TEJIENDO CAMINOS

Update of the Rapid Gender and Disability Analysis in Border Areas (RGDA) - Tejiendo Caminos 2025

This document aims to **identify the primary needs related to primary care in Protection (GBV*), Health (SRH*), and humanitarian service provision in border areas, with a gender and disability focus.**

These needs have been identified through official information, as well as primary and secondary sources. Additionally, it includes a characterization of the needs of focus groups, which involved the participation of community leaders (men and women) from border areas where the *Tejiendo Caminos* Consortium operates, with particular attention to migrant and refugee populations.

The data collected and analyzed in the previous Rapid Gender and Disability Analysis (ARGD), conducted in 2024, will be updated to better understand changes in needs, contexts, and migration flows in the border areas where the *Tejiendo Caminos* Consortium operates and provides humanitarian services to migrant and refugee populations in Ipiales (Nariño), Cúcuta (Norte de Santander), and Maicao (La Guajira).
View document here.

The information contained herein has been gathered through various sources, including reports from humanitarian organizations, data analysis, and interviews conducted by CARE Colombia and HI (Humanity & Inclusion) with affected populations and key stakeholders.

Methodology:
20 surveys

5 focus groups
in border municipalities covered by the project

47 women

6 men

9 persons with disabilities
in leadership roles, of both Colombian and Venezuelan nationality, and from diverse ethnic-racial backgrounds

This provides an approximation of the realities faced by migrants, refugees, and vulnerable populations in the migration context, highlighting barriers to accessing rights, discrimination, and vulnerability vis-à-vis the state and society. Furthermore, **we analyze this information to deliver a relevant humanitarian response aligned with identified needs, based on our organizational and humanitarian capacities and principles.**

The ARGD is a tool that enables a more detailed understanding of the realities and needs of populations in humanitarian crises, particularly girls,
women, and persons with disabilities, as it allows us to encompass the full spectrum of challenges they and their communities face.

The mass migration of Venezuelan migrants and refugees to Colombia represents one of the most significant migration phenomena in Latin America in recent decades. This migration has been driven primarily by Venezuela's economic crisis and political and social instability, which have led to food and medicine shortages, hyperinflation, insecurity, and a widespread collapse of basic services.

Nicolás Maduro's re-election has influenced the profiles of those arriving from Venezuela. No longer just migrants and refugees seeking new opportunities, safety, and livelihoods, CARE and HI under the *Tejiendo Caminos* Consortium have identified that many beneficiaries are now political refugees opposed to Maduro's government, fleeing political persecution and denial of essential services (employment, education, and healthcare) due to their political stance. **In this context, Colombia has become the primary host country.**

Hosts approximately:

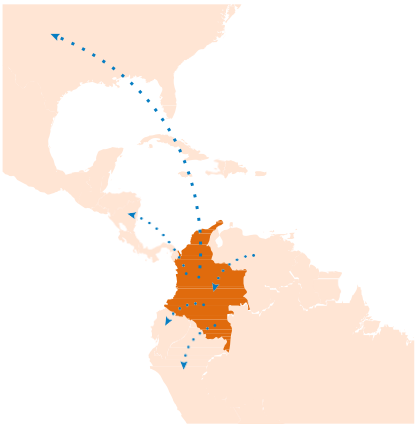
Projected to rise to

2.9 million

by 2026

(GIFMM, 2025).

Additionally, Colombia has become a **strategic transit and pendulum-flow** country for those seeking to reach other destinations in South America, Central America, and North America—particularly the U.S. and Canada.



Due to its geographic location, it receives not only Venezuelans but also migrants of other nationalities, as reported by the Ombudsman's Office.

Reported between January 1 and February 28, 2025:

there were

30,738 irregular migrants transiting through the country.

Primary countries of origin:

Venezuela	**28,164**
Ecuador	**535**
Bangladesh	**161**
Peru	**133**
Angola	**99**
Haiti	**62**
China	**37**

Various humanitarian organizations have played a critical role in addressing migrants' needs through programs and projects aimed at ensuring their wellbeing.

However, **Colombia's situation has also been exacerbated by the intensification of its internal armed conflict, leading to a progressive deterioration of the humanitarian situation.** Moreover, shifts in government priorities have resulted in the deprioritization and reduced visibility of the migration crisis, leaving thousands without adequate humanitarian assistance in the most affected areas.

* Gender-Based Violence
* Sexual and Reproductive Health

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Compounding this context, several NGOs have been impacted and forced to suspend their humanitarian services due to the U.S. Government's global **Stop Work Orders**—a situation that further restricts migrants' and refugees' access to services worldwide, particularly in Colombia where dual-impact scenarios[1] emerge. To grasp the scale of service disruptions:

The U.S. contributed

of Colombia's international humanitarian aid in 2024

Dropping to just

in 2025 (a **43-percentage-point reduction**)

With funding suspensions,

9. million people will need assistance in **2025**

Yet only **2 million** can be prioritized due to budget constraints (ACAPS, 2025)

Most affected sectors:

- Migration
- Armed conflict
- Response capacity
- Institutional strengthening

Resulting in a

78% gap in service coverage

This coincides with a planned reorganization of humanitarian architecture to merge functions and offices, which will weaken preparedness, coordination, and territorial monitoring of Colombia's crisis.

Additionally, **the migration context has been exacerbated by the armed conflict emergency in Catatumbo**, Norte de Santander, affecting both migrant populations (over **4,667 migrants reported as conflict victims due to forced displacement in Catatumbo**) and **91,483** total victims of displacement, confinement, threats, and other violations (GIFMM, 2025)[2].

Cúcuta has become the epicenter of what may be Catatumbo's worst crisis in 30 years.

During this crisis, the city has received approximately:

26,3
displaced persons (2025)

Overwhelming essential services for victims.

This overwhelmed and collapsed essential service provision for victims, straining both institutional and humanitarian organizations' capacities, not only due to the crisis scale but also massive budget cuts from international cooperation following **Stop Work Orders**. The conflict escalation has intensified humanitarian needs for populations facing overlapping vulnerabilities in Colombia.

Key findings from the **2024** ARGD on persistent territorial barriers:

1 Acute humanitarian needs:

- Over 80% of migrants have unmet needs (food, health, water), disproportionately affecting girls, women, and persons with disabilities.
- Transit populations—especially girls, women, and persons with disabilities—are most vulnerable, followed by migrants seeking permanency. Women bear disproportionate impacts from armed conflict, forced displacement, and migration.
- A triple crisis of armed conflict, migration, and natural disasters makes these phenomena inseparable.

2 Discrimination and

- Migrants face xenophobia, service access barriers, and social exclusion.
- Discrimination intensifies for intersecting identities: women, SOGIE persons (sexual orientation and gender identity/expression diversity), and persons with disabilities.

3 Precarious labor

- High informality and labor exploitation.
- Migrant women work longer hours than Colombian women (42.5 hrs/week) yet earn less and face higher GBV risks.
- Many engage in subsistence activities under inadequate or illegal conditions.

4 Barriers to rights access:

- Challenges obtaining documentation, healthcare, or recognition as conflict victims.
- Lack of mental health and SRH services is critical for migrant women.

5 Lack of support

- Migrants have weaker family/community networks, worsening emergency responses.
- Rural populations—especially in dispersed areas—face higher vulnerability due to minimal state presence and high NSAGs[3] activity.

6 Underreporting and data gaps:

- There is no disaggregated data that allow us to know how many people with disabilities are also migrants due to the barriers faced by the population to report, effectively activate the care routes and obtain documents.
- Official registries underestimate actual migrant and victim numbers.

7 Mobility restrictions:

- Imposed by armed groups and geographic conditions. Migrants in transit face heightened route risks.

[1] Double vulnerability: In humanitarian crises, when individuals/families/communities experience two simultaneous or consecutive grave vulnerabilities, escalating their risk, threats, and vulnerability.
[2] See CARE Catatumbo Bulletin, 2025.
[3] Non-State Armed Group.

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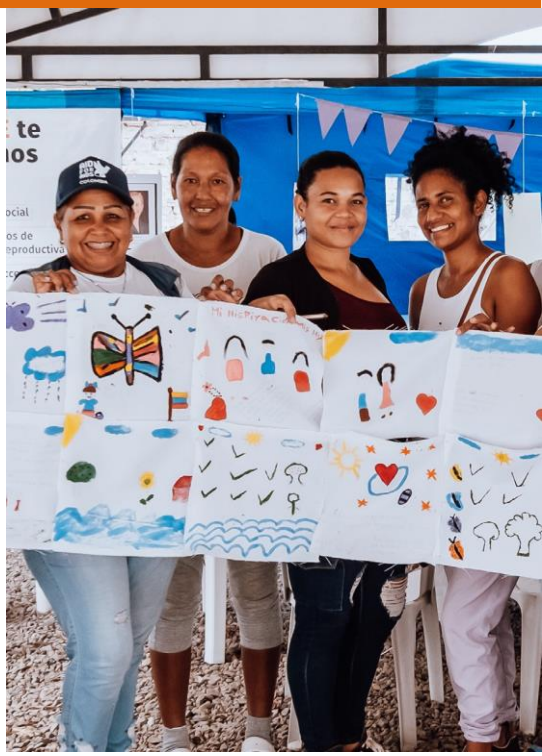
Findings on Needs in 2025:

1. Gender Roles



A **deep structural inequality disproportionately affecting girls and women** has been revealed. They bear the primary responsibility for caring for their families, even under conditions of extreme vulnerability, without adequate access to institutional support.

This **caregiving role continues even during migration journeys, where they carry out domestic tasks in makeshift spaces, further increasing their burden**. Many migrant women also face violence, discrimination, and exploitation in informal work settings, and their voices remain undervalued in community or institutional spaces—**especially when they have disabilities**.

An alarming reality compounds this situation: **many migrant women and survivors of armed conflict who receive humanitarian aid are out of school, have experienced violence, or have assumed caregiving roles from a very young age**. This limits their autonomy, particularly in matters of sexual and reproductive health, restricting their ability to make decisions about their bodies and lives.

Lack of information, access to contraceptive methods, and stigma surrounding these topics further aggravate their vulnerability.

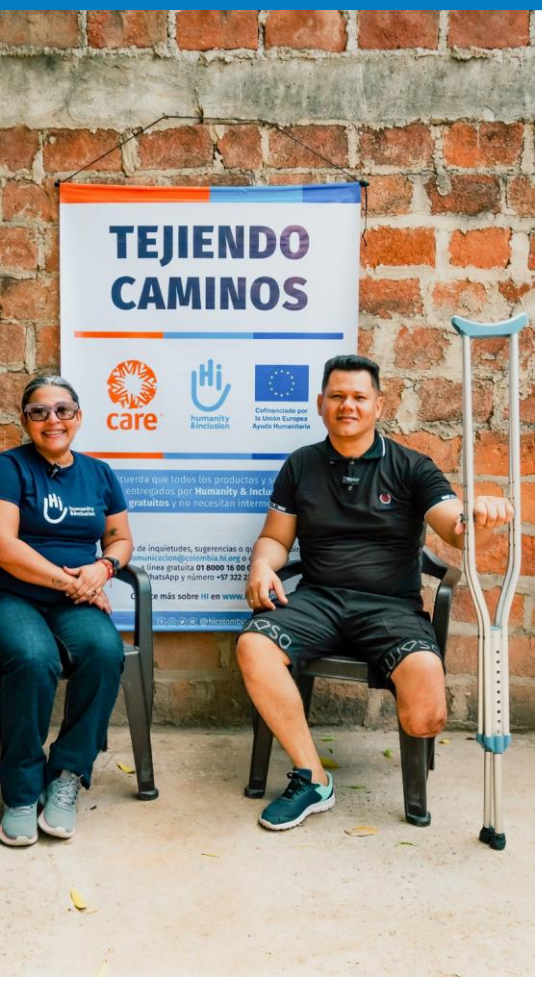
Focus group discussions revealed instances of survival sex, sexual exploitation, and abuse of girls, adolescents, and women, highlighting disparities in access to rights and opportunities during migration processes.

Although humanitarian organizations have focused their efforts on assisting women, girls, and LGBTIQ+ individuals due to differentiated vulnerabilities, it was emphasized that men—especially young men—must also be included in response strategies, particularly to prevent their recruitment into armed groups or criminal gangs.

Nevertheless, it is crucial not to divert attention from women, whose living conditions, health, and security remain precarious.

In this context, **the limited response by the State and international cooperation is also evident, especially toward those choosing to settle in affected areas, including migrant women with life projects that require more than just immediate humanitarian aid: they need access to livelihoods, education, healthcare, and dignified opportunities.**

2. Coping Mechanisms



Girls, women, and people with disabilities within migrant communities face differentiated and deep challenges that demand an intersectional perspective. Women, in particular, have demonstrated remarkable resilience by forming support networks with neighbors, women's groups, and community spaces to share information and mutual care.

However, while these networks are valuable, they are vulnerable to prolonged crises and often lack institutional backing. For people with disabilities, family support is their primary source of care, but **when these families also live under high vulnerability, access to adequate and safe care is severely compromised**.

Forced migration has led many women to take on **multiple and heavy responsibilities**, balancing economic survival with caregiving duties in contexts of **discrimination and precariousness. It is estimated that migrant girls and women in Colombia total 1,455,574, representing 51% of the migrant population (GIFMM, 2025).**

Despite the support provided by humanitarian actors in health, food, and protection, such assistance often fails to meet the specific needs of girls and women, especially those raising children in conditions of emotional, social, and economic instability.

Migrant women—often heads of household—show great resourcefulness in supporting themselves through informal entrepreneurship, street vending, or unconventional work, creatively confronting the lack of formal and secure employment.

Nonetheless, they **face stigmatization, discrimination, and informality** in host countries, which exacerbates barriers to real development opportunities. In this scenario, migrant girls are also affected by a lack of continuous, quality access to education, especially in transit contexts or when **subsistence takes precedence over schooling**.

Although migrant networks help build solidarity in various cities, these spaces are not always adapted or accessible for people with disabilities. Caregivers—often women—report constant exhaustion, limiting their ability to protect and sustain themselves.

In response to this reality, it is urgent to strengthen community-based mechanisms with institutional support, ensure differentiated access to basic rights, and raise visibility of the specific needs of girls, women, and people with disabilities in contexts of human mobility.

3. Access and Participation

In terms of **access to services for the migrant population, deep and structural barriers have been identified that particularly affect women and people with disabilities**. Despite progress in opening to migration in Colombia, significant obstacles remain—especially for those in transit or seeking to settle permanently—regarding **protection, health, and access to livelihoods**. The Temporary Protection Permit (PPT) offers limited access to services such as education and healthcare but does not guarantee dignified employment conditions.

This limitation disproportionately impacts migrant women, who face high levels of discrimination, workplace harassment, and an additional caregiving burden. People with disabilities are often excluded from employment opportunities due to a lack of consideration for functional diversity in work environments.

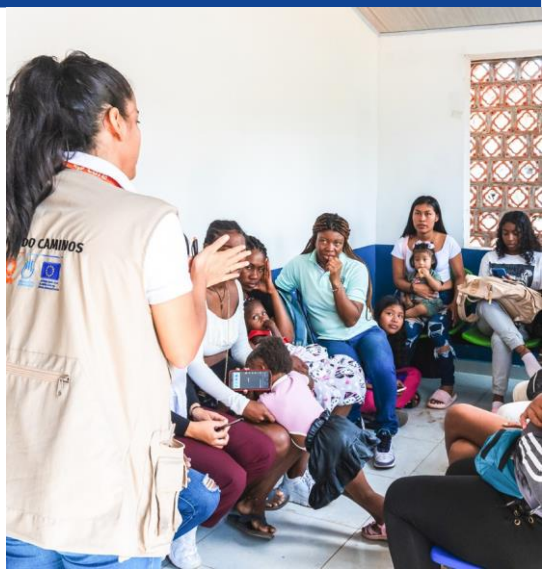
For migrants with disabilities, access barriers are even more severe. The lack of physical adaptations, accessible transportation, inclusive information formats, and trained staff on differential approaches excludes this population from many services.

Institutional infrastructure is often unprepared to meet their needs, perpetuating exclusionary practices. In addition, migrant women with disabilities experience double vulnerability, as they face not only physical and social challenges, but also high levels of gender-based violence, abuse in health and justice contexts, and constant revictimization.

In transit contexts, risks for women, girls, and people with disabilities increase due to a lack of regularization mechanisms and the loss of documentation, which leave them unprotected.

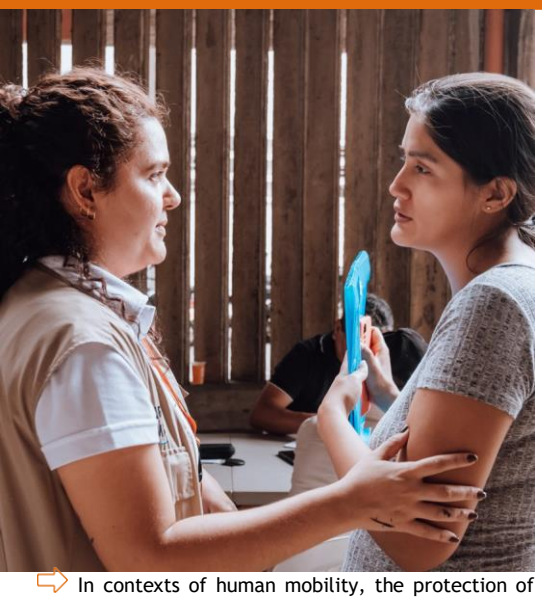
Violence from armed groups and illegal actors restricts mobility and exposes them to physical, sexual, and psychological harm. This situation is exacerbated by the absence of safe routes tailored to their specific needs, contributing to their **invisibility** and vulnerability. Despite international cooperation, available services are insufficient to meet the differentiated needs of migrant women and people with disabilities.

Participation of women, girls, and people with disabilities in decision-making processes is also hindered by the **systematic exclusion of these groups from participatory spaces**. For example, the Ipiales migration board does not include migrant leaders, limiting their empowerment and autonomy.



In cases of **gender-based violence survivors, state responses remain inadequate. The re-victimizing language used by some public officials has led to mistrust and minimal participation in decision-making processes**. However, inclusive alternatives are being proposed from within communities to enhance participation and ensure that the voices of historically excluded individuals are heard and considered.

4. Protection



In contexts of human mobility, the protection of women, girls, and people with disabilities faces multiple structural and cultural barriers that limit their access to justice, healthcare, and basic services. Gender-based violence (GBV), in its various forms, is one of the main threats, **exacerbated by migration status** and the lack of humane and accessible care pathways.

Migrants express **greater trust in international cooperation** organizations due to more respectful and humane treatment, whereas state institutions often require NGO intermediation to take reports seriously.

Migrant women, especially those with irregular status, face systematic violence in public spaces, homes, and transit routes, including harassment, threats of sexual exploitation, and discrimination.

Girls, adolescents, and young women are highly vulnerable to these risks, partly due to the lack of information and guarantees to access protection pathways from governmental organizations. Institutional violence, revictimization, and a lack of trust in government entities reinforce silence and impunity. **Community women leaders report that the normalization of this violence and discrimination based on gender, nationality, or cultural identity perpetuate exclusion**. For **people with disabilities, the risks are heightened. They face specific forms of violence such as neglect, infantilization, and psychological or sexual abuse, often by caregivers or relatives.**

In addition, migrant people with disabilities lack transportation, adequate medical care, and adapted services. The lack of physical and communicative accessibility prevents them from fully exercising their rights. This is compounded by structural discrimination and the absence of intersectional policies that recognize their particular situation within the migration phenomenon.

As part of the information gathering for this document, a "social mapping" exercise was conducted to gain deeper insight into not only the **types of GBV** present in the territory but also the spaces where they occur, the perpetrators, and the reflections that arise from local experiences. **Physical violence**, for instance, was mainly identified within the home, perpetrated by partners or outsiders, and involved strategically placed blows to avoid leaving visible marks, indicating an intent to exert control and enforce silence.

Psychological violence, occurring in both intimate and public spaces, was recognized as one of the most harmful due to its effect on self-esteem. It is often inflicted by authority figures such as public officials or employers and reinforced by stigmas toward migrant women and LGBTIQ+ individuals.

Economic and property-related violence was evident in how partners restricted access to money or shared assets as a form of domination, severely affecting women's autonomy. Sexual violence—described as **one of the hardest to talk about**—was reported in domestic settings, with coercive dynamics normalized by cohabitation, as well as in workplaces and transit routes, reflecting its pervasive nature.

These findings validate the experiences captured in the body-territory mapping, where different parts of the body represent geographic and symbolic spaces where violence is enacted, revealing how forms of aggression are deeply connected to the social, institutional, and economic environment of the municipality.

In response to this reality, communities propose **strengthening the presence of humanitarian organizations with a differential approach, creating safe spaces for children and women, ensuring transportation and technical assistance for people with disabilities, and implementing community awareness campaigns that promote empathy, solidarity among women, and rights recognition**. They also call for **effective, accessible, and culturally appropriate protection pathways**, as well as the training of public officials and coordinated work between the State, NGOs, and community leaders to dismantle the barriers that prevent real and inclusive protection.

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5. Health

Migrant women and people with disabilities face significant challenges in accessing healthcare services, particularly in critical areas such as sexual and reproductive health (SRH) and mental health care. The most frequent barriers include the lack of medical records or valid documents, **discrimination in healthcare facilities, and shortages of specialized health services and supplies**.

Many migrant women, for example, cannot access prenatal care, contraceptives, or post-GBV recovery services due to their irregular migration status or lack of health insurance. These issues are further compounded by revictimization from medical personnel who are not always trained to address the diverse needs of this population.

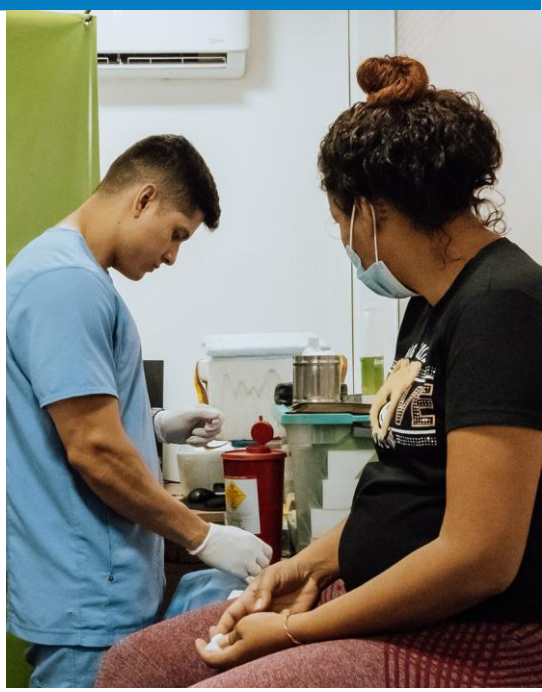
In the case of **people with disabilities**, there are insufficient care facilities or services adapted to their needs, and few professionals are trained to provide adequate care. This particularly affects **women with disabilities, who face additional barriers to accessing sexual and reproductive healthcare. They are often denied the right to make decisions about their reproductive health, infantilized, or, in the worst cases, entirely excluded from such services**. The lack of functional rehabilitation and specialized care places an even greater burden on these women, who are already in vulnerable situations due to forced mobility.

During focus group discussions, such as in Maicao, the urgency of strengthening healthcare services for both migrants in transit and those settling in communities was clearly expressed.

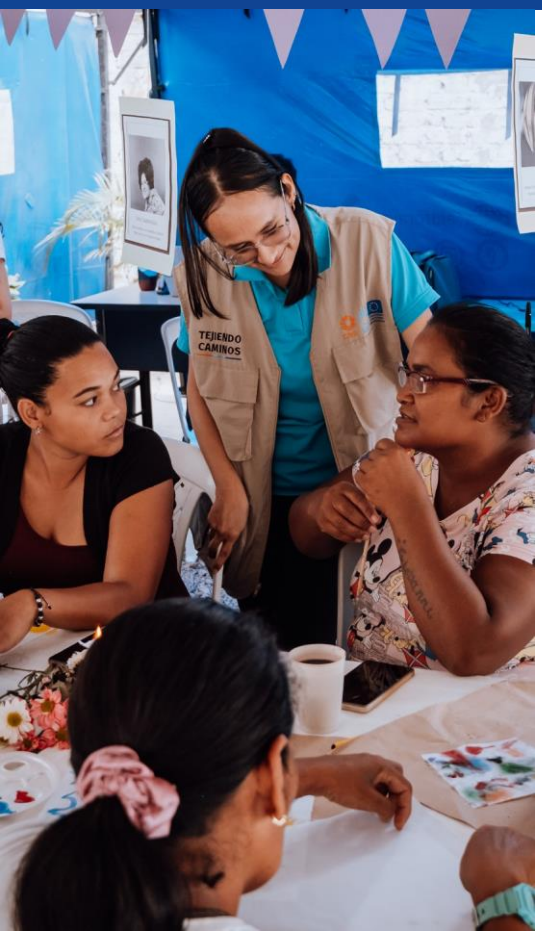
Women and people with disabilities noted that **mobile health brigades could be an effective solution** to bring services closer to transit routes where no accessible medical centers exist. They also emphasized the need to improve information and awareness about sexual and reproductive health rights, so that women—especially adolescents and young women—know their options and do not remain uninformed or unprotected.

The migrant community also **expressed concern over the loss of humanitarian support in recent years**, which has intensified economic barriers and limited access to basic services. Additionally, the lack of access to nutritious food and the closure of care facilities have increased food insecurity, especially for women, girls, and people with disabilities.

In this context, **households led by women without steady incomes and those caring for people with disabilities are the most affected**. Difficulties in accessing adequate food or economic support are directly linked to the deterioration of these populations' overall health and emotional well-being. To overcome these barriers, **the migrant community proposes several solutions**, such as creating mobile health brigades, integrating healthcare services into transit points, and strengthening community support networks. They also underscore the importance of adopting a differential approach in healthcare services that considers the specific needs of women, girls, and people with disabilities.



This includes training healthcare personnel, ensuring the availability of contraceptive methods, and creating **safe spaces for women to share their experiences without fear of discrimination or violence**. Implementing these proposals could significantly improve access to essential healthcare services for these vulnerable mobile populations. (Include a diagram box to reflect hope)



6. Humanitarian Aid

Migrant women and girls, especially those in transit, face highly vulnerable conditions during their journeys through Colombia. The State's response has been insufficient or nonexistent in meeting their basic and protection needs, forcing them to rely heavily on international cooperation and organizations such as CARE and HI.

These organizations are highly valued for providing services that partially compensate for the structural shortcomings of the system, such as humanitarian transport, shelter, healthcare, hygiene, and food. The urgent need to prioritize women, girls, and other vulnerable groups—such as the LGBTIQ+ population—in access to shelter is emphasized, given the high risks they face in insecure environments.

Despite this, many women continue to sleep on the streets, exposed to extreme weather conditions and lacking potable water, which increases their risk of dehydration, infectious diseases, and gender-based violence, particularly sexual violence. Reports of deaths due to hypothermia—especially among pregnant women and girls in cold areas such as the Páramo de Berlín—illustrate the severity of the problem.

The lack of access to **safe transportation also exposes women to multiple risks**. During informal journeys—such as using freight trucks known as "mulas"—they have been targeted for robbery and sexual assault by criminal groups. This situation is exacerbated by the absence of clear information on available services, as many women lack access to the channels that would connect them to humanitarian transport and other essential support.

In **terms of hygiene, women face enormous challenges accessing bathrooms, showers, and safe, dignified spaces to change or clean themselves**. The progressive closure of humanitarian spaces has forced many to go days without bathing, changing clothes, or washing, and to manage their menstrual cycles in precarious conditions. This not only affects their physical health but also their emotional well-being. The quality of drinking water in cities such as Ipiales is inadequate, putting the health of those who, out of need or lack of knowledge, drink it directly at risk.

The **defunding by the United States government** has triggered a large-scale humanitarian crisis, with particularly severe impacts in Colombia's border cities. The reduction in resources has led to the **closure—some permanent, others temporary—of multiple NGOs, drastically reducing access to basic services for the migrant population and also for vulnerable local communities**.

This situation has significantly limited the response capacity of international cooperation and weakened the coordination of essential humanitarian services such as food, shelter, medical care, and access to safe water and hygiene. As a result, many migrants have chosen not to stop or have reconsidered their routes upon realizing that humanitarian aid is no longer available. **This does not indicate a decline in migration but rather an increasing invisibility of the crisis**.

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During the dialogues held with participants, it was noted that there used to be a wide range of services available along the national migration route. Currently, by contrast, they face great difficulties: service centers are scarce and far apart, access to food, shelter, medication, and hygiene services is limited, and many migrants —especially those in transit— are left completely unprotected. The following issues were identified:

- Increase in unaddressed cases of gender-based violence (GBV) and sexual and reproductive health (SRH).
- Growing misinformation and confusion surrounding decisions made by the U.S. government.
- Increased institutional mistrust and a sense of abandonment.
- Deepening exclusion of women, girls, and people with disabilities - Many migrant children are not enrolled in school due to a lack of documentation, available spots, and information enabling access to education. Moreover, many families prioritize survival, causing children to work informally.
- People with disabilities are excluded from education due to lack of accommodations and physical and pedagogical barriers.
- There are no recognized inclusive education strategies for children with disabilities, particularly hearing, visual, or intellectual disabilities; in the case of physical disabilities, many access barriers remain.
- Many women do not have a safe space to protect themselves from aggressors.
- Closures of accessible temporary shelters with specialized care leave girls and women unprotected.

7. Conclusions:

There is **a clear and ongoing need for support from organizations such as CARE/HI** and, in general, from international cooperation in regions such as Cúcuta, Ipiales, Maicao, and other border areas severely affected by migration. The government of Nicolás Maduro in Venezuela continues to deepen the country's crisis, worsening not only the impact on people's livelihoods in general but also intensifying political violence and the displacement of government opponents.

In addition, recent changes in U.S. policies have had a global impact, significantly weakening the response capacity of many humanitarian projects and creating dangerous gaps that have increased risks for vulnerable populations such as women, girls, people with disabilities, and the LGTBIQ+ population, who are unable to access essential basic services, as evidenced in the dual-impact context of Catatumbo, Norte de Santander.

On the other hand, there has been a noted strengthening of some NSAGs in border areas, such as in Norte de Santander, Nariño, and Cauca, resulting in a reconfiguration of territorial control and an increase in disputes and armed clashes both among the NSAGs and against the Colombian state forces. This has led to increased crises and impacts, with civilians left unprotected and facing serious humanitarian needs.

The evidence gathered through focus groups shows that **women, girls, and people with disabilities in the context of human mobility face a complex combination of violence, exclusion, and structural barriers, which intersect with factors such as gender-based violence, xenophobia, poverty, and institutional absence.** This situation worsens in contexts where the lack of continuity in humanitarian services and the weakening of institutional provision deepen the crisis.

It is urgent to ensure access to adequate health services, including medical examinations, medications, and specialized care, as well as to strengthen the dissemination of referral pathways for cases of violence and promote access to information on SRH, especially encouraging women's autonomy in making decisions about their bodies.

Additionally, decisions and changes in international cooperation policy have affected the response of humanitarian organizations, which face increasing crises and impacts but declining resources to address them. Overall, there is still an evident lack of response capacity on the part of the state, especially where institutional capacity is weak and in areas that have historically experienced armed conflict.

Given this scenario, the limited state response to multiple social issues reinforces the importance of maintaining and strengthening strategic alliances with non-governmental organizations. Data collection, evidence-based decision-making, political advocacy with donors and the Colombian government, inter-institutional coordination, and the integration of a gender and disability perspective **remain vital to responding to humanitarian crises** and seeking alternatives amid changes in the humanitarian architecture and the escalation of violence in border regions.

It is essential to continue supporting and consolidating a transversal, intersectional, and sustained gender and disability approach that enables the voices of those who have historically been silenced to influence, transform, and lead the processes that directly affect their lives.

Recommendations

1. Non-Governmental Organizations (NGOs) and International Cooperation

- Avoid limiting assistance to a single intervention per participant, recognizing that many individuals face multiple vulnerabilities simultaneously (GBV, disability, transit, health, among others).
- Strengthen coordination with operational shelters and strategic local actors to refer cases that exceed the response capacity of projects.
- Advocate for regular and strategic GIFMM meetings to assess service delivery, coverage, and safe access in light of underfunding and project closures.
- Design specific communication strategies for the prevention of sexual abuse and exploitation during transit, especially targeting women, girls, adolescents, and persons with disabilities.
- Design and implement differentiated care pathways with clear protocols, accessible materials, and trained personnel that acknowledge the specific needs of women, girls, and persons with disabilities in human mobility. Protocols and humanitarian care pathways must include **reasonable accommodations** for persons with disabilities (flexible schedules, assistive devices, quiet spaces, personalized assistance, etc.).
- Develop and implement **protection protocols against disability-based violence**, identifying specific risks such as abuse by caregivers, institutional violence, or re-victimization.
- Ensure that all humanitarian service points (shelters, health centers, temporary accommodations) meet **universal accessibility** standards (physical, sensory, cognitive, and communicational).
- Promote ongoing awareness and training processes for humanitarian staff and community leaders on human rights, political advocacy, prevention of GBV, disability, and gender.
- Establish monitoring systems with inclusion indicators to evaluate the implementation of the gender and disability approach in each sector.
- Continue training and cooperating with the State for integrated, coordinated, and sensitive care that responds to the needs of those affected by the humanitarian crisis.
- Apply an intersectional disability approach in the design, implementation, monitoring, and evaluation of projects, recognizing how disability, gender, age, migration status, and other exclusion factors interact.
- Create accessible feedback and participation channels so that persons with disabilities can **evaluate the services received** and submit complaints, suggestions, or recommendations.

2. State Institutions

- Strengthen access to regularized documentation by **eliminating barriers caused by lack of documents** that hinder access to essential services and the exercise of fundamental rights, especially for women and persons with disabilities, through agile, accessible, and non-discriminatory mechanisms.
- Clearly disseminate and socialize care pathways for GBV and other forms of violence, with an emphasis on transit points, shelters, and border areas, ensuring they are physically, sensory, and communicationally **accessible** for persons with disabilities.
- Ensure timely and transparent funding for the response to humanitarian emergencies.
- Guarantee the **availability and gratuity of reasonable accommodations** in essential services (interpreters, guides, accessible formats), especially for women with disabilities who are victims of GBV.
- **Make visible the humanitarian crisis related to migration**, especially in the context of armed conflict, by generating information that recognizes the specific needs of girls, women, and persons with disabilities.
- Provide guidance to the migrant population on their rights to health and education, using a differentiated approach for women, girls, persons with disabilities, and LGTBIQ+ populations.
- Ensure comprehensive access to healthcare services, including medical exams, medications, and specialized care, especially in sexual and reproductive health (SRH).
- Design and implement **inclusive health policies** guaranteeing access to functional rehabilitation, mental health services, and SRH services adapted for women with disabilities.
- Promote inter-institutional coordination among state entities, humanitarian organizations, community leadership, and international cooperation to ensure a coherent and sustainable response.
- Monitor the implementation of reasonable accommodations for the inclusion of persons with disabilities in each sector.
- Include organizations of persons with disabilities (OPDs) in decision-making spaces related to migration response, education, and protection.

3. Projects Serving Migrant and Refugee Populations

- Strengthen local partnerships with active shelters and community organizations to complement project services.
- Promote the autonomy of girls, adolescents, and women by ensuring effective access to information and sexual and reproductive health services.
- Implement livelihood recovery and strengthening strategies focused on women and persons with disabilities.
- Implement inclusive care protocols that address the specific needs of persons with disabilities in transit.
- Establish **accessible community information points** in key locations (schools, churches, health centers, community kitchens), staffed with trained personnel and diverse materials.
- Ensure the **participation of persons with disabilities** in the design and implementation of project activities, including workshops, validation of care pathways, and participatory monitoring.
- Adapt procedures and timelines for care to meet the specific needs of people in transit, such as technical aids or continuous psychosocial support.
- Generate and disseminate accessible and culturally appropriate information on rights, care pathways, and available services.
- Develop materials in accessible formats and communication strategies in visual, oral, auditory formats and **Colombian Sign Language**.
- Establish community information points in strategic spaces such as schools, churches, or health centers, with bulletin boards, volunteers, or trained staff.
- Promote access to **dignified and inclusive livelihoods through adapted job training, promotion of accessible entrepreneurship**, and support for caregivers of persons with disabilities.
- Use in-person and community-based means to disseminate messages, such as meetings, loudspeaker announcements, door-to-door visits, community radio stations, and WhatsApp groups.

care
humanity & inclusion
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