Guest Editorial

POLICY AND PROGRAM COORDINATION: A SHARED CHALLENGE WITH MILES YET TO GO

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> *"It has been said: The whole is more than the sum of its parts. It is more correct to say that the whole is something else than the sum of its parts, because summing is a meaningless relation, whereas the whole-part relationship is meaningful."*[1]
>
> —Kurt Koffka

In the late 1990s, the government of Botswana instituted a multisectoral policy and program approach to address the scourge of HIV/AIDS countrywide.[2] President Festus Mogae provided vital leadership for this initiative, expressed through the National AIDS Coordinating Agency (NACA). The approach called for a policy shift from defining AIDS as a health issue to defining AIDS as a multisectoral challenge. The Botswana National Strategic Framework for HIV/AIDS clarified the tactical elements related to the various contributions and relations between the sectors—emphasizing government ministries particularly, but also involving nongovernmental organizations (NGOs), community-based organizations (CBOs), civil society, business, development partners, and other partners. This country of more than 1.8 million people, with the highest prevalence of HIV in the world,[3,4] has embarked on the daunting task of reducing HIV/AIDS through horizontal (multisectoral) and vertical (national, district, village) coordination. Achieving the synergy potential inherent in the coordination of partners, sectors, programs, and policies is a mantle we all share as public health leaders worldwide.

Whether health challenges are complex and oblige the efforts of a variety of sectors to address unique aspects, or whether a particular health challenge is sufficiently massive to require "all hands on deck," policy and program coordination is central to the solution. Yet despite this recognition, and as emerging literature on coordination indicates, our success is varied. We are challenged by traditionally distinct structures or policy history, and our actions are thwarted by a paucity of resources and capacities.

We have encouraged our collective efforts through shared policy and program experiences, both at conferences and in peer discourse. This special issue of *Public Health Reports* continues the discussion of policy and program coordination, bringing together several voices from practice and theory. Each article highlights unique aspects of coordination, whether intergovernmental, international program coordination, cross-issue coordination, or coordination across organizational cultures. Each article raises the potential benefits of and challenges inherent to coordination, and the reader is encouraged to note that the reality may be quite different from the ideal state of coordination.

Practice experience "scratches the surface" of coordination, revealing operational and logistical challenges. So, for example, while integration may be desirous for the delivery of multiple services to populations with a complex of needs, the very act of coordination or even integration is such that the whole becomes *other than* its parts, potentially challenging the availability of extant core services and supplies. As Carolyn Hart argues, the "smooth functioning" of previous supply systems is at risk without careful technical coordination infused with bidirectional information (see "No Product? No Program!," p. 23).

Several articles in this issue highlight the challenges posed by differences in organizational culture and functioning (Shelton and Fuchs; Dodds et al.; and Jourden and Etkind), or as influenced by differences in the philosophies underlying models or structured approaches (Heller, McCoy, and Cunningham). Shelton and Fuchs suggest indicators of feasibility for coordinating programs: (*1*) previously effective interventions, (*2*) common field of operation with shared target audiences, and (*3*) synergies between the two interventions (see "Opportunities and Pitfalls in Integration of Family Planning and HIV Prevention Efforts in Developing Countries," p. 12).

Other authors bring into sharp relief the tension between policy directives for coordination and current isolated funding and policy structures that prevent coordination. The very real and present need for coordinating across public health, emergency response, and security arenas assumes federal-level coordination that does not yet exist. Distinct funding mechanisms for HIV, chemical dependency, mental illness, and hepatitis are evidence of funding and policy forces preventing effective coordination. Meanwhile, efforts to fund collaborative planning are emerging, as noted by Hoffman, Castro-Donlan, Johnson, and Church (see "The Massachusetts HIV, Hepatitis, Addiction Services

Integration Experience: Responding to the Comprehensive Needs of Individuals with Co-Occurring Risks and Conditions and the Providers Who Serve Them," p. 25).

The formation of a "super structure" uniting disparate partners or programs may be viewed as a way to facilitate coordination; however, organizational histories and even problem definitions of the host structure may in fact pose a threat to the core services of one or more coordinating programs. As noted by Clements and Evans, the organizational environment forming the coordinative structure for emergency preparedness may in fact threaten public health functioning, as it might "further disunite these activities [emergency preparedness] from essential public health functions and undermine the integration of bioterrorism preparedness planning into our existing public health infrastructure" (see "Bioterrorism Preparedness Coordination: An Ataxic Saga Continues," p. 16).

Even the value of interdisciplinary research belies the current separate functioning of academic associations and journals. As argued by Slatin, Galizzi, Mawn, and Melillo, "it is one thing to acknowledge the complexity of health issues, and quite another to commit to a restructuring of health sciences that will develop the next generation of transdisciplinary research" (see "Conducting Interdisciplinary Research to Promote Healthy and Safe Employment in Health Care," p. 60). The articles by Silka, Holtgrave, and Cohen, et al. argue for coordination methods that will build bridges across communities—from academic or scientific to community-based or service providers. Cohen, Meister, and deZapien describe how community action groups can form the impetus for structural and system change (see "Special Action Groups for Policy Change and Infrastructure Support to Foster Healthier Communities on the Arizona-Mexico Border," p. 40), while Holtgrave offers a technology transfer model that incorporates quantitative policy analytic tools to bridge the gap between science and practice (see "The Role of Quantitative Policy Analysis in HIV Prevention Technology Transfer," p. 19).

As Silka notes, the field of interdisciplinary activity is in the formative stage—a stage that requires careful thought about indicators of success and challenge. In spite of the "uphill battle," she argues that the reason for initiating partnerships (or collaboratives) is due to the failure of previous, singular models (see "Partnerships Within and Beyond Universities: Opportunities and Challenges," p. 73). While our discussion here is primarily practice based, the road ahead requires an operational research agenda that will identify mechanisms for successful policy and program coordination and that can determine whether policy and program coordination can be linked to the improvements of health outcomes. So, for example, while coordination of substance abuse and HIV programs is conceived as beneficial due to the co-occurrence of both diagnoses in populations and the ability of both to fuel health disparities, does policy and program coordination cause the desired changes in these health outcomes in select populations? What kind of coordination causes the desired health improvements, or even the interim outcomes indicative of future and better health? The dangers of reifying coordinative structures are sufficiently daunting to require a careful research agenda to evaluate coordination from both formative and summative postures. Are we, for example, merely "herding cats" or are we joining hands to form a stronger net for the protection of public health? Are we creating a whole that is other than the sum of its parts, but also more? These questions should become part of our collective research agenda as we continue to think about and discuss experiences in policy and program coordination.

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