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# RESTORING ORDER IN GLOBAL HEALTH GOVERNANCE: DO METAGOVERNANCE NORMS AFFECT INTERORGANIZATIONAL CONVERGENCE?

AUTHOR: ANNA HOLZSCHEITER

Minda de Gunzburg
CENTER FOR EUROPEAN STUDIES
HARVARD UNIVERSITY

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## AUTHOR: ANNA HOLZSCHEITER

BIOGRAPHY: Anna Holzscheiter is Assistant Professor of Political Science and International Relations at the Freie Universität Berlin and Head of the Junior Research Group "Governance for Global Health", a joint research unit of Social Science Research Centre Berlin and Freie Universität Berlin.

During the academic year 2014/2015 she was John F. Kennedy Fellow at the Center for European Studies at Harvard University. Holzscheiter has been conducting research on emerging governance architectures in global health. She is seeking to explain when and why international organizations work towards more harmonious governance architectures in order to heighten their collective problem-solving capacities. Her aim is to contribute to ongoing theory-building on emerging architectures in global governance.

Her publications include Children's Rights in International Politics. The Power of Transnational Discourse (2010) and "Between Communicative Interaction and Structures of Signification: Discourse Theory and Analysis in International Relations" (International Studies Perspectives 2013).


## ABSTRACT


This paper theorizes about the convergence of international organizations in global health governance, a field of international cooperation that is commonly portrayed as particularly hit by institutional fragmentation. Unlike existing theories on interorganizationalism that have mainly looked to intra- and extraorganizational factors in order to explain why international organizations cooperate with each other in the first place, the paper is interested in the link between causes and systemic effects of interorganizational convergence. The paper begins by defining interorganizational convergence. It then proceeds to discuss why conventional theories on interorganizationalism fail to explain the aggregate effects of convergence between IOs in global (health) governance which tend to worsen rather than cushion fragmentation – so-called "hypercollective action" (Severino & Ray 2010). In order to remedy this explanatory blind-spot the paper formulates an alternative sociological institutionalist theory on interorganizational convergence that makes two core theoretical propositions: first that emerging norms of metagovernance are a powerful driver behind interorganizational convergence in global health governance, and secondly that IOs are engaged in a fierce meaning-struggle over these norms which results in hypercollective action. In its empirical part, the paper's core theoretical propositions are corroborated by analyzing discourses and practices of interorganizational convergence in global health. The empirical analysis allows drawing two far-reaching conclusions. On the one hand, interorganizational harmonization has emerged as a largely undisputed norm in global health which has been translated into ever more institutionalized forms of interorganizational cooperation. On the other, discourses and practices of interorganizational harmonization exhibit conflicts over the ordering principles according to which the policies and actions of international organizations with overlapping mandates and missions should be harmonized. In combination, these two empirical findings explain why interorganizational convergence has so far failed to strengthen the global health architecture.

# RESTORING ORDER IN GLOBAL HEALTH GOVERNANCE: DO METAGOVERNANCE NORMS AFFECT INTERORGANIZATIONAL CONVERGENCE?

## 1. Introduction

Let's get our house in order. This imperative resounds widely across the extensive landscape of actors which contribute to today's global governance of health matters. Like no other field of international concern, international cooperation in the area of health has evolved and diversified in the past 25 years (Hein and Kickbusch 2010; Smith 1995; Taylor 2002; The Lancet 2009 ) – to such an extent that global health governance is routinely captured in pictorial terminology revolving around chaos and mess. The gist of these portrayals is that today's international cooperation in the field of health is a cacophonous "many-piece orchestra" (Hermias and Kharas 2008) composed of (too) many actors, institutions and programs that perform without conductor. While the international response to HIV/AIDS in particular had helped to fortify this imagery of global health governance as a shambolic area of international cooperation, it has, over time, crystallized into a persistent truism about global health governance at large.

This paper argues that while much scholarly effort has gone into studying the causes and effects of institutional fragmentation in global governance, the reverse centripetal movement towards order and architecture deserves more attention. At present globally operating health agencies are engaged in a vigorous debate on reforming and strengthening the institutional architecture for global health. Most generally, global health governance is defined as transboundary cooperation to curtail communicable and non-communicable diseases and ensure the best possible standard of health for populations around the world. In 1948, the World Health Organization (WHO) was set up as the central international health agency with a constitutional mandate to "act as a directing and co-ordinating authority on international health-work" (WHO Constitution, Chapter II, Article 2(a)). Ever since, the broadening mandates of other international organizations (World Bank, UNICEF, UNDP), the creation of new health-specific programs, funds and coordinating bodies (UNFPA, UNAIDS, Global Fund) and the increasing power of private actors such as the Bill & Melinda Gates Foundation, have undermined the central authority of the WHO in many areas. Today, it is estimated that the global institutional landscape surrounding health is a fragmented, highly competitive structure of over 100 international organizations (Godal 2005; OECD 2011b; Schieber, et al. 2007) whose formal and effective mandates collide in many cases (Lee, et al. 1996). While the WHO is still acknowledged as the central norm-setting authority in international health, there are conflicting spheres of authority between health IOs in operations; in the co-financing of health systems in developing countries; and in capacity-building (England 2009).

There are various drivers behind the breakneck speed with which the institutional landscape in global health has expanded and diversified since the 1990s, before all the rising prominence of health on two agendas central to international politics: international development and foreign policy. Official development assistance (ODA) for health has seen a five-fold increase since 1990 from US$ 5.6 billion in 1990 (The Lancet 2009) to US$ 26.8 billion in 2010 (Institute for Health Metrics and Evaluation 2010: 9). Between 2000 and 2010 alone, ODA for health has risen by 768 per cent.[1] In the United States' foreign aid budget funds for health (8.8 billion USD) now regularly outweigh funds for security related assistance (at 8.4 billion USD).[2] What is more, health has established itself as a most welcome attachment to foreign policy and security agendas, as the soft foreign intervention to win over people's hearts and minds. And, over time, it has trumped other areas of foreign aid, because health interventions are supposedly easy to measure and show the rapid impact of do-

sures) (Natsios 2010). Finally, opinion polls consistently confirm the high value that populations around the world attach to their own well-being and to the prominence of health on the development agenda.[3]

While all of these factors have played a role in boosting health-related issues on the global agenda it was the surfacing of infectious diseases such as HIV/AIDS and, recently, Ebola as well as the health-focus of the Millennium Development Goals that has pushed health funding to historical levels (Piva and Dodd 2009).[4] Following these developments we are presently facing an unprecedented number of actors and rule systems relevant to policy-making and implementation in global health. This makes many issues pertaining to the broad field of global health governance examples par excéllence for regime complexity in global governance – a phenomenon whose popularity in academic research is rising. Population control, access to essential medicines or the ethical recruitment of health personnel are all problems governed by regime complexes as "an array of partially overlapping and non-hierarchical institutions" (Raustiala and Victor 2004: 279) pertaining to such rule-systems as human rights, reproductive rights, labor regulation or intellectual property (Orsini, et al. 2013). Thus, many issues addressed in global health governance are ripe with interface conflicts between the intersecting, overlapping or nested rule-systems belonging to a specific regime complex (Alter and Meunier 2006).

This paper starts from the essential observation that even though global health governance has come to be associated with frequent collisions between rule-systems and a byzantine landscape of institutions and actors, many of these actors are united in their search for an appropriate architecture that can hold the many pieces of a global health mosaic together. Contemporary global health governance, thus, is as much about finding appropriate solutions to transboundary health problems as it is about restoring institutional order and carving out a global health architecture with which these problems can be adequately addressed (Kickbusch, et al. 2010). Whereas, for a long time, public and private actors have channelled their efforts into experimentation with new institutional designs for tackling health issues,[5] they are now increasingly searching also for the 'master-design', i.e. the optimal institutional meta-architecture that "orchestrates" the many-piece orchestra of global health governance (Abbott, et al. 2015). This has never been more evident than during the global crisis following the Ebola outbreaks in Western Africa in 2014.[6] The international debate surrounding the 'Ebola crisis' has made it crystal clear that the global health discourse has shifted from one celebrating pluralization and valuing competing rule-systems, innovation and flexibility to one in which there is an unanimous call for order and large-scale coordination (Gostin and Friedman 2014).

Concrete attempts to restore institutional order in global health already abound: in the field of global public health, over seventy-five global initiatives and partnerships have been identified whose main purpose lies in mitigating fragmentation and coordinating multilateral and bilateral contributions to health governance (Balabanova, et al. 2010). For any major global health issue today there exist one or multiple harmonization initiatives, such as, for example, the Harmonization Working Group that forms part of the *Roll Back Malaria Partnership*.[7] Despite this trend towards convergence (which is by no means unique to health) IR scholarship on interorganizationalism is still underdeveloped and largely dominated by rationalist-institutionalist approaches. As I argue throughout this paper, the research agenda on interorganizationalizm in fragmented governance areas calls for theoretical and epistemological diversification as soon as the systemic effects of interorganizational cooperation are at stake. To that end, I advance a norm-focused approach to interorganizationalism that permits to explain the interplay between drivers of interorganizational convergence on the one hand and its systemic effects on the organizational field as a whole on the other. The paper puts forward the core theoretical proposition that the observable

convergence between global health agencies is an effect of so-called metagovernance norms, i.e. norms that relate to the appropriateness of interorganizational harmonization in global health governance. However, there is strong empirical evidence that as organizations translate metagovernance norms into concrete cooperative strategies and practices and intensify their interorganizational relationships, fragmentation and complexity increase instead of decreasing. The 'governance of governance' or the 'coordination of coordination' thus results in "hypercollective action", i.e. a proliferation of actors, policies and structures that is spinning out of control and produces ever more coordination problems (Severino and Ray 2010). As the empirical part of the paper will illustrate, hypercollective action in global health can be explained as an outcome of the interplay between the constraining influence of norms on the one hand and the human agency that moulds, enacts and transforms the meaning of these norms on the other. Hypercollective action then is a result of an emerging global normative consensus on harmonization coupled with ongoing conflicts over the precise scope of such norms and struggles among international organizations over their position and authority in a reformed global health architecture.

The paper starts with a conceptual clarification of what is meant by interorganizational convergence as the cooperative and institutionalized variant of relationships between international organizations. In a second step, the paper discusses and critically reviews existing theories on inteorganizational convergence in terms of their limited ability to grasp convergence between multiple international organizations in fragmented fields of global governance and the metarules that order and give meaning to relations between organizations within an institutional field as a whole. Thirdly, and most importantly, the paper proposes and develops an alternative explanatory approach to interorganizational convergence that builds on the effects of so-called metagovernance norms which define a) good global governance as harmonized global governance and b) the ordering principles and trajectories according to which such order should be generated. In the empirical part of the paper (4.), I will analyze the extent to which metagovernance norms have had an effect on discourses and practices of interorganizational convergence, particularly between the seven most important multilateral organizations in contemporary global health governance.

**2. Defining interorganizational convergence**

An organization is commonly defined as a purposeful, enduring social structure which is embedded in a social environment but can be delineated from it. A core proposition from organization sociology that this paper adopts is that all social and political organizations are open systems which interact with their organizational environment and are partly shaped by it (Katz and Kahn 1978). Relationships with other organizational units are a central feature of this environment and "in order to understand organizational behaviour, one must understand how the organization relates to other social actors in its environment" (Pfeffer and Salancik 1978: 257). As organizations, international organizations are by analogy embedded in an organizational environment or field with a social dynamic of rivalry and synergy, much like transnational corporations are embedded in a global market driven by competition and joint ventures. Such relations between international organizations are fraught with struggles over authority, autonomy and market power.

On a most basic level, interorganizational relations can be defined as any kind of interaction between two or more formally independent organizational units. The organizational units considered relevant for this paper are international organizations as those organizations that operate across borders; have a permanent administrative structure; have been established following an explicit formal agreement in which states were involved as principals; and in which states or intergovernmental organizations occupy a central role (i.e. are at least represented in the governing body of the organization). Fol-

lowing these criteria, interorganizational relations considered relevant for this paper encompass not only those between classical intergovernmental organizations (IGOs) such as the WHO or the World Bank but also between IGOs and public-private organizations in which states and/or IGOs play an important role. The paper therefore does not address relations between purely private (i.e. civil society or business) organizations. The Global Fund to Fight AIDS, Malaria and Tuberculosis (Global Fund) and GAVI The Vaccine Alliance (GAVI) are considered international organizations here while the Drugs for Neglected Diseases Initiative whose members are exclusively civil society actors is not.

To classify the interactions between such international organizations as a relationship, they have to be more than passing transactions. They must consist of repeated interactions or "patterns of relations" (Cropper, et al. 2008: 9). The nature of such interorganizational relationships between IOs can be quite varied: they can be conflictual or cooperative; sporadic or institutionalized; deliberate or unintended. As this paper is interested in rapprochement between IOs motivated by international norms calling for greater coherence and coordination between IOs, it logically zooms in on relationships of a cooperative, institutionalized and deliberate kind. Interorganizational convergence then denotes a progression in cooperative relationships as it implies an intensification of interactions between international organizations. It is defined here as an increase in the number and depth of deliberate cooperative relationships between two or more formally independent organizational units. What follows logically from this is a perspective on international organizations as purposeful actors that make deliberate choices on cooperative relationships with other IOs. While they are certainly constrained by external authority (member states) there is still room for manoeuvre and choice in the behavior of their bureaucracies. Cooperative relations with other IOs then are a chosen course of action and not an accidental product.

### 3. Interorganizational relations: rationalist and sociological institutionalist approaches

Since the 1960s, interorganizational relations have been a substantial part of scientific inquiry into formal organizations in the economy, in politics and in society. It was particularly Evan's seminal contribution that helped to establish theory-building on interorganizational relations (Evan 1965). As a consequence, the study of interorganizational relations became prominent in Organization Theory and Sociology (Aldrich and Pfeffer 1976; Metcalfe 1981); in Management Theory and Business Studies (Ebers 2001; Osborn and Hagedoorn 1997; Schermerhorn 1975); in Communication Studies (Atouba and Shumate 2010); and in Public Administration and Political Science (Hanf and O'Toole 1992; O'Toole 1993). The various disciplinary approaches to interorganizational relations that have been developed over time share at least three commonalities: first, a dominance of rationalist, functionalist approaches that emphasize utiliy-maximizing aspects in order to explain why, when and in what form organizations forge relationships with each other in order to exchange or pool resources. Secondly, a narrow empirical focus on dyadic or triadic interorganizational relationships (Wouters and De Meesters 2005). And thirdly, a primary interest in explaining the determinants of interorganizational relationships and the structure of interorganizational networks rather than theory-building on the effects and outcomes of interorganizational cooperation. All of these tendencies add up to an understanding of interorganizational relations as predominatly voluntary "strategic alliances" (Gulati and Gargiulo 1999) or networks between organizations which serve to exchange or offer ressources with the goal of securing comparative advantages or balancing governance deficits without jeopardising the autonomy of individual organizations (Atouba and Shumate 2010; Ebers 2001; Goes and Park 1997; Knight and Pye 2004).

*Interorganizationalism in International Relations Scholarship*

In the discipline of International Relations (IR), interorganizational relations have attracted widespread scholarly interest for considerable time – even if theory and empirical analysis have not employed the corresponding terminology. For a long time, scholarship has been looking into the emergence and effects of so-called policy or advocacy networks, analyzing the networking strategies and relationships between primarily non-governmental organizations and actors but also between state and non-state entities (Carpenter 2007; Keck and Sikkink 1998; Keck and Sikkink 1999). More recent scientific interest in public-private partnerships and networks representing new or alternative forms of governance can also be classified as scholarship on interorganizational relations (Abbott 2012; Arts 2001; Liese and Beisheim 2011; Ruggie 2004). That said, the really new or emerging research program in IR targets relations among intergovernmental organizations or between IGOs and newer hybrid public-private global organizations (Koch 2012). This finding is hardly surprising as, for a long time, specific issue-areas or regimes were taken to be dominated by a single intergovernmental organization. The rising interest in interorganizational relations between intergovernmental organizations therefore runs parallel to the real-world overlap between many IOs' mandates resulting from their observable mission creep as well as the creation of rival organizations designed to remedy governance failure of traditional IGOs.

The few existing works on causes, forms and effects of relationships between international organizations in IR so far exhibit the same programmatic tendencies as the study of interorganizationalism in other disciplines. In their early contributions to interorganizationalism in international politics, both Karen Mingst and Christer Jönsson examine the relationships between international organizations as a rational response to the growing specialization of international organizations which heightens their proclivity to share or pool resources and consequently enhances their interdependencies (Jönsson 1986; Jönsson 1993; Mingst 1987). In IR too, the empirical analysis of interorganizational relations has focused on dyadic or triadic relationships (Mingst 1987: World Bank and African Development Bank; Jönsson 1986: Civil Aeronautics Board and International Air Transport Association; Koops 2009: NATO and EU; Wouters 2005: EU, WHO and WTO) (Wouters and De Meesters 2005) and, in analogy to social science research overall, these relationships are conceptualized as networks.

Recently, one can observe a reviving interest in interorganizationalism, following a wave of scholarly work on regime complexes (Alter and Meunier 2009; Drezner 2007a; Raustiala and Victor 2004) understood as nested, overlapping or parallel international regimes without hiearchical order (Alter and Meunier 2009, S. 13). The study of such regime complexes accentuates plurality and fragmentation of rule-systems (and, thus, also of actor landscapes) and privileges collisions between different rule-systems regulating one and the same issue-area or problem (Betts 2010; Drezner 2007b; Fischer-Lescano and Teubner 2003). By contrast, interorganizationalism turns towards rapprochement and cooperation between „two or more organizations with overlapping geographic and functional domains" (Biermann 2008; Biermann 2011: S. 173; Gehring and Faude 2013; Gehring and Oberthür 2009). This nascent theoretical and empirical-analytical research program has, to date, been dominated by rationalist institutional explanatory frameworks that see interorganizational relationships as a rational response to competition between organizations with overlapping mandates. Interorganizational relationships then serve to uphold comparative advantages and to create functional niches for specialized agencies in order to avoid collisions between mandates and operations (Gehring and Faude 2013; Gehring and Oberthür 2009). To rationalist-institutionalist approaches it does not come as a surprise that global health governance is ripe with such what they see as utility-maximizing relationships as health is typically

defined as a science-driven, technological, even apolitical area of international cooperation with a large number of highly specialized international agencies.

### 3.1 Explaining interorganizational convergence in global (health) governance: conventional approaches

Cooperative relationships between international organizations are by no means a new phenomenon in global governance. After the WHO was established in 1948, one of the first tasks of the WHO Executive Board was to appoint WHO members for a joint UNICEF/WHO committee on health policy (Kickbusch, Hein and Silberschmidt 2010: 558). Over time, however, the frequency and intensity of interactions between staff of international organizations have grown to a mindboggling extent. Many of these interactions nowaways take place through interorganizational channels for communication and exchange such as interorganizational working groups, thematic groups, donor forums and expert networks.

Following functional approaches to interorganizational cooperation, it seems little surprising that interorganizational cooperation in global health is particularly pervasive. Much of interorganizational cooperation in global health governance can be neatly explained by core functionalist theories on what makes interorganizational cooperation more likely. These hypotheses can be clustered in terms of where they locate the push and pull factors explaining interorganizational cooperation: intra-organizational (rational choice; organization type; identity) or extra-organizational (issue-area; outside force; culture of cooperation). On the intraorganizational level, interorganizational theory predicts that organizations whose activities are characterized by technological specialization and innovation are particularly open to relations with other organizations offering essential ressources and knowledge (Ebers 2001). Many activities in global health are related to the collection and dissemination of scientific evidence and epidemiological data; research & development for, procurement and distribution of pharmaceuticals; and medico-technological progress. Functional collaborations between organizations that exchange highly specialized knowledge and ressources are, thus, at first sight a rational move for individual organizations. The exchange and pooling of valuable resources has, indeed, been a major motif behind the creation of a sheer endless number of new initiatives, partnerships and networks in global health such as the Medicines for Malaria Venture or the Drugs for Neglected Diseases Initiative usually involving resource exchange between state actors; non-governmental organizations; philantropies; firms; academic institutions; and think tanks.

Organization theory also predicts that organizations are particularly motivated to start relationships with other organizations when they are confronted with resource scarcity and performance distress (Schermerhorn 1975). In fact, resource scarcity is the principal driver behind cooperation of IOs, not only with regard to monetary or material resources but particularly in terms of expertise and knowledge. A good example for enhanced interorganizational cooperation due to performance distress is the Global Fund. When the Global Fund was established in 2002 it was designed to be a funding organization only, i.e. a highly specialized body. Not long after the Global Fund had disbursed the first funds to recipient countries and even more so when its legitimacy dwindled in the aftermath of a number of corruption cases, the Global Fund intensified its interorganizational relationships with organizations that could oversee fund applications and implemention on the ground due to their technical and logistical expertise, particularly the WHO, UNAIDS and UNDP.[8] Over time, the Global Fund had also broadened its mandate by including the strengthening of health systems overall as well as the safeguarding of human rights in its missions – which has further boosted its rapprochement with other IOs (Hanefeld 2014). Interorganizational relations were further intensified following plans for a thorough reform of the Global Fund financing model that sought to extend its role in the implementation of grants (GFATM 2011). The same

dynamics of performance distress, mandate broadening and increased interorganizational cooperation characterize the history of GAVI (Grundy 2010: 194).

In terms of the intra-organizational qualities that make cooperation between organizations more likely, organization theory also predicts that permeable organizations are more prone to open up to collaboration with other organizations (boundary permeability hypothesis) (Schermerhorn 1975: 851). In global health, it has been particularly the opening up of the World Health Organization towards non-state actors that was a major catalyst for ever more interorganizational relations and networks. The constitutional mandate of most IOs that were set up in global health after 1990 such as UNAIDS or the Global Fund calls for enhanced access and collaboration with other organizations (particularly non-govermental) and the history of these institutions shows high boundary permeability towards other public and private organizations.

The literature on interorganizational relations has also identified important extra-organizational factors explaining why organizations cooperate with each other. Here, the main hypothesis is that interorganizational cooperation is more likely to happen when a powerful extraorganizational force pushes organizations towards cooperation. So, for example, a more coordinated international response to the 2014 Ebola epidemic began to take shape after UN Security Council Resolution 2177 (2014) was adopted unanimously and followed by the establishment of the United Nations Mission for Ebola Emergency Response (UNMEER). Likewise, a policy shift towards health systems strengthening (HSS) and harmonization in U.S. policy on global health following the establishment of the Global Health Initiative by the Obama Adminstration spurred increasing cooperation between US health agencies and programs and other international health actors (US Government 2011)– the U.S. being the most powerful principal in international organizations dealing with health issues.[9]

### 3.2 The limitations of rationalist institutionalist interorganizationalism

All of the hypotheses discussed above help to explain why global health governance is replete with interorganizational interactions and why collaborations between organizations are seen as advantageous for the actors involved. However, with regard to the study of interorganizational relationships between IOs, traditional functionalist rationalist approaches to interorganizationalism exhibit a number of shortcomings. The history of international organizations shows, for example, that resource constraints and performance distress have been a constant challenge to IOs – there is, thus, little explanatory power that can be gained from these two independent variables. More importantly still, existing theories on interorganizationalism treat individual relationships as isolated cases and therefore fail to address the systemic effects of individual relationships between two and more organizational units. While individual collaborations can be highly beneficial to the organizations involved, they do also impact on the organizational field as a whole and not necessarily in the intended way. If international organizations are open systems interacting with their organizational environment then cooperative relationships between two or more organizations in that environment not only affect the cooperating units but also the organizational field, shifting power relationship, pulling more actors into the cooperative arrangement or triggering off new competitive dynamics with other networks.

There is, in fact, very strong evidence from global health governance that cooperation with other organizations has been a rational move benefiting the collaborating actors but impacting negatively on the policy field overall. The catchy finding of hypercollective action in global health points to the limitations of rationalist approaches to interorganizational relations, inasmuch as it testifies to the unintended consequences of initiatives and instruments aimed at interorganizational synchronization but adding rather than reducing complexity. A case in point for this dynamic is UNAIDS which has grown from a coordination mechanism for all UN bodies working on HIV/AIDS into a full-blown bureaucracy, developing a mission creep that eventually turned

its role upside down, from coordinator to competitor with other agencies (Shridar 2012). Likewise, one of the most acclaimed initiatives working towards harmonization between the actions of multiple international organizations in health – the International Health Partnership+ (IHP+) – has been found to fail in its ambitious harmonization goals (Conway, et al. 2008; see also Holzscheiter 2011). Thus, while interorganizational cooperation yields benefits for the interacting organizational units, it may undermine rather than strengthen collectively shared goals including orderly global governance. When it comes to explaining these aggregate effects of interorganizational cooperation, rationalist institutional approaches reach their limits. Interorganizational cooperation may be a rational move for the actors in the short-run, but the long-term transaction costs associated with hypercollective action call for exploring alternative drivers behind interorganizational convergence.

### 3.3. A new theory on interorganizationalism: norms, interorganizational convergence and global institutional order

The unintended or irrational systemic effects of interorganizational cooperation described above represent a severe challenge to rationalist-institutionalist approaches to interorganizationalism. Opening up the theoretical spectrum to sociological, norm-focused theories on interorganizational relations, however, helps explaining hypercollective action in global health and to understand the systemic ramifications of interorganizational convergence as a product of emerging yet contested global norms. In fact, some of the earliest approaches to interorganizationalism in organization theory already included norms as independent variables explaining cooperation between organizations. Thus, organization theory sees interorganizational cooperation as an outcome of norms that foster a "culture of cooperation" among organizations where "cooperation per se takes on a positive value" (Schermerhorn 1975: 848). These norms may either be endogenous to the organization – i.e. the organization's identity as a cooperative organization (Schermerhorn 1975: 852) – or influence organizations exogenously – i.e. a shared culture among organizations with similar identities that defines interorganizational cooperation as good organizational behaviour in the face of a collectively desired outcome. From such a perspective, international organizations are more than utility-maximing agencies seeking to forge relationships with other organizations in order to reduce transaction costs and maximize their gains. Instead, IOs are converging because they are responding to norms as standards of appropriate behaviour which define good global governance as coherent and synchronized global governance. IOs drift towards each other because they acknowledge the value of a specific social order in the governance of global health matters.

A sociological institutionalist theory on interorganizationalism posits that organizations are always embedded in an organizational field understood as the totality of actors and organizations that operate within a specific sphere of activity and are characterized by similar organizational structures and processes (Dingwerth and Pattberg 2009). Norms and rules are an essential component of such organizational fields. As the virtual form of institutions, these ground rules enable social interaction between international organizations. They are therefore constitutive of a shared identity among organizations in the same field (DiMaggio and Powell 1983; DiMaggio and Powell 1991; March and Olsen 1989; Martin and Simmons 1998; Meyer and Rowan 1977). What follows from this is that the boundaries between individual organizations' interests and motivations can no longer be neatly drawn – rather, organizations collectively form a social field in which their actions are oriented towards intersubjectively shared standards for (appropriate) behaviour. To see interorganizational convergence in global health governance as driven by norms on appropriate organizational behaviour in the face of fragmentation allows moving away from a portrayal of global health as an apolitical, technical domain and stressing its political and ideological dimensions.

Applying such a sociological institutionalist theory on interorganizational convergence to global health governance permits to highlight two things: first, it understands convergence as an effect of a powerful normative discourse in which institutional fragmentation is equated with inefficiency and irrationality while harmonization, coordination, coherence and division of labor are seen as healthy metagovernance principles for a more ordered rational health

architecture. And secondly, it opens up a new avenue for explaining the unintended consequences of convergence by looking at potentially diverging interpretations of these metagovernance principles in the discourses and actions of different international actors. The link between these two explanatory endeavours of the paper lies in balancing the power of a normative discourse on good global governance (power of discourse) with the power of international organizations to shape this discourse (power in discourse) Holzscheiter 2005; Holzscheiter 2010). International organizations are both constrained by the logic of appropriateness of norms and rules of the organizational field in which they are embedded and, at the same time, actively engaged in a meaning-struggle that shapes, contextualizes and enacts these normsin which these norms are shaped, contextualized and enacted (Krook and True 2012; Wiener 2009; Zwingel 2012). They are guided but not determined by norms – and they strategically engage in discourses about norms in order to influence the rules of their organizational field.

As the empirical part of the paper will illustrate, hypercollective action in global health can be explained as an outcome of the interplay between the constraining influence of norms on the one hand and the human agency that moulds the meaning of these norms on the other. Hypercollective action then is a result of an emerging global normative consensus on convergence coupled with ongoing conflicts over the precise scope of such norms and how to translate them into practice. As more and more actors are drawn into the logic of appropriateness of interorganizational coordination, they strive to act as norm entrepreneus and be the 'linking pin' (Jönsson 1986; Mingst 1987: 282; Whetten 1981) at the centre of the projected global governance architecture in order to retain authority and competence within the policy field. Ultimately, a norm-focused theory on interorganizationalism then rejects the dichotomous vision of interorganizational relations as either conflict-ridden or cooperative. As international organizations converge and seek to shape the rules that govern their cooperative relationships, their identity and their collective goals, new space opens up for conflicts over the norms and rules that define good interorganizational relationships and the larger institutional order towards which they should be oriented. International debates on the principles that should regulate these relationships between IOs then reflect their potentially conflicting visions on identities, responsibilities and authority of themselves and others within the organizational field of health governance. As scholars working on norms remind us, in many cases in which norms influence behaviour that behaviour shows the „conflictive impact of divergent interpretations of norms" rather than the unambiguous meaning of standards for appropriate behaviour (Wiener 2009).

Metagovernance norms and principles are not only constitutive for individual IOs but they are also ordering principles oriented towards a specific institutional order, as they ascribe identities and define what is seen as good global governance. Normative contestation surrounding such emerging norms therefore reflects different ideas about institutional order in global governance. From the standpoint of a sociological institutional theory on interorganizationalism, an intensification of interorganizational relations is then no longer a logical answer to institutional fragmentation, but rather an outcome of a specific „organizational discourse" (Hardy and Phillips 1998; Lotia and Hardy 2008; Phillips, et al. 2000) that stipulates when and how international organizations should converge to absorb the negative ramifications of fragmentation. To view contemporary convergence between IOs as embedded in a powerful normative discourse permits to expose the thruth claims that underlie organizational behaviour and to point to alternative discourses and courses of action.

The empirical analysis below evidences an overwhelming normative consensus on the undesirability of further fragmentation in global health and the desirability for more order. At the same time, looking at individual organizations' viewpoints on the appropriate "organizing principles" (Wiener 2007) for such a new global health architecture, it is more than evident that there is a fierce struggle for interpretive authority over this new global health order. In the following, I will provide empirical evidence for the two core propositions that this paper advances: first, that emerging norms of metagovernance are a powerful driver behind interorganizational convergence in global health governance and secondly, that the practice of interorganizational convergence exhibits differing visions on the ordering

principles along which the relations between international organizations with overlapping mandates and missions should be arrayed. In combination, these two propositions can explain why interorganizational cooperation has so far resulted in hypercollective action rather than reducing fragmentation and strengthening the global health architecture.

In the remainder of this paper, I will analyze dynamics of interorganizational cooperation in global health with the aim of showing how metagovernance have shaped the relations between global health agencies, drawing especially on evidence from densely populated fields such as HIV/AIDS. The analysis focuses on two things: 1.) to provide evidence supporting a powerful discursive formation that equates fragmentation with ineffectiveness and convergence with effective order and 2.) to demonstrate that while the normative belief in more architecture and enhanced interorganizational convergence is shared by all major international organizations in health, individual organizations' policies and internal debates reveal a lively and contentious debate over the trajectories of (goals) and organization principles (processes) for convergence. This meaning-struggle is quintessential for a continued conflict among international organizations over power, identity and leadership in the global health architecture. Thus, rather than projecting my own vision of a good global health order I want to pinpoint the contested nature of institutional order in global health. To this end, the following empirical part highlights effects of global metagovernance norms on three levels: 1. By analyzing discourses on institutional order in global health, 2. By analyzing practices as the response of individual international organizations to metagovernance norms and 3. By looking at the outcome of these practices, i.e. do the practices result in the desired collective outcome.

**4. Metagovernance norms and contested ordering principles in global health**

The global discourse on interorganizational coordination as a cure for costly fragmentation revolves around a particular type of norms that will be called metagovernance norms in this paper. Metagovernance norms are about the "governance of governance" (Torfing, et al. 2012: 4); they constitute "the ground rules for governance and the regulatory order in and through which governance partners can pursue their aims" (Jessop 2004: 65) and they target the "complex process through which a plurality of social and political actors with diverging interests interact […] deploying a range of ideas, rules and resources" (Torfing, Peters, Pierre and Sørensen 2012: 2). A metagovernance norm is a broad statement about appropriave behaviour in a given situation and within a shared identity (i.e. a social norm), such as when interorganizational coordination or harmonization is seen as the appropriate response to perceived costly institutional fragmentation. Thus, we might speak of a global harmonization norm lying at the heart of attempts to restore institutional order in global health governance. Metagovernance principles in turn fill this norm with meaning and define appropriate courses of action through which harmonization can be achieved. In the discourse on interorganizational convergence in fragmented fields of global governance two such global metagovernance principles can be identified: coherence and division of labour. These metagovernance principles refer to different variants of harmonization: coherence emphasizes likeness of units in a system. It therefore implies congruence between the policies, instruments, actions and goals of organizations. Harmonization as division of labor, by contrast, emphasizes difference between the units in a system and tries to compose them in such a way that they build a differentiated but harmonious whole.

The principles and strategies through which international organizations enact the harmonization norm are therefore consequential in terms of how potential collisions between mandates of individual IOs are governed: where harmonization is understood as a streamlining of organizational policies and actions, mandate overlap is accepted and authority shared in the name of "complementary official goals" (Schermerhorn 1975: 851), i.e. when different IOs seek to harmonize gender components in their organizational policies and actions in order to achieve broad social and political change. Mandate overlap is accepted but autonomy intact. By contrast, where harmonization is understood as a division of labour based on an assessment of 'comparative advantages', mandate overlap is avoided alltogether and authority is divided rather than shared. This means an increase in issue- or function-specific authority but also a loss of overall autonomy and an increase in interdependence between organiza-

tions. It follows from this that division of labor between IOs in the name of harmonization is a much more challenging principle of metagovernance.

The various principles that can be accommodated by the harmonization norm are given further concretization and meaning in the strategies through which international organizations translate them into practice – the trajectories of harmonization. To give an example: there are different strategies to enact the principle of coherence. On the one hand, two or more international organizations can reach a mutual agreement on new standards, such as the WHO Code of Conduct on Recruitment of Health Personnel adopted by the World Health Assembly in 2010 – a new standard aiming to recude fragmentation between too many regional and voluntary codes in this area (Taylor and Dhillon 2011). On the other hand, IOs can work towards coherence by transferring and/or adopting already established standards to different issues. This happened, for example, when the *Three Ones Principles* developed by UNAIDS in coordination with the World Bank and the Global Fund to harmonize international actors' policies and actions in national AIDS responses [10] were transferred to Malaria control. In the first case, harmonization and order is created through negotiated order (Peters and Pierre 2004: 81), i.e. horizontal processes of negotiating common standards and procedures. In the second case order is created through centralization, i.e. by acknowledging the authority and leadership of one or several key actors for a specific field or a specific function.

*Table 1: Metagovernance principles and trajectories*

| PRINCIPLES / TRAJECTORIES | **Coherence** | **Division of labor** |
|---|---|---|
| **Negotiated Order** | Negotiation of new standards for harmonization (e.g. *WHO Code of Conduct on Recruitment of Health Personnel)* | Dyadic or triadic agreements on problem- or function specific division of labor (e.g. *Memorandum of Understanding between two or more IOs*) |
| **Centralization** | Transfer of already existing standards to different issues/by different actors (e.g. Transfer of *Three Ones Principles* to Malaria Control) | Leadership role for one or several IOs for the policy field overall (e.g. *reform of overall global health architecture independently of problem*) |

In the following, I will discuss how meagovernance norms, principles and trajectories have figured in the international debate on restoring order in global health governance.

### 4.1. Divided in Harmony – Uncontested Harmonization Norm, Contested Organizing Principles for Global Health

Analyzing the contemporary debate on restoring architecture in global health reveals a very powerful truth claim with regard to interorganizational cooperation: interorganizational convergence is almost without exception framed as the rational answer to institutional complexity and potentially colliding rule-systems and governance structures. There is a startling unanimity among scholars, policy experts and practitioners in global health that a new international health order and a re-organization of relationships between IOs is the pathway towards more effective and efficient attainment of collective goals such as the control and prevention of major infectious diseases (Buse and Walt 1996; Kickbusch, Hein and Silberschmidt 2010; Rugg, et al. 2004; Spicer, et al. 2010). These unanimous calls for greater harmonization and unity in global health governance result from the verdict that the current institutional order in this field is not tailored to the global public goods it seeks to provide and lacks both legitimacy and effectiveness (Aldasoro, et al. 2010; Balogun 2005; Birdsall 2004). And in most cases, claims in favour of harmonization are connected to an international agreement, the 2005 Paris Declaration on Aid Effectiveness (PD), which includes harmonization in its five principles for better foreign aid stipulating that "donor countries coordinate, simplify procedures and share information to avoid duplication" (OECD 2005/2008). The Paris Declaration was signed

by 90 countries (industrialized and developing), the major international financial institutions and around 25 multilateral organizations, among them the United Nations Development Group (UNDG). It was followed in 2008 by the Accra Agenda for Action in which developing and donor countries were outlining necessary steps for implementation of the PD such as "Building more effective and inclusive partnerships for development".[11]

The PD represents the first formalized attempt to turn „aid effectiveness concepts [...] into global commitments for donor agencies" (Beloe 2005: 15), inasmuch as it enshrines tangible global goals for interorganizational cooperation in development. The five core principles of the PD – harmonization, alignment, ownership, managing for results, and mutual accountability – are meant to serve as the normative basis for good development cooperation.[12] The PD demands, for example, that 50 per cent of all technical assistance should be implemented through coordinated programs that are oriented towards national development strategies (OECD 2005/2008: 9). In sum, the adoption of the PD is a significant stept towards an institutionalization of relationships between international (donor) organizations and the collective management of development programs. Even though the PD is not a health-specific international agreement, it repeatedly singles out areas in which an improvement of aid effectiveness seems warranted – among them HIV/AIDS – and the health sector has been used as a so-called 'tracer sector' in order to evaluate the effects of the Paris Principles (Dickinson 2011; OECD 2011b). As a consequence, the PD has broadly resonated in global health governance and inspired a broad range of health-specific initiatives towards interorganizational harmonization.

*The Uncontested Harmonization Norm*

An analysis of policy documentation of the seven major international organizations in health (WHO, World Bank, UNICEF, UNFPA, UNAIDS, Global Fund and GAVI) produces the remarkable finding that the appropriateness of re-establishing institutional order by strengthening norms that outline individual responsibilities and competencies of actors with overlapping mandates seems largely uncontested (Holzscheiter 2015). This finding points to a strong desire for centralization and order among all agencies involved in global health governance. In the first place, cooperative relationships between international health agencies, thus, are defined as the appropriate response to excessive fragmentation (norm) – which points to the marked influence of the harmonization norm on intra- and interorganizational discourse. However, as this basic harmonization norm is substantiated and filled with meaning, one can identify contestation over both the trajectories of harmonization as well as the organizing principles through which harmonization should occur. While the unanimity with regards to the necessity for more interorganizational harmonization points to a powerful belief in a more rational global health order and a strong delegitimization of the status quo, the ongoing meaning-struggle revolving around principles and trajectories for establishing such order reveals conflicting visions of a good global health architecture.

Following the Paris Declaration, good global governance as ordered global governance most broadly implies clearly defined roles and expectations for all actors involved in a policy field, ideally resulting in a division of labor that helps to avoid duplication and over-fragmentation of interventions, programs and institutional structures. One of the causal beliefs underlying the Paris Declaration is that "excessive fragmentation of aid at global, country or sector level impairs aid effectiveness" (OECD 2005/2008: 6) and that enhanced coordination on all of these levels is key to effective aid policies. While the five principles of the PD cover all interactions in development cooperation at the global, national and local level, it is the principle of harmonization that specifically captures relationships between IOs. According to the PD, harmonization presupposes that donor organizations "make full use of their respective comparative advantage at sector or country level, by delegating, where appropriate authority to lead donors for the execution of programmes, activities and tasks" (OECD 2005/2008: 6). Four areas are singled out as particularly indicative for harmonization of international actors: 1.) capacity-building through the coordination of technical assistance, 2.) „common arrangements and procedures", 3.) „joint missions" and 4.) „joint country analytical work" (OECD 2011a: 19).

In the following sections, I will empirically focus on the international response to AIDS as this field is generally seen as acutely fragmented and inter-

organizational relations as conflictual. Apart from institutional complexity, HIV/AIDS exemplifies the challenges of global health governance in the 21st century like no other health issue. Ever since the PD and the Accra Agenda for Action have been adopted, the relationship managament between international organizations has been regularly assessed quantitatively and qualitatively both through the OECD itself as well as through other important actors such as the Center for Global Development in Washington DC or the *Multilateral Organisation Performance Assessment Network* (MOPAN).[13] The following empirical discussion of meaning-struggles revolving around the harmonization norm uses the results of these analyses as background information. It draws its primary data for analysis from core policy-documents and working papers in which the four most important international organizations in the field of HIV/AIDS (UNAIDS, Weltbank, Global Fund und WHO) outline their individual or collective perspective on interorganizational coherence and coordination (before all: GFATM 2005; GFATM, et al. 2006; GFATM and World Bank HIV/AIDS Program 2006; OECD 2011b; Shakow 2006; UNAIDS 2005b; UNAIDS 2008; UNAIDS 2011; WHO 2009; World Bank 2008). The empirical insights are meant to exhibit the power of the global harmonization norm on the hand and the meaning-struggle surrounding its enactment in the concrete policies and practices of IOs on the other.

*Translating the harmonization norm into interorganizational cooperation – Contested trajectories and ordering principles*

Since its adoption, the Paris Declaration has inspired a broad range of initiatives for the strengthening of interorganizational relations in development cooperation and the collective „management for results". It has, therefore, served as a catalyst for interorganizational convergence, leading to the institutionalization of old and new interorganizational relations. In the global response to AIDS, for example, the drafting of the Paris Principles has co-evolved with the adoption of the AIDS-specific Three Ones Principles that call for harmonization among multilateral and bilateral donors along One National AIDS Strategy; One National Monitoring & Evaluation System; and One National AIDS Authority (UNAIDS 2004). The Three Ones Principles thus represent a synthesis of different levels of coordination: harmonization (coordination between donor institutions), alingment (streamlining donor actions according to national priorities and into health systems) and ownership (leadership of national governments in all these coordination activities).

Since 2005, the PD and the Three Ones Principles have been implemented through a series of strategies and instruments geared towards the fortification of interorganizational convergence, spearheaded by the Global Fund, the World Bank and the UN family. There is no major international organization in health that has not responded to the Paris Principles by incorporating them into their organizational philosophy and strategies, guided by the principles of coherence and divisions of labor.[14] Since 2007, the Global Fund has been reviewing its policies in terms of aid effectiveness and the Paris Declaration to which it is a signatory (GFATM 2009). What is more, the PD framework for aid effectiveness has led to the creation of new institutionalized forums for interorganizational harmonization such as International Health Partnership + and the H4+ (Working Together for Women's and Children's Health). These forums are no legal entities in themselves, but co-hosted by a number of international organization whose staff cooperates in time-limited expert and working groups.[15] The IHP+ for example is co-facilitated by the WHO and the World Bank with the mission to "enhance aid effectiveness […] through effective collaboration and coordination of various partnerships and initiatives" (WHO/World Health Assembly 2010: 2).

One of the most important instruments towards achieving a harmonized institutional architecture for AIDS was the temporary establishment of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT). The GTT, a team of experts composed of representatives from 24 countries and institutions, met for a limited time during the year 2005 in order to make recommendations on „options for further coordination, particularly within the multilateral system, to resolve areas of duplication and gap in the global response to AIDS" (UNAIDS 2005a).

After completing its review of the harmonizing actions of multilateral health organizations it issued a number of very specific recommendations on how to improve effectiveness in the global AIDS response such as a "clarification of the division of labour among multilateral organizations" or the "harmonization of programming, financing and reporting" (UNAIDS 2005a: 6). These recommendations, in turn, prompted bilateral and multilateral consultations as well as a series of dyadic and triadic cooperation agreements between IOs (see for example GFATM, PEPFAR and Bank 2006; UNAIDS 2008). All major international organizations involved in global health governance reacted to these recommendations, by publishing reports and statements in which they laid down their interpretation of interorganizational harmonization, how they understood the roles of individual actors in a larger health architecture and their own position therein (see for example GFATM and World Bank HIV/AIDS Program 2006; PEPFAR 2007; UNAIDS 2005b; UNAIDS 2008).

As a consequence of the recommendations of the Global Task Team, global strategies and instruments for harmonization between international organizations multiplied. The World Bank and Global Fund commissioned a joint study on their comparative advantages which resulted in the recommendation that the „Global Fund should focus on AIDS prevention and on the procurement of the commodities and drugs essential for treatment, and should not include health system strengthening" while the World Bank should take a lead role in health systems strengthening (Shakow 2006: 8). UNAIDS and the Global Fund signed a Memorandum of Understanding in 2008 in which they defined shared goals and complementary roles geared towards strengthening the global response to AIDS (UNAIDS 2008). In this MoU, the two agencies agree on a division of labor in which UNAIDS provides technical support for countries applying for Global Fund funding.[16] While these policies do not represent binding treaties between the different IOs they nevertheless exemplify a move towards more institutionalized forms of interorganizational cooperation and, thus, interorganizational convergence at the global level. UNAIDS and the World Bank responded to the GTT recommendation by creating and testing a Country Harmonization and Alignment Tool (CHAT), a tool designed to assist national AIDS coordination authorities to "assess the harmonization and alignment among HIV international partners".[17]

The analysis of IOs' response to the Paris Declaration allows two important conclusions: on the one hand, all major IOs in health subscribe to the demands of the Paris Declaration and have changed their organizational policies and practices accordingly. Thus, the PD has become the central normative reference point in the global debate how to gear interorganizational relations towards a fundamental reform of the global health architecture. This finding validates the prescriptive character of the PD's 'harmonization norm' and shows that it pulls more and more actors into its logic of appropriateness. In their strategies and visions for effective global health governance, all major health IOs value coordination and coherence between international organizations as the central building block of more legitimate and effecitve global governance (see for example European Commission 2013; GFATM 2010; PEPFAR 2007; UNAIDS 2006). The causal belief interorganizational harmonization = effectiveness can be found as an unchallenged mantra in the policy documentation analyzed (see for example WHO 2009). Effectiveness, in turn, is consistently equated with "making the money work" (efficient spending) (UNAIDS 2006; World Bank 2008, S. 47) and the strengthening of national plans, strategies and governance structures. What is more, calls for more or better harmonization between international organizations in health are always connected with a vision of the position of individual organizations in the larger governance architecture. Unsurprisingly, all four major IOs working in the field of HIV/AIDS use the debate on interorganizational harmonization as a vehicle to promote their „linking pin" position in the field (Jönsson 1986; Mingst 1987: 282). This leadership status is either justified by their experience and knowledge in the field or because they see themselves as a catalyst of interorganizational cooperation and partnership (see for example UNAIDS 2010: 12; WHO 2009; World Bank 2008: 52).

Even though the desideratum of restoring order through stronger coherence and division of labor between IOs is shared by all organizations at the discursive level, the translation of the harmoniza-

tion norm into organizational policies, strategies and practices of relationship management exhibits incongruent visions of the principles and trajectories through which such order should be restored – first and foremost exemplified by the meaning-struggle surrounding the empty signifier 'harmonization'. This meaning-struggle exposes contestation revolving around the trajectories for such order (centralization vs. negotiated order) on the one hand and around the two harmonization principles of coherence and division of labor on the other. As the above examples from the field of HIV/AIDS have shown most harmonization activities so far follow the trajectory of negotiated order which is either problem-specific or related to a specific function (funding; monitoring; procurement and supply). Thus, problem- or function-specific divisions of labor or coherence strategies have been negotiated among a small number of IOs following the principles of the PD. These harmonization efforts have targeted problem- or function-specific harmonization of rules and systems for monitoring and evaluation; harmonization of procurement policies and procedures; harmonization of financing mechanisms and the pooling of finances and resources; the exchange and transfer of knowledge and resources between organizations.

There are, however, alternative visions on global health architecture that see centralization as a necessary trajectory for harmonization. In the contemporary debate on better global health governance, a number of proposals for restoring order are discussed which are based on the return to a central harmonizing authority for health. All of these revolve around the question of the position of the WHO in contemporary global health governance and of which institution would enjoy the greatest legitimacy as an overall global health coordinator. At the heart of this debate lies, logically, the question of how to enhance the authority of the WHO as a central coordinating entity in global health. Different ideas circulate in the debate on WHO's role in global health governance on how it may once more become the centerpiece of this architecture. A number of influential health experts have argued that the WHO is still the only health organization with democratic and formal legal legitimacy and, as such, the logical candidate for a global health coordinator (Kickbusch, Hein and Silberschmidt 2010). They suggest that the establishment of a so-called Committee C at the World Health Assembly could restore its central authority in GHG and therefore mitigate fragmentation, inasmuch as the WHO would be mandated to develop the rules of the game for health agencies and their interactions. A Committee C of the World Health Assembly, it is suggested, would ensure a broad democratic foundation for these rules while, at the same time, making the WHO a "suprastructural node" in today's complex networked governance. Thus, the WHO is envisioned as a metagovernance institution that negotiates and represents the norms and principles for good interorganizational cooperation in health (Kickbusch, Hein and Silberschmidt 2010: 560). Apart from these proposals for reforming the WHO by introducing a new Committee C there have also been suggestions for different "superstructural nodes" such as the establishment of a UN Global Health Panel that would coordinate initiatives within the UN as well as their relationships with external stakeholders (Hein 2013; Sridhar 2013).

While such a trajectory of centralization aims at maximal coherence between a multitude of actors and rule-systems in global health governance, there are also proposals in the other direction, i.e. centralization in terms of a function-specific division of labor between the major IOs active in health. This proposal for a reform of the global health landscape towards more order and architecture promotes the clear separation of spheres of authority between different IOs based on an assessment of their comparative advantages (UNAIDS Lancet Commission 2013). Order, thus, is established through the creation of a limited number of centers in the health architecture. In this vein, there is an ongoing discussion on the future of UNAIDS which, in times of shifting global health priorities and 'AIDS fatigue' is seen as a candidate for a UN-wide health coordination agency. Likewise, the harmonization norm has also been translated into specific broad divisions of labor at the global level. In late 2014, the Global Fund and the WHO signed a partnership agreement in which they agreed on a division of labor in the field where WHO would provide technical assistance to countries applying for GF funding. The Global Fund is also currently seeking to formalized its relationships with other UN organizations such as UNAIDS and UNICEF.[18] This interorganizational

convergence is a clear sign of a re-acknowledgment of WHO's authority in global health governance while at the same time showing how different IOs (WHO, GAVI, Global Fund) seek to negotiate the lines of division between their spheres of authority.

The different trajectories for harmonization that have emerged in the contemporary debate on a good global health order evidence disagreement over how strongly institutionalized interorganizational relationships in health should be and how authority should be divided or shared between IOs. This disagreement also finds its expression in the astonishing variety of terms that are used synonymously with harmonization. In the policy documents analyzed for this paper, harmonization is used interchangeably with the following terms: mutual support; partnership; collaboration; division of labor; collective efforts; coherence; comparative advantages; cooperation; multiple accountabilities; shared responsibility (GFATM 2004); positive synergies, or simply consultation. A widely-noted lengthy report by the WHO Maximizing Positive Synergies Academic Consortium, for example, refers to ‚donor coordination' 149 times but never specifies what coordination implies (WHO Maximizing Positive Synergies Academic Consortium 2009). The way in which the harmonization norm is filled with meaning confounds different degrees of collaboration that range from occasional consultation to far-reaching coordination in terms of programmatic coherence and division of labor. When the OECD reviewed the implementation process of the Paris Declaration in 2007, it concluded that there are „very different views emerged on what should count as co-ordination" (OECD 2007: 23).

### 4.2. Translating harmonization principles on the ground – normative ambiguity and best practices

The above discussion has made it obvious that the international debate surrounding a 'master-design' for global health governance is based on strong consensus on the inadequacy of the status quo and the desirability of more order and structure. There has been an observable shift in the discourse on good global governance, from valuing networked global governance, innovation and pluralization to renewed concern for the effects of excessive institutional fragmentation. The paper has sought to show that global metagovernance norms such as the PD and sector- or issue-specific norms have had a multiplying effect with regard to interorganizational initiatives responding to fragmentation. This normative shift has taken place alongside other shifts in the global health agenda, most importantly the contemporary trend away from prioritising specific diseases to strengthening health systems (HSS) overall. As all major global health actors venture into HSS the necessity for harmonization of bilateral and multilateral actors in national health systems is perceived to be even stronger.

Despite this consensus, though, policies and practices of interorganizational convergence have so far added very little to restoring architecture on the global level due to conflicting visions of such a global health order and the position of individual organizations within that order. As insights from domestic health systems in developing countries show, interorganizational cooperation on the ground reveals the normative discrepancies and frictions inherent to the global discourse on metagovernance norms which also have concrete effects on practices of interorganizational cooperation on the ground. These practices exhibit the numerous translation problems of good governance norms wherever they relate to the delegation of tasks and responsibilities to national and sub-national political units and the fundamental contestation of such norms by some actors (Beloe 2005; Sundewall, et al. 2009; Sundewall 2009). Most fundamentally, evidence from domestic health systems confirms that global efforts towards re-establishing institutional order in fragmented governance landscapes through divisions of labor and the distribution of competencies are at odds with simultaneous processes through which coordination in multi-level governance structures is negotiated. There appears to be strong variance in how much sovereignty individual actors are willing to defer to domestic actors, particularly in developing countries with weak governance capacities. As a consequence of their defiance towards domestic institutions, several of the global governance institutions discussed above – such as most prominently the World Bank and the Global Fund – continue to uphold their own parallel governance mechanisms for coordination such as the Global Fund's Country Coordinating Mechanism (CCM) or World Bank loans for national HIV/AIDS

programs that are coordinated through U.S. embassies (Spicer, Aleshkina, Biesma, Brugha, Caceres, Chilundo, Chkhatarashvili, Harmer, Miege and Murzalieva 2010). A Global Fund Report on Aid Effectiveness evaluating progress in implementing the Paris Principles shows that while alignment between individual global agencies and national systems works quite well, harmonization between the Global Fund and other international actors at the national level is not at all (joint analytical reports) or very slowly progressing (joint missions) (GFATM 2009).

The effects of contested principles and trajectories of harmonization on recipient countries' governance capacities become also evident in evaluations of the role and position of National AIDS Commissions (NAC) in the coordination of donors and domestic agencies in national responses to AIDS (Dickinson, et al. 2008; England 2006; Putzel 2004). The Three Ones Principles as the broadest principles structuring much of the interplay between global agencies and national governments specifically call for the establishment of one national AIDS coordinating authority. These authorities have, by now, been created in a large number of countries as the core institutional structure responsible for coordination of the national AIDS response. It is within the NACs that, ideally, the Paris Principles of harmonization and alignment should create positive synergies for all actors involved in the national AIDS response.[19] NACs therefore occupy both a critical as well as an uncomfortable position in terms of domestic translations of the harmonization norm, inasmuch as they should serve as the deliberative forums within which domestic and international priorities, policies and programs are brought into line. The work of most NACs evidences that harmonization efforts between international actors and alignment between international and domestic actors are often difficult to square – particularly where influential players such as, most importantly, the Global Fund retain their own coordination structures, thereby undermining the authority and supposed leadership of the NAC in coordination the input of external actors (Dickinson and Druce 2010).

Yet, there is also accumulating evidence from the ground which shows that in some cases harmonization of international actors can work extremely well both in terms of coherence and divisions of labor. This evidence suggests at least two things. First, that interorganizational harmonization works better in the earlier stages of the policy cycle – particularly in the preparation of projects and funding proposals and, to a lesser extent, in the implementation process (Grundy 2010; World Bank 2011). It is to be assumed that during the earlier stages of the policy cycle there is more room for deliberation and discussion between the various stakeholders (e.g. in the many donor forums that have been established at the national level) and therefore also more room for negotiating a shared meaning of the harmonization norm. The least favourable area for harmonization is monitoring & evaluation where incentives for interorganizational cooperation in the mainstreaming of evaluation indicators and the sharing of knowledge are very low (Holzscheiter, et al. 2012). Conflicts over authority seem to be unresolvable in this area, both because of the reluctance to share precious knowledge gained through expensive monitoring systems and of the prevailing interest in evaluations that allow identifying the impact of individual organizations not the aggregate impact of a coordinated donor community. And secondly harmonization benefits from strong governance at national level as well as the trust of international actors in local ownership (Spicer, Aleshkina, Biesma, Brugha, Caceres, Chilundo, Chkhatarashvili, Harmer, Miege and Murzalieva 2010). These are all important factors whose explanatory value should be explored in future research – both through cross-country comparison as well as comparison between different health issues and actors.

**5. Conclusion**

This paper has argued that norms are an important driver behind interorganizational convergence in global governance and that their study is essential in order to understand the systemic effects of interorganizational relations in any field of global governance. Analyzing the effects of metagovernance norms and principles in the field of global health, it has uncovered two important findings: first, that there is an uncontested harmonization norm shared by all major international organizations in global health. This uncontestedness is reflected in the comprehensive and far-reaching translation of the "harmonization norm" enshrined in the Paris Declaration on Aid Effectiveness in discourses and actions

of these major IOs. Secondly, however, the analysis has shown the contested nature of the principles and trajectories attached to harmonization that motivate harmonization efforts between IOs. Even though all of these activities are driven by the desire of IOs and their member states to reorganize the regime complex for health, the aggregate effects of interorganizational convergence – particularly in the context of development cooperation – amount to hypercollective action. The paper has argued that such hypercollective action is the result of a fierce interest among international actors in shaping the 'ground rules' of metagovernance that order the relationships between actors in fragmented governance landscapes.

An approach that sees harmonization as a contested norm rather than an unquestioned principle and logical course of action permits not only to identify inconsistencies and truth claims in the discourse on institutional fragmentation. It also suggests that there are alternatives to such a forceful harmonization discourse. While this paper has limited itself to uncover the power of a global harmonization norm and IOs' ambitions to shape the meaning of this norm (their power in discourse) a more comprehensive study would also tackle silencing and exclusion of alternative discourses, normative orders and modes of speaking (targeting, for example, the technical-managerial terminology and frames that dominate 'harmonization-talk'). Such a perspective ultimately helps to challenge the rationality behind convergence and harmonization that lies at the heart of contemporary attempts of restoring order in messy global health. As some critical voices remind us a counter-discourse is still around that equates institutional proliferation neither with greater efficiency and professionalism nor with ineffectiveness and 'little value for money' but with a healthy competition that "may help generate new ideas and energy for addressing the health needs of the poor" (Shiffman 2009). The Busan Partnership for Effective Development Cooperation of 2011 is often seen as a hallmark of alternative discourses on aid effectiveness, development and good global governance in which pluralism (including value pluralism) and flexibility are emphasized as a counter-balance to the power of established donor institutions (Woods 2008; Woods 2011). From the vantage point of this counter-discourse, the harmonization norm can indeed be interpreted as the cornerstone of a global institutional order that plays into the hands of established international organizations and their interest in maintaining a specific world order.

# ENDNOTES

1. WHO, Global Health Observatory (GHO) data, "Governance and aid effectiveness", available at: http://www.who.int/gho/governance_aid_effectiveness/en/, last access 8 February 2015.

2. Congressional Budget Justification, Foreign Assistance, Summary Tables, Fiscal Year 2014, available at http://www.state.gov/documents/organization/208292.pdf, last access 7 February 2015.

3. European Commission (2014), Special Eurobarometer 421, "The European Year for Development – Citizen's View on Development, Cooperation and Aid", available at http://ec.europa.eu/public_opinion/archives/ebs/ebs_421_en.pdf, last access 6 February 2015.

4. See OECD/WHO, "Distribution of 2009-2010 disbursements by purpose", Official Development Assistance for Health, available at http://www.who.int/gho/governance_aid_effectiveness/ODA_010.pdf?ua=1, last access 7 February 2015.

5. Such as UNITAID or, currently, a Global Financing Facility to mobilize support for developing countries' plans to strengthen women's and child health.

6. Washington Post, "Global response to Ebola marked by lack of coordination and leadership", 11 September 2014;

7. Roll Back Malaria, "Harmonization Working Group", available at http://www.rbm.who.int/mechanisms/hwg.html, last access 9 February 2015.

8. In fact, the corruption cases brought the message home that the outsourcing of budget oversight at national level to international consultancy firms like PriceWaterhouse or Roland Berger had led to failures in tracking how funds were spent – and that these failures were then attribute to the Global Fund and undermining its legitimacy.

9. White House, Fact Sheet on Global Health, "President Obama's Global Development Policy and the Global Health Initiative", available at: http://www.whitehouse.gov/sites/default/files/Global_Health_Fact_Sheet.pdf, last access 2 February 2015.

10. Alignment of multilateral and bilateral donors with one national AIDS strategies; one national Monitoring & Evaluation system; and one national AIDS authority.

11. OECD-DAC (2008), Accra Agenda for Action, available at http://www.oecd.org/dac/effectiveness/45827311.pdf, last access 7 February 2015.

12. OECD-DAC, The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, http://www.oecd.org/dataoecd/11/41/34428351.pdf, last access 31 January 2015.

13. MOPAN is a confederation of 17 states that are member of multiple multilateral organizations and are interested in observing and evaluating their outcome. The Paris Principles have significant- ly influenced MOPAN indicators through which the performance of international organizations is measured. See http://www.mopanonline.org/, last access 31 January 2015.

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14. GAVI, „Effective development co-operation“, available at http://www.gavi.org/about/ghd/effective-development-co-operation/, last access 7 February 2015.

15. See International Health Partnership and related initiatives (IHP+), “About IHP”, available at http://www.internationalhealthpartnership.net/en/about-ihp/, last access 9 February 2015; H4+ Working Together for Women’s and Children’s Health, available at http://www.who.int/reproductivehealth/global_strategy_women_children/en/, last access 9 February 2015.

16. A 40-page manual has been issued for staff of in-country UN Joint Teams on AIDS in which the concrete tasks and responsibilities of the two agencies are meticulously laid down.

17. UNAIDS (2007), Country Harmonization and Alignment Tool, available at http://data.unaids.org/pub/Report/2007/jc1321_chat_en.pdf, last access 7 February 2015.

18. Global Fund, “WHO and Global Fund strengthen partnership”, available at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2014-05-20_WHO_and_Global_Fund_Strengthen_Partnership/, last access 19 May 2015.

19. “For a list of all national AIDS councils see UNESCO HIV and Health Education Clearinghouse, “National AIDS Councils”, available at http://hivhealthclearinghouse.unesco.org/links/national-aids-councils, last access 19 May 2015.

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