development in the children’s learning about stress. Registrars involved in this workshop would recommend that RCPCH considers encouraging at least one child focused health workshop within a local school during registrars’ Community Child Health training posts curriculum.

Aims The role of the Community Paediatrician focuses on minimising health inequities in the community which is quite challenging in Lower and Middle Income Country (LMIC) settings.

Methods The author has worked in UK for two years as a Community Paediatrician (CP) before returning to SL as the first sub-specialty trained CP. This paper describes the initial experience of establishing CP clinic in secondary level hospital in one of the capital districts in country. Data was obtained from the clinic records of the CP clinic and no patient identifiable data are used.

Results The District under the CP has a population of about 150,000 under 5 children. Having the country’s only tertiary level disability and safeguarding centres in the same District, the CP clinic was established as a secondary centre affiliated to a Base Hospital. CP is conducting the developmental and safeguarding services in the secondary clinic while visiting tertiary centres regularly.

The secondary centre has received 33 referrals within first 2 months. Majority were from hospital Paediatric unit (15/33, 45%) and the community (12/33, 36%). The clientele consisted mostly of autism spectrum disorder (6/33, 18%), developmental delay (6/33, 18%), learning disability (5/33, 15%), cerebral palsy and other neuro-motor disorders (5/33, 15%) and Trisomy 21 (4/33, 12%).

A high-risk infant follow up program was initiated for developmental surveillance, recruiting infants from Newborn units. Seven infants are in this program and has a follow up according to International Guidelines, with General Movement Assessment, Hammersmith Infant Neurological Examination, Visual Assessment, and appropriate Early Interventions.

Four safeguarding referrals were received, two each from Paediatric Units and Community. Two were sexual abuses and the others were due to neglect. According to the National Guidelines, three case conferences were held.

Several in-service training programs were initiated.

Conclusion The clientele is similar in both settings. SL is in primary stages of establishing CP teams, infrastructure, and referral systems for CP services, compared to the well-established system in UK. Dedicated CP team should be in each district to cater the community. The country doesn’t have tiers of development care support system for families as in UK, so the future directive should take in establishing this service. However, parents are highly motivated and deeply involved with CP team in delivering interventions.

Safeguarding referral system needs to be strengthened in Community level, according to the National Guideline. In the absence of major role of social services and foster system, CP service must play a huge role in psycho-social rehabilitation and re-integration.

CP teams need opportunity for professional development activities as in UK to update on this novel sub-specialty. Capacity building is the cornerstone for solid foundation and the networking and learning from UK are important assets. Nevertheless, adapting the service structure in culture and country specific way and financial constraints are the challenges ahead.