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COMMONWEALTH MEDICAL ASSOCIATION

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COMMONWEALTH MEDICAL JOURNAL

CMJ

CMA

COMMONWEALTH MEDICAL ASSOCIATION

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Past CMA President

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CMA
Journal of Commonwealth Medical Association
Editor in Chief – Prof. Dr. S. Arulrhaj

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Dear CMA Colleagues,

Warm Greetings.

Confident, all of you enjoyed the first Issue of our Commonwealth Medical Journal (CMJ)

With all your support the second issue of CMJ is on board.

CMA under the leadership of our President, Prof.J.A.Jayalal is moving fast in Academics and Policies. Many Committees have been formed and all are active.

Post Graduate Medical Education for our NMA Members through CMA is chartered. Nearly 10 Courses are on process. Two major courses Fellowship in Cardio Diabetes Medicine (FCDM) Fellowship in Emergency Medicine (FEM) are ready to be admitted to members. You will see further details inside. This courses will be certified by International University too.

This issue we have the reports of President, Secretary, Leaders of CMA, birds eye view of the Committees & Activities along with Case Report, Spotters & Original study. Highlight your practice knowledge & skills.

On July 18th Annual Meeting of CMA along with Scientific program & Convocation is being held in London at Commonwealth Secretariat. Kindly participate and make the Landmark CMA event a grand success.

Kindly share your reports & Academic inputs, and suggestion to CMA so that CMA will become one of the most searched Academic feast.

Best Wishes

Prof. Dr. S. Arulrhaj, MD., PhD, DSc, FRCP(G), (L)MBA
Past Commonwealth President CMA, UK
Editor in Chief - CMJ

To
All National Medical Associations.
Commonwealth Nations

Subject: Strengthening Partnerships for Resilient CommonHealth: Utilizing Our Commonwealth

Dear colleagues,

Warm greetings from the Commonwealth Medical Association. It is an honor and privilege to meet with distinguished leaders and members of our National Medical Associations throughout the Commonwealth. Please accept my sincerest thanks for your tireless efforts and invaluable contributions to improving healthcare systems and millions of lives. I join the Commonwealth Secretariat in wishing everyone a prosperous and healthy New Year.

The theme for the Commonwealth is "One Resilient Common Future: Transforming Our Common Wealth." It highlights the identification and development of each country's strengths by leveraging the Commonwealth's unique network and resources for mutual benefit, fostering a connected and digital Commonwealth. Resilient CommonHealth calls us to join forces in our shared mission of creating a future that ensures affordable, accessible, and equitable healthcare for all. I urge you to include this topic in your national policies and programs, knowing that resilience is key to attaining long-term and significant healthcare outcomes. By stressing collaboration and innovation, we can address our communities' unique health concerns. Together, we can build a framework that empowers people and improves the overall well-being of communities across the Commonwealth.

Climate Change & Health:

Climate change has far-reaching health consequences, with disadvantaged groups across the Commonwealth bearing the brunt of the repercussions. Let us step up our efforts to advocate for climate change mitigation policies that prioritize public health, address environmental determinants of health, and create climate-resilient healthcare systems. We can effectively allocate resources to those in most need by encouraging collaboration among government agencies, healthcare providers, and community organizations. Furthermore, combining education and awareness initiatives will provide individuals with the knowledge they need to adapt to and combat the health risks caused by climate change.

Tuberculosis eradication:

The Commonwealth states account for two-thirds of the worldwide tuberculosis burden. This necessitates a concentrated and comprehensive approach to TB

control, including early detection, effective treatment, community participation, and cross-border collaboration. Together, we can work toward the lofty goal of eradicating tuberculosis from our countries. The Commonwealth Medical Association, in partnership with the UN Assembly's Stop TB Partnership Program, promotes high-burden countries to work with commercial and public health practitioners on the urgent goal of eradicating tuberculosis. This mission demands not just focused resources but also a shared commitment from all stakeholders. We can improve our response to tuberculosis by supporting research innovation and sharing best practices, resulting in a healthier future for all Commonwealth inhabitants.

Youth Empowerment:

Our youthful medicos and doctors are the healthcare industry's future leaders. I encourage all organizations to actively promote youth exchange programs that facilitate cross-country learning, leadership development, and collaborative creativity. Let us invest in empowering young healthcare professionals to build a more vibrant and inclusive medical workforce in the future.

Joining this participatory democracy:

The Commonwealth Medical Association invites all member countries to actively participate and share their ideas, needs, and opportunities—building a strong relationship amongst healthcare professionals across nationalborders. I strongly encourage you to renew your membership and build togetherness.

Commonwealth Individual Associate Membership:

I invite all medical professionals to join as individual associate members, strengthening our collective voice and broadening the scope of the CMA. This will create a unique platform for international information exchange, cooperation, and the sharing of best practices.

Finally, I am requesting your support for the newly formed CMA team. We shall work together to maintain the Commonwealth's objectives, confront pressing health concerns, and support new solutions for the greater good.

Let us stand together, dedicated to achieving the vision of a healthier, more equal, and sustainable future for all Commonwealth countries. I look forward to your active participation, guidance, and collaboration on our mission of health for all.

With heartfelt regards and best wishes.

Professor Dr. J.A. Jayalal
President, Commonwealth Medical Association

Commonwealth Day Message from His Majesty The King, Head of the Commonwealth

Last October, leaders from across the Commonwealth came together in Samoa to reaffirm their 'belief in the value of the Commonwealth as a trusted forum where diverse voices of our member states, the large and the small, the young and the old, come together as one family'. These gatherings are important for helping all Commonwealth nations to tackle the challenges of the day, yet they also play another vital role. In these uncertain times, where it is all too easy to believe that our differences are problems instead of a source of strength and an opportunity for learning, the Commonwealth's remarkable collection of nations and peoples come together in the spirit of support and, crucially, friendship.

This year, the world reflects on the eightieth anniversary of the end of World War 2. More than one-and-a-half million men and women who served during the War came from across the Commonwealth to support the United Kingdom and its allies. On this special anniversary, we remember with particular pride and everlasting gratitude the untold sacrifice and selflessness of so many from around our Family of Nations who gave their lives in that dreadful conflict. The Commonwealth's ability to bring together people from all over the world has stood the test of time and remains as ever-important today. Leaders recently reiterated the importance of collaboration for peace and human rights, as well as for the restoration of Nature both on land and in the oceans.

As we mark this Commonwealth Day together, there is no more important task than to restore the disrupted harmony of our entire planet. For the sake of our younger generations' threatened future, I can only hope that the Commonwealth will continue its vital work to restore that harmony.

The Commonwealth

Together We Thrive

TheCommonwealth.org/commonwealth-day
@commonwealthsec @commonwealthsec
@commonwealth_sec
#CommonwealthDay

COMMONWEALTH DAY WITH HIS MAJESTY KING CHARLES



I am indebted to Ministry of health and IMA to represent India as the President of Commonwealth Medical Association, in the Commonwealth foundation ceremony hosted by his majesty King Charles and family in the West minister Abbey London and the dinner hosted by him . The King and queen were courteous to spent time with us and king specifically conveyed his greetings to India and requested CMA to focus on NCD and Malaria Eradication.




Hearty Congratulations

TO THE NEW SECRETARY GENERAL OF COMMONWEALTH

Inaugural address from the Commonwealth Secretary-General, Hon Shirley Ayorkor Botchwey, on assuming office on 1 April 2025.

My dear friends, citizens of the Commonwealth of Nations, as I assume the office of Secretary General of our Commonwealth, today, I wanted to begin the day by speaking with you as a fellow citizen.

I do so with deep humility, but also inspired by the possibilities of what we can do to transform the lives of all who live in the Commonwealth.

The world we woke up to today is unlike any we have seen in the lifetimes of many of our 2.7 billion people.

The consequences of lower economic growth, increased defense expenditures, and a frayed multilateralism will affect our pockets directly, increase unemployment and poverty, reduce social protection, and weaken our resilience to shocks, whether climate or economic.

The value of our Commonwealth stands in bold relief, in a time like this.

Our ambitions cannot be limited by old prescriptions.

As an organisation based on common values. We can work for our common well-being as a multilateralism of the willing, and we must begin by standing with those member states that are daily targets of attack.

We must seize the moment to realise the transformation our societies seek.

Trade and investment hold the key to our economic transformation. By seeing the Commonwealth market as a key to expanding industrialisation, trade and services for all our countries, industrialised or developing, big or small, we can unlock extraordinary opportunities driving prosperity, creating jobs and lifting up communities.

I am determined that we will continue to empower our women and young people with the tools, knowledge and opportunities they need to succeed.

Closing the digital gap means opening doors to education, healthcare and economic opportunity.

It is also the moment for innovation and strategic partnerships, especially with the private sector and research institutions, in the face of the greatest challenge of our times, climate change.

For so many of our member states, the impacts are already devastating. Our response must be bold, urgent, smart and united for a green and just future. And we must work together with other multilateral bodies to transform the international financial system, taking into account the critical issues of climate and other vulnerabilities.

Let me conclude on a personal note.

It is a great honour to be the first African woman to serve as Secretary-General.

As a daughter of Ghana, the first African country to join the Commonwealth. I feel a deep personal connection to our family of nations.

As I take on this role, I do so with profound optimism and unwavering belief in what we can achieve together.

With the support of our team at the Secretariat drawn from all across the Commonwealth, I will work every day to honour and repay the trust and confidence which has been placed in me.

The challenges we face are real and serious, but together we are more than equal to them, sustained by the values that bind us, democracy, good governance, peace, human rights and equal opportunity for all, we will build a future in which opportunity, dignity and prosperity are within reach for all.

So let us move forward with purpose, with courage, and with an unshakable commitment to a Commonwealth that truly thrives, together.

New Secretary - General Shirley Botchwey pledges to advance Common wealth values in a divided world

COMMONWEALTH COUNTRIES HEALTH MINISTERS MEETING

I had the privilege of attending one of the most fruitful Health ministers meeting today . It was strange to see almost all commonwealth countries health ministers/ Secretaries including Singapore , Australia and small island were actively participating. Lesotho minister was the head of the meeting. But most of the NMAs of these countries are not joining with us. Interacted with lot of countries and also had the opportunity to talk in the breakout session. The WHO Director General, DG of African CDC and World health fund CEO addressed. The commonwealth secretary once again assured her participation in our July meet.

Ministerial Statement
17 May 2025, Geneva, Switzerland

We, the Commonwealth Health Ministers, met on 17 May 2025 in Geneva, guided by the theme "Investing in Health: Sustainable Financing for an Equitable Commonwealth," to reiterate the urgent need for innovative financing solutions and sustainable funding to strengthen health systems and ensure equitable access to comprehensive, person-centred and quality healthcare services for all through collaborations, engagements, and partnerships.

1. We recall our previous ministerial commitments to accelerate Universal Health Coverage (UHC), and sustainable financing, along with the recent 2024 Commonwealth Heads of Government commitment to achieve health-related Sustainable Development Goals (SDGs) by developing post-COVID-19 health systems that are sustainable, equitable, resilient, and inclusive, supported by robust sustainable financing.
2. We acknowledge that achieving Universal Health Coverage (UHC) and strengthening Primary Health Care (PHC) depends on sustainable health financing, which requires mobilising adequate resources, enhancing spending efficiency, and ensuring equitable fund allocation in line with the Lusaka Agenda.
3. We recognise that strengthening health financing systems and achieving sustainable health financing require a coordinated approach to effectively mobilise resources and align policies, fostering resilience in healthcare systems and equitable access to health services for all populations.
4. We look forward to the upcoming 78th World Health Assembly to further engage in in-depth discussions on options for the sustainable financing of the World Health Organisation, given the current financial context, and its implications on global public health and for support to countries.

INVESTMENTS TO BUILD ROBUST HEALTH SYSTEMS

5. We recognise that enhancing health investments and ensuring sustainable financing are essential for building robust and resilient infrastructure, improving service delivery, strengthening primary health care, advancing health goals, reducing financial hardship, and creating more equitable and sustainable and integrated healthcare systems.
6. We acknowledge that investing in health promotion and disease prevention is key for sustainable health financing, as it will reduce treatment costs overall, improve population health outcomes, and support resilient health systems.
7. We recognise that many member states are accelerating health-financing reforms, including increasing domestic financing, particularly in light of the current financial context with the aim to enhance access, quality and equity of healthcare services for improved health outcomes for all populations.
8. We recognise that investing in the health and care workforce is vital towards addressing worker shortages and increasing the resilience of health systems. This requires collaboration among various bodies, a strategic focus on training, recruitment, retention, continuous professional development, and innovation to benefit all Commonwealth member states and foster healthier societies.
9. We recognise the challenge of health worker migration, and the need to implement sustainable long-term investment and planning mechanisms and retention strategies to mitigate any potentially negative consequences on the quality of healthcare services, which can disproportionately affect Small Island Developing States (SIDS) and Low- and Middle-Income Countries (LMICs).

10. We recognise that improving the affordability, availability of and access to essential medicines is vital for UHC and the resilience of Commonwealth health systems and support the Commonwealth Heads of Procurement Voluntary Network in promoting equitable access to quality medicines, vaccines, and health commodities.
11. We acknowledge the ongoing research initiative being led by the Commonwealth Secretariat on the health sector's response to Gender-Based Violence (GBV), which aims to promote investment in services for people who may be vulnerable or in vulnerable situations, including women and children, thereby enhancing support and protection for those affected.

CLIMATE AND HEALTH

12. We recognise the adverse effects of climate change on biodiversity and ecosystems, food security, human health and health systems, nutrition, and safe and sufficient access to water, underscoring the need for rapidly scaled-up mitigation and adaption actions to make health systems more climate resilient and respond effectively to environmental challenges, keeping in view the rights and obligations under UNFCCC and the Paris Agreement.
13. We recognise the increasing linkages between climate change and health for both communicable diseases and NCDs (including mental health conditions), and underscore the importance of developing strategies to assess the vulnerabilities and exposure of health systems to climate hazards and enhance resilience to improve health outcomes for those affected.
14. We recognise the significant barriers that small and vulnerable countries, including SIDS and least-developed countries (LDCs), face in accessing sustainable and adequate financing for health-related climate activities.
15. We acknowledge the work done by the Commonwealth Secretariat to support developing and vulnerable countries, including SIDS, through the Commonwealth Climate Finance Access Hub (CCFAH) as well as the King's Commonwealth Fellowship Programme to strengthen education, health and climate resilience in SIDS.
16. We note the formation of the Commonwealth Climate and Health Technical Working Group, under the leadership of the Government of Kiribati, which will foster multi-sectoral collaboration, knowledge exchange, and sharing of best practice across the Commonwealth.
17. We welcome the leadership of WHO in drafting the WHO Global Action Plan on Climate Change and Health, noting its alignment to the identified challenges facing Commonwealth countries, particularly those most vulnerable to climate-induced events.

PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE (PPPR)

18. We acknowledge that public health emergencies, disease outbreaks, and the surge of climate-sensitive diseases, continue to hamper health systems and reverse progress on health milestones achieved in countries, highlighting the need to strengthen prevention, preparedness and response capabilities to elevate the current response mechanisms and systems to prevent future disease outbreaks and minimise their impact.
19. We recognise the need to address fragmentation in health policies and programmes and the need to prioritise and promote coherent and aligned health financing systems, including for PPPR, whilst ensuring hygiene and infection prevention control are integrated.
20. We recognise the need to work collaboratively with member states and partners to the lessons learnt from COVID-19 pandemic and other pandemics through continued learning and review to be better positioned for future epidemics.
21. We recognise our joint commitment to strengthening the global health architecture and acknowledge the adoption of the International Health Regulations (2005) (IHR) amendments at the 77th World Health Assembly in 2024 and welcome the Pandemic Agreement to support all member states to better to prevent, prepare for, and respond to pandemics for consideration by the 78th World Health Assembly.

NCDs INCLUDING CANCER AND MENTAL HEALTH

22. We acknowledge the efforts of the Commonwealth Secretariat working to address NCDs including promoting mental health and wellbeing, using a multisectoral approach through harnessing sports, education, youth, climate, food system, and gender and by leveraging partnerships with regional bodies, affiliated organisations, intergovernmental organisations, civil society and private sectors.
23. We note with concern that cervical cancer remains the most common cancer affecting women in many Commonwealth countries, and the limited progress towards the goal set by Commonwealth Heads of Government to ensure that all girls have access to HPV vaccination by age 13 by 2025, as well as access to high-quality screening services, in line with the elimination targets set by WHO.
24. We support the recognition of World Cervical Cancer Elimination Day on 17th November, with the view to further mobilise action and promote the agenda in the Commonwealth, whilst galvanising and sustaining the global goal to eliminate cervical cancer.
25. We welcome the upcoming United Nations Fourth High-Level Meeting (HLM4) on the Prevention and Control of Non-Communicable Diseases and Promotion of Mental Health and Well-being in September this year and recognise this opportunity for the Commonwealth to highlight NCD and mental health issues including interlinkages with climate change.

LEVERAGING DIGITAL HEALTH INNOVATIONS

26. We acknowledge the importance of digital systems, tools, and artificial intelligence (AI) innovations to accelerate UHC and welcome the collaboration between the Commonwealth Secretariat and the World Health Organization (WHO) in supporting countries to conduct Digital Health Maturity Assessments at the national level.
27. We recognise the need to ensure continued progress in creating efficient and accessible digital healthcare systems.

CHOGM COMMITMENTS

28. We welcome the Commonwealth 2025 Malaria Briefing Report, noting with concern the slow progress on malaria elimination, and the need for renewed leadership, increased collaboration, and resource mobilisation and replenishment to achieve our 2030 targets.
29. We note the significant progress in eliminating trachoma and improving eye care services, alongside the urgent need for vigorous actions against Neglected Tropical Diseases (NTDs), whilst ensuring sustained financing to advance control measures and implement evidence-based, effective health interventions.
30. We welcome the 2024 United Nations General Assembly commitments on antimicrobial resistance (AMR), emphasising the need for sustainable investments to strengthen national capacities for prevention, surveillance, innovation and response, through a One-Health Approach, especially in developing countries. Further we welcome the establishment of the Independent Panel for Evidence for Action against AMR by 2025 to put science and evidence at the heart of the global response to AMR and help countries make a case for AMR investment.
31. We note with concern the global challenge of demographic transition and welcome the Commonwealth's Roadmap for Healthy Ageing Across the Life Course, which aligns with the UN Decade of Healthy Ageing (2021–2030) and establishes a framework for promoting healthy ageing across the life course.
32. We welcome the 2024 Report on Dementia in the Commonwealth and its alignment with the Commonwealth's Roadmap for Healthy Ageing Across the Life Course, which can help guide actions to enhance health and well-being across member countries in accordance with the WHO Global Plan of Action on Public Health Response to Dementia (2017-2025).

PARTNERSHIPS

33. We acknowledge the important partnership between WHO and Commonwealth Secretariat which exemplifies the value of impact-driven evidence-based inter-agency cooperation.
34. We acknowledge the need to leverage and strengthen partnerships between the Commonwealth Secretariat, regional intergovernmental bodies, Commonwealth intergovernmental and accredited organisations and young people to advance ministerial and CHOGM commitments, whilst emphasising the importance of sustainable financing and actionable solutions to support these efforts.
35. We take note of the recommendations from the Commonwealth Civil Society Policy Forum, convened on 28 February 2025, which calls on governments to:
    a) incorporate financing for a sufficient and skilled health and care workforce into their sustainable f inancing plans, supported by forward planning to meet population needs and retention strategies that encourage the workforce to remain in-country.
    b) respond urgently to the severe reductions in global development assistance to protect lives, livelihoods, and health systems across the Commonwealth.

LOOKING AHEAD

36. We agree to working collectively with Ministers of Finance and other sectors, according to our national context, especially considering the current financial and global health contexts, to foster dialogue on adaptive and resilient strategies that effectively improve health outcomes through collaboration and promote coherence, transparency, and accountability in health financing systems across diverse programmes for effective and sustainable interventions.
37. We commit to working together to address critical shortages of the global health and care workforce, considering different country contexts and available resources, by conducting thorough national workforce planning and mapping exercises to assist in developing concrete policy actions and interventions for both current and future health needs.
38. We commit to working collectively to encourage increased uptake of digital health innovations and tools to enhance efficiency and accessibility in healthcare systems, thereby supporting the attainment of UHC goals.
39. We commit to support the Commonwealth Heads of Procurement Voluntary Network in promoting equitable access to quality medicines, vaccines, and health commodities and to explore the establishment of an effective pooled procurement mechanism.
40. We commit to conducting iterative climate change and health integrated vulnerability assessments, according to national contexts, to inform the development of health-focused national adaptation plans or adaptation planning strategies and support the implementation of such existing national plans and strategies.
41. We recommit to support the 2030 global elimination targets for cervical cancer and develop national integrated cervical cancer strategies (for vaccinations, screening and treatment), where appropriate, including by working collaboratively with Commonwealth initiatives, including the First Ladies and Spouses' Cervical Cancer Elimination Initiative.
42. We commit to urgent and concrete action to implement the UNGA Political Declaration on AMR, using a One Health approach to strengthen national action plans, invest in surveillance, promote infection prevention & control, and ensure responsible antimicrobial use across human, animal, and environmental health sectors.
43. We recommit to accelerating multisectoral approaches to address NCDs and mental health among young people.
44. We recommit to working together towards ending the epidemics of acquired immunodeficiency syndrome (AIDS), tuberculosis (TB), malaria, and neglected tropical diseases (NTDs) by 2030, in the face of the challenges posed by the global financial context.

45. We commit to working together to mobilise finance successful to replenish the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance, as appropriate, noting their importance in building resilient health systems that provide equitable access to healthcare services for all.
46. We commit to working together to achieve UHC by 2030, with primary health care at its core, and to improving access to comprehensive sexual and reproductive health and rights, which are critical to achieving gender equality and the highest attainable standard of health for all.
47. We commit to working collectively to implement the Commonwealth Roadmap on Ageing Well, according to national contexts, including by promoting one in-country age-friendly community or city by October 2026, which will be responsive to the needs of older residents, ultimately improving their quality of life and promoting healthy ageing.
48. We take note of the policy options discussed from the Ministerial Breakout Sessions, which can be found in Annex 1. and will explore relevant opportunities to discuss further according to country contexts.
49. We look forward to the development of the Commonwealth Secretariat's new strategic plan for 2025-2030, which will outline priorities for future implementation.

ANNEX 1. Summary of Policy Options Discussed in the Ministerial Breakout Sessions

Ministerial Breakout Session #1: Sustainable Financing for NCDs and Mental Health

On Sustainable Financing:

1. Strengthen Commonwealth advocacy on debt cancellation at UNGA targeting NCDs and mental health.
2. Develop pooled procurement guidelines needed to guide member states.
3. Strengthen internal controls such as dealing with corruption to enable sustainable financing for health systems including NCDs and mental health.
4. Strengthen the investment case for investing in NCDs and Mental Health.
5. Target the private sector towards NCDs and mental health outcomes, for example corporate social responsibility funding for mental health.

On Promoting Stronger Commonwealth Cooperation on NCDs and Mental Health:

6. Strengthen Commonwealth advocacy on a common donor strategy to leverage ODA
7. Advocate within the Commonwealth to support the 78th World Health Assembly resolution on strengthening health financing globally.
8. Work together to align approaches for greater equity at the global level.
9. Advocate for greater investment in scholarships which target medical and health prevention.
10. Develop a Commonwealth strategy which focuses on equity between

On Innovative Approaches to Addressing NCDs:

11. Enhance greater technology transfer within the Commonwealth context.
12. Leverage our comparative advantage where cooperation where young populations can help those with ageing population needs.
13. Leverage and sharing better education research, technology including the use of Artificial Intelligence.
14. Promote Health In All polices, leveraging relevant Ministries for greater health outcomes, for example in education and agriculture.

Ministerial Breakout Session #2 - Investing in Prevention to Support Ageing Well and Reduce Disease Burden

1. Create at least one age-friendly community or city by October 2026, designed to adapt services and provide physical and social environment to meet the needs of older residents, improving their overall quality of life and supporting ageing well.
2. Foster intergenerational dialogues to transform perceptions and attitudes towards age and ageing, to help dismantle stereotypes including ageists' attitudes, foster mutual understanding between different age groups, and promote respect and appreciation for the contributions of older people.
3. Strengthen integrated care including at the primary care level and within the community, to enable older people to live healthier lives.
4. Improve access to good-quality long-term care to ensure equitable access to services and improved health outcomes for ageing populations.

Ministerial Breakout Session #3 - Strengthening Climate Resilience and Adaptation Initiatives across Health Systems

1. Mobilise dedicated climate finance to strengthen health systems' capacity to prevent, withstand, and recover from climate-related shocks.
2. Prioritise sustainable investment in health infrastructure to safeguard essential services amid escalating climate risks.
3. Establish robust governance mechanisms and foster coordination across sectors to ensure coherent and climate-responsive health action.
4. Integrate climate and health education into health training and public outreach to build informed, resilient communities.
5. Deepen collaboration with partners and elevate youth leadership to accelerate progress and innovation at the climate-health interface.

Ministerial Breakout Session #4 – Leveraging Digital Health Innovations to Improve Efficiency and Access

1. Creating a cohesive digital health ecosystem requires addressing several interconnected elements including governance and legislative frameworks: - Develop a model legislation (Commonwealth, WHO and other partners) which countries can leverage to mature national digital governance.
2. Develop Commonwealth-wide, standards-based systems and building blocks (e.g. electronic health records, electronic registries, data exchanges) that member nations can re-use, implement and customize, leveraging global standards and collective expertise.
3. Develop a repository of best-case studies, policies and legislation among Commonwealth countries where countries can reference best practices and reuse applicable content to shape national digital foundations.
4. Develop Commonwealth-wide recommendations for digital and data standards to promote national and cross-border interoperability, data security and person-centred systems, to prevent vendor lock-in and to ensure citizens have access to their own health records.
5. Address rigid IP protections that limit technology adoption and person-centred health systems through governance and legislation.
6. Encourage participation in global interoperability architecture that enables personal health records to be carried by citizens, verified and used, with permission to improve patient safety and continuity of care across borders. (e.g. WHO Global Digital Health Certification Network, GDHCN, enabling the Digital ICVP/Yellow Card).

A CASE OF GIDDINESS - UNVEILING PULMONARY EMBOLISM

*Dr S Arulrhaj**Dr Aarathy Kannan***Dr Muhammed Basil ***Dr Dhinesh Kumar

HISTORY

A 68 years old Female patient presented with complaints of Giddinessand chest pain for 1 day. Each episode of Chest pain was acute in onset occurs for less than few minute, resolves spontaneously.

Patient had aself fall at home and diagnosed to have Pelvic bone fracture 15 days ago . Patient is in complete bed rest since then.

Patient is a known case of Hypertesionfor Past 5 years , on regular treatment .Hypothyroidismon Thyronorm 100mcg

GENERAL EXAMINATION

Swelling , Redness and Tenderness over both calf muscles

VITALS

Temp- Normal SPO2 97%

BP – 90/60 mmHg, Right upper limb , in supine position

PR –105 beats /min

RR – 18 /min, thoraco abdominal, regular

CVS :S1, S2 (Loud P2) Heard in all areas , No murmurs

RS :Normal vesicular Breath Sounds , Bilateral Air entry Equal

CNS :No Focal Neurological Deficit.No Nystagmus.

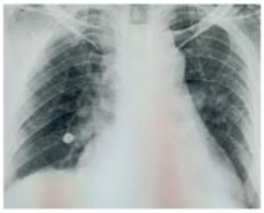
Abdomen :Soft, No Organomegaly, No Bruit

Pelvic pain on movement +

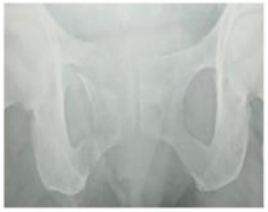
*chairman and chief physician SAH Tuticorin

**Consultant physician and diabetologist SAH Tuticorin

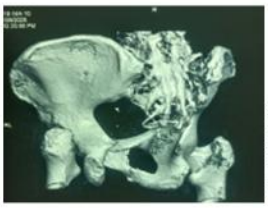
***DNB PG SAH Tuticorin



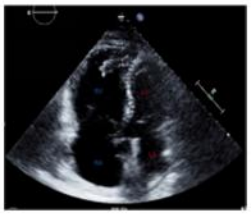
CXR – PA :Prominent Right descending pulmonary artery



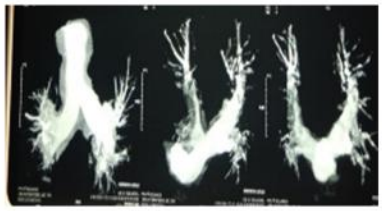
Xray Pelvis AP :Fracture of Right superior and Inferior Pubic Ramus



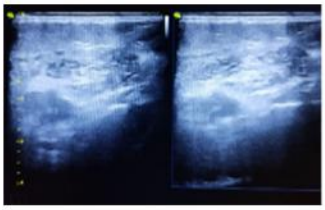
CT – PELVIS: Slightly displaced oblique fracture of Superior and Inferior Pubic Ramus.Undisplaced Fracture of Right Sacral Ala



ECHO
Severe P A H.RA ,RV Dilated. LVDD
McConnell's sign +



CT Pulmonary Angiogram-Acute Pulmonary thromboembolism.



Venous Doppler of Both Lower Limbs :AcuteDVT Involving Both lower limbs

FINAL DIAGNOSIS

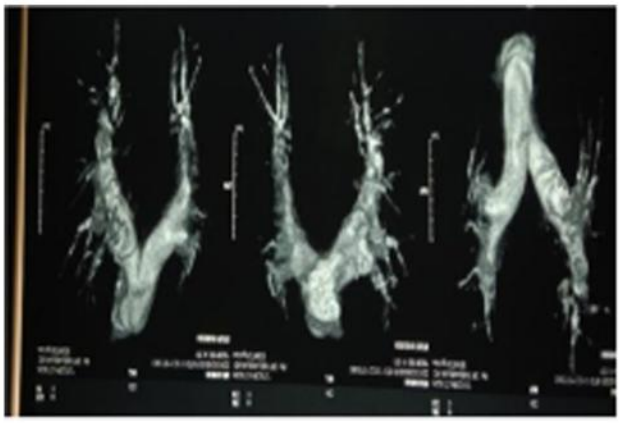
- Acute Massive Pulmonary thromboembolism
- DVT- Both lower limbs secondary to Immobilization
- Fracture of Superior and Inferior Pubic Ramus of Pelvis
- Hypertension /Hypothyroidism /Dyslipidemia

TREATMENT

- Thrombolysedwith Inj.Elaxim 30mg I.V
- InjLupenox 60mg S.C BD for 5 days Post thrombolysis
- T. Rivaroxaban 10mg BD after 5 days of LMWH

Follow up after 5 Days

CTPA- Decrease in the extent of bilateral pulmonary arterial thrombus and mild decrease in the size of dilated RA and RV



PULMONARY EMBOLISM

Definition:

- Pulmonary embolism (PE) is a blockage of an artery in the lungs by a substance that has moved from elsewhere in the body through the bloodstream mainly blood clot (embolism).
- A small proportion of cases are due to the embolization of air, fat, or amniotic fluid

Symptoms:

- Dyspnea (shortness of breath), tachypnea (rapid breathing), chest pain of a "pleuritic" nature (worsened by breathing), cough and hemoptysis (coughing up blood). More severe cases can include signs such as cyanosis

Dizziness due to reduced cerebreal perfusion

Signs :

PULMONARY EMBOLISM

Definition:

- Pleural friction rub may be audible over the affected area of the lung (mostly in PE with infarct).
- A pleural effusion is sometimes present that is exudative.
- Strain on the right ventricle may be detected as a left parasternal heave, a loud pulmonary component of the second heart sound, and/or raised jugular venous pressure.
- A low-grade fever may be present, particularly if there is associated pulmonary hemorrhage or infarction
- Larger PEs, which tend to lodge centrally, typically cause dyspnea, hypoxia, low blood pressure, fast heart rate and fainting

CLINICAL CLASSIFICATION OF PE

- Massive (High Risk) PE 5%
- Sub - Massive (Non-High risk)PE
  - With RV dysfunction 30%
- Non massive 65 %
  Without RV dysfunction

RISK FACTORS

- Those that undergo orthopedic surgery at or below the hip without prophylaxis
- Pancreatic and colon cancer patients
- Patients with high-grade tumors
- Pregnant women
- Those on estrogen medication
- Alterations in blood flow: immobilization (after surgery, long-haul flight), injury, pregnancy (also procoagulant), obesity (also procoagulant), cancer (also procoagulant)
- Factors in the vessel wall: surgery, catheterizations causing direct injury ("endothelial injury")

Factors affecting the properties of the blood (procoagulant state):

- Estrogen-containing medication
- Genetic thrombophilia (factor V Leiden, prothrombin mutation G20210A, protein C deficiency, protein S deficiency, antithrombin deficiency, hyperhomocysteinemia and plasminogen/fibrinolysis disorders)
- Acquired thrombophilia (antiphospholipid syndrome, nephrotic syndrome, paroxysmal nocturnal hemoglobinuria)

WELLS SCORE FOR PULMONARY EMBOLISM (PE)

Who to apply to	Patients in whom you have suspicion for PE. May help form a pre-test probability (i.e. how likely is it the patient has the disease).
Interpreting the score	Three-tier (<2, 2-6, >6) and two-tier options (≤4, >4) exist for interpretation of risk. A Wells <2 corresponds to a 1.3 % risk of PE; whereas a score of ≤4 results in a risk of 3-12.1% (depending on the study). Both are supported by the ACP guidelines and Tintinalli recommends the two-tier score.
Wells ≤ 4	Low Risk ("PE Unlikely") 3% - 12.1% risk of PE
Wells > 4	High Risk ("PE Likely") 37% risk of PE
Clinical signs and symptoms of deep vein thrombosis (DVT)	3 points
PE #1 or equally likely diagnosis	3 points
Heart Rate > 100 beats per minute	1.5 points
Immobilization at least 3 days OR surgery in the previous 4 weeks	1.5 points
Previously objectively diagnosed DVT or PE	1.5 points
Hemoptysis	1 point
Malignancy with treatment within past 6 months or on palliative treatment	1 point
Limitations	May perform differently in places with different prevalence of PE.
References	Wells PS, et al. Thromb Haemost. 2000;83:416-20. [PMID: 10744147] Gibson NS et al. Thromb Haemost. 2008;99:229-34. [PMID: 18217159] Wolf SJ et al. Ann Emerg Med. 2004;44(5):503-10. [PMID: 15520710]
@FOAMpodcast	

DIAGNOSIS

1) Blood Tests:

- In people with a low or moderate suspicion of PE, a normal D-dimer level (shown in a blood test) is enough to exclude the possibility of thrombotic PE
- Troponin levels are increased in between 16 and 47% with pulmonary embolism.

2) ECG :

- Sinus Tachycardia, S1Q3T3 pattern, RV strain pattern.

3) X Ray Chest

- Hampton hump refers to a dome-shaped, pleurally-based opacification in the lung
- Pala sign is a prominent pulmonary artery that can be caused either by pulmonary hyper tension that develops or by distension of the vessel by a large pulmonary embolus.
- Westermark's sign - peripheral oligemia.
- A normal chest radiograph in a patient with otherwise unexplained acute dyspnea or hypoxemia is strongly suggestive of embolism.

4)Echo- RA/ RV dilation in massive PE, May be normal in Mild / submassive PE

Mac Connell sign

5)CTPA- show filling defects

6)V/Q Scan- infinity-When CT not possible

Ventilation and perfusion lung scanning can provide valuable information if used and interpreted appropriately.A negative study rules out the diagnosis of pulmonary embolism with the same degree of certainty as a negative pulmonary angiogram and with a higher degree of certainty than can be achieved by a negative CTscan.VQ scans are divided into 4 criteria: high probability scan,Intermediate probability scan, low probability scan, and normal scan.

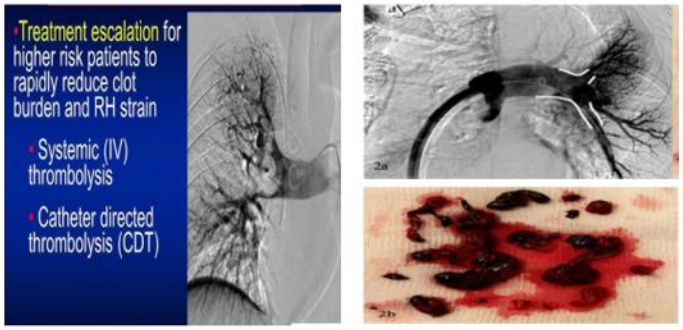
The positive predictive value of a "high probability" scan (one characterized by multiple, segmental-sized, mismatched defects) approximates 88 percent.

Pulmonary Angiography

- Pulmonary angiography remains the accepted "gold standard" for PE diagnosis.
- Only two angiographic findings are diagnostic of acute embolism: the filling defect and abrupt cutoff of a vessel.
- Catheter is inserted in the right heart and dye is injected into pulmonary trunk. Filling is observed under fluoroscopy.
- Limitations of Pulmonary Angiogram
- It requires expertise in study performance and interpretation;
- It is invasive.
- High mortality due to procedure itself.

Pulmonary Thrombectomy

- It is indicated in patients with persistent hypotension, shock, or cardiac arrest who either failed thrombolysis or have contraindications to thrombolytics.
- Its use has also been advocated in patients who are at high risk of paradoxical embolism and who are not candidates for thrombolytics, although further validation for this indication is needed.



Course In The Hospital

- A 68 years old Female patient presented with complaints chest pain and giddiness
- Initially treated as CAD

- CTPA was done in view of elevated D Dimer levels and Dilated RA, RV in Echo and diagnosed as Acute Pulmonary Thromboembolism secondary to Both leg DVT due to Immobilization
- Thrombolysedand started on LMWH followed by NOAC
- Discharged in stable condition

PTE Complications

- PHT- RHF
- Post Thrombotic Syndrome
- It is invasive.
- High mortality due to procedure itself.

Pulmonary Thrombectomy

- Post-thrombotic syndrome (PTS), also known as postphlebitic syndrome, is a chronic condition that develops after a deep vein thrombosis (DVT) and is characterized by chronic pain, swelling, and other signs in the affected limb

Post PE Syndrome

Post-pulmonary embolism syndrome (PPES) refers to persistent symptoms, functional limitations, or cardiorespiratory impairment that occur at least 6 months after an adequately treated acute pulmonary embolism (PE), often including dyspnea, exercise intolerance, and reduced quality of life

- Recurrence

Recurrence rate of Pulmonary embolism-10-year cumulative risk of 23% for PE recurrence, 9% for proximal deep vein thrombosis (DVT), and 3% for distal DVT

TREATMENT

- **Thrombolysis-** In massive PE with hemodynamic instability/ Selected cases of Submassive PE
- **Pulmonary Thrombectomy** (Surgical or catheter based)- For patients with bleeding risk
- **Anticoagulation-** LMWH/ NOAC
- **IVC Filter** for Prevention

PTE Complications

- PHT- RHF
- Post Thrombotic Syndrome

LEARNING POINTS:

- Every Dizziness is not Vertigo
- All chest pain is not ACS
- Elderly patient with prolonged bed rest leads to DVT and pulmonary embolism
- Sudden increase in the size of RA, RV size, suspect Pulmonary embolism
- It's a treatable and preventable condition
- PTE is a Pan Cardiovascular Syndrome

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A STUDY ON YOUNG CAD

*Dr S Arulrhaj**Dr Aarathy Kannan***Dr Muhammed Basil ***Dr Dhinesh Kumar

INTRODUCTION

- Coronary artery disease (CAD) oc v
- The incidence of CAD in the young has been reported to be 12%–16% in Indians.

AIMS AND OBJECTIVES

- To present an overview of coronary artery disease in young age group.
- To identify the common and distinctive risk factor associated with coronary artery disease.

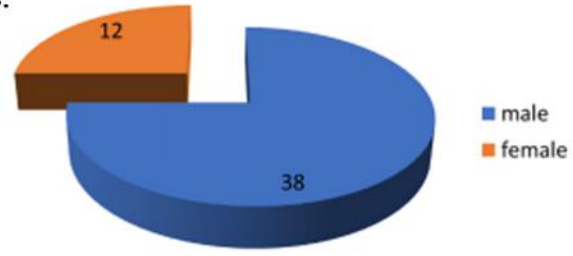
MATERIAL& METHODS

- **Study**- We report a case study of 50 young patients who had taken treatment from our hospital for CAD.
- Inclusion criteria : age <55 yrs
- Exclusion criteria : Congenital heart disease.
- **Study Duration-** july 2022 to july 2024.
- **Study Design** – Retrospective study

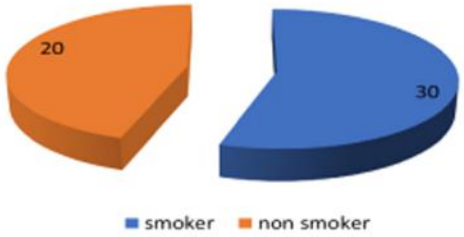
*chairman and chief physician SAH Tuticorin
**Consultant physician and diabetologist SAH Tuticorin
***DNB PG SAH Tuticorin

OBSERVATION

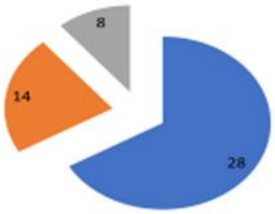
Out of the 50 patients there were 38 males and 12 females admitted with coronary artery disease.



SMOKERS VS NON SMOKERS



CORONARIES INVOLVED



LAD - (56%)

LCX - (14%)

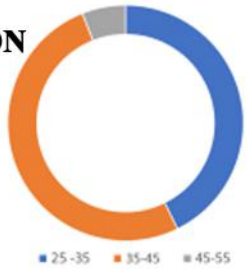
RCA - (30%)

AGE WISE DISTRIBUTION

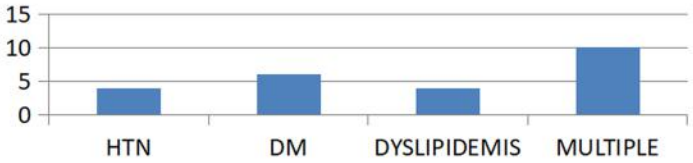
> 25 - 35 years - 10 (20%)

> 35 - 45 years - 12 (24%)

> 45 - 55 years - 28 (56%)



MULTIPLE RISK FACTORS



Multiple Risk Factors - HTN, DM, Smoking, Alcohol, sedentary Life Style

STUDY RESULTS

> 210 patients admitted with CAD in SAH between July-22- july -24.In those 130 males and 80 Female.

> In this 80 Females 16 were pre menopause rest were Post menopause.

> 50(22%) patients were less than 55 years. Inthose 38 male and 12 female.

> Youngest patient in this group was 25 year old male had TVD who was Chronic smoker.

> Risk factor In Young CAD in our study

- Smoking -55%
- HTN -10%
- DM -15%
- Dyslipidemia - 10%
- Multible risk factors -25%

> Incidence of Young CAD is 22%.

> Incidence of smoking in young CAD 55 %

> Age wise distribution of Premature CAD

- 25-35 years -10(20%)
- 35-45 years -12(24%)
- 45 -55 years-28(56%).

> Premature CAD more common in male than female.

> CAD can happen in pre menopause females.

CONCLUSION

- CAD in young is a reality.
- Avoid the risk factors - smoking, obesity ,ControlDM ,HTN Dyslipidaemia.
- Marker evaluation maybe rewarding.
- Positive lifestyle will reduce the incidence..

WORLD WIDE STATISTICS

- Studies have shown an increased prevalence of CAD in the subjects with family history of premature CAD, than in general population.
- The original as well as offspring cohort data of Framingham study, by National heart lung and blood institute (NHLBI's), from 1880 to 2003 revealed an annual incidence of cardiovascular disease of 3 per 1000 men between 35 to 44 years of age.
- Epidemiological data of United Kingdom published in the year 2000, reported a prevalence of 0.5% and 0.18% in men and women between 35 to 44 years respectively.
- The prevalence of occult CAD in 112 asymptomatic young individuals, less than 40 years of age, was found to be 11% (9 had single vessel disease and 3 had double vessel disease) in a study done in Korea. The occult CAD in these individuals was defined by performing coronary CT angiography.
- The mean age of onset of CAD in Southeast Asians seems to be 53 years as compared to European figure of 63 years. South Asians especially Indians are at greater risk of developing CAD at a young age (5% to 10%) when compared to other ethnic groups (approximately 1% to 2%).
- Reported prevalence of young CAD under the age of 40 years, in a study published from Indian subcontinent, in 1991 was 5% to 10%. This vulnerability of Indians to coronary events may be related to life style, environmental and genetic factors.
- The median age of presentation of CAD in young women is higher when compared to men. Singapore myocardial infarction registry of CAD in group less than 65 years showed that men have 4 times greater risk of CAD than women. In Asians 9.7% males and 4.4% females develop first episode of MI under 40 years of age

WHY THIS STUDY ?

- Young CAD is more common in Indian population
- Post menopausal females are prone for CAD
- Smoking is the most associated risk factor

MESSAGE

- CAD in young is a reality
- Smoking to be banned
- Control of HTN ,DM and DLP
- Life style modification is a necessity

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CLINICAL CASE - 1

A 80 year male camewith c/o progressive breathlessness since 1week. H/o fever for 2 weeks . O/E: pallor+, no cyanosis, No lymphadenopathy, O/E:P-112 /min, BP-100/70mm hg, pulsus paradoxus+ ,JVP raised, non pulsatile CVS– heart sounds muffled, no murmur,norub,Rs- Nvbs+ P/A-normal CNS- Conscious Oriented .

What is the clinical diagnosis?

Pericardial effusion .

What does this ECG show?

Electrical alternans.

How does this condition produce this ECG changes?

This rhythm is typically associated with pericardial effusion via the "swingingheart" to and fro movement from the fluid surrounding the heart.

What are the causes of Electrical alternans?

Hypothermia, Pericardial TB, Myocarditis, Pericardial Mesothelioma, cardiac Tamponade, Haemochromotosis /Amyloidosis cardiomyopathy, obesity.

How to proceed?

Hb-12.2gm%,Tc-7000/cumm, ESR- 45/95, urea-32
Creatinine- 1.2 ,Chest X ray –cardiomegaly,,ECHO

What does the ECHO show?

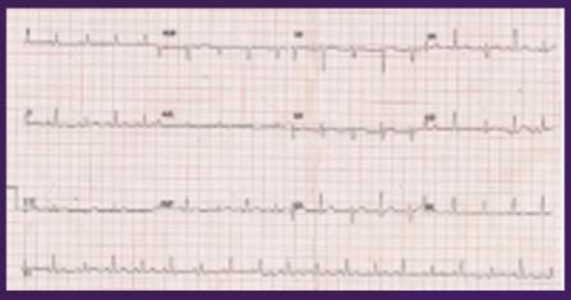
Moderate pericardial effusion with no echo evidence of
cardiac tamponade. hypokinesia of lv LW and Septum, ConcentricLVH, EF-35%.

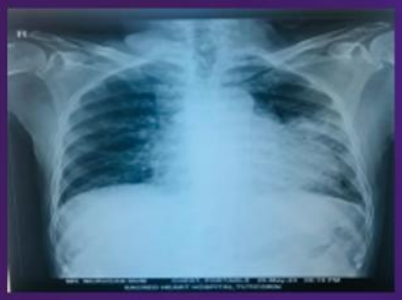
How to Manage?

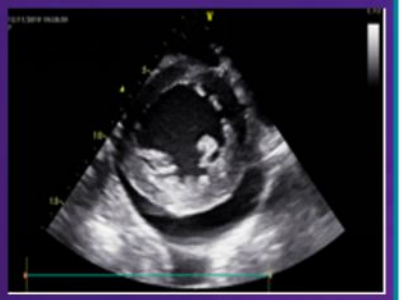
Pericardiocentesis 600ml straw color fluid aspirated. ADA-42.2, Mx-14mm (positive)
Treated with analgesics ,antibiotics and ATT.

Final diagnosis: Tuberculous pericardialeffusion .

Summary: A 80 year male came with c/o progressive breathlessness since 1week. H/o fever for 2 weeks, evaluated & diagnosed to have tuberculous pericardial effusion treated with pericardiocentesis ,antibiotics ,ATT,analgesics.







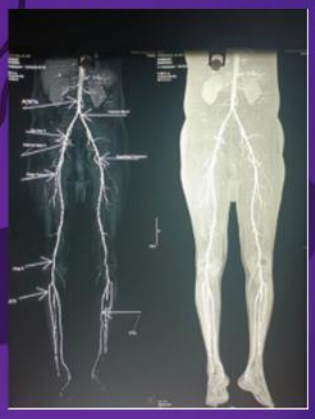
LESSON :ELECTRICAL ALTERNANS PREDICTS PERICARDIAL EFFUSION

CLINICAL CASE - 2

70 year old Female with CAD/T2DM presented with blackish discoloration of left 2nd toe -1 week. O/E- B/L pedal edema +. pt conscious , oriented, s1s2 ,P/A –soft. vitals BP: 110/60 ,HR – 120 spo2-96. Absent dorsalis pedis, Anterior Tibial pulsation left foot with local rise of temperature.

What does the CT angiogram shows?

Absent blood flow in distal part of anterior tibial artery, Posterior tibial artery , Popliteal artery at multiple levels



What are the Risk factors?

Diabetes, Hypertension, Smoking , Alcohol, CKD

What is critical limb ischemia?

ABPI < 0.3

How to manage the patient?

IV antibiotics ,Cilostazole, Pentoxtfylline
Peripheral Angioplasty
Strict Diabetic Control and supportive measures.

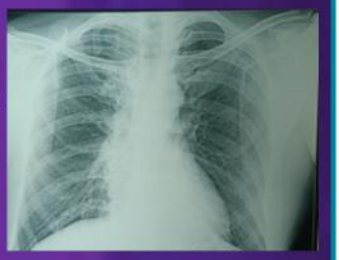
LESSON :ELECTRICAL ALTERNANS PREDICTS PERICARDIAL EFFUSION

CLINICAL CASE - 3

32 year old female, came with complaints of right upper limb pain for 2 months.
O/E- Afebrile, BP-120/80mmHG,
CVS- s1s2+, RS- Clear, PA- soft non tender . CNS: NAD
L/E : Neck- Normal,

What is the clinical diagnosis?

C8 Nerve Compression - ?Spondylosis ? Cervical disc Prolapse



What does X ray show?

Rt Cervicalrib .

What are the Neurological features of cervical rib?

Pain and paresthesia of upper limb, Atrophy of interossei , thenar and hypothenar muscles. Adson test and Roos test- Negative.

What is its importance?

The presence of a cervical rib can cause a form of Thoracic outlet syndrome due to compression of the lower trunk of the brachial plexus or subclavian artery.

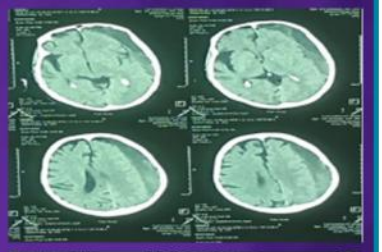
Management?

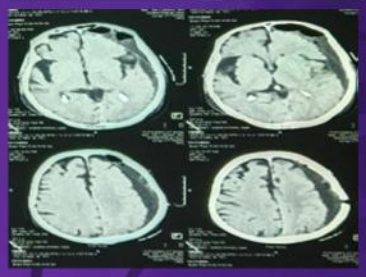
Physiotherapy, Surgical excision of cervical rib.
Final Diagnosis: Rt Cervical Rib with C8-T1 compression.

LESSON :C8-T1 NERVE COMPRESSION CONSIDER CERVICAL RIB

CLINICAL CASE - 4

77 years old male presented with complaints of giddiness and frequent falls on and off for past 3 months. O/E- Afebrile, BP-120/80mmHG, PRE OP IMAGE CVS- s1s2+, RS- Clear, PA- soft non tender . CNS: NAD





How will you evaluate this patient?

CBC, Urea, Creatinine, Electrolytes, CT Brain , EEG

What does this CT Brain Shows?

Acute on Chronic SDH along Left Fronto temporoparietal convexity2.1Cm thickness with Midline Shift of 1cm.

What are the causes of this Condition?

Trauma, Bleeding disorders, Anticoagulants, Hypertension, vasculitis

How will you manage this Patient?

Burr hole with Drainage of Hematoma
Patient recoved and discharged in stable condition.

LESSON :SDH – EVACUATION IS LIFE SAVING

CLINICAL CASE - 5

Spot the clinical diagnosis?

Macroglossia.

What is the definition to say this condition?

Macroglossia means tongue that protrudes beyond the teeth during [the] resting posture"and "if there is an impression of a tooth on the lingual border when the patients slightly open their mouths".

How to proceed?

TFT-T3-1.5,T4-1.0,TSH-9.5,B.Sugar-210, Urea-32,Creatinine-1.0.

What are the condition associated with?

* HYPOTHYROIDISM
* VASCULAR MALFORMATION
* AMYLOIDOSIS
* MUSCULAR HYPERTROPHY
* DOWNS SYNDROME
* MUCOPOLYSACCHARIDOSIS
* ANGIOEDEMA

What are the complications?

Sleep apnea syndrome (OSA),Difficulty in SPEECH and SWALLOWING ,Maloccclusion of teeth, Glossitis, Stomatitis.

Treatment?

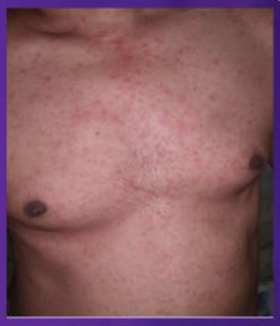
Correction of Hypothyroidism ,Surgical correction in case of Malignancy and vascular malformation
Partial glossectomy may be needed ifpatient develops OSA

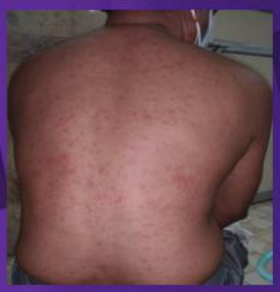
LESSON :MACROGLOSSIA CONSIDER HYPOTHYROIDISM

CLINICAL CASE - 6

A 45 years old male came to OPD with rashes all over the body since last night , patient has the history of taking linezolid yesterday for some other problem .

O/E CNS conscious and oriented CVS: S1S2+, RS: NVBS +, PA : SOFTBP-110/70, PR-94/MIN





What is your clinical diagnosis?

Drug Rash.

What is the management?

Steroids, antihistamine

What is fixed drug eruption ?

Distinctive type of cutaneous drug reaction that characteristically recurs in the same locations upon reexposure to the offending drug

what is the treatment of fixed drug eruption ?

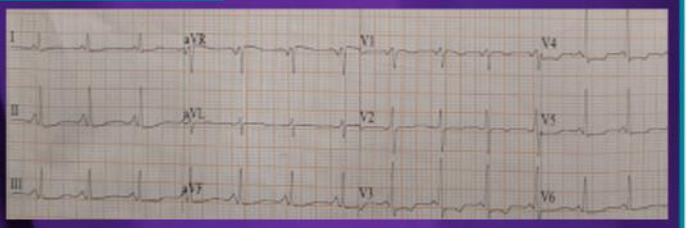
The main goal of treatment is to identify the causative agent and avoid it. other treatment is same as allergy -antihistamine and steroids

Summary: A 45 years old male came to OPD with complaints of whole body rash. Patient was having history of taking linezolid tablet 1 day before , treated with steroids and antihistaminics . Condition resolved

LESSON :DRUG RASH ALWAYS RECUR

CLINICAL CASE - 7

What does this ECG shows ?



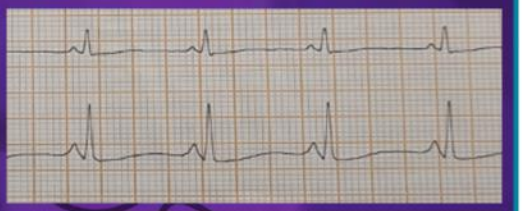
Short PR interval

What is the definitive diagnosis?

Lown Ganong Levine syndrome

What is short PR interval?

PR interval < 120 ms



What are the causes for short PR ?

WPW ,LGL , junctional rhythm

How to differentiate LGL from WPW ?

Absence of delta waveinLGL . Delta wave is seen in WPW

What is the complication associated with this condition?

Aberrant pathway can lead to arrythmias and sudden death

What is the treatment for this condition?

Radiofrequency ablation of the abberent pathway

LESSON :HB NEEDS EPS

CLINICAL CASE - 8

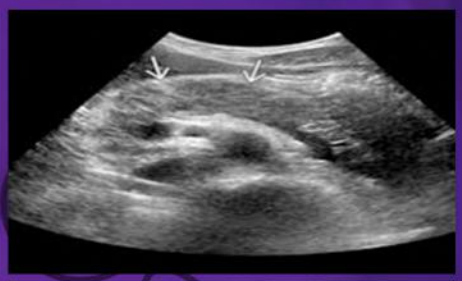
A 51 yrs male chronic alcoholic, smoker came with on and off epigastric pain radiating to back since 2 days, vomiting 4episodes O/E afebrile,PR-96, BP-130/70,P/A-Tenderness + in epigastric region,CVS-S1S2 Normal, RS-Clear.

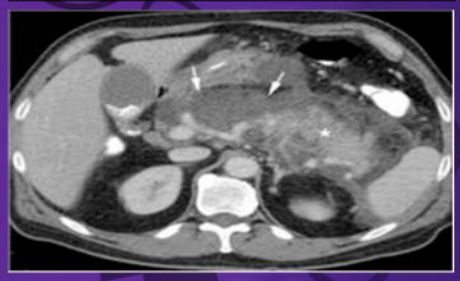
What is the clinical diagnosis?

Pancreatitis/Gastritis/Peptic ulcer

How to proceed?

S.Amylase-356 , USG Abdomen/CT Abdomen





What does USG show?

Acute pancreatitis

What does CT show?

Presence of edema in head and tail of pancreas suggestive of Acute pancreatitis

FINAL DIAGNOSIS?

Acute pancreatitis

How to manage?

Nil per oral , Adequate IV fluids,Analgesics,Antibiotics,Somatostatinanalouges, Bowel rest ,RT tube aspiration.

Summary: Middle aged male alcoholic and smoker with recurrentepigastric pain diagnosed as acute pancreatitis and managed conservatively.

LESSON:CT GOLD STANDARD FOR PANCREATITIS

CLINICAL CASE - 9

50 yr old female k/c/o DCLD ,presented with c/o fever , breathlessness, cough of 1 week, O/E chest B/L wheeze +, bilateral crepts+, vitals BP-150/90, SPO2- 76% in RA, PR- 111/mnt ALP- 200, AST -215, Bil- 2.3/1.1/1.2, Ammonia – 189, Alb/Glo – 2.5/3.5. Flapping tremor ++

USG – decompensated liver disease.

ABG – Type 1 resp failure

What is the Xray finding ?

Consolidation involving right lower lobe ?Aspiartion

What are the sites of aspiration ?

Upright Aspiration: In upright or sitting positions, the basal segments of the lower lobes, particularly the right lower lobe, are often affected.

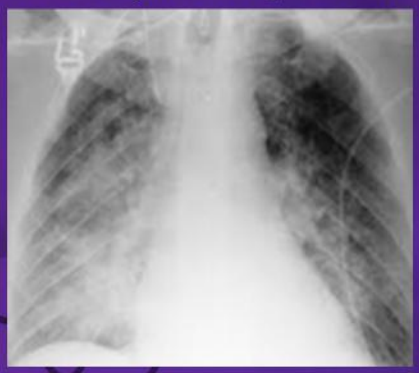
Supine Aspiration: In supine positions, the posterior segments of the right upper lobe and the right apical segment of the lower lobe are the areas most likely affected.

How to evaluate?

CBC, Sputum, AFB CBNAAT (neg), C&S(strept+)

What are the complications ?

range from localized issues like lung abscesses and empyema to systemic problems like respiratory failure, sepsis, and even death



What is the final diagnosis?

Aspiration pneumonia Rt lower lobe/ Hepatic encephalopathy/ DCLD

How to manage this patient?

NIV support,broad spectrum antibiotics, nebulisers, antitussives,given, laxatives patient improved

LESSON : HYPOXIC RESPIRATORY FAILURE COMMON IN HEPATIC ENCEPHALOPATHY

CLINICAL CASE - 10

A 10 Months old child brought by parents with complaints of dysphagia for both solids and liquids, Regurgitation of food

O/E; Child is conscious , oriented, Vitals Stable,

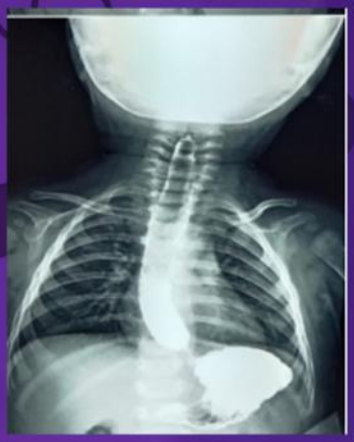
Systemic Examination; Normal

How will you evaluate this patient?

UGD Scopy , Barium Swallow, USG Abdomen

What does this Image Shows?

Barium swallow with Incomplete Relaxation Of LES showing "BIRD BEAK APPEARENCE"



What is the Diagnosis?

Achalasia Cardia

What are the Complications of this condition?

Aspiration Pneumonia, Failure to thrive

How will you Manage this patient?

Endoscopic dilatation,
POEM-Per Oral Endoscopic Myomectomy.

LESSON :BIRD'S BEAK SPEAKS FOR ACHALASIA

Commonwealth Declaration for Empowerment of Junior Doctors

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PREAMBLE

We, the representatives of Junior Doctors from National Medical Associations (NMAs) across the Commonwealth, assembled in Chennai, India, during the 27th Biennial Conference of the Commonwealth Medical Association – on 9th November 2024, acknowledge the vital contributions of junior doctors in delivering healthcare and the unique challenges they encounter in their early careers.

This Commonwealth Declaration for Junior Doctors reaffirms our unified commitment to the well-being, growth, and resilience of junior doctors, recognizing their critical role as the backbone of healthcare systems. Grounded in the principles of equity, dignity, and empowerment, this Declaration aims to create supportive environments that safeguard the mental and emotional health of junior doctors, foster personal and professional development, and build their leadership capacity.

With this Declaration, we call upon Governments, Health Institutions, and Professional Bodies across the Commonwealth to prioritize initiatives that address workplace violence, foster healthy workenvironments, and expand career and training opportunities within and beyond borders. We also advocate for strengthening mentorship, promoting research, supporting medical entrepreneurship, and building exchange programs to help junior doctors embrace family medicine, primary healthcare, and community-oriented practices. This collective commitment ensures a nurturing environment for junior doctors that will strengthen healthcare systems and enhance the well-being of communities across the Commonwealth.

RECOGNITION OF CHALLENGES

- Junior doctors frequently face workplace violence, which undermines their safety and well-being, affecting their capacity to provide effective patient care. A recent study in India shows that 80.4% of healthcare professionals experience verbal abuse and 21.7% experience physical violence(1).
- A recent study from the United Kingdom shows that Junior doctors reported poor mental health, with many severely depressed (45.2%), anxious (63.2%) and stressed (40.2%)(2). Junior doctors face unique mental health stressors, with depression, anxiety, and suicide rateshigher than in the general population, necessitating proactive support systems.
- A recent letter by the Maharashtra State Association of Resident Doctors to the Governor of Maharashtra highlights that 11 Postgraduate residents have committed suicide in the last 5 years and the residents are forced to work for up to 120 hours a week(3). The letter has also added about how the culture of mental abuse of junior doctors is glorified and how residents are threatened to be failed in examinations by seniors. Toxic work environments and unrealistic expectations contribute significantly to burnout among junior doctors, leading to high dropout rate rates and mental health issues.
- The limited awareness of available job opportunities, both domestically and internationally, creates uncertainty for junior doctors, affecting their motivation and overall career satisfaction.
- Limited support for medical entrepreneurship restricts junior doctors' potential to innovate and contribute to healthcare solutions. Entrepreneurial skills are critical for young doctors to pioneer new practices and technologies in healthcare.
- Despite their eagerness, junior doctors often lack access to research opportunities and mentorship(4), hampering their contributions to medical advancements and evidence-based practice.
- Limited opportunities for exchange programs and global exposure hinder the professional development of junior doctors, affecting their ability to learn from diverse healthcare systems and practices. Therefore, promoting international exchange programs becomes crucial(5).
- Many junior doctors lack orientation towards primary healthcare and family medicine due to training gaps, although these fields are essential for strengthening healthcare systems(6).
- Junior doctors are often underprepared for leadership roles due to inadequate training in leadership, despite their potential to become future leaders in healthcare policy and clinical practice(7).
- The demanding nature of medical training makes it challenging for junior doctors to maintain a healthy work-life balance, increasing the risk of burnout and reducing overall job satisfaction(8).

COMMITMENTS

1. We commit to advocating for policies and legal protections that prioritize the safety and wellbeing of junior doctors, including measures to prevent workplace violence, with mechanisms for reporting abuse and protecting whistleblowers.
2. We pledge to work towards establishing comprehensive mental health support systems for junior doctors, including access to counseling services, peer support networks, and mental health resources aimed at reducing rates of anxiety, depression, and suicide.
3. We commit to advocating for respectful, inclusive, and non-toxic work environments by promoting zero-tolerance policies for harassment, mental abuse, and other forms of

workplace toxicity. We also advocate for fair-workloads and realistic expectations to support junior doctors' well-being.

4. We pledge to support and promote policies that limit the working hours of junior doctors to ensure a balance that safeguards their health and well-being, with a particular focus on preventing burnout and fatigue.

5. We are committed to raising awareness about career opportunities for junior doctors within and outside their home countries through initiatives like job fairs, career counseling, and information networks to enhance their career satisfaction and stability.

6. We commit to fostering an environment that encourages medical entrepreneurship among junior doctors by offering training and mentorship opportunities, along with resources to help them develop innovative healthcare solutions.

7. We pledge to promote increased access to research opportunities for junior doctors, supporting their involvement in academic research, evidence-based practice, and clinical innovation, through partnerships with research institutions and mentoring programs.

8. We commit to promoting international exchange programs that provide junior doctors with global exposure, allowing them to learn from diverse healthcare systems, share best practices, and broaden their professional networks.

9. We pledge to emphasize the importance of primary healthcare and family medicine in junior doctor training programs, highlighting these fields as fundamental for building resilient healthcare systems and improving community health.

10. We are committed to incorporating leadership training into junior doctors' education, ensuring they are equipped to lead healthcare teams, advocate for policy change, and contribute to public health initiatives.

11. We pledge to promote junior doctors' involvement in healthcare policy discussions, advocating for their inclusion in decision making processes to bring fresh perspectives to pressing healthcare issues.

12. We commit to promoting innovative and flexible working conditions that accommodate junior doctors' personal and professional needs, ensuring a productive and supportive environment that values their contributions and well-being.

CALL TO ACTION

1. Each National Medical Association(NMA) to form a Standing Committee for Junior Doctors within one month, ensuring adequate gender representation.

2. Within 90 days, each NMA should establish a task force to address junior doctors' safety concerns and prepare formal representations to their respective governments. These representations should advocate for policy changes on critical issues such as workplace violence prevention, humane working hours, mental health support, and the mitigation of toxic work environments, fostering continuous liaison with government bodies to ensure lasting improvements.

3. Within 3 months, NMAs should organize national and regional career counseling sessions to promote awareness of domestic and international job opportunities, increasing junior doctors' career stability.

4. NMAs are called upon to introduce orientation programs within 3 months, guiding junior doctors toward careers in primary healthcare and family medicine to strengthen community health services.

5. Within 6 months, each NMA should create a committee to support medical entrepreneurship, providing junior doctors with resources, workshops, and mentorship for innovative healthcare solutions.

6. NMAs should establish mentorship programs within 6 months, connecting junior doctors with experienced healthcare professionals to foster career development and research participation. NMAs should allocate or advocate for dedicated research funds that allow junior doctors to participate in and lead medical research.

7. Within 9 months, NMAs should collaborate to establish or expand exchange programs, allowing junior doctors to gain international exposure, share best practices, and enhance their professional competencies.

8. Within 9 months, NMAs should ensure that leadership training is incorporated into junior doctors' curriculum, preparing them for roles in healthcare management, policy, and public health.
9. Allocate at least one session for Junior Doctors' wellness-related topics in the upcoming National Annual Conference of each National Medical Association and continue this annually.
10. Encourage the National Medical Associations to promote the publication of at least one Junior Doctors' wellness-related article per issue in the respective National Medical Journals.
11. Leaders of Junior Doctors' Network across Commonwealth countries to convene biannually - to review the progress and strategize future actions.

CONCLUSION

In affirming this Commonwealth Declaration for Empowerment of Junior Doctors, we, the National Medical Associations and representatives of Junior Doctors across the Commonwealth, commit to advancing the well-being, safety, and empowerment of junior doctors, recognizing their vital role in healthcare and the unique challenges they face.

This Declaration pledges to create supportive environments that prioritize mental health, safeguard against workplace violence, and expand career growth and leadership opportunities. By uniting governments, healthcare institutions, and professional bodies in this mission, we will advocate for fair work conditions, promote mentorship, encourage medical entrepreneurship, and strengthen pathways in primary healthcare. Through this collective effort, we aim to transform challenges into opportunities, ensuring junior doctors can thrive, innovate, and lead in providing quality healthcare, thereby enhancing healthcare systems and community well-being across the Commonwealth.

RECOMMENDATION

Ensuring the well-being and professional development of junior doctors is crucial for sustaining resilient healthcare systems across the Commonwealth. Addressing workplace violence, mental health challenges, and career uncertainties will not only enhance the safety and productivity of junior doctors but also improve patient care outcomes. By fostering mentorship, research, and leadership training, this declaration aims to create a supportive ecosystem where junior doctors can thrive, ultimately strengthening primary healthcare and advancing global health equity.

RELEVANCE OF THE STUDY

This declaration highlights the pressing challenges faced by junior doctors across Commonwealth nations and proposes a structured framework for their well-being, professional development, and career advancement. By addressing critical issues, this declaration adds to the existing knowledge by offering a collective policy response from National Medical Associations. It underscores the necessity of systemic reforms, mentorship programs, and international collaborations to create a supportive environment for junior doctors. The Commonwealth Declaration for Empowerment of Junior Doctors serves as a roadmap for policymakers, healthcare institutions, and professional organizations to implement sustainable changes that will enhance the resilience, safety, and career satisfaction of junior doctors, ultimately strengthening healthcare systems across the Commonwealth.

AUTHORS CONTRIBUTION

All authors have contributed equally.

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Nil

CONFLICT OF INTEREST

There are no conflicts of interest.

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Dr. Marie-Claire Wangari, Immediate Past Chair – Junior Doctors' Network, World Medical Association), Dr Jeazul Ponce (Spain), Dr Adeel Riaz (Pakistan), Dr Garima (Secretary, Young Doctors' Forum, Commonwealth Medical Association), Dr. Omprakash Bera (Regional Advisor – Global Health Advocacy Incubator), Dr Saumyaa (Publications Team, Junior Doctors' Network – World Medical Association), Dr Chinnusaara Varugehse (Hedal Health Data Lab), and Dr Krupal Joshi (All India Institute of Medical Sciences - Rajkot).

AUTHORS CONTRIBUTIONDECLARATION OF GENERATIVE AI AND AI ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the authors used ChatGPT for language assistance in drafting the Commonwealth Declaration. The declaration was developed through the consensus of Commonwealth Medical Association leaders, and ChatGPT was utilized to refine the language, enhance clarity, and ensure coherence in the document. After using this tool, the authors reviewed and edited the content as needed and takes full responsibility for the content of the publication.

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CONCEPT NOTE :

Scientific Webinar on Advancements in TB Care

An international professional development and leadership summit for medical practitioners on care of people with tuberculosis

Organized by the Private Sector Provider (PSP) Constituency of the Stop TB Partnership and supported by the Commonwealth Medical Association (CMA) and Confederation of Medical Associations of Asia and Oceana (CMAAO)

Sunday, April 27, 2025

Time: 9am GMT / 11am CEST / 14:30 IST

Background

With 10.8 million people reported to having the disease and 1.25 million estimated to have died of it in 2023, tuberculosis (TB) has re-emerged as the top killer among infectious diseases, globally. The vast majority, 87 percent of the global TB burden, is borne by people living in 30 high-burden countries. Undernutrition, HIV infection, alcohol use, smoking, and diabetes are some of the key drivers of TB. Tackling these and other critical determinants like poverty, requires actions involving partnerships between governments and multiple other sectors.

There have been many technological and process innovations made available over the past decade. These, along with scientific evidences, have improved our understanding of TB and made the fight against this preventable and treatable disease more effective. However, serious funding, operational, and social challenges remain, preventing many people from accessing proper TB care. Global funding for TB has generally been disproportionately low. This decreased further in 2023, with only USD 5.7 billion (26%) of the desired USD 22 billion becoming available, and where low and middle-income countries with 98 percent of the TB burden, were particularly. While funding gaps for 2025 may not be accurately predicted, recent conflicts and political changes create challenges that adversely impact the fight to end TB, and possibly even undermine decades of good work.

Private health care providers play an important role in providing early, quality, and affordable TB care. They also need to play a greater role in partnering with national TB programs through the sharing of resources and expertise. Substantial co-existence of public and private health care delivery sets the stage for collaboration on TB elimination. Private Sector providers improve access and availability of quality health care and in many countries, a large proportion of people with symptoms of TB, including the poor, seek care first at private clinics and hospitals. It is in the interest of private health care providers to ensure that they provide to their clients the benefits of progress in science by ensuring that they and their clients have access to modern diagnostics and drug regimen for TB. In case modern tools for TB diagnosis, treatment and prevention are not available in their geographical area of practice they have a role in reaching out to the government authorities demanding and advocating for access.

The Kochi Declaration

A first of its kind International Leadership Summit of Medical Associations on Achieving UNHLM Targets to End Tuberculosis was held on June 1 & 2, 2024, in Kochi, India. The summit, hosted by the Indian Medical Association (IMA) and co-hosted by the Kerala State Branch of IMA, was organized by the PSP Constituency of the Stop TB Partnership Board in collaboration with IMA and CMA. It was attended by representatives of national medical associations from 11 countries (Bangladesh, Ghana, India, Indonesia, Jamaica, Kenya, Nigeria, The Philippines, Tanzania (UR), Uganda, and Zambia) and of the CMA.

Representatives of all the associations present in Kochi reaffirmed, through the signing of the Kochi Declaration, 2024, their commitment to end TB globally by 2030 and support efforts of governments and other stakeholders to achieve the UNHLM 2023 targets for TB.

Participation

The webinar is meant for all doctors interested in care of people with tuberculosis. Doctors providing health care to people with TB, professional influencers in the medical community, and those who are potential or incumbent leaders of national medical associations linked to CMA or CMAAO are particularly encouraged to attend. The geographical reach of the webinar covers participants from a wide range of countries, with a

focus on those from high TB burden countries in Africa and Asia.

TB diagnosis, treatment, prevention and programmatic coordination have gone through dramatic changes in the last few years. For example:

- ►Chest X-rays are now done by ultraportable, low radiation, point of care machines and read by AI in a few seconds
- ►Rapid molecular tests are the mainstay of TB and drug-resistant TB diagnosis
- ►Drug-resistant TB treatment is shortened from 18 months to just 6 months and simplified, no longer requiring specialized and complex medical care
- ►TB preventive treatment is shortened from 180 doses to just 12 doses
- ►In many countries medical practitioners in the private sector can work very closely and without bureaucracy with public sector TB programs, to ensure that their clients get the best possible care without catastrophic out-of-pocket costs.

This webinar will equip private medical practitioners with the knowledge to benefit from these advances and also be part of a wider constituency of professionals practicing in different settings across many countries.

Objective

The purpose of this webinar is to raise the relevance and impact of private health care services through information about advancements in TB care and to build the capacity of members of national medical associations to hold meaningful dialogues with their respective governments and as effective partners in national efforts to end TB.

The 2025 theme for World TB Day is, ***"Yes! We Can End TB: Commit, Invest, Deliver".*** This webinar proposes to promote the understanding that ending TB requires a united and concerted global effort, with the medical profession represented through national medical associations playing a leading role in efforts to achieve this goal, along with governments and TB-affected communities.

The overarching objective of the webinar is to strengthen private medical care providers' understanding of TB care, resulting in improved commitment and action towards ending TB. Its specific objectives are to:

1. Update doctors on recent developments in management of TB, sharing information of academic and scientific value on TB diagnosis, treatment and prevention, thereby strengthening global best practices in TB care;
2. Secure ownership and commitment to ending TB among private health care providers through increased participation in TB elimination efforts, including taking on leadership roles in the Stop TB Partnership's Private Sector Provider Constituency.

Activity

The Leadership Summit is hosted by the PSP Constituency of the Stop TB Partnership and supported by the CMA and CMAAO. It consists of a 3-hour Continuing Medical Education session, held as a webinar on Sunday, April 27, 2025, starting at 10am (Central European Summer Time/CEST).

The webinar will be graced by Dr Teodoro Javier Herbosa, Honorable Secretary of the Department of Health, Government of The Philippines, and Chair, Stop TB Partnership, who will give the keynote address.

The agenda for the summit includes technical sessions ranging from screening, diagnosis, treatment, and prevention of TB, public health aspects of TB care from the point of view of private doctors, and mitigation of social challenges affecting people affected by TB.

FORMATION OF SUBCOMMITTEE CLIMATE CHANGE MITIGATION

The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and influence the climate change mitigation initiative in health care delivery. This subcommittee will focus on developing strategies that promote sustainable practices within health systems, as well as collaborating with various stakeholders to raise awareness about the critical intersection of health care and environmental sustainability. Its efforts aim to ensure that health care delivery not only addresses immediate health needs but also contributes to a healthier planet for future generations.

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The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and influence the CMA AMR initiative. This subcommittee will focus on developing strategies to combat antimicrobial resistance through collaboration with member countries and health organizations. By fostering innovative research and sharing best practices, the CMA aims to enhance global health outcomes and ensure effective treatment options for future generations.

FORMATION OF SUB COMMITTEE GENDER EQUALITY

The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and promote GENDER EQUALITY to benefit the medical fraternity and the community across the Commonwealth. This subcommittee will develop strategies that promote gender equality in all the administrative structures, policies, and advocacy of CMA. Additionally, the subcommittee will collaborate with various stakeholders and national medical associations to adopt gender equality in access to health care and the built environment and protect them from social stigma and discrimination. By fostering an inclusive atmosphere, the subcommittee aims to ensure that diverse voices are represented and heard within the medical field. This initiative will ultimately contribute to more equitable health outcomes and a more supportive environment for all healthcare professionals and patients alike aims to ensure that diverse voices are represented and heard within the medical field. This initiative will ultimately contribute to more equitable health outcomes and a more supportive environment for all healthcare professionals and patients alike.

Position	Name /Country	Contact Details
Chairman	Dr.Mary Coleman Ghana	+233 24 462 3553 menba19@yahoo.com
Co Chairman	Dr.Simone Mc Fee President ,Trinidad Tobago	8687325847 dr.smcfee@gmail.com
Convenor	Dr. Merlinda Shazellenne	+60194187822 dr.merlinda@gmail.com
Members	Dr.Pollyanna Howell-Chang, Jamaica	876-326-5305 pollyanna.howell.chang@gmail.com
	Dr. Trupti Bodhare India	9052408271 drtruptib@gmail.com
	Dr. Garima Garg India	9356025970 garimagarg2806@gmail.com
	Dr.Anandhi PG India	+9786445511 Pganandhi1974@gmail.com
	Dr.Susan Anku Ghana	sussieanku@yahoo.com
	Prof Dr Kumudha Lingaraj	9884658240 Kumudhalingaraj10@gmail.com
	Dr. Jacqueline Anita Sowah Ghana	jaydaytona@yahoo.com
	Dr. Simon Kigondu Kenya	simonkigondu@gmail.com
	Dr. Ayda L. Wanjiku Kenya	aydawanjiku@gmail.com
	Dr. Kanageswary Vengadasalam, Malaysia	+60166637984 Kana9966@gmail.com

FORMATION OF SUBCOMMITTE CMA EDUCATIONAL COURSES AND PROFESSIONAL DEVELOPMENT INITIATIVE

Position	Name /Country	Contact Details
Chairman	Prof .Dr.S.Arulrhaj Past President CMA, India	+91 9994580001 drarulrhaj@gmail.com
Co Chairman	Prof.Dr.Gordon Vice President CMA Malta	+356 79591565 gordoncaruanadingli@gmail.com
Convenor	Dr.T.N.Ravisankar India	+9444047724 tnravisankar@gmail.com
Members	Dr. Narendra Nath Jena India	+91-9944384994. drnaren11@gmail.com
	Dr.StaceyChamely Trinidad Tobago	+1(868)6858254 schamely@gmail.com
	Dr.Marvin Reid Jamaica	+1 8763812939 marvinreid64m@gmail.com
	Dr Mukesh Bhatia India	+917290048754 dr.bhatia@dbmi.edu.in
	Dr.Alaguvenkatesan India	9787728505. dravimatn@gmail.com
	Dr.Duane Muruga Raj Malaysia	+60167117984 duaneraj.jr2@gmail.com
	Dr.Mary Ansong Ghana	maryansong@isccghana.org
	Dr. Marion Diana Kenya	mariondoc2023@outlook.com
	Dr. Christine Mutonyi Kenya	drmutonyi@gmail.com
Technical Partner	Mr.M.N.Rao Medisys	+91 9949999744 Mn.rao@medrcedutech.com

The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and promote the CMA Educational Courses and Professional Development initiative to benefit the medical fraternity and young medicos across the Commonwealth. This subcommittee will develop strategies that promote the short-term structured courses offered through our educational partner Medisys and other CMA platforms. Additionally, the subcommittee will collaborate with various stakeholders to ensure that these courses meet the evolving needs of healthcare professionals. By fostering a culture of continuous learning, we aim to enhance the skills and knowledge of practitioners, ultimately improving patient care across the Commonwealth.

FORMATION OF SUBCOMMITTEE STOP TB INITIATIVE

The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and influence the STOP TB initiative. Two-thirds of the world's tuberculosis patients live in the Commonwealth area. Because of this, CMA executives make it a priority to use government and National Medical Association resources to create plans to protect and prevent vulnerable groups. I request that the Chairman and Convenor organize a Zoom meeting with all members to formulate a roadmap for this broader mission. Please make sure to notify all executive members about the Zoom meeting, as their support is crucial. CMA is dedicated to enhancing our collaboration with all affiliated organizations to empower one another. We must consolidate our efforts to confront these difficulties directly for the benefit of our community. Collectively, we can attain significant advancements and protect the welfare of those in need.

Position	Name /Country	Contact Details
Chairman	Dr.R.V.Asokan India	+91 9847061563 rvasokan@gmail.com
Co Chairman	Dr. MurugaRaj Malaysia	+60 167411208 mraJ231267@gmail.com
Convenor	Dr. Mary Coleman Ghana	+233 244623553 menba19@gmail.com
Members	Dr. Herbert Luswata Uganda	+256782343789 luswataherbert@gmail.com
	Dr.Kaumba Manyoni Tolopu, Zimbave	+260 97 4814088 kaumbatolopu@gmail.com
	Dr.Terry Baker Jamaica	(876) 403-7454 dr.tbaker@gmail.com
	Dr.DeasdeditNilanda Tanzania	+255 713 233075 ngoshaI@yahoo.com
	Dr ThirunavukarasuRajoo Malaysia	+60193926475 drarasu27@gmail.com
	Dr Parul Vadagama India	+91 8460348932 drparulvadgama1980@gmail.com
	Dr P S Sarma India	9440118712 drpappuss@gmail.com
	Dr.Zainab AL-Hassan Ghana	Zee0391@gmail.com
	Dr. Barasa Nekesa Kenya	neimahbarasa@gmail.com
	Dr. Linda Ombito Kenya	ombitolinda@gmail.com
	Dr.Nilanthi Senanayake Director for center for TB Srilanka	nilanthi@micro.cmb.ac.lk

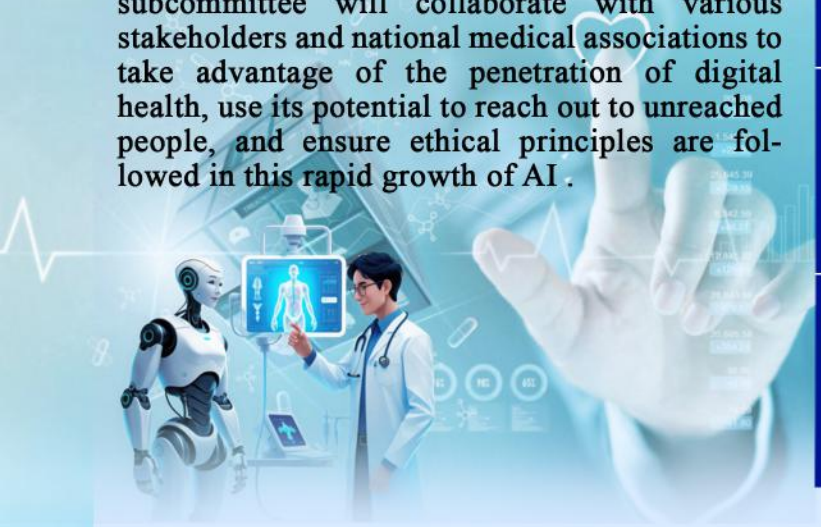
FORMATION OF SUBCOMMITTEE - YOUTH EMPOWERMENT INITIATIVE

The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and influence the Youth Empowerment Initiative. This initiative aims to provide young individuals with the necessary resources, skills, and support to take charge of their health and well-being. By fostering collaboration among health professionals, educators, and community leaders, the subcommittee seeks to create impactful programs that inspire and engage youth in proactive health practices.

Position	Name /Country	Contact Details
Chairman	Dr. Herbert Luswata Uganda	+256782343789 luswataherbert@gmail.com
Co Chairman	Dr.J.P. Tabone Malta	+35679252671 jptabone@gmail.com
Convenor	Dr.K.M. Abul Hasan India	+91 9443320505 drkmabulhasan@yahoo.com
Members	Dr. Venkatesh Karthikeyan India	+91 9578760376 4852012@gmail.com
	Dr.Dorothy Nigeria	+234 8033037796 dorryosahon12@gmail.com
	Dr.Nicolai Nunes Trinidad Tobago	+18687983268 nikolainunes@gmail.com
	Dr.Deasdeditnilanda Tanzania	+255 713 233075 ngoshal@yahoo.com
	Dr.Saurabh Varshney India	+91 8475000273 drsaurabh68@gmail.com
	Dr. K. Thirumavalavan India	+91 9443043452. drktvalavan@gmail.com
	Dr. Kannan Rajendran India	+91 9442577394. gothy75@hotmail.com
	Dr.Kristen Little Jamaica	(876) 520 5594 Kristenlittle13@hotmail.com
Wma Representative	Dr.Shiv Joshi	+91 9975155699 Drshivjoshi93@gmail.com
Cma Chair Young Doctors Forum	Dr.Merlindashazellenne Malaysia	+60 19 418 7822 dr.merlinda@gmail.com

FORMATION OF SUBCOMMITTEE - AI AND DIGITAL HEALTH

The Commonwealth Medical Association is pleased to establish a subcommittee to advance, advocate for, and promote **AI and digital health** to benefit the medical fraternity and the community across the Commonwealth. This sub-committee will develop strategies that promote basic knowledge on AI and empower our fraternity to adopt digital health. Additionally, the subcommittee will collaborate with various stakeholders and national medical associations to take advantage of the penetration of digital health, use its potential to reach out to unreached people, and ensure ethical principles are followed in this rapid growth of AI .



Position	Name /Country	Contact Details
Chairman	Prof.Dr.Vajira Dissanayake	+94777351835 Vajira@Anat.Cmb.Ac.Lk
Co Chairman	Dr.Vasu Pillai Secretary Malaysia Medical Association Vice President Cma	+60134373120 Secretary@Mma.Org.My
Convenor	DR. Prabhu Kumar Challagali India Dr.Karthick Prabhu	+91 9488338902 Doctorcaresu@Gmail.Com +91 9443256147 Karthickprabhunhb@Gmail.Com
Members	Dr. Hariharan India Dr.GuminduKulatunga	+91 9840246576 Drharan@Gmail.Com +94 77 2336353 SrilankaGumindu@Gmail.Com

SPECIAL MEMBERSHIP & FELLOWSHIP

FELLOW OF COMMONWEALTH MEDICAL ASSOCIATION (FCMA)

- Doctors with Membership in own National Medical Association for 10 years and of good standing.
- Associate Membership status as observers without voting rights in all CMA meetings.
- Will receive Electronic Communication and Publications.

▶ Fellowship fee 250 GBP

MEMBER OF COMMONWEALTH MEDICAL ASSOCIATION (MCMA)

- Membership in National Medical Association for 5 years.
- Associate Membership status as observers without voting rights in all CMA meetings.
- Will receive Electronic Communiction and Publications.
- Access to CMA Educational courses.

▶ Membership fee 100 GBP

CMA MEDICAL STUDENT FORUM

- Open to all Medical Students.
- Apply with a bonafide Certificate and get the opportunity for International Collaboration, exchange programme of Fellowships of Commonwealth.
- Access to CMA Educational courses.

▶ Membership fee 10 GBP

CMA YOUNG DOCTORS FORUM

- Doctors who have been registered with their Medical Councils for less than 10 years.
- May attend general meetings of the Association without any voting rights except for meetings of the Young Doctors' Forum.

▶ Membership fee 15 GBP

Fellowship in Cardio Diabetes Medicine

medisys

If you are interested in learning more about cardio diabetes, it's a good idea to take our course. We can provide you with personalized guidance and information tailored to your needs.

Prof. Dr. S. Arulrhaj

Click here to buy the Course

Course Outline

- Epidemiology
- Clinical presentation of the disorder
- Investigations
- Invasive procedures
- Therapeutic options
- Prevention of cardio diabetes
- Assessments

Eligibility:

Healthcare professionals in Primary Care, General Practitioners, PG Students, Interns, Specialists in Cardiology, Diabetes and Internal Medicine.

Course Duration: Six months

Course Offered & Certification By: Indo Global Cardio Diabetes Academy - IGCDA

Instruction Methodology: Designed for self-directed learning

Pricing: $350 or INR 28,000 + applicable taxes (18% in India)

Timeline: The Course is available online

Launch Offer for limited period INR 24,000

Academic Partner: Medisys Edutech Pvt Ltd, Hyderabad | **www.commonwealthmedicalassociation.org**

FELLOWSHIP IN EMERGENCY CARE

Certification & Convocation

- Successful candidates receive the FEC Certification, awarded at the British Medical Association (BMA) Headquarters, London.

Course Fees

Total Fee : **£ 1500** (for foreign Students)
₹ 1.60 Lakh INR (for Indian Students)

- (Inclusive of registration, tuition, simulation lab, materials, certification)
- Payment via Bank Transfer, Credit/Debit Card, Online Platforms, or Sponsorship.

About the Course

The Fellowship in Emergency Care (FEC) is a comprehensive, 12-month training program designed to enhance the skills of healthcare professionals in managing acute and life-threatening medical conditions. Accredited by the Commonwealth Medical Association (CMA), this fellowship equips participants with advanced knowledge and hands-on expertise in resuscitation, trauma care, critical decision-making, and interdisciplinary emergency management.

The curriculum integrates evidence-based learning, high-fidelity simulations, case-based discussions, and real-world clinical exposure across emergency departments, pediatric emergency units, and disaster response units. Participants engage in structured lectures, practical workshops, clinical rotations, and digital learning to refine their competencies.

Assessment includes Objective Structured Clinical Examinations (OSCEs), simulation-based evaluations, written exams, and a capstone research project. Successful candidates receive an internationally recognized FEC certification, awarded at a convocation ceremony at the British Medical Association (BMA) headquarters in London.

This fellowship is ideal for Emergency Physicians, Critical Care Physicians, and General Physicians providers committed to advancing their expertise and leadership in emergency care.

For more details and enrolment, visit Commonwealth Medical Association.

Prof. Dr. J.A. JAYALAL
President - CMA

Dr. MUGAMBI JOY. K
Secretary General - CMA

Dr. COLIN ABEL
Treasurer - CMA

Dr NARENDRA NATH JENA
President - TICEM

Dr S SENTHILKUMARAN
Hony. Secretary - TICEM

Commonwealth Medical Association (CMA)
British Medical Association Building, Tavistock Square, London WC1H 9JP, UK
Call: +44 207 383 6069 / +91 - 99443 84994 / + 91 94431 60026
E-mail: cmafeccourse@gmail.com
www.commonwealthmedicalassociation.org

For Registration Kindly fill the Google Form
SCAN QR

Registration Link

COMMONWEALTH MEDICAL ASSOCIATION

FELLOWSHIP IN EMERGENCY CARE (FEC)

Advance Your Expertise in Emergency Medicine

The Fellowship in Emergency Care (FEC) is a comprehensive, one-year training program tailored to empower healthcare professionals with advanced knowledge and practical skills in managing acute and life-threatening medical emergencies. Accredited by the **Commonwealth Medical Association (CMA)**, this internationally recognized program combines academic excellence with real-world clinical experience.

Designed for Emergency Physicians, Critical Care Specialists, and General Practitioners, the FEC equips participants with the expertise needed to respond effectively in high-pressure scenarios. The curriculum blends structured lectures, hands-on workshops, high-fidelity simulations, and supervised clinical rotations across emergency departments, pediatric emergency units, and disaster response teams. Learners also benefit from interactive case-based discussions and cutting-edge digital learning modules.

PROGRAM DETAILS

- **Duration**: 12 months
- **Eligibility**: MBBS or equivalent with 1–2 years of clinical experience
- **Teaching Methods**: Lectures, simulations, case-based learning, and digital modules
- **Assessments**: OSCEs, simulation exams, written tests, and faculty evaluations
- **Completion Requirements**: Minimum 85% attendance, passing all evaluations, and demonstrated skill competency

Why Choose FEC?

- **Expert Faculty** from India, the UK, Australia, and other countries
- **Global Certification** accredited by CMA
- **Hands-On Training** through simulations, workshops, and clinical postings
- **Interdisciplinary Approach** with peer discussions and feedback
- **Capstone Research Project** to build academic and clinical insight

Join the FEC Course and Become a Leader in Emergency Care!

Certification & Convocation

Graduates will receive the **FEC Certification** at a prestigious convocation **ceremony held at the British Medical Association (BMA) headquarters in London**, affirming their global standing in emergency care.

Take your emergency medicine career to the next level.

Prof. Dr. J.A. JAYALAL
President - CMA

Dr. MUGAMBI JOY. K
Secretary General - CMA

Dr. COLIN ABEL
Treasurer - CMA

Dr NARENDRA NATH JENA
President - TICEM

Dr S SENTHILKUMARAN
Hony. Secretary - TICEM

Commonwealth Medical Association (CMA)
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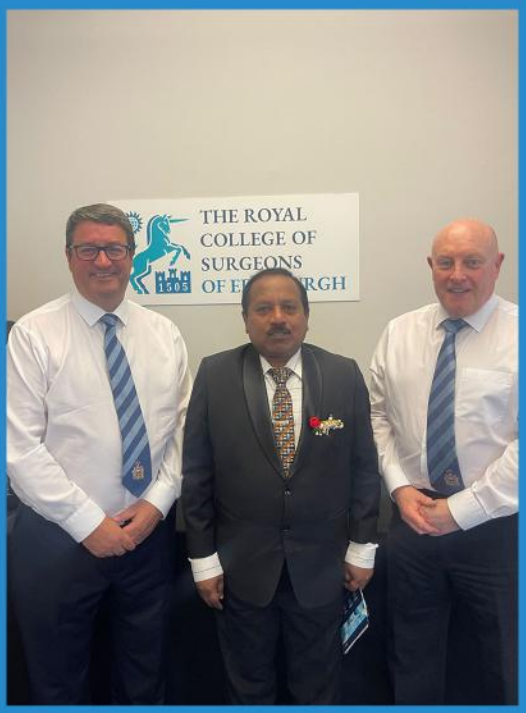
E-mail: cmafeccourse@gmail.com
www.commonwealthmedicalassociation.org

For Registration Kindly fill the Google Form
SCAN QR

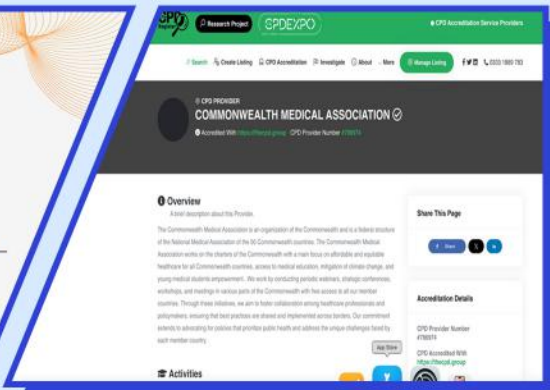
In association with
THE INDIAN COLLEGE OF EMERGENCY MEDICINE

CMA WITH ROYAL COLLEGE OF SURGEONS

As the CMA President , I had a fruitful meeting with Dr.Rowan Park the President Royal College of Surgeons Edinburgh, Dr.Tim Graham, the Vice President, Dr.Amanda International director on the possible collaboration of Royal college and CMA . It is decided to host combined webinar with combined. Certification , accreditation of courses , enhancing affiliated membership and combined CPD courses . The RCSEd will participate in the CMA Annual meet on July 15th.



CMA APPROVED FOR PROVIDING CPD POINTS



I am delighted to inform our Commonwealth Medical Association is now officially recognized by the THE CPD GROUP to provide CPD points after submitting all the requirements . In most of the countries this is accepted .I seek all our Vice presidents to promote CMA CPD Points to the scientific programs.

I am privileged to participate in the Indian Business Network annual award meet held in the British Parliament House and deliver the guest of honor address. The minister, Ms. Seema Malhotra; the mayor of East London; the member of parliament; and hundreds of business entrepreneurs participated. The Tamil celebrities from Tamil Nadu, Dr. Parveen, Dr. Suhi Sivam, and Mr. Mohanasundaram, were also present.

CMA Secretary General Dr. Mugambi Joy with Dr. Kaumba Tolopu, Vice President - Zambian Medical Association at Kenya MEdical Association Conference.

CMA Secretary General Dr. Mugambi Joy with Dr. Suvannd Sahu Deputy Director Stop TB Partnership - Geneva.

CMA
COMMONWEALTH MEDICAL ASSOCIATION

THE RISE UK

ANNUAL MEET / CONVOCATION

18th July 2025 Friday 09.00 am

Venue : Commonwealth Secretariat,
Pall Mall, ST James's, London, United Kingdom SW1Y 5HX

Host : CMA (Federation of 56 National Medical Associations affiliated to Commonwealth)

Co - Host - RISE UK / TDI

On behalf of CMA, The Commonwealth Secretariat and The Rise UK, we invite the member countries and the British Medical Association members to take part in the Annual Convention of the Commonwealth Medical Association to be held in London, on the Friday 18th July 2025.

July is an optimal summertime to visit the historic capital and rest of the United Kingdom. London is an international tourist attraction, buzzling multicultural city with iconic buildings, museums, to name a few, the shard, millennium dome, London eye, Westminster Abbey, Thames cruise, and the Europe's largest shopping mall.

Convention will be held at the Commonwealth Secretariat, St James's, Pall Mall London. The Commonwealth Medical Association convocation ceremony will be held as part of the conference, in the same venue and qualifying members are invited to participate in the convocation through prior registration.

The Commonwealth Medical Association warmly welcome you once again to be a part of this momentous event.

Prof. Dr. J.A. Jayalal
President, CMA

PROF. DR. J.A.JAYALAL
President

DR. MURUGA RAJ RAJATHURAI
Immediate Past President

DR. MUGAMBI JOY K.
Secretary General

DR. COLIN ABEL
Treasurer

REGISTRATION FEE :

- **CMA Executives - Registration for Conference FREE.**
- **CMA Associate Members (FCMA & MCMA) holder - 75 £**
- **Young Doctors - 50 £**
- **All others - 100 £**

Conference Registration is Mandatory to receive the Convocation

TRANSACTION DETAILS

ACCOUNT NUMBER : 61741004

Account Name:	Commonwealth Medical Association
Bank Name	: HSBC Bank
Bank Address	: 1 Woburn Place, Russell Square, London
Sort Code	: 40-06-07
IBAN	: Gb42 MIDL400 607 61741004
Swift Code	: MIDLGB21421E
IFSC	: HSBC UK

Agenda

FELLOWSHIP AND CMA MEMBER REGISTRATION FORM

First Name :
Middle Name :
Last Name :
Date of Birth :
Gender : Male Female Prefer not to Say
State your National Medical Association :
Are you in good standing with the Medical Regulatory Council in your country?
Year of Graduation :
Specialization :
Year of Graduation as Specialist :
Medical council Registration Number :
Membership Requested :

(Photo)

Individual Doctor associate membership (MCMA)	100 GBP
Individual Doctor Fellowship (FCMA)	250 GBP
Young Doctor's Forum	15 GBP
Student Membership	10 GBP

Medical Student

College :

Year of Study :

Address :

City :
State :
Country :
Zip/PIN :
Email :
Cell Phone :
Enclose CV : (Not more than 500 words)

Account Name	:	Commonwealth Medical Association
Account Number	:	61741004
Bank Name	:	HSBC Bank
Bank Address	:	1 Woburn Place, Russell Square, London
Sort Code	:	40-06-07
IBAN	:	Gb42 MIDL400 607 61741004
Swift Code	:	MIDLGB2142E
IFSC	:	HSBC UK

Send the filled-in application form to
The Secretary, CMA at lapsurgeon2001@gmail.com with copy of fee paid.
www.commonwealthmedicalassociation.org