# Child and Adolescent Psychiatry in Sri Lanka

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<sup>By</sup> Yasodha Maheshi Rohanachandra

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# CHAPTER 1

# INTRODUCTION

Sri Lanka is an island nation in South Asia with a multi-ethnic community, a diverse religious background and a rich cultural heritage. It has a population of approximately 21.5 million with a population density of 346 persons per sq km. The vast majority (77.4%) of its inhabitants live in rural areas (Ministry of Health, 2018).



Figure 1.1 – Sri Lanka with its nine provinces Source – Department of Census and Statistics

Sri Lanka has the highest Human Development Index in the South Asian region, with a rapid increase in life expectancy in both males and females having occurred over the past decade. Sri Lanka has the lowest neonatal and under 5 mortality rates in the region and it is also among the countries with one of the lowest under 5-year stunting rates in South Asia (Organization, 2015).

#### Chapter 1

# 1.1 Health systems in Sri Lanka

The country has a free health policy and provides free healthcare to all its citizens. The Ministry of Health, Nutrition and Indigenous Medicine (MoH) is the regulatory body responsible for the country's health sector management. The MoH is the sole authority responsible for the implementation of health policy, financial management, health sector monitoring and evaluation, and it is totally responsible for regulating the delivery of healthcare in both public and private sector healthcare institutions. The delivery of healthcare is provided through provincial health administrations in each of the nine provinces, functioning under their respective provincial councils. All healthcare facilities and other health related community services in the provinces come under the respective provincial administrations, while the administration of major tertiary care centres, usually one in each province, come under the purview of the line ministry. The country has 91 Medical Officers per 100,000 inhabitants, 641 hospitals and 84,728 hospital beds with an average of 3.9 beds per 1,000 people (Ministry of Health, 2018).



Figure 1.2 – Location of major hospitals in Sri Lanka Source – Annual Health Bulletin 2018

Chapter 1

The expenditure on health as a percentage of total government spending in Sri Lanka is 5.92% (Ministry of Health, 2018). However, only 1.6% of this total health budget is spent on mental health (Kitsiri, 2009). Therefore, it is obvious that mental health in Sri Lanka is a neglected area, which merits special attention.



Figure 1.3 – Sri Lanka's total health expenditure as a share of GDP Source – World Bank, World Data Indicator Database

Sri Lanka had the highest suicide rate in the world in 1995, which by 2017 had declined to 15.22 per 100,000 people. The Medical Statistics Unit data indicate that there is an ever-increasing trend in the number of psychiatric disorders in the country (Ministry of Health, 2018).

Sri Lanka has only 7.14 mental health workers per 100,000 members of the population, which includes – on the same scale – 0.52 general adult psychiatrists, 3.28 mental health nurses, 0.25 psychologists and 0.22 social workers (Organization, 2017). There is a severe dearth of child and adolescent psychiatrists in the country at present with a dismal figure of 0.03 per 100,000 members of the population (i.e., one child and adolescent psychiatrist per approximately 333,000 inhabitants) (Organization, 2017). Sri Lanka has a mental health policy which is aimed at providing comprehensive residential and community-based services to cater to the mental health needs of all Sri Lankans. However, this policy lacks a specific plan or strategy for child and/or adolescent mental health (Organization,

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#### Introduction

2017). Therefore, child and adolescent mental health can be considered one of the least addressed areas of mental health in Sri Lanka.

In the cultural background that prevails in the South Asian region, children have little say in decision making or in expressing an opinion. They are often forced to accept what the parents or the other elders in the family decide for them irrespective of the fairness or the validity of such decisions and actions. In short it is simply a situation of "do as you are told" in many households. This erroneous attitude results in a great deal of injustice to children, and many suffer in silence and are subject to frequent abuse and extreme hardship. Boys often enjoy a better or more privileged position in the male dominant households while females often suffer in silence. Most of the child and adolescent mental health problems never go beyond the precincts of their dwellings either due to ignorance and the lack of awareness on the part of the parents (who believe that children are rather immune to mental illness) or due to the fear of stigmatization.

However, this situation has been fast changing for the better since the turn of the century in the region, especially in Sri Lanka. This is mainly due to the changes in the social fabric of the country and the increased awareness of child and adolescent mental health issues by its people. This change was heralded by the migration of rural folk to the cities with the opening up of employment opportunities and broadening of educational opportunities (with a higher number of children gaining admission to the universities and other higher education institutions). Other contributory factors to this change include globalization, the easy accessibility of the web, and the vital role played by both print and electronic media in, on the one hand, dispelling some of the mythical beliefs held by people, and on the other, bringing into focus some of the mental health issues faced by the public in general and children in particular. The role played by non-governmental organizations (NGOs) merits special mention in this regard, especially in troubled communities or war-ravaged areas. On the trails of some of these new trends and developments, and in response to the increased demand for improvements in child mental health services voiced by the healthcare professionals who work closely with children and are interested in their welfare - as well as the response by the Sri Lankan media - the nation's

government has been promptly working to improve its child and mental health services.

# 1.2 State of children and adolescents in Sri Lanka

According to the findings of the Child Activity Survey 2016, the population of children and adolescents between the ages of 5 and 17 in Sri Lanka is 4.6 million, which accounts for 22.2% of the total population (Department of Census and Statistics, 2016). Of this population, approximately 50.5% are males and 49.5% are females. The majority of these children (77.7%) reside in the rural sector, with 17% and 5.3% residing in the urban and estate sectors respectively (Department of Census and Statistics, 2016).

Seventy eight percent (78%) of the children in the 5-17 age group of in Sri Lanka live with both the father and the mother, while 16% live with only the mother, 3% with only the father, and the other 3% live without any of the parents. About 1.7% of the estimated child population lives in households where at least one member in the family is afflicted with some form of disability (Department of Census and Statistics, 2016).

## Schooling and education

In Sri Lanka, education is free for all children in state schools and was for a long time compulsory from 5–14 years of age; the law has been recently amended to increase this age up to 16 years. There are 10,162 state schools in Sri Lanka with an average student-teacher ratio of 18:1 (Ministry of Education, 2016). The enrollment rate for primary education was 99.08% with 90.1% of the children between 5–17 years of age attending school. Out of the 9.9% of the child population that was not attending school, there was a male preponderance. In addition, higher rates of non-attendance were seen among children aged 15–17. Amongst the not-attending children about 11% had never attended school (Department of Census and Statistics, 2016). Out of the children not going to school, the majority were only engaged in household activities, while a minority were engaged in some gainful employment. The percentage of the child population found to be idle, i.e., neither going to school, nor doing any economic activity or household work, was 1.6%. Lack of interest in going to school (or receiving an education),

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financial difficulties and disability were some of the reasons for these children not attending school. The percentage of children not going to school due to lack of interest were higher in the estate sector as compared to rural and urban sectors. Corporal punishment and subjecting children to psychological aggression continue to be used as disciplinary methods in schools (de Silva et al., 2017), despite a recent policy decision to ban corporal punishment from all schools.

#### Financial status

An estimated 707,000 children and adolescents under 19 years of age in Sri Lanka live in poverty, which accounts for 11% of the under-19 population (Nanayakkara, 2006). A majority (79.2%) of these children live in the rural sector. Child poverty is highest in households headed by those engaged in the agricultural, forestry and fishery industries. The number of children in abject poverty is estimated to be 295,039, which accounts for 4.6% of the child population (Nanayakkara, 2006). Batticaloa District in the Eastern Province of Sri Lanka has the highest share of children in poverty, accounting for 8.9% of the children in poverty in the country. More than 10% of the population of children and adolescents under 19 years of age do not have access to safe drinking water and approximately 12.5% do not have access to safe sanitation (Nanayakkara, 2006).

## Child labour

Sri Lanka has made substantial progress in combatting child labour in recent decades, with a decline in both child labour and hazardous labour. In 2016, children engaged in child labour accounted for 1% (43,714) of the total child population, of which 89.2% were engaged in some form of hazardous labour. This accounted for 0.9% of the total child population in Sri Lanka (Department of Census and Statistics, 2016). However, the hazardous form of child labour has not been reported in the 5–11 age group. According to the Department of Census and Statistics, the highest percentage of working children are employed in the service sector, followed by the agricultural sector, with the lowest percentage being employed in the industrial sector. The type of work the children were employed in was shown to be largely dependent on the age of the child, with a higher percentage of older children

being engaged in the industrial sector. A great majority of these children were reported to be engaged as elementary workers such as servants. Furthermore, the majority of working children are employed in the family environment, followed by shops, markets and boutiques (Department of Census and Statistics, 2016).

#### Exposure to trauma

Sri Lanka was embroiled in a separatist civil war for nearly 30 years, which left hundreds and thousands of children either orphaned or homeless and the natural disasters such as the tsunami in 2004 and myriads of other terrorist attacks – the most recent being the Easter Sunday attack in 2019, which killed more than 250 people – have adversely impacted the child and adolescent population. A study conducted in the Northern Province of Sri Lanka revealed that 82.4% of the children have been exposed to at least one war related event, with 43.6% being exposed to either a dead or a mutilated body, 39.5% being close to a combat situation and 33.1% witnessing shelling or gunfire (Catani et al., 2008). While the civil war mostly affected the north of the country, the south was worst affected by the tsunami, where approximately 1,200 children lost at least one parent and 1,000 children lost both parents (Yamada et al., 2006). Both the civil war and the tsunami led to many children being displaced and vulnerable to exploitation and abuse.

## Child abuse

Child abuse continues to be a major public health problem in Sri Lanka. An average of 1,297 complaints related to child sexual abuse (CSA) per year were received by the National Child Protection Authority (NCPA) from 2015 to 2019 (National Child Protection Authority, Statistics) and an average of 1,593 complaints related to CSA per year were received by the police during the same period. For the 5-year period from 2015 up to (and including) 2019, more than 2,000 complaints of cruelty to children were reported annually to the NCPA, while 390 to 990 complaints per year relating to child neglect were received by the NCPA over the same period (Department of Police Statistics). Community studies have found the prevalence of sexual abuse among schoolchildren to range between 14–44% (Fernando and Karunasekera, 2009; Perera et al., 2009).



Figure 1.4 - Complains received by the NCPA in relation to CSA from 2015 to 2019 Source: National Child Protection Authority



Figure 1.5 - Complaints received by the Department of Police with regard to CSA from 2015 to 2019 Source – Department of Police, Sri Lanka

Physical and emotional abuse are also common, with community studies revealing the prevalence rates as ranging between 15.7–45.4% for physical abuse and 27.9–31.3% for emotional abuse (Chandraratne, Fernando and Gunawardena, 2018; Perera et al., 2009). Physical abuse is described to frequently involve hair pulling, shoving and beating with an object (e.g., a stick, cane, belt). Insulting, humiliating, criticism and intimidation are described as the commonest types of emotional abuse (Chandraratne, Fernando and Gunawardena, 2018; Perera et al., 2009). Parents and teachers were the most common perpetrators of physical and emotional abuse. Many of the laws relating to child abuse in Sri Lanka are outdated and need to be revised.

## Street children

The number of street children in Sri Lanka increased from 10,000 in 1991 to 15,000 in 2006 (Wijewardane, 2008). Most of these street children are concentrated in Colombo, the capital and commercial hub of the country. Although the number of street children in Sri Lanka is not substantial, the psychosocial adversities faced by these children warrant the group receiving special attention. Most of the street children are boys from ethnic minorities and are aged 14 or younger. Extreme poverty, commercial sex work of the mother, neglect by one or both parents, parental alcohol/substance dependence, death of one or both parents, imprisonment of parents, and the mother migrating for overseas employment were described as factors that led to these children ending up on the streets (Senaratna and Wijewardana, 2012, 2013).

Many of these children are known to engage in 'risk behaviours' to earn a living (e.g., begging, heavy manual labour, transportation/sale of illicit substances, stealing/robbery and commercial sex work). Their low level of education, lack of occupational skills, poverty and poor awareness about available opportunities are described as the commonest reasons for these children continuing to live on the street (Senaratna and Wijewardana, 2012, 2013).

# 1.3 Epidemiology of child and adolescent mental health problems in Sri Lanka

# Externalizing and internalizing problems

Studies on the prevalence of child and adolescent mental health problems in Sri Lanka are limited. A study by Samarakkody et al. in 2012, on externalizing behavioural problems in preschool children in the Gampaha district in Sri Lanka revealed 19.2% of preschoolers to have externalizing behavioural problems, with slightly higher incidence among boys (Samarakkody et al., 2012). This is reported to occupy a position towards the upper limit of the range of problems found in other developing countries. This study found low socio-economic status and families with single parents to be associated with higher rates of externalizing problems, which is consistent with world literature.

Ginige et al. 2014 assessed the prevalence of emotional and behavioural problems among 7 to 11-year-old school children in the Kandy educational zone (Ginige et al., 2014). The results showed a prevalence of 13.8% of emotional and behavioural problems in this population with 8.8% displaying internalizing problems, while another 8.8% had externalizing problems, which are consistent with the findings of the previous studies in the region. The study revealed that children in type 1 schools (i.e., schools with classes up to year 12) have significantly fewer internalizing problems as compared to type B and C schools (i.e., schools with classes only up to year 5 or year 10 respectively). This is in keeping with the findings of Michael Rutter who has shown that children in better managed schools have fewer emotional and behavioural problems.

A study by Prior, Virasinghe and Smart on the behavioural problems among Sri Lankan schoolchildren aged 10–13 years, revealed that 11–14% of children had behavioural problems, rates which were higher than in the British samples (Prior, Virasinghe and Smart 2005). In keeping with previous literature, problem behaviours were higher among boys than girls. High levels of problem behaviour were shown to be associated with poorer academic performance in the sample.

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### Neurodevelopmental disorders

A few studies have examined the prevalence of neurodevelopmental disorders in Sri Lanka. A study by Perera and colleagues, which examined the prevalence of autism among 18–24 month old children in a suburban area found the prevalence of autism to be 1.07% (Perera, Wijewardena and Aluthwelage, 2009). The prevalence of attention deficit hyperactivity disorder (ADHD) was assessed in a recent study carried out in the capital of Sri Lanka. This study found that the overall prevalence of ADHD stands at 6.5% with the combined type being the commonest subtype (Nazeer et al., 2020). In keeping with worldwide studies, this study described a male preponderance, with a male to female ratio of 1:3.8. A small communitybased study carried out in a suburb of Colombo in 2016 revealed a high prevalence of reading and spelling disabilities in Sinhala among 10-yearolds attending mainstream education. Up to 22.5% in this study had difficulties with reading, spelling and other related skills, which was higher than in most similar studies across the globe (Sandyanganie, Jeewandara and Perera, 2016).

#### **Emotional disorders**

A national survey on the mental health of adolescents was conducted by Perera in 2004, which included students aged 13–18 years from 14 districts in 7 provinces in Sri Lanka. The study revealed that 18.9% of the adolescents had emotional and behavioural problems with 12.9% reporting a severe impact from their difficulties (Perera, 2004). The most heavily impacted areas were academic activities (15.5%) and peer relationships (12.4%). The study concluded that the prevalence of mental health problems among adolescents in Sri Lanka was similar to that reported elsewhere in the world.

Community studies screening for depressive symptoms among adolescents have found the prevalence of depressive symptoms among this age group to be as high as 36–57.7% (Perera et al., 2006; Rodrigo et al., 2010). Prevalence of anxiety among this age group was found to be approximately 28%, with students in classes facing barrier examinations showing the highest percentage of anxiety (Rodrigo et al., 2010). Global school-based

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student health surveys (GSHSs) in 2016 revealed that 7% of adolescents (13–17 age group) in Sri Lanka had attempted suicide at least once in the preceding 12 months, while 9% of the adolescents had suicidal ideation (Epidemiology Unit, 2017).

Bullying was reported in 39% of the students in Sri Lanka, the prevalence being higher in boys (49%) than in girls (29%) (Epidemiology Unit, 2017). Bullying was reported to be significantly associated with mental health problems such as anxiety and substance use. A substantial proportion of students also reported to have no close friends.

## Substance use disorders

A study by Senanayake et al. in 2016, revealed that the prevalence of alcohol consumption among adolescents in Sri Lanka was 3.4% and that the prevalence was significantly higher among males when compared to females. It was also found that the prevalence of alcohol consumption to be higher among the non-school going adolescents when compared to school going adolescents (Senanayake et al., 2018). The prevalence of smoking was found to be 3.6%, and has been at a steady state since 2003, despite numerous steps taken by the relevant stakeholders to discourage this practice. Babul (areca nut from India), Madana Modaka (Cannabis based product), cough syrups containing codeine and cannabis were described as the most commonly used illicit substances among Sri Lankan adolescents. According to Senanayake et al., 2018). According to a UNICEF study in 2004, the prevalence of illegal substance use was 2.3%, which indicates that the prevalence rates have remained static over the last decade.

# Eating disorders

Eating disorders are considered to be less common in the Sri Lankan setting. However, a study carried out in 2012 revealed that 14% of the adolescent schoolgirls in the Colombo District had a high risk of developing an eating disorder, as assessed by the EAT-26 questionnaire (Wijeratne et al., 2012). A more recent study on eating disorders in Sri Lanka warned of the possible rise in the incidence of anorexia nervosa in Sri Lanka (Perera et al., 2002).

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## Stress related disorders

The prevalence of Post-Traumatic Stress Disorder (PTSD) in children and adolescents affected by the civil war and the tsunami disaster has been assessed by a few studies. A study by Elbert et al. in 2009 on the effect of armed conflict on school children found the rates of PTSD to be as high as 25%. In addition, difficulties with day-to-day life, poor memory, poor school performance, depressive symptoms and poor physical health were also reported among these children (Neuner et al., 2006). A study that examined the rates of PTSD following the 2004 tsunami found that up to 39% of children had PTSD. Another study revealed that exposure to the tsunami was associated with school absenteeism in adolescents (Elbert et al., 2009).

Given the mental health burden in children and adolescents in Sri Lanka, rapid development of child and adolescent mental health services remains a priority to meet the needs of this vulnerable population.

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# CHAPTER 2

# CHILD AND ADOLESCENT PSYCHIATRY TRAINING IN SRI LANKA

# 2.1 Undergraduate training

The apex body governing undergraduate education in Sri Lanka is the University Grants Commission (UGC), which was established in 1978 under the Universities Act No. 16 of 1978 (Universities Act, 1978). The UGC is the sole authority responsible for planning and coordination of university education, allocation of funds to Higher Educational Institutions (HEIs), maintenance of academic standards and regulation of the administration of HEIs. It also plays a pivotal role in overseeing the admission of students to all HEIs in the country. At present, there are 16 universities that function under the UGC. Out of these, 9 universities provide undergraduate medical education.

Name of University	Y ear established	Year medical faculty was established *	Total number of medical students in the faculty 2019	Number of new admissions 2018/2019	Total medical graduate output 2019	Total number of permanent staff 2019	Number of staff in the department of Psychiatry
Uni. of Colombo (Continuum of Uni. of Ceylon est. 1942)	1942*	1942*	1,016	201	202	161	13
Uni. of Peradeniya	1942	1962	1,065	205	200	115	6
Uni. of Sri Jayewardenepura	1959	1993	778	161	134	112	6
Uni. of Kelaniya	1959	1991	883	171	186	129	7
Uni. of Jaffna	1974	1978	728	150	126	45	0
Uni. of Ruhuna	1978	1980	872	202	112	97	5
Eastern Uni. of Sri Lanka	1981	2005	357	72	62	36	0
Uni. of Rajarata	1995	2006	903	182	176	54	3
Uni. of Saharagamuwa	1995		70	75		7	
Uni. of Wayaba	1999		72	75		9	
Total			6,583	1,494	1,188	762	
*Although the Unive School was establis	ersity of Ceylon (li hed in the vear 1	ater rechristened 870 and is regard	as the University ded as one of the	of Colombo) was e oldest medical	s established in 19 schools in the A	942, the Colombo ustralasian regio	Medical n. It was

incorporated into the University of Ceylon at the time of the latter's establishment.

Table 2.1 Characteristics of Sri Lankan Universities (Sri Lanka University Statistics, 2019) Child and adolescent psychiatry training in Sri Lanka

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# Undergraduate teaching and assessments in child and adolescent psychiatry

The UGC has formulated objectives and guidelines for the psychiatry training programme of all medical faculties in Sri Lanka in 2017. The aim of designing these national objectives and guidelines was to ensure that all medical faculties of Sri Lanka prepare their medical students to function effectively as medical officers endowed with the adequate knowledge, skills and favourable attitudes pertaining to psychiatry. This core curriculum in psychiatry was prepared by a subcommittee appointed by the Standing Committee on Medical and Dental Sciences of the UGC. The document contains general objectives of the training programme, specific objectives under each topic, minimum training requirements, guidelines pertaining to the structure of the training programme and the assessment structure.

It stresses that all undergraduates should have an adequate knowledge of certain key areas in child and adolescent psychiatry. This includes knowledge of the aetiology, clinical features, presentations and the management of (1) behavioural disorders (e.g. attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder); (2) emotional disorders (e.g. childhood and adolescent depression, anxiety disorder, panic disorder, and obsessive compulsive disorder); (3) developmental disorders (e.g. autism spectrum disorders, intellectual disability, and specific learning disabilities); (4) other disorders during childhood/adolescents (e.g. tics, encopresis and bed wetting, pica, and eating disorders); and (5) major psychiatric disorders with their onset during childhood and adolescence (e.g. schizophrenia and bipolar affective disorder).

The essential skills related to child and adolescent psychiatry that should be achieved by medical undergraduates are defined as (1) the ability to communicate with children (taking into account the setting, communication skills and the skills in engagement of the child); (2) the ability to gather information from parents and care givers; (3) understanding the impact of different symptoms on the child's functioning; (4) identifying the impact of the child's illness/behaviours on family and peers; and (5) gaining an

awareness of the existing service structure and the referral process for specialized care in the locality.

Although the objectives of child and adolescent psychiatry are well defined by the UGC, a recent study described that there is considerable variation in teaching child and adolescent psychiatry among individual medical faculties in the country's different universities. This study found that the number of hours (3–10s) and the time quota allocated for child and adolescent psychiatry as a part of all psychiatry lectures (8.5–22.8%) varied widely. It also revealed that the average number of hours allocated for child and adolescent psychiatry teaching in Sri Lanka (6 hours) was much less when compared to some other countries (12–24 hours) (Rohanachandra, 2021).

The clinical rotations in psychiatry are mandatory in the undergraduate medical curriculum, including 2–4 weeks during the 3<sup>rd</sup> or 4<sup>th</sup> year and 6–8 weeks during the final year rotations. However, the recommendations leave room for individual flexibility regarding the duration of the clinical appointments within faculties depending on the available resources. In addition, there is no mention about the required exposure or the experience in child and adolescent psychiatry within these clinical rotations. Therefore, a significant variation in the level of experience in child and adolescent psychiatry during the clinical placements has been described among different faculties and occasionally even within the same faculty. However, all universities provided some level of clinical training in child and adolescent psychiatry, in contrast to some other countries where clinical training in this speciality was provided only as an elective.

The psychiatry/child and adolescent psychiatry knowledge is assessed at the exit point of the undergraduate career at the final MBSS examination, which consists of a theory component composed of multiple-choice questions (MCQs) and six structured essay questions (SEQs), as well as a clinical component, which includes a long case and a mini observed clinical examination (MOCE). The theory component of the assessment is uniform, with all students having to face a common multiple choice question paper, which includes a specific number of questions in child and adolescent psychiatry, and one structured essay question in child and adolescent

psychiatry. However, the clinical assessments differ in their approach with some of the faculties giving adolescents for clinical cases (Rohanachandra, 2021).

## Future directions for improvement

Given the wide variation in the frequency and duration of formal teaching (i.e., lectures), the number of hours designated for child and adolescent psychiatry should be defined in the core curriculum. Furthermore, the number of hours of child and adolescent psychiatry that should form an essential part of clinical rotations, the key experiences required (e.g., outpatient services, inpatient services, medico-legal assessments, community experience) and the minimum number of patients that needs to be seen in each category should also be clearly defined in this document. A common logbook depicting the details of each exposure could be designed in all universities to ensure that all students get an equal and comparable experience in child and adolescent psychiatry during clinical placements. A previous study has suggested that video teleconferencing and simulated clinical scenarios maybe used to increase the student exposure to clinical cases (Gipson et al., 2017). This is a feasible option in faculties where child and adolescent experience is limited. It is recommended that child and adolescent cases should be included in the clinical component in all faculties to assess whether the undergraduates have acquired the necessary skills defined in the core curriculum.

# 2.2 Postgraduate training

#### Pathway to board certification in child and adolescent psychiatry

The Postgraduate Institute of Medicine of the University of Colombo is the only institution which holds the authority to conduct programmes leading to the Degree of Doctor of Medicine and to the Board Certification of Specialists. It was established under the provisions of the Universities Act No. 16 of 1978 and is governed by the Postgraduate Institute of Medicine Ordinance, or PGIM Ordinance (No. 01 of 1980). The PGIM in consultation with the relevant Boards of Study (BOS) in different disciplines issue