rural and urban settings in Mozambique; to record beliefs about the causes of mental illness; and to investigate help-seeking behaviour. In over 2700 households surveyed by use of a well designed clustering method, the authors reported that the prevalence of psychoses in adults was 4·4% in the rural town versus 1·6% in the city; mental retardation 1·9% versus 1·3%, respectively; and seizure disorders 4·0% versus 1·6%.

More than half the informants could not provide a reason for the illnesses in their families. Most of those who did have an explanation held to a supernatural model of causation and had sought help from traditional medicine; only a minority thought that the disorders had biological causes. The burden for every household due to mental disorders was heavy and mostly carried by men and rural dwellers. This finding could be the result of emigration by healthy members of the family, especially men, to cities in search of jobs and better living conditions. These emigrants then have to sustain the sick and infirm, who remain behind, with remittances.

Concerns might be expressed about the methods of this paper, the quality of data obtained from vignettes, the age of the informants, accuracy of case-ascertainment, or missing data. However, whatever its limitations, this study provides a snapshot of the burden and prevalence of three mental conditions on the affected households in Mozambique. This study is important as one of a handful from a developing country where inadequate research capacity and low literacy hinder good epidemiological and health-services research. Unfortunately, international comparative studies of the prevalence of mental disorders, such as those undertaken by the International WHO Consortium, have focused on developed countries (Canada, USA, Germany, Chile, and Netherlands)[3] or on countries with medium to high levels of income (Brazil, Mexico, and Turkey).[4] These countries can afford to do their own research; meanwhile few studies have been done on the burden of mental conditions in countries with less developed economies.

The results of this study should provide authorities in Mozambique, at whose behest the study was done, with a basis for planning health services. Mozambique and many other developing countries have an obligation to organise better services for the mentally ill. International agencies should help to mount epidemiological studies and organise services within the financial limitations of these countries. Epidemiological and health-services research to establish the burden of mental illness are urgently needed in developing countries. The integration of mental health services into primary-care systems might be the only way to cope with that burden worldwide.

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Surgical services in low-income and middle-income countries

Although substantial progress has been made in addressing the burden of communicable and vaccine-preventable diseases in low-income and middle-income countries, the burden of diseases that are surgically treatable is increasing and has been neglected. Both morbidity and mortality from surgically preventable (eg, elective hernia repair) or treatable (eg, strangulated hernia) disorders can be greatly decreased through simple surgical interventions. Why should a child die from appendicitis, or a mother and child succumb to obstructed labour, when simple surgical procedures can save their lives? Why should patients suffer permanent disability because of congenital abnormalities, fractures, burns, or the sequelae of acute infections such as septic arthritis or osteomyelitis? Many complications of HIV infection (eg, abscesses, fistulas, Kaposi sarcoma) are also amenable to simple surgical interventions. Available epidemiological information and experiential evidence lend support to the conclusion that basic surgical and anaesthetic services should be integrated into primary health-care packages.

Although surgery has previously been viewed as a high-cost treatment that lies outside the traditional

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Eye surgery clinic in Kenya

For the **GIEESC website** see http://www.who.int/surgery/globalinitiative/en/

public-health model, surgical and anaesthetic services are now recognised as public-health interventions that aim to prevent death and disability.[1] Evidence is emerging to suggest that surgical services (ophthalmological, obstetrical and gynaecological, abdominal) might compare favourably with selected primary-health interventions in terms of cost-effectiveness.[1–4] Barriers to the timely and appropriate delivery of basic surgical services in low-income and middle-income countries include poor infrastructure, inadequate physical resources, and insufficient numbers (and training) of health-care professionals. Although most patients live in rural settings, adequate surgical services are found only at tertiary centres in urban areas. Furthermore, the migration of health professionals usually creates a vacuum at the primary-health facilities, where services are provided by non-specialist or even non-medical personnel, many of whom are inadequately trained.

In response to these challenges, WHO established the Clinical Procedures Unit in 2004, in the Department of Essential Health Technologies. The Emergency and Essential Surgical Care Project is based on the notion of essential services, which target major public-health challenges and should be obtainable by everyone.[5] To strengthen the delivery of surgical and anaesthetic services at primary-health facilities, an integrated training programme has been developed that outlines WHO's minimum standards and technologies for emergency and essential surgical care. Training the trainers workshops are held in collaboration with the Ministries of Health and both local and international partners,[6] based on the Integrated Management of Emergency and Essential Surgical Care toolkit[7] and the Surgical Care at the District Hospital reference manual.[8] Topics include team responsibility and organisation, record keeping, basic resuscitation skills and anaesthetic techniques, and selected surgical problems such as burns, fractures, obstetrical emergencies, and acute intra-abdominal disorders. Workshops have been held in 18 countries, and trip reports are available online.[9] A Global Initiative for Emergency and Essential Surgical Care (GIEESC) was established in December, 2005, and represents the first coordinated effort to address the absence of adequate capacities for emergency and essential surgical care services at the primary referral level in low-income and middle-income countries. The second meeting of the GIEESC will be held in Dar es Salaam, Tanzania, in September, 2007.

This diverse training programme emphasises that simple, cost-effective treatment strategies for injuries and other surgically treatable disorders, delivered at primary health-care facilities, should reduce the burden of death and disability. In view of the barriers to achieving this aim, improving the delivery of basic surgical services in low-income and middle-income countries will be challenging, and will need a multidisciplinary, multisectoral effort. A basic level of infrastructure and technology should be provided to support safe anaesthesia and surgery. The health workforce should be strengthened by not only increasing the number of trained providers, but also by achieving, maintaining, and expanding their skills. Continual studies will be needed to assess and enhance the effect and cost-effectiveness of programmes designed to reduce the burden of surgically treatable disorders. The integration of basic surgical services into primary-health programmes accords with the recommendations of the Alma-Ata declaration; "primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible."[10]

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Mental health and the mass media: room for improvement

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The mass media exerts a powerful influence on public attitudes about mental health. However, the message that often comes across reinforces negative stereotypes about people with mental illness: they are strange, unpredictable, and probably dangerous.[1,2] Improvement of this situation will need effort on the part of both media and mental health professionals.

Earlier this year, an event in the small university town of Blacksburg, VA, USA, thrust mental health into the spotlight of the international media. On April 6, 2007, a student at Virginia Tech University opened fire in a dormitory and then a classroom, killing 33 people, including himself. A deluge of media coverage followed, much of it focused on issues related to the mental health of the shooter, Seung-Hui Cho. Several aspects of this coverage reflect broader themes common in media coverage of mental health.

"There's no way you can plan for a psycho and that's clearly what we're dealing with here", CNN commentator Jack Cafferty opined hours after the shootings,[3] before the identity of the shooter (as well as information about his mental health) had been made public. The rush to link homicide with mental illness is not new[4] and indicates the common misconception that mental illness goes hand in hand with violence. In fact, most people with psychiatric disorders are not violent,[5] and although mental illness could have had a role in the Blacksburg rampage, this broader perspective was often lost in the ensuing coverage. Some reports gave the opposite impression. A week after the shootings, the *Wall Street Journal* reported that the shootings at Virginia Tech had prompted business managers to "rethink an array of security issues, particularly how to identify mentally ill people in their midst before they harm others or themselves".[6]

In the days after the shootings, many media outlets ran stories on the reaction of the Korean-American community, members of whom were shocked and saddened that the killer was one of their own. Some

The printed journal includes an image merely for illustration

AP Photos

Media vehicles, Virginia Tech University