Evaluation of the integration of gender equality in the Pan American Health Organization's technical cooperation in health in the Americas 2005–2023

Volume I
Final report

PAHO
Pan American Health Organization
World Health Organization
Americas Region

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Washington, D.C., 2025

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ISBN: 978-92-75-12976-0 (PDF)

ISBN: 978-92-75-12977-7 (Print)

Suggested citation: Pan American Health Organization. Evaluation of the integration of gender equality in the Pan American Health Organization's technical cooperation in health in the Americas 2005–2023. Volume I: Final report. Washington, D.C.: PAHO; 2025. Available from: https://doi.org/10.37774/9789275129760.

Cataloguing-in-Publication (CIP) data: Available at http://iris.paho.org.

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PBE/2025

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Preface

In early 2024, the Pan American Health Organization (PAHO) initiated a comprehensive evaluation to assess the integration of gender equality into its technical cooperation efforts. This evaluation, conducted by an independent external team from February to November 2024, employed both face-to-face and remote data collection methods. The primary objective was to evaluate the extent to which gender equality has been incorporated into PAHO's technical cooperation and to determine the effectiveness and efficiency of these efforts in promoting gender equality across the Region of the Americas.

The evaluation aimed to serve dual purposes: summative (accountability) and formative (learning). It sought to provide valuable insights, findings, and recommendations to enhance PAHO's ongoing efforts in integrating gender equality into health initiatives and to inform the development of the PAHO Strategic Plan 2026–2031.

Covering a broad geographical scope across the Americas, the evaluation included in-depth studies in Colombia, Panama, and Trinidad and Tobago, along with less intensive analyses in Brazil, Cuba, Mexico, and Uruguay. This approach allowed for a nuanced understanding of the diverse regional, subregional, and national contexts.

The evaluation focused on actions taken from 2005 to 2023, reflecting the long-term commitment of PAHO to gender equality, as outlined in the PAHO Gender Equality Policy of 2005 and subsequent strategic plans since 2008. The methodology combined contribution analysis, theory of change, and attribution approaches, ensuring a comprehensive assessment of PAHO's efforts.

This report presents the evaluation findings, highlighting the strategic, operational, and organizational dimensions of gender integration within PAHO. It underscores the achievements, challenges, and lessons learned, providing a road map for future efforts to advance gender equality in health across the Americas.

Acknowledgments

The external evaluation team is grateful to PAHO Evaluation for the management of the evaluation, to the members of the Evaluation Reference Group (ERG), and to the Pan American Health Organization (PAHO) personnel from Headquarters, country offices, and subregional offices that contributed with their time and advice to the Evaluation of the Integration of Gender Equality in PAHO's Technical Cooperation in Health in the Americas 2005–2023.

Particular thanks are due to the personnel of the PAHO Department of Planning, Budget, and Evaluation (PBE) for their guidance and support throughout the evaluation process. Noteworthy individuals include Rony Maza, Director of PBE; Roberto La Rovere, Senior Advisor for Evaluation, Evaluation Manager, and Internal Quality Assurance and Coordination; Luisa Toro-Alzate, Lara Daibert, Lizeth Hernandez-Rubio, Kerrie Barker, and Oscar Diaz Sotelo.

The external evaluation team would like to thank the personnel, advisers, and consultants of the PAHO Department of Social and Environmental Determinants for Health Equity (DHE) and the Equity, Gender, Human Rights, and Cultural Diversity Unit for their engagement and sustained participation during the evaluation process. At the country level, the external evaluation team would like to thank those who made the "deep dives" possible in Colombia, Panama, and Trinidad and Tobago. This includes PAHO/WHO Representatives in those countries and other PAHO personnel, particularly gender focal point advisers. The external evaluation team also acknowledges the participation of ministries of health, national counterparts, partners, donors, United Nations agencies, nongovernmental organizations, and other key stakeholders who shared their time and insights.

This report was prepared by the external evaluation team, comprised of Enric Grau (Team Leader), Cecilia Delaney Mendez (Deputy Team Leader), Alejandra Faúndez and Paula Santana (senior evaluators and subject specialists), and Elvira Carrió, Fiorella Farje, María Pía Montero, and Elizabeth Posada (research assistants).

Abbreviations and acronyms

CARICOM	Caribbean Community
CCS	Country Cooperation Strategies
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COMISCA	Council of Ministers of Health of Central America and the Dominican Republic
CSO	civil society organization
DHE	Department of Social and Environmental Determinants for Health Equity
ECLAC	United Nations Economic Commission for Latin America and the Caribbean
EG Unit	Equity, Gender, Human Rights, and Cultural Diversity Unit
GBV	gender-based violence
HIAP	Health in All Policies
HIV	human immunodeficiency virus
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MERCOSUR	Southern Common Market
NCD	noncommunicable disease
SDH	social determinants of health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations country team
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

Executive summary

Context

The Region of the Americas is culturally and ethnically diverse and has high levels of violence, political instability, and inequality. Advances in public health in the Americas have reduced the burden of many infectious diseases, leading to their control and, in some cases, elimination. At the same time, the burden of noncommunicable diseases has increased, requiring comprehensive multisectoral health strategies addressing the determinants of health. In addition, the Americas is one of the fastest-aging regions in the world, with projections showing that older, dependent people will outnumber children by 2047. The COVID-19 pandemic exacerbated health-related disparities which disproportionately affected persons living in conditions of vulnerability and caused setbacks in the progress achieved so far, putting at risk the achievement of the goals of the 2030 Agenda for Sustainable Development, as well as the Sustainable Health Agenda for the Americas 2018–2030. Unequal healthcare access played a significant role in the high rates of COVID-19 mortality and mental disorders among vulnerable populations in the Region.

Health systems in the Region are fragmented, creating barriers to accessing equitable and efficient health care, particularly for populations living in situations of vulnerability, such as women, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people, indigenous peoples, and migrants. Gender inequalities in health persist, with women's health care often narrowly focusing on sexual and reproductive health, and other issues often being overlooked. Women generally live longer than men but spend more time in poor health, suffering from conditions such as obesity, depression, and asthma, and bear higher healthcare costs. They also more often assume caregiving roles, limiting their employment opportunities and reinforcing their vulnerability. Men, meanwhile, are more likely to die from external causes and diseases such as tuberculosis and HIV/AIDS.

International normative and policy frameworks, such as the Convention on the Elimination of All Forms of Discrimination against Women, and the 2030 Agenda for Sustainable Development, have set goals for achieving gender equality in health. However, recent political, social, and economic shifts have introduced new dynamics and fresh challenges for achieving these goals in the Americas. Data gaps and challenges in integrating gender-specific measures into public policies, including health policies, persist, and crises such as the COVID-19 pandemic have further exposed and exacerbated them.

Background

In early 2024, the Pan American Health Organization (PAHO) contracted an external independent team to evaluate the integration of gender equality into PAHO's technical cooperation work. The evaluation was conducted between February and November 2024,

combining face-to-face and remote data collection methods. The overall objective of the evaluation was to assess the extent to which gender equality has been integrated into PAHO's technical cooperation. The evaluation looked at how effectively such integration contributed to changes in gender equality in the Region, and how efficiently PAHO has been integrating gender equality into its technical cooperation. The purposes of the evaluation are both summative (accountability) and formative (learning). It sought to provide analysis, findings, and recommendations that would contribute both to PAHO's efforts on integrating gender equality in health in its technical cooperation to support Member States, and to the development of the PAHO Strategic Plan 2026–2031.

The evaluation had a comprehensive geographical scope across the Americas. Deep-dive studies were conducted in Colombia, Panama, and Trinidad and Tobago, while less in-depth analyses were undertaken in Brazil, Cuba, Mexico, and Uruguay. This approach informed a nuanced understanding of regional, subregional, and national contexts. The evaluation focused on actions taken from 2005 to 2023, as the integration of gender equality into PAHO's technical cooperation in health was first set out in 2005 in the PAHO Gender Equality Policy and then, from 2008 to 2023, in PAHO's strategic plans.

Methodology

The evaluation used a combination of approaches as follows:

- Contribution analysis was used to systematically assess how well gender equality has been incorporated into PAHO's technical cooperation activities and the effectiveness of PAHO's interventions in producing positive changes in health systems and policies across the Region.
- A theory of change was developed to outline how, based on PAHO's policies and strategic plans, the Organization identified pathways for change, hypotheses and risks, and defined the actions that should lead to achieving the planned outcomes of the 2005 PAHO's Gender Equality Policy.
- An attribution approach was used to analyze PAHO's technical cooperation efforts at the output level, that is, in terms of assessing to what extent the planned activities were effectively implemented.

An intersectional and intercultural approach was applied to consider how gender interacts with other political and social factors. A participatory and collaborative process was used, involving various stakeholders at different stages, to enhance ownership of the findings and recommendations.

The evaluation criteria were aligned with the guidelines of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD/DAC) and the United Nations Evaluation Group (UNEG): relevance, coherence, effectiveness, efficiency, and sustainability. The evaluation used a mixed-methods approach, drawing on primary and secondary data, including documentary reviews, interviews, surveys, and focus groups.


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Gender integration was analyzed across three dimensions: (1) strategic (PAHO's institutional positioning and contributions); (2) operational (effectiveness of technical cooperation); and (3) organizational (internal resources for addressing gender inequalities). PAHO Evaluation provided oversight, while ethical guidelines on voluntary participation, confidentiality, and data security were strictly followed. Challenges, such as the limited availability of critical informants and fragmented data, were mitigated through strategies such as snowball sampling and qualitative and quantitative data triangulation.

Findings

The findings below are presented by evaluation criteria.

Relevance and coherence

Initially, PAHO's approach to gender arose from the need to address women's health as a distinct category within public health policies, exemplified by the Women, Health, and Development Program. Over time, this approach evolved, and PAHO began adopting broader gender definitions that incorporated concepts such as intersectionality and the social determinants of health. However, the implementation of these concepts has been uneven over time and across the Region.[1]

There is evidence of efforts to integrate gender considerations into the broader framework of the social determinants of health, addressing dimensions such as ethnicity, age, disability, and migration status. However, challenges persist in putting these concepts into practice across PAHO's programs and in aligning PAHO's technical cooperation efforts in gender equality in health with international human rights frameworks such as the Convention on the Elimination of All Forms of Discrimination against Women. Gender equality has not been integrated systematically into all PAHO planning processes (e.g., Strategic Plans, Country Cooperation Strategies) and programs (e.g., noncommunicable diseases[2]), and this has led to uneven implementation of gender equality initiatives across the Region. In addition, the fragmentation of approaches to addressing issues, such as gender-based violence (GBV) and human rights, across multiple departments and the changes in the organization of PAHO's Equity, Gender, Human Rights and Cultural Diversity Unit over time have meant that PAHO's technical cooperation efforts on gender equality have been inconsistent.

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1 See: Pan American Health Organization. Women, Health, and Development [Document CE130/18]. Provisional Agenda Item 4.11. 130th Session of the Executive Committee, 24–28 June 2002. Washington, D.C.: PAHO; 2022. Available from: https://www1.paho.org/english/gov/ce/ce130-18-e.pdf.

The Program on Women, Health, and Development (HDW) of the Pan American Health Organization (1992–2002) goal was to reduce those health inequalities between men and women that are unnecessary, avoidable, and unfair. The central mandate of HDW was to mainstream gender within the programs and policies of PAHO, PAHO/WHO country representations, and Member States, in order to reduce gender inequities in health within the context of PAHO principles of equity and Pan Americanism.

2 Pan American Health Organization. Evaluation of the Pan American Health Organization Technical Cooperation in Noncommunicable Disease Prevention and Control in the Americas. Volume I. Final Report. Washington, D.C.: PAHO; 2023. Available from: https://doi.org/10.37774/9789275127735.

PAHO's technical cooperation efforts are only partially aligned with Member States' priorities for gender equality; while Country Cooperation Strategies have incorporated elements of gender equality, they have often lacked systematic standards for consultation and greater focus on gender inequalities and their determinants. Moreover, alignment with UN, on gender equality, is limited, with greater emphasis being placed on Goal 3, on good health and well-being.

Effectiveness

The implementation of the PAHO Women, Health, and Development Program has been recognized as a milestone in promoting gender equality in the health agenda in the Region. This is thanks to the mobilization of a broad spectrum of agencies and regional and international organizations, and the leadership provided by a group of professionals who transformed the strategies for gender and health work in the Region. More recently, the creation of the Department of Social and Environmental Determinants for Health Equity has further reinforced PAHO's commitment to strengthening the intersectionality and multisectoral collaboration required for a more comprehensive approach to health inequalities, including gender. However, PAHO's technical cooperation with Member States has focused primarily on risk factors and proximal determinants that affect the health of individuals, while distal determinants (such as poverty, education, and social structures beyond the reach of the health sector) have received limited attention. Moreover, the low priority afforded by Member States to the social determinants of health and related crosscutting themes (and reduced budget allocations) has hampered the implementation of the multisectoral and long-term strategies required to tackle systemic inequalities.

PAHO has contributed to institutionalizing gender equality approaches in national health systems, national institutions, and civil society organizations. It has focused on addressing critical public health issues (e.g., sexual and reproductive health, GBV, and combination HIV prevention) and access to health for population groups that face access barriers and exclusion. The evaluation identified programmatic advances in GBV prevention and in sexual and reproductive health, with a focus on indigenous women and promoting the care agenda. Interinstitutional collaboration and, in some countries, a territorial approach (in priority locations at the subnational level) involving community participation through civil society organizations, leaders, and local authorities have been drivers of change in removing barriers and addressing gender-based exclusion.

PAHO's actions in priority subnational areas have made it possible to document gender gaps in health in communities (throughout specific projects), strengthen advocacy capacity from the local to the central level (a "bottom-up" approach), promote leadership and women's and community networks to influence local administrations, and refer those in need to specialized services (e.g., GBV). In humanitarian responses, PAHO's actions have helped reinforce the equity approach and the goal of "leaving no one behind."

PAHO has introduced innovative approaches to technical cooperation that have allowed Member States to improve their responses concerning critical gender inequalities in

cancer prevention among adolescents, vaccine production for pregnant women, and violence during the perinatal period. Extensive data generation and PAHO's expertise, institutional recognition, and involvement in joint initiatives (e.g., Spotlight) have strengthened its advocacy efforts with national counterparts and stakeholders. In some countries, these advocacy efforts have helped establish new departments in ministries of health that are focused on addressing gender disparities, adopting new laws, ensuring the inclusion of indigenous and Afro-descendant communities in public health policies and programs, and promoting multisectoral approaches.

Efficiency

PAHO's Gender Equality Policy and plan of action did not include a specific budget or funding plan. Gender, as one of the crosscutting themes in the three strategic plans, has received limited funding. Moreover, the availability of human resources designated specifically for gender equality work has been chronically scarce and has varied across PAHO's country offices. Gender focal points, where present, are often overburdened with multiple responsibilities, reducing their capacity to advance gender equality agendas. Nonetheless, the contributions of gender focal points, when they exist, have been widely recognized.

PAHO has successfully tailored its gender equality advocacy and technical cooperation efforts to accommodate different national contexts and political sensitivities. It has strategically maintained a balanced and technically neutral stance, allowing it to address critical issues such as GBV and sexual and reproductive health even in countries with conservative movements.

PAHO's integration of gender considerations into health emergency responses has progressed significantly since the response to Hurricane Mitch in 1998, which marked

a milestone in the integration of a differentiated approach into emergency responses. PAHO tools, such as the Incident Management System, and guidelines for gender-sensitive emergency responses, have facilitated the inclusion of a gender equality approach in disaster and epidemic situations (e.g., the COVID-19 pandemic). Despite this progress, Member States' mainstreaming of gender into their implementation of the International Health Regulations has been uneven, collecting disaggregated data during emergencies remains challenging, and some PAHO tools lack accompanying guidance on gender disaggregation and analysis.

In terms of alliances, PAHO's collaboration with entities such as the United Nations Population Fund (UNFPA), UN Women, and the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) has increased the visibility of gender equality in health, strengthened advocacy, and supported Member States in addressing structural inequalities. Collaboration with the World Health Organization (WHO) has enabled advancing gender equality in health at the national, regional, and global levels; PAHO's innovative initiatives, such as defining gender and health indicators and addressing the needs of LGBTI people, have positioned the Region as a global reference. However, interagency collaboration has been weakened in some cases by diverging objectives, competition for resources, and overlapping mandates, particularly in areas such as GBV and adolescent sexual health. Partnerships with civil society organizations have facilitated the cultural adaptation of gender-sensitive health interventions, particularly in underserved communities. Nevertheless, collaboration with civil society organizations has diminished, with their participation being limited in developing national health plans or advisory groups – one of the strategic areas of the Gender Equality Policy.

Sustainability

The Gender Equality Policy (2005) and its related plan of action (2009–2014) have not been sufficiently recognized or embraced by PAHO teams and Member States (Resolution CD46.R16, which urges Member States to implement the Gender Equality Policy, appears to have been partially implemented and unevenly across countries), which has limited their sustainability. Implementation of the former has been partially achieved by incorporating it as a crosscutting approach into PAHO planning documents (e.g., Country Cooperation Strategies, Strategic Plans and Program Budget), establishing alliances with other agencies through country cooperation frameworks, and participating in United Nations interagency gender mechanisms within the United Nations country teams (UNCT). However, the outdatedness and lack of monitoring mechanisms for these two central instruments have limited their sustainability.

PAHO has enhanced the capacities of country offices through training on gender equality in health. However, gaps in scope, emerging topics, and dissemination need to be filled. PAHO has made substantial progress in raising awareness among its personnel of the need to integrate gender equality into technical cooperation efforts across health programs and policies. Nevertheless, limited engagement with civil society organizations and limited fostering of long-term partnerships with other organizations have weakened its ability to sustain the integration of gender equality in the long term.

Conclusions

Strategic level

1. Gender concept and approach. PAHO has shifted its approach to recognizing the strategic importance of gender equality in its technical cooperation on health efforts. PAHO now acknowledges a more inclusive range of social groups beyond women, who are impacted by gender constructs.

2. Positioning and women's leadership in gender and health. PAHO has succeeded in being an agency of technical leadership in gender equality in health and has promoted the inclusion of women in decision-making in regional public health and global health forums. However, its positioning and advocacy capacity in gender equality in health have gradually declined in recent years due to internal and external factors, in an area where there is a wide diversity of regional actors and where several United Nations agencies and organizations have intensified their work and visibility.

3. Alliances and collaborations. The alliances established with other agencies and regional organizations have been pivotal in achieving key milestones related to gender and health in the Region. These partnerships have also played a significant role in highlighting gender inequalities within the health sector and integrating them into PAHO's agenda. However, the fluctuations in some partnerships have impacted PAHO's ability to expand its technical cooperation, sustain internal accountability, and fully leverage existing regional capacities, such as collaborating centers, universities, and networks.

4. PAHO strategic planning. Since 2014, gender has been considered a crosscutting theme in PAHO's strategic planning. However, differences in the formulation of indicators in the three strategic plans to date and the indicators of the Strategic Plan monitoring framework have made it difficult to determine the contribution of each outcome to reducing gender inequalities, to analyze results over time, and to obtain an overview of changes in gender inequalities in health.

Operational level

5. Balance between gender-focused and broader approaches. The integration of the gender approach into PAHO's technical cooperation efforts has oscillated between a specific understanding focused on gender, and another whereby it is integrated into broader frameworks, such as the social determinants of health, equity, and human rights. This has generated conceptual and programmatic "tensions" over time that have made it difficult to find an adequate balance between further developing technical cooperation in support of the social determinants of health approach, while at the same time promoting focused and transformative interventions with the potential to reduce gender inequalities in health.

6. Adaptative capacity. PAHO has continued to integrate gender equality into health in its technical cooperation efforts despite changing political, social, and economic contexts, as well as national sociocultural contexts. At the country level, PAHO has provided technical cooperation not only to Member States committed to gender equality but also to other Member States that no longer prioritize the gender agenda and in which addressing rights and critical gender issues that impact public health has faced setbacks.

7. PAHO's contribution to gender equality in health outcomes. PAHO has made significant programmatic contributions to advancing progress on critical issues (GBV, sexual and reproductive health, and access to health care for populations living in situations of vulnerability). PAHO's generation and analysis of data have been recognized as part of the Organization's added value, and they have been instrumental in supporting Member States' analysis of gender inequalities in health. However, challenges persist at the country level regarding the fragmentation of information on gender and intersectionality, the need for greater disaggregation, the optimization of existing information systems, and the use of data for informed decision-making.

8. PAHO Gender Equality Policy and plan of action. Despite limited dissemination, implementing the Gender Equality Policy and its related plan of action has promoted the integration of gender considerations into national health systems and policies. This has contributed to progress in PAHO's four strategic areas (evidence, capacity-building, civil society participation, and institutionalization and monitoring) in Member States. However, the implementation of this policy and plan has been uneven and fragmented.

Organizational level

9. Organizational chart. Since 2023, the Equity, Gender, Human Rights and Cultural Diversity Unit in PAHO's Department of Social and Environmental Determinants for Health Equity has strengthened its role in providing crosscutting technical support to PAHO entities. The new configurations of the unit and the department strengthen the operationalization of intersectoral approaches. However, silo working and limited resources may limit the unit's ability to promote gender equality in health within the Organization and to strengthen PAHO's positioning and advocacy efforts.

10. Specialized human resources. PAHO has specialized human resources dedicated to gender and equality at the regional and national levels. These personnel have contributed to gaining recognition for the technical quality of PAHO's technical cooperation efforts, but they have been overwhelmed by the breadth and intensity of multiple requests or conditioned by the uncertainty of short-term funding.

11. Resource allocation. Resources allocated for implementing the Gender Equality Policy and its related plan of action and other interventions (within the frameworks of the strategic plans or specific projects) have been modest. In addition, PAHO's dependence on a few donors has at times determined the priority afforded to the gender equality in health agenda in PAHO's technical cooperation efforts and the promotion of specific gender and health issues.

Recommendations

Strategic level

R1. Integrate gender equality into the crosscutting approaches, outcomes, and outputs of PAHO's Strategic Plan 2026–2031 (aligned with the WHO Fourteenth General Programme of Work), and promote further incorporation of gender equality into Member States' national health policies and strategies, in order to strengthen the visibility and monitoring of PAHO's technical cooperation in gender equality and changes in national gender inequalities in health:

R1.1. Adopt a "twin-track" approach (combining integrated and targeted actions) to mainstream gender equality in PAHO's Strategic Plan 2026–2031 (outcomes, outputs) and across PAHO entities.

R1.2. Strengthen organizational synergies and allocate commensurate resources to the Department of Social and Environmental Determinants for Health Equity to ensure its technical support function for all PAHO entities[3] and programs.

R1.3. Promote the adoption of a gender-responsive approach by Member States as a pathway to achieving universal health coverage.

R2. Develop new guidelines for gender equality in health to reflect the evolving issues in gender and health in the Region, the needs of the Member States and communities, and WHO's global guidelines:

R2.1. Design and launch a participatory process with key regional and national stakeholders (considering the diversity of institutional, political, and sociocultural views on gender in the Region) to enable the development of new guidelines on gender equality in health and the updating of the related plan of action.

Operational level

R3. Advocate for Member States to prioritize action on health determinants, and enhance collaboration with United Nations agencies, regional and national organizations, public administrations, and civil society organizations to foster intersectoral collaboration:

R3.1. Optimize expertise, resources, and complementarities among key partners to strengthen focus on health determinants, broaden the programmatic scope and joint advocacy with Member States, and gain organizational efficiencies.

R4. Expand PAHO's technical cooperation in gender equality to prioritized subnational areas to contribute to measurable changes in health inequalities and reinforce advocacy actions at the central level:

R4.1. Identify areas with critical indicators of health inequalities and local entry points, to design and implement intersectional interventions ("flagship projects") focused on reducing inequalities and tracking changes in gender disparities over time.

3 While flexible resources go to the DHE for crosscutting themes, resources are not centralized.

Organizational level

R5. Strengthen the technical and operational capacities and skills of PAHO personnel at all levels (regional, subregional, and national) to better integrate gender equality into PAHO technical cooperation efforts:

R5.1. Develop organizational capacities to design and implement Country Cooperation Strategies where gender equality can be integrated, resourced, monitored, and assessed.

R5.2. Provide the Organization with up-to-date knowledge and the tools needed to develop staff skills in gender equality and intersectionality.


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1. Background

1.1 Context[1]

The Region of the Americas is a region characterized by cultural and ethnic diversity and emerging economies that face high levels of violence, political unrest, and pronounced inequality. Advances in public health in the Americas have reduced the burden of many infectious diseases, advancing in controlling and eliminating some of them. At the same time, the burden of noncommunicable diseases (NCDs) has increased, requiring comprehensive multisectoral health strategies addressing the determinants of health. Additionally, the Region is undergoing one of the fastest aging processes globally, with projections indicating that by 2047, the proportion of the older dependent population will surpass that of children *(1)*.

The Region's health systems are highly fragmented and segmented, creating significant barriers to efficiently delivering quality care and achieving equitable health outcomes. These structural challenges are compounded by historical, political, and economic factors further limiting the access to health care for populations living in situations of vulnerability, including women, lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons, indigenous populations, ethnic minorities, migrants, and refugees.

Gender inequalities in health encompass both sex-specific conditions and health conditions that affect genders differently. Women's health in Latin America and the Caribbean is often narrowly focused on sexual and reproductive health, which overlooks the broader spectrum of health disparities women face. Although globally women tend to live longer than men, they spend 25% more of their lives in poor health *(2)*. Women in the Region experience higher incidences of overweight, Alzheimer's disease, depression, asthma, and dengue *(3, 4)*. They also bear higher healthcare costs than men and frequently take on the caregiver role within their families and communities, limiting their employment opportunities and perpetuating their vulnerability *(5)*. High rates of maternal mortality, teenage motherhood, gender-based violence (GBV), and femicide remain persistent issues. Gender inequalities also affect men, who experience higher mortality rates from external causes, such as traffic injuries, and NCDs like chronic obstructive pulmonary disease. Men are also more likely to encounter higher incidences of tuberculosis, HIV/AIDS, and Chagas disease compared to women *(6)*.

Globally, there have been important normative and institutional milestones aimed at addressing gender inequality. These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) *(7)* and the Beijing Declaration *(8)*,

1 A more detailed background and context is presented in Appendix 2 – Context. The appendixes are provided in Volume II of this publication: Pan American Health Organization. Evaluation of the integration of gender equality in the Pan American Health Organization's technical cooperation in health in the Americas 2005–2023. Volume II. Appendixes. Washington, D.C.: PAHO; 2025.

which underscore a commitment to gender equality. The adoption of the 2030 Agenda for Sustainable Development by the United Nations General Assembly in 2015, emphasizing health for all and gender equality as part of its 17 Sustainable Development Goals (SDGs), reinforces this commitment. In the Americas, the Regional Conference on Women in Latin America and the Caribbean, active for over 45 years, demonstrates ongoing efforts to promote gender equality, bolstered by networks of indigenous and Afro-descendant organizations.

Although all States in the Region have ratified the CEDAW and equality between women and men is endorsed by practically all political constitutions in the Region *(9)*, the prevalence of conservative narratives continues to pose challenges to gender policies. These narratives often disrupt the continuity of progressive policies during government transitions, limiting the advancement of gender equality initiatives. Despite progress in improving in, monitoring, data disaggregation, and capacity-building to address gender inequalities in health *(10)*, significant data gaps persist across the value chain, including misaligned definitions, lack of gender-specific measurement scales, and insufficient data disaggregation (1). Achieving gender equality in health continues to be a challenge, especially during health crises and emergencies such as the COVID-19 pandemic. The pandemic exacerbated health-related disparities, which disproportionately affected persons living in conditions of vulnerability and caused setbacks in the progress achieved so far, putting at risk the achievement of the objectives of the 2030 Agenda for Sustainable Development, as well as the Sustainable Health Agenda for the Americas 2018–2030. Unequal healthcare access played a significant role in the high rates of COVID-19 mortality and mental disorders among vulnerable populations in the Region.

PAHO and other United Nations agencies have made progress in integrating gender into their Strategic Plans and policies *(11)*. Since 2005, PAHO has committed to integrating gender considerations into its work, aiming to achieve gender equality in health outcomes and development *(12)*.

1.2 Purpose, objectives, scope, and users of the evaluation

PAHO Evaluation contracted an external and independent evaluation team to evaluate the integration of gender equality in PAHO's technical cooperation in health. The evaluation was conducted between February and November 2024, combining face-to-face and remote modalities.

1.2.1 Purpose

The evaluation is summative (accountability) and formative (organizational learning-oriented) in nature and is intended to provide analysis and results for the development of the next PAHO Strategic Plan and work on gender equality in health.

1.2.2 Objective

The overall objective of the evaluation was to analyze the integration of gender equality into PAHO's technical cooperation in health. The evaluation assessed the extent to which the integration of gender equality in technical cooperation in health has contributed to changes in gender equality in the Region, in collaboration with Member States and other partners. The evaluation documented successes, challenges, gaps, and good practices and identified opportunities to improve PAHO's work on gender equality in health at the country and regional levels. A full glossary of terms is included in Appendix 1.

1.2.3 Scope

Geographical scope: The evaluation covered the Region of the Americas. The evaluation team conducted three "deep dives" in Colombia, Panama, and Trinidad and Tobago and less in-depth analyses in Brazil, Cuba, Mexico, and Uruguay. The evaluation also considered the three organizational levels of PAHO's technical cooperation in health: regional, subregional (Caribbean, Central America, and South America), and national. The geographical scope of the evaluation did not include Canada and the United States of America.

Temporal scope: The evaluation covers the years 2005 to 2023, with a deeper focus on the most recent technical cooperation supported by PAHO, given the limited availability of data and key informants from early years. The early years have been reconstructed through a documentary review and interviews with PAHO professionals active during the 2000s who were still available to participate in the evaluation process.

Thematic scope: The evaluation focused on assessing the integration of gender equality into PAHO's technical cooperation in health in the Americas. The analysis prioritized outcomes of the three PAHO Strategic Plans included in the evaluation period, and in the implementation of the PAHO Gender Equality Policy (2005) and its related plan of action (2009–2014). Although the evaluation provides an overview of the integration of gender equality in PAHO technical cooperation in health, the analysis of the three strategic plans focused on the following elements:

- Strategic Plan 2008–2012: Strategic Objective 7 (Social and Economic Determinants);
- Strategic Plan 2014–2019: Program Area 3.3 (Gender, equity, human rights, and ethnicity) and Program Area 3.4 (Social determinants of health);
- Strategic Plan 2020–2025: Outcome 18 (Social and environmental determinants of health), Outcome 19 (Health promotion and intersectoral action), and Outcome 26 (Crosscutting themes: equity, gender, ethnicity, and human rights).

Out of scope: The following topics or organizational areas were not part of the scope of the evaluation: (1) policies, plans, or projects of Member States, national health systems, and other actors to address gender inequalities and social determinants of health; (2) PAHO's contribution to the feminization of the medical workforce in national health systems; (3) the performance of specific PAHO departments, units, or staff; and (4) PAHO's policies or initiatives in human resources, especially those related to gender parity, work-life balance, or career development.

1.2.4 Users

The primary users of the evaluation are PAHO's Department of Social and Environmental Determinants of Health Equity (DHE), the Equity, Gender, Human Rights, and Cultural Diversity Unit (EG), the Health Promotion and Social Determinants of Health Unit (HP), and the Department of Planning, Budget, and Evaluation (PBE). PAHO's Executive Management, the different departments and units of the Organization, and the country offices are the secondary users of the evaluation, considering the crosscutting nature of gender as one of the social determinants of health and gender equality as part of the institutional policy, planning approaches, and setups.

1.3 Methodology, limitations, and ethical considerations

1.3.1 Evaluation approach

The evaluation adopted a theory-based approach through a contribution analysis to assess the integration of gender equality in PAHO's technical cooperation in health. Based on the policy and plan of action for gender equality in health, and PAHO's Strategic Plans, the evaluation reconstructed a theory of change (Appendix 6), based on several PAHO planning documents, showing how the Organization has mobilized resources (technical, human, financial, logistic) and implemented activities to support Member States through various technical cooperation modalities.2 It is important to note that the monitoring of results and impact is a shared responsibility between PAHO, Member States, and its partners. This collaborative approach was applied, using a contribution perspective, to determine the extent to which PAHO technical cooperation has produced positive changes in national health systems, policies, strategies, programs, or services. An attribution approach was adopted for the assessment of outputs.

The evaluation recognizes gender as a dynamic and evolving concept, interpreted differently across the Region's social, cultural, and political contexts. An intersectional lens was essential in the evaluation process, offering a comprehensive framework to examine power dynamics within social structures – such as racism, classism, and sexism – and to assess how these systems intersect to influence health outcomes based on individuals' social positions and identities. By adopting an intercultural approach, the evaluation team acknowledged the cultural diversity within the Region's societies and communities.

The evaluation utilized an appreciative inquiry and light footprint approach, maximizing the use of existing secondary data while minimizing the burden of generating new primary information. Additionally, the evaluation fostered a participatory and collaborative process, involving key stakeholders and providing opportunities for feedback. This approach enhanced stakeholders' understanding of the process and increased their ownership of the findings and recommendations.

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2 The external evaluation team defined PAHO's technical cooperation modalities as the specific approaches and mechanisms through which PAHO provides technical assistance to its Member States in the Americas. These modalities are designed to strengthen health systems, improve public health outcomes, and address health challenges in line with regional and global health goals. It includes advisory services, capacity-building, institutional strengthening, knowledge transfer, fellowships and exchanges, and project implementation support.

1.3.2 Evaluation criteria and questions

The evaluation questions were organized according to the criteria of relevance, coherence, effectiveness, efficiency, and sustainability, in alignment with the Organisation for Economic Co-operation and Development/Development Assistance Committee (OECD/DAC) and the United Nations Evaluation Group (UNEG) guidelines. This framework, which encompasses the evaluation design and questions, informed the data collection and analysis. The initial evaluation subquestions were refined to address the issues identified during the inception phase and to clarify their scope. The main evaluation questions were:[3]

- To what extent has gender equality been integrated into PAHO's technical cooperation in health? (Relevance and Coherence)
- To what extent has integrating gender equality into PAHO's technical cooperation in health contributed to changes in gender equality in the Region? (Effectiveness)
- How efficiently has PAHO's technical cooperation in health integrated gender equality? (Efficiency)
- What conditions have been put in place by PAHO to ensure that gender equality considerations in its technical cooperation in health are sustained over time? (Sustainability)

3 See Appendix 5 – Evaluation matrix.

1.3.3 Methodological design

The evaluation was structured around evaluation questions and subquestions (see Evaluation Matrix in Appendix 5). Gender integration was analyzed across three dimensions: strategic, operational, and organizational. The strategic dimension identified macrolevel contributions and achievements, such as PAHO's institutional positioning, changes in systems or policies, and partnerships. The operational dimension reflected PAHO's performance, focusing on the effectiveness of the various technical cooperation modalities, or projects on gender equality in health. Finally, the organizational dimension assessed PAHO's internal organization and resources to address gender inequalities and institutionalize gender-sensitive institutional policies, using data on budgets, personnel, or funding.

The evaluation used a mixed-methods approach for data collection, drawing on primary and secondary sources in a hybrid format (face-to-face and remote).

1.3.4 Data collection tools

Documentary review

With the support of PAHO Evaluation, the external evaluation team compiled a set of internal PAHO documents at the regional, subregional, and national levels (including strategies, policies, planning, reports, and technical documents; budget data from the three strategic plans; and PAHO project data), as well as external publications and reports (e.g., ministries of health, United Nations and international organizations, partners, donors, universities, civil society organizations). More than 300 documents were reviewed (65% PAHO's and 35% external).

Semistructured interviews with key informants

Key informants were selected through purposive sampling from the different types of organizations identified. The interviews of PAHO personnel and various organizations included United Nations agencies, national institutions, civil society, donors, universities, collaborating centers, and experts. The data collection involved individual, pair, or small group interviews, resulting in 165 key informants interviewed (129 women, 36 men), as shown in Table 1. During the data collection phase, a snowball technique was used to identify additional key informants; this method provided information on PAHO's work on gender equality in technical cooperation in health during the early years of the period under evaluation.

Table 1. Key informants interviewed

Type of stakeholder	Female	Male	Total
Civil society	16	1	17
Donor	5	0	5
Experts/university/research	14	2	16
National counterpart	37	10	47
PAHO personnel	38	22	60
United Nations and international organizations	19	1	20
Total	**129**	**36**	**165**

Source: Evaluation team.

Online survey of PAHO personnel

A survey was conducted among management and personnel of PAHO Headquarters and country offices to capture their views and perceptions on integrating gender equality into PAHO's technical cooperation. The survey, conducted during August and September 2024, served to triangulate the previously collected information from the interviews, focus groups, and the documentary review. The survey was distributed to 169 professionals, and 46 responses (27%) were obtained, including 28 women, 17 men, and 1 participant who preferred not to be self-identified. The survey was structured around the following sections: Alignment and Intersectionality; Gender Equality Policy (2005) and its related plan of action (2009–2014); Data Generation; Capacity-building and Training; Partnerships; Best Practices; Resource Mobilization; and Recommendations. The full survey report is available in Appendix 7.

Focus group discussions

Three focus groups were conducted with the Department of Social Determinants of Health, the gender, equity, and ethnicity focal points of the country offices, and technical advisers. A total of 22 professionals participated, of which 73% (16) were women and 27% (6) were men, as shown in Table 2.

Table 2. Focus group discussion participants

Focus group	Women	Men	Total
Social determinants of health	4	0	4
Gender, equity, and ethnicity focal points	6	4	10
Technical advisers	6	2	8
Total number of participants	16	6	22

Source: Evaluation team.

Application of the Gender Mainstreaming Scanner (adapted version)

The Gender Mainstreaming Scanner4 was adapted and applied to assess the integration of gender equality into cooperation initiatives and projects. Therefore, it was necessary to adjust the original tool's design to ensure the relevance and the effectiveness of its scoring system.[5] Using the adapted Gender Mainstreaming Scanner, the evaluation team assessed a sample of PAHO's Country Cooperation Strategies (CSS) and projects funded through voluntary contributions. For the latter, the evaluation team gathered information about 309 projects financed by voluntary contributions, reviewing a random sample of 60 projects. However, the information that was shared with the evaluation team regarding each project primarily focused on agreements between parties, addenda, and limited detailed workplans, resulting in insufficient data to effectively apply the Gender Mainstreaming Scanner as an analytical tool at the project level.

Regarding the CCS, the evaluation team collected 83 strategies, representing almost all countries/territories in the Region (except Puerto Rico and Curaçao) and covering different time periods from 2004 onward, encompassing the last three Strategic Plans. From this initial identification, the evaluation team selected a random sample of 42 strategies.

4 The Gender Mainstreaming Scanner is a voluntary and self-applicable tool used to assess the level of gender mainstreaming in programs and projects, developed by the consulting firm Inclusión y Equidad.

5 See Appendix 8 – Application of the gender scanner.

Deep-dive analyses conducted in selected countries

In coordination with PAHO Evaluation and country offices, the evaluation team conducted three deep-dive country case studies[6] on PAHO's work on gender equality in health in Colombia, Panama, and Trinidad and Tobago. The decision to conduct deep-dive case studies in the three countries was based on their representativeness of different subregions (South America, Central America, and English-speaking Caribbean), sociodemographic and health system characteristics, and the interest and availability of country offices and national partners to engage in the evaluation process. Argentina, Brazil, and Mexico were also considered, but these proved unfeasible due to contextual and institutional factors such as national elections, previous commitments from PAHO country offices, or other limitations. The detailed analyses involved visits to the three countries in June 2024, during which the evaluation team conducted interviews with decision-makers, technical experts, and officials from PAHO, the ministries of health, and other governmental sectors. They also engaged with civil society organizations (CSOs) and networks, donors, and United Nations country teams (UNCT) to expand documentation, gather data at both national and subnational levels, and gain insights into the involvement of grassroots and subnational partners on the ground. In the cases of Brazil and Mexico, a limited number of interviews with national stakeholders were conducted through the external evaluation team's network of professional contacts.

1.3.5 Data analysis and validation

The evaluation team based its analysis on data from the documentary review, interviews, focus group discussions, surveys, field observations, and the Gender Mainstreaming Scanner. Where disaggregated data were available, criteria such as age and gender were considered, following the guidelines set forth by the United Nations Evaluation Group, PAHO, and the United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women (UN-SWAP).

Triangulation of information served as the central validation exercise, with findings and conclusions organized by evaluation question and triangulated by data type (primary and secondary), method of collection, source of information, or kind of informant, and evaluator. The collaboration of a multidisciplinary team reinforced the triangulation and a balanced interpretation and analysis.

Thematic analysis of the qualitative data was carried out using a coding structure in ATLAS.ti to organize and validate the data for each of the main evaluation questions. Quantitative data were analyzed using Excel and PowerBI to assess progress against planned outcomes. All data were analyzed to produce evidence to inform the conclusions and recommendations at three levels: strategic, operational, and organizational.

At the end of the visits to Colombia, Panama, and Trinidad and Tobago, the senior members of the external evaluation team met with the PAHO country office teams to

6 Deep-dive country case studies are comprehensive analyses that focus on specific countries to explore various aspects of their socioeconomic, political, cultural, and developmental contexts. In this evaluation the focus was specific to PAHO's work on gender equality in technical cooperation in health.

discuss emerging issues and briefly present preliminary findings and conclusions. A workshop between PAHO personnel and the external evaluation team complemented the process of validating findings and prioritizing recommendations

1.3.6 Evaluation quality assurance and governance

Quality assurance followed the PAHO Evaluation Policy and Evaluation Handbook, as well as the standards of the United Nations Evaluation Group and the guidelines of the evaluation community, particularly the Evaluation Network of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD/DAC). This process was conducted internally by the evaluation team and externally by PAHO Evaluation.

The external evaluation team ensured the internal consistency and quality of all deliverables, adhering to PAHO Evaluation standards. Regular meetings were held to monitor progress and promptly address any challenges. Data collection tools were tested for reliability and adaptability across different contexts. Senior team members reviewed all deliverables internally to ensure alignment with the objectives and standards. Throughout the evaluation there was consistent and transparent communication with PAHO Evaluation. PAHO Evaluation oversaw and guided the evaluation process in close collaboration with the external evaluation team, managed the administrative aspects, facilitated communication with stakeholders, ensured that the evaluators received the necessary data, provided technical guidance, and reviewed and quality-assured all intermediate and final reports.

A dedicated Evaluation Reference Group (ERG) of relevant PAHO subject matter specialists, directors, and country representatives provided advice, guidance, and quality assurance for the inception and final evaluation reports.

PAHO country offices played a key role in logistic and administrative preparations to support the smooth execution of the evaluation. They provided documentation, data, and information; facilitated national data collection through the organization of meetings and key informant interviews; and coordinated in-country feedback on evaluation findings.

1.3.7 Ethical guidelines

The evaluation was conducted according to the Ethical Guidelines for Evaluation defined by the United Nations Evaluation Group (2020) and adhered to the principles of the PAHO Evaluation Policy, which include impartiality, independence, utility, quality, transparency, credibility, ethics, and professionalism. In addition, the evaluation is aligned with the guidelines on integrating the principles of gender equality and human rights established in the United Nations Evaluation Group Handbook.

The evaluation team systematically sought voluntary participation or informed consent from all interviewees. The PAHO Ethics Review Committee approved the data collection tools. In addition, the external evaluation team adopted the following principles: (1) respect for dignity and diversity; (2) anonymity and confidentiality; (3) data security; (4) accountability; and (5) integrity and independence.

1.3.8 Challenges and mitigation measures

The evaluation process encountered several challenges, addressed through mitigation strategies agreed upon by PAHO Evaluation and the external evaluation team. These challenges included disruptions caused by government elections in various countries during the field work and the limited availability of key informants due to prior commitments of PAHO country offices. Additional issues included fragmented information sources, an overly broad time scope, and the difficulty of reaching PAHO staff from the early years of the evaluation period. To tackle these obstacles, PAHO Evaluation and the external evaluation team coordinated closely to manage scheduling for field missions and key informant interviews in the targeted countries, adapting their approach in response to organizational and external factors.

This collaboration led to a revised proposal that included two strategically important countries in the Region, Brazil and Mexico, albeit with a less detailed analysis than the deep dives. The external evaluation team used a snowball approach to identify key informants who had previously played significant roles but were no longer active, while also leveraging their professional networks to broaden the pool of interviewees in Brazil and Mexico.

To improve survey response rates, the team monitored and followed up with respondents. The analysis of gender inequalities in health was supported by diverse information sources, which helped address issues of fragmented national data. The Gender Mainstreaming Scanner tool was adapted to analyze CCS, although its application to technical cooperation projects faced limitations due to insufficient documentation. Acknowledging the need for triangulation with qualitative data, the external evaluation team mitigated reliance on self-reported information by crosschecking data from multiple sources to ensure the validity of findings.


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2. Findings

2.1 To what extent has gender equality been integrated into PAHO's technical cooperation in health? (Relevance and Coherence)

2.1.1 To what extent has PAHO's gender definition evolved over time, in line with the concept of gender over time within the United Nations system?

Finding 1. PAHO has developed an adaptive and evolving definition of gender. Its initial definition marked a transition from focusing on addressing women's health – such as the Women, Health, and Development Program – to a more inclusive approach. This shift not only reflects a conceptual transformation but also paves the way for a broader definition that encompasses concepts related to gender diversity.

From its origins, PAHO's definition of gender arose from the need to identify, recognize, and make women visible as a specific target group of public health programs with partner governments. This objective became more complex as the concept of gender evolved. In the context of antipoverty strategies throughout the Region, policies aimed at women were initially developed for their role as mothers, and they began to be prioritized as a population living in situations of vulnerability. This approach to public policies and programs, known as "Women in Development," prioritized "role theory" over the "theory of the sexual division of labor and power relations" to explain women's disadvantage and discrimination. It also introduced tools designed specifically for women, particularly those with low incomes. Within the United Nations, dedicated units for addressing "women and development"[7] issues emerged as part of its institutional architecture, and PAHO was part of this process.[8] PAHO echoed these primary debates by adapting its institutional design, creating a specific and pioneering area with staff and budget allocation, producing knowledge through specialized publications authored by specialists from the Region, and incorporating these approaches in some of the cooperation projects under way to strengthen capacities and articulate partnerships.

In recent years, PAHO has incorporated more inclusive approaches and more precise concepts to go beyond gender equality and to include gender diversity in different countries, as reflected in the documents reviewed and by key informants interviewed. However, there is no consensus within the health sector on how to make these approaches more operational and what is the scope of those concepts. This issue extends beyond

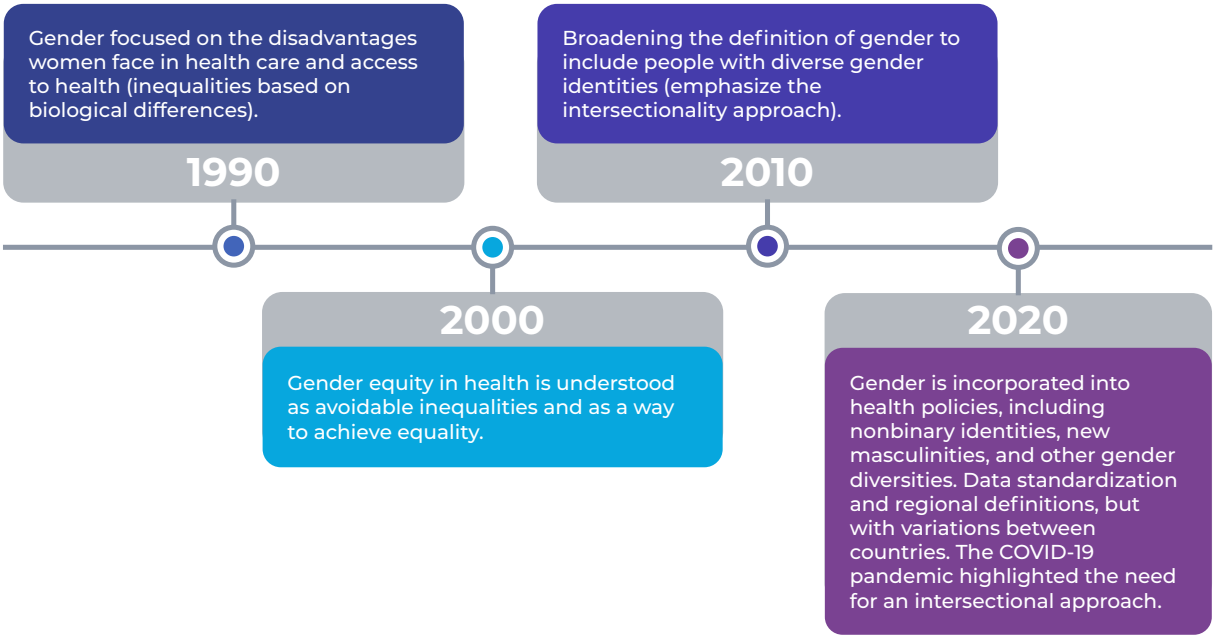
7 The Women in Development approach was based on traditional social welfare strategies, and led to cooperation, policies, and programs that viewed women through three key assumptions: (1) women are passive recipients of development; (2) motherhood is considered women's primary role; and (3) parenting, child-rearing, and caring for family members are regarded as women's most significant contributions to development.

8 See Appendix 3 – Timeline – key normative and institutional milestones.

visibility, recognition, and identification of their specific challenges in the countries. It is also noted that these changes have neglected the objectives of structural change inherent to the gender approach in the early stages.

Notably, PAHO sets and negotiates strategic priorities within the framework of the Country Cooperation Strategies (CCS)[9] with the ministries of health and with a wide range of actors and partners at the country level. In that sense, public policy priorities are influenced by the perspectives of key development actors in the countries, the normative and public policy framework not only for health but also for gender equality, and the social perceptions, attitudes, and practices regarding how gender categories are socially and culturally constructed, the power relations between genders, and the space that gender diversity and the role of LGBTI groups have in their public agenda. The following timeline (Figure 1) presents the four key periods in the evolution of PAHO's gender definition between 1990 and 2023.[10]

Figure 1: Synthetic timeline of the evolution of PAHO's gender approach, 1990–2023



Source: Evaluation team, based on PAHO documents.

9 Country Cooperation Strategies (CCS) provide a framework for shared understanding and strategic political prioritization at the country level. These strategies are defined jointly by PAHO and the ministries of health as a priority strategic partner in the countries with which the Organization works. These documents refer primarily to public health policies, development policies and strategies, and those social policies that are most relevant to this important road map.

10 See also Appendix 3 – Timeline – key normative and institutional milestones.

Finding 2. Key concepts[11] such as gender equity, gender equality, social determinants, and intersectionality are generally understood within PAHO; however, this understanding has been inconsistent and has evolved over time across various policy, planning, and organizational contexts.

Gender equality ensures that everyone has the right to enjoy all human rights without discrimination based on gender. It does not mean men and women are the same or that women must become like men to have equal rights. Instead, it involves treating men and women either identically or differently to eliminate gender-based discrimination. **Gender equity**, on the other hand, focuses on fair treatment based on individual needs, using differential approaches. The key difference is that gender equality is a legal obligation requiring states to take specific actions to eliminate discrimination, while gender equity addresses practical needs.[12]

Under these premises, the evolution of PAHO's definition and conceptualization of gender,[13] as reflected in various planning and policy documents, has progressively aligned with the World Health Organization (WHO) concepts and definitions. The findings and conclusions from the progress reports concerning the implementation of corporate gender equality in the health policies of both organizations (WHO and PAHO) reveal common themes. The main differences lie in two areas: first, the general approach of the documents – while WHO outlines areas of action for regions, PAHO defines more specific activities tailored to the regional context. Second, recent WHO documents appear to adopt a broader perspective on health inequalities, including gender. However, not all CCS in the Americas fully incorporate the latest WHO Guidelines – particularly the 2023 update – which emphasizes more intensive gender considerations, participation, and a rights-based approach that extends beyond the traditional focus on maternal health. This difference is evident in the limited consideration of CEDAW,[14] and other human rights treaties' general observations and comments related to strategy, policymaking, and planning.

The analysis of selected CCS from 2004 to 2015 and from 2016 to 2024[15] using the Gender Mainstreaming Scanner revealed that gender was only integrated during the first period analyzed (Figure 2). The Gender Mainstreaming Scanner categorized these CCS as "gender blind," indicating a systematic absence of recognition of the multidimensional

11 See Appendix 1 – Glossary of terms and definitions.

12 For example, measures to address women's exclusive responsibility for unpaid domestic work associated with health care may advocate for wages for those women who are both primary caregivers and heads of household. However, such actions fail to acknowledge that the burden of caregiving creates discrimination – not only due to the lack of remuneration but also because it results in less free time, reinforces subordinate relationships with partners, and excludes caregivers from the benefits associated with paid work, such as training and promotions. A gender equality approach advocates for the redistribution of domestic and caregiving responsibilities, ensuring that no individual is disproportionately burdened and that both men and women can equitably balance their family and work lives.

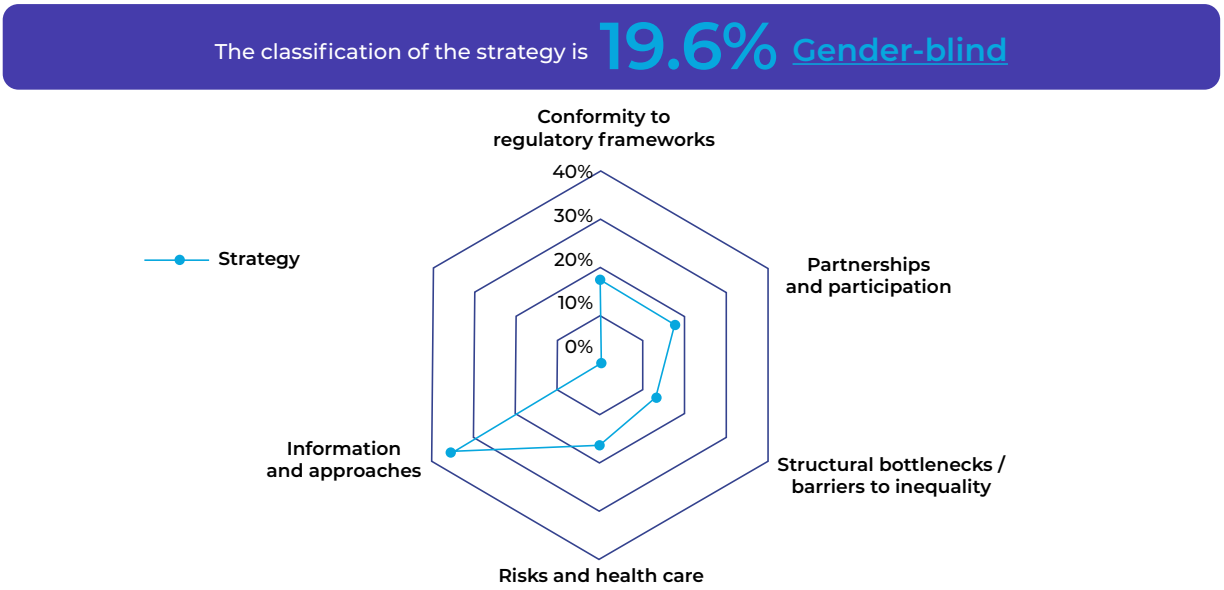
13 See Appendix 1 – Glossary of terms and definitions.

14 The CEDAW is one of the international human rights treaties. It specifically focuses on women, guaranteeing their fundamental rights and freedoms based on the principle of equality between men and women in all areas of life. This instrument is founded on two fundamental principles: equality and nondiscrimination, with the goal of achieving substantive equality through the elimination of discrimination, improving women's status, and transforming gender relations and stereotypes. It requires States Parties to implement normative changes and public policy reforms across all sectors, including health, and to report regularly on their compliance.

15 The countries selected in the review of the Country Cooperation Strategies were: Argentina; Belize; Bolivia (Plurinational State of); Canada; Chile; Dominican Republic; Ecuador; Honduras; Mexico; Nicaragua; Panama; Paraguay; Peru; Suriname; Trinidad and Tobago; Venezuela (Bolivarian Republic of); and Barbados and Eastern Caribbean Countries office.

nature of inequalities, including factors such as social class, ethnicity, religion, age, sexual orientation, gender identity, and disability/functional diversity. While sex-disaggregated data and other variables are more prominently featured in most countries, there remains a lack of robust analysis of the social determinants of health from a gender perspective.

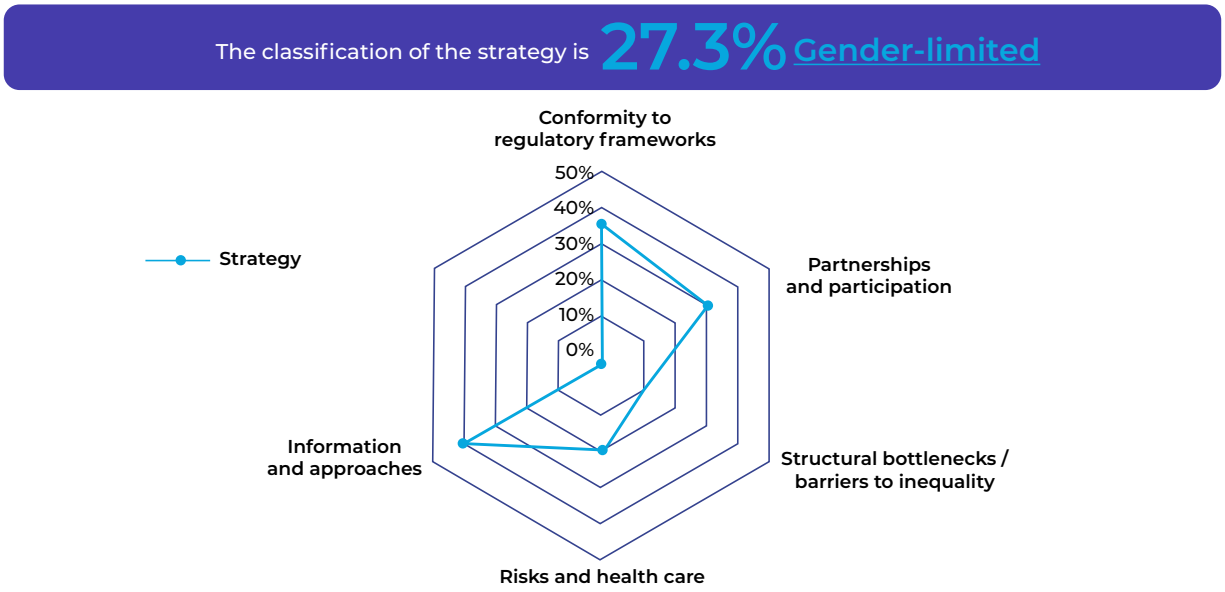
Figure 2: Results of applying the Gender Mainstreaming Scanner to PAHO's Country Cooperation Strategies in the Americas (regional level from selected countries, first analyzed period 2004–2005)



Source: Evaluation team, based on applying the Gender Mainstreaming Scanner to the CCS in the last two periods.

In the following period (as of 2017), the inclusion of the gender approach in CCS shows some progress, although some countries still presented significant lags. The results from the application of the Gender Mainstreaming Scanner indicate a shift from "gender blind" CCS to those that are still "limited" in gender mainstreaming (Figure 3). Progress and setbacks are evident in this second period. This indicates that more precise organizational guidelines enhance the understanding and application of new concepts to each country's context. Additionally, certain concepts and approaches need to be standardized so that countries can advance according to their capacities and analyses while adhering to expected standards.

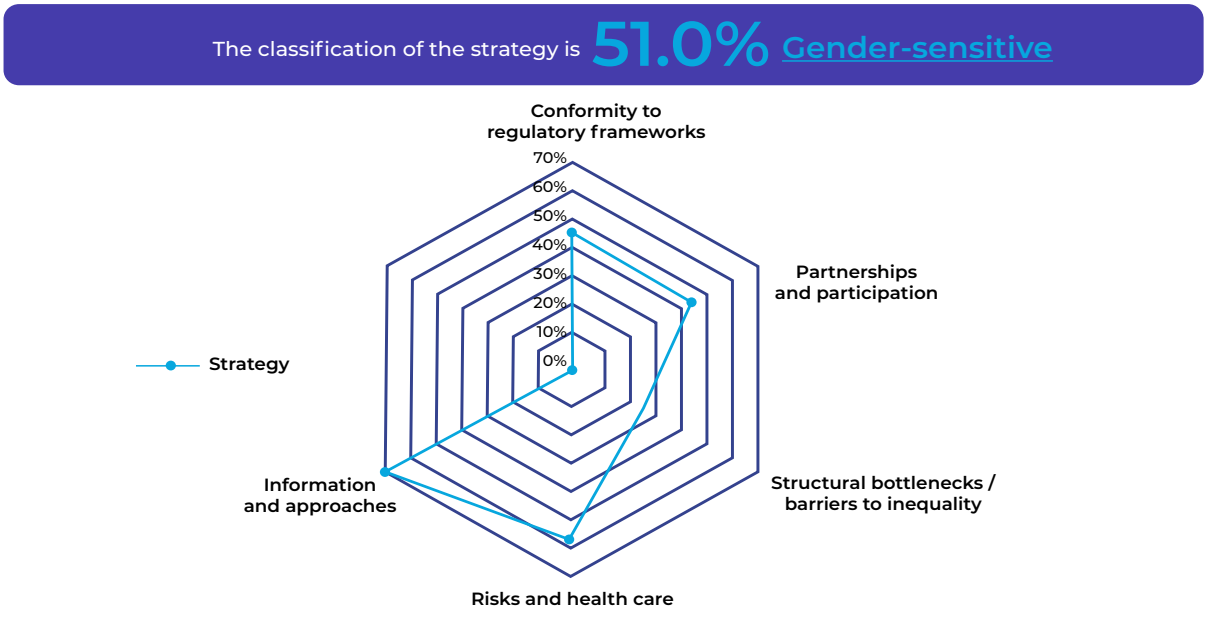
Figure 3: Results of applying the Gender Mainstreaming Scanner to PAHO's Country Cooperation Strategies in the Americas (regional level from selected countries, second analyzed period 2017–2024)



Source: Evaluation team, based on applying the Gender Mainstreaming Scanner to the CCS in the last two periods.

The review of the CCS in Caribbean countries between 2016 and 2023 rated an average of 51% in the Gender Mainstreaming Scanner, defined as gender-sensitive (Figure 4), as they consider gender inequalities and respond proactively to overcome these inequalities to achieve gender equality, rights, autonomy, and women's empowerment. The dimensions of "information and approaches" and "consideration of risks and access to health" were rated highest in the application of the Gender Mainstreaming Scanner.

Figure 4: Results of applying the Gender



Mainstreaming Scanner to Country Cooperation Strategies in Caribbean countries (selected countries, period 2016–2023)

Source: Evaluation team, based on applying the Gender Mainstreaming Scanner to the CCS in the last two periods.

2.1.2 To what extent has PAHO's technical cooperation in health been linked to PAHO's equity agenda and adopted an intersectional approach?

Finding 3. PAHO has implemented policy initiatives, plans, and institutional guidelines to operationalize intersectionality in technical cooperation in health for resource mobilization purposes. However, challenges remain in achieving clear, systematic, and standardized operationalization and implementation across country offices.

The recent focus on intersectionality has arisen from the evolution of feminist studies, which critically examine the categorization of gender and women as a homogeneous group, thereby deepening the analysis of systemic and structural inequalities. Within the social determinants of health (SDH) approach framework, it becomes possible to identify the complex interplay of multiple inequalities and their intersections. Here, gender analysis serves as a pivotal axis for understanding how various forms of inequality interact. However, despite PAHO's implementation of policy initiatives and institutional guidelines, the application of intersectionality has not been consistent across all CCS. This limitation is particularly evident in recent CCS that have aligned with WHO guidelines.

PAHO has embraced the SDH approach and advocated for the application of intersectionality by developing specific institutional policies for the LGBTI population and, to a lesser extent, for Afro-descendant populations and indigenous peoples. In several countries, CCS have addressed crucial dimensions such as ethnicity, age, disability, and migration. For instance, the Plurinational State of Bolivia focuses on inequalities stemming from ethnicity and gender; Trinidad and Tobago addresses issues related to gender, disability, and disaster preparedness; Panama highlights concerns affecting Afro-descendant and ethnic communities; Brazil incorporates ethnicity and gender into its strategies; and Mexico emphasizes the needs of individuals in situations of mobility and migration.

Furthermore, **the definition of gender equality articulated in PAHO's Gender Equality Policy and its related plan of action has not been consistently and uniformly operationalized across all phases of the project cycle or within various organizational dimensions.** As a result, corporate documents are reasonably familiar to PAHO personnel and, to a lesser extent, to its partners. Although the Gender Equality Policy has been translated into practical tools for resource mobilization and proposal writing for donors – primarily focusing on GBV – its application in monitoring project implementation remains limited.

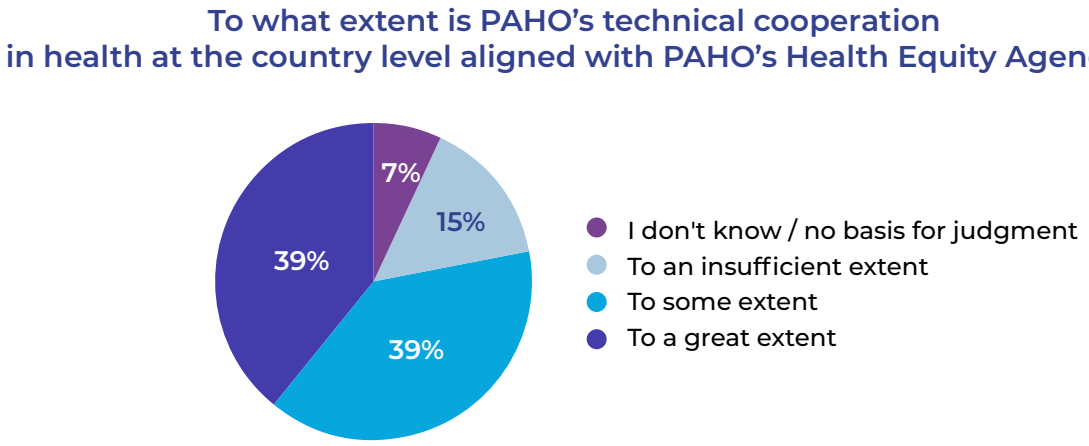
The Regional Gender Agenda was developed over the past 47 years under the auspices of the Regional Women's Conferences. A pivotal moment in this evolution occurred in 2017 with the introduction of the Montevideo Strategy, which emerged from high-level political dialogues among countries, civil society, and the United Nations concerning gender issues.[16] Nonetheless, it is still unclear how these regional processes have shaped the design of PAHO's Health Equity Agenda and its technical cooperation. In many countries, the SDH approach coexists with an epidemiological framework, often lacking

16 The Montevideo Strategy established a shared diagnosis of four structural nodes of inequality in the Americas and delineated a comprehensive plan to address these inequalities across 11 thematic areas.

the synergies and strategic dialogue necessary to engage with the Regional Gender Agenda effectively.

While some countries have successfully integrated the 2030 Agenda for Sustainable Development as a road map for their public health policies – primarily under SDG 3[17] – the incorporation of international and regional human rights frameworks, such as treaty bodies like CEDAW, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and the International Covenant on Economic, Social and Cultural Rights, has only occurred on a few occasions. This is consistent with the evaluation of PAHO technical cooperation on noncommunicable diseases, which concluded that there were missed opportunities to use human rights instruments to advance the agenda on noncommunicable diseases and limited collaboration between WHO headquarters and PAHO Legal Counsel Office.[18]

Figure 5: Alignment of PAHO's technical cooperation in health at the country level with PAHO's Health Equity Agenda



Note: N = 46.

Source: PAHO personnel survey.

Figure 5 illustrates respondents' perceptions regarding the alignment of PAHO's technical cooperation in health at the country level with the Health Equity Agenda. A significant majority, 78% (n = 36), indicated that technical cooperation was aligned with the agenda either primarily or to some extent. In contrast, 15% of respondents (n = 7) perceived the alignment as insufficient. No significant gender differences were observed in the responses.[19]

17 From the interviews conducted with key informants, it was highlighted that the focus of work with the 2030 Agenda has been mostly centered on SDG 3, and not so much on a comprehensive vision of all the SDGs with their respective targets and indicators.

18 PAHO Legal Counsel Office (and Department in the past) enlists a Health and Human Rights Advisor.

19 See Appendix 7 – PAHO personnel perceptions survey.

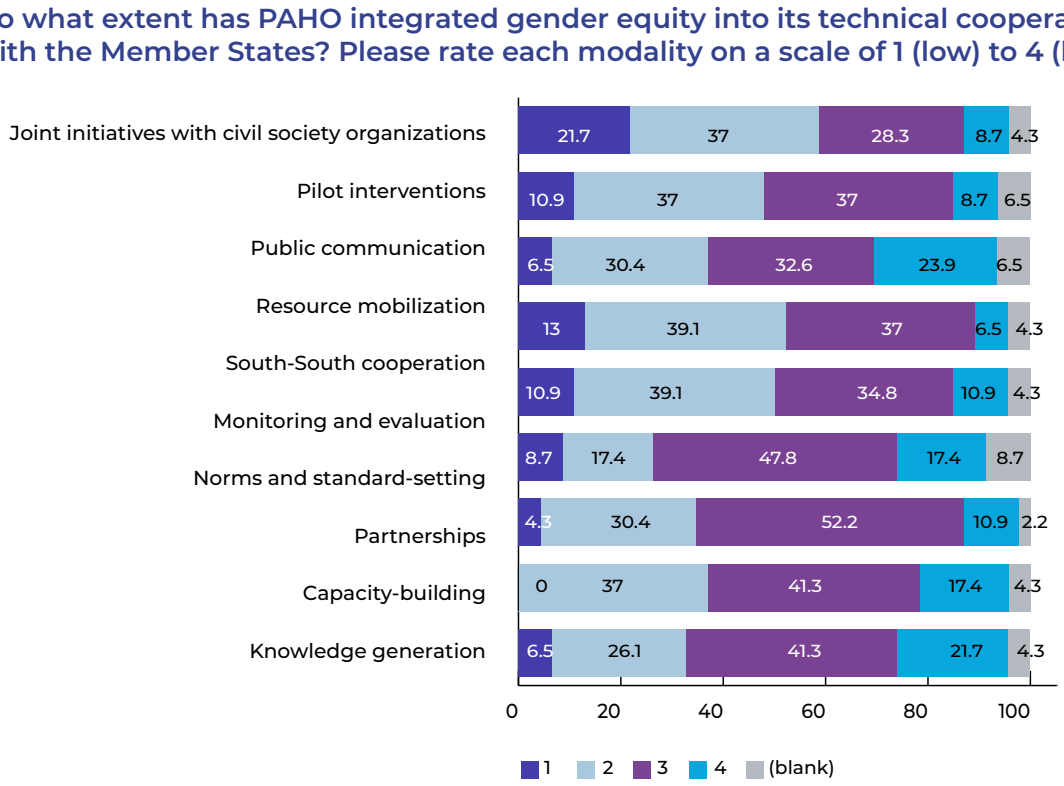
2.1.3 To what extent has the Organization's structure, policies, and outputs integrated gender equality within PAHO's technical cooperation in health?

Finding 4. PAHO has been a pioneer in embedding gender equality into its institutional framework, budget allocations, and partnerships. It has made notable strides in integrating gender equality through the establishment of norms and standards, knowledge generation, and public communication as key technical cooperation modalities. However, despite the implementation of various institutional policies and plans, this integration has not been systematically reflected in the last three Strategic Plans analyzed. Furthermore, the Organization's reference unit for gender equality in health (now the Equity, Gender, Human Rights, and Cultural Diversity Unit [EG]) has been moved from the senior management level to the new DHE, which has affected the role and visibility of the EG Unit within the Organization.

Currently, PAHO's work on gender equality in health is organized through a specific area within the DHE and a set of focal points at the country level that cover not only gender but also equity and ethnicity. It is important to mention that not all the country offices have a designated focal point on these matters. Critical issues related to gender equality in health, such as GBV and the human rights-based approach, have been fragmented into other functional areas, which sometimes makes it challenging to coordinate comprehensive actions among the personnel of the different units, departments, and country offices.

Gender equality has been integrated with more emphasis on specific components of the planning process. Nevertheless, this is not systematic or uniform across all planning and implementation phases, with significant variations between countries and periods. Likewise, there is fragmentation in data documentation corresponding to PAHO projects in different countries, with various adverse effects for monitoring implementation. Limitations have also been identified in the operationalization of the Gender Equality Policy and the Plan of Action and the generation of data, especially at the subnational level. Likewise, the minimum standards of the CCS are inconsistently applied, particularly in the latest normative documents, manuals, and guides. In the PAHO personnel survey, participants rated **the establishment of norms and standards, knowledge generation, and public communication as the technical cooperation modalities where PAHO has most effectively integrated gender equality** (Figure 6). Conversely, joint initiatives with CSOs, South–South cooperation, and resource mobilization were identified as areas with lower levels of gender equality mainstreaming.

Figure 6: Integration of PAHO's gender equality into its technical cooperation, by cooperation modality



Note: 1 To an insufficient extent; 2 To some extent but some gaps remain; 3 To a great extent; 4 Don't know / no basis for judgment.

Source: PAHO personnel survey.

2.1.4 To what extent have PAHO's technical cooperation projects and initiatives been aligned with the Member States' needs and priorities in gender equality?

Finding 5. Technical cooperation for gender equality has been only partially aligned with the needs identified by Member States. Similarly, the situational analysis and formulation of CCS and projects have only been partially aligned with Member States' priorities regarding gender equality and with regional standards and guidelines on gender mainstreaming.

In the reviewed CCS, references to gender equality policies or the 2030 Agenda[20] have not been made systematically. The breadth and characteristics of the national consultations have also varied, with the identified range of needs and priorities involving varying levels of participation from civil society, academia, and the State. **Thus, although CCS have integrated gender equality in various ways and at different levels, this integration is not systematic or uniform, as there are no established minimum standards for consultation, participation, partnership, and strategy development.** Additionally, different countries expressed their concern about the role and mandate of Resident Coordination Offices to integrate gender considerations in a crosscutting manner within national cooperation

20 The Sustainable Health Agenda 2030 (SHA2030) is the blueprint agreed upon by Member States for implementing the health-related SDGs in the Region.

frameworks. This integration is a critical and mandatory component in formulating new CCS, as it facilitates clearer interagency coordination, collaboration, and capacity-building opportunities.

2.1.5 To what extent has PAHO's technical cooperation in health been aligned with the 2030 SDG 5, aimed to achieve gender equality and empower all women and girls?

Finding 6. PAHO's technical cooperation has aligned with the 2030 Agenda for Sustainable Development, primarily emphasizing SDG 3, which aims to "ensure healthy lives and promote well-being for all at all ages," while also addressing SDG 5 to a lesser extent.

According to data collected from the interviews and survey, **the alignment with the 2030 Agenda for Sustainable Development has been mostly focused on SDG 3, the implementation of its targets and indicators**, which emphasizes ensuring healthy lives and promoting well-being for all at all ages.[21] To a certain extent, there is also an alignment with SDG 5, which aims to achieve gender equality and empower all women and girls. This focus has involved the implementation of targets and indicators centered on eliminating all forms of discrimination and violence against women and girls – as part of the Spotlight Initiative – and ensuring universal access to sexual and reproductive health – in close collaboration with other United Nations agencies such as UNFPA and UNAIDS – as well as reproductive rights.

Although more limited, the alignment with SDG 5 has primarily focused on two key areas: GBV and sexual and reproductive rights. Additionally, the survey shows that 59% of respondents indicated that this alignment has been limited, highlighting certain gaps that still need to be addressed. The interviews further expanded on this point, emphasizing the weakness of the approach in working with the 2030 Agenda, which requires a more comprehensive view of all the SDGs, their goals, and indicators.

2.2 To what extent has the integration of gender equality into PAHO's technical cooperation in health contributed to changes in gender equality in the Region? (Effectiveness)

2.2.1 How effectively has PAHO's technical cooperation in health addressed the social determinants of health (SDH) involved in gender inequalities in health?

Finding 7. The SDH approach, which includes gender, has been part of PAHO's strategic planning and technical cooperation during the evaluation period and has materialized in important milestones that demonstrate its relevance to the Organization's work. Within the SDH approach, PAHO's technical cooperation has promoted public health

21 SDG 3 aims to address a broad range of global health issues, including reducing maternal and child mortality, ending the epidemics of communicable diseases such as HIV/AIDS, tuberculosis, and malaria, and tackling noncommunicable diseases (NCDs) like cardiovascular disease, cancer, and diabetes. SDG 3 also emphasizes improving mental health, reducing road traffic accidents, combating substance abuse, reducing deaths and illnesses from pollution, and strengthening global health risk management.

policies and programs to address risk factors and proximal determinants that affect individuals' health. However, it has had limitations in promoting the multisectoral strategies and approaches needed to address the distal determinants of health, which go beyond the remit of the health sector and require the sustained involvement of multiple public administrations.[22]

PAHO's Strategic Plans have consistently incorporated the SDH approach, linking it to gender inequalities across different periods (2008–2013, 2014–2019, 2020–2025). Likewise, PAHO's Strategy for Universal Access to Health and Universal Health Coverage (2014) promoted the implementation of the WHO Commission's final report on Social Determinants of Health and the Rio Political Declaration on Social Determinants of Health, guiding the conceptual framework and indicators for monitoring gender equality in health in the Americas.

The SDH approach gained momentum globally with the establishment of the WHO Commission on Social Determinants of Health. At the regional level, the PAHO publication *Gender mainstreaming in health: Advances and challenges in the Region of the Americas* recognized the growing centrality of SDH in the global agenda. In the case of PAHO, work on SDH has been strengthened with the adoption of the Health in All Policies (HIAP) approach[23] and, more recently, the creation of the DHE. Other international frameworks, particularly the SDGs, have also underscored the importance of the SDH approach (recognizing that many of the factors that influence health are not directly related to the health sector).[24]

The integration of gender equality work within PAHO has been strongly linked to the SDH and health equity frameworks, primarily focusing on addressing the proximal determinants of health. These include factors that directly impact individual health, such as material conditions, behaviors, and access to health care. While these are critical for advancing gender equality in health, PAHO's technical cooperation provided to Member States has had a more limited impact on public policies or actions aimed at mitigating or reducing the distal determinants of health – such as poverty, education, and social structures that drive gender inequalities on a societal level. These determinants are outside the purview of the health sector (and therefore outside PAHO's scope of action) and require the involvement and contribution of several governmental institutions responsible for other public policies (e.g., development, economy, employment, housing, social protection, education). According to the SDH model, these distal determinants, often referred to as the "causes of the causes," are essential for tackling systemic inequities and achieving lasting health equity. However, the health sector's difficulties in leading or promoting the medium- or long-term multisectoral actions needed to address the root causes of inequalities are widely described, noting that ministries of health or health actors often do not have the mandate, expertise, or adequate resources.

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22 Factors that affect health are often described as either "proximal" (downstream or directly affecting health) or "distal" (upstream or indirectly affecting health).

23 HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity.

24 SDG 1 Poverty, SDG 2 Hunger, and SDG 4 Quality education.

According to interviews and documentary review, PAHO's SDH approach has favored the identification of emerging issues that are expressed in gender inequality, such as unpaid work in health and its quantification in national accounts, as well as the burden that women have as providers of health services. **Despite PAHO's progress in linking gender equality to SDH, challenges remain in addressing these deeper structural drivers, which require comprehensive societal and policy changes beyond the healthcare sector.** The role of intersectoral work was described as vital in the interviews and document review, given that many ways for addressing health inequities lie outside the health sector. Data collected from different sources also highlighted the challenges of collaborative policymaking across sectors, integrated responses, and increased accountability across different government institutions and levels.

Finding 8. The integration of gender within PAHO's SDH framework, both in the organizational structure and in PAHO's programs and projects, as well as the low priority Member States give to the SDH in PAHO's Strategic Plans, dilute its potential as a tool for advancing more inclusive and transformative health outcomes. The low prioritization of the SDH outcome and limited resources critically hamper the implementation of intersectoral and sustained action required to address the root causes of inequalities.

The integration of gender equality within PAHO's organizational structure and strategic frameworks, particularly through its positioning in the DHE, reflects a recognition of gender inequalities as a key social determinant of health. At the strategic planning level, the link between gender and SDH shows fluctuations over the period under review. For example, in the current Strategic Plan 2020–2025, gender is one of the three axes of the conceptual framework (theory of change), and it has been included within Outcome 26 – Crosscutting themes (equity, gender, ethnicity, and human rights); also, PAHO has implemented programs and projects framed in the SDH through its various technical cooperation modalities (evidence, capacity-building, partnerships, frameworks, standard setting, monitoring, and project implementation). In the previous two PAHO Strategic Plans, gender was embedded into Strategic Objective 7 (2008–2014) and Category 3 (2014–2019) related to social determinants. **However, although the SDH are clearly integrated into PAHO's strategic planning, they receive a low priority in defining the regional priorities with the Member States (which in turn implies a low budget allocation).** This is one of the factors hindering the consolidation of a comprehensive, multisectoral, and long-term approach inherent in tackling health determinants.

From a programmatic perspective, while the SDH framework provides a comprehensive lens for addressing health inequities, gender tends to be embedded under broader determinants (e.g., education, employment, ethnicity, housing), limiting its effectiveness as a stand-alone and focused approach. Furthermore, the application of the gender approach within PAHO has often adhered to traditional gender roles, particularly focusing on women's health needs that align with conventional social expectations (e.g., maternity). In contrast, other critical health issues – such as abortion, women's sexuality (especially for adolescents), menopause, masculinities, men's mental health, and health care for LGBTI populations – have been little addressed in PAHO programs and projects. For example, the evaluation of PAHO technical cooperation in noncommunicable diseases

found that gender equality was not well integrated into PAHO technical cooperation on NCDs. Another example, in this case related to health interventions for the LGBTI population, shows that PAHO's technical cooperation has been mainly linked to the response to the HIV epidemic. LGBTI-friendly clinics developed in several countries have focused on the prevention of diseases such as HIV and other sexually transmitted infections and have helped to reduce discrimination in health services but have not comprehensively addressed the rights and health needs of this population. Several interviewees pointed out that new masculinities and men's specific needs have not been sufficiently integrated or addressed in PAHO's gender approach and in the gender policies of Member States. Despite pioneering initiatives (e.g., Brazil), the lack of attention to men's specific health needs has, in some contexts, led to "passive resistance" to gender equality policies in health.

2.2.2 What were the key achievements, enabling factors, best practices, and lessons influencing the integration of gender equality into PAHO's technical cooperation in health?

Key achievements

Finding 9. PAHO has contributed to the institutionalization of gender equality approaches in health systems, national institutions, and CSOs, focusing on critical public health issues (e.g., sexual and reproductive health, GBV, combination HIV prevention) and access to health for population groups exposed to barriers to access and exclusion (e.g., indigenous peoples, Afro-descendants, migrants, LGBTI persons).

PAHO's contribution to programmatic achievements is highlighted in long-standing gender issues such as sexual and reproductive health, GBV, HIV, and unpaid domestic work. These efforts highlight the importance of interinstitutional collaboration and a territorial approach to achieve and document changes in gender inequalities in underserved communities. **Programmatic advances have been identified in GBV prevention and care (with recent and well-documented initiatives in Colombia and Uruguay during the evaluation), as well as sexual and reproductive health, with a focus on indigenous women and the promotion of the care agenda.**

In collaboration with other organizations, including UN Women, ECLAC, UNFPA, women's networks, and health professional organizations, PAHO has generated evidence on unpaid care work (2020) to advance the care economy agenda. PAHO has promoted the vision of a care society with gender equality, linking it to national health systems, highlighting the importance of accounting for care work in national accounts, and addressing the overload of caregivers' role in a Region where 73% of health professionals are women.

Interinstitutional collaboration and, in some countries, a territorial approach (in priority locations at the subnational level) involving community participation through CSOs, leaders, and local authorities have been drivers of change in reducing barriers to access and exclusion based on gender. In Panama, for example, PAHO has supported efforts of organizations for women domestic workers, who are particularly exposed to vulnerability due to their status as migrants and workers in the informal economy. PAHO's support to local actors (municipalities, nongovernmental organizations, communities, women leaders in localities on the Colombia–Venezuela border affected by violence [e.g., Cúcuta]) has made it possible to strengthen multisectoral work to support and protect survivors of GBV, improve sexual and reproductive health services, consolidate local leadership, and document improvements in access to services.

The presence in the territory and the promotion of community participation in countries where PAHO has had the capacity and resources (e.g., Brazil, Colombia, Panama) have strengthened the articulation of the local response to critical situations and its legitimacy to influence the central level. PAHO's actions in subnational priority areas have made it possible to document gender disparities in health in communities (through specific projects), strengthen advocacy capacity from the local to the central level ("bottom-up"), promote leadership and women's and community networks to influence local administrations, and refer to specialized services (e.g., GBV). In humanitarian responses (e.g., migration and forced displacement, violence, disasters, epidemics), PAHO actions in the field have contributed to reinforcing the equity approach and "leaving no one behind."

Finding 10. PAHO has introduced innovations in its technical cooperation (promoting new tools, technologies, and thematic areas) that have allowed Member States to improve their response to critical gender inequalities in cancer prevention among adolescents, vaccine production for pregnant women, and violence during the perinatal period.

Through interviews and document review, the evaluation was able to document some innovative interventions supported or promoted by PAHO through its technical

cooperation in key areas of gender equality in health in the Region. The innovations presented below do not exclude that there may be other relevant innovations in PAHO's work on gender equality in health over the last 15 years. These innovations are presented as actions for which there has been a good level of recognition.

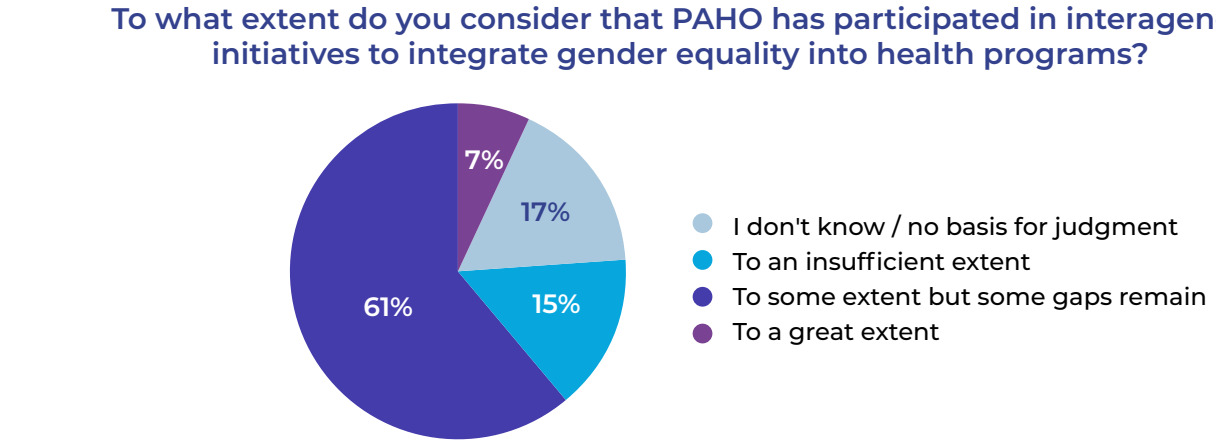
- **Development of gender and health indicators:** PAHO pioneered the development of a set of gender and health indicators to guide the work of national health systems in addressing gender gaps in health analyses and to develop inclusive policies and tools.
- **Cancer prevention in adolescents:** Within the framework of the work on Healthy Schools and intersectoral collaboration between the ministries of health and education, PAHO supported an initiative in Trinidad and Tobago to raise awareness and help girls identify health problems such as breast cancer. This intervention evolved into a broader approach that included adolescent boys and girls. In most countries in the Region, the collaboration between the health and education sectors has enabled the promotion of human papillomavirus (HPV) vaccine among adolescents (in addition to various issues of disease prevention, early pregnancy, mental health, etc.). As of 2023, 47 countries and territories in the Region have introduced HPV vaccine in their national schedule (92% of the countries/territories in the Region).
- **Gender approach and inclusion of pregnant women in vaccine production and clinical trials:** The evaluation identified PAHO's most significant collaboration with the private sector in addressing a critical gap in the vaccine response to emerging and reemerging pathogens - the needs of pregnant women and their offspring. In response, PAHO has supported clinical trials involving pregnant women, a group historically excluded from many vaccine studies. Likewise, PAHO has also participated in the analysis and definition of guidelines to promote ethical orientations in biomedical vaccine research (e.g., PREVENT Working Group, 2018). In coordination with the Southern Common Market countries (MERCOSUR), PAHO has advocated for introducing a gender approach in vaccine production, promoting gender parity in the industry, developing specific modules on gender, and strengthening the skills of human resources.
- **Increased understanding of violence in the reproductive process:** PAHO has supported national health actors in developing new approaches and tools to identify forms of violence that were not previously explicit, such as in the perinatal period (reproductive violence). Knowledge and indicators have been generated to make this type of violence visible (e.g., Trinidad and Tobago).

Enabling factors

Finding 11. Establishing alliances and partnerships has worked as a key facilitator to promote the commitment to gender equality in health of ministries of health and, in some cases, national mechanisms for the advancement of women.

The existence of mechanisms for interagency collaboration with UN Women, UNFPA, ECLAC, and other related networks has facilitated coordination and progress in this area. More than half of the survey respondents (61%, n = 28) perceive PAHO's participation in interagency initiatives to mainstream gender equality positively, albeit with some gaps (Figure 7). In addition, the sustained commitment of key donors has been crucial for advancing gender equality initiatives in health.

Figure 7: Perception of PAHO's participation in interagency initiatives to integrate gender equality into health technical cooperation programs



Source: PAHO personnel survey.

Good practices

- **Promoting multi-stakeholder collaboration in developing health plans contributes to fully incorporating a gender equality perspective.** In Uruguay, this participatory approach was applied in the five-year health plan, involving dialogues with officials, health service users, and social organizations to ensure a gender-inclusive vision in policy decisions. PAHO and the other agencies of the United Nations system have recognized Uruguay's 15-year partnership with Colectivo Ovejas Negras and other organizations for successfully integrating sexual diversity into primary health care policy. This recognition highlighted the impact, quality of evidence, sustainability, and potential for replication. PAHO has used the experience of working with other partners to develop the first module on Sexual Health and Diversity in PAHO's Virtual Campus for Public Health.
- **Harmonizing biomedical and traditional medicine has validated culturally safe childbirth practices and enhanced disease prevention efforts, particularly for indigenous communities.** The inclusion and integration of traditional, complementary, and integrative medicines in health systems to promote intercultural and inclusive health services (an initiative led by PAHO at the international level in the framework of the PAHO/WHO Action Plan on Ethnicity and Health 2019–2025 and the work of BIREME), has contributed to (1) reducing inequalities in maternal and child health, (2) promoting women's empowerment, (3) promoting models for childbirth care with an intercultural perspective; and

(4) favoring quality, timely care and acceptability of health services. In Mexico, the Model of Care for Women during Pregnancy, Childbirth, and Puerperium with a Humanized, Intercultural, and Safe Approach has been in place since 2008. In Argentina, the tool for promoting culturally safe childbirth has been tested in the Gran Chaco, which has made it possible to integrate the intercultural approach in pregnancy, childbirth, and postpartum care for women from different ethnic groups. In the Plurinational State of Bolivia, Colombia, Ecuador, Honduras, and Peru, the "Dialogues of Knowledge"[25] and the work with traditional midwives have included topics such as family planning, prenatal control, identification of signs of danger in pregnant women, and childbirth care.

- **The Methodology for Gender and Intersectionality Analysis,** developed by PAHO with funding from the Government of Canada and based on the Gender-based Analysis Plus (GBA+) tool developed by Global Affairs Canada, incorporated an intersectionality approach. Under this approach, other social identities, such as ethnicity, sexual orientation, age, and mental or physical disability, were considered to analyze how particular population groups experience government policies and initiatives. In January 2024, trainings on this methodology were conducted in Caribbean countries (Bahamas, Barbados, Belize, Guyana, Haiti, Jamaica, and Trinidad and Tobago), and it was implemented in the immunization plans of Haiti and Jamaica.

In addition to good practices, Box 1 presents selected lessons learned from a thematic evaluation of various United Nations agencies and interviews conducted during the evaluation.

25 Recently, the "Dialogues of Knowledge" methodology has been adopted to eliminate trachoma as part of PAHO's Disease Elimination Initiative. In Colombia, a "dialogue of pieces of knowledge" was carried out with women and men of the Pijao community to understand sexual practices and their views on prevention methods for sexually transmitted diseases and Chagas disease, achieving an increase in participation in screening for congenital Chagas disease.

Box 1. Lessons learned*

- **Leadership and resource allocation:** Strong personal and managerial leadership, together with the strategic allocation of resources to gender equality, act as catalysts and accelerators of change when investing in a gender architecture across the Organization. Without a meaningful and targeted allocation of resources across different levels of the Organization, gender initiatives are unlikely to have a fundamental and applied impact.
- **Organizational structure:** An effective organizational structure that links the work between the gender team and the programmatic and budget planning teams, supported by planning with indicators and a specific budget allocation, has been essential to advance gender equality objectives.
- **Participation of nongovernmental organizations:** The active participation of nongovernmental organizations and social movements – including feminist, Afro-descendant, and indigenous groups – has fostered greater alignment with local priorities, alignment with ethical frameworks, external accountability, and sustainability.
- **Interinstitutional collaboration:** Collaborating across institutions has expanded institutional capacity and advocacy efforts, while evidence has been vital in guiding transformative actions for gender equality in health.
- **Contextual adaptation:** The use of different entry points to adapt gender equality work to different institutional, political, and sociocultural contexts has helped to seize opportunities, generate interest, align initiatives with national priorities, and mitigate potential resistance to normative and rights changes.
- **Operational tools and training:** The availability of user-friendly operational tools and continuous training of PAHO and national health system professionals remain critical to lowering the implementation of gender policies at the local level and sustaining progress.
- **Guidelines for implementation:** Developing guidelines for incorporating gender into PAHO's planning, monitoring, and evaluation processes have served as technical support to the countries in the Region.

* Based on data collected in interviews with informants and on "Case study 8: Institutional integration of gender across all technical programmes, Member State health programmes, and the Pan American Health Organization," in: Riha J, Ravindran TKS, Atiim GA, Remme M, Khanna R. What works in gender and health in the United Nations: Lessons learned from cases of successful gender mainstreaming across five United Nations agencies. Kuala Lumpur: United Nations University; 2021. Available from: https://unu.edu/iigh/collection/what-works-gender-and-health-united-nations-case-study-series.

2.2.3 What were the main challenges, gaps, obstacles, and consequences influencing the integration of gender equality into PAHO's technical cooperation in health? In particular, to what extent have external factors (e.g., political positions or public policies that are not supportive of promoting gender equality) limited the integration of gender equality into PAHO's technical cooperation in health?

Finding 12. PAHO has encountered both organizational difficulties (Organization's culture, compartmentalized work, competition among crosscutting themes, lack of resources) and external challenges (lack of consensus on the concept of gender, variability in data collection, traditional gender roles and norms, and preeminence of the biomedical approach) that have limited the effective integration of gender equality into its technical cooperation.

The main internal factors hindering the effective integration of gender equality in PAHO's technical cooperation, as reported by numerous informants (and also described in internal documents), include (1) the presence of "traditional" attitudes in the Organization's culture; (2) the fragmented work between units or teams ("work in silos") involved in actions or projects related to gender equality in health; and (3) the competing priorities among both the crosscutting themes and the outcomes of the Strategic Plan; and (4) the lack of resources specifically allocated to integrate gender equality.[26] For example, PAHO has adopted, at different times, a gender policy and action plan, an ethnicity policy and action plan, and a human rights policy and action plan. **This fragmentation of interconnected topics for gender equality in health work is reflected in the internal functioning of the Organization (key topics related to gender equality in health – e.g., human rights, GBV – are placed in different departments or units), in the way how PAHO provides technical cooperation to ministries of health and interacts with health actors involved in gender equality.**

External difficulties identified include the lack of consensus on the concept of gender, the variability in data collection between countries, the persistence of traditional gender roles and norms, and the preeminence of the biomedical approach in the health sector. The gender approach is often used superficially or mistakenly since it works with a collection of concepts or categories that overlap but do not interact. There has been a tendency to construct a gender policy that focuses on specific subjects that would be representative of the concepts (e.g., intersectionality, interculturality) when they should be concepts that allow for integral and structural analyses of the living conditions of individuals and communities.

2.2.4 How effectively has PAHO's technical cooperation in health used data collection, monitoring, and evaluation systems to track progress, make informed decisions, and adjust strategies, aiming to improve gender equality in health?

Finding 13. PAHO has been a pioneering organization in promoting the analysis of health, gender, and inequalities in its platforms and publications and in conjunction with other organizations. PAHO has succeeded in providing a wide range of high-quality databases disaggregated by country, sex, and age, which have become regional

26 See budget analysis in the Efficiency section.

reference tools for health actors. However, gaps remain in data disaggregation, data sharing, and improved use of routine data at country level.

PAHO has developed an increasing number of studies, databases, and information platforms that have included variables relevant to analyzing gender inequalities in health. Regional databases and platforms have been regularly updated, expanded, and improved (e.g., Regional Health in the Americas, PAHO Gender and Public Health Series, Just Societies report; Equity in Health Policy Assessment; Unpaid Work in Health Care; Basic Indicators on Gender, Health, and Development in the Americas, Health Inequalities in Latin America and the Caribbean, among others). In 2009, PAHO adopted the Strategy for Vital and Health Statistics, which establishes guidelines for the disaggregation of information by sex and age for all information systems (revised in the 2017–2022 Strategy). In 2010, data disaggregation by sex and age was incorporated into the CCS. Subsequently, in 2012, a gender analysis in health was developed at the regional and country levels.

There is a consolidated framework document of essential indicators to monitor progress toward gender equality in health, aligned with the SDGs and the Sustainable Health Agenda for the Americas 2018–2030 (SHAA) *(13).* All these efforts have enabled PAHO to make available to countries, professionals, researchers, and actors in the health sector a historical series of homogeneous and quality data (and tools for their use) on health indicators in what has become the leading health information platform in the Region with a certain level of disaggregation (sex, age, subregion, and national level). The "core indicators" and some of the tools developed by PAHO are references for countries and professionals.

The development of platforms and data generation has made it possible to create analyses of health inequalities regionally, between subregions and countries, for a specific set of indicators, and, to a limited extent, within countries (subnational level). **Despite advances in data generation and analysis, there are still gaps in data disaggregation at the subnational level, and the integration of a nonbinary gender and intersectionality approach to better characterize gender inequalities in health in health information systems.** According to the evaluation survey, a quarter of respondents (28%, n = 13) considered that data disaggregation was not sufficiently promoted in national health information systems, and 50% (n = 23) acknowledged that it was promoted but noted that gaps still need to be addressed.

Finding 14. PAHO has supported Member States to produce disaggregated data, working closely with national statistical systems, ministries of justice, ECLAC, and other agencies to ensure that all countries report vital statistics disaggregated by sex (at least births and deaths). However, insufficient progress has been made in optimizing the data available from civil registries to produce additional relevant indicators of gender inequalities in health (e.g., fertility rates, adolescent pregnancy) and in linking them to national information systems.

There is a broad level of agreement on the role played by PAHO in conjunction with other organizations in vital statistics (Resolution on Civil Registration and Vital Statistics in 2002, PAHO Action Plan for Strengthening Vital Statistics 2017–2022). However, using other parameters of civil registries to go beyond disaggregation by sex or to develop models

and projections for specific population subgroups has been scarce. A similar limitation has existed in using epidemiological data or health information systems to deepen the analysis of health conditions. Sometimes, the challenge lies not in the absence of data but in its underutilization.

Recently, PAHO has participated in a project to analyze vital statistics in Brazil from the perspective of health determinants and the application of new technologies. It has also renewed its collaboration with specialized organizations (Vital Strategies *[14]*) to enhance data use for policy action (e.g., vital statistics and cancer registries, commercial determinants of health, injury prevention, and GBV). Moreover, the Region also has excellent capabilities in research and analysis on inequalities and health equity; the Region counts more than 180 PAHO/WHO Collaborating Centers, many of them linked to leading universities and research centers with vast scientific production on health inequalities and health equity (e.g., International Center for Equity in Health, Federal University of Pelotas, Brazil – a WHO Collaborating Center; Collaborative Group for Health Equity in the Region – the Tulane School of Public Health; Network of the Americas for Equity in Health, among others), with which PAHO collaborates mainly based on short-term projects or annual workplans. **Synergies between PAHO, national health systems, and these centers of expertise in the Region to optimize installed capacities for evidence generation (or better use of existing data) and analysis appear to be modestly developed.**

Finding 15. The recommendations from the progress reports and internal evaluation of the PAHO Gender Equality Policy and Plan of Action have been implemented unevenly. It is particularly noteworthy that PAHO did not consider the recommendation to renew the policy (recommended in the 2015 and 2020 reports, respectively).

PAHO has conducted progress reports (2012, 2020) and an internal evaluation (2015) of the Gender Equality Policy and its related plan of action. The monitoring (self-reported) of the Gender Equality Policy and its related plan of action shows progress in the disaggregation of data by sex and age, the development of national capacities, the integration of indicators and the gender perspective in national health systems, and elaborating analyses and publications. At the level of challenges, PAHO reports identified the discontinuity of advisory bodies in PAHO for policy implementation (e.g., the Gender Technical Advisory Group ceased to operate in 2013), limited resource mobilization, and moderate civil society participation in PAHO-supported gender equality initiatives and national health strategies and policies.

Overall, the PAHO Gender Equality Policy and its related plan of action defined a set of monitoring indicators aimed at measuring the implementation of activities or outputs but not at measuring changes in gender inequalities in health in the Region. These monitoring indicators have been of little use for quantitative measurement of the effectiveness of the PAHO Policy (similar to what has happened with the indicators of the Strategic Plans relevant to gender equality in health).

2.3 How efficiently has PAHO's technical cooperation in health integrated gender equality (Efficiency)?

2.3.1 How well have resources (financial, human, technical, etc.) been adjusted or allocated to integrate gender equality in PAHO's technical cooperation in health?

Finding 16. The PAHO Gender Equality Policy and Plan of Action were not given specific funding for their implementation, and the budget allocated to the crosscutting themes has been modest. In addition, the consideration of gender as a crosscutting theme (integrated into all PAHO outcomes and entities) has made it very difficult to quantify and make visible the resources and actions devoted to gender equality throughout the Organization.

Since 2014, the crosscutting themes have not been part of the prioritization exercise of PAHO Strategic Plan outcomes by Member States. The financing of the crosscutting themes has been done through flexible funds precisely to ensure that crosscutting themes are not affected by the prioritization of outcomes. Even so, with the information available, the evaluation has not been able to quantify the volume of funding (and resources in general) allocated by the Organization to work on gender and health. Additionally, the funding that PAHO has on occasion received for initiatives directly linked to gender and health has not been implemented under Outcome 26 (current Strategic Plan), but under other outcomes. In addition, it has not been possible to quantify (and make visible) the resources mobilized by other outcomes for actions that contribute to the reduction of gender inequalities. One of the limitations of gender mainstreaming in organizations and programs is precisely the difficulty in recording and making visible the extent to which such mainstreaming is being applied and in documenting the contributions or effects of the actions implemented on gender inequalities.

Finding 17. Human resources specifically allocated to gender equality work at both Headquarters and country offices have been chronically scarce and highly variable at the country level. This scarcity of human resources has resulted in differences in approaches and varying intensity of work among countries, work overload for gender focal points, and fluctuations in the technical support provided by gender focal points to PAHO personnel, national counterparts, stakeholders, and projects.

Changes in PAHO's organizational chart, with the creation of the new Department of Social and Environmental Determinants of Health in 2023 and the reorganization of the Equity and Gender Unit, have not been accompanied by additional resources, which has limited its capacity to support gender mainstreaming in all PAHO entities and to monitor and evaluate the impact of programs or initiatives aimed at reducing gender inequities in health. At the country level, PAHO's organizational capacity varies widely among country offices: while some country offices have designated focal points, others rely on the participation of external consultants, depending on the availability of funds linked to specific projects. Where they exist, gender focal points in country offices often have other responsibilities and so their time availability for advancing gender equality in the health agenda has been limited, generating inefficiencies. At the country level, the added value of gender focal points, where they exist, has been widely recognized by PAHO personnel and external stakeholders.

2.3.2 To what extent has the Organization supported the efficient use of corporate resources to advocate for gender equality in its Member States?

Finding 18. PAHO's advocacy efforts for gender equality in health with Member States have been channeled mainly through senior positions at Headquarters and country offices. However, the Organization has not provided specific resources (human or financial) to implement a comprehensive and sustained specific advocacy strategy on gender equality over time at regional, national, or subnational levels.

PAHO's advocacy actions seem to have become part of the roles and functions of the Executive Management, the PAHO EG Unit at Headquarters, and the country office representatives. In the case of the country offices, the gender focal points have also assumed some advocacy work at a technical level as an inherent component of their position vis-à-vis national actors. At the technical level, PAHO has developed a few tools for developing gender equality advocacy actions, such as the PAHO Gender and HIV/AIDS Advocacy Kit and the PAHO Gender Equity in Health Advocacy Kit (2002). However, the evaluation was not able to document the degree of use or the results of the only two gender-related advocacy tools developed by PAHO during the period covered by the evaluation. In addition, the budgetary structure of PAHO's Strategic Plans, based on budgeting by Outcome (Base Programs) and by Special Programs, has not allowed the measurement of how much funding was specifically allocated to advocacy actions, even though advocacy for gender equality in health is embedded in the work of all PAHO entities and outcomes.

Finding 19. PAHO's expertise and participation in joint initiatives (e.g., Spotlight) have legitimized the Organization's advocacy actions for gender equality before national counterparts and health stakeholders at the country and regional levels.

These advocacy actions have contributed, in some countries, to the creation of new departments dedicated to addressing gender gaps in health ministries, the adoption of new laws, the inclusion of indigenous and Afro-descendant communities in public health policies or programs, and the promotion of multisectoral approaches.

PAHO's support has contributed to the creation of gender departments or units in several ministries of health (e.g., Argentina, Bolivia [Plurinational State of], Chile, Cuba, Dominican Republic, El Salvador, Haiti, Jamaica, Uruguay, Venezuela [Bolivarian Republic of]), gender observatories (e.g., Chile) or the creation of intersectoral mechanisms (e.g., interministerial group between the Ministry of Health, the Ministry of Human Rights, and the Ministry of Women's Affairs in Brazil, and coordination between health, education, social services, and justice for cases of GBV in other countries).

PAHO's advocacy has contributed to adopting progressive legislation recognizing women's right to attain the highest health standards in line with international standards. For example, the Spotlight Initiative promoted changes to address GBV in the Caribbean. In Cuba, the Public Health Law and the Family Code include universal access to reproductive health, the legalization of voluntary interruption of pregnancy, and extend assisted reproduction services beyond heterosexual couples. Public policy advocacy has enabled gender-sensitive health initiatives to reach indigenous and Afro-descendant communities in certain countries through intersectoral collaboration and the SDH approach. In Brazil, Colombia, and Panama (among other countries), PAHO focused on Afro-descendant women, addressing ethnic and gender discrimination.

2.3.3 To what extent was PAHO's integration of gender equality in technical cooperation in health carried out in a timely and adaptive manner?

Finding 20. Adapting PAHO's technical cooperation (including advocacy) to a wide range of national contexts has been decisive in finding different but coherent entry points to continue working with Member States at the technical level to reduce gender inequalities in health.

On the one hand, the need to find a balanced and technically neutral position has allowed PAHO to work continuously on critical issues of gender equality in health. On the other hand, it has made it difficult for the Organization to position itself and speak out on sensitive issues in countries with conservative movements, where traditional gender views and norms have prevailed, and there has been opposition to addressing topics such as sexual and reproductive rights or GBV. In some countries, the prevalence of conservative and traditional social norms and values has been combined with a lack of awareness of gender equality among health professionals, which has complicated the implementation of actions that include a gender perspective in healthcare services (e.g., voluntary interruption of pregnancy, LGBTI group access to HIV/AIDS treatment). In the face of these unfavorable scenarios, "nationally tailored" advocacy has been key to overcoming political resistance in contexts where gender issues have faced opposition. In such cases, adaptive advocacy efforts and the use of the SDG framework have been instrumental in finding common ground with governments while maintaining PAHO's mandate to promote gender equality.

Finding 21. There has been a positive evolution in the integration of gender in emergency response, reflected in the development of tools and greater disaggregation of indicators, which allowed for differentiated analysis during the COVID-19 pandemic. However, further integration of gender equality in PAHO's technical cooperation during public health emergencies has been constrained by the limited integration of a gender lens in national emergency preparedness and response plans and the challenges of collecting disaggregated data in times of crisis.

The response to Hurricane Mitch (1998) has been identified as a key milestone for PAHO's integration of gender in health during national emergency responses. Since then, PAHO has progressively integrated the gender approach into some of its critical emergency response mechanisms and tools, such as the Incident Management System, the disaggregation of data during epidemic outbreaks or disasters, and training on gender and disasters for emergency advisers and health professionals. Publications such as Key considerations for integrating gender equality into health emergency and disaster response further support these efforts. However, there are gaps in key PAHO emergency response tools, such as the Damage Assessment and Health Needs Analysis in Disaster Situations (EDAN) which does not include a gender lens, the need for disaggregation by gender (and other key variables), or disaggregated analysis. In general, the national emergency preparedness and response plans and mechanisms, and the implementation of the International Health Regulations *(15)* in the Member States have not consistently mainstreamed gender.

2.3.4 To what extent have collaborations and interagency cooperation and coordination contributed to greater efficiency in integrating gender equality across the different functions of PAHO's technical cooperation in health?

Finding 22. The Women, Health, and Development Program *(16)*,[27] implemented until the early 2000s, has been recognized as a milestone in promoting the gender equality agenda in health in the Region thanks to the mobilization of a broad spectrum of agencies, regional and international organizations, and the leadership of a group of professionals that transformed the strategies for gender and health work in the Region.

The collaboration and coordination between agencies (such as PAHO, UNFPA, UN Women, UNDP), regional organizations (ECLAC), international financial institutions (World Bank), academia (Latin American Faculty of Social Sciences [FLACSO], Colegio de México, Universidad de Alicante), civil society (Mexican Foundation for Health [FUNSALUD]), philanthropy (Rockefeller Foundation), and donors (Scandinavian governments) have resulted in the production and exchange of knowledge in gender equality and health. This has facilitated the dissemination of information products on gender, health, and development issues, the design of intersectoral training instruments, and regional progress in initiatives on the valuation of women's unpaid work. The strategy of developing participatory processes involving diverse stakeholders was one of the most valuable features of the Program; in these processes, PAHO's technical and institutional leadership improved interagency capacity on gender issues and increased the Organization's visibility.

Finding 23. PAHO's leadership and participation in United Nations country team working groups, interagency collaborations, and collaborations with regional organizations have given greater visibility to key gender equality in health issues in the Member States, reinforced the legitimacy of PAHO's and the United Nations system's political-institutional advocacy, and generated a leverage effect to strengthen regional and national capacities.

In particular, the Inter-American Working Group on Women's Leadership with UN Women and the Organization of American States has been a space for alliances with multilateral organizations where PAHO has focused on women's participation in health, gender inequalities within the health professions, and the promotion of women leadership in decision-making positions in health systems. Other examples of interagency coordination and collaboration include the Spotlight Initiative (with UNFPA) and the Every Woman Every Child – Latin America and the Caribbean (EWEC-LAC) initiative. Collaborative efforts have made it possible to analyze health disparities through regional studies, such as the Health profile of women and men in the Americas *(17)*, and national and subregional statistical summaries from the Andean Council of High-Level Authorities for Women and Equal Opportunities (CAAAMI) and the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA).

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27 The goal of the PAHO Program on Women, Health, and Development (HDW) (1992–2002) was to reduce those health inequalities between men and women that are unnecessary, avoidable, and unfair. The central mandate of HDW was to mainstream gender within the programs and policies of PAHO, PAHO/WHO country representations, and Member States, in order to reduce gender inequities in health within the context of PAHO principles of equity and Pan Americanism.

Based on PAHO data, the UN Regional Collaboration Platform showed substantial progress in the multisectoral response to GBV in the Region, with 80% of Member States having included violence against women in their health plans or policies and 60% having standard operating procedures, protocols, or national guidelines *(1)*. Other relevant interagency collaborations, that have been acknowledged and documented by internal and external informants, include those between UNAIDS and PAHO on HIV, with UNFPA on reproductive health services, and with the International Organization for Migration and UNHCR in support of migrants and refugees (among others). United Nations agencies and UNCTs have also appreciated PAHO's contributions to interagency gender committees and joint interagency monitoring of progress toward SDG 5 within UNCTs.

In Cuba, for example, PAHO dedicated resources to support the work of the interagency gender group, collaborating with parliament to promote innovative gender-sensitive policies and laws. In contexts of crisis and high vulnerability – such as the COVID-19 pandemic, violence in Colombia, and issues related to migration and displacement – interagency cooperation in the framework of UNCT clusters has contributed to addressing structural gender problems at the grassroots level. This has been focused on challenges like adolescent pregnancy, GBV, and the differential impact of epidemics and pandemics.

Finding 24. The functioning and synergies in interagency cooperation have been affected by coordination difficulties, misalignment of objectives on gender equality and health between agencies, competition, different priorities and resources, and some overlap between mandates.

While PAHO may adopt a gender equality mainstreaming approach in all health programs, other agencies may prioritize other public health issues, sometimes overshadowing gender-specific actions. Overlap between mandates has been identified mainly in areas such as GBV and adolescent sexual and reproductive health. The overlap has sometimes resulted in fragmented efforts despite the United Nations mandate to work together ("Delivering as One"). This fragmentation has made it difficult to develop in some contexts a common strategy to address the challenges of gender inequality, which may have led to inefficiencies and missed opportunities. In addition, coordinating the efforts of multiple organizations has proved complex when multiple health interventions coexist, and each organization has its own goals, timelines, and ways of working.

Finding 25. The collaboration between PAHO and WHO has contributed to amplifying the work on gender equality in health at the national, regional, and global levels, thanks to the exchange of tools and experiences between the two levels and between subregions. At the PAHO level, the work and positioning on gender equality in the Region have been a reference for WHO to transfer innovative experiences to other regions. However, some gaps in the complementarity between the two organizations have hindered the incorporation of a more cohesive gender perspective between the central and regional levels and in global health initiatives.

The joint work between PAHO and WHO has been synergistic on issues of global scope (e.g., Health Equity Assessment Toolkit, Global Knowledge Network for Health Equity). PAHO's promotion of gender equality in health places the Region ahead of many other WHO regions. This advancement is primarily due to the mandate received from the

Region's Member States, specific regional resolutions, and the Organization's technical capacities. **Despite some conservative national and institutional contexts in the Region of the Americas, PAHO has promoted advances that have not occurred globally or in other regions.** For example, PAHO's work with LGBTI people has not been developed in other regions, and the Organization, in collaboration with Member States, has made the Region a pioneer in the definition of gender and health indicators.

However, national stakeholders were unaware of or did not clearly understand the mechanisms for communication and coordination between PAHO as the WHO Regional Office for the Americas and WHO Headquarters in some moments and interventions related to gender equality. Several informants noted that communication between the two levels can vary depending on the type of project or activity. Gaps in complementarity and synergies between the PAHO/WHO Regional Office for the Americas and WHO Headquarters in Geneva have also been reported in other recent PAHO evaluations.

Finding 26. Civil society organizations (CSOs) have played a relevant role in the deployment of PAHO's Gender Equality Policy and its related plan of action in culturally adapted health interventions[28] at the country level and in institutionalizing the gender approach within the Organization. However, collaboration between PAHO and CSOs, both programmatically and institutionally, has progressively diminished despite successful cases or projects at the national or subnational level.

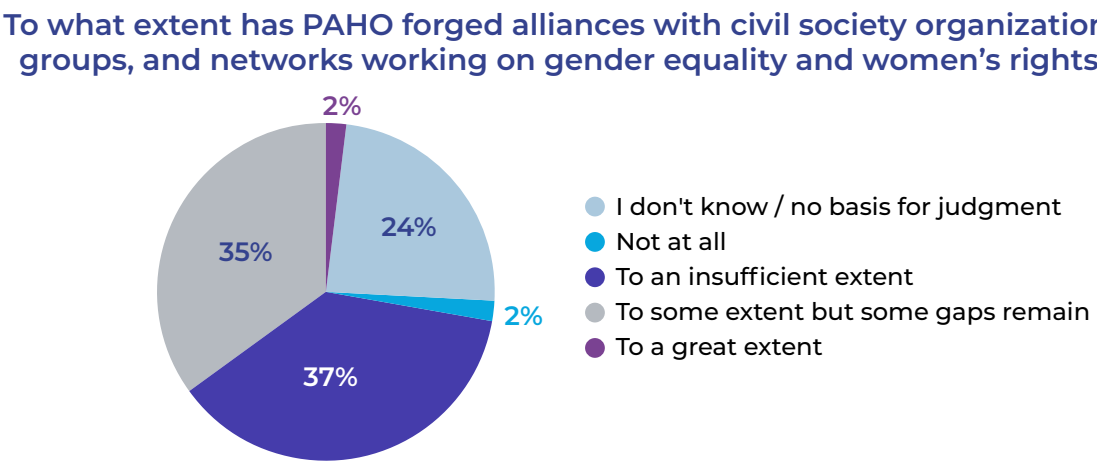
Collaboration with CSOs has strengthened PAHO's technical cooperation efficiency by leveraging local knowledge, facilitating access to communities, and providing advocacy expertise. These collaborations help integrate gender equality into the core of health interventions, particularly among communities exposed to factors of exclusion and vulnerability. In these contexts, PAHO has contributed to equipping health workers and community leaders with the skills to recognize and address gender disparities in access to health care in rural and underserved areas where traditional health systems have not adequately addressed the specific needs of women. In rural areas and indigenous communities, collaboration with CSOs has helped to implement culturally appropriate, inclusive, and community-driven gender-sensitive health programs (e.g., traditional midwifery, support networks for GBV survivors, unpaid domestic work, and migrant women) and strengthened leadership.

However, civil society participation in national health plans or advisory groups has been limited, and mechanisms to ensure their involvement in public health policies and budgets have yet to be consolidated in most countries of the Region. The results of the survey corroborate that partnerships with civil society are perceived as one of the weakest areas of action (Figure 8); 37% of those consulted stated that the Organization has not sufficiently promoted partnerships with CSOs, groups, and networks working on gender equality and women's rights.

28 Cultural adaptation is systematically modifying an evidence-based treatment or intervention protocol to consider the patient's language, culture, and context. PAHO Policy on Ethnicity and Health recognizes the differences that exist between different ethnic groups, both between countries and within them, as well as the need for an intercultural approach to health from the standpoint of equality and mutual respect, thereby contributing to better health outcomes and progress toward universal health.

Gender equality issues in health have not been prominent in the alliances and partnerships between PAHO and organizations, networks, and groups of the feminist movement, Afro-descendant population, and indigenous peoples in the Region. Nevertheless, there have been various initiatives with civil society networks on priority public health issues of the countries or subregions where gender has been considered within the SDH framework. In the Caribbean, for example, the alliances with civil society, such as the Healthy Caribbean Coalition, have focused on preventing noncommunicable diseases, especially promoting healthy eating and preventing childhood obesity. This initiative began in 2008 and involved over 65 CSOs, other regional agencies such as the Caribbean Community (CARICOM), and United Nations agencies.

Figure 8: PAHO alliances with civil society organizations, groups, and networks working on gender equality and women's rights



Source: PAHO personnel survey.

Finding 27. Stable relationships between PAHO and key donors on gender and equality have played a crucial role in PAHO's ability to advocate for and implement actions in favor of gender equality in health systems. However, the Organization's agenda and capacity in this area have been overly dependent on a small number of donors, which has sometimes posed challenges in terms of long-term continuity of action and alignment of approaches to gender work.

Funds received mainly from Scandinavian countries, Canada, the United States of America, and Spain have been instrumental in the deployment of PAHO's gender equality agenda. However, they have generated challenges in terms of sustainability and diverging priorities and approaches. Work on gender equality in health has often been associated with projects (and funding) of short duration, which has been a limitation in achieving significant transformations in gender inequalities in health and consolidating conditions and capacities for ensuring local ownership. For example, Canada has been recognized as a leading Member State in advancing gender equality, sexual and reproductive health rights, intersectional, gender diversity, and feminist approaches. Spain has supported gender and health work with an intercultural approach in Central America. **On some occasions, however, the visions and positions of donors, Member States, and PAHO have not been fully aligned.**

On sensitive issues (e.g., abortion rights), PAHO has been able to adopt and negotiate positions based on evidence and public health to maintain institutional and technical balance in the face of donors and Member States with different priorities and sensitivities. Multiyear, sustained funding has fostered internal changes within the Organization (e.g., the introduction of tools and ways of working), and has been instrumental in implementing interventions in selected countries to reduce barriers to access, or inclusive health services in contexts that require medium- and long-term strategies.

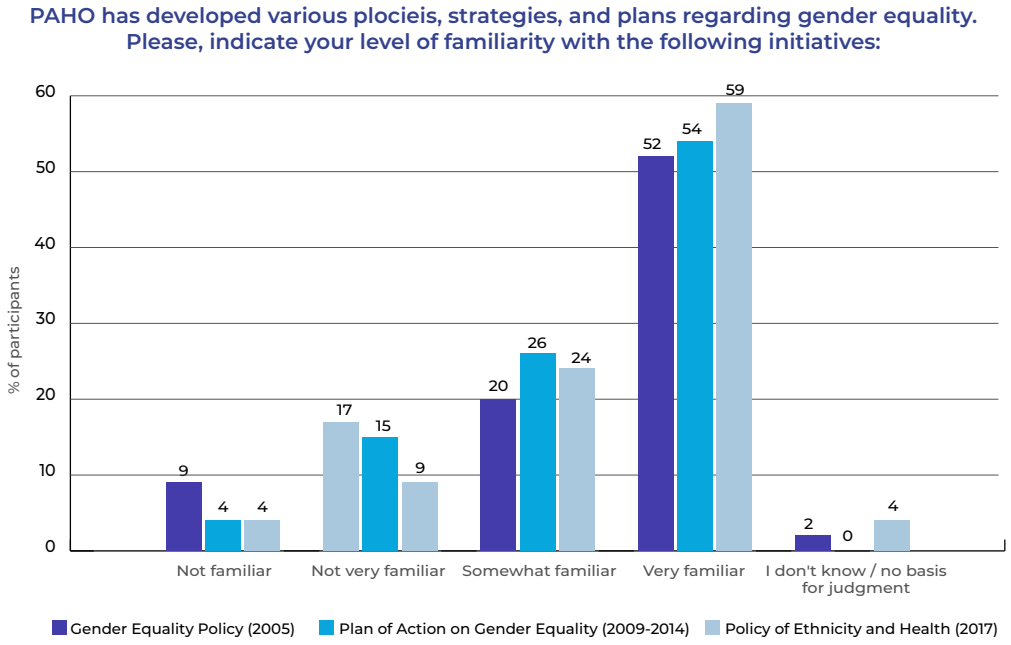
2.4 What conditions have been put in place by PAHO to ensure that gender equality considerations in its technical cooperation in health are sustained over time? (Sustainability)

2.4.1 What strategies or mechanisms have been put in place by PAHO to ensure institutionalization and the long-lasting effects of technical cooperation in health in addressing gender equality?

Finding 28. The Gender Equality Policy (2005) and its related plan of action (2009–2014) encountered dissemination challenges, as they have not been sufficiently known or embraced by PAHO teams and Member States, which has limited their institutionalization. The policy's institutionalization has been partially achieved by incorporating it as a crosscutting approach in PAHO planning documents (e.g., CCS, Strategic Plans, Program Budget), establishing alliances with other agencies through country cooperation frameworks, and participating in United Nations interagency gender mechanisms within the United Nations country teams (UNCTs).

The strategies and mechanisms implemented have encompassed a wide range of actions aimed at promoting gender equality and the inclusion of diverse identities, such as gender gender equality, ethnicity, and LGBTI policies. Among these efforts, the adoption of a Gender Equality Policy (2005) and its related plan of action (2009–2014), and the creation of specific organizational areas with different levels of functional and hierarchical dependence allowed the integration of gender equality at varying levels of strategic planning, although with variations between strategic plans over time. Nevertheless, as stated in the focus group discussions, the effective implementation of these policies required a wide process of dissemination, learning, and capacity-building across all areas and levels of the Organization, Member States, and among key partners.

Figure 9: Awareness of PAHO's gender equality-related policies by PAHO personnel



Source: PAHO personnel survey.

Figure 9 shows that personnel surveyed were generally more familiar with the Policy of Ethnicity and Health than the policy and planning instruments designed explicitly for gender equality, primarily because these involved processes with diverse characteristics and contexts. Additionally, within the focus groups conducted, it was noted that the process involved in designing this policy and the convening of experts and former PAHO technical referents have contributed to a more solid dissemination.

The integration of gender equality within the Organization is reflected in various tools and resources made available to country offices. However, these resources have not been uniformly adopted throughout the programming cycle. Interviews indicate the widespread use of tools that facilitate gender analysis in designing programs and proposals for donors. Although this documentation is not formally systematic, interviewees demonstrated familiarity with and utilization of these tools.

The Gender Equality Policy was applicable in positioning this issue throughout the Organization, with clear examples and guidelines that helped understand gender equality and integrate it into PAHO's technical cooperation. On the other hand, the Science and Knowledge for Impact Unit has established a platform to collect lessons learned across eight key attributes, one of which focuses on crosscutting themes: equity, gender, cultural diversity, and human rights. According to an interview with a key informant, this initiative was launched in 2023 and was still being fine-tuned at the time of the evaluation. The methodology and platform for good practices and lessons learned aim to document experiences based on evidence rather than just labeling something as "best practice." The focus is on analyzing how these practices contribute to sustainability, adaptability, and other critical attributes.

In addition, several factors affecting sustainability have been identified through interviews, focus groups, documentary review, and surveys. Resolution CD46.R16 (Ninth meeting, 30 September 2005), which urged the Member States to implement the Gender Equality Policy, in collaboration with relevant government sectors, the United Nations system, the inter-American system, and the civil society stakeholders, has been implemented partially and unevenly across countries, depending on local circumstances and political and institutional moments. One key issue is the outdated nature of the Gender Equality Policy, which was designed in a different regional context. Since its creation, numerous institutional and regulatory transformations have taken place in various countries that need to be considered, along with the lessons learned during this period. Moreover, challenges persist in reaching a consensus on the scope and operational application of the gender equality concept within the Organization. There is also confusion between the concepts and scope of gender equality and gender equity, and a lack of specific monitoring mechanisms for these policies has been noted.

The current Gender Equality Policy lacks clear and shared definitions and specific actions addressing the needs of LGBTI groups, particularly transgender and queer individuals. In certain national contexts, such as the Plurinational State of Bolivia, the approach to gender equality has evolved beyond the original scope of the Policy: the country has introduced the concept of "depatriarchalizing," which includes a broader gender perspective and identifies dimensions of oppression affecting women, men, and sexual diversities.

Persistent traditional social and gender norms continue to pose significant challenges in implementing gender equality policies at the country level, especially in sexual and reproductive health and comprehensive sexual education programs in school settings. This resistance often stems from entrenched societal views about gender roles, which can make it difficult to gain widespread support for such initiatives.

Finding 29. The outdatedness and lack of monitoring and evaluation mechanisms of the two central instruments for integrating gender equality in health (the Gender Equality Policy [2005] and its related plan of action [2009–2014]) have limited their sustainability.

Despite being adopted as a resolution, the plan of action did not provide a consistent monitoring framework to measure progress on gender equality. While the Strategic Plan recognizes gender as a priority, this focus has not been sufficiently integrated into the Organization's structure.

The plan of action faced significant limitations in its implementation. One major factor is its outdated nature, having been conceived in a different context as a resolution without adequate strategies for implementation or sustained monitoring and evaluation mechanisms. Additionally, the lack of training and awareness-raising among technical personnel hindered the sustainability prospects of these initiatives.

Finding 30. PAHO has enhanced the capacities of country offices through training on gender equality in health so that its personnel can implement the policy and plans, but gaps still need to be filled in terms of scope, emerging topics, and dissemination.

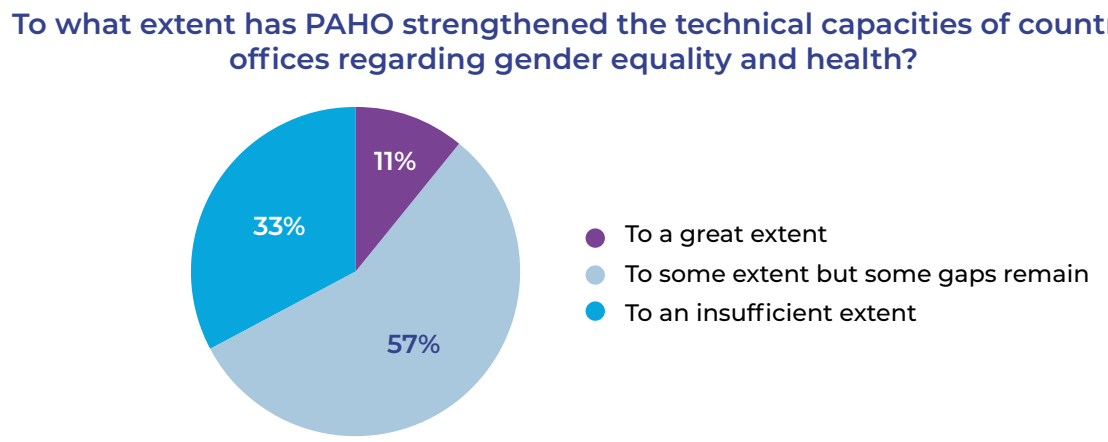
PAHO has promoted capacity-building for country offices in gender equality in health through various mechanisms, including (1) the appointment of thematic focal points to deliver technical assistance and support to the country office, (2) the implementation of virtual courses, and (3) the contracting of ad hoc consultancies in some cases.

Firstly, PAHO has established gender, ethnicity, and equity focal points in the different country offices, accompanied by a manual and tools to facilitate the inclusion of gender equality in the identification and formulation of technical cooperation projects. In addition, online courses have been offered for capacity-building in gender equality and health, and specific publications have been produced to complement these initiatives.

Secondly, the analysis of the PAHO virtual course Gender and health: Awareness, analysis, and action indicated significant growth in participation from 2016 to 2024. Registrations surged from 13 187 by January 2020 to 39 875 by July 2024, largely due to increased visibility and online education during the COVID-19 pandemic. Correspondingly, the number of certificates awarded rose from 8371 to 24 904, highlighting high completion rates and positive engagement. The course has expanded its reach from 42 to 106 countries, with most participants from Mexico, Argentina, Colombia, and Ecuador. Female participants, particularly young women under 35, dominate enrollment, emphasizing the course's focus on gender equality.

Thirdly, in contexts where the country office did not have adequate technical capacities to provide technical accompaniment to the country, as in the case of Montevideo, Uruguay, joint alternatives were explored, involving hiring local gender and health consultants and experts. However, despite the initiatives mentioned above and efforts, in the survey, only 11% of respondents stated that the country offices have strengthened their capacities in gender equality and health. For the most part, 57% of the respondents said that institutional and individual technical capacities had been somewhat strengthened, while 33% noted that capacity-building was insufficient (Figure 10).

Figure 10: Perception of PAHO's strengthening of country offices' technical capacities on gender equality and health



Source: PAHO personnel survey.

The processes of strengthening the technical capacities of the country offices involve, in addition to technical support from Headquarters, the gender focal points in the country offices, or the focal points of other United Nations agencies, such as UN Women, that focus on gender mainstreaming in the United Nations system, the hiring of expert consultants, and access to specialized training. Here, the virtual platform has played an important role, although it constitutes one of the possible training strategies. In this sense, from the survey, 54% of respondents reported receiving training on gender equality[29] in the last 24 months. It is noteworthy that 46% of respondents reported not having participated in any training on gender equality and health in the past 24 months. Interviews with several country offices revealed that the Gender Equality Policy and its related plan of action are not integrated into the contracts or terms of reference for technical teams, nor is there a requirement for mandatory training as part of the hiring process. While there is a virtual platform offering a wide range of online courses on various aspects of gender equality in health, it is not part of a comprehensive training plan with monitoring indicators that would allow for effective tracking of progress.

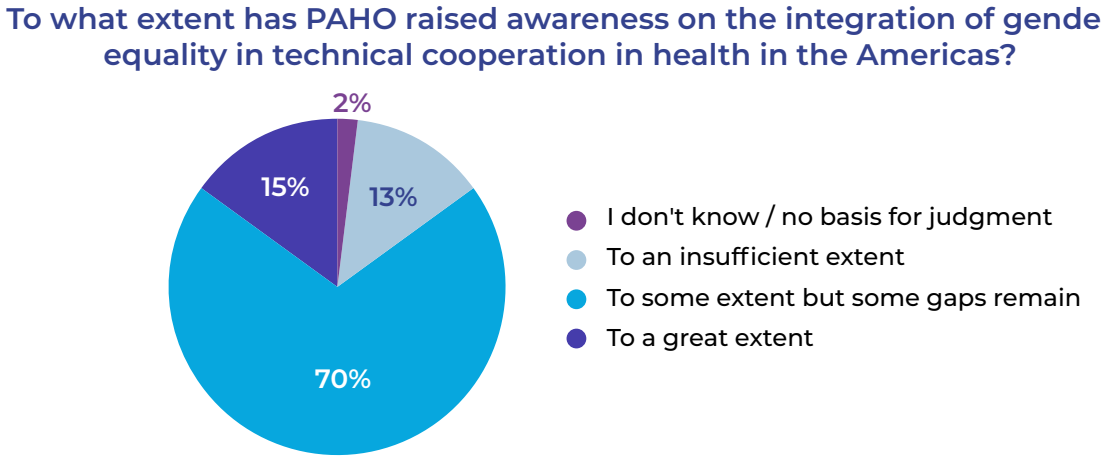
Finding 31. PAHO has made substantial progress in raising its personnel's awareness of the importance of integrating gender equality into technical cooperation across health programs and policies. However, there has been insufficient effort to engage with civil society actors, crucial for strengthening its advocacy role and ensuring sustained participation in long-term health strategies and programs.

Raising awareness and social mobilization is crucial for ensuring the sustainability of the results achieved in integrating gender equality into technical cooperation in health. Through various strategies, these efforts addressed the social and gender norms that impact the transformation of gender inequalities in public health. According to survey data (Figure 12), 70% of respondents indicated that PAHO has raised awareness to some extent about integrating gender equality into technical cooperation in health across its

29 Topics include: gender analysis in health, development of health policies with a gender perspective, integration of gender equality in program cycle management, basic understanding of gender equality in health, intersectionality in health, sexual and reproductive health and rights, gender-based violence and health, cultural competence and gender, community engagement and gender, among others.

offices in the Americas, although some gaps and obstacles remain. These gaps pertain to building consensus around the use and scope of the concept of gender equality in the design and implementation of programs in an integrated and systematic manner rather than on a voluntary or ad hoc basis. This is particularly important given the key role that Member States play in shaping national public policies and norms, with CCS serving as the road map for joint efforts with PAHO.

Figure 11: Perception of PAHO's efforts to raise awareness on the integration of gender equality in its technical cooperation in health



Source: PAHO personnel survey.

In general, networks and CSOs working on women's rights and the rights of Afro-descendant and indigenous peoples have played a less prioritized role within partnership frameworks throughout the programming cycle. CSOs and social movements not only offered complementary territorial and community-based perspectives that state structures may lack, but they also played a critical role in driving advocacy and social mobilization efforts aimed at long-term changes in the social norms and practices that perpetuate gender inequality. They also helped hold states accountable for monitoring and reporting to human rights mechanisms, the 2030 Agenda for Sustainable Development – beyond SDG 3 – and the recent Summit of the Future, which reaffirmed that the commitment to gender equality and the empowerment of all women and girls is an essential prerequisite for sustainable development.[30]

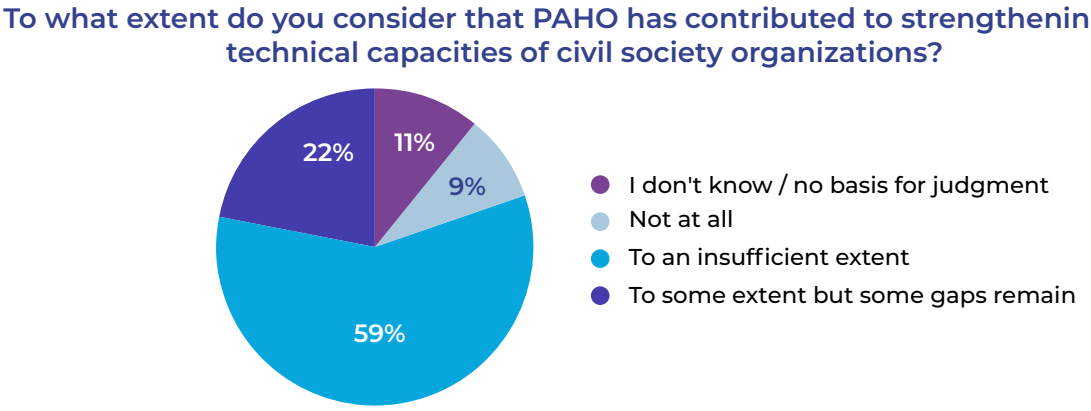
Alliances and partnerships with civil society networks, groups, and organizations have not consistently translated into processes that build their capacity for gender equality in health. While consultations with civil society have occurred during the development of CCS, they have not been prioritized. Most respondents to the survey (Figure 12) believe that PAHO has contributed insufficiently to strengthening the capacities of CSOs. In contrast, other United Nations agencies, such as UNFPA, have taken a more active role in strengthening organizational capacities and civil society networks for advocacy and

30 This is reflected in the Summit's guiding principles, commitments, and actions. In this regard, Action 8 calls for ensuring access to sexual and reproductive health and reproductive rights, and for accelerating the eradication of sexual and GBV. Additionally, Action 31 highlights the need to harness technological and innovation advancements to address violence against women and girls, while Action 42 calls for the revitalization of the Commission on the Status of Women.

social mobilization, particularly around women's sexual and reproductive rights and the prevention of maternal mortality.

PAHO's added value to CSOs has been most evident in the Spotlight Initiative to End Gender-Based Violence, a multi-stakeholder program supported by the European Union where CSOs have played a crucial role due to their close connections with the communities involved in the interventions, and their potential for advocating for normative and institutional changes. In this context, work at the subnational and grassroots levels has been emphasized as a key factor in achieving sustainable outcomes.

Figure 12: Perception of PAHO's contribution to strengthening the technical capacities of civil society organizations



Source: PAHO personnel survey.

Finding 32. During the period covered by the Gender Equality Policy, lessons were learned in different areas essential to ensure the sustainability of the integration of gender equality in PAHO's technical cooperation.

Various efforts have been made to document organizational learning processes in gender equality in health. On the one hand, there was an enormous amount of documentary production during the period analyzed, which PAHO Evaluation recorded in a Synthesis of Evidence considered in this evaluation process. On the other hand, the interviews with key informants and the survey implemented also point to lessons learned that should be considered as input in updating policies and plans so that this learning can strengthen the sustainability of achievements.

Achieving meaningful gender integration in technical cooperation in health requires a sustained commitment to continuous training, capacity-building, and resource allocation. The process must be adaptable, open to new approaches, and sensitive to cultural, social, and political challenges. Promoting gender equality involves addressing deep-seated power dynamics and societal norms, necessitating strong alliances and strategic approaches to cope with backlash.

Furthermore, generating disaggregated data and evidence is crucial for influencing public policy and fostering long-term social transformation. Interinstitutional collaboration, South–South cooperation, and partnerships with civil society are vital for embedding

gender equality as a crosscutting issue in technical cooperation. Despite progress in several countries, particularly in areas such as health care for personnel, prenatal care, and family planning, the full integration of gender equality remains a challenge. Success will depend on expanding multi-stakeholder partnerships and ensuring that gender equality is seen not as a narrow technical issue but as an integral part of all health initiatives, supported by robust internal policies that uphold gender equality as a core value.


SKYLINE

3. Conclusions

3.1 Strategic level

1. Gender concept and approach. PAHO has shifted its approach to recognizing the strategic importance of gender equality in its technical cooperation on health. PAHO now acknowledges a more inclusive range of social groups, beyond women, who are impacted by gender constructs.

The shift in PAHO's approach has been reflected in its institutional priorities, as gender equality in health has seen fluctuations within the Organization's design and strategic planning. This shift highlights the adaptation of gender conceptualization to emerging sociocultural contexts and the effort to address structural barriers beyond just ensuring equal access to health services. The conceptual evolution of gender in PAHO reflects a particular commitment to move away from political influences – considering that gender was originally a theoretical framework aimed at generating social transformations toward an egalitarian society. This evolution favors a working perspective based on the recognition of subjects and identities rather than a perspective that seeks to generate structural changes and modify hierarchical social relations. From a conceptual perspective, one of PAHO's main challenges in effectively integrating gender into technical cooperation is to go beyond the biomedical dimension of health conditions and develop analyses that integrate the social and cultural dimensions. Gender equality is based on applying a multidimensional and complex approach, and its transformative potential depends on it.

2. Positioning and women's leadership in gender and health. PAHO has succeeded in being an agency of technical leadership in gender equality in health and has promoted the inclusion of women in decision-making in regional public health and global health forums. However, its positioning and advocacy capacity in gender equality in health have gradually declined in recent years due to internal and external factors, in an area where there is a wide diversity of regional actors and where several United Nations agencies and organizations have intensified their work and visibility.

PAHO has had a group of specialists who led and promoted the work on gender equality, and health since the 1990s, and the first female Director of a WHO regional office (2003). During the pandemic, the PAHO Director emphasized the need to address gender equality and the adoption of a differential and gender approach in the context of an unprecedented health crisis (2020–2022). The COVID-19 pandemic placed public health as a priority on the political agenda and highlighted the need to strengthen the integration of gender equality in technical cooperation. Over time, and even more so during the pandemic, PAHO has been recognized as a high-level technical reference and an organization addressing gender inequalities in health with a public health and evidence-

based approach. These factors have generated trust and credibility with Member States and actors in the health sector. However, the visibility of PAHO's work on gender equality has diminished because of varying intensities and resources dedicated specifically to gender equality in health over the years, the obsolescence of the PAHO Gender Equality Policy, personnel turnover (internally and in national counterparts), resource shortfalls, and other contextual factors.

3. Alliances and collaborations. The alliances established with other agencies and regional organizations have been pivotal in achieving key milestones related to gender and health in the Region. These partnerships have also played a significant role in highlighting gender inequalities within the health sector and integrating them into PAHO's agenda. However, the fluctuations in some partnerships have impacted PAHO's ability to expand its technical cooperation, sustain internal accountability, and fully leverage existing regional capacities, such as collaborating centers, universities, and networks.

The collaboration and structured work between agencies and regional organizations (particularly ECLAC, UNFPA, UN Women, UNAIDS, Inter-American Development Bank, as well as other networks and organizations) have generated synergies that have amplified the scope of advocacy, technical cooperation, and analysis with Member States and other health stakeholders. Regional integration mechanisms, such as COMISCA's Commission on Gender and Health, have also been significant. To a lesser extent, PAHO has established alliances with organizations, networks, and civil society groups of the feminist movement, Afro-descendants, and indigenous peoples at the regional level. However, some alliances that have worked well have experienced fluctuations or have ended. The presence of CSOs in PAHO's network of partnerships and actions (one of the four strategic areas of the PAHO Gender Equality Policy) has diluted over time. Furthermore, the discontinuity in the participation of CSOs in the corporate mechanisms for guiding and monitoring the implementation of the PAHO Gender Equality Policy weakened accountability, both internally and externally. PAHO has developed relevant collaborations with universities, research centers, and collaborating centers; however, the capitalization of the experience of some of these actors, who are world referents in gender equality and equity in health, has been limited.

4. PAHO strategic planning. Since 2014, gender has been considered a crosscutting theme in PAHO's strategic planning. However, differences in the formulation of indicators in the three Strategic Plans to date and the indicators of the Strategic Plan monitoring framework have made it difficult to determine the contribution of each outcome to reducing gender inequalities, to analyze results and trends over time, and to obtain an overview of changes in gender inequalities in health.

The formulation of the key indicators of gender equality in health in the current Strategic Plan (Outcome 26 Crosscutting themes) has changed compared to previous Strategic Plans. The same occurs with other indicators of relevance to gender equality in health (e.g., Outcomes 18 and 19). The discontinuity of indicators between Strategic Plans has made it impossible to reconstruct their evolution over time. In turn, the Sustainable Health Agenda for the Americas 2018–2030 does not present progress reports, so it was not possible to track the evolution of key indicators over time. The Strategic Plans have not

included precise monitoring and accountability mechanisms that would make it possible to assess the contributions of Outputs and Outcomes to gender equality. The Strategic Plan 2020–2025 incorporates for the first time an analysis of selected parameters of health inequality in the Region which, although limited to a selection of tracer indicators, is an excellent basis for future strategic planning and analysis of gender inequalities.

3.2 Operational level

5. Balance between gender-focused and broader approaches. The integration of the gender approach into PAHO's technical cooperation efforts has oscillated between a specific understanding focused on gender, and another whereby it is integrated into broader frameworks, such as the social determinants of health, equity, and human rights. This has generated conceptual and programmatic "tensions" over time that have made it difficult to find an adequate balance between further developing technical cooperation in support of the social determinants of health approach, while at the same time promoting focused and transformative interventions with the potential to reduce gender inequalities in health.

PAHO has increasingly structured its technical cooperation on gender equality in health around the framework of the social determinants of health, but there has been a debate (or "conceptual tension") within the Organization that originated in epistemological definitions and that has had consequences for the integration of gender equality in PAHO's technical cooperation. This debate has led, on the one hand, to strategies or actions that have been perceived as "reductionist" because they do not incorporate broader frameworks. On the other hand, it has also led to actions that have diluted the importance of specific gender analysis and approaches. PAHO has integrated the concepts of equity and equality in health, intersectionality, and intersectoral work into its technical cooperation. However, its implementation has been confronted with the complexity of long-term intersectoral interventions, the low priority given by Member States to the social determinants of health, and a difficult balance between cultivating spaces for institutional and technical dialogue with Member States and influencing the protection and enforcement of rights. In addition, the evaluation identified that in the organizational structure, gender competes with other crosscutting themes, and it has become difficult to find adequate internal complementarity. In terms of personnel, the greater presence of medical profiles (and of the health sector in general) has led to the prevalence of a biomedical vision of gender and health within the Organization.

6. Adaptative capacity. PAHO has continued to integrate gender equality into health in its technical cooperation efforts despite changing political, social, and economic contexts, as well as national sociocultural contexts. At the country level, PAHO has provided technical cooperation not only to Member States committed to gender equality, but also to other Member States that no longer prioritize the gender agenda and in which addressing rights and critical gender issues that impact public health has faced setbacks.

Adapting PAHO's technical cooperation to diverse national and subnational contexts has allowed the Member States to achieve positive cultural appropriateness and acceptability

of health interventions. PAHO's efforts have brought significant value to communities and partners in contexts where it has implemented interventions at the subnational level, adapting to concrete local realities and working with front-line actors. From an institutional point of view, PAHO's legitimacy (mandate) and credibility (expertise) have allowed it to navigate a wide range of national situations, from countries that are global leaders in the gender equality agenda to countries that have dismantled public gender policies. The evaluation has captured growing and broad concerns about the emergence of conservative movements that challenge the advances in essential public health and rights issues that pose a risk to some of the achievements made in the last two decades (e.g., increasing reluctance to questions regarding family planning, sexual and reproductive health, or comprehensive sexual education in schools has been identified in some countries).

7. PAHO's contribution to gender equality in health outcomes. PAHO has made significant programmatic contributions to advancing progress on critical issues (GBV, sexual and reproductive health, and access to health care for vulnerable populations). PAHO's generation and analysis of data and tools have been recognized as part of the Organization's added value, and they have been instrumental in supporting Member States' analysis of gender inequalities in health. However, challenges persist at the country level regarding the fragmentation of information on gender and intersectionality, the need for greater data disaggregation, the optimization of existing civil and health information systems, and the use of data for informed decision-making in health.

PAHO's technical cooperation has contributed to developing more inclusive national legislation and health policies in some countries, strengthening healthcare access and intercultural care in underserved areas, and addressing critical gender health gaps. Innovative interventions include developing regional gender and health indicators, supporting maternal homes and midwifery practices, vaccinating adolescents against human papillomavirus to prevent cancer, integrating pregnant women in vaccine production and clinical trials, and increasing people's understanding of violence in the reproductive process. The generation of evidence has contributed to national strategies and interventions to reduce gender inequalities in health, as reflected in many regional and national studies and publications. Likewise, there has been consensus on the importance and potential of the PAHO Core Indicators Portal (among other tools developed by PAHO) and the work with civil registries. More recently, PAHO has contributed to filling critical gaps in the health inequalities of specific profiles and communities (e.g., statistical information on the Afro-descendant population). However, national health information systems still need to expand disaggregation (e.g., ethnicity, subnational data), data sharing, and interoperability.

8. PAHO Gender Equality Policy and Plan of Action. Despite limited dissemination, implementing the Gender Equality Policy and its related plan of action has promoted the integration of gender considerations into national health systems and policies. This has contributed to progress in PAHO's four strategic areas (evidence, capacity-building, civil society participation, and institutionalization and monitoring) in Member States. However, the implementation of this policy and plan has been uneven and fragmented.

The implementation of the policy and its related plan of action at the country level shows the most notable progress in the disaggregation of data by sex and age in the countries, the production of national profiles and studies on gender and health, the development of tools for gender and health analysis, and training of health professionals to address gender and health issues in specific population groups (indigenous women, Afro-descendants, LGBTI). Partial progress has been made in creating and consolidating national gender and health observatories and quantifying unpaid health care in national accounts. However, the indicators of the plan of action showed a lack of progress in the development of national gender and health policies or strategies (including their reporting), difficulties in mobilizing national resources specifically for gender and health, and a lack of stable mechanisms for integrating gender equality into public planning and budgeting, and civil society participation. From a monitoring perspective, the indicators of the plan of action were regularly reported. Still, they focused more on outputs (or "processes") than on outcomes (changes in gender inequalities in health).

The guidelines defined in the Gender Equality Policy have not been systematically translated into all phases of the programming cycle (projects) and CCS. In addition, fragmentation in the collection and dissemination of data on gender and other intersectional dimensions has limited PAHO's ability to consistently monitor and evaluate progress on projects and the Policy. PAHO has worked on designing and adapting tools to practically incorporate gender equality in fundraising (e.g., a checklist for project design to present to donors). This practice is limited to only one phase of the programming cycle and does not extend systematically to the implementation and evaluation phases. On the other hand, although PAHO has a virtual platform with a range of training programs on gender equality and health, the surveys and interviews show the difficulties these technical and individual capacity-building processes have in reaching the entire Organization.

3.3 Organizational level

9. Organizational chart. Since 2023, the Equity, Gender, Human Rights, and Cultural Diversity Unit in the DHE has strengthened its role in providing crosscutting technical support to PAHO entities. The new configurations of the unit and the department strengthen the operationalization of intersectoral approaches. However, compartmentalized work and limited resources may limit the unit's ability to promote gender equality in health within the Organization and to strengthen PAHO's positioning and advocacy efforts.

The creation of the DHE in 2023 responded to the need to reinforce technical support on gender and health for PAHO personnel and entities, which was identified as one of the main demands of PAHO personnel gathered during the evaluation. Given the crosscutting nature of gender equality in health (meaning technical support to all PAHO entities, including the country offices and PAHO Senior Management in its regional advocacy work), the breadth of needs observed has not been accompanied by significant changes in the allocation of resources to the PAHO EG Unit. The change in the position of the PAHO EG Unit in the organizational chart has generated different views within

the Organization. On the one hand, some PAHO personnel recognize the importance of having a technical and specialized unit to support the practical implementation of tools and work approaches in all PAHO entities. On the other hand, there are PAHO personnel who believe that moving the gender issue from the senior management level to a technical level implies less organizational capacity to promote the gender agenda (both internally and externally). In addition, some areas connected to the work on gender equality in health (e.g., GBV) continue to depend functionally and hierarchically on other units, making it challenging to have a comprehensive and integrated view of the Organization's work on gender equality in health.

10. Specialized human resources. PAHO has specialized human resources dedicated to gender and equality at the regional and national levels. These personnel have contributed to gaining recognition for the technical quality of PAHO's technical cooperation efforts. Still, they have been overwhelmed by the breadth and intensity of multiple requests or conditioned by the uncertainty of short-term funding.

Some country offices have focal points to address gender, equity, and ethnicity issues. However, the focal points do not have terms of reference or percentages of specific dedication to gender programming and often have other responsibilities beyond gender equality. The efforts of human resources specialized in gender to provide crosscutting support to other PAHO programs or entities have also been hindered by the absence of a specific training program for all PAHO personnel or adequate tools available for gender equality work. The human resources approach has been one of specialization, constituting teams with specific training but not generalized gender training, which would be necessary to develop intersectoral and transdisciplinary strategies across PAHO entities.

11. Resource allocation. Resources allocated for implementing the Gender Equality Policy and its related plan of action and other interventions (within the frameworks of the Strategic Plans or specific projects) have been modest. In addition, PAHO's dependence on a few donors has at times determined the priority afforded to gender equality in the health agenda in PAHO's technical cooperation efforts and the promotion of specific gender and health issues.

PAHO's actions on gender and health have been linked to funding from Global Affairs Canada and Scandinavian countries (and, to a lesser extent, the Spanish Agency for International Development Cooperation and the European Union). The sustained involvement of key donors has been a determining factor in providing continuity to integrating gender equality in PAHO's technical cooperation in health. This has been achieved despite budgetary fluctuations and a specific misalignment in some areas between donors and PAHO orientations. At the corporate level, the budgetary structure of the Gender Equality Policy and the three Strategic Plans has not made it possible to estimate the mobilization of resources to reduce gender inequalities.

4. Recommendations

The recommendations are structured around five main areas for action, around which there has been a high level of consensus during the evaluation, and which represent opportunities to make the integration of gender equality in PAHO's technical cooperation evolve. At the strategic level and considering the difficulty of tracking gender equality mainstreaming in the Strategic Plan 2020–2025 and in all PAHO entities (as presented in the findings), some changes are suggested in the way gender inequalities can be incorporated (and measured) in the next PAHO Strategic Plan 2026–2031. The suggested "twin-track" approach (which is in line with international guidelines and publications) combines the incorporation of gender mainstreaming as well as targeted programs or interventions to reduce gender inequalities. In addition, the obsolescence of the PAHO Gender Equality Policy and Plan of Action requires a significant update to define updated technical guidelines in line with the changes that the Region has undergone in the last 15 years. In turn, strengthening the DHE is crucial to fulfill its primary function of providing technical support to all PAHO entities and programs in response to what has been unanimously identified as a significant need during the evaluation.

From an operational perspective, the increased emphasis on social determinants and intersectionality motivates the need to strengthen coordination and joint work with other agencies, academia, and civil society. In the past, joint action with key health stakeholders enabled stronger operational and advocacy work with Member States and has made a difference. Furthermore, addressing the root causes of health inequalities also requires greater commitment from Member States to promote public policies and multisectoral interventions under a health determinants and intersectionality framework. Likewise, the need to promote measurable changes in gender inequalities in health and associated determinants motivates a recommendation to expand PAHO's technical cooperation to the subnational level, in coordination with Member States, work with local institutions and organizations, and optimize the use of local data in priority areas with protracted health inequalities.

At the organizational level, building an internal consensus around gender equality in health is essential to harmonize the vision and approaches across PAHO entities. Also, revising the Country Cooperation Strategies Guide and strengthening technical and human capacities would equip the Organization with updated knowledge, skills, and tools adapted to the challenges of gender and health in the Region.

4.1 Strategic level

Recommendation	How (suggested lines of action)	By whom	Priority	When
R1. Integrate gender equality into the crosscutting approaches, outcomes, and outputs of PAHO's Strategic Plan 2026–2031 (aligned with the WHO Fourteenth General Programme of Work), and promote further incorporation of gender equality into Member States' national health policies and strategies, in order to strengthen the visibility and monitoring of PAHO's technical cooperation in gender equality and changes in national gender inequalities in health.	**R1.1 Adopt a "twin-track" approach (combining integrated[1] and targeted[2] actions) to mainstream gender equality in PAHO's Strategic Plan 2026–2031 (outcomes, outputs) and across PAHO entities.**	DHE/ PBE/ EIH	High	2025
	• Define a specific outcome for health inequalities (including indicators), and related outputs focused on gender inequalities, under the broader framework of health determinants and intersectionality.		High	2025
	• Adopt a gender marker to track the integration of gender equality into outcomes, outputs, and budget allocation and monitor progress over time.		High	2025
	• Define the levels of disaggregation of indicators at the outcome and output levels to allow tracking of the effects of PAHO-supported interventions on the determinants generating gender inequalities in the health of population groups living in situations of vulnerability.		High	2025
	• Harmonize reporting by PAHO entities in the Performance Monitoring and Assessments (PMAs) and End-of-biennium Assessments to improve tracking of gender inequalities in health, and consolidation of data at the regional level.		High	2025
	• Integrate international human rights norms and recommendations (i.e., CEDAW) on gender and women's rights into PAHO's strategic planning.		High	2025
	• Allocate a percentage of the PAHO budget to integrating gender equality into the PAHO Strategic Plan, assigning resources to personnel, training, technical assistance, research, and collaboration agreements with institutions and universities.		High	2025
	• Seize opportunities to strengthen the integration of gender equality into emerging areas of the regional health agenda, such as climate change and health security (i.e., Global Pandemic Act).		High	2025
	R1.2 Strengthen organizational synergies and allocate commensurate resources to the Department of Social and Environmental Determinants for Health Equity to ensure its technical support function for all PAHO entities and programs.	DHE/ PBE/ AD/DIR	Medium	2025–2026
	• Allocate adequate and regular human, financial, and technical resources to ensure that DHE can crosscut technical support throughout all PAHO entities.		High	2025–2026
	• Reinforce the link between DHE and the PAHO directorate level to support the Organization's advocacy activities on gender equity in health with regional and global stakeholders.		Medium	2025
	• Strengthen DHE's technical support and oversight mechanisms at the subregional level and in the country offices to ensure the consistent deployment of the new guidelines on gender equality in health and the implementation of corporate monitoring and learning mechanisms.		Medium	2026
	• Strengthen mechanisms for collaborative work within DHE to harmonize gender, equity, human rights, and diversity approaches and coordination with gender-based violence teams.		High	2025

Recommendation	How (suggested lines of action)	By whom	Priority	When
	R1.3 Promote the adoption of a gender-responsive approach by Member States as a pathway to achieving universal health coverage.	DHE/AD	High	2025–2031
	• Strengthen gender mainstreaming in the analysis, design, implementation, monitoring, and evaluation of health policies, strategies, and services in Member States' national health systems.		High	2025–2031
	• Design and review health programs and services that acknowledge and address gender-related differences in health status, risk, behavior, need, and access, informed by disaggregated health data.		Medium	2025–2031
	• Ensure that civil society organizations and gender diversity are well represented in the design, decision-making, implementation, and follow-up of health policies and strategies aimed at reducing inequalities.		High	2025–2031
R2. Develop new guidelines for gender equality in health to reflect the evolving issues in gender and health in the Region, the needs of the Member States and communities, and WHO's global guidelines.	**R2.1 Design and launch a participatory process with key regional and national stakeholders (considering the diversity of institutional, political, and sociocultural views on gender in the Region) to enable the development of new guidelines on gender equality in health and the updating of the related plan of action.**	DHE	High	2026
	• Develop a shared definition of gender equality in health (and other relevant concepts – e.g., intersectionality) to ensure consistent understanding across the Organization.		High	2025
	• Disseminate the new guidelines among PAHO personnel, partners, and contractors and adaptation of standard operating procedures accordingly.		Medium	2026

[1] Integrated actions mean putting attention to relevant gender equality issues as a regular, routine part of policies and programs in all areas – making policies and programs gender-responsive.
[2] Targeted Interventions are those where gender equality is the principle or primary objective (focus on specific gaps and challenges to gender equality).

4.2 Operational level

Recommendation	How (suggested lines of action)	By whom	Priority	When
R3. Advocate for Member States to prioritize action on health determinants, and enhance collaboration with United Nations agencies, regional and national organizations, public administrations, and civil society organizations to foster intersectoral collaboration.	**R3.1 Optimize expertise, resources, and complementarities among key partners to strengthen focus on health determinants, broaden the programmatic scope and joint advocacy with Member States, and gain organizational efficiencies.**	DHE/ ERP/AD/ CSC	High	2025–2031
	• Continue advocating before the ministries of health to (1) update or define health policies and plans incorporating specific strategies and interventions to reduce gender inequalities, (2) design and adopt gender-sensitive healthcare protocols in national health services and programs, and (3) reinforce the Health in All Policies approach with national actors beyond ministries of health (e.g., interministerial teams).		High	2025–2031
	• Enhance interagency collaboration and coordination with United Nations agencies on common areas of the respective mandates concerning gender equality in health.		Medium	2025–2031

Recommendation	How (suggested lines of action)	By whom	Priority	When
	• Promote coordinated data collection, sharing, and joint use of data with United Nations agencies to facilitate broader analysis of inequalities and increase the visibility of diverse populations in administrative records and national statistical systems (in line with ongoing initiatives, such as the Regional Conference on Women in Latin America and the Caribbean, the Statistical Conference of the Americas, The Women Count Data Hub, and the Inter-Agency and Expert Group on Gender Statistics).		Medium	2025–2031
	• Reinforce collaboration with subregional integration processes and organizations (e.g., MERCOSUR, SICA, CARICOM) to facilitate the adaptation of gender equality approaches to subregional and national specificities.		Medium	2025–2031
	• Strengthen partnerships with academia and leading regional research centers to deepen understanding of gender inequalities in health and strengthen evidence-based strategies, policies, and decision-making.		*Medium*	2025–2026
	• Promote the participation of relevant civil society organizations in national mechanisms for the design, monitoring, and accountability of health policies and strategies to strengthen gender mainstreaming in the health sector.		High	2025–2026
R4. Expand PAHO's technical cooperation in gender equality to prioritized subnational areas to contribute to measurable changes in health inequalities and reinforce advocacy actions at the central level.	**R4.1 Select areas/locations at the subnational level with critical indicators of health inequalities and identify local entry points, to design and implement intersectional interventions ("flagship projects") focused on reducing inequalities and tracking changes in gender disparities over time.**	DHE/ EIH	High	2026–2031
	• Establish partnerships and joint working mechanisms with local authorities, communities, grassroots organizations, and leaders to promote social participation and the ownership and continuity of PAHO-supported interventions (capitalizing on the Healthy Municipalities, Cities, and Communities Movement).		High	2026
	• Support the generation and use of quality data with at least four disaggregation variables (sex, age, ethnic background, and place of residence) across the different levels of care (routine data) and optimize the data available from population-based sources (e.g., vital registration systems) and institution-based sources (e.g., hospital records) in order to measure progress in: ◊ Access to health services; ◊ Key health outcomes.		High	2026–2031

4.3 Organizational level

Recommendation	How (suggested lines of action)	By whom	Priority	When
R5. Strengthen the technical and operational capacities and skills of PAHO personnel at all levels (regional, subregional, and national) to better integrate gender equality into PAHO technical cooperation efforts.	**R5.1 Develop organizational capacities to design and implement Country Cooperation Strategies where gender equality can be integrated, resourced, monitored, and assessed.**	DHE/ CSC/ PBE	High	2025–2026
	• Encourage a regional reflection process through round tables with partners and experts to adopt a shared definition of gender equality in health for strategy-building, policymaking, and planning.		High	2025
	• Adapt the WHO Country Cooperation Strategy Guide 2023 (aligned with the new PAHO guidelines on gender equality) in order to: ◊ Reflect regional specificities; ◊ Guide countries in profiling disadvantaged and excluded populations at the subnational level and in designing locally tailored intersectoral interventions.		Medium	2026
	• Adopt the use of PAHO or WHO tools to deepen the analysis of eco-social inequalities in health (PAHO) and health equity (WHO – Health Equity Assessment Toolkit) for the elaboration of the CCS.		Medium	2025–2026
	• Promote and systematize the disaggregation of data (minimum four variables, based on nationally available sources) in the Situation Analysis of the CCS, as well as the targeting of subnational areas with persistent health inequality indicators.		Medium	2025–2026
	• Create and make available to all PAHO personnel and partners a repository of the most effective strategies and interventions to reduce gender inequalities in PAHO's various programmatic areas, to strengthen organizational learning mechanisms.		Medium	2026–2031
	R5.2 Provide the Organization with up-to-date knowledge and the tools needed to develop staff skills in gender equality and intersectionality.	DHE/ CSC/ AD	High	2026–2031
	• Design and implement compulsory training programs focused on gender equality and intersectionality for all personnel, including new hires and partners.		High	2026
	• Establish regular exchanges and meetings of gender focal points to strengthen synergies among country offices.		Medium	2026–2031
	• Document and disseminate best practices and experiences for integrating gender equality in technical cooperation in health at the subregional level, to facilitate collaboration among country offices and the exchange of experiences within communities of practice.		Medium	2026–2031
	• Enhance the integration of the gender equality approach in developing and revising PAHO operational guidelines and manuals for programmatic work (e.g., WHO Country Cooperation Strategy Guide 2023, technical guidelines for preparedness and emergency response [Damage assessment and health needs analysis in disaster situations, Mental health in disaster situations], control and elimination of communicable diseases, NCDs and mental health, management of adverse events during mass drug administration).		High	2026–2031

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Appendixes (see Volume II)

In 2024, the Pan American Health Organization (PAHO) embarked on a pivotal evaluation to assess the integration of gender equality into its technical cooperation efforts. Conducted by an independent team, this evaluation spanned from February to November 2024, utilizing both face-to-face and remote data collection methods.

This comprehensive report delves into the extent to which gender equality has been woven into PAHO's initiatives, examining its impact on health systems and policies across the Americas. With a focus on actions from 2005 to 2023, the evaluation provides a thorough analysis of PAHO's strategic, operational, and organizational efforts to promote gender equality.

Featuring in-depth studies from Colombia, Panama, and Trinidad and Tobago, and broader analyses from Brazil, Cuba, Mexico, and Uruguay, this evaluation offers a nuanced understanding of regional dynamics. It highlights PAHO's achievements, identifies challenges, and presents actionable recommendations to guide future efforts.

Essential reading for policymakers, health professionals, and advocates, this report underscores the critical importance of gender equality in health and provides recommendations for advancing these efforts in the years to come.

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