NEWSLETTER OF PERINATAL SOCIETY OF SRI LANKA

PSSL QUARTERLY

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MAY 2026 – JULY 2026 | VOLUME 07 | ISSUE 01

Exploring the latest in neonatal life support workshops, mental health crisis in NICUs, and strengthening maternal care through domiciliary visits

BEYOND SURVIVAL:
Thriving with Advanced Maternal and Neonatal Care

From Secretary's Diary

-MONTHLY UPDATE-

Institutional Milestones

Official Registration: PSSL received its official registration as the Perinatal Society of Sri Lanka.

Global Collaborations: Expanded collaborative public health services alongside UNICEF and the WHO.

CPD-Accredited Workshops & Courses

"Synergy in Skeletal Care" Workshop (19th May): A joint initiative with the Sri Lanka Orthopaedic Association (SLOA) at the Lady Ridgeway Hospital Auditorium. Addressed critical neonatal skeletal conditions and MDT clinical workflows, drawing over 150 physical attendees and an island-wide hybrid/virtual audience.

2nd Neonatal Life Support (NLS) Course (4th June): A one-day program at Lanka Hospital for 27 participants. Led by Prof. Ruwanthi Perera (President), Dr. Sandya Doluweera, and Neonatologists (Drs. S. Thennakoon, J. Fonseka, D. Dehigama, N. Gamhewage, S. Wickramaratne). Included pre-course MCQs, skill stations, assessments, and post-course evaluations.

"Newborn Screening" Workshop (26th June): Held at UCFM Tower with UNICEF and the Sri Lanka College of Paediatricians (SLCP) under the theme "Beyond Survival: Thriving with Advanced Maternal and Neonatal Care". Attended by 250 physical and 30 online participants.

Highlights: Featured the PSSL National Audit on Newborn Screening and key plenaries/symposia on hearing, cardiac (CCHD), metabolic (hypothyroidism), and genomic screening.

Dignitaries & Speakers: Included Prof. R. Perera, Prof. P. Wickramasinghe, Dr. A. Daniel (UNICEF), Dr. C. Sirithunga (FHB), Prof. N. Lucas, Prof. T. Dias, Dr. G. Gunaratna, Dr. D. Dehigama, Prof. C. Jayasundara, and other eminent specialists.

Training & Continuous Education

Monthly Webinars:

24th April: "Optimize Fetal and Neonatal Screening" (Prof. T. Dias, Dr. S. Amarasekara, Dr. N. Thenuwara) – Exceeded 500 participants.

29th May: "Multidisciplinary Approach for Congenital Defects" (Drs. M. Samarasinghe, N. Gamhewage, A. Dissanayake).

26th June: "Tackling Low Birth Weight" (Prof. C. Jayasundara, Prof. S. Mettananda, Dr. S. Godakandage).

Weekly Mini Teaching Sessions: Continuous training for perinatal staff every Wednesday (12–1 PM):

- Neuroprotection at NICU - Prof Saraji Wijesekara
- Fetal growth restriction - Dr Achintha Dissanayake
- CTG interpretation and fetal monitoring: Prof. Markandu Thirukumar
- Maternal sepsis - Drs. A. Rubasinghe, S. Godakandage, G. Gunaratne
- Intrapartum infection - Dr. A. Amarasena
- Preterm birth prevention - Prof. C. Gihan
- Respectful maternity care - Dr. S. Apputhurai
- Modern perspectives on preeclampsia - Dr.Naveen Udawella

Mass Media & Public Awareness

Led by the PSSL President, targeted mass media programs were conducted to educate the public on PSSL activities, maternal sepsis, and the vital importance of neonatal screening.

Policy Advocacy & Regulatory Representation

PSSL provided expert official representation to draft the Essential Neonatal Medicine List and collaborated with the NMRA to expedite surfactant product registration workflows.

NEONATAL LIFE SUPPORT PROGRAMS

The 5th Neonatal Life Support (NLS) Programme was successfully conducted on 4th of June 2026 at Lanka Hospital under the guidance of an expert faculty comprising Consultant Neonatologists and Paediatricians. The programme provided comprehensive training in neonatal resuscitation through evidence-based lectures, hands-on skill stations, competency assessments, and simulation-based emergency scenarios, enabling participants to strengthen their knowledge, technical skills, and team-based management of neonatal emergencies.

NEONATAL LIFE SUPPORT PROGRAM

- LANKA HOSPITAL -

FEATURE ARTICLE ★★★

THE HIDDEN MENTAL HEALTH CRISIS IN NICUS: WHY FAMILY-CENTRED CARE CAN NO LONGER WAIT

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Introduction

The admission of a newborn to a Neonatal Intensive Care Unit (NICU) is a profoundly distressing experience for families, particularly mothers. While advances in neonatal care have significantly improved survival and long-term outcomes of high-risk infants, the psychological wellbeing of mothers during and after a NICU stay often remains under-recognised and under-addressed.

The NICU is an unfamiliar, highly medicalised environment characterised by equipment, invasive procedures, restricted parental contact, and uncertainty regarding prognosis. Mothers are frequently confronted with feelings of fear, helplessness, guilt, and loss of normal parental role. Maternal psychological morbidity in the NICU setting is often multifactorial, influenced by the infant's gestational age, illness severity, length of hospital stay, and perceived threat to the infant's survival.

A cross sectional analysis of mothers in NICUs of Colombo South Teaching Hospital and De Soysa Maternity Hospital revealed an alarmingly high incidence of maternal psychological morbidity. The incidence of stress, depression and anxiety was 73%, 87% and 77.7%, respectively. At least one psychological condition was noted in 94.3% of mothers, while 59% experienced all three conditions concurrently.

Impact of Maternal Psychological Morbidity on the Neonate and the Family

Adverse maternal mental health negatively affects infant outcomes. Maternal stress, anxiety, and depression are associated with impaired mother–infant bonding, reduced breastfeeding duration, and altered caregiving behaviours. In the long term, these factors adversely influence infant neurodevelopment, emotional regulation, and attachment patterns.

Furthermore, untreated maternal mental health problems can persist well beyond discharge. When not identified and managed early, theses can evolve into chronic mental health disorders, which can increase the burden on families and healthcare systems. Therefore, maternal psychological distress must be recognised as a significant public health concern and structured support systems such as family centered care must be adopted into neonatal practice to mitigate these adverse effects.

The Role of Family Centered Care in Supporting Mothers and Families

Family-centred care (FCC) practices, where parents are considered as the part of the team caring for the neonate in the NICU is known to reduce maternal psychological burden. Inside the model of FCC, parents feel respected, empowered, and supported. The key elements of FCC are illustrated in figure 1.

Figure 1: Components of family centered care

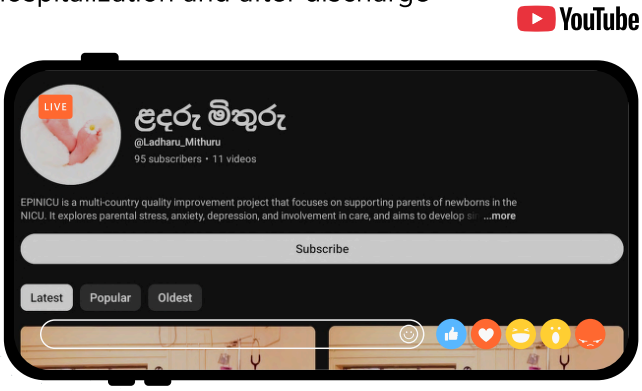
Separation in the immediate postnatal period can disrupt attachment. FCC facilitates early and sustained bonding through physical contact, shared caregiving responsibilities, and active engagement in decision-making.

Therefore, NICUs should encourage maternal participation in routine care of the neonate such as diapering, oral care, feeding, kangaroo mother care and bathing to restore the lost parental role. Time for bonding and breastfeeding support should be actively protected. When parents are included in caregiving activities under the guidance of the staff, they develop practical skills and confidence in managing their baby's needs.

Good communication with parents, where they are regularly updated regarding the progress of the baby, and involving parents in the decision-making process are key components of FCC. Communication that reduces uncertainty and helplessness is a key protective factor. Daily structured updates using consistent language, such as explaining the current situation, what is expected, and how is baby monitored help parents feel informed and included.

Providing educational materials to parents is vital and this must start very early from the admission and done at regular intervals. The family must be prepared for post discharge care, where they should be trained on routine care, basic infant life support and first aid. This preparedness enhances the transition from hospital to home and may reduce readmission rates.

"Ladharu_Mithuru", a social platform initiated to empower parents through education, was developed as part of the EPINICU multi-country quality improvement project. Through Ladharu Mithuru, families are provided with clear, practical educational videos related to NICU practices, parent involvement, and newborn wellbeing, thereby reinforcing the guidance given by healthcare professionals during hospitalization and after discharge



Additionally, having flexible visiting policies, and allowing siblings to visit the NICU allows families to re-connect and have a major impact on maternal wellbeing.

Allowing siblings to visit the sick neonate in the NICU, improves the wellbeing of the sibling and enhances bonding and there is no risk for infection outbreaks in NICU, when adhered to infection prevention protocols. FCC models foster peer support and parent-to-parent connection, as it significantly reduces isolation. However, confidentiality and cultural sensitivity are essential in all peer-support initiatives.

Identifying and supporting mothers at risk of psychological morbidity is important. Considering the significant stigma associated with mental health concerns, routine screening for maternal stress, anxiety, and depression using validated tools should be considered as part of routine NICU workflow. Screening should be coupled with proper referral pathways. Therefore, collaboration with mental health professionals for further assessment and follow-up is a necessity. (Figure 2)

Figure 2: Screening for psychological morbidity in the NICU

Beyond individual outcomes, FCC contributes to improved interdisciplinary collaboration, enhanced communication, and potentially through reduced complications and length of stay. Moreover, it promotes a culture of empathy and partnership within neonatal services. Advantages of FCC are summarized in table 1.

Table 1: Benefits of Family Centred Care

Benefits for the neonate
Improved physiological stability
Enhanced neurodevelopmental outcomes
Reduced length of hospital stay
Decreased risk of complications
Benefits for parents
Reduced anxiety and psychological distress
Strengthened parent-infant bonding
Increased parental confidence and competence
Improved satisfaction with care
Benefits for the healthcare system
Foster trust between families and staff
Reduce healthcare costs

Staff Training

In Sri Lanka, NICUs adopt the traditional approach, neglecting the parental roles and their emotional burden. The concept of FCC is new, and the maternal psychological morbidity is often overlooked. In this context, capacity building and staff training is important. In Sri Lankan NICUs, shortages in staff and burnout are common. Short regularly recurring training sessions for staff on FCC, provision of psychological support, and mental health screening must be a priority. Furthermore, staff require comprehensive training on communication strategies, particularly focusing on communicating with vulnerable groups of parents. Staff training and education is the key to success and sustainability.

Call for Action

Supporting mothers in NICU with an aim to enhance their psychological wellbeing involves implementation of structured support systems like family-centred care coupled with clear and consistent communication, environmental modifications, and access to psychosocial support. These approaches work together to empower parents, to reduce parental distress, and improve both family and infant outcomes.

In Sri Lanka, resource constraints and limited access to perinatal mental health services pose additional challenges. However, integrating basic psychological support into neonatal care does not necessarily require extensive resources. Training healthcare workers to recognise warning signs, providing peer support opportunities, advocating routine screening and strengthening referral pathways can make a meaningful difference.

Conclusions

Addressing maternal stress, anxiety, and depression in the NICU is an essential component of holistic neonatal care. By prioritising maternal mental health, we not only support mothers during one of the most vulnerable periods of their lives but also contribute to better outcomes for infants and families as a whole.

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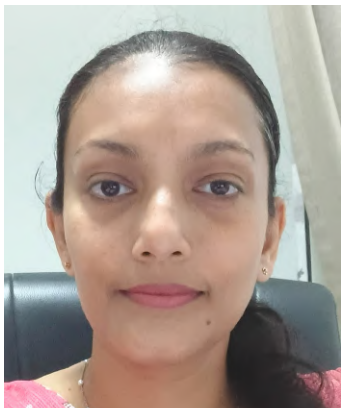

FEATURE ARTICLE ★★★

STRENGTHENING CONTINUITY OF MATERNAL AND NEWBORN CARE THROUGH DOMICILIARY VISITS

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Domiciliary visits or home visits can be considered a very impactful intervention in the maternal and child health programme, which provides an excellent opportunity for individualized care for the women and their newborns, complementing the clinic-based care provided. These visits facilitate early identification of risks and enable provision of customized health education and timely referral for specialized care.

The Public Health Midwife (PHM) is one of the grass-root level primary healthcare workers of the Medical Officer of Health (MOH) team1, contributing to the success of the maternal and child health programme in Sri Lanka, with a well demarcated geographical area of an average population of 3,000 under her care2. As a field-level preventive healthcare provider responsible for providing maternal and child health services, the PHM plays a pivotal role in ensuring that all pregnant women receive comprehensive and continuous care throughout their pregnancy and during the postnatal period. Domiciliary visits for antenatal and postnatal women is identified as one of the responsibilities entrusted to the PHM.

During the antenatal domiciliary visits, the PHM gets the opportunity to meet the family members of the pregnant woman and create awareness among them about how to care for the pregnant woman. Additionally, these home visits also give her the opportunity to learn and assess the pregnant woman's home environment, socioeconomic status of the family and the family support she receives[2]. Postnatal domiciliary visits enable the PHM to identify and take necessary action regarding the problems in both the mother and her newborn baby.

In other words, domiciliary visits provide an excellent opportunity for the health system to assess women and their babies within her own family and social environment, and to identify medical, nutritional, psychological, socioeconomic, and environmental factors that may influence maternal and foetal outcomes. It is also well-known that these domiciliary visits help in strengthening the relationship between the healthcare system and the family. They promote trust in the health system and the healthcare providers, especially trust in the PHM, which in turn helps in improving the compliance and adherence of the women and their families to recommended maternal and newborn care practices.

According to the national guidance given for healthcare providers by the Family Health Bureau of Sri Lanka[2], which is the central authority of the Ministry of Health for Maternal, Child, Adolescent and Reproductive Health[2], in the maternal care model, domiciliary visits are expected to be paid to antenatal women, at least once during each trimester, accounting for three home visits during pregnancy. These are expected to be carried out at 6-12 weeks, 24-26 weeks and at 34-36 weeks[2]. This minimum expected number of visits is advocated for low-risk pregnancies, whereas more frequent visits are expected to be paid for high-risk pregnant women. During the postnatal period, four home visits need to be done at given time durations, the first visit between 1-5 days, second visit between 6-10 days, the third visit between 14-21 days and the fourth visit at around 42 days[2].

Domiciliary Visits during the Antenatal Period

The first antenatal home visit is undertaken ideally during the first trimester. This happens either during registration of the woman in instances the woman is registered at home, or after the registration in

instances where the woman is registered at the field clinic. This visit is conducted with the objective of taking the woman under the care of the PHM, assessing the condition of the woman and her socio-economic status, examining the woman, and developing a rapport with her and her family members[2]. During this visit, a comprehensive risk assessment can be conducted, including evaluating her past obstetric history and existing medical conditions, and identifying other social determinants of health including household details, living conditions, family support systems, domestic violence, substance use, etc. This can be a good opportunity for the PHM to invite the woman for future field clinic sessions and reinforce the importance of regular antenatal clinic attendance.

Subsequent antenatal home visits are scheduled in the second and third trimesters and would be individualized according to maternal risk status. The second and third domiciliary visits will help in assessing the progression of the pregnancy and the maternal and foetal well-being, and they can also be used to provide advice to the family on the birth and emergency plan and how to prepare for the delivery and the newborn. During these visits, the PHM can encourage the mother to be vigilant of danger signs requiring urgent medical attention and to be compliant to antenatal appointments and prescribed supplements. Especially the third domiciliary visit can be utilized for educating the woman on breastfeeding, Early Childhood Care and Development, and family planning[2]. Additionally, this third home visit is a good opportunity to reiterate the woman and the family to be vigilant about danger signs such as reduced foetal movements, vaginal bleeding, severe headache, convulsions, rupture of membranes, etc., and encourage them to make timely decisions regarding hospital admission, thereby reducing delays in accessing care.

The highlighted benefit of domiciliary visits is that they allow the PHM to observe factors that may not be apparent when a woman visits the clinic. Aspects such as sanitation of the household, family and social support, relationship with the family members, etc., can be directly assessed, and vulnerable families requiring additional support can be identified. Appropriate referrals can be coordinated through the Medical Officer of Health (MOH) and other relevant services based on those observations.

The effectiveness of Sri Lanka's domiciliary maternal care programme is reflected in the high service coverage reported. The Annual Health Bulletin 2024 reports that PHMs visited 97.2% of registered pregnant women at least once at home, and this data shows a positive trend from 94.2% in 2020, with a slight fluctuation in 2021[4].

Domiciliary Visits during the Postnatal Period

Following the birth of the baby, the first 42 days after birth is considered as the postnatal period, which is a critical time for women and their newborns, and where the burden of maternal and neonatal mortality and morbidity is found to be unacceptably high[5]. The World Health Organization declares that most maternal and infant deaths occur during these first six weeks after delivery, and that postnatal care is the most neglected phase in the provision of quality maternal and newborn care[6]. Postnatal care services are therefore considered an essential component of maternal, newborn and child healthcare services. In a context where the percentage of institutional deliveries in Sri Lanka consistently remains very high throughout the years at 99.9% of all reported deliveries[4], domiciliary visits by the PHM during the early postnatal period essentially provides seamless transition from institutional care to community-based care and follow-up. These encounters are a unique opportunity for the PHM to assess both the postpartum mother and her newborn, to look into their physical, mental and social health, identify any danger signals and support adherence to subsequent clinic visits.

During the postnatal domiciliary visits, the PHM will advise the mother about the signs and symptoms suggestive of potentially life-threatening conditions to the mother and baby, and to instruct to contact a healthcare provider immediately if such symptoms exist, in view of early identification and management of conditions such as postpartum haemorrhage, thromboembolism, infection, preeclampsia and eclampsia. Assessment of maternal emotional wellbeing is an equally important component of postnatal home visits. With the good rapport and trust

built up throughout the pregnancy through regular contact, the PHM is in a very good position to identify postnatal women in need of psychological support or specialist referral. The woman should be enquired about her emotional well-being and the family support she receives. The woman herself, as well as the other family members should be encouraged to note any changes in mood, emotional state and behaviours of the woman, and seek early support2. Home visits thus provide an excellent opportunity to engage family members as active participants in maternal and newborn care.

Simultaneously, the newborn needs to be assessed for jaundice, cyanosis, pallor, abnormal breathing, abnormal tone (floppy or stiff), dehydration, cord care, temperature maintenance, etc. Particular emphasis of the PHM needs to be placed on exclusive breastfeeding, where mothers experiencing difficulties in breastfeeding need to be provided with individualized counselling and practical assistance to establish successful breastfeeding. It is also recommended that the PHM should pay home visits to all women who had experienced a stillbirth or a neonatal death, as well[2].

Provision of recommended postpartum care visits after delivery has shown a positive trend during the past five years in Sri Lanka, increasing from 89% in 2020 to a remarkable 94.4% in 20243. In 2024, the average number of home visits during the first 10 postpartum days was calculated as 1.7, which was relatively stable as a statistic during the previous four years, at 1.7-1.8 visits. At least one home visit was paid by the PHM during the first 10 days to 70.9% of postpartum mothers, and 67.3% of mothers received postpartum visits by PHM around 42 days in 20244. However, these two indicators showed a decline from the statistics of 2023 (77.9% and 73.8%, respectively).

All in all, these domiciliary maternal and newborn care services have been instrumental in maintaining favourable maternal and neonatal health indicators in the country. Equitable access to services across diverse geographical and socioeconomic settings is also ensured through this, ensuring that all women, along with their newborns, receive continuous care throughout their antenatal and postnatal period. The antenatal and postnatal domiciliary visits therefore represent one of the main strengths of Sri Lanka's public health system.

Early identification of risks and timely referral, engagement with the family and individualized health education showcase the unique benefits of this important service, which contributes to the country's longstanding achievements in maternal and child health. Hence, this unique preventive healthcare service needs to be facilitated and strengthened, in view of safeguarding the health of mothers and their newborns in the community.

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FEATURE ARTICLE ★★★

LABOR COMPANIONSHIP: WHY ARE WE STILL WAITING?

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Labor is unlike any other clinical situation. During labor, a woman is almost entirely dependent on those caring for her. Yet, until recently, no one outside the clinical team was permitted into labor rooms—a practice that had remained largely unquestioned. Across cultures, including in Sri Lanka, women have traditionally been supported during childbirth by mothers, sisters, or other trusted women from their families and communities. Ironically, modern hospital care had abandoned this age-old source of comfort.

Why had this become the norm? There were undoubtedly many reasons, but perhaps the most important was rarely acknowledged: the discomfort of care providers with having an outsider observe their work.

When we introduced labor companionship at De Soysa Hospital for Women in 2011, most believed it was simply not feasible.

By that time, the evidence in favor of labor companionship was already overwhelming. Cochrane Reviews have demonstrated that the simple presence of a companion shortens labor, reduces the need for analgesia, increases the likelihood of spontaneous vaginal birth, and improves women's overall birth experience. One review described labor companionship as "one of the most effective interventions" in maternity care. Yet these benefits had scarcely entered routine obstetric practice in Sri Lanka.

Why not allow husbands? Dr. L.A.W. Sirisena had introduced this practice years earlier at Castle Street Hospital, but it ceased after his retirement until its recent revival. At De Soysa Hospital, labor beds were separated by barely 30 inches, making privacy impossible. Moreover, most of the available evidence is about female companions.

Against this background, we chose to generate local evidence while simultaneously familiarizing staff with the presence of a companion in the labor room. We designed a study to evaluate whether educating labor companions would improve outcomes. The study was conducted in Ward 15, where mothers with low-risk pregnancies delivered.

Although the staff agreed to participate, some expressed understandable concerns that companions might become both complainants and witnesses. Following ethics approval, the hospital administration requested approval from the Ministry of Health, which the then Director General of Health Services, Dr. Ajith Mendis, gave enthusiastically.

Our results showed that educating companions did not improve clinical or maternal outcomes beyond the benefits already associated with simply having a companion present.

The response exceeded all expectations. Mothers and companions wrote to us, urging that the policy be continued. Midwives and nurses—many of whom had initially been cautious—became some of its strongest supporters.

Beyond the established clinical benefits, we observed something equally important: communication improved markedly. Women felt listened to, respected, and supported. Labor companionship was not merely another intervention; it helped restore dignity to childbirth.

Yet, despite compelling international evidence and successful local experience, labor companionship has still not become a routine practice in Sri Lanka.
Women delivering by cesarean section in many private hospitals may have their husbands by their side during the procedure, while women giving birth normally in government hospitals are often denied even the presence of another trusted woman. This is not a failure of resources. It is a failure of priorities.

Every woman has the right to respectful, evidence-based maternity care. The science has been settled for decades. Denying women the presence of a chosen companion, despite overwhelming evidence of benefit and no evidence of harm, cannot be justified on scientific, ethical, or humanitarian grounds. What is lacking is not knowledge, but the will to change.

Every day that labor companionship is denied, we knowingly withhold one of the simplest, safest, and most effective interventions in maternity care. The barrier has never been the evidence – rather, it has been us.

NEW BORN SCREENING WORKSHOP

The Perinatal Society of Sri Lanka, in collaboration with UNICEF and the Sri Lanka College of Paediatricians, successfully conducted the Newborn Screening Workshop on 26th June 2026 at the UCFM Tower. The CPD-accredited programme brought together experts to discuss advances in newborn screening, including hearing screening, critical congenital heart disease, congenital hypothyroidism, and future developments in genomic and metabolic screening, reinforcing the importance of early detection and timely intervention to improve neonatal outcomes.

WEBINAR SERIES

05

United for the Unborn: A Multidisciplinary Approach to Congenital Defects

06

Tackling Low Birth Weight: Prevention, Detection, and Survival

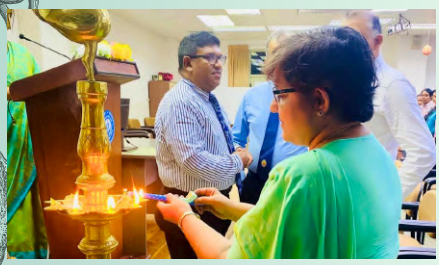
07

All Hands on Birth: Family-Centered Perinatal Strategies

Synergy in Skeletal Care: From Neonatology Referral to Orthopaedic Intervention

The Perinatal Society of Sri Lanka, in collaboration with the Sri Lanka Orthopaedic Association, successfully conducted "Synergy in Skeletal Care" - From Neonatology Referral to Orthopaedic Intervention on 19th May 2026 at the Lady Ridgeway Hospital Auditorium, Colombo. The workshop highlighted the importance of early recognition, timely referral, and multidisciplinary management of neonatal musculoskeletal conditions through expert-led sessions on neonatal hip screening, foot deformities, birth injuries, musculoskeletal infections, and collaborative case discussions.

Key Highlights



UPCOMING EVENTS

25TH ANNUAL SCIENTIFIC CONGRESS 2026

Day 01 - 26th September 2026 at Waters Edge, Sri Lanka

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

7:00 - 7:30 AM	**Registration & Morning Poster Exhibition**	
7:30 - 7:30 AM	**Free Paper Sessions**	
8:30 - 9:00 AM	**Tea Break**	
9:00 - 12:00 AM	**Official Inauguration Ceremony** • **Welcome Address** • **Address by Chief Guest** • **PSSL Oration** • **Silver Jubilee Commemoration**	
12:00 - 1:00 AM	**Lunch & Trade Exhibition**	
1:00 - 1:30 PM	**Plenary 1** **Where Do We Stand: Current Perinatal Status in Sri Lanka**	
1:30 - 2:30 PM	**WHO Symposium 01** **Perinatal Challenges Beyond SDG 2030** • Global architectures for sustainable perinatal health • Tackling the NCD surge and advanced maternal age in South Asia • Pushing the limits of viability: Implications	
2:30 - 3:30 PM	**Sepsis Symposium** • Antibiotic Stewardship in Obstetric care • Mitigating Late-onset Neonatal Sepsis	
3:30 - 4:00 PM	**Tea Break**	
4:00 - 5:00 PM	**Neonatal Symposium** **Identifying Gaps in NICU and Postnatal Monitoring** • Monitoring in NICU • Neonatal Surveillance in Postnatal Ward • Hospital to Home Transition	**Obstetric Symposium** **Transition from Partogram to Labour Care Management** • WHO Labour Care Guide • Intrapartum Fetal Monitoring • Overcoming Hurdles in Local Ward Implementation
5:00 - 6:00 PM	**Guest Lecture** Knowing When to Call Endocrinologist	**Guest Lecture** Operative Obstetrics

25TH ANNUAL SCIENTIFIC CONGRESS 2026

Day 02 - 27th September 2026 at Waters Edge, Sri Lanka

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

8:00 - 9:00 AM	**Free Paper Session**	
9:00 - 9:45 AM	**Prof. Indrajee Amarasekara Oration**	
9:45 - 10:45 AM	**Tea Break**	
9:00 - 12:00 AM	Joint Symposium 3 **Enhancing Mental Health** • Perinatal mindfulness and epigenetics • From womb to mind, Perinatal mental health and infant brain development • Catching Silent Suffering at the Doorsteps	
10:45 - 11:15 AM	**Tea Break**	
11:15 - 12:15 PM	Primary Care Symposium **Integrating Perinatal Care Into Primary Health Systems** • Streamlining risk stratification and referral pathways • Post-Discharge pitfalls in the community • Strong field networks, safe perinatal care	
12:15 - 12:45 PM	Guest Lecture **Congenital Infections**	Guest Lecture **Maternal STI**
12:45 - 1:15 PM	Plenary **Neonatal Surgical Conditions**	Plenary **Antenatal Neonatal Surgical Conditions**
1:15 - 1:45 PM	**Beyond the Scores: Screening and Care in Neonatal Abstinence**	**Interpregnancy Care: The Ultimate Window for Risk Reduction**
1:45 - 2:45 PM	**Lunch** **Yoga with Miyuru**	
2:45 - 3:45 PM	**Beyond Birth : Early Detection, Early Intervention, Complete Life** • Every Beat Counts : Screening and early care algorithms for CCHD • Hearts Under Strain: Critical maternal cardiac care during pregnancy	
3:45 - 4:45 PM	Symposium **The First 1000 Days in FGR** • In-Utero Brain Protection and Placental Insufficiency • Nourishing the Vulnerable Brain • FGR in the Field: Prevention, nutrition, and tracking	
4:45 - 5:00 PM	**Tea Break**	
5:00 - 5:30 PM	**Award Ceremony** **Vote of Thanks**	

25TH ANNUAL SCIENTIFIC CONGRESS 2026

Day 03 - Nurses & Midwives' Congress - In Collaboration with UNICEF
28th September 2026 at Waters Edge, Sri Lanka

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

7:00 - 7:45 AM	**Registration**
7:45 - 9:00 AM	**Oral and Poster Presentations**
9:00 - 9:30 AM	**Opening Ceremony** **Welcome Address by President PSSL & UNICEF Vision for 2030**
9:30 - 9:50 AM	Keynote Address: **CPD as a Tool for Reducing Preventable Perinatal Deaths**
9:50 - 10:10 AM	Plenary **Redesigning the Environment to Combat Professional Burnout**
10:10 - 10:30 AM	**Refreshment Break**
10:30 - 11:40 AM	**Parallel Session 1 : Quality & Equity in Care** • **Implementing the WHO Intelligent Labour Care Guide to ensure dignity** • **Strengthening the "Fourth Trimester": Community-based postnatal surveillance** • **Obstetric First Aid: Stabilizing high-risk mothers in rural settings** • **Antimicrobial Stewardship (AMS) in the NICU** • **Neuro-Protective Care:Early Recognition and Prevention of Neonatal Seizure** • **The Golden Thread of Follow-Up: Communicating Early Intervention Strategies in the Community**
11:40 - 12:50 PM	**Parallel Session 2 : Innovation & Zero Separation** • **Respectful maternity care (RMC): Bridging clinical excellence and patient dignity in the delivery suite** • **Maternal mental health in the perinatal period: Screening, Stigma, and Nursing role** • **Preconception Nutrition and NCD management in the community** • **The triad of crisis in the NICU : Communicate, Document, Debrief** • **Family Integrated Care (FiCare): Empowering parents as primary caregivers** • **Evidence-Based feeding strategies for Preterm and LBW neonates**
12:50 - 1:50 PM	**Lunch**
2:00 - 4:30 PM	**Practical Workshops: UNICEF Priority Skills** **Neonatal:** **Station 1:** Preterm Stabilization **Station 2:** KMC & Safe Transport: Practical "KMC Wrap" Techniques and S.T.A.B.L.E. Transport Protocols **Station 3:** NICU Stabilization and Golden Hour Practice **Obstetric:** **Station 1:** Practical Skill The "Beyond Survival" Focus Management of PPH; uterine tamponde and proper application of Bukri balloon, Preventing the long-term sequelae of PPH **Station 2:** Shoulder Dystocia (McRoberts and Other maneuvers) Minimizing neonatal birth injury (Brachial Plexus) and maternal psychological trauma **Station 3:** Eclampsia Drill, Management of hypertension, Correct preparation and administration of the "Loading Dose" and maintenance of MgSO4, Preventing neurological damage and ensuring maternal safety Station: **Community Medicine :** **Station 1:** Home-Based Newborn Care Counseling on "Early Warning Signs" **Station 2:** Breast feeding, Positioning and Attachment **Station 3:** Perinatal Depression Screening tools and communication
4.30 PM Onwards	**Concluding Ceremony** • **Presentation of UNICEF Awards** for Best Research in Neonatal Quality Improvement • **Distribution of Certificates of Participation** (Recognized for CPD Credits) • **Closing Remarks s Vote of Thanks** (Secretary, PSSL) • **Pledge of Commitment:** Towards Zero Preventable Maternal and Newborn Deaths

Perinatal Society of Sri Lanka

FOUNDED 2001

Towards healthier mothers and newborns

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
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