NATIONAL STRATEGIC PLAN 2019 - 2023

WELL WOMAN PROGRAMME

FAMILY HEALTH BUREAU - MINISTRY OF HEALTH - SRI LANKA

UNFPA

NATIONAL STRATEGIC PLAN 2019 - 2023

WELL WOMAN PROGRAMME

FAMILY HEALTH BUREAU - MINISTRY OF HEALTH - SRI LANKA

FOREWORD

I am pleased to introduce the Well Woman Programme Strategic Plan 2019-2023. While the country has paid much attention to improving the maternal and child health services over several decades, it is timely that this strategic plan intends to improve the health of older women. The nine conditions screened for at the Well Woman Clinics, namely, hypertension, nutritional status, diabetes, breast abnormalities, thyroid gland abnormalities, cervical abnormalities, family planning status, menstrual disorders, reproductive tract infections, perimenopausal/menopausal problems are important causes of morbidity and mortality among women in Sri Lanka.

The Strategic Plan is in line with the National Strategic Framework for Development of Health Services 2016-2025, the National Multisectoral Action Plan for the Prevention and Control of NCDs 2016-2020, the National Policy and Strategic Framework on Cancer Prevention and Control- Sri Lanka 2015 and the commitments of the Government to achieving the Sustainable Development Goals.

Of the six Strategic Objectives proposed in the Strategic Plan, one in particular addresses the shift to using HPV testing for cervical cancer screening. This method of screening has several advantages over cervical cytology, the method that is currently being used in the Well Women Programme. Last year we introduced HPV vaccination for girls in Grade six. We are confident that HPV vaccination and screening for HPV will pave the way for elimination of cervical cancer from this country.

Of course not everything can be changed overnight. Even I, impatient as I am to see improvements, recognise that it takes time. It's also clear that challenges remain, including finding and recruiting the health workers to make the Strategic Plan work.

I would like to thank all those involved in the development of this Strategy. In particular I would like to acknowledge the contribution and effort of the Technical Advisory Committee and the Gender and Women's Health Unit of the Family Health Bureau for the hard work and dedication they have shown during the development of the Strategic Plan.

The Government of Sri Lanka, through the Ministry of Health, Nutrition and Indigenous Medicine will continue to invest in the health of women and calls on all stakeholders and other partners to actively contribute to the implementation of the Strategic Plan.

Dr. Anil Jasinghe
Director General of Health Services
Ministry of Health Nutrition and Indigenous Medicine

MESSAGE FROM DIRECTOR MATERNAL AND CHILD HEALTH

The Well Woman Programme has been implemented for over two decades in Sri Lanka. It is therefore timely to reflect on the lessons learnt and to move forward using evidence based interventions and advances in technology to a renewal of the Well Woman Programme. The Strategic Plan addresses several important systemic issues affecting the optimal performance of the WWP and thereby aims to ensure that women receive high quality health services.

The National Strategic Framework for Development of Health Services (2016-2025), the National Multisectoral Action Plan for the Prevention and Control of Non Communicable Diseases (2016-2020) and the National Policy and Strategic Framework on Cancer Prevention and Control- Sri Lanka 2015 provide the policy framework for this strategy.

In addition, the development of the Strategic Plan is made necessary by the significant change in recent years in government approaches to service improvements, which recognises the need for strategic planning across all sectors and ministries; the need for evidence-based management; as well as the need for enhanced citizens' participation in planning and implementing development programmes in a devolved manner.

Six Strategic Objectives have been identified in the Strategic Plan and defines strategies, major activities and sub activities for each of them. This Strategic Plan will focus on the following key areas: policy and advocacy, the transition from cervical cytology screening to HPV testing, health system strengthening to deliver the WW Programme, increasing coverage and equity, quality of care (QOC) and raising community awareness on screening.

The expectation is that national, provincial and district levels will use the Strategic Plan as a framework to ensure activities related to the WW Programme are adequately reflected when developing their Provincial and District Health Plans. We therefore urge all programme managers and health care providers at all levels of health care to embrace and consistently use this plan to ensure coordinated roll out of the Well Woman Programme.

We thank all the staff of the Gender and Women's Health Unit of the Family Health Bureau and all those who supported to develop the Strategic Plan which was a long-felt need.

Dr Chithramalee de Silva
Director, Maternal & Child Health
Family Health Bureau
Ministry of Health, Colombo 10

MESSAGE OF THE UNFPA REPRESENTATIVE

The United Nations Population Fund (UNFPA) is the UN's sexual and reproductive health agency. We are pleased to be a part of the joint effort with the Ministry of Health to develop the Well Women Programme Strategy 2019 – 2023. UNFPA has been supporting the Programme since its inception in 1996 to improve the health and well-being of women in Sri Lanka.

Sri Lanka has come a long way to achieve exemplary results in maternal health. For example, 99% of mothers receive antenatal care from a skilled provider, and nearly 100% of births are delivered in a health facility assisted by a skilled attendant. However, critical gaps remain to ensure universal health coverage and tackle the last mile challenges to leave no one behind. There is a need to address long-standing issues such as preventable maternal deaths, as well as emerging ones including non-communicable diseases. We need to acknowledge that even one woman dying from a preventable cause is too many.

Over the years, the Well Women Programme has faced several challenges including inadequate basic health infrastructure and financing, and lapses in the quality of services. This is an opportune moment to establish a new Strategic Plan for the Programme, so that we can make necessary changes in the structure and services to further improve the health status of women. In fact, data reveals that quite a few indicators related to women's health have been stagnant for a decade or more. For example, the contraceptive prevalence rate has been around 65% for a few decades. Improvements in the coverage, quality and utilization of services of Well Women Clinics should help advance the situation. It is particularly important to ensure those who have not been benefiting from the Programme as much as others (younger women below age 35 and those in the Northern and Eastern Provinces) have easier access to the services.

This year marks the 25th anniversary of the International Conference on Population and Development (ICPD) in Cairo, which placed women's rights at the center of population and development policies. This meant providing individuals, couples and families with access to a range of sexual and reproductive health services because having a control over her own body is a starting point for women's rights. The old discourse, which sees family planning as a way to control population increase, was disregarded at ICPD because family planning was recognized as a human right. Advocacy for this very concept, however, has to be continued and strengthened, more so than ever before in today's world. Building on the partnership reaffirmed in Cairo 25 years ago, we need to continue to work towards making the ICPD commitments a reality.

In line with the ICPD Programme of Action as well as the 2030 Agenda for Sustainable Development, UNFPA is proud to be a part of this journey in ensuring health and well-being for all. Sri Lanka must adopt a lifecycle approach to healthcare – one that starts early and continues through the reproductive years and lasts into old age – to support the physical and emotional wellbeing of women in Sri Lanka. We stand ready to provide continued assistance to the Government of Sri Lanka and all key stakeholders to ensure women at all ages and of all backgrounds, enjoy the quality healthcare to fulfill their potential.

Ms. Ritsu Nacken
UNFPA Representative in Sri Lanka

ACKNOWLEDGEMENTS

The Strategic Plan for the Well Women Programme (2019-2023) has been prepared in consultation with a wide range of individuals and institutional stakeholders at national and sub-national levels. It is built on the evidence provided by an extensive situational analysis, key informant interviews and small group discussions.

The Family Health Bureau is extremely grateful and appreciative of all individuals and organizations that contributed to the development of the strategy. We are grateful in particular to the following individuals who gave generously of their time to share their insights and experience.

Dr Sudath Samaraweera	Director, National Cancer Control Programme(NCCP)
Dr Thilak Siriwardene	Director, Non Communicable Diseases
Dr Suraj Perera	Consultant Community Physician, NCCP
Dr Janaka Weragoda	CCP / MOMCH-RDHS Office, Colombo
Dr Asanthi Fernando	CCP Health Promotion Bureau
Dr Ramani Punchihewa	Consultant Pathologist, National Respiratory Disease Hospital, Ragama
Prof P S Wijesinghe	President SLCOG
Dr Mangala Dissanayake	VOG GH Kalutara
Dr Sanath Lanerolle	VOG Castle St, Hospital for Women
Dr Ruwan Silva	VOG/FHB
Dr Chintha Jayampathy	Deputy Chief Medical Officer of Health, (MCH), Colombo Municipal Council
Dr H. Yakandawala	Medical Director, Family Planning Association of Sri Lanka

I am grateful to the Regional Supervisory Public Health Nursing Officers, Cytoscreeners and Officers in Charge of RMSDs who participated in small group discussions.

I also express my thanks to the consultant, Dr Prasanna Gunasekera who led the development of the Strategic Plan

Finally, the Family Health Bureau would like to express its gratitude to the United Nations Population Fund (UNFPA) for their financial and technical support in developing this strategy.

With the institutionalization of the Strategic Plan 2019-2023 for the Well Women Programme, we hope that this strategic plan will clarify the national strategic direction and hence facilitate the roll out of the Well Woman Programme.

Dr. Loshan N. Moonesinghe
Consultant Community Physician
Focal Point - Well Woman Programme
Family Health Bureau
Ministry of Health, Colombo 10

LIST OF ACRONYMS

AMOH	Assistant Medical Officer of Health
BCC	Behaviour Change Communication
BMI	Body Mass Index
CBE	Clinical Breast Examination
CCP	Consultant Community Physician
CIN	Cervical Intraepithelial Neoplasia
CPSL	College of Pathologists of Sri Lanka
CCP	Consultant Community Physician
CCPSL	College of Community Physicians of Sri Lanka
CRC	Caring, Respectful, Compassionate
DDGPHS II	Deputy Director General Public Health Services II
DDGLS	Deputy Director General Laboratory Services
FHB	Family Health Bureau
FP	Family Planning
FPASL	Family Planning Association of Sri Lanka
GDP	Gross Domestic Product
G&WHU	Gender and Women's Health Unit
HEO	Health Education Officer
HIV	Human Immunodeficiency Virus
HLCs	Healthy Lifestyle Clinics
HPB	Health Promotion Bureau
HPV	Human Papilloma Virus
HR	Human Resources
ICPD	International Conference on Population and Development
IARC	International Agency for Research on Cancer
ISO	International Standards Organization
IUD	Intra-Uterine Contraceptive Device
KII	Key Informant Interviews
LMIC	Lower Middle Income Countries
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MLT	Medical Laboratory Technologists
MO	Medical Officer
MoH	Ministry of Health
MOH	Medical Officer of Health
MOMCH	Medical Officer Maternal and Child Health
MSD	Medical Supplies Division
MSG	Mothers Support Groups
MYP	Multi Year Plan
NCCP	National Cancer Control Programme
NCFH	National Committee on Family Health
NCD	Non Communicable Diseases
NGO	Non-Governmental Organization
NMRA	National Medicines Regulatory Authority
NSACP	National Sexually Transmitted Infections and AIDS Control Programme
OOPE	Out of Pocket Expenditure
PDHS	Provincial Director of Health Services
PGIM	Postgraduate Institute of Medicine

PHC	Primary Health Care
PHNS	Public Health Nursing Sister
PHM	Public Health Midwife
PMCU	Primary Medical Care Units
PSE	Pre-service Training
QA	Quality Assurance
QI	Quality Improvement
QOC	Quality of Care
RBM	Results Based Management
RDHS	Regional Director of Health Services
RFP	Request For Proposals
RHMIS	Reproductive Health Management Information System
RMSD	Regional Medical Supplies Division
RSPHNO	Regional Supervisory Public Health Nursing Officer
RTI	Reproductive Tract Infections
SBE	Self-Breast Examination
SDG	Sustainable Development Goals
SEARO	South East Asia Regional Office
SLCOG	Sri Lanka College of Obstetricians and Gynaecologists
SLDCS	Sri Lanka Diabetes and Cardiovascular Study
SLDHS	Sri Lanka Demographic and Health Survey
SLR	Sri Lanka Rupee
SOP	Standard Operating Procedures
SPHM	Supervising Public Health Midwife
SMS	Short Message Service
STI	Sexually Transmitted Infections
SWOT	Strengths Weaknesses Opportunities Threats
TAC	Technical Advisory Committee
TOR	Terms Of Reference
TWG	Thematic Working Groups
VIA	Visual Inspection with Acetic acid
WHO	World Health Organization
WWC	Well Woman Clinic
WWP	Well Woman Programme
UNFPA	United Nations Population Fund

CONTENTS

1. EXECUTIVE SUMMARY

Like in other parts of the world Sri Lanka is also facing a rising trend in the incidence of Non-Communicable Diseases (NCDs) and deaths attributable to these conditions. To compound the problem, Sri Lanka has one of the fastest aging populations in Asia. To address these challenges the Ministry of Health (MoH) commenced the Well Woman Programme (WWP) in Sri Lanka in 1996. The Well Woman Clinics initially screened women between 35 and 60 years for hypertension, diabetes, breast abnormalities, cervical abnormalities, family planning status, menstrual disorders and reproductive tract infections (RTI), and perimenopausal/menopausal problems. Cervical screening is carried out using the Papanicolaou (Pap) smear. In 2007, the FHB based on the epidemiological evidence, decided to screen cohorts of females reaching the age of 35 years. The conditions screened for at the Well Woman Clinic (WWC) have been expanded to the following nine conditions, namely, hypertension, nutritional status, diabetes, breast abnormalities, thyroid gland abnormalities, cervical abnormalities, FP status, menstrual disorders and reproductive tract infections (RTI), and perimenopausal/menopausal problems. Breast, cervical and thyroid cancers are the leading cancers in Sri Lankan women.

The WWP has encountered several challenges, namely, absence of a clear strategic vision that drives the WWP at national, provincial and district level; poor coverage; insufficient equity responsive service delivery; dichotomy between awareness and utilization of services; human resources constraints; inadequate basic health infrastructure; weak referral system; inadequate health financing; lapses in the quality of services; weak coordination and coherence between partners; weak monitoring and supervision, and; inadequate demand creation for WWC services.

After more than twenty years of operations, the case for changing the trajectory of the WWP is strong for the following reasons. Firstly, to address the gaps that have been identified during the implementation of the WWP. Secondly, it is necessary to use the limited resources available to increase coverage, quality, efficiency, effectiveness and sustainability. Thirdly, the WWP intends to transition from cervical cytology screening to HPV testing. HPV testing is being carried out as a pilot in Kalutara district. Last year the Epidemiology Unit introduced HPV vaccination for girls in Grade six. Because of these dual prevention methods it is now possible to envisage a world where cervical cancer has been eliminated. Fourthly, the expansion of the private sector provides several opportunities to increase coverage, improve quality and reduce costs. Hence, the case for change and acceleration is commanding.

The structure of the Well Woman Clinic Strategic Plan is in line with the recent strategies of the FHB such as the National Strategic Plan and Newborn Health Strategy 2917-2025 and the National Strategic Plan on Child Health in Sri Lanka 2018-2025. This Strategic Plan is anchored within the National Strategic Framework for Development of Health Services (2016-2025), the National Multisectoral Action Plan for the Prevention and Control of Non Communicable Diseases (2016-2020) and the National Policy and Strategic Framework on Cancer Prevention and Control- Sri Lanka 2015. The Strategic Plan is also motivated by the nation's commitments made at the international and regional forums; the Sustainable Development Goals (SDG) 2016-2030; the Global Strategy for Women's, Children's and Adolescent's health 2016-2030, and; the WHO Director General's global call to action towards the elimination of cervical cancer.

The Strategic Plan has prioritized the following areas; screen for the three leading cancers in women in Sri Lanka, namely, breast, cervical and thyroid cancer; shift from cytology based cervical screening to HPV testing; focus on locations and populations where the greatest impact will be felt, and; a health system strengthening approach.

The process for developing the Strategic Plan included a detailed document review, key informant interviews and small group discussions. This was followed by analysis of the data, which included a stakeholder analysis and SWOT analysis, preparation of the draft plan, review and finally approval.

VISION

SRI LANKAN WOMEN EMPOWERED TO LIVE HEALTHY AND PRODUCTIVE LIVES

GOAL

BY 2023, EVERY WOMAN IN THE TARGETED AGE COHORTS, ESPECIALLY THOSE FARTHEST BEHIND, HAS UTILIZED QUALITY WELL WOMAN CLINIC (WWC) SERVICES

TARGETS

1. Increase the number of WWCs providing all 9 signal functions to 100 percent;
2. Increase the number of functional WWCs to one per 15,000 population;
3. Increase the coverage of 35 year cohort attending WWCs from 53 percent to 80 percent;
4. Increase the coverage of 45 year cohort attending WWCs to 60 percent;
5. Increase the proportion of women undergoing clinical breast examination to 80 percent;
6. Increase the proportion of women undergoing thyroid examination to 80 percent;
7. Increase the proportion of women undergoing Pap smear /HPV testing in the 35 year age cohort to 80 percent;
8. Increase the proportion of women undergoing Pap smear / HPV testing in the 45 year age cohort to 60 percent;
9. Reduce the percentage of "unsatisfactory smears" to ≤2 percent;
10. Increase the percentage of women undergoing Pap smear /HPV testing who receive their report in 30 days or less to 90 percent.

GUIDING PRINCIPLES

Ten guiding principles have been articulated to guide the development and implementation of the Strategic Plan.

1. Good leadership and governance
2. Leave no one behind
3. Focus on equity and universal coverage
4. Transparency and accountability for results
5. Compassionate, respectful and competent human resource
6. Community engagement, empowerment and ownership
7. Evidence based interventions and appropriate technology
8. Excellence in quality improvement and assurance
9. Multisectoral and partnership collaboration and ownership
10. Balance between population-based and individual approaches

STRATEGIC OBJECTIVES

The Strategic Plan comprises of six Strategic Objectives.
These Strategic Objectives are to be achieved by implementing selected strategies and activities.

STRATEGIC OBJECTIVE 1: WIN SUPPORT FOR THE WELL WOMAN PROGRAMME FROM DECISION MAKERS

The Strategic Objective focuses on creating an enabling environment that is favourable for the implementation of the WWP and strives to engage all stakeholders and key players.

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HUMAN PAPILLOMA VIRUS BASED SCREENING

The transition from Pap smear screening to HPV testing is addressed by the Strategic Objective. It also discusses the strengthening of the cytology based screening programme which will be used to check on HPV positive results.

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS TO MAXIMIZE THE OUTCOMES OF THE WELL WOMAN PROGRAMME

This Strategic Objective identifies the areas in the health system that requires strengthening to implement the Strategic Plan.

STRATEGIC OBJECTIVE 4: INCREASE COVERAGE AND EQUITY OF THE WELL WOMAN PROGRAMME

The best methods and approaches to provide equity responsive services to different populations in different locations are identified.

STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WELL WOMAN PROGRAMME

The focus is on improving the quality of services provided through the WWP so that they are more client oriented.

STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WELL WOMAN SERVICES, ESPECIALLY CERVICAL CANCER SCREENING

This Strategic Objective aims to change behaviour of women not only by directly addressing them but also indirectly by sensitizing males and raising awareness in communities about the WWP.

Subsequently developing a Multiyear Costed Implementation Plan and a Results Based Management (RBM) plan is in the pipeline for the Well Woman Programme for better and strategic programme design and delivery including a solid Monitoring and Evaluation plan. This will provide the guidance as in what should be considered during planning, management and evaluation of activities with all actors on the ground, contributing directly or indirectly to achieving the results, ensuring that their processes and services contribute to the achievement of desired results (outputs, outcomes and goals).

A set of core and standardized indicators have been identified, with benchmarks and targets to monitor the implementation of the Strategic Plan. Annual reviews at district and national level will be conducted. A mid-term evaluation will be conducted in 2021 and a final evaluation at the end of 2023. The key roles and responsibilities of partners and stakeholders for the WWP are also presented.

2. A DEFINING MOMENT

Like in other parts of the world Sri Lanka is also facing a rising trend in the incidence of Non-Communicable Diseases (NCDs) and deaths attributable to these conditions. To compound the problem, Sri Lanka has one of the fastest aging populations in Asia. Life expectancy at birth is 78.8 years for females and 72.1 years for males. Moreover, gender roles and norms can greatly affect exposure to risk factors and health outcomes of the major NCDs in Sri Lanka.

The far-sighted approach of the Ministry of Health (MoH) in addressing these new challenges led to the introduction of the Well Woman Programme (WWP) in 1996, exclusively for women between the ages of 35 and 60 years of age. The objective of the WWP was to screen women for selected health conditions, namely, diabetes, hypertension, breast and cervical cancer in order to detect these conditions early and to downstage cancer and reduce mortality and morbidity. Health education on menopause, sexually transmitted diseases/ human immunodeficiency virus (STI/HIV), nutrition and when appropriate family planning (FP) services were also provided.[1] The Family Health Bureau (FHB) was responsible for implementing the WWP island wide.

In 1994 Sri Lanka embraced the International Conference on Population and Development's (ICPD) Programme of Action resulting in the formulation of the Population and Reproductive Health Policy in 1998 two years after the Government launched the WWP. One of the eight goals of the Population and Reproductive Health Policy was to "Ensure safe motherhood and reduce reproductive health system related morbidity and mortality".[2] Reproductive tract malignancies were recognized as one of the conditions that needed to be addressed by the new Policy. The United Nations Population Fund (UNFPA) provided financial and technical assistance for the fledgling WWP.

The Strategic Plan for the WWP 2019-2023 comes at a critical moment in the history of cervical cancer, one of the nine conditions screened for at Well Woman Clinics (WWC). There have been two important technological advances in relation to cervical cancer. Primary prevention of cervical cancer is possible by Human Papilloma Virus (HPV) vaccination and secondary prevention has been boosted by HPV testing. Therefore, it is now possible to envisage a world where cervical cancer has been eliminated by scaling up these two prevention methods. By seizing this moment, it is possible to eliminate cervical cancer by 2030 as a public health problem.

1. Guidelines for implementation of the Well Woman Clinic Programme. FHB/FE/05/98
2. Policy repository of Ministry of Health Sri Lanka - Colombo ; Ministry of Health . 2016

3. SITUATIONAL ANALYSIS

The conditions screened for at the WWC have been expanded to the following nine conditions, namely, hypertension, nutritional status, diabetes, breast abnormalities, thyroid gland abnormalities, cervical abnormalities, FP status, menstrual disorders and reproductive tract infections (RTI), and perimenopusal/ menopausal problems. Breast, cervical and thyroid cancers are the leading cancers in Sri Lankan women. A succinct account of the different conditions addressed by the WWC is found in Annex 1.

The burden of morbidity and mortality from these conditions compromises quality of life, as well as sexual and reproductive health. These conditions impose a substantial strain on the budgets of both households and the health system.

- **THE THREE LEADING CANCERS IN WOMEN OVER 35 YEARS ARE BREAST (25.2%), THYROID (11.2%) AND CERVICAL CANCERS (8.6%) (SOURCE : NATIONAL CANCER CONTROL PROGRAMME 2014)**
- **UNMET NEED FOR CONTRACEPTION FOR LIMITING PURPOSES IS HIGHEST AMONG CURRENTLY MARRIED WOMEN IN THE 35-39 AGE GROUP (5.6 PERCENT) AND GRADUALLY DECLINES WITH AGE (SOURCE: SLDHS 2016)**
- **THE PERCENTAGE OF DEMAND SATISFIED BY MODERN METHODS IN THE 35-39 AGE GROUP IS 77 PERCENT (SOURCE: SLDHS 2016)**
- **OF THE 127 MATERNAL DEATHS IN 2017, 24 DEATHS TOOK PLACE IN WOMEN BETWEEN 36-40 YEARS AND 5 DEATHS WERE IN WOMEN OVER 40 YEARS OF AGE (SOURCE: FHB 2018)**

ORGANIZATION OF THE WELL WOMAN PROGRAMME

In order to maintain standards of care and uniformity of services provided by the WWP, the FHB issued guidelines in 1999. Women found to have high blood pressure or sugar in the urine were referred to specialist clinics in the district. All women who attend the WWC are taught self-breast examination (SBE) and encouraged to do so every month at home. The Pap smear slides are sent to the nearest designated hospital with a pathology laboratory for screening and reporting back. Pap smear results are sent direct to the Medical Officer of Health (MOH) office and women are notified of the result through the Public Health Midwife (PHM). Women with abnormal smears are referred to a gynaecology clinic for evaluation and treatment. The need for proper counselling of women found to have any abnormalities is stressed to health workers.

Based on the epidemiological evidence, a decision was made in 2010 to screen cohorts of females reaching the age of 35 years. However, other women who voluntarily request screening would also be provided with services.

The WWP is an integral part of the Family Health Programme. The National Committee on Family Health (NCFH) is the highest-level policy making and decision-making body for the Family Health Programme in Sri Lanka. It is chaired by the Secretary, Ministry of Health, Nutrition and Indigenous Medicine. The Technical Advisory Committee (TAC) has oversight of the WWP and is chaired by the Deputy Director General of Public Health Services II (DDGPHS II). The Gender and Women's Health Unit (G&WHU) at the Family Health Bureau (FHB) is the focal point at the national level in the MoH for the WWP and comes under the DDGPHS II.

The FHB works in close collaboration with the Health Promotion Bureau (HPB), National Cancer Control Programme (NCCP), Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) and College of Pathologists of Sri Lanka (CPSL). The laboratories in which cytoscreening is carried out comes under the purview of the Deputy Director General of Laboratory Services (DDGLS).

At the provincial level the Provincial Director of Health Services (PDHS) and the Regional Directors of Health Services (RDHS) in charge of the districts are responsible for providing health care. Each district has several divisions which are managed by the MOHs. Assistant Medical Officer of Health (AMOH) Public Health Nursing Sister (PHNS), Supervisory Public Health Midwife (SPHM) and Public Health Midwives (PHM) assist the MOH in conducting the WWCs. PHNS assist the MOH in examination of clients. Health education and other functions such as record keeping are carried out by PHNS, SPHMs and PHMs. PHMs play a key role in motivating clients to attend WWC as well as provision of health education at the household level.

Meanwhile, the Healthy Lifestyle Clinics (HLCs) were introduced in 2011 to provide NCD screening services for both men and women mainly at Primary Medical Care Units (PMCU). They are staffed in most places by one medical officer (MO) and one health assistant and/ or a dispenser. The main service objective of the HLCs is to reduce the risk of NCDs by detecting risk factors early and improving access to specialized care for those with NCDs. The HLCs refer women to the WWC for Pap smears.

The WWC guidelines issued in 1999 were revised and circulated in early 2018.[3] MOH and heads of institutions are expected to establish at least one WWC per 15,000 population to serve women between 35-60 years of age. The 45-year age cohort was also included in screening for cervical cancer. MOHs are expected to achieve 80 percent cervical cancer screening coverage in each of the two target age groups. In addition to the public sector WWCs, some private sector hospitals and the Family Planning Association of Sri Lanka (FPASL) also conduct WWCs.

The WWP intends to introduce HPV testing as the country's primary screening method replacing cervical smears which is the current screening modality. Centres to carry out HPV testing will be determined in due course.

3. Guidelines for implementation of the Well Woman Clinic Programme. FHB/FE/05/98

CHALLENGES FACED BY THE WELL WOMAN PROGRAMME

The WWP faces several challenges and are briefly discussed in the following paragraphs.

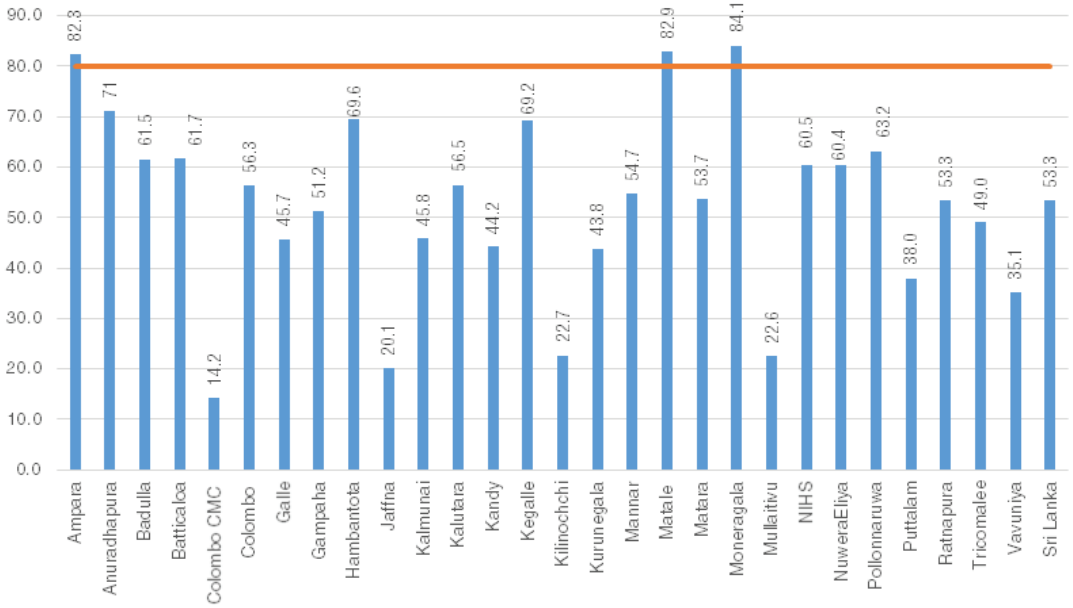
ABSENCE OF A CLEAR STRATEGIC VISION THAT DRIVES THE WWP AT NATIONAL, PROVINCIAL AND DISTRICT LEVEL

At present the WWP lacks a clear strategic vision which should provide medium to long term direction, delineates the activities to be pursued and the capabilities the programme needs to acquire so as to achieve its objectives.

POOR COVERAGE

Despite over twenty years of implementation of the WWP, coverage of the target population leaves much to be desired. Over the years the number of WWC has increased from 611 in 2015 to 980 in 2017. Even though the WWP has been in existence for over two decades, the attendance at almost 1000 clinics by the 35 year cohort is only around 50 percent, falling short of the target of 80 percent attendance. (Figure 1)

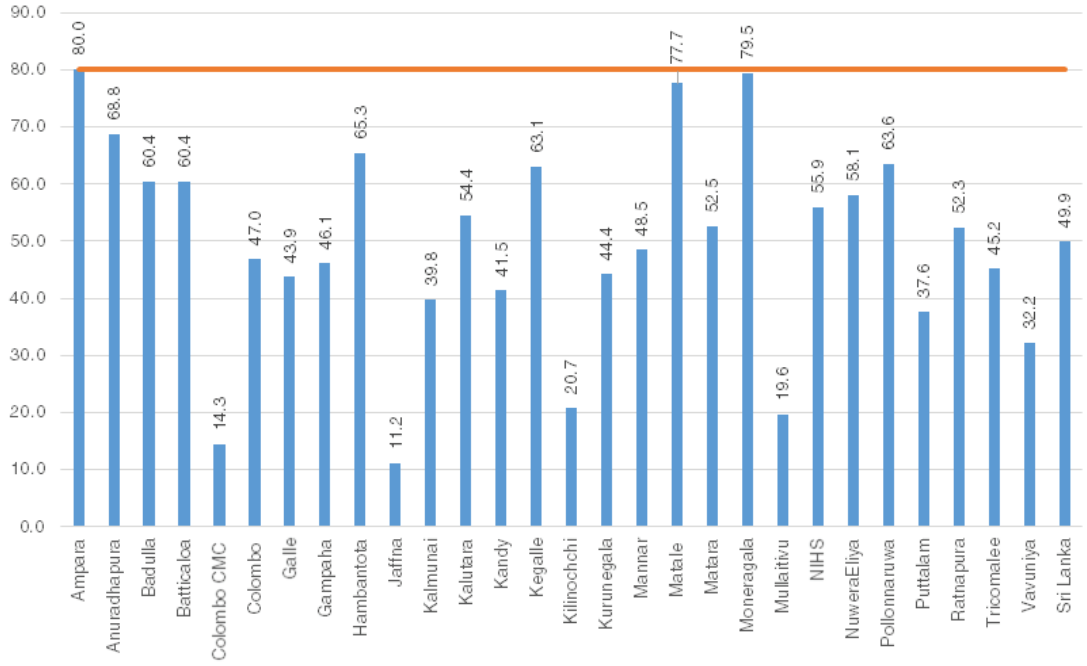
Figure 1: Percentage of 35 year cohort attendance at WWC



Source: eRHMIS 2017

Only 50 percent of women in the 35 year age cohort attending the WWCs had a Pap smear taken in 2017.

Figure 2: Percentage of 35 year cohort coverage with Pap smear



Source: eRHMIS 2017

The WHO STEPS Survey conducted between July 2014 and May 2015 also showed that cervical cancer screening coverage was low. The percentage of women aged 30-49 years who have ever had a screening test for cervical cancer was only 24.5 percent.[4] The target to be achieved by 2030 is to double the coverage.

REGIONAL DISPARITIES

As can be seen from Figures 1 and 2 there are marked disparities in attendance and coverage of Pap smears between districts. The attendance and coverage in the districts in the north are the worst. Surprisingly, attendance and coverage of Pap smears is also poor in the Colombo Municipality.

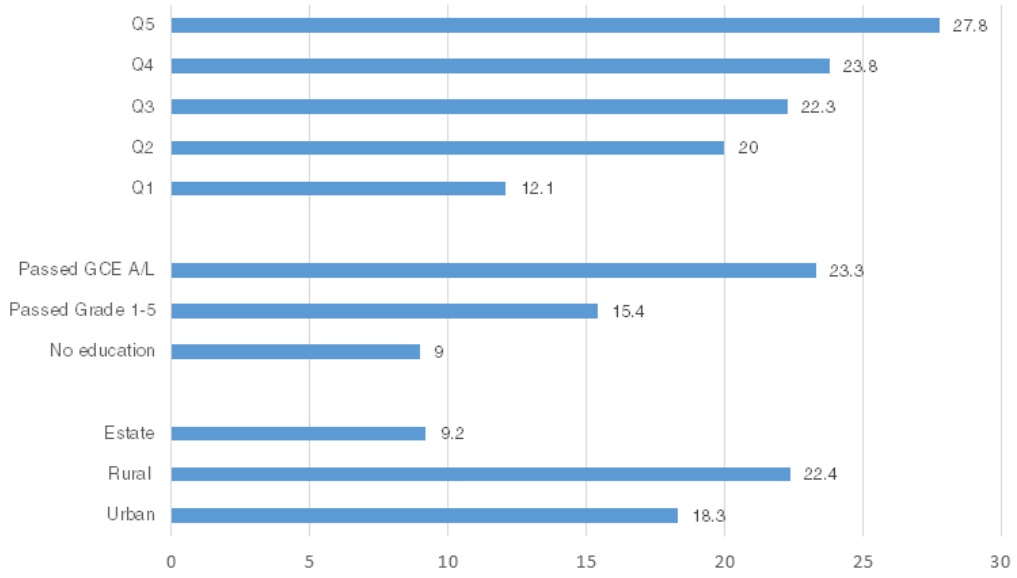
There are several reasons for the districts in the north and the CMC to have poor coverage. There is a severe shortage of human resources for health, especially PHMs throughout the country but particularly in the northern province and in the CMC. Because of this some PHMs have to cover one or two vacant midwife areas in addition to their own area. In the programme, PHMs are expected to visit homes and invite women to Well Woman Clinics. But due to the shortage of PHMs many women are not notified and the lack of awareness also leads to poor coverage. A two district study on the cervical screening programme in 2018 clearly pointed out that the shortage of midwives affected the WWP (Fernando 2018 unpublished data). To complicate matters, in the CMC, people living in slums frequently change their residence, hence tracking them is not an easy task. Thus they fail to be registered by the PHM. Another reason for the regional disparities is the lack of awareness. (See page 12, section on “Inadequate demand creation for Well Woman Clinic Services).

4. WHO Steps Survey http://www.who.int/ncds/surveillance/steps/STEPS-2015-Fact-Sheet-Sri-Lanka.pdf (Accessed 8.7.2018)

INADEQUATE EQUITY RESPONSIVE WELL WOMAN CLINIC SERVICES

Health outcomes are worse when people are poor, less educated, marginalized and live in underserved areas. The 2016 Sri Lanka Demographic and Health Survey (SLDHS) data show that the prevalence of the use of Pap tests increases with the level of education of the woman and by the wealth quintile of the household in which the woman resides. (Figure 3) By place of residence, the prevalence of the use of the Pap test is lowest in the estate sector (9 percent) followed by the urban areas (18 percent) and highest in the rural areas (22 percent).

Figure 3: Percentage of ever married women age 15 -49 who ever had a Pap test by wealth, education and place of residence



Source: 2016 SLDHS

DICHOTOMY BETWEEN AWARENESS AND UTILIZATION OF WELL WOMAN CLINIC SERVICES

The 2016 SLDHS found that only 71 percent of ever married women had heard about WWC. Women from the urban and rural sectors have higher awareness about the WWCs than those from the estate sector (61 and 74 percent for urban and rural respectively, compared to only 32 percent for the estate sector). However, women in the 35-39 age group who had attended a WWC and had a Pap smear were only 56 percent and 41.7 percent respectively.

Quality of services is just one of the issues for the dichotomy. It is not the only cause. Insufficient health workers, especially PHMs is an important cause as pointed out before as they are responsible for motivating women in the 35 and 45 age cohorts to attend the WWC.

In addition, the WWC BCC strategy has not been fully implemented by HPB yet. Mere awareness on its own does not lead to a change of behaviour and use of services. There should be an effective community mobilization effort for the expected behaviour change.

Furthermore, even if women are aware of the WWP the services, they are not readily available or the timing of the clinics is inconvenient, especially for poor working women. That is why the government wants to establish at least 1 WWC per 15,000 population. Another measure the government is taking in this regard is the referral of eligible women from Healthy Lifestyle Clinics for Pap smears to the WWC (both these initiatives are part of the “Highly Prioritized Actions for 2018-2020 for the National

Multisectoral Action Plan 2016 - 2020"). To make utilization of services easier, the many MOHs are currently conducting mobile WWCs for women in remote rural areas and for working women in factories and offices where women form the majority of the workforce.

HUMAN RESOURCES CONSTRAINTS

The cadre required for delivery of public health services in Sri Lanka has been identified.[5] Although the numbers of health workers has improved, it is still inadequate for optimum delivery of the WWP. The workforce is constrained by the unequal distribution and inappropriate skill mix of human resources. There is inequitable distribution of personnel between districts and even within districts. The discrepancies have been difficult to overcome given that the "difficult" districts have the least capacity to recruit and retain qualified staff and to provide additional incentives to attract personnel.

According to the current staffing norms the population per PHM area should be approximately 3000. However, there are some PHM areas, particularly in municipal councils, where this norm is surpassed. In some districts, there are vacant PHM areas. It is the PHM who is expected to identify women in the 35 and 45 age cohorts using the Eligible Couples Register, create community awareness and motivate women to attend the WWC through one to one interaction during the home visits. The evaluation conducted in two districts showed that inadequate numbers of PHMs was a major constraint in motivating women to come for screening. In order to increase coverage of WWC services an annual award ceremony for best performance was initiated in 2011 with the aim of motivating and encouraging staff. This strategy has produced encouraging results.

In addition to PHMs, there are shortages of MOHs, AMOHs and PHNSs who are required to conduct the WWC. Inadequate staff at clinics leads to long waiting time and dissatisfactions of clients. The shortage of MOHs, PHNSs, SPHMs also impacts on supervision and therefore invariably the quality of services suffers. It is a fact that all planned supervisory visits may not be carried out and supervision may be superficial as not all aspects can be observed due to time constraints.

The number of Medical Laboratory Technologists (MLT) trained as cytoscreeners is inadequate. These MLTs in addition to cytology screening have to carry out other functions in the pathology laboratory.

There are very few trained colposcopists in the country as well.

INADEQUATE BASIC HEALTH INFRASTRUCTURE IN WELL WOMAN CLINICS

Geographical access to WWC has increased. However, some of the clinics are located in unsuitable buildings as they are not purpose built. Many clinics are poorly maintained and lack basic amenities such as water, adequate seating in waiting areas and provision of auditory and visual privacy.

WEAK REFERRAL SYSTEM

The referral system is weak. Women who are detected with abnormalities are referred to the appropriate clinic in the nearest hospital. However there is no back referral system. To address this deficiency the WWP has recently introduced a "Follow up Register" to follow up women detected with abnormalities, especially cancers.

INADEQUATE HEALTH FINANCING

The central government through the MoH funds the WW services provided by the provincial health authorities. Services are provided free of charge at WWC. However, poor women have to bear transport costs and loss of wages in the case of those employed in the informal sector.

5. MoH Circular FHB/DIR/GF/2012 dated 26.03.2012. – Criteria for deciding cadres of health staff for Public Health Services in Sri Lanka.

The National Health Accounts 2013 found that total health expenditures accounted for 3.2 percent of the Gross Domestic Product (GDP) and per capita current health expenditure was Rs. 12,636 (97.20 US$).[6] The government was responsible for providing 55 percent of total current health expenditure, while households out of pocket expenditure (OOPE) contributed for a further 40 percent. Almost all health expenditure on prevention and public health services is funded by the Government with the private sector playing a minimum role. Government healthcare is mainly financed by general taxation revenue. Funds for the provincial health services are channelled through the Finance Commission.

The bulk of private sector financing consists of OOPE. Typically these include doctors' consultation fees, purchases of medication, costs of laboratory services, and hospital bills. Expenditure on health-related transportation are excluded from the OOPE calculations. Expenditure by companies to provide health care and medical benefits to their employees is another source of private financing. The contribution from private health insurance as a share of private financing has gradually increased and is around 6 percent. The government has commenced a health insurance scheme - Agrahara – managed by the National Insurance Trust Fund for pensionable public sector employees and their dependants.

LAPSES IN THE QUALITY OF SERVICES

Concerns about poor quality can be placed under two categories:

1. Client perspective
2. Professional/technical perspective,

Client satisfaction with the quality of healthcare is based on considerations such as: promptness of attention, good staff attitude, respect for patients and their rights, confidentiality and privacy, provision of adequate information, availability of drugs and other logistics and a clean clinic environment. Impolite staff and lack of personalised service are frequent complaints levelled at the public sector. Frequent trade union action leads to breakdown of services and dissatisfaction with public sector services. Cultural and linguistic barriers between service providers and clients act as an obstacle to effective communication and delivery of quality services.

Inadequate funds are allocated for facility infrastructure maintenance. Staff numbers are inadequate and available personnel are de-motivated by poor working conditions. There are no management committees in the preventive sector though there are hospital committees in the curative sector.

There are several quality issues related to cervical cytology screening. The evaluation of the cervical cancer screening component found that there is a 2-3-month period between smear taking and delivery of reports. Sometimes the gap may be even longer since the MLTs and the pathologists in certain centres are overloaded with their other routine work. Moreover, there are disparities in the number of Pap smears done and the reports received. Though laboratories are expected to re-screen 10 percent of negative smears very few laboratories do so. While there are national guidelines for cervical cytology screening and reporting they do not stipulate the quality control measures to be practiced in the laboratories (Basu P. National Cervical Cancer Control Program of Sri Lanka – Status Review & Suggestions for Reorganization. 2012, unpublished).

WEAK COORDINATION AND COHERENCE BETWEEN THE DIFFERENT UNITS OF THE FAMILY HEALTH BUREAU AND PROGRAMMES AND AGENCIES WITHIN THE MINISTRY OF HEALTH

Weak coordination and coherence between the FHB and other Programmes and Agencies within the MoH leads to activities not being carried out at the optimal time so as to gain from synergies. The TAC has been established to minimise such occurrences. One of the reason for this weakness is the insufficient financial resources allocated to the different agencies to mount a coordinated response.

6. Health Economics Cell, Ministry of Health, Nutrition & Indigenous Medicine Sri Lanka (2016). Sri Lanka National Health Accounts 2013. The Ministry of Health, Sri Lanka, Colombo

WEAK MONITORING AND SUPERVISION

Weak supervision is due to several factors, chief among which is the shortage of supervisory staff. Each SPHM is expected to carry out 10 supervision visits a month while the MOH and PHNS are expected to conduct 6 visits per month. Advanced supervision plans are prepared by supervisory staff but many are unable to keep to the schedule due to competing demands on time. Lack of transport is also cited as a reason contributing to poor supervision. Joint supervision is conducted from district level to divisional level but is weak. No mechanisms exist for supervision of the private sector by MoH.

INADEQUATE DEMAND CREATION FOR WELL WOMAN CLINIC SERVICES

Inadequate knowledge in communities is often influenced by socio-cultural factors or lack of correct and appropriate information. The Health Promotion Bureau (HPB) in collaboration with the FHB has developed a Behaviour Change Communication (BCC) Strategy Guide for the WWP. This work was funded by UNFPA.

There was a wide variation in awareness of WWC among districts. The SLDHS 2016 found that over 90 percent of women in Moneragala had heard of WWC while the lowest awareness was in Jaffna (14 percent). In Mannar, Mullaitivu and Killinochchi awareness of WWC was below 20 percent. Only 73 percent of ever married women aged 15-49 correctly identified 35 years as the age women should attend WWC. Of the women living in the estate sector only 59 percent recognized 35 as the age women should attend the WWC compared to 65 percent of women in the urban and 74 percent in the rural areas. Awareness was higher among the more educated women and those from the richest quintiles.

CHANGING THE TRAJECTORY OF THE WELL WOMAN PROGRAMME

After more than twenty years of operations of the WWP, the case for change and acceleration is strong for the following reasons. Firstly, to address the gaps that have been identified during the implementation of the WWP.

Secondly, limited resources for the public health sector due to competing demands has necessitated the need to get the “best bang for the buck” so as to increase coverage, quality, efficiency, effectiveness and sustainability.

Thirdly, the WWP is considering shifting from cervical cytology as the primary screening method to HPV testing for cervical cancer. FHB is currently piloting HPV testing in Kalutara district. Experience from both developed and developing countries show there are considerable advantages in HPV testing over the current cytology based screening used in the WWP.

Fourthly, improvements in purchasing power of the population in Sri Lanka coupled with actual and perceived gaps in quality and availability of public health services has contributed to increased demand for health services delivered by the private sector. The expansion of the private sector provides several opportunities. Working with the private sector can increase coverage, improve quality and reduce costs. Generally speaking, the form and scope of government engagement with the private sector is limited and does not seem to be in accordance with the importance of the latter. However, there is proof that the privates sector is willing to support the WWP. For instance, Lanka Ashok Leyland is to provide two custom made vehicles to conduct mobile clinics.

The Strategic Plan is anchored in the National Strategic Framework for Development of Health Services 2016-2025, the National Multisectoral Action Plan for the Prevention and Control of Non-Communicable Diseases 2016-2020 and the National Policy and Strategic Framework on Cancer Prevention and Control- Sri Lanka 2015. This Strategic Plan is also motivated by Sri Lanka’s commitments made at international and regional forums. Accelerated action to address the 2023 targets of this Strategic Plan

will enhance progress relating to three of the 13 health related targets of the 2030 Agenda for Sustainable Development Goals (SDGs).[7] Other important initiatives the Strategic Plan addresses are the Global Strategy for Women, Children's and Adolescent Health 2016-2030; the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; the World Health Organization (WHO) Global action plan for the prevention and control of Non-communicable Diseases 2013-2020; the WHO South East Asia Regional Office (SEARO) Action Plan for the Prevention and Treatment of Non-Communicable Diseases in South East Asia 2013-2020, and; the WHO Director General's global call to action towards the elimination of cervical cancer.[8]

PRIORITIZED ISSUES AND AREAS

The Strategic Plan has prioritized the following areas.

1. Screen for the three leading cancers in women

The Strategic Plan focuses primarily on screening for the three leading causes of cancer in females (i.e. breast, thyroid gland, cervical cancer) that require immediate attention for control and can be monitored.

2. Shift from cytology based cervical screening to HPV testing

Secondary prevention by screening, together with primary prevention by HPV vaccination, will contribute to elimination of cervical cancer from Sri Lanka in the future. The investments the country makes now on these two initiatives will reap rich dividends in the coming years, not only in monetary terms but also by reducing human suffering. WHO has identified screening and treatment of precancer as one of the "best buys" a country can invest in.[9]

3. Focus on locations and populations where the greatest impact will be felt

Principles of leaving no one behind and reaching the furthest behind first permeates the Strategic Plan. People left behind in fragile communities will be prioritized by the Strategic Plan. Although the pace needs to quicken in all districts, focused and accelerated efforts are especially needed in the north and east of the country, the estate sector and women in poor socio-economic circumstances.

4. A health system strengthening approach

The Strategic Plan has made a paradigm shift from service delivery to supporting evidence informed system strengthening in targeted areas to influence policy, planning, budgeting. This approach will inform the Government's drive to increase equitable access to services.

The benefits of the Strategic Plan will have long term benefits for women, children, partners, families and societies. Poor health among women has implications for labour force participation, productivity, earnings, family income and economic wellbeing. Women free from ill health will be able to participate in the productive workforce and contribute to reduction of poverty. Healthier women contribute to better-educated and more productive societies.

The Strategic Plan will be a guiding policy document for all stakeholders and will assist in effective, efficient, monitoring and evaluation of interventions.

---

7. SDG 3: Ensure healthy lives and promote wellbeing for all at all ages http://www.who.int/sdg/targets/en/ (Accessed 18.10.2018)
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
8. WHO Director General WHO Director-General calls for all countries to take action to help end the suffering caused by cervical cancer. May 19 2018. https://www.who.int/reproductivehealth/call-to-action-elimination-cervical-cancer/en/ (Accessed 15.10.2018)
9. From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries. World Health Organization and World Economic Forum 2011. https://www.who.int/nmh/publications/best_buys_summary.pdf (Accused 20.10 2018)

4. DEVELOPMENT OF THE WELL WOMAN PROGRAMME STRATEGIC PLAN

The development of the Strategic Plan for the WWP was initiated by the G&WHU of the FHB, Ministry of Health, Nutrition and Indigenous Medicine in mid -2018. Terms of reference (TOR) were prepared for the development of the Strategic Plan. A consultant was then identified to lead the process for the development of the Strategic Plan in collaboration with relevant stakeholders.

An extensive literature review was carried out of national policies, programmes, circulars issued by the FHB, technical guides, training materials and FHB Health Annual Reports, research finding on WWC in Sri Lanka, to identify issues, gaps and challenges with regard to the WWP. Once the information from the document review was compiled and synthesized the information was grouped into key technical issues. It also enabled an analysis of the categories of people with whom key informant interviews (KII) and small group discussions would be necessary. The document review also helped identify information gaps to be further explored during KII and small group discussions.

KII were conducted with a wide spectrum of stakeholders, e.g. managers at national and subnational levels, WWC service providers, MLT/cytoscreeners, representatives from professional associations and NGOs. KII were necessary to collect information that was not available from the desk review, to triangulate documentary evidence and other data and identity lessons learnt. The assistance of the FHB was sought in identifying the most appropriate key informants in each category to interview. Structured interview questionnaires were prepared for the different categories of stakeholders following the information gathered from the desk review. Each interview lasted for about 60 minutes.

Discussions were held with small groups of Officer in Charge and Pharmacists from Regional Medical Supplies Divisions (RMSD), Regional Supervisory Public Health Nursing Officers (RSPHNO) and Medical Laboratory Technologists (MLTs) who are trained as cytoscreeners.

The interest, support, influence and impact on the WWP of key stakeholders were identified. (Annex 2) The information from the desk review, KII, and small group discussions were categorized and it was possible to identify or imply strengths and weaknesses that are internal to the programme and opportunities and threats from the external environment, i.e. a SWOT analysis.[10] (Annex 3) All this information was then used to draft the Strategic Plan which was circulated to members of the TAC for comments.

10. Strengths, weaknesses, opportunities and threats in relation to the Well Women Programme

NATIONAL STRATEGIC PLAN 2019-2023 FOR THE WELL WOMAN PROGRAMME

5. NATIONAL STRATEGIC PLAN 2019-2023 FOR THE WELL WOMAN PROGRAMME

VISION

SRI LANKAN WOMEN EMPOWERED TO LIVE HEALTHY AND PRODUCTIVE LIVES

GOAL

BY 2023, EVERY WOMAN IN THE TARGETED AGE COHORTS, ESPECIALLY THOSE FARTHEST BEHIND, HAS UTILIZED QUALITY WELL WOMAN CLINIC (WWC) SERVICES

TARGETS

1. Increase the number of WWC providing all 9 signal functions to 100 percent;
2. Increase the number of functional WWCs to one per 15,000 population;
3. Increase the coverage of 35 year cohort attending WWCs from 53 percent to 80 percent ;
4. Increase the coverage of 45 year cohort attending WWCs to 60 percent;
5. Increase the proportion of women undergoing clinical breast examination to 80 percent;
6. Increase the proportion of women undergoing thyroid examination to 80 percent;
7. Increase the proportion of women undergoing Pap smear/HPV testing in the 35 year age cohort to 80 percent;
8. Increase the proportion of women undergoing Pap smear / HPV testing in the 45 year age cohort to 60 percent;
9. Reduce the percentage of “unsatisfactory smears” to ≤2 percent;
10. Increase the percentage of women undergoing Pap smear /HPV testing who receive their report in 30 days or less to 90 percent.

GUIDING PRINCIPLES

The formulation and implementation of this strategy are guided by the following principles.

GOOD LEADERSHIP AND GOVERNANCE: The MoH has the responsibility for establishing good governance and providing effective and good-quality health services for women.

LEAVE NO ONE BEHIND: A commitment to equity, non-discrimination and a human rights based approach

FOCUS ON EQUITY AND UNIVERSAL COVERAGE: Equitable and universal coverage of high-impact interventions are universally accessible to the marginalized and at risk population regardless of ethnicity, religion, political affiliation, disability, socio-economic status or geographical location.

TRANSPARENCY AND ACCOUNTABILITY FOR RESULTS: Effective, accessible, inclusive and transparent programme coverage and impact monitoring mechanisms and independent reviews are prerequisites for equitable coverage, quality of care and optimal use of resources. Interventions to enhance effective and efficient programme supervision, monitoring and coordination at all levels will be implemented.

COMPASSIONATE, RESPECTFUL AND COMPETENT HUMAN RESOURCE: The relationship of women clients with health care providers and the health system should be characterized by caring, empathy, trust, and an enabling environment for informed decision-making. This will in addition contribute to guaranteeing quality in WW services.

COMMUNITY ENGAGEMENT, EMPOWERMENT AND OWNERSHIP: Communities' participation in identifying the major problems, priority setting, planning, implementation and monitoring of policies and programmes that affect them is one of the most effective mechanisms for action and accountability. The Mother's Support Groups (MSG) and Mahila Samithi are good example of community engagement, empowerment and ownership. Male involvement, by raising awareness of women's health issues among men is crucial in order for them to support their wives to seek healthcare.

EVIDENCE BASED INTERVENTIONS AND APPROPRIATE TECHNOLOGY: The strategy also proposes the use of/scaling up of globally accepted and cost-effective innovations and technologies such as HPV testing, m-health and e-health in selected areas.

EXCELLENCE IN QUALITY IMPROVEMENT AND ASSURANCE: Working through the process of quality assurance (QA) and continuous quality improvement (QI) will create an environment for transforming the WWP as a key component of the health sector and achieving the health outcomes and goals described in this strategy.

MULTISECTORAL AND PARTNERSHIP COLLABORATION AND OWNERSHIP: This strategic plan will promote partnership and multi-sectoral collaboration and ownership of the planning and implementation of the WWP activities. This will avoid duplication, allow leverage and maximise available resources.

BALANCE BETWEEN POPULATION-BASED AND INDIVIDUAL APPROACHES: A comprehensive prevention and control strategy needs to balance an approach aimed at reducing risk factor levels in the population as a whole with one directed at high-risk individuals

The Strategic Plan comprises of six Strategic Objectives. These Strategic Objectives are to be achieved by implementing selected strategies. The Action plan with the strategies, key activities and sub-activities is found in Annex 4. The results framework for the Strategic Plan is found in Annex 5.

STRATEGIC OBJECTIVE 1:
WIN SUPPORT FOR THE WELL WOMAN PROGRAMME FROM DECISION MAKERS

STRATEGIC OBJECTIVE 1:
WIN SUPPORT FOR THE WELL WOMAN PROGRAMME FROM DECISION MAKERS

RATIONALE

As the epidemiological transition continues, the prevalence of the conditions that the WWP addresses will increase. These conditions greatly undermine national development as they worsen poverty and social inequalities. Unfortunately more attention and more resources are dedicated to curative care rather than to secondary prevention. There is therefore an urgent need to put the WWP on top of the development agenda and poverty alleviation strategies. This Strategic Objective will create a supportive environment for the WWP by:

1. Evidence based advocacy
2. Legislative change
3. Leverage partnerships
4. Raising the profile of the WWP

Critical areas for advocacy include:

1. Shifting from a cytology based screening programme to HPV testing;
2. Sufficient financial and human resources for the WWP;
3. Improving processes for implementation of the WWP.

Collecting evidence to analyse the cost benefit to show deaths averted will justify implementation of the WWP. This data will be made freely available to policy makers and other stakeholders.

Legislative change is necessary to make confirmed or suspected cases of breast, cervix and thyroid cancer in females, in both public and private sectors notifiable conditions. The primary purpose of notification is to achieve prevention and control of the diseases. It is a valuable source of information on incidence, prevalence, mortality and morbidity of the diseases. Notification will lead to improved awareness of common aetiological agents and better understanding of common preventable causes and better utilization of health resources. Notification will also result in better monitoring and evaluation of the effectiveness of cancer screening and cancer treatment programmes which ultimately might improve survival.

STRATEGIES

STRATEGY 1.1	**CONDUCT EVIDENCE BASED POLICY ADVOCACY AT NATIONAL AND SUBNATIONAL LEVELS TO REPOSITION THE WWP AS A NATIONAL PRIORITY**	
	Major activities	
	1.1.1	Influence government (Parliament, Ministries of Finance, Health and Local Government) on the need for introduction of HPV testing and the merits and demerits of this method over the current method - cervical cytology - and obtain their commitment;
	1.1.2	Influence the MoH to lobby WHO SEARO and health ministers from the region to introduce pooled procurement of HPV test kits and HPV vaccines so as to bring down costs;
	1.1.3	Influence the Ministry of Finance, MoH and Provincial Ministries of Health to recruit PHMs annually to reduce the current vacancies;
	1.1.4	Influence MoH and Provincial Ministries of Health to deploy midwives from institutions with few deliveries as PHMs as a temporary measures;
	1.1.5	Influence MoH and Provincial Ministries of Health to ensure equitable distribution of trained staff to MOH offices, especially underserved communities in estate, urban and rural areas;
	1.1.6	Influence the Ministry of Finance and MoH to encourage the private sector to provide WW services by granting special privileges such as tax concessions.
STRATEGY 1.2	**UPDATE LEGISLATION TO MAKE CONFIRMED OR SUSPECTED CASES OF FEMALE CANCERS (BREAST, CERVICAL AND THYROID) IN BOTH THE PUBLIC AND PRIVATE SECTORS NOTIFIABLE DISEASES.**	
	Major activities	
	1.2.1	Require compulsory reporting of confirmed or suspected cases of female cancers (breast, cervix and thyroid) in both public and private sectors.
STRATEGY 1.3	**RAISE THE PRIORITY STATUS ACCORDED TO THE WWP ACTIVITIES.**	
	Major activities	
	1.3.1	Representation through the Minister of Health to Cabinet with regards to the burden of cervical, breast, thyroid cancer, diabetes and hypertension, their social and economic impact on women and the need for the inclusion of prevention and treatment for these conditions in national development frameworks;
	1.3.2	Representation through Minister of Health to Cabinet with regards to Sri Lanka's commitments to the (a) Global Strategy for Women, Children's and Adolescent Health 2016-2030, (b) the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and (c) the Sustainable Development Goals;
	1.3.3	Periodic meetings with development partners such as World Bank, WHO and UNFPA to highlight the burden of cervical, breast, thyroid cancer, diabetes, hypertension on women and progress in implementation of the Strategic Plan.
STRATEGY 1.4	**PROMOTE AND ADVOCATE FOR A MULTISECTOR NATIONAL RESPONSE, COOPERATION AND PARTNERSHIP TO ELIMINATE CERVICAL CANCER AND STRENGTHEN THE WWP.**	
	Major activities	
	1.4.1	Identify and engage diverse stakeholders to support the WWP.

STRATEGIC OBJECTIVE 2:
TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HUMAN PAPILLOMA VIRUS BASED SCREENING

STRATEGIC OBJECTIVE 2:
TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HUMAN PAPILLOMA VIRUS BASED SCREENING

RATIONALE

Cervical screening is carried out using Pap smear, visual inspection of the cervix using acetic acid (VIA) and HPV testing. (Annex 6) A recent systematic review and meta-analysis confirmed the consensus that HPV testing is more sensitive than VIA or Pap smears.[11] Since the inception of the WWP in 1996 the Pap smear was used to screen for cervical cancer. Although Pap smear screening ushered in the decline in cervical cancer rates in the second half of the 20th century in industrial countries, it has proved difficult to establish and sustain in low- and middle-income countries (LMIC). Cytology while having a high specificity has a relatively low sensitivity which necessitates women to undergo repeat cytology on a regular basis to ensure precancerous lesions are detected. To function reliably, cytology screening require substantial infrastructure, highly qualified human resources and a well-defined quality control system which has proved to be costly and difficult to implement in LMICs. The same is true for Sri Lanka as cervical cytology has not been able to demonstrate tangible results. Some of the limitations of cervical cytology can be minimized by moving to HPV testing as standalone primary screening, since the test can be automated and interpretation is objective, thus not requiring subjective and tedious reading of thousands of cytology slides by cytoscreeners and additional pathology verification in some cases. HPV testing has a very high negative predictive value which means that screening intervals can safely be extended for women who are HPV negative. Another major advantages of HPV testing is that it can be done by the woman herself (self-sampling), without undergoing a gynaecological examination.

INITIATING THE CHANGE The shift from cervical cytology screening to HPV testing must be evidence based. Currently a pilot project is being conducted in Kalutara district using the Cobas 4800 HPV test system (Roche, Basel, Switzerland) which has been approved by the US Food and Drug Administration as a primary screening test.[12] Specimens are collected in special solutions using an endocervical brush and transported to the General Hospital, Kalutara, laboratory. The pilot will undergo rigorous evaluation and the results will be presented to the TAC. There are several phases in the process of introducing HPV testing that need to be considered.

PLANNING PHASE Firstly, approval of policy makers and firm commitment of financial resources and support are a prerequisite to introduction of HPV testing as the primary screening method in Sri Lanka.

---

11. Mustafa, R.A., Santesso, N., Khatib, R., Mustafa, A.A., Wiercioch, W., Kehar, R., ... Schünemann, H.J., 2016. Systematic reviews and meta-analyses of the accuracy of HPV tests, visual inspection with acetic acid, cytology, and colposcopy. Int. J.Gynecol. Obstet. 132, 259–265. https://doi.org/10.1016/j.ijgo.2015.07.024
12. The National Multisectoral Action Plan for the Prevention and Control of NonCommunicable Diseases 2016-2020 Desired outcome 3.1.1 has included pilot testing of HPV testing for cervical cancer screening. Pg 59.

Detailed planning for the introduction of HPV testing is necessary. An expert technical group needs to be convened comprising of representatives of the Colleges of Pathologists, Obstetricians and Gynaecologists and Community Physicians. WHO guidelines recommend cervical cancer screening for women aged 30 to 49 years.[13] The age cohorts to be screened will be the same as the current cytology screening programme i.e. 35 and 45 year age cohorts. The frequency of screening, procedure for collection and transport of HPV test samples to the laboratory, staffing norms for WWC, laboratories and colposcopy clinics need to be determined. The algorithm for managing screened women has been developed. (Annex 7) Indicators for programme monitoring and evaluation have also to be developed. The next step is to select a test that has been registered with the National Medicines Regulatory Authority (NMRA).

The TAC will require published evidence of the HPV tests benefits, including performance and cost effectiveness studies. While cost-effectiveness analyses clearly show the advantage of HPV testing[14] officials will need information on the costs anticipated for equipment, supplies, training providers and laboratory personnel, transporting specimens, providing laboratory space and maintaining the test kits. Typically only 10 -15 percent of all screened women will require follow-up care. This needs to be considered in the calculation of programme costs and the calculation of costs per person screened. Advocacy needs to stress that the prevention of invasive cancer, through HPV testing and treatment of precancerous lesions, in addition to HPV vaccination of girls will bring considerable savings from the reduced number of women who need cancer treatment and economic gains in preventing avoidable deaths. The G&WHU will prepare a detailed costed multiyear programme implementation plan.

Extensive consultations will be held with all stakeholders, ranging from policy makers in the MoH, Ministry of Finance, NSACP, NCCP, professional colleges, civil society organizations and the media. Involving the mass media to promote messages about HPV testing can help to obtain a greater commitment from the public and health providers when the programme is rolled out.

IMPLEMENTATION PHASE Once all the above are in place the programme will be launched on a small scale and expanded in line with available resources. The management team for the HPV screening programme will be located in the G&WHU. There are currently 350 MOH areas throughout the country. One WWC per 15,000 population will be established to increase access to screening. Informed consent will be sought from women undergoing HPV screening. Cervical specimens collected in the special solution will be sent to the designated laboratory. The locations of the laboratories will be decided later. HPV laboratory procedures will be determined such as quality control (QC) and quality assurance (QA) procedures including the flow of information and communication between the laboratory and the MOH. The DDGLS and the College of Pathologists of Sri Lanka (CPSL) will be responsible for the QA at these laboratories. Both internal and external quality control measure will be put in place. At the same time histology laboratories will be strengthened in order to examine and report on the biopsies taken at colposcopy clinics.

HPV test kits have expiry dates and therefore the logistics management aspects need to be considered when choosing the test for use in the conditions and context of the screening programme. Standard Operating Procedures (SOPs) for procurement, distribution and storage of equipment will be documented. The Regional Medical Supplies Divisions (RMSD) will be strengthened. The FHB will distribute the kits to the RMSDs who will in turn distribute to the MOHs in the district.

13. World Health Organization, 2013. WHO Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention. Available at. http://apps.who.int/iris/bitstream/10665/94830/1/9789241548694_eng.pdf?ua=1
14. Campos, N.G., Castle, P.E., Wright Jr., T.C., Kim, J.J., 2015. Cervical cancer screening in low-resource settings: a cost-effectiveness framework for valuing tradeoffs between test performance and program coverage. Int. J. Cancer 137 (9), 2208–2219. https:// doi.org/10.1002/ijc.29594

As mentioned above the protocol to be followed in the case of a positive or negative HPV test has been determined. HPV testing is only effective if the corresponding follow-up and treatment is provided to all women found to be HPV positive. In fact, appropriate follow-up care and treatment has a greater impact on mortality reduction than a high screening coverage.[15] There is a clear lack of diagnostic and treatment facilities for pre-cancer nationally. Such facilities must be developed at the same time as improving the screening programme. The development of colposcopy services will be carried out by the NCCP. A colposcopy clinic will be established in each district.[16] Certification of colposcpists will be introduced to ensure quality of services. Follow-up procedures after colposcopy in the case of e.g. incomplete excision; full excision with Cervical Intraepithelial Neoplasia (CIN) only or micro-invasive lesions; glandular abnormalities; pregnant women; immunosuppressed women will be documented. The closest histopathology laboratories to which biopsy specimens are to be sent from colposcopy clinics will be determined. Communication mechanism between colposcopy clinic and histopathology laboratory will be established. Reporting precancer and invasive cancer by histopathology laboratories will be made mandatory. The programme will pilot the tracking of screen positive women via mobile phone, enabling more effective follow-up.

MOH, AMOH, PHNS, SPHM and PHMs will be trained on HPV testing and transporting the specimens. Emphasis will be placed on enhancing communication and counselling skills, especially communicating about a HPV positive test. PHMs will also receive special training on teaching women about self-sampling. The HPB will provide technical assistance to the G&WHU to develop the communication plan to increase awareness of the public about the aims of the HPV screening programme.

An information system will be put in place to monitor programme indicators and monitor patient outcomes. The WWC will maintain a register of women participating in the programme. A Follow-up Register of women with a positive test who were referred will also be maintained. The laboratory to which the HPV test is sent will maintain a record of all incoming HPV test samples and record results after processing. It will help to monitor results that have not yet been reported to the health facility. Hospital clinics where diagnostic and treatment are carried out will also maintain a register of all HPV positive women who receive services and will help to monitor treatment rates.

NECESSITY OF A TRANSITION PLAN The change to HPV primary screening will take time and it is necessary to consider ways to improve cytology based screening. WWC, especially those with unacceptably high numbers of unsatisfactory smears will be targeted for refresher training. The cervical cytology guidelines will be revised and updated and QC and QA measures will be strengthened in cytology laboratories. Refresher training will be provided to cytoscreeners. The referral system and colposcopy services will be strengthened by the NCCP.

15. Murillo R, Almonte M, Pereira A, Ferrer E, Gamboa OA, Jerónimo J, Lazcano-Ponce E. Cervical cancer screening programs in Latin America and the Caribbean. Vaccine. 2008; 26 Suppl 11: L37-L48
16. See Highly prioritized actions, 2018-2020 under the 2016-2020 National Multisectoral Action Plan developed during the Task Force Mission

STRATEGIES

STRATEGY 2.1	**ENSURE THE SHIFT TO HPV SCREENING IS BASED ON CONCRETE EVIDENCE**	
	Major activities	
	2.1.1	Evaluate the demonstration project conducted in Kalutara
STRATEGY 2.2	**PLAN FOR CHANGE**	
	Major activities	
	2.2.1	Develop guidelines for HPV testing;
	2.2.2	Develop a costed Programme Implementation Plan (PIP) for cervical screening;
	2.2.3	Confirm government commitment to the shift;
	2.2.4	Conduct stakeholder consultation and build consensus.
STRATEGY 2.3	**IMPLEMENT THE PLAN**	
	Major activities	
	2.3.1	Improve availability of WW services by establishing one WWC per 15,000 population;
	2.3.2	Strengthen the laboratories where HPV testing will take place;
	2.3.3	Strengthen colposcopy services by establishing one clinic per district;
	2.3.4	Strengthen histopathology laboratories to which histological specimens will be sent;
	2.3.5	Procure and distribute equipment and HPV tests bearing in mind expiry dates;
	2.3.6	Train MOH, AMOH, PHNS, SPHM and PHMs on HPV testing including self-sampling;
	2.3.7	Improve communication and counselling skills of health service providers in the pre-screening period, about screening results, women who need further care and pre/post treatment and women with precancer;
	2.3.8	Ensure continuity of care through a clear referral pathway for women with HPV positive results;
	2.3.9	Conduct media campaign giving publicity to the new test;
	2.3.10	Establish an information system.
STRATEGY 2.4	**STRENGTHEN THE PRESENT CERVICAL CYTOLOGY PROGRAMME DURING THE TRANSITION PERIOD**	
	Major activities	
	2.4.1	Increase coverage of the target population;
	2.4.2	Provide training to WWC staff on taking and transporting Pap smears to reduce unsatisfactory smears;
	2.4.3	Revise the cytology guidelines to include quality control and quality assurance aspects in the cytology laboratories;
	2.4.4	Improve QC and QA practices in cytology laboratories;
	2.4.5	Provide refresher training to cytoscreeners.

STRATEGIC OBJECTIVE 3:
STRENGTHEN AND REORIENT HEALTH SYSTEMS TO MAXIMIZE THE OUTCOMES OF THE WELL WOMAN PROGRAMME

STRATEGIC OBJECTIVE 3:
STRENGTHEN AND REORIENT HEALTH SYSTEMS TO MAXIMIZE THE OUTCOMES OF THE WELL WOMAN PROGRAMME

RATIONALE

Achievement of the goal and objectives of this Strategic Plan requires a well-functioning and responsive health system. The SWOT analysis has identified gaps which will provide the baseline information needed for strengthening the health system for optimum functioning. The level of functionality of the district health system varies significantly across the country and within districts. In order to increase availability of WWC services, the programme will introduce services to health institutions with family planning clinics and HLCs. In addition, the WWP will engage with the private sector hospitals and general practitioners.

An adequate number of well trained personnel is crucial for the delivery of the WWP ranging from PHMs, to cytoscreeners who inspect the smears to supervisory staff. Investing in continuous professional development is necessary to keep the health workforce up-to-date and motivated. mLearning for refresher training will be piloted. The availability of equipment and supplies has improved with the use of CHANELL software at the G&WHU. Nevertheless, there are occasional issues with the distribution of commodities during the "last mile". An electronic Logistics Management Information System (LMIS) will be developed linking the FHB to the RMSDs. Improvements to quantification of needs, the FHB stores, RMSDs, distribution systems, especially availability of transport are necessary in order to ensure that the WWP functions smoothly.

Financial resources need to be secured for uninterrupted delivery of the WWP. The programme needs to develop costed multi-year plans (MYP) which give the G&WHU the ability to:

1. Guarantee implementation of medium-term activities over a long period;
2. Reduce the risk of breaks in financing as the G&WHU has more time to make adjustments to fill financial gaps;
3. Reduce the administrative burden on G&WHU of only having to extract the annual plan from the MYP;
4. Prepare resource mobilization plans;
5. Engage with development partners in more comprehensive and strategic partnerships.

The G&WHU together with the MoH will develop a policy for public private partnership (PPP) in collaboration with the Directorate of Private Health Sector Development. By fostering PPPs, the government can reduce its burden on infrastructure and trained staff and help ensure services are consistently available in the long term and concentrate efforts in reaching the most marginalized and vulnerable. Some mechanisms for PPP are: social franchising; voucher schemes which involve demand side financing, and; mobile clinics.

The need for continued improvement in data collection, analysis and reporting systems and more importantly on the use of data for decision making cannot be over emphasised. During this information age, starting from the lowest level of data collection, innovative simplified data collection and transmission tools should be explored to ease the process and to reduce the burden on the limited HR. Moreover, as the WWP activities scale up, measurement issues will change from a focus on counting the number of services delivered and other inputs to a focus on assessing population-based service-delivery coverage,

and on measuring the impact of the WWP. Periodical surveys will be conducted both at a facility and population level. This helps to capture data elements and indicators that are not obtained in the other alternative systems. WWP indicators will be incorporated into the national DHS questionnaires and other special surveys. Operational research will be fostered.

Leadership and governance of the WWP is crucial. The membership of the TAC will be expanded and the TOR revised. The capacity of the G&WHU and the districts to plan, implement and monitor the WWP will be strengthened.

STRATEGIES

STRATEGY 3.1	**STRENGTHEN WELL WOMAN SERVICE DELIVERY**	
	Major activities	
	3.1.1	Engage with private sector hospitals / GPs to provide WW services;
	3.1.2	Introduce WW services in health institutions with family planning clinics and HLC;
	3.1.3	Reduce unmet need for FP in midlife women (i.e. over 35 years).
STRATEGY 3.2	**INCREASE AVAILABILITY AND EQUITABLE DISTRIBUTION OF COMPETENT, MOTIVATED HUMAN RESOURCES WITH THE RIGHT SKILL MIX FOR DELIVERY OF THE WELL WOMAN PROGRAMME**	
	Major activities	
	3.2.1	Ensure WWCs have an adequate number of appropriately trained staff to meet the needs of the average daily client flow;
	3.2.2	Invest in continuous professional development of health workers, using a training plan, developing a regularly updated database of trainers and trainees by district and evaluating training programmes;
	3.2.3	Pilot Mobile Learning for refresher training;
	3.2.4	Introduce financial and non- financial incentive schemes to motivate and retain health staff in remote geographic area;
	3.2.5	Continue the practice of recognizing well performing staff and clinics.
STRATEGY 3.3	**ENSURE AVAILABILITY OF AN UNINTERRUPTED SUPPLY OF AFFORDABLE, QUALITY, EQUIPMENT AND CONSUMABLES INCLUDING FP COMMODITIES FOR THE WELL WOMAN PROGRAMME**	
	Major activities	
	3.3.1	Forecast, quantify and procure equipment and supplies;
	3.3.2	Build capacity of district and divisional staff, MOMCH, MOH, AMOH, RMSD on forecasting and supply planning;
	3.3.3	Strengthen “Last mile delivery”;
	3.3.4	Conduct regular monitoring and supervision of RMSD and facilities to minimise stockouts.

STRATEGY 3.4	**ENSURE THAT ADEQUATE FINANCIAL RESOURCES ARE MOBILIZED AND ALLOCATED FOR WELL WOMAN PROGRAMME ACTIVITIES**	
	Major activities	
	3.4.1.	Develop multi-year costed implementation plans for the WWP;
	3.4.2.	Review the resource allocation pattern in the districts for the WWP;
	3.4.3.	Develop a resource mobilization plan;
	3.4.4.	Leverage of private sector resources for the WWP;
	3.4.5.	Promote insurance companies to market a package for women that includes the service components provided at WWC.
STRATEGY 3.5	**IMPROVE THE AVAILABILITY, ACCESSIBILITY, QUALITY AND USE OF HEALTH INFORMATION BY THE WELL WOMAN PROGRAMME FOR DECISION MAKING**	
	Major activities	
	3.5.1	Review and revise the current WWP indicators to reflect HPV testing, quality of services and disaggregation of data for better coverage of target groups;
	3.5.2	Strengthen the RHMIS system to obtain data from WWC, laboratory and colposcopy clinics;
	3.5.3	Pilot establishing electronic linkage between MOH and cytology laboratories to reduce turnaround time;
	3.5.4	Strengthen linkages between Registrar Generals Office, Medical Statistics Unit, Department of Census and Statistics and M&E Unit to ensure quality of data through validation;
	3.5.5	Conduct operations research on the WWP and its components;
	3.5.6	Promote utilization of information for decision making by MOMCH, MOH and AMOH;
	3.5.7	Use accurate, timely, reliable data to review the WWP at all review meetings.
STRATEGY 3.6	**STRENGTHEN LEADERSHIP AND GOVERNANCE OF THE WELL WOMAN PROGRAMME**	
	Major activities	
	3.6.1	Strengthen the TAC so as to provide effective oversight of the WWP;
	3.6.2	Build the capacity of the G&WHU to plan, coordinate, monitor and provide technical assistance to the WWP;
	3.6.3	Improve the capacity of the provincial and district health authorities involved in planning, supervision, monitoring and evaluation;
	3.6.4	Advocate for the WWP related issues to be an agenda item of Provincial Health Ministers Meetings, National Health Development Committee and Hospital Directors meetings;
	3.6.5	Better coordination and coherence between the different units of the FHB and Programmes and Agencies within the MoH.

STRATEGIC OBJECTIVE 4:
INCREASE COVERAGE AND EQUITY OF THE WELL WOMAN PROGRAMME

STRATEGIC OBJECTIVE 4:
INCREASE COVERAGE AND EQUITY OF THE WELL WOMAN PROGRAMME

RATIONALE

Population based screening programmes such as a WWP need to ensure that a large proportion of the target group is screened and that those individuals in whom abnormalities are observed receive appropriate diagnosis and therapy. The WWP targets women in the 35 and 45 year age cohorts. Currently the eligible couples register is used to identify these individuals. The eligible couples register needs to be updated annually. Supervision of PHMs who are responsible for updating eligible couples register is weak due to lack of time and transport. Other sources on the population such as the voter registration list should also be used to identify women in the target age groups. Using the eligible couples register and other sources the PHMs should maintain a list of women in the 35 and 45 age cohorts. This list should be updated every six months. Health services, including FP commodities are provided free of cost in the public sector in Sri Lanka. However, the time spent travelling to facilities and waiting to receive care represents an indirect opportunity cost for many poor women who may have to forego earned income to receive care. If a woman is referred from the WWC to a hospital for further investigation the distance and cost may often deter them from seeking care. Every effort should be made to reduce out of pocket expenditure by providing services as close to their homes and at times that are convenient to all clients so as to increase coverage.

To increase coverage of WWC services it is crucial to reach out to marginalized and vulnerable groups who otherwise will be left behind.[17] A study on delay in seeking care by women with breast cancer found that if they were unmarried, divorced or widowed, of Tamil or Muslim ethnicity, had a monthly income of less than SLR 10,000 per month and lived more than 5 km from a health facility they were more likely to present late for treatment.[18] The SLDHS 2016 found the socio-economic status of women influenced the uptake of screening. Less educated women and those from the lower wealth quintiles were less likely to have a Pap smear. The regional disparities in indictors related to the WWP have been alluded to before.

Though the participation of widowed divorced, and separated women in WWC clinics was 31 percent only 16.4 percent had a Pap smear taken. Some of these women are sexually active and have an unmet need for family planning in addition. The National Family Planning Review carried out in 2016 suggested that sexually active, unmarried, widowed, divorced and separated women would prefer to obtain services from a WWC rather than from a family planning clinic per se to avoid being stigmatised. The SLDHS 2016 found that 24 percent of women were unaware that FP was provided at WWC. Language dichotomy between the service provider and clients could be a contributory factor for the lower turnouts for women from ethnic minorities.

17. For the purpose of this strategy vulnerable and marginalized groups are the following: estate sector; urban low o-economic; some minority religious and ethnic groups; recently resettled areas of the North and East; individuals within the criminal justice system; sexually active single, widowed, divorced and separated women; homeless, and disabled.
18. Kumari PBVR, CSE Goonewardena. Delay among women reporting symptoms of breast cancer. Journal of the College of Community Physicians of Sri Lanka. 2016: 16; 17-22.

STRATEGIES

STRATEGY 4.1	**ENSURE ALL WOMEN IN THE 35 AND 45 AGE COHORTS IRRESPECTIVE OF MARITAL STATUS ARE IDENTIFIED AND SCREENED SO AS NOT TO LEAVE ANYONE UNSCREENED**	
	Major activities	
	4.1.1	Develop a system to identify all women in the target age groups annually;
	4.1.2	Pilot Mobile Health technology to call and recall women in the 35 year and 45 year cohorts.
STRATEGY 4.2	**MINIMIZE HEALTH RELATED EXPENDITURE AND LOSS OF WAGES FOR POOR WOMEN ATTENDING WWC**	
	Major activities	
	4.2.1	Ensure WWC services are available on weekends and public holidays for the convenience of working women;
	4.2.2	Identify geographic areas with poor coverage and access to WWC and provide targeted support to establish field clinics;
	4.2.3	Provide mobile clinic services to areas with low coverage and difficult access identified by mapping;
	4.2.4	Provide services at workplaces with a high concentration of women (e.g. garment factories.
STRATEGY 4.3	**CUSTOMIZE WW SERVICES TO REACH VULNERABLE AND MARGINALIZED GROUPS AND INDIVIDUALS TO INCREASE THEIR UTILIZATION AND REDUCE INEQUITY**	
	Major activities	
	4.3.1	Carry out an assessment of vulnerable and marginalized groups in each district and MOH area;
	4.3.2	Obtain the support of gatekeepers in the community; `
	4.3.3	Customize culturally acceptable BCC materials for these vulnerable and marginalized groups;
	4.3.4	Design action plans together with members of the community to reach these groups with WW services;
	4.3.5	Reinforce in health workers avoidance of discrimination and the right to health of clients;
	4.3.6	Obtain feedback on quality of services provided;
	4.3.7	Establish fora for review of WWP activities in the (a) estate sector (b) Municipalities (c) newly settled areas of North and East.

STRATEGIC OBJECTIVE 5:
INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WELL WOMAN PROGRAMME

STRATEGIC OBJECTIVE 5:
INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WELL WOMAN PROGRAMME

RATIONALE

Ensuring quality of care (QOC) and safety of patients and service providers have become important objectives of the Sri Lankan health system.[19] Only a few studies exist on the quality of services at WWC, but these have shown lapses. A study to ascertain the quality of breast cancer screening services at WWC carried out among 200 women aged between 35-59 years of age found that the median percentage score for overall satisfaction was only 45.2 percent.[20] The physical facilities such as the premises and toilets were found to be substandard. Most of the clinic activities were also observed to be substandard, including punctuality of staff, health education, supervision and CBE. The National Cervical Cancer Control Program of Sri Lanka – Status Review and Suggestions for Reorganization found that there was no proper QA programme and the national guidelines for cervical cytology screening and reporting are not explicit about the quality control measures to be practiced in the laboratories. Despite efforts to improve QOC over the past decades several challenges remain to be tackled. Key among these are:

- Users routinely complain of abusive and humiliating treatment by health providers.
- Long waiting time is commonly cited as reasons for dissatisfaction with public sector services.
- Clients have limited avenues to seek redress.
- Cultural and linguistic differences between clients and service providers act as a barrier to communication and uptake of services.
- Though numerous trainings have been provided to improve the professional competence of health workers, these skills are not routinely practised and compliance with guidelines on basic patient care, workplace safety and staff working environment is poor. Health providers describe working conditions as difficult and demoralising.
- Shortage of equipment, consumable supplies and sometimes contraceptives undermines smooth functioning of clinics, damages reputation, inflates out-of-pocket costs to patients and fuels a spiral of distrust and alienation.
- In many health facilities, standard managerial practices that ensure effective use of limited resources are not universally practised.
- Referral systems are weak and compounds the poor coordination between different levels of care and further compromise care of clients.
- Quality of services in the private sector is not uniform. While large private sector health facilities strive to comply with International Standards Organization (ISO) specifications smaller institutions need to improve the quality of services.

Any future efforts to improve QOC and thereby the health status of Sri Lankans must address these challenges. The analysis presented above points to a need to pay attention to clients' needs, to address technical and provider shortcomings and to deal with systemic and managerial constraints.

19. National Policy on Health Care Quality and Safety. Ministry of Health 2015
20. Vithana PVSC, Ariyaratne MAY, Jayawardana PL. Quality of breast cancer early detection services conducted by Well Women Clinics in the district of Gampaha, Sri Lanka. Asian Pacific J Cancer Prev. 2013:14; 75-80.

STRATEGIES

STRATEGY 5.1	**ENSURE CARING, RESPECTFUL, COMPASSIONATE (CRC) CLIENT CENTRED CARE AT WWCs FOR ALL WOMEN**	
	Major activities	
	5.1.1	Introduce a “customer care” programme in all WWC;
	5.1.2	Establish a system of accountability to clients in all WWC;
	5.1.3	Strengthen interaction between WWC and communities;
	5.1.4	Introduce informed consent for women undergoing cervical cancer screening
STRATEGY 5.2	**IMPROVE CLIENT SAFETY PRACTICES IN WWCs**	
	Major activities	
	5.2.1	Infection prevention and control systems are in place.
STRATEGY 5.3	**IMPROVE CLINICAL PRACTICE**	
	Major activities	
	5.3.1	Improve knowledge of WWC staff on, hypertension, diabetes, menopause and perimenopause, and enhance their skills on cervical breast and thyroid screening;
	5.3.2	Increase availability of and use of evidence based clinical standards, guidelines and protocols;
	5.3.3	Improve recording / documentation of patient information by health workers;
	5.3.4	Establish QA systems in clinics and laboratories that are part of the WWP;
	5.3.5	Improve referral practice between the WWC and hospital clinics for clients found to have abnormalities;
	5.3.6	Improve the infrastructure and physical facilities of the WWC so as to create a “women friendly” atmosphere.
STRATEGY 5.4	**STRENGTHEN MONITORING AND SUPERVISION OF THE QUALITY OF THE WELL WOMAN PROGRAMME**	
	Major activities	
	5.4.1	Review duty lists of all categories of staff involved in the WWC to ascertain their roles, responsibilities and performance objectives;
	5.4.2	Revise the supervision tools to reflect changes in duties of WWC staff, new indicators, guidelines introduced into the WWP and QA measures adopted;
	5.4.3	Train supervisory staff on the new supervision tools and facilitative supervision;
	5.4.4	Team supervision visits are conducted regularly by G&WHU, CCP Province, RDHS, MOMCH, RSPHNO and feedback provided.
STRATEGY 5.5	**ENSURE THAT ALL PRIVATE SECTOR INSTITUTIONS PROVIDING WELL WOMAN SERVICES MEET THE QUALITY REQUIREMENTS**	
	Major activities	
	5.5.1	D/ Private Sector Development and G&WHU develop guidelines and checklist for provision of well woman services in the private sector;
	5.5.2	Collaborate with Insurance Regulatory Commission of Sri Lanka on recognizing only facilities providing well woman services that conform to quality standards.

STRATEGIC OBJECTIVE 6:
INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WELL WOMAN SERVICES, ESPECIALLY CERVICAL CANCER SCREENING

STRATEGIC OBJECTIVE 6:
INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WELL WOMAN SERVICES, ESPECIALLY CERVICAL CANCER SCREENING

RATIONALE

Communication is recognized as an important input to the WWP. Studies show that there is lack of awareness and indifference to the screening activities carried out at WWC. For instance, a study conducted in Colombo district showed knowledge on risk factors, symptom, screening and diagnostic methods and the services provided through the WWC were poor among the general public.[21] Another study to ascertain the knowledge and uptake of Pap smears among women aged 25-65 years attending a medical clinic at the National Hospital, Colombo, Sri Lanka found that 41 percent were unaware of Pap smears and 39 percent were unaware that Pap smears were used to detect pre-cancerous lesions. Only 18.1 percent of subjects had ever had a Pap smear taken.[22]

The WWC BCC strategy needs to be reviewed to ascertain why the current messaging is not resonating with the target audiences. A revised BCC strategy should reflect the recent developments such as the inclusion of the 45 year cohort in screening in addition to the 35 year cohort and the intention to include HPV testing as a screening procedure. Every effort must be made to reach out to poor and marginalized women and those who are less well educated who are unlikely to avail themselves of the services provide by the WWC. Lessons learnt from the implementation of the current BCC strategy will feed into the revised strategy. There needs to be better coordination between WWP and communication activities implemented by partners to ensure complementarity and synergy of activities at national, provincial and district levels. Mechanisms need to be established at all levels to ensure better coordination and joint action plans developed. There are few personnel trained in health communication at district and provincial levels. Moreover, inadequate budgetary allocations for communication initiatives hamper the overall impact of WWP communication services.

A series of demand creation activities will be implemented at national, provincial, district, divisional, community and interpersonal levels. In order to raise the profile of the WWP, the FHB will work closely with the media to improve information dissemination to the public. Multiple media outlets including mass media; information, education and communication materials and interpersonal communications will be utilized to disseminate messages. Mobile phone penetration is very good relative to other countries in the region. Though smart phone usage is increasing it is somewhat limited to the younger generations. The use of short text messaging (SMS) and social media to create awareness will be piloted but is limited in the amount of information that can be conveyed. Increasing knowledge and awareness at all these levels will increase the desire to access WWC services and lower the barrier to access which include power and gender dynamics that inhibit women from making open decisions. Witharana et al have shown the importance of educating both females and males about female malignancies.[23] Educating males is important as male partners can encourage females to utilize screening services. Better awareness of males may increase the uptake of screening services by females in male dominant communities. Satisfied clients can be encouraged to share their stories with their peers at forums such as the MSGs organized at community level.

21. Kuruppu C, Wijeyaratne CN, Gunawardena N, Amarasinghe I. Knowledge on breast cancer : a population based study in Sri Lanka. Asian Pac J. Health.Sci. 2015;2[4S]:41-47
22. Shivanthan MC, Arunakiri K, Wickramasinghe SI, Sumanasekera RD, Jayasinghe S,Rajapakse S. Pap smear testing among medical clinic attendees in a tertiary care hospital in Sri Lanka. Int Health. 2014: 6:138-43.
23. Witharana C, Wijesiriwardhana P, Jayasekera K, Kumari P, Rodrigo C. Awareness of female malignancies among women and their partners in Southern Sri Lanka and the implications for screening: a cross-sectional study. BMC Public Health @015. 15:1179-1189

STRATEGIES

STRATEGY 6.1	**REVIEW AND REVISE THE BCC STRATEGY TO REFLECT NEW DEVELOPMENTS IN THE WELL WOMAN PROGRAMME**	
	Major activities	
	6. 1.1	Review the recent socio-cultural, economic, political and technological developments;
	6.1.2	Identify communication gaps in the current BCC strategy;
	6.1.3	Revise BCC strategies;
	6.1.4	Develop guidelines, e.g. social media promotion for WWC, RH communication TOT etc;
	6.1.5	Develop a costed communication plan.
STRATEGY 6.2	**LINK WELL WOMAN STRATEGIC PLAN WITH WELL WOMAN BCC STRATEGY FOR BETTER COLLABORATION BETWEEN FHB, HPB AND OTHER PARTNERS AT NATIONAL AND DISTRICT LEVEL**	
	Major activities	
	6.2.1	Establish technical teams that ensure better collaboration between partners;
	6.2.2	Develop district and national joint action plans.
STRATEGY 6.3	**ENHANCE COMMUNICATION SKILLS OF HEALTH PROFESSIONALS TO BE CARING, RESPECTFUL AND COMPASSIONATE (CRC) WHEN PROVIDING SERVICES RELATED TO THE WELL WOMAN PROGRAMME**	
	Major activities	
	6.3.1	Develop a training curriculum on communication for WWC staff;
	6.3.2	Capacity building of trainers from HPB on communication skills related to the WWP;
	6.3.3	TOT program fo MOMCH, MOH and PHNS to improve their communication skills;
	6.3.4	Supply of communication equipment e,g; job aids, audio-visual equipment;
	6.3.5	Supply of IEC material on WW services.
STRATEGY 6.4	**MOBILIZE COMMUNITIES TO FACILITATE WELL WOMAN PROGRAMME**	
	Major activities	
	6.4.1.	Mobilize relevant community groups e.g. MSG;
	6.4.2	Use existing community events to create awareness;
	6.4.3	Use satisfied clients as local champions for the WWP;
	6.4.4	Sensitize religious and community leaders on the importance of the WWP and obtain their support;
	6.4.5	Collaborate with local businesses to promote WWP e.g. salons, gyms.

STRATEGY 6.5	**PROVIDE ACCURATE AND REGULAR INFORMATION ON WELL WOMAN PROGRAMME TO THE PUBLIC**	
	Major activities	
	6.5.1	Development of IEC material;
	6.5.2	Monitoring and evaluation of the distributed IEC material;
	6.5.3	Design and implement the mass media campaign;
	6.5.4	Sensitize the media houses on WWP activities.
STRATEGY 6.6	**INTRODUCE SOCIAL MEDIA AND MOBILE TECHNOLOGY TO CREATE DEMAND FOR WELL WOMAN CLINIC SERVICES**	
	6.6.1	Use SMS to promote WWC to women on their 35th and 45th birthday;
	6.6.2	Design and implement a social media campaign to promote the WWP;
	6.6.3	Strengthen the HPB hotline to answer questions from callers on women's health and promotion of WWP

GOVERNANCE AND LEADERSHIP OF THE STRATEGIC PLAN

The Strategic Plan proposes the TOR of the TAC needs to be revised and new members accommodated or co-opted as the case may be. The institutional framework for the Strategic Plan will utilize the existing structures within the MoH. The TAC – WWP under the chairpersonship of the DDGPHS II leads the coordination of partners and will provide overall oversight and guidance to the implementation of the Strategic Plan and monitor and review progress. The day to day management of the Strategic Plan will be the responsibility of the G&WHU which is headed by a Consultant Community Physician (CCP).

CHANGES TO THE TERMS OF REFERENCE AND COMPOSITION OF THE TECHNICAL ADVISORY COMMITTEE

In order to make the TAC more effective in fulfilling its role, the following additions are proposed to the composition of the TAC.

1. Sri Lanka College of Microbiologists: Since HPV testing is to be introduced to replace cervical cytology as the primary method of screening, the Sri Lanka College of Microbiologists should be invited to be part of the TAC.
2. Director NCD: As some of the interventions of the WWC are very much intertwined with NCD, the Director should also be included as a member of the TAC.
3. Director ET&R and HR Unit: In the absence of adequate human resources it is not possible to deliver health outcomes, let alone the objectives of this Strategic Plan. Hence, it is vital that the TAC should work closely with the HR Unit and the Education Training and Research Division of the MoH.
4. Director Private Health Sector Development: Many private hospitals and clinics are providing WWC services. The TAC should explore private sector financing and service delivery to expand the WWP.
5. Co-opt private health sector representatives: The private sector, including the insurance companies have a key role to play in implementing the Strategic Plan. They should also be co-opted members of the TAC.

The Strategic Plan proposes the establishment of four Thematic Working Groups (TWG).

TWG 1. The group will provide technical assistance to the HPV pilot testing underway in Kalutara and carry out the final evaluation. The TWG will make its recommendations to the TAC. This group will also provide technical assistance to the scaling up of HPV testing if it is accepted.

TWG 2. This group will be responsible for studying and making recommendations on private sector involvement in financing and service provision of the WWP.

TWG 3. This TWG will be responsible for resource mobilization and for developing a resource mobilization plan. They will also be responsible for preparing high quality funding proposals which will be channelled through the Director Maternal and Child Health to the development partners.

TWG 4. The fourth group will be responsible for raising the visibility of the WWP. This TWG will engage in high level advocacy activities and interact with the media outlets to provide accurate information on the WWP.

ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY (OEE)

The Strategic Plan has identified five areas that need to be addressed in order to improve the internal effectiveness and efficiency of the G&WHU.

1. Improved programming for results
2. Enhancing management efficiency and effectiveness
3. Strengthening staff capacity
4. Better coordination and coherence between the different units of the FHB and Programmes and Agencies within the MoH.
5. Resource mobilization and partnerships for impact

1. IMPROVED PROGRAMMING FOR RESULTS

The G&WHU and the district level implementers of the WWP will use results based management (RBM) to manage the full cycle from planning, monitoring and reporting to evaluation.

2. ENHANCING MANAGEMENT EFFICIENCY AND EFFECTIVENESS

Central procurement of equipment and supplies for the WWP will lead to economies of scale and achieve cost-saving. An electronic logistics management information system (LMIS) will be introduced to effectively and efficiently manage equipment and supplies for the WWP both at FHB and RMSDs.

A detailed multiyear costed work plan will guide the implementation of this strategy.

3. STRENGTHENING STAFF CAPACITY

The G&WHU will be strengthened in terms of human resources to ensure proper staffing in order to fulfil its functions. The cadre for the unit must comprise of a CCP and two Medical Officers (MOs) for effective management of the WWP. One MO will be responsible for programmatic issues and the other will be in charge of logistics management. In addition a development officer and office support staff are also necessary for the smooth functioning of the unit. The capacity of G&WHU and district staff will be enhanced in RBM as well as in supervision, monitoring and evaluation.

4. BETTER COORDINATION AND COHERENCE BETWEEN THE DIFFERENT UNITS OF THE FHB AND PROGRAMMES AND AGENCIES WITHIN THE MoH

Coordination and coherence between the different units delivering the Family Health Programme of which the WWP is an integral part and other Programmes and agencies of the MoH is a prerequisite for the successful implementation of this Strategic Plan. The TAC provides a forum for such interaction. However, informal mechanisms also need to be established.

The draft district health plans will be reviewed by the G&WHU to ensure WWP activities are adequately reflected prior to their endorsement by the provincial health authorities.

5. RESOURCE MOBILIZATION AND FOSTERING PARTNERSHIPS

The G&WHU will engage in evidence based advocacy to increase the allocation for the WWP from the MoH. It will also identify opportunities for resource mobilization from development partners and the private sector. The G& WHU will foster partnerships to further the objectives of this Strategic Plan. (Annex 2) The strategy for partnerships will target critical Ministries and Departments, the private sector, professional organizations, civil society and media houses in order to:

a) mobilize additional resources,

b) identify innovative solutions to address challenges identified during implementation; and;

c) to mobilize broad based social support for the WWP.

6. IMPLEMENTATION, MONITORING AND SUPERVISION OF THE STRATEGIC PLAN

The implementation of this Strategic Plan will be by the PDHS and supported by the RDHS. Technical support, operational guidance and monitoring and supervision will be provided by the G&WHU to the districts. The G&WHU will develop tools, guidelines and standards and will also facilitate advocacy and policy dialogue at provincial and district level.

RISK MANAGEMENT

An important component of the Strategic Plan is to be able to identify and manage risks that may affect its smooth implementation. Risk management is the process of developing options and actions to enhance opportunities and reduce threats to the achievement of objectives. The table below though not exhaustive, give the summary of the risks, likelihood of occurring, impact if the risk occurs, overall risk and the proposed mitigation strategies. Environmental scanning will be carried out periodically to assess risks to the programme and the risk matrix will be updated.

Risk mitigation matrix

Risk		Likelihood of occurrence	Impact if it occurs	Overall risk	Risk mitigation
Country political environment					
1.	Political will and Government commitment wavers for HPV testing	Moderate	High	High	Advocacy to continue keeping WWP high on the country's development agenda.
2.	Continued political polarization and instability	Low	High	Moderate	Very little the WWP can do but ensure services for the most vulnerable continue to be provided
Natural environment					
3.	Disaster and climate related shocks could shrink the fiscal space by diverting national resources towards response, change priorities of local authorities thus constraining available funds for the WWP.	Low	Moderate	Moderate	Very little the WWP can do but ensure services for the most vulnerable continue to be provided using mobile clinics for instance
4.	Shocks and crises can also affect the food security situation and stretch the coping capacities of households affecting access/ utilization of WWC services. Climate change is also likely to further stress water resources, increase pests and disease burdens and have broad impacts on livelihoods and patterns of human habitation in Sri Lanka	Moderate	High	Moderate	Ensure services for the most vulnerable continue to be provided using mobile clinics for instance

Risk		Likelihood of occurrence	Impact if it occurs	Overall risk	Risk mitigation
Economy and predictability of funding					
5.	The domestic economy underperforming thereby affecting the national budget allocation	Moderate	High	Moderate	Advocacy with Ministry of Health and Finance Ministry to ensure sustainable financing for the WWP Develop a resource mobilization plan
6.	Global economic shocks may impact adversely on the national economy	Moderate	High	Moderate	Monitor closely and adjust plan as appropriate
7.	Economic volatility in general poses great risks for the most vulnerable families across the country, as it can lead to decreased household income, food and fuel prices increases and a variety of other impacts that limit flexibility to continue to utilize available services that have direct and indirect costs.	Moderate	High	High	The G&WHU will have to consider providing outreach services to the most marginalized and vulnerable groups
8.	Economic transition processes are changing international aid modalities and leading to shrinking/shifting ODA for Government of Sri Lanka	Moderate	High	Moderate	This risk underscores the need for effective policy advocacy and leveraging of both national and international resources to the social sectors. This risk also underlines the need for a strong resource mobilization strategy
Programmatic issues					
9.	Low capacity at provincial and district level to provide leadership for the SP	Moderate	Moderate	Moderate	Build capacity of the provincial and district levels to plan, implement, monitor and evaluate the SP, especially the MOMCH, RSPHNO
10.	Inadequate numbers, mix and distribution of human resources	Moderate	High	Moderate	Advocate with Government to prioritize HRH and to allocate adequate HR to MOH
11.	The HPV test pilot may fail to bring satisfactory results	Low	High	Moderate	Stringent monitoring, supervision and documentation of the pilot
12.	Breakdown of supply chain management of HPV kits for WWC	Low	High	Moderate	Collaborate with WHO and other partners to ensure wider availability of quality-assured products at more competitive prices;
13.	Multiple roles and overlapping of responsibilities for health workers can affect performance	Low	Moderate	Moderate	Provide non-financial incentives to motivate staff

Risk		Likelihood of occurrence	Impact if it occurs	Overall risk	Risk mitigation
Results based management and measurement and reporting on results					
14.	Limitations in the capacity of partners and poor coordination resulting in limited results	Moderate	High	Moderate	Capacity assessment of partners prior to establishing partnerships; build partner capacity to the extent possible; Introduce coordination mechanisms
15.	Initial confusion and uncertainties in terms of roles accountability and expectations from the staff	Low	Moderate	Low	Orientation meetings with all categories of staff on the Strategic Plan

MONITORING AND SUPERVISION

The successful implementation of the Strategic Plan relies on a robust monitoring and evaluation (M&E) system. WWP recognizes the importance of M&E not only for tracking programme performance and implementation, but also for tracking financial resources and building an evidence base for decision making.

Monitoring of this Strategic Plan will be coordinated through the G&WHU but each district will be responsible for monitoring their activities and progress against relevant objectives. The M&E system will work in a decentralized manner to support the implementation of decision making at local level. The strengthening of decision-making at local level is an important component of the Strategic Plan.

Designing the M&E process in this fashion will promote the capacity of district health authorities to make more informed decisions.

In this strategy, M&E activities are broadly divided into two: regular performance tracking system and operations research, studies and evaluation.

REGULAR PERFORMANCE TRACKING SYSTEM

eRHMIS

A set of high-priority indicators and operational targets will be objectively measured (Annex 5) and used for M&E purposes to understand the scale and outcomes of implementation, to provide evidence-based guidance for actions/decisions and to improve accountability at all levels of the health system. The eRHMIS, while continuing to be vigorously strengthened, remains the main source of data for routine tracking of the performance of most of the interventions of the strategy. An indicator dashboard will be established and updated to track performance and progress in provinces and districts with emphasis on equity in access to and utilization of high-impact WWP interventions.

SUPPORTIVE SUPERVISION

Supportive supervision will be carried out at and between various levels of the health system. Frequent and regular supportive supervision will help identify problems early and lead to prompt remedial actions.

REVIEW MEETING

Review meetings will be conducted at district and national levels. During these meetings performance of plans and targets will be reviewed, opportunities, challenges and solutions will be identified and successes, best practices and lessons learnt will be shared. The district and national reviews that are

proposed for the WWP in the Strategic Plan will analyse and track progress towards the agreed targets and milestones under the strategic objectives using the performance indicators in Annex 5.

OPERATIONAL RESEARCH, SURVEYS AND EVALUATION

Research and surveys will also be used to assess the progress made in the implementation of interventions and their impacts. Equally, the necessity of research is also to inform the implementation of the strategy and triangulate data collected routinely by the health information system. A survey will be carried out to identify baseline values. The indicator values will be drawn from both past experience of the WWP as well as large- scale surveys such as the SLDHS.

The implementation of this Strategic Plan will also be assessed through, preferably, an external evaluation. The baseline will be established in 2019, with a mid-term review in 2021. This external evaluation at mid-point will focus, but not be limited to:
i. The implementation of the objectives in the Strategic Plan as measured against the agreed targets;
ii. Identifying shortcomings, challenges and areas in need of improvement or acceleration;
iii. Recommendations on any necessary modifications to the plan, the objectives, the targets or the implementation strategies.

A final evaluation will take place after 2023 to assess what happened and why, and seek answers for specific questions related to the relevance, effectiveness, efficiency, impact and sustainability of the interventions. The findings will enable recommendations to be made on any next steps needed for the WWP as the envisaged reorganization of Primary Health Care (PHC) system may be in place by then.

In addition to the baseline and final evaluations the Strategic Plan performance monitoring includes the following different types of M&E tools and activities:

a. The targets established in the Strategic Plan will be reviewed and, if required, updated annually;
b. The Strategic Plan will be used to allocate financial resources. The budget allocation will be reviewed annually and, if required, revised;
c. The draft district health plan will be sent by the MOMCH to the G&WHU for review so as to ensure the Strategic Plan activities are adequately reflected. Implementation progress will be determined on the basis of the district health plan.
d. Results based quarterly progress reports will be submitted by the MOMCH to the G&WHU. These quarterly reports will serve as one of the main monitoring tools for progress in project implementation. In addition, findings from field visits and other project reports will be included in these quarterly progress reports;
e. Field Monitoring Visits will be regularly conducted by G&WHU;
f. Regular team supervision visits will be carried out by RDHS, MOMCHs, and RSPHNO to MOH areas. In addition the MOH, PHNS and SPHM will conduct regular supervision visits to WWC and to PHM areas;
g. National Programme Reviews will be carried out in the districts annually to review progress made vis-a-vis the district annual workplan.

7. BIBLIOGRAPHY

1. Human Development Index 2018.UNDP (Accessed 03 October 2018. http://hdr.undp.org/en/countries/profiles/LKA)
2. FHB data 2015
3. Registrar General's Department. 2010
4. Policy repository of Ministry of Health Sri Lanka - Colombo; Ministry of Health. 2016
5. Guidelines for implementation of the Well Woman Clinic Programme. FHB/FE/05/98
6. Revised Guidelines for Implementation of Well Woman Service for Women of Reproductive and Post Reproductive Age. FHB/GWH/2018/02.
7. WHO Steps Survey http://www.who.int/ncds/surveillance/steps/STEPS-2015-Fact-Sheet-Sri-Lanka.pdf (Accessed 8.7.2018)
8. MoH Circular FHB/DIR/GF/2012 dated 26.03.2012. – Criteria for deciding cadres of health staff for Public Health Services in Sri Lanka.
9. Health Economics Cell, Ministry of Health, Nutrition & Indigenous Medicine Sri Lanka (2016). Sri Lanka National Health Accounts 2013. The Ministry of Health, Sri Lanka, Colombo.
10. Katulanda P, Ranasinghe P, Jayawardena R, Constantine GR, Rezvi Sheriff MH, Matthews DR. The prevalence, predictors and associations of hypertension in Sri Lanka: a cross-sectional population based national survey. Clin Exp Hypertens. 2014;36(7):484-91. doi: 10.3109/10641963.2013.863321. Epub 2014 Jan 16.
11. Katulanda P, Constantine GR, Mahesh JG, Sheriff R, Seneviratne RDA, Wijeratne S, Wijesuriya M, McCarthy MI, Adler AI, Matthews DR. Prevalence and projections of diabetes and pre-diabetes in adults in Sri Lanka – Sri Lanka Diabetes, Cardiovascular Study (SLDCS). Diabetes UK 2008; 25: 1062-69.
12. Katulanda P, Rathnapala DAV, Sheriff R, Matthews DR. Province and ethnic specific prevalence of diabetes among Sri Lankan adults. Sri Lanka Journal of Diabetes Endocrinology and Metabolism 2011; 1: 2-7
13. Wijewardene K, Mohideen MR, Mendis S, Fernando DS, Kulathilaka T, et al. Prevalence of hypertension, diabetes and obesity: baseline findings of a population based survey in four provinces in Sri Lanka. Ceylon Medical Journal 2005; 50: 62-70.
14. Gamage D, Rajapaksa L, Abeysinghe ARN, de Silva A. Prevalence of Carcinogenic Human Papilloma Virus Infection and Burden of Cervical Cancer Attributable to it in the District of Gamapaha, Sri Lanka. 2012. Epidemiology Unit and UNFPA
15. Fernando A, Jayarajah U, Prabashini S, Fernando EA, Seneviratne SA. BMC Cancer (2018) 18.482 https://www.researchgate.net/publication/324806741_Incidence_trends_and_patterns_of_breast_cancer_in_Sri_Lanka_An_analysis_of_the_national_cancer_database [accessed Aug 21 2018]
16. Forbes JF. The incidence of breast cancer: The global burden, public health considerations. Semin Oncol 1997;24 1 Suppl 1:S1-20-S1-35.
17. Sasco AJ. Epidemiology of breast cancer: An environmental disease? APMIS 2001;109:321-32
18. Lauby-Secretan B, Scoccianti C, Loomis D, Benbrahim-Tallaa L, Bouvard V, Bianchini F, et al. Breast-cancer screening--viewpoint of the IARC Working Group. N Engl J Med. 2015; 372(24):2353-8.
19. Denny L, de Sanjose S, Mutebi M, et al. Interventions to close the divide for women with breast and cervical cancer between low-income and middle-income countries and high-income countries. Lancet 2017;389:861–70
20. Ratnatunga PCA, Amarasinghe SC, Ratnatunga NVI. Changing patterns of thyroid cancer in Sri Lanka. Has the iodination programme helped? CMJ. 2003:48:125-128
21. Hemachandra, D K N N, Manderson L. Menstrual problems and health seeking in Sri Lanka. Women & Health. 2009: 49 (5): 405-21.
22. Waidyasekera H1, Wijewardena K, Lindmark G, Naessen T. Menopausal symptoms and quality of life during the menopausal transition in Sri Lankan women. Menopause. 2009: 16(1):164-70.
23. Sri Lanka Demographic and Health Survey. 2006-07. Department of Census and Statistics and Ministry of Healthcare and Nutrition. 2009

24. Sri Lanka Demographic and Health Survey. 2016.. Department of Census and Statistics and Ministry of Healthcare and Nutrition. 2017
25. Health strategic master plan 2016 - 2025 ; Volume II Preventive health services. Colombo ; Policy Analysis and Development Unit Ministry of Health . 2016 (Accessed 13.08.2018)
26. www.health.gov.lk/enWeb/HMP2016-2025/Preventivepercent20percent20Servicespercent20pdf.pdf
27. National Strategic Framework for Development of Health Services 2016-2025. Ministry of Health Nutrition and Indigenous Medicine. (Accessed 13.08.2018) http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/sri_lanka/national_strategic_framework_.pdf
28. Fernando Delani Marie Sharaine. Evaluation of cervical screening programmeme in well woman clinics in two selected districts of Sri Lanka. Submitted for a Post Graduate Diploma in Evaluation to University of Sri Jayawardenapura. 2018.
29. Behavior Change Communication Strategy Guide for Reproductive Health Programmemes in Sri Lanka. The Well Woman Clinic Programmeme. Ministry of Health, Sri Lanka, Health Education Bureau, Family Health Bureau, United Nations Population Fund (UNFPA) January 2014
30. Guidelines for cervical cytology screening and reporting in Sri Lanka 2010. College of Pathologists of Sri Lanka, College of Obstetricians and Gynaecologists of Sri Lanka, Family Health Bureau. 2010
31. Weerasinghe, M. & Fernando, D., (2011). Access to Care in a Plural Health System: Concerns for Policy Reforms. Journal of the College of Community Physicians of Sri Lanka. 14(1), pp.39–45. DOI:http://doi.org/10.4038/jccpsl.v14i1.2947
32. Health Economics Cell, Ministry of Health, Nutrition & Indigenous Medicine Sri Lanka (2016). Sri Lanka National Health Accounts 2013. The Ministry of Health, Sri Lanka, Colombo.
33. Policy repository of Ministry of Health Sri Lanka - Colombo ; Ministry of Health . 2016.
34. Revised Guidelines for Implementation of Well Woman Service for Women of Reproductive and Post Reproductive Age. FHB/GWH/2018/02.
35. Non Communicable Risk Factor Survey 2015. Ministry of Health, Nutrition and Indigenous Medicine Sri Lanka and WHO. 2016.
36. United Nations Population Fund. Comprehensive cervical cancer prevention and control. Programmeme guidance for countries. 2011
37. Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2017.
38. Cancer Incidence Data Sri Lanka 2014. National Cancer Control Programme.
39. World Bank Primary Health Care System Project 2018-2023. Project Appraisal Document. The World Bank 2018.
40. Denny L, Quinn M, Sankaranarayanan R. Chapter 8: Screening for cervical cancer in developing countries. Vaccine 2006; 24 (suppl 3):71–77.
41. World Health Organization. Cervical cancer screening in developing countries:Report of a WHO consultation. 2002. Available at: http://whqlibdoc. who.int/publications/2002/9241545720.pdf. Accessed 22.09.2018
42. World Health Organization, 2013. WHO Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention. Available at. http://apps.who.int/iris/bitstream/10665/94830/1/9789241548694_eng.pdf?ua=1
43. World Health Organization. Comprehensive cervical cancer control. A guide to essential practice. 2nd Edition. 2014
44. National Plan of Action for the Social Development of the Plantation Industry 2016-2020. Ministry of Hill Country, New Villages, Infrastructure, and Community Development. March 2016.
45. Ghebreyesus, T.A., 2018. Cervical Cancer: An NCD We Can Overcome. World Health Organization Available at. http://www.who.int/reproductivehealth/DG_Call-toAction.pdf, (Accessed 22.09.2018)
46. Mustafa, R.A., Santesso, N., Khatib, R., Mustafa, A.A., Wiercioch, W., Kehar, R., ... Schünemann, H.J., 2016. Systematic reviews and meta-analyses of the accuracy of HPV tests, visual inspection with acetic acid, cytology, and colposcopy. Int. J.Gynecol. Obstet. 132, 259–265. https://doi.org/10.1016/j.ijgo.2015.07.024
47. Basu P. National Cervical Cancer Control Program of Sri Lanka – Status Review & Suggestions for Reorganization. 2012, unpublished.

ANNEX 1

CONDITIONS SCREENED FOR BY THE WELL WOMAN PROGRAMME – THE SRI LANKAN CONTEXT

HYPERTENSION AND DIABETES

Hypertension and diabetes are important causes of morbidity and mortality in Sri Lanka. The community based Sri Lanka Diabetes and Cardiovascular Study (SLDCS) conducted between August 2005 and September 2006 in seven of the nine provinces of Sri Lanka, which excluded the North and East, found that the age-adjusted prevalence of hypertension in all adults was 23.7 percent (males 23.4 percent; females – 23.8 percent).[1] The SLDCS found the age–sex standardized prevalence of diabetes for Sri Lankans aged ≥ 20 years was 10.3 percent (males 9.8 percent; females 10. 9 percent). Thirty-six percent of all diabetic subjects were previously undiagnosed.[2] The SLDCS also found a significant variation in the province specific prevalence of diabetes with the highest (18.6 percent) in the Western and the lowest (6.8 percent) in the Uva provinces. The monthly income, body mass index (BMI), waist circumference and per capita monthly expenditure were highest in the Western province and lowest in the Uva province. In contrast, the mean physical activity level was lowest in the Western province and highest in the Uva province.[3]

Another community based study in 2005 carried out in adults between 35 and 65 years of age in four of the nine provinces found that the prevalence of hypertension was 18.8 percent for men and 19.3 percent for women.[4] The same study also found the prevalence of diabetes was 14.2 percent for men and 13.5 percent for women. The 2014-15 WHO STEPS Survey estimated that a health professional had never measured the blood pressure in 30.7 percent of adults. In addition, 21.0 percent of the adults with raised blood pressure (>140/ 90 mmHg) were not on any medication for hypertension.

The prevalence of diabetes and cardiovascular disease are higher in women. Although alcohol and tobacco consumption is far less prevalent among Sri Lankan females compared to men, the prevalence of other risk factors is higher (obesity, high blood pressure, high sugar level and heart diseases). Since women are more vulnerable to NCDs, making NCD prevention and management more gender sensitive is of utmost importance. The WWCs located at primary health care level are an opportunity for prevention and early detection of hypertension, diabetes, breast, cervical and thyroid gland cancers in addition to providing FP services for midlife women and advice on the menopause. The HLCs that have been established throughout the country screen both women and men for NCDs but refer women in the 35 and 45 age cohorts for cervical cancer screening and CBE to the WWC.

NUTRITIONAL STATUS OF OLDER WOMEN

The BMI is measured at the WWC to identify women who are underweight or obese. A cut-off point of 18.5 is used to define thinness or acute under-nutrition. Only 46 percent of the ever-married women have a normal BMI (between 18.5 and 24.9). A BMI of 25 or above usually indicates being overweight, and 29.9 or above indicates obesity (WHO, 1995). Being overweight is a concern because it predisposes them to a wide range of health problems such as diabetes and heart disease. At the other end of the spectrum, chronic energy deficiency of women leads to low work productivity and reduced resistance to illness.

1. Katulanda P1, Ranasinghe P, Jayawardena R, Constantine GR, Rezvi Sheriff MH, Matthews DR. The prevalence, predictors and associations of hypertension in Sri Lanka: a cross-sectional population based national survey. Clin Exp Hypertens. 2014;36(7):484-91. doi: 10.3109/10641963.2013.863321. Epub 2014 Jan 16.
2. Katulanda P, Constantine GR, Mahesh JG, Sheriff R, Seneviratne RDA, Wijeratne S, Wijesuriya M, McCarthy MI, Adler AI, Matthews DR. Prevalence and projections of diabetes and pre-diabetes in adults in Sri Lanka – Sri Lanka Diabetes, Cardiovascular Study (SLDCS). Diabetes UK 2008; 25: 1062-69.
3. Katulanda P, Rathnapala DAV, Sheriff R, Matthews DR. Province and ethnic specific prevalence of diabetes among Sri Lankan adults. Sri Lanka Journal of Diabetes Endocrinology and Metabolism 2011; 1: 2-7
4. Wijewardene K, Mohideen MR, Mendis S, Fernando DS, Kulathilaka T, et al. Prevalence of hypertension, diabetes and obesity: baseline findings of a population based survey in four provinces in Sri Lanka. Ceylon Medical Journal 2005; 50: 62-70.

The 2016 SLDHS found that the mean BMI for ever-married women age 15-49 years is 24.8. Women with a BMI ≥ 25 (i.e. overweight and obese) in the 30-39 and 40-49 age groups are 45.9 percent and 52 percent respectively. The percentage of women who are overweight or obese increases with the age of the woman, their level of education and the wealth of their households. Women with a BMI of ≤ 17 (moderately and severely thin) in the 30-39 and 40-49 age groups are 3 percent and 2.3 percent respectively. The prevalence of thinness varies with the place of residence (9.3 percent of women residing in the estate sector compared to 2.6 percent in the urban sector and 3.6 percent in the rural sector).

FAMILY PLANNING

Integration of FP with the WW Programme provides an opportunity to provide FP services to midlife women. The 2016 SLDHS showed that unmet need among currently married women aged between 15-49 years for limiting their families is highest in the 35-39 age group and gradually declines with age. Although pregnancy is less likely after the age of 40 years, there is a greater risk of adverse maternal and child outcomes than they do before age 40. It is important to note that of the 127 maternal deaths in 2017, 24 deaths took place in women between 36-40 years and 5 deaths were in women over 40 years of age. (Maternal Death Surveillance and Response Unit). According to the 2016 SLDHS only 24 percent of ever married women in the 15-49 age group and 28 percent in the 35-40 age group knew that FP services were available in WWC.

BREAST CANCER

Breast cancer is the commonest cancer among women in Sri Lanka.. In 2014, 3085 new cases of breast cancer were detected. The crude rate per 100,000 population is 28.8. The age standardized incidence rate for females is 24.3 per 100,000 population.[5] The breast cancer incidence appears to be rising more rapidly particularly among postmenopausal women in Sri Lanka.[6] This increase in breast cancer among postmenopausal women is particularly alarming since Sri Lanka has a rapidly ageing population. It is believed that socioeconomic and life-style changes such as later childbearing and dietary habits and associated alterations in menstrual patterns are responsible for rising risk of breast cancer in developing countries.[7,8]

Unlike with screening for cervical cancer, in breast cancer, relatively little success has been achieved in either prevention or early detection. Mammography, clinical breast examination (CBE) and self-examination of the breast (SBE) are the methods used in screening for early detection of breast cancer. The International Agency for Research on Cancer (IARC) encourages SBE and CBE as a screening methodology in low-income countries, with sufficient evidence for mammographic screening in the 50-69 age group in developed countries.[9] Screening by CBE is a promising approach because evidence suggests that it lowers stage distribution at detection, although whether breast cancer mortality is reduced remains unclear.[10] The WWP hinges on CBE conducted by a health care worker (mostly by PHM) and providing awareness and skills on regular SBE as mammographic facilities are costly and available only at a few locations.

---

5. Cancer Incidence Data Sri Lanka 2014. National Cancer Control Programme
6. Fernando A, Jayarajah U, Prabashini S, Fernando EA, Seneviratne SA. BMC Cancer (2018) 18.482 https://www.researchgate.net/publication/324806741_Incidence_trends_and_patterns_of_breast_cancer_in_Sri_Lanka_An_analysis_of_the_national_cancer_database [accessed Aug 21 2018].
7. Forbes JF. The incidence of breast cancer: The global burden, public health considerations. Semin Oncol 1997;24 1 Suppl 1:S1-20-S1-35.
8. Sasco AJ. Epidemiology of breast cancer: An environmental disease? APMIS 2001;109:321-32
9. Lauby-Secretan B, Scoccianti C, Loomis D, Benbrahim-Tallaa L, Bouvard V, Bianchini F, et al. Breast-cancer screening--viewpoint of the IARC Working Group. N Engl J Med. 2015; 372(24):2353-8.
10. Denny L, de Sanjose S, Mutebi M, et al. Interventions to close the divide for women with breast and cervical cancer between low-income and middle-income countries and high-income countries. Lancet 2017;389:861–70

THYROID CANCER

Thyroid cancer is now the second commonest cancer among women in Sri Lanka. In 2014, 1373 new cases of thyroid cancer were detected. The crude rate per 100,000 population is 12.8. The age standardized incidence rate for females is 11.3 per 100,000 population.[11] It is not clear whether this increase is due to better diagnosis and reporting or may in actual fact be a true increase in incidence. The following risk factors for thyroid cancer have been identified; multi modular goitres; autoimmune thyroiditis; iodine deficiency; and exposure to irradiation. Less clear is the role of diet, body weight, environmental pollutants and insulin resistance in causing thyroid cancer. A trend towards more differentiated thyroid cancer with lesser degree of spread was observed by Ratnathunga et al[12] and attributed it to iodination of salt in recent years. There is no recommended screening test to find thyroid cancer early.

CERVICAL CANCER

Cervical cancer is the third commonest cancer among females in Sri Lanka. In 2014, 1049 cases of cervical cancer were identified. The Crude rate per 100,000 population is 9.8 and the Age Standardized Rate is 8.2 per 100,000 population.[14] Cervical cancer is a rare outcome of persistent infection with one or more oncogenic HPV types. The population attributable risk in the development of cervical cancer for HPV genotypes 16, 18 was 69 percent in Sri Lanka.[15] Infection with HPV is very common, and most infections will resolve spontaneously. It is only in a very small number of women that infection with oncogenic HPV persists, which may lead to precancerous abnormalities, and, if not detected by cervical screening and treated, may progress to cervical cancer in around 10–20 years. Screening is possible because cervical cancer is one of the few cancers that has a precancerous stage that lasts for many years prior to the development of invasive disease, which provides an opportunity for detection and treatment.

There is a clear demarcation of roles in relation to prevention and treatment of cervical cancer in Sri Lanka. Primary prevention of cervical cancer is through HPV vaccination of girls. HPV vaccination was introduced into the National Immunization Programme in October 2017 for girls in Grade 6 and is the responsibility of the Epidemiology Unit. Secondary prevention by screening is carried out using cervical cytology i.e. the Papanicolaou smear, or 'Pap' test at WWC, National STD/AIDS Control Programme (NSACP) clinics and the National Cancer Control Programme (NCCP) to detect and treat abnormalities while they are in the precancerous stage, before possible progression to cervical cancer. Some private hospitals and the FPASL also conduct WWC and take Pap smears. The current public sector screening programme is affected by problems in collection of the smear, delay in reporting and timely treatment of abnormalities. Furthermore, there is no laboratory quality assurance system in place. Based on the FHB Annual Report 2015 only 87 percent of women attending WWC had a Pap smear taken. The WWP is piloting HPV DNA testing in the Kalutara district. It is considering replacing the Pap smear with HPV testing and genotyping every five years for HPV vaccinated and unvaccinated women.

Tertiary prevention refers to care aimed at reducing morbidity and disability in people diagnosed with, and being treated for disease. Treatment of precancer and invasive cancer are the responsibility of the NCCP. There are several centres throughout the country where invasive disease can be treated. Gynaecologic Oncology is recognized as a subspecialty of Obstetrics and Gynaecology by the Postgraduate Institute of Medicine (PGIM).

---

11. Cancer Incidence Data Sri Lanka 2014. National Cancer Control Programme
12. Ratnatunga PCA, Amarasinghe SC, Ratnatunga NVI. Changing patterns of thyroid cancer in Sri Lanka. Has the iodination programme helped? CMJ. 2003:48:125-128
13. Hemachandra, D K N N, Manderson L. Menstrual problems and health seeking in Sri Lanka. Women & Health. 2009: 49 (5): 405-21.
14. Cancer Incidence Data Sri Lanka 2014. National Cancer Control Programme
15. Gamage D, Rajapaksa L, Abeysinghe ARN, de Silva A. Prevalence of Carcinogenic Human Papilloma Virus Infection and Burden of Cervical Cancer Attributable to it in the District of Gamapaha, Sri Lanka. 2012. Epidemiology Unit and UNFPA

MENSTRUAL DISORDERS

Menstrual disorders have a major impact on the quality of life of women. Hemachandra and Manderson[16] conducted a qualitative study to determine Sri Lankan women's perceptions of menstruation, menstrual problems and help seeking behaviour. They found that menstrual problems significantly affected their daily activities, mental well-being, social life and sexual life. However, very few women sought medical help.

REPRODUCTIVE TRACT INFECTIONS

Reproductive tract infections (RTIs) include three types of infection: 1) sexually transmitted diseases (STDs), such as chlamydia, gonorrhea, chancroid, and human immunodeficiency virus (HIV); 2) endogenous infections, which are caused by overgrowth of organisms normally present in the genital tract of healthy women, such as bacterial vaginosis or vulvovaginal candidiasis; and 3) iatrogenic infections, which are associated with improperly performed medical procedures such as unsafe abortion or poor delivery practices. RTIs are preventable, and many are treatable as well.

PERI-MENOPAUSAL AND MENOPAUSAL ISSUES

With an ageing population and increased life expectancy, women in Sri Lanka will live one half to one third of their lives after menopause. A community-based study[17] conducted to collect information about the prevalence of menopausal symptoms and the relationship with their quality of life on women aged between 45 to 60 years living in the district of Colombo found that the most prevalent menopausal symptoms were joint and muscular discomfort (74.7 percent), physical and mental exhaustion (53.9 percent and hot flushes (39.1 percent). Hot flushes, sleep problems, and joint/muscular discomfort showed an increase in prevalence from the premenopausal category to the postmenopausal category. Women with menopausal symptoms had significantly lower quality of life compared with women without symptoms.

16. Hemachandra, D K N N, Manderson L. Menstrual problems and health seeking in Sri Lanka. Women & Health. 2009: 49 (5): 405-21.
17. Waidyasekera H1, Wijewardena K, Lindmark G, Naessen T. Menopausal symptoms and quality of life during the menopausal transition in Sri Lankan women. Menopause. 2009: 16(1):164-70.

ANNEX 2

STAKEHOLDERS IN THE WELL WOMAN PROGRAMME

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
National level						
Ministry of Health, Nutrition and Indigenous Medicine (MoH)	• Provides overall policy direction on health and the WW Programme • Allocation of resources • Ensuring the health and productivity of the population • Provision of infrastructure and maintenance • Procurement of equipment and supplies for screening, diagnosis and treatment • Ensure that the general population has access to information on health issues including NCD • Provide services as close to the family residence as possible • Dialogue with private sector in expansion of services	High	High	• Coordinate implementation of this Strategic Plan through the TAC; • Lobby WHO SEARO to negotiate with manufacturers of HPV tests and HPV vaccines for concessionary prices for pooled procurement which will bring economies of scale and reduce costs • Provide adequate budgetary allocation for HPV DNA technology, consumables • Promote local and international partnerships in furthering Women's Health; • Make adequate human resources available, by recruitment, training, deployment, retaining and motivating; • Make RH Diplomates a closed service to avoid transfer to non RH positions • Strengthen cytology and histopathology laboratories • Facilitate private sector participation for the WW Programme; • Set standards, provide indicators and develop guidelines in collaboration with the professional colleges; • Engage in resource mobilization from development partners together with the D/ International Health	• Inadequate resource allocation for scaling up of the DNA pilot project • Insufficient recruitment, training, deployment of human resources • Trend in allocation of resources in favour of curative services is not reversed • Bowing to trade union pressure in making RH Diplomates a closed service • Excessive taxation and lack of incentives to the private sector	• Prepare policy brief to demonstrate cost -benefit of HPV testing and HPV vaccination in the long term even though the initial investment is high. • Lobby parliamentarians / decision makers for additional financial and human resource; • Advocate with MoH to pursue with WHO SEARO pooled procurement of HPV tests and vaccines

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Technical Advisory Committee on Well Woman Programme (TAC)	• Provides overall guidance to the WW Programme	High	High	• Advocate with MoH for the Strategic Plan to be implemented • TAC WW Programme identifies and engage prominent personalities to promote WWC as champions (e.g. sports personalities, actors, musicians, artists, politicians) • Develops strategy for engagement of the private sector in the WW Programme		• Revise TOR • Broad base the membership e.g. private sector representative; D/ Private Health sector Development, College of Microbiologists once HPV testing is introduced
Gender and Women's Health Unit (FHB)	• Technical lead for the WW programme • Responsible for planning monitoring and evaluation of the WW programme by provinces and districts • Responsible for capacity development • Procurement and distribution of equipment and supplies for the WW Programme	High	High		• Inadequate human resources for managing the WW Programme	
Family Planning Unit (FHB)	• Family planning is one of the services provided by the WW Programme • Ensure FP commodities are available in WWC	High	High	• Use the WWC to address the unmet need of older women, sexually active single, widowed, divorced, separated women who are reluctant to go to formal FP clinics for services		
Planning Monitoring and Evaluation Unit (FHB)	• Responsible for the eRMIS and generation of reports and data	High	High	• Include new indicators in the eRHMIS identified by the WW Programme • Link cytology labs and WWC so as to improve turnaround time • Extend eRHMIS to PHMs so as to obtain real time data		

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Health Promotion Bureau (HPB)	• Responsible for communications and mass media on the WW Programme • Conducts the Mother Support Groups (MSG)	High	High	• Use social media, mobile technology / for creating awareness among women	• Inadequate financial resources for BCC activities	• Regular coordination meetings between National Programme Managers in addition to the TAC
NCD Unit	• Responsible for addressing risk factors related to NCD • Healthy Lifestyle Clinics • Refer women to WWC for CBE and Pap smears	High	Low	• Increase the women screened in the 35 and 45 age cohorts	• Compete for resources with the WWC	• Regular coordination meetings between National Programme Managers • Include NCD unit in the TAC • Ensure clear demarcation of roles and responsibilities
National Cancer Control Programme (NCCP)	• NCCP is the focal point for prevention and control of cancer in the country • Responsible for policy, advocacy, monitoring and evaluation of prevention and control of cancer • Responsible for establishing 1 colposcopy clinic in each district • Ensuring treatment of invasive cancer	High	High	• Ensuring the continuum of care for women with HPV +ve or abnormal Pap smears by establishing of colposcopy clinics	• Compete for resources with the WWC • Inadequate colposcopy services will lead to breakdown in the referral system from WWC for HPV + ve women and those with abnormal Pap smears	• Regular coordination meetings between National Programme Managers • Ensure clear demarcation of roles and responsibilities
Epidemiology Unit	• Responsible for the HPV vaccination programme in schools	High	High	• Influencing mothers / guardians of girls undergoing vaccination to attend WWC	• Compete for resources with the WWC	
National Medicines Regulatory Authority (NMRA)	• Responsible for the quality of contraceptive drugs, equipment and supplies for WW Programme	High	High	• Ensures the quality of contraceptives and other supplies used in the WW Programme		

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Parliamentary Sectoral Oversight Committee on Health and Human Welfare, Social Empowerment	• Review legislation in relation to health	High	High	• Support for WW Programme • Allocate adequate resources human and financial	• Unlike Capital Investment Projects there is not much visibility for programmes	• Prepare policy briefs • Conduct workshops for members • Conduct a screening and awareness session in Parliament • Identify and support potential champions
Ministry of Finance and Planning	• Allocates resource for health	High	High	• Inclusion of budget line on Women's health • Provide tax concession to private sector for expanding WWCs	• Benefits only a small segment of the population	• Demonstrate how WW Programme contributes to broader national development objectives • Explain and quantify how HPV testing and HPV vaccination are well targeted expenditure and not merely a cost • Demonstrate how investments in health sector complements investments in other sectors such as education
Ministry of Mass Media and Information	• Provide information on healthy lifestyles • Awareness creation on NCD	High	High	• Awareness creation on WW Programme – e.g Women's Day • Provide primetime for TV and radio programmes		• Conduct advocacy with Ministry
Ministry of Women and Children's Affairs	• Addresses women's issues in general • Improve the quality of life of women • Implement the Women's Charter	Moderate	Moderate	• Promote WW Programme through Women Development Officers attached to District and Divisional Secretariats • Awareness creation on WW Programme – e.g Women's Day		• Prepare policy briefs • Advocacy with Ministry and district level officials
Ministry of Plantation Industries	• Provision of incentives and other facilities to increase yield of plantation crops	Moderate	Moderate	• Encourage women in estate sector to use WWC • Persuade plantation owners to provide paid leave to attend WWC	• Unions may attribute political motives to the request	• Prepare policy briefs • Advocacy with Ministry and district level officials

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Ministry of Education	• Information in curricula on healthy life styles • HPV vaccination programme to Grade 6 Students	High	High	• Use the HPV vaccination programme to send messages to mothers to attend for screening at WWC		• Have awareness programmes for mothers of children in grade 6 • Have awareness programmes for teachers
Ministry of Higher Education and Cultural Affairs	• PGIM conducts postgraduate degrees	Moderate	Moderate	• Include colposcopy in MD Gynaecology training • Have a PG Diploma in colposcopy or include colposcopy in the RH Diploma • Increase the number of specialists trained	• To some extent postgraduate training intake dictated by MoH requirements	
Ministry of Upcountry villages, Estate Infrastructure and Community Development	• Providing basic facilities and other requirements to uplift the estate community economically, socially and culturally	High	High	• Encourage women in estate sector to use WWC • Persuade plantation owners to provide paid leave to attend WWC	• Unions may attribute political motives	• Develop policy briefs • Advocacy with Ministry and district level officials
Ministry of Labour and Trade Union Relations	• To protect and empower employed women and promote gender equity and equality • Protection of Working Women and Elimination of Child Labour • Occupational, Safety and Health • To ensure globally accepted rights and conditions at work	Low	Moderate	• Sensitize employers and the labour force on the importance of screening to maintain health • Promote workplace based screening	• Unions may attribute political motives	• Advocacy with Ministry and district level officials
Department of Samurdhi Development	• Promotion of livelihood economic development activities	High	High	• Encourage beneficiaries to use the WW services • Link benefits with screening – Conditional Cash Transfers	• Opposition politicians may claim coercion and politicization	• Lobby Department of Samurdhi Development

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Department of Census and Statistics	• Conducts DHS and other survey • Included questions on WWC in 2016 DHS	Moderate	Moderate	• Additional source of information to eRHMIS • Include questions in DHS and other surveys about WW Programme		• Engage with Department on a regular basis to identify opportunities for inclusion of questions relevant to the WW Programme
Foreign Employment Bureau	• Create awareness and disseminate information to woman migrants	High	High	• Use the opportunity to provide screening prior to departure		• Promote healthy migrant workers are sent abroad so that the FEB does not have to bear the cost of repatriation
Private sector employers with large number of female workers	• Gatekeeper to health for female employees • Return on investment from productivity of workforce, reduced absenteeism • Reduce training costs by preventing high turnover of staff due to sickness	High	High	• Encourage female staff to avail of WWC services • Support mobile clinics at workplace with unions • Provide paid leave for employees to go to WWC • Provide health insurance for employees including WW components in the insurance package • Maintenance of WWC in the vicinity to the factory as part of Corporate Social Responsibility		• Advocacy emphasizing the business case for companies to incorporate the broader health needs of workers into their business approach • Engage with private sector companies with large numbers of female staff e.g. garment factories • Stress indirect benefits from higher morale and better worker-manager communication

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Plantation Human Development Trust	• Works with the Government, Regional Plantation Companies and trade unions • To improve integrated services beneficial to plantation sector and its environs • Improve social and economic wellbeing • Ensure occupational health and safety dimensions • Improve productivity of the sector	Moderate	Moderate	• Encourage women in estate sector to use WWC • Persuade plantation owners to provide paid leave to attend WWC		• Advocacy emphasizing the business case for companies to incorporate the broader health needs of workers into their business approach • Stress indirect benefits from higher morale and better worker-manager communication
Labour unions	• Work for equal pay for women and men • Promote occupational health	High	High	• Encourage female members to avail of WWC services • Support mobile clinics at workplace with employers	• Unions may attribute political motives	• Advocacy emphasising the advantages to the membership from good health
Civil Society Organization	• Community mobilization • Advocacy with government	High	High	• Increase visibility of the WW Programme • Disseminate information on WW Programme		• Have workshops to sensitize CSO on the issue
Professional associations e.g. SLCOG, CPSL, College of Microbiologists, CCPSL	• Advocacy with the MoH • Provide technical assistance for policy formulation/review and implementation	High	High	• Developing guidelines and protocols • Establishing QC and QA standards for cytology labs • Develop curricula and conduct training • Accreditation of professionals e.g. colposcopists		• MoH and FHB to reassure professional associations they are trusted and valued partners • Clarify roles of FHB and professional colleges

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Private sector health providers	• Private sector OPD utilization is now more than the public sector • Some private sector hospitals are providing WW services	High	High	• Financing and provision of health services • Provide service statistics to the national RHMIS	• Private sector may not wish to share statistics with FHB	• Work with Director Private Health Sector Development • Provide training/ guidelines/ protocols for WWC • Include representatives from the private sector as members in the TAC • Advocacy with Ministry of Finance for tax incentives
Media houses and practitioners	• Want to increase circulation – human interest stories, • Acts as a watchdog	High	High	• Awareness creation and community mobilization	• May sensationalize shortcomings in the WW Programme	• Have workshops to sensitize media houses and practitioners on the issue • Introduce awards for media houses and practitioners who highlight the importance of screening etc

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
Provincial, district and divisional level						
Provincial Councils	• Health is devolved to the provinces	High	High	• Deployment of staff to ensure equitable distribution • Contracts can be issued in special circumstances by the Provincial Public Service Commission when it is difficult to fill vacancies. e.g. retired PHM, SPHMs, MO etc • Targeting service delivery to specific populations is a benefit of devolution. The target population varies from district to district	• May be more interested in capital development projects such as infrastructure	• Prepare position papers • Identify marginalized and vulnerable groups and areas of low coverage • Lobby and have workshops
Provincial Director of Health	• Renovation of clinics and buildings • Allocate resource for WW Programme • Monitor and supervise the WW Programme • Some categories of staff are employed and come under the administration of the provincial health authorities • Approve new private sector hospitals • Mobilize midwives in institutions with few deliveries and deploy them to the field	High	High	• Deployment of staff to understaffed areas • Renovate clinics in the province in a phased manner • Strengthen the pathology laboratories • Establish one colposcopy clinic in each district hospital • Ensure private sector hospitals with WWC provide quality services	• Competing priorities for funding and pressure to invest in capital development	• Advocacy with PDHS • G&WHU to review draft district and provincial health plans for inclusion of WW Programme activities
Regional Director of Health Services	• Establish one WWC per 15,000 palpation • Establish one colposcopy clinic in the district • Monitor and supervise the WW Programme	High	High	• Establish one colposcopy clinic in each district		• Advocacy with RDHS • G&WHU / MOMCH to review draft district health plans for inclusion of WW Programme activities

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
MOH	• Provides leadership to the health team • Implements the WW Programme • Ensure a WWC for 15,000 population • Monitoring and supportive supervision of the WWC	High	High	• Ensure the maximum coverage of the target population • Improve the quality of services provided		• Recognize and motivate • Introduce performance based incentives
Health service providers	• Provides the services in the WW Programme	High	High	• Increase coverage • Improve quality of services	• Concerned about workload • Poor remuneration • Lack of recognition • Poor motivation • Lack of facilities e.g. transport for supervision	• Awareness raising • Training programmes • Print and disseminate guidelines • Recognize and motivate • Introduce performance based incentives
Women Development Officers	• Mobilize women and conduct programmes for women at grassroots level	Medium	High	• Partner with WDO to mobilize women's groups, create awareness and encourage participation in screening	• May demand incentive/ payment	• Have workshops to sensitize WDOs on the issue

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
			Community			
General population	• Consumers of WWC services • Awareness of WWC low (2016 DHS Survey) • Health seeking behaviour is low	Moderate	High	• Satisfied clients can encourage other women to attend • Can provide feedback to improve the quality of services	• Perception of poor quality of services (e.g. disrespectful behaviour of staff) will damage the image of the programme	• Make services available at times convenient to clients • Call and recall clients in the 35 and 45 age cohorts • Improve IPC • Increase awareness by mass media • Pilot mobile technology to remind clients
Community leaders/ gate keepers	• Influence community / heads of household on issues in general • Some disapprove of FP on religious grounds • Some communities are suspicious of the motives of government programmes • May not be aware of the importance of screening	High	High	• Once males and gatekeepers are convinced of the advantages of the WW Programme they will encourage their women folk to attend	• Can discourage women in the community from attending WWC	• Prepare IEC materials targeting males • Have programme to create awareness among males and community leaders
Traditional healers	• Patients may delay in seeking care and present with advanced disease • Not empowered with accurate information	Moderate	High	• Recognise early symptoms and encourage referral to health facility or liaise with community health workers	• A bad experience can damage the image of the programme	• One to one meetings with traditional healers to convince them to encourage women to attend WWC
Community based organizations especially women's organizations	• Community mobilization • Funeral Aid Societies • Temple development societies • Reduce poverty and empower rural women	Low	High	• Awareness raising on WW Programme • Can be used by MOH for accountability to community for quality of services provided at WWC	• A bad experience by a member of the community can damage the image of the programme	• MOMCH MOH holds meetings to create awareness among members

Stakeholder	Function/interest	Influence	Impact	Potential contribution	Potential negative impact	Strategy to engage the stakeholder
International organizations						
Development partners, World Bank, UNFPA, WHO and European Union	• WB is funding the PHC system strengthening project which includes cervical screening • UNFPA funded the WWC strategy development • Advocacy	Moderate	Moderate	• Advocacy • Provide technical assistance	• Sri Lanka being a LMIC is at a disadvantage to mobilizing resources • Reduced United States contribution to the UN may have an impact on funding	• Identify strategic areas to request funding from the UN and other development partners • Develop project briefs and proposals for funding
International service organizations e.g. Rotary International Lions Clubs	• Bring together business and professional leaders in order to provide essential services such as health, education	Moderate	Moderate	• Contributions in cash and in-kind	• Deep suspicions among a minority of the population about the motives of international organizations	• Develop project briefs and proposals for funding • Conduct visits to WWC

ANNEX 3

SWOT ANALYSIS

Strengths	Weaknesses	Opportunities	Threats
SERVICE DELIVERY			
Access to health services			
• There were approximately 1000 WWC in 2018 • 1 WWC per 15,000 population is to be established • In addition to WWC held at MOH, field clinics are also conducted • Clinics are held on Saturday as well to accommodate working women • WWC are held at worksites • On average, Sri Lankans live within 1.4 kilometers of a basic health clinic and 4.8 kilometers from a free government-sponsored Western-type health care facility. • Financial access is not an issue to most women as services are delivered free • HLCs refer women to WWC for PAP smear and CBE • FP services are available at WWC • 36 cytology laboratories established • Private sector hospitals are providing WWC services • Health services are decentralized	• Geographic access is difficult in some remote areas e.g. estates • While WWC services are free some women may experience health related expenditure due to transport costs and loss of wages • Time and location of clinics is inconvenient for some working women • Language dichotomy between staff and clients acts as a barrier • Services provided by male staff may impede sociocultural access • KII say there are very few referrals for colposcopy • Not many colposcopy clinics (see HRH for colposcpists) • District health plans may not reflect WWC programme adequately • Unmet need for limiting is highest in the 35-39 age group	• Privates sector is expanding - improvement in purchasing power of the population in Sri Lanka coupled with actual and perceived gaps in quality and availability of public health services has contributed to increased demand for health services delivered by the private sector.(see also Health Financing) • Opportunity for Public Private Partnership (PPP) to expand services, especially in remote areas. (see Health Financing Section) • 1 colposcopy clinic per district is to be established	• Priority on communicable diseases and tertiary care at the expense of preventive services • PPP may face public opposition, distrust and lack of confidence mistaking it for privatization
Coverage, utilization and equity of WWC services			
• Coverage has increased over time • 35 year age cohort is targeted • 45 year age cohort has also been added • PHMs visit clients and call and recall women for screening using Eligible Couples Register	• Some PHM areas are vacant so many women are not invited individually to WWC • Socio-cultural constraints, lack of knowledge/ ignorance, poverty pose challenges in use of services • 2016 DHS showed that coverage of WW services was low among women in the lower wealth quintiles, with less education and resident in the estate sector	• Can also use voter registration to identify women in the 35 and 45 age groups • Diffuse mobile telephone network which can be used to call and recall women	• Services in WWC are free but health related expenditure for transport and loss of wages may lead to women not availing themselves of WW services

Strengths	Weaknesses	Opportunities	Threats
SERVICE DELIVERY			
Quality of health services			
• General in-service training is carried out to improve competencies of staff • Supervision and monitoring visits from national to district level and from provincial to district level are carried out but the frequency varies • District and national reviews are conducted • Guidelines on WWC have been revised and circulated in 2018 • A handbook for clinic staff was developed in 2003 and revised in 2010. • Guidelines for cervical cytology screening and reporting have been developed • CPSL and SLCOG have supported the development of guidelines • Suggestion boxes are found in some clinics but are rarely used	• Impolite staff and lack of personalised service • Long waiting time • Some clinics, especially those located in buildings belonging to the Provincial Councils are not purpose built. • In many cases health personnel have not been involved in infrastructure planning of buildings coming under the preview of Provincial Councils, DDC etc and used as clinics. • Poorly maintained facilities. Lack of basic amenities such as water, sanitation and adequate seating in waiting areas. Lack of auditory and visual privacy in some clinics • Inadequate funds are allocated for infrastructure maintenance • Frequent trade union action leads to breakdown of services and dissatisfaction with services • Poor referral system • Weak QC and QA in cytology labs and clinics • There are no management committees in the preventive sector though there are hospital committees in the curative sector • No mechanism for supervision of private sector by MoH	• More and more clients are demanding quality services because of increasing levels of disposable income and education • Consumer attitudes especially in relation to outpatient care has shifted to the private sector • Obtain informed consent prior to Pap smear	• Irregular and inadequate funding of Provincial Council health departments may limit improvements in infrastructure • Lack of commitment of managers to quality improvement • Introducing QC and QA in pathology labs may be seen as too much work by cytoscreeners and pathologists • Sustainability in terms of maintenance of infrastructure is not assured

Strengths	Weaknesses	Opportunities	Threats
SERVICE DELIVERY			
Consumer knowledge and behaviour			
• Community awareness about cancer and other NCDs in general is present • HPB has produced a BCC strategy for the WWC Programme	• Communication mainly focuses on providing information e.g. pamphlets, brochures, posters etc and are not aligned to strategic aspects such as behaviour change • BCC strategy is not widely known about and implemented • Weak coordination between HPB and FHB on BCC • Inadequate awareness about WWC (2016 DHS) • Inadequate use of mass media • Inadequate use of technology based interventions e.g. hotline, social media, mobile phones • Women don't know that FP services are available at WWC (DHS) • HEOs available in all districts but underutilized	• High literacy rate of the population • Good coverage of mobile phones networks • Conduct HE using AV equipment at WWC • Tele dramas etc are popular • Each PHM area is expected to have a MSG. These can be used to promote WW Programme • Work with gatekeepers, males in the community so as to gain their support	• High cost of sending bulk messages by mobile • Traditional practices and beliefs that may cause poor appreciation of screening for disease

Strengths	Weaknesses	Opportunities	Threats
HUMAN RESOURCES FOR HEALTH			
Active Health Workforce Stock			
• Norm is 1 PHM per 3000 population • Can mobilize institutional midwives from small hospitals which are underutilized as PHMs and deploy them to the field • Cytoscreeners available • Gynaecologists and gynaecological oncologists are available	• Many PHM areas are vacant • Recruitment of PHM not carried out on a regular basis • Some AMOH posts are vacant • Inadequate number of cytoscreeners, especially if island wide HPV testing is not approved and have to continue with cytology screening • Cytoscreeners carry out other duties in the Pathology labs • Very few gynaecologists are trained in colposcopy	• Increase the health workforce as part of generating employment but at the expense of expanding the public sector	• Inviting women in the 35 and 45 age cohorts is impeded by lack of PHM • In the absence of adequate human resources sustainability is not assured
Human resources for health education			
• PSE Training schools throughout the country	• In order to recruit more PHM the entry qualifications have been changed • No regular in service training • No language training prior to deployment • IPC of health staff is weak	• High literacy rate • Integrate cytology into the PSE of MLTs	• Source of funding for training is not assured • Sustainability is not assured
Health labour market			
• Retirees can be re-employed on contract basis • MO and MLTs engage in dual practice • RH Diploma training programme	• Career prospects are poor for PHM • Low salaries • RH Diplomates may not be retained in RH posts • Weak performance appraisal, promotion, professional development opportunities	• Extend the retirement age so as to retain staff	• Women have more job options with the open economy
Serving the populations health needs			
• Job description available for most cadres • Job aids available • Non- monetary incentives and recognition for good performance	• HRH are not evenly distributed • RSPHNO and MOH duty lists need to be update to reflect WWC • Weak supervision • No regular access to skills updates	• Change existing punitive supervision practices (reducing incentives and using blame, which cause fear) to supportive supervision	
Human resources for health policies			
• Staffing norms are available	• Though staffing norms are available there is a shortage of staff of all categories which is compounded by skewed distribution		

Strengths	Weaknesses	Opportunities	Threats
MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES			
• Existence of an autonomous NMRA responsible for regulation of drugs and devices • A functioning system for pharmaceutical and devices registration exists • The Government finances the equipment and supplies for the WWC • HPV test piloted with government funds • Private sector procures FP commodities • Contraceptives are on the Essential Drug List • Procurement has to be from suppliers registered with the NMRA • Procurement is centralized FHB procures most equipment e.g. Pap test kits for mobiles • Contraceptives for the WW Programme are procured through MSD and the SPC • Procurement is though competitive bids • Prequalification process of suppliers' and products exists • Procurement is based on reliable estimates – G&WHU uses CHANNEL • Each health area has a RMSD • A distribution plan from FHB to RMSDs exist • Distribution plans from RMSD to MOH exists	• Average turnaround time is about 1 year • Though procurement is through competitive bids sometimes this results in a compromise on quality • Some of the RMSDs are not purpose built • Weak storage practices • Though there are distribution plans deliveries may not be able to keep to schedule due to breakdowns in transport	• Regional pooled procurement of HPV tests kits with countries in the region will reduce costs	• Funds may not be sufficient for HPV test to be scaled up throughout the country • Being a LMIC development partner assistance is very little

Strengths	Weaknesses	Opportunities	Threats
HEALTH INFORMATION SYSTEM			
Health information system governance and management			
• Routine information collected by RHMIS • Non routine information from Registrar General's Department and Dept of Census and Statistics surveys are used • Vital registration system is in place • Census information is used for population estimates • There is a functional M&E Unit in FHB that coordinates HIS activities • Growing demand for health related information especially after the eRHMIS • Reporting of information is done frequently and on time. This has improved with the shift from a paper based system to the eRHMIS located at MOH and transmitted to the M&E Unit at FHB • There is a well-defined system of data collection and reporting from the facility up to the national level • There are institutionalized regular procedures to verify the quality of reported data (accuracy, completeness and timeliness) • Periodic training of WWC staff on data collection and reporting is conducted • List of core indicators exists for the WW programme	• RHMIS at grassroots level is still paper based, so liable to data quality issues • DHS not done every 5 years • Private health facilities and practitioners are not mainstreamed in the RHMIS • There are no policies, laws or regulations that compels the private sector to provide information to the HMIS except in the case of notifiable diseases. • List of core and standardized indicators is available but needs revision due to changes to the WWC programme and for better programme management	• Moving away from the paper based HMIS • Make precancer and cancer a notifiable disease	• Cost of extending the eRHMIS to grassroots level may be too exorbitant • Training costs will be high
Data management, information products and dissemination			
• Family health annual report is produced which contains information on the WW Programme	• Delays in producing the annual report which should be rectified with the use of the eRHMIS		

Strengths	Weaknesses	Opportunities	Threats
HEALTH INFORMATION SYSTEM			
Data quality and information use			
• RHMIS data for the WW programme is disaggregated by age cohorts, districts and abnormalities • The e RHMIS has improved the availability of information for the National Programme Manager, WW Programme to review progress and to make timely decisions • The district and national reviews use RHMIS data to inform of programme performance • Indicator driven short term planning is carried out at MOH, district and national level • Incentives for data use, such as awards are given to best performing PHM WWC etc	• RHMIS at grassroots level is still paper based, so liable to data quality issues • Weak supervision affects the quality of the information that is collected • Targeted service delivery improvement is impeded by inadequate data disaggregation e.g. wealth quintiles, education, residence etc • The RHMIS does not collect information on the quality of clinical services on a regular basis • Insufficient use of data for resource allocation and health promotion	• Extend the eRHMIS and provide tablets to grassroots level workers to obtain real time data • Use an electronic dashboard to inform the TAC,	

Strengths	Weaknesses	Opportunities	Threats
HEALTH FINANCING			
• Healthcare is mainly financed by general taxation revenue • Agrahar - managed by National Insurance Trust Fund provides health cover to public sector employees • Services are provided free of charge at WWC • WB is funding the PHC system strengthening project which includes cervical screening	• Majority of provider payment in the private sector is OOP, very little is by employer or insurance • Health insurance has not caught on in Sri Lanka. • The poorest segments will not be able to afford private insurance premiums and are not covered by employers as they are typically in the informal sector • Since Sri Lanka has graduated to being a LMIC external funding that is available is limited • Very little if any of health financing is from the provincial budget • Though services are provided free at WWC, women face health related expenditure for transport and loss of wages by working women • Lack of prioritization of women's health by Provincial / district health authorities • No dedicated budget line for Women's Health exists • There are no performance based incentives in place in the public sector	• Lever resources from private sector e.g. CSR • Private sector is expanding • PPP initiatives in providing health care including WW services • Include WWC in insurance packages of Agrahara and private insurance companies	• Majority of public sector funding is for curative services resulting in underfunding of preventive services • Government expenditure on health may remain static or reduce due to the poor state of the economy • PPP may face public opposition, distrust and lack of confidence mistaking it for privatization

Strengths	Weaknesses	Opportunities	Threats
GOVERNANCE			
Voice and preference aggregation			
• Mechanism are in place to ensure the participation of key stakeholders in the WW Programme e.g TAC in place	• TAC needs to be more active in monitoring and evaluation of the programme • No active moves by the MoH to solicit public inputs into policies e.g. on the shift to HPV testing • There are no governance mechanisms or incentives in place in the public sector to improve service quality, efficiency and effectiveness (e.g. incentive programmes that are tied to client feedback can provide a powerful mechanism to improve service quality)		
Accountability and oversight			
• Health professional organizations play a role in establishing guidelines etc	• There is very little oversight by the public and CSO of health service providers and institutions and how health services are financed. Client provider committees e.g. Hospital committees exist but not at MOH level		
Leadership and Governance			
• Strong and consistent leadership of the sector from MoH • Service providers in the public sector use evidence from programme results to improve the quality and efficiency of services but are limited by available resources • The private health sector is very sensitive to client perceptions	• There are no continuing professional education or recertification requirements in place, hence, very little incentive to improve performance • Very little attention is paid to client satisfaction and client needs in the public sector • Capacity of the G&WHU MoH in terms of HR needs strengtheing • Capacity in districts for delivery of the WW Programme, especially in managing the programme needs to be strengthened	• Introduce performance based incentives	• Public sector health service have strong trade unions which may resist reforms such as recertification etc
Data use for Governance			
• The routine (eRHMIS) and non-routine sources (e.g. Census DHS) of information are used by the public health sector for decision making in the public sector	• Private sector does not provide health information to the government except in the case of communicable disease notification	• Make cancer a notifiable disease which will improve reporting and will lead to the private sector providing this information • Need to move to population based cancer registry	• Private sector feels threated to release information to Government because of taxation fears and confidentiality issues related to patients

ANNEX 4

ACTION PLAN

STRATEGIC OBJECTIVE 1: WIN SUPPORT FOR THE WWP FROM DECISION MAKERS								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 1.1 Conduct evidence based policy advocacy among policy makers at national and subnational levels to reposition the WWP as a national priority.	1.1.1 Influence government (Parliament, Ministries of Finance, Health and Local Government) on the need for introduction of HPV testing and the merits and demerits of this method over the current method, cervical cytology and obtain their commitment.	1.1.1.1 Develop a position paper on HPV testing and its advantages including economic, over the current cytology based screening.	G&WHU	x	x			
		1.1.1.2 Hold workshops for policy makers.	G&WHU	x				
	1.1.2 Influence the MoH to lobby WHO SEARO and health ministers of the region to introduce pooled procurement of HPV test kits and HPV vaccines so as to bring down costs.	1.1.2.1 Develop a position paper on the merits and demerits of pooled procurement of HPV test kits and HPV vaccines.	G&WHU Epid Unit	x	x			
		1.1.2.2 Submit to WHO SEARO and circulate to member states for support.	MoH	x				
	1.1.3. Influence the Ministry of Finance, MoH and Provincial Ministries of Health to recruit midwives annually to reduce the current vacancies.	1.1.3.1 Project staff requirements for different categories for next 10-15 years based on demographic patterns (increase of aging population), gendered NCD mortality (breast, cervical and thyroid cancers) and morbidity patterns, staff attrition from retirement, recruitment etc.	G&WHU HRH Unit	x	x			
		1.1.3.2 Develop position papers showing the projections of requirement of midwives in institutions and the field in coming years.	G&WHU HRH Unit	x	x	x	x	x
	1.1.4 Influence MoH and Provincial Ministries of Health to deploy midwives from institutions with few deliveries as PHMs as a temporary measure.	1.1.4.1 Identify PHM from underutilized institutions with few deliveries in each province.	G&WHU HRH Unit	x				
		1.1.4.2 Advocate with MoH and PDs to deploy midwives as PHMs from underutilized institutions.	G&WHU HRH Unit	x				
	1.1.5 Influence MoH and Provincial Ministries of Health to ensure equitable distribution of trained staff to MOH offices, especially underserved communities in estate, urban and rural areas.	1.1.5.1 Develop position papers showing the current deployment of staff, vacancies by district and MOH area.	G&WHU HRH Unit	X				
		1.1.5.2 Sensitize policymakers. Organize advocacy workshops for members of parliament, provincial council members, civil society organizations, professional associations and media representatives.	G&WHU HRH Unit	x	x			
	1.1.6 Influence the Ministry of Finance and MoH to encourage the private sector to provide WW services by granting special privileges such as tax concessions.	1.1.6.1 Hold consultations with the privates sector providers and D/ Private Health Sector Development.	G&WHU D/ Private Health Sector Development	x				
		1.1.6.2 Lobby the Ministry of Finance	MoH	x				

STRATEGIC OBJECTIVE 1: WIN SUPPORT FOR THE WWP FROM DECISION MAKERS								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 1.2 Update legislation to make confirmed or suspected cases of female cancers (breast cervical and thyroid) in both the public and private sectors notifiable diseases.	1.2.1 Require compulsory reporting of confirmed or suspected cases of female cancers (breast, cervix and thyroid) in both public and private sectors.	1.2.1.1 Health facilities and laboratories report cases of female cancers.	MoH TAC G&WHU NCCP NCD SLCOG CPSL	x	x	x	x	x
		1.2.1.2 Use notifications to monitor the effect of screening programmes.	G&WHU	x	x	x	x	x
Strategy 1.3 Raise the priority status accorded to the WWP.	1.3.1 Representation through the Minister of Health to Cabinet with regards to the burden of cervical, breast, thyroid cancer, diabetes and hypertension, their social and economic impact on women and the need for the inclusion of prevention and treatment for these conditions in national development frameworks.	1.3.1.1 Prepare position papers, briefing notes, fact sheets.	MoH TAC G&WHU NCCP NCD	x	x	x	x	x
		1.3.1.2 Make presentations to Parliamentary Committees.	G&WHU	x	x	x	x	x
		1.3.1.3 Ensure WWP issues are reflected in policy documents.	G&WHU	x	x	x	x	x
	1.3.2 Representation through Minister of Health to Cabinet with regards to Sri Lanka's commitments to the (a) Global Strategy for Women, Children's and Adolescent Health 2016-2030, (b) the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and (c) the Sustainable Development Goals.	1.3.2.1 Prepare position papers, fact sheets for presentation at global and regional meetings highlighting commitments of the Government of Sri Lanka and achievements.	G&WHU	x	x	x	x	x
		1.3.2.2 Brief the minister and other high officials prior to meetings.	G&WHU	x	x	x	x	x
	1.3.3 Periodic meetings with development partners such as World Bank, WHO, UNICEF and UNFPA to highlight the burden of cervical, breast, thyroid cancer, diabetes, hypertension on women and progress in implementation of the Strategic Plan.	1.3.3.1 Prepare fact sheets, project briefs to present to donors.	G&WHU	x				
		1.3.3.2 Hold meetings with development partners at least biannually to inform of developments.	G&WHU	x	x	x	x	x

STRATEGIC OBJECTIVE 1: WIN SUPPORT FOR THE WWP FROM DECISION MAKERS								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 1.4 Promote and advocate for a multisectoral national response, cooperation and partnership to eliminate cervical cancer and strengthen the WWP.	1.4.1 Identify and engage diverse stakeholders to support WWC	1.4.1.1 Conduct a stakeholder mapping and identify positions of stakeholder, those for and against. Identify the best format to present the information e.g. one on one meeting, workshop.	G&WHU	x				
		1. 4.1.2 Identify stakeholders who have a potential interest in the WWP.	G&WHU,	x				
STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 2.1: Ensure the shift to HPV screening is based on concrete evidence.	2.1.1 Evaluate the demonstration project conducted in Kalutara.	2.1.1.1 Conduct a rigorous independent evaluation of the pilot - programmatic, technical and financial - looking at relevance, effectiveness, efficiency.	FHB CPSL SLCOG	x				
		2.1.1.2 Present findings to the TAC to proceed with planning for the introduction of HPV.	G&WHU	x				
2.2 Plan for change.	2.2.1 Develop guidelines for HPV testing.	2.2.1.1 Establish technical working group with experts on HPV testing from SLCOG, CPSL, Sri Lanka College of Microbiologists, Sri Lanka College of Community Physicians.	G&WHU M&E SLCOG CPSL SL College of Microbiologists, SLCCP	x				
		2.1.2.2 Develop SOP and guidelines including target age groups (35 and 45 years), frequency of screening (every 10 years); select a HPV test; develop algorithms for the management of women with HPV positive test results; procedures for HPV test sample collection and transport to the laboratory; establish staffing norms for WWC, laboratories, colposcopy clinics.	TWG	x				
	2.2.2 Develop a costed Programme Implementation Plan (PIP) for cervical screening.	2.2.2.1 Identify costs for equipment supplies, training, transport and communication, BCC material costs etc.	G&WHU	x				
		2.2.2.2 Establish HPV laboratory processes and flow of information and communication between the laboratory and WWC.	TWG	x				
		2.2.2.3 Develop a training plan for service providers in clinics and laboratory staff.	TWG	x				

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
2.2 Plan for change.	2.2.2 Develop a costed Programme Implementation Plan (PIP) for cervical screening.	2.2.2.4 Identify BCC messages and develop a BCC communication plan for HPV testing.	HPB	x				
		2.2.2.5 Establish Programme M&E processes, targets and indicators.	TWG	x				
		2.2.2.6 Finalize the multiyear costed Programme Implementation Plan (PIP).	TWG	x				
	2.2.3 Confirm government commitment to the shift.	2.2.3.1 Conduct advocacy for the introduction of HPV testing including preparation of a position paper.	G&WHU	x				
		2.2.3.2 Present the costed Implementation Plan to TAC.	G&WHU	x				
		2.2.3.3 Confirm availability of resources.	MoH	x				
	2.2.4 Conduct stakeholder consultation and build consensus.	2.2.4.1 Hold a series of consultative meetings with professional organizations, NGOs, research organization, development partners.	G&WHU	x				
		2.2.4.2 Provide journalists with basic information about HPV testing, cervical cancer, and the epidemiological situation in the country.	G&WHU HPB	x				
2.3 Implement the plan.	2.3.1 Improve availability of WW services by establishing one WWC per 15,000 population.	2.3.1.1 Map geographic location of clinics.	"Research Unit G&WHU"	x				
		2.3.1.2 Document service deficiencies, infrastructure, human resource, availability of equipment and supplies, IEC material, guidelines, stock outs of contraceptives etc.	"Research Unit G&WHU"	x	x			
		2.3.1.3 Provide feedback to PDHS and RDHS to adopt corrective measures.	"Research Unit G&WHU"		x			
		2.3.1.4 Establish new WWCs that are fully equipped and with the requisite human resources.	G&WHU RDHS MOMCH		x			
		2.3.1.5 Establish procedure for HPV test sample collection and transport to the laboratory.	G&WHU SL College of Microbiologists DDGLS	x	x	x	x	x
		2.3.1.6 MOH is responsible to inform the client of the test result regardless of whether it is positive or negative.	FHB RDHS	x	x	x	x	x

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
2.3 Implement the plan.	2.3.2 Strengthen the laboratories where HPV testing will take place.	2.3.2.1 Identify the WWC which will send samples to the national HPV testing laboratories to be established.	G&WHU DDGLS	x				
		2.3.2.2 Identify necessary infrastructure improvements, human resources, equipment and supplies.	G&WHU SL College of Microbiologists DDGLS	x				
		2.3.2.3 Carry out renovations, provide human resources and necessary supplies and equipment.	PDHS RDHS	x	x	x	x	x
		2.3.2.4 Build in workplace safety measures.	G&WHU SL College of Microbiologists DDGLS	x	x	x	x	x
		2.3.2.5 Establish internal and external quality control measures.	G&WHU SL College of Microbiologists DDGLS	x	x	x	x	x
		2.3.2.6 Establish QA measures in all laboratories.	G&WHU SL College of Microbiologists DDGLS	x	x	x	x	x
		2.3.2.7 Establish information and communication procedures between the laboratory and WWC.	G&WHU SL College of Microbiologists DDGLS	x	x	x	x	x
		2.3.2.8 Develop SOPs for all laboratory procedures.	G&WHU SL College of Microbiologists DDGLS	x				
	2.3.3 Strengthen colposcopy services by establishing one clinic per district.	2.3.3.1 Map the current colposcopy clinics and their catchment areas.	NCCP SLCOG	x	x			
		2.3.3.2 Conduct a capacity assessment with the view of establishing one colposcopy clinic in each district (see Highly prioritized actions, 2018-2020 under the 2016-2020 National Multisector Action Plan developed during the Task Force Mission)	NCCP SLCOG	x				
		2.3.3.3 Identify HR, equipment (colposcopes, cryotherapy and gas, LEEP) and infrastructure requirements.	NCCP SLCOG	x				
		2.3.3.4 Establish clinical standards for colposcopy.	NCCP SLCOG	x				
		2.3.3.5 Develop a training programme in colposcopy leading to certification.	NCCP SLCOG	x				
		2.3.3.6 Provide basic and advanced colposcopy training.	NCCP SLCOG	x	x	x	x	x

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
2.3 Implement the plan.	2.3.3 Strengthen colposcopy services by establishing one clinic per district.	2.3.3.7 Document follow up procedures e.g. in the case of incomplete excision; full excision with CIN only or micro-invasive lesions; glandular abnormalities; pregnant women; immunosuppressed women.	NCCP SLCOG	x				
		2.3.3.8 Identify histopathology laboratories to which biopsy specimens are to be sent.	NCCP SLCOG CPSL DDGLS	x				
		2.3.3.9 Develop SOP for colposcopy procedures.	NCCP SLCOG CPSL DDGLS	x				
	2.3.4 Strengthen histopathology laboratories to which histological specimens will be sent.	2.3.4.1 Map the histopathology labs to which the colposcopy clinics will send biopsy specimens.	NCCP CPSL DDGLS	x				
		2.3.4.2 Conduct a capacity assessment of the laboratories including HR, equipment and infrastructure requirements.	NCCP CPSL DDGLS	x				
		2.3.4.3 Develop SOPs for histopathology laboratories receiving specimens from colposcopy clinics	NCCP CPSL DDGLS	x				
		2.3.4.4 Develop communication mechanism between colposcopy clinic and histopathology laboratory to minimise clients visits.	NCCP CPSL DDGLS	x	x	x	x	x
		2.3.4.5 Establish QC and QA system in histopathology laboratories receiving specimens from colposcopy clinics.	NCCP CPSL DDGLS	x	x	x	x	x
		2.3.4.6 Establish notification of precancer / cancer to NCCP and FHB (see 1.2.1)	NCCP CPSL DDGLS	x				
	2.3.5 Procure and distribute equipment and HPV tests bearing in mind expiry dates.	2.3.5.1 Forecasting of requirements and preparation of specifications.	G&WHU	x				
		2.3.5.2 Prepare Request for Proposals (RFP).	G&WHU SLCOG CPSL College of Microbiologists	x				
		2.3.5.3 Identify suppliers, inspect samples and place orders.	G&WHU	x				
		2.3.5.4 Receive stocks and ensure proper storage at FHB.	G&WHU					
		2.3.5.5 Develop a distribution plan for the test kits from FHB to RMSDs.	G&WHU RMSD	x	x	x	x	x

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
2.3 Implement the plan.	2.3.5 Procure and distribute equipment and HPV tests bearing in mind expiry dates.	2.3.5.6 Ensure kits are stored according to guidelines.	G&WHU RMSD	x	x	x	x	x
		2.3.5.7 Strengthen monitoring and supervision of RMSDs.	G&WHU RMSD MOMCH	x	x	x	x	x
	2.3.6 Train MOH, AMOH, PHNS, SPHM and PHMs on HPV testing including self sampling.	2.3.6.1 Identify topics to train health workers including self sampling.	G&WHU SLCOG College of Microbiologists CPSL	x				
		2.3.6.2 Develop training material and job aids.	G&WHU SLCOG College of Microbiologists CPSL	x				
		2.3.6.3 Conduct training of all health workers especially PHMs on self sampling and reporting results to women.	G&WHU SLCOG College of Microbiologists CPSL	x				
		2.3.6.4 Evaluate training.	G&WHU			x		x
	2.3.7 Improve communication and counselling skills of health service providers in the pre-screening period, about screening results, women who need further care and pre/post treatment and women with precancer. (also see 6.3)	2.3.7.1 Analyse current counselling training.	G&WHU	x				
		2.3.7.2 Design and develop a training curriculum .	G&WHU	x				
		2.3.7.3 Conduct training on counselling of health workers.	G&WHU					
		2.3.7.4 Evaluate the training programme in 2021 and refine it further.	G&WHU			x		
		2.3.7.5 Monitor compliance to guidelines during supervision visits.	G&WHU RDHS MOMCH RSPHNO		x	x	x	x
	2.3.8 Ensure continuity of care through a clear referral pathway for women with HPV positive results.	2.3.8.1 Define and disseminate the list of referral colposcopy centres for each MOH.	G&WHU RDHS MOMCH					
		2.3.8.2 Agree on the roles and responsibilities of referring facility/provider and the facility/provider accepting the referral.	G&WHU RDHS MOMCH D/hospital VOG	x				
		2.3.8.3 Develop referral guidelines.	G&WHU	x				
		2.3.8.4. Equip WWC with referral forms and relevant tools.	G&WHU MOMCH	x				
		2.3.8.5 Educate health workers and the public on the referral system.	MOH	x	x	x	x	x

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
2.3 Implement the plan.	2.3.8 Ensure continuity of care through a clear referral pathway for women with HPV positive results.	2.3.8.6 Improve communication between MOH and the colposcopy clinic accepting the referral.	RDHS MOMCH MOH D / hospital	x	x	x	x	x
		2.3.8.7 MOH to ensure referred clients go to referral centre.	MOMCH MOH PHM	x	x	x	x	x
		2.3.8.8 Monitor and supervise referral practices and support mechanisms.	RDHS MOMCH G&WHU	x	x	x	x	x
	2.3.9 Conduct media campaign giving publicity to the new test.	2.3.9.1 Hire a private media organization to design a campaign.	G&WHU HPB	x				
		2.3.9.2 Develop press kits for the media on HPV and HPV testing.	G&WHU HPB	x				
		2.3.9.3 Hold workshops for the private and government media on HPV testing.	G&WHU HPB		x	x	x	x
		2.3.9.4 Conduct visits to WWC for human interest stories.	G&WHU HPB		x	x	x	x
	2.3.10 Establish an information system.	2.3.10.1 At WWC maintain register of all screened women. It can be used to monitor laboratory results, identify when they are missing and be used to call back women to receive their results.	MOH G&WHU	x	x	x	x	x
		2.3.10.2 WWC also maintains a referral register of HPV positive women referred.	MOH G&WHU	x	x	x	x	x
		2.3.10.3 Laboratory register is used to record all incoming HPV test samples and record results. It helps monitor results that have not yet been reported to the health facility.	HPV Laboratory Pathologist	x	x	x	x	x
		2.3.10.4 Colposcopy clinics maintains a referral care register of cases seen.	Colposcopy clinic VOG	x	x	x	x	x
		2.3.10.5 Conduct periodic reviews of the HPV screening programme until the programme is mature.	G&WHU M&E Unit College of Microbiologists SLCOG CPSL	x	x	x		

STRATEGIC OBJECTIVE 2: TRANSITIONING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 2.4 Strengthen the present cervical cytology programme during the transition period.	2.4.1 Increase coverage of the target population (see 4.2.2)	2.4.1.1 PHMs to update the eligible couples register annually.	MOMCH MOH SPHM PHM	x	x	x	x	x
		2.4.1.2 PHMs personally invite the eligible women.	PHM	x	x	x	x	x
		2.4.1.3 Pilot Mobile Health technology to call and recall women in the 35 year and 45 year cohorts.	G&WHU		x	x		
		2.4.1.4 Strengthen supervision of PHMs to ensure eligible couple registers are regularly updated.	G&WHU RDHS MOMCH MOH SPHM PHM	x	x	x	x	x
	2.4.2 Provide training to WWC staff on taking and transporting Pap smears to reduce unsatisfactory smears.	2.4.2.1 Develop /update training material.	G&WHU MOMCH CPSL	x				
		2.4.2.2 Conduct refresher training for WWC staff on taking Pap smears, transportation of smears, documentation.	G&WHU MOMCH CPSL	x	x	x	x	x
		2.4.2.3 Identify clinics from which "unsatisfactory smears" are unacceptably high and provide training.	G&WHU MOMCH CPSL	x	x	x	x	x
		2.4.2.4 Strengthen supervision of WWC.	G&WHU RDHS MOMCH MOH SPHM PHM	x	x	x	x	x
		2.4.2.5 Evaluate training.	CPSL		x			x
	2.4.3 Revise the cytology guidelines to include quality control and quality assurance aspects in the cytology laboratories.	2.4.3.1 CPSL to form committee to review and revise the guidelines and include QC and QA aspects.	CPSL	x				
		2.4.3.2 Revise the cytology guidelines.	CPSL					
		2.4.3.3 Print and disseminate the guidelines.	G&WHU					
	2.4.4 Improve QC and QA practices in cytology laboratories.	2.4.4.1 Ensure 10% of unsatisfactory smears and all abnormal smears are reviewed by the pathologist.	CPSL G&WHU DDGLS	x	x	x	x	x
		2.4.4.2 All cytology laboratories have internal and external QC and QA measures in place.	CPSL G&WHU DDGLS	x	x	x	x	x
	2.4.5 Provide refresher training to cytoscreeners.	2.4.5.1 Develop training programme based on new guidelines.	CPSL	x				
		2.4.5.2 Conduct training for cytoscreeners in batches.	CPSL G&WHU	x		x		x
		2.4.5.3 Introduce certification for cytoscreeners.	CPSL G&WHU	x				
		2.4.5.4 Provide refresher training annually.	CPSL G&WHU		x			
		2.4.5.5 Pilot online training using case histories.	CPSL G&WHU			x		

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.1 Strengthen WW service delivery.	3.1.1 Engage with privates sector hospitals / GPs to provide WW services (see 5.5)	3.1.1.1 Conduct assessment of WW services in the private sector.	G&WHU D/Private Health Sector Development	x				
		3.1.1.2 Host meeting with private sector providers to explore possibilities of partnership and encourage setting up WW services.	G&WHU D/Private Health Sector Development	x				
		3.1.1.3 Sign Memorandum of Understanding.	MoH Private sector institution	x				
		3.1.1.4 Include private sector providers in training programmes.	G&WHU	x	x	x	x	x
		3.1.1.5 Provide reporting formats so as to mainstream sector reporting to the RHMIS.	G&WHU	x	x	x	x	x
	3.1.2 Introduce WW services in health institutions with family planning clinics and HLC.	3.1.2.1 Identify health institutions with FP clinics and HLC.	G&WHU NCD MOMCH	x	x	x	x	x
		3.1.2.2 Identify additional staff and equipment required.	G&WHU NCD MOMCH	x	x	x	x	x
		3.1.2.3 Training for staff and provide equipment and supplies.	G&WHU NCD MOMCH	x	x	x	x	x
		3.1.2.4 Establish a link with the eRHMIS through MOH using Quarterly MCH Clinic Return (H 527).	G&WHU NCD M&E Unit	x				
		3.1.2.5 DG to send guideline to institutions so as to include WWC services in FP clinics and HLC.	G&WHU	x				
	3.1.3 Reduce unmet need for FP in midlife women (i.e. over 35 years).	3.1.3.1 Identify women 35 years and 45 years from the eligible couples register and household lists irrespective of marital status who are not using contraception and invite to the WWC.	PHM SPHM MOH MOMCH FP Unit	x	x	x	x	x
		3.1.3.2 Ensure sustained supplies of commodities.	FP Unit MOMCH MOH RMSD	x	x	x	x	x
		3.1.3.3 Ensure confidentiality and provide counselling on FP based on medical eligibility criteria	FP Unit	x	x	x	x	x
		3.1.3.4 Build the capacity of service providers to provide appropriate methods.	FP Unit	x	x	x	x	x
		3.1.3.5 Ensure a balanced method mix is available.	FP Unit MOMCH MOH RMSD	x	x	x	x	x
		3.1.3.6 Refer to hospital if sterilization is requested.	MOH	x	x	x	x	x

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.2 Increase availability and equitable distribution of competent, motivated human resources with the right skill mix for delivery of the WWP.	3.2.1 Ensure WWCs have an adequate number of appropriately trained staff to meet the needs of the average daily client flow.	3.2.1.1 Develop WWC staffing norms.	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x				
		3.2.1.2 Based on the target population (35-60 years) project staff requirements for different categories for next 10-15 years based on demographic patterns (increase of aging population), gendered NCD mortality and morbidity patterns, staff attrition from retirement, recruitment etc.	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x				
		3.2.1.3 Map the staff vacancies in the MNH services and fill the vacancies, prioritizing the areas with vulnerable populations.	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x				
		3.2.1.4 Develop and implement a recruitment plan based on cadre projections and capacity of the training centres (Ref MNH Strategy).	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x	x	x	x	x
		3.2.1.5 Develop deployment plans for all categories of staff.	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x	x	x	x	x
		3.2.1.6 Extend the retirement age of PHMs and recruit on contract basis retired PHMs.	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x	x	x	x	x
		3.2.1.7 Mobilize midwives from institutions with few deliveries and deploy them as PHMs.	PDHS RDHS MOMCH	x	x	x	x	x
		3.2.1.8 Make RH Diplomates service a closed system so they provide only RH services.	DDG PHII, DDGMS I&II, DDG Admin, DDG Planning, FHB	x	x	x	x	x
	3.2.2 Invest in continuous professional development of health workers, use a training plan, develop a regularly updated database of trainers and trainees by district and evaluate training programmes. (see 5.3.1)	3.2.2.1 Identify training needs and competency gaps in providing WWC services based on supervision reports.	G&WHU	x				
		3.2.2.2 Develop guidelines for refresher training, using adult learning methodology.	G&WHU	x				
		3.2.2.3 Develop trainers materials and learning materials for health workers.	G&WHU		x			
		3.2.2.4 Develop the national in-service training plan for each type of service provider including details on types and number of trainings, training of trainers etc.,	G&WHU	x	x			

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.2 Increase availability and equitable distribution of competent, motivated human resources with the right skill mix for delivery of the WWP.	3.2.2 Invest in continuous professional development of health workers, use a training plan, develop a regularly updated database of trainers and trainees by district and evaluate training programmes. (see 5.3.1)	3.2.2.5 Finalize the in service training plan with stakeholders.	G&WHU		x			
		3.2.2.6 Allocate resources in the annual workplans for training.	G&WHU	x	x	x	x	x
		3.2.2.7 Form a core group of master trainers (MOMCH, MOH, RSPHNO) for conducting competency based training on different aspects of the WW programme with at least 4 trainers per district.	G&WHU MOMCH, MOH, RSPHNO		x			
		3.2.2.8 Conduct Training of Trainers (TOT) at FHB.	G&WHU		x			
		3.2.2.9 District master trainers carry out competency based training of MOH, AMOH, PHNS and PHMs in the WWP.	G&WHU MOMCH, MOH, RSPHNO		x	x	x	x
		3.2.2.10 Develop a training database of staff that have been trained by category, district, MOH for use of FHB and districts.	G&WHU		x			
		3.2.2. 11 Use database to assess training needs and staff attrition, and plan for providing refresher training.	G&WHU			x	x	x
		3.2.2.12 Evaluate in service training and use evaluation findings to refine the in-service training programme.	G&WHU				x	x
	3.2.3 Pilot mLearning for refresher training.	3.2.3.1 Identify an implementing partner.	G&WHU		x			
		3.2.3.2 Develop the application for mobile phones	MoH TAC-WWH		x			
		3.2.3.3 Pilot test the initiative	MoH TAC-WWH		x			
		3.2.3.4 Evaluate the pilot test	MoH TAC-WWH			x		
	3.2.4 Introduce financial and non- financial incentive schemes to motivate and retain health staff in remote geographic areas.	3.2.4.1 Advocate for financial incentives with the PDHS for staff working in remote and difficult areas.	TAC	x				
		3.2.4.2 Identify nonfinancial incentives such as free quarters, scooters on concessionary rates etc.	TAC	x				
	3.2.5 Continue the practice of recognizing well performing staff and clinics.	3.2.5.1 Continue to recognize individual staff and well performing MOH areas at awards ceremonies for outstanding performance.	TAC G&WHU MOMCH	x	x	x	x	x
		3.2.5.2 Organize exchange visits between districts	G&WHU MOMCH	x	x	x	x	x

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.3 Ensure availability of an uninterrupted supply of affordable, quality, equipment and consumables including FP commodities for the WW Programme	3.3.1 Forecast, quantify and procure equipment and supplies	3.3.1.1 Develop an electronic LMIS linking FHB and RMSDs	G&WHU MOMCH	x	x	x	x	x
		3.3.1.2 Review current stocks in FHB, laboratories and RMSD and expected incoming orders	G&WHU					
		3.3.1.3 Procure via State Pharmaceutical Corporation (SPC) or direct procurement depending on spending limits	D/ MSD G&WHU	x	x	x	x	x
		3.3.1.4 Store in FHB warehouse	G&WHU	x	x	x	x	x
		3.3.1.5 Develop a distribution plan annually	G&WHU	x	x	x	x	x
	3.3.2 Build capacity of district and divisional staff, MOMCH, MOH, AMOH, RMSD on forecasting and supply planning (see also 5.3.1)	3.3.2.1 Develop WWC commodity management SOPs guidelines and job aids	G&WHU	x				
		3.3.2.2.Identify and train master trainers, two each from each district	G&WHU MOMCH	x				
		3.3.2.3 Create a core group of logistics trainers at district level	G&WHU MOMCH	x				
		3.3.2.4 Use cascade training to train district staff on quantification of equipment and supplies, commodity management and reporting	G&WHU MOMCH	x	x	x	x	x
		3.3.2.5 Order as per quantification, warehouse and distribute to WWC	G&WHU MOMCH RMSD OiC	x	x	x	x	x
	3.3.3 Strengthen "Last mile delivery"	3.3.3.1 Identify requirement of trucks required for distribution of commodities and availability of functioning vehicles at present	G&WHU MOMCH RMSD OiC	x	x	x	x	x
		3.3.3.2 RDHS to provide budget for repairs and maintenance and or procure new vehicles in annual district plans	RDHS MOMOCH	x	x	x	x	x
		3.3.3.3 RMSDs develop a distribution plan to delivers equipment and supplies to WWC	RMSD OiC MOMCH	x	x	x	x	x
	3.3.4. Conduct regular monitoring and supervision of RMSD and facilities to minimise stock outs	3.3.4.1 Develop checklists for supervision of RMSD	G&WHU MOMCH	x				
		3.3.4.2 Supervisors provide on the job training at MOH and for pharmacists and RMSD OIC at RMSDs	G&WHU MOMCH	x	x	x	x	x

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.4 Ensure that adequate financial resources are mobilized and allocated for WWP activities.	3.4.1 Develop multi-year costed implementation plans for the WWP.	3.4.1.1 Introduce multiyear costed implementation plans so as to be more flexible in planning and prioritizing activities.	G&WHU DDGPHS II DDG Finance	x	x	x	x	x
		3.4.1.2 Develop annual plans based on the multiyear plan well ahead of the deadlines	G&WHU	x	x	x	x	x
		3.4.1.3 Communicate the costed plans with planning units at MoH and Finance Ministry before the national budget every year	G&WHU DDGPHS II DDG Finance	x	x	x	x	x
	3.4.2. Review the resource allocation pattern in the districts for the WWP.	3.4.2.1 Collect information on the resource allocation pattern for districts to ensure equity in distribution of financial resources.	G&WHU CCP RDHS MOMCH	x	x	x	x	x
		3.4.2.2 Lobby for additional resources for inadequately funded districts.	G&WHU PDHS CCP RDHS MOMCH	x	x	x	x	x
		3.4.2.3 G&WHU to review district health plans to ensure that WW programme activities based on the strategy are reflected and sufficient resource are allocated to implement them.	G&WHU MOMCH	x	x	x	x	x
	3.4.3. Develop a resource mobilization plan.	3.4.3.1 Develop a resource mobilization plan based on the costed multiyear implementation plan to fill gaps in financing.	G&WHU	x				
		3.4.3.2 Identify financial resources available from the central government, provincial health authorities and private sector and development partners.	G&WHU	x				
		3.4.3.3 Present the resource mobilization plan to donors.	G&WHU	x	x	x	x	x
	3.4.4. Leverage of private sector resources for the WWP.	3.4.4.1 Mobilize non financial resource from the private sector in the form of sponsorship of clinics as part of corporate social responsibility.	G&WHU D / Private Health Sector Development	x	x	x	x	x
		3.4.4.2 Grant accreditation to privates sector institutions that conform to quality standards for WWC.	G&WHU D / Private Health Sector Development	x	x	x	x	x
	3.4.5. Promote insurance companies to market a package for women that includes the service components provided at WWC.	3.4.5.1 Conduct meetings with major insurance companies to present the case for developing a product for women's health.	G&WHU D / Private Health Sector Development Insurance Regulatory Authority	x				
		3.4.5.2 Ensure insurance companies provide the package through only accredited institutions so as to ensure quality of services.	G&WHU D / Private Health Sector Development Insurance Regulatory Authority	x	x	x	x	x

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.5 Improve the availability, accessibility, quality and use of health information by the WWP for decision making.	3.5.1 Review and revise the current WWP indicators to reflect HPV testing, quality of services and disaggregation of data for better coverage of target groups.	3.5.1.1 Review and revise indicators as necessary.	G&WHU M&EU	x				
		3.5.2 Define the indicators so as to ensure uniformity between different sources, e.g. RHMIS, DHS, Annual Health Bulletin, Census and Statistics Dept.	G&WHU M&EU	x				
	3.5.2 Strengthen the RHMIS system to obtain data from WWC , laboratory and colposcopy clinics.	3.5.2.1 Review and revise all data entry records, formats and returns originating from WWC, laboratories and hospitals to ensure data quality.	G&WHU M&EU	x	x	x	x	x
		3.5.2.2 Conduct training on the new formats for health staff.	G&WHU M&EU	x	x			
	3.5.3 Pilot establishing electronic linkage between MOH and cytology laboratories to reduce turnaround time.	3.5.3.1 Establish connectivity between MOH sending Pap smear and lab receiving specimen.	G&WHU M&EU		x			
		3.5.3.2 Evaluate pilot and if successful scale up to all laboratories and MOH.	G&WHU M&EU		x	x		
		3.5.3.3 Eventually link up with the hospitals providing diagnosis /treatment of abnormalities.	G&WHU M&EU				x	
	3.5.4 Strengthen linkages between Registrar Generals Office, Medical Statistics Unit, Dept. of Census and Statistics and M&E Unit to ensure quality of data through validation	3.5.4.1 Hold regular meeting.	G&WHU M&EU	x	x	x	x	x
		3.5.4.2 Cross validate data from different sources to ensure quality.	G&WHU M&EU	x	x	x	x	x
		3.5.4.3 Organize annual events for researchers to present their findings and to explore how the research could be put into practice.	G&WHU M&EU	x	x	x	x	x
	3.5.5 Conduct operations research on the WWP and its components.	3.5.5.1 TAC and other sources identifies research areas relevant to the WWP.	TAC	x	x	x	x	x
		2.5.5.2. Identify resources to conduct research.	TAC G&WHU	x	x	x	x	x
		2.5.5.3 Encourage postgraduate students and other researchers to conduct research on WWP related areas	TAC G&WHU PGIM	x	x	x	x	x
		3.5.5.4 Orient health workers on operational research related to WWC.	G&WHU M&EU	x	x	x	x	x
		3.5.5.5 Use research findings to improve service delivery.	G&WHU	x	x	x	x	x

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.5 Improve the availability, accessibility, quality and use of health information by the WWP for decision making.	3.5.6 Promote utilization of information for decision making by MOMCH, MOH /AMOH.	3.5.6.1 Develop a guide on analysis and interpretation of data for WWP staff and conduct training.	M&EU G&WHU	x				
		3.5.6.2 Develop an executive dashboard to monitor implementation of the WWP - identify key indicators, establish monitoring frequency and attempt to automate data retrieval.	M&EU G&WHU	x	x	x	x	x
		3.5.6.3 Disseminate data by producing regular reports and making information accessible electronically.	M&EU G&WHU	x	x	x	x	x
	3.5.7 Use accurate, timely, reliable data to review the WWP at all review meetings.	3.5.7.1 Develop guidelines formats and indicators for WWP reviews.	G&WHU M&EU	x				
		3.5.7.2 Allocate regular timeslots for reviewing the performance of the WWP.	MOH	x	x	x	x	x
		3.5.7.3 Review the above process and make improvements.	G&WHU M&EU MOMCH MOH		x		x	
Strategy 3.6 Strengthen leadership and governance of the WWP.	3.6.1 Strengthen the Technical Advisory Committee so as to provide effective oversight of the WWP.	3.6.1.1 Review the TOR and composition of the TAC.	TAC	x				
		3.6.1.2 Invite D/Private Health Sector Development, Municipality, PHDT.	TAC	x				
	3.6.2 Build the capacity of the Gender and Women's Health Unit to plan, coordinate, monitor and provide technical assistance to the WWP.	3.6.2.1 Conduct capacity assessment of the G&WHU and district health authorities.	External consultant	x				
		3.6.2.2 Appoint 2 MOs to the WWP on a permanent basis.	DDG PHII, DDG Admin, FHB	x	x	x	x	x
		3.6.2.3 Provide training on programme management to G&WHU staff.	PGIM	x	x	x	x	x
		3.6.2.4 Provide necessary equipment and supplies for the unit e.g. computers.	FHB	x	x	x	x	x

STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 3.6 Strengthen leadership and governance of the WWP.	3.6.3 Improve the capacity of the provincial and district health authorities involved in planning, supervision, monitoring and evaluation.	3.6.3.1 Provide management training to MOMCH.	G&WHU CCP	x	x	x	x	x
		3.6.3.2 Ensure district plans are reviewed by G&WHU to ensure WW programme activities are reflected in the district plan.	G&WHU and MOMCH	x	x	x	x	x
		3.6.3.3 Conduct national and district review of the WWP.	G&WHU and MOMCH	x	x	x	x	x
		3.6.3.4 Train service providers and managers so as to improve the data and information management of the WWP.	G&WHU M&EU and MOMCH	x	x	x	x	x
	3.6.4 Advocate for WW Programme related issues to be an agenda item of Provincial Health Ministers Meetings, National Health Development Committee and Hospital Directors meetings.	3.6.4.1 Request for WWP to be an agenda item with justifications.	G&WHU RDHS and MOMCH	x	x	x	x	x
		3.6.4.2 Prepare briefing notes and presentations showing progress in each health district and solicit support for improvement.	G&WHU RDHS and MOMCH	x	x	x	x	x
	3.6.5 Better coordination and coherence between the different units of the FHB and Programmes and Agencies within the MoH.	3.6.5.1 Establish technical level working groups.	FHB and Programmes and Agencies	x				
		3.6.5.2 Invite all partners to review meetings.	FHB and Programmes and Agencies	x	x	x	x	x

STRATEGIC OBJECTIVE 4: INCREASE COVERAGE AND EQUITY OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 4.1 Ensure all women in the 35 and 45 age cohorts irrespective of marital status are identified and screened so as not to miss anyone.	4.1.1. Develop a system to identify all women in the target age groups annually.	4.1.1.1 Use the eligible couples register to identify women in the 35, 45 age cohorts.	PHM MOH	x				
		4.1.1.2 Use voter registration to identify women not in the eligible couples register with the support of the Grama Niladhari of the area.	PHM MOH	x				
		4.1.1.3. Create a list of all women in the PHM area belonging to the 35, 45 age cohorts. Update this list every 6 months.	PHM MOH	x				
		4.1.1.4 Regular supervision to ensure the eligible couples register is updated annually and the list of women in the 35 and 45 age cohorts is updated bi-annually.	RDHS MOMCH RSPHNO MOH PHNS SPHM PHM	x	x	x	x	x
	4.1.2 Pilot mobile Health technology to call and recall women in the 35 year and 45 year cohorts.	4.1.2.1 Negotiate with cellular providers to setup automated notification service for check-ups.	MoH G&WHU private cellular provider	x				
		4.1.2.2 Use the system to call and recall women for screening.	MOH PHM	x	x	x	x	x
Strategy 4. 2 Minimize health related expenditure and loss of wages for poor women attending WWC.	4.2.1 Ensure WWC services are available on weekends and public holidays for the convenience of working women.	4.2.1.1 Consult with RDHS on feasibility and budget for extra duty allowance.	RDHS MOMCH MOH	x				
		4.2.1.2 MOH and MOMCH to make arrangements to hold WWC on weekends and public holidays.	RDHS MOMCH MOH PHNS PHM	x				
		4.2.1.3 PHMs invite eligible women to attend the clinic on weekends and public holidays.	PHM	x	x	x	x	x
	4.2.2 Identify geographic areas with poor coverage and access to WWC and provide targeted support to establish field clinics.	4.2.2.1 Develop scale up plans for these areas.	PDHS RDHS MOMCH MOH	x				
		4.2.2.2 Consult communities in identifying suitable locations for the clinics.	MOMCH MOH PHM Community leaders	x				
		4.2.2.3 Advocate with PDHS /RDHS to include the proposed clinic in long term capital investment plan and implement service scale-up plan. (e.g., including deploying health workers to fill vacancies, providing logistics and supplies, and monitoring progress)	PDHS RDHS MOMCH MOH	x				
		4.2.2.4 Evaluate the service to determine whether it needs to be continued.	PDHS RDHS MOMCH MOH		x			

STRATEGIC OBJECTIVE 4: INCREASE COVERAGE AND EQUITY OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 4.2 Minimize health related expenditure and loss of wages for poor women attending WWC.	4.2.3 Provide mobile clinic services to areas with low coverage and difficult access identified by mapping.	4.2.3.1 Conduct meeting at district level to identify underserved areas.	MOMCH RSPHNO MOH	x				
		4.2.3.2 Consult with communities and form health committees to identify best locations to establish clinics.	MOMOCH MOH Community leaders	x				
		4.2.3.3 Procure a customized vehicle to conduct WWC.	RDHS MOMCH	x				
		4.2.3.4 Identify suitable locations to hold the clinics.	MOMCH MOH Community leaders	x				
		4.2.3.5 Develop mobile outreach schedule.	MOMCH RSPHNO MOH	x	x	x	x	x
		4.2.3.6 Allocate staff, vehicle, equipment and stationary.	RDHS MOMCH MOH	x				
		4.2.3.7 Conduct mobile clinics.	MOH PHNS PHM	x	x	x	x	x
		4.2.3.8 Develop a mechanism to communicate results to clients.	MOH PHNS PHM	x	x	x	x	x
		4.2.3.9 Review effectiveness of mobile clinics at biannual MOMCH / district review meetings.	G&WHU RDHS MOMCH		x	x	x	x
		4.2.3.10 Obtain feedback from the community on the quality of services.	Community leaders MOMCH MOH	x	x	x	x	x
	4.2.4 Provide services at workplaces with a high concentration of women.	4.2.4.1 Engage with companies, factories (e.g. tea estates, readymade garments, government offices) willing to allow WWC to be conducted.	G&WHU RDHS MOMCH	x	x	x	x	x
		4.2.4.2 Develop mobile outreach schedule.	G&WHU MOMCH	x	x	x	x	x
		4.2.4.3 Allocate staff, vehicle, equipment and stationary.	RDHS MOMCH MOH	x	x	x	x	x
		4.2.4.4 Develop a mechanism to communicate results of tests.	MOMCH MOH	x	x	x	x	x
		4.2.4.5 Follow up to ensure compliance with referral.	MOH PHM	x	x	x	x	x
Strategy 4.3: Customize WW services to reach vulnerable and marginalized groups and individuals to increase their utilization and reduce inequity.	4.3.1. Carry out an assessment of vulnerable and marginalized groups in each district and MOH area.	4.3.1.1 Conduct rapid survey to identify areas with poor coverage and vulnerable and marginalized groups based on their unique characteristics.	MOMCH RSPHNO MOH PHNS	x				
		4.3.1.2 Map with GPS, coordinates of locations of marginalized and vulnerable groups available	MOMCH	x				

STRATEGIC OBJECTIVE 4: INCREASE COVERAGE AND EQUITY OF THE WW PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 4.3: Customize WW services to reach vulnerable and marginalized groups and individuals to increase their utilization and reduce inequity.	4.3.2. Obtain the support of gatekeepers in the community.	4.3.2.1 Awareness raising of community gatekeepers and enlist their support.	MOMCH MOH	x	x	x	x	x
		4.3.2.2 Access the women and identify the sources of health information, service availability and their concerns about the services provided. Identify levers that can be used for positive behaviour change.	MOMCH MOH PHNS PHM	x				
	4.3.3. Customize culturally acceptable BCC materials for these vulnerable and marginalized groups.	4.3.3.1 In consultation with the community develop culturally appropriate audio visual material at the appropriate literacy level in local language.	MOMCH MOH HEO PHNS	x				
		4.3.3.2 Pre-test the material prior to production.	HEO MOH PHNS	x				
		4.3.3.3 Disseminate the material.	MOH	x	x	x	x	x
	4.3.4. Design action plans together with members of the community to reach these groups with WW services.	4.3.4.1 Identify suitable locations to site clinics together with community leaders.	MOMCH MOH Community leaders	x	x	x	x	x
		4.3.4.2 Form health committees to provide feedback on quality and to encourage women to attend WWC.	MOMCH MOH Community leaders	x	x	x	x	x
	4.3.5. Reinforce in health workers avoidance of discrimination and the right to health of clients.	4.3.5.1 Orientation to health workers not to be judgemental, treat clients with respect and not discriminate.	MOMCH RSPHNO MOH	x	x	x	x	x
	4.3.6 Obtain feed back on quality of services provided.	4.3.6.1 Conduct exit interviews.	MOH	x	x	x	x	x
		4.3.6.2 Have suggestion boxes.	MOH	x	x	x	x	x
	4.3.7. Establish fora for review of WW Programme performance in the (a) estate sector (b) Municipalities (c) resettlement areas of North and East	4.3.7.1 Have annual meetings to review WWP performance in the estate sector.	D/Estates and urban Development, PDHS, RDHS, PHDT and Ministry of Hill Country, New Villages, Infrastructure, and Community Development,	x	x	x	x	x
		4.3.7.2 Have annual meetings to review WWP performance with the Colombo Municipalities.	PDHS , RDHS Chief MOH Municipality	x	x	x	x	x
		4.3.7.3 Have annual meetings to review WWP performance in resettlement areas of Jaffna, Killinochchi, Mulativu, Vavuniya, Mannar, Batticaloa.	GWHU, PDHS RDHS MOMCH	x	x	x	x	x

STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WWC PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 5.1 Ensure caring, respectful, compassionate (CRC) client centred care at WWC for all women.	5.1.1 Introduce a "customer care" programme in all WWC.	5.1.1.1 Conduct client satisfaction survey (exit interviews).	FHB	x				
		5.1.1.2 Analyse data.	FHB MOMCH	x				
		5.1.1.3 Use information to design and test a more client friendly programme.	FHB MOMCH	x				
		5.1.1.4 Institute incentives to encourage adoption of the programme, including awards for best "customer care" practice by WWC or individual health workers.	FHB RDHS MOMCH	x	x	x	x	x
	5.1.2 Establish a system of accountability to clients in all WWC.	5.1.2.1 Ensure use of official name tags/ID cards by all staff for easy identification.	PDHS RDHS	x				
		5.1.2.2 Create awareness among staff of clients rights at least every 6 months at monthly conference.	FHB PDHS RDHS	x				
		5.1.2.3 Brief provincial councils and other local government bodies, CSOs on clients rights and responsibilities of duty bearers.	FHB PDHS RDHS	x				
	5.1.3 Strengthen interaction between WWC and communities.	5.1.3.1 Establish WWC management committees that include community representatives including women	MOMCH MOH		x	x		
		5.1.3.2 Ensure the involvement of community representatives at annual performance reviews at district level by giving them active roles to play in the review process	RDHS MOMCH		x	x	x	x
	5.1.4 Introduce informed consent for women undergoing cervical cancer screening.	5.1.4.1 Develop a standard informed consent form for clients undergoing cervical screening both Pap smears and HPV testing.	FHB, NCCP		x			
		5.1.4.2 Monitor informed consent.	RDHS MOMCH		x	x	x	x
Strategy 5.2 Improve client safety practices in WWC.	5.2.1 Infection prevention and control systems are in place.	5.2.1.1 Conduct survey to establish baseline for infection control in WWC.	FHB MOMCH MOH	x				
		5.2.1.2 Provide inputs for effective infection prevention and control.	FHB MOMCH	x				
		5.2.1.3 Launch hand hygiene campaign.	FHB MOMCH	x				
		5.2.1.4 Conduct continuous orientation and supervision for all staff on infection prevention and control	MOMCH MOH	x	x	x	x	x

STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WWC PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 5.3 Improve clinical practice.	5.3.1 Improve knowledge of WWC staff on, hypertension, diabetes, menopause and perimenopause, and enhance their skills on cervical breast and thyroid screening.	5.3.1.1 Conduct a training needs assessment.	FHB SLCOG CPSL	x				
		5.3.1.2 Design training (conceptualize and plan training intervention, develop learning goals and objectives, create training schedules)	FHB SLCOG CPSL	x	x			
		5.3.1.3 Train trainers.	FHB SLCOG CPSL		x			
		5.3.1.4 Train health workers.	FHB SLCOG CPSL		x	x	x	x
		5.3.1.5 Provide supplies and basic equipment.	FHB SLCOG	x	x	x	x	x
	5.3.2 Increase availability of and use of evidence based clinical standards, guidelines and protocols.	5.3.2.1 Develop clinical standards, guidelines, protocols for the WWC.	FHB SLCOG CPSL	x				
		5.3.2.2 Adapt/ develop training materials (print and electronic) and learning activities / instructional methods.	FHB SLCOG CPSL	x	x			
		5.3.2.3 Monitor compliance to standards / guidelines/ protocols during supervision visits.	FHB SLCOG CPSL	x	x	x	x	x
	5.3.3 Improve recording / documentation of patient information by health workers.	5.3.3.1 Revise recording /documentation of client information by health workers.	G&WHU SLCOG CPSL	x				
		5.3.3.2 Disseminate and orient health workers on revised recording and reporting formats.	G&WHU SLCOG CPSL	x	x	x	x	x
		5.3.3.3 Supervise and monitor adherence to guidelines.	G&WHU SLCOG CPSL	x	x	x	x	x
	5.3.4 Establish QA systems in clinic and laboratories that are part of the WW Programme.	5.3.4.1 Increase availability and use of evidence based guidelines, SOPs and tools.	G&WHU RDHS MOMCH SLCOG CPSL	x	x	x	x	x
		5.3.4.2 Develop and introduce appropriate quality indicators for the WWP.	G&WHU RDHS MOMCH SLCOG CPSL	x				
		5.3.4.3 FHB to send letter to RDHS requesting establishment of QI teams.	G&WHU	x				
		5.3.4.4 Form QI teams in clinics and laboratories.	MOMCH MOH CPSL	x	x	x	x	x
		5.3.4.5 Train health staff on QA and QI.	MOMCH MOH CPSL					
		5.3.4.6 Monitor QA and QI at the regular unit meetings.	G&WHU RDHS MOMCH MOH	x	x	x	x	x
		5.3.4.7 Organize regular QI meetings at district level.	RDHS MOMCH MOH	x	x	x	x	x

STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WWC PROGRAMME								
STRATEGY	MAJOR ACTIVITY	SUB ACTIVITY	RESPONSIBILITY	2019	2020	2021	2022	2023
Strategy 5.3 Improve clinical practice.	5.3.4 Establish QA systems in clinic and laboratories that are part of the WW Programme.	5.3.4.8 Improve infection, prevention and control practices.	MOMCH MOH PHNO	x	x	x	x	x
		5.3.4.9 Supervise and monitor activities of QA teams.	RDHS RSPHNO, MOMCH	x	x	x	x	x
		5.3.4.10 Organize annual national QA conferences.	G&WHU	x	x	x	x	x
		5.3.4.11 Introduce a client feedback mechanism to monitor QOC.						
	5.3.5 Improve referral practices between WWC and hospital clinics for clients found to have abnormalities.	5.3.5.1 Define and disseminate the referral centres for each WWC.	G&WHU RDHS MOMCH	x				
		5.3.5.2 Agree on the roles and responsibilities of referring facility provider/ and the facility/provider accepting the referral.	G&WHU RDHS MOMCH D/hospital VOG	x				
		5.3.5.3 Develop referral guidelines.	G&WHU	x				
		5.3.5.4. Equip WWC with referral forms and relevant tools.	G&WHU MOMCH	x	x	x	x	x
		5.3.5.5 Educate health workers and the public on the referral system.	MOH	x	x	x	x	x
		5.3.5.6 Improve communication between referring facility provider/ and the facility/provider accepting the referral.	RDHS MOMCH MOH D / hospital and VOG	x	x	x	x	x
		5.3.5.7 MOH to ensure referred clients go to referral centre.	MOMCH MOH PHM	x	x	x	x	x
		5.3.5.8 Monitor and supervise referral practices and support mechanisms.	RDHS MOMCH MOH	x	x	x	x	x
	5.3.6 Improve the infrastructure and physical facilities of the WWC so as to create a “women friendly” atmosphere.	5.3.6.1 Identify the WWC requiring renovation.	G&WHU RDHS MOMCH	x				
		5.3.6.2 Provide equipment supplies, adequate IEC material and audio-video equipment for client education.	G&WHU MOMCH	x	x	x	x	x
Strategy 5.4: Strengthen monitoring and supervision of the quality of the WW Programme	5.4.1 Review duty lists of all categories of staff involved in the WWC to ascertain their roles, responsibilities and performance objectives	5.4.1.1 Review duty lists of staff involved in the WWP.	G&WHU HRD MoH	x				
		5.4.1.2 Issue guidelines from DG to redefine their roles and responsibilities in the WWP.	G& WHU and M&EU HRD	x	x			

STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WWC PROGRAMME								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 5.4: Strengthen monitoring and supervision of the quality of the WW Programme	5.4.2 Revise the supervision tools to reflect changes in duties of WWC staff, new indicators introduced into the WWP and QA measures adopted.	5.4.2.1 Revise the supervision tools in line with the new indicators and duties.	G&WHU and M&EU FHB	x	x			
		5.4.2.2 Train supervisors on the use of the new tools.	G&WHU and M&EU FHB		x	x	x	x
	5.4.3 Train supervisory staff on the new supervision tools and facilitative supervision.	5.4.3.1 Develop training objectives and materials.	G&WHU and M&EU FHB		x			
		5.4.3.2 Conduct training of trainers on the new tools.	G&WHU and M&EU FHB		x	x		
		5.4.3.3 Trainers conduct training in districts on the new tools.	G&WHU and M&EU FHB			x	x	x
	5.4.4 Team supervision visits are conducted regularly by G&WHU, CCP, RDHS, MOMCH, RSPHNO and feedback provided.	5.4.4.1 Conduct team supervision.	FHB Provincial CCP (MCH) RDHS MOMCH RSPHNO	x	x	x	x	x
		5.4.4.2 Use supervision reports for improving services.	MOMCH MOH	x	x	x	x	x
5.5 Ensure that all private sector institutions providing WW services meet the quality requirements.	5.5.1 D/ Private Sector Development and G&WHU develop guidelines and checklist for provision of WWC services in the privates sector.	5.5.1.1 Circulate guidelines to registered private hospitals and clinics and new institutions that have applied for registration	D/Private Health Sector Development G&WHU	x	x	x	x	x
		5.5.1.2 PDHS / RDHS use guidelines and checklist to inspect private institutions at least once in 2 years to ensure adherence to guidelines and provide feedback to management.	PDHS RDHS MOMCH	x	x	x	x	x
		5.5.1.3 Promote the use of the checklist by private institutions for self assessment and to resolve shortcomings.	D/Private Health Sector Development G&WHU	x	x	x	x	x
	5.5.2 Collaborate with Insurance Regulatory Commission of Sri Lanka on recognizing only facilities providing WW services that conform to quality standards.	5.5.2.1 MOU on recognizing only institutions conforming to quality standards as able to provide WW services.	D/Private Health Sector Development / Insurance Regulatory Council /G&WHU	x				
		5.5.2.2 Make supervisory visits to registered institutions to ensure quality.	D/Private Health Sector Development / Insurance Regulatory Council /G&WHU	x	x	x	x	x

STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WW SERVICES, ESPECIALLY CERVICAL CANCER SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 6.1 Review and revise the BCC strategy to reflect new developments in the WWP.	6.1.1 Review the recent socio-cultural, economic, political and technological developments	6.1.1.1 Desk review of already available data	HPB G&WHU, External Consultant	x				
		6.1.1.2 Qualitative study to explore the recent socio-cultural, economic, political and technological developments	HPB G&WHU, Consultant	x				
		6.1.1.3 Compile the report	HPB G&WHU, Consultant	x				
	6.1.2 Identify communication gaps in the current BCC strategy	6.1.2.1 Review the BCC strategy against the findings of the qualitative study	TAC HPB G&WHU	x				
	6.1.3 Revise BCC strategies	6.1.3.1 Revise BCC strategies	HPB HEO MOMCH community		x			
		6.1.3.2 Printing of the BCC WWP strategic plan	HPB		x			
		6.1.3.3 Identify modes for dissemination	HPB		x			
		6.1.3.4 Dissemination of BCC WWP strategic plan	HPB		x			
		6.1.3.5 Monitoring of the process of dissemination	HPB		x			
	6.1.4 Develop guidelines e.g. social media promotion for WWC, RH communication ToT	6.1.4.1 Identify areas where communication guidelines are necessary .	HPB HEO MOMCH community		x			
		6.1.4.2 Development of guidelines	HPB		x			
		6.1.4.3 Printing of guidelines	HPB		x			
		6.1.4.4 Dissemination of guidelines	HPB		x			
	6.1.5 Develop a costed communication plan	6.1.5.1 Develop the costed action plan in consultation with relevant stakeholders	HPB HEO MOMCH community		x			

STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WW SERVICES, ESPECIALLY CERVICAL CANCER SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 6.2 Link WW Strategic Plan with WW BCC Strategy for better collaboration between FHB, HPB and other partners at national, provincial and district level.	6.2.1 Establish a technical team that ensure better collaboration between partners	6.2.1.1 Identify relevant representatives from each area	HPB G & WHU		x			
		6.2.1.2 Establish a technical team comprising the representatives	HPB G & WHU		x			
	6.2.2 Develop district and national joint action plans.	6.2.2.1 Develop district, provincial and national joint action plans	HPB G &WHU MOMCH		x			
		6.2.2.2 Disseminate district, provincial and national joint action plans.	HPB G & WHU MOMCH		x			
Strategy 6.3 Enhance communication skills of health professionals to be caring, respectful and compassionate (CRC) when providing services related to WWP	6.3.1 Develop a training curriculum on communication for WWC staff	6.3.1.1 Identify desired communication outcomes	HPB		x			
		6.3.1.2 Develop curriculum	HPB		x			
		6.3.1.3 Pre-testing of the developed curriculum	HPB		x			
		6.3.1.4 Print developed curriculum	HPB		x			
	6.3.2 Capacity building of the trainers from HPB on communication skills related to the WWP	6.3.2.1 Identify the Trainers	HPB	x				
		6.3.2.2 Build capacity of trainers from HPB on communication	HPB		x			
		6.3.2.3 Development of training materials	HPB		x			
	6.3.3 ToT program for MOMCH, MOH, PHNS to improve their communication skills	6.3.3.1 Conduct ToT programs at National level for healthcare staff	HPB		x			
		6.3.3.2 Evaluation of the ToT program	HPB			x		
		6.3.3.3 Revision of the ToT curriculum	HPB				x	
		6.3.3.4 Training of WWC staff on communication at MOH level	MOMCH MOH PHNS			x	x	x
		6.3.3.5 Monitoring and evaluation of the training programs that are conducted at the field level	HPB				x	x

STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WW SERVICES, ESPECIALLY CERVICAL CANCER SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 6.3 Enhance communication skills of health professionals to be caring, respectful and compassionate (CRC) when providing services related to WWP	6.3.4 Supply of communication equipment e.g. job aids, audio-visual equipment	6.3.4.1 Identification of the requirement	HPB HEO MOMCH community	x	x	x	x	x
		6.3.4.2 Purchase of equipment	HPB HEO MOMCH community	x	x	x	x	x
		6.3.4.3 Distribution of communication equipment	HPB HEO MOMCH community	x	x	x	x	x
		6.3.4.4 Monitoring the utilization of the communication equipment	HPB HEO MOMCH community	x	x	x	x	x
	6.3.5 Supply of IEC material on WW services	6.3.5.1 identification of field level requirement of IEC material	HPB HEO MOMCH community	x	x	x	x	x
		6.3.5.2 Supply of IEC material	HPB HEO MOMCH community	x	x	x	x	x
Strategy 6.4 Mobilize communities to facilitate the WWP	6.4.1 Mobilize relevant community groups e.g. MSG	6.4.1.1 Identify relevant community groups	HPB G & WHU	x	x	x	x	x
		6.4.1.2 Conduct advocacy on the WWP with community leaders	HPB G & WHU	x	x	x	x	x
	6.4.2 Use existing community events to create awareness	6.4.2.1 Identify community events for the following year	HPB G & WHU	x	x	x	x	x
		6.4.2.2 Recognize relevant communication objective to be used in each events	HPB G & WHU	x	x	x	x	x
		6.4.2.3 Conduct advocacy with event organizers	HPB G & WHU	x	x	x	x	x
		6.4.2.4 Obtain feedback from event organizers	HPB G & WHU	x	x	x	x	x
	6.4.3 Use satisfied clients as local champions for the WWP	6.4.3.1 Identify potential local champions	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x
		6.4.3.2 Advocate with those identified to promote the WWP	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x
		6.4.3.3 Empower them to communicate about the WWP to the community	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x
	6.4.4 Sensitize religious and community leaders on the importance of the WWP and obtain their support;	6.4.4.1 Identify relevant religious and community leaders	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x
		6.4.4.1 Advocate with relevant religious and community leaders on the WWP	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x
	6.4.5 Collaborate with local businesses to promote WWP e.g.; Salons, gyms	6.4.5.1 Identify central level authorities / committees governing local businesses	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x
		6.4.5.2 Advocate with local business owners to promote WWP among their clients	HPB G & WHU, MOH, Provincial CCP	x	x	x	x	x

STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WW SERVICES, ESPECIALLY CERVICAL CANCER SCREENING								
STRATEGY	**MAJOR ACTIVITY**	**SUB ACTIVITY**	**RESPONSIBILITY**	**2019**	**2020**	**2021**	**2022**	**2023**
Strategy 6.5 Provide accurate and regular information on WWP to the public.	6.5.1 Development of IEC material	6.5.1.1. Conduct a needs assessment of IEC material at field level	HPB G&WHU	x				
		6.5.1.2 Compile the final report of the needs assessment	HPB G&WHU	x				
		6.5.1.3 Identification of communication objectives	HPB G&WHU	x				
		6.5.1.4 Development of relevant IEC material	HPB G&WHU		x			
		6.5.1.5 Printing / production of IEC material	HPB G&WHU		x			
	6.5.2 Monitoring and evaluation of the distributed IEC material	6.5.2.1 Development of a monitoring and evaluation plan	HPB G & WHU		x			
		6.5.2.2 implement the monitoring and evaluation plan	HPB G & WHU			x	x	x
	6.5.3 Design and implement the mass media campaign;	6.5.3.1 Identify communication areas suitable for a mass media campaign	HPB G & WHU	x				
		6.5.3.2 Liaise with communications partners to develop a mass media campaign	HPB G & WHU		x			
	6.5.4 Sensitize the media houses on WWP activities;	6.5.4.1 Approach and advocate media houses to integrate messages on WWP in their regular programs	HPB G & WHU	x	x	x	x	x
Strategy 6.6 Introduce social media and mobile technology to create demand for WWC services.	6.6.1 Use SMS to promote WWC to women on their 35th and 45th birthdays	6.6.1.1 Liaise with mobile communications partners	HPB G & WHU	x				
		6.6.1.2 Develop communications messages	HPB G & WHU	x				
		6.6.1.3 Disseminate regular SMSs to target groups	HPB G & WHU	x	x	x	x	x
	6.6.2 Design and implement a social media campaign to promote WWP.	6.6.2.1 Develop a social media plan for WWP	HPB G & WHU	x				
		6.6.2.2 Increase "likes" by boosting WWC Facebook page	HPB G & WHU	x	x	x	x	x
		6.6.2.3 Develop content to be posted on WWC Facebook page	HPB G & WHU	x	x	x	x	x
		6.6.2.4 Regular update of the WWC Facebook page	HPB G & WHU	x	x	x	x	x
		6.6.2.5 Analyse KPI of the Facebook page and identify areas for improvement	HPB G & WHU		x		x	
	6.6.3 Strengthen the HPB hotline to answer questions from callers on women's health and promotion of WWP.	6.6.3.1 Publicity for the hotline number through the WWC Facebook page and other means	HPB G & WHU	x	x	x	x	x
		6.6.3.2 Evaluate and analyse question patterns asked by clients	HPB G & WHU	x				

ANNEX 5

RESULTS FRAMEWORK

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
TARGETS							
1.	Percentage of functional WWC offering all 9 signal functions (hypertension, nutritional status, diabetes, breast abnormalities, thyroid gland abnormalities, cervical abnormalities, FP status, menstrual disorders and reproductive tract infections (RTI), and perimenopusal/ menopausal problems)	Number of WWC offering all 9 signal functions	Total number of WWC	TBD	100 %	By district	eRHMIS
2.	Availability of WWC per 15,000 population	Number of WWC	Total population	TBD	1 WWC per 15000 population	By district	eRHMIS
3.	Percentage of women in 35 year age cohort attending WWC	Number of women in 35 year age cohort attending WWC	Total number of estimated women in 35 year age cohort	TBD	TBD	By district	eRHMIS
4.	Percentage of women in 45 age cohort attending WWC	Number of women in 45 year age cohort attending WWC	Total number of estimated women in 45 year age cohort	TBD	TBD	By district	eRHMIS
5.	Percentage of women undergoing clinical breast examination	Number of women undergoing clinical breast examination	Total number of women attending WWC	TBD	80 %	By district	eRHMIS
6.	Percentage of women undergoing thyroid examination	Number of women undergoing thyroid examination	Total number of women attending WWC	TBD	80 %	By district	eRHMIS
7.	Percentage of women in the 35 age cohort who have been screened for cervical cancer using PAP smear / HPV test at WWC	Number of women in the 35 age cohort who have been screened for cervical cancer using PAP smear / HPV test at WWC	Total estimated number of women in 35 age cohorts	TBD	≥ 80%	By district education wealth quintile residence;	eRHMIS
8.	Percentage of women in the 45 age cohorts who have been screened for cervical cancer using PAP smear / HPV test at WWC	Number of women in the 45 age cohort who have been screened for cervical cancer using PAP smear / HPV test at WWC	Total estimated number of women in 45 age cohorts	TBD	≥ 60%	By district education wealth quintile residence;	eRHMIS SLDHS
9.	Percentage of Pap tests that are reported as unsatisfactory smear during a given year	Number of Pap smears which are unsatisfactory	Total number of Pap smear		≤ 2 %	By district education wealth quintile residence;	eRHMIS SLDHS
10.	Percentage of women undergoing Pap smear test who receive their report in ≤ 30 days (cytology turn-around time)	The number of calendar days from when the specimen is taken to the day the report is finalized, is averaged over a 12 month time period	Total number of Pap smear	TBD	90 %	By district education wealth quintile residence;	eRHMIS SLDHS

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 1: WIN SUPPORT FOR THE WELL WOMAN PROGRAMME FROM DECISION MAKERS							
1.1	Percentage of parliamentarians sensitized on WW Programme	Number of parliamentarians sensitized on WW Programme		TBD	TBD	By gender	FHB Annual Report
1.2	Percentage of FHB budget allocated to WW Programme (SLR)	Budget allocated to WW Programme (SLR)	Total budget allocated to FHB		5% increase each year		FHB Annual Report
1.3	Number of media outlets that publish positive information on the WW Programme			TBD	TBD		FHB Annual Report
1.4	Number of awards to motivate and mobilize media personalities covering the WW Programme			TBD	TBD		HPB
1.5	Establish a Well Woman Week						FHB Annual Report
STRATEGIC OBJECTIVE 2: TRANSITIOING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING							
2.1	HPV + prevalence among 35 and 45 year women	Number of HPV + women in 35 and 45 age cohorts	Total estimated number of women in 35 and 45 age cohorts	TBD	TBD	By age, district education wealth quintile residence ;	eRHMIS SLDHS
2.2	Percentage of women by their most severe Pap test result (the following Bethesda Pap test result categories should be monitored: 1. Negative /benign changes 2. Atypical squamous cells of undetermined significance (ASCUS) 3. Atypical glandular cells (AGC) 4. Atypical squamous cells –high grade (ASC-H) 5. Low-grade squamous intraepithelial lesions (LSIL) 6. High grade squamous intraepithelial lesions (HSIL)	Number of women by their most sever Pap test result	Total number of women with a satisfactory Pap test	TBD		By type of smear abnormality \ district education wealth quintile residence;	eRHMIS SLDHS

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 2: TRANSITIOING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING							
2.3	Number of cytoscreeners who have received training by 2023			TBD	40	By district	FHB Annual Report
2.4	Percentage of women with a high-grade Pap test result (AGC, ASC-H, HSIL+) who had a follow-up colposcopy within 4 weeks of the index Pap test report date Time to colposcopy	Number of women with a high-grade Pap test result (AGC, ASC-H, HSIL+) who had a follow-up colposcopy within 4 weeks of the index Pap test report date	Total number of women with AGC, ASC-H, HSIL+ having PAP smears within a 12 month period	TBD	90% of women with a high grade Pap test result should have a colposcopy within 4 weeks from the Pap test report date	By district, education wealth quintile residence;	eRHMIS SLDHS
2.5	One colposcopy clinic established in each district			9	24 colposcopy clinics established	By district	NCCP reports
2.6	Percentage of cytology laboratories with quality assurance systems in place	Number of cytology laboratories with QA systems in place	Total number of cytology laboratories	TBD	100%	By district	Survey
2.7	Percentage of PHM trained on HPV self-testing and counselling (planned versus actual per year)	Number of PHM trained on HPV self-testing and counselling	Total number of PHM planned to be trained	TBD	100%	By district	FHB Annual Report
2.8	Percentage of WWC that provide post-test counselling following a positive HPV test	Number of WWC that provide post-test counselling following a positive HPV test	Total number of WWC	TBD	100%	By district	Survey
2.9	Percentage of HPV + women who underwent confirmatory Pap smear testing	Number of HPV + women who underwent confirmatory Pap smear testing	Total number of HPV+ women	TBD	100 %	By district & residence	eRHMIS
2.10	Percentage of HPV+ women that are lost to follow up	Number of HPV+ women that are lost to follow up	Total number of HPV + women	TBD	0%	By district & residence	eRHMIS

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 2: TRANSITIOING FROM CYTOLOGY BASED CERVICAL SCREENING TO HPV BASED SCREENING							
2.11	Revised guidelines and manuals on cytology screening are available Scale: 0 (no existence); 1 (guidelines drafted); 2 (guidelines finalized); 3 (guidelines is endorsed by Government); 4 (guidelines is printed and distributed); 5 (guidelines are implemented			1	5	By district	Revised guidelines and manuals on cytology screening
2.12	Number of women who are referred for suspected cervical /breast / thyroid cancer (Also calculated per 100,000 women to compare against incidence and mortality rates globally for cervical / breast / thyroid cancer)			TBD		By district	Referral slips
2.13	Costed implementation plan for introduction of HPV testing is available Scale: 0 (no existence); 1 (plan drafted); 2 (plan finalized); 3 (plan is endorsed by Government); 4= (plan is implemented); 5 (plan is monitored annually)			0	5		FHB Annual Report
2.14	Pre- cancer detection rate Number of pre-cancerous lesions detected per 1,000 women who had a Pap test in a 12 month period	Number of women with CIN II and III	Number of women who had at least one Pap test during the last 12 months	TBD	TBD	By age, district & residence	eRHMIS
2.15	Percentage of HPV tests obtained by self-testing	Number of HPV tests obtained by self-testing	Total number of HPV tests	TBD	TBD	By age, district & residence	eRHMIS

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME							
3.1	PHM density and distribution per 3000 population	Number of PHM	Total population	TBD	1 per 3000 population	By district	eRHMIS
3.2	Percentage of MOH areas where cadre positions are filled for MOH, PHNS, SPHM	Number of MOH areas where the complete cadre of MOH, PHNS and SPHMs are present	Total number of MOH areas	TBD	100 %	By district	eRHMIS
3.3	Percentage of PHM positions vacant at the end of the given year at district / national level	Number of PHMs in position	PHM cadre			By district	eRHMIS
3.4	Percentage of women who were referred for high blood pressure	Number of women attending WWC who had BP more than 140/90 and are referred	Total number of women attending WWC	TBD	TBD	By age, district & residence	eRHMIS
3.5	Percentage of women who are referred with high blood sugar	Number of women whose random blood sugar measured at the WWC is ≥ 200 mg/l and are referred	Total number of women attending WWC	TBD	TBD	By age, district & residence	eRHMIS
3.6	Percentage of women with BMI ≤ 18.5 identified at WWC	Number of women with BMI ≤ 18.5 identified at WWC	Total number of women whose BMI was measured	TBD	TBD	By age, district & residence	eRHMIS
3.7	Percentage of women with BMI ≥ 25 identified at WWC	Number of women with BMI ≥ 25 identified at WWC	Total number of women whose BMI was measured	TBD	TBD	By age, district & residence	eRHMIS
3.8	Percentage of women attending WWC found to have thyroid abnormalities and referred	Number of women attending WWC found to have thyroid abnormalities and referred	Total number of women attending WWC whose thyroid was examined	TBD	TBD	By age, district & residence	eRHMIS
3.9	Percentage of women attending WWC found to have breast abnormalities and referred	Number of women attending WWC found to have breast abnormalities and referred	Total number of women attending WWC whose breasts were examined	TBD	TBD	By age, district & residence	eRHMIS
3.10	Issuance of certificate of honour or letters of recognition for outstanding performance of PHMs, cytoscreeners and MOH					By district by cadre	FHB Annual Report

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME							
3.11	Number of acceptors of FP from WWC					By FP method, age, district & residence	eRHMIS
3.12	Percentage of women referred from HLC undergoing Pap smears	Number of women referred from HLC undergoing Pap smear	Total number of women referred from HLC	TBD	TBD	By age, district & residence	eRHMIS
3.13	External resources from development partners as a percentage of the total available resources for the WWP	Resources from development partners	Total available resources for the WWP				FHB Annual Report
3.14	Costed multi year plan (CMYP) for WW Programme is available S Scale: 0 (no existence); 1 (plan drafted); 2 (plan finalized); 3 (plan is endorsed by Government); 4= (plan is implemented); 5 (plan is monitored annually)			0	5		Workplans
3.15	Existence of district health plans that include interventions related to WWC services and communication activities (Scale: 1= WW programme activities are not included; 2= partially included; 3= fully included)			TBD	3	Districts	District Annual Health Plans
3.16	Percentage of RMSD that had a stockout for WWC consumable according to the ending balance of any of the last three reporting periods, reported by family planning product	Number of RMSD that had a stockout according to the ending balance of any of the last three reporting periods	Total number of RMSD	TBD	0%	By district By method	LMIS
3.17	Electronic logistics management information system that includes last mile tracking for forecasting and monitoring linking FHB and RMSD is in place (Pronto) Scale: 0 (no existence); 1 (plan drafted); 2 (plan finalized); 3 (plan is endorsed by Government); 4= (plan is implemented); 5 (plan is monitored annually)			0	5	By district & WWC commodity	LMIS

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 3: STRENGTHEN AND REORIENT HEALTH SYSTEMS SO AS TO MAXIMIZE THE OUTCOMES OF THE WW PROGRAMME							
3.18	Percentage of MO and PHNS trained to implement WWC and eRHMIS (percentage of actually trained against the planned)	Number of MO and PHNS trained to implement WWC and eRHMIS	Total planned number of MO and PHNS to be trained			By district & cadre	FHB Annual Report
3.19	Existence of a TAC with revised membership and TOR Score: 1= no committee exists; 2= body exists without clear defined roles; 3= body exists with revised TOR; 4 = committee exists with annual workplan; 5= body exists with clear TOR and annual workplan			2	5	National	TOR, TAC minutes
3.20	Number of businesses pursuing Corporate Social Responsibility through joint projects with the WW Programme			TBD	TBD	By district	FHB Annual Report
3.21	Availability of a training plan Scale: 0 (no existence); 1 (plan drafted); 2 (plan finalized); 3 (plan is endorsed by Government); 4= (plan is implemented); 5 (plan is monitored annually)				5	By district	FHB Annual Report
3.22	Resource mobilization plan available Scale: 0 (no existence); 1 (plan drafted); 2 (plan finalized); 3 (plan is endorsed by Government); 4= (plan is implemented); 5 (plan is monitored annually)			TBD	5	By district	Resource mobilization plan

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 4: INCREASE COVERAGE AND EQUITY OF THE WW PROGRAMME							
4.1	Percentage of PHM areas where the eligible couples register has been updated during the last one year	Number of PHM areas where the eligible couples register has been updated during the last one year	Number of PHM areas	TBD	TBD	By district	MOMCH reports
4.2	Number of mobile clinics conducted in workplaces			TBD	TBD	By district	MOMCH reports
4.3	Percentage of Pap smears collected from outreach activities	Number of Pap smears collected by outreach activities	Total number of Pap smears	TBD	TBD	By district	MOMCH reports
4.4	Percentage of respondents who have to travel more than 2 hour to reach a WWC	Number of WWC clients who have to travel more than 2 hour to reach a WWC	Total number of WWC clients	TBD	TBD	By district education wealth quintile residence ;	SLDHS Surveys

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WWC PROGRAMME							
5.1	Percentage of planned supervisory visits to WWC carried out	Number of supervisory visits carried out	Total planned visits to WWC	TBD	TBD	By district	Supervision reports
5.2	Proportion of WWC obtaining consent from clients undergoing cervical smears/HPV test	Number of WWC obtaining consent from clients undergoing cervical smears/ HPV test	Total number of WWC	TBD	100%	By district	Supervision reports
5.3	Percentage of WWC referring clients with abnormalities according to agreed guidelines	Number of WWC referring clients with abnormalities according to agreed guidelines	Total number of WWC	TBD	100%	By district	Supervision reports
5.4	Percentage of WWC carrying out QA measures for improvement of services	Number of WWC carrying out QA measures for improvement of services	Total number of WWC	TBD	100%	By district	Health Facility Assessment
5.5	National standards for WWC services are available					National	National Standards

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 5: INVEST IN IMPROVING THE QUALITY OF SERVICES PROVIDED BY THE WWC PROGRAMME							
5.6	Percentage of WWC with functioning basic amenities – water, sanitation and hygiene facilities, electricity, auditory and visual privacy, adequate seating Scale: 1 = Yes (meets all criteria); 2 (partial); 3 (none)	Number of WWC with basic amenities	Total number of WWC	TBD	100%	By districts	Health Facility Assessment
5.7	Percentage of MOH areas with functional referral system from WWC to hospital clinics developed and operational Scale: 1= referral mechanism drafted; 2= referral mechanisms are operational	Number of MOH areas with functional referral system in place	Total number of MOH areas	TBD	100%	By district	WWC Follow up register
5.8	Percentage of MOH areas that have established functional WWC Management Committees	Number of MOH areas with WWC Management Committees	Total number of MOH areas	TBD	100%	By district	Minutes of meetings
5.9	Percentage of WWC clients who reported that they were satisfied with the quality of care provided	Number of WWC clients who are satisfied with the services they received	Total number of WWC clients	TBD	80%	By district education wealth quintile residence ;	SLDHS Surveys

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WW SERVICES, ESPECIALLY CERVICAL CANCER SCREENING							
6.1	Existence of a budgeted multisectoral communication strategy /plan to support the promotion of WW services drafted, finalized and under implementation Scale: 1 = Yes (meets all criteria); 2 (partial); 3 (none)			2	3		HPB Reports
6.2	Percentage of married women in the 35 and 45 year age cohorts with knowledge of at least 5 of the 9 signal functions provided at the WWC	Number of married women in the 35 and 45 age cohorts who know of 5 of the 9 signal functions provided at WWC	Total number of married women in the 35 and 45 age cohorts surveyed	TBD	TBD	By district, age cohort, residence, education, wealth quintile,	SLDHS STEPS survey

SO	Indicators	Numerator	Denominator	Baseline	2023 Target	Disaggregation by equity dimension for reporting	Means of verification
STRATEGIC OBJECTIVE 6: INCREASE HEALTH SEEKING BEHAVIOUR OF ELIGIBLE WOMEN FOR WW SERVICES, ESPECIALLY CERVICAL CANCER SCREENING							
6.3	Percentage of married women in the 15-49 age group who are aware that screening exists for cervical cancer	Number of married women in the 15 to 49 age group who are aware that screening exists for cervical cancer	Total estimated number of women in the 15 to 49 age group	77.6 %	TBD	By age, district education wealth quintile residence	SLDHS STEPS survey
6.4	Percentage of WWC staff trained on IPC as per national standard (percentage of actually trained against the planned)	Number of WWC staff trained on IPC in a given year	Total number of WWC staff planned to be trained	TBD	100 %	By district	HPB Reports
6.5	Percentage of WWC with video, posters, job aids, leaflets for communication and counselling Score: 4=video, job aids, posters, leaflets; 3=only 3 types of material available: 2=only 2 types of material available; 1= only 1 type of communication material is available	Number of WWC with communication and counselling material	Total number of WWC	TBD	100%	By district, type of communication material	HPB Reports
6.6	Number of Media houses that support the WW Programme			TBD	TBD	By media type and language	HPB Reports
6.7	Number of MSGs that have promoted the WWC services	Number of PHM areas with I functioning MSG	Total number of PHM areas	TBD	TBD	By district, MOH area	HPB Reports
6.8	Number of districts with Communication action plans Scale: 0 (no existence); 1 (plan drafted); 2 (plan finalized); 3 (plan is endorsed by Government); 5 (plan is monitored annually)			TBD	TBD		District plans
6.9	Number of religious and community leaders reached by programmes promoting WWC			TBD	TBD	By religious and community leaders	HPB Reports
6.10	Number of Civil Society Organizations that are engaged in promoting the WW Programme			TBD	TBD	By district	HPB Reports

ANNEX 6

METHODS OF SCREENING FOR CERVICAL CANCER

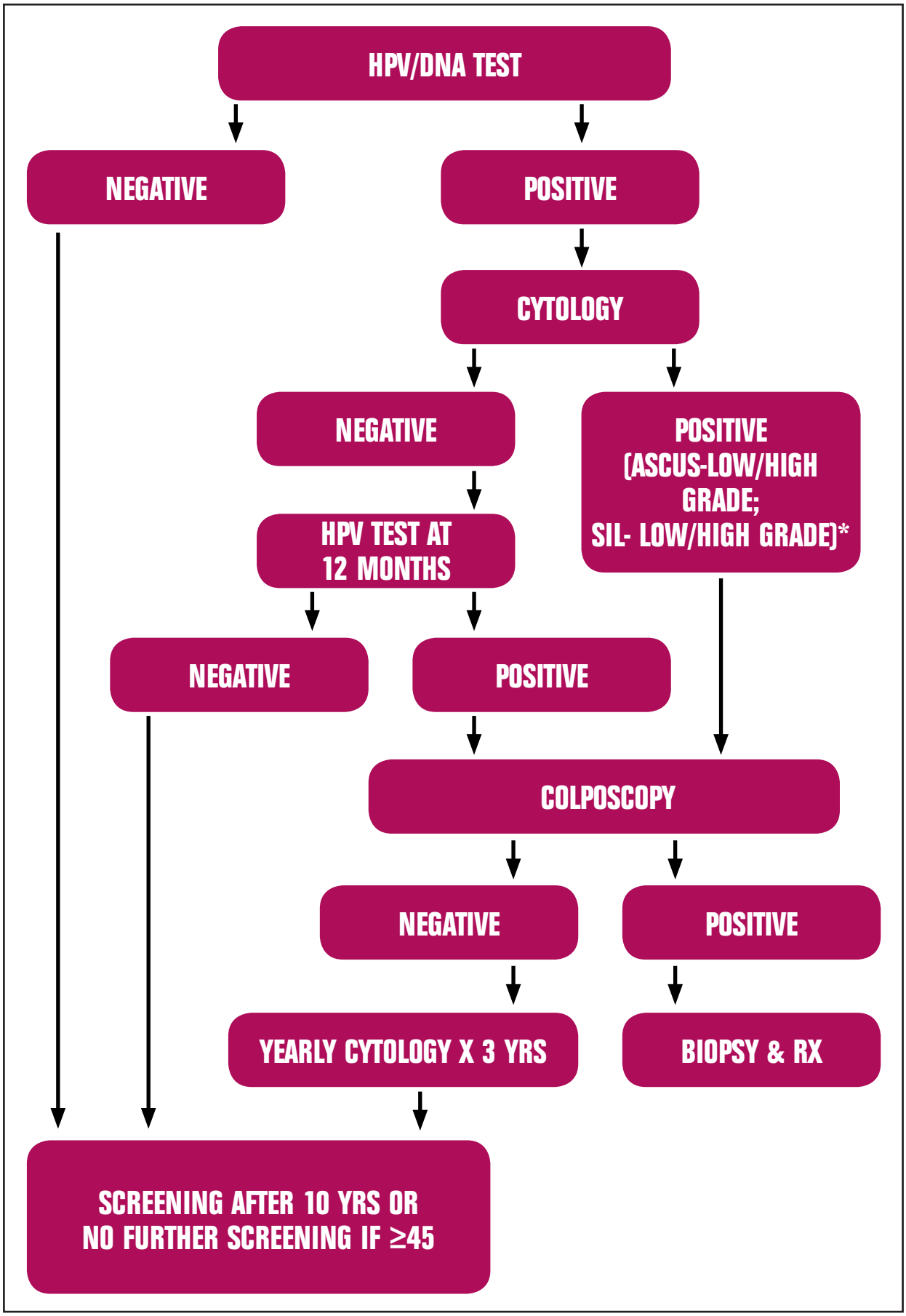
Characteristics	Conventional cytology	HPV DNA testing	Visual inspection with Acetic acid (VIA)
Sensitivity	47-62 percent	66-100 percent	67-79 percent
Specificity	60-95 percent	62-96 percent	49-86 percent
Procedure	A sample of cervical cells is taken by the provider using a spatula and/or small brush, fixed onto slides and examined by a trained cytoscreeners in a laboratory	Samples of cells taken from the cervix or vagina by a provider or woman herself, stored in a container with appropriate preservative solution and sent to the laboratory (or processed immediately on-site if a new test is used)	A trained provider examines the cervix at least 1 minute after applying 3-5 percent acetic acid, to visualize cell changes on the cervix
Number of visits required for screening and treatment	2 or more	2 or more	1 or 2
Health system requirements	Requires highly trained cytoscreeners and pathologists; microscope, stains, slides; transport system for specimens and results and a system for informing and tracking positive cases	Requires trained lab worker, electricity, kits, reader; transport system for specimens and results	Requires training and regular supervision; no equipment, few supplies
Strengths	• This method has proven effectiveness to decrease cervical cancer in the context of a well-functioning system • It is widely accepted in high-resource countries. • Training and mechanisms for quality control and quality assurance are well established	• Collection of the specimen is simple, allowing the possibility of self-collected specimens • The assay result is a definite end point • If the new test with on-site processing and rapid results is used, a positive result can be followed by an offer of immediate treatment (i.e. single visit approach)	• This method is relatively simple and inexpensive • The results are available immediately, • VIA can be performed by a wide range of personnel after brief training • Infrastructure requirements are minimal • A positive result can be followed by an offer of immediate treatment (i.e. single visit approach) • Requires less training than other methods
Limitations	• The method is difficult to introduce and maintain • Systems are needed to ensure timely return and communication of test results and follow-up care for screen positive women • Transportation is required for specimens to the laboratory and for results back to the clinic • Cytology programmes require clinical and laboratory quality control and quality assurance • Interpretation is subjective • Result are not immediately available so multiple visits are required	• It requires proprietary supplies and equipment which may not be easily accessible • The unit cost is often high • Storage of materials needed for tests can be problematic • In general, the laboratory and specimen transport requirements are complex • Using an HPV test that is currently available, the result will not be immediately available	• After training providers need initial supervision and continuing education (Refresher retraining) and quality control and quality assurance) • The end point is subjective; there is high variability in the accuracy of results between providers • Acetic acid must be prepared directly before screening • ViA is not appropriate for many postmenopausal women • Possibility for overtreatment

Characteristics	Conventional cytology	HPV DNA testing	Visual inspection with acetic acid, VIA
Comments	Assessed over the last 50 years in a wide range of settings in developed and developing countries. Test must be repeated every few years due to low sensitivity	Assessed over the last decade in many developed country settings; just beginning in developing countries. Due to high sensitivity screening may be done with less frequency	Assessed over the last decade in many settings in developing countries with good results

(Adapted from Denny L, Quinn M, SankaranarayananR. Chapter 8: Screening for cervical cancer in developing countries. Vaccine 2006;24 (suppl 3):71–77.
World Health Organization. Cervical cancer screening in developing countries: Report of a WHO consultation. 2002. Available at: http://whqlibdoc. who.int/publications/2002/9241545720.pdf. Accessed 22.09.2018
Comprehensive Cervical Cancer Prevention and Control – Programme Guidance for Countries. UNFPA 2011)

ANNEX 7

ALGORITHM FOR HPV DNA TEST



* ASCUS - Atypical Squamous Cells of Undetermined Significance
SIL - Squamous Intraepithelial Lesion

Designed & Printed by OLEECO Solutions 0773017475 (2019)