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President's Message

It is with great pleasure I take this opportunity to express my sincere appreciation to the IMPA in publishing the 2024 Journal Volume 18 once again this year. The IMPA journal supports our membership and medical professionals to express their views on several topics of significance especially in the field of medicine.

I wish to thank Dr A.L.P. De S. Seneviratne for agreeing to be the editor of the Journal this year. I also wish to thank all the members of the editorial board, Dr. Palitha Abeykoon, Dr. S.M. Samarage, Dr. S.M. Goonesekera and Dr. S.A.P. Gnanissara for their sincere efforts in assisting to complete the publication of this issue.

I am pleased to inform you that the re-vamped IMPA website www.impa-sl.com has been updated regularly and coordinated by Mr. Nilupul Gunaratne (Web Master).

The IMPA newsletter has been converted to an E-newsletter and professionally managed by Dr. Neelamani Rajapakse as editor and assisted by the journal editorial board and supported by Mr. Eranga Pushpanath.

I am also pleased to inform you that the Sri Lanka Drug Index (Published by the NMRA in collaboration with "MediVerify") is officially available on the IMPA website. A special Thanks to all the contributors of articles to give this edition value.

I would be lacking in my duty if I fail to acknowledge our very able administrative secretary Ms. Champa Silva whose untiring efforts of coordinating details to bring the final journal to fruition.

I also appreciate the effort of our printer AK 2 PRO for obliging us always in producing a journal par excellence.

Finally, this Journal would not have been possible if not for our sponsors and advertisers who contributed so magnanimously in these difficult economic times to make this journal a reality.

I wish the IMPA success in all its future achievements!!

Dr. A. H. A. Hazari
President
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Editorial

Dr A L P De S Seneviratne

Social media and youth mental health

Adolescents spend increasing amounts of time in a digital world by checking messages on X, counting likes on Instagram, or watching YouTube or TikTok. According to the latest evidence, over 30% of teenagers reported continuous online contact with others. 11% of adolescents report pathological use and addiction-like symptoms: they are unable to control their use, have withdrawal symptoms of anxiety and low mood when not able to use social media, neglect other activities, and report negative consequences on their usual daily lives. Concomitant with the growing use of social media in the past 15 years, rates of mental illness and self-harm in people aged 10–24 years have also increased. These trends have prompted many questions about the effects of social media on the mental health of young people.

That life will continue to be increasingly virtual for both adults and young people seems inevitable. However, concerns are growing that children, who often use social media in disparate ways unknown to their parents or guardians, are specifically being manipulated and harmed through algorithms and targeted marketing deliberately aimed to grow hours spent online. While browsing, teenagers will see advertisements for alcohol, fast foods, vaping, and gambling, and with greater exposure comes increased opportunities for them.

The adolescent brain goes through much neurobiological change as synaptic connections are strengthened and neurons are selectively pruned, making it particularly vulnerable and malleable. At the same time, children are expected to become independent adults capable of managing a new set of identities and responsibilities. Unsurprisingly, psychological and emotional difficulties during adolescence are common. Awareness of such vulnerabilities has prompted heated debate about at what age young people should be allowed smartphones, whether mobile phones should be banned in schools, and whether legal frameworks are needed to provide protection.

However, attempts to conclusively link rising rates of mental illness or find any clear brain changes with the growing use of social and digital media during adolescence have proved difficult. In the *Lancet* Commission on self-harm, Paul Moran and colleagues acknowledge the potential harms and arguments put forward by scientists such as Jonathan Haidt, but conclude that research on the effects of social media has so far produced mixed results. Indeed, for

some young people, it might have benefits, facilitating connections for those who are isolated, providing online support networks, and delivering therapies.

More study is clearly needed. Research thus far has focused on time spent online as the unit of exposure. But social media provide diverse environments and individual user experiences are highly specific. Users' perceptions—such as ideas about how many people will view their content or how long the content will be visible for—should be considered. Although rates of mental illness have gone up alongside rates of social media usage, many other ecological changes affecting young people have taken place in the past 15 years, including widening inequalities, tightening job markets, and climate change concerns. If there is a meaningful causal link between social media and mental illness, it is likely small, although it may also be important.
There is a bigger picture of mental health to consider. The Commission, which reports unprecedentedly high lifetime prevalence rates of self-harm—including 14% in children and adolescents—argues for the importance of addressing psychological and social factors. Most crucially, the social determinants of health. Poverty, specifically, is known to heavily influence the distribution of self-harm in all communities. Self-harm practices are also shaped by social relationships and class dynamics; Indigenous people across the world, especially Indigenous youth, have high rates of self-harm, with colonization and racism having potentially important roles in driving behaviour. Reducing rates of self-harm, which by extension would likely have a substantial effect on distress in adolescents using social media, requires a whole-of-government approach to tackle upstream drivers. Services and society need to reduce misery and build healthy communities.

If teenagers are to spend their lives online, they should be able to do so safely and free from manipulation. The rise in mental health disorders in young people is extremely concerning, and we certainly need to better understand the role that digital media and smartphones might have. But such efforts should not detract from the continued need for action against well-established determinants of mental illness.

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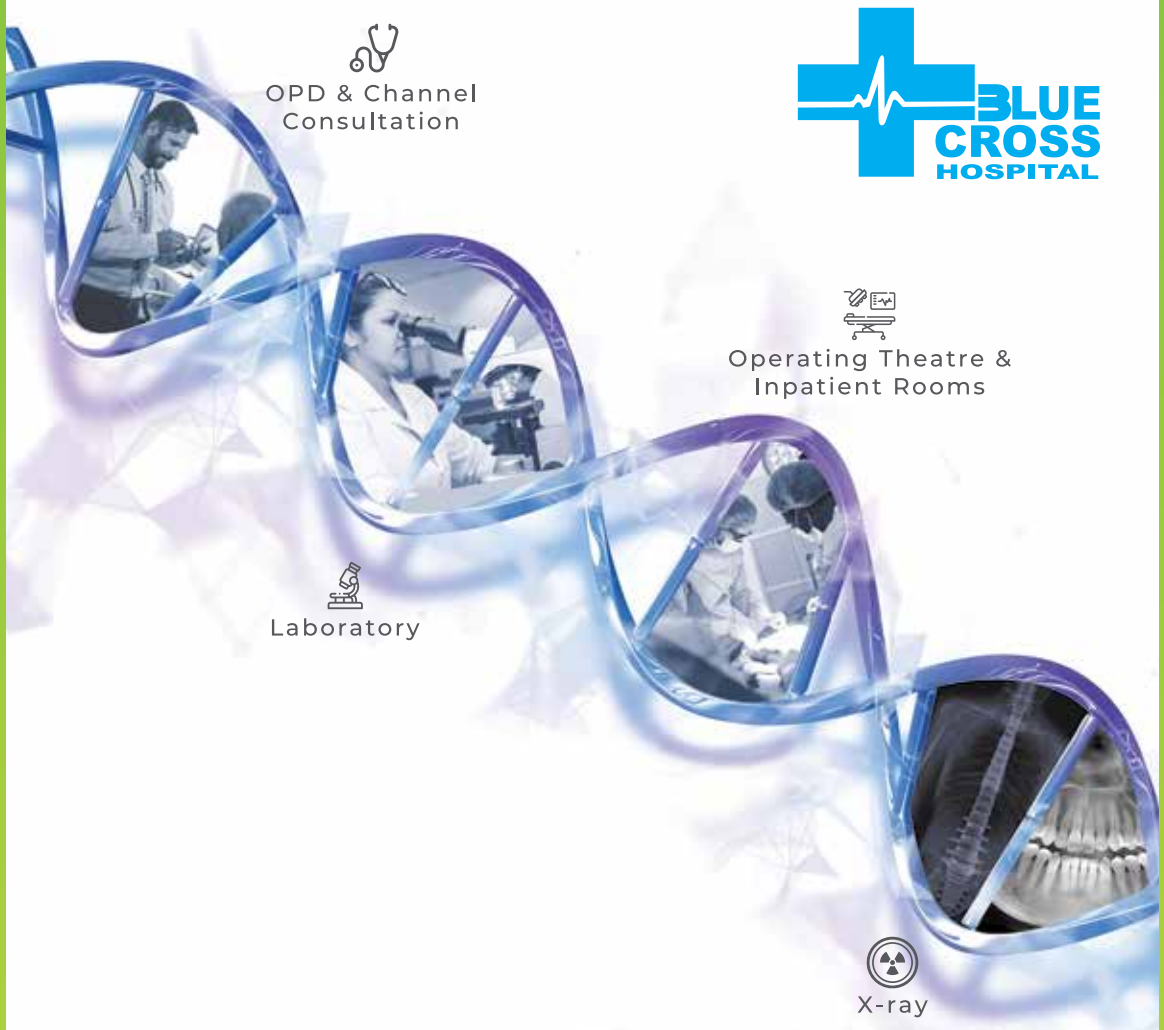

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Have you seen them, listened to them and treated them in your practice?

Dr Kanthi Ariyarathne

This is a worthwhile question to ask from General Practioners of Sri Lanka today about a group of people living in our own society. Who are "they" of whom we try to talk about from this article? They are Transgender people who live in our society with us but may be not met nor spoken with or thought of by many of us.

Introduction

Who is this group called "Transgender or Trans". Before talking about transgender, must explore what is "Gender "and what is "Sex". As per the description of the World Health Organization (WHO) "Gender refers to the characteristics of women, men, girls and boys that are socially constructed" whereas "Sex refers to the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs". Gender includes norms, behaviors and roles associated with being a woman, man, girl or boy, as well as relationships with each other which is a social construct, which varies from society to society and change over time.

There is other two definitions which are going to be important to know in this context namely "Cisgender "and "Transgender". WHO defines "Transgender is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations typically associated with the sex assigned to them at birth" (WHO). The "Britanica" defines Cisgender as the "term used in reference to persons whose gender identity corresponds with their sex assigned at birth" and further clarifies that the prefix "cis" is derived from Latin and means "on this side of" or "on the same side as". The "Britanica" further states that the term "cis" contrasts with the Latin-derived prefix "trans", which means "across" or "on the other side of" and which is used as in transgender or, simply trans to describe people whose gender identity does not align with the sex they were assigned at birth. (Samie, Britanica 2024).

Review of Literature

In 2016 an article was published by Winter S, and et al. on "Transgender people: health at the margins of society" had examined the social and legal conditions in which many transgender people live, and the medical perspectives that frame the provision of health care for transgender people across much of the world. The research showed that many transgender people live on the margins of society, facing stigma, discrimination, exclusion, violence, and poor health. They often experience difficulties accessing appropriate health care, whether specific to their gender needs or more general in nature. Some governments are taking steps to address human rights issues and provide better legal protection for transgender people, but this action is by no means universal. The mental illness perspective that currently frames health-care provision for transgender people across much of the world is under scrutiny (Winter & et.al., 2016).

Ming L, and colleagues reported a much-neglected health issue of transgender people by an article of "Transgender health in India and Pakistan", who have been officially recognized as a third gender citizen registration category in Nepal, Pakistan, India, and Bangladesh, since 2010. Locally known as hijras (hijra), this civil recognition is profound for their social rights because it translates into confirmed allocation into government and education quotas. Despite the legal recognition, access to quality health care is alarmingly scarce compared with their cisgender counterparts. More concerning is their reduced engagement in health promotion and disease prevention activities especially related to sexual health, putting them at a higher risk of sexually transmitted infections, including HIV. Because of social discrimination and stigma, most transgender people in India and Pakistan have no opportunity for schooling or access to higher education, eventually leading to poor health literacy. Even though transgender people in Pakistan and India have been given their civic identity, they are still vulnerable to verbal and psychological abuse by medical personnel. Unsurprisingly, HIV prevalence among transgender sex workers is eight times higher compared with their cisgender counterparts in Pakistan. Also, there are hardly any anti-discrimination laws in place to safeguard equality in health-care access for transgender people in Pakistan and India (Ming & et al, 2016).

In 2018, a qualitative study done by the College of Public Health Sciences, Chulalongkorn University, Bangkok, Thailand on "Social Stigmatization Access to Services and Service Satisfaction among Transgender Persons at Thai Red Cross AIDS Research Center - Tangerine Project" had identified that transgender persons are sometimes receiving different standard of service than ordinary people as stigmatization against transgender persons is still a barrier to access health care service whereas the access to healthcare services is a basic need and right for every persons in the community. Further research had been recommended to expand the sample size and study area to make these results generalizable and will be so important in a country like which has the highest incidence of transgender persons world-wide (Laphon & Chuemchit, 2018).

Rapid Situation Assessment of Transgender Persons in Sri Lanka conducted by Institute for Participatory Interaction in Development (IPID) for the Family Planning Association (FPA) of Sri Lanka intended to determine how well Sri Lanka has achieved the provision of universal access to appropriate HIV prevention, care, treatment and support for transgender people. It critically looked at existing laws, policies and human rights issues affecting transgender persons and attempted to identify both opportunities and gaps in policies and laws which may limit or provide opportunities with regards to the access to health services for transgender persons in relation to prevention and control of HIV. The study reveals that at least 31% of the participants were youth, while the majority of participants were between the ages of 25 -35 years. Forty Six percent (46%) of the participants indicated that they engage in sex work, out of which 28% engage in sex work on full time basis. The basic knowledge on modes of HIV transmission is low but in contrast to that HIV testing is higher among the transgender persons. In general transgender persons mentioned that they are treated well at the health settings, though in very few cases, they have faced verbal and non-verbal harassments mainly from the minor staff. (IPID,2016).

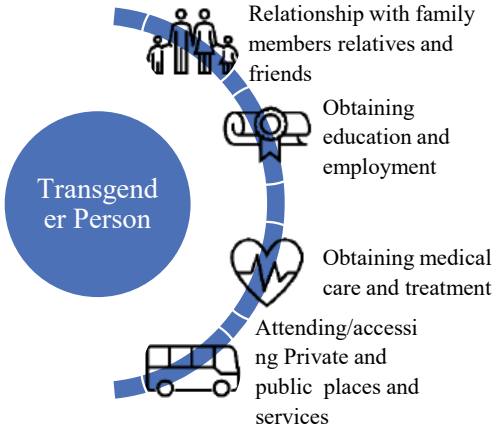
Research Methodology

A research study had been done by the writer of this titled "A Sociological Study on the socio - economic and cultural issues faced by Transgender people and their family members" with special reference to five transgender organizations in Colombo district. This study used mixed research methodologies that is a mixture of quantitative and qualitative methods. A total of twenty transgenders who were residents of Colombo District either permanently or temporarily had participated in the quantitative assessment of the study whereas five in-depth interviews were conducted to gather data for the qualitative assessment.

Conceptual Framework

Anyone being Transgender may cause many issues with respect to smooth relationships with other people. Similarly, their personal life as well as their public life could be affected to varying degrees. Being transgender may bring discrimination and stigma into their life causing many difficulties in their personal and social life. By considering all these factors the Conceptual Framework for the study was developed as follows.

Figure 1. Conceptual Framework



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Results

Table 1. Age Distribution of the Respondents

Age Category	Number
18-22 years	4
23-27 years	6
28-32 years	2
33- 37 years	2
38-42 years	1
43-47 years	2
48-52 years	2
63-67 years	1
Grand Total	**20**

It is observed that the majority of the respondents are in the age groups of 18-22 years and 23-27 years. It may be due to the fact that most of the Transgender people gathered around those organizations are young adults.

Table 2. Distribution of the Respondents by Ethnic Group and by Religion

Religion	Ethnicity		
	Sinhala	Tamil	Grand Total
Buddhism	15		15
Catholic	1		1
Christian	1		1
Hinduism		3	3
Grand Total	**17**	**3**	**20**

It is observed that seventeen (17) respondents belong to the ethnic group of Sinhalese. It may be due to the fact that most of the Transgender people gathered around those organizations are Sinhalese of whom are Buddhists.

The highest educational level the respondents have achieved is the Post Graduate University Degree and two had been succeeded. Five had obtained

Table 3. Distribution of the Respondents by the Educational Level

Educational Level	Number
Basic University degree	5
Grade 6 -11 (up to Ordinary Level)	2
Passed Advanced Level	5
Passed Ordinary Lebel	1
Post-Graduate University degree	2
University Diploma/Vocational Training Certificate	3
Up to Advanced Level	2
Grand Total	**20**

Basic University Degree whereas three had obtained either University Diploma / Vocational Training Certificate. Five had got through the Advanced Level Examination. (Table 3) As indicated by these results they had achieved good educational qualifications which is very encouraging. However, this data is gathered through a sample of respondents selected through a purposive sampling which extended to a snowball sampling as they are gathered around those selected organizations which cannot be generalized.

As presented in the Table 4 respondents reported various discriminations and harassments, they have faced in those health settings both government and private. Verbal harassments, non-verbal harassments by facial expressions, bulling, neglect, isolation, psychological harassments and forced to leave etc. had been experienced by 10 respondents (50%) in varying degrees in different situations.

The data on discriminations and harassments in three specific diseases

Table 4. Discrimination and harassment the transgender people faced from others in places such as government hospitals and clinics, private hospitals and clinics etc.

Have you ever faced any discrimination and harassment from others in places such as government hospitals and clinics, private hospitals and clinics etc. due to your gender identity or sexual orientation? (Can be more than one)	Number
Bulling, Neglect, Isolation, Psychological harassments, forced to leave	1
Bulling, Neglect, Psychological harassment, forced to leave	1
Neglect	1
No	10
Non-verbal harassment by facial expressions etc.	1
Non-verbal harassments by facial expressions etc.	2
Verbal harassments, Bulling	1
Verbal harassments, Bulling, Neglect	1
Verbal harassments, Non-verbal harassments by facial expressions etc., Bulling	2
Grand Total	**20**

entities were also collected in order to compare the three situations as in obtaining services for general illnesses, sexual illnesses and psychological and or psychiatric illnesses.

As presented in Table 5 the discriminations and harassments faced by 08 respondents as for their reporting when seeking treatment for general illnesses. Verbal harassments Non-verbal harassments by facial expressions, Bulling, Neglect, Isolation, Psychological harassments and forced to leave etc. had been experienced by 06 respondents.

Table 5. Discrimination and harassment from others when taking treatment for any general diseases.

Have you ever faced any discrimination and harassments from others when you got treatment from others when you go for treatment for any diseases	Number
Bulling, Physical harassments Psychological harassments Sexual harassments Sexual abuse Forced to leave	1
No, I haven't faced any discrimination	12
No, I haven't got treatment for any diseases such as cough and cold, asthma, heart attacks diabetes or so	2
Verbal harassments	1
Verbal harassments, Bulling Neglect, Isolation	1
Verbal harassments, Bulling	1
Verbal harassments, Bulling, Neglect, Psychological harassments, forced to leave	1
Verbal harassments, Non-verbal harassments by facial al expressions etc., Bulling	1
Grand Total	**20**

Table 6. Discrimination and harassments from others when getting tested or treatment for any Sexually Transmitted Diseases

Have you ever faced any discrimination and harassments from others when you went to get tested or treatment for any treatment for any Sexually Transmitted Diseases								
	Not treated for STD	Verbal harassment, Bulling. Non-verbal harassments by facial al expressions etc.	Bulling, Neglect, Isolation, Psychological harassments, forced to leave	No	Verbal harassments	Verbal harassments, Bulling	Verbal harassments, Bulling, Neglect	Grand Total
No	12							12
Yes		1	1	2	2	1	1	8
Grand Total	**12**	**1**	**1**	**2**	**2**	**1**	**1**	**20**

As presented Table 6 the discriminations and harassments are faced by 08 respondents as for their reporting when went to get tested or treatment for any treatment for any Sexually Transmitted Diseases such as HIV/AIDS Gonorrhea, Syphilis, Genital Warts and Genital Herpes etc. Verbal harassments Non-verbal harassments by facial expressions, Bulling, Neglect, Isolation, Psychological harassments and forced to leave etc. had been experienced by 08 respondents. However, it is observed that no sexual abuse or sexual harassment had been experienced by any one of the respondents in this sample although there is unauthenticated information are circulating time to time.

As presented in Table 7, the discrimination and harassment had been experienced by 08 respondents as for their reporting when seeking counselling or treatment for psychiatric illnesses. Verbal harassments, Non-verbal harassments by facial expressions, Bulling, of Neglect, Isolation, Physical harassments, Psychological harassments, Sexual harassments, Sexual abuse and forced to leave etc. had been reported.

Recommendations and Conclusions

Hence, the data on discriminations and harassments faced by Transgender People at health care institutions who were involved in the present study are really alarming and should be an eye opener to the health professionals. The research into these aspects may need in future to better understand the situation specially by health professionals to make recommendations and to take preventive measures. However, if these types of things are happening corrective measures have to be taken early and urgently because Transgender People are also members of the society who needs to live with dignity and respect.

The appeal is pledged here when they come to the General Practitioners clinics, not only treat them for their illnesses but also provide care empathetically and nicely by everyone working in the institute.

Acknowledgements

The guidance provided by Senior Professor Mayura Samarakoon, Department of Sociology, University of Sri Jayewardenepura as the Supervisor of the research. The support extended by Ms.

Table 7. Discrimination and harassment from others when seeking counseling services or psychiatric services for any treatment or care due to gender identity or sexual orientation.

Have you ever faced any discrimination and harassment from others when you seek counselling services or psychiatric services for any treatment or care due to your gender identity or sexual orientation? (Can be more than one)	Number
Bulling, Neglect, Isolation, Psychological harassments, forced to leave	1
Bulling, Non-verbal harassments by facial expressions etc.	1
Bulling, Physical harassments, psychological harassments, Sexual harassments, Sexual abuse, forced to leave	1
No	1
No, I haven't faced any discrimination	11
Non-verbal harassments by facial expressions etc.	1
Non-verbal harassments by facial expressions etc.	2
Verbal harassments, bulling	2
Grand Total	**20**

Anju Thakshila de Silva, Demonstrator, Department of Sociology, University of Sri Jayewardenepura. The support extended by my loving daughter Ms Kumudu Sandamali Ariyaratna in preparation of the report. The Leaders of the five Transgender organizations for their excellent coordination. The Transgender people who participated in the study for their participation.

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- Positive Social Connectedness.

Incorporating these six factors into daily living can help an individual lessen the economic burden on one-self and the country. It will help them to inculcate a decorum of healthy living. As a result, their biochemical markers can come down enabling us physicians to reduce their medication which means less expenditure on buying medicines. It becomes a beautiful symbiotic relationship.

If healthcare providers intervene to integrate prevention into their workflow, then we may see a significant decrease in the number of chronic diseases in individuals, the associated suffering, and healthcare costs for both individuals and the government.

This concept is not new. Hippocrates taught about the importance of prevention over 2000 years ago. The medieval physician and philosopher Maimonides (1) asserted that the most important cause of poor health is the food we choose to eat.

The large European Prospective Study into Cancer and Nutrition- Potsdam Study 2009 (2) identified four healthy lifestyle practices and body weight that predicted a composite healthy outcome. The four factors included having a BMI less than 30kg/m2, performing 3.5 hrs/week of moderate physical activity, consuming a predominantly plant based diet (whole grain with low meat consumption) and never smoking. Patients with these four characteristics had almost a four-fifths

reduction in chronic disease.

In 1998, Dr Dean Ornish (3) carried out a seminal study that had landmark results for initiating change. Lifestyle intervention was applied to 28 cardiac patients and compared to a cohort of patients who did not receive any intervention. The study was conducted over five years. A clinically and statistically significant reduction in the stenosis in coronary arteries was experienced in the intervention cohort versus those in the control group, who continued to use lipid lowering pharmacotherapy. This seminal trial demonstrated that coronary artery disease could be reversed.

Diabetes Mellitus is another chronic disease affecting the quality of life of an individual. In 2002, Knowler et al.(4) demonstrated that lifestyle interventions focusing on weight loss outperformed metformin in patients with type II diabetes mellitus.

In another study, the Portfolio diet(5) (a diet of cholesterol-lowering foods) was administered to patients with high cholesterol levels. The interventional group was compared to a control cohort taking lipid lowering drug lovastatin. This study showed that it is possible to duplicate the benefits of statin with a targeted diet.

Exercise is another important lifestyle factor to instil in daily life. According to the United States Preventive Services Taskforce (USPTF), almost 70% of mortality reduction benefit is achieved with 150 minutes of moderate exercise per week. The Talk Test (6) is a useful tool to measure the intensity of the workout. If one can talk but not sing, that can be considered moderate exercise and if one is exercising and cannot talk, that is considered vigorous.

Sleep is another area emphasized in lifestyle medicine. The importance of daily seven hours good quality sleep and not exceeding eight hours, is beneficial to overall mortality. Lack of sleep is shown to lead to under productivity and development of chronic diseases, including stroke, cardiovascular diseases, cancer and neurodegenerative conditions such as Alzheimers.(7)

Smoking, if habitual, is another risk factor for disease and mortality. Many well documented dangers the use of addictive substances increase cancer risk and heart disease risk. Smoking in fact maybe more detrimental risk factor than diet and exercise.

Stress and social isolation have been given recent highlight in causing chronic diseases as they contribute as risk factors for overall mortality. It is important to recognise the positive and negative stress responses and teach stress reduction techniques for improved well-being. Social connectedness can also aid in emotional resiliency and overall health.

In summary, we as physicians of the community should practise our healthy living following the six pillars of lifestyle medicine and in turn share the knowledge and experience with our patients treating and educating simultaneously for the best clinical outcome.

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Nutritional Empowerment in Ridimalliyadha Sri Lanka - a case study

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Abstract

Though Sri Lanka is well placed to achieve most Sustainable Development Goal (SDG) indicators, it lags in nutrition indicators. Low-cost study was undertaken to empower the population in one of the MOH areas where the nutrition indicators are below the national indicators. The following strategies were utilized. Capacity building of the staff in engaging with the mothers and volunteers to understand issues in collaboration with the population served and responding to them, to enhance the power of the people by understanding the resources available and not relying on outside support or goods, and managing them. Capacity building of the population comprised of families, mothers, children, and adolescents, understanding their problems and working together to address them. Engaging and capacitating existing teams and generating new teams (ex-mother support group, youth groups) involving the whole family. Working towards achieving better nutrition, addressing poverty issues. The total design of the work was done with population engagement and evaluation of community participation. Tools designed by the community were innovative. Offered a new approach. Learned from the people, applying the lessons learned, while working with them. Health promotion strategies are sustainable in the long run, but they are hard to accomplish without proper funding.

Keywords: Community empowerment, health promotion SDG nutrition indicators Sri Lanka, Ridimaliyadha.

Introduction

Sri Lanka provides free health care at the point of delivery and has health indicators compared to the economically developed countries[1]. Sustainable Development Goal 3 (SDG 3) aims to "Ensure healthy lives and promote well-being for all, at all ages." Sri Lanka has made significant progress towards achieving this goal leading in South Asia, particularly the indicators in maternal and child health, communicable diseases, and health infrastructure. Sri Lanka is lagging behind SDG Indicator 2.2.1: 'Reduce stunting to ensure that all children can achieve their full growth potential' and SDG Indicator 2.2.2: 'Reduce Malnutrition (Wasting and Overweight) in Children Under 5 Years'[2].

Ridimaliyadha is a rural area located in the Badulla District of Sri Lanka, which is part of the Uva Province. Many households in Ridimaliyadha live below the national poverty line, struggling with low and unstable incomes. The combination of low agricultural productivity, limited employment opportunities, and inadequate infrastructure contributes to persistent poverty[3]. Poverty and nutrition are closely interconnected, creating a vicious cycle. The ethical approval for the study was obtained from the ethical review committee of the Faculty of Applied Sciences Rajarata University of Sri Lanka.

Problem and intervention

Of the 755 children under one year in the Ridimalliyadha MOH area at the beginning of 2023, 255 (32%) were diagnosed with nutritional deficiencies. Of 902

Children between 1 to 2 years, 479 (53%) had nutritional issues, and of 2935 aged 2 to 5 years, 1655 (56%) showed with nutritional issues[4]. The community is not aware of preparing nutritional food in different ways, there is family disharmony and money is spent on tobacco, alcohol, and junk food. There is negligible community support.

Health promotion techniques were used to empower small groups to create teams. Used problem tree analysis with the community, community making the solution tree. They understood the baselines, understood evaluation techniques, and made tools to assess their progress.

Made a resilient community: Enhanced the power of the people to achieve economic empowerment. Showed pathways to overcome extreme poverty by managing their life issues by addressing alcohol, tobacco, and gender-based violence. The Medical Officer of Health mediated arranging self-employment opportunities such as making soap, yogurt, nutritious kanji, and fruit drinks for sale (Figure 1). Arranged food exhibitions to show the nutritious food in the area and had demonstrations of how food can be cooked and presented in different ways, for example, different jak and corn presentations. Mothers focused on enhancing meal experiences and the nutritional quality of the family. A "Happy Calendar" (Figure 2) was used to assess the family's happiness. A "kitchen calendar" was used to identify the reduction of unhealthy and junk food, as well as the reduction of consumption of salt, oil, and sugar. Promoted male participation in all work. Home gardening was facilitated by providing plants and beans. Encouraged and praised the mothers who brought children regularly for weighing and provided incentives to mothers who provided detailed and logical accounts of how they overcame poverty issues, understood, and addressed risky behaviours, and how it contributed to the growth of their child. 'A local source of micronutrient-rich supplement named

Figure 1.

Figure 2.

"wibhaga pohora' and "examination nutrition" were collectively made by the

villages which opened up youth participation.

Other interventions: community feeding programs as direct interventions targeting to address the reduction in stunting and wasting of children under five; improving the knowledge, capabilities, and confidence of the mothers on nutrition and happiness and wellbeing of children.

Impact

The main impact is in the change process and the change in how the communities as a whole operate now. The initial months were to generate interest and kindle community processes. During the short period of actual addressing of determinants of poor nutrition, changes in the final endpoint are already noticed – as indicated below. These will now continue to grow.

Children under 1 year: children with problems reduced by 3% MAM (Moderate Acute Malnutrition)reduced by 1,7%, and children aged +1-to-2-year, problems reduced by 3%, MAM reduced by 1,7%; Children aged +1-to-2-year: Children with problems reduced by 2.7% SAM reduced by 0,9% MAM reduced by 0.3%; Children aged +2-to-5-year: children with problems reduced by 1% SAM reduced by 0.7%. MAM reduced by 3.5%; Mother Support Groups (MSG) number increased (Table 1). Staff gelled with the population served and many were actively working. There was a 25% reduction in sugar, salt, and oil intake, and a 20% reduction in biscuit consumption.

Traveling of the resource persons to the area for training sessions became very difficult due to some funding delays. WhatsApp groups were made, and continuous dialogue continued. Once a month zoom discussions were arranged to showcase and share the best practices.

The sustainability of the program can be ensured as activities generated are now within the power of the communities concerned. No material or monetary incentives or supplements were provided from outside the relevant communities.

Table 1. Growth of the children in Ridimaliyadha MOH area 2023 and 2024 and the MSG*

	2023 January		2024 June		Improvement
	No	%	No	%	%
Children under 1 year	755		691		
Children identified with growth problems	244	32	203	29	3%
SAM	2	0.2	04	0.6	
MAM	33	4.3	18	2.6	1.7%
Children under +1 year to 2 years	902		764		
Children identified with growth problems	479	53	388	50.7	2.7%
SAM	12	1.3	3	0.4	0.9%
MAM	90	9.9	74	9.6	0,3%

Children under +2 years to 5 years	2935		2772		
Children identified with growth problems	1655	56	1537	55	1%
SAM	56	1.9	35	1.2	0-7%
MAM	448	15	319	11.5	3.5%
*Mothers support Group(MSG)	3 (Inactive)		Active 22		Seven times more

Call for action

Low - cost study empowering the population. Learning from the people, applying the lessons learned, while working, and community making evaluation tools are the major characteristics of this project.

Health promotion strategies are sustainable in the long run, but they are hard to accomplish without adequate funding.

The work can be generalized by adapting it to the respective local community, with good leadership following Health Promotion techniques.

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Obesity Care in Sri Lanka's Family Practice for Better Disease Prevention

Dr Achala Weerasinghe

Obesity has emerged as a global health crisis, contributing to many chronic diseases and impacting overall healthcare costs. As Family Physicians, we are positioned at the forefront of primary care and are uniquely equipped to implement obesity management and disease prevention. This article explores emerging strategies that integrate personalized care, multidisciplinary approaches, and community-based interventions to enhance obesity care within family medicine/General Practice in Sri Lanka.

Introduction

Obesity is a complex condition characterized by excessive body fat that significantly increases the risk of various health issues, including type 2 diabetes, cardiovascular disease, and certain cancers. According to the World Health Organization (WHO), obesity rates have tripled globally since 1975, with nearly 1.9 billion adults classified as overweight (WHO, 2021). The rising prevalence necessitates a paradigm shift in obesity care, particularly in family medicine, where practitioners are often the first point of contact for patients.

Traditional Approaches and their Limitations

Historically, obesity management in primary care has focused on weight loss through dietary changes and increased physical activity. While these methods are essential, they often fail to address the multifaceted nature of obesity, which includes genetic, psychological, social, and environmental factors (Puhl & Latner, 2007). Traditional models can lead to patient frustration and disengagement, as they often emphasize short-term solutions rather than sustainable lifestyle changes.

Available Treatment Options for Obesity based on BMI

Obesity is commonly classified using the Body Mass Index (BMI) scale, which categorizes individuals into different weight classes:

Underweight: BMI < 18.5
Normal weight: BMI 18.5 - 24.9
Overweight: BMI 25 - 29.9
Obesity Class I: BMI 30 - 34.9
Obesity Class II: BMI 35 - 39.9
Obesity Class III: BMI ≥ 40

Treatment Options by BMI Category

1. Overweight (BMI 25 - 29.9)

- Lifestyle Modifications:
- Diet: Focus on a balanced, reduced-calorie diet rich in fruits, vegetables, whole grains, and lean proteins (Gudzune et al., 2015).
- Physical Activity: Aim for at least 150 minutes of moderate-intensity aerobic exercise per week, combined with strength training.
- Behavioral Strategies: Goal setting, self-monitoring, and cognitive behavioral techniques to promote healthy eating and physical activity.

2. Obesity Class I (BMI 30 - 34.9)

- Lifestyle Interventions: Enhanced dietary modifications and increased physical activity.
- Pharmacotherapy: FDA-approved

medications such as orlistat, phentermine-topiramate, bupropion-naltrexone, and liraglutide can be considered, particularly for those who have not achieved significant weight loss with lifestyle changes alone (Apovian et al., 2015).

3. Obesity Class II (BMI 35 - 39.9)
- Lifestyle and Behavioral Interventions: Like Class I, but with a more intensive focus on behavioral strategies and support.
- Pharmacotherapy: Medications mentioned for Class I are also applicable here, often used in conjunction with lifestyle changes.
- Surgical Options: Bariatric surgery is considered for patients who have not achieved adequate weight loss through other means and have obesity-related comorbidities. Procedures include gastric bypass, sleeve gastrectomy, and adjustable gastric banding (Sadia et al., 2021).

4. Obesity Class III (BMI ≥ 40)
- Intensive Lifestyle Interventions: Focus on comprehensive weight loss programs, often involving a multidisciplinary team (dietitians, psychologists, exercise physiologists).
- Pharmacotherapy: As with Classes I and II, FDA-approved medications can be employed.
- Bariatric Surgery: Strongly recommended for individuals in this category, particularly if they have obesity-related health issues such as diabetes, hypertension, or sleep apnea.

Life Years Gained by Obesity Treatment Based on BMI

Obesity is associated with significant morbidity and mortality, and effective treatment can lead to substantial improvements in life expectancy and the quality of life. The potential life years gained (LYG) from obesity treatment varies by BMI classification and the methods employed:

1. Overweight (BMI 25 - 29.9)
- Intervention Options: Lifestyle modifications, behavioral therapy, and pharmacotherapy.
- Life Years Gained: Studies suggest modest improvements, typically in the range of 1 to 3 years, especially with sustained lifestyle changes and early intervention (Flegal et al., 2013).

2. Obesity Class I (BMI 30 - 34.9)
- Intervention Options: Lifestyle changes, pharmacotherapy, and potential surgery for selected patients.
- Life Years Gained: Research indicates that effective interventions can lead to life expectancy improvements of approximately 3 to 6 years, particularly for individuals with obesity-related comorbidities (Naylor et al., 2018).

3. Obesity Class II (BMI 35 - 39.9)
- Intervention Options: Intensive lifestyle modifications, pharmacotherapy, and bariatric surgery.
- Life Years Gained: Evidence suggests that patients in this category can gain about 5 to 8 years of life with comprehensive treatment, particularly when obesity-related health issues are addressed (Dawes et al., 2018).

4. Obesity Class III (BMI ≥ 40)
- Intervention Options: Comprehensive lifestyle changes, pharmacotherapy, and bariatric surgery.
- Life Years Gained: Individuals with severe obesity can potentially gain 8 to 10 years or more through effective treatment, especially when combined with bariatric surgery, which has been shown to significantly reduce obesity-related mortality (Saxena et al., 2017).

Factors Influencing Life Years Gained

1. Age at Intervention: Younger

individuals tend to gain more life years from treatment due to a longer life expectancy.

2. Comorbid Conditions:The presence of conditions like diabetes, hypertension, or cardiovascular disease can affect the potential benefits of treatment.
3. Sustained Weight Loss: Long-term maintenance of weight loss is crucial for maximizing life years gained.
4. Type of Intervention: Surgical options generally yield greater life expectancy benefits compared to non-surgical methods, particularly in severe obesity.

Conclusion

The rising prevalence of obesity requires innovative, multifaceted approaches that transcend traditional weight management strategies. By embracing personalized care, multidisciplinary collaboration, community engagement, behavioral science, and policy advocacy, Family Physicians can significantly enhance obesity care and disease prevention. As the healthcare landscape continues to evolve, Family Physicians must lead the charge in implementing these new paradigms, ultimately fostering healthier communities and improving patient outcomes.

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Statin Induced Rhabdomyolysis

Dr B G D Bujawansa

This is a condition not uncommon in family practice. The authors practice with about thousand patient visits a month has about a dozen of cases currently. It is an iatrogenic condition associated with management of dyslipidaemea. Its management is not much documented in literature. The management is a challenge but quite rewarding and common sense plays a major part. Treatment may fail in a non complying patient defaulting follow up visits.

The condition appears in patients on statins to manage dyslipidaemea. The incidence of myopathy is about 3%.The symptoms are muscle cramps fatigue and myalgia. Examination will reveal muscle tenderness. The serum creatinine phosphokinase (CPK) level has to be assessed to establish the diagnosis. The normal value is 20 to 200 microgrammes per liter.

Myoglobin escapes into the circulation with rhabdomyolysis. There is a possibility of this myoglobin obstructing the capillariries in kidneys leading to renal failure. Fortunately this is a very rare occurrence. Existence of rhabdomyolyisis definitely has an influence on quality of life because of disability caused by muscle cramps and myalgia. Therefore the condition has to be identified and managed. This could be very successfully carried out in a family practice.

Table 1. Blood Reports (December 2020 - July 2024)

	Total Cholest.	HDL	Non HDL	LDL	VLDL	Tri Glycer.	Chol / HDL	LDL / HDL	CPK	Serum Creatin
Ref. Range mg/dl	140-239	35 - 85	55 - 189	75 - 159	10 - 41	10 - 200	2.0 – 5.0	0.01 – 3.30	38.0 - 174	0.7 - 1.2
28 Dec. 20	259.2	52	201.2	180.0 *	21.2	106	4.4	3.10		
04 Mar. 21	181.3	58.0	123.3	107.1	16.2	81.0	3.1	1.84	269.5 *	
26 Apr. 21	180.2	54.5	125.7	107.1	18.6	93.0	3.3	1.96	187.9 *	
29 July 21	257.5	62.0	195.5 *	175.2 *	20.3	101.5	4.1	2.82	269.8 *	
01st Oct. 21	130.2	42.6	87.6	77.2	10.4	52.2	3.0	1.81	153.8	
28th Dec. 21	170.7	46.3	124.4	101.8	22.5	112.9	3.6	2.19	-	
20th April 22	161.0	58.0	103.0	86.5	16.5	82.6	2.7	1.49	156.9	
19th Sept 22	215.2	54.7	160.5	146.1	14.3	71.8	3.9	2.67	148.1	
05th Jan 23	171.4	49.1	122.3	108.4	13.8	69.3	3.4	2.20	133.4	
31st March 23	289.2 *	54.9	204.3 *	185.1 *	19.2	96.2	4.7	3.37 *	143.9	
28th April 23	145.4	42.2	103.2	87.2	16.0	80.1	3.4	2.06	208.0 *	
25th Aug 23	231.3	54.1	177.2	153.0	24.2	121.0	4.2	2.82	227.5 *	
29th Sept. 23	*254.9	58.2	196.7 *	175.2 *	21.5	107.6	4.3	3.01	280.8 *	
21st Oct. 23	173.7	48.9	124.8	100.5	18.3	91.6	3.5	2.17	183.9	
30th Nov. 23	165.2	43.6	121.6	105.0	16.6	83.0	3.7	2.40	189.3	
5th Jan 24	* 271.0	55.6	* 215.4	* 197.9	17.5	87.7	4.8	3.55	* 240.4	
6th March 24	136.0	41.9	94.1	79.4	14.7	73.7	3.2	1.89	217.6	1.44
9th April 24										1.33
10th May 24	167.9	43.6	124.3	107.4	16.9	84.5	3.8	2.46	212.8	1.35
23rd July 24	280.6	58.5	222.1	198.7	23.3	116.8	4.8	3.39	184.2	

Patients with suspicious features should be sent for serum CPK testing. Though according to available literature, even values 10 times the upper limit is safe, intervention should be imposed depending on severity of symptoms .The severity of symptoms is independent of the dose of statin and serum CPK level Patient's occupation and activities too have to be considered. A patient employed as a sedentary worker may be able to tolerate mild to moderate myalgia unlike a person engaged in manual labour.

Statin dose can be reduced or it can be withdrawn altogether. Ezitimibe and tri omega fatty acid can be added to the regime. Though in routine follow up serum lipid levels are monitored once in three months, this kind of situation warrants monthly testing. If the lipid profile is very unsatisfactory, statins can be reintroduced. If lipid level is only moderately unsatisfactory, one can go on for another one month without statins.

Getting the patients to tabulate the lipid levels, CPK value and serum creatinine levels as shown in the figure, one can take decisions at a glance. It is a matter of withdrawing statins when symptoms appear adds CPK is high. One can exploit ezitimibe and tri omega fatty acids to keep lipids at safe levels when patient is off statins. If the patient is on statin for secondary prevention (a patient who has a history of a cardiac or a cerebrovascular event), it is advisable to seek advice of a cardiologist or a neurologist.

These strategies will improve the quality of life of the patient who needs satins and prevent total non compliance on statin therapy which may be disastrous. All patients on statins presenting with muscle related features should be screened for rhabdomyolysis.

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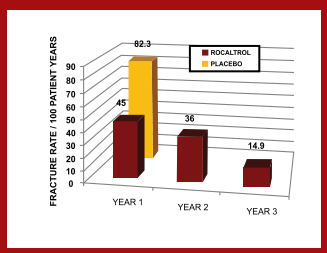

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The Family Physician and Cervical Cancer: Prevention and Early Detection

Dr I H S Kumarasinghe

Introduction

It is estimated that 604,127 (6.5%) women are diagnosed with cervical cancer globally [1]. Global cancer statistics also reveal that 341,831 (3.3%) women died of cervical cancer in 2020 [1]. In Sri Lanka, cervical cancer is the commonest gynaecological malignancy [2]. It is also the second commonest malignancy overall to affect females, being second only to breast cancer [2]. 1114 new cases of cervical cancer were reported in Sri Lanka in 2019 [2]. World Health Organization (WHO) statistics reveal that 690 women in Sri Lanka die due to cervical cancer per year [1].

Many of these deaths were preventable as there are established primary prevention and secondary prevention strategies in the country. The family physician plays a key role in ensuring that these prevention methods are carried out.

Primary prevention

It has been established that the main cause of cervical cancer is human papilloma virus (HPV) infection. Primary prevention involves the prophylactic vaccination against this virus. Three vaccines are available against HPV to date: the bivalent vaccine (2vHPV), the quadrivalent vaccine (4vHPV) and the ninevalent HPV vaccine (9vHPV). All 3 vaccines provide protection against HPV 16 and 18 which are the main HPV serotypes that are responsible for cervical cancer. 4vHPV also includes HPV 6 and 11 which cause the majority of genital warts. The 9vHPV covers an additional 5 oncogenic HPV viruses (HPV 31, 33, 45, 52 and 58) [3,4].

The WHO recommends that females aged 9 to 13 years are vaccinated against HPV [5].Vaccination should be done before the child becomes sexually active in order to reach maximum benefits. The quadrivalent HPV vaccine was introduced to the National Immunization Programme of Sri Lanka in July 2017 [6]. This vaccine is given as two doses with a minimum interval of six months between doses through the school immunization programme to girls in grade 6.

In addition to prophylactic vaccination, health education also, plays a pivotal role and provides another opportunity for the family physician to intervene. The education of females regarding the morbidity and mortality of cervical cancer, its risk factors and methods of prevention are of key importance and should be done from secondary school upwards. The risk factors for cervical cancer include early age at first intercourse, multiple sexual partners, having a partner with multiple sexual partners, multiparity, smoking, immunodeficiency, sexually transmitted diseases (STD), and low socio-economic status [7].

Secondary prevention and early detection

Cervical cancer has a well-defined pre-invasive stage which can be easily detected by screening methods. Large numbers of cervical cancers in Sri Lanka present in ~~the~~

late stages of the disease process and have less success of cure despite intensive therapy [7]. Screening will enable detection of these cancers in the early stages and thereby pave way for successful treatment [7].

Different methods are available for cervical cancer screening. High risk HPV DNA screening is available in Sri Lanka, but only in the private sector. Conventional PAP smears are the screening method that is used widely in this country. The WHO recommends screening for cervical cancer to be started at the age of 30 years and to continue until the age of 65 years. Currently in Sri Lanka screening is done targeting two age cohorts; 35 and 45 years [7].

Pap smears are an outpatient procedure that can be done by a trained medical officer. They should not be done during the menstruation or a cervical infection. The family physician should encourage patients belonging to these age groups to undergo pap smear screening.

Obtaining a cervical smear:

1) Choose an appropriately sized Cusco's speculum. Warm water may be used to lubricate the speculum if necessary.
2) Insert the speculum into the vagina and inspect the cervix.
3) Take a sample of cells from the transformation zone of the cervix using a wooden spatula with an extended tip and a cytobrush. It is important that the entire transformation zone is sampled as the majority of high-grade lesions develop in this zone.
4) Prepare two smears on two glass slides and immediately put the slides into a container with 95% ethyl alcohol for fixing the smear and preserving the cells.

The smears should then be sent to the cytology laboratory for staining.

Smears should not be repeated within three months as time is needed for the regeneration of the epithelium. Therefore, a repeat smear should only be done after 3 months.

Pap smear report and recommended follow up

The PAP smear is reported using the Bethesda system. The recommended follow-up/ referral /management depends on the cytology report. Once the cytology report is available, the family physician plays an important role in ensuring that the required follow up is done.

Management of Cervical lesions based on the Bethesda Classification:

Category	Recommendation for follow up and referral
1. Negative for intraepithelial lesion and malignancy (NILM)	Routine re-screening in 5 years
2. Low grade squamous intraepithelial lesion (LGSIL)	Follow up by Medical officer of Health (MOH) Two repeat smears 6 months apart - IF negative, routine re-screening in 5 years. IF Positive, refer to a Gynecologist
3. High grade squamous intraepithelial lesion (HGSIL)	Refer to a Gynecologist for colposcopy and Biopsy.
4. Atypical squamous cells of undetermined significance (ASCUS) - Low grade	Follow up by Medical Officer of Health (MOH) Repeat smear in 6 month

5. Atypical squamous cells of undetermined significance (ASCUS) - High grade	Refer to a Gynecologist for colposcopy and biopsy
6. Glandular cell atypia	Refer to a Gynecologist
7. Benign endometrial cells in a woman > 40 years	Refer to a Gynecologist to investigate based on clinical details
8. Squamous or glandular malignancy	Urgent Gynecological referral for appropriate management

An abnormal smear or presence of HPV infection may cause significant anxiety and fear in the patient which may even lead to relationship difficulties with the partner. In such a situation, the family physician is the ideal person to reassure and educate the patient. Patients should be informed that HPV does not cause clinical features of a typical STD and that most of the time, it is innocuous. However, that because there is a possibility that the HPV virus will damage to the cells of the cervix, that it should be investigated into in more detail.

Conclusion

Cervical cancer is the main gaynecological malignancy to affect Sri Lankan females. It is known to cause major morbidity and mortality in this population. However, cervical cancer can also be easily prevented or detected at an early stage. Primary and secondary prevention of cervical cancer and its early detection are of paramount importance and the family physician plays a key role in ensuring this process.

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Breast Cancer Screening: The Role of the Primary Care Physician

Dr I H S Kumarasinghe

Breast cancer is the number one cancer affecting women from both a global and a Sri Lankan perspective [1,2]. Breast cancer screening is done on women without any symptoms or signs of the disease. However, unlike for cervical cancer, an established breast screening programme is not available in Sri Lanka as yet. Therefore, the primary care physician, as the point of first contact, plays a key role in screening and early detection of breast cancer, thereby reducing the morbidity and mortality associated with this malignancy.

The recommended screening protocol for breast cancer in Sri Lanka is as follows [2].

- Breast self-examination once a month by all women, starting from 20 years of age.
- Clinical Breast Examination (CBE) every 3 years for all women from the age of 20 to 40 years.
- Annual CBE for women aged 40 or over.
- In women with a relative who has had a breast or ovarian cancer under the age of 40 years, annual CBE is recommended to be started 5 years before the index case.
- It is planned to offer screening mammography once in 2-3 years for women aged 50 – 69 years. However, this will only be effective when adequate mammography facilities are available throughout the country.
- More intensive screening is recommended in the following women
  - Women with at least one first degree relative with invasive breast cancer.
  - Women with atypical hyperplasia or lobular carcinoma in situ on breast biopsy
  - Women with a history of chest wall radiation at 30 years of age or younger.
  - Women with known mutations (e.g. BRCA 1 BRCA 2).

It is recommended that the primary care physician educates women regarding breast cancer, breast awareness and breast self-examination. This knowledge should thereafter be reinforced at every consultation.

The primary care physician should also refer women with breast symptoms, or abnormal findings on CBE or mammography, to the closest breast clinic or surgical clinic. These clinics are available in teaching hospitals, provincial hospitals, district general hospitals, base hospitals and private hospitals.

Here, the patient will undergo a triple assessment which includes:
History and clinical examination
Mammography/ Ultrasound scan
Biopsy/Fine Needle Aspiration Cytology (FNAC)

If there are any abnormal findings on triple assessment, the patient will be further managed according to these findings. If the triple assessment is negative, the patient will be educated on breast awareness and

breast self-examination and advised as to when and where to come for clinical breast examination.

Breast Awareness and Self Examination
Breast Awareness
Being breast aware means that the woman is familiar with the appearance and texture of her breasts. This is important as only by being aware of the normal will she be able to identify any abnormality that occurs. The role of the primary care physician and staff is to educated women about the importance of breast awareness and to encourage the reporting of any of the following:

1) A change in the appearance of the breast
   E.g. Change in the shape or colour of the breast.
   Any skin changes like puckering, dimpling or ulceration.
2) Any discomfort or pain in one breast that is different from normal.
3) Any lumps, in one breast or armpit.
4) Nipple change or nipple discharge, which is new and not milky.

Breast Self - Examination
This involves inspection and palpation of the breasts by the woman herself. It should be done once a month by all females over the age of 20 years. In a menstruating female, the best time is one week after menstruation. This is because in some women, the breasts become painful and lumpy during menstruation. In non-menstruating women, any day would suffice. Having a fixed date would ensure that it is not forgotten.

The primary care physician is in an ideal position to educate women on the importance of breast self-examination and also advise on how and when to carry out this procedure properly.

Breast self - examination consists of the following:

Inspection
The woman should examine the breasts in a mirror for the following while standing with her shoulders straight and keeping the arms hanging by her side, then by keeping the arms pressed on her hips and lastly by raising the arms above her head.

- Change in shape or distortion of the breast
- New change in symmetry of the breast
- Change in size of one breast
- Change in colour of the breast e.g. redness
- Skin changes e.g. rash or swelling of the skin, ulceration, dimpling or puckering of the skin
- Retraction, change in position, or inversion of the nipple.
- Nipple discharges other than milk.
- Any lumps in the breast or axilla.

Palpation
She should palpate the breast for lumps while lying down and then while sitting or standing.

The right hand should be used for the left breast and the left hand should be used for the right breast. Palpation should be done using the pads of the three middle fingers. The fingers should be held flat and together. The entire breast should be palpated, from the collar bone to the top of the abdomen and from the cleavage to the axilla. Palpation should be done in circular movements, then in an up and down direction and finally in wedges. Initially minimal pressure should be applied to feel the area just beneath the skin. Thereafter, the pressure should be gradually increased to feel the deep tissues. After palpating the breasts, she should palpate the armpits for lumps. Finally she should squeeze the

areola with the thumb and the index finger to see if there is a nipple discharge.

years, through the well women clinics. However, its usage is low [3].

Diagram 1. Methods of Breast Palpation

Wedges (Wagon wheel) | Circles (Concentric circles) | Lines (Strip method)

Clinical Breast Examination (CBE)

Clinical breast examination can be used as a screening method for women without any symptoms or signs of breast cancer. It is also a component of the triple assessment for diagnosing breast cancer in women with symptoms and signs. Screening via clinical breast examination is offered to all women between the ages of 50 and 70

Clinical Breast Examination involves a detailed clinical history and a thorough clinical assessment.

Clinical History

The following information should be collected

- Details regarding any presenting breast symptoms (Table 1):

Table 1 Presenting symptoms of breast disease

Symptom	Questions to ask patient
Breast lump	Site
	Duration
	New changes
	Associated symptoms
	Relationship to menstrual cycle
Breast pain	Site
	Duration
	Cyclical /non-cyclical
	Recent changes in intensity
	Associated symptoms
Skin and Nipple changes	Site
	Duration
	Changes since first noticed
Nipple discharge	Side
	Duration
	Single duct or multiple ducts
	Nature of the discharge - wblood stained, serous, purulent

- Previous history of breast disease and any investigations done (reports of most recent imaging and cytology/ histology) should be perused.
- Any risk factors the patient may have for breast carcinoma should be elicited (Table 2).

Clinical Breast Examination (CBE)

CBE should be done in a covered room with good lighting. If the examiner is a male, a female chaperone should be present. The procedure should be explained to the patient before starting the examination.

Inspection

Breasts should be inspected in each of the following positions

1. Arms relaxed at her sides
2. Hands placed on the hips and pushing

Table 2 Risk factors of Breast Cancer

Risk Factor	Comment
Age	The risk increases with age
Family history	Women with first or second degree relatives have higher risk
Genetics	Genetic mutations can be transmitted from both the maternal and paternal sides of the family
Personal history of breast cancer	Increases risk of cancer in another part of same breast or other breast
Radiation to the chest	Increases risk
Certain benign breast changes	Some benign conditions e.g. atypical ductal hyperplasia increases the risk
Menstrual history	Early menarche and late menopause increase the time period of exposure of the breast to oestrogens and progesterones and thereby increase the risk.
Pregnancy history	Women who have not had a full term pregnancy or have had their first child after 30 years have a higher risk
Breast feeding history	Breastfeeding lowers breast cancer risk, especially if done for over one year.
Contraceptive pills	A slight risk is seen on long term OCP use. This risk rapidly declines with cessation of usage.
Hormone replacement therapy (HRT)	Combined hormone replacement therapy (HRT) increases the risk of breast cancer. Oestrogen therapy alone increases the risk but to a lesser extent than combined HRT. According to the national guidelines, any woman above 50 years should be discouraged from taking HRT.
Being overweight and obesity	Overweight and obese women have a higher risk. Increased weight results in an increase in circulating estrogen. In post-menopausal females, aromatase activity in adipose tissue generates high levels of estrogen.
Lack of exercise	Exercising regularly at a moderate or intense level for four to seven hours per week lowers the risk of breast cancer.
Alcohol	Increases risk
Smoking	Increases risk

inwards to contract the Pectoralis Major muscle
3. Arms raised over her head

The breasts should be inspected from the front and from each side of the woman for:

- changes in breast size, contour, shape and symmetry
- skin changes such as erythema, dimpling, tethering or puckering, peau d' orange, eczematous skin changes, visible lumps, ulceration etc.
- nipple position, retraction, erythema, eczema, nodules ulceration and discharge

Palpation

The woman should be in supine position with her lower half and contralateral breast covered by a sheet or hospital gown. Both her arms should be placed under her head to facilitate the palpation of the outer quadrants of the breast.

The anatomical boundaries of the breast should be identified.

Superior	: Clavicle
Inferior	: 6^{TH} rib
Medial	: Lateral border of the sternum
Lateral	: Latissimus Dorsi muscle

Palpation technique:

If a side-specific breast complaint is made, the examiner should initially evaluate the opposite side. The distal phalanges of the three middle fingers should be used for palpation.

The entire breast should be palpated in overlapping one inch circles.

Three different levels of pressure (superficial, intermediate and deep) should be applied at each position to palpate the different layers of the breast.

A variety of techniques exist, but the most often used are the radial "wagon wheel" or "spoke" method, the vertical strip method, and the concentric circle's method.

Both hands should be placed on either side of the areola and gently but firmly pressed down to see for any nipple discharge.

Following a complete examination of the breast, the axilla and supraclavicular and infra-clavicular areas should be palpated for lymphadenopathy.

For palpation of the axillary lymph nodes, the patient should be seated upright on the examination bed. The arm on the side to be examined should be slightly abducted at an angle of 45^0 degrees and supported by the examiner. The patient should fully relax the arm to make it easier to palpate the lymph nodes. Palpation should be done using the middle three fingers of the examiner's free hand.

Following palpation of the axillary nodes, the supra clavicular and infra-clavicular lymph-nodes should be palpated as well.

Recommendations

- All breast lumps
- Unilateral noncyclical mastalgia
- Single duct nipple discharge, whatever the colour
- Skin and nipple changes
- Axillary mass
- Mastitis, sinuses etc.

→ Refer to breast / surgical clinic within one week

Imaging

Mammography can be utilized to check for breast cancer in women who do not have any signs or symptoms. These are screening mammograms. Mammograms can also be used to check for breast cancer in women with signs and symptoms of disease (diagnostic mammogram). Diagnostic mammography takes longer to perform than screening mammography and the total dose of radiation is higher as more x-ray images are needed.

The WHO position paper on mammography screening recommends the following:

- In limited resource settings with relatively strong health systems, organized population - based mammography screening programs are suggested for women aged 50-69 years, every 2 years only if the conditions for implementing a screening program are met. In these settings, WHO recommends against mammography screening for women 40-49 years of age and 70-75 years of age.
- In limited resource settings with weak health systems, organized population-based mammography screening programs may not be cost-effective and feasible. Early diagnosis of symptomatic women and prompt treatment should be the priority. In these settings, clinical breast examination seems to be a promising screening approach.

In Sri Lanka, though mammography is available, access is limited and there is no established mammography screening programme. According to the screening guidelines of Sri Lanka, screening mammography will offered once in 2-3 years for women aged 50 - 69 years. However, this can be adopted only when adequate mammography facilities are available throughout the country.

According to the national guidelines, there is insufficient evidence to support the use of ultrasound for routine screening as well. It is not recommended as a standalone screening test but could be used for further evaluating mammographically detected anomalies.

MRI is recognized as a screening tool as it has high sensitivity for detecting breast cancer. It can be used either as a stand-alone or as an adjunct to mammography for screening of women at high risk of breast cancer as determined by a radiologist. However, it is relatively less specific, costlier and not readily available. Therefore it is not used in routine screening in Sri Lanka.

Conclusion

Though breast cancer is the primary cancer to affect women in Sri Lanka, a routine breast screening programme is not yet available in the island. As the primary care physician is the point of first contact of many individuals in the community with the health sector, he is in a unique position to aid in the screening for breast cancer. He can achieve this by educating women about breast awareness and breast self-examination as well as conducting clinical breast examination for screening and referral of women to breast clinics for triple assessment. As such it is imperative that the primary care physician is aware of the pivotal role he plays in breast cancer screening and that he is armed with the necessary information to carry out these functions.

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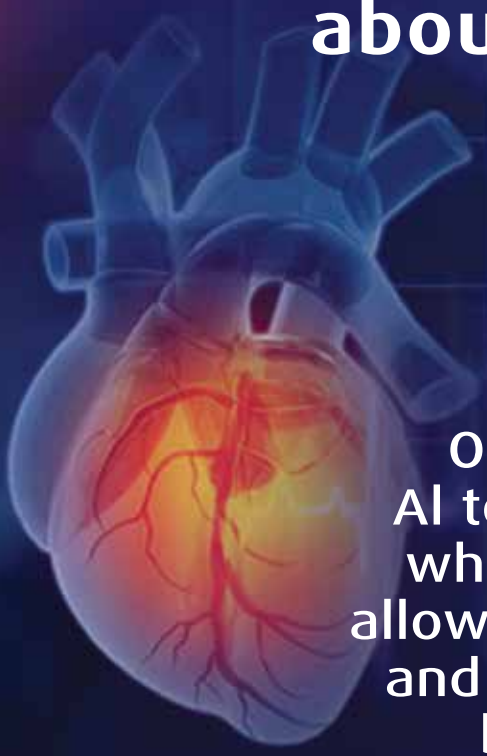

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Doctors' role in children with special educational needs

Dr Anuruddha Padeniya, Dr Ishara Sandeepani, Nethmi Dissanayake, Dr Evanthi Premaratne

Abstract

Parents approach doctors when children underachieve in their education and it is a family matter. In handling such situations physicians need competency. Such competency has several elements. Confirmation of academic underachievement, proper evaluation to seek medical, family, social, or other causes, making appropriate referrals to reach the diagnosis, collaboration with education and other relevant establishments, and directing parents to learning assisting resources are within the doctors' role. Physicians' initiatives might be authoritative and legally requisite, hence should refer to enactments in favor of Special Educational Needs (SEN) and child rights. This article aims to give an overview of the physician's role when children present with academic underachievement and to elaborate on scholastic learning difficulties (SLDs) in brief: dyslexia, dysgraphia, and dyscalculia.

Introduction

Every child is unique with regard to his/her blend of potential and weaknesses[4,5]. While appreciating exceptional potentials in children, some children struggle to read - termed dyslexic, some are too weak to process mathematics - termed dyscalculia and some cannot write well - termed dysgraphia[2,3].

- **Dyslexia** affects approximately 10% of the population[1]
- **Dyscalculia** is found in about 5-7% of the population[1]
- **Dysgraphia** affects around 5- 20% of children[1]

As per prevalence of scholastic learning disabilities (SLDs) cited in the National center of Learning Disabilities in United States (US), approximately one in five children in US have challenges with learning[1].

Struggles with academic performance is one reason for parents to seek doctors' advice. As a '*child's struggle in school*' can affect the entire family, international literature emphasizes the important role of family physicians and pediatricians in addressing these concerns, highlighting their influence in identifying underlying issues and guiding appropriate interventions[2,4]. In such consultations, the family physician has to be competent to fulfill several dimensions[2] . The success of such consultation depends on the ability to confirm academic underachievement (AU), proper evaluation to seek medical, family, social, or other causes, making appropriate referrals to reach at a diagnosis, collaboration with education and other relevant establishments to develop interventions, and directing parent towards available resources[2,4].

SLDs among school children affect academic outcomes, self-esteem and self-motivation[2]. Physicians cannot reach such diagnosis in one sitting. There is a stipulated evaluation process leading to the diagnosis and another process to arrange tailor-made

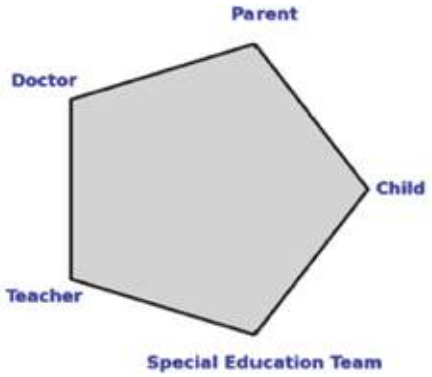
interventions[4,7]. In the process, several establishments in healthcare, education, social services, and legislation have a part to play, hence physicians' be trained to collaborate with stakeholders[7].

When evaluating children for SLDs, it is important to handle the process carefully to avoid harming the child's self-esteem[2]. The evaluation should be conducted avoiding the child feeling different or less capable than their peers[2]. The main aim is to identify their learning needs without labeling them in a negative light. Highlighting the child's strengths, framing specific learning challenges and arranging learning assistance to succeed would safeguard their confidence and foster a positive attitude toward learning[7,9].

When parents consult a physician claiming that '*my son/daughter is not doing well in school/education!*', the authors with their experience suggest five steps to follow.

1. Confirmation of parental claim of academic underachievement[2]
2. Proper evaluation to seek medical, family, social, or other causes[2]
3. Making appropriate referrals to reach the diagnosis of SLD[2]
4. Collaboration with education and other relevant establishments[2]
5. Directing parent to learning assisting resources[2]

The process of evaluation and process of educational interventions is intricately connected to several establishments in different sectors. Over time, evaluation reports have become standardized and validated to promote equity within society, and backed by legislation and law enforcement. These interventions often require a sharing of valuable resources among sectors such as healthcare, education, and social services, raising important questions about who bears the financial burden. As a result, the governance process evolves, adapting legislation and legal concepts to meet the changing needs of society.



Evaluation and interventions both involve multidisciplinary teams including the child him/herself, the parents, the teachers, the doctor and the special education team and would reflect as a pentagon.
(Figure 1)

This article will delve into the legislative and law enforcement landscapes of the US and the United Kingdom (UK) regarding academic underachievement in children. For instance, in the US, the *Individuals with Disabilities Education Act* (IDEA) guarantees that children with disabilities receive the appropriate educational services they need. Similarly, in the UK, the *Children and Families Act 2014* emphasizes the importance of supporting children with special educational needs and disabilities.

As such, addressing the AU of children is a complex but rewarding process that includes evaluation, diagnosis, arranging interventions, and guiding career paths. It is an investment for individuals as well as for society. All stakeholders could share the credit. Failing to do so might have disastrous consequences. Doctor can play

a critical role!

This article will elaborate briefly on dyslexia, dyscalculia, and dysgraphia before lining up the physician's role. In the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5), they are grouped under the umbrella term "Specific Learning Disorders" (SLDs).

Dyslexia

Dyslexia is a neurodevelopmental defect leading to difficulty in reading[2,3,4,5]. It is not due to a visual or intellectual impairment.

What is Dyslexia?

Dyslexia is defined in DSM-5 as a SLD with impairment in reading characterized by persistent difficulties in various aspects of reading[1]. These may include challenges with word reading accuracy, reading rate or fluency, phonics, spelling and comprehension[1]. Individuals may struggle to sound out words, resulting in slow or inaccurate reading. Additionally, these challenges can impact the ability to grasp the meaning of a text, making reading more demanding and less efficient.

Further, they will encounter challenges in organizing and translating their thoughts into written words[8] and they may struggle with tasks that require sequencing, such as remembering the order of letters in a word or following multi-step directions[8]. Lastly, they could show signs of difficulty in recalling specific words or names in spoken and written language[8] and they will find understanding and retaining information from reading[8] more difficult.

The British Dyslexia Association estimates that as many as 10 percent of people exhibit some degree of dyslexia, meaning one in ten children may require additional support to develop reading skills[1]. These statistics highlight the need for increased awareness, early detection, and targeted interventions to support those affected by dyslexia.

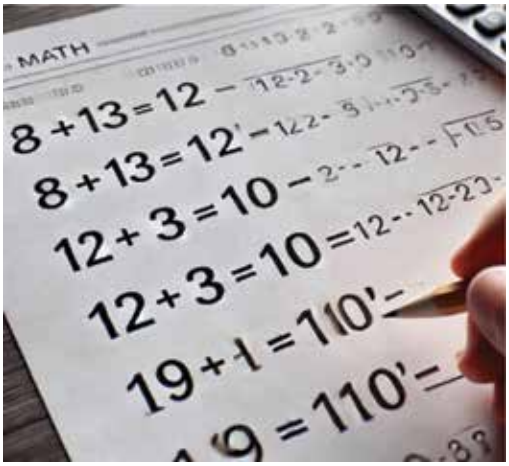
Evolution of dyslexia

Exploring the evolutionary history of dyslexia reveals key insights that can deepen physicians' understanding of this complex learning difficulty. Research suggests that the human brain did not evolve specifically for reading[9]; rather, reading is a skill that requires dedicated training and neural adaptation[11]. Unlike natural language acquisition, which humans are biologically equipped for, reading involves repurposing various brain regions to recognize written symbols and associate them with sounds and meanings[11].

Before the invention of the printing press in the 15th century, access to reading materials was limited, and literacy was primarily confined to the elite[11]. As mass-produced books and newspapers became widely available, literacy spread, and with it came increased recognition of reading difficulties among the general population. Over time, these challenges led to the identification and classification of dyslexia, with the definition of term itself evolving across centuries as understanding improved[11].

Dyslexics are differently able and extraordinary to an extent. They carry

exceptional abilities in creativity, innovative skills, analyzing abilities, verbal communication, team building, social relationships etc[3]. Therefore, dyslexia is highlighted as a blessing in disguise if handled well[3]. Dyslexic personalities have shown their outstanding capabilities in entrepreneurship, cooking, designing, constructing, art innovative science etc. World-famous figures such as Albert Einstein, Leonardo da Vinci, Henry Winkler, Keira Knightley, Richard Branson, Tom Cruise thrive despite dyslexia.



Dyscalculia

What is dyscalculia?

Dyscalculia is defined in DSM-5 as a SLD characterised by problems with processing numerical information, learning arithmetic facts and performing accurate or fluent calculations[1]. Children may struggle to understand numerical concepts, count or solve math problems.

Dyscalculia is not reflecting general intelligence and those with dyscalculia struggle with mathematics while thriving in other aspects of learning[6].

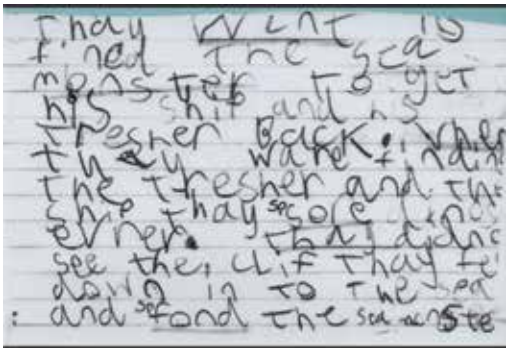
Table 1 Signs of dyslexia at different ages

Early detection signs of dyslexia according to different age categories.	
Infants (0 -3)	Delays in babbling, limited vocabulary development, difficulty forming sounds or combining syllables
Preschool (3-5)	Delays in speaking, trouble learning the alphabet, rhyming difficulties, confusing sounds in words
Early Elementary (6-9)	Difficulty reading single words, slow reading pace, letter reversals (e.g.,"b" and "d"), struggles with phonics
Late Elementary (10-12)	Reading comprehension challenges, avoids reading out loud, spelling issues, trouble understanding written instructions
Adolescents (13-17)	Difficulty with reading fluency, struggles with complex vocabulary, persistent spelling and grammar mistakes
Young Adults (18+)	Slow reading speed, difficulty with written assignments, avoidance of reading tasks, ongoing trouble with spelling

Table 2 Signs of Dyscalculia at different ages

Early detection signs of dyscalculia according to different age categories	
Infants (0-3)	Difficulty recognizing patterns or shapes, delayed understanding of object quantities
Preschool (3-5)	Struggles with counting, confusion with number names or symbols, difficulty understanding "more" vs. "less"
Early Elementary (6-9)	Trouble grasping basic math concepts (addition, subtraction), struggles with time concepts, difficulty learning math facts
Late Elementary (10-12)	Difficulty with abstract math concepts (fractions, decimals), problems applying math in real-life situations (money, measurements), struggles with multi-step math problems
Adolescents (13-17)	Trouble with advanced math (algebra, geometry), struggles with math-related tasks in science, difficulty organizing numbers
Young Adults (18+)	Ongoing problems with mental math, difficulty managing finances, trouble understanding statistics or complex calculations

Dyscalculia is found in about 5-7% of the population[1].



Dysgraphia

What is dysgraphia?

Dysgraphia is defined DSM-5 as a SLD with impairment in written expression characterized by ongoing difficulties in various aspects of writing[1]. These may include problems with spelling accuracy, grammar and punctuation, and organizing written content clearly[1]. Individuals may struggle to produce legible handwriting or consistently use correct spelling and grammatical structures[1]. Additionally, these difficulties can impact the overall coherence of written work, making the process of writing more challenging and less effective.

Dysgraphia does not reflect intelligence and dysgraphia affects around 5-20% of children[1].

Table 3 Signs of Dysgraphia according to age

Age Group	Symptoms
Infants (0-3)	Delayed fine motor skills development, struggles with picking up small objects
Preschool (3-5)	Trouble holding a crayon, difficulty drawing shapes, avoids colouring activities
Early Elementary (6-9)	Poor handwriting, difficulty spacing letters or writing on the line, pain or discomfort while writing
Late Elementary (10-12)	Persistent poor handwriting, struggles organizing written work, frequent grammar and punctuation errors
Adolescents (13-17)	Inconsistent handwriting, trouble taking notes, difficulty expressing ideas in writing, disorganized written work
Young Adults (18+)	Ongoing issues with handwriting legibility, slow writing speed, trouble with written exams or assignments

Role of the physician

The physician has an obligation to follow evidence-based path when a parent seek action on underachievement of their child. Activities are multi-disciplinary, within and beyond health team, also with an accountability extending to legal context.

Table 4 Steps to be followed by the general practitioner

Role of the General Practitioner - steps to follow

1. Confirmation of parental claim of academic underachievement
2. Proper evaluation to seek medical, family, social, or other causes
3. Making appropriate referrals to reach the diagnosis of SLD
4. Collaboration with education and other relevant establishments
5. Directing parent to learning assisting resources

Step 1 - Confirmation of parental claim of academic underachievement

Clinic visits to physicians claiming academic underachievement (AU) need to be first verified[2]. Some parents might be overenthusiastic. Some teachers, possibly with good intentions, expect every child to be in the top academic status. Some children have personality traits with very high expectations, competing with peers, and less tolerance for peer pressure. As such, the presented claim be objectively visited with evidence including the school progress report.

Once the claim is verified, it is important to see whether adequate opportunities are granted to the education of the child[2]. Incompatibility of academic material and the age of the child, too many extra activities, overburdening with extra classes making limited time to study, lack of room for a child to engage in studies, over expectations are some reasons of failure.

The General Practitioner has an important role in identifying and coordinating children who need special education support[1,2]. Proper education for every child plays an important role in long-term mental and physical health and to economic well-being[1]. It has long been noted that the level of education, and independence of income, also play an important role in determining one's overall health status[1,2]. Thus, helping children to succeed in school is utterly important and also early identification of children with learning disabilities is much needed as proper implementations can be carried out. In addition, it is a family issue that family physicians are obliged to solve. Since average income shows a clear positive correlation to level of education in US, parents consider education as the best investment and get involved in education of their children at early stage[4].

Age-appropriate developmental screening is an initial key component of analyzing the child[2]. The frequently used method is to ask parental concern as a guide for further assessment[2]. The *Parents' Evaluation of Developmental and behavior* (PEDS-R) is a tool to meet standards. Ask whether the parents have special concerns regarding scholastic disabilities such as attention, memory, dyslexia, dysgraphia, and dyscalculia[3]. Also, they should be asked about the child's expressive and receptive language, fine and gross motor skills, and social skills.

Children's school readiness should be discussed with parents before sending to school[2]. *'School readiness assessment'* (SRA) should include whether the child has experienced any difficulty in preschool, such as getting friendly with peers, or autistic behavior[2]. The child should also be toilet trained and be able to dress him/herself and be able and whether comfortable to spend time away from parents should also be assessed as readiness before schooling[2].

Basic knowledge of colors, numbers, and letters should be assessed. In older children and adolescents, concerns about school performance should be evaluated[2].

When academic problems are first seen, parents may go to the primary care physician before reaching out to the pediatrician for an initial evaluation and guidance. Children with attention deficit hyperactive disorder may first encounter a primary care physician and they should be vigilant in referring them to a pediatrician[2].

Step 2 – Proper evaluation to seek medical, family, social, or other causes

Once AU is confirmed, the physician has a unique responsibility to detect any treatable conditions and to trace for any medical

explanations. In addition, the physician can explore family and social background that would have contributed to AU. Following the medical principles, he could evaluate the history, examination, investigations and intervention trials in this process (see Table 5 & 6).

Antenatal risk factors and perinatal risk factors known to cause future learning difficulties such as hypoxia can affect different regions of the brain. Post natal insults cause deleterious effects on the developing brain and causes learning issues. Any chronic illness which leads to poor nutrition and frequent hospital stay may affect school performance[2]. Being overweight and obese has been linked to poor school performance as it is associated with lot of comorbidities and also body shaming among peers. Overweight correlates with limited future economic opportunities as well[1,2,3].

Children who have recurrent otitis media with effusion have not been directly linked with cognitive impairments. However, these children are more likely to be identified by their teachers as having difficulties in paying attention and following direction, and teachers are more likely to rank these children as being academic failures[2]. This is due to their intermittent or persistent hearing loss[2].

Visual disturbances among children and adolescents specially myopia, amblyopia or hyperopia are more likely to show academic underachievement due to difficulties in reading[1,2].

Table 5
Risk Factors for Specific Learning Disabilities

What to ask in history
Anti natal risk factors- maternal diabetes, pre-eclampsia, substance exposure.
hypoxic ischemia encephalopathy
Premature birth and low birth weight
Post natal - Meningitis, neonatal seizures, hypoglycemia
Medical conditions (e.g., recurrent otitis media, chronic illness.)
Early speech-language delay
Neurologic conditions or insults (e.g., traumatic brain injury)
Iron deficiency anemia
Hypothyroidism
Somatization disorders
Behavior- attention deficit, hyperactivity, impulsivity.
Exposure to domestic violence/sexual abuse/ bullying.
Substance abuse
Family history of specific learning disability, chronic illness.
Parental lack of education, unemployment, poverty.

Table 6
Examination

General examination
Neurocutaneous syndromes
Genetic syndromes(Trisomy 21, X Fragile
Syndrome, Turners, Prader willi)
Growth, sexual maturity,
Marfanoid habitus.
Behavior.
Ophthalmologic and ENT examination.
Neurological examination
Head circumference, higher functions
Cranial nerve examination
Cerebellar examination
Motor and sensory examination.
Cardiovascular
Cardiac murmurs relevant to syndromes.
Respiratory
Chronic illness
Abdomen.
Hepatosplenomegaly (Wilsons disease)
Developmental assessment
Parent and sibling examination.

Antiseizure medications as well as occult seizure disorders may y affect performance[1,2]. Typically the absence seizures, clinically manifested by a brief impairment of consciousness interrupts the child's activity and lasts for only a few seconds.[1]. When seizures are very brief and unaccompanied by automatism, they may be undiagnosed, may be labeled as daydreamers and may even punish!

Chronic lead poisoning, common in fishing community is associated with a variety of developmental problems, mental retardation, distractibility, AU, and school behavior problems[2].

Iron deficiency anemia adversely affects young children's cognitive development and also impairs adolescents' school performance, particularly mathematics[1,2]. Thyroid disease, particularly hypothyroidism, in children, affect cognitive development, and iodine deficiency correlates with learning disabilities[1,2]. Early diagnosis and treatment can interrupt severe developmental and cognitive problems.

Family issues

Socioeconomic status (SES) of family, parental involvement in child activities, home Environment and Stress, educational attitude at home and parental education levels correlates with AU and children's school performance[1,2,3]. Some children may serve as caregivers for younger siblings, ill parents, or grandparents in the household. Children who perform these important tasks may find that their school performance is cumbersome as they are unable to spend time on academic pursuits[2]. Students who are exposed to domestic violence are also likely to perform disruptively in school. Substance use by parents may also affect school performance. Traumatic events, such as prior or ongoing sexual or physical abuse, may affect school performance. Traumatic experiences and posttraumatic stress disorder (PTSD) are common in children and adolescents[1].

Social issues

Peer influence, school environment, teacher relationships, community outlooks and cultural expectations are published as impactful social aspects of AU.

Step 3 – Making appropriate referrals to reach the diagnosis of SLD

If a parent, teacher or physician detect AU, refer the student for evaluation.

School's designated multidisciplinary evaluation team has 3 functions[4]:

1) to determine whether the student has a disability
2) Whether the student requires special education need services
3) A determination of the type of student's special educational needs and its weightage

This initial evaluation also provides a baseline to measure later educational progress. Once the need for additional services has been established, the school must then work to develop the student's *Individual education plan* (IEP)[4]. The IEP should include current levels of performance, goals and benchmarks for short-term objectives, supplementary services, educational modifications, and behavioral intervention plans. All should be goal-oriented[4].

IEP team

The development of the IEP is a team effort, and in *Individuals with Disabilities Education Act* (IDEA) it requires student's parents, general education teachers,

special education teachers, other school representatives, and any other individuals who are invited by the parents, must also participate as a team[4]. In addition, the student is encouraged to participate. When s/he is 14 years of age, they are strongly encouraged to attend the meetings held on behalf of their IEP[4]. For those students above the age of 14, a key component of the IEP is a proper transition plan, to assist the student in moving from the education to the independent work setting which is occupation targeted[4]. The development of the formal IEP and the transitional component are yet to evolve in Sri Lanka.

Safeguarding self-esteem

Impact of SLD is shown negating academic performance, self-esteem and self -motivation. Further, research shows that children with learning difficulties often have lower academic self-esteem compared to their peers, which can affect their overall self-confidence.[9] As such self-esteem is the most important aspect that has to be safeguarded. To minimize stress, assessments should be child-friendly, incorporating breaks and using age-appropriate materials that make the process engaging. After the assessment, feedback should involve the child in a supportive way, recognizing their progress and setting realistic goals for improvement[9].

Taking a holistic approach that considers cognitive, emotional, and social factors can help the child feel supported and understood. The British Dyslexia Association advises that evaluations should include positive feedback, emphasizing strengths as well as areas for growth. When managed carefully, testing can be a positive experience, reinforcing the idea that everyone learns differently and that craving extra support is just a part of the learning journey.[5]

Step 4 - Collaboration with education and other relevant establishments

To learn guiding principles of collaboration with stakeholders, US and UK models cited as examples.

Legal aspects of Special Educational Needs (SEN)

This perspective aligns with the legal frameworks surrounding Special Educational Needs (SEN), which emphasize the importance of personalized support and accommodations.

Brief examples of policies from the USA and the UK related to healthcare and education for individuals with Special Educational Needs (SEN) would be useful to understand multi-disciplinary action holding accountability. These policies tied up with legal obligations, ensuring that students with SEN receive the support they need. *Individuals with Disabilities Education Act* (IDEA) in the USA and the SEN framework in the UK would give good insight[12,13].

Familiarity with disability laws

Primary care physicians should be familiar with laws regarding disability determination and the development of individualized education plans (IEPs)[4]. The Education for All Handicapped Children Act was passed in 1975 and revised as the Individuals with Disabilities Act (IDEA) in 1997[13]. The Individuals with Disabilities Act details the processes that schools must follow to develop appropriate educational plans for all students with disabilities and they should be career-targeted[13].

Role of General Practitioners (GPs)

The role of GPs in managing learning difficulties has become more structured with the formal recognition of SEN[12]. Accompanied by the introduction of

legislative frameworks, such as the UK's *Special Educational Needs and Disability Act* (SENDA) in 2001, and the Education, Health, and Care (EHC) plans introduced in 2014, GPs have been integrated into a multidisciplinary approach that includes educators, psychologists, and paediatric specialists[12].

EHC Plans and holistic support

The EHC plans to facilitate tailored support for students with learning difficulties, focusing on a holistic assessment of the child's needs, including medical, educational, and social factors[4]. GPs often serve as the first point of contact for concerned parents and refer children to specialists when early signs of learning difficulties, such as developmental delays or behavioural issues, are identified[4].

Approach in the United States

The United States has taken a slightly different but complementary approach with the Individuals with Disabilities Education Act (IDEA) of 2004. Under IDEA, every child is entitled to a Free Appropriate Public Education (FAPE), which includes services tailored to their specific learning challenges[13]. A significant component of this process is the Response to Intervention (RTI) model, which emphasizes early identification and intervention before formal diagnosis[10]. RTI uses a multi-tiered system of support, where students receive increasingly intensive interventions based on their response to instruction[10]. GPs in the USA collaborate with schools to monitor the child's progress through the RTI model, ensuring medical conditions like ADHD, anxiety, or speech disorders are not overlooked[10].

Step 5 - Directing parent to learning assisting resources

Physician's primary role is usually to develop an assessment and intervention team[2]. The members of this team will vary depending on the level of need and the initial assessment made in the primary care center and each member has specific roles to play. The physician's primary role is to investigate and treat potential medical problems that can affect the patient's ability to learn. As the physician is often the first professional contact for parents, he or she may become the leader of the team[2]. Most parents have more experience with medical professionals than mental health professionals. The parents themselves are important members of the team[5]. Parents are the child's primary advocates and have the primary responsibility for managing the child's behavior at home[5].

Response to Intervention (RTI) Model

Tier 1: This tier involves all students and ensures that every child receives effective teaching practices that can address basic learning needs.

Tier 2: Targeted interventions for students who are not making adequate progress in Tier 1. Small group instruction or specialized teaching methods are implemented to provide more focused support.

Tier 3: Intensive, individualized interventions for students who continue to struggle despite the additional support provided in Tier 2. These interventions are more tailored to the child's specific difficulties and may involve one-on-one instruction or specialized educational plans.

("Understanding Response to Intervention (RTI) and Multi-Tiered System of Support (MTSS)," 2001)

When parental health problems that affect the child's school performance are identified, it should be essentially addressed[5]. For example, if the primary care physician is concerned that a parent's alcohol use is affecting his child's school performance, the recommendation for decreasing the parent's drinking should be addressed[5]. The medical assessment can be seen as a teachable moment for the parents, as well as for the child. Such modifiable matters for parents are useful in helping parents to quit smoking when their children have been admitted to the hospital for respiratory problems because parents are likely to be more willing to change their own behaviors for their children's health than they are for their own. The child is the most important member of the team[1]. the child realizes that the assessments and interventions are being done with him.

School staff members also play crucial roles in the team[5]. The child's teachers are able to identify specific behaviors that impact on learning and are also important for implementing interventions in the classroom, such as curricular changes or behavioral interventions. School administrators are included in the team as they may monitor specific interventions applied to children with disabilities. A school psychologist may administer specific academic and behavioral assessments and may help to develop an intervention plan. School counselors or social workers may offer behavioral interventions in the school setting and may also serve as case managers. Primary physician should be familiar with the staff and services available at their local schools. They should maintain better personal relationships between the team members.

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Dementia deemed highly preventable: here's how

Dr A L P De S Seneviratne

JoAnn E. Manson, MD, Dr PH
August 14, 2024, Medscape education

The *new study, published in The Lancet* by the Lancet Commission on Dementia, estimates that close to 50% of cases of dementia worldwide can be prevented or delayed by improving 14 modifiable risk factors.

This is paradigm - shifting because dementia is often perceived as an inevitable consequence of the aging process, with a major genetic component. But this study suggests that modifying these risk factors can benefit everyone, irrespective of genetic risk, and that it's important to have a life-course approach. It's never too early or too late to start to modify these factors.

We've known for a long time that many chronic diseases are highly preventable and modifiable. Some that come to mind are type 2 diabetes, coronary heart disease, and even certain forms of cancer. Modifiable risk factors include cigarette smoking, diet, physical activity, and maintaining a healthy weight. This study suggests that many of the same risk factors and more are relevant to reducing risk for dementia.

Let's go through the risk factors, many of which are behavioral. These risk factors include lifestyle factors such as lack of physical activity, cigarette smoking, excessive alcohol consumption, and obesity. The CVD or vascular-specific risk factors include not only those behavioral factors but also hypertension, high LDL cholesterol, and diabetes. Cognitive engagement–specific risk factors include social isolation, which is a major risk factor for dementia, as well as untreated hearing or vision loss (which can exacerbate social isolation and depression), and low educational attainment, which can be related to less cognitive engagement.

They also mention traumatic brain injury from an accident or contact sports without head protection as a risk factor, and the environmental risk factor of air pollution or poor air quality.

Two of these risk factors are new since the previous report in 2020: elevated LDL cholesterol and untreated vision loss, both of which are quite treatable. Overall, these findings suggest that a lot can be done to lower dementia risk, but it requires individual behavior modifications as well as a comprehensive approach with involvement of the healthcare system for improved screening, access, and public policy to reduce air pollution.

Some of these risk factors are more relevant to women, especially the social isolation that is so common later in life in women. In the United States, close to 2 out of 3 patients with dementia are women.

So, informing our patients about these risk factors and what can be done in terms of behavior modification, increased screening, and treatment for these conditions can go

a long way in helping our patients reduce their risk for dementia.

From Medscape Education

Dr A L P De S Seneviratne
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Editor, IMPA

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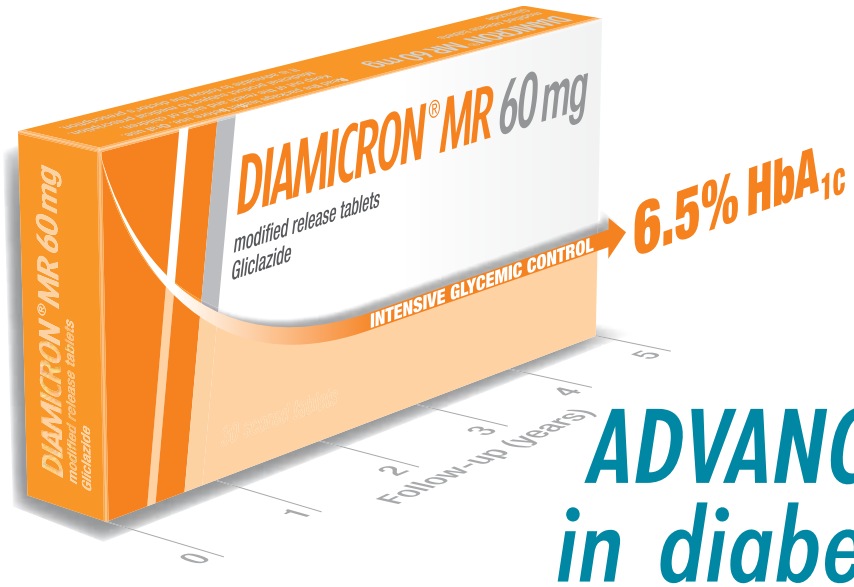

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- Protective on the β-cell[8,9] and the cardiovascular system[1,3,5,10]

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Composition: Each modified-release tablet contains 60 mg of gliclazide. **Indication:** Type 2 diabetes. **Dosage:** One half to 2 tablets per day, ie, 30 to 120 mg as a single daily intake at breakfast time, including in elderly patients and those with mild to moderate renal failure. One DIAMICRON 60 mg modified release tablet is equivalent to two DIAMICRON 30 mg modified release tablets. The breakability of the DIAMICRON 60 mg modified release tablet enables flexibility of dosing to be achieved. **Properties:** Diamicron MR 60 mg is a sulfonylurea lowering blood glucose levels by stimulating insulin secretion thereby restoring the first peak of insulin secretion and increasing the second phase of insulin secretion in response to a meal or intake of glucose. Independent hemovascular properties. No active circulating metabolite. **Contraindications:** Hypersensitivity to sulfonylureas or sulfonamides, type 1 diabetes, diabetic precoma and coma, diabetic ketoacidosis, severe renal or hepatic insufficiency, treatment with miconazole, breast-feeding. **Interactions:** Increased risk of hypoglycemia with miconazole, phenylbutazone, alcohol, other antidiabetics, β-blockers, fluconazole, ACE inhibitors, H_2-receptor antagonists, MAOIs, sulfonamides, NSAIDs. Risk of hyperglycemia with danazol, chlorpromazine, glucocorticoids, β_2 agonists, ritodrine, salbutamol, terbutaline, anticoagulants. **Adverse effects:** Hypoglycemia, gastrointestinal disturbance; more rarely: skin and subcutaneous reactions, hematological disorders, hepato-biliary disorders, visual disorders. **Overdosage:** Possible severe hypoglycemia requiring urgent IV glucose and monitoring. Please refer to the complete summary of product characteristics for your country as variations may exist.

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*In most patients

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The Certificate Course in Evidence Based Diabetes Management (CCEBDM)

Dr A L P De S Seneviratne

The primary care physicians in Sri Lanka who manage majority of diabetic patients in their clinics need to be motivated, interested and knowledgeable regarding this metabolic disease. In order to support this need the Primary Care Diabetic Group Sri Lanka, (PCDG) which consists of senior primary care physicians who have a common interest in Diabetes Mellitus has embarked on a certificate course in diabetes management. All of them are members of the IMPA. This empowering academic program named "Certificate Course in Evidence Based Diabetes Management (CCEBDM)", is well designed by PHFI in India (www.phfi.org) with the latest updates relevant to primary care providers who are in the forefront of managing diabetic patients.

The fundamental objective of the Certificate Course in Evidence Based Diabetes Management is to improve the treatment outcomes for patients by serving as evidence-based guidance for clinical decision making in risk assessment, diagnosis, prognosis and management of Diabetes.

This twelve-month on-the-job training program, conducted once a month on weekends, is jointly certified by the Public Health Foundation of India (PHFI) and Dr. Mohan's Diabetes Education Academy (DMDEA), Chennai and the Primary Care Diabetic Group Sri Lanka. There had been two batches who successfully completed this course. The 3rd batch will start on the 13th of October 2024.

The Objective of the course is :

- To enhance knowledge, skills and core competencies of Primary Care Physicians in the management of Diabetes.

This program had been globally recognized by the International Diabetes Federation (IDF) for training primary care physicians. The course has been also recognized by South Asian Federation of Endocrine Societies (SAFES).

This course consists of 12 modules:

1. Introduction to Diabetes
2. Evaluation of the Person with Diabetes
3. Lifestyle Management in Diabetes
4. Drug Therapy for Diabetes- Part 1
5. Drug Therapy for Diabetes- Part 2
6. Metabolic Complications of Diabetes
7. Microvascular Disease in Diabetes
8. Macrovascular Disease in Diabetes
9. Other Complications of Diabetes
10. Diabetes Care in Special Situations
11. Diabetes in Pregnancy and Youth
12. Conclusions and Take-Home Messages

Eligibility Criteria:
All doctors with SLMC Registration

Last date of enrolment: To be notified.
Contact Ms. Champa 0777 325 550

Participant evaluation will be through a continuous internal evaluation, course work and performance in the written

examination. The criteria for successful completion of the program shall be as follows:

- Participants need to attend 10 out of 12 Modules (including the pre-test and post -test of each module)
- Completion of assigned course work (Three interim assignments based on completed modules given at the end of 4th, 7th, and 10th Modules)
- Appearance and clearance of final written examination in the form of MCQs in an hour, along with module 12 (Min. 50% score required to clear the examination).

The candidate completing the certificate course successfully shall be awarded the certificate, to be jointly issued by PHFI, DMDEA and respective Regional Faculty (PCDGSL)

Course Highlights:

- ***EVIDENCE BASED UPDATED CURRICULUM***
- ***12- MODULAR COURSE***
- ***CASE STUDIES AND INTERACTIVE VIDEOS***
- ***MONTHLY WEEKEND INTERACTIVE LECTURES***
- ***MONITORING AND EVALUATION PROGRAMME***
- ***A CERTIFICATE CERTIFIED BY PHFI, DMDEA, PCDGSL***
- ***EDUCATIONAL WEB SITE***

Internal Faculty

Dr A.L.P. De S Seneviratne
MBBS, DFM, FRCGP, MD, MRCGP[Int.]

Dr. Sarath Paranavitane
MBBS, DCH, DFM, FCGP, MD, FCCS, MBA

Dr.Tilak Silva
MBBS, DFM, MCGP

Dr. P.R. Siriwardene
B.BS, DCH, DFM, MD, MRCGP[Int.], FCGP

Dr A.H.M. Hazari
MBBS, DFM, FCGP

Dr. Achala Weerakoon
MBBS, DFM, MD

Dr. A.J. Jameel
MBBS, DFM, FCGP, DCP

Dr. Sanath Hettige
MBBS, DFM, FCGP, MD

Dr. K. Jayanath
MBBS, DFM, MD

Prof. Kandasamy Arulanandem
MBBS, DFM, MD

Dr. C. Namaratne
MBBS, DFM, MCGP

External Faculty

- Dr. Ruvan Ekanayake, MBBS, MD, MRCP (UK), FRCP (Lond), FRCP (Edin), FRCP (Glsg), FCCP, FACC, FESC
- Dr. Aruni Hasanthi Weerakoon De Silva, MBBS, Dip. Venereology, DFM, MRCGP[INT], MD
- Prof. Ajith Malalasekara, MBBS (Col), MS(Col), MRCS(Lond), FCS(SL)
- Dr. Janaka Munasinghe, MBBS, MD
- Prof. Kamani Wanigasuriya, MBBS, MD, FRCP
- Dr. D.R. Kodikara, MBBS, DO, MS(Oph), FRCS (Edin)
- Prof. Rukshan Fernandopulle, MBBS, FRCOG, MS

PHFI - Public Health Foundation of India

DMDEA - Dr. Mohan's Diabetes Education Academy, Chennai

PCDGSL - Primary Care Diabetes Group Sri Lanka

Dr. A.L.P. De S Seneviratne
Coordinator
CCEBDM Course

Dr A L P De S Seneviratne
MBBS, DFM, FCGP, MRCGP(INT.), MD(Family Medicine)
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The College of General Practitioners of Sri Lanka (CGPSL) Celebrates 50 Years

'Look forward to knowledge but do not forget to lookback for wisdom'

Dr Ruvaiz Haniffa

Introduction

A western medical doctor who has undergone further training to deliver medical care at primary care level based on concepts and principles of Family Medicine/General Practice is a General Practitioner/Family Physician. Family Medicine/General practice is the medical specialty which provides continuing and comprehensive care for the individual and the family. General Practitioners -now commonly referred to as Family Physicians- deal with physical, mental and social signs and symptoms in individuals, their families and the community to deliver quality promotive, preventive, curative, rehabilitative and palliative care in an ethical and professional manner based on the principles of family medicine which is the academic discipline which underpins general practice. Though, in essence being a 'generalist' discipline it is classified as a 'specialty' of breath which integrates biological, clinical and behavioural sciences to deliver healthcare in holistic manner.

The Family Physician of today is rooted in the historical 'generalist' commonly referred to simply as 'A DOCTOR'. The reader is encouraged to reflect on who or what a medical doctor means to him/her at an individual, family and community level. In Sri Lanka, the terms general practitioner, private practitioner or family physician is synonymously used to identify a western medical practitioner who may or may not deliver primary curative medical care based on the principles of family medicine. This directly and indirectly implies that anyone with a medical degree (or not) is deemed fit by the medical regulators of Sri Lanka in particular and the Sri Lankan public in general as qualified, trained and competent to deliver care to patients based on the concepts and principles of family medicine. This basically allows every Tom, Dick and Harry (or to contextualize it to a Sri Lankan scenario every Silva, Perera and Fernando!!!) (Or put another way every Community Physician, Oncologist and Cardiovascular surgeon!!!) to engage in General Practice. This puts patients in harm's way and gives genuine general practitioners a bad name and image professionally. This creates a vicious cycle which leads to the academic discipline of family medicine to be looked down upon as an 'inferior' or even 'incompetent' medical discipline as compared to other medical specialties. This in turn leads to unnecessary medicalization of health issues and leads to a disease-based approach to health care at an exorbitant cost for the individual and society. The outcome of this is patients expecting and doctors' complicity delivering disease care as opposed to healthcare when often it is clearly unnecessary. There are many within the disease care industry who directly and indirectly benefit financially and otherwise from this philosophy.

Background

The concepts and principles of family medicine are as old as the field of medicine itself. Family medicine as an academic discipline is comparatively new. It was

accepted as a distinct academic branch of medicine in the UK in 1952 and in the USA in 1969 and In Sri Lanka, it was recognized as a distinct clinical discipline in May 1979.

In Sri Lanka there is no historical record of self-employed western medical practitioners during the colonial occupations by the Portuguese or even the Dutch. One of the earliest references to self-employed western medical practitioners is in the year 1835 during the British colonial occupation. These records state that a western medical practitioner named Dr Misso '*opened an exceedingly well-furnished dispensary in Pettah after spending twenty years in public service*'.

Towards the end of the 19th century, many Ceylonese doctors who were products of the Ceylon Medical College (presently the Faculty of Medicine, University of Colombo) took to private practice and established independent clinics outside the state health care system in Colombo and Kandy gradually moving to other major towns and villages.

With the increase in their numbers, by the early part of the 20th century, there were quite a few general practitioners all over Ceylon. A logical development of the proliferation of those engaged in general practice was the formation of an association to look after their interest and ensure their continuous professional development. This led to the formation in 1929 of The Independent Medical Practitioners Association (IMPA) vibrantly existing even today. Dr E.V. Ratnam (founder of one of the first private hospitals in Sri Lanka – The Ratnams Hospital- established in 1907) was the prime mover in the formation of the IMPA and was its first President until 1950. Other key figures who served as Presidents of the IMPA were Sir Frank Gunasekera (1950-51. Served as personal Physician to the British Governor), Dr M C M Kaleel (1952-63. Founder Member of the UNP, Cabinet Minister and Chairman of the UNP), Dr A D P A Wijegoonawaredne (1963-68. President of the Commonwealth Medical Association and Ceylon Medical Association), Dr A M Fernando (1969-70 Founder Chairman of the Board of Study in Family Medicine at the PGIM), Dr R. P Wijeratne (1970-71) and Dr M P M Cooray (1971-75. First President of the College of General Practitioners of Sri Lanka).

The IMPA was a medico-political body with academic general practice as a subsidiary interest amidst the many professionally related issues it had to deal with at its inception and formative years. Nevertheless, in the 1960's the leaders of the IMPA identified the need for a separate entity to spearhead and dedicate itself as an organization to the academic discipline of General Practice. This idea was the embryo which over the years developed into the College of General Practitioners of Sri Lanka, the apex professional and academic body of all grades of general practitioner in the private, state and academic sectors in Sri Lanka. In 1969, Dr A M Fernando, attended the convention of the General Practitioners of Australia in Sydney. During this visit he experienced firsthand the benefits of a formal organization dedicated to GPs and how it played a role in the continuous professional development of its members which in turn led to quality primary curative care to patients. He shared his experience with the IMPA membership who too were convinced of the benefits of such organization and its advantages to the healthcare system of the country. Dr C E S Weeratunge a General Practitioner and member of IMPA was appointed Secretary to the Ministry of Health in 1970 and having been convinced

of the idea for the need of a organization for academic family medicine he lost no time in facilitating the idea of a College for General Practitioners and converted it in to reality along with a team of colleagues spearheaded by Dr G M Heennilame. The procedural and legal aspect of this venture commenced in 1972 and culminated on the 19th of August 1974 when under the able guidance of the Speaker of the House Mr. Stanley Thilakaratne and the Clerk of the House Mr. Sam Wijesinghe, Mr. Ronnie de Mel Member of Parliament for Dondra (later Finance Minister) presented the bill which was approved and brough in to the existence the College of General Practitioners of Sri Lanka (CGPSL) by an act of parliament.

For the record the CGPSL came into legal existence by way of Parliament Bill No. 26 of 19th August 1974. The inaugural meeting of the founder members of the College was held on 6th September 1974 at SLMA House. The first general meeting was held on 18th February 1975. At this meeting all qualified doctors who were eligible for membership according to the Bill were enrolled, subject to the confirmation of the Council. In all 118 members were enrolled on that day.

I take this opportunity place on record my eternal gratitude to the Independent Medical Practitioners Association of Sri Lanka for having the vision and courage to create the CGPSL as an independent entity and for all the guidance and support it gave the CGPSL in its formative years.

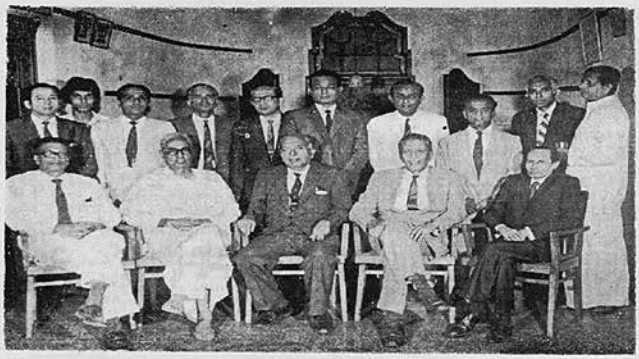
Major Achievments

Since 1975 the CGPSL has taken giant strides to firmly establish Family Medicine as a distinct clinical specialty in Sri Lanka amidst a myriad of hurdles. On this momentous occasion of our 50th Anniversary please permit me to share with you a brief list of unique achievements we have made as a college over the years.

1. ***Establishment of the Board of Study in Family Medicine, at the Post Graduate Institute of Medicine (PGIM) of the University of Colombo***

Through this academic activity the College laid the post graduate educational foundation for every single trainee in family medicine who went through the Diploma in Family Medicine Programme and all those who have gone through, are going through and will go through the MD in Family Medicine program in Sri Lanka.

FIRST COUNCIL OF THE COLLEGE
OF GENERAL PRACTITIONERS OF SRI LANKA



Seated: *Left to Right*- Drs. G. M. Heennilame, A. M. Fernando, M. P. M. Cooray, T. Nagendra, R. P. Wijeratne.

Standing: *Left to Right* - Dr. A. H. Hazari, Mr. Liyanage, Drs. Warusavitharana, A. M. Karunaratne, R. M. L. Fernando, H. Jayalath, D. H. P. R. Senanayake, B. D. J. de Silva, R. J. D. Peiris, M. Sivasuriam.

Absent: Drs. L. Kottagama, M. S. M. Refai, D. P. Kannangara, A. D. P. A. Wijegoonewardene, Mr. L. H. R. Peiris.

It must not be forgotten that the entire effort in creating this Board of Study was shouldered by Members of the CGPSL. Of the initial 10-member board 05 were Members of the CGPSL including the Chairman and Secretary of the founding Board. The stewardship of this pioneering board is considered the Golden Era which ushered Family Medicine as an academic disciple into the medical and post graduate medical education spheres in Sri Lanka and beyond. The CGPSL through the BoS successfully conducted the Diploma in Family Medicine (DFM) exam in Chennai, India in collaboration with the College of General Practitioners of the Indian Medical Association (CGPIMA). As such there are quite a few Indian Doctors with the DFM-Colombo qualification in Indian even today. To date this remains the only post graduate medical examination conducted in a foreign county by the PGIM.

2. Introduction of Family Medicine to the undergraduate medical curriculum

At the request of the CGPSL the Faculty of Medicine, University of Colombo began sending its students to General Practitioners in the Colombo area for three half day sessions in 1980 to expose them to the discipline. The NCMC which was established in 1981 had a Department Family Medicine in 1983 where students were given formal theoretical and practical inputs into Family Medicine for the first time in Sri Lanka. Subsequently the Universities of Sri Jayewardenepura and Kelaniya established Departments of Family Medicine in the years 1993 and 1994 respectively. The University of Colombo established a Family Medicine Unit in 2002 and converted it to a Department of Family Medicine in 2018. The Universities of Jaffna, Rajarata, Eastern and Ruhuna have either commenced or are in the process of establishing either Departments or Units to teach Family Medicine.

3. International Partnerships and Collaborations

a) World Organization of National Colleges Academies and Academic Associations of General Practice - WONCA

WONCA commenced in the year 1972 and the CGPSL formally joined in 1978 at its 8th meeting held in Geneva, Switzerland though professional and academic contacts had been going on since 1976.

Earlier this year in conjunction with the 50th anniversary of celebrations of the CGPSL, the WONCA South Asia Regional meeting was hosted by the CGPSL in Colombo 3rd to 5th May 2024 at the Shahgri La Hotel. Sri Lanka had twice previously hosted this conference (2005 and 2016).

This event was marked by the Philatelic Bureau of Sri Lanka issuing a commemorative stamp and first day cover marking the event.

Many members of the CGPSL play active roles in WONCA with great distinction.

b) Royal College of General Practitioners of the United Kingdom

The CGPSL established formal links with the Royal College of General Practitioners of the UK in March 1978 with the visit to Sri Lanka of the Dean of studies of the RCGP, Dr J S Norell. He was able to give technical inputs in to organization of educational programmes for the membership. This link was renewed in 2003 with the CGPSL taking a lead role negotiating with the RCGP

to conduct the Membership exam of the RCGP in the South Asia region. Many CGPSL members underwent training to function as examiners at this exam. The first MRCGP[INT]-South Asia exam was held in 2007 in Colombo. This exam is now held three times a year in rotation in Colombo, Chennai and Karachi. A Past President and Senior Member of the CGPSL Dr. Preethi Wijegoonawardene was elected as the Chair of the MRCGP[INT]-South Asia examination Board in 2016.

4. Establishment of the North Colombo Medical College

The CGPSL initiated the creation and establishment of a private medical college called North Colombo Medical College which is now carries on as the Faculty of Medicine, University of Kelaniya. The NCMC produced about 300 Sri Lanka and overseas nationals as doctors who serve their patients in Sri Lanka and throughout the world.

When Dr G M Heennilame first brought up the proposal of a private medical school in 1975 at a Council meeting of the CGPSL, he was ridiculed and had to face raucous laughter and cynical comments from his colleagues in the Council who did not allow him to continue his presentation. He re-presented his proposal in 1980 at the AGM having further refined it. The proposal won unanimous support from the general membership. Following this a memorandum was submitted to His Excellency J R Jayawardene, The President of Sri Lanka at the time. The Health Minster Mr. Gamini Jayasuriya was instructed by the President to follow the matter up with the CGPSL along with Secretary Health (Mr. B C Perera) and the Director General of Health Services. A series of logistical, medical educational, health service delivery and financial meetings with relevant officials tookplace and The President on the recommendation of his officials approved the long lease of the Thalagolla convalescent home with 5 to 10 acres of surrounding land in Ragama and designated the North Colombo General Hospital as the teaching hospital for the proposed private medical college.

Though the NCMC was acquired by the government in 1989 and the educational activities continued under state control the CGPSL was not compensated for the financial losses it had to undergo until 2024. The government, under His Excellency President Ranil Wickramasighe taking into consideration the financial aspect of the acquisition of the NCMC made arrangements to gift a piece of and within the city limits of Colombo to the CGPSL to put up its headquarters.

There were many a reason as to why this practical implementation of private medical education in Sri Lanka failed as a concept though the NCMC itself was a success both medical educationally and financially. The main reason was that the students and academic staff of the state medical faculties were concerned that since they would be conducting the exams for NCMC students, the NCMC students would be awarded the MBBS from a state university (namely Colombo University) thus placing NCMC students on an equal footing with state medical faculty students though they did not follow the course in a state medical faculty. This concern led to mass state undergraduate student protests which were juxtaposed with the second armed uprising of the Janatha Vimukthi Peramuna (JVP) in the years 1988-89. This exercise showed the world that Sri Lanka

as a society was not ready to accept the concept of fee levying medical education within its sovereign borders. This concept stems from the ongoing criticisms of private fee levying medical education (a few of which are; the cost of education will be prohibitive and the institute will become a pocket of the privilege and preserve of the rich, will admit sub-standard student in to the course, will make tertiary medical education a business and commercialize it for profit and deal death blow-blow to the free education system, patients at teaching hospitals attached to such institutions will use them as guinea pigs for teaching of fee levying medical students).

5. The Membership Programme of the CGPSL

This is currently a 2-year part time post graduate diploma level programme which leads to an examination consisting of MCQ, SEQ, OSCE, and Portfolio assessment. This diploma is a registrable with the Sri Lanka Medical Council. The introduction of a compulsory Mentoring Programme for MCGP trainees by the Faculty of Teacher of the College is also considered a unique development in a medical educational progeramme conducted by a professional college in Sri Lanka.

6. Mentoring in Sri Lankan General Practice

The aim of the mentoring programme (commenced in 2013/2014) initiated by the Faculty of Teachers in Family Medicine is to guide doctors and post graduates trainees in their personal, professional and academic development as General Practitioners in Sri Lanka. The programme is now mandatory for the MCGP trainees. It is hoped that once the Colleges efforts in establishing a Register for General Practitioners in Sri Lanka at the Sri Lanka Medical Council succeeds this mentoring programme can be offered to prospective applicants as a part of their registration process and continuous professional development.

7. Introduction of Palliative Care training programme

In the year 2009/2010 the College recognized the need for provision of quality palliative care at the community level. The College negotiated a MoU with the Institute of Palliative Care, Calicut, India which is a WHO collaborating center for community participation in palliative and long-term care, to provide training for medical and para medical staff. This led to the formation of an independent organization named the Palliative Care Association of Sri Lanka under the auspices and guidance of the CGPSL.

The Future

As Martin Luther King Jr once said, ***"We are not makers of history, we are made by history"***. Moving forwards, I am reminded also of what Geroge Orwell said ***"The most effective way to destroy people is to deny and obliterate their own understanding of their history."*** For the younger members of our profession in Sri Lanka in particular, I urge you to be familiar with these events as you take our profession into the glorious uncertainties of the future.

As we look forward to our centenary and beyond, I reflected on what I should conclude with, but the real question is whether I should or is it even fair by future generations to say anything at all?

What I wish to say is, as the apex professional and academic organization of general practitioners in Sri Lanka the CGPSL must always strive to be relevant to our profession and members to equip ourselves with the knowledge, skills and attitudes to

provide quality primary curative care to our patients. This, I firmly believe, is the framework within which future general practitioners ought to work out the details to be pursued using tools available to them to make a difference for the betterment of the health status of our fellow citizens. The key point to remember in our progression towards our centenary is we must not revolve as a scientific discipline but we must evolve as a discipline for the benefit of our patients.

Conclusion

Medicine is a matter of science. Scientific advances become medical progress only when they reach the people who need it the most. I can find no better branch of medicine which can fulfill all these parameters from the perspective of delivery of healthcare to our patients in a cost effective manner other than the discipline of Family Medicine. For me the word 'doctor' in the medical context is epitomized by the discipline of General Practice/Family medicine.

Medicine is also a matter of income, geography and justice. Access to health care is still impeded in much of the world by neglect, by distance, by governance, by prejudice and fixed ideas of what is possible. These are the social and commercial determinants of health which we as professionals and lay people must work together to overcome…….

Members of the CGPSL have stood for political correctness in the country and have spoken out and written on issues which affects the democratic system of government in Sri Lanka. Dr. R M L Fernando (better known as Riley Fernando, founder member of the CGPSL) created history, of sorts, in the early 1970's with an obituary notice he inserted in a leading newspaper on 24th April 1974. During that time the government imposed an Island-wide curfew, banned all opposition meetings and sealed the Independent Newspaper group. Dr. Fernando decided to act against the looming dictatorship which was slowly being established in the country. His obituary notice created a sensation in Sri Lanka and interest, admiration and amusement abroad. The international press gave coverage to this now famous obituary which is reproduced below.

> **O'cracy** - The death occurred under tragic circumstances of **D.E.M. O'cracy,** beloved husband of T. Ruth, loving father of L. I. Bertie, brother of Faith, Hope and Justitia. Interred on Saturday, 20th inst. – Araliya Medura, Panagiyawatte, Anduruwala.

This article is based on references taken from *A History of Medicine in Sri Lanka* by C G Uragoda and *History of Medicine in Sri Lanka 1948-2017* both published by the Sri Lanka Medical Association.

Dr Ruvaiz Haniffa
MBBS, MD(Family Medicine), MRCGP(INT), FCGP(SL)
Lecturer, Department of Family Medicine
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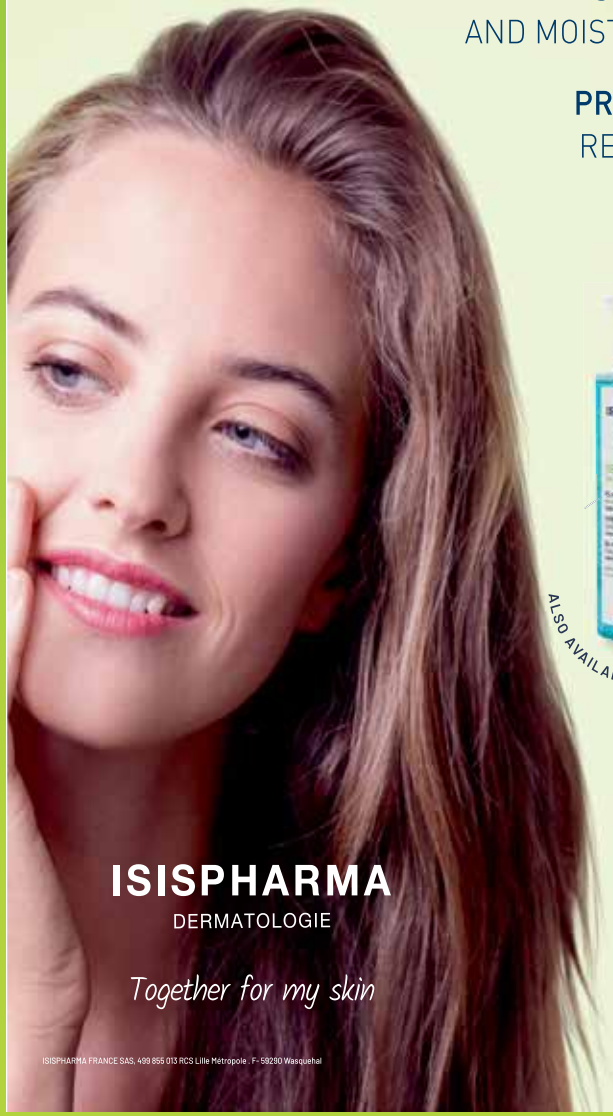

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