MINISTRY OF SOCIAL JUSTICE AND EMPOWERMENT

NATIONAL WORKSHOP WITH STATES/UTs

on

"CREATING A WELL-FUNCTIONING CARE ECONOMY"

on

22.05.2026

(Through Virtual Mode)

Record of Discussions

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CHAPTER 1

National-Level Consultative Workshop on "Creating a Well-Functioning Care Economy": Brief Overview

During the 5th National Conference of Chief Secretaries, the Hon'ble Prime Minister of India emphasized the need to institutionalize regular, structured inter-governmental dialogue through thematic conferences led by individual Ministries/Departments. In pursuance of this vision**,** it was decided to organize 12 Departmental Summits during 2026, each anchored by a nodal Ministry/Department and focused on a critical sectoral theme of national importance.

1.2. The proposed Departmental Summits are envisaged to follow a structured and time-bound consultative process comprising advance conceptualization, stakeholder consultations, a National-Level Workshop with Secretaries of States/UTs, State/UT-level internal consultations and workshops, and finally, a National-Level Deliberative Summit.

1.3. The Department of Social Justice and Empowerment, Government of India, has been designated as the Nodal Department for the thematic area of "Creating a Well-Functioning Care Economy", in view of the critical role played by care-related services in promoting social well-being, enhancing workforce participation, and supporting inclusive economic growth.

1.4. In this regard, a Draft Concept Note on "Creating a Well-Functioning Care Economy" was initially circulated among the concerned Central Ministries/Departments for their comments and inputs. Subsequently, after incorporating the feedback received, the revised Draft Concept Note was circulated to all States/UTs for further consultation and inputs **(Appendix-I).**

1.5. The "Care Economy" refers to the ecosystem of paid and unpaid care work and services that support the well-being, health, dignity, and productivity of individuals across all stages of life. It encompasses childcare, elderly care, disability support, healthcare assistance, domestic support services, rehabilitation, and community-based care systems.

1.6. Various studies indicate that unpaid domestic and care work in India is predominantly undertaken by women and largely remains invisible within the formal economy. Despite its substantial economic and social value, such work often remains unrecognized and unsupported. This highlights the urgent need for formal recognition of care work, institutional support mechanisms, skilling initiatives, and adequate social protection measures for caregivers.

1.7. As part of the consultative process, the Department of Social Justice and Empowerment organized a National-Level Consultative Workshop with States/UTs on 22nd May 2026 through virtual mode on the theme “Creating a Well-Functioning Care Economy”. The Workshop aimed to:

i. Brief States/UTs on the objectives, scope, and key issues relating to the Care Economy;
ii. Develop a shared understanding of emerging challenges, institutional gaps, and policy priorities;
iii. Facilitate the exchange of experiences, innovations, and best practices among States/UTs;
iv. Seek preliminary policy-level inputs and recommendations from States/UTs; and
v. Identify thematic areas requiring deeper consultations at the State/UT level.

1.8. The Workshop also sought to sensitize States/UTs and encourage them to undertake internal consultations and workshops as part of the continuing consultative process. Based on the learnings and outcomes of the National-Level Workshop, States/UTs are expected to organize internal consultations involving relevant Departments, institutions, civil society organizations, domain experts, care workers, and other stakeholders.

1.9. The findings and recommendations emerging from the consultations conducted by States/UTs will subsequently be included in the proposed National Summit scheduled to be held in September 2026. The Summit will deliberate upon consolidated recommendations, policy directions, scalable interventions, and implementation frameworks for strengthening the Care Economy ecosystem in India.

CHAPTER 2

Models presented by the States/ UTs : Good Practices in the field of Care Economy

Some of the States/UTs are already undertaking various initiatives within their respective domains that contribute towards the development of a well-functioning Care Economy. To facilitate cross-learning and sharing of best practices among States/UTs, two presentations were organized.

2.2. The first presentation **(Appendix-2)** was made by the State of Karnataka and focused on the crèches being developed and managed by the State Government in collaboration with various stakeholders. The presentation highlighted the need for crèches, the legal mandate, inter-departmental convergence mechanisms, and operational elements, including workforce deployment and the assets being created at the grassroots level. One of the key achievements of this model has been the enhanced participation of mothers in the labour force, along with improved outcomes in early childhood development through nutritional and care interventions.

2.3. The second presentation **(Appendix-3)** was made by the State Government of Kerala on the Comprehensive Elderly and Palliative Care Programme being implemented in the State. The State has classified its elderly population into four categories — bed-bound, home-bound, chronically ill, and active elderly with no chronic illness — for the purpose of delivering targeted healthcare services. The State has developed mechanisms to provide healthcare, home-based care, and nutritional support tailored to the specific needs of each category.

2.4. The model focuses on empowering families to undertake routine caregiving responsibilities while supplementing their efforts through the provision of materials and support required for care. A Palliative Care Grid has also been established in the State to integrate elderly and palliative care services, supported by dashboards developed for monitoring, reviews, and need assessments.

2.5. Volunteers and health professionals are being trained based on standardized training modules developed under the programme. Community participation in both implementation and monitoring is being actively encouraged, and local self-government institutions are being effectively leveraged for service delivery and oversight.

CHAPTER 3

Methodology Adopted in Workshop

To facilitate comprehensive, outcome-oriented deliberations on developing a well-functioning Care Economy in India, four key thematic areas were identified for focused discussion during the consultative process.

3.2. These themes were carefully conceptualized to examine the Care Economy from both macro and micro perspectives, encompassing policy, institutional, economic, workforce, financing, and service-delivery dimensions. The thematic areas were designed to encourage evidence-based discussions and to generate actionable recommendations to strengthen the Care Economy ecosystem in the country.

3.3. The identified themes were as follows:

i. **Valuing and Monetizing Care Work - From Social Good to Economic Asset**:- This theme focused on recognizing the economic and social value of paid and unpaid care work, particularly the unpaid domestic and caregiving responsibilities predominantly undertaken by women. Discussions under this theme were to explore the approaches for valuation of care work, inclusion of care-related contributions in economic assessments, policy recognition, social protection measures, and mechanisms for integrating care work within formal economic frameworks.

ii. **Care Economy as a Pathway to Women's Empowerment and Inclusive Livelihoods**:- This theme examined the potential of the Care Economy to enhance women's workforce participation, generate dignified livelihood opportunities, and promote inclusive economic growth. Deliberations focused on expanding employment opportunities in care-related sectors, entrepreneurship models, gender-responsive labour policies, support systems for working women, and strengthening community-based care enterprises and services.

iii. **Strengthening the Care Workforce: Skills, Standards and Mobility**:- This theme addressed the need for developing a trained, professional, and mobile care workforce capable of meeting the growing demand for care

services in the country. Discussions covered issues relating to skilling, certification, standardization of training modules, career progression pathways, occupational safety, quality standards, digital platforms for workforce management, and opportunities for domestic and international mobility of caregivers.

iv. **Understanding the Care Economy: Financing Long-Term Care (LTC)**:- This theme focused on financing mechanisms and institutional models required for ensuring sustainable and accessible long-term care services, particularly for elderly persons, persons with disabilities, and individuals requiring continuous support. Discussions included public financing models, insurance mechanisms, public-private partnerships, community-based financing approaches, and strategies for strengthening long-term care infrastructure and service delivery systems.

3.4. The four themes were allocated to separate thematic groups to ensure focused and structured discussions. The groups were chaired by senior officers from the Government of India. The thematic groups comprised representatives from stakeholder Central Ministries/Departments, States/UTs, subject matter experts, academicians, and representatives from international organizations, including the World Health Organization (WHO) and the World Bank **(Appendix 4)**

3.5. As part of the adopted methodology, each thematic group undertook structured and participative deliberations. Detailed discussions were held among the stakeholders for approximately one and a half hours in each group session. The discussions enabled participants to share experiences, present State-level initiatives and innovations, identify key institutional and policy challenges, exchange best practices, and deliberate upon possible strategies for strengthening the Care Economy ecosystem.

3.6. The deliberations also focused on identifying gaps in existing institutional frameworks, financing mechanisms, skilling ecosystems, social protection measures, and service delivery systems. Participants were encouraged to provide practical and implementable recommendations that could be considered for policy formulation, inter-sectoral convergence, capacity-building initiatives, and development of scalable care models across the country.

3.7 The thematic group discussions formed an important component of the broader consultative process and provided valuable inputs for the proposed Stage 3, which will be finally concluded in Stage 4 which is a National Summit on “Creating a Well-Functioning Care Economy”, scheduled to be held in September 2026.

Chapter 4

Detailed Deliberations

4.1 Theme 1 - Valuing and Monetizing Care Work: From Social Good to Economic Asset.

A) Objectives

i. To establish care work as a measurable economic sector with formal recognition, policy visibility, and social protection mechanisms.
ii. Recognize care work as a critical economic, social, and development issue.
iii. Explore the care economy as a driver of jobs, livelihoods, and inclusive growth.
iv. Reframe care from a welfare responsibility to a strategic economic investment.
v. Highlight the invisible and unequal burden of unpaid care work, especially on women.
vi. Chart pathways for formalizing, professionalizing, and monetizing care services.
vii. Identify policy, financing, and institutional entry points for states.

B) Goals and Outcomes

Goal 1: Develop a National Care Economy Measurement Framework by integrating unpaid and paid care indicators into state-level planning systems.

Proposed Outcomes

1) Standardized care economy indicators
2) State-level Time Use and Care Burden dashboards established.
3) Inclusion of unpaid care estimates in annual social sector reporting.

Goal 2: Pilot formal registration and certification systems for informal caregivers in the States/UTs.

Proposed Outcomes

1) Minimum 1 lakh caregivers registered digitally.

1) At least 40% linked to skilling or social protection schemes.

2) Baseline occupational standards developed for eldercare, disability care, and childcare support.

Goal 3: Introduce policy recommendations for minimum standards on wages, social protection, and working conditions for care workers.

Proposed Outcomes

1) Integration with ESIC, insurance, or pension-linked mechanisms initiated.
2) Increased formalization pathways for domestic and home-based care workers.

C) Record of Proceedings

1) Views of the Experts

Care work must be repositioned from an invisible private responsibility to recognized economic work and treated as a priority within economic planning and policy systems. India's changing demographic profile, rising longevity, and growing care needs require a more systematic and adequately financed care ecosystem. Recent findings from India's Time Use Survey 2024 reinforce the gendered nature of care responsibilities, while the economic value of unpaid care remains outside formal accounting frameworks.

Experts emphasised the need for dedicated policy interventions and greater national-level investment in the care economy to build a sustainable and professionalised care ecosystem. The experts also focussed on the following aspects:

i. Formal care services in India remain fragmented, underprovided, and expensive, with limited standardisation in training, remuneration, certification, and service delivery.

ii. There is a need for a structured and institutional approach towards scaling and professionalising the care sector nationally. Existing models such as community-based palliative care homes, day-care centres for the elderly, ageing-in-place initiatives, and Self-Help Group-led care interventions are promising but are not cohesively addressing the issues in the Care Economy.

iii. The NIMHANS-supported halfway home model was cited as a replicable example, while Care Cooperatives linked to NRLM were presented as a way to give workers collective identity and bargaining power.

iv. There is absence of standardised caregiver training and certification systems, inadequate social protection and labour safeguards for caregivers, and the lack of structured employment pathways within the sector.

v. The importance of elderly care is increasing. Healthcare remains an integral component of elderly care and therefore requires stronger convergence within the proposed care economy framework. The need for screening and high-risk identification mechanisms for elderly persons requiring targeted medical and social care interventions to enable timely support and improved health outcomes.

vi. There is a need to expand community-based healthcare systems and strengthen care services delivered closer to people's homes and communities.

vii. "Ageing at home" approach, should be adopted in the case of the Elderlies and that elderly persons should be enabled to remain within their communities and familiar social environments for as long as possible.

viii. Elderly care policy should not be focused solely on hospital-based services but should prioritise community-based care and support systems. The need for specialised services such as neuro-palliative care was also highlighted, particularly in view of increasing longevity and the growing prevalence of age-related neurological conditions.

ix. Care systems based within the community should be funded through Public–Private Partnership (PPP) models to ensure sustainability and scale. Drawing upon the experience of Kerala, it was observed that the proportion of elderly persons in the state is increasingly approaching that of younger age cohorts, reflecting rapid population ageing and signalling future demographic trends for the country. In this context, there was a call for adopting a life-course

approach to care policy, recognising that care needs evolve across different stages of life and require integrated planning and service delivery.

C.1.2. The discussions also explored scalable community-based models that simultaneously generate livelihoods and strengthen care services. One model highlighted involved women-owned collectives that combine livelihood opportunities with social services such as crèches and community care facilities. It was suggested that similar models could be expanded to include elderly care services. A second model discussed was that of integrated care systems wherein trained women workers deliver multiple community services, including water, sanitation and hygiene (WASH), nutrition support, infrastructure-related services, and elderly care. Another proposal involved repurposing available Panchayat infrastructure and community spaces to serve as centres for elderly care and social support. Such integrated service delivery models were viewed as scalable approaches capable of creating employment opportunities while addressing multiple community needs simultaneously.

C.1.3. Building institutional capacity to support the growth of the care economy is important. Suggestions included establishing Centres of Excellence for elderly care and community-based caregiving to promote research, innovation, training, and dissemination of best practices. The need to equip caregivers and community-based service providers with digital skills and facilitate their access to digital marketplaces was also emphasised to improve service delivery, visibility, and employment opportunities.

C.1.4. There is a need to develop care-related indicators, recognize unpaid care in economic accounting, and increase public financing for care infrastructure and services, for long-term institutional care, palliative and transitional care facilities, and community-based centres.

C.1.5. The deliberations concluded that the development of a robust care economy requires coordinated policy action, increased public investment, stronger community-based care systems, standardised training and certification frameworks, specialised services for the elderly, and sustainable models that recognise care work as both an economic activity and a critical social good. The discussions reaffirmed that strengthening the care economy is essential not only for social welfare and elderly

care, but also for women's economic empowerment, employment generation, and inclusive development.

2) Views of the Central Ministries/ Departments

i. There is an urgent need to recognize and strengthen the "care economy" in India in light of the country's changing demographic profile and the growing demand for caregiving services.

ii. Care work—particularly unpaid domestic and caregiving responsibilities—continues to be disproportionately undertaken by women. Caregiving is still largely viewed as a family responsibility and, within households, the burden of care falls predominantly upon women.

iii. While men spend approximately 90 minutes per day on unpaid care work, women spend significantly greater amounts of time undertaking caregiving and domestic responsibilities. Despite being critical to the functioning of households, communities, and society at large, care work often remains invisible, undervalued, and deprived of adequate dignity, recognition, and economic value. Unpaid care work contributes an estimated 15–17% of GDP, yet remains largely absent from mainstream economic and policy frameworks.

iv. There is a need to move beyond viewing care solely as a private household responsibility and instead recognize it as a strategic economic and social investment capable of driving social welfare, women's empowerment, employment generation, and inclusive economic growth.

3) Views of the States/ UTs

i. The importance of strengthening evidence-based policymaking through survey-based data collection and establishing structured training mechanisms for caregivers and care service providers was highlighted.

ii. Evidence from placement data showed that caregiving offers real employment opportunities, and Kerala proposed connecting care skilling directly to the PM Apprenticeship Programme, to provide credentials, stipends and formal pathways.

iii. The model of day-care centres for senior citizens was showcased, providing a safe and engaging environment with access to recreational activities and essential services during the day.

iv. The need to make tribal and State-specific literature, local languages and culturally relevant materials available within care and community spaces was also emphasized to enhance inclusivity and contextual relevance.

v. The establishment of dedicated recreational and community centres for senior citizens and other priority groups was recommended to promote social participation, well-being and active ageing.

vi. Strengthening institutional capacity for training and professional development in the care sector, along with replicating successful capacity-building models across States through adequate institutional and financial support, was considered essential.

vii. The importance of developing robust referral linkages among care institutions and service providers was also highlighted to ensure continuity and efficiency in service delivery.

viii. To enhance the quality and professionalism of the care workforce, the introduction of standardized six-month certificate courses for caregivers was recommended.

ix. Exploring fiscal support measures, including GST exemptions on specified care-related services for senior citizens, was also suggested to reduce the financial burden associated with accessing care and welfare services.

4.2 Theme 2 - Care Economy as a Pathway to Women's Empowerment and Inclusive Livelihoods.

A) Objectives

i. To reduce unpaid care burdens and expand women's labour force participation through accessible and affordable care services.

ii. Understand access to quality, affordable care services as an enabler of women's labor force participation.

   a) Gendered division of time use, marriage and impact of motherhood.

   b) Care services as an investment in human capital.

iii. Highlight the number and diversity of care jobs.

   a) Care work across skills and competency levels.

   b) Care work trajectories.

   c) Global care markets.

iv. Identify complementary investments for sustainable livelihoods in the care economy

   a) Quality assurance and competency certification.

   b) Other enablers.

B) Goals and Outcomes

Goal 1: Identify and map care service gaps across childcare, eldercare, disability support, and rehabilitation services in all participating States/ UTs.

Proposed Outcomes

1) State Care Infrastructure Gap Reports.
2) Priority districts to be identified.
3) GIS-enabled care infrastructure mapping to be generated.

Goal 2: Establish integrated community-based care centers across pilot districts.

Proposed Outcomes

1) Increased access to affordable local care services.
2) Measurable reduction in unpaid care burden among women beneficiaries.
3) Improved workforce participation among women in pilot regions.

Goal 3: Create livelihood opportunities in the care sector through Self Help Groups (SHGs), cooperatives, social enterprises, and local service providers.

Proposed Outcomes

1) Increased women-led care enterprises.
2) Strengthened rural and urban care entrepreneurship ecosystems.
3) Enhanced income generation for women and youth.

C) Record of Proceedings

1) Views of the Experts

The care economy is central to expanding women's economic participation, reducing unpaid work burdens, and improving quality of life across generations. Participants emphasized that women already perform a large share of care work within households and communities, but this contribution remains inadequately recognized, poorly supported, and rarely translated into secure livelihoods. The following deliberations were also made:

i. The increasing demand for caregivers, driven by changing family structures and migration for education and employment, was identified as a significant opportunity for the expansion of the care economy.

ii. A six-month palliative care training programme for rural young women in Jharkhand was highlighted as a successful model that equips participants with caregiving and basic nursing skills while creating sustainable livelihood opportunities. Such initiatives were recognised as effective pathways for women's empowerment and strengthening community-based care services.

iii. The importance of developing a skilled and professional caregiving workforce was emphasised, with caregiving recognised as requiring a combination of technical expertise, interpersonal abilities and contextual understanding.

iv. Essential competencies identified included compassion, empathy, communication skills, emotional intelligence, patience, trustworthiness and respect for the dignity of care recipients. Attention was also drawn to safe care practices, nutrition and hygiene management, active listening, caregiver well-being and sensitivity to cultural and social diversity.

v. The need for strengthening institutional frameworks through Skill India certification, alignment with the National Skills Qualifications Framework (NSQF), public–private partnerships and standardised regulatory mechanisms was highlighted.

vi. Concerns relating to inadequate working conditions, limited professional recognition of care work and the need for stronger labour protections and policy support were also noted.

vii. The care economy was viewed as a critical enabler of gender equality and increased women's participation in the workforce.

viii. Particular attention was drawn to the childcare sector, with a call for greater investment in care infrastructure, workforce development and social protection measures.

ix. Existing initiatives such as minimum wage provisions for childcare workers and NSQF-aligned skilling programmes were cited as positive steps towards professionalisation of the sector.

x. The importance of collaboration among government, private sector and civil society organisations, along with innovative approaches such as care entrepreneurship and sustainable financing mechanisms, was highlighted as essential for building an inclusive, resilient and future-ready care ecosystem.

C.1.2. The participants called for stronger care infrastructure as a medium-term policy priority to support women's livelihoods and reduce unpaid care burdens. This

includes mapping care services—especially home- and community-based services across childcare, eldercare, disability support, rehabilitation, and respite care—and developing state-level gap assessments so services can become more accessible, affordable, and responsive to the schedules of working adults in both rural and urban contexts.

C.1.3. Care economy should be understood as both a source of empowerment and a major employment opportunity. Right investments in this Sector in India could generate millions of additional jobs—many of them for women—while also strengthening a sizeable childcare economy.

2) Views of the Central Ministries/ Departments

i. There is a transformative potential of Self-Help Groups (SHGs) in strengthening the care economy. With over 10 crore SHG members active across 34 States/UTs, women are already deeply engaged in caregiving activities, although much of this work remains invisible and undervalued.
ii. Key priorities identified included creating an enabling ecosystem for caregiving livelihoods, promoting active ageing alongside palliative care, strengthening training, handholding and placement support mechanisms for SHGs. Community-based and integrated care models were strongly encouraged with emphasis on tailoring caregiving courses to local SHG requirements. Successful examples from Karnataka, where SHGs are engaged in supplying nutrition supplements such as “Chikkis.” were shared.
iii. Two flagship initiatives- Sashakt Panchayat Abhiyan and Women-Friendly Gram Panchayat Initiative- are important platforms for advancing community-centred care systems.
iv. The need for capacity building and training of Gram Panchayats, recognition of innovative and high-performing Panchayats and incentivisation of women-led Panchayats through awards and best-practice promotion.

3) Views of the States/ UTs

i. The States underscored the effectiveness and greater social acceptance of local and community-based caregiving models over institutional approaches.

Leveraging digital platforms for caregiver training and capacity building was recommended.

ii. The caregiver training under geriatric care is being implemented. It was further highlighted the growing requirement for trained caregivers for persons with disabilities. Information on the availability of caregivers for prenatal, natal and childcare support services needs to be compiled.

iii. The Self-Help Groups (SHGs) are active but substantial capacity-building support is required to strengthen caregiving services and improve service delivery systems.

iv. Support for capacity building in the caregiving sector may be provided, highlighting the shortage of subject experts and trained resource persons within the State.

4.3 Theme 3 – Strengthening the Care Workforce: Skills, Standards and Mobility.

A) Objectives

i. To professionalize India's care workforce through standardized skilling, certification, career pathways, and international readiness.
ii. Discuss practical strategies to ensure an adequate, qualified, and motivated care workforce across childcare, eldercare, long-term care, disability and other care services including:
    a) Recruitment pipelines
    b) Competency-based training and certification
    c) Decent work standards and pay
    d) Retention and career pathways
    e) Role of the private sector
    f) Mobility, both domestic and international, of care workers
iii. Identify the essential skills required for the care workforce and evaluate the current gaps in training and development programs for care providers in India. Discuss the creation and implementation of a unified set of standards for care services, ensuring quality, safety, and professionalism across the sector.
iv. Understand how jobs in the care sector can be made more aspirational for youth, bringing in the socio-emotional aspect of the job roles.

B) Goals and Outcomes

Goal 1: Review and align the National Competency Framework for Care Occupations with existing regulators and international standards.

Proposed Outcomes

1) Occupational standards to be developed in conjunction with existing health regulators for care roles.
2) Designing the National curriculum framework.

3) International benchmarking to be initiated with ageing economies.

Goal 2: Train and certify care workers through blended digital and in-person models.

Proposed Outcomes

1) Increased employability in formal care systems.
2) Creation of district-level care skilling hubs.
3) Improved quality assurance and trust in care services.

Goal 3: Launch an International Care Workforce Mobility Initiative focused on ageing economies.

Proposed Outcomes

1) Explore Bilateral partnerships.
2) Introduce Language and digital competency modules.
3) Increase in the overseas placement opportunities for trained caregivers.

C) Record of Proceedings

1) Views of the Experts

i. Regulatory Framework and Existing Health Workforce

India already has a substantial and regulated health workforce. This includes approximately more than 10 lakh ASHA Workers, nearly 14 lakh Anganwadi Workers closely associated with the health system, 40 lakh registered nurses, 9 lakh registered pharmacists, over 13 lakh medical doctors registered with the National Medical Commission. The Rehabilitation Council of India (RCI) regulates all rehabilitation professions, and a detailed National Skill Framework for geriatric care and home healthcare has already been developed. Curricula have been designed and courses are being conducted across the country.

The primary responsibility of the Ministry of Health and Family Welfare in this regard is to set clear standards and define the requisite skill sets for the care

workforce. The key opportunity lies in converging these existing frameworks and initiatives into a cohesive national system. It was underscored that the care workforce must possess not only technical competencies but also compassion, empathy, and strong interpersonal skills.

ii. Competency Standards and Training Frameworks

There is a growing need for trained geriatric caregivers, particularly to support persons with disabilities, chronic illnesses, and mental health conditions such as Alzheimer's, schizophrenia, and dementia. A fundamental shift is required from purely cognitive-based learning to performance-oriented competency frameworks, where skills are effectively learned, applied, and assessed in practice.

It was observed that many critical caregiving components were not adequately introduced under existing mechanisms and that existing caregiver standards need better implementation. Agency-employed caregivers are insufficient to meet the increasing demand. The need to develop structured, practice-based training programmes — including short-term certificate courses and competency-assessed qualifications — was strongly emphasized.

Teaching institutions, including nursing and medical colleges, have a transformative role to play in skill development. Four key responsibilities were identified for such institutions:

a) developing competency-based education incorporating digital literacy and simulation-based practices;
b) harmonizing standards and aligning curricula with caregiving requirements;
c) promoting ethical mobility and protecting workers' rights, including mental well-being; and
d) ensuring quality care through stronger government–institution partnerships and inter-ministerial convergence.

iii. Certification, Accreditation, and Formalization

A significant gap exists in the accreditation and standardization systems for caregiving institutions. While institutions are registered, periodic audits, regular training oversight, and adequate staffing mechanisms for quality assurance remain weak. There is a need to scale up the accreditation system substantially.

Informal caregivers — who constitute the backbone of caregiving in most households — remain largely unsupported, without access to mental health services, skill upgradation, or institutional backing. Formalizing caregiving systems and establishing short-term caregiver training institutes, along with provision of paid leave for caregivers, were suggested as important interventions.

The creation of a National Caregiver Registry was recommended as a critical mechanism to strengthen certification, recognition, and monitoring. It was also emphasized that the basic educational eligibility criteria for caregiver certification should be relaxed to enable engagement of school dropouts and persons without formal education, given the findings of the National Sample Survey on the educational profile of the potential caregiving workforce.

iv. Support for Family and Informal Caregivers

Family and informal caregivers shoulder a disproportionate burden of care, yet remain largely unrecognized and unsupported. There is a need for social and economic support mechanisms, including recognition under welfare boards, access to training, and financial allowances. Integration of caregiving within educational institutions was suggested — including caregiving internships for students and introduction of skill enhancement courses — to build a wider culture of care.

The need to properly categorize caregivers based on roles and responsibilities was also highlighted, along with concerns about caregivers being subjected to domestic violence, exploitation, and inadequate wages. Community-based models such as the Kerala Panchayat-linked caregiving

system were cited as successful examples of locally embedded support structures.

v. Community-Based and Palliative Care

Nearly 75 percent of the elderly population suffers from chronic diseases, and around one-third experience mental health disorders. A fundamental shift is needed in the healthcare approach — from hospital-centric to community-based care ('hospital se samudaye tak'). Mobility and affordability are the two most significant barriers to accessing elderly care services.

A simple community-based care model was proposed, comprising one community nurse, one physiotherapist, and one mental health expert at the grassroots level. Training in palliative care is particularly inadequate — even basic 10-day training programmes are often not effectively implemented. Greater emphasis on holistic health practices, nutrition, and natural lifestyle-based interventions was also recommended.

vi. Technology, Artificial Intelligence, and Assistive Devices

Artificial Intelligence has significant potential in supporting caregivers, particularly through early warning systems and assistive technologies. AI-based tools can assist in early detection of conditions such as dementia and enable timely caregiver responses. AI-enabled reminder systems for medicine administration and routine caregiving support are already being developed.

A major challenge, however, lies in making such technologies cost-effective and accessible to caregivers and elderly persons in low-resource settings. The importance of language training to improve communication effectiveness across diverse populations, and the development of affordable wearable devices and telemedicine solutions, were also highlighted as priority areas.

2) Views of the States/ UTs

i. Training, Certification, and Skill Development Initiatives: Several States and Union Territories shared ongoing initiatives and challenges in caregiver training and certification. Some have initiated one-month caregiver training courses through premier medical institutions. The need for standardized and

certified caregiver training programmes was consistently emphasized, along with the importance of structured certificate and diploma-level courses to strengthen the caregiving workforce. Two months was suggested as the minimum duration for effective caregiver training programmes.

Some States are already conducting General Duty Assistant training programmes and providing certification, while Widow Welfare Boards in certain States have begun providing training in home-based care services. Caregivers are being registered under State welfare boards, enabling them to access benefits and financial allowances.

ii. Cross-State and International Mobility: Skill-based vertical collaboration initiatives between States are underway. Two batches of caregivers have already been sent to Japan for caregiver services training and employment under such arrangements. However, language barriers have been identified as a major challenge to international deployment. It was recommended that hands-on soft skills training, cultural orientation, and language training be integrated into caregiver development programmes to enhance employability and overseas placement prospects.

Practical skill development centres at every district level were suggested so that local youth can be trained effectively, thereby improving employability and reducing overall caregiving costs at the community level.

iii. Elderly Care Services and Day-Care Centres: Several States have established day-care centres for senior citizens, offering services such as meals, snacks, recreational activities, and social support. These centres operate during extended daytime hours and cater to elderly persons who may otherwise be without supervised care. Some States provide caregiver allowances as part of disability support initiatives.

The need to develop a national caregiver ecosystem through expansion of the caregiver economy, dedicated caregiver centres, digital interventions, and stronger inter-departmental convergence was widely highlighted. Free bus travel policies for women in some States were noted as beneficial for caregivers, the majority of whom are women, facilitating access to training programmes.

iv. Community Involvement and Awareness: Non-Governmental Organisations are playing a leading role in caring for the elderly in several States, particularly in remote and hilly regions. The need for greater community involvement, awareness generation, and intermediate-level caregiver training courses was emphasized. Many villages remain unaware of palliative care services, and it was strongly suggested that school curricula should include modules on elderly care and palliative care to build awareness and sensitivity from an early stage.

Home-based caregiving services were noted to be expensive, with significant hourly costs and frequent need for round-the-clock support involving two caregivers. Developing affordable, standardized, and certified community-based care options was identified as an urgent priority.

4.4 Theme 4 – Understanding the Care Economy: Financing the Long-Term Care (LTC).

A) Objectives

i. To create affordable, scalable, and financially sustainable models for long-term and community-based care.

ii. Understand LTC financing menu of options

   a) Introduce different approaches for financing long-term care services.

   b) Highlight the continuum of LTC services requiring financing, including home-based, community-based, institutional, rehabilitative, palliative, and assistive care.

iii. Examine the current landscape of LTC financing across states

   a) Understand how different departments and sectors currently contribute to financing care services.

   b) Identify ongoing state experiences in financing elder care, disability care, rehabilitative care, and support services for dependent populations.

iv. Identify the major financing gaps and system bottlenecks

   a) Discuss challenges related to affordability, accessibility, fragmentation, and sustainability of LTC financing.

   b) Explore sustainable and innovative financing pathways for LTC.

B) Goals and Outcomes

Goal 1: Develop a National Long-Term Care Financing Framework.

Proposed Outcomes

1) Identify blended financing models.

2) Discuss Public-private-community partnership frameworks.

3) Explore Insurance-linked care financing options.

Goal 2: Pilot integrated home-based and community-based care models

Proposed Outcomes

1) Reduced institutional care dependency.
2) Improved continuity of care for elderly and persons with disabilities.
3) Increased rural care accessibility.

Goal 3: Create interoperable digital care governance systems linking beneficiaries, caregivers and service providers.

Proposed Outcomes

1) Unified caregiver registry.
2) Improved monitoring and service quality assurance.
3) Real-time data for planning and financing decisions.

C) Record of Proceedings

1) The Chairperson highlighted the following:

i. Caregivers' ecosystem is becoming increasingly important and will become even more relevant in future in light of India's changing demographic profile and healthcare requirements. Caregiving plays an important role in strengthening preventive healthcare systems and making curative care systems more effective and accessible.

ii. Caregiving is required throughout the life cycle, including maternal care, childcare, elderly care, menopausal care and support for persons with disabilities, prolonged illness and other aspirational groups. Caregiving requirements may differ across life stages and categories of aspirational populations, thereby requiring a structured and diversified approach to service provision and financing.

iii. It was emphasized that there is an urgent need to put in place a caregiving framework, lay down standards and formulate skill training and certification systems for caregivers integrated with the broader healthcare ecosystem, including both allopathic and traditional systems of medicine, as well as

community care. The importance of ensuring mental health support, quality assurance and dignity-based caregiving systems were emphasized. It was further observed that such a framework would help create value for caregivers while enhancing quality of life and extending the period of active and productive living.

iv. Need for long-term financing systems was discussed and various possible financing mechanisms including health insurance, medical insurance, blended funding systems, pension-linked models, ESG financing, CSR support, dedicated funds, inclusion under priority sector lending and start-up-based innovations were deliberated. The need for supporting these financing options through an appropriate policy framework, while simultaneously strengthening community infrastructure, day-care facilities, assisted living facilities and specialised care facilities for elderly persons and aspirational groups, was also emphasized.

2) Views of the Experts

i. Ageing, disability and dependency are increasing rapidly in India and long-term care is no longer merely a family or social issue, but is directly linked with healthcare systems, economic productivity and national development. It was observed that India's healthcare systems remain largely cure-oriented and acute-care focused, whereas long-term care requires supportive, rehabilitative and palliative approaches.

ii. The need for different forms of care infrastructure including home-based care, assisted living centres, rehabilitative care centres, dementia care systems, hospice care and community-based care models was highlighted. It was emphasized that the objective of long-term care should not merely be survival, but preservation of dignity, independence and comfort. It was further noted that caregiving in India continues to remain largely informal and unpaid, with women carrying a disproportionate share of caregiving responsibilities within households.

iii. The economic burden caused by long-term illnesses, including catastrophic healthcare expenditure and employment loss within families when individuals are forced to leave work in order to provide care, was also discussed. The

need for professionalization and standardisation of caregiving systems, structured employment generation and a comprehensive national framework for long-term care was emphasized. It was further suggested that health and medical insurance systems should cover long-term care services and that claim settlement processes should be simplified to enable timely and hassle-free access to benefits.

iv. The rapidly increasing elderly population in India and the high prevalence of non-communicable diseases and mobility-related challenges among elderly persons were highlighted. It was emphasized that long-term care should be viewed not merely as a social responsibility, but also as a public health and economic necessity.

v. Challenges including hospital overcrowding, mental health burden, rural ageing, social isolation and poverty caused by chronic illness were discussed. It was further observed that community participation and primary healthcare systems would remain central to sustainable long-term care models.

vi. Different financing pathways including government-funded care systems, insurance-based models, community financing systems, CSR support, local philanthropy, NGO participation and Public-Private Partnership (PPP) models were also discussed. Reference was made to Japan's national long-term care insurance system and Kerala's community palliative care network as important models for India.

vii. The concept of demographic and epidemiological transition in India was also discussed. It was highlighted that while the elderly population is expected to rise substantially by 2050, fertility rates are declining and chronic diseases are increasing rapidly. It was emphasized that India would witness a substantial increase in healthcare and long-term care requirements in the coming decades, underscoring the need for long-term policy planning, financing systems, trained manpower and institutional infrastructure. It was further observed that long-term care cannot be addressed by a single ministry or sector alone and would require coordinated action across healthcare systems, governments, communities and the private sector.

3) Views of the Central Ministries/ Departments

i. It was highlighted that long-term financing systems are extremely important and that elderly populations should not be viewed merely as responsibilities through the narrower lens of economic productivity. Elderly persons are capable of making valuable socio-economic contributions in their own way. It was informed that the Community Based Assessment Checklist (CBAC) form is being customised to better identify elderly and aspirational communities and support targeted interventions.

ii. It was further informed that home-based care systems are being strengthened and training frameworks for healthcare workers and Community Health Officers (CHOs) are being revised. Reference was made to examples from Thailand regarding home visits and caregiver guidance systems and to elderly support groups such as “Sanjeevani”.

iii. Innovative models such as Haryana’s family caregiver support system implemented with NGO support, wherein family members are counselled and supported to share caregiving responsibilities, were also highlighted. The importance of preventive care, opportunistic care and community support systems for improving quality of life among elderly populations was emphasized.

iv. It was informed that work is being undertaken in alignment with the Viksit Bharat vision on themes relating to inclusive societies and long-term care systems. Workshops, research studies and stakeholder consultations have been organised with international agencies including the World Bank, WHO and the United Nations. It was further noted that social security provisions and long-term care systems are being examined as part of broader policy planning and framework development.

v. It was informed that multiple qualifications and occupational standards relating to caregiving have already been developed. These include qualifications for childcare workers, palliative care providers, Alzheimer’s support personnel and elderly care assistants. The importance of standardised skilling and certification systems for caregivers was emphasized during the discussion.

vi. The discussion also referred to various financing models highlighted by the World Bank for long-term care systems. These included public financing

systems integrated with healthcare systems and supported through taxation, private insurance-based financing systems, social long-term insurance systems followed in countries such as South Korea, the Netherlands and Japan wherein mandatory insurance is purchased and managed through public agencies, and prepaid pooled financing systems for ensuring long-term sustainability and wider coverage.

4) Views of the States/ UTs

i. Existence of senior citizen homes, childcare centres and tele-consultation facilities for improving access to specialist care services and integration of long-term care systems with schemes such as Ayushman Bharat and highlighted caregiver skilling programmes and Public-Private Partnership (PPP) models were discussed.

ii. Efforts towards creating a trained pool of caregivers and strengthening community-level support systems for long-term care services were discussed. Emphasis was led on the importance of building grassroots caregiving capacity for elderly persons, chronically ill individuals and other priority groups.

iii. Caregiving support continues to be largely provided by family members within communities.

iv. Initiatives relating to elderly and palliative care systems, including model care centres, technology-based monitoring systems such as the SHATAYU App, Sakhi cadre systems and the involvement of self-help groups in caregiving support mechanisms were discussed. The importance of trained healthcare personnel and institutional caregiving systems was emphasized.

v. Initiatives relating to crèches and intergenerational bonding through Anganwadi centres, wherein elderly persons regularly interact with children through structured activities and community participation were discussed.

CHAPTER 5

Way Forward

5.1 Theme 1 - Valuing and Monetizing Care Work: From Social Good to Economic Asset.

i. States/UTs may consider integrating measurable care indicators into their planning and monitoring frameworks to enable evidence-based policymaking and assessment of care-related outcomes. Such indicators may include the extent of unpaid care work, availability and accessibility of childcare and eldercare services, female labour force participation linked to care support systems, workforce availability and regional disparities in care infrastructure.

ii. There is a need to enhance public investment in the care economy through dedicated financing mechanisms, including care infrastructure funds, support for community-based care centres and innovative financing platforms involving corporate social responsibility (CSR) and other partnership models. Particular attention may be given to strengthening institutional long-term care facilities, assisted living services, palliative care systems and community-based transitional care arrangements for priority groups.

iii. Recognizing the economic value of unpaid care work and incorporating its assessment into policy and planning processes may facilitate more informed welfare and social protection interventions. Efforts may also be directed towards establishing a dedicated institutional mechanism for coordination and convergence among relevant Ministries, Departments and stakeholders, while encouraging States/UTs to create corresponding institutional structures for local implementation.

iv. The professionalization of the care workforce requires standardized training, certification, accreditation and clearly defined career pathways across childcare, geriatric care, disability support and home-based healthcare services. Expansion of skilling programmes, improved working conditions and greater employment opportunities would contribute to building a qualified and sustainable caregiving workforce.

v. States/UTs may also promote gender-responsive labour policies that encourage the equitable sharing of caregiving responsibilities and reduce barriers to women's participation in the workforce. Strengthening data systems, digital monitoring platforms and periodic assessments of care infrastructure and workforce requirements would further support effective planning and service delivery.

vi. The care economy should be recognized as a strategic economic and social investment that contributes to employment generation, women's empowerment, human capital development and inclusive growth. Greater collaboration among government institutions, private-sector entities, community organizations, and civil society stakeholders may be encouraged to develop a resilient, accessible, and sustainable care ecosystem.

vii. Shift public discourse from viewing care as a private household responsibility to recognizing it as a productivity-enhancing investment and a source for job creation.

5.2 Theme 2 – Care Economy as a Pathway to Women's Empowerment and Inclusive Livelihoods.

i. Undertake Comprehensive Mapping of Care Service Gaps Across States and UTs : A nationwide assessment may be undertaken to identify and map gaps in childcare, eldercare, disability support, and rehabilitation services across all participating States and Union Territories. State-specific Care Infrastructure Gap Reports may be prepared to support evidence-based planning and resource allocation. Priority districts requiring urgent interventions may be identified based on demographic, socio-economic and service availability indicators. The development of GIS-enabled care infrastructure maps may further facilitate targeted investments, monitoring and efficient deployment of care resources.

ii. Establish and Scale Integrated Community-Based Care Centres: Pilot Integrated Community-Based Care Centres may be established in selected districts to provide accessible, affordable and holistic care services closer to communities. These centres may serve as convergent platforms for childcare, eldercare, disability support and rehabilitation services. Scaling such models can help improve access to quality care, particularly in underserved areas, while reducing the unpaid care burden disproportionately borne by women. The initiative may also contribute to enhancing women's participation in the workforce by enabling greater access to reliable care services.

iii. Promote Care Economy Entrepreneurship and Livelihood Opportunities: Focused efforts may be undertaken to strengthen the care economy as a source of sustainable livelihoods, particularly for women and youth. Self Help Groups (SHGs), cooperatives, social enterprises and local service providers may be encouraged to participate in the delivery of care services through capacity building, skill development, access to finance and market linkages. Such interventions can foster the growth of women-led care enterprises, strengthen rural and urban care entrepreneurship ecosystems, and generate dignified employment opportunities while addressing the growing demand for care services.

iv. Strengthening care infrastructure to expand women's employment, entrepreneurship and livelihood opportunities.

v. Promoting home-based care models to ensure accessible, affordable and culturally acceptable caregiving services.

vi. Enhancing the dignity, skills and bargaining power of caregivers through structured training and capacity-building initiatives.

vii. Strengthening convergence and coordination with the Central Ministries, State Governments, institutions, SHGs and other stakeholders in the caregiving ecosystem.

viii. Instituting recognition, incentivisation and reward mechanisms for caregivers, high-performing institutions, and community-led care models.

ix. Advancing the formalisation and professionalisation of care work through a comprehensive policy and regulatory framework.

x. Promoting active and dignified ageing by enabling quality care and support within home and community environments.

5.3 Theme 3 – Strengthening the Care Workforce: Skills, Standards and Mobility.

i. Introducing Gerontology as an Academic Discipline: There is a need to introduce and mainstream Gerontology as a formal academic discipline across universities and institutions in the country, to build a strong knowledge and research base for ageing-related care services.

ii. Standardizing and Harmonizing Accreditation and Certification - Accreditation and certification frameworks for caregivers must be standardized and harmonized to ensure uniformity across States and mutual recognition across countries. This will facilitate both domestic mobility and international deployment of the care workforce.

iii. Training should go beyond basic tasks and also teach empathy, communication, and good judgment. Current programs are based on theoretical pedagogy, and a transition to more practical and “hands-on skills” training is needed.

iv. Relaxing Educational Eligibility Criteria- Basic formal education criteria for caregiver certification should be done away with or significantly relaxed, to enable engagement of school dropouts, persons with minimal education, and other priority groups as part of the caregiving workforce.

v. Leveraging CSR Funds for Quality Assurance - Corporate Social Responsibility (CSR) funds should be systematically leveraged to support the development of accreditation systems, star-rating mechanisms for caregiver institutions, and training infrastructure.

vi. Expanding Short-Term Certificate Courses through institutions should be encouraged to undertake more short-term certificate courses in caregiving, with a focus on disability care, palliative care, and geriatric care.

vii. Social and Economic Support for Informal and Family Caregivers - Dedicated mechanisms must be established to provide social recognition, financial support, access to mental health services, and institutional backing for informal and family caregivers, who currently bear the greatest caregiving burden with the least support.

viii. National Caregiver Registry - A National Caregiver Registry should be created to strengthen certification, recognition, monitoring, and workforce planning, and to provide a basis for portability of credentials across States and sectors.

ix. Industry–Academia Collaboration for Technology and Innovation - Structured collaboration between industry and academic institutions should be promoted for innovation in AI-enabled caregiving solutions, assistive devices, wearable technologies, tele-medicine platforms, and affordable remote monitoring tools to support both formal and informal caregivers.

x. Language and Cultural Training for Caregiver Mobility - Language training, cultural orientation, and soft skills development should be integrated as core components of caregiver training programmes, especially to support the international mobility of caregivers and improve care quality in linguistically diverse domestic settings.

xi. District-Level Skill Development Infrastructure - Practical skill development and training centres should be established at the district level across the country, enabling local youth to access quality caregiver training, improve employability, and contribute to a sustainable community-based care ecosystem.

xii. Expansion of Tele medicine and Care Centres in rural areas - Since mobility and affordability are the primary barriers to care access in rural India, telemedicine infrastructure must be urgently expanded and integrated with the existing public health system to enable remote consultations and real-time monitoring.

5.4 Theme 4- Understanding the Care Economy: Financing the Long-Term Care (LTC).

i. Formalization of Caregiving Frameworks: Formalisation of the caregiving framework needs to be undertaken to create socio-economic value. Options such as home-based care, assisted living centres, rehabilitative care centres, child care centres, hospice care, community-based care centres and other care models should be formalised through training, skilling, capacity building, standardisation and certification. Modules for skilling across a range of wellness and care services need to be formulated and standardised in consultation with, or in partnership with, MoH&FW and NSDC.

ii. Policy and Programme Integration: Policy and programme-level integration of the care economy framework with policies and programmes relating to healthcare and skilling for a range of care providers may be undertaken for mainstreaming and inclusive funding of the care economy. This may be integrated with the NRHM, NHM, VH&N framework, old-age care and other relevant policies and programmes.

iii. Integration with Preventive and Community-Based Healthcare: Integration of the care economy with preventive and community-based healthcare systems may be undertaken for enhancing accessibility and reducing out-of-pocket expenditure. This may also support improved continuity of care for elderly persons and persons with disabilities and reduce dependency on institutional care models. This step will ensure the availability of Government and CSR funding for caregivers.

iv. Technology and Digital EnablementDigital platforms, telemedicine, innovation, start-ups and other technology platforms may be leveraged for enhancing the care economy. Interoperable digital care governance systems linking beneficiaries, caregivers and service providers may be created to enable a unified caregiver registry, improve monitoring and service quality assurance, and generate real-time data for planning and financing decisions. This step ensures the integration of the care economy into the broader health economy.

v. Financing and Investment Mechanisms: A National Long-Term Care Financing Framework should be developed to identify blended financing models, support public-private-community partnership frameworks and work

out insurance-linked care financing options. Guidelines may also be explored and issued for priority sector lending for the care economy, institutional development finance, ESG bonds, and dedicated funds, including venture capital and other funding mechanisms to support start-ups. Further, making health insurance inclusive of the care economy also needs to be explored.

Chapter 6

Guidance Note for the States/ UTs level Internal Workshops

States/UTs shall organise consultative workshops at the State/UT level to obtain structured feedback across all levels of administration. The workshops should focus on identifying implementation challenges, documenting good practices, exploring innovative approaches and promoting cross-learning and convergence among departments.

The proceedings of the workshops shall be comprehensively documented, capturing key challenges, recommendations and best practices. The consolidated inputs shall be shared with this Department for inclusion in the final background note.

The first and second stages of the exercise have already been completed. States/UTs are now required to undertake **Stage 3**, with active participation of State-level Line Departments/Ministries, domain experts, district-level officers and other stakeholders, including NGOs/CBOs. The discussions should focus on:

- Field-level challenges in the Care Economy;
- Successful models and best practices with potential for scaling up at the national level;
- Policy and implementation recommendations for strengthening the Care Economy ecosystem.

The consolidated report containing workshop deliberations, recommendations and best practices may be submitted to this Department by **14/8/2026**.

The tentative timeline for the activities is as follows:

S.No.	Activity	Timeline
1	Circulation of Compendium to all stakeholders of the States/UTs	5/6/2026
2	Conducting workshop at the States/UTs level	14/7/2026
3	Compilation and Sharing of the discussions/deliberations and recommendations to DoSJE	14/8/2026

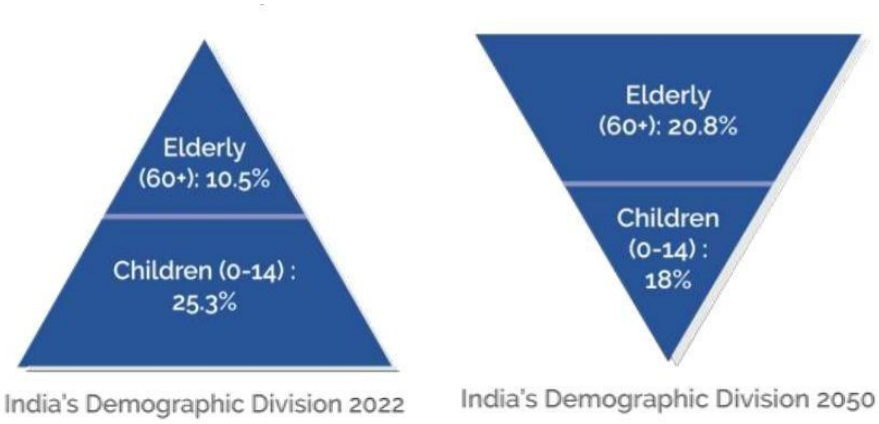
Appendix-1

Draft Concept Note on Creating a well-functioning Care Economy

1. Introduction

India stands at a critical demographic and developmental juncture. While the country continues to benefit from a large working-age population, it is simultaneously witnessing a rapid increase in its senior citizen population. The population aged 60 years and above is projected[1] to rise from **10 crore in 2011 to nearly 23 crore by 2036**, significantly altering the country's care needs.

Fig. Inverted Care Pyramid in India



Source: UNFPA, Our World in Data (2023), Census, NITI Aayog, PIB

These demographic transitions, combined with changing family structures, urbanisation, migration and increasing female labour force participation, have brought the **Care Economy** to the forefront of India's socio-economic development agenda.

2. Context

The care economy encompasses a wide range of **paid and unpaid caregiving activities**, including childcare, eldercare, healthcare support, disability care and domestic work. These services are indispensable for individual well-being, household stability and the functioning of the broader economy. However, despite its critical role, the care economy remains **historically undervalued, under-recognised and under-invested.**

1. *Estimates by Technical Group on Population Projections, National Population Commission, Ministry of Health and Family Welfare*

3. Definition

"Care can be understood as 'a species activity that includes everything we do to maintain, continue and repair our world'. Paid and unpaid care work encompasses direct care for individuals (physical and developmental support) as well as indirect care activities (such as cooking, cleaning, collecting water and firewood and transportation), carried out both within and outside the home."

The care economy includes activities related to childcare, eldercare, disability support, health-related home care and domestic services. It includes unpaid care work predominantly performed by women within households and paid care work delivered through formal and informal markets. Internationally, the ILO and UN recognise care as essential social infrastructure.

4. Landscape of Care Economy

The **care economy** comprises both paid and unpaid care work, including:

- Childcare and early childhood development
- Eldercare and geriatric support
- Healthcare and long-term care
- Care for persons with disabilities
- Domestic and household care services

Key Constituents of the Care Economy

These services underpin family well-being, support human capital formation and enable productive economic participation.

The care economy, viewed from both the demand and supply sides, can be broadly classified into care recipients and caregivers. Care recipients include children, elderly persons, persons with disabilities and sick or dependent individuals.

Caregivers can be further categorized into **unpaid** and **paid** caregivers. **Unpaid family caregivers** comprise parents, spouses, daughters, sons and other relatives who provide care within households. **Paid caregivers** include both informal and formal workers. Informal paid caregivers consist of **domestic workers, home attendants and personal helpers**, while formal paid care workers include **nurses, anganwadi workers, Accredited Social Health Activists (ASHAs) and childcare and eldercare staff**.

Care is also provided through **institutional and specialized professional services**, such as doctors, therapists, counsellors, rehabilitation professionals and palliative care workers. In addition, **community-based care systems**—including Self-Help Groups (SHGs), Non-Governmental Organizations (NGOs), cooperatives, volunteers and local care service providers—play a significant role in supporting the care economy.

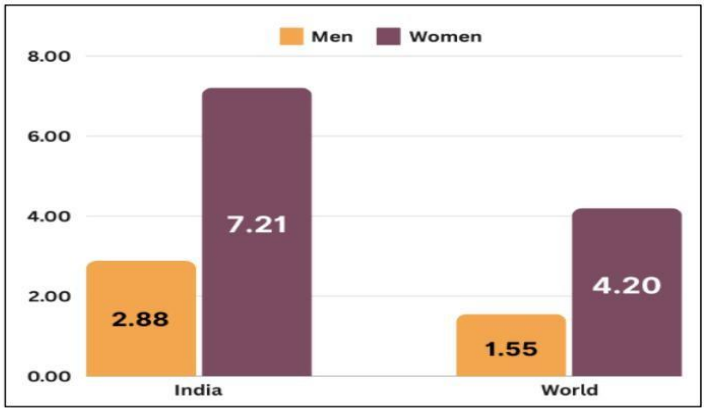
Institutional care facilities, such as Anganwadi centers, hospitals, day-care centers, old-age homes and childcare homes, further contribute to care provision. The **government machinery**, encompassing ministries, departments and local bodies, is responsible for **policy formulation, financing, regulation and service delivery** within the care economy.

5. Care Economy Matters

Despite its immense contribution, the care economy remains largely **invisible in formal statistics and national accounting frameworks**, leading to limited policy focus and investment. This invisibility has constrained the women's workforce participation, job creation potential, social inclusion and dignity of care workers.

5.1 Statistics at Glance

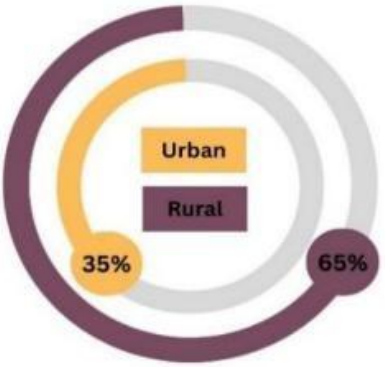
Unpaid care work in India is estimated to account for **15–17% of GDP**[2], performed overwhelmingly by women, significantly limiting their economic opportunities. Paid care work, while growing, remains predominantly **informal**, characterised by low wages, lack of social security and limited skill recognition.



Source: Time Use Survey (2019) and UN women data

As per the time use survey conducted by the Ministry of Statistics and Program Implementation, women are spending at least three times of their average day time on care giving activities as compared to men in India.

In India, women's unpaid labour amounts to a staggering **22.7 lakh crore rupees (Rural: Rs 14.7 lakh crore and Urban: Rs 8.0 lakh crore).** This is about **7.5% of India's** GDP. If the time spent on unpaid care work across the world was valued based on an hourly minimum wage, it would amount to **9% of global the GDP, which corresponds to USD 11 trillion**. These numbers indicate the advantage of investing in the care economy.



Sector-wise share of the monetary value of unpaid female labour

If the time spent on unpaid care work across the world was valued based on an hourly minimum wage. Recognising the care economy as a **productive sector** with strong linkages to employment, gender equality, human capital development and inclusive growth is therefore imperative.

2.PIB Release 5th March 2024

6. Current situation of Care Economy in India

6.1 Scale and Economic Value of care work

6.1.1 Unpaid Care Work's Contribution:

Women in India spend nearly 3 times more time on unpaid care work than men. The economic value of unpaid domestic and care work is estimated at **15–17% of GDP**, based on Time Use Surveys. SBI Research estimates women's unpaid labour at **₹22.7 lakh crore annually**, highlighting the scale of invisible economic contribution.

6.1.2 Paid Care Work's Contribution:

Approximately **3.6 crore individuals** are employed in paid care work in India. A vast majority of care jobs, particularly domestic work and personal care, remain **informal**, lacking contracts, social security and labour protections.

6.2 Care Work is still largely Invisible and Under-Valued

6.2.1 Dominance of Unpaid and Informal Work:

A large share of care work such as childcare, household support and eldercare is performed informally and without pay, mainly by women. Although unpaid care work is estimated to be a significant proportion of India's GDP, it is not counted in official GDP estimates, making it largely invisible in economic planning**.**

6.2.2 Gender Gap in care responsibilities:

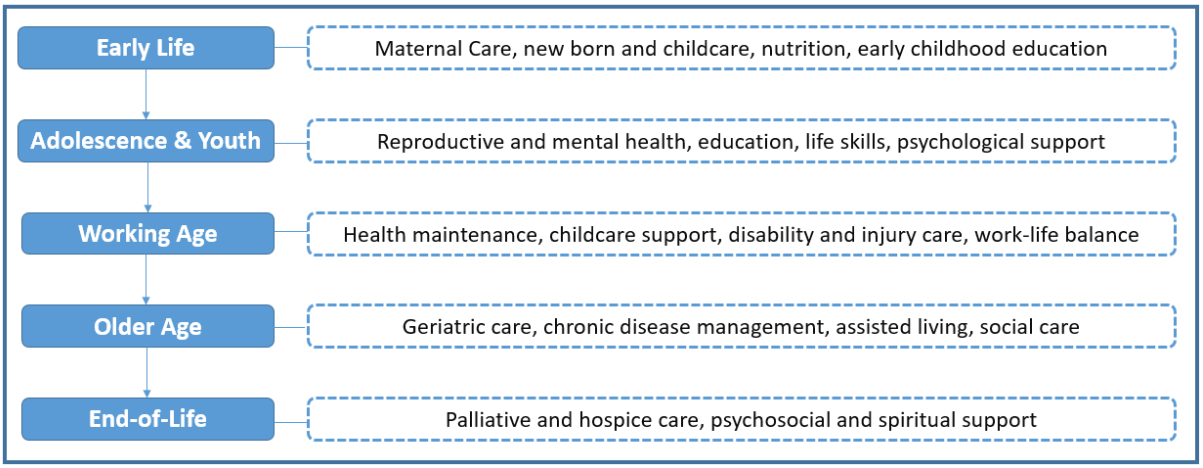
Even when employed, women in India perform about six times more unpaid care work than men (as per Time use survey). This unequal care burden limits women's ability to participate fully in the formal workforce and reduces their overall economic opportunities.

6.2.3 Fragmented Institutional Landscape**:**

At present, multiple Ministries, States and UTs implement **sector-specific schemes** addressing care needs of their respective target groups. However, the absence of convergence, standardisation and integrated planning limits efficiency and scale. There is a clear need to strengthen existing systems, identify convergence points, skill and deploy India's demographic dividend for care services.

7. Conceptual Framework: Care across the Life Course

Life-Cycle Care Continuum Approach: A '**Cradle-to-Grave Care Continuum'** recognises that care needs evolve but remain continuous throughout the life cycle. Stage-wise care requirement is given below:



This continuum integrates preventive care, curative care, rehabilitative care, daily assisted living and end-of-life care, while **ensuring 4 A's – Availability, Accessibility, Affordability, Accountability and Quality of Services.**

8. Stakeholder Group

The care economy focuses on addressing the care needs of people across the life cycle, including women, men and transgender persons, children and adolescents, youth and working adults, senior citizens and persons with disabilities, with special emphasis on tribal and priority groups, migrants and the urban poor.

- **Women, men and transgender Persons**
- **Children and Adolescents**
- **Youth and Working Adults**
- **Senior Citizens**
- **Person with Disabilities**
- **Tribal and marginalised communities**
- **Migrants and Urban Poor**

9. Care Economy and Sustainable Development Goals

Investing in the care economy directly accelerates progress across multiple SDGs:

10. Care-Led Growth Model: Employment and Economic Opportunity

10.1 Rationale

The care economy is **labour-intensive, locally rooted and resilient to** automation, making it a powerful engine for inclusive job creation, especially for women, youth and priority groups.

10.2 Key Components

i. Care infrastructure investment.
ii. Workforce training, certification and career pathways.
iii. Formalisation with minimum wages and social security.
iv. Promotion of SHGs, cooperatives and social enterprises.
v. Digital platforms for service matching and monitoring.

10.3 Employment Potential

- Geriatric caregivers
- Childcare and early education workers
- Disability support professionals
- Community health and wellness workers
- Digital care coordinators

A scaled care economy can generate **lakhs of dignified jobs**, boost female labour force participation and stimulate local economies.

11. Benefits of Developing a Robust Care Economy

11.1 Women's Economic Empowerment

Women shoulder the majority of unpaid care work, restricting their participation in paid **employment. Recognition, redistribution and professionalisation of care can significantly** enhance **female labour force participation** and become a critical driver of inclusive GDP growth.

11.2 Employment for Socially Priority Groups

Care roles are disproportionately filled by Scheduled Castes (**SCs), Scheduled Tribes (STs), Other Backward Classes (OBCs), migrants and urban poor**, often in informal conditions. Formalising and upskilling the sector can create **dignified employment pathways with social protection**.

11.3 Reduction in Intergenerational Poverty

Access to affordable and quality care services improves educational outcomes, labour participation and income stability, particularly for women and youth in priority households.

11.4 Human Capital Development

Early childhood care improves cognitive and educational outcomes which helps for development of sustained human capital. The structured eldercare enhances health, dignity and longevity of the senior citizens.

A strong care economy directly contributes to **human capital formation and social resilience**.

12. Challenges

i. **Informal nature of care work**: Much of the care work is unrecognized and unpaid, leading to under-valuation and poor working conditions for paid workers.
ii. **Gender disparity:** Care work is highly feminized and required concerted effort gender sensitive policy changes
iii. **Lack of standardization, fragmented delivery structure and regulation**: Absence of training standards and regulatory bodies for care worker roles (governess, pre & post-natal caregiver, domestic, geriatric

specialized palliative, disability support, etc.)

iv. **Skill Gaps and rising demand**: There is a significant gap in specialized skills across the care economy, even as demand for quality care services continues to rise due to demographic transitions, urbanisation, changing family structures and increased participation of women in the workforce. Sectors such as childcare, eldercare, disability support, mental health and home-based care face shortages of trained and certified care workers. Existing workers often lack formal training, standardised curricula and career progression pathways, leading to issues of quality, safety and retention. Addressing these skill gaps through structured skilling, certification, continuous training and integration with national skill frameworks is essential.

v. **Low wages / remuneration**: Many care workers in the informal sectors, face low wages, long hours and lack of social security with reasonable working conditions.

vi. **Urban- rural divide**: Formal care services remain largely concentrated in urban areas, resulting in limited access for rural populations. Rural and remote regions often face shortages of trained care workers, inadequate infrastructure and weak institutional support for childcare, eldercare, disability care and health services. This disparity is further compounded by lower public and private investment, limited awareness and challenges in last-mile service delivery. Bridging the urban–rural divide requires strengthening community-based care models, leveraging local institutions and SHGs, expanding digital and mobile care solutions and targeted public investment to ensure equitable access to quality care services across geographies.

13. Issues for Deliberation of Care Economy in States/ UTs

Key issues requiring collective stakeholder deliberation include:

i. **Lack of formal recognition of care work** (paid & unpaid) : Care work, both paid and unpaid, remains largely invisible in state planning and budgeting frameworks, despite its critical contribution to social well-being and economic productivity. The absence of formal recognition leads to under-investment, weak policy prioritisation and limited support systems for caregivers, particularly women, resulting in inequities, informality and poor working conditions across the care economy

ii. **High burden of unpaid care work on women**: Women disproportionately shoulder the responsibility of unpaid care work, including childcare, eldercare, domestic work and care for persons with disabilities. This unequal distribution limits women's participation in education, skill development and the labour market, reinforces gender inequality and constrains overall economic productivity, underscoring the need for recognition, re-distribution and reduction of unpaid care work.

iii. **Absence of state-level care economy data** (time-use surveys, gender-disaggregated care indicators): The lack of reliable and disaggregated

State-level data on care work, care workers and care needs hampers effective policy design, planning and budgeting. Inadequate data on unpaid care, informal care workers, service coverage and regional disparities limits evidence-based decision-making and the ability of States to design targeted, inclusive and accountable care economy interventions.

iv. **Limited availability and uneven quality of childcare, eldercare and disability care services:** Childcare, eldercare and disability care services remain inadequate in coverage and uneven in quality across regions. Gaps in infrastructure, trained workforce, regulatory oversight and service standards result in inconsistent and often unreliable care, particularly affecting low-income, rural and priority groups and limiting equitable access to quality care services.

v. **Urban–rural and inter-state disparities** in access to care infrastructure.

vi. **Informal nature of care work** with low wages, poor working conditions and no social security.

vii. **Skill gaps and lack of standardized training/certification** for care workers

viii. **Limited inclusion of migrant, informal and gig workers** in care support systems: Migrant, informal and gig workers remain largely excluded from formal care systems due to mobility, lack of documentation and weak social protection coverage. Their care needs are often unmet, while care workers within these groups face precarious working conditions, highlighting the need for portable benefits, inclusive service delivery models and targeted policy interventions.

ix. **Monitoring and accountability gaps** in care-related schemes and service delivery, weak monitoring mechanisms and limited accountability in care-related schemes and service delivery undermines service quality, transparency and outcomes. Gaps in data tracking, grievance redressal and outcome-based evaluation reduces the effectiveness of interventions and limits the ability to ensure timely, equitable and high-quality care for intended beneficiaries.

14. Roles and Responsibilities of Ministries/ Departments

Name of the Ministry	Roles & Responsibilities
Ministry of Rural Development (MoRD)	a) Integration of care activities with livelihood programmes. b) Mobilization of Self-Help Groups (SHGs) as community- based care providers. c) Care services under NRLM including childcare, eldercare, nutrition kitchens, domestic workers and disability support. d) Strengthening the social security net to reduce out-of-pocket expenditure.
Ministry of Women and	a) Strengthening anganwadi services as hubs of early childhood care, nutrition and parental support.

Child Development (MWCD)	b) Addressing the feminization of ageing recognizing older women's priorities. c) Expanding crèches childcare facilities and community-based care models.
Ministry of Health and Family Welfare (MoHFW)	a) Training and utilization of nursing para-medical students in community and geriatric care. b) Strengthening Primary Health Centres (PHCs) by placing trained geriatric caregivers. c) Integration of long-term and home-based care within primary healthcare. d) Inclusion of Non-Communicable Diseases (NCD) and services of geriatric caregivers in Ayushman Bharat Card (National Health Mission) and Central Government Health Scheme (CGHS).
Ministry of AYUSH	a) Leveraging AYUSH hospitals and practitioners for preventive and promotive care. b) Integrating traditional wellness systems into geriatric and chronic care. c) Developing AYUSH Grams as community wellness and care hubs. d) Skill development through AYUSH educational institutions.
Ministry of Youth Affairs and Sports	a) Engagement of NSS and NYKS volunteers in community care, elder support and disability assistance. b) Targeting the priority youth between 18 to 21 years (out of orphanage till entry in youth hostels). c) Youth hostels as hubs for care volunteering and training. d) Promoting social responsibility and intergenerational solidarity.
Ministry of Social Justice and Empowerment (MSJE)	a) National leadership on geriatric caregiver training, certification and career advancement. b) Disability-inclusive care frameworks. c) Social protection and dignity for caregivers. d) Championing care economy metrics and policy convergence.
Ministry of Education	a) Promoting healthy behavior, since childhood. b) Integrating care skills into school and higher education curriculum. c) Manoeuvring school and college dropouts for skilling in geriatric caregiving to bring them in mainstream. d) Introducing the Time Bank Concept or Social Credit Exchange Framework via which students contribute

	care hours in exchange for credits.

Ministry of Tribal Affairs	a) Training tribal youth as community caregivers and health facilitators. b) Context-specific care models respecting indigenous knowledge and practices. c) Local employment through care services in tribal areas Disincentives to outmigration
Ministry of Electronics and Information Technology (MEITY)	a) Digital platforms for caregiver registries service delivery and monitoring. b) Enabling innovation through Al tele care assistive technologies and health-tech. c) Promoting cyber-security and data protection in digital care systems.
Ministry of Skill Development and Entrepreneurship (MSDE)	a) Identifying caregivers as skilled workforce. b) Standardization of geriatric courses (short-term, advanced). c) Standardization of various streams of geriatric courses.

15. Convergence Mechanism for a National Care Ecosystem

Effective care delivery requires strong institutionalised coordination across the Union, State and local levels through:

National Care Economy Mission with inter-ministerial governance to ensure policy coherence, aligned financing and clear accountability. **Shared digital platforms** and interoperable data systems are critical for planning, monitoring and seamless service delivery, while **common skill standards and certification frameworks** help ensure quality, portability and professionalisation of the care workforce. At the local level, district-level convergence mechanisms can align departments, schemes and service providers to address diverse care needs effectively. **Public–Private–Community partnerships** further strengthen care systems by combining public financing, private sector efficiency and community-based outreach to deliver inclusive, accessible and sustainable care services.

16. Way Forward

Recognizing care as core economic and social infrastructure is essential for India's journey towards inclusive and sustainable development. A cradle-to-grave care economy strengthens human capital promotes gender equality, supports healthy ageing and builds resilient communities. Based on the above, the following key intended outcomes are:

1. To adopt a coordinated approach to jointly identify the key points of convergence among relevant stakeholders.
2. To formally recognise care work (paid & unpaid) in State policies, planning processes and budgeting.
3. Integration of care economy into Gender Responsive Budgeting (GRB) and outcome budgeting frameworks.
4. To expand and strengthen care infrastructure including childcare, eldercare, disability care, with strong focus on last-mile delivery.
5. Professionalisation of the care workforce through skill development, certification, fair wages and appropriate social security measures.
6. To achieve 4 A's: Availability, Accessibility, Affordability, Accountability, and Quality of Services for creating a well-functioning care economy.
7. A time-bound and a well-defined action plan with clearly designed strategies and roles to bridge the gaps in the continuum of care.
8. To strengthen the existing infrastructure and human resources.
9. Standardisations of skills and service delivery aligned with the needs of the country's demographic structure.
10. To create a more regulated system of service providers.
11. To enhance Community-Public-Private Partnerships.

17. International Best Practices "Baptcare" model of Australia

Baptcare is a not-for-profit organisation in Australia that delivers an integrated model of care and community support services.

Monetising Elderly Care

- Baptcare provides a *continuum of care and support*, including:
- **Aged Care:** Residential and in-home support for older people, including palliative and dementia care.
- **Home Care:** Helping people remain independent at home.
- **Retirement Living:** Secure and supported living options for retirees.
- **Community & Family Services:** Foster care, child and family support, disability services and mental health support.

Baptcare's funding mix includes, **government subsidies and contracts**, **participant-funded care (e.g.,** National Disability Insurance Scheme **(NDIS**), **home care packages)**, **client contributions**, **fundraising and donations** and **revenue from service operations**, reflecting its mission to deliver sustainable, accessible care and community support.

Key Takeaway:

- Fee-based model can create employment and entrepreneurship opportunities.
- Formation of National Policy on Care.

Presentation of Best Practices in the Care Economy: Karnataka

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Gram Panchayat Crèches

Uma Mahadevan
Additional Chief Secretary & Development Commissioner.
Government of Karnataka

Genesis:
Lack of affordable and reliable day care in rural areas stops women from going to work or compels them to bring their infants to the worksite

Government of Karnataka decided to set up crèches in convergence with MGNREGA.

31 Creches at Zilla Panchayats, 200+ Creches at Taluk Level (1 per Taluk) and 62 Creches at Gram Panchayat level (2 per district) were piloted in a phased manner.

In the year 2023's state budget, Rs. 50 crore was allocated to expand it to 4000 crèches in the state

2

Legal Mandate

Sec 58 (5)
Karnataka Gram Swaraj and Panchayat Raj act, 1993

Sec 28, Schedule II
MGNREGA act, 2005

Roles and Responsibilities

GP: Set up of infrastructure, provision of food, selection of caretakers and overall operations

WCD: Child's Growth Monitoring, Immunisation and supervision of the Creche workers

NREGA: Payment of wages to the crèche workers

Modality of Operations

Target Group	Children in the age group of 6 months to 3 years
Timings	Flexible and depending on the work schedule of the mothers.
Duration	Minimum 6.5 hours (Extendable at GP discretion)
Monitoring	By committees at GP, District and State level

Modality of Operations

Beneficiaries	Households having an active NREGA job card
Technical assistance	Mobile Creches as training partner
Caretakers	• 10 women trained per crèche. • On a rotational basis, 2 women deployed.
Food provision	Food is served 3 times a day

Information on Crèches' operations, enrolment, and training (as on 16.02.2026)

Operational crèches	• **3636** centers functional
Caretakers' information	• **29935** care takers have recieved training in first and second batches. • **7576** care takers are currently working in the crèches.
Enrolment Status	• **55415** children have been enrolled • **30280** children are attending regularly (**14957** Boys and **15323** Girls)

Exemplary innovations at Grassroot level

- Convergence with Anganwadis to supply take home ration (THR) to the crèches. (Dharwad District)
- Partnership with SHGs to provide chikki (for children>2 years) in Harappanahalli Taluk, Vijayanagara.
- Allocation of extra funds to GPs (through ZP untied funds) in Koppal Taluk- Kinnala GP

Capturing best practices in action

GP extending transport facility to children at Nallur GP, Davanagere

Installation of CC cameras at the crèche in Tambur GP, Dharwad

Capturing best practices in action

Caretaker teaching handwash and other hygiene habits at Madanbhavi GP, Dharwad

GP providing uniform to the children at Yerrangaligi GP, Ballari

Capturing best practices in action

Doctors' visit Chitta GP, Bidar Taluk

Independence day celebration at Iddalagi GP, Bagalkote







To encourage the participation of mothers in the Labour Force

To promote early childhood development and child nutrition

To develop the new service sector of 'Care entrepreneurship'

To promote Women-led development

Presentation of Community-based Integrated Care Model: Kerala

Comprehensive Elderly and Palliative Care Programme

KERALA

KERALA - the State of India with-

- Highest life expectancy
- Low fertility
- Largest share of older adults in India
- Around 17% of the population of Kerala- above 60 years old

Classifying elderly population for Health care delivery

- Category 1 - Bed bound - need support to get up from bed – 1.7%
- Category 2 - Homebound - needs support to go outside house – 3.2%
- Category 3- Chronic Illness – 23.1%
- Category 4 - Active with no chronic illness – 72%

Health care for each Category

- Category 1- Home based care coordination by Community Nurse
- Category 2- Home based care coordination by Mid level Service Provider (Nurse)
- Category 3- Treatment facility at all levels of Hospitals
- Category 4- Programmes for Healthy ageing

Home based care for Category 1 and 2

Spectrum-

- Stroke and neurological diseases
- Dementia and Psychiatric disorders
- Age related diseases
- Advanced stage of cancer
- Metabolic diseases
- Cardiac and Respiratory diseases
- Accidents
- Diseases causing disabilities

Needs

Preventive care -

- Prevention of contractures
- Prevention of pressure sores
- Fall Prevention
- Prevention of complications
- Screening

Psychological and Social support

Physical Care

- Head to foot care
- Wound care
- Badder care
- Bowel care
- Nutrition
- Physiotherapy
- Specialised Nursing Care
- Medical consultation (including teleconsultation)
- Comfort devices
- Medicines

Head to foot care & Vitals

Sponge bath, oral care, care of perineal area, skin care

P1

Basic Care And Vital Signs

A. BP Apparatus
B. Glucometer
C. Pulse Oximeter
D. Torch
E. Nail Cutter
F. Gloves
G. Sanitizer
H. Scissors
I. Shaving Set

Wound Care

- Assessment of wound and care plan
- Daily dressing
- Regular Supply of dressing materials
- Regular follow up

Wound Care

A. Sterile Tray Containing Cotton, Gauze & Artery Forceps
B. Roller Bandage
C. Adhesive Tape
D. Metrogyl Tablet
E. IV Metrogyl
F. Normal Saline
G. Scissors
H. Gloves - Sterile & Unsterile
I. Surgical Blade
J. Cotton & Gauze
K. Metrogyl Gel

Optional

L. Debrin
M. Mupirocin
N. Megaheal
O. Hydrogen Peroxide

Nutrition

Small frequent feed, oral care, ryle's tube change/care, Subcutaneous/iv fluids

P3

Ryles Tube

A. Gloves - Unsterile
B. Lignocaine Jelly
C. Dyna Plaster/Adhesive Plaster
D. Stethoscope
E. Syringe 10cc
F. Feeding Syringe
G. Scissors
H. Cotton
I. Ryles Tube - Size 16/14

Bladder Care

Assessment and proper support for urinary retention and incontinence

Diaper

Urinal/commode

Condom Catheter

Indwelling

suprapubic

Catheter care and change, bladder wash

Catheter

A. Foleys Catheter Rusch No.14, 16 & 18
B. Uro Bag
C. Disposable Syringe 10cc/20cc
D. Gloves Sterile & Unsterile
E. Water for Injection
F. Lignocaine Jelly
G. Betadine Solution
H. Sterile Tray with Cotton, Surgical Pad, Artery Forceps
I. Normal Saline for Bladder Wash
J. IV Set
K. D/S Needle
L. Hand Sanitizer
M. Condom Catheter
N. Nelcath

Bowel Care

Ensure proper bowel movements

Diet and activity

Oral Medicines

Per Rectal Examination

suppository / enema

PRE Enema

A. Unsterile Gloves
B. Lignocaine Jelly
C. Suction Catheter
D. Cotton
E. Sodium Phosphate Enema

Comfort Devices

- Airbed
- Waterbed
- Walker/crutches
- Wheelchair
- Back rest
- Stool commode
- Specialised cots
- Oxygen cylinder / concentrator

Physiotherapy

- Basic physiotherapy techniques to prevent contractures
- Assessment by a physiotherapist
- Support for regular physiotherapy for active rehabilitation
- Vocational rehabilitation
- Peer groups

Stoma Care

Tracheostomy

Colostomy

Urostomy

Follow up care and material support

Stoma Care Kit

A. Ostomy Bag
B. Base Plate
C. Scissors
D. Cotton
E. Adhesive Plaster
F. Gloves
G. Stomahesive Paste
H. Stomahesive Cream

Optional

I. Cream
J. Paste
K. Irrigation Set

Lymphedema Care

Post Surgical

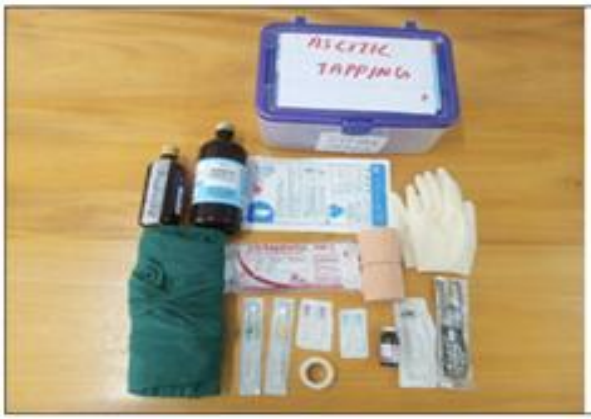
Filariasis

Lymphatic obstruction

Lymphedema

A. Crepe Bandage
B. Hosiery
C. Measuring Tape
D. Cotton & Gauze
E. Gloves

Ascites Tapping



Ascites Tapping Kit S2

A. Gloves - Sterile
B. Injection Lignocaine 2%
C. D/Syringe 5cc
D. Needle No.23 & No.16/18
E. IV Set
F. Scissors
G. Betadine
H. Spirit
I. Sterile Tray with Artery, Cotton & Pad
J. Adhesive Plaster

Medical Consultation

- Consultation by doctor in regular intervals
- Home visit or Tele consultation
- Support for basic investigation
- Regular supply of available medicines

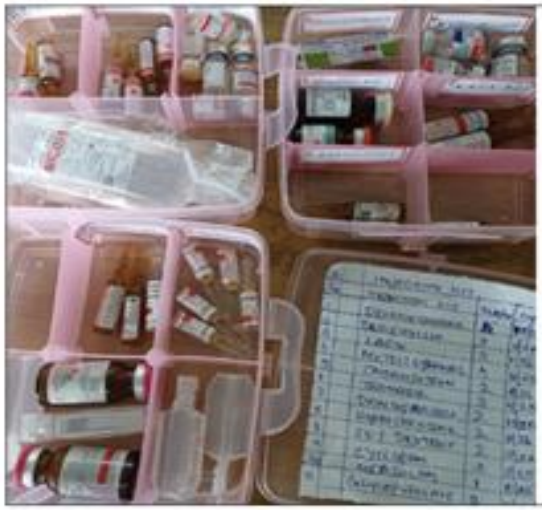
Medications for symptom management

S6

Medicines (Tablets/Capsules)

A. Paracetamol 500 mg
B. Aceclofenac 100 mg
C. Tramadol 100 mg
D. Metoclopramide 10 mg
E. Ondasetron 4 mg
F. Metformin 500 mg
G. Amlodipine 5 mg
H. Haloperidol 5mg
I. Deriphyllin 100 mg
J. Lasix 40 mg
K. Ciplox Eye Drops
L. Lorazepam 1 mg
M. Dexona 8 mg, 4 mg
N. Cyclopam
O. Bisacodyl 5 mg
P. Cremaffin Syrup
Q. Pantoprazole 40 mg
R. Domperidone 30 mg
S. Amox Clav 625 mg
T. Metroigyl 400 mg
U. Ciprofloxacin 500 mg
V. Nitrofurantoin 100 mg
W. Tamsulosin .4 mg/ Terazocin 1mg
X. Cetirizine 10 mg
Y. Fluconazole 150 mg
Z. Ethamsylate 500 mg

Injectables for symptom management



S4

Injections

A. Paracetamol
B. Dexona
C. Deriphyllin
D. Lasix
E. Metoclopramide
F. Ondansteron
G. Tramadol
H. Pantoprazole
I. Hydrocortisone
J. 25% Dextrose
K. Cyclopam
L. Midazolam
M. Glycopyrrolate
N. Buscopam (Hyoscin Butylbromide)

Parenteral administration kit (iv/sc)

S5

IV Fluid Kit

A. IV Cannula No.20, 22, 24
B. D/Syringe 10cc, 5cc
C. Needle
D. IV Set
E. IV Fluid NS, DNS, 5% RL
F. Gloves
G. Adhesive Plaster
H. Spirit & Swab
I. Tourniquet
J. SV Set

General Principles

- Empowering the family for routine care through regular home visit
- Nursing procedures at home
- Supply of materials needed for care
- Medical consultation
- Regular supply of available medicines
- Support for basic investigations
- Referral Services as per need
- Discharge follow up

For Category 3

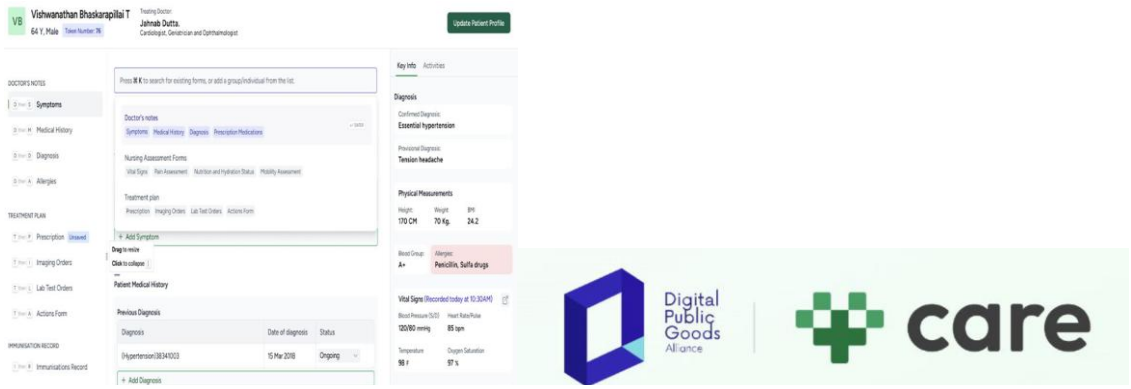
- Continuum of services at all levels of Health system
- Various levels of care
    1. Janakeeya Arogya Kendram – care coordination and follow up by ASHA and MLSP, Peer support groups
    2. Family Health Centres – Provision of regular medical follow up and medicines, Special programmes such as SWAAS, AASWASAM and Diabetic Retinopathy Screening, Mobile community clinics
    3. Community Health Centres- Chronic disease management units, Physiotherapy services
    4. Major Hospitals- Specialty services
    5. Medical Colleges and Specialty Centres- Superspecialty Services

For Category 4

- Annual health Screening
- Health promotion activities with Community involvement
- Social welfare Schemes
- Mapping and promotion of skills of elderly
- Special focus on priority elderly- Extreme poverty, Ashraya, Living alone- above 80
- Old age homes
- Day care Centres
- Assisted Living Centres

Palliative Care Grid

- Platform for linking all elderly and palliative care services
- EMR for documentation of care - Mobile friendly access
- Coordination and communication between all care delivery points
- Dashboards for review and need assessment



Unique Features of Kerala Experience

- Community participation and Ownership
- Module based training for Volunteers and health professionals
- Involvement of Community based and Non-Governmental organisations in Health care delivery
- Promotion of Nurse led Care programmes
- Promotion of Home based Care
- Involvement of Local Self Government institutions- Decentralised Planning
- System for Community level monitoring of health programmes

Appendix-4

Group Allocation for the States/UTs along with their topic for Discussion

Group-1

Theme: Valuing and Monetizing Care Work: From Social Good to Economic Asset

Chaired and moderated by: Ms Debolina Thakur, Additional Secretary and Financial Advisor, DoSJE

Officials from Central Ministries/Departments	Officials of States/UTs	Eminent Speakers (Ms/Mrs./Sh.)
1. D/o of Empowerment of Persons with Disabilities 2. Railway Board, M/o Railways 3. D/o School Education and Literacy 4. M/o Youth Affairs & Sports	1. Bihar 2. Chhattisgarh 3. Goa 4. Kerala 5. NCT of Delhi 6. Punjab 7. Telangana 8. Tripura 9. Uttar Pradesh	1. Dr. Preeti Khanna, Health & Nutrition Expert, PCI India 2. Ibadat Dhillon, WHO 3. Prof (Dr). Jahanara M Gajendragad Prof. & Head, Dept. of Psychiatric Social Work, Institute of Human Behaviour & Allied Sciences (*IHBAS*) Delhi, 4. Benazir Patil Chief Executive Officer, Vriddha Mitra 5. Prof (Dr). Rajinder Kumar Dhamija, Director, Institute of Human Behaviour & Allied Sciences (*IHBAS)* Delhi

Group-2

Theme: Care Economy as a Pathway to Women's Empowerment and Inclusive Livelihoods

Chaired and moderated by : Ms. Monali P. Dhakate, Joint Secretary, DoSJE

Officials from Central Ministries/Departments	**States/UTs**	**Eminent Speakers (Ms/Mrs./Sh.)**
1. M/o Women & Child Development 2. M/o Tribal Affairs 3. M/o Panchayti Raj 4. M/o Rural Development 5. Ministry of External Affairs	1. Andhra Pradesh 2. Arunachal Pradesh 3. Assam 4. Haryana 5. Jammu and Kashmir 6. Mizoram 7. Puducherry 8. Uttarakhand 9. West Bengal	1. Dr. A.K Dam, MD (AIIMS), MSc. Palliative Medicine (Cardiff Univ.) 2. Dr Archana Kaushik, Professor of Social Work, DU 3. Dr. Amaresha C, Associate Professor, Dept. of Psychiatric Social Work, Lokopriya Gopinath Bordoloi Regional Inst.of Mental Health, Assam 4. Prof. (Dr.) Sigamani Panneer Chairperson, Centre for the Study of Law & Governance, Jawaharlal Nehru University, New Delhi, 5. Chirashree Ghosh, Executive Director, Mobile Creches NGO

Group-3

Theme: Strengthening the Care Workforce: Skills, Standards and Mobility

Chaired and Moderated by: Ms. Kavita Narayan, Advisor, MoH&FW

Officials from Central Ministries/Departments	**States/UTs**	**Eminent Speakers** **(Ms/Mrs./Sh.)**
1. Ministry of Electronics and Information Technology 2. Department of Higher Education 3. M/o Skill Development & Entrepreneurship 4. M/o Labour & Employment 5. NITI Aayog 6. Ministry of External Affairs 7. M/o Skill Development	1. Chandigarh 2. Gujarat 3. Karnataka 4. Ladakh 5. Lakshadweep 6. Madhya Pradesh 7. Maharashtra 8. Manipur 9. Tamil Nadu	1. Dr. Pretesh R. Kiran, St. John's Medical College, Bangalore 2. Mr. R Narendhar, Executive Director, Alzheimer's & Related Disorders Society of India, New Delhi 3. Dr Mayanka Gupta, Asst. Professor, Lady Irwin College, New Delhi 4. Col. Madhumita Dhall, Nursing Director Rajiv Gandhi Cancer Institute & Research Center, Delhi 5. Bijit Roy, One Billion Life Foundation (Palliative Care and Education)

Group-4

Theme: Understanding the Care Economy: Financing the Long-Term Care (LTC)

Chaired and Moderated by : Ms. Mona K. Khandar, Addl. Secretary, DoSJE

Officials from Central Ministries/Departments	States/UTs	Eminent Speakers (Ms/Mrs./Sh.)
1. NITI Aayog 2. Ministry of Health & Family Welfare 3. D/o Expenditure 4. Skill, HSSC	1. Andaman & Nicobar 2. Dadra & Nagar Haveli and Daman & Diu 3. Himachal Pradesh 4. Jharkhand 5. Meghalaya 6. Nagaland 7. Odisha 8. Rajasthan 9. Sikkim	1. Dr. Abhishek Shukla, Founder & Secretary, Aastha Centre for Geriatric Medicine Palliative Care Hospital & Hospice, Lucknow, UP 2. Dr. Manoj Kumar, Senior Consultant, Ministry of Health 3. Dr. S. Sathiya Babu, Founder & Director, Tamil Nadu Institute of Palliative Medicine (TNIPM) 4. Dr Gahan S Jois, Amrita Medical College, RPS City, Faridabad, Haryana