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Coordination and joint authority in the global health architecture: a document-based mapping of current mechanisms and implications for reform

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Abstract

Background Reform of the global health architecture seeks stronger coordination and joint decision-making among organisations, but proposals rarely specify what existing mechanisms can decide or whom their decisions bind. We mapped the formal authority of the mechanisms in which organisations and governments meet.

Methods We compiled 167 current coordination and decision-making mechanisms from public documents and analysed 156 after excluding 11 technical networks. The main analysis covered 44 co-led mechanisms, in which two or more organisations participate as full members alongside governments; 112 other mechanisms provided comparisons. Two coders independently assessed the initial 151 entries on a five-step authority scale. Later additions were checked by the lead author. We examined decision rules, decision objects, co-location and shared membership, with alternative coding and classification scenarios.

Results Of the 44 co-led mechanisms, 16 (36.4%) held decision rights under the main coding and 24 (54.5%) under an alternative coding of eight disputed cases. Under both scenarios, decisions concerned defined funds, partnerships, programmes or frameworks. Nine of 13 mechanisms coded as taking binding decisions had rules permitting non-unanimous decisions. No document reviewed gave a co-led mechanism authority over participating organisations' separate budgets or policies. Between 55% and 79% of mechanisms of each type shared a health area and level with another. Shared-member comparisons were limited by incomplete name extraction and did not establish duplication. Illustrative precedents existed for four designs of coordination across governing bodies, with different sources and limits of authority.

Conclusions Joint decision-making among organisations exists, but within defined instruments. Reform proposals should state what is to be decided, whether existing mandates cover it and which changes need new agreements; options that confer new binding authority require approval by the competent bodies under the applicable instruments.

Keywords: global health governance; globalization; inter-organisational coordination; decision-making; formal authority; institutional fragmentation

Background

Fragmentation has been a concern in global health for two decades. Global health initiatives, funds and partnerships multiplied after 2000, and repeated commitments to coordinate, from the Paris Declaration to the Lusaka Agenda [1, 2], have produced many joint platforms without resolving the problem [3, 4, 5]. Since 2025, cuts in development assistance and the US withdrawal from WHO have renewed pressure to reform the architecture [6]. After the Executive Board considered the matter in February 2026 (document EB158/44 [7]; decision EB158(20) [8]), the World Health Assembly in May 2026 adopted a decision on a joint process to make proposals on functions, coordination and decision-making, and financing (decision WHA79(20) [9]; document A79/24 [10]). Proposals from that process are recommendations; changes to any organisation's mandate or rules remain for its own governing body to decide. Early commentary has asked whether a process in which the institutions to be reformed help to design the reform can change how they coordinate [11], and has argued that the difficulty lies less in a shortage of proposals than in aligning them [12].

In research on global governance, the fragmentation of a governance architecture varies in degree, from synergistic to conflictive, according to how far institutions are

integrated, whether their norms conflict and how their memberships are composed [13]. A regime complex, a set of partially overlapping institutions without an overall hierarchy, can be more adaptable than a single integrated regime, although it is harder to hold to account [14]. Overlapping mandates or memberships are not in themselves evidence of duplication. Members of overlapping institutions share an interest in coordinating them, and institutions that share a domain can settle into a division of labour [15]; their interaction can also be deliberately managed [16]. Studies of global health in these terms have shown how WHO has sought to orchestrate rather than command its competitors [17], how organisations cooperate through routine practices and reposition themselves relative to one another [18, 19, 20, 21], and why fragmentation persists despite commitments to reduce it, including weak incentives to collaborate where organisations compete for funding [4, 5]. Whether, and where, the architecture is duplicative therefore has to be established for specific arrangements.

Research on coordination in public administration distinguishes levels of coordination, from exchanging information and consulting, through avoiding divergence and seeking agreement, to arbitrating differences and setting common priorities [22, 23], and each level relies on different instruments [24]. Only the upper levels change who decides. Joint decision-making carries its own risk: where each party holds a veto, outcomes tend towards the lowest common denominator [25]. The decision rule, and what a joint decision may bind, are therefore central choices in the design of a joint body [26]. In global health, studies of public–private partnerships have examined how their boards are composed and governed [27, 28]. Proposals in the reform debate for stronger coordination, joint governance or alignment across boards need to specify the level of coordination, the decisions to be taken jointly, the deciding body and the source of its authority.

Existing mappings identify global health actors and their relationships [3, 29], major organisations' governance and financing [30], regional health competencies [31], country coordination arrangements [32], and partnership board composition and overlap [28]. Research also codes the depth of cooperation agreements between regional organisations [33]. Less is known about what standing mechanisms across these settings can decide, whom their decisions bind and which rules apply. Our literature search identified no study meeting all three criteria of systematically listing current mechanisms in global health, including mechanisms involving multiple organisations, and recording members, decision rules or authority. This is a search-bounded finding; only 108 of 1,754 deduplicated records underwent title and abstract screening (Supplementary Methods, Additional file 1).

We examine four questions: what mechanisms exist and what can they decide; what their joint decisions bind and whether unanimity is required; where mechanisms cluster and share members; and what existing arrangements imply for reform proposals linking governing bodies. Authority is examined primarily in co-led mechanisms, where organisations participate in decisions alongside governments. Comparisons across other types locate these mechanisms within the wider architecture. These mechanisms are where cross-border health financing, health products and emergency response are governed jointly, so the allocation of authority within them is a question of global governance rather than of any single organisation. The study concerns the formal allocation of authority in transnational health governance, not organisational effectiveness or the health effects of reform.

Methods

Design and inclusion

We conducted a document-based mapping study with the mechanism as the unit of analysis, following the READ approach to document analysis [34]. A mechanism was included if it is a standing body or platform with two or more independent members, established by a written document, whose mandate explicitly includes coordination or decision-making in health. Governing bodies of organisations were included where they met these conditions. Plans, frameworks, funds and organisations as such, bodies of experts serving in a personal capacity, treaty texts and mechanisms that have ended since 2023 were recorded in an annex and not analysed. The term mechanism is used here for bodies and platforms, which is narrower than its use for modes of coordination such as hierarchy, markets and networks [24]. Operating status was observed on 25 October 2026 and recorded as operating, time-limited, not confirmed, or ended; mechanisms confirmed to have ended were moved to the annex. Full definitions, sources, rules and procedures are given in the Supplementary Methods.

Inventory, verification and coverage

The inventory was compiled on 5–25 October 2026 from reform documents, partnership directories, governance pages and establishing instruments. Country platforms were recorded by type. Coverage checks matched 1,610 mentions in 22 reform documents, compared the inventory with the 76 regional organisations analysed by Wang et al. [31], and applied the governing-body rule to annex entries (Supplementary Table S2). These checks reflect documentary visibility, not completeness. Four key fields of the initial 151 entries were re-checked with computational assistance. A subsequent lead-author review covered 102 membership and mandate/decision fields for the then co-led subset: 100 received judgements and

two remained unjudged. One entry was reclassified and another moved to the annex; authority codes were retained. The final inventory includes 167 mechanisms, 163 documented in original sources and four in secondary sources only.

Types of mechanism by who takes part

Each mechanism was assigned to one of six types under nine written rules (Figure 1). Organisations are international organisations, global health initiatives, funds, development banks, regional organisations with their own governing body, and international non-governmental organisations, foundations and industry associations taking part as institutions; governments and their agencies are not organisations. A mechanism is inter-organisational when two or more organisations are members, hold standing seats, or jointly provide its secretariat or convene it. In co-led inter-organisational mechanisms (co-led mechanisms), two or more organisations are full members with a vote or a share in decisions and governments take part; in government-led inter-organisational mechanisms, governments decide and fewer than two organisations hold votes, the others attending as observers, non-voting members or secretariat; organisation-led inter-organisational mechanisms have no government members. The other types are intergovernmental mechanisms, in which states meet with at most one organisation as secretariat; single-organisation governance mechanisms, comprising the governing bodies and participation mechanisms of one organisation; and networks of technical, research, laboratory or regulatory institutions (11 mechanisms), which were kept in the inventory but not analysed, so the analysed population is 156. Co-led refers to formal participation in decisions, not to co-chairing. Co-led mechanisms are the main object of analysis, and the other types serve for comparison. Boards of organisations with their own legal personality are classed as single-organisation governance mechanisms even where several organisations vote on

them; such a board governs one organisation under that organisation's own statutes, so seats on it are participation in one organisation's governance rather than joint governance among organisations. Because this rule decides the type of three boards, a sensitivity analysis classes them by who takes part instead (Supplementary Table S6a). Types were assigned with AI assistance and checked line by line by the lead author; the rules for hosted boards and for organisations with their own legal personality are given in the Supplementary Methods.

Measurement of formal authority

Two coders independently coded the first 151 mechanisms (144 of which remain in the inventory; all 23 added later remain, giving 167; Supplementary Table S2) after a calibration round, receiving the factual fields with verbatim excerpts in random order; the 23 mechanisms added later were coded with AI assistance and checked line by line by the lead author. Authority was coded as the strongest authority that the establishing documents give the mechanism itself, on a five-step scale (Table 1).

Table 1. Measurement of formal authority

Authority	What the mechanism produces
Information exchange and advice	Information, consultation or advice
Joint planning	Joint plans, work programmes or division of labour; each member decides on implementation
Joint review	Joint review of the performance of members or of agreed implementers, without enforcement
Joint decisions subject to members' approval	Formal decisions in the mechanism's name, implemented or ratified by each member
Binding decisions	Decisions that bind dissenting members, or that direct the resources of the fund, partnership or programme the mechanism governs

The first three steps denote coordination and the last two decision-making. The scale records the highest assigned authority, not every function a mechanism performs: a deciding body may also plan or review. Binding decisions satisfy either of two criteria, binding dissenting members or exercising final control over a governed instrument.

We therefore separately recorded whether unanimity is required and whether decisions bind the instrument or members' separate budgets and policies. We distinguished boards governing one partnership, fund or programme from participating organisations themselves deciding jointly. Level of action was global, regional, national or across levels. Agreement was assessed using Krippendorff's α with 95% bootstrap intervals [35, 36]. The lead author adjudicated disagreements on 41 entries. An alternative scenario assigns disputed entries the other coder's code; eight cross the coordination–decision boundary. These scenarios are not statistical bounds or confidence intervals.

Analysis

Written rules assigned health area, host type, organisational family and decision object (Supplementary Table S1). Authority was cross-tabulated by level, decision locus and object. Mechanisms sharing a health area, level and, where applicable, region were treated as co-located. For pairs outside one organisational family, Jaccard indices compared extracted organisational members; another specification included hosts and non-voting roles. These are restricted-set comparisons: a fixed name-matching list omits some formally eligible organisations, notably IPPF from the HRP committee. Network statistics likewise describe extracted roles, not complete membership. The undirected network connects organisations recorded as formal co-members; normalised betweenness measures position, not authority. Sensitivity analyses varied role definitions and excluded entries with unconfirmed activity, only secondary sources, or medium-confidence type assignments. None resolves omissions from the name list. Co-location and shared membership were not treated as duplication.

Three further analyses addressed the third and fourth questions. First, we counted the mechanisms of each type in each combination of health area and level, and, because intergovernmental mechanisms rarely name organisations as members, compared the member states of the ten African regional and subregional bodies in the inventory that govern or coordinate health. Second, each mechanism was assigned a main and, where relevant, a secondary function from the six functional areas of document A79/24 [10]: setting norms, technical guidance and standards; data, monitoring and knowledge; surveillance and health security; product innovation and access; development cooperation for health; and humanitarian emergency response. Governing bodies whose remit spans all functions were classed as general governance. Under the main rule the partnerships and financing mechanisms of disease programmes belong to development cooperation; an alternative rule assigns mechanisms with a recorded secondary function to that function. Third, we grouped proposals in public reform documents into four designs for coordination across governing bodies: alignment across existing boards, including joint oversight, as the Lusaka Agenda proposes for Gavi and the Global Fund [2]; arrangements organised around the essential functions by which the joint process allocates responsibilities (document A79/24 [10]); convening or information-sharing platforms, including the mechanisms linking governance processes across levels proposed in the Accra Reset [37]; and independent panels, such as the High-Level Panel convened by the Accra Reset initiative (document A79/24 [10]). The grouping is ours. We then identified mechanisms in the inventory and its annex whose form resembles each design, as illustrative precedents rather than evaluated cases. Options in the Discussion were derived from each finding, its plausible explanations and the authority an option would require; they are inferences from documents and have not been tested.

Use of language-model tools

ChatGPT (OpenAI) supported document retrieval, checks of factual fields, draft type assignments, coding of later additions, derived-variable work and manuscript review, as described in the Supplementary Methods (Use of language-model tools). The initial 151 mechanisms were independently coded by two human coders without these tools. The lead author's checks differed by stage: the initial field-verification output was accepted as a whole, whereas type assignments and later codes were checked line by line. In the targeted review of 102 fields, 100 received judgements and two remained unjudged. Tool-assisted outputs were not treated as independent validation; responsibility for the analysis and text rests with the authors.

Results

About a quarter of mechanisms join organisations and governments as full members

Of the 151 mechanisms in the first inventory, 47 (31.1%) were named directly in at least one of the 22 reform documents, and 63 (41.7%) when mentions of only their parent organisation or treaty were counted; 23 unmatched mentions pointed to 19 candidate mechanisms, of which eight were added or merged. After all extensions and the key-field review the inventory holds 167 mechanisms. Agreement between the two coders was acceptable for authority (α 0.844, 95% interval 0.752–0.908) and level of action (α 0.859, 0.783–0.922) and tentative for whether a mechanism holds decision rights (α 0.790, 0.684–0.886); among the 50 mechanisms that both coders coded as decision-making, agreement on where decisions are taken was α 0.969 (0.896–1.000; Supplementary Figure S1). The adjudicated code was the lower of the two in 30 of the 31 disagreements on authority. The alternative coding reported below

gives every disputed entry the other coder's code, which for each of the 8 entries on the line between coordination and decision-making is the higher one.

Of the 167 mechanisms in the inventory, 78 (46.7%) were inter-organisational: 44 co-led mechanisms, 10 government-led mechanisms and 24 organisation-led mechanisms (Figure 2). Fifty-one were intergovernmental mechanisms and 27 single-organisation governance mechanisms; 11 technical networks were not analysed. Of the 156 analysed mechanisms, 56 (35.9%) held decision rights: 16 of 44 co-led mechanisms, 5 of 10 government-led mechanisms, 3 of 24 organisation-led mechanisms, 13 of 51 intergovernmental mechanisms and 19 of 27 single-organisation governance mechanisms (Figure 3).

Ten mechanisms could not be confirmed as operating on 25 October 2026: eight have no public record of activity since a given year (from 2013 to November 2025), one was not convened in 2026 because the G20 presidency left health off its agenda, and one has passed to a successor team. One is a co-led mechanism (the Executive Board of the Pan-Caribbean Partnership against HIV and AIDS (PANCAP), with no public record of a meeting since 2017), one is government-led, three are organisation-led mechanisms, four are intergovernmental and one is a technical network. A mechanism without a public record may still operate without publishing its activity. The All-Chairs Group of the Gavi and Global Fund boards, whose set term ended in March 2026, was moved to the annex of ended mechanisms.

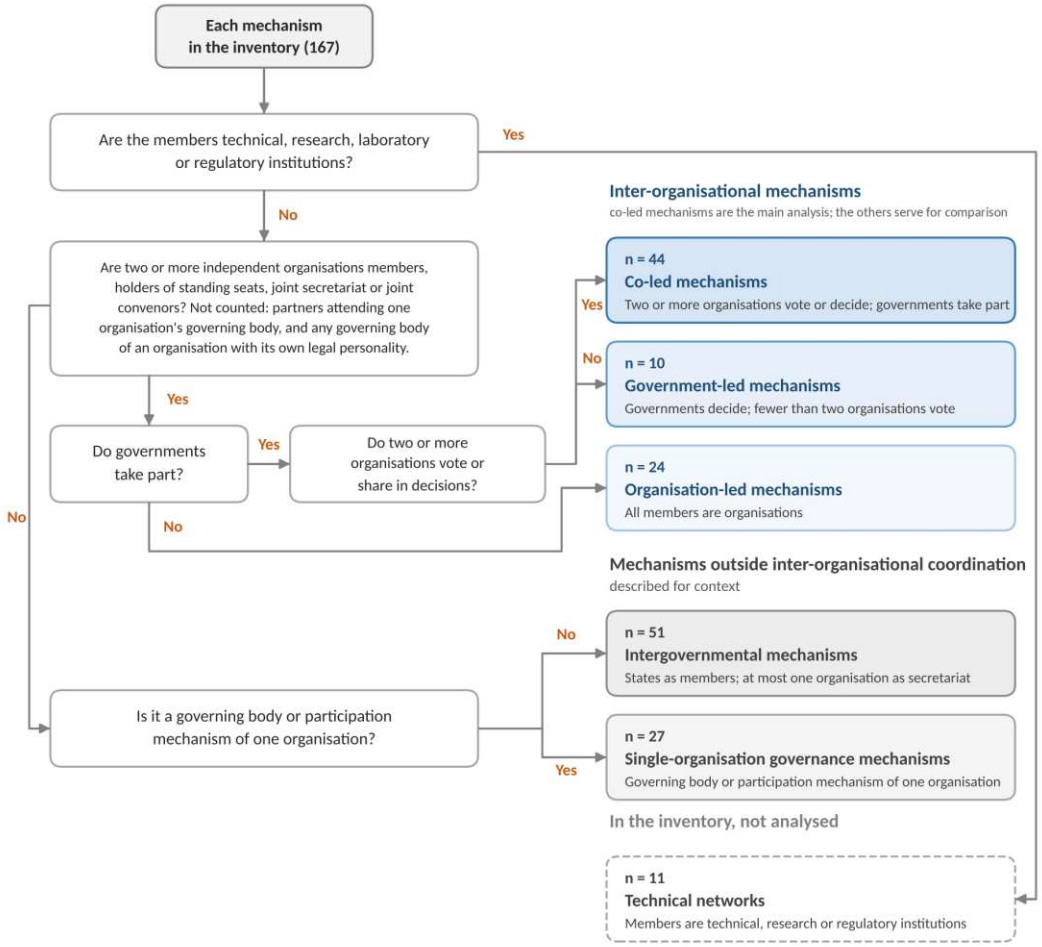


Figure 1. Types of mechanism by who takes part. Each mechanism follows one path; the shared executive board of UNDP, UNFPA and UNOPS, which governs three organisations, is classed as a government-led mechanism because governments decide and the three organisations provide its secretariat.

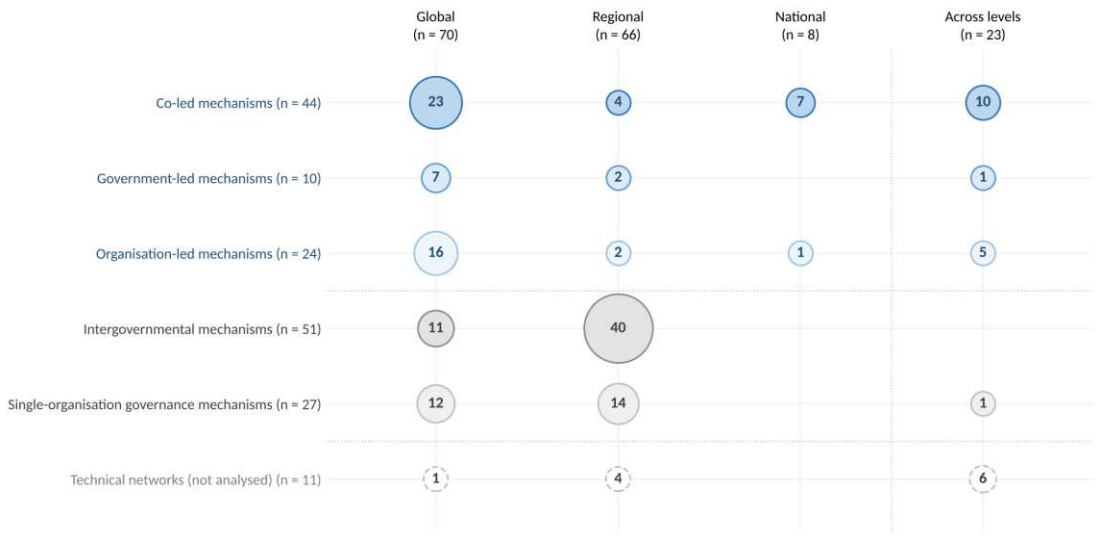


Figure 2. Mechanisms by type and level of action, 167 mechanisms. Technical networks are shown but were not analysed.



Figure 3. Authority by type of mechanism, 167 mechanisms. Each mechanism is counted at its highest coded authority; lower-level functions are not enumerated.

Decision rights vary with coding but concern defined instruments

Under the main coding, 28 of 44 co-led mechanisms (63.6%) fell below the decision-making threshold (Figure 4): 18 at joint planning, eight at information exchange and two at joint review. Joint review was the highest assigned code for the Pacific Monitoring Alliance for NCD Action and Global Fund country coordinating mechanisms. This does not mean that only two mechanisms perform review. The recorded mandates contain additional review-related functions, and distinguishing

monitoring from formal review, or partnership review from review of agreed implementers, remains uncertain (Supplementary Table S6f). Retaining the adjudicated codes preserves the original analysis; it does not resolve those boundaries.

Sixteen co-led mechanisms (36.4%) held decision rights under the main coding, 13 coded as binding. Ten were boards of hosted partnerships, funds or programmes; six involved partner organisations themselves deciding jointly (Table 2). All decisions concerned the work or resources of a defined instrument.

Table 2. Co-led mechanisms in which several organisations decide jointly

Mechanism	Level	Authority	What the decisions cover
GPEI Polio Oversight Board	Global	Binding decisions	Strategy, joint budget and resources of the Global Polio Eradication Initiative
AMR Multi-Partner Trust Fund Steering Committee	Global	Binding decisions	Project approval and allocations of the fund
Working for Health Multi-Partner Trust Fund Steering Committee	Global	Binding decisions	Project approval and staged disbursement of the fund
UN Road Safety Fund Steering Committee	Global	Binding decisions	Funding allocations to participating organisations from the fund
GPEI Strategy Committee	Global	Joint decisions subject to members' approval	Operational management and implementation of GPEI strategy
Pan-Caribbean Partnership against HIV and AIDS Executive Board	Regional	Joint decisions subject to members' approval	Management, direction and restructuring of the partnership; no public record of a meeting since 2017

When the 8 boundary entries took the other coder's code, the number of co-led mechanisms with decision rights rose from 16 to 24 (54.5%; Supplementary Figure S2). The eight are the steering bodies of four partnerships (the Global Task Force on Cholera Control, the AMR Multi-Stakeholder Partnership Platform, UHC2030 and the European Observatory on Health Systems and Policies) and four country platforms (the Global Fund country coordinating mechanism, Gavi's national coordination forums, the joint steering committees of UN cooperation frameworks and GFF country platforms). Each of them, if coded as deciding, decides on one

partnership, fund or framework; the conclusion on decision objects is the same under both codings, while the share of decision-making mechanisms is not. The two codings are alternative scenarios; they are not statistical bounds or a confidence interval. The other sensitivity analyses changed the share little (34.9% to 38.2%), as did excluding the PANCAP Executive Board, whose decision authority rests on a secondary source (34.9%, 15 of 43); this differs from the exclusion of entries documented only in secondary sources, which removes no co-led mechanism and leaves the share at 36.4%. Classing the Gavi Board and its Programme and Policy Committee as co-led mechanisms, and the board of the Innovative Health Initiative as organisation-led, gives 17 of 46 (37.0%) under the main coding and 25 of 46 (54.3%) under the alternative coding (Supplementary Table S6a).



Figure 4. Co-led mechanisms by authority and level of action. The dashed line separates coordination mechanisms (information exchange, joint planning and joint review) from decision-making mechanisms (joint decisions subject to approval and binding decisions). Categories represent the highest assigned code, not the prevalence of each function.

Joint decisions bind the governed instrument, and no document read extends them to members' own budgets

The decision rules of the 13 binding mechanisms differed (Supplementary Table S3). In nine the documented rules permit decisions without unanimity, and in a tenth, the

HRP committee, the applicable rule remains uncertain. Seven may vote when consensus fails, by a two-thirds majority (Unitaid, RBM, PMNCH, ATscale and the UN Road Safety Fund) or by simple majority (SUN and Stop TB); the rules of the HRP committee refer to the World Health Assembly's rules of procedure, which would allow a vote, but this could not be confirmed for the committee. The Polio Oversight Board decides with the affirmative vote of five members, and in the GFF Trust Fund Committee members may "dissent for the record without blocking a decision". Two require consensus (the AMR and Working for Health trust funds). The TDR documents give each member one vote but state no decision rule or threshold. These are formal rules; quorum requirements and special rights were not coded, so the rules show that unanimity is not required, not that no member can prevent a decision, and the documents do not show how often votes are taken. In all 13 the decision binds the governed instrument: its strategy, plan, budget or allocations. This follows in part from the definition, since final control over a governed instrument suffices for the binding step, which is why the two features were coded separately. None of the documents read gives the mechanism authority over the participating organisations' separate budgets or policies, and one excludes it expressly: the ATscale charter provides that "No decision taken by the Board is binding on any organisation that has representatives on the ATscale Board". The Gavi Statutes contain a similar provision for the Gavi Board, which is classed here as a single-organisation governance mechanism. The PMNCH terms of reference allow WHO as host to refrain from implementing a decision inconsistent with its rules, and the GFF governance document gives World Bank policies precedence in a conflict. The RBM bye-laws contain the only commitment by partners to follow Board-approved strategies, limited to "the context of Partnership activities".

Across all 78 inter-organisational mechanisms, 24 held decision rights. Among organisation-led mechanisms, the Inter-Agency Standing Committee and the UN Sustainable Development Group adopt common policies that their member organisations implement, while each organisation remains governed by its own governing body; and the International Coordinating Group on Vaccine Provision decides on releases from an emergency vaccine stockpile. Among government-led mechanisms, the shared executive board of UNDP, UNFPA and UNOPS decides on the programmes and budgets of three organisations, but governments take these decisions and the organisations serve as secretariat. The Pandemic Fund Governing Board allocates the fund's grants; governments hold most of its voting seats and foundations one, while the World Bank as trustee and WHO, which chairs its technical advisory panel, do not vote. We found no mechanism in which organisations, as members, decide on one another's separate budgets.

Mechanisms of every type share health areas and levels, and overlapping membership crosses types

Counted across all types of mechanism, mechanisms were most numerous in general health governance at global level (14), emergencies and health security at global level (12) and reproductive, maternal and child health and nutrition at global level (9) (Figure 5). The composition of these clusters differed. General governance at global level consisted mainly of intergovernmental mechanisms and WHO's own governing and participation mechanisms. In emergencies and health security at global level, 5 of the 12 mechanisms were organisation-led mechanisms, 3 single-organisation governance mechanisms and 2 government-led mechanisms; the one co-led mechanism, the CEPI Joint Coordination Group, holds no decision rights, and decisions in this cluster are taken by the vaccine stockpile group, the Inter-Agency

Standing Committee, the CEPI Board and Investors Council and the Pandemic Fund Governing Board. Reproductive, maternal and child health comprised 5 co-led mechanisms, 3 of them with decision rights, with 4 UN inter-agency groups. Most mechanisms of every type shared an area and level with at least one other: 33 of 44 co-led mechanisms (75.0%), 7 of 10 government-led mechanisms (70.0%), 19 of 24 organisation-led mechanisms (79.2%), 28 of 51 intergovernmental mechanisms (54.9%) and 20 of 27 single-organisation governance mechanisms (74.1%). Co-location is therefore common to all types and does not by itself distinguish co-led mechanisms.

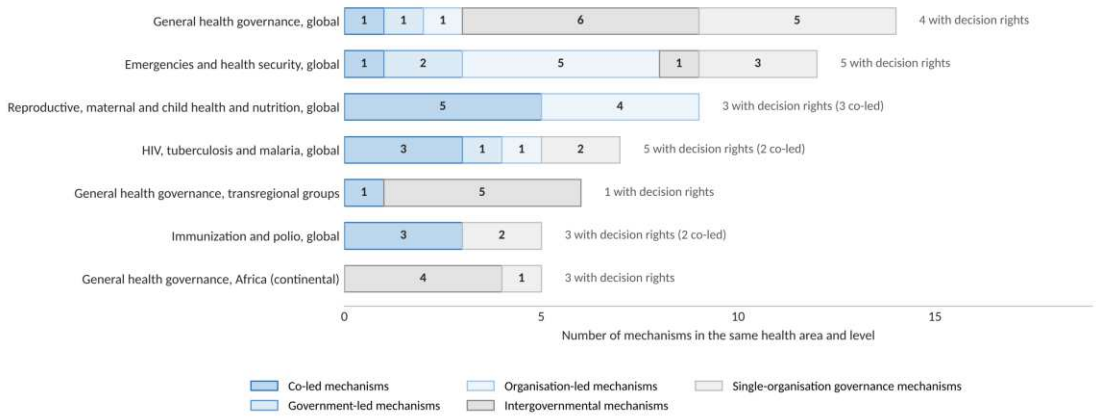


Figure 5. Health areas and levels with five or more mechanisms, by type of mechanism. Numbers in the bars are mechanisms of each type; the label gives the number with decision rights and, in brackets, how many of them are co-led mechanisms.

Co-led mechanisms covered all 11 health areas (Figure 6). Under main coding, both mechanisms in health products, research and regulation held decision rights, as did four of eight in reproductive, maternal and child health and nutrition and two of four in immunization and polio. All four in emergencies and health security fell below the threshold. Of 23 global, ten cross-level, seven national and four regional co-led mechanisms, respectively 13, two, zero and one were coded as deciding. The national zero is specific to the main coding, not evidence that country platforms lack all

decision functions. Global Fund country coordinating mechanisms nominate principal recipients, endorse programme revisions and may decide to change a recipient, although final grant approval rests elsewhere [38]. Four national types cross the threshold in the alternative scenario.



Figure 6. Co-led mechanisms by health area, level and authority. Coordination and decision-making mechanisms are shown separately; 0 marks a combination with no co-led mechanism in the inventory.

The restricted name extraction permitted comparison of six of 25 parallel co-led pairs; none shared half of its extracted organisational members (median Jaccard 0.16). Across types, 44 pairs were comparable, with nine at or above 0.50 (median 0.23). These form three clusters: Gavi and polio governing bodies; HRP, H6 and UN mortality estimation groups; and African mpox and cholera support teams (Figures 7–8). The first includes four cross-pairings sharing the Gates Foundation, UNICEF and WHO (0.50). The HRP comparisons omit IPPF from the extraction list and therefore overstate full organisational membership overlap: adding this documented permanent member changes HRP–H6 from 0.71 to 0.63 and HRP–MMEIG from 0.57 to 0.50 (Supplementary Table S6c). The plotted values and aggregate network statistics remain explicitly restricted to the extracted set. Under the alternative board

classification, four of ten comparable co-led pairs reach 0.50 on formal members and five of 15 on any named role (Supplementary Table S6a); across all types, counting any named role gives 13 of 65 pairs at or above 0.50 (Supplementary Table S5b). These exploratory results identify connections for interpretation, not comprehensive overlap or duplication.



Figure 7. Shared membership of parallel co-located mechanisms. Pairs are grouped by mechanism types, counting formal members (left) and any named role (right). Shaded parts are pairs sharing half or more of their named organisations; labels give that number, the number of pairs compared and the median Jaccard index. Across all types, 9 of 44 pairs shared half or more of their formal members (median 0.23), and 13 of 65 of their named organisations in any role (median 0.25). Results use the restricted organisation list in Supplementary Table S1; IPPF and other unmatched members are not represented.

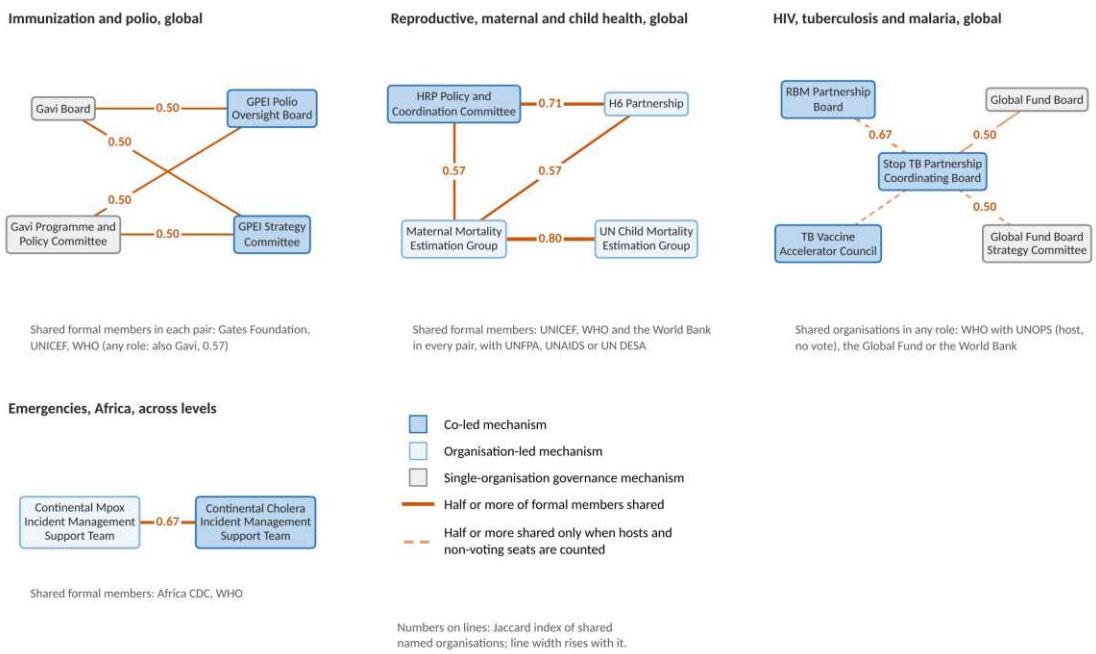


Figure 8. Parallel co-located mechanisms with high shared membership. Pairs share at least half of their named organisations and are grouped by health area and level. Solid lines: half or more of formal members shared; dashed lines: half or more shared only when hosts and non-voting seats are counted. Numbers on lines are Jaccard indices. Results use the restricted organisation list in Supplementary Table S1; IPPF and other unmatched members are not represented. HRP pair values using its additional documented permanent member are given separately in Supplementary Table S6c.

Of the 66 regional mechanisms in the inventory, 40 are intergovernmental mechanisms with one regional organisation as secretariat and 14 are single-organisation governance mechanisms; organisations are full members in 4. These four are in the Caribbean (PANCAP), Europe (the European Observatory and the Northern Dimension Partnership) and one transregional mechanism. In the CAREC health working group in Central Asia, development partners such as WHO take part alongside country representatives, but the group is chaired by countries and reports to CAREC senior officials, so it is classed as government-led. The inventory identified no regional co-led mechanism in Africa, South-East Asia, the Western Pacific or the Eastern Mediterranean; Africa has a co-led mechanism only in a continental incident management support team working across levels, and the Pacific has two co-led

mechanisms working across levels. Because 28 regional organisations in which initial screening found no health mechanism were not searched further, these are combinations not identified in the inventory.

Recorded African state memberships overlap across intergovernmental and single-organisation mechanisms. All 54 African UN member states participate in the African Union and Africa CDC; 47 belong to WHO's African regional committee and seven to its Eastern Mediterranean committee. In the recorded subregional lists, 26 states belong to at least two of eight bodies (25 if Mozambique is excluded from ECSA-HC). ECCAS–OCEAC has the largest recorded overlap (0.55). Rwanda's announced ECCAS withdrawal makes the retained list uncertain: excluding Rwanda leaves the 26-state total unchanged and changes ECCAS–OCEAC overlap to 0.60 (Supplementary Tables S5e–f and S6d). These are membership-list scenarios, not verified attendance or evidence of duplicated work.

Under the main assignment rule, co-led mechanisms decide mainly in development cooperation

Assigned to the six functional areas of document A79/24 [10], mechanisms were unevenly distributed (Figure 9). Development cooperation for health was the main function of 47 mechanisms, including 25 of the 44 co-led mechanisms and 12 of the 16 co-led mechanisms with decision rights, which are the boards and trust fund committees of disease partnerships and joint programmes. This concentration partly follows from the assignment rule, under which the partnerships and financing mechanisms of disease programmes belong to development cooperation; the Pandemic Fund, which finances preparedness, was assigned to surveillance and health security. Under an alternative rule that assigns mechanisms with a recorded secondary function to that function, development cooperation accounts for 9 of the 16 deciding

467 co-led mechanisms, product innovation and access for 3, surveillance and health
468 security for 2 (the Polio Oversight Board and the Strategy Committee of the Global
469 Polio Eradication Initiative) and data, monitoring and knowledge for 2
470 (Supplementary Table S6b). General governance across functions accounted for 50
471 mechanisms, 38 of them intergovernmental. Surveillance and health security had 16
472 mechanisms, and of the 5 with decision rights four are single-organisation governance
473 mechanisms (two Africa CDC bodies, CARPHA and ECDC) and one, the Pandemic
474 Fund Governing Board, is government-led; under the main rule none of its 2 co-led
475 mechanisms decides. Product innovation and access had 20 mechanisms, mostly
476 regulatory, procurement and research bodies of states or single organisations; the two
477 co-led mechanisms with decision rights, the Unitaid Executive Board and the ATscale
478 Board, decide over their own funds. Data, monitoring and knowledge had 10, and its
479 two deciding co-led mechanisms are the boards of the research programmes HRP and
480 TDR. Norms, technical guidance and standards (7) were set mainly by treaty bodies,
481 the Codex Alimentarius Commission and pharmacopoeia bodies, and humanitarian
482 emergency response (6) was organised mainly through organisation-led mechanisms,
483 of which only the Inter-Agency Standing Committee holds decision rights.
484 Mechanisms on noncommunicable diseases were spread across functions: the two
485 tobacco treaty bodies set norms, the global coordination mechanism and the Pacific
486 monitoring alliance belong to data, monitoring and knowledge, and the UN inter-
487 agency task force to development cooperation.



Figure 9. Mechanisms by main function and type, 156 mechanisms. Functions follow document A79/24 [10]. Numbers in the bars are mechanisms of each type; the label gives the number with decision rights and, in brackets, how many of them are co-led mechanisms. Thirty mechanisms also have a secondary functional area (Supplementary Table S5c).

WHO is prominent in the restricted co-membership network

Named organisations were extracted for 35 of 44 co-led mechanisms; nine described member categories only. WHO appeared in 30, as a formal member in 20 and host or secretariat only in ten (Figure 10). UNICEF appeared as a formal member in nine, the World Bank in seven and Gavi in six. In the restricted 29-node network, WHO's betweenness was 0.55, compared with approximately 0.07 for the World Bank and UNICEF (Figure 11). Alternative role definitions gave WHO values of 0.54–0.55 (Supplementary Table S4). These checks retain the same incomplete organisation list and do not establish robustness to omitted members. Across all 78 inter-organisational mechanisms, WHO was named in 58, including 40 in roles other than host or secretariat only. These counts describe the extraction and cannot establish institutional influence.

WHO was the main host or secretariat for 16 co-led mechanisms and shared that role in three more (Figure 12). Six of the 16 mainly hosted by WHO held decision rights, each over a hosted programme or partnership. Six of seven hosted by other UN

entities held decision rights, largely through hosted boards and pooled funds. Five nationally convened platforms fell below the threshold under main coding; this result shares the country-platform coding uncertainty described above.

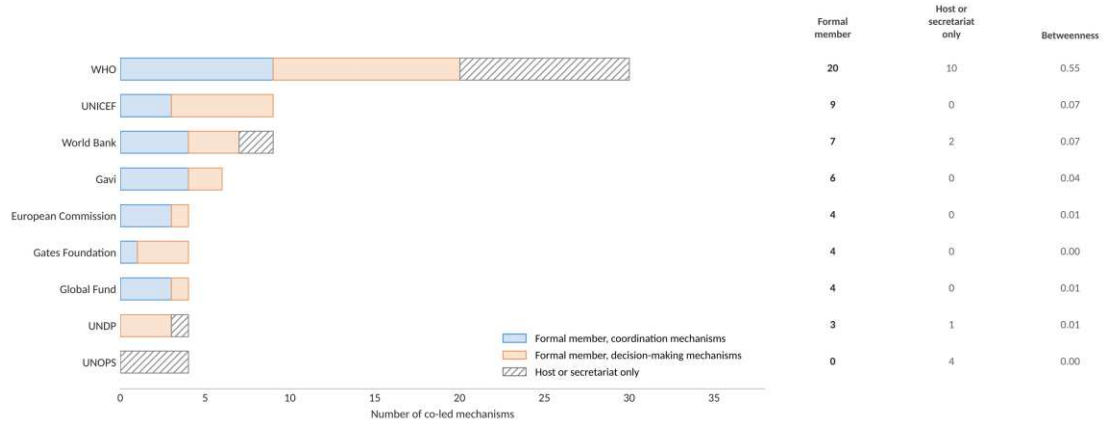


Figure 10. Organisations named in four or more co-led mechanisms, by role. Betweenness is computed in the formal co-membership network; US CDC, a national agency, counts as government participation and is not a network node. Results use the restricted organisation list in Supplementary Table S1; IPPF and other unmatched members are not represented.

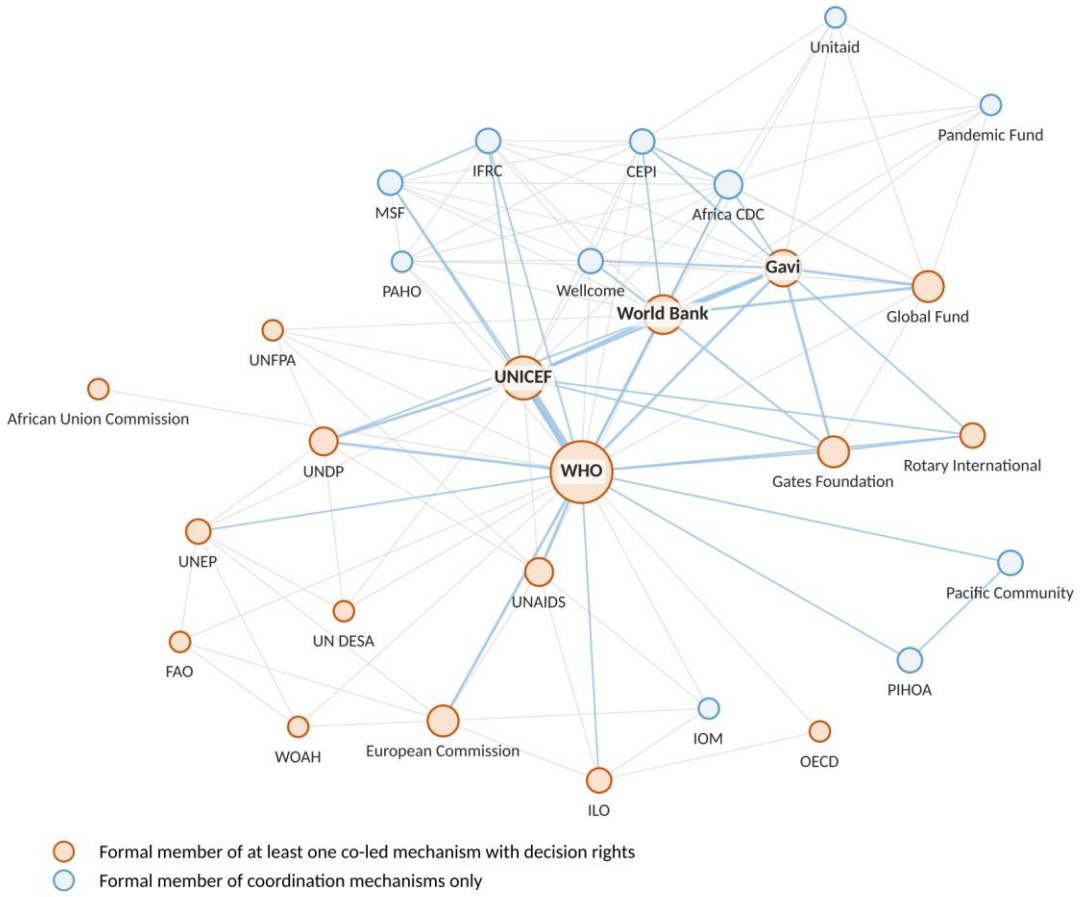


Figure 11. Formal co-membership network of co-led mechanisms, 29 organisations. Two organisations are linked when both are formal members of at least one co-led mechanism; line width shows the number of shared mechanisms and node size the number of mechanisms. Positions come from a Kamada–Kawai layout and carry no further meaning. Funds named as members, such as the Pandemic Fund, are nodes even where they lack separate legal personality. Results use the restricted organisation list in Supplementary Table S1; IPPF and other unmatched members are not represented.

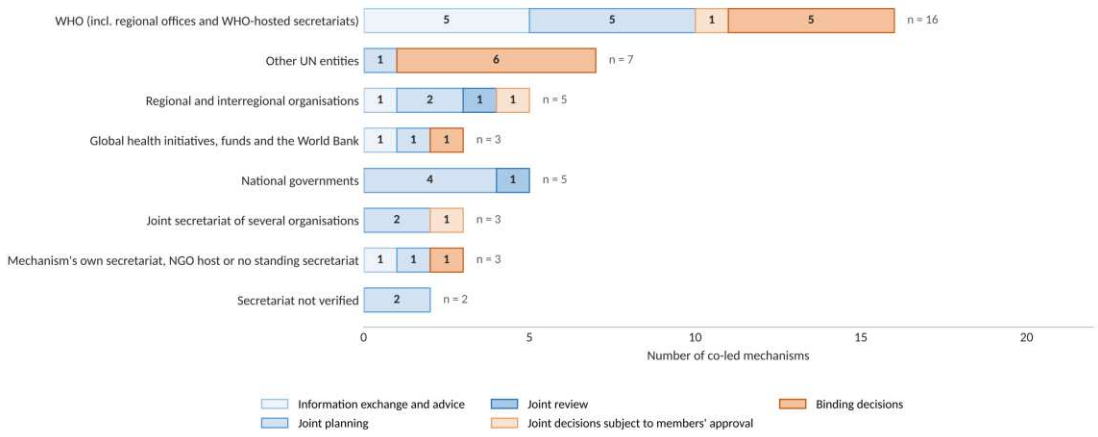


Figure 12. Co-led mechanisms by main type of host or secretariat and authority. Each mechanism is assigned to one host type.

Illustrative precedents exist for each design, and none gives organisations authority over one another's resources

Each of the four designs for coordination across governing bodies has illustrative precedents in the inventory or its annex, selected by resemblance of form rather than evaluated (Figure 13). Joint board arrangements take two forms: the Polio Oversight Board, in which partner organisations jointly govern one programme, and the Executive Board of UNDP, UNFPA and UNOPS, in which governments govern three organisations through one body. Links between the boards of Gavi and the Global Fund have consisted of a group of board chairs, whose term ended in March 2026 and which is now listed in the annex, and a secretariat taskforce that plans jointly. Function-specific arrangements are most developed in humanitarian and outbreak response, where the Inter-Agency Standing Committee adopts common policies and the vaccine stockpile group decides on releases. Convening platforms (UHC2030, the Friends of the Lusaka Agenda and the joint reform process itself) exchange information or plan jointly. The joint evaluation of the Global Action Plan for Healthy Lives and Well-being for All, a platform of agencies that has since ended, found that its efforts were "insufficient to drive substantial inter-agency cooperation and

institutional change" [39]. Independent panels are represented by the Global Preparedness Monitoring Board, which publishes annual assessments and reports to no governing body, and by a panel on antimicrobial resistance that is still being established. In none of these precedents do organisations, as members, decide on one another's budgets or policies; the one mechanism that decides on the budgets of several organisations is composed of governments.

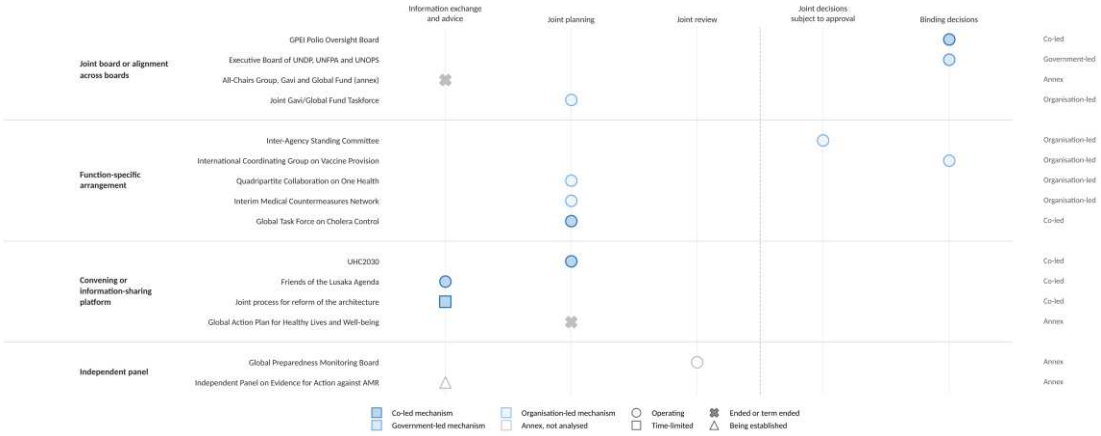


Figure 13. Illustrative precedents for four designs of coordination across governing bodies. Each row is a mechanism in the inventory or annex; the marker shows its authority, its colour the type of mechanism and its shape the operating status. Mechanisms in the annex were not analysed and their authority is taken from the annex record. The scale shows formal authority and does not rank the designs.

Discussion

Formal authority and the objects of joint decisions

The central distinction is between authority over a shared instrument and authority over participating organisations. The main and alternative codings produce different decision shares, 36.4% and 54.5%, but both locate decisions within defined funds, partnerships, programmes or frameworks. Because final control over a governed instrument is one of the two criteria for the binding step, the finding that binding decisions concern such instruments partly follows from the scale. The findings that do

not depend on it are that no document reviewed gives a co-led mechanism authority over participating organisations' separate budgets or policies, and that nine of the 13 binding mechanisms have rules permitting non-unanimous decisions. This applies to the co-led subset; elsewhere governments may govern several organisations through one board. Provisions preserving members' autonomy, host rules and trustee policies further qualify joint authority. The study maps documented arrangements and does not establish whether they are effective.

The pattern is consistent with accounts in which international organisations cooperate through routine practices while guarding their mandates [18, 19], and in which coordination among UN agencies rests on joint resource mobilisation and consensus [40]. Organisations accept binding collective decisions over instruments they have created or fund together. In 9 of the 13 binding mechanisms the documented rules permit non-unanimous decisions, and the applicable rule of the HRP committee remains uncertain. These rules do not generally require the unanimity that Scharpf [25] associated with the joint-decision trap; the study did not assess whether disagreement prevents decisions or their implementation. The common policies of the humanitarian and UN development systems, adopted by organisations without governments and implemented by each under its own governance, come closest to joint rules for several organisations. The documents do not show whether joint authority over organisations' own resources was never sought, was withheld by governing bodies, or is unnecessary because pooled instruments serve the same purposes.

What membership patterns can and cannot establish

Fragmentation and duplication feature prominently in reform debates [4, 12]. Co-location is common across all five analysed types, with particularly large clusters in global general governance and emergencies. Yet sharing a health area and level does

not show that mechanisms repeat decisions or impose avoidable costs. Our mapping identifies institutional proximity; duplication requires process and burden evidence that the inventory does not contain.

The extracted memberships connect Gavi and polio bodies, reproductive and child health groups, and continental emergency teams. These connections are compatible with a division of labour among overlapping institutions [15]. Coverage is selective: government members were not compared, nine co-led mechanisms name no organisations, and the extraction list omits IPPF. Accordingly, the numerical overlaps and centralities cannot be generalised to full memberships. The African comparison likewise depends on documentary lists and unresolved changes in membership, rather than actual participation.

WHO's repeated formal and hosting roles provide identifiable channels for coordination, consistent with its role as an orchestrator [17]. Its prominence in the extracted network should not be read as evidence of authority or a rebuttal to studies of changing influence [19, 20]. A host may facilitate meetings without controlling participants' decisions, and a central network position does not confer a mandate.

Options within existing mandates

Reform proposals could specify the intended level of coordination, the decision object, the deciding body and the source of authority [22, 23]. Existing review provisions may support more consistent use of indicators and follow-up where mandates permit, but the highest-authority scale cannot establish the prevalence or absence of review functions. Shared membership identifies potential channels for coordinating positions across boards; it does not justify merger or closure. Decisions about consolidation require evidence of overlapping processes and confirmation of operating status. These are implications of the existing mapping, not interventions evaluated here.

Functional arrangements also matter. Development cooperation contains most deciding co-led mechanisms under the main assignment, largely through partnership boards and pooled funds. Assigning the two polio bodies and the Stop TB Partnership Coordinating Board to their secondary functions reduces that concentration. In health security, existing decisions are distributed among fund boards, regional health bodies, product-release mechanisms and organisations' own governance. Reform can clarify how coordination reaches these decision-makers before proposing additional bodies. The inventory does not show that a function without a co-led deciding mechanism lacks decision capacity.

At country level, the main and alternative coding scenarios differ on four platform types. Final external approval of a grant does not remove a platform's authority to nominate recipients, endorse revisions or adopt framework-specific decisions. Alignment behind a national plan, budget and monitoring system [2] may combine joint planning with separate approvals. Binding authority over participating organisations' resources would require additional agreement. Country-specific arrangements were not mapped. Regional findings similarly concern recorded bodies and memberships; member states retain responsibility for the allocation of tasks within their respective organisations.

Options requiring new agreements or authority

Other options would change who decides, and they are of three kinds. Giving a mechanism authority over organisations' own budgets or policies would require each governing body concerned to delegate it under its constituent instruments; the inventory contains no such arrangement among organisations from which to judge how it would work. Creating a new joint decision-making mechanism, for example for decisions in emergencies, would require agreement on its membership, its decision

rule and the instruments it governs. Changing the decision rule or membership of an existing mechanism, for instance from consensus to a qualified majority, would require amendment of its founding documents by those entitled to amend them. In each case the joint reform process can make recommendations, and the decision rests with the governing bodies concerned. Studies of the reform process suggest why delegation is difficult: incentives to collaborate are weak where organisations compete for funding and accountability runs to funders [5], and the institutions to be reformed take part in designing the reform [11].

Representation choices also affect authority. Reform documents propose closer links with regional institutions [37], and document A79/24 [10] provides a regional health organisation seat in the joint process. Standing seats, rotating representation, observer roles and liaison agreements have different implications for participation and decision rights. The four designs should therefore be judged by the authority needed for a specified task. Their illustrative precedents demonstrate possible institutional forms, not evidence that any one design would resolve fragmentation.

Limitations

The inventory is not a probability sample or a comprehensive census. It partly derives from an initial list without recorded search steps and tool-assisted compilation. Reform-document coverage reflects visibility; 28 regional organisations with no initially identified health mechanism were not searched further. National types each count once, although they represent many country bodies. Zeros mean not identified, not absent. Operating status was unconfirmed for ten entries. The supporting literature search screened a selected subset of records and cannot prove the absence of relevant studies. African membership lists contain uncertainty over Mozambique in ECSA-HC and Rwanda in ECCAS.

Decision-status agreement was tentative, and adjudication by the lead author favoured the lower authority code in 30 of 31 disagreements, so the main coding may understate authority; the alternative scenario re-codes only the eight entries on the coordination–decision boundary. Later additions and derived classifications were reviewed by one author, and two targeted fields remained unjudged. The highest-authority scale cannot estimate individual functions, while review and decision boundaries remain contested. Restricted name matching omits eligible members, making network and pairwise results exploratory. Alternative role definitions do not correct that omission. Legal-personality and functional assignment rules also affect comparisons. These limitations warrant scenario-based interpretation rather than a single definitive estimate.

Formal instruments do not reveal implementation, informal influence or transaction costs. Quorum rules and special rights were not systematically coded, one binding mechanism lacked a documented threshold, and PANCAP's decision authority rests on a secondary source. The four reform designs and their precedents are interpretive classifications, not evaluated interventions. The unit of analysis is the mechanism; individual sex and gender data were neither collected nor analysed. No claims are made about the distributional or health effects of the proposed options.

Conclusions

Co-led mechanisms already take joint decisions, principally over defined instruments. Their deciding share varies substantially with coding, but neither scenario identifies authority over participating organisations' separate budgets or policies. Institutional proximity and shared members identify possible coordination channels without proving duplication. Reform proposals can use existing mandates to clarify responsibilities and connections; proposals that change decision rights, representation

or control over resources require agreement by the competent governing bodies. The mapping supports this distinction without establishing the effectiveness of any reform design.

Abbreviations

Africa CDC, Africa Centres for Disease Control and Prevention; AI, artificial intelligence; AMR, antimicrobial resistance; CAREC, Central Asia Regional Economic Cooperation; CARPHA, Caribbean Public Health Agency; CEPI, Coalition for Epidemic Preparedness Innovations; ECCAS, Economic Community of Central African States; ECDC, European Centre for Disease Prevention and Control; ECSA-HC, East, Central and Southern Africa Health Community; G20, Group of Twenty; GFF, Global Financing Facility; GPEI, Global Polio Eradication Initiative; HRP, Human Reproduction Programme; IPPF, International Planned Parenthood Federation; MMEIG, Maternal Mortality Estimation Inter-Agency Group; OCEAC, Organisation de Coordination pour la Lutte contre les Endémies en Afrique Centrale; PANCAP, Pan-Caribbean Partnership against HIV and AIDS; PMNCH, Partnership for Maternal, Newborn and Child Health; SUN, Scaling Up Nutrition; TDR, Special Programme for Research and Training in Tropical Diseases; UN, United Nations; UNDP, United Nations Development Programme; UNFPA, United Nations Population Fund; UNICEF, United Nations Children's Fund; UNOPS, United Nations Office for Project Services; US CDC, United States Centers for Disease Control and Prevention; WHO, World Health Organization.

Declarations

Ethics approval and consent to participate

This study is a secondary analysis of publicly available documents. It involved no human participants, no personally identifiable data and no interaction with individuals; ethics approval and informed consent were therefore not required.

Consent for publication

Not applicable.

Availability of data and materials

All data analysed in this study were compiled from publicly available documents, including the establishing documents, terms of reference, governance pages and reports of the mechanisms concerned and the reform documents listed in Supplementary Methods Table M1. The flow of all identifiers assigned during compilation is given in Supplementary Table S2, and the decision rules of the binding mechanisms in Supplementary Table S3. The inventory of mechanisms, the coded and derived variables, the coverage check and the literature search record are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

HY conceived and designed the study, defined the inventory criteria and coding rules, compiled the inventory, adjudicated disagreements between coders, reviewed all AI-assisted classifications, derived variables and key fields against original sources, analysed and interpreted the data, and wrote the manuscript. YH and ZL independently coded the first 151 mechanisms. YH also registered and archived the reform documents used in the coverage check. MR supervised the study and revised the manuscript critically for important intellectual content. All authors read and approved the final manuscript.

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Supplementary material

Additional file 1 (.docx). Supplementary Methods, Tables S1–S4, S5a–S5f and S6a–S6f, and Figures S1–S2. Coding rules, inventory flow, decision-rule evidence, exploratory network results, descriptive comparisons and sensitivity scenarios.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Supplementarymaterial20261107.docx