Between Coordination and Competition: How External Fragmentation Shapes the WHO's Effectiveness in Global Health Governance

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Abstract

This thesis examines how external institutional fragmentation has shaped the World Health Organization's (WHO) output effectiveness in the governance of the HIV/AIDS pandemic. Drawing on regime complexity theory, it conceptualizes fragmentation as the proliferation of overlapping institutions that diffuse authority and complicate coordination. Using qualitative process tracing, the study reconstructs key institutional shifts across four periods: the WHO's early leadership (1986–1995), the creation of UNAIDS (1996–2001), the rise of the Global Fund (2002–2010), and the partial re-integration of governance efforts (2011–2020). Evidence from primary documents, policy analyses, and scholarly accounts reveals that high fragmentation, marked by mandate ambiguity, donor realignment, and competing governance centers, reduced WHO's ability to generate coherent policies and assert strategic leadership. Conversely, moderate fragmentation, supported by mechanisms such as the UNAIDS co-sponsorship model and strengthened WHO–Global Fund collaboration, facilitated complementary specialization and improved policy uptake. The findings show that fragmentation is not inherently detrimental; rather, its effects depend on the structure of inter-institutional coordination. The thesis contributes to scholarship on global health governance by demonstrating how variations in institutional architecture condition the authority and effectiveness of the WHO

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1. Introduction

Fragmentation in the global governance architecture can undermine coordination, complicate accountability, and ultimately limit the effectiveness of international organizations (Biermann et al.: 2009; Pattberg et al.: 2014). As governance authority has become increasingly dispersed across multiple institutions with overlapping mandates, decision-making power has diffused, making collective action more difficult to organize (ibid.). This dynamic is well documented in climate and environmental governance, where the proliferation of treaties and organizations has generated complex and, at times, conflicting allocations of authority (Zelli 2011: 255–264). Scholars have shown that institutions such as the World Trade Organization and the United Nations Framework Convention on Climate Change frequently engage with overlapping policy domains, producing normative tensions and institutional inefficiencies (Zelli & Van Asselt 2013: 5). While these patterns of fragmentation have been extensively analyzed in environmental and climate governance, they have received comparatively less systematic attention in global health governance, where scholarly work has tended to prioritize public health outcomes, legal frameworks, and crisis response over institutional and governance-based analysis (Biermann et al.: 2009; Frenk & Moon 2013).

In the context of global health governance, concerns about the World Health Organization's (WHO) capacity to respond effectively to major health crises have become increasingly prominent (Gostin & Friedman 2014: 1323). The Ebola outbreak laid bare significant flaws in how the WHO was handling emergencies (ibid.). In particular, several assessments argued that the organization failed to recognize the severity of the epidemic in a timely manner, with some noting that an international health emergency was not declared until well into 2015, a delay that contributed to rapidly spreading infections (Moon et al.: 2015: 2208). Similar patterns were observed during the COVID-19 pandemic, when the WHO came under extensive criticism for not responding swiftly enough to the rapidly evolving global health emergency (Moon & Kickbusch 2021: 355). Analysts linked these delays to limited decision-making autonomy, insufficient funding, and political pressure from member states, all of which constrained the organization's ability to act decisively (Clift 2014: 8-9). In this context, the WHO's reliance on voluntary contributions and its dependence on member state cooperation further constrained its ability to coordinate effectively across several global health actors (ibid.). As a result, academic and policy debates frequently portrayed the WHO as lacking the authority necessary to lead global crisis responses.

These recurring shortcomings raise a broader analytical puzzle: to what extent are the WHO's difficulties explained not only by its internal governance or resource constraints, but by the fragmented nature of international health governance in which it operates? This question becomes particularly relevant in light of the substantial expansion of actors involved in global health over recent decades (Frenk & Moon 2013: 936-938). States, non-governmental organizations, philanthropic foundations, and public–private partnerships such as Gavi and the Global Fund have assumed increasingly central roles in agenda-setting, financing, and implementation (Youde 2018). Viewed through the lens of external fragmentation, the WHO increasingly appears as one actor among many in a crowded governance landscape, rather than as the uncontested focal institution for global health coordination.

Understanding these dynamics has important theoretical implications, because fragmentation is not inherently detrimental (Biermann et al.: 2009). Scholars argue that under certain conditions, fragmented governance structures can promote innovation, diversify funding sources, and compensate for institutional weaknesses (Biermann et al.: 2009). This perspective suggests that the key question is not whether fragmentation exists, but rather how and under what conditions it influences organizational effectiveness. Answering this requires an understanding of the WHO's formal role and the expectations associated with it. Given that the WHO is the sole universal health agency established on common values, it is expected to act as the primary coordinating institution for international health operations, offering technical direction and mobilizing resources to support comprehensive responses to health emergencies (WHO Constitution 1946). Its effectiveness, therefore, lies primarily in its capacity to provide authoritative guidance, coordinate diverse actors, and articulate coherent global strategies during health crises (ibid.). However, external fragmentation may reshape these expectations by dispersing authority, creating competing centres of expertise, and weakening incentives for actors to align with WHO leadership.

Thus, investigating how external fragmentation impacts the WHO's effectiveness provides an opportunity to investigate sustained coordination failures and diminished global responses. This leads to the main research question of this thesis: **To what extent has external fragmentation of international health governance shaped the effectiveness of the WHO in coordinating global health responses?**

The academic relevance of this research lies in its contribution to a growing yet still underdeveloped literature on external fragmentation in the global health governance. While scholars such as Biermann (2009, 2011, 2014) and Pattberg (2010, 2012) have systematically theorized fragmentation in other issue areas, global health studies have largely examined institutional proliferation descriptively, without explicitly operationalizing external fragmentation as an analytical framework. As a result, relatively little is known about how fragmented governance structures condition the authority and performance of central health institutions such as the WHO. By explicitly applying fragmentation theory to international health governance, this thesis addresses this gap and clarifies why increased pluralism has not automatically translated into more effective coordination.

Beyond its academic relevance, this research also has clear social significance. The WHO's ability to coordinate global responses directly affects the management of pandemics, emerging infectious diseases, and long-term global health challenges (Javed & Chattu 2020). Thus, understanding how current governance arrangements constrain or enable the WHO's performance can inform debates on institutional reform and the design of more resilient and responsive global health systems.

The remainder of this thesis proceeds as follows. The literature review surveys existing theories on fragmentation, regime complexity, and international organization effectiveness, highlighting gaps in the global health literature. The theoretical framework then applies regime complexity theory to explain how external fragmentation is expected to shape WHO effectiveness. The methodology section outlines the use of qualitative process tracing and justifies the selection of HIV/AIDS governance as the empirical case. The analysis traces institutional change from the 1980s to 2020, examining how the creation of UNAIDS and the Global Fund reshaped WHO authority and coordination capacity. The conclusion synthesizes the findings and reflects on their implications for global health governance.

2. Literature Review

2.1. The Dual Nature of Fragmentation in Global Governance

Scholars widely agree that the international system has become increasingly fragmented, with multiple overlapping institutions addressing similar global issues (Biermann et al.: 2009: 16–17). Fragmentation is not the concentration of power or authority in a single, coherent structure but rather the diffusion of decision-making and responsibility across numerous international organizations, regimes, and actors (Biermann & Pattberg 2008: 284). While this development is indicative of the pluralisation and democratisation of global governance, it has also sparked debate over whether fragmentation ultimately supports or undermines cooperation and institutional effectiveness.

Biermann (2009) and other scholars propose that fragmentation can be either synergistic or conflictive, with the extent of coordination between institutions (Biermann et al.: 2009: 20-21). Where governance structures are moderately fragmented and reinforced by mechanisms promoting information sharing and complementary mandates, fragmentation can support innovation, flexibility, and specialisation (Orsini et al.: 2013: 34-35). It fosters a degree of competition, allowing smaller or more focused organizations to fill niches that big centralising institutions have missed (ibid.). However, the costs of fragmentation or competition among institutions in terms of inefficiency, duplication, and lack of accountability become very high when it is this extensive (ibid.). In that regard, the extent of fragmentation is important in explaining whether it enhances or undermines governance outcomes (Ibid.).

Empirical evidence from environmental governance shows the pros and cons of the process. In climate change, “moderate” fragmentation has led to positive outcomes like policy experimentation, implementation capacity, and transnational coordination (Abbott 2012: 581-583). Efforts, including the C40 Cities network and the ICLEI partnership, have been seen to supplement UNFCCC by engaging local governments and private sector actors, thereby addressing voids left by national and intergovernmental entities (idem 586). These cases illustrate that under good management, fragmented patterns of governance can facilitate policy innovation and responsiveness.

The international biodiversity regime, in contrast, has grappled with institutional redundancy between CBD and other environmental treaties (Oberthür & Gehring 2006: 96-98). Here, institutional redundancy between the Convention on Biological Diversity (CBD) and other environmental treaties has produced overlapping mandates without clear coordination mechanisms (ibid.). This redundancy has resulted in duplicative reporting obligations, inconsistent policy guidance, and uncertainty over institutional authority, which in turn has undermined implementation and diffused accountability among participating states (ibid.). This high degree of fragmentation has resulted in inconsistent implementation and unclear accountability (ibid.). So, the central challenge for contemporary governance lies in achieving a balance that preserves diversity and innovation while maintaining overall coherence and effectiveness.

2.2. Debating the Effectiveness of International Organizations in Global Health Crises

The capacity of international organizations to respond to global health crises has been an enduring subject of scholarly debate. Some academics say these organizations have repeatedly failed to deliver timely and coordinated responses, while others claim they have played a pivotal role in containing outbreaks and marshalling resources across borders.

One strand of the literature maintains that international organizations, particularly the World Health Organization (WHO), have often proven ineffective in responding to global health emergencies (Moon et al.: 2015: 2206-2207). Critics such as Lawrence Gostin (2022), Suerie Moon (2018), and Clare Wenham (2023) claim that WHO has been incapable of acting rapidly in crises, a state of affairs partly due to the health agency's lack of fiscal autonomy, political reliance on member states, and slow decision-making processes. These scholars stress that the inertia and prudence of bureaucratic logic, especially in major outbreaks, have often slowed down crucial interventions (ibid.). Indeed, in the first months of 2014, the WHO's failure to immediately call a Public Health Emergency of International Concern in response to Ebola was sharply criticized for playing a major role in allowing the spread of that disease (Siedner & Kaemer 2014). The Independent Panel on the Global Response to Ebola reported that these delays were driven by weak internal governance, inadequate emergency finance, and an

excessive regard for state consent, which negated its capacity to lead a coherent response (Moon et al.: 2015: 2217-2219). From this point of view, the structural and political constraints international organizations come up against make it impossible for them to act robustly and organize fast global action where it is most relevant.

In contrast, other scholars highlight the critical role international organizations have played in fostering cooperation, disseminating expertise, and maintaining global norms during health crises. Devi Sridhar (2017) and Jeremy Youde (2018), along with other writers, argue that institutions such as the WHO have given crucial technical advice and legitimacy for global responses despite the institutional and political hindrances. The current response to the COVID-19 pandemic is a case in point; while initial responses were uneven, the WHO managed big information-sharing, initiated and worked on an accelerated search for vaccines and treatments with its Solidarity Trial, and contributed to COVAX as an equitable sharing of vaccines (Müller 2021: 4-6). These initiatives, which received international support and financing, indicated the continued capacity of the organization to work in a context of extreme pressure by mobilizing and coordinating several actors (ibid.). Therefore, effectiveness should not be measured solely by speed or enforcement capacity but also by the organization's ability to convene diverse stakeholders, harmonize standards, and promote cooperation in a fragmented international system.

2.3. Addressing the Gaps in the Literature on Fragmentation and Global Health

Although substantial theoretical work exists on this subject, surprisingly little of the literature provides a basis for empirically measuring the impact of fragmentation on global health. Most studies on fragmentation in international organizations focus on descriptive aspects, such as overlapping competences, the proliferation of institutions, or coordination problems, but they rarely translate these observations into measurable outcomes like response time, effectiveness, or mortality rates. Widespread measurement is, as a result, lacking, and it is therefore difficult to assess the degree to which fragmentation facilitates or impedes the effectiveness of international organizations during crises. Closing this gap would not only help the field to better understand the link between organizational forms and health but also have pragmatic applications in helping to improve governance and coordination in global health.

3. Theoretical Framework

This thesis adopts regime complexity as its primary analytical framework for understanding how international governance structures shape organizational authority and effectiveness. This framework refers to the pattern of international governance in which authority, rules, and decision-making are distributed among a number of overlapping institutions that work within the same issue area (Alter & Raustiala 2018: 331). Rather than being hierarchical, regime complexes are polycentric governance structures in which multiple centers of authority coexist, each with distinct mandates and constituencies (idem.: 331-334).

At the basis, regime complexity means a stage in the evolution of international institutionalization (idem: 345-346). As issue areas grow and diversify, states and other actors create new institutions to handle particular issues or cater to more circumscribed political or normative goals (Kijima & Lipscy 2023: 2150-2152). Eventually, this approach leads to a proliferation of partially overlapping regimes, each with its own membership, procedures, and mandates (ibid.).

At an abstract level, regime complexity is best understood as variation along a continuum from cohesive architectures of organization to disorganized or competing institutional networks (Kijima & Lipscy 2023: 2152-2155). Along this continuum, regime complexity can either facilitate or hinder effectiveness, depending on the presence of coordination mechanisms and a clear division of labor (idem: 2151-2154). On the other hand, when such connections are missing or weak, it leads to removal and institutional ineffectiveness (ibid.). Without central authority, results then depend on the collateral capacity of specific institutions to reach informal agreement by negotiation and recognition, or at least mutual adjustment (ibid.).

The central mechanism embedded within regime complexity lies in the interaction between institutional proliferation and functional overlap (Randall Henning & Pratt 2023: 2178-2180). When multiple organizations assert authority over similar policy areas, their mandates intersect (ibid.). This intersection can generate duplication of effort, contradictory rules, and uncertainty over which institution possesses legitimate authority (Haftel & Lenz 2022: 324-325). Once created, these overlaps produce a structural environment characterized by contestation and coordination. Decision-making becomes lengthened as institutions need to consider what the interests of other actors are before they act (ibid.). Regime complexity is therefore treated in

this study not as a static condition, but as a dynamic governance environment that reshapes how organizations such as the WHO exercise authority.

To move beyond conceptualisation, this thesis conceptualizes the link between regime complexity and effectiveness as a sequential causal process. First, the creation of partially overlapping institutions generates uncertainty about which organization holds legitimate authority to guide collective action (Alter & Meunier 2009: 2-3). Second, this uncertainty encourages states and organizations to align themselves selectively with the institution that best reflects their immediate preferences, which reduces incentives to follow WHO recommendations (idem: 4-5). Third, multiple centers of authority begin issuing similar or contradictory forms of guidance, which increases the effort required for coordination (Alter & Raustiala 2018: 332-334). Finally, these rising coordination demands slow collective responses, reduce the visibility of WHO leadership, and limit the ability of the WHO to convert its technical expertise into coherent global action (ibid.).

This thesis takes into consideration how regime complexity constrains effectiveness through actor-mediated mechanisms across four dimensions: authority recognition, coordination capacity, decision-making timeliness, and policy coherence. The unit of analysis is the international organization, with the WHO treated as a corporate actor embedded within a fragmented global health governance environment. Outcomes are understood as the result of decisions made by senior officials and technical leaders acting under a unified organizational mandate. Actors within and around international organizations are assumed to be motivated primarily by instrumental interests and considerations of institutional authority, while norms shape expectations of legitimacy and expertise without guaranteeing compliance. Fragmentation affects effectiveness indirectly by altering the strategic environment in which actors decide whether to align with, defer to, or bypass the WHO. As authority becomes dispersed, selective adherence, parallel coordination, and delayed responses become more likely, clarifying what empirical patterns should be observed in the case studies.

3.1. Conceptualization of External Fragmentation

External fragmentation can be understood as a consequence of regime complexity and it refers to the degree to which authority, norms and decision-making are spread out across numerous institutions within a single governance field that are formally independent from one another (Biermann et al. : 2009: 16-19). It refers to a form of structure in which there is no super-ordinate mechanism that provides for coherence, coordination or hierarchy among institutions with similar goals (ibid.). As a result, governance becomes characterized by duplication of efforts, overlapping mandates, and inconsistencies in rule-making and implementation (idem: 24-28). External fragmentation exists along a spectrum (Pattberg et al.: 2014: 10). At the lower extreme, governance systems are highly integrated and coherent: institutions are complementary, communicate well and behave in line with common norms (Biermann et al. : 2009: 24-28). At the upper extreme, fragmentation deepens to entrench a situation where institutions fragment in an uncoordinated way, norms become more divergent, and authority becomes dispersed (ibid.).

External fragmentation can be understood through four interconnected constellations: institutional, normative, actor, and discursive (Pattberg et al.: 2014: 15). These four constellations help identify where fragmentation occurs, but the main analytical value for this thesis comes from understanding how misalignment across them accumulates over time. A disruption in one constellation, for example the emergence of conflicting norms, can influence the others by shaping how actors interpret their roles or allocate authority (idem: 18-20). Fragmentation therefore grows through a chain of reinforcing developments rather than through isolated problems.

The institutional constellation refers to the structural arrangement of organizations within a governance architecture (idem: 15-18). When institutions are organized in complementary or nested ways and coordinated through shared mechanisms, fragmentation remains low (ibid.). When they operate in parallel with overlapping mandates and without coordination, fragmentation increases (ibid.). For example, if several bodies independently regulate similar policy areas without collaboration, authority becomes unclear and efforts are duplicated, reducing institutional coherence (Ibid.).

The normative constellation concerns the degree of consistency or conflict among the principles, rules, and standards established by institutions (idem: 18-20). When norms are coherent and reinforce one another, governance remains stable and predictable (ibid.). However, when different institutions produce incompatible norms, such as one emphasizing economic growth while another prioritizes environmental limits, actors face contradictory expectations, and policy implementation becomes fragmented (ibid.).

The actor constellation captures how authority and influence are distributed among participants (idem: 20-22). Low fragmentation occurs when decision-making power is centralized or effectively coordinated (ibid.). High fragmentation arises when numerous state and non-state actors operate independently and pursue competing interests, making collective decision-making more difficult and time-consuming (ibid.).

Finally, the discursive constellation reflects the diversity of narratives and problem framings that institutions employ (idem: 23-25). When actors share a common understanding of an issue, cooperation and coordination are more likely (ibid.). When institutions interpret the same issue differently, for instance, framing it alternately as a development problem or a security concern, governance becomes ideationally divided and collective action less coherent (ibid.).

3.2. Conceptualization of the Effectiveness of IOs

The effectiveness of international organizations (IOs) can be interpreted as the degree to which IOs reach their formal goals, shape government action and realize actual authority in world politics (Coen et al. : 2022: 657-658). It is not simply a question of formal authority or institutional design, but the capacity to elicit cooperation, compliance and significant policy change from diverse actors (ibid.).

Three major dimensions delineate the effectiveness of IOs, according to scholars: output, outcome, and impact (Schleifer 2023: 28-29). Its model is that of output effectiveness, the ability of an organization to produce 'rules, regulations and programmes in response to collective problems' (ibid.). It also depends on the effectiveness of outcomes, which relate to how much member states comply with these rules or adopt organizational advice (ibid.). The

highest tier of impact, impact effectiveness, reciprocates influence exerted by the organization on conditions in the real world, like reduced prevalence of disease, greater security or economic stability (ibid).

Several factors shape IO effectiveness. First, clear mandates, decision-making rules and enforcement mechanisms (institutional design) help facilitate coordination and accountability (idem: 15-16). Second, legitimacy and trust matters as states and non-state actors are more likely to lend their support to organizations considered fair, transparent, and representative (idem: 34-35). Third, resource access defines the organization's ability to function autonomously rather than depend on support of member states alone (idem: 118-119). Finally, IOs work best when institutional coherence coheres with state interests and technical expertise and normative legitimacy support their authority (Keohane 2005). The success of such mechanisms, therefore, depends at the juncture of structure and agency: the robust institutions must be cast in a regional security environment with like-minded members and an international system relatively supportive of peace (ibid.).

This thesis takes into consideration that WHO's effectiveness depends primarily on its capacity to lead and coordinate. These two functions are more relevant for assessing performance than changes in real world outcomes, which depend heavily on the willingness of member states to comply. External fragmentation affects these functions through several developments. It can dilute the authority of the WHO, which makes states less likely to defer to its recommendations. It increases the number of institutions that issue parallel forms of advice. It raises the effort required for coordination because states must navigate several institutional centers. It limits the ability of the WHO to set the agenda, since other institutions shape how problems are interpreted. It also creates inconsistent expectations, which undermines the WHO's ability to generate unified global responses.

The central expectation is that fragmentation most strongly constrains WHO's effectiveness by undermining authority recognition and coordination capacity, while effects on timeliness and coherence are conditional on the degree of functional overlap and the presence of coordination mechanisms. Accordingly, not all dimensions of complexity are expected to have equal effects: overlapping mandates and dispersed authority are anticipated to be more detrimental than institutional diversity per se.

4. Methodology

This chapter explains and justifies the research design used to assess how external institutional fragmentation has shaped the WHO's output effectiveness in global HIV/AIDS governance.

4.1. Case Selection: The HIV/AIDS Pandemic

The HIV/AIDS epidemic provides an important case to examine the influence of external fragmentation on the effectiveness of the WHO. The HIV/AIDS crisis of the early 1980s marked the first significant global health challenge of the post-Cold War era (Quinn 2021: 1). Other organizations, such as UNAIDS, the Global Fund and many NGOs started to share or even challenge WHO's role of coordination for global action against infectious diseases (Graham 2017). The case is therefore useful for tracking changes in WHO authority, coordination capacity, and policy coherence across distinct institutional configurations.

The HIV/AIDS case is selected because it exhibits clear temporal variation in the level and structure of external institutional fragmentation, allowing for within-case comparison. In the late 1980s and early 1990s, WHO exercised relatively centralized authority, whereas subsequent decades saw increasing institutional proliferation and dispersed governance. This makes HIV/AIDS a most-likely case for observing fragmentation effects, since WHO initially possessed strong formal legitimacy and technical authority.

In addition, and in contrast to explosive eruptions like Ebola or COVID-19, the spread of HIV/AIDS occurred over a period of decades, making it easier to assess long-term causal effects of fragmentation on organizational effectiveness. Because the HIV and AIDS response evolved slowly rather than erupting suddenly, it is possible to observe sequential institutional changes and connect these changes to shifts in the WHO's performance. The long time frame also allows the identification of intermediate steps that reveal whether fragmentation shaped the WHO's capacity to produce coherent policies, promote joint action, or retain a central coordinating position.

4.2. Methods: Qualitative Process Tracing

This study adopts the qualitative process tracing method to diagnose and assess one such causal mechanism between external fragmentation and WHO's effectiveness in the fight against the HIV/AIDS pandemic. Process tracing is particularly suited to this research because it allows for the systematic reconstruction of how and why an outcome emerged within a single, complex case. Rather than identifying correlations, the method focuses on causal sequences, institutional interactions, and decision-making dynamics.

In this research design, process tracing focuses on identifying observable manifestations of the causal mechanism derived from regime complexity and fragmentation theory. The key objective is to determine whether fragmentation altered the WHO's capacity to coordinate, issue authoritative guidance, or shape collective strategies. Evidence is therefore sought not only in final outcomes, but also in intermediate decisions, institutional conflicts, and changes in patterns of cooperation among the WHO, UNAIDS, the Global Fund, and major donors. By systematically studying the creation of UNAIDS in 1996, the establishment of the Global Fund in 2002, and WHO's involvement in ART (antiretroviral therapy), this thesis analyzes how institutional proliferation affected the WHO's capacity to lead, coordinate, and implement health policy. These traces include changes in coordination procedures, shifts in mandates, delays or contradictions in policy outputs, or explicit disputes between institutions. The absence of such traces would weaken the claim that fragmentation played a decisive role.

4.3. Operationalization

4.3.1. Independent Variable: External Fragmentation

External fragmentation refers to the dispersion of authority, rules, and decision-making across formally independent institutions operating within the same governance field (Biermann et al. 2009). Following Pattberg et al. (2014), fragmentation can be examined across four constellations: institutional, normative, actor, and discursive.

This paper will take the institutional constellation to be the independent variable of interest because it most directly measures the structural organization of actors involved in HIV/AIDS advocacy. Institutional arrangement refers to how institutions, including but not limited to the

WHO, UNAIDS, World Bank and Global Fund, interrelate in terms of mandates and mechanisms for coordination.

High institutional fragmentation is indicated by:

1. Proliferation of independent bodies with competing roles
2. No clear hierarchy or mechanism of coordination among the different actors
3. Overlapping efforts and objectives at odds with each other

To distinguish between higher and lower degrees of fragmentation, this study examines empirically observable features such as the proliferation of institutions with formal HIV/AIDS mandates, the extent of overlap in their operational responsibilities, and the presence or absence of sustained coordination arrangements. High fragmentation will be coded when multiple institutions act in parallel with no shared rules or agreed division of labor. Moderate fragmentation will be coded when institutions retain separate mandates but coordinate through joint platforms or formal agreements such as the UNAIDS co-sponsorship model. If the empirical record reveals only one clear configuration rather than variation between high and moderate fragmentation, the study will reconsider the use of formal hypotheses and instead focus solely on reconstructing the causal process. The other variables, normative, actor, or discursive constellations, will be used to generate more relevant context. As an example, normative fragmentation may be visible in the tension between prevention and treatment, actor fragmentation where key donors shape policy directions, and discursive fragmentation in the presentation of HIV/AIDS as a threat to development; a human rights issue; or a security issue.

4.3.2. Dependent Variable: WHO Effectiveness

WHO performance will be assessed in terms of output effectiveness, including the extent to which it generates coherent policies, programs and regulations in the face of collective health challenges. This decision is underpinned by the emphasis of this special issue on institutional coordination and agenda-setting, rather than primary health outcomes which are heavily influenced by exogenous factors.

Measures used to evaluate the effectiveness of output are:

1. The degree of alignment and uptake of WHO strategies by the partner institutions

2. The degree to which the agency has taken a leading role in developing global policies or funding mechanisms
3. The quality and relevance to the time of WHO normative guidance and technical leadership

Observable indicators of reduced effectiveness include inconsistent guidance, loss of agenda setting influence, sidelining by other institutions, or delays in policy formulation attributable to disagreements among organizations. Evidence of sustained or enhanced effectiveness includes examples where WHO guidance served as the reference point for programs such as the three by five Initiative or where partner institutions explicitly deferred to WHO expertise.

4.4. Causal Mechanism

The central causal mechanism examined in this study links fragmentation in the institutional constellation to changes in WHO output effectiveness through a sequence of organizational and strategic effects.

The mechanism unfolds in four steps. First, institutional proliferation redistributes authority. Second, this redistribution modifies coordination patterns and produces uncertainty about leadership. Third, this uncertainty affects the coherence and timing of WHO outputs. Fourth, these changes manifest in observable reductions in WHO influence or consistency.

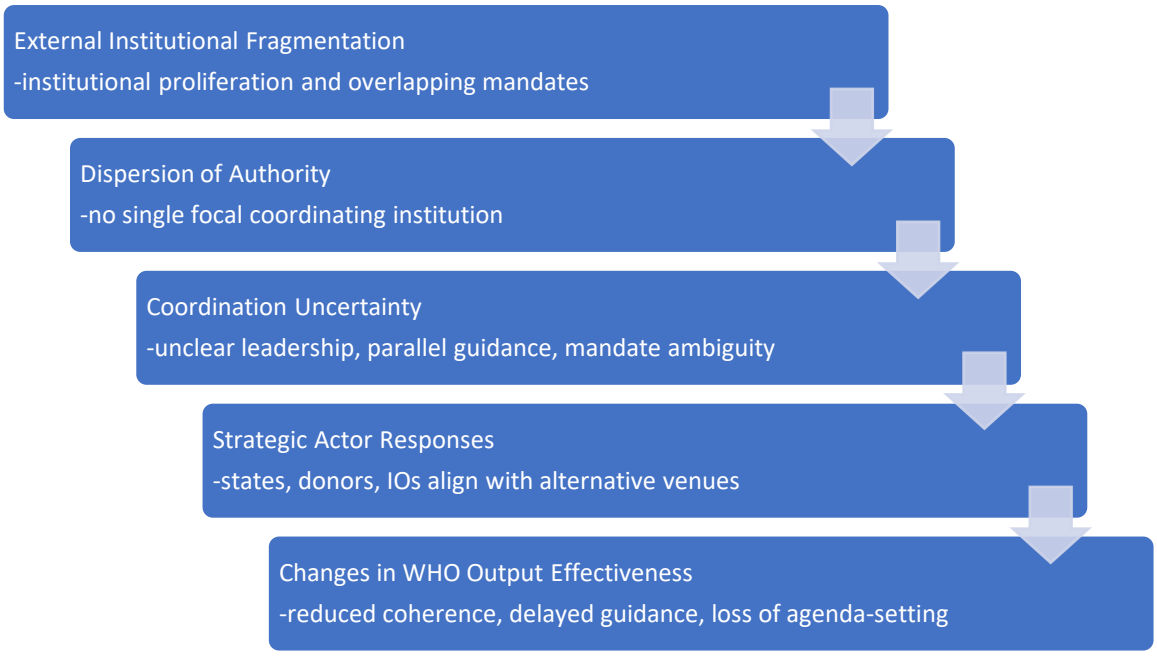

Figure 1. Causal Mechanism of Institutional Fragmentation

Each step of the mechanism generates specific empirical traces that can be evaluated using process-tracing tests. A smoking gun would consist of explicit statements in official documents, meeting minutes, or internal reports where actors acknowledge that overlapping mandates or institutional competition directly weakened WHO leadership. If such strong evidence is not available, the study will rely on hoop tests such as the consistent presence of mandate conflicts, discordant strategies, or coordination failures during key periods. These weaker tests cannot conclusively prove the mechanism, but they can establish whether fragmentation remains a plausible explanation that fits the observable sequence. Actors are assumed to be purposive but constrained decision-makers. States, donors, and organizational officials respond strategically to institutional structures, aligning with governance venues that best reflect their preferences or offer greater resources.

Two hypotheses will be used in the analysis:

1. **H1:** High institutional fragmentation undermines the WHO's output effectiveness by dispersing authority and duplicating institutional efforts.

The hypothesis is supported if the empirical record shows dispersed authority, overlapping mandates, parallel policy initiatives, inconsistent or delayed WHO guidance, and documented coordination failures or disputes that constrain WHO agenda-setting and leadership.

2. **H2:** Moderate fragmentation enhances WHO effectiveness by fostering specialization and cooperation among complementary institutions.

The hypothesis is supported if evidence shows negotiated divisions of labor, functioning coordination mechanisms, explicit deference to WHO technical authority, and relatively coherent policy outputs facilitated by complementary institutional roles.

4.5. Data Collection

Empirical evidence on institutional interactions, coordination mechanisms and WHO outputs in the HIV/AIDS governance system will be collected from 1986 to 2020. Information will be abstracted from three types of sources:

1. Primary sources –WHO resolutions, annual reports, meeting minutes and partnership frameworks like WHO-UNAIDS Memoranda of Understanding or Global Fund partnership statements. They will uncover formal remits, collaborative mechanisms and the development of institutional relationships.
2. Secondary sources – Academic articles, policy assessments and independent reports on how World Health Organization (WHO) performance was perceived and nature of fragmentation will be used.
3. Archival and media sources – News archives, public speeches, press releases will be examined to study how stories and power relations influenced institutional contacts.

In the context of process tracing, each source type serves a specific purpose. Primary documents provide evidence of formal mandates and coordination arrangements. Secondary literature helps identify debates and interpretations among scholars. Archival and media sources offer insight into the political narratives and strategic interactions that may not appear in official documents. The goal is to assemble a sequence of events where changes in institutional structure can be connected to observable shifts in WHO performance. By triangulating these types of data, this process permits tracing how external fragmentation as an antecedent led to variations in WHO policy coherence and leadership effectiveness

5. Analysis

This chapter examines how external fragmentation shaped the World Health Organization's output effectiveness in HIV/AIDS governance. Using qualitative process tracing, it reconstructs the causal mechanism linking institutional proliferation to changes in WHO policy coherence and coordination capacity. The analysis proceeds chronologically, tracing how shifts in the institutional environment preceded changes in WHO performance. Evidence is drawn from WHO documents, UNAIDS and Global Fund materials, and peer-reviewed scholarship, and is evaluated using hoop, smoking-gun, and straw-in-the-wind tests. The chapter covers three phases: consolidated WHO authority (1986–1995), the creation of UNAIDS (1996–2001), and the rise of the Global Fund and subsequent coordination efforts (2002–2020).

5.1. Baseline Before Fragmentation: WHO Leadership in HIV and AIDS Governance, 1986 to 1995

The period between 1986 and 1995 represents a phase in which the World Health Organization exercised consolidated and uncontested authority over the global response to HIV and AIDS (Liden 2013: 14-15). After the World Health Assembly adopted Resolution WHA 40.26 in 1987, which declared AIDS a global emergency requiring coordinated international action, the WHO created the Global Programme on AIDS (WHO 1988: 3-4). The programme was explicitly mandated to coordinate all international activities related to the prevention and control of AIDS according to the WHO GPA Progress Report from 1989 (WHO 1989: 1-2). These documents show that surveillance, prevention guidance and the development of national strategies were to be directed centrally through the programme rather than dispersed across multiple organizations. Berridge (1996) writes that in the late eighties there existed no alternative international body with a comparable mandate or authority to shape the global AIDS response. Therefore, there is a clear evidence that external competition had not yet emerged, which supports the use of this decade as a coherent baseline free from institutional fragmentation.

This concentrated authority enabled the WHO to generate influential and widely adopted policy outputs. The organization published the first international recommendations on HIV blood

screening in 1987, the Global AIDS Strategy in 1988 and a comprehensive set of technical guidelines on surveillance and prevention that were circulated to more than one hundred national health ministries (Mahler 1988: 2; Mann 1987: 734;). Mann (1987) reports that almost all national AIDS programmes had incorporated WHO surveillance templates into their reporting systems, and WHO internal evaluations note an increase in the number of countries implementing blood screening standards that aligned with the organization's guidance. This pattern demonstrates that the WHO was able to speak with a unified policy voice and that states treated its guidelines as authoritative reference points.

Financial flows during this period further reinforced WHO leadership. Budget records from the Global Programme on AIDS show that many international contributions for HIV related activities were channelled either directly through the programme or allocated in accordance with WHO guidance (UNAIDS 2003). Berridge (1996) notes that donors had no parallel structure through which to direct funds until the mid nineties, which meant that the WHO effectively served as the central manager of global AIDS financing. Smith and Whiteside (2010) add that major donors such as the United States and Sweden directed their contributions toward projects developed by WHO technical teams because no other institution had established a comparable capacity for programme design. These findings provide demonstrable proof that donors were structurally tied to the WHO during this decade, which reduced transaction costs and ensured that global and national activities were aligned with a single institutional framework.

The institutional landscape before 1995 shows no evidence of external fragmentation. Archival reviews conducted by Liden (2014) reveal that neither the Joint United Nations Programme on HIV and AIDS nor any other dedicated multilateral body existed during this period. No treaties, interagency committees or alternative coordinating authorities had been created that could issue their own guidance or develop independent strategies (ibid.). The fact that neither states nor donors reported confusion about which institution held authority over policy direction also provides empirical proof that mandate proliferation had not yet occurred. This evidence confirms that fragmentation was absent and that governance remained structurally unified.

Although the system was unified, it contained vulnerabilities that later facilitated institutional change. Daugirdas and Burci (2019) point out that the Global Programme on AIDS relied heavily on voluntary contributions and therefore struggled to secure predictable funding for

long term planning. Several governments expressed frustration with what they perceived as delays in programme delivery and an overemphasis on prevention rather than treatment (ibid.). Smith and Whiteside (2010) show that countries such as the United States and France began questioning the operational capacity of the programme by the early nineties. These tensions did not produce institutional alternatives during the baseline period, but they did create incentives for donors and states to consider new governance arrangements in the years that followed. This period therefore establishes the baseline condition required by the causal mechanism: centralized authority, low coordination costs, and WHO outputs functioning as the uncontested reference point for global HIV governance.

5.2. Institutional Rupture and the Creation of UNAIDS Between 1996 and 2001

The creation of the Joint United Nations Programme on HIV and AIDS in 1996 constitutes the first demonstrable moment of institutional fragmentation in global HIV and AIDS governance (UNAIDS 2008). This claim is supported by documentary evidence from the World Health Assembly and the reports commissioned for the establishment of UNAIDS, which record that responsibility for global coordination no longer resided solely within the World Health Organization (UNAIDS 1996). Before this reform, the WHO's Global Programme on AIDS produced the international strategy, issued technical norms, and oversaw donor coordination. The redistribution of these functions across several United Nations bodies created a new institutional landscape that replaced a single focal actor with a collective institutional arrangement (Buse and Walt 2000). This institutional shift represents the first observable disruption in the continuity of WHO authority, which is necessary for tracing the mechanism that links fragmentation to reduced output effectiveness.

The political origins of UNAIDS emerged from widespread dissatisfaction with the performance of the Global Programme on AIDS. Multiple governmental and independent evaluations found that the programme struggled to manage the expanding social and developmental dimensions of the epidemic and lacked adequate funding and managerial capacity (World Bank 1997). At the same time, agencies such as UNICEF, UNDP, and the World Bank had already begun to develop individual HIV initiatives, which signalled increasing institutional interest in assuming responsibility for aspects of the response (Poku

2002). This convergence of criticism and institutional ambition produced pressure for a joint arrangement that redistributed authority. The final decision to create a collaborative programme supported by six co sponsoring institutions demonstrates that fragmentation emerged from deliberate political choices rather than organic evolution.

The establishment of UNAIDS provides clear evidence of institutional proliferation, which is the first step in the causal mechanism under examination. Authority over the global response shifted from a single organizational centre to a coordinated but structurally separate secretariat. Formal documentation from the Programme Coordinating Board confirms that UNAIDS was established with an independent mandate to guide the overall response and to coordinate the activities of co sponsors, including the WHO (UNAIDS 1995). This creates an institutional configuration in which no single organization holds complete policy authority. The presence of a new institution with a mandate that overlaps with the WHO satisfies an early hoop test for fragmentation because it demonstrates that governance no longer operates through a unified institutional structure.

The emergence of overlapping responsibilities further substantiates the presence of fragmentation. Although the WHO maintained authority over clinical and epidemiological standards, UNAIDS acquired the mandate to shape advocacy, strategy, and resource mobilization, which created considerable ambiguity in practice (Joint Inspection Unit 2007). Independent evaluations note that both organizations produced guidance on prevention frameworks, national strategic planning, and priority setting for external financing (Ogden et al. 2003). The co existence of parallel guidance illustrates a dispersion of authority that affects the coherence of policy outputs. This diffusion of responsibilities provides empirical confirmation that fragmentation was not merely structural but also functional.

Financial realignment among major donors offers an additional indicator that fragmentation diminished WHO influence during this period. Several bilateral donors increased financial contributions to programmes associated with the World Bank and UNICEF, arguing that these organizations offered broader developmental reach and stronger political advocacy than the WHO (Poku and Whiteside 2002). Budget records from the late nineteen nineties confirm that a growing share of HIV related funding moved outside the WHO framework (World Bank 1997). This behaviour functions as a smoking gun because it directly links donor perceptions of shifting authority to changes in financial flows. If institutional fragmentation had not been

occurring, donors would have continued to channel resources through the WHO as the uncontested coordinator.

These institutional changes had measurable effects on WHO output effectiveness. Studies from the period report that policy formulation slowed and that guidance on national strategies became less consistent because the WHO was now required to negotiate priorities with a separate joint programme (Buse and Walt 2000). The organization no longer produced strategy documents with the same clarity or speed, in part because agreement with UNAIDS co sponsors had become essential before issuing new recommendations. This reduced the organization's capacity to exercise authoritative policy leadership and illustrates an early impact of fragmentation on output effectiveness.

However, the evidence from this period suggests emerging rather than severe fragmentation. Scholarly analyses show that the WHO continued to hold significant authority in areas related to clinical guidelines, surveillance standards, and epidemiological reporting (Lidén 2014). The organization's outputs declined in coherence compared to the pre fragmentation period, yet it retained meaningful influence over technical matters. This indicates that fragmentation operates through gradual erosion of authority rather than abrupt displacement. The years between 1996 and 2001 therefore constitute an intermediate stage in the causal sequence, in which structural changes begin to affect performance but do not yet produce comprehensive institutional dislocation.

5.3. Peak Fragmentation and the Rise of the Global Fund Between 2002 and 2010

The years between 2002 and 2010 represent the clearest intensification of external fragmentation in global HIV governance. The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria introduced an institution with autonomous financing authority that neither the World Health Organization nor UNAIDS could direct (The Global Fund 2001). The Global Fund Framework Document states that the institution was deliberately designed to operate as a financial instrument, not an implementing entity, with an independent Board and grant procedures separate from UN structures (ibid). This innovation changed the architecture of global HIV governance by relocating financial power outside the WHO system. The

structural diversification of authority visible in this period provides the strongest foundation for tracing how fragmentation began to undermine the WHO's ability to produce coherent and authoritative outputs.

The emergence of the Global Fund responded to widespread recognition that existing bodies lacked the financial capacity required for treatment scale-up. WHO reports from the early 2000s acknowledged the severe resource gap that impeded national treatment programmes and surveillance capacities (WHO & UNAIDS 2003). Donor governments consequently supported the development of a new financing mechanism that could raise and disburse substantial funds without relying on WHO administrative procedures. This reform reflects institutional proliferation because it created an additional centre of governance with its own rules and oversight structures. The appearance of a large independent financial institution confirms that authority within HIV governance was becoming increasingly dispersed.

The redistribution of financial authority strongly influenced agenda-setting capacity. Global Fund annual reports show that within three years of its creation it had approved more than three billion dollars in grants, surpassing the combined HIV-related budgets of WHO and UNAIDS (Global Fund 2005). Because grant applicants were required to design national strategies consistent with Global Fund proposal guidelines, financial incentives began shaping national priorities (ibid.). Joint Inspection Unit evaluations note that this shift reduced the extent to which WHO could direct policy because governments increasingly oriented their plans toward the expectations of the Global Fund rather than toward WHO guidance (Joint Inspection Unit 2019). The dominance of an institution outside the WHO framework provides concrete evidence of mandate displacement, which is central to the causal mechanism linking fragmentation to declines in output effectiveness.

The interaction between Global Fund procedures and WHO technical guidelines created additional barriers to the production of unified policy outputs. Several countries aligned their national HIV strategies with Global Fund performance indicators and budgeting requirements, which at times diverged from WHO's recommended sequencing of prevention and treatment interventions (WHO 2021). UNAIDS reviews of proposal rounds note that applicants occasionally adopted policy components primarily because they improved funding eligibility rather than because they corresponded to WHO protocols (UNAIDS 2006). This situation created parallel reference points for national decision-making and diminished the clarity and

consistency of WHO recommendations. The presence of two authoritative frameworks operating simultaneously demonstrates that fragmentation generated institutional duplication with direct consequences for WHO output authority.

The governance model introduced by the Global Fund further reduced the centrality of WHO expertise. The Fund's emphasis on country ownership, civil society participation, and performance-based financing contrasted with WHO's technical leadership model built on normative standard-setting (Bartsch 2007). According to the Global Fund's governance evaluations, civil society and non-state actors gained unprecedented influence through Country Coordinating Mechanisms, which became required structures for grant eligibility (Global Fund 2018). This broadened participation created new pathways for policy influence that did not depend on WHO validation. The widening set of actors involved in strategic planning illustrates how fragmentation weakens the ability of any single institution to shape widely adopted policy directions.

The expansion of antiretroviral therapy during this decade intensified the implications of these institutional transformations. WHO launched the Three by Five strategy in 2003, acknowledging in its official report that implementation depended on financial commitments from external partners far beyond the resources available to WHO (WHO 2004). Meanwhile, the Global Fund became the primary financer of national treatment programmes, allocating billions of dollars to drug procurement and health system strengthening (Global Fund 2005). UNAIDS evaluations from the mid-2000s observed that financing decisions did not always correspond to WHO priority-setting, which led to inconsistencies in programme rollout and treatment sequencing (UNAIDS 2006). The separation between financing authority and technical leadership reduced the coherence of policy outputs and aligns with expectations that high fragmentation decreases output effectiveness.

Despite these difficulties, there were instances in which Global Fund financing strengthened the implementation of WHO guidelines. The World Bank notes that enhanced financial flows accelerated the adoption of antiretroviral therapy and contributed to rapid declines in mortality in several regions (World Bank 2007). In these cases, specialized financial capacity complemented WHO's normative role by enabling countries to act on technical recommendations. Yet UNAIDS also emphasized that such benefits were uneven and did not resolve broader coordination challenges across the governance system (UNAIDS 2006). The

simultaneous presence of positive resource effects and declining policy cohesion reflects a mixed pattern, but one marked by a predominance of institutional incoherence.

The WHO attempted to adapt to the new landscape by increasing technical collaboration with the Global Fund, providing guidance for proposal reviews and assisting with implementation monitoring. However, Joint Inspection Unit analyses indicate that these efforts did not restore WHO to a central coordinating position because the Fund's governance remained independent and because formal authority over resource allocation stayed outside the WHO system (Joint Inspection Unit 2024). Once fragmentation reached this high level, the reconfiguration of authority became self-reinforcing and difficult to reverse. The trajectory of the mechanism therefore continued in the direction of diminished WHO leadership.

5.4. Organization, Global Integration and Partial Re integration 2011 to 2020

The period 2011-2020 was a crucial period of recalibration in global HIV and AIDS policymaking. Fragmentation continued to appear, but leading organizations turned in part to try and strengthen cooperation and eliminate redundancy in the planning and coherence at strategic levels. This point is particularly analytically significant, since it permits a consideration of whether moderate fragmentation and supportive collaborative functions can bring effects on a productive level consistent with theoretical expectations based on functional complementarity.

By the beginning of the 2010s, fears of institutional fragmentation became more familiar with academics and policy makers. Clinton & Sridhar (2017) pointed out that the multiplication of actors had led to overlapping responsibilities which have eroded strategic integrity and efficiency of resource management on the global stage. These evaluations highlighted that fragmentation could not be treated as an inevitable component of governance and could no longer be overlooked in favour of corrective action (ibid.). In reply, states and institutional authorities pursued reforms that clarify roles and provide more predictable channels of coordination. The greatest impact was to be noted within the co sponsorship arrangement of UNAIDS, which prompted member organizations to pledge to common outcomes and delineate lines of duties (ibid.). Under this regime, the World Health Organization assumed

primary responsibility for technical norms, surveillance standards, and clinical advice, and oversight while the Global Fund served as the principal source of finance (ibid.). The shifting of responsibilities helped eliminate some of the ambiguity in mandate which led to institutional tension during the last decade.

The second significant driver of coordination was provided by the Sustainable Development Goals (SDGs) adopted in 2015, re-affirming a global resolve to eliminate AIDS as a public health threat by 2030. The Sustainable Development Goals focused on measurable targets that necessitated collaborative action, and scholars suggest that this perspective resulted in increased institutional alignment, as attaining the goals relied on aligning with synchronised global strategies (Youde 2018). In this context, World Health Organization promulgated consolidated treatment and prevention directives and advocated the Treat All policy which urged the rapid initiation of antiretroviral care for all HIV patients (ibid.). These guidelines received broad international support and were included on individual countries' level in various geographical areas, indicating the World Health Organization's capacity for influence regarding output level policy acceptance.

During this time the relationship between the World Health Organization and the Global Fund was also more formalised. The World Health Organization was also providing increasingly technical advisory services, such as evidence reviews, surveillance expertise and assessing grant applications (WHO 2017). Such interactions were beneficial in avoiding duplication and generating greater consistency between financing decisions and clinical standards (Benatar et al.: 2010). This indicates that fragmentation was not an institutional competition-specific phenomenon. Rather it provided the opportunity for complementary strengths to mutually support one another, particularly when underpinned by formal coordination systems.

However, after this reform the full institution reintegration did not take place. Academic interpretations consistently highlight an ongoing tension about agenda setting, priority sequencing, and the allocation of financial resources (Clinton & Sridhar 2017). The Global Fund maintained its financial and administrative independence, and donor pressure continued to influence its strategic focus (ibid.). Consequently, the World Health Organization, in particular, was not empowered to guide global resource allocations, thereby hampering its involvement in implementing policy and restricting its ability to coordinate large scale

responses (ibid.). These were circumstances that showed structural fragmentation remained even if it was becoming less disruptive compared with the decade before to some extent.

Disparity in national governance capacity also played a role in shaping the potency of coordination. In the data collected, countries with established technical systems were found to adopt World Health Organization recommendations to a greater extent, while others were more likely to rely on financial motivation embedded in Global Fund schemes (Fonner et al.: 2020). Domestic institutional strength differences thus mediated the extent to which international coordination resulted in coherent national level action (ibid.). Fragmentation became intertwined with these national conditions, not serving as an isolated explanatory factor.

The period was also affected by external crises that temporarily brought the World Health Organization into the mainstream. However, throughout the West Africa Ebola outbreak and in the early stages of the COVID-19 pandemic, the organization has maintained international visibility as a primary source of technical guidance (Müller et al.: 2021). While not related directly to HIV and AIDS, these crises bolster the World Health Organization's image as an essential global health actor (ibid.). This reputational reinforcement helped indirectly in the uptake of its HIV related guidance and demonstrates that external shocks can disrupt fragmentation dynamics by increasing the authority of a single entity.

Table 1. Process-Tracing Tests

Analytical Stage	Test Type	What the Test Examines	Key Empirical Evidence	Inference
1986–1995	Hoop test (absence of fragmentation)	Whether alternative institutions or overlapping mandates existed	WHO GPA held exclusive coordination mandate; no UNAIDS, Global Fund, or parallel bodies; donors channelled funds through WHO	Fragmentation absent; baseline condition of unified authority satisfied
	Smoking gun (authority & effectiveness)	Whether WHO outputs were treated as authoritative	Uptake of WHO surveillance templates; blood screening standards widely adopted; donors aligned	WHO exercised high output effectiveness

			funding with WHO guidance	
1996–2001	Hoop test (onset of fragmentation)	Whether institutional proliferation occurred	Establishment of UNAIDS with overlapping strategic and coordination mandate	Fragmentation clearly present
	Smoking gun (authority dispersion)	Whether authority shifted away from WHO	Donors redirected funds to World Bank/UNICEF; UNAIDS issued parallel guidance	Fragmentation reduced WHO output authority
	Straw-in-the-wind	Whether outputs became less coherent	Slower strategy formulation; need for inter-agency negotiation	Early erosion of effectiveness, but not collapse
2002–2010	Hoop test (high fragmentation)	Whether financial authority moved outside WHO system	Creation of Global Fund with independent Board and grant procedures	High fragmentation confirmed
	Smoking gun (mandate displacement)	Whether WHO lost agenda-setting power	National strategies aligned with Global Fund criteria over WHO guidance	Fragmentation directly undermined output effectiveness
	Straw-in-the-wind	Whether policy coherence declined	Parallel frameworks; inconsistent sequencing of prevention/treatment	Strong support for causal mechanism
2011–2020	Straw-in-the-wind (moderation)	Whether coordination improved outputs	Clarified roles under UNAIDS; WHO Treat All guidelines widely adopted	Moderate fragmentation allowed partial recovery
	Hoop test (non-reintegration)	Whether authority was fully restored	Global Fund retained financial autonomy	Fragmentation persisted, but less disruptive

5.5. Alternative explanations and strength of causal inference

A systematic analysis of conflicting explanations is necessary to determine how closely the link between external fragmentation and changes in output effectiveness of the World Health Organization follows a causal model. Process tracing emphasizes that a causal claim is persuasive only if the proposed mechanism corresponds to the evidence better than competing accounts (Collier 2011). Thus, this evaluation explores competing explanations with respect to internal weaknesses in the World Health Organization, donor-based political influence and national capacity constraints, to help elucidate if in reality fragmentation still holds the most significant structural explanation.

One of the most prominent alternatives suggests that output effectiveness has declined due to institutional shortcomings within the World Health Organization. Researchers have recorded entrenched issues of bureaucratic rigidity, weak systems for responding in emergencies, and managerial limitations that prevent the organization from innovating or adapting (Gostin & Friedman 2015). These constraints absolutely have an effect, particularly on performance and may threaten policy coherence (ibid.). But history demonstrates that the World Health Organization also produced authoritative leadership over the 1980s and 1990s and the strong global leadership it displayed despite some internal imperfections. The organization was able to act effectively under institutional centrality and this suggests that internal weaknesses were insufficient to ensure that later falls were not due to internal shortcomings alone. They seem to have consolidated the influence only once the outside world got muddied with rival institutions, indicating that fragmentation intensified rather than developed vulnerabilities.

A second explanation is that observed differences in output effectiveness may result from political pressure exerted by donors and member states. Studies have also found that global health priorities are often influenced by strategic interests, with the major funders influencing what programs work and limiting the independent control of the agencies that carry them out (Clinton & Sridhar 2017). These dynamics can also alter policy agendas and cause inconsistency in global planning (ibid.). However, donor competition predates establishment of UNAIDS and the Global Fund. Only after these extra institutions were established did output coherence decline significantly; they provided donors with other governance venues and other resources to direct their efforts by providing the necessary structure for operations. Donor

behaviour thus seems to serve as a reinforcing mechanism played out within a dysfunctional institutional setting rather than being a proximate causal factor in the decline in organizational performance.

A third reason is related to varying administrative capacities of national governments. Poor countries with weak local capability, infrastructure and financial means might be unlikely to adhere to World Health Organization advice on a consistent basis which would lead to varying global impacts (Saluja et al.: 2022). Although this explanation adjusts for variation at a national level, it does not allow for the organization's own policy production as previously observed. International adjustments in global guidelines, alterations in partnerships structurally, and challenges in strategic planning arose independently of national roll-out arrangements. Thus domestic capacity is the reason for unequal uptake, but it cannot explain the systemic changes in the organization's capacity to produce coherent outputs. The ability to consider these alternatives adds to the validity of the fragmentation-based account.

Although each competing perspective sheds light on key aspects of global health governance, none elucidates the timing or scale of changes in World Health Organization effectiveness as comprehensively as the fragmentation mechanism. This correspondence between structural change and performance in organizations endorses the evidence that fragmentation played a decisive causal role. All together, the observed pattern meets hoop test requirements and has qualities associated with strong inferential evidence and provides a strong argument that suggests causation. While qualitative analysis cannot provide absolute certainty, the resulting trends show that external institutional fragmentation played a central role in shaping the output effectiveness of the World Health Organization in the global HIV and AIDS response.

6. Conclusion

This thesis has investigated the extent to which external fragmentation has impacted the output effectiveness of the World Health Organization in managing the HIV and AIDS response. Based on regime complexity theory and qualitative process tracing, it reconstructed how dispersed authority, overlapping mandates, and institutional proliferation transformed the World Health Organization's capability to lead, coordinate, and create cohesive policy outputs in the course of four decades. Evidence suggests that fragmentation has been a prominent structural mechanism driving the organization's performance.

The analysis provides substantial support for H1 (high institutional fragmentation reduces the effectiveness of the output at World Health Organization). The evidence to this end is found clearly between 2002 and 2010. In addition to overlapping mandates that were engendered by the establishment of UNAIDS, the emergence of the Global Fund as an independent financial authority brought about a decentralisation of leadership at multiple organizations. This generated conflicting reference points for states and donors, diminished the group's agenda setting capacity and undermined its ability to provide unified direction. These developments meet the expectations of the causal mechanism and demonstrate that fragmentation had led to reduced coherence and clarity in World Health Organization policy outputs.

The results also provide support for H2, that moderate fragmentation in support of coordination can increase output effectiveness. Between 2011 and 2020 the co sponsorship model of UNAIDS, joint sharing of strategic aims and increased technical collaboration between the World Health Organization and the Global Fund fostered an environment for mutually reinforcing specialisation. These arrangements strengthened alignment, reduced redundancy, and enabled wider adoption of World Health Organization guidance, particularly around the Treat All initiative. This time period reaffirms that fragmentation can be constructive when institutional interactions are framed around established rules and cooperation platforms.

The results show that fragmentation is not by nature destructive. On the contrary, its impact hinges on the extent to which mandates overlap, clarity of institutional roles, and coordination mechanisms. The World Health Organization performed well when fragmentation was low and performed unevenly when fragmentation increased without its counter-structures. Therefore, the research concludes that external fragmentation has structured the overall output

effectiveness of the World Health Organization in systematic and predictable ways and has been a decisive factor in whether the organization could act as champion of global leadership.

Academically, the importance of the present study is due to the limited available literature that utilizes fragmentation theory for global health. Although fragmentation has been widely studied in environmental and trade governance, it is underdeveloped for health institutions. This dissertation demonstrates that fragmentation frameworks are a key method for analysing systemic authority, coordination and policy coherence in global health governance. These results can be extended to other disease areas where fragmentation is observed, comparing regional differences in the acceptance of World Health Organization guidance, or identifying quantitative measures that better measure the extent of institutional overlap. Research might also explore how the emerging actors in global health, from philanthropic organizations and private sector partnerships, reshape the dynamics of authority and what kinds of fragmentation they're contributing to.

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