Evaluation Results

<table>
<tr><td colspan="2">1. Outline of the Project</td></tr>
<tr><td>Country: Republic of Peru</td><td>Project title: The Project of Strengthening Integrated Health Care for the Population Affected by Violence and Human Rights Violation in the Republic of Peru</td></tr>
<tr><td>Issue/Sector: Healthcare</td><td>Cooperation scheme: Technical cooperation project</td></tr>
<tr><td>Division in charge: Health Administration Team, Group III (Health Group 1), Human Development Department, JICA</td><td>Total cost : 422,339,000 yen (Actual figure from FY2003 to FY2007, including the expenses for ex-ante evaluation. It does not include the expenses for the terminal evaluation.)</td></tr>
<tr><td rowspan="3">Period of cooperation: From March 2005 to March 2008 (conclusion of R/D: January 31, 2005)</td><td>Partner country's relevant organization: Ministry of Health (MINSA), National Major University of San Marcos</td></tr>
<tr><td>Supporting Organization in Japan: System Science Consultants Inc. (corporate contract)</td></tr>
<tr><td>Related cooperation: In-country training course "Protection and Fostering of Women, Children and Youth" (MINSA)</td></tr>
<tr><td colspan="2">1-1 Background of the Project
From 1980s to 2000 in Republic of Peru (Peru), there had been extensive disruptive activities caused by the conflict between terrorist groups and the government, which mainly took place in the mountainous areas where most people live in poverty. As a result, residents affected by the act of violence and their families suffer from serious mental or physical health disorder caused after psychic trauma (posttraumatic stress disorder, PTSD), which means they are facing double difficulty of poverty and the damage of violence. According to the result of the survey conducted by the Truth and Reconciliation Commission (CVR), which was established in 2001 by the government of Peru, many of the victims were women and children, and the damages were extremely serious.
Under such circumstances, the government of Peru requested Japan to implement a project aiming to create an environment where the residents who are the victims of violence can benefit from services of higher quality and can obtain physical, mental and social health. In response to this request, the Japan International Cooperation Agency (JICA) implemented ex-ante evaluation several times, and in March 2005 started the Project of Strengthening Integrated Health Care for the Population Affected by Violence and Human Rights Violation in the Republic of Peru, a technical cooperation project for a period of three years.
With the project being close to its termination in March 2008, JICA dispatched a team for termination evaluation from October 9 to 26, 2007. This evaluation was conducted in the form of</td></tr>
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joint evaluation between the Peruvian side and Japanese side.

1-2. Project Overview

(1) Overall Goal: The health of the residents in the pilot site who were affected by violence is improved in an integrated manner.

(2) Project Purpose: Residents in the pilot site affected by violence become able to use integrated health care[1] services.

(3) Outputs

Output 1: A permanent program of systematic training for providing integrated health care to the people affected by violence is developed in the Faculty of Medicine of the National Major University of San Marcos (UNMSM).

Output 2: Capacity of the health personnel at the primary and secondary level providing integrated health care to the people affected by violence is improved.

Output 3: The capacity of the primary and secondary level health care personnel (physician, nurse, nurse-midwife) regarding maternal and child health in the targeted districts.

Output 4: Community healthcare activities are participated in by health promoters[2], non-professional healthcare providers[3], local institutions related to violence countermeasures, community-based organizations (CBOs) and NGOs, and regional health activities to benefit the people affected by violence are promoted.

1-3. Inputs (including scheduled inputs up to March 2008)

<Japanese side>

- Dispatch of experts: 59.9 man-months (56.5 man-months according to the corporate contract, deducting the work coordination portion and adding the period of work within Japan). Experts of Harvard Program in Refugee Trauma (HPRT[4]), which is the subcontractor, also conducted local technical guidance for six times in total.
- Acceptance of trainees: 50 trainees participated in the first year of the training session by HPRT (at Boston, U.S.), the subcontractor. Training was not conducted in Japan.
- Equipment: 478,000 yen (office equipment such as computers and fax machines)

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[1] "Integrated health care" to victims of violence is defined here as a care provided to realize better living as individual and collective human beings (physically/mentally/socioeconomically), by focusing not only on curative treatment but also on health promotion and prevention medicine, and especially on the problems of gender, human rights and culture. In addition to physical health care, integrated health care also includes the easing of crises and reduction of damages. It especially prioritizes women and youthful victims of violence.

[2] Health promoters are non-qualified (volunteer) healthcare service providers who live in the community and are engaged in health promotion activities.

[3] Non-professional healthcare providers are qualified healthcare and medical service providers who are not graduates of universities (which means no physicians, nurses and nurse-midwives) and work in healthcare facilities. They are also referred to as "non-professionals."

[4] HPRT is a non-governmental organization based in Boston, Massachusetts, U.S., with global knowledge and experience in the area of mental healthcare after conflicts and disasters.

- General business expenses: 187,617,000 yen (contracted value for three years, including expenses for subcontract)

<Peruvian side>

- Assignment of counterpart personnel: 51 people in total
- Local cost: Providing C/P personnel expenditures, part of training expenses, office space for experts and utility costs thereof

2. Evaluation Team

Members of Japanese evaluation team	Ikuo Takizawa (Leader): Chief, Health Administration Team, Group III, Human Development Department, JICA Kyo Hanada (Public health): Regional Project Formulation Advisor, Regional Support Office for the Centralamerica and the Caribbean, JICA Erika Tanaka (Evaluation analysis): Senior Researcher, Social Development Department, Global Link Management, Inc. Hiromi Higashionna (Interpreter): Participated locally	
Evaluator of Peruvian side	Patricia Asenjo: Evaluation specialist, MINSA	
Period of evaluation	From October 9 to 26, 2007	Type of evaluation: Terminal Evaluation

3. Results of Evaluation

3-1. Achievements

Project Purpose: Residents in the pilot site affected by violence become able to use integrated health care services.

<Project purpose>	Aug-Dec 2005	Jan-Dec 2006	Jan-Dec 2007
No. of cases of violence victims recognized in total	**2,404**	**5,881**	**14,546**
No. of cases recognized by health promoters	319	185	253
No. of cases recognized by healthcare and medical institutions	2,013	3,378	10,497
No. of cases recognized by other local institutions	72	2,318	3,796
No. of cases of care provided to violence victims in total	**2,310**	**5,783**	**13,832**
No. of cases provided by health promoters	311	137	196
No. of cases provided by healthcare and medical institutions	1,935	3,340	9,935
No. of cases provided by other local institutions	64	2,306	3,701
No. of referral cases of violence victims to relative institutions in total	**486**	**2,048**	**2,815**
No. of referral cases by health promoters	298	25	149
No. of referral cases by healthcare and medical institutions	163	352	1,192
No. of referral cases by other local institutions	25	1,671	1,474

In the five pilot areas, a system to recognize the existence of violence victims and to refer them to adequate institutions was established. As a result, the total number of violence victims recognized and being taken care of by health promoters, healthcare and medical institutions, CBOs and NGOs, and referred and transferred to other institutions (as needed) is increasing significantly since the start of the project. Because the increase in the numbers for the recognition, caring and referral of violence victims by healthcare and medical institutions is especially notable, it can be concluded that the function of healthcare and medical institutions as the core of providing integrated health care services to violence victims in the region is reinforced and that the services are being used.

Output 1: A permanent program of systematic training for providing integrated health care to the people affected by violence is developed in the Faculty of Medicine of the National Major University of San Marcos (UNMSM).

<Output 1: Curriculum changes at UNMSM>	Dec 2005	Dec 2006	Dec 2007
- No. of UNMSM teachers trained by HPRT	19 (23)	-	-
(Figures in ( ) include lecturers who are also MINSA staff)	(Jan/Feb 2006)		
- No. of subjects covering integrated health care areas included in the curriculum	30/82	37/82	51/82
of five departments at UNMSM/No. of subject that should cover the area	(37%)	(45%)	(62%)

In the Faculty of Medicine of UNMSM, programs related to integrated health care provided to violence victims are being introduced and systemized for both basic education and in-service education, and healthcare specialist personnel are being developed.

The HPRT training program held in 2006 was participated in by 19 teachers at UNMSM (target: 19) (Indicator 1-1). As for the basic education at UNMSM, the reformation of the curriculum to include care to violence victims was completed in five departments, for 51 subjects out of the 82 subjects (62%) designated as those that should include violence victims' care (target: 100%) (Indicator 1-2). Mainstreaming the violence victims' care in the medical education curriculum and establishing it as a system was a pioneering approach. As for in-service education to healthcare providers working at actual sites, the Course for Integrated Health Care to Violence Victims was established as a UNMSM program, and was approved and institutionalized as an official diploma course (permanent) by the president of the university on February 9, 2007 (Indicators 1-3/2-1).

Output 2: Capacity of the health personnel at primary and secondary levels providing integrated health care to the people affected by violence is improved.

<Output 2: Training of in-service healthcare providers (diploma course)>	Apr 2005 – Mar 2006	Apr 2006 – Mar 2007	Apr 2007 – Mar 2008
- No. of UNMSM/MINSA personnel who received training from HPRT in	50	-	-

the first year	(Jan/Feb 2006)		
- No. of participants in the training of in-service healthcare providers (in total)	Not implemented	192	392

The capacity of the health personnel at primary and secondary levels providing integrated healthcare to violence victims is found to be improving.

As for the in-service education program targeted to healthcare providers working at actual sites, the Course for Integrated Health Care to Violence Victims was established in UNMSM, which was officially approved as a diploma course in February 2007 (Indicator 2-1/1-3). 50 participants (target: 50 participants) selected from UNMSM, MINSA, national specialized hospitals and local health departments completed the training program by HPRT, and approximately 90% of them were engaged in human resources development programs in Peru thereafter (Indicator 2-2). The diploma course of UNMSM was participated in by 392 people in total (target: 400 participants) from the five pilot areas (Indicator 2-3). The participants include not only the healthcare providers within the pilot area, but also healthcare providers at regional core hospitals to which the violence victims are referred to and teachers of regional universities which serve a central role in developing healthcare and medical human resources (basic education) in rural areas.

Output 3: The capacity of the primary and secondary level health care personnel (physicians, nurses, nurse-midwives) regarding maternal and child health in the targeted districts.

<Output 3: Training of in-service healthcare providers (maternal and child health)>	Apr 2005 – Mar 2006	Apr 2006 – Feb 2007	Apr 2007 – Dec 2007
- No. of participants who completed maternal and child health training/no. of participants (in total)	46/46 (100%)	71/71 (100%)	146/146 (100%)
- Ratio of participants who are utilizing more than 80% of skills obtained through the training	59%	66%	82%
- No. of participants in cascade training programs (in total)	224	2,404	4,591

It can be said that the capacity of the health care personnel regarding maternal and child health, including the care for violence victims, is improved through the training of the National Institute of Maternal and Perinatal Care (INMP).

From the targeted nine districts, 146 primary and secondary level health care staff (including physicians, nurses, nurse-midwives and social workers) in total (target: 150) took the training course of INMP (Indicator 3-1). According to the follow-up survey by the C/Ps of INMP, 121 participants out of 146 (83%) are utilizing more than 80% of skills obtained through the training in their actual work (target: 50% of participants) (Indicator 3-2). Cascade training programs, wherein participants who finished the course convey what they acquired at their worksite, were participated in by 4,591 people (approximately 30 people per training course finisher) in total (Indicator 3-3).

Output 4: Community healthcare activities are participated in by health promoters, non-professional healthcare providers, local institutions related to violence countermeasures, community-based organizations (CBOs) and NGOs, and regional health activities to benefit the people affected by violence are promoted.

<Output 4: Regional health activities>	Apr 2005 – Mar 2006	Apr 2006 – Feb 2007	Apr 2007 – Dec 2007
- No. of DISAs implementing enlightenment workshops/no. of DIA covered by the project	5 (100%)	5 (100%)	5 (100%)
- No. of health promoters participating in workshops	147	214	192
- No. of non-professional healthcare providers participating in workshops/training	-	97	143
- No. of DISAs implementing regional health activities	5 (100%)	5 (100%)	5 (100%)

In the five pilot areas, the network of healthcare providers, local governments and regional organizations/residents engaged in violence victims' care is reinforced, and regional health activities wherein the violence victims are the beneficiaries are promoted (DISA in the above table refers to the Regional Directorates of Health).

Enlightenment workshops held in pilot areas were participated in by 45 CBOs and 18 NGOs in total (target: 30% of CBOs and NGOs) (Indicator 4-1). Committee of Consultation against Violence was also established through project activities in some of the five pilot areas, and the function of the committees that already existed was also reinforced. Also, 553 health promoters in total participated in the enlightenment workshop (111 participants per area in average) (target: more than 10 participants per area) (Indicator 4-2), and 240 non-professional healthcare providers took the training courses in line with the support guidelines prepared by the project (Indicator 4-3). Through these activities, in the five pilot areas, a mechanism to provide cross-sectoral care and support that goes beyond the border of health and medical care to violence victims is being created.

3-2. Implementation Process

In this project, consensus-building with relevant institutions was facilitated by dispatching ex-ante evaluation teams for several times in the preparation stage. Also during the implementation of the project, through the Joint Coordinating Committee (JCC), Technical Committee (TC), weekly meetings and conventions at the five pilot areas to define the operation policy of the project and to confirm the progress and share the information were held. Through such processes, understanding of and commitment to the project of relevant parties became even clearer, which facilitated the progress of the project. The PDM was revised twice during the cooperation period.

Although the commitment of MINSA and DISAs increased with the progress of the project, at the

early stage and during the unstable period such as the periods of the presidential election and local election in 2006, UNMSM, which is relatively unaffected by political situations, consistently took the leadership. This contributed significantly to holding down negative impacts and promoting project activities.

3-3. Summary of Evaluation Results

(1) Relevance

Considering the needs of Peru and the ODA policies of Japan, the relevance of the project is high.

In Peru under the Toledo administration, where this project was formulated, reconciliation of people who were suppressed by the violation of human rights and political violence was the most important political issue, and the care of residents who were the victims of violence was one of the issues of the highest priority for the administration. MINSA formulated the national plan in the area of mental health in 2007, so the project is also consistent with the development policy of the government of Peru and the sectoral development plan. Considering the current situation of Peru, the design of the project was appropriate for fulfilling the needs of the ultimate beneficiaries, for the following reasons: the project targets people affected by all kinds of violence, including domestic violence and sexual violence, as the ultimate beneficiaries; the project plans to address the issue of violence victims' care among the general healthcare services such as maternal and child health; training sessions on violence victims' care/mental health care were provided to general physicians, nurses and nurse-midwives; the project supported not only the improvement of the capacity of healthcare providers but also the improvement of the responsive capacity of regional communities consisting of the network of protection/welfare facilities for women, police/judicial system, churches and NGOs.

On the other hand, this project is also highly consistent with the ODA policies of Japan. Support for the social sector is one of the four prioritized areas in the ODA Policy to Peru. Within the social sector, improvement of maternal and child health and the development of healthcare and medical professionals are special areas of focus. Further, countermeasures against terrorism are also included as an issue in Peru.

(2) Effectiveness

The project purpose is being achieved steadily and the effectiveness of the project is high.

The total number of violence victims recognized and being taken care of by health promoters, healthcare and medical institutions and CBOs and NGOs is increasing significantly since the start of the project (refer to the table below). In particular, because the increase in the numbers for recognition, caring and referral of violence victims by healthcare and medical institutions is

especially notable, it can be concluded that the function of healthcare and medical institutions as the core of providing integrated health care services to violence victims in the region has been reinforced.

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(3) Efficiency

The inputs are being utilized adequately and the efficiency of the project is high.

Inputs from Japan are utilized efficiently, contributing in achieving the expected outputs. The project conducted several measures to increase efficiency in the activities plan. First, the cascade system (human resources developed through the project serve as a core trainer to develop other human resources, and those who finished such training courses also become a trainer to implement yet a new round of training courses to develop human resources) was introduced. Second, the diploma course on integrated health care to violence victims established in UNMSM was designed to be compatible with remote educations system for the ease of participation by in-service healthcare providers. Third, training programs by UNMSM and INMP were mainly targeted to general practitioners, aiming to integrate the violence victims' care into the ordinary medical treatment. Fourth, the monitoring of the utilization of training outcomes was implemented mainly by the C/Ps of Peruvian side.

(4) Impact

Provided that the benefit of the project is continued, that the necessary supports, including the integrated health care to violence victims, are ensured, and that the number of users of such services continues to grow, it is highly probable that the overall goal of the project will be achieved in the future.

In the five pilot areas, a system to recognize the existence of violence victims and to refer them

to adequate institutions was established. In addition, the capacity of healthcare providers regarding maternal and child health had improved through the training implemented by the project, and related efforts are carried out in various regions. Outcomes and ripple effects exceeding the level set in the original plan of the project are being achieved in some areas. If such efforts are implemented continuously and produce results, it is possible that the health of residents in the pilot area who are the victims of violence will be improved.

However, there are also several concerning factors that may inhibit the achievement of the overall goal. First, it is important to continuously stimulate active involvement by the local stakeholders. Especially, because the administration service including healthcare is subdivided in Peru, proactive involvement by the decision-makers at DISA is essential. Second, according to the significant increase in the number of violence victims who are recognized, cared for and referred, reinforcement of the treatment system that can fulfill the needs of patients who require special psychiatric treatment, in other words the improvement of personnel distribution and logistics, is becoming necessary.

As for unexpected impact, when the earthquake hit Peru in August 2007, an emergency team to support the affected area was organized in the country, and personnel who received training in the project participated as members of the team in charge of mental health. This is a case example of human resources developed in the project expanding the opportunities of their activities beyond the scope of the project.

(5) Sustainability

The sustainability of the outputs after the termination of the cooperation is somewhat high.

Currently, sustainability in terms of policy is somewhat high. MINSA formulated a national plan for mental health, and the formulation of regional plans at the departmental level based on the national plan is also under way. In particular, UNMSM and INMP are stable as an organization, and these two organizations have the large organizational capacity to lead the practical implementation of integrated health care for violence victims in the future as well. Because the activities at UNMSM are being implemented after going through the necessary certification procedures in and out of the university, the organizational sustainability of the project is high. Further, motivations and capacities of relevant organizations in the region are also generally high.

Technical sustainability is also high. Human resources who can exert leadership to promote the integrated health care to violence victims in Peru have been sufficiently developed through the project. A system to continuously supply healthcare providers with knowledge and skill on violence victims through university education was also established.

Financial sustainability is somewhat unclear. In order to continue the activities implemented

under the project, it is necessary to secure operating expenses such as personnel expenditures, training costs and follow-up activities expenses. Although it is judged that there is no problem with the personnel expenditure regarding C/Ps on the Peruvian side, other operating costs should be reviewed by the relevant organizations. It is also important to consider coalition/integration with other national programs for which the budget is secured and to stimulate commitment by local governments.

3-4. Factors that promoted or impeded the realization of effects

(1) Factors related to planning

The design changes in the project formulation stage, while maintaining the original ideas of the initiative of research and education institutes (UNMSM) and the utilization of the resources of the third country (HPRT), including the expansion of the scope of violence covered (not limited to political violence but violence in general), improvement of the implementation system of the Peruvian side (MINSA, DISAs and the national specialized institutions that participated in addition to UNMSM), improvement of the implementation system of the Japanese side (combined usage of the resources of Japan based on the corporate contract and the resources of the third country based on subcontracting) resulted in enhancing the cooperation effect. Although these changes increased the coordination cost at the early stage of the project (consensus formation among the relevant parties) and the risk of personnel transfer due to political change (personnel transfer within MINSA in relation to national election), they also resulted in the development and implementation of integrated human resources development programs that are more adequate to actual needs and strengthening the practice and sustainability of effective regional health activities in five pilot areas. In addition, 50 personnel from different institutions participated in the training program abroad (HPRT) at the early stage of the project in order to intensively develop human resources who would become the core personnel for project operation thereafter and for human resources development through the cascade system within Peru, which also contributed in realizing the effect.

(2) Factors related to the implementation process

This project was operated with a special attention to information sharing among relevant parties and the progress management of project activities, such as the decision-making at JCC and TC, and the monitoring of the situation through weekly meetings as well as the conventions held in the five areas of the pilot. Such efforts increased the transparency of project operation and raised the participatory and ownership awareness among relevant parties, which are believed to be conducive in realizing the effect of the project. Human resources development through the cascade system was effectively and efficiently implemented by incorporating follow-up programs after the training (such as monitoring and support for activities utilizing the outcome of

the training). However, the effect of the human resources development targeted to non-professional healthcare providers may have been larger if the activities had been started earlier.

3-5. Conclusion

This project was effective in contributing to the diffusion of integrated health care to violence victims and its integration into ordinary health and medical service and in establishing a human resource development system including both basic education and in-service education. In the five pilot areas, human resources who received training in the project exerted leadership in creating a system based on the regional circumstances, in order to provide necessary supports including integrated health care to violence victims. As a result, in the five pilot areas, the number of violence victims treated and cared at health facilities and other places increased not only significantly, but there are also ripple effects such as the invigoration of the Committee of Consultation against Violence, the mainstreaming of violence victims' care in the regional development plan, and the incorporation of a violence victims' care curriculum in the faculty of medicine in local universities.

Consequently, although there remain some uncertainties in terms of sustainability, it is judged that the project purpose is likely to be achieved. It is concluded that this project should terminate as planned.

This project also contributed in realizing human security through international cooperation promoted by JICA from the following perspectives: (i) the project selected victims of violence, including domestic violence and sexual violence, as the ultimate beneficiaries (support that is helpful for people who are socially vulnerable and whose life, living and dignity as human are at risk); (ii) the project supports both the human resource development/capacity development of MINSA and DISAs, and the enlightenment activities targeted to communities (making approaches both at the governmental level and community/individual level to contribute to the sustainable development of the country and community); and (iii) the project promotes collaboration between the government and research and education institutes (universities) or specialized institutions (hospitals) at the national level, and supports the establishment of a system to care and support violence victims beyond the health sector at the local level (multi-sector approach of focusing mainly on people's problems and analyzing the structure of the problems before trying to solve the problem in an integrated manner by combining various types of expertise).

3-6. Recommendations

The recommendations are summarized into following two categories: (1) items that should be dealt with jointly by the Peruvian side and the Japanese side before the termination of the project; (2) items that should be dealt with by the Peruvian side after the termination of the project; and (3) items

that should be dealt with by the Japanese side after the termination of the project.

(1) Items that should be dealt with jointly by the Peruvian side and the Japanese side before the termination of the project

The following are recommended as to be dealt with jointly by the Peruvian side and the Japanese side before the termination of the project.

- Promoting the disclosure of the termination evaluation results to relevant parties in Peru (MINSA and relevant departments, other relevant ministries, pilot areas and DISAs in areas other than pilot areas, other donors, NGOs/NPOs, etc.), and the advocacy activities to decision-makers (at both national and local levels) through such promotion.
- Promoting the integration of violence victims' care into district development plans and the prioritization thereof, as seen in Junin, in the five pilot areas.
- Certification of the maternal and child health training module integrating violence victims at INMP, and the integrated health care for violence victims training module targeted to non-professional healthcare providers and health promoters, as the official programs at both MINSA and DISAs.
- Securing the financial source for continuous activities by promoting coalition with other national policies for which the budget is secured (such as the health insurance program, comprehensive compensation plan, relief programs for the poor, etc.) and to stimulate commitment by local governments.
- Clarifying the minimum necessary costs for continuing the activities in order to promote budget allocation by the government.

(2) Items that should be dealt with by the Peruvian side after the termination of the project

- Continuation and reinforcement of technical support to the in-service healthcare providers by MINSA through the ordinary supervision of work by DISAs.
- As the mid- and long-term strategy, promotion of increasing the number of psychiatrists and the correction of their regional imbalance by MINSA.
- As the short- and mid-term strategy, improvement of the training in the mental health area (diagnosis/treatment) targeted to general physicians dispatched to local areas.
- Strategic advocacy to decision-makers (at both national and local levels) by MINSA in order to secure necessary resources and funds.
- Contribution by UNMSM to human resources development in Peru through the continuation of basic education and in-service education as official programs.
- Support by UNMSM to promote the integration of curriculum for violence victims' care in other universities in Peru in order to further expand the development of health and medical

human resources with knowledge and skills on violence victims' care.

(3) Items that should be dealt with by the Japanese side after the termination of the project

- Support by JICA to promote the integration of violence victims' care into social services in general in Peru, through policy dialogues by the office in Peru.
- Consideration of the possibility of additional support by JICA for realizing area-based diffusion of project outputs in Peru.

In order to confirm the achievement of the overall goal (to improve the health of the residents in the pilot site who were affected by violence in an integrated manner), it is necessary to continuously monitor the violence victims who were recognized in the pilot area and received care at health and medical facilities (and, if possible, the victims whose treatment is completed). However, one must note that all indicators are likely to increase for a certain period of time due to the invigoration of measures for violence victims in different areas.

3-7. Lessons learned

(1) Project design

- The implementation system on the Peruvian side involves not only administrative institutions but also research and educational institutes and specialized institutes. Although it requires higher coordination costs, this system is effective in terms of the following: (i) it is possible to ensure continuity in terms of personnel at research and education institutes and specialized institutes in countries where there are frequent personnel transfers due to changes in administration; and (ii) it is possible to utilize resources specializing in curriculum development and education for human resources development activities. In addition, because know-how can be accumulated at research and educational institutes/specialized institutes, activities can be easily expanded to areas outside the project target area.
- While the effect of the cascade-type human resource development is sometimes called into question, it worked effectively for this project. The factors that led to the success are: (i) close selection of C/Ps who received the first training to be developed into trainers excelling in ability and motivation; and (ii) focus on the follow-up process confirming how the outcome of the training is being utilized.
- Implementation of intensive training to major relevant parties at the relatively early stage of the cooperation was effective for constructing an inter-organizational network among C/Ps who serve as the leaders of the entire project and formulating common awareness. Especially for participants from local areas, the training worked to trigger motivation among them, since their opportunities to participate in overseas training sessions are limited.

(2) Implementation process of the project

- Information sharing and highly transparent decision-making realized by holding the JCC and TC meeting regularly and frequently, and through weekly meetings as well as conventions in the pilot areas, actually increased the coordination cost for activities such as the preparation of meeting or the creation and approval of minutes. However, such an approach was effective for formulating common understanding on the project operation among relevant parties. This is an important process in the case of projects involving various types of organization at the counterpart country side. Also, in the case of the shuttle-type dispatch of experts (repeating short-term dispatches), it is possible to obtain report from experts involved (including project leaders) on the progress of discussions and activities at the JCC or TC, and to take measures as needed, in a relatively timely manner.
- Regarding the training of healthcare providers, the mechanism of starting with specialists, and then having those specialists who went through the training program ' ttrain non-professional healthcare providers and health promoters (cascade-type human resource development) was efficient. However, the awareness of the importance of non-professional healthcare providers in the healthcare system providing care to violence victims was not necessarily sufficient at the early state of the project. Partly because of this, the approach for the capacity development of non-professional healthcare providers was delayed. It is believed that the mechanism would have become even more effective by analyzing the function and roles of healthcare providers from a more comprehensive point of view (perspective of health system) at the stage of preparing activity plans.