is substantial (3·8 million disability-adjusted life-years [DALYs]), it ranks well behind that of other vaccine-preventable diseases such as tetanus (8·3 million DALYs) and measles (23 million DALYs).[2] Second, the effectiveness of the HPV vaccine against cervical cancer is still unknown.[3] This uncertainty concerns African populations in particular, with their high HIV prevalence.[4] Third, to remain cost-effective in GAVI-eligible countries, the costs for a vaccinated individual should not exceed US$10 for the three doses.[5] This cost contrasts unfavourably with the arguably lowest price negotiated so far—$16·95 per dose.[1]

When the donations are drained off, GAVI will be in a difficult position: terminating this highly publicised programme will be unpopular. Representatives of vaccine manufacturers and the Rwandan Minister of Health are on the GAVI Board—an obvious conflict of interest. It would be a tragedy if funds were shifted from proven, cost-effective vaccines and the strengthening of health systems to new but costly vaccines of unknown effectiveness.

We declare that we have no conflicts of interest.

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Blocking out the real diagnosis

Antonio Gambardella and colleagues (Feb 19, p 690)[1] report a case of paroxysmal atrioventricular block misdiagnosed as epilepsy. Of note, they report that the patient's symptoms worsened with carbamazepine. Various bradycardias have been reported with carbamazepine.[2–5] In patients with epilepsy who deteriorate on carbamazepine, a cardiac cause should be considered.

I declare that I have no conflicts of interest.

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Authors' reply

We agree with the recommendation by Kathryn Hewetson to consider a cardiac cause in patients with epilepsy who deteriorate on carbamazepine. This is especially true for older women who can develop potentially life-threatening bradyarrhythmias or atrioventricular conduction delay during the course of routine treatment with therapeutic doses of carbamazepine.[1] In our patient, carbamazepine is therefore likely to have worsened her episodes because it aggravated the paroxysmal complete heart block.

However, carbamazepine can also precipitate or exacerbate absence, atonic, or myoclonic epileptic seizures in patients with generalised epilepsies,[2] or in children with mixed epilepsy disorder and generalised bilaterally synchronous discharges on the electroencephalogram.[3]

We declare that we have no conflicts of interest.

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Brazilian health-service organisation: problems at a glance

The Lancet's Series on Brazil[1] covers almost all important health fields: health politics, violence, infectious diseases, chronic non-communicable diseases, and maternal and child health. But overall it gives a biased view of a poor country with a vertical health system based on programmes.

The Series is missing at least a paper on the theory of primary care and how it is working in Brazil and a paper on health service organisation in general. Such papers might cover the uneven geographical distribution of physicians (eg, one per 574 inhabitants in the Amazonas state capital, Manaus, compared with one per 9000 in the rest of Amazonas),[2] or the poor accessibility of health centres forcing patients to visit walk-in clinics with no continuity of care.

Questions that remain unanswered are: does Brazilian society want a universal public health system?; do members of Brazil's upper and middle classes know the importance of a strong public health system?; are Brazilian politicians promoting a public health system for the poor and a private one for the rest of the population?

One main obstacle to being open to these questions is the pressure on epidemiologists, managers, and academics to collect data in a vertical fashion. Yet violence cannot be seen as detached from infectious disease, maternal mortality, drug addiction, or unemployment. The Family Health Strategy, cited in most of the Series papers, has been a vehicle by which many vertical actions have already been integrated, and the results have been well studied.[3] What readers really need to know are the obstacles to going further in this regard.

The outcome of *The Lancet*'s Series is a collection of excellent health data empty of relevant messages for taking decisions around health-policy organisation. There is a need to understand health in Brazil in terms of the best answers to health service problems.

We declare that we have no conflicts of interest.

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Post-disaster mental health care in Japan

International guidelines and principles for the promotion of psychosocial wellbeing and the prevention or treatment of mental health problems in humanitarian settings are often ignored, and Justin McCurry's World Report on Japan (March 26, p 1061)[1] is an example.

McCurry does not seem to have sought input from relevant mental health authorities within Japan, and instead cites "experts" as stating that "thousands of victims will be in need of long-term trauma counselling" and that "children who have been caught up in disasters can develop behavioural and mental health problems unless they receive counselling at an early stage".

Such statements are not consistent with guidelines[2] or published data[3] and thus send inaccurate messages. Guidelines recommend that children are best helped by reinforcing supportive family and community structures, and by restoring routines and culturally accepted activities; only a minority of children and adults will need specialised mental health services.[2,4]

Japan has considerable experience and expertise in the field of mental health and psychosocial support. The Ministry of Health, Labor and Welfare quickly mobilised human resources and guidance including from the Japanese Society of Psychiatry and Neurology and the League of Psychiatric Departments of Universities. Japanese response and support systems (including mental health care) for this disaster will be reported soon elsewhere.

We are keen to learn from international experiences and appreciate the support from international actors. However, as the Inter-Agency Standing Committee guidelines[2] note, responses must be coordinated, evidence-based, culturally informed, and build on existing capacities.

We declare that we have no conflicts of interest.

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In his World Report,[1] Justin McCurry succinctly highlights the difficulties facing the surviving victims of the earthquake and super-tsunami in northestern Japan on March 11. However, he misrepresents existing mental health-care provision in two respects.

First, his statement that "Japan's health system is ill prepared to address long-term mental health problems triggered by the disaster" does not accurately reflect the situation. Although existing provision is not perfect, valuable lessons about post-disaster mental health have been learned since the two previous major disasters at Kobe in 1995 and Niigata in 2006. In 2001, the National Center of Neurology and Psychiatry issued national guidelines for post-disaster mental health,[2] and several thousand caregivers have been trained in traumatic stress counselling over the past few years. The directors of most mental health centres have attended lecture courses in post-disaster mental health care. As a result, responses to the present disaster were very rapid, allowing prompt scheduling and dispatch of mental health-care teams to the devastated areas.

Corbis

Second, we were concerned about the inclusion of comments from Stephen McDonald of Save the Children on the fear expressed by a child he had interviewed, and the assertion that lack of counselling in the early phase can lead to subsequent mental and behavioural problems. There is no evidence for this statement. As recommended in