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Leave no woman behind: The right to contraceptives upon displacement

A mixed-methods study on access and barriers to contraceptives among female Venezuelan migrants in Colombia

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Abstract

Colombia has received global attention for their innovative response to the Venezuelan migration crisis. However, the question remains; has this response translated into an improved access to contraceptives for Venezuelan women in Colombia? This study aims to explore how migrants and health staff perceive access to contraceptives, how migration status and socioeconomic situation impede this access, and how access may improve. Employing a mixed-methods approach, data was collected through surveys and interviews with Venezuelan women and health staff.

By applying a human rights-based approach, this study identifies barriers to access within five dimensions: accessibility, accommodation, affordability, acceptability and availability. Key barriers identified include legal status, or lack thereof, socioeconomic situation and lack of information, which are deeply intertwined. Thus, despite progressive policies, many migrants remain unregularized, without access to the health care system, and experience restrictions in accessing contraceptives. The study finds that by focusing on the transportation infrastructure, outreach services and information dissemination access could improve, alongside addressing negative gender norms, combating corruption and better coordination between actors. In addition, improve the regularization process, and facilitating enrollment in the health system, both crucial to access contraceptives.

Key words: Contraceptives, contraceptive access, reproductive health, migration status, Venezuelan migration, Colombia.

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List of Abbreviations

A.k.a	Also known as
CESCR	Committee on Economic, Social and Cultural Rights
E.g	Exempli gratia (for example)
EPS	Health Promoting Entities (in Spanish Entidades Promotoras de Salud)
HRBA	Human Rights Based Approach
ICESCR	The International Covenant on Economic, Social and Cultural Rights
I.e	Id est (that is)
IGOs	Intergovernmental Organizations
IPS	Health Service Provider Institutions (in Spanish Instituciones Prestadoras de Servicios de Salud)
JAC	Community Action Boards (in spanish Juntas de Acción Comunal)
IUD	Intrauterine device
LAC	Latin America and the Caribbean
NGOs	Nongovernmental organizations
SDH	Social Determinants of Health
SISBEN	System for the Identification of Social Assistance Beneficiaries (Sistema de Selección de Beneficiarios de Programas Sociales)
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRHS	Sexual and Reproductive Health care services
TPS	Temporary Protection Status for Venezuelan Migrants
UDHR	Universal Declaration of Human Rights

1. Introduction

As stated in the Declaration of Human Rights (UDHR), signed by Colombia, "all human beings are born free and equal in dignity and rights" (UN General Assembly, 1948, Article 1). In theory, this means the fulfillment of all human rights for all people, regardless of being a migrant or not. In reality however, this is not always the case. This thesis will focus more closely on the realization of one of these rights, the right to health and reproductive rights, specifically focusing on access to contraceptives.

1.1 Research problem, objective and relevance

In August 2023, over 7.7 million Venezuelans were displaced, and roughly 80% were hosted in Latin America (R4V, 2023). This constitutes the largest migration crisis in Latin American history (R4V, 2023). Most migration research has focused on the effects in the recipient countries, which often are so-called "developed" countries. Less focus has been on south-south migration (i.e., between "developing" countries"), despite south-south migration being comparatively much bigger in numbers (Blyde et al., 2020). Furthermore, Latin American migration research has mostly focused on the impact of migration from Central America to the US, and less on the Venezuelan migration (Blyde et al., 2020).

Colombia is by far the biggest recipient country of Venezuelan migrants. In October 2022 the Venezuelan migrant population in Colombia exceeded 2.8 million people (R4V, 2023). Moreover, Colombia has gained global attention for its progressive response to the Venezuelan migration crisis. Its strategy, which focuses on long-term integration, enables Venezuelans to have the same access to social services as Colombians (World Bank, 2023b). Thus, it is relevant to study whether Venezuelans migrants' experiences mirror these efforts, and whether this has translated into better access to contraceptives.

Furthermore, migration is not a gender-neutral process, and impacts women and men differently. Looking specifically at health, women are one of the most vulnerable migration groups that suffer from poor access (Lebano et al., 2020). In general, both the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Beijing Declaration highlight that special attention needs to be given to, amongst other vulnerable groups, female migrants (Kähler et al., 2017: 18). Looking at migration through a right to

health-lens, the reasons for the vulnerability among female Venezuelan migrants is linked to, for example, heightened risks of sexual violence, forced sex work, lack of access to Sexual and Reproductive Health and Rights (SRHR) like contraceptive methods and safe abortion services, health care and mental health services (Calderón-Jaramillo et al., 2020; Profamilia, 2019). A violation of the SRHR upon migration can result in otherwise preventable consequences, such as maternal deaths caused by interrupted care, pregnancy and post-pregnancy complications, unintended pregnancies, unsafe abortions, transmission of sexually transmitted infections (STI) and including other physical and mental health problems (Profamilia, 2019; WHO, 2019).

Looking specifically at SRHR and migration, the Guttmacher-Lancet Commission in their report on SRHR highlighted refugees and migrants as one vulnerable group in terms of heightened or neglected SRHR needs, and as a group in need of more research (Starrs et al., 2018). Most research on SRHR has focused on married women of reproductive age (Starrs et al., 2018), and while research exists on the SRHR needs of youth, Tirado et al (2020) state that "there is limited information available on the SRHR of young refugees" (here ages 10-24) (Tirado et al., 2020: 2).

Therefore, to understand the specific situation of young Venezuelan migrant women and be able to make more accurate needs assessments and develop proper gender-responsive policies, it is essential to research their lived experiences (UN Women, 2023). By focusing on this group, this study will contribute to filling a gap of an under-researched field of study simultaneously as addressing the issues of inequalities by focusing the challenges faced by a vulnerable population.

1.2. Purpose and research questions

This study will focus on access to contraceptives, and interrelated to this, access to the necessary information, resources and services needed (Starrs et al., 2018). Drawing on a combined right to health framework by Penchansky and Thomas (1981), Bertrand et al. (1995) and CESCR (2000), the purpose of this study is to examine access to contraceptives among young unmarried female Venezuelan migrants in Colombia. The following research questions will guide this study:

I. How do female Venezuelan migrants and health staff working with migrants perceive access to contraceptives in Colombia?
II. How may certain social determinants of health, specifically migration status and socio-economic situation impede access to contraceptives for Venezuelan migrant women?
III. How could access to contraceptives among Venezuelan migrant women in Colombia be improved?

1.3. Definition: migrants

This study defines migrants as individuals who have left Venezuela to pursue a new life in Colombia. This is to be understood as an umbrella term, which can include, but is not limited to migrant workers, refugees, irregular migrants, and people migrating to Colombia short or long-term (United Nations, 2023).

2. Contextual background

2.1. The Venezuelan migration crisis

Between 2008-2013 the national poverty was around 32-33%, and extreme poverty in Venezuela was around 9%. Since then, the situation has worsened drastically. In 2021, the total poverty reached 94%, and extreme poverty 76.6% (ENCOVI, 2021). According to Profamilia (2019), the most common cause for migration from Venezuela is insecurity (72.5%), despair (70.8%), hunger (63.1%), high level of stress in daily life (61.9%) and uncertainty for the future (58.8%). While the migration from Venezuela stems from complex reasons of both political, economic, and social nature (Kamali Dehghan, 2021), most migrate based on economic uncertainties (Bitar, 2022). While migrants clearly had unmet needs prior to migrating, the migratory experience itself is filled with additional risks ranging from physical dangers and exploitation (e.g. dangerous terrains and transports, robbery, killings, trafficking), to economic, social, and psychological consequences (IOM, 2023). All these risks can cause violations to each individual's human rights, and of utmost relevance here to the “highest attainable standard of physical and mental health” (UN General Assembly, 1966, Article 12), a right entitled to each individual regardless of migration status.

2.2. The Colombian context

Colombia is the largest recipient of Venezuelan migrants in Latin America, receiving around 30% of all Venezuelan migrants in the region (World Bank, 2023a). Historically Colombia has been a country of emigration and for the first time, Colombia has become a recipient country of large-scale immigration, inevitably increasing the pressure on the social service delivery and the health system (Bitar, 2022). Additionally, Colombia has the second highest numbers of internally displaced people in the world, around 6.8 million people (USA for UNHCR, 2024).

After decades of violence, a peace agreement between the Colombian government and the Revolutionary Armed Forces of Colombia (FARC) was signed in 2016. Despite this, violence from different armed actors remains high (Nationalencyklopedin, 2023; ACLED, 2024). Colombia continues to be one of the most dangerous countries in the world for human rights defenders, journalists and activists (Human Rights Watch, 2024). Furthermore, Colombia has the second highest income inequalities in Latin America, and highest among the OECD-countries[1], measured through the Gini-index (World Bank, 2020). Throughout the period of the Venezuelan migration crisis, the inequalities in Colombia have increased, from an all-time low Gini-index of 0.497 in 2017 to its peak during the pandemic with 0.554 (DANE, 2022; World Bank, 2023c). Inequalities are exacerbated when looking at different groups. The World Bank (2020) demonstrates how unemployment is higher among men than women and indigenous and afro-Colombians receive less education of worse quality and are more likely to live in bad housing conditions. Moreover, Colombia has one of the highest informality rates in Latin America, almost 60% of the population works within the informal sector (World Bank, 2020). Despite Colombia's strong and growing economy and major improvements within poverty reduction, health and education (World Bank, 2023a), major inequalities persist.

2.3. Health systems and the SRHR situation in Colombia

In Colombia, there are two ways to access health services within the General System of Social Security in Health (hereafter health system); through contributory or subsidized regimes. The contributory is for people and their dependents that have financial capacity to contribute, while the subsidized programme is designed for people in conditions of vulnerabilities, most often outside the formal sector (Montenegro Torres & Bernal Acevedo, 2013). Responsible for identifying the beneficiaries is SISBÈN (DNP, 2023). For Venezuelan migrants to access the

[1] Organization for Economic Co-operation and Development

system, they must be regularized and thereafter affiliate to a regime (Rossiasco & de Narváez, 2023). There are different entities responsible for the healthcare provision. In short, the EPS (in Spanish Entidades Promotoras de Salud) are Health Promoting Entities that manage and coordinate the health insurance and people's access to it, while the IPS are Health Service Provider Institutions (in Spanish Instituciones Prestadoras de Servicios de Salud) - actors that directly provide the healthcare services (Alcaldía de Bogotá, 2021).

Through the changed constitution in 1991, Colombia recognized reproductive autonomy and family planning as a human right. Furthermore, Law 100 from 1996 established a new health coverage system, affirming the government's obligation to provide family planning services (Bertrand et al., 2015). Several measures have been implemented to address SRH in Colombia, for example, Colombia has had two national policies for Sexual and Reproductive Health (Bertrand et al., 2015), and in 2022, abortion was made legal until week 24 (Amnesty International, 2022). Looking at the coordination for healthcare for Venezuelan migrants, emphasis has been given towards intra-governmental coordination, but also on coordination with several Intergovernmental Organizations (IGOs) (Bojorquez-Chapela, 2020).

Health care access and health outcomes have improved during the last decade in Colombia (Montenegro Torres & Bernal Acevedo, 2013). In 2020, Colombia had the highest health care coverage (97%) and the lowest out-of-pocket expenditures in the region (OECD, 2023b). Nevertheless, difficulties remain with providing good quality care for all, especially for rural or lower-income areas (World Bank, 2023d).

Regardless of participating in the contributory or subsidized regime, basic contraceptives in Colombia are free of charge (Fagan et al., 2017). In 2015, UNDP reported that 80% of women aged 15-49 in Colombia had a satisfied demand for modern contraceptives (UNFPA, 2015). No updated data is available. A study from 2017 (Fagan et al., 2017) show that around half of the married women and women in a union rely on female sterilization as contraception, followed by injectables, pills, male condom and IUDs that each contribute to around 10% (Fagan et al., 2017). Male sterilization is the least used with 3.4% (Olivieri & Muller, 2019). Sterilization in Colombia is provided free of charge for anyone above 18, and since the passing of Law 1412 of 2010, sterilization is seen "as a way of encouraging responsible motherhood and fatherhood" (Olivieri & Muller, 2019: 38). With that said, the variation in contraceptives remains limited, particularly in rural areas (Fagan et al., 2017). Finally, 56% of contraceptive users have obtained

their methods from public health care, 7% from private health facilities, 18% from pharmacies and 14% from Profamilia (non-profit) (Ministry of Health and Social Protection, 2016).

2.4. Legal status for Venezuelan migrants in Colombia

> Colombia has become a global leader in its response to the unprecedented migration from Venezuela, setting new standards for integration, including the introduction of some of the most progressive, innovative, and comprehensive solutions in the world (Rossiasco & de Narváez, 2023: 3).

Colombia's immigration policy strategy is according to Rossiasco & de Narváez (2023) divided into three phases.

The first phase from 2015-2017 focused primarily on short term humanitarian assistance. Towards the end of 2017, the Special Permanence Permit (PEP) was created, offering a temporary resident permit up to two years, with access to markets and basic social services (Rossiasco & de Narváez, 2023).

During the second phase (2018-2021) efforts to improve the institutional coordination to ensure proper provision of basic services were made (Rossiasco & de Narváez, 2023). The immigration increased drastically, thus also the demand for healthcare (Rossiasco & de Narváez, 2023). Changes in attitudes towards the Venezuelan population were seen, from being received with support, partly due to long historical ties between the countries, towards attitudes of xenophobia and discrimination (Angeleri & Murphy, 2023; Rossiasco & de Narváez, 2023).

During the last phase (2021-present), focus has been on long-term integration, especially through the creation of the Temporary Protected Status for Venezuelan Migrants (TPS), that can grant Venezuelan migrants a residence permit for up to 10 years, improving Venezuelans rapid and long-term access to the formal labor market, educational and health systems. The TPS enables migrants entering Colombia on irregular routes prior to 31st of January 2021 to get granted a migration status (Angeleri & Murphy, 2023; Bojorquez-Chapela, 2020). The TPS is valid as long as the migration status is valid and is a requirement for affiliation with a health regime, thus, irregular migrants cannot affiliate (Bojorquez-Chapela, 2020). Without the TPS, Venezuelans only have access to emergency health care services (Bowser et al., 2022).

3. Literature review

3.1. The right to (reproductive) health

In article 25 of Universal Declaration of Human Rights (UDHR) it is stated that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care" (UN General Assembly, 1948, Article 25). Furthermore, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN General Assembly, 1966, Article 12). SRHR and access to sexual and reproductive health care services (SRHS) is an essential component in the realization of this right.

Despite many efforts, there is no universally accepted definition of SRHR. The most holistic definition was provided by the Guttmacher-Lancet Commission in 2018 and includes four concepts; sexual health, sexual rights, reproductive health and reproductive rights, and within each, several components, including, of particular relevance to this thesis, to "decide whether, when, and by what means to have a child or children, and how many children to have", and "a choice of safe and effective contraceptive methods" (Starrs et al., 2018). Fulfillment of sexual and reproductive rights is a precondition for sexual and reproductive health, meaning without realizing the former, the latter cannot be achieved (Starrs et al., 2018).

3.2. Health challenges for migrants

One cannot draw any conclusions on the health situations of migrants, as this depends on the conditions during the migration. Thus, it is not the migration itself that constitutes a risk factor, but vulnerabilities that might result from the migration process (Pavli & Maltezou, 2017). For example, the living conditions like settling in a location with a higher disease prevalence or lack of proper healthcare options, or the travel conditions, differing between a safe journey on a plane, versus using irregular migration routes (Zimmerman et al., 2011). Migrants that transit through camps suffer particular health vulnerabilities such as more communicable diseases due to crowding and poorer hygienic standards (Pavli & Maltezou, 2017). Furthermore, Zimmerman et al. (2011) highlights the risk of non-communicable diseases when mirroring the host-population, increased risk of worsened mental health and greater risk for pregnancy complications. Also, the interruption of care for chronic diseases, lack of follow up for hereditary diseases or difficulties of accessing necessary medicine (WHO, 2019).

3.3. Barriers to achieving the highest attainable standard of health for migrants

Studies show that aspects like legal status, discrimination, high costs, lack of information, language barriers, sociocultural norms or inability or fear to visit government owned healthcare facilities act as barriers to achieving the highest attainable standard of health for migrants (WHO, 2019). A literature review of migration in the EU shows persistent inequalities in access to healthcare services between migrants and EU-citizens, due to legal and communication barriers (Lebano et al., 2020). Legal barriers including lack of insurance access is recurring in several studies (Hacker et al., 2015). Especially vulnerable are undocumented migrants, who therefore often underutilize the health system (Hacker et al., 2015). Migrants face barriers related to the bureaucratic system such as requirements to demonstrate documentation, insurance, lacking knowledge on the functioning of the system, financial constraints and fear of discrimination and deportation. In 2021, reports showed that Venezuelan migrants faced significant challenges in healthcare, for example lack of awareness, administrative barriers and discrimination (Angeleri & Murphy, 2023). In 2022 50% of the Venezuelan migrants were still lacking proper access to healthcare (Angeleri & Murphy, 2023).

3.4. Barriers to SRHR for Venezuelan migrants

Women during migration are particularly vulnerable, for example suffering heightened risks of sexual and gender-based violence, femicide, forced sex work, mental health services, SRHR-related care and general health care (Calderón-Jaramillo et al., 2020; Profamilia, 2019). Subsequently, maternal deaths, unintended pregnancies, transmission of STIs and unsafe abortions and that under different circumstances can be prevented occurs more often (Profamilia, 2019; WHO, 2019). Looking at the SRHR situation for Venezuelan migrants in Colombia, few studies exist (Brizuela et al., 2021; Brizuela et al., 2023). Quintero et al. (2023) studied voluntary interruption of pregnancy and SRH among Venezuelan migrants in Barranquilla. This study identified lack of information as the biggest barrier for voluntary interruption of pregnancy, followed by attitudes against it, difficulties in accessing the social security system and discrimination in health care (Quintero et al., 2023). Ortiz-Ruiz et al. (2023) demonstrates how living conditions, social integration, economic resources, employment and human capital determine enjoyment of SRHR for Venezuelan migrants in Cali (Ortiz-Ruiz et al., 2023). The Danish Refugee Council identifies the three biggest barriers to access healthcare

for Venezuelans in Colombia as “lack of documentation (46.71%), distance to health centers (12.50%), and access to transportation (7.40%)” (Diaz et al., 2023: 3).

Few studies exist on the SRHR for younger migrants globally. Tirado et al (2020) however demonstrate that the barriers and facilitators faced by young refugees (aged 15-24) are very similar to those faced by the older migrant population. Barriers include, for example, stigma, lack of infrastructure, lack of information about SRHR and the social and legal contexts of the new country, financial constraints, security concerns, gender-based violence and different societal norms (Tirado et al., 2020).

3.5. Barriers to access contraceptives for Venezuelan migrants

Marquez-Lameda (2022) highlights the limited availability of contraceptives in Venezuela, due to an almost collapsed health structure. However, the contraceptive prevalence remains unidentified. Nevertheless, the crisis in Venezuela has caused a scarcity of contraceptive methods available, except for condoms (Rivillas-García et al., 2021). Furthermore, the remaining supply has become too expensive for many to be considered an option (Marquez-Lameda, 2022).

Makuch et al. (2020) interviewed Venezuelan migrants living in shelters in Brazil about contraceptives. In general, there was no scarcity of injectables, pills and condoms, however more long-term contraceptives like Intrauterine Devices (IUDs), implants and tubal ligation were inaccessible (Makuch et al., 2020). This scarcity is experienced by all women in Brazil. One aspect mentioned is the scarcity of trained providers in placement and management of contraceptives. The informants also stress discrimination as one barrier to access contraceptives (Makuch et al., 2020).

A study of contraceptive access for Venezuelans in Peru demonstrated that contraceptive usage was associated with being insured and/or having a higher socio-economic status (Márquez-Lameda, 2022). Furthermore, living in the capital with the availability of more health services in general was not associated with increased access to contraception. On the contrary, women in Trujillo had better access to contraception than women in Lima, despite being only 1/10 of the population (Márquez-Lameda, 2022).

A study by Profamilia (2019) demonstrated that stigma, discrimination, misinformation, high costs and lack of documentation were main barriers to access SRHR-related healthcare (Profamilia, 2019). According to Profamilia (2019) Colombia can satisfy the demand for short-term contraceptives, however, only 50% of the long-term demand, which inevitably limits womens opportunities to freely choose contraceptive methods. Among the top 10 unmet SRHR needs in four border regions of Colombia, access to contraceptives was the biggest in three 3/4 regions, and the second biggest in the fourth region. Neither region had good service nor contraceptive availability (Profamilia, 2019).

Rivillas-García et al. (2021) has to my knowledge produced the only study specifically on contraception access for Venezuelan migrants over 18 in Colombia, however, not exclusively on women. Nevertheless, in 98.8% of the cases women were recipients of the contraception services (Rivillas-García et al., 2021). They found a big increase in the use of contraception services for Venezuelans in 2019, compared to the previous year. Requested services ranged from vasectomies and IUDs to pregnancy tests and contraceptive counseling. Barriers like discrimination, lack of information and out-of-pocket expenses were emphasized in focus group interviews, but also good availability of services, good treatment and care - both from public and humanitarian actors. The study pointed out legal barriers, specifically for undocumented migrants as challenging (Rivillas-García et al., 2021). They analyzed inequalities in contraceptive service access and concluded that the majority was explained by both relative and absolute inequalities of “the demographic dependency rate and the lack of job opportunities” (Rivillas-García et al., 2021: 8).

4. Conceptual framework

4.1. A human rights-based approach

This study will be guided by a Human Rights Based Approach (HRBA). The core of HRBA, is that “development cooperation contributes to the development of the capacities of ‘duty-bearers’ to meet their obligations and/or of ‘rights-holders’ to claim their rights" (United Nations, 2003: 1). As such, the obligations of the duty-bearers, in this case, to ensure the realization of the right to health, becomes clearer (Broberg & Sano, 2018). Human rights are indivisible and interdependent, meaning that all rights are equally important, the realization of one is dependent on that of others. Nevertheless, this study focuses explicitly on the right to health and the right to access contraception, an essential component of the realization of one's reproductive rights (Starrs et al., 2018). Looking at health from a HRBA, it becomes essential to prioritize research focused on right-holders in conditions of vulnerability, such as migrant women (Sida, 2022).

4.2. Social determinants of health

The social determinants of health (SDH) are defined as “the conditions in which people are born, grow, work, live, and age” (WHO, 2023), and despite being non-medical factors, have major influences on the health outcomes. As aforementioned, several studies emphasize how migration status (a.k.a. legal status or undocumented migrants) and the socio-economic situation determines migrants' access to healthcare. While several determinants influence health outcomes, “those with lower socio-economic status and irregular migration status experience even greater barriers to accessing necessary services” (IOM, 2006 :6), and often lack necessary knowledge around the health system and their rights (Diaz et al., 2023). While SDH encompasses a broad range of conditions, this study, due to limitations of this thesis both in words and time, will focus on migration status and socioeconomic situation.

4.3. Health service utilization and access

Penchansky & Thomas (1981) defines access as “a measure of the "fit" between characteristics of health providers and services and the characteristics and expectations of the clients” (Penchansky & Thomas, 1981: 139). Thus, access includes the dimensions of availability (volumes, types and personnel), accessibility (geographical distance and cost), accommodation

(opening hours, mobile services, systems of appointments etc.), affordability (financially) and acceptability (attitudes about characteristics of clients and providers) (Penchansky & Thomas, 1981). If clients seeking care have problems with these five dimensions, it will impact their utilization of the services.

Bertrand et al. (1995) defined access as "the degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of the population" (Bertrand et al., 1995: 65). Access contains five elements similar to the aforementioned: geographical or physical availability, economic accessibility, administrative accessibility (rules and regulations from the health facility), cognitive accessibility (awareness of services) and psychosocial accessibility (psychological, attitudinal or social constraints, e.g. stigma or fear of accessing services) (Bertrand et al., 1995).

To clarify the right to health further a General Comment no. 14 on the ICESCR was issued. Here, the right to health includes four core components (i.e. AAAQ-framework): availability (quantity), accessibility (physical, economic, non-discrimination, and informative) acceptability (culturally appropriate, confidential and medically ethical), and quality (facilities, goods, services, and skilled personnel) (CESCR, 2000). This is reaffirmed in the General Comment no. 22 on SRH, specifying the AAAQ-components in relation to SRH (CESCR, 2016).

4.4. My conceptual framework

All frameworks include similar components; however, some include societal factors or the health system context to a larger extent. Nevertheless, all have a core of individual determinants as explanation to access to health services, or lack thereof. This study's framework synthesizes key features from each framework. As the intention is to analyze the individual's perceptions around access, and not assess the quality of the services, the quality components are not included. Based on the belief that SDH impacts health, migration status and socioeconomic situation are integrated. The following are the guiding definitions.

4.4.1 Accessibility

In this framework, accessibility encompasses geographical and information accessibility. Geographical accessibility by having the opportunity to safely access facilities providing

contraceptives “with an acceptable level of effort” (Bertrand, 1995: 65), considering aspects like travel distance, time and cost (Penchansky & Thomas, 1981). Information accessibility includes the right to seek, spread and receive information on contraceptives in a way that is appropriate for the individual (CESCR, 2000). Information accessibility includes awareness of the existence and location of a contraceptive service facility (Bertrand et al., 1995).

4.4.2. Accommodation

Accommodation refers to how well the health care can satisfy the preferences and needs of their patients. This includes convenient opening hours, user-friendliness of the booking system and reasonable requirements to book an appointment (Penchansky & Thomas, 1981; Bertrand et al., 1995).

4.4.3. Affordability

Affordability refers to the economic or financial capacity to afford contraceptives, both direct costs of the contraceptive, and indirect costs like required time off work or transportation (Penchansky & Thomas, 1981; Bertrand et al., 1995; CESCR, 2000).

4.4.4. Acceptability

In this framework, acceptability includes non-discrimination, meaning how acceptable and non-discriminating the contraceptive services were experienced by the individual (CESCR, 2000; Penchansky & Thomas, 1981). In line with Bertrand et al., (2015) definition of psychosocial accessibility, this also includes social factors such as social stigma, (dis)approval of use, or fear of side effects.

4.4.5. Availability

Availability refers to the adequate availability of contraceptives, both volumes, types, and ensuring that the facilities are adequately equipped for contraceptive purposes. Furthermore, the health facility should have sufficient personnel, and sufficient trained personnel to perform the services needed (CESCR, 2000; Penchansky & Thomas, 1981).

This conceptual framework is used to guide all stages of the study, from the formulation of the research questions to informing the interview guide and structuring the analysis.

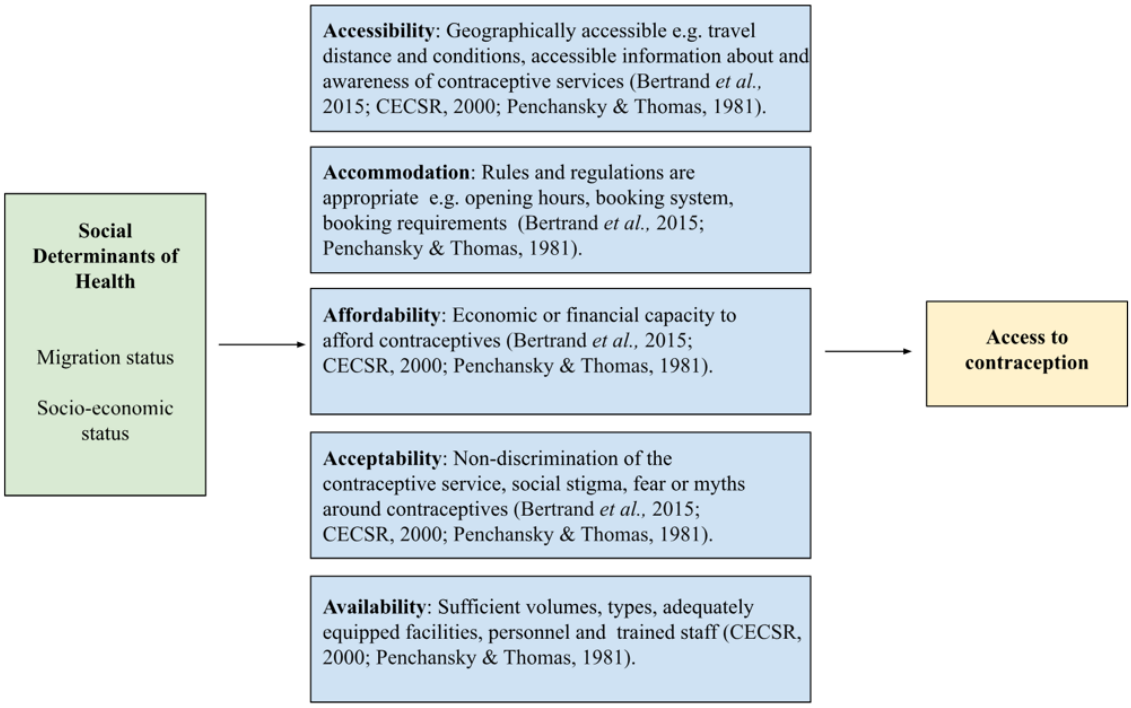

Figure 1. Conceptual framework

5. Methodology

5.1. Research Design

This study uses a single case study design, where focus is on developing a detailed understanding of a phenomena (Creswell & Plano Clark, 2017). Given the nature of the research - understanding more about contraceptive access for Venezuelan women in Colombia, the study has a strong qualitative emphasis. However, it departs from a mixed-methods research design, meaning the combined use of qualitative and quantitative methods and data (Creswell & Plano Clark, 2017).

Choosing a mixed-methods design has several advantages. You can draw from the strengths of qualitative research in bringing in the voices of the participants and creating a more in-depth understanding, while the strengths of the quantitative research in reaching a larger sample in a less time-consuming manner with an opportunity to have more transferable conclusions, at least in the quantitative component (Creswell & Plano Clark, 2017). However, using a mixed method

is more time and resource demanding as it requires knowledge around two methods. Combining the two data-collection techniques and sources of data can enable a more comprehensive understanding and provide complementary insights, for example uncover explanations behind the survey answers, while also triangulating the findings to "check and correct quantitative data and make the survey data more robust" (Bryman, 2012: 635). Therefore, the positive aspect of using this method is assessed as outweighing the negatives.

Inspired by what Creswell & Plano Clark (2017) describes as an explanatory sequential design, this research design was constructed with the idea of first collecting and analyzing the quantitative survey data, and subsequently carry out qualitative interviews to deepen the understanding of the survey results (Creswell & Plano Clark, 2017). However, due to difficulties in initiating the survey, the distribution time of the survey was cut short, and the interviews thus had to be initiated prior to ending the quantitative phase, and the sequential design could not be strictly followed, hence the results could not be analyzed in its full capacity prior to initiating the interviews. However, the large majority of the surveys were completed prior to initiating the interviews and were analyzed, and reflections were used to inform the interview-guide.

5.2 Research setting

This study was carried out remotely from the city of Bogotá with the assistance of a non-profit Colombian organization working with SRHR for migrants in different places across Colombia. To ensure the anonymity of the study participants the name of the NGO will not be disclosed. The survey was distributed in five of their attention centers. In these centers the organization provides comprehensive support, education, counseling and a wide range of medical services related to SRHR, one being contraceptives, for Venezuelan migrants. Furthermore, interviews with health staff working for this organization were realized.

The survey was distributed by the organization to female Venezuelan migrants in five different locations: Bogotá, Bucaramanga, Cali, Cúcuta and Medellín. Bogotá, Medellín and Cali are the three most populated cities in Colombia. Cúcuta is located on the border to Venezuela, and Bucaramanga a few hours from the border, both cities have a large influx of Venezuelan migrants (USAID, 2022).

Map 1. Locations of the survey distribution (created by author)

5.3. Sampling of informants

The starting point for the sample was to collaborate with a relevant organization. To find an organization, I used a study by Profamilia (2019) showing 25 organizations working with SRHR and Venezuelan migrants in Colombia. All organizations were contacted, in addition to a few others that I contacted during my internship. In the end, one organization had the opportunity to assist. A request was sent to the organization including assistance with the survey distribution and to submit an interview request to relevant employees at their organization.

The sample strategy used was purposive sampling (Bryman, 2012), a non-probability sampling strategy where the participants were strategically chosen based on their relevant experiences for the research question (Creswell & Plato Clark, 2017). With that said, the sample is not representative of the population, nor striving to be (Bryman, 2012). This strategy enables one to focus on the informants that can provide valuable information to the study from the start and thereby improving the efficiency, something essential for studies with a strict time-limit like this one (Bryman, 2012). However, since the sample is non-random, in this case meaning the whole sample is provided through one organization, the generalizability of the conclusions beyond the sample remains limited (Bryman, 2012). On the other hand, since the survey and interview sample consist of informants from six different cities in Colombia, certain generalizability can be assumed.

This study focuses on young unmarried female Venezuelan migrants. However, due to challenges in obtaining parental consent for individuals under 18 to participate in the study, and the insufficient sample size when limiting the survey to ages 18-24, the study focuses on unmarried Venezuelan women aged 18-30. This focus aligns well with the demography of Venezuelan migrants in Colombia, among whom around half are aged 15-29 (ENCOVI, 2021; Profamilia, 2019).

For convenience purposes of the distributing organization, the survey was distributed to all Venezuelan women seeking assistance at the organization's facilities. Nonetheless, when analyzing the data, only respondents meeting the following inclusion criteria were included in the study:

1. Venezuelan women aged 18 years and above
2. Venezuelan women aged 30 years or less
3. Venezuelan unmarried women

The survey received 159 responses in total. After excluding the respondents not fulfilling the criterion, 103 respondents were left for the data analysis. These were evenly distributed within the three age categories: 18-20, 20-24 and 25-30. The majority of the respondents lack both a Temporary Protection Status (TPS) and a valid Venezuelan ID (see appendix E).

The majority of the respondents (60) indicated that their household's current financial situation was neither good nor bad, however, more respondents had a bad (23) or very bad (7) financial situation than a good (12) or an excellent (1) one. To complement this, a government measure for social stratification was used. The social stratification system of Colombia classifies the residential properties and appoints them to a certain socioeconomic stratification category, i.e. strata's (estrato in spanish). The higher strata, five and six, pay more for public services such as sewage and electricity and contribute to the subsidies granted to people the strata one, two and three who are beneficiaries of subsidies. Strata four is neither paying more for public services nor receiving subsidies, i.e. pay for their consumption. Strata one is low-low, two is low and three medium-low, four is medium, five medium-high and six high (Bogliacino et al., 2018; DANE, 2024). Of the respondents that belong to a stratum, the majority belong to strata one (29), followed by strata two (22) (see figure 2).

Around 25 respondents chose not to answer or did not know. This could be both lack of knowledge, or due to stigma and sensibility of the issue of social stratification categories (Bogliacino et al., 2018). Around 20 respondents stated they were without a stratum. While individuals might not know what category they belong to and thus believe they are without one, being without a stratum can also be explained by living without a registered residential address such as within an informal settlement, or in rural or remote areas, or living in newly constructed housing (Bogliacino et al., 2018). Therefore, no conclusions can be drawn from this result.

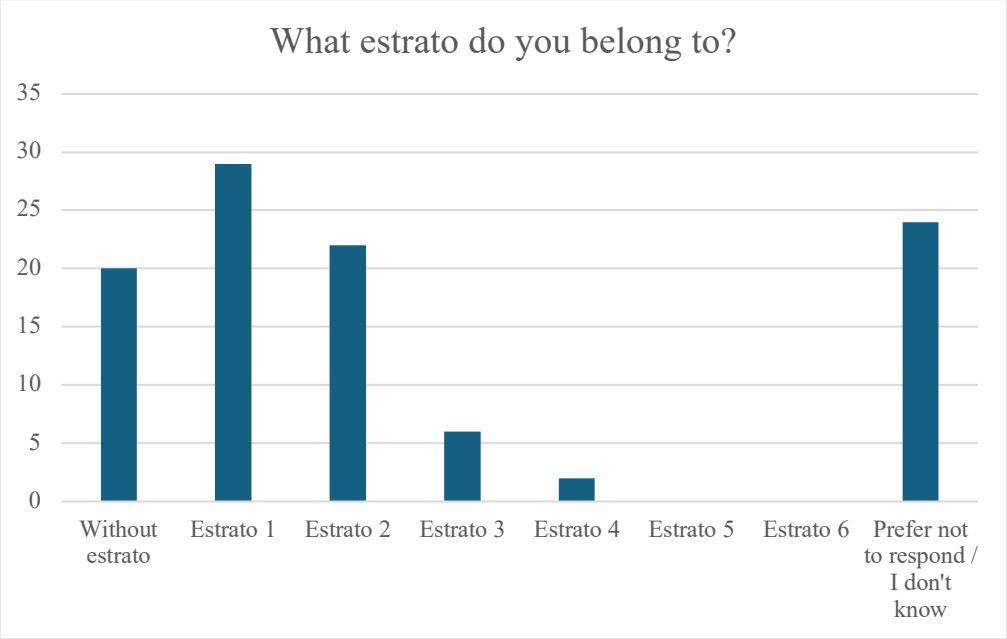

Figure 2. The number of survey respondents in different social stratification categories

For the follow-up interviews a sequential approach was adopted, using the survey results to inform the second round of sampling (Creswell, 2009). Subsequently, a form of purposive sampling called criterion sampling was chosen, meaning that all individuals that met the inclusion criterion (see above) were included (Bryman, 2016). This strategy was chosen to mitigate the risk of a sampling bias from the researcher (Bryman, 2016). Out of all contacted three women participated in an interview, two women aged 18-20 and one woman aged 25-30 (see appendix H).

The organization in question works with broader SRHR for Venezuelan migrants in Colombia,

so a purposive sampling strategy was chosen to find those working specifically with contraceptives for Venezuelan women in Colombia. Health staff from all five cities where the survey was distributed were asked to participate in the interview. In the end interviewees with three health staff from three different cities were carried out. To not disclose the identities of the respondents to their colleagues, I have chosen not to reveal their gender, city nor function. Therefore, they are only described as health staff. Furthermore, some minor alterations in certain quotes have been done, considering specific locations or names that would risk revealing the identity.

5.4 Data collection

5.4.1 The survey

The first form of data collection was carried out through a survey (see appendix C & D). To not take valuable time from respondents, many of whom already live in vulnerable situations, and to not intrude on privacy more than necessary, the decision was made to collect the main data through a survey (Banks & Scheyvens, 2014). However, since it was important to provide the opportunity for women to tell their own stories in their own words if wanting so, survey respondents could, towards the end of their survey, provide their contact details if interested in a follow up interview. All respondents that did so were contacted.

The survey was in Spanish, and most questions were closed with some questions providing the opportunity to add additional information if wanted. The aim was to make it as short as possible to avoid respondent fatigue (Bryman, 2012). To improve the quality of the survey two professionals working with SRHR reviewed and gave feedback on the survey questions prior to its distribution.

The survey was distributed between the 23rd of April 2024 and 9th of May 2024 through a QR-code. The survey tool used was Sunet Survey as required by Lund University (2024). The survey questions were constructed based on the theoretical framework, incorporating questions around all components of the framework.

According to Bryman (2012) surveys are preferred when your sample is spread out geographically, which was the situation in this case. With the help of the organization, the survey was distributed in five different cities in Colombia, allowing a larger sample than I could

have done if distributing the survey on my own. Furthermore, due to the sensitivity of the topic, respecting the integrity and anonymity of the respondents, and to minimize the risk of the researcher impacting the data collection, it was positive that the researcher was not involved in the distribution (Bryman, 2012). However, since the survey was distributed by an organization without the researcher's presence, some respondents might have believed that the survey was done in collaboration with the organization, which may have impacted their responses (Creswell, 2014). To mitigate this risk, a clear introduction text stating that the study is a master's thesis was included, in addition to the contact details of the researcher (see appendix C & D).

5.4.2 The interviews

As a complement to the survey, qualitative semi-structured interviews were carried out (Bryman, 2012). The semi-structured method was chosen for its flexibility, ensuring that follow-up questions can be made, that changing the sequence of each interview is possible if needed, while simultaneously ensuring that all topics are addressed with all interviewees (Bryman, 2012).

An interview guide was used (see appendix F & G). This was constructed based on the theoretical framework and based on a preliminary analysis of the survey results. All survey respondents who stated an interest in a follow-up online interview were contacted through email or WhatsApp, depending on what contact details they had provided. One interview was carried out through zoom, and due to difficulties with internet connections, the other two were carried out through WhatsApp voice call. All interviews were conducted in May 2024, and scheduled based on the availability of the respondents. All interviews were carried out in Spanish and were audio-recorded on a password protected dictaphone, and later transcribed. Each interview lasted between 35-60 minutes.

The identity of the Venezuelan women remains anonymous even for the researcher. The interviewees were informed beforehand that they could choose whatever name they wanted on zoom to allow for complete anonymity, and on WhatsApp they were given a name by the researcher. Informed consent was used where the informants were informed about the research, what the consent meant, and that it included the opportunity to withdraw at any time, or to abstain from answering certain questions (Banks & Scheyvens, 2014). Due to literacy being high among Venezuelans (97.5% in 2021) (UNESCO, 2021), a written consent form was sent

to all interviewees beforehand, and prior to starting the interview all interviewees were asked whether they had read the consent form, and if there were any questions. Some participants had the opportunity to sign the consent form, and others had not, in which case an oral consent was given to firstly participate in the interview, and secondly to record the interview. In total, three interviews were carried out with Venezuelan women.

The request to participate in the interview was sent to five health staff within the organization by an employee at the organization. All five stated their interest, upon which I received their contact details to send an official request, the consent form and the interview-link. In the end, three interviews through zoom were realized. All interviews followed an interview guide (appendix I & J), were carried out in Spanish and were audio-recorded on a password protected dictaphone, and later transcribed. The identities of the health staff interviewed will remain anonymous in the study.

5.5. Data analysis

The data was analyzed in two steps. Firstly, the quantitative data from the survey was analyzed manually using Excel and visualized through graphs. Secondly, the interviews were all transcribed in Spanish using the Microsoft Word transcription tool and complemented manually. Subsequently, the transcripts were read through several times and adjusted for grammatical errors and repetitions, and thereafter coded by using thematic analysis (Bryman, 2012). The thematic categories were developed based on the conceptual framework and analyzed using Nvivo. During the first coding process each transcript was coded in accordance with the categories of the framework, including migration status and socioeconomic situation. Within each theme, subcategories were created with barriers and facilitators. In the second round of coding more sub-categories were created. Finally, new themes and sub-codes were identified (see appendix H). The quotes used in this study are translated to English, which might risk some smaller aspects being lost in translation.

Due to the time limits of data collection and analysis, the qualitative aspects of the study were prioritized. However, further results could have been reached through a more thorough analysis of the quantitative data using statistical software like SPSS. This could have enabled a deeper analysis of the relationships between different variables, such as educational level, household size, income and type of contraceptive use.

5.6. Ethical considerations

While female Venezuelan migrants in Colombia cannot be treated as a homogenous group, many migrants live in conditions of vulnerability, for example those without a residence permit (Calderón-Jaramillo et al., 2020; Profamilia, 2019). Therefore, it was crucial to ensure the thorough incorporation of ethical principles in this study. Diener and Crandall (1978 in Bryman, 2014) highlight four ethical principles in particular: harm, informed consent, invasion of privacy and deception.

Contraceptives can be perceived as a sensitive topic and could trigger feelings of discomfort and be perceived as an invasion of privacy (Bryman, 2012). To minimize the risks, both the survey and interview questions were carefully elaborated, and consulted with two professionals prior to the data collection. While all Venezuelan women participating in the interviews had visited the organization's facilities, I as a researcher ensured to have relevant contact details on SRHR related services at hand if any interviewee would need assistance after the interview, to minimize potential harm (Banks & Scheyvens, 2014). Since the health staff in their interviews talk from their professional role, and not from personal experiences with seeking contraceptives, their interviews might be less sensitive. Nevertheless, carefulness in the elaboration of the interview guide was taken. In all interviews, it was clearly stated the right to at any point end the interview, pause, or skip the question.

Informed consent means that the participants have enough information about the study to make an informed decision to participate (Bryman, 2012). The process of informed consent was as previously mentioned carried out in two steps. Firstly, a written consent-form was sent to the participants through WhatsApp or email where the participants also could ask questions. This became important to minimize the feeling of invasion of privacy, to ensure participants knew beforehand what the interview would focus on, and could raise concerns or questions (Bryman, 2012; Banks & Scheyvens, 2014). Secondly, during the interview, the consent form was revisited with the opportunity to ask questions, and it was made clear that the interviewee would remain anonymous, and that recordings would be safely stored and not shared (Banks & Scheyvens, 2014). For the Venezuelan women being interviewed, it was made clear that the organization assisting in distributing the survey was not involved in the study, nor would they

have access to their interviews. In all interviews, the principles of anonymity and confidentiality were emphasized (Banks & Scheyvens, 2014).

Bryman defines deception as "when researchers present their work for something other than it is" (Bryman, 2012: 143). To avoid this, I strived to be as transparent as possible. Yet, it is possible that respondents might have misinterpreted who was conducting the research, regardless of the information provided beforehand. Furthermore, despite emphasizing the principle of voluntary participation, not all might have participated entirely by their own interest. There is a risk that the health staff participated because the request came from a supervisor within the organization, or Venezuelan women believing their participation would impact their access to services in the future, or as a sign of gratitude for the health service provided. To minimize this risk, after the initial contacts were set up and they received the consent form, they had the opportunity to choose to not continue with the interview.

5.6.1 Reflections on positionality of the researcher

The concept of positionality, which entails recognizing that the characteristics of the researcher influence all stages of the study, was carefully considered throughout this research (Bryman, 2014). It is crucial to note that my positionality, encompassing factors like my age, education, and the environment in which I was raised, was not static but changed depending on the context (Bilgen et al., 2020). For example, during the data-collection process, I realized that the language I used, and consequently the discussions I had with participants differed depending on the age of the participant. For example, the language I used was different with the 18-year-old women in comparison to the 30-year-old women, which may have influenced the outcome of the interviews and the way the informants responded to the questions. The power dynamics between me and the interviewee subsequently felt different, depending on the age, gender and educational level of the interviewee, which influenced the dynamics of the conversation and data collected (Banks & Scheyvens, 2014). This fluidity of my position demonstrates the need for reflexivity and self-awareness as a researcher, as it depends on the context and the person being interviewed (Bryman, 2014). Furthermore, my upbringing in Sweden became obvious in the way I constructed the survey questions. In the survey, I did not ask questions specifically about provision of contraceptives in the public-, respectively the non-governmental sector. This was a clear example of how my own assumptions influenced the questions asked. In my community, contraceptives are provided by public health care and not civil society. For many Venezuelan women in Colombia however, humanitarian actors play an essential role in

provision of contraceptives. While this was not addressed in the survey, it was later addressed in the follow-up interviews.

5.7. Research limitations

5.7.1. Limitations of the study

This study does not make a distinction between the type of living situation of the migrant, i.e. being a migrant in transit, pendular or resident in Colombia. While all interviewees had been living in Colombia for years, this might not be the case for all survey respondents. Along the same line, all interviewees had a TPS, unlike the majority of the survey respondents. The experiences and situations of access to contraceptives can differ a lot depending on the migration situation; however, this is not explored in this study.

The study focuses on the SDH socio-economic situation and migration status, which remains a limitation. For example, the study does not include details about the housing conditions (urban-rural), working conditions, especially formal or informal as over 60% in Colombia work informally (OECD, 2023a), or belonging to a minority group. Therefore, while the SDH are included in the conceptual framework, the analysis of different SDH in this study remains limited. Furthermore, the term socioeconomic situation was not defined by the researcher, and therefore subjectively interpreted by the respondents which might have led to differences in the interpretations. Moreover, this study does not assess the quality of the contraceptive services, but only access to them. Finally, while the focus is on unmarried women under 30 for the survey and the follow-up interviews, most times the health staff talked generally about contraceptive access in their clinic, not specifically focusing on women under 30.

5.7.2. Data limitations

As aforementioned, there are methodological limitations with this thesis, such as the consequences of the sampling strategies, the risk of the gatekeeper to select contacts within the organization and therefore steer the selection of participants, but also how voluntarily the health staff perceive their participation. Furthermore, the risk that comes with me not being present in the survey distribution and therefore risk that respondents might believe that the organization is a part of the study, which thereby may impact how they respond, or the belief that their responses might impact their opportunity to seek assistance there in the future, or the perception that participating in the survey was voluntary.

Furthermore, the data remains limited to one organization. While it was distributed in six different cities, it remains tied to one organization. The intention was to include more organizations. Data collected from more than one organization would have made the validity and reliability of the findings stronger.

It is also important to acknowledge that using an organization as distributor could impact the data in several ways, for example:

1. The respondents might answer the survey based on their experience with the organization in question, and not on their general experiences. For example, if they had a positive experience with the distributing organization, it is possible this colored their answer, and neglected potential previous experiences that were not as positive.
2. Since the survey was distributed at a facility where women can access contraceptives, only women who actually can access contraceptives, at least at that specific moment in time, had the opportunity to answer. If women had been consulted at another location, not directly connected to distribution of contraceptives, they might have had different answers and experiences.
3. No distinction was made between public, private or civil society organizations. For example, some individuals might never have had access to public health care due to being non-insured, others might have had so and had positive experiences, and others had negative experiences.

Some of these aspects were addressed in the follow-up interviews, such as the private, public and civil society distinction, as well as discussions around previous experiences outside this organization. This demonstrates the strength of the mixed methods, the opportunity to ask follow-up questions and to validate the study findings from the survey in the interviews. The triangulation therefore strengthens the data validity.

5.8. Research quality

Reliability refers to the consistency of the results (Bryman, 2012). To improve the reliability of the research, the transcripts were re-read several times to avoid mistakes and minimize misinterpretations. Furthermore, a survey and semi-structured interviews with predefined

questions also increases consistency in the data (Creswell, 2014). Validity instead refers to the credibility or accuracy of the findings (Bryman, 2012; Creswell, 2014). This study incorporated several strategies emphasized by Creswell (2014) to improve the quality of the research. For example, triangulation of findings through different sources of information, discussing biases and positionality, presenting outliers or findings that oppose previous research (Creswell, 2014; Bryman, 2012). As aforementioned, the survey was prior to its dissemination assessed by the organization and by my supervisor, in addition to pre-tested to assess the fluency and readability of the survey. Since the study follows a mixed-method approach and a purposive sampling method with sample accessed through one organization, the generalizability of findings remains limited (Bryman, 2012; Creswell, 2014).

6. Results and discussion

In the following section, each of the three research questions will be addressed in order. When talking about survey responses in the following sections, the number of responses is indicated in brackets. While the total number of respondents is 103, the multiple-choice questions can have a higher number of responses, since certain respondents ticked more than one box.

6.1 How do female Venezuelan migrants and health staff working with migrants perceive access to contraceptives in Colombia?

6.1.1 Accessibility

In the survey, only 5/139 responses indicated that 'the health care facility is far away' as one of the biggest barriers to seeking contraceptives. However, during the interviews, distances to facilities were mentioned several times, and is identified as a recurring barrier for Venezuelan migrants seeking SRHR services in general (Diaz et al., 2023). One informant said that it was complicated to reach the facility because she needed to arrange a car and was dependent on good road conditions.

> Where I live, when it rains, it's impossible to go out, so I couldn't leave [to the appointment] (Informant 1).

The organization also mentioned difficulties related to transport.

> These are users that are in a very poor economic situation, so they cannot travel to where we are [...] The transport can take an hour or, if there's a traffic accident or something, it can take longer. They have no one to leave their children with. I mean, the neighbor might say, "I'll watch 1 or 2, but I can't watch 3" (Health staff 1).

As indicated, another barrier was the difficulty for women with children to find someone to babysit. This barrier is recurring related to migrant contraceptive access throughout Latin America, for example, as aforementioned, in Brazil (Makuch et al., 2021). One health staff had had children present during the administration of the contraceptive on several occasions and relied on colleagues to watch the children while administering the contraceptive. This was one reason why the outreach services were so important.

> Well, if they have to make lunch to send with the kids to school, or if they are making breakfast or something, it will only be a matter of half an hour for her to arrive, do the medical history, give a quick counseling and provide the method she needs (Health staff 1).

For some health staff, outreach services were around half of the workload, and for others the large majority. Outreach services were described by all interviewees as a factor facilitating access.

In terms of information accessibility, 85/102 survey respondents had sufficient information to make informed decisions on how to use contraceptives, and only 10/102 had not. Most had acquired this knowledge in school (41) or from a family member (34). However, the fourth most common barrier with 21 responses was not knowing where to go. This barrier is recurring in previous studies on SRHR for Venezuelan migrants in Latin America (Quintero et al., 2023) and on contraceptive access for migrants in Colombia (Rivillas-García et al., 2021).

> Because there are people who don't know where to go and end up paying an excessive amount of money for the arm implant, the implant "down there", or even for the injection. (Informant 1).

> Well, information is lacking that these exist, like a programme from a foundation where they [...] provide free contraceptives" (Informant 3).

To address this barrier, in one city, the organization collaborates with Juntas de Acción Comunal (JAC) to disseminate information about their services. JAC is a community board that

plays a central role in community development and can represent the community to the governance and authorities (IDPAC, 2021). However, since many do not know they exist, at least initially, they do not get their information.

> The migrant population [..] do not have the culture that a community action board exists [...]. Rather, many of them are unaware, and when they arrive here and learn about it and say "Ey, look, there is a person that represents us at the state level, so whatever thing we can speak to him" (Health staff 1).

Social media was in all interviews stressed as an important communication channel. However, the overreliance on social media comes with the risk of people without access to the internet missing out on important information and must be complemented with other forms of advertising.

> Not so much like now where everything is on social media [...]. Instead, distributing brochures or things like that, that would be more on paper and not everything through the internet. Many people don't have access to the Internet or Instagram (Informant 2).

Lack of internet access has been identified as a barrier in other studies in Colombia (Diaz et al., 2023) related to accessing healthcare for migrants. The overreliance on the internet was also confirmed by the health staff.

> They are users who are migrating and often, if they have money for lunch, they don't have money for breakfast or dinner. So, it could be that they don't have access to the Internet, for example, to be able to see advertisements (Health staff 1).

The most successful strategy emphasized by all interviewed is the "voice-to-voice" communication.

> A user comes in, sees that the service is quick and leaves happy with it. Then she tells her cousin, her friend, her neighbor, the shopkeeper, and they continue spreading the word.

While organizations work hard to spread information, the flux of migrants is constant, and poses an additional challenge.

> So, the women who had the knowledge in that neighborhood [...] are leaving and three new ones arrive who do not know where to go to obtain contraceptives (Health staff 1).

6.1.2 Accommodation

The flexibility of rearranging appointments and getting assistance on short notice was mentioned during the interviews (Informant 2). The organization uses WhatsApp for the majority of the communication with patients related to their appointment, which arguably can be more user friendly for young women.

> Well, it's easy. Well, at least this time, I wrote to their WhatsApp, and they responded on the same day, like within minutes [...] I thought it was great that they were attentive (Informant 1).

Using WhatsApp also creates a continuous communication channel used to prepare women for the appointment, for example sending information on different contraceptives and what clinical history that will be needed. Women can also ask questions about the duration of certain methods or potential side effects, thus improving information accessibility.

The survey results did not indicate that accommodation-related barriers were the most common, nevertheless, 'I don't have a valid ID' (6), 'the waiting times are too long' (6) and 'I don't meet the requirements for the appointment' (5) were all mentioned as barriers. During the interviews however, one of the biggest barriers to access contraceptives identified were the requirements that one needs to fulfill to obtain contraceptives, specifically that of having a valid ID, a Temporary Protection Status (TPS) or being affiliated to the EPS.

> Many times they arrive, well, yes, they almost don't even have the passport [...] just a photocopy of the identity document [...] or a photocopy of the mother's identity document, and she is not even the one who is getting it. (Health staff 2).

Legal status and insurance are common barriers for migrant health care access globally (WHO, 2019; Hacker et al., 2015), in Latin America (Diaz et al., 2023) and for contraceptive access in Latin America (Márquez-Lameda, 2022).

Affiliation to the EPS and having a TPS were not available as options during the survey, however, the second biggest barrier identified in the survey was 'migration status', which arguably can include both affiliation to EPS and having a TPS. Migration status and accommodation are thus intertwined. For example, if lacking a regularized migration status means you cannot meet the requirements for an appointment, the health care does not show the

flexibility needed to realize the right to health. Thus, while Colombia has incorporated Venezuelan regularized migrants into their overall health system, something seemingly inclusive, it leaves irregular migrants out (Diaz et al., 2023). So, when public health care is no option, many migrants turn to the humanitarian sector. That could be one explanation to why, more than half of the women lacked a TPS and a valid Venezuelan ID in the survey (see appendix E), while only six people identified lack of ID as a barrier to accessing contraceptives.

The organization has, as described by one interviewee, a 'zero barriers policy' (Health staff 2), meaning they have no requirements to access contraceptives, except being a migrant from Venezuela.

> Our internal protocol indicates that if they present the birth certificate, the birth certificate is sufficient. If they lost their ID card and only have a photo, the photo is sufficient. If the ID card expired 4 years ago [...] For an appointment? None [requirements]. Just the desire to want to use the service (Health staff 1).

This policy was confirmed in the interviews with migrant women, who found the organization very adaptive and without any difficult requirements. However, when the migrant women were asked about previous experiences with other actors, particularly with public health care, the answers were different.

> For migrant women who are undocumented, it is more difficult to access healthcare centers, at least hospitals and all that (Informant 3).

> You have to join an EPS, and then you can go to these things [contraceptive services]. [...] I have not appeared in the EPS, so it was like, I didn't ask specifically for contraceptives but I entered the EPS to proceed to the next step, which was getting contraceptives. But they always told me "no, no, no, no." (Informant 2).

That public hospitals are often stricter with the requirements was confirmed by the health staff.

> For example, they require you to have a physical document, the ID card that is not expired, etc. So, this creates certain types of barriers for the users (Health staff 1).

When the health staff were asked why they think women choose their facilities or an NGO over the public ones, they responded by referring to the requirements and that it is free of charge.

> The agility of the process. For example, they know that if they come here at 8:20 in the morning, by 8:30 or 8:40 at the latest, they are already leaving and have received counseling, advice, knowledge and the device. Why? Because we are not going to start asking, "Do you have TPS? Are you regularized? [...] You need a document". (Health staff 1).

Language is often cited as one of the biggest barriers to healthcare (WHO, 2019; Lebano et al., 2020; Hacker et al., 2015). However, since both Venezuela and Colombia have Spanish as the official language, it is not discussed in this context.

6.1.3 Affordability

Lack of monetary resources has been identified as one of the biggest barriers to access health care (Diaz et al., 2023), and contraceptives in Colombia (Rivillas-García et al., 2021; Profamilia, 2019). This barrier was confirmed during both the survey and interviews. In the survey, financial aspects are the third most commonly identified barrier, and closely intertwined with the most commonly identified - socioeconomic situation and confirmed during the interviews.

> I had wanted to go about a month earlier to another place, but they were charging me, and it was quite an excessive fee, so I couldn't get it (Informant 2).

> There are times when I'm not doing very well financially, and it becomes difficult for me to buy them [...] and many women say, "I want to [get contraceptives], but well, I don't have the resources "(Informant 3).

As the organization in question provides contraceptives for free, the economic barriers are not as visible, until it is time to take out long-term contraceptives.

> When the method is provided, the economic issue is not really on the table. It comes up when they want to have the contraceptive method removed because that is not subsidized (Health staff 2).

While contraceptives in theory are free, 32 out of 86 survey respondents had paid to access contraceptives. Thus, migration status and the lack of information on where to seek contraceptives for free is closely interrelated to the affordability dimension and demonstrates the important role NGOs play in providing free contraceptives.

Moreover, the indirect costs also create barriers. For example, transportation costs for women and for potentially accompanying children (Hacker et al., 2015), or the direct income loss women might suffer if taking time off to seek contraceptives or being without a job altogether.

> Sometimes you are without a job and don't have sources of income, so how can you buy a box of contraceptives? There is no way, so it becomes expensive. Also, if you go to a hospital, it can take a long time, and if you have a job, you can't go. (Informant 3).

6.1.4. Acceptability

As demonstrated previously, Venezuelan migrants have faced discrimination when seeking contraceptives (Makuch et al., 2020; Rivillas-García et al., 2021; Profamilia, 2019). Against this background, it was quite surprising that almost none of the survey respondents had felt discriminated against when seeking contraceptives. 74 had not experienced discrimination, and 12 experienced some discrimination from someone at the health facility. The majority of respondents felt very (48) or somewhat (18) respected by the healthcare personnel. Only one felt disrespected.

In the interviews however, it became clear that discrimination does occur. When a health staff member was asked about the discrimination, they stated that it was rarely heard of at their facilities, because the purpose of their whole organization is to assist migrants. However, the situation looked different at public health care facilities.

> They themselves comment on it and say, "they [public healthcare personnel] make us wait because we are Venezuelan". There is still a lot of xenophobia [...]. So, they encounter barriers right from the start (Health staff 2).

Another health staff member mentioned negative stereotypes towards migrants, for example that migrants “like everything to be free and given to them” (Health staff 3), or that women who are sterilized still want contraceptives to sell. Nevertheless “It's not because they are migrants or anything, but they sell it out of necessity” (Health staff 3). In the interviews with Venezuelan women, no one had experienced discrimination outright. However, one informant explained that migrants from Venezuela are sometimes associated with something negative, so, to her surprise, she was treated very well and was happy with the services when seeking contraceptives.

> It was something that surprised me a lot, because being someone who doesn't have the resources and isn't from this country, it can be a bit complicated (Informant 2).

Against this background, could it be so that none of the survey respondents had faced discrimination? Or perhaps the respondents had a positive experience with the organization distributing the survey, and based their survey answers on this experience, or answered based on what they thought the distributing organization wanted, a so-called social desirability bias (Bergen & Labonté, 2019). Could the respondents have had a different definition of discrimination is compared to that of the researcher? For instance, having to wait longer because you are Venezuelan might not be perceived as outright discrimination by the migrants themselves, whereas the health staff views it as such?

Looking at societal factors and attitudes, studies have shown attitudes against contraceptives as a barrier for access (WHO, 2019; Shukla et al., 2022; IOM, 2006), especially for unmarried women (Chandra-Mouli, 2014). This study showed that the large majority find it always culturally acceptable to use contraceptives as a single woman (76). Yet, when asked whether stigma against obtaining contraceptives exists, a small majority found that stigma does exist (38) in contrast to those who answered no (34). According to the interviewees, contraceptives are spoken about quite openly, and young women often get encouraged from friends and family to get contraceptives.

> I think that the majority of their opinions are very positive because they say it is something we really need [...] It's something that has demand, with many women interested (Health staff 1).

> It is very common for migrants to start their sexual life very early and many are teenage mothers. To not repeat the cycles [...] they bring the girls on time and many girls have come here when they are 12 and 13 years [...] to start with a method (Health staff 3).

Moreover, it became clear in all the interviews that preconceived notions, rumors or ideas about certain contraceptive methods were prevalent.

> I don't like it because my mom, at least, got pregnant with my sister with that one, and my cousin, and many families in the past who used it, and it moved and they got pregnant. [...] The pills also aren't very good to take because they have more or more pheromones, and things like that (Informant 1).

Contraceptives have been associated with myths and misconceptions, for example, causing infertility or other medical problems (Endriyas et al., 2018). One health staff interviewed also

identified myths and misconceptions as one of the biggest barriers to access contraceptives (Health staff 2), and that they work a lot to address myths.

> The truth is there are many myths, and I just had chats when I went with our outreach services, so they know clearly what is true and what is not, what changes they might experience that are normal, and what is unusual (Health staff 3).

6.1.5 Availability

The most commonly requested methods were the implant and the IUD. The most common contraceptive however was the implant (30) followed by condom (22), oral pill (10) and sterilization (10). Why IUD is among the most requested but not most common could be because the hormonal IUD is more expensive and/or that it is more difficult to arrange for its insertion during the so-called outreach services (Health staff 3), and the somewhat bad reputation the copper IUD has (Health staff 2).

Only 3/139 responses had 'the health care facility does not offer enough variety in methods', as main barriers, and 3/139 'the health care facility I usually go to doesn't have contraceptives'. Hence, availability in general was no commonly experienced barrier. Availability of certain methods however could be a challenge.

> They [EPS] only offer one type of contraceptive, which doesn't work for me because I suffer from migraines. So [...] you have to buy it yourself (Informant 3).

The health staff mentioned that while they could provide most requested methods, they could not provide the contraceptive patch and sterilization surgeries. The surgery had been particularly requested, both by people who never had been operated, and by people who had unsuccessful surgeries.

> We have noticed that many Venezuelan women come already having had surgery, but they use contraceptive methods because the failure rate of the surgery is quite high (Health staff 2).

The health staff consistently reported a high demand for contraceptives, and all indicated an adequate supply and sufficient staff to meet the demand. Nevertheless, a shortage of adequately trained personnel (Health staff 2), a recurring challenge to address the healthcare needs of

Venezuelan migrants (PAHO, 2024). Furthermore, all health staff pointed out challenges related to funding.

> For example, let's talk about the subdermal implant [...], often the most popular. Last year, there were months when we could easily place 180-150 implants in a month. This year, in a month, it's only 80-70.
>
> Researcher: So now you receive less funding than what you had the previous year? Health staff 1: Yes, I would say it's practically half

Ensuring a proper environment for administering contraceptives during outreach services was proven difficult.

> For example, in this area where I'm telling you, where the houses are made of tin. Well, yes, it's not the most appropriate area [...] but at the end of the day, that's how it's done because they will not move from there either (Health staff 2).

The informants mentioned the variety of locations where contraceptives are available, especially compared to Venezuela. Two of the women did not specify which actors, while one stated that the majority of places easily available to seek contraceptives are operated by NGOs or foundations (Informant 3). This was supported by a health staff member who mentioned the NGOs complementary role to the state, thus, increasing the available services.

> Once the migration and everything began, there were several organizations that, as we say here in Colombia, “they went the extra mile” and started addressing all these needs that this migrant community brought [...]. What they [the government] did was call on the international community to provide support. (Health staff 1).

The informants continue by stating that this was not merely for solidarity reasons.

> As soon as the migration started, the Government told public institutions “contraceptives for the migrant population”, because: one, it is no secret, and it's to avoid the increase in population [..] and two [...] it could increase cases of child abandonment. So, there is an institution in Colombia called the ICBF[2]. And with the Colombian population they almost can't keep up, now with the

[2] The Colombian Family Welfare Institute

> migrant population and minors, giving this type of support will increase the cost for Colombia (Health staff 1).

On one hand, the government has prioritized SRHR for migrants (Ministry of Health and Social Protection, 2021), and reached out to many actors to help with this. On the other hand, implementing this in practice faces significant challenges. The reliance on external support by non-governmental actors, especially when these actors suffer cuts in funding, highlights deeper systematic vulnerabilities that must be addressed to ensure a sustainable contraceptive provision without discrimination.

6.2. How may migration status and socio-economic situation impede access to contraceptives for Venezuelan migrant women?

The two most identified barriers in the survey were socioeconomic situation (29), and migration status (27) (see appendix E). Closely correlated to socio-economic situations one can also find 'it is expensive' (22) as the second most identified barrier. Related to migration status are 'I don't have a valid ID' (6) and 'I don't meet the requirements for the appointment'. The two most identified barriers thus, correspond well to the most common barriers in previous research (IOM; 2006; Diaz et al., 2023; Márquez-Lameda, 2022; Rivillas-García et al., 2021; Hacker et al., 2015)

6.2.1 Migration status

As stated, only 39 respondents indicated that they have the Temporary Protection Status for Venezuelan Migrants (TPS), while 63 did not. Thus, a majority lacking regularized status, in contrast to the average. According to PAHO (2024), over 2.2 million Venezuelans have received the TPS, for reference Colombia has received slightly more than 2.8 million Venezuelans (R4V, 2023). Nevertheless, regularization per se is no guarantee of affiliation with the health system in Colombia. In 2024, 1.2 million migrants were affiliated, however, almost as many, 1.1 million migrants were regularized without a health system affiliation (PAHO, 2024). Thus, despite Colombia's substantial efforts to register Venezuelan migrants, there's still a long way to go.

22 survey respondents found that the status had made accessing contraceptives easier, 13 respondents that it made access more difficult, and a majority, 37 respondents found that status

did not influence the access. Again, the status per se does not influence access if seeking contraceptives at a facility without these requirements, such as with many NGO's and IGO's, however, status influences contraceptive access at public health clinics (Informant 3).

> If they don't have the documents, they won't be able to receive it. Or, that is, the only way is through donations, because there are people who care about this (Health staff 2).

Thus, it is important to acknowledge that all informants during the interviews have relied on NGOs to fulfill their contraceptive needs. Since no questions on this distinction were asked in the survey, it is not possible to know whether all survey respondents share this picture. With that said, without the international community, a larger share of migrants would be without proper access to contraceptives.

6.2.2. Socioeconomic situation

As described previously (5.3. sampling), the majority of the respondents (60) household's current financial situation was neither good nor bad, with slightly more responding bad (23) than good (12). However, the majority of respondents belong to strata one (29), followed by strata two (22) (see fig 2). While the strata measurement is by no means another measure for financial situation, it does indicate poorer housing conditions, which in turn often is associated with more difficult financial situations. For example, dampness, mold and crowding is more common among households that struggle economically (IOM, 2006). Thus, affording contraceptives simultaneously as other essential expenses can become a challenge.

> Yes, it's not that it's extremely expensive, but you also have other expenses, because you have to pay rent and other things, so it's complicated to set aside extra money to buy contraceptives (Informant 1).

When financial resources are scarce, it might force women to prioritize basic needs over contraceptives and their reproductive health. Furthermore, financial difficulties might force people to find other ways to sustain their, and their family's needs.

> We also provide contraceptive methods to this population [migrants engaging in paid sexual activities] because many of them do not do this full time [...] but when the end of the month comes, and they don't have enough for the school fee, or they don't have enough for the rent, they end up doing these types of activities, well, to get contraceptives as well (Informant 2).

Furthermore, the interconnectedness of the affordability dimension, socioeconomic situation, and the migration status becomes clear; it is not merely the migration status, but that without the status you risk paying out-of-pocket for the contraceptives, something many cannot afford.

> I am sure that if they had the financial means, they would go to a private clinic [...] These are very empowered women who know the importance of having a contraceptive method, [...] So I know that if they have the money, they would do it (Health staff 2).

Economic or financial constraints may limit the ability to prioritize contraceptives. Simultaneously, the living situation many are facing, including financial difficulties, might increase their need for contraceptives. For example, the additional financial burden more children put on already struggling households.

> What they mostly seek is to avoid pregnancy at this time, due to their economic situation, and the overall psychosocial and economic conditions they are experiencing. (Health staff 1).

6.3. How could access to contraceptives among Venezuelan migrant women in Colombia be improved?

For access to improve, firstly, the geographical accessibility must be addressed, both facilities at a convenient distance, and an improved transportation infrastructure (Diaz et al., 2023). The organization had worked with outreach services and in alliance with other actors had provided transport to groups of women to their health facility to administer the contraceptives, and then had them transported back. However, this had to stop due to lack of funding (Health staff 2). Both strategies were pointed out as essential to improve contraceptive access.

One of the most identified barriers during interviews was finding someone to stay with the children. This barrier has been recurring in contraceptives access for Venezuelans in Latin America (Makuch et al., 2021). While in some occasions children had accompanied the mother into the appointment, that is by no means a sustainable solution. Solutions are partly, as aforementioned, outreach services and flexible opening hours. However, this connects to a bigger issue of traditional gender roles and reproductive roles in Colombia, and who bears the primary responsibility of children, particularly as the focus is on unmarried young women. In Colombia, women are assigned the primary caregiving responsibilities. A study of Colombia in

2017 demonstrated that while 82% of women carried out domestic and care work, only 37% of men did so (Olivieri & Muller, 2019). On average, women in Colombia spend 22 more hours per week than men on domestic work (OECD, 2023c), and for young women aged 18-24 the time difference is the largest (Olivieri & Muller, 2019).

Improving access to contraceptives is thus not merely about flexibility from the provider or even offering child-care, but about addressing the gender norms in the society as a whole. For example, promoting new masculinities (Sims & Rodriguez-Corcho, 2022) where men become more actively engaged in domestic and caregiving responsibilities, and in family planning and contraception, can be one strategy to reduce the disproportionate labor burden and contraceptive responsibilities that women have.

While affordability was a challenge, both direct and indirect costs, interrelated, was a lack of accessible information. Both information on where to access contraceptives for free, and to address myths and rumors about contraceptives. The organization used WhatsApp, a successful strategy where questions can be addressed directly. When the interviewees were asked about how to improve contraceptive access, all mentioned more information campaigns, on and off the internet and through targeted WhatsApp messages, because, as demonstrated, not all have internet access.

> But if on every post, at every traffic light, at every station there was a poster that said, 'Look, here is this organization who provides contraceptives.' I guarantee you, the number of women would increase. (Health staff 3).

Another successful strategy to spread information was collaborating with other actors, for example through collaborating with JACs or the mayor's office to disseminate information to their community groups (Health staff 1; Health staff 2), or through arranging joint outreach sessions with other organizations (Health staff 1).

> So the idea is to go there with other organizations to help them and let them know they have services available as migrants, including health and childcare services. Everything is free, and we will also be there to demonstrate the methods available to them (Health staff 3).

The coordination with the mayor's office has also enabled contraceptive provision to otherwise inaccessible places.

> They took us to rural areas, conflict zones, and they were responsible for providing all the guarantees and security protocols, among other things (Health staff 1)

For some however, the collaboration with people in power has not worked out at all, primarily because of issues of corruption.

> I mean, they come and say to you [..] how great that you provide contraceptive methods [...], but what's in it for me or what will I get?'. I mean, you are in a position where you are supposed to be people who facilitate these types of services [...] you have the means to send a message through your cell phone, simply publish it and say the date because we [the organization] do everything else , it's just a click and it is a part of your job (Health staff 2).

When asked about what was needed to improve to reach more people with contraceptive information, the immediate response was "the corruption in this country. Yes, if we say it explicitly. The topic hurts me [starts crying]" (Health staff 2). To address this, the organization had, and wanted to do more work to engage policymakers and people in power and to raise awareness about the situation for migrant women, "working to humanize people, to make them understand – until it 'clicks'!" (Health staff 2). Thus, it was not merely a question about insufficient funding, but lack of prioritization and willingness.

> Because really, there is a lot of money on the planet, a lot of money exists, but where is it? There, sitting in some bank [...]. I believe there's a lot of knowledge missing. It is not just a matter of money and that's it, but it really begins with morality. (Health staff 2).

Thus, improved coordination with governmental entities, and an increase in funding were described as essential components for improved access, especially being able to reach more areas, and remote or insecure areas (Health staff 2).

In a study of National Health Institutes in the US, the findings demonstrate that diseases that mainly affect women tend to receive less funding (Mirin, 2021). Mirin (2021) also describes a historical gender bias in health care. For example, women tend to be underrepresented in studies and having their complaints trivialized. Being a migrant woman adds on to these vulnerabilities (Profamilia, 2019). Tobar (2014) demonstrates how donations, primarily from international cooperation, have played an essential role in advancing contraceptive coverage in LAC

countries. However, due to prioritization of other regions with higher needs, donor funding has decreased, also pointed out during the interviews. So, what is really needed in addition to an increase in funding, is a stronger political commitment to ensure access to contraceptives for all Venezuelan women in Colombia, without discrimination.

Related is another challenge raised, namely that of changing administrations with new priorities.

> We were already working with political leaders who had to live through the migration process, who were concerned about meeting those kinds of needs. [...] New ones arrived who didn't have to live through that [...] so they neither make their best effort nor spend resources to provide that kind of support [...] There are various organizations that take care of the migrants. “We are not going to have a major impact, because well, they are already taking care of it." (Health staff 1).

Hence, the bigger issue is about the obligations of the state as a duty-bearer, responsible for upholding the rights of its people. On one hand, non-governmental actors play an essential role in contraceptive access, particularly for those without a regularized migration status, or in difficult financial situations, and fills an important gap. On the other hand, what are the consequences of relying on the goodwill of these actors? Risks with such actions have already been seen in Colombia, for example a fragmented health system in certain areas, specifically in zones impacted by the armed conflict (Bernal et al, 2024). Furthermore, since NGOs most often are reliant on external funding, contraceptives access become both unsustainable and unpredictable (Barr et al., 2019), and can risk the potential erosion of both state responsibility and accountability for health care (Hushie, 2016). In a worst-case scenario, it undermines the whole health system.

Access to healthcare services in Colombia does improve when Venezuelans are affiliated to the health system (Bowser et al., 2022). However, “enrolling migrants into already established systems is difficult" (Bowser et al., 2022: 7), a challenge shared by the Ministry of Health (Presidency of Colombia, 2020). While Colombia has tried to address this, for example through granting citizenship for newborns regardless of the status of the parents (Presidency of Colombia, 2020), the challenge remains, demonstrated by the high numbers that still lack a TPS. Thus, it is no question that contraceptive access could improve by strengthening NGOs, and spreading information about their free services, but whether it should be the primary focus,

rather than improving the processes of regularization and affiliation to the health regime, and through that improve the contraceptive access for migrants. Of course, they are not mutually exclusive. While it is essential that NGOs exist and continue to provide assistance, specifically those with a 'zero barriers policy', realizing the right to health is primarily the responsibility of the state. Therefore, to improve contraceptive access, the regularization and health affiliation processes must improve, simultaneously as ensuring that the state upholds their obligations to all its citizens, without discrimination.

7. Conclusion and future research

Colombia has received global attention for their progressive response to the Venezuelan migration crisis. Particularly through the creation and implementation of the TPS and thus providing a possibility to affiliate to the health system, and an opportunity for Venezuelan migrants to, in theory, access contraceptives on equal terms as Colombians. This study sets out to explore how migrant women and health staff perceive access to contraceptives, how migration status and socioeconomic situation impede this access, and how access may improve.

Thus, by focusing specifically on young and unmarried Venezuelan women's contraceptive access in Colombia this study fills an important research gap. With the help of the conceptual framework, several barriers were identified. In accordance with previous studies, barriers within accessibility, both geographical and information accessibility including difficulties to find someone to stay with the children while obtaining contraceptives were identified. While migration status was identified as a barrier, the status in itself does not constitute a barrier if seeking contraceptives through most NGOs, as many accept both regular and irregular migrants. Primarily, it becomes an issue when seeking free contraceptives through public facilities. Interrelated are thus the affordability and socioeconomic situation, two of the most commonly identified barriers.

In contrast to previous studies, almost no women had faced discrimination when seeking contraceptives. According to the health staff however, discrimination does occur, but more often in public facilities. Thus, for future studies, analyzing access to contraceptives by differentiating between public health care and NGOs becomes essential, especially looking more closely at discrimination.

Subsequently, improving access becomes about addressing these challenges directly, for example by creating a proper transportation infrastructure, more information campaigns, outreach services or incentivizing students to study professions high in demand (e.g. midwives), but also indirectly. For example, addressing the gender norms in the society, combating corruption, improving collaboration and coordination with governmental entities, and a stronger political commitment to ensure access to contraceptives, both an increase in funding and prioritization of contraceptive access for migrant women. Finally, one of the major areas of improvement is the regularization and affiliation processes, to ensure that all eligible Venezuelans get a regularized status and get affiliated to the health system.

This study underscores the critical need for inclusive health policies and systems that specifically target the barriers faced by young unmarried Venezuelan women in this study. Thus, it demonstrates the importance of intersectional analyses that consider both gender, migration status and socioeconomic situation, and reveals how overlapping identities create unique experiences. Furthermore, this study contributes to the debate on integration versus humanitarian assistance in migration, and subsequently the role of non-governmental actors in contraceptive provision, and their complementary role to the state. Thus, while NGOs fill an essential gap, this study raises questions about sustainability of service provisions, and accountability of the state.

Since this is a single case study, with the sample from one organization, the generalizability beyond the sample remains limited. However, since the survey and interview sample consist of informants from six different cities in Colombia, certain generalizability can be assumed, especially since the most barriers correspond to other research about Venezuelan migrants' access to health.

Moreover, the conceptual framework did not consider other SDH beyond socioeconomic situation and migrant status. Thus, expanding the framework in future research to include other SDH would provide valuable insights. Lastly, the sample made no distinction between migrants in transit, pendular migrants or migrants that have been residing in Colombia for an extended period. As access to contraceptives may differ depending on the current migration situation, making this distinction could improve understanding of contraceptive access. Future research should focus on a comparative analysis of contraceptive access for regular and irregular, and affiliated and non-affiliated migrants.

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9. Appendices

Appendix A. Consent form English

Consent to Participate in a Thesis at the Faculty of Social Sciences

This study is carried out for a master's thesis at Lund University, Sweden. The aim of the study is to understand the access and potential obstacles to the use of contraceptives among Venezuelan migrant women in Colombia.

To obtain relevant data, a survey is distributed among Venezuelan women in Colombia, and interviews are conducted with staff from organizations working in this field, and with Venezuelan women. The interview lasts approximately 45-60 minutes, and your participation is greatly appreciated.

For this thesis, your email address or WhatsApp number will be collected. All information you provide for this study, including personal information, will be treated confidentially and your identity will remain anonymous. All personal information will be deleted upon completion of the thesis, and no personal data will be shared with third parties.

Do you agree to participate in this study?
☐ Yes
☐ No

Do I have your consent to record the interview?
☐ Yes
☐ No

If you have any questions, concerns, or want more information, or if you would like t oread the tesis in full once it has been published, you can contact me on WhatsApp: +57 311 872 50 65 or by email at fe2236sv-s@student.lu.se

Lund University, Box 117, 221 00 Lund, Sweden, with organisation number 202100-3211 is the controller. You can find Lund University's privacy policy at www.lu.se/integritet

You have the right to receive information about the personal data we process about you. You also have the right to have inaccurate personal data about you corrected. If you have a complaint about our processing of your personal data, you can contact our Data Protection Officer at dataskyddsombud@lu.se. You also have the right to file a complaint with the supervisory authority (the Data Protection Authority, IMY) if you believe that we are processing your personal data incorrectly.

Location:	**Signature:**
Date:	**Name clarification:**

Thank you for your participation!

Appendix B. Consent form Spanish

Consentimiento para participar en una Tesis en la Facultad de Ciencias Sociales

Este estudio se lleva a cabo con el propósito de una tesis de maestría en la Universidad de Lund, Suecia. El objetivo del estudio es comprender el acceso y posibles obstáculos para el uso de anticonceptivos entre las mujeres migrantes venezolanas en Colombia.

Para obtener datos relevantes, se difunde una encuesta entre mujeres venezolanas en Colombia, y se realizan entrevistas con personal de organizaciones trabajando en estos temas y con mujeres venezolanas. La entrevista dura aproximadamente 45-60 minutos, y su participación es muy apreciada.

Para esta tesis, se recopilará su dirección de correo electrónico o número de WhatsApp. Toda la información que proporcione para este estudio, además de la información personal, será tratada de manera confidencial y su identidad permanecerá anónima. Toda la información personal será eliminada al completarse la tesis, y no se compartirán datos personales con terceros.

¿Está de acuerdo en participar en este estudio?
☐ Sí
☐ No

¿Tengo su consentimiento para grabar la entrevista?
☐ Sí
☐ No

Si tiene preguntas, inquietudes, desea más información, o si quiere leer la tesis una vez que haya sido publicada, me puede contactar en Whatsapp: +57 311 872 50 65 o por correo electrónico a fe2236sv-s@student.lu.se

Universidad de Lund, Box 117, 221 00 Lund, Suecia, con número de organización 202100-3211 es responsable del tratamiento de datos. Puede encontrar la política de privacidad de la Universidad de Lund en www.lu.se/integritet

Usted tiene derecho a recibir información sobre los datos personales que procesamos sobre usted. También tiene derecho a corregir datos personales inexactos sobre usted. Si tiene una queja sobre nuestro tratamiento de sus datos personales, puede comunicarse con nuestro

Oficial de Protección de Datos en dataskyddsombud@lu.se. También tiene derecho a presentar una queja ante la autoridad supervisora (la Autoridad de Protección de Datos, IMY) si cree que estamos procesando sus datos personales incorrectamente.

Ubicación:	**Firma:**
Fecha:	**Clarificación de nombre:**

¡Gracias por su participación!

Appendix C. Survey (Spanish)

Estimada encuestada,

Gracias por tomarse el tiempo para responder esta encuesta. Mi nombre es Felicia y estoy escribiendo mi tesis de maestría sobre el acceso a anticonceptivos para mujeres venezolanas en Colombia. Dado que este estudio se enfoca en mujeres, solo complete esta encuesta si se identifica como mujer.

La encuesta se enfoca en su experiencia con anticonceptivos. Contiene 18-23 preguntas, dependiendo de sus respuestas, y tarda aproximadamente 15 minutos. Sus respuestas se mantendrán estrictamente confidenciales y la encuesta es completamente anónima. Si decide compartir sus datos de contacto (opcional al final), no se compartirán con terceros y solo se utilizarán con fines de esta tesis.

Mi correo electrónico y número de WhatsApp se comparten al final de la encuesta en caso de necesitar o querer más contacto.

Le agradezco por su participación.

1. ¿Cuántos años tiene?
- Menor de 18 años
- 18-20
- 20-24
- 25-30
- 35-40
- 40 o más

2. ¿Tiene Estatus de Protección Temporal para migrantes venezolanos?
- Sí

- No

3. ¿Tiene actualmente una identificación/pasaporte venezolano?
- Sí
- No

4. ¿Cuál es su estado civil actual?
- Soltera
- En una relación
- Casada
- Divorciada
- Viuda
- Otro

5. ¿Cuál es su situación de vivienda actual?
- Conviviendo con esposo/a o pareja
- Viviendo con padres u otros familiares
- Viviendo sola
- Viviendo con compañeros/amigos
- Otro, por favor especifique:

6.¿Tiene hijos?
- No tengo hijos
- Tengo 1 hijo
- Tengo 2 hijos
- Tengo 3 hijos
- Tengo 4 hijos o más

7.¿Qué nivel de educación ha completado?
- No he completado ninguna educación
- Educación básica: primaria
- Educación básica: secundaria
- Graduada de secundaria
- Licenciatura
- Maestría

8. ¿Cuántas horas trabaja por semana?
- Tiempo completo (40 horas o más)
- Tiempo parcial (15-25 horas)
- Soy estudiante
- Otro
- No trabajo

9.¿Cómo describiría su situación financiera?
- Excelente
- Buena
- Ni buena ni mala
- Mala
- Muy mala

10. ¿Cómo describiría la situación financiera actual de su hogar?

- Excelente
- Buena
- Ni buena ni mala
- Mala
- Muy mala

11. ¿A qué estrato pertenece?

- Sin estrato
- 1
- 2
- 3
- 4
- 5
- 6
- Prefiero no responder / no sé

Tema 2: Necesidades y acceso a anticonceptivos

Las siguientes preguntas tratan sobre anticonceptivos y sus experiencias en torno al acceso a ellos

12. ¿Actualmente usa anticonceptivos?

- Sí, métodos tradicionales (por ejemplo, infertilidad lactacional, método de retirada, seguimiento del ciclo menstrual (método del ritmo))
- Sí, condón
- Sí, píldora anticonceptiva
- Sí, esterilización
- Sí, anticonceptivos inyectables
- Sí, dispositivo intrauterino (DIU)
- Sí, parche anticonceptivo
- Sí, implante
- Sí otro, por favor especifique:
- No

13. ¿Por qué no?

- No quiero
- No necesito anticonceptivos
- No tengo actividad sexual
- No sé dónde conseguirlos
- Tengo miedo a posibles efectos secundarios o consecuencias para la salud
- Tengo creencias culturales o religiosas en contra de los anticonceptivos
- Tengo grandes distancias para buscar servicios
- Es demasiado caro
- Tengo miedo a la discriminación, juicio o estigma por parte de los proveedores de atención médica
- Tengo miedo a la discriminación, juicio o estigma por parte de la comunidad
- Mi pareja está en contra de los anticonceptivos
- Otra razón: por favor especifique:

14. Cuando buscaba anticonceptivos en Colombia, ¿qué métodos anticonceptivos diferentes le presentaron? ¿De cuáles podría elegir? Puede elegir más de una alternativa.

- Métodos tradicionales (por ejemplo, infertilidad lactacional, método de retirada, seguimiento del ciclo menstrual (método del ritmo))
- Condón
- Píldora anticonceptiva
- Esterilización
- Anticonceptivos inyectables
- Dispositivo intrauterino (DIU)
- Parche anticonceptivo
- Implante
- Otro: por favor especifique
- Nunca he buscado anticonceptivos

15. ¿Le costó algo obtener anticonceptivos en Colombia?

- Sí
- No

16. ¿Cuál fue su experiencia general al buscar anticonceptivos en Colombia?

- Muy buena, me sentí muy respetada por el personal de salud
- Buena, me sentí algo respetada por el personal de salud
- Ni buena ni mala
- Mala, me sentí irrespetada por el personal de salud
- Muy mala, me sentí muy irrespetada por el personal de salud

17. ¿En algún momento se sintió discriminada al buscar anticonceptivos en Colombia?

- Sí, por parte del personal en la recepción
- Sí, por parte de la enfermera/médico
- Sí, por parte de otra persona en la instalación de salud
- No

18. ¿Su estatus migratorio ha influido en sus posibilidades de acceder a anticonceptivos en Colombia?

- Sí, ha facilitado mucho el acceso
- Sí, ha facilitado un poco el acceso
- Sí, ha dificultado un poco el acceso
- Sí, ha dificultado mucho el acceso.
- No ha influido
- No sé

19. ¿Cuáles son los mayores obstáculos o desafíos que ha enfrentado al buscar anticonceptivos? Puede elegir más de una alternativa.

- Mi estatus migratorio
- Mi situación socioeconómica
- No tengo una identificación válida
- No cumplo con los requisitos para la cita
- El centro de salud no ofrece suficiente variedad en los métodos

- El centro de salud a la que suelo ir no tiene anticonceptivos
- El centro de salud está lejos
- No sé dónde ir
- No tienen horarios de apertura que me funcionen
- No sé cómo reservar / No pude reservar una cita
- Los tiempos de espera son demasiado largos
- Es caro
- Me da miedo que alguien que conozco descubra que fui a buscar anticonceptivos
- Me da miedo enfrentar la discriminación
- Mi pareja no quiere que use anticonceptivos
- Mi familia no quiere que use anticonceptivos
- No es aceptado en mi sociedad usar anticonceptivos
- Otro:

20. ¿En su comunidad, es culturalmente aceptable usar anticonceptivos como mujer soltera?

- Sí, siempre es aceptado
- Sí, a veces es aceptado
- No, no es aceptado
- No sé

21. ¿Desde su entendimiento, existe algún estigma en torno a obtener anticonceptivos?

- Sí, mucho
- Sí, un poco
- No
- No sé

22. ¿Dónde adquirió conocimiento sobre anticonceptivos por primera vez?

- En la escuela
- De un miembro de mi familia
- De amigos
- En Internet
- Del médico/ginecólogo/enfermero/a
- Campañas de salud
- Organizaciones comunitarias
- Institución religiosa
- Otro, por favor especifique:

23. ¿Siente que tiene suficiente información para tomar una decisión bien informada sobre cómo usar anticonceptivos?

- Sí
- No
- No sé

24. ¿Desea agregar alguna información adicional?

25. Como última pregunta de la encuesta. ¿Estaría interesada en participar en una entrevista de seguimiento? Si es así, deja su número de WhatsApp o dirección de correo electrónico aquí y me pondré en contacto con usted.

¡Gracias por su participación!
Le agradezco sinceramente por su aporte. ¡Su tiempo y respuestas son invaluables!
Si tiene alguna pregunta adicional sobre la encuesta, no dude en contactarme en fe2236sv-s@student.lu.se o en WhatsApp al +57 311 872 50 65.
Cordiales saludos,

Felicia

Appendix D. Survey (English)

Dear Survey Respondent,

Thank you for taking the time to respond to this survey. My name is Felicia, and I am writing my master's thesis on access to contraceptives for Venezuelan women in Colombia. Since this study focuses on women, please only complete this survey if you identify as a woman.

The survey focuses on your experience with contraceptives. It contains 18-23 questions, depending on your responses, and takes approximately 15 minutes to complete. Your responses will be kept strictly confidential, and the survey is completely anonymous. If you choose to share your contact information (optional at the end), it will not be shared with third parties and will only be used for the purposes of this thesis.

My email and WhatsApp number are provided at the end of the survey in case you need or want more contact. Thank you for your participation.

1. How old are you?
- Under 18 years old
- 18-20
- 20-24
- 25-30
- 35-40
- 40 or older

2. Do you have Temporary Protection Status for Venezuelan migrants?
- Yes
- No

3. Do you currently have a Venezuelan ID/passport?
- Yes
- No

4. What is your current marital status?
- Single
- In a relationship
- Married
- Divorced
- Widowed

- Other

5. What is your current housing situation?
- Living with spouse/partner
- Living with parents or other relatives
- Living alone
- Living with roommates/friends
- Other, please specify:

6. Do you have children?
- I don’t have children
- I have 1 child
- I have 2 children
- I have 3 children
- I have 4 or more children

7. What level of education have you completed?
- I have not completed any education
- Basic education: primary
- Basic education: secondary
- High school graduate
- Bachelor's degree
- Master's degree

8. How many hours do you work per week?
- Full-time (40 hours or more)
- Part-time (15-25 hours)
- I am a student
- Other
- I do not work

9. How would you describe your financial situation?
- Excellent
- Good
- Neither good nor bad
- Bad
- Very bad

10. How would you describe your household's current financial situation?
- Excellent
- Good
- Neither good nor bad
- Bad
- Very bad

11. What socioeconomic stratification category do you belong to?
- Without strata
- 1
- 2

- 3
- 4
- 5
- 6
- Prefer not to answer/ I don’t know

Topic 2: Contraceptive Needs and Access
The following questions focus on contraceptives and your experiences accessing them

12. Are you currently using contraceptives?

- Yes, traditional methods (e.g., lactational infertility, withdrawal method, menstrual cycle tracking (rhythm method))
- Yes, condom
- Yes, birth control pill
- Yes, sterilization
- Yes, injectable contraceptives
- Yes, intrauterine device (IUD)
- Yes, contraceptive patch
- Yes, implant
- Yes, other, please specify:
- No

13. Why not?

- I don't want to
- I don't need contraceptives
- I am not sexually active
- I don't know where to get them
- I am afraid of possible side effects or health consequences
- I have cultural or religious beliefs against contraceptives
- I have to travel long distances to access services
- It is too expensive
- I am afraid of discrimination, judgment, or stigma from healthcare providers
- I am afraid of discrimination, judgment, or stigma from the community
- My partner is against contraceptives
- Other reason: please specify:

14. When seeking contraceptives in Colombia, what different methods were you offered? Which could you choose? You may select more than one option.

- Yes, traditional methods (e.g., lactational infertility, withdrawal method, menstrual cycle tracking (rhythm method))
- Yes, condom
- Yes, birth control pill
- Yes, sterilization
- Yes, injectable contraceptives
- Yes, intrauterine device (IUD)
- Yes, contraceptive patch

- Yes, implant
- Other, please specify:
- I have never sought contraceptives

15. Did it cost you anything to obtain contraceptives in Colombia?
- Yes
- No

16. What was your overall experience seeking contraceptives in Colombia?
- Very good, I felt very respected by the healthcare staff
- Good, I felt somewhat respected by the healthcare staff
- Neither good nor bad
- Bad, I felt disrespected by the healthcare staff
- Very bad, I felt very disrespected by the healthcare staff

17. Have you ever felt discriminated against when seeking contraceptives in Colombia?
- Yes, by the reception staff
- Yes, by the nurse/doctor
- Yes, by someone else at the healthcare facility
- No

18. Has your immigration status affected your ability to access contraceptives in Colombia?
- Yes, it has greatly facilitated Access
- Yes, it has somewhat facilitated Access
- Yes, it has somewhat hindered access
- Yes, it has greatly hindered access
- It has not influenced
- I don’t know

19. What are the biggest obstacles or challenges you have faced when seeking contraceptives? You may select more than one option.
- My migration status
- My socioeconomic situation
- I don't have a valid ID
- I don't meet the requirements for the appointment
- The health care facility does not offer enough variety in methods
- The health care facility I usually go to doesn't have contraceptives
- The health care facility is far away
- I don't know where to go
- They don'y have opening hours that work for me
- I don'y know how to book/ I couldn't book an appointment
- The waiting times are too long
- It is expensive
- I am afraid someone I know will find out that I went to seek contraceptives
- I am afraid of facing discrimination
- My partner does not want me to use contraceptives
- My family does not want me to use contraceptives
- It is not accepted in my society to use contraceptives
- Other

20. In your community, is it culturally acceptable for a single woman to use contraceptives?

- Yes, it is always accepted
- Yes, it is sometimes accepted
- No, it is not accepted
- I don't know

21. From your understanding, is there any stigma around obtaining contraceptives?

- Yes, a lot
- Yes, a Little
- No
- I don't know

22. Where did you first learn about contraceptives?

- From a family member
- From friends
- On the Internet
- From a doctor/gynecologist/nurse
- Health campaigns
- Community organizations
- Religious institution
- Other, please specify:

23. Do you feel you have enough information to make an informed decision about using contraceptives?

- Yes
- No
- I don't know

24. Would you like to add any additional information?

_____

25. As the last question of the survey, would you be interested in participating in a follow-up interview? If so, please leave your WhatsApp number or email address here and I will contact you.

_____

Thank you for your participation!

I sincerely appreciate your contribution. Your time and responses are invaluable!

If you have any further questions about the survey, please feel free to contact me at fe2236sv-s@student.lu.se or via WhatsApp at +57 311 872 50 65.

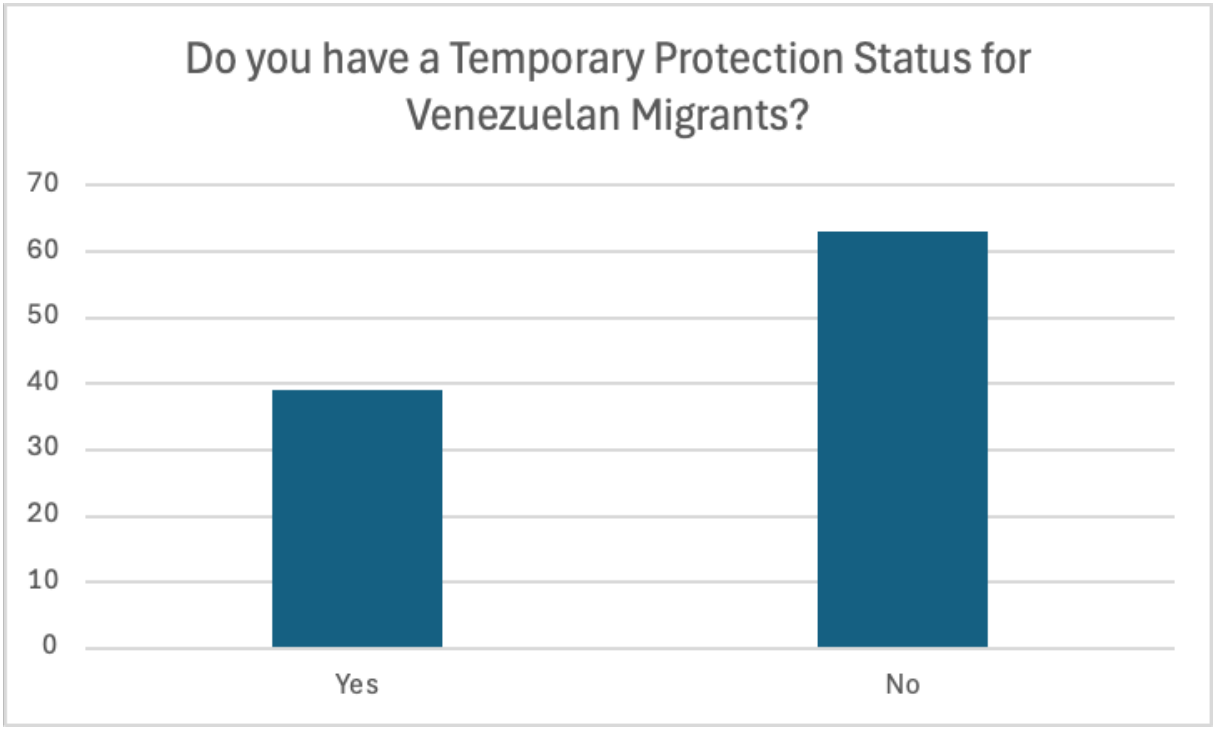
Kind regards,

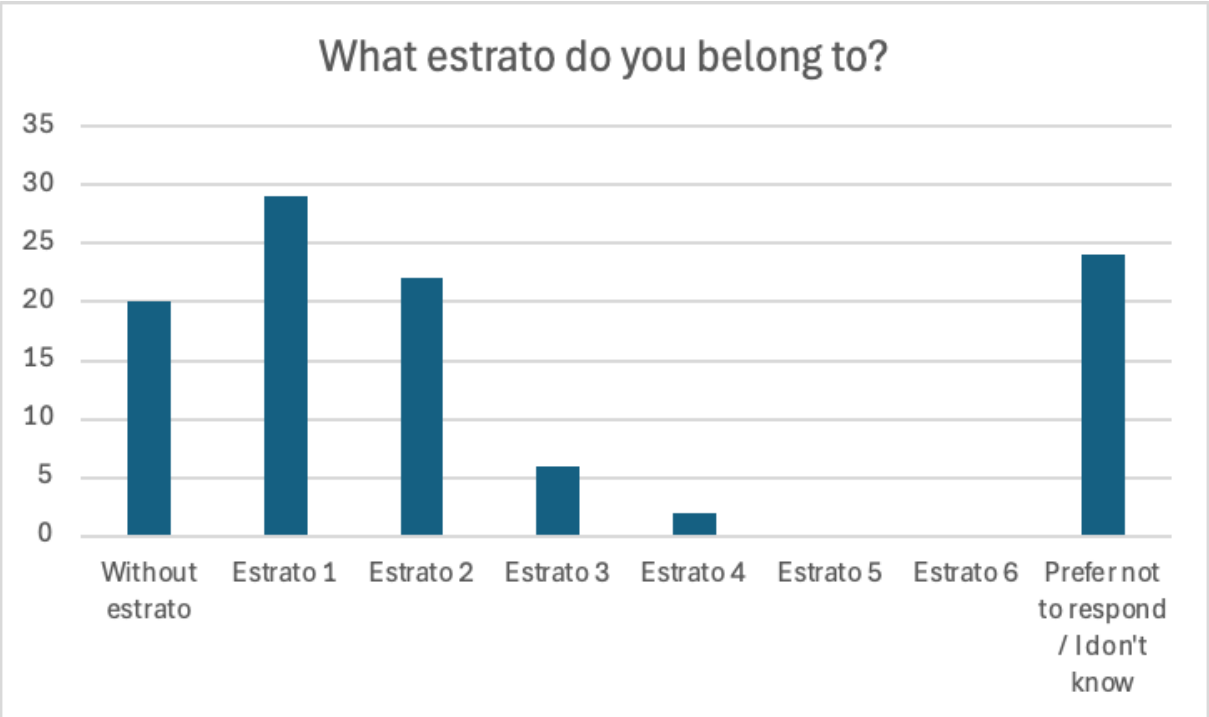
Felicia

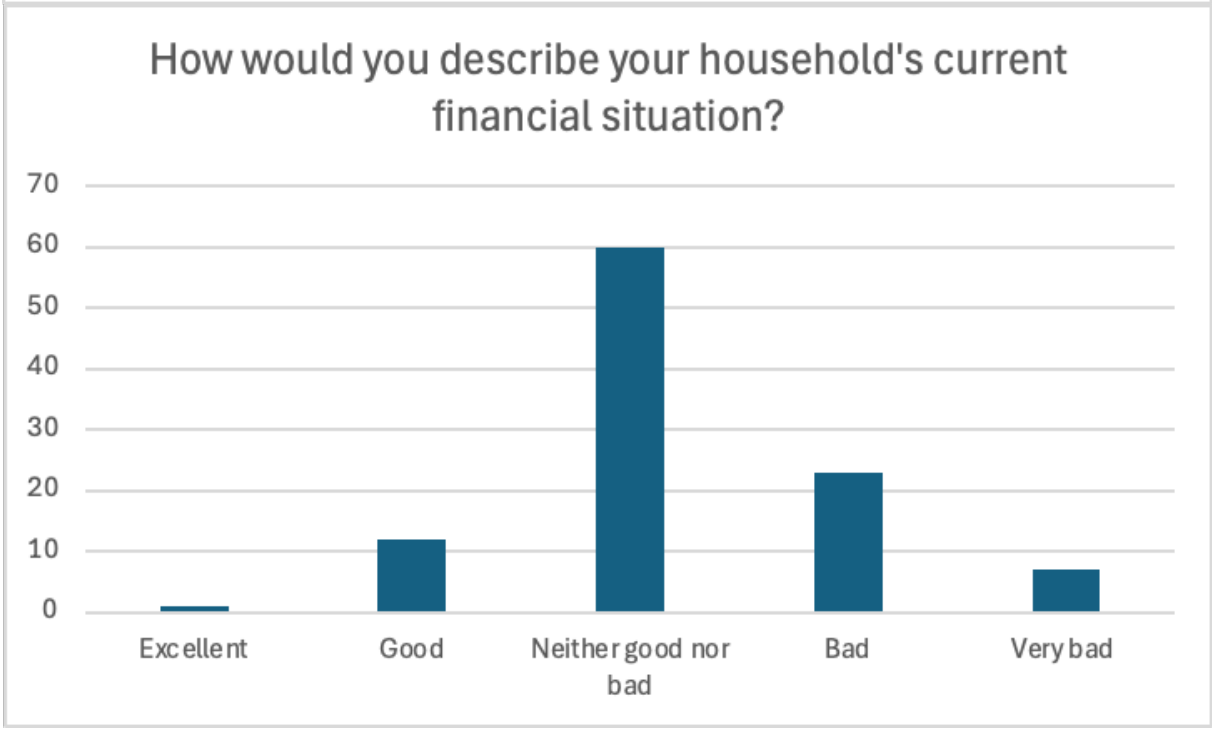
Appendix E. Selected survey responses

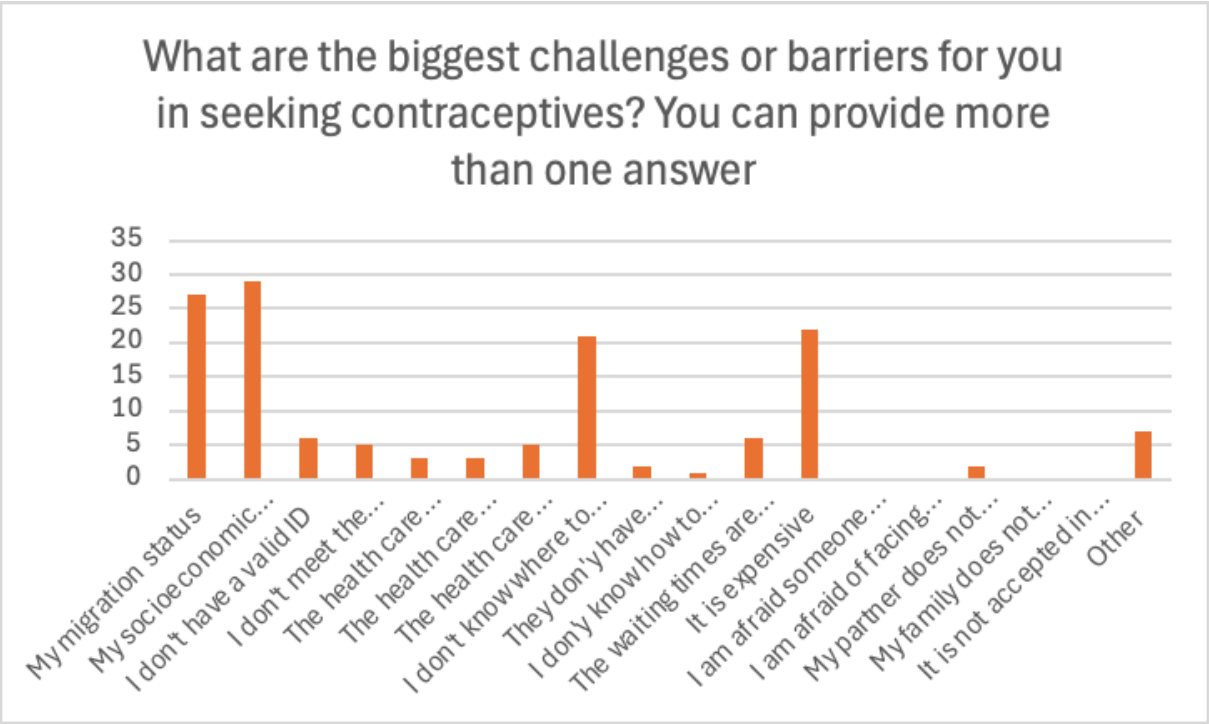
Age categories of the survey respondents.

Age	Number
18-20	37
20-24	38
25-30	28



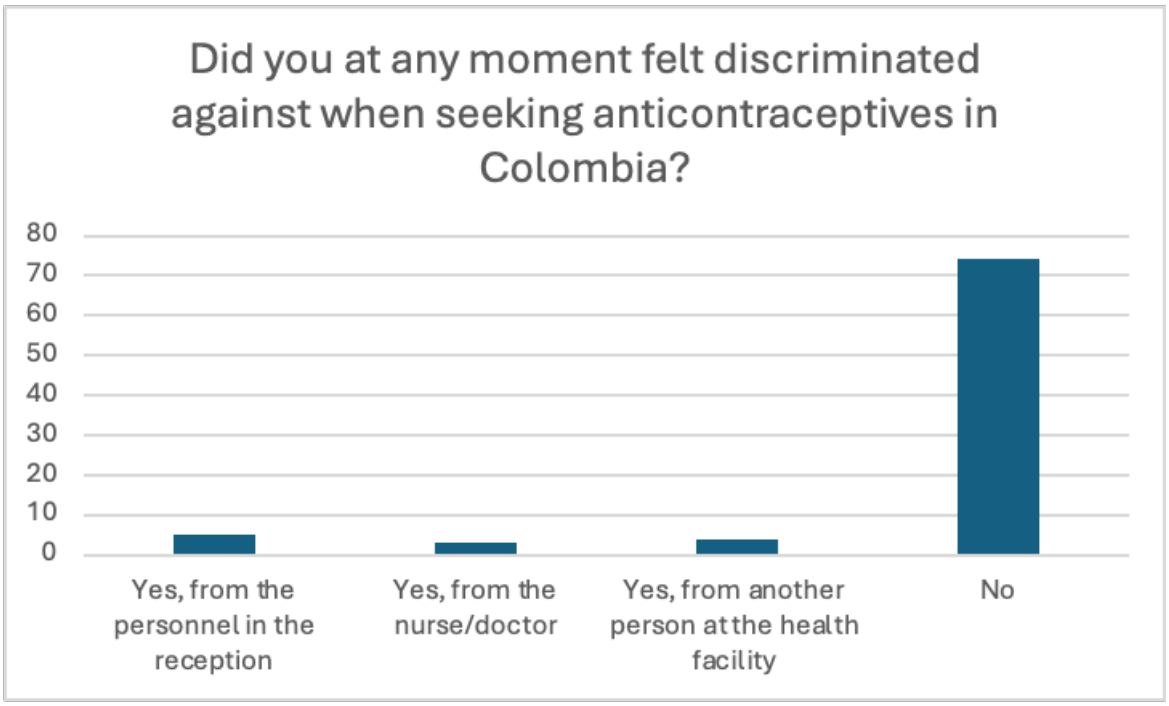

What estrato do you belong to?
35
30
25
20
15
10
5
0
Without estrato
Estrato 1
Estrato 2
Estrato 3
Estrato 4
Estrato 5
Estrato 6
Prefer not to respond / I don't know

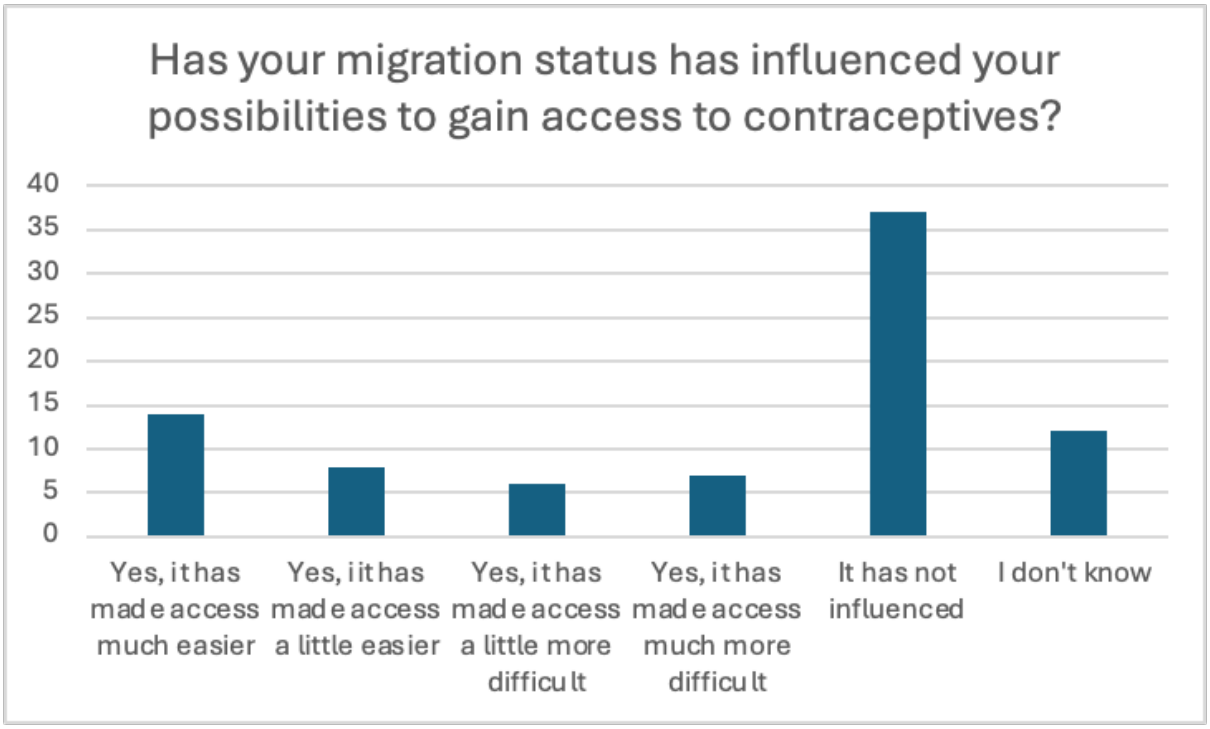

How would you describe your household's current financial situation?
70
60
50
40
30
20
10
0
Excellent
Good
Neither good nor bad
Bad
Very bad



What are the biggest challenges or barriers for you in seeking contraceptives? You can provide more than one answer	**Number**
My socioeconomic situation	29
My migration status	27
It is expensive	22
I don't know where to go	21
Other	7
I don't have a valid ID	6
The waiting times are too long	6
I don't meet the requirements for the appointment	5
The health care facility is far away	5
The health care facility does not offer enough variety in methods	3
The health care facility I usually go to doesn't have contraceptives	3
My partner does not want me to use contraceptives	2
They don'y have opening hours that work for me	2
I don'y know how to book/ I couldn't book an appointment	1
I am afraid someone I know will find out that I went to seek contraceptives	0
I am afraid of facing discrimination	0
My family does not want me to use contraceptives	0

It is not accepted in my society to use contraceptives	0





Appendix F. Interview-guide with Venezuelan women (English)

Nr	Question

	Introduccion
	• Introduce myself • Outline focus of today's conversation: access to contraceptives for Venezuelan women aged 18-30 in Colombia • Review consent form • Potential questions • Ask about consent for recording • Inform about confidentiality and anonymity, and right to stop interview or skip questions at any point in time • Inform about length of interview: roughly 45 minutes
	Demographics
	• Could you start by telling me a little about yourself? How is your living situation here in Colombia?
	• Can you share your experiences with seeking and obtaining contraceptives here in Colombia? How has it been?
	Availability and Awareness
	• What contraceptive method are you currently using? Why did you choose that method? • The first time you wanted to seek contraceptives in Colombia, was it difficult to know where to seek help? How did you do it?
	Accomodation and Accessibility
	• How easy or difficult is it for you to access contraceptive services? • What requirements did you have to meet to schedule an appointment, and was it difficult to meet them? • How do you feel your immigration status has impacted your access to contraceptives?
	Affordability
	• How much did it cost you to obtain contraceptives? If it cost something, what was the cost? • Were there any additional costs that you had to pay that were not directly for the contraceptives? • In what way can the socioeconomic situation be a barrier?
	Acceptability
	• What can you tell me about the attitudes or opinions in your community about contraceptives? Is it something that is openly discussed? In your family, with your friends, at school, etc. • Have you ever experienced stigma or discrimination when seeking contraceptives?
	Barriers and improvements
	• In your experience, what are the biggest obstacles to obtaining contraceptives? • Is there anything you think could be done to improve access to contraceptives for Venezuelan women in Colombia? What could that be?
	Closing
	• Questions • Close interview

Appendix G. Interview-guide with Venezuelan women (Spanish)

Nr	Pregunta
	Introducción
	• Presentarme • Enfoque de la conversación de hoy: acceso a anticonceptivos para mujeres venezolanas de 18-30 años en Colombia • Revisar el formulario de cnosentimiento • Preguntas potenciales • Preguntar sobre el coonsentimiento para grabar • Informar sobre la confidencialidad y el derecho a detener la entrevista o saltar algunas preguntas en cualquier momento • Informar sobre la duración de la entrevista: aprozimadamente 45 minutos
	Demografía
	• ¿Podría empezar por contarme un poco sobre usted? ¿Cómo es su situación de vida aquí en Colombia?
	• ¿Puede compartir sus experiencias buscar y obtener anticonceptivos aquí en Colombia? ¿Como ha sido?
	Disponibilidad y Conciencia
	• ¿Qué método de anticonceptivo usa actualmente? ¿Porque eligió ese método? • La primera vez que quiso buscar anticonceptivos en Colombia, ¿fue difícil saber dónde buscar ayuda? ¿Cómo lo hizo?
	Alojamiento y Accesibilidad
	• ¿Qué tan fácil o difícil es para usted acceder a servicios anticonceptivos? • ¿Cuáles requisitos tenía usted para programar una cita, y era difícil cumplir con ellos? • ¿Cómo siente que su estatus migratorio ha impactado su acceso a anticonceptivos?
	Asequibilidad
	• ¿Cuánto le costó obtener anticonceptivos? Si costo algo, ¿qué era que costaba? • ¿Hubo algún costo adicional que tuvo que pagar que no fueran directamente los anticonceptivos? • ¿De qué manera puede la situación socioeconómica ser una barrera?
	Aceptabilidad
	• ¿Qué puede decirme sobre las actitudes u opiniones en su comunidad sobre los anticonceptivos? ¿Es algo de lo que se habla abiertamente? En su familia, con sus amigos, en la escuela etc., • ¿Alguna vez ha sufrido estigma o discriminación al buscar anticonceptivos?
	Barreras y Mejoras
	• ¿En su experiencia, cual es el mayor o los mayores obstáculos para obtener anticonceptivos? • ¿Hay algo que usted cree que se podría hacer para mejorar el acceso a anticonceptivos para las mujeres venezolanas en Colombia? ¿Qué podría ser eso?

	Cierre
	• Preguntas • Cierre de la entrevista

Appendix H. Description of informants

Informant 1. 18-20 years old.	Has TPS Has a relationship Lives with partner Has 1 child Neither good nor bad financial situation Social stratification category: 1
Informant 2. 18-20 years old.	Has TPS Has a relationship Lives with parents or other family members Does not have children Neither good nor bad financial situation Social stratification category: 1
Informant 3. 25-30 years old.	Has TPS Has a relationship Lives with partner Does not have children Neither good nor bad financial situation Social stratification category: 1

Appendix I. Interview-guide with health staff (English)

Nr	Question
	Introduction
	• Introduce myself • Outline focus of today's conversation: access to contraceptives for Venezuelan women aged 18-30 in Colombia • Review consent form • Potential questions • Ask about consent for recording • Inform about confidentiality and anonymity, and right to stop interview or skip questions at any point in time • Inform about length of interview: roughly 45 minutes
	Role and professional background
	• Tell me a bit about your role and where you work, and the community in which you practice?
	Awareness and Availability
	• Can you tell me about the contraceptive services available at your facility?

	• Are there any methods you don't offer but you wish you could? Why not? • Is your facility equipped to meet women's need for contraceptives? • How do you work with reaching out to migrants about your facilities? Does the information reach the migrants?
	Accommodation and Accessibility
	• How easy or difficult is it for Venezuelan women to physically access contraceptive services? • How do issues such as documentation status or migrant status affect women's access to contraceptives? • What are the requirements to have an appointment with you? And to your knowledge, are there difficulties for women in fulfilling with requirements from the appointment?
	Affordability
	• Do Venezuelan migrant women face financial barriers in accessing contraceptives and related healthcare services? • How does the socioeconomic situation influence Venezuelan migrant women's access to contraceptives?
	Acceptability
	• What can you tell me about the attitudes or public opinions about contraceptives in the general context, and specifically for Venezuelan migrants? • Does stigma exist related to contraceptive use? • How do you think societal attitudes toward migrants affect their access to contraceptives? • Have you heard about instances of discrimination or marginalization against Venezuelan migrant women in healthcare settings?
	Barriers and improvements
	• In your experience, what are the biggest barriers that Venezuelan migrant women face in accessing contraceptives in Colombia? • What needs to happen to improve access to contraceptives for migrants?
	Closing
	• Questions • Close interview

Appendix J. Interview-guide with health staff (Spanish)

Nr	Pregunta
	Introducción
	• Presentarme • Enfoque de la conversación de hoy: acceso a anticonceptivos para mujeres venezolanas de 18-30 años en Colombia • Revisar el formulario de cnosentimiento • Preguntas potenciales • Preguntar sobre el coonsentimiento para grabar • Informar sobre la confidencialidad y el derecho a detener la entrevista o saltar algunas preguntas en cualquier momento • Informar sobre la duración de la entrevista: aprozimadamente 45 minutos
	Rol y profesión
	• Cuéntame un poco sobre su rol y dónde trabajas, y a la comunidad en la que
	Conciencia y Disponibilidad

	• ¿Puede contarme sobre los servicios de anticonceptivos disponibles en sus instalaciones? • ¿Hay métodos anticonceptivos que les gustaría ofrecer, pero no lo hacen? • ¿Están suficientemente equipados para satisfacer las necesidades anticonceptivas de las mujeres en cuanto a anticonceptivos? • ¿Ustedes cómo trabajan para difundir información para los migrantes sobre el trabajo de ustedes? ¿Llega la información?
	Alojamiento y accesibilidad
	• ¿Qué tan fácil o difícil es para las mujeres venezolanas acceder físicamente a los servicios anticonceptivos? • ¿Cómo afecta el estatus migratorio o falta de documentación el acceso de las mujeres a los anticonceptivos? • ¿Podría contarme, cuáles son los requisitos para tener una cita con ustedes? Y según su conocimiento, ¿existen dificultades para que las mujeres cumplan con los requisitos de la cita?
	Asequibilidad
	• ¿Las mujeres migrantes venezolanas enfrentan barreras financieras para acceder a anticonceptivos?
	Aceptabilidad
	• ¿Qué puede decirme sobre las actitudes u opiniones públicas sobre los anticonceptivos en el contexto general y específicamente para los migrantes venezolanos? • ¿Hay estigma en torno al uso de anticonceptivos? • ¿Cómo creé que las actitudes sociales hacia los migrantes afectan su acceso a los anticonceptivos? • ¿Ha escuchado casos de discriminación contra mujeres migrantes venezolanas en entornos de atención médica?
	Barreras y mejoramiento
	• En su experiencia, ¿cuáles son las mayores barreras que enfrentan las mujeres migrantes venezolanas para acceder a anticonceptivos en Colombia? • ¿Qué se necesita hacer para que los servicios sean más accesibles para las mujeres venezolanas en Colombia?
	Cierre
	• Preguntas • Cierre de la entrevista