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From the Editors

Dr. Lahiru Kodithuwakku
Co-Editor

Dr. Kumara Mendis
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Health Sector has been subjected to multiple issues both external and internal, with increasing frequency over the last decade. From shocks like outbreaks and pandemics to economic meltdowns, it has gone through challenging times. However, have we actually seen it all?

During the 78th World Health Assembly, Sri Lankan Health Minister highlighted another danger to our healthcare system. According the minister, more than 4500 health professionals have left the country between 2022 and 2025. This includes 726 specialist doctors, 1116 medical officers and 2800 nursing officers.

Some may argue these decisions to migrate are based entirely on personal and economic considerations. However, the underlying factors for such healthcare professionals are multiple. From a health system perspective many unanswered questions remain.

Do our hospitals provide a good, safe working environment for doctors, nurses and other health staff to exercise their duty of care?

Have we overburdened our 'skeletal health staff' at hospitals with work beyond their capacities and work norms?

Have we provided our health workers opportunities to enhance their careers other than from doing 'Postgraduate Courses?'

Do we expect the vast majority of the health professionals, who do not engage in private practice to work for a paltry salary with newly introduced high taxation rates?

If we are to sustain the top healthcare indicators that Sri Lanka has gained, because of its public health sector and the highly skilled professional work force, it is high time to provide reasonable solutions for the healthcare workers of this country. Collectively as a health sector we have to reflect, make necessary system adjustments so that at least the next generation of health workers will have system that would enhance their job satisfaction and self-esteem.

It would be impractica to request other countries to enforce limits to migration to their countries as this will be an issue regarding human rights. It is Sri Lanka's responsibility to make our country attractive for our own citizens to work with dignity.

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COVER STORY

Dr. Lahiru Kodithuwakku
Co-Editor, The SLMA Monthly

SRI LANKA'S HEALTH SECTOR: THE GLORIOUS YESTERDAY, TURBULENT TODAY AND UNTESTED TOMORROW

It is no secret that Sri Lanka's much acclaimed health sector has been a role model for other countries across the region for several decades. With its free service at the point of delivery, reach up to the last mile, extensive network of curative and public health institutions, and well-trained health workforce, Sri Lanka's health sector has achieved much more than what could have been achieved by a Lower Middle-Income Country (LMIC).

The results speak for themselves. Low maternal mortality ratio, neonatal, infant and under 5yr mortality rates, near 100%, institutional deliveries and more than 95% EPI vaccine coverage against vaccine preventable diseases are some of the key indicators that illustrate Sri Lanka's successes in the vital maternal and child health care sector. The country has eliminated Malaria, Congenital Rubella Syndrome, Mother to Child Transmission of HIV and STIs and sustains one of the lowest Case Fatality Rates (CFR) in dengue in the region, to highlight a few in respect to disease prevention and control. Sri Lankans now enjoy one of the longest life expectancies at birth in the region, 79 years for females and 73 years for males. This is a product of no magic, but prudent health planning, meticulous execution and commitment of a dedicated health staff.

Glorious past indeed! However, can we sustain what we have achieved?

Times are changing of course! With the impact of climate change hitting us hard, we see frequency and magnitude of vector borne disease outbreaks like dengue increasing and spreading far and wide. Childhood malnutrition is rising because of the economic crisis and subsequent food insecurity. Newer diseases like Covid-19 are spreading together with other infectious diseases, creating a perfect multi hazard scenario. Road Traffic Accidents are ever increasing killing and maiming people on a daily basis. Infectious diseases like measles are making a comeback among vulnerable population cohorts. An aging population is competing for services for chronic disease conditions and Non Communicable Diseases.

Amidst all this turbulence, do we have enough resources to handle this in the health sector?

The answer my friend is blowing in the wind!

Sri Lanka's much valued and skilled health workforce is migrating in ever increasing numbers, searching for better work conditions, higher salaries and due recognition and dignity for their professional services. Health care workers are harassed at their own place of work, further complicating the situation. Old, poorly maintained and cash strapped health infrastructure is failing by every passing day. With 'No Turn Down Policy', hospitals are being flooded with patients, even when the resources are skeletal and capacities are saturated. Funding lines, both local and international are drying up fast, often putting disease control and prevention programmes in limbo! On top of all these challenges, the public perception towards health professionals are undergoing a continental shift, from being hero to zero!

So are we on to untested waters?

The answer my friend is blowing in the wind!

Unless we reflect back upon, not just our successes, but also our failures, not just what we have achieved, but what else we could have achieved, our future is going to be bleak. It is high time for us to plan for a healthcare model, calculating the cost vs benefit, long-term sustainability, adaptability and above all resilience towards future uncertainties. A healthcare model that value its most treasured resource, healthcare workforce, making them feel safe and dignified at their own working spaces. Regain the public trust and confidence, by not offering everything to everyone, but what is required for the most needy!

See through the chaos and act fast!

"Yes, and how many times can a man turn his head and pretend that he just doesn't see?

The answer, my friend, is blowing in the wind!"

PRESIDENT'S MESSAGE

Dr. Surantha Perera

131st President of Sri Lanka Medical Association

HEALTH SYSTEM RESILIENCE AND THE FUTURE OF SRI LANKA: A STRATEGIC IMPERATIVE FOR NATIONAL WELL-BEING

The concept of *health system resilience* has gained global prominence in recent years, particularly in the aftermath of the COVID-19 pandemic, economic crises, climate-related disasters, and complex geopolitical uncertainties. For Sri Lanka, an island nation with a proud history of public health achievements, the need to strengthen and future-proof its health system is both urgent and essential.

Resilience, in this context, refers to the capacity of the health system to prepare for, respond to, and recover from shocks while continuing to provide essential health services, protecting public health, and maintaining core functions under stress. This concept extends beyond short-term crisis management, and it reflects a long-term vision for sustainable, equitable, and adaptable healthcare delivery.

The Sri Lankan Context

Sri Lanka's health system has historically received acclaim for its significant achievements in maternal and child health, immunization coverage, and nearly universal access to primary healthcare. These successes were realized through decades of firm public policy, a well-structured network of government health institutions, and a team of dedicated healthcare professionals.

However, the country now faces formidable challenges:

- **Rising non-communicable diseases (NCDs)** now account for over 80% of mortality (WHO, 2023).
- **Economic volatility** has impacted drug availability, workforce migration, and patient access to affordable care.
- **Climate change** is increasingly linked with vector-borne diseases, heat-related illness, and food insecurity.
- **Health workforce attrition** and burnout are accelerating, with an estimated 20% of specialist doctors and nurses considering overseas employment in 2024 alone (Ministry of Health, Sri Lanka, internal data).
- **Digital transformation** remains vastly underutilized despite its evident potential for efficiencies in telemedicine, health records, and disease surveillance.

A resilient health system must be able to withstand and adapt to such threats.

Core Pillars of Health System Resilience

1. Governance and Leadership

Effective leadership at all levels, from ministries to hospitals, is foundational. Health governance must prioritize accountability, transparency, and community engagement. Integrating public health preparedness into the broader national development agenda is no longer optional; it is a strategic necessity.

2. Health Workforce Sustainability

The resilience of any health system is directly linked to its people. Sri Lanka must urgently address the exodus of trained professionals by strengthening career pathways, enhancing workplace safety, providing psychosocial support, and investing in continuous professional development. Establishing national retention policies and fostering academic partnerships can assist in stabilising the workforce.

3. Supply Chain and Essential Medicines

A resilient health system maintains reliable access to essential medicines and supplies, especially in emergencies. Local production of key medications, diversification of import sources, and digital inventory tracking should be prioritized. Strategic stockpiles, particularly for critical care and vaccines, are imperative.

4. Health Information Systems

Timely and reliable data enable proactive responses to emerging threats. Investing in integrated health information platforms, interoperable electronic medical records, and real-time disease surveillance will significantly enhance preparedness and service delivery.

5. Financing for Resilience

Health budgets must reflect a commitment to resilience. Beyond increasing total expenditure, funds should be allocated for public health infrastructure, emergency preparedness, and strengthening primary care. Innovative financing mechanisms, such as health bonds or risk-pooling arrangements, could play a key role.

6. Equity and Social Protection

The health system must be designed to leave no one behind. Financial protection through universal health coverage (UHC) schemes, targeted outreach to marginalized communities, and gender-sensitive service delivery are crucial for achieving equitable resilience.

Strategic Priorities for the Future

1. Climate-Smart Health Infrastructure

Hospitals and clinics must be designed or retrofitted to withstand climate-related extremes, including floods, heat waves, and power outages. Renewable energy integration, water conservation, and waste management are not just environmental goals but essential resilience strategies.

2. Decentralization and Community Engagement

Empowering local health units and communities can increase responsiveness. Community health workers, traditional health systems, and civil society must be integrated into public health planning and disaster response.

3. Embracing Digital Health

Digital technologies can improve access, reduce costs, and enhance system adaptability. A national digital health strategy must promote equitable access to telemedicine, AI-powered diagnostics, and digital training for health professionals.

4. Institutionalizing Emergency Preparedness

Establishing a national health emergency preparedness and response authority with clear mandates and intersectoral coordination will ensure agility in times of crisis.

Sri Lanka stands at a crossroads. The resilience of its health system will determine its capacity to protect lives, maintain social cohesion, and promote inclusive development in the face of 21st-century challenges. Building resilience is not solely the responsibility of the health sector, and it necessitates a whole-of-government and whole-of-society approach.

The future demands more than recovery; it calls for *transformation*. Sri Lanka must commit to reimagining its health system not only to withstand the next crisis but also to thrive in an increasingly unpredictable world.

References

1. World Health Organization (WHO). (2023). *Global Health Estimates: Leading Causes of Death*. Geneva: WHO.
2. Kruk, M. E., Ling, E. J., Bitton, A., et al. (2017). Building resilient health systems: A proposal for a resilience index. *BMJ*, 357, j2323.
3. Ministry of Health, Sri Lanka. (2024). *Health Workforce Retention and Migration Analysis*. Colombo: Strategic Planning Division.

OPINION

Dr Mahesh Gunasekara
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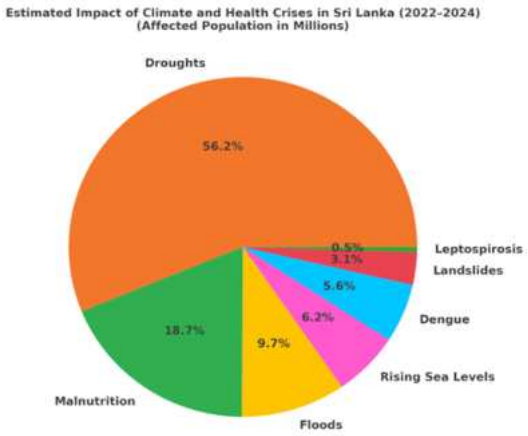
HOW RESTRICTIVE GLOBAL FUNDING IS UNDERMINING SRI LANKA'S RESPONSE TO CLIMATE CHANGE AND HEALTH CRISES: A CALL FOR SYSTEMIC REFORM

Introduction

Sri Lanka is at a critical juncture, grappling with the escalating impact of climate change, which increasingly threaten public health and livelihoods. More frequent floods, droughts, landslides, and rising sea levels are putting millions at risk [9]. At the same time, public health challenges such as the rise of vector-borne diseases (e.g. dengue and leptospirosis) and malnutrition are worsening, while mental health consequences are often neglected during disaster responses [1–4].



The Humanitarian Funding Crisis

Despite the urgency of these issues, Sri Lanka's ability to respond effectively is hindered by structural flaws in the global humanitarian funding system.

Globally, humanitarian funding is challenged by the scale and complexity of crises, which include climate disasters, conflicts, and pandemics. Unfortunately, funding remains fragmented, insufficient, and largely shaped by donor priorities rather than the nuanced realities on the ground. By mid-2024, only 30% of the funding requirement for humanitarian assistance had been met, leaving a significant gap [6].

Furthermore, around 80% of humanitarian funding is short-term (less than three years) and narrowly focused, lacking the flexibility to address the interconnected needs that span the health, environment, and infrastructure sectors.

Sri Lankan context

Sri Lanka's struggle to manage climate-sensitive health issues, such as recurring dengue outbreaks, highlights the limitations of current funding models. Effective responses require integrated strategies that involve medical care, environmental management, community engagement, and infrastructure development [5,7]. However, existing funding mechanisms often enforce sectoral silos, limiting the potential for comprehensive, coordinated solutions.

This challenge is especially pronounced in the Northern and Eastern provinces, which are still recovering from past conflict and facing chronic poverty. These areas bear a disproportionate burden of climate-related health impacts, yet remain underserved due to geographic and systemic funding disparities [7,8]. This geographic inequity reflects a broader global pattern, where marginalised populations are overlooked in the distribution of humanitarian aid.

Exclusion of Local Actors

Another critical issue is the exclusion of local actors. Community-based organisations, which hold invaluable insights into local conditions, face barriers to accessing international funds due to bureaucratic complexities and limited capacity-building support [8]. This undermines the effectiveness of sustainable interventions tailored to local needs.

Overcoming these obstacles requires a fundamental reform of humanitarian funding approaches. Donors should prioritise flexible, multi-year funding to support integrated climate–health programmes. Simplifying access for local groups and investing in data collection, research, and innovative technologies are also essential [1, 3, 5]. Aligning donor support with Sri Lanka's national climate and health strategies will further improve coordination and impact [7].

As global humanitarian challenges intensify, Sri Lanka's situation offers a critical lesson: without adaptable, inclusive, and sustained funding models, vulnerable communities remain exposed to escalating climate and health risks. Donors, policymakers, and humanitarian agencies must rethink funding mechanisms to reflect the interconnected nature of contemporary crises.

The Way Forward - Reforming the Funding Landscape

Addressing these challenges requires a transformative shift in how humanitarian funding is designed and delivered. Key priorities include:

- **Flexible and Multi-Year Funding:** Donors should support longer-term, adaptable funding frameworks to address evolving climate–health needs sustainably.
- **Integrated, Cross-Sectoral Approaches:** Breaking down silos between sectors is essential to tackling complex challenges holistically.
- **Empowering Local Actors:** Simplifying funding access and investing in local capacity will enable more effective, context-specific solutions.
- **Data and Innovation:** Strengthening disease surveillance, data systems, and innovative responses can enhance preparedness and resilience.
- **Geographic Equity:** Targeted support for vulnerable, underserved regions is critical to closing gaps in resilience and preparedness.
- **Alignment with National Policies:** Coordinating with Sri Lanka's national strategies can improve efficiency and ensure interventions are grounded in local priorities [7].

Conclusions

Sri Lanka's overlapping climate and health challenges illustrate the limitations of current global humanitarian funding, which is often rigid, fragmented, and inequitable, and fails to address the complex, interconnected risks facing vulnerable communities [6,8]. Urgent reforms towards flexible, multi-year, and cross-sectoral funding frameworks that empower local stakeholders and emphasise evidence-based interventions are needed. Such changes are essential not only for Sri Lanka's resilience but also as a model for managing the growing complexity of humanitarian crises worldwide.

Recommendations:

1. Increase funding flexibility to adapt rapidly to changing climate–health needs.
2. Promote multi-year funding programmes to sustain climate adaptation and health system strengthening.
3. Encourage integrated programming to break down sectoral silos and address challenges holistically.
4. Enhance local capacity by simplifying funding processes and supporting technical skill development.
5. Prioritise investment in data systems, disease surveillance, and innovative solutions.
6. Address geographic inequities by targeting vulnerable and conflict-affected areas.
7. Align donor funding with national policies to improve coordination and efficiency.

References

1. Ministry of Health, Sri Lanka. Weekly Epidemiological Reports. Colombo: Epidemiology Unit; 2023.
2. World Health Organization. Climate and Health Country Profile – Sri Lanka. Geneva: WHO; 2021.
3. United Nations Children's Fund. Sri Lanka Nutrition Landscape Analysis. Colombo: UNICEF; 2022.
4. World Bank. Addressing Climate-Induced Mental Health Risks in South Asia. Washington, DC: World Bank; 2023.
5. Asian Development Bank. Integrated Approaches to Climate and Health Resilience. Manila: ADB; 2021.
6. United Nations Office for the Coordination of Humanitarian Affairs. Global Humanitarian Overview 2023. Geneva: OCHA; 2023.
7. International Federation of Red Cross and Red Crescent Societies. Community-Based Adaptation in Northern Sri Lanka. Geneva: IFRC; 2023.
8. Transparency International Sri Lanka. Barriers to Local Funding Access in Humanitarian Aid. Colombo: TISL; 2021.
9. Disaster Management Centre. Sri Lanka Disaster Risk Profile. Colombo: DMC; 2022.

FEATURE ARTICLE

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THE EVOLUTION OF MANAGEMENT OF COLON AND RECTAL CANCER: A PARADIGM SHIFT IN SURGICAL AND MULTIDISCIPLINARY APPROACHES

Introduction

Colon and rectal cancer is the 3rd most common cancer in Sri Lanka and worldwide. The main treatment goal is to achieve cure or improve survival with minimum incidence of local recurrence and good quality of life. Colon and rectal cancer (CRC) has undergone significant advancements in management over the past century. From the early days of radical surgical resection to the current era of minimally invasive techniques, precision oncology, and multidisciplinary care, the evolution of CRC management reflects the integration of scientific innovation, technological progress, and evidence-based medicine. This article explores the historical progression of CRC management, highlights contemporary practices, and discusses emerging trends that are shaping the future of CRC care. (1,2)

Historical Perspective

The history of colorectal cancer diagnosis dates back to ancient times. The first historical diagnosis of cancer, specifically colorectal cancer, was made by Professor Michael Zimmerman on an ancient Egyptian mummy from the Ptolemaic period (200-400 CE). In 1895, Dr. Aldred Warthin, an American pathologist, studied a family with a pattern of endometrial, gastric, and colon cancers, leading to the identification of hereditary nonpolyposis colorectal cancer (HNPCC), also known as Lynch Syndrome. These early discoveries laid the foundation for understanding the genetic and hereditary aspects of colorectal cancer.

In the early 20th century, the primary diagnostic methods for colorectal cancer were limited to physical examinations and basic imaging techniques. Barium enema, introduced in the 1920s, allowed for the visualization of the colon and rectum using X-rays. However, this method had limitations in detecting small polyps and early-stage cancers.

The development of flexible sigmoidoscopy in the 1960s marked a significant advancement. This technique allowed for direct visualization of the lower part of the colon and rectum, enabling the detection and removal of polyps. However, it was limited to the distal colon and rectum, leaving the proximal colon unexamined. (3,5)

Past

Early Diagnosis

In the past, the diagnosis of colorectal cancer was primarily based on clinical symptoms and physical examinations. Patients often presented with symptoms such as rectal bleeding, changes in bowel habits, abdominal pain, and unexplained weight loss. However, these symptoms were often nonspecific and could be attributed to other gastrointestinal conditions, leading to delays in diagnosis.

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Diagnostic Techniques

The primary diagnostic techniques used in the past included: (3-5)

1. **Digital Rectal Examination (DRE):** This was one of the earliest methods used to detect abnormalities in the rectum. However, it had limited sensitivity and specificity.
2. **Fecal Occult Blood Test (FOBT):** This test detected hidden blood in the stool, which could indicate the presence of colorectal cancer. While it was a useful screening tool, it had limitations in terms of sensitivity and specificity.
3. **Barium Enema:** This radiographic examination involved the introduction of a barium solution into the colon to visualize abnormalities. However, it was not highly accurate and often required further confirmation with other tests.
4. **Sigmoidoscopy:** This procedure involved the insertion of a flexible tube with a camera into the rectum and lower colon to visualize and biopsy suspicious areas. It was limited to examining only the lower part of the colon.

Treatment Approaches

Surgery was the main modality of treatment for colon and rectal cancer and the foundation of CRC management was laid in the late 19th and early 20th centuries with the development of radical surgical techniques. The introduction of the abdominoperineal resection (APR) by Miles in 1908 revolutionized rectal cancer surgery, emphasizing wide resection margins and en bloc removal of the mesorectum. Similarly, the principles of colectomy for colon cancer were established, focusing on lymphatic clearance and vascular ligation. The main drawback of this approach was higher incidence of local recurrence and late metastatic disease.

In the mid-20th century, the integration of chemotherapy and radiotherapy into CRC management was introduced. The landmark trials of the 1980s and 1990s demonstrated the efficacy of 5-fluorouracil (5-FU)-based chemotherapy in improving survival and reduced incidence of late metastatic disease for stage III colon cancer. For rectal cancer, the introduction of neoadjuvant radiotherapy and chemoradiotherapy (CRT) reduced local recurrence rates and became a standard of care for locally advanced disease. (3-5)

Present

Advances in Diagnosis

The present era has witnessed significant advancements in the diagnosis of colorectal cancer. These advancements have improved early detection, accuracy, and overall patient outcomes. (2-6)

1. **Colonoscopy:** Colonoscopy has become the gold standard for diagnosing colorectal

FEATURE ARTICLE

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cancer. It allows for direct visualization of the entire colon and rectum, enabling obtaining samples for histopathology and detection and removal of polyps and early-stage tumors. It is highly sensitive and specific, making it an essential tool for screening and diagnosis.

2. **Imaging Techniques:** Advanced imaging techniques, such as computed tomography (CT) colonography (virtual colonoscopy), contrast enhanced CT and magnetic resonance imaging (MRI), have enhanced the visualization of the colon and surrounding structures. These techniques provide detailed images and help in staging the disease.
3. **Molecular and Genetic Testing:** Molecular and genetic testing has revolutionized the diagnosis of colorectal cancer. Tests such as KRAS, NRAS, and BRAF mutations, as well as microsatellite instability (MSI) testing, help identify specific genetic alterations that can guide treatment decisions and predict prognosis.

Screening Programs

Screening programs have played a crucial role in the early detection and prevention of colorectal cancer. Many countries have implemented population-based screening programs to identify individuals at risk and detect cancer at an early stage. Common screening methods include: (2-6)

1. **Fecal Immunochemical Test (FIT):** This test detects blood in the stool and is more sensitive and specific than the traditional FOBT. It is widely used in screening programs and has shown to reduce colorectal cancer mortality.
2. **Colonoscopy:** Colonoscopy is recommended for individuals at average risk starting at the age of 50. It allows for the detection and removal of polyps, preventing the progression to cancer.
3. **Flexible Sigmoidoscopy:** This procedure is similar to colonoscopy but examines only the lower part of the colon. It is often used in combination with other screening methods.

Treatment Approaches

The management of colorectal cancer has evolved significantly, with a multidisciplinary approach involving surgery, radiation therapy, chemotherapy, and targeted therapies. (3-7)

1. **Surgery:** Surgical resection remains the primary treatment for locoregional colorectal cancer. Minimally invasive techniques, such as laparoscopic and robotic-assisted surgery, have improved patient outcomes by reducing postoperative pain, hospital stay, and recovery time.
The adoption of laparoscopic and robotic techniques has transformed CRC surgery. Randomized trials, such as the COST and COLOR studies, have demonstrated the oncologic equivalence of laparoscopic colectomy to open surgery, with benefits including reduced postoperative pain, shorter hospital stays, and faster recovery. Robotic surgery, with its enhanced dexterity and visualization, has further improved outcomes in rectal cancer surgery, particularly in narrow pelvis.
The standardization of Total Mesorectal Excision (TME) by Professor Bill Heald in the 1980s revolutionized the rectal cancer surgery. TME, combined with neoadjuvant CRT, has significantly reduced local recurrence rates to less than 10%. The concept of the "holy plane" of dissection has become a cornerstone of rectal cancer surgery.
2. **Radiation Therapy:** Radiation therapy is commonly used in the treatment of rectal cancer. It can be administered before surgery (neoadjuvant) to shrink the tumor and improve surgical outcomes or after surgery (adjuvant) to reduce the risk of local recurrence.
3. **Chemotherapy:** Chemotherapy is used in various stages of colorectal cancer. It can be administered before surgery (neoadjuvant), along with radiotherapy to increase the radiosensitivity and after surgery (adjuvant) to eliminate remaining cancer cells, or in advanced cases to control the disease and improve survival. Common chemotherapy regimens include FOLFOX (5-fluorouracil, leucovorin, and oxaliplatin) and FOLFIRI (5-fluorouracil, leucovorin, and irinotecan).

Targeted Therapies: Targeted therapies have revolutionized the treatment of colorectal cancer. These therapies specifically target molecular alterations in cancer cells, such as epidermal growth factor receptor (EGFR) inhibitors (e.g., cetuximab) and vascular endothelial growth factor (VEGF) inhibitors (e.g., bevacizumab). They have shown significant efficacy in improving outcomes and prolonging survival.

Future

Emerging Diagnostic Techniques

The future of colorectal cancer diagnosis holds promise with the development of innovative techniques and technologies. (4-8)

1. **Liquid Biopsies:** Liquid biopsies involve the analysis of circulating tumor DNA (ctDNA) and other biomarkers in blood samples. This non-invasive approach has the potential to detect colorectal cancer at an early stage, monitor treatment response, and detect minimal residual disease or recurrence.

Photo by Unsplash

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2. **Artificial Intelligence (AI):** AI and machine learning algorithms are being developed to enhance the accuracy and efficiency of colorectal cancer diagnosis. These technologies can analyze large datasets, identify patterns, and assist in the interpretation of imaging and pathology results.
3. **Molecular Imaging:** Molecular imaging techniques, such as positron emission tomography (PET) and single-photon emission computed tomography (SPECT), are being explored for their potential to provide detailed information about tumor biology and guide personalized treatment strategies.

Personalized Medicine

The future of colorectal cancer management lies in personalized medicine, where treatment decisions are tailored to the individual patient based on their genetic and molecular profile. (6 -10)

Multidisciplinary Tumor Boards: The integration of surgery, medical oncology, radiation oncology, radiology, and pathology in multidisciplinary tumor boards has optimized treatment planning and improved outcomes. This collaborative approach ensures that patients receive tailored, evidence-based care.

1. **Genomic Profiling:** Comprehensive genomic profiling of colorectal tumors can identify specific genetic alterations and guide targeted therapies. This approach allows for the selection of treatments that are most likely to be effective for each patient, minimizing unnecessary side effects.
2. **Immunotherapy:** Immunotherapy has shown promising results in the treatment of various cancers, including colorectal cancer. Immune checkpoint inhibitors, such as pembrolizumab and nivolumab, have demonstrated efficacy in patients with microsatellite instability-high (MSI-H) or mismatch repair-deficient (dMMR) tumors. Ongoing research aims to expand the use of immunotherapy to a broader population of colorectal cancer patients.
3. **Precision Surgery:** Advances in surgical techniques, such as image-guided surgery and robotic-assisted surgery, are expected to further improve the precision and outcomes of colorectal cancer surgery. These techniques allow for more accurate tumor removal while preserving healthy tissues and minimizing complications.
4. **Organ Preservation Strategies:** For selected patients with locally advanced rectal cancer, non-operative management (NOM) or "watch-and-wait" approaches are gaining attraction. Patients who achieve a clinical complete response (cCR) after neoadjuvant CRT may avoid surgery, thereby preserving bowel function and quality of life. However, careful surveillance is essential to detect early recurrence.

> "The diagnosis and management of colorectal cancer have come a long way, with significant advancements in early detection, treatment options, and personalized medicine. The future holds promise with emerging diagnostic techniques, personalized treatment approaches, and efforts to prevent and detect colorectal cancer at an early stage.

Prevention and Early Detection

Efforts to prevent colorectal cancer and detect it at an early stage will continue to be a priority in the future. (5-10)

1. **Lifestyle Modifications:** Promoting healthy lifestyle choices, such as a balanced diet, regular physical activity, and avoiding tobacco and excessive alcohol consumption, can reduce the risk of developing colorectal cancer.

2. **Screening Programs:** Expanding and improving screening programs will be crucial in reducing colorectal cancer incidence and mortality. Efforts should focus on increasing awareness, accessibility, and adherence to screening guidelines.

3. **Genetic Counseling and Testing:** Genetic counseling and testing for individuals with a family history of colorectal cancer or known genetic predispositions (e.g., Lynch syndrome) can help identify high-risk individuals and implement appropriate surveillance and preventive measures.

Conclusion

The diagnosis and management of colorectal cancer have come a long way, with significant advancements in early detection, treatment options, and personalized medicine.
The future holds promise with emerging diagnostic techniques, personalized treatment approaches, and efforts to prevent and detect colorectal cancer at an early stage. Continued research, innovation, and collaboration among healthcare professionals will be essential in improving outcomes and reducing the burden of colorectal cancer worldwide.

References

1. Ministry of Health, Sri Lanka. Cancer incidence data 2020. Colombo. Sri Lanka cancer registry 22nd Publication.
2. National Cancer Institute. **Advances in colorectal cancer research**. National Cancer Institute; 2024.
3. One hundred years of curative surgery for rectal cancer: 1908-2008. Lange MM, Rutten HJ, van de Velde CJ. Eur J Surg Oncol. 2009 May.
4. A Review of Neoadjuvant Therapy and the Watch-and-Wait Protocol in Rectal Cancer: Current Evidence and Future Directions. Slavu IM, Munteanu O, Filipoiu F, Tulin R, Macovei Oprescu AM, Dima I, Dogaru IA, Tulin A. Cureus. 2024 Sep 2;16(9).
5. From dinosaurs to DNA: a history of colorectal cancer. Mulcahy HE, Hyland J, O'Donoghue DP.Int J Colorectal Dis. 2003 May;18(3):210-5. doi: 10.1007/s00384-002-0461-0. Epub 2002 Dec.
6. National Cancer Institute**. Shield blood test approved for colorectal cancer screening**. National Cancer Institute; 2024. https://www.cancer.gov/news-events/cancer-currents-blog/2024/shield-blood-test-colorectal-cancer-screening
7. Tan SC, Yeoh KG. **Current and emerging therapeutic approaches for colorectal cancer.** *Front Oncol*. 2024; 14:123456.
8. Kim Y, Park J, Lee S. **Stool and blood biomarkers for colorectal cancer management**. *Mol Cancer*. 2024;23(2):789–804. https://molecular-cancer.biomedcentral.
9. Wang X, Zhao L, Chen H. **Recent advances in therapeutic strategies to improve colorectal cancer treatment.** *Cancers (Basel)*. 2024;16(5):1029.
10. Patel S, Johnson R, Lee M. **Radiomics-based artificial intelligence models in colorectal cancer diagnosis.** *ArXiv*. 2024.

VOICES FROM THE PERIPHERIES

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UNITY IN DIVERSITY: PUBLIC HEALTH TRAINING CENTER SHINES FROM THE EAST

The Eastern Provincial Health Training Center (PHTC), located in the Batticaloa District of Sri Lanka's Eastern Province, stands as a beacon of unity in diversity. As the second-largest and the only provincial health training center in the country offering instructions in all three national languages Sinhala, Tamil, and English. PHTC Batticaloa plays a vital role in bridging language and cultural gaps in public health education. This ground breaking institution was inaugurated on 24th February 2018, under the national policy to establish a health training center in each province.

The center was founded with a clear mission: to enhance healthcare knowledge, attitudes, soft skills, and practices among the health workforce of the Eastern Province. It serves as a critical engine in building human resources in healthcare through high-quality, accessible, and inclusive in-service training. In doing so, it strengthens the region's healthcare delivery system and supports the broader objectives of the Ministry of Health.

PHTC Batticaloa is also one of the few centers in the country offering nationally accredited diploma programs for Public Health Inspectors (PHIs) and Public Health Midwives (PHMs), catering to trainees recruited by the Ministry of Health. Its hallmark is its comprehensive and inclusive approach to health training, supported by state-of-the-art facilities, a dedicated faculty, and a commitment to national service.

Key Training Programs offered at PHTC Batticaloa Include:

- Internal In-Service Training for all categories of curative and preventive health staff within the Eastern Provincial Health Department.
- Training for officers from other government departments.
- Continuous Professional Development (CPD) programs for existing healthcare personnel.
- Training of Trainers (ToT) programs, particularly for medical officers and public health staff.
- Pre-Service Diploma Programs for PHIs, PHMs, and other paramedical staff, conducted in collaboration with the Ministry of Health.

A flagship initiative currently underway is the Public Health Midwife Trainee Diploma Program (2021–2022 B batch), launched on 2nd September 2024 and scheduled for completion on 2nd March 2026. This 18-months training program includes both clinical (12 months) and community/public health (6 months) components, now fully integrated and delivered at a single institution, an unprecedented move by the Ministry of Health.

PHTC Batticaloa is one of only eleven centers island-wide designated to conduct this program for Tamil-speaking trainees. For the first time, 99 trainees from across Sri Lanka, including the Northern, Eastern, Uva, and Central Provinces were selected based on their A-Level examination Z-scores, forming a diverse cohort unified by a shared vision: to serve as professional midwives. The training environment fosters a sense of national unity, with participants forming bonds that transcend regional and ethnic boundaries.

Modern Infrastructure and Comprehensive Facilities

PHTC Batticaloa boasts modern infrastructure tailored to a high standard of academic and practical training, including:

- Fully equipped classrooms and training halls
- 50-seat conference hall and 200-seat auditorium
- 120-seat cafeteria and residential accommodation
- A computer lab with e-learning resources and audio-visual learning tools
- A fully equipped indoor stadium and gymnasium
- Hostel facilities for outstation trainees and resource persons

Integrated, Holistic Learning Approach

In addition to a curriculum grounded in theory, trainees receive instruction in modern e-learning methods, hands-on clinical skills (including childbirth procedures), communication techniques, and leadership development. The training is delivered in partnership with professionals from Teaching Hospital Batticaloa, the Regional Directorate of Health Services (RDHS), and the Faculty of Health Care Sciences, Eastern University. Hospital-based training takes place at multiple locations, including Teaching Hospital Batticaloa and Base Hospitals in Valaichenai, Kaluwanchikudy, and Kattankudy. Regular trainee assessments are conducted in collaboration with hospital administrations and obstetric units, ensuring the highest standards of professional competence.

Celebrating Cultural Harmony

To foster inclusivity and unity, PHTC Batticaloa encourages trainees to celebrate religious and cultural festivals from all backgrounds. These events, organized by the trainees themselves, promote mutual understanding, respect, and a shared sense of purpose, truly embodying the center's ethos of "unity in diversity."

A Beacon of Learning and Leadership

With its guiding motto, "Learning should be sustained, disciplined, and enjoyable for better outcomes" PHTC Batticaloa continues to shine as a beacon of public health training in Sri Lanka. Through its unwavering dedication to quality, equity, and innovation, the center exemplifies how a regional institution can make a national impact.

SPECIAL ARTICLE

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PRESCRIBING WITH CAUTION: INITIATIVE TO REGULATE NSAID AND STEROID USE IN DENGUE FEVER MANAGEMENT

Introduction

Dengue fever continues to challenge Sri Lanka's health system, particularly during seasonal surges. As clinical guidelines for dengue management emphasize the critical role of appropriate symptomatic treatment, growing concerns have emerged regarding the indiscriminate use of non-steroidal anti-inflammatory drugs (NSAIDs) and corticosteroids, both of which are contraindicated in suspected or confirmed dengue cases.

This concern is further heightened by the recent concomitant outbreak of chikungunya fever, which often presents with joint and muscle pain—symptoms commonly managed with NSAIDs and oral steroids. However, the use of these medications without first excluding dengue poses a significant risk to patient safety. Clinical best practice recommends refraining from the use of NSAIDs and oral steroids during the initial febrile phase unless dengue has been definitively ruled out.

In response, the National Dengue Control Unit (NDCU) under the Ministry of Health has launched a pioneering NSAID and Steroid Prescription Notification System, aiming to curtail these potentially harmful practices.

Why This System Was Needed

The decision to establish a notification system was driven by findings from *national reviews of severe dengue cases and dengue-related deaths*, as well as a *consensus reached by the Technical Advisory Group (TAG)* on dengue prevention and control. These reviews and subsequent discussions with *clinical and public health experts* highlighted several critical concerns:

- *Inappropriate use of NSAIDs* and *early administration of steroid injections* and *oral corticosteroids* in *febrile patients without definitively ruling out the possibility of dengue*.
- *Limited awareness or non-adherence* to national dengue management guidelines among *private practitioners, pharmacy staff*, and even some *hospital-based clinicians*.

Although these medications are commonly used to manage fever and pain, their use in dengue patients can significantly *increase the risk of bleeding, fluid leakage,* and *mask vital warning signs*, leading to *delayed diagnosis, inappropriate clinical management, severe complications* and a *high risk of mortality*.

System Overview

The *NSAID/Steroid Notification System* is designed to serve as a *surveillance and accountability tool*, rather than a punitive mechanism. It is currently being piloted in three hospitals in the Western Province — the *National Institute of Infectious Diseases*, the *National Hospital of Sri Lanka*, and the *District General Hospital, Negombo* — and is expected to be *expanded island-wide*.

The core components of the system include:

- A *dedicated WhatsApp reporting number*, made available through the *National Dengue Control Unit (NDCU)*
- *Voluntary reporting* by clinicians when NSAIDs or steroids are prescribed or dispensed to febrile patients, without excluding dengue
- As a *first step*, a *warning letter* is issued to the prescriber or dispenser, along with relevant educational information
- If inappropriate practices persist, *further actions* include notifying *regional health authorities* and, if necessary, *referring the case to the Sri Lanka Medical Council (SLMC)*

This system aims to *promote safe prescribing practices*, support *early dengue detection*, and reduce the risk of *avoidable complications* and *deaths*.

Stakeholder Engagement and Consultative Process

The development of this system followed a structured consultative process involving:

- Expert clinicians, pharmacists, and public health specialists
- Representatives from the *Sri Lanka Medical Association (SLMA)*, *Sri Lanka College of Paediatricians*, *Ceylon College of Physicians*, and the *Pharmacists* and *Pharmacy Owners' Associations*
- Field-level discussions with *hospital directors*, *hospital staff*, and *MOHs* to understand barriers and feasibility

Meetings were conducted in 2024 to finalize reporting mechanisms and to gather feedback on training needs.

Early Outcomes

While the system is still in its early stages, several *encouraging trends* have been observed:

- An *increasing number of notifications* by clinicians, indicating growing engagement with the system
- Since notifications are shared with *regional health authorities*, they are better positioned to *trace the location of inappropriate practices* and assist in *disseminating key messages* at the ground level
- In hospitals with multiple clinicians, the notification process not only reaches the *prescribing doctor*, but also *alerts the institution* as a whole, promoting *internal review* and *reinforcement of correct prescribing practices* in line with national dengue management guidelines

Preliminary findings will be analyzed and discussed with experts to guide next steps and future evaluations.

Challenges and the Road Ahead

As with any health system innovation, the *NSAID/Steroid Notification System* faces a number of challenges in its implementation and scale-up:

- *Difficulties in tracing locations*, particularly when notifications lack key details. This often requires additional follow-up with *regional health staff*, increasing coordination needs.
- *Underreporting* from certain hospitals, due to factors such as workload, limited awareness, or uncertainty about the reporting process.
- *Scarcity of human resources*, both at central and regional levels, which can hinder timely follow-up and awareness-raising.
- The system currently relies on *personal mobile phones for reporting*, which can raise concerns regarding continuity.

Despite these challenges, the NDCU remains committed to *protecting patient safety* and *strengthening dengue case management* through collaborative and evidence-based public health action.

Conclusion

The inappropriate use of NSAIDs and steroids in dengue is a preventable contributor to dengue complications and deaths. By introducing the Notification System, the NDCU has taken a proactive step toward protecting patients, strengthening clinical accountability, and promoting rational drug use. As the health system continues to battle dengue, innovations like this provide a blueprint for addressing emerging threats through multisectoral engagement, digital tools, and evidence-informed strategies.

NOVICE

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WHEN HEALTH MESSAGES MISS THE MARK: RETHINKING NCD COMMUNICATION THROUGH COMMUNITY AND CULTURE

The war against noncommunicable diseases (NCDs) is our most critical public health challenge(1–3). While advancements in medicine and policy reforms are vital in managing this crisis, they are not enough alone(4,5). Around the world, health communication is increasingly recognised as a key force in preventing these conditions(6), helping people understand risks, change behaviours, and make informed decisions about their health(7). It is not just about delivering information; it is about connecting with people in ways that motivate lasting change(8,9).

This article presents insights from a critical evaluation of health communication theories employed globally for NCD prevention, alongside a health communication theory and strategic evaluation grounded in the Health Belief Model(10), Lasswell's model(11), and the social marketing mix(12). The study also incorporated primary research, including focus group discussions (FGDs) with selected populations in the Gampaha district, addressing various socio-demographic groups. Additionally, key informant interviews were conducted with service providers from the Ministry of Health, focusing on selected Facebook content from three different Ministry of Health Sri Lanka Facebook pages. Furthermore, this article looks at how people in Sri Lanka understand health messages, and how that compares to what happens. Even with a lot of effort from health professionals to help people live healthier, studies show there's a big difference between our good intentions in health communication and how effective they are in real life. A main reason for this problem is not fully understanding the culture of the people we're trying to reach. And the lack health communication theoretical usage.

How do we access that understand and socio-cultural empathy about our target audience?

As health researchers and communicators, an in-depth understanding of our target communities is paramount before engaging with them(13–15). This necessitates gaining a very subtle and sensitive comprehension of their socio-cultural values and beliefs(16). The crucial question then becomes: How do we access this socio-cultural empathy?

We possess a variety of anthropological and sociological research methods to gain such access(17,18). Conventional methods include Focus Group Discussions (FGDs), which involve gathering small groups (e.g., rural farmers, urban youth, mothers, traditional healers) to discuss perceptions, attitudes, and experiences related to NCDs and health behaviors, providing rich, nuanced data. Additionally, In-depth Interviews (IDIs) are conducted with key informants (e.g., community leaders, traditional healers, local shopkeepers, people living with NCDs) to explore sensitive topics or obtain expert perspectives. Other methods include Participatory Rural Appraisal (PRA) / Community-Based Participatory Research (CBPR), which involve active community participation in understanding issues and developing solutions; Surveys (Quantitative), used for collecting broad data from a larger population; and Desk Research, which involves reviewing existing literature and data.

In addition to these established methods, a novel approach gaining traction in modern psychological and community health research is "Netnography". Netnography is a qualitative research method that adapts ethnographic techniques like peer observation, interviews, and social network analysis to study online communities and cultures. It involves observing and analyzing interactions within online spaces, such as social media platforms or online forums, to understand the behaviors, beliefs, and social structures of individuals and groups. Essentially, it is a form of online ethnography, where researchers immerse themselves in virtual environments to gather insights into human behavior.

Researchers can also immerse themselves in the community or observe online discussions (Netnography) to understand how daily routines, social interactions, decision-making processes, and communication patterns naturally occur. Observing family meal preparations, community gatherings (like Dansala during Vesak), or discussions in local online forums can provide insights into community attitudes and beliefs, including unspoken norms. These methods collectively help bridge gaps and foster understanding between communities and health professionals.

The professional training of public health researchers, doctors, and content developers training instils a deep appreciation for empirical evidence, clinical guidelines, and epidemiological data. We craft messages based on what the science dictates. As an example; "Eat less sugar," "Exercise daily," "Quit smoking." While scientifically sound, this often leads to a monocultural, dogmatic communication style that expects audiences to absorb and act. The reality, however, is that human behaviour is rarely a purely rational response to information(19). It is deeply embedded in social norms, cultural values, personal beliefs, socio-economic circumstances, and immediate environmental cues(20,21). So, what is the indispensable role of cultural relevance and how to fill this gap?

A major contributor to the "expectation vs reality" gap is the underestimation of cultural relevance. For health communication to be truly effective, it must be culturally sensitive, appropriate and competent. This is not simply about translating words into the local language. It is about translating meaning, understanding context and

Picture by website of the Sanka Vidanagama Photojournalism

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respecting the complex tapestry of reality that exists in a community. For example, ignoring Sri Lankan cultural values and beliefs that have been ingrained over time can undermine even the best-intentioned campaign.

The traditional beliefs and practices in other hand we called Ethnomedicine based approaches, really important. Now the question is why and how.?

Sri Lanka is a country with a rich heritage of traditional medicine such as *Ayurveda, Deshiya Chikitsa*, *Siddha, Unani* and beliefs. For example, concepts such as dhatu (elements), *dosha* (humors), *guru-kola* (hot-cold qualities of foods), or spiritual afflictions are deeply rooted in many people's understandings of health and illness(22). If a movement promoting "modern" dietary advice for diabetes ignores or contradicts the long-standing guru-kola system, resistance or confusion may arise(23,24). Instead, strategies that acknowledge or strategically integrate traditional beliefs, such as the formulation of a "balanced diet" along those theoretical foundations and concepts, may be more effective(24).

Picture by website of the Sanka Vidanagama Photojournalism

Also, the very creative *Nadagama* and *Kolam* dramas in Sri Lanka can be identified as very powerful mass communication strategies. (25) For example, if we can study the *Sokari Nadagama*/folk drama of the southern region and north and north-central, we can see with a creative eye how our people in the past communicated psychological problems and family health-related issues within the communities. This folk drama runs throughout and it is seen from a social and biological perspective that very practical issues such as the nature of a love relationship and the various situations in a family and the impact that people around us have on us as humans are very practical(25). There, we can see how a woman who is alone with a child and the good people who surround her take care of the child and the mother, how they protect their mental health, are very creatively popularised through poetry and dance, attributing divinity to them(26). Simply put, it even socialises how a child is raised. In the past, this was done by gathering small rural communities and performing this play to them. Since a deity was created around the play, fear and excitement were created in the community. The creators of that time used it as a strategy to keep the community involved until the end. As researchers, we can understand and study such cultural aspects by understanding the target communities living in the specific areas mentioned above and creatively prevent diseases and educate people about them.

The practices and objectives are the points that have emerged through the interviews and comments I have conducted with the communities.

In particular, the attitude of the people is to create health communication messages that can be understood by them and can be understood in a common way. Also, they are more willing to appreciate it if the relevant messages can be approached through their beliefs, beliefs and cultural values.

Another shortcoming that we, as health communicators and promoters, have made in the past few decades is that we have not been able to make the most of health communication strategies and communicate public health without being grounded in theoretical backgrounds based on anthropology, mass communication, behavioural science, and psychology.

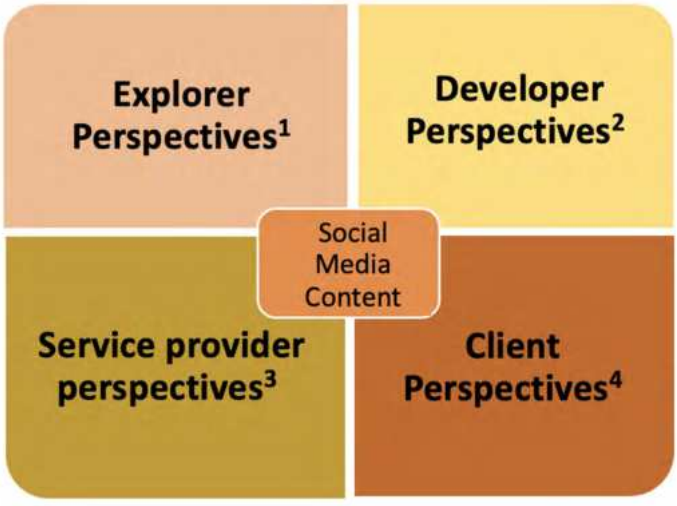
This became clear in the 5-year interdisciplinary analysis of noncommunicable diseases around the past decade. The theoretical underpinnings of the content created and published by institutions under ministry of health were found to be weak although their strategic approach was good. However, effective behavioural change can only happen through sensitive push through theoretically sound, culturally apt content delivered strategically towards the target communities. A point that emerges from the study of Aristotle's (27,28) principles is that; *"When dealing with the human soul, we must first seek understanding - this is the gift of theory. It shows us not only what people do, but why they do it. Without this insight, we risk treating symptoms without understanding the causes, and prescribing solutions without grasping the need. Theory does not distance us from humanity; it brings us closer - giving structure to empathy and logic to compassion."*

Therefore, just as we strategically think about how we send a health message to the planet, it is time to think theoretically about how the message will work in their behavioral systems, influence cultural values, and how close human communication will be and be affected.

Let's look at how we can work together to bridge these gaps and improve health messaging

In Sri Lanka, many people expect health messaging to help them live healthier lives. But the reality often falls short. Why? Because we try to solve problems by working individually. To change this, we need to work as one team, using a method called the Integrated Stakeholder Framework for Health Communication Content Development (ISF-HCC).

This is not just a step-by-step plan. It is like a cycle, where we are learning and adjusting as we go. This framework was developed with a particular focus on health communication through social media, recognising its growing dominance in the modern communication landscape. Social media has emerged as the most powerful and effective medium for reaching both individuals



Integrated Stakeholder Framework for Health Communication Content Development (ISF-HCC) by Thilak Wanasinghe

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and broader communities. Its unique strength lies in its dual capacity: it enables personalised engagement while also serving as a mass communication platform. In the context of health promotion, this duality makes social media an ideal vehicle for delivering tailored, culturally sensitive, and timely messages that can influence behaviour change at scale. It brings together four important groups and their perspectives. The explorer (researchers), the provider (health professionals), the developer (content creators) and the client perspective (the target community). Let's see how this works using everyday Sri Lankan examples.

1. **Researchers** always explain the purpose of content by asking what it is and why it is needed. They are the ones who find out what is really happening. For example, they might go to a village in Polonnaruwa and find that people believe that a long-term cough is caused by drinking too much porridge, but in fact it could be an early sign of lung disease. Researchers use evidence and theories to study why people eat too much rice or don't exercise. Their job is to uncover the truth and share it clearly, so we know what to do.

2. **Service providers/health professionals** decide how and where, when, and in what way communication content should be created.

   Our local public health inspectors, midwives or doctors are the ones who know what works and what doesn't in real life. For example, they might say that if a message about eating more vegetables is printed on a long leaflet, it won't reach people. But if the same message is shared by a respected village elder at a temple meeting or through a Veda Mahattya (traditional healer), people are more likely to listen. They help shape the ideas because they know what is happening in the community. So, the combination of these parties is essential.

3. The perspective of the **content creator's or developer's** is critical. They are the ones who work to create the look and feel of the content. They are the ones who have studied this both theoretically and practically, so their knowledge and perspectives are critical

   These are the storytellers - TV producers, designers and social media teams. They take all the research and ideas and turn them into something people enjoy and understand. For example, instead of giving statistics about diabetes, they could create a short drama or TikTok video showing a father with diabetes learning to cook delicious, healthy meals with his daughter. Or they can use a "society" stage play to deliver messages in a fun way. Their goal is to position the message within the public creatively.

4. **The client's** perspective plays a crucial role in the survival of this process. Finally, we should always listen to who the message is for. If a campaign says, *"Don't prepare sweets for the New Year, don't use salt for cook rice, don't use sugar for sweets"* and people feel that it is attacking their traditions, we need to listen to it. Their feedback should go directly to the researchers and designers so that the message can be changed. After all, health messages won't work if they don't respect people's values, beliefs, and daily struggles.

The strength of this model is that it allows everyone to talk and learn from each other. And in this framework, health communication and behavioural development theories should be used at all times and their foundations and approaches should be based on scientific work. Researchers drive the message, health workers test it, designers shape it, and people tell us if it works. Then, the cycle begins again. It is a team effort. Not a one-time event.

Let's work together: Random messages, online posts, and videos you hope someone will see are no longer influential. It is a modern social media staple in basic health communication. Health communication content should be developed to recognise the client's needs, the creators' cultural competency, and the service provider's vision towards behaviour change. We must educate people about better health and protect them from noncommunicable and communicable diseases. The need for us to be more proactive and proactive is more urgent than ever in an era of social media. However, we will never reach that goal unless we identify our strengths and work together as a team across multiple disciplines. Integrated Stakeholder Framework for Health Communication Content Development (ISF-HCC) offers us a better way forward. It brings together science, local knowledge, creative ideas and community voices. It helps us create messages that don't just tell people what to do. It inspires them to make a real difference in people's lives.

References

1. World Health Organization (WHO). World health statistics 2025. Vol. 27, The Milbank Memorial Fund quarterly. 2025. 179–187 p.
2. Statista. Social media usage in the world: 2017 to 2025 [Internet]. 2022. p. 01. Available from: https://www.statista.com/statistics/278414/number-of-worldwide-social-network-users/
3. WHO. Global Strategy on Digital Healt 2020-2025. 2021.
4. Ashcraft LE, Quinn DA, Brownson RC. Strategies for effective dissemination of research to United States policymakers: a systematic review. Implementation Science. 2020;15(1):1–18.
5. Gamlath L, Nandasena S, Silva P De, Morrell S, Linhart C, Lin S, et al. Community intervention for cardiovascular disease risk factors in Kalutara, Sri Lanka. BMC Cardiovasc Disord. 2020;20(1):1–17.
6. Bolden K. Communication: Theory and practice. Practice Nursing. 1996;7(17):19–21.
7. Johnson J, Clinton J, Knight J, Lynch R, Mccarthy T, Olson K, et al. COMMUNICATION, CRITICISM, AND THE POSTMODERN CONSENSUS An Unfashionable Interpretation of Michel Foucault. Vol. 25, POLITICAL THEORY. Sage Publications, Inc; 1997.
8. Hargie O. Skilled interpersonal communication: Research, theory and practice. Skilled Interpersonal Communication: Research, Theory and Practice. 2021 Nov 30;1–662.
9. Renata S. Health Communication: From Theory to Practice. Journal of the Medical Library Association: JMLA. 2007. 91–119 p.
10. Janz NK, Becker MH. The Health Belief Model: A Decade Later. Health Education & Behavior. 1984;11(1):1–47.
11. Wenxiu P. Analysis of New Media Communication Based on Lasswell's "5W" Model. Journal of Educational and Social Research. 2015;5(3):245–50.
12. Smith WA. Social marketing: An overview of approach and effects. Injury Prevention. 2006;12(SUPPL. 1):38–43.
13. Du Pré A. Communicating About Health: Current Issues and Perspectives. Mountain View, Calif.: Mayfield Publishing Company; 2000. 450 p.
14. Gómez EJ. Enhancing our understanding of the commercial determinants of health: Theories, methods, and insights from political science. Soc Sci Med [Internet]. 2022;301:114931. Available from: https://www.sciencedirect.com/science/article/pii/S0277953622002374
15. World Health Organisation. WHO Strategic Communications Framework. World Health Organization [Internet]. 2017;2017(July):56. Available from: https://www.humanitarianlibrary.org/sites/default/files/2020/11/communication-framework.pdf
16. Parvanta CF, Bass SB. Health communication: strategies and skills for a new era. Healt communication: strategies and skills for new era. 2020. 343 p.
17. Tian G, Borges L. The Effectiveness of Social Marketing Mix Strategy: Towards an Anthropological Approach. International Journal of Business Anthropology. 2012;3(1):102–13.
18. Trigger BG, Trigger BG. Canadian Anthropology Society Inequality and Communication in Early Civilizations Linked references are available on JSTOR for this article : Inequality and Communication in Early Civilizations. 2015;18(1):27–52.
19. Hagger MS, Cameron LD, Hamilton K, Hankonen N, Lintunen T. Changing Behavior: A Theory- and Evidence-Based Approach. In: Hagger MS, Cameron LD, Hamilton K, Hankonen N, Lintunen T, editors. The Handbook of Behavior Change. Cambridge University Press; 2020. p. 1–14. (Cambridge Handbooks in Psychology).
20. Kreuter MW, McClure SM. The role of culture in health communication. Annu Rev Public Health. 2004;25:439–55.
21. Sharara E, Akik C, Ghattas H, Obermeyer CM. Physical inactivity , gender and culture in Arab countries : a systematic assessment of the literature. 2018;1–19.
22. Manoj Jinadasa. Bali Rituals and Therapeutic Communication in the Traditional Rural Society in Sri Lanka. Journalism and Mass Communication. 2016;6(11):679–99.
23. Jones M, Liyanage C. Traditional Medicine and Primary Health Care in Sri Lanka: Policy, Perceptions, and Practice. Asian Review of World Histories. 2018;6(1):157–84.
24. Arseculeratne SN. Interactions between Traditional Medicine and "Western" Medicine in Sri Lanka. Soc Sci (New Delhi). 2002;30(5/6):4.
25. Folk S, Lanka S. A Study on the Worship of Goddess Paththini and the Cultural Values of the A Study on the Worship of Goddess Paththini and the Cultural Values of the Sokari Folk Story in Sri Lanka. 2023;(November).
26. Silva J. Preservation of an Artist Legacy : Angelo de Sousa ' s Photographic and Filmic SOIMA 2015 International Conference. 2022;(May).
27. Scott PA. Aristotle, Nursing and Health Care Ethics. Nurs Ethics. 1995;2(4):279–85.
28. Wanje CN. An Application Of The Aristotelian Theory Of Akrasia In Communication Interventions Among HIV AIDS NGOs In Kenya. 2017;4(7)

SLMA IN MAY

Highlights

Updates on Newer Frontiers for Clinical Advancement: SLMA's First Regional Meeting 2025 in Galle

First Regional Clinical Meeting of the SLMA for year 2025 was held in collaboration with the Galle Medical Association at the National Hospital, Galle. The theme for the clinical meeting was "Updates on Newer Frontiers for Clinical Advancement". Several important lectures were conducted in line with the theme including,

- Artificial Intelligence and Mathematical Modelling; Powerful Duo for Healthcare Innovations by Dr. U P Liyanage, Senior Lecturer, Department of Mathematics, University of Colombo
- Future of Scientific Research: Opportunities, Challenges and Ethics by Professor Sachith Mettananda, Consultant Paediatrician, CNTH Ragama
- From Empiric to Precision: Optimizing Antimicrobial Use Through Rational Prescribing and Microbiological Guidance by Dr. Krishantha Jayasekera Consultant Physician, Dr. Bhagya Piyasiri Consultant Microbiologist, Professor Nayana Liyanarchchi Consultant Paediatrician National Hospital, Galle
- Advances in Geriatric Medicine: Shaping the Future of Healthy Ageingby Dr. Warsha De Zoysa Consultant Physician, National Hospital Galle
- Lung Health Across the Life Course by Dr Amila Rathnapala Consultant Respiratory Physician National Hospital Galle, Dr Chana de Silva Paediatric Pulmonologist LRH, Dr. Neranjan Dissanayake Consultant Pulmonologist TH Kalutara

SLMA IN MAY

Highlights

SLMA Saturday Talks

Following Saturday Talks were held in the month of May.

- Essentials of Clinical Radiology; What Every Doctor Should Know by Dr. Aruna. S .Pallewatte, Consultant Radiologist, NHSL Colombo
- Suicidal Risk in Young People by Professor Miyuru Chandradasa, Professor in Psychiatry, University of Kelaniya.
- Blurred Line: Nephrotic, Nephritic or Both by Dr. Udana Ratnapala Consultant Nephrologist, DGH Chilaw

SLMA in MAY

Monthly Clinical Meeting for the month of May

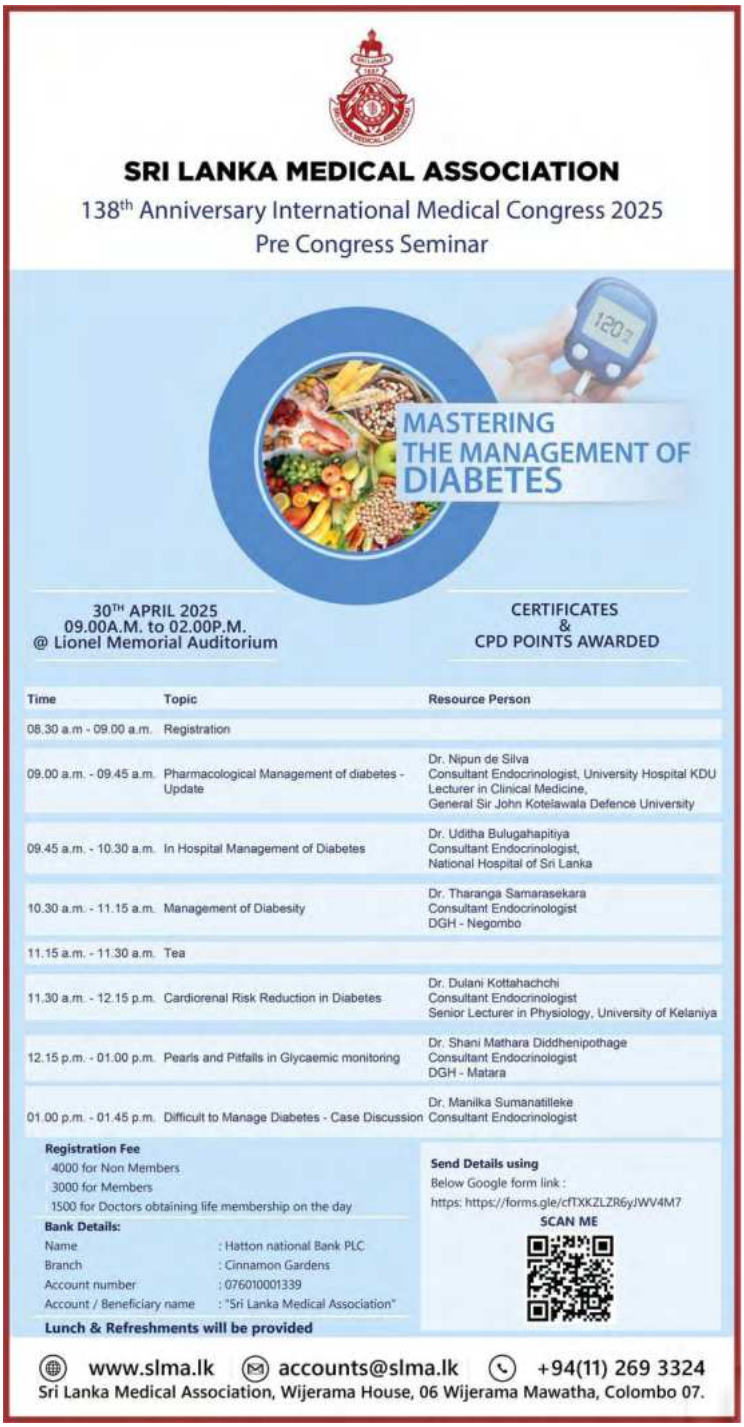
Monthly Clinical Meeting for the month of May was conducted in collaboration with the Sri Lanka College of Nutrition Physicians and Sri Lanka Medical Nutrition Association under the theme 'Obesity Across the Spectrum, From Mechanisms to Management. Resource persons include, Dr. Dhammika Rathnayaka, Dr. Nipun De Silva and Dr. Sajitha Jayasekara.

SLMA IN MAY

Highlights

Pre-Congress Workshop on 'Mastering the Management of Diabetes'

Pre-Congress Workshop on 'Mastering the Management of Diabetes' was organized with expert contributions from eminent clinicians including, Dr. Nipun de Silva, Dr. Uditha Bulugahapitiya, Dr. Tharanga Samarasekara, Dr. Dulani Kottahchchi, Dr. Shani Diddhenipothage and Dr. Manilka Sumanathilake. Nearly 200 doctors participated in the workshop.



SLMA IN MAY

Highlights

Pre-Congress Workshop on 'Acute Cardiovascular Care'

Pre-Congress Workshop on 'Acute Cardiovascular Care' was held at the Lionel Memorial Auditorium of the SLMA, in Collaboration with Sri Lanka College of Cardiology with participation of over 150 participants. Dr. Tanya Pereira, Dr. Zacky Hanifa, Dr. Ajith Wanniarachchi, Dr. Amila Walawwatta, Dr. Gamini Galapaththi, Dr. Aasanga Dunuvila, Dr. Prakash Priyadarshan contributed as the resource persons.

Pre-Congress Session on 'Foundations of Clinical Research; Principles, Practice and Publication'

Pre-Congress Session on 'Foundations of Clinical Research; Principles, Practice and Publication' was held as part of the pre congress series of the 138th Anniversary International Medical Congress of the SLMA. Professor Nuwan Wickaramasinghe, Chair Professor of Community Medicine, Rajarata University of Sri Lanka and Dr. Nadeeka Chandraratne, Senior Lecturer in Community Medicine, UCFM conducted the sessions.

SLMA IN MAY

Highlights

Media Conference on 'Dengue and Chikungunya'

Media Conference on "Dengue and Chikungunya" was conducted to educate general public through both electronic and print media. Dr. Surantha Perera, President SLMA and Consultant Paediatrician, Dr. Ananda Wijewickrama, Consultant Physician and Dr. Anoja Dheerasinge, Consultant Community Physician contributed as speakers. The media conference was given a wider publicity by all media channels including in prime-time news.

ACHIEVEMENTS OF SLMA COUNCIL MEMBERS

Professor Jennifer Perera, former President of the SLMA and current council member has been appointed as the New Registrar of the Ceylon Medical College Council

Snapshots from the SLMA Monthly Clinical Meeting in collaboration with Sri Lanka College of Nutrition Physicians and Sri Lanka Medical Nutrition Association

SLMA IN MAY

Highlights

SLMA and Pick a Book Unite to Inspire Young Minds in Piliyandala

SLMA in collaboration with 'Pick a Book' community reading platform, donated a consignment of children's books and soft toys to maternal and child health poly clinic of the Medical Officer of Health Office, Piliyandala. This is the second successful programme under 'Reach Out and Read' Organizational Social Responsibility Campaign of the SLMA and 'Read and Rise' community programme of the Pick a Book platform.

GLOBAL FOCUS

MAY 2025

'World's First' Gonorrhoea vaccine to be rolled out in England

Ushering in a landmark moment for sexual health, Health authorities in England and Wales have given the green light for a vaccine against Gonorrhoea , one of the commonest Sexually Transmitted Infections (STI) . The vaccine is an existing jab, known as 4CMenB, that is used against the meningococcal B infection. Studies by the Joint Committee on Vaccination and Immunization (JCVI) suggest that the 4CMenB vaccine has between 32.7% to 42% effectiveness against gonorrhoea, and vaccination would reduce the risk of becoming infected, however it would not eliminate it completely.

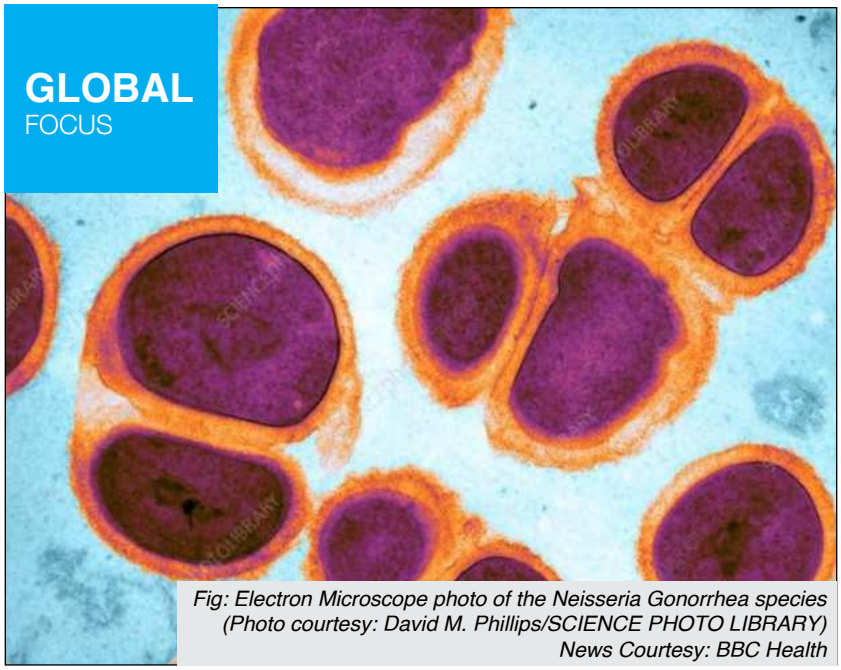


Fig: Electron Microscope photo of the Neisseria Gonorrhea species (Photo courtesy: David M. Phillips/SCIENCE PHOTO LIBRARY)
News Courtesy: BBC Health

WHO warns of an imminent famine in Gaza

Adding on to the catastrophic healthcare situation in the Gaza Strip, WHO warns that the entire 2.1 million population of Gaza is facing prolonged food shortages, with nearly half a million people in a catastrophic situation of hunger, acute malnutrition and illness and death. The latest food security analysis was released by the Integrated Food Security Phase Classification (IPC) partnership, regarded as a widely accepted tool in measuring food insecurity, revealing perhaps the worst hunger crisis of our times.

Due to the illegal blockade of emergency food aid to the Gaza strip by the Israeli authorities, vulnerable population cohorts including children are suffering on a daily basis. Since the aid blockade began in early March 2025, 57 children have reportedly died from the effects of malnutrition. This number is likely an underestimate and If the situation persists, nearly 71 000 children under the age of five are expected to be acutely malnourished over the next eleven months, according to the IPC report.

Pic courtesy :Global Center for Responsibility to Project
News Source: https://www.who.int/news/item/12-05-2025-people-in-gaza-starving--sick-and-dying-as-aid-blockade-continues

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