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.

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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 Canada[2] 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.

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

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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