Republic of Tajikistan

Ministry of Health and Social Protection of Population

The Project for Improving Quality of Primary Health Care Services

Project Completion Report

February 2026

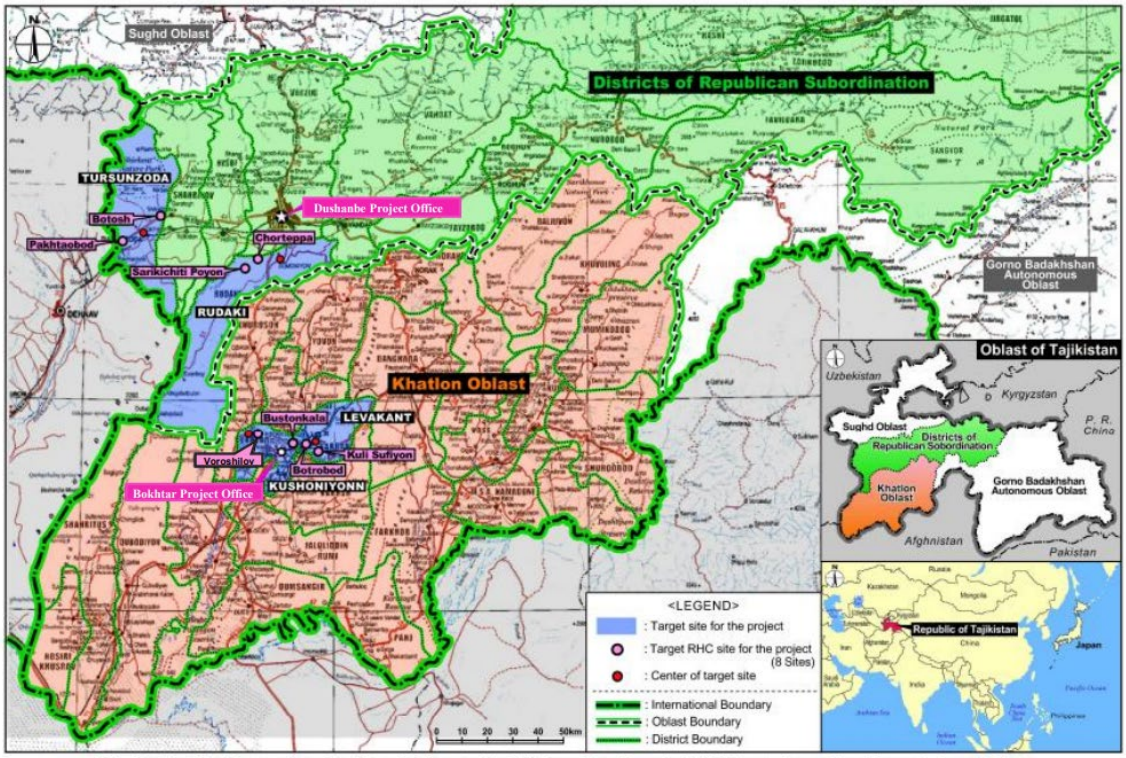
Japan International Cooperation Agency

Koei Research & Consulting Inc.

HM
JR
26-014

Exchange Rate
USD 1＝JPY 155.9910
TJS 1＝JPY 17.0061
（January 2026, JICA）

Project Site Map



The Project for Improving Quality of Primary Health Care Services in Tajikistan Location Map of Target Sites

Abbreviations

ANC	Antenatal Care
BMI	Body Mass Index
BP	Blood Pressure
CHT	Community Health Team
DAC	Development Assistance Committee
DHC	District Health Center
DRS	Districts of Republican Subordination
FMC	Family Medicine Center
FMD	Family Medicine Doctor
FMN	Family Medicine Nurse
GIZ	Gesellschaft für Internationale Zusammenarbeit
HH	Health House
HLC	Healthy Lifestyle Center
ISH	International Society of Hypertension
JCC	Joint Coordination Committee
JICA	Japan International Cooperation Agency
KRC	Koei Research & Consulting Inc.
LLC	Limited Liability Company
MCH	Maternal and Child Health
MOHSPP	Ministry of Health and Social Protection of Population
NCD	Non-communicable Disease
ODA	Official Development Assistance
PDM	Project Design Matrix
PEN	Package of Essential Noncommunicable
PHC	Primary Health Care
PNC	Postnatal Care
R/D	Record of Discussion
RHC	Rural Health Center
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedures
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Pictures

	
Kick-off Meeting (January 2023)	Project Overview and the Process of Selecting Target Rural Health Centers (January 2023)
	
Baseline Survey (April 2023)	First Joint Coordination Committee Meeting (May 2023)
	
First Technical Working Group for Family Medicine Doctors (October 2023)	First Technical Working Group for Family Medicine Nurses (October 2023)
	
Antenatal Care and Maternal and Child Health Handbook Training (DRS) (November 2023)	First In-Japan Training Program (November 2023)

	
Monitoring Activities by the Ministry of Health and Social Protection of Population (December 2023)	Community Health Team Activities (Community Health Education for Residents Using the Training Materials) (January 2024)
	
Monitoring of Screening Techniques Using Nurses as Simulated Patients (February 2024)	Training on Non-communicable Diseases for Family Medicine Doctors and Nurses (April 2024)
	
Training on Non-communicable Diseases for Family Medicine Doctors and Nurses (May 2024)	Second Joint Coordination Committee Meeting (May 2024)
	
Home-visit Training Activities (July 2024)	Second Technical Working Group for Family Medicine Nurses (September 2024)

	
Third Technical Working Group for Family Medicine Doctors (December 2024)	Second In-Japan Training Program (January 2025)
	
Third In-Japan Training Program (February 2025)	Third Joint Coordination Committee Meeting (May 2025)
	
School-based Health Promotion Activities on Nutrition (June 2025)	Home-visit Activities (July 2025)
	
Endline Survey (July 2025)	Fourth In-Japan Training Program (September 2025)

Table of Contents

Annex (No. 4 to 6 are for internal use only)

Chapter 1 Basic Information of the Project

1.1 Country

Republic of Tajikistan

1.2 Title of the Project

The Project for Improving Quality of Primary Health Care (PHC) Services in Tajikistan

1.3 Duration of the Project

From February 10, 2023 (the date of the Kick-off Meeting) to the end of February 2026—with a total period of three years.

1.4 Background of the Project (from Record of Discussions (R/D))

In Tajikistan, improvements were seen in the child mortality indicators from the period starting from 2010 to 2019. The under-five mortality rate (per 1,000 live births) declined from 42.90 to 33.78; and the neonatal mortality rate also improved from 20.19 to 14.98. Although child mortality indicators showed a downward trend, Tajikistan still has the second-highest rates in Central Asia, following Turkmenistan. Continued interventions are therefore required to achieve the 2030 targets under the Sustainable Development Goals (SDGs).

While maternal and child health (MCH) indicators have improved, there is an increase in the burden of non-communicable diseases (NCDs)—including cardiovascular diseases and diabetes—with their share of total deaths rising from 53% in 2000 to 73% in 2019. This trend highlights an increasing need for the prevention, diagnosis, and treatment of NCDs.

The Government of Tajikistan aims to improve the standard of living under the country's highest-level development framework, the National Development Strategy 2016–2030, through sustainable economic development. In the health sector, four priority areas are identified:

- Health system reform;
- Improved access, quality, and efficiency of medical services;
- Enhancement of health sector resources; and
- Promotion of healthy lifestyle models.

Strengthening primary health care—the level of care closest to communities and households—is a key priority to ensure the delivery of essential MCH services, as well as to promote NCDs prevention and early detection.

With this backdrop, the Government of Tajikistan requested assistance from Japan for strengthening PHC. In response, the Japan International Cooperation Agency (JICA) conducted information gathering and analysis on the current situation and challenges surrounding Tajikistan's PHC. The assessment revealed that while many services provided at the PHC level were related to MCH—such as antenatal care and immunizations—there is insufficient implementation of NCD screening activities that could be performed at PHC facilities, including blood pressure measurement. It was also found that user-friendly educational materials for residents were lacking, resulting in limited health education. In the area of nutrition, interventions were mainly focused on malnutrition, leaving countermeasures against the emerging risk factor overnutrition inadequate. Furthermore, in addition to delays in infrastructure development, resource-related challenges in PHC services were identified, including insufficient knowledge among family medicine doctors (FMDs), family medicine nurses (FMNs), and community health volunteers who are responsible for home visits and community outreach.

JICA has previously implemented the Project for Improving MCH Services in Khatlon Oblast (2012–2016) and its Phase II (2017–2022), which strengthened the referral system between primary and secondary health facilities for MCH and introduced clinical case conferences. Support was also provided for the introduction and dissemination of the MCH Handbook, contributing to improvements in the MCH system. Building on the foundations established through these earlier cooperation activities, the current Project aims to strengthen the overall standard of PHC in Tajikistan by providing technical transfer to PHC workers and supplying equipment to PHC facilities, thereby addressing emerging challenges such as NCDs and nutrition while continuing to reinforce MCH services.

1.5 Overall Goal, Project Purpose, and Outputs (from R/D)

The objective of this Project is to achieve the expected outcomes and attain the Project Purpose through the implementation of activities stipulated in the Record of Discussions (R/D) signed between JICA and the Ministry of Health and Social Protection of the Population (MOHSPP) on September 5, 2022, for the "Project for Improving the Quality of Primary Health Care Services in the Republic of Tajikistan." The outline of the Project, based on the R/D, is presented below.

Overall Goal	The quality of PHC services in the target districts is improved.
Project Purpose	Capacity of PHC service delivery is strengthened in integrated manner at pilot sites
Expected Outputs	Output 1：PHC facilities in the target area function better. Output 2：Health workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and NCD management Output 3：Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and NCD prevention

The scope of the Project is as follows. The target areas were determined during the Project period (details are provided in Section "2.3.3 Plans for Revision of the R/D and the Project Design Matrix (PDM)").

Target Areas	Two districts from the Districts of Republican Subordination (DRS) and two districts from Khatlon Oblast
Direct Beneficiaries	Health workers of PHC-related facilities and their managers
Indirect Beneficiaries	Approximately 40,600 residents in the target districts of Khatlon Region and approximately 46,700 residents in the target districts of the DRS

1.6 Implementing Agency

The institutions involved in the Project are outlined below:

(1) Implementing Agencies of the Recipient Country

- **Republican level:**

  Department of Reform, PHC, and International Relations from the Ministry of Health and Social Protection of the Population (MOHSPP)

- **Oblast level:**

  Khatlon Oblast Health Department

- **District/City level:**

  District Health Center (DHC), Kushoniyon District
  DHC, Levakant City
  DHC, Rudaki District
  DHC, Tursunzoda City

(2) Responsible Officials of the Recipient Country

- **Project Director**

  First Deputy Minister, MOHSPP

- **Project Manager**

  Head of the Department of Reform, PHC, and International Relations, MOHSPP

(3) Joint Coordinating Committee (JCC)

Based on the R/D, the members of the JCC are specified as follows:

- First Deputy Minister, MOHSPP (Chairperson)
- Head of the Department of Reform, PHC, and International Relations, MOHSPP (Co-chair)
- Head of the International Relations Division, Department of Reform, PHC, and International Relations, MOHSPP
- Head of the PHC Division, Department of Reform, PHC, and International Relations, MOHSPP

- Director, Family Medicine Center (FMC)
- Director, Healthy Lifestyle Center (HLC)
- Director, Reproductive Health Center
- Director, Republican Center for Medical Statistics and Information
- Director, Khatlon Oblast Health Department
- Representative, Ministry of Finance (Social Sector Financing Department)
- Directors of the target DHCs
- Representatives of the target local governments (Finance and Health departments)

Chapter 2 Results of the Project

2.1 Results of the Project

2.1.1 Input from the Japanese Side

(1) Dispatch of Experts

This Project has been implemented by Koei Research & Consulting Inc. (KRC), as contracted by JICA. As of February 2026, the cumulative inputs of experts are shown in Table 2-1.

- **Actual inputs:** 42.88 person-months (planned: 42.82 person-months)
  Note: This excludes 4.95 person-months allocated to the activities conducted under the four in-Japan technical training programs (hereinafter referred to as "in-Japan Training").

Table 2.1-1 List of Experts

Name	Title	Grading
Yoshiko Akiyama	Chief Advisor／PHC (1)	2
Nobuya Goto	Deputy Chief Advisor／PHC (2) ※～March 2024	3
Izumi Hirano	Deputy Chief Advisor／PHC (2)／Procurement Plan／Training Management (2) ※April 2024～	4
Yoshihisa Yamazaki	MCH／Nutrition (1)／NCDs Management (1)	3
Makiko Konohara	MCH／Nutrition (2)	3
Alisher Makhmudov	NCDs Management (2) ／Training Management (1)	4
Reimi Kobayashi	Procurement Plan／Training Management (2) ※～June 2023	5
Izumi Hirano	Procurement Plan／Training Management (2) ※June 2023～March 2024	5
Naoko Narafu	Training Management (3) ※March 2024～December 2024	5
Shuka Endoblum	Training Management (3) ※March 2025～	5

Source：Monthly Report on Consultant Activities

(2) Training Participants Received

A total of 42 participants, including PHC-related managerial and technical staff from Tajikistan, took part in the in-Japan training programs and international conferences (details are provided in Section 2.1.3(7)).

Table 2.1-2 List of Training Participants Received

Title	Period	Number of Participants
First In-Japan Training Program	November 5-11, 2023	10
Second In-Japan Training Program	January 19-30, 2025	10
Third In-Japan Training Program	February 2-13, 2025	10
Fourth In-Japan Training Program	August 24-September 4, 2025	10
International MCH Handbook Conference	May 9-10, 2024	2

Source：Monitoring Sheet

(3) Equipment Provision

Total Value of Equipment Provided: JPY 17,123,000

In this project, equipment was provided to eight Rural Health Centers (RHCs) in four target districts/cities. Table 2-3 shows the list of procured equipment. Equipment with a unit cost below the amount specified in JICA's regulations is treated as "consumables."

Table 2.1-3 List of Equipment Provided

No.	Description of Goods	Quantity	Basis for the Quantity
1	Electronic height and weight measuring machine for adult	16	Provided to ensure that each facility would have two units.
2	Height scale for newborns	14	Provided to ensure that each facility would have two units, combining with existing equipment.
3	Electronic weight measuring machine for newborns in facilities	4	Provided to ensure that each facility would have one unit, combining with existing equipment.
4	Portable weight measuring scale for newborns	16	Provided to ensure that each facility would have two units.
5	Electronic blood pressure meter	56	Provided to ensure seven units per facility, regardless of existing equipment; also provided to the Community Health Teams (CHTs).
6	Home visit bag for family medicine doctor	16	Provided to ensure two units per facility, regardless of existing stock.
7	Blood glucose meter (glucometer)	16	Provided to ensure two units per facility, regardless of existing stock.
7-2	Needles and strips for measuring blood glucose (50 units per box)	630	Provided to ensure that each facility can conduct approximately 4,000 tests.
8	Fetal doppler	12	Provided to ensure that each facility would have two units, combining with existing equipment.
9	Electrocardiograph (ECG)	5	Provided to ensure that each facility would have one unit, combining with existing equipment.
10	Hemoglobin A1c measuring device	16	Provided to ensure two units per facility.
10-2	Needles and stripes for measuring hemoglobin A1c (25 units per box)	690	Provided to ensure that each facility can conduct approximately 2,200 tests.
11	Cholesterol measuring device	8	Provided to ensure one unit per facility.
11-2	Needles and strips for measuring cholesterol (10 units per box)	3,250	Provided to ensure that each facility can conduct approximately 4,000 tests.
12	Salt concentration meter (salinity meter)	8	Provided to ensure one unit per facility.
13	Sugar concentration meter	8	Provided to ensure one unit per facility.
14	Laptop Computer	12	Provided to ensure one unit per facility, along with one unit for each of the four DHCs.
15	Generator	9	Provided for all RHCs due to unstable electricity supply during winter (one per RHC; two units for Voroshilov RHC due to particularly severe electricity shortages).

Source：Monthly Report on Consultant Activities and Monitoring Sheet

In addition, the equipment scheduled to be provided after the completion of the project (to the MOHSPP) is as follows.

- Two photocopiers (purchased in February 2023)
- One generator (purchased in April 2023)

2.1.2 Input by Tajikistan Side

（1） Assignment of Counterparts

Organization	Number
MOHSPP - Director of the Department of Reforms, PHC, and International Relations - Head of the PHC Division of the same department - Head of the International Relations Division of the same department	3
Director of the Khatlon Oblast Health Department	1
Heads of the target DHCs	4
Heads of the target RHCs	8

（2） Provision of Office Space

Dushanbe Office : Located inside the building of the Immunization and Prevention Center, MOHSPP

Bokhtar Office：Located inside the building of the Khatlon Oblast Health Department

（3） Other Responsibilities to be Covered by the Partner Government

There are no additional items.

2.1.3 Overall Activities

(1) Organization of the Kick-off Meeting and Development of the Work Plan

On February 10, 2023, the Project held its Kick-off Meeting. The attendees included the First Deputy Minister of MOHSPP, Dr. Gafur (at the time), the Chief Representative of JICA Tajikistan Office, the heads of the respective specialized centers, and the heads of the candidate DHCs. An overview of the Project and the plan for the baseline survey was presented by the Japanese experts, followed by an active question-and-answer session among the participants. All attendees expressed their commitment to cooperating with the Project (including the implementation of the baseline survey) and shared their expectations regarding MCH, NCDs, as well as data management.

In addition, based on the Preparatory Survey Report and other relevant documents for this Project, the Project Team reviewed the overall project framework and prepared the basic implementation policies and approaches, the activity planning process, and other operational arrangements. Accordingly, the Work Plan (in English) was developed, and its first draft was submitted to JICA in April 2023. Subsequently, based on the results of the baseline survey used to select the project target areas, the second draft of the Work Plan was prepared and submitted to JICA in October 2023.

(2) Holding of the JCC Meetings

Three JCC meetings were held during the Project period. A summary is presented in the table below (see Annex 4 for details).

Table 2.1-4 Summary of JCC Meetings Held

No.	Date	Venue	Main Discussion Points
1st	May 31, 2023	Hilton Hotel, Dushanbe	・ Baseline survey results and selection of project target areas based on the results ・ Work plan for the first year of the Project
2nd	May 30, 2024	Conference Room, MOHSPP	・ Revision of the PDM ・ Progress of project activities, particularly home visit activities and the MCH Handbook
3rd	May 23, 2025	Conference Room, MOHSPP	・ Project achievements and remaining challenges ・ NCDs screening activities and data management ・ Development of the Standard Operating Procedures (SOPs) for home visits and community health activities

Source：Monitoring Sheet

(3) Preparation, Discussion, and Agreement on the Monitoring Sheet (Ver.1)

The Monitoring Sheet (Ver.1), which included descriptions of the baseline survey and the first JCC, was submitted to the JICA Tajikistan Office on June 30, 2023. The preparation of the document called for discussions primarily with Dr. Olimjon, Head of the PHC Division of the Ministry of Health and Social Protection, until mutual agreement was reached.

(4) Implementation of the Baseline Survey and Endline Survey (Activities 1.1, 1.5, 2.1, 2.2, 2.5, and 3.1)

From February to May 2023, the Baseline Survey was conducted, followed by the Endline Survey which was carried out from July to August 2025. A summary of each is provided below.

• Purpose:

The Baseline Survey aimed to select the project target areas, identify the baseline values of quantitative indicators, and assess the existing situation for the subsequent project activities. Moreover, the Endline Survey aimed to determine the endline values of quantitative indicators and verify the Project's degree of achievement.

• Target Areas and Respondents:

The Baseline Survey covered four districts/cities in DRS—Rudaki, Hissor, Tursunzoda, and Vahdat—and four districts/cities of Khatlon Oblast—Khuroson, Kushoniyon, Dusti, and Levakant. Two RHCs were selected in each district/city, resulting in a total of 16 RHCs across the eight districts/cities. The Endline Survey targeted the four districts/cities where project activities were implemented: Rudaki and Tursunzoda in DRS, and Kushoniyon and Levakant in Khatlon Oblast. In

total, eight RHCs were surveyed. The respondents for both surveys included health workers at the target RHCs and community residents living in the respective catchment areas.

- **Survey and Analysis Methods:**

  After developing structured questionnaires for interviews, the Project Team conducted training for data collectors and provided instructions on data collection procedures. The necessary data and information were then gathered accordingly.

- **Main Question Areas:**

  Key topics included RHC health workers' data management and computer skills; their knowledge on nutrition, MCH, and NCDs; the status of health education activities; and the use of medical equipment. In addition, structured questionnaires were used to assess general community members' awareness of their own health status.

- **Results:**

  The results of each survey were compiled into the Baseline Survey Report and the Endline Survey Report.

(5) Selection of Pilot Sites

Based on the results of the Baseline Survey, consensus was reached at the First JCC meeting among the MOHSPP and relevant specialists from the republican specialized centers. From this, the areas for project implementation should meet the following conditions:

- The presence of essential human resources such as FMDs and FMNs.
- The facilities should be located near main roads to ensure easy external monitoring.
- As the Project is unable to undertake facility renovation, the building infrastructure must be in good condition.
- To establish an integrated home visit model, new knowledge related to NCDs prevention and management is required. Therefore, health workers in the target area should already possess a certain level of knowledge in MCH and nutrition education that are being provided through home visits.
- To enable NCDs management at the PHC level, essential medicines must be readily available within the community.
- Appropriate use of newly provided equipment can be expected only if existing equipment is already being properly used and functioning. Thus, it is important that existing equipment is both utilized and operational.

- As the Project introduces the MCH Handbook, priority should be given to areas where the MCH Handbook has already been introduced.

As a result, the following districts/cities were selected as the project target areas: Rudaki District, Tursunzoda City, Kushoniyon District, and Levakant City.

(6) Activities Based on the Project Design Matrix (PDM)

The activities implemented based on the PDM are described below. Since the PDM was structured in a way that different thematic areas were included within the same output, color-coding was applied for clarity:

- Green (Output 1): Provision of Equipment to the Target PHC Facilities
- Blue (Output 1): Activities Related to Data Management
- White (Output 2): Current Capacity of Health Workers
- Yellow (Output 2): Integrated Home Visits
- Grey (Output 2): Activities Related to World Health Organization (WHO) HEARTS for NCD Management
- Orange (Output 3): Health Promotion Activities in the Community
- Dark grey (Output 3): Activities Related to Sharing Lessons Learned from the Project

Table 2.1-5 Activities Based on the PDM

Activity	Implemented
Output 1. **PHC facilities in the target area function better.**	
1.1 To conduct a survey to identify medical equipment in target PHC facilities.	In May 2023, a field assessment was conducted in the candidate RHCs to identify the medical equipment required for the implementation of the Project. The survey examined the existing medical equipment and the functional status of the equipment at each RHC. Based on the information collected and analyzed through this assessment, the Project Team developed a procurement plan for the medical equipment to be provided for the strengthening of the PHC service delivery of the target RHCs.
1.2 To formulate equipment provision plan for PHC facilities in the target area	The procurement plan was formulated based on the condition of the existing equipment, in addition to the following selection criteria: ・ Equipment that is necessary for PHC services that can be provided at RHCs, particularly those enabling integrated health activities with MCH as an entry point. ・ Alignment with the "List of Essential Equipment for PHC Facilities" issued by the MOHSPP. ・ Equipment that can be technically and financially maintained by the Government of Tajikistan after the completion of the Project, including the feasibility and cost of procuring consumables. ・ Avoidance of duplicating existing equipment or equipment provided by other development partners.
1.3 To implement the provision of equipment for PHC facilities in the target area	Based on the above assessment results, equipment procurement was carried out from July to October 2023. The outline of the procurement process and results are as follows: (1) Overview of the Procurement Process A Request for Quotation was distributed, wherein three companies submitted the required documents. After which an online opening of the submitted quotations was conducted. Following the evaluation of bid prices and the required documents, a procurement contract for the equipment was concluded with Tibtajhizot Limited Liability Company (LLC). (2) Overview of the Procurement Results ・ The medical equipment listed under Section "2.1.1(3) Provision of Equipment" was delivered to the target RHCs between September and October 2023. The equipment was handed over in the presence of RHC staff and Project Experts, during which functional checks and initial operational guidance were conducted. ・ Devices requiring more complex operation—namely the blood glucose meter, hemoglobin A1c analyzer, and

	cholesterol analyzer—had their manuals translated into Russian, and SOPs were developed. ・ The salt concentration meters and sugar concentration meters were explained and distributed during the nutrition-related training sessions.
1.4 To conduct a survey of the data management capacity of DHC and PHC managers	The Project assessed the computers and internet connectivity of the head DHCs and RHCs. New personal computers (PCs) were provided for facilities with broken or outdated computers. For facilities without internet access, the Project also provided Wi-Fi routers and covered the monthly internet fee (16 GB, approximately 120 TJS[1]). Interviews were conducted with the heads of the 16 RHCs in the eight candidate districts to collect information on their use and knowledge of IT, methods of data collection, data utilization practices, and existing reporting systems. The results are as follows: ・ None of the RHCs had internet access, and even in facilities where computers were available, the models were outdated—existing for more than ten years. ・ Regarding PC skills, while some RHC heads possessed basic computer skills—such as typing in Microsoft Word—reporting in most RHCs was primarily carried out by hand. ・ For PHC level health workers, the large number of data formats and the regular submission of reports imposed a considerable burden.
1.5 To select the necessary equipment and training for DHC and PHC managers in data management	In December 2023, the Project provided the necessary equipment—such as computers and Wi-Fi routers—to the target facilities. While from December 11-29, 2023, data management training related to District Health Information System (DHIS)-2 was conducted in each district. As the implementation of NCDs screening progressed, the need to develop software for entering NCDs screening results within the Project became evident. Accordingly, the software was developed in November 2024. It enables the input of NCDs screening data—including measurement results, lifestyle interview responses, and levels of motivation for lifestyle improvement—and allows outputs to be generated at the individual, mahalla, and facility levels. When the Project's achievements were presented at the Third JCC meeting in May 2025, the First Deputy Minister expressed interest in the Project's approach to NCD data management and suggested the possibility of integrating it into Tajikistan's national health data system: Tandurisiti.

[1] At the time of commencement, the amount was approximately 1,639 yen (TJS 1 = 13.6559 JPY, JICA Monthly exchange rate in JFY 2023, December 2023). As of January 2026, the amount is approximately 2,041 yen.

1.6 To provide data management training and facilitate the implementation of data-based planning.	In December 2024, training on the use of the software for entering NCDs screening results, as well as on data analysis, was conducted for all target RHCs. During the Second In-Japan Training conducted in January 2025, the heads of the RHCs analyzed the NCDs screening results from multiple perspectives—including sex, age, and mahalla—and formulated their 2025 screening plans and health education activity plans. Similarly, head nurses conducted the same type of analysis during the Third In-Japan Training held in February 2025. By re-analyzing and cross-checking the plans developed by their respective RHC heads, the validity of the plans was verified.
Output 2 **Health workers in PHC facilities are activated on Maternal and Child Health Care (MCH), Nutrition and Diet and Non-Communicable Disease (NCD) management**	
2.1 To conduct a survey of health workers' knowledge on MCH Care, and nutrition, diet, and NCD management.	Interviews were conducted with doctors, nurses, and midwives at the 16 candidate RHCs across the eight target districts to gather information on MCH health, NCDs management, and nutrition. The results are as follows: ・ Regarding the knowledge of health workers on MCH, nutrition, and NCDs, it was found that although their knowledge related to pregnancy in women was relatively high, they lacked sufficient knowledge on infants and child growth within the MCH domain. As for nutrition and NCDs, their level of knowledge was found to be very limited. ・ Regarding the use of the MCH Handbook in areas where it had been introduced, health workers recorded antenatal care information in the handbook. However, compared with the pregnancy period, there were limited records on the time of delivery and postpartum period. ・ With regard to nutrition, although there were some opportunities for training on nutrition for pregnant women and young children, there were very few opportunities for training on adolescent nutrition or nutrition for NCDs prevention. ・ Regarding awareness-raising materials, many of the previously developed printed materials by the MOHSPP or other development partners were available. Most of the content focused on MOH (such as estimated delivery date calculation cards, danger signs during pregnancy, nutrition pyramids, breastfeeding, and immunization) and infectious diseases (COVID-19, respiratory infections, waterborne diseases, etc.) Materials related to NCDs were rarely observed.
2.2 To conduct a survey on the utilization of materials and trainings for MCH Care, and nutrition, diet, and NCD management; including the MCH Handbook.	
2.3 To design activities to integrate new NCD interventions with	In May 2023, home visits were observed to review the NCD-related activities being conducted. It was confirmed that

<table>
<tr>
<td>existing MCH visits such as antenatal visit, post-natal visit and immunization</td>
<td>blood pressure was measured for all residents aged 40 and above, and that individuals with NCDs were regularly encouraged to visit the RHC for follow-up consultations.

In September 2024, a meeting was conducted with head nurses to review the definition and scope of integrated home visits and to conduct cost estimation. During the Nurse Technical Working Group (TWG) in December 2024, a revised version was prepared which incorporated improvements based on lessons learned from the two-month pilot implementation.

Subsequently, during the Japan-based training in February 2025, the SOP outlining the procedures for integrated home visits was finalized, and a ministerial order approving its use was issued in April of the same year.

To share the content with nurses at Health Houses (HHs) within each RHC’s catchment area, the RHCs developed and implemented training modules based on this SOP. In preparation for the implementation of integrated home visits, the following trainings for nurses were conducted to effectively transfer comprehensive health knowledge.

<table>
<tr><th>Period</th><th>Topic</th></tr>
<tr><td>October 2023</td><td>Refresher Training for FMN</td></tr>
<tr><td>October - November 2023</td><td>Antenatal Care and MCH Handbook</td></tr>
<tr><td>April 2024</td><td>NCDs（WHO-HEARTS）</td></tr>
<tr><td>July 2024</td><td>Home Visit</td></tr>
<tr><td>July 2024</td><td>Antenatal Care and MCH Handbook</td></tr>
<tr><td>August 2024</td><td>Nutrition</td></tr>
<tr><td>October 2024</td><td>SOP Introduction</td></tr>
<tr><td>November 2024</td><td>Presentation of the Final Draft of the SOP</td></tr>
<tr><td>December 2024</td><td>NCD data management</td></tr>
<tr><td>June 2025</td><td>Mini Training on Integrated Home Visits</td></tr>
</table>
</td>
</tr>
<tr>
<td>2.4 To implement above integrated package (2-1, 2-2 and 2-3)</td>
<td>In June 2024, the MOHSPP requested that the procedures for “Integrated Home Visits” be compiled into an SOP. Building on the existing home-visit procedures in the MCH field, the Project began drafting an SOP that incorporated components on NCD patient follow-up and nutrition counseling. The SOP development process followed the steps described above in Section 2.3.

Since 2025, home visit activities have been carried out in accordance with the finalized SOP for Integrated Home Visits, and the following positive changes have been</td>
</tr>
</table>

	observed: ・ The clarification of procedures and the use of the SOP, which made it easier to train newly assigned nurses, have contributed to more efficient implementation of home-visit activities. ・ By integrating the content into a comprehensive approach, home visits can now be conducted for all family members, enabling nurses to better understand the health status of each individual in the household. ・ Nurses are now able to conduct home visits with greater confidence, which has also contributed to increased trust from community members.
2.5 To review the current practice based on WHO HEARTS Technical Package	Regarding the assessment on the usage of the WHO HEARTS technical package, it was found that none of the target areas had introduced it. The WHO HEARTS technical package has only been implemented once in Shahrinav District, Tajikistan, with support from WHO in 2018. In this Project, relevant stakeholders were interviewed to learn from that experience and to inform the implementation process. The key points are summarized below. • Updating of Clinical Decision-making Tools: National PHC guidelines in Tajikistan are available in the form of printed books and are used by FMDs. The national guideline on hypertension (updated in 2018) recommends the use of the WHO/International Society of Hypertension (ISH) Cardiovascular Risk Charts, and some FMDs had previously received training on the WHO Package of Essential Non-communicable (PEN) Disease Interventions. The trainings included: - HEARTS Hypertension Protocol – Diuretics as the first-line treatment - HEARTS/WHO PEN Diabetes Protocol - WHO PEN Protocol 1 – Adapted for integration with the HEARTS Hypertension Protocol - Obesity calculation tables - WHO Cardiovascular Risk Charts – WHO/ISH charts without cholesterol - Integrated management algorithm for hypertension and diabetes (HEARTS Risk Module) - Clinical decision support tools • Updating the Training Package for PHC Workers: In Tajikistan, a pre-existing two-day training program developed for the implementation of WHO PEN is available. The following topics were identified as essential areas that should be emphasized in this training: - Organization of care - Task-sharing between doctors and nurses - Maintenance of clinical records

	- Management of patients without cholesterol testing - Appropriate and timely patient follow-up - Nurse-led home visits focusing on individuals with cardiovascular risk who are not receiving adequate care - Measuring gender-related inequalities in care and health outcomes - Enhancing community awareness of cardiovascular diseases • Training of Staff at Intervention Facilities: All doctors and nurses at the PHC facilities selected for intervention are divided into groups of approximately 30 participants to receive training. To ensure relevance to practical aspects of PHC service delivery, trainers consist of FMDs and FMNs, rather than specialists or academic professionals. • Implementation of the Protocols and Support for Implementation: Participants who completed the training then implement the clinical protocols over a 12-month period. During this time, teams composed of national- and district-level experts are formed to provide supervision to PHC facilities through both remote guidance and on-site visits. These teams visit each facility once every three months (four times in total) to review performance and provide constructive and timely feedback to facility managers and individual clinicians. • In addition to the quarterly facility visits, a workshop is held six months after implementation, bringing together the heads of each PHC facility. This workshop provides an opportunity for the project management team to deliver targeted support based on needs identified during clinic visits, promote goal setting and quality improvement, and collect further information on implementation barriers. These activities were led by the FMC, and the Project adopted the same approach previously used by the FMC in Shahrinav District. In particular, the workshop was convened six months after implementation—in addition to the quarterly facility visits—was positioned within the Project as a TWG meeting.
2.6 To conduct training to implement the WHO HEARTS Technical Package.	To develop an NCDs activity plan using the WHO HEARTS technical package, training was first provided to the heads of the target RHCs. The four-day training was conducted in October 2023. During the training, role-play exercises were carried out using the NCDs screening procedure manual developed by the Project Team, enabling participants to prepare the foundational skills required for implementing NCDs screening activities at their respective RHCs. The training covered the following topics:

	• Overview of the WHO HEARTS technical package; • Cardiovascular disease risk factors and clinical diagnosis; • Assessment of cardiovascular disease risk groups; • Treatment of cardiovascular disease; and • Counseling techniques for promoting healthy lifestyles. The topics above constitute the WHO HEARTS training package. The following topics below are additional training provided by the Project. • Purpose and procedures of screening for hypertension, obesity, hyperlipidemia and diabetes. • Practical exercises on the use of medical equipment provided by the Project. • Screening practice sessions. • Methods for developing RHC-level screening plans. A similar training was conducted for nurses in April 2024. In addition, when compiling the screening results, usage of paper-based aggregation proved insufficient, the process was therefore digitalized. As a result, new software development became necessary. (For subsequent activities, see Sections 1.5 and 1.6.)
2.7 To implement and to monitor the NCD management plan	In May 2024, the results of the NCDs screening activities that had begun in October 2023 were compiled. By that time, of the 3,612 individuals screened, 71% were classified as obese, 36% had hypertension, 15% exhibited elevated blood glucose level, and 59% presented with hyperlipidemia. In December 2024, the results of NCDs screening conducted throughout the year were compiled. During the Second Japan training held in January 2025, these results were analyzed, and the screening plan for 2025 was developed. Starting in June 2025, the monthly screening data was shared by the RHC directors with the Project Team, establishing a system for ongoing monitoring.
Output 3 **The quality of Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and diet and NCD prevention**	
3.1 To conduct a situation analysis of the health education to community at target districts	Interviews were conducted with the heads of the 16 RHCs across the eight target districts to collect information on health education. For the general public, a structured questionnaire was used to assess their awareness of their own health status and related factors. The summary of the results is as follows:

	・ Health education activities with pregnant women and mothers with children under five as subjects were conducted in all target areas and were more frequent than activities related to nutrition or NCDs. ・ Planned health education activities were not implemented in most RHCs. ・ Regarding health education materials, there were substantial regional differences in both quantity and variety. In areas with a greater number of materials, RHCs possessed resources on MCH (including the MCH Handbook), nutrition, and NCDs prevention. In contrast, areas with fewer materials had mostly MCH-related materials only. ・ Regarding the activities of the CHTs, some RHCs had an active CHT while others did not, resulting in inconsistent implementation across facilities. ・ Regarding residents' awareness of their health conditions, knowledge of diabetes was low with only 3.6% in Levakant City, 5.1% in Kushoniyon District, and 5.2% in Rudaki District. Awareness of obesity was similarly low, with only 2.0% in Rudaki District and 2.9% in Levakant City recognizing their condition.
3.2 To organize a team of health workers and community members to conduct health education activities at the PHC level in the community	In November 2023, the Project confirmed the members of the CHTs who would participate in Project activities. For each CHT, one unit within the RHC's catchment area—corresponding to a Health House—was designated as a community area. Each area was assigned two CHT members: one health worker and one community leader.
3.3 To conduct training of communication and assessment skill to the workers and community members who are engaged in promoting PHC services for families at community	Training was provided for the selected CHT members from November 2023 to August 2024, covering the following topics: • Responsibilities and roles of CHTs, based on the *"Guideline on the Partnership with Communities on Health Issues."* （Guidelines on the Partnership with Communities on Health Issues）」 • Health and hygiene/water and sanitation (acute gastroenteritis, diarrhea, hepatitis A, water-related infectious diseases and their prevention, botulism and its prevention, and food preservation) • MCH Handbook • Nutrition and nutrition-related diseases (lifestyle diseases)
3.4 To conduct awareness-raising activities on PHC service focusing on MCH Care, Nutrition and diet and NCD management (including use of MCH handbooks in awareness-raising activities).	In February 2024, together with the HLC, visits were conducted in each target RHC to receive activity reports from the CHTs. Common activities reported included organized community clean-up efforts with local residents, household-level hygiene education, and nutrition counseling for pregnant and lactating women. Subsequently, the Project, HLC, and the CHTs discussed methods for reporting activities, and it was agreed that activity reports would be

	submitted monthly via WhatsApp. In June 2024, in response to crucial requests from the CHTs, one automatic blood pressure monitor was provided to each member. Following this, awareness-raising activities using blood pressure measurement as an entry point became more actively implemented. In May 2025, the Republican HLC and the Project conducted on-site monitoring of CHT activities. During the Second and Third In-Japan Trainings held in January and February of the same year, the participating RHC directors and head nurses shared with the CHTs the knowledge they had gained in Japan regarding health education on nutrition and physical activity. As a result, it was confirmed that the CHTs were actively conducting nutrition education and promoting physical activity by utilizing various community settings where residents usually gather—including schools, billiard halls, and women's group meetings. In addition, during the Fourth In-Japan Training held in August 2025, participants developed a set of exercises inspired by Japan's *Radio Taiso* that could be practiced routinely by residents in Tajikistan. With advice from Japanese instructors during the training, the content was finalized after returning to Tajikistan, and the exercises were video recorded in October. The finalized video was distributed to each RHC and was also uploaded to the HLC website.
3.5 To share lesson learned regarding health education activities to community focusing on MCH care, Nutrition and diet and NCD management	At the Third JCC meeting held in May 2025, the Project shared its activities with the participation of the World Bank, WHO, and United Nations Children's Fund (UNICEF). In August 2025, during the Fourth In-Japan Training, the participants examined how to expand the implemented pilot activities in the Project target areas to other areas, focusing on the following thematic areas: (1) Expansion of the pilot activity package (NCDs screening, integrated home visits, and community-based nutrition and physical activity promotion); (2) Feasibility of integrating NCDs screening data into the national health database of Tajikistan; (3) Development and dissemination of the Tajikistan exercise program; and (4) Development and dissemination of nutrition promotion messages for the general population. The final Project seminar, held in January 2026, invited other development partners as well as representatives from Khatlon Oblast and its districts to share the Project's activities and achievements.

Source: Monthly Activity Report

(7) Implementation of the In-Japan Training and Participation in the International Conference on the MCH Handbook

Over the course of the project period, a total of four In-Japan Training programs were conducted. The First In-Japan Training Program, held in November 2023, focused on regional health administration for officials from central government ministries and directors of health departments in the pilot districts. The Second In-Japan Training Program, conducted in January 2025, focused on the NCDs and targeted officials from the MOHSPP, as well as directors of the pilot RHCs. The Third In-Japan Training Program, held in February 2025, focused on health education and targeted key personnel such as head nurses from the pilot RHCs. While the Fourth In-Japan Training Program was conducted in August 2025 for officials from the MOHSPP and staff from technical centers, with a focus on nationwide expansion. Summaries of each training program are provided in Tables 2.1-6 through 2.1-9.

Aiming to further promote the use of the MCH Handbook in Tajikistan, the project participated in the International Conference on the MCH Handbook held in Manila, Philippines, in May 2024 (Table 2.1-10).

Moreover, after each In-Japan training program, the project experts confirmed during their field visits that the participants had shared the training outcomes within their respective organizations and were taking concrete steps toward implementing their action plans in collaboration with other trainees.

Table 2.1-6 Summary of the First In-Japan Training Program

Course Title	Local Health Administration for Improving Quality of Primary Health Care Services
Location	JICA Chubu Center
Duration	November 5, 2023～November 11, 2023
Number of Participants	Ten participants: 2: Department of Reform, PHC and International Relations, MOHSPP 1: Republican Educational and Clinical Center for Nursing 1: Khatlon Regional Training and Clinical Center for Family Medicine 1: Director of DHC, Rudaki District 2: Director and Deputy Director of DHC, Tursunzoda City 1: Director of DHC, Levakant City 1: Training and Clinical Center for Family Medicine in Kushoniyon District 1: Training and Clinical Department for Family Medicine in Rudaki District
Training Agencies	Main Lecturers: Ministry of Health, Labour and Welfare, Aichi Prefecture Government, Life Prevention Medicine Center, Aichi Health Promotion Public Interest Foundation, Graduate School of Medicine, The University of Tokyo Study Visit Destinations: Life Prevention Medicine Center, Aichi Health Plaza
Course Objectives	1) To learn about the structure of local health administration, planning, and evaluation in Japan, and deepen understanding of health planning and its evaluation methods, especially primary health care.

	2) Transfer knowledge to Tajikistan Republic-level experts from the prefectural and municipal levels in Japan about the systems and content of health checkups and health consultations, health statistics and their use, and community-based health education practices—deepening their understanding of specific measures and data utilization necessary to improve the quality of primary health care services. 3) Based on the findings from items 1) and 2) above, each republican specialized center will discuss future activities to improve the quality of primary health care services in Tajikistan.

Source: In-Japan Training Report

Table 2.1-7 Summary of the Second In-Japan Training Program

Course Title	Improving the Quality of Primary Health Care Services with a Focus on Non-Communicable Disease (NCD) Prevention
Location	JICA Chubu Center
Duration	January 20, 2025 – January 29, 2025
Number of Participants	Ten participants: 1: Department of Reform, PHC, and International Relations, MOHSPP 1: Leading specialist of the Department of Organization of Medical Services, MOHSPP 1: Head of the Secretariat, MOHSPP 7: Directors of the target RHCs
Training Agencies	Main Lecturers: Hekinan City Mayor, Life Prevention Medicine Center, Aichi Health Promotion Public Interest Foundation Study Visit Destinations: Life Prevention Medicine Center, Aichi Health Plaza
Course Objectives	1) To learn about plans and initiatives of local health administrations in Japan regarding the NCDs' management and actual methods of screening and follow-up for NCDs. 2) To understand how to use and implement data management systems that will be introduced in the target areas. 3) To discuss plans and activities for NCDs management based on the knowledge gained from items 1) and 2).

Source: In-Japan Training Report

Table 2.1-8 Summary of the Third In-Japan Training Program

Course Title	Improving the Quality of Primary Health Care Services with a Focus on Health Education
Location	JICA Chubu Center
Duration	February 3, 2025～February 12, 2025
Number of Participants	Ten participants: 2: Directors from Kushoniyon and Levakant DHCs 8: Head Nurses of the target RHCs
Training Agencies	Main Lecturers: Friends of WHO Japan, public interest incorporated association, Aichi Health Promotion Public Interest Foundation, Nagoya City Municipal Administration Study Visit Destinations: Aichi Health Plaza, Naka Public Health Center
Course Objectives	1) To learn about the plans and initiatives of local health administrations in Japan regarding health education and actual services for MCH and nutrition.

	2) To discuss the methods of health education, especially home visits, using the integrated approach to be introduced in the target areas. 3) To discuss plans and activities for health education based on the knowledge obtained from items 1) and 2).

Source: In-Japan Training Report

Table 2.1-9 Summary of the Fourth In-Japan Training Program

Course Title	Nationwide Scaling Up of Primary Health Care Activities
Location	JICA Chubu Center
Duration	August 25, 2025 – September 3, 2025
Number of Participants	Ten participants: 1: Assistant of the Minister, General Department, MOHSPP 1: Specialist, Reform, PHC, and International Relations, MOHSPP 1: Head, Department of Business Planning and Analysis of Family Medicine Development, State Institute of the Republican Center for Family Medicine 1: Head of Analytical Department, State Institute of the Republican Center for Family Medicine 1: Deputy Director, State Institute of the Republican Nutrition Center 2: Director and Deputy Director, Healthy Lifestyle Center 1: Republican Center for Medical Statistics and Information 1: Assistant of Head, Farkhor Medical College 1: Director of RHC Voroshilov
Training Agencies	Main Lecturers: Life Prevention Medicine Center, Nagoya City Municipal Administration, Aichi Health Promotion Public Interest Foundation Study Visit Destinations: Life Prevention Medicine Center, Aichi Health Plaza
Course Objectives	1) To learn about the primary health care service policies and initiatives implemented by local health administrations in Japan, with a focus on NCD management. 2) To understand the progress of project activities carried out in the target areas and discuss its effects and impact. 3) To determine the nationwide expansion action plan by each expert center after the project's completion, based on the knowledge and discussion gained from items 1) and 2).

Source: In-Japan Training Report

Table 2.1-10 Summary of the 14th International Conference on the MCH Handbook

Course Title	Ensuring Universal Health Care through Effective MCH Services and the MCH Handbook
Location	Manila, Philippines
Duration	May 9, 2024 – May 10, 2024
Number of Participants	Two participants: 1: MOHSPP 1: Republican Training and Clinical Center for Family Medicine
Main Lecturers	Disease Prevention and Control Bureau, Department of Health, Maternal Child Health and Quality Safety World Health Organization Western Pacific Region, Embassy of Japan in the Philippines, University of the Philippines- Manila, Center for Health and Development, Department of Health-CALABARZON

Expected Outcome	1) Update information on how and to what extent the MCH Handbook is being used. 2) Explore good practices from other countries that could be incorporated into the use of MCH Handbooks in Tajikistan.

Source: Monthly Report on Consultant Activities

(8) Project Public Relations

In this Project, efforts have been made to ensure that the significance and outcomes of the activities are properly communicated and understood by the people of both Tajikistan and Japan.

The public relations activities carried out during the project period are as follows:

Table 2.1-11 Public Relations Activities Related to the Significance, Activities, and Achievements of the Project

No.	Tool	Public Relations Activities Conducted During the Monitoring Sheet Coverage Period
1	JICA Website	The project overview was published on the JICA Technical Cooperation website. 13 project news articles were posted on the official development assistance (ODA) Project Website.
2	Facebook	Five articles published by the JICA Tajikistan Office: 1. NCD Prevention, Screening, and Public Awareness 2. Enhancing PHC: Training of Managers and Nurses in Japan 3. Fourth Training in Japan 4. Positive Impacts of Comprehensive Home Visits 5. Advancing Primary Health Care in Tajikistan: Ms. Sahel Rosa's Visit to the Quality of Care Improvement Project

Source: ODA Project Website, JICA Tajikistan Office Facebook

2.2 Achievements of the Project

2.2.1 Outputs and Indicators

The status of achievement for each output is presented below.

(1) Achievement of Output 1

The achievement status of the indicators under Output 1 are as follows.

Table 2.2-1 Achievement of Output 1

No.	Indicator	Status of Progress and Achievement
1	As a result of the activity to conduct a survey identifying medical equipment in target PHC facilities, a survey report including analysis became available.	**【Achieved】** It was documented in the baseline survey report and distributed.
2	As a result of the activities 1-2 (to formulate an equipment provision plan for PHC facilities in the target area) and 1-3 (to implement the provision of equipment for PHC facilities in	**【Achieved】** All necessary medical equipment was provided.

No.	Indicator	Status of Progress and Achievement
	the target area), the required health equipment was purchased and provided.	
3	As a result of conducting a survey of the data management capacity of DHC and PHC managers, the survey results became available.	【**Achieved**】 It was documented in the baseline survey report and distributed.
4	As a result of selecting the necessary equipment and training for DHC and PHC managers in data management, the number of health workers who received training increased.	【**Achieved**】 24 health workers received training on DHIS-2, and 16 health workers received training on NCD data management.
5	As a result of providing data management training and facilitating the implementation of data-based planning, the number of data-based plans increased.	【**Achieved**】 The target RHCs developed no data-driven health promotion plans in 2024; however, each RHC prepared one plan in 2025.

Source: Monitoring Sheet

(2) Achievement of Output 2

The achievement status of the indicators under Output 2 is shown below.

Table 2.2-2 Achievement of Output 2

No.	Indicator	Status of Progress and Achievement
1	As a result of conducting a survey on health workers' knowledge on MCH care, nutrition and diet, and NCD management, an assessment report became available.	【**Achieved**】 The baseline survey report was developed.
2	As a result of conducting a survey on the utilization of materials and trainings for MCH care, nutrition and diet, and NCD management, including the MCH Handbook, an assessment report became available.	【**Achieved**】 The baseline survey report was developed.
3	As a result of designing activities to integrate new NCD interventions with existing MCH visits such as antenatal visits, postnatal visits, and immunization, a design report became available.	【**Achieved**】 The design of the integrated home visit was presented at the Second JCC. Subsequently, a series of TWG meetings were held to identify and structure the essential components of the home visits, which were then compiled into the SOP.
4	As a result of implementing the above integrated package (2-1, 2-2, and 2-3), an implementation report including the description of the changes after the integration became available.	【**Achieved**】 The SOP for the Integrated Home Visit has been developed.
5	As a result of reviewing the current practice based on the WHO HEARTS Technical Package, a review report on the current practice became available.	【**Achieved**】 The SOP for NCD management has been developed.
6	As a result of conducting training to implement the WHO HEARTS Technical	【**Achieved**】 By 2024, a total of 156 health workers

No.	Indicator	Status of Progress and Achievement
	Package, the number of trained health workers increased.	(doctors and nurses) had received training. As of 2025, 20 health workers have been trained.
7	As a result of implementing and monitoring the NCD management plan, the number of plans for practicing NCD management based on the WHO HEARTS Technical Package and the number of plans implemented increased.	【Achieved】 In 2025, at least one NCDs screening plan was confirmed at each RHC.

Source: Monitoring Sheet

(3) Achievement of Output 3

The achievement status of the indicators under Output 3 is as follows:

Table 2.2-3 Achievement of Output 3

No.	Indicator	Status of Progress and Achievement
1	As a result of conducting a situation analysis of health education for communities in the target districts, a Situation Analysis Report became available.	【Achieved】 The baseline survey report was developed and disseminated.
2	As a result of conducting and organizing a team of health workers and community members to conduct health education activities at the PHC level in the community, coordination among workers and community members engaged in promoting PHC services was implemented.	【Achieved】 CHTs consisting of medical professionals and community members were formed, and community activities were implemented.
3	As a result of conducting training on communication and assessment skills for workers and community members engaged in promoting PHC services for families in the community, the number of workers and community members who received training increased.	【Achieved】 A total of 97 CHT members received training on NCD prevention, blood pressure, and MCH in 2023, and a total of 215 members received the training in 2024.
4	As a result of conducting awareness-raising activities on PHC services focusing on MCH care, Nutrition and Diet, and NCD management (including the use of maternal and child handbooks in the activities), the number of cases of awareness-raising activities among participants increased.	【Achieved】 By the time of the endline survey, a total of 5,821 awareness-raising activities had been conducted.
5	As a result of sharing lessons learned regarding health education activities with communities focusing on MCH care, nutrition and diet, and NCD management, activities for sharing the experiences were conducted.	【Achieved】 A report on activities to date was presented at the Third JCC. An activity plan anticipating nationwide expansion was formulated during the Fourth Training in Japan. Furthermore, an experience-sharing seminar for relevant organizations was held

No.	Indicator	Status of Progress and Achievement
		in January 2026.

Source: Monitoring Sheet

2.2.2 Project Purpose and Indicators

Project Purpose: Capacity of PHC service delivery is strengthened in integrated manner at pilot sites

The indicators for the above project purpose and their achievement status are summarized below. The scope of the "target areas" (i.e., the coverage for data collection for each indicator) refers to the areas under the jurisdiction of the eight targeted facilities.

Table 2.2-4 Achievement Status of the Project Purpose

No.	Indicator	Status of Progress and Achievement
1	Increase in the number of home visit conducted with the proper knowledge of Maternal and Child Health, Nutrition and NCDs.	**【Achieved】** The number of home visits conducted with appropriate knowledge of MCH, nutrition, and NCDs increased significantly. During the baseline period, the monthly number of home visits are as follows: 1,001 in the MCH field, 484 in nutrition, and 418 in NCDs. According to the endline data from August 2025, the total number of home visits reached 14,462, of which 2,330 were in MCH, 8,547 in nutrition, and 3,736 in NCDs.
2	Increase in the total number of population screened for detecting obese and/or hypertension.	**【Achieved】** The total number of people who underwent screening for the detection of obesity and hypertension increased. At baseline, no screening had been conducted; however, by the endline, 14,632 individuals had been screened, representing 70.2% of the population aged 40 and above.
3	Increase in the total number of population who acknowledge their status as obese and/or hypertension.	**【It was achieved to a certain extent; however, the target value was not met.】** The total number of people who recognized that they were obese or hypertensive increased. Awareness of obesity rose from 6.8% at baseline to 12.1% at endline, and awareness of hypertension increased from 23.3% to 25.6%. However, both remained below the target values.
4	Increase in data entry completion rate of the MCH Handbook* or its equivalent (e.g. Pre-and post-natal maternal status, child at birth status, Continuum of care for Antenatal Care (ANC) - Delivery-Postnatal Care (PNC)-Immunization-Growth Monitoring-Development)	**【Achieved】** The completion rate of data entry in the MCH Handbook or its equivalent (e.g., information on maternal condition before and after pregnancy, child status at birth, antenatal care, delivery, post-natal check-ups, immunization, growth monitoring, and developmental follow-up) increased. At baseline, each item had a recording rate of approximately 50%. By the endline, the recording rate for all indicators had risen to approximately 96–97%.

Source: Endline Survey

The changes observed for each indicator are described below.

No.	Indicator
1	Increase in the number of home visit conducted with the proper knowledge of Maternal and Child Health, Nutrition and NCDs

For this indicator, an assessment was conducted from both the quantitative and qualitative perspectives. Regarding the quantitative aspect, the monthly number of home visits at baseline was 1,001 in the MCH field, 484 in nutrition, and 418 in NCDs. In contrast, at endline, the total monthly number of home visits reached 14,462, comprising 2,330 in MCH, 8,547 in nutrition, and 3,736 in NCDs. Although the number of home visits temporarily declined during periods of extreme heat in summer and severe cold in winter when the opportunity to go outside naturally decrease the overall trend showed a clear increase.

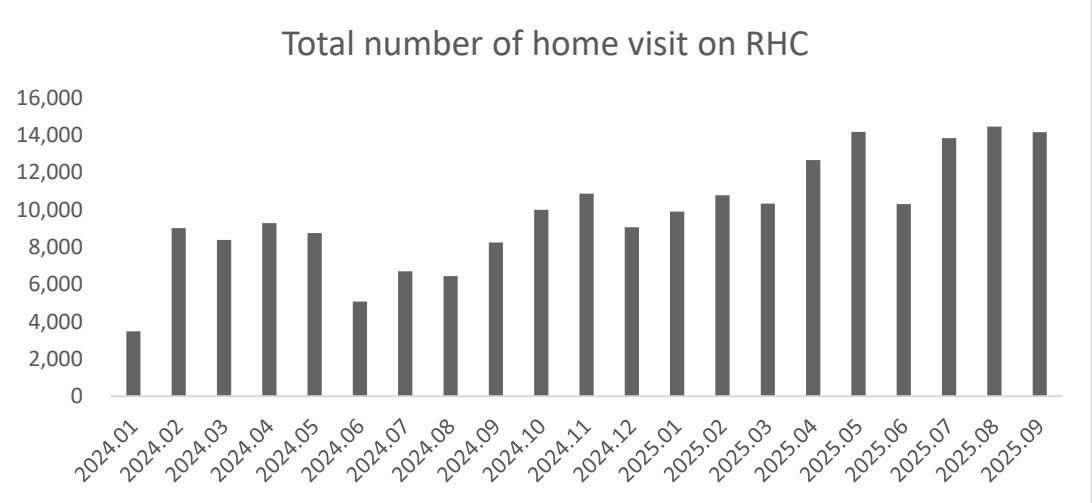


Figure 2.2-1 Change in the Number of Home Visits

Source: Project Monthly Data Collection

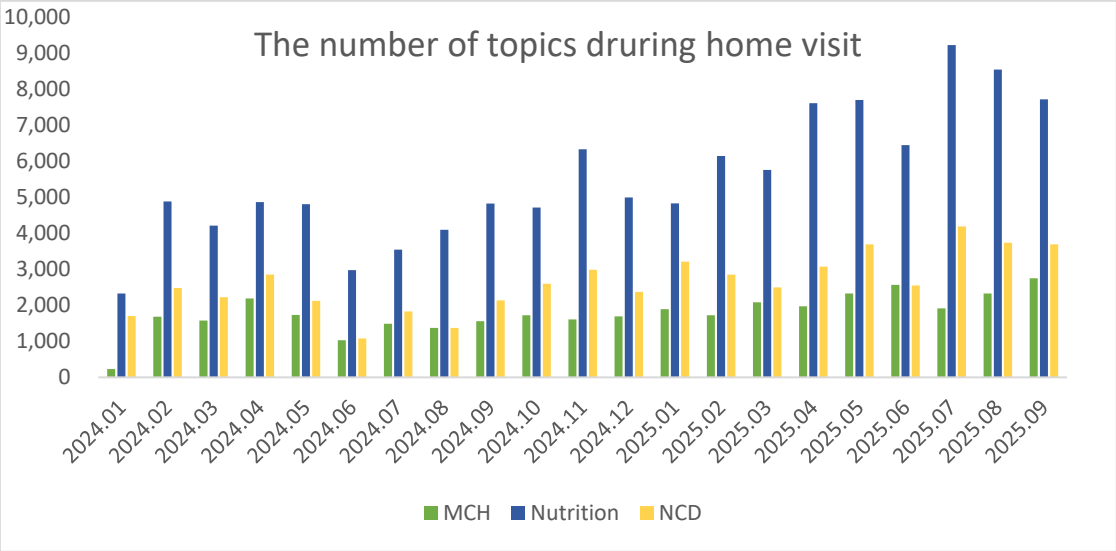


Figure 2.2-2 Change in the Number of Home Visits in the Field of MCH, Nutrition, and NCDs

Source: Project Monthly Data Collection

Next, the qualitative aspect is described. Since this indicator is defined as "home visits conducted based on appropriate knowledge," the knowledge levels of the relevant personnel were assessed through questions related to MCH, nutrition, and NCDs, and the results were analyzed. As shown in the figure below, the endline survey confirmed a substantial improvement in knowledge. For the evaluation of this indicator, a correct response rate of 70% or higher was set as the threshold for "meeting an adequate quality standard." As all items exceeded the correct response rate at the endline, it can be concluded that the home visits were conducted based on appropriate knowledge.

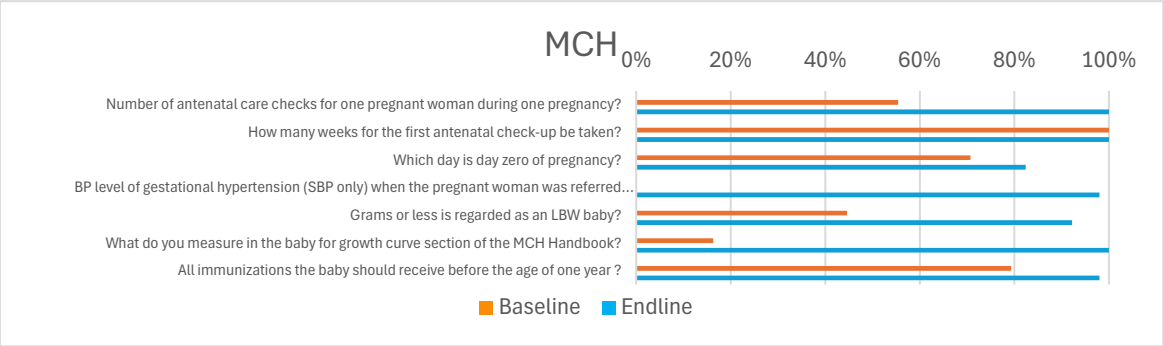


Figure 2.2-3 Comparison of Baseline and Endline Knowledge in the MCH Field

Source: Baseline and Endline Surveys

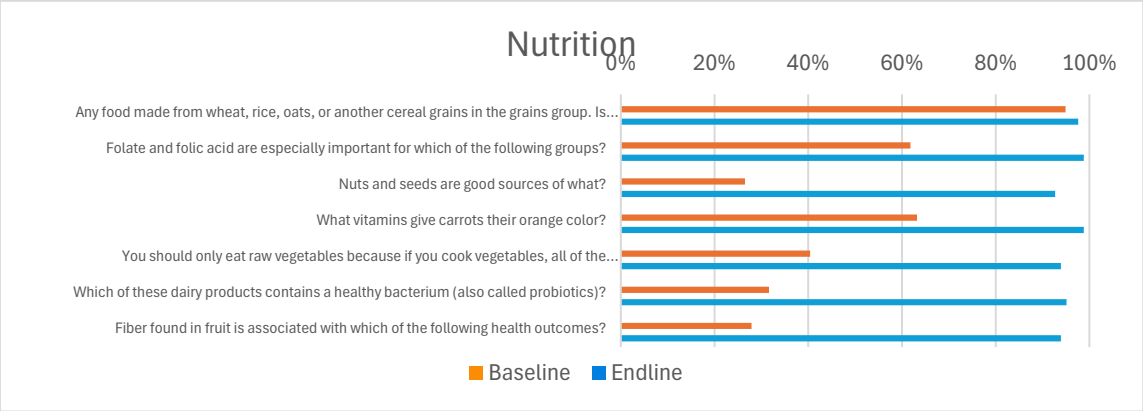


Figure 2.2-4 Comparison of Baseline and Endline Knowledge in the Nutrition Field

Source: Baseline and Endline Surveys

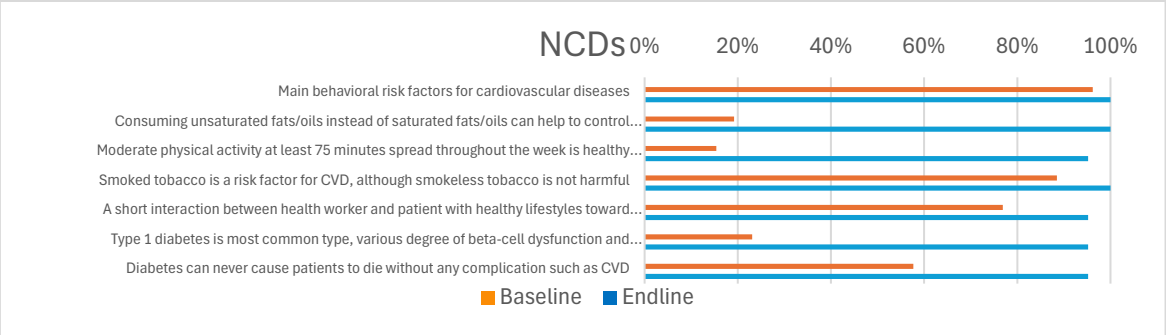


Figure 2.2-5 Comparison of Baseline and Endline Knowledge in the NCDs Field

Source: Baseline and Endline Surveys

In this Project, an SOP for home visits was developed with the aim of improving its quality. The SOP is currently being utilized in all home visits conducted in the target areas. Additionally, through training provided to nurses working in HHs under the jurisdiction of the RHCs, its application has been further expanded.

No.	Indicator
2	Increase in the total number of population screened for detecting obese and/or hypertension.

At the time of the baseline survey, some screening activities were observed: hypertension screening was being conducted at one RHC each in Hissor District and Vahdat City, and diabetes screening was being implemented at one RHC in Hissor District. However, a systematic and formal screening system had not yet been established in the Project target areas, therefore, the initial indicator value was 0% at the start of the Project.

Through the implementation of the Project, NCDs screening was introduced and expanded, and at present, all eight RHCs in the target area are conducting screening for hypertension, diabetes,

hyperlipidemia, and obesity among adults aged 40 and above. The number of individuals screened at endline and the corresponding coverage rate relative to the target population are shown below.

Table 2.2-5 Number of Screening and Coverage Rate

District/City	RHC	Population Aged 40 and Above (as of August 2025)	Number of Individuals Screened from January 2024 to August 2025	Coverage Rate
Kushoniyon	Voroshilov	2,637	1,954	74.1%
	Bustonkala	3,987	2,267	56.9%
Levakant	Kuli Sufiyon	1,056	1,022	96.8%
	Botrobod	1,818	1,373	75.5%
Rudaki	Sarilishiti Poyon	3,564	2,456	68.9%
	Chorteppa	2,678	1,454	54.3%
Tursunzoda	Pakhtaobod	2,264	2,513	111.0%
	Batosh	2,829	1,593	56.3%
Total		20,833	14,632	70.2%

Note: These data represent cumulative figures from early 2024 onward. As a result, in some areas, the screening coverage rate exceeds 100% of the target population.
Source: Project Monthly Data Collection

The data below shows the cumulative number of NCD screening procedures conducted across the eight target RHCs. Although monthly fluctuations were observed, decreases in certain months can be attributed to factors such as the availability of consumables used for screening and the influence of the annual schedule, including the Ramadan period.

The results compiled when data entry of the screening results began from October 2024 through October 2025 are presented below. During this period, screening data for 8,272 individuals were entered. Based on the data-derived classifications, the following were identified:

- Obesity (mild, moderate, severe): 2,756 individuals (33.3%)
- Overweight: 3,415 individuals (41.3%)
- Elevated blood pressure (mild, moderate, severe): 2,659 individuals (32.1%)
- High blood glucose: 303 individuals (3.7%)
- Borderline blood glucose: 1,147 individuals (13.9%)
- Elevated cholesterol: 5,323 individuals (64.3%)

Based on these results and other contributing factors, physicians' final assessments are as follows:

- Obesity: 2,777 individuals (33.6%)
- Hypertension: 1,865 individuals (22.5%)
- Diabetes: 567 individuals (6.9%)
- Hyperlipidemia: 3,473 individuals (42.0%)

According to the WHO HEARTS criteria, 1,289 individuals (15.6%) had a 10% or higher risk of cardiovascular disease and required follow-up. Meanwhile, during the same period, 385

individuals were recorded as having been identified with at least one condition through screening and subsequently followed up by RHC physicians.

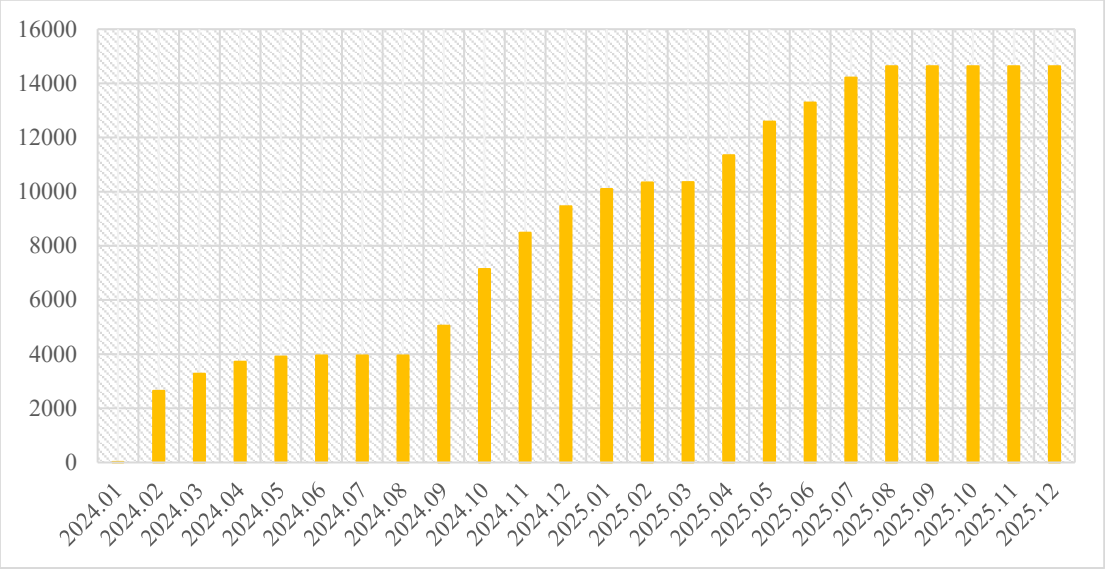


Figure 2.2-6 Cumulative Number of NCDs Screenings Conducted

Source: Project Monthly Data Collection

No.	Indicator
3	Increase in the total number of population who acknowledge their status as obese and/or hypertension.

The self-recognition of obesity increased significantly from 6.8% at baseline to 12.1% at endline, showing approximately a twofold rise. While recognition rate of hypertension also increased from 23.3% to 25.6%. When comparing across districts, Levakant, Rudaki, and Tursunzoda showed increases in self-recognition rates for both obesity and hypertension. In contrast, Kushoniyon recorded decreases in both indicators.

Upon confirming the reason for this trend in Kushoniyon, it was found that some enumerators belonging to the subcontracted survey team had mistakenly interviewed households outside the Project's target area. These non-target households were likely not exposed to the Project's awareness-raising activities, which may have resulted in relatively lower self-recognition rates and subsequently affected the overall figures. The survey methodology in the other districts was also reviewed, and no similar issues were identified.

Although an increase was observed at the endline, the self-recognition rates for obesity (12.1%) and hypertension (25.6%) did not reach their respective target values of 25.0% and 30.0%. These

targets were set by the Project Team after the baseline survey, based on the assumption that a certain proportion of residents would come to understand their health risks through NCDs screening activities, leading to improvements in self-recognition.

Possible factors contributing to the non-achievement of the target values include cases in which, despite having identified their health risks through screening, individuals did not fully understand the results or appreciate their implications. Although FMD at the RHCs provide explanations to clients using the result sheets after screening, it is likely that the interpretation of numerical values and the seriousness of the associated risks are not always conveyed effectively. During the final TWG meeting held in January 2026, the Project, together with RHC FMD and head nurses, discussed effective methods for ensuring that clients appropriately recognize their health risks.

Table 2.2-6 Comparison of Baseline and Endline Self-recognition Rates of Diseases (by District/City)

	Obesity		Hypertension	
	Baseline	**Endline**	**Baseline**	**Endline**
Kushoniyon	12.9%	7.0%	28.4%	18.7%
Levakant	2.9%	10.2%	31.1%	38.8%
Rudaki	2.0%	10.8%	18.3%	25.0%
Tursunzoda	9.9%	18.1%	23.9%	29.0%
Total	6.8%	12.3%	23.3%	25.6%

Source: Baseline and Endline Survey

In addition, as a supplementary reference to the self-recognition indicators, the Project used a household questionnaire to assess the proportion of residents who had never previously measured their blood pressure, blood glucose, or cholesterol levels. The results showed substantial declines: from 32.0% to 6.2% for blood pressure, from 73.0% to 23.3% for blood glucose, and from 80.1% to 33.0% for cholesterol. These findings confirmed a clear increase in the number of residents who have undergone such measurements. As more residents receive these measurements, the importance of understanding the results and appropriately recognizing one's own health status is strengthened.

No.	Indicator
4	Increase in data entry completion rate of the MCH Handbook or its equivalent (e.g. Pre-and post-natal maternal status, child at birth status, Continuum of care for ANC-Delivery-PNC-Immunization-Growth Monitoring-Development)

The verification of key indicators recorded in the MCH Handbook confirmed that the improved consistency of documentation from baseline to endline exceeded the target value of 70%. Specifically, the recording rates for all items, including pregnant women's weight and blood pressure at antenatal checkups, birth weight, child growth curves, and immunization records,

showed substantial increases. By the time of the endline survey, the recording rates for all indicators had reached approximately 96–97%.

In the district-level comparison, significant regional differences were observed at both baseline and endline (p=0.000). At baseline, Tursunzoda recorded extremely low registration rates across all indicators (ranging from 11.6% to 18.2%), significantly lower than those of the other districts. However, by the endline, Tursunzoda, together with Levakant and Rudaki, had achieved registration rates approaching 100% for nearly all indicators, demonstrating a remarkable improvement.

In contrast, Kushoniyon, which had shown relatively high registration rates at the baseline, exceeding 80% for many indicators, experienced slight decreases across all indicators at the endline. Despite this decline, the differences among districts remained statistically significant for many indicators at the endline (p = 0.009).

Table 2.2-7 Comparison of Baseline and Endline MCH Handbook Recording Rates

Baseline (B) Endline (E)	Weight of Pregnant Woman（%）		Blood Pressure at Antenatal Care（%）		Birth Weight（%）		Child Growth Curve（%）		Immunization（%）	
	B	E	B	E	B	E	B	E	B	E
Kushoniyon	84.9	72.3	88.3	74.2	84.0	73.0	83.6	73.0	82.1	73.0
Levakant	83.9	100	83.1	100	84.2	100	79.6	100	75.7	93.3
Rudaki	72.5	100	70.5	100	72.5	100	70.5	99.4	68.7	98.7
Tursunzoda	11.6	97.3	13.7	100	17.8	100	11.6	100	18.2	100
Total	55.5	96.1	56.4	97.4	57.6	97.2	54.0	97.0	54.9	96.0

Source: Baseline and Endline Surveys

2.3 History of PDM Modification

In the R/D signed on September 5, 2022, PDM version 1 was approved. Following the start of the Project, the PDM was revised based on the results of the baseline survey to better reflect the actual conditions, and the revised version—PDM Version 2—was approved in Monitoring Sheet Version 2 submitted at the end of January 2024. Any modifications made and the reasons for those changes are described below.

Table 2.3-1 Revisions to the PDM and Their Justifications

	PDM Ver 1	PDM Ver 2
Overall Goal	Quality of Primary Health Care Services in the Target Districts is improved.	No modifications
Indicators of Overall Goal	1 Functional PHC facilities per population increases 2 Reduced hospitalization rate of patients	No modifications

	PDM Ver 1	PDM Ver 2
	with chronic extensive diseases (diabetes, hypertension, congestive heart failure and asthma) in Khatlon Oblast and DRS	
	3 Increase in record ownership (e.g. pre-natal maternal body mass index (BMI) and blood pressure (BP) and birth weight and supplement of Vitamin A) in the form of MCH Handbook or its equivalent	
Project Purpose	Capacity of PHC service delivery is strengthened in integrated manner at pilot sites	No modifications
Indicators of Project Purpose	1 Increase in the number of home visit conducted with the proper knowledge of Maternal and Child Health, Nutrition and NCDs 2 Increase in the total number of population screened for detecting obese and/or hypertension. 3 Increase in the total number of population who acknowledge their status as obese and/or hypertension. 4 Increase in data entry completion rate of the MCH Handbook* or its equivalent (e.g. Pre-and post-natal maternal status, child at birth status, Continuum of care for ANC-Delivery-PNC-Immunization-Growth Monitoring-Development)	No modifications
Output 1	PHC facilities in the target area function better.	No modifications
Indicators of Output 1	1-1 Availability of survey report including analysis 1-2 Availability of the Plan for the rehabilitation and renovation of infrastructure 1-3 Required health equipment is purchased and provided. Rehabilitation of the infrastructure is carried out. 1-4 Number of health workers who received training 1-5 Availability of the survey results 1-6 Number of data-based plan	Indicators 1-2 and 1-3 were combined and revised to “Required health equipment is purchased and provided.” Indicator 1-4 was revised to “Availability of the survey results.” Indicator 1-5 was revised to “Number of health workers who received training.”
Justifications of Modifications	Although facility renovation and equipment provision were originally included among the activities under Output 1, the facility renovation component was later cancelled, therefore one of the output indicators was removed. In addition, for the data management-related activities under Output 1, the specific activities were defined in greater detail after the baseline survey, and the corresponding indicators were revised accordingly.	

	PDM Ver 1		PDM Ver 2
Output 2	Health workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and NCD management		No modifications
Indicators of Output 2	2-1	Availability of the assessment report	Indicator 2-6 was revised to "Number of trained health workers". Indicator 2-7 was revised to "Number of plan of practicing NCDs management based on WHO HEARTS Technical Package and Number of plan implemented".
	2-2	Availability of the assessment report	
	2-3	Availability of the design report	
	2-4	Availability of the implementation report including the description of the changes after the integration	
	2-5	Availability of the review report on the current practice based on WHO HEARTS Technical Package	
	2-6	Number of health workers who received the training to implement HEARTS	
	2-7	Number of plan implemented	
Reasons of Justifications	For Indicator 2-7, the type of "plan" referred to in the indicator was defined more clearly, and the number of activities implemented based on the plan was added.		
Output 3	Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and NCD prevention		No modifications
Indicators of Output 3	3-1	Availability of the Situation Analysis Report	No modifications
	3-2	Coordination among workers and community members who engage in promoting PHC services is implemented	
	3-3	Number of workers and community members who received trainings	
	3-4	Number of cases for awareness-raising activities among the participants	
	3-5	Activities for sharing the experiences are conducted	

Source: Monitoring Sheet Ver 2

2.4 Others

2.4.1 Results of Environmental and Social Considerations

This Project is classified as Category C under the "JICA Guidelines for Environmental and Social Considerations," indicating that it is expected to have minimal or no adverse environmental or social impacts. JICA places particular emphasis on protecting the human rights of vulnerable groups—including women, children, the elderly, the poor, indigenous peoples, persons with disabilities, refugees, internally displaced persons, and ethnic minorities. The Project is designed

to directly benefit these populations.

2.4.2 Results of Considerations on Gender/Peace Building/Poverty Reduction, Disability, Disease Infection, Social System, Human Wellbeing, Human Right, and Gender Equality

The Project's principal activities— "Integrated Home Visits" and "NCDs Screening"—are implemented for all residents in the target areas and have been beneficial to low-income populations. Both home visits and NCDs screening services are provided free of charge, ensuring that people can access health services without concern for financial barriers.

From a gender perspective, the promotion of the MCH Handbook has also contributed to encouraging greater involvement of men in childcare. While childcare has traditionally been assumed to be the responsibility of women, an increasing number of fathers are now attending explanation sessions with mothers and listening to guidance provided by nurses and CHT members.

With regard to community-based health promotion activities, the CHT—composed mainly of women—has actively engaged with female residents, who are often at home during the daytime, to promote physical activity and provide health education on nutrition. In Tajikistan, where cultural norms often limit women's ability to exercise outdoors, this resulted to an increasing number of women who have begun practicing simple exercises indoors. Furthermore, as the CHT members have become more recognized and accepted within their communities, the activities have also contributed to the women empowerment.

Through home visits, the Project ensures that all families—regardless of whether they include women, children, older persons, persons with disabilities, or households facing economic hardship—have equitable access to health services. In NCDs screening, the service was given through outreach services conducted at or near the homes of individuals who have difficulty going out, such as older persons and persons with disabilities. By leveraging the strength of Tajikistan's PHC facilities, which have a detailed understanding of household circumstances through home visits, the Project was able to provide health services that were widely welcomed and trusted by community members.

In addition, although Uzbek households are dispersed throughout the target areas, equal access to health services has been ensured by having health workers and CHT members who speak Uzbek accompany NCDs screening activities and home visits. Furthermore, subtitles and voice-over

narration were added to the videos produced by the Project, enabling persons with visual or hearing impairments to understand the content.

Chapter 3 Results of Joint Review

3.1 Results of Review based on Development Assistance Committee (DAC) Evaluation Criteria

For each of the six DAC evaluation items (relevance, coherence, effectiveness, impact, efficiency, and sustainability), the evaluation results are rated on a 4-point scale (very high, high, fairly low, low). This evaluation was conducted jointly by the Tajikistan-side Project Manager, Dr. Mannonov Olimjon, Head of the PHC Division, Department of Reform, PHC, International Relations, Ministry of Health and Social Protection of the Population, and the Japan-side Chief Advisor of the Project Team, Ms. Yoshiko Akiyama.

3.1.1 Relevance

Based on the following discussion, the Project's relevance is assessed overall as 'very high.

(1) Consistence with Development Policy

The Project is fully aligned with all priority areas of the health sector under Tajikistan's highest-level national planning document, the "National Development Strategy 2030," namely: (i) health system reform with a focus on strengthening PHC; (ii) improving access, quality, and efficiency of medical services; and (iii) promoting healthy lifestyle models. Furthermore, in the sector-level "National Health Strategy 2021–2030," strengthening PHC is positioned as a key priority for achieving Universal Health Coverage (UHC). The "Strategic Plan for the Development of Family Medicine-Based PHC (2021-2025)" that was approved under this strategy, serves as the foundational policy document for current PHC activities. The Project's interventions are deemed consistent with all of these policies.

In addition, according to Tajikistan's epidemiological trends, while there is improvement in the mortality from communicable, perinatal, and nutritional diseases, there is a rapidly increase in NCDs. The Project's focus on PHC strengthening and NCD prevention and control is therefore fully consistent with the urgent shift in the disease pattern and the country's emerging needs.

(2) Alignment with Development Needs

While the strengthening of PHC and NCD control were designated as priority areas under the "National Health Strategy 2021–2030," the MOHSPP lacked experience in implementing systematic and concrete measures in these domains. The MOHSPP specifically requested JICA's support in areas—specifically in Khatlon Oblast and DRS—where the previous WHO-led NCD initiatives left unresolved challenges. Since detailed needs assessments had not been conducted during the pre-appraisal stage, the Project Team undertook a comprehensive assessment of the

needs of the MOHSPP and both target regions after the Project commenced. As a result, the following needs were identified:

- Central level (MOHSPP): Provision of equipment required to meet the accreditation conditions for PHC facilities; capacity building of PHC health personnel engaged in NCDs prevention and control; and promotion of data management, particularly digitalization.

- Field level (PHC facilities): Provision of equipment required to meet the accreditation conditions for PHC facilities; training necessary to address NCDs, a field in which staff had limited prior experience; development of practical training materials applicable to routine work; and capacity development of community health volunteers who work in collaboration with nurses.

These needs identified at both the field and central levels were incorporated into the PDM Ver. 1, and subsequently, PDM Ver. 2 was developed and revised in accordance with the findings of the detailed needs assessment. Based on these processes, the Project is assessed to be fully aligned with the development needs.

(3) Appropriateness of the Project's Plan and Approach

The project plan appropriately covered the needs of all relevant stakeholders, using a suitable approach. The three-year implementation plan adopted a phased structure: the first year was dedicated to conducting the baseline survey to understand the existing situation, confirming stakeholder needs, selecting target areas and facilities, and formulating the activity plan for the following year; the second year onward focused on full-scale implementation of activities; and the latter half of the third year was allocated to evaluating the activities. This sequencing represented an appropriate and well-structured implementation approach.

As for the project's approach, regular meetings of the TWG were convened based on the assessment of PHC health personnel capacities obtained through the initial situation analysis. In these TWG meetings, technical guidance was carefully provided carefully, and repeated consultations were made with the participation of the MOHSPP officials. The meetings covered topics such as the integration of home-visit components, comprehensive service delivery, implementation of NCDs screening, and methods for analyzing screening results. In addition, during on-site monitoring by the Japanese experts, the MOHSPP representatives accompanied the visits, which helped deepen the national-level administrators' understanding of field operations, strengthened their sense of ownership, and facilitated reflection of field experience in policy.

Furthermore, throughout the implementation of activities, continuous efforts were made to ensure consideration for socially vulnerable groups—beneficiaries included the poor, persons with disabilities, and ethnic minorities such as the Uzbek community. During NCDs screening, special arrangements were made for residents who were unable to visit health facilities, by providing screening services at nearby health houses (HHs) or at their homes. In activities conducted within Uzbek communities, nurses who spoke Uzbek accompanied the team to avoid any language barriers. Through these measures, the Project actively contributed to reducing health disparities among socially vulnerable populations. These considerations represented an appropriate approach consistent with the principles of Universal Health Coverage (UHC) and the global commitment to "leave no one behind."

3.1.2 Coherence

Based on the following discussion, the coherence is comprehensively assessed to be 'very high.'

(1) Collaboration with Other JICA Projects

This Project built upon the achievements of the previous technical cooperation project, the "Project for Improving Maternal and Child Health Care System in Khatlon Oblast Phase II (2017–2022)," thereby enabling a smooth start-up of activities. Specifically, information on good practices and challenges identified in the MCH sector under the previous project was fully taken over and utilized in the planning and implementation. The objective of the current Project was to strengthen the capacities of PHC health workers' response to emerging needs, such as NCD prevention and nutrition counselling, while leveraging the foundation established through prior home visit activities focused on MCH. The MCH Handbook introduced under the previous project was also utilized effectively, enabling seamless implementation of activities such as providing nutrition counselling to mothers and children in the target areas.

Additionally, an Individual Expert titled "Advisor for Social Protection and Care of Vulnerable Children and Families" assumed the post in March 2025. Activities such as information exchange regarding the health and social protection sectors and arrangements for site visits to the Project areas were conducted. This initiative serves as a potential good practice for the 'Integrated PHC Services' promoted under MOHSPP's PHC reform, as it expands efforts into the social protection sector—specifically, early detection and referral of children with disabilities—by building upon the health sector foundation established by this Project.

(2) Collaboration with Other Projects

In this Project, the WHO HEARTS Technical Package was utilized to introduce NCDs screening in the target areas. As it was expected that the utilization of examples of this Project would be shared with WHO to benefit the activities of other development partners, the Project was

implemented while ensuring the sharing of activities, such as by organizing meetings as deemed appropriate, and inviting WHO representatives to the JCCs.

The World Bank–led *Millati Solim* Project has been implementing multifaceted activities-covering health financing, digital systems, and infrastructure support to improve the quality and efficiency of PHC services in the target regions of Tajikistan. Accordingly, information sharing and exchange were conducted with the Project whenever necessary. Considering the sustainability of this Project, discussions were also held on the concept of the government-led Basic Benefit Package—previously supported by the World Bank—as it represents an important policy direction. However, as the Basic Benefit Package is currently on hold and awaiting revision, no further collaboration could be pursued at this stage.

Information sharing was also conducted with UNICEF, particularly regarding activities utilizing the MCH Handbook and the development of the SOP for integrated home visits. At the start of the Project, a presentation was delivered to the PHC Sub-Group of the Development Coordination Council (DCC), and information sharing continued as necessary.

(3) Collaboration with International Frameworks

This Project is highly consistent with the principles of the "Global Coalition on PHC," an international framework led by the Republic of Kazakhstan that the MOHSPP of Tajikistan considers a model initiative. The Coalition was established as a political platform to operationalize the spirit of the 1978 Alma-Ata Declaration, the 2018 Astana Declaration, and to accelerate progress toward UHC. It plays a central role in positioning PHC as a major global agenda—promoting political commitment and facilitating knowledge exchange among countries. Officials from the implementing bodies, including the MOHSPP and specialized centers, who participated in international meetings have incorporated the latest insights and policy information obtained through these platforms into national policies, while also sharing the Project's progress and lessons learned. This engagement demonstrates that the Project's direction aligns with the global efforts to strengthen PHC and provides a foundation for leveraging its achievements in international policy discussions.

The Project also participated in the International Conference on MCH Handbooks organized by the International Committee on MCH Handbooks in 2024. The Committee is an international framework that aims to contribute to national health systems, particularly MCH, through the promotion and dissemination of MCH handbooks, capacity development, and the sharing of knowledge and research. The 2024 conference was held in Manila, Philippines, and the Project supported the participation of representatives from the MOHSPP and the relevant specialized center. During the conference, Tajikistan shared its experiences and challenges related to the use of the MCH Handbook with other countries, providing an opportunity to re-examine the Project's

initiatives which utilized Japan's experience with the MCH Handbook, within the context of international knowledge and practices. One of the participants is a field practitioner responsible for the promotion and guidance of the MCH Handbook in Tajikistan, and is currently applying the lessons learned at the conference to field activities. In addition to such practical application, utilization at the policy level is also expected in the future—such as improving the handbook to make it more practical based on examples from other countries during upcoming revisions, and considering a sustainable promotion system.

3.1.3 Effectiveness

The effectiveness is assessed as 'high' in light of the substantial achievement of the project purpose.

Level of Achievement of the Project Purposes

The level of achievement of the Project Purposes is as follows: of the four indicators established, three reached the targeted level, while one did not meet the target value. However, for the indicator that was not achieved (Project Purpose Indicator 3), an improvement was observed compared to the baseline.

For Project Purpose Indicator 3, which was not achieved, a likely inhibiting factor is that residents' self-awareness did not sufficiently increase even after their NCDs risks were identified through screening. The Project has strived to establish a procedure in which doctors and nurses explain check-up results based on the patient result sheet. However, mere information provision of this nature may have been insufficient to facilitate deep understanding and acceptance on the part of patients. It is believed that the introduction of more advanced communication techniques for medical professionals was necessary for patients to properly recognize their own risks. In addition, there appears to be a contextual factor in which the perception that "obesity equals a health risk" is difficult to instill among the residents. To examine this hypothesis, the Project shared the results of this indicator at the final TWG meeting held in January 2026. By comparing the results with field realities and community reactions, the Project discussed future improvement measures with TWG members and the MOHSPP, with the aim of enhancing residents' self-awareness of hypertension and obesity.

Table 3.1-1 Indicators for the Project Purposes in the PDM and the Level of Achievement of Each Indicator

PDM Indicator	Level of Achievement
【Project Purpose 1】Increase in the number of home visit conducted with the proper knowledge of Maternal and Child Health, Nutrition and NCDs Initial Value: MCH: 1,001; Nutrition: 484; NCDs: 418 Target Value: Knowledge scores at the endline survey is 70% or higher for each theme. Number of cases for each theme: Each topic should increase in a well-balanced manner.	Knowledge scores More than 80% < Achieved > Both the number of cases and the scope have expanded. < Achieved >
【Project Purpose 2】Increase in the total number of population screened for detecting obese and/or hypertension. Initial Value: 0 Target Value: 40% of the population aged 40 and above received screening.	70.2% <Achieved>
【Project Purpose 3】Increase in the total number of population who acknowledge their status as obese and/or hypertension. Initial Value: Obese: 6.8%; Hypertension 23.3% Target Value: Obese 25.0%; Hypertension 30.0%	Obese: 12.3% < Not Achieved > * However, the figures have improved. Hypertension: 25.6% < Not Achieved > * However, the figures have improved.
【Project Purpose 4】Increase in data entry completion rate of the MCH Handbook* or its equivalent (e.g. Pre-and post-natal maternal status, child at birth status, Continuum of care for ANC-Delivery-PNC-Immunization-Growth Monitoring-Development) Initial Value: 56.7% Target Value: 70.0%	Over 96% < Achieved >

Source: Endline Survey Report

3.1.4 Impact

Based on the discussions presented in sections (1), (2), and (3) below, the Project is assessed to have a “high” impact. While Chapter 4 provides detailed descriptions regarding the achievement of the overall goal after project completion, this section outlines the expected manifestation of impact from the following three perspectives.

(1) Projection of Overall Goal Achievement

The current status, expected achievement, and factors influencing the attainment of each overall goal are as follows:

1) **Overall Goal 1**: Initially, it was planned to assess PHC facilities using the accreditation criteria developed by GIZ; however, it was subsequently confirmed that these criteria were no longer in use following the completion of the GIZ project. As a result of multiple rounds of consultations with the MOHSPP conducted from the implementation of the endline survey through the end of the Project, it was decided that, for the purpose of judging this indicator, relevant indicators linked to Overall Goal 1 would be selected from DHIS2, a system from which the Ministry regularly collects data.

For reference, as shown in Table 4-1.2, according to the assessment by the Project using the GIZ accreditation standards originally intended for adoption, 30 items (79%) out of all criteria have been achieved. Therefore, the probability of final achievement is judged to be high.

2) **Overall Goal 2**: Indicators regarding diabetes and obesity have already been achieved as of the writing of this report. Regarding hypertension, while the target value has not been met, an improving trend is observed.

In setting the target values for these indicators, reference values were adopted from the "2020 Patient Survey" by the Ministry of Health, Labour, and Welfare of. Based on the said survey, the hospitalization rates per 100,000 population in Japan are approximately 3.6 for hypertension, 12.0 for diabetes, and 0.2 for dyslipidemia (used as a proxy indicator for obesity).

- Regarding diabetes and obesity, since sufficient measurements had not previously been conducted in Tajikistan, it was predicted that the introduction of screening by the Project would identify latent patients and would lead to a temporary increase in the number of patients (and hospitalizations). Therefore, target values were set higher than the baseline values (Target values: Diabetes: 12.0; Obesity: 2.4).
- Measurements had been conducted traditionally regarding hypertension, however, the baseline value (7.0) was significantly higher compared to the Japanese reference value (3.6). This suggested a current situation rooted in the background of Tajikistan's medical system, where patients who do not require hospitalization and could be managed at the PHC level are being hospitalized. Therefore, with the intention of shifting to an appropriate management at the PHC level through Project intervention and reducing the hospitalization rate, the target value was set at 3.6—equivalent to the Japanese level.

As a result, the hospitalization rate for hypertension decreased from the baseline of 7.0 to 4.9. While a certain degree of success was confirmed, it did not reach the target value of 3.6. Regarding this point, assumed factors include cases where patients that are manageable at the RHC level are still being hospitalized, and operational challenges involving referral criteria. The Project shared these results at the final TWG meeting, reconfirmed the actual situation on the ground, and discussed measures to reduce the hospitalization rate through effective management at the RHC level.

3) **Overall Goal 3**: A high level of achievement has already been reached, and attainment of the target is considered feasible as long as the distribution of the MCH Handbook continues.

Table 3.1-2 Indicators for the Project Overall Goal in the PDM and the Level of Achievement of Each Indicator

PDM Indicator	Level of Achievement at the Time of this Report
【Overall Goal1】Functional PHC facilities per population increases Initial Value: 0 Target Valure: 1	Not achieved; however, specific circumstances and the establishment of new evaluation criteria are detailed in Section 4.1.
【Overall Goal 2】Reduced hospitalization rate of patients with chronic extensive diseases (diabetes, hypertension, congestive heart failure and asthma) in Khatlon Oblast and DRS Initial Value: Hypertension: 7.0; Diabetes: 4.9; Obesity: 0.0 Target Value: Hypertension: 3.6; Diabetes: 12.0; Obesity 2.4	Hypertension 4.9 < Not Achieved > * However, the figures have improved. Diabetes 1.4 < Achieved > Obese 2.4 < Achieved >
【Overall Goal 3】Increase in record ownership (e.g. pre-natal maternal BMI and BP and birth weight and supplement of Vitamin A) in the form of MCH Handbook or its equivalent Initial Value: 0% Target Value: 50%	99.8% <Achieved>

Source: Endline Survey Report

Based on the expected achievement of all indicators for the overall goal noted above, attainment of the overall goal of improving the quality of PHC services in the target districts is considered highly feasible provided that the DHCs, which oversee PHC facilities within each district, demonstrate strong leadership and expand the activities to other PHC facilities. However, for the DHCs to successfully scale up and disseminate the Project's activities throughout their districts, support from the MOHSPP will be indispensable.

(2) Causes and Effects

There is no theoretical gap between the project purpose, "PHC service delivery capacity is strengthened in an integrated manner in the pilot areas," and the overall goal, "quality of PHC services in the target districts is improved."

To achieve the overall goal, in addition to the continuous capacity building of the target RHCs, it is essential that the supervising DHCs take the lead in deploying the cultivated knowledge and the standardized activities at the target RHCs. In this Project, as part of the activities aimed at achieving the overall goal, the Project promoted the strengthening of the institutional foundation by encouraging the DHCs to exercise greater initiative. This was achieved through discussions with DHC directors at key opportunities such as the JCC and supporting participation in training in Japan. Moving forward, it is expected that the improvement in the quality of PHC services across the entire target districts will be achieved, as the DHCs leverage this foundation to autonomously maintain and expand activities.

The important assumptions required for the Project Purpose, which further lead to the overall goal remain appropriate at present and are as follows:

- The national health policy and local administration do not change.
- There is no outbreak of infectious diseases that would significantly affect the achievement of outcomes.
- Activities at the time of planning are maintained irrespective of differences with existing forms of activity of other donors.

(3) Ripple Effects

In addition to the overall goal of improving the quality of PHC services, the Project is also expected to generate specific effects and impacts related to gender and equity for socially vulnerable groups, as outlined below.

1) Effects and Impacts on Gender

Through its activities targeting PHC facilities, the Project enabled the design of interventions that take into account gender-specific differences in lifestyle, thereby contributing to gender equality in the provision of health services.

PHC services, which are the focus of this Project, constitute the most accessible form of healthcare delivery for women, who tend to spend more time at home. In practice, the proportion of women receiving NCDs screening was higher than that of men, and among adults targeted for home visits—including pregnant and postpartum women—females similarly accounted for a larger share. Capitalizing on this extensive reach, the Project developed exercise videos specifically tailored for women, who culturally tend to remain at home. In addition, these exercises were introduced into women's community groups at the local level.

The results of the baseline and endline surveys conducted under this Project confirmed that the percentage of women who exercise regularly increased significantly from 3.5% at the baseline to 19.0% at the endline. Furthermore, regarding the types of exercise performed, it was revealed that there was an increase in the proportion of general exercises that are easily integrated into daily life, rather than competitive sports that significantly raise the heart rate.

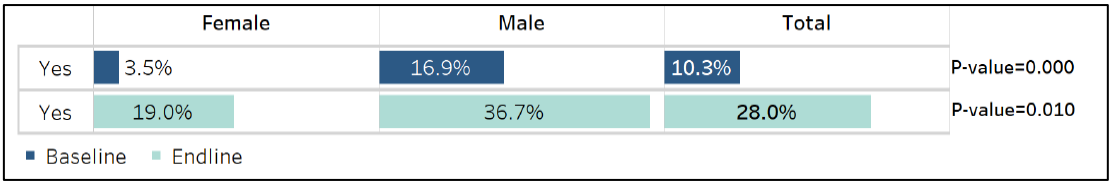


Figure 3.1-1 Exercise Habits by Gender

Source: Attachment to the Endline Survey Report

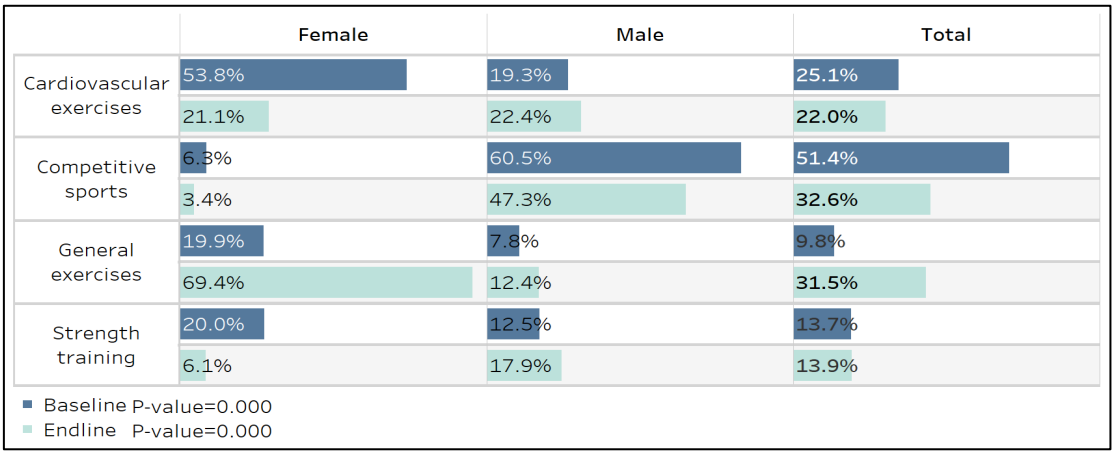


Figure 3.1-2 Types of Exercise by Gender

Source: Attachment to the Endline Survey Report

Conversely, recognizing that a large proportion of adult men migrate to Russia for work and that many are absent from home during the day, the Project implemented tailored measures that encourage concentrated screening during periods when men return from Russia or on non-working days. Furthermore, as part of health promotion activities, blood pressure measurements and discussions on NCDs prevention were conducted at mosques—where men commonly gather. These interventions contributed to enhanced effectiveness, as they are designed with consideration for gender-specific lifestyle patterns.

2) Effects and Impacts on Socially Vulnerable Groups

The Project has made a particularly meaningful contribution to reducing health disparities among socially vulnerable groups. All PHC services implemented under the Project were provided free of charge to residents, including NCDs screening and home visits. Although NCDs screening was limited to individuals aged 40 and above, the services were delivered equitably across social strata, regardless of gender, ethnicity, or other socioeconomic characteristics.

In this Project, as data on residents' income was not collected during the surveys, the impact on social class cannot be analyzed with direct evidence. However, given that free and systematic NCD screening at the PHC level did not previously exist, it can be stated that the Project made a significant contribution, particularly in terms of NCD control for socially vulnerable groups whose access to medical care tends to be limited due to economic reasons.

3.1.5 Efficiency

Based on the inputs—namely project cost, project duration, and volume of activities—the Project efficiency is assessed as “high.”

(1) Project Cost

While the planned project cost in the initial plan (ex-ante evaluation sheet) was JPY 360 million, the actual project cost was approximately JPY 369 million. This actual figure includes an increase due to a supplementary budget allocated around one and a half years after the project's commencement, which was intended for the cost of consumables for NCDs screening and the printing of MCH Handbooks. In addition to the main contract, training in Japan was conducted four times, with a total expenditure of JPY 25 million. This training served as an effective input that boosted the manifestation of results for the entire project through the participation of both field staff and management layers. Specifically, by experiencing health guidance in Japan, doctors and nurses from the field acquired practical know-how, and cases were observed after returning to their countries where they applied this to patient care and introduced health promotion activities. Furthermore, the participation of the management layer fostered ownership of the activities and accelerated the construction of an institutional foundation for the continuous deployment of activities in their own country and districts.

With these inputs, all activities planned in the work plan were completed. In particular, considering that the additional budget was allocated to essential elements directly contributing to the achievement of outputs and results—such as consumables for NCDs prevention and the provision of MCH handbooks—the scale of the project cost can be regarded as highly efficient.

(2) Project Period

The planned project period was 36 months (three years), and the actual implementation was also completed within the 36-month timeframe.

During the 36-month implementation period, the first year was primarily dedicated to conducting the baseline survey, selecting target regions and facilities, and formulating the activity plan for the second year onward. Full-scale implementation of activities was carried out based on the plan developed in the latter half of the first year, progress was managed in a phased manner, and activity evaluations were conducted in the latter half of the third year. As all activities specified in the PDM were completed within the planned period, the project duration is considered appropriate, and efficiency is assessed as high.

(3) Causes and Effects

The activities, volume of inputs, and timing of inputs under this Project were all appropriate for generating results efficiently. Each implemented activity was an essential component required to produce the intended outputs.

Regarding the quantity and timing of inputs, detailed activity plans were formulated prior to the dispatch of Japanese experts—taking into consideration events that could hinder activities during their stay, such as Ramadan and nationwide vaccination campaigns. Based on these plans,

activities such as JCC meetings, training sessions, and field monitoring visits were implemented intensively, enabling efficient and effective project activities.

Furthermore, the increased number of dispatches resulting from the amended contract in the second year enabled more intensive efforts toward the newly added activities under Output 1, including the development of the NCD data management software and the analysis of screening data. This flexible allocation of resources facilitated the collection of evidence necessary for subsequent project evaluation and contributed to improving the overall efficiency of the activity plan.

3.1.6 Sustainability

Based on the discussions presented in the following sections, the overall assessment on sustainability is "low." The greatest inhibiting factor is vulnerability in the financial aspects.

(1) Policy and System

From the perspective of policy and institutional frameworks, sustainability is assessed as high, as no changes have been observed in the relevant higher-level policies. In the "National Health Strategy 2030," the MOHSPP positions PHC strengthening as one of its core priorities and explicitly highlights the necessity of enhancing the country's capacity to address NCDs and emerging infectious diseases. The "Action Plan for the National Health Strategy 2024–2026" also outlines concrete measures related to PHC strengthening, including infrastructure development, human resource capacity building, and the promotion of digitalization. These policy directions, along with the government's recognition of NCDs as a major health challenge and its intentions to expand PHC level interventions, strongly suggest that the importance of NCDs prevention and control will continue to increase. This strong political commitment constitutes the foundation for ensuring sustainability. However, the key policy challenge moving forward will be translating this commitment into concrete budget allocations and institutional reforms, as discussed in the next section.

(2) Organization and Structure of the Implementing Agency

Sustainability from the perspective of the implementing organizations' structure and operational capacity is assessed as "moderate."

- At the RHC level: At the RHCs, NCD SOPs, home visit SOPs, various training materials were developed, and capacity building was conducted to ensure that activities can be continued even when new medical staff assume their posts. In particular, given the anticipated turnover among nurses, mechanisms for continuous in-house training were established, such as conducting internal study sessions based on the Home Visit SOP. Furthermore, through the systematic introduction of NCDs screening at the PHC level, both

doctors and nurses developed a sense of ownership. The expansion of services for residents increased the motivation of physicians and enhanced community trust in healthcare providers.

- Challenges at the DHC level: DHCs provided support to RHCs by supplying personnel assistance and sharing activity results during district level meetings. However, the position of DHC heads is typically subject to rotation every two to three years, and during the project period, three out of the four DHCs experienced leadership changes. At present, it is observed that there is a tendency that the level of understanding of project activities depends on factors such as the extent of support from heads of DHC who participated in the trainings conducted in Japan. The frequent turnover of DHC heads indicate a need for continuous measures, as there is a risk that project knowledge will remain with individuals rather than be institutionalized. To address this challenge, it will be essential for the MOHSPP to take the lead in establishing a standardized monitoring and reporting system for DHCs—one that functions effectively regardless of personnel rotations— thereby strengthening organizational capacity at the district level.
- At the central level (MOHSPP): Within the MOHSPP, the Head of the PHC Division plays an important role in advancing the PHC agenda, with the First Deputy Minister serving as Project Director and the Head of the PHC Division serving as Project Manager. During the project period, regular monitoring visits were conducted under the leadership of the PHC Division, enabling timely information sharing and discussions. As a result, activities progressed smoothly—such as the implementation of training and the internal approval of SOPs.

(3) Technical Capacity of the Implementing Facilities

The sustainability of the implementing facilities in terms of technical capacity is assessed as high. The Project introduced technologies and practices that are appropriate for the technical level of the RHCs, and a system has been established where health workers can continuously review the SOPs and transfer the acquired skills to other staff. These mechanisms are readily scalable and applicable to other regions as well. During the Project period, early signs of dissemination were already observed. For example, a head of targeted RHC shared their activities with other non-targeted heads (e.g., Voroshilov RHC), and training participants disseminated information to other health workers during regular meetings (e.g., in Kushoniyon District and Levakant City).

With a goal achieve nationwide expansion, it will be important for the MOHSPP to take the lead in formally disseminating the SOPs, the deliverables of the Project, and its key technical outputs to all PHC facilities across the country. By transitioning from the current, organically emerging

dissemination efforts to a more centrally coordinated and systematic support mechanism, the technical impact of the Project can be further expanded both within and beyond the target districts.

(4) Finance of Implementing Agencies

The financial sustainability of the implementing agencies is assessed as very low, unless the current economic situation changes.

The general budget is allocated from the Republican government to the district governments (Hukumat), and majority of the annual financial resources of RHCs are used for human resources, particularly salary payments. As a result, there are almost no funds available for service provision—including the procurement of consumables necessary for NCDs screening. Although the Project engaged in negotiations with district governments to secure financial resources, there were no concrete commitments that were obtained. In addition, although discussions were held with the MOHSPP regarding Decree No. 600 "On the procedure for the provision of health services to citizens of the Republic of Tajikistan by facilities of the state health-care system," which could serve as one of the national-level solutions to sustainably cover the cost of consumables, these discussions have not progressed into concrete action.

Further details are provided in Sections 3.2, "Key Factors Affecting Implementation and Outcomes," and 3.3, "Evaluation on the results of the Project Risk Management." Nonetheless, financial vulnerability remains the greatest bottleneck to sustaining the Project's achievements. Moving forward, it will be essential to undertake high-level policy advocacy with the district governments and the MOHSPP, using evidence generated from screening data—particularly regarding reductions in the NCD burden. Specifically, the most critical issues for sustaining the Project's outcomes will be: (i) advocating for the inclusion of NCDs related consumables in Decree No. 600 to ensure that services are provided free of charge, and/or (ii) negotiating for these consumables to be incorporated as mandatory budget items within the Republican or district-level budgets.

Following discussions during the final mission, the MOHSPP is currently considering drafting a letter to the district governments to request financial support for NCDs screening at the target RHCs.

3.2 Key Factors Affecting Implementation and Outcomes

In addition to the conventional support focused on MCH, the Project explored new activities that could be implemented at the PHC level in the high-burden area of NCDs, and conducted three pilot initiatives as follows:

1. Implementation of NCDs screening at RHCs and development/installation of software for managing the screening results, and development of SOP for NCDs.

2. Integrated home-visit activities incorporating NCDs components, and development of home visit SOP.
3. Community-based health promotion activities conducted by CHT members.

As a result, the number of home visits conducted with enhanced knowledge on MCH, nutrition, and NCDs increased, and the number of residents receiving screening, contributing to the early detection of obesity, hypertension, and other conditions, also rose. A certain degree of improvement was observed in residents' awareness of their own health conditions. These achievements were supported by the proactive efforts of the MOHSPP and the target RHCs.

On the other hand, the Project's implementation was significantly influenced by factors discussed below.

(1) Financial Constraints Related to NCDs Screening

The implementation of screening requires not only initial investments, such as height and weight scales, automatic blood pressure monitors, and devices for measuring blood glucose and cholesterol, but also the continuous procurement of consumables such as test strips. However, given the financial situation of the target districts and the MOHSPP, it is unlikely that these costs can be covered independently or that the screening activities can be sustained as an ongoing service. Consequently, concerns remained regarding the sustainability of screening activities after the completion of the Project.

(2) Delays in the Selection Process for Participants of In Japan Training

Although the Project conducted four rounds of In Japan Training, the selection of participants took significantly longer than anticipated in every case, affecting the preparation schedule on the Japanese side. Despite presenting the selection criteria in advance, considerable time was required for coordination among stakeholders on the Tajik side, and delays repeatedly resulted in missed deadlines set by Japan. Consequently, the Japanese side needed to issue multiple reminders and was compelled to devote substantial time for coordination efforts, even during limited opportunities for expert dispatches.

In particular, for the fourth In Japan Training held in August 2025, the list of trainee candidates submitted by the MOHSPP included individuals who were not involved in the Project. As a result, it became necessary to renegotiate the candidate selection with the Ministry, with support from the JICA Tajikistan Office. Although the request for trainee selection had been made in April, the process was not completed by the initial deadline set by JICA, and the final confirmation of candidates was only achieved in mid-July.

3.3 Evaluation on the Results of the Project Risk Management

Results of the Project Risk Management

(1) Financial Constraints Related to NCD Screening NCDs

The Project held multiple rounds of discussions with the MOHSPP regarding the cost burden for NCD screening. As a result, it was agreed between the Ministry and the Project that representatives from the Ministry of Finance and the district authorities of the target areas would be added as JCC members, and they were invited to participate starting from the second JCC onward. However, the Ministry of Finance did not attend, and the district authorities did not present any concrete proposals for securing financial resources.

In addition to the JCC discussions, the Project conducted separate interviews with each of the target district authorities. All districts indicated that securing a budget allocation for NCDs screening would be difficult. Furthermore, the Project also discussed with the MOHSPP regarding the possibility of adding NCDs screening to the list of free medical services defined under Government Decree No.600, however, no positive response was obtained on this matter.

Given this situation, the Japanese expert team discussed whether blood tests should be removed from the screening package as a cost reduction measure. As a result of these discussions, the HbA1c test, which had initially been conducted for all participants, was limited to individuals with elevated blood glucose levels. For the other blood tests, however, it was determined that eliminating them would increase the risk of missing early detection of serious cardiovascular conditions, which could consequently lead to substantially higher treatment costs in the future. Therefore, it was concluded that excluding blood tests would not be in the best interest of the screening recipients.

Nonetheless, as there is still time before the completion of the Project to consider revising the screening approach, the Project will continue to examine the following options:

- Transitioning to a two-step screening approach in which blood tests are conducted only for individuals identified as at-risk based on questionnaires, anthropometric measurements, and simple tests.
- Reducing screening frequency, such as changing the current “once per year for all individuals aged 40 and above” to “once every three years depending on age”
- Introducing an upper age limit to the current eligibility criterion, which covers all individuals aged 40 and above.

(2) Delays in the Selection Process for Participants in the In-Japan Training

With regard to trainee selection, delays occurred in all four rounds of the In-Japan Training. Under Tajikistan’s institutional arrangements, the final decision on overseas training cannot be made

solely by the MOHSPP as the approval process and preferences of the Presidential Office also exert significant influence, which contributed to the delays.

Even under these institutional constraints, the efforts of the Japanese experts, particularly the Chief Advisor's team, to visit Tajikistan and directly request the MOHSPP to expedite the procedures appear to have had a positive effect. At the same time, it is also true that the Japanese experts were compelled to spend a considerable portion of their limited time during expert dispatches on matters related to trainee selection.

To minimize delays, the Project undertook all possible measures. These included: explaining the content of upcoming training programs to the MOHSPP at an early stage and presenting the selection criteria required for participants at that time; advancing procedures on the Japanese side with support from JICA; and maintaining close coordination with national staff and the JICA Tajikistan Office to ensure continuous follow-up. Despite these efforts, delays in trainee selection still occurred in every case.

Lessons Learned and Application Results

As lessons from this project, the two points detailed below were identified in the ex-ante evaluation matrix.

1. In the "Project for Improving the Maternal and Child Health System in Khatlon Oblast" (evaluation year: 2016), the terminal evaluation pointed out that challenges remained regarding the appropriateness of the indicator setting for the project objectives. Accordingly, a lesson was derived when setting indicators: it is necessary to have prior understanding of the current situation through a baseline survey and then carefully examine the appropriateness of the indicators from perspectives such as whether they are realistic and whether the required data can be obtained.

2. With regard to the medical equipment provision plan, a significant delay in the equipment provision plan by the German Development Bank (KfW) resulted in delays in the provision of equipment and technical training activities for the target district central hospitals, which further became a constraining factor in the project implementation. From this experience, a lesson was derived from projects involving the provision of equipment to facilities where support from other donors is present: it is necessary at the project formulation stage to anticipate risks in the project continuity arising from insufficient stakeholder commitment, further highlighting the need to conduct thorough consideration from the perspective of efficiency. In this project, to prevent similar issues from occurring, the scope of cooperation and preconditions for cooperation were confirmed at the formulation stage, followed by the design of the main activities.

With regard to 1, based on these lessons, in this project, the current situation was first assessed through a baseline survey, after which the appropriateness of the indicators was examined and the

target values were determined. With regard to 2, although cooperative relationships with the United States Agency for International Development (USAID) in Khatlon Oblast and with GIZ in the Districts of Republican Subordination (DRS) existed under this project, the project was implemented after confirming in advance the respective activities of each donor and ensuring that there was no overlap in activities or in the provision of equipment.

3.4 Lessons Learned

(1) Early Start of Policy Discussions on NCDs Screening Financing

From the outset of introducing NCDs screening, it is essential to clearly present the required scale of financial resources and operational costs to the MOHSPP, enabling the Ministry to proactively consider a sustainable scheme on the institutional side.

(2) Addressing Delays in Trainee Selection Requires Early Submission, Continuous Follow-up, and Explicit Eligibility Requirements

For trainee selection, clearly defining and narrowing the eligibility requirements, as well as advancing the procedures on the Japanese side, is effective. At the same time, many aspects of the institutional decision-making process cannot be influenced by Japan, making persistent follow-up through close collaboration with national staff and the local JICA office indispensable.

(3) Application of a Top-Down Approach in the Context of Tajikistan

In introducing new tasks at the RHC level, such as NCDs screening, data management, and integrated home visits, this project benefited from the strong commitment of frontline staff, including FMDs and FMNs, to faithfully carry out their assigned roles and instructions, which contributed to a smooth implementation. The health system in Tajikistan is characterized by a well-established top-down structure with the MOHSPP at its apex—this structure functioned effectively in the introduction of new initiatives. In addition, it was confirmed that, at the facility level, a culture is firmly embedded where policies and directives issued by higher-level institutions, including the Ministry, are steadily implemented. Based on these observations, a lesson was derived that in Tajikistan, a top-down approach that assumes policy decision-making at the institutional level and reliable execution at the frontline level is an effective method for introducing new health services.

(4) Incorporating Field-Initiated Practices

During the implementation of this project, the targeted RHCs demonstrated a consistent commitment to steadily implementing new initiatives introduced by higher-level authorities. At the same time, proactive efforts were observed at the field-level to explore more effective approaches to implementation. However, the project did not necessarily have a sufficiently robust

mechanism to systematically and continuously capture and share these field-initiated practices, indicating the need to organize them as lessons for future similar projects.

Specifically, cases were observed in which RHC heads proactively consulted with the DHC and collaborated with members of the district quality improvement committee to enhance the quality of health services. In addition, in situations where health promotion activities faced challenges in reaching male residents, some facilities collaborated with religious leaders and utilized mosques as activity bases. There were also cases in which head nurses negotiated with school principals to use school gymnasiums to create environments where women could safely engage in exercise and light physical activities.

These examples confirmed that frontline health workers in Tajikistan possess not only the capacity to faithfully implement policies and directives from higher-level institutions, but also the initiative to identify challenges independently and develop solutions in collaboration with local stakeholders. At the same time, frontline health workers tend to be reserved and are not inclined to proactively share such initiatives externally, resulting in many cases being identified only through on-site monitoring by project stakeholders.

Based on these observations, a key lesson for future similar projects is the importance of deliberately establishing mechanisms, from the early stages of project implementation, that enable the timely and systematic capture and sharing of field-level innovations and practices as they emerge.

Chapter 4 For the Achievement of Overall Goals After the Project Completion

4.1 Prospects to Achieve Overall Goal

The overall goal of the Project is "to improve the quality of PHC services in the target districts," and the achievement status of the indicators at the time of Project completion is shown in the table below. With regard to Indicator 1, although certification by the MOHSPP requires time, several target RHCs are expected to be certified in the near future. As for Indicator 2, the current situation can be regarded as a transitional phase in which hospitalization is decreasing. Indicator 3 had already been achieved by the end of the Project. Considering these factors, it can be concluded that the overall goal is likely to be largely achieved.

Table 4.1-1 Achievement Prospects for the Overall Goal

No.	Indicator	Status of Progress and Achievements
1	Functional PHC facilities per population increases	**【Not Achieved, Under Discussion】** At the time of Project completion, no PHC facilities had yet been formally certified by the MOHSPP. Discussions with the Ministry regarding formal certification were ongoing toward the end of the Project.
2	Reduced hospitalization rate of patients with chronic extensive diseases (diabetes, hypertension, congestive heart failure, and asthma) in Khatlon Oblast and DRS	**【Not Achieved】** For the target districts of the Project, the trends were as follows: • **Hypertension:** The hospitalization rate fluctuated between 3.2 (January 2024) and 8.1 (September 2023). Over the past year, the rate remained stable or showed a slight decline, reaching 4.9 at the time of the endline survey. • **Diabetes:** A generally decreasing trend was observed. After peaking at 5.1 in July 2023, the rate remained around 1.1 in recent months, and was 1.4 at the endline survey. • **Obesity:** Except for the period from October 2023 to November 2024, hospitalization rates were essentially zero. The highest rate recorded was 1.5 in April 2024, and the rate was zero at the endline survey.
3	Increase in record ownership (e.g.,. pre-natal maternal BMI and BP and birth weight and supplement of Vitamin A) in the form of MCH handbook or its equivalent	**【Achieved】** At the time of the endline survey, the MCH Handbook ownership rate (with records) reached 99.8%. Therefore, this indicator is considered to have been achieved by the end of the Project.

Source: Endline Survey Report

The following section describes the status of each indicator at the time of Project completion.

Indicator	Justification of the Indicator
【Overall Goal 1】 Functional PHC facilities per population increases (Initial value: 0 Target value: 1)	・ At Baseline, the MOHSPP and GIZ established that PHC facilities meeting 70% or more of the designated facility standards would be certified as *enhanced PHC facilities*. ・ The measurement covers the PHC facilities in the Project's target districts and city. ・ The judgment of this indicator shall be based on whether official certification has been granted by the MOHSPP.

At the start of the Project, the MOHSPP evaluated PHC facilities using the accreditation criteria previously developed by the *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ). Facilities that met at least 70% of these criteria were designated as "accredited PHC facilities."

However, at the time of the endline survey, the GIZ project had already ended, and therefore the accreditation criteria were no longer in use. Instead, the Project Team was informed that the criteria newly developed under the World Bank-supported *Millati Solim* Project had been adopted.

Therefore, after the completion of the endline survey, the Project held further consultations with the MOHSPP regarding the criteria to be used for assessing the achievement of this indicator. The MOHSP expressed their preference for using data routinely collected by the Ministry, rather than indicators developed by other development partners. Accordingly, the following indicators from DHIS2 were selected as the final evaluation criteria.

- Number of FMD
- Number of FMN
- Number of diagnosed cases of hypertension (I10- I15)
- Number of diagnosed cases of diabetes (E10-E14)
- Number of diagnosed cases of obesity (E65-E68)

For reference, the Project Team conducted an assessment using the criteria list developed by GIZ to determine the level of achievement at the endline. According to the Project's internal assessment, the target RHCs met 30 (79%) out of all the criteria.

Table 4.1-2 Status of Accreditation Criteria for PHC Facilities at the Endline (Project Assessment)

(*Reasons for unmet criteria are noted for each corresponding item.*)

No.	Criteria of Accreditation of the PHC facility	Assessed by the Project (If unmet, reasons are stated)
1	The health care facility is provided with the required number of competent and highly qualified medical staff in accordance with the requirements of the job, in the numbers and quality required for medical services.	Met
2	A policy of continuous professional development of medical staff is being implemented.	Met
3	Patients are provided with information and consulting services.	Met
4	The rules of disinfection of medical products are followed.	Met
5	The rules of disinfection of buildings, furniture and sanitary equipment are observed.	Met
6	Hand hygiene of medical staff is observed.	Met
7	Sanitary and hygienic regime is observed in the premises.	Met
8	The rules of storage of medicines are observed.	Met

9	The rules for storing vaccines are followed.	Met
10	Availability of medicine kit for emergency medical care.	Met
11	The rules for segregation, identification, and collection of waste within the subdivisions shall be followed.	Met
12	The population is provided with information on health care facilities and access to services.	Met
13	Medical services are accessible for vulnerable groups with disabilities.	Met
14	Continuity of relations between the primary health care facilities (centers) and the hospital is provided.	Unmet (Since hospitals were beyond the scope of this project)
15	Diagnosis and treatment of patients is coordinated between the different divisions of the institution.	Met
16	Patient care is consistent between the center for health and social protection authorities.	Unmet (Since social sector was beyond the scope of this project)
17	Medical documents on the course of treatment of patients meet the established requirements, complete identification of patients and coordination of interactions between specialists (subdivisions, sections) on care of patients.	Met
18	Records on patients' case follow-up meet the specified requirements.	
19	Patient management/medical care plan meets the specified requirements.	Met
20	Pregnant women are prepared for childbirth in the prescribed manner.	Met
21	Proper vaccination planning is carried out.	Met
22	Rules on medical supervision of women during physiological and at-risk pregnancy are followed.	Met
23	The rules of medical examination of sick children are observed.	Met
24	The rules of medical examination of adult patients with the chronic non-communicable diseases are followed.	Met
25	The risk of TB transmission is assessed and managed.	Unmet (Since TB-related activities were beyond the scope of this project)
26	The established rules/algorithms for disclosure and diagnosis of TB are observed.	
27	Screening examinations are conducted among the population in order to detect tuberculosis at an early stage.	
28	Reasonable principles of referral to hospitals are followed	Met
29	Ensuring reasonable and timely referral of patients for medical and social examination.	Unmet (Since the institution in charge of 'social examination' is unclear and the project had no relation with it, this item cannot be assessed.)
30	A policy of timely coverage of pregnant women with medical supervision is implemented.	Met
31	The process of referring patients with chronic non-communicable diseases to emergency specialists tends to decline.	Unmet (As screening has been initiated, there has been a temporary increase in the number of diagnosed patients, resulting in a current rise in referrals to specialists.)
32	The facility has a system for managing the stock of medical equipment, diagnostics, and consumables.	Met
33	Availability of the required reserves of medical products and vaccines is ensured.	Met
34	There is required set of solid inventories for household and medical use.	Met
35	There is a sufficient amount of soap, detergents, and disinfectants.	Met
36	The facility has a toilet and a latrine for patients and staff	Unmet (Although toilets exist in most cases, there is a concern that they may not be regarded as appropriate for health facilities)
37	There are medical and diagnostic units at the institution, including required structure corresponding to the types of medical care provided.	Met
38	There is the required number of sets of medical supplies and equipment in the sections and rooms of the facility that meet the requirements of provision of medical services.	Met

Source: Endline Survey Report

Indicator	Justification of the Indicator
【Overall Goal 2】Reduced hospitalization rate of patients with chronic extensive diseases (diabetes, hypertension, congestive heart failure, and asthma) in Khatlon Oblast and DRS **Initial Values:** As of June 2023, the hospitalization rate per 100,000 population was as follows: • Hypertension: 7.0	・ Number of hospitalizations per 100,000 population due to hypertension, diabetes, and obesity in the target area ・ Denominator: Total population of the target area for each year Numerator: Total number of hospitalizations due to hypertension, diabetes, and obesity in the target area

• Diabetes: 4.9 • Obesity: 0.0 **Target Values:** Five years after project completion, the hospitalization rates by disease are expected to reach the following levels (based on the indicators used in the Ministry of Health, Labour, and Welfare of Japan's *2020 Patient Survey*): • Hypertension: 3.6 • Diabetes: 12.0 • Obesity: 2.4	Calculation formula: (Numerator ÷ Denominator) × 100,000 ・ The scope of measurement is limited to the Project's target districts. ・ Congestive heart failure and asthma are excluded from the indicator, as they are not among the diseases targeted by this Project.

Since the baseline, hospitalization rates for hypertension, diabetes, and obesity have progressed as follows:

- **Hypertension:**

The hospitalization rate fluctuated between 3.2 (January 2024) and 8.1 (September 2023), remaining generally stable or showing a slight downward trend over the past year. At the endline, the rate was 4.9, which did not meet the target value of 3.6.

- **Diabetes:**

A clear downward trend was observed overall. After peaking at 5.1 in July 2023, the rate stabilized at around 1.1 in recent months, reaching 1.4 at the endline. Thus, the target value of 12.0 was achieved.

- **Obesity:**

Except for the period between October 2023 and November 2024, the hospitalization rate remained approximately 0. The highest recorded value was 1.5 in April 2024, and the rate was 0 at the endline. Thus, the target value of 2.4 was achieved.

The figure below shows the monthly trends in hospitalization rates for hypertension, diabetes, and obesity.

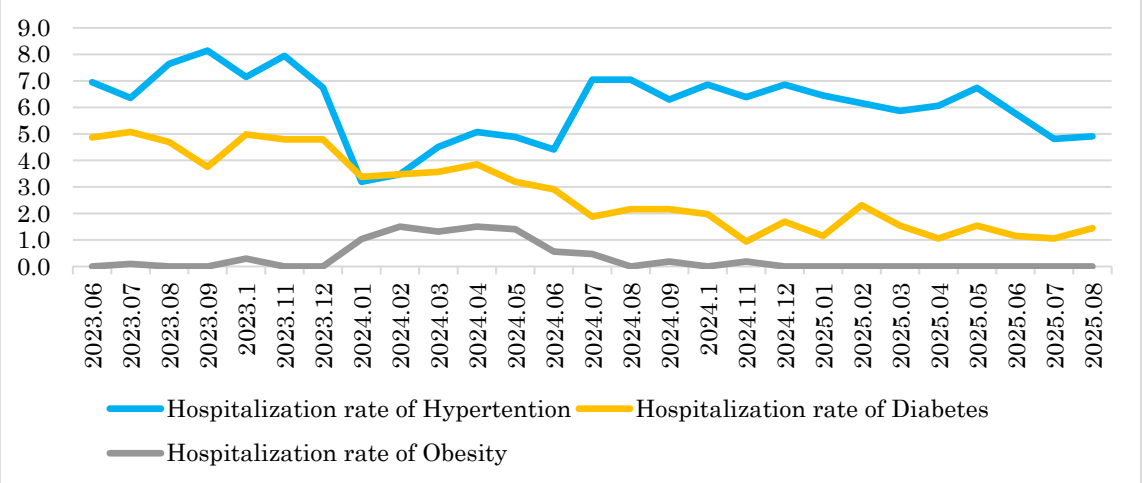


Figure 4.1-1 Monthly Trends in Hospitalization Rates for Hypertension, Diabetes, and Obesity

Source: Project Monthly Data Collection (Data is from District Hospitals)

Overall, it can be assessed that unnecessary hospitalizations have shown a declining trend, attributable to the establishment of screening systems at RHCs and the progress made in managing newly identified patients at the RHC level. On the other hand, outpatient management before the onset of severe conditions is still developing, and it is expected to take additional time before reaching the level observed in Japan. Regarding obesity, there was a temporary increase in hospitalization rates between January and August 2024. Suggesting that as obesity began to be more widely recognized and diagnosed as a disease, more cases were newly recorded in hospital admission statistics.

As one of the final activities before the completion of the Project, the following points were reaffirmed with the directors and head nurses of the target RHCs at the final TWG meeting which is held in January 2026:

- Strengthening outpatient management and follow-up of patients through home visits at the RHC level
- Reducing unnecessary referrals to higher-level medical facilities

In addition, to ensure the realization of these efforts, the Project reviewed the data entry procedures during the meeting, not only for screening records but also for follow-up management records.

Indicator	Justification of the Indicator
【Overall Goal 3】Increase in record ownership (e.g.,. pre-natal maternal BMI and BP and birth weight and supplement of Vitamin A) in the form of MCH handbook or its equivalent **Initial Value:** 0% (before the Project, no system existed for the continuous distribution of MCH handbooks.) **Target Value:** 50%	・ Denominator: Number of mothers who received ANC services ・ Numerator: Number of mothers who brought their MCH Handbook to ANC visits amounting to at least the required number of times ・ The scope of measurement is limited to the Project's target districts.

Distribution of the MCH Handbook across the entire target area began at the end of January 2024. Accordingly, the survey population for this indicator was defined as pregnant women who received antenatal care (ANC) after that period.

The trend in MCH Handbook ownership from January 2024 to the time of the Endline Survey is as follows. The ownership rate started at a high level of 88.6% immediately after the commencement of activities and steadily increased as activities were strengthened. Notably, when record-keeping guidance was intensified in December 2024, the rate reached 98%. Continued improvements brought the rate to nearly 100% by June 2025.

Based on these results, the ownership rate of the MCH Handbook in the target area has reached an exceptionally high level, and this indicator is considered to have been fully achieved by the end of the Project.

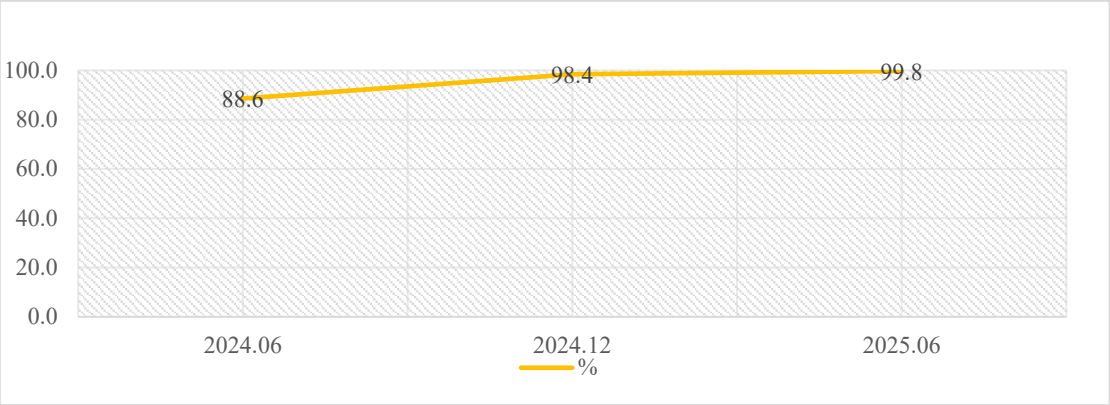


Figure 4.1-2 Percentage of Mothers who Brought their MCH Handbook to ANC Visits

Source: Project Monthly Data Collection

The breakdown of the figures used for the above indicator is as follows.

Table 4.1-3 Number of ANC Visits and Number of Times Mothers Brought their MCH Handbook

Number of ANC Received	Number of Pregnant Women Who Received ANC between January 2024 and June 2025			Number of Pregnant Women Who Brought their MCH Handbook to More Than Half of their ANC Visits		
	June 2024	December 2024	June 2025	June 2024	December 2024	June 2025
4	20	97	123	17	95	122
5	10	106	146	9	102	145
6	5	98	208	5	97	207
7	0	70	315	0	70	315
8	0	68	489	0	68	489
Total	35	439	1,281	31	432	1,278

Source: Project Monthly Data Collection

4.2 Plan of Operation and Implementation Structure of the Tajikistan Side to Achieve the Overall Goal

To achieve the overall goal, the Government of Tajikistan is expected to undertake the following efforts concerning the accreditation of functional PHC facilities, the reduction of hospitalization rates, and the improvement of MCH Handbook ownership.

(1) Accreditation of Functional PHC Facilities

Currently, the MOHSPP has adopted the accreditation criteria established under the World Bank's *Millati Solim* project, rather than the GIZ criteria used by the Project during the baseline survey. According to the Ministry, the *Millati Solim* criteria are comprehensive, covering facility infrastructure conditions, and therefore are not well-suited for measuring the outcomes of "soft

component" technical cooperation projects such as those implemented by JICA. As a result, it is difficult for the Ministry to foresee which facilities may qualify for accreditation under these criteria.

On the other hand, the Ministry highly values the NCDs screening and comprehensive home-visit activities carried out under this Project, recognizing them as pioneering initiatives. With regard to ensuring consistency with the accreditation criteria, the Ministry has expressed its intention to continue consultations with the Project. By the end of the Project, the Ministry plans to finalize accreditation criteria that can be used for assessing the indicator.

(2) Nationwide Expansion of NCD Management Approaches Aimed at Reducing Hospitalization Rates

To reduce unnecessary hospitalizations, it is essential that the management of patients with mild conditions at the PHC level, particularly at RHCs, be strengthened nationwide. For the Government of Tajikistan, NCDs management at the PHC level was introduced in a full-scale manner for the first time through this Project, and the Government now envisions scaling it up nationwide.

The NCDs management tasks that FMD and FMN are expected to perform at RHCs—including screening, risk assessment, data management, facility-based follow-up, and home-visit follow-up conducted by nurses—were consolidated into SOPs under this Project. In collaboration with the FMC, these SOPs could be further developed into textbooks for the training courses of FMD and FMN and incorporated into the curriculum.

(3) Ownership of the MCH Handbook

In this Project, the printing of the MCH Handbook was financed through the Project budget, and the handbooks were distributed to pregnant women in the target area. During home visits, nurses explained how to use the MCH Handbook, confirming that this guidance encouraged pregnant women to bring the handbook to antenatal care visits and immunization appointments.

After the completion of the Project, it will be necessary for the Government of Tajikistan to take the lead in establishing a mechanism for funding the printing of MCH handbooks. However, while no concrete prospects have yet been identified for government financing of printing costs, MOHSPP continues to engage with development partners to seek such support.

4.3 Recommendations for the Tajikistan Side

Based on the analyses presented in Sections 3.1.6 "Sustainability (DAC Evaluation Criteria)," 3.2 "Key Factors Affecting Project Implementation and Results," and 4.2 "Plan of Operation and Implementation Structure of the Tajikistan side to achieve overall goal," the following recommendations are offered to the Government of Tajikistan.

(1) Government Budget Allocation to Secure Funding for NCD Screening Costs

Major cardiovascular risk factors such as hypertension, dyslipidemia, and diabetes are often asymptomatic. However, numerous clinical trials and meta-analyses have demonstrated that early detection and the combined use of pharmacotherapy and lifestyle modification can reduce future cardiovascular events. The national guidelines for primary prevention of cardiovascular disease and WHO's total risk approach are based on this evidence and recommend systematic risk assessment for adults—including measurements of blood pressure, lipids, and blood glucose. Therefore, identifying these risk factors early through health checkups and screening at the primary care level and linking the results to continuous risk management is positioned as one of the core interventions for the prevention of NCDs, particularly cardiovascular diseases.

Despite the observed scientific evidence, a key challenge in Tajikistan is insufficient allocation of government funding for consumables and other materials required for NCDs screening. While many countries and international guidelines recommend screening for major NCDs risk factors as an essential component of primary prevention, the financial resources necessary to implement such screening are not currently secured within the national budget.

It is desirable for the Government of Tajikistan to work toward securing a stable budget for the consumables and other costs required for NCDs screening. Specifically, the Government should consider measures such as adding NCDs screening to the list of free medical services defined under Decree No. 600, thereby creating an environment, both institutionally and financially, that enables the continuous implementation of NCDs screening.

(2) Nationwide Expansion of the NCDs Management Cycle at the PHC Level Aimed at Reducing Hospitalization Rates, and Revision of Incentive Structures

Given the disease profile of Tajikistan, strengthening NCDs countermeasures at the PHC level—early and nationwide—is a priority. In this Project, the specific activities required at PHC facilities and through home visits were consolidated into SOPs. The MOHSPP has expressed its intention to incorporate these SOPs into the training curriculum for FMD and FMN, and it is expected that, in the future, the NCDs management cycle at the PHC level will be expanded nationwide.

It would be desirable for the Government of Tajikistan to support the Ministry's initiative, both institutionally and financially, and to establish the necessary conditions that ensure the sustainable nationwide implementation of NCDs screening, risk stratification, lifestyle counseling, and follow-up through home visits at the PHC level.

In addition, it has been pointed out that the allocation of public funds to health facilities in Tajikistan is based on historical expenditure patterns and inputs such as infrastructure, the number of beds, and the number of health workers is not necessarily linked to population health needs or

facility performance. Under such a payment structure, there may be limited incentives for reducing hospitalization rates or strengthening preventive and outpatient care.

Although this Project does not directly address reforms to the service delivery system or the payment system, the current input-oriented resource allocation may pose a potential barrier to achieving the overall goal of reducing NCD-related hospitalizations in the long-term. It would therefore be desirable for the Government of Tajikistan to undertake medium to long-term considerations on the design of resource allocation and incentive mechanisms for health facilities, ensuring alignment with efforts to strengthen prevention and management at the PHC level.

4.4 Monitoring Plan from the End of the Project to Ex-post Evaluation

Following the completion of this Project, JICA's post evaluation is scheduled to be conducted approximately three years after project completion. To enable an appropriate assessment of the achievement of the overall goal and the project purpose at that time, the Government of Tajikistan is requested to carry out the monitoring activities as follows. In addition, if a new phase of the Project is approved, these indicators may also be tracked through the regular monitoring framework of that subsequent phase.

- The PHC Division of the MOHSPP should continuously collect and compile information on the implementation status of NCDs screening, hospitalization rates, and the functionality of PHC facilities in both the target region and nationwide.
- The operational status of the SOPs developed under this Project, as well as the utilization of the MCH Handbook, should be regularly monitored and supervised, with the results documented and preserved in a manner that allows for efficient revert at the time of the ex-post evaluation.
- The JICA Tajikistan Office should, as necessary, exchange information with relevant ministries and agencies, and obtain the above-mentioned data and reports for use in the ex-post evaluation.

Annexes (No. 4 to 6 are for internal use only)

1. Project Implementation and Achievements（Plan of Operation）
2. List of Deliverables
3. PDM（Ver 1,Ver 2）
4. R/D, M/M, Minutes of JCC
5. Monitoring Sheet (Ver 1～Ver 5)
6. Other Project Activities

Project Monitoring Sheet Ⅱ （Plan of Operation）

Version 2
Dated June 2024

Project Title: Project for Improving Quality of Primary Health Care Services

Inputs	Year	2022	2023												2024												2025												2026		Remarks	Monitoring: Issue	Monitoring: Solution
		12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2			
Expert																																										
Chief Advisor/PHC	Plan																																									
	Actual																																									
Deputy Chief Advisor/PHC(2)/ Procurement Plan / Training	Plan																																									
	Actual																																									
Maternal and Child Health/Nutrition(1)/NCD	Plan																																									
	Actual																																									
Maternal and Child Health/Nutrition(2)	Plan																																									
	Actual																																									
NCD management(2)/Training Management(1)	Plan																																									
	Actual																																									
Procurement Plan/Training Management(2)	Plan																																									
	Actual																																									
Equipment																																									
Equipment for health facilities	Plan ★																																									
	Actual																																									
Training in Japan																																									
Country Focused Training	Plan ★																																									
	Actual																																									
Third Country Training	Plan ★																																									
	Actual																																									

Activities / Sub-Activities		2022	2023												2024												2025												2026		Responsible Organization: Japan	Responsible Organization: GOT	Achievements	Issue & Countermeasures
		12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2				
Output 1: PHC facilities in the target area function better.																																											
1.1 To conduct a survey to identify medical equipment in target PHC facilities.	Plan ★★★		Conducting a survey																																						Project Manager/Deputy Project Manager	Ministry of Health and Social Protection of the Population (MOHSPP)		
	Actual		Visit and observation of DHC/RHC		Conducting a baseline survey			Reporting	Report Completed																																			
1.2 To formulate equipment provision plan for PHC facilities in the target area	Plan ★★★				Developing equipment provision plan																																						MOHSPP		
	Actual				Developing equipment provision plan																																								
1.3. To implement the provision of equipment for PHC facilities in the target area	Plan ★								Equipment Procurement								Equipment installation				Equipment maintenance																						MOHSPP		
	Actual								Procurement proceeded	Equipment installed							Monitoring on equipment utilization				Monitoring on equipment use							Monitoring on equipment use							Monitoring on equipment use								
1.4. To conduct a survey of the data management capacity of DHC and PHC managers	Plan ★★★				Conducting a baseline survey					Reporting																																MOHSP		
	Actual		Visit and observation of DHC/RHC		Conducting a baseline survey			Reporting																																				
1.5. To select the necessary equipment and training for DHC and PHC managers in data management	Plan ★★			Selecting the necessary equipment							Conducting trainings																															MOHSPP		
	Actual				Selecting the necessary equipment				Equipment proceeded		Necessary training selected													Monitoring for designing the DHIS-2training																				
1.6. To provide data management training and to facilitate the implementation of data-based planning.	Plan ★								Reviewing and prototyping database																																			MOHSPP		
	Actual												Training conducted																														
Output 2: Health care workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and Diet and NCD management																																											
2.1 To conduct a survey of health care workers' knowledge on Maternal and Child Health Care, Nutrition and Diet and NCD management	Plan ★★						Conducting a baseline survey				Reporting																																MOHSPP		
	Actual		Visit and observation of DHC/RHC		Conducting a baseline survey			Reporting																																				
2.2 To conduct a survey of utilization of materials and trainings for Maternal and Child Health Care, Nutrition and Diet and NCD management including Maternal and Child Health Handbook	Plan ★★				Conducting a baseline survey																																						MOHSPP		
	Actual			Visit and observation of DHC/RHC		Conducting a baseline survey		Reporting																																				
2.3. To design activities to integrate new NCD interventions with existing MCH visits such as antenatal visit, post natal visit and immunization.	Plan ★★★★★								Reviewing the draft of new NCD interventions								Reviewing and revising the intervention																											MOHSPP		
	Actual								Observing current home visits and discussed the design of activities												Design content of home visit				Meeting on development of home visit SOP				Finalizing home visit SOP														
2.4. To implement above integrated package (2-1, 2-2 and 2-3)	Plan ★								Developing training program				Implementing training																													MOHSPP		
	Actual								Conducted trainings on family medicine, ANC and MCH								Training on NCD for nurses																												
2.5. To review the current practice based on WHO HEARTS Technical Package	Plan ★				Conducting a baseline survey																																						MOHSPP		
	Actual		Visit and observation of DHC/RHC		Conducting a baseline survey			Reporting																																				
2.6. To conduct training to implement the WHO HEARTS Technical Package	Plan ★							Developing Action Plan on NCDs																																				MOHSPP		
	Actual																																										
2.7. To implement and to monitor the NCD management plan	Plan ★																																									MOHSPP		
	Actual																																										
Output 3: The quality of Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and diet and NCD prevention																																											
3.1. To conduct a situation analysis of the health education to community at target districts	Plan ★★★																																								MOHSPP		
	Actual																																										
3.2. To organise a team of health workers and community members to conduct health education activities at the PHC	Plan ★★																																								MOHSPP		
	Actual																																										
3.3. To conduct training of communication and assessment skill to the workers and community members who are engaged in promoting PHC services for families at community	Plan ★★																																								MOHSPP		
	Actual																																										
3.4. To conduct awareness-raising activities on PHC service focusing on Maternal and Child Health Care, Nutrition and diet and NCD management (including use of maternal and child handbooks in awareness-raising activities).	Plan ★★★																																								MOHSPP		
	Actual																																										
3.5. To share lesson learned regarding health education activities to community focusing on MCH care, Nutrition and diet and NCD management	Plan ★★																																								MOHSPP		
	Actual																																										

Monitoring Plan		2022	2023												2024												2025												2026		Remarks	Issue	Solution
		12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2			
Monitoring																																										
Joint Coordinating Committee	Plan																																							Final Seminar		
	Actual																																									
Reports/Documents																																									
Work Plan	Plan							Ver.1					Ver.2 (Final)																														
	Actual																																									
Baseline/ Endline Survey Report	Plan								Baseline																																		
	Actual																																									
Monitoring Sheet	Plan																																									
	Actual																																									
Project Interim Report	Plan																																									
	Actual																																									
Project Completion Report	Plan																																									
	Actual																																									
Public Relations																																									
Public Relations on Project activities	Plan																																									
	Actual																																									
News Letter(local & Project Website)	Plan																																									
	Actual																																									

The Project for Improving Quality of Primary Health Care Services in Tajikistan

List of the Deliverables

(As of February 2026)

1. Report etc.

Report	Submission Period
Work Plan in Japanese (First Term)	January 2023
Monitoring Sheet (Ver. 1)	June 2023
Baseline Survey Report	July 2023
Work Plan (Second Term)	October 2023
Interim Activity Report	December 2023
Monitoring Sheet (Ver. 2)	January 2024
Monitoring Sheet (Ver. 3)	July 2024
Monitoring Sheet (Ver. 4)	December 2024
Monitoring Sheet (Ver. 5)	July 2025
Endline Survey Report	October 2025
Project Completion Report	February 2026

2. Others

(1) Project Deliverables

Deliverables	Language
Standard Operating Procedure (SOP) on the use of an electronic system for NCD management at PHC level	Tajik/English
Standard Operating Procedure (SOP) on comprehensive home visits	Tajik/English
Manual for delivered equipment	Tajik
Exercise video material	Tajik
NCD screening software	Tajik/English
Software usage instruction video	Tajik
Project activities video	Tajik

(2) Training Materials Adapted to Meet Project Objectives

Training Materials		Language
Maternal and Child Health (MCH) Training		
	Introduction of ANC	Tajik/English
	ANC during physiological pregnancy	Tajik/English
	Fetal assessment	Tajik/English
	Changes during pregnancy	Tajik/English
	Completing 029 Form and Gravid gram	Tajik/English
	Demonstration of measurements (BMI, BP, Heart rate's listening	Tajik/English
	Postnatal consultation	Tajik/English
	Birth preparedness	
Data Management Training		
	DHIS2 Conceptual Design Principles	Tajik
	1 DHIS2 MOH user	Tajik
	2 DHIS MOH user	Tajik
Family Medicine Doctor Training		
	Principles of quality assurance according to the World Health Organization guidelines	Tajik
	Specialized classification of family medicine doctors	Tajik
	Primary medical documentation at the PHC level institutions	Tajik
	Shock	Tajik
Family Medicine Nurse Training		
	Specialized classification of family medicine nurses	Tajik
Community Health Team (CHT) Training		
	Helminthiasis	Tajik/English
	Nutrition and Health	Tajik/English
	Personal Hygiene	Tajik/English
	Water and Health	Tajik/English
Non-Communicable Diseases (NCDs) Training		
	Introduction to Technical package HEARTS	Tajik/English
	Technical package HEARTS 2	Russian
	Risk factors	Tajik/English
	Assessment of the risk of cardiovascular complications	Russian/English
	Clinical assessment	Russian/English
	Cardiovascular risk assessment	Russian/English
	Self-help and healthy lifestyle counseling theory	Tajik/English
	Self-help and healthy lifestyle counseling group work	Tajik/English
	Treatment based on CVD risk assessment. Evidence-based protocols for the management of patients with hypertension and type 2 diabetes.	Russian
	Algorithm for the treatment of arterial hypertension	Russian
	Algorithm for the treatment of diabetes	Russian
	Further steps (Data collection, records and use of data)	Russian
	Interactive sessions on Diagnosis of CVD risk factors in family medicine	Tajik
Community Health Team (CHT) Training on MCH Handbook		
	Use of MCH Handbook	Tajik
NCD_Datamanagement_Training_3rd TWG for FMD		
	Presentation Training_NCD_datamanagement_day01_02	Tajik/English
	Presentation Training_NCD_datamanagement_day03_04	Tajik/English
Nutrition Training		
	Guidelines on Nutrition and physical activity of Children	Tajik/English

(3) Existing Guidelines and Materials Used in Project Training

Guidline/Material	Language
MCH Handbook	Tajik
Algorithm for the management (prevention, diagnosis and treatment) of	Tajik/English

Guidline/Material	Language
hypertension and diabetes in the adult population at the PHC level	
WHO Technical package for cardiovascular disease management in primary health care	Tajik
Guideline for Nutrition and physical activity for children	Tajik
Comprehensive home visits (Study material for family medicine nurses)	Tajik/English
Nutrition pyramid	Tajik

Project Monitoring Sheet 1 : Project Design Matrix (PDM) Version 1

Date: 2 Aug 2022

Project Title: Project for Improving Quality of Primary Health Care Services

Project Period: 3 years from the date indicated in R/D

Target Area: Total 2 to 4 Districts/Cities in Khatlon Oblast and DRS

Target Groups:
1: Health workers and managers at PHC facilities (PHC facilities include District Health Center: DHC, Rural Health Centre:RHC and Health House: HH, Healthy Life Center:HLC.)
2: Residents in the target area: approx.360,000 in Khatlon Oblast and 610,000 in DRS

Narrative Summary		Objectively Verifiable Indicators*	Means of Verification	Important Assumptions	Achievement	Remarks
Overall Goal						
Quality of Primary Health Care Services in the Target Districts is improved.	1	Functional PHC facilities per population increases	Record from Ministry of Health and Social protection of the Population		The project collected the baseline data from the baseline survey in May 2023.	
	2	Reduced hospitalization rate of patients with chronic extensive diseases (diabetes, hypertension, congestive heart failure and asthma) in Khatlon Oblast and DRS	Statistics Agency under Tajikistan Government, Republican Center for Medical Statistics and Information			
	3	Increase in record ownership (e.g. pre-natal maternal BMI and BP and birth weight and supplement of Vitamin A) in the form of MCH Handbook or its equivalent	Record from Ministry of Health and Social protection of the Population			
Project Purpose						
Capacity of PHC service delivery is strengthened in integrated manner at pilot sites	1	Increase in the number of home visit conducted with the proper knowledge of Maternal and Child Health, Nutrition and NCDs	1. Business Planning Report, 2. Ministry of Health and Social Protection of the Population, Republican Centre for Medical Statistics and Information	(1) National health policy and local administration do not change significantly. (2) No outbreak of infectious diseases that significantly affects the achievement of outcomes. (3) Activities at the time of planning are maintained irrespective of differences with existing forms of activity of other donors.	The project collected the baseline data from the baseline survey in May 2023.	
	2	Increase in the total number of population screened for detecting obese and/or hypertension.				
	3	Increase in the total number of population who acknowledge their status as obese and/or hypertention.				
	4	Increase in data entry completion rate of the MCH Handbook* or its equivalent (e.g. Pre-and post-natal maternal status, child at birth status, Continnum of care for ANC-Delivery-PNC-Immunization-GrowthMonitoring-Development)				
Output						
1 PHC facilities in the target area function better.	1-1	Availability of survey report including analysis	Survey Report	(1)There is a sufficient number of FMDs and FMNs in the target area, as well as personnel involved in nutrition. (2)Trained health professionals do not leave the workforce. (3)The Tajik side allocates adequate budget and personnel to project activities.	【1-1】was conducted by baseline survey and the results are being compiled. 【1-2】is formulating to provide medical equipment only in the next six months. 【1-3】will be conducted in the next six months for medical equipment only. 【1-4】is selecting the necessary equipment, which are PCs, and will be conducted training for DHC and RHC managers in the next six months. 【1-5】was conducted by baseline survey and the results are being compiled. 【1-6】will be conducted in the next six months.	
	1-2	Availability of the Plan for the rehabilitation and renovation of infrastructure	Planning Report			
	1-3	Required health equipment is purchased and provided. Rehabilitation of the infrastrucre is carried out.	Completion Report for the Equipment Supply and Rehabilitation			
	1-4	Number of health workers who received training	Project Report			
	1-5	Availability of the survey results	analysis			
	1-6	Number of data-based plan	Training Report			
2 Health care workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and NCD management	2-1	Availability of the assessment report	Assessment Report		【2-1】and【2-2】were conducted by baseline survey and the results are being compiled. 【2-3】will be designed. 【2-4】will be conducted after the integrated model is designed. 【2-5】was conducted by baseline survey and the results are being compiled. 【2-6】will be formulated based on WHO HEARTS Technical Package. 【2-7】will be implemented after the trainings.	
	2-2	Availability of the assessment report	Assessment Report			
	2-3	Availability of the design report	Design Report			
	2-4	Availability of the implementation report including the description of the changes after the integration	Implementation report			
	2-5	Availability of the review report on the current practice based on WHO HEARTS Technical Package	Review Report			
	2-6	Number of health workers who received the training to implement HEARTS	Project report			
	2-7	Number of plan implemented	Project Monitoring Report			
3 Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and NCD prevention	3-1	Availability of the Situation Analysis Report	Situation analysis report		【3-1】was conducted by baseline survey and the results are being compiled. 【3-2】will be conducted in the next six months. 【3-3】and【3-4】will be formulated and conducted in the next six months. 【3-5】will be shared after conducting health education activities.	
	3-2	Coordination among workers and community members who engage in promoting PHC services is implemented	Project report			
	3-3	Number of workers and community members who received trainings	Training Report			
	3-4	Number of cases for awareness-raising activities among the participants	Project Report			
	3-5	Activities for sharing the experiences are conducted	Project Report			

Activities	Inputs		Important Assumptions	
1 PHC facilities in the target area function better.	**Japanese Side**	**Tajikistan Side**	(1) Trained counterparts do not leave their position so as not to affect the outputs of the Project. (2) The Tajik side properly allocates necessary budget and distributes personnel for the project activities.	
1-1 To conduct a survey on identifying medical equipment, basic facilities and small-scale infrastructure renovation required at the target PHC facilities.	Japanese Experts Chief Advisor, Assistant Chief Advisor and Co-coordinator/Training Management, others necessary for implementing Project activities	Counterpart Personnel (C/P) (1) Project Director: - Head of Reform, Primary Health Care and Department of International Relations, MoHSSPP (2) Project Manager:s - Director, Health Department of Khatlon Oblast Government/DRS (3) Other personnel necessary for implementing Project activities		
1-2 To formulate equipment provision plan for implementation of rehabilitation plan of PHC facilities in target area				
1-3 Rehabilitation and equipment provision of selected PHC facilities at targeted area is implemented	Equipment and small scale rehabilitation of existing health infrastructure Devices and Equipment that support the execution of the project's activities Small scale renovation works for existing health facilities			
1-4 To select the necessary equipment and training for DHC and PHC managers				
1-5 To conduct a survey of the data management capacity of DHC and PHC managers	Cost of Operation Cost for training and workshops, material development cost, necessary medical equipment cost and other necessary cost for the execution of the Project's activities	Facilities, equipment and materials (1) Office spaces in the Ministry of Health and Social Protection and each oblast (2) Land, building, vehicle, and other facilities necessary for project activities		
1-6 To facilitate the implementation of data-based planning.				
2 Health care workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and NCD management	Training Training on implementation of PHC in Japan	Local costs (1) A part of operational expenses necessary for implementation of the project activities such as personnel costs of counterparts, activity costs including travel expenses, office equipment and supplies, utility costs such as water and electricity, etc.	**Pre-conditions** The political and security situation is stable.	
2-1 To conduct a survey of health care workers' knowledge on Maternal and Child Health Care, Nutrition and NCD management				
2-2 To conduct a survey of utilization of materials and trainings for Maternal and Child Health Care, Nutrition and NCD management including Maternal and Child Health Handbook				
2-3 To design activities to integrate new NCD interventions with existing MCH visits such as antenatal visit, post natal visit and immunization.				
2-4 To implement above integrated package (2-1, 2-2 and 2-3)				
2-5 To review the current practice based on WHO HEARTS Technical Package				
2-6 To formulate plan of practicing NCDs management based on WHO HEARTS Technical Package				
2-7 To implement and to monitor the plan formulated at 2-6.				
3 The quality of Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and NCD prevention				
3-1 To conduct a situation analysis of the health education to community at target districts				
3-2 To coordinate health education activities at PHC level among workers and community members who are engaged in promoting PHC services for families at community				
3-3 To conduct training of communication and assessment skill to the workers and community members who are engaged in promoting PHC services for families at community				
3-4 To conduct awareness-raising activities on PHC service focusing on Maternal and Child Health Care, Nutrition and NCD management (including use of maternal and child handbooks in awareness-raising activities).				
3-5 To share lesson learned regarding health education activities to community focusing on MCH care, Nutrition and NCD management				

ANNEX 3: Project Design Matrix (PDM) Version 2

Date: 15 February 2024

Project Title: Project for Improving Quality of Primary Health Care Services

Project Period: From February 2023 to February 2026

Target Area: Eight rural health centers in 4 Districts/Cities in Khatlon Oblast and DRS (Voroshilov and Bustonkala in Kushoniyon, Botrobod and Kuli Sufiyon in Levakant, Chorteppa and Sarikichiti Poyon in Rudaki, Pakhtaobod and Batosh in Tursunzoda)

Target Groups:

1: Health workers and managers at PHC facilities (PHC facilities include District Health Center: DHC, Rural Health Center.)

2: Residents in the target area: approx.40,300 in Khatlon Oblast and 46,700 in DRS

Narrative Summary		Objectively Verifiable Indicators*	Means of Verification	Important Assumptions	Remarks
Overall Goal					
Quality of Primary Health Care Services in the Target Districts is improved.	1	Functional PHC facilities per population increases	Record from Ministry of Health and Social protection of the Population		*Target values will be set after the baseline survey. All indicators left blank in PDM will be analyzed and agreed by the JCC
	2	Reduced hospitalization rate of patients with chronic extensive diseases (diabetes, hypertension, congestive heart failure and asthma) in Khatlon Oblast and DRS	Statistics Agency under Tajikistan Government, Republican Center for Medical Statistics and Information		
	3	Increase in record ownership (e.g. pre-natal maternal BMI and BP and birth weight and supplement of Vitamin A) in the form of MCH Handbook or its equivalent	Record from Ministry of Health and Social protection of the Population		
Project Purpose					
Capacity of PHC service delivery is strengthened in integrated manner at pilot sites	1	Increase in the number of home visit conducted with the proper knowledge of Maternal and Child Health, Nutrition and NCDs	Record from Ministry of Health and Social protection of the Population Baseline and Endline survey	(1) National health policy and local administration do not change significantly. (2) No outbreak of infectious diseases that significantly affects the achievement of outcomes. (3) Activities at the time of planning are maintained irrespective of differences with existing forms of activity of other donors.	
	2	Increase in the total number of population screened for detecting obese and/or hypertension.	Project Report		
	3	Increase in the total number of population who acknowledge their status as obese and/or hypertention.	Baseline and Endline survey		
	4	Increase in data entry completion rate of the MCH Handbook* or its equivalent (e.g. Pre-and post-natal maternal status, child at birth status, Continnum of care for ANC-Delivery-PNC-Immunization-GrowthMonitoring-Development)	Baseline and Endline survey		
Output					
1 PHC facilities in the target area function better.	1-1	Availability of survey report including analysis	Survey Report	(1)There is a sufficient number of FMDs and FMNs in the target area, as well as personnel involved in nutrition. (2)Trained health professionals do not leave the workforce. (3)The Tajik side allocates adequate budget and personnel to project activities.	
	1-2, 1-3	Required health equipment is purchased and provided.	Completion Report for the Equipment Supply		
	1-4	Availability of the survey results	Survey Report		
	1-5	Number of health workers who received training	Project Report		
	1-6	Number of data-based plan	Project Report		
2 Health care workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and NCD management	2-1	Availability of the assessment report	Survey Report		
	2-2	Availability of the assessment report	Survey Report		
	2-3	Availability of the design report	Project Report		
	2-4	Availability of the implementation report including the description of the changes after the integration	Project Report		
	2-5	Availability of the review report on the current practice based on WHO HEARTS Technical Package	Survey Report		
	2-6	Number of trained health workers	Project report		
	2-7	Number of plan of practicing NCDs management based on WHO HEARTS Technical Package and Number of plan implemented	Project Report		
3 Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and NCD prevention	3-1	Availability of the Situation Analysis Report	Survey Report		
	3-2	Coordination among workers and community members who engage in promoting PHC services is implemented	Project report		
	3-3	Number of workers and community members who received trainings	Project Report		
	3-4	Number of cases for awareness-raising activities among the participants	Project Report		
	3-5	Activities for sharing the experiences are conducted	Project Report		

Activities		Inputs		Important Assumptions
1 PHC facilities in the target area function better.		**Japanese Side**	**Tajikistan Side**	(1) Trained counterparts do not leave their position so as not to affect the outputs of the Project. (2) The Tajik side properly allocates necessary budget and distributes personnel for the project activities.
	1-1 To conduct a survey to identify medical equipment in target PHC facilities.	Japanese Experts Chief Advisor, Assistant Chief Advisor and Co-coordinator/Training Management, others necessary for implementing Project activities Equipment Devices and Equipment that support the execution of the project's activities Cost of Operation Cost for training and workshops, material development cost, necessary medical equipment cost and other necessary cost for the execution of the Project's activities Training Training on implementation of PHC in Japan	Counterpart Personnel (C/P) (1) Project Director: - Head of Reform, Primary Health Care and Department of International Relations, MoHSSPP (2) Project Manager:s - Director, Health Department of Khatlon Oblast Government/DRS (3) Other personnel necessary for implementing Project activities Facilities, equipment and materials (1) Office spaces in the Ministry of Health and Social Protection and each oblast (2) Land, building, vehicle, and other facilities necessary for project activities Local costs (1) A part of operational expenses necessary for implementation of the project activities such as personnel costs of counterparts, activity costs including travel expenses, office equipment and supplies, utility costs such as water and electricity, etc.	**Pre-conditions** The political and security situation is stable.
	1-2 To formulate equipment provision plan for PHC facilities in the target area			
	1-3 To implement the provision of equipment for PHC facilities in the target area			
	1-4 To conduct a survey of the data management capacity of DHC and PHC managers			
	1-5 To select the necessary equipment and training for DHC and PHC managers in data management			
	1-6 To provide data management training and to facilitate the implementation of data-based planning.			
2	**Health care workers in PHC facilities are activated on Maternal and Child Health Care, Nutrition and Diet and NCD management**			
	2-1 To conduct a survey of health care workers' knowledge on Maternal and Child Health Care, Nutrition and Diet and NCD management			
	2-2 To conduct a survey of utilization of materials and trainings for Maternal and Child Health Care, Nutrition and Diet and NCD management including Maternal and Child Health Handbook			
	2-3 To design activities to integrate new NCD interventions with existing MCH visits such as antenatal visit, post natal visit and immunization.			
	2-4 To implement above integrated package (2-1, 2-2 and 2-3)			
	2-5 To review the current practice based on WHO HEARTS Technical Package			
	2-6 To conduct training to implement the WHO HEARTS Technical Package			
	2-7 To implement and to monitor the NCD management plan			
3	**The quality of Awareness raising activities are enhanced to increase effective communication and meaningful participation of community for MCH care, nutrition and diet and NCD preventio**			
	3-1 To conduct a situation analysis of the health education to community at target districts			
	3-2 To organise a team of health workers and community members to conduct health education activities at the PHC level in the community			
	3-3 To conduct training of communication and assessment skill to the workers and community members who are engaged in promoting PHC services for families at community			
	3-4 To conduct awareness-raising activities on PHC service focusing on Maternal and Child Health Care, Nutrition and diet and NCD management (including use of maternal and child handbooks in awareness-raising activities).			
	3-5 To share lesson learned regarding health education activities to community focusing on MCH care, Nutrition and diet and NCD management			