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From the Editors

Dr Lahiru Kodithuwakku
Co-Editor

Dr Kumara Mendis
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This month, we explore the most talked about events at the 138th Anniversary International Medical Congress of the Sri Lanka Medical Association. A wide attention was drawn to the newly introduced policy tracks at the medical congress, to discuss nationally relevant and important policy issues pertaining to health sector. The objective of these sessions was to critically examine the policy gaps and identify probable solutions in a wide range of thematics including, medicinal drugs procurement and quality assurance, climate smart hospitals, wellbeing across life course, perinatal mortality, Renal health service financing, micronutrient deficiencies, adolescent mental health and road safety etc. Extensive brainstorming, deep discussions and constructive debates at these policy tracts helped the audience to understand the challenges in addressing critical policy gaps in the health sector, thus creating space to innovatively find solutions.

Another highlight was the 'Doctors Concert' following the medical congress, where doctors, senior and junior alike showcased their talents in singing, dancing and various performing arts. This event is loved by many and a testament to artistic abilities of our healers beyond hospital corridors and operating theaters.

These important events in the SLMA remind us how important it is for doctors to have the perfect blend of scientific rigor and creative imagination to perform their rightful duty of healing in body, mind and soul.

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COVER STORY

Dr Lahiru Kodituwakku
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PRIORITIZING HEALTH POLICY DEVELOPMENT: SLMA TAKES THE LEAD

Policy formulation is a critical step that precedes any sustainable strategy or intervention. In uncertain times, where the health sector is challenged with numerous issues of public health concern, positioning our health policy on solid grounds is of paramount importance. Although Sri Lanka has been successful in establishing sound policies to sustain our public health interventions for decades, contemporary health challenges have tested our current process of prioritizing health policy matters and invites us to expand our thinking beyond the traditional methods. In the age of climate change, demographic shift and changing epidemiological patterns, this is a necessity that we could not ignore.

Sri Lanka Medical Association, with its unique position and stature as a common platform for all the medical professional colleges in the country, has the right attributes to initiate a discourse on this matter of national significance. Hence, during the recently concluded 138th Anniversary International Medical Congress of the SLMA, a dedicated policy track was created to deep dive into existing health policy gaps and explore probable ways of addressing some of the critical health policy needs.

Following health policy priorities were identified through expert panels composed of top policy makers, academics, development partners, civil society representatives and practitioners to create an inclusive platform where all the voices are heard and accounted for.

- Unspoken burden of adolescent mental health in collaboration with World Health Organization (WHO)
- Wellbeing across the life course: Driving demand through equity, empowerment and evidence in collaboration with the WHO and Ministry of Health (MoH)
- Climate stress to health risks; Building resilient health systems in collaboration with WHO, UNFPA and MoH
- Micronutrient deficiencies and food security in Sri Lanka in collaboration with World Food Programme
- Medicinal drugs; Best practices in technical evaluation, quality assurance and accountability in collaboration with UNDP Sri Lanka
- Preventable perinatal mortality in Sri Lanka and South Asia; A road map for regional collaboration and accountability in collaboration with Federation of Asia and Ocenia Perinatal Societies (FAOPS) , Perinatal Society of Sri Lanka and College of Obstetricians and Gyanecologists (SLCOG)
- Financing Renal Services in Sri Lanka in collaboration with MoH
- Safe roads- Safe communities; Advancing evidence-based action for road traffic accident injury prevention in collaboration with the WHO, MoH and Ministry of Transport

For all thematic areas, panel discussions were held, where subject matter experts, policy formulators, practitioners, academics, development partners and activists debated and discussed the critical areas that need urgent action and way forward for policy formulation. Evidence generated were recorded and later will be compiled into a health policy road map document disseminated among key policy makers within the health sector and beyond. SLMA would follow up on the progression and inclusion of these health policy areas in upcoming National Health Policy and National Health Strategic Plan development by the Ministry of Health.

Furthermore, all panels were opened for postgraduate students in public health, medical administration and relevant disciplines to disseminate the knowledge further and promote continuous engagement of the next generation of health policy makers in the process. Overall, SLMA hopes that this unique exercise would contribute to evidence based decision making, good governance practices, inclusive stakeholder involvement, transparency and accountability in the health policy formulation process in Sri Lanka. SLMA will continue to engage with the relevant authorities until we 'walk the talk!'.

PRESIDENT'S MESSAGE

Dr Surantha Perera

131st President of Sri Lanka Medical Association

WELLNESS IN INDUSTRY: A STRATEGIC IMPERATIVE FOR A HEALTHIER SRI LANKA

Excerpts from the speech made by Dr. Surantha Perera, President SLMA on the commemoration of the 50th anniversary celebrations of the Organisation of Professional Associations (OPA).

"It is both an honour and a privilege to stand before you today at this historic gathering. We come together not only to celebrate the 50th anniversary of the Organisation of Professional Associations, but also to reaffirm our collective commitment to a healthier, more resilient Sri Lanka.

On behalf of the Sri Lanka Medical Association, I sincerely congratulate the OPA on reaching this remarkable milestone—fifty years of professional excellence, policy advocacy, and nation-building. Your impact has gone well beyond the boardroom and conference hall; you have influenced legislation, strengthened governance, and enhanced the standards of numerous professions across our country.

Today, we come together for a cause that resonates deeply across all our sectors—Wellness in Industry—a theme that holds great significance as we confront complex health and economic challenges of the 21st century.

Why Wellness in Industry?

The workplace is more than just a place of economic productivity. It is where adults spend nearly two-thirds of their waking hours. It is, in effect, a second home and, for many, a primary source of identity, routine, and, let us be honest, stress.

In Sri Lanka, the rising burden of noncommunicable diseases (NCDs)—including heart disease, diabetes, hypertension, and mental health disorders—poses a clear and immediate threat to our workforce. Over 80% of all deaths in Sri Lanka are caused by NCDs, and most of these illnesses are driven by modifiable lifestyle risks that begin, worsen, or are intensified at the workplace: poor nutrition, lack of physical activity, tobacco use, alcohol consumption, and chronic stress.

Yet amid this challenge lies immense opportunity. By redefining the workplace as a health-promoting environment, we can unlock a powerful mechanism for national well-being.

Industry Wellness: Beyond Corporate Social Responsibility

Let me be clear, wellness in the industry is not a luxury. It is not an HR bonus. It is a strategic necessity.

Organisations that integrate wellness into their core operations are not only doing the right thing; they are doing the smart thing. The evidence is unequivocal:

- Healthier employees are more productive, more resilient, and more engaged.
- Companies that invest in employee well-being see decreased absenteeism, lower healthcare costs, and better staff retention.

A study from Harvard Business Review showed that for every £1 invested in workplace wellness, there was a return of £3.27 in reduced medical costs and £2.73 in reduced absenteeism. That is not charity — it is a return on investment.

But industry wellness must go beyond gym memberships and fruit baskets. It must include mental health, emotional resilience, ergonomic safety, inclusive leadership, and above all, a compassionate workplace culture.

The Role of the Medical Community

The SLMA is honoured to be a partner in this journey. As the leading medical professional organisation in Sri Lanka, we are not only guardians of clinical expertise but also protectors of public health, workplace well-being, and the broader determinants of health.

We believe in life-course health promotion—a concept that encompasses wellness throughout all stages of life and various work environments. Our role extends beyond treating disease; it involves designing systems that prevent illness and foster people's ability to thrive.

In collaboration with the OPA and other sectors, we aim to:

- Implement workplace health promotion guidelines across various industries.
- Assist with occupational health screenings and NCD risk assessments.
- Promote awareness of mental health and provide support for stress management.
- Promote healthy canteen policies, active transport alternatives, and tobacco-free workplaces.
- Provide capacity-building for HR managers and workplace wellness officers.

Ladies and gentlemen,

It is with great pride that we celebrate this 50-year milestone by launching the 50th Wellness Birthday Card—a national initiative that unites symbolism, science, and solidarity.

What is the Wellness Birthday Card?

It is not merely a gesture. It is a public health tool, designed to celebrate personal milestones with a national message: "Your health is your wealth—and your nation's too."

We advocate this card to be given to every employee, every citizen, and every professional turning 50, encouraging them to:

- Undergo a full health screening.
- Reflect on lifestyle choices.
- Recommit to preventive care, nutrition, physical activity, and mental well-being.

Turning 50 should not be viewed as a decline. It should be a health checkpoint, a turning point, and if we may say so, a new lease on a healthier second act of life.

This card, endorsed jointly by the SLMA, represents a nationwide culture shift toward proactive, life-stage–appropriate wellness. It is a small card with a big ambition.

A Vision for the Future: Wellness by Design

Imagine a Sri Lanka where every workplace, from garment factories to IT parks, has:

- Standing desks, walking meetings, nutritious meals.
- On-site counselling and stress-relief zones.
- Flexible work hours that prioritise sleep, family, and wellbeing.
- Annual wellness awards that are as coveted as performance bonuses.

This is not a fantasy – it is a feasible future. But it demands cross-sector collaboration, policy innovation, and courageous leadership.

To our colleagues in engineering, banking, education, IT, construction, and agriculture, wellness is your responsibility. You are not separate from the health agenda. You are at its core.

And to the young professionals and future leaders in this room: take this vision forward. Embed wellness into the DNA of your organisation, not as an afterthought, but as a core value.

In commemorating 50 years of the OPA, we are not merely reflecting on the past. We are designing the next 50—a future where professionalism, productivity, and health are inseparable.

Let this joint initiative be remembered as the day we:

- Turned intention into innovation.
- Replaced illness-focused models with wellness-centred systems.
- Said clearly and collectively: health is not the enemy of profit—it is its most loyal ally.

Let us move forward, not only as professionals in our fields, but as professionals dedicated to our nation's health".

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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)

Standard lipid profile remains useful, but they may miss, up to 20-30% of high –risk patients whose cholesterol levels are "normal" yet still face elevated cardiovascular risk.
Lp(a) levels predict the genetic risks not captured by LDL cholesterol. Since Lp(a) levels are preliminary influenced by genetics, it is important to assess this biomarker, especially in patients with a family history or heart disease.

- Particularly useful in patients with:

- Family history of heart disease at a younger age
- Individuals with borderline risk levels for cardiovascular disease
- Patients with unexplained heart attacks or strokes

ADIPONECTIN

Traditional tests like glucose, HbA1c, or lipid profiles often detect problems after metabolic disease has developed. Adiponectin levels, however, give early warning of metabolic dysfunction.

Low Adiponectin = High risk

- Strongly associated with insulin resistance, type 2 diabetes, and metabolic syndrome
- Linked to obesity- related cardiovascular disease
- Predictor of atherosclerosis and hypertension

Who should consider this test?

- Individuals with a family history of diabetes, obesity, or heart disease
- Those who are struggling with unexplained weight gain, or difficulty in losing weight
- Patients with polycystic ovary syndrome, metabolic syndrome, or prediabetes
- Physicians looking for advanced metabolic screening tool

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OPINION

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FROM LENS TO RECORD: ETHICAL AND LEGAL PERSPECTIVES ON MEDICAL PHOTOGRAPHY IN SRI LANKA'S DIGITAL HEALTH TRANSITION

Introduction

Medical photography has become indispensable for documenting clinical findings, enhancing medical education, and supporting research. With the increasing use of smartphones, digital imaging tools, and cloud-based storage, the production and sharing of medical photographs have become easier than ever before. However, the act of capturing and using patient images raises important ethical concerns. These concerns include obtaining informed consent, protecting patient privacy, preserving dignity, ensuring responsible dissemination, and maintaining image authenticity.

In Sri Lanka, the integration of digital imaging into healthcare is accelerating. Several Sri Lankan Professional Colleges including College of Community Physicians and College of Surgeons have conducted photography training sessions for their members. On the other hand in the government health services, the Picture Archiving Communication System (PACS) and Radiology Information System (RIS)—a medical imaging platform—is now operational in five major state hospitals, including the National Hospital of Sri Lanka (NHSL), with plans for nationwide expansion [1, 2]. This advancement underscores the urgent need for more robust, up-to-date guidelines and regulatory circulars to govern medical photography and imaging practices in both clinical and academic contexts.

This article aims to examine the ethical principles governing medical photography and propose best practices for ethically responsible imaging in health settings.

Consent in Medical Photography

At the heart of ethical medical photography lies the principle of **informed written consent**. Implied or verbal consent is not sufficient, especially when images are to be used for any purpose beyond direct clinical care. Consent must be voluntary, specific, informed, and in writing, encompassing both the act of photography and its intended use [3, 4]. Patients must be fully aware of who will view their images, where the images will be stored, how they may be published or shared, and their right to withdraw consent at any time without repercussions [4].

It must be noted that consent must be obtained separately for each purpose—for example, care, education, or publication—and the extent of image usage must be clearly described, including whether images may enter the public domain [4, 5].

Consent processes should be tailored to the context. Three levels of consent have been considered in medical photography:

1. **Very Limited Consent**: Patients agree to use their images only for their medical records.
2. **Limited Consent**: Patients agree to use their images in addition to medical records to show their images for teaching purposes.
3. **Broader Consent**: Besides the uses mentioned in 1 and 2, patients agree to use their images in medical publications, including medical journals, textbooks, and electronic publications. Patients also acknowledge that members of the general public can view their images and further acknowledge that even without identifying information, there is a risk that someone may recognize them via the images [5].

Even when broader consent is provided, institutions must ensure patients understand the specific scope and context of such use. Consent forms should reflect this granularity and avoid blanket permissions [4, 5]. However, **assent** should be obtained for patients between 7–18 years in addition to consent from parents or legal guardians. If the child regains capacity (e.g., after sedation or mental health recovery), retrospective confirmation of consent should be obtained wherever possible [4, 5].

Privacy and Confidentiality

Medical images are considered part of the patient's health record and are subject to the same standards of confidentiality as other forms of clinical documentation [4]. Photographers and clinicians must take active measures to **de-identify** images, which may include blurring faces, cropping identifiable tattoos or birthmarks, and removing background elements that may reveal identity [6]. Even when faces are not visible, care must be taken to avoid "jigsaw identification," where a patient may be identifiable through the combination of image content and accompanying clinical data [7].

Anonymisation is not a replacement for consent. UK guidelines emphasize that even anonymised images can be re-identified, particularly those with unique features such as scars or tattoos. Black bars across the eyes are insufficient and considered ineffective [7, 8]. Images must be stored on encrypted, access-controlled, institution-approved systems. Personal mobile phones and unsecured drives must not be used. Deletion from the device should be done after secure transfer, and all access must be auditable [5, 8].

Respect for Patient Dignity

Medical photography must be conducted with the utmost respect for the dignity and comfort of the patient. Situations involving intimate body parts, vulnerable states (e.g., unconsciousness, trauma), or culturally sensitive scenarios require particular care.

UK protocols recommend the presence of a same-gender clinician, the use of appropriate draping, and documentation of a chaperone where applicable [5]. Patients should always be given the opportunity to request or refuse a chaperone. The act of photographing should never be rushed or treated as a routine task. Clinicians must remain attentive to nonverbal cues of discomfort or hesitation and be prepared to pause or cancel photography at any point if patient consent is withdrawn [4].

Ethical Use and Distribution

Medical images must be used only for the purposes outlined during the consent process. Unauthorized sharing of images—especially via social media or informal channels—can lead to serious ethical and legal violations. Institutions should implement strict policies regarding storage, access, and distribution, including encrypted storage solutions, role-based access, and audit trails for image retrieval [4, 5, 8].

Furthermore, the use of patient images on social media platforms—even in private groups—is strictly discouraged unless explicit written consent has been obtained and institutional

policy allows it. Employees must be aware that what is shared online, even in closed forums, may become public [9].

Image Authenticity and Digital Manipulation

With the advent of advanced editing tools, image manipulation poses new ethical challenges. While basic adjustments for clarity (e.g., brightness, contrast) are generally acceptable, any form of image alteration that distorts clinical reality is unethical and potentially misleading [10, 11]. Image modifications should be fully disclosed in the figure legend or methods section for research and publication.

Maintaining the integrity and authenticity of medical photographs is essential, mainly when images are used for diagnostic education or evidence in legal contexts [10, 11]. Deceptive editing can lead to misinformation, misdiagnosis, and erosion of scientific credibility. Best practices also recommend storing the original (unaltered) version of the image separately from the edited version and maintaining a record of all alterations [4, 5].

The Situation in Sri Lanka

An archaic circular issued by the Ministry of Health in 2006 still governs photography in government hospitals [12]. However, the Sri Lanka Medical Council (SLMC) has not issued any comprehensive photography guidelines to date [13]. Given these gaps, Sri Lanka can benefit from aligning its practices with established UK standards—including requiring specific consent for different uses, implementing secure digital handling procedures, and regulating the use of clinical images in educational and online platforms.

Recommendations for the Ministry of Health and the Sri Lanka Medical Council

In light of the outdated circular from 2006 and the absence of unified national guidance, the Ministry of Health and the Sri Lanka Medical Council (SLMC) are urged to develop a comprehensive, modern regulatory framework. The following are specific, actionable recommendations based on international best practices, particularly from the UK:

1. **Develop and Publish National Guidelines on Clinical Photography**: The Ministry and SLMC should jointly publish formal, enforceable guidance on the ethical and operational aspects of medical photography across all clinical settings. These should be based on globally accepted standards, such as the General Medical Council's guidance on "Making and Using Visual and Audio Recordings of Patients" [4].
2. **Mandate Written, Informed, and Purpose-Specific Consent**: Consent must be explicit, written, and separate for each intended use: medical records, teaching, research, and publication. National consent forms should be standardized and integrated into patient documentation workflows, with clear information about image use, storage, and withdrawal rights.
3. **Regulate the Use of Personal Mobile Devices**: Personal phones can be used for medical photography, but only with strict adherence to ethical and legal guidelines, including obtaining explicit patient consent, ensuring the images are transferred to the hospital's secure medical record, and deleting them from the device. Because of the difficulty in enforcing the above guidelines it is generally not recommended to the use of personal phones and prohibit unregulated apps (e.g., WhatsApp) for clinical photography. Health sector-issued secure imaging devices and applications should be implemented with encrypted storage and secure data transfer protocols.[14]
4. **Establish Secure Storage and Access Controls**: All clinical images should be treated as sensitive medical records and stored in encrypted, access-controlled systems. National infrastructure (e.g., a centralized image repository) can help standardize access and audit trails.
5. **Address Dignity and Vulnerable Patient Protocols**: Guidelines must require same-gender photographers or chaperones during intimate imaging, with documentation of patient preference. Protocols for unconscious, pediatric, bereaved, or mentally impaired patients should be clearly outlined.
6. **Build Training and Certification Pathways**: Introduce mandatory training for healthcare professionals on clinical photography ethics, data protection, and image handling. Consider introducing a "Clinical Photography Champion" certification similar to UK models for qualified staff.[15]
7. **Provide Oversight and Enforcement Mechanisms**: The SLMC should monitor compliance through licensing requirements and routine audits. Institutional policies must align with national standards, and violations (e.g., unauthorized image sharing) must have defined disciplinary procedures.
8. **Incorporate Public and Patient Awareness**: Launch public-facing awareness campaigns on patient rights regarding medical photography. Ensure patients know they can decline photography, request deletion, or withdraw consent without impacting care quality.

Conclusion

Ethical practice in medical photography is essential for maintaining patient trust, protecting confidentiality, and ensuring professionalism in clinical documentation. As medical photography continues to evolve, so must the ethical frameworks governing its use. Through robust consent procedures, protective privacy measures, respectful practices, and transparency in image use, healthcare professionals can uphold the principles of healthcare ethics and safeguard the rights of those they serve.

Healthcare regulators and institutions, including the Ministry of Health and the Sri Lanka Medical Council, are urged to develop updated, enforceable guidelines that reflect global best practices to ensure the safe, ethical, and respectful use of medical images in all settings. By implementing these reforms, the Ministry of Health and the SLMC will modernize Sri Lanka's approach to clinical imaging and ensure that patient dignity, autonomy, and trust are safeguarded.

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FEATURE ARTICLE

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POSTPARTUM MANAGEMENT OF WOMEN WITH HYPERGLYCAEMIA IN PREGNANCY

Hyperglycemia in pregnancy refers to the elevation of blood sugar levels during gestation.

Hyperglycaemia complicates between 13.9% - 27.8% of all pregnancies across countries and ethnicities, with a pooled global prevalence of approximately 19.7% [1]. This can occur in two forms.

- Gestational diabetes mellitus (GDM)
- Pre-existing diabetes mellitus
  - Type 1 diabetes
  - Type 2 diabetes
  - Other subtypes of diabetes (MODY /LADA etc)

Majority (79.2%) of hyperglycaemia in pregnancy is due to GDM. In Sri Lanka, the estimated prevalence of GDM ranges from 5.5% to 8.4% [2,3]. In addition, pre-existing diabetes (type 1 or type 2) complicates another 1–2% of pregnancies [4].

Gestational diabetes mellitus (GDM) is a form of glucose intolerance first recognized during pregnancy. GDM typically develops in the second or third trimester and is most often asymptomatic. Majority of the women are detected during routine antenatal screening. During pregnancy placental hormones such as human placental lactogen, cortisol, and progesterone is secreted promoting fetal growth [5]. These hormones induce insulin resistance in the mother. In healthy pregnancies, pancreatic beta cells compensate with increased insulin secretion. In GDM, this compensation is insufficient due to underlying beta-cell dysfunction. This leads to a rise in maternal glucose level. Glucose crosses the placenta, leading to fetal hyperglycaemia and hyperinsulinaemia, resulting in fetal complications including congenital anomalies [6].

Although insulin resistance and the hyperglycaemia, resolves after delivery, GDM is not a transient disorder. Despite most women returning to normoglycaemia within six weeks of delivery, the health implications extend well beyond the pregnancy and delivery. GDM significantly increases the risk of both the mother and the baby having diabetes and metabolic syndrome in the future.

Nearly 40% -70% of women with GDM will go on to develop type 2 diabetes within 10 years of delivery [6, 7].

Notably, women of South Asian ancestry have been found to have twice the risk of developing diabetes compared to other ethnic groups [8]. Furthermore, they are at a higher risk of developing cardiovascular complications [8].

The fourth trimester - the critical window

The postpartum period is often referred to as the “fourth trimester”. This is the time the mother recovers from the birth, and adjusts to a new normal. For women with medically complicated pregnancies, like GDM, this offers a window of opportunity to initiate long term preventive and health promoting strategies.

A coordinated care plan, involving the obstetrician, physician, general practitioner and the community health care team, should include:

1. optimal treatment of mothers with postpartum hyperglycaemia,
2. monitoring for progression to diabetes of normoglycaemic mothers,
3. assessment of cardiovascular risk factors and lifestyle modification; and
4. if a subsequent pregnancy is desired, providing preconception counseling and care and contraception until optimized health is achieved.

Picture: Gabriel Tovar via Unsplash

“The postpartum period is often referred to as the “fourth trimester”. This is the time the mother recovers from the birth, and adjusts to a new normal. For women with medically complicated pregnancies, like GDM, this offers a window of opportunity to initiate long term preventive and health promoting strategies.

Table 1 : Medication safety in pregnancy and lactation

Types of medication		Pregnancy	Lactation
Hypoglycaemic medications	Insulin - rapid acting , mixtard	√	√
	Metformin	√	√
	Sulfonylureas -gliclazide, glimepiride	X	X
	Sulfonylureas -glibenclamide	√	√
	Thiazolidinediones - pioglitazone	X	X
	DPP-4 inhibitors - sitagliptin, linagliptin	X	X
	SGLT-2 - empagliflozin , dapagliflozin	X	X
	Acarbose	X	X
Cardiovascular medications	Aspirin	√	√
	Beta-blockers -metoprolol, labetolol	√	√
	CCB- verapamil , nifedipine, diltiazem	√	√
	ACEI - enalapril	X	√
	ARB - losartan , telmisartan	X	X

FEATURE ARTICLE

Continued...

Treatment of postpartum hyperglycaemia

Mothers with GDM with persistent postpartum hyperglycaemia will need either a lower dose of insulin (half of the antepartum dose usually) or metformin, or both. They should ideally be managed by a physician until normoglycaemia is achieved and then be followed up in the community.

Mothers with pre-existing diabetes can revert to their pre-pregnancy insulin and/ or metformin doses after pregnancy [9]. However, they should continue to avoid medications that were withheld during pregnancy. (Table 1)

Both groups should be educated that metformin and insulin are safe during breast feeding.

The care team should be mindful of the fact that the requirement for insulin and oral hypoglycaemics will decrease in the post-partum period and the risk of hypoglycaemia may increase, especially during breast feeding. The mother and family members should be educated and trained to identify features of hypoglycaemia and about basic first aid in the event of an episode. Mothers should be advised to have a snack during breast feeding.

Management of hyperglycaemia should be accompanied with life-style changes (discussed in detail below).

Monitoring of progression to diabetes in mothers with GDM and assessment of cardiovascular risk factors

Primary care providers have a major role to play in managing a normoglycaemic mother with GDM. These mothers should be reassessed with a fasting blood sugar (FBS) between the 6th and 12th week postpartum. An HbA1c may not reflect the true glycemic status as it would partly reflect the antepartum glycemic control, resulting in an inaccurate value. If the assessment is after the 13th week post-partum either an FBS or an HbA1c can be used. They should also be referred at 6 to 12 weeks for a 75g 2-hour oral glucose tolerance test (OGTT). The results should be analysed according to non- pregnant OGTT criteria [9].

If the results are negative for hyperglycaemia, the caregiver should arrange for a reassessment and follow up at one year with a FBS or HbA1c and annually thereafter. If any of the results are positive, the mother should be referred to a physician for further assessment and follow up (see Table 2).

Life style modification

The primary goal of the post-partum care team should be to maintain normoglycemia through sustainable life-style changes. No disease prevention strategy is complete without a strong focus on health promotion. The treating team should strive to educate the mother and her family, to make more informed choices regarding how they navigate through this period.

Exclusive breast feeding

Breastfeeding is associated with improved glucose metabolism and a lower risk of developing type 2 diabetes in the future. Support exclusive breastfeeding where possible for the first 6 months.

Healthy diet

A balanced diet, low in glycaemic index, with high fibre, high lean proteins, healthy fats and low refined sugar content, should be encouraged. Provide examples of food that should be chosen most, less and least often. (Table 3). Promote home-cooked, minimally processed foods. Refer to a dietitian where extra support may be needed in achieving and managing weight loss goals

Physical activity and weight management

Encourage physical activity that fits into the mother's new lifestyle once obstetric clearance is given. Begin with light to moderate exercise, such as brisk walking or swimming. Aim for at least 150 minutes of activity per week (30 mins per day / 5 days per week), as per World Health Organization (WHO) and American Diabetic Association (ADA) guidelines.

South Asians are more prone to metabolic diseases and complications in relation to increasing body weight. Therefore, the recommended BMI cut offs are slightly lower than those recommended for our western counterparts.

- Healthy weight BMI 18.5 kg/m^2 to 22.9 kg/m^2
- Overweight: BMI 23 kg/m^2 to 27.4 kg/m^2
- Obesity: BMI 27.5 kg/m^2 or above.

Support a gradual return to pre-pregnancy weight or to a healthy weight target. Emphasize that modest weight loss (5–7%) can significantly reduce diabetes risk and any future cardiometabolic risk. Tailored meal planning with the help of a nutritionist and moderate physical activity will help to achieve a healthy weight.

Healthy sleep pattern and positive mental health

Poor sleep and chronic stress can impair insulin sensitivity. Offer advice and support around infant care, rest strategies, and coping techniques. Consider and screen for postpartum depression or anxiety, which may interfere with healthy behaviours and positive lifestyle changes.

Exposure to nicotine, tobacco and alcohol

Encourage and facilitate avoiding exposure to nicotine, tobacco and alcohol. Educate the family regarding avoiding exposure to secondhand smoking for both the mother and the baby.

Table 2 : Blood glucose thresholds and (postpartum) management of women with GDM

FBS (6-12 weeks postpartum) - mmol/L	HbA1c (3-6 months postpartum)	Glycaemic status	Management	Next assessment	Future risk of diabetes mellitus
< 6	< 5.7%	Normal	Lifestyle modification	FBS / HbA1c Lipid profile and BP annually	Moderate
6-6.9	5.7-6.4%	Pre-diabetes	Lifestyle modification	FBS / HbA1c Lipid profile and BP annually	High
> 7	> 6.5%	Diabetes mellitus	Refer to a physician & lifestyle modification	As per a patient with diabetes mellitus	Not applicable

Table 3: Common food options based on glycaemic index (GI) [10,11]

Low GI (<55) Choose Most often	Medium GI (56–69) Choose less often	High GI (70+) Choose least often
Barley Mung Bean Noodles Pasta Pulse Flours Rice (Converted, Parboiled) Heavy Mixed Grain Breads All-Bran cereal Oats (steel cut)	Whole Grain Wheat Bread Oats (Instant) Roti (White, Whole Wheat) Basmati Rice Brown Rice Rice Noodles White Rice (Short, Long Grain)	Bread (White) Naan (White) Corn Flakes Pittu (wheat, rice flour) Hoppers
Apple Banana (Green, unripe) Berries Grapefruit Mango Orange Pear Pomegranate	Banana (Ripe, Yellow) Grapes Pineapple Raisins Papaya	Watermelon Dates
Cow's Milk (Non fat, Low fat, Full cream) Curd Soy Milk Yogurt	Ice cream Jam	Glucose Condensed milk Brown sugar Jaggary
Chickpeas Cowpea Lentils Mung Beans Jack fruit Most vegetables (hardly affects blood sugar)	Corn Potato (Red, White, Cooled)	Carrots Potato (Red, White, Hot) Sweet potato

** Avoid choosing food with refined carbohydrates and high sugar content.

FEATURE ARTICLE

Continued...

Contraception advice

Recommend a contraception method to suit the patients requirements. Convenient, long-term, one time insertion and devices with reversible fertility would be preferable for postpartum and breastfeeding mothers planning another pregnancy.

- Sub-dermal implants - *Jadelle*
- Non hormonal copper intra uterine contraceptive devices (IUCD)
- Levonorgestrel intrauterine system (LNG IUS) - *Mirena*

goals. Further, it is important to use a safe contraception method until adequate glycaemic and metabolic control is achieved.

Achieving glycaemic control before pregnancy

For women with pre-existing diabetes mellitus, the preconception glycaemic goal is to achieve an HbA1c of < 6.5% without episodes of significant hypoglycaemia [6]. Ideally, the patient should be converted to insulin and or metformin (or glibenclamide) prior to conception.

Picture: Ella Olsson via Unsplash

In conclusion, the medical care offered to a mother with GDM should continue beyond the pregnancy and the early postpartum period, with emphasis on surveillance, prevention and health education to reduce the long term health burden and improve health across the life course.

Preconception counseling and assessment

Preconception care is a critical component of reproductive health for women with previous GDM or pre-existing diabetes. Proper glycaemic control, timely pre conceptional assessments, and effective planning and management can reduce the risk of adverse maternal and fetal outcomes. As mentioned before, health promotion and lifestyle modification plays an important part in maintaining positive lifestyle changes and achieving safe preconception

All other oral hypoglycemic agents are not recommended for use during pregnancy and lactation. For women with HbA1c of more than 10%, it is advisable to postpone the pregnancy until adequate glycaemic control is attained. Patients with type 1 diabetes should avoid periods of ketonaemia / ketoacidosis prior to pregnancy, ideally periodically tested with urine dip sticks. [9

Women with pre-existing diabetes should be screened for retinopathy and nephropathy (with urine albumin/creatinine ratio and serum creatinine) prior to conception. Both have the potential to appear or worsen during the confinement [9].

Women with hyperglycaemia in pregnancy, especially pre-existing diabetes, have up to a fourfold rise in having a baby with cardiac or neural tube defect or having a still birth or a perinatal death. [12]. To minimize this risk, high dose folic acid (5 mg/daily) should be commenced prior to conception [13].

Pre-conception assessment of women with pre-existing diabetes
Pre existing diabetes
Target HbA1c of less than 6.5% Postpone pregnancy if HbA1c > 10% or ketonaemia

Screening for complications
• Retinopathy
• Nephropathy - Refer to nephrology if
  • Creatinine > 120 micromol/litre
  • Albumin / creatinine > 30 mg/mmol
  • eGFR < 45 ml/minute/1.73 m^2

Screen for comorbidities • Hypertension • Dyslipidaemia
Medication adjustment prior to conception • Withhold medications with poor safety profile / teratogenicity • Glycaemic control with insulin / metformin
Achieve a healthy weight • BMI 18.5 kg/m^2 to 22.9 kg/m^2
Life style modification
Commence on high dose folic acid
A contraception method until goals are achieved

In conclusion, the medical care offered to a mother with GDM should continue beyond the pregnancy and the early postpartum period, with emphasis on surveillance, prevention and health education to reduce the long term health burden and improve health across the life course. A multidisciplinary approach to continuity of care post-partum is crucial for the smooth management of mothers with GDM and preexisting diabetes. Pre-conceptional care in preparation for a pregnancy is also essential. Proper evidence-based and timely assessment and management will reduce the acute obstetric and long term cardiometabolic complications of mothers and children.

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JUNIPER REAL ESTATE

12 B, Gregory's Road,
Colombo 7. SRI LANKA

JUNIPER

Patient's Name: Dr. John Perera

Sex: M **Age:** 52 **Date:** 18/09/2025

℞ C/O- No income generating assets.
No tax benefiting assets.

℞ Juniper Villas Hiriketiya
1 Down payment
Pay 1/12 for 2 years

Oshan Muthugala

Signature

0766 200 800

Juniper Villas are 3-bedroom, 3-bath private pool villas, gated and located just minutes from Hiriketiya Beach. We handle full faciltiies management and rental operations, so you can enjoy passive income without the stress of maintenance.

Ask us how this investment can offer tax benefits specifically for medical professionals. Safeguard your wealth and let it work for you.

SPECIAL ARTICLE

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NURTURING HEALTH EARLY: REDUCING SUGAR AND SALT INTAKE IN CHILDHOOD FOR BETTER ADULT HEALTH OUCTOMES: A LIFE COUSE APPROACH

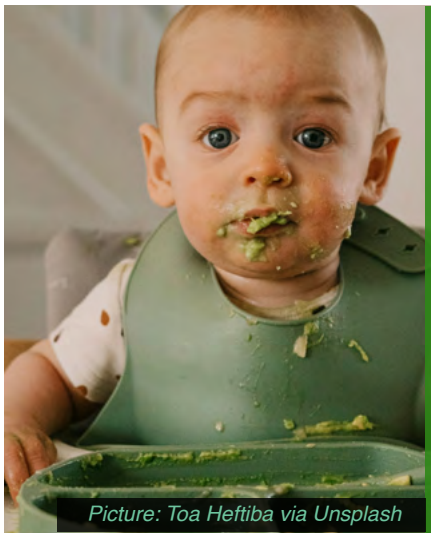
Sri Lanka is witnessing a troubling rise in non-communicable diseases (NCDs), including type 2 diabetes, obesity, and hypertension. What was once considered the burden of adulthood is now increasingly being seen among children and adolescents. At the core of this epidemic lies a growing trend in unhealthy dietary patterns—particularly high consumption of added sugars and salt (1). These habits, formed early in life, often persist into adulthood, setting the stage for chronic illness, reduced quality of life and premature mortality. Children consuming excessive sugar and sugar-sweetened beverages regularly are at higher risk of developing obesity and early-onset type 2 diabetes, while high sodium consumption in early life has been linked to elevated blood pressure—a precursor to cardiovascular disease in adulthood (2,3).

In Sri Lanka, childhood dietary patterns are shifting rapidly, with rising intakes of sugar and salt contributing significantly to the early onset of obesity, hypertension, and type 2 diabetes (1,4).

The younger generation is born with increased susceptiblity obesity via to appetite and weight dysregulation through several adverse developemental programming pathways (5). This tendency is exacerbated by increasing availability and marketing of ultra-processed snacks, sugary drinks, and fast food, through digital and other media, creating a powerful influence on food preferences and eating behaviors from a young age (6).

In this context, adovocating for a "less sugar, less salt" approach from early life, using evidence based interventions is of vital importance (2,3). Healthy eating habits must be carefully nurtured from infancy. Parents and public health midwives play an importance role in infancy, and pre-school and school based interventions can strengthen and reinforce these practices (6,7, 8, 9, 10). Health professionals, especially paediatricians and family physicians, are in a key position to initiate meaningful conversations with families. Regular dietary assessments, growth monitoring, and anticipatory guidance during clinic visits can help identify risk early and provide corrective advice.

Public health midwives and local community health workers can also be employed to counsel families on healthy cooking and shopping habits.



Picture: Toa Heftiba via Unsplash

> "The younger generation is born with increased susceptiblity obesity via to appetite and weight dysregulation through several adverse developemental programming pathways. This tendency is exacerbated by increasing availability and marketing of ultra-processed snacks, sugary drinks, and fast food, through digital and other media, creating a powerful influence on food preferences and eating behaviors from a young age

Empowering the younger generation from an early age with knowledge about nutrition, media literacy, and long-term health consequences is vital (8, 9,10). As school age children and adolescents begin to make more independent food choices, the school environment provides an ideal settting for behavior-based interventions (9,10). Children should be taught to read food labels and understand the dangers of processed food. Schools must become safe zones for healthy eating. School canteens should be regulated to eliminate sugary beverages and salty snacks. Intergrating nutrition education to the school curriculum in an interactive and engaing manner can be a very effective and accpatable method to reach the younger generation and empower them to make healthy food choices (8,9,10)

From a policy perspective, several actions are urgently needed, including the implimentation and enforcement of healthy school canteen guidelines across all districts, awareness drives on sugar and salt reduction, using social media and child-friendly messaging, and working with food and beverage manufacturers to reduce sugar and salt in commonly consumed products like biscuits, drinks, and noodles. Beyond individual clinical care, the medical community has a powerful role in advocacy. As members of the SLMA and other professional bodies, we must lead by example in promoting healthier environments for children. By integrating dietary advice into routine practice, contributing to public education efforts, and supporting legislative change, the medical fraternity can help turn the tide of NCDs.

The choices made in childhood echo through a lifetime. With coordinated action across families, schools, healthcare settings, and policy platforms, Sri Lanka can safeguard its younger generation from the growing burden of non-communicable diseases. Let us act now to empower our youngest citizens to eat smart and live well—starting with less sugar and less salt today.

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VOICES FROM THE PERIPHERIES

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AN URGENT CALL FOR ATTENTION IN NORTHERN SRI LANKA

Domestic violence in Northern Sri Lanka is more than a private matter and it has become a public health emergency, amplified by the lingering effects of decades-long conflict. The civil war not only left physical destruction but also deep psychological scars on families and communities. Recent trends indicate that domestic violence continues to pose serious risks, particularly in regions struggling with post-war trauma, economic instability, and disrupted social networks.

While nationwide statistics, the women and child protection bureau highlight that 45 women lost their lives to domestic violence in 2022, declining to 24 in 2023 and 20 in 2024, these numbers mask the lived reality of fear, intimidation, and ongoing abuse that many families endure daily in the North. Serious injuries remain high 60 in 2022, 73 in 2023, and 36 in 2024 while complaints to authorities continue to exceed 100,000 annually. Protection orders have increased from 749 in 2022 to over 2,700 in 2024, indicating that survivors are seeking help, but also revealing the scale of hidden suffering that persists in households affected by trauma.

The legacy of the civil war in Northern Sri Lanka has created conditions where domestic violence can flourish. Many families live with unresolved trauma, including loss of loved ones, displacement, and prolonged exposure to violence. Men and women who experienced war-related stress, combat, or displacement may struggle with anger, hyper vigilance, and emotional instability, which can increase the risk of aggressive behavior within the household. Women and children, already vulnerable in post-conflict communities, may face higher exposure to abuse.Research in post-conflict settings globally has shown that communities affected by war experience elevated rates of domestic violence compared to regions without such histories.

In Northern Sri Lanka, decades of disrupted social structures, economic hardship, and limited mental health resources amplify these risks. The cumulative stress of rebuilding lives while coping with war memories often manifests as conflict within homes, making domestic violence both a symptom and a perpetuator of post-war trauma.The scars of domestic violence extend beyond the visible. Survivors often carry profound psychological burdens long after the violence ceases. Exposure to domestic abuse is a strong predictor of mental health disorders, including depression, anxiety, post-traumatic stress, and suicidal thoughts. Maternal mental health is particularly vulnerable, studies show women who experience domestic violence during or after pregnancy are more likely to suffer postpartum depression and suicidal ideation, endangering both mother and child.

Children in the Northern Province are among the most invisible victims. Many grew up amidst both the horrors of civil war and domestic violence, compounding trauma across generations. Witnessing abuse disrupts brain development, emotional regulation, and social skills. These children face higher risks of academic struggles, aggression, and difficulties forming healthy relationships, threatening the mental health of the next generation in a region already grappling with post-war recovery.

Northern Sri Lanka has made notable strides in addressing these challenges. The region's psychiatrists, mental health professionals, and trained counselors play a critical role in identifying and supporting survivors of domestic violence. Services provided at hospitals, clinics, and centers such as Mithuru Piyasa demonstrate a growing awareness of the mental health impact of domestic abuse. Psychiatrists in the North have been instrumental in integrating trauma-informed care into routine clinical practice, providing specialized counseling for both women and children, and conducting community outreach to raise awareness.These dedicated professionals work tirelessly to support survivors in a region still healing from the psychological and social consequences of war. Their work shows that, with commitment and structured support, effective mental health interventions are possible even in challenging post-conflict settings.

Picture: Marco Bianchetti via Unsplash

Healthcare professionals remain a vital bridge for survivors. For many, hospitals and clinics are the first point of contact. A sensitive and empathetic approach by doctors, psychiatrists, and counselors can turn a clinical encounter into the first step toward recovery. Careful documentation, discreet referrals to counseling services, and gentle encouragement can empower survivors to seek help and safety. While progress in Northern Sri Lanka is commendable, more resources and systemic support are urgently needed. Strengthening mental health infrastructure, expanding access to trained counselors, and integrating mental health screening into primary care across the country can ensure that survivors receive timely and effective care. Legal protections must be paired with mental health interventions, while schools and community organizations need support to identify and assist children exposed to domestic abuse.

Communities across Sri Lanka must move from silence and tolerance to active intervention. Speaking out against abuse, promoting mental health awareness, and supporting survivors can break the cycle of trauma that has persisted for generations.Domestic violence is not only about visible injuries; it is about broken spirits, silenced voices, and unseen struggles. Sri Lanka has made important strides in mental health care, particularly in the Northern Province, but the need for further investment, training, and community engagement is urgent. If the country is to heal, both the health system and society must recognize and respond to the profound psychological consequences of domestic violence. Silence is no longer an option.

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NOVICE

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Once Upon a Cream...

Mirror, mirror on the wall,
Who is the fairest of them all?
“Everyone else but you!”
They giggled as my spirit bled.
My tiny heart,
Shattered into shards unseen.

Oh lo! The black sheep in the family!
An ugly duckling forgotten in the cold.
Year after year, with each cruel call,
Jokes and frowns cracked this porcelain doll.

A cream to make you white?! Why not?
“But you must make it yourself.”
Sure! Anything at all!

“Be generous with clobetasol, mix and apply,” she said.
Snow White was offered her poisoned red.
Thank you! Hope gleaming in my eyes,
Blind to the curse that lurked beneath the guise.

Day in and day out I applied.
My cinnamon skin grew pale with pride.
“You look stunning!” “Gorgeous! “Glowing!!” - they’d cry,
Words once unknown now flooded my sky.
Men craved my fair, delicate skin;
This magical cream was surely my win!
“What’s your secret?” they asked, so bold,
I never told; but only sold.

Days turned to years - “let’s make more of this cream!”
As blue as the ocean, veins rose from beneath,
Through the layers of my now paper-thin skin.
A bruise here, a bruise there,
Making me wonder - did I knock somewhere?
Did I eat too much? Oh why, oh why was I putting on so much?
My vision’s dimmed to a shadowed grey,
Aren’t my forties still so far away?

My cream reached those across oceans and seas -
Young and the old, all with pallid dreams.
I beamed to the cameras, “Behold my cream!”
And here I stand, oh what a pitch,
Living proof of a perfect glitch.

As my skin crumbled right before my eyes, so did my mind,
Voices, doubts and visions - twisted, unkind.
Please stop!
“Bipolar,” someone said. Just pop a pill and smile they said.

A feather’s touch seared me from within.
The softest rays of sunshine burnt my skin.
So away I hid where the shadows lie,
Far from the world - no watching eye.

My golden goose, brought fortune and fame,
Turned my mind to a grave.
“Iatrogenic Cushing’s!” the healers yelled.
“Impossible!” my lover exclaimed.
Conspiracies! Plots! All the world against me!
Stop! Stop!! Just make this stop!

“Be gone with thy cream!” - now the world screams.
But how can I stop? I don’t know how!
This path, this life, defines me now.

At times I wonder:
Am I the victim or the villain in this tale?
A wicked witch, with poison in my cream?
You who mocked my colour - it was YOU who made me!
How dare today, may I ask, you judge me!

So, my mirror, mirror on the wall,
Answer me true before I fall:
Are happy endings ever for us to call,
Or only for the fairest of them all?

Pictures: Hanen Boubahri and Ransford Quaye via Unsplash

Reflection:

Sri Lanka, with roots of colourism reaching back to the colonial era, serves as a fertile ground for a booming obsession with fairness and unrealistic beauty ideals. In a market flooded with unregulated products, skin lightening agents are notorious for containing harmful substances like hydroquinone, potent topical steroids and heavy metals including arsenic, lead and mercury[1,2]. Their effects seep far deeper than the skin, eroding health, identity and self-worth. The above poem reflects both the seduction and destruction of whitening products and our failure as a society to appreciate beauty in all tones and hues.

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ACHIEVEMENTS OF SLMA COUNCIL MEMBERS

Highlights

Dr. Surantha Perera , President of the SLMA received the Apex Award of Professional Excellence in the Feld of Healthcare and Medicine, awarded by the Organization of Professional Associations of Sri Lanka (OPA) for his services towards the medical profession.

Dr. Lahiru Kodituwakku, Co-Editor of 'The SLMA Monthly' received the Dr. H S R Perera Award for Health Systems Strengthening for Public Health Enhancement awarded by the College of Community Physicians, Sri Lanka for his work together with the research and development team at NIID/NDCU/SLMA, for establishing a Regional Center of Excellence in Dengue Management at the National Institute of Infectious Diseases (NIID).

GLOBAL FOCUS

AUGUST 2025

Corporal Punishment, a global public health concern!

The World Health Organization (WHO) has declared corporal punishment a global public health concern that causes serious harm to children's physical, social and mental wellbeing, and can lead to criminal behaviour. Corporal punishment is defined as "any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light."

A new report found that across 49 low- and middle-income countries, children exposed to corporal punishment were 24% less likely to be developmentally on track than children who were not exposed. Children exposed to corporal punishment are more likely to have anxiety, depression, low self-esteem and emotional instability, which continue into adulthood and can lead to alcohol and drug abuse, violent behaviour and suicidal tendencies. Globally, an estimated 1.2 billion children are subjected to corporal punishment every year.

Source: The Gurdian, UK / Photo Courtesy: University of Utah

SLMA IN AUGUST

Highlights

SLMA Saturday Talks ▶

Three Saturday Talks were held during the month of August.

- Delirium through a psychiatrist's lens: Prof Chathurie Suraweera, Honorary Consultant Psychiatrist, National Hospital Colombo
- Managing a patient with transfusion dependent thalassaemia: Dr. Ruwangi Dissanayake, Honorary Consultant Paediatrician, Lady Ridgeway Hospital, Colombo
- Stroke: Dr. Manjula Caldera, Consultant Neurologist, Teaching Hospital , Anuradhapura

Monthly Clinical Meeting for August ▼

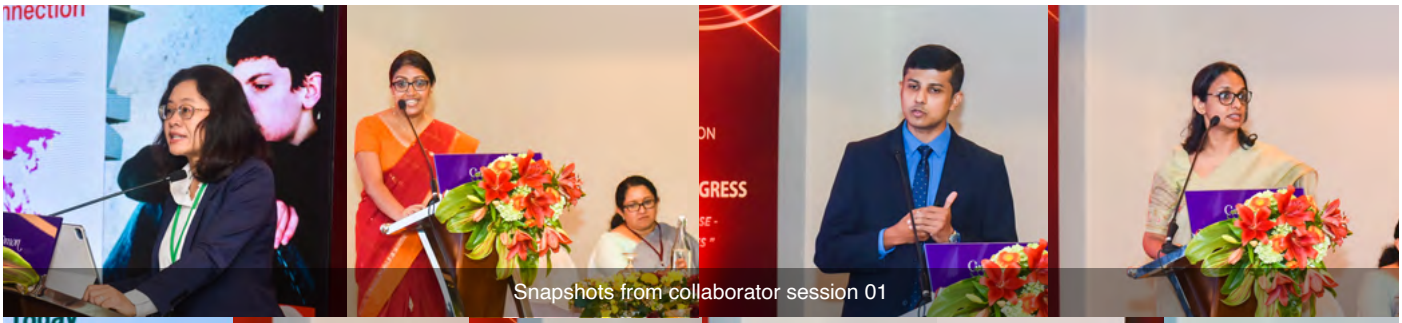
- Monthly Clinical Meeting: In collaboration with Sri Lanka College of Microbiologists - Helminth Infections in Sri Lanka; Trends, Challenges and Way forward conducted by Prof. Kosala Weeakoon, Professor in Medical Parasitology, Faculty of Medicine and Allied Sciences, Rajarata University of Sri Lanka and Dr. Jagath Ranasinghe, Consultant Pediatrician, Nawalapitiya

138TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS

Policy Forums and Collaborator Sessions

138TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS

Collaborator Sessions



Snapshots from collaborator session 01

Snapshots from collaborator session 02

Snapshots from collaborator session 03

Snapshots from collaborator session 04

Snapshots from collaborator session 05

Snapshots from collaborator session 06

138TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS

Doctors' Concert

138TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS

Snapshots from day 01

138TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS

Snapshots from day 02

138TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS

Snapshots from day 03

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