Mental health in Sri Lanka

Article *in* The Lancet · July 2010

DOI: 10.1016/S0140-6736(10)61072-0 · Source: PubMed

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obligation to avoid delay of diagnosis and management of this rare disorder.

We declare that we have no conflicts of interest.

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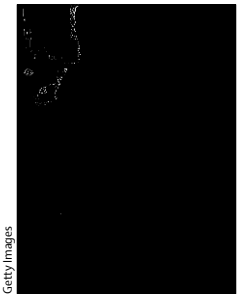
1 Wilson DR, D'Souza L, Sarkar N, Newton M, Hammond C. New-onset diabetes and ketoacidosis with atypical antipsychotics. *Schizophr Res* 2003; **59:** 1–6.

Treatment of HIV infection with drugs for HSV-2 infection



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In their Comment (March 6, p 782)[1] accompanying the study by Lingappa and colleagues,[2] Anne Buvé and Lutgarde Lynen suggest that aciclovir be given to HIV-positive individuals in resource-poor countries as part of a "care package" aimed at slowing disease progression. Indeed, the study shows a reduced risk of HIV-1 disease progression with aciclovir, but its effect is disappointingly modest at 16% over 24 months.

This reduction would have to be matched by the advantages of minimal cost, negligible side-effects, and facility of administration for treatment implementation to be justifiable. Unfortunately, aciclovir carries none of these advantages: it would require the same costly infrastructure required by potent antiretroviral therapy (ART) (clinics, training of medical personnel) and must be taken twice daily long-term, while its cost is similar to that of potent antiretroviral regimens currently used in Africa;[3] meanwhile, it is known to cause blood dyscrasias and other potentially serious side-effects.[4]

Equally importantly, the long-term effects of aciclovir on HIV resistance remain poorly defined. In particular, McMahon and colleagues[5] showed the emergence of the reverse transcriptase mutant variation V75I in 92% of in-vitro viral populations within 3 months of selective pressure of aciclovir. Genotype analyses were not available in Lingappa and colleagues' study.

Efforts to slow HIV disease progression in all populations should never cease. But why not concentrate resources on ensuring equitable access to antiretrovirals for all those in whom treatment is indicated, since potent ART is by far the best studied and most efficient approach to reducing HIV-related morbidity, mortality, and transmission?

We declare that we have no conflicts of interest.

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1 Buvé A, Lynen L. Treating HIV infection with drugs for HSV-2 infection? *Lancet* 2010; **375:** 782–84.
2 Lingappa JR, Baeten JM, Wald A, et al. Daily aciclovir for HIV-1 disease progression in people dually infected with HIV-1 and herpes simplex virus type 2: a randomised placebo-controlled trial. *Lancet* 2010; **375:** 824–33.
3 Médecins sans Frontières. Untangling the web of antiretroviral price reductions, 12th edition. http://www.msfaccess.org/fileadmin/user_upload/diseases/hiv-aids/Untangling_the_Web/UntanglingtheWeb12_prepublicationpriceanalysis_July09pdf.pdf (accessed March 18, 2010).
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5 McMahon MA, Siciliano JD, Lai J, et al. The antiherpetic drug acyclovir inhibits HIV replication and selects the V75I reverse transcriptase multidrug resistance mutation. *J Biol Chem* 2008; **283:** 31289–93.

Authors' reply

We do not think there is disagreement between our point of view, as expressed in the Comment, and the one expressed by Angela Huttner and Alexandra Calmy. We agree that suppressive therapy with aciclovir cannot (yet) be recommended as a strategy to slow down disease progression in HIV-infected patients in low-resource settings. We expressed a lot of caution, as did Lingappa and co-workers,[1] and we suggested that cost-effectiveness studies be done.

The effect of suppressive therapy with aciclovir is indeed modest and implementation of a strategy of continuous treatment with aciclovir might be too costly and too difficult in relation to the expected benefits. Huttner and Calmy give a few reasons why suppressive therapy with aciclovir might not be cost effective, but a more systematic analysis of benefits, costs, and feasibility is needed.

We declare that we have no conflicts of interest.

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1 Lingappa JR, Baeten JM, Wald A, et al. Daily aciclovir for HIV-1 disease progression in people dually infected with HIV-1 and herpes simplex virus type 2: a randomised placebo-controlled trial. *Lancet* 2010; **375:** 824–33.

Mental health in Sri Lanka

In her World Report (March 13, p 880),[1] Nayannah Siva highlights some deficiencies in mental health care in Sri Lanka, but ignores the tremendous scaling up of mental health services over the past few years.

Sri Lanka has a free national health service but the main reason for the inadequate mental health care was the shortage of mental health specialists. The State trains adequate numbers of psychiatrists (88 in 2002–09) but many have migrated to high-income countries. Without a critical mass of advocates, scaling up services becomes a difficult task. However, the dedication of psychiatrists remaining in the country has achieved much. The Mental Health Act of 1873 has been redrafted and a National Mental Health Policy adopted. A National Mental Health Survey has been completed and data for prevalence of most common mental disorders are available.

Psychiatrists' numbers have increased and currently 22 of the 25 administrative districts have a psychiatrist providing care. To cope with the shortage of psychiatrists, a 1-year diploma course was started in 2008 and those who qualified have been appointed to rural

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.

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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.
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 socioeconomic 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