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Advancing lessons for the U.S. from the Colombian & Indian care systems

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Reflections from the learning trips to Colombia and India

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Introduction

In November 2025 and February 2026, a delegation of ~15 leaders from across the U.S. care field traveled to Colombia and India to learn from local institutions, policymakers, worker unions, and community leaders building care ecosystems that many countries are beginning to study as an emerging example of integrated care innovation. The aim was to understand how Colombia's and India's national and local care systems, multisector partnerships, and community-based models support caregivers and families, and to explore what these experiences might offer U.S. actors working to strengthen and reimagine the care movement domestically.

Trip participants represented a wide range of advocacy organizations, research institutions, and practitioner networks working to strengthen care in the U.S.: the Center for Law and Social Policy (CLASP), the Child Care for Every Family Network, the Children's Funding Project (CFP), the Economic Security Project (ESP), the Family Child Care Association of Montgomery County (FCCAMC), First Focus on Children, the National Association for Family Child Care (NAFCC), the National Black Child Development Institute (NBCDI), NBCDI – Atlanta, the National Women's Law Center (NWLC), ZERO TO THREE, Alliance for Early Success, and Home Grown. Together, they brought deep expertise in childcare, family economic security, gender justice, and community-driven solutions, creating a strong foundation for rich cross-country learning. The group had outlined key learning goals ahead of the visits, which included: seeing in practice how Colombia and India were elevating care as a public good, especially how paid and unpaid caregivers are recognized and supported within a shared system; seeing how care policies and investments connect gender equity, community wellbeing, and economic opportunity, and what lessons might translate to the U.S. context; understanding how local care initiatives, like Bogotá's Care Blocks or India's ICDS scheme, operate in practice, including what has worked or not worked as well so far, and how they are being financed; and learning from caregiver and domestic worker movements about how organizing, advocacy, and storytelling have helped shift narratives and influence national policy.

In Colombia, across four days, the group visited a range of public, private and community models in Bogotá and Medellín, including Bogotá's Care Blocks, Comfama family centers, and aeioTÜ early learning centers. The group also heard from leaders across Colombia's public, private, and social sectors, who provided context on the country's care policy, advocacy and service ecosystem, and how it connects to Colombia's history and broader social attitudes and movements.

In India, the group visited large-scale publicly enabled or catalyzed models of care such as the ICDS Scheme and Mobile Creches, as well as private care innovations such as the Hippocampus model and the SUNAAD model. The group also heard from leading public, private, and civil society leaders on the care system, its context and evolution, and the role and leadership of workers and worker cooperatives in India's care movement.

During both trips, participants paused regularly to synthesize what they observed, share reactions, and consider the implications for the U.S. context. These discussions generated a set of core insights that shaped the group's interpretation of Colombia's and India's models. Participants reflected on the importance of shifting mindsets and narratives around care, bolstering collaboration across national, state, and local levels, using pilots to make the case in different jurisdictions and drive towards scale, and working more intentionally to share power across movements.

Setting the Context: Why Colombia and India and Why Now

Both Colombia and India offer compelling examples of what it looks like when a society begins to center care as part of its public agenda. In Colombia, the country's National Care System has elevated care as a collective responsibility and has created dedicated mechanisms to coordinate actions across sectors. Bogotá's Care Blocks illustrate how services for caregivers and care recipients can be combined in one place. And the emphasis on community participation and gender equity reflects decades of feminist organizing, rights-based advocacy, and municipal innovation. Similarly in India, the long-standing ICDS scheme, policy frameworks such as those guaranteeing maternal benefits and access to childcare ("creches"), and newer innovations providing holistic, integrated care for specific populations all serve as interesting exemplars to inform the US.

These advances resonated with the U.S. delegation because they highlighted, through contrast, some of the core challenges facing the American care system, whilst also providing principles & concrete strategies for response. Participants reflected that in the U.S., narratives of individual responsibility, fragmented funding streams, and a lack of recognition of care as public infrastructure make it difficult to address needs in a comprehensive way. Colombia and India's approaches did not present simple templates, but they offered a way of thinking that prompted deeper questioning. Delegates asked what it would take to build a similar sense of shared public, private, and community responsibility around care in the U.S., and what types of narrative, political, and institutional shifts would be required to sustain such a vision.

Colombia's and India's advances also build on efforts similar to those that the delegates and other U.S. care leaders have been championing domestically, making knowledge and experience exchange even more relevant. In the U.S., momentum is growing through state and local pilots aimed at filling the gap left by limited federal investment, including early childhood program consolidation to strengthen and integrate services while reducing administrative burden. Public programs and providers, working with civil society, are improving data on needs in underserved communities. Innovators are expanding supports for home-based and Family, Friends, and Neighbors (FFN) caregivers, and easing the challenges of running a care business. At the same time, initiatives to build a sustainable, diverse early childhood workforce continue to expand, and care workers are strengthening their own organizing. The organizations represented by trip participants mirror these efforts, from national advocacy groups advancing gender justice and anti-poverty policy, to networks supporting the childcare workforce and institutions developing innovative public financing strategies. Together, they reflect a broad U.S. care movement driving reforms in affordability, universal access, income supports, and the valuation of care work, while building the collective power of caregivers, parents and providers.

Our Guiding Framework

Throughout the trip, the delegation used a three-part framework to structure learning and reflection.

1. **Advocating for and delivering care as a public good:** How public, private, and social actors collaborate to design, finance, and advocate for care as public infrastructure.
2. **Ensuring equitable access to care:** How municipal, community-led and social-enterprise models build inclusive systems that reach those underserved by formal institutions.
3. **Dignifying and valuing care work:** How labor movements and advocacy groups elevate caregivers' rights, wages, and collective voice.

Each learning session provided a practical example of how these themes operate in Colombia and India. The reflection sessions then allowed participants to examine what these experiences might mean for the U.S., considering how care systems can be strengthened through narrative change, multisector collaboration, and strategies that reflect the realities of families and workers.

1. Advocating for and Delivering Care as a Public Good

What We Saw and Heard in Colombia and India

The delegation observed how Colombia and India were both formalizing care as a public good through national commitments and coordinated institutions. In Colombia, national leaders described the emerging National Care System, the Ministry of Equality's role in setting policy direction, and the long-standing mandate of the Colombian Institute of Family Welfare (Instituto Colombiano de Bienestar Familiar – ICBF) to uphold children's rights and early-childhood standards. These structures are anchored in global frameworks such as the Convention on the Rights of the Child, which hosts referenced as a shared language for accountability and public expectation. Together, they outline care as a right, define the state's responsibility for delivering it, and establish the policy backbone that guides implementation nationwide.

Bogotá's Women's Secretariat described how Care Blocks integrate services across health, education, sports, and social development to reduce the burden on caregivers. The Ministry of Equality explained that it is supporting other municipalities through a national capacity-building strategy that helps local governments design and strengthen their own care systems. Civil society partners described participating in working tables where they help set priorities, monitor implementation, and ensure that community needs shape public investments.

In India, trip participants observed the long-standing ICDS scheme including its integration and supplementation with the Mobile Creches model. Launched more than 50 years ago, ICDS provides integrated services for young children, pregnant women, and mothers, with a focus on rural, tribal, and economically disadvantaged communities. ICDS now operates nearly 1.4M community-based Anganwadi centers, delivering nutrition, early learning, and education to over 70 million children. This service, largely available in rural India, is comple-

mented by creches, a form of employer-funded care, as well as additional supports from civil society (for example, via care cooperative models) and the private sector (for example, that integrate care into health and education).

Colombia's and India's models show how national direction, local implementation, and community participation can reinforce one another to make care a shared public and private responsibility. They specifically demonstrated how the government can provide the policy framework as well as enablement of care delivery, without having to do all the actual delivery or additional innovations itself.

What Participants Reflected On

Child care is a labor of love and should not be purely transactional; it should be based on genuine care and treated as a top priority for the government.

Advancing care as a public good in the U.S. will require a fundamental shift toward collective responsibility. Many in the group noted how naturally Colombian and Indian partners spoke about childcare and other care needs as rights rather than discretionary supports. This stood in contrast to the discourse domestically, where care is widely perceived as an individual burden and narratives of deservingness shape public attitudes and policy conversations. The discussion surfaced that shifting these underlying mental models is essential for meaningful policy reform and that the U.S. care field will need to bridge a significant gap in perspectives to position care as central and natural to community social and economic wellbeing.

What's needed is strong federal and/or state principles, including rights-based frameworks, that hold together fragmented programs and leave space for community tailoring and leadership.

Rights based framing, even when implied, created coherence across care efforts and offered a useful reference point for the U.S. Delegates observed that even when explicit rights language was not used, institutions operated with an implicit rights orientation that reinforced public investment and gave communities a basis for accountability. In Colombia, models like Confama conceptualized care as social insurance: a universal right that, like healthcare or pensions, requires collective investment over the long term. This was the case in India as well, where explicit rights-based language was not used, but the implicit orientation was for care as a right. Several participants wondered whether U.S. cities or states could symbolically adopt international frameworks such as the Convention on the Rights of the Child to anchor local care strategies. They noted that even non-binding commitments and consistently embracing a rights-oriented approach could help establish shared expectations, strengthen advocacy, and signal a cultural shift toward recognizing care as a core public responsibility.

Colombia and India's whole-of-life approach offered a unifying narrative that helped temper zero-sum dynamics across constituencies, even as competition for resources still exists across government agencies. In Colombia, delegates noted that agencies involved in Care Blocks, such as health, education, recreation, and social services, continue to negotiate budgets, responsibilities, and visibility. However, they are guided by a shared mandate that care spans the entire life course, which creates a stronger sense of collective purpose. As a result, Colombia offers a vision of care as a comprehensive, intergenerational

ecosystem, with opportunities for seniors, children, and caregivers to interact. Similarly in India, models observed, such as those for the elderly transitioning out of surgical care as well as children with hearing impairments, often considered long-term needs of people served even after the care in question has been fully "delivered." For example, an early childhood diagnosis and monitoring center for children with hearing impairments also considered their school-age needs, and future employment needs. Participants contrasted these approaches with the U.S., where childcare, disability services, aging services, and caregiver support often operate in separate silos and compete for limited funding and attention. Several participants observed that adopting a life course orientation in the U.S. could help unify advocates, reduce fragmentation, and reinforce that care is a collective need at every stage of life.

While the Indian government sets the laws, schemes led by grassroots organizations lead the implementation of these laws. In the U.S., organizations such as ours must fill in the gaps without any such laws.

The Colombian and Indian experience highlighted the need to align policy, narrative, practice, and organizing. Participants noted that Colombia's care advances persisted across political transitions in part because multiple ecosystem actors held a shared understanding of the importance of care. The conversation underscored that the U.S. care ecosystem is fragmented across service providers, researchers, organizers, and policymakers. Participants emphasized that narrative work alone cannot shift systems without coordinated organizing, consistent public investment, and visible practices that demonstrate care as a public resource. In India, it was clear that civil society actors influenced care policy wins by deeply coordinating (e.g., via a recurrent forum where advocates came together to share notes and caucus on strategies) as well as strategically locating leverage points in existing laws (e.g., using the right to work laws as a way to pool demand for care services, and linking the availability of care to the realization of the right to work).

Cross-sector collaboration is central to strengthening care as a public good. Participants pointed to the way Colombian municipalities and Indian civil society and government actors brought together education, health, labor, and gender institutions to design and coordinate care services (e.g., the Nurturing Neighborhood challenge in India). They noted that strengthening U.S. care systems will require partnerships across agencies, movements, and sectors to build structures capable of reflecting the needs of families and communities. Several emphasized that multisector leadership is critical for building legitimacy and sustaining long-term commitment.

Pilots and demonstrations can help make the case for care as a public good in different U.S. jurisdictions, but their scale-up must maintain connection to local relational infrastructure. Delegates discussed how community led pilots, when thoughtfully designed, can illustrate what it looks like to coordinate services, build shared infrastructure, and center community needs. They pointed to the potential of Care Block-like models in U.S. cities, especially when leveraging existing infrastructure such as closed schools, recreation centers, or YMCAs/YWCAs. Others noted the value of pilots that test cross agency collaboration or explore small scale social insurance models that direct resources to community infrastructure. The group stressed that the purpose of these pilots is not only to expand services but also to generate political lessons, build narratives about what is possible, and create evidence that supports broader adoption across states and municipalities. At the same time, scale-up of care solutions must be balanced with the need to maintain trust, local leadership, and community connection, given the inherently relational nature of care and the importance of local relational and community-centered infrastructure for success.

Ensuring Equitable Access to Care

What We Saw and Heard in Colombia and India

The group observed how both Colombia's and India's care systems emphasize community trust, proximity, and flexibility. Care buses in Colombia were established to serve neighborhoods and rural areas that lack formal infrastructure, even though they are not yet sufficient in number to have the necessary geographic reach and do not fully solve access barriers faced by families dealing with disability. In India, Anganwadi centers and creches were often installed within 500m distance of the community served, with deep encouragement given to community owned and led models. Municipal leaders in Colombia described tailoring models to local needs, using community infrastructure as care hubs, and involving residents in decisions through mechanisms such as "children's tables." Leaders highlighted how solutions like deploying mobile teams supported access among diverse populations that would otherwise face barriers, and how modest but intentional infrastructure served as a powerful lever for inclusion.

Building on this systems-level emphasis on inclusion, care leaders in Colombia noted that care needs are shaped by intersecting gender, racial, ethnic, and socioeconomic inequalities. They use vulnerability indicators from national surveys to guide where to locate new care infrastructure in order to reach communities with the highest need. Public agencies like ICBF apply a social justice lens that prioritizes remote or marginalized areas when expanding services, while national actors like the Ministry of Equality promote care supports for Indigenous families aligned with their knowledge systems and practices of caring for life. They also monitor shifts driven by migration and implement offerings like Integrated Attention Centers that provide care and training for migrants while preventing labor exploitation, and so ensure migrant families are effectively served and recognized as both providers and recipients of care.

In India, multiple care leaders noted how recruiting men into the provision and delivery of care was a key strategy to create durable, community-wide support for care equity.

What Participants Reflected On

Equitable access requires balancing regional autonomy with a national commitment to minimum guarantees. Delegates noted that both Colombia's and India's models allowed local governments and communities to design care in ways that fit their contexts, while still operating within national commitments to inclusion and basic support/social protections. Even if the quality and availability of services in Colombia and India vary significantly state-by-state due to uneven access to resources at the state level, the existence of national commitments puts in place the necessary underlying frameworks to standardize service access across the population. The group contrasted this with the U.S., where the absence of a federal-level baseline means that families' access to care can vary significantly by state and risks leaving marginalized communities with very limited support. Participants suggested that establishing even partial national standards could help create a more consistent and equitable foundation across jurisdictions, while still allowing local communities to tailor care to their needs.

Considering the regional and national frames for policy implementation is important. Some of the biggest innovations in the programs we learned about [show] how reflective they were to the needs of their community.

Community trust and participation were demonstrated conditions for equity. Many participants contrasted Colombia's and India's orientation toward trusting communities with the U.S. tendency to emphasize monitoring, compliance, and verifying deservingness. They observed that these patterns are shaped by longstanding racial and immigration narratives that cast certain groups as less trustworthy. The discussion emphasized that creating equitable access will require dismantling these mental models and positioning communities as decision makers or agents of change rather than subjects of oversight. Participants reflected that resourcing community-based organizations to lead local design is essential for shifting this dynamic.

Power-building across movements is necessary to build sustainable, equitable change.

Equitable access is also a question of power and partnership with other movements. The group's conversations underscored that access gaps reflect deeper structures of exclusion and that care equity is intertwined with the work of civil rights, immigrant justice, disability justice, women's rights, and Indigenous movements. Participants highlighted that Colombia's feminist organizing helped anchor care as a political priority while building alliances across sectors. Similarly, the links between the movement for fair work, ending GBV, and health equity in India all intersected with care. The group discussed the importance of mapping unions and grassroots organizations in their own jurisdictions, identifying where new worker formations may be needed, and developing shared advocacy strategies that distribute power and risk. Finding new allies could broaden the constituency for care but will require power-sharing in a way participants recognize as distinct from past collaborations.

Grassroots organizations are key to mobilizing communities to collaborate in learning, designing, and implementing programs that support a comprehensive childcare system.

Bridging service delivery and community organizing is critical for equitable care. Participants noted that service organizations hold deep proximity to families but often have limited influence on policy decisions, while organizing groups have political power but less daily contact with the realities of care. The group highlighted the opportunity to link these two ecosystems so that care delivery becomes a channel for leadership, voice, and long-term civic participation. This approach, they observed, could create care systems that are both responsive to community needs and capable of driving structural change.

Dignifying and Valuing Care Work

What We Saw and Heard in Colombia and India

Conversations with organizations such as IMA Limpia, Unión Afrocolombiana de Trabajadoras Domésticas (UTRASD), "Hablemos de Trabajo Doméstico", and SEWA illustrated how Colombia and India are working to increase recognition and empowerment of care workers. Public campaigns highlight the economic and social value of care. Worker centers create space for leadership development, rights education, and visibility for domestic workers, many of whom have historically been excluded from formal labor protections Cooperatives create ownership and wealth-building opportunities. These efforts frame care workers as skilled and essential contributors to collective wellbeing.

Leaders in care worker rights and advocacy traced the long history of exclusion experienced by domestic workers—many of whom are central providers of care—and how grassroots organizing, including the formation of entities like UTRASD and SEWA, helped secure major legislative and policy gains. They underscored the deep ties between domestic work, race and class, noting the central role Afro-Colombian women and Dalit women have played in a sector where they have faced abuse and wage discrimination yet organized in solidarity to demand not just labor rights, but dignity and racial justice.

What Participants Reflected On

We need to work on the narrative; not just what caregiving is (apart from the "branding conversation"), but the dignity and human rights aspects.

Dignifying care work requires shifting public narratives and mental models that shape how care workers are viewed. Participants discussed how narratives of individual responsibility and racialized deservingness influence perceptions of care work in the U.S., often reducing it to low skill labor rather than recognizing it as foundational to family stability and economic health. The conversation underscored that improving conditions for care workers will require confronting these long-standing beliefs and expanding public understanding of care as skilled, relational, and essential work.

We need to make sure we are centering the providers and children in this work.

Strengthening the dignity of care work requires recognizing both formal and informal caregivers' contributions and expanding their collective power. Participants noted that informal caregivers play major roles in many communities and that supporting these workers without compromising their autonomy requires strategies that blend recognition, protection, and respect for community-based practices. For example, an initiative called Durga, studied in India, showed ways in which street vendors and pushcart vendors can be supported to create more caring public spaces that reduce gendered violence and protect children, and that these same workers can be celebrated through incentives, rewards, and recognition programs that build their confidence and respect their dignity. At the same time, the group emphasized that narrative work alone is insufficient without building the political power of caregivers. They highlighted the importance of organizing, leadership

development, and shared decision-making structures that allow care workers to influence policy and shape the systems that affect their lives. Together, these efforts create the conditions for a more inclusive and durable care ecosystem, one in which caregivers have visibility, voice, and agency.

[It's] important to keep making a case for wages that bring work parity, especially on the care economy that is dominated by women. [It's important] to build collective power and advocacy. Partner with you community to bring an identity (Art) [to the work].

Visibility emerged as a critical strategy for elevating the value of care. Participants noted that care in the U.S. often happens out of sight, and therefore out of public awareness, even though everyone relies on it; and that the need to care for and support caregivers themselves is not sufficiently emphasized. This is amplified by the gendered aspect of caregiving in the U.S. but also in Colombia and India, including in formal caregiving spaces like ECE centers and creches, which prevents society from seeing care as a priority and a responsibility for everyone, often treating it as women's work and compartmentalizing it. They discussed ways to make care feel more visible and understood as part of our shared public infrastructure. They also highlighted that narratives regarding who carries what care responsibilities and plays what care roles must be renegotiated, not just in public spaces but at home, elevating ongoing efforts like a movement in the U.S. ECE sector to increase men's representation as providers. Ideas to shift these narratives included creating campaigns that show how care, or the absence of it, shapes people's daily lives, and collaborating with artists and storytellers to portray care across different communities.

[Colombia showed] care as a comprehensive campaign: the possibility of senior groups and child groups to come together.

Participants reflected on the strategic role art and storytelling play in rebuilding narratives, helping communities confront histories of exclusion, and strengthening collective identity within public care systems. Several participants emphasized that these efforts should build toward a long-term cultural strategy rather than one-time campaigns. They also suggested aligning with existing movements focused on democracy, racial justice, and economic justice, since those networks already have experience shifting narratives and could help amplify a broader story about the value of care.

Short-term policy interventions can lead to long-term cultural change, such as treating gender-based violence as a public safety issue.

Closing Remarks

These learning trips offered participants a chance to step back from their daily work and experience two care ecosystems shaped by collective responsibility, care grounded in community trust, and families placed at the center of public policy. Seeing how Colombia and India integrate narrative, infrastructure, and lived experience gave participants a clearer sense of how care systems can function when they are designed with long-term wellbeing in mind. Many left with a sharpened understanding of the mindsets and conditions that must shift in the U.S. for families and caregivers to thrive.

There are so many innovations happening in other nations that we should consider for our policy advocacy in the U.S., and there are incredible innovations happening in the care economy around the world. I learned so much from this trip, and it will influence my work for years to come.

The trips also surfaced meaningful alignment across participants' work and the broader vision for strengthening care in the U.S. Conversations throughout the trip yielded small and large opportunities for subsequent collaborations and learning exchanges between participants. The group raised, for example:

- **The need to drive a shift from an individual, transactional mindset of care responsibilities towards a collective, rights-oriented mindset:** This was perhaps the biggest transferable lesson that participants identified from both India and Colombia, where care is seen more as a collective responsibility and right of children, and less as an individual responsibility that each family holds in their own budgets.
- **The need to transform the role of government in care:** Participants discussed how the role of government in care in the U.S. was currently unclear and undefined, and how there was scope to both define a role and demand a stronger role, holding government accountable against that expectation. There was agreement that care is a public good, which implied that the government needed to, at minimum, enable, regulate, and fund care; and that involvement of central government in care should not imply support for disadvantaged groups, but provision for everyone's wellbeing. There was also agreement that over-regulation and over-commercialization of care was a real concern, and that a rights-based, principled approach to government involvement in care was necessary in the U.S. (like in India and Colombia). Participants noted the growing role of private capital, including venture capital, in care in the U.S., with implications for the role of government. They also highlighted an opportunity to create a more curated capital stack for care in the U.S. that blends more effectively private for profit, philanthropic, local and federal public funding, based on what they saw in India (where philanthropy, corporate taxes, and corporate social responsibility efforts are combined with public funds to support care).
- **The need to create/leverage spaces for coordination:** Participants noted how in both India and Colombia there were spaces for the sector to come together and set shared strategies and narratives. There was a desire and interest to build up similar spaces in the U.S. (recognizing that they do exist, but are ad hoc and not always well attended).

Finally, the trip demonstrated why learning exchanges matter. They create space for practitioners, organizers, and leaders to deepen relationships, explore new models, question assumptions, and step into shared purpose in ways that are hard to achieve in isolation. By encountering two different care systems, that

reflected different cultural mindsets around care, together, participants were able to imagine new possibilities for their own communities, identify opportunities for collaboration across states and sectors, and return with renewed clarity on the long-term work ahead. A post-trip feedback survey showed that trip participants found the trip very valuable for their professional work and gained new perspectives on how care can be designed and delivered as a public good. Participants also built meaningful connections that could support future collaboration to change the U.S. care field, deepened their understanding of how collaborations across the public, private and social sector can strengthen care systems, and left the trip with clarity on next steps or partnerships to pursue (see Figure 1 below for more specifics from the participant survey). Experiences like this strengthen the field by cultivating trust, inspiration, and the collective resolve needed to build care systems that support all families.

As part of an organization that is building care thought family childcare leadership and models, the Colombian trip ratifies that our work is in the right direction. Sharing the journey with other partners is a promise to amplify this work to build collective power, to ensure leadership and training programs, to support and engage campaigns for better care and to try to bring one north star across the nation.

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