CARE SYSTEM RESILIENCE DURING NATIONAL TRANSITIONS

Lessons from Subnational Implementation in Colombia

ICRW
INTERNATIONAL CENTER FOR RESEARCH ON WOMEN

ABOUT ICRW

The International Center for Research on Women (ICRW) is a global network consisting of three autonomous regional entities—ICRW-Africa, ICRW-Americas, and ICRW-Asia. For 50 years, ICRW has set the global agenda for gender equity, inclusion, and shared prosperity with action-oriented research and solutions. Our global experts generate groundbreaking insights and develop gender-transformative strategies on topics like economic opportunity and security, health and reproductive rights, gender norms, and climate action. Our vision is to create an equitable, sustainable, and prosperous world where women, girls, and structurally excluded populations lead and thrive.

AUTHOR AND ACKNOWLEDGMENTS

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CONTENTS

Executive Summary ↗ 07

Introduction ↗ 09

Introduction
Creation and Status of the SNC ↗ 11

Introduction
Methods and Limitations ↗ 13

Analysis by Dimension ↗ 15

Analysis by Dimension
Institutionalization ↗ 17

Analysis by Dimension
Service Design and Territorial Delivery ↗ 22

Analysis by Dimension
Financing ↗ 19

Analysis by Dimension
Indicators and Evidence ↗ 24

Analysis by Dimension
Populations Served ↗ 21

Lessons Learned ↗ 28

Conclusions ↗ 33

References ↗ 34

Annex 1: Comparison Table ↗ 41

Annex 2: Analytical Framework ↗ 44

Contents ↗

LIST OF ABBREVIATIONS

ILO	International Labour Organization
MinIgualdad	Ministerio de Igualdad y Equidad (Ministry of Equality and Equity)
PDET	Programas de Desarrollo con Enfoque Territorial (Territorial Development Programs)
POT	Plan de Ordenamiento Territorial (Territorial Land-Use Plan)
SNC	Sistema Nacional de Cuidado (National Care System)
ZOMAC	Zonas Más Afectadas por el Conflicto Armado (Zones Most Affected by Armed Conflict)

EXECUTIVE SUMMARY

At a time of growing challenges to gender equality across the Americas, ICRW-Americas recognizes that evidence is essential for advancing policy solutions and understanding which gains endure, where they remain vulnerable, and what can protect them from rollback. ICRW-Americas produced this paper as part of its work to advance care policies and support the translation of care commitments into effective and durable systems at the territorial level.

Colombia offers a particularly valuable case for this analysis because it has been a dynamic laboratory for care policy, combining an ambitious national care agenda with rapid experimentation across diverse urban, rural, departmental, Indigenous, and community contexts. Between 2022 and 2026, Colombia developed a national architecture intended to recognize care as a right, strengthen support for caregivers and people who require care, promote cultural change, and expand the role of territorial governments and community care organizations. At the same time, the dissolution of the Ministry of Equality and Equity, combined with the 2026 national political transition, is testing whether these advances can survive beyond the institutions and political leadership that initially promoted them. At the time of the ministry's closure, 14 subnational initiatives had been officially recognized as territorial care systems.

This white paper asks which characteristics strengthen or weaken the resilience of local care systems during changes in government by looking at the ministry-recognized cohort. The analysis compares the cases across five dimensions: institutionalization and governance; financing; populations served; service design and territorial delivery; and, indicators and evidence. The review draws primarily on legal instruments, territorial plans, budgets, government reports, technical publications, evaluations, academic research, and, where necessary, local press, but information is still limited.

Although a common core has diffused from Bogotá's template, the cases show that care can be organized through proximity infrastructure, mobile routes, home-based support, night services, rural productive models, and community and Indigenous networks. This diversity is a strength because care needs and institutional capacities differ sharply across territories. However, the central finding is that Colombia's territorial care agenda has diffused faster than the fiscal, operational, and evaluative infrastructure needed to consolidate it.

A transformative territorial system shifts care away from women's unpaid availability, expands and regulates public provision, finances community contributions fairly, improves paid care work, represents affected groups, and protects the autonomy and well-being of people receiving care. National transition increases the urgency of building that institutional, fiscal, and evidentiary foundation.

Lessons from Colombia can, therefore, inform both the next phase of the country's care agenda and wider debates across Latin America on how to build care systems that are territorially responsive, gender-transformative, and politically and institutionally durable.

INTRODUCTION

Between 2022 and 2026, the Petro-Márquez administration advanced a national architecture for care infrastructure in Colombia. This architecture relied on a national body that was dissolved in mid-2026, the Ministry of Equality and Equity (Ministerio de Igualdad y Equidad, or MinIgualdad) (Congreso de la República de Colombia, 2025; Corte Constitucional de Colombia, 2024a). However, the ministry's closure did not automatically erase the national care agenda, particularly because part of the National Care System (Sistema Nacional de Cuidado, or SNC) strategy was to promote the strengthening and development of subnational care systems.

When MinIgualdad closed in mid-2026, it had officially recognized 14 subnational care systems: 11 are municipal, district, or local cases, and three operate at the departmental level (see Figure 1 and Table 1). The question now is how durable this approach will prove to be in light of shifting national priorities and which features might enable those initiatives to survive.

Table 1. Included subnational care systems

Territory	Level	Subnational care system
Antioquia	Departmental	Antioquia Care System, includes Care Farms [Sistema del Cuidado de Antioquia, incluye Granjas del Cuidado]
Bogotá D.C.	Capital district	District Care System (SIDICU), which includes Care Blocks, Care Buses, and Personal Assistance [Sistema Distrital de Cuidado (SIDICU), incluye Manzanas del Cuidado, Buses del Cuidado, y Asistencia Personal]
Boyacá	Departmental	"Abrigo" Departmental Care System / Abrigo Network, including Abrigo Homes and Provincial Care Pathways [Sistema Departamental de Cuidado "Abrigo" / Red Abrigo, incluye Casas Abrigo y Rutas Provinciales del Cuidado]
Bucaramanga (Santander)	Municipal	"Asegurarte" Municipal Care System, organized through Care Circuits [Sistema Municipal del Cuidado "Asegurarte", organizado a través de Circuitos del Cuidado]

Table 1. Included subnational care systems

Territory	Level	Subnational care system
Cali	Municipal / Special district	"CuidArte" District Care System and Care Ecosystems [Sistema Distrital de Cuidado "CuidArte" and Ecosistemas del Cuidado]
Cúcuta (Norte del Santander)	Municipal	Municipal Care System, including CuidArte Centers [Sistema Municipal del Cuidado, incluye Centros CuidArte]
Cumbal (Nariño)	Municipal	"Cumbal, a Territory That Cares 2025–2035" ["Cumbal, territorio que cuida 2025–2035"]
La Ceja (Antioquia)	Municipal	Municipal Care System, including the Care Ecosystem/ Care Polygon, Care Center, and Basket of Services [Sistema Municipal del Cuidado, incluye Ecosistema/ Polígono del Cuidado, Centro del Cuidado, y Canasta de Servicios]
Manizales (Caldas)	Municipal	Municipal Care System, including the Care Club-Time for Me [Sistema Municipal del Cuidado, incluye Club del Cuidado–Tiempo para Mí]
Medellín (Antioquia)	Municipal / Special district	Medellín Care System, which includes Care Circles, also known as Care and Equity Centers [El Sistema de Atención de Medellín, que incluye los Círculos de Atención, también conocidos como Centros de Atención y Equidad]
Pereira (Risaralda)	Municipal	Municipal Care System, including the pilot program for the Municipal Care Center [Sistema Municipal del Cuidado, incluye el piloto del Centro Municipal del Cuidado]
Popayán (Cauca)	Municipal	Municipal Care System [Sistema Municipal del Cuidado]
Valle del Cauca	Departmental	"The Valle Cares for You" Departmental Care System includes Nighttime Daycare Centers, a Comprehensive Care Center, and Comprehensive Care Centers [Sistema Departamental de Cuidado "El Valle Cuida de Ti", incluye Arrullo/Jardines Infantiles Nocturnos, Centro Integral del Cuidado, y Centros de Atención Integral]
Villavicencio (Meta)	Municipal	Municipal Care and Support System, including the Care Block in Ciudad Porfía [Sistema Municipal de Cuidados y Apoyos, incluye la Manzana del Cuidado en Ciudad Porfía]

CREATION AND STATUS OF THE SNC

Colombia's Congress approved the creation of MinIgualdad in December 2022, enacted as Law 2281 of 2023 and led initially by Vice President Francia Márquez (Congreso de la República de Colombia, 2023a). The ministry was charged with formulating and coordinating policies to reduce structural inequality across 14 population groups: women, LGBTQI+ people, people with disabilities, Afro-descendant communities, Indigenous peoples, rural workers, migrants, and others. Its structure included five vice-ministries: Women; Youth; Marginalized Communities and Territories and Poverty Alleviation; Diversities, covering LGBTQI+ people and people with disabilities; and Ethnic Peoples and Rural Communities. The SNC was developed within the Vice-Ministry for Marginalized Communities and Territories and Poverty Alleviation, organized around the "invisible women" providing care, through three pillars of action:

1. Institutional response to guarantee the rights of caregivers;
2. Strengthening of community care organizations and their own organizational processes for care; and
3. Cultural change toward a caring society.

The explicit national attention to community care was a distinctive contribution of the SNC and is important in interpreting the subnational cases.

The national care agenda also rests on a broader legal and policy framework. Legislation in 2023 establishes measures supporting the autonomy and rights of persons with disabilities and their caregivers, including concepts of care and personal assistance (Congreso de la República de Colombia, 2023b). CONPES 4143 of 2025 adopted the National Care Policy (Consejo Nacional de Política Económica y Social, 2025). The Constitutional Court described care as an autonomous fundamental right with three facets: the right to receive care, the rights of people who provide care, and the right to self-care (Corte Constitucional de Colombia, 2024b). Similarly, in June 2025, the Inter-American Court also recognized care as an autonomous human right with the same three dimensions: being cared for, caring, and self-care (Corte Interamericana de Derechos Humanos, 2025).

However, in May 2024, the Constitutional Court declared the law creating MinIgualdad unconstitutional (unenforceable) on procedural grounds because Congress had failed to conduct a required fiscal impact assessment during the legislative process (a violation of Law 819 of 2003 and Article 151 of the Constitution), thus precipitating the ministry's closure (Corte Constitucional de Colombia, 2024a).

The court acknowledged the ministry's importance to marginalized populations and declined to order immediate dissolution; instead, it gave Congress two legislative sessions (until June 20, 2026) to pass a corrected law. A corrective bill advanced through a first debate, reportedly clearing 15 of its 17 articles, but did not complete its passage before the deadline (MinIgualdad, 2026; Cambio, 2026; Congreso de la República de Colombia, 2025).

With the deadline unmet, the national government issued a decree ordering the ministry's liquidation, and another decree to initially appoint the liquidator These decrees envisaged reassigning responsibilities to the Ministry of the Interior and the Administrative Department for Social Prosperity through further structural and budgetary measures, but they did not establish a fully operational successor for each care-related function. Separately, a third decree regulates the SNC governance model, including intersectoral, technical, territorial, and advisory bodies. These provisions preserve elements of a formal governance framework, although their staffing, financing, coordination, and implementation during the transition remain uncertain (Presidencia de la República de Colombia, 2026a, 2026b, 2026c).

Although MinIgualdad's liquidation has created uncertainty, the legislative agenda continues. In July 2026, Bill 001 of 2026 was introduced in the House of Representatives to recognize the right to care and (re) establish the SNC (Congreso de la República de Colombia, 2026). The bill proposes that the SNC be a permanent mechanism for coordinating national, territorial, community, social, and economic actors, while protecting the rights of people requiring care and those who provide paid and unpaid care. As of this writing, the bill remains at the beginning of the legislative process and has not been enacted. However, its introduction signals continued political efforts to consolidate the care agenda beyond a single political administration.

The closure also coincides with a phase of government transition: In the June 2026 runoff, Abelardo de la Espriella defeated Iván Cepeda 49.7% to 48.7%, and took office on August 7, 2026, ending the Petro-Márquez period and bringing to the presidency a platform sharply different in orientation (El Tiempo, 2026). That platform emphasizes family, faith, property, work, and security, and it proposes reducing the size of the state by up to 40% and eliminating ministries it considers superfluous. It does not commit to reconstituting MinIgualdad or the rights-based care architecture built under it (Defensores de la Patria, 2026; Mompotes Lemos, 2026).

Of the relevant subnational care programs, Bogotá began implementation in 2020 and is the oldest operational system in the cohort. The most recent confirmed system-creating legal instruments in the list of subnational care systems recognized by MinIgualdad , including Cúcuta's decree (Alcaldía de San José de Cúcuta, 2025), Popayán's decree (Alcaldía de Popayán, 2025a), and Villavicencio's agreement. Cumbal's 2025–2035 framework is newer as a programmatic horizon, but this review could not locate a publicly accessible municipal adopting instrument.

MinIgualdad publicly reported growth from one to 14 territorial systems, but this review did not locate a definitive national registry establishing uniform admission criteria. The 14 should, therefore, be understood as a ministry-recognized or publicly promoted cohort, not an audited certification that all 14 meet a common system standard.

METHODS AND LIMITATIONS

This paper examines the characteristics that may strengthen or weaken the resilience of subnational care systems during political and institutional transitions. It compares the 14 territorial care initiatives publicly recognized by the former Ministry of Equality and Equity across five dimensions: institutionalization, financing, populations served, service design and territorial delivery, and indicators and evidence. The comparative analytical framework is presented in Annex 2.

This analysis relied on desk research, with sources prioritized in the following order: legal instruments and official normative repositories; territorial development plans, budgets, management reports, and system documents; national and international technical publications; independent evaluations and academic research; and, where primary documentation was unavailable, local press. The review utilized the analytic approaches described in Annex 2 and distinguishes enacted instruments from announcements, executed services from targets, unique users from service contacts, and official administrative reporting from independent evidence. The cutoff date for data collection was July 30, 2026. However, select national publications released subsequently were incorporated when relevant.

Three important limitations apply throughout:

- **Data quality:** With the partial exception of Bogotá, all of the results and figures discussed in this paper are self-reported administrative outputs (e.g., attendance, enrollments, and certifications) published by the implementing governments themselves. They are not independently audited, use non-comparable units (e.g., services provided, service users, registered caregivers), and almost none are tied to a counterfactual.

  Bogotá has the most developed evaluation evidence among the systems reviewed. In 2023–2024, the District Planning Secretariat commissioned an independent evaluation of the operations and short- and medium-term effects of the Sistema Distrital de Cuidado (District Care System). The evaluation was structured around a theory of change and combined quantitative and qualitative methods. It included 2,674 surveys of people using the Manzanas del Cuidado, Buses del Cuidado, and Asistencia Personal (Care Blocks, Care Buses, and Personal Assistance) models and a comparison population, as well as administrative records, semi-structured interviews, focus groups, participatory workshops, and micro-ethnographic observations.

It examined the system's intersectoral operation, its operating models, and its effects on the recognition, reduction, and redistribution of unpaid care work (Unión Temporal Economía Urbana–Fedesarrollo, 2024).

- **Recency:** Several systems launched between 2024 and 2026 and are evolving quickly; figures are dated where possible.
- **National context:** All of these systems operate against the backdrop of a national transition and uncertainty, and the appointment of a liquidator via Decreto 684 of July 1, 2026. The reassignment of MinIgualdad's care/SNC functions, including the Department of Social Prosperity's role, should be tracked against the official liquidation decisions, which have not been confirmed.

02

ANALYSIS BY DIMENSION

This section assesses whether the diffusion of territorial care initiatives has been matched by the institutional, fiscal, operational, and evaluative capacities required for comprehensive and transformative care systems. It compares the systems across five dimensions: institutionalization; financing; populations served; service design and territorial delivery; and indicators and evidence.

Institutionalization assesses whether a care system has legal and administrative arrangements capable of continuing beyond the administration that created it. Municipal and district council agreements and departmental assembly ordinances can establish obligations that are more difficult to reverse than programming contained only in a four-year territorial development plan. Financing determines whether commitments have the resources needed for implementation. The populations served indicate whether caregivers, care recipients, people with disabilities, families, workers, rural communities, and men experience benefits and may defend the system during a transition. Service design matters because reliable services that reduce or redistribute care responsibilities can build public expectations and political constituencies. Finally, indicators and evidence help a system demonstrate its reach and outcomes to successive governments.

Taken together, the five dimensions highlight the key characteristics of local care systems that may strengthen or weaken their resilience during changes in government. Annex 1 provides a system-level comparison of the 14 cases, and Table 2 shows how the dimensions support or weaken local care system resilience.

Table 2: Dimensions and how they can strengthen or weaken care system resilience

Dimension	Strengthens resilience when…	Weakens resilience when…
Institutionalization	Continuing duties and governance mechanisms are established.	The system/initiative depends only on a four-year plan.
Financing	Recurrent budgets, national co-funding, and fiscal equalization mechanisms exist.	Services rely on annual contracts or cooperation.
Population served	Multiple groups experience benefits	The system is perceived as serving a narrow group.
Service design and territorial delivery	Benefits are visible, relevant, regular, and transformative.	Activities are occasional or add to caregivers' workload.
Indicators and evidence	Results can be demonstrated.	Reporting is limited to activities performed.

INSTITUTIONALIZATION

Although institutionalization, or how a system is anchored legally, does not guarantee survival of the system, it can strengthen its resilience to political transitions. This analysis establishes four categories of institutionalization that consider legal durability and operational maturity to support comparisons across systems (Table 3):

- **Category 1:** Durable and consolidated;
- **Category 2:** Legally anchored, still consolidating;
- **Category 3:** Operational, less durable system-wide anchoring; and
- **Category 4:** Emerging , pilot, or cooperation-supported

Table 3: Categories of institutionalization: Legal durability and operational maturity

Category	Legal durability	Operational maturity	Illustrative cases
Durable and consolidated	Legislative establishment plus regulation and planning protection	Multi-service, broad intersectoral coordination, information architecture, and evaluation efforts	Bogotá
Legally anchored, still consolidating	Agreement, ordinance, or decree establishes the system	Services are operating, but coverage, recurrent financing, or results architecture remain incomplete .	La Ceja, Villavicencio, Boyacá, Cali, Cúcuta, Popayán
Operational, less durable system-wide anchoring	Primarily in the development-plan, program, or policy architecture; a system-wide agreement has not been verified	Visible portfolio, recurring delivery or significant territorial reach	Medellín, Manizales, Antioquia, Valle del Cauca
Emerging, pilot, or cooperation-supported	No public system-creating instrument identified, or a long-term framework is not yet linked to an adopting act	Pilot sites, technical assistance, characterization or early service bundle	Bucaramanga, Pereira, Cumbal

Bogotá's district care system is legislatively established through a District Council agreement, regulated by a district decree in 2023, and supported by the city's land-use planning framework from 2021. The Territorial Land-Use Plan (Plan de Ordenamiento Territorial, or POT) is Bogotá's binding long-term instrument for organizing land use, infrastructure, public facilities, and urban development. The current POT, adopted by decree, reserves 45 Manzana del Cuidado (Care Blocks) sites. Embedding care infrastructure in the POT helps protect locations and investments beyond one mayoral term. In Bogotá's case, the system survived the López-to-Galán mayoral transition (2024) intact and expanding (21 to 27 Manzanas), which its architects explicitly attribute to having the *acuerdo* (a legally binding agreement adopted by a municipal or district council; Alcaldía Mayor de Bogotá, 2021, 2023; Concejo de Bogotá D.C., 2023; Secretaría Distrital de la Mujer & Sistema Distrital de Cuidado, 2025; Vargas Fonseca, 2024). La Ceja similarly used a municipal council agreement to anchor its care system (Concejo de La Ceja del Tambo, 2024).

Villavicencio's 2025 council agreement and Boyacá's 2023 departmental ordinance and 2024 decree provide the foundation and strengthen the legal continuity of the care system, while their networks remain much smaller and newer than Bogotá's (Asamblea Departamental de Boyacá, 2023; Gobernación de Boyacá, 2024c; Concejo de Villavicencio, 2025). Cúcuta and Popayán have also adopted decrees establishing municipal care-system arrangements, while Cali's 2023 decree established a district-level care committee. These instruments provide different degrees of legal and administrative anchoring (Alcaldía de San José de Cúcuta, 2025; Alcaldía de Popayán, 2025a, 2025b; Alcaldía de Santiago de Cali, 2023). Conversely, Medellín and Manizales have visible service portfolios and Medellín has an earlier municipal policy addressing family and volunteer caregivers, but this is distinct from a comprehensive legal instrument institutionalizing the current care system (Concejo de Medellín, 2015). For Medellín and Manizales, this review did not identify a current system-wide legislative instrument with the breadth of Bogotá's framework.

Development-plan programs with intersectoral governance occupy a middle position. A territorial development plan authorizes priorities, targets, and public investment for the four-year administration and can create real operating capacity. However, a successor administration can change priorities more readily than when a council agreement or departmental ordinance establishes continuing duties, governance, participation, and reporting. The risk is greatest when the operating model depends heavily on annual contracts, a political champion, or an external cooperation agreement.

FINANCING

Regional guidance emphasizes that comprehensive care systems require adequate, progressive, and sustainable public financing, together with tools to identify, cost, track, and evaluate care expenditure (Economic Commission for Latin America and the Caribbean, 2022; Scuro et al., 2022). This section analyzes existing financing information about local care systems. However, verified financing information is limited, which is a finding in and of itself. In addition to missing amounts, "published figures" refer to different things: for example, an entire gender-secretariat budget, one infrastructure contract, a four-year program envelope, municipal budget tagging, cooperation financing, private in-kind contributions, or an appropriation that may not have been executed. Therefore, the amounts identified should not be compared or ranked as comparable care system expenditures. For subnational systems, this section also raises a fiscal-equalization question: Territorial responsibilities cannot be matched equitably if poorer jurisdictions must rely principally on their own revenues or short-term cooperation.

Bogotá finances its system through the articulated budgets of 13 district sectors coordinated by the District Secretariat for Women (Secretaría Distrital de Mujer) rather than through a single fund. This review identified no consolidated system budget figure. The care buses, blocks, and personal caregivers rely on sectorial appropriations, plus POT-driven infrastructure (Secretaría Distrital de la Mujer & Sistema Distrital de Cuidado, 2025; Secretaría Distrital de la Mujer, 2023).

Medellín announced at the launch of its system (2024) that COP$60 billion would be utilized for the four-year period of the Círculos de Cuidado (Care Circles) strategic project (Alcaldía de Medellín, Secretaría de las Mujeres, 2026).

In **Cali**, CuidArte is one of two social well-being projects funded partially through an approximately COP$15 billion public credit approved by the city council (i.e., debt-financed care infrastructure) (Alcaldía de Santiago de Cali, 2024a).

In **Antioquia**, official reporting identifies project-level investments within a much larger women's-policy portfolio. The Secretaría de las Mujeres (Women's Secretariat) 2025 budget was approximately COP$34 billion (the highest since its creation), covering the entire gender portfolio, including, but not limited to, the Sistema del Cuidado (Care System). Specific verified line items include COP$449 million for upgrading seven Granjas de Cuidado, rural spaces that combine caregiver training and support with collective food production and solidarity-economy (co-financed with Fundación Oleoductos de Colombia), and COP$1 billion to equip Women's Centers (Casas de la Mujer) in 33 municipalities. Regalías (royalties) appear as a source for PDET/ZOMAC[1] infrastructure (Gobernación de Antioquia, 2025a, 2025b; Al Poniente, 2025).

1 Programas de Desarrollo con Enfoque Territorial (PDET) are long-term Territorial Development Programs covering 170 municipalities especially affected by violence, poverty, illicit economies, and institutional weakness. Zonas Más Afectadas por el Conflicto Armado (ZOMAC) are municipalities legally designated as among the areas most affected by armed conflict, with associated development and tax instruments.

La Ceja used a care-tagging exercise across the entire municipal budget, where 67% of the budget figure (COP$335 billion of $505 billion over four years) is to be tagged for care (that is, the exercise labels existing budget lines across sectors as care-related; it does not represent new or additional money allocated to care services) (Alcaldía de La Ceja del Tambo, 2024). Analytically, it is closer to a gender-budgeting/care-budgeting methodology than a system budget.

Bucaramanga and **Cumbal** illustrate the importance of external financing. Bucaramanga's care schools involved national co-financing through a 2024 agreement with the MinIgualdad's Fondo para la Superación de Brechas (Fund for Overcoming Inequality Gaps) and the United Nations Development Program. This is precisely the kind of national-territorial financial mechanism whose continuity is now in question with the likely transfer of the ministry's functions to the Department of Social Prosperity or the Ministry of the Interior. Cumbal's care system is mostly funded by international cooperation (specifically Canada and UN Women's Entornos que Cuidan program) (Alcaldía de Bucaramanga, 2025; UN Women Colombia, 2026). Public sources do not provide a complete split among municipal resources, cooperation funding, in-kind support, and community contributions. International cooperation can accelerate innovation and reach smaller territories, but it also creates a transition risk when services are not absorbed into recurrent territorial budgets. The 2025 suspension of many United States foreign-assistance activities in Colombia demonstrated how quickly externally supported social programs can be interrupted.

For **Boyacá**, **Valle**, **Cúcuta**, **Manizales**, **Pereira**, **Villavicencio**, and **Popayán**, this review found no verified consolidated figures. Financing is embedded in sectoral budgets, with private/philanthropic partners playing visible roles (Éxito Foundation in Boyacá; Asocolflores, Haceb, and Imusa in La Ceja; Sura Asset Management/Impact Hub in Medellín; María Cano University in Medellín and Popayán; AARP accompaniment in Pereira; and Comfama/Comfenalco, Davivienda, and mining companies in Antioquia).

Overall, publicly available documents reviewed for this report show a patchwork of sectoral appropriations, credit operations, royalties, national transfers, cajas de compensación (employee family benefits funds), cooperation, and philanthropy. The review did not identify a consistently reported, consolidated, and recurrent budget for the full care system in any territory. Financing is, therefore, both the weakest link in sustainability and the least comparable dimension.

POPULATIONS SERVED

Who a care system is designed to serve underscores the logic behind the system's construction, the breadth of its constituency, and how easily a successor government can characterize it as serving limited subinterests or the larger public. Distinct targeting logics coexist in the 14 systems observed:

1. **Caregiver-centered (the dominant model):** Bogotá, Medellín, Cali, Cúcuta, Bucaramanga, Popayán, Manizales, Pereira, and Boyacá employ this model. The primary subject is the unpaid—overwhelmingly female—caregiver, with *oferta espejo* (simultaneous services for people receiving care that enable caregivers to participate in activities.) for care receivers (children under 5, older persons, people with disabilities) as the enabling condition. Bogotá formalizes this as three service families: services for caregivers, services for care receivers, and cultural-transformation services aimed especially at men. Urban systems often target women caregivers through nearby facilities.

2. **Whole-population/life-course:** La Ceja explicitly frames care for *"toda la ciudadanía en todas las edades"* ("all citizens of all ages") and positions itself as a retirement-and-care destination; the system is coordinated from the Education Secretariat and treats care as territorial identity. Valle del Cauca's model also mixes caregivers, people with disabilities, and working/studying mothers (night childcare).

3. **Rural, ethnic, and conflict-affected populations:** Departmental and rural initiatives place greater emphasis on dispersed populations, campesino women, Indigenous communities, PDET and ZOMAC municipalities, and mobile delivery. Antioquia's Granjas del Cuidado and Boyacá's provincial routes target *veredas*, or administrative rural subdivisions,across 15 provinces and address rural production, food security, mobility, and dispersed access to services. Cumbal is particularly relevant because it targets Indigenous community care networks in four *resguardos*, or legally recognized Indigenous collective territories.

4. **Men:** Men are a notable secondary population addressed programmatically in Bogotá (*"A cuidar se aprende"* or "Caring can be learned"), Medellín (workshops for men in Círculos), and Antioquia (*Paternidades Cuidadoras*, or Caring Paternities, 352 men).

Rurality and conflict-affectedness are explicitly addressed (e.g., Antioquia's PDET/ZOMAC prioritization and Boyacá's provincial routes), Indigenous governance appears in Cumbal, and disability is a strong entry point in several systems (Villavicencio, Pereira, Popayán, and Bucaramanga's Bono del Cuidador, or Caregiver Allowance). Other intersections remain largely invisible in system design and public reporting: Publicly available system documents reviewed for this paper did not consistently identify Afro-descendant, migrant, or LGBTIQ+ caregivers as target populations or report results for these groups. Afro-descendant women are not specifically named as a target population even where systems operate in predominantly Afro-descendant territories (for example, Cali's eastern comunas [boroughs]).

Migrant caregivers are also not explicitly named in Cúcuta's design despite the city's border context, and there is no visible attention to LGBTIQ+ caregivers, to older caregivers who are themselves becoming care-dependent, or to paid domestic workers who also carry unpaid care loads at home.

Weak public documentation does not confirm program exclusion, but further investigation is needed on whether the systems apply an intersectional lens and how one could be applied throughout the program cycle. Bogotá's care needs index (Índice de Condiciones y Necesidades de Cuidado) incorporates differential criteria for siting, but even in Bogotá, published results are rarely disaggregated beyond sex and broad population group. Bogotá's system has also been found to present access barriers, particularly for caregivers of people with disabilities with severe dependency and children under 1 year (Ramírez Bustamante & Camelo Urrego, 2023). A minimum standard for the next phase would be reporting data disaggregated by ethnicity, rurality, disability, age, and migration status.

SERVICE DESIGN AND TERRITORIAL DELIVERY

What care systems are designed to deliver determines whether the system redistributes care or merely adds demands on caregivers' time. It also shapes the system's perceived value among stakeholders such as the public, policymakers, and potential financial donors. This section analyzes the common service core among the 14 programs and the distinctive innovations that depart from it.

A common core has diffused from Bogotá's template (e.g., respite and self-care activities, flexible education, income generation/entrepreneurship, psychosocial and legal orientation, and laundry services with simultaneous [oferta espejo] programming) and is visible in Medellín, Cali, Cúcuta, La Ceja, Antioquia's centers, and Bucaramanga (Alcaldía de Santiago de Cali, 2024b). Recognition activities can make unpaid work visible; infrastructure and substitute services can reduce its total volume; services directed at men and expanded public provision can redistribute responsibilities; labor standards can reward paid care; and participatory governance can represent caregivers, care workers, and care recipients (International Labour Organization [ILO], 2018). The most consequential design feature is simultaneous services or substitute provision of care to allow a caregiver to use a service while another person or program safely supports the person for whom they care. Without that provision, training or self-care can become an additional demand on an already time-poor caregiver.

Service expansion must also be assessed from the perspective of people receiving care. A rights-based system requires quality, continuity, accessibility, safeguarding, autonomy, and mechanisms for complaint and redress. Personal assistance and respite should expand the recipient's participation and choice rather than substitute one form of dependency for another (Committee on the Rights of Persons with Disabilities, 2017; EU-LAC Foundation et al., 2023).

There are also distinctive service innovations in addition to this template:

- **Bogotá:** The June 2025 ABC del Sistema Distrital de Cuidado (official overview of the District Care System) describes four formal models: Manzanas del Cuidado (Care Blocks), Buses del Cuidado (Care Buses), Asistencia Personal (Personal Assistance), and Unidades Operativas (Operational Units), complemented by itinerant and community-care strategies (Secretaría Distrital de la Mujer & Sistema Distrital de Cuidado, 2025). The personal assistance model provides time-limited support at home to reduce the burden on households with high care needs while promoting care recipients' autonomy and participation. Care buses serve rural and underserved urban areas. In March 2026, the district announced plans to include 30 additional community organizations in five localities in the community-care strategy by the end of 2026 (Secretaría Distrital de la Mujer, 2026).
- **Manizales:** The relevos (caregiver relief) program provides temporary in-home support by nursing assistants, alongside other services including access to washing machines (Alcaldía de Manizales, 2026b).
- **Valle del Cauca:** Overnight childcare services (Arrullo, from 5 p.m. to 7 a.m.) support caregivers working or studying outside standard daytime hours. The department also offers an integrated 24-hour care center in Cartago (Gobernación del Valle del Cauca, 2025a).
- **Antioquia:** Rural Granjas del Cuidado (Care Farms) combine food production, solidarity-economy activities, and support for caregivers. This review did not identify a directly comparable rural care model among the other cases.
- **Bucaramanga:** The system combines locally organized care services with the Bono del Cuidador (Caregiver Benefit), which provides in-kind food or supplies to eligible caregivers.
- **Cumbal:** The initiative prioritizes strengthening existing, predominantly Indigenous community care networks rather than creating new state-run service facilities. This approach emphasizes recognizing and supporting community arrangements already in place.
- **La Ceja:** The Polígono del Cuidado (Care Polygon) concentrates care-related facilities and services within walking distance, adapting Bogotá's proximity-planning approach to a smaller municipality.

Tangible services generate user constituencies, particularly when they meet the needs of community members. Limited hours, services that do not redistribute care or reduce care hours, or trainings and workshops that do not generate visible benefits generally do not create the public demand or the political will to maintain or expand care systems. Conversely, systems that provide services that address contextualized community leads are more likely to generate support for their resilience.

INDICATORS AND EVIDENCE

In times of reducing social budgets, increased scrutiny of public programs, and increasing rhetoric around "government efficiency," evidence is needed to defend existing initiatives and argue for which to maintain, expand, or cut. As such, indicator selection and measurement capabilities become related to durability, and it's important to know what each system is capable of counting. In this cohort, with the partial exception of Bogotá, the systems present generally weak measurement capacity, and the available indicators mostly focus on outputs instead of on outcomes.

Bogotá is the most advanced in the group in terms of its measurement architecture. Its reports distinguish atenciones (individual service contacts) from personas únicas atendidas (distinct people who received one or more services during the reporting period). A single system user may, therefore, generate multiple atenciones. Bogotá's system recognizes different user groups, including unpaid caregivers, people who require care or support, and other household or family members who access services. Bogotá also uses an original index (Índice de Priorización de Manzanas, 2020) for territorial prioritization and a care needs index (Índice de Condiciones y Necesidades de Cuidado) with gender and differential criteria; POT-defined siting criteria (care demand, poverty, caregiver density, and participatory budgeting); systematic attendance counting by model of operation; and quarterly reporting (through an intersectoral commission). It also publishes outputs such as baccalaureate completions, SENA (Servicio Nacional de Aprendizaje, or National Learning Service) certifications obtained, and caregiver skill certifications.

Bogotá is also the only system where an independent evaluation was identified; however, the findings were mixed. Participation in system services had a positive effect on the recognition of care work and gender roles. Caregivers also reported a perceived redistribution of some care responsibilities and greater possibilities to resume personal projects. However, the evaluation did not identify substantial overall effects on the reduction or redistribution of unpaid care work. Although the evaluation found an increase in the view that men should participate in domestic and care activities, this change was not statistically significant. The findings, therefore, suggest that the system had achieved more visible progress in recognizing care and providing services and opportunities to caregivers than in changing the total volume of unpaid care or its distribution within households (Unión Temporal Economía Urbana & Fedesarrollo, 2024).

Smaller academic and implementation studies broadly reinforce this interpretation. A difference-in-differences study focused on the Engativá Manzana del Cuidado (Care Block), based on a sample of 50 participants and time-use questions collected in 2019 and 2022, did not find a statistically significant reduction in care hours (Téllez Garzón & Murcia Valderrama, 2022). Qualitative research, including Proyecto Digna, has nevertheless documented benefits related to caregivers' recognition of their work, psychological well-being, peer networks, and access to information and educational opportunities (Ramírez Bustamante & Camelo Urrego, 2023).

Taken together, the evidence indicates substantial reach and promising gains in recognition, well-being, and access to services, but still-limited evidence that the system has produced sustained reductions in unpaid care time or measurable household-level redistribution (Unión Temporal Economía Urbana & Fedesarrollo, 2024; Ramírez Bustamante & Camelo Urrego, 2023; Téllez Garzón & Murcia Valderrama, 2022). Bogotá's Guangzhou International Award (2023), multiple international delegation visits (26 reported in 2024), and replication interest from national and international cities attest to the popularity of the model's logic and the municipality's advocacy efforts (Alcaldía Mayor de Bogotá, 2025). However, evaluations are needed that specifically look at the outcomes of the different care system designs and implementations. Cali's Development Plan, or Plan de Desarrollo Distrital, includes output indicators such as women enrolled and the number of care ecosystems implemented.

Medellín reports care-system outputs through municipal management and gender-equality reporting. City communications have also cited changes in the wage and unemployment gaps, but those city-wide movements cover broader labor-market periods and policies, and they cannot be attributed to the care system without an evaluation design. They are, therefore, excluded from this report's results comparison.

For Boyacá, published administrative totals combine different categories of activities, including material assistance and attendance at services. Such aggregates cannot establish the number of unique users or the intensity of care received without clearer reporting definitions (Gobernación de Boyacá, 2024a, 2024b, 2026).

Table 4: Types of indicators for care systems

Level	Question answered	Examples	Current availability
Inputs	What resources were committed?	Budget, staff, facilities, cooperation contributions	Fragmented
Outputs	What was delivered?	Unique users, service contacts, hours of respite provided, workshops, certifications	Most commonly reported
Outcomes	What changed for users?	Unpaid care hours, well-being indicators, employment or income, care redistribution	Rarely reported
Impact	What change can be attributed to the system?	Causal effect compared with a counterfactual	Not identified in the cohort

Table 5: Minimum cooperative framework based on the care diamond, the 5 Rs, and a rights-based approach to care system monitoring

Analytical lens	Core question	Illustrative outputs	Priority outcomes
Care diamond and multilevel governance	Which actor provides, finances, regulates, and bears the risks of care?	Budget source, services by provider, intergovernmental agreements, coverage by territory	Equitable territorial financing, reduced household and community cost-shifting
Recognize	Are unpaid and community care visible in policy, data, and public narratives?	Caregiver registration, time-use data, skills certification	Greater social recognition and policy visibility without reinforcing perceptions of women as natural caregivers
Reduce	What changed for users?	Hours of substitute care, laundry, transportation, childcare, and personal assistance	Reduced unpaid care hours, time poverty, stress, and unmet care needs
Redistribute	Does responsibility for care shift between women and men, and among the state, market, community, and household?	Men's participation in unpaid care and domestic work, public service slots, employer measures, household distributions	Increased men's care time, increased public provision of care services, more equitable household division
Reward	Are paid and community care workers employed under decent conditions?	Contracts, wages, training, social-security enrollment, occupational safety	mproved earnings, formality, retention, safety, and career progression
Represent	Do caregivers, care workers, and recipients influence decisions?	Seats in government bodies, consultations, complaints resolved, worker organizations involved	Meaningful influence over budgets, standards, services, and accountability
Rights-based approach	Are care recipients' autonomy, safety, accessibility, and choice protected?	Quality standards, accessibility audits, support plans, safeguarding protocols	Improved autonomy, participation, continuity, satisfaction, and safety

Across the case studies, no systems use a shared indicator framework. There is no common definition of a "beneficiary," no shared time-use outcome, and no standardized service taxonomy. While this limits evaluation and cross-case comparisons, it also means that care systems risk being perceived as collections of disconnected programs rather than an actual system that integrates components of a coherent public policy. A shared idea of how a core care system should function and what "success" looks like helps governments to coordinate actions and investments. However, it is also important to establish realistic expectations related to what can be measured about care systems and in what time period.

In September 2026, Universidad del Rosario and Consejo Privado de Competitividad launched the 2026 *Medición Subregional de Brechas de Género* (*Subregional Gender Gaps Measurement*). The measurement applies a common framework across all 32 departments and Bogotá, including a dedicated care-infrastructure pillar with indicators related to public care infrastructure, access to care technologies, and time dedicated to domestic work (Universidad del Rosario & Consejo Privado de Competitividad, 2026). However, it does not substitute care-system monitoring because it measures broader territorial gender gaps instead of the performance or effects of particular care systems. It nevertheless demonstrates the feasibility of comparable territorial measurement and could provide contextual indicators alongside a future common SNC monitoring framework.

Without such system-level measures, care systems risk being perceived as collections of disconnected programs rather than components of a coherent public policy. A shared idea of how a core care system should function, and what "success" looks like, helps governments coordinate actions and investments, while territorial indicators can help interpret why needs and results differ across places.

03

LESSONS LEARNED

Territorial care initiatives have spread through exchanges among local governments, technical assistance, and partnerships. Cúcuta's team credits a visit to Cali's CuidArte initiative; Cúcuta and Popayán received technical assistance on adapting care services to local contexts from Fundación Saldarriaga Concha; and UN Women's Entornos que Cuidan program, supported by Canada, has worked with Cumbal and municipalities in Cauca. Colombia Líder and Fundación Saldarriaga Concha have also introduced an award category for local care systems (Fundación Saldarriaga Concha, 2025; UN Women Colombia, 2026). These developments suggest that establishing a local care system has gained public visibility and political appeal, although that visibility does not itself establish long-term sustainability.

Legal anchoring and funded operating capacity are needed for system survival. Bogotá's transition-proofing via legally binding agreement worked, and La Ceja copied this method. Medellín and Bucaramanga illustrate the exposure of development plan-only systems. For advocacy under the current national government: the agreement/ decree layer is where care infrastructure can be defended regardless of national policy direction. However, agreements, ordinances, and decrees do not necessarily guarantee a budget, permanent staff, daily services, or quality. Institutional resilience requires legal duty and a funded operating model.

The national level matters financially and technically, and retrenchment is a live risk. MinIgualdad co-financed Bucaramanga, backed Popayán's decree, and partnered in Cauca and Cumbal. With the ministry closed and SNC functions in limbo, the co-financing and technical assistance needed—particularly by the smaller municipalities that lack Bogotá's fiscal muscle—is the most exposed part of the ecosystem. The territorial systems' momentum partially protects the care agenda against national retrenchment, but unevenly, favoring richer capital cities.

Urban service hubs and distributed rural delivery require distinct operating strategies. Cities often concentrate services in recognizable sites such as Care Blocks, Care Circles, and integrated care centers. Rural and departmental systems may rely more heavily on itinerant routes, existing facilities, productive-care spaces, and coordination across municipalities. Departmental approaches in this review were less thoroughly documented and evaluated than the Bogotá-style urban hub model; more comparative research is needed on the characteristics of these different models and their effectiveness.

Simultaneous services are required instead of caregiver-only activities. The care systems need to redistribute care in order to avoid adding more activities to already overburdened caregivers. Training, self-care, or entrepreneurship can be valuable, but their effect is constrained when caregivers must bring dependents without adequate support, arrange replacement care, or add activities to already overburdened schedules.

Community care is a distinctive national contribution that needs stronger territorial implementation and evaluation. The SNC explicitly recognized and sought to strengthen community care organizations. The ILO/MinIgualdad mapping of territorial community care experiences found high decent-work deficits among community caregivers and recommended integrating these caregivers into the SNC with state financing and social-solidarity-economy models. Among the 14 systems, Cumbal (Indigenous networks) and Bogotá's incipient community care strategy documented their community care approach. Yet community provision can conceal unpaid labor, weak contracts, and cost transfer from the state to women-led organizations. The Colombian mapping of community-care experiences similarly identifies decent-work and sustainability challenges (ILO & MinIgualdad, 2025). Public-popular partnerships should be maintained and strengthened to include transparent financing, worker protections, representation, quality standards, and community control over design.

Political champions accelerate systems but can also put them at risk during transitions. Gestoras sociales[2] and visible political leaders have helped launch several initiatives (in Cúcuta, Popayán, Boyacá, Manizales, Valle, Antioquia, and Bucaramanga). Their leadership can accelerate a system's launch and secure visibility, but may weaken bureaucratic ownership and increase transition risk. Long-term continuity is stronger when leadership, budgets, data, participation, and accountability are lodged in statutory public entities.

Cooperation dependence needs an exit plan. Every externally supported pilot should identify which territorial entity will assume staff, operating costs, data, and quality assurance, and by what date. The disruption of international assistance in 2025 underscores this risk.

Family well-being can be a pragmatic entry point, but it must not re-familialize care. Care systems can be framed pragmatically around family well-being, disability support, childhood, older age, employment, and local economic development. To avoid reinforcing women's unpaid responsibility, these entry points must retain public provision, co-responsibility, autonomy, diverse family recognition, decent work, and measurable redistribution. If there is a shift toward subsidies as the primary framing, this repositions the state's role from coordinating and redistributing care toward compensating it, as well as pushes responsibility from the state to families. Additionally, if care systems are issues that are led by and primarily framed as initiatives of first and second ladies, it may reinforce stereotypes of care as a "women's issue" instead of as a co-responsibility of all people and society.

Redistribution is essential for transformative care systems. Colombia's care diamond, like many others in the region, had long been organized with mostly families, followed by communities, absorbing what the state and market did not provide. The SNC chose to invest in the community corner, strengthening organizations and building public-popular alliances to formalize the state's relationship with them. The subnational cases alter this diamond in different ways.

2 Gestoras sociales ("social managers," also translated as "first ladies") is widely used in Colombia to refer to the wife of a mayor or governor in terms of her role in community development.

Public infrastructure and personal assistance expand the state corner; private and philanthropic partnerships introduce market or nonprofit provision; community-care strategies strengthen collective organization; and subsidies may support households without changing who performs care. None of these shifts are automatically redistributive. The key questions are whether women's unpaid hours fall, men's participation rises, public provision and regulation expand, community labor is fairly financed, and care recipients gain autonomy and quality. This is why the care diamond should be paired with the 5Rs (recognition, reduction, redistribution, reward, and representation) rather than used only to catalog providers (Razavi, 2007, p. 21; ILO, 2018, p. 18).

Visible and useful services can create constituencies that strengthen the political resilience of care systems. When residents perceive care systems as delivering tangible benefits, they can be mobilized to defend those systems. Services that respond to widely shared needs, such as childcare, elder care, disability support, and caregiver respite, can create relationships between governments and communities. As beneficiaries, caregivers, community organizations, and local institutions experience these benefits, they can become important constituencies advocating for continuing and expanding care policies. While constituency-building alone cannot substitute for legal guarantees or sustainable financing, broad public support can increase the political costs of dismantling or underfunding care systems during changes in government.

Measurement is the collective weakness. A minimal common indicator set using output indicators (e.g., caregivers enrolled with unique IDs, hours of simultaneous services delivered, caregiver time reallocation, education/certification completions, caregiver labor-market transitions) would convert Colombia's 14-system diffusion into an actual comparative evidence base. Systems need household-level and institutional redistribution indicators, not only sensitization counts. Measures should include changes in women's and men's unpaid-care time, hours of public or substitute provision, use of released time, employer and market contributions, public expenditure, and the financing and labor conditions of community organizations.

This system-level framework could be complemented by broader territorial indicators, such as those now available through the Medición Subregional de Brechas de Género (Subregional Gender Gaps Measurement; Universidad del Rosario & Consejo Privado de Competitividad, 2026). The distinction is important: Common SNC indicators should measure what care systems provide and whether they contribute to recognition, reduction, redistribution, reward, and representation, while territorial gender-gap measures can help identify the different contexts and needs to which those systems must respond. A national evidence architecture does not imply standardized territorial implementation.

A practical next step for the national entity responsible for coordinating the SNC, potentially supported by UN Women or the Economic Commission for Latin America and the Caribbean, would be a minimum common framework of output and outcome indicators.

Shared definitions, reporting periods, disaggregation requirements, and data-collection guidance would enable comparison without imposing identical delivery models on different territories. Indicators should cover services provided and people reached, but also unpaid care time, redistribution of responsibilities, quality, care workers' conditions, and the well-being and autonomy of caregivers and people receiving care.

CONCLUSION

Colombia's subnational care agenda has been growing since the simultaneous establishment of a National Care System (SNC) that encouraged territorialized care strategies, increasingly recognized community care, and pushed for new forms of public-popular alliances. The 14 cases discussed in this paper were officially recognized as subnational care systems integrated into the SNC. They show that care can be organized through proximity infrastructure, mobile routes, home-based support, night services, rural productive models, and community and Indigenous networks. This diversity is a strength because care needs and institutional capacities differ sharply across territories.

The comparison also shows that diffusion has outpaced consolidation. Legal instruments, political visibility, and activity counts are more common than recurrent system budgets, service guarantees, decent-work standards, common data, and evidence of reduced or redistributed unpaid care. Bogotá offers the most developed operational and evaluative architecture, but even its evidence indicates stronger progress in recognition and access than in sustained time reduction and household redistribution.

The subnational advancements should be maintained and strengthened, but a system links rights, governance, services, regulation, training, information, cultural change, participation, and sustainable financing.

The next phase of Colombia's territorial care agenda should, therefore, accompany the expansion of the care system with consolidated financing, coordinated national and subnational government responsibilities, service guarantees, workforce conditions, territorial accessibility, participatory governance, and measurable contribution to redistribution.

Territorial care systems also need a dual strategy: institutionalize a non-negotiable rights and gender-equality floor while communicating care through multiple publicly salient outcomes, including family well-being, disability rights, childhood development, dignified aging, women's economic participation, local employment, community resilience, and efficient public services. The strategy needs to be able to dialogue with the local realities, using language and providing services that meet local demands to build a wide constituency of supporters.

Finally, a transformative territorial system shifts care away from women's unpaid availability, expands and regulates public provision, finances community contributions fairly, improves paid care work, represents affected groups, and protects the autonomy and well-being of people receiving care. National transition increases the urgency of building that institutional, fiscal, and evidentiary foundation.

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ANNEX 1: COMPARISON TABLE

Official program and institutional names are retained in Spanish, with brief English explanations where useful. Spanish administrative terms are translated rather than treated as equivalent legal instruments. Municipal figures reflect the reporting dates and administrative definitions of their sources, not independently audited or directly comparable service outcomes. Acronyms are expanded in the table or the report's List of Abbreviations.

Territory	System/flagship model	Legal-institutional status	Lead entity	Territorial infrastructure	Reported scale (date/ source as available)
Antioquia (department)	Sistema del Cuidado de Antioquia: training initiatives, Granjas del Cuidado (Care Farms), simultaneous services for care recipients (oferta espejo), care centers, and the Paternidades Cuidadoras (Caring Fatherhood) initiative	Departmental coordination led by the Secretariat for Women and the governor's social-management office; departmental, subregional, and municipal arrangements; no departmental system-wide ordinance verified	Secretaría de las Mujeres (Secretariat for Women), with the governor's social-management office	98 Granjas del Cuidado (rural production and care spaces); presence in 76 municipalities; 31 Casas de la Mujer (Women's Centers) equipped; seven farms upgraded in PDET/ ZOMAC municipalities	Approximately 847–1,000 women involved in the farms (some 3,000 household members indirectly); 2,500–3,000+ women in training; 1,100 participants in family-care programming (22 municipalities); 352 men in Paternidades Cuidadoras. Figures refer to different activities and periods.
Bogotá (district)	Sistema Distrital de Cuidado (SIDICU): Manzanas del Cuidado (Care Blocks), Buses del Cuidado (Care Buses), Asistencia Personal (Personal Assistance), Unidades Operativas (Operating Units), and itinerant and community-care strategies	**District Council Agreement 893 of 2023, regulated by District Decree 415 of 2023; care infrastructure included in the Territorial Land-Use Plan (POT, art. 231); intersectoral commission involving 20 district entities**	Secretaría Distrital de la Mujer (District Secretariat for Women), coordinating 13 sectors	27–28 Care Blocks reported during 2026; two care buses serving urban and rural areas; target of 31 Care Blocks by 2028	842,278 people and over 5.9 million service contacts cumulatively through January 2025; more than 297,000 people served during 2025. Counts cover different reporting periods (Alcaldía Mayor de Bogotá, 2025; Secretaría Distrital de la Mujer, 2026).
Boyacá (department)	Sistema Departamental de Cuidado / Red Abrigo: Casas Abrigo (care centers) and Rutas Provinciales del Cuidado (provincial care routes)	**Departmental Ordinance 025 of 2023 provides a policy framework; Decree 1134 of 2024 establishes the care-system intersectoral commission; technical support from Fundación Saldarriaga Concha**	Secretaría de Integración Social (Social Integration Secretariat) and governor's social-management office	First Casa Abrigo in Tunja; traveling care routes across rural communities (veredas); proposed coverage across 15 provinces	The government reported more than 18,000 contacts or people reached across 50+ municipalities during the first six months of 2024, using an aggregate that includes activities and material support; this is not a verified count of unique care-system users.

Territory	System/flagship model	Legal-institutional status	Lead entity	Territorial infrastructure	Reported scale (date/ source as available)
Bucaramanga (municipality)	Sistema Municipal del Cuidado / Asegurarte, organized through Circuitos del Cuidado (care-service circuits; Alcaldía de Bucaramanga, 2026a)	Municipal Development Plan 2024–2027 commitment; a proposed municipal council agreement to expand care-service circuits was announced, but its approval was not verified	Secretaría de Desarrollo Social (Social Development Secretariat), with the former MinIgualdad and the United Nations Development Programme (UNDP)	Circuito Norte (northern care circuit) operating through six service locations; eastern circuit announced	More than 400 women caregivers associated with the northern circuit; around 200 certifications through care schools; separate in-kind caregiver support for families of people with disabilities (Alcaldía de Bucaramanga, 2026b).
Cali (district)	Sistema Distrital de Cuidado, including CuidArte centers and Ecosistemas del Cuidado (care ecosystems)	**Decree 0304 of 2023 established the district care committee (not necessarily the full system); District Development Plan 2024–2027 incorporates care programming**	Secretaría de Bienestar Social (Social Welfare Secretariat) / Subsecretaría de Equidad de Género (Gender Equity Office)	Six CuidArte service locations reported in October 2025, in three urban neighborhoods (comunas 15, 20, 21) and three rural districts; target of 12 locations by 2027	5,870 caregivers reportedly enrolled by October 2025; 7,840 women is a development-plan target, not an observed outcome.
Cúcuta (municipality)	Sistema Municipal del Cuidado, with Centros CuidArte (CuidArte care centers)	**Municipal Decree 0081 of 2025 created the system and its intersectoral commission; linked to Law 2297 of 2023**	Secretaría de Equidad, Género y Mujer (Gender Equity and Women's Secretariat) and Secretaría de Bienestar Social (Social Welfare Secretariat)	Three care centers reported: La Libertad, Scalabrini, and Niña Ceci	Local background figures suggest that most unpaid caregivers are women; no verified consolidated count of unique care-system users was identified.
Cumbal (municipality)	Sistema Local de Cuidados: Cumbal, territorio que cuida 2025–2035 (Cumbal, a caring territory)	Ten-year programmatic framework developed with UN Women and the Government of Canada through Entornos que Cuidan; a public municipal instrument formally adopting the system was not located	Municipal government, Indigenous governing authorities (resguardos), Asociación Minganvis and INESUR	Community care networks across four Indigenous collective territories (resguardos): Chiles, Mayasquer, Cumbal, and Panan; support to five community care organizations	Caregiver skills certification and support to existing community organizations; small-scale initiative without a consolidated, independently verified beneficiary count.
La Ceja (municipality)	Sistema Municipal del Cuidado, including Polígono del Cuidado (Care Polygon), Centro del Cuidado (Care Center), and Canasta de Servicios (service package)	**Municipal Council Agreement 08 of 2024 established the care system as a municipal policy; Municipal Development Plan 2024–2027 links related services to local priorities**	Secretaría de Educación (Education Secretariat), coordinating across municipal departments	Polígono del Cuidado integrates care-relevant facilities within a walkable area, including a care center, older-adult center, hospital, laundry and community kitchen (Alcaldía de La Ceja del Tambo, 2026)	The municipality reported 95 in-person workshops reaching 253 people through its Canasta de Servicios by June 3, 2026 (Alcaldía de La Ceja del Tambo, 2026). Separately, approximately COP 335 billion of a COP 505 billion four-year municipal budget was classified as care-related; this is budget tagging, not a dedicated care-system appropriation.
Manizales (municipality)	Sistema Municipal del Cuidado: Club del Cuidado – Tiempo para Mí (Care Club – Time for Me), caregiver-relief services (relevos), washing machines, and Cuidando al Cuidador (Supporting Caregivers)	Municipal programming led by the Secretariat for Women and Gender Equity	Secretaría de las Mujeres y Equidad de Género (Secretariat for Women and Gender Equity)	Care clubs operating in northern and central urban areas, plus itinerant activity in urban and rural communities	Target of 700 caregivers for Tiempo para Mí; six training modules of approximately 100 spaces each; caregiver-relief service provides temporary in-home substitution (Alcaldía de Manizales, 2026a, 2026b). Figures are targets, not verified completed services.

Territory	System/flagship model	Legal-institutional status	Lead entity	Territorial infrastructure	Reported scale (date/ source as available)
Medellín (district)	Sistema de Cuidado de Medellín, including Círculos del Cuidado (Care Circles)	District Development Plan "Medellín Te Quiere" includes the care system; Council Agreement 027 of 2015 establishes an earlier family-caregiver policy; a system-wide district council agreement was not verified	Secretaría de las Mujeres (Secretariat for Women)	Twelve Care Circles reported operating in early 2026; goal of one in each urban and rural administrative district	Approximately 6,868–8,000+ women caregivers reported as served, plus 11,357 participants in awareness activities; four-year target of 30,000 women. Figures use different reporting units.
Pereira (municipality)	Sistema Municipal del Cuidado, with a pilot Centro Municipal del Cuidado (Municipal Care Center; Alcaldía de Pereira, 2025)	Municipal initiative under the Social and Political Development Secretariat, with international accompaniment from AARP	Secretaría de Desarrollo Social y Político (Social and Political Development Secretariat)	Pilot care center offering simultaneous activities for caregivers and in-home support for people receiving care	Approximately 300 caregivers reportedly certified during 2026; about 100 training spaces per cohort; no independently verified count of unique service users.
Popayán (municipality)	Sistema Municipal del Cuidado (Municipal Care System)	**Municipal Decree 265 of 2025 established the system; technical contributions from UN Women, former MinIgualdad, and Fundación Saldarriaga Concha**	Municipal Government, Women's Office and Health Secretariat; supported by the social-management office	Registration system and services delivered through existing municipal programs and university partnerships	157 caregivers certified through the National Learning Service (SENA) at launch; disability certification activity is reported separately and should not be mistaken for care-system coverage (Alcaldía de Popayán, 2025b).
Valle del Cauca (department)	Sistema Departamental de Cuidado, including El Valle Cuida de Ti (The Valley Cares for You), Arrullo overnight childcare, and integrated care centers	Departmental gender-equality policy framework; system development includes a care-needs assessment and mapping of existing facilities (Gobernación del Valle del Cauca, 2025b, 2026)	Secretaría de Mujer, Equidad de Género y Diversidad Sexual (Secretariat for Women, Gender Equity and Sexual Diversity), with governor's social-management office	Arrullo overnight childcare in Yumbo and an integrated center operating day and night in Cartago	The municipality reports capacity for 25 caregivers, 25 people with disabilities and 35 children at the Cartago site; approximately 45 children served through the Yumbo night-care program. Figures reflect service capacity and local reporting, not consolidated system coverage.
Villavicencio (municipality)	Sistema Municipal de Cuidados y Apoyos (Municipal Care and Support System), including the Ciudad Porfía Manzana del Cuidado (Care Block)	**Municipal Council Agreement 688 of October 2025; an intersectoral commission established in 2025; technical cooperation with UN Women and Canada (Alcaldía de Villavicencio, 2025; UN Women Colombia, 2025)**	Secretaría de la Mujer (Women's Secretariat) and Secretaría de Gestión Social, Participación e Inclusión (Social Management, Participation and Inclusion Secretariat)	Initial care services in Ciudad Porfía and the Rubí pilot, with a particular focus on disability-related support	Pilot- and workshop-scale activities; no consolidated count of unique care-system users identified.

ANNEX 2: ANALYTICAL FRAMEWORK

This document considers subnational approaches in light of Razavi's care diamond, which envisions care provision in four interconnected spheres: households and families, the state, markets, and communities or nonprofit organizations (Razavi, 2007). This paper looks at where services exist and whether a territorial initiative changes where the costs, labor, risks, and responsibilities of care are located. State support can redistribute care away from households, but poorly designed subsidies or community partnerships can also compensate women for care without reducing their workload, or they can transfer public responsibilities to under-resourced organizations.

The second analytical lens is the ILO's 5R Framework, which establishes that transformative policy should recognize, reduce, and redistribute unpaid care work; reward paid care work through decent wages, contracts, and social protection; and represent care workers and caregivers through political empowerment and social dialogue (ILO, 2018). Applying all five Rs prevents the analysis from treating caregiver training, self-care activities, or entrepreneurship as sufficient evidence of redistribution. It also directs attention to the working conditions of the people who provide substitute, home-based, institutional, and community care.

A third lens concerns scale and decentralization because local governments can innovate and demonstrate new models, but national governments remain decisive for rights, regulation, fiscal capacity, labor standards, data systems, and territorial equalization (Mahon, 2024). The Colombian cases are, therefore, assessed as part of an intergovernmental architecture, not as self-contained municipal projects. This is particularly important because poorer, rural, and conflict-affected territories often face greater care deficits while having weaker own-source revenues and administrative capacity. This need for territorial differentiation is reinforced by Colombia's 2026 *Medición Subregional de Brechas de Género (Subregional Gender Gaps Measurement)*, which found that territories with similar aggregate gender-gap scores can have markedly different underlying configurations of inequality. This reinforces the case for a common national care architecture that allows for implementation to respond to different territorial conditions (Universidad del Rosario & Consejo Privado de Competitividad, 2026).

Finally, a people-centered system must protect the rights and autonomy of those receiving care as well as those providing it. For people with disabilities, support should be available, accessible, affordable, adaptable, and chosen by the person, including in rural areas. Personal assistance should enable independent living and participation rather than reinforce dependency or substitute family control (Committee on the Rights of Persons with Disabilities, 2017). Accordingly, this report treats caregiver relief, service quality, safeguarding, and the autonomy of care recipients as connected but distinct dimensions.