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The SLMA Monthly

Official Newsletter of the Sri Lanka Medical Association

FEBRUARY 2026

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FROM THE EDITORS

Dr Lahiru Kodithuwakku
Co-Editor

Dr Kumara Mendis
Co-Editor

February has been a dynamic month for the Sri Lanka Medical Association (SLMA), characterized by a diverse array of professional activities and capacity-building initiatives.

Continuing our mission to bridge the gap between central academic discourse and regional clinical practice, the SLMA organized a Joint Regional Clinical Meeting alongside the Colombo North Clinical Society and the Welisara Chest Society. This successful collaboration underscores our core belief that professional growth and access to specialized knowledge should never be limited by geography.

In a significant academic partnership, we also collaborated with the Sri Lanka College of Pulmonologists (SLCP) for a Pre-Congress Session held in conjunction with RESPIRE 2026. This workshop on Sleep Medicine provided comprehensive insights into the field, covering everything from common sleep disorders to the latest diagnostic sleep studies and therapeutic techniques.

Beyond clinical updates, we recognized the immense pressure facing today's medical professionals by hosting a dedicated workshop: "Mental Health & Well-being Across the Lifespan." Facilitated by leading psychiatrists and mental health experts, the session moved beyond traditional diagnosis to address the critical issues of physician burnout, mindfulness, and the necessity of self-care.

Our commitment to public health remained equally strong throughout the month. We conducted numerous awareness campaigns, including a timely update on the Nipah virus infection and several radio programs dedicated to educating the public on diabetes, women's hormonal health, and elderly care.

As we move forward, the SLMA remains dedicated to expanding its wings, continuously evolving to meet the needs of our profession and the public we serve.

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COVER STORY

Dr Lahiru Kodituwakku

Co-Editor, The SLMA Monthly Magazine

Dr Kumara Mendis

Co-Editor, The SLMA Monthly Magazine

FOSTERING A CULTURE OF COLLABORATIVE GROWTH

The Sri Lanka Medical Association's (SLMA) greatest asset is its vibrant and energetic membership. Their professional development is inextricably linked to the SLMA's growth as a premier professional body. Consequently, a primary objective for any SLMA Presidential year is to enhance the knowledge, skills, and capacities of our colleagues nationwide.

Despite their dedication, colleagues in the peripheries often face barriers to continuous professional development due to demanding workloads and geographical distances. To bridge this gap, the SLMA has renewed its commitment to creating accessible pathways for professional advancement. A key strategy is collaborating with regional clinical societies to co-create and co-host joint meetings and symposia. This approach provides regional colleagues with vital academic updates while creating a platform for sharing best practices in clinical care and public health within regional settings.

A recent milestone was the Joint Regional Meeting hosted alongside the Colombo North Clinical Society and the Welisara Chest Society. The program covered a broad spectrum of critical topics, from antimicrobial stewardship and diabetes management to the practical application of AI in medicine. The high engagement in the SLMA North Medical Quiz further demonstrated the value of interactive learning.

Moving forward, the SLMA remains dedicated to nurturing a culture of co-learning that transcends geographical boundaries. Join us in this significant national effort; together, we can propagate a culture of excellence and lead our profession to greater heights.

PRESIDENT'S MESSAGE

Dr Manilka Sumanatillake

132nd President of Sri Lanka Medical Association

SERVING THE PROFESSION, SERVING THE NATION

Dear Members, Colleagues and Students,

As we navigate the evolving landscape of healthcare in Sri Lanka, our mission remains anchored in the theme: "Wellness in the Nation through Local and Global Partnerships". Central to this vision is our commitment to strengthening the backbone of our health system, our medical professionals at every level.

Empowering the Regional Setup

The strength of our national healthcare is only as resilient as its most remote outpost. Capacity building in the regional setup is a primary focus for the SLMA this year. By facilitating Regional Clinical Meetings and collaborative sessions with local clinical societies, such as our recent partnership with the Colombo North Clinical Society and Welisara Clinical Society, we aim to bridge the gap between central expertise and peripheral practice. These efforts will further extend to other clinical societies and associations, including upcoming Inaugural Annual cademic sessions of the Chilaw Clinical Society.

Investing in Our Future: Junior Doctors and Medical Students

Our junior medical officers and medical students represent the future of our profession. We recognize the unique challenges they face, from career uncertainty to demanding work environments. The SLMA continues to host vital learning platforms like Saturday Talks, Lunchtime Webinars and Monthly Clinical Meetings, designed to help junior doctors navigate various specialties and explore both local and international technical content relevant to their fields of study. From this month onwards we have also dedicated space for young upcoming researchers particularly among medical undergraduates to showcase their research in 'The SLMA Monthly'.

Reaching the Public through Media

Beyond the walls of our hospitals and lecture halls, the SLMA is actively engaging with the nation. We have intensified our media outreach through radio and TV talk shows, monthly seminars and briefings on critical public health issues and common health ailments. By leveraging digital platforms and traditional media, we are fulfilling our role as a trusted voice, educating the public and advocating for a healthier society.

Together, let us continue "Serving the Profession, Serving the Nation".

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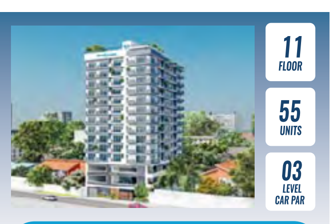

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OPINION

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BUILDING A CLIMATE-RESILIENT HEALTH SECTOR IN SRI LANKA: PROGRESS, CHALLENGES, AND THE PATH FORWARD

When Cyclone Ditwah recently battered the Sri Lankan coast, destroying clinics and hospitals, it delivered a stark message: climate change is no longer a distant threat but a present-day reality with direct consequences for health. The cyclone demonstrated our vulnerability to extreme weather, revealing that health systems must be not only equipped to treat climate-related illnesses but also resilient to climate shocks themselves. Though rapid responses by the defense forces, the Ministry of Health, the Sri Lanka Medical Association (SLMA), hospital staff, saved many lives, more could be done to develop coordinated and effective actions to prevent, mitigate and adapt to future climate-related disasters. This short article is to increase awareness of the SLMA membership to understand the situation in more depth and engage in activities related to the topic of climate change and planetary health. At the forefront of Sri Lanka's health sector response to climate change stands the Environmental and Occupational Health Directorate (EOHD) of the Ministry of Health and Mass Media.

1. Expected Health Impacts

There are quite a few health impacts of climate change.

Vector-borne diseases remain an immediate threat. Changes in rainfall and temperature directly affect mosquito breeding cycles. Warmer temperatures shorten the dengue virus incubation period within mosquitoes, accelerating transmission. Though malaria has been eliminated, the risk of resurgence remains as warming makes high-altitude regions increasingly suitable for Anopheles mosquitoes, exposing non-immune populations.

Heat-related illnesses are becoming critical. With projected temperature rises of 1.0–1.5°C by mid-century, heat stress is escalating. Studies from the University of Moratuwa demonstrate "Urban Heat Island" effects in densely populated areas like Colombo. These are smaller environments like a tree-less low-income areas near a road, which register higher ambient temperatures, promoting the development heatstroke, dehydration, and cardiovascular strain among outdoor workers and the elderly. The effect is further exacerbated with poor ventilation and metal roof sheeting.

> "The cyclone demonstrated our vulnerability to extreme weather, revealing that health systems must be not only equipped to treat climate-related illnesses but also resilient to climate shocks themselves.

Water-borne and food-borne diseases increase with heavy rainfall contaminating drinking water, causing diarrhoeal outbreaks and typhoid. Leptospirosis risk is particularly high for flood-affected communities and farmers.

Nutritional security is threatened as extreme weather damages crops, leading to food insecurity that impacts child nutrition and increases malnutrition. This is a looming danger in Sri Lanka, post-Ditwah.

Mental health consequences follow displacement and livelihood loss, with high rates of anxiety and depression among affected populations.

2. Response by the Health Sector

There are several responses by the health sector which could aim at promoting prevention, mitigation and adaptation to climate change.

Building Resilient Infrastructure

In line with Sri Lanka's international commitments, the EOHD is transforming health facilities through Green, Healthy and Safe Hospital Guidelines and the National Action Plan for Healthcare Waste Management 2025–2034 as low carbon climate resilient facilities. The "Green Hospital" concept, is being promoted by the Sri Lanka Medical Association (SLMA), and includes relocating facilities to low-risk areas and modifying hospitals to withstand extreme weather through flood-proofing generators and reinforcing roofs.

Surveillance and Early Warning

The Epidemiology Unit, Dengue Control Unit, and Anti Malaria Campaign have strengthened surveillance by integrating climate data into early warning systems. The University of Colombo's Department of Mathematics has developed models to predict dengue hotspots based on rainfall and temperature patterns. Plans for decentralized community-run early warning systems will collect hazard information and disseminate warnings effectively, enabling rapid resource deployment.

Disaster Management

The Disaster Preparedness and Response Unit has enhanced health sector resilience through national emergency plans that integrate climate-induced hazards like floods, droughts, cyclones, and landslides. Risk assessments, contingency planning, and emergency operation mechanisms now prepare the health system for climate shocks.

Cross-Sectoral Collaboration

Health cannot function in isolation. The Disaster Management Centre is the mandated lead agency for the country's disaster response. The health sector is liaising with the Climate Change Secretariat, Disaster Management Center and other relevant stakeholders in delivering climate change and health measures. The health sector is also implementing energy-efficient systems, rainwater harvesting, and proper waste management to reduce its environmental footprint.

Capacity Building and Training

Public education on climate risks—hydration during heatwaves, cleaning dengue breeding sites—empowers communities to participate actively in resilience and health protection.

The EOHD has prioritised workforce training on climate change and health at basic, undergraduate, and in-service levels, targeting public health professionals, field staff, and curative personnel. The NAP calls for specialized training in vulnerability assessments, carbon

OPINION

Continued...

footprints, and disaster risk reduction.

The Faculty of Medicine, University of Colombo, has established a Centre for Planetary Health to promote advocacy, training, and research, collaborating with The Lancet on the Lancet Countdown initiative tracking climate change and health progress. Relevant courses now available include the MSc in Climate Change and Environmental Management (University of Colombo), a Certificate course in Planetary Health (in preparation), and various online and regional training programmes.

3. The Path Forward

Leading the Response

As the national focal point for climate change and health, the EOHD has played a central role in steering the health sector toward a climate-resilient, low-carbon future. The Directorate collaborates with the Epidemiology Unit, Dengue Control Unit, Anti Malaria Campaign, Disaster Preparedness and Response Unit, Nutrition Unit and other agencies to plan and implement climate adaptation actions, while working closely with the Ministry of Environment and the Climate Change Secretariat.

Strategic Policy Leadership

The EOHD has provided technical leadership in formulating key national policies. It led the development and implementation of the Health Sector National Adaptation Plan (NAP) 2016–2025 and coordinated its revision for 2026–2035. The Directorate was pivotal in developing the health sector's Nationally Determined Contributions (NDCs) for 2021–2030 and supported NDC 3.0 (2026–2035), integrating low-carbon and climate-resilient approaches into national commitments. Expert contributions to the National Climate Change Policy 2023 ensured that health systems are now a strategic priority.

These efforts have influenced broader health planning, with climate resilience and environmental sustainability now embedded as core principles in the National Health Policy and National Health Master Plan 2026–2035.

Through sustained leadership, the Environmental and Occupational Health Directorate has advanced a climate-resilient, low-carbon health sector in Sri Lanka. Its contributions span policy development, strategic planning, facility-level interventions, workforce capacity building, surveillance strengthening, and community engagement.

> "While significant progress has been achieved, continued financial, technical, and technological support is essential to scale up green health facility initiatives, strengthen climate-informed surveillance, and further embed resilience across the health system.

Local research is urgently needed to understand specific impacts, such as heat stress on outdoor workers and temperature thresholds for Chronic Kidney Disease of unknown etiology in the Dry Zone. University-level courses will stimulate this research ecosystem, fostering systems-based collaboration across disciplines.

While significant progress has been achieved, continued financial, technical, and technological support is essential to scale up green health facility initiatives, strengthen climate-informed surveillance, and further embed resilience across the health system. Only through such sustained commitment can Sri Lanka remain well-positioned to protect health in a changing climate.

From Cyclone Ditwah's destruction to the heatwaves threatening outdoor workers, each event reinforces the urgency of this work—and the importance of the foundation being laid by the Ministry of Health, its partners, and dedicated health professionals across the country.

DOCTORS AND CLIMATE CHANGE - WHAT ELSE CAN WE DO?

Doctors are in a unique and powerful position to tackle climate change: Not only does the healthcare sector have a significant carbon footprint, but as highly trusted voices inthe community. Climate change is fundamentally a public health crisis, and your expertise makes you an ideal advocate.

Here are ten actions you can take, ranging from professional practice to advocacy, to tackle climate change.

Related to clinical work

Advocacy

Advocacy to act against climate change. When you see patients with exacerbations of asthma or COPD, you can say, "Conditions like this are becoming more frequent and severe due to our changing climate and air pollution"

Prescriptions

Metered-dose inhalers (MDIs) contain hydrofluoroalkanes (HFAs), which are potent greenhouse gases. Where clinically appropriate and acceptable, use dry powder inhalers (DPIs)

Expand telemedicine services

Think of simpler ways to repeat prescriptions in chronic diseases such as diabetes. Consider having telephone consultations and longer intervals for routine follow-ups.. Arrange several appointments on the same day to limit the number of visits for a patient to the clinic

Clinical waste

The healthcare sector is a major waste producer. Lead by example in reducing, reusing, and recycling. Segregate waste and use reusable surgical instruments and linens where safe and feasible. Encourage labs to print reports sparingly.

Climate and health

Work with the clinic or hospital to develop an emergency preparedness plan for heatwaves, floods, and landslides. Educate your most vulnerable patients (the elderly, those with chronic illnesses) on having their own personal emergency plan. Watch out for epidemics such as dengue, leptospirosis and imported malaria

Other activities

Behaviours

Your personal choices can set an example for colleagues, staff, and patients. Walk, cycle, or use public transport to work when possible.

Energy efficiency in your workplace

Hospitals and clinics are energy-intensive. Ask about energy audits, the transition to LED lighting, and the use of natural light or renewable energy.

Join a Professional Organisation active on climate issues

There is strength in numbers, and medical organisations have significant lobbying power. For example, the SLMA has an Expert Committee on Climate Change and Planetary Health

Educate the next generation

If you are involved in teaching medical students or residents, integrate climate health into the curriculum.

Fuel use

If you must use a car, consider an electric or hybrid vehicle.

FEATURE ARTICLE

Dr Jude Jayamaha
M.B.B.S. (Colombo), PG Dip in Med. Micro., M.D. (Med. Virology)
Consultant Virologist
Medical Research Institute

NIPAH VIRUS

Nipah virus is a virus found in animals but can also affect humans.

- People with infection can develop a fever, and symptoms involving the brain (such as headache or confusion), and/or the lungs (such as difficulty in breathing or cough).
- Cases of Nipah virus infection were first reported in 1998. Since then cases have been reported in Bangladesh, India, Malaysia, Philippines and Singapore. The case fatality rate is estimated at 40% to 75%.
- Fruit bats of the *Pteropodidae* family are the natural host of Nipah virus. Nipah virus is usually transmitted from infected bats and other animals to humans and can also be transmitted directly between people.
- There is currently no treatment or vaccine available for Nipah virus, however several candidate products are under development. Early intensive supportive care can improve survival.

Overview

Nipah virus is a zoonotic virus, usually transmitted from animals to humans, but can also be transmitted through contaminated food or directly between people.

> Nipah virus can also rarely spread between people. It has been reported in health-care settings and among family and caregivers of sick people through close contact.

Nipah virus was first identified in 1998 during an outbreak among pig farmers in Malaysia. In 1999, an outbreak was reported in Singapore following the importation of sick pigs from Malaysia. No new outbreaks have been reported from Malaysia or Singapore since 1999. In 2001, Nipah virus infection outbreaks have been detected in India and Bangladesh. In Bangladesh, outbreaks have been reported almost every year since. In India, outbreaks are periodically reported in several parts of the country, including the latest one in 2026.

Transmission

Fruit bats from the *Pteropodidae* family are considered the natural host of Nipah virus and are present in different parts of Asia and in Australia. African fruit bats of the genus *Eidolon*, family *Pteropodidae,* have been found to have antibodies against Nipah and Hendra viruses, indicating that these viruses might also be present within the geographic distribution of *Pteropodidae* bats in Africa.

Infection with Nipah virus does not appear to cause disease in fruit bats.

Transmission of the virus to humans can occur from direct contact with infected animals like bats, pigs or horses, and by consuming fruits or fruit products, such as raw date palm juice, contaminated by infected fruit bats. The virus can also cause severe disease in farming animals such as pigs.

Nipah virus can also rarely spread between people. It has been reported in health-care settings and among family and caregivers of sick people through close contact. In health facilities, the risk of spread can increase in overcrowded, poorly ventilated hospital environments with inadequate implementation of infection prevention and control measures.

Signs and symptoms

The incubation period – that is the time from infection to the onset of symptoms – ranges from 3 to 14 days. In some rare cases incubation of up to 45 days has been reported.

For some people, Nipah virus infection may be asymptomatic. However, most people develop a fever, and headache or confusion, and/or difficulty of breathing or cough. Other organs can also be affected. Other frequent symptoms include chills, fatigue, drowsiness, dizziness, vomiting and diarrhoea.

Severe disease can occur in any patient but is particularly associated with people presenting with neurological symptoms, with progression to brain swelling (encephalitis) and frequently, death. Careful supportive care and monitoring during this period is critical.

Most people who survive the acute phase make a full recovery, but long-term neurologic

FEATURE ARTICLE
Continued...

conditions have been reported in approximately 1 in 5 people who recovered from the disease.

Diagnosis

It is difficult to distinguish Nipah from other infectious diseases, or other causes of encephalitis or pneumonia, without laboratory testing. The main diagnostic test is real time polymerase chain reaction (RT-PCR) of respiratory samples, blood or cerebrospinal fluid. Antibody detection in blood via enzyme-linked immunosorbent assay (ELISA) may also be used.

Samples collected from patients are a biohazard risk. Laboratory testing on non-inactivated samples should be conducted under maximum biological containment conditions.

Samples taken from people and animals with suspected Nipah virus infection should be handled by trained staff working in suitably equipped laboratories.

PCR test is available at the Department of Virology, Medical Research Institute.

Treatment

While there is no specific treatment for Nipah, early diagnosis will promote early supportive care.
For all severe viral infections, high-quality supportive medical care can prevent deaths, and includes:

- identifying any complications (brain swelling, pneumonia, other organ damage);
- personalizing treatment to account for patients' other health conditions;
- administering oxygen when required;
- applying specific organ support therapies as needed (such as ventilation, renal dialysis); and
- ensuring adequate rehydration and nutrition with frequent monitoring.

There are currently no approved drugs or vaccines for Nipah virus infection.

Prevention

- Reducing the risk of infection in people

  Raising awareness of the risk factors for infection and on measures people can take to protect themselves and prevent transmission is critical. WHO recommends taking measures as noted below.

- Reducing the risk of bat-to-human transmission

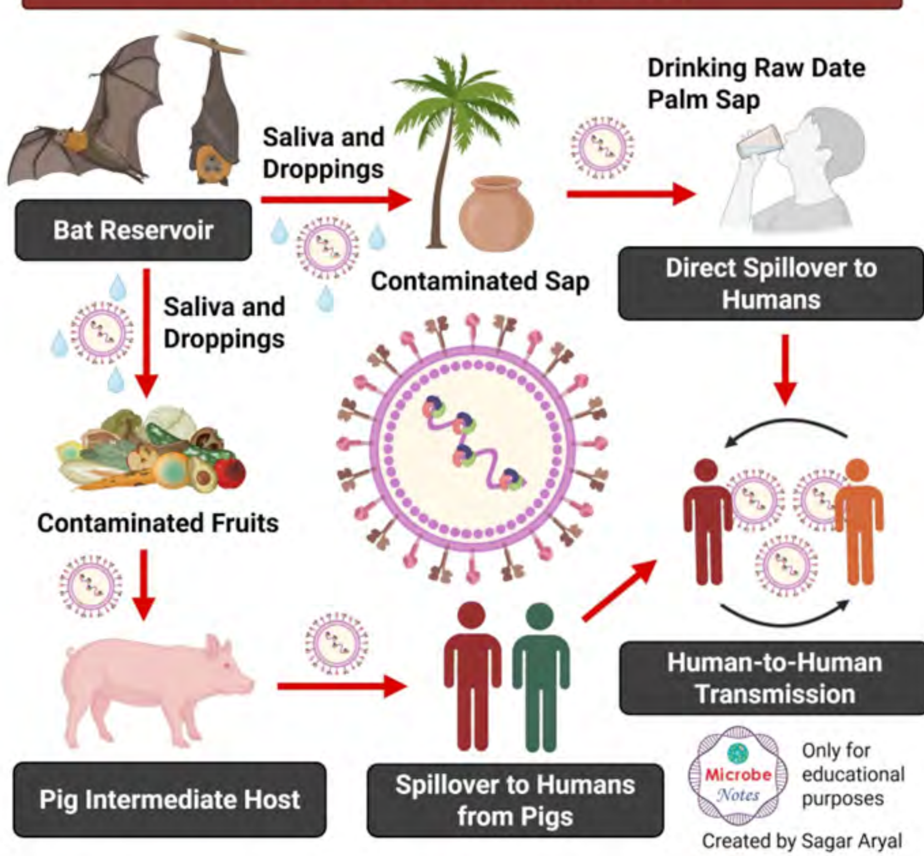
  Efforts to prevent transmission should first focus on decreasing bat access to date palm sap and other fresh food products. Keeping bats away from sap collection sites by using protective coverings may be helpful. Freshly collected date palm juice should be boiled, and fruits should be thoroughly washed and peeled before consumption. Fruits with any sign of bat bites should be discarded.

- Reducing the risk of animal-to-human transmission

  Gloves and other protective clothing should be worn while handling sick animals such as pigs or horses, and during slaughtering and culling procedures. In areas where the virus is present, when establishing new pig farms, consideration should be given to the presence of fruit bats in the area and in general, pig feed and pig sheds should be protected against bats when feasible.

- Reducing the risk of human-to-human transmission

  People experiencing Nipah-like symptoms should be referred to a health facility, as early supportive care is the key in the absence of licensed treatment. Close unprotected physical contact with sick people should be avoided. Regular hand washing should be carried out after caring for or visiting sick people along other preventive measures.



Controlling infection in health-care settings

WHO advises health-care workers to implement standard precautions for infection prevention and control at all times, for all patients:

- suspected or confirmed cases of Nipah virus infection should be placed in a single-patient room;
- when caring for patients, WHO advises the use of contact and droplet precautions including a well-fitting medical mask, eye protection, a fluid-resistant gown, and examination gloves;
- airborne precautions should be implemented during aerosol-generating procedures, including placing the patient in an airborne-infection isolation room and using a fit-tested filtering facepiece respirator instead of a medical mask; and
- for family members and caregivers visiting patients with suspected or confirmed Nipah virus, similar precautions should be applied.

While Nipah virus infection poses a minimal risk to Sri Lanka as per health officials, we should be vigilant about it, especially patients with suspected clinical features of travel to reported geographic areas.

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RESEARCH IN FOCUS

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SECOND PREGNANCIES ARE NOT LOW RISK: EVIDENCE FROM TERTIARY CARE MATERNITY HOSPITALS IN COLOMBO

Second pregnancies are commonly perceived as relatively low risk when compared to first pregnancies. However, emerging local evidence suggests that women in their second pregnancies represent a distinct obstetric group with specific risk profiles that deserve careful attention.

A recent cross-sectional study conducted among a sample of 147 women in their second pregnancies who delivered in government sector tertiary care maternity hospitals in Colombo examined maternal characteristics, associated factors, pregnancy complications, and maternal and neonatal outcomes. The findings provide useful insights for routine obstetric practice in Sri Lanka.

Why Focus on Second Pregnancies?

Second pregnancies constitute a substantial proportion of annual deliveries in Sri Lanka. Despite this, they are often managed with less intensive surveillance than first pregnancies. Importantly, outcomes in a second pregnancy are influenced not only by the woman's current health status, but also by medical conditions, obstetric complications, and health behaviours established during and after the first pregnancy. Recognizing these factors early allows opportunities for prevention and targeted care.

Key Observations from the Study

Most women were within the optimal reproductive age group; however, as expected, a higher proportion (24.5%, n=36) were aged 35 years or older compared to primigravidae. Advanced maternal age was consistently associated with adverse maternal and neonatal outcomes, highlighting the importance of age-appropriate counselling and risk stratification at booking.

A notable proportion of women had pre-existing chronic medical conditions (30.6%, n=45), including hypertension, diabetes mellitus, and thyroid disorders. These conditions were significantly associated with complications in the second pregnancy (p=0.004), emphasizing the need for pre-conception optimization and continuity of medical care beyond the first pregnancy.

Previous obstetric history played a central role in determining risk in the current pregnancy. Women with a prior caesarean section had a higher likelihood of operative delivery ($p<0.05$), while complications experienced in the first pregnancy increased the risk of recurrence or persistence in the second (p=0.006). This underscores the importance of careful documentation and systematic review of prior pregnancy outcomes during antenatal assessment.

Although most women reported that family planning had been discussed following their first delivery (81.0%, n=119), actual postpartum contraceptive use was low with a large proportion of women not utilizing any method of contraception (64.6%, n=95). This suggests a gap between counselling and effective uptake, contributing to unplanned second pregnancies and suboptimal birth spacing. This was reflected in the inter-pregnancy intervals which were frequently below the WHO recommended minimum (20.4%, n=30). A considerable proportion of women had an inter-pregnancy interval exceeding 60 months (32%, n=47) which also could be tied to adverse outcomes.

Interpregnancy maternal weight gain was evident, with the prevalence of overweight and obesity increasing from 23.8% in the first pregnancy to 36.7% in the second, resulting in a significantly higher proportion of women having a body mass index above the recommended range at the booking visit of the second pregnancy compared with the first (p = 0.004). This highlights the need for structured nutritional and lifestyle interventions during the postpartum period, particularly for first-time mothers adjusting to the new role of childcare.

Implications for Clinical Practice

1. Avoid assuming low risk. All second pregnancies should undergo early and systematic risk assessment at the booking visit.
2. Prior obstetric history matters. Previous mode of delivery, complications, and birth outcomes should actively guide current antenatal planning and decision-making.
3. Strengthen preconception and postpartum care. Clinicians should promote optimal birth spacing, healthy body weight, control of chronic medical conditions, and effective family planning.
4. Target high-risk subgroups - Enhanced surveillance is warranted for women with prior caesarean delivery, hypertensive disorders, gestational diabetes, advanced maternal age, and extremes of inter-pregnancy intervals.
5. Bridge the counselling–uptake gap. Postpartum family planning should move beyond information provision to shared decision-making, method availability, and follow-up to support sustained contraceptive use.

Take-Home Message for Clinicians

Second pregnancies represent a unique and important opportunity for preventive, longitudinal maternal care. Events and exposures during the first pregnancy have a lasting influence on subsequent pregnancies and outcomes.

Early identification of risk factors, targeted antenatal surveillance, and continuity of care during the interpregnancy period can substantially improve maternal and neonatal outcomes in Sri Lanka. Reframing second pregnancies as a priority group for proactive intervention may help reduce avoidable complications and strengthen long-term maternal and child health.

Frequency distribution of family planning practices

Characteristic	Number (n=147)	%
Most recently used contraceptive method		
• None	95	64.6
• Traditional methods	2	1.4
• Oral contraceptive pills	14	9.5
• Condoms	15	10.2
• Injectable contraceptives	5	3.4
• Intra-uterine contraceptive device	6	4.1
• Subdermal implants	10	6.8
Healthcare providers discussed family planning		
• Yes	119	81.0
• No	28	19.0

Association between maternal characteristics and complications in second pregnancy

Maternal characteristic	Complicated second pregnancy		Uncomplicated second pregnancy		Total		Significance
	No.	%	No.	%	No.	%	
Age							χ^2 = 9.741, df = 1, p = 0.002
• <35 years	41	36.9	70	63.1	111	100	
• 35 years or older	24	66.7	12	33.3	36	100	
Pre-existing chronic disease							χ^2 = 8.523, df = 1, p = 0.004
• Yes	28	62.2	17	37.8	45	100	
• No	37	36.3	65	63.7	102	100	
First pregnancy status							χ^2 = 7.582, df = 1, p = 0.006
• Complicated	29	60.4	19	39.6	48	100	
• Uncomplicated	36	36.4	63	63.6	99	100	

VOICES FROM THE PERIPHERY

Dr Amila Chandrasiri
MBBS, MSc (Com Med), MD (Com Med)

MUSIC BASED 'LIFE SKILLS PROMOTION' PROGRAM – 'RHYTHM TO LIFE'

Background

Promoting life skills among adolescents through innovative and effective interventions has emerged as a priority need as contemporary school children are facing serious challenges like risky sexual behaviors, drug abuse and violence. Though several interventions have been implemented, it's important to design and deliver them in a 'youth-friendly' manner with focused objectives.

Objectives of the program

1. To motivate adolescents to determine their career dreams and focus their lives to realize them
2. To strengthen parent-child bonds and develop relationship skills focusing on building and maintaining healthy inter-personal relationships
3. To develop resilience among adolescents to manage risk behaviors like substance abuse, risky sexual contacts, and violence
4. To deliver correct and age-appropriate knowledge on physical and psychological changes in adolescence and related sexual and reproductive health issues.

Content and delivery

The program is delivered as a 'music based lecture-discussion' targeting Grade 9-10 children.

Three to four consultants/doctors conduct each program. The program consists of 4-5 segments where each segment focuses on particular objective/topic. Content is developed based on ten life skills introduced in the National Adolescent Health program. One-two popular, youth-loving songs are played in each segment to supplement the flow of discussion. There are three broad scripts for boys, girls and mixed schools. A specific script is prepared for each school considering socio-demographic status of student population and identified issues.

A brief qualitative assessment is usually done before each program to explore prevailing issues in the particular school and choices of songs. The program is organized as collaborative project with Southern Provincial Education Department and RDHS Galle.

After each program a system is established and promoted in the school to confidentially forward issues and problems to counseling teacher. A response system will also be initiated while connecting the counseling teacher to external support network including area MOH, MO-Mental Health and (if available) group of doctors (past students of the school).

Progress and evaluation

More than 60 programs were successfully conducted in five Districts so far which reached more than 10,000 students. A formal evaluation of the program was done by using four evaluation criteria: relevance, acceptance, effectiveness and coherence. Evaluation results of first few programs had shown that the program was highly accepted and embraced by participants and the program had addressed 'most of the prevailing issues' of youth. Qualitative assessment had shown that the program resulted in early positive changes in behavior and relationships with parents.

NOVICE

Sivalingam Harshini
BA. Hons in Peace and
Conflict Resolution, University of Kelaniya.
MSc in Public Policy and Management (Reading), University of Sri Jayewardenepura

IS PEACE SIMPLY THE BRAIN FEELING SAFE?

When we hear the word *peace*, we often imagine silence after war, harmony between nations, or calm within the heart. We think of it as something moral, spiritual, or political. But what if peace is something even more basic? What if peace begins inside the brain in the simple biological feeling of safety?

To understand this, we must first understand what peace truly is. Peace is not just the absence of violence. It is the presence of emotional balance. It is the ability to pause instead of react. It is the strength to respond calmly instead of aggressively. On a social level, peace depends on shared rules and norms, fairness, respect, empathy, cooperation. But these social values only work if individuals have the internal capacity to regulate fear and anger. And that capacity lives in the brain.

The amygdala, a small, almond-shaped structure located deep within each of us, is frequently referred to as the brain's alarm system. Its job is simple but powerful in detecting danger and trigger immediate survival responses. When activated, the heart races, muscles tense, and stress hormones like cortisol surge, preparing us to fight or flee. This system is essential for survival. But when the amygdala remains chronically active, the brain and body stay on constant alert, making peace calm, balance, and safety difficult to experience.

Research on 136 children raised in orphanages with limited caregiving, compared to children raised in supportive families (Tottenham et al., 2011) showed that children who experienced early-life stress had greater baseline cortisol levels and amygdala sizes that were roughly 15% larger. Even in secure settings, these children had trouble controlling their reactions and were more emotionally reactive. They found quiet elusive because their brains had been trained to anticipate danger.

Fortunately, the brain is not powerless. The prefrontal cortex, the region of the brain responsible for reasoning behind the forehead, serves as a check on the amygdala. This area aids in impulse control, emotion regulation, and clear thinking. When in use, it has the ability to silence the alarm system, replacing anxiety and reactivity with composed and deliberate reactions. Transcranial magnetic stimulation (TMS) was employed in one study to increase prefrontal brain activity. When compared to a control group, participants exposed to scary images had a 26% decrease in amygdala activation (Ironside et al., 2019). In other words, when the thinking brain steps in, serenity can be deliberately created.

> "Peace is not merely the absence of war but the presence of justice, of law, of order —in short, of government."
>
> - Albert Einstein -

Our ability to be calm is also shaped by chemistry. Aggression and emotional instability are associated with low levels of serotonin, which controls mood and impulse control. The "bonding hormone," oxytocin, encourages social interaction and trust. Humans are biologically more likely to cooperate, empathise, and react softly rather than violently when these systems are in balance (Coccaro, Lee, & Kavoussi, 2011; Heinrichs, von Dawans, & Domes, 2009). Therefore, peace is ingrained in our nature and is not just a social ideal.

Our early life events have a lasting impression. Stronger emotional regulation and a well-tuned amygdala are traits of children raised in secure, caring homes. People who have experienced trauma or ongoing stress frequently exhibit hyperactive threat reactions, which heightens their sensitivity to risk on a biological level (Tottenham & Sheridan, 2010). This is adaptability, not a defect. When a brain is exposed to danger, it learns to survive first, then to be calm.

However, the brain is changeable. Neural pathways are reshaped by repeated experiences through neuroplasticity. For example, mindfulness meditation has been demonstrated to improve the connectivity between regulatory brain regions and decrease amygdala activity, resulting in increased emotional regulation and calmness (Hölzel et al., 2011). Therefore, peace is teachable. In addition to learning fear, the brain can also learn safety, composure, and trust.

So, is peace simply the brain feeling safe? The evidence strongly suggests yes. Peace appears when the brain interprets the world as manageable rather than threatening. It arises when emotional alarms are balanced by thoughtful regulation. It grows when chemistry supports trust instead of aggression. Social norms and laws are important, but they depend on individuals whose nervous systems are not constantly in survival mode.

If we truly want peace in families, communities, and nations, we must consider the biology behind behavior. Safe childhoods, stable environments, emotional education, and stress reduction are not luxuries; they are foundations for social harmony. When the brain feels safe, the body relaxes. When the body relaxes, the mind thinks clearly. And when minds think clearly, cooperation becomes possible.

Perhaps peace does not begin in treaties or speeches. Perhaps it begins in the quiet moment when a brain decides it is safe. And if that is true, then building peace means building safety, neuron by neuron.

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NOVICE
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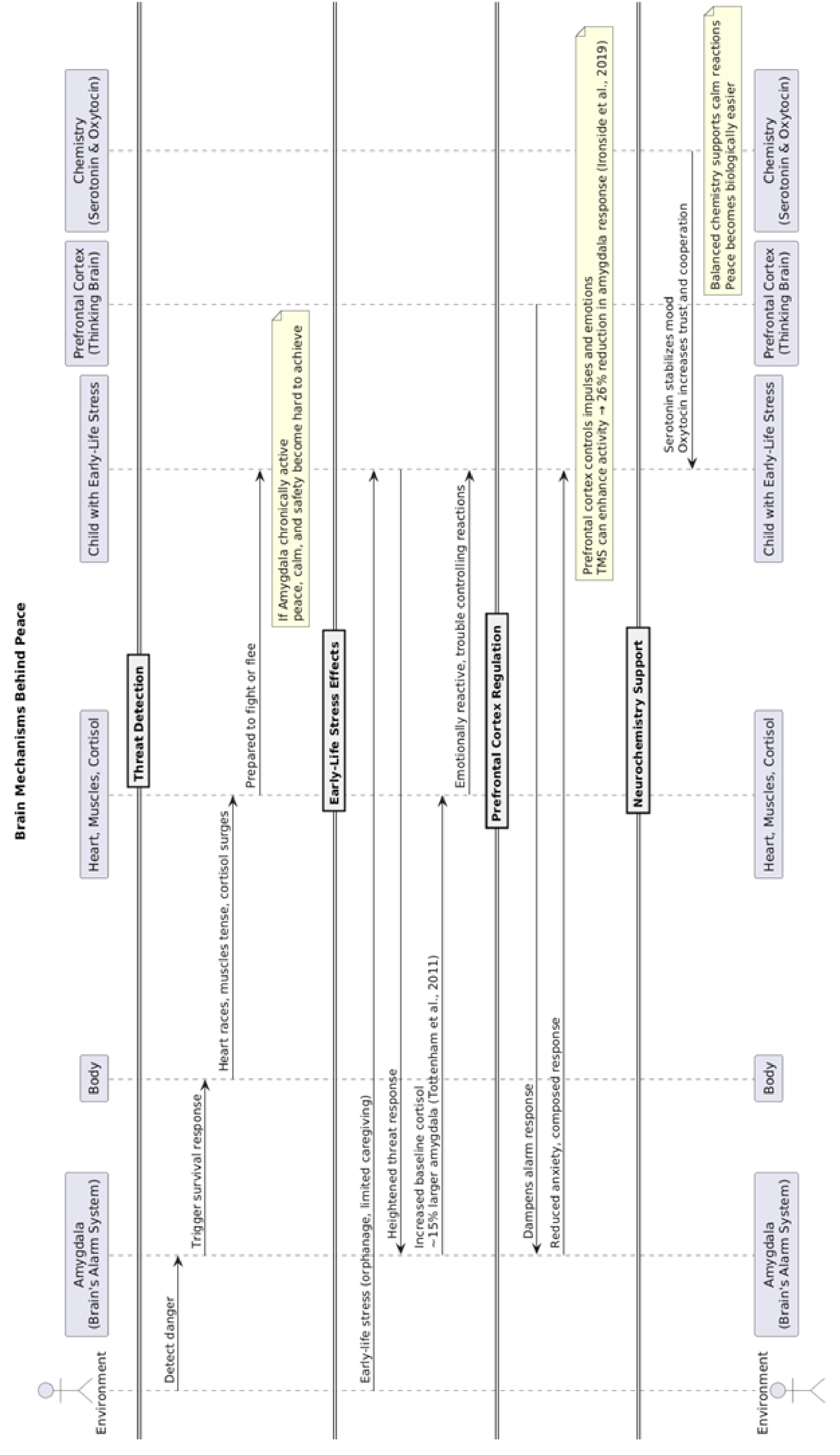

Figure 1. Brain mechanisms behind peace: sequence diagram illustrating amygdala activation, early-life stress effects, prefrontal cortex regulation, and neurochemical support. (Author Originated Source: 2026)

> Perhaps peace does not begin in treaties or speeches. Perhaps it begins in the quiet moment when a brain decides it is safe. And if that is true, then building peace means building safety, neuron by neuron.

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SLMA IN FEBRUARY

Highlights

SLMA Regional Clinical Meeting 2026 Successfully Held in Ragama ▶

The first Regional Clinical Meeting of the SLMA for the year 2026 was successfully held on 22nd January at Wave n' Lake, Ragama, bringing together our regional colleagues from Colombo North Clinical Society and the Welisara Chest Society. The programme featured a diverse range of topics including diabetes management, antimicrobial stewardship, lung cancer screening, thyroid disorders, gastroenterology, stroke rehabilitation, child protection, and the practical use of artificial intelligence in clinical practice.

The meeting also featured the SLMA – Colombo North Medical Quiz, fostering engagement and learning in an interactive setting. The SLMA wishes to acknowledge the efforts of all expert resource personnel, organizers and participants who contributed to the success of this regional academic event. A special word of appreciation for Dr. Dulani Kottahachchi, Vice President, SLMA for her leadership in organizing this important event.

SLMA IN FEBRUARY

Highlights

SLMA Saturday Talks

Following Saturday Talks were conducted with enthusiastic participation of junior doctors and medical students.

- Thinking Like a Clinician – Case-Based Clinical Pearls in General Medicine by Dr. Praveen Weeratunga, Consultant Physician and Senior Lecturer in Medicine, Faculty of Medicine, University of Colombo
- Cirrhosis by Dr. Uditha Dassanayake, Consultant Gastroenterologist and Senior Lecturer in Medicine, Faculty of Medicine, University of Kelaniya
- Endometriosis: The 1/10 Tragedy of Women by Professor Dhammike Silva, Professor in Obstetrics and Gynaecology, Faculty of Medical Sciences, University of Sri Jayawardenapura
- Peripheral Arterial Disease by Dr Thushan Gooneratne , Consultant Vascular and Transplant Surgeon and Senior Lecturer in Surgery, Faculty of Medicine, University of Colombo

SLMA in FEBRUARY

Lunch Time Webinar Series

The Palliative & End-of-Life Care Task Force together with the SLMA conducted a Lunchtime Webinar on “Comfort First; Practical Management of Gastrointestinal Symptoms in Palliative Care by Dr. J Sampath Kondasinghe, Consultant Physician, Palliative Care Service, Sir Charles Gairdner Hospital, WA, Australia.

SLMA IN FEBRUARY
Highlights

Workshop on Mental Health and Well-Being Across the Lifespan

A comprehensive one-day workshop focusing on Mental Health & Well-Being Across the Lifespan was conducted recently, with the participation of leading psychiatrists and mental health professionals in Sri Lanka.

The Programme featured expert-led sessions on physician well-being, burnout prevention, mental health assessment in busy OPDs, child, adult and geriatric mental health, case-based group discussions, and update on practical screening tools. This Programme is part of SLMA's efforts to enhance understanding on holistic health and wellbeing among a diverse group of healthcare professionals in line with this year's Presidential theme.

SLMA Symposium Explores Preparedness for Nipah Virus Infection

The Expert Committee on Communicable Diseases at the SLMA organized a symposium on Nipah Virus Infection, covering technical components from virological and diagnostics aspects, prevention and treatment to epidemiology. Experts from the Epidemiology Unit, Ministry of Health, Medical Research Institute and Teaching Hospital Kalutara contributed to the technical panel and subsequent discussion.

SLMA IN FEBRUARY

Highlights

Monthly Clinical Meeting Highlights Paediatric Palliative Care for All Clinicians

The SLMA in collaboration with Sri Lanka College of Paediatricians organized a Monthly Clinical Meeting on Monthly Clinical Meeting on "Paediatric Palliative Care Beyond Specialists: What All Clinicians Can Do". The session was conducted by Dr. Dr. Malithi Guruge, Consultant Paediatrician and Senior Lecturer at Faculty of Medical Sciences, University of Sri Jayawardenapura and moderated by Dr. S A S S Dilankani, Medical Officer in Palliative Care.

Pre-Congress Workshop on Advances in Respiratory and Sleep Medicine

Sri Lanka College of Pulmonologists in collaboration with the SLMA conducted a Pre Congress Workshop "Breathing New Life: Resilience, Innovation, and Equity in Respiratory Care" recently at the PGIM, Colombo. Workshop featured sessions on types of sleep studies, common sleep disorders, principles of sleep scoring and real-life case-based scenario discussions.

SLMA President and Vice President Honoured with Fellowship of Diabetes India

Dr. Manilka Sumanatilleke, President SLMA and Dr. Dulani Kottahachchi were conferred the prestigious Fellowship of Diabetes India during the recently concluded World Congress of Diabetes in India, in recognition of their services to the discipline and academic discourse. We wish to congratulate them on this significant recognition bringing glory to the SLMA and the nation.

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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
- 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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GLOBAL HEALTH WATCH

Highlights

Baby born using a transplanted womb from a dead donor

A baby boy has become the first child in the UK to be born using a womb transplanted from a dead donor. His mother suffering from a rare disorder known as MRKH syndrome was born without a viable uterus and was told she is unable to bear a child of her own.

Once a compatible womb became available from a dead donor, transplant operation took place at The Churchill Hospital in Oxford in June 2024. Couple received IVF treatment some months later - followed by embryo transfer - at The Lister Fertility Clinic in London. This successful womb transplant from a deceased donor is just one of 10 such transplants taking place as part of a UK clinical research trial.

The couple may decide to have a second baby, after which surgeons will remove the transplanted womb to save baby's mother from taking a lifetime of immunosuppressants to prevent the body's immune system attacking the transplanted organ.

The happy couple with their baby
Story and Picture Courtesy; BBC Health

A Single Vaccine to protect against all coughs, colds and flus

Researchers in the USA say, single nasal spray vaccine could protect against all coughs, colds and flus, as well as bacterial lung infections, and may even ease allergies. The team at Stanford University, USA have tested their "universal vaccine" in animals and awaiting human clinical trials for the vaccine.

The approach described in the journal Science does not train the immune system. Instead, it mimics the way immune cells communicate with each other. The vaccine leaves macrophages in lungs on "amber alert" and ready to jump into action no matter what infection tries to get in.

However, there are still many questions to answer. The vaccine was given as a nasal spray during the experiments but may need to be breathed in through a nebulizer to reach the depths of human lungs. It is also not known how long the immune system would stay in 'amber alert'. Nevertheless, researchers have high hopes that this finding could mark a major step forward, offering protection against infections that place a heavy burden on individuals and health systems across the globe.

To read the full article in Science: https://www.science.org/doi/10.1126/science.aea1260

Story and Picture Courtesy: BBC Health

INAUGURAL ANNUAL ACADEMIC SESSIONS OF CHILAW CLINICAL SOCIETY IN COLLABORATION WITH SRI LANKA MEDICAL ASSOCIATION

10th & 11th March 2026

"Bridging Care: Advancing Clinical Excellence through Collaboration"

Main Scientific Session - 11th March 2026

Venue: Main Auditorium, DGH Chilaw

Time	Programme
08.50 - 08.55	Welcome speech by President- Chilaw Clinical Society
08.55 - 09.00	Welcome speech by President-Sri Lanka Medical Association
Symposium 1 - Non communicable diseases	
09.00 - 09.20	MAFLD: The Metabolic Liver Disease Hiding in Plain Sight Dr Uditha Dassanayake Consultant Gastroenterologist, University of Kelaniya.
09.20-09.40	Type 2 Diabetes in 2025: What's New and What Matters Dr Manilka Sumanathilake Consultant Endocrinologist – NHSL, Colombo President – SLMA
09.40 - 10.00	Don't Miss a Heart Attack: Practical Pearls in ACS Management Dr Ajith Wanniarachchi – Consultant Cardiologist, DGH Negombo
10.00 - 10.05	Q & A
10.05 - 10.30	**Tea**
Plenary Lecture 1	
10.30 - 11.00	21st Century Physician: Challenges and Opportunities Beyond the Clinic Prof Saroj Jayasinghe Emeritus professor, University of Colombo. Consultant Physician
Symposium 2 : Paediatric Essentials	
11.00 - 11.20	Approach to the First Seizure in a Child: Diagnosis and Management Prof Jithangi Wanigasinghe, Consultant Paediatric Neurologist, University of Colombo
11.20 - 11.40	From Plate to Play: Combating Childhood Obesity through Diet and Lifestyle Dr Shamila Rajarathnam, Consultant Nutrition Physician, TH Rathnapura.
11.40 - 11.45	Q & A
Plenary Lecture 2	
11.45 - 12.15	Overcoming the issues in managing snakebite Prof Anjana Silva Professor of Parasitology, University of Rajarata
Interactive Case Discussion	
12.15 - 12.55	The Eternal Heart- Kidney Conflict in a Diabetic: Which should we prioritize? Dr Dulani Kottahachchi – Consultant Endocrinologist, University of Kelaniya Dr Neranga Samarathunga – Consultant Cardiologist, BH Puttlam Dr Buddhika Wijayawickrama – Consultant Nephrologist, NHSL Kandy
12.55 - 14.00	**Lunch and Poster Presentation**
Symposium 3: Essentials in Primary care	
14.00 - 14.20	Wound Management Essentials: Improving Outcomes in Clinical Practice – Prof Joel Arudchelvam Consultant Vascular Surgeon, University of Colombo.
14.20 - 14.40	Subfertility: Common Pitfalls in Diagnosis and Management — What We often Miss? Dr Udara Jayawardena Consultant in Subfertility, CNTH, Ragama.
14.40 -15.00	Primary care approach to back pain: When to reassure, when to refer? Dr Hiran Amarasekera, Consultant Orthopaedic Surgeon Neville Fernando Teaching Hospital, Malabe
15.00 - 15.05	Q & A
Quiz	
15.05 - 15.35	Chilaw Clinical Society Academic Quiz
15.35 - 15.45	Thanking speech Dr Geethika Manchanayake Consultant Transfusion Physician Joint Secretary – Chilaw Clinical Society
15.45	**Tea & End of Program**

(For Doctors Only)

Parallel Session for Pharmacists 11th March 2026

Venue: Old Auditorium, DGH Chilaw

Time	Programme
9.30 – 9.55	**Tea and Registration**
9.55- 10.00	Welcome speech President – Chilaw Clinical Society
10.00 – 10.25	Antiplatelets and Anticoagulants: Must know Pharmacology Dr Neranga Samarathunga Consultant Cardiologist – BH Puttlam
10.25 – 10.50	Thyroid, Calcium & Osteoporosis: What Pharmacists Must Get Right? Dr Dulani Kottahachchi Consultant Endocrinologist -University of Kelaniya
10.50 – 11.15	Drugs and Kidney: Avoiding Common Errors Dr Buddhika Wijayawickrama Consultant Nephrologist – NHSL, Kandy
11.15 – 11.40	Safe Use of Medicines in Pregnancy and Lactation Dr Ajith Walisundara Consultant Gynaecologist – DGH Chilaw
11.40 – 12.05	Optimizing Insulin Therapy: Types, Administration Techniques, and Managing Hypoglycemia Dr Tharanga Samarasekara Consultant Endocrinologist – DGH Negombo
12.05 - 12.30	DMARDs: Essential Knowledge for Pharmacists in Rheumatology Care Dr Savidya Appuhami Consultant Rheumatologist – DGH Chilaw
12.30 -12.55	Respiratory Pharmacology: Inhaler Techniques and Adherence Monitoring Dr Daupadee Dharmasena Consultant Respiratory Physician – DGH Chilaw
12.55 - 13.00	Thanking Speech
13.00	**Lunch and End of Program**

INAUGURATION CEREMONY

10th MARCH 2026

Venue: Main Auditorium, DGH Chilaw

BY INVITATION ONLY

Parallel Session for Nursing Officers 11th March 2026

Venue: Auditorium , Ministry of Fisheries, Chilaw

Time	Programme
09.00 – 09.15	**Registration**
9.15 - 9.25	Welcome speech President – Chilaw Clinical Society
9.25- 9.45	Opening Remark: The role of Nightingales in Modern medicine Dr Surantha Perera Consultant Paediatrician Past President SLMA
9.45- 10.05	Postoperative Care Essentials: What Every Nurse Must Know Dr Kishan Rupasingha Consultant Anaesthetist, DGH Chilaw
10.05 – 10.25	Early Recognition of Sepsis: The Nurse's Role in the First Hour Dr Chaminda Dharmadasa Consultant Anaesthetist – BH Puttlam
10.25- 10.45	**Tea**
10.45- 11.05	Infection control in low resource settings Dr Chandani Mendis Consultant Microbiologist – DGH Chilaw
11.05 – 11.25	Nutrition as Treatment: Identifying and Preventing Hospital-Related Malnutrition Dr Pubuditha Weerasinghe Consultant Nutrition Physician- TH Kaluthara
11.25 – 11.45	Documentation and Legal Accountability in Nursing Practice Dr Prasanna Appuhami Consultant Judicial Medical Officer – BH Puttlam
11.45 -12.05	Developmental care of the new born Dr Asiri Hewamalage Consultant Family Physician – Family Health Bureau
12.05 – 12.25	Managing Diabetic Patients in the Ward: Insulin Administration and Hypoglycemia Protocols Dr Maheshi Amarawardena Consultant Endocrinologist - DGH Chilaw
12.25 – 12.45	Caring for the Caregiver: Promoting Mental Wellbeing in Nursing Practice Dr Samanmalee Jayasinghe Senior Registrar in Psychiatry – TH Ragama
12.45 – 13.05	Academic Quiz
13.05- 13.10	Thanking speech
13.10	**Lunch & End of Program**

Join us — registration is completely free!!!

Main scientific session	contact	Dr Thushan Madhawa	0710387420
Parallel session for Nursing Officers	contact	Ms Asinsa Madhurawala	0714197795
Parallel Session for Pharmacists	contact	Ms Padmini Ekanayake	0777471943
For any other inquiry	contact	Dr Geethika Manchanayake	0773511261

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