



**Neonatal Life Support Program**

**DELAYED CORD CLAMPING:**

A simple change with powerful benefits for newborns



**From Secretary's Diary - Monthly update**

**ANTIBIOTIC STEWARDSHIP**

**IN NEONATAL CARE :**

An Urgent Priority



**Capacity Building Workshop**

**FETAL ECHOCARDIOGRAPHY FOR BETTER DIAGNOSIS OF CONGENITAL HEART DISEASE**

**BEYOND SURVIVAL:**

**Thriving with Advanced Maternal and Neonatal Care**



# From Secretary's Diary

-MONTHLY UPDATE-

## I. Advocacy and Policy Advancements

The Society continues to engage with national departments to improve parental and neonatal welfare:

**Paternity Leave:** Negotiations regarding the formal approval of paternity leave have reached their final stage.

**Maternity Support:** The Society is collaborating with the Labor Department to strengthen maternity leave approvals for private sector employees, aiming to facilitate continuous breastfeeding practices.

## II. Professional Development & Webinars

Our monthly webinar series remains a cornerstone of our educational outreach, with all programs now offering CPD-accredited e-certificates:

**Previous Success:** The 2nd monthly webinar, "Together to prevent and manage preterm birth," saw an impressive turnout of 600 participants.

**Recent Session:**

The 3rd webinar, focusing on a holistic approach to Neonatal Sepsis, was successfully conducted on March 27.

And The 4th webinar, centered on Fetal Surveillance and Neonatal Screening, was also successfully conducted on April 24, 2026.

## III. Regional Capacity Building & Clinical Training

We are expanding our reach through localized workshops and life-support training:

**Regional Workshops:**

The 1st Regional Capacity Building Workshop was successfully conducted at District General Hospital Kalutara on 24th April 2026, strengthening clinical competencies among healthcare professionals.

**Neonatal Life Support (NLS):** Following the successful 3rd collaborative NLS programme at Colombo North Teaching Hospital on 5th March 2026, the 4th workshop was conducted on 22nd April 2026 at District General Hospital Gampaha

**Mini Teaching Sessions:** Weekly Wednesday lunchtime virtual sessions on Antibiotic Stewardship and Neonatal Neurodevelopmental Care continue to attract over 100 participants, including consultants, PG trainees, and nursing staff.

## IV. Quality Improvement & Audits

To ensure the highest standards of care, the Society has conducted a formal Audit on National Neonatal Screening Practices. The findings will be used to improve quality of care across all regions.

Respectfully submitted,

—◆◆◆◆◆—  
The Honorary Secretary Perinatal Society (PSSL)



# NEONATAL LIFE SUPPORT PROGRAMS

Three Neonatal Life Support (NLS) Programmes were successfully conducted on 24<sup>th</sup> February 2026 at Hemas Hospital, Wattala; on 5<sup>th</sup> March 2026 at Colombo North Teaching Hospital and on 22<sup>nd</sup> April 2026 at District General Hospital, Gampaha. These sessions focused on essential newborn resuscitation and early neonatal care, with interactive and hands-on training that enhanced participants' skills and confidence in managing neonatal emergencies, contributing to improved newborn outcomes.



## NEONATAL LIFE SUPPORT PROGRAM

- COLOMBO NORTH TEACHING HOSPITAL -





## NEONATAL LIFE SUPPORT PROGRAM - HEMAS HOSPITALS -





# NEONATAL LIFE SUPPORT PROGRAM

- DISTRICT GENERAL HOSPITAL GAMPAHA -



## FEATURE ARTICLE

# Delayed Cord Clamping: A simple change with powerful benefits for newborns

Dr Nimesha Garnhewage MD (Paed), DCH, MRCPCH (UK)  
 Consultant Neonatologist, Colombo South Teaching Hospital  
 Senior Lecturer in Paediatrics, University of Sri Jayewardenepura

In Obstetrics, where time is critical, and every second counts, one simple act, "waiting" is gaining importance. Delayed cord clamping (DCC) is now recognised as a valuable practice that can improve the health of newborn babies, especially for preterms.

This feature article explains delayed cord clamping, its benefits, challenges, and how hospitals can introduce it. It also explores an interesting concept known as the placental transfusion window.

## What is Delayed Cord Clamping?

Delayed cord clamping means waiting at least 30–60 seconds, often up to 1–3 minutes, or until the cord stops pulsating. Whereas early cord clamping implies separation from the placenta within 15–30 seconds after birth

During this delay, blood continues to flow from the placenta to the baby. This process is called placental transfusion. This extra blood transfer provides more red cells, iron and a better blood volume.

The World Health Organization (WHO) recommends delaying cord clamping for at least one minute in both term and preterm babies who do not need immediate resuscitation.

## Brief History

Interestingly, delayed cord clamping is not a new idea. Historical accounts suggest that midwives in many cultures naturally waited before cutting the cord, allowing the baby to stabilize and the cord to cease pulsation.

However, in the 20th century, the rise of hospital-based obstetrics brought a shift toward early cord clamping (ECC). This change was driven by several factors:

- Desire to quickly assess and manage the newborn
- Concerns about maternal bleeding
- Standardisation of delivery practices

By the mid-1900s, ECC became routine, even though strong physiological evidence supporting it was limited. In recent decades, a growing body of research has challenged this practice. Systematic reviews and global guidelines now emphasise that delaying cord clamping is not only safe but beneficial, marking a return to a more physiologically aligned approach.

## Why Timing Matters?

At birth, the newborn undergoes a dramatic transition from placental support to independent breathing. During this period, the placenta still contains a substantial portion of the infant's blood volume, especially in preterm babies.

Delaying cord clamping allows:

- Continued oxygen delivery while the lungs begin functioning

- Gradual cardiovascular transition
- Transfer of iron-rich red blood cells

Up to 50% of a preterm infant's blood volume may initially reside in the placenta, making the timing of clamping particularly critical.

## The "Placental Transfusion Window"

One of the most fascinating emerging ideas in neonatal physiology is the concept of the placental transfusion window: a brief but critical period immediately after birth when the newborn is still physiologically connected to placenta.

During this window :

- The placenta acts as a natural life- support system
- Oxygenation continues while the lungs inflate
- Blood volume equilibrates gradually

Rather than viewing birth as an abrupt separation, this perspective reframes it as a continuum, where the placenta remains an active partner in the newborn's transition

## Benefits of Delayed Cord Clamping

### 1. Improved iron stores and reduced anaemia

One of the most well-established benefits of DCC is improved iron status. The additional blood transferred during the delay provides sufficient iron stores for the first 6–8 months of life, reducing the risk of iron deficiency anaemia.

This is especially important because early-life iron deficiency can have long-term effects on cognitive and motor development.

### 2. Better cardiovascular stability

DCC supports smoother transition from fetal to neonatal circulation, stabilising blood pressure and reducing stress on the newborn's cardiovascular system.

### 3. Enhanced immune protection

Placental blood contains immune cells and stem cells that may contribute to improved immune function and tissue repair.

### 4. Potential developmental advantages

Improved iron stores and oxygenation may translate into better neurodevelopmental outcomes, though long-term studies are ongoing.

## Special Benefits for Preterm Infants

While all newborns benefit from DCC, the advantages are particularly striking in preterm infants.

### Key Benefits:

- Reduced mortality
- Lower need for blood transfusions
- Decreased risk of intraventricular hemorrhage (brain bleeding)
- Reduced incidence of necrotizing enterocolitis (a severe intestinal condition)
- Improved circulatory transition and oxygenation

These benefits arise because preterm infants are more physiologically fragile and rely heavily on the additional blood volume and oxygen provided by placental transfusion.

In fact, some guidelines describe delayed cord clamping as a life-saving intervention for preterm babies.

## Are There any Risks?

Delayed cord clamping is generally safe. Although it increased the risk of jaundice requiring phototherapy, there is no association with increased requirement for exchange transfusions. Importantly, studies show that DCC does not increase the risk of postpartum hemorrhage in mothers

## How to implement delayed cord clamping

### 1) Develop clear protocols

- Define timing ( e.g., >=60 seconds or until pulsation stops)
- Include exceptions(e.g., need for resuscitation)

### 2) Train Staff

- Conduct workshops and simulations
- Emphasize physiological rationale and benefits

### 3) Integrate into Routine care

- Combine with skin-to-skin contact
- Allow neonatal assessment while cord remains intact

### 4) Adapt for Cesarean Sections

- Hold the baby at placental level
- Delay clamping without interfering with surgery

### 5) Monitor outcomes

## Global Implications: A low-cost, high-impact intervention

One of the most compelling aspects of delayed cord clamping is its simplicity. It requires:

- No equipment
- No medication
- Minimal training

Yet it has the potential to:

- Reduce anaemia globally
- Improve developmental outcomes
- Save lives in preterm infants

This makes it especially valuable in low-resource settings, where access to iron supplementation and advanced neonatal care may be limited.

## The Future of Cord Clamping

As research continues, several questions remain:

- What is the optimal duration of delay?
- Can DCC be safely extended in more situations?
- How can it be integrated with advanced neonatal resuscitation techniques?

Innovations such as bedside resuscitation with an intact cord are already being explored, aiming to combine immediate care with the benefits of placental transfusion.

## Conclusion

Delayed cord clamping represents a powerful example of how small changes in clinical practice can yield significant health benefits. By simply waiting, allowing nature to complete a final act of support we can enhance neonatal outcomes, particularly for the most vulnerable infants.

From improved iron stores and reduced anaemia to life-saving benefits in preterm babies, the evidence is clear: timing matters.

Yet, the continued variability in practice reminds us that translating evidence into routine care is not automatic. It requires education, system change, and a willingness to challenge long-standing habits.

Ultimately, delayed cord clamping is more than a technique, it is respecting the physiology. It reflects a shift toward respecting the physiology of birth, recognizing that sometimes, the best intervention is patience.

## References

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2. American College of Obstetricians and Gynecologists (ACOG). **Delayed Umbilical Cord Clamping After Birth.** Available at: ACOG Committee Opinion
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4. Rabe H, et al. **Delayed cord clamping in preterm infants.** Systematic review, Cochrane Database.
5. Andersson O, et al. **Effect of delayed vs early cord clamping on neonatal outcomes and iron status.** BMJ.
6. Fogarty M, et al. **Delayed vs early umbilical cord clamping in preterm infants:** systematic review and meta-analysis.
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8. National Institute for Health and Care Excellence (NICE). **Intrapartum care for healthy women and babies.**



## FEATURE ARTICLE

# Antibiotic Stewardship in Neonatal Care: An Urgent Priority

Dr. Gayana P. S. Gunaratna  
Senior Lecturer and Consultant Microbiologist  
Department of Medical Microbiology  
Faculty of Medicine, University of Kelaniya

## Introduction

Neonatal sepsis is a significant cause of neonatal mortality and morbidity, and the increasing antimicrobial resistance further challenges the management, despite the developments achieved in the field of neonatal medicine. Antimicrobials are among the most frequently administered drugs in NICU settings globally. Neonates, who are uniquely vulnerable to infections, receive antimicrobials either to prevent infection or to halt the progression of sepsis to overwhelming, fulminant disease. The combinations of antimicrobials used even for early-onset neonatal sepsis show wide geographical variation, likely due to the changes in the prevalence of pathogens causing sepsis, ever-increasing antimicrobial resistance, and non-adherence to recommended guidelines. However, the uncontrolled use of broad-spectrum antibiotics plays a significant role in the emergence of antimicrobial resistance (AMR). Thus, global efforts are increasingly focused on identifying strategies to curb the overuse and misuse of antibiotics, with antimicrobial stewardship (AMS) programmes emerging as an effective approach that maintains quality of care.

## Neonatal Sepsis and AMR

The global death toll caused by neonatal sepsis is estimated to be 400,000 annually, with survivors experiencing significant long-term sequelae, including higher post-discharge mortality rates and cognitive and physical disabilities. The early use of potent, broad-spectrum empirical antibiotics to treat neonatal sepsis is a common practice, mostly in low- and middle-income countries (LMICs). Thus, the burden of AMR disproportionately affects LMICs and is expected to continue doing so, as their comparatively fragile health systems are less equipped to address this growing challenge. Emerging data in Africa and South Asia have demonstrated concerning levels of resistance to common first-, second-, and third-line empirical treatment regimes, to the extent that it is now estimated that

one-third of neonatal sepsis deaths are directly attributable to AMR.

The Asian region, which includes our country and is home to the largest share of the global population, accounts for 40% of global cases of neonatal sepsis, and is anticipated to have the greatest number of deaths attributable to AMR by 2050.

## Antimicrobial Stewardship Programme

Antimicrobial stewardship programme aims to ensure the appropriate use of antimicrobials, minimize adverse side effects, enhance patient outcomes, reduce healthcare costs, and, most importantly, prevent the occurrence of antimicrobial resistance. To achieve these objectives, AMS programmes encompass key components such as accountability, expertise, action, tracking, reporting, and education. The available literature indicates a significant reduction in antibiotic days per 1000 patient days in neonates, including in extremely preterm neonates, following successful implementation of AMS programmes. Across the world, AMS programmes are widely implemented, targeting the rational use of antimicrobials in adult populations. However, such programmes are minimal for children and scarce for neonates. The well-established neonatal AMS programmes have proved successful in reducing antimicrobial use without negatively affecting neonatal mortality, indicating the need to establish them mostly in LMICs where the magnitude of AMR is alarmingly high.

Establishing an AMS programme in neonates is challenging due to their heightened vulnerability to infection, distinct infection risks, limited treatment options, scarcity of clinical and AMR data, and the significant short- and long-term consequences of sepsis. Consequently, neonates are a part of the population for whom an AMS is essential, but most difficult to establish. Any such programme needs to look into

1. A more objective basis for antimicrobial initiation, as rapid progression and non-specific presentation of neonatal sepsis drives high rates of antimicrobial use.
2. Ensuring appropriateness of antibiotic choice by adhering to standard guidelines and making local AMR data available for reference. The availability of unit-specific antibiogram-guided antimicrobial protocols would play a pivotal role in narrowing the spectrum of antimicrobial agents.
3. Prevent prolonged use of antimicrobial agents by ensuring regular reassessments
4. Rational use of the laboratory by implementing laboratory stewardship, which provides the right test for the right patient at the right time

The hospitals that have implemented AMS programmes mostly use antibiotic stewardship rounds, with prospective audit and feedback, and such activities have revealed considerable benefits in reducing the duration of antimicrobial exposure while ensuring appropriateness of antibiotics (both choice and duration). Outcomes such as economic impact, sustainability of interventions, and changes noted in AMR following implementation of AMS were reported in only a handful of studies, although this information is extremely important when analysing the broader benefits of AMS programmes.

Challenges likely to be faced when establishing neonatal AMS in local settings:

1. Lack of solid data on the magnitude of AMR in neonatal sepsis probably causes fear in prescribing narrow-spectrum antibiotics / non-adherence to guidelines
2. The quality of antimicrobials available
3. Resistance to change
4. Limited diagnostic facilities available
5. Limited human resources
6. Financial constraints

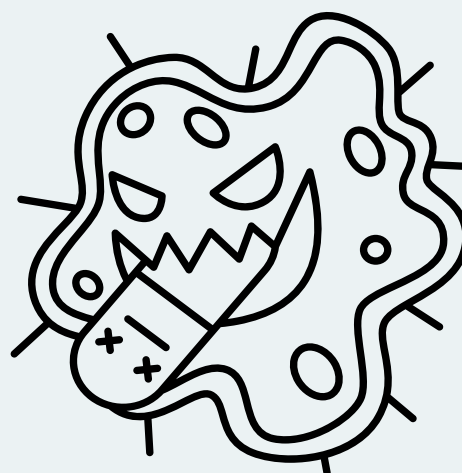
The country has implemented several steps to implement AMS in the local setting in keeping with the WHO's global action plan to combat antimicrobial resistance. The WHO Essential Medicines List Access, Watch, and Reserve (AWaRe) classification largely facilitates simple stewardship interventions that are widely applicable. The health authorities have taken essential steps to implement the same in local settings. The continuous awareness sessions are in place to obtain the compliance of prescribers.

## Conclusion

The management of neonatal sepsis is increasingly challenged by the rising burden of AMR. LMICs urgently require updated empirical treatment regimens to ensure judicious antimicrobial use, improved access to novel therapeutic agents, and strengthened laboratory capacity to better understand the mechanisms underlying AMR emergence and spread in high-burden settings. Therefore, the establishment and strengthening of AMS programmes is essential to curb the progression of AMR, which continues to significantly compromise the care of neonates with sepsis.

## References

1. Villanueva P, Freyne B, Hickey L, Carr J, Bryant PA. Impact of an antimicrobial stewardship intervention in neonatal intensive care: Recommendations and implementation. *J Paediatr Child Health*. 2021 Aug;57(8):1208-1214. doi: 10.1111/jpc.15427.
2. Flieschmann, C.; Reichert, F.; Cassini, A.; Horner, R.; Harder, T.; Markwart, R.; Tröndle, M.; Savova, Y.; Kisson, N.; Schlamann, P. Global incidence and mortality of neonatal sepsis: a systematic review and meta-analysis. *Archives of Disease in Childhood* 2021, 106, 745-752.



## FEATURE ARTICLE

# Fetal Echocardiography for Better Diagnosis of Congenital Heart Disease

Dr. Achintha Dissanayake  
Senior Lecturer in Obstetrics & Gynaecology  
University of Sri Jayewardenepura

## Introduction

One child every 15 minutes is born with a congenital heart disease. Nearly 25% of such babies will require surgery or intervention to survive. With congenital heart disease (CHD) remaining one of the most common congenital anomalies, early detection through targeted cardiac imaging significantly improves perinatal outcomes.

Fetal echocardiography has become an indispensable component of modern prenatal care, enabling detailed evaluation of the fetal heart's structure and function.

## Evolution of Fetal Echocardiography

Roots of fetal echocardiography dates back to 1954 when Hertz and Elder from Univeristy of Lund, Norway used M mode to assess fetal heart motion using an ultrasound device known as a reflectoscope. In 1964 Wang reported M mode echocardiography of fetal heart. In 1984 Maulik, Nanda and colleagues demonstrated a combination of two dimensional echocardiography and a pulsed doppler beam (Duplex) for assessing intra cardiac flow. Colour doppler was applied for fetal echocardiography in 1986. 3D echocardiography was developed in 1970s to 1980s and was incorporated into fetal echocardiography subsequently. Latest developments in ultrasonography led to spatio temporal image correlation (STIC), tissue Doppler imaging, speckle-tracking, and three-/four-dimensional (3D/4D) imaging, which have enhanced both structural and functional evaluation of the fetal heart.

## Indications of Fetal Echocardiography

Fetal echocardiography is typically performed between 18–24 weeks gestation. Although earlier assessment is increasingly feasible better images are obtained at mid trimester.

Indications can be broadly categorized into maternal, fetal, and familial factors:

**Maternal indications** : Pre- existing diabetes mellitus, Autoimmune disorder( e.g., anti-Ro/SSA antibodies); Exposure to teratogens (e.g., retinoids, lithium); Infections such as rubella or cytomegalovirus

**Fetal indications** : Abnormal findings on routine anomaly scan( e.g., abnormal four- chamber view), Increased nuchal translucency, Fetal arrhythmias, Extracardiac anomalies or hydrops fetalis

**Familial indications** : Previous child with congenital heart disease, Firs-degree relative with CHD, Known genetic syndromes associated with cardiac defects

A systematic assessment of the fetal heart is done. It includes assessment of situs, identification of the four chambers of the heart, **left and right outflow tracts, three vessel trachea view, aortic arch view, ductal arch view and SVC IVC view.**

During each view colour doppler is utilized to assess direction of flow for the presence of regurgitation and stenosis. Flow across valves are assessed using pulse doppler. Cardiac chambers are assessed for size and orientation. Cardio thoracic ratio and cardiac axis is assessed.

Z scores are automated to compare with normal values. The additional planes assessed significantly improve detection rates of conditions such as transposition of the great arteries, tetralogy of Fallot, and coarctation of the aorta—lesions missed on basic screening.

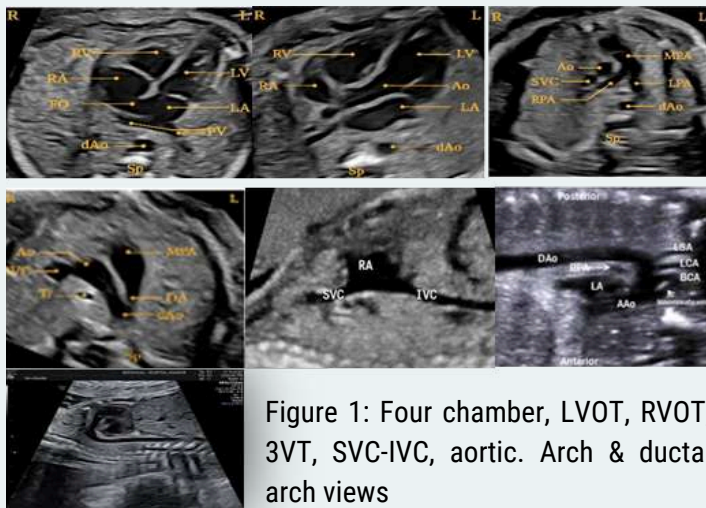


Figure 1: Four chamber, LVOT, RVOT, 3VT, SVC-IVC, aortic. Arch & ductal arch views

Early detection allows multidisciplinary planning, including delivery at tertiary centers and immediate neonatal intervention when required. More importantly it enables for prostaglandin infusion in duct dependent circulations to maintain patency of the PDA. Fetal echocardiography is not limited to structural assessment of the fetal heart but also incorporates functional assessment of the fetal heart as well.

**E/A Ratios** : Diastolic function in the fetal heart is commonly assessed using Doppler-derived E/A ratios across the atrioventricular valves E wave represents early passive ventricular filling and A wave indicates active filling due to atrial contraction. In the fetus, the myocardium is relatively noncompliant, resulting in **E/A ratios <1** (A wave dominance). Abnormal E/A ratios may indicate: Diastolic dysfunction, myocardial disease, volume or pressure overload states.

### Myocardial Performance Index (MPI) :

Also known as the Tei index, is a global measure of both systolic and diastolic function. It is calculated using time intervals derived from Doppler waveforms:

$$\text{MPI} = \frac{\text{Isovolumetric contraction time} + \text{Isovolumetric relaxation time}}{\text{Ejection time}}$$

Normal MPI values are relatively constant across gestation. Increased MPI suggests impaired cardiac function. Clinical applications include: Monitoring fetuses with growth restriction; Assessing cardiac compromise in twin-to-twin transfusion syndrome, evaluating fetuses with suspected cardiomyopathy or structural heart disease

Fetal echocardiography has transformed prenatal diagnosis by providing detailed structural and functional insights into the fetal heart. Its utility extends beyond detection of congenital anomalies to guiding antenatal management, delivery planning, and postnatal care. With continued technological advancements, fetal cardiac assessment is poised to become even more precise, further improving outcomes for affected pregnancies.

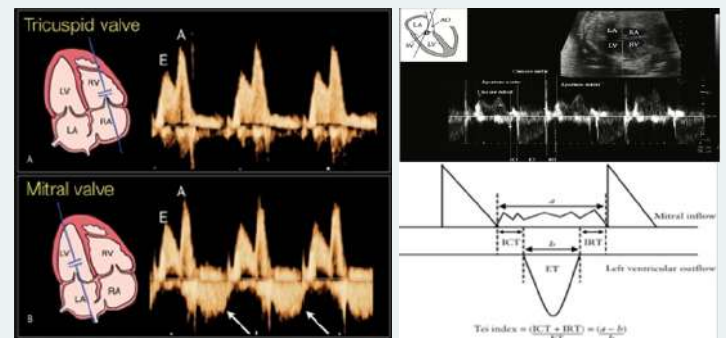
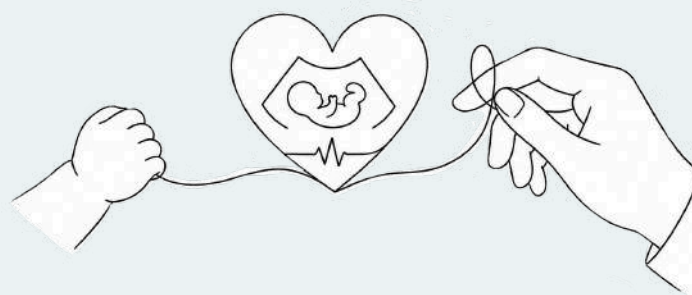


Figure 2: E/A ratio and calculation of myocardial performance index






## WEBINAR SERIES - 01

### Gestational Diabetes Uncovered

#### Case-Based Webinar

Organized by the Perinatal Society of Sri Lanka



**Dr Shamitha Dassanayake**  
Consultant Physician in Internal Medicine  
Castle Street Hospital for Women  
Colombo



**Dr Prabath Randombage**  
Consultant Obstetrician and Gynaecologist  
Colombo North Teaching Hospital, Ragama  
Senior Lecturer, FOM, IJCK



**Dr L.P.C. Saman Kumara**  
Consultant Neonatologist  
Midland Metropolitan University Hospital NHS  
United Kingdom

🕒 8:00 – 9:00 pm | 📅 30<sup>th</sup> January, 2026

**Registration**





**Moderator**  
**Dr Achintha Dissanayake**  
Consultant Obstetrician  
Colombo South Teaching Hospital  
Senior Lecturer  
Faculty of Medicine, University of Jayawardenepura

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**"Beyond Survival: Thriving with Advanced Maternal and Neonatal Care"**




## WEBINAR SERIES - 02

### "Together to Prevent and Manage Preterm Birth"

#### Organized by the Perinatal Society of Sri Lanka



**Dr Nethmini Thenuwara**  
Consultant Community Physician  
National Program Manager  
Intrastatal and Newborn Care  
Family Health Bureau  
Ministry of Health



**Dr Dinusha Liyanapatabandi**  
MBSB, MD, MRCP(Ob), MRCP(OG)  
Consultant Obstetrician and Gynaecologist  
Senior Lecturer  
Faculty of Medicine  
University of Moratuwa



**Professor Nishani Lucas**  
MBSB, DCH(Ed), (Paediatrics), MRCPCH(UK)  
IBCLC, FRCPCH, FRCR(Ed), PhD (Col)  
Professor in Neonatology  
Consultant Neonatologist  
Department of Paediatrics  
Faculty of Medicine, University of Colombo  
and De Soysa Hospital For Women, Colombo

🕒 7:00 – 8:00 pm | 📅 27<sup>th</sup> February, 2026

**Registration**





**Moderator**  
**Dr Sangeetha Wickramaratne**  
Consultant Neonatologist  
Colombo North Teaching Hospital – Ragama  
Senior Lecturer, Department of Paediatrics  
Faculty of Medicine, University of Kelaniya

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**"Beyond Survival: Thriving with Advanced Maternal and Neonatal Care"**

# Webinar series




## WEBINAR SERIES - 03

### "United Against Neonatal Sepsis: Bridging Obstetrics, Microbiology and Neonatology"

#### Organized by the Perinatal Society of Sri Lanka



**Dr Amila Rubasinghe**  
Consultant Obstetrician and Gynaecologist  
Castle Street Hospital for Women



**Dr Gayana Gunaratna**  
Consultant Clinical Microbiologist  
Senior Lecturer  
Department of Medical Microbiology  
University of Kelaniya



**Dr Dilani Dehigama**  
Consultant Neonatologist  
District General Hospital Gampaha

🕒 8:00 – 9:00 pm | 📅 27<sup>th</sup> March, 2026

**Registration**





**Moderator**  
**Dr Sangeetha Wickramaratne**  
Consultant Neonatologist  
Colombo North Teaching Hospital – Ragama  
Senior Lecturer, Department of Paediatrics  
Faculty of Medicine, University of Kelaniya

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## WEBINAR SERIES - 04

### Perinatal Pathways: Optimizing Fetal and Neonatal Screening Outcomes

#### Organized by the Perinatal Society of Sri Lanka



**Prof Tiran Dias**  
Cadre Chair and Professor in Fetal Medicine  
Department of Obstetrics & Gynaecology  
Faculty of Medicine, University of Kelaniya



**Dr Sathika Amarasekara**  
Consultant Neonatologist  
The German – Sri Lanka Friendship Hospital  
for Women



**Dr Nethmini Thenuwara**  
Consultant Community Physician  
Director – Intrastatal and Newborn Care  
Family Health Bureau

🕒 8:00 – 9:30 pm | 📅 24<sup>th</sup> April, 2026

**Registration**





**Moderator**  
**Dr Sangeetha Wickramaratne**  
Consultant Neonatologist  
Colombo North Teaching Hospital – Ragama  
Senior Lecturer, Department of Paediatrics  
Faculty of Medicine, University of Kelaniya

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**"Beyond Survival: Thriving with Advanced Maternal and Neonatal Care"**

# MINI TEACHING SESSIONS

## For NICU Doctors and Nurses

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### SESSION 1 (MICROBIOLOGY)

#### Basic Principles in Infection Prevention in NICU

- Dr Gayana Gunaratne  
Consultant Clinical Microbiologist

### SESSION 2 (NEONATAL NEUROLOGY)

#### Neuroprotection in the Neonatal ICU

- Prof Saraji Wijesekara  
Professor in Paediatric Neurology

### SESSION 3 (MICROBIOLOGY)

#### Antimicrobial Stewardship for Neonates

- Dr Gayana Gunaratne  
Consultant Clinical Microbiologist

### SESSION 4 (NEONATAL NEUROLOGY)

#### Neuroprotection at NICU Key Practices:

1. Protection of skin
2. Positioning and handling

- Professor Saraji Wijesekara  
Professor in Paediatric Neurology

### SESSION 5 (MICROBIOLOGY)

#### Prescribers Role in Antimicrobial Stewardship

- Dr Gayana Gunaratne  
Consultant Clinical Microbiologist

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# Capacity Building Workshop for Maternal and Newborn Healthcare



## Capacity Building Workshop for Maternal and Newborn Healthcare

For Medical Officers, Nurses and Midwives  
Organized by the Perinatal Society of Sri Lanka



### Inauguration - Auditorium, MCH Kalutara

Time	Programme (Venue - Auditorium, MCH Kalutara)
08.00	Registration
08.20	Welcome address by <b>Dr. Sharada Jayalath</b> , Consultant Obstetrician and Gynaecologist at MCH Kalutara
08.25	Address by <b>Prof. Ruwanthi Perera</b> , President of Perinatal Society of Sri Lanka
08.35	Address by <b>Dr. Madhubashini Karunarathna</b> , Director TH Kalutara
08.40	Address by <b>Dr. K. Nanthakumaran</b> , Director NIHS
08.45	Address by <b>Dr. Naveen De Soya</b> , RDHS Kalutara
08.50	Address by <b>Dr. (Mrs.) Dhammika Jayalath</b> , PD, Western Province
08.55	Address by <b>Dr. Chandima Sirithunga</b> , Director FHB
09.00	Address by <b>Dr. Asela Gunawardhane</b> , DGHS
09.05	Address by <b>Dr. Anil Jasinghe</b> , Secretary, Minister of Healthcare and Nutrition
09.10	Address by <b>Dr. Nalinda Jayatissa</b> , Minister of Healthcare and Nutrition
09.15	Vote of Thanks by <b>Dr. Jithma Fonseka</b> , Secretary Perinatal Society of Sri Lanka
09.20	Tea

### Programme for Field Staff - NIHS Kalutara

Time	Topic
9.30	MPDSR programme and updates <b>Dr. Harendra Dassanayake</b> , Consultant Community Physician
10.00	Role of field staff in reducing maternal mortality <b>Dr. Sharada Jayalath</b> , Consultant Obstetrician and Gynaecologist
10.30	Danger Signs in Newborn <b>Dr. Dammika Pathiraze</b> , Consultant Paediatrician
11.00	Maternal danger signs in antenatal period and management <b>Prof. Sanath Lanerolle</b> , Consultant Obstetrician and Gynaecologist
11.30	Updated Field Newborn Care package - Strengthening Continuum of Care at Community Level - <b>Dr. Nethmini Thenawara</b> , Consultant Community Physician
12.00	Postpartum sepsis <b>Dr. Sudath Senarathna</b> , Consultant Obstetrician and Gynaecologist
12.30	Quality Improvement in Newborn Care at MOH Level: Using Data for Action™ <b>Dr. Hemali Jayakody</b> , Consultant Community Physician
13.00	Postpartum Care: How to optimize mothers health <b>Dr. Ruwan Silva</b> , Consultant Obstetrician and Gynaecologist
13.30	Practical session on breast feeding support at community <b>Dr. Sandya Doluweera</b> , Consultant Paediatrician
14.00	Closing Remarks and Lunch

### Programme for Hospital Staff - MCH Kalutara

Time	Topic	
09.30	<b>Programme for Obstetric Staff</b>	<b>Programme for Neonatology Staff</b>
	Respectful Maternity Care <b>Dr. A. Shrirathar</b> , Consultant Obstetrician and Gynaecologist	First Breath, Lasting Impact: Navigating the Preterm Transition™ <b>Dr. Dilani Dehigama</b> , Consultant Neonatologist
10.00	New Labour Care Package and Meows Chart <b>Dr. Mangala Dissanayake</b> , Consultant Obstetrician and Gynaecologist	"Smallest patients, biggest decisions" - Ethics and communication in NICU <b>Dr. Dilusha Athukorala</b> , Consultant Paediatrician
	PPH Management - <b>Dr. Manoj Perera</b> , Consultant Obstetrician and Gynaecologist	"Extra uterine placenta": Optimal preterm nutrition <b>Dr. Jithma Fonseka</b> , Consultant Neonatologist
11.00	CTG Interpretation - <b>Dr. Dinusha Liyanapatabendi</b> , Consultant Obstetrician and Gynaecologist	The Invisible Threat: Late-Onset Sepsis in NICU <b>Dr. Gayana Gunaratne</b> , Consultant Microbiologist
	Instrumental Deliveries <b>Dr. Wedisha Gankanda</b> , Consultant Obstetrician and Gynaecologist	Fragile Frontier: Safeguarding the Preterm Brain <b>Prof. Saraji Wijesekara</b> , Professor in Paediatric Neurology
12.00-14.00	Hands on Training - PPH Management - Instrumental Delivery (Vacuum / Forceps) - Shoulder Dystocia - Breech Delivery <b>Dr. Sharada Jayalath</b> , Consultant Obstetrician and Gynaecologist	Hands on Training - Stabilization and safe transport of a preterm and sick newborn, <b>Dr. Kapilani Withanarachchi</b> , <b>Dr. Dilusha Athukorala</b> , <b>Dr. Dilani Dehigama</b>
14.00pm	Closing remarks and Lunch	



**Kalutara**

**CPD accredited**



**24<sup>th</sup> April 2026**



**More Information : 0777 072 520**

"Beyond Survival: Thriving with Advanced Maternal and Neonatal Care"

#### Programme Coordinators



Prof. Ruwanthi Perera, President, PPS



Dr. Jithma Fonseka, Secretary, PPS



Dr. Sharada Jayalath, Consultant Obstetrician and Gynaecologist



Dr. Ruwan Silva, Consultant Obstetrician and Gynaecologist

The Capacity Building Workshop for Maternal and Newborn Healthcare, organized by the Perinatal Society of Sri Lanka, was successfully conducted on 24<sup>th</sup> April 2026 at MCH Kalutara.

## Key Highlights



# Save the Date

## 25<sup>th</sup> Annual Scientific Congress 2026



Save the Date

Perinatal Society of Sri Lanka  
Towards healthier mothers and newborns

## 25<sup>th</sup> Annual Scientific Congress 2026

Perinatal Society of Sri Lanka

26<sup>th</sup> to 28<sup>th</sup> September, Waters Edge, Sri Lanka

<b>26<sup>th</sup> September</b> Inauguration and Annual Scientific Congress Day 1	<b>27<sup>th</sup> September</b> Annual Scientific Congress Day 2	<b>28<sup>th</sup> September</b> Annual Scientific Sessions: Nurses & Midwives
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For information  
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*"Beyond Survival: Thriving with Advanced Maternal and Neonatal Care"*



### About the Congress

The Perinatal Society of Sri Lanka is pleased to announce its 25<sup>th</sup> Annual Scientific Congress, scheduled to be held from **26<sup>th</sup> to 28<sup>th</sup> September 2026** at **Waters Edge Hotel**. This year's academic sessions will feature a diverse range of engaging and relevant topics spanning neonatology and maternal health, addressing both preventive and curative aspects of care. The program is designed to cater to a multidisciplinary audience, with dedicated sessions tailored separately for midwives, nurses, as well as for postgraduate trainees and medical officers. Participants can look forward to insightful discussions, knowledge sharing, and updates on current best practices in perinatal care.



### STAY TUNED

Registration details and full programme will be announced soon.  
Don't miss the premier event in perinatal care!



### **Vision**

To be actively committed towards achieving continuous improvement in the quality of health care for mothers and infants by promoting networking for providers of perinatal healthcare, supporting education for providers and consumers as well as improving availability, accessibility and continuity of preventive and primary perinatal healthcare services together with promoting initiatives toward improving health care of mothers and infants.

### **Mission**

The Perinatal Society of Sri Lanka is a not-for-profit multidisciplinary organisation striving to promote continuing improvement in the quality of healthcare from pre-conception through birth of the baby and into infancy. It advocates ideal and ethical care through education and research to influence national policies and encourage strategic collaboration among health-care providers and stakeholders in order to ensure optimal pregnancy outcomes for mothers and babies.

## **PSSL EDITORIAL COMMITTEE**

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