

CGPSL

MY COLLEGE



NEWSLETTER OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA



07

We are all GPs. Be proud

June 2025

MCGP
Membership of the College of General Practitioners of Sri Lanka



& FCGP
Fellowship of the College of General Practitioners of Sri Lanka
2025

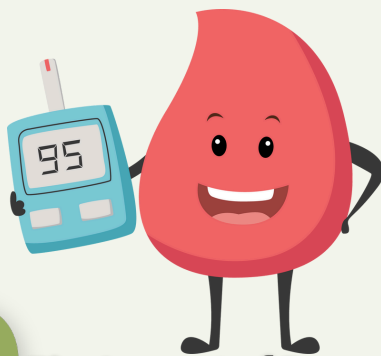
MCGP GRADUATION & FELLOWSHIP CONFERMENT CEREMONY

Sunday, 18th May 2025

At the Bandaranaike Memorial International Conference Hall (BMICH)

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MCGP Graduation & Fellowship Conferment Ceremony



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The Impact of Proactive Care and Continuous Learning on Diabetes Management



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Community Knowledge and First Aid Practices on Snakebite in Rural Sri Lanka

05,08,25

GP Sri Lanka '25

50th Annual Academic Sessions
College of General Practitioners of Sri Lanka

*"Transforming Primary Care:
General Practitioners at the Heart of the Community"*

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WONCA SAR Conferences 2025, Bengaluru, India

Editor: Shihari S. Abeyseena
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Message from the President CGPSL

Dr Pushpa Weerasinghe



Dear Colleagues,

Month of May was a truly hectic month for the college.

MCGP convocation together with the conferment of Fellowships and 50th Annual Academic Sessions of the college “GP Sri Lanka ‘25”, were held in May 2025.

MCGP Convocation together with Fellowship Conferment Ceremony

The MCGP Graduation & Fellowship Conferment Ceremony was held at the Lotus Hall, BMICH on 18th May 2025. 16 successful MCGP graduates from the 9th batch received their certificates from the chief guest, Mr. Pradeep Saputhanthri, Secretary to the Prime Minister. My congratulations to all the diplomates and hope that all of them become college members and serve the college in various capacities.

16 distinguished college members who had served the community and college were awarded fellowships this year. Dr Ranjit Gamini Bulathsinhala, Dr Batapola Hewage Maya Sandhyakanthie De Silva, Dr Palliyaguruge Lalitha Kuruppu Arachchi, Dr Neeluka Dayani Bernadette Abeysekera, Dr Manickavasagar Raguram, Dr Serasin Bulathge Sugath Serasinghe, Dr Diyawadanage Don Bandula Samarasinghe, Dr Athauda Arachchige Kapila Jayanath, Dr Conganige Michael Asela Anthony, Dr Chandana Lesley Kumara Atapattu, Dr Nimal Mahanama Dissanayaka, Dr Kalpanie Dulanthi Wijewardana, Dr Dumindu Wijewardana, Dr Ajanthan Joseph Prathapkumar Jeyaseelan, Dr Thalagaha Gedara Sankha Dashanana Randanikumara, Dr Vellala Hettige Suneth Senarath Rajawasan were the recipients.

I congratulate and thank them for the unwavering support given to the college by them and sincerely hope that their services will be available to our college in the future too.

The success of this event was due the hard work done by the MCGP Board Secretary Dr. Chandana Atapattu, assisted by MCGP Board Chair Dr. Sri Ranjan and the members of the Board. I thank them.

After a lapse of five years, a full programme which included, pre and post congresses and an evening inauguration ceremony, in addition to the main congress, were held for the Annual Academic Sessions. The theme for this year was “Transforming Primary Care: General Practitioners at the heart of the community”. I am happy to inform you, that we had the highest participation during all days of the congress (332 participants). Pre and post congresses had the maximum participation, we could accommodate (Pre Congress: 196 & Post Congress: 196). The participants appreciated the topics which were included in all days.

We were able to have two orations, because many submissions were received this year. Largest number of abstracts were received for free papers and there were 15 oral presentations and 11 poster presentations. This is an indication that the college is moving forward academically.

The inauguration was graced by Chief Guest – Dr. Nalinda Jayatissa, M.P. Honourable Minister of Health & Mass Media, Guest of Honour - Dr Chrishantha Abeysena, M.P. Honourable Minister of Science and Technology, Special Guest - Dr Raman Kumar, Chairman Emeritus, Academy of Family Physicians of India.

I thank the steering committee and scientific committee this year, for the success of the Annual Scientific Congress. I will be failing in my duty if I do not thank Dr. R Gobith, Chair, steering committee, Dr. Sankha Randenikumara, Chair, scientific committee and their secretaries Drs. Priyanthi Premaratne and Manoj Liyange for the success. The valuable support given by Drs. Chandana Atapattu, Punyajith Walgampaya, Chamini Kuruppuarachchi and Indika Karunamuni is much appreciated. The advice given by Past Presidents Drs. Sri Ranjan and Eugene Corea too were helpful in ensuring success.

Our academic work continued in the month of June too. OSCE workshop for the doctors, who are sitting for family medicine exams were held for three full days in June, with 53 participants. I must acknowledge the dedicated work done by Drs. Buddhika Raigamkorale and Sankha Randenikumara. The workshop was greatly appreciated by the registrants.

A webinar titled “Beyond the Pale Patch: A Practical Guide to Diagnose and Control Leprosy in General Practice” was held on 7th June with 100 participants.

WONCASAR 2025

Month of April was devoted to overseas activity, to keep the college in the world map of family medicine. Around 30 members including me and Dr. Sri Ranjan who is the President WONCA SAR took wing to Banglore, India, to participate in the WONCA SAR 2025 congress. Our college had the biggest delegation from a foreign country. Our delegates took part in academic activities such as resource persons in scientific programmes, panel discussions, debates, presenting free papers and poster presentations. They enjoyed taking part in fashion shows and singing. Song “Menike mage hithe” was enjoyed by all who were present, by singing with us and dancing.

As my term office comes to an end, I am satisfied that I was able to achieve some of my goals. The credit for this must go to some members in council and out of it, who worked tirelessly, dedicating their efforts to the greater glory of our college. Once again, my sincere thanks to you, my dear colleagues, for believing in me and electing me as the 21st President of this prestigious college.

GP Sri Lanka '25

50th Annual Academic Sessions
College of General Practitioners of Sri Lanka

*"Transforming Primary Care:
General Practitioners at the Heart of the Community"*

Inauguration
Ceremony
&
Dr. M P M Cooray
(College) Oration
2025

23RD MAY
2025



GP Sri Lanka '25

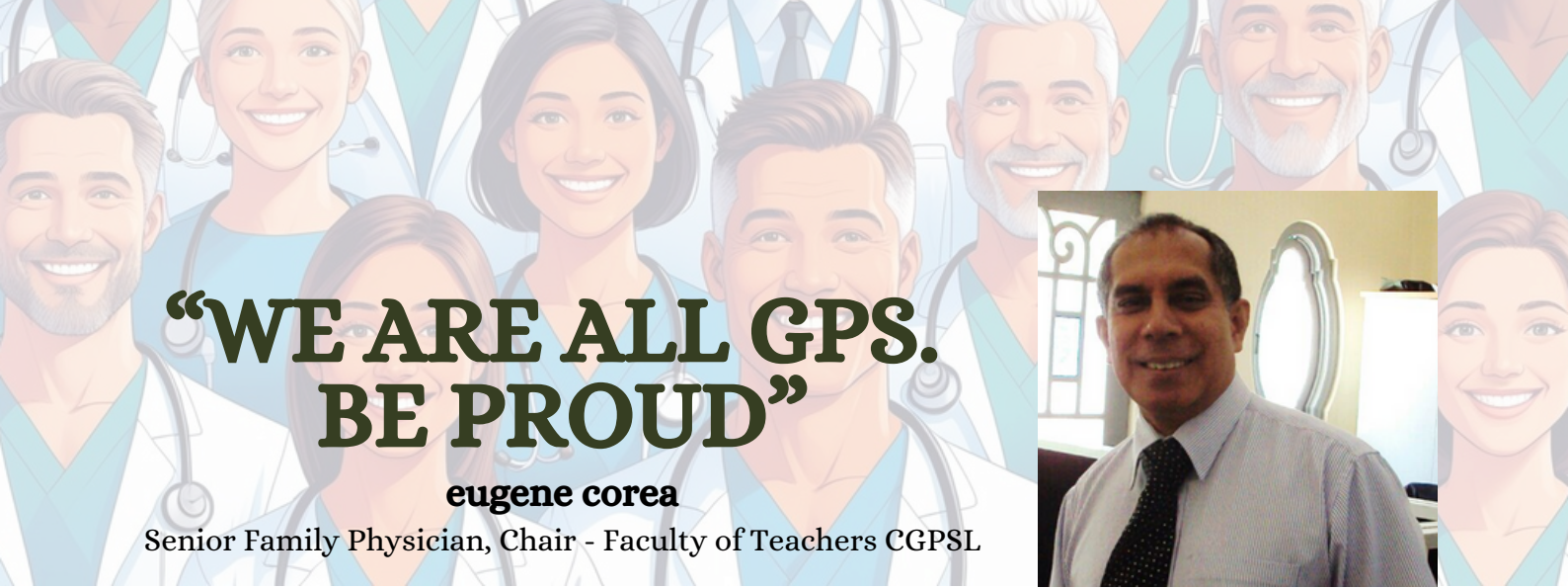
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“WE ARE ALL GPs. BE PROUD”

eugene corea

Senior Family Physician, Chair - Faculty of Teachers CGPSL

I have always been uncomfortable with the terms full time GP" and "part time GP " You have part time GP s working for much longer than some full time GP s and full time GP s also working in other places.

If a doctor is trained, qualified and observes the precepts and the practice of Family Medicine, she or he is a GP, Period.

The session on "Stories from general practice" on day 2 of the academic sessions should have cleared any doubts or diffidence about the worth of GPs. Sorry if you missed the session.

Drs. Kanthanesan (7th intake from Jaffna), Thushari from Kegalle and Neranja from Wattala (both MCGP trainees) with stunning stories demonstrated the professionalism, patient centeredness and empathy that any GP would be proud to possess. All three presenters had general practices with day jobs in the state sector.

Listening to their stories I realized that we should not refer to such doctors as part time GPs. Rather we should refer to them as GPs who also work in the state sector. Mind you such GPs add value to their own practices based on where they work in the state sector (Cardiology, Neurology, Surgery etc.)

Once you become members of the College, you are all GPs and we are proud of you.

GP Sri Lanka '25

50th Annual Academic Sessions
College of General Practitioners of Sri Lanka

*"Transforming Primary Care:
General Practitioners at the Heart of the Community"*

Dr. Desmond
Fernando Oration
2025

24TH MAY
2025



GP Sri Lanka '25

50th Annual Academic Sessions
College of General Practitioners of Sri Lanka

*"Transforming Primary Care:
General Practitioners at the Heart of the Community"*

Main Congress
Day 1 & 2



24TH & 25TH
MAY
2025



The Impact of Proactive Care and Continuous Learning on Diabetes Management

Dr. Shane Halpe

MBBS, MRCP [INT], MD Family Medicine

Senior Registrar in Family Medicine



My journey as a family physician has been a continuous process of learning and growth. When I first began practicing independently in 2020, managing complex conditions like diabetes felt daunting. I was still developing my clinical skills and navigating the intricacies of patient care. However, through dedicated effort, continuous professional development, and valuable mentorship, I have witnessed a significant transformation in my approach to patient care.

One particular case vividly illustrates this evolution. I encountered a 62-year-old male, a retired engineer with a history of inferior ST elevation myocardial infarction with percutaneous coronary intervention, type 2 diabetes, hypertension, chronic kidney disease, and psoriasis. He led a sedentary lifestyle, occasionally consumed alcohol and was a non-smoker. Despite a family history of diabetes and ischemic heart disease, his previous care plan had not been sufficiently proactive. His HbA1c was 8% and the blood pressure was above 140/80mmHg.

This case highlighted the critical need for a comprehensive and personalized approach to managing patients with multiple chronic conditions.

Recognizing the limitations of the previous care plan, I embarked on a journey of continuous learning. I dedicated myself to staying abreast of the latest research and guidelines in diabetes management through resources like the BMJ Learning website¹ and the BMJ Best Practice app². The diabetes management guidelines published by the Non-Communicable Diseases Unit of the Ministry of Health^{3,4} and Sri Lanka College of Endocrinologists⁵ provided further insights. These platforms provided invaluable access to up-to-date information and clinical guidelines, empowering me to make informed decisions at the point of care.

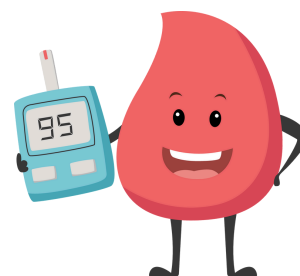


Figure 1 - BMJ Best Practice

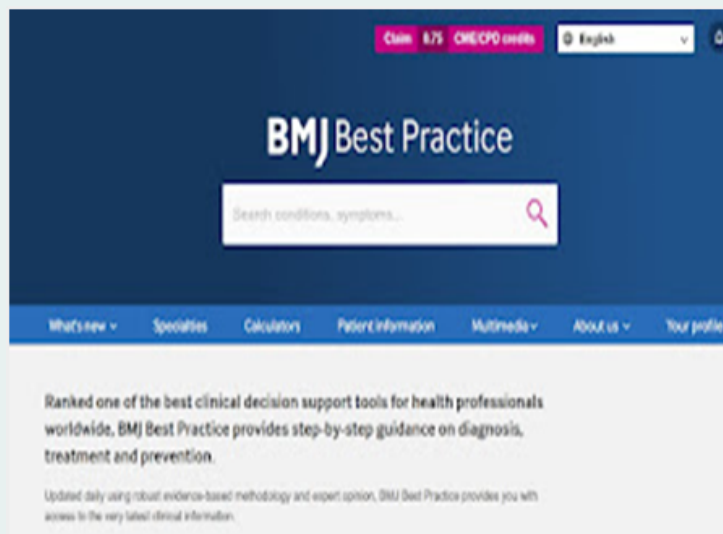
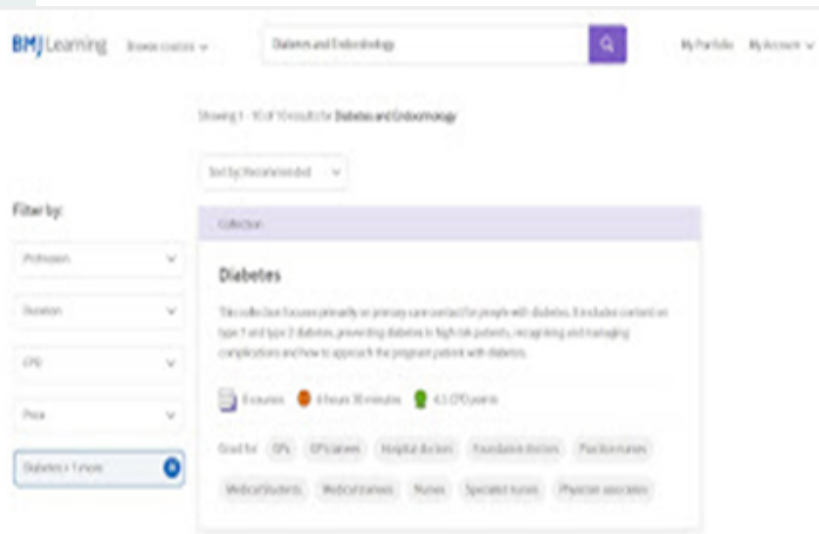


Figure 2 - BMJ Learning



Furthermore, I actively sought opportunities to enhance my clinical skills. Engaging in discussions with colleagues and senior physicians, and participating in continuing professional development courses, broadened my understanding of chronic disease management, particularly diabetes.

Beyond theoretical knowledge, I focused on implementing practical strategies to improve patient care. This included meticulous record-keeping, effective communication with patients, active listening to their concerns, and providing clear, concise explanations of their treatment plans. I also leveraged technology to enhance patient engagement, utilizing mobile apps to track progress and offer personalized support.

In this particular case, the patient demonstrated significant improvement in glycemic control, with his HbA1c improved to 7.5% in 3 months. His renal function remained stable, and his psoriasis also showed signs of improvement. Empowered by a smartphone app (Figure 3), the patient actively participated in his care by tracking physical activity and adhering to a personalized diet plan.

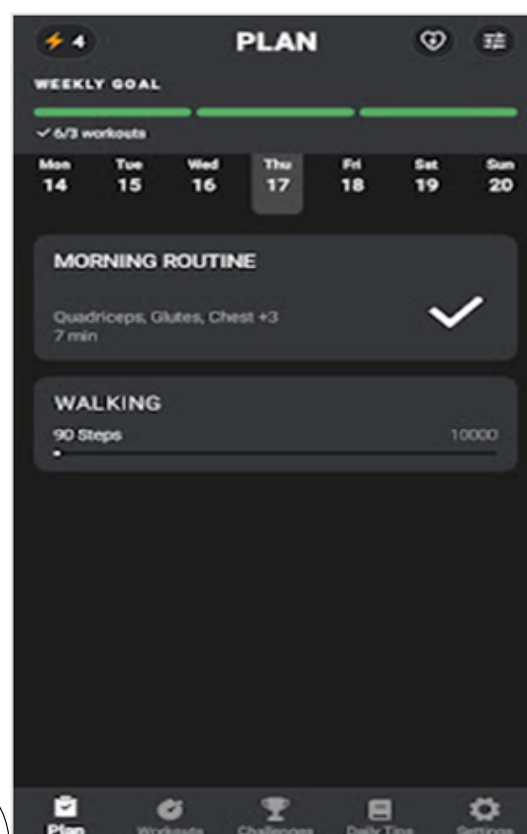


Figure 3 - Smartphone app

This case beautifully illustrated the essence of family medicine. I approached it with a holistic lens, focusing on the patient as a whole person rather than just the diabetes. Understanding his unique circumstances, I built a strong rapport, making myself readily available for consultation. I listened attentively to any concerns and worries, acknowledging the emotional and social impact of their condition.^{6,7}

Every interaction became an opportunity for health education and preventive measures. I diligently utilized the available resources within the healthcare system including modern technology, ensuring they received timely and appropriate care. This collaborative approach, involving other specialists when needed, allowed me to provide comprehensive and personalized care, ensuring continuity and ultimately achieving the best possible outcome for my patient.

This experience reinforced the profound impact of a multifaceted approach to patient care, encompassing health education, lifestyle modifications, and regular monitoring. It also underscored the importance of continuous professional development in ensuring the highest quality of care for my patients. As I continue to learn and grow, I am committed to providing compassionate and effective care to all those I serve.

For primary care providers, I strongly recommend the Oxford Handbook of General Practice as an invaluable resource. The clinical guidelines published by the Ministry of Health and relevant professional colleges offer practical guidance for busy GPs.

For those who prefer digital resources, mobile apps like BMJ Best Practice and UpToDate provide readily accessible, evidence-based information. Continuous professional development, through participation in online webinars and workshops offered by local and international organizations, is crucial for enhancing patient care. Ultimately, our patients deserve the highest quality of care, and ongoing learning is essential to achieve this. Continuous professional development through participation of online webinars and workshops of colleges and professional bodies locally and internationally will help to improve your patient care. Because we owe it that much to our patients.

***"In nothing do men more nearly approach the gods than in giving health to men."
— Cicero (106 B.C. - 43 B.C.)***

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Community Knowledge and First Aid Practices on Snakebite in Rural Sri Lanka: A Cross-Sectional Survey and Educational Intervention by a General Practitioner

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Abstract

Snakebite continues to pose a substantial public health risk in rural Sri Lanka, especially in agrarian communities where the risk of exposure is high. Providing timely first aid and rapid access to medical care are crucial in determining the outcome of envenomation. This study aimed to evaluate the baseline knowledge and misconceptions about snakebite first aid among community members attending a general practice clinic in Ulukkulama, Anuradhapura, and assess the impact of an immediate educational intervention. A cross-sectional survey using a structured 10-question questionnaire was administered to 29 participants, covering both factual and scenario-based items on evidence-based first aid, common myths, preventive behaviours, and recognising danger signs. After the survey, participants received a culturally suitable educational leaflet. The mean knowledge score was 6.06 out of 10, indicating moderate baseline awareness. A significant proportion of respondents correctly identified the need for hospital care and antivenom administration, but misconceptions persisted, particularly regarding the use of tourniquets and ice application. The educational leaflet was well received and allowed for the immediate correction of harmful beliefs. This study highlights the vital role of general practitioners in rural health education and emphasises the need for structured, low-cost community-level interventions to improve pre-hospital outcomes in snakebite cases.

Keywords: Snakebite, First Aid, Community Knowledge, Rural Health, Sri Lanka, General Practice

Introduction

Snakebite envenomation continues to pose a major public health burden in Sri Lanka, particularly in rural and agricultural regions where occupational and environmental exposure to venomous snakes is frequent. The World Health Organization (WHO) classifies snakebite as a neglected tropical disease due to its high morbidity, mortality, and socio-economic impact in low- and middle-income countries (World Health Organization, 2016). Sri Lanka reports an estimated 30,000 to 40,000 snakebites annually, with substantial variation in clinical severity and geographical distribution (Ediriweera et al., 2016). Despite national availability of antivenom and supportive care, pre-hospital practices—including first aid responses—continue to influence patient outcomes significantly.

Effective snakebite management begins at the community level. Timely, evidence-based first aid can mitigate complications, reduce the progression of envenomation, and facilitate safer transport to health facilities. However, numerous studies have identified widespread reliance on traditional and often harmful practices, such as the application of tourniquets, use of herbal remedies, wound incision, or suction of venom (Kularatne et al., 2014). These practices not only delay medical care but may also exacerbate tissue damage and increase the risk of systemic complications.

Community-level health education plays a pivotal role in addressing these knowledge gaps. General practitioners (GPs), particularly those serving rural populations, are uniquely positioned to contribute to preventive health through patient education and community engagement. Within the scope of family medicine, the GP's role extends beyond diagnosis and treatment to encompass health promotion, behaviour change communication, and local advocacy for evidence-based practices.

This study was conducted as part of the Member of the College of General Practitioners (MCGP) training program to evaluate community knowledge on snakebite first aid and to introduce an educational intervention tailored to the rural context. Specifically, the objectives were: (1) to assess baseline knowledge and misconceptions regarding first aid for snakebites among community members in Ulukkulama, Anuradhapura; and (2) to implement and reflect on a simple educational strategy aimed at correcting misinformation and reinforcing appropriate first aid behaviours. This work intends to demonstrate how GP-led initiatives can influence public health knowledge and practice at the grassroots level in Sri Lanka.

Methods

Study Design and Setting

This was a community-based cross-sectional descriptive study conducted in the rural village of Ulukkulama, situated in the Anuradhapura district of Sri Lanka. The area is predominantly agricultural, where residents face heightened risk of snakebite due to occupational exposure in paddy fields and scrubland. The study was carried out as part of a community outreach initiative during the author's training under the Member of the College of General Practitioners (MCGP) program, integrating elements of both public health education and reflective clinical practice.

Study Population and Sampling

The study population comprised adult and adolescent individuals visiting a general practice clinic located in Ulukkulama. Participants were selected through convenience sampling. Inclusion criteria consisted of residents aged 18 years and above, capable of providing informed consent. A total of 29 participants were recruited over a month.

Development of the Questionnaire

A structured questionnaire comprising 10 items was developed to assess the level of knowledge regarding first aid practices in the event of a snakebite. The questionnaire was based on current recommendations by the World Health Organization and the Sri Lankan Ministry of Health, as well as common myths and misconceptions observed in rural clinical practice.

The tool included five binary Yes/No items evaluating basic knowledge and beliefs, and five Single Best Answer (SBA) questions designed to assess decision-making in practical scenarios. The items were thematically categorised into five domains: (1) Exposure and Awareness, (2) Misconceptions and Harmful Practices, (3) Evidence-Based First Aid, (4) Preventive Measures and Risk Reduction, and (5) Medical Knowledge on Treatment and Danger Signs.

Prior to implementation, the questionnaire was peer-reviewed for content validity by senior academic colleagues and pilot-tested among a small group of non-participant patients for clarity and comprehension. Minor wording adjustments were made to ensure cultural appropriateness and simplicity of language.

Data Collection Procedure

Participants were verbally invited to take part in the survey upon visiting the clinic. Informed verbal consent was obtained prior to administration of the questionnaire. The survey was conducted in the participants' native language (Sinhala or Tamil, as appropriate) to ensure full understanding. Each response was scored as either correct (1) or incorrect (0), with a total possible score of 10 per participant.

Immediately following completion of the questionnaire, each participant was provided with a printed educational leaflet titled “First Aid After Snakebite – What You Need to Know!” The leaflet was designed with simple language and pictorial instructions to reinforce key first aid principles and debunk harmful myths.

Educational Intervention

The educational leaflet served as a corrective intervention and was developed using WHO and local clinical guidelines as source material. The leaflet content was organised around the five domains represented in the questionnaire and included culturally appropriate visual cues. In addition to leaflet distribution, a brief one-on-one explanation was offered to each participant to clarify content, answer questions, and reinforce accurate first aid behaviours.

Data Analysis

Responses were manually recorded and analysed using descriptive statistics. Participant scores were summarised using means, frequencies, and percentages. The performance of individual questions and thematic categories was examined to identify trends, strengths, and knowledge gaps. Visual representations, such as bar charts and tables, were used to aid interpretation and highlight areas for targeted health education.

Ethical Considerations

The study was conducted as an educational and service activity under the supervision of the MCGP training program. Ethical approval was obtained from the Training Committee of the College of General Practitioners of Sri Lanka. Verbal informed consent was obtained from all participants. Anonymity and confidentiality were maintained throughout the process, and no personal identifiers were recorded.



Thematic Categories and Survey Questions

Thematic Category	Question No.	Question Summary
Exposure and Awareness	Q1	Have you ever received any formal education or training on first aid for snakebites?
Exposure and Awareness	Q5	Would you seek immediate medical attention if bitten by a snake?
Misconceptions and Harmful Practices	Q2	Do you believe that tying a tight band above the snakebite helps prevent venom spread?
Misconceptions and Harmful Practices	Q4	Is applying ice or soaking the snakebite in water a good first aid method?
Misconceptions and Harmful Practices	Q7	Which of the following actions should be avoided after a snakebite?
Evidence-Based First Aid	Q3	Should the bite area be washed with soap and water after a snakebite?
Evidence-Based First Aid	Q6	What is the most appropriate first step after a snakebite?
Preventive Measures and Risk Reduction	Q8	What is the best way to prevent snakebites in rural areas?
Medical Knowledge on Treatment and Danger Signs	Q9	What is the most effective treatment for a venomous snakebite?
Medical Knowledge on Treatment and Danger Signs	Q10	Which symptom is a warning sign of severe envenomation?

Results

A total of 29 community members from the rural area of Ulukkulama participated in the survey. Participants ranged in age from 19 to 74 years, with a diverse representation of both genders. All respondents completed the 10-item questionnaire, allowing for analysis of overall knowledge and question-specific performance.

Overall Knowledge Scores

The **mean total score** was **6.06 out of 10**, indicating a moderate baseline level of awareness regarding snakebite first aid. A total of **10 participants (34.5%) scored 8 or above**, demonstrating a high level of knowledge, while **2 participants (6.8 %) scored 5 or below**, reflecting minimal understanding and potential reliance on incorrect practices.

Performance by Question

Analysis of individual questions showed variation in performance:

- **Q3: Washing the bite area with soap and water** – 100.0% correct
- **Q5: Seeking immediate medical attention** – 100.0% correct
- **Q2: Rejecting the use of a tight band or tourniquet** – 72.4% correct
- **Q1: Prior training in snakebite first aid** – 51.7% correct
- **Q4: Avoiding the use of ice** – 31.0% correct
- **Q6: Identifying immobilisation as the first step** – 51.7% correct
- **Q7: Recognising harmful actions like applying a tourniquet** – 31.0% correct
- **Q8: Awareness of preventive measures (e.g., protective footwear)** – 89.7% correct
- **Q9: Knowing antivenom as the most effective treatment** – 82.8% correct
- **Q10: Recognising signs of severe envenomation** – 75.9% correct

These findings confirm that while the community has excellent knowledge in certain particularly hygiene, hospital access, and preventive footwear use, gaps persist in procedural first aid, symptom recognition, and rejection of outdated traditional methods.

Thematic Category Performance

Grouped by thematic domain, the strongest performance was seen in:

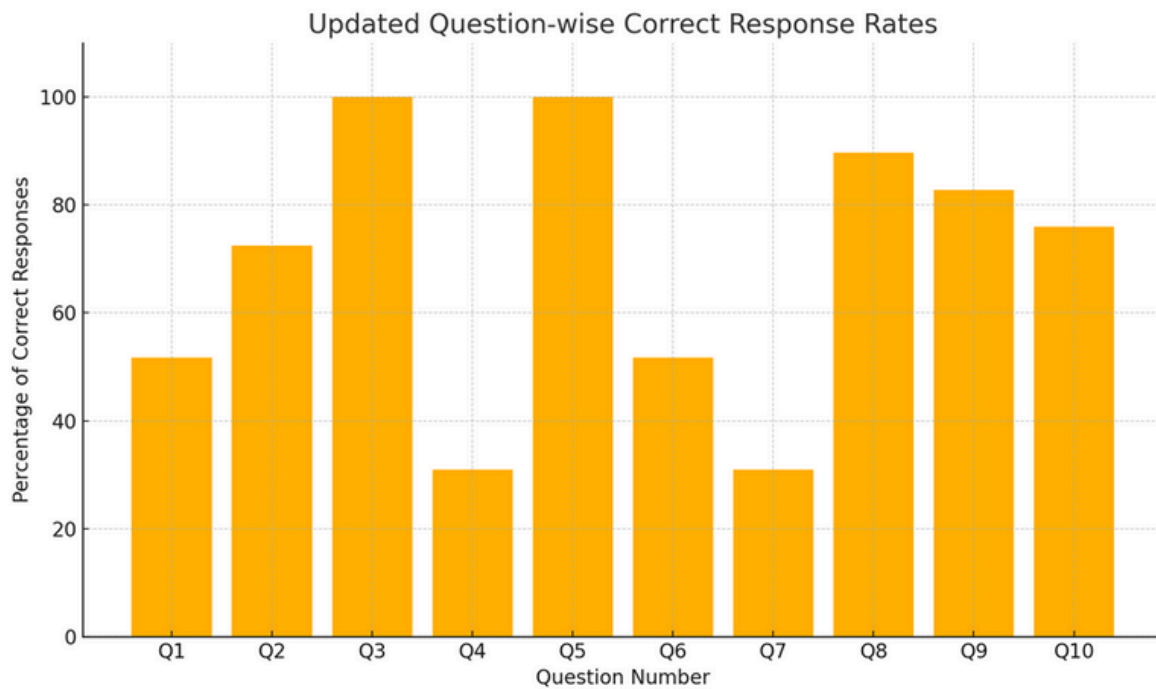
- **Exposure and Awareness (Q1 and Q5):** 76.0% average accuracy
- **Preventive Measures and Risk Reduction (Q8):** 89.7%
- **Medical Knowledge on Treatment and Danger Signs (Q9 and Q10):** Combined mean 79.4%

The lowest scores were observed in:

- **Misconceptions and Harmful Practices (Q2, Q4, Q7):** Average correct response rate 44.8%
- **Evidence-Based First Aid (Q3 and Q6):** While Q3 had 100% accuracy, Q6 lagged at 51.7%

Feedback on Educational Intervention

After the survey, participants received a printed leaflet explaining correct first aid practices. Informal verbal feedback suggested that the intervention was well received. Several participants reported that the visual format and brief explanation helped them understand and remember correct responses, particularly regarding the avoidance of ice and tourniquets.



Discussion

This study assessed community-level knowledge and misconceptions regarding snakebite first aid among residents in a rural Sri Lankan setting. The findings indicate a **mean knowledge score of 6.06 out of 10** suggest a moderate level of awareness. Encouragingly, **34.5% of participants scored 8 or above**, indicating good retention of key facts. However, the persistence of dangerous misconceptions and procedural uncertainties underscores the need for targeted health education in snakebite-endemic areas.

As in previous literature, respondents demonstrated strong knowledge regarding the need for hospital care and the role of antivenom therapy (Kularatne et al., 2014; Ediriweera et al., 2016). Both **Q3 (washing the wound)** and **Q5 (seeking immediate care)** achieved 100% accuracy, suggesting that general health messaging about emergency response has been relatively effective. Similarly, high scores for **Q8 (89.7%)** and **Q9 (82.8%)** reflect positive attitudes toward preventive measures and formal medical treatment.

However, the **lowest-performing questions Q4 and Q7 (both 31.0%)** highlight dangerous traditional practices such as **applying ice** and **using tourniquets**, which remain entrenched in local beliefs. This finding is consistent with other South Asian studies that report similar challenges in dislodging folk remedies and non-evidence-based practices. Alarming, nearly half of the participants could not correctly identify **limb immobilisation** as the first recommended action, further reflecting procedural uncertainty (Q6: 51.7%).

Response to **Q10 (75.9%)**, indicates recognition of severe envenomation symptoms such as breathing difficulty and visual changes. Nevertheless, the inconsistency across questions suggests that while some factual knowledge is being retained, the ability to apply this knowledge in real-time scenarios remains inadequate.

The analysis shows that the **"Misconceptions and Harmful Practices" domain** remains the most vulnerable area, with an average accuracy of only **44.8%**. This gap can only be addressed through deliberate, repeated community engagement and culturally appropriate education.

The educational intervention used a simple, illustrated leaflet, which proved to be both feasible and impactful in the general practice setting. Participants provided informal but positive feedback, noting that the visual and direct nature of the material helped clarify common doubts.

From a family medicine perspective, this project reinforced the importance of integrating **preventive education into routine practice**. The general practitioner's proximity to the community, coupled with trusted patient relationships, offers a unique opportunity to correct harmful beliefs and promote evidence-based responses in emergency situations like snakebite.

Conclusion

This study highlights the urgent need for structured community education on snakebite first aid in rural Sri Lanka. While general awareness of the importance of hospital-based care and antivenom therapy was encouraging, significant knowledge gaps and reliance on harmful traditional practices such as ice application and tourniquet use persist. These misconceptions have the potential to worsen clinical outcomes and delay effective treatment.

The successful implementation of a simple, culturally appropriate educational leaflet as part of routine general practice demonstrates that general practitioners are well-positioned to lead public health education initiatives at the grassroots level. The positive reception of this intervention underscores the feasibility and impact of integrating preventive health messages into day-to-day clinical encounters.

Moving forward, primary care physicians should be supported and encouraged to adopt similar community-based educational strategies, particularly in high-risk regions. Such initiatives not only enhance patient knowledge but also strengthen the preventive and community-oriented dimensions of family medicine in Sri Lanka.

Recommendations

Based on the findings of this study and the reflective observations made during implementation, the following recommendations are proposed to strengthen snakebite first aid education and public health preparedness in rural Sri Lanka:

1. **Integrate Snakebite First Aid into Community Health Education Programs:** Local health authorities and public health inspectors (PHIs) should incorporate snakebite first aid into ongoing health promotion activities, particularly in high-incidence rural areas.
2. **Leverage General Practice Clinics as Educational Platforms:** General practitioners serving rural populations should be empowered to deliver brief, evidence-based educational interventions during routine consultations, especially during peak agricultural seasons.
3. **Develop and Distribute Culturally Adapted Educational Materials:** Health communication tools such as leaflets, posters, and videos should be developed in local languages with visual content to counteract myths and promote correct first aid practices.
4. **Introduce Snakebite Awareness in School Curricula:** Basic knowledge of snakebite prevention and first aid should be incorporated into school health education, targeting children in agricultural communities.
5. **Conduct Community Simulation and Role-Play Sessions:** Participatory training through role-play, demonstrations, or community drills may enhance real-time readiness and correct procedural responses.
6. **Replicate and Scale the Survey Model in Other Regions:** The 10-question thematic survey used in this study may be adapted for use in other rural settings to evaluate baseline knowledge, monitor impact, and tailor interventions over time.
7. **Support GP-Led Research and Outreach Through Institutional Backing:** Professional bodies and health institutions should encourage and support reflective, practice-based research and outreach by GPs as part of continuing medical education and professional development.

Personal Reflection

Engaging in this project profoundly influenced my professional development as a family medicine trainee. Initially conceived as a small community survey to fulfil a component of the MCGP curriculum, the initiative evolved into a meaningful exercise in health advocacy, patient engagement, and reflective practice. Through designing the questionnaire, interacting with participants, and facilitating on-the-spot education, I gained a deeper appreciation for the preventive and educational roles of the general practitioner.

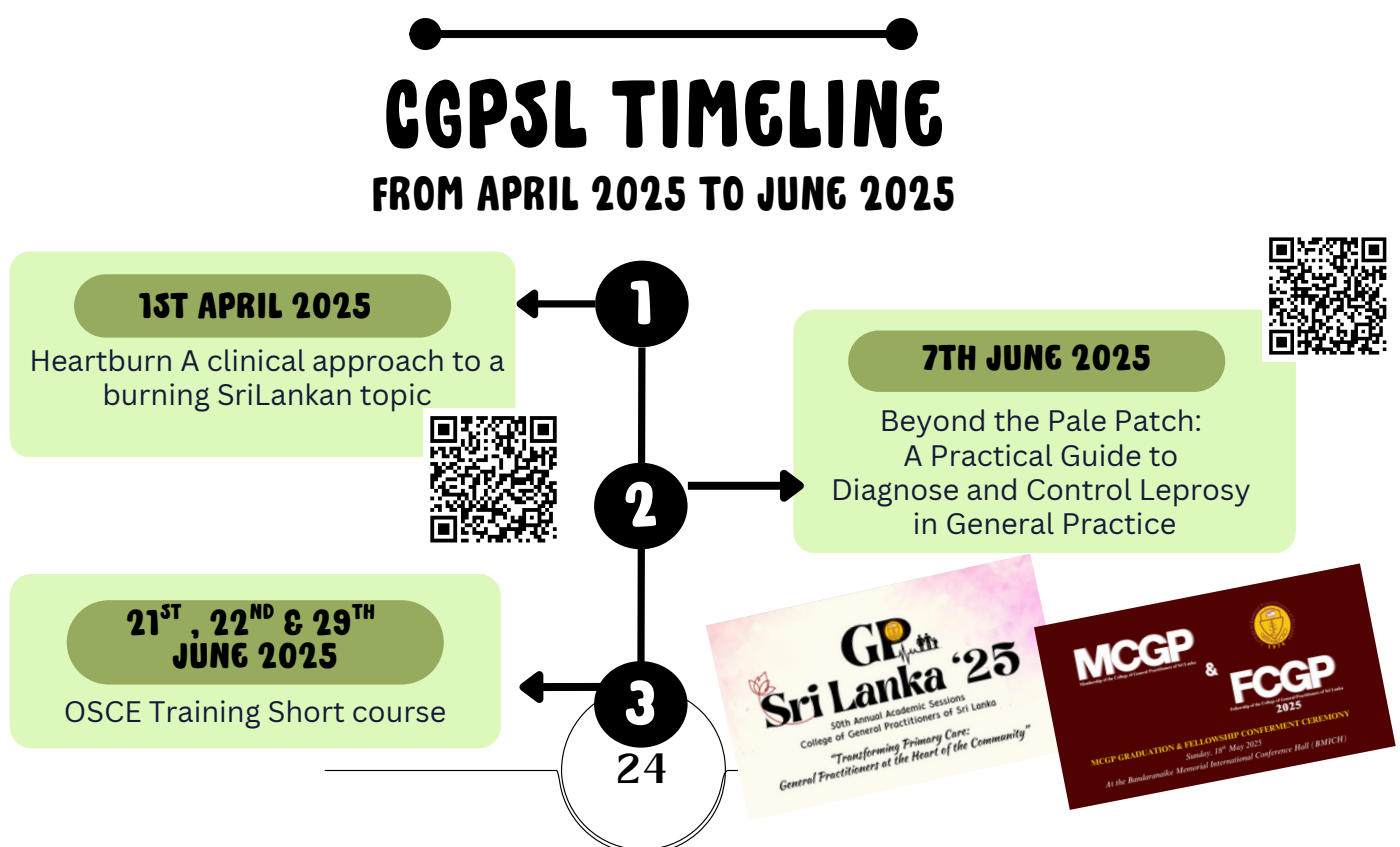
One of the most valuable insights was recognizing the gap between what communities believe and what evidence-based guidelines recommend. It became clear that knowledge transfer is not merely about delivering facts but about respectfully challenging misconceptions that have cultural and generational roots. This reinforced the need for trust, cultural sensitivity, and visual communication in primary care education.

The experience also allowed me to explore the power of simple, low-cost interventions. A single printed leaflet, when paired with a genuine conversation, became a tool for dialogue, reflection, and empowerment. It affirmed my belief that every consultation is an opportunity for health promotion, and every patient encounter can extend beyond treatment to include prevention.

Moreover, the project underscored the importance of integrating public health thinking into everyday general practice. As a future GP, I am motivated to adopt similar reflective, community-based initiatives throughout my career—especially in rural and resource-limited settings where the impact can be both immediate and long-lasting. This experience has deepened my commitment to family medicine’s holistic ideals and strengthened my resolve to serve not only individuals but the wider community

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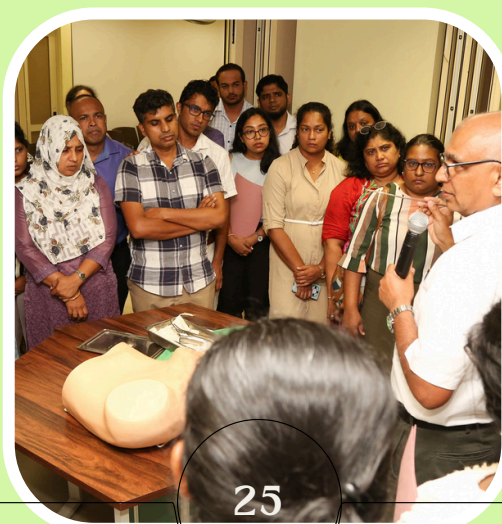
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