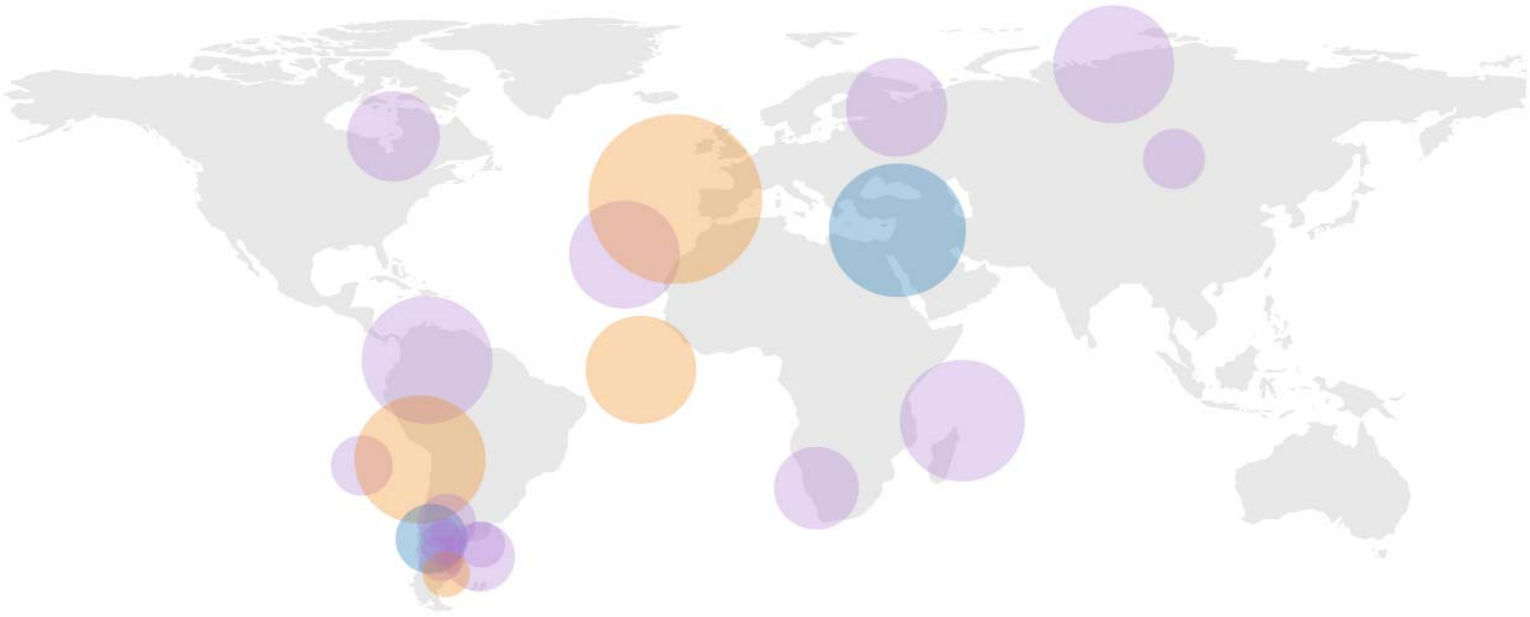

Scoping Study on Sexual, Reproductive and Maternal Health (SRMH) in Latin America and the Caribbean

Component 2 - Mapping of stakeholders and landscape analysis report

Executive Summary

CIPS
IMPLEMENTACIÓN E INNOVACIÓN EN POLÍTICAS DE SALUD

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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 should consider how the SRMHR needs of their population are met throughout the life course). 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.

In the context of the Scoping Study about Sexual, Reproductive and Maternal Health (SRMH) in Latin America and the Caribbean, we present the second component of the study: mapping of stakeholders and landscape analysis.

The analysis was carried out to evaluate the feasibility of the policies and to identify barriers and facilitators for the application and development of SRMHR policies. Gaps in regional capacities, capabilities, and performance were identified as well as good practices to reinforce the policy environment to move forward action steps.

Conclusions are aimed at understanding which are the key stakeholders that move forward the SRMH agenda in LAC, what is the status of research evidence, and which are the opportunities to broaden the research agenda and information access on SRMHR in LAC.

2. Methods

We conducted a stakeholder mapping and landscape analysis in reproductive and maternal health and rights (SRMHR) of women, adolescent girls, LGBTQI+, migrants, indigenous and Afro-descendant populations in Latin America and the Caribbean (LAC). This process had a special focus in Argentina, Colombia, Peru, Mexico, Guatemala, Jamaica, and Guyana.

We adapted the policy feasibility methodological framework proposed by Michael Reich based on political will, political analysis and political strategies. The stakeholder characterization was complemented by other approaches used for stakeholder mapping.

The domains considered in the stakeholder analysis were: Antenatal, intrapartum, and postnatal care; Gender-based violence prevention, support, and care; Gender identity; Family planning/contraception; Comprehensive Sexuality Education; Safe abortion; post-abortion care; Prevention and control of HIV and other sexually transmitted infections and Cancer of reproductive system.

The stakeholder analysis had five main stages: 1) main guiding research questions; 2) identifying key stakeholders (list of stakeholders); 3) search for information on the selected stakeholders (mapping); 4) in-depth analysis of the selected stakeholders, to understand their strategies, perceptions, positions and power 5) semi-structured interviews. A description of each of these stages is presented below.

2.1. Stage 1: Main research questions

The following research questions guided the narrative review:

- Who are the key national, regional, and international players among governments, health providers, agencies, funders, social movements that move forward the SRH agenda in LAC?
- What are the related processes to set the scientific, social and policy agendas in LAC?
- Which players take the lead and which ones have active roles in these processes? (With emphasis in prioritized countries).

- Who leads the regional and national policy debate in prioritized countries?
- Who are the main producers of research evidence on SRHM in the LAC region (types of institutions and specific names)? Are there some that also focus on one or more of the vulnerable groups of interest?
- Where are the main research capacity gaps?
- Where can a multi-actor and agencies partnerships strengthen the scientific capacities and build the necessary evidence?
- Where can the policy environment facilitate work on SRHR priority issues?
- Which donors, national/international agencies can be interested in SRMH in LAC? Among these, who can provide compatible perspectives to IDRC's mandate and approach?
- What contextual and strategic risks should be considered when undertaking this type of work?

2.2 Stage 2: Stakeholder identification

The first step in the stakeholder mapping and analysis process was the identification of the stakeholders. A comprehensive search strategy was developed to identify relevant published studies from the last 17 years (2005-2022). The search was conducted in different databases: LILACS, PUB MED, DOAJ, JURN, CLACSO, REDALYC, CAICYT-CONICET, EBSCOHOST, SCIELO, GOOGLE AC, WILEY.

The second step in stakeholder identification process was an intentional search on the internet, conducted in Spanish and English. From the information gathered, we also used a "snowball strategy" to identify other key actors.

Finally, in-depth interviews with regional key stakeholders also allowed to identify new actors, as well as to validate information on the existing ones.

2.3 Stage 3: Stakeholder mapping

The identified stakeholders were selected for the mapping process through the following inclusion criteria:

First set of inclusion criteria
- Non-governmental or governmental organization, social movement, academy, international or regional organization, association, cooperation agency. - Work on topics of interest for the research, - Women as their target population - Information retrieved in the last 7 years - Regional scope and/or in the prioritized countries.
Second set of inclusion criteria (For federal countries or countries with a large number of stakeholders)
- Existence of public information of the actor over the last 5 years (website or social networks) - Prioritization of national stakeholders over local stakeholders - Specific governmental actors prioritized over other general governmental actors with secondary participation in policies or programs. - Influence measured by number of followers or likes, in the case of social networks.

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.

In those categories where no public information was available "*No Information*" was used to categorize it. When there was a clear focus on a topic, population or even clarity on the use of funds, "*No*" was used for the excluded cases. For example, organizations working with only LGTBIQ+ population, were categorized as NOT working with women in general.

2.4 Stage 4: Stakeholders in-depth analysis of position and power

The position and power of key stakeholders involved in each policy was evaluated using the resources and information available for each player. These resources include 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 decision influence on a specific policy arena. 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 also used.

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 might differ among policies.

Stakeholders were positioned in each multiple-quadrant diagram considering the POSITION and POWER categories revealed in the matrix. The maps were analyzed in terms of dispersion or concentration along the quadrants, identifying those policies in which the players were more dispersed and therefore there was greater disagreement vs. those policies in which the players shared the agenda.

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

2.5. Semi-structured interviews

We conducted semi-structured interviews with key regional informants identified as stakeholders.

a) Design: While the stakeholders mapping was developed, a qualitative research approach was used to further describe key stakeholders at a regional level and to explore key informants' perceptions of main gaps and barriers on SMRHR.

b) Participants and data collection: A purposive sample of organizations working at a regional level was selected based on their relevance in terms of scope and the approach on the selected policies.

Semi-structured interviews were conducted focused on obtaining both descriptive and transformative information, as described by Hankivsky et. Al.

The main structure of the questionnaire was designed and then adapted for each informant. The questionnaire had the following objectives:

- Obtaining information on target populations, validating the topics on which the institution works; and identifying the main barriers and facilitators in the achievement of their goals.

- Validating and/or expanding the stakeholders map as well as validating some assumptions about the degree of support and power.
- Obtaining information on main barriers and facilitators in terms of legislation, policies, and access to SRMHR in the region, with particular emphasis on the effective access to SRMHR rights.

c) Data analysis: A rapid content thematic analysis was conducted, two analysts listened and read all the interviews. Manual codification of the transcripts was performed and discussed by two analysts. The findings were organized in themes of analysis.

3. Stakeholder mapping and analysis results

Eight-hundred and fifty-six (856) stakeholders were identified at a regional level and in prioritized countries. After applying the inclusion and exclusion criteria, 542 stakeholders were mapped

We present the main findings below, organized by region (section 3.1) and country (section 3.2), and then by policy (section 3.3). Each of these subsections contains a descriptive analysis of the stakeholders 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. Then, the analysis continues with the position and power maps categorizing each stakeholder according to the policies selected for this study.

Regarding the qualitative analysis, the organizations selected to participate in this first round of interviews include international agencies and regional networks. We performed five interviews to:1) a Regional Sexual and Reproductive Health Commodity Security Advisor UNFPA; 2) a Regional Sexual and Reproductive Health Advisor UNFPA; 3) a Regional Maternal Health Advisor CLAP, PAHO/WHO; 4) a Regional Sexual and Reproductive Health Advisor CLAP, PAHO/WHO; and 5) an Executive Secretary of the Latin American Consortium Against Unsafe Abortion - CLACAI.

The analysis of the interviews describes the main challenges and key barriers to equity and rights for the most vulnerable populations from the perspective of the participating stakeholders in Latin America and the Caribbean (section 3.4).

3.1. LAC-Overview

3.1.1 Descriptive Analysis

Universe: 99 actors were mapped at a regional level.

Experience: Most of the actors included (81% n=81) have more than 10 years of experience working in the selected topics.

Geographic scope: Almost half of the actors (53% n=53) have an international scope and deploy actions in Latin America and/or the Caribbean, either through partners or through their countries' offices. It is interesting to note that, only 19% (n=19) of the analyzed stakeholders have presence in all the prioritized countries and Argentina.

Guyana and Jamaica are the countries where the least presence of regional or international actors was found. 75% (n=75) of the stakeholders do not have information about Guyana and 69% (n=69) do not have information about Jamaica or do not explicitly include them in their scope of work. On the other hand, Colombia and Mexico lead the list of countries with the largest presence of regional stakeholders.

Sector: Most of the stakeholders (54% n=53) are non-governmental actors (regional 22% and international 32%) constituted in networks or social movements. 16% (n=16) are international

financial and technical cooperation agencies and 10% (n=10) religious actors. Finally, governmental actors represent 4% (n=4) of the stakeholders.

Topics of interest: Gender-based violence is the most common issue addressed at a regional level 62% (n=62). Safe abortion and prevention, control of HIV and other sexually transmitted diseases and family planning and contraception are addressed by half of the stakeholders (51%, 51% and 49%, respectively).

Most of the stakeholders analyzed develop an agenda that includes several of the SRMHR topics selected in this study. Except for 11% (n=11) of the stakeholders working specifically on HIV or reproductive cancers, the rest incorporate two or more of the topics analyzed.

Regarding the topics addressed by sector, if we add the categories of non-governmental, international NGO and social movements as "civil society", the issues more frequently addressed by this sector are gender violence, followed by abortion and comprehensive sexual education. 61% of the stakeholder's work on the gender-based violence agenda, 45% (n=29) on abortion, and 44% (n=28) on comprehensive sexual education.

International funding and technical cooperation agencies also prioritize the gender-based violence and HIV agenda (94% n=15 in both cases). Although the number of academic entities included is low (4), it can be observed that 75% of them address issues such as abortion and HIV. Finally, it is also important to highlight the work of religious organizations in abortion (80% n=8), gender identity, sex education and family planning (50% n=6 in both cases).

Target population: In most cases, the target population were not clearly specified. If other population groups were not specified, the stakeholders target population was categorized as "*women*" in general. Most of the stakeholders (83% n=83) work with women (in general), except for 14 (14%) that specify they work only with adolescents or LGTBIQ+. In turn, in several cases, the actors incorporate some other vulnerable groups prioritized in this study, although the strategy used to address these population groups is often not explicit.

Activities: Most stakeholders develop information dissemination activities (94% n=94), either through their websites, webinars and events, blogs, social networks, etc. A high percentage (83% n=83) of the stakeholders also engage in advocacy activities.

Although they are not considered specifically as academic entities, 54% of the stakeholders (n=54) conduct research projects. It is also important to highlight that 21% of the stakeholders (n=21) have the capacity to finance other organizations.

Funding: 38% (n=38) of the stakeholders did not specify their funding sources. Almost half of the organizations (48% n=48) receive private donations. No information was found to analyze the proportion of funding that each source represented for each organization.

Alliances: Most of the regional stakeholder's work in alliances with other organizations. Consorcio Latinoamericano Contra el Aborto Inseguro (CLACAI), Red Latinoamericana y del Caribe de Personas Trans (RedLacTrans), Red Latinoamericana y del Caribe de Jóvenes que Viven con VIH (J+LAC); are actors whose essence is collaborative work, since they are constituted as consortiums or networks. This is specially found in non-governmental organizations. There are also international financing and technical cooperation agencies that establish working alliances with non-governmental organizations, as is the case of UNFPA.

It is important to note that most of the international financing and technical cooperation agencies, such as IDB, World Bank and WHO, work directly in partnership with the countries.

It is also important to highlight some joint initiatives such as Spotlight; Every woman; every child; "Es con ESI"; the Interagency Strategic Consensus for the Reduction of Maternal Morbidity and Mortality; among others. These are initiatives promoted to advocate on specific issues. There are also collaborative projects aimed at disseminating information such as "Mira que te miro";

Gender Equality Observatory of Latin America and the Caribbean[119] or the Budget and Gender in Latin America and the Caribbean.

At a regional level, alliances appear to be a key factor to promote the agendas of these stakeholders.

3.1.2 Position and Power analysis

In summary, the policies mostly supported were antenatal, intrapartum, and postnatal care; gender-based violence prevention, support and care; prevention and control of HIV and other sexually transmitted diseases and cancer of reproductive system. On the other hand, it is important to highlight that the policies in which more stakeholders were identified that hinder the agenda of SRMHR were gender identity; family planning and contraceptive use; comprehensive sexual education and abortion. In general, these actors mostly carry out advocacy and information dissemination actions and were faith-based organizations with an international scope.

It is also observed that at a regional level, considering the 99 stakeholders mapped, almost all of them deploy lobbying or advocacy actions (83%), a little more than half of the actors (54%) conduct some type of research, a third provide technical cooperation (33%) and only 16% provide health service. This is consistent with the role of regional or international stakeholders who are not primarily responsible for expanding or managing health services

Please see the main document for map viewing and detailed analysis.

3.2. Prioritized Countries

3.2.1. Argentina

3.2.1.1. Descriptive Analysis

Universe: 92 stakeholders were mapped at a country level.

Experience: 74% (n=68) of the actors have more than 10 years of experience working in the selected topics.

Sector: Non-governmental and academic institutions represented most of the actors mapped in Argentina, 55% and 22% respectively (n=51 y n=20). Governmental actors represented only 6% (n=5) of total stakeholders because they were considered as one stakeholder when they belonged to the same governmental area. In relation to regional and international actors mapped on section 3.1 (n=99), we observed that 74% of them have presence in Argentina (n=73).

Topics of interest: Topics prioritized are comprehensive sexuality education (66,3% n=61), gender-based violence prevention, support a care (60,8% n=56) and gender identity (57,6% n=53). Nevertheless, family planning-contraception (51% n=47), safe abortion - post-abortion care (48,9% n=45) and prevention and control of HIV and other sexually transmitted diseases (43,5% n=40) are also addressed by different actors. It is interesting to note some of the priority issues (such as abortion) are mainly worked by younger organizations (only 32% have more than 10 years of experience), while other topics such as HIV and cancer are developed by stakeholders with more experience (88% working on cancer and 87% on HIV have more than 10 years of work on these issues).

If we analyze the prioritized topics by sector or type of actor, we find that all governmental agencies address gender-based violence, prevention, support, and care. This is related to the current public agenda and is reflected in the recent creation of the Ministry of Women, Gender and Diversity. In addition, we observe that social movements prioritize topics as gender identity and abortion, while non-governmental organizations, academic actors, and media-opinion leaders prioritize comprehensive sexuality education as a central topic in their agenda. NGOs also

prioritize gender-based violence, and media-opinion leaders support issues related to abortion and family planning. Lastly, health services providers prioritize antenatal, intrapartum, and postnatal care, and religious actors intervene mostly in family planning and abortion.

Target population: We observe an intersection between different target populations, in all mapped stakeholders. In general, they have a primary target population but, in their activities and actions they also address other populations. According to institutional objectives and other public information 87% (n=80) of the stakeholder's address women in general as target population, 73% (n=67) address adolescent girls, 51% (n=47) LGBTQI+, 32% (n=30) migrants, 26% (n=24) persons with disabilities, 24% (n=22) indigenous population, 22% (n=20) elderly and 17% (n=16) afro-descendant population.

Activities: 93% (n=83) of the actors mapped develop information dissemination activities, 79% (n=73) also carry out advocacy activities, while almost 59% (n=54) develop research activities. Only 11% (n=11) of the actors at national level are donors.

Funding: For the cases where the information was available (n=56), private donors represent 84%, public funding 46,5%, international cooperation 39%, other 19% and international grants 3,57%.

Alliances: In 60% (n=55) of the actors, there is explicit information about their work with other national, regional, and international actors.

3.2.1.2. Position and Power analysis

Summarizing this section, the most controversial policies to advance for their effective implementation were access to safe abortion and gender identity. However, the number of actors in favor of these policies in the country continues to be high (90% and 80% respectively). In relation to the activities developed by opponents, we found only dissemination and advocacy activities, while in the case of actors in favor of these policies, we also observed research and project implementation, among others.

The policies where we found greater support were prenatal, intrapartum, and postnatal care, prevention, support and care of gender violence and cancer of the reproductive system. In those cases, the position is significantly homogeneous and supportive among all the stakeholders identified.

Except for religious actors or social movements with strong religious influence, most of stakeholders identified support the SRMHR agenda.

Finally, if we consider the 20 academic stakeholders identified, all the policies or services that are included in the SRMHR agenda are object of study. Something similar occurs with the non-academic sectors that also conduct research as another activity within the scope of their work.

Please see complete document for map viewing and detailed analysis.

3.2.2. Colombia

3.2.2.1 Descriptive Analysis

Universe: 87 were identified in Colombia.

Experience: Among the actors included, 75 % (n=65) have more than 10 years of experience working in the selected topics

Sector: Non-governmental organizations lead the ranking of national stakeholders (40%, n=35), while academic sector is in second place (25%, n=22). Government Organizations and religious actors represent 14% (n=12) and 7% (n=6) of the total of actors mapped, respectively.

At the regional level, International NGOs account for 29% (n=23), non-governmental organizations represent 22% (n=17), and Financing and cooperation agencies contribute

with19% (n=15). Social movements and religious sector contribute with 13% (n=10) and 9% (n=7) of the total, respectively.

Topics of interest: The stakeholder's map shows that gender-based violence prevention, support, and care and comprehensive sexuality education are addressed by more than a half of actors. On the other hand, antenatal, intrapartum, and postnatal care and cancer of reproductive system were barely targeted by actors, despite the profound inequities about these issues in Colombia. A similar pattern is shown for HIV and other sexually transmitted infections, and family planning and contraception, although these topics have a higher proportion of long-experienced stakeholders. The secondary role of STIs different from HIV in the agenda of SRMRH should also be highlighted.

When crossing prioritized topics by sector, it was found that non-governmental, academic, and media-opinion leaders consider gender-based violence prevention, support, and care, comprehensive sexual education, gender identity and safe abortion family planning as priority topics in their agendas. On the other hand, private and religious sectors target their actions on HIV and cancer of the reproductive system. Governmental actors prioritize mainly gender-based violence prevention, support and care, and comprehensive sexuality education.

Target population: Women (in general) is the most prevalent population targeted by national stakeholders in Colombia (85%, n=74). Adolescent girls, indigenous and LGBTQI+ are addressed as targeted populations in a similar proportion (51%, n=44; 49%; n=42, and 48% n= 32%, respectively). Afro descendant and migrants represent 39% (n=34) and 33% (n=29) of groups included in actions and activities developed by the included stakeholders. Finally, persons with disabilities and elderly people only are targeted by 18% (n=16) and 11% (n=10) of actors identified. On the other hand, 11% of actors in Colombia (n=10) only prioritize actions aimed at specific communities, like indigenous (n=7), migrants (n=3), or afro descendants (n=2). Furthermore, some actors specially target victims of armed conflict, which is a specific, long lasting, and still current problem in Colombia.

Activities: Dissemination leads the ranking of activities developed among stakeholders (93%; n=81). Research is conducted by 74% (n=64) of actors, while 51% (n=44) and 46% (n=40) of them carry out community prevention and health promotion campaigns, and implementation projects, respectively. Advocacy is carried out by 41% (n=36) of the actors mapped, mainly from governmental, non-governmental and academic sectors with high support and medium on high power. It must be highlighted that 25% of actors mapped (n=22) develop implementation projects, research, and advocacy simultaneously.

Funding: No information about funding sources was found in 40% (n=35) of stakeholders. For stakeholders that reported information on their official webpages about funding (n=52), grants provided financial support in 60% (n=31), private donors in 50% (n=26), public funding in 42% (n=22), and international cooperation in 35% (n=18).

Alliances: 86% (n=75) of stakeholders mapped in Colombia provide information about their work with other national, regional, and international actors, as well as the only international non-governmental organization and the single health provider mapped. All religious institutions included (n=6) constitute networks with other international or national actors, while only 60% of private actors do so.

3.2.2.2. Position and Power Analysis

Summarizing this section, the stakeholder's map shows that gender-based violence prevention, support, and care and comprehensive sexuality education are addressed by more than a half of actors. On the other hand, topics traditionally included on SHRMH agenda, like antenatal, intrapartum, and postnatal care and cancer of reproductive system were barely targeted by actors, despite the profound inequities about these issues in Colombia. A similar pattern is shown for HIV

and other sexually transmitted infections, and family planning and contraception, although they have a higher proportion of stakeholders, and all of them have large experience on these topics. The secondary role of STIs different from HIV in the agenda of SRMRH should also be highlighted.

Women in general, adolescent girls, indigenous, and LGBTQI+ were the target populations for a half of the stakeholders. Conversely, elderly people and persons with disabilities remain out of the scope of most actors mapped.

Dissemination leads the ranking of activities developed in SRMHR, followed by research. A quarter of stakeholders develop implementation projects, research, and advocacy simultaneously.

No information about financial support was found in 40% of stakeholders mapped, while international grants and private donors are the main funding sources for actors that reported information.

Almost all stakeholders have alliances with other national, regional, and international actors.

Government institutions were considered as high-power actors. However, the information provided in their websites shows medium or even low support on some topics like antenatal, intrapartum, and postnatal care, gender identity, family planning and contraception, comprehensive sexuality education, safe abortion and post abortion care and cancer of the reproductive system. An exception is the Presidential Advisory Office for Women's Equity, which builds strategic alliances with all sectors of national, regional, and international stakeholders, including research. Many academic institutions and scientists highly support SRMHR and were considered as medium and high-power stakeholders.

Please see complete document for map viewing and detailed analysis.

3.2.3 Guatemala

3.2.3.1. Descriptive Analysis

Universe: 29 actors were mapped at a country level.

Experience: Most of them have more than 10 years of work in the selected topics (55%).

Sector: Most stakeholders belong to the non-governmental sector, 52% (n=11), including civil associations or social movements. Social movements/interest groups and governmental stakeholders represent 28% (n=8) of the total stakeholders each. Only 3% (n=1) of the actors are international NGO or health services provider. Regarding regional and international actors mapped, we observe that 65 of them have presence in Guatemala (66%).

Topics of interest: Gender-based violence is notoriously the most common topic at the national level, 83% (n=24). Gender identity is addressed by 38% (n=11) of the actors, Comprehensive Sexuality Education (CSE), 34% (n=10), family planning and prevention and control of HIV and other sexually transmitted infections, 31% each (n=9). Safe abortion 21% (n=6), cancer of the reproductive system 17% (n=5) and antenatal, intrapartum, and postnatal care 14% (n=4), are the least attended topics on the agenda of the stakeholders analyzed.

When analyzing the topics that the stakeholders prioritize in their agenda by sector, we find that governmental and non-governmental organizations, as well as social movements/interest groups, are primarily focused on gender-based violence. The following topics addressed by the governmental sector are antenatal, intrapartum, and postnatal care, and family planning. Non-governmental organizations and social movements attend CSE and gender identity, in second place.

Target population: All the stakeholders' work with "women (in general)", except for 6 (21%) stakeholders who explicitly state that they work only with adolescents, indigenous or migrants.

Activities: As shown in the graph below, most stakeholders carry out information dissemination activities (89.6% n=26), either through their websites, organization of webinars and events, blogs, social networks, etc. We found that more than half stakeholders are engaged in advocacy activities (62% n=18), while 13 actors (44.8%) do research and 11 (37.9%) implement different types of projects.

Funding: For 19 stakeholders (66%), no information was found about any form of financing. For some organizations (13% n=4), private donations were explicitly shown on their websites. No information was found to analyze the proportion of funding that each source represents for each organization.

Alliances: Regarding the stakeholders' alliances in Guatemala, scarce information was found. Of the total number of stakeholders mapped (n=29), 10 (34.4%) work with other national, regional, or international organizations. The United Nations Population Fund (UNFPA), United Nations, UNAIDSWHO, UNESCO, OXFAM, are some examples of their international alliances. The organizations that work in alliances mostly belong to the non-governmental sector and social movement/interest groups. Some regional and national alliances work specifically in gender-based violence and comprehensive sexuality education.

3.2.3.2. Position and power analysis

Summarizing this section safe abortion and post abortion care is the policy in which the greatest dispersion of stakeholders in Guatemala is registered. Scarce information was found regarding actors that addressed these policies on their agendas. It can be hypothesized that the recent sanction of the Law for the Protection of Life and the Family influenced the visibility of the subject. We identified the Pro-Life organization AFI, as an actor with a greater presence in the country and as a high-power organization that hindered the SRMHR agenda.

The activities developed by oppositional actors are mainly dissemination and advocacy, while in the case of actors in favor of these policies, we also observed research, project implementation, among others.

Another policy where there is significant support by all sectors is prevention, support, and care of gender violence. The position is significantly homogeneous among all the actors surveyed.

We observe that almost all of the stakeholders mapped support the SRMHR agenda except for Provida Guatemala and Asociación La Familia Importa.

Finally, 48% (n=13) of the actors mapped develop research activities and more than half belong to the governmental sector.

Please see complete document for map viewing and detailed analysis.

3.2.4 Guyana

3.2.4.1 Descriptive Analysis

Universe: 25 actors were mapped at the national level in Guyana. The process

Experience: 88% (n=22) of the actors included have more than 10 years of experience working in the selected topics.

Sector: Most of the actors mapped belong to the non-governmental sector 76% (n=19)

Topics of interest: Analyzing the explicit agenda of Guyanese stakeholders, we observe that HIV prevention and control (68%, n=17) and gender-based violence prevention and care (64%) were the most common topics addressed by them, followed by family planning and contraception (52%, n=13). Safe abortion and post abortion care, as well as antenatal, intrapartum, and

postpartum care, were the topics least present in the agenda of the stakeholders mapped. Only 4% and 12% of the actors included these topics in their agenda respectively. When it comes to abortion, the only stakeholder that addresses this issue is the Ministry of Health[361].

When analyzing the issues prioritized by the stakeholders by sector, we find that non-governmental organizations focus on HIV prevention and control, gender-based violence prevention and care, family planning and comprehensive sexuality education. Government actors (and as it was stated previously), address safe abortion and post abortion care, gender-based violence prevention, support and care, HIV prevention and control, family planning, cancer of the reproductive system and antenatal, intrapartum, and postpartum care.

Target population: 80% (n=20) of the stakeholder's work with women in general, 60% (n=15) with adolescent girls, 52% (n=13) with LGBTQI+ population, 32% (n=8) with indigenous, 28% (n=7) with elder adults, 20% (n=5) with afro-descendant's population, and 16% (n=4 each) with persons with disabilities and migrants

Activities: The large majority stakeholders develop more than one type of activity. 84% (n=21) engage advocacy activities and 76% (n=19) carry out information dissemination activities mostly through their social media and community events. In addition, 72% (n=18) of the actors participate in community prevention and health promotion campaigns; 60% (n=15) implement projects and 32% (n=8) develop research activities. Lastly, 10 stakeholders (40%) are health services providers and 10 (40%) are donors.

Funding: 32% of stakeholders (n=8) report no information about their funding sources. For the cases where the information was available (n=17), 60% declare to receive donations from private donors and the same percentage reports to have access to international grants. 47% have access to international cooperation and the same percentage to public funding. Lastly, 23% reports to have other sources.

Alliances: 94.7% of non-governmental actors analyzed developed alliances with other actors. It is important to note that the analyzed stakeholders have, in many cases, alliances with each other. In addition, 42% (n=8) work with governmental agencies, as the Ministry of Social Protection and the Ministry of Health

Of the total number of stakeholders mapped, 44% (n=11) have developed alliances with international and regional actors such as UNICEF, Pan American Health Organization (PAHO/WHO), United Nations Population Fund (UNFPA) and US Agency for International Development (USAID). Finally, as for both the religious and health services provider stakeholders, there is no information available about their alliances.

3.2.4.2. Position and Power Analysis

Summarizing the findings and analysis of Guyana's stakeholders on SRHR, there were several barriers to access the information. Many of the stakeholder's websites and social media networks did not have all the information required for this analysis, and in several cases, the information was not updated.

Even so, we were able to identify and map 25 actors, and most of them show support to this agenda and belong to the non-governmental sector.

The main subjects they address are both prevention and control of HIV and other sexually transmissible infections and/or prevention, support, and care on gender-based violence.

Of those stakeholders who show high power, both the Ministry of Health and the Women and Gender Equality Commission of Guyana stand out. These institutions are present in most of the topics analyzed.

As for the opposition stakeholders, it was hard to access to detailed information about their activities, topics of interest and power.

Please see complete document for map viewing and detailed analysis.

3.2.5 Jamaica

3.2.5.1 Descriptive Analysis

Universe: 17 actors were mapped at a country level.

Experience: All of them have more than 10 years of work in the selected topics (100%).

Sector: Most stakeholders belong to the non-governmental sector, 59% (12), including civil associations or social movements. In second place is the governmental sector with 29% (n=5). The remaining stakeholders are distributed equally among academic and health service providers (6% n=1 each). In relation to the regional and international actors mapped, we observe that 30 of them have presence in Jamaica (30%).

Topics of interest: Gender-based violence is the most common topic at the national level, 82% (n=14). In second place is prevention and control of HIV and other sexually transmitted infections, 59% (n=10). Cancer of the reproductive system 24% (n=4), antenatal, intrapartum, and postnatal care 12% (n=2), and safe abortion 6% (n=1)[16], are the least addressed topics on the agenda of the stakeholders analyzed.

When analyzing the topics that the stakeholders prioritize in their agenda by sector, we find that governmental and non-governmental organizations are primarily focused on gender-based violence. Prevention and control of HIV and other sexually transmitted infections is also an addressed topic for both sectors, representing the second place.

Target population: All the stakeholders included work with "*women (in general)*", except for one actor (6%) who explicitly states it works only with LGBTQI+. As presented in the graph below, most of the stakeholder's target population is concentrated on *women (in general),* 82% (n=14), followed by adolescents, 47% (n=8).

Activities: All the stakeholders carry out information dissemination activities (n=17),. More than half of the stakeholders (82.35%) are engaged in advocacy activities (n=14), provide health services (58.82%, n=10) and do research (52.94%, n=9).

Funding: We found information about the funding sources for almost all stakeholders. For some organizations, private donations were explicitly shown on their websites. No information was found to analyze the proportion of funding that each source represents for each organization.

Alliances: Most of the actors mapped work in alliances, whether with national or regional stakeholders. Some actors specify they work with international organizations such as The United Nations Population Fund (UNFPA UNICEF, UNAIDS, The Global Fund, European Union, (IPPF) International Planned Parenthood Federation, among others. On the other hand, national alliances were especially found between organizations that primarily work with prevention of HIV and other sexually transmitted infections.

3.2.5.2. Position and Power Analysis

Summarizing the findings and analysis of Jamaica's stakeholders on SRMHR, there were several barriers to access to the information. Many of the stakeholder's websites and social media networks did not have all the information required for this analysis, and in several cases, the information was outdated. This difficulty was also present when identifying stakeholders in opposition of the SRMHR agenda.

Nevertheless, we were able to identify and mapped 17 actors, of which the majority belong to the non-governmental sector and support SRMHR policies.

The main subjects they address are both prevention, support, and care on gender-based violence, and prevention and control of HIV and other sexually transmissible infections.

Of those actors who show high power, we found that both the Ministry of Health and Wellness and the University of the West Indies (UWI) have greater presence in most of the topics analyzed.

Please see complete document for map viewing and detailed analysis.

3.2.6. México

3.2.6.1 Descriptive Analysis

Universe: 134 stakeholders were mapped at a country level in Mexico.

Experience: Most of the stakeholders assessed, 67.9% (n=91), have more than ten years of experience working in the selected topics.

Geographic scope: Among actors working at a national level, 84.3% (n=113) have national coverage and deploy actions in at least two states of Mexico, either through partners or with state offices.

Sector: Most national stakeholders belong to the non-governmental sector, 72% (n=96), including civil associations, foundations, or social movements. With only 8% (n=11) of the share, we found media-opinion leaders in the second place and governmental stakeholders in the third place with 6% (n=8).

Seventy-six (76) international organizations were found to work in Mexico. 29% of them are International NGOs (n=22), and there are also other types of non-governmental organizations that represent 21% (n=16) of the regional organizations currently developing SRMHR-related activities in the country. It is also remarkable that 14 international financing and cooperation agencies work in this territory.

Religious organizations with representation in the country account for 12% of the regional stakeholders assessed (n=9). Finally, only 5% correspond to governmental actors and 3% to academic ones (n=4 and n=2 respectively).

Gender-based violence and comprehensive sexuality education were the most common topics addressed at a country level (n=64 47.76% and n=63 47%, respectively). Gender identity and HIV prevention and control are also among the main issues addressed by almost a third of the stakeholders (n=48 35.8% and n=45 33.58%, respectively). Antenatal, intrapartum, postnatal care and safe abortion care were the topics least attended in the stakeholders' agendas analyzed (n=20 14.92% and n=30 22.38%, respectively).

When analyzing the topics prioritized by the stakeholders by sector, we found that non-governmental organizations, social movements, and governmental organizations prioritize gender-based violence topics. In contrast, the academic sector is focused on activities related to comprehensive-sexuality education.

Target population: Most of the stakeholder's work with "women (in general)" 95% (n=127), except for 7 (5.22%) stakeholders who explicitly state that they work only with adolescents, LGTBIQ+ or person with disabilities. On the other hand, some stakeholders explicitly incorporate other vulnerable groups prioritized by this study.

Most stakeholders' activities include information dissemination through their websites, webinars, events, blogs, social networks, etc. 62.7% (n=84) of stakeholders also participate in advocacy activities. Instead, very few of the stakeholders analyzed develop implementation projects (n=22) or are donors (n=5) at a country level.

Funding: We found scarce information regarding funding sources of most of the stakeholders. In fact, for 89 (66.4%) stakeholders, no information was found about any source of financing. Of these, 66 (74.15%) are NGOs. However, it was explicitly found that approximately a quarter of the organizations receive private donations. No information was found to analyze the proportion of funding each source represents for each organization in most of the cases.

Alliances: In the case of Mexican stakeholders, we did not find information to assess if they work in alliances in most of the cases. However, some organizations specifically stated the international or national alliances they work with, such as CENSIDA, UNFPA, INMUJERES, UNAM, USAID, WHO, UN, Viva Glam, and RESURJ among others. This is specially found in non-gubernamental organizations, such as Observatorio Ciudadano Nacional del Feminicidio (OCNF, Equidad de Género, Ciudadanía, Trabajo y Familia (Equidad, among others. There are also international financing and technical cooperation agencies that establish working alliances with non-governmental organizations, for instance UNFPA and CEPAL.

3.2.6.2 Position and power analysis

As reported in the first component of this project, Mexico is a federal republic that has 32 autonomous States. According to data from the 2020 census, Mexico's population is approximately 126 million, one of the most populous countries in the region. The large number of stakeholders assessed in this study represents mainly those working on SHRMR-related topics previously identified by national and international organizations' stakeholders' mapping.

Most organizations assessed in this country are non-governmental organizations (71.6%), which could be related to the sources examined for actors screening. We found that experienced actors are the most prevalent (67.9%), reflecting Mexican stakeholders' trajectory in SHRHM-related topics. Advocacy in the prioritized policies has been important for civil society to impulse legal framework changes and policy development—for instance, the constant update of abortion policies in the different Mexican states. Per our analyses, gender-based violence, and comprehensive sexual education are the most relevant topics in the country, with multiple organizations working on these subjects. It is noteworthy that research activities are limited to only a third of the stakeholders assessed (31.3%), disregarding the sector to where they belong.

Finally, vulnerable populations are not explicitly targeted by the stakeholders evaluated. Indigenous people are targeted by 16.4% of the actors, LGBTQI+ by 7.46% of stakeholders, migrants are target populations for 7.46% of the organizations, and afro-descendants are the target population for only 4.46% of the stakeholders evaluated. The current legal framework of Mexico, national policies, and programs highlight the need for culturally appropriate and tailored interventions in SRHRM-related topics for vulnerable populations. Our study highlights the opportunity to continue raising awareness of these populations' specific needs among the Mexican stakeholders.

Please see complete document for map viewing and detailed analysis.

3.2.7 Peru

3.2.7.1 Descriptive Analysis

Universe: 59 actors were mapped at a country level.

Experience: Most of the actors included 74.5% (n=38) have more than 10 years of experience working in the selected topics.

Sector: Regarding the sector to which the stakeholders belong, almost a half of actors are non-governmental organizations (n=29). In second place, the social movements or interest groups represent a quarter of the total (24% n=14). The government has a remarkable role as a stakeholder. It develops most of its work related to SRMHR topics through specific offices, especially in the Ministry of Women and Vulnerable Populations and the Ministry of Health. In relation to regional and international actors mapped on section 3.1 (n=99), we observe that 71 of them have presence in Peru (71%).

Topics of interest: Comprehensive sexuality education and gender-based violence prevention, support, and care were the most widespread topics addressed by the organizations (n=42

(71.18%), each). Additionally, more than a half of the stakeholders (n=30 50.84%) focus on gender identity as part of their main programs.

Regarding the activities according to the sectors the organizations belong, gender-based violence prevention, support and care and comprehensive sexual education are addressed mainly by non-governmental organizations and social movements. Also, more than 50% of government agencies develop activities on this topic. On the other hand, safe abortion is mainly addressed by social movements (42.8%), who perform advocacy activities for its decriminalization at the national level. All religious organizations identified (n=2) also include activities regarding abortion, however they are against to it access

Target population: Close to 90% of stakeholder's work with women in general (n=52). Likewise, 62.7% (n=37) address adolescent women as their target population, this is probably connected with the current rates of adolescent pregnancies in the country. The LGBTQI+ population is the target population in the activities for 57.6% of organizations (n=34). Even though Peru is a multi-ethnic country, slightly more than a third of organizations (35%) carry out specific activities with indigenous populations. Only one organization dedicated exclusively to afro-descendant women was identified.

Activities: Dissemination and advocacy activities are the most frequent types of actions performed by the stakeholders (96% and 95% respectively). The community prevention and health promotion campaigns are in the third place (67%) which are developed mainly by non-governmental organizations. Research is conducted by 25 (45.75%).

Funding: 42 (71.1%) of stakeholders do not have financial information available on their official platforms. Private donations are the most reported (n=9 15.2%). There is a significant presence of government funding (n=8 13.55%) due to the number of governmental stakeholders (n=7 11.86%).

Alliances: In Peru, we have detected that few actors report alliances, according to the sources we have had access to. Some of these actors work in alliances with international organisms such as the United Nations (through the Economic and Social Council, the Trust Fund to Eradicate Violence against Women, UNFPA, UNICEF and FAO) and Organization of America States (OAS). This is a case of PROMSEX (Center for the Promotion and Defense of Sexual and Reproductive Rights), Asociación Benéfica PRISMA and Asociación AMAR.

Other alliances appear to be a key to carry forward the agendas of some actors linked with cancer, for example Asociacion Peruana Vidas sin Cancer and Peruvian League Against Cancer which are related to the UICC-Union for International Cancer Control and International Alliance of patients 'Organizations.

Among the alliances with regional organizations (in Latin America), it is worth mentioning the joint work with the Latin American Consortium against Unsafe Abortion (CLACAI) and the Latin American and Caribbean Forum for Reproductive Health Supplies Assurance (Foro Lac).

At national level some Peruvian actors make alliances with networks linked with VIH-SIDA, transgender groups, and most notably, with the Center for the Promotion and Defense of Sexual and Reproductive Rights (PROMSEX) an organization that is also an actor in the country itself.

3.2.7.2. Position and Power Analysis

Summarizing, there is a variety of stakeholders from different sectors, almost all have a position in favor of the policies on the SHRH issues studied (95%). Most of the topics addressed are related to gender-based violence, comprehensive sexual education, gender identity and family planning, which are topics of wide debate in recent years.

Three stakeholders (5%) were identified who present opposition at different levels on the different issues. In fact, their opposition roles and high political influence is notorious in some issues where

there is greater support: Comprehensive sexual education, gender identity and family planning. Unlike the actors in favor, the actors who showed opposition develop mainly advocacy activities.

However, the actors in favor develop a wider variety of activities that include implementation projects and research

Please see complete document for map viewing and detailed analysis.

3.3. Public policies and programs

3.3.1. Antenatal, intrapartum, and postnatal care

3.3.1.1 Descriptive analysis

Seventy-one (71) actors were mapped at national level in the 7 prioritized countries. Additionally, 31 stakeholders in the region that address the same topic were identified.\97% of the actors(n=69) related with this topic have a national scope. Mexico and Argentina, have the highest concentration of stakeholders (n= 20 each).

In most cases, the target populations with whom stakeholders work were explicit as "women" in general (69 of 71 stakeholders, 97%). Furthermore, almost 70% of the actors work with adolescents among other populations (n=50). Regarding LGTBIQ+ people, 30 actors (42%) include this target population. Other vulnerable people included in this study, such as indigenous and migrants, are incorporated by 31 (43.66%) and 20 (28.16%) stakeholders respectively.

Most stakeholders develop information dissemination activities (87% n=63), either through their websites, webinars and events, blogs, social networks, etc. A high percentage (72% n=51) of stakeholders also engage in advocacy activities. Although all the stakeholders are not academic entities, 43 of them (60%) carry out some type of research. In this group, there are academic institutions (n=13 18.3%%), government offices (n=12 16.9%), and non-governmental organizations (n=13 18.3%). On the other hand, 37 stakeholders (52%) develop community prevention and health promotion activities and 27 (almost 38%) provide health services. A small group of stakeholders from Argentina and Guyana (n=6 8.4%) make donations or finance activities as part of their scope of work, 50% (n=3).

Regarding funding information, for 34 (48%) stakeholders no information was found about any type of financing. Public funding is the most frequently encountered source of financing (33% n=24). The organizations that receive government funding correspond mainly to government agencies (15 out of 24), academic institutions such as research centers.

A quarter of national organizations reported receiving private funding (n=18). In this group, 50% (n=9), are NGOs located in Argentina, Colombia, Guyana, Mexico, and Peru. On the other hand, 46% of academic institutions (6 out of 13) reported receiving private funding, this represents a third of all organizations that reported receiving private donations.

Less than a half of the actors (n=29; around 40%) report alliances, according to the sources to which we have had access. Few actors (n=6; 8,3%) work in alliances with international organisms such as the United Nations (through UNICEF, WHO, PAHO and USAID). Some actors (n=8; more than 11%) make alliances with academic institutions which have influence at a national level as is the case of many Societies related with Medical or Midwifery practices and universities or at regional level which is for example the case of the Consejo Latinoamericano de Ciencias Sociales, CLACSO. If we analyze the alliances established by the stakeholders of South American countries such as Argentina, Colombia, and Peru; there is a remarkable national collaboration between organizations in the same territory that promote the empowerment of vulnerable populations.

3.3.1.2. Position and Power Analysis

The following is an analysis of the positioning and power of the stakeholders, according to the topic(s) they work on. Given that stakeholders generally work in more than one of the lines of action analyzed and do not always allocate resources equally or prioritize the topics, the analysis was carried out separately by topic.

Illustration 1 Stakeholders position and power in antenatal, intrapartum, and postnatal care

(n=71)

Source: Own elaboration

Seventy-one (71) stakeholders were mapped, there were no actors with a position against the policies related to the matter. According to the latest reports, maternal mortality have decreased to 67.2 deaths per 100,000 live births[612]. Consequently, this situation represents a priority agenda for the governments of Latin America and the Caribbean.

Regarding the distribution of the stakeholders, more than 90% have medium and high support (n=65). However, the percentage of actors with medium and high power reaches 69% (n=49). Analyzing the group of high-power stakeholders (n=18), two thirds of the parts have a high support. In this subgroup, a half of stakeholders are government agencies belonging to Argentina, Peru, and Mexico. This tendency revealed a difference with Guatemala, Jamaica, Colombia and Guyana, countries in which their Ministries of Health have high power, but they do not provide high support for this policies. In general, the high-power stakeholders are composed by institutions from the Government (n=11 61.1%), Academic (n=4 22.22%) and non-governmental organizations (n=3 16.66%).

Evaluating the activities performed by the high-power stakeholders, almost all of them perform dissemination activities (94%, n=17), followed by research (83%, n=15), implementation projects and community prevention and health promotion campaigns (77%, n=14). Advocacy is performed by the 66% of stakeholders (n=12). Lastly, a half of the total actors provide health services (n=9) and just two organizations realize donations.

Please see complete document for map viewing and detailed analysis.

3.3.2 Gender-based violence prevention, support, and care

3.3.2.1 Descriptive analysis

Two hundred and eighty (280) stakeholders were mapped at the national levels in Argentina, Colombia, Guatemala, Guyana, Jamaica, Mexico and Peru and 62 international and regional actors that address gender-based violence prevention, support and care policies.

70% (n=196) of the national actors have more than 10 years of experience working on gender-based violence prevention, support, and care policies. On the other hand, 15% (n=42) of the actors have less than 10 years of experience in the field. No information about the experience was obtained for 15% (n=42). If we look at the international and regional actors working on this policy of, 85.5% (n=53) have more than 10 years of experience.

At a country level, non-governmental actors predominate among the mapped actors, with 56.43% (n=158), while governmental and academic actors represent about 12% (n=34 and n=35 respectively). The remaining stakeholders (religious and health services providers) represent less than 5%.

In relation to the regional and international actors mapped in section, we observed that 66% (n=62) work on gender-based violence policies.

In all mapped actors we observed an intersection between different target populations. In general, they have a primary target population, such as LGBTQI+, people living with HIV, migrants, adolescents, however, in their activities and actions they also explicitly address other populations, such as women in general, people with disabilities, the elderly, among others.

If we look specifically at each target population, we observe that 87% (n=244) of the stakeholder's target women in general, 59% (n=165) adolescents, 53% (n=148) LGBTQI+ population, 36.5% (n=102) indigenous people, 28% (n=79) migrant population, 22% (n=62) afro descendant population, and finally, about 14% people with disabilities and older adults (n=40 and n=38 respectively).

Of the 280 actors surveyed that address interventions related to gender-based violence, 63 actors (22.5%) have the Afro-descendant population as their target population and are located in Argentina, Colombia, Guyana, Mexico and Peru; we haven't found this intersection with actors from Guatemala and Jamaica. In relation to the indigenous population, we found this intersection in 103 actors (36.78%) and in the migrant population in 80 actors (28.57%), in both cases these actors are in the 6 prioritized countries, except in for Jamaica.

If we look at international or regional actors, we also see a broad intersection between gender-based violence work and different target populations. Of the 66 actors that address this issue, 13 (19.69%) target people with disabilities, 16 (24.24%) the afro descendant population, 19 (28.78%) the elderly population, 26 (39.39%) migrants and the indigenous population, 36 (54.54%) the LBTBQ+ population, 48 (72.72%) adolescents and 52 (78.78%) women in general.

93% (n=261) of the mapped stakeholders carry out information dissemination activities. This is done through their websites, events, webinars, blogs, social networks, among others. 74%of the actors (n=207) perform advocacy activities, while 54% (n=151) develop research activities, although they are not necessarily actors categorized as academics.

On the other hand, 51% (n=144) of the stakeholders implement different types of projects, 47% (n=132) develop community prevention and health promotion campaigns, 21% (n=60) provide health services and only 5% (n=15) of the actors at a country level are donors. There are 106 stakeholders (38%) that also carry out other types of activities such as professional training, among others.

According to the questions posed by the study, it is worth noting that we found actors conducting research on gender-based violence policies in the seven prioritized countries. In Mexico,

Colombia, Argentina, and Peru, 25, 54, 33 and 15 actors respectively have been identified; in Guatemala, Guyana, and Jamaica, 10, 7 and 7 stakeholders respectively have been identified).

In relation to international actors addressing the issue of gender-based violence, 61 actors (99%) have been identified as disseminators, 14 (22.58%) actors carry out prevention and health promotion campaigns in the community, 25 (40.325) actors develop implementation projects, 40 actors (64.51%) carry out research, 51 (82.25%) are advocates, 6 actors (9.6%) are health service providers, and 13 actors (21%) are donors.

In 45.70% (n=128) of the actors analyzed, no information was found on their sources of financing. For this reason, the following information will analyze only positive cases. Most of the stakeholders have different sources of funding for their activities, but if we look specifically by type of funding source, we see that 56% (n=72) of the stakeholders receive part of their funding from private donors and 51.50% (n=66) from public funding. On the other hand, funding from international cooperation and international grants finances 39% and 30% of the actors (n=50 and n=39 respectively).

In 55.30% (n=155) of the country stakeholders there is explicit information on their work in alliances or collaborations with other national, regional, and international stakeholders. If we observe actors by sector, in the first place, we find that 71.5% (n=25) of the academic actors surveyed develop alliances with other actors, while 83% (n=5) of the media-opinion leader actors surveyed develop them. Secondly, with respect to the governmental, non-governmental and private actors mapped, we found that nearly half of them work in alliances or collaboration (53% n=18 59% n=93 and 50% n=2 respectively). Thirdly, 25% (n=7) of the social movements and 8% (n=1) of the health service providers engage in partnerships. Finally, we found that 100% of the surveyed religious developed alliances with others from other countries or regions (n=3).

3.3.2.2. Position and Power Analysis

The following is an analysis of the positioning and power of selected countries stakeholders in the topic addressed in this section. Regional stakeholders are not included in this map.

Illustration 2 Stakeholders position and power in gender-based violence prevention, support, and care

(n=280)

POSITION				
	High opposition			
	Medium opposition			
	Low opposition			
	Low support	28	2	2
	Medium support	31	35	8
	High support	69	72	33
		Low	Medium	High
		POWER		

Source: Own elaboration

All the mapped actors support this policy, although their position and power vary in intensity, and in all the prioritized countries we found actors working on the issue. Thus, no opposition actors were identified, nor was there an absence of actors in favor of the policy in the countries analyzed.

Considering stakeholders with high support position and power with respect to the issue, in all countries we find governmental actors and in Argentina, Guatemala, Jamaica, Mexico and Peru we also found non-governmental and/or academic actors with the capacity to intervene.

Finally, the important number of stakeholders with a high position on the issue and medium power is highlighted. Here we find 19 stakeholders in Argentina, 13 in Mexico, 12 in Colombia, 11 in Peru, 7 in Guyana, 5 in Guatemala and 5 in Jamaica. This quadrant of the matrix represents the composition of the public arena and the potential for interventions

Please see complete document for map viewing and detailed analysis.

3.3.3 Gender identity

3.3.3.1 Descriptive analysis

One hundred and eighty-six (186) actors that address gender identity were mapped at the national level in Argentina, Colombia, Guatemala, Guyana, Jamaica, Mexico, and Peru. In addition, we found 37 (out of 99 total) international and regional actors that also address this topic. 24% (n=9) are financing and cooperation agencies and the same amount and percentage applies to non-governmental organizations. International NGOs represent 16% (n=6) and social movements and religious actors represent 14% and 13%, respectively.

One hundred and twenty-five (n=125, 62%) of the national and local actors that work with gender identity have more than 10 years of experience in the field, and 34 (18%) have less than 10 years of experience.

Women (in general) were the most prevalent population targeted by national stakeholders who undertake gender identity policies in their agendas (81%), followed by LGBTQI+ population (75,8%) and adolescents (58,6). The high proportion of LGBTIQ+ population is consistent with the characteristics of the topic in analysis. In addition, 83,7% (n=31) of regional and international stakeholders focus in LGBTIQ+ population, and the same percentage applies for women in general. Lastly, 24% (n=9) of them focus on all of the target populations.

Dissemination is the most frequent activity among the actors at the level country (96%), followed by advocacy activities (77,4%) and research (51%). Besides, 31% of the mapped stakeholders develop these three activities simultaneously. Regarding international actors, 54% of them carry out implementation projects, research, and advocacy simultaneously.

No information about sources of financing was found in 58,6% of stakeholders at national level. Private funding provides financial resources to 61% of the actors mapped giving information. The ranking is followed by public funding (44%), international cooperation (41,6%), and international grants (31%).

Only 50% of stakeholders at the level country offer explicit information about their work in alliances. This is the case for 76% of the academic actors, 52% of non-governmental and 80% of the religious actors.

3.3.3.2. Position and Power Analysis

The following is an analysis of the positioning and power of country stakeholders in gender identity.

Illustration 3 Stakeholders position and power in gender identity

(n=186)

POSITION				
	High opposition	2	2	3
	Medium opposition		2	
	Low opposition			
	Low support	19		
	Medium support	28	20	3
	High support	41	49	15
		Low	Medium	High
		POWER		

Source: Own elaboration

According to the stakeholder mapping analysis in gender identity, the large majority (175 out of 186, which represent 94%) support to this topic, even though there is, as stated previously in Component 1, a lack of an adequate legal framework on gender identity in most of the countries of Latin America and the Caribbean. Of those, 60% (n=105) show high support, 29% (n=51) medium support and 11% (n=19) low support.

Of the stakeholders that show high support, 14% also have high power to influence the agenda of gender identity. 26% (n=4) of them are governmental actors from Argentina, Peru, and Colombia. These are the Ministry of Women, Gender and Diversity from Argentina, two directions that belong to the Ministry of Women and Vulnerable Populations from Peru and the direction of Human Rights from Colombia. On the other hand, CELS (Center for Legal and Social Studies) from Argentina is the only academic actor found that has shown high power and high support. The remaining actors are non-governmental organizations from Peru and Mexico (n=4 in each case) and Argentina and Jamaica (n=1 in each case).

Among the national stakeholders with high support (n=105), 41% (n=44) develop information dissemination, research and advocacy in gender identity simultaneously. Of those with high power, the only governmental actor is the Directorate of Human Rights of Colombia, and the rest are the non-governmental stakeholders Foundation for Studies and Research on Women (FEIM) from Argentina, Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos PROMSEX, Centro de la Mujer Peruana Flora Tristán from Peru, J-Flag/Equality for All Foundation from Jamaica, and Elige Red de Jóvenes por los Derechos Sexuales y Reproductivos, Fundación Unidos por un México Vivo and Balance: promoción para el desarrollo y junventud from Mexico. Also, Center for Legal and Social Studies CELS from Argentina is the only academic stakeholder with high power that works with gender identity. The remaining are mostly non-governmental organizations and social movements with medium and low power.

Lastly, there are 9 actors (4.8%) that show either high or medium opposition to gender identity policies. As for those who show high opposition and high power, we found the social movements

"Con mis hijos no te metas" from Peru and "Frente nacional por la familia" from Mexico, and "Asociación La Familia Importa", a non-governmental actor from Guatemala. In addition, 2 actors from Argentina show high opposition and medium power. Finally, 2 non-governmental actors showed medium opposition and also have medium power.

Please see complete document for map viewing and detailed analysis.

3.3.4 Family planning and Contraception

3.3.4.1 Descriptive analysis

One hundred and fifty-four (154) actors that address family planning and contraception were mapped at the national level in Argentina, Colombia, Guatemala, Guyana, Jamaica, Mexico, and Peru. In addition, we found 49 (out of 99 total) international and regional actors that also address this topic.

Among the 443 stakeholders mapped at the national and local levels, 34,8% (n=154) of them address family planning and contraception in their agendas in Argentina (n=47; 30%), Mexico (n=33; 21,4%), Peru (n=27; 17,5%), Colombia (n=20; 13%), Guyana (n=13; 8,4%), Guatemala (n=9; 6%) and Jamaica (n=5; 3,2%). Non-governmental actors predominate among the mapped stakeholders, with 52% (n=80), while governmental and academic actors represent 13% each (n=20 in each case).

Regarding LAC, 49% (n=49) of the 99 actors mapped develop actions related to family planning in the region. 31% are international NGO's, 23% (n=11) are financing and cooperation agencies, 16% (n=8) are religious actors, 10% (n=5) are non-governmental organizations and the same amount and percentage applies to social movements.

The stakeholder's map shows that women (in general) were the most prevalent population targeted by national stakeholders who undertake family planning and contraception policies in their agendas (93,5%), followed by adolescent girls (75,3%), LGBTQI+ population (53,8%) and indigenous populations (37,6%).

Dissemination is the most frequent activity among the actors at the level country (94,8%), followed by advocacy activities (74,6%), community prevention and health promotion campaigns (57%) and research (55,8%). Regarding international actors (n=49), 100% of them carry out dissemination activities, 87,8% advocacy, 61,2% develop research activities and 42,8% implement projects.

No information about sources of financing was found in 49,3% of stakeholders at national level that address family planning and contraception. Private funding provides financial resources to 57,7% of actors mapped giving information. The ranking is followed by public funding (56,4%), international cooperation (33,3%), and international grants (25,6%).

Only 50,6% of stakeholders at the level country offer explicit information about their work in alliances with national, regional, or international organizations. This is the case for 60% of the religious actors, 57,5% of non-governmental organizations and 50% of the academic and government actors, in each case.

3.3.4.2. Position and Power Analysis

The following is an analysis of the positioning and power of country stakeholders in family planning and contraception.

Illustration 4 Stakeholders position and power in family planning and contraception (n=154)

POSITION				
	High opposition	1		3
	Medium opposition	1	2	
	Low opposition	1		
	Low support	12	3	1
	Medium support	19	14	6
	High support	25	42	24
		Low	Medium	High
		POWER		

Source: Own elaboration

According to the stakeholder mapping analysis in family planning and contraception, it is important to note that the large majority (146 out of 154, which represent 94,8%) show support to this topic. Of those, 62% (n=91) show high support, 26,7% (n=39) medium support and 11% (n=16) low support.

24 stakeholders have shown high support and have high power. 54% (n=13) are non-governmental organizations, 37,5% (n=9) are government agencies and 12n5% (n=3) are academic actors that have the position and the power to influence the political agenda around this topic to drive change. The non-governmental organizations are Foundation for Studies and Research on Women (FEIM) from Argentina; PROMSEX - Center for the Promotion and Defense of Sexual and Reproductive Rights, Peruvian Women's Center Flora Tristan, DEMUS: Estudio para la Defensa de los Derechos de la Mujer, Movimiento Manuela Ramos, APROPO – Apoyo a Programas de Población and Catholics for the Right to Choose from Peru; the organizations Equidad de Género, Ciudadanía, Trabajo y Familia (Equidad), Fundación Mexicana para la Planeación Familiar (MEXFAM), Elige, Red de Jóvenes por los Derechos Sexuales y Reproductivos, Fundación Unidos por un Mexico Vivo, Comité promotor por una maternidad segura en México and Balance promoción para el desarrollo y juventud, all of them from Mexico.

As for the governmental agencies with high support and high power, these are the Ministries of Health and Social Development from Argentina; the Ministry of Health of Peru; the Ministry of Health and Wellness and the National Family Planning Board of Jamaica; the Center of Education and Prevention of HIV/AIDS (CEPVIDA), the National Center of Gender Equity and Reproductive Health, and the National Women's Institute of Mexico. Lastly, the academic stakeholders are Sociedad Peruana de Ginecología y Obstetricia, Ana Cristina González Velez from Peru and the National Public Health Institute (INSP) of Mexico.

When looking at those actors who show medium support to family planning and contraception, we found that 15% (n=6) of them have also high power, and for that reason are capable to promote advances in policies around this topic. These are 5 government agencies: The Women and Gender Equality Commission and the Ministry of Health from Guyana, the Guatemalan

Institute for Social Security (IGSS), the Presidential Council for Women Equity and the Ministry of Health of Colombia, and finally, the Autonomous University of Mexico that is an academic stakeholder.

Lastly, 8 actors, who represent 5% of the total of the stakeholders mapped, show either high, medium, or low opposition to family planning and contraception, with different levels of power. As for those who show high opposition and high power, we found the social movement “Con mis hijos no te metas” and the religious organization “Alas sin Componenda” from Peru and the non-governmental organization “Frente nacional por la familia” from Mexico. In addition, the only actor that shows high opposition but low power is the non-governmental organization from Mexico, “Salva una Vida”.

Please see complete document for map viewing and detailed analysis.

3.3.5. Comprehensive Sexuality Education

3.3.5.1 Descriptive analysis

We mapped 238 actors at the national and local levels in Argentina, Colombia, Guatemala, Guyana, Jamaica, Mexico and Peru and 41 international and regional actors that address comprehensive sexuality education policies in the countries of interest. At the country level, we found greater presence of non-governmental actors, follow by academic actors.

72% (n=171) of the national and local actors have more than 10 years of experience working on comprehensive sexuality education. If we look at the international and regional actors working on the policy of interest, 34% (n=34) have more than 10 years of experience.

At the country level, most of the actors mapped belong to the non-governmental sector, representing 56% (n=134), while academic actors represent 15% (n=35).

It is important to mention that for more than half of the actors surveyed, we did not find any information about their sources of funding, representing 58% (n=137).

The stakeholder’s map shows that women (in general) were the most prevalent population targeted by national stakeholders who undertake comprehensive sexuality education in their agendas, followed by adolescents and LGBTQI+.

Most of them carry out information dissemination, perform advocacy activities, do research -although they are not necessarily categorized as academic actors-, develop community prevention and health promotion campaigns. To a lesser extent, we found actors that provide health services. At last, we found few actors that are donors.

Regarding stakeholder’s alliances, we observe that more than half of the actors surveyed are explicit about their work in alliances or collaborations with other national, regional and/or international actors. Observing actors by sector, 60% (n=73) of the non-governmental actors have alliances. In all the prioritized countries there are actors that work with organizations such as, UNFPA, WHO, USAID, UNICEF UNAIDS, Open Society Foundation, UNDP, CLACAI, SIDA, UNWOMEN, OAS, RedLac and The Global Fund, among others.

3.2.5.2. Position and Power Analysis

The following figure summarizes the power and position of all the actors that addressed comprehensive sexuality education on their agendas.

Illustration 5 Stakeholders position and power in comprehensive sexuality education (n=238)

POSITION	Low	Medium	High
High opposition			3
Medium opposition	3	3	
Low opposition			
Low support	29	3	
Medium support	32	38	10
High support	38	57	22
	POWER		

Source: Own elaboration

Among the 443 stakeholders mapped at the national and local levels, 54% (n=238) of them address comprehensive sexuality education in their agendas. In Argentina (n=61; 26%), Colombia (n=47; 20%), Guatemala (n=10; 4%), Guyana (n=10; 4%), Jamaica (n=5; 2%), Mexico (n=63; 26%), and Peru (n=42; 18%). Non-governmental actors predominate among the mapped stakeholders, with 56% (n=134), while academic and governmental actors represent 15% and 8% respectively (n=35 and n=20).

Of the 238 stakeholders mapped, we found that in terms of percentage, the highest concentration is between high and medium support for these policies, representing 49% and 34% respectively. With a lower percentage, in third place are the actors that have low support (13%).

In relation to those with high support, we found that 22 actors have high power, 57 medium power and 38 low power. The actors that have high power and high support come from Mexico, Peru, and Argentina. Regarding the stakeholders who oppose these policies, we identified 3 actors (from Peru and Mexico). These actors belong to the religious sector or are social movements with strong religious influence. Through their websites or social pages, we found that they agree and sustain that the parents have the primary and inalienable right to educate their children in accordance with their moral and religious convictions.

Please see complete document for map viewing and detailed analysis.

3.3.6. Safe abortion; post-abortion care

3.3.6.1 Descriptive analysis

We mapped 128 actors at the national and local levels in Argentina, Colombia, Guatemala, Guyana, Jamaica, Mexico, and Peru and 51 international and regional actors that address safe abortion, post-abortion care policies in the countries of interest. At the country level, we found greater presence of non-governmental actors, follow by academic actors and social movement/interest groups.

Sixty-six (66% n=85) of the national and local actors have more than 10 years of experience working on safe abortion, post-abortion care. If we look at the international and regional actors working on the policy of interest, 88% (n=45) have more than 10 years of experience.

The stakeholder's map shows that women (in general) were the most prevalent population targeted by national stakeholders who undertake safe abortion, post-abortion care in their agendas, followed by adolescents and LGBTQI+.

It is important to mention that for more than half of the actors mapped, we did not find any information about their sources of funding, representing 59% (N=75).

Most of them carry out information dissemination, perform advocacy activities or do research, although they are not necessarily categorized as academic actors. To a lesser extent, we found actors that develop community prevention and health promotion campaigns, implement projects, and provide health services. At last, we found few actors that are donors.

Regarding stakeholder's alliances, we observe that half of the actors surveyed are explicit about their work in alliances or collaborations with other national, regional and/or international actors.

3.3.6.2. Position and Power Analysis

The following figure summarizes the power and position of all the actors that addressed safe abortion, post-abortion care, on their agendas.

Illustration 6 Stakeholders position and power in safe abortion, post-abortion care (n=128)

POSITION	Low	Medium	High
High opposition	5	8	4
Medium opposition			
Low opposition			
Low support	5	1	2
Medium support	10	10	5
High support	28	30	20

POWER

Source: Own elaboration

Of the 128 stakeholders mapped, we found that in terms of percentage, the highest concentration of actors can be observed in those who have high support for these policies, representing 61% (n=78). In second place are the actors who have medium support with 20% (n=25) and in third place are the actors that have high opposition with 13% (n=17).

The actors that have high power and high support come from Argentina, Mexico, Peru, and Colombia, while in Guyana and Jamaica we found actors with low support. In Guatemala there is more diversity but those with high power have low support or high opposition for these policies.

We found that some of these actors who oppose belong to religious sectors or are social movements with strong religious influence.

Please see complete document for map viewing and detailed analysis.

3.3.7. Prevention and control of HIV and other sexually transmitted infections

3.3.7.1 Descriptive analysis

209 stakeholders working on HIV and other STIs prevention and control were mapped at a country and regional and in our research. Among them, 51 stakeholders develop their work at a regional level and 158 at a country level[1]. The present section will focus on stakeholders at a country level. Most of the actors working at a country level (83.5%, n=132) have more than ten years of experience in HIV and other STIs prevention and control. 28.5% develop their activities in Mexico (n=45), 25.3% (n=40) in Argentina, 12% (n=19) in Colombia, 11.4% (n=18) in Peru, 10.7% (n=17) in Guyana, 6.32% (10) in Jamaica, and 5.7% (9) in Guatemala. Most stakeholders (64.5% n=102**)** at the country level were from the non-governmental sector. Academic (n=16 10.1%) and governmental (n=15 9.4%) actors account for our sample's second and third most represented sectors in HIV and other STIs prevention and control.

Regarding the regional actors (n=51), we observed that 31% (n=16) work on HIV and other STIs prevention. 29% are financing and cooperation agencies (n=15), 16% are non-governmental actors (n=8), followed by academic, religious, and government stakeholders with 3% of the share each (n=6, n=6, and n=6 respectively). Finally, we found only one media-opinion leader (2%) among the regional actors working in this field.

Most of the stakeholders (82.3%, n=130) work with women (in general), except for 15 organizations (9.5%) who explicitly state that they work only with adolescents or LGTBIQ+ populations (Guyana Trans United[344], United Brick Layers[345], Asociación de Travestis, Transexuales y Transgénero de Argentina[133], Sociedad Argentina de Pediatría (SAP)[205], Capicúa[137], Infancias Libres[211], Red de interesex, travestis y transexuales de Argentina (RITTA)[195], Trans Argentinxs, Red Argentina de Jóvenes y Adolescentes Positivos (RAJAP)[193], Red Nacional de Jóvenes y Adolescentes para la salud sexual y reproductiva (REDNAC)[198], J-FLAG/Equality for All Foundation[646], Asociación LAMBDA[309], GOJoven Guatemala[332], Confederación Mexicana de Organizaciones en favor de la Persona con Discapacidad Intelectual (CONFE)[394], Centro de Apoyo a las Identidades Trans[428].

89% of the stakeholders assessed at a country level (n=141) develop dissemination activities. The most frequent means employed are websites, social media, webinars, and events. Advocacy activities are also developed by 70.9% of the actors evaluated (n=112). It is remarkable that even though most of the actors are non-governmental organizations, they are involved in research activities 45.5% (n=72). In the countries prioritized, 39.9% of the actors evaluated provide health services (n=63), and 44.9% develop implementation projects. Finally, only 6.32% of stakeholders (n=10) can provide funding to other organizations.

Information concerning funding was not available for all the actors assessed. There was no information available for 47.5% of the stakeholders evaluated (n=75). Most of these actors are non-governmental organizations and social movements (n=56 69%). Among those whose financial information is available, 50 actors (61.7%) receive funding from private donors (i.e., the option to "donate" can be found on their websites); public financing is declared by 38 (47%), and 33 (40.7%) stakeholders receive funds from international cooperation. Finally, 24 organizations have international grants. Twenty-six actors (32%) present other funding sources. There was scarce data to analyze the proportion of funding each source represents for each organization.

We have identified actors working in alliance with established organizations working on this topic. There are international financing and technical cooperation agencies that are the most frequent organizations working mainly with non-governmental organizations such as UNFPA[385],

PAHO/WHO[366], UNESCO[336], USAID[695], UNICEF[386], Global Fund[42], PEPFAR, International AIDS Society[724], Red Latinoamericana y del Caribe de Personas Trans (RedLacTrans)[79], Red Latinoamericana y del Caribe de Jóvenes que viven con VIH (J+LAC)[682]; Amnesty International[17], CLACAI[35], Caribbean Family Planning Affiliation[725], and UNDP[697]. In the HIV and other STIs prevention and control field, it is also important to highlight that most international financing and technical cooperation agencies, such as World Bank[21], Inter-American Development Bank[671], and PAHO/WHO[366], work directly in partnership with the States; therefore, with governmental stakeholders.

3.2.7.2. Position and Power Analysis

Position and power: We analyzed the positioning and power of the stakeholders that develop activities related to HIV and other STIs prevention and control.

***Illustration 7* Stakeholders position and power in Prevention and control of HIV and other sexually transmitted infections**

(n=158)

POSITION	Low	Medium	High
High opposition			
Medium opposition			1
Low opposition	1		
Low support	16	1	
Medium support	31	16	5
High support	21	46	20

POWER

Source: Own elaboration

Our search identified stakeholders 80 stakeholders (51.28%) that strongly support the agenda of prevention and control of HIV and other STIs. Among them, twenty also have high power (Ministry of Health of Guyana, Fundación Huésped, Argentinian Society of Infectology, Fundación para Estudio e Investigación de la Mujer (FEIM), Argentinian Ministry of Health, Argentine Ministry for Social Development, Dirección Ejecutiva de Salud Sexual y Reproductiva - Dirección General de Intervenciones Estratégicas en Salud Pública (DGIESP), Dirección Ejecutiva de Prevención y Control de VIH-SIDA, Enfermedades de Transmisión Sexual y Hepatitis Peru Ministry of Health, Sociedad Peruana de Ginecología y Obstetricia, Amnesty International Perú, MOHW, Ministry of Health and Wellness, NFPB, National Family Planning Board, Ministry of Health and Social Protection, Colombian League Fighting against, Clínica Condesa Iztapalapac, Centro de Educación y Prevención del VIH/SIDA (CEPVIDA), National Council for the prevention and control of AIDS (Conasida), Fundación Unidos Por Un México Vivo, National Center for Prevention and Control of HIV AIDS (CENSIDA), Eve For Life). 60% of these actors are governmental organizations, followed by non-governmental organizations (25%). 100% of these

organizations carry out dissemination activities, 95% community prevention and health promotion campaigns and 75% research activities. Only 15% (n=3) of them provide funding to other organizations working in the field.

On the other side of the spectrum, two stakeholders (1.2%) present medium and low opposition to HIV and other STIs prevention and control topics. Familias del Mundo Unidas por la Paz (FAMPAZ), a religious organization from Argentina promoting family values and advocating against abortion, presents low opposition and low power, and Inter-Religious Organization of Guyana, a non-governmental organization with medium opposition and high power, no further information regarding their mission was available.

Please see complete document for map viewing and detailed analysis.

3.3.8. Cancer of reproductive system

3.3.8.1 Descriptive analysis

90 Stakeholders address cancer of reproductive system in their agendas at a national level: in Argentina (n=16; 18%), Colombia (n=13; 14%), Guatemala (n=5; 6%), Guyana (n=7; 8%), Jamaica (n=4; 4%), Mexico (n=33; 37%), and Peru (n=12; 13%). Regarding LAC, 16% (n=16) of the 99 stakeholders mapped develop actions related to reproductive cancer system in the region

The stakeholder's map shows that women (in general) were the most prevalent population targeted by national stakeholders who undertake cancer of the reproductive system in their agendas (94%), followed by adolescent girls (46%). Compared with other services evaluated in this study, the higher proportion of elderly people and persons with disabilities in this section of cancer must be highlighted and it may be interesting to go in depth to explore this gap. 38% of regional and international stakeholders focus simultaneously on all the populations of interest for this study.

Dissemination is the most frequent activity among the actors at the level country (90%), followed by community prevention and health campaigns, research, and health services provision. 20% of stakeholders mapped carry out implementation, research, and advocacy simultaneously. Regarding international actors, 41% of them carry out implementation projects, research, and advocacy simultaneously.

No information about on sources of financing was found in 16% of stakeholders at national level. Private funding provides financial resources to 54% of actors mapped giving information. The ranking is followed by governmental, international cooperation, and international grants.

Only 42% (n=38) of stakeholders mapped at the level country offer explicit information about their work in alliances or collaborations with other national, regional, or international stakeholders. Non-governmental organizations represent 50% (n=19) of these actors (n=38), followed by governmental and academic sectors (21%, n=8, and 10%, n=4, respectively).

On the other hand, 67% (n=8) of the total government stakeholders (n=12), and 39% (n=19) of the total non-governmental organizations (n=49), explicitly constitute networks with other international or national actors. Among the 4 stakeholders from private sector, 50% of them (n=2) build alliances, while the total academic sector (n=12) and health service providers (n=9) engage in partnership with other national or international actors in 33% (n=4; n=3, respectively).

3.2.8.2. Position and Power Analysis

The following is an analysis of the positioning and power of selected countries stakeholders in the issue addressed in this section. No regional stakeholders are included in this map.

Illustration 8 Stakeholders position and power in cancer of the reproductive system (n=90)

Source: Own elaboration

According to the stakeholder's map in cancer of the reproductive system (n=90), 100% of actors at the level country support this policy, although their position and power vary in intensity. The active support given to the topic among must be underlined, since 43% (n=39) of stakeholders show high support, and 39% (n=35) of them were classified as medium-support actors.

Stakeholders giving strong support to this issue classified as high power represent 10% (n=9) of the total mapped. Among them, 67% (n=6) are governmental organizations, mainly Ministries of Health (n=3). These actors belong to Guyana (n=2), Argentina (n=1)[183], Jamaica (n=1), México (n=1) and Perú (n=1) . The only one academic institution in this quadrant of the matrix is the Peruvian Society of Gynecology and Obstetrics, while League Against Cancer Peru, and the Medical Society of Oncology of Mexico are non-governmental organizations.

Among national stakeholders with high support (n=39), 33% of them (n=13) develop implementation, research, and advocacy on reproductive cancer simultaneously. In this group, National Ministry of Health (Argentina), and Ministry of Health and Wellness (Jamaica) show high power, while 9 are medium-power actors. These include the National Coordinating Coalition (Guyana), La Casa del Encuentro (Argentina), Grupo FUSA(Argentina), Chicas poderosas argentinas (Argentina), Instituto Peruano de Paternidad Responsable (INPPARES Peru), Red Nacional de Promoción de la Mujer (Perú), Centro IDEAS (Perú), Ana Cristina Gonzalez Velez (Colombia), National Institute of Cancer (Colombia). It must be also highlighted that all of these actors, with the exception of the National Institute of Cancer (Colombia), address most of the topics related to SRMHR and many of the targeted populations studied in this report.

Please see complete document for map viewing and detailed analysis.

3.4. Challenges and barriers, from a regional perspective

From the semi-structures interviews conducted with regional stakeholders we identified the main challenges and barriers to advance in the agenda of sexual, reproductive, and maternal health rights and effective access to health services for the most vulnerable populations in Latin America and the Caribbean.

Regional agencies have challenges in prioritizing funding for the region. The reduction of government and international donors' funds for international agencies was critical; especially affecting efforts in middle-income countries not considered as priority countries. Sexual and reproductive health was overshadowed by other health priorities, such as the migration crises in the region or the global health emergency caused by the COVID-19 pandemic; it was also affected by the withdrawal of funding to UN agencies by some countries.

In some countries, establishing and sustaining agency agendas is hindered by governments that are reluctant to advance legislation and implementation of sexual and reproductive health policies in some socially divisive rights such as the legal status of abortion, access to emergency contraception, comprehensive sexuality education from a gender perspective, policies focused on the LGTBIQ+ population such as the legalization of marriage or same-sex unions, and recognition of gender identity in the transgender population. The alternation in government also makes continuity difficult or generates setbacks in improvements. On the other hand, there is also strong opposition from some organized civil society groups. To overcome this resistance, agencies must look for "entry points" to move forward on the most controversial issues.

There are challenges related to policy implementation within many countries. In countries with federal governments, deep gaps can be identified among regions as for example in the implementation of comprehensive sexuality education among districts or provinces.

There are gaps in the generation of policies based on local evidence due to the absence of good quality data, which especially impacts on the generation of policies that benefit the most vulnerable groups such as indigenous or afro-descendant populations among others. While progress is noted in this area, there are gaps in the generation of effective policies to eradicate gender-based violence such as school retention to prevent early marriages. Regional agencies should focus on finding customized solutions adapted to local reality.

Despite some progress in legislation, most countries lack of adequate and sustained funding for policy implementation. There is a lack of human and material resources allocation planning as for example for some countries that have comprehensive sexuality education programs. Gaps between legislation and effective access to SRMHR services include, among others, the limited access to contraceptive methods in some groups (e.g., adolescents); lack of access to emergency contraception (due to lack of supplies or reluctance of professionals to provide it even in cases of sexual violence); lack of access to treatments for transgender population; among other.

At the level of health services, there are also a lack of resources to ensure access to SRMH policies. The lack of free contraceptives in many services means that people have to pay out of pocket, leaving the most disadvantaged groups out of access; another gap in some services is the lack of drugs for post-abortion care. In the context of the health emergency caused by the COVID-19 pandemic, access barriers increased due to supply shortages.

The low quality of SRMHR services provision is also related to the lack of trained human resources specifically in post abortion care services, for instance. It should be noted that, in some countries, healthcare services were not hiring existing competitive personnel for key positions in

SRMHR services or were not authorized to do so. For example, midwives with significant potential for care of contraceptive demands (such as placing intrauterine devices or performing post abortion care) do not perform these tasks in health services.

Some professionals are refusing to perform some recommended practices, such as the insertion of intrauterine devices in adolescents (practice supported by scientific evidence). Regarding safe abortion care in health facilities, another barrier for the service provision is related to predominant restrictive interpretations of the legislation among health personnel.

The region faces major challenges in the generation of good quality data. 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. 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. The inadequacy of some indicators to measure access to SRMHR services include prevalence of accessing to family planning or contraceptive methods use or indicators to measure gender-based violence.

Moreover, the limited generation of evidence in some countries leads to the use of data from more developed countries to set priorities that have little to do with local settings and especially with vulnerable groups such as rural or indigenous people. Information gaps include data related to prenatal care (for example vertical transmission of congenital syphilis); abortion (for example clandestine and unsafe abortions in countries that penalize the practice, unmet demand, access drugs and abortion recidivism); and gender-based violence (for example, evidence about the effectiveness of actions to reduce it).

There is collaboration and competition among regional stakeholders. 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. In particular, regarding advocacy, monitoring, research and access improvement to health services.

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. Among the alliances between regional and local organizations, tangible initiatives to advance advocacy and the definition of policies stand out.

4. Conclusions

The present report is the second component of the Scoping Study on Sexual, Reproductive and Maternal Health (SRMH) in Latin America and the Caribbean. We have identified and mapped the main stakeholders related to sexual, reproductive, and maternal health and rights agenda in LAC and prioritized countries (Colombia, Peru, Mexico, Guatemala, Jamaica, and Guyana). Argentina has been incorporated for this component, given the importance of its legal framework and its public policies on these issues, which are taken as an example and model by other countries in the region, as indicated by the results obtained in the review made in the first component.

Our analysis focused on the main actions developed by these stakeholders, their priorities in the SRMH agenda, their target population, sources of funding, alliances and their positioning and level of influence on the following policies: antenatal, intrapartum, and postnatal care; gender-based violence prevention, support, and care; gender identity; family planning/contraception; comprehensive sexuality education; safe abortion; post-abortion care; prevention and control of HIV and other sexually transmitted infections and cancer of reproductive system.

This section is organized in 3 axes, which encompass the questions that inspired this component:

1) Key stakeholders that move forward the SRMH agenda in LAC

At the regional level, there are many actors working to achieve effective access to maternal, sexual, and reproductive health and rights. Mexico and Colombia are the countries with the greatest presence of these regional actors, 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 then, religious organizations (10% n=99). Strictly academic institutions at the 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, PAHO, WHO) and Banks (IADB, World Bank), seem to have the greatest impact at the regional level. There are also some non-governmental organizations with an international scope located at that level (high power and high support), as Planned Parenthood Global or ILGA LAC (Asociación Internacional de Lesbianas, Gays, Bisexuales, Trans e Intersex). It is precisely this sector that encompasses the financial and technical capacities to carry forward the SRMH rights agenda. However, they need to build alliances with countries through their governments or with civil society organizations that advocate for rights at the local level. In other words, high technical and high financial capacity organizations build alliances with social organizations, which in turn build regional alliances through networks, federations, and consortiums. Of course, the situation is not the same for each of the policies analyzed.

Some other interesting questions to analyze are related to the internal agenda of the technical cooperation agencies and the mandate of the authority in charge, who can be more in favor or against a SRMH rights agenda or make it explicit.

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.

On the other hand, if we analyze the prioritized countries, we see those governmental institutions, together with some civil society organizations, are the ones that most promote SRMH rights agenda, in some cases with the greater incidence of regional or international organizations already mentioned. Clearly, the governmental structures are the ones who 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, or in an adoption stage in the legislature, or even if it is in the stage of execution after the policy has been officially adopted by the government. Depending in which stage is situated, there is greater involvement of civil organizations to put an issue on 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 find: 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.

The situation of the last two policies (cancer and antenatal, intrapartum, and postnatal care) may be related to one of the limitations of the study regarding the selection of stakeholders. These are policies that, in general, are in the phases of formulation, adoption or implementation by governments, where the main agents responsible are the health providers, which were not surveyed by this study. On the other hand, in the other selected policies, especially those of the first group (prevention of gender-based violence, comprehensive sexual education and prevention and control of HIV and other sexually transmitted infection), their level of development in several countries has not reached the stage of effective implementation, or if it does, it is still far from guaranteeing the rights promoted by the regulations. As it was mentioned in the Scoping Review we can notice the progress made by Latin-American countries in complying with the Montevideo Consensus and the international recommendations. However, the legal framework and policies on sexual, reproductive, and maternal health and rights stand out heterogeneity and lack of update. In addition, disparities increase when considering the effective implementation for vulnerable groups. Central America and the Caribbean is the region with the greatest gaps in policy design, adoption and implementation.

2) Research evidence on SRMH in the LAC region

A first point to consider is that only 23 stakeholders (including regional and national stakeholders) were categorized as strictly belonging to the academic sector having a research agenda related to the SRMH rights and policies. This represents only 4% of the universe of mapped stakeholders. In general, these are universities, study centers or research institutes. These include, at the regional level, IDRC[107],Guttmacher Institute[49], Institute for Gender and Development Studies Mona Unit (IGDS)[53], among others.

At first glance, this data might suggest a lack of interest in public health research, specifically on sexual, reproductive, and maternal health and rights issues. However, when we analyzed the number of stakeholders whose activities included some type of research, we observed that this percentage rised to 50% (n=269). In other words, civil society organizations, technical cooperation and funding agencies, and even governmental institutions carry out actions to better understand the situation in their countries in terms of SRMH. Of course, it is not possible to conclude on the quality or type of research they develop.

It is interesting to note that, 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.

Although it was not possible to identify information gaps in the mapping of the 542 stakeholders, some interesting perspectives were obtained from the stakeholders interviewed.

They identified some challenges in the generation and quality of data and available evidence:

*Difficulties in producing quality data***.** The limited production of SRMH data in the region and the lack of reliable information to measure indicators in SRMH.

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, even in prioritized topics such as adolescent pregnancy prevention.

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.

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 accessing 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 SRMH, in relation to prenatal care, they mentioned difficulties to access data on vertical transmission of congenital syphilis, for example. Regarding abortion, they mentioned the 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. Regarding gender-based violence, they mentioned the lack of evidence about the effectiveness of actions to reduce it.

3) Opportunities to expand the research agenda and information access on SRMH

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 base their SRMH 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.

Thus, 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 policies (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. But there always must be a political decision that supports it.

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.