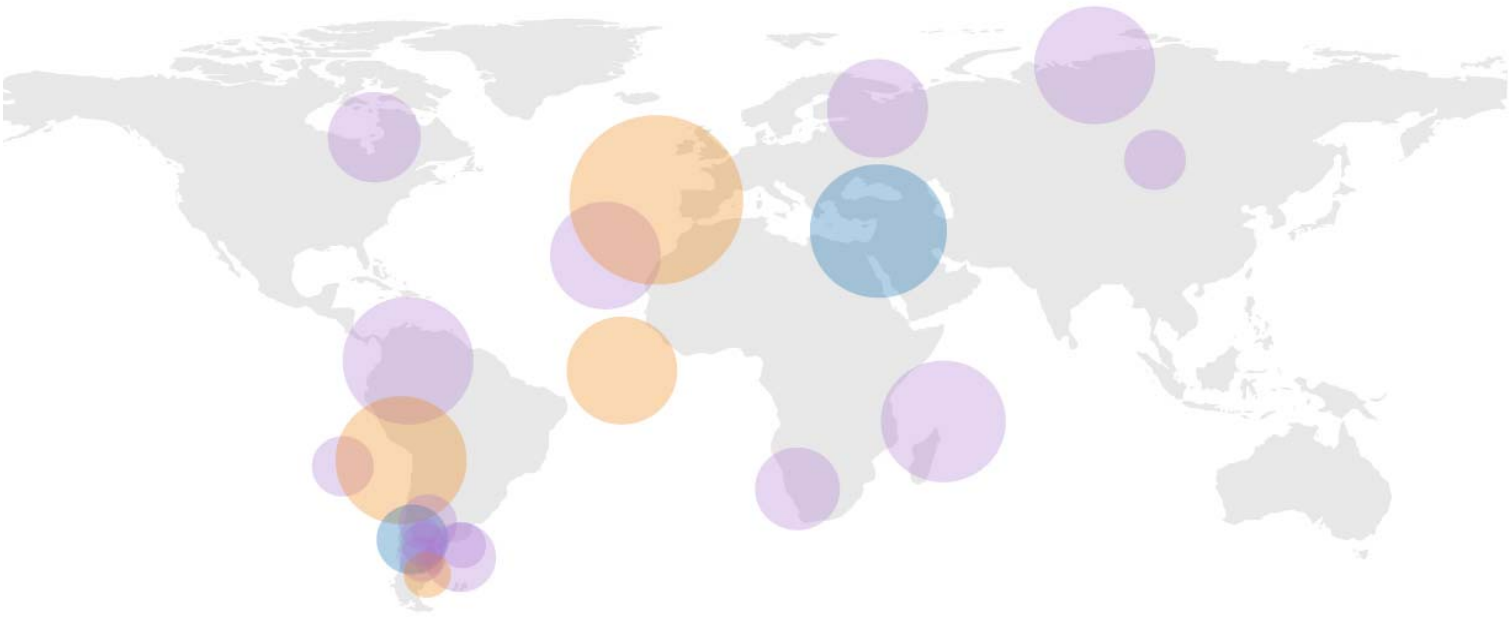

# Scoping Study on Sexual, Reproductive and Maternal Health (SRMH) in Latin America and the Caribbean

## Final Report

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CIPS IMPLEMENTACIÓN E INNOVACIÓN EN POLÍTICAS DE SALUD

IECS INSTITUTO DE EFECTIVIDAD CLINICA Y SANITARIA

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# 1. Introduction

Sexual, reproductive, and maternal health and rights (SRMHR) are an essential part of universal health coverage (UHC). Countries moving towards UHC need to consider how the SRMHR needs of their population are met throughout the life course, from infancy and childhood through adolescence and into adulthood and old age. In this regard, SRMHR targets have been included as part of the United Nations (UN) Sustainable Development Goals under Goal 3 (targets 3.1 and 3.7) and Goal 5 (target 5.6). To meet effectively the SRHR needs, a comprehensive and life course approach is required, focusing on equity gaps in health care and rights, quality of care, and accountability across implementation without discrimination.

Large disparities among and within Latin American and Caribbean (LAC) countries are common. Women who are disadvantaged socially and economically, including those who are young, poor, have little education and/or live in rural areas, have the greatest difficulty obtaining the services they need to prevent unintended pregnancies, to remain healthy throughout pregnancy, childbirth, and postnatal period, and to ensure the health of their newborns. In addition, highly vulnerable populations comprising systematically marginalized groups such as: indigenous populations; Afro-descendants; Lesbian, Gay, Bisexual, Trans, Queer and Intersex plus (LGBTQI+), persons with disabilities, elderly, migrants, among others, often suffer discrimination and stigmatization that deeply affects their health rights and access to health care services. All these conditions of vulnerability are enhanced when they coexist.

In the context of a **Scoping Study about Sexual, Reproductive and Maternal Health and Rights (SRMHR) in Latin America and the Caribbean**, we present the **Final Report**.

This study began in December 2021 with the objective to develop a scoping study to set the basis for the development of a priority research to policy agenda to address the health gaps that affect SRMHR of vulnerable population: women, adolescent girls, elderly, persons with disabilities, LGBTQI+, migrants, indigenous and Afrodescendant populations in LAC.

To achieve this purpose, the study was developed in four components: 1) Literature and Policy Review; 2) Mapping of stakeholders and landscape analysis; 3) Rapid country studies (in six selected countries) and; 4) Consultation process.

The following pages present a synthesis of the methods used in each component as well as the main results. Also includes the list of research priorities as well as barriers and facilitators to advance in the SRMHR research and key actors to make alliances for research.

After going through the review of studies, policies, legal frameworks and interviews with key actors, we can conclude that we began the process as a roadmap to not only know and better understand the root causes of these equity gaps but also to identify those priority issues and strategic stakeholders required to address and involve in order to improve SRMHR in the LAC region.

# 2. Methods

## 2.1. Literature and Policy Review

We conducted a rapid narrative review about priorities, policies, access, and gaps in sexual, reproductive, and maternal health and rights of women, adolescent girls, LGBTQI+, migrants, indigenous and Afro-descendant populations in LAC, with particular focus in Colombia, Peru, Mexico, Guatemala, Jamaica, and Guyana.

We used an adaptive methodological framework proposed by Arksey and O'Malley [1] for scoping review. A comprehensive search strategy was developed to identify relevant literature from the last five years (2017-2022), underpinned by key inclusion criteria. We aimed to identify the main sexual, reproductive, and maternal health policies, programs and legislation implemented, health priorities, and main gaps in access to SRMHR, as well as research gaps and how they relate to the policies in place in LAC countries.

Twenty published review studies (narrative, systematic and non-systematic reviews) that included at least two LAC countries and total of 477 records from grey literature were included.

The search strategy for grey literature included searching in websites of Ministries of Health of the six prioritized countries; the websites of global and regional NGOs in LAC, contacting authors to identify additional sources and experts to identify unpublished information on relevant legislation, policies, programs and ongoing research. The current status of laws was checked on official web pages. A Google search was conducted related to sexual and reproductive rights and each of the services included in the report.

We analyzed if intersectionality and diversity or if gender, rights, and equality approach were considered in public health policies. To organize the findings, we used an adapted WHO framework that describes the components of sexual health, as well as its linkages to reproductive health and the context (Fig.1) considering the following domains: Antenatal intrapartum and postnatal care, Gender-based violence prevention, support and care, Gender Identity, Family planning and contraception, comprehensive sexuality education, safe abortion and post abortion care, prevention and control of HIV and other sexually transmitted diseases and cancer of the reproductive system. [2]

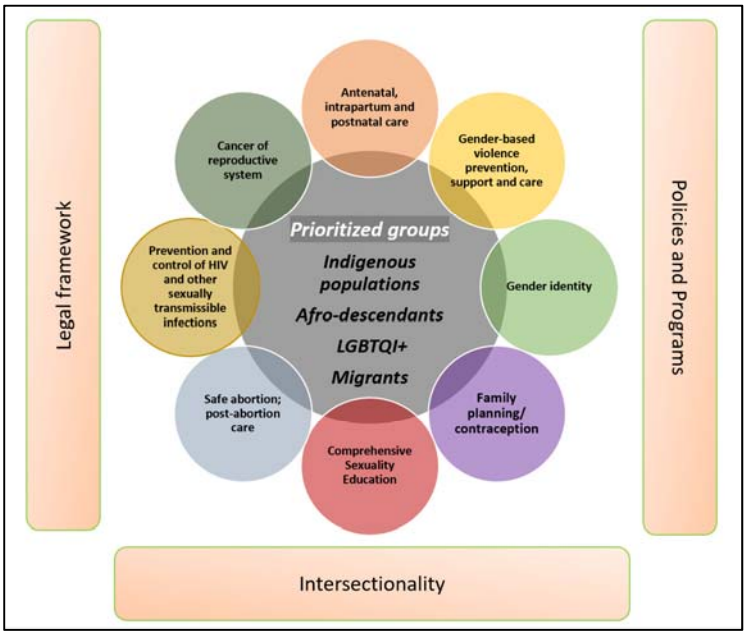


Figure 1- Adapted framework (Sexual health and its linkages to reproductive health: an operational approach. Geneva: World Health Organization; 2017)[2]

Besides, and as a complement, we analyzed the research studies identified in this component. A comprehensive and rapid search strategy was developed to identify relevant literature in different databases from 2017 to 2022, underpinned by pre-defined key inclusion criteria. Finally, we included 20 studies and described them by: authors gender and affiliation; main objective; main research questions addressed; type of design; countries included; data (year and source, demographic surveys used); type of SRMH service/s included; target Population; and, intersectionality.

## 2.2. Mapping of stakeholders and landscape analysis

We conducted a stakeholder mapping and landscape analysis in SRMHR of women, adolescent girls, LGBTQI+, migrants, indigenous and Afro-descendant populations in LAC.

We adapted the policy feasibility methodological framework proposed by Michael Reich[3] based on political will, political analysis and political strategies.

The domains considered in the stakeholder analysis were those derived from the adapted WHO framework (figure 1).

The stakeholder analysis had four main stages: 1) Identification of key stakeholders; 2) search for information on the selected stakeholders (mapping); 3) in-depth analysis of the selected stakeholders, to understand their strategies, perceptions, positions and power 4) semi-structured interviews.

**Stakeholder identification:** A comprehensive search strategy was developed to identify relevant published studies from the last 17 years (2005-2022). Then an intentional search on the internet, was conducted in Spanish and English. From the information gathered, we used a "snowball strategy" to identify other key actors. Finally, in-depth interviews with regional key stakeholders allowed to identify new actors, as well as to validate information on the existing ones.

**Stakeholder mapping:** For the identified stakeholders, we recorded information on the following data points: stakeholder's name, source of information, influence area, sector, topic/s of interest, beginning of work (year), target population, mission/objectives description, type of activities, alliances, funding, position for each topic, and power for each topic. Information used to complete the database was obtained from official websites, grey literature, social networks, blogs, newspaper articles and in-depth interviews.

**Stakeholders in-depth analysis of position and power:** The position and power of key stakeholders regarding each policy was evaluated using the resources and information available for each stakeholder. These resources included human, material and financial resources, capacity to mobilize an organization, and symbolic resources (such as leadership charisma or social media followers), technical capacity, as well as the actual influence on a specific policy area. In most cases, the evaluation of position and power was defined in terms of public statements or actions, or the number of followers and likes in the case of information obtained through social networks. Information obtained in the in-depth interviews was used to validate and complete the findings.

For each stakeholder, the position (to be in favor or against) and power was characterized separately for each of the policies given that their involvement and degree of support could differ among policies.

For players with high power, both supporters and opponents, we especially analyzed the activities they carried out (especially research), the sector they belonged to, the alliances and resources they had, either in terms of funding or technical capabilities.

**Semi-structured interviews**

We conducted semi-structured interviews with key regional informants identified as stakeholders to obtain additional information on target populations, to validate the topics on which the institutions worked; and to identify the main barriers and facilitators in the achievement of their goals.

## 2.3. Rapid Country Studies

Six rapid country studies were conducted in Peru, Colombia, Mexico, Guatemala, Jamaica, and Guyana to identify key topics and stakeholders where IDRC could make a difference in specific country or subregional contexts

We analyzed the legal framework, programs and policies related with SRMHR and the main stakeholders identified in previous stages for each country. We also selected a set of indicators to assess SRMHR in each country and complemented the analysis with in-depth interviews with key actors.

**Semi-structured interviews with key informants at country level**

A purposive sample of key informants was selected for each prioritized country. The sample sought to include a variety of informant profiles including representatives from government, civil society organizations and academia.

We developed an interview guide (adapted for each informant profile) addressing: gaps in progress on the SMRHR agenda in terms of legislation, policy implementation and access to services; barriers to achieving progress on the SMRHR agenda; availability and quality of data on SMRHR; information gaps and research priorities at country level; and, lessons learned for progressing on the SMRHR agenda. To explore their perceptions regarding these topics, we used a rapid qualitative appraisal research approach.[4]

**SRMH Indicators selection**

The indicators were selected after a comprehensive search in several sources. The information was obtained through web services from each of the sources and processed using the R software.

For most of the selected indicators, we did not find information, but we decided to include them to visualize the gaps and the need for registration and research on these topics.

Some limitations of our search can be mentioned. In some countries, underreporting may have led to report indicators with better values than the real ones. We analyzed the most updated values and not the time trends that could have provided more information to analyze the status of each indicator.

## 2.4. Consultation process

We conducted a consultation process with key stakeholders in SMRHR at a regional and national level to obtain feedback on the list of research topics identified in previous stages of the study. The consultation process was carried out in different phases. The overall process was based on a modified Nominal Group Technique (NGT). [5,6]

An initial list of priority areas and topics for SRMHR research identified in previous components was consolidated and used as the main input for the dialogue with key stakeholders. The identification and selection of key stakeholders to participate in the consultation process was based on the stakeholder mapping and analysis performed in Component 2 of this study and the opinion of SRMH expert's members of the research team. We included participants with different profiles, such as, representatives of government, civil society organizations and academia from prioritized countries, and representatives of regional or international organizations related to SRMHR. Selection criteria especially emphasized the regional vision and expertise of the stakeholders.

Finally, a virtual dialogue was held on August 19th, 2022 with the objective to gather stakeholders' opinions to identify important or priority research areas or topics to include in the consolidated list, topics that should be excluded, topics with the greatest impact on reducing gaps in access to

sexual, reproductive and maternal health for vulnerable populations and strategies for implementing a research agenda in SRMHR in the region.

Based on the feedback provided by the informants, the consolidated list of priority research topics in SRMHR was reviewed and completed, and the most relevant topics and possible strategies for their implementation at a regional level were identified.

# 3. Results

## 3.1. Literature and Policy Review

Regarding **legal framework** in general:

- **Seven countries' Constitutions recognize sexual and reproductive rights**, either explicitly or through other consecrated human rights (equality, freedom, health, education) (México (1974), Colombia (1991), Paraguay (1992), Venezuela (1999), Ecuador (2008), Plurinational State of Bolivia (2009) and Cuba (2019).
- **Five countries have specific laws**: Argentina (2002), Guatemala (2005), Uruguay (2008), Chile (2010), and Paraguay (2011). Chile, Paraguay, and Uruguay recognize certain rights that must be guaranteed to users of the listed sexual and reproductive health services. Argentina and Guatemala establish sexual and reproductive health programs, and public institutions are responsible for implementing them.
- Except for Paraguay, Guatemala, and Jamaica, **most countries have some regulation that ensures the right to non-discrimination based on sex, sexual orientation, or sexual identity**. However, ECLAC's 2021 survey on sexual and reproductive health laws mentions, *"No specific legislation is found that guarantees the sexual and reproductive rights of indigenous and Afro-descendant women and girls."* There are some partial mentions in Guatemala's Social Development Law (2001) about sexual and reproductive health and rights (SRMHR). We also found that Panama (1999), Honduras (2000), Peru (2007), Nicaragua (2008), and El Salvador (2011) have gender equity laws.
- **No specific legislation guarantees the sexual and reproductive rights of indigenous and Afro-descendant women and girls**. There are some partial mentions in the Constitution, Laws, or Resolutions in Bolivia, Ecuador (2006), Guatemala (2001), Panama (1999), Mexico (2004), Paraguay (2001), and Nicaragua (2008).
- **The rights of children, adolescents, and young people to access sexual and reproductive health are guaranteed in numerous laws and codes.** However, **both the socio-cultural context and the restriction on the exercise of autonomy imposed by the legal framework present barriers to access to contraception, HIV or STI testing, and abortion in many countries**[7]. In the region, many countries have age-of-consent laws about sexual activity. The good news is that according to the latest UNAIDS Report, the removal of laws that require parental permission for access to sexual and reproductive health and HIV services has demonstrated an improvement in health-seeking behaviors in some countries in LAC.
- **21 of the 23 countries explicitly mention legal access to modern family planning methods/contraceptives with not required parental/guardian consent in any law/resolution**. Jamaica and Guyana do not refer to this legal status in their laws/resolutions.
- **Regarding access to HIV testing, nine countries** (Ecuador, Guatemala, Honduras, México, Panamá, Paraguay, Trinidad and Tobago, and Venezuela) **do not report the current situation for this right in adolescents and young people in their legal framework**. [8]

The heterogeneity of **policies** on sexual and reproductive health and rights among the LAC countries highlights. Disparities increase when considering the practical implementation for vulnerable groups.

- **Ten countries have specific sexual and reproductive health programs**: Argentina, Colombia, El Salvador, Guatemala, México, Nicaragua, Panamá, Paraguay, Uruguay, and Venezuela.[8] These programs are part of the general health policies in the rest of the countries.[7] There are gaps regarding the implementation of programs for continuous training of human talent, specific budget allocation, and implementation monitoring systems.
- **In all countries, youth and adolescent-friendly spaces have been created**, which provide differentiated guidance and care with quality standards. However, some countries lack of strategic approaches to ensure that they reach the most vulnerable groups among adolescents.
- In an analysis of the progress in structures, methods, organizational strategies, barriers, and facilitators that contribute to the implementation of a gender perspective in health, we noticed **the need for more institutionalization and higher monitoring of data and results with specific monitoring tools and practices to measure progress towards gender equality in health**.
- **There were no reproductive, maternal, newborn, and child interventions/programs intersecting with ethnicity in our search**. For example, coverage in contraception, antenatal care, and skilled attendants at birth was lower in indigenous women than in the reference group in women between 15 and 49 years. These differences persisted after ' adjustment to education, residence, or wealth in most countries.

### 3.1.1. Antenatal, intrapartum, and postnatal care

- Although all countries have some **regulatory framework for perinatal care**, Guatemala, Ecuador, and Argentina have specific laws to guarantee the rights of pregnant women to universal, timely, free, and quality care and to reduce maternal and neonatal morbidity and mortality.
- **Most countries have specific policies to prevent unintended adolescent pregnancies**, which is considered an outstanding advance in recent years. Some of these policies include intersectoral actions. In LAC, 15% of deliveries are to adolescent mothers in which. In addition, there are profound inequalities in the distribution of wealth, income, and opportunities.
- **Regarding prenatal care, although 90% of women in Latin America and the Caribbean have at least four antenatal visits during their last pregnancy, significant inequalities exist.** Afro-descendant women in Brazil and Indigenous women in Guatemala, have been reported to have less than four antenatal care visits, are less likely to receive the recommended antenatal procedures and examinations. Low socioeconomic status, poor education, not having health insurance, not speaking the most common language in the country, and living in rural areas intersect with gender and ethnicity and result in fewer controls during pregnancy or less cervical cancer screening.
- **Newborn postnatal care is lower for rural newborns**. The widest gaps were in Bolivia (26 %), Paraguay (21%), Panama (18%), Dominican Republic (16%), Haiti (15%), and Honduras and Haiti (14%).
- **Regarding labor and intrapartum care, gaps in skilled birth attendance exist for women from different social economic status, education status and geographic distribution**. These gaps are most apparent in Haiti, where only 10 % of women from

the poorest quintile and 14 % of those without education have skilled birth attendance. The gap between the poorest and the wealthiest quintiles is 75 % in Guatemala, 69% in Haiti, 42% in Bolivia, and 41% in Honduras.

- **Indigenous and Afro-descendant women experience more significant barriers to skilled birth attendance**. Only 30% of indigenous women in Guatemala and 57% of indigenous women in Nicaragua were attended by skilled birth personnel compared with 70 and 81 % of non-indigenous women in their respective countries. Skilled birth attendance for indigenous women in Mexico and Peru has increased throughout the past decade. It is a need for Traditional Birth Attendants (TBA) to be involved in the formal health care system.
- **Inadequate provision of cesarean sections may indicate that not all women who need one will receive an emergency cesarean section**. Haiti is the only country in the region where the national average of cesarean sections is below 10%. In addition, less than 10% of women from the poorest quintiles in Bolivia, Guatemala, Guyana, Honduras, Nicaragua, and Peru deliver by cesarean section.
- **Some countries have had a breakthrough in reducing maternal and child mortality, whereas others' rates remain high despite their efforts.** Thus, a broad approach is urgently needed to tackle this region's maternal and newborn health. Maternal mortality rate per 100,000 live births in LAC was reported by the World Bank as 74 per 100,000 live births for 2017. The following 13 countries are above the regional average: Jamaica (80), Colombia (83), Peru (88), Dominican Republic (95), Guatemala (95), Nicaragua (98), St Lucia (117), Suriname (120), Venezuela (125), Paraguay (129), Bolivia (155), Guyana (169) and Haiti (480).
- **Despite the relevance of maternal mortality, its social impact, and the profound inequalities, more than half of the countries do not have a specific budget to reduce it.** The PAHO's Analysis of Afro-descendant women found that the maternal mortality rate (MMR) is four times higher for Afro-descendant women in Ecuador than the general population, twice as high in Colombia and 1.4 times in Brazil. Regarding direct causes of maternal mortality (MM), LAC was the region where more women died because of hypertensive disorders compared to all the other areas of the world. The leading indirect causes of MM and severe maternal morbidity (SMM) found were anemia 50%, followed by infections (31%), malaria and dengue (17%), and lung disease (10%).

### 3.1.2. Gender-based violence prevention, support, and care

- **Thirteen countries have comprehensive Gender-based violence (GBV) protection laws**. Colombia, Guatemala, Mexico, and Peru enacted comprehensive protection laws against violence. Twenty-three countries in LAC have domestic or intrafamily violence legislation. Laws and penal code reforms have also been approved in 17 regions, including Colombia, Guatemala, Mexico, and Peru. All countries in the region criminalize rape. All the countries, except Chile and Nicaragua, have a regulatory framework to refer victims of gender-based violence to sexual and reproductive health services, to other health services or judicial and social protection systems.
- According to UNICEF Global databases during the de period 2014-2020, **the LAC region had one of the highest prevalence of child marriage in the world**, with an average of 4% married by age 15 (Colombia 5% and Guatemala 6%) and 29% by age 18 (Guatemala and Guyana 30%). Since 2015, several countries, such as Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, and Panama, have banned child marriage outright or tightened legislation by reducing exceptions
- **There is a lack of laws and public policies that ensure the right to asylum for people**

**suffering violence and persecution based on their gender**. Therefore, it is necessary to analyze this problem from an intersectional perspective.

- **Gender-based violence affected one in every three women in Latin America and the Caribbean in 2018**.The United Nations development program established that Latin America was the most violent region in the world for women, outside conflict contexts, in 2017 and had the highest rate of sexual violence against women. **Health care systems do not have suitable protocols or guidelines to identify gender-based violence effectively**. The lack of institutional resources generates mistrust between health professionals and patients and exposes people who suffer violence to greater danger.
- **The gender-based violence directed toward transgender people is defined as transphobia**. Additionally, the criminalization of sex work exposes them to abuse, exploitation, and violence and leads transgender people to precarious living conditions. **Most of the victims are black, migrant, and trans sex workers. The lack of legislation and systemic protection for trans and gender-diverse people allows these groups to be repeatedly silenced and disregarded**. The average age of transgender people murdered in LAC is 30 years old (13-63 years); the country that reported most of the murders was Brazil (n=125), followed by Mexico (n=65).
- **The literature search did not provide specific data on the violence suffered against indigenous women**. Information discriminated by place of residence, educational or socioeconomic level, both for the indigenous population and for people from the LGBTQI+ group, was neither found **and represents a gap in research**.
- **Venezuela**, **Argentina, Bolivia, Panama, and Mexico have legislation addressing obstetric violence**, a new legal construct has emerged in Latin America that encompasses elements of quality of obstetric care and the mistreatment of women during childbirth**. No local research was found to estimate the prevalence of this critical issue in the region.**

### 3.1.3. Gender Identity

- In the past decade, **many Latin American countries changed their legislation to include laws about same-sex marriage and adoption, acknowledging gender on national ID cards and anti-discrimination laws**. Argentina was the first country in Latin America to enact a specific rule in this regard in 2010, followed by Uruguay in 2013. Some countries accept civil unions of same-sex marriages (Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, some Mexican States, and Venezuela). Uruguay, Argentina, and Chile have clinical guidelines for reaffirming self-perceived gender. In Argentina and Chile, hormonal or surgical treatments are available when required.
- **These policy advances contrast with the fewer legal rights, protections, and benefits and the high rates of violence that sexual gender minorities face in many countries of Latin America**. The civil society organizations stated for the “recognition of the intersectionality of ethnicity and sexual orientation, as a major issue requiring specific statistics and data, to develop action plans aimed at eliminating the multiple burdens of discrimination.” **Barriers to accessing health services among transgender women also include high levels of discrimination in public services that reduce their contact with prevention services.**
- **The global disease and health burden of transgender people remain understudied, particularly studies about the impact of stigma, discrimination, social and structural factors that affect the health of this underserved population**. Access to gender-affirming care (such as hormone therapy) can be a priority for transgender people as an incentive for transgender women to seek and adhere to HIV care, especially to

antiretroviral treatment.

### 3.1.4. Family Planning/Contraception

- The Constitutions of Bolivia, Cuba, Ecuador, Mexico, Paraguay, and Venezuela guarantee access to contraception. This right is also included in the general laws of Bolivia, Cuba, Ecuador, Mexico, Peru, Argentina, and the Dominican Republic. In Guatemala, it is included in the Social Development Law of 2001. Brazil has a specific law. Emergency contraception is legalized and approved in all countries in the region except Honduras.
- **Although all modern contraceptive methods are available in the region, there is a striking prevalence of the use of certain methods in some regions and groups**. **The use of services and modern contraceptive methods has increased in every country in LAC**. The modern contraceptive prevalence rate (mCPR) was estimated at 66.7%. The unmet need for family planning was estimated at 10.7% in 2015 due to limited access to modern contraceptive methods, fear of adverse effects, cultural or religious opposition, poor quality of available services, and gender-based barriers.
- However, **the use of modern contraceptives was lowest among the vulnerable population, predominantly indigenous and poor women**. Available data shows that the indigenous people in Colombia, Costa Rica, Guatemala, Honduras, and Peru had mCPR 20% lower than the general population. The use of traditional methods was observed to be highest in countries with large indigenous people, such as Peru and Guatemala. A report by UNFPA shows that **indigenous and Afro-descendant women with less education have more significant difficulties accessing family planning services**. In Latin America and the Caribbean, female sterilization and oral contraceptives are the most commonly used methods (16.0 and 14.9 percent, respectively). However, it is crucial to ensure informed decisions on the use of female sterilization as programs systematically designed to reduce fertility within vulnerable groups such as indigenous, disabled, and HIV-positive women in LAC.
- To increase demand for contraception and improve health services accessibility, understanding the stigma about adolescent sexuality, misconceptions of family planning, and decision-making power are necessary. **Studying adolescent attitudes towards pregnancy in LAC is essential for designing health programs adapted to their needs**.

### 3.1.5. Comprehensive Sexuality Education

- According to the latest UNAIDS Report, age-appropriate comprehensive sexuality education was highlighted as significant for preventing HIV, STIs, unwanted pregnancy, and gender-based and sexual violence. **All countries have a regulatory framework that formalizes its implementation, except Belize, Trinidad, and Tobago, Jamaica, Panama, and Guyana.**
- However, since profound gaps persist, co**mprehensive sex education is one of the most significant challenges for accessing sexual and reproductive rights effectively**. Addressing curricular content, in-service teacher training, using evidence for design and planning, budget allocation, and policy monitoring and evaluation are critical to ensure effective implementation. **A teacher training program reinforcing the use of contraceptive methods, gender, and human rights should be evaluated to enable a better impact on the sexual and reproductive health of adolescents in LAC**.

### 3.1.6. Safe abortion and post-abortion care

- **LAC has the most restrictive legal framework for abortion compared to what is**

**happening globally**. The regulation about access to legal abortion has the most significant gaps in the region. Moreover, abortion is criminalized in most countries, with legal permission to perform it on specific grounds, such as risk to life or health, fetal problems that prevent life outside the uterus, and when the pregnancy results from sexual violence. It is absolutely prohibited in Nicaragua, Honduras, Dominican Republic, and El Salvador (under any circumstances). Currently, regional advances have been made, and it is allowed without restrictions up to certain gestational ages in Cuba, Guyana, Uruguay, and some Mexican states, including Mexico City, Argentina (2020), and Colombia (2022). However, there have also been setbacks, reactive to these guaranteeing legislations, in other countries with a strong religious background, such as Guatemala (2022) or Honduras (2021).

- **Although guidelines are available for risk and harm reduction for unsafe abortion and postabortion care, the legal and policy context in LAC limits the provision of safe abortion, and post-abortion quality care. Stigma, and conscientious objection are barriers to adequate access to safe abortion.** The exposure of persons to the legal system, whose actors may violate confidentiality or deny the practice, may force them to resort to illegal channels of abortion provision and thus expose them to unsafe practices.
- **It is necessary to facilitate women's access to information about what is allowed by law (especially in contexts where abortion is permitted on some grounds).**
- **The elimination of criminal law in the regulation of abortion and the guarantee of the effective enjoyment of sexual and reproductive rights would reduce the stigma and barriers to access to safe abortion in cases where it is already permitted.** This is crucial to increase the proportion of women coming directly to the health system and, thus, avoid unsafe abortions.
- There is also a **need for research studies that evaluate the implementation of countries' laws and policies and the implementation of evidence-based practices such as the WHO guidelines on induced abortion.**

### 3.1.7. Prevention and control of HIV and other sexually transmitted diseases

- Most countries have regulations that protect the rights of people living with HIV/AIDS and ITS. However, some countries still criminalize anyone who transmits the infection or has sexual relations with persons of the same sex. **The region has made progress in implementing policies, programs, and plans to protect the rights of people living with HIV. All countries have protocols for the care of people with HIV/AIDS. However, the fragmentation in programs and service delivery in some LAC countries lead to a lack of integration between HIV care services and Sexual Reproductive Health Services (SRHS)**. In the region, programs for the prevention of Mother to child transmission (MTCT) of HIV have been in place since the late 1990s.
- **All countries have guidelines to reduce vertical transmission of HIV.**
- **Most countries have national strategies and protocols for eliminating congenital syphilis.**
- **Despite this legal framework, the region could not meet the 90–90–90 targets**, with significant late diagnoses among people living with HIV. The HIV epidemic is heterogeneous in LAC. Based on prevalence data, the Caribbean is one of the most affected territories, second only to sub-Saharan Africa. The prevalence in people between 14- 49 years old ranges from 0.4% (0.3 - 0.4%) in Mexico to 1.9% (1.6 - 2.1%) in Haiti in 2020.In the last decade, nearly half of the people living with HIV in LAC were younger women, predominantly those of reproductive age. It is estimated that 23% of people living with HIV are unaware of their infection, and approximately one-third are

diagnosed late with advanced immunodeficiency. The HIV epidemic in the region disproportionally affects specific sub-populations including men who have sex with men, female sex workers, transgender women, incarcerated people, and people who use drugs. Adolescents are also included as a group at higher risk of acquiring HIV in most of the countries in the region. Transgender women have a 34 times greater risk of HIV acquisition than other adults. Suboptimal HIV care engagement has been reported in this population. The lack of visibility of the impact of HIV on indigenous people is the result of the lack of inclusion of these populations in public policies. The availability of data on the burden of HIV/AIDS in pregnant indigenous and Afro-descendant women in Latin America is minimal, and evidence of a low burden (< 1% prevalence) is observed in two prevalence studies from Brazil (0.07%) and Peru (0.16%).

- **Social inequalities are linked to Congenital Syphilis, with a higher incidence among younger women, afro-descendants, women with low schooling, and without prenatal care**. LAC has the third-highest estimated prevalence of maternal syphilis in the world (0.42%), after the African region (1.68%) and the Eastern Mediterranean region (0.57%). There has been an increase in the incidence rate of congenital syphilis since 2010, while syphilis screening among pregnant women that attended antenatal care declined from 74% in 2011 to 69% in 2017. There is insufficient data on STI prevalence among adolescents and young women in the region. The estimated chlamydia prevalence is between 7 % to 31 %.
- **Very little evidence of HIV burden was found in pregnant women and children; this represents a substantial information gap that limits the reaching of the regional goal of eliminating vertical transmission of HIV and Syphilis**. There are gaps in the existing data on the burden of HIV, sexually transmitted diseases, and Viral hepatitis among indigenous people and Afro descendants, showing a need for a systematic collection of ethnicity variables as well as the need to implement an intercultural approach to health service delivery. The gaps in the information become even broader when gender is taken as an intersecting factor. It was identified the need to implement effective and sustained measures of decentralization of antiretroviral medicines and laboratory testing together with socioeconomic support for people with HIV. Regarding syphilis, major challenges include improving prenatal care, expanding syphilis test coverage, training health workers about syphilis, and providing access to institutional deliveries. Other problems include lack of rapid tests, shortages of benzathine penicillin, and substandard laboratory quality. Improving the poor follow-up of maternal syphilis cases and their sexual contacts is another challenge in the region.

### 3.1.8. Cancer of the reproductive system

- **Cervical cancer is the third most common cancer among women in LAC**. About 72,000 women are diagnosed yearly in the Americas, and 34,000 die from the disease. It is estimated that at least 32 million women need cervical cancer screening in the region.
- **The HPV vaccine is available in 35 countries and territories in the region**. However, in most of them, the coverage rate with the two doses still falls short of the target of 80% of girls.
- **There are gaps in access to screening and treatment services for precancerous lesions**, and screening coverage falls short of the target of 70% of women aged 30-49 years. In Brazil, the Afro-descendant women had less access to cervical cancer screening than white women.

### 3.1.9. Analysis of the studies reviewed

In addition, a specific analysis of the studies found was performed. From the total studies reviewed (20 reviews published between 2017 and 2021), we found that:

- The **primary and last authors** were mainly **women** (65% 13/20).
- Most of the reviews had the goal to **describe a situation, condition, or status of a public health problems in a determine population in LAC countries**.
- **The top ten LAC countries involved in the publications** were: Colombia (n=16); Honduras (n=14); Peru (n=13); Brazil (n=12), Dominican Republic (n=11); Argentina (n=10); Mexico (n=10); Guatemala (n=9); Haiti (n=8) y Nicaragua (n=8).
- **Family planning** was the most prevalent topic found in the literature reviews (50% 10/20).
- The **target population included in the studies were mainly woman in general** (70% 14/20) and adolescent girls (55% 11/20).
- Only **six of the studies reviewed analyzed intersectionality**.
- Regarding the design in our review, we found six systematics reviews [9–14], two scoping reviews [15,16], nine multicounty cross-sectional studies using secondary data from surveys [17–25], two narrative review [26,27] and one review of qualitative studies [28].
- The main research questions addressed were related to family planning-contraception; antenatal care; bender-based violence, safe abortion, comprehensive sexuality education, antenatal care and maternal health, child or forced marriage, sexual health and wellbeing, sexual transmitted infections.
- In relation to the data (year and source, demographic surveys used), the following surveys were used in nine studies: Demographic and Health Survey (DHS) in four studies [17–20]; DHS and Multiple Indicator Cluster Surveys (MICS) in two studies [21,22]; DHS, MICS and Reproductive Health Survey (RHS) in one study [23]; DHS, MICS, RHS and National Health Survey (NHS) in one study[24] and WHO Multi-Country survey on Abortion (WHOMCS-A) in one study [25].
- For the Demographic and Health Surveys (DHS), data from the following countries and years were analyzed: Dominican Republic (2007, 2013, 2014), Guyana (2009, 2014), Colombia (2000, 2005, 2010, 2015), Honduras (2005, 2011, 2012), Bolivia (2003, 2008, 2011), Nicaragua (2001), Haiti (2012, 2016), Peru (2000, 2009, 2010, 2012), Guatemala (2014, 2015) and a modified version of DHS in Brazil (2006).
- Data from the Multiple Indicator Cluster Surveys (MICS) were analyzed for Argentina (2011), Barbados (2012), Belize (2011, 2015, 2016), Costa Rica (2011), Cuba (2010, 2011, 2014), the Dominican Republic (2013, 2014), El Salvador (2014), Guyana (2009, 2014), Mexico (2015), Panama (2013), Paraguay (2016), Saint Lucia (2012), Suriname (2010, 2018), Trinidad and Tobago (2006) and Uruguay (2012, 2013). The National Health Survey (NHS) of Brazil dated from 2013. The Reproductive Health Survey (RHS) of Ecuador (2004), Nicaragua (2006) and Paraguay (2008) were analyzed. Finally, data from the WHO Multinational Abortion Survey (WHOMCS-A) for Argentina, Bolivia, Brazil, the Dominican Republic, El Salvador, and Peru were published.

We identified some areas for improvement that would benefit from implementation research in the region:

- **To address and combat violence against women in all forms and in all populations.**

- **To address adolescent violence and preventing early pregnancy using contraception, particularly in the context of early marriage.**
- **To evaluate and improve adolescent health interventions in and out of schools in the region.**
- **Family planning uptake, methods used, and engagement.**
- **Health workers and Health system**
    - The need for better informed and trained reproductive health care providers and policies as well as access to services and tolerance for vulnerable groups such as sexual minorities, transgender people, rural women, pregnant people, and those with mental health needs.
    - To create more specialized and comprehensive protocols for health care professionals to identify and manage GBV.
    - To improve the services, practices, and quality of care for both mother and newborn during childbirth.
    - To increase attention to cervical cancer including treatment and prevention with the HPV vaccination,
- **The need of more reliable data and studies regarding STI prevalence in the populations for the regions.**
- **To measure abortion-related complications using the standardized methodology in LAC countries**

Through this rapid review of literature, we found very few publications evaluating the implementation of interventions. Strong partnerships between stakeholders, researchers, implementers, and policymakers are key to ensure the success of implementation research studies.

## 3.2. Mapping of stakeholders and landscape analysis

We identified and mapped the main stakeholders (n=542) related to sexual, reproductive, and maternal health and rights agenda in LAC and prioritized countries (Colombia, Peru, Mexico, Guatemala, Jamaica, and Guyana). Argentina was included in this component, given the importance of its legal framework and its public policies on these issues, which are taken as an example by other countries in the region, as indicated by the results obtained in the review made in the first component.

In response to the questions posed in this component, the main findings are presented below.

### 3.2.1. Key stakeholders that move forward the SRMHR agenda in LAC

- At a regional level, many actors working to achieve effective access to maternal, sexual and reproductive health and rights were found. **Mexico and Colombia are the countries with the greatest presence of these regional stakeholders, while Guyana and Jamaica seem to be lagging the regional agenda.**
- **Regarding regional stakeholders, slightly more than a half (54% n=99) are civil society organizations organized in networks and consortiums**, followed by international funding and technical cooperation agencies (16% n=99) and religious organizations (10% n=99). Strictly academic institutions at a regional level barely reach 4%.
- **When analyzing their level of position and influence, international financing and technical cooperation organizations, mainly composed by the United Nations**

**agencies (UNFPA[29], PAHO[30], WHO[31]) and Banks (IADB[32], World Bank[33]), seem to have the greatest impact at the regional level**. There are also some non-governmental organizations with an international scope with high power and high support, as Planned Parenthood Global[34] or ILGA LAC (International Association of Lesbians, Gays, Bisexuals. Trans and Intersex) [35]. It is precisely this sector that encompasses the financial and technical capacities to carry forward the SRMHR agenda. However, they need to build alliances with countries through governments or civil society organizations that advocate for rights at the local level. High technical and financial capacity organizations build alliances with social organizations, which in turn build regional alliances through networks, federations and consortiums.

- Another important point to consider is the **financial power of religious based organizations**. **Although they are fewer in number, their level of power and support, for many of the policies analyzed, is high enough to stop political decisions or maintain the status quo**. Such is the situation of policies about gender identity, family planning/contraception, comprehensive sexuality education and abortion. The lobbying power of religion organizations not only translates into the population behavior, but also permeates political decisions through the support of certain political candidates who occupy positions of governmental power.

- In the **prioritized countries** governmental institutions, together with some civil society organizations, were the ones that most promoted SRMHR agenda. **The governmental structures lead the political processes, although public information provided in their websites shows medium or even low support on some topics**.

- This panorama has its nuances in the selected countries and depends on the stage of the policy implementation cycle in each country: whether the policy is at the point of agenda-setting, in an adoption stage in the legislature, or if it is in the stage of execution after the policy has been officially adopted by the government. Depending the stage, **there is greater involvement of civil organizations to include an issue in the agenda or to demand the effective guarantee of rights to governments.**

- **The top three policies in which the greatest number of stakeholders (national and regional included) work are: prevention of gender-based violence (63% n=342), comprehensive sexual education (51% n=279), and prevention and control of HIV and other sexually transmitted infections (48% n=260).** In a second group we found: gender identity (41% n=223), family planning/contraception (37% n=203), and abortion and post-abortion care (33% n=177). Finally, cancer of reproductive system (19,5% n=106) and antenatal, intrapartum, and postnatal care (19% n=102) are the policies in which the fewest stakeholders were identified.

### 3.2.2. Research evidence on SRMHR in the LAC region

- **Only 23 stakeholders (including regional and national stakeholders) were categorized as strictly belonging to the academic sector** having a research agenda related to the SRMHR and policies. This represents only 4% of the universe of the stakeholders mapped. In general, these are universities, study centers or research institutes and include, at the regional level, IDRC[36],Guttmacher Institute[37], Institute for Gender and Development Studies Mona Unit (IGDS)[38], among others.

- At a first glance, this data might suggest a lack of interest in public health research, specifically on SRMHR issues. However, when we analyzed **the number of stakeholders whose activities include some type of research, we observed that this percentage raised to 50% (n=269). Civil society organizations, technical cooperation and funding agencies, and even governmental institutions develop**

**SRMHR related research**. It was not possible, with the available information, to conclude on the quality or type of research they develop.

- **Of the 269 stakeholders that carry out research activities, 68% (n=182) also carry out advocacy actions**. Then, it could be stated that **research will eventually give the organizations the capacity to influence the public agenda.**

Through interviews to key stakeholders we could identify these information gaps:

— ***Difficulties in producing quality data*.** The limited production of SRMHR data in the region and the lack of reliable information to measure indicators in SRMHR. Weaknesses in record keeping, problems with the information systems used, and low priority given to the production of primary data, affect quality data generation in a regular and timely manner. Also, participants stressed the lack of nominalized registers to track contraceptive delivery and continuity of use. Another major limitation in data production was the lack of disaggregated data by equity strata, limiting the evidence generation from an intersectionality perspective and the design of targeted policies. Information systems usually do not include variables that allow measuring the differential impact in vulnerable populations.

— ***Lack of quality indicators in the region***. The inadequacy of some indicators to measure access to SRMH services was also mentioned, such as the limitation of assessing the prevalence of access to family planning or contraceptive methods use and the lack of reliable indicators to measure gender-based violence.

— ***Limitation in the generation of evidence.*** The lack of capacity to develop evidence on SRMH in the region and the concentration of available evidence in a just a few countries were highlighted. This is interpreted as the result of insufficient resources allocated to promote research and the need to strengthen research capacities at the country level.

- **The available evidence used for policy design usually comes from central and high-income countries, whose research do not necessarily is adapted to local needs**. In particular, the lack of evidence regarding access to SRMH services for vulnerable populations, such as rural, indigenous, and afro-descendant populations, stands out.

- **Regarding information gaps in SRMHR**, in relation to prenatal care, difficulties to access data on vertical transmission of congenital syphilis, was mentioned Regarding abortion a lack of data about clandestine abortions in countries that penalize the practice; about abortion demand and unmet demand; about access to safe abortion drugs (misoprostol, mifepristone) and abortion recidivism to improve estimates of post-abortion contraceptive needs was found. Regarding gender-based violence, there is a lack of evidence about the effectiveness of actions to reduce it.

### 3.2.2. Opportunities to expand the research agenda and information access on SRMHR

- A mention should be made about **the notable absence of policies targeting the vulnerable groups explored in this study**. Adolescent women may be the subgroup most included by the national and regional mapped stakeholders (57% n=309) or LGTBQI+ groups (43% n=234) because of the presence of organized civil society organizations. However, very few stakeholders focus their SRMHR actions on migrants (22%n=122), Afro-descendants (17% n=90), persons with disabilities (14% n=78), elderly (15% n=82) and/or indigenous (29% n=158). The knowledge about the access to effective rights and the policy design for these groups seems to be quite scarce.

- Expanding the research agenda to improve the diagnosis of effective access to policies seems to be a great challenge, mainly in two areas:

— **Generation of primary information (at the point of care) but also aggregated information like dashboards for decision making to know how much the most vulnerable groups are accessing to SRMH services** (especially in access to safe abortion, family planning and contraceptive methods and comprehensive sexual education).
— **Implementation of interventions and policies, focused on vulnerable populations,** that can be adapted to the region to reduce the impact of gender violence, for example.

Especially for the first item, **the support of government institutions and health service providers, where primary data are generated, is fundamental**.

Both items are presented as challenges but also as opportunities for a collaborative agenda between governments, organizations that develop some type of research and those with greater technical and financial capacity.

## 3.3. Rapid country studies

Six rapid country studies took place in three sub-regional clusters (Andean Region: Peru and Colombia; Meso America: Mexico and Guatemala; Caribbean Region: Jamaica and Guyana) in order to guide where and with whom can IDRC make a difference in specific country or sub- regional contexts.

The following is a brief summary of the findings by country. For each country, we describe the main strengths identified, the challenges as well as the research priorities.

### 3.3.1. Colombia

**Strengths:**

- Solid, consistent, and expanding legal and normative corpus for the guarantee of sexual and reproductive rights. The jurisprudence of the Constitutional Court has been strategic for the progress achieved in gender issues, gender-related violence, comprehensive sexual education, abortion and the rights of people living with HIV and LBGTI+ people.
- Health policies and programs are aligned with the legal framework, with a differential and intersectional approach.
- The Presidential Advisory Office for Women's Equity, which builds strategic alliances with all sectors of national, regional, and international stakeholders, including research.
- Strong representation and visibility of civil society organizations in advocacy actions for the guarantee of sexual and reproductive rights and in the monitoring of the process and results of public policies.
- A quarter of stakeholders mapped in this study implements projects, develop research, and do advocacy simultaneously. Also, they have alliances with other national, regional, and international actors.

**Challenges:**

- Access to quality information, tailored data process, and trusted health indicators.
- Gaps in the effective access to the right to legal abortion.
- Difficulties in the implementation of CSE in the field of education due to institutions' criteria.

- Limitations in the provision of counseling services in SRMH for adolescents, more pronounced in rural or indigenous population.
- Gaps between the extensive framework of laws, regulations and protection policies of gender-based violence.
- Difficulties in accessing to a wide range of services due to geographic, cultural and language barriers.

**Research priorities:**

- Access of indigenous and women of rural areas to SRMH services, particular in abortion.
- Barriers to access to contraceptives.
- Studies on knowledge and attitudes of health care professionals (knowledge of rights and professional responsibility).
- Studies that implement interventions to prevent unintended pregnancies.
- Research on evidence-based practices in vulnerable population.
- Studies of impact and cost-effectiveness evaluations of sexual and reproductive health interventions/programs/policies using rigorous research designs.
- Evaluate the impact of telemedicine implementation to improve access to contraception and safe abortion services.

### 3.3.2. Guatemala

**Strengths**

- Civil society organizations, specifically those that work in relation to women's rights and gender identity, are articulated to enhance their actions and visibility in the media.
- Some civil society organizations work together with the health sector to strengthen the availability and quality of data in SRMH.
- Universities represent an opportunity to generate alliances for the development of research.
- Civil society organizations work with the education sector to improve the implementation of CSE.

**Challenges**

- Conservative groups and political instability limit the recognition of sexuality and sexual health care, especially in the LGTBIQ+ population.
- Limitations in the availability and quality of SRMH data.
- Barriers in the recognition and incorporation of midwives to the health system.
- Difficulties in accessing to gender-based violence counselling due to geographic and language barriers.
- Implementation of CSE in the field of education.
- Gaps in accessibility to services and contraceptive methods, especially among young people and adolescents.

**Research priorities**

- Barriers to access to antenatal care services, family planning and contraception, and gender-based violence counselling, especially in vulnerable groups such as adolescents and indigenous
- Access and quality of care to SRMH services for the LGBTIQ+ population.
- Studies to improve information systems and indicators in SRMH, especially in violence against women and maternal mortality.
- Preferences for contraceptive method use and sexual and reproductive health services, with focus in adolescents.
- Qualitative research on sexual practices in rural or indigenous communities (abduction, sexual violence).

### 3.3.3. Guyana

**Strengths**

- Joint work of NGOs with the Government in the implementation of programs to improve access to contraception and family planning, prevention of gender violence plus the enormous work in the prevention and control of HIV and other sexually infections (STIs),
- NGOs working together to encourage cultural and regulatory changes, especially related to gender identity in order to fight against discrimination and homophobia.

**Challenges**

- Difficulties in the implementation of SRMH policies, such as abortion, gender-based violence and CSE policies.
- Gaps to access to health care in rural areas, including lack of access to abortion or contraceptives.
- Lack of quality data.
- Limit access of vulnerable groups (and a main reason for maternal mortality) to SRMH services due to geographic and language barriers.

**Research priorities**

- Gaps in the implementation of CSE in the educational field.
- Access to safe abortion: barriers, facilitators and training in health professionals.
- Access and barriers to contraceptives by adolescents and women in rural areas.
- Barriers to effective access to prenatal, childbirth and post abortion care.
- Access of migrants to SRMH services.
- Access to prevention and control of HIV and STIs, especially in vulnerable groups.

### 3.3.4. Jamaica

**Strengths**

- Coordinated response between the Ministry of Health and national and international organizations through economic support for prevention and control of HIV and other transmitted infections.
- Articulation between the Ministry of Health and the Ministry of Education to advance in the implementation of CSE.
- Ministry of Health works together with LGBTIQ+ organizations to train health personnel in relation to HIV stigma and discrimination.
- Alliances between civil society organizations and international or regional organizations to conduct evidence-based research.

**Challenges**

- Access to complete and updated information on antenatal, intrapartum, and postnatal care, CSE and family planning- contraception.
- Lack of information regarding abortion and gender identity.
- Gaps in adolescents' comprehensive sexuality education, access to contraceptive methods, access to privacy.
- Limited access to health care by the LGBTIQ+ community.
- Inconsistent or incorrect use of long-acting reversible contraception (LARC) in the general population.
- Challenges in the reduction of maternal and infant mortality.
- Gaps in the implementation of gender-based violence prevention policies.

**Research priorities**

- Gaps in adolescents' access to contraception and comprehensive sexuality education.
- Research studies for the evaluation of access to reproductive care by adolescents.
- Studies on sexual and reproductive practices of the LGTBIQ+ population.
- Exploring barriers to access to SRMH services especially in young people, adolescents, and LGTBQI+ population.
- Studies on knowledge, attitudes, and practices of sexual and reproductive practices of the LGTBIQ+ population, attitude and commitment of men in sexual and reproductive health.

### 3.3.5. Mexico

**Strengths**

- Organized civil society, especially feminist organizations, have jointly contributed to the visibility and inclusion of prevention and care of gender-based violence on the agenda.

- Implementation of inter-institutional actions coordinated with national, state and municipal policies and plans for the prevention of adolescent pregnancy.
- Although the country does not have a Gender Identity Law, anti-discrimination laws based on sexual orientation have been passed at the federal level, and multiple states across the country have passed gender identity bills**.**

**Challenges**

- Limitation of policies for the prevention of violence against women.
- Limitations in access to SRMH data due to the fragmentation of the health system.
- Lack of disaggregated equity data, such as gender identity, LGBTIQ+ population, indigenous or rural population.
- Lack of regulation and implementation of comprehensive sexuality education with a gender and human rights perspective.
- Absence of specific policies for access to SRMH services for the migrant population.
- Difficulty in access to abortion due to the federal organization of the country.
- Neglect of the vulnerable population in the care of HIV and other STIs, such as women and especially women from rural or indigenous communities.

**Research priorities**

- Evaluation of the quality of services in abortion and post abortion situations.
- Access and barriers to SRMH services in indigenous women.
- Access to diagnosis and timely treatment of syphilis in women of reproductive age and prevention of congenital syphilis.
- Research on prevention and management of STIs in migrant population.
- Assess access to SRMH services, knowledge, preferences, and risk perception in women and adolescents.
- Studies that assess sex work and health care practices.
- Barriers to access HIV testing as part of the antenatal care.
- Access to healthcare for the LGBTIQ+ population.
- Barriers to access contraceptive methods especially among adolescents, migrants, and the indigenous population.

### 3.3.6 Peru

**Strengths**

- Some NGOs work together in order to strengthen its political incidence for the decriminalization of abortion.
- The impact of the policies of international organizations with a gender and human rights approach in civil society organizations, favors the advancement of a SRMHR agenda.

- Through advocacy and research, many non-governmental organizations advanced in the implementation of CSE in the country, despite not having a specific legal framework on this matter.

**Challenges**

- Limitation in the inclusion of a gender and diversity perspective in comprehensive sexuality education.
- Deficiencies in the training of health providers regarding adolescent care.
- Difficulties in the implementation of regulations and programs in comprehensive care of women who suffer sexual violence.
- Weakness in implementing and guaranteeing access to SRMH services, especially in rural areas.
- Lack of differentiated policies and programs for the indigenous, rural and Afro-descendant population.

**Research priorities**

- Studies that prioritize indigenous and Afro-descendant populations.
- Access of migrants to SRMH services.
- Implementation research aimed at improving the quality of SRMH services.
- Research studies of impact and cost-effectiveness evaluations of sexual and reproductive health interventions.
- Studies on knowledge and attitudes in SRMH of adolescents.
- Access and barriers to prenatal and postnatal care in women in rural areas and indigenous people.

In addition, the main findings from the in-depth interviews with representatives of the selected countries are presented below.

### 3.3.7. Challenges in SRMHR policies and accessing health services

- **Lack of political will and political instability.** Informants from most countries mentioned the resistance of governments to advance legislation and implementation of sexual and reproductive health policies, especially on topics such as legalization of abortion, comprehensive sexuality education, emergency contraception and the rights of the LGTBIQ+ population, among others. The lack of political will is sometimes combined with political instability and the arrival of conservative parties to government. These issues were mentioned as an important barrier for the implementation and continuity of SRMHR policies.
- **Advocacy by civil society groups opposed to the advancement of SRMHR.** Another barrier identified by informants from all countries, although with unequal lobbying capacity, was advocacy by civil society groups opposing the advancement of the SRMHR agenda. The groups' actions include lobbying activities at the political level to influence legislation, judicialization strategies, and pressure.
- **Weakness of sexual and reproductive health programs.** In some countries there is a weakness of sexual and reproductive health programs, and a lack of coordination between them. The relegated position of the programs in the organizational chart of the ministries of health, the scarce funding for the design and implementation of policies (an

aspect shared by informants from most of the countries), and the lack of human resources allocated to the area at the managerial level were highlighted. Additionally, the low governance capacity of the programs to monitor and guarantee the implementation of policies and regulations by the different health sub-systems and by the providers is a mayor challenge. Informants from Colombia, for example, referred to the limited capacity of the national program to monitor health insurers to ensure effective access to contraception and abortion.

- Key informants from all countries mentioned **the impact of the COVID-19 pandemic on the provision of SRMHR services and the reduction of sexual and reproductive health budgets**. The closure or limitation of services (such as prenatal check-ups, family planning, provision of contraceptive methods, among others), the low prioritization of SRHMR in health emergency response strategies, and the reduction in budgets allocated to the area had a negative impact on SRMHR. Normal levels of services provision have not been reestablished in some countries.
- **Unequal policy implementation in federal countries.** A challenge highlighted by informants from countries with federal systems of government, such as Mexico, was the unequal implementation of policies in the different states or provinces.
- **Gaps in the implementation of gender-based violence prevention policies.** Difficulties in accessing sexual violence clinics for rural populations or those far from large urban centers were mentioned, as well as failures in the protocols for adolescent pregnancy. Informants remarked the obstacles and delays in the intersectoral response to minors who are victims of sexual violence, due to difficulties in the articulation of the different actors involved (health system, Justice, etc.).
- **Lack of inputs to guarantee access to SRMHR.** Another challenge mentioned was the lack of supplies to ensure SRMHR, such as limitations in the availability of some types of contraceptives and medical abortion supplies.
- **Limitations in the availability and quality of data in SRMHR**. The low quality of data, the difficulty in accessing and the limited use of data for policy design and evaluation was highlighted by informants from most of the countries. There is also a lack of consistency between data reported at the national and sub-national levels due to fragmentation of registration systems. The coexistence of different information systems under different administrators (epidemiology directorate, registries under specific programs, etc.) leads to duplication of resources and fragmentation of registries. In Guatemala, Peru, and Jamaica, for example, it is difficult to access data produced by the Ministry of Health, obtained through access to public information laws by NGOs or research institutes. Another major limitation in data production **is the lack of disaggregated data by equity strata, limiting the evidence generation from an intersectionality perspective and the design of targeted policies**. Information systems usually do not include variables that allow measuring the differential impact in vulnerable populations. With some exceptions, data do not allow disaggregation of access to SRMHR by indigenous, rural, LGBTIQ+ groups or people with disabilities.
- Key informants identified different gaps in accessing to sexual and reproductive health services, such as **gaps in access to diagnosis of sexually transmitted diseases, in access to contraception (such as long-acting methods and emergency contraception) and family planning counselling, barriers to access to abortion, CSE**, among others.
- Informants highlighted specifically **greater barriers in the access** to a wide range of services (from access to contraceptives, prenatal care, childbirth care, timely diagnosis of sexually transmitted infections and abortion, among others) **for vulnerable**

**populations**, such as adolescents, women from rural communities, indigenous population, migrants and LGBTIQ+. Among the main barriers to access, **language barriers, geographic barriers to access to health centres, cultural barriers, community resistance, displacement of nomadic groups and discrimination by health providers** were mentioned. As an example of cultural barriers, informants from Guatemala, Peru, and Colombia, mentioned deficiencies in the implementation of culturally relevant childbirth care as well as situations of mistreatment and obstetric violence during childbirth. In rural areas, there are noticeable geographic barriers to access to timely referral systems for at-risk pregnancies, delays and/or reluctance of rural and indigenous women to go to health centres, and lack of community support for women.

- The **migrant and the LGBTIQ+ population** not only have less access to SRMHR services but also, experience **discrimination in health services, stigmatization and criminalization**. In relation to this, key informants from most countries noted deficiencies in the training of health personnel and stressed the lack of training in gender and human rights approaches. Peru and Mexico also highlighted the low level of training of health providers in intercultural health for the care of indigenous or rural populations. All these factors lead to a low quality of health care in general, and in SRMHR services in particular.
- Key informants from all countries also identified the **difficulty to access services for adolescent (counselling, access to long-acting contraceptives, abortion)**. In relation to this issue, another challenge is the limited access to comprehensive sexuality education, either because of the lack of implementation of programs or lack of content on a gender and human rights perspective.
- Finally, a challenge mentioned by most informants was the **limited access to legal abortion (such as lack of access or lack of timely access), despite the regulations in force**.

### 3.3.8. Research priorities to advance the SRMHR agenda

- **Exploring barriers to accessing sexual, reproductive, and maternal health services.**

In the six countries informants mentioned the necessity to conduct research on the challenges people face when accessing sexual and reproductive and maternal health services. Research should focus on populations facing the greatest challenges, such as adolescents, indigenous and rural populations, people with disabilities, LGBTIQ+ groups, sex workers, Afro-descendants, and migrant populations.

The informants emphasized the need to identify barriers to contraceptive access for populations that have contact with health services (missed opportunities). It was also mentioned that research should focus on resistance to contraception by the general population and health teams. An identified priority was to study barriers to reproductive health services and their associations with the prevention and management of sexually transmitted infections.

- **Research on population needs and preferences.**

To be able to work on access barriers, knowing the needs and preferences of specific population groups should be a priority. According to some informants, it is necessary to explore not only the needs of the population using the services to advance in guaranteeing rights but also the health care worker's needs.

- **Studies on knowledge, attitudes, and practices (KAP) in SRMHR**

Many informants mentioned the need for research on the KAP in sexual, reproductive, and maternal health in different population groups. Informants from some countries emphasized exploring men's knowledge and attitudes toward reproductive health, their perceptions of the

responsibilities of having children and their role in the prevention of sexually transmitted diseases. Furthermore, participants mentioned the need to study the knowledge and care practices of sex workers and the behavior of LGBTIQ+ groups to support health promotion strategies. The need to explore the knowledge and attitudes of health care providers was also stated.

- **Quality of care evaluation**

As improving quality of care is a priority to meet needs, improve access and have an impact on the most vulnerable groups, informants noted the need for research to evaluate the quality of care being provided. Specifically, informants mentioned the quality of abortion and postabortion care; strategies such as telemedicine for accompaniment and counseling in the context of abortion; and obstetric violence.

- **Research for the design of interventions to provide SRMHR**

Informants identified the need of local research to inform the design of new strategies to guarantee sexual, reproductive, and maternal health rights. They mentioned that research to guide the development of strategies to improve access to and provision of services is a priority. They proposed conducting formative research to design strategies to improve the access to and quality of services for target groups.

Some of the needed strategies are interventions that guarantee equity of access to services and adapted policies to vulnerable populations. Formative research was also identified as a priority to implement strategies proven to be successful in other sites or other health specialties, such as remote care or telemedicine.

### 3.3.9. Barriers and facilitators to advance in the SRMHR research

- **Barriers and challenges.**

The countries studied face common barriers to conducting good quality and useful research to inform both progress on SRMHR and to inform and guide improvements in access and quality of services. Informants mentioned that **there is not a culture to conduct research locally and that there are isolated efforts with little support (lack of research culture).** The low research productivity in some countries was attributed to a lack of political will to support research because of religious issues or conservatism (lack of political will). Consequently, there is limited funding for research (lack of local funding). The lack of funds also impacts the training of human resources to carry out research (lack of qualified human resources).

**Despite efforts, sexual, reproductive, and maternal rights are not a priority in many countries; therefore, research is not supported.** Informants pointed out that when an issue was considered a priority, resources were allocated with positive results, as prioritized by governments, such as HIV treatment efforts implemented in the Caribbean countries, or the reduction of maternal mortality efforts made in the all the included countries. **The lack of good quality, locally produced data was mentioned as a constraint on setting research priorities or conducting research (lack of quality data).**

- **Facilitators to perform research.**

**Working with different governmental and nongovernmental agencies**. Informants noticed the need to involve stakeholders from ministries of health, education, social services, and international relations; the police forces; universities and academic institutions; and civil society advocacy bodies.

**International agencies impact gender mainstreaming and support and involve civil society and human rights organizations.**

**Raised awareness among policy makers on the importance of evidence-based and solid research conducted by countries**. This awareness has been achieved through advocacy

groups: dialog and political pressure promoted by civil society and citizens and advocacy through media reporting or social media campaigns.

### 3.4. Consultation process

A consultation process with key stakeholders in SRMHR at a regional and national level in LAC and some prioritized countries was carried out, with the objective of gathering opinions on areas and topics of research aimed at reducing the gaps in access to SRMHR in vulnerable populations in LAC countries and identifying strategies for their implementation.

Taking as a starting point a consolidated list of research areas and topics identified as priorities in previous stages of the study, key stakeholders discussed: 1) research areas or topics they considered important or a priority for inclusion in the list, and topics to be excluded; 2) research areas or topics with greatest impact on reducing gaps in access to SRMHR for vulnerable populations; and 3) strategies for implementing an SRMHR research agenda in the region, considering aspects such as funding or support needed, articulation among stakeholders, and potential facilitators and barriers.

The main results of this dialogue were as follows:

- **Participants noted that the list of research areas and topics identified as priorities was complete** and comprehensive and confirmed that the items listed were important and set priorities for SRMHR research in the region. There was no proposal to exclude any area or topic from the list.
- **It was also mentioned that some of the topics covered in the list could be addressed in greater detail or disaggregated**, for example, issues related to HIV, sexual and reproductive health of the transgender population, sex work, issues related to masculinities studies and, mainly, gender-based violence. Regarding the last point, it was suggested that obstetric violence should be included as a priority topic, which is considered an area of vacancy in the region.

The participants suggested incorporating some specific topics into the list, such as:

- **Barriers to access to menstrual hygiene measures for menstruating women**. The importance of menstrual hygiene was mentioned as a condition to fulfil the sexual and reproductive rights of menstruating women and the need to explore the barriers or obstacles to access to supplies to guarantee this right.
- **Survey and mapping adolescent sexual and reproductive health care facilities.** The existence of different access points to health services outside the health care institutions setting by adolescents, such as counselling in schools, was mentioned. The lack of research on these modalities of care was highlighted.

Other general research topics suggested by the participants were:

- **Analysing the impact of cultural changes and social media** on people's subjectivity, including aspects related to their sexuality and the new mechanisms of participation of users of health services through social networks and internet forums (rating of services, etc.).
- **The importance of research on strengthening cross-cutting aspects of health systems and service provision,** and not only in the field of SRMHR, was also mentioned (e.g., strengthening systems for the purchase and distribution of medicines that can serve the entire system).

Coincidentally with what was detected in the previous components of this study, during the dialogue the following topics were identified as having the **greatest impact on reducing health gaps in vulnerable populations.**

- **Evaluation of the quality of SRMH services and user satisfaction.**
- **Design, implementation, and evaluation of culturally adapted interventions for vulnerable groups.**
- **Studies on knowledge, attitudes, and practices in SRMH of the user population and health providers.**
- **Research on SRMH needs and preferences of the population.**

# 4. Conclusions

Through the development of the previous four components we conclude with the answer of these main questions:

- What are some of the priority implementation research questions that emerge from the countries?
- Considering the contextual and strategic risks, where and in which topics can IDRC make a difference?
- If these are new topics, how can IDRC work with to address them? If they are existing topics, what networks and evidence bases should IDRC be leveraging to maximize impact?
- Which are their main areas of interest and potential engagement strategies to join a SRM health rights alliance or to promote country-based collaborations?
- Where and around which priority issues can IDRC contribute to make a difference?

## 4.1. Research priorities to advance the SRMHR agenda

As summarized in Table 1, the research areas prioritized and validated during consultation process included the following:

**a) Exploring barriers and facilitators to access to sexual, reproductive, and maternal health (SRMH) services (users and providers level)**

In all countries, informants mentioned the necessity to conduct research on the challenges people face when accessing sexual and reproductive and maternal health services. Research should focus on populations facing the greatest challenges, such as adolescents, indigenous and rural populations, people with disabilities, LGBTIQ+ groups, sex workers, Afro-descendants, or migrant populations. According to the stakeholders, some populations have greater limitations in accessing safe abortion, even in settings where abortion is legal, making this issue worth investigating. For example, the barriers that indigenous and peasant women in Colombia encounter in access to abortion where mentioned. Additionally, the stakeholders highlighted the need to study the barriers adolescents face in accessing contraceptives and reproductive health services. This is the case in Guatemala, Mexico, Guyana, and Jamaica that present gaps in adolescents' access to services and comprehensive sexuality education.

The need to identify barriers to contraceptive access for populations that have contact with health services (missed opportunities) was also identified, for example, in post obstetric or post abortion contraception. Stakeholders mentioned that research should focus on resistance to contraception by the general population and health teams. An identified priority was to study barriers to reproductive health services and their associations with the prevention and management of sexually transmitted infections. Specifically, there are concerns about access to timely treatment for syphilis and congenital syphilis prevention in women of reproductive age. Another priority

identified is the access to maternal health, for example, access to prenatal care in Peru's indigenous population.

**b) Research on SRMH needs and preferences of the population**

To be able to work on access barriers, knowing the needs and preferences of specific population groups should be a priority. These include adolescents' preferences in terms of contraceptive methods and family planning services. According to some informants, it is necessary to explore not only the needs of the population using the services to advance in guaranteeing rights but also the health care worker's needs.

**c) Studies on knowledge, attitudes, and practices (KAP) in SRMHR of user population (sexual and reproductive practices) and health providers (health practices)**

The need for research on the KAP in sexual, reproductive, and maternal health in different population groups was identified. Both surveys and qualitative research were proposed to help understand sexual practices and cultural issues that influence the use of sexual, reproductive, and maternal health services. These include adolescents' knowledge, preferences and risk perception of HIV and other sexually transmitted diseases such as syphilis (Mexico). Stakeholders from Peru, Guatemala and Guyana emphasized the need to explore men's knowledge and attitudes toward reproductive health, their perceptions of the responsibilities of having children and their role in the prevention of sexually transmitted diseases. Furthermore, participants mentioned the need to study the knowledge and care practices of sex workers and the behavior of LGBTIQ+ groups to support health promotion strategies. The need to explore the knowledge and attitudes of health care providers was also identified as a priority.

**d) Evaluation of quality of services**

As improving quality of care is a priority to meet needs, improve access and have an impact on the most vulnerable groups, stakeholders identified the research on quality of care being provided as priority. Specifically, they mentioned the quality of abortion and postabortion care; strategies such as telemedicine for accompaniment and counseling in the context of abortion; and obstetric violence.

**e) Studies to improve information systems/indicators in SRMH**

The quality of data must be improved to have informed policy design and evaluation. Limited data and delays in making data public need to be studied and find strategies to product quality and accessible data in a timely manner to improve the information systems.

As it was mentioned, another limitation in data production is the lack of disaggregated data by equity strata, limiting the evidence generation from an intersectionality perspective and the design of targeted policies. Information systems usually do not include variables that allow measuring the differential impact in vulnerable populations. With some exceptions, data do not allow disaggregation of access to SRMHR by indigenous, rural, LGBTIQ+ groups and people with disabilities.

**f) Research studies for the design, implementation, and comprehensive evaluation of interventions of the provision of sexual, reproductive, and maternal health services**

The need of local research to inform the design of new strategies to guarantee sexual, reproductive, and maternal health rights was prioritized. Stakeholders identified research to guide the development of strategies to improve access to and provision of services as a priority. They proposed conducting formative research to design strategies to improve the access to and quality of services for target groups.

Some of the needed strategies are interventions that guarantee equity of access to services and adapted policies to vulnerable populations, such as indigenous and rural populations, adolescents, LGBTIQ+ communities or people with disabilities. For example, exploring the best

ways to implement community interventions such as peer accompaniment for prevention and adherence to HIV treatment or community mobilization to ensure access to prenatal check-ups. Formative research was also identified as a priority to implement strategies proven to be successful in other sites or other health specialties, such as remote care or telemedicine.

## 4.2. Research topics with the greatest impact on reducing health gaps in vulnerable populations

Some specific areas and topics with the greatest impact on reducing gaps in access to SRMH services were identified.

**Evaluation of the quality of SRMH services and user satisfaction**: Stakeholders noted the high coverage of some services but the absence of evaluations of the quality of the services provided. The importance of analyzing the mechanisms for user participation and dialogue with health services was also mentioned, considering practices such as the rating and discussion of health services in internet forums, social networks, etc. The importance of including an intersectional approach in the evaluation of the quality of services was also highlighted. The relevance of initiatives on improving health information systems and measuring modern indicators.

**Design, implementation, and evaluation of culturally adapted interventions for vulnerable groups**: The importance of implementation studies for the cultural adaptation of services, including other modalities of care such as telemedicine, was noteworthy. It was also mentioned that there can sometimes be tensions between countries' legal frameworks and proposals to adapt interventions or services according to the cultures of communities. The legal framework should drive decisions so that such adaptations do not contradict or limit access to established rights due to the greater cultural acceptability.

**Studies on knowledge, attitudes, and practices in SRMH of the user population and health providers**: The participants emphasized the need to generate more evidence on knowledge and practices in the SRMH of vulnerable populations in order to improve services. Another aspect that was highlighted was the need to analyze and clarify the degree of knowledge of the regulatory frameworks in SRMHR by health providers, especially those working with the adolescent population, as this is a major barrier to access to services and to the adaptation to new modalities of care.

**Research on SRMH needs and preferences of the population:** The lack of information and the presence of stereotypes that affect the provision of services were highlighted, especially in the indigenous population, LGBTIQ+ population, etc.

## 4.3. Barriers and facilitators to advance in the SRMHR research

**Barriers and challenges:** The countries studied face common barriers to conducting good quality and useful research to inform both progress on SRMHR and to inform and guide improvements in access and quality of services. Stakeholders mentioned that there is not a culture to conduct research locally and that there are isolated efforts with little support (lack of research culture). The low research productivity in some countries was attributed to a lack of political will to support research because of religious issues or conservatism. Consequently, there is limited funding for research (lack of local funding). The lack of funds also impacts the training of human resources to carry out research (lack of qualified human resources).

Despite efforts, SRMHR are not a priority in many countries; therefore, research is not supported. Stakeholders pointed out that when an issue was considered a priority, resources were allocated with positive results, as prioritized by governments, such as HIV treatment efforts implemented in the Caribbean countries, or the reduction of maternal mortality efforts made in the all the included

countries. The lack of good quality, locally produced data was mentioned as a constraint on setting research priorities or conducting research (lack of quality data).

**Facilitators to perform research:** Despite these barriers, there are many examples of high-quality and high-impact research and activism. Some of the facilitating factors mentioned by informants were as follows:

- Working with different governmental and nongovernmental agencies. Informants noticed the need to involve stakeholders from ministries of health, education, social services, and international relations; the police forces; universities and academic institutions; and civil society advocacy bodies.
- International agencies impact gender mainstreaming and support and involve civil society and human rights organizations.
- Raised awareness among policy makers of the importance of evidence-based and solid research conducted by countries. This awareness has been achieved through advocacy groups.
- Dialog and political pressure promoted by civil society and citizens.
- Advocacy through media reporting or social media campaigns.

## 4.4. Key actors to make alliances for research

We consider of utmost importance to push forward for an interagency collaboration agenda and more appropriate cooperation mechanisms at regional and international levels, to advance the SRMHR agenda in LAC. Most of the key informants´ agencies that were interviewed had governments as their main partners, but they considered fundamental involving and consulting members of the civil society in discussions, both at the regional and country level. This is the necessary scene to consider the key actors to make alliances for research.

The key actors that were mapped in each country, classified according to their work experience in the selected issues, their geographic scope, the sector to which they belong, the topics of interest, their target population, the main activities they develop, the sources of funding and their main alliances, including the position and power maps categorizing each stakeholder according to the policies selected for this study, can be found in the report of component 2.

The Table 1 resume the prioritized research areas and topics that were validated in the consultation process.

**Table 1: Prioritized research areas and topics**

| Research areas | Proposed topics |
|---|---|
| **Barriers and facilitators to access to sexual, reproductive, and maternal health (SRMH) services in the region (user and provider level)** | **Access to information, care, and appropriate contraceptives:**<br>- Sexual and reproductive health counselling.<br>- Comprehensive sexuality education (CSE) in the field of education.<br>- Measures for ensuring menstrual hygiene<br>- Prevention of unintended pregnancy in adolescence in all government areas.<br>- Immediate post obstetric event contraception (ICPOE)<br>- Long-acting reversible contraceptives (LARC), in particular (evaluation of providers´ resistance)<br>- for specifically vulnerable groups (rural women, migrants, indigenous, Afro-descendants, people with disabilities, LGBTIQ+ people, including transgender people, etc.).<br>**Access to adequate prenatal care for the general population and especially for vulnerable groups.**<br>**Access to safe abortion, for all ages and especially for vulnerable groups, including availability of drugs and other supplies.**<br>**Access to programs for prevention, early detection, and assistance/treatment**<br>- To situations of gender-based violence<br>- Sexually Transmitted Infections (STIs), including HIV<br>- Maternal syphilis and congenital syphilis<br>- Genito-mammary cancer |

| Research areas | Proposed topics |
|---|---|
| **Research on SRMH needs and preferences of the population.** | **Preferences for contraceptive method use and sexual and reproductive health services**<br>- In the general population<br>- In adolescents (including a scoping review of SRH facilities and counselling outside health care settings)<br>-In indigenous population<br>-In LGTBIQ+ population |
| **Studies on knowledge, attitudes, and practices in SRMH of user population (sexual and reproductive practices) and health providers (health practices).** | **User population**<br>- Risk perception about HIV and other STIs.<br>- Attitude and commitment of men in sexual and reproductive health.<br>- Sexual and reproductive practices of the LGTBIQ+ population.<br>- Qualitative research on sexual practices in rural or indigenous communities (abduction, sexual violence).<br><br>**Health care providers**<br>- Knowledge and attitudes of health care professionals (knowledge of rights and professional responsibility).<br>- Knowledge of and respect for sexual, reproductive, and maternal rights.<br>- Incorporation of a gender perspective in professional practice.<br>- Guaranteed access to long-acting contraceptives, especially IUDs. |
| **Evaluation of the quality of services** | **Quality of care**<br>- In abortion and postabortion situations.<br>- Services that serve the LGBTIQ+ population. |

| Research areas | Proposed topics |
|---|---|
| | - Prenatal, childbirth and postabortion care.<br>- Satisfaction of users with sexual, reproductive, and maternal health services. |
| **Studies to improve information systems/indicators in SRH** | **Design information systems that can capture sensitive data for the construction of health indicators.**<br>**Impact assessment of the introduction of new technologies and their scalability**. |
| **Research studies for the design, implementation, and comprehensive evaluation of interventions for the provision of sexual, reproductive, and maternal health services.** | **Design, implementation, and evaluation of culturally tailored interventions that:**<br>- Increase equity in access to services for vulnerable populations, such as indigenous, migrant, rural, LGBTIQ+, persons with disabilities, and adolescents.<br>- Improve adherence to HIV treatment.<br>- Improve access to prenatal care for vulnerable populations.<br>- Improve the implementation of the law on respected childbirth.<br>- Ensure access to safe abortion.<br>**Design, implement and evaluate the effectiveness of interventions to reduce gender-based violence (including obstetric violence)**<br>**Evaluate the impact of telemedicine implementation to improve access to contraception and safe abortion services.**<br>**Impact and cost-effectiveness evaluations of sexual and reproductive health interventions/programs/policies using rigorous research designs**<br>**Effectiveness and safety studies on safe abortion drugs, such as misoprostol and mifepristone, in local populations.** |

## 4.5. Strategies for implementing a SRMHR research agenda in the region

The main strategies for implementing a SRMHR agenda in the region are presented below:

- **Make strategic alliances with organizations and groups dedicated to SRMHR.** Strategic alliances between regional and international organizations dedicated to SRMHR (such as FLASOG, FIGO, PAHO, UNFPA, etc.). The importance of involving governments, particularly ministries of health and SRMHR programs, was also noted.
- **Support partnerships with universities.** Similarly, the possibility of partnerships with universities, which have human resources trained in research (epidemiological, quantitative, qualitative, etc.) despite the lack of SRMHR training curricula.
- **Establish funding support for research through institutional channels in each country.** One of the main barriers mentioned for SRMHR research in the region was the lack of funding. Participants emphasized that the potential support and/or funding modalities to implement a SRMHR research agenda should be adapted to the countries' particularities and used usual channels of funding or supporting for research in each country. Possible avenues for funding and/or support for research would include coordination with national science and technology organizations through public competitions; direct contracting or consultancies on demand with leading SRMHR research organizations in the region; or support through governments and ministries of health.
- **Include advocacy on the SRMHR agenda.** The stakeholders also stressed the importance of the prioritization of advocacy activities to set sexual and reproductive health issues on the public agenda, providing evidence on the impact of SRMHR on the societies development or the cost-effectiveness of interventions and policies in this area, among other aspects.

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