Gender Action Plan - Quarterly Progress Report - 2025

Sri Lanka: Health System Enhancement Project (HSEP)

Project Number: SRI 51107 - 002
ADB Loan and Grant Numbers – Loan - 3727 and Grant – 0618

Sri Lanka: Health System Enhancement Project – Additional Financing (HSEP-AF)

Project Number: SRI 51107 -003
ADB Loan and Grant Numbers – Loan - 4121 and Grant – 9222

Quarter Two – 1st April 2025 to 30th June 2025

Prepared by HSEP (Health System Enhancement Project) Project Management Unit for the Ministry of Health Colombo, Sri Lanka.

GOVERNMENT OF SRI LANKA

MINISTRY OF HEALTH & MASS MEDIA

GENDER ACTION PLAN

QUARTERLY PROGRESS REPORT

(Q2) - 2025

HEALTH SYSTEM ENHANCEMENT PROJECT

Project Management Unit
3/19, Kynsey Road, Colombo 8, Sri Lanka

HEALTH SYSTEM ENHANCEMENT PROJECT – GAP IMPLEMENTATION

In order to make the assessment of the Gender Action Plan easier, we suggest that we will submit the GAP form in the form of a narration which will be updated at the end of every quarter. We have extracted the presentation of the indicator from the format that was used earlier.

Activity and Indicator	Progress	Expected date of Completion
Output 1: Primary and secondary health care services enhanced in Central, North Central, Sabaragamuwa, and Uva provinces		
1.1 Incorporate gender responsive construction features into all upgraded or renovated PMCUs and divisional hospitals		
1.1.1 At least 80% PMCUs and divisional hospitals upgraded or renovated under the project have separate toilets for male and female patients	Out of the 125 PMCUs and DHs to be upgraded or renovated under the project, **87.2% (109 numbers)** construction has been completed. Out of those completed (109) PMCUs and Divisional Hospital, **98.16% (107 numbers)** have separate toilets for male and female patients. Upgrading and renovation of the balance PMCUs and DHs is ongoing.	November 2025

* The indicator 1.1 is related to the sections or the parts upgraded in institutions were only part of the PMCU/DH has been renovated under the project.

Table 1.1.1: Details of the PMCUs and Divisional Hospitals to be upgraded or renovated under the HSEP project

	Total No of Constructions	Number of Renovated completed	Number of upgraded or renovated institutions with separate toilets	Number of upgraded or renovated institutions without separate toilets	Remark
Divisional Hospitals	64	57	57	0	
PMCUs	61	52	50	2	2 PMCUs in Central Province do not have a separate toilets. ▪ Madawalaulpotha ▪ Hatton
Total	125	109	107	2	

Out of the 125 PMCUs and DHs to be upgraded or renovated under the project, **84.8% (109 numbers)** have been completed. Out of the

109 completed PMCUs and Divisional Hospitals, 98.16% (107 in total) have separate toilets.
Out of the remaining 16 PMCUs and Divisional Hospital to be renovated or upgraded under the Project, in % (11 numbers) construction work is ongoing. 2 Nos in the procurement process

Out of these 16 PMCUs and Divisional Hospitals, where construction is ongoing, the designs have included in the renovated section for separate toilets in 98.16% (107 numbers) PMCUs and Divisional Hospital. This information was verified by an assessment done in October 2022 conducted through the Project Implementation Unit to check whether separate toilets for males and females have been already built or it has been incorporated in to the designs of the PMCUs and DHs to be upgraded under the project. This information was confirmed by the Medical Officer in Charge of the respective PMCU/DHs.

Activity and Indicator	Progress	Expected Date of Completion
Output 1: Primary and secondary health care services enhanced in Central, North Central, Sabaragamuwa, and Uva provinces		
1.1 Incorporate gender responsive construction features into all upgraded or renovated PMCUs and divisional hospitals		
1.1.2 All ADB-funded cluster linked facilities have gender responsive designs with facilities for privacy during patient examination and for changing clothes (Baseline: less than 10%)	According to health facility survey 2024, 75.0 % of cluster PHC have separate toilets for males and females, in OPD; and 22.1% had a separate examination area for females and males; and 41.7% a separate changing area for females and males **Next assessment of the indicator will be available with the next annual survey by the end of 2025.**	November 2025

Table 1.1.2: Comparison of the Monitoring and Evaluation firm survey results for Indicator 1.1.2

	Baseline Survey	Annual Survey 2024
Separate toilets for men and women	Out of 39 PMCUs and DHs where health facility survey was conducted 30 (76.9%)	Out of 68 PMCUs and DHs where the health facility survey was conducted 51 (75.0%)
Gender responsive patient examination areas	Out of 39, 27 (86.8%)	Out of 68 PMCUs and DHs where the health facility survey was conducted 21 (22.1%)
Separate Changing area	41.7.%	Out of 68 PMCUs and DHs where the health facility survey was conducted 28 (41.17%)

Interventions undertaken to achieve the target in the indicator:

A Baseline Survey was conducted in October 2022, to identify the institutions that require separate changing areas and separate toilets for men and women. This was used to identify the gaps. Usually, a separate changing area is not available in most State hospitals at Primary Care level. Therefore, a low-cost modification of the examination area was proposed to accommodate a changing area adjoining but separated from the examination area. This was accepted and is in the process of being procured and changes made through PHC Innovation Fund proposals.

Activity and Indicator	Progress	Expected date of Completion
1.2 Integrate gender- responsive and inclusive PHC services with the implementation of the essential service package for outpatient and clinic services in the nine newly established clusters		
1.2.1 At least 90% of ADB funded cluster linked facilities in target provinces provide essential services in a gender responsive and inclusive manner2 (Baseline: 0)	Of the total of 152 cluster-linked facilities in target provinces, 55 out of 68 sample from the pilot cluster (80.9%) provide the essential services package in a gender-responsive manner. (Ref. Table1.2.1. given below) – Updated with the Annual Survey 2024 **Next assessment of the indicator will be available with the next annual survey by the end of 2025.**	Nearly Completed.

Table 1.2.1: Comparison of the Monitoring and Evaluation firm survey results for Indicator 1.2.1

	Baseline Survey Report	Annual Survey Report 2024
A gender responsive and inclusive essential Services	Not Available	86.8%

The monitoring and evaluation firm has assessed this indicator using a composite index with 20 items that proxy gender responsive and inclusive essential services. (Ref. Table A)

Table A: Items used for Composite Index for gender responsive and inclusive essential service package for outpatient and clinic services

Items from Health Facility Survey	Score 0.0 absent 1.0 present
1. At least one staff member is trained on gender sensitivity and responsiveness	.00 1.00
2. Separate toilets are available for females and males at OPD	.00 1.00
3. Door of toilet can be locked from inside	.00 1.00
4. Bin with a lid is available for disposal of sanitary towels in the toilet used by females	.00 1.00
5. Separate corner or dedicated space ensuring privacy is available for Breastfeeding	.00 1.00
6. Privacy is maintained always or often during consultations with health personnel	.00 1.00
7. Privacy is maintained always or often during clinical examination / procedure	.00 1.00
8. PHC promotes participation of husbands/partners in the consultations on dedicated service provision points on reproductive health for women, namely antenatal clinics, family planning clinics, well women clinics or mithuru piyasa services	.00 1.00
9. PHC conducted Training Of Trainers (TOT) targeting health officials and/or local organizations for male engagement	.00 1.00
10. PHC Identifies gender-based violence among patients during care	.00 1.00
11. Reports gender disaggregated data to e-RHMIS, e-surveillance system of notifiable diseases or to the provincial and district level authorities	.00 1.00
	Total
	Mean score (out of 5)
12. Do you think a person's gender (being a woman or man) influenced care provided in this health facility in general	
13. Did you feel any embarrassment or discomfort when you were examined by health staff?	
14. Did you feel any embarrassment or fear when using toilet facilities?	

15. Did you feel any embarrassment or discomfort when interacting with health staff?	
16. Were you treated badly just because you are a woman / man	
17. Did you feel insecure in this health facility just because you are a woman / man	
18. How satisfied are you with being treated in a manner appropriate for your gender	
19. Are you satisfied with the facilities for changing clothes without embarrassment (having separate changing areas for men and women)	
20. Are you satisfied with the facilities for physical examination without Embarrassment	

Activity and Indicator	Progress	Expected Date of Completion
1.2 Integrate gender- responsive and inclusive PHC services with the implementation of the essential service package for outpatient and clinic services in the nine newly established clusters		
1.2.2 At least 80% of health staff in ADB-funded cluster linked facilities are trained on gender sensitivity and responsiveness when providing essential services (Baseline health staff:2950 as of February, 2024)	All staff in the Four Provinces (2950), 96.91% (2,859 Numbers) were trained on gender sensitivity and responsiveness when providing essential services. The training included the key areas of Gender discrimination, the Connection between Gender and Health care and gender-responsive health care provision. Q and A sessions and interactive discussions on how gender-responsive care can be delivered in day-to-day care were discussed with special reference to how this knowledge could be used to make the services user-friendly and effective for both men and women.	Indicator achieved, activity continuing because funds are available

Total Number of Health Staff (Medical, Nursing, Paramedical) –: 2,950
Number trained as of 30th June 2025 –: 2,859
During the reporting quarter, the following trainings were conducted. A Training of Trainers were conducted for the selected Trainers among the preventive sector medical staff (Mostly MOHs) and a Training Plan was developed to conduct training of PHMs and PHIs.

Table 1.2.2: Summary of the Gender Trainings completed up to 30.06.2025.

No	Province	District	Date	Training Topic	# Male Participants	# Female Participants	# Total Participants
1	All	All	2022	Zoom Training	121	148	269
2	Uva	Bibile	03/02/2022	Gender Training	14	42	56
3	Uva	Welimada	24/03/2022	Gender Training	9	42	51
4	North Central	Anuradhapura	06/01/2022	Gender Training	12	37	49
5	North Central	Polonnaruwa	27/01/2022	Gender Training	16	33	49
6	North Central	Anuradhapura	16/06/2022	Gender Training	22	26	48
7	Central	Kandy	21/04/2021	Gender Training for Program for PMU & PIU Staff	13	9	22
8	Central	Matale	17/02/2022	Gender Training	18	49	67
9	Central	Kandy	24/02/2022	Gender Training	10	50	60

10	Central	Nuwaraeliya	19/04/2022	Gender Training Program	6	58	64
11	Sabaragamuwa	Kegalle	1/2/2022	Gender Training	31	34	65
12	Sabaragamuwa	Ratnapura	22/02/2022	Gender Training	6	45	51
13	Sabaragamuwa	Kegalle	7/4/2022	Gender Training	15	35	50
14	Sabaragamuwa	Ratnapura	27/06/2022	Gender Training	74	119	193
15	Central	Matale	17/03/2023	Gender Training for the Staff of Apex Hospital	8	35	43
16	Sabaragamuwa	Kegalle	18/11/2023	Gender Training	38	32	70
17	North Central Province	Polonnaruwa	27/12/2023	Gender Training	38	18	56
18	Uva	Badulla	10/11/2023	Gender Training programme	8	32	40
19	All 9 Districts		14.03.2024 15.03.2024	Gender Training of Trainers Programme	21	10	31
20	Central	Dambulla	17/03/2024	Gender Training for the Staff of Apex Hospital , DBH Dambulla	8	35	43
21		Kandy	21/03/2024	Gender Training for the Staff of Apex Hospital , DBH Theldeniya	15	48	63
22		Dambulla	28/03/2024	Gender Training for the Staff of Apex Hospital , DBH Dambulla	8	35	43
23		Kandy	05.04.2024	Gender Training for MOH areas	16	31	47
24		Kandy	10.04.2024	Gender Training for MOH areas	17	24	41
25		Kandy	17.04.2024	Gender Training for MOH areas	14	27	41

26		Kandy	25.04.2024	Gender Training for MOH areas	11	33	44
27		Kandy	30.04.2024	Gender Training for MOH areas	14	31	45
28		Hanguranketha	15.10.2024	Gender Training Programme	14	33	47
29	Central & Uva	Kandy Matale Nuwaraeliya Badulla Monaragala	19.06.2024 20.06.2024	ToT Program onMale Engagement forPrimary Health Care	30	25	55
30	Central	Ragala	06.11.2024	Gender Training Programme	10	32	42
31		Walapane	20.11.2024	Gender Training Programme	14	27	41
32	North Central	Polonnaruwa	07/03/2024	Gender Training	17	57	74
33		Anuradhapura	12/03/2024	Gender Training	10	28	38
34	Sabaragamuwa	Ratnapura	04/03/2024	Gender Training	11	47	58
35		Kegalle	18/03/2024	Gender Training	14	24	38
36	Sabaragamuwa & North Central	Anuradhapura Polonnaruwa Ratnapura Kegalle	06.05.2024 07.05.2024	ToT Program on Male Engagement forPrimary Health Care	34	21	55
37		Kahawatta	14.08.2024		27	60	87

38	Sabaragamuwa	Karawanella	30.08.2024	Gender Training	30	30	60
39		MOH Bulathkohupitiya	10.07.2024		7	13	20
40		MOH Opanayake	01.08.2024		10	16	26
41		MOH Godakawela	21.11.2024		20	30	50
42		DH Godakawela	28.11.2024		13	12	25
43		DH Kithulgala	08.12.2024		10	48	58
44		PMCU Kalalella	09.12.2024		6	4	10
45		PMCU Udahawpe	10.12.2024		7	8	15
46		MOH Pelmadulla	Before 20th December 2024		20	30	50
47		DH Amithirigala	20.12.2024		13	27	40
48	Uva		11.11.2024 12.11.2024 03.12.2024 06.12.2024	Gender TOT	13	12	25
49	Central	Mathurata	06.02.2025	Gender TOT	8	22	30
50	PMU	Anuradhapura	24.04.2025 25.04.2025	Gender TOT	25	53	69
51	North Central	Rajanganaya	08.05.2025	Gender Training for the staff of MOH office Rajanganaya	7	18	25
52		Eppawala	31.05.2025	Gender Training for the staff of DH Eppawala	12	30	42
53		Galnewa	04.06.2025	Gender Training for the staff of	12	22	34

				MOH office Galnewa			
54		Thalawa	12.06.2025	Gender Training for the staff of MOH office Thalawa	8	27	35
Total					**985**	**1874**	**2859**

Activity and Indicator	Progress	Expected Date of Completion
1.2 Integrate gender- responsive and inclusive PHC services with the implementation of the essential service package (ESP) for outpatient and clinic services in the nine newly established clusters		
1.2.3 At least 75% of women and men report increased satisfaction over the gender sensitivity of healthcare services provided at PHC facilities (Baseline: 52% women and 54% women report satisfaction)	In the baseline survey by the Monitoring and Evaluation Firm Consultant: Out of a total of 443 men, 57.6% expressed satisfaction over gender responsive health care services provided at PHC facilities. Out of a total of 577 women, 56% expressed similar views. In the annual survey for 2024: Overall 70.1% of patients are satisfied with services Satisfaction in the pilot cluster by gender Females –65.0% Males –76.5% **Next assessment of the indicator will be available with the next annual survey by the end of 2025.**	November 2025 Through the Endline Survey Nearly Achieved

Table 1.2.3: Comparison of the Monitoring and Evaluation firm survey results for Indicator 1.2.3

Year	Men (%)	Women (%)
Baseline Survey	Out of 443 Men, 255 men (57.6%)	Out of 577 women, 323 women (56%)
Annual Survey report 2024	Out of 301 Men, 230 men (76.5%)	Out of 379 women, 246 women (65.0%)

Activity and Indicator	Progress	Expected Date of Completion
1.3 Increase the utilizations of the PHC facilities by women and men		
1.3.1 BCC campaign strategy and materials (such as leaflets, video clips, and/or street dramas) developed and implemented.	A consultative discussion was undertaken by the BCC and Male Engagement Consultant with the involvement of the FHB and Medical Officer of Health from the 4 provinces to develop the BCC campaign strategy as per the end user requirement. BCC campaign strategy drafted with input from a consultative discussion with the involvement of the FHB/MOHH from the 4 provinces, reviewed and approved by the Human Resource Development Committee of the HSEP project. Digital media video scripts, theater scripts developed, drafted awareness creation mini booklet, developed PHC for men, Training manual in Sinhala, English, and Tamil.)	September 2025
1.3 Increase the utilizations of the PHC facilities by women and men		
1.3.2 Use of PHC facilities is increased by 20% each for women and men	Use of PHC Facilities was assessed using a household survey reported in the Baseline Survey report. The household survey was conducted for 1296 households within the cluster area. Females:28.5% (Out of 7255, 2070 Female) indicated that they are using the PHC facilities Males: 23.4% (Out of 7233 males, 1688 males) indicated that they are using the PHC facilities The next assessment is to be done at the end of the project through an Endline Survey by the Monitoring & Evaluation Firm.	November 2025

<table>
<tr><td colspan="3">1.4 Encourage Establish partnerships with local organizations for gender responsive and inclusive services at the PHC level</td></tr>
<tr><td>1.4.1 At least 30% of the medical officer of health areas will establish partnerships with local organizations for encouraging male participation in PHC utilization (Baseline: 0)</td><td>Mapping of the CSOs have been completed and submitted.

Two Training of Trainers have been conducted during the Second and fourth Quarters 2024.

<table>
<tr><th>Province</th><th>Date</th><th>Male Participants</th><th>Female Participants</th><th>Total Participants</th></tr>
<tr><td>Sabaragamuwa and North Central</td><td>06.05.2024
07.05.2024</td><td>34</td><td>21</td><td>55</td></tr>
<tr><td>Central and Uva</td><td>19.06.2024
20.06.2024</td><td>30</td><td>25</td><td>55</td></tr>
<tr><td>Uva</td><td>11.11.2024
12.11.2024
03.12.2024
06.12.2024</td><td>13</td><td>12</td><td>25</td></tr>
</table>
Partnerships are to be established by November 2024.

No to be achieved 80 participants & already done for 110 participants</td><td>September 2025</td></tr>
<tr><td>1.4.2 Conduct at least 30 awareness raising sessions for local organizations on the advantages of PHC utilization with a focus on encouraging male participation</td><td>Awareness creation workshops will be conducting July to August in selected 30 cluster locations. It includes 9 theater-based workshops and 21 inhouse programs.
(To be started)

(Progress -Discussed with ADB & they recommended 21 In-house Awareness Sessions & 9 theatre-based sessions)
Planning to do the train the theater base session team</td><td>September 2025</td></tr>
</table>

1.4.3 At least 75% of ADB funded cluster linked medical officer of health areas provide gender responsive and inclusive5 nutritional services (2018 baseline: 0)	According to the first interim report submitted by the Nutrition firm, 124 out of 138 (89.86%) of the cluster-linked medical officer of health areas provide a gender-responsive and inclusive nutrition service. Nutritional services provided by the preventive health staff is essentially awareness raising and guidance on balanced nutrition and identifying the individuals with deficiencies and referral for relevant eservices. This activity was to capacitate the staff to provide this service The training included determinants of nutrition improvement including gender moms and attitudes through a process of collective reflection, promoting them to build on the determinants including gender norms attitudes, and debunking myths based on gender, improving their awareness on factors operating at different levels (individual, household, community and society) and different stages of life cycle. Under Family support section how gender affects fulfilling nutritional aspects of family wellbeing has been discussed. As an intermediate outcome "Mutually supportive gender equitable families" which includes gender responsive and inclusive nutrition services.	Completed.
Activity and Indicator	**Progress**	**Expected Date of Completion**
1.5 Strengthen male engagement to promote reproductive health, maternal and child health/nutrition, PHC, and diminish violence against women		
1.5.1 A male engagement approach is designed to promote reproductive health, maternal and child health, nutrition, PHC for men, and diminish violence against women	Training Manual designed and developed in Sinhala/ Tamil and English. Printing versions will be disseminated in August during the awareness workshops.	Completed.

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<tr>
<td>1.5.2 At least 50 health officials and/or local organizations who can transfer knowledge to men at PHC facilities trained in TOT programs</td>
<td>Two Training of Trainers have been conducted during the Second and Fourth Quarter 2024.
<table>
<tr><th>Province</th><th>Date</th><th>Male Participants</th><th>Female Participants</th><th>Total Participants</th></tr>
<tr><td>Sabaragamuwa and North Central</td><td>06.05.2024
07.05.2024</td><td>34</td><td>21</td><td>55</td></tr>
<tr><td>Central and Uva</td><td>19.06.2024
20.06.2024</td><td>30</td><td>25</td><td>55</td></tr>
<tr><td>Uva</td><td>11.11.2024
12.11.2024
03.12.2024
06.12.2024</td><td>13</td><td>12</td><td>25</td></tr>
</table>
</td>
<td>Completed.</td>
</tr>
<tr>
<td>1.5.3 Over 1,500 men reached through training and awareness</td>
<td>On going
Awareness creation workshops will be conducting July to August for 30 cluster locations. It includes 9 theater-based programs and 21 inhouse workshops.</td>
<td>September 2025</td>
</tr>
</table>

Activity and Indicator	Progress	Expected Date of Completion
Output 2: Health information system, disease surveillance capacity, and COVID-19 response strengthened		
2.1 Provide sex-disaggregated data in health information systems		
2.1.1 Include sex disaggregated data included in the Health Information System (HIS) developed and implemented by the project (Open MRS) on the 29 notifiable diseases in Sri Lanka for the newly established clusters (Baseline: 0)	A list of 29 Notifiable diseases was obtained from the Epidemiology Unit - Ministry of Health and the request was made through to the HIIT firm to include in the sex -disaggregated date for the notifiable disease. **A list of 29 notifiable diseases included in the HIS developed & implemented by the project**	Completed
2.1.2. Analyze sex disaggregated data collected from the HIS (Open MRS) and identify gaps in access to health for women and men, and integrate in programming by the regional epidemiology unit/MOMCH, FHB and Epidemiology Unit (Baseline: 0)	HIS is established only in some hospitals and only some modules are operational. Sex disaggregated data requested from HIS and some of it has been received, It is being analyzed **(In progress)**	September 2025

Activity and Indicator	Progress	Expected Date of Completion
Output 3: Policy development, capacity building, and project management supported		
3.1 Build institutional capacity to integrate gender mainstreaming into all operation policies and guidelines developed for health sector (FHB)6		
3.1.1 Develop guidelines on inclusive consultative processes and incorporating gender considerations into operational policies, strategic plans and guidelines for use by FHB	The guideline on gender mainstreaming in health policies has been developed and finalized by the Director General of Health Services. It is scheduled to be launched in early August, following its translation	Awaiting the launch of the guideline developed by DGHS
3.1.2 At least 40 relevant officials7 (50% are women) who are involved in developing operational policies, strategic plans and guidelines of all 11 units of FHB are trained and report increased knowledge on guidelines developed for integrating gender and inclusive dimensions (3.1.1 above) (Baseline: 42 officials, including 21 women)	Once the guideline is launched, training under Indicator 3.1.2 will be conducted (Propose a high-level workshop.)	To be done after 3.1.1. Indicator

Activity and Indicator	Progress	Expected Date of Completion
3.2 Integrate gender dimensions into policies and strategic plans of the FHB and the existing package for newly married couples		
3.2.1 By 2025, develop operational policies, strategic plans or guidelines with gender dimensions for delivering a comprehensive package of PHC, and management and functioning of cluster hospitals	Guidelines for the functioning of the cluster system are in the process of being developed. After which the developed guidelines would be assessed from a gender perspective. **(Progress – Guidelines for the functioning of the cluster system are being developed. The Gender Consultant will send it to the Public Health Consultant for review & make recommendations to strengthen gender dimensions.**	September 2025

3.2.2 By 2022, 11 units of the FHB of the ministry that have integrated gender dimensions into all their policies and strategic plans (Baseline: 0)	Discussions with the Director FHB and Programme Director of Gender Unit were successful; Awareness raising discussion was held with 11 units Programme Directors Gender Unit of the FHB - We are requesting them to identify the policies, strategic plans, and guidelines to conduct the gender analysis.	November 2025

3.2.3 By 2025, the package for newly married couples is reviewed and recommendations to be incorporated into the package agreed upon, with FHB	Draft Review report has been developed by the consultant and shared with the Director FHB and awaiting comments. Once their comments are integrated, it will be finalized and submitted to FHB. A meeting is planned to be held in the next quarter to finalize the report.	September 2025

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<tr>
<td>3.2.4 By 2024, nine advocacy workshops conducted as one per district (nine districts) with registrars of marriages (Baseline: 0)</td>
<td>All 9 workshops completed in Ratnapura, Kegalle, Polonnaruwa, Anuradhapura Dambulla, Kandy, Matale, Monaragala and Badulla.

They were trained on the following topics:
1. Overview: Marriage, relationships, gender and a health family life
2. Introduction to the package of newly married couples.
3. Why is the package so valuable to the newly married couples?
4. Question and answers
5. Group work: to identify the challenges in implementing and suggestions to promote the package.

A total of 434 Registrars of marriage (94 male and 340 female) participated in the workshops. The advocacy workshops were a 1-day programme.

<table>
<tr><th>District</th><th>Male</th><th>Female</th><th>Total</th></tr>
<tr><td>Rathnapura</td><td>12</td><td>110</td><td>122</td></tr>
<tr><td>Kegalle</td><td>7</td><td>20</td><td>27</td></tr>
<tr><td>Polonnaruwa</td><td>7</td><td>13</td><td>20</td></tr>
<tr><td>Anuradhapura</td><td>15</td><td>44</td><td>59</td></tr>
<tr><td>Kandy</td><td>9</td><td>36</td><td>45</td></tr>
<tr><td>Matale</td><td>8</td><td>31</td><td>39</td></tr>
<tr><td>Nuwara eliya</td><td>11</td><td>28</td><td>39</td></tr>
<tr><td>Badulla</td><td>12</td><td>37</td><td>49</td></tr>
<tr><td>Monaragala</td><td>13</td><td>21</td><td>34</td></tr>
<tr><td>Total</td><td>94</td><td>340</td><td>434</td></tr>
</table>
</td>
<td>Completed</td>
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<table>
<tr><th>Activity and Indicator</th><th>Progress</th><th>Expected Date of Completion</th></tr>
<tr><td colspan="3">3.3 Conduct a gender training needs assessment to identify training gaps, develop a gender TOT module and roll out a training program for the PHC staff</td></tr>
<tr><td>3.3.1 By 2021, a gender expert recruited</td><td>Completed</td><td>Completed</td></tr>
<tr><td>3.3.2 By 2021, a gender training needs assessment conducted and a TOT training module for PHC staff developed (Baseline: 0)</td><td>A gender training needs assessment conducted and a TOT training module for PHC staff were developed.

Please find the attached Attachment 1 – for details on the training needs analysis report and details of the Key areas of topics covered by the TOT training.</td><td>Completed</td></tr>
<tr><td>3.3.3 By 2022, nine TOTs on gender conducted as one per district (at least 40% women) (Baseline: 0)</td><td>On account of the Covid 19 situation in the country it was agreed to have one National TOT covering all 9 Districts and have a hands-on TOT for the same district trainers when a gender training is conducted by the Consultant in those districts.

An additional TOT for selected Trainers from all seven districts were conducted during the 1st Quarter 2024.

Out of the number of trainers trained, 27% are women
<table>
<tr><th>District</th><th>Male</th><th>Female</th></tr>
<tr><td>Kandy</td><td>5</td><td>4</td></tr>
<tr><td>Matale</td><td>2</td><td>2</td></tr>
<tr><td>Nuwara Eliya</td><td>4</td><td>3</td></tr>
<tr><td>Anuradhapura</td><td>7</td><td>0</td></tr>
<tr><td>Polonnaruwa</td><td>3</td><td>1</td></tr>
<tr><td>Kegalle</td><td>10</td><td>0</td></tr>
<tr><td>Rathnapura</td><td>5</td><td>1</td></tr>
<tr><td>Badulla</td><td>3</td><td>2</td></tr>
<tr><td>Monaragala</td><td>5</td><td>3</td></tr>
<tr><td>Total</td><td>43</td><td>16</td></tr>
</table></td><td>September 2025</td></tr>
</table>

3.3.4 At least 30% of medical officers and other staff of PMCUs and divisional hospitals (of whom 35% are women) in the target provinces with increased knowledge on PHC. (2018 baseline: 0)	Suggest doing a Google survey among MO and other PMCU staff in target provinces with increased knowledge on PHC	November 2025

Activity and Indicator	**Progress**	**Expected Date of Completion**
3.4 Introduce an updated training program on gender sensitive nutrition counselling and PHC		
3.4.1 At least 75% of PHMs in ADB-funded cluster linked facilities trained on gender sensitive nutrition counselling program (Baseline: 0)	77.04% of PHM Trained on gender sensitive nutrition counselling. Total Number of PHM = 2400 Number trained = 1849 (All Female) Overview of the contents of the program: • Real-life practice and feedback guidance on how improved nutrition practices can be made a part of everyday routines of families and communities. • Addressing the underlying factors that facilitate or impede the preparation and consumption of healthy meals. • To improve their current capabilities and to encourage them to be more active in promoting better nutrition.	Completed.

3.4.2. At least 30% of PHC staff from PMCUs, divisional hospitals, and medical officer of health areas (of whom 35% are women) in target provinces report increased knowledge on gender sensitivity9, and gender related guidelines and interventions (2018 baseline:0)	An assessment tool has been developed in the form of a Google Form. The assessment tool has been shared with the medical officers and other staff of the PMCUs and Divisional Hospitals by June 2025. Google survey on increased knowledge of gender sensitivity, and gender related guidelines and interventions done, findings. Questionnaire analysis – 70 responses 39.4% - Medical Staff 25.8% - Nursing Staff 16.7% - Other Staff 18.2% - Not given gender training Gender Training useful for improving the Quality of work 51(96.7%) out of 61 participants.	September 2024

3.5 Strengthen the capacity of PHMs and PHIs respond to GBV		
3.5.1 The life skills training course for PHMs and PHIs is gender mainstreamed	Gender analysis of the module on Life training course conducted by the Gender Consultant and the draft report with the recommendations submitted for comments to FHB **Ongoing**	September 2025
3.5.2 A basic family counselling module developed for PHMs and PHIs (Baseline: Not available)	To be started.	September 2025
3.5.3 75% of PHMs and PHIs in ADB-funded cluster linked facilities trained on providing life skills and family counselling, violence against women prevention and services, including referral systems (at least 50% women) (Baseline: 873 female PHMs and 173 male PHIs as of February, 2024)	To be started.	September 2025

Attachment 1: Assessment of the Gender related training needs of staff in health institutions under the HSEP

(PMCUs, DHs, MOH Offices, FHCs, and Apex Hospitals)

Consultancy :Gender
Consultant :Dr.Lakshmen Senanayake
Ref. to ToR :Detailed Task and/or Expected Output: Assess gender related training needs of staf f (PIUs, sub project office staff, PMUCs, DHs, MOH Offices, FHCs, and Apex facilities) to identify and address knowledge and practice gaps related to effective gender mainstreaming; **Task:** Gender Training Needs Assessment
Study location: Four Project Provinces: Central, North Central Uva and Sabaragamuwa Provinces
Contact person Dr.Lakshmen Senanayake
Conducted by: Dr.Lakshmen Senanayake with the assistance of the four PIUs
Utilized in: Developing the gender Training Curriculum.
Background:
The Health System Enhancement Project (HSEP) is a primary health care service development project of the Ministry of Health financed by Asian Development Bank (ADB) and the proposed project is envisaged with the intent of improving efficiency, equity, and responsiveness of the Primary Health Care (PHC) system in the project areas, based on the concept of providing universal health coverage and continuum of care of high-quality essential health services. The project pursues an equity perspective inclusive of gender equity, in planning and delivering of essential primary health care services with assistance of ADB which supports an equity- focused health care delivery.
The HSEP is expected to enhance the utilization of Primary Health Care units and increase the patient satisfaction among those using them. In order to achieve these objectives, the Gender Component of the project, aims to ensure that the project activities are implemented according to gender initiatives defined by the ADB and the relevant policies of Government of Sri Lanka in providing a gender responsive and inclusive outpatient and clinic services as defined by the Essential Service Package.
Gender is a key determinant in the in care seeking practices as well as in the effectiveness in provision of care[1]

Men and women frequently think and behave differently and there is broad – and often broadly predictable – differences in the way men and women engage with the world. These patterns of behaviours and attitudes of men and women predispose them to particular health conditions to different degrees and influences their care seeking differently[2]. Health care providers themselves are influenced by gender socialization and their gender norms and attitudes are likely to add another dimension to the complex interaction between gender and health.

[1] Gender Check list Health ADB https://www.adb.org/publications/gender-checklist-health

[2] David Wilkins Dr Sarah Payne Dr Gillian Granville Dr Peter Branney ; The Gender and Access to Health Services Study Department of Health UK 2008 https://www.menshealthforum.org.uk/sites/default/files/pdf/gender_and_access_to_health_services_study_ 2008.pdf

Gender related activities included in this project include, capacitating the staff on providing a gender responsive service.

This Training Needs Assessment is the first step in the process of capacity building of the staff towards providing gender responsive care. The findings were utilized in drafting the Training Curriculum.

Purpose of the Assessment

The Gender Training Needs Assessment was conducted to identify the knowledge, attitude and practice gaps related to Gender issues among the staff. The findings were integrated in designing a capacity building programme to address these gaps, unlearn misconceptions and promote positive gender attitudes.

Target Population:

The Gender Training Needs Assessment centered on health care providers (Doctors Nursing Officers PHMs and other staff) working in the PMCUs, and DHs supported by the HSEP.

Methodology:

An anonymous self-administered questionnaire-based assessment of knowledge, attitudes and practices among the health care providers was conducted. The Questioner was made available in all three languages Sinhala, Tamil and English.

37 PMCUs/DHs (one third) were selected to cover all four provinces through a process of randomization. List of PMCUs was prepared in alphabetical order and every third PMCU was included starting with a randomly selected number (1-3)

Providers from the PMCUs/DH: All members in all categories of staff within the randomly selected institutions, who are on duty on the date of the assessment were included (Medical Officers, Nursing Officers, PHMs PHIs Minor staff) . (Total of 37 institutions out of 111)

Staff available on a randomly selected date (one day) were given the questioner consent form and an information sheet.

Coordination of the process of data collection: Coordination of this task was done by the HSEP, PIU Teams in the four provinces. If not for their effort and commitment this task would have been very difficult. Their assistance is very much appreciated.

Ensuring Confidentiality:

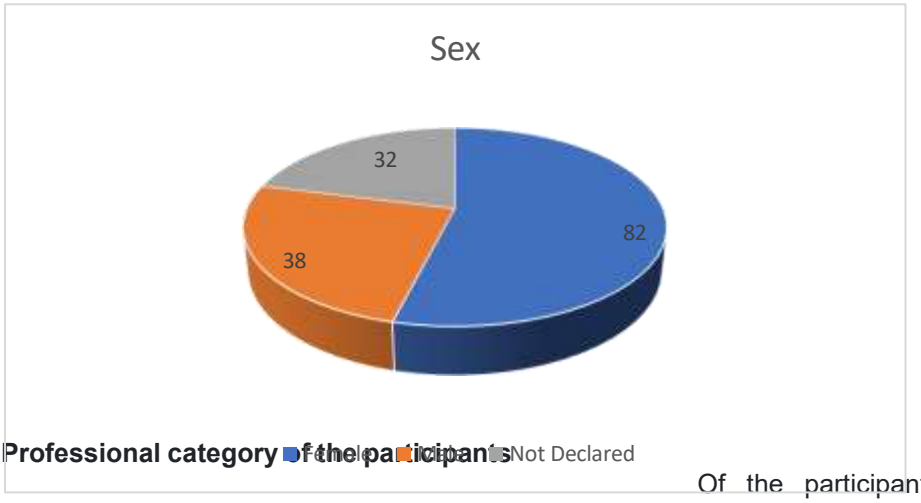
Questioners administered to the participants of the assessment are anonymous and not even linked to the institutions they work. This is declared in the consent section of the document **Findings of the assessment**

A Total of 37 randomly selected health institutions (PMCUs and DHs) were included in the study (a list of these hospitals is annexed as Annexure 1

152 Health care Providers including Medical Officers, nursing Officers, Midwives and other staff such as Pharmacists, completed the Questionnaire.

Sex of the participants:

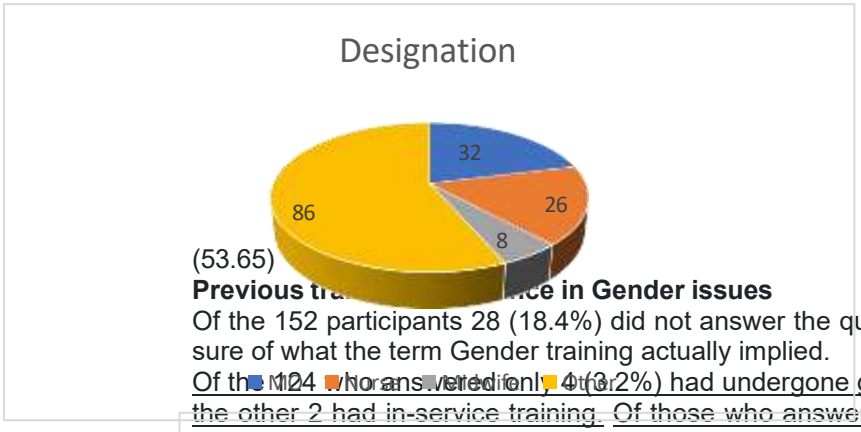
Of the 152 participants 82 (53.9%) identified themselves as females, 38 (25%) as males and 32 (21.05%) did not answer the question at all!!



Predominance of females is understandable with majority of nursing professional and all of the midwifery professionals being females.

Professional category of the participants

Of the participants 32 (21%) were medical officers, 26 (17.1%) were nurses 8 (5.3%) were Midwives. Balance (56.1 %) comprised of other providers such as pharmacists, dispensers' attendants etc. This picture is not surprising, given that the total health provider picture in the PMCUs, DHs and MOH areas (except Midwives) in the four provinces is: Medical Officers 219 (14.9%), Nursing Officers 309 (20.7%), Midwives (163 (10.9%) and other providers (1492 (53.65)



Previous training/service in Gender issues

Of the 152 participants 28 (18.4%) did not answer the question. It may be possible that they were not sure of what the term Gender training actually implied.

Of the 124 who answered only 4 (3.2%) had undergone gender training, two of them pre service while the other 2 had in-service training. Of those who answered (96.8%) had no training in gender issues in the pre-service or in-service period.

Although the questions are looked at in the domains of knowledge, attitudes and practices there is much overlap but in toto it gives an idea about the understanding of gender the participants have which gives some direction to pitch the training. The questioner is given as annexure 2.

Questions related to Knowledge of Gender issues: (Chart)
It was noted that some aspects of knowledge and understanding such as “being gender responsive does not mean giving always giving preferences to women, Men should always do what women tell them to do, sexual harassment at workplace is punishable by law and importance of privacy during examinations were correctly identified by most of the participants. However, on issues such as the weightage given to traditional values and beliefs as the basis of gender-based violence and, disadvantage women face in accessing services due to limitations to travel was not clear to them.

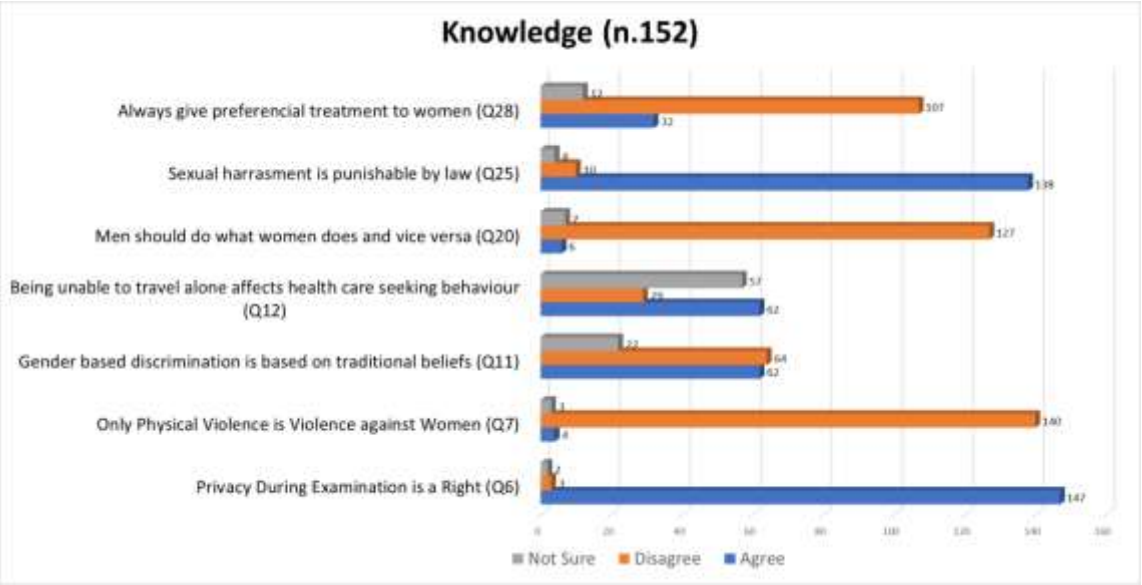
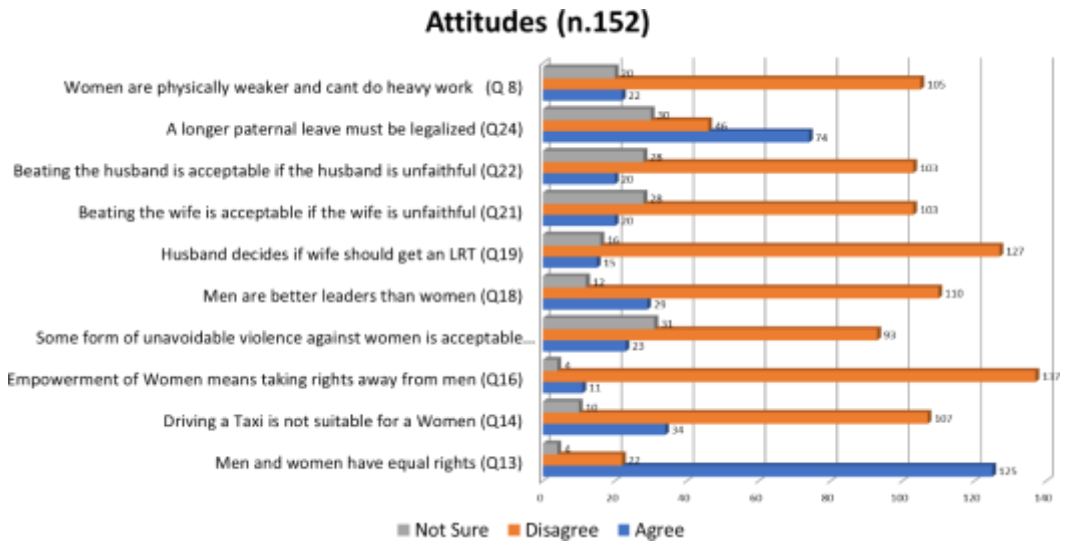


Figure 1 Answers to questions on knowledge

Questions related to Gender Attitudes : (Chart)
It was noted that in most of the questions nearly 2/3 of the providers answered the questions correct showing they had the correct attitude to a good measure. Few of such example are:” Women are physically weak and can’t do heavy work”, “Beating the husband is acceptable if the husband is unfaithful”, Husband decides if the wife should get an LRT or not”” Men are better leaders than women” and “Empowerment of women means taking away rights from men”
However, in some complex questions such as some form of unavoidable violence is acceptable against women, Driving a Taxi is not suitable for women and longer paternal leave there was confusion with close to half either gave the wrong answer or did not answer the question.



The practices they accepted as correct such as “Should promote husbands to attend antenatal consultations, A chaperone should be provided for a man if he requests were quite gender responsive. In some questions such private space for breast feeding, women should conform to traditions and culture there appears to be uncertainty and confusion.

Conclusions.

1. Hardly anybody among the care providers had gender related training in the pre-service or in-service period.
2. For a group who had no formal training their knowledge, attitudes and practices assessed in this assessment is reasonably good.
3. However, much needs to be done in capacitating the health care providers through clarification of gender issues and definitions, un-learning of some of the myths and beliefs, improving gender attitudes, understanding of basis of violence as gender and gender responsiveness in health care in order to make a gender transformative change in these providers.
4. Based on these findings the mindset of the health staff appears to be favorable and is very likely to a group of receptive participants.

Annexure 1

Table 1 List of Hospitals randomly selected for the Assessment

Name of the PMCU/DH	District	Province
Aluthwewa PMCU	Matale	Central
Batumulla DH	Kandy	Central
Digana-Rajawella PMCU	Kandy	Central
Handungamuwa DH	Matale	Central
Hattota amuna DH	Matale	Central
Kolongoda DH	Kandy	Central
Lendora DH	Matale	Central
Madipola DHB	Matale	Central
Manakola PMCU	Nuwaraeliya	Central
Mathurata DH	Nuwaraeliya	Central
Menikhinna DHA	Kandy	Central
Muloya DHC	Nuwaraeliya	Central
Munwatte PMCU	Nuwaraeliya	Central
Rupaha PMCU	Nuwaraeliya	Central
Theripeha DHC	Nuwaraeliya	Central
Ududumbara DH	Kandy	Central
Wahakotte PMCU	Matale	Central
Ambaguswewa PMCU	Polonnaruwa	NCP
Divulankadawala PMCU	Polonnaruwa	NCP
Galnewa DHC	Anuradhapura	NCP
Katiyawa DHC	Anurdhapura	NCP
Negampaha DHC	Anuradhapura	NCP
Rajanganaya tract 5 DHC	Anuradhapura	NCP
Atala PMCU	Kegalle	Sabaragamuwa
Boralankada PMCU	Kegalle	Sabaragamuwa
Bulathkohupitiya PMCU	Kegalle	Sabaragamuwa
Endana DHC	Ratnapura	Sabaragamuwa
Gonagaldeniya DHC	Kegalle	Sabaragamuwa
Hiramadagama PMCU	Ratnapura	Sabaragamuwa
Kalallela PMCU	Ratnapura	Sabaragamuwa
Narissa PMCU	Ratnapura	Sabaragamuwa
Panawatta (Estate) DHC	Kegalle	Sabaragamuwa
Rakwana DHA	Ratnapura	Sabaragamuwa
Haggala DHC	Badulla	Uva
Keppetipola PMCU	Badulla	Uva
Pitakumbura DHC	Monaragala	Uva
Wewegama DHC	Badulla	Uva

Annexure 2
Gender related training needs Assessment Data collection Tool

Dear Dr/Mr/Ms……

Purpose of the Assessment:
To recognize gaps in the knowledge, attitudes and practices, related to gender, relevant to provision of health care as primary health care providers, in order to design a comprehensive training package to ensure provision of a gender responsive health care in the Primary health Care System in the target institutions included in the HSEP.
This is a self-administered questionnaire-
Note:

- Please do not write your name or identify yourself in any way.
- Please attempt to answer all questions giving your frank opinion

1. I am a Man / Woman / Will not comment

2. I work as a Medical Officer / Nursing Officer / Technician / Midwife / Attendant / ……..

3. Place of employment : PMCU / DH/ Apex hospital / FHC/ MoH

4. I have had / not had training on Gender or Gender-based Violence Yes /No If yes please specify
   ……
   ……
   ……
   ……
   …….

5. If yes, was it during Pre service or In-service (Pre-service e.g. university/ during training period before employment) **Pre -service** ☐ **In -Service** ☐

- Please indicate whether you agree or disagree with the following statements using a X
- Please read the statements carefully before answering .

		Agree	Not agree	Not sure
6.	Privacy during examination is the Right **of the patients both men and women**			
7.	Violence against Women is **only physical violence**			

8.	Female labourers being paid less in the informal sector is not discrimination because **women are physically weak and can't do heavy work**			
9.	Not having a lock on the door of the toilet will prevent most **women** using it			
10.	Not having a lock on the door of the toilet will prevent most **men** using it			
11.	Gender-based discrimination is often based on **traditional beliefs** about women and men			
12.	The **limitation to mobility** (cannot travel alone) that many women faces, **can affect their health care seeking behavior**			
13.	Men and women, are **considered equal** and are entitled to **have equal rights**			
14.	Driving a Taxi is **not a suitable job** for a women			
15.	**Unlike men,** women need to conform to tradition and culture.			
16.	When women get rights, they are really **taking rights away from men**			
17.	**Some forms** of violence against women **are acceptable** because it is unavoidable			
18.	Men are **better leaders** compared to women.			
19.	**Husband should** be the one who should **decide**			

	whether the wife should have an LRT.			
20	**Gender equality means men should do what women do**, and women should do what men do.			
21	It is okay for a man to hit his partner/ wife **if she has another partner**			
22	It is okay for a woman to hit her partner/ husband **if he has another partner**			
23	Providing a private **space for breast feeding** will improve post natal clinic attendance			
24	Sri Lanka should legalize **a longer** paternal leave.			
25	**Sexual harassment** of a staff member by a colleague **is punishable by law**			
26	If a **man requests a chaperone** at the time of examination one should be provided			
27	Promoting **husbands to attend the consultation** at the antenatal clinic is a good practice			
28	**Gender equality** is always giving preferential treatment to women.			

Attachment 2:

Concept Note

Implementation of the Gender Action Plan (GAP): Health System Enhancement Project (HSEP) Output 3:

Policy development, capacity building, and project management supported

Targets and Indicators:3. 2.4 By 2024, nine advocacy workshops conducted as one per district (nine districts) with registrars of marriages (Baseline: 0)

Activity: Conducting advocacy workshops for Registrars of Marriage on the Package for Newly Married Couples implemented by the Family Health Bureau:

Background:

The Family health Bureau (FHB), as the focal directorate is responsible for addressing GBV, and has designed and implemented through its' Gender and Women's Health Unit, a "Package for Newly Married Couples **".**
This programme was ratified through the General circular FHB/GWH/2018/08 dated 2018/03/06" and one of the key objectives of the programme is "To *promote and enhance psycho social and spiritual wellbeing of the couple through a good marital relationship"* and addresses improving knowledge in reproductive health matters and *discourage* unhealthy life styles leading to a positive behavioural change in the couple towards a healthy relationship with no violence.
The programme includes inviting the couples to two knowledge sharing sessions delivered by the Field Health Officers: Medical Officer of Health/Public Health Nurses and offering a basic health screening using a purpose designed tool "*Nawa Divi Suwa Piriksum Patha"* and handing over a especially prepared booklet *"Sonduru Kedellakata Suwahasak Subha pathum*"
Registrars of Marriages provide a key interphase in this pathway by linking the newly married couples with the Field health structure through a specially designed invitation for newly married couples to utilize this service offered by the FHB/MoH.
While appreciating the assistance given by the registrars of Marriages in promoting the couples to access the services the FHB/HSEP would like to invite the Registrars of Marriage to a information sharing session and provide an update on the current situation of the programme.

Objectives:

1. To share the current situation on the access of newly married couples to the "Package for Newly Married Couples
2. To identify the challenges faced in implementing the programme and identify ways of promoting the Package with Newly Married Couples

Methodology:

1. Develop a brief concept note
2. Zoom Meeting with Pos, PSs and M&E officers to explain the activity and request assistance
3. Permission from PMU/PIU for payment of Honorarium and arrangement of other logistics
4. Development of training material (Gender Consultant/FHB)
5. PIU Teams to arrange the Programmes
6. Conducting the Programme: Gender Consultant, FHB and MOMCH
7. Documentation PIU :M&E, POs

Contents of the Advocacy workshop:

1. Brief discussion on marriage, relationships, and gender in the context of a healthy family life.
2. Introduction to the Package for Newly Married Couples implemented by the Family Health Bureau
3. Why is the Package so valuable to the newly married Couples? : to be highlighted through a brief discussion on the topics included in the Package/booklet[3]
    a. Sexuality
    b. Sexually Transmitted Diseases
    c. A well-Planned Family
    d. Good Nutrition
    e. Wellbeing and Understanding
    f. Family without Violence
    g. Before getting Pregnant
4. Identifying key Challenges and barriers in promoting the Package and Suggestions to overcome them

[3] https://drive.google.com/file/d/1DMZ3rRzfAn1BOtlJsdCd4W3wKf4xzrxL/view

Agenda of the Advocacy workshop

Agenda		
9.30 a.m.-9.45 a.m.	• Welcome by Director PIU/…… • Address by Supervising Registrar of Marriage • Address by FHB • Objectives of the workshop • Agenda of the workshop	Gender Consultant/ MOMCH
9.45 a.m.-10.00 a.m.	**Tea**	
10.00a.m to10.30 a.m.	Overview: Marriage, relationships, and gender and a healthy family life.	L.S./MOMCH
10.30.a.m. to 10.45 a.m.	Introduction to the Package for Newly Married Couples	FHB / MOMCH/Gender w
10.45 a.m. to 11.15 p.m.	Why is the Package so valuable to the newly married Couples?	L.S./MOMCH
11.15 a.m. to 11.30 a.m.	Questions and answers	
11.30 a.m. to 12.15a.m.	Group work to identify the Challenges in implementing and suggestions to promote the Package	LS/FHB/MOMCH
12.15.p,m, to 12.45 p.m.	Presentation by the Groups	
12.45 p.m. to 1.00 p.m.	Summing up and closing the workshop	LS/FHB
1.00 p.m. onwards	**Lunch**	

Responsibilities:
Gender Consultant:

1. Develop the material to be used ,Agenda, Invitation letter and conduct the programme on site.

PIU Team:

1. Identification of the Marriage Registrars ,Inviting /contacting them and making other arrangements: Venue, Refreshments and honorarium for the participants
2. Supporting the Gender Consultant and other resource in conducting the workshop
3. Documentation of the workshop :Participants' information, payments and reporting to HSEP/M&E

PMU Team: Approval and facilitating the budgetary support
FHB Team including MOMCH: Participation at the workshop and material to be given to participants (Samples) A questioner to be developed to evaluate the workshop.

www.statistics.gov.lk/Population/StaticalInformation/VitalStatistics/NumberofBirthsDeathsMarriagesInfantandMaternalDeathRate2000-2021

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
No. Marriages	194,217	190,988	197,589	195,914	193,317	195,067	196,817	196,236	198,578	194,970	200,985	200,314	198,710	180,760	177,792	177,730	173,990	169,365	170,027	163,378	143,061	162,628

Attachment 2:

Indicator 3.2.3: By 2022, the Service package for newly married couples is reviewed and finalized

Review Report on the Service Package for Newly Married Couples
Family Health Bureau
(1st Draft)

Implementation of the Gender Action Plan (GAP)
HSEP supported by the ADB

Output 3: Policy development, capacity building, and project management supported

Activity 3.2.: Integrate gender dimensions into policies and strategic plans of the FHB and the existing package for newly married couples

Indicator 3.2.3: By 2022, the Service Package for Newly Married Couples Programme is reviewed and finalized

Task: Review the Service Package for Newly Married Couples and make recommendations to strengthen it.

Review Report on the Service Package for Newly Married Couples

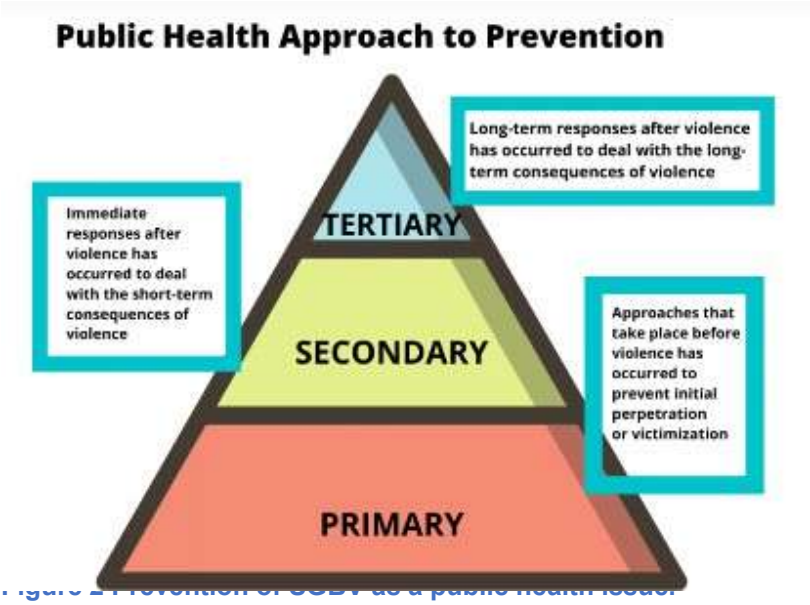
Developed by the Gender Consultant

HSEP 23rd May 2024

1. Background

Sexual and Gender-based Violence (SGBV) requires a multi-sectoral response and within that, the health sector has a crucial role to play. The response to SGBV effected through the the health system is multi-dimensional and could be broadly considered as two components: prevention of SGBV and responding to those affected by SGBV, effectively and adequately.

Prevention of GBV may be classified as: Primary, i.e. Preventing violence before it occurs, Secondary i.e. preventing recurrence of violence among survivors (victims) through immediate responses and Tertiary: i.e. preventing death and disability by long term response effective treatment etc[4].



However, Primary prevention is the most strategic approach to ending violence against women and girls[5] and is undoubtedly critical for long-term reduction of SGBV. However, the process of changing deep-rooted societal gender attitudes and gender norms is never quick or easy and the expected outcome will take a long time, sometimes decades, to materialize and be visible in the form of numbers.

Sri Lankan health ministry, through its Gender and Women's health Unit has embarked on a unique programme intended to effectively implement primary prevention of SGBV, targeting couples at the point of registering their marriage, in order to to prevent domestic violence in their marital relationship by integrating the subject of healthy relationships, zero tolerance to violence and preventing SGBV as a key component of the Pre-Conception Care Programme(PCCP) ,

This Pre-Conception Care Programme targets (only) the newly married couples, by engaging them at the point registration of their marriage and hence called Service Package for Newly Married Couples. It is also well known that violence within relationships, starts early in the relationships/marriage and[6] this point of intervention was considered suitable in primary prevention of SGBV as a national programme.

This programme includes health screening, nutrition counseling and awareness raising on multiple issues including healthy relationships with no violence, by way of primary prevention of IPV/DV.

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[4] Understanding primary prevention: University of Utah. Understanding primary prevention – #SAFEU (utah.edu)

[5] UN Women https://www.endvawnow.org/en/articles/318-promoting-primary-prevention-.html#:~:text=Primary%20prevention%20or%20stopping%20violence%20before%20it%20occurs,a%20serious%20public%20health%2C%20security%20and%20justice%20problem.

[6] Preventing intimate partner violence Across the Life span:A Technical Packsge of Programmes,Policies and Practices. Published by the Center for Disease Control (CDC) 2017

The Family health Bureau (FHB), as the directorate responsible for Gender & Women's Health in the Ministry of Health (MoH) has designed and implemented this program through its Gender & Women's Health Unit (2009).

The programme was ratified by the MoH through the General circular FHB/GWH/2018/08 dated 2018/03/06" and one of the key objectives of the programme is " *To promote and enhance psychosocial and spiritual wellbeing of the couple through a good marital relationship"* and addresses improving knowledge reproductive health matters and discourage unhealthy lifestyles leading to a positive behavioral change in the couple towards a healthy relationship with no violence.

This programme includes inviting newly married couples to participate in two knowledge sharing sessions, delivered by the Field Health Officers: Medical Officer of Health/Public Health Nurse and offering a basic health screening using a purpose designed tool: *"Nawa Divi Suwa Piriksum Patha"* and loaning an especially prepared booklet *"Sonduru Kedellakata Suwahasak Subha pathum*" which is recirculated..

Although, the programme had been operational island wide for more than a decade the coverage is still less than what was expected and it is felt that full potential of the programme has not been exploited. Therefore, a review of the programme has been suggested.

2. Objective of this review :

a. Primary Objective:

To revisit the Service Package for Newly Married Couples from a gender perspective and prevention of SGBV point of view in order to strengthen it from a gender perspective.

b. Specific Objectives:

i. Conduct a situation analysis on the Service Package for Newly Married Couples from a gender perspective and prevention of GBV point of view.

ii. Make recommendations to enhance the quality , effectiveness and the coverage of the programme from a gender perspective and prevention of GBV point of view.

3. Methodology

c. Situation analysis was conducted on the prevention of GBV activities (relevant to this programme).

d. Available official documents regarding the Service Package for Newly Married Couples: Circulars, annual reports, etc. were reviewed.

e. Information available in the eRHMIS on the the programme was accessed and studied.

f. KIIs was conducted with :

	Key Informant	Position/Relevance
	Dr.Nettanjali Mapitigama	Programme Manager Gender and Women's Health
	Dr. Dinusha	Programme Manager Gender and Women's Health
	Dr. Manoj Fernando	Consultant Health Promotion

g. FGDs

	Participants	Venue/where
	A representative group of PHMs	FHB
	A representative group of MoHs	MOH
	A Group of Clients *(Anonymous volunteer group of clientswith their consent)*	Held with clients from MP Kethumathie Hospital, Panadura
	2 Groups of Registrars of Marriage	Conducted as a separate session in the Workshops for Marriage Registrars held in Sabaragamuwa Province

4. Findings:

4.1. Policy Response

Policy Response of the Health sector relevant to Programme for Newly married couples /Preconception Care Package is given below

The National Policy on Maternal and Child Health 2012[7] recognizes the importance of pre-pregnancy interventions in:

Section 3.Scope *"In order to be most effective, appropriate interventions must be introduced before pregnancy and continued after delivery to prevent and detect early and manage appropriately any health conditions and risk factors that contribute to adverse maternal and infant outcomes"…." In the formulation of this policy, such a broader perspective is pursued that would not only emphasize broad policies relating to maternal, newborn, infant and child care but also include those relating to pre pregnancy care, care of older children including adolescents. The Goal 1 is to "Promote health of women and their partners to enter pregnancy in optimal health, and to maintain it throughout the life course"*

Goal 8: To promote reproductive health of men and women assuring gender equity and equality.

"Even though gender equity and equity in Sri Lanka are considered as being satisfactory ..... there are still several health-related areas that have a direct effect on reproductive health and need attention. These areas include specific issues related **to gender such as gender-based violenc**e, including ....."

"In today's context men need to be encouraged to be more concerned about their own health and the health of the family while playing an active role in child care as well as sharing household work. There is a gap in the current healthcare delivery system to actively involve the males in MCH/FP activities…."

Strategy b) *"Ensure an effective response from preventive and curative health sector for prevention and management of gender-based violence issue."*

Strategy: f) *"* Promote and enhance male participation in reproductive health care"

Strategy g) Empower men and women to promote community mobilization towards prevention and management of gender-based violence.

NATIONAL HEALTH STRATEGIC MASTER PLAN 2016 – 2025: Vol. II Preventive Services

5. Description of the Service Package for Newly Married Couples

The "Service Package for Newly Married Couples'' is a programme designed to provide Preconception care (PCC) targeting the Newlyweds, Prevention of SGBV has been integrated in this

programme which is implemented island wide

"The "Service Package for Newly Married Couples'' developed by the Gender and Women's Health Unit of Family Health Bureau, is comprehensive and addresses most components of the WHO Pre Conception Care package with prevention of SGBV/DV integrated in to it.The Sri lankan programme consists of health screening: health status and risk factors of the couple: behavioral and environmental, delivering health information and health care provision if needed. This package is supported and guided by the "Guideline for the delivery of the Service Package for newly married couples" [8] developed and disseminated by the Family Health Bureau/MoH.

Policy ratification of this programme is given by the General circular FHB/GWH/2018/08 dated 2018/03/06", which iterates that the "Guideline for the delivery of the Service Package foe newly married couples" to be adhered to by the preventive health staff (Annexure 1).

5.1. **Objectives of the ''Service Package for Newly Married Couples "**are: [9]

5.1.1. To improve the knowledge and awareness of the couple on reproductive health and to minimize unhealthy lifestyles such as alcohol and tobacco use, gender-based violence and family wellbeing etc, in order to create a conducive behavioral change in the couple.

5.1.2. To improve the health status of women maximally to ensure healthy pregnancy before they become pregnant.

5.1.3. To identify, correct or minimize the health problems of husband and wife .before they become parents.

5.1.4. To minimize maternal and infant mortality, reducing complications during pregnancy and delivery (to end preventable maternal and child mortality due to conditions which may arise before or during pregnancy)

It is a national programme implemented islandwide through the Medical Officer of Health (MOH) Offices by the Medical Officer of Health team, comprising of MOH, PHNS (Public Health Nursing Sister), PHI (Public Health Inspector), and PHM (Public Health Midwife).

5.2. Identification and inviting the couple.

At the point of registering a marriage, a printed invitation card requesting the couple to attend the programme is handed over by the Registrars of Marriages. This has been designed, printed, and distributed by the FHB. In addition, Field health staff (PHMs and PHIs) also identify the couples

[8] Annual Health Bulletin 2020 Chapter 8.

[9] Guideline for the delivery of the "Service Package for newly married couples

eligible for this service during their field visits and invite them to attend the sessions and screening. They also follow up on the information if received from the Registrars of marriages which does not always happen.

5.3. Registration of the couple in the preventive health system: at the MOH office.

The newly married couples are registered in the Eligible Family Register (H526) by the PHM.

5.4. Sensitization of the couple

Raising awareness of the couple is done by the PHM on the benefits of the Service Package for Newly Married Couples provided at the MOH Office.

5.5. Delivery of the Screening Tool for the couple and guide them on completing the relevant section.

Screening tool is a part self-administered with a section for the couple to complete. The screening tool is given with adequate explanation in order to promote them to complete and bring it along, when they attend the screening and awareness raising sessions held at the MOH Office. The completed tool is to be evaluated by the PHM to identify any risk factors.

5.6. Attending the two sessions: information sharing and health screening held at the MOH office

Appointment is given to attend the sessions to be held at the MOH office . The Care package described below should be delivered in two sessions. The two sessions can be held on consecutive months. A schedule for sessions for newly married couples should be maintained and displayed at the office.

The two sessions are designed to provide:.

1. Health screening for both partners.
2. Appropriate management of identified conditions (if any) to reduce risk factors that might affect future pregnancies.
3. Provision of family planning information and services (if required.)
4. Provision of health education on:
    a. Preconception Care Package
    b. Sexuality and sexual relationship*
    c. Sexually transmitted diseases and responsible sexual behavior*
    d. Family Planning for a well-planned family*
    e. Good Nutrition and good health habits
    f. Good marital relationship and wellbeing of the family*
    g. Benefits of non-violence*
    h. Male participation and parenthood*

*Topics related to gender norms, attitudes and prevention of GBV.

5.7. Health screening:

The couple is directed to the MOH with the preconception screening tool, which has been partly completed by the couple, and validated by the PHM ,along with the measurement of height and weight and the value of BMI, basic investigations: Blood sugar level and Hemoglobin level.(If facilities are available other investigations such as Blood Grouping & Rh, VDRL can be carried out.

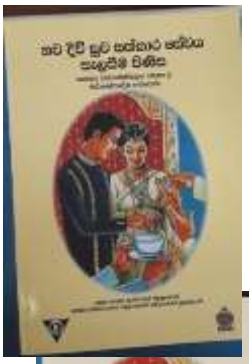
MOH validates the information provided in the preconception screening tool and if necessary, obtains more information.

A basic medical examination which includes CVS, RS, CNS and abdominal examination with blood pressure in both partners and a breast examination in the wife should be carried out by the MOH.

Risk factors and other health problems related to the couple will be identified.

Identified issues and risk factors need to be managed appropriately, or if needed referred to higher levels of care and If needed, appropriate family planning services will be provided

Finally, the completed preconception screening tool should be handed back to the couple, to be kept safely and presented at the first contact with antenatal care provider, when conception occurs.



6. Tools developed for this programme include:

Handbook for health care providers *"Nawa divi suwa sathkaara sewaya salaseema pinisa saukhya kaaryamandalaya sandaha wu maargopadesha athpotha"* : A 46 paged document covering seven technical areas. : Sexuality, Sexually Transmitted Diseases, Planned family, Nutrition requirements for the wellbeing of the mother and children, Good marital relationships and wellbeing of the family , Family with no violence and parenthood. The handbook is very rich and informative on technical and theoretical information, but has limited guidance on communication and delivery of sensitive material "unfamiliar " to the audience, especially for a group of "Newly married"

A Booklet to be loaned to the couple to be read and returned :" *Our best wishes for your blissful home/ Sonduru Kedella"* A 77 paged document, well designed covering many topics and very much reader friendly. However, being a large booklet, with escalating cost of printing a large number of copies, the chances of all participants accessing the booklet may be a challenge in the future.

Two Films (2) are available to be used in delivering the sessions.

7. Monitoring and Information management

A printed clinic attendance register for the 'Service Package for Newly Married Couples' is maintained by the MOH staff at the MOH office to record data related to both husband and wife during the sessions.

A summary of the data to be entered in the Quarterly MCH Clinic Return (RH MIS 527) is sent to FHB on a regular basis.

Indicator used to monitor the programme

The indicator used at present and reflected in the e-RHMIS is: *" the percentage of newly married couples who received services through this package."* This is derived as follows:

"***Half the number of couples who attended the Sessions**** *(Eachsession is taken as one unit) should be divided by the number of* ***new couples registered by the PHMM*** *during the year (RH MIS 509) x 100% (number of couples is divided into 2, because a couple has to attend 2 sessions). *(indicated in RH-MIS 27)*

Number of couples who attended the sessions during the year/**2 x100**

number of couples registered by PHMM during the year.

A minimum % of this is used as a cut off to assess the performance under the assumption *"Normally the percentage of marriages in Sri Lanka is about 1% of the population. Hence, the number of couples who should get this package is about 1% of the population"* This indicator was decided in 2009 and is being used up to today..

8. Demographic changes taking place in the country (2009-2023)

Since the inception of the programme in 2009 many sociodemographic changes in multiple dimensions have taken place . Information on the Sri Lankan population and number of marriages is given below[10]

Table 2 Changes in the population and the number of marriages over 2009-2023

	Year	No. of Marriages	Population of Sri Lanka	Marriages as a % of the Population
	2009	194970	20482477	0.951
	2010	200985	20668557	0.972
	2011	200314	20859743	0.96o
	2012	198710	21017147	0.953
	2013	180760	21131756	0.855
	2014	177792	21239457	0.837
	2015	177730	21336697	0.832
	2016	173990	21425494	0.812
	2017	169365	21506813	0.787
	2018	170027	21580710	0.787
	2019	163378	21649664	0.754
	2020	143061	21715079	0.658
	2021	162628	21773441	0.746
	2022	171140	21832143	0.783
	2023	151356	21893579	0.691

[10] Department of Census and Statistics statistics.gov.lk/Population/StaticalInformation/VitalStatistics/NumberofBirthsDeathsMarriagesInfantandMaternalDeathRate2000-2021

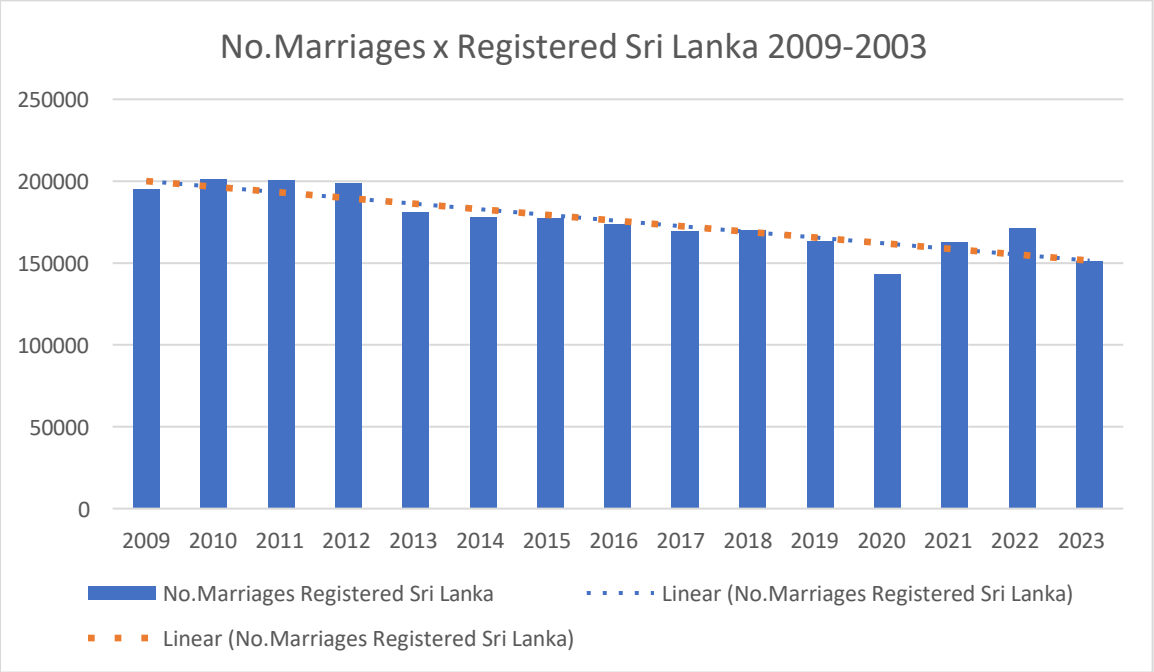


Figure 3 Trend of Marriages in Sri Lanka 2009-2023

The number of marriages in Sri Lanka has gone down from 194970 in 2009 to 152356 in 2023 a drop of 42514 over the last 14 years and the trend line shows a constant decline of 21.4%.

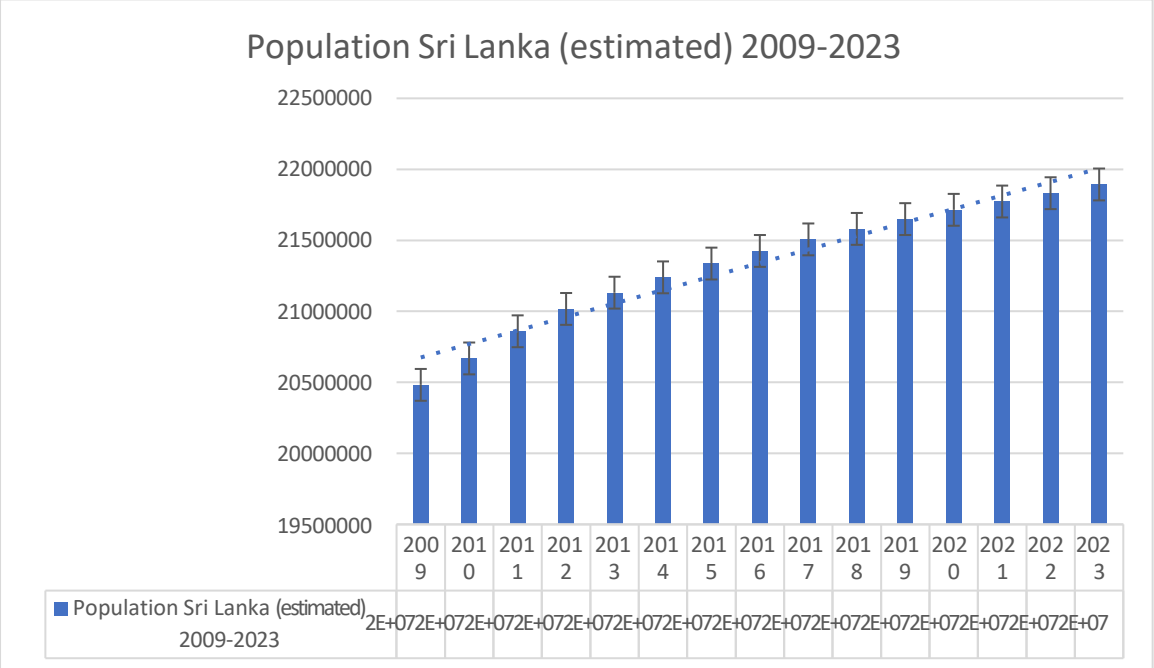


Figure 4 Population of Sri Lanka (estimated) 2009-2023

In contrast to the number of marriages the total population in the country has gone up from 20482477 in 2009 to 21893579 in 2023 a íise of 1,411,102 amounting to 5.6%. (Figure 3)

Accepting that trend in Marriages and trend in population are moving opposite direction the % of marriages in relation to the population has gone down significantly.

When the No. of marriages as a % of the total population is considered, at the beginning of the programme (2009) was 0.951% and the same at present (2023) is 0.651% which is a 31% drop (0.300%)

When the No. of marriages is considered as a % of the total population for the respective year, it was found to be 0.951% at the beginning of the programme (2009), and the same at present (2023) is 0.651% , which is a 31% drop of marriages. (Figure 5 and Table 1)

Therefore, using 1% of the population in calculating the above indicator is unrealistic in the present context .

9. Coverage of the target population

The information given below was collected from the e-RHIMS with the permission of the Gender and Women's Health Unit.

The % of Newly Married Couples registered by the PHM, is given as no. of couples registered, out of the presumed No. of marriages that is expected to happen. (No. presumed as 1% of the population under her care).

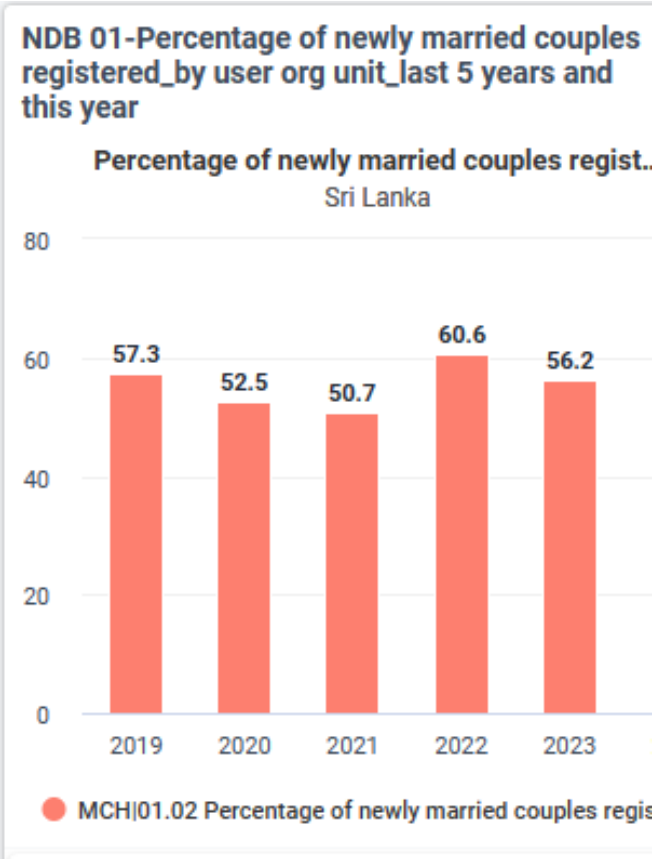


Figure 5 Percentage of Newly Married Couples registered with the Public Health Midwife (PHM)

(Figure 4) Shows the % of couples who were registered with the PHM (as described earlier). The couples who were registered out of the expected number appears to be around 55%-60% over the last few years. The denominator is the expected number of marriages as calculated through the formula given earlier).

The possible reasons for this stagnation could be :

- Lack of positive response to the midwife's request by the public
- PHMs contact predated the date of the appointment by a long period.
- Couples' resistance/negative attitude to access the offered services.
- Logistic issues that make the couples not attend.
- The programme has not been popular enough to gather momentum by word of mouth.
- Lack of publicity on the programme and its benefits

Therefore, there is an ample opportunity to improve the coverage of the programme and ways of promoting a higher level of registration of couples and improving attendance needs to be looked in to and addressed.

The drop of the coverage in the years 2020 and 2021 possibly corresponds to the Covid 19 pandemic and the fuel crisis in the country.(Figure 4)

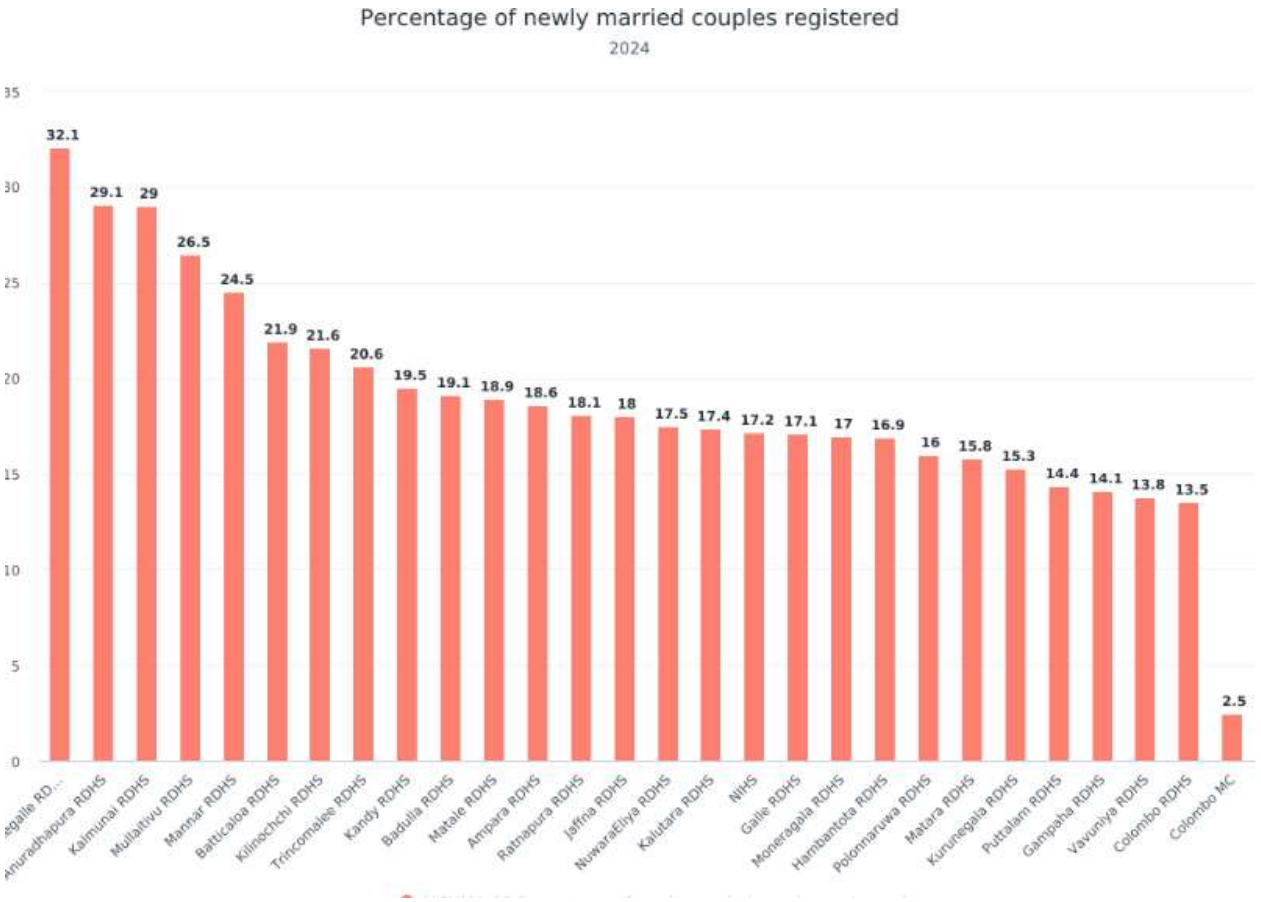


Figure 6 % of Newly married couples registered by PHM up to May 2024 disaggregated by RDHS divisions

The Chart No.4 shows the % of Newly Married couples registered up to May 2024 this year disaggregatedaccording to RDHS Divisions

The range of utilization of the services among districts is very wide with higher rates in Kegalle, Anuradhapura, Kalmunai, Mullaitivu and Mannar RDHS areas. (Top 5) The lower rates came from Puttalam, Gampaha, Vavuniya, Colombo RDHS and Colombo MC areas (Lowest 5)
Colombo MC area showing a remarkably low rate.
The closer liaison of the PHMs in the rural areas relative to that in the highly urban areas may be one of the reasons.
The Colombo municipality with a population of 752,993 has achieved the lowest coverage Colombo District's population was **2,309,809** according to the 2012 census which may have increased further by now.
Therefore, Colombo Municipality area and Colombo RDHS areas needs to make an extra effort to conduct special programmes to popularize this valuable service .

Figure 7 Percentage of newly married couples who attended the programme out of those who were registered with the PHM

The number of Newly married couples who attend the prescribed sessions appears to be around 50% reaching 58% in 2023. While the drop in 2020 and 2021 may be attributed to the Covid 19 epidemic and the situation of the country which may have reduced the number of marriages as well as the mobility of those who registered their marriages still there is opportunity to reach the balance 40% of the newly weds.(Figure 5)

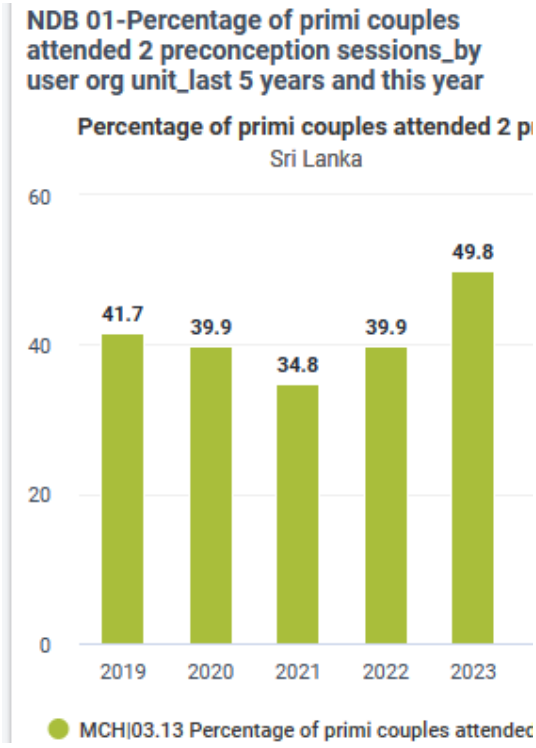


Figure 8 Percentage of couples who complete the programme by attending both sessions

Figure 6 shows the % of couples who completed the programme by attending the both sessions out of those who attended the programme. It is significant that around 60% of those who come in to contact with the Team at the first session appear to have dropped out of the programme. This clearly is an indication to make the programme more “couple friendly” and attractive and “generation friendly” by using newer modalities of communication suitable to the social milieu of the country that exist today

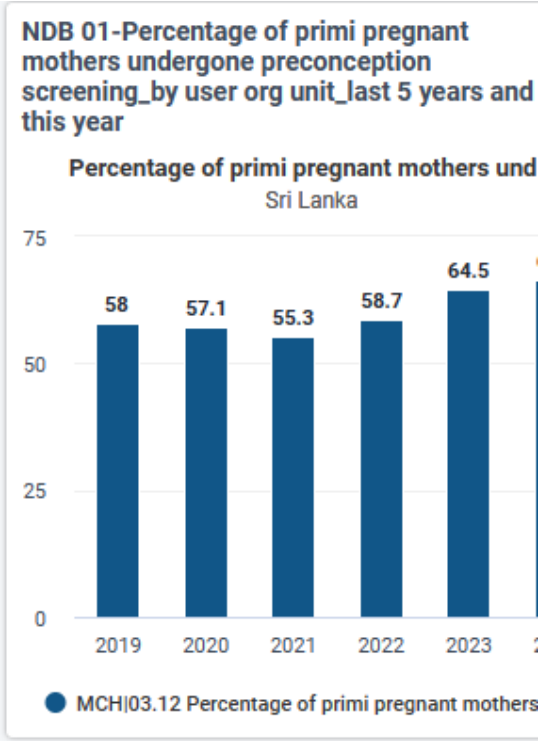


Figure 9 Percentage of women in their first pregnancy who had been exposed to the Newly Married Programme

Figure 7 shows the coverage of the programme as a Pre-Conception Care Package targeting newly married couples by assessing the % of women in their first pregnancy registered by PHMs who had attended the Programme. Unfortunately, only 50%-60% of the target group has been exposed to the programme.

10. **Information gathered from the Focus Group discussions and KIIS**

10.1. Focus group discussions held with Registrars of Marriage as a component of Training of Registrars of Marriage held in Ratnapura and Kegalle Districts

A total of 122 Marriage Registrars and 16 District Registrars in Rathnapura and Kegalle Districts, coming from all Divisional Secretarial Divisions who attended a training workshop were invited for the focus group discussions (30 participants in each group). One separate session of 90 Mts was allocated for this activity.

The hierarchy of the officials relevant to Registration of marriage is given in Figure10 .

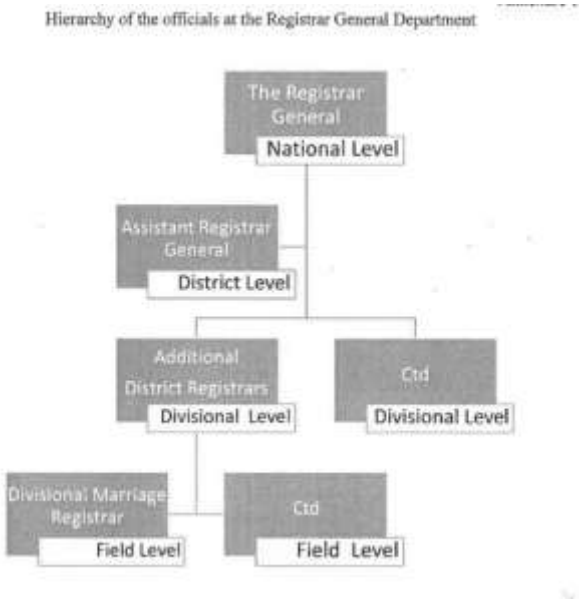


Figure 10 Officials involved in the Registration of Marriages

Input received from these discussions are summarized below:

- They all agreed that this is a very important and timely programmatic intervention and were happy to cooperate.
- They appreciated the discussion and the interaction with the health providers, which they felt should happen more often.
- Most of them were familiar with the basics of the programme and the invitation to be given to the couple , but did not realize the objectives, process and the benefits of the programme till they participated at the training.
- One of the challenges identified was that, being a voluntary programme they could only inform and promote the couples to attend but have no way to effectively ensure participation.
- They understood the underutilization of such a valuable intervention conducted for the public and explored ways of improving the situation by identifying ways of submitting the information on the couple to the field health team.
    - PHMs to visit the Registrars on a regular basis and collect the information at the end of the month.
    - Individual Registrars to send the information to MOH of the area and thereafter to be submitted to the relevant PHMs.
    - Health authorities/MOMCH/MOH to get the information from the Additional District Registrars and share it with the relevant PHMs.

Challenges of each method was discussed at length and sharing of information sent to the Additional District Registrar by the Divisional Medical registrar by sending a copy to the MOH of the area was considered as the most favorable.

Thereafter the MOH can inform the details to the relevant PHM or the relevant MOH if the couple is from another area.

- Meetings or discussions to share information between Marriage registrars and health officials to find solutions to local challenges on a regular basis with the and Registrars to be held
- Formal guidelines/ instructions to formulated by Registrar General sent to all Registrars of Marriages.

10.2. Focus group discussion held with a cross section of health providers involved in delivering this programme including MOHs, MOMCHs ,PHNs, and PHMs was held at the FHB.

Lengthy discussions identified the following points:

Most agreed that it is a valuable programme that needed strengthening and updating to accommodate the sociodemographic and attitudinal changes taking place in the modern society.

- Suggestions to improve the two-health promotion and health screening sessions.
    - The contents of the programme are orientated to provide information which is more theoretical and medically orientated rather than to of practical use.
    - Subject matter as presented in the present module is not "participant friendly" and should be redesigned in a different format such as FAQs and problem oriented.
    - Unattractive presentation of the subject matter
    - Inadequate experiences/skills/capacity of some of the MOH/PHNs on talking about sensitive areas such as sexuality and GBV. They themselves are uncomfortable and cannot deliver an effective programme
    - Maintaining a social gap between the lecturer and the participants during the lecture: lack of skill in communication.
- The training of the MOHs/PHNS should be revisited and include communicating skills on sensitive subjects such as sexuality , engaging the young audience and to improve the commitment of the individual MOHs as leaders in this programme
- Improve the sex education and family planning module by re-designing and pitching it at the mindset of the target group, young, newly married and shy in the backdrop of negative gender norms and attitudes Lack of reading materials to be handed over to all participants for immediate follow on of awareness. (Loaning the booklet is not very effective)
- Increase the awareness of this Programme among newly married couples to promote early participation in order to support the antenatal care programme.
- Invitation card to be accompanied by a brief note/brochure/SMS/WhatsApp message with a link to a document available on the web, explaining the value of the programme.
- Introduce a brief leaflet to take home after the visit to MOH (in addition to sharing the book through the PHM), which is easier to read and attractive.
- Get feedback of the participants at the end of the lecture. (Q & A session).
- When conducted on weekends try to begin early and finish before 12 noon.

Recommendations.

1. Revisit the objectives of the Service Package for Newly Married in order to give more weightage to the Primary prevention of SGBV, by including "Primary Prevention of Sexual and Gender-based Violence as the fifth objective for this programme.

2. Revisit the life skills section of the Pre Conception check list to include questions to pick up unhealthy relationships issues, toxic gender attitudes, and warning signs/red flags so that the PHMs may be vigilant.
3. As the mean age of marriage is increasing with many young couples living together, rather than or prior to marriage, this programme should be opened out to young individuals in a sustained relationship "awaiting to be married" as well. Although this group is not barred from attending the sessions, the environment of a programme for "Newly Married" excludes them from the benefits of this programme. Therefore, "Newly The Package may be re-named "Package for Newly married and To be married"
5. The contents* of the Teaching Guide *"Nava divi sathkara sevaya salaseema pinisa"* needs to be reviewed to make it less technical, practically orientated and directed towards delivering information to a nonmedical lay group unfamiliar with such technological matter. The teaching Guide should be targeted towards capacitating the Health care provider in delivering a "difficult" subject . It is likely that some of the staff members themselves may find it difficult to talk about some of the subjects such as sexuality. The guide should have a section for FAQs (Frequently Asked Questions" as some if not most, females are reluctant to ask questions. Promote the facilitator to get questions anonymously from the audience by using slips of paper notes.

* *Sexuality and sexual relationship, responsible sexual behavior, Family Planning for a well-planned family,Good marital relationship and wellbeing of the family, Benefits of non-violence,Male participation and parenthood**

4. The training of the MOHs/PHNS should be revisited and include communicating skills on sensitive subjects such as sexuality , engaging the young audience and to improve the commitment of the individual MOHs as leaders in this programme.

5. Develop and use an Online training module for MOHs and PHNs on delivering the Package for Newly Married Couples and make it available at the FHB website. .Once completed they could br issued with a certificate of completion automatically.

6. The Booklet " *Our best wishes for your blissful home/ Sonduru Kedella*" to be loaned to the couple to be read and returned is well written, easy to understand and reader friendly. However, the process of distributing the information with a "library" of few copies available with the PHM in practical terms seems to be ineffective. In the present context with escalating costs and scarcity of printed material it may become more difficult However, the dissemination of the information given in this module is very important. Therefore some or all of the following methodologies may be used.
    a. Select the key contents (related to gender and SGBV as identified in Recommendation 3) and develop brochures (1-2 page) on the key topics and make them available to all the couples who attend on their first visit.
    b. Make the booklet available on the FHB website (in the area available to the public) and give the link to the couple on registration.
    c. Develop a mobile App and make it available for the participants to download and use it as and when they like.
7. In addition to the two films available at present as teaching tools, which are rather lengthy , shorter film clips (3-5 Mts) just enough to generate interest to start an open discussion

needs to be developed ,made available to the resource persons to be used in delivering the Package..

8. There must be a clearly defined mechanism operated through the local health system to deliver an adequate supply of invitation cards to the registrars of marriages in the language used in the respective area
9. Develop and make available a brief note/brochure and/or online material such as /SMS/WhatsApp message to the couple explaining the value of the programme. Encouraging them to participate at the sessions.
10. As the rate of marriages is changing due to multi-dimensional factors, a constant rate being used in the formula in calculating an indicator is not advisable. Using the number of marriages as a % the population needs to be be calculated using the last available information on marriages and population with the Registrar General rather than an assumption.
11. The Gender and Women's Health Unit needs to strengthen the already established linkage with the Registrar General and promote constant dialogue between local health care providers ay all levels and the Registrars of Marriages in the area.
12. A well-defined and uniform methodology should be developed and used islandwide to get the information from the Registrars of Marriages on the Newly married individuals to the respective midwife. With adequate consultation and consensus with the Registrar General and other officials a mechanism to share contact information on the newly married with the MOH of the area needs to be developed. Thereafter the MOH could inform the relevant PHM.
13. Once identified the mechanism should be formalized through a circular through Registrar General and shared with the health authorities.
14. After an in-depth discussion strategies need to be identified for the Colombo Municipality area in particular and for other urban areas such as Colombo RDHS area to overcome challenges and make this programme available to this large population.

Annexure 1 Tool used for information collection from the Registrars of Marriages.

Group Work : To identify ways to improve the Newly Weds Programme of the FHB	
Time	30 30 Minutes for Discussion and 30 Minutes for presentations by the Groups)
Number in each group	10-15 persons
Objective of the Group Work	To identify the challenges faced by the Registrars of marriages in implementing this programme and make recommendations to strengthen the programme and ensure wider coverage.
Instructions	1. Group 1 will proceed with discussing the **challenges and constraints in promoting newly married couples to join the programme** 2. Group 2 will use their background knowledge and experience as Registrars and suggest any improvements to the administrative and operational aspects of the Programme., 3. Group 3 will suggest **any changes to the contents of the programme and the assistance needed (Non financial) to improve the efficient implementation**
Presentations	Each Group[will present their recommendations .

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சுகாதார,போசணைமற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health, Nutrition& Indigenous Medicine

All Provincial Directors of Health Services,
All Regional Directors of Health Services,

Guidelines for delivery of the "Service Package for Newly Married Couples"

As you may be aware, at present the Public Health Officials of all the districts have been sensitized and orientated by the Family Health Bureau on the implementation of the above mentioned package, and it is envisaged that these services are being delivered to all the newly married couples by Medical Officer of Health teams in your area.

The availability of guidelines is considered as an essential requirement to improve the quality and to strengthen and streamline the above package. Therefore, guidelines to deliver the package have been developed by Family Health Bureau and are attached herewith.

Please be kind enough to instruct all Medical Officers of Health in your area to adhere to these guidelines in delivering the services to the newly married couples through the "service package for the newly married couples" in order to improve and strengthen the pre-conceptional care provided by the public health field staff in your area.

Dr. Anil Jasinghe
Director General of Health Services

Dr. Anil Jasinghe
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine,
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Cc: Secretary/ Ministry of Health, Nutrition & Indigenous Medicine
Deputy Director General/ Public Health Services II
Director/Maternal and Child Health
Director/ National Institute of Health Sciences
Chief Medical Officer of Health/ Colombo Municipal Council
Provincial Consultant Community Physicians
Medical Officers/Maternal & Child Health
Medical Officers of Health

385, [illegible] 10. 385, [illegible] 10.
385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka.