

areas. A medical officer of the mental health training programme has allowed appointment of trained non-specialists to rural clinics. The undergraduate medical programme provides mental health training for all its doctors. Undergraduates in three of the six medical faculties undergo intensive 2-month training in psychiatry and it is examined as a final-year subject.

Rather than being a failure, Sri Lanka provides a model of psychiatric care for low-income and middle-income countries.

Both authors are consultant psychiatrists working in Sri Lanka and members of the Board of Study of the Postgraduate Institute of Medicine, University of Colombo, which is responsible for postgraduate psychiatry training. They are senior lecturers in Psychiatry in the Faculty of Medicine, Colombo.

**Varuni de Silva, Raveen Hanwella*
varunidesilva2@yahoo.co.uk

Department of Psychological Medicine, Faculty of Medicine, Colombo, Sri Lanka

- 1 Siva N. Sri Lanka struggles with mental health burden. *Lancet* 2010; **375**: 880–81.

The World Report “Sri Lanka struggles with mental health burden”¹ focuses on mental health problems faced by this country emerging from long-term civil conflict and political violence, but fails to note the efforts being made by local people, often working under adverse circumstances, in providing support for people affected by conflict and building up an infrastructure for mental health services.

For example, substantial progress has been made in delivering services to internally displaced populations in eastern Sri Lanka during the past 2 years. Training of mental health professionals—not necessarily doctors—is being expanded. Efforts are being made in capacity building and knowledge transfer in mental health, led by local institutions such as the National Institute of Mental Health and the local non-governmental organisation the People’s Rural Development Association, in partnership with Canada² and other countries. And there seems to be a new mood in the country to face up to many years of neglect of mental health.

Articles presenting purely negative facts do a disservice to valuable initiatives underway by local people struggling with scarce resources. We hope that *The Lancet* will sustain efforts to provide a more balanced picture while reporting on countries undergoing complex emergencies in the future.

We declare that we have no conflicts of interest.

**Suman Fernando, Duncan Pedersen, Chamindra Weerackody*
sumanfernando@btinternet.com

University of Kent, Canterbury CT2 7NZ, UK (SF); Douglas Institute, McGill University, Montreal, QC, Canada (DP); and People’s Rural Development Association, Colombo, Sri Lanka (CW)

- 1 Siva N. Sri Lanka struggles with mental health burden. *Lancet* 2010; **375**: 880–81.
- 2 McGill University. Trauma and global health program. <http://www.mcgill.ca/trauma-globalhealth> (accessed May 25, 2010).

Causes of death in children younger than 5 years in China in 2008

Igor Rudan and colleagues (March 27, p 1083)¹ describe striking improvements in child survival in China since 1990 (ie, the period covered by Millennium Development Goal 4 [MDG 4]). Some caution is warranted when interpreting this paper.

To arrive at their estimates, Rudan and colleagues used cause of death data from 206 “high-quality” studies of child mortality and applied these to official mortality data. Given the widespread perception of epidemiology in China, and in Asia in general, as being weak, the statement that Rudan and colleagues found 206 high-quality mortality studies from China is in itself surprising. Furthermore, the reader cannot assess the quality of the official data sources. The official data at the national level come from a surveillance system in 5% of the administrative units in China. The authorities selected the surveillance sites to be nationally representative, but we do not know how this selection was undertaken.

The paper reports an astonishing 48% reduction in child mortality in just 5 years between 2002 and 2007, and, according to figure 2, a 66% reduction in pneumonia-specific mortality rates (from about 9.4 to 3.2 per 1000). Rudan and colleagues ascribe this success not to a major national campaign to control pneumonia (since there was no such campaign), but to improved socio-economic circumstances. However, the most dramatic improvement in pneumonia mortality rates that has been described in association with improved living conditions was in the USA, where between 1900 and 1940 pneumonia-specific mortality fell by 65%, but this was over a 40-year period.² Moreover, most child deaths, and most pneumonia deaths, occur in poor rural communities, which have been largely excluded by China’s economic boom.

Although we welcome analyses of Chinese data, the results presented in this paper are not plausible, and as such should not form the basis of a major revision of Global Burden of Disease estimates.

We declare that we have no conflicts of interest.

**Kim Mulholland, Beth Temple*
kim.mulholland@lshtm.ac.uk

London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK (KM); and Menzies School of Health Research, Casuarina, NT, Australia (BT)

- 1 Rudan I, Chan KY, Zhang JSF, et al. Causes of deaths in children younger than 5 years in China in 2008. *Lancet* 2010; **375**: 1083–89.
- 2 Scott JA, Brooks WA, Peiris JS, Holtzman D, Mulholland EK. Pneumonia research to reduce childhood mortality in the developing world. *J Clin Invest* 2008; **118**: 1291–300.

Authors’ reply

Kim Mulholland and Beth Temple’s main argument is that the reported rate of child mortality reduction (and particularly of childhood pneumonia) is implausible because nothing similar to the reported level of progress has been seen before. They also mention general concerns over the quality of the statistics from this part of Asia.

We used data from 206 studies to establish the relation between child mortality rates and proportional



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mortality from childhood pneumonia and seven other main causes of child death. If these studies were of a questionable quality, the predictive power of these models would be poor. However, a high R^2 (0.58) implies a strong (and plausible) relation between child mortality and proportional mortality from pneumonia. Appendix 4 in our paper shows beyond doubt that pneumonia steeply declines as a proportional cause of death when child mortality declines, with narrow confidence intervals.

The most recent global estimates of child mortality for 2008,¹ which are based on the best available multicausal evidence from all countries, also show a steep rate of decline in pneumonia mortality relative to change in mortality rate for children younger than 5 years during the same period and so does the forthcoming global single-cause model.

Furthermore, our Chinese colleagues cross-validated our cause-specific estimates against the most recent output from the Chinese Maternal and Child Surveillance system (MCMS), which is nationally representative but not in the public domain. They found that the differences between directly observed causes of death within MCMS and our modelled estimates were within 2% of each other for all eight major causes of death in 2008, which directly confirmed the validity of our cause-specific predictions for 2008. Therefore, we believe that the estimates of proportional causes of death in our paper should be considered reliable and that the rapid decline in pneumonia mortality in China can be largely explained by a rapid decline in the overall mortality rate in children younger than 5 years.

The remaining question is whether we can trust the Chinese MCMS, which was the source of the reported declining overall mortality trend. We spent time in China with the local experts studying the quality of MCMS.

We can confirm that the changes in MCMS, which we explained in our webappendix, have considerably improved the quality of this registry. Its national representativeness, quality-control protocols, and checks for under-reporting make it substantially more reliable than the routine reporting system that was in place previously.

The reported progress in reduction of the mortality rate for children younger than 5 years might seem spectacular, but there are several unique reasons why this should perhaps be expected. China has addressed child mortality through careful central planning and the co-ordinated, massive improvement in social determinants of child survival, near-universal primary health care, expanded vaccination coverage, economic growth, infrastructure development, health-systems building, integration of minority populations, maternal education, improved sanitation, and the introduction of the "one child" policy. It would not come as a surprise if all these parallel positive developments have led to unprecedented levels of reduction in child mortality in a multiplicative, rather than additive, way.

We declare that we have no conflicts of interest.

**Igor Rudan, Kit Yee Chan, Jian Shayne F Zhang, Evropi Theodoratou, Yan Guo, Harry Campbell*
irudan@hotmail.com

Centre for Population Health Sciences, University of Edinburgh Medical School, Edinburgh, UK (IR, ET, HC); Nossal Institute for Global Health, University of Melbourne, Melbourne, VIC, Australia (KYC, JSFZ); and School of Public Health, Peking University, Beijing, China (YG)

- 1 Black RE, Cousens S, Johnson HL, et al, for the Child Health Epidemiology Reference Group of WHO and UNICEF. Global, regional, and national causes of child mortality in 2008: a systematic analysis. *Lancet* 2010; **375**: 1969–87.

Department of Error

International Carotid Stenting Study investigators. Carotid artery stenting compared with endarterectomy in patients with symptomatic carotid stenosis (International Carotid Stenting Study): an interim analysis of a randomised controlled trial. Lancet 2010; 375: 985–97—In this Article (March 20), in the list of International Carotid Stenting Study investigators (pp 995–96) H-C Nasser's name should have been spelt "H-C Nahser".

Triglyceride Coronary Disease Genetics Consortium and Emerging Risk Factors Collaboration. Triglyceride-mediated pathways and coronary disease: collaborative analysis of 101 studies. Lancet 2010; 375: 1634–39—In this Article (May 8), JJ Kastelein should have been listed as a member of the Triglyceride Coronary Disease Genetics Consortium investigators for Bloodomics.

Vaidya JS, Joseph DJ, Tobias JS, et al. Targeted intraoperative radiotherapy versus whole breast radiotherapy for breast cancer (TARGIT-A trial): an international, prospective, randomised, non-inferiority phase 3 trial. Lancet 2010; 376: 91–102—In this Article (published online June 5), "Ninewells Cancer Campaign" should have been listed in the Funding section of the Summary and in the list of funders in the Acknowledgments section. Additionally, in the list of TARGIT-A team members, R Choudhury should have been spelt "R Chaudhuri". These corrections have been made to the online version as of July 9, 2010, and also to the printed Article.