

WEEK 14 – DETERMINING POLICY PRIORITIES

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Working with governments and NGOs requires inter-sectoral actions that are, by definition, highly collaborative and voluntary. Creating a conducive policy framework and approach to health brings together many of the issues we've touched upon in the lectures during this semester, starting with effective communication and common language. Forming partnerships, creating a shared framework regarding visions and missions, determining implementable and sustainable goals, garnering political support, and ensuring transparency and accountability are all important elements in creating consensus on policy priorities.

An important consideration in global health is that one size does not fit all, or even that the one size is something that can be acted upon by a specific country due to its income, lack of infrastructure, and/or political unrest. However, all countries can agree in principle that action A is a critical issue and that they can support it as an actionable item.

By using a social determinants of health approach in global behavioral health policy making, we are looking at an extremely complex issue that is made more complex by addressing the very fabric of a society and even, of a government. How can we best monitor and measure actions to address the MDGs that can inform policy making, evaluate implementation, and ensure accountability? What data do we collect?

How we normalize the data, so we know we are comparing apples with apples, much less red apples with red apples? How do we disaggregate data to better understand baseline levels and potential impacts of policies? Keep in mind that the availability of data on social determinants is poor. Not all governments collect the same type of data consistently over a period of years within the same reason, or even among a specific population.

Something as simple as registering all children who are born into a national registry doesn't happen in every country. UNICEF estimates that the births of nearly 230 million children under the age of five have never been recorded. For example, 39% of the children born in south Asia were unregistered and 44% of all births in sub-Saharan Africa were unregistered.

Children in poor households, or from remote or rural areas with uneducated mothers, are less likely to be registered. Lack of a birth certificate or registration may deny child access to basic education and health care. Without documentation that a child exists, that child does not exist and cannot be counted. And that brings us back to a major issue in behavioral health, as well as health care, establishing prevalence to show the need for services.

Within the United States, estimating prevalence is extremely difficult due to the lack of a standard inclusive definition for a minimum functional level of impairment for an agreed upon duration in determining prevalence of disorders among children and adolescents. If the United States can't even agree upon a standard inclusive definition, how can a global standard be agreed upon? This is

just one of the problems in determining policy priorities for addressing global behavioral health problems in children and adolescents.