

Diversity, inclusivity, and equity*

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Journal of the Ceylon College of Physicians, 2024, 55, 3-7

When I was young, I liked conformity. Conformity with my views, my ideas, and aspirations.

As long as, the rest of the world was aligned with my expectations, I was perfectly at peace with the world. However, the rest of the world was often unkind and reminded me that I cannot always expect conformity.

Gradually I began to realize that conformity was synonymous with monotony. Sri Lanka, our motherland we all live in, by choice or out of obligation, for what she has done to us, is never a monotony. We are colourful, we are bountiful in what we reap and what we rope in. We are the plains, and we are the majestic hills. We are the slow-moving streams, and we sometimes are the cascading waterfalls. We are the arid Mannars yet the rain soaked Watawalas at the same time. Just like its geography, as a nation, we are different, yet beautiful.

Our beauty is on our diversity, not in conformity. We are diverse in our ethnicity, language, religion, culture, sexual orientation, and so on.

However, the diversity that does not go hand in hand, with inclusivity and equity, makes life harder for the nonconformists. We see it every day, but do not feel it, as most of us are the privileged conformists.

Take a look at my ward round. My house officer presents the CASE in English. We discuss our CASE and after much deliberation decide on what to do. All in English. We discharge him after a couple of days, with a diagnosis card written in English. The only thing, in common language is the date and time in Indo-Arabic numerals for the clinic visit.

Our literacy in English is still twenty-three-point eight percent (23.8%) among the population above 10 years of age according to the Department of Census and Statistics Report on Population and Housing 2012.¹ I believe, I am a good person, a considerate human being. However, my behaviour says that I am not, considering our patients not even as subjects but mere objects. Imagine yourself in the patients' position.

You are there sick, not knowing what ails you, when you would go home, whether you are going to go home at all; the big boss comes and does their round in a strange language which only twenty-three-point eight percent 23.8% of the population understands. You must remember that the patient population in a government hospital is not a true representation of the Sri Lankan population and the English speakers among them are likely to be much less.

How do we include them in the equation and make our health service inclusive?

I, under no circumstances advocate, abandoning English as the medium to teach medicine, or use of Sinhala or Tamil in ward rounds. We need to train our doctors, to be able to communicate with the rest of the world and learn in a global language, but a few words to the person in the bed in their language explaining what we are going to do, will do wonders.

However, when my patient does not speak either English or Sinhala, but speaks only Tamil, the patient is a person at disadvantage. My splatter of Tamil will not allow me to explain coherently, in their native tongue.

The Tamil speakers of Sri Lanka are twenty eight percent (28%) of the total population. Only six point four (6.4%) of Sinhala people can speak Tamil whereas

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* Presidential address delivered at the Induction Ceremony on 19th January 2024 at Cinnamon Grand Hotel, Colombo.

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only thirty-two point eight (32.8%) of Tamil people can speak or understand Sinhala. The reason I do not feel ashamed is that I am not sensitized to the problem. We have not made our health service inclusive. Therefore, it is inequitable.

The Ministry of Health has tried its best to address this issue by making Tamil and Sinhala language speaking, mandatory for grade one promotion. However, what you learn, is quickly forgotten when not practiced. The situation is far from satisfactory.

The postgraduate students in medicine do an outstation appointment for about a month savouring the taste of medicine in the periphery. This is to sensitize them on the difficulties faced by the physician in periphery with meagre facilities doing a thankless job. Sometimes, the PG trainees who have gone to medical school in Colombo, done the internship at NHSL and doing the registrar-ship at NHSL can be critical of the management done in the periphery not knowing the ground realities.

I propose that we should have a similar program, for registrars to do an appointment in linguistically different location for six months. Sinhala speakers to Jaffna and Batticaloa and Tamil speakers to Colombo, Kandy, Galle etc. When dropped in at the deep end, they will inevitably learn to swim. They will be exposed not only to the language but the culture and customs of the other ethnic groups as well. This will make them better doctors. The representatives of the College, at the Board of Study in Medicine will take it up during future revisions of the prospectus.

If it is bad for the people speaking the minority languages, look at the plight of the differently abled. According to the census of 2012¹, we had almost one million persons (996,939) with difficulty with seeing, 389,077 persons with difficulty in hearing, 343,689 persons with difficulties with cognition and 180,833 persons with difficulties with communication. When a person stands before me with a physical disability, I see it. I acknowledge it. But communication difficulties are not so apparent to us. Therefore, they have no equitable accessibility to healthcare in most of the government or private healthcare facilities. What happens when we encounter a patient unable to communicate, due to any of these disabilities, we communicate with the person who speaks on their behalf, completely overlooking the person as if that person is a mere object.

This is not because, we are bad people. I for example do it unconsciously most of the time. We need to make that extra effort. We should be perceptive

enough to recognise the abilities and disabilities of individuals in an apparently homogeneous population.

The Ministry of Health and the National Medicines Regulatory Authority (NMRA) have done a brilliant job in making it mandatory that medication labels are in all three languages. I propose that we go the extra mile and enact that, Braille letters should be there in medication boxes and labels as in other countries. This is a difficult start but in the long run should be sustainable. This will reduce medication errors and make our health service more inclusive and equitable.

Digressing a little from the subject, though the patients have the right to know what they take on doctors' orders we still see unlabelled drugs being dispensed by some medical practitioners. Perhaps they may not be aware of the inherent problem there. We urge the Ministry of Health to take lead in stopping this unethical practice.

We have a culture which boasts that we treat women with dignity. We have individuals who get in to fights when they hear a slur on a female friend or a family member. Yet, women in this country are not safe on the roads. With our so-called culture of 2500 years, we have not been able to provide the same safety, which men in the country feel after darkness. Similarly, we have failed to provide them with equitable healthcare. The hospitals do not provide them with adequate privacy. Most of the time the wards are open with no screens to preserve modesty. Sometimes wards are manned by men in different categories of staff, and a person first time in a ward feels overwhelmed.

There was this woman whose ECG had to be taken. The female ECG technician came with a male helper who connected the ECG leads while the woman was bare chested. I am sure that the very same healthcare worker would have taken offence if this happened to his wife or daughter. The female ECG technician was not sensitive enough to prevent the discomfort. We are sensitive when it happens to US but when the same happens to THEM, we shut our eyes and our minds. We have fifty-one-point five percent (51.5%) of our population as women. We have elected the first woman prime minister of world. Yet, our women do not get equitable care.

How does our culture affect our access to health? Certain beliefs of the communities hinder their access and acceptance of healthcare.

For example, false beliefs of vaccines causing infertility have hampered the country's efforts in com-

bating vaccine preventable communicable diseases. We should engage more with such communities and their leaders to combat those beliefs. Similarly, a healthcare worker may not be sensitive to the cultural taboos, and sensitivities like not exposing in front of males, in certain cultures, and it leads to awkward situations. This cultural phenomenon makes them a disadvantaged group especially when female doctors are not available in certain localities and specialities. Unless we take proactive measures to make them comfortable, they are excluded from the equitable healthcare.

Cultural sensitivity is a key factor in provision of healthcare in the west where there are migrant communities. If we are to be inclusive and equitable in our care, the health force in the country should be made more culturally sensitive to at least our own population. Inequity is there in front of our own eyes yet we do not see it.

Being away from the majority religion is another disadvantage our patient has. In the time of adversity, the patient and the family try to obtain some relief psychologically and spiritually by turning to religion. We have temples, buddha statues and Bo trees in almost all the hospitals. In Hindu majority areas there are Kovils. In some hospitals there are Christian churches. In few of them some prayer rooms. However, the unfortunate patient who is in the minority in such a locality is not thought of. We are not sensitive to the diversity of religion in the populace.

We have another group who face difficulties with obtaining healthcare due to their sexuality or gender identity. The LGBTIQ community.

Equal Ground in 2021² in its report on mapping LGBTIQ individuals in Sri Lanka states, only 88% of Sri Lankan population were non-LGBTIQ. It is stated that 8% were bisexual, 1% transgender, 0.5% were gay, 0.5% lesbian and 2% were others. We have a mammoth 12% LGBTIQ population in the country against whom the majority discriminates.

As France elects its first openly gay prime minister, a report on human rights violations faced by LGBTIQ community in Sri Lanka from August 2021 to March 2023, issued by Bridge to equality³ states the following alarming facts. According to the analysis, those responsible for the reported human rights violations included police officers (40.85%) and medical sector workers (26.81%). It is indeed deeply disconcerting that human rights violations against LGBTIQ community committed by medical sector workers

constituted almost 27% of total violations. Alas, the supposed protectors have turned to be the perpetrators.

We are signatory to numerous human rights conventions. The society is very conscious about human rights and are ready to fight when theirs are violated. However, the Sri Lankan polity does not recognize LGBTIQ individuals as human – and consequently denies them their rights. When late minister Mangala Samaraweera voted in favour of gay rights at the United Nations in 2015, being the only South Asian country to do so, several politicians claimed that he should be arrested (for violating) the Penal Code of Sri Lanka. Issues relating to the LGBTIQ communities are not freely discussed because of so-called cultural taboos. But they openly discriminate against this community by virtue of tradition.

In terms of historical, social, cultural, religious, political, and legal settings, they consider the LGBTIQ concept to be unacceptable. This hostility pervades through the society, starting from the family through to all the institutions, political, religious, educational and security and so on. This is seen in the use of derogatory words used to refer to LGBTIQ individuals such as “ponnaya” to transgender people, “aappa” to lesbians and “butterfly” to gays. There have been times where political leaders used these terms in rallies to improve their lot, receiving cheers from their crowds in response.

However, homosexuality, androgyny and all different forms of gender identities and sexual orientations have been a part of human culture from ancient times. From ancient Egypt, Rome, Greece to the Americas, and then Asian civilisations including Japan, India, and China.

Similarly, there are insinuations about King Kumaradasa's intimate relationship with the male poet Kalidasa contained in Mahawansa and in folklore without any criticism. Sri Lanka, during the pre-colonial era, was a relatively sexually accepting and tolerant society. So, this is not about an 'LGBTIQ issue' we have inherited from the “west”. What we now call “our tradition” and ‘the cultural purity of 2500 years’ was imposed by the British in the colonial era. We continue to be as puritanical as the medieval puritans who imposed and propagated heteronormative values to the rest of the world, and the Victorian era British who imposed their values in the form of legislation on us, whilst their descendants have evolved into what we were before.

While Diagnostic and Statistical Manual (DSM) does not consider homosexuality as a mental illness,

many Sri Lankan parents take their LGBTIQ children for psychiatric treatment. That is because they believe those children are ill, that they would destroy their family values, morals, and culture and bring disgrace to them.

Moreover, LGBTIQ individuals are often forced into straight marriages, despite their true sexual orientation and romantic feelings, destroying the lives of two individuals, simply because heterosexuality, masculinity, and femininity are the only concepts that the so-called 'Sri Lankan culture' accepts.

Even by 2013, according to a survey by Priya Thangarajah, a well-known queer feminist, there was a lack of LGBTIQ friendly psychiatrists and psychologists in Sri Lanka. 97% LGBTIQ people did not like to have support from psychiatrist or psychologist to come out from violence faced. 80% were afraid of negative reactions by the doctors and 12% have experienced such reactions and a lack of understanding from doctors. Even as late as in November 2021 a so-called psychologist at a police officers' training, maintained that LGBTIQ is an unnatural and psychiatric issue.

The situation has changed during last few years under the leadership of the Sri Lanka College of Psychiatrists and now a person can expect to see a psychiatrist, with no prejudice against non-hetero-normative orientations and genders. With the insistence of the College, a circular was passed to issue Gender Recognition Certificates to transgender people in 2016 by the Sri Lankan government. This allowed them to change their gender on birth certificates, national identity cards and passports. We salute the Sri Lanka College of Psychiatrists for the bravery shown and continuation of their good work. And we are fully committed to improve the quality of care the LGBTIQ community receives in healthcare institutions.

We understand that the prejudices someone carries on, from their childhood cannot be changed overnight. This will need patience, and at the same time perseverance on the part of those who try to change the system. There will be dialogue initiated among healthcare workers and we seek the good offices of the Ministry of Health to help us in this regard. As a professional medical organization, we will start among our members, then medical officers, and medical students. We will further go in to our co-workers, nursing professionals and other categories of health staff.

We see a small light at the end of the political tunnel as well. Hon Premanath C. Dolawatte MP

submitted a Private Members Bill to Parliament on the 23rd of August 2022 aiming to repeal the Archaic colonial-era law, banning homosexual sex. Although the constitutionality of this was challenged before the Supreme Court through a Special Determination petition, citing it may lead to the LGBTIQ agenda being promoted in schools and that it does not preserve the best interests of children. The petitioner further argued that the proposed amendment may lead to the decriminalization of homosexual activities which can worsen the current HIV and AIDS epidemic. Despite the petitioner's arguments the Supreme Court greenlit the bill in May 2023, concluding that the Bill as a whole or any provision thereof is not inconsistent with the Constitution.

Having legislation is not good enough. We need to change the people's mind set. We need to start with us, healthcare workers if we are serious about provision of inclusive and equitable healthcare. We need to speak about it. Let it not hide under cultural taboos. We need to be fair by the 12% of our population.

Similarly, sometimes having HIV and Hepatitis B makes a person less welcome in healthcare institutions. Though the government legislation says otherwise, the ground situation is different. There is one doctor in this audience who bears testimony to the story where a person with a bad cut injury to the arm was diverted from three major private healthcare institutions just because he was righteous enough to inform the admitting officer that he was Hepatitis B positive.

The clients with HIV still receive less than friendly care at certain healthcare institutions despite the valiant efforts of my colleagues at the College of Venereology.

Who are responsible for this social injustice?

It is you and I, who are going along the flow not having the will or the strength to swim against the tide.

During my tenure as the President, Ceylon College of Physicians, the College will recognise the diversity of our populace, fight for inclusivity and the equity in healthcare provision in the country under the theme "Diversity, inclusivity, and equity".

Forging head against the current is not easy. Worse if it is flood waters. You need the strength and specially courage to fight the urge to go along with the flow; to take the easy way out.

We do have that **strength, courage and determination**. Let us do so.

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