

changes are noteworthy, little attention has been paid to the assessment of these initiatives.

We have begun to address this gap through an epidemiological study in one municipality of São Paulo state. This study investigated use of mental health services in a representative population-based sample of children aged 6–13 years (n=345) from 2002–03 (time 1 [T1]) to 2007–08 (time 2 [T2]). At T1, 124 participants (35.9%) had mental health problems according to the Child Behavior Checklist total problem scale. At T2, all of them were recontacted and 93 (75.0%) were reassessed. Of 32 mothers of children with persistent mental health problems (ie, scores in the clinical range at T1 and T2), 19 had considered that the child needed mental health treatment during this time; of these, 16 sought treatment for the child and 12 obtained it.

These findings provide important preliminary data on the use of mental health services in a group of children with persistent mental health problems in the metropolitan area of São Paulo. First, only 19 of 32 mothers of children with persistent mental health problems thought about seeking treatment for their child. This low rate could be explained by poor knowledge about mental health problems, services, or available treatments, or because of stigmatising beliefs. Second, 12 of 16 mothers who tried to seek help in the past 4 years obtained treatment for their children.

These findings suggest that the most significant barrier to accessing mental health services could be parental recognition of mental health problems and that provider or system barriers are present, but to a lesser extent. This could be the result of recent health-system changes aimed at better integration of mental health care into primary care,³ and the consequent expansion of access to mental health services. Nevertheless,

additional investment in strategies to improve access are needed given that only 12 of 32 children with persistent mental health problems received any type of care over 4 years. Moreover, interventions aimed at improving awareness about mental health problems, sources of help available, and how to access them could be developed to target specific barriers present in Brazilian communities.

We declare that we have no conflicts of interest.

**Daniel Fatori, Sara Evans-Lacko, Isabel A Bordin, Cristiane de Paula*
daniel.fatori@gmail.com

Instituto de Psiquiatria da Faculdade de Medicina da Universidade de São Paulo, São Paulo, SP 01060-970, Brazil (DF); Health Service and Population Research Department, Institute of Psychiatry at King's College London, London, UK (SE-L); Psiquiatria Social, Departamento de Psiquiatria, Universidade Federal de São Paulo, Escola Paulista de Medicina, São Paulo, SP, Brazil (IAB); and Programa de Pós-Graduação em Distúrbios do Desenvolvimento, Universidade Presbiteriana Mackenzie, São Paulo, SP, Brazil (CdP)

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Non-communicable disease priority actions and social inclusion

The *Lancet* NCD Action Group and the NCD Alliance¹ highlight links between non-communicable diseases (NCDs) and some vulnerable groups such as children, young people, women, people with disabilities, and people living in poverty. They acknowledge that “policies, strategies, plans, and calls to action are common in international and national reports” but also note that their “implementation has been slow”. Although calls to action might well exist, the commitment to addressing such calls to the needs of vulnerable and marginalised groups remains largely untested. There is an urgent need to assess what health policies actually say, and commit to, in terms of social inclusion and human rights. Only then can we assess the practical value of calls to action, and establish whether any such action is, in fact, likely. If such calls and policies are inclusive of vulnerable groups and uphold core concepts of human rights, they are much more likely to contribute to the provision of equitable health care.

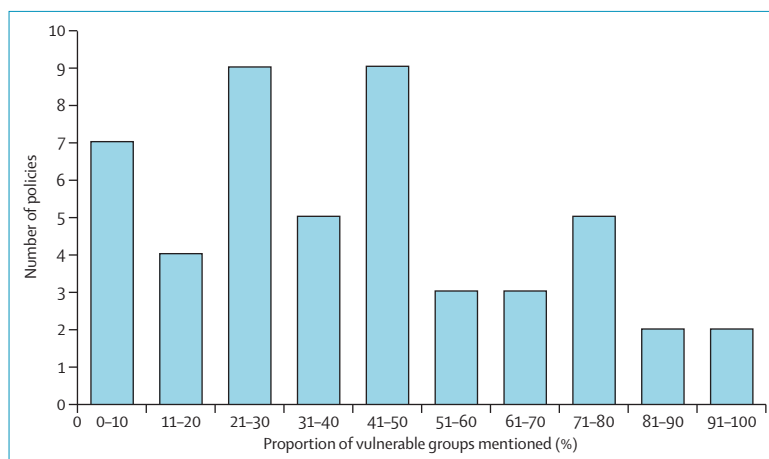


Figure: Frequency of mention of different vulnerable groups in health policies across Sudan, Malawi, Namibia, and South Africa

Vulnerable groups: those with chronic illness, disabled people, those living away from services, displaced people, ethnic minorities, young people, older people, children with special needs, those at increased risk of maternal and child mortality, those with increased relative risk of morbidity (WHO top 10 health conditions resulting in death), women-headed households, and those with limited resources.

The EquitAble consortium has developed a policy analysis framework—EquiFrame^{2,3}—through consultation with more than 100 stakeholders across Sudan, Malawi, Namibia, and South Africa. This framework has been used to assess 49 country health policies in terms of their commitment to 12 vulnerable groups (figure). These findings indicate that much work needs to be done to make our health policies more inclusive. *The Lancet* initiative on NCDs presents the opportunity to address this challenge through the application of systematic policy analysis instruments that seek to assess social inclusion, such as EquiFrame. NCD policies, or calls to action, that omit mention of how the needs of vulnerable groups can be addressed will fall short of our aspiration of “health for all”.

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**H Mannan, M Amin, M MacLachlan, and the EquitAble Consortium*
mannanh@tcd.ie

National Institute for Intellectual Disability, Trinity College Dublin, School of Social Work and Social Policy, Dublin 2, Ireland (HM); Ahfad University for Women, Omdurman, Sudan (MA); and Centre for Global Health, Trinity College Dublin, Dublin, Ireland (HM, MM)

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