University of Southampton

Faculty of Social Sciences

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Towards Contraceptive Autonomy: Examining Actors' Inclusion of Adolescent Migrant Girls' Voices in Responses to Humanitarian Crises. A Case Study of Venezuelan Migrants in Colombia

by

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Thesis for the degree of Politics and International Relations

January 2024

University of Southampton

Abstract

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Doctor of Philosophy

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How are decisions regarding contraceptive care of Venezuelan adolescent migrant girls in Colombia made by state and non-state actors? How and when do they consider the contraceptive needs and wants of these migrant girls? This thesis explores how state and non-state actors consider and include migrant adolescent girls' (aged 15-19 years old) in the design and implementation of responses and the consequences for *voice*, autonomy and justice.

The Reproductive Justice (RJ) movement seeks to address inequalities and combat oppression by combining sexual and reproductive health rights (SRHR) and social justice. Contraceptive autonomy, as an essential component of RJ, is understood as an individual's right to make and actualise their contraceptive choices (Senderowicz, 2020). The study introduces *The Scale of Voice*, a framework that identifies modalities of consideration and inclusion in contraceptive care decision-making, drawing from and contributing to the literature on RJ and youth participation models. *The Scale of Voice* framework examines state and non-state actors' use of mechanisms relating to key pillars of *voice*: intersectionality, participation, and opportunities to (not) use a variety of contraceptives and the implications for contraception autonomy. Empirically, the study utilises quantitative health utilisation data obtained from records of both state and non-state actors, alongside survey responses. This is triangulated with data from interviews conducted during fieldwork in Bogotá, Colombia, in March 2022 with adolescent migrant girls and key informants at various levels of decision-making and design implementation.

Applying *The Scale of Voice*, I reveal a pattern of constrained agency where structural factors curtail their ability to make fully informed and autonomous choices regarding contraceptive methods. First, responses put in place by state and non-state actors overlook the intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration), doing little to address inequalities in access and service utilisation. Secondly, those actors do not provide sustainable mechanisms of participation and feedback by which adolescent girls can share decision-making power. In addition, opportunities to use, or not use, a variety of contraceptive methods were shaped by short-term, one-off interventions and did not promote a variety of methods, nor the ability to change or discontinue using long-term methods. Instead, actors emphasised short-term, 'emergency' responses characterised by risk aversion, disease management, and access to resources. Finally, I claim that it is imperative to avoid nonautonomous contraceptive care, which has negative effects on the development of girls and the societies in which they live. Instead, this thesis advocates for a transformative shift in responses, urging the creation of autonomy-enhancing conditions for marginalised groups in accordance with the principles of RJ.

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Research Thesis: Declaration of Authorship

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I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

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2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
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Acknowledgements

First and foremost, I would like to express my sincere gratitude to my supervisors Professor Pia Riggirozzi and Professor Amos Channon for their unlimited support and guidance. I could not have asked for a better supervisory team. I would also like to thank my examiners for their insight and discussion.

Secondly, I am grateful for the funding provided by the Economic Social Research Council and the South Coast Doctoral Training Partnership which made this research possible.

I would also like to extend my thanks to all my key informants and interviewees who dedicated their time and expertise.

To my colleagues in Colombia, I would like mention Mariana Sarmiento, Jeanine Legato and Juan Camilo Tovar Castro for their help and guidance during my fieldwork. As well as my dear friends Laura Lucía Rodriguez and Maria Adelaida Melo Torres for their outstanding hospitality and kindness.

I, of course, need to mention my all fellow Gender, Violence and Conflict alumni and friends with special thanks to Ana Pandal de la Peza and Aaliyah Burns. You are amazing. Your research and activism continually inspire me. Don't ever stop!

Additional thanks to my Southampton colleagues Becca Harris, Alice Wolfle, Nandini Das, Oki MacPherson, Laurence Cannings – I probably would not have completed this thesis without you. It would be remiss not to mention the other insightful conversations I have had with many others including Arjun, Adam, Charlotte ,Tanay, and of course Natalia. Aside from your intellect, I have to thank you all for every posh pickle, every podcast recommendation and every pint. They are the fuel on which this thesis was written.

Finally, but the most importantly, I would like to thank all my friends and family. I'm sorry for every dinner, night out and holiday I missed, I promise I will make it up to you. Special thanks go to Aimee, Becky, and Daisy. I would like to thank Lola, whose *joie de vivre* is infectious and who ensured I took regular breaks.

To Charlie. Thank you for providing me with snacks, forcing me to do Park Run and for listening to me complain every single day. Thank you being my side to put out every PhD-related fire – without you I would still be surrounded by flames. More importantly, thank you for being you.

Lastly, thank you to my mum to who I dedicate this thesis. You always have and always will be my inspiration. I know you'll say you do regardless, but I really hope you like this.

Definitions and Abbreviations

AFHS ..... Adolescent-Friendly Health Services

AIDS ..... Acquired Immune Deficiency Syndrome

CNPV ..... National Population and Housing Census

CONPES ..... National Policy for Gender Equality

COVID-19 ..... Coronavirus Disease

DANE ..... National Administrative Department of Statistics

DHS ..... Demographic Health Survey

ENCOVI ..... Nation Survey of Living Conditions

EPM ..... Migration Pulse Survey

EPS ..... Entidades Promotoras de Salud

EPTV ..... Temporary Statute of Protection

FBO ..... Faith-Based Organisations

GBV ..... Gender-Based Violence

GIFMM ..... The Interagency Group for Mixed Migration Flows

HIV ..... Human Immunodeficiency Virus

HRBA ..... Human Rights-Based Approach

HRW ..... Human Rights Watch

IAWG ..... Inter-agency Working Group on Reproductive Health in Crises

ICD-10 ..... International Statistical Classification of Diseases and Related Health Problems, Tenth Revision

ICPD ..... International Conference on Population and Development

IDP ..... Internally Displaced Persons

INGO ..... International Non-governmental Organisation

IOM ..... International Organisation for Migration

IPPF ..... International Planned Parenthood Federation

IPS ..... Instituciones Prestadoras de Servicios de Salud

IUD ..... Intrauterine device

LARC..... Long-acting Reversible Contraception

LGBTQIA2S+..... Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, two spirit plus other sexual and gender identity terms

MDG ..... Millennium Development Goals

MISP..... Minimum Initial Service Package

MSF,..... Doctors Without Borders

NGO ..... Non-Governmental Organisation

PAHO ..... Pan American Health Organisation

PNDSDSDR ..... National Policy on Sexuality, Sexual Rights and Reproductive Rights

PoA ..... Programme of Action

R4V ..... The Platform of Interagency Coordination for Refugees and Migrants

RIPS..... The Individual Registry of Service Provision

RJ ..... Reproductive Justice

RMRP ..... Regional Refugee and Migrant Response Plan

SDG ..... Sustainable Development Goals

SGBV ..... Sex and Gender-Based Violence

SGSSS ..... General System of Health and Social Security

SISPRO ..... National Information System for Social Protection

SNARIV..... National System for Comprehensive Victim Support and Reparation

SRH ..... Sexual Reproductive Health

SRHR ..... Sexual Reproductive Health Rights

STD..... Sexually Transmitted Disease

STI ..... Sexually Transmitted Infection

UHC..... Universal Health Coverage

UN..... United Nations

UNFPA ..... United Nations Population Fund

UNHCR ..... United Nations High Commissioner for Refugees

UNICEF..... United Nations Children's Fund

UNPD ..... United Nations Development Programme

Definitions and Abbreviations

VACS ..... Colombia Violence Against Children and Youth Survey

WHO ..... World Health Organisation

Chapter 1 Introduction

1.1 Rationale

Adolescent migrant girls are subject to widespread sexual and reproductive health (SRH) injustices rooted in structural power imbalances. This thesis develops the concept of contraceptive autonomy (framed as *voice*) to identify and redress these injustices. It argues that the structural power imbalances are linked to the ways in which state and non-state actors consider and include adolescent migrant girls' *voices* in the design and implementation of responses to their SRH care, focusing on contraceptive care.

Contraceptive care for migrant women and girls is vital, as disruption can lead to riskier sexual behaviours, experiences of sexual and gender-based violence (SGBV), increased rates of STIs/HIV, and unwanted pregnancies (UNFPA, 2015, pp. 39-43). Since it is predominantly women and girls who seek sexual and reproductive health (SRH) services, they are disproportionately affected by the disruption of these services during crises (UNFPA, 2015). However, crisis responses often overlook gendered aspects of healthcare, deepening existing inequalities (Davies and Bennett, 2016; Lafrenière, Sweetman and Thylin, 2019).

Contraceptive care is a key part of rights and justice frameworks. Sexual and reproductive health rights (SRHR) encompass many interconnected human rights, such as the right to health, education, equality, and non-discrimination. In addition, they specify the 'right to decide the number and spacing of children', including the means to realise one's decisions through contraceptive education, information and resources or contraceptive care (UNFPA, 2014a). Beyond 'use' or 'access' paradigms, the Reproductive Justice (RJ) movement seeks to understand how processes such as policymaking, programme design and implementation have shaped how those with intersecting non-hegemonic social identities experience SRHR, that is, those in positions of marginality (Ross and Solinger 2017; Abji and Larios 2020).

Embedded in RJ are two central claims which have implications for understanding how actors consider and include adolescent migrant girls in their responses regarding contraceptive care. First, justice cannot be achieved while marginalised groups and individuals remain involuntarily silenced (Solinger, 2005; Ross, 2018). Second, by acting without centring on the experiences of marginalised people through participation, actors are acting based on assumptions, which often causes more harm (Ibid.). As part of this movement, RJ scholars seek to redress power imbalances which have so far meant some individuals and groups have had greater contraceptive autonomy than others. This means that some groups have had more freedom to make decisions relating to their contraceptive care and to be able to realise those decisions (Senderowicz, 2020, p. 165). The work done by

Senderowicz (2020) and others has demonstrated that various dimensions of autonomy are enhanced or constrained depending on the way in which contraceptive care is delivered (Mann, Chen and Johnson, 2022; Tumlinson *et al.*, 2022). As a consequence, RJ encompasses how policy, provider training, and the provision of education, information, and resources on contraceptive methods are conceptualised, implemented, and measured (Cadena, Chaudhri and Scott, 2022). The focus is on cultivating environments that promote full, free, and informed choice, ensuring that both the use and non-use of contraception are regarded as positive outcomes when autonomy is respected (Senderowicz, 2020; Cadena, Chaudhri and Scott, 2022). A RJ lens is essential to gain a rich understanding of how responses have been designed and delivered without the experiences of marginalised groups to create environments where contraceptive autonomy is afforded depending on social identities.

A parallel but separate discussion can be found in childhood studies literature on the 'voices of children', which when manifested in line with the United Nations Convention on the Rights of the Child (UNCRC), has led to positive outcomes for adolescent health and well-being (Lundy, 2013; Caputo, 2016; Patton *et al.*, 2016; Saldanha and Nybell, 2016; van den Muijsenbergh *et al.*, 2016; Koenig *et al.*, 2020; Campbell, 2021). Under a human rights framework, 'voice' or 'the right to be heard', is developed with maturation, so that children's ability to be responsible for decisions affecting their lives reduces their need for protection (United Nations, 1989). This concept, also known as 'evolving capacities', is formally defined as 'processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realised' (UNCRC, General Comment No. 7: para. 17). As in RJ literature, here research has shown that ignoring the perspectives of marginalised girls during crises can (re)produce situations of vulnerability and marginalisation (Hajisoteriou, Karousiou and Angelides, 2021; Kusumaningrum, Siagian and Beazley, 2021; Potts, Kolli and Fattal, 2022). Yet, evidence shows that adolescent girls are frequently prevented from accessing contraceptive education, information or resources they want, due to gendered social and cultural norms that argue adults 'know best' (Goicolea *et al.*, 2010; Mann, Chen and Johnson, 2022).

It is evident that only by listening to adolescent migrant girls can actors begin to remedy the inequalities that give some groups greater freedom to choose how they use (or do not use) contraceptive methods. Following this logic, if migrant adolescent girls are not included in the decisions that relate to their contraceptive care, actors are at risk of further reproducing (reproductive) inequalities and injustices. This thesis seeks to combine models of youth participation (Shier, 2006) with the concept of contraceptive autonomy (Senderowicz, 2020), to develop a novel framework *The Scale of Voice* to explore the modalities and implications of the inclusion of migrant

adolescent girls in decisions pertaining (their) SRH. This *scale* highlights the various ways actors have or have not considered and included adolescent migrant girls in their responses to contraceptive care. *Voice* is defined here as a vehicle for self-expression as in social and political thought linked to power (Lawy, 2017). *Voice* in matters related to contraceptive care here refers to a process of sharing decision-making power in matters related to contraceptive education, information and resources. It builds on contraceptive autonomy, and 'evolving capacities' as a form of relational autonomy so that when actors include the *voices* of adolescent migrant girls, they create an environment which is contraceptive autonomy-enhancing.

Contraceptive care is an intersectional matter. On the one hand, gendered social norms often distribute reproductive responsibilities unequally, delegating contraception to one person (usually women and girls), whilst relieving the other from this responsibility (Brown, 2015; Littlejohn, 2021). On the other hand, marginalised groups of women and girls often struggle to gain access to contraceptive autonomy, when they are seen as 'unworthy of rights' by decision-makers (Morgan and Roberts, 2012).

Adolescents in non-crisis settings often lack access to care that matches their differentiated needs. For adolescents, who are not yet considered adults, yet engage in adult-like behaviours (Brisson, Ravitsky and Williams-Jones, 2021), SRHR create entitlements to participate in their SRH relative to their knowledge, competencies and understandings (United Nations, 1989). However, health professionals tend to give less priority to adolescents' SRH, receive less training, and hold clinics in locations and during hours that are not accessible for adolescents (Goicolea *et al.*, 2017). Shortages in resources mean that services are not always available (Bearinger *et al.*, 2007; Mason-Jones and Nicholson, 2018; MacKinnon and Bremshey, 2020). Sometimes, the financial cost of seeking healthcare can discourage or prevent adolescents (who rarely have disposable income) from accessing SRHR (Plesons *et al.*, 2019; Mann, 2022; Nowshin *et al.*, 2022). When services offer care to adolescent girls, providers are more likely to violate patient confidentiality; pass judgment on sexual behaviours; and disregard their preferences (Plesons *et al.*, 2019; Mann, 2022; Nowshin *et al.*, 2022). In some cases, barriers are formalised into policy or legal barriers, including restrictions based on age, marital status, parity, and the presence of a parent or guardian to access SRH services (Schwandt, Speizer and Corroon, 2017). As such, SRHR care for adolescents tends to adopt an 'adult worldview' which makes it difficult to access (Buthelezi *et al.*, 2007; MacDonald *et al.*, 2011).

Migrants, particularly forced migrants – regardless of their age – risk being overlooked by actors. Governments have been criticised for failing to deliver policies or interventions which address the barriers to SRHR for migrant women and girls (Cintra, Owen and Riggirozzi, 2023; Heide et al. 2015; Abbas et al. 2018; Chen 2022). Notably, South-South migration is markedly different from South-

North migration, as migrants may arrive to find less-developed infrastructure than they would have faced in the Global North (Nyberg–Sørensen, Hear and Engberg–Pedersen, 2002). Health systems may face a lack of human, financial, and medical resources leaving actors ill-equipped to deal with the complex demands presented by migrants (Mengesha *et al.*, 2017; Plesons *et al.*, 2019; Davidson *et al.*, 2022). Healthcare workers may lack knowledge of migrants' needs, experiences, cultural values, and expectations (Mengesha *et al.*, 2018 ; Sutan and Siregar, 2021; Tirado *et al.*, 2022). In the worst cases, primary healthcare workers may exhibit discriminatory behaviour (Meyer-Weitz, Oppong Asante and Lukobeka, 2018; Davidson *et al.*, 2022). Political and legal barriers mean that migrant women and girls may struggle to have the correct documents to receive healthcare (Meyer-Weitz, Oppong Asante and Lukobeka, 2018; Sutan and Siregar, 2021; Marquez-Lameda, 2022; Wegelin *et al.*, 2022). It is therefore unsurprising that, compared to host populations, migrants in humanitarian settings are more likely to have unintended pregnancies, higher rates of HIV/AIDS, and poor knowledge about SRHR (Metusela *et al.*, 2017; Ivanova, Rai and Kemigisha, 2018; Davidson *et al.*, 2022; Tirado *et al.*, 2022).

Whilst migrant women experience the above-mentioned barriers and vulnerabilities, adolescent migrant girls may have distinctive reproductive realities because they simultaneously embody all three dimensions; that is, gender, migrant and adolescent. The intersection of these dimensions is important for the study of contraceptive care and its practice, and yet one that is notably overlooked in the literature on migration and health. Originating from Black feminist scholars, intersectionality is seen as the critical insight that race, class, gender, nation, and age (amongst other dimensions) interlock to create 'reciprocally constructing phenomena', that in turn shape complex social inequalities (Collins, 2015, p. 2; Crenshaw, 2017).[1] In this thesis, I bring these issues together acknowledging the multiple conditions of privilege and oppression that shape the experiences of adolescent migrant girls, and how these are different to those who are adolescents, women or migrants; and their opportunities to exercise *voice* regarding contraceptive care.

At the intersection of age, gender, and migration, adolescent migrant girls disproportionately experience complex vulnerabilities, needs, and barriers which prohibit the realisation of their SRHR. These include (but are not limited to) issues with documentation, greater risk of SGBV, lack of knowledge of how to use the health system, fear of deportation or discrimination, lack of disposable income and greater risk of mental health issues (Christine *et al.*, 2017; Ivanova, Rai and Kemigisha,

[1] Intersectionality is distinct from vulnerability, because the former places power at the centre of analysis looking at how hierarchical power inequalities shape life experiences. Whereas the latter, concentrates only on susceptibly to vulnerability. Lokot, M. and Avakyan, Y. (2020) 'Intersectionality as a lens to the COVID-19 pandemic: implications for sexual and reproductive health in development and humanitarian contexts', *Sex Reprod Health Matters*, 28(1), p. 1764748.

2018; Endler *et al.*, 2020; Tirado *et al.*, 2020). Despite recent accounts that explore the experiences, beliefs, and attitudes of adolescent migrant girls, existing research is largely disconnected from the responses provided by states, non-governmental organisations, public health professionals, and civil society to adolescent migrant girls needs and rights (Heide *et al.*, 2015; Tirado *et al.*, 2020; Chalmiers *et al.*, 2022). Furthermore, the academic literature on SRHR for adolescent migrant girls frequently fails to consider how SRHR are enacted in accordance with unique circumstances, experiences, and needs, which I call 'reproductive realities' (Villa-Torres and Svanemyr, 2015; Nowshin *et al.*, 2022). As such, it avoids any discussion of how power operates in the design and implementation of responses. In this way RJ, provides a broader basis for analysis. RJ scholars show how actors' responses (re)produce intersectional oppression[2] to marginalise young people or migrants in a world that is primarily designed for adults and citizens, to meet their needs (Hans and White, 2019; Abji and Larios, 2020; Wegelin *et al.*, 2022). However, this literature has yet to apply a RJ lens to actors' responses to adolescent migrant girls' contraceptive care.

Acknowledging the paucity of literature which examines how actors account for the *voices* of adolescent migrant girls, this thesis centres on how actors consider adolescent migrant girls' contraceptive autonomy (as voice) in the case study of Venezuelan migrants in Colombia. Currently, there are an estimated 7.8 million Venezuelan migrants and refugees worldwide (R4V, 2023b). This makes the Venezuelan crisis one of the region's largest exoduses in the region and one of the largest worldwide. Colombia is home to the largest proportion of Venezuelan migrants. In 2015, there were 48,714 Venezuelan migrants in Colombia as of 2022 there were 2,477,588 Venezuelan migrants in Colombia (R4V, 2023a). Of these, the majority have entered the country irregularly (R4V 2021). Many migrants have low socioeconomic status due to the economic situation in Venezuela (R4V 2021). In Venezuela, contraceptives are increasingly unavailable in public and private health institutions (Albaladejo, 2018). As a result, many women and girls who migrate from Venezuela to Colombia arrive with an existing need to access SRH services (Profamilia, 2019; Cintra, Owen and Riggirozzi, 2023). Studies at the border highlight that the risk of violence, or exposure to violence, is multiplied for Venezuelan women and girls (Doocy *et al*., 2019; p. 82; Calderon-Jaramillo *et al*., 2020). Despite evidence suggesting that younger individuals face greater vulnerabilities and barriers to accessing SRH services, limited knowledge exists on how actors respond to the contraceptive care priorities and preferences of the adolescent migrant girl population, often grouping adolescents, with all women of reproductive age (those aged 15-49) (Profamilia, 2019; Ortiz-Ruiz et al. 2023).

[2] In lieu of specific definition of oppression from RJ scholars, I adopted Young's five 'faces' of oppression: violence, exploitation, marginalisation, powerlessness, and cultural imperialism - with specific attention to marginalisation, powerlessness, and violence. Young, I.M. (2020) 'Justice and the Politics of Difference', in *The new social theory reader*. Routledge, pp. 261-9.

In response to the influx of Venezuelan migrants, a regional platform was established – The Regional Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela (R4V). This non-state response, led by the IOM and WHO, created the Health Cluster in Colombia, dedicated to improving services and addressing the gaps of the healthcare system. Meanwhile, the state response has focused on regularising the migrant population so that they can become affiliated with the health system through health insurance. In 2021, the state issued the Temporary Statute of Protection (EPTV) to grant temporary protected status (PPTs) to Venezuelans in Colombia for the next 10 years (Migración Colombia, 2021). Additional reforms provided access to urgent or emergency care (Decree 216 of 2021). This thesis will examine how both state and non-state actors deliver responses to Venezuelan adolescent migrant girls' contraceptive care. Considering this mosaic of actors and overlapping responses, it seeks to determine how actors meet the contraceptive needs of adolescent migrant girls and how power is shared in the decision-making process.

The overarching research question asks, how do state and non-state actors consider adolescent migrant girls' (aged 15-19) contraceptive autonomy in the design and implementation of their contraceptive care policies, programmes, and strategies?

The sub-research questions are:

1. Are there inequalities in access to contraceptive-related services by age, nationality for women and adolescent girls of reproductive age in Colombia?
2. How have actors acknowledged and enacted the need for differential contraceptive care services for adolescent migrant girls?
3. To what degree have adolescent migrant girls' *voices* been included? What are the specific modalities of engagement and inclusion utilised by state and non-state actors in their responses to adolescent migrant girls' contraceptive care?
4. What are the key challenges and barriers facing state and non-state actors in effectively engaging and considering the *voices* of adolescent migrant girls?

The main aim of the study is to take a RJ approach to explore the extent to which state and non-state actors engage with, and consider, adolescent migrant girls in the design and implementation of their responses, and how they do so. The study places a particular focus on whether the responses are engineered so that adolescent girls (aged 15-19) are consulted, heard, and included in their contraceptive care. The corresponding objectives which have been developed to achieve this aim are as follows:

- Develop new empirical evidence on the policies, programmes and strategies that offer contraceptive education, information, and resources to Venezuelan adolescent migrant girls in Colombia.
- Create an analytical framework (*The Scale of Voice)* using a RJ approach to examine how actors include adolescents' *voices* as a vehicle of contraceptive autonomy.
- Utilise the framework (*The Scale of Voice*) to identify the modalities of engagement and inclusion of adolescent migrant girls in responses that concern their contraceptive care.

In this study, the conditions of *voice*, as a proxy for contraceptive autonomy, are explored in the acknowledgement that the intersectional reproductive realities of adolescent migrant girls should inform differentiated responses to meet those realities. They should provide direct channels of participation and feedback which not only enable the development of evidence-based responses but further develop the 'evolving capacities' of adolescent migrant girls. Meanwhile, there should also be a broad mix of contraceptive methods available and opportunities to use, change or discontinue methods as individuals' priorities and preferences change. The extent to which these aspects of *voice* are included determines the degree to which actors create autonomy-enhancing conditions that align with their 'evolving capacities'. This approach is more likely to safeguard their SRHR and create an environment conducive to contraceptive autonomy. In the absence of such conditions, one can presume actors take action on behalf of girls, limiting their autonomy.

In answer to these questions, I find that state and non-state actors create environments which restrict Venezuelan adolescent migrant girls' contraceptive autonomy. Firstly, responses overlook the intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration), doing little to address inequalities in service utilisation. Secondly, actors' provision of mechanisms of participation and feedback for adolescent migrant girls tends to be restricted to one-off or community-level actions. Consequently, there are few opportunities to share decision-making power regarding contraceptive care. Additionally, opportunities to (not) use a variety of contraceptive methods were shaped by short-term, one-off interventions which restricted methods available as well as the ability to (re)negotiate method use. Instead, actors emphasised short-term, 'emergency' responses characterised by risk aversion, disease management, and access to resources, at best providing conditions of constrained agency. Finally, I address challenges actors currently face such as lack of knowledge, the data environment and the public health and humanitarian structure. I contend that these barriers are indicative of wider structural power imbalances which must be redressed. All of this supports my argument that states, and non-state actors need to do more to centre and include adolescent migrant girls' *voices* and progress to RJ.

1.2 Defining Key Terms

The section defines key terms used throughout this thesis. For the convenience of the reader, the most frequently used terms are found in the glossary of this thesis. SRHR as defined by Starrs *et al.*, (2018) comprises sexual health, sexual rights, reproductive health, and reproductive rights. They define sexual health is as 'a state of physical, emotional, mental, and social well-being in relation to sexuality,' emphasising a positive and respectful approach to sexual experiences, free from coercion, discrimination, and violence. This includes access to counselling and care related to sexuality, services for the prevention and management of sexually transmitted infections, psychosexual counselling, and treatment for sexual dysfunction, as well as prevention and management of reproductive system cancers (WHO, 2017). To attain and maintain sexual health, the sexual rights of all individuals must be respected, protected, and fulfilled.

Sexual rights, recognised as human rights, encompass various aspects such as: achieving the highest standard of sexual health, seeking and imparting information related to sexuality, receiving comprehensive sexuality education, having bodily integrity respected, choosing a sexual partner, deciding on sexual activity, engaging in consensual relations, making decisions regarding marriage, and pursuing a satisfying, safe, and pleasurable sexual life free from stigma and discrimination (Kismödi *et al.*, 2017).

Reproductive health, on the other hand, is described as 'a state of complete physical, mental, and social well-being' in matters related to reproduction (United Nations General Assembly, 2015). This entails the right to receive accurate information about the reproductive system, manage menstruation hygienically, access services to prevent intimate partner violence, and have access to safe, effective, and acceptable contraception methods (WHO, 2014). Additionally, reproductive health involves accessing appropriate healthcare services for safe pregnancy and childbirth, safe abortion services, and services for infertility prevention, management, and treatment.

Finally, Starrs *et al.*, (2018) emphasise that reproductive rights, building on the recognition of human rights, emphasise the freedom to decide the number, spacing, and timing of children (World Conference on Women, 1996; UNFPA, 2014a). These rights include making reproductive decisions free from discrimination, coercion, and violence, ensuring privacy, confidentiality, respect, and informed consent, and fostering mutually respectful and equitable gender relations (UNFPA, 2014b).

Contraception is defined as 'the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs or surgical procedures' (Jain and Muralidhar, 2011). This thesis, which is centred on contraceptive care, refers to modern contraceptives as defined by the WHO (2018b), this includes oral contraceptives pills, emergency contraception pills, implants,

injectables, patches, vaginal rings, intrauterine devices (IUDs), condoms, surgical methods, lactational amenorrhea method, standard days method, basal body temperature method, two-day method, and symptom-thermal method. In doing so, I reject the usage of 'family planning' given its association with 'choice' paradigms and neo-Malthusian population control, which can exclude adolescent girls (Rodriguez, Say, and Temmerman 2014). Additionally, I acknowledge that contraceptives can have other non-contraceptive health benefits such as reducing maternal mortality and morbidity, preventing STI/HIV infections etc. (Kavanaugh and Anderson, 2013). The emphasis on contraceptive care – as opposed to contraceptive access – was favoured because it encompasses education, information, and resources. As a result, it can view both the use and non-use of contraception as a positive outcome (Senderowicz, 2020; Cadena, Chaudhri and Scott, 2022).

A humanitarian response is national or international action taken in response to a crisis. In the literature, it is sometimes as 'humanitarian action', 'emergency response', 'disaster relief', and 'crisis management' (Eklund and Tellier, 2012, p. 593). When referring to state and non-state actors this thesis includes those who play a hand in designing, and implementing policies, programmes and strategies related to the SRHR of Venezuelan adolescent migrant girls in Colombia. This includes the Colombian government, multilateral organisations such as United Nations (UN) organisations, non-governmental organisations, and civil society actors and coordinated efforts between actors such as committees including The Interagency Group for Mixed Migration Flows (GIFMM in its Spanish acronym). In addition, I include those who play a role in the provision of contraceptive education, resources, and information to Venezuelan young women and girls (see Table 1). Outside the humanitarian response, the providers of SRH might be public or private, as is common in most health systems in lower and middle-income countries (Campbell *et al.*, 2015). Table 1 demonstrates the categorisation of the state and non-state actors that can provide SRH care, education, information, resources, policies, programmes or strategies.

Table 1 Categories of State and Non-State Actors Involved in the Design and Implementation of Contraceptive Care Responses

Category of Actor	Design	Implementation
State actors	• Government ministries including health and social protection, migration and border control • Local government officials (e.g. sub-secretariats of health) • Multisectoral working groups	• Public hospital, health centre, women's health centres, 'family planning' clinics, government pharmacy, public community health worker or other government distributor,

Non-state actors	• Foreign governments • United Nations (UN) agencies • International or national NGOs • Pharmarceutical companies • Philanthropic donors • International NGOs • Interagency groups or humanitarian clusters (R4V)	• Private hospital or clinic, private doctor, private nurse, private health centre • Civil society: NGOs; charitable foundations; not-for profit organisations or faith-based organisations • Pharmaceutical retailers or dispenseries

It is important to address why I use the term migrant throughout this thesis. It is not the purpose of this thesis to explore the legal differentiation between the terms migrant, refugee and displaced persons which has been detailed elsewhere in the literature on the protection of Venezuelan migrant women and girls (Cintra, Owen and Riggirozzi, 2023). However, it is important to acknowledge the debate.

The term refugee is largely defined by the UNHCR 1951 Convention. The 1951 Convention has been heavily criticised for being selective (or discriminatory) application (Crisp, 2001; Gatrell, 2013; Hathaway, 2018). As a result, the 1951 Convention's definition of a refugee was inherently gendered (Piper, 2006). Overall, the 1951 Convention left *some* types of forced migrants eligible for classification as refugees, and left states with the limited responsibility to protect *a few* economic and social rights (Gatrell, 2013; Owen, 2020). The 1984 Cartagena Declaration was a non-binding regional instrument which expanded the grounds[3] of refugee had potential applicability to Venezuelans (Cintra, Owen and Riggirozzi, 2023, pp. 54, 71). Nevertheless, many states have not categorised Venezuelans as refugees, thus limiting their obligations to provide services such as healthcare and social protection (Ibid.). Instead, a new category of 'Venezuelans displaced abroad' was temporarily introduced by UNHCR. The category Venezuelans displaced abroad, which applies to 'persons of Venezuelan origin who are likely to be in need of international protection under the criteria contained in the Cartagena Declaration, but who have not applied for asylum in the country in which they are present. Regardless of status, Venezuelans displaced abroad require protection against forced returns, and access to basic service (UNHCR, 2019a, p. 64). However, as of 2023, the UNHCR no longer uses this term instead referring to 'Venezuelan refugees and migrants' (UNHCR,

[3] This was expanded to include, 'persons who have fled their country because their lives, safety or freedom have been threatened by generalised violence, foreign aggression, internal conflicts, massive violation of human rights or other circumstances which have seriously disturbed public order.'

2023). Since the Colombian government has reported that there is a relatively low number of refugees relative to the number of migrants[4], I have decided to use the term 'migrants' throughout. I recognise that this broad categorisation is far from perfect as it predominately denotes a journey that is free from the poverty, violence and difficulties which have come to be associated with the Venezuelan experience. However, in being so broad it captures all adolescent migrant girls who made the journey.

Adolescent girls, refers to older adolescent migrant girls in line as established by the UN Organisations and the WHO (2021). The WHO (2021) defines adolescents as 10-19 years of age, differentiating between younger (10-14 years of age) and older (15-19 years of age) adolescents. There are several reasons for this decision. Firstly, sexual activity in adolescents at 14 years or below is classified as an early sexual debut and is linked to forced sexual activity and therefore requires different responses (Igras *et al.*, 2014; Lee *et al.*, 2018). Secondly, in lower-middle-income countries (LMICs), young women tend to become sexually active, enter a union, and/or have children between the ages of 15-19 (Sandhya and Jeejeebhoy 2015; Sully et al. 2020). For this reason, I felt that 15-19 struck a balance between being large enough to provide a substantial sample, without generalising between individuals at different developmental stages.

The emphasis on adolescent migrant girls does not imply that other groups are undeserving of similar attention, nor does it suggest that this group is internally homogenous. Instead, it recognises that gendered norms place a greater burden on women and girls to be responsible for contraceptive management (Littlejohn 2021; Brown 2015). Other groups besides women and girls are frequently excluded from responses. The growing literature on masculinity and SGBV demonstrates how men experience different forms of violence during crises (Bearinger *et al.*, 2007; Carpenter, 2016; Ruane-McAteer *et al.*, 2019). (Dis)abled, LGBTQIA+ and indigenous migrants also face distinct forms of violence due to their marginality. To address these here would provide a shallow analysis that would fail to give each group the attention it deserves. Furthermore, it is important to acknowledge that the 'category' adolescent migrant girl is internally heterogenous with differences related to ethnicity, (dis)ability, socioeconomic status, level of education and social networks. Therefore, this thesis should be considered as a leaping off point for understanding the experiences of adolescent migrant girls and the heterogeneity within this group.

[4] From 2017-2022, Colombia granted asylum to 1,289 refugees, 1,224 of which were Venezuelan Estrategia para la integración de la población migrante venezolana como factor de desarrollo para el país.

1.3 Structure of the Thesis

The development of the analysis is structured as follows, in Chapter 1 I have provided the reader with the rationale; the research questions, aims and objectives; and defined the key terms, before now outlining the structure of the thesis.

In Chapter 2 I conduct a review of the literature on politics, gender, international development, feminist demography, anthropology, global health, security studies and migration and refugee studies. This review critically examines how existing literature has approached the consideration of contraceptive autonomy for adolescent migrant girls by various actors. The analysis reveals that while advancements have been made in understanding SRH inequalities during crises, as well as adolescent girls' *voices* and participation, these issues have often remained isolated. The former, instead focuses on 'technical', short-term 'emergency' responses, whilst adolescent participation is rarely discussed in terms of SRH or migration. I then develop a novel conceptual framework called '*The Scale of Voice*,' aiming to bridge the gap in RJ and adolescent participation literature.

Turning to Chapter 3, I outline the methods of data collection and analysis used to answer the research questions. Given the nature of the topic, I felt it best to conduct the study using a mixed methods approach. These included descriptive statistics of health utilisation data and multi-perspective, semi-structured interviews. The former addresses the scale of the inequalities, and the latter delves into the reasons behind the gaps and inequalities. Here, I articulate how these come together to answer each research question, before describing the ethical protocols I undertook.

In Chapter 4, I provide a summary of the context of the case study of Venezuelan migrants in Colombia. Here I argue examining state and non-state provision of contraceptive care to Venezuelan adolescent migrant girls in Colombia as a case study adds a valuable example to the literature on adolescent migrant girls in humanitarian settings, which tends to overlook much of Latin America.

Prior to any analysis, the reader is provided with the context of the normative frameworks at international and national levels which are relevant to the discussion of contraceptive care of Venezuelan migrant girls in Colombia. These include the ICPD Programme of Action, the United Nations Convention on the Rights of the Child (UNCRC), the Minimum Initial Service Package (MISP) for reproductive health in crises and their national iterations in the Colombian National Sexual Reproductive Health Plan (PNSDRSDR), the National Model of Adolescent-Friendly Health Services (*servicios amigables*) and health plans to include the Venezuelan migrant population. Overall, it shows how initially siloed frameworks relating to SRHR, adolescents or migrants have become increasingly progressive, interlinking policies which acknowledge the multiple vulnerabilities experienced by adolescent migrant girls and advocate for a gendered and differentiated approach

which includes adolescent migrant girls so they can realise their SRHRs. Having provided a reader with this context for how actors should be conducting their responses, I then turn to an analysis of if and how actors have responded to the contraceptive care needs of adolescent migrant girls in practice, and how contraceptive autonomy (through voice) has deprioritised in the responses.

In Chapter 5 this thesis begins its substantive analysis, drawing on a secondary quantitative understanding of the numbers of adolescent migrant girls who are accessing services related to contraceptive care. In turn, this highlights inequalities between the migrant and host population and between age groups for the numbers of persons accessing services and the types of services they seek when they receive attention. The findings from this section reveal inequalities between the migrant and host population, and how, on average, these disparities are more pronounced when the age group 15-19 is isolated. In the case of the healthcare provider Profamilia, the results show that differences in the type of healthcare depend on the institution providing the healthcare, and thus may be linked to ease of access to sustainable care. Together these findings are discussed with existing literature to demonstrate that greater attention is needed for adolescent migrant girls.

Subsequently, Chapter 6 attempts to understand the extent to which actors have differentiated their responses to account for the intersectional reproductive realities of the adolescent migrant population. This chapter uses multi-perspective interview data to demonstrate that responses are often driven by short-term, emergency responses which deprioritise sustained access to contraceptive care. It exposes a lack of differentiation in responses, where access to contraceptive care for adolescent migrant girls is often side-lined in favour of 'emergency' or 'short-term' care. The chapter underscores the need for longer-term, holistic responses that consider the complexity of adolescence, migration, and gender, as well as the importance of addressing intersectional reproductive realities.

Chapter 7 aims to understand to what extent adolescent migrant girls' *voices* are included in the decision-making processes. Here, I incorporate the framework of *The Scale of Voice*, to illuminate the ways in which adolescent migrant girls have or have not, been included in state and non-state actors' responses to their contraceptive care. While there is a partial acknowledgement of the importance of giving voice to these girls, the findings reveal that this recognition is often fragmented and limited to short-term, community-based initiatives, neglecting the larger structural barriers to access to contraceptive care. As a result, I determine actors create conditions of constrained agency, rather than autonomous decision-making.

Chapter 8 identifies key challenges and barriers faced by state and non-state actors in engaging with the voices of adolescent migrant girls. This chapter uses key informant interviews to understand the

reasons behind a lack of *voice*. Major themes include a lack of knowledge about appropriate mechanisms, data environment constraints, and a perception that *voice* is not a priority. It is evident that the omission of mechanisms of *voice* is a political decision that prioritises surface-level interventions and maintains the status quo.

Finally, Chapter 9 provides a conclusion and recommendations for actors for future responses in Colombia, and in other humanitarian settings. Building upon that, it demonstrates the utility of this research for academics interested in adolescent SRH in humanitarian or crisis settings. As a final point, it discusses the avenues for further research, which this project has illuminated.

Chapter 2 Literature Review, Theoretical & Conceptual Framework

This chapter offers a review of the literature, demonstrating the current paucity of research on adolescent migrant girls' autonomy in contraceptive care. Thereafter, I address this gap in the literature with a theoretical foundation in RJ and adolescent participation. In the final section, I integrate and expand upon two key concepts—contraceptive autonomy and the ladder of youth participation—to create a conceptual framework known as *The Scale of Voice*. This framework is designed to analyse the modalities and implications of involving adolescent migrant girls in decisions related to their contraceptive care.

2.1 Literature Review

The purpose of this literature review is to explore how different disciplines address actors' responses to adolescent migrant girls' contraceptive decision-making. I examine the literature from biomedical approaches; SRHR; feminist security studies; gender and global health; international development; and reproductive freedom and decision-making. In doing so, I seek to explore how they address three foundational elements of contraceptive autonomy that are central to answering my research question: a) the intersectional reproductive realities of Venezuelan adolescent migrant girls as shaped by gender, age, and migration; b) participation in the decision-making process, c) the opportunity to (not) use a variety of contraceptive methods.

Traditionally, literature has focused on disease-based and risk-averse approaches which focus on supplying access to contraceptive care. Although there has been an increasing integration of SRHR into responses, this has not been comprehensive in humanitarian crisis settings. Furthermore, positivist or risk-averse, disease-based approaches do not address modalities of engagement with adolescent migrant girls. This means that they disregard the conditions in which services are received and hence overlook discussions of autonomy and participation, which are central to this thesis.

Here RJ is an exception because it centres marginalised individual experiences to show how actors' responses can encourage or discourage the realisation of SRHR and reproductive autonomy. By emphasising individuals' reproductive realities, RJ effectively addresses issues such as

intersectionality, participation and the opportunity to (not) use a variety of contraceptive methods. These aspects align closely with the core research objectives of this thesis, to understand how adolescent migrant girls are included and considered by actors. RJ is beginning to expand to cover issues such as age and migration, however contraceptive autonomy in adolescent migrant girls has not yet been discussed. I explain how I build upon, and push the boundaries of this literature, to make a unique contribution by constructing a conceptual framework of *voice* in the remainder of the chapter (Section 0).

2.1.1 The Limits of Biomedical Approaches to Sexual and Reproductive Health Literature

Biomedicalisation involves the integration of technoscientific innovations into medical practices (Clarke *et al.* 2003). This field of study adopts a positivist approach which claims that SRH can objectively measure factors through 'scientific' inquiry, adopting a focus on what is known as 'evidence-based medicine' (Walsh and Gillett, 2011). Biomedical scientists tend to focus on ways to develop treatment and improve health outcomes by changing modifiable factors by using methods of inquiry with the belief that there is an objective reality (Lynch *et al.*, 2021; Schaaf *et al.*, 2022). Such biomedical approaches are, therefore, particularly applicable in primary healthcare or clinical settings, where a patient has an illness or a disease that needs to be treated. For contraceptive care, biomedical approaches are essential to examining the effectiveness of different contraceptive methods, as well as their side effects and risks on populations (Parker *et al.*, 2004; Diez Roux, 2007). However, these biomedical approaches are less straightforward in the context of contraceptive care, where the objective is not to cure a disease but rather to achieve an individual's specific reproductive goals. In such situations, the one-size-fits-all approach of evidence-based medicine may fall short, because the success lies in the ability of the actors to provide care that matches the subjectivity of the individual, that is their individual preferences and priorities, rather than to alleviate pain or disease.

For example, a study by Bahamondes et al. (2018) on Venezuelan migrants in Brazil advocates for an increase in the number of long-acting contraceptives (LARCs) such as subdermal implants and intrauterine devices (IUDs). They argue that LARCs are an 'effective tool' for reducing undesirable health outcomes such as unplanned pregnancy, unsafe abortion, and abortion-related complications as well as maternal mortality. I maintain that Bahamondes et al.'s (2018) research exemplifies the 'technofix' solutions so heavily criticised by decolonial global health and feminist science and technology studies. Technical biomedical interventions often disregard individuals' priorities or

preferences and the extent to which their environment encourages or discourages their ability to realise those preferences (Brian, Grzanka and Mann, 2020). Instead, it is assumed that fertility reduction is a 'win-win' solution, without interaction with individuals to understand their perspective (Ibid). Therefore, they tell us little about whether contraceptive autonomy, as full, free, and informed choice, was fulfilled by providing LARCs.

Increasingly, public health and social epidemiologists have used socio-ecological understandings to link certain health outcomes to certain social, environmental or political factors, showing how these determine future health outcomes (aka, the determinants of health). The Social Determinants of Health (SDH) offers a comprehensive model for understanding the social and structural factors influencing health across various levels, categorised by their causal proximity to a health issue—either upstream and distal (e.g., general socioeconomic and environmental conditions) or downstream and proximal (individual factors) (Egli-Gany *et al.*, 2021). In essence, these approaches are concerned with defining casual relationships between determinants and an elevated risk of poorer health outcomes. Whilst the SDH model can understand social, material and (to some extent) structural factors, it has been criticised for using determinants as proxies for social structure, which fail to understand how elements interact or are reinforced by social practices (Frohlich et al., 2001, p. 781 cited in Herrick and Bell, 2022). Feminists, global health scholars, and social scientists – which I will explore throughout the rest of this literature review – have drawn on such work to challenge the notion that these processes are devoid of politics, instead emphasising their embeddedness in colonial and gendered structures[5] (Shannon et al. 2017; Mason-Jones and Nicholson 2018; Davies and Bennett 2016). They argue that, by lacking a political understanding of power, biomedical approaches are unable to explain in any real depth how forces such as oppression, coercion or autonomy manifest in contraceptive decision-making (Walsh and Gillett, 2011; Storeng and Mishra, 2014; Lynch *et al.*, 2021).

Thus, in this thesis, the limitations of biomedical approaches are identified for two reasons. First, biomedical approaches run short in explaining the structural dimensions of SRHR health inequalities, beyond the individual level. Hence, second, the issue of values, such as justice and autonomy are overlooked, excluding the mechanisms by which marginalised groups participate in decision-making processes to realise their priorities and preferences. These issues are central to explaining adolescent migrant girls' contraceptive autonomy which is at the core of this thesis. There is a need

[5] Colonial and gendered structures refer to processes which uphold the domination, oppression and exploitation of indigenous persons, values, and beliefs by colonial powers.

to examine the power relationships between adolescent migrant girls, and actors at various levels to explore how *voice* as a proxy for contraceptive autonomy is considered and included.

2.1.2 Adolescent Migrant Girls' Sexual and Reproductive Health Rights Without Justice

As aforementioned, the preoccupation of biomedical approaches with evidence-based approaches overlooks discussions of autonomy and participation in decision-making. These limitations in biomedical literature have, in part, been addressed by developments which have increasingly focused on the social determinants of health in relation to SRHR. Yet, choice, enacted in a SRHR sense, is still narrowly construed as the focus is on access, and providing technical solutions that increase access or avoid risk, rather than on issues of inclusion and *voice*. Consequently, they focus on how actors can increase access to services, as opposed to whether the services are appropriate for, and desired by, adolescent migrant girls, the latter of which is inherently linked to contraceptive autonomy, and hence RJ. Access-centred approaches to SRHR have three main limitations. First, they are focused on individual rights without due attention to the spaces within which, nationally and internationally, the application of rights has been shaped by conservative ideologies. Second, in doing so, SRHR alone ignore that choice and access are stratified along intersectional axes of oppression by race, gender and coloniality. Third, this means that migrant women and girls, especially in the Global South, are often not afforded autonomy in the responses to their SRH in humanitarian crises.

A rights-based approach is used to describe any approach which uses the international human rights framework as a normative basis to inform its practice (UN Sustainable Development Group; Hunt, 2016). In terms of SRHR, rights-based approaches centre on the obligations first articulated in the 1994 International Conference on Population and Development (ICPD) which formalised rights related to reproduction including (a) All couples and individuals have the right to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so; (b) Decisions concerning reproduction should be made free from discrimination, coercion and violence (UNFPA, 2014a). The ICPD emphasised the rights of individuals to hold decision-making power to achieve their reproductive intentions. State actors have an obligation to provide the resources to respect, protect and fulfil those rights (Brown *et al.*, 2019). The ideas raised here, are central to those later developed in the discussion of contraceptive autonomy: full, free, and informed choice. Although, as I will continue to demonstrate, rights alone do not provide the conditions for contraceptive autonomy.

Literature on migration and SRH for adolescent migrants and refugees has seen the adoption of a rights-based approach to focus singularly on access and barriers to access. The table below (Table 2) shows the barriers identified in existing research and reviews of both peer-reviewed and grey literature. I categorised these barriers into the following: those rooted in individuals' experiences in migrant host societies (such as limited SRH knowledge or poverty), issues stemming from the societal dynamics within migrant or host communities, challenges within the health and social care systems of the host country, and political or legal structures that create formal barriers to access.

Table 2 Author's Compilation of Existing Literature on Barriers Affecting Adolescent Migrant Girls Seeking Care Related to Their SRHR.

Level	Barriers Shaping Accessing to SRHR	Evidence in the Literature
Individual barriers	• Experience of SGBV and trafficking • Risky sexual behaviour • Lack of knowledge of SRH • Lack of information on how to navigate the health system • Poverty	(McMichael and Gifford, 2009; Irani, Speizer and Barrington, 2013; Ivanova, Rai and Kemigisha, 2018; Ganle *et al.*, 2019; Col *et al.*, 2020; Endler *et al.*, 2020; Jones *et al.*, 2020; Alatinga, Allou and Kanmiki, 2021; Bwambale *et al.*, 2021; Korri *et al.*, 2021)
Socio-cultural barriers	• Misinformation and myths • Sex as taboo • Lack of trust • Religious beliefs • Partner/ family influence	(Irani, Speizer and Barrington, 2013; Metusela *et al.*, 2017; Ivanova, Rai and Kemigisha, 2018; El Ayoubi, Abdulrahim and Sieverding, 2021)
Systemic barriers	• Lack of training for health workers • Discriminatory towards migrant girls' attitudes/behaviour • Lack of trust between migrants and workers • Lack of resources • Funding limitations	(Mengesha *et al.*, 2017; Meyer-Weitz, Oppong Asante and Lukobeka, 2018; Jennings *et al.*, 2019; Tirado *et al.*, 2022)

Political or legal barriers	• Permits/documentation • Lack of policies for migrant health • Lack of research • Lack of political will	(Ivanova, Rai and Kemigisha, 2018; Mason-Jones and Nicholson, 2018; Tirado *et al.*, 2020; Nowshin *et al.*, 2022)

To detail one example, a multi-country study on family planning in refugee settings found women aged 20–29 years were significantly more likely to be aware, to have ever used or be using a modern method as compared to adolescent girls aged 15–19 years (Tanabe et al., 2017). Despite availability, Tanabe et al. (2017) found that across all the sites studied adolescents reported many accessibility-related barriers to using existing services, including distant service delivery points, cost of transport, and a lack of knowledge about different types of methods. On the supply side, the authors found services often lacked a variety of methods or that consultations were too short to lead to informed decision-making. This evidence suggests that displaced adolescent girls face additional barriers and provides potential insights into technical solutions such as improving the number of service points, methods available and education initiatives. This brings us to the first limitation of SRHR-based approaches to studying health inequalities – they do not account for context. They also fail to engage with the power relations caused by the intersectionality of age, migration, and gender.

Returning to the limitations applying to Tanabe's study of the literature as an example. First, they are focused on individual rights without due attention to the spaces within which, nationally and internationally, the application of rights has been shaped by conservative ideologies. In the case, of Tanabe et al. (2017) and the other authors cited in Table 2 they overlook the fact that shortages in contraceptive care provision or policies that create unequal access are largely spurred on by religious conservative ideologies in the West, like in USA, that consider adolescent SRH provision immoral. From an RJ perspective, it is essential to acknowledge these wider political structural forces which prevent contraceptive autonomy so that they can be dismantled.

Tanabe's study lacks the insight so clearly expressed by Girard and Waldman, (2000, p. 167). Girard and Waldman, (2000, p. 167) demonstrate how state obligations from rights-based documents, are situated within the eco-system of non-state actors and how both are influenced by ideological, cultural or moral reflections. This means that 'many of the most needed and simplest reproductive health interventions for refugees, such as emergency contraception or condom distribution to adolescents, remain mired in ideological controversies' (Ibid.).

Latin America is an excellent example of how generalist rights-based approaches to SRHR fail to account for ideological forces. Elgar (2014) argues that democratisation combined with existing Catholic influences has led to the promotion or blocking of access to reproductive services. Providing a broader more nuanced understanding, Htun argues that 'the political institutionalisation of religious authority, not religious denomination or religiosity alone' is the key factor for shaping women's rights on doctrinal issues (Htun 2018).

RJ approaches instead argue that rights need to be viewed in terms of the wider structures of 'reproductive governance', which refers to the ways in which governments, institutions, and actors exert control over various aspects of reproduction (Morgan and Roberts, 2012). This includes policies, practices, and interventions that influence individuals' decisions, behaviours, and access to reproductive health services. It demonstrates the need to understand complex power relations that influence reproductive decision-making at multiple levels taking into account contextual factors such as culture, religion, and politics. Therefore, it enhances analysis by going beyond identifying specific policies, to understand how types of policy become normalised. By drawing attention to previously overlooked studies of reproductive governance, RJ approaches can consider how power relations operate during contraceptive decision-making and begin to tackle ideological forces which continue to divert contraceptive autonomy choice away from women and girls.

Two, generalist approaches to SRHR, fail to consider the heterogeneity of culture, social and religious norms, and the histories of intersectional oppression of different populations based on those differences (a theme which I return to throughout this review). This involved promoting anti-natalist policies for some groups whilst pursuing pro-natalist policies for other groups. For example, twentieth-century programmes of contraception and sterilisation are heavily bound up with eugenic ideas of creating 'perfecting the human race' in relation to African American and Native women in postbellum U.S.A., as well as in twentieth-century Finland and Peru (Getgen, 2009; Connelly, 2010; Ross and Solinger, 2017). The authors listed in Table 2 frequently mention that certain barriers or health outcomes are more likely to be experienced by adolescent migrant girls, but few acknowledge how the structures of age and migration interact and reciprocally reproduce to make new intersecting axes of oppression.

Thirdly, this means that groups such as adolescent migrant girls, especially in the Global South, are often not afforded autonomy in responses to their SRH in humanitarian crises, which I will return to later (in subsection 2.1.5). In the case of migration literature, viewing women and girl migrants as 'passive victims', incapable of making decisions, limits their autonomy (Bastia *et al.*, 2022). In this

sense, some RJ advocates have maintained that SRHR as a legislative body of rights, cannot be substituted for bodily autonomy (Singer, 2019).

Overall, rights offer a shared language for advocacy, but one that is heavily dependent on how rights are interpreted by governing bodies. Going beyond rights, justice demands favourable conditions positioning marginalised individuals and groups as holding the power to make decisions on and realise their rights. I return to these three criticisms: structures of governance; intersectionality and frames of 'passive' women and girls, throughout the remainder of this literature review. This demonstrates how literature from the adjacent fields of global health security, humanitarianism and international development has historically excluded adolescent migrant girls from their responses. Following this, I address what efforts have been made to include adolescent migrant girls, and how RJ scholars have revealed new understandings of contraceptive autonomy and coercion. Finally, show how I bridge these two strands of literature to examine how actors consider and include adolescent migrant girls' contraceptive autonomy in response.

2.1.3 Global Health Security and Governance

SRHR and contraceptive autonomy, in terms of global health security, means avoiding threats such as communicable diseases or physical violence. Consequently, authors from this strand of security studies focus on removing obstacles that threaten decision-making, rather than the ability to participate in decision-making. In other words, they focus on 'freedom from' rather than 'freedom to'. Security and governance have focused on bodily integrity as *freedom from* acts to which they do not consent (Patosalmi, 2020; UNFPA, 2021). Whilst this is essential for the fulfilment of SRHR and RJ, there is a need to go beyond bodily integrity to secure autonomy for adolescent migrant girls. Regardless of their age, migration or gender, it is fundamental that we go beyond risk-based concepts like bodily integrity to advocate for reproductive, and contraceptive, autonomy.

The central frame through which security studies understand global health is that 'x' is a threat/risk to a referent object in respect to which we must put defensive/protective measures in place (McInnes *et al.*, 2012). 'Global health,' in general, considers the health needs of the people of the whole planet above the concerns of particular nations (Brown et al. 2011). As stated in the 1946 Constitution of the World Health Organisation (WHO) claimed that the 'health of all peoples is fundamental to the attainment of peace and security', before identifying inequality in health promotion and disease control as a 'common danger' (Nunes, 2014). Following the broadening of the conception of security to include global health, the subsequent field of thought termed 'global

health security' was created. According to Davies *et al.*, (2014) security scholars and professionals' interest in global health can be attributed to three reasons. Firstly, a renewed sense of crisis due to an increase in communicable diseases in the 1990s and early 2000s. Secondly, a sense of failure that the 'worldwide poor' remained at a disproportionately higher risk of disease. Lastly, the recognition that globalisation had impacted health and political relationships so that new styles of governance (not of, but for) health were required. Central to this school of literature is how to avoid the risk of harms such as disease or violence.

Securitisation of SRH has also focused on contraceptive care to prevent the spread of sexually transmissible communicable diseases such as HIV (Howell, 2014; Sekalala and Harrington, 2020). Consequently, in 2000 the UN Security Council declared HIV/AIDS a threat to peace and security in Africa (Elbe, 2006).

Viewing SRH through the lens of global health security is advantageous because it removes reproductive health as a 'women's matter' typically associated with the private sphere or 'low' politics onto the national and international community's agenda. Subsequently, SRH has been understood as a matter of international and personal security. The political implications of this include the promotion of issues of SRH such as sexual and gender-based violence (SGBV) in the Women, Peace, and Security Agenda and the G7 commitments to adolescent SRHR in crises (Cahn, 2018; Lucas, 2019, p. 21).

However, the 'securitisation' of health has had detrimental consequences for the access to health for migrants. In terms of migrant health, 'securitisation' has led to the restriction of access to health services for migrants over fears they will threaten the supply of services available to the host population (Voss, Wahedi and Bozorgmehr, 2020). This approach prioritises the host population over the needs of migrants, overlooking the obligations to provide healthcare or rights. Policies for migrants' healthcare are more forthcoming when they concerns communicable diseases which have the potential to spread to the host population (Voss, Wahedi and Bozorgmehr, 2020). However, they are usually less forthcoming in matters that promote responses for non-disease-related healthcare such as contraceptive autonomy.

In this way, securitisation presents a limited view of SRH that justifies contraceptive care only in relation to disease outbreaks such as HIV. Considering the intersectional reproductive realities of adolescent migrant girls, the 'securitisation' of SRH is limited because it focuses on national, and

global, populations as opposed to individuals. Such approaches thus use a top-down approach that uses threats of harm as an excuse to overlook the rights of individuals.

Feminist security scholarship has conceptualised the 'securitisation' of SRH at an individual level (Pierson, 2023). Personal security has been conceptualised through concepts such as bodily integrity. Whilst security studies are primarily concerned with the health of populations, feminist security studies have focused on how global health governance might affect their personal security. The idea is that the security of some largely relies on the insecurity of others (Nunes, 2014). Feminist global health security studies see a crucial link between personal (in)security and bodily integrity. Bodily integrity is important to discuss because there is considerable overlap between bodily integrity and autonomy. In some cases, when bodily integrity is defined broadly to include the ability to freely choose, the lines between the two concepts are blurred (Nussbaum, 2008). However, in this thesis, I make a clear distinction between the two. Bodily integrity is understood as 'the right to security in and control over one's body' (Corrêa, Petchesky and Parker, 2008). Bodily integrity relies on liberal political understandings of negative freedom and personal inviolability (Patosalmi, 2020). For this reason, bodily integrity is especially illuminating in discussions of sexual violence or harmful practices (Patella-Rey, 2018; Higashi, 2023). On the other hand, bodily autonomy necessitates being the primary decision-maker concerning one's body, making a violation of bodily integrity indicative of a lack of bodily autonomy.

This research has significantly advanced our understanding of how gender and individual women's bodies are intricately linked to security matters, with a central focus on the importance of women and girls having control over their bodies. This has led to calls from scholars such as Thomson and Pierson, (2018) to advocate for the inclusion of a wide range of topics like contraception and abortion into the WPS Agenda. They argue that as the current security agenda stands, selective approaches are incompatible with RJ approaches that view SRH as a spectrum of issues, connected to broader issues of equality, justice and health (Fried, 1990 in Thomson and Pierson, 2018). This criticises the narrow foundation of any SRHR response that prioritises violence or 'freedom from' as opposed to focusing on the 'freedom to' access comprehensive care and participate in decisions about contraceptive care to realise one's priorities and preferences.

2.1.4 Intersectionality in Humanitarian Crisis Response

Intersectionality, as I mentioned, has shaped how adolescent migrant girls are included and considered in contraceptive care responses. Where humanitarian solutions have sought to address

SRHR, their approach has been selective and has overlooked aspects such as intersectionality, mechanisms of participation and inclusion, and the opportunity to (not)use a wide variety of contraceptive methods.

Traditional humanitarianism aims to alleviate the suffering of individuals, regardless of national boundaries or social groupings (Andrew, 2010; Colombo and Pavignani, 2017). Humanitarian approaches are underpinned by the basic humanitarian principles of humanity, impartiality, neutrality, and independence (UNHCR, 2019b). Humanitarian crises include natural disasters, conflict, displacement, and disease outbreaks. Organisations such as the International Committee of the Red Cross, the Bill and Melinda Gates Foundation, Doctors Without Borders (MSF), UN agencies such as the Office of the United Nations High Commissioner for Refugees (UNHCR) and United Nations Population Fund Technical (UNFPA), World Health Organisation (WHO) International Organisation for Migration (IOM) to name a few. This network, also known amongst development scholars as the 'international community,' is a complex and fragmented network of non-state actors, who play a pivotal role in shaping the response to adolescent migrant girls in humanitarian settings.

In the 1990s, traditional forms of humanitarianism characterised by problem-solving notions of emergency and leading needs-based relief were criticised by scholars identified with ‘new humanitarianism’ (Fox, 2001; Donini and Gordon, 2015). One critique of traditional humanitarianism was that it portrays recipients of aid through the lenses of deservingness and victimhood. This criticism, notably articulated by Harrell-Bond, redefines humanitarian action as a form of charity or gift-giving (Harrell-Bond, Voutira and Leopold, 1992; Harrell-Bond, 2002). In her critique, Harrell-Bond (2002) contends that humanitarian action tends to be influenced by perceptions of the deservingness or merits of the recipients. Who is deserving is often the result of dichotomous categorisations of refugee, migrant, and internationally displaced peoples as ‘good’/’bad’, ‘deserving’/‘undeserving’ (Hamlin, 2021). So that the provider possesses the power to decide who is entitled to services (Harrell-Bond, 2002). Through the earmarking of assistance, donors wield the power to define the broad category or nationality of beneficiaries. Further power can be exerted by fieldworkers who distribute material supplies to individuals.

Rights-based approaches posed a promising solution to this issue because they positioned recipients as rights-holders entitled to healthcare, protection and other basic services (Harrell-Bond, 2002). Therefore, they possessed a higher capacity to acknowledge individuals’ priorities and preferences, evoking a responsibility to ensure that these are taken into account when making decisions. Inspired by liberal political agendas in the Global North, ‘new humanitarianism’ is characterised by a rights-

based approach to humanitarianism, more explicitly linked to a goal-orientated, long-term, sustainable approach to crisis response (Chimni, 2000; Heidari, Onyango and Chynoweth, 2019).

Whilst broadening the agenda, 'new humanitarianism' remains the subject of much critique – especially from global health anthropologists and feminist international politics. As I will discuss they continue to silo responses, overlooking intersectionality and deprioritising vital services like contraceptive care services. In maintaining unidirectional top-down, 'technical' solutions, they fail to include and consider adolescent migrant girls as decision-makers capable of contraceptive autonomy. However, anthropological and international relations approaches to humanitarianism have continued to illuminate the inherently political nature of agenda-setting and response design in global health and humanitarian contexts (Redfield, 2005; Binder, 2009). Binder (2009) refers to a 'selectivity gap' demonstrating how the international community responds to crises to different extents using various types of interventions. Taking the empirical cases of Northern Iraq, Somalia, Bosnia, and Kosovo compared to other similar cases like Angola, Congo, Kurdistan, Chechnya, Darfur, and Myanmar, Binder (2009) contends that the former cases, the international community took stronger action than in the latter cases as it served their interests.

This critique is extended by the concept of structural violence, which aims to reveal hierarchical power relations of oppression and privilege that shape individual suffering during disease outbreaks (Galtung, 1969; Farmer, 2004). Hierarchies which privilege humanitarian and development categories, serve to reinforce colonial mechanisms of control and maintain health inequalities. Critiques such as donors controlling resources have persisted (Harrell-Bond, Voutira and Leopold, 1992). Donor preferences play a pivotal role in selecting the foci of responses, leading to cases like 'HIV exceptionalism' in Sierra Leone (Benton, 2015). Treating some conditions and not others, created 'siloed' interventions, favouring 'HIV-positive' individuals (Ibid.). In the case of Ebola, the international community favoured the provision of direct aid rather than investing in training local doctors or strengthening health systems as 'international health experts deemed [these actions to be] uncost-effective' (Farmer, 2020). These 'technical' responses are in many ways immune from the criticism of non-medical experts, as such failing to implement local knowledge (Colombo and Pavignani, 2017). Benton (2015) coins the term 'aid colonialism' to describe the practice of donors withholding resources from governments that do not align with the donors' priorities. Thus, 'aid colonialism' allows the international community to implement their agendas in countries by offering aid whilst maintaining influence over that region.

Humanitarianism has also been criticised for focusing on emergency or 'urgent care' over gender and intersectionality. In reference to Foucauldian biopolitics, whereby populations are regulated by state and non-state actors, structures of humanitarian governance that focus on supplying the bare minimum for survival have been termed 'minimalist biopolitics' (Foucault, 1990; Redfield, 2005). Similarly, the concept of the 'tyranny of the urgent', argues that actors set aside structural issues in favour of addressing immediate biomedical needs (Smith 2019; Davies and Bennett 2016; Watson and Mason 2015). Crucially, the latter acknowledges that gender and intersectionality are often absent from response. The 'urgent' is conceptualised relative to 'later', with 'later' referring to the 'patriarchal time zone' where women are asked to put their hopes on hold for 'the greater good' (Enloe 2004, 215). As such the 'tyranny of the urgent' demonstrates how the rights of marginalised groups and intersectional experiences fail to be upheld by responses that neglect social dimensions of gender and individual experiences (Smith 2019). Even if the aim is to 'save lives', overlooking structural aspects such as gender is to accept that some parts of the response will fail to reach women and girls (Eklund and Tellier, 2012, p. 593). As a result, actors' responses are framed in 'single-axis' terms which discount gendered forms of oppression experienced by the intersections of age, migration, and gender (Laurie and Petchesky, 2008; Singer, 2019; Bastia *et al.*, 2022). In turn, they make those at the intersections invisible and fail to consider how these complex power relations might affect the realities of migrant women and girls and the responses to those realities.

Rights-based approaches to humanitarianism involve ensuring rights are a focus (DuBois, 2018). A rights-based approach is often linked to the needs-based approach given that the fundamental necessities crucial for life-saving aid, such as food, water, and medicines, are inherently tied to human rights (Fox, 2001, p. 283). In terms of adolescent migrant SRH, these developments have led to the establishment of the Inter-agency Working Group on Reproductive Health in Crises (IAWG) in 1994 and later the Minimum Initial Service Package (MISP). These developments demonstrated a commitment to merging the humanitarian principles with the ICPD commitments to SRHR (Heidari, Onyango and Chynoweth, 2019).

The combination of rights and needs has resulted in an international community of actors with ill-defined and overlapping commitments (Gilbert, 1998; Chimni, 2018; Crisp, 2018). There have been claims by refugee scholars such as Chimni (2000) that the rights-based language has been used to justify a range of questionable practices in the governance of displaced persons. Other critiques maintain the 'rights-based' language used by organisations such as the UNHCR is 'confusing' and

does not reflect the reality of assistance, which is oriented towards needs (Stevens, 2016, p. 2). This is acutely felt in the realm of SRHR and the implementation of MISP.

MISP aims to define which SRH services are the 'most important' in preventing morbidity and mortality while protecting the right to life with dignity, particularly among women and girls, in humanitarian settings (IAWG, 2021). Creating tension with the idea of SRHR as interdependent, interconnected and indivisible (Yamin, 2020), MISP has been implemented unsuccessfully in Haiti (2010), Kenya (2008), Indonesia (2005), Chad (2004) and Pakistan (2002/3) due to a lack of awareness about MISP, a lack of human resources, poor logistics and poor coordination (Onyango, Hixson and McNally, 2013). These findings strongly support evaluations of MISP implementation in Colombia, which is inconsistent and lacks coordination which I discuss in greater depth in Section 4.3.2 (Profamillia, 2019). In addition to these issues, MISP has been criticised for its failure to adequately include issues of contraception and adolescent SRH (Onyango, Hixson and McNally, 2013; Singh *et al.*, 2018). The new 2018 package has been further criticised for being too vague (Tran and Schulte-Hillen, 2018). Therefore, whilst well-intentioned, MISP has not had the effect it desired on SRH in humanitarian settings. The findings from these studies demonstrate the lack of sufficient policies and guidance continues to be a barrier to the provision of comprehensive SRHR care (Tazinya *et al.*, 2023). In particular, the appeals to priority care, at the expense of adolescent care, demonstrate how the intersectionality of age, gender and migration is side-lined.

In short, the shift from traditional forms of humanitarianism to 'new humanitarianism' continues to be plagued by issues of selectivity and urgency. These fail to capture the intersecting reproductive realities of women in the Global South, and in particular of adolescent migrant girls. Consequently, while some authors, like Sully *et al.*, (2020), highlight how narrowly conceived humanitarianism leads to gaps in essential services such as adolescent-friendly services and contraceptive care, adopting an intersectional approach enables us to explore whether and how actors deliver their responses to match the complex contraceptive care needs of Venezuelan adolescent migrant girls in Colombia.

2.1.5 Participation in Decision-Making in International Development

Early development literature and policies predominantly emphasised 'family planning' as a vehicle for progress, often excluding the participation and voices of marginalised groups. These frames relied heavily on the narrative of actors in the Global North providing solutions to helpless women and girls in the Global South who were often framed as 'passive recipients' of aid. In doing so, they

too overlooked intersectionality and failed to include mechanisms of participation and feedback in their responses.

Traditional development theories focused on the 'modernisation' of women in the Global South preferred technological fixes. In the paradigm of Women in Development (WID) during the 1970s, development was primarily viewed through the lens of economic progress, away from poverty (Rathgeber, 1990). Conversely, the Gender and Development (GAD) framework of the 1990s approached development by examining the outcomes tied to the position of women relative to men (Rathgeber, 1990; Jaquette, 2017). Mainstream development saw 'frequent pregnancies and malnutrition' as key barriers to women's economic empowerment (Maguire 1984, p.13 in Rathgeber, 1990). The solution to overcoming these barriers included schemes to provide 'family planning,' microcredit and the provision of sewing machines (Sholkamy, 2010). 'Family planning' as a means of controlling and regulating fertility, was devised in the early 19th century as a hybrid of women's empowerment spearheaded by Margaret Sanger and neo-Malthusian population control (Senderowicz and Maloney, 2022). Advocating for 'birth control', Western feminists advanced the claim women should have control over their bodies through 'family planning'; as this would increase their social, political and economic opportunities (Chesler, 2007; Critchlow, 2010). While the notion of 'family planning' was indeed empowering for some, the coercive nature of 'family planning programmes' became pronounced among marginalised groups. For example, the refusal of services to unmarried individuals, such as adolescent girls makes their sexuality invisible (Braeken and Rondinelli, 2012; Barroso, 2014; Rodriguez, Say and Temmerman, 2014). More overt practices included forcing the sterilisation of poor or indigenous women (Getgen, 2009; Chaparro-Buitrago, 2022). Thus, coercion stemmed from the implementation of programmes without providing groups the opportunity to actively participate in decisions.

Postcolonial approaches to development illustrated how the North-South dichotomy portrayed women in the South as 'victims' in need of 'help' from the North (Jaquette, 2017; Mohanty, 2019). This reflected the humanitarian discourse that women and girls in crises, especially the Global South or 'refugee women', are one homogenous group 'in need' of saving and 'grateful' for any aid to be given (Harrell-Bond, 2002; Crawley, 2022). Development came to be cast as a moral as well as an economic endeavour, famously described by Gayatri Spivak (2015) as 'white men rescuing brown women from brown men'. This unilateral provision of technical assistance from the Global North to the Global South, in which recipients were voiceless and passive (Malkki, 2005; Sigona, 2014). Women and children, or 'womenandchildren', from the Global South are often seen as the ideal

'passive victims' of Western aid (Enloe, 1993; Spivak, 2015). In fact, it is because they are associated with powerlessness or the inability to act that they are considered more deserving than those who are traditionally cast as perpetrators of violence (Mikdashi, 2014; Crawley, 2022). One study of actors found that non-state actors such as civilian protection advocates felt that framing claims in terms of 'women and children' is more attractive to global media, transnational networks, and partners in the international women's network (Carpenter, 2005). This thesis builds on the critique of seeing women and girls as 'passive' or 'incapable' of decision-making.

Through a decolonial perspective, development aid has been shown to perpetuate colonial logics (Gautier *et al.*, 2022). Here, the preference for 'technical', and 'expert' knowledge over local native knowledges evokes the dichotomous hierarchies 'modern/traditional, civilised/barbaric, Western/non-Western, us/them, developed/undeveloped' that has sustained the domination, oppression and exploitation of indigenous populations (Mignolo, 2007; Quijano, 2007). Inevitably, when some aspects of responses are privileged, others are left unaddressed. Applying these ideas to our study, it has been demonstrated that Western, medical, and modern epistemologies frame 'giving birth' as a biomedical process that can be safely controlled by humans through 'family planning' (Gautier *et al.*, 2022, p. 186). As a result, technical approaches to 'family planning' exemplify Western colonial logic (Ibid.). These, I argue, provide a narrow focus that excludes efforts to create autonomy-enhancing conditions.

One of the most notable examples of the danger of viewing 'technical' SRHR interventions in isolation without considering autonomy is the Darfur firewood case. To prevent the sexual violence experienced by women and girls when collecting firewood, United Nations (UN) agencies and international non-governmental organisations (INGOs) provided refugee and internally displaced persons (IDP) camps with gas stoves, in an attempt to negate the need to leave the camp to collect firewood (Patrick, 2007). However, women and girls still left the camp to collect firewood – in part because selling excess firewood was their only source of income inside the camp (Patrick, 2007). Another solution offered was armed guard patrols, so women did not have to be alone during collection. However, women and girls were often hesitant to have the guards, who often perpetrated the violence, accompany them on their patrols. In other words, attempts to provide 'technical' solutions failed because they did not consider the reproductive realities in which migrant women and girls were living. Efforts to include women and girls in decision-making through direct participation and women inside the camp resulted in systemic consultation in the day-to-day

running of the camp, and the development of gender-sensitive responses such as women-led fire patrol (Gururaja, 2000; Laurie and Petchesky, 2008).

Contraceptive autonomy falls outside what Chaudhuri *et al.*, (2021) refer to as 'metrical logic'. Global health literature on the politics of responses shows that indicators, although appearing neutral, are political in their design. Here, research argues state and non-state actors have generated metrics (used to measure the success of a response) in a way that (re)produces Euro-centric knowledge structures (Andrew, 2010; Benton, 2015; Adams, 2016; Davies and Bennett, 2016). Like biomedical and medical humanitarian approaches, these metrics emphasise 'technical' responses, devised by medical 'experts' who are in many ways immune from the criticism of non-medical experts (Colombo and Pavignani, 2017). Thus, responses which focus on metrics, targets and indicators rarely challenge the notion of adolescent girls in the Global South as 'passive recipients of aid'. However, RJ scholars have begun to challenge concepts such as family planning and the unmet need for contraception (Rodriguez, Say and Temmerman, 2014; Nandagiri, 2021; Senderowicz and Maloney, 2022).

Implicit assumptions in metrics like 'unmet need for contraception' perpetuate colonial logic because they are based on Western assumptions about pregnancy and motherhood. For example, if women are not planning to become pregnant, they are actively avoiding pregnancy and thus 'need' a method (Senderowicz and Maloney, 2022). The imposition of these measures on women is said to (re)produce 'colonial narratives of disempowered women' (Senderowicz and Maloney, 2022, p. 690). Following this Nandagiri, (2021) has argued that goals tied to fertility reduction such as the Millennium Development Goals, the Sustainable Development Goals, and the Family Planning 2020 Programme, instrumentalise the use of family planning in a way that directly contests individual autonomy. Instead, she argues that there needs to be a greater departure from 'family planning' towards contraceptive autonomy.

Drawing on this pivotal work to highlight the way that development has discounted the reproductive realities, preferences, and priorities of women, I build upon and push this literature to understand how these ideas can be applied to adolescent migrant girls whose inclusion is at times implicit through discussions of 'women and girls' but whose autonomy rights to participate in decisions has rarely been discussed in terms of contraceptive care.

2.1.6 Approaches to Participatory Methods for the Direct Inclusion of Adolescents in Decision-Making Responses During Crises

A review of youth participation literature shows that there are several different methodologies to incorporate young people into decision-making roles. Most of this work has been done as part of Community-Based Participatory Research (also known as CBPR). CBPR is broadly understood as research that is designed to ensure the participation of all relevant stakeholders in different aspects of the research process (Cornwall and Jewkes, 1995). The purpose of CBPR is to build relationships between researchers, health providers, community members and other relevant stakeholders to improve patterns of healthcare utilisation (Dulin *et al.*, 2011). CBPR can include methods such as Youth Participatory Evaluation, in which youth and relevant stakeholders come together to conduct interviews and focus groups or other methods of data collection to monitor and assess the facilities which are designed to serve them (Checkoway and Richards-Schuster, 2004; Flores, 2007; Villa-Torres and Svanemyr, 2015). Equally, Community Youth Mapping has been used as another method of CBPR which can use interviews, focus group discussions and observations to situate adolescent SRH within the community context. That is, how adolescents use facilities, social and cultural norms, and key stakeholders. This method is useful because it reflects on the priorities and preferences of adolescents – how often they go to certain spaces and which providers they are aware of and in contact with (Villa-Torres and Svanemyr, 2015). In turn, providing a greater understanding of the reproductive realities of adolescents, before implementing responses – instead of attempting to act based on assumptions.

Much of the literature focuses on arts and theatre-based interventions such as performance arts, digital platforms and photovoice (MacDonald *et al.*, 2011; Taggart *et al.*, 2016). These methods are preferred because they position adolescents as the creators, allowing them to convey their understandings of health-related concepts outside of the 'adult worldview' (Buthelezi *et al.*, 2007; MacDonald *et al.*, 2011). Including other young people can also help break down normative constraints of the 'adult worldview'. Peer education methods have also been discussed as an effective method of intervention in the community (Roth and Brooks-Gunn, 2003; Benton *et al.*, 2020). Examples could include the well-known Big Sister scheme or Girls Clubs which provide education and support to adolescents (Roth and Brooks-Gunn, 2003). Schemes can be integrated as part of wider community or arts-based interventions (Taggart *et al.*, 2016). Peer education methods have benefits not only for those who receive information but also for the adolescents or youth

people who deliver information (Fisher *et al.*, 2019). This can also help overcome barriers like distrust of adult educators (Ibid.).

Considering the focus on adolescent migrant girls in this thesis, one key issue is a lot of the youth-participation examples provided were set in schools or other formal settings (Fisher *et al.*, 2019; Dickson *et al.*, 2023). However, migrants, refugees and other out-of-school groups do not benefit from this type of response. Estimates suspect that 28% of Venezuelan migrant children are not attending school – instead engaging in informal work to alleviate poverty (Plan International, 2021). So, relying on school-based interventions means that Venezuelan migrants or other marginalised groups are missed from such responses, thus reinforcing their marginality.

Most interventions were found to largely focus on risk prevention in sexual behaviours such as the prevention of STIs including HIV/AIDS or the prevention of adolescent pregnancy (Buthelezi *et al.*, 2007; Cook, 2008; Taggart *et al.*, 2016; Simuyaba *et al.*, 2021). As a result, fewer interventions engaged with adolescent SRH positively (Goicolea *et al.*, 2010; Braeken and Rondinelli, 2012). This means that the interventions do not positively develop skills or understandings of adolescents' own sexuality or healthy relationships (Haberland and Rogow, 2015). Morgan (2001) highlights the tension between standardised, pragmatic approaches that are easily operationalised, but which include very little participation and are ill-suited for the local context in which they are implemented.

Consequently, very little is known about the efficacy of youth participation interventions in SRH (Cook, 2008). It is also difficult to measure the quality of adolescent and youth participation interventions. In an attempt to address this gap, Tiffany, Exner-Cortens, and Eckenrode (2012) developed a quantitative measure for assessing youth participation in SRH, but as noted by Villa-Torres and Svanemyr (2015) further testing is needed to ensure its applicability. Their scale, the Tiffany-Eckenrode Programme Participation Scale (TEPPS), attempts to measure theoretically significant characteristics of programme participation. Participants are asked how long they had been involved with the programme and the extent to which measures were true (Tiffany, Exner-Cortens and Eckenrode, 2012). From the 20-item scale, the below shows the measures included for 'personal involvement' and 'voice/influence':

- The programme's activities are challenging and interesting.
- I think that participating in the programme will help me to continue my education.
- I learn a lot from participating in the programme.
- Staff at the programme pay attention to what's going on in my life.

- I think that participating in the programme will help me to get a job.
- Adults at the programme respect me.
- Adults in the programme listen to what I have to say.
- I help decide things like programme activities or rules.
- I feel I have a lot of voice/power to influence decisions about the programme.
- It was easy for me to get involved in the programme.
- I am very involved in programme activities (Tiffany, Exner-Cortens and Eckenrode, 2012, p. 286).

Despite acknowledging the importance of voice, the scale of programme participation developed by Tiffany, Exner-Cortens and Eckenrode, (2012, p. 286) shows limited engagement with theoretical concepts of voice, power, participation and inclusion. As an extension of their failure to engage with concepts theoretically, they also disregard crucial aspects often overlooked in biomedical literature. Namely, they depoliticise the concepts, and fail to enquire what it means to truly 'have a voice'. Subsequently, their scale of participation, inclusion, and voice remains distant from concepts such as intersectionality or participation. Concepts which I have identified as lacking in dominant approaches to adolescent migrant girls' contraceptive care in the preceding sections of this literature review.

Even less is known about the effectiveness of adolescent participation in SRH in humanitarian settings. This is because in general there is a lack of research on adolescent SRH, and contraceptive care in humanitarian settings (Desrosiers *et al.*, 2020). Here, it is helpful to draw on a handful of recent systematic reviews. In a review of interventions for young people, including adolescents, in humanitarian settings, three studies involved adolescents in the planning and implementing interventions, one in the Democratic Republic of Congo, one in Malawi and another in Uganda (Jennings *et al.*, 2019). These included a pilot intervention for workshops on contraception, youth clubs and the design of community outreach programmes respectively. All these interventions were recorded in grey literature, by the donor implementing the intervention (UNFPA, 2013; International Rescue Committee, 2018). Their recommendations included greater access to family planning services, greater investment in adolescent SRH earlier on in crises and increased participation for adolescents (Ibid.).

In another review on SRH interventions for young people in humanitarian and lower-and-middle-income settings, Desrosiers *et al.*, (2020) found that out of 55 studies, 17 demonstrated effective interventions and 8 included mention of education on contraceptive methods (Kenya, Niger, Myanmar, Vietnam, Mexico, India, Ghana and South Africa) and half of those contraceptive

education. In all, only 3 offered youth-friendly services or programmes to enhance sexual decision-making skills. Aside from the low numbers of interventions, the researchers found the most effective studies included: a mixture of SRH outcomes and psychosocial components, lasted a longer length of time (roughly 1-2 years), and high levels of training and coordination between actors. However, the quality of evidence in this area is low and there are calls for improvements. For example, articles often do not mention what is meant when they use the term adolescent or youth-friendly services, and most of the interventions identified did not include migrant or refugee populations (Desrosiers *et al.*, 2020). In many cases, interventions do not disaggregate utilisation by population groups (e.g. adolescent girls), so it is difficult to gain an understanding of patterns in usage (Singh *et al.*, 2018).

There are several absences in the literature to which this thesis aims to help address. First, is the issue of a lack of theories or conceptual frameworks through with to understand adolescent girls' contraceptive autonomy. Second, there is a lack of literature on adolescent-friendly health services (AFHS) or participation for migrant girls in humanitarian settings. Third, there is a lack of examples from Latin America, and in particular South America on adolescent migrant contraceptive autonomy- or the related concepts (e.g., participation, inclusion, agency, etc.). Therefore, drawing on the case study of Venezuelan migrants in Colombia, this develops a conceptual framework for understanding adolescent girls' contraceptive autonomy, before demonstrating how this framework can be used to highlight how decision-making power is distributed in state and non-state actors' responses. Before, I address this, it is important to understand how existing discussions of reproductive choice, autonomy and coercion have rarely conceptualised adolescents as holders of autonomy rights.

2.1.7 Reproductive Autonomy, Coercion, and Voice

Conceptual debates on the definition of autonomy, freedom and choice have surrounded discussions of women's and girls' SRHRs and contraceptive use over the past 50 years (Robertson, 1983; Hartman, 1987; Corrêa, 2001). Several yet overlapping concepts have emerged since then shaping responses to SRHRs. Table 3Concepts and definitions vary greatly depending on the underlying assumptions and knowledge claims of the author and their field of study. These in turn impact the recommendations for policies, programmes, and strategies for the provision of comprehensive contraceptive care. These concepts are summarised in Table 3.

The greatest limitation of these definitions, considering the research question, is that most of the concepts discussed in the table below focus on the acquisition of autonomy as a binary state. Autonomy is either achieved or not. This is incompatible with the idea of 'evolving capacities'

developed under the UNCRC- that adolescent girls have certain autonomy rights which can be accumulated over time. This is because the latter relies on there being a more relational form of autonomy, one whereby different degrees of autonomy can be attained.

One exception is *The Reproductive Autonomy Scale* which was developed as a set of questions for providers to ask patients to identify instances of reproductive coercion between women and their partners (Upadhyay *et al.*, 2014). *The Reproductive Autonomy Scale* was developed to assess a woman's power to achieve reproductive autonomy. This questionnaire to apply this scale is composed of 14 items, subdivided into three subscales: decision-making, absence of coercion and communication (Upadhyay et al. 2014). In addition, it has shown that when adapted it demonstrates high levels of replicability in other contexts (Elionara Teixeira Boa Sorte *et al.*, 2019). The scale is limited for its application to this project as it focuses on women self-reporting instances of intimate partner violence, and therefore cannot tell us much about actors' inclusion of adolescent migrant girls into their SRH responses. However, the format of the scale is useful to note as a scale permits the understanding of autonomy to go beyond binary categorisations purported by other theorists (Senderowicz, 2020).

Furthermore, the *Reproductive Autonomy Scale,* whilst a valuable contribution to the psychological interventions to intimate partner violence, excludes the power relationships which characterise state and non-state actors' responses to adolescent migrant girls' contraceptive care. For example, being limited to the individual level, there is no focus on how upstream factors such as policymaking influence access to contraceptive care education and resources. Secondly, the scale assumes the individual is in a relationship or union of some kind – which is not the case for many adolescent migrant girls who wish to receive contraceptive education or contraception for non-contraceptive benefits. This leads me to my final issue, that the model does not include adolescents 'evolving capacities'. For these reasons, the *Reproductive Autonomy Scale* cannot capture the necessary power relations to understand the extent to which actors have included adolescent migrant girls in their responses to contraceptive care.

Table 3 Concepts Related to Contraceptive Decision-Making Created by the Author.

	Concept	Definition	Origins and Purpose
Enhancing	Reproductive Choice (Cadena, Chaudhri, and Scott, 2022)	Affirming the basic human right to self-determination, including the right to use or not use contraception, choose a preferred method of contraception or a pregnancy option such as abortion.	Western, Liberal, Pro-choice Feminism Arguments against biological determinism that equates femininity with motherhood and argues for access to abortion and contraception.
	Agency in Contraceptive Use (Margherio, 2019; Hayer *et al.*, 2022)	Ability to exert some level of control over the social environment within which one is enmeshed, that is to accept or resist norms and expectations.	Global Health Attempts to understand the contraceptive experiences and patterns of use, what constrains or enhances the ability to make decisions.
	Contraceptive Autonomy (Senderowicz, 2020)	The factors that need to be in place in order for a person to decide for themselves what they want in regard to contraceptive use, and then to realise that decision' Based on informed choice, full choice, and free choice.	Feminism, Demography Concerned with operationalising contraceptive choice as an alternative indicator to unmet contraceptive need that includes matters of reproductive autonomy/coercion.
	Contraceptive Security (Wickstrom and Jacobstein, 2011)	When all people can choose, obtain, and use the contraceptive methods and services they desire, from the full range of potential methods, in order to achieve their reproductive intentions.	Public Health, Policy Emphasis on the availability of a variety of contraceptive methods through strengthening supply chains, financing, and logistical procedures

	Procreative Liberty (Robertson, 1996; de Melo-Martin, 2013; Bognar, 2019)	The individual freedom to decide on matters related to reproduction, including whether or not to have children. Procreative liberty involves a basic negative right, with which others, may interfere only for very weighty reasons.	Policy, Ethics, Legal rights Concerned with the justification of intervention in reproductive health in terms of a rights-based approach to liberty e.g., in matters of assistive reproductive technologies
	Informed Consent (Zampas *et al.*, 2020; FIGO Committee for Ethical Aspects of Human Reproduction and Women's Health, 2021)	A form of consent obtained freely, without threats or improper inducements after the patient has been provided with information about the treatment's advantages and disadvantages, side effects and alternative treatment options.	Law, International Human Rights and Bioethics Creates obligations for providers including training staff, ensuring women and girls are free to ask questions, and information is not 'over-medicalised'.
	Reproductive Autonomy (Upadhyay *et al.*, 2014; Johnston and Zacharias, 2017; Senderowicz and Higgins, 2020)	Emphasises the importance of individuals having the power to make decisions and control matters related to contraception, pregnancy, and childbearing, free from interference or coercion.	Global Health, Feminist Demography and Bioethics Highlights how concepts such as autonomy apply to people's reproductive lives considering notions of freedom, self-determination, self-governance, and justice.
Constraining	Provider Bias (Schwandt, Speizer and Corroon, 2017; Mann, Chen and Johnson, 2022)	When providers create barriers to contraceptive use by centring their own beliefs and biases (such as about who should use which type of contraception) above the patients' priorities.	Global Health, Public Health Used to determine structural barriers to contraceptive care, and to create guidelines for person-centred contraceptive counselling.
	Contraceptive Desert (Kreitzer *et al.*, 2021)	A locality that not only has low access to the family planning resources provided by public policy due to the	Public Health and Geography

	built environment but also may be where populations who are already made vulnerable due to socioeconomic and racial inequalities are isolated from a geography of opportunity.	Devised to explain how geographies of public health centres can create barriers and inequities in contraceptive access.
Reproductive Anxiety (Grzanka and Schuch, 2019)	A preoccupying negative concern about becoming pregnant or the wish to become pregnant.	Psychology and Social Science Used to explain women's lived experiences of what motivates them to use/not use contraceptives.
Reproductive Coercion (Grace and Anderson, 2018; Tarzia and Hegarty, 2021)	Behaviour that interferes with the autonomous decision-making of a woman's reproductive health. Birth control sabotage (e.g., removing a condom), coercion or pressure to become pregnant or controlling the outcome of a pregnancy.	Intimate Partner Violence, Public Health, Nursing Detection of specific types of coercion to make recommendations on how to create interventions to detect, prevent and treat cases of coercion.
Contraceptive Coercion (Brandi *et al.*, 2018; Senderowicz, 2019; Tumlinson *et al.*, 2022)	A form of reproductive coercion refers to any behaviour that interferes with contraception use in an attempt to either promote or discourage pregnancy.	Clinical and Social Sciences Designed to make recommendations to prevent providers' behaviour restricting the choice of patients to use contraceptives of a certain type or not at all.
Stratified Reproduction (Colen, Ginsburg and Rapp, 1995; Riley	The unequal opportunities of reproduction available to different groups of people.	Gender studies, Politics, Demography

and Brunson, 2018; Smietana, Thompson and Twine, 2018)		A concept to describe and analyse how differences create and sustain inequalities in reproductive health across populations such as colonialism, migration status, and race.
Reproductive Violence (Zammit Borda, 2022)	Violence intended to target the reproductive system organs, process or capacity to reproduce of people or groups could include forced pregnancy, forced sterilisation or forced contraception.	Conflict Studies, International Relations Used to identify types of violence relating to reproductive – not sexual violence – in cases of genocide or crimes against humanity which are usually ideologically driven and used to persecute specific groups.

Senderowicz (2019, p. 8) developed the concept of reproductive and contraceptive coercion further by applying a spectrum of coercion. In doing so she expands the concept of contraceptive coercion to include '1) coercion as bidirectional (both upward and downward); 2) coercion as a spectrum (from subtle to overt), rather than a dichotomous outcome; and 3) coercion as a structural phenomenon, rather than simply an interpersonal one'. Upward coercion results when a person does not want a contraceptive method but has one, and alternately downward coercion is when a person wants contraception but does not have it. The aim is to recognise that autonomy is the end goal for all contraceptive counselling and that indicators should acknowledge autonomous non-use as a positive contraceptive outcome (Senderowicz, 2020). Equally subtler forms of coercion may include a limited mix of methods or biased counselling, whereas more overt displays of coercion are refusal to remove a method or inserting a method without knowledge or consent. Senderowicz acknowledges that coercion is mostly viewed as interpersonal (see Table 3). Yet, there are many structural factors involved in the 'spectrum of coercion'. Senderowicz looks at forms of coercion rather than at the inclusion of marginalised groups. This still holds utility here presenting coercion as a dynamic and fluid concept operating across several modalities.

Other RJ scholars have investigated more subtle forms of coercion, such as limited contraceptive choices, which have restricted the reproductive autonomy of marginalised groups by limiting their ability to decide whether to use certain contraceptive methods. In reaction to this, RJ scholars have recently shifted to focus on LARCs as a form of 'soft sterilisation' or 'social Malthusianism' (Winters and McLaughlin, 2019; Brandão and Cabral, 2021, p. 2679). These terms have been used to describe the process of uneven or 'selective' LARC provision as a hidden form of reproductive control over marginalised groups (Gomez, Fuentes and Allina, 2014; Winters and McLaughlin, 2019; Brian, Grzanka and Mann, 2020; Brandão and Cabral, 2021; Mann, 2022; Morison, 2023). Often marginalised groups are the ones who are pressured into using LARC through what has been referred to as 'LARC-first' or LARC hegemony (Gomez, Fuentes and Allina, 2014; Davidson *et al.*, 2017; Brandão and Cabral, 2021). These include both covert and subversive mechanisms of reproductive coercion from denial to financial incentives to discourses which present LARC as the only appropriate option. In such instances, decision-makers such as health insurers, public health politicians and medical professionals have the authority to insert, monitor or remove LARCs at the expense of individual autonomy (Brian, Grzanka and Mann, 2020).

> '…LARCs are *technically* reversible. Soft sterilization does not imply that LARCs cannot be removed. Instead, because LARCs require a healthcare professional for safe removal, LARC users are dependent upon the provider to reinstate fertility. Women who are unable to access medical care or obtain consent to remove the device from a healthcare provider may be forced to keep their LARC after the device removal date or after they decide to become pregnant. Therefore, LARCs have the capability of producing the same

> reproductive control outcome—prevention of pregnancy without the consent of the user—as involuntary sterilisation' (Winters and McLaughlin, 2019, pp. 225-6).

The promotion of LARCs for some groups (re)produces the unequal power relations that were present in previous regimes of reproductive control. LARCs replace sterilisation as a form of reproductive control that is selectively and unevenly applied along intersecting lines of oppression and privilege. LARCs have been emancipatory for privileged groups of women, but tools of oppression for those already marginalised (Winters and McLaughlin, 2019). Essentially, when decision-makers centre policy aims or social objectives they decentre women's autonomy.

The erosion of autonomy is often a product of its being seen as secondary to 'urgency', 'cost-effectiveness', 'effectiveness', and 'rationality' (Brian, Grzanka and Mann, 2020; Eeckhaut and Hara, 2023; Morison, 2023). These discourses present LARCs as 'the only responsible and appropriate choice' (Brian, Grzanka and Mann, 2020). LARCs are rationalised as a 'good choice' for adolescent girls whose sexuality is often depicted as a risk to themselves, others, and larger society (Brandão and Cabral, 2021; Mann, 2022; Morison, 2023, p. 545). Risks are often based on assumptions about normative expectations, particularly concerning their young, unmarried, poor, and minority patients' reproductive behaviour (Eeckhaut and Hara, 2023, p. 4). Conversely, LARCs are appealing in that they could be inserted and 'forgotten' so are therefore suitable to those who have the potential to be 'noncompliant' with other methods, who were seen as inherently 'irresponsible' (Brian, Grzanka and Mann, 2020). This incited urgency to insert methods whilst women were in clinics, in order to meet public health and social reform agendas (Brian, Grzanka and Mann, 2020; Morison, 2023). Here, technical approaches to 'risk', cost and 'urgency' ensure that LARC is applied unevenly.

In essence, understandings of SRHR that focus on access to avoid risk and disease conceal the many other ways reproductive injustices occur especially at the intersections of oppression. Instead, we need to look beyond access to models of autonomy which centre individuals' reproductive realities and account for intersectional forms of discrimination. As such, the rest of this thesis will continue to use Senderowicz's concept of contraceptive autonomy. This defines reproductive autonomy as an individual's ability to be fully empowered agents in their reproductive needs and decisions and to access reproductive health services without interference or coercion (Senderowicz and Higgins, 2020). In this regard, contraceptive autonomy is 'the factors that need to be in place in order for a person to decide for themselves what they want in regard to contraceptive use, and then to realise that decision' informed by the principles of informed choice, full choice, and free choice (Senderowicz 2020, p.165). Informed choice involves making decisions only after receiving sufficient and unbiased information pertaining to a range of family planning options, comprehensively assessing both the benefits and risks associated with their utilisation. Full choice underscores the

importance of having access to a diverse selection of contraceptive methods, ensuring that individuals can choose from a wide array of options to best suit their needs. Lastly, free choice emphasises the decision-making process concerning contraception. Here the decision-making process of whether or not to use contraception and which method to employ should occur voluntarily, devoid of any barriers or coercion (Ibid.).

Building on this, I contend that the fluidity Senderowicz applies to coercion should be applied to contraceptive autonomy. A relational, multifaceted understanding of contraceptive autonomy would go beyond contraceptive autonomy as a binary state of attained or not attained. In turn, this would make it compatible with notions of relational autonomy espoused by child rights and participation literature such as 'evolving capacities'. Doing so would provide an excellent opportunity to overcome the paternalism/protectionism bind which has prevented adolescent migrant girls from being viewed as rightsholders.

2.2 Theoretical Framework

2.2.1 Using Reproductive Justice to Analyse Intersectional Sexual Reproductive Health Inequalities

So far, I have discussed how the literature in social sciences has historically perceived SRH to focus on curing diseases, reducing risk and providing technical solutions. Furthermore, I have demonstrated how SRHR-based approaches partially overcome this issue but fall short in addressing the environments where rights are enacted, often shaped along axes of intersectional oppression. In response to these weaknesses, I continue this thesis using a RJ lens.

Coined in 1994 by the Combahee River Collective, RJ is a social movement and theoretical framework which understands women's healthcare requires access to a variety of services rather than simply healthcare. The ultimate aim is to achieve RJ; to disrupt power relations that cause reproductive oppression through social, economic and cultural inequities and to build power in people-centred movements working towards reproductive freedom (Solinger, 2005; Chrisler, 2013; Luna and Luker, 2013; Roberts, 2015; Ross, 2018). RJ draws on the interconnectedness of rights to demonstrate how socioeconomic inequalities have shaped reproductive politics for marginalised women.

> '[RJ] is rooted in the belief that systemic inequality has always shaped people's decision-making around childbearing and parenting, particularly vulnerable women. Institutional forces such as racism, sexism, colonialism, and poverty influence people's individual

> freedoms in societies. Other factors—such as immigration status, ability, gender identity, carceral status, sexual orientation, and age—can also affect whether people get appropriate care' (Solinger, 2005, p. 291).

Expanding discussions of reproductive rights beyond access or 'pro-choice' debates, RJ focuses on three main principles: (1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments (Ross, 2018; Ross and Solinger, 2017). RJ does not aim to replace reproductive rights (as legal advocacy) nor reproductive health (as service provision) but instead emphasises the wider intersectional forms of oppression that infringe upon women's ability to control their own bodies (Chrisler, 2013; Ross, 2018).

RJ goes beyond a legal framework of SRHR because it enables us to contextualise actors' responses to matters of SRHR by grounding inequalities in histories. In this sense, RJ evokes an intersectional structural approach. Intersectionality rejects the idea that people's experiences can be understood by unitary structures of gender, race or class nor can experiences be understood as additive binary factors (Collins, 2015; Crenshaw, 2017; Shannon *et al.*, 2017). As Lokot and Avakyan, (2020, p. 42) articulate taking an intersectional approach may mean 'instead of assuming that "women and girls" as a homogenous collective lack access to SRH, asking the question of "which women and girls?"' Predominantly in the field of SRH, intersectionality has been used to understand oppression which occurs at individual and institutional levels (Nandagiri, Coast and Strong, 2020). But RJ illuminates how intersectionality operates at a structural level, showing how norms, policies, practices, and socioeconomic factors regulate and delimit one's capacity to make decisions and act upon those decisions (Morison, 2022). In this case, I apply structural intersectionality to look at how actors and their responses consider or include Venezuelan adolescent migrant girls as individuals of gender, age, and migration.

Widening the frame of analysis, RJ scholars emphasise how political, social and cultural histories have shaped intersecting socioeconomic inequalities which affect women of colour and indigenous women's reproductive choices (Solinger, 2005; Chrisler, 2013; Luna and Luker, 2013; Zucker, 2014; Roberts, 2015; Ross, 2018). Using RJ to examine responses illustrates how policies, seemingly unrelated to SRH, are extensions of population control (eugenics) (Ross and Solinger, 2017; Ross, 2018). RJ in this way offers a structural explanation of how reproductive choice is stratified upwards (Zucker, 2014; Grzanka and Schuch, 2019). For example, in the USA, where state policies might limit the reproductive choice of women of colour to reduce the number of pregnancies but promote fertility and maternal health in white women – choice is stratified upward based on structures of race, class, and gender. On this basis, advocates might argue for a range of matters to achieve RJ such as abolition of the police, environmentalism, universal health coverage and a national living

wage (Ross and Solinger, 2017). As such RJ is advantageous for the study of actors' responses because they show structures of reproductive governance, regardless of their intentions, perpetuate harmful logics about which groups should be encouraged to reproduce and which should not.

As I have alluded to, RJ primarily focuses on women of colour in the United States. However, because it emphasises lived experiences, intersectionality and marginality it can be applied as a broader approach to examine SRH in neglected populations such as adolescent migrant girls. Recently this theory has been used to understand how age is understood as one social category contributing to the intersectional oppression that marginalises young people in a world that is primarily designed for adults, to meet the needs of adults. For example, RJ has been used to examine the shame and stigma attached to young mothers and reframe adolescent pregnancy not as a social problem but as a result of structural inequality and/or as a life stage in the same way it is for older women (Hans and White, 2019). In applying RJ to adolescent migrant girls then, it is important to acknowledge how historical discourses have reproduced ideas of migrants as 'parasitical', 'non-productive', and 'undeserving' beneficiaries of rights (Sargent, 1998; Piper, 2006; Brown *et al.*, 2019). It is essential that actors' responses do not perpetuate these power imbalances to constrain adolescents and young migrant women's abilities to achieve their SRHRs, regardless of their intentions.

This thesis builds upon these studies of RJ in the contexts of adolescents or migrants, to apply RJ as an analytical framework to understand the actors' response to adolescent migrant girls' contraceptive care. Here, it is fitting to return to the key claim of RJ which I introduced in the rationale of this thesis. RJ argues the loss of women's voices and tools to communicate are symptomatic of the oppression experienced by marginalised groups (Zola, 1983 in Ross, 2018). Based on these experiences of exclusion, RJ movements focus on comprehensive, inclusive women-centred and/or women-led movements which bring women's otherwise unheard needs to the forefront of the discussions on women's reproductive health (Solinger, 2005; Roberts, 2015; Ross, 2018; Hans and White, 2019; Cadena, Chaudhri and Scott, 2022). For only when all the voices of all women are heard, will reproductive rights movements make a difference for all women (Solinger, 2005, p. 310). RJ therefore demonstrates the necessity to examine how power operates throughout the *process* by which actors set agendas, create policies and programmes as well as the evaluating the *impact* they have on populations SRHRs.

In short, RJ broadly unites socioeconomic factors, structural violence, human rights and intersectionality to 'make visible' the conditions that 'limit reproductive options for women of colour, Indigenous people, and other marginalised communities globally' (Ross, 2017, p.291). It demonstrates that given the histories of population control, marginalised women need to be able to have the right to choose whether or not to have children – and that that choice needs to be

expanded to a range of freedoms and entitlements beyond liberal or 'choice feminist' conceptions of freedom. Lastly, RJ places value on the inclusion of women in programmes and policies on the SRH as part of the path towards reproductive freedom. RJ, therefore, serves as a useful framework for understanding inequalities in reproductive choice for women and girls in positions of marginality.

The application of RJ to the study of adolescent girls and young women presents a tension that has often been neglected in the literature on RJ. Political and social scientists generally are of the view that children, adolescents, and some young persons are not capable of full autonomy (Purdy, 1994; Hafen and Hafen, 1996; James, 2008; Zermatten, 2014; Daly, 2020). How then do adolescent girls achieve RJ? Are adolescent girls entitled to reproductive freedom? Should they be included in programmes about their SRH and if so, how? The next section will consider contraceptive autonomy through the application of RJ and youth participation frameworks in attempts to provide a framework for understanding the ways in which actors do or do not, consider and engage with adolescent migrant girls regarding their contraceptive care.

2.3 Contraceptive Autonomy as an Analytical Framework

2.3.1 Contraceptive Autonomy as Full, Free, and Informed Choice

Contraceptive autonomy is considered to be 'the factors that need to be in place in order for a person to decide for themselves what they want in regard to contraceptive use, and then to realise that decision' informed by the principles of informed choice, full choice, and free choice (Senderowicz, 2020, p. 165). Informed choice involves making decisions only after receiving sufficient and 'unbiased' information pertaining to a range of family planning options, comprehensively assessing both the benefits and risks associated with their utilisation. Full choice underscores the importance of having access to a diverse selection of contraceptive methods, ensuring that individuals can choose from a wide array of options to best suit their needs. Ideally, a method from each of the groups presented in Figure 1 should be present. Lastly, free choice emphasises the decision-making process concerning contraception. Here the decision-making process of whether or not to use contraceptives and which method to employ should occur voluntarily, devoid of any barriers or coercion (Ibid.).

Here it is important to mention the distinction between autonomy and agency, two concepts which are frequently conflated by actors, and authors who avoid articulating a distinction between the two (Senderowicz, 2020; Morison, 2022). Essentially, underscoring both concepts is the extent to which individuals can make and realise decisions that are free. In this thesis, considering the different conceptualisations above, I adopt the distinction articulated by Sherwin (1998), whose definition of

agency is closer to informed decision-making, and which can exist in various degrees. Applied to the example here, contraceptive agency would be achieved by choosing between the range of different methods available. So, agency is a less comprehensive notion of freedom than autonomy (Sherwin, 1998). Agency is an action, whereas autonomy is a state one reaches (Mackenzie, 2019). Agents are fully autonomous when they can make decisions in an environment free from coercive social structures. In this way, autonomy cannot exist without justice. Mackenzie's definition of relational autonomy is central to the conceptual approach of this thesis because it goes beyond the traditional individualist notion of autonomy espoused by traditional biomedical scholars or liberal political theory to account for structural factors (Mackenzie and Stoljar, 2000; Mackenzie, 2019). In this way, like RJ, autonomy is reliant upon more than education and freedom from coercion, it depends on other social factors and structures which influence decision-making (Sherwin, 1998;2008; Wardrope, 2014; Mackenzie, 2019)

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Figure 1 Algorithm for Operationalising Contraceptive Autonomy by Senderowicz 2020 p. 166.

Informed Choice	Full Choice	Free Choice
• Knows how to use a method from each group# • Knows a benefit/ advantage of non-use of family planning • Knows a risk/ disadvantage of non-use of family planning • Knows a benefit/advantage of their method*[1] • Knows a risk/ disadvantage of their method* • Knows what to do in case of side-effects* • Was told about method removal or permanence	• A method from each group# is available to them • A method from each group# is affordable to them • Could get the method removed if they wanted** • Could afford to get the method removed if they wanted**	• Made the choice to use/not use family planning voluntarily • Was not offered incentives to use/not use method • Felt that they were able to refuse method* • Is not using the method against their will* • Has not met provider refusal to discontinuation**

# Contraceptive Attribute Groups	
Duration of use	Long-acting *and* short-acting (emphasis in original)
Presence of hormones	Hormonal *and* non-hormonal
Coital dependence	Coitally dependent *and* coitally independent
Provider dependence	Provider dependent *and* provider independent
Control	Male controlled *and* female controlled
Return to fertility	Immediate return to fertility
Effectiveness	Tier 1

Note: *Current method user **Current LARC user ^Permanent method user

2.3.2 Models of Participatory Decision-Making for Adolescents

An issue arises when contraceptive autonomy is applied to adolescent girls. For it is at this point we encounter the nexus of protection versus participation which has plagued debates about adolescents' rights since the 1990s (Caputo, 2016; Collins, 2016). It is not within the scope of this thesis to weigh into the critical debate that has been so well-articulated elsewhere (Purdy, 1994; Hafen and Hafen, 1996; Sargent, 1998; Naker, Mann and Rajani, 2007; Uvin, 2007; Lundy, 2013; Åkerlund and Gottzén, 2016; Caputo, 2016; Collins, 2016; Campbell, 2021; Hajisoteriou, Karousiou and Angelides, 2021). Yet it is essential to briefly outline the prevailing arguments for and against children's autonomy.

Researchers have argued that granting adolescents the right to full autonomy and the responsibilities that come with it would undermine adults' obligations to protect children, who are understood as vulnerable to harm (Hafen and Hafen, 1996). Furthermore, granting children equal rights could end in undesirable outcomes, beyond children's comprehension. Therefore they should not be given the responsibility of such decision-making (Purdy, 1994). Other understandings of children's and adolescents' rights have argued that if children are excluded from participation this can result in miscommunication (with children), inaccurate judgments (about children's intents and motivations), misuse of power (to limit children's self-determination), and undermining strengths and competencies (Peter, 1992, pp.408-9 in Campbell, 2021). Overall, since the 1990s there has been an increasing number of arguments for the involvement of adolescents as agents capable of decision-making beyond objects of protection (James, 2008; Wong, Zimmerman and Parker, 2010; Åkerlund and Gottzén, 2016; Caputo, 2016; Campbell, 2021; Hajisoteriou, Karousiou and Angelides, 2021).

This thesis will use the autonomy rights outlined to adolescents in the UNCRC. Despite the rhetoric on the interdependence of rights, the UNCRC places one principle above others. The central pillar of the UNCRC is the principle of the best interests of the child- which determines that above all else decisions should be driven based on what is deemed 'best' for the child (United Nations, 1989). Another distinction worth noting is that whilst children are not granted full autonomy for decision-making, they are entitled to certain autonomy rights. Instead, the emphasis is on the participation of children in the decision 'shall assure' to children the right to be heard (Article 12[1]), and children should be 'provided the opportunity to participate in proceedings affecting them (Article 12[2]). Article 12 is often known as 'the voice of the child' (Lundy, 2013). Part of facilitating children's autonomy rights is to ensure not just that children are heard, but that what they say is 'given due weight'. The Committee states that 'simply listening to the child is insufficient, but that the views of the child have to be seriously considered (Committee on the Rights of the Child, 2009). The weight of the decision-making or based on the principle of evolving capacities.

'Evolving capacities' function as a type of relational autonomy which is defined in Article 5 as 'processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realised' (United Nations, 1989). Departing from the idea that the right to decide is linked to age, this principle is dynamic and evolving. As a result, duty bearers are encouraged to enhance adolescents' capacity for autonomy whilst acknowledging that the vulnerability of this population means that they may require specific protection.

Reducing adolescents' power to decide is sometimes justified under the UNCRC. Under Article 12, protection is encouraged when the risks of decision-making are greater than the benefits, such as in instances where the child is at serious risk of harm, neglect, abuse and violence (United Nations, 1989). In this instance, interference is permitted when it supports adolescents' capacity to make reflective decisions also known as 'autonomy-enhancing paternalism' (Binder and Lades, 2015). This is justified on the grounds it helps the autonomy of the child so 'better decisions' can be made in the future (Ibid.). However, as children as positioned as rights-holders, any intervention in their decision-making must be justifiable in line with reasons that consider the child's best interests (Yamin, 2013). In summary, rights which protect autonomy for children and adolescents are rights to express views and be involved in the decision-making process in a way that evolves and progresses over time towards full decision-making and self-determination.

This thesis builds on existing models of child, adolescent, and youth participation. It aims to develop a framework of *voice* specifically designed to consider the participation of adolescent migrant girls in decisions relating to their contraception care. The goal is for the *Ladder of Participation* to function as a route of inclusion and promote contraceptive autonomy. Originating from Arnstein's (1969) *Ladder of Citizenship Participation*, Hart (1995; 2013) adopted the ladder to create a model of children's participation. The relevance of this model for our focus on the SRHR of adolescents is that Hart, (1992, p. 5) defines participation as 'sharing decisions which affect one's life and the community in which one lives'. Therefore, if we are going to discuss adolescents' choice and decision-making capabilities as shaped by actors and responses it is important to understand how ideas around involving children and adolescents have emerged.

Shier, (2006) outlined what would it look like for actors to involve children in decisions about them. He identifies five levels of participation for children: listening, supporting their views, considering their views, involving them in decision-making processes, and sharing power (Shier, 2006, p. 110). At each level, there are three stages of commitment: openings, opportunities, and obligations. Openings occur when a worker is ready to operate at a certain level, opportunities arise when needs are met, and obligations are established when it becomes the organisation's policy to operate at a

certain level. In doing so, he references the obligations and recommendations of the UNCRC to show the minimum standard of participation required under a rights-based approach. In Table 4 the level 'views are taken into account' is considered enough to realise the rights of children (Shier, 2006). Below this level, actions cannot be justified by the principle of the 'best interests of the child'. As Shier does not deal with the aspects of non-participation, the levels of non-participation Table 4 have been taken from Hart's Ladder *of Participation* (Hart, 1992;2013).

Table 4 *Ladder of Participation* for Children Adapted from Hart (1992) and Shier (2001)

	Level of participation	Description	
Participation	Share power and responsibility for decision-making	An explicit commitment is made on the part of adults to share their power; that is, to give some of it away.	
	Involved in decision-making	Children are directly involved at the point where decisions are made.	
	Views are taken into account	Children's views are one of several factors taken into account. Even when children's views are `given due weight', other factors may still outweigh them.	Level required for UNCRC
	Supported in expressing their views	Positive actions to elicit children's views and to support them in expressing those views (e.g., age-appropriate training and techniques for communication between adults and children).	
	Listened to	When children take it upon themselves to express a view, this is listened to, and with due care and attention, by the responsible adult(s).	
Non-participation	Tokenism	Children are asked to say what they think about an issue but have little or no choice about the way they express those views of the scope of the ideas they can express.	
	Decoration	Children take part in the event for example by singing or wearing T-shirts with logos on the data not really understand the issues.	

	Manipulation	Children do or say what adults suggest, they do have no real understanding of the issue or children are asked what they think, adults use some of their ideas but do not communicate back the influence they had.

In their review of youth participation models Villa-Torres and Svanemyr, (2015, p. 551) page number have noted that 'although none of [the conceptual frameworks on youth participation] are SRHR specific, they have the potential to be adapted and applied also for adolescents' SRHR programmes'. Building upon this rights-based model of child and youth participation, I will apply the autonomy rights of adolescents to the conceptualisation of contraceptive autonomy by developing the concept of *voice*. I maintain that *voice* as a mechanism of participation can serve means of attributing power to young people and permitting them to partake in decisions about their body, health, and community.

2.3.3 *Voice* as a Measure of Contraceptive Autonomy

Extending the logic from the concepts of reproductive autonomy, reproductive coercion and child participation, this section develops a framework. Table 5 outlines in detail, the conceptual framework developed from the work of (Arnstein, 1969; Shier, 2006; Hart, 2013). Here, *voice* is developed as a scale to understand the distribution of power from coercion/manipulation through to models of fully shared decision-making creating the conditions necessary for contraceptive autonomy. By adding *voice* as a proxy for contraceptive autonomy, this new scale bridges the gap between the frameworks for adult women's reproductive autonomy and adolescent participation, which has previously excluded adolescent migrant girls from decisions about their contraceptive care.

To be more specific, it highlights the importance of taking positive actions to address the intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration); participation in decision-making processes, and the opportunity to (not) use a variety of contraceptive methods. *The Scale of Voice* is designed to highlight the different modalities in which power-sharing can occur in the decision-making process at various levels. This was designed to apply to actors from policymakers and programme designers to service implementors. It is suggested that actors who include elements in their response design and implementation can provide environments where the priorities and preferences of adolescent migrant girls can be realised. If actors do not take *voice* into account, they cannot be said to be respecting the autonomy rights of adolescents. As a result, the responders' behaviours could be deemed as coercive.

Intersectionality

To remove any conceptual ambiguity *voice* is defined here as a vehicle for self-expression as in social and political thought (Lawy, 2017). *Voice* is linked to the ideals of power and representation in terms of 'claiming voice' or 'having a voice' (Lawy, 2017). *Voice* in matters related to contraceptive care here refers to a process of sharing decision-making power in matters related to contraceptive education, information and resources. *Voice* is not the same as speech – speaking is a bodily act made using the larynx, mouth, tongue, lips, and lungs (Butler, 2004, p. 172; Lawy, 2017). Furthermore, *voice* requires an audience, a dialogue to listen to the views or opinions expressed. It might be more helpful to think of *voice* as an event with words, hearers and speakers (Alcoff, 1991, p. 26). As Klugman *et al*. (2014, p.2) argue *voice* is essential to decision-making as '[f]ull and equal participation also requires that all people have a voice – meaning the capacity to speak up and be heard... To shape and share in discussions, discourses and decisions that affect them'. Similarly, those who are considered 'voiceless' are often seen as involuntarily silenced (Farmer, 2004; Mehta, Haug and Haddad, 2006; Spivak, 2015; Ross, 2018). Often, those who occupy marginal identities – particularly migrants are frequently considered 'unheard', lack representation or are not considered by those in positions of power (van den Muijsenbergh *et al.*, 2016; Azzam, 2018; Pécoud, 2020). To be clear, *voicelessness* is inherently linked to experiences of oppression in the form of marginality and powerlessness.

Returning to our discussion of RJ, the *voices* of marginalised women, especially those at intersectional axes of oppression, are seen as central to redressing structural power imbalances which have prevented the realisation of SRHR and justice. RJ argues women's loss of *voice* and tools to communicate is partly the cause of oppression, this is because when actors fail to understand the experiences of women and girls, they act based on assumptions which frequently create more barriers to SRH access (Solinger, 2005; Ross, 2018). In this sense, listening to the *voices* of adolescent migrant girls prevents actors from speaking on their behalf – which can perpetuate the idea that women and girls in the Global South are 'distant victims in need of saving', further disempowering them by denying them the opportunity to be heard (Alcoff, 1991).

Recognising and taking positive steps towards addressing intersections of age, gender and migration is thus a central pillar of *The Scale of Voice*. *Actively supporting* requires that actors acknowledge the differentiated needs of groups of migrants and take action to understand those needs. This ensures the response is expanded beyond hegemonic foci on men, adults, and citizens to make visible those who experience multiple disadvantages. Equally, it prevents 'single-axis' approaches which focus on women, adolescents or migrants as age-less, gender-less – or yet still the homogenising 'women and children'. To address adolescent migrant girls as migrants or as adolescents would make visible only

one part of the conditions that limit reproductive choice. By doing this, actors accept that some parts of the response will fail to reach women and girls (Eklund and Tellier, 2012, p. 593). Thus, if actors do not recognise adolescent migrant girls as a group of rights-holders, they cannot be seen to be considering nor including them in their responses.

This component is necessary for answering the first research question, which examines the inequalities in access to contraceptive-related reproductive services based on age and nationality for women and girls of reproductive age in Colombia. This exploration seeks to understand the extent to which reproductive realities are shaped by the interplay of age, gender, and migration, particularly focusing on the disparities faced by adolescent migrant girls relative to other groups. This is essential for understanding how the intersections of gender, age, and migration interact. This intersectionality component is also crucial for the second sub-research question which asks how actors in the healthcare system acknowledge and take positive actions towards the need for differential contraceptive care services for adolescent migrant girls. It centres on the recognition of power relations within intersectional groups and assesses whether responses took affirmative steps to make contraceptive care more suitable for the intersectional reproductive realities of adolescent migrant girls.

Table 5 Conceptual Framework of *Scale of Voice*: Measuring Adolescent Migrant Girls' (AMG) Contraceptive Autonomy

Level of Voice	Definition and Relation to Adolescent Migrant Girls' (AMGs') Contraceptive Autonomy	Examples of Mechanisms
Prioritisation AMGs' voices are centred in the agenda-setting and response design, which is then supported by actors.	• AMGs are informed about issues they see as important in addition to comprehensive sexuality education. • There is adequate resource allocation so that choices are full, providing the greatest variety available. • AMGs initiate dialogue resulting in free choice on what issues are raised and influence how they are realised. Direct consultation at all levels reduces the chance of external interference. • Power is shared equally during all key decision-making phases.	• Adequate allocation of funds to areas with high proportions of AMGs such as transit points or sites where migrants settle. • High-level participation including forums, assemblies. • Peer-led intervention.
Collaboration AMGs' voices shape responses at certain points of the response.	• Choices are full in that the responses are comprehensive and offer a variety of methods. • Informed choice is made so that comprehensive sexuality education is provided, and the information provided on methods is up-to-date. • Choice is mostly free, but the actors may guide actors at certain points, in line with AMGs' best interests. • AMGs share power with actors, they can influence responses so that they align with their choices.	• Commitments in policy, with accountability mechanisms. • Open-data environment. • Multi-sectoral integrated interventions such as arts or sports-based sessions integrated with SRH.

Consultation Partake in decision-making of responses led by actors.	• Choices are fully informed in that the information, education, and knowledge. • Choices are full as AMGs have access to comprehensive counselling services and offer a variety of methods. • Choices are free from undue influence from a third party. • Power sharing is limited, as voices are only heard on the topic in consultation. Actors retain decision-making power over the process to achieve the AMGs' desired result.	• Non-binding policy commitments or recommendations. • Multi-sectoral, multi-level cooperation to address differentiated needs. • Development of disaggregated indicators. • Complaints procedures.
Consideration Views are considered, but do not determine the outcome.	• Actors providing information to make more informed choices about the risks, benefits, side effects etc given the vulnerability of their situation. • Choice is full in that a variety of methods are available and affordable to them. • Choices are free to a limited extent as they are approved by an adult. • Although AMGs' choices are not realised, the process of consultation is 'autonomy-enhancing' in that the process strengthens capabilities required for future autonomous decision-making.	• Campaigns to change norms harmful to AMGs' SRHR. • Confidential complaints mechanisms. • Attitudes, beliefs, & opinions surveys. • Delivering comprehensive SRH information, education, and resources.
Active Support Positive actions to support AMGs to express their views.	• Actors provide appropriate and accessible information and education to ensure an informed choice. • Choice is full in that a variety of methods are available and affordable to those with health insurance or income to pay for out-of-pocket healthcare. • Choices are free to the extent permitted by pre-existing structures; this process does not result in choices being realised.	• Adolescent-friendly & migrant-inclusive spaces and services e.g. provide age-appropriate legal support. • Provider training on migrants SRHR.

	• Actors acknowledge differentiated needs for adolescent migrant girls, taking actions to understand those needs.	• Access to primary SRH care e.g., including access to contraceptive resources, counselling.
Passive Listening Listened to, but not encouraged to express opinion.	• AMGs have free choice in that feel able to communicate their views, opinions or preferences because they fit with those of the actors. • Informed choice is dependent on the socioeconomic characteristics of the individual, e.g. internet, peers, family or school activity. • Choice is not full in that a variety of methods are available and affordable to those with urgent or emergency care needs e.g. HIV+, post-abortion care. • AMGs' views are not recognised as a group influential to decision-making processes and do not existing responses.	• Commitments to specialist services for differentiated needs e.g. adolescent-friendly spaces (not migrant-inclusive). • Raising awareness of and referrals to existing services. • Improving the capacity of health institutions via resources. • Indirect consultation through professional representatives.
Generalisation Views generalised or communicated inappropriately.	• Information has been provided in a way that is difficult to understand. • Choice is limited, as actors restrict the scope of methods offered. • Choice is not free as some methods are promoted over others. • Actors have the decision-making power. • Participation is sought with women, adolescents or migrants, so AMG views are not represented.	• Acknowledge differentiated needs of migrants, women or adolescents. • Use of non-evidence-based claims. • Non-context-specific event scaled from another programme.

Manipulation Views are not respected, and/or choices not fulfilled.	• Choice has not been informed as AMGs are not in possession of sufficient knowledge/information. • Choice is not free as there is pressure to use a particular method. • Choice is not full as no option to change or discontinue a method. • Participation is largely superficial. The majority of the power is in the hands of actors, who assume the majority of the benefit.	• Misrepresentation of views. • Short-term or one-off events • Delivering information or services using traditional lecture methods. • Discourses that reiterate the actor 'knows best'
Coercion No/limited say.	• No choice has taken place. • Failure to address adolescent migrant girls altogether. • AMGs are excluded from giving an opinion. Instead, the actor holds all the decision-making power.	• Lack of resources. • Lack of information and/or education regarding SRHR/contraception. • Failure to address adolescent migrant girls altogether.

Participation and Feedback

To incorporate participation and feedback into *The Scale of Voice*, I build upon the main categories of participation identified in child, adolescent, and youth participation literature (in the column Level of Voice). *Voice* is a useful concept because under the human rights framework individuals of all ages are entitled 'to be heard'.

In an attempt to understand what 'giving voice' means, children's rights scholars argue that children's 'right to be heard' requires listening to and giving 'due weight' to children's voices (Cook and Dickens, 2000; Zermatten, 2014; Collins, 2016). Then, under the principle of 'evolving capacities', as individuals gain the skills required to understand the consequences of their decision-making are given more weight, and they are given more power in the decision-making processes. As in the work of Shier, (2006) it should be noted that the level *Consideration* is the level which is needed to fulfil the UNCRC. Where *voices* do not directly influence the outcome of decisions actors still have the duty to demonstrate they are taking positive actions to enhance the autonomy of the adolescents in line with their 'best interests'.

Incorporating mechanisms of participation and feedback provides a greater understanding of how power is shared in the decision-making process between state or non-state actors, and adolescent migrant girls. This is fitting seeing the focus of this thesis is on actors' responses to adolescents and how they include adolescent migrant girls in their responses. In providing this link between participation and autonomy I show how autonomy can be developed relationally in a way that fulfils the 'evolving capacities' of adolescent migrant girls, or at the very least creates conditions that are autonomy-enhancing by developing the necessary capacities. If power is not shared in the decision-making process – so that the priorities and preferences are not considered or included - then actors work based on assumptions, with a high risk of adopting coercive practices.

The participation and feedback component delves into the specific modalities employed by state and non-state actors in their responses to include the *voices* of adolescent migrant girls in contraceptive care decisions (in the final column to the right). This involved examining mechanisms of participation and feedback, seeking to understand why and how various forms of *voice* were integrated into the decision-making processes. As such it is vital for answering the research question, 'To what degree have adolescent migrant girls' voices been included?' As well as 'What are the specific modalities of engagement and inclusion utilised by state and humanitarian actors in their responses to adolescent migrant girls' contraceptive care?'

The Opportunity to (Not) Use a Variety of Contraceptive Methods

The final pillar of *The Scale of Voice* is the opportunity to (not) use a variety of contraceptive methods. This has been informed by the principles of informed choice, full choice, and free choice, which are central 'sub-domains' of contraceptive autonomy (Senderowicz, 2020, p. 165).

Although relational autonomy (developed in line with the 'evolving capacities') may mean that adolescent migrant girls share decision-making power with actors so that it is not entirely free, it is still important they retain certain elements of full, free, and informed choice. Adolescent migrant girls should be fully informed (in ways appropriate for their maturity) of the benefits, disadvantages, and side effects of the contraceptive methods that they choose – or do not choose to use. Notably, there should still be a broad mix of contraceptive methods available to adolescent migrant girls who wish to use a method. This should include short and long-term methods, hormonal and non-hormonal methods, barrier, and non-barrier methods and so on (see Figure 1). Lastly, the lack of medical resources or the refusal to provide access to services, for example, because of a lack of documentation or disposable income is equally unjust. This is because restrictions of freedoms do not enhance autonomy and thus go against the principle of the 'best interests of the child'.

Therefore, this component of *voice* is also essential for answering the research question regarding the degree to which adolescent migrant girls' *voices* have been included, as well as understanding the specific modalities of engagement and inclusion actors use in their responses to adolescent migrant girls' contraceptive care. If there is not a broad mix of contraceptive methods, if service providers cannot deliver information appropriately, or if methods are not accessible financially and bureaucratically, then there are no tools with which to realise the decisions made. So, when actors restrict access to specific contraceptive methods and determine the circumstances under which they can be accessed, it not only limits reproductive freedom but also fails to create conditions that enhance autonomy for individuals with 'evolving capacities' to make decisions in the future.

In developing the examples of mechanisms (the column on the far right of Table 5), several works were particularly relevant, as their reviews of literature proved a useful foundation for considering current SRHR interventions in humanitarian crises (Warren *et al.*, 2015; Jennings *et al.*, 2019; Desrosiers *et al.*, 2020; Tirado *et al.*, 2020; Larrea-Schiavon *et al.*, 2022). These mechanisms serve as suggestions, given the current evidence on the matter. However, it should be noted that these are not essential and may not be appropriate given the heterogeneous mix of adolescent migrants from different religions, races, cultures, classes, (dis)abilities, sexualities, and gender identities across and between crises. Thus, they serve more as a jumping-off point for anyone considering this framework.

The final sub-research question is on barriers to implementing mechanisms of *voice.* This explores the key challenges and barriers faced by state and non-state actors in effectively engaging with and

considering the *voices* of adolescent migrant girls in matters related to their contraceptive autonomy. It uses *The Scale of Voice* to identify and comprehend the areas where actors are missing opportunities to include adolescent migrant girls in responses. I then use this as a basis for future recommendations.

2.4 Conclusion

In summary, the current literature on adolescent migrant girls primarily focuses on access-based models (Ivanova, Rai and Kemigisha, 2018; Desrosiers *et al.*, 2020; Tirado *et al.*, 2020). Likewise, the literature on humanitarian responses shows them to be characterised by appeals to 'technical' responses, that claim to be apolitical (Redfield, 2005; Gautier *et al.*, 2022). RJ scholars, amongst feminists and decolonial scholars, argue that the selectivity with which responses are applied along axes of oppression such as age, gender and migration shows this is not the case (Ross, 2018; Abji and Larios, 2020; Brandão and Cabral, 2021; Cadena, Chaudhri and Scott, 2022). In fact, they call for responses to centre contraceptive autonomy – especially for marginalised women (Gomez, Fuentes and Allina, 2014; Senderowicz, 2020; Edmondson *et al.*, 2023). However, this concept is not yet applied to adolescent migrant girls in its current form. As it stands, it sees autonomy as present or absent, with no nuance. This goes against how adolescents view autonomy in SRH (Brisson, Ravitsky and Williams-Jones, 2021).

I put forward a novel framework combining contraceptive autonomy and the *Ladder of Participation*, to bridge the gap between contraceptive autonomy and the 'evolving capacities' in the UNCRC (Arnstein, 1969; Hart, 1992; Shier, 2006). *The Scale of Voice* uses *voice* (*voice* being the common ground between the two bodies of literature) as its starting point to identify aspects of response which either enhance or constrain autonomy. Central to this framework, are the components of intersectionality, participation and feedback and the opportunities to (not) use a variety of contraceptive methods. *Voice* as a conceptual framework was operationalised in the choice of research methods and analysis, which I will discuss in the following chapter.

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Chapter 3 Methodological Approach

Theoretically underpinned by structural intersectionality, as promoted by RJ, this thesis uses multiple methods as way of exploring actors' responses to (re)produce power relations by creating environments which discourage contraceptive autonomy amongst marginalised groups – in this case those at the intersection of age, gender, and migration.

This chapter presents the research methodology, methods of data collection and analysis that will be used to answer the question, how do state and non-state actors consider, adolescent migrant girls' (aged 15-19) contraceptive autonomy in the design and implementation of their sexual and reproductive healthcare policies, programmes, and strategies? To begin with, I explain why I have chosen to adopt a case study approach, and why Venezuelan migrants in Colombia in particular. Secondly, I justify the decision to use a multiple method design, relating the research questions to different methods have been triangulated. Thirdly, I discuss the details of data collection to ensure that each element of this study is reproducible. Finally, there is a summary of the ethical procedures undertaken in line with international and national norms.

3.1 A Case Study of Venezuelan Migrant Girls in Colombia

3.1.1 Justifying a Case Study Approach

Case studies involve examining specific phenomena in-depth, with the aim to gather rich detail on how that phenomenon occurs from a specific context. Case studies, as a research methodology, offer a valuable approach by concentrating on specific contexts, allowing researchers to delve into the complexities of a situation and gain insights into how a particular phenomenon occurs in a specific population and space at a given time. In this study, this is the actors' responses to contraceptive care, for Venezuelan adolescent migrant girls, in Colombia in 2021-22.

This study adopts an instrumental case study research design as it focuses on specific concerns through one example (Stake, 2008). Firstly, because it provides a valuable insight into how a particular phenomenon (actors' responses to adolescent migrant girls' contraceptive care) is enacted in this instance. Secondly, it shows how this case might enable us to build theories for other actors responding to adolescent migrant girls' contraceptive care in other humanitarian settings.

Depending on one's position, this research could be interpreted as a 'snapshot' single case study – of the response of actors in one humanitarian crisis or several 'patchwork' case studies of organisations, each in itself an observation (Jensen and Rodgers, 2002). Given the focus is on actors' responses to

adolescent migrant girls in humanitarian settings, I consider this case study to be the former, a rich example of actors' responses in one humanitarian setting.

Feminist research acknowledges the researcher's social position, challenging the notion of objectivity or value-free research, in order to expose power dynamics and generate knowledge that can contribute to freedom (Johnston and MacDougall, 2021). Intersectionality in particular rejects 'the regressive designation of lived experience in marginalisation as 'bias'' (Walsh, 2015, p. 62). In this sense to exclude non-normative experiences as outliers, non-representative of the majority, is to invalidate the experiences of the most marginalised because they are not frequent. This research seeks to examine actors' consideration of those face interlocking axes of oppression because they are marginal, not despite their marginality.

3.1.2 Venezuelan Migrants in Colombia as a Case Study of Adolescent Migrant Girls in Humanitarian Settings

This thesis will focus on Venezuelan adolescent migrant girls in Colombia as a case study. This case study is significant because it examines how successfully NGOs, multilateral, and governmental response to the needs of this group of migrants against the backdrop of humanitarian crises.

As aforementioned, Colombia is the largest recipient of Venezuelan migrants (Migración Colombia, 2021; UNHCR, 2021). Of the 1.7 million Venezuelan migrants and refugees in Colombia, 12% are under the age of 18 (Migración Colombia, 2021; UNHCR, 2021). As a result, there is a large proportion of the population who are adolescent migrant girls affected by the Venezuelan crisis.

Now is a crucial time to conduct valuable research on the case study of Venezuelan migrants in Colombia as the policy environment is shifting from short-term crisis measures to longer-term integration of migrants. At the beginning of the crisis, the Colombian state and non-state actors first reacted with emergency humanitarian measures, implemented to provide short-term relief (World Bank, 2021a). It is only in the past two years, that we have seen a move towards longer-term solutions including efforts to regularise Venezuelan migrants through the legislation (discussed further in Chapter 6).

At the beginning of this thesis, the motivation for this case study was the paucity of literature on this corridor of migration. Since then, there have been several valuable additions to the literature on Venezuelan migrants' access to healthcare in Colombia (Calderon-Jaramillo *et al.*, 2020; Flórez García *et al.*, 2020; Angeleri, 2021; Murillo-Pedrozo *et al.*, 2021; Rivillas-Garcia *et al.*, 2021; Pires *et al.*, 2022; Amuedo-Dorantes *et al.*, 2023; Ortiz-Ruiz *et al.*, 2023; Pérez and Freier, 2023). However, few focus on adolescent migrant girls' or on contraceptive care.

Comparing by region, there is still a relatively low number studies on adolescent SRH in resource-scarce settings focuses in Latin America relative to those on Sub-Saharan Africa or Asia (Hindin and Fatusi, 2009; Tanabe *et al.*, 2017; Ivanova, Rai and Kemigisha, 2018). So far, research has suggested heightened vulnerabilities, barriers and risks faced by Venezuelan migrant women and the difficulties in accessing contraception; if this logic is extended to adolescents it could partly explain the high numbers of adolescent pregnancies and unintended pregnancies amongst Venezuelans (as discussed in Chapter 4) (Calderon-Jaramillo *et al.*, 2020; IOM, 2020; Save the Children, 2020; Plan International, 2021).

More broadly, the case study analysing SRHR in adolescents in Colombia will add to a growing body of literature on the SRHR of adolescent migrant girls and refugees in other parts of the world such as China, Tanzania, Bangladesh, Ghana and Lebanon and other part of Africa, Asia, Europe and the Middle East from a Latin American context (Sudhinaraset *et al.*, 2012; Irani, Speizer and Barrington, 2013; Tanabe *et al.*, 2017; Ainul *et al.*, 2018; Ivanova, Rai and Kemigisha, 2018; WHO, 2018a; Alatinga, Allou and Kanmiki, 2021; El Ayoubi, Abdulrahim and Sieverding, 2021).

In short, the findings from this study can contribute a South American perspective to existing studies on adolescent migrant girls in humanitarian settings. Meanwhile, it will also provide a focus on the contraceptive care of adolescent girls to the literature on Venezuelan migrants in Colombia.

3.2 Mixed Methods

3.2.1 Justification of Transformative Mixed Methods

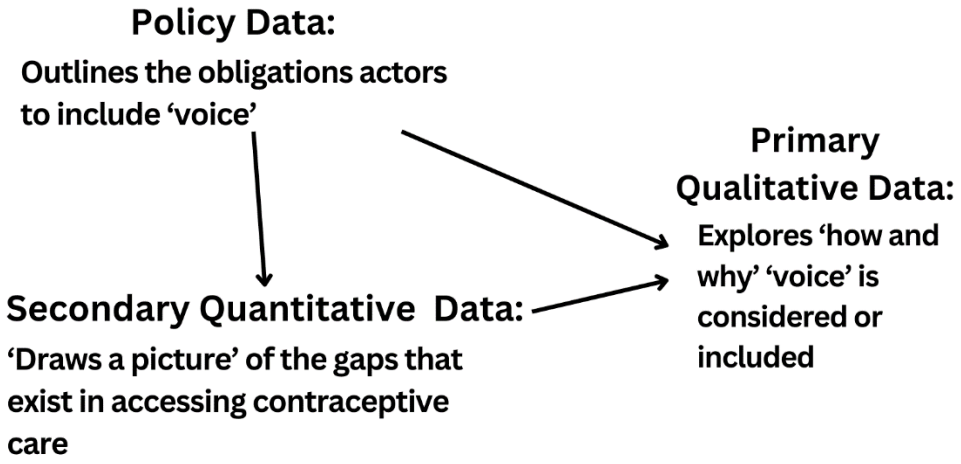
To answer how state and non-state actors consider and include contraceptive autonomy- developed as voice- in their responses, I adopted a mixed methods approach. A mixed-methods approach uses different research methods to answer separate sub-research questions, before triangulating the findings to generate a more 'complete' answer to the overarching research question (Bryman, 2016). Other authors in fields such as public health and nursing have named the use of several methods to answer separate research questions in one project as multiple methods, as opposed to mixed methods, (Martha, Sousa and Mendes, 2007). However, research in social sciences overwhelmingly uses the term mixed methods to describe the mixing of methods, regardless of the frequency or state at which methods are mixed (Creswell and Plano Clark, 2011; Bryman, 2016).

In particular, I adopt a transformative mixed method where researchers are driven by a theoretical framework that focuses on – for example – feminism or social justice with the aim of making recommendations to improve situations for marginalised populations (Creswell and Plano Clark,

2011). Considering this thesis promotes a reproductive justice framework, utilising a feminist epistemology to focus on marginalised populations, this research design is the most appropriate.

The mixing of methods was planned during the design phase (Creswell and Plano Clark, 2011), as *The Scale of Voice* demands that we understand what should be happening, where gaps exist, as well as 'how and why' they have or have not been addressed in actors' responses. As such, this thesis collected different types of quantitative and qualitative data simultaneously. The contribution of each method is illustrated in the figure below:

Figure 2 Demonstration of How Methods were Mixed in a Transformative Concurrent Research Design



In presenting the findings I first used quantitative methods to describe the extent to which inequalities exist on a national level. The goal of this chapter is to provide the reader with a sense of the scale of the issue or 'to draw a picture' of how inequalities are shaped by age, gender and migration in this case study (Gray, 2021). The remaining chapters utilise qualitative research methods to capture data which reveals 'how' and 'why' these inequalities have been (re)produced. Qualitative methods, such as allow for a nuanced exploration of individuals' experiences, perspectives, and decision-making processes concerning contraceptive autonomy. A review of the policies was conducted because this was felt to be the best way of observing what was 'supposed to be happening' (Goicolea, San Sebastián and Wulff, 2008). This included the responsibilities and obligations driving the practical design and implementation responses. As such, policy review was felt to be an important pretext to the fieldwork stage of the thesis. By delving into the attitudes and practices of stakeholders, including policymakers, healthcare providers, and community members, this research aims to explore the extent to which state and humanitarian actors engage with, and consider, adolescent migrant girls in the design and implementation of their responses, and how they

do so. Through this qualitative data collection, I sought to uncover the underlying factors that influence the ways in which state and non-state actors address or neglect issues of contraceptive autonomy. The table below, Table 6, shows how each different method of data collection contributes to answering a different sub-research question.

Table 6 Research Questions and the Methods of Data Collection Used to Answer Them

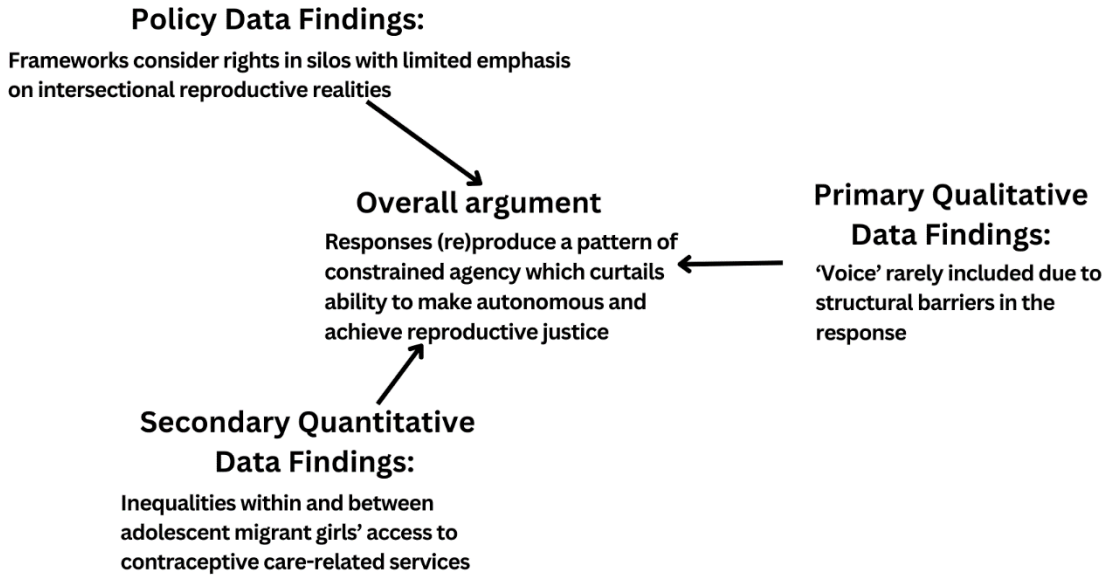
Research Question	**Links to *Voice***	**Data Source**	**Methods**
Are there inequalities in access to contraceptive-related reproductive services by age, and nationality for women and girls of reproductive age in Colombia?	Identifying the extent to which inequalities exist for adolescent migrant girls relative to other groups, as a means of understanding how the intersections of age, gender, and migration shape reproductive realities.	• Quantitative data on the service provision of services related to reproduction from Ministry of Health data and Profamilia (SRH provider in Colombia).	• Descriptive statistical analysis using cross-tabulation of data to determine the differences between the proportions of Venezuelan adolescent migrant girls seeking services related to reproduction compared to older migrants, and the host population using the most recent data available (2021).
How have actors acknowledged and enacted the need for differential contraceptive care services for adolescent migrant girls?	Acknowledgement of, and positive steps towards redressing of power relations for intersectional identities in implementations, so as to make responses appropriate for adolescent migrant girls.	• Interviews with adolescent migrant girls and key informants on the nature of their response, and the ways in which responses have been differentiated to account for the needs of adolescent migrant girls e.g., disaggregated data, AFHS etc.	• 5 informal pilot interviews with key informants. • 30 semi-structured, multi-perspective interviews conducted during fieldwork in Colombia in March 2022. Interview themes included: o Adolescent-friendly health services (AFHS) o Migrant-specific responses o Identify and respond to specific challenges o Specialist training offered by the employer o Rights-based issues such as privacy, misinformation, discrimination.

To what degree have adolescent migrant girls' voices been included? What are the specific modalities of engagement and inclusion utilised by state and non-state actors in their responses to adolescent migrant girls' contraceptive care?	What mechanisms did actors use, and how were they implemented? E.g., was dialogue both ways and did they use more than one method?	• Interviews with key informants and adolescent migrant girls to identify how actors conceptualise voice, modalities of participation, feedback, variety of methods made available to adolescent migrant girls.	• 5 informal pilot interviews with key informants.
			• 30 semi-structured, multi-perspective interviews conducted during fieldwork in Colombia in March 2022. Interview themes included:
			  ○ Defining *voice*
			  ○ Mechanisms to ensure *voices* are heard
			  ○ Factors that influence contraceptive (non-)use
			  ○ Feedback mechanisms

What are the key challenges and barriers faced by state and non-state actors in effectively engaging with and considering the voices of adolescent migrant girls when it comes to their contraceptive autonomy?	What barriers are preventing actors from using mechanisms of *voice*?	• Interviews with key informants to identify the main reasons why voice has not been (fully) included and their responses.	• 5 informal pilot interviews with key informants.
			• 30 semi-structured, multi-perspective interviews conducted during fieldwork in Colombia in March 2022. Interview themes included:
			  ○ Biggest issue faced when delivering responses
			  ○ Suggestions for improvement

Methods were then mixed again during the triangulations of findings in the 'interpretation phase' of the research. A term which is used by Creswell and Plano Clark, (2011) the final stage of the research process. At this stage of the thesis triangulates policy analysis, and secondary demographic health data alongside semi-structured interviews to understand how adolescents are consulted and heard by responders. As in a puzzle, each part contributes to the main argument of the research: namely that responses fail to consider and include the *voices* of adolescent girls. The policy shows that their intersectional reproductive realities are unaccounted for in normative frameworks. The secondary data shows how those at the intersections of age experience greater inequalities in terms of access and methods of contraceptive use, suggesting that actors are not creating responses that appropriately consider or include the priorities and preferences of adolescent migrant girls. Whilst the interview data demonstrated how *voice*, was often deprioritised or poorly implemented in ways that lacked consideration for the development of contraceptive autonomy for adolescent migrant girls. Several barriers were highlighted to explain *why* this was the case.

Figure 3 Illustration of data triangulation during the interpretation phase of the research.



The following sub-sections devolve into the particular methods of data collection in detail, describing why these methods are the most suitable to answer the sub-research questions and the overarching research question.

3.2.2 Policy Review

The purpose of the policy review was to understand the policies that apply to SRHR of adolescent migrant girls, and how these include the essential components of *voice*. The latter, consists of positive actions to account for the: intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration); participation in decision-making processes, and the opportunity to (not) use a variety of contraceptive methods. How is *voice* understood in the

frameworks and what obligations are placed on actors as a result? Policies were selected from international and national levels covering international human rights, international consensus documents, national law, national policies, programmes, and strategies as well as humanitarian guidelines.

International policies were sourced from digital databases for key terms. International norms and documents were through the UN database (https://juris.ohchr.org/) or for non-UN treaties the original source website. Key search terms included 'sexual and reproductive health', 'family planning', 'adolescent', 'girl-child', 'migrant', 'family planning', 'contracept*'[6]. To complete the systematic search, I hand-searched for mentions of relevant human rights when they appeared during the review of the literature, for example, in articles by Petchesky, (2007); Laurie and Petchesky, (2008); Goicolea, (2010); Barroso, (2014); Brown *et al.*, (2019). After reviewing the results to see if they applied to SRHR or to adolescents' or migrants health, those which did were placed in a matrix displaying the human right they applied to as in the international bill of human rights, the convention or consensus document that contained that right, and the article. The search yielded a total of 78 articles (which can be found in Appendix B), the key policies identified in the policy review were: the International Conference on Population and Development Programme of Action (ICPD PoA), Beyond 2015 and ICPD+25; the United Nations Declaration on the Rights of the Child, and the New York Declaration for Refugees and Migrants.

The same process was repeated to search for national-level policies, programmes, and strategies. National policies in Colombia were selected via a search of the Colombian Government's databases (https://www.funcionpublica.gov.co/; https://www.minsalud.gov.co/; https://www.corteconstitucional.gov.co;). Again, policies were selected which made changes in the application of the right to health, women, and girls' SRH and migrants' access to health rights. In total 70 national-level policies were selected due to their, relevance to health; women's SRH, adolescent SRH and Venezuelan migrants' SRH (which can be found in Appendix C). Those chosen for discussion were those which discussed the SRHR as a central component of the policy. These included: The National SRH Plan or PNSDSDR 2014-2021

I concentrated on normative strategies and operational guidelines that were identified as crucial in official correspondence during the research conducted for this chapter. The rationale behind this focus was based on the understanding that the Ministry of Health and Social Protection (MSPS), being a prominent state actor, holds significant influence, and many non-state actors either collaborate with or adhere to their guidance. Therefore, it was deemed essential to closely examine

[6] Which searches for all words beginning with 'contracept' including contraception, contraceptive and contraceptives.

the guiding instruments of the MSPS, considering their pivotal role in shaping policies and practices in the context under investigation. Consequently, the operational guidelines and strategies were the Adolescent and Youth-Friendly Health Services Model (or *servicios amigables)* and the Practical Guide for the implementation of MISP in Colombia

The analysis was driven by the questions identified in the conceptual framework of this thesis, where I developed *The Scale of Voice*. These included identifying who is implementing the policy, programme or strategy; what the objectives or aims are; who stands to benefit and why and how. In doing so, I was able to identify the key actors involved in the response, their obligations and whether these were binding or not, and finally the extent to which obligations included actions based on the intersectional reproductive realities of adolescent migrant girls.

3.2.3 Secondary Quantitative Descriptive Analysis

Once my desk review of the policies was completed, I began requesting permission for secondary data from the relevant data sources (listed in Table 7). To answer my first sub-research question of my research, 'are there inequalities in access to contraceptive-related reproductive services by age, nationality for women and girls of reproductive age in Colombia?'

I conducted descriptive statistical analysis to determine the absolute and relative inequalities within and between groups by age and migration status. To do this, I sought data on the use of contraceptive counselling, contraceptive use and types of methods used. Based on these requirements I identified the MSPS, Profamilia, Together for Girls, and Migración Colombia as key sources of data as shown in Table 7.

The MSPS being the main entity responsible for the delivery of the right to health, and the holder of all health utilisation data from health systems seemed an obvious choice given the prominence of this approach in existing literature (Calderon-Jaramillo *et al.*, 2020; Rivillas-Garcia *et al.*, 2021). Profamilia has a three-pronged purpose: it conducts research, delivers services and humanitarian projects to both Colombians and migrant populations. Most research on Venezuelan migrants in Colombia so far, has come from Profamilia (Profamilia, 2019; Calderon-Jaramillo *et al.*, 2020; Rivillas-Garcia *et al.*, 2021). During consultations they collect patient data that goes beyond legal requirements meaning their data is more detailed and comprehensive, meaning I was able to conduct disaggregation not available by some sources. This made this selection another strong choice for secondary data analysis.

Table 7 Secondary Data Sources in Connection to the Research Questions and Aims

Source	Name of Data Source	Information about the data source	Relevant data used in this study
National Information System for Social Protection (SISPRO)	The Individual Registry of Service Provision (RIPS) for the Colombian population The Circular Cube 029 for the Venezuelan migrant population for 2021	Data collected by the Ministry of Health and Social Protection's (MSPS) from health services in the country using health services[7]. The data recorded includes patient information on number of appointments, reason for the appointment, as well as basic demographic data for host and migrant population in Colombia[8] totalling roughly 2,200,000 people.	Data was collected for all persons who identified as female, with Colombian or Venezuelan nationality, and who were of reproductive age (15-49 years old) and accessed a health centre for services related to reproduction (ICD-10 Z30-Z39) in 2022 totalling 283,037 people.[9].
Profamilia	Secondary Data on Health Utilisation for year 2022	Patient data registry from Profamilia clinic. The data recorded includes patient information on number of appointments, reason for the appointment, as well as basic demographic data for host and migrant population who visited Profamilia health centres in Colombia[10] in 2022 totalling 283,037 people.	Data was collected for all persons who identified as female, with Colombian or Venezuelan nationality, and who were of reproductive age (15-49 years old) and accessed a health centre for services

[7] Health services encompass the institutions providing health services (IPS), independent professionals or professional practice groups, the entities administering benefit plans and the management, surveillance, and control bodies of the SGSSS Ministerio de Salud (2015) *Preguntas Frecuentes Registro Individual de Atención*. Available at: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/OT/FAQ-RIPS.pdf (Accessed: 22/07/2023).
[8] Collected through author's correspondence with MSPS.
[9] Codes Z30-39 as classified as 'Encounters with Health Services Related to Reproduction' according to International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) WHO (2019a) 'ICD-10 Version: 2019'. 2023/08/04/. Available at: https://icd.who.int/browse10/2019/en.
[10] Collected through author's correspondence with Profamilia.

			related to reproduction (ICD-10 Z30-Z39) in 2022 totalling 283,037 people.
National Administrative Department of Statistics (DANE)	National Population and Housing Census (CNPV) Population Projections for 2021	This data contains the population projections based on the results of the National Population and Housing Census – CNPV- 2018, by territory, age and sex (DANE, 2023b). Calculations are based on a detailed analysis of the recent past of the components that produce changes in the population, such as deaths, births, and migration patterns.	Used to calculate the total population of Colombians, to work out the percentage of persons 'seeking services related to reproduction'.
Migración Colombia	Distribution of Venezuelans in Colombia for 2021 (published 2022)	A scan of the Venezuelan migrants in Colombia based on Migración Colombia's own administrative data by age, sex and department (Migración Colombia, 2022). Sources include: The Current Immigration Cards (CE), The Special Permanence Permits issued (PEP), Records collected within the framework of the Temporary Protection Statute for Venezuelan Migrants (ETPV), from those who completed the survey completion phase, the migratory flows of Venezuelan migrants who entered Colombia, with Entry and Permanence Permits, in any of their 3 types[11], and the numbers of detections of Venezuelan migrants who left irregularly across the border with Panama.	Used to calculate the total population of Venezuelans, to work out the percentage of persons seeking reproduction-related healthcare.

[11] These include the Tourism Permit (PT), Integration and Development Permit (PID) or Other Activities Permit (POA) without a vocation for permanence

All these sources have their limitations (see Table 8), and a potential issue if using only one or two sources is that the full view of the situation for Venezuelan adolescent migrant girls will not be obtained. As a result, I used the best available sources of data as pieces of a puzzle to construct a larger picture of the situation of contraceptive care for Venezuelan migrants in Colombia in comparison to the host population, by age. Although each data source has its advantages and disadvantages, for the purpose of this research they were not viewed as separate entities. The following paragraphs address the limitations of each source; however, it should be acknowledged that each limitation has been in part mitigated by the fact the data has been triangulated to obtain as comprehensive a picture as possible.

Table 8 Limitations of Secondary Data Sources

Name of Data Source	Limitations of Data Source
RIPS for the Colombian population Circular Cube 029 for the Venezuelan migrant population	This data could include possible double counts, as there is no patient identification to account for if an individual uses the service first as one age, and then again after their birthday. Data is limited by the tendency to for medical professionals to use wide catch-all diagnostic codes.
Profamilia Secondary Data on Health Utilisation	The only data suitable for use was 2022 because the previous years it was not mandatory to ask the nationality of the person seeking healthcare. This meant there was no way of determining who was a Venezuelan migrant and who was a part of the host population.
National Population and Housing Census (CNPV) Population Projections for 2021	The accuracy of population projections depends on the reliability of the methods used. Assumptions about birth rates, death rates, migration patterns, and other demographic factors can introduce uncertainties.
Distribution of Venezuelans in Colombia for 2021 (published 2022)	Data is only available, despite further requests, for the figures by aggregated age group, which differed from I required to determine differences for ages 15-19. Therefore, the Arriga method for data smoothing was applied. Whilst this could still lead to some inaccuracies, it was deemed the most rigorous way of disaggregating data.

MSPS RIPS and 029 Cube

Data from the RIPS and 029 shows all the counts of interactions with the health system by both numbers of persons attended, and the number of appointments. Using the data from the Cube, I filtered the data so that only the relevant counts remained. This included filtering to show data from 2021, for those categorised as female, for individuals whose nationality was listed as Venezuelan or Colombian for the ICD-10 codes Z30-Z39. The details of which are listed in Table 9. This data was then grouped by 5 year age groups, excluding those under 15 and over the age of 49. As the data cube only functions in Excel and given the depth of statistical analysis required, I continued to used Excel to conduct the analysis for this data source.

Table 9 ICD-10 Codes Z30-Z39 Persons Encountering Health Services in Circumstances Related to Reproduction

ICD-10	Description
Z30	Encounter for contraceptive management
Z31	Encounter for procreative management
Z32	Encounter for pregnancy test and childbirth and childcare instruction
Z33	Pregnant state
Z34	Encounter for supervision of normal pregnancy
Z35	Encounter for supervision of high-risk pregnancy
Z36	Encounter for antenatal screening of mother
Z37	Outcome of delivery
Z38	Liveborn infants according to place of birth and type of delivery
Z39	Postpartum care and examination

To ensure the data collected reflected the research question I focused on Z30, Z34 and Z35 (see Table 10 and Table 11). The reason being that Z30 contraceptive-related care, and Z34 and Z35 are indicative of a lack of contraceptive care (where through autonomous or nonautonomous non-use). Previous research has extensively explored the intricate link between pregnancy and contraception.

Focusing for now on encounters with the health service for the supervision of pregnancy (Table 10), the codes Z340, Z348 and Z49 were merged to indicate the number of persons who received healthcare for supervision of 'normal pregnancy'. The remaining codes (Z351-Z359) were collated to generate the numbers of persons seen for supervision of high-risk pregnancy.

Table 10 ICD-10 Codes for Encounters with the Health Service for the Supervision of Pregnancy

ICD-10 Code	Description
Z340	Supervision of normal pregnancy
Z348	Supervision of other normal pregnancy
Z349	Supervision of normal pregnancy, unspecified
Z351	Supervision of pregnancy with history of abortive outcome
Z352	Supervision of pregnancy with other poor reproductive or obstetric history
Z353	Supervision of pregnancy with history of insufficient prenatal care
Z354	Supervision of pregnancy with grand multiparity
Z356	Supervision of pregnancy of very young primigravida
Z357	Supervision of high-risk pregnancy due to social problems
Z358	Supervision of other high-risk pregnancies
Z359	Supervision of high-risk pregnancy, unspecified

The choice of focusing on Z34 and Z35 is rooted in the understanding that contraceptive-related care is crucial in preventing unintended pregnancies. Notably, existing studies have highlighted that a significant portion of pregnancies among Venezuelan migrants is unintended (Flórez-García *et al.*, 2020). Additionally, that Venezuelan adolescent migrant girls tend to perceive 25 as an appropriate age to have their first child (Plan International, 2021). This information provides context for the investigation into contraceptive care and its potential impact on pregnancy outcomes. Beyond the connection between contraception and pregnancy, the study delves into the distribution of normal and high-risk pregnancies. This exploration aids in understanding whether Venezuelans, particularly migrant women, have adequate access to maternal care as, it provides insights into whether maternal care is sought primarily in emergency situations or if it is accessed regularly. By distinguishing between normal and high-risk pregnancies, the study aims to uncover patterns and

disparities in SRH utilisation among the Venezuelan migrant population. As Venezuelans are entitled to maternal care by law, this serves as a useful litmus test for the likelihood contraceptive care is being provided.

When examining contraceptive-related care (Z30) I removed the following ICD-10 codes from the dataset: sterilisation, admission for interruption of fallopian tubes or *vasa deferentia* (Z30.2); and menstrual extraction, interception of pregnancy and menstrual regulation (Z30.3). The reason for this being that their relevance to the research question was tangential. The remainder is what I refer to as contraceptive-related services.

Table 11 ICD-10 Codes Z30.0- Z30.9 for Services Related to Contraception and their Definitions

ICD-10	Description
Z30.0	General counselling and advice on contraception
	Family planning advice (not otherwise specific)
	Initial prescription of contraceptives
Z30.1	Insertion of (intrauterine) contraceptive device
Z30.2	Sterilisation
	Admission for interruption of fallopian tubes or vasa deferentia
Z30.3	Menstrual extraction
	Interception of pregnancy
	Menstrual regulation
Z30.4	Surveillance of contraceptive drugs
	Repeat prescription for contraceptive pill or other contraceptive drugs
	Routine examination for contraceptive maintenance
Z30.5	Surveillance of (intrauterine) contraceptive device
	Checking, reinsertion or removal of (intrauterine) contraceptive device
Z30.8	Other contraceptive management (not classifiable elsewhere)
	Postvasectomy sperm count

Z30.9	Contraceptive management, unspecified

To analyse this dataset, I initially calculated the ratio of appointments to services by dividing the number of appointments by the total number of persons. Following that, I determined the percentage of persons who attended each service in relation to the population, stratified by age and nationality, using population estimates as denominators. This approach allowed for the examination of variations in the frequency of attendance across different demographic groups. To assess the inequality in attendance percentages between Colombia and Venezuela, I divided the percentage of persons attended from Colombia by the corresponding percentage from Venezuela. The difference between these ratios was then calculated by subtracting the percentage of persons seen for Venezuelans from that of Colombians. Confidence intervals were not produced because it was felt given the focus on relative differences as opposed to absolute differences, they did not add a meaningful contribution to the interpretation of the data.

As with all administrative health data, the MSPS RIPS and 029 Cube data has limitations. For starters, accuracy is limited by the ICD-10 codes and how they are input (see also Chapter 8). By that I mean, some codes aggregate various contraceptive methods into one code, e.g. supervision of contraceptive medicines (Z30.4) could refer to any of the following methods: barrier (Z30.49), diaphragm (Z30.49), examination (Z30.8), injectable (Z30.42), intrauterine device (Z30.431), pills (Z30.41), subdermal implantable (Z30.46), transdermal patch hormonal (Z30.45) or the vaginal ring hormonal (Z30.44). In addition, that the number of people using services by age category may be susceptible to double-count individuals who transitioned from one age group to another, for example, someone who has their first pregnancy supervision appointment at age 19 and then again at 20 will be counted as a person attended in both categories. This last limitation is not present in the data from Profamilia.

Profamilia

The data received from Profamilia covered 2020-2022 for those categorised as female whose encounter with the health service was for ICD-10 codes ranging for Z30-Z39. The data presented the number of appointments, along with demographic data and the diagnostic codes applied during the appointment. In this dataset, patients have an identification number which makes it possible to track the usage of one individual over another. Using the same steps for calculating the percentage, ratios, and difference between the ratios as with the MSPS data, I was able to assess the patterns in usage. This was useful, as Profamilia is a non-for-profit health provider, whereas most health centres are

financially independent so seek to make a profit. Profamilia provides some patients with services through humanitarian efforts, whereas health centres are more likely to provide reproductive services to those affiliated with the health insurance (or in the case of an emergency). Therefore, Profamilia would be expected to be more accessible to irregular migrants. Any variations in patterns of appointments indicate whether accessibility changes patterns of attendance or usage. Because the original data set was large all the data could not be contained in a single Excel file, I used STATA 17 to conduct this part of the analysis.

Population Denominator

The calculation of total population to be used as the denominator for working out utilisation rates has been conducted with the most accurate method possible. For the Colombian host population, the number of persons in 2021 disaggregated by sex and age was available from the postcensus analysis of the census data by DANE (DANE, 2023b). Because data was already disaggregated no further analysis was required. This was used as a denominate for the Colombian population.

For the Venezuelan population, using the original data was unavailable. Data was only available from the distribution of the Venezuelan population in Colombia by sex in the following age groups, 0-4, 5-17, 18-29, 30-39, etc. These age groups needed to be reconstructed so they matched 15-19, 20-24, 25-29 and so on. To do this I used the Arriaga method to smooth data into individual years and then regroup them according to the desired age groups (Arriaga, 1968; Dyrting, Flaxman and Sharygin, 2022). The results are detailed in Appendix D. Once the required age groups were attained this was used as the population denominator for the Venezuelan migrant population.

As aforementioned, this thesis adopts methods in line with other studies who have measured inequalities in the migrant population (Profamilia, 2019; Calderon-Jaramillo *et al.*, 2020; Rivillas-Garcia *et al.*, 2021). However, it is plausible that the actual proportion of 15–24-year-olds is higher than estimated in the population projections, potentially leading to an underestimation of the inequalities. Consequently, it is imperative to recognise that the actual level of relative inequalities between Venezuelan women of reproductive age in contraceptive coverage may indeed be higher than indicated by these calculations. It is important to underscore that it represents the most suitable method available for estimating contraceptive coverage in this specific context.

3.2.4 Multi-perspective, Semi-Structured Interviews

The aim of conducting semi-structured interviews was to develop qualitative empirical evidence on the responses that offer contraceptive services, resources or information to Venezuelan adolescent migrant girls in Colombia; gather data on responses to SRHR of adolescent girls in humanitarian settings and how responders consider adolescents' voice – and by extension contraceptive autonomy. Multi-perspective interviews were used, offering a 'birds-eye view' of the different perspectives to gain a richer understanding of the process, in this case, the process of responses between actors and migrant girls (Jane, Holland and Gillies, 2010; Vogl, Schmidt and Zartler, 2019). They are often used in health research to determine differing views between policymakers, patients, doctors, and nurses (Kendall *et al.*, 2009; Jane, Holland and Gillies, 2010; Benton *et al.*, 2020). One of the benefits of using multi-perspective interviews is that they acknowledge the different lived experiences of participants. This can enable the researcher to any points of contention and differing perspectives between participants. Multi-perspective interviews are also beneficial here, given the focus on relational autonomy, to understand the perspectives and tensions of different actors at both the individual and structural levels (Ibid.).

To decide who to interview I mapped all the actors that were identified as taking part in the processes of designing and implementing responses to adolescent migrant girls' contraceptive care. This was done using desk-based research about Venezuelan migrants in Colombia (Chapter 4) and through informal interviews. The table of state and non-state actors I developed in the introduction of this thesis also guided the interview sampling process Table 1 Categories of State and Non-State Actors Involved in the Design and Implementation of Contraceptive Care Responses. I selected interviewees from each stage of the policy or programme design, implementation and monitoring and evaluation stages, which is presented in (Table 12).

Prior to formal data collection, 10 informal interviewees were used to assess the appropriateness of interview guide, to develop networks of key informants etc. Informal interviewees were selected through the authors existing network of academics, journalists, international NGOs (INGOS) professionals, health providers, and teachers from schools with large proportions of Venezuelan migrant girls. These individuals were informal interviewees and not key informants, because they either did not work closely enough with adolescent migrant girls SRH sufficiently answer key parts of the interview guide, or they had a conflict of interest.

In total, I contacted 33 organisations, and discounted 7 because their services ended up not servicing migrants or had no relation to SRHR. In total there were 16 non-state actors, 11 state actors and 3 adolescent migrant girls as seen in Table 12.

Table 12 Number of Interviewees by Sector and Type of Organisation

Sector	Type of Organisation	Number of Participants
Public Health	State	3
Public Health	Departmental	2
Health	Multilateral	4
Medical	Not-for-Profit	4
Migration	Multilateral	3
Legal	NGO	3
Migration	State	2
Health (Non-Medical)	Foundation	3
Migration	NGO	1
Education	Medical	1
Education	NGO	1
Total		27
Adolescent migrant girls from Venezuela in Bogota		3

Interviewees were asked questions from the interview guides. There were separate interview guides for key informants and for adolescent migrant girls. The main difference was that the adolescent migrant interviews were shorter because it asked about adolescent migrant girls' experience of the response, whilst key informants asked about the design and implementation of the response. The latter also used more technical language, whereas the former used Plain English. The full interview guide is detailed in Appendix A.

Table 13 Table Linking the Research Questions, Voice and Interviews

Sub Research Questions	Link to Levels of Voice and Mechanisms
Are there inequalities in access to contraceptive-related reproductive services by age, nationality for women and girls of reproductive age in Colombia?	• Who are the main beneficiaries of the responses? Which sub-populations and how many persons? (e.g., host and migrant population, adolescent migrant girls)
How have actors acknowledged and enacted the need for differential contraceptive care services for adolescent migrant girls?	• Did the response differentiate to account for intersectional reproductive realities? (e.g., did it provide staff with training on adolescent-friendly, migrant-inclusive responses?)
To what degree have adolescent migrant girls' voices been included? What are the specific modalities of engagement and inclusion used by state and non-state actors in their responses to adolescent migrant girls' contraceptive care?	• What mechanisms did actors use, and how were they implemented? (e.g., was dialogue both ways, did they use more than one method?)
What are the key challenges and barriers faced by state and non-state actors in effectively engaging with and considering the voices of adolescent migrant girls when it comes to their contraceptive autonomy?	• What barriers are preventing actors from using mechanisms of *voice*?

Data analysis consisted of transcription, two rounds of coding, and thematic analysis in line with the stages presented by Braun and Clarke, (2006). Parent codes were determined deductively in accordance with the literature review, research questions, and the interview guide and inductively as I became more familiar with the patterns emerging in the transcripts. At this stage a total of 36 codes were identified. From these, some codes were considered less relevant, less internally

consistent or were merged with other codes. The second round of coding adopted a more in-depth iterative process to present the final themes presented in the table below. From here, key quotes were selected as examples for use in the body of the these. These were then considered using *The Scale of Voice* as an analytical framework for answering the sub-research questions.

Table 14 Themes Identified During Thematic Analysis

Theme	Definition of Theme
Emergency Care	(In)access to emergency care only
Affiliation to Health System	Mentions of the migrants need to be affiliated
Coordination Across Sectors and Levels	Response covers more than one sector and/or operates at different levels of governance.
Donor Influence	Donors influence the nature of the response.
Differentiation for Venezuelan Adolescent Migrant Girls	Mechanisms of implementation that demonstrate a gendered, differential, migrant-responsive, child-inclusive approach
Adolescent-Friendly Health Services	Identification of servicios amigables or services which include those elements
Training Given to Participants	Evidence of rights-based training to professionals to deliver differential approach
Methods	Types of modern contraceptives used in responses, the motivation behind the choice of methods and how they are made accessible.
Defining Voice	Interviewees' conceptualisation of voice, (before the interviewer introduces their understanding).
Feedback Mechanisms	Mention ways in which Venezuelan adolescent migrant girls can share opinions on the contraceptive care they have received
Participation	Ways in which Venezuelan migrants have been part of designing, implementing, and monitoring responses
Challenges for Including Voice	Factors which have prevented actors including adolescents' voices more strongly

3.3 Ethics

The research was approved by the University of Southampton's Board of Ethics ERGO II. This includes key informant interviews (ERGO 70067) and adolescent interviews (ERGO7081). In Colombia, ethics was approved by Profamilia (CEIP-11-2022). This research project respects the principles of voluntary participation, informed consent, respect, integrity, transparency, the right to withdraw and avoidance of harm. This research project was conducted in full compliance with research ethics norms, including the codes and practices established in the ESRC framework for research ethics including fairness, respect, care, and honesty.

Furthermore, methods were designed in compliance with appropriate legislative frameworks and be compliant with guidelines that inform best research practices. It has been developed in line with ethical guidelines of the Conseco de Organisations Internationals de las Ciancia's Medicos –CIOMS-), Ethical Research Involving Children, the WHO Ethics Review of Guidelines of Health-Related Research with Human Participants and the Resolutions No. 008430 de 1993 (Ministerio de Salud, 1993; WHO, 2011; ERIC Compendium, 2013; Council for International Organizations of Medical Sciences, 2017).

Written consent was acquired, and all data has been anonymised and stored in line with the University of Southampton's Data Management Policy. When adolescents were interviewed, they were over the age of 18. Informed consent was explicitly given through consent forms for key informants and adolescent interviews. Before signing, the participants were given a participant information sheet (PIS). The PIS were available in different formats depending on the audience and were available in both Spanish and English.

As I have discussed in the introduction of this thesis, adolescent migrant girls often find themselves in situations of vulnerability. Therefore, additional ethical protocols were adopted during the interviews with adolescent migrant girls. The fieldwork was conducted during March 2022. All interviews were conducted in person, via a gatekeeper institution who was present but not in the room during the interview. This consisted of a team of a lawyer, psychologist and programme manager who had sustained contact with those interviewed to provide follow-up care and/or support if needed. Interviews with adolescent migrant girls were also shorter than the interviews with key informants to avoid fatigue or inconvenience. All interviews were conducted in private – which was difficult to come by in community settings. The interpreters were trained before interviews took place, on matters of confidentiality, respect, anonymity and to spot signs of distress.

Chapter 4 Contextualising the Venezuelan Migrant Crisis: Background and Policy

Venezuela is experiencing a protracted crisis, which has led to the displacement of 7.8 million Venezuelan migrants and refugees (R4V, 2023b). The crisis led to an initial wave of Venezuelan migrants and refugees who left for political reasons, however, since 2018, many people have left Venezuela for socioeconomic reasons (Jeronimo Kersh, 2020). This chapter details the drivers of migration from Venezuela to Colombia, the conditions in which Venezuelans arrive in Colombia and the policy and legal obligations. These discussions frame the responses discussed in the substantive chapters of this thesis.

4.1 The Venezuelan Migrant Population in Colombia

GIFMM estimates that 2.9 million of those 7.8 million Venezuelan migrants and refugees reside in Colombia (R4V, 2023b). Venezuela's protracted crisis is complex, but this sub-section provides a brief overview of the background of the crisis that provides the reader with the essential context of the drivers of migration from Venezuela to Colombia.

4.1.1 Background to the Venezuelan Crisis

Formerly united as Gran Colombia, Colombia and Venezuela were liberated in 1830 by Simon Bolivar to form Colombia and Venezuela. Contemporary estimates suggest Venezuela has a population of 28,704,954 (World Bank, 2021b). The following period from 1830 was characterised by a series of military dictatorships until democratic rule began in 1958 (Boraz *et al.*, 2007).

In 1998, the so-called Bolivarian revolution took place in which Hugo Chávez developed a populist-authoritarian regime. The ideology, based on the ideas of Venezuela's founding fathers Simón Bolívar and Simón Rodríguez, focused on using the state's resources to benefit the poor (Trinkunas, 2005). Venezuela's economy heavily relied on revenues from the state-owned oil company and benefited from high oil prices during the Chavez period. In 2010, Chávez declared 'economic war' on the 'stateless bourgeois' as shortages of food and basic supplies increased amidst price controls (Cancel, 2010). The economic situation worsened under Chávez' successor Nicolas Maduro (2013-present).

Petroleum dependency, falling oil prices, international sanctions, insufficient investment in health, infrastructure and human services, corruption, and hyperinflation have led to social and economic crises (ONU: Oficina del Alto Comisionado de Derechos Humanos (ACNUDH), 2019). The current Maduro administration denies the existence of a humanitarian crisis and further denies accusations of brutality, torture, and political persecution (Human Rights Watch, 2017). Since 2014, the legitimacy of Maduro's presidency has been questioned and there has been a rising number of protests, which have been violently suppressed (Ibid.). Political and economic instability has led to what has been deemed the Venezuelan crisis.

The political and economic crisis has deeply impacted the health system in Venezuela. The true extent to which the political and economic crisis has affected the health system is unknown as the Venezuelan Health Ministry ceased to publish official statistics and health indicators. The government's recent refusal to release epidemiological data has resulted in a lack of peer-reviewed literature about the magnitude of the socioeconomic situation inside Venezuela (Page et al. 2019). Some data is still received by Pan American Health Organisation (PAHO) and individual testimonies, and reports from NGOs, multilateral and civil society indicate that there are high levels of unemployment, malnutrition, poverty, and disease (Human Rights Watch, 2018).

According to ENCOVI (*La Encuesta Nacional de Condiciones de Vida*), an effort by Venezuelan academics to replicate the standard household survey, poverty has risen from 48.4% in 2014 to 91% in 2017 (Escobari, 2019). Estimates of poverty levels have since increased. In 2020, 96% of Venezuelan households were in income poverty, with 79% in extreme income poverty and unable to purchase basic foods (Amnesty International, 2020). Four out of every ten households experience daily disruptions in electricity and 80% do not have safe drinking water (Van Praag and Arnson, 2020). In 2019, it was reported that hospitals have less than 30% of the medical supplies they need (Escobari, 2019).

During the COVID-19 pandemic, the government neglected the deteriorating hospital conditions and water shortages (Human Rights Watch, 2020). The already inadequate health system now faces further shortages of medication and resources, basic healthcare facilities have been interrupted and there is a shortage of medical staff (Save the Children, 2020). Additionally, there has been an increase in vaccine-preventable diseases such as measles (Human Rights Watch, 2018; Doocy *et al.*, 2019; Van Praag and Arnson, 2020). Alongside physical health, the crisis has had an impact on the psychological well-being of Venezuelans. In a recent report on adolescent Venezuelan migrants, 13% of respondents said they had symptoms of depression, demonstrating the harmful effect that the

crisis is having on their wellbeing (Plan International, 2021). The shortages in the public health system have significantly impacted the lower and middle classes who used to rely upon state-provided healthcare (Bahar, Piccone and Trinkunas, 2018). This has severely impacted the ability of Venezuelans to realise their contraceptive care priorities and preferences autonomously.

4.1.2 Sexual and Reproductive Health for Venezuelan Migrants in Colombia

The lack of social protection, limited access to basic resources, and the unstable public infrastructure in Venezuela have created a precarious environment, particularly in terms of accessing appropriate contraceptive care.

It is important to acknowledge that many drivers of displacement are heavily gendered, in that they affect women and girls in distinct ways. Feminist approaches to the study of migration have shown how gendered issues influence women and girls' reasons for migrating, their experiences *en route*, and in their host country. For example, the 'feminisation of migration', recognises migration as a gendered process that can exist as a form of violence linked to the violation of women's rights (Piper, 2003; Cunneen and Stubbs, 1997 cited in Piper, 2006, 152; Lutz, 2010). Another example is the way SRH, as a gendered form of healthcare, has motivated migration patterns. In cis-gendered heterosexual relationships gendered social norms often distribute reproductive responsibilities unequally, delegating contraception to one person, usually women and girls (Brown, 2015; Littlejohn, 2021). Hence, SRH is an area of interest of key concern to many migrant women and girls (Cintra, Owen and Riggirozzi, 2023, p. 27). Venezuelan migrants in Latin America have been forced to flee not only due to practical reasons but also because their situation as women and girls has produced gendered forms of risk (Cintra, Owen and Riggirozzi, 2023).

Importantly, poor maternal and neonatal health outcomes are highlighted as key issues facing Venezuelan migrants (Doocy *et al.*, 2019). A combination of factors such as malnutrition, lack of resources and services, and increased levels of disease have culminated in a rise in maternal, neonatal and child mortality-related indicators. The last available official statistics indicated that from 2015-2016, maternal mortality increased by 66% and infant mortality by 30% (Fraser, 2017). A rise in maternal and child mortality indicates severe obstacles in the availability, access and acceptability of maternal and child services and the low level of vaccination coverage (Coalición de Organizaciones por el Derecho a la Salud y a la Vida, 2015). Further, there has been a rise in HIV rates of infection and unintended pregnancies (Albaladejo, 2018). The rise in unintended pregnancies within an environment where abortion is both illegal and subject to strong social stigma

compels numerous women to seek unsafe abortions (Profamillia, 2019). As a result, doctors report an increase in women presenting with complications from clandestine abortions (Albaladejo, 2018).

The lack of SRH care extends to contraceptive care. In 2018 it was estimated that 80% of women had an unmet need for contraception (UNFPA, 2019b). Reports suggest contraceptives are increasingly unavailable even from private health institutions and are only available to those who can afford and know how to buy them at 25 times their price on the black market (Albaladejo, 2018; CARE, 2019). For adolescent girls, the lack of contraception in Venezuela has been linked to a 65% increase in adolescent pregnancy since 2015 (ONU: Oficina del Alto Comisionado de Derechos Humanos (ACNUDH), 2019). Furthermore, adolescent pregnancy has been cited as the main reason that adolescent girls drop out of school (ONU: Oficina del Alto Comisionado de Derechos Humanos (ACNUDH), 2019; Save the Children, 2020). In turn, reducing the number of girls who complete their education or continue to pursue higher education pathways. This leaves many with limited options for future careers and earning potential.

Being a major host country has impacted the capacity of the Colombian health system to meet demand. In addition to the host population, and those internally displaced by conflict, an estimated 6 million non-nationals are using the health system (Wenham, 2021). Providing healthcare for migrants has increased economic pressure on the government. Reports suggest Colombia has spent $187.8m (£133.2m) on migrant healthcare; a figure which Colombia's Central Bank expected to quadruple between 2020-2022 (the figures have not yet been released) (Buschschlüter, 2021). As I will detail later in Section 4.2 GIFMM, established in 2016 by UNHCR and IOM, leads the national response to the Venezuelan migrant and refugee crisis through its R4V platform. These non-state actors collaborate with state actors through GIFMM which is designed to support the state health system. Therefore, it is important to provide a brief context of how the health system is structured for the host population in Colombia.

The Colombian health system has two main health insurance schemes which make up the Sistema General de Seguridad Social en Salud (SGSSS) national health coverage system. The contributory scheme, mandatory for formal workers over a certain pay threshold, is the most common type of insurance (Guerrero *et al.*, 2015). This scheme called Entidades Promotoras de Salud (EPS) is administered by various insurance companies including SURA, Comfenalco, and Coomeva. Once an individual registers with an EPS, they are assigned to a health centre or Instituciones Prestadoras de Servicios de Salud (IPS) in Spanish. The subsidised regime (Sistema de Selección de Beneficiarios Para Programmeas Sociales or SISBEN) provides health insurance for the unemployed, informal sector

workers and those of lower socioeconomic status (Guerrero *et al.*, 2015). For those on the EPS, once this basic plan has been purchased, there is an option (for those who can afford it) to add an extra package on top of their basic health plan to guarantee access to a wider variety of treatments or to access different high-standard facilities.

The main barrier to Venezuelan migrants accessing healthcare and thus, claiming their right to health, is status and documentation. Angeleri (2021) in setting the structural context of the right to health in Colombia, details the legal mechanism by which Venezuelans have acquired legal status. Tracing the most recent legislation, which I discuss in the next sub-section, and again in Chapter 6, Angeleri (2021) demonstrates how difficult acquiring regularisation through these mechanisms is for irregular migrants. They fail to consider simple factors, such as that many Venezuelans in poverty cannot meet the conditions, do not have a passport or do not have sufficient information to regularise (Angeleri, 2021).

There is a further issue brought by the unprecedented migration from Venezuela to Colombia that relates to how age and gender interact in this migratory flow. So far, studies focus on the needs and experiences of the population of the reproductive age – grouping adolescents, young women, and women in their late 20s and 30s with perimenopausal women (Doocy *et al.*, 2019; Calderon-Jaramillo *et al.*, 2020; Flórez García *et al.*, 2020; Murillo-Pedrozo *et al.*, 2021; Rivillas-Garcia *et al.*, 2021). For example, Flórez García *et al.*, (2020) conducted a study of pregnant Venezuelan women in Barranquilla and Riohacha, which are areas with high proportions of Venezuelan migrants. They found that nearly all of the women knew about contraceptive methods and where they could be accessed. However, only half managed to get it the last time they tried to obtain it, meaning that most of the pregnancies were reported as unplanned (62.3% of all pregnancies).

However, those studies with disaggregated data have found that younger people experience greater vulnerabilities and difficulties accessing services (Profamilia, 2019; Ortiz-Ruiz *et al.*, 2023). This makes sense considering that many older women in Venezuela, without access to regular contraception have turned to permanent surgical methods (Albaladejo, 2018). The table below shows the conditions in which Venezuelan migrant women of reproductive age in Colombia seek contraceptive care, their needs, expectations, circumstances, and gaps in service provision based on these expectations (Rivillas-Garcia *et al.*, 2021, 8). It is particularly relevant to draw attention to the findings presented in this table because they show that adolescents have a high need for contraception and have high conditions of vulnerability.

Figure 4 Figure Reproduced from Rivillas-Garcia et al. 2021

Needs	**Circumstances**
• Contraception with modern reversible long-term and emergency methods at all levels (emergency, outpatient extramural actions). • Adherence and access to cost-effective contraceptive services and free of discrimination. • Quality information and comprehensive sex education (CSE).	• Irregular adolescents and youth without support networks. • Sexually active adolescents. • Adolescents in a state of pregnancy. • Adolescents in abandonment or family breakdown without support networks. • Adolescent victims of different types of violence. • Adolescents and young people in labour exploitation. • Women and girls as victims of SGBV. • Women and men sex workers.
Expectations	**Opportunities for attention focused on the expectations of migrants and refugees**
• Receive high-quality information on how to secure the General System of Social Security in health and the right to health. • Receive information without discrimination and free of stigma. • Achieve insurance to the health system quickly and effectively. • To find contraceptive methods easily, without barriers and according to their SRH needs	• Generate key information on guidelines and mechanisms for membership and avoid excessive bureaucracy. • Ensure that health system staff provide transparent non-stigmatising and sensitive information. • Make the most of the first contact with migrants seeking information on methods and provide them during that first contact in a timely and effective manner. • Improve the supply chain of contraception methods so that its services are regular and continuous without risks of being interrupted

	even in the most difficult situations within the humanitarian response.

Elsewhere, it was stated that contraceptive methods and adolescent-friendly services were among the top needs reported by migrants themselves (Profamillia, 2019). To be sure then, there is evidence that Venezuelan migrant women lack access to contraceptive care. These studies have noted, as an aside, the complex situation of adolescent migrant girls. Yet so far no one has considered the responses to adolescents' contraceptive care needs. Nor, have they addressed this from a perspective that critically assesses the roles of state and non-state actors – since for the most part, such studies are funded by organisations providing services such as Profamilia (Rivillas-Garcia et al., 2021) or the International Organisation of Migration (IOM) (Flórez-García et al. 2020). In addition, there has been no discussion about the provision of contraceptive methods in terms of contraceptive care, autonomy, and reproductive justice. The latter is important because so far, it is clear actors have not been adequately responding to the contraceptive care needs of adolescent migrant girls in a way that combats the complex reproductive realities they experience.

This thesis uses contraceptive autonomy as a way of identifying injustices that need to be redressed and that are associated with structural power imbalances which underpin reproductive health inequalities amongst adolescent migrant girls. These imbalances come from the way and extent to which adolescent migrant girls are included and their *voices* are taken into consideration when state and non-state actors make decisions about SRH care, particularly contraceptive care. To comprehend the extent to which actors have incorporated and acknowledged the voices of these girls in their responses, it is essential to consider the frameworks of reproductive governance that shape access to citizenship and, consequently, the healthcare system. Understanding the international and national frameworks to which these actors are held accountable provides critical context for their roles, purposes, and the extent to which they see themselves as responsible for providing care.

4.2 Actors Roles and Responsibilities

In Colombia, the programmes, projects and policies are designed and implemented by a web of different actors. Varying combinations of state, civil society and humanitarian actors work in cooperation and unilaterally to deliver responses. From the desk review of the empirical literature

and interviews with key informants, I identified four categories of responders, as can be seen in the table below.

Table 15 State and Non-State Actors Roles in the Response to Venezuelan Migration into Colombia

Actor	Type of Actor	Roles and Responsibilities
State actors	• Government ministries including health and social protection, migration and border control. • Local government officials (e.g. sub-secretariats of health). • Multisectoral working groups.	• Designing policy and identifying priority policy areas, to which to distribute resources. • Joint role in coordinating international cooperation, setting priorities, and guiding donors in design and implementation. • Delivering the territorial model based on the needs of the population and resources given in line with national advice. • Point of coordination for donors in the region implementing responses.
	• Public hospitals, health centres, women's health centres, 'family planning' clinics, community health workers or another government distributor.	• To provide subsidised healthcare services via the 'Basic Healthcare Plan' to those of lower socioeconomic status. They work at the point of service provision, having daily contact with migrants.
Non-state actors	• Foreign governments. • Interagency groups or humanitarian clusters (R4V). • United Nations (UN) agencies, • International or national NGOs • Pharmaceutical companies. • Philanthropic donors.	• These actors provide information, financial support, technical support, resources or direct medical care. When providing support, international cooperation typically contracts other non-state actors to implement the response on their behalf.

	• Private hospital or clinic, private doctor, private nurse, private health centre. • Civil society: NGOs; charitable foundations; not-for-profit organisations or faith-based organisations (FBOs). • Pharmaceutical retails or dispensaries.	• These local actors provide psychosocial support, medical services, bureaucratic assistance, basic resources, and signposting to other services. They work at the point of service provision, having daily contact with migrants.

Non-state actors such as NGOs, FBOs, charities, foundations, and not-for-profit organisations, served three primary functions. The first was as the providers of care, education, information, and resources on the ground.[12] This approach was most common in local Colombian or national civil society actors, who had adapted services to include Venezuelans. However, some were Venezuelan civil society actors based in Colombia. Secondly, many key informants described how civil society actors, who provided services, also functioned as sources of up-to-date information about migrants' health needs to international organisations and state actors.[13] Thirdly, many undertook advocacy roles to create awareness and lobby the government on matters concerning the rights of Venezuelan migrants. Civil society actors then served a fluid role in delivering services, but also creating data to communicate to actors at a departmental or national level. This included adopting a 'migrant-inclusive' focus into policies that were formulated on SRH such as the amendment to the abortion laws following C-055 of 2022, as well as the campaign to continue SRH services throughout the COVID-19 pandemic.[14]

Cooperation from international organisations often took indirect action through funding civil society programmes or contracting tasks to civil societies. This process involved giving financial support or technical assistance that transformed the types of service available.[15] In this case, to offer more comprehensive contraceptive care where the national health system could not meet demand. In areas with less of a state presence, international cooperation served to 'fill the gap.'[16] Alternatively,

[12] Participant 30, a not-for-profit health provider.
[13] Participant 15, a professional from a multilateral organisation.
[14] Participant 18, a public health medical professional, and Participant 26, a public professional working in social protection.
[15] Participant 26, a public professional working in social protection.
[16] Participant 28, a professional from a multilateral organisation.

international organisations were seen providing care directly to migrants or in conjunction with existing civil society actors.[17] So, whilst the state was seen as the actor ultimately responsible; the role of international cooperation was seen as essential to support the national health system in achieving its obligation. They had an important role in coordinating the response between different actors, alongside the state by providing guidance, designing responses, contact with donors through GIFMM and its associated partners and donors. This created a designated point of coordination through different themes or 'clusters' which was beneficial to structure the response. The Cluster Approach is designed to distribute responsibility for providing services, such as health and shelter, among various cluster-lead agencies (UNHCR, 2024). This ensures that no single agency bears accountability for the entire response. Although many actors mentioned are GIFMM partners, it is important to note not all responses are part of the Cluster.

The third category of responder is the Ministry of Health (MSPS), which as the central government body creates national advice and policy frameworks for local governments. Most participants saw responsibility and accountability as ultimately residing with the central government – that is the MSPS[18]. Meanwhile, the MSPS coordinates with international organisations through the Health Cluster and the sub-cluster on SRH. Through the cluster the MSPS facilitates coordination across various levels, setting priorities and guiding donors in design and implementation. Key informants spoke of an upcoming national meeting on migrant health as a way of delegating and coordinating their response[19].

As several aspects of health governance are decentralised, local governments serve as a useful point of coordination for activities in their territories. Local governments' responsibilities include creating territory-specific health plans that align with the developmental plans and public health policy dictated by the MSPS. International organisations also supported local government efforts to implement those plans, receiving guidance from them about which types of services are required from location to location. The national and local health sub-secretaries further work with other government institutions such as the Ministry of Foreign Relations, Migration Colombia, the ICBF, and the National Planning Department on specific issues such as protection, integration or reducing xenophobia.[20]

[17] Participant 18, a public health medical professional.
[18] Participant 11, a lawyer from an NGO, and Participant 28, a professional from a multilateral organisation.
[19] Participant 27, a public health professional.
[20] Participant 25, Participant 19, and Participant 28, a professional from a multilateral organisation.

At times there was not an easy delineation between state and non-state actors as often there is multisectoral coordination. Secondary data from the R4V provides examples of how this type of coordination across and between levels was pervasive throughout the response to Venezuelan migration. Under the umbrella of the RMRP 2021 activities, Save the Children received financial donations from the Norwegian government, GlaxoSmithKline, and private donors, to implement an integral intervention to prevent unwanted pregnancies and to access safe abortion services which leads to Save the Children professionals directly implementing family planning activities in Maicao. In comparison, in Cúcuta, Bucaramanga, Pamplona, Villa Del Rosario and Ipiales CARE implemented their activities indirectly through and in conjunction with Profamilia. Profamilia is a not-for-profit, which has its private health centres throughout Colombia but also runs education and research programmes to fulfil the SRHR of the population. Another example is the Canadian government's financing of IOM's project 'Sin Barreras' (Without Barriers), which included training professionals in the health system on how to deliver quality and comprehensive care to victims of sexual violence, especially Venezuelan adolescent girls, in Cartagena, Barranquilla and Santa Marta. Some projects such as those by the IRC have focused on financial support to cover the cost of primary healthcare to public services visits for Venezuelan migrants. All four examples demonstrate the cooperation between state and non-state actors in SRH responses for Venezuelan migrants in Colombia. This highlights the collaborative efforts of various actors involved in shaping the environments where Venezuelan adolescent migrant girls exercise autonomy and *voice*; particularly in the decision-making processes related to contraceptive care. The consequences of this fragmentation and collaboration of services are explored in more depth in Chapter 6.

4.3 Obligations for Adolescent Migrant Girls' Contraceptive Care in International and National Normative Frameworks

I now turn to focus on how normative frameworks have considered and engaged with the concepts related to the contraceptive autonomy and *voice* of Venezuelan adolescent migrant girls in Colombia. This section provides an important context of the international and national norms which state and non-state actors are expected to adhere to when responding to the contraceptive care needs of adolescent migrant girls. It demonstrates how international human rights treaties rarely address contraception as a specific issue, leaving key concepts of autonomy and *voice* such as intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration); participation in decision-making processes, and the opportunity to (not) use a

variety of contraceptive methods are treated as disparate issues. Where intersectionality or participation, is acknowledged it rarely extends to migrants. Unsurprisingly, there is little discussion of adolescent migrant girls being able to participate in decision-making processes in relation to contraceptives. Thus, at an international, and national, agenda-setting level commitments to key concepts of adolescent migrant girls' voices are not adequately considered or included.

The review was performed using a search of databases, as listed in the methods. The full matrix of policies and their relevant articles or paragraphs has been inserted into Appendix B of this thesis. From that matrix, the international framework identified in the policy review were the International Conference on Population and Development (ICPD) Programme of Action 1994, the New York Declaration on Migrants and Refugees 2016, and The United Nations Convention on the Rights of the Child (UNCRC). The national legislation and their accompanying strategies for implementation identified including the National Sexual and Reproductive Health Plan, (PNSDSDR) 2014-2021, the Adolescent and Youth-Friendly Health Services Model (servicios amigables), the Practical Guide for the Implementation of MISP in Colombia, External Circular No.25 of 2017 and COPNES 3950 Strategy for attention to migrants from Venezuela, Resolution 1035/2022 Ten-Year Public Health Plan 2022-2031) which have been displayed in Table 16.

Table 16 International and National Normative Frameworks Shaping Obligations to Venezuelan Adolescent Migrant Girls' Contraceptive Care

Name of Framework	Lead Actor(s)	Purpose/Aim	Relevance to Venezuelan Adolescent migrant girls' contraceptive Care
International Conference on Population and Development (ICPD) Programme of Action 1994	The United Nations Population Fund (UNFPA)	Formalised the right to SRH, including the right to decide the number and spacing of children and the right to education information and resources to do so.	Reproductive healthcare programmes should cater to women's and girls' needs, involve them in decision-making, and be designed to be responsive to their 'powerlessness', with governments and organisations taking positive steps to include women at all levels.
New York Declaration on Migrants and Refugees 2016	The Office of the High Commissioner for Human Rights (UNHCR)	Comprises several tenets, such as the complete protection of all refugees' and migrants' rights as holders of those rights, irrespective of their status, and the creation of responses that adhere to international human rights law.	Commits to providing access to SRH services with a gender perspective, and with full, equal, and meaningful participation. Acknowledges forms of intersectional discrimination and differential needs, vulnerabilities and capacities of women and girls.
The United Nations (UN) Convention on	The UN General Assembly and the United Nations	Formally recognises children under the age of 18 as rightsholders. Outlines formal commitments to protect children's rights to non-discrimination, act in the best	Adolescents are to provide access to healthcare without discrimination and have the 'right to be heard' with their opinions 'given due weight' in matters regarding them.

the Rights of the Child	Children's Fund (UNICEF)	interest of the child, promote life survival and development, and the right to be heard.	
The National SRH Plan or PNSDSDR 2014-2021	Colombian Ministry of Health and Social Protection (MSPS)	Prioritises the principles of health as a fundamental human right while recognising the diverse needs of different population groups regarding sexual and reproductive rights. It adopts a differential[21] and sub-differential approach that takes into account various socioeconomic characteristics.	All citizens are to be included, at different levels, for the realisation of SRHR and the exercise of autonomy. Given the differential approach actions should be taken to include adolescents in the process related to SRHR.
The Adolescent and Youth-Friendly Health Services Model or *servicios amigables*	MSPS and UNFPA	Requires that health institutions generate spaces and forms of comprehensive and differential care for the population between 10-29 years old and in this way that that centres the realities of this population and contributes to the guarantee of SRHR.	As a minimum, health centres should have a member of staff trained in AFHS and should be able to provide family planning consultations with a mix of contraceptive methods available. Additional amendments include a dedicated space for young people.

[21] The principle of differential approach recognises that there are populations with characteristics because of their age, gender, sexual orientation, and disability (adapted from Article 13 of Law 1448 of 2011) Salud, M.d. (2023) 'ABC victims'. 2023/12/19/. Available at: https://www.minsalud.gov.co/English/Paginas/ABC-victims.aspx.

The Practical Guide for the Implementation of MISP in Colombia	Inter-Agency Working Group for Reproductive Health in Crisis (IWAG), UNFPA, MSPS	Provides guidance on the minimum, life-saving SRH needs that humanitarians must address at the onset of an emergency – originally in the case of armed conflict.	Addresses contraception and AFHS as an additional priority action. During crises, the packages only need to provide LARCs and IUDs, with targets for supervision per quarter based on the latest Demographic Health Survey.
External Circular No.25 of 2017 and COPNES 3950 Strategy for attention to migrants from Venezuela	National Council for Economic and Social Policy, Republic of Colombia National Planning Department (COPNES)	Articulates the existing institutional framework and defines new provisions for the care of the migrant population from Venezuela over a three-year horizon.	Recognises adolescents are a population in need of humanitarian attention at the border. Establish and implement strategies for emergency healthcare, housing, water, sanitation, and protection for children and adolescents.
Resolution 1035/2022 Ten-Year Public Health Plan 2022-2031 Differential Chapters	MSPS	Addresses the health needs of the migrant population through the promotion of environments free of discrimination, the development of capacities for comprehensive healthcare, and psychosocial accompaniment strategies.	Commits to ensuring the health rights of the Venezuelan migrant population in Colombia through human rights and public health approaches, promoting participation through formal or informal organisations so that responses align with needs. This includes promoting free access to modern contraception methods, especially among young people and those in an (ir)regular situation

4.3.1 International Human Rights Frameworks, Consensus Documents and Operational Guidelines

At the international level, the 1994 ICPD PoA was the first agreement to formalise SRHR and highlights those commitments that were later formalised in CEDAW, such as the right to decide the number and spacing of children, and the right to education, information and resources to do so (UNFPA, 2014a, 13). Thus, internationally recognising the importance of autonomous decision-making to realise reproductive intentions, alongside access to 'family planning' education information and resources.

Regarding intersectionality, the ICPD PoA acknowledges the vulnerable situation of adolescent migrant girls. Paragraph 7.11 states that migrants and displaced persons in many parts of the world have limited access to SRHR and that services must be 'sensitive to the needs of individual women and adolescents and responsive to their often-powerless situation…' (Ibid.). This statement established state actors' obligation to differentiate responses to recognise, in part, the intersectional oppression faced by age, gender and migration. This recognition was only partial, as there was no mention of intersectionality, nor obligations to actively include or redress power relations of adolescent migrant girls as a marginalised group in a vulnerable situation.

However, later reports such as the ICPD Beyond 2014, have made progress toward a greater more holistic approach to adolescent SRHR that acknowledged the 'intersecting forms of discrimination' including those faced by adolescent girls, as well as the persistent inequalities faced by migrants (UNFPA, 2016, 18). The Beyond 2014 Report, informed by recommendations from the Bali Youth Forum, formalised attention to adolescent girls and the importance of providing them with gender parity, comprehensive sexuality education, elimination of harmful traditional practices and political participation (UNFPA, 2016). As well as breadth, detail was added to guide states on the particulars of entitlements. The ICPD Beyond 2014 For the first time, increased access to modern contraceptives was explicitly referred to as part of the family planning measures (UNFPA, 2016, 21). This shift in terminology demonstrates progress from euphemistic references to 'family planning' to clear articulations of modern contraceptive methods. However, there is little about conditions in which contraceptive care is delivered of full, free, and informed choice.

In terms of participation and feedback mechanisms, the original 1994 ICPD PoA obliged governments to create conditions which facilitate adolescents' participation in decision-making in SRH. Paragraph 7.7 stated that,

> 'Reproductive healthcare programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation organisation, and evaluation of services.

> Governments and other organisations should take positive steps to include women at all levels of the healthcare system.'

In addition, the ICPD Beyond 2014 committed 'to strengthening the participation of young people in political decision-making and planning at all levels' (UNFPA, 2016, p. 15).

In later renditions of the ICPD, a greater focus on adolescents was accompanied by a focus on family planning and SRH in humanitarian crises. The Nairobi ICPD+25 focused on SRHR aspiring to 'zero unmet family planning needs' and 'universal access to safe contraceptives'. In doing so, they emphasised the difference between the unmet need for family planning and the unmet need for family planning services and education (UNFPA, 2019a, 56). It further called for access for all adolescent girls to 'comprehensive and age-responsive information, education, and adolescent-friendly services' to be able to make 'free and informed decisions' about their sexuality and reproductive lives, 'to adequately protect themselves from unintended pregnancies' and STIs/ HIV (Ibid.). Lastly, it encouraged states to 'uphold the right to [SRH] services in humanitarian and fragile contexts'. Ensuring that the 'basic humanitarian needs and rights' of girls are met through access to comprehensive SRH (Ibid.). It is important to acknowledge that strides have been taken to establish comprehensive contraceptive care for adolescents, incorporating their participation. However, limitations exist in terms of the degree to which this participation translates into meaningful decision-making. Additionally, there is a notable absence of effective feedback mechanisms, ensuring adolescent migrant girls' *voices* and contraceptive autonomy are considered and included in the overall ICPD response framework.

At this point, it is relevant to return to the UNCRC, which is discussed in section 2.3.2. The UNCRC has several key tenets for the rights of children and adolescents under the age of 18, relating to both health and participation. The most prominent for our discussion is the principle of 'the best interests of the child', the principle of participation and access to healthcare (United Nations, 1989). The principle of 'the best interests of the child', as aforementioned, states that actors must conduct responses with the health and well-being of the child as the first and foremost concern (Article 2). This includes preventing discrimination of access to services – such as healthcare, regardless of the status of the parents (or guardians). Child participation- another pillar of the UNCRC- is defined as, an ongoing process involving information-sharing and dialogue between children and adults based on mutual respect (Article 12). The decision on the extent to which a child should be involved requires attention to the best interests of the child and the societal context in which they are situated. Of course, when children's participation steers actions towards those that are against the principle of 'best interests', parents and stakeholders have a responsibility to protect children from harm. In the case of adolescent migrant girls' *voice*, the right to healthcare and the right to participate in decisions

affecting one's health are the two most central tenets. The guidance supplied on these rights states that actors have the responsibility to ensure access to 'sexual and reproductive information, including on family planning and contraceptives,' (Office for the High Commissioner for Human Rights, 2003). In addition to this, they must adopt measures to reduce the vulnerability of adolescent migrants, collecting data on adolescent migrants by 'sex, age origin, and socioeconomic status' with their participation to ensure that the information is understood and used in an adolescent-sensitive way (Ibid.). The UNCRC has undoubtedly positioned adolescent girls as right-holders with decision-making capacities. However, the UNCRC's obligation to ensure access to contraceptives is not a central component. So, whilst participation for adolescents in health is a central obligation under the UNCRC there is no binding obligation to provide contraceptive care to adolescents.

In the context of international migration, the New York Declaration articulates important non-binding commitments to migrants' rights regarding intersectionality, SRH and participation. The New York Declaration 2016 Article 31, concerning both migrants and refugees reads,

> 'We will ensure that our responses to large movements of refugees and migrants mainstream a gender perspective, promote gender equality and the empowerment of all women and girls … We will provide access to sexual and reproductive healthcare services. We will tackle the multiple and intersecting forms of discrimination against refugee and migrant women and girls… We will work to ensure their full, equal, and meaningful participation in the development of local solutions and opportunities. We will take into consideration the different needs, vulnerabilities, and capacities of women [and] girls…' (United Nations, 2017).

It is important to highlight this section as it demonstrates that SRH services a formal obligation to respond to migrants SRH in a way that acknowledges their 'intersecting forms of discrimination'. In addition, it stipulates that this be done with the involvement of migrant women and girls.

The New York Declaration 2016, subsequently led to the Global Compact for Safe Orderly and Regular Migration (GCM) as a means of articulating how these commitments could be implemented. Despite being non-binding, it marks progress in that it is an international commitment which, for the first time articulates states' obligations to migrants, whereas the parallel Global Compact for Refugees was based on the UNHCR 1951 Convention (IOM, 2018). Advocates for 'child-sensitive' and 'gender-responsive' approaches (UN General Assembly, 2018; Hennebry and Petrozziello, 2019; Zenner *et al.*, 2019). Gender-responsiveness is defined in the GCM as 'mainstream[ing] a gender perspective, promotes gender equality and the empowerment of all women and girls, recognising their independence, agency and leadership to move away from addressing migrant women primarily

through a lens of victimhood' (UN General Assembly, 2018, p. 4). Whereas a child-sensitive approach is defined as 'promot[ing] existing international legal obligations in relation to the rights of the child, and upholds the best interests of the child at all times, as a primary consideration in all situations concerning children in the context of international migration, including unaccompanied and separated children' (UN General Assembly, 2018, p. 5). As such, they acknowledge that differential approaches are needed and that align with existing legislation on gender equality, and child rights.

However, an age-sensitive approach tends to group children and youth, failing to acknowledge the intersectionality of adolescent migrant girls. Whilst acknowledging the need to promote 'leadership' and 'agency' in child-sensitive approaches and the need to 'uphold the best interests of the child' there is little on how this might be overcome, especially concerning contraceptive care.

Much like the Nairobi Summit of the ICPD, which replaces the emphasis on comprehensive care for adolescents with a focus on providing 'basic needs for adolescent *migrant* girls, the Global Compact on Migrants follows a similar trajectory. References to 'basic healthcare' overlook commitments to comprehensive primary healthcare and commitments to eliminate unmet needs (Rumbold *et al.*, 2017; Bozorgmehr and Biddle, 2018). Rather, commitments to SRH are side-lined for global labour market or security concerns (Bozorgmehr and Biddle, 2018; Devakumar *et al.*, 2019).

As a result, international normative frameworks neglect issues such as adolescents' SRH and in particular contraceptive care. Furthermore, these tendencies reinforce governance structures that impose obligations merely for survival without extending commitments beyond this threshold. This inadvertently contributes to a discourse implying that migrants are deemed 'not worthy' of the same level of intersectionality, mechanisms of participation and feedback or opportunity to (not) use a variety of contraceptive methods as those with citizenship.

4.3.2 National Legislation on Sexual and Reproductive Health

For the Colombian population, the National SRH Plan (PNSDSDR) guides individuals' rights and parallel state obligations. The PNSDSDR 2014-2021 prioritises the principles of health as a fundamental human right while recognising the diverse needs of different population groups regarding sexual and reproductive rights (Profamilia *et al.*, 2014). It adopts a differential and sub-differential approach that takes into account various factors, such as life cycle, sexual orientation, gender identity, ethnicity, disability, displacement, victims of conflict, and poverty. In particular, for the care of populations in vulnerable contexts, it emphasises the need for services and actions to be culturally and socially sensitive, considering religious particularities and social demands. This approach aims to ensure equality, equity, and non-discrimination in healthcare services and actions.

Furthermore, it highlights the importance of the life-cycle approach, recognising that SRH needs evolve throughout one's life.

The PNSDSDR 2014-2021 addresses participation and inclusion in Objective 8.2 which ensures the state 'promotes the inclusion of all citizens… in the different levels of state, social, community, and institutional action in the health sector, for the materialisation of sexual and reproductive rights, as well as the full exercise of the autonomy of all persons' (Profamilia *et al.*, 2014, p. 72). Subsequent actions for this objective include the promotion of equal opportunity participation of individuals, community organisations, and networks – especially adolescents and youth – in social processes related to SRHR (Profamilia *et al.*, 2014, p. 78). This acknowledges the importance of participation in SRHR as well as differentiation to account for adolescents. The specific obligations of AFHS are addressed in a separate policy.

The guidance on differentiation of SRH services to account for the specific needs of adolescents is articulated by the AFHS model, also known as *servicios amigables*, which aims to provide comprehensive and differential care for adolescents and young people (Ministerio de Salud and UNFPA, 2018). In the latest edition of the model, guidelines only refer to Colombian young people and adolescents, there is no indication that the policy would apply to international migrants (Ministerio de Salud and UNFPA, 2018, pp. 19-229). The model articulates that the health centre should adopt one of three structures. One is, 'differentiated services' the conditions for which are met by having a member of staff trained in AFHS within usual hours. In this context, services that are differentiated have the narrowest service offerings. 'Friendly units' expand on this to include accessible hours, staff trained in AFHS, and a dedicated space for adolescents and young people. 'Friendly centres' include separate facilities for young people with staff specialising in AFHS, psychosocial and formative development care, and areas for young people to interact. Friendly centres have the broadest service offering. All three include access to family planning consultations of at least 20 minutes, offering some modern contraceptives available on the Basic Health Plan (POS), now known as the Health Benefits Plan.[22] However, it must be noted that the PNSDSDR and the adolescent and youth-friendly health services model refer only to Colombian citizens, excluding any discussion of migrants, even if they are adolescents.

[22] The AFHS specify that the following modern methods be made available: emergency contraception, low-dose oral contraception, monthly injectables, subdermal implants, and condom latex for patients with STI diagnosis Ministerio de Salud and UNFPA (2018) 'Servicios de Salud Amigables para Adolescentes y Jóvenes. Segunda edición'. 2018/10/18/. Available at: https://colombia.unfpa.org/es/publications/servicios-de-salud-amigables-para-adolescentes-y-j%C3%B3venes-segunda-edici%C3%B3n.

In the context of migrant SRH in humanitarian settings, The Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations is the key normative framework the MSPS uses to guide their response.[23] MISP aims to deliver guidelines on the minimum, lifesaving SRH needs that humanitarian actors must address at the 'onset of an emergency' (UNFPA, 2019d). There is an appendix to MISP for the deliverance of adolescent-friendly SRH which acknowledges that adolescents are differentially affected by emergencies (UNFPA, 2019d)[24]. The areas mentioned in the Adolescent Toolkit including family planning and participation are briefly alluded to as 'priority obligations' but 'additional obligations'. Under MISP, 6 months after the onset of a crisis, access to comprehensive care should be implemented. However, the paucity of initial actions addressing adolescent SRH, participation and family planning (encompassing modern contraceptive methods), demonstrates how these issues are side-lined by international normative frameworks.

UNFPA and the MSPS in Colombia adapted MISP (or PIMS by its Spanish acronym) as part of the humanitarian response from the national SRH sub-cluster, which seeks to offer SRHR to the migrant population, including adolescents[25]. MISP is designed to be implemented in each of the departmental territories, districts, and municipalities according to the supply of public, private, and international cooperation services through health service provider institutions (IPS) authorised for these services, within the existing framework of the health system (SGSSS) (UNFPA, 2019c). Structured according to four objectives, the MSPS aims to coordinate the implementation of MISP; prevent and address the consequences of sexual violence; reduce the transmission of HIV and other STIs and prevent the increase in maternal and neonatal morbidity and mortality (UNFPA, 2019c). As such, it is reflective of the risk-averse approach discussed in section 2.1, which employs reactive responses focused on the avoidance of harm. Rather than, emphasising concepts central to *voice* such as intersectionality, participation in decision-making and a variety of methods.

MISP states 'to use only long-term and emergency contraceptives until the population is stabilised and/or comprehensive contraceptive services are established' because of the mobility of the population affected by the humanitarian crisis, the health situation and barriers to access to health services (UNFPA, 2019c). Thus, it makes steps to overcome these barriers. The methods of contraception which are promoted under MISP are long-acting reversible and emergency contraceptives (the white package) and IUDs (the black package). Numbers for the desired supply of contraceptives are estimated using percentages of women of reproductive age demanding

[23] Correspondence with MSPS, File No. 202216002491121, 14/12/2022.
[24] Appendix G for Save the Children/UNFPA's Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.
[25] Correspondence with MSPS, File No. 202216002491121, 14/12/2022.

emergency contraceptives, subdermal implants, and IUDs in the 2015 Demographic Household Survey.[26] Advising and promoting certain methods such as condoms, IUDs, and implants over others, reduces obligations to comprehensive primary care which would ensure a broad mix of contraceptive methods required by the principle of full choice. If state and non-state actors deliver MISP they fail to provide a variety of services by length, hormonal options, and the ability to remove or change methods are unavailable.

Whilst adolescents are mentioned throughout Colombia's MISP, there is little on differentiation that would consider the intersectional reproductive realities of adolescent girls which is so central to *voice*. MISP does promote participation mechanisms such as coordinating with the affected population through existing channels to disseminate information on HIV/AIDS services and design SGBV services (UNFPA, 2019c, pp. 22, 100-1). However, because the emphasis of the MISP is on emergency care, it focuses on reducing risk or treating victims of harm there is little focus on the differentiation of services or participation in contraceptive care beyond access. This poses the risk of failing to create autonomy-enhancing conditions which enable adolescent migrant girls to have the resources, information and particularly, the education required to develop their 'evolving capacities'. Without these aspects of *voice* actors risk excluding Venezuelan adolescent migrant girls from responses, which do not match their realities.

National legislation on Venezuelan migrants and their entitlements has been adopted to make explicit the entitlements authorised under the health system. Policies on Venezuelan's right to health, including SRH, have been increasingly progressive but are determined by categories of regular/irregular migrants and emergency/outpatient care. Policy developments since 2017 have included permitting the affiliation of Venezuelans to the health system and allowing access to emergency care regardless of status. The process of becoming affiliated to the health system has been addressed in legislative changes from 2017-2021 (see Table 17).

Table 17 National Policies on Venezuelan Migrant Health in Colombia from 2017-2022

Authority	Name	Year	Description

[26] Resolution number 0769 of 2008. Update of the Technical Standard for Family Planning Care for Men and Women established in Resolution 412 of 2000. Resolution repealed as of February 3, 2019, by Article 7 of Resolution 3280 of 2018, through which the update of the Technical Standard for Family Planning Care for Men and Women established in Resolution 412 of 2000 is adopted. Resolution 5592 of 2015 through which the contents of the Compulsory Health Plan (POS) are updated. Title III, Chapter 1, Art. 20 on male condoms.
Protocols for nursing care for women's sexual and reproductive health. MSPS. Bogotá, 2014
Card for contraceptive counselling in Colombia MSPS-UNFPA, 2015 in Guide to implementing MISP in Colombia

Government	Ext Circular No.25	2017	Strengthening Public Health Actions to Respond to the Migration Situation of the Population from Venezuela
Government	Decree 216	2021	Adopts the Temporary Protection Statute for Venezuelan Migrants under the Temporary Protection Regime (including emergency care must be provided to any national or foreign person, without any requirement or discrimination)
Government	External Circular No.35	2022	Recommendations for strengthening the inclusion and care of the Venezuelan migrant population in the General System of Social Security in Health

One of the key pieces of legislature that shape the way Venezuelan adolescent migrant girls are seen by state and non-state actors is the decision not to recognise Venezuelans as refugees. Although, as Selee and Bolter (2021) note, Venezuelan migrants could be considered refugees under the Cartagena Declaration, the Colombian state decided to grant Venezuelan migrants a temporary migrant status instead of a refugee status. In 2017, Resolution 5797/2017 granted a special temporary permit for Venezuelans Special Permit of Permanence (PEP). Following this development, Venezuelans with an ID (including a PEP) can affiliate to the health system to access the basic health plan (Circular 25 of 2017; Resolution 3015/2017). Following this change, Resolution 971 2021 and Decree 216/2021 implemented the Statute Temporal de Protection/Temporary Statute of Protection (EPTV) to grant temporary protected status (TPS) to Venezuelans in Colombia for the next 10 years. The conditions for meeting this were: having arrived before 31 January 2021; having arrived in the first two years of the statute validity; be seeking asylum; in a regular immigration situation, with a document such as a PEP or with a safe passage SC-2 status (meaning they are in the process of recognising refugee status). All PEPs are extended till 28 February 2023 with the idea being migrants can transfer to the EPTV. However, the EPTV retains the need for documentation to acquire status, which is known to be extremely difficult for many Venezuelans given the nature of the crisis. There are exceptions if minors (including children and some adolescents) are under the protection of the State, they automatically regularised with the guarantee of being able to access all State services (Pelacani, 2022).

Health-specific legislature implemented has recently demonstrated a shift in the rhetoric towards a comprehensive provision of contraceptive methods regardless of migration status, the impact of which is yet to be determined. Legislation specific to Venezuelan migrants is comprised of several policies (see Table 17), including External Circular No.25 of 2017 and External Circular 0035 of 2022,

which guide the actions taken by territories to integrate Venezuelan migrants into the health system. External Circular No.25 was the first document to outline plans for integration into the health system. Meanwhile, for those unaffiliated, it guaranteed emergency healthcare (Ministerio de Salud, 2017). This followed the pattern of other legislation expanding what was considered an emergency, namely that victims of violence should receive comprehensive healthcare including access to emergency contraceptives (Ministerio de Salud, 2016). Later, 'urgent healthcare' was expanded to include maternal care and 'catastrophic diseases' such as AIDS and cancer including medication and follow-up (T-074/2019/ T-197/2019). Finally, the circular discusses promoting education strategies for the promotion of sexual reproductive rights, prevention of unintended pregnancy, prevention of GBV, prevention of STIs, including HIV/AIDS, and promotion of the use of latex male condoms (1.6.2). These services align with the objectives of MISP and thus are subject to the same limited contraceptive methods. Therefore, they continue to demonstrate a prioritisation of reducing fertility rates and preventing STIs/STDs, meanwhile lacking provisions for follow-up care or opportunities to use other methods.

The most recent development in policy on Venezuelan migrants' right to health and SRHR can be found in External Circular 35/2022 published on 22 August 2022. External Circular 0035 sets out how the general system of Social Security and health can be strengthened to include the care of the Venezuelan migrant population.

Regarding contraceptive care, Objective 3.4 of External Circular 35/2022 takes a gender and differential approach to protect the sexual reproductive rights of Venezuelan migrant girls. This includes promoting free access to modern contraception methods, especially among young people and those in an (ir)regular situation. Additionally, it focuses on comprehensive SRH services, educational campaigns, and collaboration between healthcare services and educational institutions to promote sexual and reproductive rights among Venezuelan migrant girls. The Circular underscores the importance of involving community-based organisations in realising 'inclusive' and 'participatory' health services and ensuring migrant populations actively participate in monitoring health resources (1.1.1.2 and 4.2.6). Furthermore, it states the migrant population is to be integrated into strategies such as the Ten-Year Public Health Plan, the Intersectoral Commission on Public Health, and the Territorial Council on Social Security and Health (1, 2.2.1 and 4.2.5) (Ministerio de Salud, 2022a).

The strategy for improving attention to migrants from Venezuela, also known as COPNES 3950 of 2018, outlined priority areas to identify needs and deliver attention, with the MSPS designated as the main implementer (Departamento Nacional de Planeación, 2019). Under COPNES 3950, the MSPS focused on immediate emergency response and basic needs such as temporary shelter, water, and sanitation at the border. Meanwhile, SRHR policies were limited to emergency actions such as

obstetric care. The strategy aimed to assess needs, provide technical assistance, and strengthen health systems, whilst increasing the number of migrants affiliated to the health system.

The focus on emergency health has recently shifted with the publication of the Ten Year Public Health Plan providing a longer-term strategy for integrating Venezuelan migrants into the health system – creating the ability to access primary healthcare (Ministerio de Salud, 2022b). The plan aimed to address Venezuelan migrants' health needs by promoting non-discriminatory environments and comprehensive healthcare using a gender and differential approach (Ibid.). Additionally, mention is made to social determinants and '[p]romotion of environments free of stigmatisation, discrimination and xenophobia, favourable to a culture for life and health where human life is valued and respected without distinction of nationality or socioeconomic condition.' Differentiation manifests as multisectoral cooperation, culturally sensitive health promotion communications and planning that considers the health conditions of the migrant population. Finally, it includes the promotion of participation in health services for the migrant population in Colombia through their formal or informal organisations, community-based organisations, and other social entities, as well as host communities. The details on how to enact these commitments are to be decided in a collective action plan which will be made by the sub-secretary for health at a departmental level.

Contraceptive care and particularly that for adolescent migrant girls is conspicuous by its absence for the majority of the Colombian state response to including Venezuelan migrant girls into the health system. The main legislation is non-binding and provides few incentives for actors to implement these recommendations (as I discuss in Chapter 6). For the most part, Colombia produces two different responses: one for Venezuelan migrants and one for Colombian adolescents. Remembering how RJ and SRHR, depend on the acknowledgement of, and positive actions for intersectional needs, normative frameworks that add or respond to a single axis of oppression are insufficient.

4.3.3 Discussion

The findings of the policy analysis reveal that the key components of *voice* such as intersectionality of gender, age, and migration; participation and feedback mechanisms; and the opportunity to (not) use a variety of contraceptive methods are rarely addressed at the same time.

The international normative frameworks laid out here have addressed family planning or contraceptive care as an issue separate from adolescent-friendly services and SRH in humanitarian crises. Instead, adolescent girls' access to contraceptives and participation in health are siloed from obligations to migrants' access to 'basic' services. The policies programmes and strategies are constructed as top-down approaches, with limited insight into the intersectional reproductive

realities of adolescent migrant girls. For example, there is little emphasis on sociocultural factors or intersectional components that may involve, for example, adopting a migrant-inclusive adolescent-friendly health service. Thus, there is an overall lack of incentives to create autonomy-enhancing conditions which would support *voice,* contraceptive autonomy, and by extension reproductive freedom.

Furthermore, these tendencies reinforce governance structures that impose obligations merely for survival without extending commitments beyond this threshold. This inadvertently contributes to a discourse implying that actors responding to the contraceptive care needs of adolescent migrant girls are not required to provide the same level of differentiated care, mechanisms of participation and feedback or opportunities to access a variety of methods as those with citizenship.

National frameworks in Colombia for Venezuelan migrants have been considered 'progressive' (Frydenlund, Padilla and Palacio, 2021; Grandi, 2021). Yet, critics have challenged the state discourse of Colombian generosity towards Venezuelan migrants (Palma-Gutiérrez, 2021). Researchers focusing on refugee and migrant law have questioned the protection afforded to young people from Venezuela in Colombia (Angeleri, 2021; Pelacani, 2022). Whilst all policies are underpinned by a 'gender focus' and 'differential approach', policies on Venezuelan migrants have shown little account for variation within the migrant population. As a result, there has yet to be a focus on AFHS which takes into account their reproductive realities in policies.

Recognising and taking positive steps towards addressing intersections of age, gender and migration is a central pillar of *The Scale of Voice*. Under *The Scale of Voice,* a lack of differentiated policies demonstrates a lack of positive actions to consider and account for the intersectional reproductive realities of Venezuelan adolescent migrant girls. Without these, policies cannot be said to address the gendered nature of migrants' SRH, nor the need for 'evolving capacities' that are central to the development of adolescent migrant girls' contraceptive autonomy. Consequently, these can produce 'single-axis' approaches which focus on migrants, on women, adolescents, or migrants as age-less, gender-less. Failing to recognise these groups as rightsholders further marginalises them, creating reproductive injustices.

Likewise, policies which create entitlements to partial access, mean there is unequal access to opportunities to (not) use a variety of contraceptive methods. These deny Venezuelan adolescent migrant girls the tools to realise their contraceptive decisions in a way that recognises informed choice, full choice, and free choice, which are central 'sub-domains' of contraceptive autonomy (Senderowicz, 2020, p. 165). For example, by providing access to certain methods such as condoms,

or IUDs, or emergency-only care policymakers are creating environments where comprehensive contraceptive care is discouraged.

Overall, this policy review has shown how initially siloed frameworks relating to SRHR, adolescents or migrants have become increasingly progressive, interlinking policies which acknowledge the multiple vulnerabilities experienced by adolescent migrant girls and advocate for a gendered and differentiated approach which includes adolescent migrant girls so they can realise their SRHRs. I further demonstrated how these responses were limited by their capacity to include positive actions simultaneously addressed gender, age, and migration; participation and feedback mechanisms; and contraceptive care – components which are central to *voice* and contraceptive autonomy.

Having provided a reader with this context for how actors should be conducting their responses, I then turn to an analysis of if and how actors have responded to the contraceptive care needs of adolescent migrant girls in practice, and in particular how the issue of contraceptive autonomy (through *voice*) has been breached.

Chapter 5 Inequalities in Contraceptive Care Services for Venezuelan Adolescent Migrant Girls

The previous chapter highlighted the different policies and normative frameworks related to the SRH of adolescent migrant girls from Venezuela in Colombia at the international, and national level. There I discussed how components of *voice* such as intersectionality of gender, age, and migration; participation and feedback mechanisms; and the opportunity to (not) use a variety of contraceptive methods are rarely addressed at the same time.

This chapter continues this line of inquiry to determine if the gaps in the normative frameworks are replicated by inequalities in service utilisation. In doing so, it answers my first sub-research question, 'Are there inequalities in access to contraceptive-related reproductive services by age, and nationality for women and girls of reproductive age in Colombia?' In the broader context of this thesis, this chapter serves an important role. For, if there are no differences between the services used or key outcomes, there is no requirement for *voice*, or *voice* may already be included. Conversely, greater inequalities suggest some parts of the population are underserved. Equally, as the dominance of one method (such as LARCs) has been associated with reductions in contraceptive autonomy, evidence of this suggests further injustices. By examining these differences, I aim to provide a critical analysis of contraceptive care services accessed by adolescent Venezuelan migrant girls, highlighting the extent to which they are centred or included, in contraceptive-related responses.

As described in sub-section 3.2.3, I examine data from health utilisation records to provide as comprehensive a picture as possible. Using this data, I conduct a basic descriptive statistical analysis to reveal three key empirical findings. Firstly, there are significant disparities in the utilisation of contraceptive-related care between Venezuelan migrant and host populations, with a more pronounced inequality observed in the age group of 15-19. Secondly, a greater proportion of Venezuelan migrants opt to use LARCS or do not use any contraceptive methods at all, whereas Colombian women and girls tend to opt for shorter and mid-term contraceptive methods. Finally, in the Profamilia data, where we would expect more sustained access to contraceptive care for migrants without affiliation, the proportion of Venezuelan migrants using LARCs was less, and the proportion using shorter, and mid-term contraceptive methods was higher.

These findings are then discussed with reference to *The Scale of Voice* (as my conceptual framework) and the literature. I conclude by suggesting that actors are not providing Venezuelan migrant women and girls, and in particular *adolescent* Venezuelan migrant girls with the conditions they need to access contraceptive care that aligns with their reproductive realities. In terms of *voice*, these inequalities may indicate that actors are not engaging with this group in a way that accounts for their intersectionality, nor full or free choice, suggesting that they are not considered or included as the beneficiaries of current responses.

5.1 National Service Utilisation for Reasons Related to Contraceptive Care

This section firstly studies the utilisation of national SRH services of both the Colombian and the Venezuelan migrants in Colombia, comparing the reasons for attendance. This data is from the MSPS, specifically the Individual Patient Registry (RIPS) and its counterpart for the migrant population (Cube 029). These findings collectively suggest disparities in both pregnancy-related and contraceptive care access between the Colombian host population and the Venezuelan migrant population. The inability to access care can lead to nonautonomous contraceptive care decision-making, that fails to take into account key dimensions of contraceptive autonomy.

The results demonstrate that firstly, for pregnancy-related care the proportions of the Colombian population using services are consistently higher than for those from Venezuela. The only exceptions to this pattern are services encountered for high-risk pregnancies. This shows Venezuelans are more likely to be seen for high-risk pregnancies but not for normal supervision, suggesting that there are inequalities in accessing maternal care. Secondly, the analysis highlights that for contraceptive-related care there are higher proportions of Venezuelan migrants accessing health services for insertion of the IUD in women of reproductive age, but lower levels of supervision of IUD, indicating that there is an issue in conducting follow-up appointments for this method. This issue is particularly pronounced in the 15-19 age group. Thirdly, there are higher proportions of Colombians seeking health services for general contraceptive management than Venezuelans. These inequalities are even more marked when considering age, illustrating that access to contraceptive-care-related services for the Venezuelan migrant population is shaped by intersectional factors including age and migration. Finally, comparing pregnancy and contraceptive-care-related data highlights that there is greater inequality for Venezuelans and Colombians accessing healthcare services for contraceptive-related care than pregnancy-related care. This may suggest that maternal care is more accessible

than contraceptive care for migrants from Venezuela. More equal access to maternal care is unsurprising given the frameworks discussed in section 4.3.2, which highlighted that health facilities were legally bound to provide maternal care, but not contraceptive care.

5.1.1 Inequalities in Access to Services for Contraceptive-Related Care

As described in the methods chapter of this thesis (Chapter 3.2.3), I divided the number of persons who attended the health service in 2021 by the total population of Colombian and Venezuelan women of reproductive age by age group, to get an overall percentage for each group relating to service use. So, for the percentage of Colombian adolescent girls aged 15-19 who visited health centres for 'normal pregnancy' I added all numbers of women in the codes under Z34 (72,569) and divided them by the population of 15–19-year-old Colombians (2,010,594) to get 3.61%. After repeating the process for adolescent Venezuelan girls aged 15-19, I divided the percentage of Colombians (3.61%) by the percentage of Venezuelans (1.7%) to get 2.12. This estimates that the proportion of Colombians ages 15-19 who visited health centres for normal pregnancy is 2.12 times the proportion of Venezuelans in the same age group. The process was replicated with all age groups. For supervision of high-risk pregnancy, the ICD-10 codes under Z35 were used (see Table 10). The numbers of persons attended and the percentages are presented in the corresponding tables (in this example Table 20). The final column presents the difference between the percentages, which was derived by subtracting the percentage of Colombians from the number of Venezuelans. The difference in the percentages illustrates the relative inequalities between Colombians and Venezuelans, especially as in some cases the percentages presented are relatively low.

For contraceptive-related care, there are higher proportions of Venezuelan migrants accessing health services for insertion of the IUD in women of reproductive age, but lower levels of supervision of IUD. These findings indicate that there could be an issue in conducting follow-up appointments. The disparity between insertions and supervisions is particularly pronounced in the 15-19 age group, suggesting that the challenges in maintaining contact with the health system are shaped by age.

Table 18 shows the number of women and girls who attended health centres in Colombia for contraceptive-related services in 2021. Table 19 presents these numbers as percentages of the entire population. A closer look at Table 15 shows that a higher proportion of the Venezuelan population (0.43%) attended health services for the insertion of IUDs than Colombians (0.15%). However, the proportion of the Colombian population who sought services for the supervision of IUD (2.68%) was 3.6 times higher than that of Venezuelans (0.74%). It would be expected that the

proportion of IUD supervisions would be equal to or higher than the number of insertions. Recommendations for health providers suggest that after IUD insertion there be a follow-up appointment after 6 weeks, meaning the number of insertion and supervision appointments should be at least equal. I would further anticipate there to be an additional number who encountered problems related to insertion or sought to change or remove their IUD, leading to a greater number of supervisions. The fact that for Venezuelans this trend is reversed suggests that there are barriers to sustained access or less likely, but still possible, that Venezuelan women and girls are deciding not to visit health centres for IUD supervision. The consequences of not having access to comprehensive contraceptive care pose problems for the renegotiating of contraceptive (non-) use or the ability to address issues or manage side effects of methods, which I will return to in the discussion of this chapter.

For the supervision of contraceptive methods, the proportion of women of reproductive age from Colombia (2.68%) is greater than the total number of women of reproductive age from Venezuela (0.74%). The difference between the percentages reveals Colombians are 3.6 times more likely to be seen for a repeat prescription of a contraceptive method than their Venezuelan counterparts. When looking at the 15-19 age group this disparity increases 8.9 times (3.67% versus 0.41%). The same pattern emerges for specific and non-specific contraceptive attention, which are terms used when patients seek contraceptive-related care for reasons that are not otherwise classifiable. In these instances, there are disparities between Colombian and Venezuelan women of reproductive age, but this then increases when the age group of 15-19 is viewed in isolation. As such, the total difference between those seeking contraceptive-related care for the total women of reproductive age is 1.47, as opposed to 2.73 for those aged 15-19.

For total women of reproductive age, the proportions of the Colombian population for other specific contraceptive attention (0.95%) and non-specific contraceptive attention (1.58%) were higher than for Venezuelans. For Venezuelans, the percentage for specific contraceptive attention (0.58%) and non-specific contraceptive attention (1.80%). However, there were higher proportions of Colombians aged 15-19-year-olds using services for specific attention (1.40%) and non-specific attention (2.13%) compared to Colombians the total women of reproductive age (0.95% and 1.58% respectively. This trend was reversed for Venezuelans who had lower proportions of specific attention (0.52%) and non-specific contraceptive attention (1.34%) compared to the total Venezuelans of reproductive age (0.58% and 1.80%), and Colombians aged 15-19.

These findings highlight that adolescent migrant girls aged 15-19 from Venezuela experience significant disparities in accessing contraceptive attention. This aligns with the earlier observations regarding the proportions of IUD insertions, supervisions, and general contraceptive counselling. Therefore, it is evident that migration and age collectively influence healthcare-seeking behaviours, particularly in the context of contraceptive services.

Table 18 The Numbers and Percentages of Venezuelan and Colombian Women of Reproductive Age who Sought Contraceptive-Related Care in 2021

Type of Reproductive Care Accessed	ICD-10 Codes	Colombian Host Population		Venezuelan Migrant Population		Ratio of the Percentage of Colombians to Venezuelans
		Number of Persons	Percentage of Population	Number of Persons	Percentage of the Population	
General Contraceptive Consultation	Z30.0	938,172	6.92%	33,431	4.72%	1.47
Insertion of IUD	Z30.1	20,547	0.15%	3,021	0.43%	0.36
Supervision of Contraceptive Medicines	Z30.4	363,549	2.68%	5,270	0.74%	3.60
Supervision of IUD	Z30.5	35,527	0.26%	1,622	0.23%	1.14
Other Specific Contraception Attention	Z30.8	128,136	0.95%	4,127	0.58%	1.62
Non-specific Attention with Contraception	Z30.9	213,739	1.58%	12,717	1.80%	0.88
Totals	Z30	1,699,670	12.54%	60,188	8.51%	1.47

Table 19 The Numbers and Percentages of Venezuelan and Colombian Adolescent Girls Aged 15-19 who Sought Contraceptive-Related Care in 2021

Type of Reproductive Care Accessed	ICD-10 Codes	Colombian Host Population		Venezuelan Migrant Population		Ratio of the Percentage of Colombians to Venezuelans
		Number of Persons	Percentage of the Population	Number Attended	Percentage of the Population	
General Contraceptive Consultation	Z30.0	198,488	9.87%	7,177	3.70%	2.67
Insertion of IUD	Z30.1	2,881	0.14%	660	0.34%	0.42
Supervision of Contraceptive Medicines	Z30.4	73,735	3.67%	792	0.41%	8.98
Supervision of IUD	Z30.5	2,911	0.14%	102	0.05%	2.75
Other Specific Contraception Attention	Z30.8	28,213	1.40%	1,009	0.52%	2.70
Non-specific Attention with Contraception	Z30.9	42,879	2.13%	2,598	1.34%	1.59
Total	Z30	349,107	17.36%	12,338	6.36%	2.73

Figure 5 Graph Showing the 'Total Women of Reproductive Age Attended for Encounters to the Health Service for Contraceptive-Related Care'

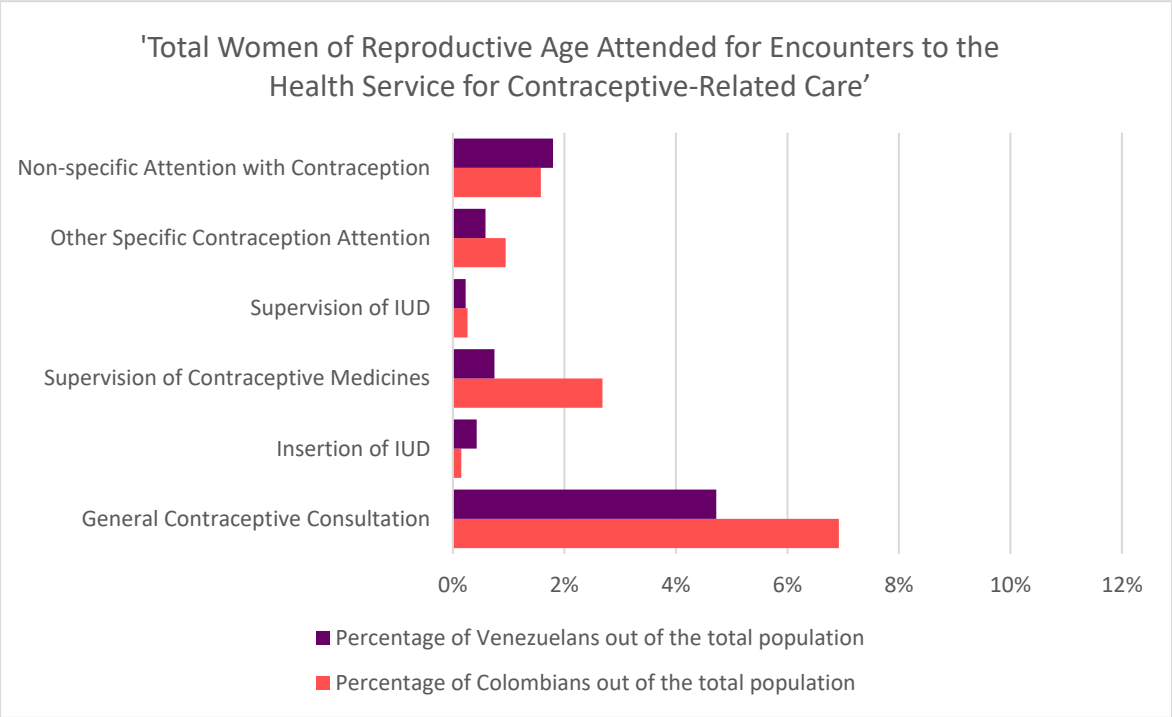
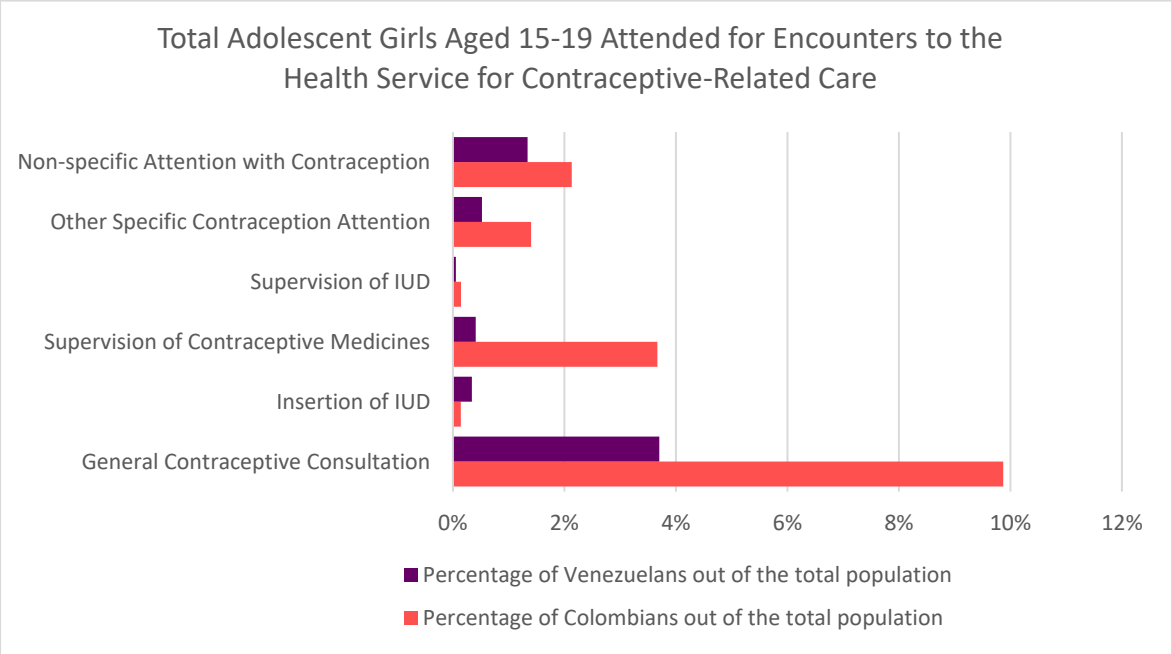


Figure 6 A graph Showing the 'Total Adolescent Girls Aged 15-19 Attended for Encounters to the Health Service for Contraceptive-Related Care'



A comparison of the data in Table 18 is visualised in Figure 5, and Table 19 in Figure 6. This shows that a larger percentage of the Colombian population is accessing health services for general contraceptive counselling or the initial prescription of contraceptive methods (ICD-10 Z30.0), across both age groups (6.92% versus 4.97%).

Within the Colombian population, a higher proportion of adolescent girls aged 15-19 (9.87%) are seeking health services for general contraceptive counselling compared to the proportion of women in the entire reproductive age group (6.92%). This observation aligns with expectations, as we anticipate that women in the 15-19 age range would begin seeking contraceptive services and might change methods more frequently than older women who generally have more time to determine their preferred contraceptive methods (Blanc *et al.*, 2009).

In contrast, when focusing on Venezuelan girls aged 15-19, there is a lower percentage of the population seeking services for general contraceptive counselling (3.7%) compared to the majority of women of reproductive age from Venezuela (4.97%) and the Colombian population aged 15-19 (9.87%). The discrepancy is best illustrated by comparing the ratios of women and girls disaggregated by migration and age group. Colombian women in this age group are 1.47 times more likely to access services for contraceptive counselling than their Venezuelan counterparts. However, this disparity increases to 2.67 times more likely when focusing only on the 15-19 age group. This highlights that while there are higher proportions of Colombians seeking health services for Z30.0, the differences become even more pronounced when considering age, clearly illuminating that adolescent migrant girls' contraceptive access is shaped by both gender, age, and migration.

5.1.2 Inequalities in Access to Services for the Supervision of Pregnancy

For pregnancy-related care higher proportions of the Colombian population are consistently higher except in services encountered for high-risk pregnancy[27]. This shows Venezuelans are more likely to be seen for high-risk pregnancies but not for normal supervision, suggesting that there are inequalities in accessing maternal care. All types of supervision of pregnancy show smaller inequalities than were present in the analysis of contraceptive care, showing how different aspects of SRH are treated differently by providers.

Pregnancy-related care is valuable to understanding contraceptive autonomy because it reveals how Venezuelans and Colombians experience access differently. In turn, this demonstrates a particular need for an intersectional and differential approach to delivering contraceptive care. The policy chapter (Chapter 4.2) demonstrated how maternal care was classified as a type of urgent care which Venezuelan migrants are entitled to by law. Examining the numbers of persons who access services

[27] For more details on the ICD-10 codes see Table 9 in the Methodological Chapter 3.2.3.

pregnancy-related care compared to contraceptive-related care shows how these aspects of SRH are treated differently in practice. It should come as no surprise then that there is less inequality for Venezuelans and Colombians accessing healthcare services for supervision of pregnancy than there is for accessing contraceptive-related care.

What is more surprising is that the MSPS data shows that inequalities persist in access to services for the supervision of normal pregnancy. Venezuelan migrant women are less likely to have an appointment for the supervision of pregnancy unless there is a risk of harm.

I will continue exploring these two key claims, first exploring the idea that those seeking healthcare for services related to the supervision of normal pregnancy experience greater levels of inequality. Below, Table 10 reveals the ratios and percentages of Venezuelan and Colombian women and girls who attended health centres in 2021 for supervision of 'normal pregnancy', whilst Table 21 shows the same data for supervision of pregnancy with 'high risk'.

Looking at the results for supervision of normal pregnancy Colombians were 1.48 times more likely to be seen, indicating that there might be additional challenges faced by Venezuelan migrants in accessing routine pregnancy supervision services compared to the Colombian host population. For adolescent girls aged 15-19, this figure increased to 2.12, signifying that, in this age group, the proportion of the Colombian host population seeking care was more than twice as much as that of Venezuelan migrants. Overall, this indicates that these challenges are felt more acutely by Venezuelan adolescent migrant girls.

Table 20 Ratios and Percentages of Venezuelan and Colombian Women and Girls who Attended Health Centres in 2021 for Supervision of 'Normal Pregnancy'

Age	Colombian Host Population		Venezuelan Migrant Population		Ratio of the Percentage of Colombians to Venezuelans
	Number of Persons	Percentage of Population	Number of Persons	Percentage of Population	
15-19	72,569	3.61%	3,296	1.70%	2.12
20-24	135,973	6.29%	5,573	3.72%	1.69
25-29	120,409	5.53%	3,905	3.26%	1.70
30-34	74,866	3.71%	1,806	2.06%	1.80
35-39	29,230	1.55%	515	0.77%	2.02
40-44	7,467	0.43%	139	0.27%	1.60
45-49	1,206	0.08%	4	0.01%	7.29
Total	430.692	3.18%	15,238	2.15%	1.48

Table 21 Ratios and Percentages of Venezuelan and Colombian Women and Girls who Attended Health Centres in 2021 for Supervision of High-Risk Pregnancy

Age	Colombian Host Population		Venezuelan Migrant Population		Ratio of the Percentage of Colombians to Venezuelans
	Number of Persons	Percentage of Population	Number of Persons	Percentage of Population	
15-19	128,920	6.41%	8,598	4.43%	1.45
20-24	200,016	9.25%	13,079	8.74%	1.06
25-29	197,150	9.06%	9,466	7.91%	1.15
30-34	139,315	6.91%	5,052	5.76%	1.20
35-39	78,391	4.15%	2,111	3.14%	1.32
40-44	2,4359	1.40%	571	1.11%	1.27
45-49	2,512	0.16%	46	0.12%	1.32
Total	745,180	5.50%	38,923	5.50%	1.00

For the supervision of pregnancy with risk, the proportion of the population seen varied from 6.41% for Colombian adolescent girls to 4.43% for Venezuelan adolescent migrant girls – giving a ratio of 1.45 for Colombians to Venezuelans. However, for the total number of women of reproductive age, an equal percentage (5.50%) of Venezuelan migrants and Colombian populations sought healthcare services for supervision of pregnancy with risk. So, there was an overall equal ratio of the percentage of Colombians to Venezuelans (1) but for adolescent girls ages 15-19 there were a greater number of Colombians seen (1.45). Overall, these findings demonstrate that fewer Venezuelan adolescent girls attended health services than Colombians of the same age group, for both high-risk and low-risk pregnancies.

This could be because the overall fertility rate of Venezuelan migrants was lower than it was for Colombians. However, this would go against the existing literature. Furthermore, even if the fertility rate were lower and more skewed towards high-risk pregnancy, then we would speculate that there would be a greater proportion seeking contraceptive-related care. However, other data presented by the Colombian government from 2020 demonstrates that Venezuelan migrants in Colombia have a higher fertility rate as well as higher levels of adolescent pregnancy compared to the host population (1.90 versus 2.11 for Colombian versus Venezuelan migrants respectively) (DANE, 2021). This is in line with statistics from the World Bank which estimated the fertility rate in Venezuela in 2021 at 2.2, whereas in Colombia the fertility rate in 2021 was at 1.7 (World Bank, 2023). There is further evidence to suggest that regularisation is linked to a decline in fertility amongst Venezuelan migrants in Colombia (Amuedo-Dorantes *et al.*, 2023). So, the data demonstrates that migrants with an irregular status or who have recently arrived would be expected to have, on average, a higher fertility rate than the host population.

One other possible and more likely explanation would be that pregnancy-related care is available to migrants when the pregnancy is deemed as risky because of policy developments. As aforementioned, Venezuelan migrants are entitled to access to healthcare when it is considered urgent or an emergency – that is when there is a *risk* to life. So, access to pregnancy-related care with risk could be higher because there is a legal obligation to provide this type of care. Therefore, medical staff and hospitals are more likely to provide this type of care. Another possibility could be that there was a greater representation of Venezuelan migrants recorded as 'high-risk due to social problems', given the high levels of poverty experienced.

An alternative suggestion could be that these services are more likely to be sought by migrants themselves, either through the public or private system when there is a risk. Of course, both scenarios could also be true. Without data to infer the cause, then, the most we can say is that those who have a riskier pregnancy are more likely to access services than those who have a 'normal pregnancy'.

Comparing the supervision of pregnancy to the contraceptive-related care discussed earlier in the chapter reveals that there are nearly equal proportions of Venezuelan adolescent migrant women and girls seeking services for the supervision of pregnancy as there are those seeking contraceptive-related care. In comparison, for Colombians, there is a far greater proportion of the population seeking contraceptive care than pregnancy.

Looking at Table 18, the total percentage of women of reproductive age from Colombia who sought contraceptive-related care was higher (12.54%) compared to the number of women of reproductive age who sought healthcare services for the supervision of pregnancy (8.68%). Overall, it shows that for every person who attended a health service for the supervision of pregnancy, there were 1.44 attending services related to contraception. For Venezuelan women of reproductive age, there was a lower proportion seeking contraceptive services relative to the supervision of pregnancy, so the two figures were nearly equal (8.51% versus 7.65% giving a ratio of 1.1).

A greater number of adolescents aged 15-19 in the Colombian population sought contraceptive-related care (17.36%) compared to pregnancy supervision (10%). This means that adolescent girls in this age group were more likely to seek contraceptive care of some kind, as opposed to pregnancy supervision. However, for the Venezuelan population aged 15-19, these numbers were a lot more closely aligned (6.36% versus 6.13%) showing that a nearly equal amount of people attended for supervision of pregnancy and contraceptive-related care. This indicates that non-emergency or primary healthcare such as contraceptive care is not as readily accessed as the supervision of pregnancy. One potential reason for this, which I explore in the discussion, could be additional protections afforded to maternal care, whereas only certain methods of contraception are obliged to be provided under normative frameworks such as MISP and COPNES 2895.

Table 22 The ratios and percentage differences between the ratios of Venezuelans and Colombians seeking healthcare services related to reproduction in 2021

Description of Services	**Age group**							
Contraceptive-related care	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**Total**
Ratio of Colombians to Venezuelans	2.70	1.60	1.40	1.40	1.50	1.80	2.70	1.50
Difference between percentage of population	11.00%	8.10%	4.50%	3.20%	2.70%	2.50%	2.30%	4.00%
Supervision of normal pregnancy								
Ratio of Colombians to Venezuelans	2.12	1.69	1.70	1.80	2.02	1.60	7.29	1.48
Difference between percentage of population	1.91%	2.56%	2.27%	1.65%	0.78%	0.16%	0.07%	1.02%
Supervision of high-risk pregnancy								
Ratio of Colombians to Venezuelans	1.45	1.06	1.15	1.20	1.32	1.27	1.32	1.00
Difference between percentage of population	1.98%	0.51%	1.15%	1.15%	1.02%	0.30%	0.04%	0.00%

5.2 Utilisation of Services Related to Reproduction: Evidence from Profamilia, a Non-State Provider

The Profamilia data shows that the institution providing the care influences the type of service likely to be accessed. There are three main findings from Profamilia data. Firstly, the proportion of Venezuelan migrants seeking general contraceptive counselling is higher compared to the Colombian host population. Secondly, a lower percentage of Venezuelans and Colombians had IUDs inserted to the extent that the proportion of supervisions exceeded insertions. Thirdly, the inequalities between age groups are less stark for those accessing care through Profamilia.

Profamilia has been selected as a data source because it is the primary SRH provider in Colombia. As a not-for-profit, it conducts research on the SRH inequalities in Colombia, including those for the Venezuelan migrant population (Profamilia, 2019; Rivillas-Garcia *et al.*, 2021). Beyond its research, Profamilia also conducts comprehensive sexuality education programmes in schools and carries out humanitarian programmes to deliver SRH education, information, and resources to those in need – including Venezuelan migrants. This means that they are more accessible than most other health centres which would only accept those with affiliation to a health insurance scheme or who require emergency care. Therefore, we would expect Profamilia to be able to provide contraceptive-related care to irregular migrants who do not have health insurance. Equally, unlike one-time interventions from INGOs, multilateral organisations or charitable foundations, Profamilia is a well-known name with a sustained presence throughout Colombia, therefore we would also expect a greater level of sustained interaction than with the typical non-state actors.

The data analysed was sent directly from the Profamilia research department, covering ICD-10 codes Z30-Z39 from 2020-2022. However, as described in the methodology chapter (sub-section 3.2.3) only the year 2022 was used as the previous years did not record nationality. To analyse the data, I undertook the same steps as with the MSPS data. This involved using the number of persons attended (Table 23) and the total population estimates (Appendix D) to derive the percentage of each population who attended the health service for services related to contraceptive care (Table 24).

Table 23 Numbers of Persons Attended Profamilia for Contraceptive-Related Services by Age and Migration Status

	15-19		20-24		25-29		30-34		35-39		40-44		45-49		Total	
Description	COL	VEZ	COL	VEZ	COL	VEZ	COL	VEZ	COL	VEZ	COL	VEZ	COL	VEZ	COL	VEZ
General Contraceptive Consultation	25,068	3,664	22,297	4,668	14,442	3,301	8,304	1,876	4,533	1,055	2,172	537	572	194	77,388	15,295
Insertion of IUD	45	4	120	10	153	9	148	3	166	3	170	3	134	1	936	33
Supervision of Contraceptive Medicines	1,363	362	1,056	490	636	382	321	197	197	116	83	46	28	23	3,684	1,616
Supervision of IUD	506	44	1,390	125	1,344	153	935	67	694	28	604	20	393	9	5,866	446
Other Specific Contraception Attention	489	12	514	17	352	18	252	4	163	5	69	3	27		1,866	59
Non-specific Attention with Contraception	17,108	1,359	21,318	1,926	17,905	1,497	12,681	859	7,618	407	3,792	168	863	31	81,285	6,247

Table 24 Contraceptive Services Utilisation at Profamilia as a Percentage of the Total Population by Age and Migration Status

	15-19		20-24		25-29		30-34		35-39		40-44		45-49		Total	
Description	**COL**	**VEZ**	**COL**	**VEZ**	**COL**	**VEZ**	**COL**	**VEZ**	**COL**	**VEZ**	**COL**	**VEZ**	**COL**	**VEZ**	**COL**	**VEZ**
General Contraceptive Consultation	1.25%	1.89%	1.03%	3.12%	0.66%	2.76%	0.41%	2.14%	0.24%	1.57%	0.13%	1.04%	0.04%	0.51%	0.57%	2.16%
Insertion of IUD	0.00%	0.00%	0.01%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.00%	0.01%	0.01%	0.01%	0.00%	0.01%	0.00%
Supervision of Contraceptive Medicines	0.07%	0.19%	0.05%	0.33%	0.03%	0.32%	0.02%	0.22%	0.01%	0.17%	0.00%	0.09%	0.00%	0.06%	0.03%	0.23%
Supervision of IUD	0.03%	0.02%	0.06%	0.08%	0.06%	0.13%	0.05%	0.08%	0.04%	0.04%	0.03%	0.04%	0.03%	0.02%	0.04%	0.06%
Other Specific Contraception Attention	0.02%	0.01%	0.02%	0.01%	0.02%	0.02%	0.01%	0.00%	0.01%	0.01%	0.00%	0.01%	0.00%	0.00%	0.01%	0.01%
Non-specific Attention with Contraception	0.85%	0.70%	0.99%	1.29%	0.82%	1.25%	0.63%	0.98%	0.40%	0.60%	0.22%	0.33%	0.06%	0.08%	0.60%	0.88%
Total	1.37%	2.11%	1.17%	3.55%	0.78%	3.23%	0.49%	2.45%	0.30%	1.79%	0.18%	1.18%	0.07%	0.60%	0.66%	2.47%

Examining the results in Table 23, it is evident there is a higher number of Colombian women and girls attending Profamilia for contraceptive-related services (81,285) than Venezuelan migrant women and girls (6,247). This result is consistent with our expectations given the size of the Colombian population relative to the Venezuelan population from our estimates. It affirms that Profamilia is a large provider that consults with both migrants and host populations.

Looking at Table 24, it is interesting that there is a greater proportion of Venezuelan migrants (2.47%) seeking contraceptive-related care compared to the Colombian host population (0.66%). This is true across all the age groups for women of reproductive age, for all services related to reproduction. The greatest difference is between the percentage of total women of reproductive age seeking services for general contraceptive counselling (2.16% for Venezuelans versus 0.57% for Colombians). In contrast, an equal percentage of the population sought services for other specific attention (0.01%). This means that, whilst the absolute number of Colombians using Profamilia services is higher than the Venezuelan migrant population, a greater *proportion* of the Venezuelan population are seeking health services.

It is worth noting that, there is a higher proportion of Venezuelans aged 15-19 years old seeking general counselling related to contraception (1.89%), compared to Colombians (1.25%). These findings are contrary to those represented by the MSPS (Section 5.1), where there were greater percentages of Colombians accessing contraceptive-related services compared to Venezuelans. An absence of SRH inequalities in Profamilia health services suggests that Profamilia health centres are more accessible to Venezuelan migrants.

However, the difference between the two groups for general counselling (0.64%) is considerably smaller in all other age groups apart from 45-49 (where it is 0.48%). This shows both age and migration play an important role in access to contraceptive-care-related healthcare. In this way, the findings are similar to those from the MSPS data, because although the inequalities are not as pronounced, they still demonstrate that adolescent migrant girls' access to contraceptive-related care is disproportionately lower than older migrant women.

Another key finding is that a lower percentage of Venezuelan women and girls (<0.00% or 33 women and girls) than Colombians (0.01% or 936 women and girls) had IUDs inserted. In addition, the overall number of insertions was lower, as well as the percentage of persons who attended the health service for the supervision of an IUD. However, a greater proportion of Venezuelans attended a health centre for the supervision of an IUD (0.06%) than Colombians (0.04%). Once again, this trend is reversed for adolescents aged 15-19, where a higher proportion of Colombians (0.03%) attended the health service for the supervision of an IUD compared to Venezuelans (0.02%). Although the percentages are very low, these findings contrast with the findings from the MSPS which reported greater numbers of insertions for Venezuelans, with lower numbers of follow-ups. This suggests that

Venezuelan migrant women of reproductive age access services related to the supervision of IUDs more readily at Profamilia health centres than most health centres. However, Venezuelans from the age group 15-19 years old still experience relative inequalities in accessing the supervision of IUDs. Further, this indicates that Venezuelan adolescent migrant girls are less likely to have IUDs inserted at Profamilia clinics.

Overall, inequalities are less pronounced between migrant and host populations seeking contraceptive-related services. In most cases, the proportion of Venezuelans seeking services surpassed Colombians. Substantially lower proportions attended for insertion of IUD with appointments weighted towards supervision of IUDs or contraceptive medicines, potentially indicating that Profamilia has fewer barriers or challenges to sustained access. While the disparities between Venezuelan migrant women and girls were less pronounced, there were still discernible differences. This underscores the significance of both age and migration status in influencing access to contraceptive-related services in Profamilia clinics.

5.3 Discussion

The findings from MSPS data show that there is inequality between the Venezuelan migrant population and the Colombian host population seeking services related to reproduction. There is the greatest inequality between general contraceptive counselling and supervision of IUDs. However, there is less inequality in services concerning the insertion of IUDs and high-risk pregnancies. Combined these findings suggest that there is a problem with sustained access to the healthcare system for Venezuelan migrants, care is more likely to be short-term, one-off basis or when there is a risk of harm. Interestingly, the Profamilia data shows fewer IUD insertions and greater levels of supervision for Venezuelan migrants. Relative to Colombians, there are greater proportions of Venezuelans seeking contraceptive counselling. However, the inequalities are less stark for the age group 15-19 – suggesting that Profamilia are better at engaging Venezuelan migrants in contraceptive care.

The remainder of this chapter will discuss the relevance of these findings concerning the research question: To what extent do disparities exist in the provision of contraceptive services to adolescent migrant girls (aged 15-19) in Colombia? In particular, it will discuss how inequalities in access are likely markers of difficulties in accessing contraceptive care. Using RJ, I will demonstrate how this is problematic for crucial elements of *voice* such as participation and feedback mechanisms. Inequalities between migrants and the host population, which also vary by age, indicate that actors' responses are not differentiated to match the intersectional reproductive realities of adolescent migrant girls – another key element of *voice*. Overall, these inequalities suggest that actors, in

particular state actors, do not adequately consider Venezuelan adolescent migrant girls in their service provision.

5.3.1 Inequalities in Access to Services Related to Reproduction by Migration and Age

The problems in access show that Venezuelan adolescent migrant girls are not centred in the response. For them to achieve contraceptive autonomy, it is imperative to have access to services that facilitate the realisation of their contraceptive choices, as these underpin inequalities in access to services. After all, one cannot make free and full decisions about which contraceptive methods to use, if those services are not available. In cases where Venezuelan adolescent migrant girls have lower capacities to exercise *voice*, they should at the very least be *considered* and involved in these decision-making processes concerning contraceptive education and counselling.

Non-use indicates a lack of access in the migrant population. Granted, contraceptive non-use can be autonomous (Senderowicz, 2020). Findings from other surveys show that there are a large proportion of the Venezuelan migrant population, especially the young Venezuelan migrant population do not use any contraceptive methods at all. In Appendix G and H, I highlight how this is the case in two surveys involving Venezuelan adolescent migrant girls. To briefly summarise the Violence Against Children Survey (VACS) data shows that most sexually active Venezuelans and Colombians aged 13-24 are not using any contraceptive method to prevent pregnancy. Likewise, the Migration Pulse Survey (EPM) reveals that almost half of young people aged 15-24 were not using any contraceptive method.

This is consistent with other studies revealed that Venezuelan migrants have raised issues in accessing contraceptive care and AFHS, meaning it is likely that in this instance high levels of non-use are not autonomous. In 2018, a study by Profamilia showed that access to contraceptive services was a high priority for Venezuelan migrant women that was going unmet (Profamilia, 2019). Equally, another study of Venezuelan migrants in Colombia found a minority (37.7%) of pregnancies were planned, and that despite knowledge of contraceptive methods most migrants were unable to access them (Flórez-García *et al.*, 2020). A more recent study by colleagues at Profamilia found that despite an increase in the use of methods from 2018, there continue to be inequalities in access to contraceptive methods both in the migrant and refugee populations versus the host population (Rivillas-Garcia *et al.*, 2021). Either way, the history of difficulties in access and these patterns of non-used in the migrant population should provoke further investigation.

The fact that inequalities are persistent in the supervision of normal pregnancy, but not for high-risk pregnancies, shows that there is a smaller disparity between Venezuelan migrants and women and

the host population for high-risk pregnancies compared to those for a normal pregnancy. One reason for this could be that the fertility rate for Venezuelan migrants is lower but that women who are pregnant are at higher risk. However, other data presented by the Colombian government from 2020 demonstrates that Venezuelan migrants in Colombia have a higher fertility rate as well as higher levels of adolescent pregnancy compared to the host population[28] (DANE, 2021). This is in line with statistics from the World Bank which estimated the fertility rate in Venezuela in 2021 at 2.2, whereas in Colombia the fertility rate in 2021 was at 1.7 (World Bank, 2023). Further evidence suggests that regularisation, and by extension, improved access to services is linked to a decline in fertility amongst Venezuelan migrants in Colombia (Amuedo-Dorantes *et al.*, 2023). So, the data demonstrates that migrants in irregular situations or who have recently arrived would be expected to have, on average, a higher fertility rate than the host population. Notably, this evidence suggests that the inequality is more pronounced than presupposed. Either way, if we assume that the levels of usage of Venezuelan migrants in Colombia would be similar, as others have suggested (Rivillas-Garcia *et al.*, 2021; Amuedo-Dorantes *et al.*, 2023), then these findings indicate there are issues in accessing maternal care.

Difficulties accessing regular maternal care could partly be due to the obligations to provide urgent care under the normative framework discussed in the previous subsection (4.3.2). As aforementioned, Venezuelan migrants are entitled to access to healthcare when it is considered urgent or an emergency – that is when there is a *risk* to life. So, the proportions of access to pregnancy-related care with risk for Venezuelan migrants could be higher because there is a legal obligation to provide this type of care. Therefore, medical staff and hospitals are more likely to provide this type of care. An alternative suggestion could be that these services are more likely to be sought by migrants themselves, either through the public or private system when there is a risk. Of course, both scenarios could also be true. Regardless, these observations underscore how structural factors in the healthcare system prioritise certain types of care, particularly those categorised as 'high risk,' over others such as contraceptive counselling or supervision.

Across all data sources, inequalities related to migration status and age. In some cases, the inequalities were nearly doubled for Venezuelan adolescent migrant girls than their Venezuelan migrant counterparts (see Figure 5) and other women of reproductive age (see Figure 6). The continued inequality faced, especially in non-use and contraceptive counselling demonstrates that Venezuelan adolescent migrant girls are not accessing non-emergency services. These findings imply that the intersections of age, gender *and* migration play a role in shaping access to services related to reproduction in a way that disproportionately disadvantaged migrant girls aged 15-19. In particular,

[28] As of 2020, the total fertility rate for Colombians is 1.90 versus 2.11 for Venezuelan migrants.

they suggest that actors are not effectively engaging with Venezuelan adolescent migrant girls in a way that matches their reproductive realities.

High levels of non-use and low levels of service provision relative to other SRH services show that some elements of *voice* have been compromised in service delivery. Addressing inequalities is an imperative part of achieving justice, as often access to services is designed and implemented with hegemonic groups in mind (adults, citizens). In this case, inequalities in access, are indicative of an inability to access care. A lack of access or exclusion from services is considered *coercion*. This is because there is no opportunity to (not) use a variety of contraceptive methods. Choice has been completely removed from Venezuelan adolescent migrant girls. Therefore, *coercion* could occur in either of the ways construed by Senderowicz, (2019, p. 8) either downwardly, where adolescent migrant girls want to use a method and cannot or upwardly, where they are unable to discontinue a long-term method (as I will discuss in the next sub-section 5.3.2.) Either way, under *The Scale of Voice,* a complete lack of consideration and inclusion of adolescent migrant girls in decisions about their contraceptive care is classified as *coercion.* In lieu of a comprehensive response, the structure perpetuates a system where crucial modes of *voice*—such as participation, feedback or acknowledgement of intersectionality—are continually overlooked. The consequence of this reproductive injustice is a further marginalisation of Venezuelan adolescent migrant girls.

5.3.2 Differences in Access to Contraceptive Care by Service Providers

Beyond inequalities in access, differences in services sough reveal further inequalities that indicate that the *voices* of adolescent migrant girls might not be sufficiently considered or included.

In the RIPS and 029 Cube, there is a higher proportion of Venezuelan migrants having an IUD inserted. This is unsurprising given the promotion of the IUD in the MISP guidelines which the Colombian government adopted as part of their response to Venezuelan migration (sub-section 4.3.2). However, it is concerning that there is also a relatively lower number of appointments for the supervision of IUDs, suggesting that there is an issue in accessing follow-up appointments. This idea is further continued by the low numbers of Venezuelan migrants seeking supervision for contraceptive medicines compared to those of the same age in the host population.

Furthermore, high levels of IUD usage were not present in the Profamilia registry. Profamilia, as a not-for-profit organisation, provides free care to migrants of both irregular and regular status. Interestingly, there is a difference between the methods selected compared to the national-level data. The lower levels of IUD insertion compared with higher levels of supervision and even higher levels of contraceptive consultation and supervision of contraceptive medicines imply that Profamilia

has greater levels of sustained interaction with patients than other healthcare providers. This further demonstrates that not all Venezuelan migrant women and girls prefer LARCs. Given these findings, it is possible to speculate that preference in methods could be at some level, influenced by ease of access to services.

To elaborate on these further using the framework of RJ and contraceptive autonomy requires greater consideration of the conditions influencing independent decision-making in contraceptive care (Gomez, Fuentes and Allina, 2014; Biggs *et al.*, 2020; Mann, 2022; Morison, 2023). In extending this exploration, I have incorporated *The Scale of Voice* framework, which serves as an illustrative tool to capture the various modalities through which power-sharing among actors unfolds in the decision-making process across different levels. This allows us to comprehend not only the accessibility of services but also the power relations that shape autonomy and *voice*.

However, as the levels named *manipulation* articulates, access does not automatically equal *voice* nor the creation of contraceptive autonomy-enhancing conditions. Instead, access can be provided in conditions in which decision-making is constrained because there is a reduced number of contraceptive options. That is, because providers promote certain methods over others or because care is interrupted or discontinued (Senderowicz and Maloney, 2022). This is particularly concerning considering debates in RJ about LARC hegemony or LARC-first approaches to consultation. For example, groups typically cast as 'non-compliant' like adolescent migrant girls, are provided LARCs because they can be inserted and 'forgotten' they are inserted more to meet public health and social reform agendas, as opposed to enhancing autonomy (Brian, Grzanka and Mann, 2020; Morison, 2023). In short, whilst LARCs are *technically* reversible, the focus on insertion over surveillance or removal means that individuals are not free to decide when they are removed (Winters and McLaughlin, 2019, pp. 225-6). Therefore, provider actors with greater decision-making power than women and girls, neglecting the principles of full and free choice. Thus, when the removal of LARCs prevents Venezuelan adolescent migrant girls from becoming pregnant, when she wants to become pregnant – the process can be seen as *coercive*.

Using *The Scale of Voice*, it is not only accessing the method in the first place which seems to be an issue but continued medical supervision of LARCs. Even though these methods may be desired by Venezuelan migrants to start with, there are few opportunities for women and girls to renegotiate their contraceptive use as their priorities and preferences. As such they demonstrate levels of *manipulation*, where full and free choice have been compromised, with the potential to become *coercive.*

5.4 Conclusion

This chapter conducted a descriptive statistical analysis of secondary health utilisation data from state and non-state actors, alongside relevant survey data to detect the inequalities of contraceptive care services accessed by adolescent Venezuelan migrant girls, compared to other Venezuelan migrants and the Colombian host population. Using RJ and *voice* to critically analyse the findings I highlight the extent to which they are centred or marginalised, in contraceptive-related responses I considered the idea actors may not be providing Venezuelan migrant women and girls, especially adolescent Venezuelan migrant girls, with the necessary conditions fulfil key components of *voice*.

This chapter serves as the foundation of the empirical inquiry of this thesis, analysing both secondary health utilisation data and survey responses to shed light on the issue of services related to reproduction (ICD-10 Z30-Z39), with a particular emphasis on contraceptive care services for adolescent Venezuelan migrant girls in comparison to the host population. The data, drawn from the SISPRO RIPS Cube 029 dataset for the year 2021, Profamilia health utilisation data from 2022. This provided the best overview available despite the acknowledged limitations of the data (discussed in the methods sub-section 3.2.3).

Findings from the analysis revealed the percentages of Venezuelan migrants accessing contraceptive-related care to be lower than those of the host population. Notably, the findings reveal that this inequality is more pronounced within adolescents aged 15-19 compared to other age groups. In other words, actors' responses are not doing enough to address the intersectional contraceptive care needs of this population. High levels of non-use and low levels of service provision relative to other SRH services show that some elements of *voice* have been compromised in service delivery. Exclusion from responses is antithetical to the inclusion required by *The Scale of Voice*, and contraceptive autonomy. The consequence of this reproductive injustice is that actors' responses further marginalise Venezuelan adolescent migrant girls.

Differences in the types of contraceptive services were detected, indicating that there was dominance of LARCs without supervision. On average, higher percentages of Venezuelan migrants seek services related to IUD insertion, while the levels associated with the supervision of IUD are comparatively lower. This trend was reversed for Profamilia data, where free contraceptive care is provided without the need for affiliation to a health insurance scheme. Building on RJ scholars and using *The Scale of Voice*, I demonstrated how this pattern indicates constraints on comprehensive contraceptive care. This was reasoned as actors hold most of the decision-making power either through preferring one method or discontinuing access to services which limited Venezuelan adolescent migrant girls' ability to realise their decisions concerning their contraceptive care.

Considering the normative frameworks discussed earlier in section 4.3, these inequalities are unsurprising. The normative frameworks detailed how states' obligations for Venezuelan adolescent migrant girls were limited to 'basic' services offering emergency or 'urgent' care. For example, the MISP package prioritises LARCs such as IUDs whilst simultaneously overlooking the use of short and mid-term contraceptive methods. Therefore, whilst I have identified how contraceptive autonomy has been constrained by restrictions to access and lack of surveillance, these do not necessarily depart from the obligations to provide 'basic services' as understood in normative frameworks.

Given that the results of this chapter found inequalities are more pronounced in adolescent migrant girls compared to the majority of Venezuelan migrant women of reproductive age it is important to consider the extent to which responses are differentiated to account for the complex reproductive realities experienced by the intersections of age, gender *and* migration. After all, differentiation to acknowledge intersectionality is a fundamental part of *voice*. Without accounting for intersectional reproductive realities actors cannot be said to be centring them in their responses. With this in mind, the next chapter will explore how responses are differentiated to account for the gaps in the intersectional reproductive realities of Venezuelan adolescent migrant girls.

Chapter 6 How State and Non-State Actors Focus on Emergency Compromises *Voice* for Adolescent Migrant Girls

The previous chapter found that there were inequalities in service utilisation between Venezuelan adolescent migrant girls, adult Venezuelan migrants and the host population. Overall, this suggests that actors are not meeting the intersectional contraceptive care needs of the Venezuelan adolescent migrant population. This chapter, continues this discussion by asking, 'How have actors acknowledged and enacted the need for differential contraceptive care services for adolescent migrant girls?'

By answering this question, this section will demonstrate the extent to which actors account for intersectionality (as a central component of *voice*). According to the *Scale of Voice* developed in the conceptual framework (detailed in Chapter 2.3.3), for responses to create the conditions that foster *voice*, and by proxy contraceptive autonomy, they should acknowledge and positively respond to the differentiated need presented by intersections of age, gender and migration so as to account for the complex reproductive realities. If actors demonstrate that their responses do this, they can be considered to fulfil this dimension of *voice*.

To answer this question, data was collected during fieldwork in Colombia, using semi-structured, multi-perspective interviews with Venezuelan adolescent migrant girls and key informants from state and non-state actors, as detailed in Chapter 3.2.4. Analysis is then conducted thematically, using *The Scale of Voice* as an analytical framework to determine the ways in which responses are, or are not, differentiated.

I highlight four key empirical findings. Firstly, state actors focus on regularisation schemes. Meanwhile, other attempts to offer SRH care are implemented unevenly. Secondly, non-state actors prioritise short-term 'urgent', emergency responses. Thirdly, coordinated responses between state and non-state actors are fragmented. They are driven by donors with certain actors, who are focused on addressing aspects of SRH in specific moments. Within this, adolescents and contraceptive care are deprioritised. Finally, few actors consider Venezuelan adolescent migrant girls' intersectional contraceptive care needs to be within the scope of their responsibility.

Using *The Scale of Voice*, as well as literature on humanitarian crisis response, I demonstrate how these responses display a lack of intersectionality, in turn failing to account for gender, age, and migration. Instead, Venezuelan adolescent migrant girls' contraceptive care is largely shaped by their identities as migrants. Through *The Scale of Voice,* I highlight the absence of intersectional responses

such as a lack of AFHS, a lack of comprehensive care, and a lack of accountability all provide conditions that constrain *voice*, and as a result, create conditions which constrain contraceptive autonomy. I discuss how the lack of intersectionality, goes part way in explaining the inequalities in Chapter 5. Overall, actors do not create positive actions to recognise the intersectional reproductive realities of adolescent migrant girls, preferring to offer partial or temporary services to 'emergency' services. Failure to move beyond this 'tyranny of the urgent' continues to perpetuate reproductive injustices that see adolescent migrant girls deprioritised and excluded from responses.

6.1 Findings: Approaches to the Inclusion of Adolescent Migrant Girls in Responses

6.1.1 State Actors' Approaches

State actors including the MSPS and sub-secretariat to the MSPS were often driven by what they referred to as 'public health' or 'development' agendas[29]. Key informants articulated that these agendas were informed by the national legislature discussed in sub-section 4.3.2. These included a 'gender and differential approach' and a human rights-based approach. When asked to explain how this approach was applied in the responses to adolescent migrant girls' contraceptive care, participants pointed towards two policies – the regularisation of Venezuelan migrants, and the provision of emergency care.

The EPTV – the policy was designed to encourage Venezuelan migrants to affiliate to the health system via a health insurance plan (EPS) so that they would be entitled to 'the same care as Colombians'[30]. Whilst this policy did little to directly address the contraceptive care of adolescent migrant girls, it was seen as a way of reducing inequalities by proving level access whilst utilising the existing health system.

> 'There is a structural response which is through the temporary statute of protection for migrants, which is that they [sic] can enter the Colombian health system and there they could access sexual and reproductive services with a package like the Colombian one.' Participant 8, a public health professional.

Key informants from state institutions placed great emphasis on the role the EPTV would have in increasing the range of contraceptive care services available. Prior to this, the lack of legislation to affiliate with the health system was one of the main barriers which had prevented state providers

[29] Five interviews with public health and medical professionals.
[30] Participant 9, a public health professional.

from providing contraceptive care to Venezuelan adolescent migrant girls who had asked for it, as articulated by Participant 26. This policy reform, therefore, demonstrates positive actions towards including Venezuelan migrants in the health system.

> 'I have to mention that there is a huge barrier because they're a migrant with regular migration status, then we can set them up with a roadmap for care. But if they have an irregular status, we can't link them into the health system' Participant 26, a public professional working in social protection.

To be clear, where care is denied, because of status this is akin to *coercion* on *The Scale of Voice*. For how can the denial of contraceptive care to adolescent migrant girls, who are requesting it, be anything other than a prevention of the means to realise their contraceptive decisions?

Whilst the EPTV policy was considered an essential step towards providing a pathway to contraceptive care, those such as Participant 10 highlighted issues in the implementation of the policy. As articulated below, there was a perceived gap between providing a legal entitlement and arriving at the point where Venezuelan adolescent migrant girls were able to receive contraceptive care.

> 'I think it is a great first step, but from there onwards I think that is where the challenges lie, because beyond handing over the paper that they are entitled to, it is how to effectively materialise and achieve the access.' Participant 10, a lawyer from an NGO.

Some key informants identified the barriers to implementation in the conditions of the EPTV. For example, the application required documentation that many Venezuelan migrants did not have or could not afford to renew, as articulated by Participant 27. Other key informants pointed out that in some cases, Venezuelan adolescent migrant girls might be wary to affiliate with the system because of their irregular entry into Colombia or because they have become under the influence of criminal gangs during the migration process from Venezuela[31].

> 'We have campaigns to get them insured. But it's difficult because for us to do that we need their documents, many of them don't have them…' Participant 27, a public health professional.

This clearly demonstrates that whilst the policy can be deemed a positive action, aimed at being a response to integrate Venezuelan adolescent migrant girls into the health system and allowing them to access contraceptives via health insurance, the lack of differentiation in the policy

[31] Participant 18 a public medical professional and Participant 29 a migration and integration professional.

means it does not match the reproductive realities of the most disadvantaged adolescent migrant girls.

Venezuelan adolescent migrant girls also saw affiliation with health insurance as the biggest barrier to accessing contraceptive care. This can be seen in the following quotation from Participant 4:

> 'I would say that the biggest barrier is documentation because before I wasn't documented, and I didn't have an EPS … if you have an EPS then you can ask for an appointment, you could go see the gynaecologist and now I'm going to be affiliated because they're helping me with my visa, but if you don't have that, then you have to get private care and it's too expensive.' Participant 4 Venezuelan migrant living in Bogotá.

As such, the findings from the interviews showed that adolescent migrant girls' contraceptive care is largely dependent on whether they have regularised status and are affiliated with the health system. The economic crisis in Venezuela left many migrants in situations of poverty (Albaladejo, 2018). Consequently, private healthcare costs, as Participant 4 highlighted, were often too expensive[32]. Seeking legal advice was typical as in the case of Participant 4, because the regularisation process is known amongst Venezuelan migrants in Colombia for its bureaucratic complexity and document requirements (Murillo-Pedrozo *et al.*, 2021). For this reason, many of the non-state actors delivering humanitarian aid, had a legal expert to help Venezuelan migrants with the EPTV process.

The EPTV was supposedly designed to help affiliation to health insurance schemes and thus access to primary healthcare. However, the complexity of the process meant it is not being implemented as designed. The EPTV is implemented without differentiation. It does not consider how the policy might be more difficult to realise for migrants who are poor, have no documents or are not equipped with the legal literacy to navigate the process. Therefore, the state response does not appear to implement the 'gender and differential' approach beyond the single axis of migrant. In this sense, the state cannot be considered to be creating opportunities for *voice*, beyond *generalisation.* In this landscape, Venezuelan adolescent migrant girls are not considered central or included. Rather they remain unheard. In fact, the current implementation of the policy means that it is still challenging to gain access to contraceptive care via the EPTV and affiliation.

As articulated in sub-section 4.3.2 all migrants were entitled to emergency or urgent care, regardless of affiliation status, the actual provision could be inconsistent, with the decision of 'emergency'

[32] Participant 18, and Participant 25 public medical professionals.

assessed on a case-by-case basis[33]. However, this policy is not specific to Venezuelans or adolescents, rather it serves as a country-wide rule under the constitutional commitment to the 'right to health' (Angeleri, 2021). Interviews with key informants have stated that this policy, far from being differentiated to include Venezuelan adolescent migrant girls, was not 'effectively implemented for migrant women'.

> 'I will say regarding contraception, about emergency contraception for cases of sexual violence, we have seen that there is a specific protocol from the Minister of Health here in Colombia, that includes that kind of services, a contraceptive, emergency contraception, … etc. And we have seen, like, some barriers that women face, because this protocol has not been effectively implemented for migrant women.' Participant 16, a lawyer from an INGO.

The perspectives of key informants aligned with the Venezuelan adolescent migrant girls interviewed, whose experiences of receiving emergency care were varied. Participant 4 recalled her own experience of seeking legal assistance from another organisation. She filed a constitutional writ (a *tutela*), to secure access to maternal care. On receiving care, she specified that the care did not extend to any SRH care for *her*. Rather, the care was instead focused on the baby. There was no offer of postpartum contraceptive care or gynaecological check-up[34].

> '[I]t's not that I could get a gynaecological check-up or talk to anybody about my health as a woman it's that I was able to get in the door because I was pregnant.' Participant 4 Venezuelan migrant living in Bogotá.

This experience demonstrates once more, the bureaucratic nature of seeking healthcare for migrants in Colombia. Not only that, but it is also clear that this participant felt that the care provided was conditional and temporary, no higher than *manipulation.* Yet, conditional care does not fulfil obligations to human rights.

Participant 3 was in a similar situation, seeking pregnancy-related care. However, she did not seek legal assistance. Her understanding was all services were unavailable to migrants unaffiliated with the health system. As a result, Participant 3 was denied prenatal care altogether through the state system. She was able to afford a private ultrasound but no further surveillance.

[33] What constitutes an emergency should be decided by a doctor (Resolution 5596/2015). As far as contraception, the law states women and girls who are victims of violence should receive emergency care including access to emergency contraceptives (Law 1719/2014; C-754/2015; Decree 1630/2019).
[34] Post-partum contraceptive care is recommended by WHO *et al.* (2015) *Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice*. 3rd ed. edn. Geneva: World Health Organization.

> '[D]ocumentation because if you don't have that, no one's going to give you services. And so, for example, I got an ultrasound through a private ultrasound, I wasn't able to get one publicly for my pregnancy and they won't help me with any check-ups or surveillance without documentation.' Participant 3 Venezuelan migrant living in Bogotá.

Her experience serves to demonstrate how Venezuelan adolescent migrant women and girls' SRH care is primarily decided through migration status, as opposed to their rights as pregnant women and adolescents. Further emphasising the precarious nature of seeking SRH care for Venezuelan adolescent migrant girls. Participants cited other examples including security guards refusing entry, administrative staff's inability to process payments, and a variation in perceived 'urgency'[35].

These cases illustrate the inconsistent access to emergency SRH care for Venezuelan migrant women. The denial of healthcare without documentation experienced here goes some way to explaining why the proportion of adolescent migrant girls who sought health services related to pregnancy and contraceptive-related care are so much lower than their Colombian counterparts (as demonstrated in section 5.1). For if their service is reliant on documentation, and at the time of data collection roughly half of Venezuelan migrants did not have regularised status, then this is a significant barrier to any type of non-emergency SRH, including contraceptive care.

So, although contraceptive care is not considered 'urgent' care, these experiences served to contextualise the realities in which Venezuelan adolescent migrant girls are seeking SRH. They demonstrate the bureaucratic nature of the process and the frequent demand for legal assistance in seeking care. Further, given that existing legally binding legislation on maternal care is implemented unevenly what will these mean for new non-binding recommendations to provide contraceptive care to irregular migrants? [36] The findings in these interviews demonstrate that challenges in obtaining any form of contraceptive care were attributed to their (ir)regular immigration status. Therefore, state actors are seen to differentiate health policy to include migrants, although the extent to which this is implemented successfully is yet to be considered. Making care conditional on affiliation to the health insurance system, whilst overlooking the barriers to affiliation, demonstrates how Venezuelan adolescent migrant girls have not been centred or included in state responses to their contraceptive care. As I have alluded to, single-axis approaches are classified as *generalisation* on *The Scale of Voice*. Beyond that, partial access is understood as *manipulation,* with complete refusal akin to

[35] Participants 16, a lawyer from an INGO, Participant 17 a professional from a multilateral agency on migration, Participant 22 a professional from a charitable foundation, and Participant 25 a public health medical professional.

[36] See discussion of External Circular 0035 of August 2022 in Section 4.3.2

coercion. The consequences for this in terms of RJ and *The Scale of Voice*, are articulated in the discussion of this chapter (Section 6.2).

6.1.2 Non-State Humanitarian Responses

The health system's lack of capacity was compensated for by non-state actors such as foreign governments, multilateral organisations concerned with migration, INGOs focusing on women's and/or migrants' rights, as well as national and local level not-for-profits and charitable foundations. These organisations were supposed to provide assistance to fill 'gaps' in healthcare for the irregular migrant population whilst they were becoming affiliated[37]. Key informants referred to various normative frameworks guiding their response such as the *Sphere Handbook: Humanitarian Charter and Minimum Standards Humanitarian Response,* the *WHO Life Course Approach* and a human-rights-based approach, to name a few (Sphere Association, 2018; WHO, 2019b). As evidenced by Participant 18, there were several, at times conflicting, normative frameworks used to guide non-state actors' responses.

> 'Well, each organisation or each cooperation, depending on its mandate, has its own way of providing either direct care, care through NGOs or care through hospitals.' Participant 18, a public health medical professional.

In addition to these frameworks, most of the non-state actors interviewed characterised their involvement as 'humanitarian', informed by the Humanitarian Principles in the Humanitarian Charter: humanity, impartiality, neutrality, and independence (UNHCR, 2019b). This is exemplified by Participant 13 who connects their organisation's actions with the preservation of human life. Thus, despite claiming to be driven at times, by more comprehensive normative frameworks such as human rights or life course approaches, it is clear humanitarian actors did not aim to address *all* rights. Their focus was instead 'centring around preventing maternal deaths', and in some cases, STDs, and SGBV[38].

> '… [W]hen we're talking about a context of humanitarian response, there are rights that save lives and that's where we play on actions with that focus.' Participant 13, a professional from a multilateral organisation providing medical care.

The focus on 'rights that save lives' was limited to efforts to reduce diseases or complications that could reduce mortality rates. Hence, there was little motivation to design and implement humanitarian programmes that included contraceptive care. Primarily because contraceptive care

[37] Participant 9 from a public health professional.
[38] Participant 23, a professional from a multilateral organisation focused on migration and health.

was a primary healthcare activity which bore little consequence on mortality indicators (in the minds of key informants) participants would emphasise, that my enquiring about contraceptive care was to misunderstand the problem - namely that there were not enough resources 'to fulfil all needs such as contraceptives'[39]. This is essential because it underlines how actors' aim or normative framings, guided the SRH care they did (or did not) see as important, generating hierarchies of care.

Humanitarian non-state responses were further characterised by their short-term approach. The number of responses adhering to short-term projects led many participants, including Participant 16, to characterise them as 'reactive',

> 'There is a humanitarian situation. So humanitarian aid has taken place, and that is important, but what we see is that the responses are being implemented from a crisis perspective, not with permanent solutions.' Participant 16, a legal professional from an INGO.

Here, Participant 16, demonstrates how this short-term 'crisis' approach has been occurring for the past 5 years. As with state responses, the fixation with partial access means that inclusion can only be seen to the point of *manipulation.* This suggests that whilst attention had been focused on immediate relief efforts, there was a lack of comprehensive, long-term planning to address the underlying problems.

> 'But at this point, most of [the Venezuelan adolescent migrant girls] aren't asking for emergency access to contraception, because they're pretty well settled in the country. And so, they're looking for more options like contraception for the next five years or for longer term.' Participant 2, a professional from a not-for-profit medical service provider.

Participant 2 and Participant 16 exemplify the finding that instead of being driven by the priorities and preferences of adolescent migrant girls or by human rights frameworks that emphasise 'the right to decide' and 'the right to be heard', actors were instead implementing responses based on their assessment of critical need. In this way, responses continued to be driven by traditional humanitarian risk-reduced, disease-based frameworks rather than comprehensive responses, which included care that was differentiated for the intersections of age, gender, and migration. As a result of not acknowledging the intersections of age, they failed to consider the principles of 'the best interest of the child', and of 'evolving capacities'. A lack of perceived need for differentiation leaves actors at the level *manipulation*. Without taking steps to acknowledge and redress power imbalances they remain unequal.

[39] Participant 23, a professional from a multilateral organisation focused on migration and health.

One of the consequences of this type of intervention is exemplified by the experiences of Participant 5, a Venezuelan adolescent migrant girl living in Bogotá. After travelling to Colombia, from Venezuela to seek an abortion,[40] she was offered one-off contraceptive care.

> 'I first went to that organisation for that reason asking for resources and they helped me receive an abortion […] then after that process was over at the last session, they offered me different contraceptives. They gave me a few minutes to think about it and I decided on that one given all the options because it seems like the most effective to me.' Participant 5, a Venezuelan adolescent migrant girl living in Bogotá.

Participant 5 had an IUD fitted as part of post-abortion care from an international humanitarian organisation. This organisation provided several different options alongside information about each of those options. Regrettably, the participant was unable to recollect the name of the organisation and had not since had contact with them, prohibiting the possibility of scheduled removal check-ups to monitor the condition of the IUD. Hence, there was no post-insertion follow-up or the sustained availability of healthcare services in the event of complications or a possibility of discontinuing use, as advocated for in established guidelines (WHO, 2018b)[41]. This could part way into explaining the reasons for the inequalities between the proportions of Venezuelan adolescent migrant girls having IUDs inserted relative to their supervision as discussed in Section 5.1. Further, this has consequences for *voice*, in terms of intersectionality which I discuss later in this chapter (section 6.2.2), but also in section 7.2.3 of Chapter 7, where I discuss the opportunity to (not) use a variety of methods. For the inability to remove a method once it has been inserted, has been identified as a means of reproductive *coercion.*

6.1.3 Coordinated Responses Between State and Non-state Actors

State and non-state actors' responses were not always clearly demarcated due to the multisectoral cooperation of the migration response. The rationale for this was explained articulately by Participant 8.

> 'We work with the different departments and of course, we look then to our partners within the Cluster to know who can go in fill in the gap of the maybe lacking presence, the state presence that we may not have in a particular region.' Participant 8, multilateral programme designer.

[40] At the time of writing abortions are illegal in Venezuela but not in Colombia.
[41] Participants 16, 18 and 20 professionals from (I)NGOs and not-for-profits.

The most notable instance of this cooperation was the GIFMM Health Cluster, comprised of state and non-state actors who collaborated to effectively address these challenges, led by the WHO and IOM. As previously mentioned, this implemented the Cluster Approach which is designed to distribute responsibility for providing services, such as health and shelter, among various cluster-lead agencies (UNHCR, 2024). This ensures that no single agency bears accountability for the entire response. Through this approach working groups were established, focusing on specific issues, and coordinating their efforts across multiple sectors and levels of governance. The humanitarian needs were determined by the Cluster, employing tools like the Persons in Need (PiN) analysis, to determine the basic needs of Venezuelan migrants using this information to request funds from the Central Emergency Response Fund (R4V, 2021a). The latter of which is funded by UN member states.

Regarding SRH, tailor-made packages were designed to address 'priority issues' such as HIV/AIDS, maternal care, violence, and protection for vulnerable groups within the migrant population such as 'pregnant women and children' as articulated in the quote by Participant 7,

> 'So, the packages have been defined by the Ministry of Health […] sometimes contraception and the maternal health package, we also have another package for care for children and adolescents […] all of these are financed by international cooperation within the public hospitals or through their own hospitals and clinics... they cover the cost of this type of attention a type of guarantee of comprehensive care while the population obtains insurance.' Participant 7, a public health professional.

Here, women's SRH was largely considered in terms of maternal care and SGBV, whilst children were focused on vaccines, nutrition, and education. As such, issues were siloed with key informants speaking about topics independently of one another. Hence, adolescent migrant girls' SRH was not discussed and thus was considered less of a priority. One reason for this, given by Participant 9 was that adolescent migrant girls' contraceptive care was not considered because adolescent migrants were a smaller portion of the migrant population.

> 'But we have not put so much emphasis on adolescents because we know that they are a priority population, vulnerable, but they are not the majority of the population. The population that is in the country is older than 18 to 29 years old, and 30 to 39 years old, this is the majority population of migrants in these groups, adolescents are not so much.' Participant 9, a public health professional.

This reflected the pattern which has come to characterise this thesis, the flattening of Venezuelans adolescent migrant girls to Venezuelan migrants in what can only be describe as *generalisation*.

To implement centrally defined issues, local healthcare providers or civil society actors who focus on SRHR were contracted to carry out the necessary tasks. This approach ensured that each issue was addressed by an actor with a pre-existing relationship with the Venezuelan migrant community, thereby increasing the likelihood of success in the implementation process. The local departmental health authorities were responsible for overseeing the implementation of these packages, according to the needs of that geographic territory. The central government had 'requested' that local authorities differentiate their territory-specific development plans (called, Collective Intervention Plans) 'to include Venezuelan migrants'.

> 'Collective intervention plans, which are funded by the Ministry […] may include things like preventing adolescent pregnancy or fighting discrimination, that kind of thing. And so, we have asked that when they implement these collective interventions that they include the Venezuelan migrants...' Participant 19, a public health professional.

Commenting on the feasibility of this in practice, Participant 19 continued, 'I'm not going to say that this is systematically carried out it depends on the local government, but it's a recommendation that we make.'[42]. Thus, centrally devised recommendations were not consistently implemented at the departmental levels. In some areas, gaps were easier to address than others, as Participant 27 a departmental-level public health professional illustrates.

> '[International cooperation] provide services, but not all of them. Unfortunately, not all of them provide the necessary number of check-ups or all the tests. So, we do have support from them for the care of irregular migrants, but it is not complete. And it's also identified that there's a lot of oversupply [sic] because all three [out of 14] offer pretty much the same services.' Participant 27, a public health professional.

This shows how maternal care was privileged over other types of care. This is consistent of the hierarchies of care that were identified in both state and non-state responses in which emergency care or life-saving care was prioritised. In turn, this leads to partial access or *manipulation,* under *The Scale of Voice.* Departmental-level responses were further fragmented in that they offered select services for some groups. For example, as Participant 26 demonstrates,

> 'There is a new territorial model for public health, and it goes directly to these tolerance zones […] where there's paid sexual services, which are offered then to trans men and women migrants who are involved in sex work. There are fairs where they offer rapid

[42] Participant 19 from a public health professional.

testing for HIV, syphilis, other services […]' Participant 26, a public professional working in social protection.

Variations in the type of care offered, for who, and for how long, were accompanied by variations in the locations where care was available. Each territory had a humanitarian response tailored to its specific context, depending on the focus of the local departmental health authorities and the assistance they received from international donors. This was beneficial as it ensured the response was contextualised in terms of the region's infrastructure and population needs. However, it also generated inequalities between departments[43]. Participants emphasised that humanitarian efforts have predominantly focused on border cities, which have experienced an influx of migrants with chronic health needs, and which have limited infrastructure.

'I feel that the discussion about Venezuelan migrants, like starts in Cúcuta, and stays there.' Participant 16, a lawyer from an INGO.

Participant 16 highlighted how important it was to provide this care. However, they also demonstrated the need to extend attention to cities and towns beyond the border. This is further exemplified by Participant 17, who articulated how part of their responses was limited by the resources they had. Therefore, instead of delivering the intervention as was needed, they were forced to prioritise those hospitals in areas with the highest numbers of Venezuelan migrants.

'So, one of our strategic objectives was about raising awareness amongst service providers and teaching them about the situation of migrants …We have done this in 50 hospitals, but there are 95 hospitals in the country. So, it doesn't surprise me that you will still hear Venezuelan migrants speaking among themselves and talking about that, that issue. We've only gotten to half of the hospitals...' Participant 17 a professional from a multilateral agency for migration and health.

Whilst the prioritisation of services for the migrant population is essential, the differentiation of services for some groups and not others highlights that there are substantial gaps in the provision of contraceptive care to Venezuelan adolescent migrant girls. Continually, the findings from this chapter so far have demonstrated how contraceptive care was not considered a part of this response, and when it was Venezuelan adolescent migrant girls were rarely the intended recipients of this care. This means that adolescent migrant girls were often without access to contraceptive care, in line with *coercion.* As Participant 18 stated,

[43] Participant 10, a lawyer from an NGO.

> 'The needs and rights to contraception for adolescent migrants from Venezuela have not been the same in all territories […] In terms of all these places, however, generally speaking, the answer is not sufficient anywhere, but the answers are different.' Participant 18, a medical professional.

As the reader will see from the evidence provided in this chapter so far, respondents were quick to generalise their answers to address, 'services that are given to adolescent migrants not just adolescents but the Venezuelan population in general'[44]. What then was preventing them from differentiating services to include Venezuelan adolescent migrant girls in their responses?

6.1.4 Lack of Differentiated Responses to Adolescent Migrant Girls' Contraceptive Care

It became apparent that actors were dependent on the donors being able to fund a vast array of programmes. Key informants argued that donors such as international multilateral organisations, foreign national governments or philanthropic individuals who financed many of the humanitarian programmes often had predetermined ideas of what activities should be performed, restricting their ability to implement contraceptive care response. Several participants referred to the Global Gag Rule, the policy by which the United States of America refused to finance any organisations that spoke about or offered abortion, as part of their service offering. Key informants stated that several actors had to choose between accessing funding from the United States and being able to offer comprehensive services[45]. Participant 20 provides an example of how donor ideology influenced their ability to provide comprehensive contraceptive care.

> '…[W]e've even had some donors that want to give contraceptives to all the girls and didn't really care about the education behind it. They just like to put some contraceptives for all so that they don't get pregnant […] When they, realise that we talk about abortion and that we are a feminist organisation- they withdraw.' Participant 20, a professional from a not-for-profit organisation providing education.

In this case, the participant discusses how the donors did not fund education or abortion because they do not align with the donors' ethos. They noted it was more 'attractive' to be able to say, 'We provided contraceptive methods for 1,000 women and girls' rather than investing in long-term relationships providing education and information that matches the context on the ground. As a

[44] Participant 19 a public health professional.
[45] Participant 17 a professional from a multilateral organisation, Participant 20 a professional from an NGO, and Participant 29 a state integration professional.

result, the organisation delivered a water, sanitation, and hygiene (WASH) project where they addressed menstrual health, but not contraceptive care.

Other less-prominent issues emerged such as the prioritisation of COVID-19 and the Russian-Ukrainian war as reasons why they had trouble securing funding for programmes. Some of the actors involved in designing policies were able to negotiate a broader service offering at this stage. However, the majority felt they had to make similar compromises on elements of their response design. As one health programme designer put it, their ability to widen the scope of the project 'depends on the donor's logic of monitoring and evaluation'.[46] Inevitably, trade-offs were made between the different aspects of SRH, with those central to the agenda gaining more attention than others. For *voice*, this means that adolescent migrant girls' priorities and preferences had little to no influence over responses. Instead, decision-making power was negotiated between actors and donors from international organisations, foreign governments or private individuals.

In addition to restrictions on funding for contraceptive care there was a notable absence of AFHS. Overall, key informants saw the AFHS policy, *servicios amigables*, as a strong policy but hard to implement into the health system even for members of the host population.

> 'In Colombia, we have this, and I've already found it, but we have this policy on *servicios amigables*… but that is still very much in the paper. It works in some cities. But obviously, not in the rural areas.' Participant 20, a professional not-for-profit organisation providing education.

One difficulty during implementation was ensuring confidentiality and privacy in smaller towns and cities - with concerns about gossip and shame surrounding the access to services, especially in more religiously conservative areas[47]. One public health professional mentioned that the low uptake of services justified ending the programme. When key informants spoke about *servicios amigables*, they limited their discussion to the challenges in operating the services to adolescents in the host population. This demonstrates, as was highlighted by some key informants, how little had been done to rethink these policies for the migrant population[48]. Notably, key informants either spoke about Venezuelan migrants or the adolescent host population. Again, this shows how thinking was limited to a single-axis approach with key informants discussing adolescents or migrants.

Adolescent-friendly spaces were offered in some of the humanitarian responses by non-state actors such as not-for-profits, INGOs and multilateral organisations. However, key informants noted this

[46] Participant 2 from a private health provider.
[47] Four interviews medical professionals and international and local NGOs.
[48] Interview with an international NGO professional.

was difficult to implement consistently given that a lot of the work done with the Venezuelan migrant population on contraceptive care was done in the community[49]. For example, the AFHS model articulates the need for adolescent-friendly spaces and private consultations. Yet many humanitarian organisations were operating through mobile units or temporary service points where this was not possible. Adherence to this resulted in increased waiting times and reduced the number of people able to be seen.

> '[The migrant response is] kind of looked at as a broad package and doesn't have the differential needs implemented in it that have to do with the different populations, whether adolescence or early childhood…' Participant 14, a multilateral organisation professional on health.

As Participant 14 shows, adolescent-friendly services were a scheme that ran parallel to the Venezuelan migrant response, but that very rarely adapted for the migrant context[50]. In turn, this highlighted how both state and state responses continued to view adolescent migrant girls, through an 'adult-centric' gaze, with little attention to their intersectional reproductive realities. All in all, where *the servicios amigables* framework is differentiated for adolescents but not for migrants, the migrant responses address the needs of Venezuelans but not adolescents.

Despite the lack of adolescent-friendly, migrant-inclusive health services some barriers were felt more acutely by Venezuelan adolescent migrant girls. Participants identified a lack of information as a prominent barrier to accessing contraceptive care. As Participant 11 describes unfamiliarity with the processes of requesting care slowed down or prevented access to contraceptive services.

> '[M]igrants may arrive and want to have access to contraceptives, but they don't know where or how to ask for them.' Participant 11, a lawyer from an NGO.

The reality from those working with migrants in communities, such as Participant 11, is that these services are in need and that currently, the way the state and non-state response are implemented, that need is not being met. In the case of Venezuelan adolescent migrant girls, it was felt that their inexperience in navigating health services (in Venezuela and Colombia), served as an additional barrier.

> '[I]n Venezuela, there aren't a lot of foundations or organisations and in Colombia there are, and in my opinion, it's really difficult especially for adolescents when they change a

[49] Participant 3, a professional from a not-for-profit health provider and Participant 6 a professional from an INGO.
[50] Participant 18, Participant 25 medical professionals and Participant 16 a lawyer from an INGO.

> setting or change their home because especially because [we] don't know a lot about that topic.' Participant 5, a Venezuelan migrant living in Bogotá.

As public healthcare was not available to irregular migrants, they relied on word of mouth or social media to stay informed and know where and when care would be available, leaving many open to misinformation[51]. One adolescent migrant girl interviewed maintained she relied on civil society actors for guidance on available services because there were 'so many programmes and you hear so much information and sometimes it's overwhelming'[52]. It was common for Venezuelan adolescent migrant girls to approach asking 'for any humanitarian help they could offer'[53]. In short, the presence of multiple responding entities frequently was confusing for adolescent migrant girls trying to access contraceptive services.

Beyond this, there was a further lack of appropriate information regarding what type of care Venezuelan adolescent migrant girls were able to access. Where information was provided it failed to acknowledge that their perspectives might differ regarding pregnancy-related care and contraceptive-related care. Participant 21, articulates how public hospitals often did not grant Venezuelan adolescent migrant girls access to emergency services when they were not insured,

> '[W]e see among first time mothers, that they experienced many of the changes that if they were a second time mother, they might realise or rather normal, but they become concerned and take it as a high alert. […] [E]mergency services of course, don't share their opinion that it's an emergency.' Participant 21, a professional working at a charitable foundation.

Additionally, the cultural disparities in healthcare-seeking behaviours between Venezuelan migrants and Colombians posed a significant challenge for both participants and healthcare providers in Colombia.

> '[Venezuelan migrants] use different words for condoms that we do in Colombia, and I think that, on the other hand, there's a cultural influence they see family planning […] as a family issue. It's not something that you talk about in public. So, if I send them to ask a woman, "What contraceptives are you using?" She kind of looks at me blankly because it is a taboo question to her, and she doesn't want to answer it.' Participant 22, a health professional for a charitable foundation.

[51] Participant 18, a public medical professional and Participant 29 a state integration professional.
[52] Participant 5, a Venezuelan adolescent migrant living in Bogotá.
[53] Participants 4 a Venezuelan adolescent migrant living in Bogotá, Participant 21 and 22 professionals working at a charitable foundation.

As shown in the quote by Participant 22, concepts of contraceptive care as private, type of language, and stigma surrounding sexual activity, emerged as examples of cultural barriers to both providing and accessing care. For example, feelings of shame and hesitancy in discussing matters related to contraceptive care prevented migrants from seeking information[54]. To exacerbate the issue, the lack of private spaces in mobile units meant that Venezuelan adolescent migrant girls had little opportunity to discuss these 'taboo' topics in private. This was also touched upon by Participant 20,

> 'I think, for some Venezuelan communities as well, family planning doesn't mean what family planning means, in some Western minds. So, family planning, to some people means planning to have a child […] for us, it means sometimes making the decision informed decision whether or not to have children. But that's not what the history of it means, you know.' Participant 20, a professional from an NGO providing education.

Concealing contraceptive care in the language of 'family planning' overlooks the fact that many Venezuelan adolescent migrant girls did not want to plan to have a child or were not in a union. Therefore, it excluded those who wanted contraceptive education or contraception for non-contraceptive benefits. Considering this, it is crucial to emphasise that the responses lacked appropriate adaptations that would have taken into account the specific challenges faced by Venezuelan adolescent migrant girls' age, gender, and status as migrants. Overlooking the unique ways in which gender, age, and migration shape contraceptive care means that actors' responses are limited to the level of *generalisation* on *The Scale of Voice*. This oversight hindered the creation of an environment where adolescent migrant girls could access care tailored to their reproductive realities.

Overall, these findings highlight substantial gaps in the provision of contraceptive care to Venezuelan adolescent migrant girls. It demonstrates how primary contraceptive care from state services is dependent on the affiliation to the health insurance system, but how the implementation policies facilitating this affiliation act as a barrier. As such the policy of EPTV is seen as *generalisation* of Venezuelan adolescent migrant girls' contraceptive care needs to the wider population of Venezuelan migrants and health. Meanwhile, access to emergency services does not cover contraceptive care but instead highlights how unevenly, existing legislation is implemented for irregular migrants, as such leading us to classify it as *manipulation* under *The Scale of Voice*. Likewise, non-state actors' responses were characterised by humanitarian responses which prioritised 'saving lives' through short-term interventions, thus deprioritising contraceptive care and creating partial access akin to *manipulation*. As a result, contraceptive care was not available to Venezuelan

[54] Participant 3 a Venezuelan migrant living in Bogotá.

adolescent migrant girls with any regularity. Coordinated responses between responses continued to focus on emergency care, through packages specifically for certain SRH needs, for certain populations in designated cities, but none of which included access to comprehensive contraceptive care for adolescent migrant girls. In some cases, when care was refused or withheld altogether, these practices were regarded as *coercive*.

On the whole, key informants felt the supply of services was largely determined by donor preferences, where adolescent contraceptive care was not a priority. It comes as no surprise that AFHS were not reconsidered so that they applied to the migrant population. The landscape of overlapping, fragmented, temporary responses was challenging for Venezuelan adolescent migrant girls to negotiate, especially given euphemistic references to 'family planning' over contraceptive care. Consequently, responses rarely considered how adolescent migrant girls' perspectives might vary, and how to shape responses accordingly. These issues highlighted the lack of positive actions which had been taken to include Venezuelan adolescent migrant girls in responses.

6.2 Discussion

Throughout this discussion, I consider the findings above through the framework of *voice* and by extension a RJ lens, highlighting how individuals with intersectional reproductive realities shaped age, gender and migration are discouraged from accessing contraceptive care by structures that promote fragmented short-term emergency care over comprehensive contraceptive care.

Overall, using *The Scale of Voice* I demonstrate how actors lack of differentiation is classified as *passively listening* at best. This is because actors differentiated services for migrants *or* for adolescents but did not recognise how these identities could intersect to create unique barriers. As such, they went no way to addressing the inequalities identified in Chapter 5. I further reveal how actors who only provided short-term one-off care discourage contraceptive autonomy even further, to level *manipulation,* by making access contraceptive care conditional. Those who failed to provide contraceptive care, instead providing other SRH services, can be understood as *coercive,* because they withhold services altogether, creating environments Venezuelan adolescent migrant girls are prevented from realising their contraceptive intentions.

6.2.1 Uneven Implementation of State Policies for Venezuelan Migrants' SRH

The findings from interviews detailed above demonstrate the policies, whilst seen as a positive step towards providing contraceptive care are implemented unevenly along lines of gender, age, and

migration. This means that they do not adequately differentiate for the intersectional reproductive realities of adolescent migrant girls.

State responses like the EPTV are identified as *generalising* the contraceptive care needs of Venezuelan adolescent migrant girls to the wider Venezuelan migrant population. Therefore, they focused solely on 'single axis' approaches to Venezuelan migrants without due consideration of gender, age, and how these interact with one's status as a migrant.

In the absence of specific state responses to contraceptive care, key informants pointed towards the EPTV as a scheme which would provide access to primary healthcare for Venezuelans. Whilst routes to regularisation and affiliation to the health system for irregular migrants demonstrate a step, towards guaranteeing contraceptive access there were several problems with implementation. Issues such as difficulties in documents and the bureaucratic nature of the process meant that disproportionately affected poorer Venezuelan migrants who often required legal assistance to complete the process (Angeleri, 2021; Pelacani, 2022). What do these challenges for regularisation mean for contraceptive care?

Policies that fail to provide instruments for effective and equitable implementation make it more difficult to realise contraceptive care for adolescent migrant girls. Without positive actions to acknowledge the challenges to accessing immediate contraceptive care then state actors cannot be said to *actively support* the consideration and inclusion of adolescent migrant girls.

In this case, Venezuelan adolescent migrant girls experience interrelated barriers including a lack of documents, bureaucratic hurdles, and a lack of adolescent-friendly SRH services. This is especially concerning when such policies are regarded as 'progressive' (Frydenlund, Padilla and Palacio, 2021; Grandi, 2021). Whilst they acknowledge the need for better access to care for migrants – the EPTV overlooks the fact that healthcare needs are shaped by gender and age, and fails to afford the necessary steps to differentiate based on these intersectional reproductive realities. As such, they overlook the obligations in ICPD frameworks, the UNCRC, and the New York Declaration to acknowledge, and to develop responses that tackle 'intersecting forms of discrimination'. Without taking these into consideration, responses cannot be said to *consider* the priorities and preferences of Venezuelan adolescent migrant girls.

As it currently stands, the state response overlooks gendered aspects of migration – such as the fact that SRH care is a driver for migration (Cintra, Owen and Riggirozzi, 2023). Further, that on arrival migrants report expecting to achieve insurance to the health system quickly and effectively and to find contraceptive methods easily, without barriers and according to their SRH needs demonstrates how this policy has overlooked the realities of migrants (Rivillas-Garcia *et al.*, 2021). It fails to

acknowledge that this immediate need for SRH is also shaped by age, for adolescents who often lack CSE and who have less experience in navigating the health or legal system (Ramírez-Martínez *et al.*, 2023). Instead access to SRHR is shaped by migration status, at the expense of all other axes of identity (Abji and Larios, 2020). Once affiliated, entitlement to 'the same care as Colombians' assumes that integrating the Venezuelan population into the health system will adequately address these disadvantages. Therefore, framing this policy as a solution to the provision of long-term contraceptive care needs thus masks the immediate and ongoing needs for SRH, and in particular contraception. This failure to address the intersectional reproductive realities of migrants' contraceptive care may result in a lack of access, and ultimately, perpetuate inequalities in SRH.

A failure to acknowledge and overcome these inequalities means responses are considered to constrain the contraceptive autonomy of Venezuelan adolescent migrant girls. In this way, the policy served as a barrier, rather than a way of facilitating it. From a RJ perspective, scholars have used the experiences of individuals and contraceptive providers to develop policies to respond to the realities of the diverse populations they are intended to serve. For example, finding policy in New Mexico inadequate for the realities in which people lived, diversified the service pathways to include the dispensing of contraception as over-the-counter medicine meaning that transgender individuals could avoid unwanted questioning about their SRH (Cadena, Chaudhri and Scott, 2022). This acknowledgement of difference is in essence of what is absent from the current EPTV framework, which in the attempt to offer care 'the same as Colombians'. As *The Scale of Voice* requires a level of differentiation to acknowledge and centre those most marginalised the absence of this can only be seen to constrain *voice,* and by extension, contraceptive autonomy.

In some instances, contraceptive care constitutes emergency care, and in these cases, the law dictates that services must be provided regardless of status (see sub-section 4.3.2.). This was deemed in line with the level of *manipulation,* under *The Scale of Voice.* The reason for this was that access was conditional depending on Venezuelan adolescent migrant girls' status as (not) pregnant or (not) a victim of violence. Therefore, the response cannot be said to be taking into account the reproductive realities of Venezuelan adolescent migrant girls who do not fulfil these conditions. As many noted, access to emergency care was highly varied. Often care was specific to the emergency and did not, for example, include postpartum contraceptive care. Whilst these findings on maternal care do not directly relate to contraceptive care, they illustrate the environment in which SRHR are enacted for Venezuelan adolescent migrant girls. Thus, as SRH issues they are connected under a SRHR and a RJ framework. More importantly, from the perspectives of Venezuelan adolescent migrant girls, they were connected. The uneven application of emergency care goes some way to explaining why there were lower levels of supervision for 'normal pregnancy' but equal proportions

in the supervision of 'high-risk' pregnancies, as discovered in Chapter 5. Further, this demonstrates that, despite being a legally binding policy, access to maternal care is not implemented evenly for migrant women and girls. Given the unpredictable implementation of this policy, there is little reason to think that the recommendations such as Circular 35 of 2022, which recommends providing contraceptive care to irregular migrant women and girls, will be implemented differently.

This is relevant because it demonstrates that policy recommendations are not considered powerful enough to create healthy environments. Rather, their effectiveness in practice is often shaped by the implementation of those policies. In this case, these have been shown to be consistently uneven. As a result, there are many adolescent migrant girls whose contraceptive care priorities and preferences are not met by current state responses.

6.2.2 Humanitarian 'urgent' responses for irregular migrants legitimise a lack of intersectional long-term responses

The reality is that there are high numbers of adolescent migrant girls seeking contraceptive care, have irregular status, and are not in 'urgent' situations. At the time of fieldwork, half of the 2.5 million Venezuelan migrants in Colombia were not regularised (R4V, 2021b). These girls were mostly directed towards non-state actors providing medical aid, such as multilateral organisations, charitable foundations or not-for-profit organisations. In some cases, this humanitarian was coordinated with and by, state actors through networks such as GIFMM.

Humanitarian responses by non-state actors focused on 'rights that save lives' which created a hierarchy of services, instead of treating them as a spectrum of issues. This context of fragmented responses created gaps – namely Venezuelan adolescent migrant girls' contraceptive care. These responses, viewed in terms of *The Scale of Voice*, reveal how power relations operate to maintain the status quo by discouraging longer-term comprehensive contraceptive care that would address intersectional reproductive realities. Thus, creating access to partial services in line with the level of *manipulation*. These short-term responses are beneficial to actors, rather than Venezuelan adolescent migrant girls because they legitimise the absence of intersectional adolescent-friendly, migrant-inclusive responses.

State and non-state actors worked together on the response to Venezuelan migration. Each actor had their own institutional aims and objectives through which they understood their intervention and their responsibilities. Coordination efforts like GIFMM can be understood as a mechanism to promote international responsibility sharing, as understood in the ICPD[55]. However, in practice, this

[55] Principle 15 of the 1994 ICPD PoA.

frequently resulted in the fragmentation of SRHR. By this, I mean to say that issues and groups have been divided into separate areas with distinct actors treating different groups for different issues – rather than as a spectrum of interconnected and interdependent issues.

Key informants maintained how some 'gaps' in services were easier to fill than others. Maternal health packages were seen to be in oversupply, whilst other areas were left unaddressed by donors altogether. Especially difficult was the ability to acquire funding for 'taboo' topics like adolescent contraception and abortion – given the Global Gag Rule, and the religious or conservative attitudes of major donors. Donors' preferences to fund some of these topics over others has created a hierarchy where some types of interventions are preferred over others. Contraception was found to be particularly hard to fund, and these gaps were left unaddressed. In addition to this, by delivering care needs in 'packages' the response divided the migrant population up in terms of pregnant health, children and adolescents and victims of violence. Here, needs were only established within these predefined groups, failing to account for intersectional differences within groups.

The categorisation of 'pregnant women and children' as explained by Enloe's (2004) concept of 'womenandchildren' in healthcare services reflects a reductionist view of women in the Global South that serves to reduce unique experiences of women and children into one category, in which women are recognised as vulnerable due to their identity as mothers. I further contend that the categorisation of 'pregnant women' and 'children 'as two separate groups overlooks adolescent migrant girls – who straddle the space between these two identities. Without understanding and responding to these, these responses will continue to homogenise the reproductive realities of Venezuelan adolescent migrant girls, with Venezuelan migrant women.

The practice of prioritising certain types of care has been observed in other international humanitarian responses. In Benton's (2015) example of Sierra Leone, 'HIV exceptionalism' where HIV+ patients were treated preferentially, certain issues received more attention. In Colombia, my findings showed a focus on emergency issues SRH was only offered to pregnant women, HIV+ patients, and victims of violence. Contraceptive care was not in itself a standalone service. Just as Enloe and Benton seek to explain why 'womenandchildren' and HIV are high on donors' agendas, other feminist scholars have explained why some decision-makers would rather avoid SRH topics. Htun (2003) identifies how, in Latin America, certain issues that go against existing ideological and religious beliefs are perceived as controversial or 'taboo' and thus as less likely to gain support. Non-divisive elements often focus on issues that are seen as essential, such as maternal and child health, education or violence prevention, rather than policies that aim to understand the reproductive realities and create long-term transformative change.

Responses framed as 'saving lives' or emergency care to 'fill gaps' were often limited to priority areas so that aspects such as lack of adolescent-friendly services, and comprehensive contraceptive care did not form part of needs assessments or subsequent programmes According to the documents outlined in the policy summary, by now the MSPS and other Cluster members should have provided contraceptive care for irregular migrant women and girls. Under MISP, 6 months after the onset of a crisis, access to comprehensive care should be implemented.

However, many participants felt the responses were stuck in short-term 'crisis' interventions. Responses stuck in these cycles of measuring predetermined indicators, actors on the 'most urgent', before repeating the process with the next issue. Such fragmented and indicator-driven responses have meant there has been little focus on generating data on the needs outside of those predetermined indicators. Because of this programme designers had to adapt their programmes to match donors' preferences. This reinforces the idea that certain programmes, that focus on short-term, technological fixes to 'priority issues' are more appealing to donors.

Furthermore, the absence of sustained, long-term intervention further underscores the limitations in addressing the intersectional needs of adolescent migrant girls. This highlights the disjointed accountability and lack of responsibility which aligns more closely with the humanitarian practice of 'traditional humanitarian risk-reduced, disease-based frameworks rather than comprehensive responses as opposed to care that was differentiated for the intersections of age, gender, and migration. The continued focus on emergency short-term responses reflects the critique advanced by the 'tyranny of the urgent', which puts aside structural issues in favour of addressing immediate biomedical needs (Watson and Mason, 2015; Davies and Bennett, 2016; Smith, 2019). The 'tyranny of the urgent' demonstrates how the rights of marginalised groups and intersectional experiences are neglected by responses that overlook social dimensions of gender and individual experiences (Smith, 2019). Applying a RJ approach to the 'tyranny of the urgent' demonstrates silo-ing certain issues can discourage access to contraceptive care for marginalised groups, by dividing SRHR and creating a hierarchy of issues where some issues are more valuable (emergency care) and can justify the absence of others (contraceptive care). In this sense, the evocation of 'crisis' and 'emergency' maintains the status quo keeping attention away from intersectionality structural issues.

Using *The Scale of Voice*, to demonstrate how non-state responses do not account for the intersectionality of age, gender and migration shows how humanitarian approaches constrain autonomy to the level of *manipulation.* This is because they are characterised by short-term on-off events for migrants but not differentiated to include adolescent-friendly responses. Instead viewing adolescent migrant girls as adolescents or migrants. Short-term care further limited the potential decision-making power (as I will discuss in more detail in Chapter 7) because the choice is only

available to Venezuelan adolescent migrant girls in that moment, it does not acknowledge that there is a longer-term need for contraceptives. In terms of intersectionality, this means that responses to age, gender and migration are seen as less relevant to the current crisis, decentring and excluding adolescent migrant girls.

6.2.3 Fragmented Accountability and Services

Between the attempts at regularisation and the emergency, short-term or one-off humanitarian care adolescent migrant girls' contraceptive care was missing.

There was a clear need to differentiate care, as adolescent migrant girls had specific difficulties in accessing contraceptive care and SRH in general. One example was the lack of information on navigating services, as there were so many different services that all provided different care. This affected adolescents especially due to their lack of experience in navigating SRH care. Likewise, key informants related difficulties in differences between language and culture in what was expected by family planning programmes. Western development terms like 'family planning' did not translate to girls who were not planning to have a family, and thus refused such services. This is not unique, to this situation, as other literature has warned of the confusion of using euphemistic terminology with adolescent girls (Rivillas *et al.*, 2018). In this sense, the environment continues to discourage access to adolescent migrant girls because it fails to acknowledge and address the way that responses might be perceived from the perspectives of Venezuelan adolescent migrant girls. Further, the lack of appropriate information for Venezuelan adolescent migrant girls, alongside the difficulties in regularisation, and the humanitarian focus on urgency, are all factors which could account for the inequalities in contraceptive care services identified in the previous chapter (Chapter 5). By not prioritising these issues in the response, responses decentre Venezuelan adolescent migrant girls' reproductive realities.

There was a notable absence of AFHS included in the migrant response, which might have helped address these issues. Here, there was a missed opportunity to develop existing infrastructure. Existing health centres, for example, could be trained to make AFHS suitable for the needs of adolescent migrant girls shaped by age, gender, and migration. Instead, the policies remained separate. This, of course, stands in direct contention with RJ's claims for comprehensive contraceptive care, which require seeing different forms as it requires seeing Venezuelan adolescent migrant girls as adolescents, as well as migrants. Without AFHS, that are specific for migrants, Venezuelan adolescent migrant girls do not have access to information that is appropriate, to make an informed decision about their contraceptive care.

Key informants felt that intersectional responses were not within their scope of responsibility. In the findings, this was often communicated by diverting attention to other actors and their (in)action as a way of justifying the lack of action on the part of actors. Repeatedly actors excused themselves from taking positive actions because they were collaborating with another actor who had executed a programme or intervention related to the question. Or, that they had not acted because they were busy on something else, and this was regardless, not their responsibility.

In state responses, key informants in policy decision-making roles advised that Venezuelan migrants be included in their plans. However, key informants at a departmental level there was a lack of resources to implement this, leading to gaps in the services provided. The 'request' that local governmental actors include Venezuelan adolescent migrant girls in their Collective Intervention Plans fails to place any real obligation onto local government actors. In short, the de-centralisation of the implementation of policies for the inclusion of adolescent migrant girls into the health system fragments accountability because it passes down responsibility without providing any commitments to resources or knowledge. In return, actors fail to generate any monitoring systems to ensure that implementation is occurring successfully. This reinforces global trends which demonstrate that a lack of sufficient policies and guidance continues to be a barrier to the provision of comprehensive SRHR care (Tazinya *et al.*, 2023). In this case, the appeals to priority care, at the expense of adolescent care, demonstrate how the intersectionality of age, gender and migration is side-lined. For *voice,* this means that whilst differentiation might be acknowledged in policy, this acknowledgement is not enactment. Overall, this demonstrates a need to allocate time, and resources to how contraceptive care can be effectively implemented, with a mechanism to hold actors to account if they fail to do so.

Equally, when examining non-state responses within the framework of short-term 'humanitarian' efforts, it becomes apparent that these actors are not bound by any obligatory commitment to provide care for a specific duration. Their responses are framed as supplementary assistance to 'fill gaps', stemming from a duty to uphold (rather selectively) 'rights that saved lives'. This demonstrates a continuation of needs-based and suggests that the traditional principles persist, whilst areas of 'new humanitarianism' such as rights-based, longer-term solutions have been applied (Gilbert, 1998; Chimni, 2018; Crisp, 2018). Within this framework, those with the resources hold the decision-making power determine who 'deserves' what type of care. As such, it goes against the principles of RJ, which encourages us to reconsider how migrants from the Global South have been primarily framed as 'unworthy' of rights (Harrell-Bond, 2002; Morgan and Roberts, 2012). Framing some populations as (un)worthy of certain types of care perpetuates an atmosphere of fragmented accountability because it allows actors to be selective in their response. By distancing themselves

from being accountable to non-emergency needs then they can legitimise their non-inclusion of contraceptive care and of Venezuelan adolescent migrant girls.

6.3 Conclusion

This chapter sought to answer how state and non-state actors differentiate their responses to account for the intersectional reproductive realities of adolescent migrant girls. Bearing in mind the inequalities found in the use of services in the previous chapter, this sought to explore how responders differentiated their delivery of contraceptive education, information, and resources to close these gaps. For, it was reasoned that differentiation is a necessary and essential part of *The Scale of Voice,* which is being used here to identify modalities of power-sharing, with the goal of contraceptive autonomy.

To answer the sub-research question, I collected data through semi-structured interviews with adolescent migrant girls and key informants from state and non-state actors across various sectors and organisational levels. Using *The Scale of Voice*, I analysed data to reveal that responses to contraceptive care for Venezuelan adolescent migrant girls lack differentiation.

I argued that whilst on paper, affiliation to the health system seems like a suitable long-term solution, through the *Scale,* we can see how alone legal amendments such as regularisation are insufficient to create conditions where contraceptive care is encouraged for adolescent migrant girls. For irregular migrants, accessing public services for contraceptive care, whether differentiated or not, is almost impossible. The manner in which existing entitlements are unevenly implemented for irregular migrants holds out little hope this will change.

The uneven implementation of state response has created a reliance on non-state humanitarian actors to 'fill gaps'. Where humanitarian or aid organisations are involved, their interventions often prioritise 'emergency' or 'short-term' care, side-lining contraceptive care in the response to Venezuelan migrants. Conceptualising contraceptive care in this way means that instead of viewing contraceptive care as an essential and interdependent part of SRHR, particular aspects of SRHR are isolated and prioritised or deprioritised according to actors' agendas.

Here, the sole focus on emergency care has side-lined attempts to design longer-term, holistic responses that would provide primary care, education, and information. The further fragmentation of accountability between state and non-state actors and between development and humanitarian responses means that there is no entity to hold responsible because each is able to deflect blame. Because longer-term interventions are those which generate effective responses suited to the context, the 'tyranny of the urgent' and fragmented accountably not only deprioritises contraceptive

care but also restricts nuanced approaches that consider the complexity of adolescence, migration, and gender.

Whilst actors avoid taking Venezuelan adolescent migrant girls' views into account in the implementation of policies and delivery of humanitarian aid, responses can score no higher than *passively listening* to Venezuelan adolescent migrant girls. This is because, they overlook how age, gender, and migration intersect. Instead, viewing Venezuelan migrants as age-less and gender-less. In cases where access is temporary, or partial this constrains contraceptive autonomy to the point of *manipulation*, as Venezuelan adolescent migrant girls are not provided with the means to realise their contraceptive decisions (either through access to services or through a limited service offering). The denial of services to Venezuelan adolescent migrant girls altogether is *coercive*, as it prevents their ability to realise any contraceptive choices whatsoever. Both prevent Venezuelan adolescent migrant girls from using a method where they desire to or being able to stop using a method that they are unable to (which I will return to in more detail later in sub-section 7.2.3).

In short, there is a gap in actors' consideration of adolescent migrant girls' intersectional contraceptive care needs. Such lack of intersectionality does not necessarily mean actors are not engaging with adolescent migrant girls. So, the next chapter will apply *The Scale of Voice*, to identify modalities of engagement, operating on the idea that if adolescent migrant girls' preferences and priorities are considered, actors will be able to create responses that match their reproductive realities.

Chapter 7 Modalities of *Voice* in State and Non-State Actors' Responses: Patterns of Participation, Feedback and Choice

The previous chapter presented how actors considered and included the intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration) in their responses to contraceptive care. It found that adolescent migrant girls' contraceptive care is often deprioritised in favour of responses that prioritise emergency care. As such both state and non-state actors overlooked how age, gender, and migration shaped access to contraceptive care. Recognising this, it is equally important to explore if responses have considered adolescent migrant girls' priorities and preferences through mechanisms of participation and inclusion that lead to shared decision-making power.

This chapter examines the ways in which actors have considered and included the remaining aspects of *voice*: participation in decision-making processes, and the opportunity to (not) use a variety of contraceptive methods in the formulation and implementation of contraceptive care responses for Venezuelan adolescent migrant girls. Subsequently, answering the research question: To what degree have adolescent migrant girls' *voices* been included? What are the specific modalities of engagement and inclusion utilised by state and humanitarian actors in their responses to adolescent migrant girls' contraceptive care?

The empirical findings show that while there is some recognition of the need for *voice*, it is often not integrated into the agenda-setting and planning phases instead it is left to the discretion of local actors such as not-for-profit organisations, charitable foundations and (I)NGOs who provide services. Mechanisms of *voice* identified included activity-based educational workshops, community-based interventions, art-based activities, focus groups, and satisfaction questionnaires to understand needs and respond to those. There were two exceptions by non-state actors, which are discussed in the findings. Notably, the inclusion of *voice* is primarily seen through short-term, local programmes which overlook opportunities to develop the 'evolving capacities' of adolescent migrant girls and structural factors that limit access to contraceptive care. In terms of providing opportunities to (not) use a variety of contraceptive methods, the limited access to services alongside a discernible preference for LARCs raises concerns about the ability to discontinue or change methods.

The subsequent discussion utilises *The Scale of Voice*, to reveal those current mechanisms of participation and feedback yield responses spanning from levels of *coercion* through to *consideration*. These examples demonstrate a lack of *voice* above levels of *consideration* or *generalisation* highlighting the limited decision-making power of adolescent migrant girls, instead, revealing a pattern of constrained agency. This pattern shows how the structure of the responses curtails adolescent girls' ability to make fully informed and autonomous choices regarding contraceptive methods.

7.1 Findings

7.1.1 Actors' Reasons for Recognising the Importance of Voice

Before *voice* was defined by the researcher, participants were invited to discuss their own definition of *voice* regarding the SRH of adolescent migrant girls in Colombia. When discussing *voice*, all key informants – from both state and non-state entities perceived it as essential to response to adolescent migrant girls' contraceptive care. Key informants' definitions of *voice* often began with a general statement such as: 'voice is fundamental'[56]. However, there were two distinctions which I consider to be fundamental for how these considerations are understood in *The Scale of Voice.* One is primarily concerned with the intrinsic benefit that *voice*, would have in terms of fulfilling SRHR, empowerment and developing skills needed to articulate priorities and preferences. The second adopted a more pragmatic approach which understood *voice* as a tool for providers to design and implement more efficient responses.

Key informants who appealed to the intrinsic benefits of *voice* justified the importance of being able to make decisions over one's body, which heavily reflected SRHR discourse[57].

> 'I think it's extremely important because- and this is what they need, they need these activities to empower themselves to be able to talk about their rights and understand what they are so that they end up being guaranteed…' Participant 21, a professional from a charitable foundation.

[56] Participant 1, a professional from a not-for-profit health provider, Participant 21 a professional from a charitable foundation, Participant 23 a professional from a multilateral organisation.
[57] Participant 22, a professional from a charitable foundation,

As can be seen in the quotation above, *voice* was perceived as a mechanism used to promote or 'empower' adolescent migrant girls to claim their rights. Thus, it was a crucial means of accumulating power. *Voice* was therefore talked about in terms of enabling Venezuelan adolescent migrant girls to increase their perceptions of themselves and articulate their priorities and preferences.

> 'So, I see it as a matter of recognising themselves as subjects of rights and making themselves visible. So that's how I understand voice, it's being visible.' Participant 26, a public professional working in social protection.

A few key informants went on to discuss the future consequences of having *voice*. For example, to link *voice* to the completion of 'future life projects', as shown in the quote below by Participant 22, in reference to the ability to plan their life choices according to their preferences. This demonstrates how contraceptive care was influential not just to other aspects of SRH but other domains of life such as education, career prospects, as well as positive aspects of well-being.

> '[I]t will help these rates of unintended pregnancies to go down so that they're not just in a situation where they're saying, "well it just happened and so I have to get used to it", and for them to be able to plan ahead and projection themselves into the future. Also, this has to do with them being able to enjoy their right to live their sexual life the way they want.' Participant 22, a psychologist working at a charitable foundation.

Voice was seen to be valuable both intrinsically to individuals, as it would provide a process by which they would be able to claim their rights and thus make decisions that aligned with their preferences.

> 'We're always orienting our work, to be able to promote dialogue. But we also know that a lot of adolescents aren't used to being or talking or speaking for themselves, and they often aren't asked what it is that they need or want. And so that's a whole process for them to be able to get to a point where they can decide …' Participant 2, a professional from a not-for-profit health provider.

The quote above, from Participant 2, demonstrates that the adolescent population, in general, is not well-practised in voicing their opinions or preferences amongst other organisations and institutions. Socioeconomic status was an important factor, in that Participant 2 'really [felt] the difference in the quality of education' influenced the ability of adolescents to express themselves. This, they explain, may require the development of additional capacities to get adolescents and adults to the point

where they have the skills to express their views and be heard. In essence, their justification was linked to the central components of 'evolving capacities'.

Aside from the intrinsic value, *voice* was seen as a useful instrument for actors responding to the needs of adolescent migrant girls. By expressing their needs and preferences adolescents would assist actors in the identification of needs. The benefit of this is that actors' responses suited the local context in which a programme was to be delivered, ensuring that the project would align with the evolving needs and realities of the target population. The overall assertion was that the best way to understand the needs of adolescent migrant girls would be to directly ask them.

> 'We can't identify them without their voice. So, we need their active participation to define what the priorities are, and also how they perceive those priorities as Venezuelans.' Participant 27, a public health professional.

Conversely, those key informants who could not identify mechanisms of participation and feedback in their responses conceptualised *voice* as idealistic. As can be seen in the quote from Participant 27, *voice* was something that the organisation *should* do, but the organisation they worked for did not provide any mechanisms to facilitate this. Subsequently, these actors saw participation and feedback mechanisms as something to consider once the response had taken care of the emergency health needs. For example, Participant 13 noted that there were some strategies in place for listening to the *voices* of adolescents, indicating efforts to understand their perspectives and needs. However, while there are actions to involve adolescents in the decision-making process and identify their needs, there is a gap in translating these into positive change.

> 'I can tell you that there have been specific actions in which we've sought out the voices of adolescents, which helped us identify their needs above all, but to be able to say that then has an effect on the design or the planning of policy at this point and in a comprehensive way. I think we're not there yet.' Participant 13, a professional from a multi-lateral organisation.

In this way, the reaction to this line of questioning was similar to actors' thoughts on intersectionality in contraceptive care mentioned in Chapter 6. The emphasis on 'not there yet', is reminiscent of the emphasis on 'responses that save lives' which I connected to the 'tyranny of the urgent' – the process by which issues are deprioritised and delayed in favour of those characterised as 'urgent'. Here, *voice* as participation and feedback mechanisms is clearly depicted as an additional priority. The continued de-prioritisation of aspects of *voice*, whilst claiming their importance, means

that *voice* can be considered in a more performative, superficial manner. This contrasts with the need to enact *voice* as a practice that results in the redressing of power relations in the programme design and implementation process.

In short, the *voice* through participation and feedback was widely acknowledged as important for two reasons. One, it enables adolescent migrant girls to develop their skills. Two, it allows key informants to design more specific, contextualised responses.

7.1.2 *Voice* as Mechanisms of Participation

The findings show that few actors utilised participation mechanisms. When participation is included, the participation mechanisms most used by state and non-state actors use community networks, activity-based educational workshops, focus groups, and interviews. In turn, actors omitted other types of participation such as peer-led interventions or high-level assemblies. Therefore, the use of mechanisms of participation for adolescent migrant girls' voices was highly varied between actors.

Participation was principally understood as mechanisms by which: a) adolescent Venezuelan migrant girls were able to develop the skills to express their opinions and b) the extent to which this opinion influenced the decision-making process during the policy and programme design and implementation phase. The theme of participation involved identifying mechanisms in relation to the levels of *voice* (e.g., *prioritisation, collaboration, consultation, consideration* and so on) as discussed, the conceptual framework of this thesis, and which I have reproduced for the reader in the discussion of this chapter.

During the interviews conducted with adolescent migrant girls, a recurring theme emerged: they were consistently excluded from receiving essential education, information, and services related to contraceptive care.

> 'Have I felt like I've been heard? I'm not sure because sincerely this is the first time somebody has asked me…' Participant 4, a Venezuelan adolescent migrant girl living in Bogotá.

Participant 4 conveyed a lack of prior opportunities to express their priorities and preferences regarding her contraceptive care. This quote exemplifies how adolescent migrant girls were often side-lined when it came to participating in decision-making processes.

When key informants were asked to identify mechanisms of participation, several key informants diverted the question, mentioning other organisations, that had used focus groups or community networks. The quotation provided below illustrates a typical example of the ways in which questions were avoided.

> '[W]e're really focused on the humanitarian, I understand completely what you're saying […] about involving youth in the design stage […] I think that would be an interesting conversation for you to have, for example, with [name of organisation] or other sort of more grassroots or local organisations that are offering healthcare services.' Participant 15, a professional from a multilateral organisation.

The inability to draw on specific mechanisms suggests adolescent migrant girls are not included in the decision-making processes of this organisation. They rationalised the absence of participatory mechanisms by pointing to the collaboration they had with organisations that included the *voices* of adolescents. Evidently, Participant 15 viewed participation as an activity predominantly done by local community health organisations. Such an approach negates the participation of adolescent migrant girls in any high-level decision-making positions.

> 'We have been at many, many tables, discussions, meetings, etc. […] there is a more lack of presence of women and young girls' voices in this discussion. So, I think... there is a need to see more voices of Venezuelan women, like more leadership in these in this discussion' Participant 16, a lawyer from an INGO.

Some participants were critical of the lack of mechanisms in place to support the *voices* of adolescent migrant girls at higher levels. In the example above, Participant 16, whose work focused on advocating for Venezuelan migrant rights, acknowledged the absence of *voices* from the Venezuelan migrant population. Importantly, the *voices* of younger women and girls were lacking – which demonstrated that the intersection of age, gender, and migration corresponded to decreased representation.

Regardless of their justification, by not including mechanisms of participation actors are choosing to not centre the experiences of adolescent migration state and non-state actors. Failure to give Venezuelan adolescent migrant girls anything less than *consideration* violates the rights 'to be heard' under the UNCRC. Beyond that, in terms of justice, whilst some *voices* are excluded from formal decision-making processes, they are denied the opportunity to shape responses in a way that matches their reproductive realities. Consequently, policies and programmes are externally imposed

practices. This is why, as I elaborate on in the discussion, a failure to include Venezuelan adolescent migrant girls in responses can be categorised as *coercion.*

Whilst the majority could not identify mechanisms of participation, some actors (three non-state and one state actor) noted their use of activity-based educational workshops.

> '[O]ur methodologies are Learning Circles, we've had always at least one Venezuelan – they're all over the territory. But especially we work with [organisation name] in Arauca that is in the border, and they worked with 900 women that were migrants.' Participant 20, a professional from a not-for-profit organisation providing education.

Participant 20 further explained how their organisation does not focus on migrant girls, but also because of the number of Venezuelans, always has at least one present. Similarly, the other key informants mentioned that their workshops were open to host and all migrant populations. Thus, Venezuelan adolescent migrant girls were able to develop their 'evolving capacities' by accessing sexuality education. The direct engagement with Venezuelan adolescent migrant girls, in a way that enhances their skills means that this type of education reaches the level of *consideration.* But when topics are restricted, or when increased decision-making capacities are not met with access to services (to realise those decisions), this reduces the autonomy-enhancing potential of activity-based educational workshops (see 7.2.2.1).

Some key informants discussed community networks as a form of participation. This involved staff going into migrant communities and liaising with community leaders. The intention behind doing so varied depending on the main implementation actor. The examples below, demonstrates how one actor used community networks to gather data to inform future programmes; whilst the other served as a space to signpost to other services.

Participant 23 demonstrates how community networks have been key in highlighting important local issues and developing strategies to address those issues. Because community networks were focused generally on social inclusion within the community and protection from violence, it is unclear the extent to which adolescent migrant girls were invited to participate or, that issues of contraception arose. As aforementioned, some of the other programmes discussed in (Chapter 6), were available in specific locations and were only available for the length of the project (which in this instance was nine months).

> ‘There are community networks, specifically working on health issues, and these are made up of Venezuelans and Colombians … these community meetings, are part of the coming up with strategies for health promotion and prevention.’ Participant 23, a professional from a multilateral organisation.

Meanwhile, Participant 26, working in a public social protection role, shows how their community networks could be used to convey information about the service offerings available. As described, community leaders were used as a point of contact to determine the needs. They were then able to focus efforts on those issues, by providing services or signposting to other actors who could provide those services.

> ‘We always made a point of contact with community leaders, and community leaders would then convene the community and we would offer workshops they would either be in person or they would be virtual, and we offered education about sexuality.’ Participant 26, a public professional working in social protection.

The main difference between Participant 23 and Participant 26 is that one is designed to receive information from community groups, whereas the other is designed to impart knowledge from community groups. This variation in the implementation of community networks means that under *The Scale of Voice*, this mechanism ranges from *passively*, down to *generalisation*. This variation depends on the extent to which ‘community’ includes adolescent migrant girls, and the extent to which their views are accurately captured, represented and communicated. Regardless, as I later discuss (in section 7.2.2.2), the lack of direct engagement means that there is no means for Venezuelan adolescent migrant girls to develop their ‘evolving capacities’.

Focus groups were the most common mechanisms pointed to when highlighting how Venezuelan adolescent migrant girls were able to participate in the design and implementation of contraceptive care responses. Non-state actors employed focus groups to assess needs and understand experiences, as described by Participant 2. Unlike community representation, focus groups addressed SRH and included Venezuelan adolescent migrant girls. This means that they were less likely to *generalise* the priorities and preferences to the needs of the community or to the Venezuelan migrant population. Conversely, they were more likely to be attentive to their intersectional reproductive realities, than those who used interlocutors.

Key informants spoke about focus groups as one-off events that were confined to the projects or programmes. Once again, the participant points to two specific investigations which Venezuelan

migrants, which has implications for generalisability to other adolescent migrant girls in other locations or at other times, something discussed later analysed in the discussion session of this chapter.

> '… [T]hrough focus groups, where we talk about the relevance of search certain projects or actions that were carried out with patients. That's actually the way that we were able to put together the two investigations that … helped us identify the needs of the Venezuelan migrant population. So, then we ended up putting into this is how we compile information to report to donors, and that creates a process a discussion process.' Participant 2 from a professional from a not-for-profit service provider.

Focus groups were mechanisms of *voice* that had the greatest opportunity to provide autonomy-enhancing conditions. They provide direct engagement, ranging from the levels of *actively supporting* to *consideration* (see 7.2.2.3). Whilst the use of focus groups demonstrated progress in involving the Venezuelan migrant population in responses regarding their health, it became clear that this was not common practice.

Overall, there is a lack of established frameworks or standardised practices - leading to individual organisations determining their own rules of engagement with adolescent girls. Key informant interviews highlight various mechanisms for participation (and thus, *voice*), including community networks, activity-based educational workshops, focus groups, and interviews. The majority were implemented by non-state actors as they were the ones primarily in contact with irregular Venezuelan adolescent migrant girls. Still, many non-state actors did not report using any mechanisms which would include the *voices,* and thus enhance the contraceptive autonomy of, adolescent migrant girls. For example, there was a notable lack of participation in high-level assemblies or peer-led interventions. These organisations attempted to avoid the question by diverting attention to the organisations that did implement participatory mechanisms. All in all, whilst some actors mentioned programmes that included participatory approaches, only a few organisations routinely used them to inform how programmes were designed and implemented.

7.1.3 Voice as Feedback Mechanisms

Participants were asked what type of feedback mechanisms existed within their organisation. That is, how, if at all, could Venezuelan adolescent migrant girls could provide their opinions of the care or services they had received and the extent to which this shaped future practice. The results

highlight three different types of mechanisms: services rendered, surveys or questionnaires, and activity-based educational workshops. Nevertheless, it was clear that there was a distinct lack of meaningful mechanisms through which adolescent migrant girls could feedback their priorities and preferences.

Of the adolescent migrant girls who were interviewed, none had had the opportunity to feedback on their experiences of contraceptive care. As demonstrated by Chapter 0, quite often irregular migrants were not able to access care, so the ability to feedback or input into future opportunities was a moot point of discussion. Participant 5 who had attended a group that allowed them to reflect on themselves and share their feelings.

> 'In terms of organisations that you can go and share your opinion with not so much, but I do know that there are some groups because I've been to that myself… The one that I went to, and actually I would go back, they were giving me guidance about like, showing sharing and my attitude and my feelings.' Participant 5, a Venezuelan adolescent migrant girl living in Bogotá.

She explained that this group was not directly related to contraceptives but was a collective of Venezuelan migrants facilitating human rights discussions, which could provide the skills to feedback on care in the future. This demonstrates that existing efforts to mobilise are also arising from the migrant community, but still are not differentiated for SRHR or adolescent migrant girls.

> 'We collect data on services rendered. So that's one way for us to understand what people are asking for.' Participant 2, a professional from a not-for-profit service provider.

Some key informants such as Participant 2, and Participant 15 used feedback mechanisms, such as monitoring the levels of demand at health centres, similar to that discussed in Chapter 6. The idea was that user statistics demonstrated demand and that those health services in the highest demand should be those where attention was focused. This type of feedback consisted of collecting information from health service providers who were interacting with migrant adolescent girls. Once data had been collected, it passed up the hierarchy to decision-makers, who would then use this information to shape future responses.

> '[... S]o what will happen is we might receive requests or demands from the population and so we will be able to approach aid organisations and ask if they can offer or be able to meet that need.' Participant 15, a professional from a multi-lateral organisation.

So, for example, if nurses were reporting that there were several requests for implants, programme designers would ensure that stock levels were sufficient to meet demand. In this case, feedback would be collected through a representative. Therefore, the *voices* of adolescent migrant girls were not consulted directly, rather they relied on service providers as interlocutors. There were no positive actions taken to realise the authentic priorities and preferences, rather they are assumed to be reflected in their health-seeking behaviours. Hence, this can be classified as *passively listening* at best. Since direct engagement with Venezuelan adolescent migrant girls did not occur, the services rendered can be viewed as a feedback mechanism that aligns more with community networks, at the level of *generalisation.*

Key informants also identified activity-based educational workshops as opportunities to create dialogue with adolescent migrant girls and then fed these ideas up to higher levels within the organisation or their interagency networks. Therefore, activity-based educational workshops operated as feedback mechanisms, as well as participation mechanisms.

> 'It really comes down to what gets delivered in the form of sort of cultural activities, whether it be through art therapy or through play or through theatre activities[...] That's where we get the most feedback and where we hear their voices the most.' Participant 13, a professional from a multilateral organisation.

As demonstrated by Participant 14, these activities could be multisectoral responses that provided multiple ways for adolescents to express their feelings and opinions. These interventions go beyond traditional medical approaches and include activities such as art therapy, play or theatre activities. One gave the example of rights-based education through activities, such as champeta (a type of music and dance, associated with the Caribbean coast). According to Participant 14, these activity-based educational workshops, such as art therapy or theatre, become channels to obtain valuable feedback and hear the *voices* of migrant girls. The use of art-based participatory interventions served as channels for the girls to express themselves, share their thoughts, and communicate their perspectives more creatively. Arts-based approaches are considered to be beneficial because they challenge the hegemonically 'adult-centric' worldview. This indicates that such activities can be valuable mechanisms through which adolescent migrant girls' *voices* are *considered*.

The main limitation of these activities was that they rarely covered issues such as contraception. The activities tended to be about on topics of protection from violence, health and/or rights in general,

as opposed to contraceptive care[58]. So, as in the case of access noted in Chapter 6, there is great variation between organisations regarding which topics are breached and in what depth. Therefore, if actions did not discuss contraceptive care, then they cannot be seen as creating environments which enhanced Venezuelan adolescent migrant girls' ability to make decisions about their contraceptive care or realise them.

Satisfaction questionnaires provided a more traditional method to collect feedback from services rendered. The use of surveys or questionnaires was not frequently mentioned by key informants. Overall, three mentioned surveys, with two being from the same organisation. For example, where state actors contracted work to local non-state actors, they often required that the implementing actor disseminate satisfaction surveys, as demonstrated in the quote below by Participant 6. Questionnaires thus served as a means of monitoring the actions of the implementing actor, as well as understanding Venezuelan adolescent migrant girls' experiences.

> '[W]e hire operators, which could be foundations, for example, that offer activities in La Guajira or Atlántico [who] then provide satisfaction surveys that ask the youth themselves what it is they thought and how they felt about the programming. So that is how we find out, through our supervisory role, with the operators...' Participant 6, public professional health, and social protection.

It is important to note Participant 6 felt that adolescents were satisfied with the services they received. This was surprising given the inequalities found in Chapter 5, which inferred problems with sustained access. These claims were further echoed by participants in the previous chapter (Chapter 6). The questions were set by donors and contractors, and then implemented by local organisations, which could lead to adolescent migrant girls feeling pressured to answer positively. More information is needed, specifically the design and implementation of questionnaires, to understand the extent to which Venezuelan adolescent migrant girls are happy with the services they receive. However, I have identified this to be *actively supporting* on *The Scale of Voice*, because they demonstrate positive actions to understand the intersectional reproductive realities of migrant girls and enable them to provide suggestions on future responses - albeit in very narrow terms.

Another participant mentioned the use of social networks, and one mentioned using interviews with adult women. These sub-themes should be noted not only to highlight that attempts are being made to include feedback mechanisms, even if they are not pervasive or transformative.

[58] Participant 20, Participant 23, and Participant 26.

The remainder of the key informants found this question difficult to answer this question and, for the most part, avoided the question by talking about the context of the situation, giving updates on the number of migrants or the new status on regularisation. Through this, I inferred that they did not include mechanisms of feedback in their responses. Hence, these actors cannot be said to be centring and including the *voices* of adolescent migrant girls to any extent.

Participant 28's response exemplifies the limited progress in integrating humanitarian activities with broader aspects of the migrant situation. They acknowledged that conversations about integration were beginning to take place but guarantees or concrete actions were not yet evident. Similar to their definition of *voice,* feedback mechanisms were mechanisms that the actors were moving towards but were not yet realised.

> 'These are conversations that are beginning to be had. I cannot say that it is something that is guaranteed at the public health but as a humanitarian response, I can say that it's something that has been discussed and is under construction [...] We are really just getting started, though we are aware.' Participant 28, a professional from a multilateral organisation.

In summary, the findings revealed three different types of mechanisms that key informants felt enabled adolescent girls to share opinions on the contraceptive care they had received: services rendered, surveys or questionnaires, and activity-based educational workshops. In general, there was a distinct lack of meaningful mechanisms through which to feedback the opinions of adolescent migrant girls. Despite the limited progress, there was an awareness of the need to address these issues in the future. Throughout this chapter, I have mapped each of these mechanisms onto *The Scale of Voice.* However, I will return to an in-depth analysis in the discussion (sub-section 7.2.2).

7.1.4 The Opportunity To (Not) Use A Variety of Contraceptive Methods for Adolescent Migrant Girls

Services and methods offered through actors' responses to adolescent migrant girls' contraceptive care needs varied. Most were found to offer limited methods, promoting LARCs over other methods of contraception.

Two service providers emphasised the importance of being able to provide 'a broad service offering', meaning they were able to offer a variety of contraceptive methods.

> 'There's a contraceptive it's called Mirena [IUD], that's a little bit more expensive, but it is the appropriate option for someone because of the needs that they have. And that is contemplated in the broad service offering that the [we can provide when we work with organisation A].' Participant 30, a not-for-profit health provider.

As can be seen from the quote by Participant 30, one of the organisations was able to offer certain types of contraception that were not usually offered during collaborations with organisations because of the cost. This participant continued by contrasting their ability to offer a variety of contraceptive methods, with the limited or partial offering that was available when they worked with other funders.

> '[W]ith [organisation B], for example, it's more restrictive not only in terms of services but also the medicines that are contemplated in the service offering. So, if they're not validated by certain US-owned pharmaceutical companies, they're not going to be in the service offering. And so, when we look at what we can offer the population, that's what we have to take into account, and it causes us to need to adapt quite frequently.' Participant 30, a not-for-profit health provider.

Due to restrictions on public funds and donors' aversion to funding adolescent contraceptive services (as also in Chapter 7.3), some actors had to restrict what methods of contraception they could offer. In the case of Participant 30 above, their collaboration with international organisations from the USA meant their service offering was restricted by the demands of that organisation's donors. This is one example of how external factors, beyond the preferences and priorities of Venezuelan adolescent migrant girls, constrained their opportunity to use a variety of contraceptive methods. Thus, in some cases, it was clear that full choice, meaning several types of different types of contraception, was not in place.

State actors, like Participant 26, demonstrated how had had to refuse contraceptive care because of the lack of affiliation for migrants. They maintain that beyond condoms, she was unable to provide contraceptive care for adolescent girls who were asking for methods.

> 'We had all these Venezuelan women coming, were 18 years old and who wanted access to contraceptives- they already had two to three children- and the Secretary wanted to give them this offering that we had but he couldn't because they weren't affiliated to the health system.' Participant 26, a public professional working in social protection.

The denial of methods was attributed to the lack of funding or pathways through which to distribute contraceptive methods. In context, this quote was given during the discussion of the structure of the response, as External Circular 25/2017 only allowed for the provision of condoms for HIV prevention. The result was that Participant 26 and her colleagues found themselves directing migrants towards humanitarian organisations that they knew would be able to provide contraceptive care – regardless of affiliation status. In such cases, it is difficult to discuss the extent to which choices were free or informed because requests were denied.

Whilst state actors only offered condoms, international non-state actors frequently limited the variety of methods on offer, preferring to use long-term methods, known as LARCs. Key informants from international organisations stated that they provided LARCs because Venezuelan adolescent migrant girls preferred these methods. The first line of argument was that this was the evidence on the ground or 'scientific evidence', although the exact details of this evidence often remained ambiguous.

> 'LARCs prevent pregnancies for three, five or 10 years depending on what method they choose. Also, [there is] based on scientific evidence to say that the evidence shows that this is the preferred method for adolescents. Also, the fact that for other methods people need to have like the health provider available or money to pay for them...' Participant 23, a professional from a multilateral organisation.

Another point made by Participant 23, as well as other doctors and humanitarian professionals, was that LARCs were able to overcome several of the access barriers posed by the process of migration. Because many adolescent migrant girls did not have access to disposable income or health insurance and did not want to use permanent surgical methods (more common in older Venezuelan women), LARCs were the most 'common-sense' option. The inference here is that they can be installed and forgotten.

> 'But subdermal has been the most popular because of the amount of time that is good for and it's really just a matter of inserting it and removing it. And there aren't other access issues like keeping it on hand, for example, it's just a one-time thing.' Participant 15.

Key informants highlighted the financial inaccessibility of condoms from pharmacists as a barrier to their use. At the time of the interviews, key informants noted that condoms are 'really very

expensive' with a box of three condoms costing '10,000 pesos [which] is like 2 and a half dollars.'[59] The principle of full choice requires that methods be affordable (Senderowicz, 2020). Considering condoms were considered expensive, they cannot be considered an affordable option, for Venezuelan adolescent migrant girls.

Another reason that LARCs were preferred was that they were able to provide contraceptive care beyond the length of a funded project. The uncertainty of procuring future funds for a continued provision of short or long-term methods was further used to explain the benefits of LARCs. Actors noted that due to the programme cycle and the short-term nature of the humanitarian response they often 'don't know if the money's going to be guaranteed for those methods. So that's why LARCs are better.'[60]

The creation of numerical targets had a further effect on 'the way contraceptive care was offered to Venezuelan adolescent migrant girls. The idea of 'marking a point' and then measuring the impact based on the number of contraceptive methods administered to migrants appeared to be the dominant method of evaluating the success of a programme or policy[61]. There did appear to be a focus on indicators, particularly amongst state actors who saw a need to reduce the number of adolescent pregnancies[62]. As seen by Participant 27, and Participant 8 below.

> 'We've noticed an increase in worrisome indicators like an increase in adolescent pregnancy […] so we're focusing on that now.' Participant 27, a public health professional.

There is a notable lack of distinction between reducing the number of pregnancies and ensuring that the means by which this is achieved do not compromise the autonomy of adolescent migrant girls. Participant 20 discussed how they believe that other actors see indicators as an easier way to measure progress because it is less time and labour-intensive than addressing enhancing the decision-making power of Venezuelan adolescent migrant girls.

> 'I think it is a numbers thing. 'We've been able to implement 1000s of contraceptives blah blah blah' or this idea of really bringing down the teenage pregnancy rates forcibly because that is a very, very attractive indicator of results, … And [other actors] believe that donors

[59] Participant 25, a public medical professional.
[60] Participant 22, a health professional working for a charitable foundation.
[61] Participant 25, a public medical professional, Participant 13 a professional from a multilateral.
[62] Participant 8, a public health professional.

> or big organisations want to have results of reduced adolescent pregnancies…' Participant 20, a professional from a not-for-profit organisation providing education.

The quotation above shows this participant's organisation places emphasis on decision-making but that this is not the norm. In addition to this, they discussed 'stories of forced sterilisations, especially with migrants' or 'forcibly bringing down pregnancy rates' are particularly concerning. In fact, this participant mentioned how donors 'want to give contraceptives to all the girls and didn't really care about the education behind it'. This view was supported by Participant 18 and Participant 6, who stated that non-state actors had hosted day events that provided contraceptives and STI/HIV testing without follow-up care. These evidenced how harmful partial access to SRH could be to the Venezuelan migrant population. So, although no organisations mentioned practices of administering contraceptive methods without consent, it is concerning that there are actors, like Participant 20, who believe that it is happening.

Indeed, as evidence from the beginning of this sub-section, and from Chapter 6 demonstrated, funders and donors play a significant role in the types of services available. Unsurprisingly, implementing actors were focused on how their actions are perceived by donors, rather than how they impact the decision-making power of adolescent migrant girls.

Overall, the results reveal that there is an acknowledgement of the need for *voice*, but that actors rarely apply this need in practice. The mechanisms of participation that were included were community networks, activity-based educational workshops, focus groups, and interviews. Therefore, where actors' responses include mechanisms of participation, this is limited to a local level. Feedback mechanisms identified included services rendered, surveys or questionnaires, and activity-based educational workshops. These often relied on gathering opinions via interlocutors rather than with adolescent migrant girls. Regarding the opportunity to use a variety of methods, some actors tried to offer broader mixes of contraceptive methods, to account for different needs, but this was not a pervasive practice. From the findings, it seems this was the exception, rather than the standard for the response. Some actors adopted a goal-oriented focus on indicators, without acknowledging the conditions in which power is distributed can have extremely harmful effects on the contraceptive autonomy of Venezuelan adolescent migrant girls, as Participant 20 began to allude to. In this section, I began to refer to how these mechanisms would be understood under *The Scale of Voice*. However, the next section will explore this in more detail, explaining how each mechanism provides conditions which enhance, or constrain contraceptive autonomy.

7.2 Discussion

This section considers these findings in relation to the third research question which asks, to what degree have young peoples' *voices* been included? What approaches are used to incorporate the *voices* of Venezuelan migrant girls in their approach when designing and implementing response? This section draws together the findings above using *The Scale of Voice* to analyse the mechanisms of participation, feedback and the opportunity to (not) use a variety of contraceptive methods, as identified in the interviews. Overall, this demonstrates the value of using *voice* as a framework for understanding the modalities of contraceptive autonomy at play and to highlight moments where autonomy is constrained. The below shows how autonomy is considered unevenly and is restricted by several limitations such as a failure to address 'evolving capacities', a lack of influence, and overlooking structural factors. Importantly, the use of this novel framework reveals previously unconsidered power relations, which (re)produce disparities in contraceptive care for adolescent migrant girls.

7.2.1 A Voice for Whom?

The key findings demonstrated that *voice* was broadly understood in two different ways. Whilst all participants saw voice as something desirable, some participants reasoned this was because of the intrinsic value it held, which is that it is beneficial for adolescents' development, rights, and autonomy. Conversely, *voice* was also framed as instrumentally beneficial. The reasoning here is that, by using voice, actors would be able to say that they generate responses that were more appropriate to the needs of adolescents. In this sense, voice was beneficial because it was a means to an end, rather than a means in itself. These dimensions play a crucial role in shaping our understanding of how actors engage adolescents in the process of expressing their views and opinions. According to *The Scale of Voice*, both are important. However, understanding voice as purely instrumental or in some cases not at all, can have negative consequences for adolescents' contraceptive autonomy.

Using *The Scale of Voice*, actions that include voice as an instrumental component may be perceived as *manipulation*, as this participation primarily serves the interests of the actors involved. To unpack this idea further, incorporating the *voices* of adolescents when the sole purpose is to aid actors, risks using *voice* as an additive. Superficially incorporating *voice* into the existing responses is autonomy-constraining because actors utilise *voice* to affirm their existing actions, rather than to redress power

imbalances in decision-making processes. This is reminiscent of critiques of participation as 'projectised' – whereby concepts like participation are used to legitimise a project (Hickey, 2004, p. 16; White and Choudhury, 2007; Malik and Rana, 2020). Malik and Rana, (2020) take this further stating that using participation in this way does little for recipients of programmes, as programme designers make promises to, and are held accountable by donors. Here, actors use the *voices* of adolescents' *voices* to demonstrate to donors that they are cognisant of the importance of *voices* because it increases their likelihood of securing future funding, rather than because it grants adolescent migrant girls the conditions to realise their priorities and preferences.

The focus on practical applications over intrinsic motivations is also problematic because it does little to address inequalities in skills possessed by adolescent migrant girls. It was clear that those who worked with adolescent migrant girls found that there was a distinct difference in their education level, confidence, and fullness of their participation. This suggests that the most marginalised adolescent migrant girls are those who require more sustained engagement in order to make up for their lack of experience in voicing their opinions. This is unsurprising and is supported by Brisson, Ravitsky and Williams-Jones, (2021), who noted that Colombian adolescents from higher classes *(estratos)*, and who were older, engaged more knowledgeably on the subject of autonomy in SRH. Conversely, for marginalised adolescents it can be more difficult to express views due to a lack of skills or a lack of confidence in formal institutional settings (Macpherson, 2008). A lack of sustained, intervention could overlook adolescent migrants' distrust of authorities and fear of deportation, such as in Sweden and the US (Davidson *et al.*, 2022; Tirado *et al.*, 2022). Intrinsic motivations ensure the individual receives benefits such as developing their 'evolving capacities', as in the UNCRC. Therefore, if responses are to truly centre and include Venezuelan adolescent migrant girls, the development of skills as 'evolving capacities' needs to be addressed. Without this, responses cannot surpass the level of *actively supporting* on *The Scale of Voice*.

Those actors who framed *voice* as something to be developed in the future evaded responsibility by avoiding mechanisms of participation, feedback, and full choice altogether. Under *The Scale of Voice,* a lack of mechanisms of *voice* for adolescent migrant girls altogether can be equated with *coercion*. In essence, the absence of any mechanisms by which to influence their contraceptive care means Venezuelan adolescent migrant girls cannot share their priorities and preferences. Beyond (re)produces harmful social norms where migrant women and girls are seen as 'passive' recipients of aid, rather than as experts of their own reproductive realities. Thus, this reinforces the paternalistic attitude often ascribed to women of the South and adolescent girls (Mohanty, 2019). Furthermore,

the findings also demonstrated how some actors justified not including *voice* because their work was 'humanitarian' or focused on refugees. Here, it is fitting to return to the concept of the 'tyranny of the urgent' which was carried throughout the interviews into discussions of voice (Lafrenière, Sweetman and Thylin, 2019; Smith, 2019). Regarding the discussions of *voice*, this was considered something that should be done once all emergency matters had been dealt with. Once more, aligning it with Enloe, (2004) concept of later, that 'patriarchal time zone' where women are asked to place their concerns. In putting adolescent' migrant girls' *voices* in the time zone of 'later', actors once again deprioritised adolescent migrant girls' contraceptive care. Only this time, they were being asked to hold onto their opinions indefinitely. The idea that some needs are more 'urgent' to address than others valorises technical, risk-based responses over the creation of autonomy-enhancing conditions. Thus, actors legitimise the absence of any mechanisms that constrain contraceptive autonomy by depriving adolescent migrant girls of the opportunity to develop 'evolving capacities', all whilst they fail to redress power relations.

7.2.2 Participation and Feedback Without Influence

This section focuses on the choice of mechanisms and how they were implemented to reveal important lessons about how actors create conditions that enhance or constrain contraceptive autonomy. The results above found some evidence of mechanisms of participation including focus groups, activity-based educational workshops, and community networks. Further, feedback mechanisms found included inferences made from user data, non-medical participatory events, and surveys. Here, I will draw specific attention to activity-based educational workshops, community networks and services rendered and how their use applies to *The Scale of Voice*, (see Figure 7).

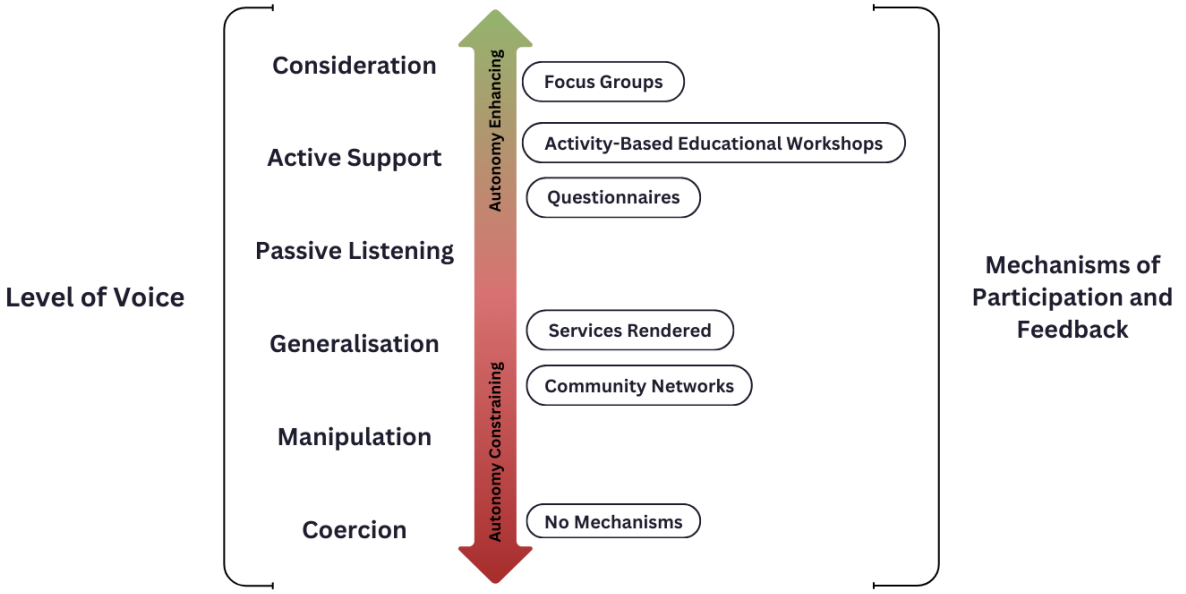


Figure 7 Mechanisms of Participation and Feedback on *The Scale of Voice*

7.2.2.1 Activity-Based Educational Workshops

Activity-based workshops were participatory as they used Learning Circles, and art-based activities to enhance the skills and capabilities of adolescent migrant girls. They were also used to feed back the experiences and needs of Venezuelan adolescent migrant girls. However, there was little evidence they went on to impact response design or implementation.

The benefits of activity-based workshops are twofold. Firstly, the opportunity to increase rights-based knowledge on topics addresses and develops Venezuelan adolescent migrant girls' 'evolving capacities'. Namely, they provide empirical knowledge about elements of SRH, in addition to those intrinsic elements of *voice* such as self-efficacy, communication skills, and rights education. Such skills are required because adolescent migrant girls during this phase of psychological and emotional development can be seen as lacking the capacities for autonomous decision-making, but equally, because they undergo phases of exploration and experimentation in their SRH decision-making (Alatinga, Allou and Kanmiki, 2021). Given that actors have noted the different levels of skills between Venezuelan adolescent migrant girls, and the lack of CSE available in Venezuela these are important interventions (Save the Children, 2020). Furthermore, there is evidence to suggest interventions involving young people increase SRH service utilisation in humanitarian settings (Jennings *et al.*, 2019). Thus, they could decrease the gap in service utilisation identified in Chapter 5. By providing activity-based workshops, actors equip adolescent migrant girls with the skills they need to know their SRHR.

Similarly, activity-based educational workshops and cultural activities allowed programme facilitators to understand which topics are important to adolescents and how they reflected upon and engaged with those topics. They position adolescents as the creators, allowing them to convey their experiences in their own words (Buthelezi *et al.*, 2007; MacDonald *et al.*, 2011). Thus they, signify a move away from more formal mechanisms of participation that adopt a predominantly 'adult worldview' (Ibid.). In this way, using activity-based educational workshops provides greater autonomy-enhancing conditions than formal methods because they do not automatically privilege one way of knowing over another.

On the other hand, activity-based educational workshops were an insufficient form of participation because they did not lead to a change in response design and implementation. Providing these activities creates conditions when they have the skills to make decisions about their contraceptive priorities and preferences, but it does not necessarily provide the means to realise them. According to youth participation literature, actors need to be able to provide opportunities for adolescents to be heard in order to facilitate genuine participation (Shier, 2006). So, whilst adolescent migrant girls might have been able to exercise and develop the skills necessary to use voice, they often lacked the opportunity to use it to provoke meaningful change at higher levels of governance. In terms of realising their priorities and preferences in service provision, activity-based educational workshops did not provide opportunities to use contraceptive methods. Their choice might be informed in that they are aware of the types of methods available, their benefits, side effects and level of supervision required for use, they might not have a full range of choices because of their lack of access to the health system. Thus, there was a lack of opportunity to be heard.

In a similar vein, there are weaknesses to relying on activity-based educational workshops as a feedback mechanism as they rely on facilitators as interlocutors for Venezuelan adolescent migrant girls' priorities and preferences. As aforementioned in Chapter 6, there are differences in perceptions and languages regarding contraceptive care regarding stigma and the use of terms like 'family planning'. Thus, the extent to which *voices* are interpreted accurately depends on the skills of the facilitator, which might be more difficult to manage in cross-cultural groups. Similarly, feedback will usually be limited to the topics covered in the curriculum. In some cases, this had been imposed by donors, so that abortion and contraception could not be addressed. In this manner, the extent to which Venezuelan adolescent migrant girls can discuss their priorities and preferences could be limited by the restrictions placed by the facilitator or international donors.

On balance, considering the positives and weaknesses of activity-based educational workshops as a form of participation and feedback, the application of mechanisms can be classified as the level of *consideration* under *The Scale of Voice*. Adolescent migrant girls' *voices* were *considered* because responses targeted them using age-appropriate mechanisms that developed their skills in line with 'evolving capacities'. Hence, they addressed them as adolescent migrant girls, not just as migrants. Activity-based educational workshops cannot be classified as more autonomy-enhancing under *The Scale of Voice* because Venezuelan adolescent migrant girls did not determine the outcomes of any decisions. Nor were adolescent migrant girls' preferences realised by the acquisition of knowledge or information. Thus, whilst they equipped girls with essential skills, their impact on power relations in the design and implementation process was a limiting factor.

7.2.2.2 Community Networks and Services Rendered

Community networks and analysis from the data on health services are both valuable forms of participation and feedback because they generate data from the communities in which responses are situated, and thus are more sensitive to reproductive realities. However, they cannot be said to be truly participatory because they do not directly consult with adolescent migrant girls, instead relying on the service providers as interlocutors.

Community networks and analysis from the data on health services rendered are both valuable because they are 'bottom-up' approaches that present a welcome perspective to health systems that have overwhelmingly favoured 'top-down' approaches (Hickey, 2004). Additionally, community-based interventions provide useful data on local barriers to healthcare (Castaneda *et al.*, 2015; Mulubwa *et al.*, 2020). As such, they go beyond one-size-fits-all approaches by centring the needs of the community.

However, there are limitations of community networks and services rendered that leave these mechanisms less likely to create conditions that are autonomy-enhancing than mechanisms such as activity-based educational workshops. This is because community leaders or service providers act as representatives of the entire Venezuelan migrant population, on a range of health-related issues. Consequently, actors did not directly engage with adolescent migrant girls regarding their contraceptive care priorities, preferences, and decision-making skills. Instead, decision-making power lies in the hands of the community representatives passing on the information to the actors designing the response. The direct involvement of adolescent migrant girls or at least a representative sample of those with a variety of intersectional characteristics is required to

communicate the priorities and preferences of this population without the risk of being misunderstood or generalised. Scholars have warned that homogenising 'the community' as an undefined monolith fails to recognise the different power structures that operate within and between communities (Cooke and Kothari, 2001). Likewise, social norms have also affected the quality of service provision for marginalised groups (Goicolea *et al.*, 2010; Tanabe *et al.*, 2017; Senderowicz, 2019; Mann, Chen and Johnson, 2022). According to RJ, as long as service providers control access to resources, this is classified as controlling, coercive and hampering attempts at reproductive freedom (Winters and McLaughlin, 2019; Brian, Grzanka and Mann, 2020; Mann, 2022). In both mechanisms, community networks and services rendered, there is a risk that what is considered participatory might be considered to be more akin to a process of representation (Hickey, 2004). With any such process, failing to take an intersectional approach which centres marginalised groups can result (re)produce marginalisation and powerlessness.

So, whilst listening to demands and requests is crucial, it is equally important to recognise that not all needs and preferences may be explicitly voiced. Some adolescent migrant girls might face cultural or social barriers that prevent them from expressing their needs openly or from accessing services altogether. Where the needs of these adolescent migrant girls are communicated via an interlocutor, adolescent migrant girls are often unaware this has occurred. This means this type of response takes no positive actions to develop their intrinsic skills or to enhance their 'evolving capacities'. Furthermore, it risks overlooking the intersectional barriers such as shame, embarrassment or stigma, which might prevent adolescent migrant girls from sharing their thoughts, and feelings with community members or medical professionals (Tesso, Fantahun and Enquselassie, 2012; Metusela *et al.*, 2017; Ivanova, Rai and Kemigisha, 2018). Indeed, research in other settings has shown lower levels of health literacy can make it more difficult for migrants to seek healthcare and to understand the variety of options presented to them (Chuah *et al.*, 2018; Hawkins *et al.*, 2021). The use of community networks and services rendered risks excluding those irregular Venezuelan adolescent migrant girls who have fewer 'evolving capacities' and for whom access to healthcare is already restricted. Thus, they risk leaving behind those who are the most marginalised, further excluding their needs from responses.

Analysing these mechanisms using *The Scale of Voice* community networks as a participatory mechanism and user data on the services rendered as a feedback mechanism can be classified as *generalisation* because they generalise the needs of the Venezuelan migrant community as a whole. They rely on intermediaries to communicate contraceptive care needs, which removes adolescent

migrant girls from decision-making conversations altogether. Thus, adolescent migrant girls cannot be said to truly have their voices *considered*.

Yet, interlocutors who authentically communicate the views of adolescent migrant girls may result in *passively listening*. Where no positive actions have been taken to enhance the 'evolving capacities' of adolescent migrant girls because redressing decision-making power is not the main objective of the interaction, but accurate insight is taken from preferences offered. Both have a risk of overlooking the most vulnerable, adolescent migrant girls who do not have access to services or do not have a strong community presence.

7.2.2.3 Focus Groups and Satisfaction Questionnaires

Actors who use focus groups and satisfaction questionnaires are more likely to create conditions where *voice* is realised because they directly listen to the preferences of adolescent migrant girls. However, they often serve an instrumental benefit such as the evaluation of a project, rather than centring Venezuelan adolescent migrant girls' reproductive realities.

Focus groups and satisfaction questionnaires both generate direct ways to enable adolescent migrant girls to express their priorities and preferences. Focus groups, enhance autonomy to a greater degree because they also offer a process in which adolescent migrant girls develop the skills necessary for 'evolving capacities' such as communication and self-efficacy. Venezuelan adolescent migrant girls might be able to express and claim their SRHR through, but the lack of contact means relationships between adults and adolescents are not as strong. Regardless, the direct engagement shows that adolescent migrant girls are being centred and included in responses to a greater degree than with services rendered.

Focus groups and satisfaction questionnaires have two main weaknesses in creating conditions which enhance *voice* and by extension contraceptive autonomy. Namely, they are often limited in the topics they cover, being specific to a project or a service provider. Focus groups and surveys are limited because they constrain the topic of discussion. Adolescent migrant girls can share their opinions and priorities but in ways that are determined by actors. Therefore, what is said, and how it is communicated on depends on the actors' priorities. This constraint means that participatory activities like surveys and focus groups are predominantly viewed as adult activities. Consequently, they will not be appropriate for all adolescent migrant girls and therefore, tend to attract a certain type of young person (Shier, 2006; Macpherson, 2008). This is especially true with one-off or short-term focus groups which do little to advance the 'evolving capacities' of adolescent migrant girls. As

such, whilst the views of adolescent migrant girls might be communicated, they are not guaranteed to redress the power imbalances between themselves and the actors implementing the response.

This leads to the other weakness, which is that focus groups and satisfaction questionnaires are likely in many cases, to be used to benefit the project, and the actors – rather than the *voices* of adolescent migrant girls. Where focus groups are used to demonstrate the need for a project or to show the efficacy of a past project, then they will likely use these methods as more of an evaluation of the service. Equally, where satisfaction questionnaires are used to monitor contracts between funders and service providers, they may focus on a very specific instance of service delivery. Therefore, they are susceptible to 'projectisation' – a process where the focus on participation overrides the project itself to prove a project has achieved participatory credentials (Hickey, 2004, p. 16; White and Choudhury, 2007). By focusing on specific services or particular providers, they overlook the experiences of Venezuelan adolescent migrant girls as a whole. By this I mean, they are likely to disregard the wider structural issues such as migrant status, poverty and access to health services which shape reproductive realities.

In accordance with *The Scale of Voice* focus groups and satisfaction questionnaires facilitate participation and feedback to the level of *active support.* The reason for this is that these mechanisms take positive actions to directly consult with adolescent migrant girls. The extent to which they enhance 'evolving capacities' depends on the relationships established during the process. Just because adolescent migrant girls are listened to does not mean that their priorities and preferences will be reflected in response design and implementation. If they are given 'due weight' (as in the UNCRC), then they can be said to reach the level of *consideration,* as this would encourage a greater redistribution of power. There is one exception to note, where no actions are taken to include the priorities and preferences of Venezuelan adolescent migrant girls, where 'evolving capacities' are not enhanced – or where actors deploy mechanisms to secure future funding or to prove the effectiveness of their project they can be seen as no more than *manipulation*. This is because actors will have been the main beneficiaries of participation, and power relations will remain unaltered.

7.2.3 Full and Free Choice: Agency Over Autonomy

In several cases, a full choice of a broad range of contraceptive methods was not made available. The findings demonstrate that some services offered no services at all, whilst some state actors offered only condoms, and some non-state actors only offered LARCs. Under *The Scale of Voice,*

anything less than a full, free and informed choice of methods constrains autonomy because it means there are no opportunities to (not) use a variety of methods. Thus, this sub-section will explain how the constraints placed on Venezuelan adolescent migrant girls instead demonstrated constrained agency.

The inability to offer any method of contraception or any contraceptive education can be considered *coercive* according to *The Scale of Voice*. Elsewhere, this practice has been identified as downward coercion – where an individual wishes to use a method but is denied one (Senderowicz and Maloney, 2022; Tumlinson *et al.*, 2022). Where access is withheld altogether, Venezuelan adolescent migrant girls cannot realise their priorities and preferences. As a result, actors cannot be said to provide opportunities to use a variety of methods.

Where state actors only offered condoms *generalisation*, as a limited mix of contraceptive methods were available violating full choice. Consequently, the preference for condoms over other methods undermined the principle of free choice. According to the principle of full choice, there should be a broad mix of contraceptive methods available, so that service providers can respond to the needs of Venezuelan adolescent migrant girls on a case-by-case basis. However, restrictions in legislature through MISP and External Circular 24 of 2017 which promote condoms as a way of preventing the spread of STDs/STIs, including HIV/AIDS, prioritise risk-aversion over Venezuelan adolescent migrant girls' priorities and preferences.

The promotion of LARCs over other methods is demonstrative of *generalisation* at best, and *coercion* at worst. Key informants maintained that LARCs were 'better' and were the preferred method to be used by adolescents. Upon questioning why LARCs were considered better the following reasons were given. Firstly, they last a long time, which is good considering that irregular adolescent migrant girls do not have regular access to health providers. This was further beneficial given that responses could not guarantee sustained access to patients. The second reason given was that adolescent migrant girls could not afford to pay for short-term methods such as condoms which were expensive. Thirdly, it was better to help organisations say that they have achieved their targets and prove they are meeting their objectives to 'reduce adolescent pregnancy', which was seen as a desirable outcome for actors. These reasons are problematic for two reasons, upon which I will elaborate further.

Each of the reasons above creates conditions where LARCs are the preferred option because short-term options are not accessible. If irregular adolescent migrant girls had sustained access to service

providers, it is possible LARCs would not be the 'better' option. The lack of follow-up care to the insertion of IUDs highlighted in Chapter 5 demonstrates that current methods are not applied in line with *The Scale of Voice,* contraceptive autonomy, and thus perpetuate a form of reproductive injustice.

RJ scholars have warned of the dangers of promoting LARCs over other methods. When LARCs are framed as 'effective', 'rational' or 'cost-effective' they position these values as more important than contraceptive autonomy (Brian, Grzanka and Mann, 2020; Eeckhaut and Hara, 2023; Morison, 2023). As access to a medical provider is required to remove a LARC, a lack of sustained access compromises the principles of full and free choice (Senderowicz, 2020). So, if Venezuelan adolescent migrant girls felt pressured to use one method or that they could not refuse the method then this goes against the principle of free choice (see Figure 1). Alternatively, if there were not a range of contraceptives available, or they cannot be removed then this also violates the principle of free choice. These principles, I have argued are central to voice*,* as a proxy to contraceptive autonomy. Because an inability to provide them means it does not enhance autonomy in any way and thus goes against 'the best interests of the child'.

Of course, LARCs are *technically* reversible (Winters and McLaughlin, 2019, pp. 225-6). But a focus on insertion over surveillance or removal, such as we have seen in Chapter 5, means that policymakers, programme designers and service providers hold the power to decide when LARCs can be removed (Ibid.). Thus, when the removal of LARCs prevents Venezuelan adolescent migrant girls from becoming pregnant, when she wants to become pregnant – the process can be seen as *coercive*. This is what Senderowicz refers to as upward coercion – when an individual wishes to not use a method but has one (Senderowicz and Maloney, 2022; Tumlinson *et al.*, 2022). Meanwhile, Winters and McLaughlin (2019) refer to this as 'soft sterilisation'. Regardless, there is agreement that this type of practice is *coercive.* If inequalities in the access to contraceptive care for Venezuelan adolescent migrant girls in Colombia persist, for example, where IUDs have been inserted but offer no options for removal (as in Chapter 5 and Chapter 6) then the responses of non-state actors can be regarded as *coercive.*

The inability to discontinue or change methods can be particularly contentious for adolescent girls, who tend to be more experimental in their use of methods, and therefore are more likely to change their minds about contraceptive methods (Alatinga, Allou and Kanmiki, 2021). Furthermore, LARCs are effective in preventing unintended pregnancy, but promoting them over other methods ignores the non-contraceptive benefits of other contraceptive methods, such as the prevention of STIs

including HIV/AIDs or the management of symptoms during menstruation – which are some of the main reasons adolescents seek contraceptive care (Kavanaugh and Anderson, 2013). It further stands that using numerical indicators as targets to control the fertility of Venezuelan adolescent migrant girls, without consideration for their priorities and preferences (re)produces patterns of reproductive coercion for marginalised adolescent migrant girls.

Overall, I maintain that fragmented, short-term responses which promote access to some methods of contraception over others demonstrate constrained agency, rather than the opportunity to (not) use a variety of contraceptive methods. As discussed in the beginning of this thesis contraceptive autonomy (Section 2.3.1), encompasses the ability to make decisions free from external constraints or coercion, and being able to realise those decisions. Agency, on the other hand, refers to the capacity to act on one's preferences within the context of available options. In the context of contraceptive decision-making, adolescent migrant girls may have agency in choosing from a limited set of contraceptive methods, but their autonomy may be compromised if external factors influence their decisions (Sherwin, 2008). So, despite holding decision-making power in the moment of service provision, adolescent migrant girls find themselves presented with limited contraceptive options which might not align with their priorities and preferences, and which might be influenced by their lack of future access.

7.3 Conclusion

The start of this chapter aimed to answer the question, 'To what extent to which adolescent migrant girls' *voices* been included? What are the specific modalities of engagement and inclusion utilised by state and humanitarian actors in their responses to adolescent migrant girls' contraceptive care?' This was achieved through the use of semi-structured key informant interviews with key state and non-state actors involved at various levels of the response to adolescent migrant girls' contraceptive care needs. The reason being, the disparities in health service utilisation in Chapter 5, and the lack of intersectional responses found in Chapter 6, could be understood if actors included and considered adolescent migrant girls' priorities and preferences through mechanisms of participation and inclusion that lead to shared decision-making power. However, this is not the case.

The results, guided by *The Scale of Voice*, have highlighted the limitations in the consideration and inclusion of Venezuelan adolescent migrant girls. Whilst actors saw *voice* as important, some overlooked their responsibilities to enhance it. According to *The Scale of Voice*, the current responses often fall short, ranging from limited *consideration* to instances resembling *coercion*.

Consideration included those actors who took positive steps to include community-based participatory mechanisms to understand needs, such as surveys and questionnaires. However, these actors often recognised that there was a lack of action resulting from this participation. Below this, actors who used indirect methods such as community leaders or staff anecdotes were deemed to include mechanisms of participation and feedback that were *generalisation or manipulation,* because they did not facilitate direct contact with Venezuelan adolescent migrant girls the opinions of girls mainly benefitted actors. Finally, those who did not provide any mechanisms through which Venezuelan adolescent migrant girls participate or feedback were classified as *coercion* because they did not allow for *voices* to be heard. In short, the responsibility for enhancing *voice* is often delegated to local actors. As a result, *voice* is predominantly observed within short-term, community-based initiatives that (re)produce unequal power relations in the decision-making process.

Furthermore, limited options in method choices contribute to environments of constrained agency. The promotion of long-term methods, or the preference for use over non-use led to a lack of full, free, and informed choice. Without access to the opportunities to (not) use a variety of methods, adolescent migrant girls cannot have the tools to realise their contraceptive decisions and risk being in positions where they are unable to change or discontinue a method that they no longer wish to use.

Overall, whilst *voice* is recognised as fundamental, the implementation of genuine mechanisms of participation that give share power, or distribute resources towards, Venezuelan adolescent migrant girls remains rare. Given that few actors were found to include key aspects of *voice*, the next chapter aims to identify the barriers and challenges that actors faced.

Chapter 8 Barriers for Including *Voice* in Colombian State and Non-State Actors' Responses to Venezuelan Adolescent Migrant Girls' Contraceptive Care

The preceding empirical chapters analysed the different mechanisms and modalities through which the three central aspects of *voices* were considered and included in responses to Venezuelan adolescent migrant girls' contraceptive care. Chapter 5 highlighted the inequalities between Venezuelan adolescent migrant girls, Venezuelan migrants of reproductive age, and their peers in the host population. Chapter 6 found that state and non-state actors did little to differentiate their responses to account for the intersections of gender, age, and migration – in turn exacerbating inequalities. Chapter 7 demonstrated a lack of participation in decision-making processes, and the limited opportunities to (not) use a variety of contraceptive methods. The results reveal that each of the central aspects of *voice* has been overlooked in one way or another. Consequently, actors do not consider and include adolescent migrant girls' *voices* in their responses. However, until now the barriers to the inclusion of *voice* have not been explored. This is important in the broader context of this thesis as through knowing these barriers, it may be possible to remove them in order to create pathways to progress towards contraceptive autonomy and RJ for adolescent migrant girls.

This chapter now turns the attention to the challenges and the barriers that affect state and non-state actors' ability to effectively engage with Venezuelan adolescent migrant girls specifically this chapter answers the sub-research question 'What are the key challenges and barriers faced by state and non-state actors in effectively engaging with and considering the *voices* of adolescent migrant girls when it comes to their contraceptive autonomy?'

Through the interviews with key informants, three crucial barriers are identified. First, key informants demonstrated a limited understanding of how to incorporate mechanisms of participation and feedback in responses. This deficiency coupled with a misperception of adolescent migrants as apathetic, further impedes their inclusion in decision-making processes. This means the *voices* of adolescent migrant girls are underrepresented.

Second, the process of collecting, managing, and analysing data is identified as a barrier, leading to insufficient information about the intersectional reproductive realities of adolescent migrant girls. The absence of high-quality data hinders responders from fully understanding the unique challenges and needs of this demographic, limiting the effectiveness of tailored and informed decision-making processes.

Finally, structural factors, of both the health system and the humanitarian response such as the prevalence of short-term and 'urgent' responses, contribute to a prioritisation that side-lines the *voices* of adolescent migrant girls.

As with previous chapters, these findings are analysed in the discussion alongside existing debates in the literature on humanitarian responses, youth participation and reproductive justice. As I discuss, whilst actors, and their responses, continue to decentre and exclude Venezuelan adolescent migrant girls power relations remain unchallenged. Failure to redress power imbalances inevitably creates conditions where adolescent migrant girls have their *voices* unevenly constrained. But, by highlighting these barriers, we can begin to identify potential recommendations on how researchers and practitioners might challenge the status quo (as I do in Chapter 9).

8.1 Findings

8.1.1 Lack of Knowledge and Adolescent Apathy as Mutually Reinforcing Barriers

One major barrier to centring and including Venezuelan adolescent migrant girls' *voices* was the lack of knowledge of appropriate methods of engagement. When interviewees stated that they did not include adolescent migrant girls' *voices* in their responses, they were asked what sort of mechanisms they would like to include if funding or structures would allow. Several participants were unsure of methods or were only able to name one method of participation, as shown by the quotation below,

> 'I'm not sure the best way, it's probably we have to start like low like just making some focus groups, with migrants with Colombians. No, I'm not sure about the mechanisms…' Participant 30, a professional from a not-for-profit service provider.

During the interview, Participant 30 was only able to identify focus groups as a potential source of *voice*. This is unsurprising, given the use of focus groups was one of the most popular methods of including adolescents identified in the findings of the previous chapter. Additionally, the participant discussed the use of participatory mechanisms below, at a 'low' level rather than including avenues for participation at a higher level.

Other challenges noted by participants included difficulties in applying a differential approach to the Colombian population. Owing to the heterogeneity of the Colombian population, it was difficult for them to cater to everybody's unique needs.

> '[I]t's enough of a challenge when we're talking about just one population like an indigenous group.' Participant 14, public health professional.

As a result, the participants felt overwhelmed by the amount of differentiation required to cater to the needs of Venezuelan adolescent migrant girls. Key informants specifically acknowledged the heterogeneity of the adolescent migrant population.

> 'It's not the same thing to think about putting together a response for an indigenous adolescent as it is for an Afro-Colombian, adolescent or for somebody who has been a victim or is a migrant.' Participant 13, a multilateral professional.

When asked about the training they received, key informants stated they rarely received training in adolescent participation and inclusion. Some organisations trained psychologists and health professionals who were providing services on the ground in best practices for specialist issues that would address adolescent migrant girls[63]. However, these largely pertained to SGBV and trafficking that adolescent migrant girls might have experienced *en route*. For the most part, when training was discussed, it largely depended on the role of the individual, as opposed to whether the actor was a state or non-state actor. If they did not play a role which provides services directly to Venezuelan adolescent migrant girls, they did not receive specialist training. Some key informants who belonged to feminist, youth or migrant organisations or institutions were more likely to have had specialist training. Contrary to expectations, there was no mention of multisectoral or multilevel training on implementing participation mechanisms and differentiation in line with national policies or strategies such as MISP or the Ten-Year Public Health Plan.

Another key theme which emerged as a discussion was the idea that adolescents (regardless of gender or migration status) do not want to participate in decisions regarding the response to contraceptive care.

> '[…] However, we know that because of their status as adolescents direct involvement in a health activity, this is not the most attractive thing for them. That's why cultural and sporting events are held that involve health in a certain way, but not as a central focus.' Participant 18, a public medical professional.

For example, Participant 18 claimed that adolescents do not want to participate in health activities because, as adolescents, health activities are not attractive. The insinuation from this participant was that these types of activities are boring or at least lack excitement. One potential solution suggested was the combination of health topics with cultural and sporting events - thereby effectively involving adolescents in health-making decisions. In other words, although participation in health would not be

[63] Participant 2, a professional from a not-for-profit service provider; Participant 6, a professional from a not-for-profit service provider, and Participant 18 a public health professional.

the focus, this would allow actors to establish a relationship with Venezuelan adolescent migrant girls.

The issue of adolescent apathy, at least as perceived by actors engaged in delivering policy and services in response to contraceptive care, was seconded by Participant 11, however, the reasoning behind the apathy was slightly different. This participant stated main challenge,

> '[I]s how to call young people, because many times spaces are opened up, but the same people end up participating. So, the voices that are heard are always the same and they are not necessarily represented in the community in general [sic]. So, there is also an apathy on the part of young people that they don't believe that things are going to change much, … but one can identify very few youth leaders who really want to participate in scenarios… Participant 11, a lawyer from an NGO.

Participant 11 maintains that a select few young people participated in higher-level discussions. For example, Colombia has a *Youth Council* which is the national body designated to fulfilling the participation rights of young Colombians in line with the Statute of Youth Citizenship through Law 1622 of 2013 (Consejería de Juventud Colombia, 2023). However, this does not apply to adolescent migrant girls as non-citizens. Therefore, it does not centre on or include Venezuelan adolescent migrant girls – it exacerbates how the ability to participate in high-level decision-making practices is stratified along the lines of migrant/citizen.

Another important point made by Participant 11, which contrasts with the views of Participant 18, is that in the former the justification for apathy is a lack of belief that participation will influence the decision-making process and lead to transformative change. Therefore, participation is less about being interested and perhaps more about frustration or mistrust that adolescent migrant girls' priorities and preferences will result in positive actions.

In short, both themes highlight the difficulties in interacting with adolescents in a way that is appropriate or effective. Subsequently, there is a tension between perceptions about what adolescents would find interesting and an admitted lack of knowledge of how to attract adolescents.

8.1.2 Data Environment

The collection, management, and sharing of data created a closed environment in which it was difficult to generate evidence-based claims regarding the reproductive realities of Venezuelan adolescent migrant girls.

During discussions with both those implementing the programme and those designing it at a higher level, the issue of gatekeeping data emerged as a prominent theme. Essentially, this theme referred to situations in which the accessibility, quality, and management of data made it challenging to incorporate them into decisions about contraceptive care.

> '[W]hen I sit down actually to think about a project proposal, I can find a handful of case studies or maybe something from focus groups, but there's really, I think, a lack of understanding about the broader context and that ends up contributing to issues it for the visibility of [Venezuelan adolescent migrant girls] …' Participant 2, a not-for-profit organisation providing medical services.

Participant 2 identified two key issues. One issue discussed is the lack of data to create programmes and responses that suit the local context. As aforementioned, Colombia is a large country with a heterogeneous population. Between cities, there are differences in the capacities of the institutions as well as the presence of different organisations. Thus, generalising the reproductive realities of Venezuelan adolescent migrant girls in one city to those in another was futile. This leads to the second issue, which is that there is insufficient information about the situation of Venezuelan adolescent migrant girls. Therefore, to be able to write a nationwide programme based on the focus groups in one locality or that occurred at one specific moment in time, felt insufficient. Participant 2 continued this line of reasoning, highlighting how a lack of research into the needs of adolescents is one of the contributing factors that cause their lack of visibility.

> 'Of course, some of that information gets filtered through these groups like GIFMM, there's no general exercise of research. And I think that that contributes to a lack of visibility for the needs of adolescents.' Participant 2, a not-for-profit organisation providing medical services.

In addition to this, the lack of data sharing between organisations and between different sectors was an issue that arose for those within and outside GIFMM. Smaller organisations felt as though larger organisations or coordination groups did not share data with them[64]. Equally, it became clear that some, but not all of the data collected were shared between organisations within GIFMM.

Another distinction made in this theme was the difference between 'filtering information' and 'doing research'. There was an awareness that organisations produce data which meets their organisational aims. Some organisations publish in peer-reviewed journals and investigate best practices to implement in their clinics. Others operate on a level more akin to monitoring, evaluating, and

[64] Participant 21 and Participant 22, professionals from a charitable foundation.

learning in that they measure indicators pre- and post-intervention to determine the success of their programmes. In each case, the person who collects the data, how it is collected, its intended purpose and who will be expected to act upon the results are all factors which influence the quality of the data produced.

The quality of the data produced was further limited when actors interacted with the heads of households, usually the mothers of adolescent girls, rather than the adolescent girls themselves. Inevitably this meant that some actors had little to no direct contact with Venezuelan adolescent migrant girls altogether.

> 'We're aware of girls of the age of 16 or 17, many of whom are pregnant. […] So, if they haven't access to emergency services yet we tell them how to, but I will say we mostly have contact with their mums not with those girls to themselves, so we don't have very precise data on the adolescent at on the other adolescents we're in communication with mum.' Participant 21, a professional from a charitable foundation.

The lack of direct interaction means that data Is not always reliable, because it is being passed through an intermediary. As a result, actors are unable to gather 'precise data' on adolescent migrant girls. Given the sensitive nature of contraceptive care, there are concerns that passing such information through adolescents' parents may not fully capture the true nature of adolescent migrant girls' experiences or their opinions. Filtering adolescents' experiences and opinions through their parents can also compromise privacy and confidentiality. Because there is no standard practice for speaking to adolescents directly or for reporting data collected through parents it is difficult to know which data has been collected through directly speaking to adolescent migrant girls and which comes from the communication with their parents. This means that actors cannot fully understand the priorities and preferences of adolescent migrant girls or their intersectional reproductive realities.

8.1.3 Structural Barriers to Including *Voice*

In line with the findings of previous chapters, it was clear that (ir)regular migrant status largely determined the ability to access conditions where contraceptive autonomy might be fulfilled. This result was also one of the challenges to including Venezuelan adolescent migrant girls' *voices* in their responses. In this theme, key informants emphasised that *voice* was as exceptionally difficult to fulfil because migrants are not a part of the structures which influence matters relating to their health.

> 'I think it's very important. But the issue there is the system itself. I think especially when we're talking about migrants, if they have irregular status, they don't have many

> possibilities to use their voice or to access health in general. So as fundamental as that is as a need it is the system itself that doesn't allow it to be fulfilled.' Participant 22, a professional from a charitable foundation.

Participant 22 underscored the structural barriers that impede their ability to receive essential healthcare. Beyond that, they identified a lack of opportunities for Venezuelan adolescent migrant girls to express their opinions and feelings through participation or feedback mechanisms. For, one would imagine that if Venezuelan adolescent migrant girls could partake in discussions about their health and influence them in any meaningful capacity, they would not choose to exclude themselves. Furthermore, the absence of accessible SRH care, particularly contraceptive care, is a clear indicator that the *voices* of adolescent migrant girls, especially irregular migrant girls do not have a variety of opportunities to (not) use a contraceptive. This finding builds on those from the previous chapters that have continually shown that irregular migrants have had greater difficulties in accessing services. In doing so, it demonstrates how inaccessibility is often a result of legal and administrative restrictions placed on migrants in comparison to the host population.

These challenges can be viewed as symptoms of issues built into the health system. For example, as Participant 17 states, the decentralised health system and financial independence of hospitals and health centres meant that decision-making was largely influenced by resource management and budgetary constraints.

> '…[Y]ou need to understand that hospitals really function as autonomous businesses in this country and so they're always focused on resources. They're always afraid of bankruptcy and remaining solvent so managers in hospitals, for better or for worse are always focused on resources coming in. Participant 17, a professional from a multilateral organisation.

Operating in a resource-constrained environment meant that ensuring contraceptive autonomy through *voice* was not high on the agenda of managers of individual health centres. As a reminder, hospitals are reimbursed by the Ministry of Health for providing emergency treatment to non-affiliated persons, in line with the law[65]. However, this does not cover primary care, and there is no legal mandate to provide contraception. So, from a purely financial perspective hospitals and health centres have no incentive to provide contraceptive care or to listen to people who are not patients (or customers) of that health centre[66]. The challenge to including *voice* here is that each role in the system is designed to serve a purpose: the manager to oversee costs, the medical staff to deliver care, the central government to design policy and allocate public funds and patients to pay health

[65] See discussion of Circular No.25 of 2017 in sub-section 4.3.2 of Chapter 4.
[66] Participant 18, a public medical professional.

insurance (or subscribe to the subsidiary health insurance scheme – SISBEN). Meanwhile, there is no designated body to implement the conditions in which participation, feedback and *voice* could be fulfilled for adolescent migrant girls. Instead, *voice* remained outside the established framework of healthcare and social protection.

Like the health system, non-state humanitarian aid, development, and charitable organisations faced barriers to including the *voices* of Venezuelan adolescent migrant girls in their responses. The most commonly discussed challenges were related to the activities they were permitted to do by donors; reminiscent of the barriers to intersectionality and types of participation discussed in the previous chapters of this thesis. When stating the barriers to *voice*, interviewees often circled back to the inability to receive funding, as exemplified in the quote from Participant 30.

> 'But you have to understand that when it comes to SRH within the framework of humanitarian response, there are limitations to financing many people do not consider sexual reproductive health a priority within humanitarian response and so that restricts funding. So, if we want there to be funding, for example, for contraceptives for things like HIV and AIDS or involuntary termination of pregnancy, there are gigantic barriers to access because of the funding we receive.' Participant 30, a not-for-profit service provider.

The funding received was earmarked for specific activities, with little scope for activities that involved developing environments for autonomy-enhancing conditions or establishing longer-term relationships to build trust and share experiences. One of the key difficulties in implementing *voice* was the perception of donors from above that investing in contraceptive care was not a worthwhile endeavour for donors to undertake.[67] Unsurprisingly, this lack of prioritisation of contraceptive care carried over to the *voice* of adolescent migrant girls in contraceptive care.

In short, structural challenges were identified in the health system and the humanitarian aid responses. The health system, concerned with the provision of healthcare to customers or patients who paid insurance in a way that ensured they continued to make a profit, left no room to engage in activities or with populations that did not serve this purpose. In addition, the structure of charity or aid delivered through humanitarian and development initiatives was focused on short-term emergency aid leaving little to no space for *voice*. Within these structures, actors operated on a limited capacity where *voice* was not seen as valuable as other interventions which provided more tangible outcomes.

[67] Participant 20, a professional from an NGO providing education.

Overall, the findings show that the main challenges to including the *voices* of Venezuelan migrant adolescents in contraceptive care responses are the structure of the health system and the lack of effective methods of engaging with migrant adolescents. Where there is political will to include adolescent Venezuelan migrant girls in their health responses, there is a lack of knowledge about the most appropriate and effective means of doing this. Some key informants noted apathy on the part of adolescents in general and took the position that adolescents were choosing not to participate in decisions about their health. In addition to these, there was a lack of overall data-sharing between actors working with migrant adolescent girls. Specifically, issues arose around the quality and quantity of accessible data, as this prevented actors from generating firm conclusions.

In summary, the results demonstrated that the structures of the health system and the humanitarian response have limited the opportunities to consider and include the *voices* of adolescent migrant girls. The limited capacity of the health system and continued focus on access to healthcare mean that there is no designated body to deal with the participation of Venezuelan adolescent migrant girls. Regarding the humanitarian responses, given the crisis-driven approach to responses, donors did often not fund activities that included elements of *voice.* Consequently, actors responding to the Venezuelan migration crisis did not prioritise intersectionality, participation, feedback or opportunities to (not) use a variety of contraceptive methods.

8.2 Discussion

So, what is preventing actors from including *voice*? The findings from this chapter so far, have highlighted three barriers: i) the lack of knowledge and misperception of apathy; ii) the data environment and iii) wider structural issues with the public health and humanitarian aid systems. Identifying these barriers is essential in understanding the reasons actors do not include or consider adolescent migrants. Identifying these through *The Scale of Voice*, and wider discussions of participation, contraceptive autonomy, and RJ, is essential to understand these barriers in the context of wider structural imbalances. Identifying the barriers is thus a crucial stepping stone to be able to redress structural power imbalances and wider reproductive injustices.

8.2.1 Lack of Engagement Between Actors and Adolescent Migrants Girls

Previous research and experience suggest a connection between the two issues: inappropriate methods of participation, stemming from neglect or lack of knowledge, and adolescent apathy. Key informants often perceived adolescents as apathetic when it came to engaging in health-related activities. However, there were varying perspectives on the underlying reasons that key informants believed might contribute to this apathy. Some attributed it to a lack of interest in health-related

topics, while others pointed to a lack of confidence that their participation would lead to meaningful change.

Scholars on youth participation call for actors to challenge their assumptions about youth involvement as a first step (Checkoway and Richards-Schuster, 2004; Cook, 2008; Villa-Torres and Svanemyr, 2015). In this case, it requires challenging the assumption that all adolescents are apathetic to participation in SRH.

Given that existing evidence shows that Venezuelan women in Colombia have specified a need for AFHS and greater access to contraceptive methods, it is hard to fathom that Venezuelan adolescent migrant girls would be apathetic to involvement (Profamilia, 2019; Flórez García *et al.*, 2020). Instead, it is more reasonable to suspect that the mechanisms of participation are not appropriate for the situation. That is, it is not that adolescents lack interest in involvement because it is unattractive. Instead, the manner in which individuals attempt to engage Venezuelan adolescent migrant girls on the topic of contraceptive care or health in general, makes it challenging to establish meaningful connections. Those such as O'Toole, (2003) have warned against equating non-participation with apathy.

Several studies have shown that marginalised populations such as migrants or indigenous groups display apathy towards culturally inappropriate mechanisms of participation (Macpherson, 2008; Teufel-Shone *et al.*, 2011). It has been argued that it is more productive to change existing structures to fit people's participation rather than changing people's participation to fit existing structures (Skidmore, Bound and Lownsbrough, 2006; Lister, 2007). When actors restrict ways and spaces in which marginalised groups can participate, individuals are 'put off' participating or refrain from expressing their views due to discomfort or fear (Lister, 2007). Similar struggles have been noted for adolescent populations because community participation has been historically viewed as a predominantly adult activity (Macpherson, 2008). As such, the mechanisms of *voice* used in the Venezuelan migrant response can be predominantly seen through an 'adult lens'.

The Scale of Voice requires positive actions to be taken by actors to provide a range of ideas which would enable adolescent migrant girls to express their views openly and confidently. This idea builds upon existing theoretical and policy frameworks of adolescent participation, actors should provide a diverse array of opportunities and mechanisms for adolescents to engage with health-related matters, both in formal and informal settings, catering to a range of interests (Shier, 2006; Ministerio de Salud, 2022b). The need for innovative approaches to including *voice* is one of the reasons that so many practitioners who adopt methods of youth participation focus on creative methods or peer education systems which challenge the dominant 'adult worldview' (Buthelezi *et al.*, 2007;

MacDonald *et al.*, 2011). It is important to steer clear of standardised pragmatic approaches which can be insensitive to other cultures and perspectives (Morgan, 2001). However, if such opportunities are lacking, it may be necessary to re-evaluate the existing mechanisms and explore more diverse and creative solutions.

Since RJ and youth participation models encourage challenging hegemonic norms, it seems fitting to reframe this challenge. Rather than assuming adolescents are not interested in participating in SRH interventions, we could instead ask if actors are interested in reshaping traditional structures of responses so that adolescent migrant girls are given a chance to engage. For example, interventions with adolescent migrant girls have been found to largely focus on risk prevention in sexual behaviours such as the prevention of STIs including HIV/AIDS or prevention of adolescent pregnancy (Buthelezi *et al.*, 2007; Cook, 2008; Taggart *et al.*, 2016; Simuyaba *et al.*, 2021). As a result, interventions do not positively develop skills or understandings of adolescents' own sexuality or healthy relationships (Haberland and Rogow, 2015). What if actors find ways to discuss SRH positively? What effect does this have on engagement?

Without new modes of engagement, actors risk creating a self-fulfilling prophecy, where the belief that adolescent migrant girls are not interested in being included in mechanisms of *voice*, means there is no effort to establish or develop appropriate mechanisms of *voice*.

8.2.2 Selectivity in Evidence-Based Responses

The production, collection, and utilisation of data posed challenges to the key informants. Appropriate and reliable data is needed to adequately differentiate responses according to needs and to implement mechanisms of *voice* that match the intersectional reproductive realities of adolescent migrant girls. Policymakers and health practitioners, including humanitarian actors, need data to design informed programmes and strategies.

One of the most common issues identified in this study was that data is not adequately disaggregated. When data is only presented in aggregated form, it becomes challenging to identify and address specific issues that affect certain subpopulations. As Enloe, (2004) notes in her articulation of the concept of 'womenandchildren' homogenising women and children into one group obscures women as independent from their role as mothers. In this context, the reverse is also true – the absence of data collection specifically related to mothers prevents us from viewing adolescent girls as independent individuals separate from their roles as daughters. Aggregated data collection makes it harder to understand the ways that gender, age, and migration intersect. Therefore, it is difficult to determine the impact of migration on different population groups (Ahmad-

Yar and Bircan, 2021). In this sense, actors cannot provide genuinely intersectional responses that account for complex reproductive realities. Without disaggregated information, it is more difficult to understand how interventions reach different subpopulations (Larrea-Schiavon *et al.*, 2022). Previous research has attempted to view intersectional identities as additives, but such work can be criticised for depoliticising intersectionality as it fails to account for how different social locations reciprocate to form new types of oppression (Collins, 2015). It also goes against the pillars of RJ: that responses should centre the most marginalised, and that such responses should consider how structural forces have shaped individual choice (Solinger, 2005).

Lack of data makes groups or situations invisible and hence it masks their reproductive realities, priorities, and preferences. Actors are unlikely to provide responses without evidence for need so these groups, and issues remain unaddressed assuring SRH inequalities. Looking at data collection related to contraceptive care in the Venezuelan migrant crisis reveals colonial narratives of disempowered women' (Senderowicz and Maloney, 2022, p. 690). This is because they impose metrics and indicators without considering their reproductive realities. The previous chapter demonstrated the measures to administer targets and key performance indicators can be damaging because they encourage providers to favour certain types of methods which can damage the extent to which choices are free. To elaborate, where responses primarily focus on access through targets like 'unmet need' or 'number of persons who attended a workshop' there is no information about the priorities or preferences of adolescent migrant girls which could be used to help inform responses. As Senderowicz and Maloney, (2022) note in their discussion of 'unmet contraceptive need' the greatest weakness is the inability to determine women's (and here including girls') preferences. By assigning women an unmet need based on researcher-perceived discordance between their reproductive desires and contraceptive use, rather than asking women about their contraceptive needs and preferences, this approach to measurement treats women like they are voiceless or that their own perceptions of their needs are not to be trusted.

The findings from this thesis highlight the lack of disaggregated data on adolescent migrant girls' contraceptive care needs. The exception to this is the monitoring of and efforts to reduce the incidents of SGBV, and adolescent pregnancy rates. Nandagiri, (2021) has argued that goals like these which are tied to fertility reduction instrumentalise contraceptive use in a way that directly contests individual autonomy. Furthermore, such approaches position access as the solution to deal with the 'problem' of adolescent pregnancies, rather than reframe adolescent pregnancy not as a social problem but as a result of structural inequality and/or as a life stage in the same way it is for older women (Hans and White, 2019). In essence, the current data collection practices cannot capture the nuances of personal experiences. Without addressing this gap, we cannot reasonably expect actors

to understand how to respond effectively to the intersectional reproductive realities of adolescent migrant girls. Therefore, it is crucial to be vigilant not only about the subjects of data collection but also about the validity of the methods employed and the underlying purpose they serve.

The participants in this study noted that there was a limited evidence base of focus groups or services available from which to design responses. Findings from the interviews found that this was often worse for smaller less well-known actors who sit outside of groups such as GIFMM, but who still work closely with the Venezuelan migrant population. This is reminiscent of some of the methodological challenges I faced in collecting secondary data for Chapter 5, such as the inconsistencies in the questions used to assess the health and needs of migrants. This lack of universal standards in data collection methods results in data that cannot be readily compared over time or between different groups. As noted by Colombo and Checchi (2018, p. 216), health authorities and humanitarian agencies spend large amounts of time collecting situation analyses, needs assessments, project proposals, routine activity data, surveillance data, and internal reports. Yet, the majority of these are not standardised or not published so they are not able to be used by external stakeholders, who may well have benefitted from such information. Or, that data from some organisations is less ethically and methodologically sound. As a result, research can end up in cluster information bubbles where the data from different clusters is fragmented and misaligned (Comes, Van de Walle and Van Wassenhove, 2020). The creation of information bubbles led to further difficulties in accessing and making sense of information from other organisations. Consequently, the collection and sharing of data between state and non-state actors occur in isolated bubbles at different levels and across sectors. This fragmentation makes it challenging to obtain a comprehensive view of the evidence base and creates difficulties in creating multilevel and multisectoral responses.

8.2.3 *Voice* is Not a Priority

The two specific issues of methods of engagement and the data environment can be seen as symptomatic of a third, more abstract issue which key informants highlighted. Namely, that *voice* is not a priority, because actors are primarily focused on providing access to contraceptive resources.

Key informants interviewed suggested there was no possibility of providing mechanisms of *voice* because the limited resources meant that there was never enough capacity for health authorities or humanitarian aid agencies to go beyond the provision of emergency needs, especially in the case of irregular migrants. This approach manifested differently in the public health system and the humanitarian response. As the key informants here noted, limited capacity in the health system

means that the health centres are focused on remaining solvent. On the other hand, humanitarian aid responses were focused on the provision of emergency needs.

One key assumption here is that anything beyond the narrow focus on technical interventions that are 'cost-effective' is seen as a burden. Such assumptions can be seen as a conceptual barrier which is embedded in the structure of the humanitarian response. This assistance is intended to address immediate needs and is not geared towards delivering comprehensive care or delving into the underlying causes of inequalities (Smith, 2019). Justification of such a narrow scope can be found in claims that investing in health systems through training staff or building health facilities is not 'cost-effective' or that doing so will create a health system that is dependent on the international community (Redfield, 2005; Farmer, 2020). As Redfield, (2005) notes, the issue is not so much the crisis but the codification of the crisis into an action which limits the actions taken.

Another issue is that between the health and social protection authorities and humanitarian aid organisations, there is no single actor primarily concerned with ensuring that adolescent migrant girls' *voices* are heard. Consequently, actors were not held accountable for their actions through systems of checks and balances. For state actors, the decentralised nature of the Colombian healthcare system means the central government lacks the authority to dictate resource allocation within local administrations (Selee and Bolter, 2021). As a result, they are unable to enforce soft legislation. Further, irregular migrants are not able to hold state authorities to account in the same way as members of the host population, due to their lack of citizenship (Abji and Larios, 2020). In a similar vein, local implementing humanitarian actors are simultaneously outside of state control and without accountability mechanisms like user satisfaction to which most other organisations are held (Harrell-Bond, 2002). As such, non-state actors remain accountable to the international donors who fund and determine their actions.

Currently, actors justify the lack of mechanisms for *voice* through an emphasis on short-term, technical fixes, which focus on disease and risk rather than access to comprehensive contraceptive care. For, they rationalise, it does not make sense for adolescent migrant girls to be invited to make decisions about services that they are not able to use. Thus, *voice* requires moving beyond surface-level, short-term access. It requires genuine commitments to comprehensive solutions which tackle asymmetrical power relations. Concentrating on access to resources continues to emphasise 'quick-fix', technical solutions which detract from the fact that technical solutions require political decisions about who should be consulted, what policies should be implemented and how they should be enforced (Davies and Wenham, 2020).

Through the lens of RJ, it is clear that the decision not to include mechanisms of *voice*, for whatever reason, is inherently political because it assures asymmetrical power relations. This is directly opposed to *The Scale of Voice* and by extension contraceptive autonomy and RJ, which are united in their understanding that power must be shared with the most marginalised groups who are often made invisible by these dominant structures. As the reader will recall, without listening to the most marginalised, RJ cannot be achieved (Solinger, 2005; Ross, 2018). Likewise, ignoring the perspectives of marginalised girls during crises can (re)produce situations of vulnerability and marginalisation (Hajisoteriou, Karousiou and Angelides, 2021; Kusumaningrum, Siagian and Beazley, 2021; Potts, Kolli and Fattal, 2022). Thus, keeping migrants excluded from participating reinforces that migrants are 'not deserving' of rights or that they 'drain resources' from public institutions. Equally, downplaying the contraceptive care needs of adolescent migrant girls conforms to the idea that adolescent migrant girls do not have the capacity to shape or partake in decision-making about their health and that health providers, policymakers, and international donors 'know best'. For *voice,* contraceptive autonomy and RJ to be realised, Venezuelan adolescent migrant girls need to be positioned as experts in their reproductive realities.

8.3 Conclusion

This chapter aimed to identify the key challenges and barriers faced by state and non-state actors which prevent them from engaging with and considering the *voices* of adolescent migrant girls from Venezuela in Colombia. It asked, why there was a lack of positive responses to differentiate for the intersectional reproductive realities of Venezuelan adolescent migrant girls. Why were there limited or only partial attempts to ensure the participation of Venezuelan adolescent migrant girls in decision-making processes? Finally, why was there often a lack of opportunity to (not) use a variety of contraceptive methods?

The results highlighted three fundamental challenges to including *voice*: lack of knowledge of appropriate methods, the data environment, and finally, the structure of the state and humanitarian responses.

One major challenge highlighted was the lack of ideas or knowledge on how to utilise mechanisms of participation. The lack of knowledge of methods of differentiation, I anticipated was related to the perceived apathy that both state and non-state actors held. In the sense that, traditional adult-centric mechanisms were not appropriate for adolescents who felt that these mechanisms did not centre their reproductive realities. This disinterest reinforced the idea that Venezuelan adolescent migrant girls did not want to participate in decision-making processes. The need to clarify such

matters is important given that the belief that adolescents are apathetic could justify the continued lack of investment in developing appropriate mechanisms to include adolescents.

The second major challenge was the data environment. Key informants' maintained that the lack of accessible data, and the low quality of that data that did exist, made it difficult to develop evidence-based responses. These findings are crucial to the research question, revealing that adolescent migrant girls and their contraceptive care are not considered a group worthy of focus in their own right; making it difficult to identify their specific contraceptive care needs accurately. Where data was available, its production, collection, and utilisation posed challenges to the key informants, especially where data was collected or published selectively so that it only represented improvements in one-off access and resources. As data was often the property of individual organisations, the selectivity of data raised issues for transparency and data sharing.

Both these former issues were discussed in conjunction with wider complaints about the lack of space for *voice* within the wider structures of the response. Key informants felt that *voice* was not possible due to the demands of the structure. Views of *voice* as below or additional to access to resources responses were discussed in relation to structural power relations. Thus, resource-centric solutions forewent any opportunities to invest in structural issues such as intersectionality or comprehensive contraceptive care which would enhance the autonomy of adolescent migrant girls.

Through the lens of RJ, these barriers are not just procedural limitations but symbolic of a broader issue – the reproduction of power imbalances stratify *voice* along the axis of gender, age and migration. I contended that the omission of mechanisms of *voice* in responses for adolescent migrant girls is an inherently political decision as it foregrounds surface-level interventions based on solving risk-averse, disease-based problems. This, in turn, prevented any further commitments to comprehensive care or that meaningfully redressed power relations. In short, they lacked elements of transformative change, instead (re)producing power dynamics that leave state and non-state actors determining the conditions under which adolescent migrant girls can make and realise decisions about their contraceptive care.

Chapter 9 Recommendations and Implications for the Inclusion of Adolescent Migrant Girls' Voices in Colombia and Beyond

9.1 Summary of the Findings

The central claim of this thesis is that state and non-state actors create conditions which constrain Venezuelan adolescent migrant girls' contraceptive autonomy. Firstly, responses overlook intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration), doing little to address inequalities in service utilisation. Secondly, they do not provide mechanisms of participation and feedback which redress power imbalances in decision-making power. Finally, opportunities to (not) use a variety of contraceptive methods are shaped by short-term, one-off interventions. These promote limited methods or the inability to (re)negotiate method use providing conditions of constrained agency as opposed to conditions which were autonomy-enhancing. Having drawn attention to the previously hidden modalities of constraint and exclusion, I advocate for a greater need to provide responses that centre and include adolescent migrant girls through intersectional, participatory and comprehensive responses.

To reach this argument, this thesis began adopting a RJ approach to investigate the state and non-state actors' responses to adolescent Venezuelan migrant girls' contraceptive care in Colombia. The rationale explained how the ability 'to decide the number and spacing of children' and the 'right to be heard' were central tenets of SRHR and child rights frameworks. I noted these were absent given the intersectional reproductive challenges faced by marginalised adolescent migrant girls, who experience multiple disadvantages of youth, women/girls, and non-citizenship. By extension, I adopted the RJ concept of contraceptive autonomy which requires an intersectional approach to ensuring people have the conditions to make a full, free, and informed choice and then realise those choices (Senderowicz, 2020). Understanding that these intersecting axes of oppression give some groups less freedom to choose how they use (or do not use) contraceptive methods, I asked to what extent actors consult, listen to, and include the *voices* of adolescent girls in decision-making processes.

The review of the literature demonstrated current responses often neglect and inadequately account for these distinct reproductive realities. Instead, service providers, policymakers, and donors are repeatedly framed as 'knowing best' focusing on technical risk-averse disease-based solutions whilst adolescents and women in the Global South are frequently seen as passive recipients or 'undeserving' of care comprehensive intersectional care. These technical responses have been found

to assume or misunderstand marginalised groups' experiences so that they inadvertently perpetuate SRHR inequalities (Solinger, 2005; Ross, 2018). Where the autonomy to make contraceptive choices is discouraged, this contributes to a lack of reproductive freedom, dignity, and respect; compromised socioeconomic opportunities; hindered psychosocial development; elevated mortality or morbidity rates, and the potential for causing further harm. Following this logic, if migrant adolescent girls are not included in the decisions about their bodies, for example through contraceptive care, then actors risk reproducing further (reproductive) inequalities and injustices.

To explore this in relation to adolescent migrant girls, this thesis developed a new conceptual framework to help address what is still missing in current research, that is, how humanitarian actors consider and include adolescent migrant girls in programmes and responses regarding contraceptive care. To this end, I introduced *The Scale of Voice*, a framework that identifies modalities of inclusion in contraceptive care decision-making, drawing from and contributing to existing debates about RJ and youth participation models. I drew on Senderowicz's (2020) concept of contraceptive autonomy because it highlights aspects which are often overlooked in the traditional access-focused, risk-averse, technical responses. As such, I also noted that this concept could not be applied to adolescent migrant girls because it focused on a binary understanding of autonomy. This means that autonomy was either present or absent, leaving little room for nuance. This stood in direct contention with the relational view of 'evolving capacities' espoused by child rights frameworks and youth participation scholars, who saw autonomy rights as slowly accrued over time. Therefore, I combined the concept of contraceptive autonomy with Arnstein's *Ladder of Citizenship Participation* (1969), subsequently developed by Shier (2001), to focus on the role of actors and institutions. As a result, the *scale* presents a more relational understanding of contraceptive autonomy. The development of *The Scale of Voice* is timely because as Villa-Torres and Svanemyr (2015), stated the body of literature which looks at co-production, participation and inclusion for young people has yet to interact with the body of literature on SRHR or RJ. The conceptual argument is novel in that it bridges the gaps in the literature on contraceptive autonomy and youth participation. As a result, I proposed that state and non-state actors who included adolescent migrant girls' voices in their responses would have a greater capacity to realise their SRHR by addressing the specific reproductive realities of those who experience intersectional disadvantages as adolescents, migrants, *and* girls.

This scale examines three central pillars of consideration and inclusion in order to achieve *voice*: a) differentiation for intersectional experiences of age, gender and migration b) participation and feedback, and c) opportunities to (not) use a variety of contraceptive methods and the implications for contraceptive autonomy. Intersectionality was a key focus because it foregrounds the notion that the ability to choose and realise one's choice is shaped by intersectional axes of privilege and

oppression. Hence, intersectionality has been central to understanding the reason adolescent migrant girls have historically been excluded from responses. Mechanisms of participation and feedback were adapted from literature on youth participation and on migrants' SRH (Arnstein, 1969; Shier, 2006; Villa-Torres and Svanemyr, 2015). Furthermore, the component opportunities to (not) use a variety of contraceptive methods were derived from the principles of full, free and informed choice as articulated by Senderowicz (2020). The creation of this *scale* means that reproductive justice can be expanded to include adolescents or other groups which may lack capacities to make fully autonomous decisions. Further, it highlights previously hidden power relations to understand how adolescent migrant girls are or in most cases are not, centred and included in responses.

The research objectives included the development of qualitative empirical evidence on contraceptive education and resources. In accordance, the empirical argument focuses on how these concepts play out in the case study of Venezuelan adolescent migrant girls in Colombia. To do this, I used a mixed methods approach to understand the existence of disparities in contraceptive service provision, how actors recognised the need for differentiated contraceptive care and the barriers that hindered the inclusion of adolescent voices. I will now present a summary of the research questions, methods of data collection, key findings and discussion points.

Chapter 5 focused on the research question 'Are there inequalities in access to contraceptive-related services by age, and nationality for women and adolescent girls of reproductive age in Colombia?' To answer this, it looked at quantitative health utilisation data sourced from the Ministry of Health and Profamilia on service provision related to reproduction. The overall chapter demonstrated absolute and relative inequalities in access to services related to reproduction compared to the host and adult migrant population of reproductive age. There were four key findings that contributed to this conclusion. One of these findings was the inequalities in the utilisation of contraceptive-related care between Venezuelan migrant and host populations, with a more pronounced inequality observed in the age group of 15-19 years old. I subsequently determined a greater proportion of Venezuelan migrants opt to use LARCS or do not use any contraceptive methods at all, whereas Colombian women and girls tend to opt for shorter and mid-term contraceptive methods. Conversely, in the Profamilia data, where we would expect more sustained access to contraceptive care for migrants without affiliation, the proportion of Venezuelan migrants using LARCs was less, and the proportion using shorter, and mid-term contraceptive methods was higher. Where access was available utilisation data indicated they did not have sustained contact with Venezuelan adolescent migrant girls largely focused on partial, one-off interventions akin to *manipulation*, or *coercion.* Overall, the disproportionate inequalities in contraceptive care for Venezuelan adolescent migrant girls suggested that actors are not currently meeting the intersectional contraceptive care needs of the

adolescent Venezuelan migrant population. Instead, actors overlook the fact that responses might be inappropriate or even harmful to marginalised groups, depending on their experiences. Without taking positive actions to match the intersectional reproductive realities of Venezuelan adolescent migrant girls, actors continue to disregard their priorities and preferences.

Chapter 6 sought to understand 'How have actors acknowledged and enacted the need for differential contraceptive care services for adolescent migrant girls?' It used multi-perspective key informant interviews to examine differentiation in responses considering the needs of adolescent migrant girls, and the implementation of strategies such as disaggregated data and adolescent-friendly, migrant-inclusive services. To analyse the findings, I explored how actors considered the intersectionality of age, gender, and migration in *The Scale of Voice*. The results and discussion confirm my suspicions from Chapter 5, revealing a lack of intersectional responses that consider gender, age, and migration. Responses are predominantly shaped by migrant identity, with public health actors focusing on regularisation schemes, which are difficult to navigate. Humanitarian actors often saw differentiation as a component of responses that actors could deprioritise for 'later'. They preferred instead to respond to the elements of SRHR that were 'urgent'. As a result, the SRHR became fragmented with elements such as contraceptive care being deprioritised. This partial access was determined to be *manipulation*, on *The Scale of Voice*, because more often than not views were not respected, and Venezuelan adolescent migrant girls did not have the means to realise their contraceptive decisions. Equally, adolescent migrant girls as a marginalised population were often left out of the responses or had their realities *generalised* to those of the Venezuelan population so that they were viewed as migrants but not adolescents. That is, actors often failed to account for the unique ways in which age, gender, and migration interacted.

Chapter 7 asked 'To what degree have adolescent migrant girls' voices been included? What are the specific modalities of engagement and inclusion utilised by state and non-state actors in their responses to adolescent migrant girls' contraceptive care?' Drawing on the same interviews, it similarly applied The *Scale of Voice,* to illustrate the ways in which mechanisms of feedback and participation, as well as the opportunity to (not) use a variety of contraceptive methods were present in responses. The findings highlight how adolescents were partially listened to by some actors in given moments. *Voice* was acknowledged as fundamental, but it rarely influenced the outcome of response design and implementation. According to *The Scale of Voice,* current responses are limited to the level of *consideration* and in some cases are as low as *coercion*. This is because responses rarely include the direct participation or feedback of adolescent migrant girls in their design and implementation. More tellingly, it demonstrated that actors often used mechanisms of *voice* to their own benefit, rather than appealing to the 'evolving capacities' of adolescent migrant girls. In that

sense, participation did not always come with influence and structural factors were often unchanged by mechanisms of *voice*. Regarding opportunities to (not) use a variety of methods, limited service offerings and claims that 'LARCs are better' means actors create conditions where adolescent migrant girls exercise agency under constrained conditions, rather than full, free, and informed choice required for autonomous decision-making.

Chapter 8, answered the sub-research question, 'What are the key challenges and barriers faced by state and humanitarian actors in effectively engaging with and considering the voices of adolescent migrant girls when it comes to their contraceptive autonomy?' Drawing on the interviews with key informants I identified the main reasons why voice has not been (fully) included and their responses. Key informants cite a lack of knowledge, perceived adolescent apathy, insufficient data quality, and structural factors favouring short-term, 'urgent' responses as barriers to implementing components of *voice* in their responses. Presenting this evidence, I discussed how the omission of mechanisms of *voice* is a political decision that prioritises surface-level interventions and maintains the status quo. Consequently, both state and non-state actors avoid mechanisms that would redress power imbalances and SRH inequalities. Without *The Scale of Voice* to cast an RJ lens on these structural barriers, responses will continue to perpetuate agency over autonomy, and reproductive injustices over RJ.

Having demonstrated how I answered each research question, I will now articulate the implications of this research and provide recommendations.

Implications and Recommendations for Contraceptive Autonomy in Adolescent Migrant Girls in Humanitarian Settings

Due to the conditions imposed by state and non-state actors, the existing responses to adolescent migrant girls' contraceptive care fail to align with the principles of *voice,* contraceptive autonomy, and RJ. In accordance with the key pillars of *voice:* intersectionality, participation, and opportunity (not) to use a variety of contraceptive methods, and the challenges identified in implementing these – this section offers three sets of implications and recommendations, based on the findings above.

Firstly, age needs to form an essential part of responses to ensure they are truly intersectional. As such, we can see how RJ directly challenges traditional humanitarian approaches, characterised by the 'tyranny of the urgent'. Intersectionality needs to be present from the beginning of responses. If this is not the case, then adolescent migrant girls will not be included in the response, perpetuating reproductive injustices.

Secondly, working towards RJ requires reshaping how *voice* is conceptualised. As long as actors are driven by metrics which reflect disease-based and risk-averse, then *voice* will be considered less of a priority. This calls for a need to develop indicators which measure aspects of *voice*, such as participation and the impact this has on 'evolving capacities'.

Thirdly, the limited opportunity to (not) use a variety of contraceptive methods needs to be considered in terms of the discourse on marginal women, to reveal how external pressure to use LARCs over other methods exerts forms of reproductive control, limiting the contraceptive autonomy of adolescent migrant girls. Overall, using *The Scale of Voice* has enabled us to see how actors' responses have created space for autonomous and nonautonomous contraceptive decision-making.

By highlighting the ways in which adolescent migrant girls have, and have not, been considered in responses we can identify recommendations to redress power imbalances so that actors create responses that align with their priorities and preferences. These recommendations encourage responses to overcome current ways humanitarianism paradoxically affects claims to RJ, by appealing to 'urgent', short-term care, whilst deprioritising central components of *voice*.

9.1.1 Intersections of Age, Gender, and Migration

I have highlighted intersectionality as a central component of *voice*. This was because the application of intersectionality to RJ has been essential for understanding that biomedical, 'technical', access-based paradigms have not been emancipatory for all groups. Rather groups who suffer multiple axes of oppression are less likely to be afforded contraceptive autonomy. This section outlines how the findings, summarised above, have implications for how we come to know, and respond to, the reproductive realities of adolescent migrant girls in crisis settings considering the intersections of age, gender, and migration. The findings of this thesis demonstrated that actors do little to address intersectionality. Instead of holistic responses, they favour selectivity responding to specific care needs in the population in general.

Throughout this thesis, the findings have shown how state and non-state have disregarded the impact of age, gender, *and* migration in shaping their contraceptive care responses. In Chapter 5 I demonstrated that in this case study, there are wide-ranging inequalities between the host population and the migrant population in access to health services related to reproduction. These are markedly worse when looking at older adolescents (aged 15-19). Chapter 6 showed that these disparities were mirrored by state and non-state actors' discussions of responses. State responses considered and made limited steps to include Venezuelan migrants in the public health system, but these often failed to consider how migration, age and gender shaped reproductive realities.

Meanwhile, a small minority of non-state actors were able to provide care that was sensitive to the needs of migrants or adolescents. For the most part the sector often deprioritised intersectionality, in favour of short-term, one-size-fits-all approaches. In Chapter 8, the lack of data available on this subpopulation was noted by participants as one of the challenges to inclusion. Overall, using *The Scale of Voice* actors' lack of differentiation meant that responses did not enhance contraceptive autonomy beyond *passively listening*, because they took no positive actions to mitigate these inequalities or barriers. Actors who only provided emergency care discourage contraceptive autonomy even further, to level *manipulation,* by making access to contraceptive care conditional.

From a policy perspective, this goes against the guidance provided in normative frameworks which asks that they consider the situations of vulnerability that adolescent migrant girls often find themselves in. As noted in Chapter 4, the Nairobi Summit demonstrates that elements of intersectionality such as age have been considered as essential to the realisation of SRHR. These commitments included international obligations to be responsive to 'powerlessness' (ICPD PoA 1994) or, to acknowledge forms of intersectional discrimination and differential needs (the New York Declaration 2016) or the adolescent-friendly, gender and differential approach of national frameworks. They overlook key principles of the UNCRC such as the 'principle of the best interests of the child' as well as specific rights such as the right to healthcare and the right to participate in decisions affecting one's health. As such, responses overlooked the duties to protect adolescent migrant girls. However, the policy analysis also revealed how intersectionality was rarely discussed in connection to the other key components of *voice:* participation and opportunities to (not) use a variety of contraceptive methods. This demonstrated how the inequalities in access to services reflected commitments in international and normative frameworks that rarely encourage states to consider intersectional responses to contraceptive care of adolescent migrant girls.

The revelation that policy commitments to intersectionality are not always implemented in practice is not new. The lack of intersectionality in humanitarian settings is reflective of the research in other humanitarian settings. Previous work has observed that during crisis settings, those who already experience SRHR inequalities, disproportionately suffer the consequences of crises (Tanabe *et al.*, 2017; Ivanova, Rai and Kemigisha, 2018). For example, in public health emergencies during disease outbreaks, such as Ebola, Zika and AIDS, gender has been notably absent (Davies, 2014; Wilkinson and Leach, 2014; Davies and Bennett, 2016; Harman, 2016; Wenham *et al.*, 2021). Related research on COVID-19 has shown that failing to consider age gender and other intersectional considerations essential to consider in the outset of a crisis deepens inequalities which have long-term consequences for the lives of adolescents (Guglielmi *et al.*, 2020; Lokot and Avakyan, 2020; Borras,

2021). It is important to move beyond traditional cut-outs of 'womenandchildren' to consider how adolescent girls might also have health needs, some of which may differ from older women.

Until recently, responses to migrants' needs have often failed to acknowledge the way gender shapes migration (Hennebry and Petrozziello, 2019; Bastia *et al.*, 2022; Cintra, Owen and Riggirozzi, 2023). Beyond SRHR, RJ scholars have shown how responses use non-citizenship to determine responses, overlooking other axes of oppression that make women vulnerable to harm. For example, Abji and Larios (2020) who investigated pregnant women in detention in Canada showed how SRHR were the result of a 'birthright lottery' – illuminating the way citizenship affects SRHR. They contend that structural violence against non-citizen pregnant women is instrumentalised to curtail their rights, establishing a critical link between migrant justice and reproductive justice.

The continued focus on emergency short-term responses reflects the critiques postulated by the 'tyranny of the urgent', which puts aside structural issues in favour of addressing immediate biomedical needs (Watson and Mason, 2015; Davies and Bennett, 2016; Smith, 2019). The 'tyranny of the urgent' demonstrates how the rights of marginalised groups and intersectional experiences are neglected by responses that overlook social dimensions of gender and individual experiences (Smith, 2019). Furthermore, it shows how current humanitarian approaches have a paradoxical impact on the fulfilment of RJ. Applying a RJ approach to the 'tyranny of the urgent' demonstrates that silo-ing certain issues can discourage access to contraceptive care for marginalised groups, by dividing SRHR and creating a hierarchy of issues where some are more valuable (emergency care) and can justify the absence of others (contraceptive care).

The evidence here, and in other studies show that current attempts to deliver traditional SRHR maternity care and disease-based care are not responding to the intersectional reproductive realities of adolescent migrant girls. One recommendation is that contraceptive care should also be understood as an important part of the continuum of SRHR. It seems often that respondents wish to focus on maternal, obstetric care, abortion and rising levels of STI/STDs whilst overlooking the fact that these issues are inherently connected to contraceptive care. Not only access to contraceptive methods but these issues are connected to education programmes and other services which enhance the ability to make full and informed choices. Recognising the value of interventions beyond disease-based and risk-averse, 'technical' or 'hard' interventions could change perceptions about what type of intervention is perceived as valuable or worthy of time.

The findings also showed that actors consider Venezuelan adolescent migrant girls as migrants before adolescents. A second recommendation I suggest is to see adolescent migrant girls as *adolescent* migrant girls, emphasising their identities as adolescents rather than as non-citizens.

Using *voice* has highlighted the need to challenge the adult-centric perspective in many responses. In response, I posit that age should be recognised as an equally important axis shaping contraceptive care. As in the UNCRC, the principle of the 'best interests of the child' should be central to actors' response, ensuring a minimum standard for attention. Even when the immediate response is to 'save lives', overlooking structural aspects such as gender is to accept that some parts of the response will fail to reach women and girls (Eklund and Tellier, 2012, p. 593). By extending this line of thinking to include age, we can greatly advance our understanding of how actors think about the way intersectional identities such as age, gender and migration can shape reproductive realities.

9.1.2 Mechanisms of Participation and Feedback

This thesis found that actors do not provide sustainable mechanisms of participation and feedback through which to share decision-making power. Participation and feedback mechanisms are essential to *voice* and by extension contraceptive autonomy. If power is not shared in decision-making, actors risk relying on assumptions and adopting coercive practices, that go against the priorities and preferences of adolescent migrant girls.

Chapter 7The findings overall demonstrated that *voice* was considered important, but not a priority action. As a result, actors often fail to take positive actions to action these feelings. In many cases, key informants often overlooked the intrinsic benefits such as 'evolving capacities', which would particularly assist in adolescent well-being and development.

Chapter 7 further showed *voice*, where it was present, was included in low-level community-based mechanisms and often was limited to the same few mechanisms, used by two or three organisations. As a result, there was a lack of variety of mechanisms used, and also a reduced number of actors implementing those mechanisms. Under *The Scale of Voice*, the variety of approaches to participation and feedback yielded responses spanning from *coercion* to *consideration*. *Consideration* included those actors who took positive steps to include community-based participatory mechanisms to understand needs, such as surveys and questionnaires. However, these actors often recognised that there was a lack of action resulting from this participation. Below this, actors were deemed to include mechanisms of participation and feedback that were *generalisation or manipulation,* because they only included the opinions of girls to the benefit of actors, usually through indirect methods such as community leaders or staff anecdotes. Finally, those who did not provide any mechanisms through which Venezuelan adolescent migrant girls could participate or feedback their views were classified as *coercive* because they did not allow for *voices* to be heard.

Upon investigating why there was such limited inclusion of participation and feedback mechanisms, Chapter 8 found actors felt it was hard to include *voice* because of a lack of successful engagement with Venezuelan adolescent migrant girls. Actors both lacked knowledge of mechanisms to include Venezuelan adolescent migrant girls' voices in responses, whilst also feeling that adolescent migrant girls were largely apathetic to inclusion.

Prior research has shown how apathy was often the result of improper, inauthentic or inappropriate mechanisms of participation (Skidmore, Bound and Lownsbrough, 2006; Lister, 2007; Macpherson, 2008; Teufel-Shone *et al.*, 2011). In particular, research with marginalised groups such as children or migrants often felt as though participation was an uncomfortable process, which yielded little change (Ibid.). Beyond this, the literature review identified a gap in research on the efficacy of youth participation interventions in SRH (Cook, 2008; Villa-Torres and Svanemyr, 2015). This demonstrated that the lack of engagement with adolescents is mirrored in non-crisis settings. However, the fact that there was no consensus on effective mechanisms of adolescent migrant girls' participation or adolescent girls' participation in humanitarian settings demonstrates a need for more studies which consider how positive elements of SRHR, including contraceptive autonomy in these contexts.

Considering the literature on adolescent participation in non-crisis settings, I argued that in this case, the perceived lack of apathy could be a result of the limited mechanisms of engagement. This has implications for how researchers and actors consider adolescent migrant girls' participation in responses. Instead of assuming that adolescent migrant girls do not want to participate these findings suggested that there was a need to develop new innovative mechanisms of participation so that actors could create environments where shared decision-making was encouraged, and where adolescent migrant girls felt comfortable to share their priorities and preferences. As such, this implication serves as a practical recommendation to continue to pursue the ways in which adolescent migrant girls could be included in responses which address their contraceptive care.

As well as developing innovative methods, *The Scale of Voice* highlights the need for researchers and actors to investigate the effectiveness of different mechanisms of participation and feedback on adolescent migrant girls and actors. As shown by Chapter 5 and Chapter 8 of this thesis, whilst we can ascertain the number of services accessed, we do not know the number of adolescent migrant girls who have received comprehensive sexuality education, levels of satisfaction or priorities of this group. When data is available it is rarely published externally, and where it is only a handful are peer-reviewed or use standardised samples. Here, my recommendation would be to improve the data quality through standardisation of existing data, transparency of data – including unsuccessful stories, and the variety of measures available. In cases where adolescent-friendly services were used, providers should be clear about which aspects were available, for how long and under what

conditions. In addition to this, a greater variety of indicators could be developed to measure how participation and feedback have been conducted and the effect this has. For instance, involving youth in decision-making in other health settings has used indices which ask youth and adults how they determine the contents of programmes, how youth are consulted and how often (e.g., once a month) (Akiva, Cortina and Smith, 2014). Similarly, an index of the mechanisms of voice could be developed to measure the mechanisms of participation and feedback, the result of involvement, the skills attained by adolescent migrant girls and so forth. In the context wherein actors are shaped by metrics, targets, and indicators, the implementation of participation mechanisms emerges as a strategic imperative. This serves to motivate decision-makers to acknowledge the instinct value encapsulated in the concept of *voice*, warranting dedicated investments of time and financial resources. In short, creating and publishing indicators related to adolescent migrant girls' participation in contraceptive care could serve as a valuable strategy to address the current lack of knowledge on effective mechanisms.

This paradigm shift diverges from conventional, technically oriented, short-term, and risk-averse approaches, aligning instead with a RJ framework. The latter aims to centre the experiences of marginalised women and girls. Such a framework is designed to be delivered with a focus on inclusivity, recognising the agency of adolescent migrant girls rather than imposing solutions upon them. The risk of failing to incorporate mechanisms of participation and feedback means that actors are left trying to assume the correct response to the complex needs of adolescent migrant girls, without understanding the priorities or preferences of adolescent migrant girls. Doing so not only prevents the development of 'evolving capacities' but can cause lasting harm to individuals and societies.

9.1.3 Opportunities to (Not) Use a Variety of Contraceptive Methods

Chapter 5, Chapter 6, and Chapter 7 exhibited three key findings relating to the opportunity to (not) use a variety of contraceptive methods. Firstly, there was no regular or non-urgent access to contraceptive care for the majority of Venezuelan adolescent migrant girls with irregular status. Secondly, in some instances, a limited choice of methods was provided through one-off or short-term interventions which offered temporary access. This was linked to the subsequent finding that in these instances state actors, and in particular non-state actors promoted LARCs over other methods to mitigate for temporary access. This confirmed the results of Chapter 5, which found high levels of non-use or insertion of IUDs, relative to supervision of methods or general contraceptive counselling. Overall, I warned that these conditions could create conditions where *voice* was *generalised, manipulated or coerced*. In other words, *The Scale of Voice* was used to analyse actors' responses to

adolescent migrant girls' contraceptive care to reveal regimes of reproductive control that were previously hidden.

The relational conceptualisation of contraceptive autonomy developed in *The Scale of Voice* maintains that adolescent migrant girls might not always have full contraceptive autonomy as conceived by Senderowicz, (2020). In the early stages of girls' development, they are not considered to have sufficient 'evolving capacities' to understand the information being imparted or the risk involved with making the decision. However, none of these justify preventing access to contraceptive care, limiting methods available or ability to (re)negotiate method use, as none of these actions assist in creating autonomy-enhancing conditions. Instead, these actions show how preventing the risk of unintended pregnancies is privileged over the autonomy of adolescent migrant girls.

The finding that actors constrain the agency of Venezuelan adolescent migrant girls instead of promoting autonomy-enhancing conditions has implications for RJ. These results demonstrate how state and non-state actors exert hidden modes of reproductive control over adolescent migrant girls. This makes a valuable contribution to RJ as it shows that current conceptualisations of contraceptive autonomy, as either present or as absent, overlook the multiple ways in which autonomy can be enhanced or constrained (Senderowicz, 2020).

The modes of reproductive control identified in this thesis bear striking similarities to the works discussed in the literature review, which demonstrated how marginalised women and girls across the Global North and Global South, have had governments, institutions, and actors exert control over various aspects of reproduction reducing their autonomy (Morgan and Roberts, 2012; Elgar, 2014; Htun and Weldon, 2018). Some examples of contraceptive coercion for women and girls included historical ideologies such as eugenics and neo-Malthusianism (Getgen, 2009; Connelly, 2010; Ross and Solinger, 2017). I further noted how contemporary legislation such as the 'Global Gag Rule' further blocked or restricted access to reproductive services so that, for 'many of the most needed and simplest reproductive health interventions for refugees, such as emergency contraception or condom distribution to adolescents, remain mired in ideological controversies' (Girard and Waldman, 2000, p. 167).

More subversive mechanisms of control were exemplified by RJ scholars who highlighted processes of uneven or 'selective' LARC provision as a hidden form of reproductive control over marginalised groups (Gomez, Fuentes and Allina, 2014; Winters and McLaughlin, 2019; Brian, Grzanka and Mann, 2020; Brandão and Cabral, 2021; Mann, 2022; Morison, 2023). Drawing from discussions of sterilisation, they demonstrate how pressure to use LARCs that are unevenly promoted in

marginalised groups can be understood as a form of contraceptive coercion (Winters and McLaughlin, 2019; Brian, Grzanka and Mann, 2020; Eeckhaut and Hara, 2023; Morison, 2023).

As I discussed in Chapter 5 and Chapter 7, I found striking similarities between my findings and the prioritisation of 'urgency', 'cost-effectiveness', 'effectiveness', and 'rationality' over contraceptive autonomy in existing RJ literature (Brian, Grzanka and Mann, 2020; Eeckhaut and Hara, 2023; Morison, 2023). Just as in the work of US service providers who saw LARCs as 'the only responsible and appropriate choice' (Brian, Grzanka and Mann, 2020), in this thesis state and nonstate actors saw LARCs as 'better'. Equally, emphasis on insertion over removal or surveillance was shared.

However, examinations of the LARC-first or LARC-hegemonic have been conspicuously absent from discussions of humanitarian settings, where the emphasis is placed on 'urgent', 'efficient', and 'rational' responses. The application of RJ to adolescent migrant girls in humanitarian settings in particular shows how intersectional privilege and oppression of gender, age, and migration. At this intersection, adolescent migrant girls miss out on the opportunity to develop their decision-making capacities. Instead, actors produce responses whose uneven and selective application of contraceptive care, deepens existing SRH inequalities.

This has implications for the thinking about how contraceptive care is offered to adolescent migrant girls in humanitarian settings. Currently, humanitarian responses are shaped by frameworks and decision-makers who legitimise the uneven applications through normative claims captured by the concept of the 'tyranny of the urgent' which centres immediate biomedical needs over structural issues (Watson and Mason, 2015; Lafrenière, Sweetman and Thylin, 2019; Smith, 2019). Thus, humanitarian approaches are considered to be entirely incompatible with RJ.

Highlighting how such regimes (re)produce patterns of contraceptive coercion emphasises the necessity of examining the context in which actors consider contraceptive care. Beyond the urgency often associated with humanitarian crises, it becomes increasingly apparent that the pervasive challenges faced by marginalised groups, including adolescent migrant girls, demand a more comprehensive approach. In order to redress the reproductive injustices felt by adolescent migrant girls in humanitarian settings, actors need to challenge short-term, urgent responses and provide a wide range of opportunities to (not) use a variety of contraceptive methods. Such responses should actively work *with* adolescent migrant girls to understand the wider context of barriers and challenges to access, as well as individual priorities and preferences.

9.2 Limitations

One limitation to note regarding the conceptual framework concerns the examples of practical mechanisms of *voice.* Several works were particularly relevant, as their reviews of literature proved a useful foundation for considering current SRHR interventions in humanitarian crises (Warren *et al.*, 2015; Jennings *et al.*, 2019; Desrosiers *et al.*, 2020; Tirado *et al.*, 2020; Larrea-Schiavon *et al.*, 2022). This list, however, is not comprehensive, which some might regard as a limitation. For example, some of the examples of mechanisms listed may not be appropriate to implement in some settings, given the heterogeneous mix of adolescent migrants from different religions, races, cultures, classes, (dis)abilities, sexualities, and gender identities across and between crises. They were instead designed as a starting point for anyone considering this framework, and therefore reflect current evidence on the matter.

Some limitations occurred due to the quality and quantity of the secondary health utilisation data, as previously mentioned in Section 3.2 and in Table 8. The greatest limitation in health utilisation data was not having the most precise level of ICD-10 code so as to determine the exact reason for attending. Greater attention to coding by health administrators could have helped identify patterns in which types of methods used by nationality and age.

After the interviews were conducted, a new initiative (External Circular 0035 2022) was announced. This policy, although non-binding, suggested local health authorities include adolescent migrant girls in their responses. Further, they offer free contraceptive methods to irregular migrants. Seeing as the interviews were conducted in March 2022, and this announcement was not made until 22 August 2022, the full effect of this guidance could not be measured. So, it is important to note that during the fieldwork period, policy stipulated that irregular migrants could only access emergency care if they were affiliated to the health system. Future research should focus on the provision of contraceptive care to irregular migrants to see if this guidance has had any effect. However, based on the implementation of binding legislation creating obligations to supply maternal care (Chapter 6), one would expect implementation to be similarly uneven.

A final limitation was the extent to which the project engaged with Venezuelan adolescent migrant girls. Given that RJ centres marginalised women in their research and praxis, some would consider the number of adolescent migrant girls' voices a limitation. However, as an intersectional and structural framework, RJ is used in this thesis to focus on the way responses consider and include adolescent migrant girls in their responses. The emphasis is therefore on the actors, who need to be held accountable. The impact these responses have on adolescent migrant girls is equally important and should be the subject of future research as I discuss below. However, considering the research

questions focus on the perspectives of actors, and their reasons for not including aspects of *voice*, I decided to focus on actors.

9.3 Avenues for Future Research

Drawing this thesis to a close, I offer some potential areas of research which will aid the theoretical contributions to *The Scale of Voice*, as a proxy for contraceptive autonomy in adolescent migrant girls, but also provide practical applications which can be adopted by actors in the future.

My first suggestion is that future research should continue to adapt and utilise existing indicators that measure contraceptive autonomy, as I have done here so that we are not limited to models which only examine risk-based models of contraceptive access. The latter is dangerous because it can encourage the use of contraceptive methods against the priorities of the adolescent. Senderowicz and her colleagues have already begun to apply her model of contraceptive coercion through interviews with women on their experiences and through interventions like the 'mystery client' (Senderowicz, 2019; Tumlinson *et al.*, 2022). Likewise, other scholars have attempted to assess their reproductive autonomy scales in different settings (Upadhyay *et al.*, 2014; Elionara Teixeira Boa Sorte *et al.*, 2019). Future research should apply *The Scale of Voice*, to adolescent migrant girls in Colombia, but also in other settings as both a contribution to academic literature and scholarly debate but also as a in communication with adolescent migrant girls, practitioners, policymakers, and service providers.

As part of the process of developing the models, the dimensions themselves should be developed through participatory co-design which prioritises the experiences of adolescent migrant girls but also includes the expertise of state and non-state actors. Certain aspects which were not within the scope of this project but would prove insightful to developments of contraceptive autonomy include temporality, the role of cultural and religious norms and other intersections of oppression. Adolescents far from being a homogeneous group, have several other intersections that were outside the scope of this thesis including LGBTQIA2S+, care experienced, Afro Latina, disabled or victims of violence. Another potential avenue of future research would be to explore other axes of oppression intersect to create different reproductive realities, how actors negotiated these, and the subsequent effect on *voice.*

Additionally, future research could consider how contraceptive autonomy changes through time. Although this thesis was limited in time, longitudinal data collection or periods of ethnographic observation could yield interesting data on the experiences of those receiving 'short-term' or one-off interventions at various points after the intervention. For example, examining how easy it is to re-

negotiate contraceptive autonomy in the months after these appointments, as prioritise and preferences shift.

Another possibility for future research is to determine how actors' responses to contraceptive care needs vary in other humanitarian settings. Whilst the same international normative frameworks apply, it will be interesting to see how these are adapted to national and local contexts. Inevitably some international non-state actors will operate using similar, if not the same, programme design. However, there will be differences that will reflect the unique socio-cultural, political, and economic landscapes of each humanitarian setting. Investigating the variations in actors' responses to contraceptive care needs in other humanitarian settings will provide valuable insights into the contextual factors shaping the implementation of international normative frameworks.

9.4 Conclusion

This thesis began by introducing one of the central tenets of RJ: only when the voices of all women are heard, will reproductive rights movements make a difference for all women (Solinger, 2005, p. 310). There, I connected this to the idea that 'the right to be heard' is essential as neglecting the perspectives of marginalised girls during crises can (re)produce marginality (Hajisoteriou, Karousiou and Angelides, 2021; Kusumaningrum, Siagian and Beazley, 2021; Potts, Kolli and Fattal, 2022). From there, I developed a novel conceptual framework in an attempt to highlight previously hidden structural power imbalances between state and non-state actors and adolescent migrant girls. Specifically, I focused on *voice,* as a means to achieve contraceptive autonomy. Throughout this thesis, I have continually referred back to this *Scale of Voice* explored and developed the way in which state, and non-state actors, have considered and included adolescent migrant girls in their responses to contraceptive care. Using the *scale,* I revealed that state and non-state actors create conditions which constrain Venezuelan adolescent migrant girls' contraceptive autonomy. The results show there is still work to be done.

To ensure that actors create environments which enhance *voice* as a proxy contraceptive autonomy for adolescent migrant girls in humanitarian settings, it is crucial for state and non-state actors to transcend conventional approaches focused solely on access, risk aversion, and disease-centric models of SRHR. In the case of Venezuelan migrants in Colombia, those existing models fell short in considering and including the *voice* of adolescent migrant girls – that is, their ability to actively decide and actualise their contraceptive choices – due to three primary reasons.

Firstly, responses put in place by state and non-state actors overlook the intersectional reproductive realities of Venezuelan adolescent migrant girls (as shaped by gender, age, and migration).

Consequently, those responses inadequately addressed the absolute and relative inequalities in access to reproductive services, which disproportionately affect adolescent migrant girls. The process of affiliation to the public health system and limited access to contraceptive methods through humanitarian actors represented only partial solutions to broader issues (such as issues with affiliation, lack of information, and miscommunication), meaning these responses did not centre and include adolescent migrant girls.

Secondly, when including few (if any) mechanisms of participation and feedback actors cannot be said to fully understand the priorities and preferences of adolescent migrant girls. This insufficiency increased the likelihood of policy design and implementation based on assumptions rather than evidence, with the potential to cause more harm than good. Such an oversight denies adolescent migrant girls the opportunity to be centred in the response, as well as the opportunity to develop their 'evolving capacities'. Beyond that, structural power imbalances remain unaddressed, leaving actors with the majority of decision-making power. Consequently, short-term, superficial mechanisms of participation can cause severe long-term consequences for contraceptive decision-making.

Third and finally, the limited provision of opportunities to (not) use a variety of contraceptive methods restricted the choices available to adolescent migrant girls, undermining their priorities and preferences. This narrow approach favoured 'cost-effective', technical, and short-term strategies at the expense of considering the unique priorities and preferences of adolescent migrant girls. Moreover, the promotion of long-term methods in groups with limited to no access to medical services to discontinue, or change methods was regarded as especially damaging to contraceptive autonomy.

In light of these shortcomings, I claim that it is imperative to avoid nonautonomous contraceptive care, which has negative effects on the development of girls and the societies in which they live. As long as power imbalances remain unaddressed, justice cannot be achieved. Moving forward, the thesis advocates for a transformative shift in responses. I recommend a shift towards comprehensive responses that focus on the creation of autonomy-enhancing conditions for marginalised groups in accordance with the principles of RJ.

Appendix A Semi-Structured Interview Guide for Fieldwork

Interview Guide

This study asks how responders to SRH include the voice of adolescent Venezuelan female migrants.

This question has been broken down into four questions as follows:

1. What policies and programmes exist to respond to adolescent migrant girls' sexual reproductive health?
2. Who delivers sexual reproductive health rights and how are they implemented to include adolescent migrant sexual reproductive health?
3. How are sexual reproductive health rights addressed in normative frameworks, policies/programmes/ strategies?
4. What approach do they take to incorporate the voices of adolescent Venezuelan female migrants?

Considering these questions, the following interview script for semi-structured elite interviews will follow four separate themes that each aim to answer the questions above. The questions will be administered by an interpreter, and I will be present. To keep the interview fluid and as natural as possible potential probing questions have been preidentified.

<u>Interview Script</u>

- Thank the participant for their time
- Introduce interviewer and translator and confirm informed consent form has been signed and returned. The participant should be provided the opportunity to ask any questions. Something along the lines of:

  'Thank you very much for taking the time to talk to us today, I'm Hannah and this is [name of interpreter] who will be translating for us they are from [name of place]. So, as you know I am a PhD student doing research into the responses to Venezuela migrants' sexual and reproductive health to try and gather more information. I was wondering if before we began you had any questions for me or any doubts to clarify?'
- Explain the interview will take approximately 45-60 mins and will cover the four following themes: institutional responses, sexual and reproductive health rights, responsibility, and voice of the girls.
- Ensure you are in a private environment, if face-to-face ensure you cannot be overheard, if online ask if the participant is in a quiet space where they speak freely will not be disturbed
- Start recording the interview only if the participant has consented to being recorded.

Section 1: Preliminary Information	
1. Name of the interviewee: _____	5. Name of institution _____
2. Contact information (only if they wish to be contacted again) Phone number: Email address:	7. Type of institution: ☐ Public medical ☐ Public non-medical ☐ Private medical ☐ Private specialised drug seller ☐ Faith-based Organisation ☐ NGO
3. Date of Interview	8. Position within organisation:
4. Consent Obtained: If yes continue ☐ If no, stop interview immediately ☐	9. Place of Interview _____

Section 2: Interview Script		
	Main questions	Probing questions
Interviewee Profile/ Context	To know you better, could you please tell us about yourself and your role within X? How long have you worked there?	So, do you yourself get to talk to the migrants or is your role more office-based?
	What does your institution do to support migrants?	
Define SRH	Define SRH briefly	Do you agree? Are you happy with that definition?
Institutional Response	Does your institution offer any kind of support for Venezuelan adolescents related to sexual reproductive health?	Like for example, information, education or resources.
	Is it different to the approach that adult migrant women receive?	
Sexual Reproductive	What do you understand by rights, especially relating to SRH of adolescents?	Can you tell me about some of the rights?

Health Rights (SRHR)		
	Have you heard of 'adolescent-friendly SRH'? What do you think it means?	
	Did your institution provide any special training for employees about SRHR or anything related?	What kind specialist training did you undertake? How often do you repeat this training?
	Do you see many adolescents who know their rights with respect to their sexual and reproductive health?	Do they for example, know where to get to get information or to receive care?
	What barriers do you think stop adolescent migrant girls realising their rights?	What about cost/stigma/attitudes/structuring or health systems?
	Is privacy an issue for adolescent migrant girls when receiving SRH treatment?	For example when seeking advice or treatment on contraceptives or other SRH issues?
	How prevalent is the issue of misinformation or misconceptions with regards to their SRH?	Are there many myths that are spread through social media or gossip?
Voice	What do you think it means for adolescents to have a voice in their SRH care?	
	Does your institution try to make sure that adolescent migrant girls get their voices heard in sexual reproductive healthcare?	
	What do think girls consider when they make the decision to use (or not to use) contraceptives?	Is it for example advice or is it their family's opinion?
	Is there any way that adolescent girls can provide feedback about the care and services they receive?	If yes, what mechanisms? What is done with that feedback?
Suggestions for	What could be done to help adolescent migrant girls realise their rights to SRH further?	

Improvement of Responses		
	What one thing would improve access to contraceptive information, education, and resources?	
Closing	Is there anything else that you would like to talk about that I didn't ask you about?	
	What other institutions are you aware of that work with adolescent migrant SRH?	Can you name the institution and describe what they do? Which geographic location do they cover?
	Is there anyone else that you think I should be talking to about this topic? Anyone you would recommend?	

Appendix B International Rights, Treaties and Conventions

Table 25 International Treaties and Conventions Relating to Contraceptive Care for Adolescent Migrant Girls

The Right	International Treaties & Conventions	Article
The Right to Life	Universal Declaration	Article 3 Everyone has the right to life, liberty, and security of person
	Civil and Political Rights Covenant	Article 6(1) Every human being has the inherent right to life. This right shall be protected by law.
	Children's Rights Convention	Article 6(1) State Parties recognize that every child has the inherent right to life.
	Children's Rights Convention	Article 6(2) State Parties shall ensure to the maximum extent possible the survival and development of the child.
	Disability Rights Convention	Article 10 States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.
	Universal Declaration	Article 3 Everyone has the right to... liberty and security of person.

	Civil and Political Rights Covenant	Article 9(1) Everyone has the right to liberty and security of person.
The Right to Liberty and Security of Person	Disability Rights Convention	Article 14 States Parties shall ensure that persons with disabilities, Onan equal basis with others: 1) Enjoy the right to liberty and security of person; 2) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
	Disability Rights Convention	Article 25 States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.... In particular, States Parties shall: Provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes....
	Universal Declaration	Article 25(1) Everyone has the right to a standard of living adequate forth health and well-being of himself and of his family....
The Right to Health, Including Sexual and Reproductive Health	Economic, Social, and Cultural Rights Covenant	Article 10(2) Special protection should be accorded to mothers during a reasonable period before and after childbirth.
	Economic, Social, and Cultural Rights Covenant	Article 12(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Economic, Social, and Cultural Rights Covenant	Article 12(2) The steps to be taken by the States Parties to... achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;... (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
Convention against Racial Discrimination	Article 5 States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee [to] everyone... (e)(iv) the right to public health, medical care, social security and social services.
CEDAW	Article 12(1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order tonsure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.
CEDAW	Article 12(2) States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
CEDAW	Article 14(2) States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas [and] ensure to such women the right:... (b) To have access to adequate healthcare facilities, including information, counselling and services in family planning....
Children's Rights Convention	Article 24(1) States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.... [N]o child... [shall be] deprived of his or her right of access to such healthcare services.

	Children's Rights Convention	Article 24(2) States Parties shall pursue full implementation of... [the]right [to health] and, in particular, shall take appropriate measures: (a)To diminish infant and child mortality;... (d) To ensure appropriator-natal and post-natal healthcare for mothers;... (f) To develop preventive healthcare, guidance for parents and family planning education and services.
	Disability Rights Convention	Article 25 States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.... In particular, States Parties shall: Provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes....
The Right to Decide the Number and Spacing of Children	CEDAW	Article 16(1) States Parties shall... ensure, on a basis of equality omen and women... (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access tithe information, education and means to enable them to exercise these rights....
	Disability Rights Convention	Article 16(1) States Parties shall... ensure, on a basis of equality omen and women... (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access tithe information, education and means to enable them to exercise these rights....
The Right to Consent to Marriage and	Universal Declaration	Article 16(1) Men and women of full age, without any limitation due trace, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and aits dissolution.
	Universal Declaration	Article 16(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

to Equality in Marriage	Civil and Political Rights Covenant	Article 23(2) The right of men and women of marriageable age to marry and to found a family shall be recognised.
	Civil and Political Rights Covenant	Article 23(3) No marriage shall be entered into without the free and full consent of the intending spouses.
	Civil and Political Rights Covenant	Article 23(4) States Parties... shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution.
	Economic, Social, and Cultural Rights Covenant	Article 10(1) Marriage must be entered into with the free consent of the intending spouses.
	CEDAW	Article 16(1) States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women…
	CEDAW	Article 16(2) The betrothal and the marriage of a child shall have nonlegal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.
	Disability Rights Convention	Article 23(1) States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure... [t]he right of all persons with disabilities who are of

		marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognised.
The Right to Privacy	Civil and Political Rights Covenant	Article 17(1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his [sic] honour and reputation.
	Civil and Political Rights Covenant	Article 17(2) Everyone has the right to the protection of the law against such interference or attacks.
	Children's Rights Convention	Article 16(1) No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
	Children's Rights Convention	Article 16(2) The child has the right to the protection of the law against such interference or attacks.
	Disability Rights Convention	Article 22(1) No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.
The Right to Equality and	Universal Declaration	Article 2 Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colourise, language, religion, political or other opinion, national or social origin, property, birth or other status.

Non-Discrimination	Civil and Political Rights Covenant	Article 2(1) Each State Party to the present Covenant undertakes to respect and to ensure to all individuals... the rights recognised in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
	Economic, Social, and Cultural Rights Covenant	Article 2(2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, colanguage, religion, political or other opinion, national or social origin, property, birth or other status.
	CEDAW	Article 1 [T]he term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which haste effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.
	CEDAW	Article 3 States Parties shall take in all fields... all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.
	CEDAW	Article 11(2) In order to prevent discrimination against women on the grounds of... maternity... States Parties shall take appropriate measures: (a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital

		status;... (d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.
	Children's Rights Convention	Article 2(1) States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parents or legal guardian's race, colour, sex, religion, political or other opinion, ethnic or social origin, property, disability, birth or other status.
	Children's Rights Convention	Article 2(2) States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions or beliefs of the child's parents, legal guardians or family members.
	Children's Rights Convention	Article 5 States Parties shall respect the responsibilities, rights and duties of parents or where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the 'evolving capacities' of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention.
	Disability Rights Convention	Article 6(1) States Parties recognise that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
The Right to be Free from	CEDAW	Article 2(f) [States Parties undertake t]o take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women....

Practices that Harm Women and Girls		Article 5(a) [State Parties shall take all appropriate measures t]o modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for Menand women....
	Children's Rights Convention	Article 24.3 States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial tithe health of children.
The Right to not be Subjected to Torturer Other Cruel, Inhuman or Degrading Treatment or Punishment	Universal Declaration	Article 5 No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
	Children's Rights Convention	Article 37 (a) [States Parties shall ensure that n]o child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.
	Civil and Political Rights Covenant	Article 7 No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
	Convention against Torture	Article 1 [T]he term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on adperson for... any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity....
	Disability Rights Convention	Article 15(1) No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

	Economic, Social, and Cultural Rights Covenant	Article 15(2) States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.
The Right to be Free from Sexual and Gender-Based Violence	CEDAW	Article 5(a) [State Parties shall take all appropriate measures t]o modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men adwomen....
	CEDAW	Article 6 States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.
	Children's Rights Convention	Article 19(1) States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from alloforms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
	Children's Rights Convention	Article 34 States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent: (a) The inducement or coercion of a child to engage in any unlawful sexual activity;(b) The exploitative use of children in prostitution or other unlawful sexual practices; (c) The exploitative use of children in pornographic performances and materials.

	Disability Rights Convention	Article 16(1) States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
	Rome Statute of the ICC	Article 7(1) For the purpose of this Statute, 'crime against humanity 'means any of the following acts when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack:... (g) Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation or any other form of sexual violence of comparable gravity....
The Right to Enjoy the Benefits of Scientific Progress	Universal Declaration	Article 27(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
	Civil and Political Rights Covenant	Article 7 [N]o one shall be subjected without his [sic] free consent to medical or scientific experimentation.
	Economic, Social, and Cultural Rights Covenant	Article 15(1) The States Parties to the present Covenant recognise the right of everyone:... (b) To enjoy the benefits of scientific progress and its applications....
Right to Access Sexual and Reproductive Health Education and	CEDAW	Article 10 States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:... (c) The elimination of any stereotyped concept of the roles of men and women at all levels and in alloforms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school

Family Planning Information		programmes and the adaptation of teaching methods;... (h) States Parties shall … ensure … [a]access to specific educational information to help to ensure the health and wellbeing of families, including information and advice on family planning.
	Disability Rights Convention	Article 23(1) States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure... [t]he rights of persons with disabilities... to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided....

Appendix C National Laws, Policies and Rulings

Table 26 National Legislation Relating to Contraceptive Care for Venezuelan Adolescent Migrant Girls

Authority	Name	Year	Title/Description	Population Impacted
Departmental assemblies and municipal council	Agreements 293, 335, 400	2005, 2006, 2008	Whereby resources are allocated from the Promotion Subaccount of the Solidarity and Guarantee Fund (Fossae) to strengthen sexual and reproductive health programmes and other provisions are issued	Women
High Courts	C-055	2022	Decriminalised abortion during the first 24 weeks of pregnancy	Women
Government	External Circular No.35	2022	Recommendations for strengthening the inclusion and care of the Venezuelan migrant population in the General System of Social Security in Health.	Venezuelan Migrants
	Law 2194	2022	Amends Law 1384 of 2010, in order to eliminate access barriers to support programmes for the comprehensive rehabilitation of people diagnosed with cancer, as well as general provisions regarding the treatment and prevention of cancer in Colombia.	
Government	External Circular No.43	2021	Instructions for vaccination against COVID-19 for pregnant women	Women
Government	Decree 216	2021	By means of which the Temporary Protection Statute for Venezuelan Migrants under the Temporary Protection Regime is adopted and other provisions on migration matters are enacted: emergency care must be provided to	Venezuelan Migrants

			any national or foreign person, without any requirement or discrimination; to adhere to strategy developed in CONPES 3950 for health attention to Venezuelans	
High Courts	T-085	2020	Protecting rights of pregnant adolescents to education	Children, Adolescents and Young People
Government	Decree 1710	2020	By which the Articulating Mechanism for the Comprehensive Approach to Violence for Reasons of Sex and Gender, of women, children and adolescents, is adopted as a management strategy in public health and provisions are issued for its implementation.	Women
Congress	Law 1955	2019	Issued the National Development Plan 2018-2022 'Pact for Colombia, Pact for Equity' which, establishes as one of the pacts for equity, the strengthening of institutional capacities in mainstreaming the approach of gender through consolidating and strengthening inter-institutional and intersectoral coordination on gender issues for women.	
Government	Decree 1630	2019	Health and Social Protection Sector regarding women victims of violence	Women
Congress	Law 1885	2018	Reforming Law 1622/2013 established a political electoral system allowing youth between 14-28 to elect members of, and be elected to, municipal youth councils.	Children, Adolescents and Young People
	T-210/2018		Ruled that urgent care extends beyond restoring vital functioning to encompass	Venezuelan Migrants

			protecting life and preventing severe or long-term health consequences, both physically and mentally. Such care must be provided immediately in line with the progressive realisation of social and economic rights.	
Government	CONPES 3950	2018	Strategy for attention to migrants from Venezuela - sets out priority areas for identifying needs and delivering attention as well as naming The Ministry of Health and Social Protection as main implementing actor	
Government	External Circular No.25	2017	Strengthening Public Health Actions to Respond to the Migration Situation of the Population from Venezuela	Venezuelan Migrants
Government	External Circular No.20	2017	Operational guidelines for the web service for the migration of data including registry of births, deaths and to the social protection system.	Venezuelan Migrants
Congress	Law 1804	2016	Establishes a policy for the Integral Development of Early Childhood from Zero to Forever	Children, Adolescents and Young People
Government	Decree 1768	2015	By which the conditions are established for the affiliation to the General System of Social Security in Health of Colombian migrants who have been repatriated, have voluntarily returned to the country or have been deported or expelled from the Bolivarian Republic of Venezuela.	Venezuelan Migrants
High Courts	C-754	2015	Requires that victims of sexual violence be provided with comprehensive healthcare with dignity as a minimum	Women

			that the State must guarantee immediately without requiring a police report.	
Congress	Law 1751	2015	Enshrined the right to health and key principles. Recognised health as a social right. Made it mandatory to provide emergency services, placed the health system not SGSSS duty-bearer to realise this.	Right to Health
Government	External Circular No.35	2015	Strengthening of vaccination strategies against the HPV, for girls between the fourth grade of elementary school and eleventh grade of high school who have turned 9 years old and the non-school population aged 9 -17 years old.	Children, Adolescents and Young People
Plan	National Sexual and Reproductive Health Plan 2014–2021	2014	The objectives of the PNSDSDR are: 1. Health promotion, through promoting sexual and reproductive rights 2. Health risk management through the management of factors affecting sexual and reproductive health. 3. Public health management through SRH actions	Women
Congress	Law 1719	2014	In the case of sexual violence police report no longer required to request a legal abortion	Women
Congress	Law 1618	2013	guarantees the full exercise of the rights of persons with disabilities including SRH	Women
Congress	Law 1620	2013	Creation of the national system of school coexistence and training for human rights, education for sexuality and prevention and mitigation of school violence, which promotes and	Women

			strengthens citizenship education and the exercise of human, sexual and reproductive rights of preschool, elementary and middle school students	
Congress	Law 1622	2013	Youth Citizenship Statute defines a young person as aged 14-28 and other provisions are issued including measures of prevention, protection, promotion and guarantee of the right to SRH with a differential approach	Children, Adolescents and Young People
Government	External Circular No.17	2013	Publicising the coverage and care of the health services contained in the Plan of Benefits for children and adolescents.	Children, Adolescents and Young People
Departmental assemblies and municipal council	Agreement 034	2012	Misoprostol (used for medical abortions) becomes covered by public healthcare in connection to T-627/2012	
High Courts	T-627	2012	Reiterates the State's obligation to ensure all women their sexual and reproductive rights through the provision of health services, including access to the voluntary interruption of a pregnancy under certain circumstances. Further states it's the obligation of public servants to provide accurate, reliable and timely information to women regarding their rights to SRH.	Women
Resolution	Resolution 459	2012	Alongside Law 1791/2014 focuses on victims of sexual violence	Women
Government	Ten-Year Public Health Plan 2012-2021	2012	Seeks to reduce health inequity under the following objectives: 1) to work towards ensuring the effective enjoyment of the right to health;	Right to Health

			2) to improve the living conditions which alter the health and reduce the burden of existing disease; 3) to maintain zero tolerance for mortality, morbidity, and avoidable disability.	
Ministry of Health	Resolution 459	2012	Protocol and Model for the Integral Attention of Victims of Sexual Violence in the Healthcare System	
Government	Decree 2734	2012	Care measures for women victims of violence are regulated	Women
Congress	Law 1438	2011	Recognises a differential approach to which the GSSS will offer special guarantees including differential approach for age and gender approach including reproductive rights policy.	Women
Congress	Law 1438	2011	Aimed to improve healthcare e.g. through UHC, equity between public and private schemes, focusing on health prevention and promotion. Gov will make a Ten Year Public Health plan	Right to Health
Congress	Law 1412	2010	Legalises permanent surgical contraception	Women
High Courts	T-760	2008	Recognised the right to health as a fundamental right worthy of direct constitutional adjudication.	Right to Health
Congress	Law 1257	2008	Establishes norms for prevention of violence and discrimination against women including sexual violence	Women
Resolution	Resolution 769	2008	State-provision of contraception alongside education and knowledge to reduce unwanted pregnancy	Women

Government	Resolution 1963	2008	Through which the Technical Standard for Family Planning Care for Men and Women is modified, adopted by means of Resolution 0769 of 2008	Women
Plan	National Public Health Plan 2007-2010	2007	The purposes of the National Public Health Plan are the following: 1. To improve the health status of the Colombian population. 2. Avoid progression and adverse outcomes of the disease. 3. Facing the challenges of population aging and demographic transition. 4. Reduce inequities in health of the Colombian population. Includes SRH as a priority area	Women
Congress	Law 1146	2007	Issues standards for the prevention of sexual violence and comprehensive care for sexually abused children and adolescents	Children, Adolescents and Young People
Government	National Public Health Plan 2007-2010	2007	The National Public Health Plan includes: 1. The health priorities, objectives, goals and strategies, in coherence with the health situation indicators national health policies, international treaties and conventions signed by the country and the. international treaties and conventions signed by the country and the cross-cutting social policies of other sectors. 2. Defines the public health responsibilities of the Nation, the territorial entities, and all other and of all the actors of the General Social Security Health System (SGSSS), which will be	Right to Health

			complemented by the actions of actors in other sectors, as defined in the national development plan, the national development plan and in the territorial development plans	
Government	Decree 4685	2007	Enacts the 'Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women', adopted by the United Nations General Assembly on October 6, 1999.	Women
Government	Agreement 380	2007	By means of which hormonal contraceptive medications and the male condom are included in the Compulsory Health Plan of the Contributory Regime and the Subsidised Regime	Women
President	Decree 444	2006	Provides technical guidelines regulating the provision of abortions in the public and private healthcare systems.	Women
High Courts	C-355	2006	Decriminalised abortion for health or life-threatening circum- stances, severe fatal malformation incompatible with life, sexual violence or forced insemination	Women
Congress	Law 1029	2006	Sexual education (amends Law 115/1994, on Mandatory Education) provides that all public and private educational establishments offering formal pre-school, elementary, and high school education specific programmes are to be approved by the municipal or national Education Secretariat.	Children, Adolescents and Young People
Congress	Law 1098	2006	Code for children and adolescents - ensures the right to health of children	Children, Adolescents

			and adolescents, to guarantee adolescents free access to specialised SRH services.	and Young People
Government	Agreement 350	2006	Care for the voluntary interruption of pregnancy is included in the Compulsory Health Plan of the Contributory Regime and the Subsidised Regime	Women
Congress	Law 984	2005	Approves the 'Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women', adopted by the United Nations General Assembly on October 6, 1999.	
Government	National Youth Policy: for Youth Ten-year Plan 2005-2015.	2005	The national youth policy has three main objectives: 1) Youth participation in public life; 2) Access to good public services; 3) Broadening of social, economic and cultural opportunities.	Children, Adolescents and Young People
Congress	Law 890	2004	Reformed 599/2000 increasing term of imprisonment to 16-54 months	Women
Plan	National Sexual and Reproductive Health Plan 2003-2006	2003	Set out priorities to guide state intervention in six areas of intervention: safe motherhood, family planning, adolescent sexual and reproductive health, cervical cancer, sexually transmitted infections and HIV/AIDS, and domestic and sexual violence.	Women
Congress	Law 823	2003	Special efforts will be made to achieve adolescents' access to comprehensive health services, including SRH.	Children, Adolescents and Young People

Congress	Law 823	2003	Equal opportunities and rights of women. Includes principles of non-discrimination on basis of gender, and women's access to comprehensive health services, including sexual and reproductive health.	Women
High Courts	T-850	2002	Rules against the forced sterilisation of disabled persons	Women
Government	Agreement 26	2001	By which resources are allocated from the Promotion and Prevention Subaccount of the Solidarity and Guarantee Fund to develop plans and projects aimed at reducing the social and economic impact of sexually transmitted diseases and the HIV-AIDS epidemic	Women
Congress	Law 599	2000	Criminalisation of abortion - Article 122-124 of the Penal Code punished women who self-induced or consented to someone else inducing her abortion to imprisonment for a period of one to three years,	Women
Government	Resolution 412	2000	Establishes and the technical standards and care guides are adopted for the development of specific protection actions and early detection and care of diseases of interest in public health. Including prevention of pregnancy and access to family planning and sexual education	Women
High Courts	T-656	1998	Prevention of discrimination pregnant adolescents in education	Children, Adolescents and Young People

Government	Decree 1543	1997	By which the management of infection by the Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and other Sexually Transmitted Diseases (STD) is regulated	Women
Government	Resolution 288	1996	Whereby the Basic Care Plan of the General Social Security System (SGSSS) is defined ARTICLE 9. The district or municipality shall develop promotional actions in accordance with the competencies of the health sector in the following areas: a) The comprehensive health of children and adolescents; the elderly; persons with, disabilities and the population of the informal sector of the economy. b) SRH	Right to Health
High Courts	T-474	1996	Ruled that minor's legal incapacity was relative not absolute, and that minor adults had the right to partake in decisions related to health and medical treatment. Minor adults are males aged 14-18 and females 12-18	Children, Adolescents and Young People
High Courts	T-477	1995	Parents and their children have a 'shared capacity' to consent in the decision-making in medical settings	Children, Adolescents and Young People
Congress	Law 115	1994	General Education Law states that educational establishes are obliged to provide sexual education, imparted in each case according to the psychic, physical and affective needs of the students according to their age	Children, Adolescents and Young People

Congress	Law 100	1993	Reformed the health system, created SGSSS to increase health coverage through insurance	Right to Health
Government	Resolution 1531	1992	Enunciated the rights of women in the health sphere: the right to their fulfilment as mothers, the right to take decisions on matters affecting their health, the right to personalised medical care, the right to comprehensive healthcare programmes, the right to information and guidance for living a free and responsible sex life, the right to working environments that are not harmful to their fertility	Women
Government	Resolution 1531	1992	Through which it associated itself with the commemoration of International Women's Day by recognising a series of rights related to women's health, life, body and sexuality.	Women
Congress	Law 12	1991	Ratifies the CRC	Children, Adolescents and Young People
Congress	Law 60	1991	Decentralised health resources	Right to Health
Constitution	Article 42	1990	States that '[t]he family is the basic nucleus of society... The couple has the right to decide freely and responsibly the number of their children...'	Women
Constitution	Article 44	1990	That article 44 of the Constitution establishes the principle of prevalence of the best interests of children and adolescents.	Children, Adolescents and Young People

Constitution	Article 43	1990	Gives women and men equal rights and opportunities. Women cannot be subjected to any type of discrimination	Women
Constitution	Article 45	1990	The adolescent is entitled to protection and integral development… The State and society guarantee the active participation of adolescents in public and private organs that are responsible for the protection, education, and progress of the youth.'	Children, Adolescents and Young People
Constitution	Article 49	1990	All individuals are guaranteed access to services that promote, protect, and restore health. Health services shall be organised in a decentralised manner, according to care levels and with the participation of the community.	Right to Health
Constitution	Article 50	1990	Any child under a year old who may not be covered by any type of protection or Social Security shall be entitled to receive free care in all health entities that receive state subsidies.	Children, Adolescents and Young People

Appendix D Population Estimates

Table 27 Colombian Total Host Population by Age Group

Age Group	Number of Colombian Women in Host Population
15-19	2010594
20-24	2163015
25-29	2176015
30-34	2017562
35-39	1886979
40-44	1736154
45-49	1560984
Total	13551303

Table 28 Total Venezuelan Migrant Population Smoothed into Age Groups

Age Group	Number of Venezuelan Women in Migrant Population
15-19	193875
20-24	149720.792
25-29	119673.208
30-34	87766.375
35-39	67282.625
40-44	51551.6667
45-49	37767.3333
Total	707637

Appendix E MSPS Data

Table 29 Number of Appointments by Age for Colombians According to MSPS Data

Number of Appointments								
Colombia								
ICD-10 Codes	age group							
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	383,417	512,675	402,547	284,754	181,870	114,711	70,889	1,950,863
Z30.1	4,080	7,469	7,586	4,964	3,103	2,184	1,117	30,503
Z30.4	128,729	186,425	160,393	114,580	73,858	46,742	26,012	736,739
Z30.5	3,934	10,545	12,590	9,740	6,900	4,854	2,965	51,528
Z30.8	45,651	61,458	48,136	31,787	19,135	11,094	5,413	222,674
Z30.9	67,233	100,552	82,310	53,649	31,177	17,463	8,333	360,717

Table 30 Number of Appointments by Age for Venezuelan Migrants According to MSPS Data

Number of Appointments								
Venezuela								
ICD-10 Codes	age group							
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	10,716	15,640	11,808	6,316	2,995	1,247	428	49,150
Z30.1	680	1,160	780	332	150	72	18	3,192
Z30.4	868	1,734	1,739	1,036	453	200	66	6,096
Z30.5	145	552	675	363	270	133	75	2,213
Z30.8	1,072	1,591	1,063	441	190	58	8	4,423
Z30.9	3,532	5,587	4,211	2,307	969	372	78	17,056

Table 31 Number of Colombians Who Attended Services by Age According to MSPS Data

Number of Persons Attended								
Colombia								
ICD-10 Codes	age group							
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	198,488	245,285	194,931	134,719	88,292	56,647	35,421	938,172
Z30.1	2,881	5,207	4,974	3,271	2,096	1,433	725	20,547
Z30.4	73,735	98,906	80,731	54,426	33,425	19,992	10,654	363,549
Z30.5	2,911	7,457	8,605	6,704	4,720	3,354	2,012	35,527
Z30.8	28,213	35,888	27,519	17,927	10,736	6,044	2,980	128,136
Z30.9	42,879	60,678	48,865	31,098	17,834	9,732	4,792	213,739

Table 32 Number of Venezuelans Who Attended Services by Age According to MSPS Data

Number of Persons Attended								
Venezuela								
ICD-10 Codes	age group							
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	7,177	10,502	7,983	4,382	2,141	927	319	33,431
Z30.1	660	1,121	717	308	139	61	15	3,021
Z30.4	792	1,541	1,463	853	388	176	57	5,270
Z30.5	102	408	512	277	185	93	45	1,622
Z30.8	1,009	1,504	982	398	175	51	8	4,127
Z30.9	2,598	4,165	3,115	1,745	735	296	63	12,717

Appendix F Profamilia Data

Table 33 Number of Appointments at Profamilia Services by Age for Colombians

Number of Appointments								
	Colombia							
ICD-10	age group							
Codes	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	28625	24999	16155	9306	5156	2507	671	87419
Z30.1	45	122	165	156	170	186	142	986
Z30.2	388	2195	3508	3820	2950	1450	274	14585
Z30.4	1456	1,114	667	339	206	91	28	3,901
Z30.5	581	1,600	1539	1089	762	689	463	6,723
Z30.8	514	543	372	264	169	77	27	1,966
Z30.9	22176	31263	31185	24680	16158	8092	1760	135,314

Table 34 Number of Appointments at Profamilia Services by Age for Venezuelan Migrants

Number of Appointments								
	Venezuela							
ICD-10	age group							
Codes	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	4598	6195	4282	2621	1392	717	258	20063
Z30.1	4	12	9	3	5	3	1	37
Z30.2	12	145	225	175	117	45	5	724
Z30.4	390	542	419	220	128	53	23	1,775
Z30.5	44	147	186	75	41	22	9	524
Z30.8	12	17	20	4	5	3		61
Z30.9	1590	2579	2257	1427	740	321	45	8,959

Table 35 Number of Colombian Persons Who Attended Profamilia Services by Age

Persons Attended								
	Colombia							
ICD-10	age group							
Codes	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	25,068	22,297	14,442	8,304	4,533	2,172	572	77,388
Z30.1	45	120	153	148	166	170	134	936
Z30.2	325	1,700	2,563	2,542	1,784	940	174	10,028
Z30.4	1,363	1,056	636	321	197	83	28	3,684
Z30.5	506	1,390	1,344	935	694	604	393	5,866
Z30.8	489	514	352	252	163	69	27	1,866
Z30.9	17,108	21,318	17,905	12,681	7,618	3,792	863	81,285
Total	44,904	48,395	37,395	25,183	15,155	7,830	2,191	181,053

Table 36 Number of Venezuelan Persons Who Attended Profamilia Services by Age

Persons Attended								
	Venezuela							
ICD-10	age group							
Codes	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Z30.0	3,664	4,668	3,301	1,876	1,055	537	194	15,295
Z30.1	4	10	9	3	3	3	1	33
Z30.2	9	94	146	115	53	26	3	446
Z30.4	362	490	382	197	116	46	23	1,616
Z30.5	44	125	153	67	28	20	9	446
Z30.8	12	17	18	4	5	3		59
Z30.9	1,359	1,926	1,497	859	407	168	31	6,247
Total	5,454	7,330	5,506	3,121	1,667	803	261	24,142

Appendix G Migration Pulse Survey (EPM)

Examining the data from the EPM reveals that almost half of young people aged 15-24 were not using any contraceptive method. In short, the level of contraceptive non-use in younger people is almost twice that of their older counterparts. Of those that did use methods, hormonal methods were the most popular. The results of the survey showed that most people felt that they did not need to use a method but gave little detail why. It did reveal that a slightly greater proportion of young people found access to be a barrier than older people.

The Pulse of Migration Survey - EPM 2021 also explores contraceptive use in Venezuelan migrants. The EPM Survey aims to capture relevant information about the Venezuelan migrant population in each moment, from a sample of 6,966 selected from the Large Integrated Household Survey (GIEH). In this case, data is collected from the July 2021 round of phone interviews. The weightings were conducted by Department of National Statistics (DANE) using the 2018 census (CPNV) and the Large Integrated Household Survey (GIEH) (DANE, 2023a). As I explained beforehand (see Chapter 3.2.3), it was not possible to access for 15-19 adolescent migrant girls because the data was not disaggregated by age and sex to the extent required for an accurate analysis. However, the data still provides a useful insight into the proportions of Venezuelans using or not using contraceptive methods, and which type of methods they are using.

To analyse this data the weighted numbers and percentages were taken from the question, 'During the last month, did you or your partner use any of the following methods to prevent pregnancy and/or sexually transmitted diseases?' The results of which are presented below by sex (Table 37) and by age (Table 38). The response was grouped into the following options:

- Traditional methods included coitus interruptus, rhythm of menstrual period, cervical mucus, breastfeeding, and body temperature.
- Hormonal method included daily pills, injection or intrauterine device or implant.
- Permanent method included tubal ligation or vasectomy.
- Emergency contraception (morning-after pill)
- Other methods not included above.

Table 37 Numbers and Percentages of Venezuelan Migrants Contraceptive Use by Sex According to the Migration Pulse Survey.

	Women	Men	Total

Method	Weighted Percentage	Weighted Numbers	Weighted Percentage	Weighted Numbers	Weighted Percentage	Weighted Numbers
Condom, female condom or diaphragm	7.29%	91,366	20.55%	249,942	13.82%	341,308
Traditional method	1.46%	18,278	1.58%	19,250	1.52%	37,527
Hormonal method	32.20%	403,635	22.34%	271,718	27.34%	675,353
Permanent method	21.72%	272,234	11.25%	136,864	16.56%	409,097
Emergency contraception	1.00%	12,475	0.42%	5,107	0.71%	17,582
Other	0.88%	11,076	0.48%	5,794	0.68%	16,870
Not using any method	37.37%	468,506	45.17%	549,346	41.21%	1,017,852
Total	101.91%	1,253,595	101.79%	1,216,297	101.85%	2,469,893

The EPM shows that over a third (37.37%) of Venezuelan migrant women were not using any method of contraceptive. Given the gendered burden on contraceptive usage (Littlejohn, 2021), it is unsurprisingly, more men than women were not using any method of contraceptive (45.17%). The potential reasons for this, I will return to in a moment. Of those using a modern contraceptive method, most common type of contraceptive method was the hormonal method (32.20%), followed by a permanent method (21.72), and finally condoms or diaphragms (7.29%). The finding that hormonal methods were the most popular methods were to be expected given that this encompasses daily pills, injection or intrauterine device or implant. However, it is still useful to see how these methods were used relative to barrier methods or permanent surgical methods. To understand if inequalities in access or usage occur across intersectional lines of age, and migration, it is necessary to assess the different patterns of usage occurred between age groups.

Looking at the same results, disaggregated by age, the proportion of method use varies slightly. The comparison with the ages 15-24, and 25-54 shows that a greater number of younger people are not using any method (48.02%) compared to the older age group (34.24%). In both 15-24, and 25-54-year-olds, where a method was used, it was most likely to be a hormonal method (28.75% and 30.04%). As expected, it shows older people are more likely to have a permanent method such as tubal ligation or vasectomy (22.01%) given that this process is irreversible. Whereas young people

are more likely to use condoms (20.11%). These findings suggest that there are different patterns in usage, with a larger proportion of younger Venezuelan migrants not using any method at all, and slight variation between the use of short-term and permanent methods.

Table 38 Numbers and Percentages of Venezuelan Migrants Contraceptive Use by Age According to the Migration Pulse Survey.

	Age group			
	15-24		25-54	
Method	**Weighted Percentage**	**Weighted Numbers**	**Weighted Percentage**	**Weighted Numbers**
Condom, female condom or diaphragm	20.11%	136,087	12.66%	200,788
Traditional	1.34%	9,054	1.79%	28,407
Hormonal method	28.79%	194,778	30.04%	476,587
Permanent method	2.00%	135,12	22.01%	349,108
Emergency contraception	1.12%	7,560	0.59%	9,353
Other	0.71%	4,793	0.67%	10,674
Not using any method	48.02%	324,878	34.24%	543,119
Total	102.08%	676,617	102%	1,586,382

In answer to the question, 'Why did you not use any method to prevent pregnancy and/or sexually transmitted diseases last month?' about two-fifths of 15–24-year-olds of those not using any method (41.01%), replied that had not have sex in previous month (see Table 39). This percentage was greater compared to their older counterparts (21.88% and 30.38%). Another sizeable portion answered that they did not need it, for reasons which were not elaborated upon (54.87%). The percentage who marked that they did not need a contraceptive method were considerably lower in the 15-24 age group than the older age group (72.16%).

Table 39 Reason for Not Using Contraception by Age According to the Migration Pulse Survey

Age		**15-24**	**25-54**
I did not need it	Persons	178,089	391,177
	%	54.87%	72.16%

I do not know how to use them	Persons	2,011	4,194
	%	0.62%	0.77%
I did not have money to buy them or health insurance to provide them	Persons	16,255	16,636
	%	5.01%	3.07%
The service or programme I was a part of was interrupted due to the pandemic	Persons	0	617
	%	0.00%	0.11%
My partner prevented me or did not agree to use one	Persons	850	1751
	%	0.26%	0.32%
I did not have sex last month	Persons	133,081	118,594
	%	41.01%	21.88%
Other	Persons	13,211	26,414
	%	4.07%	4.87%
	Total	324,547	542,100

If I were to speculate, some could have already been pregnant (3.3% according to a later question) or had a partner who was pregnant. From the review of the literature, and experiences during fieldwork, I would speculate other possible explanations could be that they wanted to conceive, that they felt that contraceptive methods were not their responsibility or that they were engaged in same-sex relationships. Without more information, it is impossible to tell for definite.

A surprisingly low number of respondents answered that their reason for not using contraceptive care was related to their inability to buy or access them through the health insurance (5.07%). However, this percentage was still noticeably higher than in the 25-54 age group (3.07%) showing that this is a greater problem for those who are younger. It was further reassuring to see that there was a relatively low proportion of respondents who cited knowledge of how to use methods as a barrier for 15–24-year-olds (0.62%) and 25-54-year-olds (0.77%). Overall, then these show that where access is a problem is a greater problem for younger Venezuelan migrants.

Appendix H Violence again Children Survey (VACS)

Consistent with the findings from the EPM, the VACS data demonstrates that there are high levels of non-use amongst the Venezuelan adolescent migrant population. Overall, indicating that there are inequalities between access for the Venezuelan migrant population versus the Colombian host population.

The VACS sampled 1,406 individuals ages 13-24 in Colombia during 2018. The survey results were attained with the weightings calculated by Together for Girls, (2023). The greatest advantage to using survey is that it disaggregated contraception by different methods. In comparison, the ICD-10 codes used in RIPS and 029, as well as the Migration Pulse survey, mainly grouped contraceptive methods based on varying criteria which meant that the details of which contraception is being used was lost. Given the smaller sample of Venezuelan migrants in the VACS it is hard to draw any other conclusions, as discussed in Chapter 3.2.3.

Table 40 shows the results for the question used from the Colombian VACS female questionnaire, 'Are you and this person currently doing something or using any method to delay or avoid getting pregnant? If yes, which method are you and this person using?' Unlike EPM, the answers were not grouped into aggregate methods, so we can see differences between methods used

It is interesting to note how those who had lived in Venezuela before moving to Colombia were 1.79 times less likely to use a method of contraception when they had sex with their most recent partner. That means just under half of the Venezuelans sampled were likely to use no method at all (47.5%) compared to roughly a quart of Colombians (26.4%). This figure reflects the 48.0% of Venezuelan migrants aged 15-24-years old who were not using any method in the EPM survey above.

Roughly two fifths of the Venezuelan migrant population used hormonal methods such as injectables, pills (37.90%), compared to over half of Colombian respondents (51.80%). The percentage of Venezuelans is slightly higher than seen in the EPM, but equally, the inequalities between host and migrant population from the VACS is also greater. It was surprising to find that none of the respondents reported using female or male condoms.

Table 40 Numbers of Persons Surveyed and Weighted Percentages for Contraceptive Use Within the Venezuelan Migrant Population and the Colombian Population

Method	Host Population		Venezuelan Migrants	
	Numbers Surveyed	Weighted Percentages	Numbers Surveyed	Weighted Percentages
Female sterilisation	24	5.0%	5	1.9%
IUD	16	1.9%	2	18.2%
Injectables	172	24.0%	7	13.1%
Implants	82	14.7%	8	4.3%
Pill	60	11.2%	5	2.3%
Male condom	0	0.0%	0	0.0%
Female Condom	0	0.0%	0	0.0%
Diaphragm	125	15.4%	7	9.4%
Foam/Jelly	4	0.1%	0	0.0%
LAM	3	0.4%	1	2.4%
Rhythm method	3	0.1%	0	0.0%
Withdrawal	2	0.9%	3	1.0%
No method	175	26.4%	28	47.5%
Declined	0	0.0%	1	0.0%
Total	668	100%	67	100%

Overall, the VACS data shows that a large proportion of sexually active Venezuelans and Colombians are not using any contraceptive method to prevent pregnancy. Of those that do use contraceptive methods, the majority use a form of hormonal contraception with none using condoms.

Glossary of Terms

Adolescent..... The WHO (2021) defines adolescents as 10-19 years of age, differentiating between younger (10-14 years of age) and older (15-19 years of age) adolescents.

Adolescent-Friendly..... Adolescent-friendly health services refer to healthcare facilities and practices specifically designed to meet the unique needs and preferences of adolescents.

Contraception..... The intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs or surgical procedures' (Jain and Muralidhar, 2011).

CSE..... Comprehensive sexuality education gives young people accurate, age-appropriate information about sexuality and their sexual and reproductive health, which is critical for their health and survival.

Contraceptive Autonomy .... 'The factors that need to be in place in order for a person to decide for themselves what they want in regard to contraceptive use, and then to realise that decision' (Senderowicz, 2020, p. 165).

Comprehensive Contraceptive Care Encompasses education, information, and resources. As a result, it views both the use and non-use of contraception as a positive outcome (Senderowicz, 2020; Cadena, Chaudhri and Scott, 2022).

Evolving Capacities ..... 'Processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realised' (UNCRC, General Comment No. 7: para. 17)

Humanitarian Response ..... National or international action taken in response to a crisis (Eklund and Tellier, 2012, p. 593).

Intersectionality ..... The critical insight that race, class, gender, nation, and age (amongst other dimensions) interlock to create reciprocally constructing phenomena', that in turn shape complex social inequalities (Collins, 2015, p. 2; Crenshaw, 2017)

LARCs..... Long-acting reversible contraceptive methods includes intrauterine devices and implants.

Non-State Actor..... Refers to an entity or organisation that operates independently of a government or sovereign state.

Migrant..... A migrant is an individual who moves or relocates from their habitual residence to another across an international border.

Migrant-Inclusive..... Refers to healthcare systems and practices that intentionally consider and address the healthcare needs of migrants.

Modern Contraceptive Methods Include oral contraceptives pills, emergency contraception pills, implants, injectables, patches, vaginal rings, intrauterine devices, condoms, surgical methods, lactational amenorrhea method, standard days method, basal body temperature method, two-day method and symptom-thermal method (WHO 2018b).

Oppression ..... I adopt Young's five 'faces' of oppression: violence, exploitation, marginalisation, powerlessness, and cultural imperialism. (Young, 2020)

Refugee..... A refugee is an individual who has been forced to flee their home country due to well-founded fears of persecution, conflict, violence, or other circumstances that seriously threaten their safety and well-being. Refugees seek international protection and are recognised as such under international law, particularly the 1951 Refugee Convention and its 1967 Protocol.

Reproductive Health..... A state of complete physical, mental, and social well-being' in matters related to reproduction (United Nations General Assembly, 2015). This entails the right to receive accurate information about the reproductive system, manage menstruation hygienically, access services to prevent intimate partner violence, and have access to safe, effective, and acceptable contraception methods (WHO, 2014).

Reproductive Realities ..... How SRHR are enacted in accordance to unique circumstances, experiences, and needs

Reproductive Rights ..... Emphasise the freedom to decide the number, spacing, and timing of children (World Conference on Women, 1996; UNFPA, 2014a). These rights include making reproductive decisions free from discrimination, coercion, and violence, ensuring privacy, confidentiality, respect, and informed consent, and fostering mutually respectful and equitable gender relations (UNFPA, 2014b).

Sexual Health	'A state of physical, emotional, mental, and social well-being in relation to sexuality,' emphasising a positive and respectful approach to sexual experiences, free from coercion, discrimination, and violence.
Sexual Rights	Achieving the highest standard of sexual health, seeking and imparting information related to sexuality, receiving comprehensive sexuality education, having bodily integrity respected, choosing a sexual partner, deciding on sexual activity, engaging in consensual relations, making decisions regarding marriage, and pursuing a satisfying, safe, and pleasurable sexual life free from stigma and discrimination (Kismödi *et al.*, 2017).
State Actor	Refers to an entity or organisation that operates on behalf of a government or sovereign state
Total fertility Rate	The average number of children that would be born to a woman, if she were not subject to mortality and bore children in accordance with age-specific fertility rates of the specified year.
Unmet contraceptive needs	Used to describe 'sexually active, fecund women who report wanting to delay their next birth by at least two years or to stop childbearing altogether but are not using a contraceptive method' (WHO, 2021).
Venezuelans displaced abroad	'Persons of Venezuelan origin who are likely to be in need of international protection under the criteria contained in the Cartagena Declaration, but who have not applied for asylum in the country in which they are present. Regardless of status, Venezuelans displaced abroad require protection against forced returns, and access to basic service' (UNHCR, 2019a, p. 64).

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