Strategy 2028

Member Association Consultations

2021

Prepared by

A.I.S.E. Consulting and IPPF SRT

CONTENTS

List of abbreviations 4

Executive Summary 5

Methodology 5

Key findings 6

MA Context 6

MA Horizon 8

Federation 10

Recommendations 13

MA Consultations Analysis Report 14

Background and Scope 14

Methodology 14

Section 1: MA VOICES 16

MA Consultation process 16

Section 2: MA CONTEXT 17

Current Gaps in Services 17

Current Service Barriers 23

CSO Strategies 32

MA Contributions 35

Section 3: MA HORIZON 39

Advocacy Issues 39

Advocacy Strategies 45

Future Clients 50

Service Needs 52

Service Access 54

MA Funding 56

Funding Sources 56

Funding challenges 58

Funding opportunities 62

MA Structure 65

Structural changes 65

Governance changes 68

Section 4: FEDERATION 69

Global SRHR horizon 69

Moving Beyond Cairo 73
SRHR innovations 75
Strategy Core values 76
Secretariat Support 77
MA Support needs 77
Federation Changes 78
Board & Committees Changes 80
MA Centricity 81
Section 5: OTHER RECOMMENDATIONS........ 84
APPENDIX 87
Table 1: National Consultative process........ 87
Table 2: Summary of key findings by IPPF MA region 95
REFERENCE 114

List of abbreviations

ASRH	Adolescent sexual and reproductive health
COVID-19	Coronavirus
CSO	Civil Society organisations
CSE	Comprehensive sexuality education
FP	Family planning
GBV	Gender-based violence
ICPD	International Conference on Population and Development
MAs	Member Associations
SE	Sexuality education
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
WHO	World Health Organization

Executive Summary

With less than two years remaining in its current strategic period, IPPF is developing its next strategic framework spanning the period 2023-28. This report presents the findings from the qualitative analysis of the current national and global SRHR gaps experienced by Member Associations (MAs) and factors influencing current and future SRHR programming which will inform IPPF's upcoming 2023-28 strategic framework development process.

Methodology

A five (5) phased approach is utilized by IPPF in the design of their 2023-2028 strategic framework. As part of a pool of activities in the second phase of the strategic design, the MAs were engaged in a consultative process to solicit their views and experiences and ensure that their voices informed the strategic review process.

The MA consultation process was undertaken as one of five key activities at four levels of strategic input of the second phase of the review process. It focused on exploring the current national SRHR contexts in the various MAs gaps and current strategies utilized to address these gaps and elucidating MA's perspectives on their future activities including clients, client service needs, priorities and structures advocacy, and funding / sustainability as well as opportunities for improving the Federation, including the role of the Secretariat.

All IPPF MAs were invited to participant in the qualitative study using a pre-designed opened-ended questionnaire (subsequently referred as MA form in this report). Seventy-five (75) MA forms were completed and returned for coding and data analysis. A deductive thematic approach was applied to data analysis using a predesigned codebook. During initial coding using QRS NVivo qualitative software, open-ended inductive approaches enabled the identification of emerging themes and codes which were used to revise the codebook. MA forms were coded in constant comparison using the revised codebook and patterns and linkages between quotes, codes and themes were explored for contextual relevance, convergence, and divergence. Incomplete transcripts were also returned for participant checking and clarification prior to inclusion. Four experienced qualitative researchers coded all transcripts while the lead researcher coded a sample of 20 transcripts for quality control and validation. In general, the terms "majority", "some" and "few" imply more than half, about half and less than a half respectively

Key findings

Key findings of the qualitative MA consultation process are summarized for this executive summary using a section-by-section list of consultation findings following the format of the MA questionnaire form. Detailed findings including supporting quotations are presented in subsequent pages of the report. Figure 1 presents a word cloud of the most frequent words used in the consultations.

Figure 1: Project word cloud of 100 most frequent words

MA Context

In answer to the sections of the questionnaire, the MAs started by outlining the existing SRHR gaps in their national context. Many to most MAs spoke about CSE: poor or no integration of comprehensive sexual education (CSE) in the education sector (school) curriculum; lack of legal frameworks to guide development and integration of CSE into the education sector; limited access to SRHR information and services and inadequate SRHR resource mobilization and poor utilization of SRHR products (e.g. family

planning contraceptive products/ abortion care services). CSSE was mainly mentioned in Africa, Arab world, South Asian and Americas and the Caribbean regions. CSE needs and challenges vary by region, ranging from inadequate or no availability of CSE services in the African, Arab, and South Asian regions to varied quality of CSE services on the quality-of-service continuum and limited integration in the European network and Americas and the Caribbean regions.

Limited access to family planning (FP) /contraception, abortion care and gender-based violence (GBV) services were commonly reported in and across all regions. Inadequate SRHR resources and products such as contraceptives and screening equipment and inadequate SRH capacity among health service professionals further hinders the provision of quality SRH services particularly in the African, Arab, South Asian and Americas and the Caribbean regions.

Barriers

The MAs listed many legislative, political, socio-cultural, religious, economic, and structural barriers. Legally, poor implementation of national SRHR legislation, restrictive laws on access to SRHR information and services such as abortion, CSE and poor population-level awareness of SRHR legislation, particularly for abortion care, impedes effective access to SRHR information and service in countries across all regions. Even in countries with liberal abortion laws, access to safe/comprehensive abortion care services are still hampered by health professionals' refusal to provide abortion services because of personal/cultural/ religious beliefs (conscientious objection practices).

In addition, persisting socio-cultural and religious traditions and norms prevent access to SRHR for all. particularly vulnerable or marginalized populations such as women and adolescents in countries with strong traditional and patriarchal or religious societies. Furthermore, security and humanitarian crises in several low- and middle-income countries (LMICS) across several regions also constitute barriers to the delivery of and access to SRHR information and services. The lack of a multisectoral approach to SRHR programing was also highlighted as a key factor hampering efforts to effectively address gaps and barriers to SRHR interventions, policies, and programs in several countries.

CSO Strategies

MAs reported that various CSO strategies used to address national policy and effective SRHR programing. MAs have contributed to these strategies by providing vocational skills training for women and young girls; SRHR training of health service providers; provision of SRH services using multiple channels such as mobile clinics, fixed, community and franchise service delivery to improve availability and access to SRHR

services and information; and facilitated public-private partnerships to deliver affordable and quality SRHR information and services.

Advocacy was a key strategy to address barriers to SRHR programing. Both traditional media (television, radio, community public address platforms), social and electronic media platforms (Facebook, twitter etc.) have been reportedly leveraged on to promote and sensitize the public, particularly, adolescents and young people on SRHR issues such as contraceptive products, legislation governing access to abortion care services, GBV services etc.

MAs reported that they collaborate and network among themselves and with CSOs to collectively advocate for specific issues such as increased budgetary allocation for SRHR, lobby to improve legislation governing SRHR issues or stimulate public interest and support for SRHR programs.

MA Horizon

In this section, the MAs described their horizon in terms of important issues, focus areas, demographics shifts and changes to their operating model.

Future Advocacy

With regard to the legal and policy context, MAs reported that their advocacy focus over the next decade will be on vulnerable and hard to reach populations; progressive law reform; comprehensive sexuality education (CSE); access to safe abortion care; increased access to SHRH information and products; gender equality; involvement of men in promotion contraceptive uptake; child marriage; sexual and gender-based violence; and violence against children.

Analyzed across regions, the MAs reported the following:

- Development and/or implementation of national SRHR policy (mostly for MAs in the African region)
- SRHR service delivery and access for displaced populations or rights of minority groups such as LGBTQ and transgender (mostly in the European Network region)
- Adolescent sexual and reproductive health (ASRH) (mostly in the America and the Caribbean and Africa regions)
- Integration of CSE into the education curriculum (mostly in the America and the Caribbean and Africa regions

- ❖ Access to family planning/contraceptives (mostly in the Africa, South Asia, America and the Caribbean)
- ❖ Access to safe abortion service including repeal/review of restrictive abortion laws (mostly in the African, Arab, America and the Caribbean, East and Southeast Asia and Oceania regions)

Future Clients

MAs detailed that future client would include the general population, with a focus on women, girls, children, and minors; elderly populations; adolescents and young people; victims of SGBV; rural, and poor communities; marginalized populations (sex workers, LGBTQ, undocumented migrants, and transgender); indigenous people and ethnic minority groups; professionals; persons in prison. Particularly for the European MAs marginalized populations (sex workers, LGBTQ, undocumented migrants, and transgender) are a key priority area while adolescents and young people are a focus for Africa region MAs.

MAs highlighted vulnerable and marginalized populations such as:

- ❖ Adolescents and young people (mostly in the African and the America and the Caribbean regions)
- ❖ Women and girls (particularly those experiencing GBV) (mostly in the African, Arab, South Asia, and East and Southeast Asia and Oceania regions)
- ❖ People with disabilities (mostly in the African and the America and the Caribbean regions)
- ❖ LGBTQ (mostly in the European Network and the America and the Caribbean regions)
- ❖ Men (mostly in the East and Southeast Asia and Oceania, the America, and the Caribbean and African regions)

Future Delivery Modalities

MAs detailed psychosocial support services, online counselling, distance education, contraceptive products, quality sexual reproductive health information, digital health services (hotlines and telemedicine), as well as online provision of contraceptive and abortion products as key potential service requests for future clients.

Many MAs, particularly in the America and the Caribbean region, will further contribute to improving the availability and access to SRHR information and services through digital, clinic and community-based service delivery methods and the provision of teaching and learning materials on CSE.

MA Structure Changes

MAs were asked to describe the structural changes that would be required to prepare their organizations for the future and to meet the needs of future clients. A myriad of structural responses were given. These included fundraising resources, human resources changes encompassing an increase in the number of employees, other forms of structural changes, organizational chart restructuring, separation of roles, and addition of training components. Other structural components highlighted included management and budgeting, monitoring and evaluation, and position of organizations through name, marketing, and communications. Physical infrastructural changes including technology revamp were also part of the mentioned structural changes.

Funding

Diminishing donor funding is a key challenge that MAs will face in the coming decade. MAs summarized their various fundraising strategies to mitigate the decline. These included sourcing grants and unrestricted resources, use of social enterprising and internally generated income from services provided from future MA clients. The main anticipated sources for MA funding include.

- national and local public /governmental budgets through public subsidies and partnerships with local health insurance companies (all regions)
- international funding agencies and diplomatic missions such as USAID, UNFPA, the European Commission, UNICEF and the diplomatic missions of The Netherlands, Sweden, France, Norway, Canada, UK, Belgium (mostly in the African region)
- IPPF grants (all regions)
- bank loans and investments (mostly in the Arab region)
- donations and legacies

There is an urgent need for capacity building for MA staff on grant application, fund management and administration (both local and international) and social entrepreneurship. They further emphasized the need for rebranding MAs and strategically positioning MAs as leaders in SRHR information and services provision and innovation.

Federation

In considering the global context, the MAs noted that the key issues that will define SRHR over the next decade will include:

- Gender equality (mostly in all regions except the European network region),

- Safe abortion (all regions)
- SRHR within the context of global pandemics (all regions)
- Insecurity and humanitarian crisis (mostly in African and East and Southeast Asia and Oceania regions)
- LGBTQI+ (mostly in the European Network and the America and the Caribbean regions)

Beyond Cairo

To move the Strategy beyond the International Conference on Population and Development (ICPD), there should be a focus on transformative laws & policies; active engagement and involvement of young people, strengthening of international cooperation for SRHR, capacity building for stakeholders, and ensuring universal access to SRHR. These, they explained can be addressed using innovations such as online SRH service provision, promoting contraceptives for men, designing, and promoting a self-screening initiative for SRH conditions like cervical and breast cancer and conducting action research.

Innovations

Asked what they perceived to be important innovations that the new strategy should consider, they reported that improved communication and management strategies, funding opportunities, the development and use of technological innovations, digital and telemedicine and SRHR products should be key considerations in the new strategy to enhance SRHR service delivery.

Core Values Strategy 2028

MAs detailed that the core values that should define the next strategic framework should include diversity; inclusivity and social inclusion; accountability, trustworthiness, integrity, and transparency; empowerment, equality, and equity; human rights-based approach to SRHR; passion, empathy, commitment, and volunteerism; innovation; accessibility, availability, collaboration, and sustainability of quality services; intersectionality and evidence-based work; and MA's autonomy.

Federation Support

All regions except Europe highlighted key areas where they expect the federation to support MAs. They mentioned support mechanisms such as capacity building for advocacy, resource mobilisation and social enterprising; funding support; technical assistance for grant writing; avenues for shared learning and coordination between MAs and with the federation for generation and use of research evidence; and regular supply of contraceptive products and commodities are key areas that the IPPF secretariat should support MAs with over the next decade.

Most MAs requested the use of more MA centric approaches, setting up platforms for shared learning and experiences, inclusion of more languages, setting realistic deadlines for MA activities,

implementation of the 2019 agreed on reforms and improved and transparent communication between MA offices, regional offices and the federation were largely recommended by MAs as key changes that should be implemented by the IPPF Secretariat over the next decade.

Resolution of MA issues/challenges, transparency in communication and the need to develop creative and effective mechanisms for capturing and sharing good practices and lessons learned across MAs by the IPPF Secretariat were practices requested by some MAs. In general, most MAs requested that the federation should allocate more funding and technical support for MAs to sustain them.

Governance

The IPPF Board and Committees were challenged by MAs to develop funding mechanisms and formulate policies to guide fundraising for MAs both externally and internally to step up resource mobilization for institutional sustainability. MA focused activities were also recommended for evaluation with the inclusion of youth movements and capitalize on the influence of the Federation to create visibility to improve the resource base of the Federation. Some MAs, particularly in the Africa, Arab and East and Southeast Asia and Oceania regions added that the Federation should consider contextual differences between MA countries, while developing new policies and strategies to reduce implementation challenges and ensure that strategies are relevant to the MA context. The Board and Committees were also encouraged to the respect the opinions from Secretariat and MAs and some MAs recommended that board members should be recruited from diverse sub-regions and language backgrounds to ensure diversity of composition in the Board.

MA Centric Definition

Most MAs described the term an "MA Centric Federation", as a bottom-up approach to SRHR planning and delivery, equal representation of MAs, prioritisation of MAs, agreements, actions and cooperation between MAs and the Federation towards shared goals and funding support for sustaining MAs in conducting their activities. MAs pointed out that the term implies that IPPF is totally supportive to its MAs, operates based on needs of the MAs with the MAs driving the agenda of the Federation.

They added that MA Centricity implied that the Federation should listen, allow MAs to take lead and be involved in all important decisions. Some MAs noted that the term is related to management strategies and strengthening of MAs to collectively achieve IPPF goals and objectives. Others indicated that; the relationship between the union and the member associations is an interactive complementary relationship, a Federation of associations pushing boundaries and leading tough conversations surrounding SRHR and uplifting the images of MAs at the lobal level.

Additional key recommendations that MAs provided included support for performance monitoring and evaluations systems, obtaining IPPF accreditation, capacity building of MA staff and data management competencies for the generation and use of evidence to inform practice in their work.

Recommendations

Participatory approach to MA engagement: One of the key findings from this process, was the need for active participatory engagement of MAs in decision making processes. MAs want to be seen as experts, knowledgeable about their local context and realities, and consulted on policy and strategy development processes concerning their countries and regions. This requires an in-depth reflection on the power dynamics between the IPPF Secretariat and its MAs. Are MAs routinely engaged as local experts or engaged with as passive contributors or as beneficiaries of capacity development efforts?

Underlying discourses around power and insufficient engagement of MAs arose from the analysis and need to be focused on during the strategic review process. MAs have requested more diverse and regional engagement with the IPPF Board. Are MAs aware of current efforts around engagement or does more work need to be done around regional representation?

Capacity development and knowledge transfer: Most of the MAs requested capacity development in several components including monitoring and evaluation and fundraising. They also recognised the potential for cross-regional learning from each other. This interest might be useful and strategic to develop, by means of a knowledge hub or 'communities of practice' to encourage sharing of knowledge across MAs. Existing knowledge transfer and management systems might need to be reviewed and adapted to see if they currently address this need from the MAs.

Prioritisation of context-specific SRHR issues in policy-development: Despite the existence of a few common trends across different regions on specific abortion and SRHR issues, MAs elucidated the importance of national consultation to understand the context and priorities of each country and region, in policy development processes, in a participatory way.

Background and Scope

The International Planned Parenthood Federation (IPPF) is a global service provider and advocate of sexual and reproductive health and rights (SRHR) for all. IPPF is made up of 118 Member Associations, 15 partners, and a secretariat that is spread over 10 offices worldwide. IPPF currently works in 142 countries.

With less than two years remaining in its current strategic period, IPPF is due to developing its next strategic framework spanning the period 2023-28. The purpose of this consultancy is to provide support through a qualitative analysis of the MA Consultation Forms Content (within the Listening & Visioning phase of the new Strategic Planning Process (IPPF 2028) conducted during the strategic consultation. The specific objectives include:

- ❖ To explore MAs views and experiences of key SRHR topics and strategies towards achieving SRHR outcomes at the national and global levels
- ❖ To explore the contextual and multilevel factors that influence SRHR programming towards achieving national and global SRHR outcomes
- ❖ To explore key practices and lessons learnt during SRHR programming to inform future SRHR programming
- ❖ To explore the future context of SRHR programming and IPPF organisational strategy towards enhancing the approach to future SRHR programme learning.

Methodology

As part of a larger methodological framework, this study was assigned to AISE Consulting by IPPF Secretariat to provide qualitative analysis support to the strategic review process of the MA consultation process for the IPPF's Strategy Design Roadmap 2020-2022, which aims to contribute to its next strategic framework spanning the period 2023-2028. A utilization-focused approach is based on the principle that an assessment should be judged on its usefulness to its intended users. As such, two basic characteristics were used;

- ❖ IPPF Member Associations as primary intended beneficiaries of the assessment were identified and engaged from the onset of the assessment by responding to the topic points outlined in the survey form designed by IPPF Secretariat.
- ❖ The intended uses of the assessment by IPPF MA and Secretariat guide all other decisions made in this assessment by the study analysis team including the use of co-creation approaches to allow IPPF's strategic needs to drive the focus on the analysis.

As such, three main sources of data were utilised namely,

- ❖ Grey literature: Internal reports and documents provided by IPPF that allow for an understanding of the study context
- ❖ Academic literature: papers and research that have used a similar method approach including literature using qualitative analysis for topics related to the SRHR framework.
- ❖ 75 filled-in questionnaires, designed and disseminated by the IPPF Secretariat, and filled in by different actors within Member Associations in different countries.

Four work phases using a utilization-focused assessment approach were utilised in this qualitative analysis in QRS NVivo 12 pro by the team of multinational and multi-disciplinary researchers with specialised and complimentary qualitative skills at AISE consulting. These include:

- ❖ Phase 0: An inception meeting and regular feedback meetings with IPPF Secretariat was carried out by the AISE Team online to define a work plan, timeline, scope of work and strategic focus of the evaluation. Bi-weekly follow-up meetings were held to ensure that activities vis-a-vis timelines are met, and emerging issues were clarified.
- ❖ Phase 1: A light desk review on the key topic of the evaluation allowed the AISE Team to gain an in-depth understanding of the strategic framework, scope of the Member Association (MA) consultations, stakeholders involved in the process and contextual background information collected from the member association.
- ❖ Phase 2i: The AISE team subsequently reviewed a sample of completed MA forms and the IPPF designed codebook to explore emerging themes and codes using a deductive content analysis approach to align the codebook with the objectives of the assessment. MA forms were double coded to ensure alignment in the coding process. Weekly meetings were held with the AISE coding team, to agree on and add relevant codes to the codebook.
- ❖ Phase 2ii: The AISE Team identified MA forms with incomplete or unclear information and where needed requested recontacting the MAs to provide more information or to clarify phrases. This was done with the IPPF team, and discussions on which were the most crucial forms that needed to be revised was done collaboratively.
- ❖ Phase 2iii: The AISE team utilised a network approach to a narrative and discourse analysis to explore linkages between code groups and co-occurrences to identify important discourses in the MA forms. This fed into understanding how key components of the strategy might have influenced outcomes, enablers, hindrances, and recommendations to improve future programming. Cadres of staff or focal persons in the MAs' responses were carefully considered.

- ❖ Phase 3: All data were coded and analysed by the AISE team. A total of 83 MA forms were received out of which eight (8) MA forms from Tunisia, Belgium (2) and Algeria, Yemeni, Pakistan, Samoa, Thailand, were filled in duplicate and excluded from the analysis. Both the original and revised MA forms from

MA forms from Japan (2), Belgium (2), Aruba (2), Democratic People's Republic of Korea (2) and Vietnam (3) , were additionally coded and analysed as revised duplicates. As such, a total of 75 MA forms are included in this analysis as shown in Table 2. A deductive thematic approach was applied to data analysis using a predesigned codebook. The lead Consultant set up the predesigned codebook in NVivo 12 Pro, shared this with the coding team and conducted an NVivo training on coding using the software programme. During initial coding using QRS NVivo qualitative software, open-ended inductive approaches enabled the identification of emerging themes and codes which were used to revise the codebook. Two team members were responsible for refining the codes in NVivo by precoding an initial sample of 5 MA forms each and identifying new themes which was discussed and agreed on during the weekly team meeting. Subsequently, other members of the team were assigned MA forms for coding using the refined codebook. MA forms were coded in constant comparison using the revised codebook and patterns and linkages between quotes, codes and themes were explored for contextual relevance, convergence, and divergence. Incomplete transcripts were also returned for participant checking and clarification prior to inclusion. Four experienced qualitative researchers coded all transcripts while the lead researcher coded a sample of 20 transcripts for quality control and validation.

Once coding was completed, individual NVivo files were merged into a complete project file and a code-by-code report was generated. The initial structure of the codebook was used to draft the first report which contained all codes and quotes from the data file. The report was refined to suit the structure of themes present in the MA questionnaire forms in order to be more responsive to the questionnaire themes. The results are presented in line with the structure of the themes present in the questionnaire with some quotations from the MA forms highlighted. All other quotations are presented in Table 3. In general, the terms "majority", "some" and "few" imply more than half, about half and less than a half respectively.

Section 1: MA VOICES

MA Consultation process

Several countries across the different IPPF regions were involved in the MA consultation process. The Member associations were a mix of civil society organisations focused on advocacy as well as service-based organisations and providers. MA information was not provided on an individual basis, information from the MAs was synthesized at a national level and sometimes involved a mix of guided group discussions, participatory workshops, and key informant interviews. The different regions covered by this consultation process are described below. The total number of 75 MA forms from the African, America and the Caribbean, Arab, East and Southeast Asia and Oceania, European Network and South Asia regions were coded and analysed. Table 1 presents the characteristics of the MAs involved in the consultation process. Not all MAs provided numbers (frequencies) of stakeholders consulted and not all MA provided descriptions of which stakeholders were

involved in the process. As such the numbers (frequencies) and descriptions presented are derived from those provided in the MA forms. As such about 58 female MA governance, 53 female MA staff, 55 MA clients and over 150 clients were involved in the consultative process. In general, MAs used a mix of individual interviews, survey questionnaires (self-administered) and group discussions using physical meetings, emails, zoom and other forms of video modes to engage key stakeholders in the process. In the Appendix (Table 2) we have provided an overview of key gaps and recommendations per region. Figure 2 presents a word cloud of the 100 most frequent words in the data.

Figure 2: National consultative process word cloud: 100 most frequent words

Section 2: MA CONTEXT

Current Gaps in Services

The MAs in each country described the main SRHR service gaps currently prevailing in their countries across various themes described them below: Figure 3 presents a word cloud of the 100 most frequent words under this theme.

Figure 3: Current SRHR gaps word cloud: 100 most frequent words

Inadequate access to adequate and quality SRHR information and services

MAs reported inadequate access to adequate and /or quality access to SRHR information and services such as contraceptives and abortion care among various populations groups and countries and resulting in inequities in access to SRH information and services. Referral systems for SRH were also reported as largely limited. While most MAs focused on women and the youth, other specific groups such as women with disabilities, women living in rural areas, women with low educational status and persons in the lesbian, gay, bisexual, lesbian, gay, bisexual, trans, and/or intersex (LGBTI) were also reported as poorly sensitised with little or limited awareness of their SRHR and access to services. MAs reported that in addition to inadequate logistics, infrastructure, equipment and supplies for health, there were shortages of health personnel, particularly trained health personnel for the provision and delivery of SRHR services and information. Particularly for MAs in LMICs, they added weak health systems resulting in the poor integration of SRHR services and information into the primary healthcare system. This, they added contribute to the poor quality SRHR services, poor documentation or record keeping of client information and inadequate patient confidentiality.

> Weak and Fragmented Primary Healthcare System. Low readiness of PHC to integrate SRHR, absence of SRHR indicators for primary healthcare. Lack of mechanism of mandatory

> continuous education program on for family /Village Doctors on SRH counselling and Rights- based gender sensitive approaches…. There is no integration of a minimum package of reproductive health services (MISP) In the emergency preparedness and response plans of the Ministry of healthcare which represents an urgent issue to address during pandemic. Georgia

> The quality of SRH services provided is often considered as inadequate and below recommended standard. Poor documentation/record keeping practices among service providers. Lack of client appointment scheduling systems. Nigeria

Inadequate access to health care for specific (neglected) SRHR needs

MA MAs in Nigeria reported the lack of health care for infertility in the public health system forcing people to seek care for infertility in the private health sector which is largely expensive for people with lower socio-economic status. MA MAs added the neglect of male SRH and poor attention to increasing teenage pregnancies and unsafe abortion.

> The issue of infertility remains neglected in Nigeria's reproductive health policies without the availability of any government programme on infertility. Most infertility services are offered by private providers and remain unaffordable for the unwealthy population. Nigeria

> There are many problems, such as neglect of male reproductive health, increasing teenage pregnancies and abortions. Mongolia

Contraceptive care gaps

MAs detailed gaps in contraceptive care including inaccessibility, inequities, and poor coverage of contraceptives by public health care. Contraceptive care is not covered by public health care. They also detailed gaps in access to and utilisation of contraceptive care information and services largely due to their availability in public health care spaces. While in some countries like Peru, adequate and quality contraceptive counselling and guidance is not provided in public health facilities for the youth, including adolescents, even among the adult population, it was reported that access to quality family planning counselling and services pre and post-natal including access to comprehensive abortion care is limited. In other countries like El Salvador, governmental committee, and budget for access to and security of contraceptives for the country's populace was not formed and available. Likewise, in Japan, access to the emergency contraceptive pill (ECP) is restricted due to the lack of its sales by OTC.

> Provision of Contraception is not included in Universal Healthcare Package limiting access to socially vulnerable groups of women with high unmet need (23%). Georgia

> OTC (Over the counter) sales of ECP has not started yet. Japan

Contraceptive counselling for adults is not covered by health insurance. Expenses for all contraceptives are not covered by public health insurance. Austrian

Some MAs reported that even though most contraceptive methods are freely provided in their countries, uptake of contraceptive methods remains low and, in some countries, decreasing uptake of modern contraceptive methods. In some countries, it was reported that there were limited modern contraceptive choices resulting in the decreasing uptake of modern contraceptive methods. The limited choice in modern contraceptive methods was largely explained to result from the inadequate capacity of health providers to provide modern contraceptive method choice. MAs reported that as a result of the low uptake of contraceptives among women, the rate of unintended pregnancies was high in their countries with some MAs indicating that over half of the women in their reproductive years reported their last pregnancy as unplanned.

usage of contraception has not increased. Georgia

Despite freely available modern contraceptive methods at all public health facilities in SI, uptake of contraception is very low, and rates are decreasing; 24% of married women and 8% of sexually active unmarried women use modern contraceptive methods to prevent pregnancy… 57% of all women between 15-49 years reporting that their last pregnancy was unplanned…high rates of unintended pregnancies and low contraceptive uptakes in the Solomon Islands. Solomon Islands

Main contraceptive option is the male condom, and the usage rates of OC and IUD are low. Modern contraceptive options are severely limited. Japan

MAs in some countries reported limited access to contraceptive care and services particularly for vulnerable groups such as people living in rural or hard to reach places, urban slums, and women with disabilities largely due to limitations in access, ineffective supply chain for contraceptive commodities, stock-outs of contraceptive commodities, and/or insecurities and humanitarian crisis in those countries and areas. Some MAs reported that access to contraceptive methods requiring surgical procedures was also limited in some countries.

The health sector's funding and access for contraception is very poor. Mongolia

provision and continuity of commodities has always been a barrier. Aruba

Not all remote rural communities (have access to SRH services). Togo

Lack of mechanisms in place to provide SRH services special community segments such as women over 40, women in urban slums, rural communities, and sexual minority groups. Sri Lanka

Limited available choices for abortion care and unsafe abortion

Some MAs reported that there was limited awareness and sensitisation on abortion care and self-management practices. In some countries, the abortion pill is not accessible and largely abortion services were restricted, in other countries, access to comprehensive abortion care was not available at the local, community or primary health care level but available at the secondary level of health care. In a few countries, while the laws and regulations provide legal access to medical abortion care in certain circumstances, such instances do not cover circumstances such as rape or genetic malformations. In such instances, migrant women were reported as particularly more vulnerable, often resorting to the utilisation of unsafe abortion services, contributing to complications and high mortality rates. Other MAs reported that is in countries where abortion legislation is legal, accessibility, recognition of rights and mandatory waiting times contribute to poor utilisation of the services. They added that accurate estimates of the abortion rates are hindered because of most are inadequately classified.

> Low level of safe abortion methods among artificial termination of pregnancies (42%) …Despite officially abortion rate officially is decreased, usage of contraception has not increased. Nearly half of the abortions performed in Georgia are registered as spontaneous abortion, resulting in data flow. Despite Abortion is legal, Accessibility barriers, Mandatory Waiting times and Prohibition of Abortion realization to right to safe abortion. Georgia

> Abortion services are not available in primary health care services, but only through hospitals. Norway Peru does not have a law decriminalising abortion in cases of rape or genetic malformations incompatible with life. The therapeutic abortion protocol does not include these causes…. Peru does not have a law that allows women to decide freely over their bodies in the event of an unwanted pregnancy, so many women resort to unsafe abortion… Migrant women are exposed to unwanted pregnancies. This is one of the main reasons for death and sequelae, as they are pregnancies that are miscarried or not accompanied by a doctor. Peru

Comprehensive Sexual Education (CSE) gaps

MAs reported on several gaps in accessing CSE including inadequate information, youth friendly centres, inadequate CSE capacity and initiative to facilitate parent-children dialogue.

Inadequate SRH information for adolescents and young people

Some MAs indicated that there was limited SRH information covered by educational institutions particularly for adolescents with makes them ill-informed about their SRHR issues. In some other countries, where comprehensive sexuality education was already available, issues around the appropriate age to begin sexuality education, content, and quality where some of the issues that arose.

Though there are a number of reproductive health topics in the curriculum, we are developing and improving existing materials. Bahrain

Insufficient topics on SRHR in school curricula. Guadeloupe

Limited access to CSE and lack of youth friendly centres

In most countries, particularly in the African, Arab, and Asian regions, MAs reported that CSE has not yet been incorporated into the education curriculum with few legal laws or statutes guiding the framing access to CSE. A few MAs indicated that CSE was only provided by a few civil society organisations (CSOs).

There is a lack of CSE programs in all levels of education. Mongolia

In countries where CSE is included in the school curriculum, MAs reported that it was not comprehensive, or topics covered were selective with key SRHR topics being restricted from the curriculum. They added that there was low progress in integrating CSE into the school curriculum with poor implementation of the CSE curriculum and called for increased advocacy to facilitate the inclusion and integration of CSE into the educational training curriculum.

Despite international commitments, comprehensive age-appropriate sexuality education is not integrated in school-based settings according to UNESCO standards. Only few elements are covered by Biology and Civic Education subjects. Georgia

CSE components covered in the Maldives not included completely in the school curriculum. Maldives

Inadequate funding

MAs reported inadequate funding for the development, implementation, and integration of CSE into educational institutions.

Insufficient funding for ESC. Benin

MAs reported that there was a gap in provision and access to comprehensive abortion care due to limited availability of information and services, inadequate appropriate implementation mechanisms and social factors that hinder access and utilisation of abortion care services.

Interruption of the late term pregnancy for social reasons could not be performed due to lack of appropriate mechanisms for law implementation. Albania

Availability of abortion services in the public sector need to be improved (only around 58% of HC in Cambodia have safe abortion service. Cambodia

Abortion care is not covered by health insurance (public health insurance only pays for medically/psychologically indicated abortions). Austrian

Geographic disparities in access to abortion care services

Another key national gap was reported to geographic disparities in access to abortion care services as the majority of states/regions/towns/communities in various countries have limited access to comprehensive abortion care

Safe and legal abortion services are theoretically only offered in four out of thirty-two states in the country. Mexico

Access to therapeutic abortion is only available in some health facilities in Peru due to lack of knowledge of the protocol. Peru

Access is characterized by an east-west divide, whereas services are much less available in the east. Austria

Current Service Barriers

MAs detailed the following current barriers to SRHR services under policy and legal barriers, population and public awareness and utilisation.

Policy and legal barriers

Lack of legislation and SRHR and ASRHR laws/acts/policies that do not take into consideration vulnerable populations were mentioned as key reasons for the reported low awareness of SRHR at the population level in most countries. MAs also mentioned were inconclusive laws and legislation, the ineffective application of laws and legislation governing SRHR, inadequate dissemination of information regarding such laws, restrictive laws and legislation regarding SRHR issues such as abortion and the criminalisation of some vulnerable populations. In some countries, it was detailed that there was a poor alignment of SRHR services with national policy programs or guidelines, especially for vulnerable populations.

the SRHR Act is outdated (dating from 1950) and prohibits any promotion of SRHR. Ivory Coast

SSSRs and SSR services, especially for young people and vulnerable groups, are not aligned with national policy programmes. Tunisia

MAs indicated limited access to comprehensive abortion care as one of the key national SRHR gaps. In a most countries, MAs reported that legal regulations for abortion care are restraining, limiting the type of abortion care provided to counselling and care for complications while in a few countries, abortion care was reported as illegal and forbidden. Population-level awareness regarding the restrictive abortion laws was reported as high.

Abortion laws are restrictive …Access to abortion care is limited by the country's laws and policies; therefore. Guinée

The management of abortion remains limited to the counselling phase and the prevention and treatment of minor complications. Morocco

There are still doubts among the population due to the country's laws and policies on abortion… The conflict of international and national laws on abortion issues. DRC

MAs reported there is a lack of legal acknowledgement for a transgendered person often resulting in the lack of appreciation and understanding for varied gender definitions seeking SRHR information and services.

No legal recognition of a third gender-category resulting in a lack of official and public recognition and understanding of the diversity of gender definitions. Norway

Some MAs reported that poor/weak political will and commitment to national SRHR policy development, legislation and implementation was a contributory factor to the low SRHR progress.

National SRH policy not consistently reviewed… Political commitment to SRH is uncertain. Samoa

Lack of political will. Lack of recognition of European and democratic values by duty bearers and parts of fragmentized society, widespread myths and misconceptions which serves as solid ground for strengthening ultraconservative groups, are key obstacles with the consequences of political instability, economic and social inequality. Lack of accountability of public institutions; Georgia

Population and public awareness and utilisation

Socio-cultural, traditional, and religious barriers were also reported by most MAs across all regions as limiting access to and utilisation of SRHR information and services.

Socio-cultural barriers and taboos surrounding access to quality SRH information and services. DRC

Cultural, religious, generational, and social barriers are often products of lack of information and guidance. Aruba

Socio-cultural and religious barriers limit the… Burundi

Several MAs reported the lack of population-level awareness of SRHR issues particularly among vulnerable populations such as adolescents and how to access SRHR services such as safe abortion services due to inadequate sensitisation, communication, and dissemination of SRHR information and services.

Advocacy efforts on the part of CSOs very minimal and very disintegrated – CSOs not working as one and are rather in competition with one another. Botswana

People in remote areas and people with disabilities do not have access to information and services. Mongolia

The standards set in the country for access to health services for young people and adolescents are not adequately disseminated nor are they monitored for compliance…. Few women access abortion because they do not know about the protocol and ground 11, which allows women to access abortion for any reason that affects their health (physical, psychological, and social). Peru

MAs reported that migrant women are most vulnerable to unwanted pregnancies with little access to medical care and often resulting in miscarriage.

Migrant women are exposed to unwanted pregnancies. This is one of the main reasons for death and sequelae, as they are pregnancies that are miscarried or not accompanied by a doctor. Peru

For HIV and STI, MAs reported low awareness about prevention and health care services for prevention and treatment due largely to the lack of information about them in the public domain. They added health system gaps to STI/HIV including inadequate health personnel capacity and poor STI/HIV testing by public healthcare.

Low awareness of the means of preventing sexually transitional diseases. Bahrain

Insufficient information and services to prevent and treat sexually transmitted infections, including HIV/AIDS. Peru

Some MAs reported that the youth had limited access to crucial SRHR and ASRHR information and services to prevent unplanned pregnancies and the resulting impacts of unplanned pregnancies on their lives. They added that when the youth have unplanned pregnancies, they also receive poor quality family planning information and counselling during and after the pregnancy and poor-quality comprehensive abortion care. They explained that despite the availability of guidelines and standards set for the youth to access SRHR and ASRHR information and services, these are not effectively disseminated to the youth with ineffective monitoring mechanisms set in place to ensure compliance.

Young people and adolescents do not have access to differentiated information and services in all facilities to reduce unplanned pregnancies and their effects on their life plans, including quality family planning guidance and counselling in prenatal, postpartum, and post-abortion care…. The standards set in the country for access to health services for

young people and adolescents are not adequately disseminated nor are they monitored for compliance. Peru

Other groups less frequently mentioned as a neglected vulnerable population in SRHR programming were the elderly.

Sexual health in the elderly. Hong Kong

SRHR monitoring, evaluation, and accountability, coordination, and resource mobilisation networking among stakeholders

MAs reported the insufficient gathering of SRHR data resulting in poor monitoring and evaluation mechanisms, inadequate M&E capacity and poor dissemination and accountability mechanisms to inform SRHR programming and decision making.

Operational reinforcement issues, including capacity building and M&E (no checklist to monitor the progress). Cambodia

The standards set in the country for access to health services for young people and adolescents are not adequately disseminated nor are they monitored for compliance…. The implementation of quality management policies in services so that they are more widely used and accessible to the population. Peru

A key reason that MAs reported as contributing to the poor SRHR outcomes was inadequate coordination and communication between SRHR stakeholders in the public and private sectors.

Insufficient networking between partners on these issues…Lack of action with private health actors. Guadeloupe

MAs indicated that there was low resource mobilisation including funding for SRHR programming. Most countries reported a heavy reliance on donor funding to support the provision of general health and SRHR services. They added that sub-optimal management of funding resources further constrain SRHR programming. Participants, particularly in the African region reported that inadequate resources particularly funding often resulted in stock out of SRHR commodities and products.

Low level of mobilisation and optimal management of NRIS-N funding. Guinée

The financing of health services remains heavily dependent on external funding. [no] budgets allocated. Togo

Insufficient resources and supply chain for securing RH products. Burkina Faso

CSE and educational system settings and practices

In some countries, MAs reported that access to and implementation of CSE is not backed by legal laws while in other countries, the definition of CSE was not clearly and properly elucidated by the education ministries to facilitate comprehensive and uniform teaching of CSE.

CSE is not properly defined by the Norwegian Directorate for Education. Norway

The ESC in its 7 components is not integrated in the training curriculum of the national education programme. The ESC is only partially provided. The country programme does not develop all 7 components of the ESC… The SRH component of the CSE of the national programme does not take into account certain aspects such as abortion and family planning. The low level of popularisation of the Maputo Protocol in the community. DRC

Peru does not have a national law on Comprehensive Sex Education (ESI). Peru

Several MAs reported that there is opposition from various stakeholders including teachers regarding the integration of CSE in school curricula. They mentioned that teachers tasked with proving CSE in schools have little training on CSE and hence do not have adequate CSE capacity to provide CSE in schools. They added that the lack of adequate teacher CSE training and capacity is compounded by the use of outdated teaching and learning materials for teaching.

Lack of ESC materials. Burundi

There is widespread opposition to school SE including parents, community members and teachers who argue that schools should promote moral values instead of implementing SE (2). Albania

Moreover, some MAs reported that lack of a gendered approach to teaching and learning to address inequalities among the populace.

There is no gender-based education that minimises the effects of inequalities in Peruvian society. Peru

Gender-Based Violence (GBV) gaps

MAs indicated a high prevalence of sexual and GBV particularly for women and young girls which severely hinders their ability to exercise their SRHR. They reported the harsh social and economic situation caused by the COVID pandemic as further disempowering women and girls in negotiating their SRHR. They added that in general, there are inadequate numbers of SGBV support centres with access to SGBV support services further hindered by inadequate numbers of trained health counsellors. In urban areas, there were some support services for women

and girls who had experienced SGBV which was inaccessible to the bulk of people living in rural areas. They called for issues of SGBV to be prioritised and increased coordination to address the high prevalence of SGBV.

The weak application of the law on gender-based violence. DRC

42% of women between the ages of 15-49 years had experienced physical and/or sexual violence in the last 12 months…Widespread sexual and gender-based violence (SGBV) minimizes a women's ability to access contraception and their ability to negotiate consensual sex is often limited by pressure or violence from their partners and support services for survivors of violence are frequently concentrated in urban areas, with little coordination and few trained counsellors whereas most of the population is based in remote and rural areas of the many islands. Solomon Islands

Need to focus more on SGBV services among the public sector and also improve coordination mechanism. Cambodia

MAs detailed that legislation and laws governing aspects of GBV were not well defined with gender inequality and community acceptance and tolerance for GBV also reported as key contributors to the increasing GBV prevalence.

Gender inequality and community tolerance of gender-based violence. Benin

Marital rape is not properly… access to GBV services. Sri Lanka

Health system related barriers

MAs detailed several health systems related barriers to SRHR service delivery.MA MAs detailed limited access to SRHR information and services particularly for adolescents, young people, and people with disabilities.

Limited access to SRHR information and youth friendly services… The middle age group (e.g., out of school youth, young adults, parents) in our society are not fully exposed to SHRH education. Botswana

SRHR services provided only through one CSO (SHE Maldives) Difficulties in accessibility of comprehensive SRHR services throughout the atolls. No youth friendly service approaches available, although establishments such as Youth Health Clinic are placed under the Ministry of Youth, it does not function effectively. Maldives

Access to SRH services and information of PLWD is not comprehensive. Samoa

MA MAs also reported the poor supply of health resources such as infrastructure, logistics, supplies and equipment for supporting comprehensive SRHR service delivery within an enabling environment. They added

poor monitoring and evaluation practices and inadequate capacity to assess and share SRHR date for informed decision making and public awareness creation.

> supplies and equipment for integrated service delivery and comprehensive SRH information and service. Nigeria

> The inadequacy and dilapidation of health infrastructures and equipment. Insufficient youth centres for sharing reliable information on sexual and reproductive rights. DRC

> Implementation, monitoring and evaluation of policies inadequate due to unavailability of timely disaggregated data… Lack of capacity for analysis and dissemination of SRHR data. Botswana

Bureaucracy was also reported as a key health system barrier to the delivery of SRHR service delivery which hinders rapid delivery of SRHR information and services.

> The weak application of the law on gender-based violence. DRC

> Health system characterised by excessive bureaucracy, which slows down the intervention process. Peru

Several MAs reported geographic barriers to the delivery of SRHR services in several countries. Geographically, some MAs reported that in rural and or remote or hard to reach places, there were few health facilities where SRHR services could be delivered often requiring people living in these places to travel long distances to access SRHR information and services. Contextual factors such as poor transport/roads further widen geographic barriers to the delivery of SRHR services and information.

> Depending on the geographical location abortion is often/mainly performed in specialized private facilities, which results in higher prices for abortion care. Another reason for depending on private facilities is the offer of free choice. The east-west divide in abortion care results in long journeys for women to access abortion care services. Austria

> SRHR services are not always geographically and economically accessible. Mexico

> Solomon Islands has a widely dispersed population with 347 inhabited islands and over 80% of our population live in rural areas. Long distances from SRH information and services and poor transportation conditions affect utilization of SRH services, especially population groups living in remote and rural settings. These populations may already have limited education and health facilities available. Access to a range of youth friendly SRH

services and comprehensive sexuality education, particularly in rural and remote areas, is also limited. Solomon Islands

Economic Barriers

Moreover, MAs reported that despite the implementation of universal health coverage in some countries, economic barriers hinder access to quality health care and delivery of SRHR information and services. They explained that some SRHR services were expensive, and the poor quality of services provided in public health facilities often make people seek health care in privately owned health facilities.

Women have to pay for abortion care (except for medically inducted abortion is). Adults have to pay for contraceptive counselling. Men and women, regardless of age, have to pay for ...prescription birth control and condoms, wherefore especially women living in poverty suffer from discrimination and the challenges in acquiring affordable contraceptive care. Men and women have to pay for preventive STI-testing. Austrian

Price for abortion services is high…Price of contraception is high. Lithuania

Economic barrier, despite having universal health coverage, not everyone has access to it and in order to have quality care they must seek private services. Many people do not have access to these services because of the cost… Prices for vasectomy are very high and care at the health ministry is poor. Peru

Capacity Problems

MAs further reported that the inadequate capacity of services providers was largely due to the irregular and infrequent training and refresher courses for health providers to provide specialised SRHR services including CAC or adhere to guidelines for women's health and SRHR, particularly during public health emergencies.

Lack of trained professionals specifically for SRHR in the country Less trained youth in providing services. Maldives

Lack of professional human resources and inadequate capacity building make it difficult to provide equal access to reproductive health care and education. Mongolia

Lack of technical assistance to the health sector for the formulation and implementation of guidelines for women's care and continuity of sexual and reproductive health services in pandemic contexts. More than 60% of health personnel are unaware of the therapeutic abortion protocol in Peru. Peru

Insufficient qualified and appropriate staff. Togo

In some countries, MAs reported that medical officers' refusal to provide abortion services are backed by law and or legislation.

Conscientious objection by medical professionals' results in limited access to abortion options. Austrian.

Doctors have the right to reserve themselves from providing abortion services. Norway

Judgmental attitude and matters of confidentiality. Maldives

Language barriers were reported to hinder the delivery of SRHR information and services as some health providers are unable to communicate with people seeking SRHR services and information in their native languages. Even fewer health providers are reported as able to communicate in sign language for the deaf-mute.

Language barriers and lack of awareness often prevent migrant women from accessing health care facilities, including sexual and reproductive health services. Austrian

Language barrier: many professionals are not trained to provide care in sign language and other native languages. Peru

In addition, long waiting times were reported in public health facilities which deter people from seeking SRHR information and services.

Non-conducive operating hours, long queues and waiting periods at health facilities Botswana

Long waiting time for health care in public sector. Hong Kong

Lack of Specialisation

Some MAs mentioned the lack of adequate specialised SRHR services and centres for persons in the LGBTQI community. They added that health providers are not adequately equipped to provide quality SRHR information and services for LGBTQI.

The health system has limited capacities (technical and management) to address the specific SRH care and treatment needs of young people, PWDs and LGBTQIA+. Nigeria

Insufficient specialised service centres for the LGBTI population. There are no specialised services for the LGBTI population and no sensitised service providers. El Salvador

There are no quality services for the LGTBIQ+ population. Peru

They added that in addition to limited access to health facilities providing health services for trans-persons, there are also limited health services for trans-persons undergoing gender-confirming treatment surgically or with

medication. Often such limited health services and facilities were reported to be only available in the national capital.

> Health services for gender confirming treatment (medicine or surgery) for trans people, is not available throughout the country… Monopoly in one hospital in the capital city for accessing gender confirming treatment and operations. Norway

CSO Strategies

MAs reported on key CSO strategies ongoing in their countries.

Figure 4: CSO and MA national strategies word cloud

People-oriented approaches to providing age-appropriate and adolescent-friendly SRHR services

MAs in a few countries reported CSO advocacy and support to increase adolescent and youth access to age-appropriate and adolescent-friendly SRHR information and services in the public and or private health sector. They called for the inclusion of people-centred and disability-inclusive approaches in the provision of adolescent-friendly SRHR services. They called for the continuity of SRHR services even amidst the efforts to manage the COVID-19 pandemic.

> Increase age-friendly elements in existing services. age appropriate and adolescent friendly SRHR services. Hong Kong

Establishment of youth spaces to enable young people to share reliable information on sexual and reproductive health with their peers. Continuity of SRH services in the COVID context 19. DRC

Enhance joint advocacy strategy with National Human Rights Institute for legalising abortion services Joint advocacy strategy with stakeholders for inclusion of FLE/CSE in schools' curriculum and for out of school. And to advocate on SRHR and SGBV issues. Resource sharing and resource mobilization. Samoa

Advocacy and campaigning at national and population levels

At the national level, CSOs are involved in advocacy efforts to promote SRHR issues to inform health policy and programming. Some MAs reported that CSOs advocate for the effective implementation of SRHR policies and for the development and adoption of SRHR topics that are currently not covered by national SRHR policies and strategies such as CSE curriculum development, integration, and implementation. To ensure effective implementation of the CSE curriculum, CSOs were also reported to advocate for teacher training educational institutions to include CSE into their curricula to build the capacity of teachers to provide CSE. They also advocate for the digitalisation of health services as national strategies to improve access to health services.

Civil society and intersectoral working groups to work and promote public policies on issues related to SRHR (CSE, abortion, etc.). Projects for the implementation of policies or strategies for the benefit of SRH in the country. Peru

The group jointly recommend that the government develop and adopt a comprehensive sexuality and family life education curriculum following the UN International Technical Guidelines on Sexuality Education (ITGSE). This includes integration of mandatory CSE into all school curriculums both primary and secondary levels, beyond just biological information as part of Home Economics, Science and Health subjects. Further, training on CSE must be incorporated in the national teacher training programs and include adequate financial resource allocation for continuous teacher training and the development of CSE tools. Solomon Islands

In addition to advocacy at the national level, CSO lobbies with governments to increase the national budget or funding for the supply of SRHR services and commodities such as access to free family planning commodities and counselling, particularly for adolescents. They also mobilise people to demand that governments address specific SRHR issues such as GBV. They added that CSO also advocates against early or forced marriages as an SRH right, conduct SRHR research studies and strengthen research capacity to generate evidence to inform advocacy for SRHR policy decisions.

> A coalition of CSOs under the umbrella of Association for the Advancement of Family Planning have been advocating for increase in budgetary allocation for family planning. PPFN under the umbrella of the coalition network_ the Association for Advancement of Family Planning (AAFP) _is mobilizing local CSOs and grassroots movements and influencing state governments to increase budgetary allocations and actual spending on FP. Nigeria

> Participation as an expert auditor in government audits. Guadeloupe

> Several CSOs have developed studies on DSSR, GBV, ESC. Tunisia

At the population level, MAs added that social and electronic media campaigns have been used to inform and disseminate targeted SRHR information and provide freely accessible SRHR services and information electronically or physically in various contexts. Particularly for adolescents and youth, MAs reported several avenues to engage and interact with them using social media and community-based strategies to sensitise and provide SRHR information and services.

> Civil society organizations work to cooperate and advocate for rights through their educational programs and activities as well as by spreading messages through social media because of their impact on all segments of society… Issuing awareness booklets. Bahrain

> Awareness-raising and/or prevention action day for the general public with partners. Guadeloupe

> Community-based social organisations have started to develop communication strategies such as audio-visual campaigns, webinars, among others, with health and education institutions and personnel…Free, informative campaigns on comprehensive sexuality education, STI screening and sexual and reproductive health services through the use of virtual platforms, in person, at home and in the health centres themselves. Peru

CSO Networking

MAs further reported that CSOs network among themselves and with other SRHR stakeholders in and out of the country to work collectively to advance SRHR issues and provide quality SRHR services. They added that they build networks with youth and facilitate public-private partnerships to address key SRHR issues such as GBV and improve access to CSE. They also mentioned CSOs holding specialised workshops to strengthen collaboration and build capacity to promote key SRHR topics. In Mexico, MAs mentioned the existence of an expert network that litigates special cases in court to create legislation in favour of SRHR programming and service delivery.

Cooperation with civil society organizations in holding specialized workshops. Civil society organizations are trying to convey their message and objectives to the leadership in the country by allying with some influential groups (parliamentarians). Bahrain

Build networks with youth and other CSO to improve SRHR… Continue to collaborate with services providers (both public and private) to improve quality services on SRHR… Replace large group education sessions by smaller group sessions… Capacity building for stakeholders, e.g., public health sector, on abortion/VCAT, SGBV, YFS, etc. Cambodia

An alliance of like-minded organisations documents and makes visible the state of SRHR through a citizen observatory. Networks and alliances are formed that strengthen political work… A group of expert organisations litigate cases before the judiciary to create jurisprudence in favour of SRHR. Mexico

social reasons...The "Jo tabu" platform of UNFPA has created a network of journalists that collaborate on issues pertaining to SRH. Albania

MAs also mentioned that due to gaps in SRHR service provision in the public health sector, some CSOs provide low-cost and quality SRHR information and services to expand the public access to SRHR information and services particularly for vulnerable populations and during the COVID pandemic. While some of the services were reported as freely provided, other products were reported as subsidized by CSOs to make them affordable to people. Some MAs mentioned having digital systems in place where people can request and have SRHR products delivered to them privately. Other participants, particularly in the African region reported the use of community systems and mobile clinics to provide SRHR services to the population. CSOs were also reported as involved in the implementation of CSE in educational institutions.

online store and delivery service. Providing a digital service where all products are visible and accessible, coupled with delivery at locations and during time slots most convenient for the user. Aruba

We provide information and advice to everyone, including hard to reach populations. Belgium

Subsidies on SRH services and products for vulnerable populations served by ADS. El Salvador

MA Contributions

MAs reported that MAs engaged with various key stakeholders in public and private sectors at national and/or subnational levels to advocate and collaborate with them in program implementation, improving access to SRHR

information and services and the introduction of innovations to improve on SRHR programming and service delivery particularly for vulnerable populations. They also advocate with decision-makers and policy makers to ensure equitable access to SRHR services in the country. They added that MAs also support SRHR programming and service delivery by providing technical advice to in-country advocacy groups and policy makers and SRHR youth trainers. Some MAs were reported as having a stronger presence in utilising digital technology to reach partners and stakeholders while other MAs were reported as using more traditional communication.

> We engage national program partners and other stakeholders (schools, media groups...) in program implementation and introducing new innovative approaches… Work in partnership with NMCH National Program of MoH, with School Health Department of MoEYS to improve strategies and fill the gaps. …. RHAC is in various technical working groups, and we will work with partners toward improving SRHR in the country We have stronger online communication platforms, and we will continue to strengthen and expand the reach. Cambodia

MAs also detailed that several MAs collaborate with, support, and provide quality SRHR services to cover for public health gaps in SRHR service delivery and access in underserved areas. MAs reportedly work with both private and public health facilities including pharmacies, and community groups, provide virtual consultations and mobile health services and stimulate demand for free or low-cost quality SRHR services and products. While Sri Lanka MA MAs reported financing public health structures and training of health providers to improve the quality of SRHR service delivery, Hong Kong MA was reported to have shared SRHR care programs run in collaboration with public facilities to improve SRHR care delivery. Burkina Faso MA also reported being engaged in the implementation of a monitoring tool for assessing country progress towards achieving the objectives of the FP2020/FP2030 initiative.

> online consultations and mobile health services. Albania

> Support to public and private health centres for the provision of quality SRH services. Provision of quality SRH services in mobile clinics in underserved areas. Benin

> We are contributing to improving and expanding access to SRH services especially to marginalized and vulnerable groups by: Conducting mobile integrated outreaches in hard-to-reach areas…. Using DHI, peer providers, CHEWs, CBDs and PPMVs to generate demand and reach the rural and hard-to-reach population with FP/SRH information and services. …Strengthening the SRH capacity of healthcare providers in humanitarian settings…Direct provision of lifesaving SRH services in humanitarian settings. We are bridging the gap in human resources for SRH and strengthening health systems to deliver quality integrated SRHR services through: Clinical Service Provider Training programme for CHEWs, Nurses and Midwives. Capacity-building among cluster facilities. Institution of

quality-of-care processes in cluster facilities. Supply of tools, SRH commodities and medical consumables to cluster facilities. Nigeria

Shared care programmes with public hospitals. Hong Kong

MAs were also reported as engaged in the delivery of CSE. In some MAs, their engagement in the delivery of SE and or CSE was aimed at both formal and informal sectors and harness innovative and digital approaches to training teachers and peer educators on key SRHR topics. MAs mentioned that Norway MA also develops and offer CSE teaching materials for schools freely.

educational work taking place in schools… the Education on SRHR" was included as a specific objective in the Gender Equality strategy 2021-203… including through informal education and innovative and digital approaches for 600 teachers and 470 peer educators in Tirana, Vlora and Shkodra (2019-2021). Delivered 82,459 rights-based services including for safe abortion and HIV through static clinics, mobile and outreach work in last three years (2019-2021). Albania

Established clinics to provide free sexual and reproductive health services including post-abortion care. Organises advanced service delivery strategies: mobile teams, mobile clinic. Designed a simplistic guide for ESC sensitisers previously used only by the MAJ; Initiated the process of designing an ESC manual with the National Programme for Adolescent Health, the Ministry of Education, and the Ministry of Youth; Has set up youth ESC spaces in 4 of its clinics across the country Is among the leading associations in the country in the field of ESC delivery. DRC

We develop and offer free CSE-teaching materials for schools. The material was used by more than 3400 teachers this year, who registered a total of 240 000 students. Norway

MAs reported that MAs were involved in knowledge production through operational research to generate the needed evidence on challenges and make recommendations for improving SRHR. They reported that they disseminate research findings to relevant stakeholders notably governments, via electronic media, workshops, conferences and terminations, presentations to policy and decision makers.

We have a stronger research team, and we will continue to collect evidence to identify gaps and advocate for SRHR improvement. Cambodia

We organise webinars, talks, live broadcasts, etc. on issues related to SRHR and DRR advocacy. Peru

We are conducting research on SRHR issues. Sri Lanka

MAs also provide SRHR training to build the capacities of health providers in some countries. Youth organisations, youth peer trainers and volunteers have also been trained on SRHR and gendered approaches to SRHR by some MAs in some countries. MA MAs reported organising and conducting SRHR trainings and refresher courses for teachers at national and local levels to improve teachers’ capacity and other MAs reported conducting training for CSOs and associations/groups of vulnerable people on SRHR issues.

capacity building. Albania

We strengthen the expertise of professionals. Belgium

Contribute to building capacity and morals of stakeholders (e.g., in the area of CSE, both online and in-person) addressing sensitive issues. Cambodia

Section 3: MA HORIZON

Figure 5 presents a word cloud of the most frequent words under this theme.

Figure 5: MA Horizon word cloud_100 most frequent words

Advocacy Issues

MAs report that the MAs' focus over the next decade will be on: vulnerable and hard to reach populations; progressive law reform; comprehensive sexuality education (CSE); access to safe abortion care; increased access to SHRH information and products; gender equality; involvement of men in promotion contraceptive uptake; child marriage; sexual and gender based violence; and violence against children.

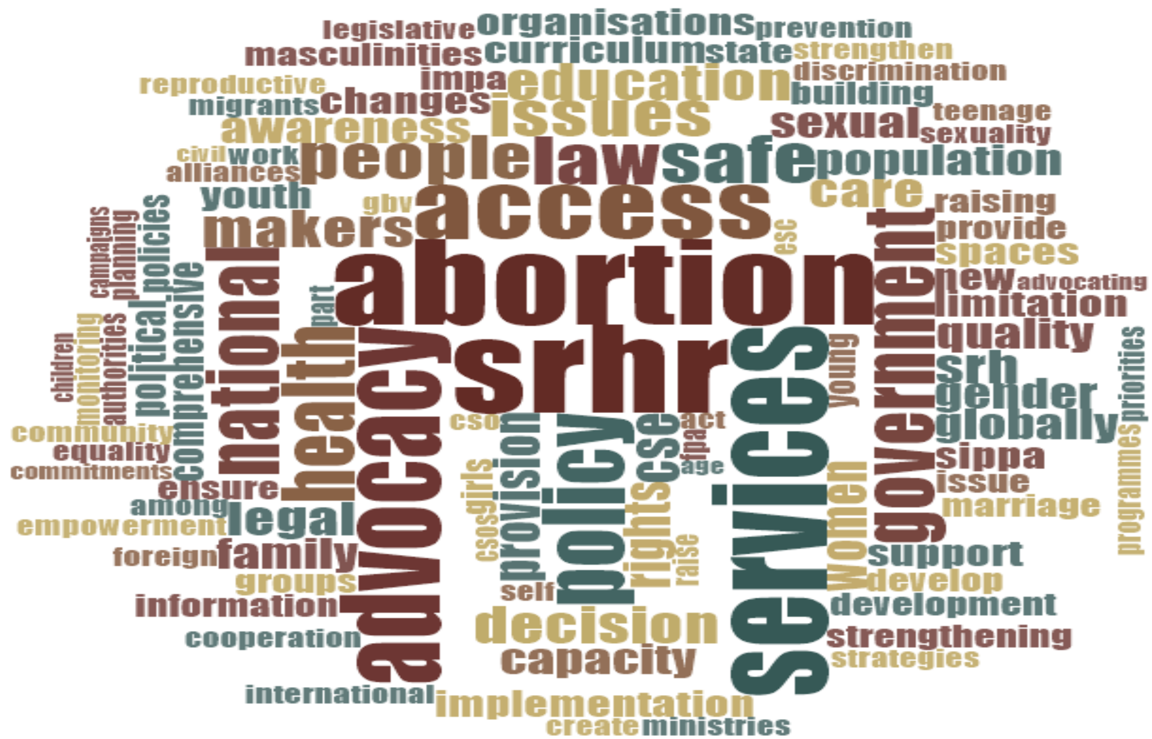

Figure 6: Future policy and legal environment word cloud

Abortion

A key focus area for most MA s reported by MAs was advocacy to decriminalise abortion care to improve access to abortion care services. Other MAs in the Asian region reported a focus on advocacy efforts to certify safe abortion pills to improve their accessibility to the population. Limitations or conditions under which access to and utilisation of abortion care services for such cases as rape or incest in countries like Solomon Island will also form a key advocacy focus for the Solomon Island MA. MA advocacy efforts for making abortion legal is also a focus in countries that currently have restrictive laws. Advocacy efforts to improve compliance to existing safe abortion care guidelines in countries with these guidelines was cited as an area of interest in the next decade, for instance, in Peru.

> Certification of abortion pills/safe abortion options. Japan

> Access to self-determination of abortion up to week 18 (in Norway), Access to safe and legal abortion globally and as part of Norway's foreign policy priorities. Norway

> The Family Protection Act (FPA) still have some limitation or gap that requires legal interpretation and legal advice. One of the limitation that is currently brought to the surface for debate is the absence on the provision of safe abortion for women and girls who are raped/incest and get pregnant to the perpetrator. Another provision under FPA it the limitation in relation to safe abortion for teenage girls who willing fully wants to abort her pregnancy. Under the FPA there is limitation on this area. Solomon Islands

Expansion of the abortion law. Benin

Changes to Law 449 on abortion. Morocco

Advocacy for gender equality and against GBV

Advocacy against gender inequality and GBV was reported as one of the key SRHR areas that some MAs will focus on advocacy efforts to address and reduce over the next decade. They added that advocacy efforts will also focus on the provisions of appropriate psychosocial care and support services including access to contraceptive commodities. The Bahrain MA also reported an advocacy focus on improving women's participation in politics while for most African MAs, empowering women in rural areas will be the main focus area. Violence against girls and boys remain a focus area particularly for MAs in the Arab world while marital and marital rape is a priority to other MAs (Sri Lanka).

combat violence against children and girls. Tunisia

Violence against women. Equal opportunities... Women's political participation…Gender equality. To raise awareness of the means of spacing births Bahrain

Advocacy for the creation of psychosocial care and support services for people affected by GBV, including emergency contraception services. El Salvador

Marital rape is included in the act. Sri Lanka

Marginalised populations

The majority of MAs reported advocacy focus on the provision of SRHR information, services, and products to vulnerable populations to reduce inequities in access and utilisation of SRHR information, services, and products including abortion care. They added that such advocacy efforts will include issues of masculinities and gender definition and identity particularly for Spanish MA while MAs particularly in the African region detailed male involvement in SRHR as a key focus area. They reported that MAs vulnerable populations as women and children (including minors), adolescents in out and out of school, young people, sex workers, persons with disabilities, men and boys, indigenous people members of the LGTBIQ+ community, migrants (documented and undocumented), persons living with HIV, displaced populations, refugees, persons in prison, humanitarian settings, and ethnic minority groups., LGBTQ and transgender and decriminalization of sex workers was highlighted as an area of focus by MAs of the European Network. Other.

Accompanying the gender identity law. Actions to make the issue of equal marriage a priority. Peru

Prioritising access to RH services for adolescents and young people…Men's involvement in improving access to and use of FP services. Burkina Faso

Develop and implement minimum standards for the effective participation of representatives of minority and marginalized groups. Implementation of the Youth Friendly Services Guidelines at primary health care. Albania

Promotion and defence of the rights of people of sexual diversity (LGBTI), people with disabilities and migrants… Institutionalisation of programmes for the construction of new masculinities in the prevention of GBV. El Salvador

The issue of non-discrimination of the most vulnerable people: minors, migrants, undocumented migrants. Guadeloupe

SRH Rights Management of Displaced Populations (Migrants)… implementation of women's empowerment programmes in disadvantaged and rural areas. Algeria

decriminalize LGBTIQ community. Sri Lanka

Promote important issues such as masculinities…Promote important issues such as masculinities, gender identity. Peru

Child marriage

Some MAs reported that MA's advocacy efforts will aim to address child or underage marriages.

Law 103-13 on combating underage marriage. Morocco

Muslim marriage law… "Health of young persons' policy". Sri Lanka

SIPPA is currently advocating on Island Marriage policy Act. Under the current IMPA underage (refers to teen under the age of 18) marriage provision is allowed. The provision of IMPA if remains acted as a law can lead to the negative impact of the nation's population. IMPA can be a threat to the organization if loggers and foreigners are taking advantage on the act and or corruptly influential the government of the day. Solomon Islands

Expand the national legal framework on SRHR information, services, and products

Several MAs mentioned that over the next decade, one of the key issues that MAs will advocate for is a review of national legislation to cover the broad range of SRHR information, services, and products. They added that MAs would be pushing for legislation that further accommodates and remains sensitive and responsive to SRHR issues. They reported that a few MAs will have to advocate for the development and adoption of legal policy frameworks to improve access to SRHR information, services, and products for all sections of the population. They added that

advocacy efforts will also focus on the implementation of existing SRH legislation and the provision of SRHR products freely for adolescents and the youth. In MAs like Belgium, advocacy focus areas would include decriminalising sex work. Advocacy for less restrictive laws to allow for access and utilisation of safe abortion care was a key focus for MAs in the Africa region with the development or adoption of specific SRHR national agendas and laws considered an important area of focus. Special legislation in some areas where abortions remain illegal would be an area of focus to push for safe abortion care for rape associated pregnancies. Legislation that respects the rights of minorities (LGBTQ, transgender) will be of interest to many European Network MAs.

Improving the legislative framework and adapting it to societal change. Algeria

Creation and modification of a favourable legal framework that respects and guarantees SRHR. Mexico

Review and implementation of RH policy documents, standards, and protocols...Establishment of a mechanism to monitor the implementation of the SR law. Guinée-Bissau

Monitoring progress towards national SRHR commitments and health insurance

They added that MAs will also focus on monitoring progress towards country-level SRH policy commitments. They reported that MAs will also be advocating for access to SRHR information, services, and products to be covered by institutional and private health insurance schemes. Other MA actions would include advocacy for parliament to ratify the Maputo Protocol (Morocco). In Benin for instance, monitoring of government adherence to its family planning commitments will be an area of focus.

Monitoring the Government's 2030 Family Planning Commitments. Benin

Institutional and private violence [insurance]. Guadeloupe

Ensure effective commitment from the government and donors 'community to support family planning services and programs. Albania

Advocacy against anti-SRHR and gender ideologies

MAs also detailed a Norway and Peru MA advocacy focus aimed at addressing anti-SRHR and gender ideologies globally and at the national levels.

Backlash/rise of right-wing political environments globally…counter the anti-gender movement. Norway

Facing an anti-rights government. Fighting for rights activism in SRHR. Peru

Advocacy addressing teenage pregnancy and AIDs

MAs reported that while the Bahrain MA will also focus on advocacy to address stigma and discrimination towards persons living with AIDs, the Peru MA will also focus advocacy efforts to measures to reduce teenage pregnancy within the country.

> AIDS and its cohabitation (reducing stigma and discrimination). Bahrain

> Participate in spaces that promote actions to reduce teenage pregnancy. Peru

> Permanent OTC switch of EC and OC…Increase contraceptive options in Japan. Japan

Advocacy for improved SRHR information and service delivery

MAs reported that MAs will advocate for the digitalisation of care for SRHR to make progress towards achieving universal health coverage. Improving access to quality (validity) SHRH information was reported as a key MA focus area by participants. Advocacy for the provision of health care services sensitive to the reproductive health needs of adolescents will be a focus of MAs across regions.

> Use of digital health interventions, including Telemedicine. Cambodia

> SRH service provision through digital technologies and telemedicine and contributing to universal health coverage. Albania

Advocacy for foreign policy on SRHR

MAs reported that MAs in Norway and Belgium over the next decade will focus their advocacy efforts on influencing foreign policy on access and utilisation of SRHR services, information, and products through prioritisation of SRHR in humanitarian policies or increased funding for SRHR.

> Access to safe and legal abortion globally and as part of Norway’s foreign policy priorities. Access to CSE as part of Norway’s foreign policy priorities. Decriminalisation and non-discrimination based on SOGIE globally and in Norway’s foreign policy. Prioritisation of SRHR in Norwegian humanitarian policy. Norway

> increased financial support for SRHR in Belgium’s international cooperation. Belgium

Comprehensive Sexuality Education (CSE)

Comprehensive Sexuality Education (CSE) was reported as a priority area for some MAs over the next decade. While some MAs indicated a and advocacy focus on establishing systems and processes to enable access to CSE, other MAs reported, advocacy focus on the training of teachers to provide CSE in school. Some MAs reported an

advocacy focus on the national integration of CSE into school curriculum and/or the review of the CSE curriculum to update it. In high-income countries, MAs the focus was largely on improving upon the quality of existing CSE packages, monitoring the adequacy and completeness of the existing packages, ad improving age-appropriate access of CSE to younger/primary school children. Apart from the European Network, advocacy for the integration of CSE education institutions in schools was a major area of focus for all other regions, as these packages remained non-existent in most of these countries.

Establishment of mechanisms for enabling CSE for vulnerable groups. Albania

Include CSE in national education curriculum. Japan

CSE-Program into the national educational curriculum. Aruba

Quality CSE from an early age on …On CSE we advocate for an evaluation of the current educational policies, to make the case for increased qualitative integration in the classes and systematic control/inspection. Belgium

family life education. Burkina Faso

Mental health, climate change and humanitarian settings

MAs in Peru, Cambodia and Burkina Faso also reported advocacy focus on mental health and prioritising the provision of SRH information and services in alignment with climate changes, and during natural disasters or in conflicted or insecure settings.

Generate alliances with organisations/institutions specialised in mental health to create spaces for care/self-care. Peru

SRHR and climate changes, natural disaster Cambodia

Prioritizing reproductive health rights in the humanitarian context. Burkina Faso

Advocacy Strategies

Networking and collaboration for sensitisation programs and campaigns

MAs reported that MA will strengthen networks and collaborate with governmental stakeholders and other key stakeholders to advocate for SRHR and strengthen public health sensitisations programs and campaigns to create awareness of SRHR issues including issues of masculinity and gender equality. Advocacy targeting parliamentary networks on SRHR and increased networking with other CSOs will utilise strategies which as host meetings and policy dialogues with policy makers and other key stakeholders who can influence SRHR policy.

Influence the relevant state bodies to create training and sensitisation programmes for their personnel in the construction of new masculinities for the prevention of GBV. El Salvador

Strengthening relations with the responsible authorities of the state in order to put pressure on decision makers. Bahrain

Host meetings with Ministers and civil servants. Norway

Identify policy-makers who can influence SRHR issues…Advocacy with governments and decision-makers…Convene national policy makers or decision-makers to put DSDR issues on the political agenda. Strengthen awareness-raising among the population. Peru

Work with other stakeholders and partners as a key advocator for SRHR… Provide technical support to the government of Sri Lanka on drafting new policies. Sri Lanka

They added that MAs will also focus on building partnerships with other MAs, CSOs and other stakeholders to coordinate advocacy strategies that impact legislative and programmatic programming to improve access to SRHR information and services.

Partnership with other CSOs …Continue to collaborate with local authorities and build a stronger community networks. Cambodia

Identify organisations aligned with our goals and objectives to develop and implement an advocacy plan to achieve legislative and programmatic changes to ensure access to HIA and SRH services for diverse populations. Establish alliances with CSOs to advance the decriminalisation of abortion on 4 grounds. El Salvador

JOICFP and other CSOs in advocacy campaigns. Japan

Cooperation with the first supporter of women in the Kingdom of Bahrain (Supreme Council of Women) …. Cooperation with the Advocacy and Information Committee of the National AIDS Commission to reduce the stigma and discrimination of those living with it…strengthening relations with the responsible authorities of the state in order to put pressure on decision makers. Bahrain

Use of electronic and social media

Some MAs reported the use of social media for population-level advocacy and stimulate partnerships with the media to disseminate appropriate valid SRHR information. They also mentioned the use of electronic modes of

meeting such as webinars and animations as part of their advocacy strategy. More traditional forms of communication such as community-based shows and would also be utilised as a key SRHR advocacy strategy.

Editing of documentary films, capsules, podcasts…Signing of petitions for changes in the laws…Strengthen coalitions with other NGOs working on SRH rights. Participate in the capacity building of youth workers in primary, secondary and high schools on the components of the ESC…. Organisation of conferences, workshops, round tables in favour of DSSR…Carrying out studies in the field Morocco

Focus on an underserved population through social media outreach and community visits …Possible partnerships with the media to talk about SRHR issues. This would aim to raise interest at the political level. Disseminating valid information on SRHR issues… Develop webinars / social monitoring / communication campaigns, etc. Peru

Online and offline advocacy… Organise animation sessions on the ESC…Make available the necessary ESC materials. Organise "ROAD SHOWs…Awareness-raising and coaching in the communities. Burundi

Technical and financing determining opportunities

MAs reported that one of the advocacy strategies that MA would adopt would include the provision of technical and financial support to support the implementation of relevant SRHR policies at the national level. they added that they would advocate through national budget process hearing where they could influence funding for SRHR. At the technical level, MAs will provide support in the drafting of policies, sharing of SRHR knowledge and information and the provision of expert SRH advice to national governments or governmental sectors to inform SRHR policy formulation and adoption.

Supporting technically and financially the process of implementing FLE (Family Life Education) at national level…Disseminate laws, policies and standards and protocols for safe abortion…Provide quality abortion care services at AOS health facilities…Strengthen the provision of adolescent and youth-friendly services. Burkina Faso

We inform parliamentarians and their working groups and invest in alliances with other organizations. Belgium

Anticipating legislative changes favourable to SRHR. Mexico

International networking and funding

MAs particularly in the European and Americas/Caribbean regions reported an advocacy strategy focused on regional, international, and global networking to generate more funding for SRHR programming. They, therefore, indicated that MAs would strengthen their capabilities to raise financing for SRHR programming.

> Seeking funding for research to provide scientific evidence for decision-making in the provision of comprehensive SRH services. El Salvador

> Host conferences with IPPF sister organisations and other NGOs to highlight the issues at stake globally...Engage in global normative and fundraising process, such as the UN, advocating for strong Norwegian commitments. Norway

> Government ministries such as MWYCFA, PSO, MEHRD with international NGO such Save the Children Australia, World Vision and CSO like SDT, Voice blo Mere, SIDP and SIPPA have jointly recommending to the government to amend the IMPA. Several combine meetings between government ministries and INGO and CSO deliberating on this issue has been staged. Solomon Islands

Monitoring, evaluation, accountability on SRHR issues

Another strategy that MAs reported would be used was the use of monitoring and evaluation mechanisms and research to provide evidence for informed decision making on topics of SRHR. MAs reported that over the next decade they will be monitoring adherence to national SRHR commitments, therapeutic abortion, and school-based CSE.

> Follow an evidence-informed approached for CSE. Hong Kong

> Systematic monitoring of the Mexican government's SRHR commitments (accountability)…Demanding transparency and accountability in the programmatic and budgetary aspects of SRHR at the federal, state, and municipal levels…. Achieving the highest standard of quality and excellence in the services provided by MEXFAM, both in its operational centres and clinics. Mexico

SRHR knowledge production and exchange

MAs reported that another strategy that MAs would be utilising in their advocacy will be the production and sharing of context-relevant information on key SRHR issues through the design and conducting of research. They added that key research findings will be disseminated to stakeholders at conferences, at meetings internally or during policy dialogues.

> Research and evidence collection, advocacy. Cambodia

Host conferences with IPPF sister organisations and other NGOs to highlight the issues at stake globally. Norway

Lead roundtables for dialogue and development of proposals that contribute to multisectoral policies for the prevention of teenage pregnancies…Continue to generate learning/discussion spaces both internally and in educational or other spaces outside the organisation. Peru

Training and capacity building

To make key strides in achieving their goals for the future, MAs reported that MAs will utilise training and capacity building programs to strengthen internal members' research, advocacy, and dialogue skills. They added that MAs will also aim to influence educational training programs to include key SRHR topics and build the capacities of their key stakeholders such as volunteers and youth leaders to actively advocate for SRHR issues.

Strengthening our talents and capacities for operation, advocacy, and policy dialogue. Mexico

Internal capacity building to response to new emerging issues. Cambodia

Capacity building and empowerment…Conduct research studies…national communication and advocacy strategies for SRH related issues. Sri Lanka

Capacity building and involvement of volunteers at all levels in advocacy. Guinée-Bissau

Future Clients

Figure 7 presents a word cloud of the future clients that MAs anticipate over the next decade.

Figure 7: Future MA clients

MAs detailed that future client would include the general population and health facilities. Women, girls, children, and minors; elderly populations; adolescents and young people; victims of GBV; rural, and poor communities; marginalized populations (sex workers, LGBTQ, undocumented migrants, and transgender); indigenous people and ethnic minority groups; professionals; persons in prison. Particularly for the European MAs marginalized populations (sex workers, LGBTQ, undocumented migrants, and transgender) are a key priority area while adolescents and young people are a focus for Africa region MAs.

Supreme Council of Women…Advocacy and Information Committee (National AIDS Commission) ... Community leaders. Bahrain

Underserved population socially excluded marginalized underserved community… Women over 40, urban and working women. … PLWHIV. Sri Lanka

Women and girls from vulnerable groups …Lesbians, bisexual women. Young People Transgender people. Albania

Women of childbearing age and refugees affected by humanitarian and security crises…Gender professionals and key populations. Adolescents and young people…

refugees affected by humanitarian and security crises…Gender professionals and key populations…The elderly. People with disabilities. Burkina Faso

Girls and women (and their partners) in general. Men and boys… In- and out-of-school youth… Vulnerable groups: MSM, TG, Entertainment Workers, factory workers, PLHIV, migrant workers, etc Cambodia

Men and women of reproductive age Adolescents and young people …Diversity populations (LGBTI, persons with disabilities and migrants) …Poor and vulnerable populations. El Salvador

Aging population. Hong Kong

Girls and boys in and out of school...sexual minorities. People living with disabilities. Togo

Adolescents and young people in and out of school. Poor and marginalised people. Clients who have already visited our clinics and are satisfied. Benin

Refugees and sub-Saharan migrants and asylum seekers. Sea professionals…Special needs populations. Morocco

Refugees… People with disabilities …The indigenous people. Guinée

People living with HIV. People with disabilities. Peru

Victims of violence against women and minors. Sex workers Guadeloupe

Health, educational and other professionals for whom we develop (educational). Belgium

Students/health professionals who attend CSE/training seminars. Health centres of local governments (for catalogue sales). Japan

teachers, health service providers, facilitators, members of civil society, opinion leaders, public officials. Mexico

Expatriates working in the Solomon Islands…National working clients in all levels of work of life. Solomon Islands

Service Needs

MAs detailed psychosocial support services, online counselling, distance education, contraceptive products, quality sexual reproductive health information, digital health services (hotlines and telemedicine), as well as online provision of contraceptive and abortion products as key potential service requests for future clients.

Counselling and sensitisation on SRH

With regards to counselling, MAs mentioned that future client service requests will focus on access to SRH information including user-friendly information on STIs and HIV, family planning, contraceptive use, and abortion care. Counselling and support for victims of GBV were also mentioned as potential requests from future clients. They added that they will utilise a range of traditional and electronic strategies including digital and telehealth interventions to provide counselling and sensitization on SRH.

> SRH information…Psychological Counselling services… Clinical services… Legal consultation. Sri Lanka

> Gender-based violence services psychological care services. Tunisia

> Psychological Consultations... contraception, abortion, screening… Social support ...Workshops on sexual health. Guadeloupe

> Specialised services including GBV. Digital health service. El Salvador

> Family planning. Virtual website for the sale of products (Decido Yo). Peru

> Family Planning services. Teleconsultation Peru SIPPA will adapt technology changes and will use digital SRHR services. Solomon Islands

> User-friendly services adapted to the needs of adolescents and young people; Awareness raising on menstrual hygiene management in schools; Holistic SRH services for difficult populations. Burkina Faso

> SRH education, to enhance aging population's awareness on monitoring and caring their sexual health, early diagnosis and treatment of the related illness, and relationship issues etc. online formats. Hong Kong

Access to SRH service, commodities, and products

MAs reported that future client requests will include improved access to SRHR services, commodities, and products such as abortion and post-abortion care services, affordable contraceptive commodities, STI/HIV care services, urology services, fertility and obstetrics and gynaecology services.

Post-abortion services… STI/HIV services. Infertility Services …Gynaecology and Obstetrics. Urology Services. El Salvador

Access to contraceptive products. Aruba

Gynaecology/obstetric services…Urology services. Solomon Islands

Surgical procedures. Peru

They added that future clients would require improved access to laboratory services, diagnostic services, screening for NCDs and vaccinations. They further mentioned the ned to improve pharmacy services, shopping and delivery of commodities and products.

Laboratory/home service…Cancer prevention in the reproductive system. Imaging services. Diagnostic assistance care. Vaccination services. Peru

Diagnostic. Imaging services. Mexico

Examination and scanning services. Solomon Islands

Pharmacy/delivery/shopping cart services. Peru

Targeted, quality and respectful SRHR services for vulnerable groups

MAs further detailed future requests for targeted quality, respectful and confidential SRHR service provision for vulnerable groups including people suffering from mental health issues

Quality SRHR services that are non-discrimination, non-judgemental, and with ensured privacy and confidentiality. Cambodia

LGTBQ+. Services for men. Sex Workers. Differentiated services for young people and adolescents. Mental health. Peru

Paediatric Services. El Salvador

Mental health and emotional health services. Mexico

Training for SRHR

Comprehensive sexuality training in general and specifically for adolescents and young people was commonly reported as a foreseen future client request by participants. They added that this would include CSE for adolescents and youth both in and out of school and will focus on CSE information for teachers, adolescents, and young people. It was only in Morocco that CSE training for parents/guardians was foreseen as a future client request.

Health education, attitude, and behaviour changes (including new way of living in response to the pandemic). Cambodia

Latest SRHR information, CSE, and professional skills. Japan

Educational services whose guiding principle is comprehensive sexuality education. Mexico

Teachers will need more capacity building in teaching CSE to their students. Cambodia

Provide training for parents in comprehensive sexuality education. Morocco

Service Access

Health facility, mobile clinics, and community-based delivery models

In the Africa and Southeast Asia region, MAs report that services will be accessed based on a fixed in-person attendance at health facilities, mobile clinics, and community-based delivery models. They added that online consultations (telemedicine) will be carried out in places and cases where it is feasible.

They will have access to services through fixed teams, mobile teams, and advanced strategy. Burkina Faso

Community services. Home health service… Mobile clinics. El Salvador

Clients who dwells in the provinces will access SIPPA services at their doorstep through mobile clinic or medical mission outreach program. Solomon Islands

Appointment and mobile outreach. In-person services. Cambodia

Mobile strategies…Community-based delivery networks. fixed clinics. Burundi

Community Based delivery and outreach Mobile clinics…. Community Based delivery. Albania

In the centres Conferences and seminars. Guadeloupe

Digital and telehealth

MAs reported that future clients will mostly use digital technology to access SRH services. Although the use of telemedicine was mentioned in most regions, it was more commonly reported by MAs from the European Network.

Providing teleconsultations for service seekers telemedicine. Morocco

Hotlines and telemedicine. Sri Lanka

Digital access through teleconsultation. Togo

Educational platforms and extended health facility hours were also reported as future client practices to accessing SRH services and information.

Educational platform. Peru

Working clients will access SRHR services in during late hours and weekends. Solomon Islands

Health financing strategies

MAs mentioned that institutional and individual health insurance will be used by future clients to access SRHR services and information. They added that SRHR services can be subsidised by service providers to generate income for the purchase of services and information.

Institutional and individual insurance. They can be subsidised with part of the income generated by the provision of services by the institution. Peru.

Electronic Information

MAs detailed that future clients' practices to accessing SRHR information are mostly through traditional and electronic sources. They explained that they access SRHR information from their peers, social media and seminars and workshops at the institutional level.

Peer to peer counselling (youth activists, women champion, etc.). Cambodia

Peer group formation. Social media. Talks and workshops for institutions. Peru

Through online and in-person seminars. Japan

MA plans to facilitate future clients access to SRHR information and services.

MAs reported on current and plans underway to facilitate future clients' practices in accessing SRHR services and information. The Solomon Islands MA reports geographic expansion to improve coverage by establishing and operating in four additional provinces while the Peru MA reports the use of omnichannel platforms to improve access to their SRHR services.

SIPPA is currently established and operating in five (5) provinces in the Solomon Islands and will still expand to the other four provinces. Solomon Islands

Omnichannel platform. Peru

Strengthen networks with CSOs and partnership with government clinics

To further improve future clients' practices to accessing SRHR services and information, MAs reported that MAs will strengthen networks and partnerships with CSO and key SRHR service delivery institutions such as public health facilities and health insurance companies.

Networking with community development organisations to link our services and expand our reach.…Creating spaces that promote the integration of the community with MEXFAM's centres of operation. Mexico

Agreements with autonomous institutions, local governments, businesses, and insurance companies. El Salvador

SIPPA will build relationship with government health clinics in the most rural areas to partner with to provide SRHR services. Solomon Islands

MA Funding

Funding Sources

One of the key sources for future MA funding reported by MAs was national and local public /governmental budgets through public subsidies and partnerships with local health insurance companies. Most European Network MAs reported state funding as a key source of future MA funding.

Local Government. Partnership with our local health insurance. Aruba

Public subsidy. Guadeloupe

Government Funding. Albania

the Flemish Government. Belgium

Government. Guinée

Social Marketing Program. Sri Lanka

A few MAs reported that MA could acquire bank loans for investment to finance future MA activities. The Bahrain MA further reported investments in physical buildings to generate revenue to finance future MA activities.

Bank loans for investments. Peru

Investment buildings. Bahrain

Most MAs especially those located in the African region reported the potential of receiving funding from international partners, most especially: The USAID, UNFPA, The European Commission, Save the Children International, and UNICEF. Some MAs reported diplomatic missions such as the embassies of The Netherlands, Sweden, France, Norway, Canada, The UK, Belgium, and Japan as key future MA funding sources.

Embassy of France… Embassy of United States …. Embassy of Netherlands…Embassy of Sweden…Embassy of Germany… Embassy of UK. United Nations Population Fund Albania (UNFPA), UN, Women UNDP, UNICEF, USAID, WHO European Union, Save the Children, SOS Villages. Albania

The Netherlands Embassy, The Belgian Embassy, The Chinese Embassy, The Japanese Embassy …The Government of Canada. USAID. Benin

international organisations and governments. Algeria

Nearly all MAs reported that the main source of funding for MAs in future will be internal IPPF grants. Some MAs reported that in addition to IPPF grants, they will utilise other funding sources for future MA activities.

International Planned Parenthood Federation. Albania

Donor funding, including IPPF, GF, UN agencies, and other bilateral donors or foundations. Cambodia

Fund management through the IPPF linkage which will represent 10% of MEXFAM's total income. Mexico

MAs also reported that for future MA funding, MAs utilise various fundraising strategies such as sourcing grants and non-earmarked resources, use of social enterprising and income from services provided for funding future MA activities. Social enterprising was commonly reported by most MAs as a fundraising source that could fund future MA activities. They added that internally generated funds from the provision of services, as well as donations, legacies, and private sector contributions, will be key sources for future MA funding.

Diversified fundraising strategies for the management of non-earmarked resources will represent 10% of MEXFAM's total income. The management of funds from calls for proposals to finance projects and programmes, corresponding to 10% of MEXFAM's total income. The development of a social franchising model through MEXFAM clinics. MEXFAM's clinic business model will account for 65% of total revenues. Mexico

Local income from clinics and social enterprises. Congo

Member association through the social franchise. Ivory Coast

Grants. Agreements. Pharmacy and Drugstore. Implementation of operating theatres. Provision of health services. Laboratory. Donors Individual fundraising. Peru

Social enterprises The private sector Contributions, donations, and legacies from volunteers. Burkina Faso

We are in danger of missing out on our own financial resources if we do not create our policies and strategies for mobilising funds at local levels. DRC

Call for proposals Private funding: Social and solidarity activities. Guadeloupe

Donations, gifts Social Enterprise strategy. Morocco

A few MAs reported that they would provide specialised services for training and take on consultancies to generate funds for future MA activities.

Seminars and training. Japan

The sale of specialised services (training, consultancy) of MEXFAM will represent 5% of total annual revenues. Mexico

Training platform. Peru

Funding challenges

MAs reported that their funding for MA activities had reduced or was limited and elaborated on future funding challenges.

The decrease in financial resources. Algeria

Limited funding for SRHR. Sri Lanka

Reduce or not fund the association by the Federation. Bahrain

Covid19

The impact of the ongoing COVID-19 pandemic was reported as a key challenge to future funding opportunities as the pandemic has resulted in a lot of changes to the global economy and the economies of countries and funding contributions. MAs in Hong Kong and Mexico further reported that the pandemic has resulted in the inconsistent generation of income from services provided adversely impacted MA’s development and facilitation of training and seminars as a key source of income for MAs.

Unstable service income. Hong Kong

Decline of seminar and trainings due to COVID restrictions. Japan

The emergence of pandemics and epidemics. Guinée

The impact of the pandemic on the global economy. Morocco

Economic changes in the country that decrease purchasing power and therefore donations or consumption of services. Mexico

decline in partner interventions due to Covid 19. Ivory Coast

The effects of the COVID aftermath on the global economy. Aruba

Government and donor interests and policy changes

MAs reported that government and donor interests largely shape funding for SRHR programming and hence shifts or changes in interests, priorities, and policies place challenges to future funding for MA. They indicated changes governmental prioritisation and commitment to SRHR programming leads to shifts in funding and resource allocation which could adversely affect future funding for MAs. They added that changes in policy and tax reforms leads to considerable reductions in funds raised which adversely affects fund investments for future SRHR programming.

Change in donor funding architecture the emergence of other priorities (climate change, COVID-19 pandemic, security crisis); Reduction of the core grant in favour of donor-targeted funds. Burkina Faso

Maintaining IPPF Mimbro Association status. El SalvadorPolicy changes and tax reforms that reduce the benefits for grantees and deductibility, resulting in reduced donations or limiting the possibility to engage in all types of unlabelled fund management activities. Mexico

Government and Donors policy changes/redirection and shift resources from organisation intents… Funding consistency and level of funding allocation from donors. Solomon Islands

The lack of involvement of national donors in funding SRHR and FP projects. Algeria

Albanian MA MAs reported that although fewer CSOs are working in the area of SRHR, it remains a politized topic with inadequate governmental support for the SRHR program which will hinder future funding for its MA.

low number of CSO working in reproductive and sexual health area; SRHR is a politicized topic government support through the Agency for the Support of Civil Society Organization is weak. Albania

For donors, MAs reported that their investments in SRHR appear to be dwindling with some donors placing restrictions on what their funds should be used for which creates challenges for comprehensive SRHR programming. For instance, while some funding sources do not cover the cost of human resources, some donors place restrictions on the use of their funds for the provision of abortion services while other funders

future of donor investments in SRHR beyond 2020 does not look very optimistic Albania

Some donors restricting their funding to entities providing abortion services. Cambodia

Many funding sources do not support the cost of manpower. Hong Kong

High donor dependency for funding

MAs reported the high dependency on donors for funding as a key challenge that MAs would face in future and called for MAs to mobilising local resources to fund their future activities.

High dependence on donors. Benin

Mobilising domestic resources for RH/FT. Burkina Faso

We are in danger of missing out on our own financial resources if we do not create our policies and strategies for mobilising funds at local levels. DRC

Country income status and IPPF classification influences funding opportunities

Country income classification was reported by MAs as having a significant influence on access to funding support. They explained that to the income level classification countries which had moved one step up e.g., from a low-income country to lower-middle-income countries had limited access to funding opportunities as donors and funder shift priority to countries with lower income classifications. They added that IPPF classification of countries by income status creates challenges for their MAs to funding.

Drying up of funding from donors Cambodia has a status of lower middle-income country, although it is still poor and needs assistances. Cambodia

International donors' lack of interest in Mexico as an OECD member and emerging economy. Mexico

IPPF categorizing Aruba as a high-income country. Aruba

The decrease in the number of donors interested in Morocco as a non-priority country.

Morocco

Increased competition for funding

MAs detailed that the increasing multitude of CSOs, NGOs and international organisations competing for funding reduces funding sources requiring MAs to compete for limited funding and further creating funding barriers for MAs. The Bahrain MA also reported that their inability to sublet all the buildings that they had invested in could challenge future funding for their MA.

Increase competition for funding among CSO, NGO, and international organizations.

Cambodia

The inversely proportional growth of foundations over first-tier organisations, which shortens funding possibilities. Competition for funding sources with other organisations.

Mexico

The inability to rent the association's investment buildings in full and therefore the lack of sources of income. Bahrain

Short- and long-term funding agreements

MAs indicated that both short and long term fund agreements are a challenge to future funding for MAs. Particularly for short term fund agreements, MAs in El Salvador and Hong Kong reported that they hinder institutional and project stability and sustainability. The lack of non-earmarked funding to sustain MAs finances and allow for flexibility in MA activities was also reported in Norway.

Long term funding agreements are currently a challenge and are anticipated to continue being so. Non-earmarked funding to build the sustainability and flexibility of the organisation. Norway

Maintaining institutional financial sustainability. El Salvador

Many service projects lack of sustainability due to limited funding time frame. Hong Kong

Service provision and competition

Although some MAs reported that future funding sources for MAs would include resource mobilisation and investment in SRHR service provision, other MAs reported that funds from such service provision will be hindered by other organisations offering the same or similar medical services and thus creating competition which would reduce the income generated for future MA funding.

Investment for the adaptation of premises, expansion of seating capacity and differentiated attention…investment in infrastructure and equipment to provide new services such as Surgical Centre, ultrasound, etc…Working capital to develop the Drugstore, Vaccination Centre, and other pharmaceutical establishments at the other sites… Providing more complex services (day surgery services) ...Expand and strengthen health and education services. Expansion and diversification of health and education services. Peru

The growing offer of medical services in direct competition with MEXFAM's clinics. Mexico

Some challenges due to the dynamics in contraceptive market. Sri Lanka

Inadequate income generation and management experience of MA staff

MAs reported that in most MAs, staff have inadequate experience managing international funding and using social enterprise to generate income which has adverse effects on future MA funding opportunities.

Lack of experience in applying for and managing international multi-country funding. Lack of experience in social enterprise. Benin

Resource mobilisation. Burundi

Develop an autonomous financing capacity through Social and Solidarity Entrepreneurship. Guadeloupe

Insecurity and social instability

Some MAs, particularly in the African region reported that insecurity, social and political crisis in the country would be key challenges to future funding for MAs in country.

security crisis. Burkina Faso

the wars. social and political crises. Guinée

Funding opportunities

MAs detailed future funding options that MAs would utilise.

Innovations and digitalisation

MAs in most regions reported that to expand funding for their work, MAs would have to focus on social entrepreneurship and the use of innovative digital technologies to facilitate revenue generation through the sales of their services and products.

Exploitation of innovations in information and communication technologies for the sale of products and services (digital marketing, e-commerce). El Salvador

Expansion of virtual and mobile health services More channels for users to access services. Peru

Funding opportunities from national and regional governmental agencies

European Network MAs were reported pushing for increased national and public funding institutions and organisations.

Development programme funding from Norwegian Development Agency European funding from Norway's EEA agreement. Norway

Funding opportunities from the private sector

Some MAs will explore funding opportunities from the private sections in the form of donations from charities or foundations and collaborating with other organisations and local health insurance companies or organisations

Possibility of starting a programme with a Belgian NGO in the coming years. Benin

Other funding sources such as corporate foundations. Hong Kong

Private foundations in Norway and globally Agreement with the Norwegian private sector might be an opportunity in the future. Norway

Intensification of MA resource mobilisation activities

MAs also reported that MAs will intensify the mobilisation of resources both internally and externally. Internally, MAs will broaden their funds through the provision of services and information electronically and generate income through the development and sale of new and old SRH products and MA resources such as conducting seminars and training on SRHR and investing their funds to ensure future funding sources. They will aim to increase coverage and broaden the range of SRHR services and products to the populace. MAs that have invested their funds will also access them for funding their future activities. They added to effectively mobilise funds internally, MAs will build the capacities of staff on social enterprising and resource mobilisation and advocacy techniques. The Togo MA will aim to reduce fixed costs accumulated by the MA while the Mexico MA added that MAs will push to decriminalise abortion care and offer legal services for accessing abortion care in MEXFAM clinics.

Financing of new projects. Design and implementation of innovative fundraising strategies. Financial leverage with internal and external funds. Access to investment funds. Expansion of services such as the surgical centre. Expansion and diversification of health and education services. Rental of surgical centre for procedures, etc. Peru

Strengthening internal mobilisation with the help of a network of volunteers. Innovations through social enterprise development. Guinée

Construction of an apartment in one of the association's buildings to increase income. Furnishing one of the association's apartments to increase the chances of renting them and increase their income from the unscathed apartments. Bahrain

Expansion of the SSR product range, including own brands to be distributed by commercial marketing. Expansion of coverage and diversification of the range of products and services. El Salvador

The creation of new donors through the exchange of services offered by MEXFAM. The exploration of non-traditional donors with a presentation on MEXFAM's comprehensiveness, geographic coverage, and social outreach. Train the governance body on resource mobilisation and advocacy techniques. Increase the attractiveness and performance of the CPSs Advocate to decision-makers and donors on the DSSR by practicing a communication policy aimed at raising funds; Designing sponsorship packages and training staff for better resource mobilisation Investing in social entrepreneurship Develop a web-based participatory funding platform Morocco

Scaling up and expansion of Social Marketing Program Diversification of internal funding sources... Strengthen resource mobilization arm... Expansion of product portfolio. Sri Lanka

Strengthening social enterprise. Reduction of fixed costs. Subsidy and/or fee-for-service partnership with private sector companies. Togo

MAs also reported that MAs will need to rebrand themselves and build staff capacity to adequately position themselves as leaders in SRHR

MA’s capacity and image as the leading SRHR in the country. Cambodia

Positioning of the institution based on principles and values of rights, ethics, equity, and quality. Peru

MA Structure

MAs were asked to describe the structural changes that would be required to prepare their organizations for the future and to meet the needs of future clients. A myriad of structural responses as outlined by the MAs are highlighted below with extracts. These included fundraising resources, human resources changes encompassing an increase in the number of employees, other forms of structural changes, organizational chart restructuring, separation of roles, and addition of training components. Other structural components highlighted included management and budgeting, monitoring and evaluation, and position of organizations through name, marketing, and communications. Physical infrastructural changes including technology revamp were also part of the mentioned structural changes. Figure 8 presents a word cloud of the future organisational changes that MAs anticipate.

Figure 8: Future MA organisational changes

Structural changes

MAs outlined the need for organizations to investigate innovative ways to raise and diversify funds through fundraising resources.

> We need to get our fundraising in order and that is the way to expand it. It is also required to find new funding streams and work more in consortiums. There IPPF could be a good partner. Finland

> Focusing on resource mobilization activities and strengthening the current activities. Iran

To establish another unit that will focus on the resource mobilization plan and other income generating activities. It is also very important for KFHA to develop new and longer-term Projects that will continue to support the operations and programmes of the MA. Kiribati

Several MAs felt the need to increase human resources capacity in their organizations as part of the necessary structural changes. Some MAs felt the need to increase key staff members and have dedicated staff as part of the structural changes needed.

Expanding the scope of work and increasing the number of employees. Bahrain

Increase/improve staff capacity at the central level (key staff members). Cambodia

Increase in management and support staff – currently many personnel are functioning in dual roles as well as some positions are outsourced which may lead to delayed and/or reactionary responses. Trinidad

Another human resource structural change that MAs outlined included awarding salaries to staff as a capacity-building strategy. Volunteers also needed capacity building regarding ensuring they are equipped with skills in advocacy, governance, and resource mobilization. Some MAs felt there was a need to evaluate the concept of volunteering and ensure that governance was adopted in all environments. Social enterprise creation and digitalization were also highlighted by MAs as part of the human resource changes needed to happen in line with the current times.

Capacity building of the association's volunteers. Bringing the association's staff up to par with the salaries of other member associations. Awarding salaries. Algeria

Expand our online offer. To master the ever-expanding project portfolio, a Project management Office will have to be installed. Belgium

Adapting governance to changes in the national and global environment. Burundi

MA respondents noted restructuring their structure/organogram. One MA noted that the process of changing the organizational structure would allow the incorporation of advocacy and resource mobilizations components.

Reshaping and strengthening the staff's tasks. Congo

Change in the organizational structure incorporating the advocacy and resource mobilization units. El-Salvador

MAs also reported felt the need to rebrand and package themselves as they communicate and market their services. The name change in some instances was reportedly to broaden the scope to gain donor visibility. Other MAs aimed to focus on using their brand names to create partnerships and also promote services.

Strategic alignment of the organization towards new priorities and customer needs. El Salvador

Promote FPA India as a brand and focussed marketing on it. Marathon is one ways that it is being done currently, but new innovations and ideas to reach larger people. India

Develop better way of promoting our service and expertise. Latvia

Structural changes also encompassed physical infrastructure changes and MAs sought to increase their infrastructure including; buying vehicles, expanding office and clinic spaces, and building premises to cater for service delivery.

Mobile vans. Namibia

Set up FP commodity warehouse. Finalize the pharmacy structure at the front of FPOP national office. Philippines

Clinic expansion (e.g., separate doctor consultation rooms, FP counselling room, scan room, administrative room, rooms for mothers for breastfeeding and changing, child friendly environment). Maldives

MAs also opted for enhance use of technology to serve better their clients. Enhancement of information technology and digital health interventions infrastructure was a common theme among MA respondents.

Technology advancement and supporting resources to develop more online services and education channels and revamp the existing systems. Hong Kong

Introducing full-fledged telemedicine services in each clinic. Bangladesh

Upgradation of technical infrastructure to meet the priority areas of digital health interventions. India

IT infrastructure. New Zealand

MAs also presented the need for strengthening community networks as part of their structural changes to be implemented. A few MAs noted they had not anticipated performing any structural changes at the moment.

Expand and strengthen our community networks (youth, women groups, vulnerable groups, etc.) Cambodia

New finalized strategy of IPPF may influence and become the reason of structural changes. Georgia

Not well researched, so no structural changes are needed, because in retirement, voice no longer holds high value to contemporary leaders. Vietnam

Governance changes

MAs were also tasked to highlight ways in which their governance can be improved, and their suggestions are marked under sub-topics for governance. All MAs highlighted different aspects of governance changes ranging from accountability to new members and leadership which were meant to improve their functionality.

Recruit qualified and specialized... Building the capacity. Guinea Bissa

Redefine "purposed. Revisit the technical advisory committees and revise the ToRs. Sri. Lanka

Monitoring and Evaluation System. Morocco

Strengthening and adherence to set standards in the organization including safeguarding policies and anti-corruption and fraud policy. Zimbabwe

Audit of organization's structure, duties of employees. Latvia

MAs highlighted a number of recommendations in regard to governance restructuring with an aim of achieving implementation of code of good governance. Some countries noted that resource mobilization and fundraising coupled with proper budgeting as recommendations in restructuring governance. Monitoring and evaluation systems and strengthening volunteer advocacy and having better orientation of volunteers on governance issues were part of the recommendations highlighted by MAs. Other ways governance could be improved in MA's countries included; conducting governance assessment to ensure its boards are measured against established standards or results, provision of equality and decentralize power to regional offices among other listed below:

Extend the participation of board on the necessity of mobilizing resources, institutionalization of resource mobilization priorities, drafting budget allocation and identification of programs for increasing the base of supporters and contributors. Albania

Follow up of budget and activities by the board will be more frequent. We will make more use of the full potential on competences of board members and members of the general assembly. Belgium

Setting up an evaluation and motivation system. Collaboration between volunteers and staff. Burundi

Board composition and size. Sri. Lanka

Allocation of a performance contract to each member. Joint evaluation of governance by the Senior Management Committee and the General Assembly of Volunteers... Opening the board to people from the diaspora and scientists. Togo

Empowering members of Executive Committee. Iran

MA constitution and regulations will fix that experts will cover 20% of governing body members. Korea

Identify the roles and responsibilities of all governance members. Integrating people with disabilities into policies and commission protocols Palestine

Strengthen volunteer compliance to the MA constitution and other governance polices and guidelines. Zambia

Section 4: FEDERATION

Global SRHR horizon

MAs highlighted the global horizon issues that were likely to define SRHR in the coming decade. Common mentions included access to abortion, contraception and CSE. MAs emphasized in the coming decade there would be increased backlash towards SRHR both from conservatism and working in areas on humanitarian setting. Other global issues for the next decade included digitalization, fertility and GBV and increase in gender inequalities based on gender and sexual orientation. Figure 9 details a word cloud of the most frequent words under this theme.

Figure 9: MAs common words associated with SRHR Horizon

Future global SRHR issues

Global SRHR issues over the next decade as reported by the MAs in the different regions include will include access to CSE, access to contraceptives and abortion care and backlash on SRHR issues.

> Implement work through schools and expand to the community around the schools. Thailand

> Access to contraceptives …. Marketing of short- and long-term MACs and reversibility for men (pills, ampoules, etc.). Access to safe and legal abortion. Norway

> Increase in the number of women needing abortion services. Kiribati

> Maintaining the awareness for the need of family planning is also crucial. Nepal

MAs detailed that the global horizon for future SRHR would still face political, traditional, cultural, and conservative public attitudes and opposition from society and right-wing groups. They acknowledged that despite current global discussions for enhanced development cooperation, opposition to SRHR as well as human rights are still abused particularly in conflicted or fragile settings.

> Social norms and environment which prohibit or enhance SRHR. Cambodia

Gender equality and equity… Human rights issues. Guinea Bissau

Acceptance and willingness to move forward and achieve recognition of sexuality and equality. …Changes in behaviour/attitude towards issues related to sexuality. Mexico

Discussions around the decolonization of aid and development cooperation. Opposition and the rise of conservatism (in North and South). Belgium

The rise of opposition in the areas of SRHR. Humanitarian context. Burkina Faso

MAs reported that the future SRHR will have to adapt to and utilise digital technology particularly innovative technologies that would have significant effects on global SRHR programming.

The role of Telemedicine and Telehealth in access to sexual and reproductive health services. Peru

The use of new technologies. Burkina Faso

Digital Health Interventions; m-health, Artificial Intelligence, and its integration in regular service delivery. India

MAs also detailed that fertility, women, and maternal health issues were also reported as future SRHR issues. They added male SRHR issues and prevention of STIs will also dominate future SRHR programming. GBV and gender inequalities were reported as key global SRHR issues that will arise over the next decade. While some MAs reported the need for programming and interventions that prevent and provide supportive services for victims of GBV, other MAs focused on addressing issues of gender inequalities.

Reproductive health linked to fertility in men and women. Prioritize menstrual hygiene. Re-Making SRHR into a men's issue. (or everybody's issue). New Masculinities. Prevention of sexually transmitted infections. The exercise of rights and people's participation in seeking information and services…. Increased access to sexual and reproductive health education information. Eradication of GBV…. The fight against violence… Pursuit of gender equity… Right to civil partnership and Access to equal marriage in more countries around the world. Peru

Climacteric, menopause. Mexico

Gender equality in SRH, society, and economy. Japan

Discrimination and stigmatization based on gender, age, and sexual orientation. Guinee Bissau

Discrimination in the provision and accessing SRHR information and services faced by vulnerable populations such as LGTBI, people with chronic conditions and people with mental health issues, were key global issues that will SRHR programming as reported by several participants. Improving SRHR access for vulnerable groups such as adolescents and young people, people living in rural setting.

Providing SRHR information and services to the LGBTQI+ population. Japan

Sexual orientation, Gender equality / gender affiliation, Sexual rights, Sexual education. Aruba

Gender equality, Access to modern contraception and Menopause. Tunisia

Mental and emotional health work in response to global crises and emergencies. Mexico

Marginalized groups (people with special needs - living with AIDS. Youth issues and targeting children and developing concepts related to their reproductive and sexual health. Bahrain

MAs also detailed the slow implementation of policies, strategies and plans by governments and donor to achieve the global agenda for SRHR as a key issue that will face future SRHR programming.

Involvement of governments in implementing ICPD resolutions. Algeria

Agreements of International Conventions and Treaties on SRHR. El Salvador

Fulfilment of the Sustainable Development Goals of the United Nations Global Agenda 2030…International and UN agendas, 2030 agenda...Fulfilment of the Population Agenda. Mexico

They added the current governmental and donor focus on Covid has affected funding for SRHR and will affect future SRHR programming towards achieving the global and national commitments.

The evolution of the COVID-19 pandemic will set the tone for the subsequent work of our organizations. Mexico

The impact of the pandemic on "non-prioritized" services…Economic impact of the most at-risk population. Peru

LGBTIQ, Abortion, Reduction of donor funding during and post COVID-19. Sri Lanka

Moving Beyond Cairo

MAs suggested ways to move SRHR beyond Cairo/ ICPD in their respective organizations. Advocacy and increased service provision were focus areas to strengthen efforts towards improving SRHR. MAs emphasised the need for strengthening partnerships and effectively engagement and involvement of all stakeholders particularly at the community level

Engage and involve communities at the grassroots level…Encourage and support public and private partnership. Guinee

Creating strong alliances with civil society for advocacy and advocacy. Mauritania

Joint partnership, collaboration, coordination, and networking between CSOs, Government, private sector, and general public. Nepal

They also recommended strengthening communication structures and harnessing effective communication strategies involving the use of media, social networks, and campaigns to address prevailing socio-cultural and religious barriers and sensitisation and increasing access to SRHR information.

Investment in dissemination and communication strategies to more remote and multicultural populations…. Dissemination of information and discussion spaces related to sexual and reproductive health, demystifying misconceptions, and clarifying doubts and concerns, through social networks. Peru

Lead strong youth movement on gender equality and SRHR. Japan

Creation and strengthening of inter-institutional networks with international partner organizations. Mexico

MAs further recommended that MAs should focus on building and strengthening their regional and global networks and implementing the recommendations made at the Cairo CPD conference and other regional and global conventions and agreements.

Agreements of International Conventions and Treaties on SRHR. El Salvador

Building regional and global networks of activists. Sri Lanka

MAs reported that MAs should put more advocacy efforts to improve and consolidate legislation governing SRHR issues to effectively address future SRHR challenges. They called for the inclusion of SRHR issues on the national commissions on human rights and the promotion of existing legislation that support human rights.

Laws and government policies enacting access as a right to SRH and guaranteeing people to exercise SRHR. Follow-up government commitments on SRHR issues. Redefining population policy and strategies so SRHR is essential. Japan

Placing and advancing SRHR on the agendas of the Commission on Human Rights, the women's equality agenda and the SDGs. Mexico

Issuing laws and regulations that support rights. Bahrain

MAs also called for a focus on promoting in the inclusion of sexual rights in international and national documents and agreements as way to addressing issues surrounding SGBV and other forms of human rights abuse.

Focus more on the recognition and tackling of multiple and intersecting forms of discrimination and marginalization. Belgium

Human right-based approach in addressing SRHR. Cambodia

Agreements of International Conventions and Treaties on SRHR…Providing SRH services with a gender and human rights approach. El Salvador

Legalize abortion. Sri Lanka

MAs and the federation would have to advance the SRHR agenda at all levels, particularly at the global level. MAs called for a renewal of efforts and global commitment to addressing SRHR issues and suggested strengthening research to provide evidence for informed decision making at the global level. MAs also recommend that richer countries should provide more funding support for SRHR is less richer countries

Advance SRHR. Belgium

Remaking global commitment for SRHR. Cambodia

Organize a global meeting to define priorities and strategies for SRHR implementation. Guinee-Bissau

Put forward the design and implementation of youth friendly programmes, gender sensitive and life-skills based comprehensive sexuality education. Albania

Increase domestic government funding by exploring new and innovative financing instruments and structures to ensure the full, effective, and accelerated implementation of the ICPD Programme of Action. Central Africa

Mobilisation of domestic funding from non-government sources – private foundations and philanthropist to bridge the gap in funding for SRHR. Nigeria

MAs also need to improve or strengthening their monitoring of policies and their implementation progress to inform SRHR programming.

Monitoring policies in our countries. Peru

Improve M&E, support research, and apply knowledge and lessons learnt in policy and planning. Samoa

SRHR innovations

MAs highlighted innovations that IPPF needed to consider in the strategy. They ranged from effective communication strategies, funding mechanisms, disaster preparedness, intersectional approach to work, management strategies and monitoring and evaluation.

Use new and different means to raise awareness of the importance of family planning. Bahrain

Strengthening community services Action research. Togo

SRHR disaster preparedness (developing and deploying disaster preparedness plans that include SRHR and considers a diverse population including vulnerable groups). Japan

Strengthen Social Marketing. Strengthen the research arm of IPPF. Sri Lanka

Re-examine the role of regional offices to achieve efficiencies of cost and operations and technical support. India

New resource mobilization strategies such as further exploring social enterprise models, role of corporate sector in resource generation and diversifying donor's base. Pakistan

Development and/or use of technology IPPF products and branding

MAs called for the development and or use of technological innovations, digital and telemedicine for enhanced and protective service delivery. MAs called on the need for MAs and the federation to invest in the development and use of SRHR products and improved branding of federation

Putting in place adequate online service delivery mechanisms. Define and implement an innovative and relevant model for youth centres. Benin

Specialized and differentiated sexual and reproductive health care services through virtual and mobile channels…Automatic MAC dispensers. Development of IPPF's own brands of

contraceptives that are competitive in international markets (economy of scale). Support for research to develop contraceptive methods for men. Peru

STI self-diagnosis tests that are becoming more and more reliable. Belgium

Male contraception. Guadalope

Training, knowledge exchange

MAs highlighted training and knowledge exchange as part of the new innovations that IPPF needs to consider in the new strategy. Some of the trainings noted was medical and others geared towards service delivery.

Strengthen spaces for exchanging experiences and sharing knowledge among MAs…Create "Educate the Educators" training programmes. Mexico

Training of providers in the management of obstetrical and gynaecological emergencies. DRC

Organize specialization and professional online trainings /service providers and volunteers of MAs can study online and get a certificate. Mongolia

Strategy Core values

MAs highlighted core values that should inform IPPF next strategic framework. These included accessibility, accountability, inclusiveness, commitment, empathy, empowerment, recognition of diversity in sexual orientation, gender identity, expression and gender characteristics, equality and equity, collective construction

UHC and SRHR: leaving no one behind… SRHR is not only for women; it's everybody's issue. Japan

Inclusion for all. Algeria Accountability, Diversity. Transparency Cambodia

Focus on qualitative over quantitative. Collective construction Respect for the particularities and autonomy of MFAs. Equality for all MFAs. Objective criticism. Openness to communication. Mexico

Accountability, commitment, diversity, empathy, empowerment through information, equity, freedom of decision, Intersectional approach. Passion, Responsibility. Rights, Sustainability in the organisation, inclusion. Peru

Secretariat Support

MA Support needs

MAs highlighted a number of support mechanisms IPPF could be able to support them, with financial support being common. MAs noted that availability of substantial financial support from IPPF could enable them to address the many challenges facing them. Others noted IPPF should help in additional resource mobilization and availability of resources for fragile countries and international and national levels. The Nordic and European countries felt they could benefit from the funding opportunities IPPF has to offer. Other support from IPPF to member MAs included provision of technical assistance in areas of advocacy, monitoring and evaluation, innovation, resources mobilization and implementation of policies.

> Technical intelligence and collaborations on global advocacy efforts Norway

> Give priority attention to Family Planning Programmes to provide services to vulnerable populations and in the context of humanitarian emergencies Higher award amount in the Indicative Planning Amount. Be recipients of funding for project implementation from international donors. Financial support for the acquisition of an ERP system for integrated business process management. Do not neglect efforts to seek resources to financially support MFAs in low and middle income countries. El Salvador

> Generate innovation labs to promote new initiatives, test them and support their expansion. Maintain some degree of subsidy to work in economically disadvantaged populations, where services cannot be self-financing…Direct communication of new grant opportunities to implement innovation strategies to improve sexual and reproductive health…Financing of investment projects…Financing of revolving funds. Internalise the critical situation of institutional sustainability and act empathetically by facilitating opportunities for MFA. Direct funding to boost local projects. In recent months we have seen the expected attitude. However, the financial situation of the institution is critical, as the pandemic has badly affected private service providers such as INPPARES and much more collaboration is required. Peru

Capacity building of MAs, technical assistance and knowledge and information provision were areas that MAs sought support from IPPF. Other MAs mentioned support areas include; fostering social enterprise and creating an avenue for MAs to exchange experiences and learn from each other. Political support against anti-SRHR movements and supply of SHR commodities such as contraceptives were also requested by MAs as key areas that IPPF secretariat would be required to support them with in the next decade.

Collaborate and involve the researchers to ensure wide-ranging contribution to the evidence base and approaching the emerging needs for SRHR. Involving target population in the design of locally appropriate mHealth Solutions. Albania

updates and timely resources on the global SRHR policy processes and support Facilitate the exchange on vision and good practices between MAs Help build the bridges to (allies in) other sectors and sponsors. Facilitate the exchange on vision and good practices between MAs. Belgium

Implementation to systems of excellence. Specialised training. Conduct studies and monitoring of internal processes of MFAs. Generate open spaces for discussion of various topics of interest to promote research and publications. Generating evidence to improve partnership decision-making. Specialised technical support. Peru

Opportunities for knowledge sharing and learning Paid and free access to online SRH courses offered by world recognize universities. Sri Lanka

Capacity building in monitoring and evaluation; Technical assistance for statistical data management. Technical assistance for strategic and operational planning. Guinée-Bissau

Federation Changes

Figure 10 presents a word cloud of the 100 most frequent words under this theme.

Figure 10: Future Organisational Changes needed in IPPF Federation word cloud

Changes in IPPF Secretariat practices

As part of the organizational changes at IPPF Secretariat, MAs noted that IPPF should consider making efforts to build headquarters and if possible, also clinics in each MA to help in sustainment of IPPF activities. There was also an idea presented that IPPF Secretariat should try to separate regions so that autonomy exists. An MA for example noted that the East Asia region should be separated from the Pacific Region. Practice changes at the IPPF Secretariat MAs requested to happen in the future included the federation to be more MA centric by strengthening capacity building efforts of MAs in need.

Other MAs felt resolution and communication was a challenge with the Secretariat. MAs advocated for issues ought to be dealt prompt from the Secretariat. MAs also added there is need for the Secretariat to develop creative and effective mechanisms for capturing and sharing good practices and lessons learned across MAs. Funding was mentioned as an area the IPPF Secretariat can do differently in the future. MAs noted that the federation needs to allocate more funds to activities so that MAs can sustain them. There was also the notion that the Secretariat should provide technical support to MAs.

> We look forward to the Secretariat adopting and implementing the agreed reforms in 2019, MEXFAM is ready to provide the necessary accompaniment. Mexico

Develop sharing materials (presentations/documents) in different languages. For example: Sometimes meetings have translation, but presentations/documents are in English. Assess the reality of each MFA. Include indigenous staff in its secretariat. Peru

The secretariat should change to be MA centric in practice not only in words. Norway

Relying more on the expertise of MAs and being more accommodating to the realities on the ground Focus on evidence and proof rather than theories of change, Really listen to the MAs and the people who are best suited to take decisions that affect the life of the institution Togo

Clear communication strategy. Japan

Board & Committees Changes

MAs detailed the need for several changes to the IPPF broad and committees' practices as key to improving the future of the organisation of the IPPF foundation. Improved and transparent communication between MA offices, regional offices and the federation was commonly reported as an important future change to the IPPF broad and committee by MAs in the East and Southeast Asian and African regions. They called for transparency in the sharing of information and continuous up to date information about actions and related activities. MAs, particularly in the African and Arab regions were keen on shared learning among MAs to enable them share best practices and learn from the experiences of other MAs. They also called for increased technical support to MAs, involvement and consultation with MAs and people working at the grassroots to ensure that proposed strategies address the contextual and practical challenges of MAs. Guinee called for further decentralised sub-regional coordination while the Burkina Faso MA reported the need for increased international presence to have a stronger voice at international SRHR meetings and programs. It was only the Japan MA that emphasised the need for future organisational changes to strongly focus on MAs and not on the organisation at large and called for future changes to avoid sectionalism while the Bahrain MA requested for increased technical support.

Share more information on current conditions…Discuss for the sake of MAs and not the Federation… No more sectionalism. Japan

Improve communication between the regional office and the MAs… Increased presence of IPPF in major international meetings on SRHR. Burkina Faso

In the Americas and Caribbean region, MAs reported the need for regularly and informed communication between the Federation and the regional offices in order to strengthen the network and facilitate mutual understanding of shared aims and goals and contextual and regional challenges.

> Maintain constant liaison between IPPF central and the Latin America and Caribbean regional office…Keep us informed about the scope and channels of participation in the Board and Committees. Mexico

> The Board of Directors should maintain regular and timely communication with the boards of the member associations, in order to better understand what it expects from its role in the local associations, under the principle of autonomy and self-determination…The Federation should promote a healthy relationship between the Board and Executive Directors and be clear about the scope of work and role of Executive Directors and train them in governance. El Salvador

> Empathetic behaviour is observed, accompaniment would be required until sustainability results are achieved. Peru

It was only in the South Asian region that it was reported that key changes to the IPPF board and communities' practices should include a recognition of the differences in the abilities of various MAs in funding arrangements and support to diversify scope and include various SRHR topics should be complemented by leveraging on national and global partnerships.

> Recognize the variance of MA capacity as a key criterion for grants… Encourage MAs to expand the scope and engage in diverse sub-themes of SRH… Help leverage global partnerships and for at a regional and national level on areas as GBV. Sri Lanka

MA Centricity

A word cloud of the 100 most frequent words under this sub-theme is presented in figure 11 below.

Figure 11: MA Centric approach withing IPPF Federation word cloud

Several MAs indicated that the key for a MA centricity approach is to involve MA in all important decisions. This need is expressed in different positions within a continuum between MA having autonomy and MA's being having a voice in the Federation. On one side, some MAs demand being able to make autonomous decisions while being supported by IPPF or that MA is at the IPPF's decision-making centre. Others indicate that the Federation needs to put itself at the service of MA or that the MAs are the main source of information when the secretariat engages in a/the MA country. Several others indicate that the voice of MAs is heard and considered and that have active participation in any macro decisions.

> A federation that puts itself at the service of the MAs and their well-functioning…. A federation that strikes a balance between support and respect for the autonomy of MA. Belgium

> The voice of MAs is heard and taken into account in all processes in an inclusive and fair manner. Taking into account the opinion of the MAs in the Federation's decision making. Sharing experience with other MAs to increase the capacity of young volunteers. Youth training on advocacy and leadership Burundi

> Federation that shows closeness to the MAs and builds a joint vision of the future for the benefit of the populations it serves. El Salvador

Involvement of MAs as a priority in decision making. Guinée

That the MAs are the main source of information when the secretariat engages in a/the MA country. That the secretariat does not contact funders in a country without FIRST speaking to the MA in the country. Norway

Some MAs detailed that the use of an MA centricity approach requires internal cooperation between MAs. They detailed that the concept of cooperation focuses on peer support sharing of experiences and lessons learnt to inform and support each other.

Co-operation between MAs. Hong Kong

A federation with a focus on peer support. Burkina Faso

MAs indicate that an MA centricity approach suggests equal regional representation and equal consideration of all MA views and resource allocation.

Regions are equally represented. Japan

No perceived difference between what one MFA receives and another. Perú

MAs held the opinion that IPPF should involve MAs in making key decisions and develop strong association with the MA to enable both the federation and the MAs achieved their visions, aims and goals while strengthening MA activities at the country level.

Federation that shows closeness to the MAs and builds a joint vision of the future for the benefit of the populations it serves. El Salvador

That the secretariat are familiar with and strengthens the work of the MAs. Norway

A few MAs reflected on management strategies and reported that a central secretary coordinates the work of the Federation and manages and disburses its funds. They recommended the development and accessibility of internal complain management systems for MA and suggested transparency in communication, information sharing and structures.

Central Secretary coordinates the work of the Federation…Central Secretary distributes union funds. Mauritania

Availability of internal complaint management for MAs. Transparent communication, information, and overall structure. Austria

MAs held the view that IPPF should provide technical assistance in identifying varied sources of funding for MA and should also provide funding to ensure institutional financial stability and sustainability for MAs.

The search for different sources of funding to support the operation of MAs…Federation that addresses funding and technical assistance needs to assist in the financial sustainability and sustainability of MA programmes. El Salvador

A federation that brokers access for MAs to policy, financial and organizational support. Belgium

Increasing basic grants Establish a support mechanism for the development of social enterprises Burkina Faso

Several MAs held the opinion that an MA centric approach considers MAs voices and their applied work on the field and suggests that IPPF's strategy is built upon these actions and the goals they aim to achieve. They suggested IPPF strategy and planning must fit these local strategies and be available to offer applied support when needed. They added that it also requires respecting and adhering to cultural, and religious contexts of each MA country.

Bottom-up structure. Austria

MAs is the face of IPPF, in particular at the country level. The world sees IPPF as a collective of MA presence in the many countries we are now. Cambodia

Strengthening the support teams for MFAs to ensure an adequate response to needs in all areas of intervention. El Salvador

Goals are accumulated from the local level. Japan

Section 5: OTHER RECOMMENDATIONS

MAs provided additional recommendations to IPPF secretariat regarding all phases of project life cycle.

Concepts used, Monitoring, Evaluation and Quality

MAs appreciated, and considered people centred programmatic approaches as central in IPPFs programmatic work. MAs recognized the utmost importance of performant monitoring and evaluations systems in their work. External evaluations of MAs can be useful in identifying gaps and improving their performance. There was an expressed need for support in obtaining IPPF accreditation. Capacity building in this domain was recommended by most MAs. Some MAs added the inclusion of evidence informed practice in most aspects of their work. With increasing adoption of data and evidence informed policy making and practice as a normal, receiving basic research and data management competencies where possible was highlighted by MAs. The Mexico MA reflected on the key concepts used in the framework and proposed new concepts that they felt were more in tune with the SRHR frameworks.

The concepts of business plan and client, especially the latter, made us reflect on possible synonyms that reflect us as organisations committed to the social and humanistic agenda. For example, fundraising plan and beneficiary population. Equally, the balance and focus on people-centred programmatic work should continue to be reflected plan of this nature must be accompanied by a constant evaluation exercise from the outset. México

When it comes to the future DHIS2 reporting. We experience a great lack when it comes to CSE reporting. As one a few MAs that does not give direct training but provides curriculum material directly to teachers, we reach a much higher amount of students than through direct training. Currently there is no way of capturing this in the DHIS2 system. Since youth and CSE is likely to continue to be a priority for IPPF, we recommend that this will be changed in the future systems. Norway

Support MAs more directly in complying with the IPPF accreditation process. El Salvador

Funding and innovation

While some MAs requested more funding support for MAs, other MAs requested the development of effective strategies that MAs could utilise for access funding. They also requested support for strengthening service provision and for MAs to develop and use social enterprises to generate income internally. MAs interest to develop own funds included developing capacity for writing grant applications for funding and managing own funding for instance, from agencies like the USAID. Though social entrepreneurship was the main direction opted for by MAs in the coming years, expertise in this business model was reportedly lacking. They also suggested context appropriate funding models with guidance from the IPPF would be welcome by the MAs.

Increasing basic grants…. Establish a support mechanism for the development of social enterprises. Burkina Faso

Implement a fundraising strategy for small sub-regional projects. Guinée Bissau

Strengthen service provision…Make SRH services available throughout the country, even in remote areas. DRC

Capacity building and training

Capacity building needs were raised across various issues. Most MAs called for more capacity building and training for MA staff to equip them with the necessary skills for their work and SRHR programming. They also suggested inter-MA support processes that could facilitate shared learning. Most of the sectors where MAs expressed capacity building needs included: monitoring and evaluation, grant writing and specific funding stream management, increased capacity in training volunteers, and social entrepreneurship. Though capacity was a general important theme, the needs varied significantly across MAs.

> Sharing experience with other MAs to increase the capacity of young volunteers…Youth training on advocacy and leadership. Burundi

> Create a working group at the IPPFAR secretariat level to assist AM in developing its skills …Create support mechanisms between MAs through champions. Guinée Bissau

Feedback on Strategy Design Roadmap 2020-2022 methodology

Only the Mexico MA provided feedback about the methodology used in this consultation process and indicated that the timeframe for the process was short/limited and did not give room for MAs to provide a broad diversity of views to inform the process.

> This questionnaire required a thorough and analytical exercise that MEXFAM approached with due seriousness. Had we had more time, we would surely have expanded and included a greater diversity of voices within our organisation. Mexico

APPENDIX

Table 1: National Consultative process

Table 1: National Consultative process				
Who	Country	Frequency/ number (average)	Description	Quotation
11A - TYPE OF CONTRIBUTORS				
Contributors - MA GOVERNANCE	Congo Nigeria Samoa	7		▪ The governance team at the regions and NHQ participated in the group discussions held at both the regional level and NHQ level. Nigeria
Contributors - MA governance female	Albania Ivory Coast Morocco Solomon Islands Sri Lanka Togo DRC Mongolia Austrian	58		
Contributors - MA governance male	Albania Algeria	50	▪ Chairman of the	

	Ivory Coast Mexico Morocco Solomon Islands Sri Lanka DRC Mongolia		Board of Directors ▪ Secretary to the Board of Directors ▪ EBM	
Contributors - MA governance youth (<25 years)	Algeria	2		
Contributors - MA governance adults (=>25 years)	Cambodia Mexico Norway Lithuania	4	▪ Ex-youth representative, ▪ Chairman of the Board of Directors, ▪ ED ▪ Senior advisers in the	

			organization ▪ President	
Contributors - MA STAFF	Bahrain Belgium Guinée-Bissau Nigeria Samoa	60	▪ Program, ▪ M&E ▪ Finance ▪ Clinic focal persons from the state, regions, and headquarters	▪ The Program, M&E, Finance and Clinic focal persons from the state, regions and headquarter were included in the consultation. Nigeria
Contributors - MA staff youth (<25 years)	Guinée-Bissau Austrian	25		
Contributors - MA staff female	Albania Algeria Mexico Solomon Islands Mongolia	53	▪ Director General ▪ Strategic Director for Advocacy and Inter-Agency Relations ▪ Evidence for Advocacy Coordinator Subnational Advocacy Coordinator	

	DRC Lithuania Austrian			
contributors - MA staff male	Albania Algeria Solomon Islands DRC Lithuania Mongolia Austrian	37		
contributors - MA VOLUNTEERS	Algeria Solomon Islands Morocco Nigeria Samoa	153	▪ The National Coordinator and the Alternate Coordinator of the PPFN Youth Action Movement group Nigeria...Youth Volunteers. Nigeria	
contributors - MA volunteers' youth (<25 years)	Albania Algeria Cambodia El Salvador Peru DRC	150	▪ Young staff ▪ Volunteers	▪ Young staff and volunteer. Cambodia

contributors - MA volunteers (=<25 years)	El Salvador Mongolia	14	▪ Meetings with representatives of the Leaders' Group and young volunteers. El Salvador
contributors - MA CLIENTS	Albania Belgium Cambodia Solomon Islands Nigeria Samoa		▪ from constant evaluation of clients. Albania ▪ Through an extensive stakeholder survey 2020. Belgium ▪ Social workers and community staff who work closely with our clients. Cambodia ▪ In the consultation process 50 clients were interviewed. Solomon Islands ▪ Some FP clients from the NHQ clinic and 6 regional clinics. Nigeria
contributors - MA clients female	Morocco DRC	55	
contributors - MA clients male	Morocco DRC	25	
contributors - MA PARTNERS	Albania Bahrain Belgium Morocco DRC Nigeria Samoa	12	▪ 3 representatives from the Ministry of Education, Youth and Sports; 4 representatives from the Ministry of Health and Social Protection (Mohs); 6 representatives from the Institute of Public Health (IPH); 2 representatives from the Operatory of Health Care and representatives from partner organizations and networks were contacted and provided their input on specific issues. Albania ▪ Ministry of Health, UNFPA, ALCS, parliamentarians, Comity de Coordination Maroc (CCM), AMPF/Y-Peer Coalition and UFL. Morocco

			▪ PNSR Kwela, PNSR Haut Katanga, Univers Santé Plus (USP), AFIA MAMA, SCOSAF. DRC ▪ PPFN consulted with 15 key representatives of partners organizations (UNFPA, MSI, BMGF, FMoH, National Population Commission, Pathfinder International, Education as a Vaccine, Society for Family Health, Women's Health and Action Research Center, Association for Reproductive and Family and MacArthur Foundation). Nigeria
contributors - OTHER STAKHOLDERS	Albania Guinée-Bissau Nigeria	12	▪ A round table will be carried out on strategy with key stakeholders on 29th of September. Albania ▪ Key representatives of PWD groups Nigeria
A- CONTRIBUTORS ENGAGEMENT METHODS			
Questionnaires/survey	Belgium Solomon Islands Japan Morocco El Salvador Peru Solomon Islands Togo DRC Mongolia	▪ survey response. Opinion polls in pro-family clinics. El Salvador ▪ The form was administered to Inppares' clients through a survey. Inppares' main strategic partners were surveyed on the form. Peru ▪ MA staff which is the junior staff and senior staff were also part of the consultation. A total of 14 female staff and 10 male staff. The methodology apply, group discussion and debates and providing questionnaires. Solomon Islands	

	Nigeria Samoa	
one-to-one discussions/ interviews	Benin Burkina Faso Congo Solomon Islands Togo Botswana Nigeria	▪ Clients were involved on the basis of testimonials from individual interviews. Congo ▪ The volunteers plays a very important role in the organization. They are often involved and engaged in the community programs. In this consultation process 15 volunteers were interviewed. In the consultation process 50 clients were interviewed. Solomon Islands ▪ Some FP clients from the NHQ clinic and 6 regional clinics were consulted through interviews. Nigeria
group discussions/ focus groups	Peru Benin Congo Solomon Islands Togo Albania ARUBA Botswana DRC Georgia Mauritania Mongolia Nigeria	▪ A zoom focus group has been conducted with the members of the BoD… Young volunteers …A zoom focus group was conducted with the members representing each committee of the Futuro Youth Centre. Peru ▪ Youth Volunteers...Focus group discussion. Botswana ▪ The work took place in the form of interactive focus group meetings. Congo ▪ through traditional meetings. social media counseling sessions. ARUBA ▪ The MA executive board members (EBM) was part of the consultation. The EBM consist of 5 males and 5 female. The methodology apply in the consultation group discussion and debate…MA staff which is the junior staff and senior staff were also part of the consultation. A total of 14 female staff and 10 male staff. The methodology apply, group discussion and debates and providing questionnaires. Solomon Islands ▪ Collective answer Ask questions to a group of volunteers They shared some questions. Mauritania

	Samoa Mauritania		
Mode of engagement			
Virtual/electronic/telephone	Mexico Peru Burkina Faso Benin Burundi El Salvador Hong Kong MA Japan Mexico Morocco Sri Lanka Togo Tunisia Botswana DRC Lithuania Maldives Mongolia Nigeria	▪ ZOOM ▪ Emails ▪ Self-administered online questionnaire ▪ Virtual meeting (webinar) ▪ video conferences	▪ A zoom focus group was conducted with the members representing each committee of the Futuro Youth Centre. Peru ▪ Meetings with the Board of Virtual meetings Directors. Meetings with representatives of the Leaders' Group and young volunteers. El Salvador ▪ video conferences Zoom…Face-to-face + Videoconferencing Zoom… Through suggestion boxes and satisfaction questionnaires. Morocco ▪ Exchange of e-mails…Telephone exchanges. Togo ▪ Feedback by e-mail Discussions on WhatsApp Meeting Feedback by e-mail. DRC ▪ Phone calls, Zoom calls, conversations on Facebook Messenger. Lithuania ▪ This was done through email surveys using questionnaires. Nigeria

Physical	El Salvador Burkina Faso Congo Morocco Norway Tunisia Botswana Maldives Samoa	▪ Meetings with representatives of the Leaders' Group and young volunteers. El Salvador ▪ The work took place in the form of an interactive working meeting. Congo ▪ During a staff seminar on June 18, 2021. Norway ▪ Face-to-face meetings Zoom meeting Telephone exchanges. Tunisia ▪ Facilitated Meetings Email Feedback. Maldives ▪ Board meeting Staff in-service training Stakeholder's meeting. Samoa

Table 2: Summary of key findings by IPPF MA region

Table 2: Summary of key findings by IPPF MA region					
Total forms coded so far 80 forms					
MA region	Countries	Countries included	Key gaps	Barriers	Recommendations
	Afghanistan Bangladesh India Iran	Afghanistan Bangladesh India Iran	❖ Geographical disparities in access –inequalities in access for contraception-safe abortion services	❖ Restricted legal and social environment to deliver safe abortion services.	❖ MA advocacy (value clarification and sensitization programs) ❖ Advocacy for adaption of Muslim marriage law to prevent early marriages. Some prior Advocacy

South Asia (Bangkok hub and Delhi sub-office)	Maldives Nepal Pakistan Sri Lanka	Maldives Nepal Pakistan Sri Lanka	❖ The rape of male children is not included in the country's law on rape ❖ Marital rape is not properly defined, and this propels GBV ❖ Criminalization of LGBTQ communities ❖ Religion (Muslim) propelling child marriages ❖ Conservative socio-cultural factors limit the provision of CSE in schools. ❖ Socio-economic and cultural factors, the stigma for key SRHH issues and religious fundamentalist groups opposed to SRHR. ❖ SRH rights are yet to be recognized and understood widely.	❖ Contradictory laws and policies e.g., on abortion and restrictive access to comprehensive abortion care ❖ Socio-cultural and religious barriers, stigma and prejudices hindering access to abortion services and contraception in NGOs with aspects of CSE information not provided ❖ Stigmatising attitudes and barriers for key populations as they are not mainstreamed in the regular service delivery and hence 'invisible. ❖ CSE training not included in teacher and health professional training curriculum	efforts have resulted in the establishment of an abortion fatwa which permits abortion under five circumstances by the Islamic Fiqh Academy. ❖ Advocacy work to influence Government policies to establish abortion rights and to legalize self-care MRM. ❖ Provide psychological counselling services in the future and legal consultations ❖ Advocacy for SRH service provision and engaging authorities for support for medical abortion and GBV laws ❖ Advocacy and strengthening networks with CSOs and other stakeholders for collective movement on specific issues and lobby government on laws such as abortion. ❖ Strengthen resource mobilization capability and funding should be mainly internally generated through eg. social marketing programs ❖ Propose strengthening of the research arm of the IPPF to conduct more SHRH research (future priority area)

			❖ Lack of comprehensive and integrated SRH services for gender-diverse people and reaching the hard-to-reach population. ❖ The inadequate and negligible domestic budget provision in the health sector hampering universal access to SRH services. ❖ Inadequate and inaccurate information on SRHR facilitating myths and misconceptions; stigma and bias of service providers. ❖ Lack of and opposition to CSE including lack of CSE curriculum. ❖ Limited access to SRHR services including inadequate youth-friendly services and ineffective referral	❖ Low prioritisation of SRHR by governments.	❖ Strengthening of skills in data management and M&E ❖ Facilitate the provision of free family planning services and commodities and gynaecological services with government support.

			procedures and linkage between different SRHR areas. ❖ COVID-19 pandemic and diversion of SRH funding to COVID-19 response ❖ Limited human resources for health providing in SRHR ❖ Challenges of commodities supplies at the national and provincial level.		
European Network (Brussels)	Albania Austria Belgium (SENSOA) Bosnia and Herzegovina Bulgaria Cyprus Denmark Estonia Finland	Albania Austria Belgium (2) Bosnia and Herzegovina Finland Georgia Latvia Lithuania Republic of Serbia	❖ Opposition to school SE in some countries ❖ Health insurance does not cover abortion, contraception services ❖ Gender and sexuality issues with inadequate SRHR knowledge e.g., among minority groups ❖ Comprehensive age-appropriate sexuality	❖ Inadequate/low political will for progressive SRHR policies ❖ Poor SRHR prioritisation by politicians in health care programs. ❖ Economic barriers to accessing SRHR services partly due to high costs for abortion and contraceptive services	❖ Advocate for expansion of legal framework and service provision at low cost to cover the existing gaps ❖ Quality control of the CSE package is need ❖ Joint and own advocacy strategies and efforts. ❖ Advocate for SRHR services provision to be tailored to suit vulnerable groups ❖ Advocate for free provision of contraception for young people

	France Georgia Germany Ireland Israel Kazakhstan Kyrgyzstan Latvia Lithuania Netherlands Norway Portugal Republic of Macedonia Republic of Serbia Romania Slovak Republic Spain Sweden Switzerland Tajikistan	Norway Tajikistan	education is not integrated into school-based settings according to UNESCO standards. ❖ Inadequate youth-friendly services ❖ Inadequate government provision and coverage to improve access to contraception for young people and women from socially deprived groups resulting in high costs of services such as abortion care with no contraception reimbursement for adolescents. ❖ Barriers to accessing medical abortion and contraception	❖ Cultural norms limit discussions for SRH for mentally challenged people ❖ Opposition to legal SRHR reforms from religious organisations such as Catholic Church, religious organizations, and right-wing politicians.	❖ Advocate for the inclusion of age-appropriate comprehensive sexuality education in preschool curricula. ❖ CSOs have developed several action coalitions, networks, and platforms, for joint advocacy and reporting on human rights violations including the right to health. ❖ Advocacy and strengthening networks with partners, women's NGOs, and other stakeholders to lobby governments for the free provision of SRH information and services

	Ukraine				
East and Southeast Asia and Oceania (Kuala Lumpur)	Cambodia China Cook Islands Fiji Hong Kong Indonesia Japan Kiribati Korea, Dem. People's Rep of Korea, Republic of Malaysia Mongolia New Zealand Papua New Guinea Philippines Samoa Solomon Islands Thailand	Cambodia Fiji Hong Kong Japan Kibirati People's Rep of Korea (2) Mongolia New Zealand Philippines Samoa Solomon Islands Thailand Tuvalu Vanuatu Vietnam	❖ Socio-cultural norms limiting access to SRH and CSE services ❖ Inadequate access to and supply of SRH services to people living in rural and mountainous areas ❖ Low male engagement. ❖ Inadequate SRH awareness among policymakers and decision-makers results in low prioritisation of SRHR as a core primary care service. ❖ Poor political commitment to SRH ❖ Inadequate health sector funding for SRH and CSE ❖ Fragmented SRH service provision and a patchwork of providers with different associated costs, training and	❖ Inadequate funding ❖ Socio-cultural (regional customs and practices) and religious barriers hindering access to free SRHR service and information, facilitating prejudices, and hindering discussions on sexuality issues in public ❖ Contextual barriers result in limited SRH for people with disabilities and rural poor living in mountainous areas ❖ Inadequate professional human resources for health with inadequate SRH capacity ❖ Poor prioritisation of SHR services in primary care and	❖ Advocacy on comprehensive SRH collectively with CSOs ❖ Joint advocacy strategy with CSOs development for active engagement of men in promoting SRHR. ❖ Networking with other CSOs for lobbying and public discussions to support policymakers advancing SRH service provision, demand creation and funding for SRH activities. ❖ Mobilizing investment resources to support universal access to SRH services. ❖ Networking with government and other CSOs to provide support for the provision of SRH information and services. ❖ Lobbying with the government to improve SRH access e.g., provision of youth centres. ❖ Advocacy campaigns for SRHR and SGBV and decriminalize and legalize abortion services. ❖ Joint advocacy strategy with stakeholders for inclusion of FLE/CSE in in school's curriculum and out-of-school youth sensitisation including

	Tonga Tuvalu Vanuatu Vietnam		access resulting in inequity in access for different groups. ❖ High unmet need for family planning among married women. ❖ Inadequate access to SRHR information and services for youth as CSE not included in the school curriculum and not available for out of school youth. ❖ Laws do not allow for performing proactive SRH services (ID needed for service provision) and need to be reviewed ❖ SRH services do not target all vulnerable groups e.g., LGBTQA ❖ Inadequate laws on SRH care for LGBT people.	significant stigma around SRH issues. ❖ Access to SRH services and information of young people is limited. ❖ Population health illiteracy and health providers' attitudes towards SRH services provision. ❖ Inadequate SRH provision for adolescents and young adults both at central and local levels with poor youth engagement ❖ Limited access to SRH commodities. ❖ Unfavourable legal environment with stringent anti-abortion laws resulting in high rates for unsafe abortions and	youth engagement. ❖ Advocate and support capacity building of teachers for CSE provision. ❖ Improve networking and collaborating with other NGOs, sectors and MoH departments. ❖ Promote NGOs who had their health service providers trained on sexual rights and working with marginalized communities ❖ Participate in the development and implementation of socialization projects to provide SRH information, services, and products suitable to the needs and affordability of target groups in the community.

			❖ Bureaucracy and poor communication between Government MOH and other departments. ❖ Inadequate sexual rights training for public sector health providers. ❖ Poor implementation of ununiform strategies and policies related to SRHR is not across regions.	inadequate access to post-abortion care. ❖ Women who undergo abortion are stigmatized with gender norms dictating men as FP decision-makers	
Arab World (Tunis)	Algeria Bahrain Djibouti Egypt Lebanon Mauritania Morocco Palestine Somaliland Sudan Syria	Algeria Bahrain Egypt Lebanon Mauritania Morocco Palestine Sudan Tunisia Yemen	❖ Small number of SRH centres in disadvantaged and poor areas. ❖ CSE is not included in the school curriculum in some countries and other countries, CSE education does not cover sexuality. ❖ Strong cultural and religious norms disprove SRHR and	❖ Inequities/disparities in the access of SRHR services (rural-urban, rich-poor) ❖ Restrictive laws and policies on SRH and non-application of penalties eg., access to abortion is limited by existing laws and policies ore outdated resulting in young women	❖ Improving monitoring and evaluation strategy, mechanisms, learning and training for MAs ❖ Explore and prioritise the impact of climate change on SRHR ❖ Provision of technical assistance (how to set up a business plan) and investment in social enterprise to generate funding ❖ Training staff for resource mobilization as a future potential source of funding ❖ Support the development and provision of specialized training on CSE for parents

	Tunisia Yemen		facilitate prejudices for those accessing SRHR services ❖ Limited access to SRH services and information particularly in humanitarian settings resulting in poor population awareness of SRHR ❖ Weak political commitment to SRHR issues resulting in scant policies on SRH service delivery eg. no strategic national plan to provide SRH services in remote and marginalized areas in most countries. ❖ Inadequate laws governing access to key SRHR issues eg. CSE and GBV ❖ Insecurity contributes to deteriorating SRHR service provision and results in poor	being disproportionately affected. ❖ Strong cultural, traditional, gender and religious norms hinder SRHR activities and impede access to information and health services for women and girls with low male involvement in SRHR. ❖ Political conflicts and insecurity and resulting consequences on movement and safety hinder health providers provision of health services in general and SRHR services in particular. People also face difficulties moving to and accessing the limited SRH services available	❖ Form/join joint advocacy alliances with CSOs - institutions and associations of civil society to create awareness for SRHR issues, review existing and outdated policies and laws governing SRHR including marriage rights, activation, and implementation of revised laws ❖ Strengthen existing networks and create new networks for SRHR advocacy and service provision ❖ Continue to support the development and revision of national SRHR strategies through continuous research activities. ❖ In countries where CSE curriculum is being implemented in schools, support CSE implementation ❖ Prioritise the provision of GBV services and psychological care services. ❖ Empower community groups through sensitisation and educating to support vulnerable groups including advocate for their SRH ❖ Create awareness on SRHR and service provision using various approaches

			coverage and low access to service.	❖ Inadequate internal or regional advocates for SRHR issues to generate awareness and facilitate SRHR acceptance ❖ Inadequate governmental will to effectively activate and/or implement the limited laws governing SRHR. ❖ Fractured policies and implementation of family planning services in different administrative areas (regions) within the same country. ❖ Inadequate donor support and priority for SRHR particularly within the context of the COVID pandemic.	❖ Partner and coordinate with CSOs and governmental implementation bodies. ❖ Integrates SRHR services and information into human relief and response programs.

				❖ Deterioration economy of some countries creating economic barriers to access to and utilisation of SRH services ❖ Poor coordination between health and education sectors in most countries.	
Americas and the Caribbean (Colombia and Trinidad)	Aruba Barbados Caribbean Family Planning Affiliation Colombia El Salvador Guadeloupe Jamaica Mexico Peru Suriname	Aruba Colombia El Salvador Guadeloupe Mexico Peru Mexico Peru Trinidad and Tobago	❖ CSE, not conclusive recurrent laws prohibit persons under the age of 18 years old from accessing SRH services in the absence of a parent or guardian. ❖ CSE not included in the school curriculum ❖ Lack of involvement of parents regarding SRH ❖ Increase in GBV	❖ Implementation of CSE is limited by social and cultural barriers e.g., young people's access to SRH services is limited by laws, policies, misperceptions of laws and policies, social and cultural barriers. ❖ Public health policies and guidelines do not create equitable access to public healthcare services by	❖ Prioritise people with disabilities, LGBTQ, migrants' access to SRHR services and information ❖ For MAs, explore future funding directions e.g, explore the use of social enterprise logic ❖ Recommend IPPF should communicate and interact more in the French language ❖ Prioritise and create awareness around male contraception ❖ Networking with CSOs to support the implementation of the National SRH Policy aimed at improving access to SRH services.

	Trinidad & Tobago United States		❖ Inequitable access to healthcare services by LGBT+ community. ❖ Outdated laws and policies e.g., on abortion	members of the LGBT+ community.	❖ Advocacy initiatives that voice concerns around SRH, SRHR and particularly those most disenfranchised
Africa	Benin Botswana Burkina Faso Burundi Cameroon Cape Verde Central Africa Chad Comoros Congo DRC Cote d'Ivoire Eswatini Ethiopia Ghana Guinea-Bissau Guinea-Conakry	Benin Botswana Burkina Faso Burundi Cameroon Cape Verde Central Africa Congo MA DRC Ivory Coast Eswatini Ethiopia Guinée Guinée-Bissau Lesotho Namibia Niger	❖ Outdated SRHR and ASRHR policies and acts do not take into consideration vulnerable populations e.g., age of consent for services not determined and recognized through national policies. ❖ Inadequate funding for SRHR activities and sustained provision of basic healthcare services ❖ Shortage of human resources for health due to brain drain of health service providers. ❖ Limited SRH services provision in hard to reach areas.	❖ MAs main challenge is resource mobilization ❖ Inadequate experience applying for and managing international funding by MAs ❖ Little involvement of MAs in key decision making ❖ Inadequate experience in social enterprise by MAs ❖ Insecurity creating physical barriers to provide SRHR in humanitarian contexts ❖ Poor dissemination of SRHR normative documents by government.	❖ Capacity building and technical support in social enterprise to stimulate the needed skills among MAs ❖ Development of innovative approaches through social enterprise among MAs ❖ Prioritize the development of social entrepreneurship to generate internal funds as a source of funding for MAs ❖ Capacity-building among volunteers working with MAs in governance and resource mobilization ❖ Build MAs capacity and managerial support to respond to funding calls (grant/funding application skills) for resource mobilization and empowerment ❖ Refocus and value for volunteering

	Kenya (suspended) Lesotho Liberia (suspended) Madagascar Malawi Mali Mozambique Namibia Niger Nigeria Senegal Sierra Leone Tanzania Togo Uganda Zambia Zimbabwe	Nigeria Tanzania Togo Zambia Zimbabwe	❖ Poor quality of care for SRH services provided ❖ Stock outs of essential SRHR commodities at service delivery points and limited choice of SRHR services and commodities ❖ Socio-cultural and religious barriers to accessing SRHR services including GBV services. ❖ Gender inequality and community tolerance to GBV despite a high prevalence of GBV. ❖ Scarce youth-friendly services especially in a rural setting. ❖ Limited youth engagement ❖ Socio-cultural, traditional, and religious barriers to the inclusion of CSE to school curriculum e.g., strong	Customs hinder effective communication ❖ Inadequate male involvement in FP ❖ Lack of respectful SRHR care by health providers ❖ Inadequate women empowerment and gender inequity ❖ Strong religious, socio-cultural norms, traditions, customs, and gender norms hindering access to services for women ❖ Lack of inclusive SRH policies, services, and care for marginalized groups ❖ Large dependence on donor funding for health services particularly for SRHR	❖ Restructure MAs action areas towards research and innovation ❖ Mobilization and networking with international partnerships ❖ Decentralized IPPF with regional/African region representations to ensure context-specific approaches and governance ❖ Advocacy for uptake of male contraception ❖ Prioritise and advocate for ASRH issues ❖ Advocate and lobby governments to financially support SRHR programmes and create conducive legislative policies and regulations e.g., on abortion ❖ Strengthen existing networks to provide integrated SRHR to marginalized populations in rural settings ❖ Network with other MAs in the region to implement advocacy aimed at improving the SRH of young people and marginalized groups. ❖ Undertake sensitization campaigns to generate demand for SRHR services

			opposition from Christian religious groups ❖ CSE is not inclusive i.e., topics covered in schools restricted ❖ No CSE support for out of school youth. ❖ Limited funding for CSE ❖ Inadequate initiatives to encourage parent-child dialogue ❖ Inadequate dissemination of SRHR normative documents by government. ❖ Insecurity and political unrest ❖ Customs hinder effective communication. ❖ Legal framework limits access to services e.g., abortion services leading to high unsafe abortion prevalence particularly	❖ Low funding for SRHR programming ❖ Geographical and legal barriers to accessing SRHR information and services for rural and vulnerable populations ❖ COVID-19 pandemic hindering provision of health services ❖ International donors are not willing to provide funding for some countries due to international restrictions imposed on some countries ❖ Age-based and societal restrictions resulting in limited access to SRHR supplies for young people despite human rights and choice-based approaches	❖ Continued involvement and support for a coalition of CSOs under the umbrella of the Association for the Advancement of Family Planning to advocate for increased budgetary allocation for family planning to address anticipated stock-outs. ❖ Support the provision and expansion of SRHR services. ❖ Advocate for and develop innovative initiatives to expand FP/SRH services. ❖ Advocate and network to address barriers to SRH and access to CAC. ❖ Support the provision of Youth Friendly Services through different channels. ❖ address structural barriers through poverty alleviation by layering economic strengthening programmes for youth especially adolescent girls and young women. ❖ Advocate for the age of sexual consent to be linked with the constitution child's rights, religious and cultural expectations.

			among AGYW due to lack of easy access to termination of unwanted pregnancies discriminates against poor households	❖ Limited coverage of SRHR in health insurance schemes/mechanisms. ❖ Structural barriers such as long distances, absence of facilities, limited numbers of health providers providing SRHR services and poverty especially among unemployed adolescent girls and young women. ❖ Stock-outs of essential SHRH commodities. ❖ Unconducive legislative laws restricting access to SRH services e.g., contraception for adolescents, and abortion resulting in especially, young women being	❖ Strengthening the development and or implementation of CSE

<table>
<tr><td></td><td></td><td></td><td></td><td>disproportionally affected short and long term
❖ In some countries, inadequate public information and sensitisation on abortion laws and aspects permit access to legal abortion care services.</td><td></td></tr>
<tr><td>other opinions from MAs on the SRHR and IPPF Secretariat</td><td colspan="5">Targeted issues:
❖ Adolescent SRH
❖ Access to contraceptives
❖ Comprehensive sexual education
❖ Repeal/expansion of abortion laws
❖ SRHR management of displaced populations
❖ Update and regulation of national SRH policies
❖ Access to safe abortion service
Barriers
❖ Funding challenges:
❖ High competition
❖ Decrease in amount of funding
❖ Lack of experience in apply for and managing funds</td></tr>
</table>

	❖ Poor knowledge in social enterprising ❖ Socio-cultural and economic barriers to SRHR Approaches: ❖ Advocacy ❖ Stakeholder engagement ❖ Improved access to learning resources for CSE ❖ Awareness creation on CSE ❖ Online and Community-based SRH service delivery ❖ Population-centred program design and implementation ❖ Active involvement of young people ❖ Strengthening international cooperation for SRHR ❖ Capacity building for SRHR key stakeholders ❖ Funding opportunities ❖ Social entrepreneurship ❖ Identification other sources of funding including local sources of funding Target populations: ❖ Adolescents/Young people (10-24 years) ❖ Vulnerable women ❖ Marginalized populations ❖ SRHS providers ❖ People with disabilities Policy/issues:

	❖ Gender equality ❖ Safe abortion ❖ Positioning SRHR in context of global pandemics, insecurity, humanitarian crisis ❖ LGBTQI+ Moving beyond ICPD ❖ Transformative laws & policy ❖ Universal access to SRHR Innovations ❖ Online SRH service provision ❖ Promoting contraceptives for men ❖ Self-screening initiative for cervical cancer ❖ Action research
Considerations	❖ Take into consideration French-speaking associations in terms of training, project proposals" = a feeling of marginalization from English speaking MAs? This could be a subtle issue to be carefully investigated. ** language is a major issue: for French speaking countries for instance, they simply did not understand the questions (I suppose, most of the time).

REFERENCE

1. Ritchie J, Lewis J, Nicholls CM, Ormston R. Qualitative research practice: A guide for social science students and researchers: sage; 2013.

2. Saldaña J. The coding manual for qualitative researchers: sage; 2021.