic patterns, vulnerable groups, including children in need, persons with disabilities and individuals battling mental health issues are often left behind in the shadows. This two-day conference, *Growing the economy and meeting the care needs of the Malaysian society* held from 24 – 25 September 2024 at ISIS Malaysia, aimed to take stock of the diverse needs, progress, challenges, gaps and opportunities unique to caring for specific target groups, and the enablers within the care economy ecosystem.

Datuk Denison Jayasooria as Senior Visiting Fellow at ISIS Malaysia convened paper presenters and discussants comprising representatives from government ministries, academia, NGOs and think tanks in this series of 8 paper discussions.

In Session 1, Datuk Denison Jayasooria presented on policy papers, initiatives, legislations and regulations in Malaysia to provide an overview of the care economy landscape in Malaysia. He was joined by two discussants, Prof Datuk Dr Norma Mansor (Social Wellbeing Research Centre, Universiti Malaya) and Puan Fatimah Zuraidah Hj Salleh (*Bahagian Kolaborasi Strategik, Kementerian Pembangunan Wanita, Keluarga dan Masyarakat*). The first two sessions were moderated by Harris Zainul (ISIS Malaysia).

In Session 2, Dr Teo Sue Ann and Dr Khairil Ahmad (Society for the Promotion of Sustainable Development Goals) presented on lessons from the global South with a review of the care economy in Malaysia. They highlighted the ground realities of the care sector in Malaysia and drew lessons from Brazil, Cuba and Indonesia. Pn Masneh Abd Ghani (Institute for Development Studies (IDS) Sabah) and Dr Yuen Kok Leong (Sarawak Development Institute) enriched the discussion through their perspectives from East Malaysia.

Session 3 featured a presentation on care economy and older persons in Malaysia: long-term care in an ageing society by Assoc Prof Dr Rahimah Ibrahim and Mr Chai Sen Tyng from the Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia. Prof Dr Tan Maw Pin, a consultant geriatrician at the Faculty of Medicine, Universiti Malaya and Mr Jeffrey Phang, Adjunct Professor, UNITAR joined as Discussants. This third and fourth session was moderated by Dr Diana Katiman, (IKRAM; Hospital Al-Sultan Abdullah UiTM).

Session 4 focused on Persons with disabilities - Program Pemulihan Dalam Komuniti (PDK) whereby Pn Sapura Arshad (PPDK Sg Buloh, Selangor) and En Haji Mohd Fouzi Haji Mohd Isa (PPDK Kuala Klawang, Jelebu) shared about the services provided, needs and challenges, initiatives and suggestions to improve PDKs. Ms Lydia Ann Bill (APPGM-SDG) presented on the challenges faced by PDK workers including the need for professional development and training for PDK workers and the struggle of the East Malaysian PDKs. Pn Emilia Syatirah Derahim from Jabatan Pembangunan Orang Kurang Upaya (JPOKU), KPWKM and Dato' Ghazali Yusoff, Former National Chairman, PDK Kebangsaan shared their perspectives as discussants.

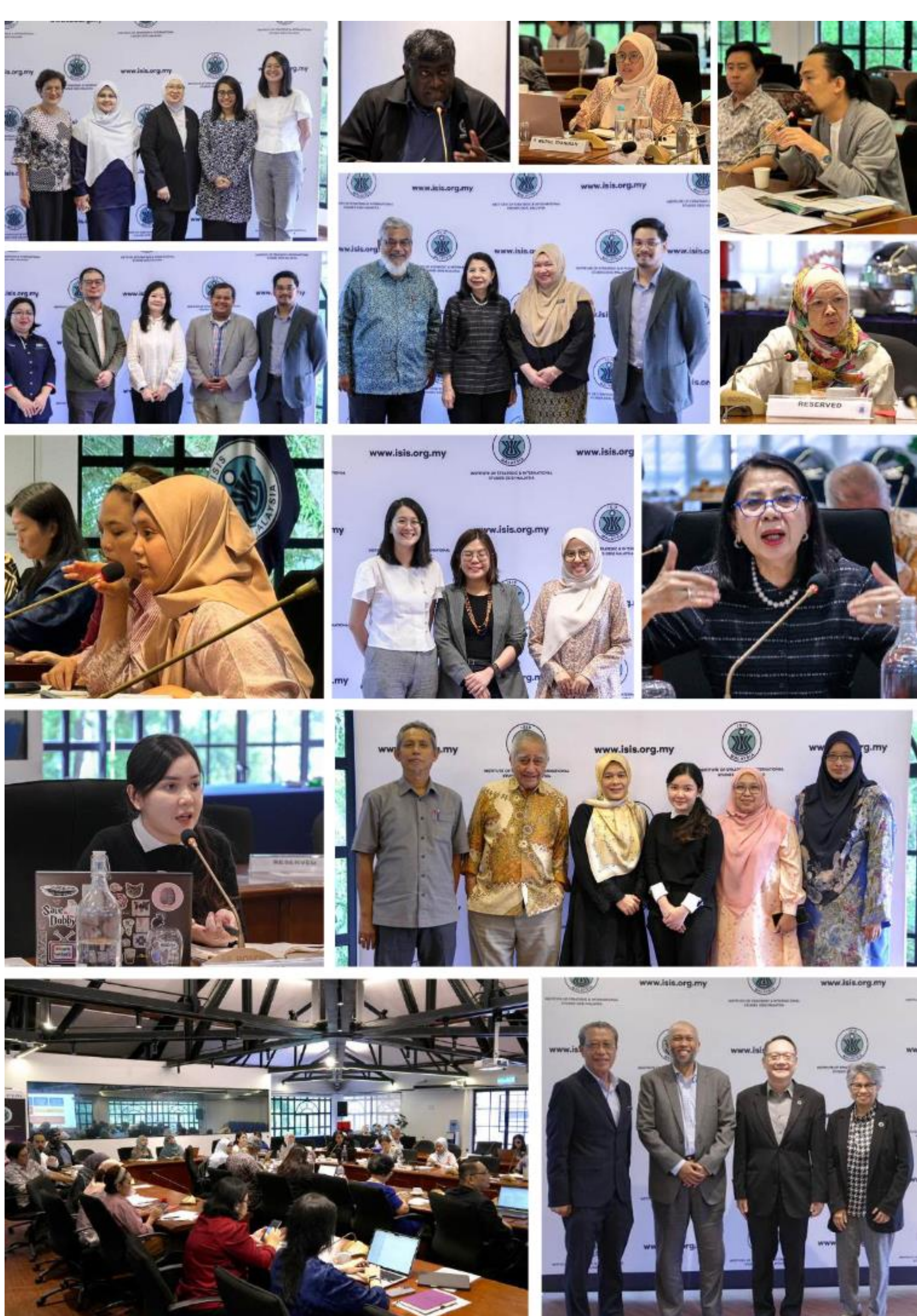
In Session 5, Pn Anisa Ahmad (House of Wisdom PLT) and Ms Debbie Ann Loh (APPGM-SDG) presented on children in need, with a focus on education, health and child protection. Datin Wong Poai Hong (Childline Foundation) and Assoc Prof Dr Mazlina Che Mustafa (National Child Development Research Centre (NCDRC), Universiti Pendidikan Sultan Idris (UPSI)) shared valuable insights. The fifth and sixth session was moderated by Yvonne Tan (ISIS Malaysia).

Session 6 presented the opportunity to hear from Ms Laura Kho (Mental Health Association of Sarawak), a trained pharmacist experienced in psychiatry medicine and qualified in global mental health. She highlighted the need to harmonise legalisations with the Convention on the Rights of Persons with Disabilities, the importance of normalising and integrating mental health and physical health, and destigmatising those with mental health conditions. She stressed that mental health is symptomatic, identifying and addressing the root causes of mental health issues including poverty, job security and broken family relationships are crucial. Ms Nurul Syahirah Abd Aziz, a development psychologist, also shared about the challenges of limited funding, the absence of an act for psychologists, the danger of unregulated pseudo-psychology, distinguishing between mental health disorders and mental health illnesses and the lack of mental health specialists in the nation, which now stands at 10 times below the WHO recommendation of 1 psychiatrist per 10,000 individuals in the population.

During Session 7, Dr Teoh Ai Hua (President, Malaysian Association of Social Workers (MASW); Senior Lecturer, School of Applied Psychology, Social Work and Policy, Universiti Utara Malaysia) presented on the professional standards and trainings for the social care industry. Ir. Ts. Dr. Azmi bin Ahmad (Deputy Director General, Skills Development Division, Ministry of Human Resources) and Prof Dato' Dr Rashila Ramli (Principal Visiting Fellow, United Nations University International Institute for Global Health (UNU-IIGH)) joined the panel to share their perspectives and review of the paper. This final two sessions were moderated by En Rashidi Yahaya (SETERRA Group of Companies and Kendana Malaysia).

In the final session, Dr Teo Lee Ken (Society for the Promotion of Sustainable Development Goals) presented on care economy as a growth sector, highlighting care growth as social growth and development, and proposed approaches and strategies moving forward. Pn Shakira Teh Sharifuddin (Senior Economist, Social Protection and Labor, World Bank Inclusive Growth and Sustainable Finance Hub) and Pn Hawati Abdul Hamid (Director of Research, Khazanah Research Institute) shared their insights and input as discussants.

In conclusion, this conference provided an insightful exploration of the care economy in Malaysia, bringing together experts from various sectors to address the evolving care needs of the society. The critical role of the care sector in fostering social well-being and national economic growth was evident in the discussions. The contributions from various stakeholders emphasised the need for integrated approaches, professional development and stronger collaborations across sectors. As Malaysia continues to confront the challenges of an ageing population and growing social needs, the papers presented and discussions initiated at this conference will serve an input into an upcoming book on care economy. It is hoped that the book will contribute towards future policies, economic growth and strategies to provide better and equitable care for all, policy and practice.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Overview

<table>
<tr><th>No.</th><th>Criteria</th><th>Description</th></tr>
<tr><td>1</td><td>Objectives</td><td>1. To provide a critical review of all the work undertaken namely policy papers, studies, and reports on the care economy in Malaysia and to chart a policy framework for the promotion of a more professional approach to care services in Malaysia.

2. To chart strategies in shifting from an informal approach of care services to the flourishing of a new economic growth industry fostering investments and job creation.

3. To promote multi stakeholder partnerships and engagements for the social care services and industry in Malaysia especially in clearly defining the roles of the government, private sector, the voluntary and informal sectors.</td></tr>
<tr><td>2</td><td>Format</td><td>A series of 8 sessions of paper presentations with input from two discussants each</td></tr>
<tr><td>3</td><td>Role Players</td><td>▪ 12 Presenters
ISIS Malaysia, Society for the Promotion of SDGs, Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia, PPDK Sungai Buloh, Selangor, PPDK Kuala Klawang, Jelebu, APPGM-SDG, House of Wisdom PLT, Malaysian Association of Social Workers (MASW); Universiti Utara Malaysia

▪ 16 Discussants
University of Malaya, Ministry of Women, Family and Community Development (KPWKM), Institute for Development Studies Sabah, Sarawak Development Institute, UNITAR, Malaysian CSO-SDG Alliance, PDK Kebangsaan, Childline Foundation, Universiti Pendidikan Sultan Idris (UPSI), Mental Health Association of Sarawak (MHAS), Persatuan Psikologi Malaysia (PSIMA) , Ministry of Human Resources, United Nations University International Institute for Global Health (UNU-IIGH), World Bank Inclusive Growth and Sustainable Finance Hub, Khazanah Research Institute

▪ 4 Moderators
ISIS Malaysia, Pertubuhan IKRAM Malaysia, Hospital Al- Sultan Abdullah UiTM, SETERRA Group of Companies, Kendana Malaysia</td></tr>
</table>

4	**Representation**	Representatives were from across government, think tanks / research institutions, civil society, academia and private sectors.

Sector	Presenters	Discussants	Participants	Total
Ministry / Government agencies	-	Ministry of Women, Family and Community Development - Strategic Collaboration Division - Jabatan Pembangunan OKU - PDK Kebangsaan Ministry of Human Resources - Skills Development Division	Ministry of Women, Family and Community Development - Policy Unit, OKU Ministry of Human Resources - Skills Development Division Ministry of Health (2)	**8**
Think tanks / Research institutions	ISIS Malaysia	Institute for Development Studies Sabah, Sarawak Development Institute, World Bank Inclusive Growth and Sustainable Finance Hub, Khazanah Research Institute	Khazanah Research Institute (2)	**7**
CSOs / NGOs	Society for the Promotion of SDGs (3), PPDK Sungai Buloh, Selangor, PPDK Kuala Klawang, Jelebu, APPGM-SDG (2), Malaysian Association of Social Workers (MASW)	Malaysian CSO-SDG Alliance, Childline Foundation, Mental Health Association of Sarawak (MHAS), Persatuan Psikologi Malaysia (PSIMA)	Women's Aid Organisation, Malaysian Association of Social Workers (MASW) (2), Malaysia Rare Disorders Society, APPGM-SDG (7), AWAM, Malaysian Care (2), Majlis Pusat Kebajikan Semalaysia (MPKSM) (2), Pertubuhan IKRAM Malaysia, Toy Library	**30**
Academia	Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia (2), Universiti Utara Malaysia	University of Malaya (2), UNITAR, Universiti Pendidikan Sultan Idris (UPSI), United Nations University International Institute for Global Health (UNU-IIGH)	Universiti Kebangsaan Malaysia (UKM), Multimedia University (MMU)	**10**
Private sector	House of Wisdom PLT	-	ENGENDER Consultancy, Pusat Latihan Angsana Connect	**3**
TOTAL	**13**	**17**	**28**	**58**

5	**Key Highlights**	<u>Policy papers, legislations and regulations in Malaysia</u> • Reviewed **7 key policy papers and reports** on care economy in Malaysia • Presented an analysis of key areas of the care economy **at the national level** and the **care service providers' level** • Key recommendations include the need for **a national blueprint on the care economy**, **investment** by the Malaysian government into the care economy (**social infrastructure**) similar to physical infrastructure and establishing **a harmonised legislative and regulatory framework** for the care economy. <u>Issues in governance: Federal-state relations, public, private and voluntary sectors, urban-rural divide and lessons from the Global South</u> • Highlighted the **regional disparities in care needs** exacerbated by the lack of basic infrastructure, particularly in rural and interior areas, such as Kelantan, Sabah and Sarawak • Identified significant hurdles for implementing effective care services in these regions. These include **affordability, accessibility, socio-cultural, developmental issues and geographical barriers**, underscoring the need for more inclusive and region-specific policy strategies. • Presented **case studies from the Global South such as Brazil, Cuba and Indonesia** which offer insights into successful care economy models and best practices that Malaysia can glean from. <u>Care economy and older persons in Malaysia: Long-term care in an ageing society</u> • The long-term care models in Malaysia currently offer varying levels of support depending on needs, costs, and purpose. • The enactment of the Private Aged Healthcare Facilities and Service Act 2018 (Act 802) has driven the **increasing marketisation and commodification of care services** and a shift in **the State's role from social welfare provider to regulator and facilitator** of the care industry. • Crucial considerations include the **gendered nature of caregiving** calling for more male participation in the purple economy, **professionalisation of care workers, financing** the burden of care and exploring **technology-augmented care solutions**. <u>Challenges faced by PDK workers in Malaysia</u> • Two PDKs (PPDK Sg Buloh and PPDK Kuala Klawang) were invited to share their experiences, providing an insight into the **ground realities, successes and challenges in running a PDK** in Selangor and Negeri Sembilan, respectively. • **Key challenges** identified include insufficient allowance for community-based rehabilitation (PDK) workers and supervisors, scarcity of professional services such as physiotherapists, inadequate physical environment, limited access to professional development courses, and the unique struggles of East Malaysian PDKs which include accessibility and the severe lack of healthcare professionals.

- Recommendations presented include **collaboration with private sector, fostering social entrepreneurship and professionalisation of PDK workers.**

Children in need

- The rights of children as enshrined in the United Nations Convention on the Rights of the Child (CRC) 1989 that Malaysia is a party to. However, **significant gaps** in children's needs **in education, health and child protection persists.**
- Highlighted the barriers in education, health and child protection experienced by **children with disabilities, indigenous children, children in institutionalised care, children in poverty, and refugee, stateless and migrant children** in Malaysia.
- Recommendations include **training and professionalisation of child care workers**, **increased surveillance and enforcement to beef up child protection**, and **developing culturally-sensitive approaches** to improve awareness and access among indigenous children.

Knowledge, skills and values required by care workers and social workers to provide effective care and services to persons with psychosocial disabilities

- Highlighted the **structural, operational and social challenges** faced by mental health care workers and social workers in Malaysia.
- Emphasised the need for **formal recognition and capacity building** of mental health care workers, **public awareness campaigns to destigmatised** those with mental health concerns and **technological integration** in mental health care.
- Proposed the social work be **extended and better integrated into healthcare and educational** systems.

Care economy, care workers, social workers, and professional standards and training for the social care industry

- Presented **a thorough mapping** of the area of care, types of service providers, relevant legislations and authorities and main workforce for care-dependent people.
- Compares the **unique needs in a mixed care economy** - childcare has begun to regulate the education and training pathways though unregistered child care centres remain a great concern. For elderly care services, the cost and quality of care differs while also acknowledging the need to cater to their preference to age in place, remaining in their homes and communities.
- Calls for the industry to remain robust to **draw young Malaysians** through com**petitive compensation, highlighting clear career progression, featuring success stories** of skilled and meaningful care roles to retain the care workforce and grow the care sector.

		Care economy as a growth sector • Provided an **overview** of the public-private collaborations at play in the care economy, the need for increased standards of care, the importance of coherent legal frameworks and standardised regulations and sustainability in the care sector • Centred on **how care is a public good**, how the care economy **drives human and holistic development** and must be **rights-based** rather than merely GDP or profit-driven • Proposed approaches and strategies included **decentralisation of care services and delivery, a cross-ministerial taskforce**, and **formulation of financing methods for vulnerable groups** **Cross-cutting issues**: Legislation and regulation, professionalisation of care workers, disparities in provision, accessibility and affordability of care services, cultural and gender dimensions of care, financing of care, the role of technology. **Filling in the Gaps:** • People with mental health needs are currently not in the mainstream focus of care economy in Malaysia. As the prevalence of mental health issue rise, these group must not be left behind since mental health concerns can be a silent epidemic requiring trained care workers and thus, can create job opportunities. This conference provided a platform for dialogue for those with mental health concerns within the context of the care economy. • The discussion on persons with disabilities (OKU) was limited to PDKs in this conference. Hence, another author who is a renown subject matter expert, has been invited to write a paper on persons with disabilities which will be submitted post-conference.
6	**Drawbacks / Opportunities**	• One presenter (Paper 6) sent apologies and was not able to attend due to an emergency. The session proceeded with discussants sharing their comments and input on the paper. • To engage and invite discussants from the private sector and presenters from the government sector. •
7	**Next Steps**	• Arising from this conference, a book on the care economy in Malaysia is in-progress. The team of paper writers are currently working with the ISIS Editorial Team (Muhammad Sinatra and Ariane Yasmin) on their paper revisions, incorporating the discussants and editorial comments. • An additional paper on people with disabilities written by Dato' Amar Singh-HSS, a key opinion leader in children and disability, and his team is due for submission in mid-November 2024.

RAPPORTEUR NOTES

Growing the economy and meeting the care needs of the Malaysian society
24-25 September 2024 | ISIS Malaysia

Paper 1 Policy papers, initiatives, legislations and regulations in Malaysia
Rapporteur: Yvonne Tan
Moderator: Harris Zainul

Key takeaways: (3-5 points)

- The rights-based approach in the paper is good and the way forward instead of a charitable model
- Gaps in the paper that can be explored:
    - Institutional:
        - Inter-agency coordination: including the role of Ministry of Economy, Finance and Health
        - Explore the role of local governments to take ownership on care management
    - Care service providers need to also have an attractive renumeration package and career pathway
    - Public-private partnerships on how to build a social financing model for the care economy

Rapporteur notes
Presenter: Datuk Denison Jayasooria

- **Conceptual understanding** – key reports in focus
    - Asia Foundation Report (Care Economy Dialogue: Toward a Resilient and Sustainable Care Economy in Malaysia)
    - ISIS Malaysia policy paper (Building a cradle-to-grave care economy for Malaysia)
    - Khazanah Research Institute (Gender Inequality, Unpaid Care Work and Time Use Survey)
    - UNDP Policy Paper (Investing in the care economy: opportunities for Malaysia)
    - Asia-Pacific Care Economy Forum
    - UNDP (Enabling investments into the Malaysian care economy)
    - Roundtable discussion on conversations on care economy in Malaysia compilation report 26-27 June 2024, ISIS Malaysia
    - Right to care is seen as a basic human right
- **At the national level**
    - Thematic analytic framework with 8 major thematic concerns
        - Care policies
        - Legislation governing care professional care workforce
        - Care industry
        - Public good
        - Financing

        - Data
        - Gender dimensions
        - Cultural dimensions
    - **Care service providers' level**
        - Target groups
        - Care needs
        - Care work
        - Care services
        - Care service providers
        - Capacity building and competencies
    - **Recommendations & Conclusions**
        - National policies, roadmap and blueprint on the care economy
        - Formulate appropriate legislation to support the care economy
        - The recognition of the care economy as a new economic growth area
        - Establish an inter-agency taskforce
        - Address the cultural dimension and gender stereotyping

Discussant 1: Prof Norma Mansor, UM

- Both the Ministry of Economy and the Ministry of Finance need to be involved as well in order to change mindset. The planning agency needs to be at the center of our discussion.
- While we inherited the idea of a welfare state from Britain, caregiving is seen as an unpaid responsibility.
- The paper taking the rights approach that care should be seen as a right.
- The Malaysian median age is 30 years old in comparison to Singapore's median of 44 years old but we cannot lose the window to build up the care economy. There is a growing demand for care with the ageing population. Social contract between the government and their responsibilities.
    - On the supply side, the responsibility of the government is to come up with policies and services to encourage the private sector to support the care economy.
    - Institutional arrangements where the emphasis has to be more on the local level. The local authorities are the ones that can keep track, not the federal government. Having a roster of the older people in their communities
    - Women start to leave the labour force at age 34 and need to work with the Ministry of Education that still uses the two-session school system that doesn't support women to remain in the labour force. There is a need to look at the education system to free the mothers who want to work but cannot due to the current education system set up.

Discussant 2: Puan Fatimah Zuraidah, KPWKM

- Highlighted the ASEAN Declaration on strengthening the care economy and fostering resilience toward the post-2025 ASEAN community. KPWKM adopted the ASEAN declaration last month. The declaration defined "care economy" as consumption of goods and services necessary for the physical, social, mental and emotional well-being of care-dependent groups and includes both paid and unpaid care work.
- Gaps in the paper:
    - how technological innovation can contribute to the care economy
    - public-private partnerships on how to build a social financing model for the care economy.
- Recommended additional literature:
    - OECD's SIGI Regional Report for Southeast Asia: Time to Care
    - ILO's Care Work and Care Jobs: For the Future of Decent Work
    - World Economic Forum's The Future of the Care Economy
- Madani government initiatives under KPWKM
    - May-June 2024 MWFCD initiative series of lap to develop Malaysia Care Strategic Framework
    - Amendments to Care Centers Act 1993 and Private Aged Healthcare facilities and services act 2018
    - Community Support: Home Help Services
    - Next year will table to parliament on professionalising care workforce
    - Looking to develop a care industry ecosystem which looks at the individual, support networks, formal care services and larger policy and regulations
    - To develop Madani Care which will encompass care service provider, capacity building competencies, care work and care services to meet care needs.

Q&A

- Questions on **affordability** even on existing systems. More men are dropping out of the labour force due to care responsibilities. Large numbers of older people headed households fall under relative poverty. Investments can also be more targeted to address this problem holistically rather than in a fragmented matter which can result in better monitoring of the impact.
    - **Prof Norma:** When we say it is a public good, it should mean you are able to afford. Under the social protection framework, there is a proposal for old age pension including purchasing care that helps support the family. The government should provide the basic services needed by the citizens as a social protection floor with financing for childcare and age care.
- Points raised on how KKM also shoulders the burden of patients who are terminally ill, and numbers of **palliative care** patients expected to rise.
    - **Prof Norma:** Inter-ministerial and inter-sectoral to include all, in some countries like Ireland, their social workers are under Ministry of Health where it is seen on the same level as nurses and doctors. When planning for social work in the care economy, we should not forget about existing services where nurses typically perform care work and where

renumeration is good with social security. Thus, why the push for the Social Workers Act which includes these aspects including compensation and social security. Usually added responsibilities but in terms of the budget, nothing changes so more inter-ministerial work needs to be done in that regard.

- Models of care work to be covered in this exercise.
- Prevention should be explored also in this larger ecosystem.
- Funding problems where if the corporate sector would like more labour participation, they would also need to invest with their CSR budgets. Corporates are a key player that can fund social care.

Paper 2 Issues in governance: federal-state relations, public, private and voluntary sectors, urban-rural divide and lessons from the Global South
Rapporteur: Yvonne Tan
Moderator: Harris Zainul

Key takeaways:

- The grounded realities of Malaysia's care sector should be seen as adding to the care burden, can investigate conceptualising how the care economy looks like with these socioeconomic disparities.
- Important to define the idea of "transformative care economy" proposed in the paper and/or investigate best models for emulation for Malaysia's care economy.
- The discussion on urban-rural divides, federal-state dynamics, and various care models in the global south is ambitious, suggesting a potential shift toward emphasizing policy recommendations. Incorporating a framework based on public, private, and voluntary sectors could enhance the paper's depth.

Rapporteur notes
Presenters: Dr Teo Sue Ann and Dr Khairil Ahmad

- Ground realities of Malaysia's care sector, three main issues that need to be addressed to reform care economy in Malaysia:
    - Regional disparities and poverty
        - Long-term challenges on urban-rural divide across states and regions in Malaysia
        - Local and grassroots communities deal with challenges that precede their need and demand for social care including poverty, lack of basic infrastructures and natural disasters
    - High cost of care services
        - Typically out of reach for many communities and households
        - NGOs and charities have high cost and lack of government support which restrict their ability to render quality services to communities and households
    - Gender imbalances in care work

        - Traditional gender norms play a key role in shaping the discourse on social care in Malaysia but it is something that should be shared between both parties
- Case studies
    - Integrated yet decentralised system: Brazil's Unified Social Assistance System (SUAS)
        - Federalist solution to distributing social assistance and care in Brazil 2005. SUAS is a system that organises and funds social assistance in a participatory fashion among all levels of government across Brazil. Functions through a collaborative governance structure, does not prescribe or spell out how state or local government should provide those services
    - Putting 'value' into the care economy: Cuba's integrated social justice approach
        - Care workers are professionally trained and the ethos is on social justice, supporting the profession to deal with communities and vulnerable groups
    - Transforming gender norms in Indonesia's care sector
        - Indonesia just released its Care Economy Roadmap that focuses on the gender imbalances to facilitate the creation of a gender equal labour market and fairer access to work for women which will result in a fairer distribution of the burden of care.
- Conclusion
    - Need to reflect upon socioeconomic barriers that have hindered certain communities' access to care and articulate the right solutions for them. Exacerbated by longstanding governance issues.

Discussant 1: Puan Masneh Abd Ghani, IDS

- There is opportunity and demand for Sabah's care economy but still needs more investment in its health and social care infrastructure at large.

Discussant 2: Dr Yuen Kok Leong, SDI

- The paper defines certain concepts such as "transformative value of care"
- Looks at urban-rural divide, federal-state relations, public-private-and voluntary sectors and global south care economy models, which is ambitious and maybe scaling down with more emphasis on the policy recommendations can be helpful, guided by a set of matrices such as public-private-and voluntary sectors
- Geographical focus - if the aim is to identify the best model for emulation for Malaysia's care economy then limiting the scope to Global South care economy models might not necessarily be productive.
- Regional disparity is highlighted specifically in Kelantan, Sabah and Sarawak in terms of basic infrastructure, but it should be discussed together on how care is made even more difficult to add on to the burden of care. It should be discussed in tandem with one another and discussed how the care economy will be carried out within the context of the poverty disparity.

- The market aspect of the care economy can be seen as not "moral" and based on our previous roundtable, we can consider the mixed model care economy to pay the high costs.
- The Institute of Cancer Centre can be an example of how federal-state relations were managed in Sarawak.
- Suggested to refer to his previous paper on Care Economy in Sarawak presented at the roundtables at ISIS in June 2024.

Q&A/Comments

- More data and descriptions of causes in differences in women's labour participation including demographic analysis, population structure and income levels to map out the care needs of the various regions.
- To look more on community-based care to support the care economy.
- Can investigate splitting the two separate papers given that there are too many things to look at with the concept of "transformative care economy". To bring out the indicators and ground it in Malaysian realities.
- Akta 171 on revising and consolidating the laws relating to local government could be one way to help address any gap in the establishment of care services in different areas.
- Persistent issues continue to come up and how can we operationalise the care economy with interest from the civil society to work together with the government on this. Building on what the government has already been committed, how can we leverage on that to foster action including monitoring and evaluation.
- Incentivising a care credits system – timebank.
- Research on the return of investments into early childhood education system.
- Can investigate the Venezuela case which looks at community healthcare system which focuses on the poor communities based on social justice.

Paper 3 Older persons
Rapporteur: Hirzawati Atikah Mohd Tahir
Moderator: Dr. Diana Katiman

Key takeaways:

- The care sector is undervalued, often staffed by underpaid, unqualified workers, including foreign labor – leads to poor treatment and exploitation
- Aged people can be supported through community-based care models – retirees and older people provide mutual care, including using assistance via technology such as telemedicine, electronic devices, and apps that enhance remote care and support systems.
- Government must facilitate long-term care by supporting home and community-based services and avoiding over-institutionalization – Collaboration between ministries and local authorities (PBT) are key to creating age-friendly communities
- A need for more qualitative research to understand how care systems function

- Regulation is needed to make care services affordable, address gaps in laws governing elderly care facilities, and ensure existing services are not dismantled through inappropriate regulations.

Rapporteur notes

Speaker 1: Chai Sen Tyng

- Ageing population – phenomenal all over the world
- There's an urgency on what we need to do
- We have to take note of policy measures to take
- Most of the older people are in town/cities
- Selangor – 10% increase of older population
- Household composition by age group – important
    - How many households has an older person living in the house
    - Demand for child care – despite decreasing percentage, still seeing an increase in demand
- When writing this paper
    - How to restructure the people this paper is written on – adult care dependent
- They need care but didn't get it – unmet care
- They need care but do get it – met care
    - Formal vs. informal care – we should look at this structure
- Adult care dependent population
    - Health and mobility survey
    - Do you have the ability to care for yourself?

- In recent years:
    - Who has been providing the service is important but not that important
    - A third axis should exist
- 1st axis – premium vs. low cost
- 2nd axis – institutionalization vs. home
- 3rd axis – independent vs. dependent
- We always talk about residential care but not so on non-residential care
- When it comes to old people – it's more on residential care – how to fulfill this demand of old care centre beyond constitution
- Don't build old care centres based on numbers

Speaker 2: Assoc. Prof. Dr. Rahimah

- Variations of old care ageing
- Female participation is both affecting and being affected by traditional child and elder care arrangements
- Social responsibility should be handles by everyone
- Family-based age care
- Care giving – not met at home – use formal services to compliment what the family cannot provide
- It used to be a taboo to send parents to age care centre and residential care services – but now it's changing – but we need to tackle the issue

- Residential age care centres – we have issues:
    - Operation
    - Underdeveloped health and social care community services

Discussant 1: Prof Dr Tan Maw Pin, UM

- There should be no differentiation between health and social care
- The older population are using acute hospitals as a surrogate for long-term care
- Older people spending last few months/years of their lives between care homes, own homes, hospitals or in an ambulance – this situation can no longer continue
- In addition to hospital overcrowding, we have rising insurance premium and increase waiting list – can be avoided if people address that not just health and social care as a single entity but also healthy aging
- We should see “care economy” as part of the continuum in healthcare through work health organization integrated care for older persons
- We do acknowledge that death is inevitability of life but disability is not
- The need for care might be necessary for some, but this could be kept to a minimum and that would lead to an increase standards and a much greater satisfaction
- Main issues of the care industry now – it’s not considered a glorious profession – fully paid, often delegated to school dropouts and foreign workers, care industry is as bad as black market where majority of our care homes are not registered and domestic workers are being mutually exploited
- We need to reassess our addiction to foreign labour and our desire not to continue staying active and healthy throughout life – need to be addressed as part of the care ecosystem
- The lack of appreciation between health and social care – when someone forsake and they might need care when they are sick, they lost the ability to care for themselves – there’s a need to prevent them needing any assistance, maintenance of independent and restoration of function – care is not a one-way street
- Mutually caring for each other (old couples or old people caring for each other) already exist, can be extended to a community level – retired people can continue providing for each other
- How are we going to fund long-term care? Main issue – to look at how we can reduce the need for long-term care. Less demand = more fund for better quality care for individuals
- Have to consider long-term care insurance vs. mandatory salary sacrifice
- Hospitals need regulation – people need to be taught from the beginning – consideration for treatment need to take into the cost of rehabilitation and care after treatment – a part of human and medical ethics
- Our structure of medical education and healthcare workers education – need a rapid revamp – now there’s a rapid hemorrhage of all healthcare workers whereby it’s not a brain drain but people leaving the healthcare workforce globally – this problem need to be addressed
- Problems with our healthcare industry – need to be addressed in order to make our country ready for the care industry for the older adults

Discussant 2: Jeffrey Phang, UNITAR/Malaysian CSO-SDG Alliance

- The paper – the numbers were great, can input into context what is actually happening leading to how we are setting a proper system of care that's comprehensive
- Filling in the gaps:

1. 3rd (retired) and 4th (after retirement) age – our attention has been towards the 4th age but 3rd age is as important – they are well, they can care for themselves but they are not disabled but less abled – the activities that we are giving to them, bringing them back to employment & revising the age of retirement – will help them mentally alert and help them not to sleep in the 4th age.
2. "In place ageing" – things have changed
   - It takes a village to educate a child and the old people
   - No single caregiver can just provide fellowship & support but also need the community
   - Technology – Zoom, 3D imaging outcome, graphics – can compensate even though they live far away from each other
   - E.g. of other technology to help: Telemedicine and diagnostic etc., electronic wheelchairs (but limited infrastructure facilities to be used), Google Home, CCTV, build a software/app for community assistance for the age
3. Whole of government-society approach
   - The government sets the ecosystem for the success of looking after the age people
   - In the process of connecting the dots – if we cannot see the interdependency of different ministries & players, we will do very well in our silo which doesn't help the overall ecosystem
   - The process of policy and implementation – a success?
   - Need to have servanthood leadership

4. The narrative of filial piety
   - Very traditional but we kind of lost it – Singapore reminded us again (through their law) for the need of children to look after their parents
   - We need government as a facilitator in this new era – to support and facilitate the aged people
   - Community-based assistance – if you want a community to be cooperative and to look out for each other, you have to build up the community

- Unless you can get JP9 get involved and use their resources (e.g. Rukun Tetangga) to empower the community and building harmony - then we can bring the community-based services.
- Market driven – care is underrated and underpaid. But if there's a business model for it – hopefully it won't be like a private hospital – profit is the main motive
- 5Ps of SDGs – important if people-centric model to be put in
- Facilitating a fluid age population support structure would be something that we want to put in, put in a structure that is fluid enough to flow with technology and people – when we are connecting the dots, we connect with willing partners
- The most important is PBT – local authorities have tremendous influence over what is happening but they don't have OKU & age-friendly community

- Another thing that is upsetting – Urban Renewal Act – a lot of old people will be displaced if this act is passed
- Quantitative research has to shift on to qualitative research – we know what is happening but now we want to know how it works – if we keep on repeating until we have a good model to replicate, that would help everyone to play their part in a more interdependent manner

Q1 (Dr. Teo Lee Ken):
In universities, we don't combine STS (Science, Technology & Social Science). We don't even combine interdisciplinary social science and social science-science. Is there a possibility within university/ministry to do interdisciplinary research etc.?

A1 (Assoc. Prof. Dr. Rahimah):
- Transdisciplinary research – something we need to do more
- Connecting the dots are not easy – there are willing and unwilling partners even when it comes to research
- At MyAgeing and other research centres on ageing are increasingly collaborating to do multidisciplinary and transdisciplinary research - there are opportunities to collaborate and do transdisciplinary research
- We are pushing for ageing nexus – to look at different note of ageing research and the different centres in universities

A1 (Chai Sen Tyng):
- Government/ministry doesn't listen to researchers – but more and more ministries are getting into the ageing population bandwagon (including ministry of transportation)
- The local industry needs a voice, get operators together, work beyond that – get people together
- Foreign workers (by Prof Tan) – we have the same view but the industry people will be upset – because they have to survive and it is an operational cost issue
- Government needs to evaluate different voices – what is good long term vs. what is good short term & how to keep everyone on the table
- Age care/childcare – we have to wake up and realize that it's not going to be cheap and the government cannot come in and make it into institutionalized care for elderly but the government can do (via public hospitals etc.) is to make sure the people have the alternatives – e.g. government to support home & community-based services (with public funding) – it may result to less need to turn into nursing homes etc.
- Any homes under the care centre act 506 who is providing healthcare services and nursing services to elderly in their homes is actually breaking the law – because the act is not meant for nursing services
- Many homes, the reason why we have act 802, is because they're breaking the law openly – but the government has no way of shutting them down because we are they going to go to – charitable homes is also the same – if they are not registered under act 586, they are breaking the law if they are taking care of sickly elderly even if they have nurses

Q2 (Yvonne Tan):
What kind of existing structures could be the main focal point for coordinating between health & social care in building an ecosystem for the ageing population?

A2 (Prof. Tan):

- In Malaysia, the structure is already there. When we do the research to look at what's available in their community, the range of services that are inexistent are already there – what is in threat is putting in the regulations that potentially dismantled the existing services
- A lot of older people have access to home care – but getting more expensive and it's cheaper to put them in a long-term care (residential facilities) than to hire someone to come and provide care – main problem is because our care provider is resisting the need to break up care
- We do need to bring in regulations to make care affordable and commercially and economically viable for those people who need it – if not, they'll end up in hospitals (when the actual reason is because the family can no longer provide for them and hospitals are the safest place)

A2 (Chai Sen Tyng):

- Health and social care problems come from our ministerial structure – arguments today about federal, state and local government's differences (e.g. Ministry of Health's presence up to a district level, Ministry of Women/JKM has its own structure up to a district level) – every ministry is not connected to one another and can implement their own programmes
- Getting ministries to work together (e.g. health & social care) – PAWE (JKM); Kelab Warga Emas (MoH); U3A – Different ministries try to cover different programme separately – everyone wants to be seen to be doing something with credit
- The fact that care economy is being championed by Ministry of Women is disconcerting for us because long-term care is actually a health issue – different from children (more to education & child development)
- We need to keep reminding the government that there must be a way to bridge whatever training we provide like caregiver etc. - we lack proper standardization of the profession

Q3 (Dato' Mastika): PAFAS act – still pending - are we ready for 2030 negara penuaan?

A3 (Dr. Liyana/KKM):

- PAFAS – already gazetted but not enforced yet because the legal subsidiaries have not received approval by the attorney general chamber (AGC) – now they are still finalizing the approval
- But there are implementation issues that we need to iron out before we can take over old folks home/private aged old folks home from JKM – because funding is from JKM but once MoH taken over, the funding will stop (e.g. for NGO-run old folks home)

Paper 4 Persons with disabilities – Program Pemulihan Dalam Komuniti, PDK
Rapporteur: Hirzawati Atikah Mohd Tahir
Moderator: Dr. Diana Katiman

Key takeaways:

- PDKs can be operated as an NGO and have to work towards being self-sustaining in their daily operation
- Professionalizing workers in PDKs - to attract skilled individuals and ensure job stability, recognition and financial security
- Main challenges faced by many PDKs remained the same – insufficient funds for operation, low allowance for workers and trainers, and poor facilities and equipment

Rapporteur notes

Speaker 1: Pn Sapura Arshad, PPDK Sg Buloh

- Introduction to PDK and objectives of PDK
- Every month, there will be therapists, dietitians and physiotherapists who will come for consultations (depending on their availability)
- Have 52 male trainers and 25 female trainers
- Challenges:
    - Equipment from 2009 – old and broken
    - Lack of space
    - Trainers have insufficient trainings
    - Parents don't understand how PDK works
    - Allowance to officers – not enough
    - Lack of attention/awareness from the public
- PPDK Sg. Buloh's own initiatives:
    - Create own teaching assistant tools
    - Want to use a land from a committee member to plant hydroponics but no modal

Speaker 2: En. Haji Mohd Fouzi Haji Mohd Isa, PPDK Kuala Klawang

- 23 students have learning disabilities
- Challenges:
    - Limited funding
    - Parents don't understand how PDK works
    - Costs – some parents don't want to pay
- Suggestion:
    - Review the ratio of officers and trainers

Speaker 3: Lydia Ann Bill

- Introduction to PDK (Community Rehabilitation Centre)
- 2023 – 637,537 PWDs in Malaysia
- 2022 – 619,273 PWDs in Malaysia
- 559 – PDK in Malaysia (as of 2023)

- Budget for PDK – increased from RM 91 million in 2019 to RM 133.5 million in 202, however, structural issues still persist
- Data is from Pontian, Tanah Merah, Sibuti and Pagoh
- Challenges:
    - Insufficient allowance for workers and trainers
        - Allowance increased in 2021 but not enough
        - Minus EPF/SOCSO – allowance reduces further
        - Status as "volunteer" – struggle to convince banking institutions in loan applications
    - Scarcity of professional services in PDK
        - Expertise limited
        - Unable to meet the needs of the PWDs
        - Lack of specialist doctors, physiotherapists and special education teachers
    - Inadequacy of physical environment
        - Require frequent maintenance and upgrades to remain functional
        - Lack of room partitions (e.g. for autistic & ADHD children who may require separate/different environments)
        - Lack specialized equipment
    - Limited access to professional development courses and training
        - Volunteers – benefit is not the same with regular employees
        - Gap in capacity building for workers
    - The struggle of the East Malaysian PDK
        - Geographical reasons – the higher costs of maintaining and improving infrastructure especially in rural areas
        - Long journeys to healthcare services and PDK
        - Severe shortage of healthcare professionals
- Recommendations:
    - Collaborate with private sector
        - Address gaps in funding, infrastructure and service provisions at PDK
        - Enhance CSR efforts
        - Training programs for PDK staffs
    - Fostering social entrepreneurship
        - Self-sustainability
        - Empower PWDs and caregivers
    - Professionalize workers in PDKs
        - To ensure job stability, recognition and financial security for caregivers and staffs

Discussant 1: Pn. Emilia Syatirah Derahim, JPOKU, JKM

- PDK – to give opportunity to the community to sympathize and help the PWDs in the community; "pemulihan dalam komuniti"
- To unite the community to provide services to the PWDs themselves

- In 2018, PDK couldn't make own decisions and when they're doing programs or collecting funds, they had to get approval
- Now, we can register PDKs as NGOs:
    - can do programs and collect funds by themselves
    - to self-sustain – JKM wants to encourage the organization to operate on its own and not rely on government's fundings
    - can create their own courses using government funding
    - even though registered as NGO, can still get some funding from the government
    - the government can bear the costs of 1:5 (staff: students) but if PDK wants to hire more, they can do that based on their own budget/fund
- PDKs as NGOs can:
    - Decide the direction/way forward of the PDK
    - No need approval from JKM unless related to the government's laws/policies

Discussant 2: Dato' Ghazali Yusoff, Former Chairman, PDK Kebangsaan

- PDK must change its parameters – PDK has grown its usefulness
- PWDs redevelopment
- We should have a national conference – a relook
    - Introduce to universities
    - Have a small meeting with NGOs to strategise the way forward

Q1: Prof. Datuk Dr. Denison Jayasooria

- How are grants being determined for PDK? If PDK is a NGO, does that mean the government doesn't have to monitor anymore? Staff support?

Q2: Datuk Hajah Mastika Junaidah Husin

- PWDs should be given some funding for learning
- Status as "NGO" – worrying & the policies should be formed by the government
- PDK should be monitored

A1 & A2: Emilia

- PDK in rural areas:
    - Given financial aid monthly and yearly to support the administrative cost every month
    - Collaboration with KPM & KKM
    - JKM – financial aid
    - Other skills – required from other agencies to assist in the community

Q3: Chai Sen Tyng

- For PAWE & PDK – whose land/building are they using?
- How do we change the perception that this is a government initiative and doesn't need the fund etc?

- If it is a NGO, then we need to look for funding
- “professionalizing workers at PDK” – more important
- Datuk Hajah Mastika: “NGOs won’t get a land/building” - responded by Mr Chai: “Some charitable homes have their own land and they rent out – how they fund their activities”

Q4: Dr. Lin Mui Kiang

- 600k of PWDs in Malaysia can be very vague
- How many of these 600k are willing to go to PDK?
- Why do registered PWDs not want to register themselves at PDK?

A4: Lydia

- The numbers are based on JKM
- The other questions may need to further research

Paper 5 Children in need
Rapporteur: Dana Dumpangol
Moderator: Yvonne Tan

Key takeaways:

- The need for a comprehensive framework that emphasizes the rights of children to access care, focusing on both formal and informal care systems to support their development and participation.
- Highlighting the importance of collaboration between government, private and community sectors to improve the accessibility and affordability of childcare services, with specific attention to training for child protection workers.
- Recognizing the interconnectedness of health, nutrition, and education, especially regarding the impact of poor nutrition on educational outcomes for children
- Identifying gaps in existing child care regulations, advocating for deinstitutionalization, and exploring alternative care models to better serve children, especially those with disabilities.
- Emphasizing the need for long-term strategies for affordable childcare, a national action plan, and the political will to modernize childcare laws, ensuring a holistic approach that integrates community-based services.

Rapporteur notes

Discussants 1 and 2: Datin PH Wong and Assoc Prof Dr Mazlina Che Mustafa

- **Title and Scope:** The title should not just be labeled "in need." The title and focus of the paper should reflect that every child requires access to care. (Discussant 1 Datin Wong)

- **Survival & Participation Rights:** More emphasis on children's participation rights and how care facilitates their development. Very little is discussed about how care facilitates children's participation (Discussant 1 Datin Wong)
- **Data and Statistics:**
    - Include data on how childcare affects workforce participation, particularly regarding women leaving the workforce due to lack of childcare options (reference Yayasan Khazanah's report) (Discussant 1 Datin Wong)
    - Include statistics on pre-school enrollment, particularly for children from urban-poor settings (PPRs), as per UNICEF data
    - Include data on alternative form of informal care such as playgroups
- **Government's Role**: The paper should not only highlight the role of government (running 20% of childcare centers) but also explore the need for partnerships to expand home-based and enabling community-based childcare, which is accessible and affordable. (Discussant 2 Prof Mazlina)
- **Education:**
    - **Structure of paper:** Clearly separate early childhood education (0-4 years) from pre-school education (5-6 years). This distinction should be reflected in the structure of the paper to avoid lumping education into one category. (Discussant 1 Datin Wong)
    - Recommendations should focus on foundational literacy and numeracy skills starting from taskas, rather than waiting until primary school.
    - Highlight the need for a systemic change in the approach to early childhood education. Focus on ensuring all children, regardless of socioeconomic background, have access to high-quality education (Discussant 2 Prof Mazlina)
- **Special Needs**: The importance of early intervention for children with disabilities. There is no need for a specific act for special needs, however the paper should recommend amending the current Education Act that caters to special needs, which is inclusive education. The inclusion of children with disabilities should begin at the taska level. Children with disabilities: inclusion and not segregation (Discussant 1 and 2 Datin Wong & Prof Mazlina)
- **Health:**
    - The paper does not have reference to child health. Should incorporate references to national child health frameworks, such as the 2021-2030 National Framework to reduce under-5 mortality (Discussant 1 Datin Wong).
    - Interconnectedness of health, education, and poverty. The paper should explore how issues such as poor nutrition affect educational outcomes, particularly for children in low-income families. (Discussant 2 Prof Mazlina)
- **Child Protection Policies:** The paper should examine gaps in the current Childcare Services Act, particularly in regulating home-based and community-based taskas. Institutional childcare centers are covered, but non-institutional forms of care need more attention. This should be reflected in the policy recommendations. (Discussant 1 Datin Wong)
- **Training and Capacity Building:** To highlight the need for systematic training programs for child protection workers. Capacity-building initiatives could be

recommended to raise the standard of care for children (Discussant 2 Prof Mazlina)

- **Legislative Alignment:** The paper should address inconsistencies in local laws that affect child protection. Harmonizing local laws with international standards is crucial to ensuring the well-being of children. (Discussant 2 Prof Mazlina)
- **Deinstitutionalization**: The paper to promote the deinstitutionalization of children's care. It should advocate for alternative care models, such as family-based, home-based, foster care and move away from large institutional settings toward smaller, more home-based environments. (Discussant 1 Datin Wong)
- **Role of JAKOA**: (Discussant 1 Datin Wong) noted that many papers do not mention the role of JAKOA. To look into JAKOA's effectiveness and relevance as an agency for indigenous communities
- **Children in Poverty**: The paper should consider recommendations from previous reports such as the Child Act Coalition Report (2019) and the latest forthcoming 2024 report (15th October). (Discussant 1 Datin Wong)
- **Recommendations:**
    - The paper should focus on long-term strategies for making childcare affordable for low-income families. Recommendations should include funding mechanisms from both the government and private sectors, along with clear targets (Discussant 2 Prof Mazlina)
    - The government's role in compliance and monitoring of child protection policies should be strengthened, with clear accountability and implementation mechanisms. (Discussant 2 Prof Mazlina)

Q&A Highlights:

- **Child nutrition:** Emphasis on the need for educating parents on proper nutrition, and reducing junk food consumption among children as there is a rise in obesity even within B40 communities.
- **Affordability**: Long wait times for public health services like speech therapy (up to a year) force parents to seek expensive private options. Need for more affordable and accessible early intervention.
- **Healthcare**: Gaps in the healthcare system for children with disabilities, particularly the lack of proper training for doctors and inadequate facilities for wheelchair users. Criticism on the siloed approach between government ministries.
- **Poverty and Abuse** Poverty's impact on childcare, with particular attention to period poverty and the lack of proper adolescent guidance. Suggested more active monitoring of child care centers
- **Care Economy**: Support for community-based care economy models, integrating early childhood education with public-private partnerships to make services more accessible.
- **Inclusive education and certification:** Highlighted the need for specialized certification for those caring for special needs children and advocated for inclusive education environments that integrate tailored activities.
- **Decentralization**: Improving regulations, and decentralizing care services for fragmented communities

- **ECCE Graduates**: Highlighted the lack of passion among ECCE graduates, linking it to pay issues and the perception of being "pengasuh" rather than "pendidik."
- **National plan**: Urged for a national plan for action or national policy. To modernize outdated child care laws, emphasizing community-based childcare that is affordable and accessible, especially in rural and PPR areas.
- **Resources:** The need for comprehensive investigations into families' needs to better design supportive services and providing them with list

Closing Remarks:

- Implications of the challenges
- The political will
- Collaborative approaches

Paper 6 People with mental health concerns
Rapporteur: Dana Dumpangol
Moderator: Yvonne Tan

Key takeaways:

- There is a lack of formal regulations for social workers and psychologists in Malaysia, with a shortage of specialized mental health professionals, including psychiatric nurses and social workers. The system requires structured training, standardized knowledge, and multidisciplinary approaches to address diverse mental health issues.
- Mental health services are expensive, long-term, and often inaccessible due to a limited number of community mental health centers. Stigma and parental denial further complicate early diagnosis and treatment, particularly for children.
- Stigma around mental health persists, with legal barriers preventing individuals diagnosed with mental illness from holding public office. This discourages individuals from seeking help and contributes to the underreporting of mental health issues.
- Importance of early intervention and upstream solutions: Addressing the root causes, such as poverty, family dynamics, and food security, alongside early interventions for mental health issues in children, is crucial to preventing long-term mental health problems.
- Integration of mental and physical healthcare: There is a strong need for a holistic approach to healthcare, integrating mental and physical health to fully address the underlying issues and improve outcomes across the healthcare system.

Rapporteur notes

Discussant 1: Laura Kho

- **Care Workers and Social Workers**
    - The roles of care workers and social workers should be clearly defined.

    - The paper could benefit from additional context on psychosocial disabilities and how these differ from care provided in aged care or childcare settings.
- **Diversity of care needs**:
    - Care needs are diverse and vary widely, particularly concerning fluctuating mental health conditions.
    - The background could include the concept of deinstitutionalization, emphasizing the transition from state-run institutions to community living, which faced significant challenges, especially with funding and successful patient discharge.
- **Knowledge requirements for social workers:**
    - Social workers must be well-versed in mental health frameworks, including the Mental Health Act and relevant international conventions
    - A shift away from a charity model toward recognizing the rights of individuals to be treated with dignity and respect is essential.
- **Skills**: More detailed explanations of specific skills needed in service delivery and psychosocial models would enhance understanding
- The discussion should encompass both formal and informal care systems, including state-run hospitals, private nursing homes, and family care.There is a notable lack of regulation within the care sector.
- **Accessibility of care facilitie**s: For example, there are very few care homes, with most located in Kuching. Those living outside Kuching must travel far to access these facilities, separating them from family and community support.
- **Home psychiatric service**s: Emphasizing the role of multidisciplinary teams providing home psychiatric services to address the needs of patients, including support for social workers in applications for aid and psychoeducation for the community and families.
- **Addressing social challenges**: The discussion should expand on the social challenges associated with mental health, particularly the stigma that acts as a barrier to support.

- **Support systems:**
    - Explore what support systems are available, including volunteering and private sector initiatives that could aid in recovery.
    - Identify specific needs and provide practical examples linked to the paper's content.
- **Recommendations:**
    - Recommendations should directly address the challenges identified, linking formal care systems to how they can support individuals.
    - Partnerships with the private sector are vital for enhancing care options.

- The discussion should encompass both formal and informal care systems, refining the focus on how to tackle stigma surrounding mental health and improving overall care delivery.

Discussant 2: Nurul Syahirah Abd Aziz

- There are significant challenges in advancing within the social work and human services field, particularly due to a lack of formal regulations and recognition of expertise. Standardized knowledge, especially in psychology, is necessary for growth and effectiveness in addressing mental health issues.
- **Specialized training modules**: There is a need for specific training modules focusing on psychosocial disabilities. Social workers should be equipped to address diverse mental health conditions such as anxiety and depression, recognizing that not all mental health issues lead to disorders. These modules should include early intervention strategies for children to prevent severe mental health conditions later in life.
- **Multidisciplinary approaches**: A multidisciplinary approach to mental health is crucial. Social workers, psychologists, and other experts need to collaborate effectively to address the spectrum of mental health issues, especially at early stages
- **Education and trainin**g: There is a need for quality education and training for professionals, particularly those who are passionate and compassionate about helping those in need. Ethical considerations are important in ensuring effective care
- **Lack of centers for adults and teenagers**s: While there are centers for children with psychosocial disabilities, there is a shortage of such centers for adults and teenagers. Additionally, the sector suffers from a lack of adequately trained staff to support these groups.

Q&A highlights:

- Malaysia is lacking community mental health centers, with a severe shortage of psychiatrists and psychiatric nurses. There's also no specific legislation for psychologists, complicating the validation and regulation of their services.
- The lack of specialized social workers in the mental health sector was highlighted, and comparisons were made to the UK, where mental health social workers are designated to apprehend mental health concerns at a senior level.
- Barriers to Treatment: Treatment for mental health is often expensive and long-term, with many undiagnosed cases due to stigma. There is a need for more accessible and affordable treatment options.
- There are challenges in getting people, especially children, diagnosed and treated due to parental denial and a lack of tracking mechanisms for follow-up care.

- Although Malaysia has run mental health awareness campaigns like Minda Sihat, these efforts have not been targeted or widely successful. In contrast, campaigns like Singapore's Beyond the Label have had better outcomes by focusing on reducing stigma.
- There's a need for upstream interventions, addressing root causes such as family dynamics, poverty, and food security, rather than only treating symptoms.
- Most Malaysian insurance companies do not cover mental health treatment, and EPF/SOCSO claims for mental health are limited.
- More women seem to report mental health concerns, but this could be due to men being less open to seeking help rather than women being more prone to mental health issues.
- A key point was the need to address both mental and physical health together, as separating them would not fully solve the underlying issues. A top-down and bottom-up approach is needed to integrate mental health more effectively into general healthcare systems.

Closing remarks

- Stigma and awareness:
  - The ongoing stigma surrounding mental health. Being diagnosed with a mental illness creates significant barriers, such as the inability to stand for election or hold public office.
  - Additionally, there are no clear legal avenues or grounds for individuals with mental health conditions to seek redress, further discouraging people from coming forward for diagnosis or treatment. This stigma, along with limited support systems, continues to prevent broader acceptance and understanding of mental health issues in society.

Paper 7 Professional standards and training for the social care industry
Rapporteur: Farhan Khairulannuar
Moderator: En. Rashidi Yahaya

Key takeaways:

- Lack of residential care regulation for major areas of care/services. No regulations in terms of qualifications of the workforce. This means the workforce is largely untrained to properly care for their respective areas of care.
- As it stands, care work is not attractive to future applicants due to lack of upskilling opportunities and recognition.
- Multi-dimensional approach from both care providers and JKM is needed to bolster for-profit care economy workforce

Rapporteur notes

- Availability alongside quality of care must be considered.

- Preventative aspect of care must be looked at, care in its current state is reactive in nature
- Quality of care provided is not regulated. No NOSS-specific courses provided in dedicated institutions. Additionally, care work is at the lowest rung of the operational hierarchy. Lack of attractiveness of care work
- Market encompasses: care providers, workers, users
- Care economy from social welfare perspective
    - Social care falls under social welfare alongside health, education
    - Shared responsibility between gov, non gov, private, non-profit, community
    - As such, mixed economy of care is needed. Cannot solely rely on government for care needs
    - This presentation focuses on for-profit workers
- Workforce and service providers
    - NOSS (national occupational skill standard): formed by JKM placed under TVET, to provide framework for dexterity required by care workers (residential and non-residential), Displayed via levels
    - National Education Code (NEC) and Malaysian Standard Classification of Occupations (MASCO) lists social welfare related careers and corresponding NOSS code
    - Although NOSS is current industry standard, it is not enforced by care providers

- Way forward
    - Upskill people already within the system. JKM must update qualifications to entice new workers. Prohibitive cost of certification/education deters applicants not eligible for PTPTN as it is not recognised within education system
    - Current acts are enough to enhance existing competencies and qualifications
    - The Social Work Profession Bill is a first step towards standardising and officialising pay for care work

Paper 8 Care economy as a growth sector
Rapporteur: Farhan Khairulannuar
Moderator: En. Rashidi Yahaya

Key takeaways:

- Addressing care economy challenges must be from a multi-dimensional standpoint involving all stakeholders on all levels. Government is not able to operate on its own in this regard. Thus, a bottom-up approach stemming from collaborations with for-profit sector and social enterprises is the main driver to facilitate change.

- Challenges persist in the growth of care economy as a sector in the form of institutional limitations which act as roadblocks for effective and timely policies to be introduced. Revamping the ecosystem accordingly will allow for smoother integration of policies already being discussed by relevant authorities.

Rapporteur notes:

- To be an industry, it requires being a national agenda for it to be socialised and implemented in an effective manner

- Major changes to the country in all aspects, not only via demography but due to external factors, necessitate the need for timely policy implementations. Failure to do so will cause the country to be left behind.

- Predictions for what is to come due to ageing society:
  - Larger collaboration between public and private sector
  - Increased standard of care services
  - Change in legal framework in some capacity at every level
  - A larger focus on a sustainable care economy
    - Sustainability of care economy necessitates the need for viewing care work as dignified work. Therefore, social entrepreneurship must be viewed as a legitimate means of providing care which should be compensated fairly
- Challenges faced in growing care economy as a sector:
  - Accessibility of care services faced by both provider and receiver
  - Imbalanced development. Implementation of a new system upon an existing one will lead to an unequal outcomes and needs
  - Ecosystem challenges: building an ecosystem to address demands on all levels. Approach must be done from a multi-dimensional perspective
  - Multi-stakeholder partnership: Government cannot operate on its own as it does not know everything. Working together with private and non-profit sector will allow for a more holistic approach to care

- The care economy must be viewed as a spectrum; from those who need it to those who can afford. Approach regardless of target group must include this consideration

- When discussing the care economy, growth also includes social growth, not only material and financial.

- Areas which need to be addressed:

- Policy and legislation
- Financing mechanism: Methods of financing differ based on tier financially. Appropriate mechanisms must be introduced in this regard
- Capital

- Structurally and ideals-wise, a separation exists between stakeholders (i.e. government and social enterprise. Cross-industry collaboration will allow for gaps to be bridged in terms of knowledge and implementation. Academia, operators, government, and private sector are included in this.

- Policy recommendations (or lack thereof):
  - Prerequisite for a policy recommendation is for it to be introduced within the right and conducive structure, allowing it to be utilised to the fullest. Therefore, a larger emphasis must be placed on correcting the ecosystem in preparation for future policy recommendations.
  - Political will and institutional reform are the ingredients needed for an ecosystem overhaul.

PRESENTERS' PAPERS AND SLIDES

Growing the economy and meeting the care needs of the Malaysian society
24-25 September 2024 | ISIS Malaysia

Session 1: Policy papers, initiatives, legislations and regulations in Malaysia

0930 – 1100 hrs | Tuesday, 24 September 2024

Role Players:

Moderator	**Harris Zainul**, Deputy Director (Research), ISIS Malaysia
Paper Presenter	**Prof Datuk Dr Denison Jayasooria**, Senior Visiting Fellow, ISIS
Discussant 1	**YBhg Emeritus Prof Datuk Dr Norma Mansor**, Director, Social Wellbeing Research Centre (SWRC), University of Malaya
Discussant 2	**Pn Fatimah Zuraidah Hj Mohd Salleh**, Ketua Penolong Setiausaha, Bahagian Kolaborasi Strategik, Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM)
Secretariat	**Yvonne Tan** – Rapporteur **Afiqah Abdul Malik** – Timekeeper

(L-R: Datuk Denison Jayasooria, Prof Norma Mansor, Pn Fatimah Zuraidah Salleh and Harris Zainul)

PAPER 1

CARE ECONOMY POLICY PAPERS, INITIATIVES, LEGISLATION AND REGULATIONS IN MALAYSIA

Denison Jayasooria, Senior Visiting Fellow, ISIS Malaysia

Introduction

It is significant to note that there are heightened calls for the care economy at the global and national levels including Malaysia. The Minister for Women, Family and Community Development, Dato' Sri Hajah Nancy Shukri[1] announced that the care economy will be incorporated into national development and economic planning. She recently affirmed that an action plan is being formulated for the development of the care industry in Malaysia.[2]

Part 1 CARE ECONOMY CONCEPTUAL UNDERSTANDING

LITERATURE REVIEW

There are many policy papers and reports on the care economy by academics, policy makers, policy advocates and social service activists. These make it a key policy consideration for governments to view care economy as a public good. These reviews and analysis illustrate a major need in Malaysian society for a service industry which caters for vulnerable groups in society especially the elderly, children, persons with disabilities and those with mental illness. Care economy also has the potential as a new engine for economic growth and opportunities for the creation of professional and competent service sector work force.

Based on literature search, one can identify seven key reports on the care economy undertaken by think tanks and UN based agencies in Malaysia. While there are many more references this review focuses on only these seven documents.

Document One is the *ISIS Malaysia policy paper: Building a cradle-to-grave care economy for Malaysia*[3] launched on 21 June 2024 at ISIS Malaysia

A well-researched paper written by Ms Lee Min Hui and ISIS team of three others. Has expert contributions from experts like Prof Norma Mansor and Dr Teoh Ai Hua. This paper provides a comprehensive review of care needs from cradle to grave. It highlights the aging society and the burden of care work upon women in unpaid care work. It also recognizes the potential of care economy as a potential driver of economic growth. There is a monetary calculation of the value of unpaid care work which can be valued at RM379 billion. The paper affirms that if care

[1] https://www.malaymail.com/news/malaysia/2023/07/11/nancy-shukri-care-economy-to-feature-in-national-development-planning/79134
[2] https://www.nst.com.my/news/nation/2024/05/1050185/nancy-shukri-launches-workshops-development-care-industry-malaysia
[3] ISIS Malaysia (2024). https://www.isis.org.my/2024/06/12/building-a-cradle-to-grave-care-economy-for-malaysia/

work is adequately address it could mean 3.2 million women can participate in the labour force. ISIS calls for integrating social care into social protection provisions, affirms the needs for a policy roadmap and declares that care must be seen as a public good and government must adopt a life cycle approach to care. The document provides a useful glossary definition.

Document Two is the *Asia Foundation report: Care economy dialogue. Towards a resilient and sustainable care economy in Malaysia*[4].

While this is a brief paper of eight pages, it contains some key pointers towards care economy in Malaysia. This paper was launched on 28 March 2023 in Kuala Lumpur. It provides the background document for a dialogue of the care economy including an understanding of the care sector and a discussion on the way forward. Two key points stand out namely that *care is a basic human right* so is being viewed from a rights framework. It is also regarded as *a silver economy*.

By silver economy it means all “economic activities, products and services designed to meet the needs of people over 50. This concept, derived from the so-called silver market that emerged in Japan, — the country with the highest percentage of people over 65 — during the 1970s to refer to the senior market, brings together sectors as diverse as health, banking, automotive, energy, housing, telecommunications, leisure and tourism, among others”[5]. In Malaysia the figure stands at 7.7% of the population[6] and it is projected to increase over the years.

Asia Foundation also highlights the need for professionalizing of care work and the issues of access especially to child care facilities by all sectors of society. Similar to ISIS Malaysia, Asia Foundation also highlights that “women bear the burden of unpaid care responsibilities which translated to low labour participation and return to work rates”[7]. In addition, this paper highlights that care work is also undervalued. There is also a call for a blueprint on care economy citing the ASEAN document. Asia Foundation also calls for a whole-of-society collaboration in addressing the care economy in Malaysia.

Document Three is the *Khazanah Research Institute (KRI) Paper: Time to Care: Gender Inequality, Unpaid Care Work and Time*[8] This is a 2019 document by KRI team of researchers headed by Christopher Choong and four others. This is a 159-page report. The executive summary highlights six key takeaways of their research findings. The first, unpaid care work is a pressing issue in the nation. The second is care work is undervalued and the third is women

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[4] Asia Foundation (2023) https://asiafoundation.org/wp-content/uploads/2023/06/Care-Economy-Dialogue-Toward-a-Resilient-and-Sustainable-Care-Economy-in-Malaysia.pdf

[5] Silver economy, older people will be the engine of the economy of the future. https://www.iberdrola.com/innovation/silver-economy

[6] Malaysia’s population in 2024 (DOSM). https://bernama.com/en/news.php?id=2323839#:~:text=Mohd%20Uzir%20said%20the%20composition,cent%20over%20the%20same%20period.

[7] Asia Foundation (2023) op. cite. Page 3

[8] KRI (2019) https://www.krinstitute.org/assets/contentMS/img/template/editor/Publications_Time%20to%20Care_Chapter%201.pdf

face the double burden of family and career. The fourth takeaway is unpaid care work has a negative impact on labour market outcomes. Fifth is formal childcare services are hampered by affordability and accessibility. Finally, the sixth takeaway is that there is a need to strive towards gender equality in the workplace and at the home.

One major contribution of this research paper is both the importance of measuring unpaid care work as well as how to measure unpaid care work especially its value as a market transaction.

Document Four is the *UNDP Policy Paper: Investing in the Care Economy: Opportunities for Malaysia*[9] This is dated June 2023. The focus is the early findings of a policy paper and the full report was later launched in July 2024.

The focus is on the challenges facing women in the employment sector impacting labour force participation rate (LFPR) negatively due to their caring role in the home front. This is regarded as a "disproportionate distribution of unpaid care responsibility based on biased social norms and gender stereotypes"[10]. The call here is to strengthen the care economy by adopting "a new vision of economics that recognizes the importance of empowerment and autonomy of women who bear the brunt of unpaid care, to the functioning of the economics, the wellbeing of societies and life sustainability"[11].

The paper provides a triple thrust for the future namely tapping the investment approaches of the private sector, strengthen the community-based care workers through at-home and care centre approaches as well as securing a higher role for the public sector.

A major shift for public policy and use of public funds is the call to view public spending on care system as an investment instead of a consumption expenditure[12]. Here, care must be seen as social investment in the same way as physical infrastructure such as building railways, ports and bridges to enable economic growth. In a similar way, social spending will facilitate economic growth too.

Document Five is the *Asia-Pacific Care Economy Forum*[13]. This is an Asia-Pacific level forum held on 22-23 June, 2023. They note care work as *"invisible"* as well as *"a lost opportunity for economic advancement".* The report also notes that care work is not an economic activity and remains unrecognized and undervalued. Their concern is also for the low and declining female labour force participation rates. They deliberated on how to strengthen care delivery models through expanding the market dimensions of the care diamond. Two halves- one side of the non-market namely government, family and non-government provisions and on the other, markets - business, investors and enterprise delivery models. The report has many models from around Asia as the participants were from 15 different countries.

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[9] https://www.undp.org/sites/g/files/zskgke326/files/2023-06/issue_brief_care_economy_investment.pdf
[10] Ibid page 1
[11] Ibid page 3
[12] Ibid page 5
[13] https://asiapacific.unwomen.org/sites/default/files/2023-07/highlights-and-recommendations-for-practitioners-asia-pacific-care-economy-forum-en.pdf

Within the Asia-Pacific Forum report is a specific reference titled as *"Malaysia deep drive"*[14]. Here, there is a highlight that the Malaysian government recognizes care economy. It also notes that there is a lack of formal recognition of the care economy. Therefore, by the end of the forum, the Malaysian government agreed to follow up these matters through the establishment of a national process namely the Malaysian Forum for the care economy. Their focus is to "develop care as a sector" through formulating "a care industry development fund, development human resources cadres and promoting training and education on care within universities"[15].

Document Six is the *ISIS Malaysia Roundtable Discussion – Conversations on Care Economy in Malaysia Compilation Report*[16] ISIS Malaysia hosted a two-day (26 – 27 June 2024) conversations among academics, government agencies and civil society-NGO actors. This is a report on two days of discussion among 71 participants with 30 key role players. This document contains a summary report, a rapporteur's report of each of the sessions and all the slides and papers presented. It is a very large compilation of 465 pages.

Among the topics and themes highlighted are the need for legislation and protection for children, the elderly and people with disabilities including regulations to monitor and evaluate the quality of care. Noted the need for professional services especially among the various target groups where there is a need to move beyond custodial care to higher competencies in addressing their socio-psychology needs. Among the target groups, the needs, concerns and issues of people with mental health issues are also discussed here widen the services to this target group too.

Document Seven is the most recent *UNDP - Enabling Investments into the Malaysian care economy*[17] which was launched in July 2024. This is the latest report published and is also very comprehensive in the treatment of the concerns. Four main sections namely care and economy, strengthening the policy and regulatory environment, care work and the worker, and finally, financing the care economy.

In this report, care is approached from a right to care dimension and there is a call for a new vision of care namely non-institutional approach to care which is care in the home. Another dimension which is new among the seven literature reviews is the UNDP SDG Investor Map which is an effort to mobilise private sector capital to advance SDGs. In this SDG IM they recognized "personalised and regular caregiving services for various needs as a key area in the health sector"[18] and see this dimension as an investment opportunity area. The thrust here is for a "business model for personalized caregiving services including in-home care, companionship, personal hygiene, medication management and specialized care."[19] The social enterprise model is recommended.

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[14] Ibid pg 17
[15] Ibid.
[16] https://drive.google.com/drive/folders/1PMYdoEy8FaeGwQxUDsu0K5BIgqtDBGSk?usp=sharing
[17] https://www.undp.org/malaysia/publications/enabling-investments-malaysian-care-economy
[18] https://www.undp.org/policy-centre/istanbul/publications/sdg-investor-map-malaysia
[19] Ibid pg 38

Care here must be seen as an investment and not a cost as there is much potential in care economy as a new source of economic growth, job and income creation. The document is full of case studies from other countries which enrich the care economy and highlight the possibilities for Malaysia. There is also a call for a national roadmap focused on strengthening the regulatory space as well as enhancing the quality of care through appropriate training and competencies. This report also contains specific recommendations pertaining on financing for care.

THEMATIC ANALYTIC FRAMEWORK

A 15-point thematic policy analysis of each of these documents is undertaken under two main themes. Part One is on care economy at the national level with eight sub-themes and Part Two is on Care economy at the care service provider's level with seven sub-themes. This 15- point thematic policy analysis framework are summarised in the table below:

THEMATIC AREAS	DESCRIPTION
Part 1- Care economy at the national level: Description of key points that have a national significance.	
1 Care policies	There are national level care policies linked to national development agenda, relevant legislation governing care practices and regulatory guidelines.
2 Legislation governing care & professional care workforce	There is a need to review legislation and regulations which are relevant to social economy and social work. There could be a reference to existing Acts and proposed bills. Could reflect on the guidelines on care and social work. One example is the JKM - Handbook of Social Work Skills (2020)
3 Care industry	Seeing the care economy not as a cost as government expenditure or in the voluntary sector/informal sector domain but as an economic growth, investment-driven and job creation. Ensuring the care economy is considered as an economic activity.
4 Public good	Care economic is viewed as a public good to ensure that the government investment into the social infrastructure which is needed to build a conducive policy environment for the care economy. It is building a friendly eco-system for the care economy to flourish and improve the quality of life.
5 Financing	On care economy, the key question is who will finance this. Current dominant model is the family especially women in the informal sector. However, in the mixed economy, there is therefore, a balanced financing between government, private and voluntary sectors. There could be

	inclusion of care economy in social protection measures and insurance schemes.
6 Data	Data evidence is most critical on demographic trends, women's participation in the informal sector and out of labour market, on specific target groups, care providers including economic data.
7 Gender dimensions	This is an area of major concern as majority of the caregivers are women who remains unrecognized and undervalued. It also keeps women out of formal, productive labour force participation. It also raises questions on the role of men especially fathers in joint parental responsibilities and the need to break away from cultural steroid types of male-female roles in the family unit.
8 Cultural dimensions	While the overdependence on women can be seen from a negative aspect, nonetheless the dominant caring role of women in the context of the family is still very popular. Therefore, there is a need for discussion and awareness from cultural and religious perspectives on this theme. How do we address the need for a balance in service provision between family, government, private and voluntary sectors
PART 2- Care economy at the care service providers level: Description at the care services to specific groups	
1 Target groups	The vulnerable groups are young children, the elderly, people with disabilities and those with some mental illness.
2 Care needs	A description of the needs of the targets groups at different levels such as domestic tasks like feeding, bathing, cleaning and cooking on one hand and on the other, the main care giving roles such as counselling, psychological support, companionship as well as physiotherapy.
3 Care work	Based on the care needs of the specific target group, these could range from domestic tasks by a care worker to higher care tasks with the support of social workers and psychologists.
4 Care services	A variety of services from personal home-based, day care, community-based, residential-based at a public sector or private sector or voluntary initiatives. Affordability and accessibility are key aspects.
5 Care service providers	This can range from the informal, the family to voluntary sector providers to cooperatives or community based non-profit initiatives to social enterprises and finally, public or private sector providers.
6 Capacity building and competencies	There is a need for a comprehensive capacity building training programs to provide a comprehensive range at different levels of knowledge, competencies and values. A vocational-based course might be suited for basic tasks of caring to higher demands. These must lead from informal to more formal training including degree and postgraduate qualifications. There must be a basic set of competencies to be certified as a care worker with the possibilities of upgrading

	competencies, knowledge, and values of practice. These could be offered at the certificate, diploma, degree and postgraduate qualification levels.
7 Examples from other countries	Drawing examples from a cross-section of countries in Europe as well as Asia on how governments organized care economy, noting their achievements, challenges, gaps and models.

PART TWO

CARE ECONOMY AT THE NATIONAL LEVEL

In this section we will focus on eight key points on the case economy which has a national significance as highlighted in the six major policy papers under review.

1 Care Policies

While there is a political statement towards a care economy and its importance, however, there is currently no care economy policy or roadmap. There are calls for a national care blueprint, a roadmap and a national care act[20]. Such a national policy must be holistic taking a life cycle approach to care, from cradle-to-grave approach as advocated by the ISIS Paper. It could also include a National Aging blueprint as it is important to incorporate aging as a development agenda[21]. In this context the National Policy of Older Persons (2011) by the Ministry of Women, Family and Community Development[22] as well as the National Health Policy for the Older Persons (2008) from the Ministry of Health[23] should be taken into account.

There is a need to shift our policy thinking on the care economy just as government expenditure and a claim on the annual fundings of the government. However, there is a call to view the care economy as a driver of economic growth as well as in addressing the wellbeing and welfare of everyday Malaysians[24].

The national care policy must take serious account of the workplace child care centres[25] which are preferred. However, majority of these child care centres run by government funded centres are not accessible to public. Private sector provisions are accessible only to those who can afford them.

Both Asia Foundation and the UNDP call for a national care economy policy that must be based on a right to care. Based on the principles of human rights and therefore the theme of rights for all- universal care, accessible, affordable and quality care.

[20] ISIS Malaysia (2024) op.cite page 20
[21] Ibid page 9
[22] https://www.kpwkm.gov.my/kpwkm/uploads/files/Muat%20Turun/MOST/S4_P1_Tuan%20Hj_%20Fazari.pdf
[23] https://www.kpwkm.gov.my/kpwkm/uploads/files/Dokumen/Dasar/Dasar%20Kesihatan%20Warga%20Emas%20Negara.pdf
[24] ISIS Malaysia (2024) op.cite page 24
[25] Ibid page 11

Care services could be undertaken by multi stakeholder groups - government, private sector, community, the family and the informal sector. However, the policies must enhance the equal rights of women and not be based on traditional male-female work divisions.

2 Legislation governing care & professional care workforce

Adopting a human rights approach to the care economy is possible as Malaysia acceded to the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC) in 1995. In addition, Malaysia ratified the Convention on the Rights of Persons with Disabilities (CRPD) on July 19, 2010. The conventions provide a solid human rights basis for policies and legislation

Currently, there are a number of legislations pertaining to the elderly, women and children. There is a need to review them to enhance them towards the UN Convention standards and requirements. For the elderly, relevant acts include the Care Centres Act (Act 506) 1993; the Private Healthcare Facilities and Services Act (Act 586) 1998 and the 2016 revision. Another is the Private Aged Healthcare Facilities and Services Act (Act 802) 2018 which is not gazetted yet.

The KRI paper[26] provides a good write up on regulating child care centres is the Child Care Centre Act 1984 (Act 308). It is the Child Care Act 1984 (Amendments 2007) which outlines the implementation of childcare centres. This act governs four types of child care centres namely homebased child care with fewer than 10 children, workplace child care centres with more than 10 children, community-based child care centres with more than 10 children and institution-based child care centres. The questions raised are the sufficiency of this provision and if access by majority of the people. The other is affordability and finally the question of quality. KRI indicates that 98% of Malaysians opt for informal child care. [27]

The matters pertaining to the Social Work bill in order to promote the professional nature of social work is well articulated by Dr Teoh Ai Hua[28]. He draws a distinction between social worker and care worker. Here he states “care workers typically engage directly with clients in daily activities and personal care, social workers engage with the welfare system to effect broader changes”[29] It is noted as complementary roles within the care ecosystem. However, the promised legislation on social work has been delayed and require specific calls for its urgent tabling in parliament soon.

3 Care industry

The ISIS Malaysia (2024)[30] study projects the care economy as a potential driver of economic growth. It recognises that the value of unpaid care economy jobs when compared in GDP terms

[26] KRI (2019) op.cite page 102
[27] Ibid page 113
[28] ISIS Malaysia (2024) op.cite page 12
[29] ibid
[30] Ibid page 3

could reach RM379 billion which is the largest service subsector after manufacturing if valued in GDP terms.

The KRI (2019)[31] study calls for Malaysian development planners to re-frame care economy not just as helping increase women participation in the labour market but to view care economy as a source of economic growth.

The UNDP (2024) report too also recognises "the potential to become a new source of economic growth and job and income creation for the country." In a nutshell, by creating incentives to boost the care economy, the Government can create economic and social ripple effects beyond its initial intervention costs"[32]

4 Public good

The idea of a public good[33] is when the public sector or government through its development budget begin to recognize and revalue care as a public good as a service it provides. It can be regarded like physical infrastructure but here it is social infrastructure. Our problem is a cultural one where social care is regarded in the domain of the personal and family level and not a public sector role. However, the literature on the care economic is advocating for great state involvement so as to ensure the new challenges facing families can be effectively addressed. Therefore, public investment is necessary.

5 Financing

There is a call for more public funding but to view this spending not as a cost dimension but as an investment. There is also the call to integrate social care into social protection, a matter highlighted in the ISIS Malaysia study. The call extends to instituting caregivers' allowance as well as enabling full-time caregivers to contribute to EPF coverage and for "the government to incentivise voluntary contributions by offering matching contributions or top-up to caregivers' EPF."[34]

There is also a call to initiate "a true accounting of care work, looking into its unpaid nature and providing a measure of its contribution to the economy and national GDP."[35]

6 Data

Data is essential for policy advocacy. However, Asia Foundation notes that "there is limited data on the care economy to guide effective programming and policymaking"[36]. The literature review provides some key data which can enhance policy advocacy. The general statistics reveal the rise in the aging population.

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[31] KRI (2019) ibid. page 116
[32] UNDP (2024) op cite page 37
[33] ISIS Malaysia (2024) op.cite. page 3
[34] Ibid page 17
[35] Asia Foundation (2023) op.cite page 4
[36] Ibid. page 3

The KRI (2019) study indicates that “vast majority of households (98.8%) resort to informal forms of childcare including relatives, babysitters and unregistered childcare centres”[37]. It is further noted at 98% are women in these caring roles and an estimate 3.2 million Malaysian women are impacted by domestic work obligations.[38]

7 Gender dimensions

Women are regarded as the informal carers for the elderly, children and persons with disabilities. Unpaid care work also widens gender inequalities. It also negatively affects women participation in the labour market. There is a heavy reliance on informal care arrangements.

All the literature highlights this dimension. KRI (2019) affirms the “double burden” facing women. Women shoulder “more unpaid work than men despite working almost equal hours in paid employment.”[39] It is also clear that “additional hours of unpaid care work is associated with fewer hours of market work and less income.”[40]

8 Cultural dimensions

Cultural norms have a strong bearing on the roles played by women and men in the caring sector. KRI research highlights three global models[41]. The first is *“the male breadwinner model”* where the man is the breadwinner and the women is the homemaker. The second model is *“the universal breadwinner model”* where both male and female have market place jobs. Here women have a double role but men are also responsible for caring roles. The final model is *“the care giver parity model”*. Here the care work is compensated through greater state support through allowances and benefits.

The KRI report affirms that in Malaysia has traditionally been that of a male breadwinner and female homemaker model. We are caught by cultural norms of gender divisions. KRI also notes that “women are entering the labour market at a faster rate than men are participating in the domestic realms.”[42]

PART THREE

CARE ECONOMY AT THE CARE SERVICE PROVIDERS LEVEL

In this section, we will focus on seven key points on care services to specific groups as highlighted in the six major policy papers under review.

1 Target groups

All the research papers refer to the elderly, children and persons with disabilities. It is the ISIS Malaysia RTD which also extends this discussion to incorporate another vulnerable group

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[37] UNDP (2024) ibid. page 113
[38] ISIS Malaysia (2024) op.cite page 6
[39] KSI (2019) op.cite page 89
[40] Ibid page 90
[41] ibid. pages 93-95
[42] Ibid. page 118

namely those with mental health issues. These are different target groups with their specific needs and concerns. The intervention could also differ. There is a need to shift our mindset to ensure that these target groups are treated with respect and dignity.

2 Care needs

As the papers were more focused on policies the socio, economic, psychological needs of the target groups were not discussed except for the key points that a more professional approach is needed.

3 Care work

All the documents and research focus on care work and does not bring social work into focus. There is a need to build the care ecosystem where care workers, social workers, psychologists and others having expertise in addressing the needs and concerns of the elderly, children and various groups with disabilities. This would also require specific set of skills, competencies and knowledge to service the target groups professionally and with compassion.

4 Care services

Care services will include residential care, day care, counselling services and depending on the needs of the target group. Children, older persons or different natures of disability will require specific intervention and professional services including educational aspects.

5 Care service providers

This is a need to increase care providers in other sectors such as the private sector including social enterprises, the voluntary and community sector. The increase in private nursing homes and care homes for the elderly is a significant departure especially in urban centres. In a similar way, the voluntary and community sectors have also increased services. However, these lack the resources and personnel. There must be this shift from informal care to more formal and organised care.

Private providers especially social enterprises expressed concern at the ISIS RTD that the registration process and requirements were not very welcoming to new operators and therefore require some changes to enhance more informal sector groups to become registered.

6 Capacity building and competencies

There is a good description of training needs for competent workers. This could be at the basic certificate and diploma levels or much higher at the degree and postgraduate levels. It could range from TVET skills training to more specific training which also address emotional wellbeing. While the care worker seems to be focused on domestic duties, these too need care and patience in handling the elderly, children and persons with disabilities. Competent skills as well as values in treating people as human being with gentleness and compassion are essential. At the same time there must be a pathway from certificate to diploma to degree and postgraduate studies in care work.

The Ministry of Human Resources as well as the Ministry of Women, Family and Community Development together with the Ministry of Health must recognise care and social work job and

provide guidelines for salaries and conditions of service. This will facilitate the job market and locals to specialise in care the elderly, children, persons with disabilities and those with mental health concerns.

7 Examples from other countries

The UNDP (2024) cited numerous examples which illustrates that these concerns are not peculiar to Malaysia alone. The illustrated examples show us best practices from policy intervention to care services which we can learn from and adopt.

The Asia Pacific report 2023[43] also has many example projects. A significant initiative is Care Accelerator 2.0 a network of 13 care enterprises across Asia. This is part of a larger "Gender-inclusive care entrepreneurship ecosystem programme" with the aim of strengthening gender-inclusive care ecosystems.

RECOMMENDATIONS AND CONCLUSIONS

Five key policy recommendations:

First, the need for **national policies, roadmap and blueprint on the care economy**., Incorporate this into development planning and develop a new chapter in the 13th Malaysia Plan on this. There is a need to include social care into social protection schemes.

Second, formulate **appropriate legislation to support the care economy** especially the recognition of care and social workers including the professional aspects of this service. Also to review all legislation pertaining to the care of elderly, children, persons with disabilities and person with mental health issues so that services will be accessible, affordable and of quality.

There is a need for serious thought in reversing the ISIS Malaysia conclusion – "Malaysia lacks consolidated legislation and policy on the care economy as well as regulatory framework to sustain a highly qualified social care workforce in the long term."[44] There is clearly a need for a National Care Act[45] where all the target groups are given the right to access care.

There is a need for the Parliament to review the Social Workers Bill and Older Persons Bill which was presented for first reading in 2023 and activate this so as to enact these as Acts of Parliament in 2024.

Third, the recognition of **the care economy as a new economic growth area** is vital in order that public funds are released to build the social infrastructure similar to physical infrastructure and enhance job creation, investments and economic contributions from the care economy sector. Here, the Ministry of Economy could play the lead role and facilitate economic advancement.

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[43] Asia-Pacific (2023) op.cite page 7
[44] ISIS Malaysia (2024) Op.cite page 11
[45] Ibid page 20

Fourth, establish an **inter-agency taskforce** incorporating officials from the Ministry of Women, Family and Community Development, the Ministry of Human Resources and the Ministry of Health together with academics and representatives of professional bodies such as the Malaysian Association of Social Workers. This requires **a multi-stakeholder taskforce** as we need to mobilise the government, private sector, academic community, professional bodies and citizen's groups including NGOs and consumer organisations.

Fifth, address **the cultural dimension and gender stereotyping** through a wider public awareness and educational programme on gender literacy. This is the major challenge in Malaysian society to address both cultural and religious views on the division of labour between men and women. Therefore, making care economy policies and initiatives more gender-sensitive and culturally-respectful.

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CARE ECONOMY POLICY PAPERS, INITIATIVES, LEGISLATION AND REGULATIONS IN MALAYSIA

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Introduction

- Thanks for the opportunity
- Government determined to promote Care Economy
- Exploring the possibilities to enhance this in Malaysian society

Outline of the paper

Introduction

- Part 1: Care Economy conceptual understanding
- Part 2: Care Economy at the National level
- Part 3: Care Economy at the Care service providers level

Recommendations & Conclusions

PART 1 CARE ECONOMY: CONCEPTUAL UNDERSTANDING

Literature Review

1) ISIS Malaysia policy paper: Building a cradle-to-grave care economy for Malaysia

2) Asia Foundation report: Care economy dialogue. Towards a resilient and sustainable care economy in Malaysia

3) Khazanah Research Institute Paper: Time to Care: Gender Inequality, Unpaid Care Work and Time Use Survey.

4) UNDP Policy Paper: Investing in the Care Economy: Opportunities for Malaysia (June 2023).

PART 1 CARE ECONOMY: CONCEPTUAL UNDERSTANDING

5) Asia-Pacific Care Economy Forum.

6) Roundtable Discussion – Conversations on Care Economy in Malaysia Compilation Report, 26 – 27 June 2024. ISIS Malaysia

7) UNDP - Enabling Investments into the Malaysian care economy (July 2024)

PART 1 CARE ECONOMY: CONCEPTUAL UNDERSTANDING

- Thematic Analytic Framework
- 15 pointers - divided in 2 parts

- **For National Level** – 8 points are key emerging themes in the reading
- Pointers we need to consider and respond to
- Provides an outline for the national policy on care economy

- **For Care service providers level** - 7 key points
- Similar to national these are key pointers emerging in the writings
- They serve as a check list of the key dimensions which need to be taken into account

PART 2 CARE ECONOMY AT THE NATIONAL LEVEL

1. Care policies
2. Legislation governing care professional care workforce
3. Care industry
4. Public good
5. Financing
6. Data
7. Gender dimensions
8. Cultural dimensions

PART 3 CARE ECONOMY AT THE CARE SERVICE PROVIDERS LEVEL

1 Target groups

2 Care needs

3 Care work

4 Care services

5 Care service providers

6 Capacity building and competencies

7 Examples from other countries

RECOMMENDATIONS AND CONCLUSIONS

1 National policies, roadmap and blueprint on the care economy

2 Formulate appropriate legislation to support the care economy

3 The recognition of the care economy as a new economic growth area

4 Establish an inter-agency taskforce

5 Address the cultural dimension and gender stereotyping

Session 2: Issues in governance: Federal-state relations, public, private and voluntary sectors, urban-rural divide and lessons from the Global South

1100 – 1230 hrs | Tuesday, 24 September 2024

Role Players:

Moderator	**Harris Zainul**, Deputy Director (Research), ISIS Malaysia
Paper Presenters	**Dr Teo Sue Ann**, Director, MySDG Centre for Social Inclusion, Society for the Promotion of SDGs **Dr Khairil Ahmad**, Research and Policy Consultant, MySDG Centre for Social Inclusion, Society for the Promotion of SDGs
Discussant 1	**Pn Masneh Abd Ghani**, Penyelidik Bersekutu Kanan, Institute for Development Studies (IDS) Sabah
Discussant 2	**Dr Yuen Kok Leong**, Senior Research Officer, Sarawak Development Institute
Secretariat	**Yvonne Tan** (ISIS Malaysia) – Rapporteur **Afiqah Abdul Malik** – Timekeeper

(L-R: Pn Masneh Ghani, Dr Yuen Kok Leong, Dr Teo Sue Ann, Dr Khairil Ahmad and Harris Zainul)

PAPER 2
From Global South to Malaysia: A Review of Care economy in Malaysia

Teo Sue Ann and Khairil Ahmad

Introduction

The development of care economy has historically been concentrated in the context of developed and industrialised societies. Different aspects of social care have entered the policy discourses of many of those contexts since the era of post-World War II rebuilding as part of the effort to define the state's role in the provision of welfare support for its population. It is therefore not surprising that developed countries, especially those in the Global North, have become the standard bearers of social care models that others take as examples to learn from. This is also the case in Malaysia – as the societal discourse about care economy gathers momentum, there is a tendency to explore and learn from social care models from contexts such as the Scandinavian countries, UK, the Netherlands, Australia, Japan, South Korea, and Singapore (Lee and Cheng, 2024; UNDP, 2024).

The increasingly urgent needs for revitalising the care economy largely due to aging of the society (Chan et al., 2023a) and the urgent call for recognising the unpaid care work (Jawahir et al., 2021; Kong et al., 2021; Nasreen et al., 2024). On 23 June 2024, the Malaysia Women, Family and Community Development Minister Datuk Seri Nancy Shukri stated that between 10 per cent and 39 per cent of a country's gross domestic product when properly regulated. The care economy is perceived as a business industry that includes childcare, elder care, care of special needs, education, healthcare, welfare and personal, social and domestic services that are provided in both paid and unpaid forms and within the formal and informal sectors and employment.[46] It is interesting when compared to the UNDP's notion of care economy, which entails a diversified range of products and productive work to deliver direct and indirect care necessary for the physical, psychological, and social wellbeing of primarily care dependent groups such as children, the elderly, disabled, and ill as well as for prime age working adults. Both concepts illuminate the pivotal attention that the Malaysian society needs, especially for the important groups such as children, older people and women who are unpaid caregivers.

This is not an unusual development – in fact, it is natural in policy conversations to allude to established models as examples that represent the spectrum of tried and tested systems of care to analyse their suitability to the Malaysian context, ranging from the levels of involvement of the state in the provision of care, regulation and financing of the care sector, technological

[46] According to the Malaysia Department of Statistics (DOSM), the informal sector is the enterprises, companies, or any other professional bodies that do not register with the Companies Commission of Malaysia (CCM) and the Local Authority (LA). The sectors involve in non-agricultural activities, often with less than 10 employees who are not covered by any social protection schemes. Informal employment, on the other hand, is defined as employment in informal and formal sector. The latter includes employees or family members who do not receive social protection contribution (EPF and SOCSO) from the employer, paid annual and sick leaves. It also includes family members who work domestically and do not receive social protection contribution from the employer, paid annual and sick leaves (DOSM 2020).

change and adaptation in social care, coverage of care services, as well as who should be considered the beneficiaries of care.

The insurgent interests also prompt the Malaysian government to delve deeper into exploring the scopes and economic prospects of the industry. On the one hand, the Malaysia Minister of Women, Family and Community Development, Datuk Seri Nancy Shukri stated her emphasis on women unpaid and underpaid caregivers (Faiqah, 2023). To address the gaps in between paid and unpaid women caregivers, the Minister decided to focus on increasing the numbers of skilled and trained care givers in the paid care economy. Nevertheless, the needs for care services is not confined to only women who are daughter, daughters-in-law, mothers and single mothers. Men who are sons, sons-in-laws, father and single fathers also need care services. Based on previous studies, in parallel with the increasingly matured Malaysian society, the 'sandwich' generation is also expanding. The 'sandwich' generation is referring to daughters and sons who also have families of their own (Syed Zahiruddin, n.a). While they must provide for their household expenses, they must also take care of their elderly parents and parents- in-law (Chan et al., 2023b).

On the other hand, the Malaysia Deputy Economic Minister, Datuk Hanifah Hajar Taib opined that by tapping on the rising global market potential for ageing population, the Malaysia care economy could attract revenue on investment, at the same time, stimulate growing demands for healthcare services, both domestically and internationally (BERNAMA, 2024).

The ministers' narratives echoed the familiar Malaysia state interventionalist policies in development that predominated since Independence, which the government focused on provide conducive environment – infrastructure, deregulation, liberalisation and overall micro economic management (Chee & Barraclough, 2007). This to enable the private sectors as driving forces for enhancing the care economy in Malaysia. Such interventionalist policies was particularly prominent during the Mahathir's administration in the early 1980's, which was particularly evident in the Malaysian healthcare industry. It is noteworthy that before the 1980's, the primary healthcare provider was the Malaysia government. The healthcare services were welfare-oriented and the people relied on the government healthcare services, such as general hospitals in the urban areas, and widespread healthcare clinics at the rural areas for needed services (Chee & Barraclough, 2007). The government hypothesised that the privatisation of healthcare industries would stimulate competitiveness among the private healthcare providers. More hospitals and healthcare facilities would be built, with competitive medical fees and more state-of-the-art services.

Many private sectors and service providers have also piggybacked on the government's call for advancing the care economy, by echoing the urgent needs to legalise the current informal service providers. The legalisation would ensure minimal wages for the service workers (Sharayu Pillai, 11 January 2023). Furthermore, some also call for more gender equality in the narratives for care economy, by giving equal emphasis on women and men (Goh, 2023).

Despite the discourses revolving the Malaysia care economy, few have discussed the pragmatism in executing the strategies for stimulating the Malaysia care economy. The pragmatism based on the realities on ground is persistently lacking in the discussion. Such discussion underscores the success of any care giving business in the country.

There is, however, still a dearth of discussion that considers Malaysia's evolving approach to social care in relative context with other Global South counterparts, in terms of drawing parallels for challenges that we face as well as learning from their experiences in managing those challenges. This paper, therefore, considers the issues that have been highlighted above and relates them to examples from several contexts from the Global South, which are Brazil, Cuba, India and Indonesia.

We address not only the dynamics of care from regional, country and local levels. Addressing these dynamisms are crucial in confronting cross-cutting and longstanding issues that are plaguing some of the countries. In Malaysia, the issues of imbalanced development, socio-cultural, religious beliefs, communalism and local politics have been the persistent stumbling block for policy implementation of Malaysia government. Without accelerating the current Malaysian government's efforts in addressing these longstanding and persistent issues, any effort to stimulate care economy in Malaysia would deem to be futile.

This paper is derived from several important sources. Firstly, we review the past and current initiatives from the Global South about the economic potential, challenges and hindrances in advancing the care economy in these countries. Then, we consider the expert opinions and lived experiences shared by the participants during the roundtable discussions that was held in the Institute of Strategic and International Studies (ISIS) from 26-27 June 2024. Furthermore, we also analyse the inputs from the qualitative inputs documented during the issue mapping process of the All-Party Parliamentary Group Malaysia on Sustainable Development Goals (APPGM-SDG), specifically on its localisation SDG initiatives in Kelantan, Sabah and Sarawak.

Integrated yet decentralised social assistance system: Brazil's Unified Social Assistance System (SUAS)

One of the perennial and most controversial political questions in federalist administrative systems is regarding how the powers of the national and subnational governments can be effectively distributed. This is especially so in contending with the question of fiscal responsibilities and how funds are shared and distributed between the different constituent parts of the overall governmental system. Within developing contexts, this question is especially important in trying to come up with a structure that would distribute development benefits fairly between all parts of administrative systems which are often times complex and bound by rigid constitutional arrangements (Frey and Eichenberger, 1999).

As we have observed earlier in this paper, Malaysia's federal-state dynamics similarly revolves around similar issues, and they feed into the different realms of the country's governance

structures, including on social care and welfare. They include, among other things, overlapping and/or conflicting jurisdictions of federal and state governments, silo-ed ways of working between government agencies and departments, and the lack of coordination between the different levels of government in dispensing social assistance and welfare.

To address those issues, the federal government in Malaysia has worked towards establishing integrated database systems that contain information about the welfare and assistance needs of poor and vulnerable households in Malaysia, starting from e-Kasih in 2007 to the Central Database Hub (PADU) in 2023. Notwithstanding other issues related to both those systems, their roles as mere information databases to be used by public agencies to plan their respective social assistance could be further enhanced through the presence of an agency which broadly defines the types of services or assistance that should be rendered to those in need and which coordinates the distribution of those assistance across all levels of government. Far from making the provision of social assistance and care centralised in the hands of the federal government, it is possible for such a system to be the catalyst to define the roles of the different levels of government in providing care services more clearly and generate a more coordinated and context-sensitive dispensation of care. In other words, while the system provides the guidelines for the types of services that must exist in all parts of the country, the responsibility to provide those assistance is left in the hands of state or local governments that work within their respective contexts. An example of such a system is the Unified Social Assistance System (SUAS) in Brazil.

Brazil's dynamics as a federalist system is one that has alternated in terms of the emphasis on centralisation and decentralisation. Its current constitution, which was written in 1988, has strong decentralisation tendencies compared to its military dictatorship-era predecessor which was written in 1967, which emphasised on the dominant and central role of the federal government (Ter-Minassian, 1997; de Almeida, 2006; Serra and Afonso, 2007). Among other developments, the 1988 constitution generated a vision about welfare and social assistance from a public policy perspective in Brazil – something that was previously left to the non-state domains (Paixao, 2021). This vision was one that is underpinned by the shared responsibilities of the union, state, and municipal governments in providing social assistance to the Brazilian population.

In 2005, the Brazilian government introduced SUAS to ensure effective and fair distribution of welfare and social assistance to all parts of the country. Although SUAS was introduced by the federal government, it does not operate in a top-down and centralised fashion. Rather, it is a system that organises and funds social assistance in a participatory fashion among all levels of government across the federation (World Without Poverty, 2015). As the Brazilian tax system heavily favours the federal government, SUAS also facilitates the transfer of federal funds to state governments for the provision of social assistance. It also has a collaborative governance structure comprising agencies across all levels of government. According to de Arruda (2023a, p. 6), the system "lays out important enablers" to allow for the efficient coordination for the dispensation of social assistance in an intergovernmental fashion.

What is interesting about SUAS is that while it provides indicative guidelines to support the targeting of services and a list of typified services that are offered, it does not prescribe or spell out how state of local governments should provide those services (de Arruda, 2023b). It therefore de-centralises the provision of social assistance while at the same time ensures multiple and overlapping symptoms and causes of socioeconomic issues such as poverty are addressed simultaneously. It also plays the role of managing the inclusion of new poor households into the Brazilian government's Unified Registry database, an equivalent to Malaysia's e-Kasih, as well updating the information of already registered households (de Arruda, 2024). Having an implementing agency that coordinates – not directs – the distribution of social assistance across so many levels of stakeholders makes a lot of sense for a country like Malaysia as well, which has been looking for a solution to streamline its welfare system. It also provides a platform for communication and dialogue between public and non-governmental service providers, who all move in the same sort of direction in terms of the areas of welfare services they cover as provided for by the list of national typified services. The people who are the beneficiaries of those services will also be clear in terms of the benefits that they will be able to access based on their needs. The types of service coverage will also be standardised, whereby people no matter where they live – in the urban or rural areas – are able to access assistance via more locally driven approaches. The result will also be a dynamic system that can accommodate more typified services in the future upon collaborative determination for their needs. It may also be a cost-effective way to provide care services to people living in the different parts of the country.

Putting 'value' into the care economy: Cuba's social justice approach

While Cuba is admittedly not a federal state, if we are to discuss Global South countries that have managed to provide welfare and social benefits universally to their citizens, few countries are more fascinating and studied (Erikson, Lord and Wolf, 2002; Jones, 2016). The outcomes of Cuba's safety nets provision, which includes free and universally accessible healthcare and education, worker housing, and a comprehensive pension system, among others, have showed positive trends over the years since they were instituted in the 1960s (Uriarte, 2002).

Not discounting the fact that Cuba's safety nets system – which places the burden of funding responsibility on the shoulders of the government – has been facing strains in the face of an ageing population (Diaz-Briquets and Gonzalez, 2023), it provides interesting lessons to be learned in helping our thinking about the *value* of social services in Malaysia, including social care. Value here is does not refer to economic figures or indicators. Rather, it refers to the codes or standards that should be driving the way we provide social care to the needy and most vulnerable communities we transition from traditional to professional care structures in the country.

One of the key transformations that has been identified in Malaysia is to embark upon the professionalisation of care work to ensure that that the sector is staffed by qualified workers with the necessary qualifications and is aligned to other professional careers (Norma, Lee and Cheng, 2024). Alongside this call is also the emphasis on the economic opportunities that

awaits the nation as the sector flourishes as an industry that fulfils the growing demand for care (BERNAMA, 2024). The catalyst for this shift will be a better regulated care sector which is based on professional standards to move us away from traditional and unpaid care. The narrative, overwhelmingly, seems to be couched very strongly on economic progress.

In this sea of transformation in Malaysia, the risk may be that the moral aspect of social care will take a back seat especially if the policy focus leans strongly on the push towards marketisation and commodification of care (Peng, 2019). More specifically, as we attempt to transition from informal and unpaid forms of care, what should be transformative meaning of care (Rottenberg, 2018)?

This is a question that is already under-explored in our current understanding of the care economy landscape in Malaysia. Nonetheless, it is important to note that the performance of care work, even at the informal level, is not necessarily only tied to their economic cost and outcomes. For many who perform care work at the informal level, the reasons may be for financial gains or more, which are tied to their moral functions. Recognising the moral dimension of care and making sure it is captured as we transform the care sector is an acknowledgement that the value of care goes beyond monetary quantification and is also tied to the notion of social justice.

Such values are embedded in the Cuban social care sector. While workers are professionally trained, the ethos of social care in Cuba is one that is embedded in the sense of social justice – an important aspect to furnish the profession especially as those workers deal with communities that live in poverty and are vulnerable (Truell, 2017). In transforming social care in Malaysia, especially at the grassroots and community levels, perhaps the emphasis on the transformative value of care should also be emphasised even if the preference of the government is to invite the involvement of the private sectors. The aim should be to foster support networks that are meaningful among those communities and empower care workers to respond to local needs, which would allow for a more transparent diagnosis of what the communities they care for really require in terms of support from the federal government.

Transforming gender norms in a traditional society: Indonesia’s care economy road map

One of the sociocultural challenges in navigating the care economy debate in Malaysia, as we have highlighted earlier, is traditional gender norms that have contributed to women carrying the burden of care in the society (Khazanah Research Institute, 2019). So far, the reform narrative has been one that emphasises the need for there to be more accessible and affordable childcare facilities that would help facilitate greater women participation in the labour market as they are able to leave their children in the hands of professional carers at those facilities (UNDP, 2024).

While building a quality and accessible care ecosystem is important to reduce the burden of care on women, challenging the gender inequality that has shaped traditional expectations

should also be on the policy agenda. This is important to allow for fundamental and long-term shifts in the way gender roles are imagined by the society, which would result in a fairer distribution of the burden of care between women and men. Such reform is common in the Western contexts such as the Scandinavian countries, through the introduction of gender equality legislations that shape ways gender roles are taught in school as well as labour market changes that facilitate opportunities for men and women to attend to their family responsibilities through subsidised childcare, equal parental leave, and flexible working arrangements (Nordic Co-operation, 2019).

The need to address the gendered division of care work has also been recognised by regional and national initiatives across the Global South. Closer to home, the Association of Southeast Asian Nations (ASEAN), in its pioneering report Addressing Unpaid Care Work in ASEAN has identified "shifting norms, cultural practices and individual behaviours" as one of the six levers of change to reforming care policies in member countries (UNESCAP and ASEAN, 2021, p. 58). This involves a whole-of-society effort to challenge patriarchal assumptions about gender roles and shifting prevailing mindsets about caregiving in the member countries.

The importance of including strategies to affect shifts in gender norms has also been recognised by Indonesia, which has recently launched its Road Map for Care Economy for a Transformative, Fair and Equal Work. The Road Map lists seven priority areas to be addressed by the year 2045, with "the increasing the involvement of men, including paternity leave" counting as one of them (Nuriana and Lingga, 2024). Ultimately, in addition to transforming Indonesia's care economy landscape, the road map aims to facilitate the creation of a gender equal labour market and a fairer access to work for women. This will be done through efforts to shift societal attitudes about women's role in caregiving through public campaigns to address stigma about care work especially among boys and men to foster willingness to share the burden of caregiving in their families and communities. Socially based initiatives such as this, alongside information and advocacy campaigns via local channels and social media will be complemented by policy and legislative measures to improve women political representation at all levels as well to challenge and sanction harmful practices such as gender-based violence (The World Bank, 2024b).

Malaysia's care economy from policy to the ground realities

The current and seemingly mainstream discourse of care economy revolves primarily on the realities of paid and unpaid care work with gender perspectives. Nonetheless, one of the prominent hindrances that has been persistently highlighted by care service providers is the high cost of the services, instead, while the debate of paid-unpaid care work and gender remain secondary. It is worth noting that as of the current practices by many of the non-governmental organisations, the funding are channelled through private companies philanthropy and investment. For the private care givers, they remain loyal to providing necessary high-quality services that entail high service fees (Care Economy Roundtable Discussion, 2024). The discussion of fundings and service fees prompt the question of affordability of care services for

the grassroots, especially the Malaysia working classes of women and men, who would require the services the most.
The issues related to care emerged from the APPGM-SDG's issue mapping process in various narratives, situations and rationalities, depending on the geographical, social, economic and political backgrounds of the participants. Particularly, the diverse rate of regional development between Peninsular, Sabah and Sarawak have significant implication to the care industry in these three regions. The issue mapping findings from the three regions demonstrates that the development in Sabah and Sarawak regions, in particularly, is not in par with the development in Peninsular. Besides the regional developmental differences, the imbalanced urban-rural development is also a crucial consideration for the discourse of the Malaysia care economy. Nonetheless, such nuanced and dynamism of Malaysia context is often discounted from the care economy discourse. In this section, we delve deeper into reviewing the existing policies for the care industry, and to address the significant gaps that constitute the challenges and hindrances for care economy to flourish different regions of Malaysia.

Regional disparities

The discourse of affordability of the care economy is pivotal to address how to ensure inclusivity of care economy for Malaysia society. This begs the needs for ensuring the care economy can benefits those who are in the working classes, especially those working in informal sectors. Hence, it entails confronting longstanding and persistent incidents of poverty in different regions and between the urban and rural areas. Indeed, the regional imbalanced development and disparities in Malaysia have been widely studied. Based on the Malaysia Department of statistics, Kelantan has a record of the highest incidents of hardcore poverty in Peninsular region, while Sabah and Sarawak regions also recorded among the highest incident of hardcore poverty in Malaysia. Besides, Sabah and Kelantan also recorded the highest rate of informal employment (The World Bank, 2024).

It is important to note that the grassroots communities of different state and regions conceptualise poverty contextually and hence wide-ranging and diverse. Nonetheless, for many grassroots communities in Kelantan, Sabah and Sarawak, it is issue of deprivation that underscores the persisting poverty. More importantly, the deprivation that they face is not necessary child and elderly care support. Rather, they are deprived of more urgent basic needs such as water, electric, internet connectivity and rubbish collections, on the one hand. On the other hand, they will be facing constant issues of flooding and poor conditions of the existing roads.
In Kelantan, for instance, for participants who are single mother in Rantau Panjang, the most pressing issue may not necessary be the juggling of children tor elderly cares. Instead, they were more concerned with the constant flooding, the lack of treated and clean water, and the poor conditions of the roads that are also without sufficient streetlights, which make them unsafe for the road-users.

"In Rantau Panjang, we experience flooding incidents every year, it is just a matter of frequency. Like this year, it (the flooding) happens a lot." (Rantau Panjang, Single mother, 2023)[47]

While many communities in Rantau Panjang must deal with constant flooding, they also have to find ways to ensure continuous supply of clean water. It is important to note that many Rantau Panjang villagers rely on boring system to obtain clean water supply. The boring system is installed by themselves. Some would receive assistance from their local politicians for installing water piping system for the village. It is evident that the group of single mothers in Rantau Panjang did not perceive the lack of childcare or elderly care issues to be as urgent and important than to resolve the issue of basic needs for their daily lives.

Besides of the deprivation of basic facilities and infrastructures are not only the urgencies for the grassroots communities. In Sabah, instead of support for childcare, many mothers are concerned with the registrations of their newborns which are important to secure their children citizenship status as Malaysian. In Kudat, Sabah, a participant related the issue of citizenship with the lack of necessary health facility.

"… (we) need clinics for mothers and children here… because we have a lot of issues of documentation of children because (we) could not afford to go there (the health facilities in town), many mother give birth at home..." (Villager, Kudat, 2023). [48]

It is important to note that if parents fail to register their newborn within 60 days, they will be fined for RM1,000. However, if the parents face difficulties to register their newborn in the registrar office due to the long distance or high cost of travelling, they will most likely delay the registration process. The undocumented children would face difficulties in registering themselves to receive education.

In Sarawak, instead of addressing the needs and potential of care economy in the region, to eradicate poverty in the region has been on top of the agenda for the regional and federal government. Many studies have identified factors such as low productivity, low income occupations, falling prices of agricultural products, low education and skill, rural-urban migration of youths, lack of productive assets and credit facilities, and inaccessibility in rural areas (Shari & Osman-Rani, 1996). Previous studies focused on diversifying the income streams of farmers as the most pressing need for eradicating poverty in the region (Nor Diana & Siwar, 2015), and housing for resettling the poor (Haris Fadzilah et al., 2018). The APPGM-SDG issue mapping findings in Sarawak from 2020-2023 also documented the challenges of increasing high cost for agricultural production, and the lack of clean and treated water supply and electricity to be the pressing issues of many communities.

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[47] Translated from: *Rantau Panjang ni tiap-tiap tahun wajib tenggelam. Cuma sedikit atau banyak yang tenggelam. Tahun ni banyak*

[48] Translated from: "*…perlu ada klinik ibu dan anak sini..sebab banyak yang masalah dokumentasi sebab tidak mampu ke sana..bersalin dirumah saja…*"

It is also important to note that we do not dispute the urgent needs for addressing the disparities of gender and paid/unpaid care works in Malaysia care economy. Rather, we stress the pivotal consideration of the dynamics of regional issues for advancing the care economy in inclusive manner, and in ensuring no one is left behind. It is precisely such nuanced consideration that has been consistently lacking in the current policies and new policies recommendations for Malaysia care economy, to date.

Policy reviews

In Malaysia, there are two related policies, each regulating the care centres for older people who are 60 years old and above (Care Centre Act 1993), and children (Child Care Centre Act 1984, Act 308) for regulating Malaysia care centres. These policies provide outlines for qualified care centres to be granted for licence for operations, control and inspect the centres. In this section, we discuss these outlines and whether they encourage or hinder the legalisation of existing informal care centres in Malaysia.

The Act 308 specifies that the centres must registered regardless it is home based or an institution. According to the Act, a home-based childcare centre can only provide a maximum of ten children. An institution childcare centre can house ten children and more ("Child Care Centre Act 1984," 2006). To obtain a licence, the centres must be registered with ROS or SSM. The qualified centre must also fulfil the requirement by the Welfare Department and approval by the local authorities, Fire and Rescue Department, and Health Department. In Sarawak, specifically, the centre must also obtain an additional approval from the Land and Survey Department to be qualified with licencing to operate.

Under Malaysian law, there is no definition of foster care, however, the Child Act 2001 (CA 2001) defines ‘foster parent’ as a person who is taking care of the child but is not a parent or relative of the child (Child Act 2001; s.2). On the other hand, based on the practice of the Social Welfare Department (the SWD) in Malaysia, foster care has been defined as placement of a child in the care, custody and control of foster parents under section 30(1)(e) of the CA 2001 (Kassim, N.; 2011).

On the other hand, the Care Centre Act 1993 regulates licenced care centre for older people over 60 years old ("Care Centre Act 1993," 2006). Based on the Act, a Malaysia care centre or institution must register with the Welfare Department (JKM). Through the JKM, the centre would then be referred to the Local Authority (PBT), the Malaysian Fire and Rescue Department (JBPM) and the Ministry of Health (KKM). It is through this process that the JKM will have a database of registered centres or institutions and can control and inspect the care centres In line with the government's desire to control daycare centres (Azlini et al., 2023).

Despite the regulations, in realities, there are still many privately-run childcare centres that remain unregistered. These centres are often home-based, run by individual and non-governmental organisations (NGO) (Azlini et al., 2023). The lack of registrations of these institutions also means that neither the establishments are recorded nor comply with the

standard and facilities requirement set by the JKM. This includes ensuring the welfare and safety of the residents in the care institutions are guaranteed (Azlini et al., 2023). Nonetheless, few studies have addressed the factors that hinder the centres and institutions to register their services. It is essential to understand the factors, especially when the registration would benefit with the institutions with the subsidies and financial assistance from the government, through the JKM.
In the roundtable discussions, the obstacles of Sarawak were emphasised. Geographical isolation as the biggest challenge in Sarawak persists. The vast terrain with the poor to non-existed infrastructures have further hindered any expansion of care economy. In a media report, the Minister for Women, Early Childhood and Community Well-being Development, Dato Sri Hajah Fatimah Abdullah listed several projects, programmes and assistance catered for Sarawak poor and vulnerable children, women, persons with disabilities and older persons (Rakan Sarawak, 2023).[49] However, according to Dato Sri Hajah Fatimah, the challenges remain and revolve around the need for standard procedures, cost form implementation, the lack of data and shortage of staff members in the department. These challenges have further become obstacles especially with the large geographical areas of Sarawak.

Furthermore, it is also noteworthy that despite the challenges connectivity and infrastructure, the initiatives for providing the much-needed care services still on-going. For instance, the programme of ‘wakil kesihatan kampung’, a model which train villagers with first aid skills, and the ‘Kenyalang Gold Card’ state initiative programmes caters for enhancing the quality of life for the senior citizens aged 60 and above. The card allows registered older people to discount and special rates on goods and services, access to healthcare benefits, and participation in community activities within Sarawak. In the pipeline, the Sarawak government also has a collaborative project for establishing Sarawak Cancer Centre to provide services and operational frameworks in ensuring comprehensive cancer care and advanced treatment facilities for the region. Although the challenges of mobility for the villagers in the rural and interior areas persist, it is evident that the Sarawak government continue to work on providing adequate care services for these communities.

In Sabah, the lucrative care services though deemed necessary, may not be affordable for many grassroots Sabah communities. During the roundtable discussions, the most pressing issue for communities in Sabah is the limited employment rate. The high unemployment rates implies that unaffordability of care services for many communities in Sabah. More importantly, it also indicates that investment in medical tourism would be the key for providing more job opportunities, instead of care economy. This is because improvement in medical tourism would entail necessary enhancement to the current infrastructure and flight connectivity. This will enable the advancement of care economy in Sabah. Currently, the government initiatives for care service such as the Activity Centre for Older People (PAWE) are mostly located in urban

[49] The projects, programmes and assistance are: Integrated Social Development and Intervention System (ISDIMS); Community Social Support Centre (CSSC); Integrated Sarawak Social Intervention Programme and Community Support, Special Needs Community Centre (SNCC); Rumah Seri Kenangan (RSK) Sibu Phase 2; Temporary Shelter for Low-Income Recovery Community; Sarawak Care Medical Assistance for Children; and Elderly Social Support and Intervention; Child and Family Development Programme.

areas. With the lack of childcare and elderly care facilities, families often rely on women to leave their jobs to take care of children and elderly at homes.

Conclusion

It is evident from the reviews of care economy in other countries of Global South that the potential of care economy would not only benefits the providers but also the recipients. Care services are increasingly important for socio-economic wellbeing of the Malaysia society. Hence, it is pivotal for the strategies and action plan for implementations to be inclusive and ensuring no one is left behind. Nonetheless, to date, discourse of advancing care economy is still do not addressed adequately the needs of the communities living in rural and interior areas, such as Kelantan, Sabah and Sarawak. As discussion above demonstrate, Kelantan and the regions of Sabah and Sarawak are still working on improving the basic amnesties and infrastructure such as ensuring continuous clean and treated water supply and electric supply, internet connectivity, rubbish collection and good road conditions. Some are more worried about the increasingly frequent flood incidents that have been damaging their possessions and properties. Under such circumstances, the needs for care become secondary. As we discussed above, the contextual and nuanced understanding of the ground realities are paramount in any initiative to advance to care economy policy and strategies for it to be beneficial across different stakeholders.

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LESSONS FROM THE GLOBAL SOUTH: A REVIEW OF CARE ECONOMY IN MALAYSIA

Dr. Teo Sue Ann & Dr. Khairil Ahmad

Care Economy Conference @ ISIS Malaysia

24-25 September 2024

Presentation outline

1. Introduction
2. Ground realities of Malaysia’s care sector
3. Case studies from the Global South
4. Conclusion

1. Introduction

This paper reviews socioeconomic challenges that impacts the effective delivery of social care at the grassroots level in Malaysia.

Drawing from APPGM-SDG's issue mapping data, the paper spotlights ground realities faced by communities and households in accessing social care and highlights three main issues that need to be addressed to reform care economy in Malaysia: 1) regional disparities and poverty; 2) high cost of care services; and 3) gender imbalances in care work.

The paper also draws lessons from selected cases in the Global South to help us reflect on ways to address the underlined issues.

2. Ground realities

Regional disparities and poverty

Long-term challenges in federal-state relations and urban-rural divide have resulted in imbalanced development across states and regions in Malaysia.

Local and grassroots communities deal with challenges that precede their need and demand for social care including poverty, lack of basic infrastructures, and natural disasters.

Regional disparities affect and vary the functioning of social care across regions, states, and communities in Malaysia, as well as accessibility and availability of care services.

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> ***"In Rantau Panjang, we experience flooding incidents every year, it is just a matter of frequency. Like this year, it (the flooding) happens a lot" (Single mother, Rantau Panjang, 2023)***

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Regional disparities affect and vary the functioning of social care across regions, states, and communities in Malaysia, as well as accessibility and availability of care services.

"… (we) need clinics for mothers and children here… because we have a lot of issues of documentation of children because (we) could not afford to go there (the health facilities in town), many mother give birth at home…" (Villager, Kudat, 2023).

High cost of care services

Quality care services come at a cost that is typically out of reach for many communities and households.

For care providers on the ground, such as NGOs and charities, high cost and lack of government support restrict their ability to render quality services to those communities and households.

This raises the question of whether shifting policy focus towards more privately and market-driven care economy is an appropriate solution.

What is the ‘value’ of care economy to needy communities and households?

Gender imbalances in care work

Traditional gender norms have played a key role in shaping the discourse on social care in Malaysia.

Women are both primary care givers and the group more likely to require access to care compared to men (Lee, et.a., 2024).

Also, despite their overrepresentation in the care sector, they perform unpaid or low-paying work.

Lee, M.H., Cheng, C.K.W., Shazana, A. and Anis F. (2024). Building a cradle-to-grave care economy for Malaysia. Kuala Lumpur: ISEAS Malaysia. https://www.isis.org.my/wp-content/uploads/2024/06/Policy-brief-ISIS_230524_PDF-HR.pdf

3. Case studies from the Global South

Integrated yet decentralised system: Brazil's Unified Social Assistance System (SUAS)

A federalist solution to distributing social assistance and care in Brazil, introduced in 2005.

SUAS is a system that organises and funds social assistance in a participatory fashion among all levels of government across Brazil - it also facilitates the transfer of federal funding to subnational and local governments.

It functions through a collaborative governance structure - it provides indicative guidelines to support the targeting of services and a list of typified services that are offered, it does not prescribe or spell out how state of local governments should provide those services (de Arruda, 2023).

de Arruda, P.L. (2023b). Management of the Unified Social Assistance System in Brazil (Tr. Karina Miragaia Camargo). Brasilia: Federative Republic of Brazil Brazilian Cooperation Agency and UNICEF, https://www.gov.br/abc/pt-br/centrais-de-conteudo/publicacoes/documentos/policy-brief-4.pdf

Putting ‘value’ into the care economy: Cuba’s social justice approach

In the sea of the transformation of the care sector in Malaysia, the risk may also be that the moral aspect of social care will take a back seat especially if the policy focus leans strongly on the push towards marketisation and commodification of care.

What should the transformative meaning of care be, apart from its value from the economic perspective?

In Cuba, while care workers are professionally trained, the ethos of social care is one that is embedded in the value of *social justice* – an important aspect to furnish the profession especially as those workers deal with communities that live in poverty and are vulnerable (Truell, 2017).

Truell, R. (2017). Castro's casa: social work lessons from Cuba. The Guardian, https://www.theguardian.com/social-care-network/2017/jul/18/social-work-cuba-fidel-castro-ageing-population

Transforming gender norms in Indonesia’s care sector

Challenging the gender assumptions that have shaped traditional expectations about care is also important to allow for fundamental and long-term shifts that would result in a fairer distribution of the burden of care.

This has been recognised by Indonesia, which recently launched its Care Economy Roadmap, which among other things aims to facilitate the creation of a gender equal labour market and a fairer access to work for women.

The reform will be done via public campaigns to address stigma about care work and policy and legislative measures to improve women political representation at all levels as well to challenge and sanction harmful practices such as gender-based violence (The World Bank, 2024).

The World Bank (2024b). The care economy in Indonesia: A pathway for women’s economic participation and social well-being. Washington, DC: World Bank.
https://www.undp.org/sites/g/files/zskgke326/files/2024-07/enabling_investments_into_the_malaysian_care_economy_2.pdf

4. Conclusion

Amidst the enthusiasm to reform the care sector in Malaysia, there is a need to reflect upon socioeconomic barriers that have hindered certain communities' access to care and articulate the right solutions for them.

Those challenges are, among other factors, exacerbated by longstanding governance issues, marked by state and regional disparities.

Apart from economic growth and the possible reduction of the role of government, any reform of the care sector must consider inclusivity, fairness and equitability both for receivers and providers of care.

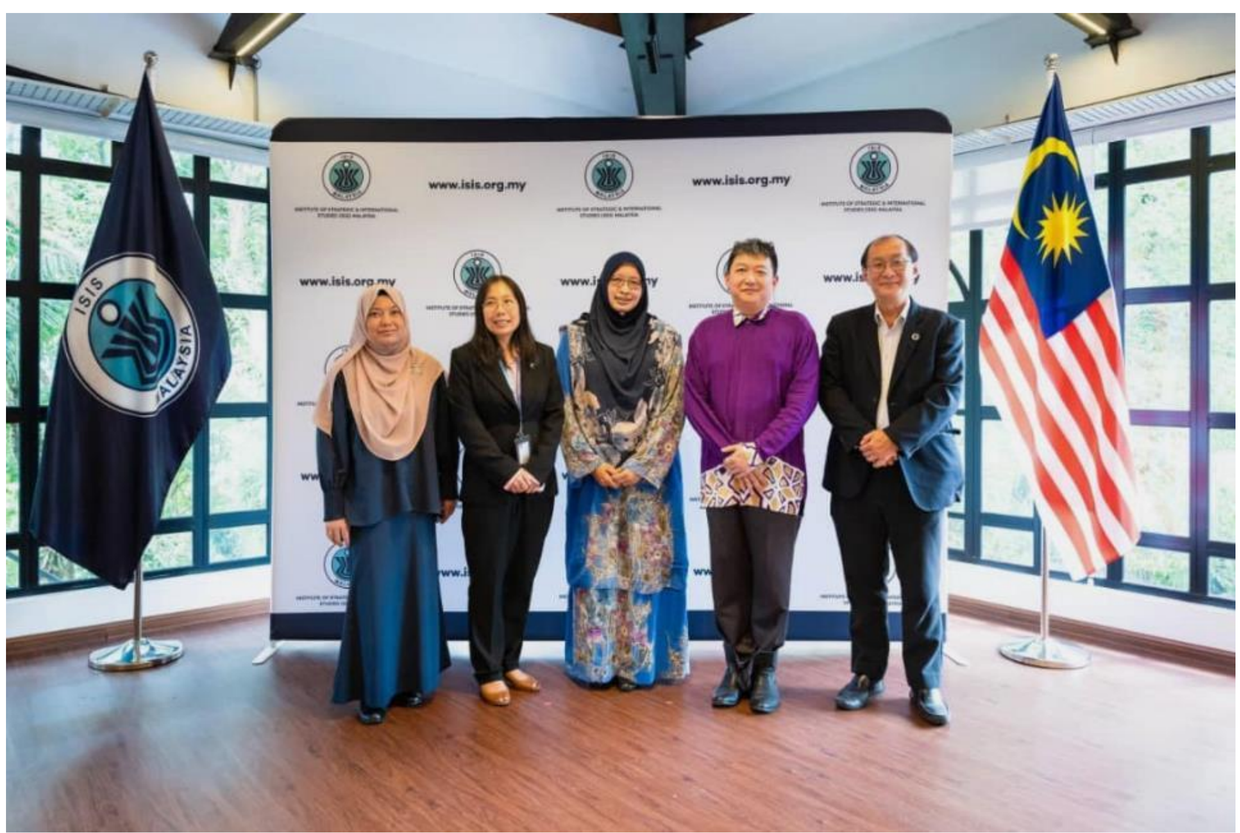
THANK YOU

Session 3: Older Persons

1400 – 1530 hrs | Tuesday, 24 September 2024

Role Players:

Moderator	**Dr Diana Katiman**, EXCO, IKRAM; Palliative Care Physician, Hospital Al-Sultan Abdullah UiTM
Paper Presenters	**Assoc Prof Dr Rahimah Ibrahim**, Director, Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia **Mr Chai Sen Tyng**, Senior Research Officer, Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia
Discussant 1	**Prof Dr Tan Maw Pin**, Professor in Geriatric Medicine, Department of Medicine, Faculty of Medicine, University of Malaya
Discussant 2	**Mr Jeffrey Phang**, Adjunct Professor, UNITAR; Governance Lead, Malaysian CSO-SDG Alliance
Secretariat	**Hirzawati Atikah Mohd Tahir** (APPGM-SDG) – Rapporteur **Afiqah Abdul Malik** – Timekeeper



(L-R: Dr Rahimah Ibrahim, Prof Tan Maw Pin, Dr Diana Katiman, Mr Chai Sen Tyng and Mr Jeffrey Phang)

PAPER 3

Care Economy and Older Persons in Malaysia: Long-term Care in an Ageing Society

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Authors' Note

Data collection and analysis for primary data used were undertaken over the years under a number of research projects by MyAgeing, UPM in 2012 (ERGS), 2017 (MWFCD), 2020 (WHO), 2021 (NAPREC) and 2024 (WB). Portions of these findings were presented at Roundtable Discussions and Conversations on the Care Economy in Malaysia. We have no conflicts of interest to disclose.

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Abstract

Malaysia is undergoing a significant demographic shift as its population ages, resulting in growing demands for long-term care services. According to the World Population Prospects, the number of individuals aged 60 and over in Malaysia is projected to increase from 4.1 million (11.6%) in 2024 to 5.9 million (15%) over the next decade. This chapter explores how demographic and economic forces are fueling the expansion of the aged care economy in Malaysia. As the country faces an increasing care-dependent adult population, shifts in caregiving responsibilities and the marketization of eldercare services are likely to adversely affect older persons' access to quality care and support in later life, unless these changes are matched by appropriate policy responses. The chapter examines both the expectations and realities of aged care in Malaysia, with a focus on the characteristics of current residential (institutional) and non-residential (home and community-based) long-term care models. These models offer varying levels of support depending on needs, costs, and purpose. In our country, the care needs of older persons are still predominantly met by family members, reflecting deep-rooted cultural and religious expectations of filial piety and responsibility. However, the increasing marketization and commodification of care services necessitates a shift in the State's role from being a social welfare provider to a regulator and facilitator of the care industry, as evident by the enactment of the Private Aged Healthcare Facilities and Service Act 2018 (Act 802). This transition is punctuated by a growing reliance on private aged care centers, home care services, and paid carers. This chapter also emphasizes the gendered nature of caregiving within the purple economy that is dominated by women and calls for greater male participation in the care workforce to achieve a more equitable distribution of care responsibilities. Cross-cutting issues such as care quality and the certification of care workers highlight the need to strengthen manpower and promote professionalization within the sector. Additionally, the financial burden of care and the potential for technology-augmented solutions are explored as part of the longevity economy which presents new economic opportunities. By adopting a comprehensive approach, Malaysia can create a sustainable, high-quality care system that meets the evolving needs of its ageing population.

Care Economy and Older Persons in Malaysia: Long-term Care in an Ageing Society

Malaysia is undergoing a significant demographic shift as its population ages over time. Birth rates are falling steadily across all ethnic groups, and rising life expectancy has contributed to a rapidly ageing Society. In addition, inter-state migration patterns are affecting the age-sex structure of urban and rural populations. In recent years, population growth rates in Malaysia have slowed to about 1% annually and this has huge ramifications on dependency ratios as well as demands for potential care and support. This chapter explores an estimation for the adult care dependent population and examines the impact of population ageing on long-term care. We assess current provisions on care for older persons and the national situation of aged care, both residential and non-residential. This includes discussions and recommendations on cross-cutting issues and challenges towards a sustainable care economy for Malaysia. This paper aims to demonstrate how demographic and economic forces are fueling the expansion of the aged care economy in Malaysia, along with the complexities and implications involved due to an increasing commodification of care.

Population Ageing in Malaysia: A Brief Overview

In the simplest of terms, population ageing refers to the increase in number and percentage of older persons in a geographical area or location. The chronological ages of 60 or 65 are typically used, and in Malaysia a '*warga emas*' or older person is someone aged 60 years or over (MWFCD, 2011). Demographers use a variety of indicators or cut-offs to measure the speed or scale of population ageing, but many of the underlying assumptions are less straightforward than they appear (Cowgill & Holmes, 1970; Chen & Jones, 1989; Coulmas, 2007; Spijker, 2016). An 'ageing society' is generally defined as a country where 7% or more of the population is aged 65 and older; an 'aged society' when it reaches 14% or more; and a 'super-aged society' when it surpasses 20% or 21%. While these milestones are useful for illustrative purposes, their arbitrary nature provides little practical insight into the actual needs, demand and supply of eldercare services.

Nevertheless, it is evident that Malaysia is ageing rapidly from the bottom with a shrinking of births and increasing longevity, leading to the argument that the country is growing old before getting rich. The total fertility rate (TFR), an estimation of the average number of children that a women would have over her childbearing years (15 - 49), has fallen from 4.9 in 1970 to 1.7 in 2020 (DOSM, 2001; 2022a). The average household size in Malaysia has shrunk from 5.5 persons in 1970 to 3.9 in 2020 (DOSM, 2022b). Life expectancy at birth increased from 61.6 years for males and 65.6 years for females in 1970 to 72.6 and 77.6 years old in 2020 (DOSM, 2022c; KRI, 2023). Life expectancy at 60 was 18.2 for males and 20.9 years for females respectively in 2020 (DOSM, 2022c). This means that half of the hypothetical cohort is expected to survive beyond these estimated average remaining years. Fertility, mortality and migration are fundamental determinants of population ageing, and all figures clearly indicate that this is a growing phenomenon.

As shown in Table 1, the proportion of older persons in Malaysia nearly doubled from 5.5% in 1980 to 10.3% in 2020. In the past four (4) decades, some states experienced a remarkable shift in the number and percentage of older persons. While Perak remains the 'oldest' state in Malaysia, the number of older persons in Selangor grew almost tenfold to 714.4 thousand in the same period. Considering that one-fifth or 21.4% of the total older population in Malaysia lives in Selangor, this puts considerable strain on the demand for long-term care in the state. The Federal Territory of Kuala Lumpur maintained the highest median age on record at 33.6 years in 2020, meaning that its population size is equally divided into two parts at that midpoint figure. In Malaysia, the Chinese (13.8%) community is ageing much faster than the Indian (11.3%) as well as Malay and Bumiputera (9.7%) groups due to lower fertility rates and higher life expectancy. Out of the 3.34 million older persons aged 60 years or over in 2020, 1.99 million are Malay and Bumiputera, followed by the Chinese (0.95 million) and Indians (0.23 million). We will examine how these ethnic differences influenced the history and marketization of aged care services in Malaysia, particularly in shaping the demand for eldercare services. According to the World Population Prospects (2024 revision), the number of individuals aged 60 and over in Malaysia is projected to increase from 4.1 million (11.6%) in 2024 to 5.9 million (15%) over the next decade in 2034 (United Nations, 2024). Malaysia had a GNI per capita (Atlas method) of USD11,970 in 2023 and is expected to breakthrough

the middle-income trap and become a high-income country in the next few years (World Bank, 2024).

The care economy is crucial for the country's transition to a high-income economy because by investing in the aged care sector services and infrastructure, we address the needs of an ageing population while creating new jobs at the same time. We need to capitalize on the economic opportunities arising from a growing demand for aged care facilities and services, but we must also ensure equitable access to high quality care.

Table 1. Distribution of Older Persons (60 years or over) by State / Region / Territory, 1980 - 2020

State / Region / F. Territory	**1980**			**2000**			**2020**		
	N_{60+} '000	**$\%_{60+}$**	**Md_{age}**	**N_{60+} '000**	**$\%_{60+}$**	**Md_{age}**	**N_{60+} '000**	**$\%_{60+}$**	**Md_{age}**
Johor	89.6	5.4	19.0	172.4	6.3	24.5	401.8	10.0	29.3
Kedah	68.4	6.1	19.5	130.9	7.9	23.1	257.3	12.1	28.0
Kelantan	55.2	6.2	18.4	94.1	7.3	18.8	180.5	10.1	24.4
Melaka	30.7	6.6	19.4	51.1	8.0	24.3	97.2	9.7	29.2
N. Sembilan	37.0	6.4	19.1	63.4	7.4	23.9	127.1	10.6	29.8
Pahang	37.5	4.7	18.6	69.8	5.7	22.2	149.9	9.4	28.8
Perak	111.1	6.1	19.3	189.8	9.3	25.1	335.0	13.4	31.0
Perlis	10.7	7.2	21.9	18.8	9.2	23.9	32.9	11.5	28.5
Pulau Pinang	63.1	6.6	22.0	103.6	7.9	27.0	194.9	11.2	31.8
Sabah	33.4	3.2	18.3	100.2	3.9	20.1	276.7	8.1	26.4
Sarawak	74.1	5.5	18.8	133.5	6.5	23.6	282.8	11.5	30.9
Selangor	73.0	4.8	20.4	189.6	4.5	24.5	714.4	10.2	31.6
Terengganu	31.4	5.8	18.4	54.9	6.1	19.3	102.4	8.9	26.4
W.P. Kuala L.	44.4	4.5	22.1	75.0	5.4	26.6	181.2	9.1	33.6
W.P. Labuan	-	-	-	2.3	3.1	21.7	6.7	7.0	27.7
W.P. Putrajaya	-	-	-	-	-	-	3.0	2.7	27.3
MALAYSIA	**759.6**	**5.5**	**19.6**	**1,451.7**	**6.2**	**23.6**	**3,343.8**	**10.3**	**29.7**

Source: Department of Statistics Malaysia, 2001; 2011; 2024 (Author's Tabulations)

Estimating Demand and Supply: Sizing Up the Aged Care Sector

The care economy encompasses both paid and unpaid activities related to caregiving, which are fundamental to all human productivity. Caregiving work involves not only physical assistance but also socio-emotional support for individuals dependent on others. At this point, it's essential to consider some basic assumptions. First, if we identify the care-dependent population in Malaysia, we can then assess whether their care needs are being met. For those whose needs are met, it's important to determine whether this support comes from formal care, informal care, or a combination of both. This relationship can be expressed through the following equation:

Care dependent population = Unmet needs + Met needs (Informal care* x *Formal care)

Dependency is a prolonged state in which individuals, for whatever reason, require assistance or significant help from others to cope with daily life activities (e.g. eating, bathing, dressing, using the toilet), particularly those related to self-care. There are various methods to estimate the adult care-dependent population based on health and functional measures. Past studies have used Activities of Daily Living (ADL), Washington Group Disability Measure, physical mobility questions and other disability assessments (UN Women, 2022; Pan American Health Organization, 2022; Medellin, 2020; Geerts, Willeme & Mot, 2012; Weissert, 1985). The National Health and Morbidity Survey (NHMS) 2019 dedicated an entire chapter on disability, measured using the Washington Group on Disability Statistics (WG) question sets. The prevalence of disability in 2019 among adults (18 years or over) was found to be 11.1%, and 4.7% among children 2 to 17 years of age (NIH, 2020). Specifically, the study of 4,703 living quarters interviewed 14,965 respondents which included an assessment of difficulty in self-care (NIH, 2020) (Table 2). If the adult care dependent population estimates from the NHMS2019 is used as reference, about 9.1% (295,074) of the 3.2 million older persons aged 60 years or over face difficulty in caring for themselves and will need care and support assistance. Older persons make up 62.9% of the total adult care dependent population in Malaysia in 2019 (Table 2).

The next steps in estimating met and unmet care needs of care dependent older persons become more challenging. We lack sufficiently robust data to estimate the scope and economic value of family caregiving, although living arrangements of older persons have been used as a common proxy measure. The responsibility of caring for ageing parents remains with adult children and less than 1% of the older population reside in institutions (Ibrahim, Hamid, Chai & Ashari, 2018; United Nations, 2017). How do we know this with some degree of certainty? In Malaysia, the expectations and realities of aged care reflect the tension between traditional family caregiving and the growing need for formal care services due to demographic shifts.

Table 2. Adult Care Dependent Population by Age Group, 2019

Age Group	Difficulty in Self-care[50]			
	Count	**Estimated Population**	**Prevalence**	**95% Confidence Interval**
18 – 29	17	45,626	0.7	0.34 - 1.26
30 – 39	18	33,025	0.6	0.35 - 1.19
40 – 49	24	45,219	1.3	0.59 - 2.75
50 – 59	45	50,004	1.6	1.10 - 2.45
60 – 69	77	105,874	5.2	3.96 - 6.87
70 – 79	88	91,440	10.1	7.49 - 13.37
80 & above	80	97,760	33.0	24.57 - 42.75
MALAYSIA	**349**	**468,946**	**2.1**	**1.81-2.54**

Source: Institute of Public Health (IKU), NHMS2019

Conventionally, caregiving obligations have fallen primarily on families, particularly women, who have long been seen as primary carers for the young and the old alike. However, multiple reasons are making this arrangement increasingly untenable. First, changing family structures, characterized by smaller household sizes and increasing mobility, thus reducing families' capacity to provide care. Urbanization exacerbates the problem, as more people relocate to cities for better job prospects, frequently leaving older family members behind (Wan Ahmad, 2018; Yusof, 2005). Furthermore, women's participation in the labour force is both affecting and affected by traditional gender roles and expectations on caregiving (Siah & Koh, 2024; KRI, 2019; Syed Salleh & Mansor, 2022; Koh, Lee & Bomhoff, 2016). Additionally, as people get older, they are more likely to develop chronic illnesses and disabilities that require higher levels of care over a long period of time. Family caregivers might not be able to cope and require assistance, training and support. This has put significant strain on families, communities, and the State to provide adequate, accessible and equitable care and support for older persons. Even with the assumption that families will remain the main source of aged care, a major challenge for most Malaysians is the limited availability of formal care options. Home and community-based care for older persons remain scarce and unregulated. Institutional care or care for older persons in residential settings, on the other hand, has a relatively long history in the country. In 2022, there are 418 registered care centres with 2,122 care workers and 9,648 older residents under the purview of the Department of Social Welfare Malaysia (Table 3), although the actual number of such facilities is estimated to be closer to a thousand if we include unregistered ones. In 2021, the Ministry of Health conducted in-situ COVID-19 vaccinations for staff and residents of 808 aged care centres and old folk's homes throughout the country.

[50] Do you have any difficulty in caring for yourself (such as cleaning yourself or wearing clothes)? Would you say… (1. No Difficulty; 2. Some difficulty; 3. Lot of difficulty; 4. Cannot do at all)

The Care Centres Act 1993 (Act 506) is a key legislation that regulates the establishment and management of private and NGO homes for disabled persons, child care centres, orphanages and other vulnerable populations that requires shelter. In general, most registered care centres for older persons are residential (96.7%), while the majority of childcare (77.8%) and persons with disability (73.2%) centres are day care / non-residential facilities (DSW, 2023). This distinction in the caregiver-to-resident ratio is evident in published annual statistics (Figure 1), reflecting the increasingly intensive nature of residential aged care as older persons become more frail over time. Whether it is care centres for children, PWD or older persons, the number of registered facilities have been increasing steadily. This does not include unregistered aged care facilities, state or federal government operated old folks' homes (n = 15), and a small number of nursing homes (*Rumah Jagaan Kejururawatan Swasta Berlesen*) licensed under the Private Healthcare Facilities and Services Act 1998 (Act 586) (n = 20; MOH, 2024). With passage of the Private Aged Healthcare Facilities and Services Act 2018 (Act 802), a new regulation is expected to come in force in 2025.

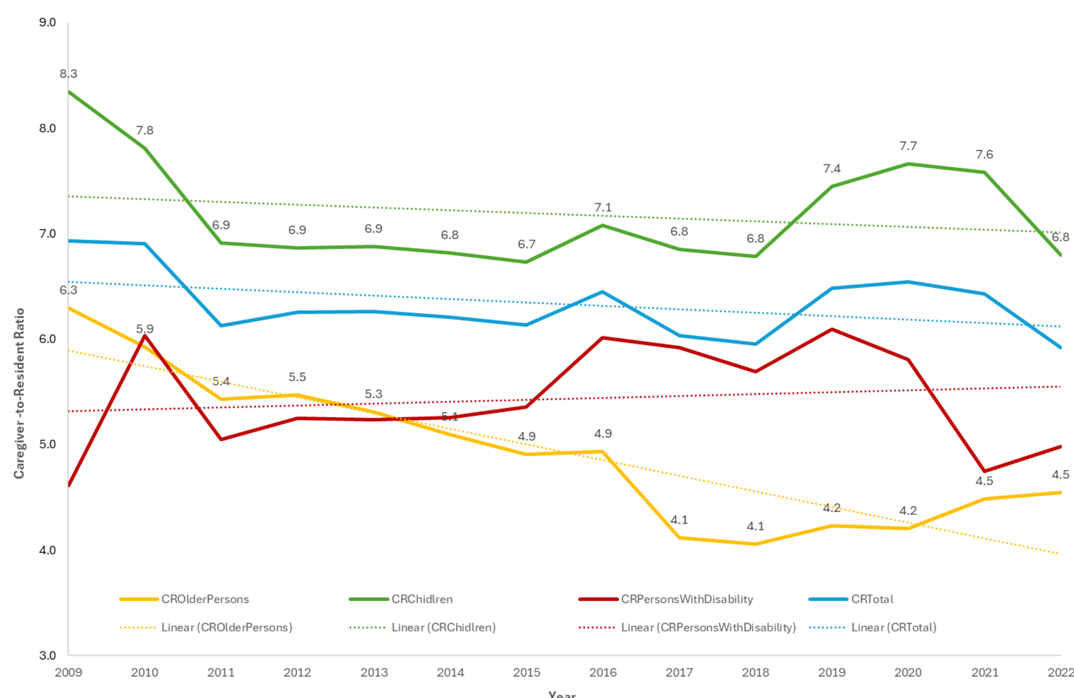
Table 3. Statistics of Registered Care Centres[51] for Children, Persons with Disability and Older Persons, 2009 - 2022

Year	Childcare Centres						PWD Centres						Aged Care Centres					
	Number		Type		Ownership		Number		Type		Ownership		Number		Type		Ownership	
	Carers	Child	Day Care	Resi-dential	Private	NGO	Carers	PWD	Day Care	Resi-dential	Private	NGO	Carers	OP	Day Care	Resi-dential	Private	NGO
2022	4,895	33,263	1,050	300	1,080	270	1,254	6,244	161	59	100	120	2,122	9,648	14	404	342	76
2021	4,936	37,419	999	263	1,025	237	1,301	6,176	145	57	76	126	1,838	8,241	8	376	314	70
2020	4,726	36,207	864	287	887	264	1,378	8,000	138	60	74	124	1,860	7,818	10	368	312	66
2019	4,578	34,090	805	289	851	243	1,296	7,901	125	59	64	120	1,758	7,440	15	343	296	62
2018	3,968	26,934					1,328	7,560					1,706	6,927				
2017	3,870	26,505					1,160	6,870					1,582	6,518				
2016	5,013	35,491					1,591	9,569					1,627	8,025				
2015	4,200	28,267					1,172	6,282					1,290	6,334				
2014	3,767	25,685					1,089	5,724					1,121	5,714				
2013	3,262	22,435					1,046	5,474					973	5,168				
2012	2,744	18,839					999	5,246					849	4,644				
2011	1,763	12,186					869	4,385					648	3,521				
2010	976	7,620					490	2,956					459	2,720				
2009	1,004	8,378					538	2,483					276	1,738				

Source: Department of Social Welfare Malaysia (various years)

[51] Care Centres Act 1993 (Act 308) or *Akta Pusat Jagaan* includes day care and residential homes for children, persons with disability, older persons, women and others (multiple/mixed)

Figure 1. Caregiver-to-Resident Ratio for Different Care Centres, Malaysia, 2009 - 2022



Source: Department of Statistics Malaysia (various years)

A simple analysis of the registered care centre statistics yielded other interesting observations. While the absolute number of care centres are increasing year-on-year (6.5% growth per annum), the number of residents per facility is dropping with the singular exception of aged care facilities. Here, it becomes evident that the care economy landscape is far more dynamic and multifaceted than previously recognized. Many aspects, such as the evolving roles of caregivers, the economic value of unpaid care work, and the impact of demographic shifts, remain poorly understood. This underscores the urgent need for further research and insights to better inform policies and support systems that can address the growing complexities of the care sector. In the next section, we will explore the issues, challenges and opportunities within the nascent aged care industry in Malaysia, shedding light on factors shaping its development. We will delve into the obstacles - such as regulatory gaps, workforce shortages, and cultural attitude towards the marketization of aged care, while identifying the untapped potential for innovations.

Expectations and Reality of Aged Care: Issues, Challenges and Opportunities for Malaysia

It is important to understand how the aged care industry in Malaysia arrived at its current state so that we can better appreciate the strategic directions that may define the future of eldercare across generations. Since pre-Independence Malaya, charity-run old folk's homes for unmarried, ageing migrant workers have played an integral role in providing care and support for the vulnerable elderly. The Central Welfare Council of Malaysia (*Majlis Pusat Kebajikan Se-Malaysia*), for example, has been a key partner to the Department of Social Welfare Malaysia and its storied history has left an indelible mark on the aged care sector till this day[52] (Sushama, 1992; MPKSM, 2013). In the late 1990s, the liberalization of Malaysia's

[52] See history of *Rumah* / *Pondok Sejahtera* at MPKSM website https://mpksm.org.my/v1/pdf/mpksm.pdf

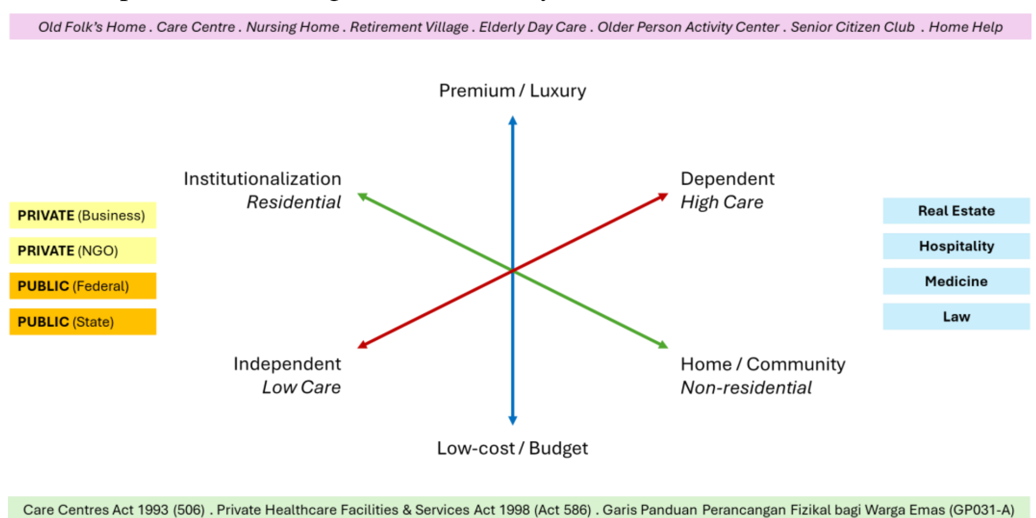
healthcare sector significantly transformed the eldercare landscape, leading to the emergence of new nursing homes and aged care facilities that are increasingly in demand in urban areas and towns (Chee & Barraclough, 2007; Ong, 2002). Nevertheless, the decision to send elderly family members to care centers is often perceived as a form of neglect and abandonment due to socio-cultural values surrounding filial piety. Even when families struggle to provide proper care due to work commitments or other challenges, feelings of guilt, shame and social stigma sometimes result in elderly family members being kept at home despite inadequate support for both the older person and caregiver alike.

A watershed moment in the aged care sector occurred in 2012 when 'Senior Living' was identified as a significant Business Opportunity (BO) under the Health NKEA[53] (National Key Economic Areas) with several Entry Point Projects (EPP) proposed. Various avenues for growth in the senior living and aged care sectors were explored, including modern retirement villages, assisted living and nursing homes, long-term care services, community and home-based care businesses and to a lesser degree, transborder care and gerontechnological solutions. Many of the new entrants, key players and legislative developments in the aged care industry today can trace its beginnings to the on-boarding session at Kelana Jaya in September 2012. The tacit government support helped create a favorable environment for legislative reform and investment in eldercare solutions, particularly in response to the growing need for comprehensive senior living options across the country.

Segmenting the Aged Care Market

We conceptualize continuum of aged care in Malaysia along three axes: High - Low care, Residential - Non-residential care, and Premium - Low-cost care. Rather than dividing or segmenting the aged care sector according to actors (e.g. by the government, civil society or businesses), each axis represents different dimensions of care needs, cost and location. Together, they provide a framework to understand the variety as well as gaps of care services for the elderly in Malaysia.

Figure 2. Conceptualization of Aged Care in Malaysia - Who, What, Where, and How Much?



[53] Part of the Government Transformation Program (GTP) and Economic Transformation Program (ETP) managed by the Performance Management And Delivery Unit (PEMANDU) under the Prime Minister's Office

It is important to note that the aged care situation in Malaysia is unique for several reasons. As previously mentioned, varying rates of demographic transition and historical factors have resulted in a majority of aged care residents being Chinese. Most private facilities and services cater primarily to this community, influenced by both economic and cultural factors although there is a clear and increasing demand for Islamic care homes. Charitable homes rely on grants and donations, while private aged care centers and nursing homes sustain themselves through monthly fees paid by adult children or next of kin. This is a common - and indeed preferred - distinction, as little public aid is available for fee-based facilities and services. The economic value of the services provided by the aged care sector is often underestimated, and the notion of 'free' versus 'paid' aged care services presents a false dichotomy because it oversimplifies the complexities of eldercare. There are considerable trade-offs as unreliable or limited public financing models may hamper an operator's ability to manage high care patients, and some providers may have to cross-subsidize to reduce the burden on out-of-pocket payments from families. We have observed diverse arrangements on transportation, medications, and supplemental care, but the aged care sector, in general, is heavily reliant on the public healthcare system.

Construction-wise, only a fraction of residential or non-residential facilities are purpose-built while most are renovated, refurbished or retrofitted from domestic buildings (e.g. bungalow, semi-d, terrace house). Like kindergartens and childcare facilities, and perhaps even more so due to social stigma and cultural values, there is a resistance among local communities to the setting up of aged care centres or nursing homes in their neighbourhoods - a classic Not In My Backyard (NIMBY) mentality. Due to a limited understanding on the importance and benefits of senior housing alternatives, conventional aged care facilities and services are being perceived as disruptive and unwelcomed developments that could negatively impact the property value in an area. The local authorities, in particular, play a critical role apart from regulation and oversight by the fire brigade, the Ministry of Health and the Department of Social Welfare.

Usually, residential care or institutionalization offers higher levels of care for individuals who require continuous medical supervision, especially when families cannot cope with the complex care needs of elderly with multiple disabilities and/or severe health conditions. It is also the main reason why it is so costly. However, in Malaysia, the out-of-pocket cost of residential care is sometimes more related to amenities (i.e. air-conditioning, room-sharing) than quality or intensity of care provided. Due to a lack of home or community-based care packages, and the fact that it is more cost-efficient from a business standpoint to put elderly with high care needs in a facility cared for by a team of trained professionals rather than sending individual nurses to provide in-home care, a facility can optimize resources, reduce overhead costs, and ensure that staff can manage multiple patients simultaneously in a controlled environment - ultimately leading to better care outcomes and lower overall expenses. But this leads to the ultimate question - what do our elderly, and their family members, want?

What do Older Persons Want?

In Malaysia, the care needs of older persons are still predominantly met by family members, reflecting deep-rooted cultural and religious expectations of filial piety and

responsibility. However, this is fast becoming unfeasible nor sustainable. Past studies by the Institute of Gerontology and the Malaysian Research Institute on Ageing have consistently shown that adult children and spouse are expected to care for ageing family members and most elderly prefer ageing-in-place (77.6%) (Ibrahim, Hamid, Chai & Ashari, 2018; Universiti Putra Malaysia, 2017; Hamid & Chai, 2013; Hamid, Abdullah, Chai & Abu Samah, 2012). This is consistent with findings from the latest Malaysian Ageing and Retirement Survey (Wave-2) where 83% of the respondents wish to age-in-place (Universiti Malaya, 2023). Spouse (39.6%), daughter (31.8%) and son (19%) were identified as individuals who would be most likely to care for the respondents when they are in need (UM, 2023). The MARS report also indicated that only 16.7% of the respondents were prepared to move to an assisted living facility, compared to 61% who were prepared to receive home care services.

The wealth of data, both qualitative and quantitative, have shown us that a majority of older persons in Malaysia are 'institutionalization averse' and they prefer independent living in the community. In fact, if we analyze the microdata from past Household Expenditure Surveys by the Department of Statistics Malaysia, we can see that the increase in the share of households with ONLY older persons did not come from the elderly living alone (Table 4).

Table 4. Household Size and Composition by Age, Malaysia, 1999 - 2019

Household Composition	**1999**			**2009**			**2019**		
	n	**%**	**Hh_{size}**	**n**	**%**	**Hh_{size}**	**n**	**%**	**Hh_{size}**
One-person Household									
Adult (18-59)	259	9.4	1.0	436	6.7	1.0	809	4.9	1.0
Older Person (60+)	77	2.8	1.0	159	2.4	1.0	540	3.3	1.0
Multi-person Household									
No Older Person (OP)	1,861	67.4	4.8	4,350	67.0	4.6	9,530	58.3	4.3
Mixed OP & Non-OP	516	18.7	4.9	1,373	21.1	4.7	4,678	28.6	4.4
Older Persons Only	48	1.7	2.0	177	2.7	2.0	797	4.9	2.0
Total Households	**2,761**	**100.0**	**4.3**	**6.495**	**100.0**	**4.2**	**16,354**	**100.0**	**3.9**
Hh with at least 1 Child (<18)	1,859	67.3	5.4	4,083	62.9	5.2	8,772	53.6	5.1
Hh with at least 1 Older Person	641	23.2	4.2	1,709	26.3	4.1	6,015	36.8	3.8

Source: 30% HES Microdata (DOSM, 2012; 2020)

While multigenerational living and extended family households are on the decline - partly due to housing design, the data reveals a notable rise in older households where older persons are aging alongside their spouse in empty nest settings. In an increasingly mobile workforce, adult children often no longer live with or in close proximity to their ageing parents.

Considering successive government's policy to increase Malaysia's female labor force participation, we are in a transitional phase where the commodification and marketization of unpaid family care is taking place. As care services become increasingly market-driven, the State's role is shifting from that of a social welfare provider to a regulator and facilitator of the care economy, exemplified by the recent spate of activities[54] to put care economy at the center of the country's national development agenda. This transition is marked by a growing dependence on private aged care centers, community-based care services, and paid home caregivers. These long-term care models offer varying levels of support depending on needs, costs, and purpose.

It would be a mistake, however, to assume that there are no past or current alternatives between unpaid family caregivers and professional carers. Traditionally, Malaysian families have relied on kinship networks to support caregiving responsibilities, especially when no close family members (i.e. daughters or daughters-in-law) is available. Yet, the Chinese in Southeast Asia is certainly no stranger to *mui tsai*, *ma jie* or amahs - specific groups of women who work in servitude as domestic helpers during the colonial period (Twomey, 2023; Ooi, 2013; Leow, 2012). Despite their disappearance by the 1970s and 80s, the demand for domestic servants remained with maids from the Philippines and Indonesia arriving on our shores. Rural girls as bondservants were replaced by foreign maids, and the middle-class continues to employ domestic workers as a more affordable alternative to professional carers. These contemporary domestic workers face many of the same challenges as their historical counterparts, such as abuse, exploitation, low wages, and lack of legal protection. The real challenge to sustainable home or community-based aged care services goes beyond the use of domestic helpers or servants; it also includes an overdependence on foreign workers in the formal health and social care sector, whether residential or non-residential. The hiring of foreign labour is a short-term solution to address local workforce shortages, but this reliance is ultimately unsustainable. It serves as a quick band-aid fix that does not address deeper structural issues within the aged care sector, particularly concerning manpower shortages, inadequate training and poor LTC financing models. Without addressing these fundamental problems - such as creating a stable, skilled local workforce and developing long-term funding mechanisms, Malaysian families will be compelled to rely on whatever care arrangements they can afford, even if these options carry significant risks and long-term consequences.

Lessons and Insights on the Purple Economy

As the country faces an increasing care-dependent adult population, shifts in caregiving responsibilities and the marketization of eldercare services are likely to adversely affect older persons' access to quality care and support in later life, unless these changes are matched by appropriate policy responses. The care economy is intricately linked to the 'purple economy' - an economy driven by women, both as primary caregivers and as a significant proportion of the care workforce. With population ageing, the balance between expectations and reality of care requires careful consideration, especially in the gendered dynamics of care work.

[54] The MWFCD organized a series of workshops to develop a national plan of action for the care industry after the Prime Minister called for the empowerment of women's roles in the care economy to boost their labour force participation in the final phase of the 12th Malaysia Plan in September 2023.

The care economy in Malaysia, like many other countries, is heavily gendered. Women dominate both unpaid caregiving roles and the formal care workforce, but they are not adequately compensated. For examples, women make up 71.8% (401.7 thousand) of the total employed persons in the Human Health and Social Work Activities category but their average pay is still lower than their male counterpart. There is also a growing recognition of the need to involve men in caregiving roles, both within families and professionally. Encouraging men to take on caregiving responsibilities can help alleviate the burden on women and ensure a more equitable distribution of care work. Furthermore, gender-sensitive policies are needed to support caregivers, including flexible work arrangements and financial incentives for those providing unpaid care.

To summarize and recap the three (3) main issues and challenges of aged care industry in Malaysia, we focus on the 1. Care Recipients, 2. Caregivers, and 3. LTC Financing;

1. Care Recipients
   The current aged care ecosystem in Malaysia faces significant challenges pertaining to regulatory and monitoring oversight. Different care service providers - whether public, private, or non-governmental organizations, are subject to varying levels of regulation. Ensuring that facilities and care workers are properly licensed, registered, and meeting minimum standards is crucial for safeguarding the well-being of older persons. Unfortunately, enforcement of these regulations remains inconsistent, often resulting in disparities in care quality. The rights of older persons to care and security are fundamental principles that ensure their dignity and quality of life. Often, older Malaysians are not given the autonomy to make decisions and choices about their own care. Promoting and protecting these rights is essential to ensure that older persons can live fulfilling lives, maintain their independence, and receive the care and security they deserve. Consent and advance directives are critical components of care for older persons, ensuring that their rights and preferences are respected throughout the caregiving process.

2. Caregivers
   There is a persistent shortage of qualified caregivers in both formal and informal sectors. Manpower issues have been a constant problem for the aged care industry. Low wages and demanding work conditions lead to high staff turnover, and it is difficult to retain skilled carers or attract new talent to the field. Because of limited training and career professional development, carers suffer from emotional and physical burnout. As the aged care workforce in Malaysia is largely unregulated, many caregivers lack formal certification or accreditation. The contributions of caregivers, particularly unpaid family members, are often unrecognized and unsupported. This lack of acknowledgment can lead to feelings of isolation and undervaluation. There is a pressing need for professionalization within the sector, including standardized training, certification, and fair remuneration for aged care workers. Moreover, the gender imbalance in care work must be addressed, with efforts to encourage more men to enter the caregiving profession. Caregiving is a

vital and essential profession in any Society and a multifaceted approach is needed to create a sustainable aged care workforce.

3. LTC Financing

   The financial burden of long-term care is a significant concern for families and the state. The cost of institutional care, home-based services, and even informal caregiving can be prohibitive. Exploring alternative financing options, such as insurance schemes or subsidies for lower-income families, is essential. Additionally, technology-augmented care, such as telemedicine, remote monitoring, and assistive devices, presents opportunities to enhance care while reducing costs. However, the integration of these technologies into long-term care models remains in its infancy in Malaysia. While residential care may be a solution for families that are unable to provide sufficient support for older persons, accompanying costs and unpredictability in care quality make it an expensive and unsustainable alternative. We need home and community-based services that are affordable to create a level playing field for low and middle-income families. The high cost of care, limited public funding and support, as well as lack of insurance options are driving up out-of-pocket expenses that can lead to financial burden, strain and stress for Malaysian families.

To summarize, we need to develop a clear industry-wide plan of action to realize the full potential of the aged care economy as seniors and their family members. The COVID-19 pandemic exposed the vulnerability of older persons in institutions and in community settings and we need to reevaluate our priorities to strengthen community-based health and social care services for the elderly. Policymakers should prioritize comprehensive action that includes both formal and informal care systems (Tur-Sinai et al., 2021; Steinman et al., 2020). The situation of home and community-based care is changing with the development of smart technology and assistive devices in improved monitoring as well as a more supportive environment for ageing. Many western and European countries have aggressively promoted age-friendly paradigms that not only seek to increase care accessibility and lower costs, but also to highlight the value of social inclusion and support networks for older persons (Xue et al., 2022).

Beyond Long-term Care: The Longevity Economy and Way Forward

The senior living industry is poised for further growth, driven by both demographic changes and government support for the aged care sector. As the population ages rapidly, there is a rising demand for formal aged care services with a tandem increase in the silver economy. The demand for such care is diverse, ranging from assistance with daily chores to comprehensive medical supervision. The World Health Organization (2021) notes that the demand for long-term care is likely to increase dramatically, with forecasts predicting that the number of older persons in need would double by 2050. However, Malaysia currently lacks a comprehensive long-term care infrastructure, with relatively limited nursing homes and aged care facilities compared to an increasing number of older persons. Moreover, the quality and

accessibility of these services vary widely. Despite the critical need for long-term care, many present programs are underfunded and lack the capacity to fulfill increasing demand. The high cost of aged care services is a substantial barrier, especially for low-income families who may struggle to obtain critical support and assistance. The government must adopt a holistic strategy to meet the changing needs of an ageing Malaysian population. This involves increasing the availability and quality of long-term care programs and services, supporting community-based care models, and providing financial assistance to needy families. Furthermore, public awareness campaigns are crucial in shifting the cultural conceptions of ageing and

In conclusion, Malaysia's demographic trend toward an older population requires immediate attention and action from all sectors of society. As the traditional caring model becomes increasingly unworkable, intelligent solutions and collaborative efforts are critical to ensuring that older individuals receive the care and assistance they need to lead satisfying lives. As more and more Malaysians survive into older ages, the longevity economy comes into play. The 'longevity economy' refers to the economic possibilities and opportunities that come with longer healthy life expectancy. Breaking down normative ages of education, work and retirement, the older population can play active roles as consumers, producers and contributors to Society. The longevity economy and the care economy are closely interconnected, with the ageing population increasing both the demand for care services and the creation of new economic opportunities. This intersection emphasizes the importance of developing policies and systems that simultaneously support economic growth and meeting the holistic needs of older persons, fostering a sustainable future for all generations.

Malaysia's ageing population presents both challenges and opportunities for the care economy. Old age is not just about healthcare and social support and by capitalizing on this latent potential, Malaysia may alleviate the fiscal strains of an ageing population while fostering a more equitable, intergenerational economy. Addressing the growing demand for long-term care requires a comprehensive approach that includes improving the quality and accessibility of care services, professionalizing the care workforce, and ensuring sustainable financing options. Gender dynamics play a crucial role in shaping the future of care, and involving both men and women in the sector is essential for its success. By harnessing the potential of the longevity economy and integrating technology into care models, Malaysia can build a more resilient and inclusive system of long-term care for older persons.

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Session 3: Older Persons, Growing the Economy and Meeting the Care Needs of the Malaysian Society,
24 - 25 September 2024, Auditorium, ISIS Malaysia

Care Economy & Older Persons in Malaysia: Long-term Care in an Ageing Society

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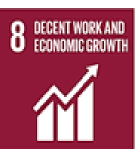


Population Ageing in Malaysia, 2020

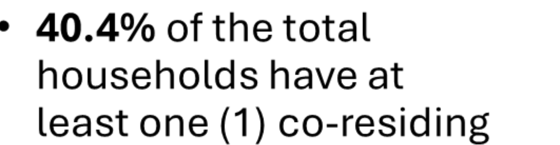
Population of older persons (60+)

2020 Census

- **3.4 million** persons
- **10.3%** of total population

Households with older persons (60+)

HIES 2022 (30% sample)



- **40.4%** of the total households have at least one (1) co-residing older person (60+)

Old-age sex ratio (60+)

2020 Census

- Sex ratio = 109.6 number of men per 100 women
- Old-age sex ratio = **96.7**

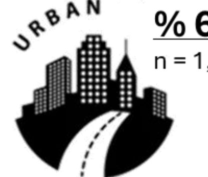
Life Expectancy of older persons (60+)

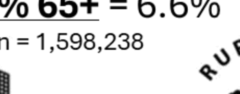
Life Table 2020

- LE_{60} = **18.7** years

  Male LE_{60} = 18.2 years
  Female LE_{60} = 20.9 years

- $LE_{atbirth}$ = **73.4** years





% 65+ = 6.6%
n = 1,598,238

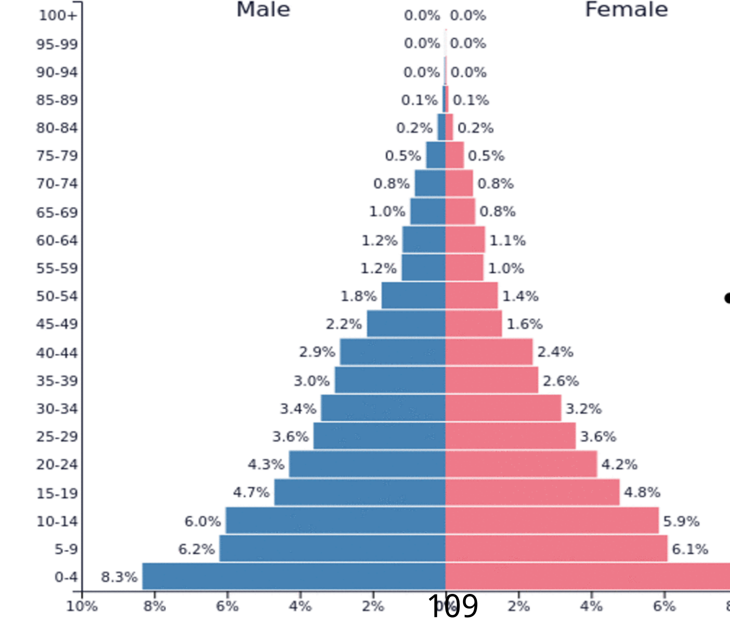
% 65+ = 7.3%
n = 592,991

2020 Census

- Urbanization rate = 75.1%
- Urbanization $rate_{65+}$ = **72.9%**

2020 Population & Housing Census (DOSM, 2022)

60+ pop.	*60+ Malay*	*60+ Chinese*	*60+ Indian*
3.34 mil.	**1.99 mil.**	**0.95 mil.**	**0.23 mil.**
(10.3%)	(9.7%)	(13.8%)	(11.3%)



Monthly Household Gross **Income**

$Median_{KIR65+}$ = RM 3,372
$Mean_{KIR65+}$ = RM 5,282

HIES 2019

- Incidence of poverty for head of households aged 65+ = **5.7%**

1980

tfr = 4.1

2020

tfr = 1.7

21.1% of 60+ are still working

- $Urban_{60+}$ = 17.0%
- $Rural_{60+}$ = 28.9%

[HES2022]

Distribution of Older Persons by State, 1980 - 2020

State / Region / F. Territory	1980			2000			2020		
	N_{60+} '000	$\%_{60+}$	Md_{age}	N_{60+} '000	$\%_{60+}$	Md_{age}	N_{60+} '000	$\%_{60+}$	Md_{age}
Johor	89.6	5.4	19.0	172.4	6.3	24.5	401.8	10.0	29.3
Kedah	68.4	6.1	19.5	130.9	7.9	23.1	257.3	12.1	28.0
Kelantan	55.2	6.2	18.4	94.1	7.3	18.8	180.5	10.1	24.4
Melaka	30.7	6.6	19.4	51.1	8.0	24.3	97.2	9.7	29.2
N. Sembilan	37.0	6.4	19.1	63.4	7.4	23.9	127.1	10.6	29.8
Pahang	37.5	4.7	18.6	69.8	5.7	22.2	149.9	9.4	28.8
Perak	111.1	6.1	19.3	189.8	9.3	25.1	335.0	13.4	31.0
Perlis	10.7	7.2	21.9	18.8	9.2	23.9	32.9	11.5	28.5
Pulau Pinang	63.1	6.6	22.0	103.6	7.9	27.0	194.9	11.2	31.8
Sabah	33.4	3.2	18.3	100.2	3.9	20.1	276.7	8.1	26.4
Sarawak	74.1	5.5	18.8	133.5	6.5	23.6	282.8	11.5	30.9
Selangor	73.0	4.8	20.4	189.6	4.5	24.5	714.4	10.2	31.6
Terengganu	31.4	5.8	18.4	54.9	6.1	19.3	102.4	8.9	26.4
W.P. Kuala L.	44.4	4.5	22.1	75.0	5.4	26.6	181.2	9.1	33.6
W.P. Labuan	-	-	-	2.3	3.1	21.7	6.7	7.0	27.7
W.P. Putrajaya	-	-	-	-	-	-	3.0	2.7	27.3
MALAYSIA	**759.6**	**5.5**	**19.6**	**1,451.7**	**6.2**	**23.6**	**3,343.8**	**10.3**	**29.7**

Source: DOSM (various years)

Household Composition by Age Group, Malaysia, 1999 - 2019

Household Composition	1999			2009			2019		
	n	%	Hh_{size}	n	%	Hh_{size}	n	%	Hh_{size}
One-person Household									
Adult (18-59)	259	9.4	1.0	436	6.7	1.0	809	4.9	1.0
Older Person (60+)	77	2.8	1.0	159	2.4	1.0	540	3.3	1.0
Multi-person Household									
No Older Person (OP)	1,861	67.4	4.8	4,350	67.0	4.6	9,530	58.3	4.3
Mixed OP & Non-OP	516	18.7	4.9	1,373	21.1	4.7	4,678	28.6	4.4
Older Persons Only	48	1.7	2.0	177	2.7	2.0	797	4.9	2.0
Total Households	**2,761**	**100.0**	**4.3**	**6,495**	**100.0**	**4.2**	**16,354**	**100.0**	**3.9**
Hh with at least 1 Child (<18)	1,859	67.3	5.4	4,083	62.9	5.2	8,772	53.6	5.1
Hh with at least 1 Older Person	641	23.2	4.2	1,709	26.3	4.1	6,015	36.8	3.8

Source: 30% HES Microdata (DOSM, 2012; 2020)

Critical Feminism & Care

Nancy FOLBRE,
Professor Emerita of Economics, University of Massachusetts Amherst

"Economists generally treat care for others - including expenditures of time and money by individuals, families, communities, states, and businesses - as a form of redistribution. Yet care provision can be conceptualized more broadly as the **production, development, and maintenance of human capabilities** whose value extends far beyond individual rates of return in the labor market."

Folbre, N. (2024). Care Provision and the Boundaries of Production. ***Journal of Economic Perspectives****, 38(1), 201 - 220*

United Nations | United Nations Economist Network

NEW ECONOMICS FOR SUSTAINABLE DEVELOPMENT

PURPLE ECONOMY (CARE ECONOMY+)

INTRODUCTION

The Purple Economy, also sometimes referred to as the care economy, obtains its name from the color adopted by many feminist movements. It represents a new vision of economics that recognizes the importance of care work, empowerment and autonomy of women to the functioning of the economies, wellbeing of societies and life sustainability. Care work consists of two overlapping activities and can be paid or unpaid: 1) direct, personal, and relational care activities, such as feeding a baby or nursing an ill partner; and 2) indirect care activities or domestic work, such as cooking and cleaning. Paid care work refers to occupations where workers provide direct face-to-face care or indirect forms of care that provide the preconditions for caregiving. It thus includes the work carried out by nurses, childminders, community health workers and elderly care assistants as well as domestic workers, cooks, and cleaners. Unpaid care and domestic work are provided without explicit monetary reward in homes and communities. Care workers perform their tasks in a variety of settings: public, private, not-for-profit organizations as well as private homes[1]. The bulk of care work worldwide is provided by unpaid carers, mostly women and girls. Paid care work is also predominantly carried out by women, often those from socially disadvantaged groups, including migrants. Being mostly in the service sector, care work is often associated with significant wage penalties and poor working conditions[2].

Care work sustains people on a day-to-day basis, from one generation to the next, and contributes to production and reproduction of a labor force that is fit, productive, creative and capable of learning[3]. Despite this invaluable contribution, unpaid care continues to be largely treated by mainstream economics as an externality, being unaccounted for in policies and national accounts. The associated costs in the form of forgone wages and opportunities for women and girls amplify gender inequality; two key concepts of the Purple Economy.

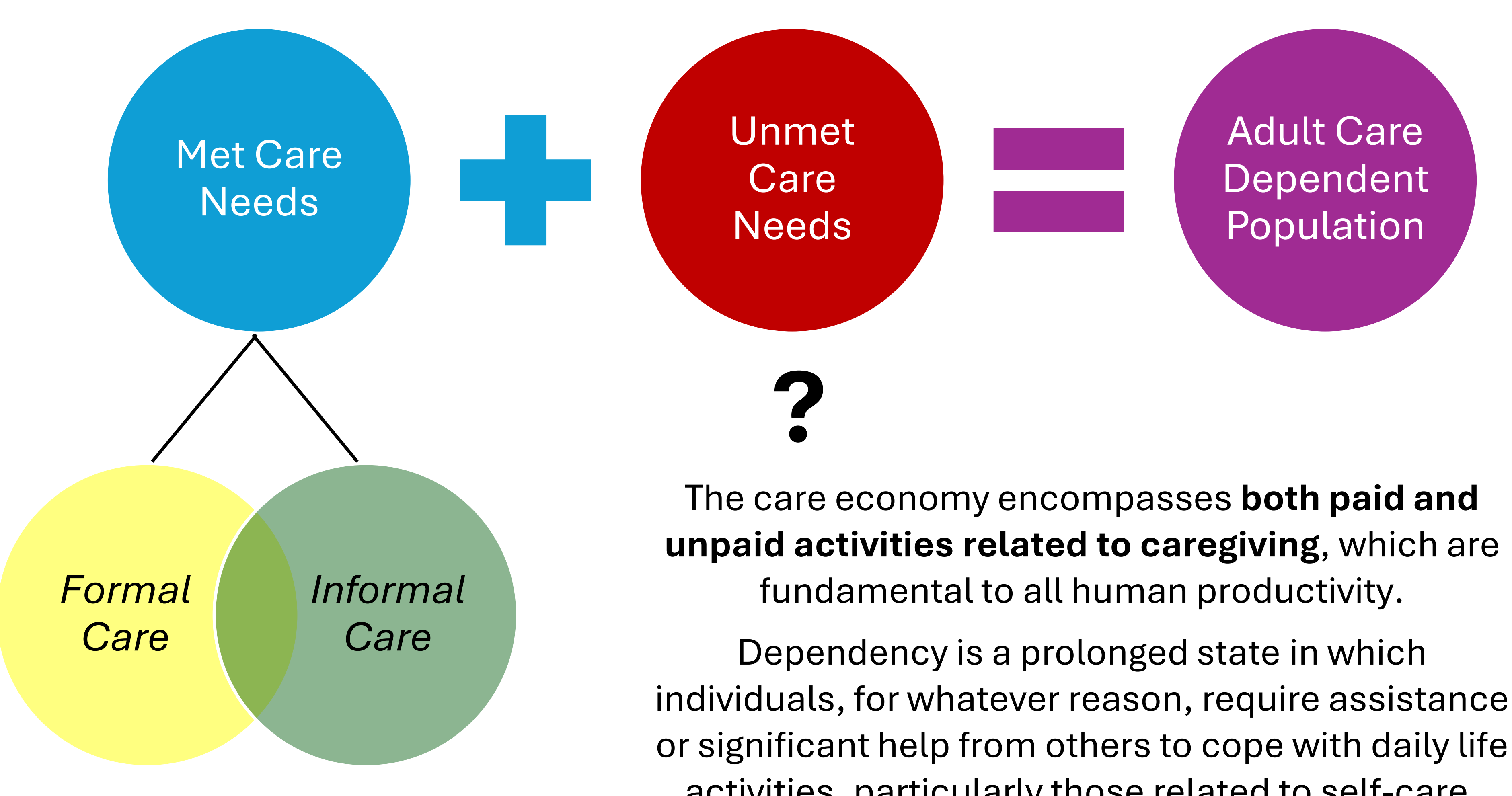
The COVID-19 pandemic has exacerbated and brought further to the fore these costs. With schools and day-care centres shut down, families witnessed a massive shift of childcare responsibilities into their homes. While both women and men increased their unpaid workloads, women continued to shoulder the bulk of unpaid care and domestic work, with negative ripple effects on their working hours and earnings, mental health and wellbeing. Many mothers have left the workforce altogether to care for children amid prolonged school and day-care centre closures[4].

Though the pandemic raised social recognition of paid care workers – particularly those in the health sector – the high numbers of nursing home deaths, in advanced economies for example, have confirmed what many had called a looming care crisis. The large proportion of deaths in public elderly care facilities were attributed to longstanding infrastructure deficits, poor working conditions, and high turnover rates among staff, as well as dependence on private-for-profit providers[5]. Overall, public care services remain underdeveloped and chronically underfunded in many countries, with negative implications for unpaid caregivers, paid care workers, children and care-dependent adults. Women's growing participation in the paid labor force has reduced the supply of unpaid family care, while poor working conditions and wages have exacerbated labour shortages in the paid care sector[6]. At the same time, population ageing has driven up demand. This has led to large-scale migration of nurses and domestic workers from poorer to more affluent countries, both reflecting and exacerbating inequalities between countries[7]. This search for economic opportunities often leaves care deficits in countries of origin with potentially negative implications for children and increased burdens on the women who stay behind, including grandmothers, siblings and daughters[8].

As we enter the third year of the pandemic, economic penalties and occupational health and safety hazards in the sector remained largely unaddressed, with migrant women and women of color being disproportionately affected. The pandemic raises the urgency of addressing looming care labor crises around the world.

The Purple Economy aims to overcome the fragility of the care economy at the national and international levels and address the multiple and intersecting inequalities created by the disproportionate reliance on women's unpaid and underpaid labour, and under-investment in the care sector.

Sizing Up the Care Economy



The care economy encompasses **both paid and unpaid activities related to caregiving**, which are fundamental to all human productivity.

Dependency is a prolonged state in which individuals, for whatever reason, require assistance or significant help from others to cope with daily life activities, particularly those related to self-care.

Adult Care Dependent Population, 2019

The national prevalence of overall difficulty was 27.3%, with 25.9% having some difficulty, 3.6% having a lot of difficulty, and 0.9% cannot do at all (**NHMS2019**).

Difficulty in Self Care (2019)

18+ = **2.2%** [n = 468,948]

60+ = **9.3%** [n = 295,074]

Age Group	Number (%)	Difficulty in Self Care (Percent)
18-29	45,626	0.7
30-39	33025	0.6
40-49	45,219	1.3
50-59	50,004	1.6
60-69	105,874	5.2
70-79	91,440	10.1
80+	97,760	33.0

NATIONAL HEALTH & MORBIDITY SURVEY 2023

NON-COMMUNICABLE DISEASES AND HEALTHCARE

NHMS2023

have difficulties with **caring for themselves**, of which only

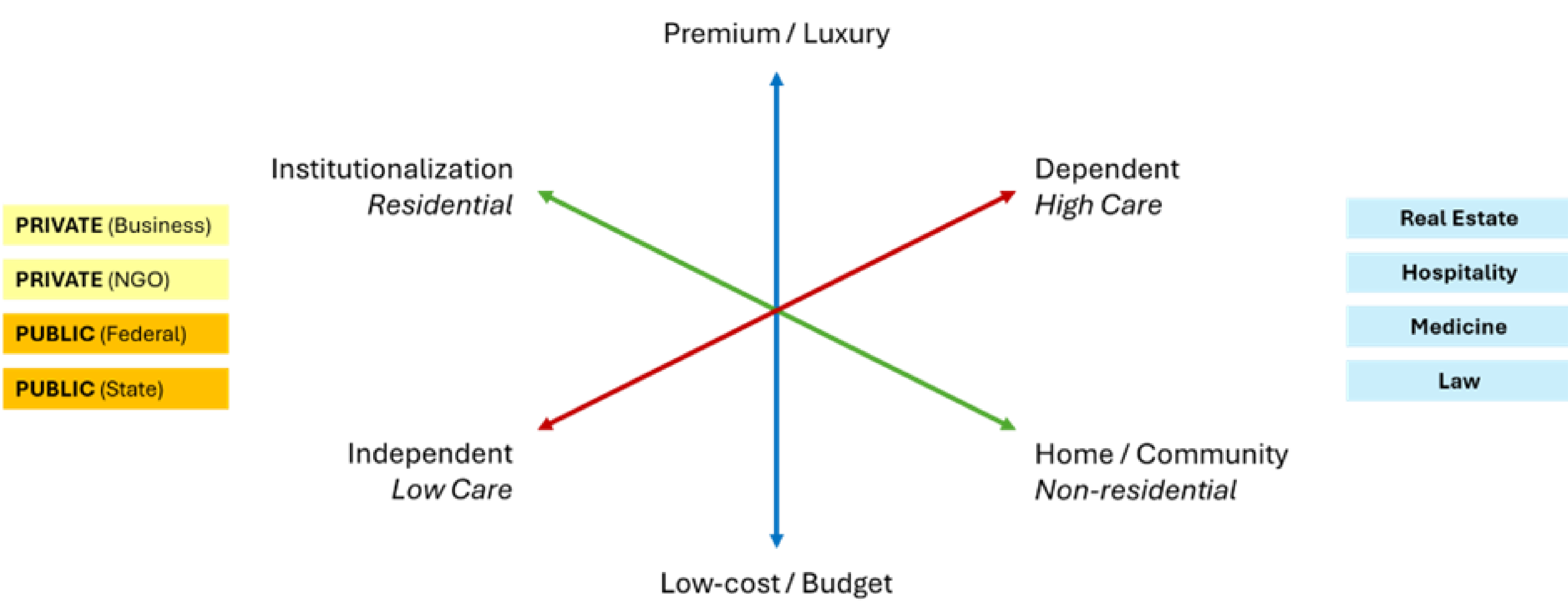
15%

sought help for it

Source: IPH, 2020; 2024

The prevalence of disability in 2019 among adults (18 years or over) was 11.1%, and 4.7% among children (2 - 17 years old) (NHMS2019, IKU, 2020).

Conceptualization of Aged Care in Malaysia



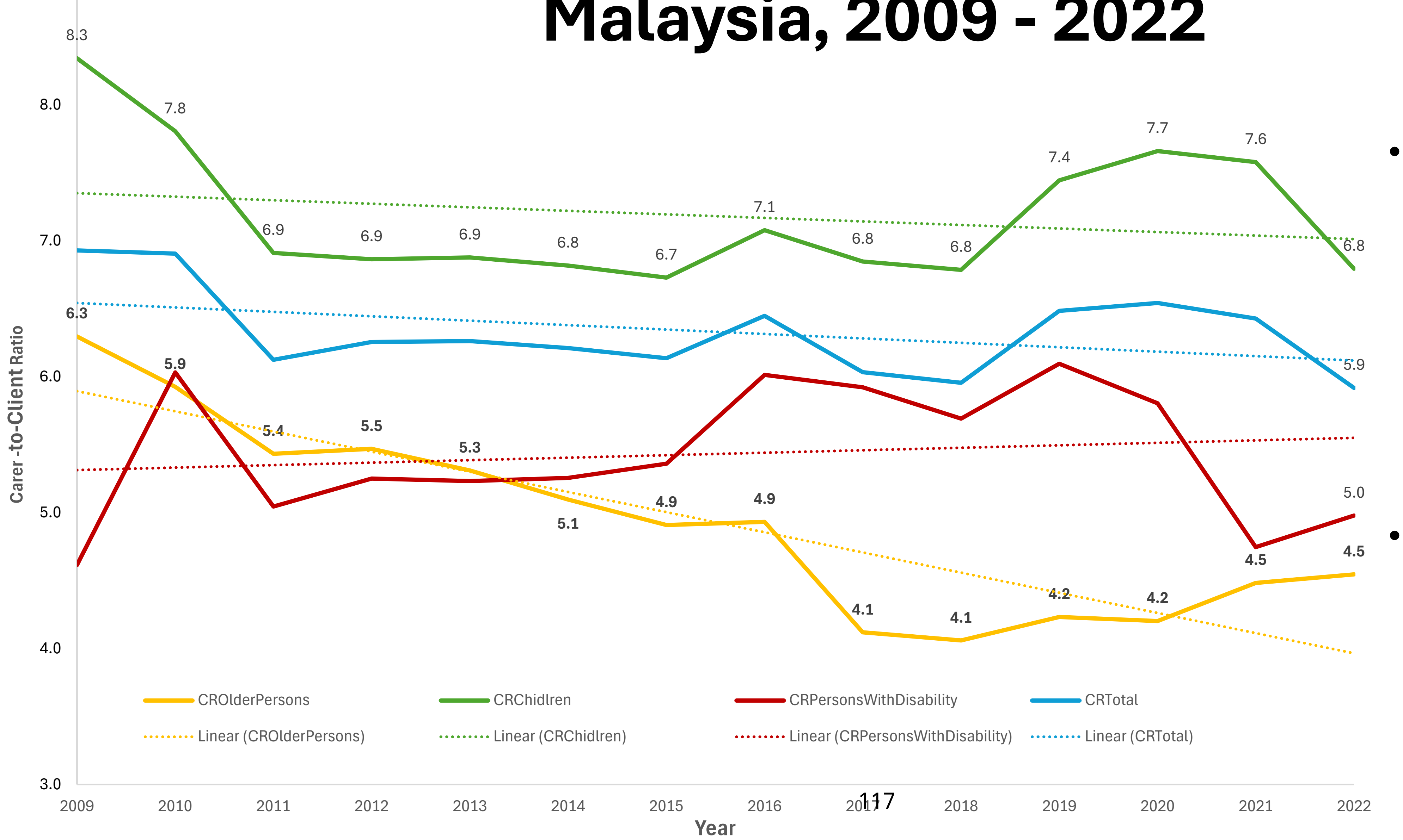
Care Centres Act 1993 (506) Statistics, 2019 - 2022

Year	Childcare Centres						PWD Centres						Aged Care Centres					
	Number		Type		Ownership		Number		Type		Ownership		Number		Type		Ownership	
	Carers	Child	Day Care	Resi-dential	Private	NGO	Carers	PWD	Day Care	Resi-dential	Private	NGO	Carers	OP	Day Care	Resi-dential	Private	NGO
2022	4,895	33,263	1,050	300	1,080	270	1,254	6,244	161	59	100	120	2,122	9,648	14	404	342	76
2021	4,936	37,419	999	263	1,025	237	1,301	6,176	145	57	76	126	1,838	8,241	8	376	314	70
2020	4,726	36,207	864	287	887	264	1,378	8,000	138	60	74	124	1,860	7,818	10	368	312	66
2019	4,578	34,090	805	289	851	243	1,296	7,901	125	59	64	120	1,758	7,440	15	343	296	62

Year	Childcare Centres						PWD Centres						Aged Care Centres					
	Carer to Client Ratio	Carer per Centre	Client per Centre	% Resi-dential	Number	Growth per Annum	Carer to Client Ratio	Carer per Centre	Client per Centre	% Resi-dential	Number	Growth per Annum	Carer to Client Ratio	Carer per Centre	Client per Centre	% Resi-dential	Number	Growth per Annum
2022	6.8	3.6	24.6	22.2	1,350	-	5.0	5.7	28.4	26.8	220	-	4.5	5.1	23.1	96.7	418	-
2021	7.6	3.9	29.7	20.8	1,262	0.9	4.7	6.4	30.6	28.2	202	0.2	4.5	4.8	21.5	97.9	384	0.3
2020	7.7	4.1	31.5	24.9	1,151	1.1	5.8	7.0	40.4	30.3	198	0.0	4.2	4.9	20.7	97.4	378	0.1
2019	7.4	4.2	31.2	26.4	1,094	0.6	6.1	7.0	42.9	32.1	184	0.1	4.2	4.9	20.8	95.8	358	0.2

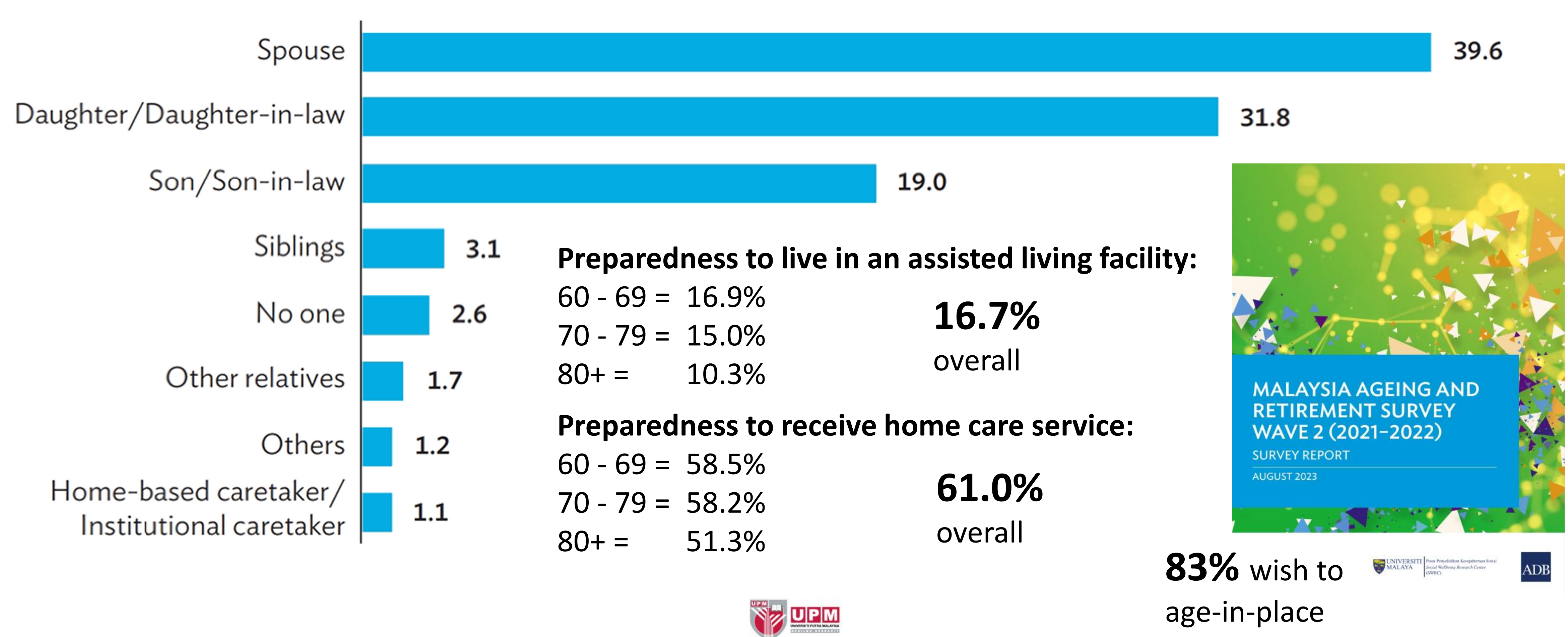
Source: Department of Social Welfare, Malaysia (various years)

Carer-to-Client Ratios by Care Centre Type, Malaysia, 2009 - 2022



- There is a fundamental risk in the plan to meet aged care needs / demands to be fulfilled from a centre- or residential-based approach
- The ratios also masked significant variations in the facilities and services on the ground

Who Cares? Expectations and Reality



Preparedness to live in an assisted living facility:

60 - 69 = 16.9%
70 - 79 = 15.0%
80+ = 10.3%

16.7% overall

Preparedness to receive home care service:

60 - 69 = 58.5%
70 - 79 = 58.2%
80+ = 51.3%

61.0% overall

83% wish to age-in-place

Care Economy & Older Persons in Malaysia

- Demographic and economic forces are fueling the expansion of the aged care economy in Malaysia. Female labour force participation is both affecting and being affected by traditional child- and eldercare arrangements.
- Shifts in caregiving responsibilities and the changing nature of eldercare services are likely to adversely affect older persons' access to quality care and support in later life, unless these changes are matched by appropriate policy responses.
- The care needs of older persons are still predominantly met by family members, reflecting deep-rooted cultural and religious expectations of filial piety and responsibility. Residential aged care are predominant with underdeveloped health and social care services in the community and at home.
- This transition is punctuated by a growing reliance on private aged care centers, home care services, and paid carers.
- Regardless, the increasing marketization and commodification of care services necessitates a shift in the State's role from being a social welfare provider to a regulator and facilitator of the care industry.

Issues, Challenges & Opportunities

Care RECIPIENTS

- Regulatory and monitoring oversight - **public, private, or non-governmental organizations**, are subjected to different scrutiny.
- Ensuring that facilities are properly licensed, registered, and meeting minimum
- Fundamental rights of older persons to care and security (dignity, fulfilling lives, and independence).
- Older Malaysians are not given the **autonomy to make decisions and choices** about their own care, including end-of-life care.
- Consent and advance directives are critical components of care for older persons.

Care PROVIDERS

- Persistent **shortage of qualified caregivers** in both formal and informal sectors.
- Low wages and demanding work conditions lead to high staff turnover, and it is difficult to retain skilled carers or attract new talent.

recognition, certification or accreditation.

- Professionalization of the aged care sector, including **standardized training and fair remuneration** for aged care workers who perform an essential service.
- Gender imbalance in care work, with efforts to **encourage more men to enter the profession**.

Care FINANCING

- Financial burden of **long-term care** is a significant concern for families and the State.
- Alternative financing options, such as insurance schemes or subsidies for lower-income families, is needed.
- **Technology-augmented care**,

presents new opportunities to enhance care while reducing costs.

- Residential care is expensive and beyond the reach of most families, with hidden costs and unpredictability in care quality
- **Home and community-based services** that are affordable are needed to create a level playing field for low and middle-income families.

The high cost of aged care, limited public funding and support, as well as lack of LTC insurance options, are driving up out-of-pocket expenses that can only lead to greater financial burden, strain and stress for families.

Residential Aged Care Industry Survey, 2024

(Preliminary Findings-I)

Yes | No | Not Applicable

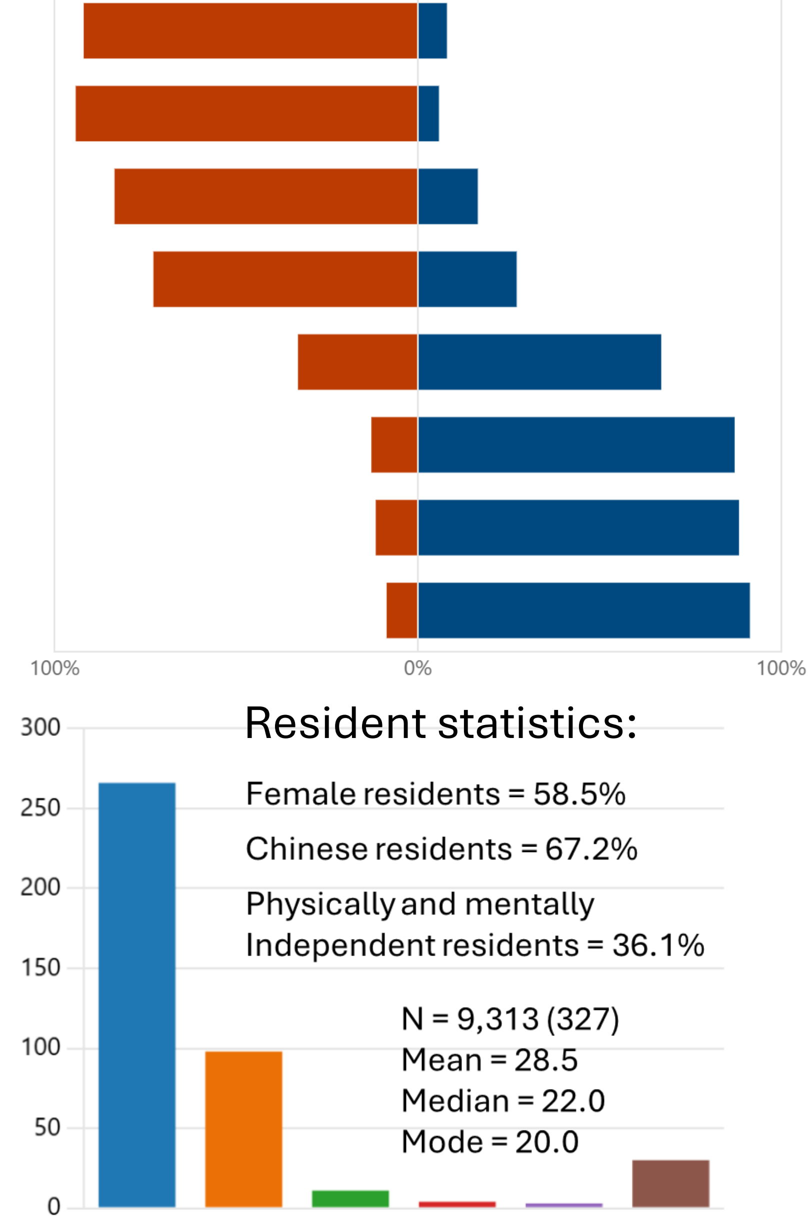
- Is the older person's **consent** obtained, wherever possible, pertaining to their residence at the Premise?
- Is there a legal **contract** or agreement signed between the operator and client for residency at the...
- Is there a **guideline** provided for family members or visitors to the Premise?
- Is there a **waiting list** to be admitted to this Premise?
- Are the residents allowed to **leave and return** to the Premise on their own, with or without specific...
- Is there a daily **activity schedule** to be observed by the residents at this Premise?
- Does the Premise operator file an annual tax return with the **Inland Revenue Board**?
- Are residents required to undergo a **medical check-up** and make full disclosure of health status prior to...
- Does the Premise have any guidelines on protecting **confidentiality** and disclosure of residents' health...
- Does the Premise accept residents with **blood-bourne virus infections** such as Hepatitis B, Hepati...
- Does the Premise carry out needs assessment and develop **individualized care plan** for each resident?

100% 0%

Yes | No

- Personal care services
- Day care services
- Medical care (treatment, nursing care)
- Dementia care (cognitive / Alzheimer's Disease)
- Physiotherapy, Occupational therapy & Other Rehabilitation services
- Respite care services
- Palliative and Hospice care
- Others

Monthly fees	266
Donations (e.g. public, corporati...	98
Government grants	11
Endowments (e.g. wakaf, trust f...	4
Investment income (e.g. rent, bu...	3
Other	30



Residential Aged Care Industry Survey, 2024

(Preliminary Findings-II)

No Problem At All | Some / Little Problem | Manageable Problem | Major Problem | Very Serious / Critical Problem

- Cash flow / financing problem
- High staff turnover
- Difficulty in staff / volunteer recruitment
- Manpower lacks required training
- Premise is unsuitable or too small
- Neighbourhood is not supportive of Premise services
- Unable to meet Government regulations & requirements
- Unreasonable demands by family members / relatives
- Harassment by Local Authorities and/or other enforcement agencies
- Licensing and renewal issues
- Other issues

100% 0% 122 100%

Department of Social Welfare (A...	256
Ministry of Health (typhoid)	170
Ministry of Health (Act 586)	17
Local Government / Local Autho...	32
Registrar of Societies (ROS)	72
Registrar of Companies / Comp...	249
Fire Brigade	261
Act of Parliament	2
Other	31

300
250
200
150
100
50
0

Manpower statistics:

Paid staff = 3,116 (1:3)
Female paid staff = 64.3%
Care staff = 1,590 (1:6)

Take Home Message

- We are in a transitional phase where the **commodification and marketization of unpaid family care** is taking place.
- Malaysian families have relied on kinship networks to support caregiving responsibilities, especially when no close family members is available. Rural girls as bondservants were replaced by foreign maids, and the middle-class continues to employ domestic workers as a more affordable alternative.
- The real challenge to sustainable home or community-based aged care services is an overdependence on foreign workers in the formal health and social care sector, whether residential or non-residential.
- Malaysia currently lacks a comprehensive LTC infrastructure, with relatively limited nursing homes and aged care facilities and services compared to an increasing older population. Moreover, the quality of care and accessibility of these services vary widely due to a lack of viable financing models.
- The government must adopt a holistic strategy to meet the changing needs of an ageing Malaysian population. We need to support community-based care models, use of technology to cut cost and providing financial assistance to needy families. Public awareness campaigns are crucial in shifting the cultural conceptions of ageing and care (NIMBY).

Four action areas of the United Nations Decade of Healthy Ageing 2021-2030

Ensuring that communities foster the abilities of older people.

Changing how we think, feel and act towards age and ageing.

Age-friendly Environments

Combating ageism

Integrated care

Long-term care

Delivering person-centered integrated care and primary health services to older people.

Providing access to long-term care for older people who need it.

Image Source: Chinese University of Hong Kong (https://www.ioa.cuhk.edu.hk/en-gb/research/research-projects/age-friendly-community-and-the-decade-of-healthy-ageing)

The United Nations Decade of Healthy Ageing (2021 - 2030) is a global collaboration, aligned with the last ten years of the Sustainable Development Goals, to improve the lives of older people, their families, and the communities in which they live.

Integrated care and **long-term care** are two (2) key action areas highlighted.

UPM
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THANK YOU

Terima Kasih . 谢谢 . நன்றி

MALAYSIAN RESEARCH INSTITUTE ON ageing

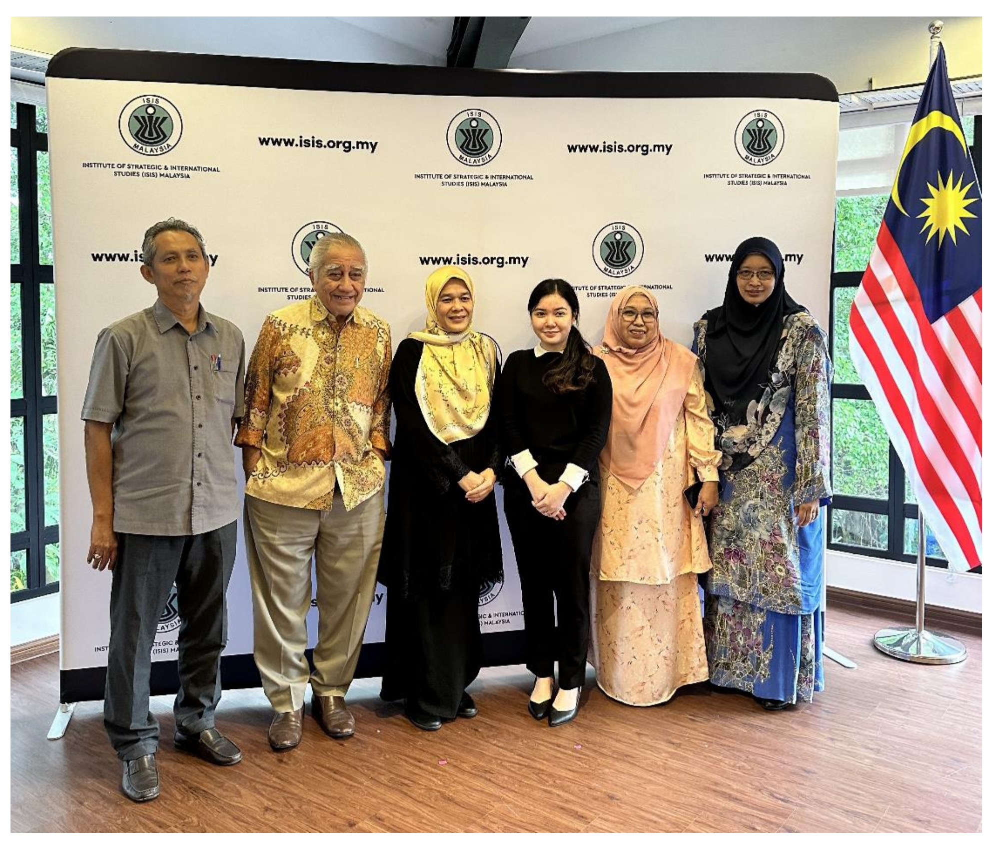
pensioner workers older dementia geography families social psychogeriatrics psychological place learning welfare biological aged financial continuity hypertension retirement hypercholesterolemia culture rate organ daily will love adults empowerment life longevity protection impairment active years activities dignity death cellular person eageing demography ageism community employment elderly care experience disengagement event healthy citizen spirituality dependency geriatrics tradition nest gerontechnology molecular coping age bereavement living diabetes old family planning empty retiree gerontology depression functioning personality estate senior senescence activity environment u3a population ratio fertility statistics later society ageist spiritual disease dying lifelong wisdom productive expectancy end theory alzheimer's discrimination successful birth

Session 4: Persons with disabilities - Program Pemulihan Dalam Komuniti (PDK)

1530 – 1700 hrs | Tuesday, 24 September 2024

Role Players:

Moderator	**Dr Diana Katiman**, EXCO, IKRAM; Palliative Care Physician, Hospital Al-Sultan Abdullah UiTM
Slides Presenters	**Pn Sapura Arshad**, Penyelia, PPDK Sungai Buloh, Selangor
	En Haji Mohd Fouzi Haji Mohd Isa, Pengerusi, PPDK Kuala Klawang, Jelebu
Paper Presenter	**Ms Lydia Ann Bill**, Policy and Research Officer, All-Party Parliamentary Group Malaysia on Sustainable Development Goals
Discussant 1	**Pn Emilia Syatirah Derahim**, Ketua Penolong Pengarah, Jabatan Pembangunan Orang Kurang Upaya (JPOKU), Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM)
Discussant 2	**Dato' Ghazali Yusoff**, Former National Chairman, PDK Kebangsaan
Secretariat	**Hirzawati Atikah Mohd Tahir** (APPGM-SDG) – Rapporteur
	Afiqah Abdul Malik – Timekeeper



{L-R: En Mohd Fouzi Mohd Isa, Dato' Ghazali Yusoff, Pn Emilia Derahim, Ms Lydia Ann Bill, Pn Sapura Arshad and Dr Diana Katiman)

PAPER 4

Challenges Faced by PDK Workers in Malaysia

Lydia Ann anak Bill

Introduction

Initially, the World Health Organization (WHO) viewed rehabilitation as a complex subject matter requiring broad and expensive resources, which were frequently concentrated in medical institutes where teams of specialists offered such care services. This strategy hindered many people's access to rehabilitation, particularly those living in low-income and rural areas. Recognising this gap, the World Health Organization altered its perception of rehabilitation care towards community-based access to rehabilitation treatments. This transition signalled the start of a new policy aimed at empowering local communities to help people with disabilities. In the 1980s, the World Health Organization (WHO) then launched Community-Based Rehabilitation (CBR) guidelines to improve access to rehabilitation services for people with disabilities, particularly in low- and middle-income countries (Khasnabis et. al., 2010).

By utilising sufficiently trained local human resources and establishing effective referral systems, the WHO envisioned better access to rehabilitation services. This community-based model enabled people with disabilities to participate more fully in social and economic activities, leading to enhanced inclusion and improved quality of life.

In Malaysia, there are a total of 637 537 numbers of registered People with Disabilities (PWDs) with the Department of Welfare as of January 2023 in Malaysia, an increment from 619 273 number registered in August 2022 (Department of Welfare, 2024). This means that a greater fraction of the Malaysian population requires caregiving services that involve complex and ongoing needs, which can place significant financial burdens on households, the economy, and the government. Consequently, the CBR program, known as Pemulihan Dalam Komuniti (PDK), has been established with the aspiration of the WHO’s community-centric development approach to foster social inclusion and community support in helping the disabled. Headed by the Ministry of Women, Family and Community Development through the Department of Welfare (also known as Jabatan Kebajikan Malaysia) since the 1980s, the program offers three primary types of services to people with disabilities across Malaysia; home-based, center-based and central-home-based care.

Home-based services involve providing rehabilitation and support directly within the individual’s home. This approach is particularly beneficial for individuals who are unable to travel to a centre due to mobility issues, severe disabilities, or living in remote areas. Meanwhile, centre-based services are offered at dedicated CBR centres, where people with disabilities can receive various therapies, skills training, and support in a structured environment. On the other hand, the central-home-based services combine elements of both home and centre-based care, offering flexibility for individuals who may require home visits but also benefit from accessing specific services or facilities available at the CBR centres. According to the Department of Welfare Malaysia, there are a total of 559 PDKs across Malaysia. The budget allocated for PDKs is also increasing each year, from RM91 million in

2019 increase to RM133.5 million in 2024 (Media Madani, 2024), an increase of RM42.5 million in 5 years.

Table 1: Number of PDKs in Malaysia according to states and regions.

States/ Regions	**Number**
Perlis	9
Perak	41
Pulau Pinang	26
Kedah	43
Pahang	51
Terengganu	46
Kelantan	45
Selangor	58
Wilayah Persekutuan Kuala Lumpur	10
Wilayah Persekutuan Putrajaya	4
Wilayah Persekutuan Labuan	2
Johor	73
Melaka	18
Negeri Sembilan	43
Sabah	37
Sarawak	53
Total Number	**559**

Source: Department of Welfare Malaysia

However, despite the increment in budget for the centre, challenges and gaps are not silenced. Recently, the announcement to increase trainees' (pelatih) allowance from RM150 to RM300 and the increment of allowances for workers as well as supervisors, yet there are structural issues still persist among PDKs in Malaysia. This paper, seeks to understand the major deprivation that communities of PDKs face and suggest a way forward to improve the livelihood of the caregivers as well as people with disabilities to ensure no one is left behind.

Methodology

The research employed a desktop research methodology based on 2023 available data in APPGM-SDG (All-Party Parliamentary Group Malaysia- Sustainable Development Goals). In this year, districts involved were Pontian, Tanah Merah, as well as data from 2024 that is fieldwork conducted in Pagoh. These districts were selected with a mixture of suburban, rural and remote, allowing for a representative sample of different socio-economic settings in Sabah in that year.

The study used Focus Group Discussions (FGDs) to collect qualitative data and acquire insights into community members' viewpoints, experiences, and perceptions. On average, 10 FGDs were held in each district over three days, with participants coming from a variety of backgrounds, positions, and roles in society, allowing research to collect a wide spectrum of viewpoints on the difficulties communities face. The qualitative data were then examined by identifying repeating themes, emerging issues, and contextual nuances connected to socioeconomic challenges experienced by the PDK communities.

Discussion

It is identified that challenges among the PDK communities consist of systemic issues and environmental issues. Both require more than a budget commitment from the government. Furthermore, some of these issues require more than government intervention, it requires multistakeholder support to uphold the sustainability of PDKs. To understand how to move forward, this section will first discuss issues faced by the PDKs.

Insufficient allowance for workers and trainees

Workers and trainees in Malaysia's Community-Based Rehabilitation (CBR) Centers, also known as Pusat Pemulihan Dalam Komuniti (PDK), are typically underpaid. The issue of insufficient allowances was raised during the 15th Parliament's third-term debates in July 2024. Members of Parliament highlighted concerns that the current allowances do not adequately reflect the work and responsibilities involved in caring for individuals with disabilities. Although the allowances for workers were increased from RM800 to RM1200 in 2021, and supervisors received an increment from RM1200 to RM1500 during the same period, these adjustments still fall short of fairly compensating their efforts in Community-Based Rehabilitation Centres (PDKs). It was additionally pointed out that workers and supervisors in PDKs have had to wait 10-15 years for an increase in their allowances, calling into doubt the current system's ability to meet the current economic demands and recognize their achievements.

To further support the concerns raised by Members of Parliament, the APPGM-SDG reports also highlight that since the roles of supervisors and workers in PDKs are classified as voluntary, they are unable to demand higher allowances or negotiate better salaries. This limitation further underscores the inadequacy of the current allowance structure in compensating their contributions. In addition, although PDK workers and supervisors are included in retirement savings schemes and social security systems, such as EPF and SOCSO contributions, their remaining take-home allowance is still very minimal. Some responses from PDK Sungai Petani highlighted "Sekarang taraf kami, RM1200. Tapi bila dipotong EPF, SOCSO, kami hanya dapat RM1,083 ringgit. Kami sebagai sukarelawan. Lebih bagus kalua kita boleh fight untuk dapatkan status dari sukarelawan kepada kontrak" [Now our allowance level is RM1200. But when EPF and SOCSO are deducted, we only get RM1,083. We are volunteers. It be great if we could fight to get the status from volunteer to contract workers] (Siti Nur Ain, 2023).

The status of Community-Based Rehabilitation (PDK) workers in Malaysia, where they are classified as volunteers rather than contract employees, poses various issues, particularly regarding financial stability and access to services such as bank loans. The focus group discussion from one of the workers in PDK Pagoh stressed that the title status of workers in PDKs is as such "Status tidak termasuk dalam bawah akta pekerjaan. Disebabkan status sukarelawan. Slip gaji, bank tidak pandang. Sebab kita dalam tiket sukarelawan." [Workers at PDK are not covered by the Employment Act because they are volunteers. The bank does not recognise the pay slip, because we are under the ticket of volunteers] (Wan Suzita, 2024). Without paychecks or established employment status, PDK employees may struggle to convince banking institutions of their ability to repay loans. This creates a big barrier for people who need to buy homes, vehicles, or other large assets. Even if they get allowances or stipends from PDK centres, these are frequently deemed informal income and may not meet the criteria established by banks and other lenders. Besides that, many PDK workers are unable to build a strong credit history because financial institutions do not officially recognize their income, leaving them without financial flexibility. Overall, the hiccups of systemic challenges directly impact the livelihood of PDK workers and supervisors.

Scarcity of professional services in PDKs

The lack of professional services such as physiotherapists, doctors, or nurses in Community-Based Rehabilitation (PDK) centers significantly affects the quality of care provided to people with disabilities. These professionals are essential for providing specialized treatment, rehabilitation, and healthcare services, which are often beyond the expertise of volunteer caregivers in the community.

Jaafar et al. (2021) emphasized that, while physiotherapy sessions can be conducted by PDK workers or supervisors, it should be noted that they are volunteers with little professional background. In practice, they only take courses or training once a year and are unable to meet their needs of the disabled. Another element influencing the efficiency of PDKs is the scarcity of professional services in PDK. The presence of health experts such as physiotherapists and occupational therapists is also limited to once a month or two, and their purpose of visit is usually limited to monitoring and evaluating the overall development of impaired children rather than doing a hands on (Jaafar et.al., 2021).

This situation was again brought up during the 15th Parliament's third-term debates in July 2024, where member of the parliaments stated there is a growing lack of specialist doctors, physiotherapists, and special education teachers, reflecting a growing challenge as the demand for special needs services continues to rise. In Johor Bahru, there is only one specialist who can give a diagnosis for a special child and the appointment with this specialist can take up to six months (15th Parliamentary Debates, 2024).

Inadequacy of physical environment

The existing infrastructure in many PDKs, particularly in rural and underserved areas, is often insufficient to accommodate the specific requirements of people with various physical, mental, and developmental disabilities. The inadequacy of Community-Based Rehabilitation (PDK) centres in Malaysia can indeed be divided into two primary issues.

Firstly, many PDK centres are housed in ageing buildings that require frequent maintenance and upgrades to remain functional. Over time, these facilities may face structural issues such as leaking roofs, damaged floors, or outdated electrical systems, all of which pose challenges for providing safe and effective services. This is evident especially in rural Sabah and Sarawak where most PDKs are located far from the city. Many PDK centres in rural areas, particularly in Sabah and Sarawak, face serious maintenance issues, which severely impact the quality and safety of the facilities. An example of such inadequate infrastructure is the PDK in Sibuti, where the center is housed in a wooden structure. This type of infrastructure presents various safety hazards, including potential structural instability due to wear and tear, risk of fire, termites and other potential risks. With poor road networks and difficult access to these areas, the challenges of upgrading and maintaining PDK centres become even more severe. The centers are often left in a dilapidated state, with limited resources for repairs or renovations.

Additionally, the lack of room partitions in many Community-Based Rehabilitation (PDK) centers poses a significant challenge, especially when working with children with special needs, such as those with autism or ADHD. These children often have specific sensory and behavioral needs that require environments designed for focused and individualized attention. Pengelley et. al. (2008) stated that dedicated physical space is important for children with autistic spectrum syndrome (ASD) because it affects behavior, sleeping patterns, and stress. This was aso found in the report conducted in Pontian and Pagoh where supervisors discussed that autistic or ADHD children need a separate room from their peers because they have different stimulation to their environment and may lead to tantrum.

Secondly, many PDK centers lack the specialized equipment needed to meet the diverse needs of people with disabilities. This includes mobility aids (such as wheelchairs, walkers, and crutches), as well as rehabilitation equipment for physical therapy and other services. Discussion from PDKs Pontian's reports stated that "Peruntukan bilik fisioterapi, tetapi kami kekurangan. Kami juga kekurangan peralatan yang baru untuk kegunaan pesakit kami. Juga bilik pemulihan." [Funding for physiotheraphy room and rehabilitation room is limited. We also lack equipment that is necessary to treat the needy] (Siti Nur, 2023).

Limited access to professional development courses and training

Since PDK workers in Malaysia are often classified as volunteers, they do not enjoy the same benefits as regular employees, such as paid time off for attending training or courses. This lack of benefits is a significant challenge, especially given that workers are frequently expected to upgrade their skills through professional development programs.

According to the Deputy of Women, Family and Community Development during the 15th Parliamentary Debate, the Department of Welfare had organized courses that would empower workers and supervisors of PDK in their capacity building. From 2009 to 2023, a total of 1838 PDK supervisors and workers attended the Basic PDK Wokers Course (Kursus Asas Petugas PDK). In addition, they receive an appreciation token from the Department of Welfare in the form of course sponsorship. The course is titled Malaysian Skills Certificate Level 3 Rehabilitation Operations in the Community (Sijil Kemahiran Malaysia Tahap 3 Operasi Pemulihan Dalam Komuniti). However, despite such support from the government, there are

still gap in capacity building for workers of PDK. As discussed by the member of parliament "Petugas PDK berdepan dengan masalah kekurangan kursus asas professional yang menyeluruh dan ini juga menyebabkan mereka kerap kali berhadapan dengan tugas-tugas penting tanpa pengetuahuan professional yang diperlukan." [PDK officers are faced with lack of comprehensive professional basic courses, and this also causes them to do significant work for the disabled without the necessary professional guidance].

Thus, it is vital for caregivers in PDKs to have confidence in their competence to care for differently abled children and protect their own well-being (Mustafa et al., 2021). Without continuous learning opportunities and skill enhancement, caregivers may feel stagnant in their roles. This can lead to reduced enthusiasm, affecting the quality of care provided to the individuals under their supervision.

The struggle of East Malaysian PDKs

In this section, it is recognized that the issues discussed above are issues faced by PDKs in Malaysia however it is worth while to note that the challenges faced by East Malaysian PDKs differ from those in West Malaysia due to several unique regional factors. This can include geographical and infrastructure barriers, economic disparities, as well as governance and policy implementation.

Based on site visits undertaken in Sibuti, Sarawak in 2024, it was discovered that PDK in Sibuti, Sarawak is experiencing major infrastructure issues, which could have a negative influence on the quality of care and services offered. The building's poor condition, including a broken roof, the fact that the majority of the structure is constructed of wood, and a lack of maintenance, may pose safety risks for both caretakers and individuals who rely on the center for rehabilitation. Being the region with more remote and rugged terrain, including mountains, rivers, and dense forests, makes it difficult and costly to transport building materials and personnel. This drives up the cost of maintaining and improving infrastructure, especially in rural areas Sabah and Sarawak. Therefore, limited access to skilled labor in remote regions further complicates efforts to maintain buildings like PDK centers.

In addition, Takom & Nawi (2019) studied on challenges faced by parents from rural Sabah and found that the frequency of long journeys to healthcare services as well as PDK centres, transit frequency and disruptions the reason parents find it difficult to get quality treatment and rehabilitation services for their children. As an illustration, a mother from a district in Sabah named Spitang would even go to an extend of travelling 40km everyday just do their special child could get access to PDKs (Arifin, 2022).

Hence, the combination of geography, manpower shortages, and transportation costs faced by Sabahans and Sarawakians makes the quality of care in PDKs more unique and in fact demands more attention from multi-stakeholders.

Recommendations

Collaborating with the private sector to improve Community-Based Rehabilitation (PDK) centers in Malaysia offers a range of benefits for both PDKs and private companies. By engaging in partnerships, the private sector can help address gaps in funding, infrastructure, and service provision at PDK centers, while also enhancing their Corporate Social Responsibility (CSR) efforts. Private companies can allocate a portion of their CSR budget to fund essential repairs, upgrades, and operational costs of PDKs, addressing infrastructure issues like those in Sibuti. This support can ensure that the facilities remain safe and functional for caregivers and clients.

In addition, companies can provide training programs for PDK staff, helping them acquire new skills or certifications. This strengthens the ability of caregivers to deliver higher-quality care and rehabilitation services, improving outcomes for individuals with disabilities. Some examples where company run CSR projects include the Columbia Asia Hospital who brought food essentials and other necessities to support PDK Klang Utara welfare home's operations.

Hence, CSR projects often involve the wider community, creating a sense of shared responsibility and pride. By involving local residents in PDK-related activities or events, the community can feel more connected and invested in the center's success.

Besides that, another measure to uplift PDK is through **fostering social entrepreneurship** within PDKs can be a powerful way to promote self-sustainability while also empowering individuals with disabilities and their caregivers. PDKs can help develop small businesses where participants produce handicrafts, traditional foods, or other local products. These items can be sold in local markets or online, generating income for the center and providing vocational training for people with disabilities.

In some of the site visits conducted by researchers from APPGM-SDG, PDK Pagoh for example started their own small farming of chilli to increase financial stand of the centre. This also give individuals with disabilities a sense of purpose and independence. It also motivates caregivers, as they can see the direct positive impact of their work and efforts, leading to increased job satisfaction. By adopting these strategies, PDKs can become more self-sustaining while also providing valuable life skills and economic opportunities to the individuals they serve.

The next solution to enhance the governance of PDKs is to **professionalizing workers in PDKs** to ensure job stability, recognition, and financial security for caregivers and other staff. As discussed above, this will also allow them to be more financially secure and able to apply loans from financial institutions.

By providing certification programs for caregivers and other workers, their skills can be formally recognized, improving their job status and employability. This recognition can also increase their motivation and commitment to the PDK. Moreover, professionalizing the workforce ensures that PDKs can attract more skilled individuals to the field, especially students who graduate with social work degrees. Thus, professionalizing PDKs workers can

raise the overall standard of care provided in the centers and enhance their reputation as well-run organizations.

Conclusions

As community-based rehabilitation centers, PDKs play a crucial role in supporting individuals with disabilities, offering essential services that can dramatically improve their quality of life. However, without addressing both structural and workforce-related challenges, the effectiveness of PDKs remains limited.

According to APPGM-SDG's reports, insufficient allowance for workers and supervisors, scarcity of professional services, inadequate physical environment, limited access to professional development courses, and the unique struggle of East Malaysian PDKs are the key issues found.

However, these issues can be addressed by engaging private companies in CSR projects, not only can the PDKs receive financial assistance, but the local community can also benefit from a strengthened sense of involvement. Secondly, PDKs should be more active and embark the journey of social enterprises. PDKs can not only reduce their dependence on external funding but also create an environment where individuals with disabilities can actively contribute to the community and gain independence. Thirdly, professionalizing the workforce helps build a stronger PDK system. With formal employment contracts and recognized skills, the centers can attract more skilled workers, thereby increasing the quality of rehabilitation services provided.

By tackling these issues holistically, PDKs can become more self-sustaining, offer higher-quality services, and empower their caregivers and beneficiaries alike. This strategy ensures that PDKs can continue to fulfill their mission of providing essential care and support to individuals with disabilities, while also contributing to broader community development and economic empowerment.

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Challenges Faced by PDK Workers in Malaysia

Lydia Ann (Policy and Research Officer, APPGM-SDG)

Introduction

- The concept of Community-Based Rehabilitation also known as PDK (Pemulihan Dalam Komuniti) was initially coined by the World Health Organization (WHO).
- The World Health Organization (WHO) viewed rehabilitation as a complex subject matter requiring broad and expensive resources, which were frequently concentrated in medical institutes where teams of specialists offered such care services.
- **But what about those living in low-income or/and rural areas?**

- In the 1980s, the World Health Organization (WHO) then launched Community-Based Rehabilitation (CBR) guidelines to improve access to rehabilitation services for people with disabilities, particularly in low- and middle-income countries.
- In Malaysia, PDK has been established with the aspiration of the WHO’s community-centric development approach to foster social inclusion and community support in helping the disabled.

According to Department of Welfare (2023), there are a total of 637 537 numbers of registered People with Disabilities (PWDs) from 619 273 in 2022.

This means that a greater fraction of the Malaysian population requires caregiving services that involve complex and ongoing needs, which can place significant financial burdens on households.

Number of PDKs in Malaysia according to states and regions.

States/ Regions	Number
Perlis	9
Perak	41
Pulau Pinang	26
Kedah	43
Pahang	51
Terengganu	46
Kelantan	45
Selangor	58
Wilayah Persekutuan Kuala Lumpur	10
Wilayah Persekutuan Putrajaya	4
Wilayah Persekutuan Labuan	2
Johor	73
Melaka	18
Negeri Sembilan	43
Sabah	37
Sarawak	53
Total Number	**559**

Source: Department of Welfare Malaysia, 2023

The budget allocated for PDKs is also increasing each year, from RM91 million in 2019 increase to RM133.5 million in 2024.

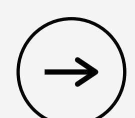
However, structural issues still persist among PDKs in Malaysia

Methodology

Data from APPGM-SDG (All-Party Parliamentary Group Malaysia for Sustainable Development Goals)

Grounded Research - Issues Identification

Focus Group Discussions (FGDs) with communities



Data from Pontian, Tanah Merah, Sibuti and Pagoh were used for this study + (Sri Aman as a author’s reflection)

Challenges experienced by the PDK communities

Discussion

Insufficient allowance for workers and trainees

Although the allowances for workers were increased from RM800 to RM1200 in 2021, and supervisors received an increment from RM1200 to RM1500 during the same period, **these adjustments still fall short of fairly compensating their efforts in Community-Based Rehabilitation Centres (PDKs).**

Although PDK workers and supervisors are included in retirement savings schemes and social security systems, such as EPF and SOCSO contributions, their **remaining take-home allowance is still very minimal.**

"Sekarang taraf kami, RM1200. Tapi bila dipotong EPF, SOCSO, kami hanya dapat RM1,083 ringgit. Kami sebagai sukarelawan. Lebih bagus kalau kita boleh fight untuk dapatkan status dari sukarelawan kepada kontrak" PDK Sungai Petani

The status of Community-Based Rehabilitation (PDK) workers in Malaysia, where they are classified as volunteers rather than contract employees. **Struggle to convince banking institutions** of their ability to repay loans

"Status tidak termasuk dalam bawah akta pekerjaan. Disebabkan status sukarelawan. Slip gaji, bank tidak pandang." PDK Pagoh

Discussion

Scarcity of professional services in PDKs

These professionals are essential for providing specialized treatment, rehabilitation, and healthcare services, which are often **beyond the expertise of volunteer** caregivers in the community.

While physiotherapy sessions can be conducted by PDK workers or supervisors, it should be noted that they are volunteers with little professional background. In practice, they only take courses or training once a year and are **unable to meet their needs of the disabled**

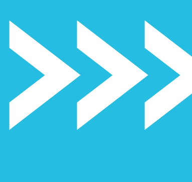
There is a **growing lack of specialist doctors, physiotherapists, and special education teachers,** reflecting a growing challenge as the demand for special needs services continues to rise.

"In Johor Bahru, there is only one specialist who can give a diagnosis for a special child and the appointment with this specialist can take up to six months." (15th Parliamentary Debates, 2024)

Discussion

Inadequacy of physical environment

Many PDK centres are housed in ageing buildings that require frequent maintenance and upgrades to remain functional. Over time, these facilities may face structural issues such as leaking roofs, damaged floors, or outdated electrical systems, all of which pose challenges for providing safe and effective services.
Example, PDK in rural area in Sarawak: Sibuti



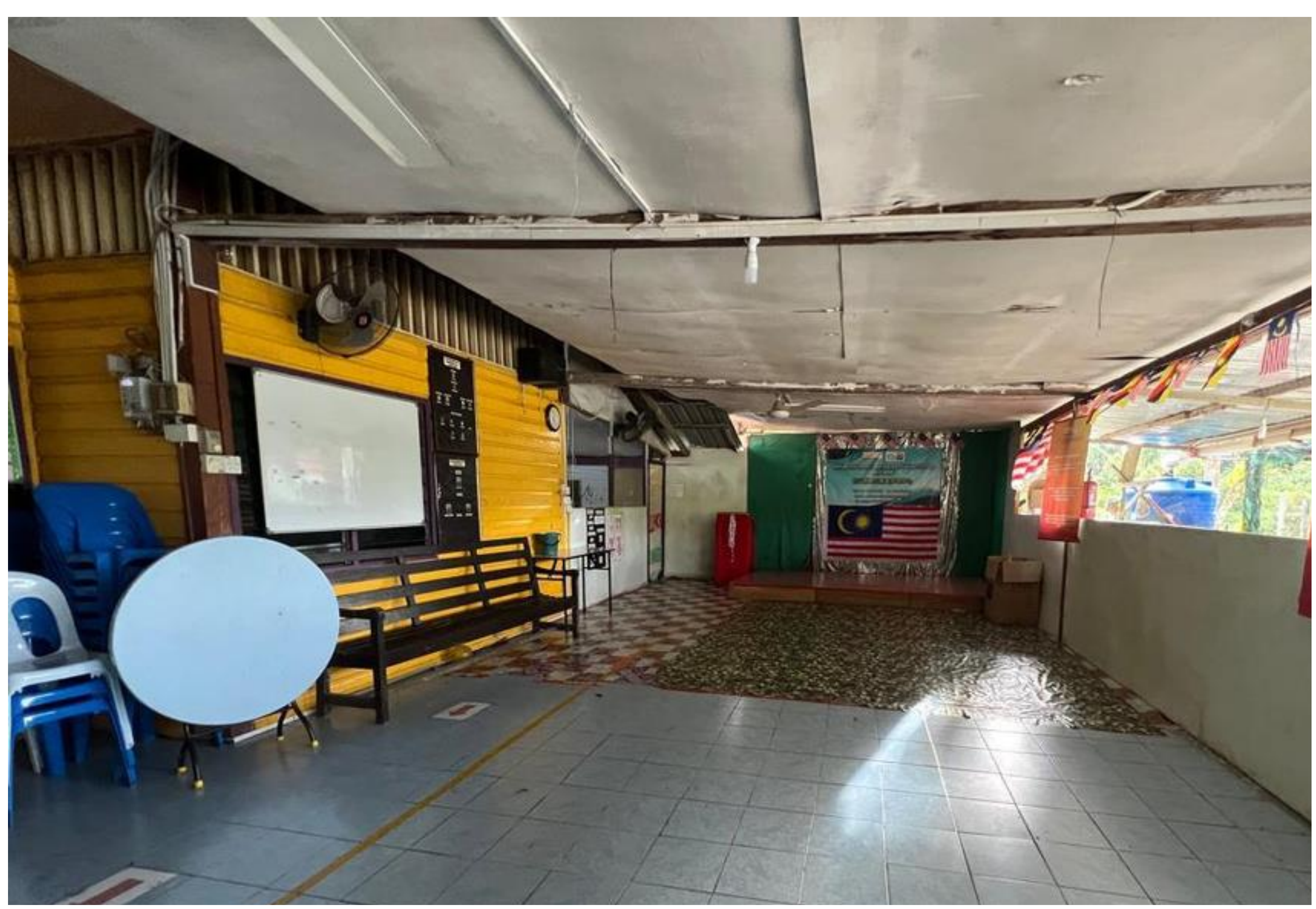
The lack of room partitions in many Community-Based Rehabilitation (PDK) centers, especially when working with children with special needs.

This was also found through the study conducted in Pontian and Pagoh where supervisors (penyelia) discussed that autistic or ADHD children need a separate room from their peers because they have **different stimulation to their environment and may lead to tantrum.**

PDK centers **lack the specialized equipment** needed to meet the diverse needs of people with disabilities. This includes mobility aids (such as wheelchairs, walkers, and crutches), as well as rehabilitation equipment for physical therapy and other services.

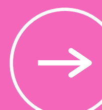
Inadequacy of physical environment

Photo: PDK Sibuti, Sarawak



Discussion

Limited access to professional development courses and training



Since PDK workers in Malaysia are often **classified as volunteers, they do not enjoy the same benefits as regular employees, such as paid time off for attending training or courses.**

From **2009 to 2023, a total of 1838 PDK supervisors and workers attended the Basic PDK Wokers Course (Kursus Asas Petugas PDK).**
In addition, they receive an appreciation token from the Department of Welfare in the form of **course sponsorship.**

However, despite such support from the government, **there are still gap in capacity building for workers of PDK.**
Without continuous learning opportunities and skill enhancement, caregivers may feel stagnant in their roles. This can lead to reduced enthusiasm, affecting the quality of care provided to the individuals under their supervision.

Discussion

The struggle of the East Malaysian PDKs

Challenges faced by East Malaysian PDKs differ from those in West Malaysia. Being the region with more **remote and rugged terrain, including mountains, rivers, and dense forests, makes it difficult and costly to transport building materials and personnel**. This drives up the **cost of maintaining and improving infrastructure, especially in rural areas Sabah and Sarawak**. Therefore, limited access to skilled labor in remote regions further complicates efforts to maintain buildings like PDK centers.

Takom & Nawi (2019) studied on challenges faced by parents from rural Sabah and found that the frequency of **long journeys to healthcare services as well as PDK centres, transit frequency and disruptions the reason parents find it difficult to get quality treatment and rehabilitation services for their children.**

A severe shortage of healthcare professionals, particularly in rural districts, has created significant challenges for people requiring rehabilitation services. For example, a couple of physiotherapists had to attend to 6 PDKs in the Sri Aman and Betong districts,
District Sri Aman - 4 PPDKs (PPDK Sri Aman, PPDK Lingga, PPDK Stumbin, PPDK Batang Air)
District Betong- PPDK Betong, PPDK Saratok

The struggle of East Malaysian PDKs

Sanggup ulang-alik 40km setiap hari bawa anak OKU ke PDK

Syah Hairizal Kamalul Arifin
26/04/2022 11:40 MYT

Golongan OKU menerima sumbangan Aidilfitri di Pusat Pemulihan Dalam Komuniti (PDK). - Astro AWANI

SIPITANG: Berulang-alik sejauh kira-kira 40 kilometer hampir setiap hari ke Pusat Pemulihan Dalam Komuniti (PDK).

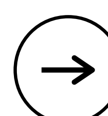


Photo: News Article from Astro Awani

Collaborating with the private sector

By engaging in partnerships, the private sector can help address gaps in funding, infrastructure, and service provision at PDK centers, while also enhancing their Corporate Social Responsibility (CSR) efforts. Private companies can allocate a portion of their CSR budget to fund essential repairs, upgrades, and operational costs of PDKs, addressing infrastructure issues.

In addition, companies can provide training programs for PDK staff, helping them acquire new skills or certifications. This strengthens the ability of caregivers to deliver higher-quality care and rehabilitation services, improving outcomes for individuals with disabilities

Recommendations

Fostering social entrepreneurship

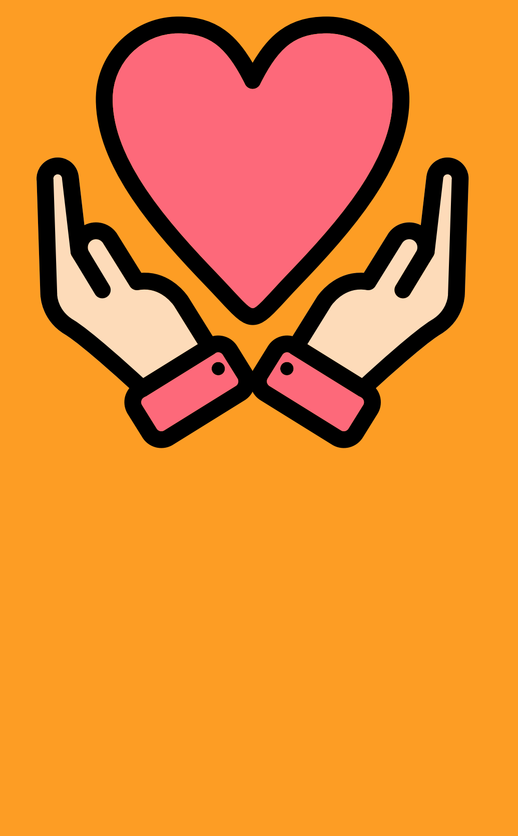
This can be a powerful way to promote self-sustainability while also empowering individuals with disabilities and their caregivers. PDKs can help develop small businesses where participants produce handicrafts, traditional foods, or other local products.

In some of the site visits conducted by researchers from APPGM-SDG, PDK Pagoh for example started their own small chilli farming to increase financial stand of the centre. This also give individuals with disabilities a sense of purpose and independence. It also motivates caregivers, as they can see the direct positive impact of their work and efforts, leading to increased job satisfaction

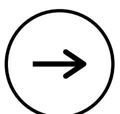
Professionalizing Workers in PDKs

The next solution to enhance the governance of PDKs is to professionalizing workers in PDKs to ensure job stability, recognition, and financial security for caregivers and other staff. As discussed, this will also allow them to be more financial secure and able to apply loans from financial institutions.

By providing certification programs for caregivers and other workers, their skills can be formally recognized, improving their job status and employability. Moreover, professionalizing the workforce ensures that PDKs can attract more skilled individuals to the field, especially students who graduate with social work degrees



Conclusions



Initially launched by the World Health Organization (WHO) to expand access to rehabilitation services at the community level, CBR has evolved into a holistic, multisectoral approach that promotes social inclusion and economic participation for individuals with disabilities.→PDKs

By utilizing local resources and trained community members, the CBR approach fosters greater independence, self-reliance, and empowerment, while also addressing broader societal goals of inclusion and equal opportunity.

Nevertheless, to truly reap the benefits of PDKs and its initial idea, these gaps must be addressed with private-public partnerships, fostering social entrepreneurship and professionalizing PDKs' workers.

Thank you

Session 5: Children in need

0930 – 1100 hrs | Wednesday, 25 September 2024

Role Players:

Moderator — **Ms Yvonne Tan**, Senior Researcher, ISIS Malaysia

Paper Presenters — **Pn Anisa Ahmad**, Chief Strategy Officer, House of Wisdom PLT

Ms Debbie Ann Loh, Head of Secretariat Officer, All-Party Parliamentary Group Malaysia on Sustainable Development Goals

Discussant 1 — **Datin Wong Poai Hong**, Executive Director, Childline Foundation

Discussant 2 — **Assoc Prof Dr Mazlina Che Mustafa**, Director, National Child Development Research Centre (NCDRC), Universiti Pendidikan

Secretariat — **Dana Dumpangol** (APPGM-SDG) – Rapporteur
Afiqah Abdul Malik – Timekeeper

(L-R: Datin Wong Poai Hong, Dr Mazlina Che Mustafa, Pn Anisa Ahmad, Ms Debbie Loh, Ms Yvonne Tan)

PAPER 5
Children in need

Anisa Ahmad and Debbie Ann Loh

INTRODUCTION

There can be no keener revelation of a society's soul than the way in which it treats its children. This incisive line from Nelson Mandela that holds up a mirror to how the most vulnerable are regarded in any society.

This paper will focus on children in need in Malaysia, beginning with definitions of a child followed by child's rights, needs and challenges in education, health and child protection within the local context. The next section discusses five categories of children in need. Perspectives from a childcare provider are put forward before the paper concludes with specific policy recommendations.

Definitions of a child

In Article 1 of the United Nations Convention on the Rights of the Child (CRC) 1989, "a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier."[55] Therefore, the status of a child is awarded to persons who are below eighteen years of age.

The definition of a "child" or any provision fixing the "age of majority" under other written laws may differ in accordance with the purposes of that law. In Malaysia, under the Child Act 2001 [Act 611] Section 2: Interpretation, a "child":

(a) means a person under the age of eighteen years; and

(b) in relation to criminal proceedings, means a person who has attained the age of criminal responsibility as prescribed in Section 82 of the Penal Code [Act 574].[56]

According to the Children Statistics, Malaysia 2023 report released by the Department of Statistics Malaysia (DOSM), the number of children under the age of 18 is estimated at 9.13 million, registering a slight decline compared to 9.19 million children in 2022. As of 2023, children constitute 27.4% of Malaysia's total population with 4.72 million boys and 4.42 million girls.[57] Of these, approximately a quarter (25.7%) or 2.35 million of the total number of children in Malaysia are under the age of five.[58]

CHILD'S RIGHTS, NEEDS AND CHALLENGES

[55] United Nations. (1989). *Convention on the Rights of the Child.* 20 November 1989. General Assembly resolution 44/25. https://www.ohchr.org/sites/default/files/crc.pdf

[56] Laws of Malaysia. (2018). *Child Act 2001 [Act 611].* https://learningpartnership.org/sites/default/files/resources/pdfs/Child-Act-Malaysia-2001-English.pdf

[57] Department of Statistics Malaysia (DOSM). (2023). *Children Statistics Malaysia 2023.* https://www.dosm.gov.my/portal-main/release-content/children-statistics-malaysia-2023

[58] Ibid.

Every child has rights as enshrined in the CRC, guided by four guiding principles of non-discrimination, best interests of the child, right to be heard and right to life, survival and development.[59] The question that arises then is, what is the state of the children in Malaysia? Where have we progressed, digressed or remained at status quo in honouring their rights as children? In this section, the state of the children in Malaysia with a focus on their fundamental rights to education, health and child protection will be discussed.

1. Education

Early childhood and pre-school education

In 2023, there were a reported 2.34 million children below the age of four in Malaysia.[60] Yet, as of January 2024, there are only 3,804 registered TASKA nationwide.[61] These child care centres encompass institution-based, work place-based, community-based or home-based centres, and are regulated by Child Care Centre Act 1984 (Akta Taman Asuhan Kanak-kanak Akta 308).[62] Assuming an average of 50 children were enrolled in a registered TASKA, that reaches only an approximate 190,200 children. The remaining children may be with family members, babysitters or non-registered TASKA, which may raise concerns of child safety and protection. From an operator's perspective, the low fees charged for TASKA leave operators struggling to keep up with rising operation expenses. To increase access for low-income and lower-middle income families, the government should consider owning at least 20% of the TASKAs.

Malaysia has made significant progress in preschool enrolment rates, achieving 84% in 2020 up from 67% in 2009. However, challenges with access and quality in preschool education that include lack preschool seat availability, low parental awareness about the benefits of preschool education, affordability concerns and low teacher quality, remain unresolved.[63]

Primary and secondary education

A 2024 World Bank report highlighted Malaysia's success in achieving near universal primary education,[64] attaining a 98.26% primary enrolment rate in 2021.[65] While this success

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[59] United Nations. (1989). *Convention on the Rights of the Child.*
[60] DOSM. (2023). *Children Statistics Malaysia 2023.*
[61] National Child Development Research Centre (NCDRC) and Universiti Pendidikan Sultan Idris (UPSI). (2024). *National Child Data Centre (NCDC).* https://ncdc.upsi.edu.my/v2/
[62] Laws of Malaysia. (2006). *Child Care Centre Act 1984 [Act 308].* https://unicefeaproecdtoolkit.wordpress.com/wp-content/uploads/2017/08/act-308-child-care-center-act-1984.pdf
[63] World Bank. (2023). *Shaping First Steps: A Comprehensive Review of Preschool Education in Malaysia.*
[64] World Bank. (2024). *Malaysia Economic Monitor - Bending Bamboo Shoots: Strengthening Foundational Skills (English).* Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/099041724092521963/P50085018195b80ed18e76160218d3ea80a
[65] Ministry of Education Malaysia. (2022). *Quick Facts 2022: Malaysia Educational Statistics.* https://www.moe.gov.my/storage/files/shares/penerbitan_dan_jurnal/quick-facts/QUICK%20FACTS%202022.pdf?_t=1686283850

is applauded, many of these children, particularly those from disadvantaged backgrounds lag behind and struggle with learning outcomes.[66] They lack school-readiness skills resulting in challenges in reading, writing and mathematics throughout their schooling years. Malaysian teenage students' performance in reading, mathematics and science were behind their peers, as attested by international assessment scores.[67] This demonstrates how weak foundational skills in early schooling years leads to low attainment of skills in later life.

In responses to these challenges, Malaysia has implemented programmes such as the Reading Aid Programme and the Primary School Literacy and Numeracy Programme. The aspirations in the Malaysia Education Blueprint (MEB) 2013-2025 aligns with global good practices, however, these have not demonstrated their desired outcome.

Special needs education

Special needs education for children with disabilities in Malaysia are outlined in the MEB 2013 – 2025. Three types of special needs education are available, namely, Special Education School, Special Education Integration Programme and Inclusive Education Programme, under the Ministry of Education. In 2023, about 107,020 children with special needs were enrolled under the Ministry. However, with only 7,582 children registered with the Social Welfare Department, the underreporting poses a challenge for early intervention.[68]

Complementary to the education system, there are TASKA Orang Kurang Upaya (OKU) typically run by non-government organisations (NGOs), and Program Pemulihan Dalam Komuniti (PDK),[69] also known as Community-Based Rehabilitation (CBR) managed by local communities. The low salary and fees for the caregivers and operators at both of these care centres make it difficult to provide adequate facilities and services. For TASKA OKU, there is no set curriculum; instead, they are taught a generalised course, Kursus Asuhan dan Didikan PERMATA (KAP), which is not appropriate for them. Importantly, a specific Act on special needs education for children is non-existent.

Out-of-school children

Children out-of-school warrant attention. A closer examination of DOSM's tabulated findings revealed that in 2022, an estimated one in four pre-school-aged, one in ten primary-aged and one in five secondary-aged children are not enrolled in government or private schools registered under the Ministry.[70] This accounts for an approximate 1.1 million Malaysian children who are missing out on their learning and development. Further, drop-out rates remain

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[66] World Bank. (2024). *Malaysia Economic Monitor - Bending Bamboo Shoots: Strengthening Foundational Skills.*

[67] Organisation for Economic Co-operation and Development (OECD). (2023). *PISA 2022 Results: Factsheet - Malaysia.* https://www.oecd.org/publication/pisa-2022-results/country-notes/malaysia-1dbe2061/

[68] Lihan, G. (2023, November 18). Rise in children with special needs. New Sarawak Tribune. https://www.newsarawaktribune.com.my/rise-in-children-with-special-needs/

[69] Ministry of Women, Family and Community Development. (2017). *Program Pemulihan Dalam Komuniti (PDK).* http://pdk.jkm.gov.my/ms_MY/community-based-rehabilitation-program-cbr/#1501833085404-f938d3c3-9bad

[70] DOSM. (2022). *Children Statistics Malaysia 2023.*

a significant concern, with only 90.76% primary school students transitioned to lower secondary schools in 2022.

Findings from a study among Malaysian and non-citizen out-of-school children in Sabah identified that financial barriers, parental apathy towards education and the lack of documentation were key factors that kept children out of school.[71] In addition, 'invisible children' or children who are excluded from official databases due to the lack of documentation were also studied. The majority of these children did not attend school due to financial reasons, parental apathy, accessibility to alternative learning centres and gender-based reasons where boys were expected to participate in the labour force and house chores for girls.[72]

2. Health

Malaysian children continue to experience undernutrition, which includes stunting, wasting and underweight. The National Health and Morbidity Survey (NHMS) 2022 findings reported that one in every five children (or 21.2%) aged below 5 is stunted or experienced low height-for-age whereas wasting or low weight-for-height among children aged below 5 years stands at 11%.[73] The prevalence of underweight Malaysian children aged below 5 who have low weight-for-age is 15.3%. Amidst an obesity epidemic, these upward trends of undernutrition warrants attention, their underlying causes must be addressed and their long-term implications should not be ignored.

Stunting may be associated with poor maternal health and nutrition, inadequate feeding in the child's early years, poor socioeconomic conditions and frequent illness. Wasting, is typically due to severe weight loss associated with inadequate food intake or illnesses such as diarrhoea.[74] Importantly, an underweight child may be stunted, wasted or both. If left unaddressed, these forms of undernutrition are significantly associated with poor health outcomes including lower cognitive performance, reduced productivity, an increased risk of obesity, non-communicable diseases and premature deaths.[75]

Within clinical settings, services for children are not on par with services for adults. While curative health services for adults and ICU services have grown by leaps and bounds, intensive care services for children, in particular, the neonatal inclusive care unit (NICU) and paediatric

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[71] United Nations Children's Fund (UNICEF) Malaysia. (2019). *Children Out of School: Malaysia – The Sabah Context.* https://www.unicef.org/malaysia/media/921/file/Out%20of%20School%20children%20%20(OOSCI)%20Accessible%20version.pdf

[72] Ibid.

[73] Institute for Public Health, Ministry of Health, Malaysia (2022). *Fact Sheet - National Health and Morbidity Survey (NHMS) 2022: Maternal and Child Health (MCH).* https://iku.gov.my/images/nhms-2022/5a.-fact-sheet-nhms-mch-english.pdf?_t=1684481335

[74] World Health Organisation. (2024). *Malnutrition.* https://www.who.int/news-room/fact-sheets/detail/malnutrition#:~:text=Malnutrition%20refers%20to%20deficiencies%2C%20excesses,low%20weight%2Dfor%2Dage)%3B

[75] HSS, A-S., San, Y., Sivapunniam, S. K. et al. (2023). *Do we love our children?* https://codeblue.galencentre.org/2023/09/12/do-we-love-our-children-dr-amar-singh-hss-yuenwah-san-dr-selva-kumar-sivapunniam-ph-wong-dr-musa-mohd-nordin-hartini-zainudin-sangeet-kaur-deo/

intensive care unit (PICU) remain terribly inadequate.[76] Paediatricians nationwide having to search for an intensive care bed for a premature baby or ill child, every single day, as highlighted by renown consultant paediatrician. Not forgetting the need for adequate provision of age-appropriate in-patient services for adolescents, those aged between 12 to 17 years, who tend to be admitted into adult wards.[77] This necessitates the need for a higher budget allocation within the Ministry of Health budget for paediatric health, which sadly, in 2023, dipped to a ten-year low at 1.7% of the total health budget.

For chronically-illed children, the *Sekolah Dalam Hospital* (SDH) or School in Hospital initiative introduced in 2011, seeks to provide students who are hospitalised in government hospitals, with continuous and structured learning. Teachers serve as facilitators and prepare lessons that are flexibly tailored to the student's health condition and ability.[78] Students who wish to sit for national level examinations may also do so with assigned invigilators. As of August 2023, a total of 17 hospitals have participated in this programme and SDH continue to receive support from NGOs and corporations as part of their corporate social responsibility efforts.[79]

3. Child Protection

As Nelson Mandela said, "safety and security don't just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear."

In Malaysia, the Child Act 2001 (Act 611) and Regulations, the Child Care Center Act 1984 (Act 308), the Care Centers Act 1993 (Act 506) and Regulations, the Child Sexual Crimes Offences Act 2017 and the Child Protection Policy are among the laws that are designed to protect the children. They define the roles that caregivers, parents and the general public have towards children. A summary of these laws is provided below:

1. Child Act 2001 (Act 611)

This Act focuses on the protection and welfare of children in Malaysia, including those in residential care.

- Establishment of Child Protection Teams: Section 7 enables the formation of Child Protection Teams at district levels to monitor and assess the welfare of children in residential care facilities.

[76] HSS, A-S. (2022). *The health of children and youth in Malaysia.* https://mpaeds.my/wp-content/uploads/2022/08/Slides-Health-of-Children-and-Youth-in-Malaysia-4-Amar.pdf
[77] Ibid.
[78] Ministry of Education Malaysia. (2024). *Pengenalan SDH.* https://www.moe.gov.my/index.php/pengenalan-sdh
[79] Hilmy, I. (2023, August 6). Hospital Sultanah Bahiyah latest to join 'School in Hospital' programme. The Star. https://www.thestar.com.my/news/nation/2023/08/06/hospital-sultanah-bahiyah-latest-to-join-school-in-hospital-programme

- Appointment of Protectors: Sections 8–10 allow the appointment of child protectors responsible for the welfare of children, including those in residential homes.

- Protection Orders: Section 30 allows courts to issue protection orders that place children in need of protection under the care of suitable persons or institutions, including residential care facilities.

- Registration and Monitoring of Care Institutions: Section 53 mandates the registration of residential care homes and continuous monitoring to ensure the safety and well-being of children.

- Prohibition of Harmful Practices: The Act criminalizes abuse, neglect, abandonment, or exposure to moral and physical danger in any care environment, including residential facilities (Sections 17–18).

- Child Offenders: Part VII (Sections 91-98) includes provisions for sending children who commit offenses to approved schools or residential care facilities, with stipulations to ensure their welfare and proper treatment.

ii. Child Care Centre Act 1984 (Act 308)

This Act specifically regulates child care centres, including those offering residential care services for children.

- Registration of Child Care Centres: Section 5 mandates the registration of all child care centres that provide residential services for children, ensuring these institutions meet specific criteria related to child safety and welfare.

- Safety and Hygiene Standards: Section 6 sets minimum standards for child care centres regarding safety, health, and hygiene, directly protecting children in residential care from unsafe environments.

- Child-to-Caregiver Ratio: The Act outlines the required caregiver-to-child ratio in residential settings to ensure that each child receives adequate supervision and care.

- Training Requirements for Caregivers: Section 7 outlines the need for proper training of caregivers to ensure that they have the skills and knowledge to care for children in residential care settings, particularly focusing on the emotional and physical needs of children.

- Closure or Suspension of Non-compliant Centres: Section 9 allows for the suspension or closure of child care centres that do not meet the Act's standards, protecting children from potentially unsafe or harmful environments.

- Parental Consent and Engagement: The Act emphasizes the need for continuous engagement with parents and guardians, even when children are placed in residential care, ensuring that the child’s broader social network is considered in care decisions.

iii. Care Centres Act 1993 (Act 506)

This Act governs the establishment, registration, and management of care centres, including residential care facilities for children.

- Registration of Care Centres: Section 4 mandates that all care centres, including those offering residential care for children, must be registered with the authorities.

- Licensing Requirements: Section 6 sets out conditions for licensing care centres, which include standards for the physical environment, staffing, and care provided.

- Monitoring and Inspection: Section 8 enables the Director General to inspect and monitor registered care centres to ensure compliance with regulations and safety measures for children.

- Fit and Proper Person Test: Section 11 requires that care centre operators and staff be deemed fit and proper to manage children, safeguarding them from abuse, neglect, or exploitation.

- Penalties for Non-compliance: Sections 14–15 impose penalties for operating without registration or failing to meet the required standards for child safety and care.

iv. The Sexual Offences Against Children Act 2017

This Act reinforces the legal framework to combat sexual crimes against children. The act includes provisions for:

- Child sexual abuse material: Making, producing, and distributing such material.

- Child grooming: Engaging in sexually explicit communication with a child or meeting a child following grooming.

- Sexual assault: Both physical and non-physical forms.

- Sexual performance and extortion: Involving a child in sexual performances or extorting them sexually.

It also outlines the responsibilities of individuals in positions of trust and the procedures for handling evidence from child witnesses.

In sum, good legislation to support children are in place including the Child Act 2001 (amended 2016) and Sexual Offences Against Children Act 2017 (amended 2023). However, the Penal Code (Act 574) and other legislations have yet to be harmonised with the UN CRC nor the Child Act.

Child Protection Concerns

Recent shocking incidences of child abuse with intensifying horror reported at unsuspecting residential institutions have made international headlines.[80] Still, many go undetected, suffer in silence and trapped in fear. These adverse childhood experiences or ACEs negatively impacts the child physically, mentally, emotionally, psychologically and socially,[81] with negative repercussions perpetuating into adulthood.[82] Online abuse is also rife with an estimated 100,000 children aged 12 to 17 years in Malaysia facing online sexual exploitation.[83]

In terms of child protection services, the gatekeepers of children safety in society which include the police, welfare officers and healthcare professionals, have limited training in child protection. The establishment of the Children's Development Department is a welcomed move, however, the child protection services in our nation needs to be urgently strengthened. Systematic and mandatory capacity building for the police, welfare officers and healthcare professionals is key.

Trained social workers are crucial in safeguarding all the children in our nation. As of 2019, there was a reported 3,814 Social Welfare Department (JKM) personnel that focused on social work. Of which, very few are trained social workers with a small number involved in child protection. The dearth of JKM officers is exacerbated with each officer managing an overwhelming caseload of 50 to 100 child protection cases annually. Hence, if the nation desires to meet the bare minimum needed for child protection services, a 10-fold increase in the number of social workers is necessary, translating to an aspirational target of 30,000 to 40,000 trained social workers in JKM.[84]

However, major thrusts to drive training and strengthening the social welfare workforce are yet to be seen. In the meantime, perhaps JKM can consider working closely with CSOs to support in child protection efforts including surveillance, capacity building and mobilisation of resources. In addition, the pipeline of trained social workers qualifying from local higher institutions are trickling at best; raising the question of the low intakes and interest in this valuable yet undervalued profession.

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[80] Malaysian police rescue over 400 allegedly abused children from welfare homes in two states. (2024, September 11). Channel News Asia. https://www.channelnewsasia.com/asia/malaysia-selangor-negeri-sembilan-welfare-homes-children-rescued-4601146

[81] Webster, E. M. (2022). The impact of adverse childhood experiences on health and development in young children. *Global Pediatric Health*, *9*, 2333794X221078708. https://doi.org/10.1177/2333794X221078708

[82] Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of public health*, *36*(1), 81-91. https://doi.org/10.1093/pubmed/fdt038

[83] Ibrahim, J. (2022, September 29). Unicef: 100,000 children in Malaysia face online sexual exploitation. https://www.thestar.com.my/news/nation/2022/09/29/100000-children-in-msia-face-online-sexual-exploitation-and-abuse-says-unicef-report

[84] HSS, A-S., San, Y., Sivapunniam, S. K. et al. (2023). *Do we love our children?*

CATEGORIES OF CHILDREN IN NEED

1. Children with disabilities

Disability advocates and organisations have emphasized the departure from the term, *special needs* as it conjures negativity and has become an ineffective euphemism, and recommend using *disability* instead,[85-86] which will be applied in this section.

Approximately 15% of children have disabilities.[87] When compared to their peers without disabilities, children with disabilities are at greater risk of being marginalised and have to confront a myriad of challenges daily including stigma, discrimination and societal barriers.[88] Caregivers, childminders, parents and teachers are often ill-equipped with the knowledge, skills, training, resources and understanding on how to care for children with disabilities.[89]

In terms of education, children with disabilities continue to experience segregated or integrated education systems instead of an inclusive education.[90] Experts stress that integration is not inclusion, and call for *Unit Pendidikan Khas* (Special Education Unit) to be changed to *Unit Pendidikan Inclusive* (Inclusive Education Unit) to reflect the Malaysian Education Blueprint.[91] They add that as long as segregated learning continues, the national target of 75% inclusion by 2025 will not be reached. While the 'zero reject policy' stipulates that all children should be granted admission into schools regardless of their legal or disability status,[92] children with disabilities continue to struggle in accessing education. Others lag far behind their peers without adequate facilities and support and the lack of universal design for learning.[93]

Children with disabilities and their families also face barriers in accessing healthcare services including prevention and early detection of disability, access to vaccination, nutrition and growth monitoring programmes, due to attitudinal, physical and institutional barriers.[94] Most healthcare staff are ill-equipped to support the needs of children with disabilities. This disappointingly reality surfaces the need for medical schools to evaluate and revise their

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[85] Gernsbacher, M. A., Raimond, A. R., Balinghasay, M. T., & Boston, J. S. (2016). "Special needs" is an ineffective euphemism. *Cognitive research: principles and implications*, *1*(1), 29. https://doi.org/10.1186/s41235-016-0025-4

[86] HSS, A-S. (2023, June 15). Letter: Using respectful and appropriate disability language. Malaysiakini. https://www.malaysiakini.com/letters/668819#google_vignette

[87] HSS, A-S. & Wong, W. Y. (2018, August 29). Five major gaps in services for children with disabilities. Malay Mail. https://www.malaymail.com/news/what-you-think/2018/08/29/five-major-gaps-in-services-for-children-with-disabilities-dr-amar-singh/1667185

[88] UNICEF Malaysia. (2019). Issue brief: Children with disabilities in Malaysia. https://www.unicef.org/malaysia/media/906/file/Issue%20Brief:%20Children%20with%20Disabilities%20in%20Malaysia.pdf

[89] HSS, A-S., & Dusuki F. N. (2024, September 2). Reflection on the State of our Children.

[90] Malaysian Education Blueprint 2015 – 2025.

[91] HSS, A-S. & Wong, W. Y. (2018, August 29). Five major gaps in services for children with disabilities.

[92] Chua , T. S., & Low, H. M. (2024). Inclusive Education: Perception, Practice and Implementation Within Malaysia. *Jurnal Pendidikan Bitara UPSI*, 17, 126–134. https://doi.org/10.37134/bitara.vol17.sp.13.2024

[93] HSS, A-S., & Dusuki F. N. (2024, September 2). Reflection on the State of our Children. CodeBlue. https://codeblue.galencentre.org/2024/09/02/reflections-on-the-state-of-our-children-dr-amar-singh-hss-farah-nini-dusuki/

[94] UNICEF Malaysia. (2019). Issue brief: Children with disabilities in Malaysia. https://www.unicef.org/malaysia/media/906/file/Issue%20Brief:%20Children%20with%20Disabilities%20in%20Malaysia.pdf

curriculum to include training on assessment and plan management for people with disabilities.[95]

In community settings, particularly in rural areas, families often turn to community-based rehabilitation (CBR) or PDK as their 'one-stop centre' to obtain assistance with registration, early detection, rehabilitation and advocacy.[96] Amidst this positive development, families are faced with transport costs, and centres often experience the perennial issues of shortage of staff due to low salaries and burnout, rehabilitation personnel and sustainable financial support.[97] Early intervention programmes (EIP) are crucial for children with disabilities,[98] however, most of these services are concentrated in urban areas and are provided by non-governmental[99] or for-profit organisations.[100] CBRs lack this core element,[101] and thus, a cross-ministerial effort between Health, Education and Women, Family and Community Development ministries to implement quality EIP services for rural, undeserved communities.

In the absence of support, mothers who often have to shoulder caregiving duties have to rely on state assistance when they have to leave the labour force or are abandoned by their spouse or wider family. The loss of income and/or additional costs due to disability may have an impact on the food security, nutritional status and access to opportunities for their siblings.[102]

2. Indigenous children

Indigenous children in Malaysia are from the culturally-diverse Orang Asli communities in Peninsular Malaysia and the Orang Asal communities in Sabah and Sarawak. The harsh reality is that the indigenous children of our land, particularly those in rural and remote areas, are painfully left behind in their access to education, health and services. Given the scope of this paper, this section will focus on the Orang Asli children.

The Orang Asli communities in Malaysia form 0.7% or approximately 206,777 of the Malaysian population and are comprise 18 different tribes, broadly categorised into three main

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[95] HSS, A-S. & Wong, W. Y. (2018, August 29). Five major gaps in services for children with disabilities.
[96] Ibid.
[97] Yakup, K. A. M., Thanapalan, C. K. K., & Poot, E. F. M. (2024). The straing among caregivers of children with disabilities at the community-based rehabilitation centres in Kudat division of Sabah, Malaysia. *Medical Journal of Malaysia, 79*,(1), 59-66. https://www.e-mjm.org/2024/v79s1/children-with-disabilities.pdf
[98] Why early intervention programmes are crucial for children with special needs. (2023, March 17). The Star. https://www.thestar.com.my/lifestyle/family/2023/03/17/why-early-intervention-programmes-are-crucial-for-children-with-special-needs
[99] The National Autism Society of Malaysia (NASOM). (2022). *Our services.* https://www.nasom.org.my/our-services/
[100] Early Autism Project (EAP). (2024). *Therapy programmes.* https://www.autismmalaysia.com/therapy-programmes/
[101] Persatuan Sindrom Down Malaysia (PSDM). (2024). *Sheltered homes and care homes for young and older adults with DS.* Norhana Abu Bakar. https://drive.google.com/file/d/1hQ4JFreUqEp9i2wzkJqfNy80kW5I08hB/view?usp=sharing
[102] UNICEF Malaysia. (2019). Issue brief: Children with disabilities in Malaysia.

groups, the Senois, the Proto-Malays and Semang.[103-104] This minority ethnic group largely live in poverty, with approximately 34% living below Malaysia's hardcore poverty line, having a household income of less than RM 1,169 per month.[105] They also have low education attainment, lack access to quality healthcare services and are often subject to oppression and injustices, in particular, their native land rights.[106]

In schools, Orang Asli children bear the brunt of bullying and discrimination, and have been widely associated with underachievement, low attendance and high dropout rates – a deficit framing which researchers argue are merely symptoms of underlying problems.[107-108] When the struggles of the Orang Asli children were delved into deeper and the collective voices of the students, their parents and communities were heard, bullying, an often underplayed issue, emerged as the main push factor for dropout.[109] Physical and verbal bullying, and sexual harassment of Orang Asli children are being uncovered, and stories of their lived experiences have emerged.[110] These intersectionalities undoubtedly make school challenging physically, emotionally and psychologically for Orang Asli children. Within the stinging stigmatisation, the role of supportive teachers who seek to understand their worldview and seek to create more inclusive environments are acknowledged.[111]

Most educational initiatives implemented for Orang Asli children tend to solely focus on the children and their parents, while ignoring the external factors that are equally, if not more, important elements to reckon with. Often, a participatory approach that includes the Orang Asli communities in the planning and design of programmes and intervention are glaringly lacking. The Education Ministry's implementation of K9 and K11 schools in indigenous communities, where students can complete their primary and secondary education on the same school grounds, are welcomed initiatives.[112] These have contributed to lower attrition rates and reduced transport costs but does not address their long-term needs for community integration,

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[103] Dong M. M., Midmore P., Plotnikova M. (2022). Understanding the experiences of Indigenous minorities through the lens of spatial justice: The case of Orang Asli in Peninsular Malaysia. *Regional Science: Policy & Practice*, 14(5), 1223–1239. https://doi.org/10.1111/rsp3.12512

[104] Angit (Temiar), S., & Jarvis, A. (2024). An Indigenous view of social justice leadership in the Malaysian education system. *AlterNative: An International Journal of Indigenous Peoples*, *20*(1), 215-224. https://doi.org/10.1177/11771801241235422

[105] Saifullah M. K., Masud M. M., Kari B. K. (2021). Vulnerability context and well-being factors of Indigenous community developments: A study of Peninsular Malaysia. *AlterNative: An International Journal of Indigenous Peoples*, 17(1), 94–105. https://doi.org/10.1177/1177180121995166

[106] Angit (Temiar), S., & Jarvis, A. (2024). An Indigenous view of social justice leadership in the Malaysian education system.

[107] Nicholas C. (2010). *Orang Asli: Rights, problems, solutions*. Suruhanjaya Hak Asasi Manusia.

[108] Wan Y. S. (2020). *Education policies in overcoming barriers faced by Orang Asli children: Education for all*. IDEAS Policy Research Berhad.

[109] Angit (Temiar), S., & Jarvis, A. (2024). An Indigenous view of social justice leadership in the Malaysian education system.

[110] Paul M. P., Jehom W. J., bin Fadzil K. S. (2021). Bullying amongst Orang Asli children: A qualitative study in an Orang Ali primary school in the Klang Valley Malaysia. *SARJANA*, 36(2), 1–24. https://mjs.um.edu.my/index.php/SARJANA/article/view/36878

[111] Danker B., Idrus R. (2019). *Kami pun ada hak bersekolah: Wanita Orang Asli bersuara* [We also have the right to go to school: Indigenous women speak up]. Freedom Film Network.

[112] Bernama. (2024, April 22). Education minister: K9, K11 schools reduce dropout rate among Orang Asli children. Malay Mail. https://www.malaymail.com/news/malaysia/2024/04/22/education-minister-k9-k11-schools-reduce-dropout-rate-among-orang-asli-children/130245

confidence to interact and compete with those outside their community. Hence, efforts that promote and build social justice, inclusion and national integration must be prioritised to bridge the invisible divides between Orang Asli students and their non-Orang Asli peers, and forging bonds of mutual understanding, respect and unity.

In terms of health, an astonishing 80% of Orang Asli children live in poverty, with 60% to 70% of those aged 5 to 7 years malnourished.[113] Under-five mortality rates among Orang Asli children are reportedly 11 times higher than other major ethnic groups, revealing persistent and deepening health inequalities. Here, environmental factors including land encroachment, deforestation, river pollution and resettlement schemes depletes food sources and worsens malnutrition.[114] Prevalence of anemia among children at markedly high at 61.6%.[115] The most successful upstream effort has been establishing community re-feeding programmes, however, funding constraints have interrupted consistency.[116] The perpetual disease among indigenous children are soil-transmitted helminth infections which presents opportunities for water, sanitation and hygiene-related interventions.[117]

3. Children in institutionalised care

In Malaysia, a child is placed in orphanages or institutional care under two circumstances:

i. Children who are true orphans - those whose parents have both died;
ii. Children who are unable to live with or must be separated from their parents or guardians owing to circumstances such as parental death, abandonment, neglect, abuse and for whom the government provides protection and aid.[118]

The welfare of institutionalised children in Malaysia are accorded protection under the Care Centre Act 1984, Care Centre Act 1993, the Child Act 2001 and the Registration of Adoptions Act 1952. By mandating these laws or regulations in all institutional care or foster care, it will serve to give the children an adequate and protective environment, particularly from cases of abuse, abandonment, violence and exploitation.

Without good governance and regular surveillance, children with disabilities are often left vulnerable and defenseless to abuse, neglect, maltreatment and bullying. Increasing reported

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[113] HSS, A-S. (2019). Malnutrition and Poverty among the Orang Asli (Indigenous) Children of Malaysia. https://www.ohchr.org/sites/default/files/IndigenousChildren.pdf
[114] Ibid.
[115] Ab Aziz M, Ai Kah N, Ismail M, Majid HA. The Prevalence and Determinants of Anemia Among Indigenous (Orang Asli) Children in Peninsular Malaysia: A Systematic Review. *Asia Pacific Journal of Public Health*. 2024;36(5):437-446. doi:10.1177/10105395241248545
[116] HSS, A-S. (2019). Malnutrition and Poverty among the Orang Asli (Indigenous) Children of Malaysia.
[117] Nasr, N. A., Al-Mekhlafi, H. M., Lim, Y. A. L., Elyana, F. N., Sady, H., Atroosh, W. M., … Mahmud, R. (2020). A holistic approach is needed to control the perpetual burden of soil-transmitted helminth infections among indigenous schoolchildren in Malaysia. *Pathogens and Global Health*, *114*(3), 145–159. https://doi.org/10.1080/20477724.2020.1747855
[118] Joyce, J. (2023, March 23). Protecting institutionalied children. The Sun. https://thesun.my/opinion-news/protecting-institutionalised-children-EO10784044

accounts of such cases in homes and residential institutions cannot be met with apathy,[119-120] notwithstanding those that go unreported.

Given the trauma, ranging from physical, verbal, emotional to psychological and sexual abuse, that children entering institutionalised care have experienced, providing counselling and therapy services for these children are crucial in their healing journey. Institutionalised children at up to seven times more at risk of mental and behavioural problems.[121] This requires a thoughtful and compassionate approach and involves collaborating with licensed counsellors, psychologists, therapists and healthcare professionals to provide holistic care for the wellbeing of these fragile and vulnerable children. By advocating for the child's interests, celebrating their strengths and focusing on building their coping skills, resilience and character, these contribute to improving their quality of life and shaping their futures (Anonymous care home staff, personal communication, 26 June 2024).

Engaging with the family of the child is equally important as the child may return to this environment at a certain point in time. As observed by a local shelter, providing family support and guidance for parents who children are under their care, though not without its challenges, is an important road to embark on in the reconciliation efforts and rebuilding of families. Another key consideration is supporting children during their transition from institutionalised care to their family, a new environment, institution of higher learning or a job placement. (Anonymous care home staff, personal communication, 6 August 2024).

The health and nutrition of institutionalised children and their access to quality education including documentation issues are equally important. From the caregivers' perspective, the high caregiver-to-child ratio along with the demanding physical needs and emotional load in caring for the children tends to lead to high staff turnover, burnout and child maltreatment. Hence, adequate support, resources, training and respite are critical safeguards for both caregivers and the children under their care.[122]

4. Refugee, Stateless and Migrant Children

Under international law, a refugee child or a minor is defined in accordance with the ruling of the United Nations High Commissioner for Refugees (UNCHR), which combines the definition of a "refugee" in the 1951 Convention Relating to the Status of Refugees (CRSR) with the definition of a "child" in Article 1 of the UN CRC. Thus, refugee children are persons who are below the age of 18 years and who:

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[119] Infographic: The twists and turns of the Zayn Rayyan case. (2024, June 13). The Star. https://www.thestar.com.my/news/nation/2024/06/13/the-twists-and-turns-of-the-zayn-rayyan-case

[120] Bernama. (2022, November 24). Bella suffered physical, emotional injuries under Siti's custody, court finds. Free Malaysia Today. https://www.freemalaysiatoday.com/category/nation/2022/11/24/bella-suffered-physical-emotional-injuries-under-sitis-custody-court-finds/

[121] Mohammadzadeh, M., Awang, H., Ismail, S., & Kadir Shahar, H. (2019). Improving emotional health and self-esteem of Malaysian adolescents living in orphanages through Life Skills Education program: A multi-centre randomized control trial. *PloS One*, *14*(12), e0226333. https://doi.org/10.1371/journal.pone.0226333

[122] Jayakumar, J. J. D. (2023). Urgent Need of Protection and Welfare of Institutionalised Children in Malaysia. https://www.emirresearch.com/urgent-need-of-protection-and-welfare-of-institutionalised-children-in-malaysia/

"…. owing to a well-founded fear of being persecuted either because of race, religion, nationality, membership of a particular social group, political opinion, are outside the country of nationality or former habitual residence and are unable to or unwilling to avail themselves to the protection of the country of nationality or unable to or unwilling to return to his country of residence."[123]

As of June 2024, UNHCR reported that approximately 53,225 refugee children below the age of 18 are currently residing in Malaysia.[124] Similar to many stateless children, refugee children are denied access to formal education with only 34% having access to informal education through alternative learning centres.[125] Being excluded from the education system means that these children are left without recognised qualifications, social connections, mentors, peer support and are at risk of detention. Education is a fundamental right and all children regardless of their status, should have the opportunity to attend and learn in school without fear.

The nation continues to grapples with the statelessness crisis with almost 2.6 million people, of which, just under a million reside in Sabah.[126] The children tend to suffer poorer health outcomes due to their status, impoverished conditions and geographical barriers. For example, the Bajau Laut who live on houses built at sea cannot afford travelling to hospitals in the towns.[127]
Although Malaysia has ratified the Convention on the Rights of the Child, however, actions and inactions fall short of international standards. For example, the health, education and wellbeing of the 1,030 undocumented migrant children in the Immigration Department of Malaysia's detention centers are grossly neglected and initiatives to move them to safe shelters have shown no urgency.[128] Concerted efforts are needed to defend the rights-based needs of these forgotten children, calling on the nation's leaders and lawmakers to ensure that the signed international declarations on the rights of children are upheld.

CHILDREN IN POVERTY

An approximate 8 out of 10 families are struggling to meet their basic needs, exceeding pandemic levels.[129] The escalating costs of living have pushed more families into poverty, with

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[123] United Nations High Commissioner for Refugees. (n.d.). *Refugees*. UNHCR. https://www.unhcr.org/refugees
[124] United Nations High Commissioner for Refugees (UNHCR) Malaysia. (n.d.). *Figures at a glance in Malaysia*. UNHCR. https://www.unhcr.org/my/what-we-do/figures-glance-malaysia
[125] UNICEF. (2024). *UNICEF's statement on access to education for refugee and stateless children.* https://www.unicef.org/malaysia/press-releases/unicefs-statement-access-education-refugee-and-stateless-children
[126] Ko, Z. Y., & Cooray, M. A. E. (2024). Legal and Social Issues of Stateless Children in Malaysia. *Asian Journal of Law and Policy, 4*(1), 77-98. https://doi.org/10.33093/ajlp.2024.4
[127] Ibid.
[128] Alaidrus, F. (2022). *Explainer I: "Don't Come Back, Soldiers Are Here": Children in Malaysia's Immigration Detention Centres.* https://newnaratif.com/children-in-malaysias-immigration-detention-centres/
[129] UNICEF. (2024). Living on the Edge: Increased cost of living adds pressure on low-income urban familiess https://www.unicef.org/malaysia/press-releases/living-edge-increased-cost-living-adds-pressure-low-income-urban-familiess

the bottom half of the middle class also struggling to survive. These deepening socio-economic inequalities result in children, in particular those living in urban poor areas, indigenous children and undocumented children, experiencing hunger, food insecurity, malnourishment and period poverty, which negatively impacts their health, development, wellbeing and quality of life.

Professor Sir Michael Marmot, a renowned thinker, author and researcher on health equity, often highlights the existence of the social gradient in health.[130] In saying, those living in most deprived neighbourhoods tend to experience poorer health outcomes and higher mortality rates compared to those residing in least deprived neighbourhoods.

The health inequalities observed are inextricably linked to economic, social and environmental disadvantages, termed as the social determinants of health which includes housing, education and income. When applied to children, parents with lower educational attainment, income levels, parental unemployment and lack of housing tenure adversely affected child health and development outcomes in their early years, resulting in obesity and impaired social and emotional skills and functioning, with ramifications throughout their life course.[131]

PERSPECTIVES FROM A CHILDCARE PROVIDER

Challenges faced

Apart from having to manage rising operating costs, the problem of obtaining the services of a child minder (*pengasuh*) is also very worrying. This is because graduates from local universities or colleges do not want to enter the industry due to minimal salary and challenging work conditions. For them, a small salary and low-risk job is preferred. In addition, for them, there is no career path that can ensure their future. There is no glamour in being a child minder or child educator.

The challenge with the local councils is varying legislation by area makes it difficult for TASKA operators to continue operating at a profit. As the author proposed in a meeting with PLANMalaysia and the district-level local councils, TASKA, TADIKA, and Pusat Jagaan should be classified as social industries under category A, which includes houses of worship, community centers, and other similar establishments. This way, there will be minimal fees associated with converting residential buildings to commercial ones.

Childcare Workforce

To be employed at a child care facility, child minders and child educators need to pass the written and practical Kursus Asuhan dan Didikan Awal Kanak-kanak PERMATA (KAP). The

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[130] Geddes, I., Allen, J., Allen, M., & Morrisey, L. (n.d.) The Marmot Review: Implications for spatial planning. https://www.nice.org.uk/media/default/About/what-we-do/NICE-guidance/NICE-guidelines/Public-health-guidelines/Additional-publications/Spatial-planning/the-marmot-review-implications-for-spatial-planning.pdf

[131] Pillas, D., Marmot, M., Naicker, K. *et al.* (2014). Social inequalities in early childhood health and development: a European-wide systematic review. *Pediatric Research,* 76, 418–424. https://doi.org/10.1038/pr.2014.122

Care Center does not need it. In addition to KAP, they must take the food serving and CPR courses. This will give students a foundational understanding of early childhood care, emergency assistance, and food hygiene. It is required of you to attend and pass all three even if you have a diploma, degree, master's degree, or PhD from a college or university. However, ECCE graduates find this unappealing because they have studied for years and paid a lot of money, only to have to attend KAP.

Insufficient pay, a hazardous and unglamorous work environment, coupled with physical and mental strain, deters young people and recent graduates from applying for jobs. Despite the same minimum wage, they would prefer to work in a mall since it is less hazardous and unclean. It is much less engaging when there is no clear professional path or potential for advancement. However, things change if they work for a government child care facility. There is a clear career path for them with better compensation and perks. Hence, a whole-of-nation approach that is intentional, creative and holistic is needed to build a pipeline of professional childcare workforce in our nation.

POLICY RECOMMENDATIONS

1. Implement and enforce a child protection policy as requirement for everyone who works with children in addition to existing legal requirements. This is to ensure child's safety and protection from harm for all children in Malaysia.

2. Establish more government-run child care centers and pre-schools to meet the care need demands. This way, the government must actively play its part in promoting the welfare of all. The private sector in this industry will be supported and kept in balance as a result.

3. Provide incentives and support to registered private child care centres. Along with the developers, this involves creating development designs that incorporate a family center, which comprises a child care centre, care centre and kindergarten into town planning. It will be given a tax refund and be regarded as Corporate Social Responsibility (CSR).

4. Mandate that university graduates receive post-secondary education and training that genuinely teaches them the value of early child care education and the legal implications for them. This is to ensure that these graduates have a true understanding of and passion for ECCE as a career.

5. Conduct a systematic mapping of families at risk of poverty, the development of a comprehensive safety net, gender-sensitive health interventions and bottom-up, sustained economic support to ensure food and economic security.

6. Reform education for children with disabilities, dismantling segregation and promoting inclusive education and universal design learning. Establish early intervention

programmes (EIP) at community rehabilitation centres (CBR) through a sustainable financing model.

7. Develop a culturally-sensitive and participatory approach to improve the health and education access among indigenous communities. This would include involving the indigenous people with lived experienced in the design, development, implementation and monitoring of these strategies while seeking to understand and respect their beliefs, values, traditions and indigenous wisdom.

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Children in Need

Anisa Ahmad
Debbie Ann Loh

25 September 2024

Outline

1 Introduction

2 Child Rights – Needs and Challenges

3 Categories of Children in Need

4 Perspectives from a Childcare Provider

5 Policy Recommendations

1 Introduction

Introduction

There can be no keener revelation of a society's soul than the way in which it treats its children.

Nelson Mandela

- **Definition of a 'child'**

  "a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier." *Article 1, United Nations Convention on the Rights of the Child (CRC) 1989;*

  "means a person under the age of eighteen years;" *Malaysia, Child Act 2001 [Act 611] Section 2: Interpretation*

- **Children Statistics in Malaysia**

  Estimated 9.13 million children (2023) constituting 27.4% of Malaysia's population

2 Child Rights – Needs and Challenges

Education

Child care centre and pre-school education

Concerns with unregistered TASKAs and informal carers

Challenges with early child care and education, and pre-school education

Primary and secondary education

Disadvantaged children lagging behind in school-readiness skills

Malaysian adolescents show decline in international assessment scores

Special needs education

About 107,020 children enrolled under the Ministry of Education, less than 10% are registered with JKM.

Challenges at TASKA OKU and Community-based rehabilitation (CBR / PDK)

Out-of-school children

Dropouts, stateless and 'invisible' children

Reasons include documentation issues, financial reasons, gender-based expectations

Education

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Reasons include documentation issues, financial reasons, gender-based expectations

One in every five children aged below 5 years are stunted (2022).

11% of children below 5 years experiencing wasting.

15.3% aged below 5 years are underweight.

Health

Sekolah Dalam Hospital (SDH) for chronically-ill children.

Intensive care services - neonatal inclusive care unit (NICU) and paediatric intensive care unit (PICU) are gravely inadequate. Requires a higher budget allocation for paediatric health.

Child Protection

- Child Act 2001 (Act 611)
- Child Care Centre Act 1984 (Act 308)
- Care Centres Act 1993 (Act 506)
- The Sexual Offences Against Children Act 2017

Concerns

- Cases of abuse in residential institutions / homes
- Child protection services – requires systematic capacity building
- Shortage of trained social workers, child minders, child educators and caregivers

3 Categories of Children in Need

Children with disabilities

Credit: The Rakyat Post

- **Among the myriad of challenges, children with disabilities still struggle with access, facilities and segregation in education.**
  - 'Zero reject policy'
  - Segregated or integrated education instead of *inclusive* education
  - Lag far behind their peers

- **Barriers in accessing healthcare services**
  - Many healthcare staff lack required knowledge and skills
  - Attitudinal and institutional barriers prevent early detection

- **Challenges in community-based rehabilitation (CBR) / PDK**
  - Are of support to rural families
  - Lack early intervention programmes, sustainable funding, professionally trained rehabilitation personnel and adequate staff

Indigenous children

Credit: Chris Humphrey / Mongabay

- **The struggles of Orang Asli children at school**
  - Widely associated with underachievement, low attendance and high dropout rates, and parental disinterest in education
  - However, bullying at school a major push factor for dropout
  - K9 and K11 schools are helpful but long-term needs for social and national integration remain
- **Majority of Orang Asli children are poor and malnourished**
  - Approximately 8 in 10 Orang Asli children live in poverty, with 60% to 70% of those aged 5 to 7 years malnourished
  - Under-five mortality rates are reportedly 11 times higher than other major ethnic groups
  - Community re-feeding programmes while a positive development face funding constraints

Indigenous children

Credit: Chris Humphrey / Mongabay

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Children in institutionalised care

Credit: The News Minute

- **The welfare of institutionalised children is worrying**
  - Lack of good governance and regular surveillance leave these children vulnerable to abuse, neglect, maltreatment and bullying

- **Institutionalised children at up to seven times more at risk of mental and behavioural problems**
  - Given the trauma and abuse they have experienced, a collaborative and compassionate approach is key to provide holistic care.
  - Physical and emotional demands of caregiving necessitate adequate support, training and respite for caregivers
  - Rebuilding families and reconciliation is equally important as is supporting children in transition

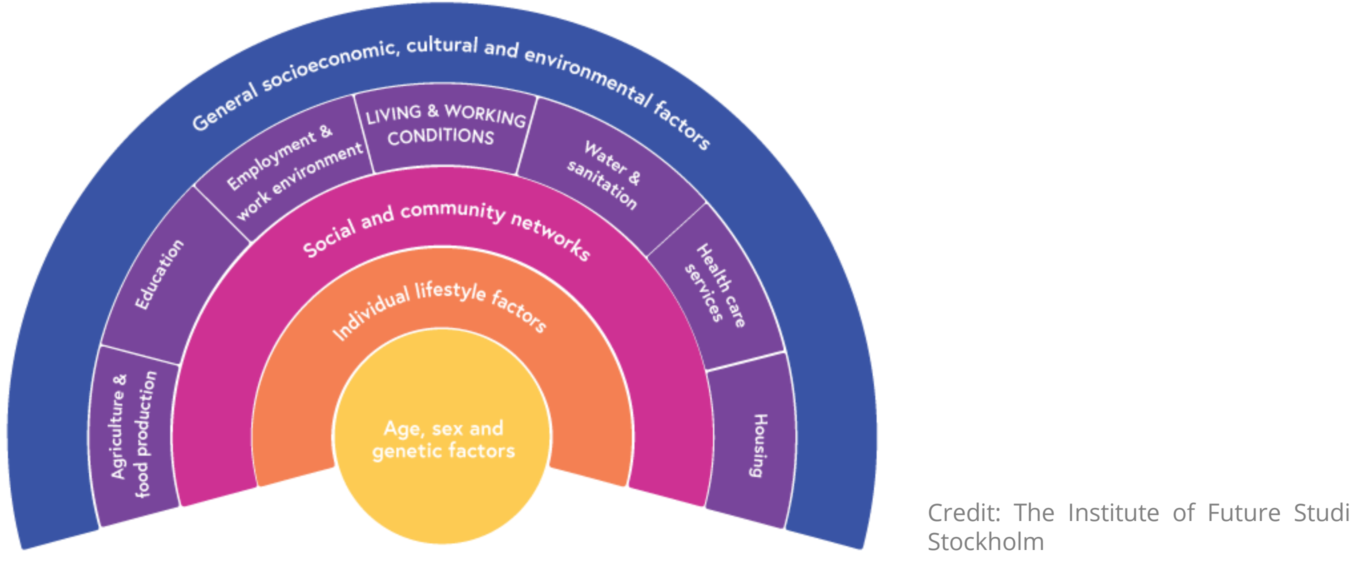
Refugees, Stateless and Migrant Children

Credit: Iskul Sama DiLaut Omadal

- **Often excluded from the education system due to their status**
  - Only 34% of the 41,000 school-aged refugee children in Malaysia have access to informal education at alternative learning centres
  - Stateless children face various obstacles in school enrolment due to documentation issues, higher school fees and are ineligible for subsidised programmes and services

- **The rights-based needs of these forgotten children must be upheld**
  - The health, education and wellbeing of undocumented migrant children in Malaysia's detention centers that have been grossly neglected
  - Long-term implications of these inequalities

Children in Poverty



Credit: The Institute of Future Studies, Stockholm

Social determinants of health and health inequalities

Credit: Bigstock

- **Escalating costs of living have pushed more families into poverty including the lower-middle class**
  - **UNICEF reports that Approximately 8 in 10 families are struggling** to meet their basic needs, exceeding pandemic levels.
  - Deepening socio-economic inequalities result in children in urban poor areas, indigenous children and undocumented children experiencing hunger, food insecurity, malnourishment and period poverty.

4 Perspectives from a Childcare Provider

Challenges Faced

- **Rising operations costs**
- **Recruitment challenges** in finding child minders (*pengasuh)* and child educators
- **Low interest in the ECCE industry** among the younger generation
  - minimal salary, challenging work conditions and lack of career pathway
  - mandatory passes in *Kursus Asuhan dan Didikan Awal Kanak-kanak PERMATA* (KAP), food serving and CPR courses
- **Varying legislations at the local council levels**

5 Policy Recommendations

Recommendations

- Implement and enforce **a child protection policy** as a mandatory requirement for everyone who works with children.
- Establish **more government-run child care centers and pre-schools** to meet the care need demands.
- Provide **incentives and support to registered private child care centers** eg. tax refunds and CSR opportunities for developers involved in integrated development.
- Mandate that all ECCE university graduates receive **training on child care education** that teaches them the value of early child care education and the legal implications involved.
- Conduct **a systematic mapping of families at risk of poverty** and develop gender-sensitive health intervention, bottom-up economic interventions and education initiatives.
- **Reform education for children with disabilities**, dismantling segregation and promoting inclusive education. Establish **early intervention programmes** in PDKs.
- Develop **a culturally-sensitive and participatory approach** to improve awareness and access to education, health and child protection among indigenous communities.

Thank You

Session 6: People with mental health concerns

1100 – 1230 hrs | Wednesday, 25 September 2024

Role Players:

Moderator	**Ms Yvonne Tan**, Senior Researcher, ISIS Malaysia
Paper Presenter	**Prof Dato' Dr Andrew Mohanraj Chandrasekaran**, President, Malaysian Mental Health Association (MMHA) [Sent apologies due to an emergency]
Discussant 1	**Ms Laura Kho**, Board Member, Mental Health Association of Sarawak
Discussant 2	**Ms Nurul Syahirah Abd Aziz**, Developmental Psychologist; Member, Persatuan Psikologi Malaysia (PSIMA)
Secretariat	**Dana Dumpangol** (APPGM-SDG) – Rapporteur **Afiqah Abdul Malik** – Timekeeper

(L-R: Ms Yvonne Tan, Ms Laura Kho and Ms Nurul Syahirah Abd Aziz)

PAPER 6

Knowledge, Skills, and Values required by Care workers and Social Workers to provide effective care and services to persons with psychosocial disabilities

Andrew Mohanraj Chandrasekaran

1. Introduction

Care workers provide hands-on, daily assistance to individuals who are unable to care for themselves fully. This can include family members providing informal care or paid caregivers working in healthcare or home environments. Care workers in Malaysia often support elderly individuals, especially with the rise of an ageing population and those with chronic illnesses or disabilities.

Conversely, social workers offer a broader scope of support, including counselling, advocacy, and connecting individuals to resources and services. They work in various settings, such as hospitals, schools, community centres, and government agencies. Their focus is on improving the social functioning of individuals and addressing systemic issues that affect communities.

In Malaysia, care workers and social workers significantly contribute to community-based care, especially in the absence of extensive institutional support. They fill critical health and social services gaps by helping individuals maintain dignity, independence, and quality of life. In a multicultural society with diverse economic backgrounds, caregivers and social workers are essential in bridging the disparity in access to health and social care services.

With the Malaysian population rapidly ageing, care workers' roles have gained increasing attention. Similarly, social workers are at the forefront of tackling complex social issues, such as poverty, mental health stigma, family violence, and child protection. Both professions are critical to promoting social justice, enhancing well-being, reducing inequalities, and fostering social inclusion in Malaysia.

2. Historical Background of Social Services and Caregiving in Malaysia

The development of social services and care worker roles in Malaysia has evolved in response to changing social and economic conditions. Historically, caregiving was essentially an informal, family-based responsibility, particularly in rural settings with solid community support structures. As Malaysia transitioned from a rural to a more urbanised society in the 20th century, traditional caregiving networks began to erode, leading to a growing need for formal caregiving services.

The British colonial administration introduced early social services, including welfare and health programmes, but these were limited in scope and primarily served urban populations. After independence in 1957, Malaysia began expanding its social welfare programmes, creating government departments and agencies focused on social work and welfare.

By the late 20th century, formal caregiving roles emerged alongside the rise of professional social work programmes at Malaysian universities. This period saw the establishment of government and non-governmental organisations (NGOs) focused on the welfare of

marginalised populations, such as the elderly, children, and refugees. Over the years, legislative frameworks such as the Children's Act 2001 and initiatives under the Ministry of Women, Family and Community Development have bolstered the recognition of social work and caregiving as essential services.

Despite the progress, challenges remain, particularly in ensuring adequate training, support, and recognition for both caregivers and social workers. The formalisation of these roles continues to evolve, driven by demographic changes and the need for a more robust social welfare system.

This historical background highlights Malaysia's gradual yet significant transformation of social services and caregiving, underlining their indispensable role in modern society.

Specialised mental health care workers and psychiatric social workers are significantly lacking in Malaysia while the unmet needs of persons with psychosocial disabilities grow exponentially. Therefore, there is an urgent need to focus on the Knowledge, Skills, and Values required by Care workers and Social Workers to provide effective care and services to persons with psychosocial disabilities

3. Knowledge, Skills, and Values required by Care workers and Social Workers specific to the needs of persons with psychosocial disabilities

Knowledge

Care workers and social workers need to have a broad understanding of what constitutes psychosocial disabilities .

Social workers in particular need to be familiar with the existing Mental Health Frameworks including the relevant provisions under the Mental Health Act 2001 in order to ensure optimum accessibility to mental health services as well as to prevent potential abuses in the system . One area of concern is coercion in treatment and involuntary hospital admissions of persons with psychosocial disabilities.

A deep understanding of legal and ethical standards in the context of the Malaysian health and social care systems will lead to the robust, high-quality provision of social work services.

Care workers who are often non-citizens may need to have additional cultural competence in carrying out their responsibilities. Social workers too need to have a high degree of cultural sensitivity in navigating through the challenges of clients in a multi-cultural society like Malaysia.

Skills

Undoubtedly, specialised yet practical communication skills need to be incorporated into the service provision of caregivers and social workers who deal with persons with psychosocial disabilities and their families. Additionally, social workers would need to be empowered to conduct the appropriate assessment and evaluation. Familiarity with crisis intervention, problem-solving, trauma-informed care, and case management is also essential.

Social workers who are ordinarily familiar with advocacy principles may need additional knowledge about the advocacy needs of the community with psychosocial challenges. In navigating these demands, caregivers and social workers need to know the importance of self-care and resilience.

Values

The inherent values of empathy and compassion and a nonjudgmental attitude in a social worker or caregiver cannot be emphasised more. A deeply ingrained commitment to social justice and respect for the dignity of persons with psychosocial needs will contribute to the empowerment and inclusion of such a vulnerable community. Confidentiality and trust are the other components that make serving persons with psychosocial disabilities more robust.

4. Standards required to ensure good quality care and services in Malaysia

Training mechanisms must be standardised, leading to professional qualifications and certification. This opportunity for professional qualifications must be socialised to attract more applicants to the training programme. Such training must lead to a registrable qualification with professional body.

Care delivery standards in mental health caregiving and psychiatric social work must be established.

Ethical and service delivery standards must be monitored by an independent body that can also incorporate a complaint and redressal mechanism.

Such a body can expand its terms of reference to include monitoring and evaluating services and providing input into policies and laws regarding caregiving and social work. It also needs to collaborate with other key stakeholders in the industry.

5. Challenges for social work organisations, including social enterprises in Malaysia

For care workers, there is lack of formal recognition and support. They also face emotional and physical burden due to long hours and lack of respite care. Additionally, there is financial strain as many are unpaid or underpaid.

As for or social workers, limited resources and funding in public sectors, leading to burnout. The general public lacks awareness or understanding of the profession.

Legal and bureaucratic challenges, particularly in dealing with sensitive populations such as persons with psychosocial disabilities, children or refugees, may be a significant obstacle.

Broadly, these challenges can be categorised into structural, social, and operational challenges.

Structural Challenges	Operational Challenges	Social Challenges
1. Complex regulations regarding the practice of mental health care workers 2. Lack of clear policies relating to psychiatric social work and mental health care worker practice 3. Limited service provision Infrastructure 4. Technology gaps exist in the absence of optimal usage of technology-driven services by social workers, e.g., mapping services, and responding to needs through mobile Apps. 5. Financial challenges in building the appropriate service infrastructure	1. Lack of human resources in social work and care worker services mainly due to poor uptake in these careers 2. Fragmentation of services of social work in different stakeholders including government agencies 3. Lack of collaboration and Partnerships with formal and non-formal stakeholders and agencies. 4. Dependent on political and economic stability and the agenda of the government of the day.	1. Poor public perception and awareness of the role of psychiatric social workers and mental health caregivers. 2. Cultural barriers in Malaysia limiting the optimal utilisation of human resources in psychiatric social work and mental health care worker services

6 . Strategies to Address Challenges

Advocacy and policy reforms need to be initiated by the relevant government agencies, taking a multistakeholder approach. Funding has been a major obstacle in providing such grass-roots services, so diversifying funding sources from federal and state government agencies as well as independent donor agencies is imperative.

Capacity building of mental health care workers and enhancement of social work to specialised psychiatric social work needs to be considered.

Simultaneously public awareness campaigns and community engagement to create the push factor towards meeting the needs of persons of psychosocial disabilities need to be socialised.

Technological integration, such as the use of mobile Apps in operational infrastructure in psychiatric social work and mental health care provider services, can help meet unmet needs.

7. Recommendations

1. Formal recognition and support for caregivers through advocacy for caregiver policies, financial incentives, training, and mental health support.
2. Strengthening social work by pushing for more comprehensive legislation and standards.
3. Encourage partnerships between government agencies and NGOs to boost resources.
4. Educational and training programs through upskilling caregivers and social workers, with a focus on mental health, trauma-informed care, and elder care.
5. Expand social work role through greater integration into healthcare and educational systems.

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Session 7: Professional standards and training for the social care industry

1400 – 1530 hrs | Wednesday, 25 September 2024

Role Players:

Moderator	**En Rashidi Yahaya**, Group CEO, SETERRA Group of Companies; Chairman, Kendana Malaysia
Paper Presenter	**Dr Teoh Ai Hua**, President, Malaysian Association of Social Workers (MASW); Senior Lecturer, School of Applied Psychology, Social Work and Policy, Universiti Utara Malaysia
Discussant 1	**Ir. Ts. Dr. Azmi bin Ahmad**, Deputy Director General, Skills Development Division, Ministry of Human Resources
Discussant 2	**Prof Dato' Dr Rashila Ramli**, Principal Visiting Fellow, United Nations University International Institute for Global Health (UNU-IIGH)
Secretariat	**Farhan Khairulannuar** (ISIS Malaysia) – Rapporteur **Afiqah Abdul Malik** – Timekeeper

(L-R: Ir. Ts. Dr. Azmi Ahmad, En Rashidi Yahaya, Dr Teoh Ai Hua and Prof Rashila Ramli)

PAPER 7

Care Economy, Care Workers, Social Workers, and Professional Standards and Training for the Social Care Industry

Dr. Teoh Ai Hua
Senior Lecturer in Social Work and Policy
School of Applied Psychology, Social Work and Policy
Universiti Utara Malaysia

1. Introduction

The demand for social care is rising due to several interconnected factors which caused by demographic shifts and family dynamics. First, our growing aging population means more individuals require care as they live longer. Simultaneously, changing family structures—such as nuclear families and geographical mobility—reduce the availability of informal caregiving for children, older persons, and those living with dependency. These shifts place pressure on formal social care services which may have grown over the years yet not sufficient nor mature to meet demands.

Additionally, the prevalence of complex health needs, including comorbidity and mental health conditions, further drives demand for competent and skilled workforce. Meanwhile, funding models vary, and the rising cost of care compounds financial pressures on the individuals, family, and government. Balancing affordability with quality care provision remains a delicate task. Effective integration between health and social care systems is essential, as is finding the right balance between preventive and reactive care approaches.

The care economy is a crucial concept that encompasses the production and consumption of goods and services necessary for the well-being of care-dependent groups. For the social care sector to thrive and to develop into an industry, we need to focus on the market which encompasses the care service providers, social care workforce, and the users. Therefore, this paper aims to (i) explore the concept of care economy and the roles of different service providers in social welfare perspective, (ii) examine the current state of workforce and its related training and regulations, and (iii) discuss the conditions and challenges in developing a viable social care industry.

2. Care Economy from the Social Welfare Perspective

As a start, it would be beneficial to understand care economy from a larger social welfare context where social care is normally situated. Welfare is a broader concept that refers to an overall condition emphasizing happiness, contentment, and well-being of individuals, communities, or entire nations. While welfare is often seen from financial or material well-being perspectives, it also extends to mental, emotional, and social aspects. In contrast, social welfare typically denotes government-funded programs designed to assist society as a whole. Social welfare specifically targets individuals and families in need, offering services such as

social services, food and income support, health care, education, and housing assistance. Social welfare policies and programs are formulated as an essential part of a government's efforts to meet human needs and create a safety net for vulnerable groups.

Nonetheless, the responsibility on social welfare does not rest entirely on the government. The idea of welfare pluralism and mixed economy of welfare in the western welfare states had since shifted the burden of welfare provision to a shared responsibility among the state, the community or informal sector, voluntary or not-for-profit sector, and the private sector[132][133]. Most countries now have in practice included a range of welfare provisions, some services being directly provided by the state whilst others have been provided through the private market or through voluntary organisations. Hence, people in need of help or care have four basic options in seeking assistance. They can seek the support of their family, relatives, neighbours or friends (community); second, attempt to pay for services they need from the private care providers (private); third, look for free services from voluntary organisations or individuals (voluntary), and fourth, turn to government social services agencies (state). Therefore, when there are more than one options exists in care provisions, we may speak of a "mixed economy of care"[134].

Meanwhile, the focus and definition of care economy involves the production and consumption of goods and services necessary for the physical, social, mental, and emotional well-being of care-dependent groups, and this include both the paid and unpaid care work[135]. The World Economic Forum (WEF) defines the care economy as the sector responsible for providing essential care services. Their white paper emphasizes the critical role of the care economy in economic growth and societal well-being[136]. Similar definition is used in Malaysia which calls for a more inclusive life cycle approach[137]

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[132] Stewart, J. (2007). The mixed economy of welfare in historical context. In M. Powell (Ed.), Understanding the mixed economy of welfare (1st ed., pp. 23–40). Bristol University Press. https://doi.org/10.2307/j.ctt1t89b4m.7

[133] Brodiez-Dolino, A. (2022). A "mixed economy of welfare" model. Public and Private Welfare in Modern Europe, 58. https://www.taylorfrancis.com/chapters/oa-edit/10.4324/9781003275459-4/mixed-economy-welfare-model-axelle-brodiez-dolino

[134] Forder, J., Knapp, M., & Wistow, G. (1996). Competition in the Mixed Economy of Care. Journal of Social Policy, 25(2), 201–221. doi:10.1017/S0047279400000313

[135] PROMOTING WOMEN'S ECONOMIC EMPOWERMENT: RECOGNIZING AND INVESTING IN .... https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2018/Issue-paper-Recognizing-and-investing-in-the-care-economy-en.pdf.

[136] The Future of the Care Economy - The World Economic Forum. https://www.weforum.org/publications/the-future-of-the-care-economy/.

[137] ISIS Malaysia policy paper: Building a cradle-to-grave care economy for Malaysia. https://www.isis.org.my/2024/06/12/building-a-cradle-to-grave-care-economy-for-malaysia/

In addition, care economy also highlighted both the paid and unpaid care work in connection with the issues on gender parity. Traditionally, much of caregiving – such as looking after children, the elderly, or people with disabilities – falls under unpaid care work. This work primarily occurs within households and is disproportionately performed by women. On the other hand, paid care work includes formal employment in sectors like healthcare, education, and social services. Nurses, teachers, and social workers are part of this category. These occupational groups in the caring profession are predominantly by women[138].

This paper focuses on care economy within a larger social welfare context. As highlighted earlier, modern social welfare has shifted from sole state's responsibility on welfare to a mixed economy of welfare with shared responsibility. Using health and education as examples, we can clearly see the rapid growth of private service providers in these two sectors. For example, the numbers of private hospitals are more than public hospitals[139] and the numbers of private clinics were almost tripled that of public clinics[140]. Likewise, with the exception of primary and secondary schools, numbers of private colleges and universities[141] are more than the numbers public institutions of higher learning. The number of enrolments in private pre-schools also indicates an upward trend from 2013 to 2020 compares to the numbers enrolled in government pre-schools which remains static[142]. Both the health and education sector have clear policies and legislations in regulating both the services and professionals in the field.

In contrary, although the Department of Social Welfare (Jabatan Kebajikan Masyarakat, JKM) was established in 1946 and has been entrusted to provide various social welfare services, there was no specific policy on social welfare until 1990. The National Social Welfare Policy (NSWP 1990) was launched The Ministry of National Unity and Social Development launched in 1990 out of growing concerns over increased social problems that affected Malaysian society (Faizah & Siti Hajar, 2000). In fact, the NSWP 1990 has listed a number of social ills which is seen to be a threat to the social well-being of the country which includes the increasing crime rate, prostitution, child abuse, school drop-outs, juvenile delinquency, domestic violence, divorce, abortion, child abduction, elderly abuse, drug abuse, and youth loitering.

The NSWP 1990 also calls for "Every individual and groups, voluntary organizations, local communities, government agencies, and private organizations to internalize and contribute creative ideas while actively fulfilling their roles comprehensively at all levels to make the

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[138] Khunou, Grace & Pillay, Roshini & Nethononda, A. (2012). Social Work is "women's work": an analysis of student's perceptions of gender as a career choice determinant. The Social Work Practitioner-Researcher. 24.

[139] https://www.statista.com/statistics/794860/number-of-public-and-private-hospitals-malaysia/

[140] Malaysia Health Care at a Glance 2018. https://www.moh.gov.my/moh/penerbitan/MYHAAG2018.pdf

[141] https://studymalaysia.com/education/top-stories/list-of-universities-in-malaysia

[142] Kong, K. (2022). Early Childhood Education in Malaysia. In: Symaco, L.P., Hayden, M. (eds) International Handbook on Education in South East Asia. Springer International Handbooks of Education. Springer, Singapore. https://doi.org/10.1007/978-981-16-8136-3_13-1

policy a success". Taking this into context, it is clear that the then government were already looking into the concept of mixed economy of welfare of encouraging more involvement from the community, non-governmental and voluntary organizations as well as the private sector in the social welfare sector. However, it did not come up with any plan of actions or measures in intensifying the participation of the voluntary and private sector in welfare or care services.

From the social policy perspective, with the introduction of the NSWP 1990, social welfare in Malaysia was seen to have moved from a more traditional reactive approach into developmental and preventive areas[143], and the need to develop a more professional care service with minimum standards. This is evident with the introduction of legislation like the Care Centre Act 1993. However, the NSWP 1990 document is no longer mentioned in the official website of JKM. The website of the Ministry of Women, Family and Community Development (KPWKM) does mention about the policy but has no link to the document either to be read online or to be downloaded[144]. The only place to get hold of the original document is from the website of the Prime Minister Office[145]. Hence, the existing status of the NSWP 1990 remains unclear.

In 2003, the government officially launched the National Social Policy (NSP 2003)[146]. then Ministry of National Unity and Social Development to formulate the Policy. The NSP is deemed 'the umbrella policy that covers the philosophy and various national social development policies' which aims to 'create a developed and well-established Malaysian community with each member have opportunity to develop their potential to the optimum in a healthy social environment based on the characteristics of cohesive, resilient, democratic, moral, tolerant, progressive, caring, fairness and equity in accordance with goals of Vision 2020'[147]. Again, the idea of mixed economy of welfare is embedded as it calls for a synergistic multisectoral collaboration between the public, private and voluntary sector where social development is a shared responsibility. Nonetheless, the lack of any plan of actions, like the NSWP 1990, has not provide the country with a clear policy direction in developing a robust and sustainable social care provisions to cater for the increasing care needs.

In comparison, almost at the similar period of time, the British government has taken several measures in shifting the role of public sector as main service providers to a more mixed economy of care through The Griffiths Report (1988)[148], and followed by the White Paper

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[143] Faizah Yunus & Siti Hajar Abu Bakar (2000). Community care in Malaysia. In: Roziah Omar & John Doling (Eds.) Issues and challenges of social policy: East and West. (pp.109-129) Kuala Lumpur: University of Malaya Press.

[144] https://www.kpwkm.gov.my/kpwkm/index.php?r=portal%2Fsearch&title=dasar+kebajikan

[145] https://www.pmo.gov.my/dokumenattached/Dasar/Dasar_Kebajikan_Masyarakat_Negara.pdf

[146] Mohamad Zahir & Roziah, 2012

[147] Dasar Sosial Negara (2003).
https://www.kpwkm.gov.my/kpwkm/uploads/files/Dokumen/Dasar/DASAR_SOSIAL_NEGARA.pdf

[148] Griffith Report (1988). Community Care: Agenda for Action. London: HMSO.

'Caring for People' (1989)[149]. The British government continued to emphasis on the promoting of care in the community, especially on elderly care, with a mixed economy of care by the community itself, private care regardless of whether in domiciliary or institutional settings and the residualizing of the social services[150]. All these proposals became reality with the introduction of the National Health Services and Community Care Act 1990. The Act promotes competition for better choices and needs-led services for greater individual determination on care by the service users. The local authorities[151] became responsible, as lead agencies, for assessing individual need, designing care arrangements, and ensuring services (including private and voluntary service) are delivered.

Of course, it is not fair to compare the social welfare services between Malaysia and the United Kingdom as both countries embrace a different orientation where Malaysia is more akin to a residual welfare model[152] while the United Kingdom has established as a welfare state[153]. Nevertheless, one should take serious note of the importance of social policy for government in formulating social welfare policies, programs, fundings and services in addressing social needs and promoting the well-being of the people in timely matter. For this reason, in developing a care economy or creating a care industry, what would be the main reference policies and directions for Malaysia?

It is therefore heartening to note that KPWKM has drafted the Plan of Action for Care Industry Malaysia (*Pelan Tindakan Industri Penjagaan Malaysia*)[154]. According to the Minister of Women, Family and Community Development, Datuk Sri Nancy Shukri, the Plan of Action for Care Industry Malaysia aims to produce skilled caregivers or care workers for children, older persons, and people with disabilities, and making care work a professional career. Based on the news report, it is clear that the Minister is focusing on the care industry workforce. It's intriguing to consider how we can transition from a low-skilled workforce to a highly skilled one within the care economy. Additionally, we're still waiting to see how the government will

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[149] Department of Health (1989). Caring for People: Community Care in the Next Decade and Beyond (Cm849) London: HMSO.

[150] Walker, A. (1993). 'Community Care Policy: From Consensus to Conflict' in Bornat, J. et. al. (eds.) *Community Care: a reader*. London: Macmillan.

[151] In the UK, social service is put under the local authority through Local Authority Social Services Act 1970.

[152] Farrah Shammen Mohamad Ashray (2018). Social Welfare Service in Malaysia: The Role of Government. https://www.researchgate.net/publication/325725548_Social_Welfare_Services_in_Malaysia_The_Role_Of_Government. The Residual Model of Welfare serves as a last resort, providing limited and short-term assistance to individuals or families who have exhausted all other sources of help and are in crisis. Its goal is to encourage recipients to achieve self-sufficiency promptly.

[153] Thane, P. (1989). The British Welfare State: Its Origins and Character. In: Digby, A., Feinstein, C. (eds) New Directions in Economic and Social History. Palgrave Macmillan, London. https://doi.org/10.1007/978-1-349-20315-4_12

[154] Pelan Tindakan Industri Penjagaan Malaysia Dijangka Siap Julai – Nancy. https://lifestyle.bernama.com/news.php?id=2297229

shape policies for funding and promoting the care industry, including involving non-profit and private sectors in care provision. After all, there were obstacles in creating a market in social care even in a welfare state like the United Kingdom.[155]

3. Workforce and Service Providers in the Care Economy

This paper will next examine the workforce and service providers in the care economy by focusing on three major groups of care-dependent people namely children, older persons, and people with disabilities (PWDs). This paper refers to the definition of social service workforce coined by the Global Social Service Workforce Alliance[156].

> "The social service workforce is an inclusive concept referring to a broad range of governmental and nongovernmental professionals and para professionals who work with children, youth, adults, older persons, families and communities to ensure healthy development and well-being…The social service workforce constitutes a broad array of practitioners, researchers, managers and educators, including but not limited to, social workers, social educators, social pedagogues, child care workers, youth workers, child and youth care workers, community development workers/community liaison officers, community workers, welfare officers, social/cultural animators and case managers" (page 7).

In the Malaysia context, the common designations in the social welfare and social care sector are care workers, welfare officers, welfare workers, social workers, social case workers, case managers, and community workers.

The following Table 1 is prepared to give a simple and non-exhaustive mapping of area of care, type of service providers, relevant legislations and authorities, and main workforce for these three groups of people. The care for people with long-term mental health problems will be discussed together with PWDs as chronic mental illness is categorized as one form of disabilities under the Persons with Disabilities Act 2008.

Table 1: Mapping of area of care, type of service providers, relevant legislations and authorities, and main workforce in for care-dependent people

Target Group	Area of care / services	Examples of services	Type of Service Providers				Main Legislation / Regulation	Main Ministry	Main Workforce
			G	N	P	C			

[155] Wistow, G., Knapp, M., Hardy, B., & Allen, C. (1992). From providing to enabling: local authorities and the mixed economy of social care. Public Administration, 70(1), 25-47.
[156] Global Social Service Workforce Alliance (2023). 2023 State of the Social Service Workforce Report. https://socialserviceworkforce.org/wp-content/uploads/2024/03/2023_State_SSW_Report-compressed_0.pdf

Children	General Day Care	Child care centre (Taksa)	/	/	/	/	Child Care Centre Act 1984	KPWKM	• Child Care worker / Caregiver • Early childhood educator
	Residential Care	Children Home	/	/			Child Act 2001 Care Centre Act 1993	KPWKM	• Care worker • Social/Case worker • Welfare worker • Nursing aide
	Child Protection Care	Children Home	/	/			Child Act 2001 Care Centre Act 1993	KPWKM	• Care worker • Social/Case worker
Older Persons	Day Care	Elderly Day Care Centre		/	/		National Older Persons Policy 2011 Care Centre Act 1993 Private Aged Healthcare Facilities and Service Act 2018	KPWKM KKM	• Care worker • Nurses and allied health professionals
	Residential Care	Rumah Seri Kenangan Rumah Ehsan Old Folks Home	/	/	/	/	National Older Persons Policy 2011 Care Centre Act 1993 Private Aged Healthcare Facilities and Service Act 2018	KPWKM KKM	• Care worker • Nurses and allied health professionals • Social/Case worker • Welfare worker
	Elderly Activity Centre	PAWE	/	/			National Older Persons Policy 2011	KPWKM	• Centre supervisor (Penyelia)

							Garis Panduan Pusat Aktiviti Warga Emas (PAWE) Pindaan 2018		• Social/case worker • Welfare worker
	Nursing Care (Private)	Nursing home			/		Private Aged Healthcare Facilities and Service Act 2018	KKM	• Nurses and allied health professionals
People with Disabilities	Community Based Rehabilitation / Day Care	PPDK		/	/	/	Persons with Disabilities Act 2008	KPWKM	• PDK teachers • Centre supervisor • Caregivers
	Residential Care	Taman Sinar Harapan	/	/			Persons with Disabilities Act 2008 Care Centre Act 1993	KPWKM	• Care workers • Social/case worker • Welfare worker
	OKU Activity Centre	Bengkel Daya	/	/			Persons with Disabilities Act 2008	KPWKM	• Centre supervisors • Social/case worker
	Mental health related services (non-residential care)	Mental health therapy	/	/	/		Mental Health Act 2001 Persons with Disabilities Act 2008	KKM KPWKM	• Health and mental health professionals • Social worker • Counsellor

Note:
G: Government
N: NGO/Non-profit
P: Private
C: Community
KPWKM: Ministry of Women, Family and Community Development
KKM: Ministry of Health

From Table 1, it is quite clear the main government agencies involved in social care services are KPWKM and Ministry of Health (KKM). Among these services, children day care services

(Taman Asuhan Kanak-kanak, TASKA) is the earliest being regulated through Child Care Centre Act 1984 and demonstrates a clearer mixed economy of care with services provided by the government, private, voluntary and community sector. This sector is sometimes lumped together as Early Child Care and Education (ECCE)[157]. Nonetheless, the scope of work and workforce in this sector are clearer defined and regulated[158] as compared to those working in child residential care, and the workforce working with older persons and PWDs. There is also more private sector participation in child day care as compared to other care services.

The next care service that exhibits a mixed economy of care would be residential and nursing care services for older persons. In the absence of a specific legislation on older persons, the main references on elderly care falls upon the National Policy on Older Persons 2011 (Dasar Warga Emas Negara 2011) and the Plan of Action on Older Persons (Pelan Tindakan Warga Emas Negara, PTWEN), as well as the Care Centre Act 1993 under JKM, and the Private Aged Healthcare Facilities and Service Act 2018 under KKM. In this regard, KPWKM regulates elderly general care services in the public and voluntary sector, while KKM regulates elderly nursing care services run by the private sector. As KKM has already put in place legislations that regulates the health and allied health professions, the workforce in private aged healthcare is clearer defined and regulated as compared to elderly care centres regulated under JKM.

On the other hand, care service for PWDs is still very much depending on the government and non-government/non-profit sector[159], with very little participation from the private sector. The Community Based Rehabilitation Centre (Pemulihan dalam Komuniti, PDK) which was initiated by JKM in 1984 as an early detection and intervention service for PWDs in the community. In 2018, all PDKs has been registered with Registrar of Society as a non-government organization (Pertubuhan Pemulihan dalam Komuniti, PPDK) which in return receives grants from JKM for the purpose of giving allowances to trainees with disabilities, utility expenses, premises rent, supervisor and staff allowances, as well as contributions to the Employees Provident Fund (KWSP) and Social Security Organization (PERKESO), and activity grants.[160]
Finally, the social service for people with mental health problems are rather limited. Most mental health services are provided by KKM and small numbers of private mental health

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[157] Foong et. al. (2018). Private sector early child care and education in Malaysia: Workforce readiness for further education. http://web.usm.my/km/36(1)2018/km36012018_6.pdf

[158] Rahmatullah, B., Muhamad Rawai, N., Mohamad Samuri, S., & Md Yassin, S. (2021). Overview of early childhood care and education in Malaysia. Hungarian Educational Research Journal, 11(4), 396-412. https://doi.org/10.1556/063.2021.00074

[159] Malaysian Care Online Directory of People With Disabilities in Malaysia https://malaysiancare.org/pwd_list

[160] https://dewan.selangor.gov.my/question/pusat-pemulihan-dalam-komuniti-ppdk/

providers and NGOs[161], and still under-developed and insufficient to reach those living in the rural areas[162]. The workforce is predominantly trained health and mental health professionals.

In summary, when considering the care economy perspective in Malaysia, social care services exhibit varying degrees of development and regulation. The workforce may also varies depending on types, sizes and scope of services provided by each organization. Care worker is the generic term that may be used interchangeably with caregiver. Social worker, nurses and allied health professionals maybe employed by more established agencies or organizations. Notably, services for children are comparatively better-established, benefiting from a diverse mix of providers. Following closely are services for older adults. Clearly, service users in these categories are increasingly willing to pay for care, leading to greater private sector participation.

However, the landscape changes when we turn to persons with disabilities (PWDs). While care services for children with disabilities receive significant government support through organizations like PPDKs, the same level of availability is lacking for adult PWDs. Persistent barriers related to participation and inclusion[163] continue to challenge the accessibility and affordability of care for PWDs.

To foster the growth of the care economy, it is essential to establish a robust market for the care industry. This market should not only encourage greater participation from diverse care providers but, equally importantly, entice individuals to view the social care sector as a viable job opportunity and career path.

4. Education and Training for the Workforce

The section analyses the education and training available in Malaysia for the social care workforce based on several official documents such as The Malaysia Standard Industrial Classification (MSIC)[164], Malaysian Qualification Framework 2nd edition by the Malaysian Qualification Agency (MQA)[165], and the National Occupational Skills Standard (NOSS)[166].

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[161] Psychiatric and Mental Health Services Pandemic Report (2020-2021). https://www.moh.gov.my/moh/resources/Penerbitan/Psikiatri/Psychiatric_Services_MOH_Pandemic_Report_2020-2021.pdf

[162] Hamzah, Nurul Amirah & Othman, Nooraini. (2024). Mental Health Policy in Malaysia: A Review and Recommendations. International Journal of Academic Research in Business and Social Sciences. 14. 10.6007/IJARBSS/v14-i1/18846.

[163] UNICEF Malaysia (2019). Issue Brief: Children with Disabilities in Malaysia. https://www.unicef.org/malaysia/reports/issue-brief-children-disabilities-malaysia

[164] The Malaysia Standard Industrial Classification (MSIC) 2008. https://msic.stats.gov.my/bi/

[165] Malaysian Qualification Framewrok 2nd edition. https://www.mqa.gov.my/new/document/2024/new/MQF%20(2024).pdf

[166] National Occupational Skills Standards. https://www.skillsmalaysia.gov.my/index.php/en/service/noss

The MSIC 2008 version 1.0 is an update of industry classification developed based on the International Standard of Industrial Classification of All Economic Activities (ISIC) Revision 4. The Malaysia Standard Sector Classification (MSIC) was used as the main reference for the classification of sector/subsector. In the MSIC 2008, Social Care Sector falls under Section Q Human Health and Social Work Activities, and Division 86 for human health activities, Division 87 for residential care activities, and Division 88 for social work activities without accommodation as seen as the following Diagram A.

Diagram A: Section Q Human Health and Social Work Activities

SEKSYEN Q **AKTIVITI KESIHATAN KEMANUSIAAN DAN KERJA SOSIAL**
HUMAN HEALTH AND SOCIAL WORK ACTIVITIES

BAHAGIAN/ *DIVISION*	KUMPULAN/ *GROUP*	KETERANGAN/ *DESCRIPTION*
Q86		***HUMAN HEALTH ACTIVITIES***
	Q861	*HOSPITAL ACTIVITIES*
	Q862	*MEDICAL AND DENTAL PRACTICE ACTIVITIES*
	Q869	*OTHER HUMAN HEALTH ACTIVITIES*
Q87		***RESIDENTIAL CARE ACTIVITIES***
	Q871	*RESIDENTIAL NURSING CARE FACILITIES*
	Q872	*RESIDENTIAL CARE ACTIVITIES FOR MENTAL RETARDATION, MENTAL HEALTH AND SUBSTANCE ABUSE*
	Q873	*RESIDENTIAL CARE ACTIVITIES FOR THE ELDERLY AND DISABLED*
	Q879	*OTHER RESIDENTIAL CARE ACTIVITIES*
Q88		*SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION*
	Q881	*SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION FOR THE ELDERLY AND DISABLE*
	Q889	*OTHER SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION n.e.c*

Samples of Section Q and its division can be seen in the following Diagram B and Diagram C.

Diagram B: MSIC 2008 Code Section Q Division 87 Residential care activities

Information Display MSIC 2008 Code

Section : Q - Human health and social work activities
Division : 87 - Residential care activities
Group : 873 - Residential care activities for the elderly and disabled
Class : 8730 - Residential care activities for the elderly and disabled
Item : 87300 - Residential care activities for the elderly and disabled

Table for 5 digits

Item	Description	Includes	Excludes	MSIC 2000	Survey Code	Survey Description
87300	Residential care activities for the elderly and disabled			85312		

Diagram C: MSIC 2008 Code Section Q Division 88 Social work activities without accommodation

Information Display MSIC 2008 Code

Section : Q - Human health and social work activities
Division : 88 - Social work activities without accommodation
Group : 881 - Social work activities without accommodation for the elderly and disabled
Class : 8810 - Social work activities without accommodation for the elderly and disabled carried out by government offices or by private organizations
Item : 88101 - Day-care activities for the elderly or for handicapped adults

Table for 5 digits

Item	Description	Includes	Excludes	MSIC 2000	Survey Code	Survey Description
88101	Day-care activities for the elderly or for handicapped adults			85329		

Information Display MSIC 2008 Code

Section : Q - Human health and social work activities
Division : 88 - Social work activities without accommodation
Group : 881 - Social work activities without accommodation for the elderly and disabled
Class : 8810 - Social work activities without accommodation for the elderly and disabled carried out by government offices or by private organizations
Item : 88109 - Others social work activities without accommodation for the elderly and disabled

Table for 5 digits

Item	Description	Includes	Excludes	MSIC 2000	Survey Code	Survey Description
88109	Others social work activities without accommodation for the elderly and disabled			85329		

Basically, any care activities that involves residential or accommodation services will be under Division 87 while day care and non-residential services will be under Division 88. The division between residential and non-residential care activities is also used in developing National Occupational Skills Standard (NOSS) in the classification of skills standards as shown in Table 2. NOSS is a document that outlines the dexterity required of an employee working in Malaysia at a certain level of employment to achieve specific skills.

TABLE 2: NOSS CLASSIFCATION FOR SOCIAL CARE, SOCIAL WELFARE AND SOCIAL WORK

TYPE OF SERVICE	TARGET GROUP	NOSS	LEVEL	MSIC CODE
RESIDENTIAL CARE	PUSAT JAGAAN OKU / DISABLED CARE	OPERASI PUSAT JAGAAN (ORANG KURANG UPAYA)	3	Q873
		PENTADBIRAN PUSAT JAGAAN (ORANG KURANG UPAYA)	4	Q873
		PENGURUSAN PUSAT JAGAAN (ORANG KURANG UPAYA)	5	Q873
	PUSAT JAGAAN ORANG TUA /	OPERASI PUSAT JAGAAN ORANG TUA	3	Q873
		OPERASI PUSAT JAGAAN ORANG TUA	4	Q873

	ELDERLY CARE	OPERASI PUSAT JAGAAN ORANG TUA	5	Q873
	PUSAT JAGAAN KANAK-KANAK / CHILDREN CARE CENTRE	PENGURUSAN JAGAAN DAN KEMAJUAN KANAK-KANAK (CHILDREN CARE AND PROGRESS MANAGEMENT)	5	Q879
		PENYELIAAN PENJAGAAN DAN KEMAJUAN KANAK-KANAK (CHILDREN CARE AND PROGRESS SUPERVISION)	4	Q879
		PENJAGAAN DAN KEMAJUAN KANAK-KANAK (CHILDREN CARE AND PROGRESS)	3	Q879
NON-RESIDENTIAL / DAY CARE	CHILDREN WITH SPECIAL NEEDS	CHILDREN WITH SPECIAL NEEDS CARE & EDUCATION PRACTICE	3	Q889
		CHILDREN WITH SPECIAL NEEDS CARE & EDUCATION ADMINISTRATION	4	Q889
	PEMULIHAN DALAM KOMUNITI (OKU) / COMMUNITY BASED REHABILATION (PWD)	OPERASI PEMULIHAN DALAM KOMUNITI (COMMUNITY BASED REHABILATION OPERATION)	3	Q881
		PENTADBIRAN PUSAT PEMULIHAN DALAM KOMUNITI (OKU) / COMMUNITY BASED REHABILITATION CENTRE ADMINISTRATION (PWD)	4	Q881
		PENGURUSAN PUSAT PEMULIHAN DALAM KOMUNITI (OKU) / COMMUNITY BASED REHABILITATION CENTRE MANAGEMENT (PWD)	5	Q881
OTHERS	SOCIAL WELFARE	SOCIAL WELFARE PRACTICE	3	Q889
		SOCIAL WELFARE COORDINATION	4	Q889
		SOCIAL WELFARE MANAGEMENT	5	Q889
	COMMUNITY SERVICES	COMMUNITY SERVICE	3	Q889
		COMMUNITY SERVICE ADMINISTRATION	4	Q889

		COMMUNITY SERVICE MANAGEMENT	5	Q889
	SOCIAL WORK	SOCIAL WORK OPERATION AND ADMINISTRATION	4	Q889
		SOCIAL WORK MANAGEMENT	5	Q889

Note: Extract from Daftar Standard Kemahiran Pekerjaan Kebangsaan (SKPK) / National Occupational Skills Standard (NOSS) Registry dated 7 August 2019

As shown in Table 2, the list of NOSS that have been developed thus far for social care are mainly for the three major care-dependent groups of people except social welfare and social work which are gearing more towards case work practice and social administration practice. Interestingly, early childhood care and development (ECCD) is put under Division T98 - activities of households as employers, and Group T982 - Undifferentiated goods – producing activities of households for own use. Perhaps that is due to the qualifications recognized in the Child Care Centre Regulations 2012 under the Child Care Centre Act 1984 for owners, operators, supervisors, and child care workers include *Kursus Asuhan dan Didikan Awal Kanak-Kanak* PERMATA which became the blue print in developing NOSS for ECCD.

The National Skills Development Act 2006 (Act 652) provides for the implementation of a Malaysian Skills Certification System, leading to the award of five (5) levels of national skills qualification, namely Malaysian Skills Certificate Level 1,2 and 3; Malaysian Skills Diploma; and Malaysian Skills Advanced Diploma. The skills standards for social care workers, social welfare workers, community workers and social workers start at Level 3 which is a certificate level, and as high as level 5 which is equivalent to advanced diploma. The Malaysian Qualification Framework (MQF 2.0) developed by the Malaysian Qualification Agency (MQA) has aligned the NOSS under the Technical and vocational education and training (TVET) category as shown in Diagram D.

DIAGRAM D: Malaysian Qualification Framework 2.0

Malaysian Qualifications Framework (MQF) Second Edition and Lifelong Learning

MQF Level	Minimum Graduating Credits*	Academic Sector	TVET Sector	Lifelong Learning/APEL Criteria for APEL(A)
8	No credit rating	PhD by Research		Admission criteria: 35 years old Bachelor's degree in relevant field/equivalent 5 years of work experience Passed APEL assessment
	80	Doctoral Degree by Mixed Mode & Coursework		
7	No credit rating	Master's by Research		Admission criteria: 30 years old STPM/Diploma/equivalent Relevant work experience Passed APEL assessment
	40	Master's by Mixed Mode & Coursework		
	30	Postgraduate Diploma		
	20	Postgraduate Certificate		
6	120	Bachelor's Degree		Admission criteria: 21 years old Relevant work experience Passed APEL assessment
	64	Graduate Diploma	6	
	34	Graduate Certificate		
5	40	Advanced Diploma	5	
4	90	Diploma	4	Admission criteria: 20 years old Relevant work experience Passed APEL assessment
3	60	Certificate	3	Admission criteria: 19 years old Relevant work experience Passed APEL assessment
2	30	Certificate	2	3R
1	15	Certificate	1	3R

* Inclusive of general studies subjects for an undergraduate programme.

Under the MQF 2.0, the highest level that can be attained under NOSS is Level 6 equivalent to a Graduate Diploma, which is one rank lower than an undergraduate degree. This shows that all the social care qualifications developed under NOSS are skill-based training, yet the skill level is deemed lower than a university graduate. It also indicates that the salary scale for social care workers may be lower than the scale for graduates. Taking the example of the social (S) scheme in the public service, the entry for social development officer S41 is an undergraduate

degree recognized by the Public Service Department. A college diploma qualification is the entry for assistant social development officer S29. A secondary school certificate (Sijil Pelajaran Malaysia, SPM) is the entry qualification for welfare assistant S19. In short, the qualifications and skillset of the social care workforce can be seen as semi-skilled (level 3) to skilled (level 5). Their status whether as being recognized as professionals or para-professionals can only be determined a professional legislation is enacted to give due recognition.

The last document to be examine is the Malaysian Standard Classification of Occupations (Piawaian Pengelasan Pekerjaan Malaysia, MASCO)[167], which is the national benchmark for job classification within the national labour force structure. The following Table 3 summarizes the category of worker according to MASCO code, job title used in the industry, relevant field of study at tertiary level (NEC Code), and level of skills required (NOSS) in Malaysia.

Table 3: Category of Worker with MASCO Code, Job Title, NEC Code and NOSS Level

MASCO CODE	JOB TITLE	NEC CODE	NOSS LEVEL EXAMPLES
1614 SOCIAL WELFARE MANAGERS	• 1614-01 Social Work Manager • 1614-02 Social Work Operation Manager • 1614-03 Community Centre Manager • 1614-04 Welfare Centre Manager • 1614-05 Family Services Manager • 1614-06 Housing Services Manager	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling • 0414 Management and Administration • 0921 Care Of Elderly and Of Disabled Adults	Social Welfare Management (Level 5)
2825 SOCIAL WORK AND COUNSELING PROFESSIONALS	2825-01 Community Development Officer Grade S41 2825-02 Social Worker, Professional* 2825-09 Parole Officer 2825-10 Probation Officer 2825-11 Women's Welfare Organizer	• 0923 Social Work and Counselling	Social Welfare Coordination (Level 4) Social Work Operation and Administration (Level 4)

[167] https://emasco.mohr.gov.my/masco

	2825-12 Youth and Sports Officer Grade S41 2825-13 Anti-Drug Officer Grade S41		*Social Work Management (Level 5) Community Service Management (Level 5)
3611 SOCIAL WORK ASSOCIATE PROFESSIONALS	3611-01 Social Worker 3611-02 Social Worker, Group Work 3611-03 Welfare Officer, Industry 3611-04 Welfare Officer, Probation 3611-05 Parole Officer, Associate Professional 3611-06 Probation Officer, Associate Professional 3611-07 Officer, Family Planning 3611-08 Social Welfare Worker 3611-09 Social Welfare Worker, Case Work 3611-10 Social Worker, Child Welfare 3611-11 Social Worker, Delinquency 3611-12 Social Worker, Community 3611-13 Social Worker, Medical 3611-14 Social Worker, Psychiatric 3611-15 Welfare Organizer 3611-17 Community Development Worker 3611-18 Community Service Worker	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling • 0921 Care Of Elderly and Of Disabled Adults	*Social Work Management (Level 5) Social Work Operation and Administration (Level 4) Social Welfare Coordination (Level 4) Social Welfare Practice (Level 3) Community Based Rehabilitation Centre Administration (PWD) (Level 4) Community Based Rehabilitation Operation (Level 3)

	3611-19 Disability Services Officer 3611-20 Family Service Worker 3611-21 Life Skills Instructor 3611-22 Mental Health Worker 3611-23 Welfare Support Worker 3611-24 Women's Shelter Supervisor 3611-25 Youth Worker 3611-26 Assistant Social Research Officer Grade N29 3611-27 Assistant Community Development Officer Grade S29 3611-28 Assistant Psychological Officer Grade S29 3611-29 Assistant Anti-Drug Officer Grade S29 3611-30m Assistant Executive Officer (Psychology) Grade 31		
1611 CHILD CARE SERVICE MANAGERS	1611-01 Child Care Centre Manager	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling • 0414 Management and Administration	Children Care and Progress Management (Level 5) Early Childhood Care and Development Management (Level 5)
1613 AGED CARE SERVICES MANAGERS	1613-01 Aged Care Services Manager 1613-02 Aged Care Home Director	• 0921 Care Of Elderly and Of Disabled Adults	Elderly Care Centre Management (Level 5)

	1613-03 Community Aged Care Coordinator 1613-04 Aged care facility Manager 1613-05 Nursing Home Care Manager 1613-06 Aged Care Centre Manager 1613-07 Aged Care Hostel Manager 1613-08 Matron, Nursing Home	• 0414 Management and Administration • 0923 Social Work and Counselling	
5311 CHILD CARE WORKERS	5311-01 Child Care Worker 5311-02 Baby Amah 5311-03 Nanny 5311-04 Baby-sitter	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling	Carer (After School) (Level 2)
5322 HOME-BASED PERSONAL CARE WORKERS	5322-01 Care Aide (Home) 5322-02 Birth Assistant (Home) 5322-03 Nursing Aide (Home) 5322-04 Personal Care Provider 5322-05 Care Aide (Home) Grade K3 5322-06 Assistant, Day Care: Aged 5322-07 Companion, aged care 5322-08 Helper, Aged Care 5322-09 Helper, Caring for Aged (home) 5322-10 Worker, Home Care 5322-11 Assistant, Day Care: Disabled 5322-12 Helper, Caring for Infirm (home)	• 0921 Care Of Elderly and Of Disabled Adults • 0922 Child Care and Youth Services • 0923 Social Work and Counselling	Healthcare Support Service (Level 2)

In the social welfare and social care sector, the MASCO Code classifies the workforce into four levels. At Level 1000, we find managerial positions held by individuals with tertiary degrees—such as social welfare managers, child care service managers, and aged care managers. Level 2000 comprises undergraduate officers, while Level 3000 includes diploma-level officers. Finally, Level 5000 encompasses care aides, assistants, and helpers, who may or may not have completed SPM but need to achieve at least level 2 in NOSS. Additionally, the NEC Code represents a field of study in tertiary education (diploma or degree) tailored for those pursuing careers in this sector.

While the care industry appears well-structured on paper – complete with job titles, qualifications, and envisioned career paths – a critical question arises: Can this industry truly grow and evolve organically if no proactive steps are taken?

5.0 Gaps and Ways Forward

Let's remain mindful that discussions surrounding the care economy and care industry in Malaysia are relatively recent. Referring to Table 3 as a guide, where do we currently stand in terms of the state of the care industry in our country? Can we confidently label it as an industry where the production of goods and services can be quantified? Is it appropriate to call it a care industry when services are primarily provided by public agencies and voluntary organizations? And further, can we use the term 'care industry' when the workforce remains unregulated and is often perceived as having low skills and low wages?

First, we need to know the main care service providers in the field. The earlier discussion has pointed out that only child care and elderly care, to a certain extent, have exhibited indicators of a mixed economy of care. This can be a good starting point for the government and relevant stakeholders to focus on these two services as the blueprint for the care industry in Malaysia. Of the two, child care is in more advanced positions with the education and training pathway and standards being regulated. The demand for ECCE at tertiary level seems to be more attractive as the private sector is willing to pay higher salary for graduates with a diploma in ECCE compares to one with a Level 3 NOSS in child care. The issues of unregistered child care facilities and services needs more intense intervention from the authority to ensure safety and well-being of the child in care.

On the other hand, elderly care service is increasing in demand as the nation gearing towards an ageing society soon and the demographic change in society. However, the quality of care may differ between non-profit or charity-based run facilities relying on untrained staffs as compared to private nursing care or nursing home who can afford to employed qualified health professionals. Many elderly individuals prefer to age in place, ie. remaining in their homes and communities. The care industry needs to address the challenges due to the high costs associated with domestic caregiving and the need for specialized care services.

Second, we need to develop a care industry that is attractive for young Malaysian to seek employment, and not resort to use foreign workers. The care industry must be robust to ensure the retention of care workers with higher income and career pathways. To make the care

industry appealing to young Malaysians, we must actively engage with them. This involves promoting awareness about the diverse roles within the sector, emphasizing its societal impact, and showcasing success stories of care professionals. Highlighting clear educational pathways and career progression opportunities is crucial. Young people need to see how their skills and interests align with meaningful roles in caregiving, whether as nurses, social workers, or allied health professionals.

CARE ECONOMY CONFERENCE
24-25 SEPTEMBER, ISIS MALAYSIA

Paper 7: Professional standards and trainings for the social care industry

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Outline of the presentation

1. Introduction
2. Care Economy from the Social Welfare Perspective
3. Workforce and Service Providers in the Care Economy
4. Education and Training for the Workforce in Care Industry
5. Gaps and Ways Forward
6. Conclusion

Introduction

- Demand for social care is rising -- factors caused by demographic shifts and family dynamics.
- Achieving a delicate balance between **affordable care** and **quality provision** requires effective **integration** of **health and social care** systems, emphasizing both **preventive** and **reactive** approaches.
- The **care economy** is a key concept that encompasses the **production and consumption of goods and services** necessary for the well-being of care-dependent groups.
- For social care sector → industry, need to focus on the market - the care **service providers**, social care **workforce**, and the **users**.

Introduction

This paper aims to

(i) explore the concept of care economy and the roles of different service providers in social welfare perspective,

(ii) examine the current state of workforce and its related training and regulations, and

(iii) discuss the conditions and challenges in developing a viable social care industry.

Care Economy from the Social Welfare Perspective

- Social care is within a larger **social welfare** system which should be a **shared responsibility** (*National Social Welfare Policy 1990 & National Social Policy 2003 but without plan of actions*).
- **Mixed economy of welfare** – government, non-government/ voluntary, non-profit, private/for profit, and community.
- **Mixed economy of care** – more than one option in care provision.
- **Care economy** – sector responsible for providing essential care services for the well-being of care-dependent groups, and this include both the paid and unpaid care work.
- This paper primary focus on **paid workforce**.

Workforce and Service Providers in the Care Economy

The **Malaysian Standard Industrial Classification (MSIC)**

- numerical system where each code corresponds to a specific industry
- a standardized classification by the Department of Statistics Malaysia (DOSM),
- aims to simplify the complex landscape of industries and businesses and classify economic activities into different sectors and sub-sectors.

SEKSYEN Q AKTIVITI KESIHATAN KEMANUSIAAN DAN KERJA SOSIAL

HUMAN HEALTH AND SOCIAL WORK ACTIVITIES

BAHAGIAN/ *DIVISION*	KUMPULAN/ *GROUP*	KETERANGAN/ *DESCRIPTION*
Q86		***HUMAN HEALTH ACTIVITIES***
	Q861	*HOSPITAL ACTIVITIES*
	Q862	*MEDICAL AND DENTAL PRACTICE ACTIVITIES*
	Q869	*OTHER HUMAN HEALTH ACTIVITIES*
Q87		***RESIDENTIAL CARE ACTIVITIES***
	Q871	*RESIDENTIAL NURSING CARE FACILITIES*
	Q872	*RESIDENTIAL CARE ACTIVITIES FOR MENTAL RETARDATION, MENTAL HEALTH AND SUBSTANCE ABUSE*
	Q873	*RESIDENTIAL CARE ACTIVITIES FOR THE ELDERLY AND DISABLED*
	Q879	*OTHER RESIDENTIAL CARE ACTIVITIES*
Q88		*SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION*
	Q881	*SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION FOR THE ELDERLY AND DISABLE*
	Q889	*OTHER SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION n.e.c*

Residential

Non-Residential

National Occupational Skills Standard (NOSS)

- NOSS is a document that outlines the **dexterity** required of an **employee working** in Malaysia at a certain level of employment to achieve **specific skills**.

TYPE OF SERVICE	TARGET GROUP	NOSS	LEVEL	MSIC CODE
RESIDENTIAL CARE	PUSAT JAGAAN OKU / **DISABLED CARE**	OPERASI PUSAT JAGAAN (ORANG KURANG UPAYA)	3	Q873
		PENTADBIRAN PUSAT JAGAAN (ORANG KURANG UPAYA)	4	Q873
		PENGURUSAN PUSAT JAGAAN (ORANG KURANG UPAYA)	5	Q873
	PUSAT JAGAAN ORANG TUA / **ELDERLY CARE**	OPERASI PUSAT JAGAAN ORANG TUA	3	Q873
		PENTADBIRAN PUSAT JAGAAN ORANG TUA	4	Q873
		PENGURUSAN PUSAT JAGAAN ORANG TUA	5	Q873
	PUSAT JAGAAN KANAK-KANAK / **CHILDREN CARE CENTRE**	PENJAGAAN DAN KEMAJUAN KANAK-KANAK (CHILDREN CARE AND PROGRESS)	3	Q879
		PENYELIAAN PENJAGAAN DAN KEMAJUAN KANAK-KANAK (CHILDREN CARE AND PROGRESS SUPERVISION)	4	Q879
		PENGURUSAN JAGAAN DAN KEMAJUAN KANAK-KANAK (CHILDREN CARE AND PROGRESS MANAGEMENT)	5	Q879

National Occupational Skills Standard (NOSS)

TYPE OF SERVICE	TARGET GROUP	NOSS	LEVEL	MSIC CODE
NON-RESIDENTIAL / DAY CARE	CHILDREN WITH SPECIAL NEEDS	CHILDREN WITH SPECIAL NEEDS CARE & EDUCATION PRACTICE	3	Q889
		CHILDREN WITH SPECIAL NEEDS CARE & EDUCATION ADMINISTRATION	4	Q889
	PEMULIHAN DALAM KOMUNITI (OKU) / COMMUNITY BASED REHABILATION (PWD)	OPERASI PEMULIHAN DALAM KOMUNITI (COMMUNITY BASED REHABILATION OPERATION)	3	Q881
		PENTADBIRAN PUSAT PEMULIHAN DALAM KOMUNITI (OKU) / COMMUNITY BASED REHABILITATION CENTRE ADMINISTRATION (PWD)	4	Q881
		PENGURUSAN PUSAT PEMULIHAN DALAM KOMUNITI (OKU) / COMMUNITY BASED REHABILITATION CENTRE MANAGEMENT (PWD)	5	Q881
OTHERS	SOCIAL WELFARE	SOCIAL WELFARE PRACTICE	3	Q889
		SOCIAL WELFARE COORDINATION	4	Q889
		SOCIAL WELFARE MANAGEMENT	5	Q889
	COMMUNITY SERVICES	COMMUNITY SERVICE	3	Q889
		COMMUNITY SERVICE ADMINISTRATION	4	Q889
		COMMUNITY SERVICE MANAGEMENT	5	Q889
	SOCIAL WORK	SOCIAL WORK OPERATION AND ADMINISTRATION	4	Q889
		SOCIAL WORK MANAGEMENT	5	Q889

* All the existing NOSS in social care were developed by JKM as industrial lead.

The Malaysian Qualification Framework (MQF 2.0) by Malaysian Qualification Agency (MQA)

MQF Level	Minimum Graduating Credits*	Academic Sector	TVET Sector	Lifelong Learning/APEL Criteria for APEL(A)
8	No credit rating	PhD by Research		Admission criteria: 35 years old Bachelor's degree in relevant field/equivalent 5 years of work experience Passed APEL assessment
	80	Doctoral Degree by Mixed Mode & Coursework		
7	No credit rating	Master's by Research		Admission criteria: 30 years old STPM/Diploma/equivalent Relevant work experience Passed APEL assessment
	40	Master's by Mixed Mode & Coursework		
	30	Postgraduate Diploma		
	20	Postgraduate Certificate		
6	120	Bachelor's Degree		Admission criteria: 21 years old Relevant work experience Passed APEL assessment
	64	Graduate Diploma	6	
	34	Graduate Certificate		
5	40	Advanced Diploma	5	
4	90	Diploma	4	Admission criteria: 20 years old Relevant work experience Passed APEL assessment
3	60	Certificate	3	Admission criteria: 19 years old Relevant work experience Passed APEL assessment
2	30	Certificate	2	3R
1	15	Certificate	1	3R

* Inclusive of general studies subjects for an undergraduate programme.

Malaysian Standard Classification of Occupations (MASCO) & National Educational Code (NEC)

MASCO CODE	JOB TITLE	NEC CODE	NOSS LEVEL EXAMPLES
1614 SOCIAL WELFARE MANAGERS	• 1614-01 Social Work Manager • 1614-02 Social Work Operation Manager • 1614-03 Community Centre Manager • 1614-04 Welfare Centre Manager • 1614-05 Family Services Manager • 1614-06 Housing Services Manager	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling • 0414 Management and Administration • 0921 Care Of Elderly and Of Disabled Adults (Degree level)	Social Welfare Management (Level 5)
2825 SOCIAL WORK AND COUNSELING PROFESSIONALS	2825-01 Community Development Officer Grade S41 2825-02 Social Worker, Professional* 2825-09 Parole Officer 2825-10 Probation Officer 2825-11 Women's Welfare Organizer 2825-12 Youth and Sports Officer Grade S41 2825-13 Anti-Drug Officer Grade S41	• 0923 Social Work and Counselling (Advanced Diploma to Degree Level)	Social Welfare Coordination (Level 4) Social Work Operation and Administration (Level 4) *Social Work Management (Level 5) Community Service Management (Level 5)

Malaysian Standard Classification of Occupations (MASCO) & National Educational Code (NEC)

MASCO CODE	JOB TITLE	NEC CODE	NOSS LEVEL EXAMPLES
3611 SOCIAL WORK ASSOCIATE PROFESSIONALS	3611-01 Social Worker / 3611-02 Social Worker, Group Work 3611-03 Welfare Officer, Industry / 3611-04 Welfare Officer, Probation 3611-05 Parole Officer, Associate Professional 3611-06 Probation Officer, Associate Professional 3611-07 Officer, Family Planning / 3611-08 Social Welfare Worker 3611-09 Social Welfare Worker, Case Work 3611-10 Social Worker, Child Welfare 3611-11 Social Worker, Delinquency / 3611-12 Social Worker, Community 3611-13 Social Worker, Medical / 3611-14 Social Worker, Psychiatric 3611-15 Welfare Organizer / 3611-17 Community Development Worker 3611-18 Community Service Worker / 3611-19 Disability Services Officer 3611-20 Family Service Worker / 3611-21 Life Skills Instructor 3611-22 Mental Health Worker / 3611-23 Welfare Support Worker 3611-24 Women's Shelter Supervisor / 3611-25 Youth Worker 3611-26 Assistant Social Research Officer Grade N29 3611-27 Assistant Community Development Officer Grade S29 3611-28 Assistant Psychological Officer Grade S29 3611-29 Assistant Anti-Drug Officer Grade S29 3611-30m Assistant Executive Officer (Psychology) Grade 31	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling • 0921 Care Of Elderly and Of Disabled Adults (Diploma Level)	*Social Work Management (Level 5) Social Work Operation and Administration (Level 4) Social Welfare Coordination (Level 4) Social Welfare Practice (Level 3) Community Based Rehabilitation Centre Administration (PWD) (Level 4) Community Based Rehabilation Operation (Level 3)

Malaysian Standard Classification of Occupations (MASCO) & National Educational Code (NEC)

MASCO CODE	JOB TITLE	NEC CODE	NOSS LEVEL EXAMPLES
1611 CHILD CARE SERVICE MANAGERS	1611-01 Child Care Centre Manager	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling • 0414 Management and Administration (Advanced Diploma to Degree Level)	Children Care and Progress Management (Level 5) Early Childhood Care and Development Management (Level 5)
1613 AGED CARE SERVICES MANAGERS	1613-01 Aged Care Services Manager 1613-02 Aged Care Home Director 1613-03 Community Aged Care Coordinator 1613-04 Aged care facility Manager 1613-05 Nursing Home Care Manager 1613-06 Aged Care Centre Manager 1613-07 Aged Care Hostel Manager 1613-08 Matron, Nursing Home	• 0921 Care Of Elderly and Of Disabled Adults • 0414 Management and Administration • 0923 Social Work and Counselling (Advanced Diploma to Degree Level)	Elderly Care Centre Management (Level 5)

Malaysian Standard Classification of Occupations (MASCO) & National Educational Code (NEC)

MASCO CODE	JOB TITLE	NEC CODE	NOSS LEVEL EXAMPLES
5311 CHILD CARE WORKERS	5311-01 Child Care Worker 5311-02 Baby Amah 5311-03 Nanny 5311-04 Baby-sitter	• 0922 Child Care and Youth Services • 0923 Social Work and Counselling (Certificate Level)	Carer (After School) (Level 2)
5322 HOME-BASED PERSONAL CARE WORKERS	5322-01 Care Aide (Home) 5322-02 Birth Assistant (Home) 5322-03 Nursing Aide (Home) 5322-04 Personal Care Provider 5322-05 Care Aide (Home) Grade K3 5322-06 Assistant, Day Care: Aged 5322-07 Companion, aged care 5322-08 Helper, Aged Care 5322-09 Helper, Caring for Aged (home) 5322-10 Worker, Home Care 5322-11 Assistant, Day Care: Disabled 5322-12 Helper, Caring for Infirm (home)	• 0921 Care Of Elderly and Of Disabled Adults • 0922 Child Care and Youth Services • 0923 Social Work and Counselling (Certificate Level)	Healthcare Support Service (Level 2)

Mapping of type of care, service provider, main legislation & ministry, main workforce and regulated qualifications

Target Group	Area of care / services	Examples of services	Type of Service Providers				Main Legislation / Regulation/ Main Ministry	Main Workforce	Regulated Qualifications of workforce
			G	N	P	C			
Children	Day Care	Child care centre (Taksa) Taska Rumah?	/	/	/	/	• Child Care Centre Act 1984 • Garis Panduan Penubuhan dan Pendaftaran Pusat Jagaan Kanak-kanak di Tempat Kerja • KPWKM	• Child care worker (*Pengasuh*) • Early childhood educator	Kursus Asuhan Permata (KAP)
	Residential Care	Children Home	/	/			• Child Act 2001 • Care Centre Act 1993 • KPWKM	• Child care worker • Social/Case worker • Welfare worker • Nursing aide	Not specified
	Child Protection Care	Children Home	/	/			• Child Act 2001 • Care Centre Act 1993 • KPWKM	• Care worker • Social/Case worker	Not specified

Mapping of type of care, service provider, main legislation & ministry, main workforce and regulated qualifications

Target Group	Area of care / services	Examples of services	Type of Service Providers				Main Legislation / Regulation/ Main Ministry	Main Workforce	Regulated Qualifications of workforce
			G	N	P	C			
Older Persons	Day Care	Elderly Day Care Centre		/	/		• Care Centre Act 1993 / National Older Persons Policy 2011 (KPWKM) • Private Aged Healthcare Facilities and Service Act 2018 (KKM)	• Care worker • Nurses and allied health professionals	Not specified in KPWKM legislation. Health and allied health professionals are regulated by KKM
	Residential Care	Rumah Seri Kenangan / Rumah Ehsan / Old Folks Home / Nursing Home (Private)	/	/	/	/	• Care Centre Act 1993 / National Older Persons Policy 2011 (KPWKM) • Private Aged Healthcare Facilities and Service Act 2018 (KKM)	• Care worker • Nurses and allied health professionals • Social/Case worker • Welfare worker	Not specified in KPWKM legislation. Health and allied health professionals are regulated by KKM
	Elderly Activity Centre	PAWE	/	/			National Older Persons Policy 2011 / Garis Panduan Pusat Aktiviti Warga Emas (PAWE) Pindaan 2018 (KPWKM)	• Centre supervisor (Penyelia) • Social/case worker • Welfare worker	Not specified in KPWKM legislation

Mapping of type of care, service provider, main legislation & ministry, main workforce and regulated qualifications

Target Group	Area of care / services	Examples of services	Type of Service Providers				Main Legislation / Regulation/ Main Ministry	Main Workforce	Regulated Qualifications of workforce
			G	N	**P**	**C**			
People with Disabilities#	Community Based Rehabilitation / Day Care	PPDK		/	/	/	Persons with Disabilities Act 2008 (KPWKM)	• PDK teachers • Centre supervisor • Caregivers	Not specified
	Residential Care	Taman Sinar Harapan / Rumah Penjagaan OKU (NGO)	/	/			Persons with Disabilities Act 2008 / Care Centre Act 1993 (KPWKM)	• Care workers • Social/case worker • Welfare worker	Not specified
	OKU Activity Centre	Bengkel Daya / Sheltered workshop (NGO)	/	/			Persons with Disabilities Act 2008 (KPWKM)	• Centre supervisors • Social/case worker	Not specified

What about care services/facilities for people with mental illness?

Gaps

Market for Care Industry

- Who are the main service providers?
- Are the demand lucrative for service providers to enter?
- Legislation: Centre/ Institutional-based > Community-based or Home-based services
- Which sector is more ready than others (mixed economy of care)?

Social Care Workforce

- Are education and training opportunity available? How many and where?
- Are qualifications regulated?
- Are positions/employment with decent pay available?
- Are the locals interested in care work?

Users / Consumers

- Accessibility and affordability? Do they have a choice?
- Quality assurance?
- Complain and compensation channel?

Ways Forward for Care Industry and its Workforce

Sector	Suggested Approach	Suggested Actions
Child Care	Professionalize the workforce: upscaling low skills to high skills through NOSS and tertiary education	KPWKM: specifiy relevant qualifications (NOSS, Diploma or degree) in child care work and positions in regulations under Child Centre Act 1984 and Care Centre Act 1993.
Elderly Care	Professionalize the workforce: upscaling low skills to high skills through NOSS	KPWKM: specifiy relevant qualifications (NOSS or Diploma) in elderly care work and positions in regulations under Care Centre Act 1993.
PWDs Care	Professionalize the workforce: upscaling low skills to high skills through NOSS	KPWKM: specifiy relevant qualifications (NOSS or Diploma) in PWDs care work and positions in regulations under Care Centre Act 1993.
Social Work & Social Welfare	Professionalize the workforce + occupationalize the profession: upscaling existing workforce and recruit people with qualifications into related positions	KPWKM: Passing the Social Work Profession Bill is first step in regulating social workers and associate social workers because they do not fall under Care Centre legislation. Social Worker's roles exists in both residential and non-residential settings and with multiple (prevention, support, intervention, protection and control) functions
Care Industry	Encourage and stimulate more service providers (NGOs, Private and Individuals)	Government and KPWKM: Formulating new Social Policy/Welfare Policy on Care Economy; Blueprint for Care Industry; Incentives for care providers to participate

Conclusion

- A viable and sustainable care industry in Malaysia is not able to develop organically. It requires clear policy direction, legislation and regulatory framework for the market or a mixed economy of care – service providers, social care workforce and the users.
- Social care workforce needs to be regulated to ensure competent service and safeguarding the safety and well-being of care-dependent people.
- Child care exhibits more readiness in terms of market demand in care industry, follows by elderly care. PWDs care is still lacking such conditions.

THANK YOU

Session 8: Care economy as a growth sector

1530 – 1700 hrs | Wednesday, 25 September 2024

Role Players:

Moderator	**En Rashidi Yahaya**, Group CEO, SETERRA Group of Companies; Chairman, Kendana Malaysia
Paper Presenter	**Dr Teo Lee Ken**, Associate Director, MySDG Centre for Social Inclusion, Society for the Promotion of SDGs
Discussant 1	**Ms Shakira Teh Sharifuddin**, Senior Economist, Social Protection and Labor, World Bank Inclusive Growth and Sustainable Finance Hub
Discussant 2	**Pn Hawati Abdul Hamid**, Director of Research, Khazanah Research Institute
Secretariat	**Farhan Khairulannuar** (ISIS Malaysia) – Rapporteur **Afiqah Abdul Malik** – Timekeeper

(L-R: Pn Hawati Abdul Hamid, En Rashidi Yahaya, Dr Teo Lee Ken and Ms Shakira Teh Sharifuddin)

PAPER 8

Care Economy as a Growth Sector

"Care Growth as Social Growth: *Looking at Growth through a Multidimensional Lens, and Growth as Social Development"*

Teo Lee Ken
MySDG Center for Social Inclusion, Society for the Promotion of SDGs

1. Introduction

Trying times require paradigm shifts in ideas and action. As society changes, national agendas perform a pivotal role in facilitating great transformations.[168] Malaysia is at such a juncture. At the back of the COVID-19 pandemic, the Malaysian government has come to realized that there are limitations in its reach to ensure social services and delivery for the public.[169] One such arena is that of the social and care sector. In view of this, the government has decided to embark on a project to build and consolidate a care economy.

A **care economy** is defined as a "new vision of economics that recognizes the importance of care work, empowerment and autonomy of women to the function of economies, wellbeing of societies and life sustainability. Care work consists of two overlapping activities and can be paid or unpaid: 1) direct, personal, and relational care activities, such as feeding a baby or nursing an ill partner; and 2) indirect care activities or domestic work, such as cooking and cleaning."[170] Groups or individuals that provide care work include "nurses, childminders, community health workers and elderly care assistants as well as domestic workers, cooks, and cleaners."[171] The target groups or beneficiaries of the care services include people with disabilities and special needs, children, and senior citizens and the aged.

The contributions of a care economy to Malaysia can be viewed in **two ways**. The **first** is the role of the care economy itself as an engine of growth to the Malaysian economy. And this should be seen not only in material terms, but also social terms.[172] **Secondly**, is how by creating and running a care economy, it allows sectors of society particularly women and mothers, among others, who are confined to care work, informal or even formal, to participate in the labor market. *For purposes of this paper, it is the* ***first point or view*** *that this paper seeks to unpack and critically discuss*.

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[168] Please see Marshall Berman, All that is Solid Melts into Air: The Experience of Modernity (1982); Karl Polanyi, The Great Transformation (1944)

[169] Part of the reason is the fiscal limitations of the government, and the expected potentials, both economic and social, of building a care economy to serve the care needs of the Malaysian society

[170] New Economics for Sustainable Development: Purple Economy (Care Economy+), United Nations Economist Network, United Nations

[171] Ibid

[172] Please see: How can an inclusive and resilient care ecosystem be built? Care delivery models to advance women's economic empowerment, Asia-Pacific Care Economy Forum, 22-23 June, 2024. See also: Investing in the Care Economy: Opportunities for Malaysia, UNDP Policy Paper, June 2023

In a recent publication by ISIS Malaysia, the authors of a study noted that the unpaid care work in Malaysia if it were to be calculated in GDP numbers, it would amount to approximately RM379 billion. And it would be the fifth biggest contributor of the services sector.[173] The study further notes that if those who are kept in care work are released in the labor force, there will be an additional 3.2 million workers who will be able to engage in paid employment.[174] [175]

The benefits that a potential care economy might bring to the country, and the present limitations of the government has made the need to find alternative to the landscape of care services in Malaysia imperative.[176]

This paper is divided into 4 main parts. It, firstly, has discussed in the previous section the background and context for the emergence of the perspective seeing the care services and sector as an economy. It proceeds to discuss some key highlights, and benefits in building the care practice and sector as an industry and growth sector in Malaysia. Thirdly, the paper seeks to highlight some of the challenges that may emerge as a result of the move to develop the care economy as a growth sector. It examines some of the social and economic implications this move might have on Malaysian society. And lastly, the paper ends with some concluding thoughts as to what might be key areas that government leaders and policy makers, researchers, academics, activists and community workers should attend to in discussing this subject matter. The attempt to discuss the care economy as a growth sector in this paper would focus not only on the quantitative aspects and numbers, but will also assess the qualitative aspects and dimensions, including benefits that the establishing of a care economy will bring to the country. In line with this, throughout the discussions in the paper, reference will also be made to the issues mapping findings and work of the *All-Party Parliamentary Group on SDGs* (APPGM-SDG) and the SDGs agenda and framework.

2. Social Welfare and the Care Economy in Malaysia: Key Highlights and Benefits

As a general point and broad view, the creation of a care economy and its consolidation would create more employment opportunities, drive economic growth and contribute to the country's GDP, cushion the burden of the government and public sector in the care services and provisions arena, allow the growth and expansion of private enterprises and operators, and provide better and professional care services that cater to the needs of the most vulnerable and left behind communities in society.

As a starting point, the Malaysian government **firstly** sees advantages in building the care economy as this would allow more public-private collaboration. It would allow the private sector and care operators to be more involved in providing care services. Existing operators and stakeholders present in the field are also welcome the move at it would allow them to better

[173] Lee Min Hui et al, Building a Cradle-to-grave care economy for Malaysia, ISIS Malaysia (2024)
[174] Ibid
[175] Please see also: Time to care: Gender inequality, unpaid care work and time survey, Khazanah Research Institute, October 2019
[176] Please see: Women's Minister wants government to prioritize care economy, The Star, October 9, 2023; Giving social work due recognition, The Star, Nov 5, 2023

run their operations and also expand their services in different ways. More employment opportunities can be created, and the number of caregivers as well as care receivers among the vulnerable can be increased. There will be more coverage, and awareness and access of and to services and programs.[177]

In a previous workshop undertaken by the Ministry of Women, Family and Community Development (KPWKM) in partnership with PEMANDU Associates, operators and the private sector who attended the workshop responded encouragingly to the initiatives of the Ministry and government in general to develop and launch a care economy refined roadmap and action plan. Noting how many of the earlier initiatives and programs of the past have heavily focused on the government as the main providers, such collaborations would release of the centralization and burdens on the Federal government.

Following from this, and **secondly**, the Ministry and stakeholders involved view the establishing of a care economy as potentially increasing the standard of care services. As many of these sectors and services are run informally and within community or residential settings, the level of expertise possessed by care givers formal or informal, also varies and are uncertain. By creating a care economy and by way of the professionalizing of services, there is a belief that care givers and social workers will be better equip with the necessary skills to manage the needs and issues of the target groups.

Thirdly, and corresponding to this, the discussion on standards of care services cannot be separated from the discussions on legal frameworks and uniform or standardize regulations. Laws and regulations, it is noted will be better streamlined with the institutionalizing of a care economy. These would include laws, and rules and regulations that specify the needed qualifications and skills to run social and care services. It would also potentially provide the foundations, both legal and policy, to establish a national level council that governs the care ecosystem. The council would comprise of diverse stakeholders including the government and public sectors, private operators and establishments, academics and policy researchers, activists, and community and social workers.

Frameworks on law and regulations will also be formulated for facilitating the benchmarks and standards for the premises and facilities of care centers. As there are many existing social and care services that are informal and situated in residential settings, the formation of a care economy would fill in some of the gaps and weaknesses present in the existing structure of informal care.

Finally, and **fourthly**, the formalizing of a care economy would be able to ensure sustainability in the care sector and practices. The government does not have infinite resources and the capacity to sustain long term social provisions and services through public expenditure and subsidies, and also the giving of grants generally and extensively. There is a need, therefore, for a shift from being grant and subsidy recipients to become social enterprises or

[177] Please see: Investing in the Care Economy: Opportunities for Malaysia, UNDP Policy Paper, June 2023

organizations. This is especially needed for care centers and providers that run care services and programs for persons with disabilities, children and senior citizens.

The SGDs framework, particularly the localization agenda and empowerment model of the APPGM-SDG, and the social and solidarity economy (SSE) framework provide guides for this endeavor to build sustainable and inclusive projects and enterprises that cater to the needs of the most vulnerable, including the key target groups of the care economy.[178]

Overall, by institutionalizing public-private collaborations, increasing standards and benchmarks for care services and practices, creating uniform and coherent legal frameworks and regulations, and SSE all through and as a result of the development of a care economy, this will contribute to the growth for the country in material and economic, and social terms.

3. Challenges in Creating and Consolidating the Care Economy as a Social Growth Sector

Notwithstanding the potentials and benefits that might result from the formalizing of a care economy and professionalizing care services and facilities, critical challenges remain. The **first** being the accessible and affordability of the care services. In the research work undertaken by the APPGM-SDG, for instance, findings from the ground illustrate that many of the social services related to care or within the area of care are subscribed by the B40 communities.[179] These communities have neither the financial resources nor access to engage decent quality social and care services. Examples are the PDKs (Pusat Pemulihan Dalam Komuniti) that are run by the Department of Social Welfare (JKM, Jabatan Kebajikan Masyarakat) in rural areas. The participants of these centers come from families who confront issues and challenges of poverty, and vulnerability. The professionalizing of the care services will significant implications on the livelihoods of those families and the well-being of the dependents that attend and depend on those centers. In this context, the SDGs of 1 (no poverty), 3 (good health and well-being) and 8 (decent work and economic growth) are vital.

Secondly, is the challenge of imbalance and unequal development. As the existing socio-economic landscape in Malaysia is drastically different from state to state and also regions, the creation of a care economy will also amplify and reinforce these inequalities. This is particularly so if inadequate safeguards are formulated and incorporated in the care economy framework that minimizes and provides affirmative action for vulnerable and marginalized communities in rural areas and regions. It has been previously reported that out of the 10 poorest districts in Malaysia, 8 are in the region of Sabah, one in the region of Sarawak, and another in the state if Kelantan.[180] Principles and mechanisms derived from SDGs 1 (no poverty), 10 (reduced inequalities) serve as valuable guides to navigate through this challenge.

[178] Please see Denison Jayasooria, Walking in the Footsteps of Faith (2024); Denison Jayasooria and Ilcheong Yi, The Sustainable Development Goals and the Social and Solidarity Economy; Denison Jayasooria, Mapping the Social and Solidarity Economy Landscape in Asia: Spotlight on Malaysia, International Labor Organization, September 2021

[179] Please see APPGM-SDG Annual Reports (2020, 2021, 2022, 2023). Please see also Issue Mapping Findings Reports (unpublished), 2020-2024

[180] Twelfth Malaysian Plan (RMK-12, 2021-2025), Ministry of Economy, Malaysia

In previous dialogues and focus groups, operators have noted how running a care center incurs high costs and is a risky enterprise in terms of sustainability and efficiency.[181] As existing costs of operations and services are high, it remains to be seen the impacts the professionalizing of care services and the care economy would have on vulnerable communities, including B40 groups.

The availability of a ready pool, and need for a group, of qualified and skilled human capital is the **third** challenge. Specific skills and training, and qualifications are needed to run decent and competent services in the care centers. There are diverse and specific issues to this particular challenge of human capital. The presence and availability of skilled and qualified social workers are not consistent across all care centers and premises. Further, personnel involved in formal centers, and informal centers whether residential or community-based, also have divergent and differing skill sets and competency.

Operators have also noted how they faced difficulties in recruiting qualified and motivated workers. Young graduates, in particular, are not interested in the available openings in the care sector. Those that are interested, whether from the young or older age categories, might not be qualified, or not motivated, or in worst case scenarios, both. Stakeholders have commented how to encourage more uptake among younger people and graduates, there needs to be a clear career pathway as a social worker and better remuneration in terms of wages and social security. There would also be initiatives to streamline academic and vocational trainings, and the tools to assess competency and performance among social workers and key stakeholders in the providing of care services at the grassroots level. The SDGs 4 (quality education), 5 (gender equality), and 9 (industry, innovation and infrastructure) and the values and guidelines derived from these SDGs are pertinent to inform the discussion on this challenge.

The **fourth** and last challenge that this paper seeks to highlight is the imperative to create an ecosystem, coherent to facilitate the needs of the care operators and care recipients, but flexible and open enough to allow for autonomous actions at the ground level to cater to lived realities and needs. This ecosystem, and the identification of the custodians of this ecosystem in terms of the roles, jurisdictions and responsibilities of every key stakeholder, is a critical task. As the issues and needs of the vulnerable communities in relation to care is diverse and multifaceted, cross ministerial collaboration is also crucial at the government.[182]

At present, initiatives on the care economy are led by the KPWKM. However, other ministries from the Ministry of Economy, to the Ministry of Housing and Local Government, to the Ministry of Education and Ministry of Higher Education are needed to ensure an organized flow of jurisdiction and command. And a functional ecosystem can be created as the foundations for a sustainable, inclusive and expansive care economy. Participants in roundtables hosted by the *MySDG Center for Social Inclusion* of the APPGM-SDG have

[181] Please see Roundtable Discussion – Conversations on Care Economy in Malaysia, Compilation Report 26-26 June, 2024

[182] How can an inclusive and resilient care ecosystem be built? Care delivery models to advance women's economic empowerment, Asia-Pacific Care Economy Forum, 22-23 June, 2024

commented how the existing workload on social services is unevenly weighed on the Department of Social Welfare (JKM) of the KPWKM. To build a well-functioning and responsive ecosystem to facilitate the care economy, changes have to be made to the governance structure and paradigm of the various ministries, and the State. For this, the guidelines and spirit of SDGs 16 (peace, justice and strong institutions) and 17 (partnerships for the goals) are instructive to formulate a better perspective to unpack and address this challenge of functional ecosystems and responsive custodians of power.

4. Conclusion: Looking at the Care Economy as a Means to Social Growth and Development

The APPGM-SDG approach and school of thought to development continuously emphasizes the need to understand development as holistic and human development.[183] Such a view is in contrast to views that consider development as merely material and financial development and growth fixated on GDP and quantitative numbers and indicators.

If development is conceived as such, then the care economy that is tasked with the role of ensuring growth would have to be set up in a manner that supports the ideals of humane development for the country. The care economy itself, which focuses on social services and caring for the vulnerable communities, ought to be constructed on the pillars of people, prosperity, and partnerships, and based on the values of leaving no one behind, justice and inclusivity.

I would like to conclude by suggesting three main takeaways in this paper. The first is that the care economy can be an engine of growth for the Malaysian economy guided by the paradigm of humane and justice-based development. Secondly, the care economy's purpose is to serve and benefit the needs of the most vulnerable and left behind communities in Malaysia. And third and finally, the SDGs and SSE frameworks serves as instructive guides for the creation and running of a care economy that is sustainable, inclusive, and intimate with local communities at the grassroots level.

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[183] Please see Amartya Sen, Development as Freedom

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CARE ECONOMY AS GROWTH SECTOR

CARE GROWTH AS SOCIAL GROWTH AND DEVELOPMENT

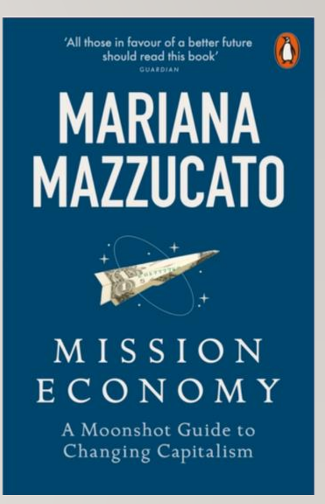
TEO LEE KEN

MYSDG CENTER FOR SOCIAL INCLUSION (MYSDG-CSI), SOCIETY FOR THE PROMOTION OF SDGS

Abdul Razak briefing on National Economic Policy to government agencies on 31 July 1975
Source: National Archives Malaysia, Accession No. 2001/0043298W

OUTLINE

1. Context and Scope
2. Key Highlights
3. Challenges
4. Way Forward
5. What's Different?



1. CONTEXT AND SCOPE

- Global and external changes
- Changing demographics
- **Social change**
- National transformation
- Scope of paper – **providing of framework and approaches**

ISSUE BRIEF

UNDP

INVESTING IN THE CARE ECONOMY: OPPORTUNITIES FOR MALAYSIA

Development Challenge

A central part of UNDP narrative on gender is that women's empowerment is an attractive incentive for governments simply because women form a major resource base of a country. Women's participation in the economy often leads to better education and health outcomes for children, as they tend to invest more than men in their families. This contributes to the well-being of the whole nation. Their role in boosting productivity, innovation and economic growth in many countries shows that wherever women are empowered, they become agents of change for society.

However, in most societies, care work is considered a natural responsibility for women and girls. The disproportionate distribution of unpaid care responsibility, based on biased social norms and gender stereotypes, often reinforces gender inequalities by restricting women's opportunity to pursue educational, economic and employment goals outside of their homes.

According to a survey conducted by the International Labour Organization (ILO), women carry out an overwhelming 76.4% of unpaid care work globally, spending an average of 4 hours and 32 minutes per day on these activities, compared to men who spend just 1 hour and 24 minutes per day (Charmes, 2019).

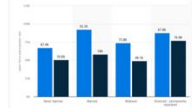
The KRI's pilot Time Use study conducted in 2018 found that when it comes to unpaid care work, Malaysian women spent on average—3.6 hours (15.2%) of their time compared with men—2.2 hours (9.3%). In other words, women spent 63.6% more time on average for unpaid care work compared with men.

The Unpaid Care Conundrum

Unpaid care continues to be largely treated by mainstream economics as an externality, being unaccounted for in policies and national accounts. The associated costs from unpaid care work in the form of forgone wages and opportunities for women and girls amplify gender inequality.

Malaysian women's economic participation is still low in general, however, as Figure 1 below shows, this can vary widely by marital status and also by age. Malaysia's female labour force participation rate (LFPR) is one of the lowest among ASEAN countries (55.6% as of July 2022 while male LFPR is 82.5%). The rate of female LFPR growth has slowed down substantially to only 0.02% in the current five-year period.

FIGURE 1. LABOUR FORCE PARTICIPATION RATES FOR WOMEN AND MEN IN MALAYSIA BY MARITAL STATUS, 2021

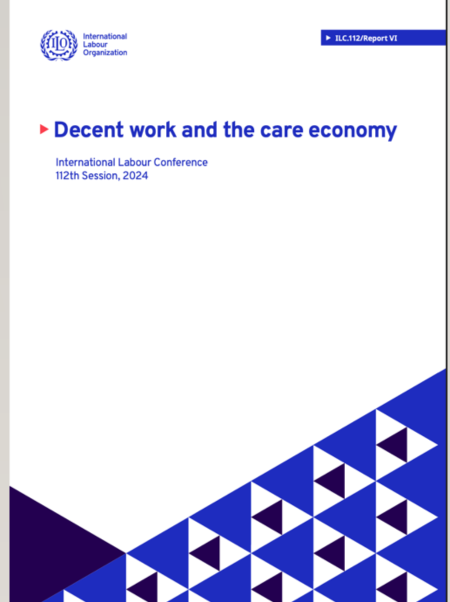


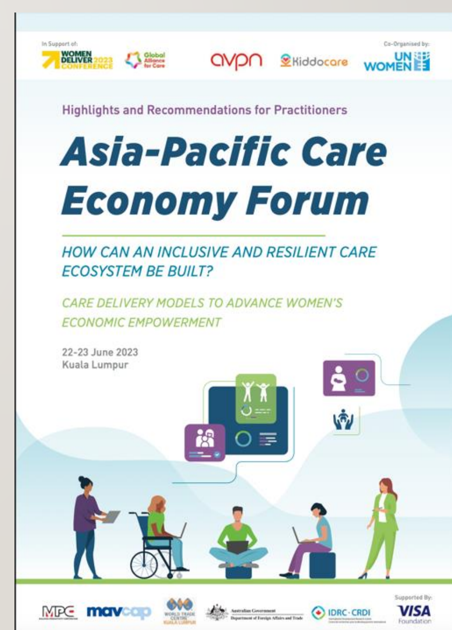
Source: World Bank based on ILO database

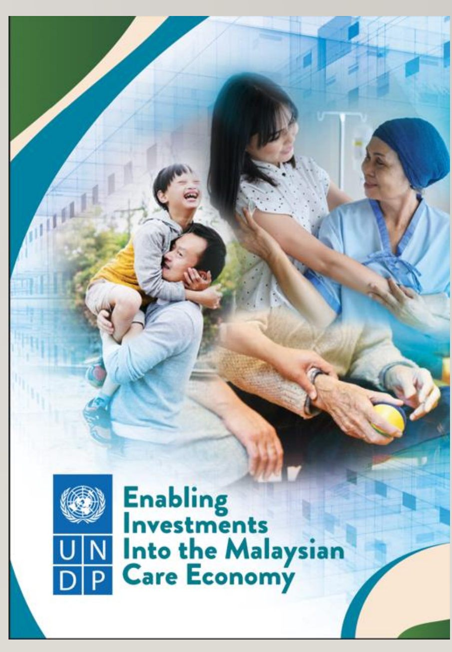
For more information: registry.my@undp.org
United Nations Development Programme, Malaysia Country Office
Level 10, Menara PjH, No. 2, Jalan Tun Abdul Razak, Precinct 2, 62100 Putrajaya, Malaysia.

June 2023

MySDG Center FOR SOCIAL INCLUSION







1.1 DEFINING THE CARE ECONOMY

- Care economy:
- *"new vision of economics that recognizes the* ***importance of care work****,* ***empowerment*** *and* ***autonomy of women*** *to the function of economies,* ***wellbeing*** *of societies and life* ***sustainability****. Care work consists of two overlapping activities and can be paid or unpaid: 1) direct, personal, and relational care activities, such as feeding a baby or nursing an ill partner; and 2) indirect care activities or domestic work, such as cooking and cleaning."*
- *"…production and consumption of* ***goods and services necessary for the physical, social, mental and emotional well-being of care-dependent groups****, such as children, the elderly, the ill and people with disabilities, as well as* ***healthy, prime working-age adults****. Care-related economic production activities are wide-ranging, including both direct and indirect services and production of goods."*

1.2 VALUE OF CARE ECONOMY

- Estimated value of unpaid care and domestic work in Malaysia – **RM379 billion** to GDP
- Estimated potential market value of care economy – **US$25.5 billion**
- Those involved in care work if enter labor force – around **3.2 million workers**

2. KEY HIGHLIGHTS

- Public-private collaboration
- Increased standard of care services
- Coherent legal frameworks and standardize regulations
- Sustainability in the care sector

KEY HIGHLIGHTS

- Public-private collaborations
  - State and private sector/operators linkages
  - Increase employment opportunities
  - Remunerate and give value to care work
- Increased standard of care services
  - Professionalization of care work
  - Increase quality of care
  - Enhancing of skills and knowledge

KEY HIGHLIGHTS

- Coherent legal frameworks and standardize regulations
  - Reduce red tape
  - Standardization of laws and rules
  - Consistency of processes
  - Formation of a governing national council
- Sustainability in the care sector
  - From grant and subsidy recipients, to empowered communities
  - Building social enterprises in care sector
  - SSE and ILO framework

3. CHALLENGES

1. Accessibility and affordability of care services
2. Imbalance and unequal development
3. Qualified and skilled human capital
4. Coherent and open ecosystem

ACCESSIBILITY AND AFFORDABILITY

- *"…untuk dapat gaji yang minimum tu memang tak boleh lah sebab kita kan sagu hati, kita ikut apa yang diberi oleh kerajaan…Kalau macam sekarang, elaun untuk penyelia adalah 1500, untuk petugas 1200…"*
- *"Nak bergerak macam mana? Kalau daripada segi elaun kalau dia nak suruh kita cari, memang memang kami tak akan mampu. Kalau kita nak bayar sewa pun tak akan mampu…"*
- *"…waris-waris nak bayar macam kita macam mana, sebulan RM35 pun tidak boleh…"*

(*Tasek Gelugor*, 2024)

IMBALANCE AND UNEQUAL DEVELOPMENT

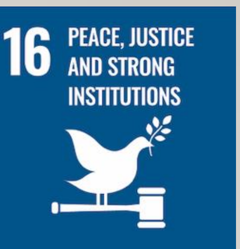
- Disparate levels of development
  - States and Regions
  - Rural and urban
  - Class
  - Generational
  - 10 poorest districts – 1 in Kelantan, 1 in Sarawak, 8 in Sabah
- Unequal level playing – leading to different socio-economic outcomes, and needs

QUALIFIED AND SKILLED HUMAN CAPITAL

- At present, different career and educational trajectories
- The need for appropriate skills and competencies
- The need for formal education and training – social work, care
- The need for a standard assessment process and benchmark
- Low wage scale, lack of social security

COHERENT AND OPEN ECOSYSTEM

- Cohesion in planning and framework, responsive in implementation and local needs
- Interdisciplinary and multidimensional understanding
- Cross ministerial collaborations
- Multistakeholder partnerships – State, society, market, CSOs/NGOs



4. CARE ECONOMY: WAY FORWARD

FRAMEWORK & CONCEPTUAL LEVEL

- Perspective of growth as social growth and development
- Development as human development
- Care economy as driving human and holistic development
- Focusing on dignity and human rights, and not merely GDP and profits – economy serving the people, and not people serving the economy
- Care as a social and public good

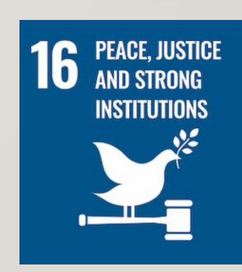
APPROACHES & STRATEGIES

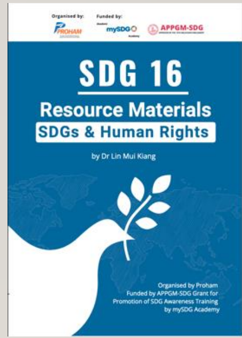
- Decentralization of care services and delivery
- Formulation of a mission-based taskforce/committee (cross ministerial)
- Formulation of methods of financing for vulnerable groups
- Three things: policy landscape, human capital, financing

5. WHAT'S DIFFERENT?

- The idea of development
- Ground work-research-policy nexus

- Institutional readiness and memory
  - "… the overused term 'political will' is a misnomer, the real nexus between politics and institutions is often rooted in the actual options available to those who dominate political settlements in their management of power."





WHAT NEW INSTITUTIONAL ARRANGEMENTS MAY LOOK LIKE?

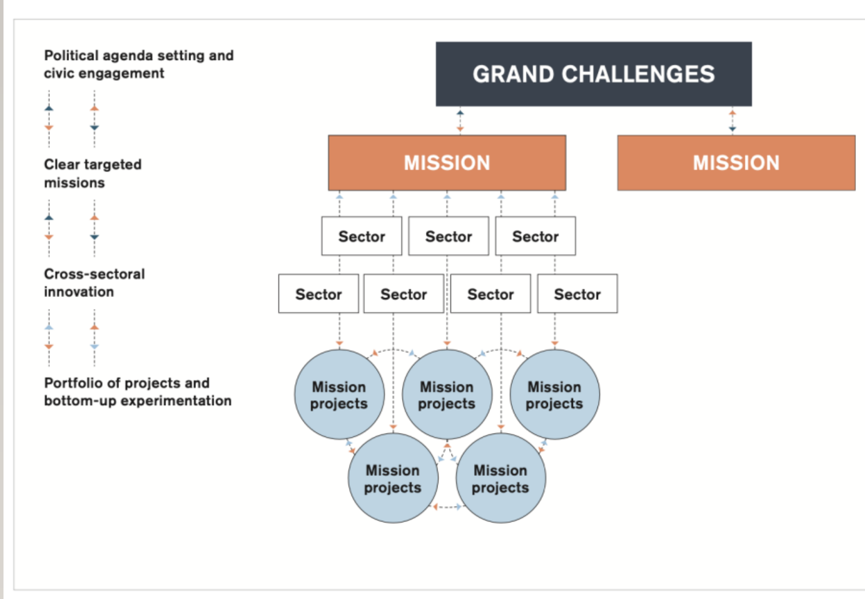


Figure 2: A mission map (Mazzucato 2018; 2019).

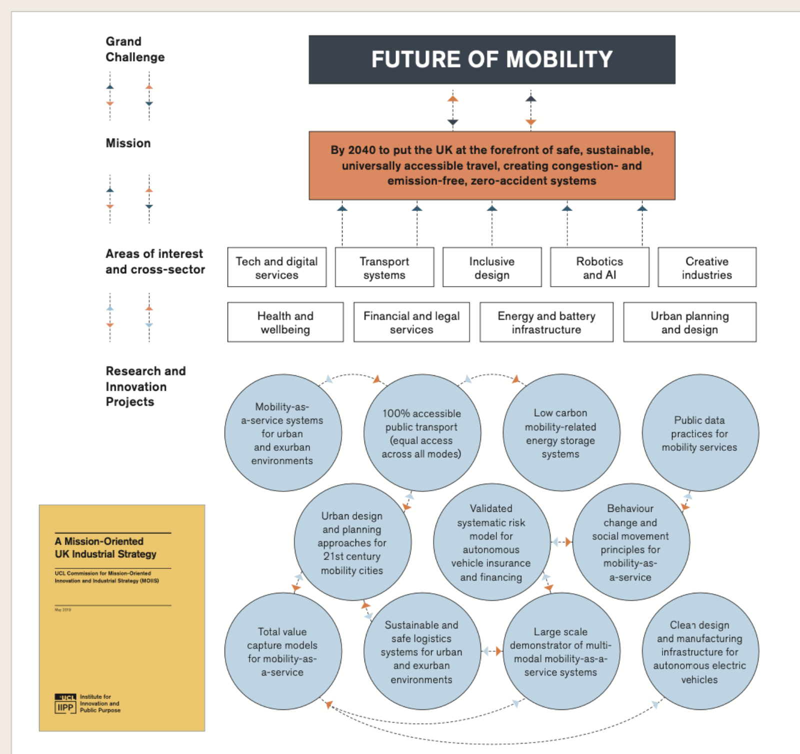


Figure 4: MOIIS mission to ensure the safety, sustainability, and accessibility of the UK mobility system (MOIIS, 2019).

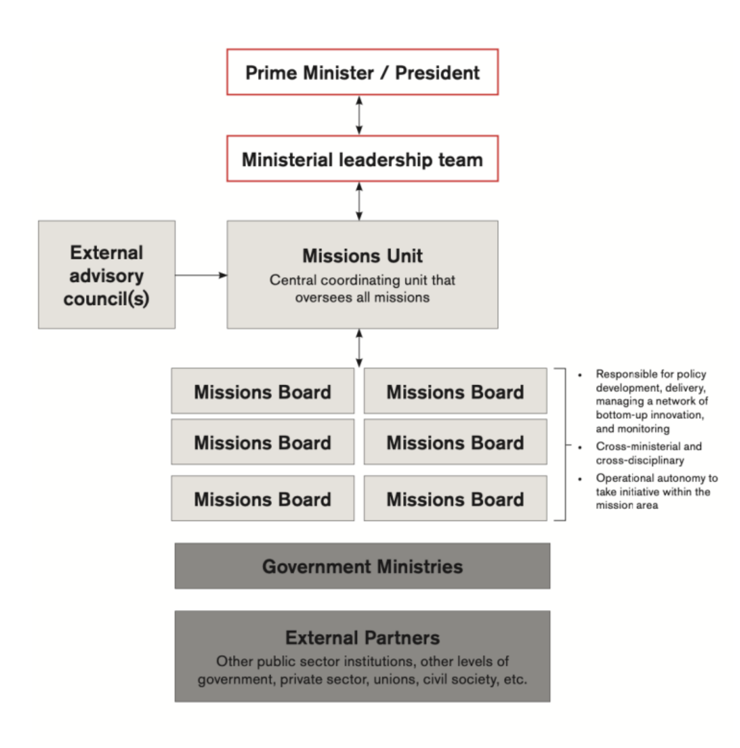


Figure 6: Potential mission governance structure (modified from: MOIIS, 2019; Mazzucato et al., 2024).

APPENDIX

CARE ECONOMY CONFERENCE

Growing the economy and meeting the care needs of the Malaysian society

Date: **24 & 25 September 2024** (Tuesday and Wednesday)

Venue: **ISIS Malaysia, Kuala Lumpur**

The Malaysian government has taken a positive policy approach to recognise the need for the care economy in order to meet the needs of families and communities. It recognises the demographic shift towards an ageing society as well as urbanisation with a shift from rural to urban centres, increasing demands for improved public service delivery.

The government also recognises that most of the burden of care for the elderly, children, persons with disabilities and persons with mental health issues are borne by women in the informal sector. This adversely impacts women, keeping them out of the workforce with low return-to-work rates, resulting in economic loss to the country.

It is also noted that the informal carers require professional training and support beyond domestic tasks. These professional care services are typically offered by social workers, psychologists, therapists (occupational and speech therapists, and physiotherapists), healthcare professionals including nurses and those trained in gerontology, psychiatry, palliative care, as well as early childhood educators and special education needs teachers.

There is a call to recognise the care economy not as a cost centre incurring government expenditure, that largely consists of informal and voluntary sector workers. Rather, its economic value and position in the service sector and potential to create jobs and generate investments must be acknowledged and supported.

On 21 June 2024, ISIS Malaysia launched a policy document entitled, 'Building a cradle-to-grave care economy for Malaysia' and hosted two days of conversations with social care practitioners, researchers, policy makers and academics across four roundtable discussions.

This conference on the care economy will build on these and undertake a comprehensive and in-depth review of all the issues and concerns including the potential and opportunities in growing the care economy as well as improving the quality of care services, from informal arrangements to professional practices.

In order to ensure policy coherence and effective delivery, there is a need for multi stakeholder engagements and partnerships between the public sector (Federal and State governments), voluntary sector (CSOs, NGOs and community-based organisations), professional bodies (social work and mental health) and academic institutions (research, training and think tanks).

Objectives of the Conference:

4. To provide a critical review of all the work undertaken namely policy papers, studies, and reports on the care economy in Malaysia and to chart a policy framework for the promotion of a more professional approach to care services in Malaysia.

5. To chart strategies in shifting from an informal approach of care services to the flourishing of a new economic growth industry fostering investments and job creation.

6. To promote multi stakeholder partnerships and engagements for the social care services and industry in Malaysia especially in clearly defining the roles of the government, private sector, the voluntary and informal sectors.

Outcome of the Conference:

To publish a book on the Care Economy in Malaysia arising from the papers presented at the conference. This book will attempt to provide an in-depth review of the policy themes and practice implications for care services in Malaysia. These findings could feed into the 13th Malaysia Plan (2026-2030), recognising the care economy as a growth sector that meets the care needs across the lifespan of individuals.

PROGRAMME

DAY ONE 24 September 2024, Tuesday

TIME	DETAILS
8:30am – 9:15am	Registration
9:15am – 9:30am	• Opening Address by **Datuk Prof Dr Mohd Faiz Abdullah**, (Chairman, ISIS Malaysia) • Welcoming Remarks by **Prof Datuk Dr Denison Jayasooria**, (Senior Visiting Fellow, ISIS Malaysia)
A. THE CARE ECONOMY AS IT STANDS	
9:30am – 11:00am	**PAPER 1: Policy papers, initiatives, legislations and regulations in Malaysia** Paper Presenter: **Prof Datuk Dr Denison Jayasooria** (Senior Visiting Fellow, ISIS Malaysia) Discussant 1: **Emeritus Prof Datuk Dr Norma Mansor** (Director, Social Wellbeing Research Centre (SWRC), University of Malaya) Discussant 2: **Pn Fatimah Zuraidah Hj Mohd Salleh** (Ketua Penolong Setiausaha, Bahagian Kolaborasi Strategik, Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM)) Moderator: **Harris Zainul** (Deputy Director of Research, ISIS Malaysia)
11:00am – 12:30pm	**PAPER 2: Issues in governance: Federal-state relations, public, private and voluntary sectors, urban-rural divide and lessons from the Global South** Paper Presenters: **Dr Teo Sue Ann and Dr Khairil Ahmad** (Director; Research and Policy Consultant, MySDG Center for Social Inclusion, Society for the Promotion of SDGs) Discussant 1: **Pn Masneh Abd Ghani** (Penyelidik Bersekutu Kanan, Institute for Development Studies (IDS) Sabah) Discussant 2: **Dr Yuen Kok Leong** (Senior Research Officer, Sarawak Development Institute) Moderator: **Harris Zainul** (Deputy Director of Research, ISIS Malaysia)
12:30pm – 2:00pm	**LUNCH BREAK**

B. CARE FOR VULNERABLE GROUPS	
2:00pm – 3:30pm	**PAPER 3: Older persons** Paper Presenters: **Associate Prof Dr Rahimah Ibrahim and Mr Chai Sen Tyng** (Director; Senior Research Officer; Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia) Discussant 1: **Prof Dr Tan Maw Pin** (Professor in Geriatric Medicine, Department of Medicine, Faculty of Medicine, University of Malaya) Discussant 2: **Mr Jeffrey Phang** (Adjunct Professor, UNITAR; Governance Lead, Malaysian CSO-SDG Alliance) Moderator: **Dr Diana Katiman** (EXCO, IKRAM; Palliative Care Physician, Hospital AlSultan Abdullah UiTM)
3:30pm – 5:00pm	**PAPER 4: Persons with disabilities - Program Pemulihan Dalam Komuniti, PPDK** Paper Presenters: **Pn Sapura Arshad*** (Penyelia, PPDK Sungai Buloh), **En Haji Mohd Fouzi Haji Mohd Isa*** (Pengerusi, PPDK Kuala Klawang) and **Ms Lydia Ann Anak Bill** (Policy and Research Officer, APPGM-SDG) Discussant 1: **Pn Emilia Syatirah Derahim** (Ketua Penolong Pengarah, Jabatan Pembangunan Orang Kurang Upaya (JPOKU), Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (KPWKM)) Discussant 2: **Dato’ Ghazali Yusoff** (Former National Chairman, PDK Kebangsaan) Moderator: **Dr Diana Katiman** (EXCO, IKRAM; Palliative Care Physician, Hospital AlSultan Abdullah UiTM) **slides presentation only*

Note: *The above paper titles are indicative of the focus area, the final paper title may vary.*

DAY TWO 25 September 2024, Wednesday

TIME	DETAILS
8:30am – 9:15am	Registration
9:15am – 9:30am	Welcoming Remarks by Prof Datuk Dr Denison Jayasooria, Senior Visiting Fellow, ISIS Malaysia
B. CARE FOR VULNERABLE GROUPS (continued)	
9:30am – 11:00am	**PAPER 5: Children in need** Paper Presenters: **Pn Anisa Ahmad** (Chief Strategy Officer, House of Wisdom PLT) and **Ms Debbie Ann Loh** (Head of Secretariat Officer, APPGM-SDG) Discussant 1: **Datin Wong Poai Hong** (Executive Director, Childline Foundation) Discussant 2: **Assoc Prof Dr Mazlina Che Mustafa** (Director, National Child Development Research Centre (NCDRC), Universiti Pendidikan Sultan Idris (UPSI)) Moderator: **Ms Yvonne Tan** (Senior Researcher, ISIS Malaysia)
11:00am – 12:30pm	**PAPER 6: People with mental health concerns** Paper Presenter: **Prof Dato' Dr Andrew M Chandrasekaran** (President, Malaysian Mental Health Association) Discussant 1: **Ms Laura Kho** (Board Member, Mental Health Association of Sarawak) Discussant 2: **Ms Nurul Syahirah Abd Aziz** (Developmental Psychologist; Member, Persatuan Psikologi Malaysia (PSIMA)) Moderator: **Ms Yvonne Tan** (Senior Researcher, ISIS Malaysia)
12:30pm – 2:00pm	**LUNCH BREAK**
C. CARE WORKFORCE	
2:00pm – 3:30pm	**PAPER 7: Professional standards and trainings for the social care industry** Paper Presenter: **Dr Teoh Ai Hua** (President, Malaysian Association of Social Workers (MASW); Senior Lecturer, School of Applied Psychology, Social Work and Policy, Universiti Utara Malaysia (UUM))

	Discussant 1: **Ir. Ts. Dr. Azmi bin Ahmad** (Deputy Director General, Skills Development Division, Ministry of Human Resources) Discussant 2: **Prof Dato' Dr Rashila Ramli** (Principal Visiting Fellow, United Nations University International Institute for Global Health (UNU-IIGH)) Moderator: **En Rashidi Yahaya** (Group CEO, SETERRA Group of Companies; Chairman, KENDANA Malaysia)
D. LOOKING AHEAD	
3:30pm – 5:00pm	**PAPER 8: Care economy as a growth sector** Paper Presenter: **Dr Teo Lee Ken** (Assistant Director, MySDG Center for Social Inclusion, Society for the Promotion of SDGs) Discussant 1: **Ms Shakira Teh Sharifuddin** (Senior Economist, Social Protection and Labor, World Bank Inclusive Growth and Sustainable Finance Hub) Discussant 2: **Pn Hawati Abdul Hamid** (Director of Research, Khazanah Research Institute) Moderator: **En Rashidi Yahaya** (Group CEO, SETERRA Group of Companies; Chairman, KENDANA Malaysia)
5:00pm – 5:15pm	Concluding Reflections by **Prof Datuk Dr Denison Jayasooria** (Senior Visiting Fellow, ISIS Malaysia)

Note: *The above paper titles are indicative of the focus area, the final paper title may vary.*

GUIDELINES FOR ROLE PLAYERS

I. Paper Writers

While these papers are presented at the Care Economy Conference in 2024, all paper writers must be mindful that these papers are for publication as **chapters** in a new book to be launched **by January 2025**.

Important author guidelines for Chapters:

- Between 5,000 and 6,000 words, in English
- Please follow ISIS house style
- Use APA referencing style
- Include literature review, emerging themes, traditional / cultural roles and aspects, gender dimension and specific policy recommendations.

Kindly review the 6 key reports and findings on the Care Economy below - make references and address gaps identified:

1. ISIS Malaysia Policy Paper: Building a cradle-to-grave care economy for Malaysia. https://www.isis.org.my/2024/06/12/building-a-cradle-to-grave-care-economy-for-malaysia/

2. The Asia Foundation Report: Care economy dialogue. Towards a resilient and sustainable care economy in Malaysia. https://asiafoundation.org/wp-content/uploads/2023/06/Care-Economy-Dialogue-Toward-a-Resilient-and-Sustainable-Care-Economy-in-Malaysia.pdf

3. Khazanah Research Institute: Time to Care: Gender Inequality, Unpaid Care Work and Time Use Survey. https://www.krinstitute.org/assets/contentMS/img/template/editor/Publications_Time%20to%20Care_Chapter%201.pdf

4. UNDP Policy Paper: Investing in the Care Economy: Opportunities for Malaysia. https://www.undp.org/sites/g/files/zskgke326/files/2023-06/issue_brief_care_economy_investment.pdf

5. Asia-Pacific Care Economy Forum. https://asiapacific.unwomen.org/sites/default/files/2023-07/highlights-and-recommendations-for-practitioners-asia-pacific-care-economy-forum-en.pdf

6. Roundtable Discussion – Conversations on Care Economy in Malaysia Compilation Report, 26 – 27 June 2024. https://drive.google.com/drive/folders/1PMYdoEy8FaeGwQxUDsu0K5BIgqtDBGSk?usp=sharing (includes rapporteurs' notes and speakers' slides / papers)

- Chapter Writers for **Part B: Care for Vulnerable Groups** ie. Papers 3 – 6 on Persons with disabilities, Older persons, Children in need and People with mental health concerns, please include the following in your respective chapters:
    - Introduction to your target group
    - Their needs and challenges
    - Types of services required
    - Financing
    - The role and/or involvement of the public, private and voluntary sector
    - Diversity observed among the states (Peninsular Malaysia including East Coast, Sabah and Sarawak) in terms of care needs or services
    - Include a box to spotlight the B40 group in your vulnerable group of focus

Papers must be submitted to the Secretariat via Ms Debbie Loh (debbie@appgm-sdg.com) as follows:

- First draft: **by 17 September 2024, Tuesday** (for discussants to review and for circulation prior to the Conference)

- Final draft: **by 15 October 2024, Tuesday** (incorporating feedback from discussants, copy for editing)

Paper writers are to take note of the following for their presentation:

- Allocated 30 minutes to present

- Kindly submit your presentation slides to the Secretariat via Ms Debbie Loh (debbie@appgm-sdg.com) **by 23 September 2024, Monday.**

II. Discussants

The papers will be reviewed by two discussants at the Care Economy Conference and paper writers are to take note of the comments and pointers to strengthen the paper.

Discussants are to take note of the following:

- Each discussant is given 15 minutes to share their comments during the Conference (slides not necessary)
- Their roles are to:
    - focus on reviewing the paper and not address the topic independently.
    - highlight any additional points or references that need to be added.
    - comment on the content and analysis. It is a critical review with a view of strengthening the paper.
- Submit the corrections and comments on the paper to the Secretariat via Ms Debbie Loh (debbie@appgm-sdg.com) **by 26 September 2024, Thursday.**

III. Moderators

Their roles are to:

- Introduce the topic, the paper presenter(s), and the discussants.
- Ensure that everyone keeps to time.
- Kindly note the flow of the presentation slots are as follows:

5 mins:	Introduction
30 mins:	Paper Presentation
15 mins:	Discussant 1
15 mins:	Discussant 2
15 mins:	Q&A
10 mins:	Session ends; group photo and transition to next session

- Ensure that the participants introduce themselves - name, organisation and state their question or comment.

LIST OF INVITED CONTRIBUTORS

(in order of paper / book chapter writers)

Prof Datuk Dr Denison Jayasooria is Senior Visiting Fellow at ISIS Malaysia. He is also the Head of Secretariat at the All-Party Parliamentary Group Malaysia on Sustainable Development Goals (APPGM-SDG). Datuk Denison is also President of the Society for the Promotion of SDGs (PPMPL) and an Honorary Professor at the Institute of Ethnic Studies (KITA), at the National University of Malaysia (UKM). Datuk Denison holds a PhD in Sociology from Oxford Brookes University, United Kingdom.

Dr Teo Sue Ann is Director, MySDG Center for Social Inclusion, Society for the Promotion of SDGs. She graduated from Victoria University of Wellington with a PhD in Religion / Religious Studies.

Dr Khairil Ahmad is Research and Policy Consultant with the MySDG Center for Social Inclusion, Society for the Promotion of SDGs. He holds a PhD in Political Theory from University of Essex, UK.

Ms Lydia Ann Anak Bill is Policy and Research Officer at APPGM-SDG. She graduated from University of Malaya with a Masters of Development Studies, Development Economics and International Development.

Mr Chai Sen Tyng is Senior Research Officer at the Malaysian Research Institute on Ageing (MyAgeing) at Universiti Putra Malaysia. He is a key opinion leader in social gerontology and has been featured on radio and TV interviews. Mr Chai holds a BSc in Human Development from UPM.

Dr Rahimah Ibrahim is Associate Professor and Director at MyAgeing, UPM. Her extensive experience in care-related research projects ranges from psychosocial dementia care to comparative studies on care relations among Asian countries. Dr Rahimah has also lent her expertise to the revision of two major national action plans on ageing in Malaysia, administered by the Ministry of Women, Family and Community Development and the Ministry of Health. A much sought-after key opinion leader, Dr Rahimah holds a PhD specialising in Gerontology and Human Services from Queensland University of Technology, Australia.

Pn Anisa Ahmad is Chief Strategy Officer (CSO) at House of Wisdom PLT, an early childhood care and education (ECCE) consultancy that provides training and event management, ranging from ECCE continuous professional development, EECE management and centre operations to child rights and protection. Pn Anisa holds a Bachelors (Hons) in Early Childhood Education and has 20 years of experience in ECCE. She served as the Past President of the Association of Malaysian Registered Early Childhood Care and Development (Persatuan Pengasuhan dan Perkembangan Awal Kanak-Kanak Berdaftar Malaysia, PPBM). A committed and passionate advocate for ECCE, Pn Anisa has been featured in the media including BFM 89.9, Bernama and The Sun.

Ms Debbie Ann Loh is Head of Secretariat Officer at APPGM-SDG. She graduated with a MSc in International Public Health from Liverpool John Moores University, UK. She also holds a Masters in Medical Science from University of Malaya.

Prof Dato' Dr Andrew M Chandrasekaran is President of the Malaysian Mental Health Association. He holds several notable positions including Board Member, World Federation for Mental Health; Member, Mental Health Promotion Advisory Council to the Minister of Health, Malaysia; and Consultant – Mental Health & Substance Abuse, World Health Organization (Western Pacific Regional Office). Dr Andrew holds a MBBS (Calicut), MPM (Malaya), Fellowship in Community Psychiatry (Melbourne), AM (Malaysia) and IARCPsych (UK).

Dr Teoh Ai Hua is Senior Lecturer at the School of Applied Psychology, Social Work, and Policy, Universiti Utara Malaysia (UUM). He also serves as the President of the Malaysian Association of Social Workers (MASW) and Vice-President of the National Council on Welfare and Social Development Malaysia (MAKPEM). Dr Teoh holds a PhD in Social Work (UUM), an MA in Social Work Studies from the University of Kent at Canterbury and a Bachelor's in Public Administration from UUM.

Dr Teo Lee Ken is Assistant Director, MySDG Center for Social Inclusion, Society for the Promotion of SDGs. He holds a PhD in Malay Studies (Political History) and a Masters of Laws – LLM, Asian Legal Studies from the National University of Singapore.

Growing the economy and meeting the care needs of the Malaysian society

24-25 September 2024 | ISIS Malaysia

ATTENDANCE

Role Players					
No.	**Salutation**	**First name**	**Last name**	**Designation**	**Organisation**
24 September 2024 – Session 1: Policy papers, initiatives, legislations and regulations in Malaysia					
1	Prof Datuk Dr	Denison	Jayasooria	Senior Visiting Fellow	ISIS Malaysia
2	Prof Datuk Dr	Norma	Mansor	Director, Social Wellbeing Research Centre (SWRC)	University of Malaya
3	Pn	Fatimah Zuraidah	Hj Mohd Salleh	Principal Assistant Secretary (Strategic Collaboration Division)	Ministry of Women, Family & Community Development (KPWKM)
4	Mr	Harris	Zainul	Deputy Director (Research)	ISIS Malaysia
24 September 2024 – Session 2: Issues in governance: Federal-state relations, public, private and voluntary sectors, urban-rural divide and lessons from the Global South					
1	Dr	Sue Ann	Teo	Director, MySDG Centre for Social Inclusion	Society for the Promotion of SDGs
2	Dr	Khairil	Ahmad	Research and Policy Consultant, MySDG Centre for Social Inclusion	Society for the Promotion of SDGs
3	Pn	Masneh	Abd Ghani	Penyelidik Bersekutu Kanan	Institute for Development Studies Sabah
4	Dr	Kok Leong	Yuen	Senior Research Officer	Sarawak Development Institute
5	Mr	Harris	Zainul	Deputy Director (Research)	ISIS Malaysia
24 September 2024 – Session 3: Older Persons					
1	Assoc Prof Dr	Rahimah	Ibrahim	Director	Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia
2	Mr	Sen Tyng	Chai	Senior Research Officer	Malaysian Research Institute on Ageing (MyAgeing), Universiti Putra Malaysia
3	Prof Dr	Maw Pin	Tan	Professor in Geriatric Medicine, Department of Medicine, Faculty of Medicine	University of Malaya
4	Mr	Jeffrey	Phang	Adjunct Professor; Governance Lead	UNITAR; Malaysian CSO-SDG Alliance
5	Dr	Diana	Katiman	EXCO, IKRAM; Palliative Care Physician, Hospital Al- Sultan Abdullah UiTM	Pertubuhan IKRAM Malaysia
24 September 2024 – Session 4: Persons with disabilities - Program Pemulihan Dalam Komuniti (PDK)					
1	Pn	Sapura	Arshad	Penyelia	PPDK Sungai Buloh, Selangor
2	En	Haji Mohd Fouzi	Haji Mohd Isa	Pengerusi	PPDK Kuala Klawang, Jelebu
3	Ms	Lydia Ann	Bill	Policy and Research Officer	APPGM-SDG
4	Pn	Emilia Syatirah	Derahim	Principal Assistant Director, Jabatan Pembangunan Orang Kurang Upaya (JPOKU)	Ministry of Women, Family & Community Development (KPWKM)
5	Dato'	Ghazali	Yusoff	Former National Chairman	PDK Kebangsaan
6	Dr	Diana	Katiman	EXCO, IKRAM; Palliative Care Physician, Hospital Al- Sultan Abdullah UiTM	Pertubuhan IKRAM Malaysia
25 September 2024 – Session 5: Children in Need					
1	Pn	Anisa	Ahmad	Chief Strategy Officer	House of Wisdom PLT
2	Ms	Debbie Ann	Loh	Head of Secretariat Officer	APPGM-SDG
3	Datin	Poai Hong	Wong	Executive Director	Childline Foundation
4	Assoc Prof Dr	Mazlina	Che Mustafa	Director, National Child Development Research Centre (NCDRC)	Universiti Pendidikan Sultan Idris (UPSI)
5	Ms	Yvonne	Tan	Senior Researcher	ISIS Malaysia
25 September 2024 – Session 6: People with mental health concerns					
1	Prof Dato' Dr	Andrew M	Chandrasekaran	President	Malaysian Mental Health Association (MMHA) **with apologies*
2	Ms	Laura, Sui San	Kho	Board Member	Mental Health Association of Sarawak (MHAS)
3	Ms	Nurul Syahirah	Abd Aziz	Developmental Psychologist; Member	Persatuan Psikologi Malaysia (PSIMA)

4	Ms	Yvonne	Tan	Senior Researcher	ISIS Malaysia
25 September 2024 – Session 7: Professional standards and training for the social care industry					
1	Dr	Teoh	Ai Hua	President; Senior Lecturer, School of Applied Psychology, Social Work and Policy	Malaysian Association of Social Workers (MASW); Universiti Utara Malaysia
2	Ir. Ts. Dr	Azmi	Ahmad	Deputy Director General, Skills Development Division (JPK)	Ministry of Human Resources
3	Prof Dato' Dr	Rashila	Ramli	Principal Visiting Fellow	United Nations University International Institute for Global Health (UNU-IIGH)
4	En	Rashidi	Yahaya	Group CEO; Chairman	SETERRA Group of Companies; Kendana Malaysia
25 September 2024 – Session 8: Care economy as a growth sector					
1	Dr	Lee Ken	Teo	Assistant Director, MySDG Centre for Social Inclusion	Society for the Promotion of SDGs
2	Ms	Shakira Teh	Sharifuddin	Senior Economist, Social Protection and Labor	World Bank Inclusive Growth and Sustainable Finance Hub
3	Pn	Hawati	Abdul Hamid	Director of Research	Khazanah Research Institute
4	En	Rashidi	Yahaya	Group CEO; Chairman	SETERRA Group of Companies; Kendana Malaysia

Participants					
No.	**Salutation**	**First name**	**Last name**	**Designation**	**Organisation**
1	Ms	Alicia	Lee	Senior Research Officer	Women's Aid Organisation
2	Mrs	Amy	Bala	Honorary Secretary	Malaysian Association of Social Workers (MASW)
3	Mr	Anthony	Tan	Senior Director	APPGM-SDG
4	Dato'	Hatijah	Ayob	Founder and President	Malaysia Rare Disorders Society
5	Mr	James	Raj	Director	APPGM-SDG
6	Ms	Jayamalar	Samuel	Capacity Building Director	AWAM
7	Mr	Joshua, Hung Jian	Hor	Director	Malaysian Care
8	Mr	Josiah	Jayasooria	Photographer	APPGM-SDG
9	Ms	Laila Nasuha binti	Mohd Jalil	Programme Officer	Malaysian Association of Social Workers (MASW)
10	Datuk Hajah	Mastika Junaidah	Husin	Yang DiPertua	Majlis Pusat Kebajikan Semalaysia (MPKSM)
11	Dr	Maznah	Ahmad	Committee Member	Pertubuhan IKRAM Malaysia
12	Mr	Muhammad Fahimuddin Azim	Mohd Fouzi	Student	Universiti Kebangsaan Malaysia (UKM)
13	Dr	Mui Kiang	Lin	Deputy President	APPGM-SDG
14	Hajah	Nornisa	Sahid	Coordinator	Toy Library
15	Ms	Nur Alya Sarah	Abdul Hamid	Policy Research Intern	Khazanah Research Institute
16	Dr	Nur Liyana	Ismail	Principal Assistant Director	Ministry of Health
17	Ms	Puteri Marjan	Megat Muzafar	Research Associate	Khazanah Research Institute
18	Ms	Nur Shafira	Husain	Intern	APPGM-SDG
19	Dr	Olivia, Swee Leng	Tan	Director, Technology Transfer Office	Multimedia University (MMU)
20	Mrs	Omna	Sreeni-Ong	Consultant	ENGENDER
21	Tuan Haji	Othman	Mawi	Penyelaras KBDR Kebangsaan	Majlis Pusat Kebajikan SeMalaysia
22	Mr	Paniirselvam	Jayaraman	Director	APPGM-SDG
23	Ms	Rebecca	Ang	Leader, Policy, Advocacy and Research	Malaysian Care
24	Mrs	Rusminah	Sukim	Head of Academic	Pusat Latihan Angsana Connect
25	Ms	Salbiah	Hussein	Principal Assistant Director, Skills Development Division (JPK)	Ministry of Human Resources
26	Dr	Suryani	Mohamad Suhane	Principal Assistant Director	Ministry of Health
27	Ms	Wan Asiah Nurjannah binti	Wan Ahmad Tajuddin	Policy Officer	APPGM-SDG
28	Ms	Wardatun Adawiah	Roslee	Assistant Secretary, Policy Unit (OKU)	Ministry of Women, Family & Community Development (KPWKM)

Secretariat					
1	Ms	Afiqah	Abdul Malik	Head of Secretariat Officer	APPGM-SDG
2	Mr	Ali	Yarmamat	System Administrator	ISIS Malaysia
3	Mr	Arif Azhad	Ghaffar	Digital Marketing & Communications Officer / Photographer	APPGM-SDG
4	Ms	Atikah	Ishak	Senior Manager, Public Affairs & Events	ISIS Malaysia
5	Ms	Dana	Dumpangol	Rapporteur	APPGM-SDG
6	Ms	Deda	Ridzwani	Director, Public Affairs & Events	ISIS Malaysia
7	Ms	Elise	Tai	Event Executive, Public Affairs & Events	ISIS Malaysia
8	Mr	Farhan	Khairulannuar	Rapporteur	ISIS Malaysia
9	Mr	Jefri	Hambali	Event Assistant & Photographer, Public Affairs & Events	ISIS Malaysia
10	Ms	Hirzawati Atikah	Mohd Tahir	Rapporteur	APPGM-SDG
11	Ms	Nani	Aris	Event Executive, Public Affairs & Events	ISIS Malaysia
12	Mr	Syahir	Adnan	Web Administrator	ISIS Malaysia

Presenters: 12 (excludes 1 with apologies)
Discussants: 16
Moderators: 4
Participants: 28
Secretariat: 12
Total: **72 persons**