

Singapore SLEEP REVIEW

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SINGAPORE SLEEP SOCIETY NEWSLETTER



SSS NEWS

This issue introduces a refreshed layout that reflects a shift in our editorial mission: to highlight the diverse professions within our membership, bringing together researchers and clinicians, private practice and institution, and building collaborative bridges across disciplines. Beyond these pages, we hope to foster a greater sense of community and belonging within the Society – a place where members recognise one another's work, find common ground, and are prompted to reach out across the divides of specialty and setting.

This issue also marks the official handover of editorial duties, and I am honoured to guide our publication into its next chapter. On behalf of the Society, I want to thank our outgoing editor, Dr Stijn Massar, for his dedication and stewardship of this newsletter, since its inception in 2019.

We share recent updates on local research as well as introduce a new section "*In conversation with...*" where we interview fellow colleagues in the sleep field to gain valuable insights which will serve to strengthen communication and collaboration in interdisciplinary care.

All members are warmly invited to contribute insights, case studies, and research findings for our upcoming issues, and to take an active part in the life of the Society. Every new voice adds to the conversation.

Dr Elaine Ng
Editor

SAVE THE DATE

10-13 SEP ASSM 2026
interim meeting

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In Conversation With...

a Polysomnographic Technologist

We sat down with Mr Hairul Bin Borhan, RPSGT, the principal medical technologist at the Sleep Lab Department of Medicine, National University Hospital, to understand why good communication and the human touch are keys to successful sleep testing.

Getting acquainted

How did you end up in sleep – deliberate choice, or happy accident?

"I was initially trained in microbiology during my varsity days studying in NUS. Prior to joining the sleep medicine field, I spent some time deep in the trenches of the pathology lab. As fate would have it, I was later offered a job as a med tech in the sleep medicine field. My whole job experience was turned upside down – from dealing only with lab specimens, to having direct patient contact."

What's the biggest misconception about your job?

"At festive gatherings we often get asked, what do you do for a living? My reply 'I work in the sleep lab', will be met with an incredulous stare, followed by 'oh you watch people sleep ah?'."

The reality is, we are constantly monitoring signals, troubleshooting artifacts, reapplying electrodes, managing anxious patients, and documenting events in real time. It's clinical care, tech support and customer service rolled into one."

There's irony in shift workers running a sleep service. What does night work cost, and what helps?

"The cost for us, is disrupted circadian rhythm, weight gain, social impact, fatigue. What would help is a shorter work week. One good point about shift work, is that you have opportunity to take care of your banking and shopping needs during off peak periods, but at the expense of your sleep."

Preparing the patient

Take us through the hour before the first patient arrives. What goes on that referrers never see?

"We work non-stop the moment we step into the lab at 8pm. We are racing against time constantly, so that the start of test will not get delayed. Admin work will be top on our list, reviewing the doctors' orders, and assigning patients to the correct rooms. Prepping sensors, laying out trolleys and ensuring that PSG amplifiers can connect to the computer. To me this is the most stressful part, because if the computer is unable to detect the headbox for whatever reason – all hell will break loose. Especially when PSG equipment are required to connect to the hospital network as part of IT security measures."

Describe the perfect referral. What's in it, and how does it benefit both patient and technologist?

"The perfect referral includes clear orders – meaning no ambiguous orders with the relevant patient history, and previous studies if any."

What is something in your routine that often affect the success of the test?

"Reassuring patients that everything will be fine. Our mantra for them will be 'no pain, no injection, just sleep'. For patients undergoing CPAP titrations, they may need further reassuring and extra steps to calm them down, to prevent claustrophobia and panic attacks. These are issues that usually never make it into the final report."

Cognitive impairment, sensory issues, anxiety, claustrophobia – in these situations what helps the sleep study run smoothly?

"This is the human factor, which clinical workflow sometimes doesn't take into account. We allow the caregiver to stay with the patient, especially for elderly patients or those with special needs. Their presence might help to calm them down. Extra time may need to be spent for desensitization with equipment, and clear communication in a soothing calm voice. Knowing this in advance lets us plan a successful night instead of reacting in crisis."

Building bridges with clinicians and researchers

What would researchers gain by bringing technologists in at the design stage?

"Intimacy and familiarity. Basically we know best what can work in sleep testing, and what cannot. If we're involved early, studies get better recruitment, better data quality, and fewer protocol amendments later."

What have clinicians taught you that changed the way you work? And what is one small change referring clinicians could make tomorrow?

"That the 'why' behind the referral matters. Knowing what question the doctor is trying to answer helps me to focus the monitoring and notes, not just collect data. Referring clinicians can help by including 2 lines in the referral: 'key question to answer' and 'any patient-specific challenges.' That alone would improve setup and study quality."

Finish this sentence: "The night goes well when..."

"...the patient feels safe, the team is prepared, and we wake up knowing the data will actually help answer the clinician's question."



Singapore cephalometric airway norms for paediatric SDB risk screening

Reference: Chee SYC, Koh LH, Foong KWC, Lai CWM, Sim YF, Yow M. (2026) Paediatric Sleep-Disordered Breathing: Pharyngeal Airway and Lymphoid Tissues in Risk Assessment. *Journal of Clinical Medicine*. <https://doi.org/10.3390/jcm15134991>

Paediatric sleep-disordered breathing (SDB) is estimated to affect 0.7–5.7% of children globally. There are indications that risk factors in Asian population might be related to craniofacial anatomy in addition to body weight. Yet in routine care, many children with anatomical risk factors are first seen in orthodontic and dental settings, where lateral cephalograms are already part of standard work-up.

This paper analysed lateral encephalograms taken from 404 dental paediatric patients taken for routine orthodontic diagnosis (2018–2023) at the National Dental Centre Singapore (NDCS), comprising one of the largest Singapore datasets of its kind. Importantly, the authors establish population-specific “norms” for upper airway, soft palate, hyoid position, and craniofacial variables in this real-world orthodontic population, rather than relying on overseas reference values that may not generalise well to local patients.

A total of 404 children aged 7–11 years were included (203 boys, 201 girls). The sample was predominantly Chinese (87.6%), with 55.0% classified as antero-posterior Class I, 11.1% Class II, and 33.9% Class III; vertically, 71.8% were average-angle, 15.1% high-angle, and 13.1% low-angle. Across the cohort, a very high proportion met cephalometric ratio thresholds for lymphoid tissue enlargement: 92.3% had adenoid and/or tonsillar hypertrophy, comprising combined adenotonsillar hypertrophy (49.5%), isolated tonsillar hypertrophy (36.6%), and isolated adenoid hypertrophy (6.2%), while 7.7% were classified as non-hypertrophied.

Airway measures differed by age and sex, with more pronounced sex differences in the older (9–10.99 years) group. Girls generally showed larger airway dimensions at the tonsillar and uvula levels, larger minimum airway space, and greater hypopharyngeal airway depth, alongside a more superior (and in some analyses more anterior) hyoid position compared with boys. Age effects were present but less extensive than sex effects: younger boys showed greater adenoid size/Ad:Np ratio and a more superior hyoid position than older boys, while older girls showed larger hypopharyngeal airway depth and a more anterior/inferior hyoid position compared with younger girls. Craniofacial pattern was associated with airway morphology. By antero-posterior classification, Class III children tended to demonstrate larger nasopharyngeal width and larger tonsillar-level oropharyngeal width, together with smaller soft palate inclination and shorter soft palate length compared with Class I/II.

By vertical pattern, low-angle children showed less adenoid hypertrophy (lower Ad/Np) than average- and high-angle groups, and differed from high-angle children in hyoid position and some adenoid-related measures. Between ethnic groups, one airway variable differed: non-Chinese children showed a more anteriorly positioned hyoid than Chinese children, although the non-Chinese subgroup was small and heterogeneous, limiting interpretation.

Take-home message

This study provided Singapore-specific cephalometric reference values for upper airway and related craniofacial structures in 7–11-year-old orthodontic patients, and show that airway measures and adeno-tonsillar proportions vary meaningfully by age, sex, and skeletal pattern. The work supports using routinely obtained lateral cephalograms as a screening adjunct to flag children with anatomical features associated with higher SDB vulnerability.

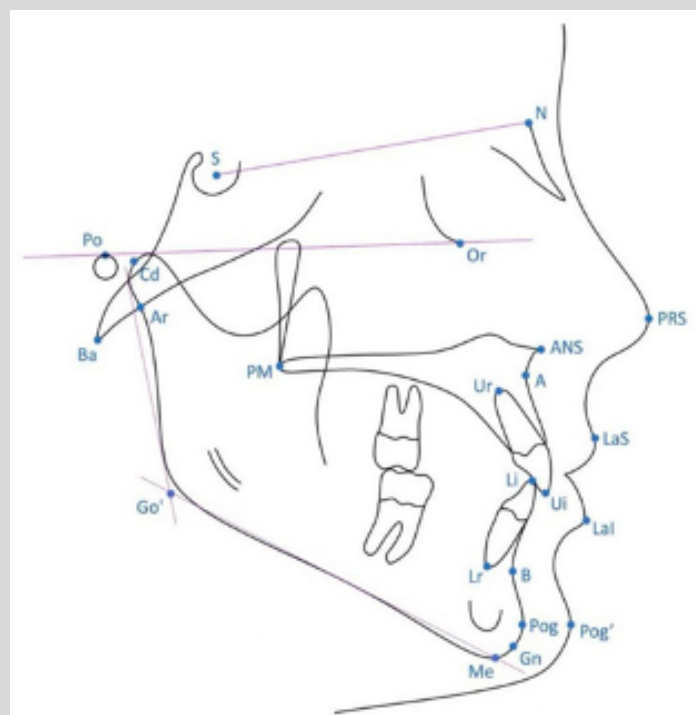
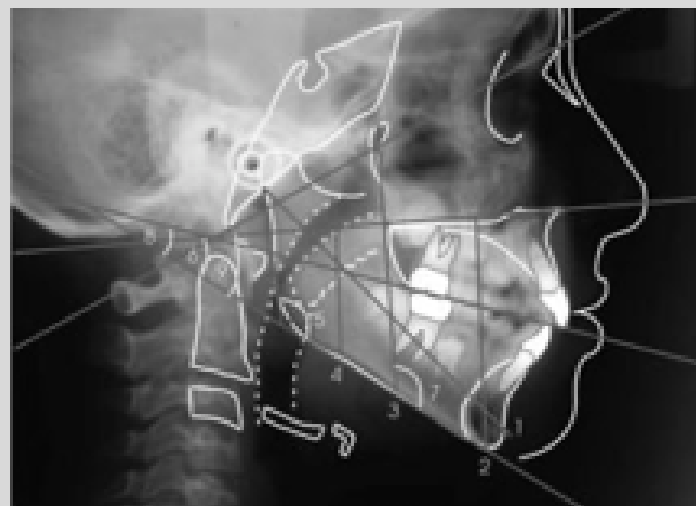


Figure 1. Skeletal, dental, and soft tissue cephalometric landmarks. Definitions of labelled points are provided in the [Supplementary Materials](#).

Sleep health within the family system : three Singapore studies across the life course

Sleep professionals are often consulted at the point where a sleep complaint has become disruptive—poor child sleep, exhausted households, older adults losing function. Three recent Singapore papers argue, in different ways, that sleep health is best understood when placed within broader lifestyle patterns and the routines that sustain them. Read together, Lin (early childhood), Mahirah (family health climates), and Teng (older adults) support a life-course message that sleep health is shaped by lifestyle and family structures rather than being an isolated symptom.

Early childhood sleep in Singapore: practices, guideline awareness, and modifiable targets for clinical counselling

Reference: Lin W, Chiong YK, Liu M, Shah MAT, Yuen WY, Lee YS, Tardif T. (2026) Early childhood sleep practices, patterns, and awareness of guidelines in Singaporean parents and children. Sleep Medicine 145:109015. <https://doi.org/10.1016/j.sleep.2026.109015>

Adequate sleep in early childhood supports neurocognitive development, emotional regulation, and physical health. Yet, in modern-day society, sleep is often constrained by late bedtimes, inconsistent routines, and parental fatigue. A recent study provides contemporary data on sleep patterns and bedtime practices among young children in Singapore, alongside parental awareness of age-appropriate sleep guidelines. This multi-centre cross-sectional study surveyed 500 parent-child dyads recruited from healthcare clinics in Singapore. Children ranged from



newborn to 6 years (pre-school), and parents reported child sleep timing and duration, night awakenings, settling practices, parental sleep duration, and awareness of recommended sleep durations.

Children's sleep was generally described as being at the lower end of recommended ranges. A clinically meaningful minority did not achieve minimum recommended sleep durations, including 24.5% of infants aged 6–12 months (<14h) and 10.8% of toddlers aged 1–2 years (<11h). Parental sleep duration was also short. Across age groups, a large proportion of parents did not meet minimum recommended sleep (<7h), with the greatest shortfall observed among parents of infants under 6 months (average <6h).

Bedtime timing and routines appeared to be important behavioural correlates. Only about half of children were asleep by 9 pm, and a substantial proportion of families reported inconsistent bedtime routines. Most parents used settling strategies that do not promote independent sleep onset: only ~11% of children were put to sleep independently, while active parental involvement at sleep onset (e.g., holding, rocking, patting) was common, particularly in younger children. Parental awareness of child sleep guidelines was limited. Fewer than half of parents reported being aware of recommended sleep durations, and overall only about one-third both reported awareness and provided estimates consistent with minimum age-appropriate recommendations. Importantly, parents' awareness of recommended practices was associated with children's sleep duration, such that lower awareness, later bedtimes, and fostering dependent sleep practices were associated with children's shorter sleep duration.

Take-home message

This study reinforces that sleep health promotion in Singaporean families can be strengthened. A pragmatic counselling focus for primary care and paediatric practice could include: (1) prioritise bedtime timing as a high-yield target, (2) promote consistent routines, and (3) correct misconceptions about sleep needs, particularly in infancy and early toddlerhood.

Family health climates as archetypes for nutrition, activity—and sleep quality

Reference: Mahirah D, Ho Y-CL, Chia ZH, Chew MS-L, Koh XH, Lim J-J, Thumboo J, Doshi K. Archetypes of Family Health Climates for Nutrition and Physical Activity Among Families in Singapore: A Cross-Sectional Study. Healthcare. 2026; 14(5):669. <https://doi.org/10.3390/healthcare14050669>

A paper by Mahirah and colleagues describes how health behaviours cluster in families are shaped by environmental factors. Using data from 200 cohabiting family dyads (400 individuals) in Singapore, the authors assessed “family health climate” looking at health domains such as nutrition and physical activity, together with other individual and lifestyle factors. Similarities in these family health climates were used to identify clusters with similar health profiles, family archetypes, which were examined for associations with household demographics, family routines, individual behaviours (including leisure physical activity and diet quality), and sleep quality measured by the Pittsburgh Sleep Quality Index (PSQI).

The analysis arrived at four archetypes. Sixteen percent of families could be described as having low health climate for both nutrition and activity, associated with less favourable routines and lower socioeconomic indicators (Survivors). Another 16% of families had stronger nutrition habits, but scored worse in physical activity (Nourished Sedentary). The largest group was comprised of families that scored moderate on both domains (41%, Satisficers). A last group (17%, Flourishers) was characterised by healthy food choices, frequent family meals, high physical activity scores, and higher social economic status. More supportive family health climates also aligned with healthier sleep scores. An interesting insight is the finding that communication about nutrition was one of the strongest discriminators between clusters.



For clinicians, this is a reminder that “behaviour change” is often mediated by communication and shared norms within the family.

The archetype approach has practical value for intervention planning. Survivors may benefit most from low-burden, high-feasibility changes and structural supports (e.g., simplified routines, realistic targets, community resources). Nourished Sedentary families may respond well to activity-oriented strategies without needing major dietary intervention. Satisficers may need minimal scaffolding to move from “adequate” to more consistent routines. Flourishers may already have strong routines; the clinical role may be focused on maintenance and early detection of changes (e.g., when a new baby arrives or caregiving responsibilities increase).

Take-home message

Sleep health is not merely a matter of individual habits and planning. It often reflects a household’s constraints and routines. Framing sleep improvement as a family systems issue can increase engagement, improve adherence. In practice, health improvement efforts (including sleep) may fail not because the plan is physiologically unsound, but because the household cannot coordinate it: inconsistent bedtime boundaries, disagreement between caregivers, or a lack of shared expectations.

Lifestyle profiles and intrinsic capacity in older adults—placing sleep within functional reserve

Reference: Teng Jun Wei J, Khoo SS, Merchant RA, Tan LF, Jia L, on behalf of the Health District @ Queenstown. Association Between Healthy Lifestyle Habits and Intrinsic Capacity Among Community-Dwelling Older Adults in Singapore. Nutrients. 2026; 18(6):918. <https://doi.org/10.3390/nu18060918>

Teng and colleagues examine sleep as one component of healthy aging within the WHO concept of intrinsic capacity (IC, a composite of physical and mental capacities that underpins function and independence. Using data from 1,644 community-dwelling older adults in Singapore (aged ≥60) in the Queenstown health district cohort, the authors analysed the association between a Healthy Lifestyle Score (HLS) and the presence of one or more intrinsic capacity deficits.



The HLS comprised five behaviours: non-smoking, low-frequency alcohol use, adequate physical activity, sufficient sleep duration (≥ 7 hours/night), and healthy BMI (Asian cut-offs). Intrinsic capacity was assessed using a modified WHO ICOPE screening covering cognition, vitality, locomotion, sensory domains, and psychological wellbeing. Roughly half of the cohort had at least one IC deficit, and only a minority met recommended physical activity levels, highlighting the scale of modifiable risk in the community. When stratified by lifestyle score categories, participants in the healthiest lifestyle group were more likely to have no IC deficits than in intermediate or unhealthy groups. Here, sleep is not treated as an isolated symptom but as part of a behavioural bundle that influences function. In the multivariable model, insufficient sleep showed a strong independent association with IC deficits, second only to physical inactivity. This is consistent with clinical observations that sleep impacts multiple domains relevant to intrinsic capacity: energy, mood, cognitive performance, and motivation for activity. It also supports a practical point for aging care: sleep optimisation is not only about sleep outcomes, it may influence the trajectory toward frailty, falls risk, and

dependence by affecting multiple upstream capacities.

Take-home message

These findings align with preventive health strategies by framing function (intrinsic capacity) as the target, not only disease diagnosis. Sleep duration is a simple measure that can be incorporated into routine screening alongside activity and weight. Research findings support placing sleep within integrated healthy aging programs, rather than treating it as an optional add-on.



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Sleep Technology - AI Wearable

Henry Cheng International Conference Centre
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Date: 10 Sept 2026

Time: 2pm – 6pm

Target Audience

Clinicians, medical practitioners,
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Half-day workshop
Conducted in English

Programme Highlights

- AI Wearables for Personalized Sleep Health and Sleep Disorder Screening
- Transforming Sleep Health: Innovations in Commercial Wearables
- Wearable and Multimodal AI for Sleep and Mood Detection
- Multimodal AI applications for behavioral phenotyping in neuropsychiatric disorder
- Wearable and Smartphone digital biomarkers for REM sleep behavior disorder

Speakers

Dr. Jae Kyoung KIM
Associate Professor, KAIST
Chief Investigator, IBS

Dr. Stijn Agus Adrianus MASSAR
Research Assistant Professor, NUS

Dr. Man Ho Tim LI
Assistant Professor,
Department of Psychiatry, CUHK

Dr. Lizhou Leo FAN
Vice-Chancellor Assistant Professor,
Department of Psychiatry, CUHK

Dr. Bei Joanne HUANG
Assistant Professor,
Department of Psychiatry, CUHK

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Presented by Philips Sleep & Respiratory Care, ASEAN

Learning
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Patients who do not fit the textbook OSA profile Asian phenotypes, and Singapore's case-finding gap

AS TAR THANT

RPSGT
Clinical Manager,
Philips Sleep & Respiratory Care ASEAN

A forty-seven-year-old man comes in with difficult-to-control high blood pressure. His BMI is 24.8. His wife does not report snoring. No one has seen him stop breathing at night. He does not say that he feels sleepy in the day. Based on the Western training he received, he does not seem like a patient with obstructive sleep apnea. In Singapore, he very likely is. Yet the screening tool on our intake form is unlikely to pick him up. This is the quiet side of our sleep apnea problem. Obstructive sleep apnea is common here. A meaningful share of it stays invisible because we rely on screening tools built for other populations.

A large denominator, mostly unmeasured

A community study in Singapore found that 30.5% of adults have moderate-to-severe obstructive sleep apnea (OSA)¹, with an apnea-hypopnea index (AHI) of at least 15 events per hour¹. What should concern us more is the second number that comes with it: most moderate to severe cases go undiagnosed. Even if we cannot pin down the exact proportion, we know the situation is serious. The real clinical problem is the gap between how common the condition is and how often it is diagnosed.

Why the phenotype runs differently here

Most of us learn that obesity and OSA are closely linked, and in many groups that is true. But when Lee, Sutherland, Cistulli and their colleagues compared Chinese and Caucasian patients with similar OSA severity, they found something different. Caucasian patients were, on average, heavier, with a body mass index (BMI) of 30.7 compared with 28.4. Chinese patients had more restriction in their facial bones and a narrower, more crowded upper airway. In them, this anatomical narrowing played the role that excess fat plays in other patients. That single finding explains much of what sleep physicians in Singapore already notice in daily practice. Some patients seem low risk when we look only at the numbers, yet they still have OSA. Anatomical crowding does not always show itself as clearly as obesity does. It may appear as a small or set-back lower jaw, a high arched palate, a Mallampati III or IV airway, crowded teeth, or a history of teeth removed during orthodontic treatment.

Where the screening tools drift

STOP-BANG remains a reasonable first pass. However, two of its eight items, BMI

over 35 and neck circumference over 40 cm were derived in populations that are, on average, considerably heavier than ours. Singapore's health authorities already use lower BMI action points for cardiometabolic risk (23.0–27.4 kg/m² as moderate risk, 27.5 and above as high risk). This is an acknowledgment that Asian body composition carries risk at lower thresholds. Researchers have proposed adjusted neck circumference cut-offs for Asian cohorts for the same reason. None of this means we should abandon STOP-BANG. It means we should read it for what it is: a triage tool calibrated elsewhere, not a rule-out test here. A low score in a patient with a crowded airway and significant comorbidities is not reassuring. It is a screening tool used outside its calibration range.

What to look for instead

A practical way forward is to guide clinical suspicion by physical features and related illnesses, not by body type alone. On examination, look beyond weight. Notice a receding chin, a high or narrow palate, a high Mallampati score², crowded teeth, and how well the nose passes air. A blocked nose forces mouth breathing and can make the airway more likely to collapse.

On history, pay attention to patterns that do not fit the surface picture. Look for high blood pressure that stays raised despite three or more medicines. Ask about irregular heart rhythms at night or early in the morning. Note type 2 diabetes that remains poorly controlled even when the person takes medicines as prescribed. Morning headaches and depression that does not improve with treatment can also signal possible sleep apnea. Each of these features is a strong reason to screen for sleep apnea, even when BMI and neck size seem normal.

A note for the sleep lab

This is not a formal guideline. No society has issued a graded checklist for this. Each item below comes from the evidence we discussed above. Some items come from studies in Asian patients. You can add all of them to the intake form at no extra cost.

- Record the Mallampati grade at intake as a direct marker of craniofacial restriction, instead of inferring it later.
- Measure neck circumference at the cricothyroid membrane, using cut-offs of 40 cm for men and 35 cm for women.
- Take a detailed positional history and note nasal patency, since supine-predominant OSA and mouth breathing both increase airway collapsibility.
- Note dental arch shape and crowding on physical exam, and do not rely solely on a history of orthodontic extractions as an OSA risk marker.
- Use these findings to enrich the report for the referring physician, explaining why the patient has their AHI and supporting phenotype-driven care.

Three takeaways

- First, moderate-to-severe OSA affects roughly a third of adults in Singapore, and many of those cases are believed to be undiagnosed.
- Second, Asian-phenotype OSA is more often craniofacial than obesity-driven; screen the airway and the comorbidities, not just the BMI.
- Third, STOP-BANG and similar tools were designed and tested mainly in other populations. In a high risk patient, a low risk score may reflect the limits of the tool, not true safety. Stay guided by the patient's risk, not just number.

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SLEEP CONFERENCE CALENDAR

2026

10-13 SEP ASSM 2026 The interim meeting of the Asian Society of Sleep Medicine (ASSM)
Hong Kong SAR
<https://www.assm2026-hk.com/>

20-23 OCT Sleep Europe 2026 The 28th Congress of the European Sleep Research
Society, Maastricht, the Netherlands
<https://esrs.eu/event/sleep-europe-2026/>

11-14 NOV Sleep Down Under 2026 The Annual meeting of the Australasian Sleep
Association, Brisbane, Australia
<https://www.sleep.org.au/Public/Public/Events/SDU2026.aspx>

2027

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