International Labour Organization

Assessment of the care cooperative and social and solidarity economy (SSE) ecosystem in Sri Lanka

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Foreword

Sri Lanka is at an important moment in the evolution of its care economy. Rapid demographic changes, increasing migration, changing family structures, and persistent gender inequalities are reshaping the ways in which care is provided, accessed, and valued. Across the country, women continue to shoulder the overwhelming burden of unpaid care work, while paid care workers often remain in informal, undervalued, and poorly protected forms of employment. At the same time, the demand for accessible, affordable, and quality childcare, eldercare, and care for persons with disabilities continues to grow. These realities call for innovative, inclusive, and sustainable approaches to care that place people, dignity, and decent work at the centre.

The International Labour Organization (ILO) recognizes the care economy as both a social imperative and an important driver of inclusive economic development. Access to paid care services, allows for women to participate in productive work and help increase their labour force participation. Investing in care has the potential not only to improve well-being and social protection outcomes, but also to generate significant employment opportunities, particularly for women, who are in traditional care giving role and often work as unpaid, undervalued care workers. Recognizing their role in provision of care services, and enabling their rights as care workers can help support more equitable and resilient societies.

In this regard, Social and Solidarity Economy (SSE) entities, including cooperatives, mutual organizations, worker collectives, and community-based enterprises, offer promising pathways for organizing care services in ways that are community-responsive, democratic, and rooted in principles of solidarity and decent work. Sri Lanka already possesses a strong foundation for such approaches through its long-standing cooperative movement and vibrant community-based organizations. Building on this foundation, the ILO has been working closely with national stakeholders, including the Department of Cooperatives and workers' and employers' organizations, to explore the role of care cooperatives and other SSE models in strengthening the country's care ecosystem. The recent development of model by-laws for care cooperatives and the growing national dialogue around care provision represent important milestones in this journey.

This report is the first comprehensive situational assessment examining the potential for SSE entities and cooperatives to contribute to care provision in Sri Lanka. It provides valuable insights into the existing care landscape, institutional and regulatory frameworks, workforce dynamics, and opportunities and challenges for developing community-based care models that align with the principles of decent work, gender equality, and social justice. Importantly, the report demonstrates that SSE-based care models can contribute not only to expanding access to care services, but also to formalizing care work, improving labour protections, strengthening community participation, and advancing inclusive local development.

The findings and recommendations presented in this report offer an important foundation for future policy dialogue, institutional collaboration, and practical action. They also reinforce the importance of integrated approaches that connect care provision with labour rights, skills development, social protection, and cooperative development. The ILO remains committed to supporting the Government of Sri Lanka and national stakeholders in advancing a care economy that is inclusive, rights-based, and sustainable. I hope this report will serve as a useful resource for policymakers, practitioners, cooperatives, workers' organizations, development partners, and all those committed to strengthening Sri Lanka's care ecosystem through solidarity-based and people-centred approaches.

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Abbreviations

5R Framework	-	Recognize, Reduce, Redistribute, Reward, and Represent (ILO framework for care and decent work)
C189	-	ILO Convention concerning Decent Work for Domestic Workers (Convention No. 189)
CBO	-	Community-Based Organization
CEDAW	-	Convention on the Elimination of All Forms of Discrimination Against Women
CEPA	-	Centre for Poverty Analysis
CMC	-	Colombo Municipal Council
Coop. Dept.	-	Department of Cooperative Development
DCS	-	Department of Census and Statistics (Sri Lanka)
DSS	-	Department of Social Services (Sri Lanka)
ECCD	-	Early Childhood Care and Development
EPF	-	Employees' Provident Fund
ETF	-	Employees' Trust Fund
FGD	-	Focus Group Discussion
GDP	-	Gross Domestic Product
GOSL	-	Government of Sri Lanka
GN	-	Grama Niladhari (village-level administrative division)
ILO	-	International Labour Organization
KII	-	Key Informant Interview
LKR	-	Sri Lankan Rupee
NICD	-	National Institute of Cooperative Development
NGO	-	Non-Governmental Organization
NCPA	-	National Child Protection Authority
NCP	-	National Cooperative Policy
NSE	-	National Secretariat for Elders
NVQ	-	National Vocational Qualification
OSH	-	Occupational Safety and Health
PDSS	-	Provincial Department of Social Services
PHDT	-	Plantation Human Development Trust
PHI	-	Public Health Inspector

RPC	-	Regional Plantation Companies
RPL	-	Recognition of Prior Learning
SDG	-	Sustainable Development Goal
SEWA	-	Self-Employed Women's Association (India)
SHG	-	Self-Help Group
SLBFE	-	Sri Lanka Bureau of Foreign Employment
SME	-	Small and Medium-sized Enterprise
SSE	-	Social and Solidarity Economy
SUWASETHA	-	A pilot initiative by the health department thrift and credit coop society to empower cooperatives to provide care services
SWOT	-	Strengths, Weaknesses, Opportunities, and Threats
TVEC	-	Tertiary and Vocational Education Commission
TVET	-	Technical and Vocational Education and Training
UNICEF	-	United Nations Children's Fund
USD	-	United States Dollar

1. Introduction

Currently the majority of care provision in Sri Lanka remains unpaid and is primarily undertaken by women, which constrains their participation in the labour force and perpetuates gender inequalities. Paid care work, where it exists, is often informal, underpaid, and care workers have no access to decent work and are excluded from social protection. Formal long-term care and community-based services remain scarce, particularly outside major cities, leaving significant gaps in provision of care services for a vast majority of the Sri Lankan population. While childcare facilities, primarily as day care facilities, are available across the island, institutional care for elders and people with disabilities, both for short term and long-term care, do not meet the current demand. As a result, the bulk of care is provided through unpaid family members, mostly by women. Within such a context, this study aims to assess Social and Solidarity Economic (SSE) entities (including cooperatives) potential as a viable and inclusive model for care provision - one that aligns with both national priorities and global commitments to decent work, gender equality, and social justice- in proving care.

As per the International Labour Organization's (ILOs) Resolution on Decent Work and the Social and Solidarity Economy (SSE), the SSE encompasses "The SSE encompasses enterprises, organizations and other entities that are engaged in economic, social, and environmental activities to serve the collective and/or general interest, which are based on the principles of voluntary cooperation and mutual aid, democratic and/or participatory governance, autonomy and independence, and the primacy of people and social purpose over capital in the distribution and use of surpluses and/or profits as well as assets. SSE entities aspire to long-term viability and sustainability, and to the transition from the informal to the formal economy and operate in all sectors of the economy. They put into practice a set of values which are intrinsic to their functioning and consistent with care for people and planet, equality and fairness, interdependence, self-governance, transparency and accountability, and the attainment of decent work and livelihoods. According to national circumstances, the SSE includes cooperatives, associations, mutual societies, foundations, social enterprises, self-help groups and other entities operating in accordance with the values and principles of the SSE. (ILC.110/ Resolution II, adopted on 10 June 2022). . SSE entities operate within a values-based framework emphasizing care for people and the planet, equality and social justice, interdependence, transparency, and self-governance. These values distinguish SSE entities from conventional market enterprises and position them as mechanisms capable of balancing economic viability with social inclusion and environmental sustainability.

The SSE presents a compelling alternative framework for organizing and financing care provision, particularly in contexts where public systems remain under-resourced and private markets exclude large segments of the population. Rooted in principles of collective ownership, mutual support, and democratic governance, SSE

entities such as cooperatives, mutuals, and community enterprises can bridge the persistent gap between rising care needs and limited state capacity. Unlike for-profit providers that prioritize entities market returns, SSE entities are mission-driven and reinvest surpluses into service quality, workforce conditions, and affordability. The ILO recognizes SSE as a key mechanism for generating decent work in care, while ensuring that services remain accessible and responsive to community needs. By aligning care provision with social objectives rather than profit motives, SSE models advance both the "care" and "work" dimensions of the ILO's Decent Work Agenda.

Globally, SSE entities have demonstrated significant potential in the organization and provision of care services, often characterized by informality, undervaluation, and gender inequality. By combining collective ownership with social objectives, SSE-based care models such as cooperatives, mutuals, and social enterprises have created innovative pathways for improving accessibility, affordability, and quality of care. Country experiences illustrate this potential: in Italy, 4,452 social cooperatives employ more than 170,617 workers in social and care services, with strong community participation and gender inclusion (European Commission 2016); in Uruguay, domestic workers' unions and cooperatives have jointly influenced national care policies (Goldsmith 2012); and in Japan, the "Fureai Kippu" time-banking cooperative model has enabled intergenerational caregiving rooted in community solidarity (Marcus 2025). Trade unions have historically utilized the cooperative model to safeguard workers' rights and welfare while providing essential services. In South Asia, in India, the Self-Employed Women's Association (SEWA) exemplifies this approach, supporting approximately 1.8 million women engaged in the informal economy (International Labour Office 2022). These examples reveal that when care is organized through SSE principles, democratic participation, shared responsibility, and local ownership services become more equitable, sustainable, and aligned with the ILO's Decent Work Agenda.

The ILO's 5R Framework–to recognise, reduce, redistribute unpaid care work, and to reward and represent paid care workers-offers a structured lens to understand how SSE and cooperative models advance decent work within the care economy. SSE entities help recognize care work by formalizing and valuing it through collective organization; reduce unpaid care burdens by providing affordable, accessible services; redistribute responsibilities between families, communities, and the state; reward care workers through fair pay, safe working conditions, and social protection; and represent their voices through democratic governance. In this way, SSE entities and cooperatives embody the multidimensional approach required to address both the demand for quality care and the rights and well-being of care workers.

In Sri Lanka, the ILO has been a longstanding partner in promoting cooperative development and, more recently, in extending these models to the care economy. The country has over 16,000 registered cooperatives with around 8 million members, of whom 65 percent are women—reflecting an established institutional and social foundation for solidarity-based enterprises (International Cooperative Alliance 2020). In 2025, the ILO, in collaboration with the Department of

Cooperatives, launched a process of setting up care cooperatives in Sri Lanka and organized a series of national level dialogues and engagement with stakeholders. Through these dialogues and initiatives, currently the process of establishing care cooperatives is underway. ILO also worked with the Department of Cooperatives to develop and launch model by-laws for care cooperatives, and developing a broad road map of action in promoting care cooperatives in Sri Lanka, marking an important milestone in formalizing care services through cooperative structures. This initiative responds directly to Sri Lanka's demographic and economic realities: a rapidly aging population, the erosion of traditional family support systems, rising youth migration, and limited access to affordable formal care services, and care responsibilities preventing women to join the productive and full-time labour market.

Recognizing the high potential of SSE entities and cooperatives in addressing systemic gaps in care economy and considering the ILO's renewed engagement with Sri Lanka's care economy, there is a pressing need to assess the current landscape, capacities, legal and policy framework, stakeholders, and opportunities for setting up and scaling such care cooperative/ SSE models. To date, no comprehensive situational analysis has been conducted to evaluate the feasibility and potential of SSE-based or cooperative approaches to care in Sri Lanka. Undertaking such an analysis is thus essential to inform policy and practice, identify institutional and financial enablers, and explore how solidarity-based models can contribute to decent work and equitable access to care.

1.1 Objectives and Methods

The overall objective of this study is to produce a comprehensive assessment of the potential for care service provision through Social and Solidarity Economy (SSE) entities, including care cooperatives, in Sri Lanka. The study aims to examine how SSE mechanisms can strengthen the care economy by improving access to affordable and quality care services while promoting decent work opportunities within the sector.

Specific Objectives

1. To review and analyse global and national literature, policies, and international best practices related to SSE entities and care cooperatives, identifying lessons that can inform the Sri Lankan context.

2. To identify and map the existence, distribution, and types of care services currently provided by SSE entities and cooperatives in Sri Lanka, including childcare, eldercare, and care for persons with disabilities and to identify key stakeholders within the care ecosystem.

3. To analyse existing organized care worker entities providing care and to explore the potential for unorganized care workers to form cooperatives or other SSE entities.

4. To explore challenges and enabling factors affecting the formation, sustainability, and expansion of care cooperatives and other SSE entities in Sri Lanka.

5. To assess the legal, policy, and regulatory frameworks governing the formation, registration, and operation

of SSE entities and cooperatives engaged in care provision, including their compliance with relevant national standards and institutional requirements.

6. To validate and refine the assessment findings through stakeholder consultations, ensuring that recommendations for strengthening existing entities or establishing new cooperatives are practical, inclusive, and responsive to local realities.

Methods

To meet the above-mentioned objectives, this study adopted a mixed-method approach, combining a comprehensive desk review with qualitative field-based analysis to assess the potential for care service provision through Social and Solidarity Economy (SSE) entities including cooperatives in Sri Lanka. The desk review examined global and regional literature, policy frameworks, and international best practices on SSE and care cooperatives to contextualize their success in care provision. At the national level, the review drew upon available secondary data from the Department of Census and Statistics, provincial Cooperative Department offices, and Divisional Secretariat offices to map the existing landscape of SSE entities including care cooperatives. The findings from this phase informed an assessment of identifying enabling factors affecting the formation, sustainability, and expansion of SSE entities for care provision and the challenges, opportunities, and gaps in Sri Lanka's current care ecosystem, particularly in relation to the potential role of SSE entities in addressing care deficits while promoting decent work.

Building on the desk review, primary qualitative data were collected through stakeholder mapping and consultations with key actors across the care and cooperative ecosystems with data collected through Key Informant Interviews (KIIs), In-depth interviews, and a Focus Group Discussion (FGD). The interviews conducted are distributed as follows: six KIIs with representatives from government institutions, seven interviews with charitable and community-funded civil society organisations which currently provide care in both formal and informal settings, five interviews with SSE entities involved in care provision including cooperatives, two interviews with representatives of donor agencies, and three interviews with representatives of care worker associations. In addition, a FGD was conducted with individuals engaged in paid care work, while two in-depth interviews were also conducted with members of livelihood societies.

Data collection efforts were limited to identified districts within the country to capture and reflect the regional diversity, with consideration for limited resources available for this assessment as well as responsiveness of identified stakeholders. The locations under consideration for this assessment were Kandy, Jaffna, Kilinochchi, Galle, and Colombo. Colombo was selected as it represents the urban core with complex care needs linked to women's employment and migration, alongside a relatively higher concentration of private care providers. Galle, reflects a peri-urban context with existing agricultural and fisheries-based cooperative traditions that could be utilised to address seasonal care needs. Jaffna and Kilinochchi districts were selected to obtain insights from a post-conflict setting and a significant

care support from population overseas. Kandy was included due to its proximity to estate communities, and the specific care demands and service gaps that arise in these contexts. These selected locations aimed to capture diverse perspectives on existing care needs, operational barriers, and the enabling environment for SSE-based care models. Thematic analysis was employed to interpret qualitative data, focusing on identifying opportunities, constraints, and policy gaps relevant to strengthening care provision through SSE entities including cooperatives.

2. Background: Global Context and Sri Lankan Setting for the Care Economy and Social Solidarity Solutions

2.1 The Sri Lankan Context: Rationale for Exploring Alternative Care Solutions

The demand for care work in Sri Lanka is rapidly increasing, driven by significant demographic shifts. By 2042, one in four Sri Lankans is expected to be 60 years or older, positioning the country as having the oldest population in South Asia (Nadaraja 2012). This demographic transition, characterized by declining birth and death rates and increasing life expectancy, is reshaping the age-sex structure of the population (Perera 2017). Women constitute the majority of both the overall population and the elderly population. Over half of older people experience physical or mental impairments, and around one-fifth face difficulties with vision and mobility (Perera 2017).

Traditional family support systems are weakening as households transition from extended to nuclear structures. Concurrently, youth migration has risen in recent years, affecting both the labour force and the broader economy. Registration data from the Sri Lanka Bureau of Foreign Employment (SLBFE) shows that in 2023, 297,656 individuals were registered, despite a slight decrease from 310,953 in 2022 reflecting the continuity of increased departures compared to pre-crisis levels of 203,087 in 2019 (Sri Lanka Bureau of Foreign Employment 2023).

However, the country's care sector remains underdeveloped and is insufficient to meet growing demand. Consequently, the majority of care needs are addressed through unpaid care work, predominantly undertaken by women in the family or extended family due to entrenched gender norms and cultural expectations. This dynamic significantly limits women's labour force participation, contributes to gender wage gaps, reduces work engagement, and hinders career advancement, thereby perpetuating gender inequalities in the labour market.

According to Sri Lanka's 2023 Labour Force Survey, 5% of men and 57.2% of women are economically inactive due to engagement in housework (Department of Census and Statistics 2024). These figures underscore that most care work in Sri Lanka remains unpaid and occurs within households, predominantly undertaken by women. Time-use survey data from 2017 by the Department of Census and Statistics (DCS) indicate that 94.7% of employed women engage in unpaid care activities, compared to 65.9% of men, highlighting the disproportionate burden on women (Department of Census and Statistics 2017). This situation poses a substantial barrier to workforce entry while imposing a "double burden" on women who combine full-time paid employment with unpaid domestic responsibilities—a burden that intensified during the COVID-19 pandemic. Estimate shows that the value of unpaid household, care, and voluntary work in Sri Lanka contributes between 10.3% (minimum wage valuation) and 42% (maximum valuation) of GDP, with women performing the majority

of this work contributing 8.6–35% of GDP (Gunawardena and Perera 2022).

For older persons and people with disabilities, family-based care remains the primary mode of support. Data from the DCS on long-term care services both publicly provided and privately paid for children, older persons, and persons with disabilities confirm this trend, particularly across the districts considered in this study. While Sri Lanka provides universal public healthcare and some social welfare schemes, formal care services, especially community-based and home care, remain limited. From Table 1 below it is possible to observe that there are few formal long-term care facilities for elders, particularly outside major urban centres.

Table 1: Number of Homes for Children, Older Persons, and Persons with Disabilities, and the Number of Residents by Gender

District	Type of Home	No. of Homes		No. of Residents	
		Gov	Private	Male	Female
Kandy	Elders' Home	6	2	44	123
	Children's Home	3	3	41	136
	Disabled Home	.	.	.	.
Jaffna	Elders' Home	1	8	148	188
	Children's Home	3	1	60	183
	Disabled Home	1	.	71	61
Galle	Elders' Home	.	29	305	445
	Children's Home	7	19	245	463
	Disabled Home	1	7	62	95
Colombo	Elders' Home	.	92	682	1151
	Children's Home	14	8	147	333
	Disabled Home	2	14	323	308
Kilinochchi	Elders' Home	.	5	70	55
	Children's Home	.	9	144	348
	Disabled Home	.	3	60	63

Source: (Department of Census and Statistics 2024)

The available (limited) paid care work in Sri Lanka is undervalued and inadequately remunerated. Individuals engaged in paid care, particularly domestic workers, often fall outside formal legal protections, lacking contracts, social protection, minimum wages, and pensions. Domestic work, the most common form of paid care, is highly feminized and underrecognized; the 2023 Labour Force Survey reports that 90.66% of domestic workers are women, and 75,382 out of 76,453 domestic workers are informally employed. This informality reinforces both gender and class inequalities. Furthermore, caregivers are often insufficiently trained: the 2019 Census of Children in Care Institutions indicates that only 44% of childcare staff had relevant childcare training, and merely 25% held vocational qualifications (Centre for Poverty Analysis 2024). Sri Lanka has ratified key international conventions, including CEDAW and ILO Convention No. 111 on Discrimination (Employment and Occupation), but has not ratified ILO Convention No. 189 on Decent Work for Domestic Workers or ILO Convention No. 190 on Violence and Harassment in the World of Work. These conventions are critical for ensuring minimum wages, rest periods, protection from violence, and equal treatment, particularly for informal and residential care workers.

Sri Lanka has two main types of residential elderly care facilities, one type providing shelter for older persons and another offering long-term care and nursing support. Most facilities belong to the first type "elders' homes," providing housing rather than formal care, though residents may develop long-term care needs over time. Currently, the country has approximately 255 eldercare homes serving around 7,100 elderly residents, with only a small proportion (five public elder care homes) operated by the government accounting for about 7% of elderly residents according to historical data. The majority of these elder care homes are privately run or managed by faith-based and non-profit organizations, and 220 private and non-profit homes out of 255 accommodate over 85% of the elderly people receiving residential care services. Limited availability of affordable, quality care services highlights the need for alternative mechanisms to meet demand (International Long Term Care Policy Network 2021) .

Given the high costs of private care[1] and the infeasibility of fully subsidized state provision, alternative mechanisms are essential to ensure equitable access to care. Historically, care has not been a policy priority in Sri Lanka, but recent government efforts indicate a shift. For instance, Sri Lanka's Social Protection Strategy, which is grounded in the National Social Protection Policy (2024), has recently been introduced as a 10-year plan (2025–2035) comprising four pillars, one of which is specifically focused on social care. Investment in the care sector could generate substantial employment, particularly for women: ILO estimates suggest that by 2035, Sri Lanka could create 876,000 care jobs – 275,000 in childcare, 538,000 in long-term care, and over 63,000 indirect jobs – with 93% filled by women and 95% in formal employment bringing the labour force participation to 46.1%, narrowing the gender pay gap, and providing essential care (International Labour Organization 2024).

1 The costs of private eldercare services range from free to LKR 400,000 per month, according to the 2025 Elderly Home Register of the National Secretariat for Elders (Source: http://srilankaeldercare.gov.lk/web_3/Elder%20Homes.html).

To support these objectives, the ILO has introduced model by-laws, and the Cooperative Department has committed to promoting nationwide care cooperatives in 2025 (International Labour Organization 2025). The current government has signalled interest in collective and solidarity-based economic models ("economic democracy"), including cooperatives and SSE entities, alongside policy reforms to strengthen the care sector (Sanasa International 2025). Considering the ILO's global work on SSE and cooperatives in care provision, and the lack of previous studies analysing Sri Lanka's current situation, this situational analysis provides a first-of-its-kind, locally grounded assessment of potential pathways for developing quality, affordable care services while promoting decent work.

2.2 Social and Solidarity Economy (SSE) and Cooperatives as a Solution: Global Trends

The Social and Solidarity Economy (SSE) refers to a diverse set of enterprises and organizations that operate with the dual objective of pursuing economic viability and social well-being, while fostering solidarity and collective benefit. The International Labour Organization (ILO) defines the SSE as The SSE encompasses enterprises, organizations and other entities that are engaged in economic, social, and environmental activities to serve the collective and/or general interest, which are based on the principles of voluntary cooperation and mutual aid, democratic and/or participatory governance, autonomy and independence, and the primacy of people and social purpose over capital in the distribution and use of surpluses and/or profits as well as assets. SSE entities aspire to long-term viability and sustainability, and to the transition from the informal to the formal economy and operate in all sectors of the economy. They put into practice a set of values which are intrinsic to their functioning and consistent with care for people and planet, equality and fairness, interdependence, self-governance, transparency and accountability, and the attainment of decent work and livelihoods. According to national circumstances, the SSE includes cooperatives, associations, mutual societies, foundations, social enterprises, self-help groups and other entities operating in accordance with the values and principles of the SSE/ " (International Labour Office 2022). These entities aim to balance economic performance with social justice, inclusion, and sustainability positioning people and the planet at the centre of economic activity rather than profit maximization (International Labour Office 2022).

Values of the SSE (International Labour Office 2022)

The SSE is underpinned by a distinct set of values that differentiate it from other segments of the economy. These values, as reflected in national and subnational SSE legislation and ILO frameworks, can be grouped into five broad categories:

1. **Care for people and planet** – promoting integral human development, meeting community needs, embracing cultural diversity, and advancing ecological sustainability.
2. **Egalitarianism** – upholding justice, equality, fairness, equity, and non-discrimination.
3. **Interdependence** – fostering solidarity, mutual aid, cooperation, social cohesion, and inclusion.

4. **Integrity** – ensuring transparency, honesty, accountability, trust, and shared responsibility in operations and governance.
5. **Self-governance** – emphasizing self-management, democracy, participation, autonomy, and subsidiarity in decision-making.

Together, these values highlight the SSE's commitment to inclusive, ethical, and sustainable economic practices, prioritizing social and environmental outcomes alongside financial sustainability.

Principles Guiding the SSE (International Labour Office 2022)

Recent SSE legislation from diverse contexts including Argentina, Belgium, Cabo Verde, Colombia, France, Mexico, Portugal, Senegal, Spain, Tunisia, and Uruguay identifies several core principles that guide the governance and functioning of SSE entities. These are:

- **Social or public purpose:** Economic activities are designed to serve collective interests, or community needs rather than private gain.
- **Prohibition or limitation of profit distribution:** Profits or surpluses are reinvested to advance the organization's social mission or benefit members.
- **Democratic and participatory governance:** Decision-making processes are inclusive, with equal participation and voice for members or stakeholders.
- **Voluntary cooperation:** Participation is based on free association and mutual consent, fostering solidarity and community ownership.
- **Autonomy and independence:** While SSE entities may collaborate with public or private actors, they maintain self-governance and decision-making independence.

These principles ensure that SSE entities function as people-centred, participatory, and equitable systems of production and service delivery, consistent with ILO's vision for decent work and sustainable development.

Actors within the SSE (International Labour Office 2022)

The SSE encompasses a wide range of organizational forms that collectively contribute to inclusive economic and social progress (Figure 1).

Figure 1: Actors within the SSE

Source: (International Labour Office 2022)

Table 2: Key Actors within the Social and Solidarity Economy (SSE) Ecosystem Identified by the ILO

Actor Type	Key Features
Cooperatives	Cooperatives are autonomous associations of individuals who voluntarily come together to meet their shared economic, social, and cultural needs through a jointly owned and democratically governed enterprise. Members participate in decision-making on the basis of equality, and profits are either reinvested or distributed fairly among them.
Mutual Societies	Mutual societies are organizations formed by individuals who collectively seek to improve their economic security by sharing risks. Members make regular contributions to a common fund, which provides financial support in times of need. Unlike cooperatives, their main purpose is risk management such as health or property insurance rather than production or trade.
Associations	Associations are legal entities primarily engaged in providing non-market services for households or communities. They rely mainly on voluntary contributions and often deliver welfare, cultural, or advocacy services. Community-based associations, in particular, are member-driven and focus on supporting or representing people in a specific locality or community.
Foundations	Foundations are organizations that manage financial assets or endowments to support charitable or development-oriented activities. They use the income generated from these assets to provide grants to other organizations or to implement their own programmes and projects aimed at social or community benefit.

Actor Type	Key Features
Self-Help Groups (SHG)	Self-help groups are voluntary groups of individuals who join together to achieve mutual goals often related to savings, credit, or technical support that would be difficult to accomplish alone. While they share features with cooperatives and mutual societies, SHGs are usually informal and not primarily engaged in commercial activities. They play a key role in empowering marginalized groups, especially women.
Social Enterprise	Social enterprises are businesses that use market-based approaches to achieve social or environmental objectives. They generate income through the sale of goods or services but reinvest most of their profits to support their mission such as employing disadvantaged individuals, providing training, or producing goods and services that benefit vulnerable communities.

Source: (International Labour Office 2022)

Cooperatives as the Backbone of the SSE entities in Asia and the Pacific

Cooperatives represent the most established and widespread form of Social and Solidarity Economy (SSE) entities in the Asia–Pacific region. Rooted in long-standing cultural traditions of self-help, solidarity, and mutualism, cooperatives have historically played a vital role in advancing social cohesion and community-based economic development across the region. The resurgence of cooperative and solidarity-based approaches following events such as the Asian Financial Crisis of 1997 reflects a renewed appreciation for reciprocity and collective resilience embedded in many Asian societies (International Labour Organization 2022). While cooperatives form the backbone of the SSE, social enterprises have also gained momentum over the past two decades particularly in Southeast Asia though most countries in the region still lack comprehensive legal and policy frameworks to support SSE development (International Labour Organization 2022).

Cooperative Principles and Values

Cooperatives operate on universally recognized principles that align closely with SSE values and the broader objectives of decent work. According to the ILO Recommendation Promotion of Cooperatives Recommendation, 2002 (No. 193) 193 (2002), the promotion and strengthening of the identity of cooperatives should be encouraged on the basis of:

(a) cooperative values of self-help, self-responsibility, democracy, equality, equity and solidarity; as well as ethical values of honesty, openness, social responsibility and caring for others; and (b) cooperative principles as developed by the international cooperative movement and as referred to in the Annex to the convention. These principles are: voluntary and open membership; democratic member control; member economic participation; autonomy and independence; education, training and information; cooperation among cooperatives; and concern for community.

On similar lines, International Cooperative Alliance, these principles include (International Cooperative Alliance 2024):

- **Voluntary and open membership**: Cooperatives welcome individuals without discrimination based on gender, social, racial, political or religious discrimination.
- **Democratic member control**: Members actively participate in decision-making and have equal voting rights.
- **Member economic participation**: Members contribute equitably to the capital of their cooperative and share in the benefits generated. Allocate surpluses for development of the cooperative, or supporting other activities approved by the membership.
- **Autonomy and independence**: Cooperatives maintain self-governance while engaging in partnerships that respect their democratic integrity.
- **Education, training, and information**: Continuous learning ensures members can effectively manage and sustain cooperative development.
- **Cooperation among cooperatives**: Collaboration strengthens collective success and shared learning across cooperative networks.
- **Concern for community**: Cooperatives prioritize community well-being and invest in sustainable local development.

These principles make cooperatives particularly suitable for addressing the affordability, accessibility, and quality challenges in care provision, especially in contexts like Sri Lanka where public services are insufficient and private care remains unaffordable for many.

SSE including Cooperatives as a Framework for Inclusive and Decent Care Provision

Evidence from the ILO and international experiences demonstrates that SSE entities including cooperatives, mutuals, and social enterprises create decent and sustainable work opportunities, particularly in socially essential sectors such as care, health, and education. SSE units not only generate direct and indirect employment but also provide services that improve livelihoods, extend social protection, and promote inclusive local development. For example, in Japan, trade unions in the 1950s established worker-oriented cooperatives to deliver welfare, insurance, and housing services for workers. Similarly, in the Philippines, cooperatives facilitate the enrolment of their members in national health insurance schemes, while in Hong Kong, Japan, the Republic of Korea, and Singapore, cooperative-based models deliver long-term care and senior housing services (International Labour Organization 2022).

SSE entities can be multi-purpose and multi-stakeholder in nature, engaging workers, beneficiaries, and local governments in collective governance. The participatory approach of SSE entities to the provision of care services contributes to ensuring a reflection of community needs and that care workers receive improved wages, working conditions, and social protections thereby reducing labour turnover and improving service quality.

Contribution to Decent Work, Gender Equality, and Social Protection (International Labour Organization 2022)

The SSE contributes directly to the ILO's Decent Work Agenda and the Sustainable Development Goals (SDGs) by promoting:

- **Employment and income generation** through worker-owned enterprises and community-based initiatives.
- **Transitions to formality,** by organizing informal workers into structured, representative entities that enhance voice and bargaining power SSE organizations are also key actors in crisis response and resilience-building, supporting livelihoods during economic downturns and contributing to socially just transitions—whether digital, environmental, or economic.
- **Access to social protection** for those traditionally excluded from formal schemes, including informal and rural workers.
- **Gender equality,** by strengthening women's participation and leadership in SSE organizations, expanding employment opportunities in care, and providing affordable services that reduce women's unpaid care burden.
- **Social dialogue and representation**, enabling workers and communities to collectively negotiate better conditions and influence policy.

The majority of cooperatives are concentrated in rural areas, where they frequently serve as a **significant source of employment**. Alongside other SSE entities, cooperatives are increasingly recognized for their role in facilitating the transition from informal to formal economic activities. They have the potential to improve working conditions by ensuring regulated working hours and safe, healthy workplaces for both members and employees. For instance, garment sector cooperatives in countries such as Vietnam and Thailand provide eight-hour workdays or flexible schedules, coupled with adequate living wages for their worker-members (International Labour Office 2019). In Italy, the social care sector alone comprises 4,452 cooperatives—accounting for 40 percent of all social cooperatives—and employs more than 170,617 workers (European Commission 2016). An additional 32 percent of cooperatives focus on creating employment opportunities for marginalized groups, including persons with disabilities and ex-prisoners.

In several contexts, cooperative and mutual models have been **instrumental in extending social protection to workers in the informal economy**. In Rwanda, Senegal, and Ghana, community-based mutual health insurance schemes cover a substantial proportion of rural and informal workers. Occupational groups such as waste pickers and taxi drivers often organize cooperatives to gain access to health insurance, while ageing domestic workers in Trinidad and Tobago utilize cooperatives to secure income in later life. Similarly, cooperatives and other SSE entities in Namibia, Tanzania, and eSwatini have supported HIV/AIDS prevention and related care initiatives. In Europe, particularly in France and Belgium, mutual insurance schemes have expanded their reach to include workers in emerging sectors such as the platform economy (International Labour Office 2019).

Box 1 illustrates an innovative cooperative childcare model from Ghana, which engages numerous women vendors and traders who were previously unorganized and not part of formal unions. This case highlights the **potential of the SSE to promote gender equality.** Women-only cooperatives are present in countries ranging from Mexico, India, and Nepal to Nigeria, Morocco, Iran, Lebanon, and Turkey, often in sectors where women are the primary producers and service providers (International Labour Office 2019). Cooperatives and other SSE initiatives are particularly well-positioned to enhance women's economic participation by expanding access to employment, fostering economic agency, and promoting inclusive leadership and management opportunities. By providing these pathways, SSE entities contribute to greater economic democracy and enable women to develop skills and experience that strengthen their role in both the workforce and decision-making processes.

Box 1: Makola Market in Ghana

The Makola Market in Accra, Ghana is a workplace for thousands of women informal traders and vendors, many of whom have no viable alternative but to bring their children to work. When government funding for a childcare center ended, vendors and traders came together with childcare workers from the center and representatives from the Ghana Association of Traders to form a Parent-Teacher Association and take joint responsibility for operations. The center now provides care for 140 children, starting at 6 am and running until the last child is picked up. A flexible payment system is in place, with subsidies and free spaces for those who cannot afford the monthly fee. Some vendors also provide fresh vegetables and fruit from their own stalls for the children's daily meals.

Source: (Grantham and Somji 2022)

Worker cooperatives have been specifically recognized for their potential to address inherent tensions within social enterprises, including the balance between democratic governance and hierarchical structures, the reconciliation of individual and collective interests, and the commitment to innovative or alternative operational models rather than reverting to conventional mainstream approaches enabling **social dialogue and representation** (Audebrand 2017).

Trade unions have historically utilized the cooperative model as a means to safeguard workers' rights and welfare while providing essential services. In India, the Self-Employed Women's Association (SEWA) exemplifies this approach, supporting approximately 1.8 million women engaged in the informal economy. SEWA employs a dual strategy, combining trade union activities to defend members' rights with cooperative structures that facilitate livelihood security, access to social protection, and the provision of additional essential services (International Labour Office 2022).

Likewise, the ILO's 5R Framework (Recognize, Reduce, Redistribute, Reward, and Represent) provides a structure for understanding how SSE and cooperative models can directly contribute to transforming the care economy.

Table 3: SSE Contribution to the 5R Framework in Care

ILO 5R	SSE/Cooperative Contribution
Recognize	Formalize and value care work through cooperative structures and statistics
Reduce	Deliver affordable, accessible community-based care services. Through collective organization, SSE entities can help reduce unpaid care burdens by offering accessible, affordable, and community-based care services particularly in underserved areas.
Redistribute	Share responsibilities among workers, users, and the State For example, Japan's "Fureai Kippu" time-banking care model redistributes caregiving among community members (Marcus 2025).
Reward	Ensure fair pay, safe work, and social protection for care workers
Represent	Empower workers' voice through democratic governance In Uruguay, for example, domestic workers' unions have collaborated with cooperatives to negotiate national care policies and wage standards illustrating how SSE structures can institutionalize representation at both local and national levels (Goldsmith 2012)

Source: Author's compilation

2.3 SSE Entities and Cooperatives in Sri Lanka

Sri Lanka does not yet have dedicated policy or legal framework that recognizes the SSE as a distinct overarching sector. However, cooperatives – which are a key component within the SSE – are governed by established cooperative legislation and the underlying SSE values and practices of cooperation, mutual aid, and community-based organization are deeply embedded in the country's socio-economic fabric.

Historically, Sri Lanka has had a strong cooperative movement, dating back to the early 20th century, which has played a central role in rural development, agricultural marketing, and credit provision. Cooperatives remain the most institutionalized and recognized form of SSE entities in the country, encompassing primary societies and federations across multiple sectors, including agriculture, fisheries, handicrafts, and finance.

Beyond cooperatives, a range of community-based organizations (CBOs), self-help groups, women's rural development societies, NGOs and workers' rights organisations engage in activities aligned with SSE principles. These entities contribute to local development, livelihood generation, and social welfare particularly in areas where state and market mechanisms are less effective (refer Box 2). Women's organizations and community-based care initiatives have long supported early childhood development, elderly care, and social support systems at the local level.

Given Sri Lanka's current socio-economic challenges, including rising care needs, and regional disparities, the SSE presents a potential pathway for inclusive and sustainable development. Its people-centred, democratic, and solidarity-based

model aligns closely with the country's long tradition of community welfare and can play a transformative role in promoting decent work, social protection, and gender equality, particularly through cooperative and community-driven care solutions.

Box 2: The Sarvodaya Shramadana Movement – Sri Lanka's Longest-standing Example of Social and Solidarity Economy in Practice

The Sarvodaya Shramadana Movement (SSM), founded in 1958, represents one of the most established examples of the Social and Solidarity Economy (SSE) in Sri Lanka. Rooted in the principles of self-help, collective action, and solidarity, Sarvodaya (meaning "awakening of all") began as a small village-level initiative based on voluntary community labor (Shramadana) and has since expanded to more than 15,000 villages across the country.

Sarvodaya operates through a network of over 5,200 legally independent village societies, functioning as community-based organizations that promote local empowerment, participatory decision-making, and self-reliance. Its activities span multiple domains aligned with SSE values including economic empowerment through microfinance services (via Sarvodaya SEEDS), social welfare and care provision for vulnerable groups (through Sarvodaya Suwasetha), women's empowerment, and peacebuilding. These initiatives combine social objectives with sustainable local enterprise, providing employment, training, and essential services across both urban and rural communities.

Sarvodaya's cooperative-like structure exemplifies the democratic governance, autonomy, and concern for community that define SSE entities. It has also played a major role in social protection, delivering health and nutrition programs for children, rehabilitation for conflict-affected populations, and community-level vocational training for youth and ex-combatants. Through its inclusive, people-centered approach, Sarvodaya demonstrates how SSE models can effectively bridge welfare and economic development fostering decent work, gender equality, and social cohesion within a culturally grounded framework.

Sarvodaya remains a key national example of how SSE values can be institutionalized within community-based systems, offering valuable lessons for expanding care cooperatives and other SSE-led care services in Sri Lanka.

Source: (Sarvodaya Shramadana Movement, n.d.)

However, despite the diversity, Sri Lanka's SSE ecosystem remains fragmented and largely informal, with limited coordination among actors and insufficient policy recognition. These organizations often operate under different legal regimes such as cooperative, trust, or voluntary organization laws but would need to be recognised as SSE institutions to ensure coherence in operational guidelines.

This is evident in the numerous community-based societies across Sri Lanka, which have been formed to provide mutual support in informal settings. These include Rural Development Societies, Youth Clubs, Sports Clubs, Funeral and Welfare Societies, Women's Societies, Elders' Societies, and Children's Clubs.[2] While not all of these community-based societies work as cooperatives or SSE entities in the strict technical sense, they often embody the principles of self-help, solidarity, and cooperation that underpin the overall characteristics of the SSE. With appropriate promotion and support, these informal societies have the potential to formalize and expand their activities. For instance, Table 4 shows the widespread presence of Funeral and Welfare Societies, reflecting community-recognized needs for mutual support (DCS, 2023). The Plantation Human Development Trust (PHDT) in the estate sector is another example of a community-based entity which is established as a social development and welfare implementation agency for workers of the estate sector tied to the Regional Plantation Companies (RPCs) managed estates. It is noted that in some RPC estates, the PHDT implements social development programmes and manage child day care centres for children of plantation workers. If care provision were similarly identified as a community need, these societies and entities could extend their activities to provide care services, transitioning from informal arrangements to more formalized structures. Collaborative efforts within these societies could further enhance their capacity to deliver care, nurture mutual learning, and improve outcomes. However, at present, care needs are only informally addressed in certain areas and remain limited by social norms, resulting in unpaid care work largely undertaken by women.

2 These community-based societies are usually formed informally at a village or GN level and adopting standard constitutions, electing office-bearers, and subsequently registering (primarily through the Divisional Secretariat and relevant provincial/national structures) so they can operate and be supervised as recognised local organisations.

Table 4: Different Types of Societies in Sri Lanka

Type of Society	District				
	Kandy	Jaffna	Galle	Colombo*	Kilinochchi
Rural Development Societies	1288	310	840	288	174
Youth Clubs	808	372	703	270	104
Sports Clubs	807	409	755	240	108
Funeral and Welfare Societies	**3857**	**56**	**2080**	**759**	**.**
Women's Societies	1108	366	567	387	145
Elder's Societies	844	312	706	447	70
Children's Clubs	1095	323	629	190	107
Other	.	1641	158	464	30

Note: *In Colombo, Sri Jayewardenepura Kotte and Thimbirigasyaya divisional secretariat divisions have not given data

Source: (Department of Census and Statistics 2024)

Historical Background of Cooperative Movement in Sri Lanka

The cooperative movement in Sri Lanka has deep historical roots, dating back to the early twentieth century during British colonial administration. The establishment of the first cooperative society around 1906 marked an effort to address rural economic challenges, followed by the enactment of the Cooperative Societies Ordinance in 1911 (Department of Cooperative Development 2021). Over subsequent decades, the movement expanded beyond credit-based organizations to include a diverse range of cooperative forms such as agricultural, consumer, savings and credit, multipurpose, rural service, and retail distribution societies.

In 2019, with the technical support of the International Labour Organization (ILO), Cooperative Development Department of Sri Lanka introduced its first National Policy on Cooperatives (International Cooperative Alliance Asia 2021). The policy seeks to enhance the cooperative sector across provinces, promote the inclusion and empowerment of marginalized populations particularly women, youth, and persons with disabilities and strengthen the role of cooperatives within national and local development frameworks.

While cooperatives are widespread across the country, their density and nature vary among provinces, influenced by local economic activities (e.g., agriculture, fisheries) and historical development patterns. Agricultural cooperatives are especially dominant in agrarian and rural provinces, whereas consumer and retail cooperatives are more active in urban and densely populated regions.

As of 2019, Sri Lanka hosts over 16,000 registered cooperative societies with an estimated membership of 8.1 million individuals representing approximately 38 percent of the national population. Women constitute about 65 percent of this membership base (International

Cooperative Alliance Asia 2021). The sector commands substantial economic resources, with total assets valued at approximately USD 1.8 billion and member savings amounting to around USD 1 billion (International Cooperative Alliance 2020). Furthermore, cooperatives provide direct employment to roughly 65,000 individuals (International Cooperative Alliance 2020). Operating across 27 cooperative districts, they maintain a significant presence in all provinces, with key activities concentrated in agriculture, consumer goods, savings and credit, multipurpose operations, retail trade (notably through cooperative shops), and services supporting small and medium-sized enterprises (SMEs) and rural livelihoods.

Tables 5 and 6 below present data from the Department of Census and Statistics (DCS) on the number of cooperative societies and their membership by type for the period 2015 to 2021. Table 5 shows the distribution of cooperative societies by type, while Table 6 details the number of members across these societies. According to the data, credit cooperatives constitute the largest share of societies, while membership is highest in banking unions and multipurpose cooperatives, followed by credit societies. These statistics clearly demonstrate cooperatives as an established and institutionalized form of SSE in Sri Lanka.

Table 5: Number of Cooperative Societies by Type

Type of Cooperative Society	2015	2016	2017	2018	2019	2020	2021
Primary Societies	**10582**	**10418**	**9904**	**9259**	**8878**	**10078**	**10077**
Credit	6558	6557	6086	5594	5592	6483	6317
Agriculture	233	358	256	347	147	300	234
Industrial	301	277	238	209	182	258	255
School co-operatives	722	711	664	604	361	483	414
Multi- Purposes	304	286	304	248	266	277	303
Fisheries	844	962	935	883	898	916	908
Others	1620	1267	1421	1374	1432	1361	1646
Secondary societies	**188**	**217**	**194**	**174**	**166**	**162**	**237**
Banking unions	31	33	35	32	19	16	87
National co-operative councils	.	1	1	2	1	.	.
District co-operative councils	28	25	25	28	26	22	26
Multi - purpose unions	24	9	21	4	3	5	12
Other unions	105	149	112	108	117	119	101
All societies	**10770**	**10635**	**10098**	**9433**	**9044**	**10240**	**10314**

Note: Southern province data are excluded from 2018 data.

Source: (Department of Census and Statistics 2023)

Table 6: Number of Members Across Different Types of Cooperative Societies

Type of Cooperative Society	2015	2016	2017	2018	2019	2020	2021
Primary Societies (Thousands)	**5734**	**7851**	**8049**	**6478**	**6237**	**8129**	**7573**
Credit	1408	1897	1984	1013	1546	1851	1530
Agriculture	52	43	61	65	23	70	206
Industrial	17	40	35	23	17	26	28
School co-operatives	309	149	159	131	114	182	109
Multi- Purposes	3127	4823	5094	4711	3668	5146	5104
Fisheries	48	229	231	126	444	219	113
Others	773	670	485	409	425	635	480
Secondary societies (Units)	**7540**	**26363**	**20534**	**56678**	**59152**	**11113**	**15543**
Banking unions	652	6146	4792	41021	43617	943	6144
National co-operative councils	.	39	295	322	166	.	.
District co-operative councils	1088	1602	1447	2124	1949	2131	2214
Multi - purpose unions	71	336	99	68	102	112	189
Other unions	5729	18240	13901	13143	13318	7927	6736

Note: Southern province data are excluded from 2018 data.

Source: (Department of Census and Statistics 2023)

Despite its long history and broad social reach, the cooperative movement in Sri Lanka has faced persistent structural and operational weaknesses that have limited its effectiveness. Particularly multipurpose and rural banks struggle with weak governance, inefficient management, and low financial sustainability, partly due to politicization and excessive state involvement (Mula and Jayamaha 2010; Samarasinghe 2023). Overall, while remaining an important community-based economic organization, their performance in Sri Lanka has been constrained by poor governance structures, overregulation, and weak adaptation to market conditions (Mula and Jayamaha 2010; Samarasinghe 2023; Samarasinghe and Jayawardena 2021).

A recent study found that many individuals now join cooperatives primarily to obtain loans rather than to participate in collective development (Samarasinghe 2023). Given that member capital contributions are minimal and withdrawal is easy, mechanisms to assess or ensure commitment to the cooperative are weak. The study also revealed that voting rights, though equally distributed among members, are often influenced by political agendas or lack of awareness, resulting in decisions that do not reflect the true will of the membership (Samarasinghe 2023). Corruption and mismanagement have further limited the productive use of cooperative capital, while heavy dependence on government subsidies has weakened self-reliance. The findings further indicate that cooperatives in Sri Lanka

have not fully adhered to key cooperative principles particularly education, training, inter-cooperation, and concern for community. Strengthening member education, promoting collaboration among cooperatives, and encouraging sustainable practices were identified as essential for revitalizing the movement (Samarasinghe 2023).

As of current published literature, there are no well-documented SSE or cooperative entities in Sri Lanka dedicated explicitly to care services (childcare, eldercare and disability care) with wide visibility. However, only one example was identified through desk research—the *Nylander Industrial Cooperative Society*, the first cooperative society for persons with disabilities in Sri Lanka, for individuals located within the Gampaha district. It was established in 1985 by Margit Nylander from Sweden as a space aimed at fostering self-reliance and independence among young people with disabilities and subsequently registered as a cooperative in 1990 (Nylander Co-Operative Society Ltd 2024).

Potential ILO Involvement, Opportunities and Gaps

Aligning with ILO's broader global efforts to promote SSE enterprises (including cooperatives), as vehicles for delivering quality, accessible care and ensuring decent work within the care economy, the ILO Sri Lanka office initiated a multi-pronged approach to promote care cooperatives as a means of delivering accessible care services and creating opportunities for decent work – particularly for women.

As part of this intervention, ILO Sri Lanka office convened a national-level policy dialogue in May 2025 to raise awareness and build consensus around the potential of care cooperatives, which led to the development of a draft national action plan. Training and capacity building workshops were undertaken through ILO's Think. Care.Coop and Start.Care.Coop training modules in an effort to integrate the care cooperatives concept into the existing institutional action plans. In consultation with unions and tri-partite stakeholders ILO has also supported two unions to establish union-backed care cooperatives.

The new Model By-laws for Care Cooperatives, launched in August 2025 by the Department of Cooperatives in collaboration with the ILO, represent a significant recent development (International Labour Organization 2025). The initiative aims to facilitate the establishment of new care cooperatives and to enable existing cooperatives to expand into care service provision. Following participation in ILO's training workshop and subsequent discussions, the Health Department of the Thrift and Credit Cooperative, is noted to have decided to extend care services through its nationwide network through pilot care services as part of the "Suwasetha" pilot proposal in five districts by recruiting skilled recent retirees from the government health sector, with plans to scale up nationally.

The introduction of the model by-laws for care cooperatives signals growing institutional recognition of the care economy and represents a timely opportunity to formalize care work within cooperative structures. It provides a legal and governance framework that can enhance clarity, establish standards, and create pathways for cooperatives to engage more effectively in the care sector.

Sri Lanka faces multiple challenges in the care sector, including an aging population,

high numbers of youth migration, resulting in significant burdens on family caregivers, compounded by insufficient formal care provision in rural, remote, and low-income provinces. These conditions create substantial potential for SSE initiatives, particularly cooperatives, to address unmet demand by providing localized, affordable, and decent care services. Drawing on both global theory and the Sri Lankan context, SSE cooperatives appear especially well-suited to the country's care landscape, where much of the care burden is informal and many caregivers lack formal protection. By formalizing support structures, SSE-based cooperatives can provide quality care services to those who need them and provide legal recognition, training, social protection, and sustainable employment opportunities to the caregivers. The existing policy momentum, including the National Cooperative Policy and recent model by-laws for care cooperatives, offers a favourable institutional environment to advance these initiatives. SSE cooperatives can also bridge geographic and affordability gaps in care services, particularly in rural areas, while women who constitute a large proportion of both care recipients and providers can benefit from formal employment, relief from unpaid labour, and representation in governance. When carefully designed, SSE models can deliver care in a more sustainable and equitable way than purely market-driven or charitable approaches.

In practical terms, SSE-based care models can enhance affordability, quality, and sustainability through mechanisms such as cooperative ownership, community co-financing, and social contracting with public authorities. These approaches encourage local participation, build trust, and ensure that care workers often women in informal or precarious roles receive fair wages, training, and social protection. Embedding care services within communities also promotes cultural relevance and extends coverage to underserved areas where public or private provision is limited. According to ILO guidance on the care economy, expanding access to quality care requires diversified financing and delivery systems, and SSE entities are well-positioned to complement public efforts in creating universal, equitable care systems that also generate dignified employment.

Nevertheless, research exploring the potential of care cooperatives in Sri Lanka remains scarce. The success of SSE-based care models depends heavily on promoting development of new care cooperatives or supporting existing cooperatives/SSE entities to start care services, creating awareness amongst the care workers and the users of care services, promoting multiple models which can work in different situations, alongside effective implementation of the model by-laws, adequate financing, capacity-building initiatives, access to business development services, and functional regulatory and oversight systems. Furthermore, the capacity of existing cooperatives including governance, management, and scalability varies significantly across provinces, based on their existing operations and demand for care services from its members or community constituents which may influence the viability and effectiveness of care cooperatives in different districts.

2.4 Skills Landscape of Paid Care Workers

This sub-section provides a brief overview of the paid care workers in the country who represent critical group of actors that sustain the care sector at present. Framed

through a specific focus on their skills status, potential connectors and synergies with SSEs to improve worker conditions and skill acquisitions will be explored in this sub-section and in section six.

Sri Lanka's paid care workforce is small, highly feminised, and overwhelmingly informal. Workers often acquire competencies and experience on the job but lack recognised credentials, with skills formation occurring in a fragmented and uneven manner across subsectors. Labour Force Survey analysis shows that a majority of paid care workers are women and that around nine in ten are engaged in the private and informal economy, concentrated in household-based babysitting and day-care activities for children, older persons and persons with disabilities (Centre for Poverty Analysis 2024).

Although provision of care-related training exists it remains constrained by access, availability, affordability and weak standardisation. Current offerings range from TVEC recognised state programmes, private hospital academies, to NGO-led initiatives. Courses based on curricula designed and approved by the TVEC include: Certificate for Care Giver, Certificate Course in Daycare Worker, Certificate in Aged Care, Certificate for Child Caregiver, Certificate for Child Care and Therapy Assistant (Special Needs), Certificate for Child Care Centre Operations, Certificate for Care Giver(Elderly Care), Certificate in Healthcare and Supportive Assistant, Certificate for Early Childhood Care and Development Teacher, Caregiver Course on maintaining personal hygiene and appearance of the client. It is noted that curricula, course duration, and qualification standards differ by provider and are subject to limited national oversight, undermining portability and verification of skills. However, as per the KII with a representative from the TVEC, NVQ certification can only be offered through TVEC approved courses and examination (KII 23, 2025).

Skill expectations differ across settings. Employers frequently prioritise willingness to undertake care work, prior experience, and appropriate attitudes, with formal qualifications more consistently required in private early-childhood centres (e.g., ECCD/ first-aid certification) and fee-based long-term facilities—where pay scales also tend to reflect skill requirements (Centre for Poverty Analysis 2024). The current skills landscape is also shaped by labour market dynamics and migration. Wage data show that both men and women in care earn less than workers in other sectors; these patterns alongside better opportunities overseas, contribute to attrition of supply among trained workers (Centre for Poverty Analysis 2024).

Regulatory gaps further depress the skills premium as most care workers tend to remain in the informal economy, either as own-account workers or as informal workers in informal and formal establishments. Domestic workers constitute a core segment of paid carers; they continue to remain outside the scope of existing labour protections, making it difficult to enforce minimum wages and basic working conditions – particularly within the domestic sphere. Remuneration is therefore determined by locality, demand and individual bargaining; thus, weakening incentives for certified training and career progression outside demand from formal care providing facilities (Centre for Poverty Analysis 2024). Interviews with domestic workers further indicated that they are rarely hired solely for direct care

provision, but are instead expected to provide childcare or eldercare alongside a wide range of household tasks, further disincentivising upskilling in the current operational context (KII 15, 2025).

Expanding quality care provision through institutions founded in SSE principles requires a workforce whose skills are visible, portable and rewarded. Formalising caregiving skills and specifying skills provision for each care category responds directly to addressing these gaps, while at the same time building user trust in service provision.

Practical constraints for skills uptake

While structured pathways for training and skills recognition are noted, stakeholders consulted as part of the assessment stressed that skills uptake will remain limited unless binding constraints in the current labour market are addressed. First, depressed wages and weak social recognition of care work continue to dampen incentives to go for formal skilling programs as employers are often reluctant to compensate workers on par with skill levels. Where job roles are informal and pay does not match the competencies, workers see little return on investing time and fees in certification—particularly women who already shoulder heavy unpaid care burdens. Secondly, direct and opportunity costs resulting from course fees, transport, time away from paid work are noted to deter both new entrants and experienced domestic/community carers from pursuing training. This changes when workers are looking for employment opportunities overseas. The international labour markets are recognized to offer stronger pull factors in the form of higher wages, and employer-funded training for foreign employment in care services sector (KII 23, 2025; KII 13, 2025).

The following avenues are proposed for transitioning to formal programs in caregiving skills:

- **Competency-based training** aligned to national qualifications can define core profiles (early childhood care, prenatal- postnatal care, home-based elder care, support for persons with disability, long term hospice care, infirm adult care etc.). Such training should include safeguarding of care recipient and care provider. Course curricula are already prepared by the tertiary vocational education centre (TVEC) and implemented across the country (KII 23, 2025). This can be supplemented with targeted specialisations such as dementia care, or rehabilitation support creating opportunities for advanced roles or pathways for supervision, which could be facilitated through existing National Vocational Qualification (NVQ) level 4 modules.
- **Recognition of prior learning (RPL)** can assess and certify experienced caregivers—especially domestic and community workers—so their informally acquired skills translate into recognised standards and levels (e.g. NVQ) and wage progression.
- **Modular and work-based learning** (micro-credentials, supervised practicums, apprenticeships) can allow entrants to upskill rapidly while keeping services running, while also minimizing loss in work opportunities while learning.

SSE entities and care worker skills strengthening (expanded further in section six): These skills/qualifications can be supplemented with cross-cutting training for cooperative and community

managers encompassing aspects such as rostering, supervision, grievance handling, data and quality assurance, which would contribute towards strengthening institutional governance, accountability, and sustainability of any community interventions devised for the provision of care. SSE-based institutions are well placed to knit these elements together; cooperatives, associations, and livelihood societies could act as local "training organisers": aggregating learners, hosting practice sites, co-financing short courses from solidarity funds, and partnering with public training providers and TVET authorities for assessment and certification. Better jobs—with clearer progression and protection—help attract and retain workers, while standardization of skills can assist in the transition of care work from informal to formal/recognised work (Raiber, Visser, and Verbakel 2023).

3. Mapping of Care Providing Entities in the Sri Lankan Context

This mapping of care services is motivated by the need to better understand the specific constraints and opportunities in care providing services in Sri Lanka to determine the potential for community-based services. The aim is to consider whether such services can meet the growing care needs through entities organized along the SSE principles, ensuring affordable, and quality care services, while also taking wellbeing of the workforce development into consideration. The analysis takes into consideration the ILO's "5R framework" to ascertain the extent to which care providing entities currently do or have the potential to recognize, reduce and redistribute unpaid care work, while also reward paid care work and ensure representation of care workers.

The rapid mapping exercise catalogues a spectrum of caregiving entities operating in the country while at the same time assessing the extent to which they embody the SSE features. The categories of care providing entities profiled below include: (i) government-funded services (notably programmes of the Department of Social Services; the National Secretariat for Elders), which anchor statutory responsibilities; (ii) services operated by multi-purpose cooperatives, where existing member networks can be leveraged to add childcare or home-based elder/disability care; (iii) charitable and religious organisations that have long provided residential, day-care and community outreach, sometimes with volunteer labour and donor finance; (iv) donor-driven interventions, piloting innovative models that can inform scale-up; (v) domestic workers' unions engaged in organising, skills recognition and advocacy—critical for bringing home-based care into decent-work frameworks (and aligned with ILO Convention No. 189); and (vi) community-based collectives and livelihood societies that have the potential to diversify into care as a locally governed service responding to community demand.

3.1 Key Actors Providing Care

3.1.1 Government Institutions

The provision of care through government funded entities operate on a mandate to protect the rights of the most vulnerable segments of the population, set standards, and ensure last resort access for children, elders and persons with disabilities. The role of these government entities is especially critical in the current context of demographic shifts and persistent care related barriers for female labour force participation which are driving demand for care services.

While government departments and local authorities providing care services are not SSE entities in the strictest sense – as they are neither member-owned or democratically governed by member/workers – many of their practices (i.e. community orientation, utilization of budgets in service of the community wellbeing, primacy of social purpose, and multi-stakeholder coordination) are compatible with the SSE ecosystem. The inclusion of these institutions within the mapping enables the identification of

features that could be replicated either independently or in partnership with SSE entities.

a. National Secretariat for Elders (NSE)

The National Secretariat for Elders (NSE) functions under the Ministry of Rural Development, Social Security, and Community Development and is one of the major government institutions that directly focuses on protecting the rights of elders and their welfare.

Service type: The NSE directly operates four residential homes for individuals with limited means and in addition oversite for the operations of 190 'elder day centres' established through elders' societies at the Divisional Secretariat level (KII 7, 2025).[3] It is also responsible for registering older individuals, registering, monitoring and regulating elder care facilities, as well as providing welfare measures for identified vulnerable older persons through divisional level Elders' Rights Promotion Officers and Development Officers appointed through the Social Service Department.

Geographic distribution and coverage: The NSE's mandate is national. Its directly run residential homes are located in Kataragama, Maligatenne, Gampaha, and Pannala (concentration in the Southern and Western provinces). Locations for the establishment of care centres are stated to be determined by infrastructure and financial considerations, existing services available, in addition to accounting for cultural considerations, particularly in the northern province and estate areas (KII 7, 2025).

The NSE oversees the operation of 451 privately operated residential care centres distributed across the country (Table 7), while providing oversight to 315 unregistered privately operated residential care centres.

3 It is noted that although 292 day centres have been established and registered with the NSE, only 190 are currently active

Table 7: Distribution of privately-owned elder care homes registered with the NSE

District	Number of Privately-owned Registered Elder Care Homes
Colombo	87
Gampaha	97
Kalutara	80
Kandy	20
Kurunegala	29
Galle	33
Ratnapura	14
Matara	14
Kegalle	10
Puttalam	9
Badulla	8
Hambantota	7
Batticaloa	5
Polonnaruwa	5
Kilinochchi	5
Matale	4
Vavuniya	4
Anuradhapura	3
Monaragala	2
Nuwara Eliya	2
Ampara	2
Trincomalee	2
Jaffna	13
Mannar	1
Total	**451**

Source: The list of Privately Owned Registered Elder Care Homes, National Secretariate of Elders (2025)

Table 8 below lists the district-wise distribution of privately-operated day care centres registered with the NSE.

Table 8: Distribution of privately-owned elder care centres registered with the NSE

District	Number of Day Care Centres
Colombo	8
Gampaha	8
Kalutara	28
Ratnapura	5
Kegalle	33
Matale	4
Kandy	10
Nuwara Eliya	4
Polonnaruwa	5
Anuradhapura	14
Monaragala	2
Matara	4
Galle	8
Hambantota	5
Puttalam	9
Total	147

Source: The list of Privately Owned Day Care Centres, National Secretariate of Elders (2025)

Financing model: The four residential facilities operated by the NSE are funded by the central government and combine paying and non-paying accommodation under one roof. This mixed paying and non-paying design reflects a redistributive or cross subsidization approach that could be adapted by community-based care service entities alongside a sliding scale of fees levied as they scale.

Through the NSE, registered elders' societies that operate privately are eligible to obtain funding support of up to LKR 100,000 to cover the cost of their operations, while 20 centres annually are eligible for a one-time grant of LKR 3,500,000 for the construction

of an elder day care centre, and LKR 500,000 can be claimed for purchasing equipment for day care centres.

SSE replication potential: Two features are readily transferable to SSE care: (i) mixed-income design (paying and subsidised places), and (ii) transparent admission pathways via local government and courts for neglected elders. These features correspond with the rise in demand for care services as stated by the NSE representatives particularly among the segment of the population who have migrated for employment, and who seek out a reliable facility to care for their elderly parents left behind due to their perception of accountability of service quality attached to a government run entity (KII 7, 2025). The demand from this segment of the elderly population is reported to be highest in the Western Province and the urban areas as, "*There is no one to take care of the elderly at their homes*" (KII 7, 2025). Challenges arising from economic pressures are also reported to have contributed to higher incidents of elderly individuals being abandoned by their families, contributing to the growing demand for residential care services.

b. Department of Social Services – National care services overview

The Department of Social Services (DSS) functions under the Ministry of Rural Development, Social Security and Community Empowerment. This entity operates at both a national and provincial level. The DSS provides support to elders and persons with disabilities belonging to marginalized and disadvantaged communities in an effort to provide them a supportive environment to be self-reliant.

Service type: The DSS operates a diverse portfolio of care services spanning a residential care centre for homeless elder persons referred to by the Courts, as well as a day care centre for children with disabilities, 2 residential care facilities for adults with intellectual disabilities, a pre-vocational skills development centre for children with disabilities, and 11 residential vocational training centres for youth with disabilities which combine care, habilitation and pathways to income generation opportunities.

Engagement of children with disabilities from an early age through skills development centres is recognized to help nurture independence, confidence, and essential social abilities in children, while simultaneously helping to reduce the long-term social and government burden (KII 11a, 2025).

The DSS is responsible for conducting periodic follow ups for individuals without guardians through inspection and reporting mechanisms to maintain minimum standards established by the National Child Protection Authority, and the regional Probation Departments for children, while medical certifications must be regularly updated for individuals with disabilities to ensure auditable use of limited resources.

Geographic distribution and coverage: Eighteen centres nationwide (mix of residential and non-residential) with 11 vocational sites across multiple districts demonstrate national reach where private or community provision is thin.[4]

4 2 Child Guidance Centres for children with disabilities (non-residential)-in Amabalanthota and Navinna; 2 Care Centres for mentally retarded men and women (residential) – in Puwakpitiya and Batugammana; 1 Pre-vocational Skill Development Centre for children with disabilities with a day care centre (non-residential) - in Kottawa; 11 Vocational Training Centres for youth with disabilities (residential) – in the districts of Gampaha, Kandy, Hambantota, Ratnapura, Puttalam, Trincomalee. Kilinochchi, and Batticaloa.

Financing model: Services are predominantly funded via the central government's budget allocation from which the DSS also channels allowances and grants to provincial level DSSs and non-state service providers (including charitable and NGO-run entities). Sourcing a proportion of funding from the DSS on the basis of performance-based contracts is an instrument that could be adapted by SSE entities.

SSE replication potential: DSS's integrated "care-to-skills" model (day care → pre-vocational → vocational) for persons with disabilities is a strong template for service or multi-stakeholder cooperatives to operate community-level units under DSS standards, with public financing blended with modest fees from users and donor top-ups. Feedback from representatives from the DSS indicated the motive for establishing skills-based development day care centres for children with disabilities stemmed from the need to support parents or guardians of these children to engage in economic activities as well as to provide a respite for the caregivers in the home. **"***When children with disabilities are cared for in safe, specialized environments during the day, parents are relieved from constant caregiving responsibilities. This gives them the opportunity to pursue employment, business, or educational activities that improve household income and overall quality of life*" (KII 11a, 2025).

The potential for replication and demand for a similar day care and/or vocational services in close proximity to the community would foster increased engagement. However, its replicability is highly dependent on the availability of skilled and qualified carers alongside adequate demand within an identified geographical locality particularly for non-residential care services.

c. Provincial Department of Social Services – Western Province

The Provincial Department of Social Services (PDSS) while maintaining the same objective as that of the national level DSS, is accountable and equipped to independently operate and monitor the provision of care within its geographic purview. As part of the rapid mapping exercise, the Provincial Department of Social Services for the Western province provided insights into their operations covering the districts of Colombo, Gampaha and Kalutara in addition to its national level counterpart.

Service type: Services by this department are eligible for households which earn an income of LKR 15,000 or less each month. The portfolio of services by the PDSS encompasses a residential elder-care home, an elder day centre in each district, two residential care centres with day-care facilities for children, a child guidance day centre[5] with medical facilities for children with disabilities, a residential care facility for adult women directed by the courts. Eligibility for use of services has to be validated by the Grama Niladhari (GN) officer indicating lack of alternative support mechanisms, while persons with disabilities have to submit a state hospital approved medical request.

The PDSS is also responsible for the oversight of operations of the care providing entities to ensure the minimum standards of care are met in keeping with the legal and policy mandate.

5 This is a non-residential service where children with developmental, behavioural, emotional, or learning difficulties come during the day for assessment, therapy, and structured activities and assistance for vocational skills development opportunities where suitable

Table 9: Distribution of Care centres managed by the Western Province Department of Social Services

	Number of Registered Entities	Fee status		Number of Entities not registered	Fee status	
		Fee levied	Free of charge		Fee levied	Free of charge
Disability care centres	34	No information available		3	No information available	
Elder care centres	94	No information available		64	40	21

Source 1: Data from KII with Department of Social Services

Geographic distribution and coverage: Care services and support for care is concentrated in the districts of Colombo, Gampaha and Kalutara. The western province is identified to have the highest demand for care support services for children, elders and persons with disabilities (KII 11, 2025).

Financing model: The PDSS is funded through the provincial budget and charitable donations which supplement operational expenses. Through its allocated budget, the PDSS provides targeted subsidies and financial support to registered care institutions providing services for free along the following criteria:

- LKR 1500 per disabled child per month if enrolled and attending school; for disabled children not attending school, the monthly allowance provided to the care service provider is LKR 750.
- An annual allowance of LKR 50,000 is available for maintenance and LKR 75,000 for small renovations for registered entities providing care services for persons with disability.
- Care providing institutes are eligible to apply for a one-time allowance of LKR 50,000 to purchase equipment
- Registered elder societies are eligible to apply for a one-off grant of LKR 100,000 to start up an income generating activity on the basis that a project completion report is submitted at the end of the year.

These financing measures have the potential to help existing community-based SSE organizations professionalize and scale locally.

SSE replication potential: Long waiting lists to access services currently offered by the PDSS indicate existing unmet needs particularly for residential and community-based care for a financially vulnerable segment of the population, particularly for residential eldercare. SSE entities could operate on the basis of a blended model of funding support from the PSSD alongside targeted grants and donations similar to a service cooperative to invest in a service at a nominal fee in an effort to bridge the identified/existing care gaps.

d. Local Authorities – Colombo Municipal Council

Apart from the national and provincial-level government institutions, the local authorities, including the municipal councils, urban councils, and the Pradeshiya Sabha, also fulfil the care needs within their ward. As part of this assessment, insights were obtained from the Public Assistance Division of the Colombo Municipal Council (CMC) with regard to its provision of care services to its constituency. These services are guided by the Municipal Councils Ordinance (1947) and the Poor Law Ordinance (1940) which allow for authorities to provide necessary relief to persons unable to support themselves. Beneficiary surveys and residency-based eligibility criteria are used to ensure responsiveness to local needs and maximise resource allocation.

Service types: The CMC operates a residential elder care home, three day care facilities for children, and one day care centre for children with special needs. All services are provided free of charge for residents of belonging to the CMCs purview through qualified staff. The CMC also supports the operations of 12 pre-schools run by religious entities. Access to these childcare services is afforded to households belonging to lower socio-economic strata and where childcare is recognized to hinder the opportunity for mothers to engage in paid employment outside the home.

Geographic distribution: Services are situated in high-need neighbourhoods, particularly across divisions located in Colombo North.

Financing model: Services offered through the CMC are financed by the government (national transfers and municipal budget allocations), with all services offered free at the point of use.

SSE replication potential: Although the demand for childcare services – particularly within the urban context – is noted to be high and growing, service without compensation would not be a sustainable model for replication, unless a blended financing model is adopted with regulatory oversight provided by the CMC to ensure quality of service delivery.

3.1.2 Charitable and Faith-based Care Provision

Charitable and faith-based organisations are among Sri Lanka's most visible first-responders in the provision of care - running residential care homes, day centres and community programmes for the benefit of low- and middle-income households. Although many such entities are not member-owned or democratically governed by users or members, and they may not work independently, but man of these organizations have primacy of social purpose , use donations from public or benefactors for providing services, deep community embeddedness, and collaboration with public authorities. Therefore, care provided through these entities can be considered a bridge for meeting urgent gaps and eventually a platform that can be developed for partnership in the provision of SSE aligned care, if the SSE principles are followed.

Service types: Care provided via these entities span the care continuum, from residential (long-term) elder care, day care for older persons and persons with disabilities, children's homes, mother and child shelters, and preschools, day cares

and after-school programmes for children.[6] Illustrative examples from primary data include Sarvodaya's diverse network of care provision across the country, faith-run children and elders' homes in the Kilinochchi district and a residential elders' home in Moratuwa.

Geographic distribution and coverage: Charitable care entities are widely dispersed and found to be clustered where need is highest such as urban low-income areas (e.g., within Colombo Municipal limits), districts with war-affected populations have a higher demand for elder care due to emigration of family members or loss of children during the war (e.g., Northern Province), and towns with high out-migration where older parents live alone (e.g., Kurunegala district and Northern province). This place-based care footprint matches ILO findings that community-proximate provision is vital to reduce access barriers—travel time, costs and cultural acceptability—and to counter "care deserts" created by migration and women's time poverty (Kuluski et al. 2017). Conversely, the lower distribution of care services for persons with disabilities is attributed to the challenges associated with access and cost of transportation to central locations particularly for non-residential care provision.

Financing models: The predominant funding mechanism utilized by this category of care providers is donation-led financing from local philanthropy (alms givings, birthday remembrances), diaspora support, and in-kind contributions in the form of food, medicines, or volunteering time ensuring the service is available free-of-charge for users. Funds are stated to be used for meeting *"food expenses, clothing, bedding, medical expenses, hospital transportation, care worker salaries, funeral rites of elders, as well as religious and cultural events"* (KII 17, 2025). During primary data collection, some entities reported diversifying their funding portfolio through own-revenues in the form of renting properties, revenue from produce of agricultural plots such as coconut holdings, or operating small shops (KII 5, 2025; KII 17, 2025; KII 18, 2025; KII 8, 2025); while others reported the receipt of small per-capita grants[7] or maintenance subsidies from public authorities. Even among those who received these government subsidies, it was acknowledged that the value of the subsidies and donations was not sufficient to meet a fraction of the cost of operation.

The type of registration of the entity can also pose additional challenges. For example, a charitable foundation indicated ongoing difficulties in securing adequate funds to meet operational expenses as well as payment of staff wages. This was because in the Articles of Association, staff payments were not accounted for as an operational cost. This entity further stated that even if users were willing to pay for use of the facilities, the entity could not accept payment except in the form of donations, further restraining their operational resources; *"some elderly people in these centres are willing to pay an amount to the centre as a fee, but the existing legal background does not support getting funding in this manner"* (KII 4, 2025).

SSE replication potential: The operational model adopted by charitable or faith-based entities has high potential for replication, particularly due to their prioritization

6 At this point, given the limited and overlapping regulatory frameworks for the different categories of care services, a breakdown of entities registered as charities cannot be separated from privately run operations, making it difficult to provide an accurate estimate.

7 The allocation made by the state is usually paid annually as a lumpsum post-payment

of social objectives and re-investing of resources into operations. Further, high levels of embeddedness in communities contribute towards ensuring higher responsiveness to community needs; these can be formalized into management frameworks ensuring democracy in decision making pertaining to the operations of the entity, similar to a service cooperative. Room for improvement exists particularly with regard to ensuring decent work conditions of care providers, as staffing in charitable or faith-based entities is often informal or underpaid and not mandated by existing legal frameworks creating challenges in attracting or retaining qualified care workers.

3.1.3 Cooperative Societies

As part of the mapping exercise, cooperatives were considered as they were determined to be uniquely positioned to expand person-centred, quality care provision while adhering to SSE principles of democratic member control, primacy of social purpose, and reinvestment of surpluses, while also ensuring dignified and sustainable livelihoods for care workers. It is of note that Sri Lanka has a long history of the cooperative movement, spanning multipurpose societies, producer/worker co-ops, thrift and credit societies, and cooperative hospitals which offer practical platforms to expand for the purpose of care provision.

Service types: Care services provided as part of existing cooperatives are established as a supplementary operation to the primary purpose of formation, but cater to the needs identified within the community, particularly members of the existing cooperative entity.

At present, care services offered through existing cooperatives extend to the operation of pre-schools and day care services for children as part of multipurpose cooperatives or thrift and credit societies, and the provision of elder care units as an extension of the operations of the cooperative hospital.

The Nylander Industrial Co-operative Society Ltd, which was formed to support individuals with physical disabilities and was originally established as a care home for persons with disabilities and eventually registered as a cooperative to engage in income generating activities and skill development services for its worker members. Even though this entity does not directly provide care, the worker/members reside at the cooperative premises, and a part of their constitution entails contributions to the health and well-being of its members.

Geographic distribution and coverage: At present there are 29 multipurpose cooperatives registered through the provincial Department of Cooperatives operating preschools with two of these pre-schools extending their services to provide day care services for children. These entities are located in the districts of Galle, Matara and Hambantota in the Southern province; in the district of Kalmunai in the Eastern province; the districts of Kandy, Matale, and Nuwara Eliya in the Central province; the districts of Badulla and Monaragala in the Uva province; and the districts of Ratnapura and Kegalle in the Sabaragamuwa province.

With regard to the cooperative hospitals, there are 16 hospitals[8] across the country registered as cooperative hospitals under the Department of Cooperative

8 Of these 16, only 13 are in operation at present

Development across different districts, with the hospital services registered under the purview of the Ministry of Health. Primary data collection revealed that the Moolai cooperative hospital in Jaffna district has an operational elder care unit, while the cooperative hospital in Matara has recently begun operations of an elder care facility, and the cooperative hospital in Kurunegala is in the process of initiating an elder care centre in response to increasing demand.

Financing models: Most cooperative care activities are self-financed through member shares, annual dues and operating surpluses from core businesses. In an example of a pre-school managed by a fisheries cooperative society in Negombo (in the Gampaha district), users of the pre-school were expected to make a nominal monthly contribution towards the teachers' salaries, while individuals with financial challenges were allowed to pay what they could afford, with the cooperative covering the balance payment – characteristic of SSE principles of cross-subsidized pricing for low-income users.

In the example of the Nylander Industrial Cooperative society, their operations and member wellbeing were self-funded through multiple income generating activities – plant nursery, room rental, laundry services, and a grocery store – led by member initiatives, with dividends distributed as agreed upon by the executive committee and informed by the extent of own-contributions.

Members of cooperative hospitals contribute an annual membership fee LKR 3,000 which entitles them to direct benefits in the form of discounts for medical treatments, in-house care, and diagnostic services like scans, alongside a dividend from profit earned for services rendered. In the provision of elder care located at the Moolai cooperative hospital, respondents indicated that the elder care unit operated independently of the cooperative hospital (in financial terms), with the entity registered under the Private Nursing Home Act rather than through the Department of Cooperatives, with no financial cross-subsidization of either entity. As such, the fees for the use of the elder care unit reflected the operational costs associated with the provision of care, with additional fees being charged to the user depending on additional services requested, with operational surpluses reinvested back into the eldercare unit for the purpose of expanding the service offerings (KII 21, 2025).

As with the guidelines stipulated by the department of cooperatives, all entities registered as a cooperative are subject to an annual financial audit and monitoring of operations. Where a profit has been generated, the societies are obligated to pay 10% of their profits to the cooperative department after 10% has been allocated to the statutory risk fund of the cooperative.

SSE replication potential: The "SUWASETHA" pilot initiative by the Health Department of the Thrift and Credit Cooperative has created the necessary platform and frameworks for cooperatives to provide care services as an expansion of existing operations in five districts by recruiting skilled recent retirees from the government health sector (International Labour Organization 2025). It is noted that there are plans to scale operations nationally indicating interest and potential for replication based on learnings from the pilot interventions. Clear guidelines and oversight concerning care provision for children, elders and persons with

disabilities is of the utmost importance, while access to finance, procurement of care workers with decent work clauses, and capacity-building must also be taken into consideration. Partnership with the department of cooperatives will ensure that care provision can be rolled out among cooperative members to address existing care gaps utilizing the SSE principles while at the same time taking into consideration community needs alongside cultural sensitivities pertaining to 'outsourcing' care.

3.1.4 Donor Driven Interventions

Donor funded initiatives have the potential to step in where public supply is thin and private services are unaffordable. As part of this mapping, a project initiated by a donor organization was reviewed. The primary aim of this project was to pilot community-based day care models for children, elders, and persons with disabilities for the purpose of reducing unpaid care burden borne predominantly by women and allowing them the opportunity for respite or engagement in income generating activities was reviewed (a day care facility for each category was reviewed).[9] The project also aims to examine the potential pathways to create formal jobs in childcare and long-term care from within the community. In the words of a project representative, "*we proposed not just a day care centre, but also to reduce the burden on women who engage in care work. We also focus on advocating to protect women's rights, because women are often marginalized [in care giving]*" (KII 14, 2025). As a pilot initiative launched in April 2024, with day care centres beginning operations in August 2025, findings and lessons learned throughout the project interventions have the potential to be replicated and applied within the broader care provision context.

Service types: The donor programme profiled here focuses on community-based day-care across three care streams—children, elders, and persons with disabilities—designed to free up daytime hours so family carers (most often women) can participate in paid work, education, or personal care. Providers emphasise caregiver relief as a core objective. A representative of the elder day-care centre in Jaffna noted that its purpose "*is to reduce the burden of care faced by family caregivers at home and to provide appropriate care and attention to elderly women*" (KII 22, 2025).

All the centres prioritise households with limited means, offering safe, structured care that would otherwise be unaffordable. As a representative from children's Day Care Centre in Galle explained, *"the parents can't afford the paying day care centres even though there are centres in close vicinity. There is one educated woman, a single parent, who has stopped working since she had no place to keep her child. So, we help that woman by taking care of that child"* (KII 24, 2025).

In practice, these facilities deliver supervised daytime support, basic stimulation and social interaction, regular nutrition, and caregiver respite, with tailored adaptations for each stream (early childhood routines for children; mobility, companionship and monitoring for elders; and accessible activities and training on independent living for persons with disabilities).

The programme also runs a component focused on capacitating women care providers from the respective communities.

9 Children's day care centre in Galle district, elders day care centre in Jaffna district, and day care centre for persons with disabilities in Colombo district.

They have the opportunity to participate in funded caregiver training programmes and the skills and qualifications acquired to be potentially used for gainful employment either at the project-funded care centres or independent employment.

Geographic distribution and coverage: The project spans across 7 districts: namely, Jaffna, Batticaloa, Kurunegala, Galle, Anuradhapura, Nuwara Eliya, and Colombo, in collaboration with 8 community-based organisations. The geographic locations were stated to have been purposively selected to reflect diversity of urban, rural and estate areas and representation of community diversity and respective needs. To this end, particular consideration has been made to include Malaiyaha Tamil women in Nuwara Eliya; women engaged in informal-sector employment in Kurunegala and Muslim women in Kaththankudi in the Batticaloa district. Identified demand for day care centres was also a consideration based on applications submitted for project partnership.

Financial model: As part of the project, all the care centres are being provided with preliminary financial support for capital expenditure for "*purchasing necessary furniture and equipment, setting up the centre, and renovating the premises*" (KII 14, 2025; KII 22, 2025). Financial support is limited to a two-and-a-half-year period, during which operators must find a way to sustain the care centre in the future using its own strategies that correspond with the community context. During the funded period the donor is committed to providing technical knowledge and capacity building support to facilitate the sustainable operations of the entity. At the outset, care facilities will be accessible free-of-charge to ensure access for indigent households. As grant period concludes, through learning from experience sharing among grantees, implementers expect to adopt hybrid SSE-compatible financing, incorporating modest user fees with waivers, solidarity contributions (community donations), micro-enterprises (as a supplementary income source).[10]

Operational and regulatory considerations: Interviews with representatives from the elder day-care centre located in Jaffna indicate that, although operations commenced recently, there is no dedicated registration pathway or minimum standards for care workers for elder day-care or services for persons with disabilities at present, with the government in the process of developing specific guidelines.[11] In the interim, the centre functions under the legal umbrella of the sponsoring social service organisation, which provides a compliant institutional identity for oversight and reporting. Once the new guidelines are promulgated, the centre is expected to obtain independent registration as a facility providing care services for elderly population.

Given the launch of the Department of Cooperative Development's model by-laws for care cooperatives, structured collaboration between the Department of Social Services and the cooperative authorities would help ensure regulatory coherence as alternative and community-based care services expand. Such

10 As the project has only just been implemented, the funding models are yet in the testing phase.

11 This finding was verified during the interview with the representatives of the NSE who indicated that a new National Policy on senior citizens was being drafted. The stated policy was reported to have been launched on October 1, 2025 (https://www.parliament.lk/en/news-en/view/4810?category=33&tmpl=component&print=1). However, it has not been possible to access a copy of this policy at the time of preparing the report.

coordination could align standards on admissions, safeguarding, staffing, supervision, and data reporting, and clarify inspection mechanisms across provider types.

For children's day-care, representatives reported that established guidelines and minimum standards already exist under the purview of the Department of Probation.[12] In this regard, care providers were expected to receive a short-term, six-month permit while completing compliance steps toward full registration. This staged approach—using time-bound provisional authorization to test operational viability—mirrors standard operating procedures in the cooperative sector and offers a practical mechanism to balance service continuity with progressive compliance and quality assurance.

SSE replication potential: The pilot interventions administered through this project address the demand for care services arising within the community, especially targeting the indigent and vulnerable segments of the population who are currently unable to afford paid care services. To this end, the pilot already exhibits SSE adjacent features such as social purpose, community embeddedness, and eventual reinvestment of revenue.

Once models are fully developed, consideration should be given to the replication of successful models with explicit specifications (facility standards, staff ratios and qualifications, safeguarding and referral protocols, admissions criteria, and grievance systems). This codification enables horizontal replication by local groups which should be combined with decent employment conditions for care workers at these entities.

3.1.5 Domestic Workers' Organisations/Unions

In the context of (direct) care provision, domestic workers constitute a significant and growing share of the in-home care workforce, providing support to children, older persons and persons with disabilities through live-in (residential) and non-residential arrangements. Worker organisations have the potential to play a dual role by facilitating job matching between households and workers while representing members' interests. This combination helps address care deficits at community level and contributes to safer, more reliable and better-remunerated home-based care. For the purpose of this mapping, insights gathered from two worker unions and one worker collective in the process of registering as a cooperative are reflected.

Service modalities: Domestic workers facilitate a continuum of household-based (direct) care services. These include personal care and support for daily living for older persons and persons with disabilities in the form of mobility assistance, hygiene, nutrition, medication reminders, companionship and supervision; as well as childcare through daytime care, after-school supervision and basic learning support.

Union representatives observed that domestic workers' tasks rarely consist of direct care tasks alone. Care responsibilities are frequently bundled with indirect household work—cooking, cleaning and related duties—making it difficult to distinguish and recognise care as a specific service particularly within a household environment (KII 13, 2025; KII 15, 2025). This blurring of roles, compounded by the

12 Detailed information pertaining to the existing guidelines and policies is elaborated on in section 4.1

informality of the sector and limited legal and social recognition, poses challenges for ensuring workers' rights, appropriate remuneration and overall well-being of workers.

Selected workers' collectives[13] provide pre-placement and wrap-around support which entails expectation-setting between workers and employers, and basic training on leadership, communication, workers' rights and financial literacy. Some organisations also offer the service of facilitating an in-person meeting between worker and employer to confirm duties, hours, remuneration and working conditions (KII 15, 2025). Domestic worker union representatives noted however that such formal discussions between union members and employers occur infrequently, as employers prefer to reach out to workers directly (sans obligations towards decent working condition) (KII 15, 2025); reinforcing their objective to ensure workers are capacitated to advocate for their rights and ensure decent working conditions.

Rights protections and skills development: (Domestic) workers' unions continue to advocate to extend statutory protections to domestic workers—including coverage under National Minimum Wage Act —promote written contracts, safe working conditions, and full and timely payment of wages, as well as strengthening access to social protection for workers within the informal economy. As domestic workers do not presently come under the purview of the existing labour law, a key mandate of the domestic workers union is the provision of training and awareness of labour rights, financial literacy support, skills development, collaboration towards the formalisation of domestic work and contribution to enhance the quality in care provision.

Coverage and membership: The workers' collectives consulted as part of this assessment have membership that spans the country, with concentrations in urban and estate areas and representation from rural locations. Geographically, membership is concentrated in the districts of Kandy, Colombo, Hatton, Jaffna, Vavuniya, Hambantota, Mannar, Galle, Ampara and Batticaloa, reflecting broad territorial reach and linguistic diversity. Women constitute approximately 90 per cent of members. While domestic workers form the majority of the membership, workers' unions also organise other informal workers, including street vendors, estate workers and pre-school teachers engaged in Early Childhood Care and Development (ECCD). Given the nature of domestic work—dispersed workplaces, irregular hours and limited time off— respondents reported persistent difficulties in convening members regularly and in recruiting new members, particularly among live-in workers and those holding multiple short-term work placements.

Financing and sustainability: Worker organisations are primarily financed through modest (and often non-compulsory) membership contributions of approximately LKR 100 per month collected by branch leaders. These fees support member training and organisational activities. However, not all members are in a position to make the required financial contributions based on their economic conditions.

13 The term "Workers' collective" is used here to encompass both domestic worker unions representatives and the (pending) worker cooperative.

At present, additional income for the workers' collective is not generated through placement facilitation services offered – although the potential does exist. While these entities are not fee-for-service providers (such as manpower agencies), their organising infrastructure underpins the matching, follow-up and member support functions that enable care delivery.

Governance and accountability: Worker unions are registered with the Labour Department under the Trade Union Ordinance; registration is possible from as few as seven members. They may also affiliate with other unions and form federations to strengthen representation and service delivery. Governance is member-based and typically exercised through an elected executive committee, supported by local leaders and regular meetings.

Accountability to members is maintained through: (i) standard approaches to wage floors, hours and leave; (ii) procedures for grievance handling and prevention of harassment; (iii) guidance on access to social security and savings instruments; and (iv) routine reporting to members on activities and finances. These arrangements reinforce democratic control, transparency and responsiveness, consistent with principles of the social and solidarity economy.

Consistency with SSE characteristics: Domestic workers' organisations exhibit features that are consistent with the social and solidarity economy. Their primary purpose is social: improving livelihoods and dignity for a predominantly female workforce while responding to community care needs. Governance is democratic and member-led, with participatory decision-making. Economically, the organizations mobilise solidarity finance through pooled membership contributions and reinvest resources in member services—such as placement, training and support—thereby aligning with the SSE principles of primacy of people over profit, democratic control and reinvestment for social objectives.

Pathways for SSE correspondent replication: In order to consolidate and scale contributions to care through worker organisations within a SSE framework, the following measures can be considered. Transition of selected operations into cooperative or multi-stakeholder service entities that issue standard contracts, set transparent wage parameters and provide pooled benefits such as insurance, leave, and occupational safety and health provisions. Another measure would be to standardise quality and safeguarding through service specifications—skills verifications, reference checks (for workers and employers), complaint and redress mechanisms, and routine data reporting—to enhance reliability for households and protection for workers. Strengthening skills pathways by partnering with TVET institutes and recognised providers to certify competencies in elder care, disability support and childcare, enables wage progression linked to skills.

While the potential to evolve placement and support functions alongside enhancing skills and embedding democratic governance and accountability through a worker-owned collective or union-backed cooperative could strengthen service quality and job security, some union representatives cautioned against pursuing organisational changes that might weaken advocacy. In the current context—where domestic work is not fully recognised in law—disbanding or reconfiguring unions to manage service delivery is perceived

to potentially dilute their core mandate of organising and lobbying for legal reforms. *"Unions and cooperatives are different, and cooperatives can't secure the rights of the workers. We should not apply the cooperative system to fulfil the rights, and cooperatives are done only for social solidarity. Also, the cooperatives are for financial sustainability, where a membership fee and interest are included. But the unions are for rights. Therefore, a cooperative system is not for the workers in the care sector"* (KII 13, 2025). These Domestic Worker union representatives emphasised that sustained, independent union action remains essential, particularly to advance recognition of care work undertaken within the domestic sphere and to press for the ratification and effective implementation of standards consistent with the ILO Domestic Workers Convention, 2011 No. 189. A pragmatic path, they suggested, was to maintain robust unions for rights-based advocacy while exploring complementary, SSE-aligned service models that do not compromise the unions' primary representational role. It is noted that perspectives among organised workers are not uniform; an interview with a representative of another worker union indicated openness to experimenting with a union-backed cooperative model as a pragmatic option in the current context where legal recognition and protections remain limited, provided that such structures are explicitly grounded in a rights-based agenda. This points to potential space for differentiated strategies in which some unions continue to prioritise independent organising , while others pilot cooperative arrangements a complementary vehicle for securing pooled benefits and improved oversight of working conditions for domestic and home-based care workers.

3.2 Actors with the Potential for Caregiving

While the following two entities – community-based associations and livelihood-based societies – do not engage in the provision of care services at present, their operational characteristics indicate the potential for them to do in a manner that is consistent with SSE principles.

3.2.1 Community-based Associations (as platforms for SSE aligned care)

Community based associations in Sri Lanka such as elders' societies, death-benefit societies, women's rural development societies (WRDS), were not originally constituted to deliver care. Nonetheless, they are embedded in the very communities where care needs are growing and have the potential to close the emerging care gaps. Furthermore, they already operate with democratic practices (executive committees, member meetings, elected office-bearers) and a primary social purpose; practices which correspond with the SSE principles and make such groups credible vehicles to expand affordable, quality, community-based care while advancing decent work.

Geographic distribution and coverage: Community based associations like elders' societies are widely present at the Grama Niladhari (GN) level and can be federated upward (Divisional Secretariat, district and provincial layers), creating a ready-made territorial network that mirrors how demand for care manifests locally. This neighbourhood footprint is particularly relevant as Sri Lanka faces an ageing population, and care-related constraints affect women's employment.

Financing models: Most associations collect modest membership dues and mobilise in-kind solidarity through volunteering time, refreshments, and/or transport. Some entities also undertake micro-enterprise activities such as renting community assets (tents, halls) or undertaking small service contracts which contribute towards the development of a common fund. Representatives from the PSSD reported that, "*some elders' associations get the contracts for road construction, and they hire someone else to do that and keep 3% commission for their fund*" (KII 11, 2025). As local authorities and the Department of Social Services already provide seed grants for small livelihood activities, these can be ring-fenced to co-finance care pilots.

Governance and accountability structures: These associations already practice member democracy through elected executive committees, conducting periodic meetings, and maintaining of basic financial records, often audited or reviewed by divisional or provincial authorities.

How they can expand to deliver care: Similar to how multi-stakeholder cooperatives operate, these entities can expand their existing operations to provide care services; this can be facilitated through codifying or expand existing Articles of Association to establish minimum standards pertaining to admissions and safeguarding protocols for care receivers and care givers, staff/volunteer roles and training, complaints and redress mechanisms, and routine data reporting which align with local regulatory requirements and inspection systems (public health departments, probation/child protection, social services offices where relevant).

With some standardisation, regular meetings by elder societies can be formalised into structured day services (fixed opening hours, planned social and stimulation activities, nutrition checks, medication reminders) in a dedicated community facility, where upon development, home-visiting and wellness checks for frail older persons and persons with disabilities, could be coordinated with local public health teams. At the same time, the care workers also receive decent wages and working conditions and benefit from the different labour protection measures, including social protection.

3.2.2 Livelihood Societies as Platforms for Care Provision

Livelihood-based societies/collectives such as producer groups, thrift-and-credit associations attached to value chains, and women-led enterprise collectives—are well placed to act as vehicles for community care. They are rooted in local economies, governed by members, and oriented to mutual benefit. These features align with the SSE principles under consideration and have the potential to be leveraged and expanded for the provision of affordable, quality care while supporting women's economic participation.

Sectoral entry points: Livelihood groups are widespread in Sri Lanka's districts and often organised along value chains (fisheries/seaweed, agriculture, handloom, dairy). In the Northern Province, for example, ILO-supported women's seaweed initiative has strengthened producer organisations and market access—creating a practical platform to co-locate childcare near processing or aggregation points. While contexts differ by district, the underlying model—linking care provision to the rhythms and places of work—is replicable across urban, rural and estate areas. Integrating care into this

organisational fabric directly addresses time and mobility constraints—especially for women workers—thereby reducing unpaid care and enabling steadier engagement in paid work as reiterated by a representative of the seaweed society in Kilinochchi district who stated, *"if there were a proper child care centre, our work could be completed within three or four hours instead of five to six hours"(*KII 20, 2025).

Community feedback and implications for childcare, contrasting needs in seaweed cultivation and crab processing: Evidence from two livelihood streams.

Evidence from women engaged in seaweed farming

Qualitative feedback from the president of the seaweed farming society in the district of Kilinochchi highlighted the developmental and practical value of a community childcare centre due to existing care gaps. She emphasised that at present, members of the society without care support networks would bring their young children with them to the shoreline where they were kept in cloth cradles hung from trees; the children would subsequently be minded by other mothers who would take turns to watch the children when they needed to wade into the water to hang and clean the seaweed. In light of their current practices, she expressed a willingness of her fellow members to co-finance childcare collectively if a reliable, affordable centre were available near their work sites. Such a dedicated and safe space where children could "run, sing, and play together" is expected to foster social development, especially for children who would otherwise be subject to daily isolation while their mothers work. She also linked centre-based care to improved nutrition of the children and to the ability of society members to complete work within a predictable three to four-hour window (as opposed to the current five-to-six-hour duration accounting for time taken to mind children in shifts). Importantly, she stressed the need for trained caregivers, proposing that "suitable women from our village" be trained and employed—an approach consistent with the SSE emphasis on local job creation, skills development, and reinvestment in community capacities.

Despite the recognised need and willingness for usage, a key constraint in establishing a care centre is attributed to start-up capital for building and furnishing. In terms of utility, it was stated that approximately 100 children of society members were likely to enrol, indicating an ability to contribute towards caregiver salaries. Furthermore, women engaged in income generating activities outside of this industry, are also stated to have expressed willingness to make use of a centre if established.

Evidence from a crab shelling factory worker

According to a female a worker at the crab processing factory in Kilinochchi, although a childcare building was constructed at the outset within the factory premises, it was never utilised. In this context, the respondent stated a preference among the women in the community to leave children with relatives or pause work until their children started schooling due to concerns about quality of care and inability to pay. She went on to state that *"we have some hesitation, as care provided by others may not equal our own*" (KII 19, 2025). While a worker did agree that a nearby child-friendly facility with play areas and snacks would help, it was expected that the employer should contribute to caregiver salaries given their low and variable earnings – affected by

seasonality and the size of the crab. In this context therefore, the existence of a facility did not translate into uptake because it lacked perceived quality assurance and did not match workers' financial realities. Thus, indicating that uptake and sustainability depend on trust, demand, quality, and affordability.

Therefore, it is recognised that livelihood-based societies can serve as credible, SSE-consistent vehicles for childcare when models are tailored to the specific needs, risks and resources of each community. The feedback from the seaweed society points to the efficacy of short, proximity-based ECCE with locally trained caregivers and cost-sharing mechanisms anchored in producer solidarity; the feedback from the respondent attached to the crab-processing plant underscores that infrastructure alone is insufficient without trusted quality assurance, employer co-financing and fee policies aligned to irregular, piece-rate incomes. An SSE approach therefore implies community (democratic) governance (parent–worker committees and transparent reporting), blended financing that protects affordability while securing decent work for childcare staff, and service standards adapted to local work patterns. By coupling democratic oversight with reinvestment of any surplus in training, safeguarding and materials, livelihood societies have the potential to deliver child development benefits, reduce women's unpaid care, and stabilise labour-market participation—provided that models are, co-designed with users, responsive to context, and embedded in district systems for inspection, referral and support.

4. Overview of Legal and Regulatory Requirements for Operating Care services

An enabling legal and policy environment is essential for the delivery of safe, quality care while advancing decent work. The importance of this requirement is anchored by two global instruments. First, the ILO Promotion of Cooperatives Recommendation, 2002 (No. 193) calls on Members to establish supportive legal frameworks and public policies that respect cooperative autonomy while ensuring sound governance, transparency and oversight. Second, the 2022 International Labour Conference Resolution on decent work and the SSE urges governments to create conducive conditions including clear legal forms, access to finance and public procurement, capacity-building, and coordination with line ministries, so that SSE entities can expand services without compromising rights or quality. Together, these set the expectation that care cooperatives and community-based providers operate under robust sectoral regulation, and that public authorities put in place coherent inter-agency stewardship.

Sri Lanka does not have a "Framework Law", i.e., a general law, applicable to Social Solidarity Economy from a 'whole of government' approach to integrate SSE principles across different SSE Organizations engaging in different sectors. Nevertheless, in view of the SSE values, principles and organizational forms already identified, it can be argued that several legal enactments including the Cooperatives Societies Act No.5 of 1972 (as amended), Societies Ordinance 16 of 1891 and the Companies Act No.7 of 2007 encompasses SSE components in general. Thus, it can be contended that Sri Lanka has specific legislation, i.e., piece-meal legislation, applicable to a particular type of Organizational form belonging to the SSE. However, it is noted that due to the absence of established cooperatives or other SSE entities engaging in care work in Sri Lanka, a general examination on the legal and policy framework on such specific legislation in Sri Lanka was conducted with a special focus on Cooperatives and is available as Annex A.

In Sri Lanka, existing cooperative law does not preclude cooperatives from adding care services to their objectives or delivery of services, provided their articles of association and respective by-laws are amended; as such cooperatives operate on **self-governance principles** through their bylaws and working rules approved by the General Body. However, one of the ongoing challenges for the cooperative sector in Sri Lanka is the limitation placed on their ability to engage in certain types of economic ventures due to other overlapping laws (International Co-operative Alliance 2020).[14] In view of the above, it can be argued that care cooperatives operating in the care sector would likely be subject to the legal and regulatory requirements governing the said sector.

14 For example, for the formation of a cooperative engaged in insurance, obligations under insurance law, monitory law and BOI related legislation would necessitate the formation of a public company listed in the Stock Exchange. See ICA, 'Legal Framework Analysis: National Report – Sri Lanka' (n 5) 6

The effective protection of care recipients requires cooperative registrars to work in tandem with competent authorities for each subsector—childcare, care for older persons, and disability support. As SSE-specific rules pertaining to care are not yet codified, care providers should be guided by established standards for the provision of care that govern particular care sectors and by core labour standards with regards to care workers. Aligning cooperative and community-run services with these instruments—through licensing, routine inspection, grievance and redress mechanisms, and data reporting— will help ensure the welfare and rights of users while operationalising SSE principles of democratic governance, primacy of purpose and reinvestment.

Following are the existing regulatory requirements with regard to the provision of care for children, elders and persons with disabilities.

4.1 Legal and Policy Framework Governing Childcare

Sri Lanka's policy and legal framework for childcare comprises a series of statutes and policy instruments that together seek to safeguard children's rights, welfare, protection, safety, development and education, particularly in early childhood and in non-family settings. At the national level, the Department of Probation and Child Care Services under the Ministry of Women and Child Affairs is responsible for licensing, regulation, supervision, welfare facilities for orphans, abandoned, destitute children, and coordination with provincial authorities. The National Child Protection Authority (NCPA) is responsible for policy formulation on child protection, coordination, minimum standard setting (including for CDCs) and monitoring abuse. The National Secretariat for Early Childhood Development is tasked with formulating and operationalizing Early Childhood Care and Development and acts as the central agency in implementation, coordination and networking of early childhood development programmes across governmental, non-governmental and private providers (Ministry of Women and Child Affairs 2025).

4.1.1 Licensing requirements for establishing a child development centre

Under Policy 1.1.1 of the National Guidelines and Minimum Standards for Child Development Centres (2019), before commencing operations, a CDC must obtain a licence or temporary permit from the relevant Provincial Department of Probation and Child Care Services. Applications include police reports for workers and three character certificates for each member of the management committee, which must comprise at least five members, three of whom reside locally. Licences are valid for three years, non-transferable, and separate licences are required for each branch.

The said National Guidelines defines a Child Development Centre as follows:

> *A child development centre is an organization where children who are looked after by persons other than their relations are (living) and that provides love, protection and accommodation equally to every child living in that organization. It is an organization that has met all the prescribed standards, that maintains all those standards throughout the relevant period, and that functions as*

> *a child development institute having obtained a licence issued by the Provincial Department of Probation and Childcare.*
>
> *Such organizations (include) all child receiving centres run by the government, government detention homes, certified schools, houses of detention, child development centres (children's homes), safe houses and children's homes/childcare institutes* ***run by private, voluntary or charity organizations*****"**.

Accordingly, the licensing requirement is applicable to government, private, voluntary or charity organizations which run child development centres.

Temporary permits may be issued for one year to centres operating while they complete statutory requirements; applicants must meet all prerequisites and agree to implement the Guidelines. If standards are not met by expiry, the application is rejected, and the centre is subject to legal closure. Licences must be renewed every three years, with complete documentation submitted at least three months before expiry; late or incomplete applications result in expiry of the licence and render operations illegal, triggering closure. However, the implementation of the National Policy Framework is very much dependent on the institutional framework which will be addressed under section 4.4. of this study.

4.1.2 Training, Skills and Qualification of Childcare Workers

Provincial probation–childcare services departments are tasked with developing capacity-building plans and conducting periodic educational programmes. The *National Policy on Preschool Education (2019*), prepared by the National Education Commission, reinforces quality in preschool education, including a dedicated focus on workforce development to ensure preschool teachers are appropriately qualified (National Education Commission 2019). The *Orphanages Ordinance* when considering registration, demands that the manager or other staff in the orphanage are fit in character and repute; this requires that staff be physically/mentally fit, and free from alcohol/drug addictions.

The *National Guidelines and Minimum Standards for Child Development Centres* (CDCs) *(2019),* which is applicable to *"all child receiving centres run by the government, government detention homes, certified schools, houses of detention, child development centres (children's homes), safe houses and children's homes/childcare institutes* ***run by private, voluntary or charity organizations",*** require centre managers to arrange staff skills development and stipulates that managers and caregivers attend at least three training or development sessions per year. The Guidelines also set educational and qualification thresholds for staff:

- Managers: NVQ Level 6 in Child Development, two subjects at G.C.E. Advanced Level, and a minimum of five years' experience
- Assistant centre managers: NVQ Level 5
- Child Caregivers: NVQ Level 4 and at least six G.C.E. Ordinary Level subjects (including language and mathematics).

When recruiting staff (managers, assistants, caregivers, substitutes, domestic workers, and volunteers) for employment at CDCs, all staff are expected to be registered and approved by the Provincial Department,

with approval renewed every two years. Only female caregivers/managers are allowed to work in centres for girls. Adequate staff to child ratios are expected to be maintained as determined by the respective Provincial Departments of Probation and Child Care Services.

The recently approved *National Policy on Child Daycare Facilities in Sri Lanka (2024),* recognizes "the Quality of Care" as its first area for policies and strategies, and Policy 1.6 therein requires to ensure that "*caregivers in every child day care centre are professionally qualified*". The Policy also states that the Daycare Centre Management should be held responsible for ensuring structural quality of the care provided, including staff qualifications.

4.2 Legal and Policy Framework Governing Eldercare

The legal and policy framework for the provision of elder care in Sri Lanka is built on the statutory framework laid by the Protection of the Rights of Elders Act, No.9 of 2000 (as amended) (PREA), and accompanying regulatory regimes which govern private medical and nursing institutions. Sri Lanka does not have specific legislation addressing long-term care in Sri Lanka.

Moreover, under the statutory framework set by the PREA, the primary "duty and responsibility" of caring for "parents" under Section 15(1) falls on their children. Although Section 15(2) stipulates the duty of the State to provide "appropriate residential facilities to destitute elders", the PREA has not prescribed detailed operational or technical standards for elder care institutions or caregivers.

4.2.1 Licensing requirements for establishing an elder care centre

Under the amended section 16(1) of the PREA, "any person or organisation" ("voluntary or otherwise") that provides services or assistance to elders must be registered with the NSE, "if such institution has more than five elders residing therein". The failure to register such organization is an offence under Section 16(2) of the said Act.

The Council is empowered, including under section 36, to visit and inspect registered entities and, where there is reason to believe eldercare is being provided, unregistered entities as well. The NSE, established by the PREA, is responsible for formulating and implementing national policy on elder welfare, coordinating public and private efforts, and supervising eldercare institutions. Until 2015, the standards for operation of such "approved organizations/persons" were governed by '*Sri Lanka Standard (SLS) 1506:2015 for eldercare homes'* by the Sri Lanka Standards Institute which accounted for infrastructure of the care providing entity than the quality or standards of care services; monitoring under that standard has since been paused pending revision and the introduction of a new process.

Implementation is decentralised with Divisional Secretariats and Provincial Departments of Social Services responsible for identifying and supporting vulnerable older persons, delivering services at community level, and monitoring local institutions. This devolution allows responses to be tailored to demographic and regional needs, within a nationally coordinated framework.

The *Private Medical Institutions (Registration) Act, No. 21 of 2006* (PMIRA), which regulates medical and nursing institutions (including nursing homes) mandates under Section 2 (together with Section 4) that no person shall establish or maintain or operate a private medical institution without a certificate of registration issued by the '*Private Health Services Regulatory Council*' (PHSRC). Under Section 9, 10, 13 and 14 of the Act, the PHSRC is empowered to authorize to inspect, enforce standards, set minimum standards for staffing and care, quality assurance, thus applicable to elder care homes or institutions providing medical or nursing care. However, based on the interpretation of "Private Medical Institutions" under Section 20 of the PMIRA, the provisions of the Act are likely not applicable to services providing in-home nursing assistance.

The Auditor General's 2023 Report on the Private Health Service Regulatory Council observes that despite registration requirements stipulated under the said Act, a "formal method had not been prepared and implemented by the Regulatory Council to identify and register the private medical institutions that should be registered and to implement the provisions under the section 4 of the Act regarding the institutions that do not get registered (Auditor General's Department - Sri Lanka 2023)".

4.2.2 Training, Skills and Qualification of Care Workers

Provisions on workforce competencies are partial and distributed across instruments. The National Elderly Health Policy (2017) identifies capacity building among service providers as a core strategy, signalling the need for training of public health staff and caregivers involved in eldercare. Under the PMIRA, the PHSRC is mandated (including via section 10(b)) to ensure minimum standards for the recruitment of staff in private medical institutions; caregivers employed in facilities regulated by the PMIRA must therefore meet qualification requirements set by the Council. However, as of 2023, it has failed to publish any regulations relating to the minimum qualifications of staffing and personnel (especially for non-medical staff, paramedical services, nursing etc.) (Auditor General's Department - Sri Lanka 2023).

By contrast, while the PREA establishes registration and oversight of organisations, it does not prescribe specific training or qualification standards for individual caregivers in non-medical eldercare institutions. This creates a regulatory gap in settings that provide social or residential care without falling under the PMIRA. In practice, advancing quality and safety will depend on aligning forthcoming standards and inspection processes with explicit competency requirements, and on strengthening capacity-building obligations for all cadres engaged in eldercare.

4.3 Legal and Policy Framework Governing care for Persons with Disabilities

Sri Lanka's disability-care framework is anchored in the *Protection of the Rights of Persons with Disabilities Act, No. 28 of 1996*, as amended by Act No. 33 of 2003 ("PRPWDA"), and complemented by the National Policy on Disability (2003). The Act establishes a regulatory architecture for registration, supervision and accountability of organisations providing services to persons with disabilities, while the Policy identifies priority areas—care and rehabilitation, community-based rehabilitation, and capacity-building—without prescribing

uniform qualifications for care workers across institutions.

Under section 2 of the 1996 Act, the National Council for Persons with Disabilities is constituted as the central authority to promote and protect the rights of persons with disabilities. Section 12 sets out the primary function of the Council to be promotion, advancement and protection of the rights of persons with disabilities. Under Section 13(l) of the Act, other functions of the Council include "*to establish and maintain institutions* to accommodate and care for persons with disabilities and provide educational and vocational training for such persons".

4.3.1 Licensing requirements for establishing a centre for persons with disabilities

The Act requires providers to operate within a formal oversight system. Section 20 prohibits any "voluntary organisation" from offering "services or assistance in any form or manner" to persons with disabilities unless it is registered under the Act. Section 32 empowers the Council to enter and inspect premises providing such services to monitor compliance. Such power to enter and inspect extends under Section 33(b) even to voluntary organizations which are operating without being registered under the Act. Nevertheless, the PRPWDA does not stipulate any operational conditions or requirements such registered organisations must follow.

Furthermore, it is important to note that the PRPWDA under Section 3(b) refers "voluntary organizations" to be "any bodies corporate or unincorporate which are engaged in providing services to persons with disabilities including self-help organizations of persons with disabilities". Thus, the registration requirement under the statutory framework appears to be limited and does not encompass a fully-fledged licensing requirement applicable to all private and informal care providers. Operationally, the Council is supported by the National Secretariat for Persons with Disabilities (NSPD), which implements national policies, coordinates registered institutions, oversees welfare services, compiles statistical information and supervises care facilities. The Department of Social Services delivers services at ground level—such as assistive devices, vocational training, support to inclusive education and caregiver training—in coordination with provincial and divisional social service offices. This arrangement facilitates decentralised delivery while maintaining national oversight.

4.3.2 Training, Skills and Qualification of Care Workers

Mandatory, cross-cutting standards for individual caregiver qualifications are limited in current law. The *Protection of the Rights of Persons with Disabilities Act* does not impose statutory certification requirements on individual care workers. The *Rehabilitation of the Visually Handicapped Trust Fund Act, No. 9 of 1992* focuses on the welfare and training of beneficiaries (visually impaired persons) and likewise does not establish uniform certification requirements for personnel across disability-care institutions. Policy instruments such as the *National Policy on Disability* (2003) requires that teachers, instructors and other categories of workers in Early Childhood Care and Development (ECCD) Programmes, Pre-schools and Kindergartens will have training adequate for the inclusion of children who have disability, while the *National Health Policy*

(2016–2025) and the *National Strategic Framework for Palliative Care Development* (2019–2022) set goals to strengthen human resources for disability and chronic care, but serve as policy guidance rather than enforceable legal mandates.

Overall, the legal framework provides an institutional and regulatory basis for the registration and oversight of disability-care providers (as institutes), while standards for individual worker qualifications remain largely advisory and dispersed across policy documents. Furthermore, it is observed that no centralised mechanism currently enforces minimum qualifications for all care workers or standards of care across the sector. It can also be concluded that the current legal and policy framework on the provision of care for persons with disabilities focuses primarily on the beneficiary, rather than care provider.

4.4 Decentralized Implementation of the Regulatory Framework

Across the sectors of childcare, elder care and care for persons with disabilities, Sri Lanka adopts a decentralized approach for the implementation of its laws and policies.

For example, under List I ("Provincial Council List") in the Ninth Schedule to the Constitution, "Education and Educational Services" and "Probation and Child Care" are respectively devolved expressly to Provincial Councils. Thus, implementation of the regulatory framework relating to childcare and education is devolved, with Provincial Departments of Probation and Child Care Services responsible for the administration and regulation of preschools and childcare institutions.

Similarly, "Rehabilitation and welfare of physically, mentally and socially handicapped persons", "The Rehabilitation of destitute persons and families;" and "Relief of the disabled and unemployable" are also devolved powers under List I ("Provincial Council List") in the Ninth Schedule to the Constitution. Thus, care for persons with disabilities and eldercare also fall within the purview of the Provincial Councils.

However, under 'Item 9.2', 'The supervision of private medical care, control of nursing homes and of diagnostic facilities within a Province' falls under the "Concurrent List' of the Constitution, whereby both the central Government and the Provincial Councils share power. Despite this architecture, and at times resulting therefrom, the sector faces numerous discrepancies in practice, particularly pertaining to uneven implementation of policies across provinces.

For example, while day care centres should be registered with the Provincial Departments of Probation and Childcare, in many provinces, child day care centres catering to children under five years of age are in fact registered with the regulatory bodies established for preschool education. In the Uva Province, day care centres or any other centre conducted for the physical and mental development and security of children below five years of age have to register with the Early Childhood Development Authority. Furthermore, there are day care centres registered as businesses in the Provincial Departments of Business Names Registration, raising the question of consistency. Furthermore, the absence of standardised fees for private day cares and preschools can impede inclusivity and equitable access overall.

Such observations as to the discrepancies pertaining to the registration requirements were made expressly in the '*National Policy on Child Daycare Facilities in Sri Lanka (2024)*' which was recently introduced with the primary goal of standardizing and formally regulating day care centres uniformly across the country" (National Child Protection Authority 2024). Thus, there is acknowledgment from the State and its stakeholders that the decentralized framework is impeding the uniform application of the regulatory framework. This is particularly the case with regards to national policies as they are inherently non-binding in nature.

It is worth noting that in view of its primary goal, the policy makers had specifically considered possibility of the devolved institutional framework impeding the uniform implementation of the policy across the country. Therein, the following observations had been made by the officials:

"The official representing the Attorney General's Department pointed out that though matters related to probation and child care services are under the purview of Provincial Councils, since Provincial Councils have not been established, the Central Government can act in this regard. Furthermore, the provincial chief secretaries also pointed out that if the Cabinet approves this national policy, there will be no problem in implementing it in the provincial councils. Furthermore, the Provincial Chief Secretaries, who informed the Committee regarding the current methods related to child day care facilities, pointed out that by implementing this national policy, a common method can be implemented for the entire country (Parliament of Sri Lanka 2024)".

4.5 Concluding Remarks on the Legal and Policy Framework on the Provision of Care

In view of the above analysis, it can be concluded that the statutory framework applicable to the provision of care for children, elders and persons with disabilities views care from a traditional perspective and prioritizes to regulate "medical care" provided by care providers. Thus, important contemporary aspects of care such as long-term care and non-medical care, aid and/or assistance are not adequately addressed by the existing statutory framework.

While the policy framework governing early childhood and education and childcare is robust and comprehensive, the inherent non-binding nature of policy documents coupled with the decentralised implementation approach poses concerns about the efficacy and effectiveness of the national policy framework in general.

Overall, the legal and policy framework has identified the need for registration and/or licensing, the need to ensure standards of care and capacity building and the need for oversight and accountability of care providers. Nevertheless, the regulatory framework appears to be fragmented, inconsistently implemented and insufficiently aligned with contemporary needs.

Recognizing the fact that registration requirements, standards of care and monitoring and supervision are attempts to ensure the dignity, safety and security of care recipients and are directly related with and founded on substantive human rights of care recipients, the same standards should apply to all care providers across the three sector, including care provided through any potential SSE entities.

Factors that Enable and Challenge the Operationalization of Care Cooperatives and other SSE Entities in Sri Lanka

Sri Lanka's demand for care is rising. It is driven by demographic trends such as ageing, migration, and changes in household structures, while formal, affordable provision remains sparse outside major urban centres. In this context, lessons from other countries indicate that cooperatives and other SSE entities are recognized to be well placed to expand access to quality care and create decent work, characterized by their embeddedness with the community, and operation modality of people-centred governance and reinvestment norms. In the Sri Lankan context, the pathway from potential to scale of care provision through entities informed by SSE principles runs through a thicket of regulatory, accountability and compliance gaps, financing fragility, skills bottlenecks, over-reliance on public subsidies and uneven demand. The factors below synthesize what enables (and impedes) the formation, sustainability, and expansion of care cooperatives and allied SSE entities in Sri Lanka, drawing on the mapped institutional landscape, legal environment and early operational examples presented above.

5.1 Formation

Enabling factors

- **A wide cooperative footprint and a range of SSE-consistent platforms.** With over 16,000 registered cooperatives there is an institutional base, governance familiarity, premises, and audit routines that new care arms can leverage. Multipurpose cooperatives already run preschools; cooperative hospitals are adding elder-care units—displaying clear precedents for care as a sub-arm. Community associations (elders' societies, women's societies) and faith-based providers present further platforms for local pilots.
- **Policy momentum and model by-laws.** The Department of Cooperatives—working with the ILO—has issued model by-laws for care cooperatives, giving founders a compliant template for governance, membership, safeguarding, and service scope. This significantly lowers the transaction cost of starting up.
- **Care Cooperative training tools:** The ILO has also provided training on setting up of new care cooperatives or extending care services through existing COOP/SSE entities through Think.CareCOOP and Start.CareCOOP training tools. These along with Manage.COOP training, can build the capacities to encourage care provision via care COOP/SSE entities in Sri Lanka.
- **Public programmes to partner with.** The National Secretariat for Elders (NSE), the Department of Social Services (DSS), provincial

social services, and local authorities already run elder care centres, disability day care, and pre-schools. Their standards, referral channels, and (in selected places) mixed-fee models are frameworks for cooperative entrants and potential users of services.

Challenges

- **Fragmented regulation for care, especially non-medical elder and disability support.** Childcare has clearer standards; but non-medical eldercare and disability care lack uniformly enforced worker qualifications and safeguarding rules. Existing regulations emphasise wellbeing of care beneficiaries rather than working conditions and labour rights of paid care providers. Founders of care providing entities face uncertainty on licensing pathways and inspections across multiple authorities (cooperatives, social services, health, probation department for childcare).
- **Start-up capital and premises.** Care facilities need compliant spaces and equipment. Where cooperatives lack assets, they depend on philanthropy or concessional access to public buildings; many charities' constitutions also constrain fee collection, complicating hybrid models from day one, affecting recruitment of qualified workers.
- **Cultural trust and demand formation.** Households often prefer family-based care, uptake hinges on visible quality and safety. Centres that exist without credible staffing or standards struggle to attract users (e.g. crab factory worker); conversely, where trust is built, women's groups (seaweed society members) have indicated a willingness to co-finance proximate childcare facilities.
- **Willingness to pay for services.** Ability and willingness to outsource care is dependent on perceived quality of care as well as service fees relative to income.

5.2 Sustainability

Enabling factors

- **Blended financing templates already in the system.** The NSE and DSS demonstrate cross-subsidy (paying and non-paying care provision), maintenance grants and small capital inputs; municipal childcare shows free access for the poorest; cooperative hospitals use member fees and discounts. These existing frameworks can be adapted into sliding-fee, solidarity funds, and performance-based public purchasing for SSE providers.
- **Workforce pipelines via TVET and RPL.** TVEC curricula (at NVQ levels 3–4) and RPL exist for caregiving; modular training and apprenticeships can upgrade skills while services run. Where used, these raise quality and worker retention and support transitions from informality, paving the pathway for better working conditions for paid care workers
- **Multipurpose cooperative diversification.** Provision of care alongside other profitable lines

(retail, credit) spreads risk, shares back-office functions, and reduces unit costs.

Challenges

- **Donation volatility and thin margins.** Charitable care is exposed to the risk of shocks; existing service models are unable to pay decent wages at current price points. Without predictable public co-finance or diversified income (e.g., facility rental, micro-enterprises), providers underinvest in quality of care services provided and labour protection.
- **Weak incentives for skills uptake.** Low domestic wages, time costs, and stronger overseas pull dampen training participation for standardisation of skills; uptake of NVQs and RPL remains limited unless linked to better pay and stable hours.
- **Labour-rights baseline for home-based care.** Domestic workers—key to in-home elder and disability care—operate informally; absence of full legal recognition and limited contract use (either verbal or written) make it hard to pool benefits and enforce standards at scale. Worker unions caution against service models that dilute advocacy for stronger protections.

5.3 Potential Expansion (replication and scale)

Enabling factors

1. **Network effects and federation.** Cooperative federations and GN-to-district association layers enable codified opportunities to replicate care provision models at scale: common facility specs, staff ratios, safeguarding systems (for workers and care recipients), can be replicated horizontally with local adaptation.
2. **Place-of-work childcare and day services.** Livelihood societies (e.g., fisheries/seaweed, estates) can co-locate childcare and day services near production/aggregation sites—directly reducing women's unpaid care burden and contributing to improved female labour participation.
3. **Public stewardship.** Clearer inter-agency cooperations between the Departments of Cooperatives, Social Services, Probation/NCPA and NSE on licensing, inspection, and data can de-risk expansion and speed-up approvals.

Challenges

- **Compliance complexity across care verticals.** As entities add children's, elder, and disability services, they must satisfy distinct regulators (and sometimes health-facility rules). Without a coordinated inspection calendar and one-window guidance, expansion can stall.
- **Human resources churn.** International demand for carers will continue to drain experienced staff unless domestic providers can offer better pay, predictable schedules, social protection, improved recognition/dignity - especially for worker-collective models that rely on member commitment.

- **Urban bias.** Market-led growth gravitates to cities; without explicit rural/estate prioritisation in public purchasing and grant schemes, geographic inequities are likely to widen.

A summary of Strengths, Weaknesses, Opportunities and Threats (SWOT) of the key factors that enable and challenge the operationalization of care cooperatives and other SSE entities in Sri Lanka

Table 10 below presents a summary of strengths and weaknesses of the existing SSE models in Sri Lanka and identifies opportunities and threats for establishment, expansion and maintenance of SSE entities with a specific focus on care service provision.

Table 10: SWOT analysis of key factors that enable and challenge the operationalisation of SSE and care cooperatives in Sri Lanka

Strengths	Weaknesses
• **Established regulatory anchors in parts of the system:** Child development centres operate under clear national guidelines, with provincial level operationalization. These cover licensing requirements, with defined staff-to-child ratios and basic qualification thresholds.	• **Fragmented standards and uneven enforcement:** While childcare standards are specified, oversight varies by province. Non-medical eldercare and home-based disability support lack uniform, enforceable workforce and safeguarding standards for both care workers and recipients.
• **Community-embedded delivery platforms:** Charitable/faith-based institutions, cooperative hospitals, multi-purpose cooperatives, local authorities, and provincial departments already operate with democratic oversight, creating trusted access points that can be standardised and scaled.	• **Gaps in workforce development and protection:** Competency pathways are partial, and uptake is low relative to need; RPL, OSH provisions, and access to social protection are inconsistent for frontline carers (particularly for home-based care workers).
• **Institutional base for SSE expansion:** Multipurpose cooperatives, cooperative hospitals, and livelihood societies provide existing governance, audit commitments, premises, and member financing mechanisms suited to add to or professionalise care services.	• **Affordability and coverage constraints:** Fee structures are largely unregulated; cross-subsidies and waivers are ad hoc, limiting equitable access—especially beyond major urban centres.
• **Policy traction:** Recent attention to care-cooperative by-laws and cooperative policy instruments signals government openness to formalise community-anchored provision and clarifying roles across tiers.	• **Uncertain financial sustainability:** Charitable services rely heavily on donations, subject to volatility and cannot consistently remunerate staff at decent wages.

Opportunities	Threats
• **SSE-led professionalization:** Worker collectives and service cooperatives can pool training, supervision, and insurance, setting transparent wage floors and codifying safeguarding for care workers - raising quality of service provision while facilitating transition to formalising work.	• **Migration and labour market pull factors:** (growing) Demand for care workers overseas risks turnover and widening domestic shortages unless wages, protections, and career paths improve, overall professionalising the sector, ensuring worker dignity and recognition.
• **Blended financing models:** Combining modest fees (with waivers), member contributions, and targeted grants can stabilise operations and embed decent-work clauses. This can also contribute towards access to affordable care services.	• **Regulatory ambiguity and compliance costs:** Multiple authorities and unclear inspection mandates can delay licensing, deter new entrants, and weaken accountability.
• **Leveraging existing facilities:** Cooperative premises, faith-based centres, and local authority facilities can host day care, respite, and community rehabilitation services at lower marginal operational cost.	• **Financial fragility:** Donation-dependent or purely fee-for-service models are vulnerable to shocks; without blended finance and predictable public purchasing, services may underinvest in quality service provision and workforce protection.
• **Standard setting and Recognition of Prior Learning (RPL):** Scaling TVEC linkages and RPL can upgrade existing skills rapidly, align cadres across child, elder, and disability care, and support progression pathways.	• **Trust and cultural norms:** Household preferences for family-based care and concerns about safety can depress uptake for centre-based or in-home services unless providers demonstrate strong safeguarding, supervision, and community governance.
• **Decentralised reach:** Cooperative and community networks enable service delivery in rural and estate areas where market incentives for private entrants are weak.	• **Geographic inequity:** Persistent urban bias in service locations risks widening disparities if expansion strategies do not explicitly prioritise underserved GN/ divisional areas.

The emerging policy momentum – with the recent launch of model by-laws for care cooperatives – signal an appetite for building on SSE-aligned approaches in Sri Lanka.

5.4 Conclusions and Recommendations:

Sri Lanka is experiencing a significant transformation in its care economy driven by rapid population ageing, migration, changing household structures, and the persistent gendered burden of unpaid care work. Despite growing demand for childcare, eldercare, and care for persons with disabilities, the country's formal care infrastructure remains limited, unevenly distributed, and inaccessible for many low- and middle-income households. Care provision continues to rely heavily on unpaid labour performed predominantly by women, constraining female labour force participation and reinforcing gender inequalities. At the same time, paid care work remains highly informal, undervalued, and weakly protected, with many care workers lacking contracts, social protection, standardized training, and recognition of their skills.

Within this context, the study finds that Social and Solidarity Economy (SSE) entities, including cooperatives, present a viable and potentially transformative pathway for expanding access to affordable, community-based, and decent care services in Sri Lanka. Global experiences demonstrate that SSE models can successfully combine social objectives, democratic governance, local ownership, and economic sustainability to deliver care services while generating decent work opportunities. The Sri Lankan context already contains important foundations for such an approach, including a long-standing cooperative movement, extensive community-based organizational networks, and growing policy attention to both the care economy and SSE development. However, to enable care provision by SSE entities and Cooperatives, it is important to strengthen the cooperative/SSE ecosystem. At the same time, it is important to look at the SSE entities and Cooperatives which offer pathway for formalization for the informal care workers, who are currently engaged in provision of care services, and work in precarious conditions with weak labour rights protection and lack of access to social security etc.

The assessment identified multiple existing actors and structures that could serve as platforms for SSE-aligned care provision, including cooperative societies, charitable and faith-based institutions, worker organizations, livelihood societies, and community associations. Several emerging initiatives—including cooperative hospital eldercare services, union-backed care models, and donor-supported community day-care pilots—demonstrate that localized and solidarity-based care provision is operationally feasible and socially relevant. Yet, their numbers are limited and these are currently insufficient to the growing need for care services. The need for SSE entities and cooperatives in provision of care services is immense. New SSE entities cooperatives in care sector are needed, as well as existing cooperatives need to be encouraged to provide care services. The recent introduction of model by-laws for care cooperatives by the Department of Cooperatives, with ILO support, further provides an important institutional entry point for formalizing and scaling care services through cooperative structures.

At the same time, the study identifies important structural and operational challenges that must be addressed if SSE-based care models are to become sustainable, equitable, and scalable. The legal and regulatory framework

governing care remains fragmented across sectors and institutions, with inconsistent implementation and limited clarity regarding operational requirements for community-based providers. Governance weaknesses historically associated with parts of the cooperative movement—including politicization, weak member participation, and management inefficiencies—present risks that must be proactively mitigated. Financing constraints, workforce shortages, low wages, weak incentives for formal skills acquisition, and strong international migration pull factors also pose significant barriers to long-term sustainability.

The study further highlights that care provision cannot be understood solely as a service delivery issue, but must also be viewed as a labour market, gender equality, and social protection challenge. SSE entities have the potential to function not only as care providers, but also as labour market intermediaries capable of aggregating workers, facilitating certification and recognition of prior learning, strengthening worker representation, and supporting the transition from informal to formal employment within the care economy.

Overall, the findings suggest that SSE-based care models cannot replace the responsibility of the State in guaranteeing social protection and care provision. However, they can serve as an important complementary mechanism for expanding access to quality care services, particularly in underserved and low-income communities where public and private provision remain insufficient. With appropriate governance safeguards, supportive policy reforms, sustainable financing arrangements, and institutional coordination, SSE entities and cooperatives can contribute meaningfully to building a more inclusive, gender-responsive, and decent work-oriented care ecosystem in Sri Lanka.

Recommendations and way forward

1. **Establish a coherent national policy and institutional framework for SSE-based care provision:** The Government of Sri Lanka should integrate the role of care SSE entities including cooperatives in the Care Policy framework for the Sri Lanka that explicitly recognizes SSE entities and cooperatives as legitimate actors within the care economy. This should include clarifying institutional responsibilities among the Department of Cooperatives, Ministry of Women and Child Affairs, Department of Social Services, National Secretariat for Elders, and other relevant authorities. An enabling environment for the SSEs and cooperatives to entre the care economy should be facilitated by harmonize legal requirements for starting care services, quality standards, inspection systems, and support services across different care sectors and provider types. The entry barriers for SSE entities and care cooperatives should be set at the minimum standards, especially for cooperatives serving low income and underserved communities. This includes allowing cooperatives of workers, and other vulnerable groups, to come forward to start care services for their members and non-members who are from excluded communities and weaker sections of the society. The cooperatives and SSE entities can provide affordable and quality care to women and men, enabling them to enter job markets.

2. **Strengthen governance and accountability mechanisms for care cooperatives:** Given the governance challenges historically associated with

sections of Sri Lanka's cooperative sector, emerging care cooperatives should incorporate strong governance safeguards from the outset. Mandatory governance and financial management training should be introduced for board members and managers, alongside standardized operational procedures, transparent reporting systems, digital accounting mechanisms, and regular independent audits. Cooperative federations and apex organizations could also play a role in technical supervision, peer learning, compliance monitoring, and social auditing to strengthen accountability and democratic participation.

3. **Clarify and simplify the legal and regulatory environment for care providers:** A clearer and more harmonized regulatory framework is needed to support SSE-based care provision. This should include clarifying whether cooperatives can legally establish and operate residential and community-based care facilities under existing laws, as well as providing guidance on licensing procedures, staffing ratios, liability and insurance requirements, occupational safety obligations, and facility standards. Simplified and phased registration mechanisms could help newly established community-based providers transition into the formal care economy while maintaining minimum quality and safeguarding standards.

4. **Position SSE entities as mechanisms for formalizing care work and improving decent work conditions**

   SSE entities should be recognized not only as service providers, but also as institutions that can formalize and professionalize the care workforce. Cooperatives and worker collectives can support standardized contracts, fair wage-setting, social protection enrolment, grievance handling, and occupational safety measures for care workers. Strengthening pathways for Recognition of Prior Learning (RPL), competency-based certification, and modular work-based learning can help formalize existing skills while improving quality of care and worker mobility within the labour market.

5. **Invest in skills development and workforce retention within the care economy:** The expansion of care services will require sustained investment in workforce development. Partnerships should be strengthened between SSE entities, TVEC, vocational training institutions, and community organizations to deliver accessible, affordable, and context-specific care training programmes. Training should include not only caregiving competencies, but also safeguarding, disability inclusion, eldercare specialization, cooperative management, and occupational safety. To reduce labour attrition and outward migration, improvements in wages, career progression pathways, and social recognition of care work are essential.

6. **Develop sustainable and blended financing mechanisms for care cooperatives:** Long-term sustainability of care cooperatives will require financing models that combine public support, member contributions, user fees, and donor or community-based financing. Public authorities should explore targeted subsidies, service contracting

arrangements, concessional loans, and social procurement mechanisms for SSE-based care providers, particularly those serving low-income and underserved communities. Cooperative banking networks and development finance institutions could also support access to start-up capital and working capital financing. Financing mechanisms should explicitly account for the costs associated with decent work conditions, fair wages, training, and social protection for care workers.

7. **Strengthen demand-side analysis and affordability mechanisms:** Future policy and programme design should incorporate stronger analysis of household demand for care services, including willingness and ability to pay across different socio-economic groups and geographic regions. Special attention should be paid to the affordability constraints faced by low-income households, women in informal employment, rural communities, and estate populations. Sliding fee structures, targeted subsidies, and cross-subsidization mechanisms may be necessary to ensure equitable access to care while maintaining financial sustainability.

8. **Promote community-based and place-sensitive care models:** Care solutions should be tailored to the social, cultural, and economic realities of different communities. Livelihood societies, women's groups, and community-based organizations can play an important role in developing proximity-based childcare and eldercare models linked to local economic activities and work patterns. Care provision models should therefore be flexible, decentralized, and co-designed with local communities to ensure trust, cultural acceptability, and sustained uptake.

9. **Strengthen collaboration between SSE entities, trade unions, and worker organizations:** The expansion of SSE-based care models should complement rather than replace the role of worker organizations and unions in advocating for labour rights. Partnerships between cooperatives and domestic worker organizations could support worker protection, skills certification, standard contracts, and legal awareness while preserving independent advocacy functions. This will be particularly important in advancing legal recognition and protections for domestic and home-based care workers in line with international labour standards, including ILO Convention No. 189.

10. **Pilot, document, and scale successful SSE-based care models:** Given the limited evidence currently available in Sri Lanka, pilot interventions should be systematically monitored and evaluated to generate operational learning and policy evidence. Existing initiatives—including cooperative hospital eldercare units, donor-supported community day-care centres, and union-backed care models—should be documented to identify lessons regarding governance, financing, service quality, worker conditions, and community uptake. Successful models can then be adapted and scaled through cooperative federations, local government partnerships, and national policy support mechanisms.

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