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FINAL REPORT

Evaluation
Improved Health of Women and Adolescent Girls in Situations of Vulnerability

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Acronyms

AFP	United Nations Agencies, Funds, and Programmes
Annual work pl	Biennial Work Plan
C4H	Communications for Health
CCS	Country Cooperation Strategy
CHW	Community Health Worker
CLAP	Latin American Center for Perinatology, Women and Reproductive Health
CrCA	Cervical Cancer
DAG	Decentralized Autonomous Government
EIH	Department of Evidence and Intelligence for Action in Health
DHE	Department of Social and Environmental Determinants for Health Equity
FP	Family Planning
GAC	Global Affairs of Canada
GBV	Gender-Based Violence
GEH	Gender Equality and Health
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPPCS	Culturally Safe Childbirth Tool
HSS	Department of Health Systems and Services
HSS/WH	Women's Health Unit of the Department of Health Systems and Services
IDB	Inter-American Development Bank
IHWAG	Improved Health of Women and Adolescent Girls in Situations of Vulnerability
ILO	International Labor Organization
IMT	Department of Medicines and Health Technologies Access
IO	Immediate Outcome
IUD	Intrauterine Device
LAC	Latin America and the Caribbean
LARC	Long-acting Reversible Contraceptives
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer, and other
MCCS	Movement of Healthy Municipalities, Cities, and Communities
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MTCT	Mother-to-Child Transmission
MUSA Network	Women Experiencing Abortions Network of Hospitals
NGO	Non-Governmental Organization
NMH	Department of Noncommunicable Diseases and Mental Health
PAHO	Pan American Health Organization
PMF	Performance Measurement Framework
PTA	Parent Teacher Association
PWR	PAHO/WHO Representative
SAFCI	Family, Community, and Intercultural Health from Spanish *Salud Familiar Comunitaria Intercultural*
SIP Plus	Perinatal Information System web version
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SHAA2030	Sustainable Health Agenda for the Americas 2018-2030
ToR	Terms of Reference
UN	United Nations
UN WOMEN	United Nations Programme for Gender Equality and the Empowerment of Women
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WB	The World Bank
WHO	World Health Organization

1. Introduction

This report presents the findings of the final evaluation for the "Improved Health of Women and Adolescent Girls in Situations of Vulnerability" (IHWAG) Project (henceforth "the Project"), implemented by the Pan American Health Organization (PAHO) with the financial support of the Government of Canada, through its Department of Global Affairs Canada (GAC). Its main objective was to improve the health of women and adolescent girls in situations of vulnerability in six Latin American countries: Bolivia, Colombia, Ecuador, Guyana, Honduras, and Peru, with the participation of several PAHO headquarter entities[1]. With an approach based on human rights, gender, and cultural diversity, the Project aimed to reduce maternal mortality, adolescent fertility, and neonatal mortality by promoting equitable access to sexual and reproductive health services and empowering women and adolescents.

The Project logic model centered on integrating strategies to expand access to and coverage of sexual and reproductive health (SRH) services and strengthen institutional capacity. One of the primary purposes of the Project was to ensure that a greater number of women and adolescents had their family planning needs met through access to modern contraceptive methods, with special attention to groups traditionally excluded for reasons of age, ethnicity, or socioeconomic status. In addition, it promoted skilled birth attendance and the reduction of mother-to-child transmission of HIV and syphilis, consolidating people-centered and culturally sensitive primary health care networks.

The Project also sought to empower women and adolescents and to strengthen their participation and leadership in decision-making on their sexual and reproductive health, expanding their capacity to influence public policies and advocate for their rights. This was achieved through the creation of spaces for participation, the promotion of comprehensive sexual education, and the generation of mechanisms to facilitate their inclusion in platforms for dialogue and community planning. At the same time, the Project established collaboration initiatives with national, subnational, and local governments to consolidate public policies that address the social determinants of health and reduce inequities by promoting legal and regulatory frameworks.

At the operational level, the Project prioritized strengthening health systems through various training processes for healthcare workers, maintaining a focus on comprehensive care with a gender, cultural diversity, and rights perspective. In addition, within the framework of strengthening competencies, the Project provided supplies for maternal and neonatal care and improved basic services, including water and sanitation. It also promoted the creation of robust information systems that enable the disaggregation of data by age, sex, ethnicity, and geographic location, facilitating the monitoring and evaluation of progress toward achieving health equity.

In addition, actions to prevent and respond to gender-based violence were advanced, ensuring that health services had adequate protocols and that victims had access to comprehensive and specialized care. The Project's logic model also included operational research to identify structural barriers to accessing sexual and reproductive health services and developing contextualized solutions.

The implementation strategy was based on intersectoral coordination, involving collaboration between levels of government (national, subnational, and local), communities, civil society organizations, and multilateral organizations. This ensured that actions responded to local needs and strengthened the capacities of both the health system and the communities. In this way, the Project not only generated

[1] The Department of Communicable Disease Prevention, Control, and Elimination (CDE), the Women's Health Unit of the Department of Health Systems and Services (HSS/WH) (formerly the Latin American Centre for Perinatology, Women's and Reproductive Health (CLAP), the Department of Social and Environmental Determinants for Health Equity (DHE), the Department of Evidence and Intelligence for Action in Health (EIH), the Department of Health Systems and Services (HSS), the Department of Medicines and Health Technologies Access (IMT), and the Department of Noncommunicable Diseases and Mental Health (NMH).

impacts on maternal, neonatal, and adolescent health indicators but also laid the foundations for structural transformations that contribute to the sustainability of the results.

With a budget of CAD$15,000,000 and a duration from 2021 to 2025, the Project catalyzed change in the Region, contributing to the creation of fairer and healthier environments for women and adolescents in situations of vulnerability.

2. Purpose, scope, and objectives

As stipulated in the Terms of Reference, the overall purpose of this evaluation is to determine the results achieved after the implementation of the Project and to identify good practices and lessons that this initiative has generated in terms of the health of women and adolescent girls (Annex 1). It is expected that the results of this evaluation will be shared with PAHO senior management and technical teams from PAHO Country Offices and GAC, so that its findings and recommendations will be available as part of the Organization's continuous learning for future collaborations.

The evaluation of this Project, in which six countries of the Region participated, was guided by the following objectives:

- Determine the extent to which the expected results were achieved to improve access to quality services and strengthen the role and empowerment of women and adolescents for their health.
- Identify the differentiating and innovative strategies used to achieve the Project objectives.
- Identify key aspects that provide information on the management and monitoring mechanisms used during Project implementation.
- Identify good practices and establish recommendations and lessons learned that will contribute positively to the implementation of similar initiatives in the future.

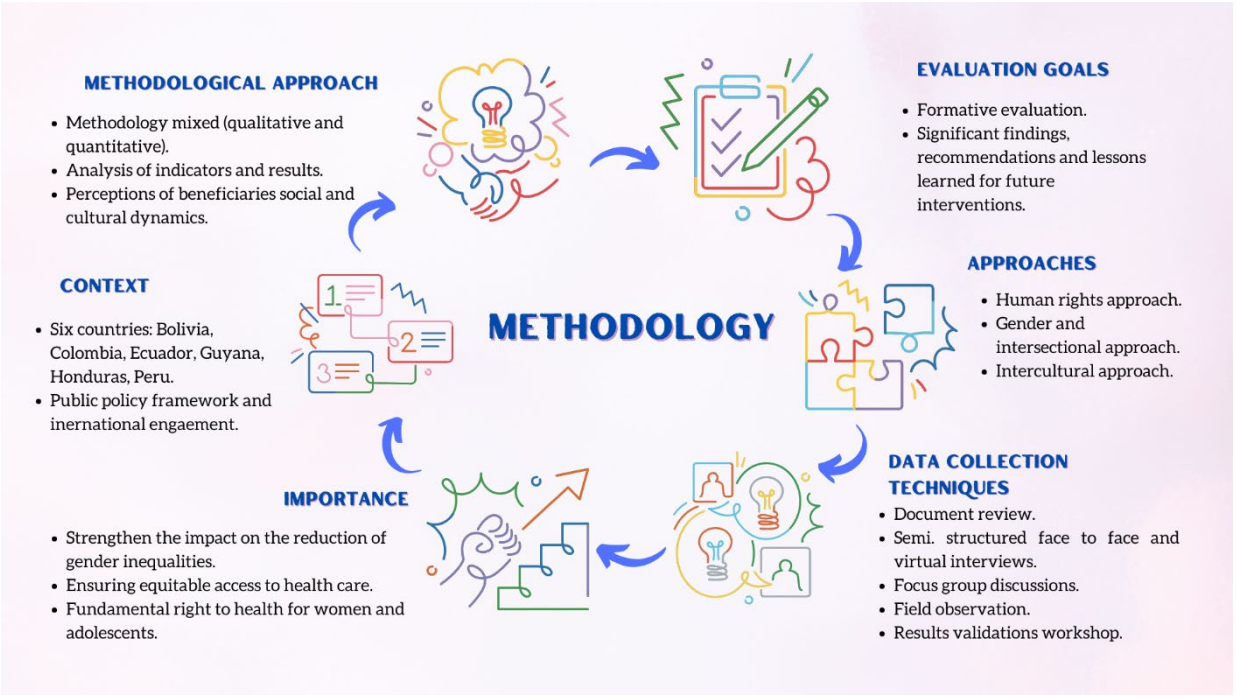
3. Methodology

The evaluation covered the implementation period from 2021 to 2024 and spanned the six participating countries, with fieldwork conducted in Colombia, Guyana, and Honduras, which represent the Project's three subregions. The evaluation was conducted virtually for Bolivia, Ecuador, and Peru.

A summary of the evaluation approach and methodology can be seen in Graphic 1. The evaluation applied a rights-based, gender-responsive, intersectional, and intercultural approach throughout its design, data collection, and analysis. Using a human rights lens, the team examined how the Project strengthened institutional, community, and individual capacities to exercise the right to health—particularly among women, adolescents, Indigenous and Afro-descendant populations. The gender approach enabled the evaluators to identify structural barriers that limit equitable access to sexual and reproductive health services and to assess the Project’s contributions to shifting social norms, addressing unequal power dynamics, and reducing discriminatory practices. An intersectional perspective ensured that overlapping identities and vulnerabilities—such as age, ethnicity, gender, and geographic isolation—were systematically analyzed to understand differentiated impacts and gaps. Finally, the intercultural approach guided the assessment of how national and local health systems integrated community knowledge, traditional practices, and culturally grounded models of care, and how these contributed to more respectful, acceptable, and relevant health services. These approaches were applied transversally, shaping the formulation of the evaluation questions, the construction of tools, the selection and interpretation of evidence, and the development of findings and recommendations.

The Project was developed within a regulatory and public policy framework that incorporates international commitments and regional gender and public health policies (Annex 2). The evaluation aimed to contextualize its findings within this framework, which facilitated the identification of both the specific Project results and opportunities for enhancing its impact on reducing gender inequalities and promoting equitable access to health in the participating countries.

Graphic 1: Evaluation approach and methodology



Source: Inclusión & Equidad, 2025

The methodological strategy utilized for this evaluation was a combination of summative and formative approaches. Thus, it contributed to identifying a set of findings, feasible and relevant recommendations, and lessons learned for similar interventions. A mixed-methodological approach was applied, combining qualitative and quantitative techniques, enabling the analysis of indicators and their results according to the logic model defined during the Project's design phase across the six selected countries (Annex 3).

The evaluation was guided by the criteria and questions outlined in the evaluation Terms of Reference (Annex 1), summarized in the table below. To address these questions, the evaluation team created an evaluation matrix that allowed them to visualize the questions and their relationship to evaluation sub-questions, indicators, data collection tools, sources of information, formats, risks, and limitations (Annex 4).

Table 1: Evaluation questions and sub-questions

EVALUATION CRITERION	EVALUATION QUESTIONS	EVALUATION SUB-QUESTIONS
RELEVANCE	Q.1. Were the Project objectives consistent with the national priorities and programs of the six intervention countries, as well as with the needs of the beneficiary populations, which were predominantly Indigenous and Afro-descendant women and adolescents?	1.1. Were the Project's approach and the design of its logic model aligned with national health and development priorities, as well as with the priorities of PAHO's Strategic Plan 2020-2025; PAHO's Action Plan for Women's, Children's and Adolescents' Health 2018-2030; the 2030 Agenda; and Canada's Feminist International Assistance Policy? 1.2. Was the Project adapted to the contexts of the territories of implementation and the conditions of Indigenous and Afro-descendant women and adolescents? 1.3. What is the beneficiary population's perception of the importance of addressing issues related to maternal and child health, women's health, and adolescent health?
EFFECTIVENESS	Q.2.After Project implementation, what is the level of achievement of the results and indicators established in the Performance	2.1. To what extent did the Project respond to the challenges in access to and coverage of sexual and reproductive health and maternal health services in the implementation territories? 2.2. To what extent did Project implementation reach target populations in remote and hard-to-reach geographic areas?

EVALUATION CRITERION	EVALUATION QUESTIONS	EVALUATION SUB-QUESTIONS
	Measurement Framework and overall Project monitoring?	2.3. To what extent did the Project contribute to strengthening the leadership of women and adolescents in the implementation territories regarding the exercise of their sexual and reproductive health rights? 2.4. What strategies can be highlighted as innovative, including the incorporation of communication actions, during the implementation of the Project's activities? 2.5. To what extent did the Project contribute to strengthening gender, human rights, and cultural diversity approaches in health services?
EFFICIENCY	Q.3. Were the mechanisms and practices used to manage, monitor, and implement the Project innovative and effective in achieving its overall objectives?	3.1. To what extent did the technical and human resources available for Project implementation contribute to achieving the Project objectives at the regional and national levels? 3.2. How efficient was the overall management and implementation of the Project, as well as the monitoring of its objectives and indicators? 3.3. Did the Project's coordination and liaison mechanisms with the various strategic partners contribute to the achievement of the Project results?
SUSTAINABILITY	Q. 4. How will the results achieved through the implementation of the Project continue to have a positive impact on the population, predominantly Indigenous and Afro-descendant women and adolescents living in situations of vulnerability?	4.1. Following the implementation of the Project, have the overall response capacity of the health services and the operational capacities of local health teams been strengthened? 4.2. What measures were taken by the implementing countries to ensure the sustainability of Project impacts? 4.3. What level of institutional, national, and/or subnational capacity do countries have to sustain results after Project implementation?

Source: Terms of Reference, PAHO 2024.

The data collection techniques used included document review, face-to-face and virtual semi-structured interviews, focus groups, and on-site observation missions.

- Document review. A total of 81 documents and 52 communication products were reviewed[2].
- Semi-structured face-to-face and virtual interviews. Throughout the evaluation process, interviews and focus groups were conducted, reaching 139 key informants from PAHO, Ministries of Health, civil society organizations and networks, the private sector, and women and adolescent beneficiaries of local health services, where possible. The main stakeholders included government representatives from the respective Ministries of Health, national and local decision-makers and experts, as well as representatives from PAHO headquarters and country offices. Interviews were also conducted with representatives of civil society organizations, other agencies from the United Nations system, networks, as well as with the beneficiary population. The interviews lasted approximately one hour, allowing for a detailed exploration of perceptions, achievements, and challenges.
- Focus group discussions with specialists and technical experts from PAHO HQ and Country Offices. They facilitated a deeper understanding of the operational dynamics, strategies, and results.

[2] This included the following documents: (a) Subsidiary Arrangement and amendment; (b) Project concept note; (c) Project implementation plan; (d) Project monitoring plan; (e) PAHO Strategic Plan 2020-2025; (f) GAC Feminist International Assistance Policy; (g) PAHO Action Plan for Women's, Children's and Adolescents' Health 2018-2030; (h) Narrative reports and annual work plans (countries and regional entities); (i) Annual project progress reports; (j) Project financial reports; (k) Focal point meeting reports; (l) Project communication plan; (m) Written and audiovisual project communication materials; (n) Letters and correspondence; (o) Country Cooperation Strategies.

Focus groups were also conducted with strategic partners from civil society and with various entities that comprise the primary and specialized sexual and reproductive health care system[3].

- Field observation. The observation focused on community interventions and health care services in the prioritized areas of Colombia, Guyana, and Honduras. This technique provided direct evidence of the Project's implementation context and allowed for the validation of both qualitative and quantitative findings. It also allowed us to approach the users, whenever possible and feasible, following their consent and willingness to participate.

The selection of key informants drew on lists provided by PAHO Country Offices and on an assessment of the person's level of involvement in the Project's design and implementation, as well as the quality of the information they could provide, to arrive at the final sample of informants. The evaluation team developed data collection tools for both regional and country levels and depending on the type of respondent (first- or second-level service provider).

Tables 2 and 3 present a summary of the stakeholders that participated in the evaluation, including their institutional affiliation, at the regional level and by selected countries (see Annex 6 for the initial mapping of stakeholders).

Table 2: Key informants consulted at the regional level

KEY INFORMANT	Number
Technical Advisor, Office of the Assistant Director, PAHO	1
Project Support Specialist, Office of the Assistant Director, PAHO	1
International Consultant (IPC), Office of the Assistant Director, PAHO	2
PAHO Regional Advisors/Regional Entities (DHE, HSS, HSS/WH, IMT)	8
External relations, alliances, and resource mobilization (ERP)	1
Total	13

At the country level, the following stakeholders were identified: i) the Pan American Health Organization (Country Representative, Project focal points and technical implementation team; ii) representatives from the Canadian Mission; iii) implementing partners (national and subnational health sectors, health providers, education personnel; beneficiaries subnational and local governments and civil and community organizations; women, adolescents and families; iv) other stakeholders (academia and scientific societies, NGOs, United Nations agencies, private sector). It should be noted that the total number of people consulted varied by country due to the availability of individuals for interviews or the identification of other key stakeholders suggested during the fieldwork, which was defined in consensus with the country's PAHO office.

[3] Each focus group discussion was designed to comprise a total of six to eight participants, selected according to criteria of gender, age, institutional affiliation, and territory. However, in the reality of each country, there was varied participation. During the sessions, the participants contributed their reflections, visions, and knowledge based on a guideline of questions included in Annex 5.

Table 3: Key informants by Project country

	BOLIVIA	COLOMBIA	ECUADOR	GUYANA	HONDURAS	PERU	TOTAL
Pan American **Health** Organization							26
PAHO/WHO Representatives	1	1	1	1	1	0	5
Focal points and technical team	5	6	2	3	1	4	21
Canadian Mission (GAC)							1
Senior International Assistance Officer - Analyst at Embassy of Canada	-	1	-	-	-	-	1
Implementing partners							75
Ministries of Health	2	5	10	11	5	1	34
Health care providers	2	-		7	11	1	21
Regional/local government	5	3	2	-	6	-	16
Education sector personnel	1	-	2	-	1	-	4
Beneficiaries							25
Representatives of community organizations	2	14	2	2	-	-	20
Women, adolescents, and families	-	-	1	4	-	-	5
Other **Stakeholders**							4
Academia	-	-	1	-	-	-	1
NGO	-	-	1	-	-	-	1
United Nations	-	1	-	-	-	-	1
Private sector (private hospital)				1			1
TOTAL	**18**	**31**	**22**	**29**	**25**	**6**	**131**

Following the face-to-face visits to Colombia, Guyana, and Honduras, a meeting was held to present the preliminary findings to the Project management team and subsequently to the Assistant Director of PAHO. The analysis process used triangulation to ensure confidence and credibility of the results through the convergence and overlap of different methods. *Atlas.ti* was used to facilitate the systematization and analysis of the data for interpretation and visualization in the Final Evaluation Report.

4. Limitations

The evaluation of the IHWAG Project encountered a series of context-related and procedural limitations and risks. One of the primary challenges was the limited availability of key stakeholders to participate in the interviews and consultations, including government officials, civil society representatives, health personnel, and beneficiaries. This was due to overloaded schedules, staff turnover, distrust toward external evaluators, and the influence of ongoing electoral processes in some countries. In Honduras, a health workers' strike during March and April 2025 further complicated access to relevant informants, delaying the coordination of key interviews.

The consultations in Bolivia and Peru faced substantial difficulties due to connectivity issues, which hindered the participation of stakeholders, such as community health workers. Furthermore, interviews with women and adolescents could only be conducted in Ecuador and Guyana, limiting the diversity of voices gathered from across the six intervention countries. During the evaluation process, we actively followed up with Project focal points in each participating country to obtain contact details of relevant respondents. It is also important to emphasize that we requested that countries share the names of individuals who were directly and closely involved in the Project's implementation. This was done to ensure the quality, relevance, and reliability of the feedback. As a result, we intentionally prioritized targeted, knowledgeable respondents over a larger pool of individuals who may have been only tangentially familiar with the Project. This approach may have contributed to differences in the number of responses across countries.

Political and social instability, especially in Bolivia, Colombia, and Ecuador, posed additional risks. These volatile conditions, including social protests and potential conflicts, threatened the planning and execution of evaluation activities, creating uncertainties regarding access to specific territories. Linguistic and cultural barriers also posed challenges, particularly in Indigenous communities where Spanish was not the primary language and Western health frameworks were not always applicable.

Another critical limitation was the lack of reliable, updated, and disaggregated data in several countries, especially Bolivia. This restricted the capacity for in-depth and intersectional analysis. In general, the complexity of capturing the effects of intersectional discrimination, stemming from overlapping factors such as gender, ethnicity, age, or geographic location, was a persistent analytical challenge.

Despite these constraints, the evaluation team implemented mitigation strategies, including flexible data collection methods, culturally appropriate engagement approaches, data source triangulation, and collaboration with local actors. As a result, all major obstacles were effectively addressed, and none of the limitations significantly compromised the validity or integrity of the evaluation findings.

5. Findings

5.1. Relevance

EQ.1. Were the project objectives consistent with the national priorities and programs of the six intervention countries, as well as with the needs of the beneficiary populations, which were predominantly indigenous and Afro-descendant women and adolescents?

Finding 1. The Project's objectives responded to national priorities for populations in situations of vulnerability. It was built on national policy frameworks to advance maternal, newborn, child, and adolescent health, with a strong focus on marginalized groups.

- In the selected countries, the Project aligned with national and subnational priorities in maternal health, SRH, and gender equality. The most successful approaches aligned with country strategies related to interculturality, sexual and reproductive rights, and the prevention of gender-based violence (GBV).
    - For example, the six Project countries have specific legal and policy frameworks to advance the main project themes - gender equality, access to sexual and reproductive health services, the prevention of gender-based violence, and the reduction of maternal mortality and adolescent pregnancy (see details in Annex 2 on regulatory frameworks).
- The Project demonstrated relevance at the national level, particularly in the following areas:

a. Its territorial scope, which prioritized reaching remote and highly vulnerable areas. The Project also targeted culturally diverse territories, including mestizo, Indigenous, and Afro-descendant populations.
b. In terms of programs and policies, the Project strengthened maternal and neonatal health programs, as well as differentiated care for adolescents and interculturality.
c. In maternal health, it focused on obstetric emergency care, linking institutional medicine with traditional medicine.
d. It enabled a response for the care of pregnant adolescents and health promotion actions, strengthening knowledge, skills, and health rights.
e. Communication and training tools were used widely and effectively in the territories.
f. The Project was able to align itself with the implementation of national strategies to address the specific needs of adolescents in different vulnerable territories in each country. In terms of cultural diversity, the Project improved national intercultural policies and introduced new methodologies and instruments.

- Another key element closely aligned with national strategies is the Project's strong focus on capacity building through face-to-face and virtual training opportunities. The initiative effectively addressed the needs of women and adolescents in critical areas such as maternal health, neonatal care, prevention of maternal mortality, adolescent pregnancy, and gender-based violence. To this end, the Project implemented intensive training programs targeting health care providers and traditional birth attendants, with a particular emphasis on the management of obstetric emergencies.
  Some country-specific examples include:

  - In **Colombia**, a country with a robust regulatory framework for gender equality and health, the Project was integrated in a coherent manner with national policies through cross-cutting approaches and specific actions. The key components were: a) Health equity as a central axis, which prioritizes the reduction of health inequalities, focusing on vulnerable populations such as women, girls, and adolescents and reaching the community level in territories identified and prioritized by the country, and b) Action at the highest level in public policies through the National Plan for the Acceleration of the Reduction of Maternal Mortality.

  - In **Honduras**, the Project's objectives were aligned with national priorities and gender and human rights frameworks, focusing on six highly vulnerable health regions with a high concentration of Indigenous and Afro-descendant populations, poverty, migration, and high maternal mortality rates. It strengthened staff technical capacities, equipped hospitals and health facilities, reviewed regulations, and promoted the establishment of strategic alliances with community actors and projects from other program areas operating in remote areas.

  - In **Ecuador**, emphasis was placed on an integrated vision of health, coordinating actions with other programs, including nutrition. This led to comprehensive actions in the territories related to water treatment, family gardens, and nutrition. In terms of maternal and neonatal health, the successful implementation of the Kangaroo Mother Care Method in thirteen hospitals improved neonatal care and survival rates for premature newborns.

  - The Project was highly consistent with national women's health priorities in **Bolivia**, and the importance of local institutional dynamics was emphasized, as Project actions were aligned with municipal policies, including initiatives focused on women in situations of violence, sexual and reproductive health, and adolescent pregnancy. Civil society and municipalities recognized that initiatives using methodologies such as "Knowledge Dialogues," health fairs, and work with young people responded directly to local problems, with an intercultural approach and territorial relevance.

EQ.1.1. Were the Project's approach and logic model design aligned with national health and development priorities, as well as the priorities of PAHO's Strategic Plan 2020-2025; PAHO's Action Plan for Women's, Children's and Adolescents' Health 2018-2030; Agenda 2030; and Canada's Feminist International Assistance Policy?

Finding 2. The Project aligned its approach and logic model with international, regional, and national priorities, leveraging global frameworks to strengthen maternal, child, and adolescent health, and gender equality. It made a virtuous and synergistic use of the existing international normative and strategic framework, including the PAHO Strategic Plan 2020-2025, Biennial Work Plans (BWP), and PAHO mandates including the Plan of Action for Women's, Children's and Adolescents' Health 2018-2030, the Canada's Feminist International Assistance Policy, as well as global commitments to which Project countries have subscribed, such as the Sustainable Development Goals of the 2030 Agenda.

- The PAHO Strategic Plan 2020-2025 prioritized improving maternal and child health, the reduction of inequalities in access to health services, and the strengthening of public policies focused on the social determinants of health, with special attention to Indigenous and Afro-descendant populations. Aligned with these priorities, the Project incorporated key elements in its design and implementation, such as applying the Primary Health Care (PHC) approach to train health personnel (especially in remote areas in all countries), while ensuring cultural relevance for the target populations.
- All three Project ultimate outcome indicators, four of the five intermediate outcome indicators and five of the eleven immediate outcome indicators included in the Performance Measurement Framework (PMF) were directly aligned with the PAHO Strategic Plan, while its programming supported the implementation of PAHO´s BWP.
- PAHO's Gender Equality Policy was reflected in the Project's approach and implementation through the Organization's commitment to the principles of equity, respect for human rights, empowerment, and the exercise of rights, particularly in addressing GBV issues across countries.
- In 2018, PAHO adopted the Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030, which aligns with the WHO Global Strategy for Women's, Children's, and Adolescents' Health 2016-2030. These mandates gained momentum in the Project countries, particularly in efforts to reduce adolescent pregnancy. Five of the Project's outcomes and indicators were aligned with those of the Plan.
- All countries, to varying degrees, participated in the commitments of the PAHO Sustainable Health Agenda for the Americas 2018-2030 (SHAA 2030), which seeks to guide regional health policies aligned with the Sustainable Development Goals (SDGs). It should be noted that several Project outcomes and indicators correspond to SDG indicators, particularly for Goal 3 (Good Health and Well-being) and Goal 5 (Achieve gender equality and empower all women and girls).
- In response to persistently high maternal mortality rates, PAHO- together with other partner organizations - launched a Regional Campaign in 2023 to accelerate the reduction of maternal mortality. The campaign focused on: i) strengthening primary care in reproductive health; ii) training medical personnel in obstetric emergencies; and iii) promoting universal access to contraceptive methods and sexual education. All Project countries engaged in this initiative, with the least impact on policies on adolescent sexual education.
- Canada's Feminist International Assistance Policy, implemented since 2017, aims to eradicate poverty and foster peaceful, inclusive, and prosperous societies by advancing gender equality and empowering women and girls. This policy provided a framework for the Project´s technical cooperation and implementation, particularly in "Gender equality and empowerment of women and girls", supporting efforts to reduce gender-based violence, strengthen organizations and movements that promote women's rights, enhance government capacity to deliver services, and promote gender analysis.
- Additionally, the Project's approach and logic model were aligned with the "Human Dignity" action area, promoted by the Government of Canada to support populations in situations of vulnerability, lacking access to essential services of affected by conflict or natural disasters. Each area established targets and indicators consistent with the 2030 Agenda - particularly SDGs 3 and 5 - enabling synergies at international, regional, and national levels from normative, strategic, programmatic, and institutional perspectives.

Finding 3. Drawing on PAHO's Country Cooperation Strategies (CCS), the Project responded to contextual differences by setting tailored thematic priorities across public-policy arenas, national women's health strategies, and programmatic initiatives in each country.

- The Project's relevance was reinforced by its flexible yet structured alignment with country-specific strategies and policy priorities, effectively translating regional goals into locally grounded actions. This approach enhanced the Project's relevance and perceived legitimacy among national and subnational stakeholders, while contributing to more sustainable and community-rooted interventions.

- Each of the targeted countries signed a CCS with PAHO to establish joint priorities and commitments (Annex 7). In some cases, these strategies were agreed upon after the Project began (Colombia, Ecuador, and Guyana), and the Project itself contributed to national priorities in technical cooperation while also extending beyond the strategy's central themes. Across all the CCSs, the integration of maternal health and sexual and reproductive health as fundamental components of technical cooperation is a standard feature, adapted in different ways to address each country's specific needs.

  It is important to highlight that Project implementation began in 2021, at a time when several CCSs were already in their implementation phase. Nevertheless, the Project sought to ensure coherence by aligning its components, where possible, with the priorities articulated in these strategies.

- Moreover, the IHWAG Project's responsiveness to national strategies is evidenced by the update and implementation of 99 technical guidelines across countries, tailored to each context, and the creation of country-specific data dashboards to follow up on key plans, policies, and strategies. Some key examples include:

  - In **Bolivia**, the IHWAG Project aligned with both the 2021–2025 and 2023–2027 Country Cooperation Strategies (CCS), which prioritize intercultural health, modernization of health services in the Altiplano, and the strengthening of the SAFCI policy. The Project contributed to health promotion, universal access, and integrated care with a gender and intercultural approach. Also, in Bolivia, the Project integrated with local government agendas to address maternal mortality and access to contraceptives in rural areas, reinforcing health equity in hard-to-reach populations. Finally, the Project supported the creation of a subnational SRH dashboard to support evidence-based planning and decision-making.

  - In **Colombia**, the Project aligned with the 2024–2028 CCS initiative, "Health Equity for Life," which targets rural, Indigenous, Afro-descendant, and conflict-affected populations. It supported multisectoral efforts to reduce maternal mortality and partnered with the Ministry of Education to prevent adolescent pregnancy. The Project was also key in supporting Colombia's Plan to Accelerate the Reduction of Maternal Mortality and supported the creation of its maternal mortality platform. Finally, in Colombia, the Project's focus on adolescent pregnancy, differentiated care, and intercultural approaches resonated strongly with subnational priorities in departments such as Cauca and Risaralda, as confirmed by interviews with health officials and community leaders.

  - In **Ecuador**, the Project focused on reducing maternal and neonatal mortality by building the capacity of local health workers, incorporating intercultural childbirth care, and collaborating with territorial authorities to integrate SRH into local agendas, particularly for women and adolescents.

  - In **Guyana**, alignment with the 2023–2027 CCS and national strategies (Health Vision 2030 and SDGs) ensured integration of SRH into universal health coverage. The Project contributed to reducing maternal and infant mortality and preventing gender-based violence, with a substantial equity and rights-based approach.

  - In **Honduras**, the Project built on key components of the 2017–2021 CCS priorities by strengthening the health system, improving maternal and child health, and enhancing emergency preparedness, with a focus on vulnerable groups and primary care.

- In **Peru**, the Project operationalized priorities of the 2018–2022 PAHO-Peru Strategy, including SRHR, gender, interculturality, and health system strengthening. It supported prenatal and postnatal care, particularly in Indigenous and rural areas, reinforcing national commitments to universal health. Also, in Peru and Ecuador, telemedicine and community empowerment strategies were adapted to the Amazonian context, where geographic barriers and the presence of Indigenous communities required innovative and culturally adapted solutions. Finally, the integration of traditional midwives into maternal health protocols strengthened trust and uptake of prenatal care services in Indigenous communities.

- These country-specific strategies were not only reflected in implementation modalities but also in how stakeholders perceived the Project's relevance. As respondents highlighted:

> "The Project aligned clearly with Bolivia's national priorities on maternal and women's health. It strengthened our teams by updating protocols and clinical practices that are essential for reducing maternal mortality."
>
> Interview with Key Informant, Bolivia. IHWAG, 2025.

> "In Colombia, the Project responded directly to our territorial needs: it not only provided technical guidance but empowered women, adolescents, and health workers through a more human and culturally sensitive approach."
>
> Interview with Key Informant, Colombia. IHWAG, 2025.

> "In Ecuador, reaching indigenous and rural territories is what makes the Project truly relevant. It brought culturally adapted tools to places where adolescent pregnancy and maternal deaths remain highest."
>
> Interview with Key Informant, Ecuador. IHWAG, 2025.

> "In Guyana, the Project was highly relevant because it targeted populations who are usually left behind—indigenous communities, mining areas, adolescent mothers, and remote hinterland regions."
>
> Interview with Key Informant, Guyana. IHWAG, 2025.

EQ.1.2. Was the Project adapted to the contexts of the implementation territories and the conditions of Indigenous and Afro-descendant women and adolescents?

Finding 4. The Project was tailored to each country's particular context. In Colombia and Ecuador, needs assessments targeted territories with the highest maternal mortality rates, while in Guyana, they focused on the health impacts of mining. Across all participating countries, interventions prioritized rural or remote areas and indigenous or Afro-descendant communities. Several contexts placed special emphasis on migrants (specifically the Venezuelan population), most notably Guyana and Colombia. In contrast, Ecuador incorporated school-aged adolescent girls, and both Bolivia and Ecuador implemented measures at the municipal level.

- The Project installed various measures to ensure the adaptation of its design to different national and local contexts. These included: i) the presence of the Project management team in the various areas of intervention; ii) the adaptation of institutional and individual capacity-building strategies; and iii) the development of a training process for trainers to replicate teaching and learning strategies in remote and hard-to-reach rural areas.

- The use of methodologies such as the "Knowledge Dialogues" and gender-intersectionality workshops in all countries allowed the Project to adapt its approaches to diverse sociocultural realities. Several informants emphasized efforts to tailor health services to different national and local environments, as well as to coordinate community networks and intercultural work through the Knowledge Dialogues:

"...We adapted the protocols to the reality of the territory, and that facilitated our arrival in indigenous communities."

- The flexibility of the approach enabled the integration of ancestral and Western medicine, respecting traditional knowledge and enhancing the legitimacy of the health system. The inclusion of anthropologists, traditional midwives, and actors from the education and judicial systems strengthened the Project's adaptability and results. The formation of multidisciplinary teams stands out as a strategic success, reinforcing not only service coverage but also their quality, relevance, and legitimacy in underserved communities.

    - In all Project countries, and notably in **Bolivia and Ecuador**, the inclusion of decision-makers from parish and cantonal governments was a key factor in coordinating actions between health services and these bodies, both in urban and remote areas, making the interventions better adapted to the local context.
    - In **Bolivia,** a respondent stated that adapting the Project to local realities was shown by respecting community timelines: "...The work with PAHO has been consistent from the start, respecting local timelines and processes, and that has been very important in building trust." It also helped establish participatory planning at the local level, as "...the Healthy Municipalities initiative promoted by PAHO has strengthened participatory health planning processes at the local level".
    - In **Colombia,** the testimonies gathered highlight the value of adapting content and methodologies to ethnic and cultural contexts, as seen in the work with the Misak and Afro-descendant communities.
    - In **Ecuador**, adaptations were made, and adolescent leadership schools addressed taboo topics such as sexual violence and early pregnancy, while respecting local norms.

- Beneficiaries in **Ecuador** and **Guyana** highlighted the Project´s adaptability and flexibility as key strengths that enhanced its relevance and effectiveness. Although consultations were not fully systematic, the participatory approach enabled target groups to shape priorities and influence response strategies, assigning different levels of emphasis to the issues most pressing in their local contexts. This flexibility reinforced the Project's responsiveness and contextual relevance in diverse territories.

- The Project incorporated, to some extent, an intersectional perspective on SRH that included gender identity and sexual orientation as relevant dimensions for equity. Based on interviews with key informants, it is essential to note that although a gender assessment was not initially conducted during the planning stage, a regional *intersectional analysis tool* was adapted. However, the evidence documenting the systematic application of the tool to targeted countries is limited, with most of it focused on **Bolivia**, **Colombia,** and **Ecuador**. This approach highlighted the needs of traditionally excluded populations, including LGBTIQ+ adolescents. D.

- The Project promoted the implementation of national policies on maternal mortality among the most vulnerable populations. It also generated a series of national mechanisms that have been a significant initiative, especially the Acceleration Plan for the Reduction of Maternal Mortality (**Colombia**), the Intersectoral policy for the prevention of teenage pregnancy (**Ecuador)**, and the Comprehensive Care Protocol for Victims/Survivors of Sexual Violence (**Honduras**).

EQ.1.3. What is the beneficiary population's perception of the importance of addressing issues related to maternal and child health, women's health, and adolescent health?

Finding 5. The perception of the beneficiary population, including health personnel, local authorities, and community representatives, highlighted a strong appreciation for components related to maternal, women's, and adolescent health.

- Key informants highlighted that the Project aligned with pre-existing local priorities and responded to long-standing demands for reproductive health care, adolescent pregnancy prevention, and strengthened services for women in vulnerable situations.

- The relevance of the comprehensive approach, ongoing staff training, and technical support from PAHO was mentioned as a key factor in enabling beneficiaries to perceive concrete improvements in access to and quality of sexual and reproductive health services. For example:

    - In **Bolivia**, a respondent stated that "…the Project has been aligned with local priorities in maternal and child health, which has allowed the actions to be better received and sustained by local teams"[4].

    - In **Peru**: "…traditional birth attendants and community agents were trained and are now better equipped to identify obstetric emergencies" and "…the community values the respect shown for their ancestral knowledge while promoting maternal and neonatal health through new approaches"[5].

- The individual and group interviews conducted with women beneficiaries in rural areas of **Guyana**, as well as with adolescents and young people in rural areas of **Guyana** and **Ecuador**, have shed light on the importance of the problems addressed by the Project and the flexibility and adaptability it has demonstrated in addressing them.

    - In **Ecuador** the adaptability and participatory nature of the Project were consistently highlighted by key informants as factors that enhanced its contextual relevance. Stakeholders emphasized that the Project reached rural and hard-to-access territories, where few health initiatives had previously been present, and adjusted its strategies accordingly based on local realities. The territorial approach allowed for the inclusion of adolescent leadership schools and intercultural practices, addressing sensitive topics such as early pregnancy and gender-based violence. Although community consultations were not always systematic, the openness to local voices and needs helped shape more relevant and accepted interventions, fostering a sense of ownership and sustainability at the community level: "…Leadership schools for teenagers have been places where pregnancy, violence, and sexual health are discussed, topics that were previously invisible"[6].

    - In **Guyana** the adolescents and young people consulted highlighted the flexibility and receptiveness of regional and local health services in organizing spaces and days of care as a positive aspect. The adolescents and young women reported having accessed the services on the recommendation of others or professionals. They highlighted the friendliness of the staff, personalized attention, and respectful treatment as key elements in making them feel comfortable. They found it a welcoming space where they could express themselves and receive valuable information[7].

    - A group interview with members of the Guyanese School Health Clubs revealed significant changes in terms of youth empowerment, adolescent health promotion, and community strengthening. The training received was positively evaluated in terms of a structure adapted to the local cultural and linguistic reality. This has been reflected in the inclusion of terms in the Makushi language[8] in the production of materials. Additionally, the club's activities included community campaigns on social media platforms, which were well-received. The suicide prevention video had more than 11,000 views, complemented by talks at school assemblies. Finally, the active participation of adolescent boys was highlighted, overcoming initial resistance

[4] Interview with Key Informant, Bolivia. IHWAG, 2025.
[5] Interview with Key Informant, Peru. IHWAG, 2025.
[6] Interview with Key Informant, Ecuador. IHWAG, 2025.
[7] Transcript of the Group Interview with two adolescents and young adults from Bartica, Guyana. IHWAG, 2025.
[8] It is an indigenous language of the Carib family spoken mainly in Brazil, Guyana, and Venezuela. It is one of the most widely spoken Caribbean languages and is considered to be in an endangered language by the United Nations Educational, Scientific and Cultural Organization (UNESCO).

through personalized communication strategies and creating safe spaces for dialogue[9]. Participants emphasized the dedication and continuity of the Project team's visits (from PAHO and the Ministry of Health), differentiating them from other similar initiatives. The training received the highest score, thanks to its participatory approach, use of incentives (such as T-shirts), and age-appropriateness for adolescents[10].

- The adolescents and young women in **Guyana** felt listened to and supported in planning their future as young mothers. As some of them already work or have entrepreneurial projects (such as contract sales or home care), they valued very positively that the Health Center has helped them to imagine a life project compatible with motherhood, with explicit and safe references on how to take care of their health and that of the baby, as well as the possibility of forming networks among themselves[11].

    - The testimony of the young women in Bártica, **Guyana,** highlighted the importance of providing sensitive, accessible, and respectful services to support their life trajectories. In this context, the Project was valued as a positive experience, with a high potential for impact if its components of closeness, continuity, and comprehensive support are expanded and consolidated.

5.2. Effectiveness

EQ.2. After Project implementation, what is the level of achievement of the results and indicators established in the Performance Measurement Framework and overall Project monitoring?

Finding 6. The Project showed positive overall performance, with varying degrees of progress across the results framework.

- Project performance was evaluated against its PMF (Annex 8). As shown in Table 4, the Project demonstrated substantial achievements in ultimate outcomes and key immediate results. Still, it fell short in several intermediate and systemic indicators, reflecting both the successes and the structural challenges of implementation.

- The **ultimate outcome indicators**—maternal mortality ratio, adolescent fertility rate, and neonatal mortality rate— were met. Most **immediate outcome indicators** were also fully achieved, particularly those related to adolescent health standards, post-rape care services, integration of health promotion, intersectoral policies, and mechanisms for women's and adolescents' participation and awareness of sexual and reproductive health and rights. However, progress was uneven among **intermediate outcomes**: while some advances were noted in family planning coverage and institutional responses to equity and human rights, other indicators were not met, including those related to skilled birth attendance, and mother-to-child transmission (MTCT) of HIV and syphilis.

Table 4: Progress towards the Ultimate, Intermediate, and Immediate Outcome indicators contained in the PMF, IHWAG Project (2021-2024)

INDICATORS	BASELINE DATA	FINAL VALUE 31 December 2024	TARGET TO 2025	COMMENT
ULTIMATE OUTCOME				
Maternal Mortality Ratio (MMR) (deaths per 100,000 live births)	103	57.4	69	The indicator was achieved.

[9] Transcript of interview with members of the School Health Club, Guyana. IHWAG, 2025.
[10] Idem.
[11] Idem.

Fertility rate in adolescents aged 15–19 years (births per 1,000 adolescent girls)	69.2	61.6	62.3	The indicator was achieved.
Neonatal mortality rate (per 1,000 live births)	11.8	9.8	10.3	The indicator was achieved.
INTERMEDIATE OUTCOME				
Proportion of women and adolescents of reproductive age (10–49 years) who have their need for family planning satisfied with modern contraceptive methods	71.4	73.1	80.7	While modest progress was made, the indicator was not achieved.
Proportion of births attended by skilled health personnel	95.4	91.2	97.3	The indicator was not achieved.
MTCT Plus: Rate of mother-to-child transmission of HIV	12.5	11.0	2.1	The indicator was not achieved.
MTCT Plus: Rate of mother-to-child transmission of HIV and syphilis	0.9	0.8	0.5	The indicator was not achieved.
Number of countries with institutional responses and accountability mechanisms advancing health equity, gender and ethnic equality in health, and human rights	0	4 (BOL, COL, ECU, HON)	5 (BOL, COL, ECU, HON, PER)	While significant progress was made, the indicator was not achieved.
Number of countries and territories with recent data (≤5 years) on the proportion of women aged 15–49 years making their own informed decisions regarding SRH	3 (BOL, COL, GUY)	0	6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was not achieved.
IMMEDIATE OUTCOMES				
Percentage of women and young girls using modern methods of contraception	61.3	60.6	69.5	The indicator was not achieved.
Number of countries implementing national standards for quality health care services for adolescents	4 (BOL, ECU, GUY, PER)	6 (BOL, COL, ECU, GUY, HON, PER)	6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved.
Number of countries that increase UBAT (units of blood available for transfusion per 1,000 inhabitants) by ≥5% per year to the target of 30 UBAT	0	4 (BOL, COL, HON, PER)	1 (COL)	The indicator was achieved.
Number of countries providing comprehensive post-rape care services in emergency health services (per WHO guidelines)	0	0	6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was not achieved.
Number of countries with strategies to strengthen first-level care capacity, mainstreaming SRH services	0	3 (BOL, HON, PER)	6 (BOL, COL, ECU, GUY, HON, PER)	While modest progress was made, the indicator was not achieved.
Number of countries and territories generating, analyzing, and using data and information disaggregated by context	1 (COL)	6 (BOL, COL, ECU, GUY, HON, PER)	6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved.
Number of countries with mechanisms for ongoing monitoring of health inequities affecting women and adolescent girls	0	4 (BOL, COL, ECU, PER)	3 (BOL, COL, PER)	The indicator was achieved.

Percentage of women/adolescent girls aware of their SRHR	NA	80.0%	60%	The indicator was achieved.
Number of countries with mechanisms for women and adolescent girls to engage in public policy development, monitoring, and evaluation	2 (COL, GUY)	6 (BOL, COL, ECU, GUY, HON, PER)	6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved.
Number of countries integrating health promotion into health services based on PHC	1 (BOL)	6 (BOL, COL, ECU, GUY, HON, PER)	6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved
Number of countries implementing intersectoral policies to address the social determinants of health of women and adolescent girls	3 (BOL, COL, PER)	6 (BOL, COL, ECU, GUY, HND, PER)	4 (BOL, COL, HON, PER)	The indicator was achieved.

Source: PAHO (2025). Improving Health and Well-being of Women, Adolescents and Children in Vulnerable Situations in Latin America and the Caribbean (IHWAG) Project: Final Report Year 4.

Ultimate Outcome: Improved health of women and adolescents in situations of vulnerability in Bolivia, Colombia, Ecuador, Guyana, Honduras, and Peru

- During the 2021-2024 cycle, the Project made tangible progress toward achieving its overall objective in health outcomes, despite specific measurement gaps and challenges persisting. The maternal mortality ratio decreased from the baseline of 103 to 57.4 deaths per 100,000 live births, consistent with the expansion of prenatal coverage and emergency obstetric care.

- Indicators of adolescent reproductive health and autonomy show a similarly favorable, although heterogeneous trend. Among young women aged 15-19 years, the fertility rate fell from 69.2 to 61.65 births per 1,000. Neonatal mortality rates decreased from 11.8 to 9.83 per 1,000 live births; however, Guyana (16.08) and Bolivia (12.66) continue to maintain rates that reflect inequalities in the quality of perinatal care between countries.

- These results demonstrate that the Project components, which focused on strengthening the maternal and child health network and providing critical inputs, constitute essential contributions. However, they also reveal that the sustainability of these achievements depends on addressing territorial gaps, improving data collection, and changing the norms and conditions that perpetuate the vulnerability experienced by women and adolescents.

Analysis of the intermediate outcomes

Intermediate Outcome 1100: Access to and coverage of comprehensive sexual and reproductive health (SRH) services

- The data show some progress, although not uniform, in meeting the demand for family planning with modern methods: the average of the six countries in the Project rises from 71.4% to 73.1%, driven by achievements in Colombia (87.2%) and Ecuador (84.5%). In comparison, Honduras lags (56%), and Bolivia barely reaches 60%. In terms of skilled birth attendance, there was a slight overall drop (from 95.4% to 91.2%), related to the situation in Honduras (57.3%), which places this country outside the range of universal coverage achieved by Peru (98.6%), Bolivia (98.3%), and Colombia (98.6%).

- Regarding persistent barriers to expanding access to health services and specialized treatment, administrative obstacles, the shortage of specialized personnel, and the use of approaches that are not focused on multidisciplinary teams stand out. In Colombia, for example, "...Many patients with depression were left without follow-up because there was no psychologist in the area..." which has also been seen in other locations, such as Santa Bárbara, Honduras, where "...high turnover of

medical personnel and lack of incentives in rural areas affected the continuity of services. The creation of incentives for health personnel who remain in the communities was proposed." At the regional level, "...when the budget is limited to a specific stream, such as sexual and reproductive health, it is difficult to sustain multidisciplinary teams. A more comprehensive approach is needed to strengthen access..."

Intermediate Outcome 1200: Empowerment and leadership of women and adolescents

- Between 2021 and 2024, of the five countries that had intended to do so, four (**Bolivia, Colombia, Ecuador, and Honduras**) incorporated institutional response and accountability mechanisms for gender equity, ethnicity, and human rights in health. This progress, from zero to four, validates the strategies adopted.

- On the other hand, the number of countries with recent data on the ability of women (15-49 years old) to make informed decisions about sexual relations and contraceptive use fell from three to zero, because the available national surveys were more than five years old. This setback highlights the limitations of information systems in capturing the dimensions of bodily autonomy and reveals that normative advances do not automatically translate into evidence production.

Analysis of the immediate outcomes

The Project shows progress in the generation of norms, data, and participatory governance, while progress in coverage, especially in modern contraception and post-rape services, is not uniform.

Immediate Outcome 1110: Capacity of health facilities to provide comprehensive SRH and maternal health services based on the PHC approach

- The capacity of health facilities to provide comprehensive SRH and maternal health services within a primary health care framework reflects uneven progress across the six countries. The leading indicator of satisfied demand for modern contraception has remained virtually stagnant, declining slightly from 61.3% to 60.6%, with marked disparities ranging from 77% in Colombia to only 37.2% in Guyana. This scenario suggests that the availability of contraceptive commodities is insufficient without sustained community outreach targeting adolescents, rural populations, and ethnic groups.

- In contrast, progress is evident in the adoption of national quality standards for adolescent care, which increased from four to six countries, and in the expansion of critical resources such as blood for transfusions, with **Bolivia**, **Colombia**, **Honduras**, and **Peru** reporting annual increases of 5% or more. Despite these advances, a gap remains in comprehensive post-rape care and the establishment of emergency protocols aligned with WHO standards.

Immediate Outcome 1120: Capacity of government authorities to address SRH and maternal health inequities through PHC

- **Bolivia**, **Honduras**, and **Peru** implemented strategies to strengthen the first level of care by integrating SRH services. Although progress is modest, the Project managed to advance the regulatory agenda in areas with weaker primary coverage. However, there are still budgetary or political barriers that limit the replication of Project activities in other territories, especially in **Colombia**, **Ecuador**, and **Guyana**.

Immediate Outcome 1210: Knowledge and participation of women and adolescents

- Country offices report that 80% of the women and adolescent girls surveyed are now aware of their sexual and reproductive rights. As for the growth of formal spaces for participation, mechanisms have been created for women and adolescents to influence the formulation and evaluation of

public policies (from two to six countries), a sign that the advocacy component of the Project has permeated the institutional architecture.

Immediate Outcome 1220: Intersectoral coordination and action on social determinants

- Six countries integrate health promotion into primary health care (PHC) services today, compared to one in 2021. They have intersectoral policies to address social determinants affecting the health of women and adolescents, which, to a certain extent, reflect an appropriation of the equity agenda.

Analysis of the outputs (products and activities)

- Regarding Project outputs and activities (Table 5), significant levels of effectiveness were achieved across the 19 indicators, as 17 of the established goals were met, and progress was made on two.
- However, the gap between the outputs delivered and improvements in coverage indicates that external or structural factors, such as health crises, turnover of authorities and health personnel, and insecurity, have slowed ownership in certain intervention countries. The high level of financial execution and solid technical production constitute a favorable basis for closing these gaps from the perspective of the initiatives' sustainability.

Table 5: Main achievements of the IHWAG Project (2021-2024)

Expected Result	Main achievements (2021-2024)
Strengthening health service delivery	*Professional capacities* • 61,041 health professionals were trained in sexual and reproductive health, maternal and adolescent health (77% women), far exceeding the projected targets. *Organizational capacities* • 99 new technical guides. • 976 establishments with FP protocols with a rights-based approach. • Non-pneumatic devices for obstetric shock were provided to 609 health facilities. • Clinical simulation centers were set up and equipped in Bolivia, Guyana, and Honduras. *Increased safe blood available for transfusions*: • Four countries (Bolivia, Colombia, Honduras, and Peru) increased the number of units per thousand inhabitants. *Expansion of prenatal telemedicine (Honduras, Peru) and simulation centers (all).* • Pilot strategies for prenatal care via teleconsultation were implemented in Peru and Honduras, benefiting 307 women in rural areas. • Availability of disaggregated SIP Plus systems installed. • The SIP Plus system was expanded to new regions of Guyana and referral hospitals.
Informed demand and empowerment	*Information sharing, awareness raising, and cross-cultural perspectives on healthcare* • Community campaigns with brigades, IUDs/implants, and culturally adapted communications for health (C4H) materials. • Knowledge Dialogues and meetings on maternal and neonatal health were held with indigenous peoples in five countries, promoting an intercultural approach to care. *Education and adolescent participation* • 5,075 women and adolescent girls were trained in sexual and reproductive rights. • Leadership schools and school clubs' initiatives were organized and highlighted in Ecuador and Guyana as essential spaces. • Digital platforms such as *YouthSpeak 360* and *Sexualidad sin Misterios* (Sexuality Without Mysteries) were promoted in Ecuador and the Region. *Women's empowerment and leadership* • Networks of female mayors were strengthened across the targeted countries. They are shaping the public health agenda, with municipalities contributing to the mainstreaming of sexual and reproductive health, as well as maternal mortality, into planning and, to a lesser extent, into budgeting, where significant obstacles persist to facilitate resource allocation and public investment.

Coverage	*Contraceptive Methods.* • 13,552 professionals (77% women) were trained in long-acting contraception, and subdermal implant and IUD donation brigades. *Institutional care during childbirth.* • Although stable at the national level, the proportion of births attended by trained personnel increased in priority territories in Bolivia and Peru (for example, in Ucayali, it rose from 75% to 92% between 2022 and 2024). In Amazonian territories, the rate rose from 85% to 98%.

Source: Pan American Health Organization, IHWAG Project Final Report (2025).

EQ.2.1. To what extent did the Project respond to the challenges in access to and coverage of sexual and reproductive health and maternal health services in the implementation territories?

Finding 7. The Project has provided a high and verifiable response to the challenges of access and coverage of sexual, reproductive, and maternal health services in the six intervention countries. However, gaps persist that need further strengthening.

- The combination of regulations, equipment provision within the framework of capacity building, extensive training, and community strategies has successfully expanded the availability, quality, and acceptability of SRH and maternal health services, particularly in Indigenous, rural, and hard-to-reach communities. The goals of expanding access to modern contraception and implementing key technologies were met or exceeded. At the same time, full coverage of births with skilled personnel and the usability of some clinical registries remain challenges to be consolidated in the future.

- Access to healthcare at the territorial level was highlighted positively during the interviews and focus group discussions, as support for community networks that helped expand health service coverage and improve access to healthcare.

  - In **Ecuador**: "…it was important to work with promoters in the field, train them, and accompany them for referrals and follow-up"[12].

- The interviews with key informants demonstrated that the coordination between PAHO and the Ministries of Health, as well as the experiences where primary health care, sexual and reproductive health, GBV prevention services, and mental health have been successfully integrated, were specifically highlighted by the key informants interviewed.

  - In **Bolivia**: "...this was the third phase of a partnership between the National Health Insurance Fund and the Ministry of Health (MoH). The Comprehensive Health Units were strengthened"[13].

EQ.2.2. To what extent did Project implementation reach target populations in remote and hard-to-reach geographic areas?

Finding 8. The Project expanded health services and provided essential information on sexual, reproductive, and maternal-neonatal health to previously underserved areas—primarily rural, remote, and hard-to-reach communities.

- In **Honduras** and **Peru**, the tele-consultation model, with the support of community health volunteers, connected pregnant women in rural areas with obstetricians online, after providing three facilities and 18 volunteers with telemedicine equipment and clinical blood pressure measurement kits with a "traffic light" alert system. The experience was made visible in the "Digital Hope" story and increased community confidence in health services.

[12] Interview with Key Informant in Ecuador. IHWAG, 2025.
[13] Interview with Key Informant in Bolivia. IHWAG, 2025.

- In **Colombia**, the "Sponsor Hospitals" strategy reinforced providing specialized information to support local health teams from high-complexity hospitals, including referral guidelines, all of which were included in the National Acceleration Plan for the Reduction of Maternal Mortality. This initiative expanded the initial experience to all the country's departments.

- In **Bolivia**, **Colombia**, **Ecuador**, and **Peru**, more than 300 midwives from Indigenous and Afro-Descendant communities received intercultural training and clean obstetric delivery kits, reinforcing safe care in dispersed Indigenous and Afro-Descendant communities.

- The Project deployed SIP-Plus in *offline* mode and situational dashboards in Region 1 (Barima-Waini), as well as Regions 2, 7, and 9 of **Guyana**, and integrated it with Wawa Red in the **Peruvian Amazon**, enabling continuous surveillance even in the absence of stable connectivity. It also included Indigenous and mining communities in **Guyana** and **Colombia** in education, mental health, and gender-based violence actions in the same remote territories.

- Interviews with key informants indicated that, while gender and interculturality were included as cross-cutting principles rather than stand-alone components, stakeholders consistently highlighted the need to strengthen their operational integration in future interventions—particularly to address better the needs of women, adolescents, and the most marginalized groups.

EQ.2.3. To what extent did the Project contribute to strengthening the leadership of women and adolescents in the implementation territories regarding the exercise of their sexual health, reproductive health and rights?

Finding 9. The Project bolstered women's and adolescents' leadership in participating territories through a range of context-specific approaches: training health personnel; providing information for informed health decisions; fostering political influence via networks of mayors and civil-society leaders; empowering communities by supporting youth and adolescent leaders and volunteers; and elevating the social standing of traditional midwifery.

The Project contributed to the strengthening of women and adolescent leadership in a sustained manner:

- Between 2022 and 2024, the Project promoted the participation of 4,196 women and adolescents in community and municipal decision-making platforms and it directly trained more than 3,500 women and adolescents in their sexual and reproductive rights and advocacy skills, including train-the-trainer sessions and school health clubs that adopted the peer education model.

    - In **Ecuador**, the SRH information and education strategies for adolescents were strengthened through the creation of a digital platform "Sexuality without Mysteries" coordinated by the MoH. This is a space for exchange that allows adolescents to get information, ask questions, and discuss their problems with the National Adolescent Health Program.

- In parallel, it created or reactivated at least 78 advocacy organizations and networks that drive the sexual and reproductive health agenda in the territories.

- The Project applied the "Knowledge Dialogues" methodology with community leaders in five (**Bolivia**, **Colombia**, **Ecuador**, **Honduras**, **Peru**)countries, covering topics such as sexual health, culturally safe childbirth, and neonatal health with agreed-upon local action plans, and made it possible to promote the leadership of women in the communities (midwives, volunteers, community workers), as well as that of adolescents and youth.

- The strengthening of the Network of Women Mayors for Healthy Municipalities was promoted in all participating countries. Its work plan was incorporated into the Movement of Healthy Municipalities, Cities, and Communities (MCCS) of the Americas. The strengthening of the Network enabled it to influence decision-making, priority setting, and public budgets. In contexts such as **Bolivia**, their thematic priorities were also incorporated into Municipal Local Development Plans.

In **Bolivia**, **Honduras**, and **Peru**, the provision of spaces and opportunities for collaboration, networking, leadership, and decision-making has been highlighted. Finally, a Network of Women Mayors was established at the First International Meeting in 2024 (120 local decision-makers signed a declaration of commitment).

- These actions were complemented by methodological tools and media visibility, which positioned their testimonies as a central part of the communication strategy.

EQ.2.4. What strategies can be highlighted as innovative, including the incorporation of communication actions, during the implementation of the Project's activities?

Finding 10. The Project introduced methodological and communication innovations (Tables 6 and 7, respectively) that strengthened health systems across the six countries. Key advances include strategic planning, digital transformation of maternal and neonatal care through telemedicine and the SIP Plus platform, and the integration of ancestral and biomedical knowledge. The initiative promoted the routine use of data for clinical decision-making, developed culturally adapted tools, expanded the gender agenda on maternal care, and leveraged multichannel storytelling to amplify local voices.

- The Project fostered innovations that contributed to more equitable and quality care in rural and underserved areas, offering a replicable model for future regional efforts[14]. Within its framework, PAHO has adopted several innovative strategies to amplify the intervention's positive impacts. These strategies were geared towards communications, and the methodologies developed and adopted to carry out the planned actions were also taken into account.

- The Project had a Communication Strategy and Plan, and a specialist who has performed her functions in close collaboration with the communication focal points of the PAHO Country Offices and the technical specialists.

- Likewise, other key innovations identified have focused on digital transformation through the adoption of telemedicine strategies; the strengthening of liaison between ancestral knowledge and formal health systems through the Knowledge Dialogues; strengthening Perinatal Information System (SIP Plus) to expand access to data and identification of trends; the production and use of culturally relevant tools; developing the work agenda on equity and human rights; and the adoption of narratives adapted to multiple communication channels and platforms and social networks.

- Collectively, these innovation mechanisms—anchored in digital transformation, multisectoral coordination, and community engagement—enhanced the relevance, scalability, and effectiveness of the Project across all six countries, despite persistent structural limitations in their health systems.

Table 6: Main methodological innovations of the IHWAG Project (2021-2024)

Dimension	Innovation	Evidence
Digital transformation with a community focus	• Hybrid tele-consultations (telephone + video call) that combine remote and face-to-face accompaniment by volunteers and midwives in remote rural areas with difficult access.	• The story "*Digital Hope: telemedicine for rural pregnant women in Honduras and Peru*" shows how community calls increase confidence and result in 82% of pregnant women starting their vaccination schedules on time.
Dialogue between ancestral and formal knowledge	• Knowledge Dialogues have been consistently highlighted as an appropriate and effective approach to reducing maternal and neonatal mortality.	• The story "Traditional midwives: Saving Lives..." details how the combination of ancestral medicine and biomedical tools

[14] Here, we define innovation as turning an idea into social value through successful implementation. It requires creativity, discipline, experimentation, and learning.

Dimension	Innovation	Evidence
	• Training programs have been implemented for more than 1,000 traditional birth attendants in five countries. • Portable perinatal technologies (such as Pinard Bell and vital signs monitoring) adapted for use in environments without regular electricity have been introduced. • This intercultural approach was integrated through the authorization of Indigenous midwives to be present during hospital births.	can detect preeclampsia or appendicitis early.
Maternal health data management and analysis	• The implementation of SIP-Plus—the web-based version of the Perinatal Information System—and its module for safe abortion has strengthened information management at various levels of care within the National Health System. \ • Although there is room for improvement in the design, the adoption of the system has enabled the digitization of medical records for pregnant women and girls, facilitated case tracking, identified risks early, and enhanced user interaction.	• The article "Hospitals in Honduras highlight the use of the SIP..." highlights how data control reduced the loss of clinical information and facilitates epidemiological surveillance. • The interviews conducted in Guyana demonstrated how it has been integrated at various levels of care (national, regional, and local) in the prioritized territories and has successfully involved a private hospital in Georgetown. • The MUSA Network of 29 hospitals that share real-time indicators and data quality control models.
Protocols and tools for culturally relevant care	• Tools have been developed and utilized for culturally relevant healthcare for Indigenous women and youth. • Promoted participatory spaces where the health sector and Indigenous/Afro-descendant populations in rural or remote areas in the intervention countries co-designed protocols and tools.	• Coverage of the Culturally Safe Childbirth Tool workshop in Honduras (April 2024) with the participation of medical, nursing, and midwifery managers. National training has been developed to incorporate an intercultural approach to childbirth and the puerperium.
Expanding the health equity and human rights agendas	• The Project has been flexible in adapting and expanding the agendas on health equity and human rights, depending on the regulatory and public policy frameworks of the respective countries of intervention regarding gender equality in health. • In Bolivia, an intersectional analysis methodology applied to a dialogue with LGBTIQ+ groups (Bolivia) has been used to co-create the 2025 inclusive health agenda. • In Guyana, a gender perspective has been adopted in the identification of the needs of adolescent boys and young men, their integration in the promotion of sexual and reproductive health, and suicide prevention.	• The Note "Honduras leads a dialogue on menopause" highlights the commitment to integrating the care of menopausal women at the primary care level. First National Forum on Menopause as a public health and social justice issue (Honduras, 2024). • Acknowledgment of the historical exclusion of LGBTIQ+ adolescents from SRH initiatives, which have traditionally focused narrowly on pregnancy prevention. In Bolivia, the application of an *intersectional gender analysis tool* enabled a deeper understanding of the health needs of LGBTIQ+ youth, leading to inclusive participatory workshops and the co-creation of a cooperation agenda between LGBTIQ+ collectives and the MoH. This process helped expand the conceptual scope of gender and promoted meaningful engagement between

Dimension	Innovation	Evidence
		marginalized communities and health authorities. Nonetheless, key informants stressed the need further to integrate LGBTIQ+ perspectives from the outset of future initiatives and to adopt a holistic approach that responds to the full range of health needs and rights of LGBTIQ+ populations.

Source: Pan American Health Organization, IHWAG Project Communication Products (2021-2024).

- The innovations introduced in the design of education, communication, and community awareness materials enabled better adaptation to local needs and preferences. The following table describes each dimension and highlights its contribution to achieving the Project's objectives.

Table 7: Main communications innovations of the IHWAG Project (2021-2024)

Tool	Elements of Innovation	Contribution to the achievement of Project objectives
Multi-platform and multi-format narratives	• The Project produced audiovisual materials, written press releases, and social media posts, utilizing a convergence of web stories (long-form, photojournalism), YouTube videos, Spotify podcasts, and microcontent on Facebook and Instagram for diverse audiences. • Multilingual publications were produced in Indigenous languages (**Guyana, Peru**) to broaden the regional scope. Systematic use has also been made of testimonials from beneficiaries, volunteers, and young people (in the case of **Guyana**, the School Health Clubs), which humanize the evidence. However, in the fieldwork interviews conducted in **Guyana**, for example, the importance of improving the design with a greater focus on graphic and written pieces, as well as the use of local languages, has been highlighted to enhance awareness-raising, community mobilization, and preventive interventions.	Communication products range from 8M podcasts to network threads that amplify the Project's messages and the support from GAC. • In Ecuador, the digital platform Sexualidad sin Misterios (Sexuality without Mysteries) was created to strengthen adolescents' awareness of their sexual and reproductive rights.
Poster and tele-consultation kit for community health workers	• Hybrid community service model: the volunteer visits, takes blood pressure with a "traffic light" device for measuring blood pressure, and then links the pregnant woman with the health professional by telephone. Structured interview sequence and alarm checklist that can be used offline.	• Allows for increased prenatal contacts without increasing staffing. Facilitates rapid decision-making.
Notebook/Handbook for community health workers	• The notebook was created by the Colombia Office and then adapted by Honduras and Guyana. Includes a customizable calendar, test charts, a QR code app, and postpartum and breastfeeding quick guides.	• Empowers CHW as a "digital extension" of the team. Promotes continuity of care after the call.
Neonatal Care Flipchart and Guide	• Utilized the Knowledge Dialogues Methodology to foster intercultural consensus among promoters, families, and services on neonatal care. Risk scheme based on colors and community actions.	• Integrates ancestral and biomedical knowledge. Creates differentiated visitation routes according to vulnerability level.
Educational support material on contraception	• Two-sided design: one side for health personnel and the other for the user, allowing simultaneous information. Thematic tab system (postpartum IUD, postabortion, implants) for quick navigation.	• Improves the effectiveness of information and awareness-raising in high-flow environments. Promotes informed decisions with a rights-based approach.

Tool	Elements of Innovation	Contribution to the achievement of Project objectives
Basic Manual for Applying the Culturally Safe Childbirth Promotion Tool	• Annual self-assessment with five dimensions and 43 indicators applicable from the perspectives of indigenous users, staff, and external observers. • Results were presented on a color scale that prioritizes improvement plans. • Based on regional consensus and validated in eight countries, it is potentially adaptable to other ethnic groups.	• Provides objective metrics for monitoring cultural relevance. • Facilitates the development of participatory improvement plans.
IHWAG bilingual infographic	• Scrolling bar format for web and print; features achievements, figures, and interactive links to YouTube listings.	Turn technical data into high-impact visual storytelling for donors and media.
Toolkit for Effective Communications	• The Toolkit provides practical step-by-step instructions for identifying communication opportunities, collecting testimonies, capturing culturally sensitive audiovisual materials, managing social media visibility, and overseeing the work of external communication agencies. It also includes clear recommendations on inclusive language, gender, and multicultural sensitivity, representation of LGBTIQ+ communities, and accessibility for persons with disabilities, ensuring that all project-related content reflects PAHO and Canada's shared commitments to gender equality, equity, and human rights.	It contributed to stronger community engagement and a more harmonized regional communication strategy that reinforced the Project's technical and strategic objectives.

Source: Pan American Health Organization, IHWAG Project (2021-2024).

- The combination of printed, digital, and self-assessment tools permitted the expansion of the Project to other rural, remote, or hard-to-reach areas in the countries, even in areas with structural problems of limited connectivity.

- Different innovative tools, such as the ´Basic Manual for Applying the Culturally Safe Childbirth Promotion Tool', generated actionable guidance for PAHO and Ministries of Health's teams on the ground. They also created a continuum from postpartum contraception to neonatal follow-up and integrated telemedicine into the community-based approaches. Here, innovation has been fostered through participatory approaches and methodologies, transforming data into evidence for informed decisions on designing and adapting healthcare services, and facilitating digital expansion in contexts where connectivity has traditionally been limited.

- The Project Communication Strategy and Plan, focused on stories and the voice of local users and providers, contributed to increasing social acceptance and legitimacy of the technical interventions. In contrast, the strategic use of channels, combined with stories tailored for decision-makers and micro-content for the public, strengthened the strategies of information, awareness, and community mobilization to change the population's knowledge, attitudes, and practices.

    - The communication products effectively incorporated elements of cultural and gender relevance, conveying messages of non-discrimination and referencing mechanisms for dialogue with Indigenous and Afro-descendant communities.

EQ.2.5. To what extent did the Project contribute to strengthening gender, human rights, and cultural diversity approaches in health services?

Finding 11. The Project made a significant contribution to integrating gender equality, human rights, and cultural diversity approaches within health systems across the six countries. This was achieved by influencing policy and normative frameworks, strengthening institutional and individual capacities—

particularly of female health personnel—and ensuring greater inclusion of traditionally excluded groups. However, challenges remain in achieving universal accessibility and non-discrimination.

- The Project contributed in multiple ways to strengthening the integration of gender equality, human rights, and cultural diversity approaches. This was achieved through the creation of enabling political and normative environments[15], expanded access to information and leadership development, and the enhancement of individual and institutional capacities, with a central focus on health personnel, particularly women, who comprise most of the health workforce in the countries of intervention.

- *Creation of enabling environments for gender equality, human rights, and cultural diversity:*

    - The Project influenced public policies, normative frameworks, and operational standards by developing and adapting technical guidelines and protocols, and by shaping subnational public health agendas, particularly through the work of Healthy Municipalities Networks and the active participation of women mayors. In **Bolivia**, this translated into the development of Municipal Action Plans and greater visibility of Project themes within local public health agendas. However, the lack of dedicated budget allocations remains a challenge.

    - In **Honduras,** the Project influenced the set-up of the Gender Unit at the Secretariat of Health (SESAL)[16]. According to interviews with key informants, these actions demonstrated a straightforward integration of gender, human rights, interculturality, and territoriality. Services were adapted to the cultural worldviews and practices of Lenca and Maya Indigenous communities, ensuring respectful and context-appropriate engagement. A territorial lens guided the planning and deployment of mobile brigades and differentiated services, allowing interventions to respond to the specific needs and characteristics of each locality and population group. While gender and human rights considerations were consistently applied in service delivery, stakeholders noted that other areas (for example, disability) remain less developed and require further strengthening to ensure full accessibility and inclusion[17].

    - The Project shaped the normative frameworks by promoting the adoption of 27 sexual and reproductive health regulations, plans or guidelines, as well as the updating or creation of protocols with explicit references to gender equality, cultural relevance, and the application of the principle of non-discrimination, thus providing a common denominator to organize the provision of health services for women, adolescents and young people, especially those in rural, remote and hard-to-reach areas, Afro-descendants and Indigenous communities, as well as migrants and residents of extractive and mining areas. In clinical care, five of the six countries (all but Guyana) already have post-sexual violence protocols aligned with at least four of the five WHO components, thanks to the rapid assessment tool applied through the Project together with the Ministries of Health, and 43 intercultural maternal indicators that were agreed with Indigenous communities for culturally safe childbirth and puerperium, with a neonatal pilot scheduled for 2025.

    - The inclusion of adult and young men in Project interventions, although not systematic, has shown the adoption of a gender approach in contexts such as **Guyana**, where they have actively

[15] It is essential to note two important factors at this point. Firstly, PAHO has been working on establishing standard terms and visions for gender equality and equity over the last few years. A recent evaluation suggests the importance of grounding standard definitions and working parameters in addressing gender equality, intersectionality, and equity across different countries. Secondly, it is essential to recall that Member States play a crucial strategic and operational role in designing and implementing public health policies and National Public Health Systems, which underpin the key priorities of the Country Cooperation Strategies implemented in collaboration with the Pan American Health Organization (PAHO) and its respective Country Office.

[16] Executive Decree No. PCM-15-2024, dated 1 June, 2024, published in the Official Gazette No. 36,549 dated 1 June, 2024, with the objective of creating the General Directorate of Population Risks and the Gender Unit.

[17] Interviews with Key Informants, Honduras. IHWAG, 2025.

participated in the School Health Clubs. This has contributed to progress towards a gender- and intersectional-approach, even in regional contexts where the gender equality agenda has been firmly rolled back.

- Likewise, in **Ecuador**, the creation of the Adolescent Clubs and the Leadership School in the territories where the Project is implemented was an effective tool to promote environments for gender equality and human rights. A toolbox was created for these spaces that include informative materials, guides, games, and more, providing information on preventing GBV, promoting empowerment, and advancing sexual and reproductive rights. Two leaders (male and female) interviewed highlighted that these spaces allowed them to talk openly about sexuality, rights, and prevention, and to reach other adolescents in remote areas. However, it is considered insufficient because it does not reach a larger number of adolescents.

- In some countries, traditional midwives and traditional medicine practitioners were included and trained, as was the case in **Bolivia**, **Colombia**, and **Ecuador**. In all these countries, health providers were also trained to interact respectfully and non-discriminatorily with vulnerable populations, especially those with ancestral knowledge and intercultural practices.

- *Inclusion of population groups that have been traditionally excluded or discriminated against in public health policies.*

  - Through highly innovative, locally and regionally based work, it has been possible to reach adolescent girls and women in rural and remote areas, predominantly Indigenous and Afro-descendant women, and women in mining areas. The Knowledge Dialogues methodology, the use of telemedicine solutions, and participatory approaches have played a key role in this work. They enabled the translation of existing priorities into specific activities tailored to this population's needs and preferences.

- *Strengthening access to information, training, and building leadership among women's health providers.*

  - Over sixty-five thousand health service providers were trained through the Project, of which 77% were women. This training focused on a range of Project related topics, including sexual and reproductive health, HIV and sexually transmitted infections (STIs) prevention and treatment, cervical cancer, GBV, the use of data for decision-making, and water, sanitation, and hygiene (WASH).
  - A total of 945 health care providers were explicitly trained in gender equality and health (634 women and 311 men), which contributed to strengthening gender and cultural diversity approaches in health services.

5.3. Efficiency

EQ.3. Were the mechanisms and practices used to manage, monitor, and implement the Project innovative and effective in achieving its overall objectives?

Finding 12. The planning, management, and follow-up mechanisms implemented by the Project and its partners were timely and technically sound, enabling the achievement of the set objectives, considering the institutional and financial conditions of the participating countries.

- Project planning, management, and follow-up mechanisms demonstrated strong contextual adaptability, enabling the achievement of planned outcomes across diverse institutional and financial settings. They proved effective in mitigating systemic constraints, including limited infrastructure, high staff turnover, and suboptimal resource allocation, while reinforcing national stewardship and the sustainability of interventions.

- A critical component was the strategic coordination between PAHO's regional and national offices, which facilitated technical harmonization, avoided duplication of efforts, and promoted efficient resource utilization. This coordination enabled the identification and prioritization of high-impact interventions; however, evaluative evidence suggests that misalignments in execution timelines between governance levels occasionally hindered operational fluidity.

- In all countries, the deployment of coordinators in the Project territories further enhanced operational oversight, enabling agile responses to local implementation challenges.

- In **Colombia** and **Ecuador**, the integration of digital learning tools and real-time data systems facilitated adaptive management and performance monitoring.

EQ.3.1. To what extent did the technical and human resources available for Project implementation contribute to achieving the Project objectives at the regional and national levels?

Finding 13. In all Project countries, the high technical capacity of PAHO staff at the national and regional levels, and especially those based in the Project communities was highlighted, along with their cultural sensitivity, service orientation, and commitment to human rights.

- The technical accompaniment provided by PAHO, both at the national and subnational levels, was described as "valuable", "enriching," and "formative" by institutional and community actors, particularly in territories with high levels of exclusion and rurality.

- Fieldwork led by local teams enabled the adaptation of strategies to cultural contexts (like in **Colombia, Guyana, Peru**), strengthened the capacities of health teams, integrated community actors such as traditional birth attendants and Indigenous leaders (**Bolivia, Colombia, and Ecuador**), and scaled up effective practices in sexual and reproductive health, maternal health, and adolescent health.

- In **Ecuador**, coordination among local human talent, intersectoral roundtables, parish governments, and community organizations expanded the scope of preventive actions, despite budgetary limitations.

- In **Colombia**, the involvement of local physicians and individuals with ancestral knowledge in indigenous areas has strengthened the implementation of emergency obstetric services, as well as the voluntary interruption of pregnancy, from the first level of care.

- In **Bolivia**, working in collaboration with municipal authorities and community leaders was crucial to prioritizing social agendas and reaching hard-to-reach areas.

- In **Guyana**, technical supervision visits were implemented from national and regional coordination, with good articulation with the country's programmatic priorities.

However, persistent challenges were noted in sustaining trained personnel, especially in rural areas, where high turnover among medical personnel and the lack of institutionalization of technical teams affect process continuity, as seen in **Colombia**. Likewise, in some countries (such as **Bolivia** and **Colombia**), the need to integrate indicators for evaluating technical performance and the quality of accompaniment, beyond fulfilling quantitative goals, was highlighted.

EQ.3.2. How efficient was the overall management and implementation of the Project, as well as the monitoring of its objectives and indicators?

Finding 14. Project management and implementation have demonstrated significant efficiency, based on strong inter-institutional coordination, the strategic use of local human and technical resources, and contextual adaptation to local realities.

- According to available records and inputs gathered during technical follow-up meetings, budget execution percentages showed significant progress, starting from 41% of the executed budget in 2021, and progressively increasing to between 78% and 87% in 2023, reaching figures of 93% to 95% in 2024[18]. This sustained growth reflects both the strengthening of the implementing teams' operational capacities and the gradual adaptation of strategies to specific national contexts.

- In analyzing the efficiency criterion, it is essential to examine the evolution of the Project's budget execution throughout its implementation. A review of the consolidated financial information enables the identification of trends in resource allocation and utilization, as well as an assessment of the consistency between strategic planning and the achieved results.

- In terms of expenditure distribution, there is evidence of consistent technical prioritization. Approximately 60% of the executed budget was allocated to component "Increased capacity health institutions to provide SRH, maternal, adolescent girl and women's health services, based on the primary health care approach" (IO 1110), aimed at strengthening services for the prevention of maternal and neonatal mortality, universal access to sexual and reproductive health, and comprehensive attention to gender-based violence. This approach enabled the allocation of resources to key health interventions that directly impact the target population. In turn, 23% of the execution corresponded to component "Strengthened evidence-based to address inequalities in access to sexual, reproductive and maternal health services and rights" (IO 1130, which focused on the development and strengthening of information systems —an essential element for improving the capacity for monitoring, analysis, and decision-making at both local and regional levels.

Finding 15. The Project operated with a Monitoring Plan that generally functioned adequately; however, monitoring and reporting practices were often overly focused on detailed activity-level information, emphasizing descriptive accounts of activities and providing limited analysis and harmonized data to assess the Project's broader impacts.

- The monitoring and reporting system, while functional, generated demands for highly granular information and tended to emphasize activity tracking over impact, leading sometimes to reporting fatigue. Key informants identified the need to simplify indicators, streamline reporting tools, and reinforce project management skills among technical staff to enhance efficiency in future interventions. Despite these limitations, on-site monitoring visits, strong communication flows between regional and country teams, and the strategic deployment of subnational coordinators were seen as highly efficient practices that accelerated implementation and improved responsiveness to local needs.

    - In **Honduras**, surveillance systems were strengthened from the first level of care to specialty hospitals, with cascade referral mechanisms and periodic reports. However, limitations persisted in disaggregating data by ethnic groups and in automating the flow of clinical information.

    - In **Colombia**, monitoring mechanisms were effective at the territorial level, supported by subnational technical teams and participatory methodologies. However, in areas such as Chocó, gaps existed due to high staff turnover and a lack of institutional continuity.

[18] It is important to note that the initial years of project implementation took place during the COVID-19 pandemic or in its immediate aftermath. During this period, national authorities and PAHO offices were still addressing pandemic-related challenges, which likely reduced the priority given to SRH topics and contributed to lower levels of financial implementation.

- **Ecuador** showed a rich experience in territorial monitoring articulated with Decentralized Autonomous Governments (DAGs) and intersectoral roundtables. However, formal follow-up was not always institutionalized or translated into systematic reports.

- In **Peru**, integrated planning and monitoring processes were developed to operationalize regional health networks, utilizing a combination of digital tools and face-to-face mechanisms; however, gaps were identified in the feedback of results at the local level.

- In **Bolivia**, follow-up was sustained through regular PAHO structures, although gaps existed in operational capacity to cover all municipalities, particularly in rural areas with difficult access.

Finding 16. Compliance with the implementation of planned activities varied significantly across countries, shaped by structural, institutional, and operational factors.

- While the initial programming was technically sound, budget execution was uneven due to disparities in local capacities, budgetary allocations, and differing administrative procedures and timelines among countries. Informants from PAHO regional and country teams highlighted that collaboration with local civil society actors tended to be more effective at the community level—where partners facilitated access, trust-building, and operational continuity—than at the national level, where political dynamics and institutional turnover often slowed progress. Coordination with UN agencies was described as positive yet partial, with synergies materializing in some countries but remaining limited in others due to differing mandates and operational rhythms.
- Resource allocation was largely efficient, with approximately 70% of funds invested in technical cooperation for improving maternal and neonatal care; this translated into expanded simulation rooms, strengthened referral systems, and large-scale trainings. However, interviewees noted challenges in maintaining consistent execution patterns across countries, given political volatility, staff rotation, and varying levels of engagement from Ministries of Health.

    - In **Bolivia**, the planned activities were executed efficiently in prioritized municipalities. The MoH demonstrated a strong commitment and a strategic vision aligned with the social determinants of health, a commitment consistently observed at national, departmental, and local levels. The active participation of local actors—particularly women mayors and community leaders—proved critical, as they prioritized social and community well-being over infrastructure-centered agendas. The Project's strategic alliances with key stakeholders further strengthened implementation, while work at the local level was essential given its proximity to the population and its capacity for rapid response. Local staff also played a decisive role through their commitment and sustained efforts. In terms of efficiency, stakeholders reported solid execution of planned activities. Coordinated work enabled the optimal use of existing resources, facilitated access to remote municipalities, and was supported by the logistical arrangements put in place.

    - In **Colombia**, despite the high level of territorial appropriation and the strengthening of institutional networks, delays were identified due to access barriers in remote municipalities, a lack of transportation coverage for women leaders, and logistical difficulties in Indigenous areas.

    - In **Ecuador**, implementation was facilitated by flexible planning that allowed for local adaptations; however, challenges arose in scheduling activities due to insufficient human resources, overlapping institutional agendas, and a lack of continuity in key actor participation.

    - In **Guyana**, while implementation planning was technically sound and aligned with national priorities, execution was affected by delays due to the limited availability of essential technical equipment. Delays in the procurement processes for non-pneumatic shock

garments and for clinical training materials affected the implementation of activities and adherence to the Project timeline.

- In **Honduras**, although significant technical progress was made, implementation was hindered by delays due to limitations in hospital infrastructure, staff turnover, and gaps in institutionalized coordination with community actors, especially in Afro-indigenous areas.

- In **Peru**, the training and operational processes were primarily executed according to schedule, although limitations arose due to geographical dispersion, technical staff turnover, and administrative delays at the regional level.

- These challenges underscore the importance of strengthening procurement planning and logistical coordination to ensure the timely delivery of key inputs across countries.

Finding 17. The Project's financial implementation was assessed positively across the intervention areas, demonstrating efficient management of financial resources, even amid budgetary and operational restrictions.

- The budgetary execution of the Project was evaluated positively across all analyzed countries, reflecting a consistent demonstration of efficient financial resource management, even in environments marked by institutional fragility, operational complexity, and budgetary constraints.

- This favorable assessment underscores a strategic and context-sensitive approach to financial implementation, which enabled progress toward Project objectives without compromising the technical quality, coverage, or relevance of interventions.

- Several enabling factors contributed to this outcome:

  - National teams in **Bolivia, Ecuador, and Honduras** successfully leveraged existing local capacities and community networks to optimize costs and resources. By utilizing pre-established training facilities, institutional infrastructure, and grassroots partnerships, they directed resources toward strengthening human capital and basic infrastructure in maternal, neonatal, and reproductive health, maximizing value in resource-constrained contexts.

  - **Colombia** and **Peru** demonstrated strong results through flexible financial planning aligned with local priorities. This adaptive approach enabled the timely reallocation of resources in response to contextual challenges, enhancing the relevance and viability of interventions in areas with significant institutional gaps, without incurring inefficiencies or exceeding budget thresholds.

  - In **Guyana**, financial efficiency stemmed from technically rigorous planning, focused technical assistance, and sustained multisectoral collaboration. These elements ensured that investments were aligned with national priorities and tailored to the country's structural constraints, allowing for targeted interventions that yielded high returns within a limited fiscal space.

The desk review and interviews with key informants during country visits showed persistent challenges and limitations in subnational and local governments. These challenges were related to the high staff turnover in local health facilities and their limited capacity to document, organize, and report information using existing administrative and technical resources. Added to this were logistical and operational limitations at the territorial level experienced by local governments.

Several testimonies indicated that in **Colombia**, rural medical staff change regularly, which hinders the continuity of training and knowledge transfer. This is clearly a subnational limitation, dependent on the human resource management systems of ministries and local governments. Interviews in **Bolivia**, **Ecuador**, and **Peru** show that in several territories there is a lack of support to the work of the regional health services from the central levels, which limits adherence to monitoring and follow-up processes. On the other hand, at the PAHO Country Office level, obstacles included the management burden of preparing

and submitting reports, the challenges of systematic and continuous evaluation of training processes, and, in specific contexts, interagency coordination.

EQ.3.3. Did the Project's coordination and liaison mechanisms with the various strategic partners contribute to the achievement of the Project results?

Finding 18. The Project's coordination and liaison mechanisms with strategic partners significantly contributed to achieving its results, optimizing the use of technical, human, and financial resources in complex contexts.

- The Project's coordination and liaison mechanisms with strategic partners made a significant contribution to strengthening maternal and adolescent health outcomes. By enabling the efficient use of technical, human, and financial resources—particularly in contexts of institutional fragmentation and socio-territorial disparities—the Project helped expand access, improve service quality, and enhance continuity of care.

- In all six countries, PAHO's technical cooperation fostered intersectoral alignment, reduced duplication of efforts, and reinforced territorial ownership of health interventions. Concrete practices illustrate these gains:

    - Intersectoral roundtables in **Ecuador** and **Honduras** improved governance and accountability.
    - Participatory planning in **Colombia** increased local relevance and buy-in.
    - Collaborative implementation with community health networks in **Peru** expanded service coverage and enhanced equity of access.

- At national and regional levels, interagency coordination—despite challenges such as overlapping mandates and fragmented budgets—has helped to consolidate multisectoral platforms and reach underserved rural, Indigenous, and Afro-descendant communities.
- Strategic inter-institutional coordination—especially with Ministries of Health, municipalities, UN agencies (e.g., UNFPA, UN Women, UNICEF), NGOs, and academic institutions—proved critical for effective, locally adapted delivery of sexual, reproductive, maternal, and neonatal health interventions.

5.4. Sustainability

EQ.4.1. Following the implementation of the Project, have the overall response capacity of the health services and the operational capabilities of local health teams been strengthened?

Finding 19. The Project strengthened both the overall response capacity of health services and the competencies of local health teams through a blend of in-person and virtual training. In several instances, these training courses were opened to professionals from other sectors, creating a critical mass of practitioners equipped with up-to-date knowledge that they can apply both in their current settings and in any new contexts where they may serve.

- Mechanisms such as virtual learning environments, clinical simulation platforms, and structured e-learning curricula enabled the delivery of sustainable, scalable, competency-based training in underserved and geographically dispersed areas, effectively addressing the challenge of human resource volatility and increasing the capacity of health service delivery at the territorial level.
- To amplify knowledge dissemination, PAHO leveraged mass webinars, representing a cost-efficient modality for regional technical updates. Concurrently, the reinforcement of midwifery networks fostered experiential learning, knowledge retention, and the institutionalization of culturally appropriate care models within maternal and reproductive health services.

- The training programmes implemented by the Project, both face-to-face and virtual, was a fundamental pillar for capacity building in the territories.

- The PAHO Virtual Campus for Public Health provided a space for teaching and learning, and in turn, it is a crucial mechanism to ensure the sustainability of individual capacity-building strategies. These training actions were not only aimed at medical personnel: from the operational levels, community personnel and decision-makers, managers or those responsible for programs at the national levels of the MoH; but also included traditional midwives, community promoters, social workers and adolescent leaders, which allowed a wide dissemination of key knowledge on sexual and reproductive health, maternal care and interculturality.

- In this regard, it is worth noting that the PAHO Virtual Campus for Public Health was mentioned in various interviews in **Ecuador** and **Honduras** as a fundamental training space, not only for the health sector, but also for other professionals in different fields.

- In addition to the technical competencies strengthened through the Project, the diverse profiles of training participants—ranging from frontline providers to mid-level managers—demonstrated a strong professional commitment and a high degree of sensitivity to the needs of women and adolescents. This intrinsic motivation, repeatedly highlighted in interviews, has been a key enabler of sustainability: trained personnel have continued to apply and replicate respectful, rights-based, and culturally grounded practices even in contexts marked by high turnover and operational constraints. This commitment from the local health staff and community actors reinforces the persistence of Project approaches and strengthens the continuity of community-embedded models of care.

- Midwives, health promoters, youth leaders, and municipal women's networks have continued to replicate project approaches independently, reinforcing culturally grounded practices and maintaining demand for respectful, rights-based care. Local leadership structures—such as municipal health committees, adolescent clubs, and intersectoral roundtables—have integrated elements of the Project into routine planning mechanisms and local development agendas.

    - In **Honduras**, a critical mass of health professionals trained in highly complex obstetric care, emergency management, and updated clinical protocols has been consolidated thanks to the continuous training model implemented at the Clinical Simulation and Training Center in the framework of the Project. This training, based on high-fidelity obstetric simulation, has proven highly replicable, allowing personnel to rotate through clinical scenarios without putting real patients at risk, improving response times, and reducing the risk of medical errors.

- One of the most valued elements highlighted by key informants during the interviews was the inclusion of non-conventional sectors of the formal health system, which strengthened the articulation between ancestral knowledge and biomedical knowledge. In this sense, traditional birth attendants and community health promoters were recognized as strategic actors for reaching the most remote communities, with a special emphasis on Indigenous peoples.

- Concerning community personnel, across all countries, the training and strengthening of traditional birth attendants and community health promoters, who remain in their communities for extended periods, is noteworthy. This approach is expected to make these actions sustainable for at least three years and is anticipated to continue in the future. A strengthened community fabric has been one of the most significant contributors to sustainability. Midwives, community health promoters, adolescent leaders, school health clubs, maternal surveillance committees, and networks of women mayors and "healthy municipalities" have continued to use and replicate the Project's tools, methodologies, and culturally grounded practices beyond the Project's direct support.

- Another element favoring sustainability is that Project training contributed to creating a critical mass of trained individuals who, although they may not remain in the same institutions after the Project's completion, now possess updated knowledge and tools that they can apply in various

contexts. This approach strengthens local and national institutional capacities, as knowledge circulates and adapts to different levels within the system.

- Finally, the use of resources available in the municipalities, such as existing personnel, was highlighted, which promotes the sustainability of learning beyond external financing. The combination of technical training, intercultural awareness, and use of local teams has been key to ensuring sustainable impacts on the care of women and adolescents in situations of vulnerability.

EQ.4.2. What measures did the implementing countries take to ensure the sustainability of the Project's impacts?

Finding 20. Countries implemented various strategies to ensure that the Project impacts will last beyond the Project implementation period. The main measures included capacity building at various institutional and community levels, the institutionalization of processes in national and local regulations, the strategic utilization of resources, and the innovative application of technologies.

- According to the documentary review and interviews with key stakeholders, in terms of sustainability, the Project "has been designed and implemented with a long-term strategic vision, ensuring that its progress does not fade after the end of the operational cycle," in the words of one interviewee. The Project was articulated and supported by PAHO's regular structure and inter-programmatic frameworks, ensuring that the Project results and methodologies are cross-cutting and contribute to other projects and areas aimed at strengthening the health and rights of women and adolescents in Latin America and the Caribbean. This transversality favors institutional anchorage and increases its technical and political viability.

- The training strategy, detailed in the previous point, incorporated a Training of Trainers (ToT) model, that aimed to expand knowledge that can be reproduced independently by the Ministries of Health at the national level. To this end, the courses, materials, and tools are available online and are hosted in the virtual spaces of the Ministries of Health and PAHO. This approach, combined with the use of information technologies, has enabled not only to broaden training coverage but also to establish capacities that remain active even after the Project has concluded.

- Another measure to ensure the sustainability of the Project's impacts was institutionalizing processes, such as:
    - Integrating the Project's actions into their local municipal plans and regulations, which allows for continuity even with changes of administration. In this sense, strengthening regional networks (such as intersectoral roundtables or associations of mayors) helped consolidate sustainable political and technical commitments. Key informants interviewed in all countries mentioned that this Project promoted a "bottom-up" process based on focused work at the territorial and community levels, with "demonstrative experiences" that, in addition to generating evidence, strengthen national women's and adolescent health programs, including sexual and reproductive health, prevention of maternal and neonatal mortality, and intercultural and gender approaches.
    - Strengthening of adolescent leadership and women's networks, more significantly in **Guyana** and **Ecuador**.
    - Strengthening of a network of mayors committed to the health and rights of women and adolescents in **Bolivia** and **Honduras**.

- In contexts where economic resources are limited, priority was given to the approach of "doing more with what we have", promoting sustainable actions with low cost and high impact. Additionally, technological tools have been developed, including local information systems and digital platforms, that enable monitoring and follow-up with reduced investment. For example:

    1. *Optimization of available human resources*: Instead of relying on new personnel or large budgets, several municipalities and local actors took advantage of existing teams (psychologists, community promoters, ombudspersons, social workers, traditional midwives, etc.) to implement key activities in sexual health, teenage pregnancy prevention, and health

education. This made it possible to carry out continuous actions without significantly increasing operating costs, enhancing sustainability.

2. *Community interventions with a territorial approach:* Health fairs, awareness-raising workshops, and activities with the elderly and young people were organized in vulnerable communities. These actions, many of which were logistically supported by community personnel or existing networks, were developed with minimal budget input but with significant participation and local impact.

3. *Capacity building:* The strategy of training multiple actors at different levels (municipal, technical, and community) was considered a sustainable investment. Once trained, these actors could replicate the information and sensitization without requiring permanent external assistance, multiplying the effect of the knowledge acquired.

4. *Strategic use of alliances and intersectoral cooperation*: In several cases, actions were articulated with institutions already present in the territories (such as health centers, schools, municipal ombudspersons' offices, and local NGOs), which avoided duplication of efforts and made it possible to share resources and responsibilities.

- Despite these efforts, the high level of personnel and political authority turnover was identified as a risk to sustainability, and the need for continuous accompaniment was emphasized, along with the need to continue to strengthen capacities that are not dependent solely on individuals but rather on established institutional structures.

Finding 21. UN Interagency coordination provided financial resources and allowed for technical complementarity, with each agency contributing its specific expertise in health, sexual and reproductive rights, adolescence, or gender equality.

- According to the information gathered, interagency coordination with the other UN agencies, funds, and programs (AFP) and other international development partners was neither systematic nor visible within the framework of this Project. Instead, this action is part of a broader cooperation framework aligned with the cooperation agreements between the AFP and PAHO.

- In this context, the evaluation explored whether inter-agency actions would have contributed to strengthening strategies for the sustainability and/or replicability of the Project's successful results.

- Key informants from AFP and civil society organizations recognized that collaboration with UNFPA allowed them to utilize resources better, avoiding duplication and strengthening joint implementation. This coordination favored the planning of actions aligned with national public policies and sustainable development frameworks.

    - In **Ecuador**, PAHO, as part of the roundtable of cooperating partners, leads the women's health roundtable, in which the IDB, WB, and other organizations participate. Through this mechanism, PAHO advocated for the cost of the basic health package for women and children in urban, rural, and remote areas and determined the investment cost. The result of this process was an advocacy document and recommendations for governments to target resources and make adequate investments in women's health.
    - In **Colombia**, alliances were established with different organizations, and efforts were made to strengthen actions, mainly with UNFPA, in the accelerated reduction of maternal mortality.
    - In **Guyana**, the interagency collaborations aimed to generate funds to support new initiatives and deepen the Project's territorial impact.

- At the regional level, alliances have also been established around training. For example, a collaboration was developed with the Regional Working Group (RWG), a multi-agency consortium focused on maternal health.

EQ.4.3. What level of institutional, national, and/or subnational capacity do the countries have to sustain the results after the implementation of the Project?

Finding 22. Implementing countries strengthened the sustainability of Project results by anchoring key approaches within Ministries of Health, integrating tools into local plans, and updating clinical protocols on respectful childbirth, Kangaroo Mother Care, and intercultural care. At the community level, mayors, traditional midwives, youth leaders, and maternal surveillance committees continue to apply the Project's methodologies, creating a durable foundation for continuity. While these advances have established strong institutional and community bases, ongoing commitment and investment are still required to consolidate long-term sustainability fully.

- Across countries, the sustainability of the IHWAG interventions is shaped by a combination of institutional commitments, community ownership, and the degree to which Project components have been integrated into national and subnational health systems. A key driver of sustainability was the early involvement of Ministries of Health, which facilitated the incorporation of Project methodologies into existing policies, guidelines, and clinical protocols—such as updated obstetric care standards, intercultural care tools, and newborn health strategies. In several contexts, the Project contributed to strengthening long-term capabilities by training a critical mass of health professionals, establishing simulation-based training models, and embedding technical materials and tools within national platforms and virtual learning systems.

- Overall, the Project has laid essential foundations for sustainability by strengthening institutional frameworks, capacities, and community ownership. However, to ensure that these gains endure beyond external funding cycles, countries will require sustained political commitment, national investments, and continued technical accompaniment to deepen institutionalization and reduce territorial inequities.

- The Project's focus on developing technical skills in health personnel and promoting the leadership and empowerment of social and community actors advances longer-term sustainability. For example, when human resources rotate, if they are trained, they will be able to implement changes or improvements in other geographic areas that the Project did not include.

- Social and community actors, being empowered and generating demands for services, serve as facilitators of local processes in areas where institutional presence is limited due to various factors. Another fundamental aspect of sustainability involves promoting behavioral change by strengthening women's and adolescents' leadership and empowerment.

- The focus on a territorial approach in Project countries enabled the inclusion and participation of various local actors residing in the territories, including mayors, other institutional actors with administrative or managerial functions, traditional midwives, traditional healers, youth leaders, healthcare personnel, and civil society organizations. Engaging these actors is another mechanism by which countries expanded their capacity to sustain Project impacts.

- In all Project countries, significant efforts were made in terms of training and the development of relevant methodologies to address key SRH issues. However, a structured approach to ensure follow-up and continuity of these trainings was not identified.

    - In **Bolivia**, the Project was institutionalized through the incorporation of the Healthy Municipalities movement and the alignment of Project topics with municipal health plans, focusing on key pillars such as childhood, family, and comprehensive health. A dedicated budget exclusively for health and prevention in the municipality's Annual Operating Plan (POA, acronym in Spanish) ensures sustainability in the medium term. The ownership of healthy practices, such as sports activities and food fairs, also strengthened local appropriation. Intermunicipal networks and the empowerment of community actors reinforce the continuity of these efforts. However, continuity depends on local political will, the strengthening of health personnel, and PAHO's technical support.

- In **Colombia**, efforts focused on building the capacities of territorial stakeholders and incorporating tools into institutional processes. Regulatory and inter-institutional support helped consolidate progress, paving the way for replication. The documentation of processes was also recognized as key to institutional learning and sustainability. Participating institutions incorporated the Project's methodologies into existing policies, guidelines, and clinical protocols—such as updated obstetric care standards, intercultural care tools, and newborn health strategies. Community-level engagement also emerged as a significant pillar of sustainability. Traditional birth attendants, health promoters, youth leaders, and municipal women's networks have continued to replicate Project approaches independently, reinforcing culturally grounded practices and maintaining demand for respectful, rights-based care. Local leadership structures—such as municipal health committees, adolescent clubs, and intersectoral roundtables—integrated elements of the Project into routine planning mechanisms and local development agendas. Work was carried out with the mayor of Bogota on care issues, a topic typically associated with women's leadership in decision-making spaces.

- In **Ecuador**, the territorial approach was robust. The importance of institutionalization through inter-institutional alliances at the parish and cantonal levels was emphasized, as well as the implementation of municipal ordinances to address adolescent pregnancy prevention, women's health, and the needs of other vulnerable populations.

- In **Guyana**, the sustainability of Project results was promoted by establishing a link between the educational and family community: the involvement of teachers and community health workers was key to sustaining the adolescent health club's activities. Mothers and fathers were also involved through meetings of the Parent-Teacher Association (PTA), thereby strengthening the program's legitimacy. In an interview, it was mentioned that "PAHO's intervention through the IHWAG Project was brief but significant. Its replication and sustainability require funding, inter-institutional alliances, and empowerment of community organizations such as the Hope Foundation, which operate on the front line of attention to vulnerable youth".

- In **Honduras**, regional technical health roundtables were institutionalized, and local governments were linked through the POAs to maintain the services and processes that had been implemented in the framework of the Project. There are trained personnel, intersectoral health committees operating in the municipalities, and a community surveillance structure that must be reinforced with stable financial resources and permanent human teams. A network of women mayors was established, and the municipalities are focusing on primary healthcare issues and promoting SRH.

Despite these advances, several structural risks limit prospects for full sustainability. High turnover of government staff, shifting political priorities, and the absence of stable budget lines for maternal health, gender equality, adolescent health, and intercultural approaches undermine continuity and institutional memory. The implementation of updated national protocols remains uneven, particularly in rural, remote, and Indigenous territories, where infrastructure, staffing, and culturally appropriate materials remain insufficient.

Finding 23. As noted in Finding 22 above, there is considerable institutional potential in all participating countries, particularly at the sub-national level. Yet the extent of Project institutionalization and ownership varies across countries, shaped by their respective priorities, technical and financial resources, cross-sector partnerships, and the strength of their ties with territorial authorities.

- The institutionalization of the Project achievements has been a priority in all the countries involved, thanks to the impetus provided by the Project and the commitment of the governments. Regulatory bodies and intersectoral policies on maternal and child health have been updated, including accelerated reductions in maternal mortality, through alliances with public, academic, and social actors, as well as strengthened political and financial support.

- In **Colombia**, the National Plan for the Reduction of Maternal Mortality has been prioritized, with high political will and intersectoral participation. Regulatory frameworks were strengthened, and Project tools were incorporated into institutional processes, including health education and promotion from a primary healthcare approach.

- In **Ecuador**, the early involvement of the MoH, the institutionalization of methodologies such as the "Kangaroo Mother Method", and the development of local ordinances have consolidated its sustainability. Additionally, initiatives such as the "Sexuality without Mysteries" webpage, developed within the framework of the Project but appropriated by the MoH, stand out as examples of Project initiatives that were institutionalized by the national health authority.

- In **Guyana**, the SIP Plus was strengthened as the basis for a national maternal health data network. Additionally, the School Health Clubs program has proven to be an effective peer-to-peer social change strategy, focusing on adolescent health and emphasizing projects related to sexual health, contraception, mental health, and life skills.

- In **Honduras**, obstetric care and community surveillance protocols have been institutionalized, and maternal health plans have been integrated into the Municipal Development Plans. The creation of updated regulations and joint work with donors and universities were key.

- In **Peru**, a national platform for continuing education was established, supported by regulations, with the participation of the MoH and academia, which enabled it to broaden its scope and increase replicability.

- Together, these examples indicate that countries have strengthened institutional capacities, established regulatory frameworks, articulated levels of government, and fostered youth and community leadership, laying a solid foundation for the long-term sustainability of Project results.

Finding 24. The Project aligned well with Canada's priorities and contributed to strengthening PAHO's broader resource mobilization strategy. Canada's contribution—large, flexible, and multi-year—met the highest standards of funding quality, supporting a portfolio-based management approach. This approach facilitated coherent branding, reporting, communication, and operational coordination across several Canada-funded initiatives. The strong and responsible performance of PAHO as an implementing partner enhanced donor confidence, leading to new agreements and increased funding allocations, even in a constrained global financing environment.

- PAHO's technical leadership and institutional presence have been instrumental in aligning Project objectives with national priorities, fostering multi-stakeholder partnerships, and facilitating the integration of key initiatives into existing health systems and policy frameworks.
- The countries identified advocacy and political articulation as central elements to ensure financial sustainability. However, it was also noted that this requires continuity, public visibility, and a formalized advocacy strategy at both national and local levels.

Finding 25. Project sustainability is significantly shaped by structural and contextual factors across the implementing countries. While significant progress has been made in ownership, institutionalization, capacity building, and territorial coordination, multiple systemic challenges may jeopardize the Project's long-term sustainability.

- In countries such as **Colombia** and **Ecuador,** the allocation of national and regional budgets was actively promoted through awareness-raising and advocacy processes with health authorities and actors in the political system. These actions aimed to integrate the Project results into the regular budget structure.

- In **Ecuador**, an effective strategy was the involvement of mayors from the outset, which facilitated the approval of ordinances and the incorporation of municipal funds to guarantee continuity in health, prevention, and education actions.

- In **Guyana**, the need to continue advocacy efforts to ensure that authorities prioritize the financing and institutionalization of youth strategies, such as the "School Health Clubs," was highlighted. It was recognized that their sustainability would depend directly on institutional support and the political will to mobilize resources.

- Despite the progress achieved in institutionalization, capacity building, and territorial articulation, there are still structural and contextual challenges that threaten the Project's sustainability in the implementing countries.

- Political instability remains one of the most critical threats to sustaining advances in SRH. Frequent changes in local and subnational authorities, combined with shifts in policy priorities, undermine the continuity of institutional commitments.

- In contexts marked by rising insecurity—such as **Ecuador**, where escalating violence has affected the well-being and mobility of women and girls—the fragility of local governance further complicates the consolidation of SRH initiatives. Similar dynamics have been documented in territories of **Colombia** affected by armed actors, where health personnel face high security constraints that limit service provision and community outreach. In **Ecuador,** rising violence has adversely impacted the integral health of women and girls. This underscores the urgency of developing health approaches with a community security perspective. Similar challenges are observed in some regions of Colombia affected by the presence of armed actors.

- Territorial inequalities also persist as a significant barrier to sustainability. Rural, remote, and peri-urban areas face chronic underinvestment, limited connectivity, rugged geography, and climate-related disruptions that hinder the consistent implementation of Project approaches. For example, in **Honduras**, second-level hospitals continue to lack essential supplies, trained staff, and adequate infrastructure to apply standards such as respectful childbirth or intercultural obstetric care—highlighting the distance between national norms and local realities.

- Differences in institutional capacity across levels of government further affect the Project's prospects for sustainability. Although the territorial approach has strengthened local ownership, many municipalities lack the technical, administrative, and financial autonomy required to operate independently once external support concludes. This underscores the need for formal institutionalization—integrating gender, interculturality, and differentiated SRH approaches into regulatory frameworks, operational plans, and stable budget lines.

- At the operational level, human resource vulnerabilities continue to pose serious risks. High turnover among health workers disrupts continuity, while persistent overburdening and burnout undermine the gains achieved through training. Moreover, the reliance on community-based volunteers—often women, traditional midwives, and local leaders—entails uncompensated costs and emotional work that threaten the long-term viability of community engagement unless recognition and support mechanisms are institutionalized.

- Finally, although the Project has made notable progress in mainstreaming gender and rights-based approaches, their sustainability depends on embedding them within national public policies, monitoring systems, and dedicated financing. Without stronger regulatory and budgetary frameworks, advances remain fragile and highly susceptible to political cycles and structural inequalities within each national context.

- Although the territorial approach has been key to local ownership, unequal institutional capacity between levels of government is another critical challenge. In **Bolivia**, for instance, many municipalities still lack sufficient technical and financial autonomy, which limits continuity in the absence of external support. This is directly linked to the need for formal institutionalization to ensure the incorporation of the Project's approaches, such as gender and interculturality, into regulatory, operational, and budgetary frameworks.

6. Conclusions

Relevance

- The IHWAG Project achieved tangible and verifiable progress in strengthening sexual, reproductive, and maternal health services in rural, Indigenous, Afro-descendant communities across the six intervention countries. Through a combination of innovative, culturally relevant, and rights-based approaches, the Project made significant contributions to reducing maternal and neonatal mortality, reducing adolescent pregnancy, strengthening culturally appropriate care, and building institutional, normative, community, and individual capacities.
- The implementation of methodologies such as the Knowledge Dialogues, the expansion of community-based telemedicine, and the promotion of intercultural traditional midwifery demonstrate the Project's capacity to adapt solutions to local realities. These strategies, recognized for their impact in historically excluded geographic areas, offer a replicable model for future interventions.

Effectiveness

- The evidence gathered across interviews indicates that the IHWAG Project achieved substantial and measurable effectiveness in strengthening health-system capacities and improving access to maternal, neonatal, sexual, and reproductive health services in highly diverse and often fragile territorial contexts.
- The Project's most consistent contribution was the large-scale development of professional and community capacities, including the training of tens of thousands of health providers, the installation of simulation centers, the roll-out of "training of trainers" models, and the empowerment of community actors such as traditional midwives, health volunteers, and local leaders, who became critical intermediaries for early detection, referral, and culturally relevant care. These investments translated into improved handling of obstetric emergencies, increased use of technologies such as telemedicine and semi-automated blood-pressure devices, and stronger articulation between the community and the first level of care.
- The Project also fostered greater participation and amplified the voices of women and adolescents, informing local policies, communication strategies, and community-based prevention initiatives, and in several cases influencing local authorities and ministries to adopt or update guidelines, protocols, and acceleration strategies for maternal and adolescent health.

Efficiency

- The Project leaves behind installed institutional and community capacities, tools, and knowledge that should be leveraged in future initiatives. Effective continuity will require maintaining the momentum achieved, consolidating monitoring and evaluation mechanisms, and further integrating gender, intercultural, and human rights-based approaches at all levels of the health system. PAHO, as a trusted technical partner, is well-positioned to support the institutionalization and scaling up of the transformative changes promoted by the Project.

Sustainability

- One of the most significant achievements was the ownership of standards, tools, and protocols within public health services, supported by strategic investments in technical training, digital platforms (such as SIP Plus), and local partnerships, all of which were aligned with national health plans and public policies.

- In this process, PAHO's technical cooperation has been instrumental. Its ability to forge strategic partnerships, support governments in policy development, and embed results into national health planning and financing cycles has been key to ensuring the sustainability of achievements beyond the Project's operational timeline.

- Despite persistent challenges—such as high staff turnover, political volatility, digital limitations, and barriers at secondary and tertiary care levels—the Project consistently demonstrated its effectiveness by improving knowledge, practices, coordination mechanisms, and community engagement. The IHWAG Project functioned as a laboratory for scalable, context-sensitive interventions, showing that integrated technical training, participatory methodologies, and strengthened community-health system linkages can generate meaningful improvements in maternal and neonatal outcomes across diverse country contexts.

7. Lessons learned

These lessons highlight critical pathways for strengthening the design and implementation of future interventions supported by the Government of Canada and other partners. They underscore the value of investing in inclusive and context-sensitive approaches—such as face-to-face training adapted to diverse literacy levels, intersectional strategies to address inequality, and the respectful integration of ancestral knowledge—that can ensure interventions are both practical and locally grounded.

They also demonstrate the importance of strengthening systemic enablers: fostering intersectoral coordination, retaining rural health personnel, building resilient information systems, and supporting institutional ownership of innovations.

Moreover, the lessons emphasize that partnerships with women's and youth organizations, as well as empathy-driven psychosocial support for adolescents, can catalyze broader social change and advance Canada's commitments under the Feminist International Assistance Policy to gender equality and rights-based development. By translating these lessons into action, future projects can be better positioned to sustain impact, influence policy, and foster long-term transformation in health and social systems across diverse contexts.

1. Face-to-face training and methodological adaptation are still necessary in under-resourced contexts and when dealing with sensitive topics.

- Experience has shown that face-to-face training remains significant, especially for sensitive issues that require hands-on practice, live clarification of questions, and contextualized feedback.
- Health professionals and traditional midwives, many of whom had never participated in ongoing education, showed remarkable engagement, staying for evening sessions, requesting extended consultations, and practicing with real-life materials.
- The methodological innovation of tailoring sessions to various literacy and training levels—including graphic materials for non-literate traditional birth attendants and technical protocols for doctors—proved highly effective.
- The COVID-19 pandemic further highlighted the need for in-person learning, particularly in areas with limited internet access and digital literacy.
- Learning by doing, especially in under-resourced contexts, proved not only to be a method but also a necessity.

2. Multidisciplinary teams and intersectoral coordination enabled more comprehensive responses.

- From its inception, the Project aimed to build bridges across sectors and disciplines. This expectation was not only met but exceeded. The inclusion of teams combining clinical, anthropological, social, and logistical expertise enabled more holistic responses.
- Coordination between PAHO, Ministries of Health, local health workers, and traditional community actors functioned as a crucial bridge between policy and territorial implementation. Notably, the deployment of national professionals in remote areas ensured continuity and trust, even in challenging contexts. The experience confirmed that horizontal and vertical articulation is not just ideal but essential for structural reform, avoiding duplication, optimizing resources, and sustaining momentum.

3. Digital transformation must be accompanied by organizational change and a long-term vision that outlasts funding cycles.

- The Project advanced digital tools, such as SIP Plus and telehealth, which enhanced data utilization and service delivery. However, the key lesson was that digital tools alone are insufficient. Their success depends on maintaining a consistent record-keeping system, providing technical support, and fostering a culture of data-driven decision-making.

4. Intersectional approach to inequality enhanced Project impacts.

- Adopting an intersectional approach deepened the impact of the Project by focusing on structural gaps affecting women, adolescents, and Indigenous peoples, and integrating these perspectives into training, policy frameworks, and community dialogues. The Project strengthened institutional transformation. This approach enabled the design of more inclusive, rights-based responses and helped reveal overlooked layers of exclusion. Intersectionality proved not just a theoretical lens but also a practical compass for action.

5. Respectful integration of traditional practices enriches biomedical approaches.

- By recognizing and valuing the contributions of traditional midwives, wise elders, and Indigenous health counselors, the Project co-developed culturally relevant and trusted care models. This not only increased service uptake but also enhanced the legitimacy of institutional actors in historically excluded communities.

6. Empathy-driven, humanized care is a driver of systemic change.

- The Project was expected to improve adolescent maternal health outcomes through targeted services, but what made a profound difference was the nonjudgmental psychosocial support provided. This approach fostered strong emotional bonds and enhanced maternal attachment.
- Participation strategies and educational materials raised awareness among adolescents, their families, and the broader community. Simultaneously, the formation of adolescent clubs and the promotion of youth leadership created a multiplier effect, allowing key messages to reach remote and ethnically diverse populations. The lesson: empathy-driven, humanized care is a driver of systemic change.

7. Robust, field-based knowledge is crucial for scaling innovations and shifting institutional norms.

- It was expected that evidence generation would support monitoring, but in practice, its influence went much further. Field-level documentation of results became a tool for advocacy and policy dialogue, helping to legitimize new models of care and promote uptake at national levels. Technical briefs and impact evidence opened doors to ministerial conversations and shaped strategic decisions.

8. Collaboration with civil society is a cornerstone for legitimacy and long-term change.

- The Project planned to engage communities, but partnerships with youth networks, feminist movements, and grassroots actors had even greater transformative effects. These alliances catalyzed social change, amplified the voices of the marginalized, and embedded the Project in local realities. They also advanced critical agendas—such as positive masculinities, sexual and reproductive rights, and the prevention of gender-based violence—in a way that felt locally owned and sustainable.

9. To set up a strong regional governance model for the Project's implementation since the onset has a transformative value.

- A key lesson emerging from the IHWAG Project is the transformative value of a strong regional governance model. The Project's governance architecture—anchored in precise planning,

coordinated leadership, and systematic monitoring—was consistently perceived by stakeholders as exemplary. This structure not only ensured coherence and alignment across countries but also enabled rapid adaptation to operational challenges while maintaining consistent quality standards. The experience underscores that sustained investment in technical leadership and robust regional coordination mechanisms is not merely supportive but foundational to achieving efficient, harmonized, and responsive implementation at scale.

10. The combination of capacity-building with ownership of methodologies allowed central health authorities to internalize and institutionalize intercultural approaches.

- Ministries began to mainstream these approaches in various health programs, while also opening new spaces for adolescent participation and consultation. This reinforced the importance of coupling technical support with institutional empowerment to generate lasting system-level changes.

8. Good practices

1. **Participatory design and territorial focus foster local relevance and ownership.**

This modality generated greater social legitimacy for the Project, increased the effectiveness of the response to high-risk pregnancies, and strengthened primary care capacity, as reflected in progress in reducing gaps in prenatal checkups and institutional care during childbirth in priority areas. Key informants from all countries acknowledged this strategy as a primary factor in the Project's success and sustainability at the local level.

- From the outset, the Project was built "from the bottom up." National teams, local authorities, Indigenous organizations, and youth networks participated in planning roundtables to discuss territorial assessments and set targets. This process ensured that activities aligned with each country's normative and cultural realities while separating two intervention tracks: optimizing health services and strengthening community empowerment.

- When governments pinpointed "critical territories"—for example the **Peruvian** Amazon, **Colombia's** Chocó and Cauca, **Bolivia's** Altiplano, and the mining and rural zones of **Guyana** and **Ecuador**—the Project deployed field staff and tailored measures accordingly. In **Honduras**, the same participatory model identified priority, hard-to-reach municipalities in Santa Bárbara. Roundtables with local authorities, health workers, community-based organizations, and traditional midwives harmonized Project goals with municipal health plans and culturally rooted care practices.

- These collaborations produced context-specific interventions, bolstered first-level care, and deepened community ownership. Continuous on-the-ground technical support and respect for local knowledge proved crucial in achieving compelling and socially legitimate implementation and ownership.

2. **Capacity building is most effective when it is transformative, context-grounded, and embedded in real service-delivery environments.**

By bringing training directly into delivery rooms, clinics, and remote health posts, the initiative ensured that professionals, traditional midwives, and, ultimately, pregnant women and adolescents benefited immediately from strengthened professional and institutional capacities.

- The Project showed a strong commitment to capacity building through transformative, context-based methods. Combining a training-of-trainers model with on-site obstetric simulation, enabled rapid and highly localized skills transfer. These efforts were further reinforced through hybrid learning modalities—online and in-person courses, complemented by illustrated videos and adapted print materials for staff and midwives with limited literacy—showing that

multimodal, culturally attuned capacity-building strategies can accelerate learning and deepen adoption across diverse contexts.

3. The application of the Knowledge Dialogues methodology strengthened context and culturally adapted interventions.

This practice reduced resistance to institutional childbirth care, increased coverage in Indigenous communities, and built trust between traditional and biomedical medicine, which is key in obstetric emergencies. Social acceptance and cultural appropriateness were reflected in increased spontaneous demand for services and a reduction in births not attended by trained personnel in rural and Indigenous areas.

- The country office teams highlighted the systematic adoption of the "Knowledge Dialogues" methodology as a key element to bridge the health systems and the local communities across a range of SRH topics. In **Ecuador**, it was adopted as an official methodology of the MoH. In **Peru** and **Bolivia**, it facilitated consensus with traditional midwives on adapting 43 maternal health indicators and introducing vertical birth practices in hospitals.

- Intercultural maternity centers, bilingual mobile brigades, and educational materials in Miskito, Akawaio, Quechua, and Aymara further reinforced the strategy. By respectfully embracing Indigenous worldviews, the Project enhanced social acceptance, reduced resistance to institutional childbirth, and built mutual trust between traditional and Western medicine, which is crucial for managing obstetric emergencies in rural, remote, and hard-to-reach areas.

4. Awareness raising strengthened women's autonomy, participation, and decision-making.

Women and adolescents accessed key information to exercise their sexual and reproductive rights, contributing to greater bodily autonomy, informed use of contraceptive methods, and prevention of adolescent pregnancies.

- The Project brought equity, human rights, and cultural diversity to the forefront of national health agendas.

- The Network of Women Mayors advanced municipal plans that combine health, violence prevention, and environmental stewardship, while Maternal Surveillance Committees reviewed every adverse obstetric event through a gender lens.

- WHO-compliant post-sexual-violence protocols and large-scale trainings on HIV, gender-based violence, and cervical cancer empowered women and adolescents with information tailored to informed decisions about their bodies, health, and futures.

7. Strong governance, intersectoral coordination, and technical innovation advanced Project results.

This coordination enabled the adoption of 27 standards or guidelines on sexual and reproductive health with a gender perspective and cultural relevance, consolidating a technical and regulatory framework that structures the provision of comprehensive services in rural and vulnerable contexts.

- The Project was integrated into PAHO's BWP and technical cooperation, consolidating a long-standing partnership with Canada and combining resources from donors and state counterparts.

- The networks of Healthy Municipalities and the experiences of South-South cooperation facilitated the exchange of evidence and the updating of various regulatory frameworks on sexual and reproductive health in the countries.

8. **Engaging community health workers is an effective way to adopt a comprehensive approach to sexual and reproductive health in populations in situations of vulnerability**.

> *This integration has helped prevent maternal anemia, increase awareness of reproductive rights, and enhance access to family planning in communities with limited prior access. Monitoring this line of action is recommended to demonstrate future collaborative impacts on indicators such as maternal nutrition and adolescent health.*

- The integration of sexual and reproductive health with family gardens and water, sanitation, and hygiene (WASH) strategies at the community level by community health workers improved nutrition and family care while also introducing sexual and reproductive health-based services, such as family planning.
- Future evaluations could explicitly track outcomes from this integration (e.g., maternal anemia rates, adolescent nutrition) to demonstrate the health benefits of adopting multidisciplinary approaches.

9. Recommendations

Based on the findings of the evaluation, seven recommendations were developed (Table 8), each with specific action points. The criteria used to define each recommendation were its strategic relevance, opportunity, operational and technical feasibility for implementation, potential impact, and appropriateness.

The set of these recommendations is intended to provide guidance, primarily to PAHO as the implementing organization of the Project, for the design and implementation of similar interventions to be carried out in collaboration with the Government of Canada or other partners[19].

[19] It is worth noting that, although the recommendations are addressed to PAHO, they also consider the various stakeholders involved—such as the respective Ministries of Health, civil society organizations, groups and networks, and academic institutions that act as partners throughout different phases of project implementation. We believe that the engagement and active participation of these actors provide a strong foundation for reinforcing the sustainability of results and fostering the ownership of the methodologies, approaches, and knowledge promoted through projects of this kind.

Table 8: Recommendations

CRITERION	Related Finding	RECOMMENDATION
RELEVANCE	Finding 1: The Project's objectives responded to national priorities for populations in situations of vulnerability. It was built on national policy frameworks to advance maternal, newborn, child, and adolescent health, with a strong focus on marginalized groups. Finding 2: The Project aligned its approach and logic model with international, regional, and national priorities, leveraging global frameworks to strengthen maternal, child, and adolescent health, and gender equality. It made a virtuous and synergistic use of the existing international normative and strategic framework, including the PAHO Strategic Plan 2020-2025, BWPs, and PAHO mandates including the Plan of Action for Women's, Children's and Adolescents' Health 2018-2030, the Canada's Feminist International Assistance Policy, as well as global commitments to which Project countries have subscribed, such as the Sustainable Development Goals of the 2030 Agenda. Finding 4: The Project was tailored to each country's particular context. In Colombia and Ecuador, needs assessments targeted territories with the highest maternal mortality rates, while in Guyana, they focused on the health impacts of mining. Across all participating countries, interventions prioritized rural or remote areas and indigenous or Afro-descendant communities. Several contexts placed special emphasis on migrants (specifically the Venezuelan population), most notably Guyana and Colombia, whereas Ecuador incorporated school-aged adolescent girls, and both Bolivia and Ecuador implemented measures at the municipal level.	**Recommendation 1**: **Promote the integration and institutionalization of community-based, gender-responsive, and intersectional approaches by applying regular assessments of the needs and priorities of target populations, the use of culturally appropriate tools and methodologies, and the adaptability of intervention design to local and territorial contexts.** <u>*Points for action*</u> • Strengthen strategies for continuously assessing needs and priorities of targeted populations, especially the most marginalized population groups. • Continue and strengthen the application of the "Knowledge Dialogues" methodology in the design, implementation, and evaluation of intervention areas across health topics. • Strengthening the development and application of hybrid training methodologies that combine classroom and distance learning components, and train trainers in capacity-building strategies, ensuring follow-up and continuity of trainings. • Continue consolidating the processes of construction and validation of shared operational definitions regarding the gender, intersectionality, and sexual diversity approaches at the central and Country Office levels. Allocate specific budget lines to address these priorities further.
EFFECTIVENESS	Finding 7: The Project has provided a high and verifiable response to the challenges of access and coverage of sexual, reproductive, and maternal health services in the six intervention countries. However, gaps persist that need further strengthening. Finding 8. The Project expanded health services and provided essential information on sexual, reproductive, and maternal-neonatal health to previously underserved areas—primarily rural, remote, and hard-to-reach communities. Finding 10: The Project introduced methodological and communication innovations that strengthened health systems across the six countries. Key advances include strategic planning, digital transformation of maternal and neonatal care through	**Recommendation 2: Enhance installed capacities in terms of digital health initiatives, including training of trainers and leveraging existing social networks, to ensure that health services and messages reach rural and remote communities in a sustained and culturally relevant manner.** <u>*Points for action*</u> • Close the data-use gap in maternal and neonatal health by expanding the application and analysis of the SIP Plus, ensuring sustained improvements in service coverage and quality. • Consolidate and expand the Project's territorial presence through a tiered approach with locally led community nodes, community

CRITERION	Related Finding	RECOMMENDATION
	telemedicine and the SIP Plus platform, and the integration of ancestral and biomedical knowledge. The initiative promoted the routine use of data for clinical decision-making, developed culturally adapted tools, expanded the gender agenda on maternal care, and leveraged multichannel storytelling to amplify local voices. Finding 11. The Project made a significant contribution to integrating gender equality, human rights, and cultural diversity approaches within health systems across the six countries. This was achieved by influencing policy and normative frameworks, strengthening institutional and individual capacities—particularly of female health personnel—and ensuring greater inclusion of traditionally excluded groups. However, challenges remain in achieving universal accessibility and non-discrimination.	telemedicine strategies with hybrid tele-consultations (computer/mobile), and community maps for the rapid referral of obstetric emergencies. • Co-create awareness and training materials using illustrations and audiovisuals for adolescents, youth, Indigenous and Afro-descendant women (graphic kit, folding sheets, mini-comics, graphic stories, or *stickers*) with simple and adapted local language, illustrations, color codes, translations into Indigenous languages, and QR codes for offline access. Distribute these materials through volunteers, schools, youth groups, and community radios to amplify sexual and reproductive health messages. **Recommendation 3. Continue to support the institutionalization of national policies and programs aimed at reducing maternal and neonatal mortality and advancing sexual and reproductive health in the countries of intervention, including promoting that these strategies are fully integrated into national monitoring and accountability frameworks, enabling the systematic use of data for both programmatic improvement and evidence-based policymaking.** *Points for action* • Expand community-based tele-referral systems to ensure broader access to timely obstetric and neonatal care in remote and underserved areas. • Enhance safe blood management systems, including the scaling-up of the blood simulation training model in Ecuador and Guyana, countries where maternal hemorrhage remains a leading cause of mortality. **Recommendation 4. Reinforce and expand strategies for information, awareness, and community mobilization to transform social norms, attitudes, and practices, particularly among target groups, including expanding to populations not originally considered by the Project, such as women with disabilities.** *Points for action:*

CRITERION	Related Finding	RECOMMENDATION
		• Promote adolescent and youth leadership as a core pillar of community empowerment and health promotion, building successful models such as the School Health Clubs in collaboration with Ministries of Education. • Foster early engagement of families and parent-teacher associations, recognizing their critical role in shifting norms and enhancing the prevention of gender-based violence from early adolescence. • Advance culturally relevant approaches to positive masculinities, focusing on the shared responsibility for the health and well-being of women and adolescents, and challenging harmful gender norms.
EFFICIENCY	Finding 12: The planning, management, and follow-up mechanisms implemented by the Project and its partners were timely and technically sound, enabling the achievement of the set objectives, considering the institutional and financial conditions of the participating countries. Finding 13: In all Project countries, the high technical capacity of PAHO staff at the national and regional levels, and especially those based in the Project communities was highlighted, along with their cultural sensitivity, service orientation, and commitment to human rights. Finding 14: Project management and implementation have demonstrated significant efficiency, based on strong inter-institutional coordination, the strategic use of local human and technical resources, and contextual adaptation to local realities. Finding 15. The Project operated with a Monitoring Plan that generally functioned adequately; however, monitoring and reporting practices were often overly focused on detailed activity-level information, emphasizing descriptive accounts of activities and providing limited analysis and harmonized data to assess the Project's broader impacts.	**Recommendation 5. Strengthen management and coordination mechanisms to support workforce planning, address territorial gaps, streamline monitoring and reporting tools, reinforcing results-based management, strengthening systematic data disaggregation, and embedding user-friendly digital solutions to reduce fragmentation and duplication, and improve timeliness of decision-making.** *Points for action* • Promote a practical culture of monitoring, evaluation, and learning within Project teams and national counterparts, by simplifying monitoring tools, strengthening country reporting processes, and embedding user-friendly digital solutions compatible with PAHO's Project cycle. • Strengthen the measurement of Project contributions and impact using quantitative, qualitative, and mixed methods approaches, ensuring that evidence is rigorous and actionable. • Strengthen the capacities of national PAHO Country Offices in results-based management, emphasizing the use of practical digital tools for real-time or routine data collection, analysis, and decision-making relevant to maternal health, SRHR, and adolescent health services.

CRITERION	Related Finding	RECOMMENDATION
	Finding 16: Compliance with the implementation of planned activities varied significantly across countries, shaped by structural, institutional, and operational factors.	• Strengthen data collection, use, analysis and dissemination and ensure systematic disaggregation of data and analysis by territory, age, ethnicity, disability, migratory status, and other priority groups, to support inclusive, equity-driven planning and targeted Project's responses.
SUSTAINABILITY	Finding 19: The Project strengthened both the overall response capacity of health services and the competencies of local health teams through a blend of in-person and virtual training. In several instances, these training courses were opened to professionals from other sectors, creating a critical mass of practitioners equipped with up-to-date knowledge that they can apply both in their current settings and in any new contexts where they may serve. Finding 20: Countries implemented various strategies to ensure that Project impacts will last beyond the Project implementation period. The main measures included capacity building at various institutional and community levels, institutionalizing processes through national and local regulations, strategic utilization of resources, and the innovative application of technologies. Finding 21: UN Interagency coordination provided financial resources and allowed for technical complementarity, with each agency contributing its specific expertise in health, sexual and reproductive rights, adolescence, or gender equality. Finding 22: Implementing countries strengthened the sustainability of Project results by anchoring key approaches within Ministries of Health, integrating tools into local plans, and updating clinical protocols on respectful childbirth, Kangaroo Mother Care, and intercultural care. At the community level, mayors, traditional midwives, youth leaders, and maternal surveillance committees continue to apply the Project's methodologies, creating a durable foundation for continuity. While these advances have established strong institutional and community bases, ongoing commitment and investment are still required to consolidate long-term sustainability fully. Finding 25: Project sustainability is significantly shaped by structural and contextual factors across the implementing countries. While significant progress has been	**Recommendation 6. Develop a transition plan that gradually transfers technical and operational responsibility to various levels of the health system, ensuring continuity after the end of external financing.** *Points for action* • Establish inter-institutional cooperation agreements that facilitate the shared allocation of resources, optimize implementation schedules, and reduce operational fragmentation with UN agencies that have similar or complementary strategic, operational, and program priorities (e.g., UNFPA, UN Women, and UNICEF). • Strengthen intersectoral actions that broaden the impact on access to comprehensive health services, reduce gaps due to social determinants, and enhance the empowerment of women and adolescents about sexual and reproductive rights. • Continue and amplify the documentation and dissemination of successful experiences and methodological innovations developed by the Project, both in improving access to health services and in actions for the empowerment and leadership of women and adolescents, which can be scaled up or replicated in similar contexts. **Recommendation 7: Strengthen multi-actor advocacy strategies that bring together women's and adolescent groups, community organizations, local governments, donors, and academic institutions to advance IHWAG's initiatives. By consolidating these diverse platforms into a coordinated regional advocacy architecture—rooted in interculturality, gender equality, intersectionality, and community leadership- PAHO can help**

CRITERION	Related Finding	RECOMMENDATION
	made in ownership, institutionalization, capacity building, and territorial coordination, multiple systemic challenges may jeopardize the Project's long-term continuity.	**ensure continuity of political commitment, visibility of marginalized groups, and long-term integration of IHWAG's tools, methodologies, and approaches into national and territorial health agendas after external financing ends.** *Points for action:* • Integrate community structures into Project implementation pathways to facilitate sustainability. • Strengthen women's and adolescents' leadership as a core Project strategy to secure continuity of actions. • Forge alliances with subnational governments and the Network of Healthy Municipalities and establish liaisons with Networks and Associations of Municipalities. • Document the experience with the Network of Healthy Municipalities to build the case before donors.

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Saving maternal lives in Peru's Amazon Region: https://www.paho.org/en/stories/saving-maternal-lives-perus-amazon-region

Digital Hope: How Telemedicine is Improving Quality of Care for Pregnant Women in Rural Areas of Honduras and Peru: https://www.paho.org/en/stories/digital-hope-how-telemedicine-improving-quality-care-pregnant-women-rural-areas-honduras

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2022

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Ucayali: Health personnel from three districts of the province of Atalaya are trained in obstetric emergencies: https://www.paho.org/es/noticias/19-4-2022-ucayali-capacitan-emergencias-obstetricas-personal-salud-tres-distritos

2023

Students from the Tekove Katu School of Public Health and community health promoters from Camiri strengthen their capacity to identify obstetric risk: https://www.paho.org/es/noticias/4-9-2023-estudiantes-escuela-salud-publica-tekove-katu-promotores-comunitarios-salud

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PAHO supported the Ministries of Health and Education to conduct peer education training and launch school health clubs in region 1 and 8: https://www.paho.org/en/news/3-10-2023-paho-supported-ministries-health-and-education-conduct-peer-education-training-and

Hospitals in Honduras highlight the use of the SIP to improve care for women undergoing abortion: https://www.paho.org/es/noticias/21-8-2023-hospitales-honduras-destacan-uso-sip-para-mejorar-atencion-mujeres-situacion

Ministry of Health, with technical cooperation from PAHO/WHO, leads efforts to reduce perinatal and neonatal mortality in Honduras: https://www.paho.org/es/noticias/20-6-2023-secretaria-salud-con-cooperacion-tecnica-opsoms-lidera-esfuerzos-para-reducir.

PAHO continues its technical cooperation efforts in Peru to save maternal lives: https://www.paho.org/es/noticias/14-7-2023-ops-continua-sus-esfuerzos-cooperacion-tecnica-peru-para-salvar-vidas-maternas

Community agents for maternal health in Atalaya, Ucayali: https://www.paho.org/es/noticias/25-3-2023-agentes-comunitarios-por-salud-materna-atalaya-ucayali

2024:

Midwives and midwives together with SAFCI professionals strengthen their skills and knowledge in maternal and neonatal management: https://www.paho.org/es/noticias/8-4-2024-parteros-parteras-junto-profesionales-safci-fortalecen-sus-capacidades

LGTBIQ+ collectives and the Bolivian Ministry of Health and Sports agree on an agenda to move towards a more inclusive and equitable Health System: https://www.paho.org/es/noticias/13-12-2024-colectivos-lgtbiq-ministerio-salud-deportes-bolivia-acuerdan-agenda-para

Strengthening maternal care and care networks in Colombia: Workshop on the use of community-based perinatal technologies: https://www.paho.org/es/noticias/1-8-2024-fortaleciendo-atencion-materna-redes-cuidado-colombia-taller-sobre-uso

Colombia celebrates World Sexual Health Day, 2024: https://www.paho.org/es/noticias/10-9-2024-colombia-celebra-dia-mundial-salud-sexual-2024.

Sensitization workshop on the Culturally Safe Childbirth Tool: https://www.paho.org/es/noticias/10-4-2024-taller-sensibilizacion-herramienta-parto-culturalmente-seguro

Honduras leads a historic dialogue on menopause: towards inclusive public policies for women: https://www.paho.org/es/noticias/18-9-2024-honduras-lidera-dialogo-historico-sobre-menopausia-hacia-politicas-publicas.

Guyana Health Professionals Build Capacity on Medico-Legal Response to Intimate Partner Violence and Sexual Violence: https://www.paho.org/en/news/9-9-2024-guyana-health-professionals-builds-capacity-medico-legal-response-intimate-partner

Guyana Ministry of Health, with the support of PAHO/WHO, trained twenty-two students as champions for adolescent school health: https://www.paho.org/en/news/19-3-2024-guyana-ministry-health-support-pahowho-trained-twenty-two-students-champions

PAHO discusses the role of nurses in adolescent health: https://www.paho.org/es/noticias/10-7-2024-ops-analiza-papel-enfermeras-enfermeros-salud-adolescentes

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Pan American Health Organization (PAHO). (2023, February 5). *Success stories in the implementation of telemedicine in rural areas*. Facebook. https://www.facebook.com/story.php?story_fbid=pfbid02przwQzp1JA5njk8NiaJFhyFwc5jfa5ipKbDxLYxdPxjdt42FH5weS8izoZUEqAJkl&id=100069166331128

Pan American Health Organization (PAHO). (2023, March 10). *Training Program for Traditional Midwives in Colombia*. X (formerly Twitter). https://x.com/OPSOMS_Col/status/1630277677016924161

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Pan American Health Organization (PAHO). (2023, September 25). *Video: Community health experiences in Peru*. YouTube. https://www.youtube.com/watch?v=8_dCUS2rGiY&t=1s

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Pan American Health Organization (PAHO). (2023, November 10). *Sexual and Reproductive Health Training in Bolivia*. Facebook. https://www.facebook.com/OPSOMSBolivia/posts/pfbid0bwgqQaRstVaBoVjniX2R7rbMy8FEcuR3WqnWR75ndFGixskZi2SuYQ4KvpVHox9Kl

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Ministry of Health of Chile (2024, June 10). *Youth sexual health awareness campaign*. X (formerly Twitter). https://x.com/Salud_CZ5/status/1864301026519441810

Pan American Health Organization (PAHO). (2024, July 15). *Success stories in the implementation of telemedicine in rural areas*. Facebook. https://www.facebook.com/permalink.php?story_fbid=pfbid0YbigFB73gNVq292uiFKdfjd7oE1bWtMhijr4L288uU73jp6XAqYFb7pQxTu7rxJkl&id=100069166331128

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11.Annexes

Annex 1. Terms of Reference

External Evaluation of the
Improved Health of Women and Adolescent Girls in Situations of Vulnerability (IHWAG) Project
Terms of Reference (November 2024)

Title	External evaluation of the "Improved Health of Women and Adolescent Girls in Situations of Vulnerability" (IHWAG) Project
Purpose	Evaluate the impact of the IHWAG Project in the six intervention countries after its implementation over the period 2021-2024
Type of contract	Consultancy contract (evaluation firm/group)
Modality	External consultancy contract with deliverables, to be supervised by the Office of the Assistant Director
Duration	Four months after the official signature of the contract
Starting date	March 2025
Final date	June 2025
Location	Hybrid (remote and on-site work, with field work to be conducted in the three intervention countries)
Required language(s)	Spanish and English, spoken and written
Commissioner	Heidi Ullmann, Technical Advisor, Office of the Assistant Director
Person responsible for the evaluation	David Palacios, International PAHO Consultant, Office of the Assistant Director

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I. Background

Although the Region of the Americas has shown significant advances in the health of women, children, and adolescent girls over the last decade, progress has been uneven. Women and adolescent girls from households in a precarious socioeconomic situation, those living in rural or marginalized areas, those belonging to Indigenous or Afro-descendant populations, those who have lower levels of schooling, and those who are migrants have higher rates of morbidity and mortality because they face obstacles in accessing quality essential health services. Even if they can access these services, they do not receive care of the necessary quality and timeliness, and they remain underserved by health programs, strategies, and plans[1].

This unequal progress results from inequities in society that create specific obstacles to access to health care for certain groups, particularly women and adolescent girls in situations of vulnerability. Gender inequalities, which manifest as restrictive gender norms and asymmetries in power relations between men and women and between boys and girls, are central factors in these inequalities. Although gender inequalities also adversely affect the health of boys and men (e.g., violence and the harmful use of alcohol and drugs), their most profound impact is on girls and women. Urban areas, the level of schooling, and income play a crucial role in these inequalities.

The Pan American Health Organization (PAHO) is committed to enhancing the health outcomes and well-being of women and adolescent girls, particularly in terms of their sexual and reproductive health, rights, and maternal health. PAHO is also committed to the 2030 Agenda for Sustainable Development, aiming to reach people living in vulnerable situations. Moreover, PAHO supports the Global Strategy for Women's, Children's, and Adolescents' Health 2016-2030[2]. In line with this strategy, PAHO Member States approved the Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030 with the aim of generating progress so that every woman, child, and adolescent not only survives but thrives in a transformative environment where everyone is able to exercise their right to the enjoyment of the highest standard of physical, mental, sexual, and reproductive health and well-being with social and economic opportunities and full participation in shaping prosperous and sustainable societies[3]. This plan seeks not to focus on what can already be observed in regional and national averages, but to probe more deeply into the inequities that affect the most vulnerable groups, which are often hidden behind these national averages.

In this context, a subsidiary agreement was signed between PAHO and Global Affairs Canada (GAC) for a total of CAD $15 million to implement the Improved Health of Women and Adolescent Girls in Situations of Vulnerability (IHWAG) Project during the period from 2021 to 2025. This initiative addresses the issues of maternal health, women's health, adolescent health, and sexual and reproductive health with a focus on rights, interculturality, and gender; it also seeks to ensure that health needs are addressed through interventions that are equitable, comprehensive, gender-sensitive, culturally sensitive, and person-centered across the life course. The Project implemented activities between 2021 and 2024, with 2025 being a period for conducting the present evaluation and Project close-out.

The initiative includes the development and implementation of activities using an interprogrammatic, interinstitutional, and multisectoral approach. Their purpose is to promote the involvement of the target population-women and adolescent girls-in spaces for social participation, and to strengthen their empowerment in decision-making regarding their health, at the national and subnational levels.

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1 Pan American Health Organization. Plan of Action for Women's, Children's, and Adolescents' Health 2018 -2030. 56th Directing Council, 70th session of the WHO Regional Committee for the Americas; September 23-27, 2018; Washington, D.C.: PAHO; 2018.(document CD56/8,Rev.1). Available at: https://www3.paho.org/hq/index.php?option=com_docman&view=document&alias=46461-cd56-8-e-poa- wca&category_slug=56-directing-council-english-9964&Itemid=270&lang=en.

2 Every Woman, Every Child: Global Strategy for Women's, Children's, and Adolescents' Health 2016-2030. New York: EWEC; 2015. Available at: https://platform.who.int/docs/default-source/mca-documents/rmncah/global- strategy/ewec- globalstrategyreport-200915.pdf?Status=Master&sfvrsn=b42b6d22_4.

3 Pan American Health Organization. Plan of Action for Women's, Children's, and Adolescents' Health 2018 -2030. 56th Directing Council, 70th session of the Regional Committee of WHO for the Americas; September 23 -27, 2018; Washington, D.C. Washington, D.C: PAHO; 2018 (document CD56/8, Rev.1). Available at: https://iris.paho.org/handle/10665.2/49609

Regarding the geographic scope of the Project, although it has been administered, managed, and coordinated from the Office of the Assistant Director at PAHO Headquarters, it was implemented in six countries of the Region (Bolivia, Colombia, Ecuador, Guyana, Honduras, and Peru) with the support of various technical departments at PAHO Headquarters. These countries were selected after an extensive analysis of a set of criteria related to the health situation in the countries and their performance in the sector of focus. The specific geographic emphasis within each country (e.g., departments and municipalities) was defined as part of the more detailed planning process with the countries once implementation began.

The IHWAG Project is aligned with Canada's international development priorities, specifically with its Feminist International Assistance Policy regarding maternal, newborn, child, and adolescent health, women's and girls' rights to autonomy and representation in matters concerning their sexual and reproductive health. The Project also aims to advance the achievement of the goals and objectives of the PAHOO Strategic Plan 2020-2025[5]in the six target countries.

The Project funds were allocated as part of the implementation of PAHO biennial work plans (BWPs); therefore, the project feeds into six national and ten regional annual work plans (AWPs). These AWPs in countries and regional units have been the basis for implementing the Project in a decentralized manner and for annual reporting.

This Project has served as a platform through which PAHO provides technical cooperation and support to increase access to health services, with emphasis on essential maternal, child, and adolescent health services that benefit populations in situations of vulnerability. The main components of the initiative are the following: (a) strengthening the response capacity of local health services and teams, (b) preventing adolescent pregnancy, (c) preventing maternal and neonatal morbidity and mortality, (d) addressing inequality gaps in terms of access to and coverage of health services, and (e) advancing the comprehensive health of women and adolescent girls with a focus on rights, gender, and interculturality. To achieve the expected results, the participating countries adapted the Project framework to their national priorities, identifying the health needs of specific population groups.

Finally, the IHWAG Project has promoted and strengthened inter-programmatic collaboration among PAHO technical departments, both at Headquarters and within the Organization's country offices, to promote the efficient use of resources and ensure compliance with PAHO mandates on gender and ethnic equality, cultural diversity, and human rights.

After having completed the implementation of the IHWAG Project in December 2024, and as per the subsidiary arrangement, PAHO needs to conduct an external evaluation of the Project, hiring an expert consulting firm/group (hereinafter, "the firm") to carry out an evaluation of the impact generated by the Project in the various areas of intervention in the six countries.

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4 Government of Canada, Global Affairs. Feminist International Assistance Policy. Available at: https:/ /www.international.gc.ca/world-monde/assets/pdfs/iap2-eng.pdf?_ga=2.229230556.1745052222.1729625745- 2012179575.1729625745

5 Strategic Plan of the Pan American Health Organization 2020-2025: Equity at the Heart of Health (Official document: 359). Pan American Health Organization, 2020. ISBN: 978-92-75-37361-3. Available at: https://iris.paho.org/handle/10665.2/52473

II. Purpose and Objectives

As established in the subsidiary arrangement for the implementation of the IHWAG Project, an evaluation will be carried out to assess the impact of this initiative's interventions. To this end, the aim of the call for proposals is to hire a firm to implement a decentralized evaluation in accordance with PAHO's Evaluation Handbook and operational guidance (2022).

The general purpose of this evaluation is to determine the results achieved after the implementation of the Project, and to identify the most significant impacts and good practices that this initiative generated in terms of the health of women and adolescent girls in the intervention areas during the 2021-2024 period. The results of this evaluation will be shared with PAHO senior managers and decision-makers, the technical teams of PAHO country offices, as well as with GAC, so that its conclusions and recommendations will be available as part of the Organization's ongoing learning for future collaborations.

The evaluation of this Project, which will involve six countries of the Region and various technical departments of PAHO Headquarters, has the following main objectives:

- Determine to what extent the expected results were achieved to improve access to quality services and strengthen the role and empowerment of women and adolescents with respect to their health.
- Identify innovative strategies that were used to achieve the Project objectives.
- Identify key aspects on the management and monitoring mechanisms used during Project implementation.
- Identify good practices, establish recommendations, and lessons learned that will positively contribute to the implementation of similar initiatives in the future.

III. Scope and Approach

Scope

This evaluation will focus on the six implementing countries of the IHWAG Project. The evaluation will examine data from 2021-2024 during the Project execution phase, including an overall review of the entire implementation process to examine the results achieved and to determine the contribution to the intermediate and immediate outcomes of the Project. This review is also expected to identify the impacts that this initiative had on the health and participation of women and adolescent girls; its positive impacts on health systems at all levels; and the degree to which gender, ethnicity, and human rights approaches were addressed. It is also expected to highlight good practices, as evidence of possible mechanisms for scaling up interventions in different contexts and localities in the Region.

The evaluation will cover the period 2021 to 2024, and the firm conducting the evaluation will consider the following:

A detailed field evaluation is to be carried out in Colombia, Guyana, and Honduras, which were selected to ensure representation of each of the subregions targeted by the Project. A general remote evaluation is to be carried out in Bolivia, Ecuador, and Peru.

The evaluation will provide conclusions and recommendations, and highlight lessons learned, good practices, to guide similar collaborations in the future.

Approach

Given that the Project focused on the implementation of a variety of interventions that were addressed through an interprogrammatic, interinstitutional, and multisectoral approach to promote the involvement of women and adolescent girls in spaces for social participation, to strengthen their empowerment in health decision-making, and to improve their access to quality health services in the intervention areas, this will be a formative evaluation, using

a mixed assessment method with special emphasis on qualitative assessment to determine whether and how results were achieved during the intervention period.

The firm awarded the evaluation contract will collect information from the following primary sources: (i) document review, including work plans and progress reports, generated from information provided by the countries and technical departments implementing the Project; (ii) annual reports prepared by the Project management team; (iii) interviews with counterparts and beneficiaries of the Project in the participating countries; (iv) interviews with technical teams and PAHO focal points in the country offices; and (v) observational exercises during field visits in the three countries mentioned above.

IV. Evaluation Criteria and Key Evaluation Questions

The questions contained in Table 1 will be used to guide the evaluation process and will form part of the basic tools that the firm will have to apply in developing its work methodology and evaluation deliverables throughout the intervention process. It is also important to note that, although the scope of the evaluation will encompass these questions, it will not be limited to them.

Table 1. Guiding evaluation questions

EVALUATION CRITERION	EVALUATION QUESTIONS	EVALUATION SUB-QUESTIONS
RELEVANCE	Q.1. Were the Project objectives consistent with the national priorities and programs of the six intervention countries, as well as with the needs of the beneficiary populations, which were predominantly Indigenous and Afro-descendant women and adolescents?	1.1. Were the Project's approach and the design of its logic model aligned with national health and development priorities, as well as with the priorities of PAHO's Strategic Plan 2020-2025; PAHO's Action Plan for Women's, Children's and Adolescents' Health 2018-2030; the 2030 Agenda; and Canada's Feminist International Assistance Policy? 1.2. Was the Project adapted to the contexts of the territories of implementation and the conditions of Indigenous and Afro-descendant women and adolescents? 1.3. What is the beneficiary population's perception of the importance of addressing issues related to maternal and child health, women's health, and adolescent health?
EFFECTIVENESS	Q.2.After Project implementation, what is the level of achievement of the results and indicators established in the Performance Measurement Framework and overall Project monitoring?	2.1. To what extent did the Project respond to the challenges in access to and coverage of sexual and reproductive health and maternal health services in the implementation territories? 2.2. To what extent did Project implementation reach target populations in remote and hard-to-reach geographic areas? 2.3. To what extent did the Project contribute to strengthening the leadership of women and adolescents in the implementation territories regarding the exercise of their sexual and reproductive health rights? 2.4. What strategies can be highlighted as innovative, including the incorporation of communication actions, during the implementation of the Project's activities? 2.5. To what extent did the Project contribute to strengthening gender, human rights, and cultural diversity approaches in health services?
EFFICIENCY	Q.3. Were the mechanisms and practices used to manage, monitor, and implement the Project innovative and effective in achieving its overall objectives?	3.1. To what extent did the technical and human resources available for Project implementation contribute to achieving the Project objectives at the regional and national levels? 3.2. How efficient was the overall management and implementation of the Project, as well as the monitoring of its objectives and indicators? 3.3. Did the Project's coordination and liaison mechanisms with the

EVALUATION CRITERION	EVALUATION QUESTIONS	EVALUATION SUB-QUESTIONS
		various strategic partners contribute to the achievement of the Project results?
SUSTAINABILITY	Q. 4. How will the results achieved through the implementation of the Project continue to have a positive impact on the population, predominantly Indigenous and Afro-descendant women and adolescents living in situations of vulnerability?	4.1. Following the implementation of the Project, have the overall response capacity of the health services and the operational capacities of local health teams been strengthened? 4.2. What measures were taken by the implementing countries to ensure the sustainability of Project impacts? 4.3. What level of institutional, national, and/or subnational capacity do countries have to sustain results after Project implementation?

V. Methodology

As described in the previous sections, this process will include a formative evaluation of Project implementation; a mixed assessment method will be used, with special emphasis on qualitative aspects. Within this framework, the firm awarded the evaluation contract will gather information from primary and secondary sources. This will include the following tasks.

Document review:

- Policies, plans, and programs to understand the extent to which the Project has aligned its interventions with the PAHO Strategic Plan 2020-2025; the PAHO Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030; and Canada's Feminist International Assistance Policy.
- Project documents, including monitoring and communications plans, focal point meeting reports, work plans, and progress reports generated by PAHO country offices and regional entities that implemented the Project.
- Annual reports by the management and the Project management team.
- Structured and semi-structured interviews with:
    - Country counterparts and representatives of government agencies involved in the Project's implementation and in supporting local coordination during the Project period.
    - Project beneficiaries in the intervention countries, with special emphasis on Indigenous and Afro-descendant women and adolescent girls.
    - PAHO technical teams and/or focal points in the country offices and regional technical departments.
    - Observational exercise
    - Review and inquiry during field visits to intervention areas in Colombia, Honduras, and Guyana.

Data collection activities, strategies, and protocols should be gender-sensitive, and the firm should ensure equitable participation regardless of gender, socioeconomic status, ethnicity, and social identity; furthermore, protection protocols should be followed. The Evaluation Reference Group (ERG), the Evaluation Commissioner, the PAHO Evaluation Manager for this Project, and the quality assurance member of the evaluation firm will review the evaluation protocols before their implementation. These activities and protocols should follow the principles of inclusion, participation, reflection, respect, transparency, and accountability.

Finally, it is expected that, for the submission of the proposal during the bidding period, as well as during the initial phase of the contractual process, the firm will elaborate in greater detail on the methodological approach and the tools and mechanisms it will employ for data collection, taking into account all of the above-mentioned references.

VI. Possible Limitations

Limitations that may arise during the development of the evaluation process are listed below; however, the firm will be responsible for identifying additional constraints and presenting, as part of its work proposal, contingency mechanisms it plans to use to mitigate the impacts these limitations may cause.

- Challenges regarding the availability of the parties identified for consultations and/or interviews, which may limit their representation and participation.
- Linguistic barriers are encountered in the process, which entails consultations and interviews with Afro-descendant and Indigenous populations from the intervention areas.
- Political and/or social situations in the countries and areas of intervention may delay the evaluation activities.
- Availability of data and information in intervention countries.
- Challenges relating to intersectional discrimination and inadequate awareness of how multiple layers of discrimination and disadvantage (ethnicity, age, disability, sexual orientation and gender identity, socioeconomic status) interact with and influence health systems, which can lead to an incomplete understanding of the gender equality landscape.

VII. Use and Audience

The findings, results, and recommendations resulting from this evaluation will be used as part of the Organization's continuous learning and strengthening of its technical cooperation in public health, with an emphasis on improving maternal and child health, women's health, and adolescent health in the Region of the Americas.

The final report of this exercise will also be shared with PAHO senior management and decision-makers, technical teams, and officials from PAHO Headquarters and country offices, and with GAC. This group will constitute the primary users of the evaluation and will be able to consider the results as background information for future collaborations with donors and cooperation partners.

Secondary users may include policymakers at the country level, focal points for health promotion, staff dedicated to addressing social determinants and health inequities in Member States, and communities and partners or stakeholders from civil society involved with the topics addressed by the Project. The results of this evaluation may be used to inform the next PAHO Strategic Plan, to be submitted to Member States for consideration in 2025 and will also be made available for use and consultation by the general public.

VIII. Products and Work Plan

The firm's technical-methodological proposal must include the work phases outlined below to be carried out and deliverables to be provided during the evaluation of the Project.

Additionally, the firm must ensure that all officially delivered documents are formatted as follows: Arial, Aptos, or Verdana 12-point font; 1.15 line spacing; and APA-style bibliographic reference citations.

<u>Phase one: Inception report</u>

During the implementation of the first phase of this contract, the firm will develop and officially submit Deliverable 1.

- After the contract is officially awarded to the firm, an initial coordination meeting will be held with the ERG to review the terms of reference (ToR) and the contractor's proposal.

Deliverable 1. Inception report, 10 to 20 pages long (excluding annexes), detailing the following:

- Timetable and work plan
- Evaluation methodology

- Proposed adjustments to the scope, context, purpose, objectives, and evaluation criteria
- Interview guide and key questions for respondents
- Tools for the collection and systematization of quantitative and qualitative data
- Methods and strategies for data collection
- Mapping and a list of stakeholders (internal and external) to be consulted and interviewed (together with the Evaluation Commissioner)
- Risk analysis on methodology, limitations, and mitigation measures for potential foreseeable risks.
- Annexes containing tools and instruments related to the evaluation.
- Deliverable 1 must be officially submitted no later than 30 calendar days after the contract is signed and takes effect.

The ERG will review deliverable 1 as the official PAHO group responsible for analyzing and reviewing the deliverables of this consultancy. Upon approval, the first payment for this delivery will be made.

Phase two: Document review

Upon completion of the first phase, the firm will fulfill the requirements of the second through fourth phases of this contract and officially submit Deliverable 2.

- The firm will conduct a review of documents, reports, and sources of information relating to the purpose, scope, and implementation of the IHWAG Project.
- This review will include, among other relevant documents:
    - Memorandum of understanding (subsidiary agreement and amendments)
    - Project concept note
    - Project Implementation Plan
    - Project monitoring plan
    - PAHO Strategic Plan 2020-2025
    - GAC Feminist International Assistance Policy
    - PAHO Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030.
    - Narrative reports and AWPs (countries and regional entities)
    - Annual progress reports on the Project
    - Project financial reports
    - Focal point meeting reports
    - Project communications plan
    - Project communications materials
    - Letters and correspondence, as appropriate
    - Any other document that the firm or the ERG consider relevant.
    - PAHO/WHO will provide the above documents through the Evaluation Commissioner.

Phase three: Interviews, field visits, and qualitative data collection

- Following the review and systematization of documents relevant to the implementation of the IHWAG Project, the firm will conduct the following activities:
    - Interviews with beneficiaries in the six countries and with Project stakeholders, according to the stakeholder mapping, carried out for the first deliverable
    - Online interviews with technical teams and focal points of the Project at PAHO, both in the PAHO country offices in the six countries and at Headquarters
    - Interviews with GAC representatives
    - Field visits to selected areas covered by the Project in the three countries selected for on-site evaluations.
    - Observational exercise at the community level and in the health services of the intervention areas in the three countries selected for on-site evaluations.

Phase four: Draft report

- Preparation of a draft report on the overall evaluation process and of an executive summary in the form of a presentation to be made to the PAHO Assistant Director and ERG members, providing a preliminary review of the findings and results.

Deliverable 2: A report of 25 to 35 pages (excluding annexes), which will include the following sections:

- Brief description of the purpose and objectives of the evaluation
- Brief description of the methodology and strategies applied for the assessment and information gathering exercise
- Main findings and conclusions of the evaluation
- Current status of achievement of the Project's expected results
- Descriptive analysis of qualitative findings/results and quantitative triangulation
- Lessons learned
- Good practices
- Recommendations
- Limitations
- Conclusions
- Presentation and executive summary

The draft report will also include the following annexes: (i) evaluation plan; (ii) list of documents reviewed; (iii) meetings and stakeholders interviewed, by location; (iv) detailed evaluation methodology; (v) brief standardized summary of field visits; (vi) data collection tools and other tools considered relevant to the process.

Deliverable 2 must be officially submitted within 60 calendar days after submission of Deliverable 1.
Deliverable 2 will be reviewed by the ERG as the official PAHO group tasked with analyzing and reviewing the deliverables of this consultancy. After its approval, the second payment, corresponding to this delivery, will be made.

Phase five: Final report

Upon completion of the second through fourth phases, the firm will fulfill the requirements of the fifth phase of this contract and officially submit Deliverable 3.

Preparation of the final report, which will incorporate comments from the ERG. The final report will follow the same structure and contents of the draft report. Deliverable 3 must be officially submitted no later than 30 calendar days after submission of Deliverable 2.
Deliverable 3 will be reviewed by the ERG as the official PAHO group tasked with analyzing and reviewing the deliverables of this consultancy. After its approval, the third payment, corresponding to this delivery, will be made.
Payment for the aforementioned deliverables will be distributed as set forth in the table below (Table 2). However, it is important to bear in mind that these percentages are subject to adjustment at the final signing of the contract, once the technical and economic proposals of the candidate firms are reviewed.

Table 2. Schedule of payment

Phases	**Product**	**Percentage of payment**
One	Deliverable 1	30%
Two to Four	Deliverable 2	40%
Five	Deliverable 3	30%

IX. Quality Management and Assurance

This evaluation forms part of the activities established in the subsidiary arrangement for the implementation of the IHWAG Project.

The evaluation is being commissioned by the Office of the Assistant Director of PAHO, through the Project Management Team, and this will be the entity tasked with the official administration of the contract awarded to the firm. Prior to initiating the evaluation process and in accordance with the PAHO Evaluation Handbook, the ERG will have been appointed. The ERG will comprise PAHO staff from various areas who have knowledge and experience regarding both the technical content of the topics addressed under the Project and previous evaluation processes.

The evaluation process will be carried out by the selected firm, which will be external to and independent of PAHO. The firm will be responsible for and will maintain regular and periodic communication with the Project Manager/Evaluation Commissioner and the Evaluation Manager, both of whom will be members of the ERG, to ensure that the entire process is being implemented in accordance with the ToR. The PAHO Department of Planning, Budget, and Evaluation (PBE) will provide support during the implementation of the process for specific matters falling within its purview and as a member of the ERG.

The ERG will be responsible for ensuring the quality, objectivity, and independence of the evaluation and, as part of quality assurance, the ERG will monitor and review all deliverables (preliminary report, draft reports, final report) to verify compliance with the PAHO Evaluation Policy, the PAHO Evaluation Handbook, and the United Nations Evaluation Group (UNEG) quality standards. The ERG will also provide technical advice during the implementation of the evaluation process.

In addition, the ERG will provide advice to guide the firm in understanding the context of the PAHO and facilitating the necessary consultations during the design, initiation, implementation, and closure phases. In this regard, the IHWAG Project Management Technical Team will have carried out a process of reviewing and collecting documents/information repositories that will be submitted to the firm for consideration.

In accordance with the PAHO Evaluation Policy (2021), all PAHO evaluations are based on the UNEG Norms and Standards for Evaluation (2016) and comply with the UNEG Ethical Guidelines for Evaluation. The quality of the evaluation results must be in accordance with the guidelines of the United Nations Evaluation Group and the PAHO Evaluation Handbook (2022). Evaluations of PAHO- supported activities must be independent, impartial, and rigorous, and the evaluation firm must be models of personal and professional integrity. The external firm must comply with PAHO requirements for external contractual arrangements. Evaluation team members are expected to comply with the UNEG Code of Conduct for Evaluation in the UN System throughout the evaluation process.

X. Evaluators and Evaluation Firm/Group

The firm should have a multidisciplinary team of professionals with the following qualifications:

- Graduate degree in project management and evaluation, public health, sociology, or other social sciences
- Specialization in methodologies for gender-responsive evaluation of programs and projects
- Specialization in the application of qualitative and quantitative methods for evaluation/research
- The firm should have demonstrated experience in the following areas:
    - At least 7 to 10 years of experience in the implementation of evaluation, monitoring, and follow-up processes for health projects and/or programs with a regional scope
    - Demonstrable experience in assessment, evaluation, and/or analysis processes in which gender, intercultural, and human rights approaches have been considered
    - Demonstrable experience in similar complex evaluation processes conducted in countries of the Region of the Americas

- Understand (or be willing to learn about) the context of PAHO at the country, subregional, and regional levels.
- It would be considered an advantage if the firm also has demonstrable experience in managing and/or implementing evaluations for United Nations agencies or major bilateral programs of donor countries.

Technical skills and abilities of the firm:

- Theoretical and practical knowledge of the concepts and tools of results-based management and accountability and their applications
- Demonstrable ability to evaluate, analyze, synthesize, and provide recommendations on relevant technical issues
- Organizational and analytical skills for the production of reports and presentations
- Ability to communicate in culturally diverse contexts
- Familiarity with theory of change models
- Good level of teamwork and people skills
- Institutional work experience
- Analysis, information synthesis, and knowledge management
- Planning and strategic management of technical cooperation interventions
- Proficiency with software programs such as Microsoft Office, Word, Excel, PowerPoint, SharePoint, and Outlook. Other computer skills, and knowledge of other data analysis software programs
- Excellent command of Spanish and English, both written and spoken

General qualifications expected from the firm:

- The team should include at least one member with relevant methodological expertise in quality assurance for evaluation processes.
- The team must include at least one member as a data/research assistant.
- Consistency of roles and the likelihood of cohesion of the proposed team will be important considerations (e.g., it may be advantageous to include team members who have worked together on previous assignments)
- It would be advantageous for the team to have evaluators who reflect the diversity of the Region of the Americas and can provide a deeper understanding of contextual, cultural, and gender equality issues in the Region
- It would be advantageous for the firm to be based in a country of the Region of the Americas, or to be part of a consortium that includes teams from countries of the Region
- Team members should have no conflicts of interest, either individually or in relation to the proposed approaches; if any conflict of interest is perceived, the candidate firm should explain why it would not affect the credibility or independence of the evaluation.

XI. Application Process and Submissions

PAHO/WHO will evaluate proposals based on the extent to which their experience, qualifications, availability, and technical aspects align with the criteria outlined above. Another consideration in the selection of the firm will be its knowledge of the Region and its experience in evaluations involving issues and approaches similar to those of the IHWAG Project. The main criteria for evaluating proposals are summarized in Table 3 below. While it is not expected that candidate firms will be able to fully meet all of the criteria, or fully meet each criterion, the selected firm will be expected to meet the criteria to the greatest extent possible.

The selection process will also take into account the profile of the team members proposed by the firm and their capabilities (experience, qualifications, mix of expertise relevant to the task, presence of members from the Region of the Americas, and the proposed approach, including creativity, innovation, and the ability to propose a clear and adequate conceptual and analytical framework for the evaluation in the PAHO context). Please attach any other information considered relevant to the proposal.

Interested consulting firms are requested to submit the following:

- Résumé and cover letter, including the following information: availability, relevance, background, previous experience, and roles of the team members who will constitute the evaluation group.
- Technical proposal highlighting methodologies, methods, strategies, and approaches for conducting this evaluation.
- Financial proposal, including substantiating documents and corresponding breakdown to comply with these ToR.
- Other supporting materials, including copies of documents or links to previous evaluation reports.

Interested firms should submit their applications and proposals (résumé, cover letter, technical proposal, financial proposal, attachments) by email to the PAHO Procurement Office no later than 23:59 (in Washington, DC) on 10 December 2024.

Table 3. Main criteria for the evaluation of proposals

Criteria	Evaluation
Background and experience	Strong background and experience of the firm in evaluation and monitoring processes relating to health and applying gender, human rights, and cultural diversity approaches.
	Team members with extensive experience in program evaluation, evaluation planning and implementation, and in the use and combination of solid methods.
Team members	Role consistency and the likelihood of team cohesion are also related to task similarity.
	Presence of evaluators reflecting the diversity of the Region of the Americas who can provide a deeper understanding of equity and gender issues.
	Firm(s) based in countries of the Region of the Americas and/or that form part of consortia that include firms from countries of the Region.
Understanding of The PAHO/WHO context	The team must understand (or be willing to learn about) the context of PAHO at the country, subregional, and regional levels.
Methodology	Innovation in the proposed approaches and methods, and the ability to propose a conceptual and analytical framework suitable for this evaluation within the context of PAHO.
Conflicts of interest	Members must be free of conflicts of interest, both personally and with respect to what is proposed.

Annex 2. Regulatory frameworks of the Project countries

Within the framework of the analysis of public policies and regulations on public health and social protection, the main legal provisions implemented in the countries under evaluation are presented in Table 1. These regulations reflect the States' structural commitment to comprehensively protect and promote the well-being of women and adolescents, guaranteeing their equal access to fundamental rights, including health, education, prevention of gender-based violence, and social protection.

As shown in Table 1, below, the regulatory frameworks include laws specializing in the eradication of violence against women, strategies for the prevention of teenage pregnancy, comprehensive sex education policies and programs aimed at reducing maternal and neonatal mortality. Also noteworthy are the ten-year public health plans and regulations aimed at strengthening gender equity, as well as the incorporation of a human rights approach into the formulation of sectoral policies. The articulation of these regulations with national strategic plans strengthens governance in health and social protection, enabling more effective responses to the problems affecting women and adolescents.

Table 1: National regulatory frameworks

COUNTRY	MAIN REGULATORY FRAMEWORKS
Bolivia	• Law 2026 (1999) - Code of the Child and Adolescent • Political Constitution of the Plurinational State of Bolivia (2009) National Plan for the Integral Health of Adolescents and Youth (2009) • Law 054 (2010) - Law on the Legal Protection of Children and Adolescents • Law 348 (2013) - Comprehensive Law to Guarantee Women a Life Free of Violence. Law No. 548 (2014) - Child and Adolescent Code • National Strategy for the Prevention of Adolescent Pregnancy (2015-2020) • Ministry of Health Institutional Strategic Plan (2016-2020) • National Strategic Plan for Sexual and Reproductive Health (2015-2020) • Plurinational Public Policy for the Comprehensive Development of Early Childhood "Growing Together" (2020) • Multisectoral Plan for Integral Development for the Well-Being of Children and Adolescents (2021-2025) • Sectoral Plan for Integral Health Development (PSDI-S) 2021-2025
Colombia	• Law 1804 of 2016: Establishes the State Policy for the Comprehensive Development of Early Childhood from Zero to Forever • Law 1953 of 2019: Adopts measures to guarantee comprehensive health care for the adolescent population • Law 2084 of 2021: Establishes guidelines for the prevention of teenage pregnancy and the promotion of life projects • Law 2114 of 2021: Amends the Substantive Labor Code in relation to shared and flexible parental leave • Law 2244 of 2022 Law on Dignified, Respected and Humanized Childbirth: Recognizes the rights of women during pregnancy, labor, delivery, and postpartum, promoting a dignified, respected, and humanized childbirth • Law 2281 of 2023: Creates the Ministry of Equality and Equity • Law 2306 of 2023: Promotes the protection of maternity and early childhood, creating incentives and regulations for the construction of areas that allow breastfeeding in public spaces • Law 2310 of 2023: Mandates the issuance of technical guidelines for comprehensive maternal and neonatal health care • Law 2326 of 2023: Adopts the pink alert and other measures of prevention, protection, and reparation for girls, boys, young people, adolescents, and women victims of disappearance • Law 2433 of 2024: Guarantees universal access to the Mother Kangaroo Mother Method for premature or low birth weight newborns • Health Benefits Plan (2013): comprehensive care during maternity, childbirth, and for newborns

	• Ten-Year Breastfeeding and Complementary Feeding Plan 2021-2030: strategies to promote, protect, and support the practice of breastfeeding and adequate complementary feeding
Ecuador	• Law for the Promotion, Support and Protection of Breastfeeding (1995): Promotes the practice of exclusive breastfeeding during the child's first year of life and establishes norms to guarantee its implementation in public and private health services • Comprehensive Organic Law to Prevent and Eradicate Violence against Women (2018) • National Plan to Prevent and Eradicate Violence against Women 2020-2030 • National Intersectoral Policy for the Prevention of Pregnancy in Girls and Adolescents 2018-2025 • Childhood and Adolescence Code (2003) • Organic Health Law (2006) • National Agenda for Gender Equality 2021-2025 • National Sexual and Reproductive Health Plan (2017) • Free Maternity and Child Care Act (1994) • Standard for Essential Obstetric and Neonatal Care (2013) • National Plan for the Accelerated Reduction of Maternal and Neonatal Mortality • Organic Law on the Right to Human Care (2023): Guarantees rights related to human care in the labor and social sphere to persons with gestational capacity, during pregnancy, childbirth, puerperium, and breastfeeding
Guyana	• National Strategy for the Prevention of Adolescent Pregnancy (2022-2027) • Domestic Violence Law (1996) • Child Protection Act (2009) • Persons with Disabilities Act (2010) • National Health Plan 2021-2025 • Social Protection Law (2015) • National Youth Policy (2015)
Honduras	• Equal Opportunity for Women Law (Decree No. 34-2000) • Childhood and Adolescence Code (Decree No. 73-96) • Law against Domestic Violence (Decree No. 132-97) • Law for the Integral Protection of Children and Adolescents (Decree No. 35-2013) • National Women's Policy (2002) • National Sexual and Reproductive Health Policy (2016) • National Strategy for the Prevention of Adolescent Pregnancy in Honduras (ENAPREAH) • National Health Plan 2021-2030 • Framework Law of the Social Protection System (Decree No. 56-2015) • Law on the Promotion and Protection of Breastfeeding (2013) • Updated Protocols for Comprehensive Maternal and Neonatal Care (2025) • National Plan for the Reduction of Maternal Mortality 2022- 2026
Peru	• Law 30364 (2015) - Law to prevent, punish, and eradicate violence against women and family group members • Law 31155 (2021) - Law that prevents and punishes political harassment against women in political life • Law 30314 (2015) - Law to prevent and punish sexual harassment in public spaces • Law 27942 (2003) - Law for the Prevention and Punishment of Sexual Harassment • Law 30862 (2018) - Law that strengthens the fight against femicide, family violence and gender violence • National Gender Equality Policy (2019) - Framework aimed at closing gender gaps and promoting equality between men and women • Multisectoral Plan for the Prevention of Adolescent Pregnancy 2013-2021 - National strategy to reduce the incidence of teenage pregnancy • Law No. 31727 (2023) - Law that promotes the creation of the National Observatory for the Surveillance of the Integral Health of the Pregnant Mother and the Newborn • Technical Health Standard for Comprehensive Neonatal Health Care (2024): Approved by Ministerial Resolution No. 545-2024-MINSA

Annex 3. Project Logic Model

Ultimate Outcome	**1000.** Improved health of women and adolescent girls in situations of vulnerability in Bolivia, Colombia, Ecuador, Guyana, Honduras, and Peru.				
Intermediate Outcomes	**1100.** Increased access and coverage to integrated, equitable, rights-based, gender responsive, and culturally sensitive, people-centered, comprehensive SRH, maternal, adolescent girl, and women's health services and technologies based on the PHC approach.			**1200.** Strengthened empowerment and leadership of women and adolescent girls related to sexual, reproductive, and maternal health care and rights, considering social determinants of health.	
Immediate Outcomes	**1110.** Increased capacity of health institutions to provide SRH, maternal, adolescent girl, and women's health services, based on the primary health care approach.	**1120.** Enhanced capacity (policy, legal, program, and process) of national, sub-national, and local government authorities to address inequities in sexual, reproductive, and maternal health and rights based on the PHC. Approach.	**1130.** Strengthened evidence base to address inequalities in access to sexual, reproductive, and maternal health and rights.	**1210.** Increased knowledge, representation, and participation of women and adolescent girls in decision-making platforms that address gender-responsive and culturally sensitive sexual, reproductive, maternal, and child health and rights.	**1220.** Strengthened coordination and cooperation across relevant sectors and stakeholders at national, subnational, and local levels to address social determinants of health related to inequities in sexual, reproductive, and maternal health and rights.
Outputs	**Output 1111.** Technical cooperation provided to national/sub-national/local MoH authorities for the strengthening and/or adaptation of national technical guidelines and tools towards enhancing SRH, maternal, adolescent girl, and women's health services	**Output 1121.** Technical cooperation provided to national/sub-national/local MoH, government authorities, with community participation, for the enhancement and/or adaptation of policies, legislation, and/or strategies for SRH, maternal, and adolescent girls. and women's health with a community focus.	**Output 1131.** Technical cooperation provided to national, sub-national, and local health and/or other government authorities to reinforce health information, surveillance, and monitoring systems to measure and monitor access and quality of SRH, maternal, perinatal, adolescent girl, and women's health, and rights of women & adolescent girls.	**Output 1211.** Technical cooperation and support provided to the government, civil society, and organized community to address challenges related to comprehensive health education, engagement, practices, and utilization of services for SRH, maternal, adolescent girl, and women's health and rights at the individual, family, and community level.	**Output 1221.** Support provided to national, sub-national, and local health and government authorities and communities for the operationalization and institutionalization of participatory coordinating and decision-making mechanisms/platforms to address social determinants of health related to SRH, maternal, adolescent girls, and women's health and rights within the equity, gender responsiveness, and cultural diversity perspective
	Output 1112. Support provided to national, sub-national, and local governments towards strengthening the capacity of human resources for the delivery of SRH, maternal, perinatal, adolescent girls, and women's health services		**Output 1132.** Technical cooperation provided to national, sub-national, and local government for the implementation of operational research to improve effectiveness, efficiency, quality of services, and acceptability of SRH, maternal, adolescent girl, and women's health and rights.		

	Output 1113. Technical cooperation provided to national, sub-national, and local governments to improve equitable access to safe, cost-effective, quality, culturally appropriate medicines, health technologies, and related services for the provision of SRH, maternal, adolescent girl, and women's health in health facilities supported by the project	
	Output 1114. Support provided to national, sub-national, and local government to enhance hospital waste management, sanitation, and Infection Prevention and Control (IPC) programs in health facilities and communities supported by the project	

Annex 4. Evaluation Matrix

EVALUATION QUESTIONS	EVALUATION SUB-QUESTIONS	INDICATORS	DATA COLLECTION TOOLS	SOURCES OF INFORMATION	FORMATS	RISKS AND LIMITATIONS
Q.1. Were the Project objectives consistent with the national priorities and programs of the six intervention countries and with the needs of the beneficiary populations, predominantly indigenous and Afro-descendant women and adolescents?	1.1. Were the Project's approach and the design of its logic model aligned with national health and development priorities, as well as with the priorities of PAHO's Strategic Plan 2020-2025; PAHO's Action Plan for Women's, Children's and Adolescents' Health 2018-2030; the 2030 Agenda; and Canada's Feminist International Assistance Policy? 1.2.Was the Project adapted to the contexts of the implementation territories and to the conditions of indigenous and Afro-descendant women and adolescents? 1.3. What is the perception of the beneficiary population on the importance of addressing issues related to maternal and child health, women's health and adolescent health?	I.1.1. Degree of alignment of objectives with priorities of governmental public health and development policies (high/medium/low). I.1.2. Existence of initial needs assessment (YES/NO) I.1.3 Degree of adaptation of the objectives, results and activities of the Project with the needs of the beneficiary population in the countries of intervention (high/medium/low) I.1.3.1. Perception of the level of priority of the Project's problems by the beneficiary population (high/medium/low)	I.1.1 Documentary review and analysis & semi-structured interviews with officials and technicians of the Ministries of Health of the intervention countries; I.1.2. Review and analysis of the needs assessment. I.1.3 Focus group discussions with beneficiary population in 6 countries; I.1.4.	I.1.1 National Strategies and Plans, Health and Development Strategies of the 6 (six) countries of intervention. I.1.2. Initial Diagnosis of Needs I.1.3 Sound and written record of the testimonies of the beneficiary population I.1.4. United Nations Country Cooperation Frameworks UNFPA Regional Program for LAC PAHO's Gender Strategy in LAC	A. Registration matrix for document review B. Semi-structured interview guideline with government officials and technicians, PAHO and Government of Canada. C. Focus group discussion guideline with beneficiary population.	Difficulties of access to officials and technicians of the Ministries of Health due to change of authorities. Difficulties in accessing the beneficiary population. Effects of the electoral calendar
Q.2.Following Project implementation, what is the level of achievement of the results and indicators established in the Performance Measurement Framework and overall Project monitoring?	2.1. To what extent has the Project responded to the challenges related to access and coverage of sexual and reproductive health and maternal health services in the territories of implementation? 2.2. To what extent did Project implementation reach target populations in remote and hard-to-reach geographic areas? 2.3. To what extent did the Project contribute to strengthening the leadership	I.2Proportion of women and adolescents of reproductive age (10-49 years) meeting their need for family planning with modern contraceptive methods (disaggregated by 10-14 years, 15-19 years, 20+ years and by ethnicity, socioeconomic group at subnational level) (AOP indicator 3.1.1 of the AOP); Proportion of births attended by skilled health personnel; MTCT Plus: Mother-to-child transmission rate of HIV and syphilis; Satisfaction of health users (%) with the quality of health services provided at the first level of care in selected countries (disaggregated by age, sex, ethnicity, place of residence, income level). I.2.2. % coverage (Baseline/Targets/implementation level) disaggregated by sex, age, and place of residence.	I.2.1. Quantitative analysis of the Project's records and sources of verification according to the LFM indicators. I.2.2. Online survey of users of health services on quality of services I.2.2. Mixed analysis of the records and sources of verification of the Project according to indicators of the LFM Semi-structured interviews with officials and technicians of the	Project Baseline Updated beneficiary population database Documentary verification sources (records) according to Project monitoring and evaluation reports. User satisfaction survey database (Project history + final evaluation) Audio and written records of interviews with officials and technicians of the	B. Semi-structured interview guidelines with government and PAHO officials and technicians. C. Focus group discussion with population beneficiary/historical satisfaction surveys	Lack of registration and data gaps Difficulties of access to rural and remote areas.

	of women and adolescents in the implementation territories regarding the exercise of their sexual and reproductive health and maternal health rights? 2.4. What strategies can be highlighted as innovative, including the incorporation of communication actions during the implementation of the Project's activities? 2.5. To what extent did the Project contribute to strengthening gender, human rights and cultural diversity approaches in health services?	I.2.3. Number of countries with institutional responses and accountability mechanisms that are promoting health equity, gender and ethnic equality in health and human rights; Percentage of women reporting increased decision-making or control over reproductive health, contraceptive use, and sexual relations (link to Por 2.2.3); Number of countries with specific mechanisms through which women and adolescents can participate in the development, monitoring, and evaluation of public policies. I.2.4. Number and type of innovative strategies proposed by the Project	Ministries of Health of the intervention countries.	Ministries of Health of the intervention countries. Project communication strategy		
Q.3. Were the mechanisms and practices used to manage, monitor and implement the Project innovative and effective in achieving its overall objectives?	3.1. To what extent did the technical and human resources available for Project implementation contribute to achieving the Project objectives at regional and national level? 3.2. How efficient was the overall management and implementation of the Project, as well as the monitoring of its objectives and indicators? 3.3. Did the coordination and liaison mechanisms with the different strategic partners carried out by the Project contribute to the achievement of its results?	I.3.1. Perception of the Project's technical and human resources. I.3.2.Existence of a regularly applied Monitoring and Evaluation Plan. I.3.2.1.Degree of compliance with the implementation schedule I.3.2.2.% of delays in technical and budgetary implementation I.3.2.3.% of economic execution of the Project I.3.3.Level of appreciation of the coordination and liaison mechanisms by the strategic partners I.3.3.2.3.% of delays in technical and budgetary execution	I.3.1. Semi-structured interviews with Project staff (focal points). Mixed analysis (qualitative/quantitative) of the approved/modified/implemented budget. Semi-structured interviews with strategic partners I.3.1. I.3.1. Focus groups with Project implementation teams. Online satisfaction survey of training participants.	Verbal and written records of semi-structured interviews. Monitoring and Evaluation Plan and Reports Agreements signed with strategic partners	A. Documentary registry matrix B. Semi-structured interviews with strategic partners. C. Focus groups with Project implementation teams. D. Historical documentary analysis of satisfaction surveys (Guyana/Ecuador) and on-site observation.	Lack of access or response of the beneficiary population to be included in the online survey
Q.4.How will the contributions and results obtained during Project implementation continue to have a positive impact on the population, predominantly indigenous and Afro-descendant women and adolescents living in vulnerable situations?	4.1. After the implementation and input of the Project, has the overall response capacity of the health services and the operational capacities of local health teams been strengthened? 4.2. What measures were taken by the implementing countries to ensure the sustainability of Project impacts?	I.4.1. % of technical and health management staff in the 6 intervention countries who claim to have strengthened: a) general response capacities and b) local teams. I.4.2. Number, level (national/subnational) and type of measures taken by Project implementers (regulatory, policy, institutional, and technical) I.4.3. Existence of normative (laws, regulations, etc.), political (plans, strategies, etc.), institutional (creation of areas, commissions, with allocated budget) and/or technical (newly trained personnel; acquisition of equipment) national and subnational capacities installed with the	I.4.1.-I.4.2. Online survey addressed to technical and health management personnel from the 6 intervention countries participating in training. I4.2.3. On-site observation I.4.1. Semi-structured interviews with management personnel (managers) and Project implementation (focal points) of PAHO and the	Database and graphs with the survey data Field observation records United Nations Country Cooperation Frameworks UNFPA Regional Program for LAC PAHO Gender Strategy in LAC	A. Semi-structured interview D. Online survey of health care teams E. Observation guideline	Lack of response from the personnel to whom the survey is addressed. Negative impacts of the change of authorities. Lack of prioritization of the Project's themes in the public policies of new government authorities.

	4.3. What level of institutional, national and/or subnational capacity do countries have to sustain results after Project implementation?	contribution of the Project. I.4.4. Degree of coordination with other similar Projects at inter-agency/inter-institutional level.	Government of Canada.			

Annex 5. Data collection tools

"IMPROVED HEALTH OF WOMEN AND ADOLESCENT GIRLS IN SITUATIONS OF VULNERABILITY " PROJECT

Semi-structured interview questionnaire for first and second level health service providers

Name of interviewee: _____
Institution/ post: _____
Time in office: _____

Free and informed consent/authorization to record the interview: Yes ( ) No ( )
Contextual questions:

1. What was your role in the implementation of the "IMPROVED HEALTH OF WOMEN AND ADOLESCENT GIRLS IN SITUATIONS OF VULNERABILITY" PROJECT?
2. When did your institution become involved in the implementation of the Project?

Criteria	Ask	Notes
RELEVANCE	1.1. Were the Project's approach and the design of its logic model aligned with national health and development priorities, as well as with the priorities of PAHO's Strategic Plan 2020-2025; PAHO's Action Plan for Women's, Children's and Adolescents' Health 2018-2030; the 2030 Agenda; and Canada's Feminist International Assistance Policy? 1.2. Was the Project adapted to the contexts of the territories of implementation and to the conditions of Indigenous and Afro-descendant women and adolescents? 1.3. What is the perception of the beneficiary population on the importance of addressing issues related to maternal and child health, women's health, and adolescent health? 1.4. To what extent did the Project integrate specific strategies to reduce maternal and neonatal mortality within the first and second-level health care systems?	
EFFICACY	2.1. To what extent did the Project respond to the challenges related to access to and coverage of sexual and reproductive health and maternal health services in the implementation territories? 2.2. To what extent did Project implementation reach target populations in remote and hard-to-reach geographic areas? 2.3. To what extent did the Project contribute to strengthening the leadership of women and adolescents in the implementation territories regarding the exercise of their sexual and reproductive health and maternal health rights? 2.4. What strategies can be highlighted as innovative, including the incorporation of communication actions, during the implementation of the Project's activities? 2.5. To what extent did the Project contribute to strengthening gender, human rights, and cultural diversity approaches in health services? 2.6. What actions did the Project implement to improve the capacity of health personnel in the prevention, care, and management of obstetric and neonatal emergencies?	

EFFICIENCY	3.1. To what extent did the technical and human resources available for Project implementation contribute to achieving the Project objectives at the regional and national levels? 3.2. How efficient was the overall management and implementation of the Project, as well as the monitoring of its objectives and indicators? 3.3. Did the Project's coordination and liaison mechanisms with the various strategic partners contribute to the achievement of the Project's results? 3.4**.** How did the allocation and management of Project resources contribute to improving the quality and availability of maternal and newborn health services?	
SUSTAINABILITY	4.1. After the implementation of the Project, have the overall response capacity of the health services and the operational capacities of local health teams been strengthened? 4.2. What measures were taken by the implementing countries to ensure the sustainability of Project impacts? 4.3. What level of institutional, national and/or subnational capacity do countries have to sustain results after Project implementation? 4.4. What strategies were implemented to ensure the continuity of maternal and neonatal health interventions after Project completion?	
CROSS-CUTTING APPROACHES	5.1 Did the initiatives that were undertaken take into account the particularities (gender approach, human rights, equity and socioeconomic inequalities) of the different territories of the country? 5.2**.** How were intercultural approaches and new masculinities incorporated into maternal and neonatal care in first and second level health services?	
RECOMMENDATIONS	6.1. What are the lessons learned and good practices that you identify in the implementation of the policy? 6.2. What recommendations would you make for future projects? 6.3. What strategies could be implemented to strengthen the sustainability of maternal and newborn health actions in future interventions?	

"IMPROVED HEALTH OF WOMEN AND ADOLESCENT GIRLS IN SITUATIONS OF VULNERABILITY " PROJECT

Semi-structured interview questionnaire addressed to authorities, decision makers, in Ministries of Health, representatives of PAHO headquarters and country offices, representatives of the Government of Canada, agencies of the United Nations system

Name of interviewee: _____
Institution/ post: _____
Time in office: _____

Free and informed consent/authorization to record the interview: Yes ( ) No ( )

Criteria	Ask	Notes
Relevance	1.1 How did the Project respond to the specific health needs of women and adolescents in the different territories of the country, considering their socio-cultural and economic contexts? 1.2. How did the Project contribute to strengthening the health system's capacity to address maternal and neonatal mortality in the intervention territories?	
Efficiency	2.1 What were the major achievements of the Project in terms of access to sexual and reproductive health services for women and adolescents? What barriers persist? 2.2. What were the Project's most effective strategies to reduce maternal and neonatal mortality, and what challenges remain in the care of obstetric and neonatal emergencies?	
Efficiency	3.1 What was the coordination and articulation between your institution and other actors (NGOs, UN agencies, government, civil society) to maximize the impact of the Project? 3.2. How has the investment of Project resources impacted the improvement of infrastructure, equipment and training of health personnel for maternal and neonatal care?	
Sustainability	4.1 What measures were taken to ensure the continuity of the Project's progress after its completion? Are there financial and political commitments for its sustainability? 4.2. Have national policies or protocols been established to ensure the sustainability of the actions implemented by the Project in reducing maternal and neonatal mortality?	
Cross-cutting approaches	5.1 To what extent did the Project effectively integrated gender, human rights, and intercultural approaches in the provision of health services? 5.2**.** How did the Project integrate intercultural and equity approaches in maternal and newborn care to ensure accessible and culturally relevant services?	
Recommendations	6.1 From your experience, what elements should be maintained or strengthened in future projects? What changes or improvements would you recommend? 6.2. What actions do you consider necessary to improve coordination between the government, international cooperation and civil society in health Projects for women and adolescents? 6.3. What additional measures would be necessary to consolidate and expand the Project's achievements in reducing maternal and neonatal mortality?	

"IMPROVED HEALTH OF WOMEN AND ADOLESCENT GIRLS IN SITUATIONS OF VULNERABILITY " PROJECT

Semi-structured interview form for Civil Society Organizations and Non-Governmental Organizations

Characterization of the interviewee
Name of interviewee: _____
Institution/ post: _____
Time in office: _____
Location: _____

Free and informed consent/authorization to record the interview: Yes ( ) No ( )
Contextual questions:
What was the institutional experience prior to your involvement with the implementation of the Project?

Criteria	Ask	Notes
Relevance	1. Was the Project aligned with national health priorities and international commitments on women's and adolescents' rights? 2. How did your organization participate in adapting the Project to the socio-cultural realities of indigenous and Afro-descendant women and adolescents? 3. What have been the main challenges in ensuring that the needs and priorities of the communities are incorporated into Project planning? 4. Were there gaps in the Project design that could be addressed to improve impacts on communities in situations of vulnerability? 5. How has the Project contributed to the improvement of maternal and neonatal care in Indigenous and Afro-descendant communities, ensuring alignment with national health priorities?	
Efficiency	6. What progress has your organization seen in terms of access to sexual and reproductive health services for women and adolescents since the implementation of the Project? 7. What have been the main obstacles to the implementation of sexual health and reproductive rights education and awareness strategies in the communities? 8. Has the Project contributed to strengthening the leadership of women and adolescents in the promotion of their health rights? How? 9. What Project strategies have been most effective in reaching communities in remote or hard-to-reach areas? 10. What strategies implemented by the Project have been most effective in reducing maternal and neonatal mortality in the communities served?	
Efficiency	11. How do you evaluate the allocation of technical and human resources in the execution of the Project? Have they been sufficient to achieve the objectives? 12. Have there been challenges in coordinating with other organizations and governmental entities for Project implementation? How has this been handled? 13. How would you assess the efficiency of the Project's monitoring and follow-up mechanisms? What improvements would you suggest?	

	15. To what extent has your organization received the necessary support from the implementing agencies to ensure efficient Project implementation?	
Sustainability	16. What strategies were implemented to ensure continuity of health services after Project completion? 17. How did the Project contribute to strengthening the institutional and operational capacity of local actors in the provision of health services for women and adolescents? 18. Is there commitment on the part of local and national governments to continue supporting the Project's achievements? How has this been evidenced? 19. What recommendations would you make to ensure the sustainability of the interventions implemented by the Project in the medium and long term? 20. What actions were taken to ensure that progress in reducing maternal and neonatal mortality is sustained after Project completion?	
Cross-cutting approaches	21. How has the Project incorporated cross-cutting approaches such as gender, human rights, and cultural diversity into the provision of health services for women and adolescents? 22. What were the main challenges that your organization has identified in the implementation of strategies for equity and reduction of socioeconomic inequalities in access to sexual and reproductive health services? 23. How did the Project integrate an intercultural and equity approach to maternal and newborn care to ensure inclusive and relevant access?	
Recommendations	1. What adjustments or improvements would you recommend for future projects, to ensure a more sustainable impact on the health and well-being of women and adolescents? *2.* What measures would you recommend to strengthen the sustainability of actions focused on reducing maternal and neonatal mortality in future interventions?	

"IMPROVED HEALTH OF WOMEN AND ADOLESCENT GIRLS IN SITUATIONS OF VULNERABILITY " PROJECT

Focus group guideline: technical implementers

Participants

Name	Institution	Cargo
1. 2. 3.	1. 2. 3.	1. 2. 3.

Free and informed consent/authorization to record the interview: Yes ( ) No ( )

Guiding questions

1. From your experience in the implementation of the Project, what do you consider are the main milestones or achievements? (Explore key aspects such as improvements in access to health, capacity building, impact on vulnerable communities, among others).
2. In your opinion, which elements of the Project should be maintained in the next phase, and which should be changed? Why? (Probe for good practices, effective strategies and areas for improvement in terms of planning, implementation and sustainability).
3. Were the strategies implemented adapted to the socio-cultural and economic reality of women and adolescents in the intervention territories? How was this reflected in the response of the communities? (Explore if there were cultural adjustments, if local customs, access barriers and adaptation mechanisms of the Project were respected).
4. Which of the proposed results were achieved and which were not? What were the factors that facilitated or hindered their achievement? Were any unplanned effects or impacts identified? (Obtain information on the key success factors and challenges faced in implementation).
5. If you had to evaluate the training processes of the technical staff involved in the implementation of the Project, how would you rate it on a scale of 1 to 5 (5 being the best grade) and why? (Evaluate the quality and relevance of the training, the impact on the team's performance and opportunities for improvement).
6. What do you consider to be the main challenges and opportunities for the changes generated by the Project to be maintained over time? (Inquire about sustainability factors such as public policies, community leadership, continuity of financing and institutional strengthening).
7. What strategies were most effective in reducing maternal and neonatal mortality, and to what extent were they adapted to the socio-cultural and economic needs of the communities served?
8. What challenges did you face in implementing actions to improve maternal and neonatal care, and what measures do you consider necessary to ensure the sustainability of the progress achieved?
9. Do you have any further comments, suggestions, or recommendations for the initiation of this evaluation? (Allow space for additional input on approaches, indicators, or key issues that should be considered in the Project analysis.)

"IMPROVED HEALTH OF WOMEN AND ADOLESCENT GIRLS IN SITUATIONS OF VULNERABILITY " PROJECT

Observation guideline

A. Identification

Date:
Evaluator:
Institution:
Country:
Location:
Representative/person in charge.
General aspects.
Free and informed consent/ authorization for photographic or video recording: Yes ( ) No ( )

B. Elements to consider - **Observation matrix**

Evaluation Criteria	Observation category	Key aspects to evaluate	Observation indicators	Evidence
Relevance	**Accessibility and coverage**	Location, transportation, opening hours, and mobile services.	Proximity of the center to the community, transportation available, and signs with visible schedules.	Easy access to the center, flexible and extended care, and convenient transportation options.
Efficiency	**Attention with a gender and human rights approach**	Separation of spaces for differentiated attention, educational material in different languages.	Presence of posters and brochures in indigenous/local languages, specific rooms for women and adolescents.	Use of inclusive language in materials, privacy in service, and cultural adaptation of the service.
	User perception	Behavior and comfort level of patients in the waiting room and during care.	Facial and body expression of satisfaction or discomfort, willingness of patients to ask questions or give feedback.	Confidence and comfort in patients, fluid interaction with health personnel.
	Inter-institutional coordination	Liaison with NGOs, local institutions and health programs.	Presence of partner logos on documents and posters, information on referencing on murals.	Existence of clear information on support networks, posters or brochures with references to other services.
	Registration and documentation	Organization of the administrative area, visibility of data collection tools.	Organized files, software in use on workstations, and visible confidentiality protocols.	Accessible and orderly records, compliance with privacy regulations.
Effectiveness	**Effectiveness**	Changes observed in care and coverage.	Comparison of patient flows (before and after the Project), and infrastructure improvement.	Increase in the number of patients attended, improvement in waiting times, and attention.
Sustainability	**Use of resources**	Availability and condition of medical supplies, office supplies and equipment.	Inventory in sight, equipment in operation, and adequate storage conditions of supplies.	Resources are available in sufficient quantity and are used efficiently and adequately.
	Strategies for continuity	Evidence of planning for Project continuity.	Presence of visible plans or agreements, commitments from local authorities.	Documents or posters on institutional commitments and ongoing programs for service continuity.

During the observation visits, the consultant team will also pay attention to the state of the equipment, supplies, availability of space and sanitary infrastructure. However, it should be noted that the Project has not contemplated specific components for this purpose that are subject to evaluation. Its approach will be descriptive and complementary.

INFORMED CONSENT FOR INTERVIEW

Presentation of the evaluation

The purpose of the process is to evaluate the Improved Health of Women and Adolescent Girls in Situations of Vulnerability Project 2021-2024 (IHWAG), which is being implemented by the Pan American Health Organization, to learn, systematize, and evaluate the key elements of the intervention with a view to its completion.

We want to thank you for agreeing to participate in this interview/workshop/or focus group, which will last approximately 45 minutes. All information collected is confidential and will be used exclusively for the evaluation. For more information, please read the ***attached personal data security protocol***.

Participation in the evaluation process is entirely voluntary, and you may withdraw in whole or in part, without any prejudice. In case of any questions, you can write to Cecilia Delaney at the following e-mail address: cecilia.delaney@c.inclusionyequidad.org

Background of the person participating in the interview

Name	
Organization	
Position held	
Year in office	
Contact (phone or mail) Date	

_____

Signature Informed consent.

PROTOCOL FOR THE USE OF INFORMATION

Inclusion y Equidad, as the consultant firm in charge of the external evaluation, will process the personal data of the interviewees (personal interviews or focus groups) lawfully and transparently in relation to the data subject.

Personal data, such as the interviewees' names and surnames, will be treated confidentially and not published. The information collected during the interviews and focus groups, i.e., all opinions, knowledge, and comments related to the work of OPS, will be used for the evaluation process and the drafting of the final evaluation report, and will remain anonymous.

The data may be collected through audiovisual recordings or written notes made by the staff of Consultora Inclusión y Equidad, with the interviewees' consent. The data will be stored for the duration of the evaluation process (February - July 2025). They will not be shared with third parties; access will be limited to the consultants in charge of drafting the evaluation report. The transcribed interviews, recordings, notes, and field observations will be stored electronically and protected by a password known only to the consulting team. Inclusion and Equity will make regular backup copies of these files, which will also be stored offline.

The entity will process the data in a manner that ensures adequate data security, including protection against unauthorized or unlawful processing, by implementing the appropriate technical and organizational measures described above. Inclusion and Equity will only process personal data when it complies with the unequivocal consent of the data subjects, as provided by a clear affirmative manifestation. Consent must be "unequivocal," and forms of tacit consent or consent by omission will not be admitted. For face-to-face interviews and focus groups, an informed consent document will be provided in advance to each person involved in the evaluation as an attachment to the invitation email, while for virtual interviews, an oral statement will be requested from the interviewee at the beginning of the meeting.

Personal data will be collected for specified, explicit, and legitimate purposes related to the evaluation process. They will not be processed in a manner incompatible with those purposes or in a manner different from those purposes. The data shall be adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed and shall be stored no longer than necessary for their processing. Once that time has elapsed, the data will be permanently deleted.

The interested party may at any time object to the processing of their personal data and request its cancellation, without justification. For this purpose, if necessary, you may contact the Director of Consultora Inclusión y Equidad, Alejandra Faúndez, at the following email address: alejandra.faundez@c.inclusionyequidad.org

Annex 6. Initial mapping of institutional actors and key informants

REGIONAL LEVEL List for individual or group interviews				
	Institution/Organization	**Position**	**Role in the project**	**Contact information**
Pan American Health Organization				
1	PAHO	Regional Advisor	Focal point-CDE	
2	PAHO	Regional Advisor	Focal point - DUS	
3	PAHO	Regional Advisor	Focal point - EIH	
4	PAHO	Regional Advisor	Focal point - HSS	
5	PAHO	Regional Advisor	Focal point - IMT	
6	PAHO	Regional Advisor	Focal point - NMH	
7	PAHO	Regional Advisor		
8	PAHO	ERP		

BOLIVIA List for individual interviews and focus groups (face-to-face/virtual modality)						
	Name	**Institution/ Organization**	**Position**	**Role in the Project or thematic area of expertise**	**Contact information**	**Territory**
Pan American Health Organization						
1		PAHO	PWR			National
2		PAHO	DHE/HSS Advisor	Focal point		National
3		PAHO	Consultant	Implementing team		National
4		PAHO	Consultant	Implementing team		National
5		PAHO	Consultant	Implementing team		National
Direct Beneficiaries						
6		Ministry of Health Universal Health Information System	Technical Area Manager	Activity coordination		National
7		Departmental Health Service	Network and Services Manager	Activity coordination		Santa Cruz
8		Departmental Health Service	Sexual Reproductive Health Officer	Activity coordination		Cochabamba
9		GAIOC - Charagua	Health personnel	Knowledge Dialogues trainings		Santa Cruz-Chaco
10		Intercultural Community Family Health - SAFCI	Responsible Physicians SAFCI	Training for health personnel and midwives on obstetric maps and danger signs in pregnancy.		Santa Cruz-Camiri
11		Hospital de la Mujer - La Paz	Neonatal Physician in charge of Intensive Care	Neonatal resuscitation facilitator training		La Paz

12		Hospital Fray Francisco Del Pilar - Chaco	Area Director of Cabezas, Santa Cruz	Competence development centers		Santa Cruz - Chaco
Intermediate Beneficiaries						
13		Autonomous Municipal Government of Toledo	Mayor	Network Constitution Constitution of Healthy Municipalities		Oruro
14		Autonomous Municipal Government of Coroico	Mayor	Constitution of Healthy Municipalities		La Paz
15		Autonomous Municipal Government of Carmen Rivero Torrez	Mayor	Constitution of Healthy Municipalities		Santa Cruz
16		Autonomous Municipal Government of Mizque	Mayor	Constitution of Healthy Municipalities		Cochabamba-Mizque
17		Municipal Autonomous Government	Secretary of Human Development	Knowledge Dialogues trainings		Santa Cruz - Chaco
18		Association of Councilwomen of Bolivia-ACOBOL	Chief Executive Officer	International Meeting of Women Mayors Training for women councilors in La Paz		La Paz
19		Tekove Katu School - Gutiérrez	Beneficiary	Knowledge Dialogues trainings		Santa Cruz - Chaco
20		Tekove Katu School - Gutiérrez	Director of the Training School	Adolescent health Adolescent leadership Training in obstetric emergencies Obstetric Maps Dialogue of Knowledge		Santa Cruz - Chaco

COLOMBIA **List for individual interviews and focus groups (face-to-face/virtual modality)**						
	Name	**Institution/ Organization**	**Position/Role in the project**	**Role in the Project or thematic area of expertise**	**Contact information**	**Territory**
Pan American Health Organization						
1		PAHO	PWR			National
2		PAHO	DHE/HSS Advisor	Project focal point		National
3		PAHO	Gender and GBV Consultant	Gender-based violence		National

4		PAHO	Territory Consultant	Activity implementation		La Guajira
5		PAHO	Former Territorial Consultant Chocó	Activity implementation		Chocó
6		PAHO	Consultant	Project coordination		National
Canadian Cooperation						
7		GAC	Counterpart in Canadian mission			
Direct Beneficiaries						
8		National Institute of Health	Safe motherhood group coordinator	Health information systems		National
9		Ministry of Health and Social Protection	Life Course group coordinator.	Maternal and neonatal health		National
10		Ministry of Health and Social Protection	Ethnic and intercultural liaison	Intercultural activities		National
11		Secretary of Health of Cauca	Sexual and Reproductive Health Referent	Sexual and reproductive health and rights		Cauca
12		Ministry of Health and Social Protection	Sexuality Group - GBV Hotline	Sexual and reproductive health and rights		National
13		Ministry of Health and Social Protection	Contraception and teenage pregnancy	Adolescent health, family planning		National
14		Ministry of Health and Social Protection	Sexuality specialist	Sexual and reproductive health and rights		National
15		Secretary of Health - Guajira	Health expert	Sexual and reproductive health and rights		La Guajira
16		Secretary of Health - Risaralda	Health expert			Risaralda
Intermediate Beneficiaries						
19		Asorediparchocó	Traditional birth attendant	Maternal health		Chocó
20		Asorediparchocó	Traditional birth attendant	Maternal health		Chocó
Indirect Beneficiaries						
21		Beneficiary	Leader - GBV	Training participant		Bosa- Bogotá
22		Beneficiary	Leader - GBV	Training participant		Bosa- Bogotá
23		Beneficiary	Leader - GBV	Training participant		Bosa- Bogotá
24		Beneficiary	Leader - GBV	Training participant		Bosa- Bogotá
25		Beneficiary	Traditional birth attendant	Maternal health		Chocó
26		Beneficiary	Traditional birth attendant	Maternal health		Chocó

27		Beneficiary	Traditional birth attendant	Maternal health		Chocó
28		Beneficiary	Traditional birth attendant	Maternal health		Chocó
Other Actors						
29		UNFPA	SRH Advisor	Sexual and reproductive health and rights		National
30		Scientific Society	Colombian Association of Obstetrics and Gynecology			National

ECUADOR **List for individual or group interviews and focus groups (virtual modality)**						
	Name	**Institution/ Organization**	**Position**	**Role in the Project or thematic area of expertise**	**Contact Information**	**Territory**
Pan American Health Organization						
1		PAHO	PWR			National
2		PAHO	International Advisor	Project focal point		National
3		PAHO	National consultant	Project coordinator		National
Direct Beneficiaries						
4		Ministry of Education	Ayangue school tutor	Leadership, participation, empowerment, adolescent health		Santa Elena-Santa Elena
5		Ministry of Public Health	Community nutritionist	Neonatal health		Morona Santiago-Sucúa
6		Ministry of Public Health	First Level of Care Health Services Monitoring and Control Specialist	Maternal health		National
7		Simiatug Health Center	Obstetrician	Gender equity, maternal and neonatal health, leadership, participation, empowerment		Bolivar, Guaranda
8		Ministry of Public Health	Continuous Quality Improvement Specialist	Maternal and neonatal health		National
9		Ministry of Public Health	District Interculturality Officer	Gender equity, maternal and neonatal health, leadership, participation, empowerment		Morona Santiago-Méndez-Tiwintza
10		Ministry of Public Health	District Nutritionist	Leadership, participation, empowerment, adolescent health		Pastaza-Arajuno
11		Ministry of Public Health	Obstetrician Colonche Health Center-District 24D01	Maternal and neonatal health		Santa Elena-Santa Elena
12		Ministry of Public Health	National Director of Intercultural	Gender equity, maternal and neonatal health, leadership, participation, empowerment		National

			Health and Equity			
13		Ministry of Public Health	Director of District Health Promotion and Interculturalism 24D01	Gender equity, maternal and neonatal health, leadership, participation, empowerment		Santa Elena-Santa Elena
14		Ministry of Education	DECE/Arajuno Psychologist	Leadership, participation, empowerment, adolescent health		Pastaza-Arajuno
15		Ministry of Public Health	Project Analyst for the Prevention of Pregnancy in Girls and Adolescents Project	Leadership, participation, empowerment, adolescent health		National
16		Ministry of Public Health		Leadership, participation, empowerment, adolescent health		National
Intermediate Beneficiaries						
17		Cantonal Gad	Sowing Leaders	Adolescent health		Bolivar, Guaranda
18		Parochial Autonomous Government	Vocal GAD Parroquial	Gender equity, maternal and neonatal health, sexual and reproductive health		Pastaza-Arajuno-Curaray
19		GAD	Assistant to the Mayor of Santa Elena Canton	Leadership, participation, empowerment		St. Helena-
20		District Health Directorate 02D01	Community Facilitator	Gender equity, maternal and neonatal health, leadership, participation, empowerment		Bolivar, Guaranda
21		Patuca Community	Traditional birth attendant	Gender equity, maternal and neonatal health, sexual and reproductive health		Morona Santiago - Tiwintza
22		Community	Commission on Peoples and Nationalities	Leadership, participation, empowerment, adolescent health		Santa Elena-Santa Elena
23		Women's Forum	Administrator of the Bolivar Women's Forum Comprehensive Care Center	Leadership, participation, empowerment, adolescent health		Bolivar, Guaranda
Indirect Beneficiaries						
24		Educational Establishment	Marianitas School	Leadership, participation, empowerment, adolescent health		Bolivar, Guaranda
25		Community	Leader of adolescents in Ayangue	Leadership, participation, empowerment, adolescent health		Santa Elena-Santa Elena
26		Educational establishment	Student of Roberto Arregui School	Leadership, participation, empowerment, adolescent health		Bolivar, Guaranda, Los Trigales

GUYANA List for individual or group interviews and focus groups (virtual modality)						
	Name	**Institution/ Organization**	**Position**	**Role in the Project or thematic area of expertise**	**Contact Information**	**Territory**
Pan American Health Organization						
1		PAHO	PWR			National
2		PAHO	International Advisor	Project focal point		National
3		PAHO	National consultant	Project coordinator		National
Direct Beneficiaries						
4		Ministry of Health	Ministry of Health	All Topics		National
5		Ministry of Health	PMTCT Nursing	Prevention of Mother-to-Child transmission of HIV/Syphilis		MCH Departme nt
6		Ministry of Health	Adolescent Health Coordinator	Adolescent health, sexual and reproductive health, health promotion		Adolesce nt Health Unit
7		Ministry of Health	Director of Primary Health Care	Prevention of Mother-to-Child transmission of HIV/Syphilis, maternal and neonatal health		National
8		Ministry of Health	Manager	Health information systems		Public Hospital
9		Ministry of Health	Health management information system	Health information systems		National
10		Ministry of Health	Public Health Consultant/Hea lth Systems Specialist	Maternal and neonatal health, health information systems		National
11		Ministry of Health	Maternal and Child Health Officer, Region 9	Maternal and neonatal health, health information systems		National
12		Ministry of Health	Regional Health Officer, Region 9	Prevention of Mother-to-Child transmission of HIV/Syphilis, maternal and neonatal health		National
13		Ministry of Health	Mother-to-Child Transmission Prevention Coordinator	Maternal and neonatal health		National
14		Ministry of Health	Medical Director	Prevention of Mother-to-Child transmission of HIV/Syphilis, maternal and neonatal health		National
15		Ministry of Health	Maternal and Child Health Officer	Family planning		National
Other Actors						
16		Dr. Balwant Singh's Hospital Inc.	CEO	Health information systems in a private hospital		National

HONDURAS List for individual or group interviews and focus groups (virtual modality)						
	Name	**Institution/ Organization**	**Position**	**Role in the Project or thematic area of work**	**Contact Information**	**Territory**
Pan American Health Organization						
1		PAHO	PWR			National
2		PAHO	International Advisor	Project focal point		National
3		PAHO	National consultant	Project coordinator		National
GLOBAL AFFAIRS CANADA						
4		Embassy of Canada	Ambassador			National
Direct Beneficiaries						
5		Region of Gracias a Dios	Brus Laguna Municipal Coordinator	Sexual and reproductive health, maternal and neonatal health, leadership, participation, empowerment		Gracias a Dios
6		Leonardo Martínez Valenzuela Hospital	Gynecology and Obstetrics Specialist Physician	Maternal health, health information systems		Cortés
7		Hospital Escuela Bloque Materno Infantil	Medical Specialist in Pediatrics	Neonatal health		National
8		Region of Gracias a Dios	Regional Health Director	Sexual and reproductive health, maternal and neonatal health, leadership, participation, empowerment		Gracias a Dios
9		Secretary of Health	PAIPFC Technician	Sexual and reproductive health, maternal and neonatal health, leadership, participation, empowerment, health information systems		National
10		Intibucá Health Region	Regional Health Director	Sexual and reproductive health, maternal and neonatal health, leadership, participation, empowerment, health information systems		Intibucá
11		Secretary of Health	Deputy Secretary of Regulation	Leadership, participation, empowerment, health information systems		National
12		Gabriela Alvarado Sud Hospital	Assistance Director	Sexual and reproductive health, maternal health		El Paraíso
13		Cortes Health Region	Regional Health Director	Sexual and reproductive health, maternal health		Cortés
14		Atlantida General Hospital	Obstetrics and Gynecology Physician Specialist	Maternal health		Atlantida

15		Atlantida Health Region	Regional Health Director	Sexual and reproductive health,		Atlantida
16		Santa Barbara Health Region	Regional Health Director	Sexual and reproductive health, maternal and neonatal health, leadership, participation, empowerment, health information systems		Santa Barbara
17		Yamaranguila Educational Center	Teacher	Sexual and reproductive health, leadership, participation, empowerment		Intibucá
18		Dr. Enrique Aguilar Cerrato Hospital	Obstetrics and Gynecology Physician Specialist	Maternal health		Intibucá
Intermediate Beneficiaries						
19		Municipality of Yamaranguila	Municipal Mayor	Sexual and reproductive health, maternal and neonatal health, leadership, participation, empowerment		Intibucá
20		Trinidad SMI	Trinidad Municipal Health Coordinator	Sexual and reproductive health, health information systems		Santa Barbara
21		Mayor's Office of Trinidad	Municipal Mayor (SSSR, SMyN, L/P/EMP)			Santa Barbara
22		Traditional birth attendant	Traditional birth attendant	Maternal health		Santa Barbara
Other Actors						
23		Medical College and IHSS	Obstetrics and Gynecology Physician Specialist	Sexual and reproductive health, maternal health		National
24		National University of Honduras-UNAH	Graduate Nursing Coordinator	Sexual and reproductive health, maternal and neonatal health		National
25		UNFPA	Sexual and Reproductive Health Officer	Sexual and reproductive health, maternal health		National
26		Doctors without Borders	MSFCH-Choloma Coordinator	Sexual and reproductive health		National

PERU **List for individual interviews and focus groups (face-to-face/virtual modality)**						
	Name	**Institution/ Organization**	**Position**	**Role in the Project or thematic area of expertise**	**Contact information**	**Territory**
Pan American Health Organization						
1		PAHO	DHE/HSS Advisor	Focal point		National
2		PAHO	Consultant	Project coordinator		National
3		PAHO	Consultant	Activity implementation		National
4		PAHO	Consultant	Activity implementation		National
Direct Beneficiaries						

5		Ministry of Health of Peru (MINSA) Regional Directorate of Health, Amazonas	Regional Coordinator	Intercultural health		National
6		Atalaya Health Network	People's Health Coordinator	Activity coordination		National
7		Atalaya Health Network	Atalaya Health Network Director	Activity coordination		Atalaya
8		Atalaya Intercultural Hospital	Traditional community health worker and birth attendant midwife	Community health, maternal health		Atalaya
9		Atalaya Intercultural Hospital	Traditional community health worker and birth attendant midwife	Community health, maternal health		Atalaya
10		Ministry of Health	Executive Director of Indigenous Populations	Intercultural health		Lima

Annex 7. PAHO Country Cooperation Strategies main themes

Country	Strategic priorities
Bolivia	Country Cooperation Strategy 2023- 2027: 1. Strengthen health promotion and disease prevention throughout the life course, considering the determinants of health with an intercultural, gender, and rights-based approach. 2. Contribute to the development of a resilient Unified Health System (SUS) based on Primary Health Care with emphasis on the development of the Community and Intercultural Family Health Policy (SAFCI), guaranteeing free and equitable access. 3. Strengthen access to quality, integrated and comprehensive health services that respond to health needs centered on the person, family, and community, based on the SAFCI policy and incorporating a focus on rights, gender, and interculturality. 4. Strengthen the health system's preparedness, response, and early recovery capacity for health emergencies and disasters with community participation. 5. Strengthen the country's capacity to move towards the elimination of communicable diseases and the control of Non-Communicable Diseases (NCDs).
Colombia	Country Cooperation Strategy "Health Equity for Life" 2024- 2026: 1. Action on the social determinants of health and intersectoral work for the identification and intervention of health inequities. 2. Strengthened capacities for health governance, health sovereignty, inter-institutional coordination, decentralization of responsibilities, health management, and accountability. 3. Capacity building for the implementation of a resilient, responsive, and universal health system with a predictive and preventive health model based on PHC. 4. Health personnel development as a cornerstone of the health system. 5. Information systems enable informed and timely decision making in the health system. 6. Strengthened capacity in emergency preparedness and response, under the International Health Regulations (IHR) multi-threat framework, resilience, and the 'One Health' approach. 7. Strengthened capacities in the implementation of PAHO's Disease Elimination Initiative.
Ecuador	Country Cooperation Strategy 2024- 2028: 1. Contribute to the development of a resilient National Health System (NHS) to achieve universal health access and coverage. 2. Strengthen intersectoral action on the social, economic, and environmental determinants of health, with an emphasis on vulnerable population groups, to reduce inequity and inequality gaps in health. 3. To promote the well-being and health of people throughout the life course through a holistic approach to health, the promotion of healthy lifestyles, and the prevention of diseases to reduce the burden of disease, disability, and mortality. 4. Strengthen national capacity to manage natural and anthropogenic risks and future health emergencies and their impact on people's health.
Guyana	Country Cooperation Strategy 2023- 2027: 1. Strengthen health systems to achieve universal health coverage and access. 2. To reduce morbidity and mortality from non-communicable diseases and mental health through a holistic approach. 3. Strengthen surveillance and response to prevent, control, and eliminate communicable diseases. 4. Improve health and well-being throughout life. 5. Strengthen health emergencies, disaster risk management, and response, including the International Health Regulations (IHR).
Honduras	Country Cooperation Strategy 2017- 2021: 1. Health for All, Strengthening the Stewardship of the New Health System: Governance and Financing in the Health Field 2. Access to medical products and strengthening regulatory capacity: Fundamental pillars for achieving universal health coverage. 3. Towards social and health equity by acting on the social determinants of health and well-being, applying a comprehensive intersectoral approach.

	4. Organization and management of health services based on PHC: integrated, person-centered, and high quality health services. 5. Together in a comprehensive response to health emergencies of national and international importance: Emergency, risk, and crisis management. 6. Honduras as a leader in addressing communicable diseases. 7. Participation of Honduras in the global and regional health policy agenda towards resource mobilization.
Peru	Country Cooperation Strategy 2014- 2019: 1. Contribute to the strengthening stewardship and management of the health sector reform process with equity and a focus on gender, rights, and cultural diversity. 2. Contribute to improving and expanding access to and quality of comprehensive, PHC-based health services. 3. Contribute to the strengthening of national, regional, and local capacities for health surveillance, prevention, and control of communicable and non-communicable diseases and reduction of gaps. 4. Contribute to the development and implementation of inclusive health policies and programs with a life cycle approach and social and environmental determinants.

Annex 8. Progress towards the Ultimate, Intermediate, Immediate outcome, and Output indicators contained in the PMF, IHWAG Project [1]

INDICATORS	BASELINE	FINAL VALUE[2]		2025 TARGET	COMMENT
ULTIMATE OUTCOME					
Maternal Mortality Ratio (MMR) (deaths per 100,000 live births)	103	57.4		69	The indicator was achieved
Fertility rate in adolescents aged 15-19 years (births per 1,000 adolescent girls)	69.2	61.6		62.3	The indicator was achieved
Neonatal mortality rate (per 1,000 live births)	11.8	9.8		10.3	The indicator was achieved
INTERMEDIATE OUTCOME INDICATORS					
Proportion of women and adolescents of reproductive age (10-49 years) who have their need for family planning satisfied with modern contraceptive methods (disaggregated by 10-14 years, 15 – 19 years, 20+ years and by ethnicity, socioeconomic group at subnational level)	71.4	73.1		80.7	While modest progress was made, the indicator was not achieved
Proportion of births attended by skilled health personnel	95.4	91.2		97.3	The indicator was not achieved
MTCT Plus: Rate of mother-to-child transmission of HIV	12.5	11.0		2.1	The indicator was not achieved
MTCT Plus: Rate of mother-to-child transmission of HIV and syphilis	0.9	0.8		0.5	The indicator was not achieved
Number of countries with institutional responses and accountability mechanisms that are advancing health equity, gender and ethnic equality in health, and human rights	0	4 (BOL, COL, ECU, HON)		5 (BOL, COL, ECU, HON, PER)	While significant progress was made, the indicator was not achieved

[1] Cells shaded in grey denote that the data are not available.

[2] The final value is measured to 31 December, 2024.

Number of countries and territories with recent data (five years or less) on the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care	3 (BOL, COL, GUY)	0		6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was not achieved
IMMEDIATE OUTCOME					
Percentage of women and young girls using modern methods of contraception disaggregated by age, ethnicity, place of residence and income level	61.3	60.6		69.5	The indicator was not achieved
Number of countries implementing national standards for quality health care services for adolescents	4 (BOL, ECU, GUY, PER)	6 (BOL, COL, ECU, GUY, HMD, PER)		6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved
Number of countries that increase the number of units of blood available for transfusion per thousand inhabitants (UBAT) by at least 5% per year to reach the target of 30 UBAT	0	4 (BOL, COL, HON, PER)		1 (COL)	The indicator was achieved
Number of countries that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines	0			6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was not achieved
Number of countries that have implemented strategies to strengthen the response capacity of the first level of care mainstreaming SRHS	0	3 (BOL, HON, PER)		6 (BOL, COL, ECU, GUY, HON, PER)	While modest progress was made, the indicator was not achieved
Number of countries that generate, analyze, and use data and information according to health priorities, disaggregated by geopolitical and demographic strata, as appropriate to the national context	1 (COL)	6 (BOL, COL, ECU, GUY, HON, PER)		6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved
Number of countries that have established mechanisms for ongoing monitoring of health inequities affecting women and adolescent girls, including sexual and reproductive health for their policies and programming	0	3 (BOL, COL, ECU, PER)		3 (BOL, COL, PER)	The indicator was achieved

Percentage of women and/or adolescent girls aware of their sexual and reproductive health and rights	NA	80%		60%	The indicator was achieved
Number of countries with specific mechanisms through which women and adolescent girls can engage in public policy development, monitoring, and evaluation	2 (COL, GUY)	6 (BOL, COL, ECU, GUY, HON, PER)		6 (BOL, COL, ECU, GUY, HON, PER)	The indicator was achieved
Number of countries that have integrated health promotion into health services based on the principles of primary health care	1 (BOL)	6 (BOL, COL, ECU, GUY, HON, PER)		2 (BOL, HON)	The indicator was achieved
Number of countries that have implemented intersectoral policies to address the social determinants of the health of women and adolescent girls	3 (BOL, COL, PER)	6 (BOL, COL, ECU, GUY, HND, PER)		4 (BOL, COL, HON, PER)	The indicator was achieved
OUTPUTS					
Number of technical guidelines and tools in SRH, maternal, adolescent and women's health developed and/or implemented	21	TechGd: 99 Tools: 58		64	The indicator was achieved
Number of health facilities with family planning services with protocols and delivery practices that are gender-responsive and promote women's rights	327	976		575	The indicator was achieved
Number of health care service providers trained in SRHR services through GAC-funded Projects	2,099	61,041		2577	The indicator was achieved
Number of health care service providers trained in gender equality and health, HIV and STI prevention and treatment, cervical cancer and gender-based violence	284	GEH: 945 HIV/STI: 480 CrCa: 140 GBV: 1,400		1,150	The indicator was achieved
Number of people who have experienced, or are at risk of, any form of SGBV that have received related services in the previous 12 months through GAC-funded Projects	0	30,997		1,200	The indicator was achieved

Number of health facilities using the NPAS device to prevent maternal death due to hemorrhage	239	609		277	The indicator was achieved
Number of health facilities that have tools in place for the timely access and rational use of health technologies	287	581		618	While significant progress was made, the indicator was not achieved
Number of primary service delivery points with at least 3 modern methods of contraception available on the day of the assessment	21	307		52	The indicator was achieved
Number of health facilities (hospitals/PHCs) provided with basic water, sanitation and hand hygiene services including protocols for clean and hygienic health care facilities	52	252		198	The indicator was achieved
Number health providers trained in WASH and medical waste management practices	102	346		304	The indicator was achieved
Number of national laws, policies, strategies and/or plans relating to SRHR implemented or strengthened, through GAC-funded Projects	0	79		27	The indicator was achieved
Number of women, adolescent girls and/or women's rights organizations participating in community decision-making processes that promote women's and adolescent health	Women: 0	Women: 2,001		Women: 0	The indicator was achieved
	Adolescent girls: 3	Adolescent girls: 2,195		Adolescent girls: 116	
	Women's organizations: 5	Women's organizations: 40		Women's organizations: 32	
Number of health professionals trained to collect, analyze and use data for decision making purposes (for example, programming and resource allocation)	121	730		1,098	While progress was made, the indicator was not achieved

Number of national, subnational and local information systems that disaggregate mortality and morbidity data by age, sex, race/ethnicity, place of residence and income level	4	69		18	The indicator was achieved
Number of policymakers trained at subnational and local levels on evidence based SRHR planning that is equity focused and gender inclusive	0	2,411		60	The indicator was achieved
Number of operational research initiatives to identify barriers to equitable access to SRHS and/or maternal health services	0	57		29	The indicator was achieved
Number of women's rights organizations and networks (local) actively advancing SRHR as part of the implementation of the Project	10	78		42	The indicator was achieved
Number of women and adolescent girls trained in SRHR issues	275	5,075		1,340	The indicator was achieved
Number of countries with established mechanisms (Knowledge Dialogues) to bridge coordination between community and health services	0	4 (BOL, COL, ECU, PER)		3 (BOL, COL, PER)	The indicator was achieved