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Ushering A New Era

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FROM THE EDITORS

Dr Lahiru Kodithuwakku
Co-Editor

Dr Kumara Mendis
Co-Editor

As we embark on a promising 2026, we look back at the past year with immense gratitude. Under the guidance of our Immediate Past President, Dr. Surantha Perera, and the SLMA Council, The SLMA Monthly grew in both reach and depth, exploring new horizons in medical journalism. We thank you for your steadfast support and continued trust.

This year, under the leadership of SLMA President Dr. Manilka Sumanatilleke and the Council, we strive to sustain this momentum through innovative additions and expanded outreach across the medical fraternity. Our focus remains bold yet grounded in the traditions of our profession, highlighting public health concerns, amplifying the voices of our youth and peripheral colleagues, and embracing healthcare innovation.

Aligned with our 2026 theme, "Wellness in the Nation through Local and Global Partnerships," we will connect with local experts while providing a platform for global best practices. We invite you to join this exciting journey and share your expertise with The SLMA Monthly.

To brighter days ahead!

The SLMA Monthly
Official Newsletter of the Sri Lanka Medical Association

COVER STORY

Dr Lahiru Kodituwakku
Co-Editor, SLMA Monthly Magazine

Dr Kumara Mendis
Co-Editor, SLMA Monthly Magazine

USHERING A NEW ERA

"In the middle of difficulty lies opportunity" — Albert Einstein

Sri Lanka's healthcare sector is at a pivotal crossroads. As our demographic and epidemiological profiles shift, so too do the expectations of a public demanding better health outcomes. Today, our resolve is tested by the persistent threats of natural and man-made disasters. When coupled with chronic funding shortages and human resource scarcity, the very integrity and sustainability of our system are at risk.

However, periods of great difficulty provide the necessary friction for reflection. We must ask ourselves: Have we truly identified the priorities for the next decade? Is our system resilient enough to anticipate, accommodate, and adapt to future shocks? Or are we resting on the glories of the past while ignoring the tremors of the future?

To build a resilient health system, we must have the vision to navigate these rough waters. This journey requires an honest assessment of past performance, a willingness to embrace change, and the audacity to think beyond traditional boundaries.

This is the mission of the Sri Lanka Medical Association (SLMA) in 2026. Under new leadership, the SLMA will face these challenges head-on. We will constructively question systemic approaches, learn from our failures, and engage with international colleagues to integrate global best practices. By strengthening local and international collaborations, we will develop innovative solutions for system stability, prioritizing the holistic well-being of our citizens.

From NCD prevention and Men's Health to Medical Education and Emergency Response, our goal is not merely to achieve piecemeal outputs, but to secure tangible, sustainable outcomes. Our approach remains firmly grounded in medical ethics and professional integrity. We will work transparently with partners, from government bodies to civil society, upholding our accountability to both our members and the populations we serve.

With your dedication, we will transform these difficulties into a new era of growth for our profession and prosperity for our country. Join us as we build a healthier, more resilient Sri Lanka!

PRESIDENT'S MESSAGE

Dr Manilka Sumanatillake

132nd President of Sri Lanka Medical Association

WELLNESS IN THE NATION THROUGH LOCAL AND GLOBAL PARTNERSHIPS

It is with profound humility and gratitude that I assume the Presidency of the Sri Lanka Medical Association (SLMA), our nation's most prestigious professional body for medical doctors.

I step into this responsibility at a pivotal moment. Our healthcare system stands at a crossroads, having been tested by adversity yet emerging with a renewed drive to "build back better." As it has been for decades, the SLMA will continue to guide our fraternity through these challenges with vision, leadership, and an unwavering commitment to both our profession and our country. I am honored to lead a competent, experienced team that remains rooted in the lessons of the past while remaining agile enough to embrace the future.

Building upon the monumental legacy of my predecessors, my vision for 2026 is centered on the theme: "Wellness in the Nation through Local and Global Partnerships." My goal is to steer this hallowed organization toward achieving holistic health for every Sri Lankan by leveraging strategic domestic and international collaborations.

To realize this vision, we advocate for a decisive shift toward patient-centered care and a proactive approach to prevent Non-Communicable Diseases (NCDs).

As an endocrinologist and a proponent of addressing the social determinants of health, I am committed to promoting lifestyle modifications that ensure well-being across the life course. By prioritizing the prevention of conditions such as diabetes and cardiovascular disease, we can ensure sustainable health outcomes and optimize our national resources.

In 2026, we are also committed to "reaching the unreached." A key priority this year is Men's Health, addressing the urgent—and often overlooked—physical and mental health challenges facing men in our society. Furthermore, we remain dedicated to strengthening medical education, fostering a profession deeply rooted in ethical practice and humanitarianism. The SLMA's greatest strength is its membership. This year, we will renew our focus on capacity building through expanded Continuous Professional Development programs. We aim to better support our colleagues in the periphery while tailoring our portfolio to meet the needs of medical students, junior doctors, and postgraduate trainees.

Colleagues, while we traverse a challenging era for our sector, our strength lies in our collective unity. Our progress must be grounded in mutual respect, professional courtesy, ethics, and accountability. I invite you all to join the SLMA as we navigate the path toward total well-being for all Sri Lankans.

Together, let us unite under our shared mission: "Serving the Profession, Serving the Nation."

My vision for 2026 is centered on the theme:

"Wellness in the Nation through Local and Global Partnerships",

My goal is to steer this hallowed organization toward achieving holistic health for every Sri Lankan by leveraging strategic domestic and international collaborations.

OPINION

Professor Dilanthi Amaratunga
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BUILDING BEYOND DITWAH: INTERDISCIPLINARY PATHWAYS TO CLIMATE-RESILIENT HEALTH SYSTEMS

1. Health and Climate

Climate change is a direct threat to human health. This has led to an increased focus on climate change impacts on health and assessing health vulnerabilities to climate change. By aligning health and climate policies as a core objective of climate solutions, we can mitigate and adapt to the climate crisis and unlock significant co-benefits for society, including improved health outcomes, social equity, and economic stability. Despite a significant increase in the number of articles, research on climate and health remains patchy. Most of the currently available studies are focused on assessing health vulnerabilities to climate change, while there is a lack of research on the health impacts of the mitigation actions and effectiveness of adaptation measures, as well as potential health co-benefits. Research is unevenly distributed across geographical regions, with more studies conducted in high-income countries compared to low- and middle-income countries. Many uncertainties prevail on how different climate scenarios might affect the existing vulnerabilities of health systems, thus exposing the vulnerabilities of the populations they serve.

2. Sri Lanka Context

Sri Lanka is facing multiple and compound climate hazard threats – biological, hydro-meteorological, and economic – that have the potential to interact and cause negative health outcomes and multiplicatively destructive consequences. Extreme weather events in Sri Lanka, such as flooding and drought, are increasing in frequency and severity due to climate change, and they have disrupted the delivery of healthcare services. In the context of the current landscape, the impact of Cyclone Ditwah has been a defining moment for the country's health system [1]. It challenged the physical infrastructure and disrupted health services, causing severe economic and social stress, and people living in poverty are particularly vulnerable. The impact was multi-dimensional, affecting infrastructure, service delivery, and the long-term mental health of the population. This is adding an additional burden to a healthcare delivery system in Sri Lanka that is already constrained by an economic and political crisis. This is also compounded by a longstanding and disproportionate investment that favours curative rather than preventative healthcare. This responsive approach to healthcare service delivery is especially ill-suited to the dynamic risk landscape posed by multiple and compound hazard threats, and there is a high potential for inequitable health outcomes.

3. Financial and Physical Devastation, and Immediate Health Risks

Cyclone Ditwah caused catastrophic damage to health infrastructures. The scale of the damage to the health sector has been described as a "national tragedy" by the Ministry of Health. Over US$562 million in damages were reported for non-residential buildings, including a significant number of hospitals and clinics. The national health system incurred losses estimated at Rs. 21 billion [2]. Out of 500 initially reported affected facilities, 33 state hospitals were severely damaged. In many smaller divisional hospitals and clinics, floodwaters destroyed vital paper-based patient records and pharmaceuticals. Critical medical equipment was destroyed in several Base Hospitals. At smaller clinics, floodwaters reached roof levels, destroying vital paper-based patient records. The disaster placed immense pressure on search-and-rescue and emergency medical services, leading to a temporary surge in trauma cases. The cyclone shifted the disease profile of the affected regions almost overnight. The death toll reached over 640 fatalities, with hundreds still missing as of early 2026. Massive flooding in the Kelani River basin led to a surge in Leptospirosis and Dengue risks.

4. Hospital Readiness: "Recover Before the Disaster"

The UNDRR's approach to hospital readiness [3] is no longer just about "surviving the storm" but ensuring functional continuity, the hospital stays open and operational even when the surrounding area is devastated. In 2026, the UNDRR Readiness for Recovery initiative [4], launched at the World Resilient Recovery Conference held in June 2025, is built on the principle that recovery is most successful when planned before a shock occurs. For hospitals, this initiative represents a shift from reactive rebuilding to pre-disaster planning—ensuring that when a facility is hit, the systems to "Build Back Better" (BBB) are already in place and legally/financially authorised, and involves three main linkages:

4.1. Pre-Disaster Recovery Planning

Hospitals to have a dedicated Recovery Roadmap that goes beyond immediate emergency response, including arrangements with clear legal frameworks that allow hospital directors to avoid certain procurement delays for "resilient upgrades" during the recovery phase. Hospitals also to have systems for data safeguarding by ensuring patient records and administrative data are hosted on resilient, interoperable cloud systems so that even if the physical hospital is destroyed, the "digital hospital" survives.

4.2. Functional Interdependency

The World Bank guidelines emphasise that a hospital's readiness is only as strong as the lifeline infrastructure which supports it. The "Frontline Scorecard" [5] is a tool that can be used to assess how a hospital depends on water, energy, and transport. Recovery initiatives need to prioritise rebuilding these "lifelines" simultaneously with the hospital to ensure the facility can actually provide services, not just stand as a shell. From the point of view of energy resilience, integrated solar and battery storage systems can be part of the standard part of recovery readiness to prevent total shutdowns during grid failures.

4.3. Inclusive & Human-Centric Recovery

This initiative links hospital reconstruction to social equity. Recovery readiness now mandates that Mental Health and Psychosocial Support be a core "wing" of any rebuilt facility, rather than an afterthought. Hospitals must be rebuilt with universal design standards to ensure that the 15% of the population with disabilities can access services during and after a disaster, promoting disability inclusion.

5. Build Back Better

The Sri Lankan health system is moving from the acute response phase of Cyclone Ditwah into a high-stakes reconstruction era. While the physical recovery is ongoing, the Sri Lankan health system needs to use the "Build Back Better" philosophy to integrate climate/disaster resilience into its national health strategy [6]. The Ministry of Health, in coordination with the "Rebuilding Sri Lanka" national programme, needs to prioritise climate-resilient infrastructure. Ditwah, which impacted over 250 health facilities and cost the health sector an estimated Rupees 21 billion in recovery needs,

OPINION

Continued...

has triggered a fundamental redesign of how healthcare is delivered and protected. A major policy shift is needed on vertical relocation of assets, which mandates that critical medical equipment (e.g.ICU ventilators, dialysis machines, and scanning units) be housed on upper floors. Areas faced the double threat of floods and landslides, which have necessitated new geological stability assessments before hospital wings are rebuilt.

6. Locally-Led Disaster Governance

Readiness happens at the local level. Every major hospital can have a documented "Incident Command" role as part of its Hospital Disaster Committees. Regular drills and Simulation Exercises involving local Public Health Officers and community members are to be executed to ensure rapid evacuation and clinic restoration. The provision of data and indicators of risk and vulnerability to support decision-making at local levels needs to be developed and facilitated. Governance arrangements that include international agreements, cross-government action and independent expert oversight need to be in place, which supports improved decision-making to enable transformative governance processes that are more secure, evidence-based, inclusive and equitable.

7. Adaptation strategies

There is a need for adaptation measures for multiple, concurrent challenges of biological and climate-induced hazards, aiming to increase resilience to alleviate the adverse health effects of current and future impacts of climate change [7]. These adaptation strategies in building climate-resilient health systems are critical, including optimising healthcare systems for extreme weather events, enhancing global monitoring for disease outbreaks and developing comprehensive risk assessments and response plans. The provision of an effective multi hazard early warning system for health and climate-induced hazards as an adaptation strategy can be prioritised [8], along with strengthening early surveillance and response systems for climate-sensitive health hazards, which has become fundamental under rapid global environmental change, population movements, disease vectors and infections. However, several obstacles prevent health system adaptation to climate risk, such as poor policy implementation and evaluation. These obstacles are further exacerbated by poverty, a lack of political commitment, inadequate data, and deficient healthcare systems, especially in developing countries.

8. What else can we do?

In addressing interconnected health crises amplified by climate change, a holistic, multidisciplinary preventive approach should be applied in a rational manner. To utilise knowledge, relevant stakeholders must be actively involved in this collaborative learning process. There is a need to facilitate data sharing across multiple sectors (e.g. environment, healthcare) to ensure that all drivers of the climate and health impacts are accounted for to guide risk reduction programs and policies. Several other initiatives will also help, including:

- Strengthening the understanding of the interdependencies and interconnectedness of human and environmental health to better address health impacts due to climate change
- Greater understanding of health impacts and the systemic nature of risk.
- Promote the application of an intersectionality perspective in the study of vulnerable groups in disaster and health emergencies, which provides a better and more nuanced picture of social inequalities, vulnerabilities and vulnerable groups in varying localities and cultures, and during different crises
- Improve crisis communication by increasing the ability of vulnerable groups to access, read, interpret and use information related to disaster risk and health emergencies
- Improve understanding of the health impacts of natural and other hazards, drivers of vulnerability, including attitude and behaviours, to inform public health action and localised planning and response efforts
- Develop and evaluate interventions to protect health from the longer-term physical and mental health impacts of hazards such as flooding
- Assess the economic impacts of hazards such as flooding on health and include the economic benefits in the evaluation of interventions to understand the most effective approaches to protect people, infrastructure, and services in at-risk area
- Understand and consider health co-benefits and implications for equity when assessing the impacts and effectiveness of interventions to protect health from the effects of hazards such as flooding
- Integrate health considerations and implications in research related to land use planning, maintenance and upgrades to ageing infrastructure, coastal degradation, ecosystem restoration, ecosystem functioning, and flood resilience
- Improve the understanding of the health implications for communities forced to relocate due to hazards
- Strengthen emergency preparedness and resilience of health services, so that they are able to respond effectively and sustainably to extreme weather events such as flooding and drought, and provide more equitable health outcomes.

Cyclone Ditwah is a national tragedy. It should therefore be a turning point in how Sri Lanka thinks about climate resilience and its nexus with the health sector. The country has an opportunity to ensure that "build back better" includes building more resilient, more connected, and more anticipatory disaster preparedness systems, with interventions that will help develop climate-informed and more efficient and inclusive health care service delivery amidst compound hazard threats.

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FEATURE ARTICLE

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METABOLIC SURGERY: REVOLUTIONIZING TREATMENT FOR OBESITY AND TYPE 2 DIABETES

Introduction

Metabolic surgery has emerged as one of the most effective treatments for obesity and its metabolic complications, particularly type 2 diabetes (T2D). While historically grouped under "bariatric surgery," metabolic surgery goes beyond weight loss to directly improve metabolic health, including glucose regulation, cardiovascular risk factors, and long-term mortality. Modern research shows that metabolic surgery can produce sustained benefits that are not achievable with lifestyle changes or medical therapy alone in many patients.

This article explores metabolic surgery's definition, underlying mechanisms, indications, clinical outcomes, benefits and risks, and future research directions.

What is Metabolic Surgery?

Metabolic surgery refers to a group of gastrointestinal surgical procedures originally developed for weight loss but now recognized for their profound effects on metabolic disease processes. These procedures modify the structure and physiology of the stomach and/or small intestine, leading not only to reduced caloric intake and absorption but also to hormonal and metabolic changes that improve glucose metabolism and insulin sensitivity.

Although the terms *bariatric surgery* and *metabolic surgery* are often used interchangeably, "metabolic surgery" emphasizes the metabolic benefits—especially diabetes remission—beyond simple weight loss.

Mechanisms: How Metabolic Surgery Works

Weight-Dependent Mechanisms

The most obvious effect of metabolic surgery is weight reduction. Reduced stomach volume limits caloric intake, and in procedures that bypass portions of the small intestine, decreased nutrient absorption also contributes to weight loss. Weight loss itself improves peripheral insulin sensitivity and reduces insulin resistance thus reversing the deliterious processes in type 2 diabetes.

Weight-Independent Mechanisms

Surprisingly, surgery improves glucose metabolism not only through weight loss. After procedures like Roux-en-Y gastric bypass (RYGB) and sleeve gastrectomy (SG), levels of gastrointestinal hormones such as glucagon-like peptide-1 (GLP-1) increase, enhancing insulin secretion and improving glycemic control independent of weight change.

Additionally, metabolic surgery alters bile acid circulation, gut microbiota composition, and even adipokine profiles, factors that collectively enhance insulin sensitivity and glucose homeostasis.

It has been shown that these hormonal and metabolic shifts contribute significantly to T2D remission and improvements in several metabolic parameters after surgery.

Common Metabolic Surgery Procedures

Several surgical approaches are employed depending on patient characteristics and surgical expertise:

Sleeve Gastrectomy (SG)

In SG, a large portion of the stomach is removed, leaving a narrow sleeve. This restricts food intake and also impacts hormones involved in hunger (especially Grehlin) and glucose regulation. SG has become increasingly popular due to its relative technical simplicity and strong outcomes.

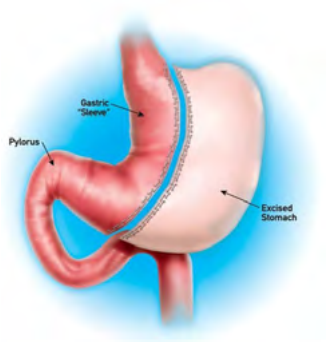

Fig 1 Sleeve Gastrectomy

Roux-en-Y Gastric Bypass (RYGB)

RYGB is one of the most widely studied and effective procedures. A small stomach pouch is created and connected directly to a lower segment of the small intestine, bypassing much of the stomach and duodenum. This reduces nutrient absorption and significantly alters gut hormone secretion.

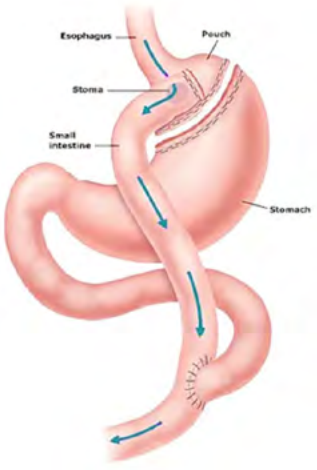

Fig 2 Roux-en-Y Gastric Bypass

One-anastomosis gastric bypass (OAGB) and Biliopancreatic Diversion (BPD)

More complex malabsorptive procedures like One-Anastomosis Gastric Bypass (OAGB) and BPD offer greater weight loss and metabolic effects but may have higher nutritional complication rates. Studies have shown that OAGB to have the highest diabetes remission rates.

Single anastomosis duodenal-ileal bypass with sleeve gastrectomy (SADI-S)

This procedure is for high-risk or severely obese patients. Early data suggest significant long-term weight and metabolic outcomes, though nutritional management is critical.

Clinical Outcomes: Diabetes Remission and Beyond

Diabetes Control and Remission

Large randomized controlled trials and meta-analyses demonstrate that metabolic surgery significantly improves glycemic control and often leads to remission of type 2 diabetes. Patients who undergo surgery experience larger reductions in hemoglobin A1c (HbA1c) compared with those receiving intensive medical therapy. Complete remission rates are significantly higher with surgical procedures than with non-surgical approaches. Long term studies have shown that patients with T2D had better long-term blood glucose control after surgery, with some achieving remission lasting over a decade.

Weight Loss and Cardiovascular Benefits

Metabolic surgery is among the most effective long-term weight loss strategies. Average weight loss ranges depending on the surgery type, but many patients maintain substantial reductions over years.

Importantly, recent large studies show that surgery leads to improved macrovascular and microvascular outcomes, including lower incidence of heart disease, kidney disease, and retinopathy compared with novel drug therapies like GLP-1 receptor agonists.

FEATURE ARTICLE

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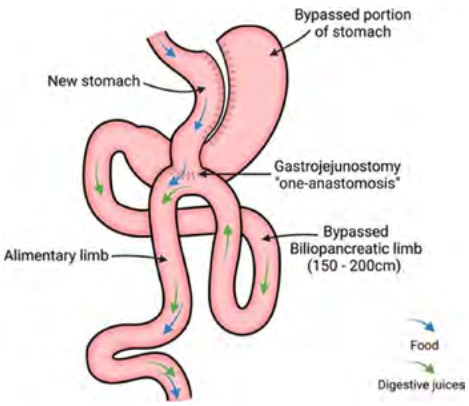

Fig 3 One Anastomosis Gastric Bypass

Effects on Other Comorbidities

Beyond diabetes and cardiovascular risk, metabolic surgery can improve conditions like non-alcoholic fatty liver disease (NAFLD), obstructive sleep apnea, and dyslipidemia.

Indications and Patient Selection

The traditional indication for metabolic surgery has been severe obesity (body mass index [BMI] ≥ 40 kg/m²) or BMI ≥ 35 with significant comorbidities like type 2 diabetes or hypertension. However, emerging evidence supports surgery in individuals with lower BMI thresholds (e.g., 27–34) when diabetes is difficult to control with medical therapy.

Patient selection involves comprehensive evaluation of metabolic status, surgical risk, willingness to adhere to lifelong follow-up, and psychological readiness. A multidiciplinary assessment by nutrionists, endocrinologists, cardiologists, pulmonologists, psyciatrists/ psychologists is essential during pre-operative preparation to ensure good surgical outcomes.

Risks and Complications

Short-Term Surgical Risks

As with any major surgery under general anaesthesia, metabolic surgery carries risks of perioperative complications. Specific surgery related complications include leaks (especially after sleeve gastrectomy) and intra-abdominal fluid collections. Mortality is rare and risk varies with surgical complexity and patient health.

Long-Term Nutritional Concerns

Because many procedures alter nutrient absorption, long-term nutritional deficiencies—such as iron, vitamin B12, calcium, and fat-soluble vitamins—are common and require lifelong monitoring and supplementation. These deficiencies can lead to anemia, bone loss, and neurologic symptoms if untreated.

Gastrointestinal and metabolic complications

Some patients experience gastrointestinal symptoms such as dumping syndrome, small bowel bacterial overgrowth, or persistent nausea. Therefore, follow-up with a multidisciplinary team is crucial.

Comparisons With Medical Therapy

With the advent of potent medications such as GLP-1 receptor agonists, there has been debate about the role of surgery versus drugs. However, large comparative studies suggest that metabolic surgery offers greater long-term benefits in weight reduction, diabetes remission, and reduction in cardiovascular and microvascular complications than medicines alone.

Additionally, surgery may reduce medication dependency, and in many cases, patients can reduce or eliminate their need for diabetes, hypertension, and lipid-lowering drugs.

Health Economics and Accessibility

Multiple analyses show metabolic surgery to be cost-effective in the long term due to reductions in diabetes complications and use of long-term medications. However, access remains a challenge in many regions due to costs, insurance coverage limitations, and surgical capacity constraints.

There are concerns in some countries that surgeon availability may decline due to rising professional indemnity costs and legal pressures, potentially reducing access to care.

Future Directions and Research

Personalized Medicine

Research using advanced biomarkers and omics technologies (e.g., genomics, metabolomics) aims to identify predictors of individual outcomes, tailoring surgical decision-making to maximize benefits while minimizing risks.

Novel Strategies

Studies are also exploring less invasive surgical techniques and combinations with pharmacotherapy to optimize efficacy and reduce complications. As understanding grows about metabolic pathways affected by surgery, new therapies may emerge that mimic surgical metabolic effects without invasive procedures.

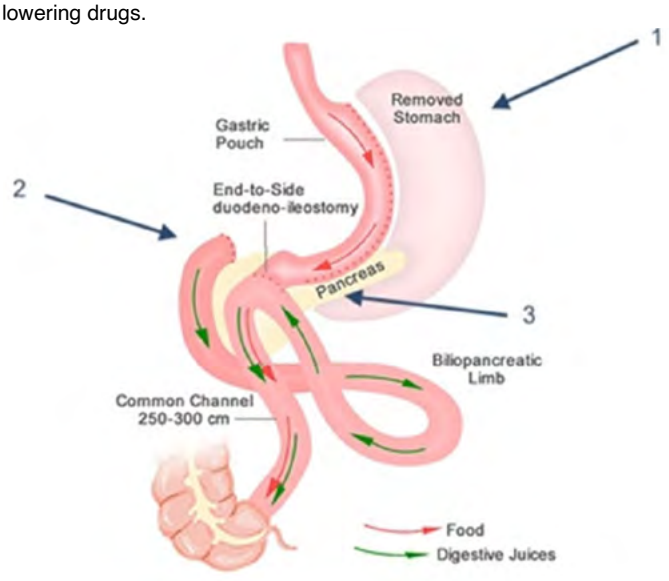

Fig 4 Single Anastomosis Duodeno-ileal bypass

Conclusions

Metabolic surgery represents a transformative approach to treating obesity and its metabolic sequelae, especially type 2 diabetes. With demonstrated benefits in weight loss, glycemic control, reduction in cardiovascular and microvascular risks, and improvements in quality of life, surgery should be considered a cornerstone of comprehensive metabolic disease management.

While not without risks and requiring lifelong follow-up, metabolic surgery continues to outperform most non-surgical interventions in appropriate patients. Future research will further refine patient selection, expand indications, and potentially integrate surgery with metabolic therapies.

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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 preliminarily influenced by genetics, it is important to assess this biomarker, especially in patients with a family history of 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
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- Predictor of atherosclerosis and hypertension

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FROM SHAME TO EMPATHY: RETHINKING HEALTH COMMUNICATION ON SUBSTANCE MISUSE IN SRI LANKA

Substance use disorders due to alcohol, tobacco and illicit drugs cause serious morbidity, mortality, social and economic burden in Sri Lanka. While these harms justify a strong public health response, its framing requires careful historical reflection. Since the mid-20th century, the tobacco and alcohol industry has been glamorising substance use targeting young adults. In response, public health bodies initiated a worldwide campaign of counter-advertising during 1990s. To counter glorification most campaigns resorted to a shame-based approach (1). The substance user was alternatively portrayed as unattractive, weak and unintelligent. Even today, this strategy continues to be used by many anti-substance movements in Sri Lanka.

Over the past two decades, both industry strategies and public health understanding of substance misuse has evolved considerably (2), compelling us to re-evaluate shame-based communication. In a recent article published in the *Sri Lanka Journal of Psychiatry,* we argue for an alternative communication approach to substance misuse that centres on empathy (3). We base our arguments on current evidence, behavioural change and ethical principles. While we remain unequivocal in opposing industry influence, we are committed to distinguishing individuals with substance misuse from the drug industry. In addressing substance use, the true adversary is the industry itself, not those affected by its products.

Evaluation of shame-based approaches gives inconclusive evidence for primary prevention. While some studies showed a reduction in the intention to smoke, other evidence suggests that messages portraying unattractiveness or social manipulation are ineffective. (1). Alternative communication styles such as positive framing that instils hope and self-efficacy, and some negative framing techniques such as fear-appeals have shown efficacy (4). Evidence in relation to secondary prevention is more straightforward. Paternalistic or derogatory messaging induces defensive reactions and makes tobacco users dismiss health information than engaging. Consequently, they failed to encourage smokers reveal addiction issues (1). Notably, there is a dearth of studies assessing the effectiveness of substance-related communication approaches in Sri Lanka.

Proponents of shaming in the name of primary prevention tend to disregard the importance of ethics, justice and human dignity (5). As physicians guided by the Hippocratic oath, our clinical and public-health responses should prioritise doing no harm. Interventions that rely on shame fuel a self-perpetuating cycle of substance use by deepening internalised stigma, reducing help-seeking, encouraging unassisted quitting attempts and normalising stigmatising attitudes among healthcare providers that compromises care (5). When professional entities employ shame or ridicule, they risk further dehumanising people who use drugs. Appeals to a utilitarian "greater good" that ultimately harm individual patients represent a troubling ethical stance for the medical profession.

Substance misuse, such as smoking, is disproportionately prevalent among marginalised populations with lower income and limited education in Sri Lanka. Shame-based framing of substance misuse as a personal failure neglects the role of broader social determinants that influence substance use. The resultant stigma amplifies existing inequities. Such approaches do not align with the contemporary biopsychosocial understanding of addiction, as well as behavioural-change frameworks grounded in empowerment.

The way forward

The proposed way forward is a paradigm shift towards empathy-based communication. Drawing from principles of motivational interviewing, we advocate for a non-judgmental approach that mitigates defensive reactions from misusers, enabling behavioural change, while maintaining anti-smoking attitudes among non-users. Many alternative communication strategies already centre on empathy. For example, self-efficacy and hope statements are positive framing techniques that will not perpetuate stigma towards patients with substance misuse (4).

This shift in health communication should happen across individual, institutional and community levels. Healthcare staff, especially those who provide public and mental health services, should undergo shame-sensitive communication training. Professional organisations need to renounce shaming as a public health tool and adopt communication strategies based on empathy (5). Media professionals need to be educated on the importance of avoiding stigmatising language on mass media. Indirect promotion of substances within Sri Lankan media should be addressed through stronger regulatory measures rather than through shame-based strategies. There is a clear need for greater locally relevant research on substance-related communication, alongside the meaningful inclusion of lived experience in designing public health messages. Together, these measures offer a pathway for health professionals to combat industry influence while ensuring that people with substance misuse are not unfairly harmed in the process.

The article is available at: Beyond blame and shame: Empathy-based health communication for substance misuse in Sri Lanka, December 2025, *Sri Lanka Journal of Psychiatry* 16(2):59-61, DOI: *10.4038/sljpsyc.v16i2.8650*

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RESILIENCE AND PSYCHOSOCIAL WELL-BEING IN EVERY CHILD

A Post-Action Reflection on Supporting Disaster-Affected Children

In the aftermath of the recent national disaster, the children in those affected communities suffered a sudden displacement, a loss, fear, and a great deal of uncertainty. It should be clear that recovery must address more than physical needs. In this regard, Save the Children, Sarvodaya, and the Center for Children's Happiness (CCH) collaborated to establish a joint humanitarian response that would prioritize children's mental health and psychosocial well-being (MHPSS).

A child-centred humanitarian response

The holistic, multi sectoral nature of the response is justified because it strives to provide disaster affected children and their families with immediate and long term benefits before emergency recovery phases are implemented. The response included lifesaving humanitarian assistance, including Multi Purpose Cash Assistance (MPCA), Education in Emergencies (EiE), Water, Sanitation and Hygiene (WASH), and child protection services. Nonetheless, one critical mental health and psychosocial support system (MHPSS) has been prioritized in recovery processes.

Children tend to experience anxiety, grief, changes in behavior, diminished feelings of security, and their future uncertainty becomes more extended in cases of displacements caused by disasters. In response to it, partners place emphasis on returning safety, routine, and emotional connection through structured evidence-based psychosocial interventions as provided in localities where children live.

TeamUp Facilitators & Training on Psychological First Aid (PFA)

TeamUp: movement, play, and healing

TeamUp was one of the key responses to this initiative. This is an evidence-based psychosocial intervention developed by War Child Holland, UNICEF Netherlands, and Save the Children Netherlands. TeamUp involves structured movement, play, and routine to help children reduce their stress and take control of their emotions, as well as strengthen their resilience, without needing to verbally report their traumatic experiences whom voiceless between struggles.

CCH has been modeling and implementing TeamUp in Sri Lanka since 2022, covering schools, children's homes, rehabilitation centers, and communities. CCH, therefore, was the main technical partner in the disaster response, with MHPSS, the participation of children, Psychological First Aid (PFA), safeguarding children, and TeamUp expertise, while field operations were handled by Sarvodaya teams.

In addition, Early Adolescent Skills for Emotions (EASE), developed and endorsed by the World Health Organization (WHO) and UNICEF, has been added as an evidence-based group intervention to support adolescents experiencing stress, anxiety, and depressive symptoms, particularly in adversity-affected communities. The ReachNow tool (formerly the Community Case Detection Tool - CCDT) will also be used in this project to enable early identification of psychological difficulties and timely referral for appropriate psychosocial support.

Building local capacity for sustainable impact

While preparing for the anticipated initial response, TeamUp methodology, child protection, and child safeguarding are compulsory modules are being trained to ensure effective and safe psychosocial support delivery. A TeamUp Global Master Trainer and team of Save the Children-Sri Lanka provided technical support and ensured quality and model adherence.

The conscious strategy to engage local volunteers. Sarvodaya's huge networks held strong community presence fingerprints, making it very easy to mobilize those with context knowledge

VOICES FROM THE PERIPHERY

Continued...

Play and movement based psychosocial intervention at disaster-affected area

and community trust. Thus, the partnership laid good foundations for sustainable, community-based psychosocial responses extending beyond the immediate emergency phase.

In addition, joint field visits to disaster-affected areas in Badulla, Nuwara Eliya, and outer Colombo districts were observed higher levels of emotional distress among children now residing in temporary camps and in affected villages and host communities. Common stressors included fear of another disaster, uncertain relocation, and disruption to their education.

It also showed that children are remarkably resilient when given the opportunity to enjoy safe, structured, and firm psychosocial support all around. These elements included Child Friendly Spaces and TeamUp sessions, games, connections, and emotional regulation to help caregivers and responders realize that play is a critical part of healing.

Strengthening systems and engagement with the field will moreover refine key operational prioritizations for successful scale up. More specifically, these include appropriate location targeting based on vulnerability, better coordination with government stakeholders, and alignment with the district systems, such as Child Rights Promotion Officers, Disaster Management Units, and the regional health authorities. Clear referral pathways for children needing specialized services should be established, along with regular peer supervision.

With respect to the likely protracted displacement in several of those areas in temporary camps and newly planned permanent settlements, there was quite clear necessity for continued Child Friendly Space activities and psychosocial programming as well. Integrating comprehensive monitoring and evaluation framework, ensure child safeguarding measures, and clear field coordination guidelines will be essential to ensure quality, accountability, and child centered outcomes.

Looking ahead

This post-action reflection reaffirmed the fact that the joint initiative by Save the Children and implemented by Sarvodaya, and the Center for Children's Happiness is relevant and timely. By pooling the efforts of communities, these responses demonstrate that the best evidence based psychosocial interventions are an effective means of inducing children in disaster contexts to recover.

Investing in children's mental health and psychosocial wellbeing reflects that investment in the future resilience of the country as Sri Lanka moves closer to recovery. With appropriate structures, partnerships, and sustained commitment, every child affected by disaster can be supported to heal, develop, and thrive.

Field visit at the disaster-affected area

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Play time at the temporary shelter

NOVICE

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ARTIFICIAL INTELLIGENCE–BASED EYE SCREENING: CLINICAL POTENTIAL, HEALTH SYSTEM INTEGRATION, AND IMPLEMENTATION PATHWAYS IN SRI LANKA

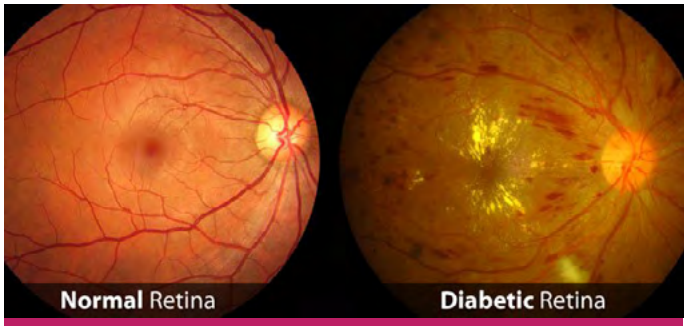
Preventable blindness remains a major public health challenge globally and in Sri Lanka. Among its leading causes, diabetic retinopathy (DR) represents a silent yet progressive microvascular complication of diabetes mellitus. DR often remains asymptomatic until advanced stages, at which point visual loss may be irreversible. Evidence shows that timely detection and treatment can prevent most diabetes related blindness, highlighting the importance of systematic screening

Sri Lanka has achieved commendable health outcomes through a universal, free public healthcare system. However, the rapid rise in non-communicable diseases, particularly diabetes, has placed increasing pressure on existing eye care services. Current screening pathways rely predominantly on specialist driven models that are neither scalable nor equitable in the face of a growing diabetic population. In this context, artificial intelligence (AI) - based eye screening has emerged as a promising, evidence based approach to strengthen early detection, optimise specialist resources, and protect vision at a population level.

Burden of Diabetic Eye Disease

Globally, diabetes affects hundreds of millions of individuals, with a disproportionate burden borne by low and middle income countries. Epidemiological studies consistently demonstrate that approximately one third of people with diabetes develop some degree of DR, while around 10% develop vision threatening disease such as proliferative DR or diabetic macular edema. Critically, many individuals remain unaware of ocular involvement until late stages, when treatment options are more complex and outcomes less favourable.

In Sri Lanka, nationally representative data show that DR is present in a substantial proportion of adults with diabetes. The Sri Lanka Diabetes and Cardiovascular Study reported that nearly one third (27.4%) of adults with known diabetes had DR, with over 90% classified as non-proliferative disease. This indicates a large pool of individuals with early, asymptomatic retinal disease who could benefit from timely detection before progression to irreversible visual impairment. The Preferred Practice Pattern further notes that many people with diabetes do not receive recommended annual eye examinations, reinforcing the need for systematic, population level screening that reduces dependence on specialist availability.



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Limitations of Current Screening Pathways in Sri Lanka

Despite the availability of free eye care services in the public sector, Sri Lanka does not currently operate a structured, nationwide DR screening programme. Screening remains largely opportunistic, relying on patient initiated attendance at specialist eye clinics. Community based, nationally representative evidence demonstrates that a substantial proportion of adults with diabetes already have DR, most of which is non-proliferative and asymptomatic, indicating that many affected individuals are unlikely to be identified through symptom driven or referral based pathways alone.

Qualitative studies from Sri Lanka have identified multiple barriers to screening uptake.Barriers include limited awareness, examination related concerns, indirect costs, long waiting times, poor clinic coordination, and workforce constraints. Consequently, many patients present late with advanced disease, placing a heavy burden on tertiary services and leading to avoidable visual impairment.

AI-Based Eye Screening Concepts Capabilities and Clinical Integration

AI-based eye screening uses machine learning algorithms, most commonly deep learning models, to analyse retinal images for ocular disease detection. Trained on large datasets of labelled fundus photographs, these systems recognise patterns associated with DR and related conditions and classify disease severity with consistency comparable to trained human graders.

Most AI eye screening systems employ convolutional neural networks optimised for image recognition. These models assess pixel level patterns to identify features such as microaneurysms, intraretinal hemorrhages, hard exudates, and neovascularization, and evaluate the overall pattern of retinal changes rather than individual lesions in isolation, generating clinically meaningful screening results.

Screening outputs are typically risk stratified into categories such as no DR, non referable DR, or referable vision threatening disease. This approach aligns with established screening pathways and supports timely referral decisions rather than definitive diagnosis.

Accuracy, Validation, and Real World Performance

A growing body of international evidence supports the diagnostic performance of AI-based DR screening. Real world studies have reported sensitivities commonly exceeding 85–95% for detecting referable disease, with specificities varying according to thresholds and population characteristics. High sensitivity is deliberately prioritised to minimise the risk of missed vision threatening disease.

Importantly, more recent evaluations demonstrate that AI systems maintain robust performance outside controlled research environments, including in primary care clinics and community screening programmes. These findings are particularly relevant for countries such as Sri Lanka, where screening conditions may be

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Continued...

less standardised and specialist oversight is limited.

Autonomous and Assisted Screening Models

AI-based eye screening can be implemented using two complementary models,

1. Autonomous screening, where AI independently analyses images and generates screening results without immediate human review. This model has been shown to significantly improve screening coverage and reduce reliance on specialist graders in settings with workforce shortages.
2. Clinician assisted screening, where AI functions as a decision support tool to assist clinicians or trained technicians in triaging and prioritising referrals.

For Sri Lanka, a phased approach beginning with clinician assisted models may be appropriate, allowing trust and familiarity to develop while maintaining clinical oversight.

Workflow Integration and Health System Impact in Resource-Limited Settings

One of the major strengths of AI-based eye screening is its ability to integrate into existing clinical workflows. Retinal images can be captured using non mydriatic fundus cameras or portable devices operated by trained non physician staff, and analysed via secure cloud based or on device systems, with results generated within minutes. This enables same day counselling and referral planning, addressing a key limitation of conventional referral based screening.

While diabetic retinopathy remains the most validated application, some AI systems can also flag additional ocular conditions as secondary alerts, supporting primary care and community based screening without increasing diagnostic risk. By enabling task shifting to nurses, medical officers, and technicians, AI reduces dependence on scarce ophthalmology resources while preserving safety and quality. Importantly, AI does not replace ophthalmologists; rather, it helps direct specialist expertise to patients most likely to benefit from timely intervention.

International experience indicates that AI-based screening can improve screening uptake, adherence, and service efficiency when integrated into primary care. Cost effectiveness analyses suggest potential reductions in long term healthcare costs and improved quality adjusted life years, largely through earlier detection and more efficient use of tertiary eye services. These system level benefits are particularly relevant to Sri Lanka's publicly funded health system, where optimal allocation of limited specialist resources is essential.

> AI-based eye screening offers a timely, evidence based approach to reducing preventable blindness in Sri Lanka.

Ethical, Regulatory, and Clinical Considerations

The adoption of AI in eye screening must be guided by robust ethical and regulatory frameworks. AI systems should undergo local validation to ensure consistent performance across Sri Lanka's diverse population. Data privacy, informed consent, and secure data handling are essential to maintain patient trust.

Equally important is the clear delineation of clinical responsibility. AI outputs must be embedded within defined referral pathways, with ultimate decision making remaining with healthcare professionals. International guidance, including the International Council of Ophthalmology recommendations for resource appropriate diabetic eye care, provides a strong foundation for responsible implementation.

Way Forward

AI-based eye screening offers a timely, evidence based approach to reducing preventable blindness in Sri Lanka. A phased implementation beginning with pilot programmes in diabetic clinics and MOH-level facilities can generate local evidence while maintaining public sector stewardship, potentially supported through public–private partnerships. However, screening alone is insufficient; success depends on effective referral pathways, adequate treatment capacity, and patient education to ensure early detection translates into improved visual outcomes. With responsible adoption, AI-assisted screening can strengthen Sri Lanka's response to diabetic eye disease and reduce avoidable blindness.

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SLMA IN JANUARY

Highlights

SLMA New Year Welcome and Multi-Religious Blessing Ceremony 2026

On January 1, 2026, the Sri Lanka Medical Association (SLMA) organized its annual multi-religious ceremony and customary New Year welcome. The event was graced by the President, Council Members, Past Presidents, and staff of the SLMA. Religious leaders from Buddhist, Hindu, Catholic, and Islamic faiths invoked blessings upon the membership for the coming year. Additionally, the SLMA honored the memory of the late Dr. E. M. Wijerama, commemorating his generous and lasting contributions to the Association.

The official unveiling of the photograph of the outgoing President

The official unveiling of the photograph of the outgoing President, Dr. Surantha Perera, was held in the presence of the President and Council Members of the Sri Lanka Medical Association (SLMA). Following the unveiling, the first Council Meeting of the year was convened, marking a seamless transition of leadership to the new President, Dr. Manilka Sumanatilleke.

Health Workforce Migration in Asia

Council Member, Prof. Saroj Jayasinghe, participated as an expert panelist in the Webinar 'Health Workforce Migration in Asia: Regional Realities, Global Consequences', organized by The Asian Collective For Health Systems (TACHS), with its Secretariat at the Centre for Social and Economic Progress (CSEP) New Delhi India. Dr. Lahiru Kodituwakku, Public Relations Officer, SLMA moderated the session.

SLMA in JANUARY

SLMA IN JANUARY

Highlights

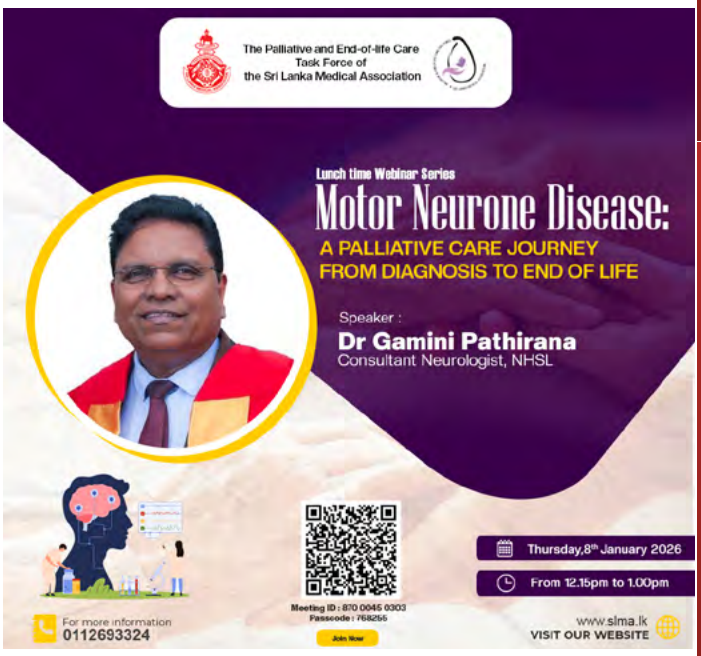
SLMA Saturday Talks

Two Saturday talks were conducted during the month with enthusiastic participation of medical students and junior doctors.

- Pancreatitis by Dr. Malith Nandasena, Consultant General and Hepato-Pancreato-Billiary Surgeon and Senior Lecturer in Surgery at the Faculty of Medicine, University of Colombo
- Prolonged Fever in Children by Dr. Kasun Jayasundara, Consultant Paediatrician and Head of the Department of Paediatrics and Neonatology, Faculty of Medicine, University of Moratuwa

Lunch Time Webinar Series

The newest addition to the SLMA's capacity building platforms, 'Lunch Time Webinar Series' was launched in January with a webinar on 'Motor Neuron Disease, A Palliative Care Journey from Diagnosis to End of Life' by Dr. Gamini Pathirana, Consultant Neurologist at the NHSL, Colombo.



Association of Sri Lankan Neurologists Donates Rs. 3.79 Million to SLMA Relief Fund

- Association of Sri Lankan Neurologists made a Rs 3.79 million donation to the SLMA Relief Fund, for rebuilding efforts at the DGH Chilawa, spearheaded by the SLMA with the support of professional colleges and associations.

SLMA PRESIDENTIAL INDUCTION CEREMONY 2026

Captures

SLMA PRESIDENTIAL INDUCTION CEREMONY 2026

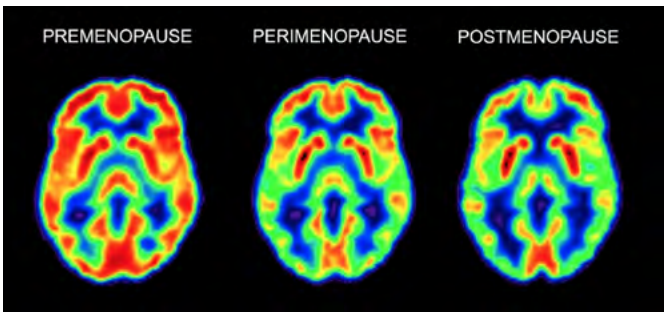
Captures

GLOBAL HEALTH WATCH

January 2026

USA withdraws from the WHO

United States of America officially withdrew from the World Health Organization (WHO), creating a huge vacuum in funding and resources for the global health body. USA was one of its biggest global donors. This coincides with the reluctance of the Trump Administration in the USA to continue collaborations with UN agencies including the WHO. Trump administration has accused the WHO of "mishandling" of the pandemic. In response WHO has reiterated its evidence-based approach towards managing the pandemic and highlighted the creation of an international pandemic treaty designed to prevent, prepare for, and respond to future pandemics, including sharing vaccines and drugs more fairly, agreed upon by all WHO member states except the US.



Source: BBC Health, The Wall Street Journal

Menopause linked to Alzheimer's-like brain changes

In a new study, published in the journal Psychological Medicine, researchers from the UK have revealed that the loss of grey matter in areas involved with memory and emotion following menopause might partly explain why women are generally at greater risk of dementia than men. The study involved nearly 125,000 women, of whom 11,000 had MRI brain scans. Study also revealed that Hormone Replacement Therapy (HRT) use did not appear to prevent the grey matter loss.

Citing this important finding, Prof Channa Jayasena, an expert in hormones at Imperial College London, said: "The effect of HRT on brain health in menopause continues to be a topic of debate, and old clinical trials like the Women's Health Initiative have failed to answer this question. Either way, this is an important complication that millions of women experience in the UK, so deserves close attention in the future."

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