APRIL 2025

theSLMAMonthly

Official Newsletter of the Sri Lanka Medical Association

Registered at the Department of Posts under no. DOP/NEWS/62/2024

APRIL 2025 I VOLUME 18
ISSUE 04
ISSN: 1800-4016 (PRINTED)
2550 - 2778 (ONLINE)

Scan here to read online

COVER STORY

SLMA Health Walk for Road Safety Awareness 2025

Page 3

President's Message

Dr. Surantha Perera

Page 4

The Economic Returns of Investment in Public Health for Sri Lanka

Mr. Talal Rafi

Opinion I Page 6

A study analyzing the situation of Gastroesophageal reflux disease (GERD) in Sri Lanka

Dr. Nilanka Anjalee Wickramasinghe

Feature Article I Page 8

Editor's Notes

Dr. Lahiru Kodithuwakku & Dr. Kumara Mendis

Page 2

▶ Meeting with Print Media Personnel

SLMA NEWS Page 15

◀ Pre-Congress Workshop on "Acute Kidney Injury and CRRT for Nurses"

SLMA NEWS Page 15

CONTENTS

Sponsored by:

PRIME RESIDENCIES

DURDANS LABORATORY

DPA David Pieris Automobiles

CONTACT DETAILS

Address: Sri Lanka Medical Assiociation,
Wijerama House, No. 6, Wijerama Mawatha, Colombo 07
Telephone: +94 112 693 324
Website: https://slma.lk/
E-mail: officeslma.lk

From the Editors

ROAD TRAFFIC ACCIDENTS: THE SILENT EPIDEMIC

Dr. Lahiru Kodithuwakku
Co-Editor

Dr. Kumara Mendis
Co-Editor

Sri Lanka is facing a silent epidemic! We are losing precious lives at an alarming rate on our roads. According to the statistics of National Council for Road Safety, nearly 2000 deaths were reported annually over the last five years due to road traffic accidents. Additionally, six persons on average die in road accidents in Sri Lanka per day, meaning that every four hours, one mortality is reported, at least three are seriously injured as per the police data sources. The economic fallout is even worse, as country bleeds on average USD 4.1 Billion annually due to road traffic accidents.

So why doctors should bother? One thing is certain given the rate of road accidents in this country, you or me could be the next unfortunate victim. Secondly, it exerts a substantial burden on the country's health care system. The cost of treatment and long road to recovery and rehabilitation are an extra burden to the health staff, health finances and the health system as a whole.

Hence, the Sri Lanka Medical Association (SLMA) has taken a keen interest in addressing this critical public health concern. Apart from advocacy efforts through its expert committee on road accident prevention, SLMA has walk the extra mile to educate the public on road safety and essential tips for accident prevention.

This month's 'the SLMA Monthly' highlights some of these recent initiatives, including SLMA Road Safety Walk which concluded recently. So, buckle up, abide by the rules and start your journey towards a road traffic accident free Sri Lanka.

theSLMAMonthly
Official Newsletter of the Sri Lanka Medical Association

Editorial Board

Co –Editors
- Dr. Lahiru Kodituwakku
- Dr. Kumara Mendis

Editorial Board
- Dr. Sarath Gamini de Silva
- Prof. A. Pathmeswaran
- Dr. Vinya Ariyaratne
- Dr. Surantha Perera
- Prof. Sachith Mettananda

External Board Members
- Prof. Indralal De Silva
- Prof. Buddhi Marambe

Bulletin Design
- Chameera Randil via Ceylon Traverze Pvt. Ltd

Disclaimer Statement

SLMA Monthly is published by the Sri Lanka Medical Association (SLMA). The views expressed in it are not necessarily those of the SLMA. All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the Editor.

Permission may be sought directly from the SLMA, Wijerama House, No. 6, Wijerama Mawatha, Colombo 07, via telephone +94 112 693 324 or E-mail: officeslma.lk

COVER STORY

SLMA Health Walk for Road Safety Awareness 2025

Sri Lanka Medical Association (SLMA) as the premiere professional association for doctors in Sri Lanka, is at the forefront of advocacy and public awareness efforts, addressing major public health concerns in the country. Given the numbers of lives lost in the roads at an alarming rate due to road traffic accidents, SLMA recently initiated an advocacy effort, calling for greater attention by policy makers on road traffic accident prevention. Simultaneously, SLMA also launched a massive public awareness campaign to educate public on accident and injury prevention, including SLMA Health Walk for Road Safety Awareness 2025.

The walk organized in collaboration with the Ministry of Health, supported by the Sri Lanka Police, Tri Forces, Professional Colleges, medical faculties and nursing colleges and numerous well wishers took place on 29th March, starting from the Galle Face Green to Vihara Mahadevi Park. Hon. Minister of Health, the Commander of the Sri Lanka Army, Secretaries of Ministry of Health and Ministry of Transport, top officials of the Ministry of Health and Presidents of the professional colleges graced the occasion. Active participation of sports icons, Mr. Sanath Jayasooriya, Mr. Aravinda Silva and Mr. Dilantha Malingamuwa in the walk, amplified the message for greater attention on road traffic accident and injury prevention. Placards, leaflets and public addressing systems were used to spread the message among the public while mass media provided the live coverage and extensive media foot print for the event.

Following the walk a public gathering was held at the Vihara Mahadevi Park to propagatethe importance of public participation and strict law enforcement to prevent road traffic accidents, calling for greater involvement of the civil society to escalate the message. SLMA will take the initiative forward with a Ten Point Policy Statement on the Way Forward in Road Traffic Accident Prevention in Sri Lanka which is to be forwarded to the country's highest policy making authorities for urgent action.

PRESIDENT'S MESSAGE

Dr. Surantha Perera

131st President of Sri Lanka Medical Association

BUILDING A SAFER SRI LANKA: A PUBLIC HEALTH CALL TO PREVENT ROAD TRAFFIC ACCIDENTS

Road traffic accidents (RTAs) in Sri Lanka have evolved into a public health emergency with far-reaching consequences. Beyond the tragic loss of life and severe injuries, RTAs burden our health systems, disrupt families, and undermine national productivity. The Sri Lanka Medical Association (SLMA), recognizing that mobility is a fundamental right and that safety on our roads is a matter of public health justice, has issued a bold and comprehensive declaration to prevent road traffic accidents. As public health professionals, it is imperative that we view road safety not merely through a lens of transport or law enforcement, but as an essential pillar of our national health and development agenda.

1. A Modern Road Safety Law

Sri Lanka's Motor Traffic Act, conceived in a different era, no longer reflects the realities of modern road use. An updated, integrated Road Safety Law is urgently needed. It must address drunk and drug-impaired driving, mandate helmet and seatbelt use, regulate distracted driving, and allow for GNSS-based vehicle tracking to enforce compliance. Without legislative reform, technical interventions cannot gain traction.

2. National Road Safety Commission

Effective road safety governance requires authority, expertise, and continuity. The SLMA proposes transforming the existing National Council for Road Safety into an independent Commission with legislative backing. Such a body must be empowered to lead the national strategy, coordinate stakeholders, and be accountable for results. Road safety must be elevated to a priority across all levels of government.

3. Safe and Roadworthy Vehicles

Vehicle safety is non-negotiable. The continued influx of substandard, poorly maintained, or modified vehicles poses a systemic risk. We must enforce compliance with UN vehicle safety standards, introduce compulsory periodic inspections, and implement a garage accreditation system to ensure only qualified professionals service our vehicles.

4. Safer Infrastructure

Unsafe road design kills. Adopting the International Road Assessment Programme (iRAP) 2-star standards or higher for all new and upgraded roads is a pragmatic step forward. Urban infrastructure must incorporate pedestrian safety, intelligent crossings, and traffic-calming measures. Road safety must be designed, not just enforced.

Road traffic accidents (RTAs) in Sri Lanka have evolved into a public health emergency with far-reaching consequences.

Beyond the tragic loss of life and severe injuries, RTAs burden our health systems, disrupt families, and undermine national productivity.

5. Post-Crash Trauma Care

Preventing death after a crash is as critical as preventing the crash itself. The SLMA calls for a robust post-crash response system, including a national trauma registry, standardized EMS protocols, real-time GPS tracking of ambulances, and universal access to trained paramedics. Equity in trauma care can no longer be a privilege of geography.

6. Driver Licensing Reform

Licensing must evolve from a perfunctory test into a structured competency-based certification process. Using driving simulators, digital learning platforms, and a tiered licensing system can ensure that drivers of high-risk or heavy vehicles are adequately trained and periodically re-certified, medically and skill-wise.

7. Intelligent Speed and Traffic Management

Speed is a determinant of injury severity and mortality. Intelligent Transport Systems (ITS)—including speed governors, smart traffic signals, radar-based speed enforcement, and CCTV surveillance can deter violations and support real-time monitoring. Passive deterrents such as rumble strips and speed bumps also save lives.

8. Road Safety Education and Awareness

Long-term behavioural change must begin early. Embedding road safety into the school curriculum will create a culture of responsible mobility. Parallel public campaigns, shaped by behavioural science and sustained through mass media and digital influencers, must target high-risk groups, particularly youth and motorcyclists.

9. Protecting Vulnerable Road Users

The highest burden of RTA deaths and injuries is borne by pedestrians, cyclists, schoolchildren, and the elderly. Every road project must include safe walkways, cycle lanes, school safety zones, and universal design features. Inclusion is not an add-on; it is a necessity for safe roads.

10. Data-Driven Accountability

What we don't measure, we can't manage. The proposed Sri Lanka Accident Data Management System (SLADMS) will enable accurate tracking, analysis, and reporting of RTAs. Public access to anonymized data will promote transparency and drive evidence-based policymaking. Citizen reporting and audit mechanisms will deepen accountability.

Governance and Implementation

The SLMA further recommends immediately establishing a *Presidential Task Force on Road Safety*, with cross-sectoral representation, to coordinate the implementation of this agenda and report directly to the President and Parliament. For sustained long-term impact, a *National Transport Safety Commission* should be created under statute, with powers to regulate, audit, and certify all road safety-related entities—from infrastructure to EMS.

A National Imperative

Road traffic injuries are not accidents but preventable events rooted in policy gaps, institutional inertia, and public indifference. Every lost life is a policy failure. The SLMA's declaration is a clarion call to break this cycle. As public health professionals, we must champion road safety as a national priority, advocating for policy reform, supporting intersectoral action, and engaging our communities.

This is not just about reducing statistics. It is about preserving life's sanctity, ensuring the safety of every journey, and building a Sri Lanka where our roads reflect our values of care, responsibility, and shared humanity.

DURDANS LABORATORY

CALLING ALL MEDICAL PRACTITIONERS!

TO REGISTER WITH DURDANS LABORATORIES

*Obtain **Reliable Laboratory Results** and*
***Exclusive Discounts** for both you and your patients*

SPECIAL DISCOUNTS

TAILORED EXCLUSIVELY FOR OUR ESTEEMED PARTNERS

Durdans Laboratories offers an extensive range of specialised tests including
Glycated Albumin, Lipoprotein Lp(a), and Adiponectin, among others

GLYCATED ALBUMIN	Glycated albumin indicates an average blood glucose level for the past 2-3 weeks whereas, glycated haemoglobin (HbA1c) reflects the average blood glucose level for the past 2 to 3 months. Therefore, when there is a change of medication; glycated albumin test will provide results in 2 to 3 weeks rather than waiting for 2 to 3 months to repeat a (HbA1c) test.
LIPOPROTEIN Lp(a)	An increased Lp(a) value is a major risk factor correlated with cardiovascular disease (CVD) inclusive of heart attacks and strokes. Precautions and necessary measures should be taken to reduce cholesterol levels and adapt a healthy lifestyle with increased exercise and physical activity if your Lp(a) levels are high.
ADIPONECTINE	A positive adiponectic test indicates the likelyhood of developing diabetes in the future. Individuals with a family history of diabetes can request for an adiponectic test to assess the likelyhood of getting diabetes in the future and change lifestyle.

Contact Us Now For More Details

077 342 7931

OPINION

Mr. Talal Rafi

Economist & Director Consulting at Ernst & Young Sri Lanka

THE ECONOMIC RETURNS OF INVESTMENT IN PUBLIC HEALTH FOR SRI LANKA

Investment in public health and public education alike are strategic economic investments that drive economic growth especially in the long term. According to the World Bank, improvements in health can bring significant improvements to the economy in terms of better educational outcomes, higher investment and savings rates and increased worker productivity. The economic success of a nation is calculated by looking at GDP per capita, which can only improve if the productivity of citizens improves. Health, though seen at a microeconomic angle as crucial, is not given as much prominence at the macroeconomic level. Policymakers should focus on public health investments as a long term stimulus for sustainable economic development.

Economic Benefits of Public Health Investments

Higher Productivity - Across countries, data shows that higher life expectancy is associated with a higher income per capita. Extended working years result in higher productivity from an individual. An individual is most experienced at the latter part of his/her career and this is also his/her most lucrative period for knowledge based work. An extension of that period of their career can largely benefit productivity in the economy. Increased public investment also results in healthier workers with lower absenteeism.

Fiscal Policy - Sri Lanka is coming out of an economic crisis and its fiscal position is weak. It needs investment in public health in particular. The Ministry of Health was allocated over half a trillion rupees. But the capital expenditure was less than Rs 100 billion which is less than 20% of the total health budget. Capital expenditure by the government is investment by the government and it is much needed. Investment into the public health sector will help reduce healthcare costs as prevention is better than treatment from an economic perspective as well. A smooth functioning health sector will increase productivity resulting in higher tax revenues. Healthcare investments also lead to long term fiscal sustainability as it helps senior citizens stay independent longer resulting in reduced eldercare costs and less welfare costs for the government in the long term.

Higher savings and investment rates - At a macroeconomic level, a good healthcare system which can prevent diseases would help increase savings and investment rates. According to UNDP, in Sri Lanka, over half of the population are under multidimensional vulnerability. This means, it only takes a family health crisis to push many people deeper into debt from which they may not be able to come out of. Savings and investment rates can improve if the overall healthcare investments can increase in Sri Lanka targeting prevention.

Reduced inequality and poverty - Investing in health equity particularly by targeting underserved communities yields powerful long-term returns. Programs that focus on maternal and child health not only improve immediate wellbeing but also generate intergenerational benefits. By ensuring that children are born healthy, receive proper nutrition, and have access to healthcare and education, these interventions break cycles of poverty and significantly boost future earnings potential. Moreover, strengthening health systems to protect vulnerable populations reinforces social stability

Resilience to shocks - A robust health system is a strong economic defense especially when there are outbreaks of diseases or even other disruptions not related to health. A good example is Covid, where the total global costs due to Covid up to 2024 is a staggering $13.8 trillion. Though no country could have gone scratch free due to Covid, the countries with better healthcare systems were in a better position to reduce its detrimental effects on the economy.

Challenges facing Sri Lanka

Sri Lanka is only spending around 2% of GDP on health which is much lower compared to many other nations. But after 2022, Sri Lanka is also in a very difficult position to increase public spending on health. Sri Lanka declared bankruptcy in 2022 when debt reached 128% of GDP. Sri Lanka is in an IMF program and one of the targets is for Sri Lanka to reduce its debt to GDP to 95% by 2032. But Ghana defaulted when its debt to GDP was only around 92% of GDP. So Sri Lanka is working hard to bring down its debt in 2032, just so its debt to GDP can be slightly worse than what Ghana had when it defaulted. This is the sorry state of Sri Lanka's finances at the moment. Even now, Sri Lanka is having a breathing space as external debt repayments are largely suspended till 2028. But starting 2028, Sri Lanka will have to allocate a sizable portion to paying external debt as well. The situation globally is also gloomy as 54 countries are under debt stress according to the United Nations with global debt standing at around $100 trillion. Global recession fears due to the US President's global tariff wars and his decision to withdraw the United States (which was the largest donor to the WHO) from the World Health Organization makes global efforts on health care more challenging. It also makes Sri Lanka even more economically vulnerable.

Recommendation

Health information - A simplified education program at the A-Level grade on the basics of health issues, preventative measures and cures can prevent many medical issues as there is the problem of lack of knowledge. Public information sessions at village and town levels informing people about the dangers of sugary foods and alcohol can help prevent many potential medical problems.

Public Health as an Investment - Sri Lanka should see public health expenditure as an investment, rather than a cost. A mindset change is important. Though understandable that Sri Lanka is financially constrained, cutting down on healthcare expenditure should be a red line as the government should look to cut expenditure in other sectors instead. Health care is most important as it relates to the lives of Sri Lankans and even one life lost, is an invaluable loss.

Focus on Prevention - Sri Lanka should focus on prevention rather than cure as it can lead to a more efficient health care system at a lesser cost. Focusing on immunization, nutrition programs and child healthcare can have long term benefits.

Sustainable Financing - Looking at other ways of increasing public spending on health such as increasing sin taxes. This will not only increase government revenue but also prevent people from drinking alcohol and smoking in excess which is detrimental to their health.

Insurance Schemes - Developing and expanding health insurance schemes which can help pool risk and prevent many households from going into debt when a costly medical emergency occurs.

Collaboration with Universities - Aligning the health sector goals with the medical faculties of Sri Lanka's universities can help drive research and development. Overall government spending on R&D is low in Sri Lanka and this needs to be increased so that technology can bring more efficiency and find solutions to the problems.

THE ALL-NEW BAIC

SPECIAL PRICE FOR PERMIT HOLDERS

LKR 13,195,000 ONLY

FINANCE FACILITIES CAN BE ARRANGED!

1.5L TURBO PETROL

SLEEK DESIGN

BEST IN CLASS LUXURY

INDUCTIVE PANORAMIC SUNROOF

+ MANY MORE FEATURES

0114 700 678

Marketed by

David Pieris Automobiles

120, 120A, Pannipitiya Road, Battaramulla | BAIC SRI LANKA

* Conditions apply

FEATURE ARTICLE

Dr. Nilanka Anjalee Wickramasinghe

MBBS. M.Sc. PhD
Lecturer, Department of Physiology, Faculty of Medicine, University of Colombo

A STUDY ANALYZING THE SITUATION OF GASTROESOPHAGEAL REFLUX DISEASE (GERD) IN SRI LANKA

Introduction

Gastroesophageal reflux disease (GERD) is defined as a condition in which the gastric contents reflux back into the esophagus, resulting in symptoms and complications. [1,2] Symptoms of GERD include heartburn and regurgitation, chest pain, bloating, dysphagia, and odynophagia, while esophagitis, strictures, and cancer are a few of its complications. GERD leads to poor quality of life and high healthcare costs.

It is a common disease condition worldwide, with the most recent systematic review and meta-analysis on GERD by Nirwan and his team in 2020, analyzing 102 studies, reported a global prevalence of 13.98%, with the lowest prevalence in China (4.16%), and the highest in the USA and UK (21.04%) [3,4]. Despite being perceived as quite common, the exact prevalence of GERD and associated risk factors have not yet been previously studied in Sri Lanka. Many misinterpret symptoms of angina as “gastritis” and self medicating with often disastrous consequences.

Suggested underlying pathophysiological mechanisms for GERD include increased frequency of transient lower esophageal sphincter relaxations (TLESRs), ineffective esophageal motility, hiatus hernia, delayed gastric emptying, gastric stasis, increased gastric acid secretion, etc. [5] Commonly recognized risk factors for this condition are diet, lifestyle, obesity, and stress.

The diagnosis of GERD involves symptom characteristics, upper gastrointestinal endoscopy, and pH impedance studies. Since many conditions, including functional dyspepsia, rumination, recurrent vomiting, and esophageal motility disorders, can present with similar symptoms to GERD, it is essential to establish the diagnosis in patients with recurrent symptoms.

GERD can be managed with medical and surgical treatment modalities. Medical treatment mainly focuses on acid-lowering drugs such as proton pump inhibitors (PPI). Anti-reflux surgery is reserved for severe cases of GERD not responding to medical treatment. Treatment-resistant GERD is a major challenge in gastroenterology practice. The main reasons for poor treatment response include misdiagnosis (due to diseases mimicking GERD such as reflux hypersensitivity, functional heartburn etc. and management related factors such as poor compliance.

Gastroesophageal reflux disease (GERD), although commonly found in Sri Lanka, has not yet been fully studied at a national level. There are no Sri Lankan guidelines for the management of GERD, despite it being a relatively common condition. We do not have studies done in Sri Lanka on the treatment-refractory patients of GERD.

Therefore, we conducted a research project as part of a PhD thesis to improve knowledge regarding GERD prevalence, associated factors and management practices in Sri Lanka and provide baseline data for developing Sri Lankan guidelines on diagnosis and treatment.

> “
>
> Gastroesophageal reflux disease (GERD), although commonly found in Sri Lanka, has not yet been fully studied at a national level. There are no Sri Lankan guidelines for the management of GERD, despite it being a relatively common condition.

Methods

The study was conducted in three phases. Phase 1 is a cross-sectional, community-based epidemiological study to assess the island-wide prevalence of GERD and associated factors. A total of 1200 individuals aged 18–70 years (male: female, 1: 1.16, mean age 42.7 years [SD 14.4 years]) were recruited from all 25 districts of the country using stratified random sampling. An interviewer- administered, country-validated questionnaire was used to assess the GERD prevalence and associated factors. Weight, height, waist, and hip circumference were measured. Heartburn and/or reflux at least once a week, an internationally used criterion for probable GERD, was used to diagnose GERD

Phase 2 was a hospital-based prospective study to assess the outcome of medical and surgical treatment for patients with symptoms suggestive of GERD. A total of 209 patients attending the gastrointestinal clinics and endoscopy units of the National Hospital of Sri Lanka with complaints of GERD symptoms were recruited. Their information was obtained using the same interviewer-administered questionnaire used in Phase 1. Additional hospital reports, such as endoscopies, etc., were reviewed. Follow-up questioning was done at 6 months and 1 year to monitor the symptom progression and treatment.

During phase 3, a hospital-based prospective study was carried out to assess the value of gastrointestinal physiology investigations, namely high resolution esophageal manometry (HRM) and 24-hour pH impedance testing, in 46 treatment-resistant GERD patients.

Results

Of the normal population, 25.3% suffer from heartburn or regurgitation at least once a week. At the same time, 38.4% were using medication for the symptoms while 19.8% were on proton pump inhibitors. [6]

Of the patients with GERD symptoms who were referred for treatment to a specialized gastrointestinal (GI) unit, 95% have undergone endoscopy. Of them, erosive GERD was detected in 33%. The rest of the patients were left without a definitive diagnosis due to the very limited number of patients undergoing 24-hour pH impedance testing (22%). Meanwhile, 99% of patients were offered anti-reflux medication, though the follow-up management of them was not adequate, leading to ad hoc improper use of medications later. Treatment-resistant GERD was estimated at 15%. Of the patients who did undergo 24-hour pH impedance testing , a diagnosis of GERD was obtained for 28.3%, while conclusive evidence of reflux hypersensitivity and functional heartburn was obtained for 17.8% and 13.3%, respectively. Newer metrics, such as mean nocturnal baseline impedance, showed a significant ($p < 0.001$) impact on identifying patients with GERD. Using the results of all three phases of the study, a crude estimated value of 7% was calculated for GERD prevalence in Sri Lanka.

Mental stress and inadequate sleep were significantly higher in subjects suffering from GERD symptoms and those objectively diagnosed with GERD. [7] Certain diet-related habits, such as sleeping after meals, were detected in patients with GERD and GERD symptoms. Considerable changes in dietary intake and patterns were noted in patients with GERD.

Discussion

A quarter of adult Sri Lankans suffer from GERD symptoms. This is higher than the estimated global prevalence of 13.8%. More than 1/3 of the population uses anti-reflux medications, indicating the high disease burden. Several meal-related lifestyle habits, mental stress, and the use of some medications are significantly associated with GERD, indicating the importance of lifestyle and dietary modification and stress reduction in its management.

Newer metrics in 24-hour pH impedance testing , such as mean nocturnal baseline impedance, showed a significant impact on identifying patients with GERD. However, despite the usefulness of GI physiology investigations in giving a proper diagnosis, they are offered only to a very limited number of patients, leading to questionable treatment practices due to a lack of a proper diagnosis.

GERD management practices seemed more reliant on proton pump inhibitors (PPI)-based medical management, with less emphasis on lifestyle change and behavioral therapies and even less on anti-reflux surgery. Diagnosis, follow-up, and management are ad hoc and not streamlined according to internationally recommended guidelines. Establishing centers with specialized investigation facilities such as 24-hour pH impedance testing will optimize the diagnosis of GERD in Sri Lanka and help in the effective management of patients.

In this study, we found that almost one-fifth of the Sri Lankan population suffers from heartburn or regurgitation at least once a week, which is higher than the estimated global prevalence of 14% and even higher than in Western countries, where the prevalence is thought to be the highest. In addition, one-fourth of the population has used medication for symptom control, showing a high disease burden in the community. Treating GERD symptoms, which are considered one of the most common non-communicable diseases, is a costly endeavor that also drains the quality of life of the sufferers, leading to poor productivity.

Of the patients with GERD symptoms who were referred for treatment at a specialized GI unit, endoscopy was offered to almost all of them. Of them, erosive GERD was detected in one-third of the patients. Unfortunately, the rest of the patients were left without a definitive diagnosis due to the very limited number of patients undergoing 24-hour pH impedance testing (which is the gold standard for the diagnosis of GERD) due to limited resources and referrals.

Meanwhile, 99% of patients were offered anti-reflux medication, though the follow-up management of them was not adequate, leading to ad hoc improper use of medications later.

The number of diagnosed GERD patients receiving anti-reflux surgery is very limited due to many reasons, including the lack of many centers or surgeons offering it. Lack of confidence in the outcome of anti-reflux surgery carried out locally could prevent physicians from referring patients for this procedure. The novel surgical procedures and endoscopic treatments offered elsewhere in the world are not available for the patients in Sri Lanka.

Despite the large percentage of gastritis shown in upper GI endoscopy in our cohort, no secondary test for identifying H. Pylori, such as the H. Pylori breath test, was available during the study period at NHSL, and only a few were prescribed H. Pylori eradication treatment.

Of the patients who did undergo 24-hour pH impedance testing, a diagnosis of GERD was confirmed for nearly a third of patients, while conclusive evidence of reflux hypersensitivity and functional heartburn was obtained for others. Newer metrics in 24-hour pH impedance testing, such as mean nocturnal baseline impedance, showed a significant impact on identifying patients with GERD. HRM was also useful to identify motility disorders and hiatal hernias that impact the diagnosis and management of patients.

Thus, though treatment for GERD symptoms starts after a consultation regarding the patient's symptoms, an objective diagnosis of GERD or other related diseases is needed to deliver the most effective management form.

The diagnosis of GERD, despite international consensus and guidelines, is still a controversial topic worldwide, mainly because it is based on only a few research studies. While it is established that 24-hour pH impedance testing is the gold standard for objectively diagnosing GERD, reflux hypersensitivity, and functional heartburn, there is much confusion regarding the normal values to be used, despite several international consensus statements. Future research needs to be carried out to find the normal values using healthy controls related to 24-hour pH impedance testingand UGI manometry, especially for newer metrics in Sri Lanka, for various categories of GERD and similar diagnoses, and correlate them with the patient symptom profiles.

Mental stress and inadequate sleep were significantly higher in subjects suffering from GERD symptoms and those diagnosed with GERD.

Our all-island study found that a considerable number of subjects were experiencing mental stress and that there was a statistically significant increase in stress in those suffering from symptoms of heartburn and regurgitation. And thus, alleviation of stress, either through psychological therapy or medication, should be a key part of the management of a patient with GERD symptoms.

Photo by Freepik

This should also be part of the patient management guidelines for GERD, which are yet to be developed in Sri Lanka. Apart from that, considering the number of Sri Lankans suffering from mental stress, much needs to be done to alleviate stress and improve mental health in Sri Lanka.

Certain lifestyle-related habits, such as sleeping after meals, were detected in patients with GERD and GERD symptoms. Considerable differences in dietary intake and patterns were noted in patients with GERD compared to healthy, asymptomatic controls. This intertwined relationship between food and GERD symptoms makes patients more psychologically distressed when their food patterns are limited or disturbed. It is important to keep in mind that blanket bans on common trigger foods could severely limit the patient's diet, leading to unhealthy nutrition as well as reduced quality of life.

While we identified a considerable number of associated factors, further research is needed on newer factors, such as the association between symptoms such as heartburn and bloating and consuming wheat products and bread. This should include looking into the prevalence of wheat intolerance in Sri Lanka, which is not done yet, and factors related to local bread that cause heartburn, such as the role of excess yeast use in local bakeries.

Accurately identifying these factors can help to modify lifestyle management strategies for GERD, which we feel are not adequately addressed in patient management. Lifestyle modifications and stress relief methods are given a back seat in patient management, though they are very much associated with GERD symptoms.

Encountering patients with symptoms of GERD is a common, almost daily situation for doctors of most specialties. The general knee-jerk reaction when a patient complains of GERD is to prescribe PPIs and antacids. While there are well-laid-out, current guidelines, such as those of the American College of Gastroenterologits, the British College of Gastroenterologists, and other experts, it seems that these are not much followed in the Sri Lankan system. Treatment geared towards reflux hypersensitivity and functional heartburn, though established in international guidelines, is not practiced efficiently in Sri Lanka, once again due to the lack of diagnosis through MII-Ph.

More than half of the patients resorted to self-medication for the management of their

symptoms, as they believed that they only got the same medication, such as PPI, with no different management or investigation plan despite several visits to one or more doctors.

Obtaining prescription-only drugs without a prescription is a common occurrence in unregulated pharmacies in Sri Lanka. Not much research has been done regarding this practice, nor have effective steps been taken to control it, though it interferes with proper patient management.

Sri Lanka has a robust private medical sector where patients get treatment from consultants and other doctors and a lax system where most drugs can be obtained from pharmacies by patients with ease, including those who self-medicate. The country also does not have a database, an electronic patient referral system, or a records system. The lack of proper patient data management systems and a central patient referral and management system further creates turbulence in the already murky waters. Thus, it is seen as a common practice for patients to visit different doctors and specialists in both government and private hospitals when their response to medication is not satisfactory. This pattern causes disturbances in the investigation and management pathways of diseases. Repeated investigations and prescriptions from different hospitals and doctors will add further financial strain and wastage of time and resources. This leads to increased healthcare costs not only for the government but also for patients in private healthcare.

Thus, many patients presenting with GERD symptoms and those who have been diagnosed with GERD are left in the lurch, not only in the community but also in the hospital system. This translates to reduced quality of life and reduced productivity, which can affect the economy of the country.

Thus, many patients presenting with GERD symptoms and those who have been diagnosed with GERD are left in a lurch, not only in the community but also in the hospital system. This translates to reduced quality of life and reduced productivity, which can affect the economy of the country.

Despite the usefulness of GI physiology investigations in giving a proper diagnosis, they are offered only to a very limited number of patients, leading to ad hoc treatment practices and self-medication due to a lack of a proper diagnosis. This is partly due also to the lack of infrastructure, where investigations such as endoscopy and pH impedance testing are not readily available.

Therefore, it is important to invest more in establishing centers where 24-hour pH impedance testing and other GI physiology investigations are made available. Established Sri Lankan management guidelines for a patient presenting with GERD symptoms are the need of the hour.

One of the biggest obstacles we had during this thesis was the lack of a proper term for “gastrointestinal reflux disease” in Sinhala.

In Tamil, GERD is termed இரையக உணர்குழலியப் பின்னோட்ட நோய் as per the Wikipedia page and several patient awareness articles from Tamil Nadu, India. A group of experts and native Tamil-speaking doctors from Sri Lanka agreed that the term was acceptable even in the varying forms of Tamil used in Sri Lanka.

The lack of a Sinhalese term for GERD forced us to use a somewhat long-winding term in our information sheets and consent forms as “**අම්ලාශයේ සිට ගලනාලයට ආපසු අම්ලාශයේ ද්‍රව්‍ය පැමිණීමේ රෝගය**”. Despite heartburn and regurgitation being quite common, since there was no formal term for GERD, it was lumped as a form of “gastritis”. Laymen would call “gastritis” as a somewhat lay term for “gaastric” (**ගෑස්ට්‍රික්**). This is probably due to the wrong assumption that the symptoms are due to excess gas in the system! “Gastritis” would encompass almost all the gastrointestinal complaints among our almost 1400 research participants, including heartburn, regurgitation, chest pain, belching, burping, bloating, distension of the stomach, constipation, diarrhea, abdominal pain, dyspepsia, early satiety, increased appetite, and even, according to one lady, the burning sensation of her urethral area.

Therefore, a team of fvie doctors and one layman discussed and came up with the term “**ආමාශ-ගලනාලික ප්‍රතිවාහ රෝගය**” (āmāśa-galanālika prativāha rōgaya). There are two terms for esophagus in Sinhala, namely “**අන්නශ්‍රෝතය**” and “**ගලනාලය**”. While “**අන්නශ්‍රෝතය**” will be the more scientific term, it is relatively unknown, while “**ගලනාලය**” will be more recognized by laymen.

With the new proposed term, the back translation from Sinhala to English came out perfectly as “Gastroesophageal reflux disease” in Google Translate. (as seen in Figure 1) “Naming” an entity is linked to the exertion of power over the entity name, as something “unnamed” is difficult to work with. Without a proper term for GERD, the diagnosis, symptoms, and patient education and management were obscured. We hope that the proposed term will shed light on and raise awareness of this condition among the people of Sri Lanka and that our research findings will help diagnose and manage this troublesome disease better.

Figure 1: Google back translation from Sinhala to English of the proposed Sinhalese term for gastroesophageal reflux disease

1. Katz PO, Gerson LB, Vela MF. Guidelines for the diagnosis and management of gastroesophageal reflux disease. Am J Gastroenterol. 2013;108(3):308-328. doi:10.1038/AJG.2012.444

2. Vakil N, van Zanten SV, Kahrilas P, Dent J, Jones R. The Montreal definition and classification of gastroesophageal reflux disease: a global evidence-based consensus. Am J Gastroenterol. 2006;101(8). doi:10.1111/J.1572-0241.2006.00630.X

3. Nirwan JS, Hasan SS, Babar ZUD, Conway BR, Ghori MU. Global Prevalence and Risk Factors of Gastro-oesophageal Reflux Disease (GORD): Systematic Review with Meta-analysis. Scientific Reports 2020 10:1. 2020;10(1):1-14. doi:10.1038/s41598-020-62795-1

4. Wickramasinghe N, Devanarayana NM. Insight into the global burden of gastroesophageal reflux disease: Understanding its reach and impact. World J Gastrointest Pharmacol Ther 2024; In press

5. Wickramasinghe N, Devanarayana NM. Unveiling the intricacies: Insight into gastroesophageal reflux disease. World J Gastroenterol. 2025 Jan 7;31(1):98479. doi: 10.3748/wjg.v31.i1.98479. PMID: 39777237; PMCID: PMC11684178.

6. Wickramasinghe N, Thuraisingham A, Jayalath A, Wickramasinghe D, Samarasekera DN, Yazaki E, Devanarayana NM. Gastroesophageal reflux disease in Sri Lanka: An island-wide epidemiological survey assessing the prevalence and associated factors. PLOS Glob Public Health. 2024 May 1;4(5):e0003162. doi: 10.1371/journal.pgph.0003162. PMID: 38691536; PMCID: PMC11062562.

7. Wickramasinghe N, Thuraisingham A, Jayalath A, Wickramasinghe D, Samarasekara N, Yazaki E, & Devanarayana NM. (2023). The association between symptoms of gastroesophageal reflux disease and perceived stress: A countrywide study of Sri Lanka. PLOS ONE, 18(11), e0294135. https://doi.org/10.1371/journal.pone.0294135

VOICES FROM THE PERIPHERIES

Dr. A.G.M.M. Dharmadasa
MBBS, MSc (Medical Administration)
Former MS Base Hospital - Kantale

SAHURDA DANAWWA: A HEALING TOUCH FOR THE HEALERS OF BASE HOSPITAL KANTALE

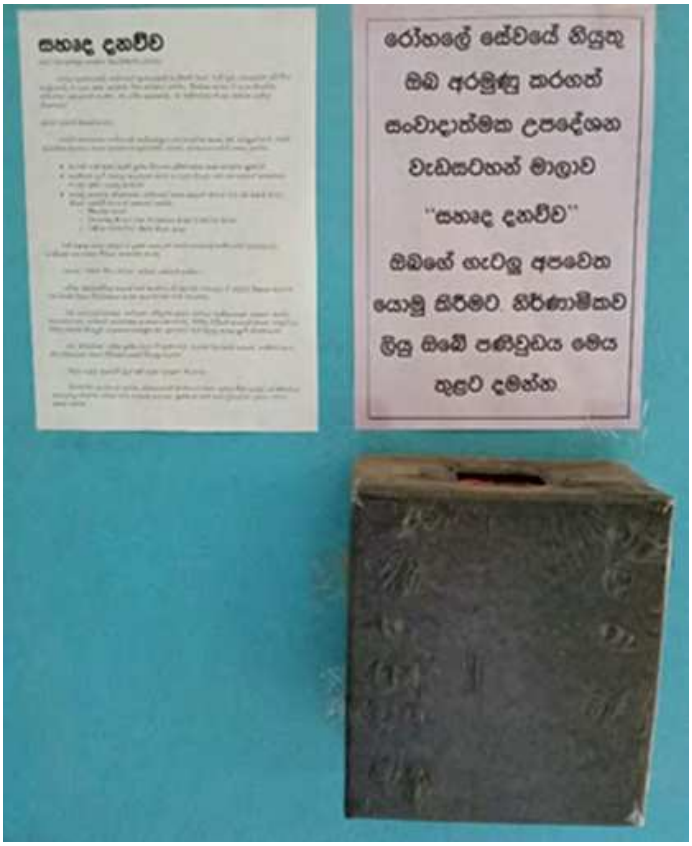
By the Healthcare Team, Base Hospital Kantale

In the aftermath of the COVID-19 pandemic, as hospitals across Sri Lanka slowly returned to normal operations, an invisible yet growing crisis began to emerge — one that affected the mental well-being of healthcare workers. At Base Hospital Kanthale, where I served as the Medical Superintendent in 2022, we witnessed first-hand how psychological stress and emotional exhaustion were silently taking a toll on our dedicated staff.

Although the pandemic had waned, its scars remained. Our hospital had been a multi-disciplinary COVID-19 treatment Centre during the peak of the crisis. The emotional toll on doctors, nurses, minor staff, and support teams was profound. Just as services were normalizing, Sri Lanka entered a severe economic downturn, further amplifying pressures on already-stressed frontline staff. We began noticing signs of emotional fatigue, increased interpersonal conflicts, and burnout among the hospital workforce. Behind the professionalism and compassion of our healthcare heroes, there was silent suffering. We realized that a proactive, inclusive, and innovative approach was urgently needed.

The Birth of Sahurda Danawwa

Recognizing that conventional counselling services were underutilized — largely due to stigma and fear of lack of confidentiality in a close-knit rural setting — We, along with Consultant Psychiatrist Dr. Rasitha Bashitha, and Dr. Ama Bandara envisioned a novel approach. We needed a safe, anonymous, and continuous platform where staff could



voice concerns without fear or judgment.

Thus, Sahurda Danawwa was born — meaning “A meeting place of minds and hearts” or “circle of friends.” It was more than a mental health program; it was a movement to restore kindness, empathy, and trust among hospital staff.

We began with three suggestion boxes placed in secluded areas of the hospital, inaccessible to the general public. Staff were invited to submit questions, concerns, or personal struggles anonymously.

These boxes were opened every 22nd of the month, and the contents were discussed on monthly forums held on the last Thursday.

The forums featured expert-led discussions on topics derived from the anonymous submissions: managing stress and burnout, conflict resolution, handling relationship and family issues, balancing work and life, and more. Initially, participation was limited. Many staff mistook the boxes for formal complaint mechanisms. But as the word spread and trust was built, engagement steadily increased.

Beyond Talk: Creating a Supportive Culture

From the very beginning, we recognized that healing required more than just talk. During the early phase of the program, we organized musical and talent shows, launched sports events, and conducted donation programs — including school stationery packs for children of staff members and supplies for surrounding schools. These activities created a friendly and inclusive culture, reinforcing the hospital as not just a workplace, but a supportive community.

They brought warmth and joy back into our hospital culture and reminded everyone that they were not alone.

What began as a modest initiative quickly evolved into a trusted pillar of support. Staff who were once hesitant began opening up. Participation in forums increased. Suggestions became more frequent. The sense of connection deepened.

Continuity and Growth

The outcomes went beyond strengthening morale and mental health. Despite cardre shortages and resource constraints, the improved teamwork and collective spirit enabled the successful launch of a new dialysis unit and the establishment of a non-communicable disease (NCD) clinic. These major milestones underscore how a mentally supported and motivated team can achieve excellence, even in difficult times.

After our initial phase, the program subsequently continued under the leadership of Dr. Paul Roshan, Dr. Wasula Rathanaweera and Dr. Piyumi Edirisinghe, who were appointed as Medical Superintendents following our tenure. They brought new ideas to the program, including exploring online submission methods

and expanding the scope of discussions. Crucially, Sahurda Danawwa remained true to its roots — an initiative by the staff, for the staff.

The topics addressed continued to be diverse and meaningful: ranging from anger management and marital stress to adolescent mental health and personal financial planning. This holistic approach ensured that the emotional, social, and practical needs of our workforce were addressed.

A Model Worth Sharing

The results speak for themselves. Staff morale improved. Conflicts declined. Burnout decreased. Most importantly, we witnessed a transformation in the culture—one rooted in empathy, teamwork, and shared humanity.

With minimal cost, using internal resources, and sustained through collective effort, Sahurda Danawwa has proven to be an adaptable and sustainable model. We believe it is one that can and should be replicated in other healthcare settings across the country.

In Reflection

Sahurda Danawwa began as a simple idea — that those who care for others deserve care for themselves. Today, it stands as a testament to what can be achieved when leadership, mental health professionals and staff come together with compassion and purpose. As a team, we are proud of what we have built — and hopeful that our pioneering effort will inspire others to create healing spaces in their own institutions.

NOVICE

Dr. Nilanka Mudithakumara
MBBS, MD (Emergency Medicine)
Senior Registrar in Emergency Medicine,
Colombo South Teaching Hospital

A TOUCH OF EMPATHY AMIDST THE CHAOS

Breaking bad news in the busy emergency setting

Yet another typically busy evening in a large Accident and Emergency department, filled to the brim. The hours spent inside didn't let us realize the persisting stormy weather outside.

The resuscitation room was alerted about a lady in her sixties with an extensive STEMI. Explanation of the risks and possible complications was done and consent for therapeutic intervention was taken from the family. Thrombolysis seemed to be successful until the patient suddenly went into a cardiac arrest fue to sudden cardiac rupture. Medical management with perfect team work was carried out with no success. But the biggest dilemma was to inform the agitated family who already sensed "something was not right" seeing the rushing staff.

Hearing the unspoken

> The deceased is gone, but the rest will live with the bitter memories of bereavement forever

The tall glass doors, are a fortification for the anxious family. "Breaking bad news in Emergency department" is always a challenge amidst dozens of other critically ill patients who need urgent care at the same time. And the series of ominous events may follow in a rapid sequence, and the unanticipated adverse reactions from the family may follow any moment afterwards.

The " Breaking bad news " should never become "a second blow" to the family, even though the Emergency Department setup in our part of the world is extremely busy , overcrowded with a heavy patient load managed with a pathetically sparse healthcare staff and an unimaginably high doctor to patient ratios. And the expectations of the patient populations are quite high, while the "patience" to wait to be seen is alarmingly low. The Emergency doctor takes up the challenge to communicate with the patients and the family at an optimal level amidst all these chaos.

SPIKES protocol

The "SPIKES protocol" (Setting, Perception, Invitation, Knowledge, Empathy, Strategy & Summary) as a commonly utilized tool of breaking bad news in the Emergency Department setting, prevents arbitrary speculation, arguments and conflicts with the medical staff.

Setting: Guiding the family to a calmer area of the busy Emergency setting itself instigate the sixth sense of the family of what the doctor is about to say.

Perception: Is a guide to the level of depth the matters should be discussed or explained. This will initiate a rapport with the family.

Invitation: Invitation to disclose the "bad news" , may perhaps be objected to by the receiver, even though this is not commonly seen in our setting.

Knowledge: Clear and simple details, with a "warning shot" of the status, makes the family understand the condition without confusion. This can be simply saying "I have some bad news for you. "Your mother has died" instead of indirect disclosure with terms such as "passed away, no more" etc.

A shocked family may not grasp some words and explanations given. It is usual for them to have "gaps of receiving the information" amidst the grievance. Checking the understanding of the receiver will help to make sure that they have grasped the message the doctor wanted to convey. This will prevent their question "Will she survive?", immediately after informing "Your mother has suffered a rupture of her heart, and her heart and breathing has stopped." Avoidance of medical jargon is paramount.

Empathy: Silence and being with the family allowing to cope with their emotions (with awareness and equipped to accommodate any of the five stages of grief : denial, anger, depression, bargaining, and acceptance), or responding with empathy when they plead for the life of their loved one to be saved, when nothing else can be done.

Strategy & Summary: Summarization, and stating the strategic plan or offering support will help to close the communication with compassion.

Escalation Matrix of communication

This action should be strengthened with the "Escalation Matrix of communication in the Emergency department". The involvement of a senior clinician in certain cases sometimes ease the tension between the staff and the family. This is the "twist" to be applied to a better tolerated response from the family.

In an era of e-self prescribing, treating the doctor as a "god figure" is dissolving, and the roars and waves of "anger" is hitting hard; effective communication done with empathy in a timely manner could be the saviour and the key to success.

Our story ended with an unexpected reaction from family thanking the hard work of the staff, and for giving the information of the critical condition at the outset, leaving no room for any conflicts. And it continued to be the same in a significant number of cases that followed.

> People will forget what you said and what you did,
>
> But, people will never forget how you made them feel.
>
> **Maya Angelou**
> (American memoirist, poet & civil right activist - receiver of Presidential Medal of Freedom 2010)

References

1. Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Stover, E., Tulsky, J. A., & Back, A. L. (2000). SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. The Oncologist, 5(4), 302-311.
2. Ptacek, J. T., & Eberhardt, T. L. (1996). Breaking bad news: a review of the literature. JAMA, 276(6), 496-502.
3. Girgis, A., & Sanson-Fisher, R. W. (2007). Breaking bad news: a practical approach. Current Oncology Reports, 9(1), 44-50.
4. Collini, A., Parker, H., & Oliver, A. (2020). Training for difficult conversations and breaking bad news over the phone in the emergency department. Emergency Medicine Journal, 37(12), 780-783.
5. Joyce, N. R., & Ogunyemi, O.O. (2017). Breaking bad news in the emergency department. Emergency Medicine Clinics of North America, 35(2), 307-317.
6. 일, H. J., & 일, Y. S. (2023). Effect of Using SPIKES Protocol for Delivering Death News to Patient Family Members on Their Anxiety Symptoms. Evidence-based Care Journal, 13(1), 7-14.

SLMA IN APRIL

Highlights

Pre-Congress Workshop on "Acute Kidney Injury and CRRT for Nurses"

Second Pre-Congress session of the 138th Anniversary International Medical Congress of the SLMA was held at the Lionel Memorial Auditorium of the SLMA on 3d April 2025. Nearly150 nursing officers across the country actively participated in the workshop, learning essential skills in continuous renal replacement therapy. Resource panel included Consultant Nephrologists Dr. Udana Ratnapala, Dr.Buddika WEijayawickrama and Consultant Intensivists Dr. Dilshan Priyankara, Dr. Sankalpa Vithanage and and Dr. Sanjeewa Eranda.

Meeting with Print Media Personnel

Dr. Surantha Perera, President of the SLMA met will print media personnel of all the leading newspapers and magazines to update them on the future SLMA initiatives and plans. The SLMA Road Map for 2025 was presented and clarifications regarding the current SLMA work under different national issues were also addressed. Media professionals committed their fullest support in propagating SLMA initiatives among the public.

SLMA IN APRIL

Highlights

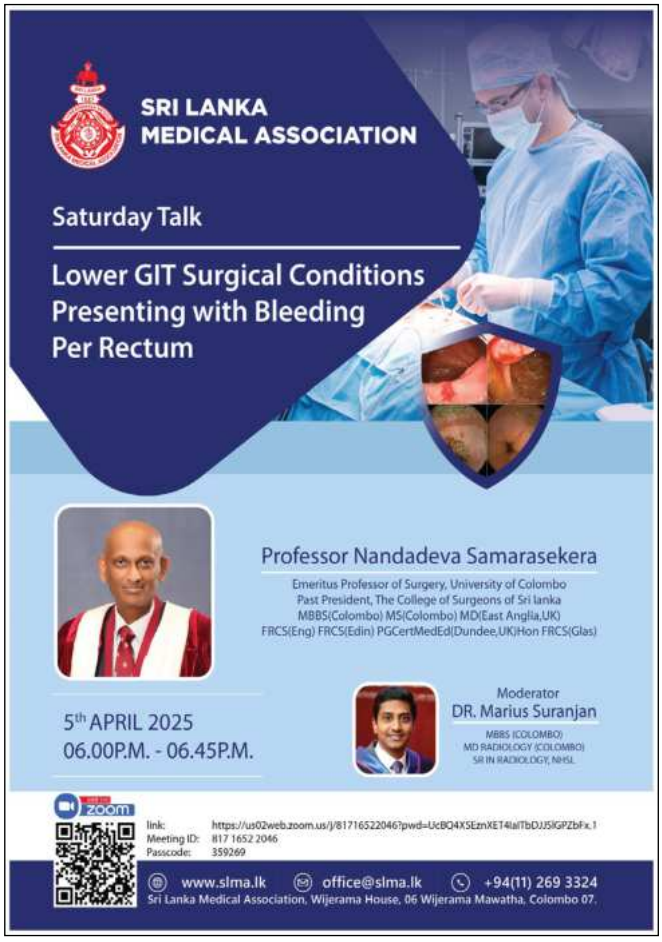
SLMA Saturday Talks

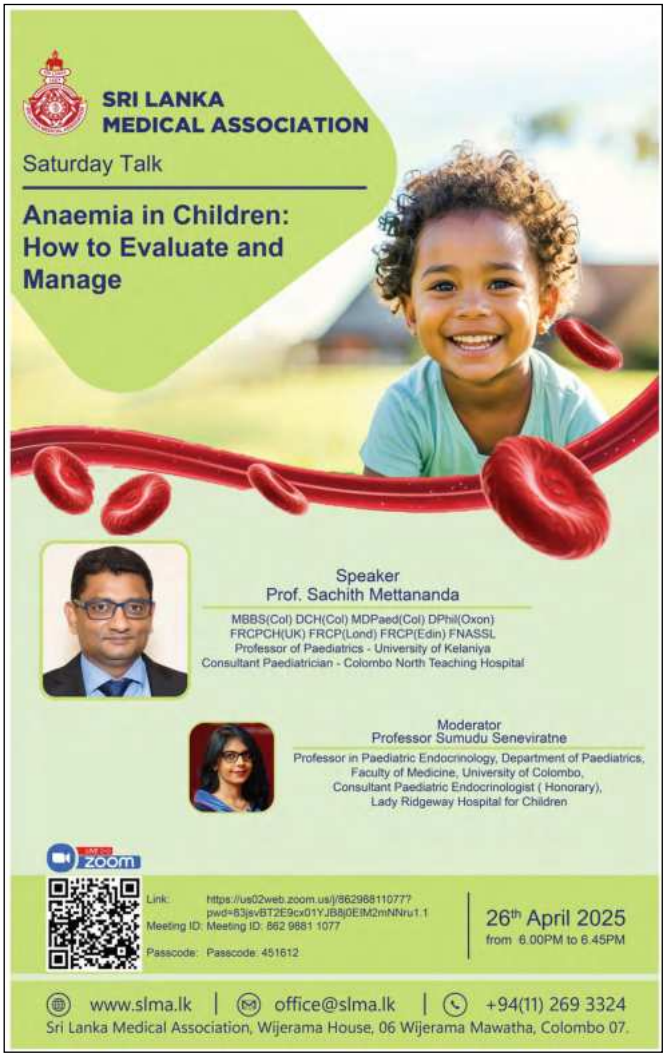
SLMA Saturday Talk was delivered by following expert resource persons during the month of April.

- Lower GIT Surgical Conditions, Presenting with Bleeding Per Rectum by Professor Emeritus Nandadeva Samarasekera.
- Anaemia in Children: How to Evaluate and Manage by Professor Sachith Mettananda.

Therapeutic Update

Therapeutic Update was conducted by Dr. Sujeevani Kulakulasuriya on Systemic Lupus Erythematosus.





SLMA
in APRIL

Monthly Clinical Meeting

This month's monthly clinical meeting was held in collaboration with Ceylon College of Physicians. Two important topics were discussed, namely

- Rickettsial Infections; the bedside challenge by Prof. Ranjan Premaratne.
- Early Detection and Management of Dengue Shock and Bleeding by Dr. Eranga Narangoda and Dr. Thisara Perera.

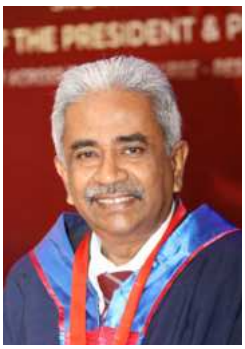
SLMA IN APRIL
Highlights

Climate Insights and Future

Expert Committee on Planetary Health and Climate Effects of the SLMA participated in the panel discussion 'Climate Insights and Future' organized by the Association of Disaster Risk Management Professionals Sri Lanka (ADRiMP). Dr. Lahiru Kodituwakku represented the expert committee and presented on the climate impact on the health system. Other panelists include disaster and climate science professionals from the government agencies, UN bodies and private sector.

SLMA in APRIL

Achievements of SLMA Council Members



SLMA Former President 2023, Dr. Vinya Ariyaratne appointed as a Member of Georgetown University - Lancet Commission on "Faith, Trust and Health".

We are delighted to announce that our former President Dr. Vinya Ariyaratne was recently appointed as a member of Georgetown University - Lancet Commission on "Faith, Trust and Health".

Lancet Commission is a science-led, international, and multidisciplinary collaboration, convened by The Lancet, a leading medical journal, to address an urgent and often neglected or understudied global health issue, aiming to achieve transformational change with a focus on policy or political action.

Congratulations to our President Elect Dr. Manilka Sumanathilake, Consultant Endocrinologist for being elected as the Chair (elect) for South East Asia region of the International Diabetic Federation (IDF).

Dr. Lahiru Kodituwakku, Council Member and Honourary Secretary 2024 appointed as the Vice President of the Association of Disaster Risk Management Professionals Sri Lanka (ADRiMP) for 2025/2026. ADRiMP is the premiere professional association of the disaster and crisis management fraternity in Sri Lanka.

GLOBAL FOCUS

APRIL 2025

The Little Victims of Anti-Microbial Resistance (AMR)

More than three million children around the world are thought to have died in 2022 as a result of infections that are resistant to antibiotics, according to a study by two leading child health experts. Dr. Yanhong Jessika Hu of Murdoch Children's Research Institute in Australia and Professor Herb Harwell of the Clinton Health Access Initiative who authored the paper also revealed that children in Africa and South East Asia were found to be most at risk.

Between 2019 and 2021 the use of "watch antibiotics", drugs with a high risk of resistance, increased by 160% in South East Asia and 126% in Africa, while use "reserve antibiotics" - last-resort treatments for severe, multidrug-resistant infections - rose by 45% in South East Asia and 125% in Africa. When inquired about a probable solution to this grave public Health concern, Dr Lindsey Edwards, a senior lecturer in microbiology at King's College London, said, "These findings should serve as a wake-up call for global health leaders. Without decisive action, AMR could undermine decades of progress in child health, particularly in the world's most vulnerable regions."

Source: BBC Health
Picture Courtesy: AMR Control

WHO calls for revitalized efforts on Malaria Elimination

On World Malaria Day, falling on 24th of April, the World Health Organization (WHO) has called for revitalized efforts at all levels, from policy to community action, to accelerate progress towards malaria elimination.

To date, WHO has certified 45 countries and one territory as malaria-free, and many countries with a low burden of malaria continue to strive towards Malaria elimination. Out of the remaining 83 malaria-endemic countries, 25 reported fewer than 10 cases of in 2023, which signifies their commitment in curbing the disease and its transmission. However, according to world leading experts in Malaria and vector control, such achievements could be lost in no time, if control and re-introduction prevention measures are not updated regularly.

In addition, African nations, the most affected by the Malaria epidemic, are continuing to introduce Malaria vaccine drives among their population, Mali being the latest addition to 19 other African countries in introducing malaria vaccines—a vital step towards protecting young children from this deadly disease

Source: World Health Organization News 2025
Photo Courtesy: John Hopkins Center for Communication


22M
UPWARDS
LIMITED
TIME OFFER
RESERVE TODAY AND GET YOUR
LIVING & DINING SPACES FULLY FURNISHED!
THE PALACE
0710 666 222
PRIME
RESIDENCIES

Stamp

To:

If undelivered, please return to:

Sri Lanka Medical Assiociation,
Wijerama House, No. 6, Wijerama Mawatha,
Colombo 07

theSLMAMonthly
Official Newsletter of the Sri Lanka Medical Association

Registered at the Department of Posts under no. DOP/NEWS/62/2024

APRIL 2025 I VOLUME 18 I ISSUE 04
ISSN: 1800-4016 (PRINTED) 2550 - 2778 (ONLINE)
ISBN: 978-624-5972-13-5

Scan here to
read online