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The Global Fund's China Legacy

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Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CASAPC	China Association of STD and AIDS Prevention and Control
CBO	community-based organization
CCM	country coordinating mechanism
CSO	civil society organization
DOTS	directly observed treatment, short-course
GONGO	government-organized NGO
HIV	human immunodeficiency virus
HSS	health system strengthening
ITN	insecticide-treated mosquito net
MARP	most-at-risk populations
MDR-TB	multidrug–resistant tuberculosis
MMT	methadone maintenance therapy
MOH	Ministry of Health
MPS	Ministry of Public Security
MSM	men who have sex with men
NGO	nongovernmental organization
OIG	Global Fund's Office of the Inspector General
PLWHA	people living with HIV/AIDS
PLHATM	people living with HIV/AIDS, TB, or malaria
PR	principal recipient
RCC	rolling continuation channel
SFDA	State Food and Drug Administration
SOE	state-owned enterprise
SR	sub-recipients
SSR	sub–sub-recipients
TB	tuberculosis
TRP	technical review panel
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS

Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter "the Global Fund" or "the Fund") is the world's main multilateral funder in global health and the largest financier of anti-AIDS, anti-tuberculosis (TB), and anti-malaria programs. Since its inception in 2002, the Global Fund has disbursed $23.2 billion to more than 140 countries; today, it accounts for 21 percent of the international funding for the prevention and treatment of HIV/AIDS, 82 percent of that for TB, and 50 percent of that for malaria.[1] Until recently, it awarded grants based on the need of individual countries and the quality of each proposal. As a performance-based initiative, it closely tracks the results flowing from each grant disbursement. As a value-oriented organization, it requires recipients to have transparent, accountable, and inclusive governance mechanisms. Indeed, in terms of multisectoralism and civil society participation, the Fund is considered the most progressive global health institution.[2] But unlike many other health-related multilateral organizations, it is not an implementing agency and lacks in-country presence. Instead, as a funding mechanism, it has grant applications and project/program implementation in each country overseen by a "country coordinating mechanism" (CCM), which draws representatives from government, UN and donor agencies, nongovernmental organizations (NGOs), the private sector, and people living with the diseases.

China has been one of the Global Fund's largest recipients. Since 2003, the Fund has approved $1.81 billion and by 2012 had disbursed more than $805 million to support China's fight against the three diseases. In particular, China is the top recipient for TB funding. The country has received $366 million, accounting for 10 percent of the Global Fund's TB-specific disbursements.[3] Active in more than two-thirds of China's counties and districts, the Global Fund has also been the largest international health cooperation program in China.

In light of difficulties raising funds and growing pressures for emerging economies to shoulder more international responsibilities, however, the Global Fund made China and several other Group of Twenty (G20) countries ineligible for Phase Two renewal of existing grants in November 2011. Since China also decided to forego transitional funding from the Global Fund, the organization officially closed its portfolio in China by the end of 2013. That said, China asked for and received approval to have a twelve-month extension of the existing grants. As of March 2014, China is still completing the Fund-supported projects.

As China moves into the post–Global Fund era, it is useful to examine the Fund's legacy in the country for the following reasons. First, over the past few years, there has been a growing emphasis in global health on assessing the effectiveness of specific health interventions. The Fund's experience in China offers a perfect opportunity to examine the strengths and limits of a major global health funder in international health interventions. Second, with some rare exceptions, existing scholarship has little to say about how international institutions sway public policy processes in nondemocratic, Leninist regimes, which often present a "tough case" for demonstrating the effects of internationalization. Third, though growing attention has been paid to emerging powers' participation in global health governance, few examine the role of international actors in producing domestic health policy change.

One decade of the Global Fund's presence in China has left behind a deeply mixed legacy. Although the Fund's money has made important contributions to China's fight against AIDS, TB, and malaria, as well as its domestic health governance in ideational, institutional, and policy domains, it is associated with uneven progress in grant performance, low value for money, unintended effects on civil society–building, and enduring challenges to scale-up and sustainability. The mixed legacy has important implications for global health governance, the Fund's future financing model, and China's handling of its own public health challenges.

The Good News

EFFECTS ON DISEASE PREVENTION AND CONTROL

Diagnostic review conducted by the Fund suggests that its work has triggered strong and successful national responses to the three diseases in China. According to the Global Fund, by 2010, 32 percent of those in need of antiretroviral therapy (ART) were receiving it, compared to 25 percent in 2005.[4] From 2004 to 2009, the number of patients receiving methadone maintenance therapy (MMT) increased from 1,029 to 242,000, which, in combination with the expansion of other harm-reduction measures, is associated with a marked fall in new HIV infections in injecting drug users.[5] Important progress has also been made in turning around the TB epidemic. In 2002, the TB case-detection rate was only 30 percent. By the end of 2005, China achieved 80 percent case detection, surpassing the World Health Organization (WHO) global TB control target of 70 percent. Today, the number of new smear-positive TB cases that were detected and treated has reached 2.9 million in China, accounting for over 30 percent of the global figures for directly observed treatment, short-course (DOTS). As a result of the expansion and enhancement of DOTS coverage, China saw a drop of nearly 60 percent in the prevalence of smear-positive TB between 2000 and 2010.[6] Meanwhile, the Global Fund has supported the distribution of 4.5 million insecticide-treated mosquito nets (ITNs), particularly long-lasting insecticidal nets.[7] The Global Fund support has helped China to shift the priority of its malaria program from malaria *control* to malaria *elimination*.

That said, finding metrics to reliably measure the outcomes of the Fund's spending can be a tricky intellectual exercise. For one thing, the Fund's financing model emphasizes partnership, which makes it almost impossible to disentangle the unique effects of each actor. At the same time, it is hard to know whether and to what extent the significant level of government funding was a result of a Global Fund matching requirement—China might have invested more in the three diseases if the Fund grants were not available. Also, the programs rely heavily on various aspects of the broader health system not subsidized through the Fund's disease-specific budgets. Estimating the project results as if produced by the Global Fund alone may understate the role played by other critical actors.

Thanks to the Fund projects, Chinese health officials and civil-society organizations (CSOs) have not only been equipped with badly needed supplies and facilities but have also improved their skills in fundraising, management, budgeting, and personnel training, all of which are crucial for capacity-building. For instance, Chinese health officials and civil society activists indicated in the interviews that through the Fund projects they "learned how to ask for money."

The Global Fund also enabled Chinese health workers to explore new approaches for disease prevention and control. Based on the success of the Round One and Round Four expansions of the DOTS approach to controlling TB, China began to use some Fund money to experiment with ways to control multidrug-resistant tuberculosis (MDR-TB). Today, the Fund underwrites the lion's share of efforts in Chinese provinces to treat and manage MDR-TB. Evidence also supports the synergistic effect of Global Fund monies in improving access to treatment for people living with HIV/AIDS (PLWHA). According to a survey conducted in China between October 2006 and April 2007, in counties funded only by the Global Fund, 36 percent of PLWHA received treatment. On the other hand, in counties funded only by the Ministry of Health (MOH) pilot program, which allocates extra funding to local governments for comprehensive HIV/AIDS prevention and control, only 25 percent

of PLWHA received treatment. In counties that benefitted from both the Global Fund program and the MOH pilot program, nearly 80 percent of the PLWHA received treatment.[8]

EFFECT ON DOMESTIC HEALTH GOVERNANCE

The Global Fund's activism also had considerable positive influence on China's domestic health governance. Since the Global Fund is both a performance-based financing mechanism and a value-based initiative, it is imperative not only to examine whether its program reached established targets and achieved intended outcomes, but also to assess whether the funded projects were implemented in ways consistent with the values and procedures set forth by the Fund.

As far as the values and procedures are concerned, the past decade saw the increasing ideational convergence between China and the global health community toward HIV/AIDS prevention and control. The global HIV/AIDS paradigm (as represented by the Global Fund) embraces the principles of transparency, inclusiveness, destigmatization, community participation, and science-informed interventions. By contrast, denial and inaction characterized China's response to HIV/AIDS until 2002.[9] Discrimination and stigmatization against PLWHA was common in China, where "there was no alliance of 'all actors' under one powerful plan, there was no assumption that testing and treatment are indispensable parts of a success response (in fact, neither was available), and there was certainly no official endorsement for community participation."[10] The most-at-risk populations (MARP) were viewed as targets of public health intervention, not as agents in government policy. Similarly, activists seeking to participate in the campaign against HIV/AIDS and other infectious diseases were discouraged, harassed, and even persecuted. In the absence of civil society participation, rampant discrimination and fear not only inhibited people from seeking counseling and treatment, but also encouraged the abuse of state power in a way that focused on curbing behaviors the government considered undesirable, instead of reducing the rates of disease transmission associated with such behavior. For a time, the mere possession of a condom by a female worker in a nightclub constituted evidence of prostitution in the Chinese legal system, and thereby served as grounds for prosecution. Harm-reduction measures such as needle exchange and methadone maintenance were discouraged because they were thought to be ineffective or incompatible with Chinese values.

Now, ten years later, the ideational gap between China and the global health community appears to have been significantly reduced. Chinese health authorities now share data more openly and exhibit more willingness to debate areas for improvement. There is more frequent use of the non-moralizing names of MARP: "injecting drug users" instead of "drug addicts," "commercial sex workers" instead of "prostitutes," and "men who have sex with men" (MSM) instead of "homosexuals." By 2010, 87 percent of the general population, 95 percent of policymakers, and 93 percent of public-security officials had "adequate" knowledge about HIV/AIDS. Accordingly, 41 percent of the general population, 54 percent of policymakers, 66 percent of medical personnel, and 43 percent of public-security officials expressed "accepting" attitudes toward PLWHA.[11]

Meanwhile, the Global Fund has also opened doors for CSOs to operate in China. Since 2003, almost every round of its funding to Chinese AIDS programs has earmarked a certain percentage to support their activities and help build their capacity. Round Three and Round Four programs set aside 20 percent of total funding to support CSOs, and Round Five set aside 50 percent. With 100 percent set aside for NGOs, the Round Six grants were designed specifically to mobilize and support

Chinese civil society to scale up HIV/AIDS control efforts. By the end of 2010, more than one thousand Chinese CSOs had reportedly received financial support from the Fund.[12] Participation in the Fund projects and exposure to the ideas and approaches introduced by the Fund have led the nascent Chinese NGOs and community-based organizations (CBOs) to identify themselves as important components of the Chinese civil society. Furthermore, the Global Fund projects have provided an opportunity for Chinese CSOs to demonstrate their distinctive roles, including accessing at-risk or socially marginalized populations. Over time, the government has increasingly acknowledged their roles. In recognition of the importance of a multisectoral approach to HIV/AIDS, Premier Wen Jiabao said in 2011, "To defeat AIDS, it will take the whole society."[13]

Though the normative change has been incremental, the need to comply with the Fund requirements has compelled the Chinese government to make more radical policy shifts over controversial issues such as harm reduction. As Evan Lieberman observed, the questions raised in the application forms and the Geneva-based review process provided powerful inducements for countries wishing to receive the funding to carry out the "best practices" touted by the Global Fund.[14] China's application for first round Global Fund grants to support HIV/AIDS prevention in injection drug users (submitted in March 2002) was rejected by the Fund's technical review panel (TRP) in part because it failed to include harm-reduction measures. In 2004, when China was applying for the fourth-round Global Fund grants, the proposal included methadone substitution and needle exchange as important harm-reduction components. In July 2006, in recognition of the lack of progress in fulfilling the grant targets of enrolling drug users on MMT, the MOH, Ministry of Public Security (MPS), and State Food and Drug Administration (SFDA) issued a new protocol that included building and expanding methadone clinics in provinces with a high number of drug users.

Similar dynamics have led to growing government commitment to HIV/AIDS treatment. The second Global Fund proposal on the treatment for former plasma donors, which was submitted in September 2002 and asked the Fund to cover the entire ART cost, was rejected for lack of political commitment on China's part. Despite speculation that the rejection was politically motivated, the government took the TRP comments and criticisms seriously. In May 2003, China submitted the third Global Fund proposal, in which the government not only proposed to cover the entire cost of first-line ART and treatment for opportunistic infections, but also promised to significantly increase government contribution over five years—from $5.2 million to $30.4 million.[15]

Occasionally, the Fund leveraged its influence to send explicit signals to the Chinese government in order to pursue its desired change. By tying China to an external commitment (i.e., a salient international grant), the Global Fund raised the stakes and gave domestic actors, especially Chinese CSOs, additional leverage to overcome strong domestic resistance and push for their preferred policy change. For instance, in May 2010, a Chinese NGO leader sent a letter to the Global Fund Secretariat protesting China CDC's failure to meet the Fund's 20 percent NGO funding requirements. This occurred against the backdrop of the alleged fund misuse in Africa. In July, the Global Fund dispatched its officials to China to negotiate with China CDC on this issue. Sensing no breakthrough in the negotiations, the Global Fund asked two independent consulting firms to conduct an external assessment of its AIDS program in China. Based on the assessment report, in October 2010, the Fund Secretariat suspended AIDS program funding in China. At the end of November, the Global Fund East Asia portfolio manager wrote an administrative letter to Wang Yu, director-general of China CDC, stating that China was unable to meet nine terms and conditions stipulated in the project agreement, four of which referred to China's failure to effectively involve the CSOs in funding,

strategic planning, project management, and implementation. In May 2011, the Fund froze payments of almost all grants to China to protest the lack of CSO participation and the misuse of the funds. This eventually led Minister of Health Chen Zhu to set up a special working group with sixteen supervisory teams to investigate the issue. Meanwhile, Chen took the unusual step of holding two special meetings seeking advice from civil society representatives. By late May 2011, China reached an agreement with the Global Fund pledging to ensure sufficient civil society involvement and improve bookkeeping in implementing the Fund-supported projects.

Besides bridging the attitudinal gap and fostering policy change, the Global Fund has also shaped the institutional basis for interventions on the three diseases. The Fund developed a grant application process that has required each country to set up a CCM responsible for reviewing and coordinating grant applications, in addition to monitoring and guiding the implementation of approved projects. Established in 2002, China CCM was envisioned to adhere to the principles of transparency, broad participation, and efficient operation in the grant application and implementation process. Unlike the traditional reliance on ad hoc policy coordination mechanisms whose members are almost entirely from government agencies, the China CCM includes actors outside of government, such as international organizations, NGOs, and individual representatives. It initially had fifty-four members and included thirteen government agencies, nine government-sponsored organizations, five academic institutions, twenty international organizations, five pharmaceutical representatives, and two patient representatives. With its requirement on the participation of multiple actors, the CCM process increased attention to the three diseases within the Chinese government while also serving as a forum to bring together a multitude of actors and make decisions even on controversial issues such as harm reduction. The need to include a signature from every CCM member in the proposals generated strong incentives for consensus-building among various parties. As observed by an MOH official, "We look at the Global Fund not just as a source of financial resources. We look at the Global Fund as a provider of good incentive to encourage the government to be more open, more cooperative, and to have more chance to have a good experience and learn lessons from other countries, from international societies."[16]

Unlike many other recipient countries, China relies on a distinctive set of policy actors in implementing the Fund projects. It designates China CDC, a government organization directly affiliated with the MOH, as the principal recipient (PR) to take overall responsibility for managing China's Global Fund programs. For each of the three diseases (AIDS, TB, and malaria), the PR set up a program office. At the subnational level, provincial and county CDCs are designated as sub-recipients (SRs) or sub–sub-recipients (SSRs). This relatively streamlined system enabled the Global Fund resources to be deployed quickly and efficiently to project sites in nearly three thousand cities and counties, bypassing bureaucratic restrictions and the political allocation process that might have diverted funds earmarked for health projects. At the subnational level, local CDCs act as the primary mechanism responsible for coordination. A study found that this arrangement led to better exchanges and information-sharing between different activities, programs, and government organizations.[17]

The Global Fund–induced institutional change also transformed the landscape of state-society relations in the field of disease prevention and control. In 2006, the Global Fund reformed its guidelines for building CCMs and required proof of a transparent and documented process for electing a representative for each sector. With the help of Bernard Rivers, the director of an independent watchdog of the Global Fund, China's CCM eventually reduced the overall number of members from fifty-four to twenty-three, thereby increasing the representation of CBOs and PLHATM (Table

1). Since 2010, "social organization advisory groups" have also been created at both national and provincial levels as a platform/mechanism for CSOs to participate in project planning, implementation, and management.

Table 1. Composition of the China CCM, 2006–2012

Category	*Number*	*Representatives*
Conveners	6	Chair Vice Chair Chair of AIDS Working Group Chair of TB Working Group Chair of Malaria Working Group Chair of Drug and Health Products Working Group
Government sector	5	Ministry of Health and four other central government agencies
Nongovernment sector	6	China CDC (1) Professional/educational institution (1) Mass/social organization (2) CBO or other NGO (1) International NGOs (1)
People living with HIV/AIDS, TB, or malaria (PLHATM)	1	Patient representative
Private sector/state-owned enterprises (SOE)	1	Private sector/SOE
International organizations	4	Bilateral organizations (2) Multilateral organizations (2)
Total	23	

The formal participation of CSOs in the policymaking process, in conjunction with the Fund's requirement of providing funding for civil society, galvanized Chinese CSOs as the main way of reaching those MARP in China. NGOs focusing on AIDS treatments in China have witnessed a period of rapid proliferation since 2004, particularly after 2006–2007, during the election for a civil society representative to China CCM. By August 2006, there were about five hundred NGOs working on HIV/AIDS in China; in 2012, the number reached 967.[18] They include Tianjin Deep Blue Working Group (an AIDS-prevention NGO), Chengdu Tongle (the largest MSM health counseling NGO), and Beijing Ark of Love (an information support organization for PLWHA). As a new set of rationally calculating actors, these NGOs joined the game previously played only between government actors and the Global Fund.

The Global Fund's push for CCM reform led to an open, transparent, and independent election of a CCM NGO representative in April 2006. This was the first time Beijing had allowed nonmembers of the Communist Party to organize a national, independent election process. Despite the lack of legal status for most participating CSOs due to onerous requirements for NGO registration, the Global Fund and an independent review group established by China CCM affirmed the election results

and thus formally legitimized the rising civil society. Also, being represented in China CCM meant that Chinese civil society representatives could for the first time sit as equals with government officials on a decision-making body and truly have their voices heard.

Since June 2008, China has consolidated all the ongoing grants into three rolling continuation channel (RCC) programs, one for each disease, in an effort to fully integrate each type of Global Fund grant into the appropriate national disease strategy. In contrast to previous Global Fund grants, which were international projects matched by Chinese government funding, RCCs are budgeted government programs matched by Global Fund money. Provided adequate time to fully implement the programs, China would see the spread of a new governance model whereby many of the Global Fund's institutional innovations are integrated into China's domestic health process.

In short, Global Fund financing has helped positively transform health governance on ideational, policy, and institutional fronts. It has helped bridge the normative gap between the global health community and China on disease prevention and control; contributed to increased state commitment to relatively neglected diseases and improved public health interventions; and promoted institutional innovations that led to the increased participation of the Chinese civil society.

The Limited Reach

The Global Fund has made inroads in China's health policy process, but these have been limited by the mediocre performance of RCC programs, the low-value-for-money problem, the difficulty of enabling the scale-up of existing projects and programs, the struggle to support meaningful participation of Chinese civil society, and the obstacles to sustaining what has already been achieved.

MEDIOCRE PERFORMANCE OF RCC PROGRAMS

Although China had an exemplary reputation for Global Fund project implementation prior to the grant consolidation that was kicked off in 2008, the overall performance of RCC programs has not been impressive. In order to evaluate grant performance, the Global Fund has developed a consolidated quantitative-indicator rating system that weighs achieved results against original targets. The average ratings for China since January 2010 were "meeting expectation" (for HIV/AIDS grants) and "adequate" (for TB and malaria grants). The overall rating for Global Fund's grants in China is B1, meaning that, on average, 60 to 89 percent of the targets were achieved. Of the more than 140 countries receiving Global Fund money, forty-five, or nearly one-third of the recipient countries, received ratings higher than China, with either A1 ("exceeding expectation") or A2 ("meeting expectation") ratings. Only seventeen were rated lower than China (with B2, or "inadequate but potential demonstrated," ratings).[19]

Moreover, the Fund ratings probably overestimated China's overall performance, because the Fund's performance-based funding model tends to generate clear and strong incentives for grant recipients to portray their performance more positively, and because local Chinese health authorities still have incentives to cover up or underreport the infection rate of certain at-risk groups in their jurisdictions. But even if their performance was not overstated, the existing assessment points to China's inability to garner adequate support from its own bureaucracy in disease prevention and control. In part, this is because the consolidation efforts decentralized project management from China CDC to local CDCs. The latter still receive professional guidance from upper-level CDCs, but are subject to administrative leadership from territorial governments. Compared to China CDC, local governments prefer to keep the Fund resources under their own control and have little interest in involving grassroots NGOs in project financing and implementation. Right after the rollout of RCC programs, for example, Beijing CDC excluded a local AIDS CBO by tightening eligibility requirements for CBOs to participate in bidding or tendering. This might explain why the Global Fund portfolio manager pointed out, in the administrative letter dated November 26, 2010, that financial performance was poor, with expenditure rates at all levels (PR, SR) at less than 30 percent.[20] Later, as the Global Fund tightened fiduciary control and became less interested in investing in building infrastructure and updating facilities, local governments found that they lost autonomy over program implementation and were therefore less motivated to cooperate with the Fund programs.

In addition, the ratings probably failed to take into account the pervasive corruption and fund misuse in the implementation of projects and programs in China. In examining the flow of the Fund resources, Joan Kaufman noted that despite large amounts of donor funds, little reached the bottom,

especially grassroots NGOs.[21] Because of the dominance of government actors in funding-related decision-making, the Global Fund grants were first directed to the China CDC, which then passed funds to local CDCs before reaching grassroots implementers. What further complicates this "filter model"[22] is a highly fragmented bureaucratic structure, under which multiple actors from different functional domains—each of which has influential policy resources at its disposal—are involved in the policy process.[23] Within China CDC, officials in charge of Global Fund projects often have to rely heavily on interdepartmental or inter-unit cooperation to accomplish their policy goals. As a former MOH official described, "In our country, a single policy task is associated with all departments, including financial and logistics departments. If you don't bribe them, you cannot get things done." He further admitted that China CDC officials, including staff from the financial department, received subsidies from Global Fund grants, with officials of high rank paid more than those of low rank. Since bureaucratic fragmentation is reproduced at the subnational level, local CDCs have equally strong incentives to intercept the Global Fund money to serve their organizational or private interests. It is thus no surprise that as Fund money was filtered at each administrative level, little arrived at the grassroots level. The problem was made worse in less developed provinces, where governments merely promised to match the Global Fund money in budget allocations. The Global Fund was said to be aware of the problem, but it chose to turn a blind eye to this "Chinese national situation" in order to keep its China programs running.[24]

LOW VALUE FOR MONEY

Official data also suggests that the Fund has a low-value-for-money problem, which alludes to the inability of an organization to maximize the benefit of each dollar it spends in the funding and project implementation process. Specifically, in 2012, the Global Fund's Office of the Inspector General (OIG) report identified a risk of low value for money on purchases of condoms due to the "low quantity compared to target groups and lack of treatment for opportunistic infections."[25] As an NGO leader observed, among all the AIDS-related NGOs, the MSM organizations have received the most funding from the Global Fund, but infection rates among MSM have increased significantly and become extremely high.[26]

Low value for money is not simply a problem of project implementation; it is also an indication of poor funding-related decision-making. China's application for first-round Global Fund TB and malaria grants was welcomed by the Global Fund primarily because of the quality of the proposals. With assistance from the World Bank and the UK's Department for International Development, China had been planning the TB control project for two years. The decision to offer grants to China had little to do with the actual disease burden in the country. In 2002, prior to the Global Fund's decision to inject money into China's malaria-control efforts, the country had 25,520 malaria cases and forty-two malaria-related deaths, accounting for 0.007 percent of the total worldwide cases and 0.004 percent of the total deaths (Table 2). The following year, the Global Fund allocated 9.2 percent of its total Round One funding for malaria control in China ($6.24 million), at a time when the disease was killing an African child every thirty seconds.[27] The performance-based funding model also meant that more funding would be available as long as China claimed success from implementing the existing projects. The authoritarian government's ability to roll out new projects and expand successful ones rapidly made China an ideal place for international donors to set up promising projects. As a China CDC official said: "We succeeded [in applying for the Global Fund grants] round after round;

we were guaranteed success as long as we applied." Ten years later, China saw the incidence of malaria and related fatalities drop markedly, to 7,855 and 19, respectively.[28] The magnitude of the decline (69 percent and 55 percent) was higher than the global average. But even if we attribute the drop entirely to the Global Fund, it remains unclear whether it was wise for the Global Fund to spend $115.7 million in China just to reduce the malaria deaths from forty-two to nineteen when the money might have been spent more effectively in other areas or in other countries.[29] To be sure, China's experience in eradicating malaria could be useful to Africa, but as Jack Chow noted, China received more malaria funding than the Democratic Republic of Congo, which reported nearly twenty-five thousand malaria deaths in the same period.[30] In order to prove the value for malaria money in a nearly malaria-free country, China deployed a majority of the Global Fund allotment for antimalarial funding in the Sino-Burmese border region.

Table 2. Malaria Cases and Deaths in China and the World, 2002, 2012

	2002	2012	Decline
World cases	350–500 million	219 million	37–56%
deaths	1 million	660,000	34%
China cases	25,520	7,855	69%
(% global total)	(0.005-0.007%)	(0.004%)	
deaths	42	19	55%
(% global total)	(0.004%)	(0.003%)	

CHALLENGES TO SCALE-UP AND SPILLOVER

Given the Global Fund's emphasis on achieving a narrow set of concrete, quantifiable, and immediate results in specific disease prevention and control, a major concern is that the Fund's programs may underemphasize sustainability, long-term capacity development, and comprehensive health system strengthening (HSS).[31] Despite the efforts to integrate Global Fund projects with the national strategy, the scale-up and spillover effects of the Global Fund's investment remain limited. For example, even with the growing knowledge about HIV/AIDS, Chinese individuals still strongly disfavor HIV/AIDS NGOs for donations, in part because many Chinese people view those who contract HIV/AIDS as having a "moral problem."[32] Chinese civil society groups today still have only a shallow understanding of issues such as antidiscrimination, sex and disease transmission, access to medicine, and NGO advocacy. The Chinese government has not fundamentally changed its top-down, state-centered approach to disease prevention and control. For example, methadone is now widely available in China, but the treatment is not decentralized, which sustains barriers to care. In part because of the resistance of the public security authorities, practices such as condom use, needle exchange, and methadone treatment were promoted and introduced under the more neutral term "social marketing." China remains slow and selective in adopting global health norms. As early as 2006, the Global Fund ceased funding detoxification centers. But China's detoxification policy remains focused on compulsory incarceration and detoxification despite the high relapse rate and the abuse and corruption within the system.

The CCM process facilitated decision-making and consensus-building, but it has not significantly improved bureaucratic coordination, especially at the central level. In 2009, a McKinsey report on Global Fund grants in China found that central programs were managed independently with limited coordination.[33] The National Audit Office, for instance, refused to conduct the audit of the PR and SR financial statements. The lack of cooperation from the SFDA in issuing permits to import badly needed anti-TB drugs also hampered the scale-up of MDR-TB treatment. Indeed, one of the often-mentioned complaints from the Global Fund Secretariat was foot-dragging by the Chinese in the implementation process.

The interdepartmental coordination problem reflects the limits of the Global Fund's vertical, disease-specific approach to public health governance. The Fund's priority on selected and measurable interventions, as evidenced by the narrow focus on numerical targets for ART, ITNs, and DOTS, may have displaced funding and attention from other important interventions, such as advocacy (which the Fund does not directly support). Despite their expanded scope and scale, the Global Fund projects failed to integrate their efforts with those of other disease-specific initiatives or with each other. Instead, the project-based grant model created "a multiplicity of large, disconnected projects" at the national level, requiring high levels of "often uncoordinated design, monitoring, reporting and financial oversight—often with duplication, divergence and discord, and accompanying inefficiency."[34] By 2012, the Chinese government had undertaken grant consolidation for the three diseases in an attempt to extend project-based inventions to national-level programs, under the framework of National Actions Plans, with a single program management structure. Unfortunately, the Global Fund's playbook did not have program-specific approaches to respond to this shift. Moreover, the disease-specific interventions have contributed little to HSS in China. Only 3.9 percent of the Global Fund expenditure on HIV, 6.2 percent of the Fund expenditure on TB, and nearly 0 percent of the Fund expenditure on malaria was spent on HSS.[35] The lack of investment in HSS may in part explain why the national health insurance coverage excludes coverage of TB treatment–related costs, posing considerable risk to treatment adherence. Also, the vertical approach encourages Chinese CSOs to work only on high-profile diseases such as HIV/AIDS and hinders health-related CSOs from coordinating with each other and with international and government agencies in pursuing broader, system-wide public health objectives.

UNINTENDED CONSEQUENCES FOR CIVIL SOCIETY–BUILDING

When asked about the Global Fund's biggest legacy in China, one NGO leader responded sarcastically that it was the emergence of "numerous genuine and fake NGOs." The Global Fund's efforts to promote CSO participation unintentionally encouraged unhealthy civil society growth in China by supporting numerous ineffective NGOs and sustaining counterproductive competition among them. In encouraging the participation of CSOs, the Global Fund tended to focus on the number of CBOs/NGOs working with the Fund and the share of funding channeled to such organizations. In order to see measurable growth of CSOs, the Fund even threatened to suspend funding if the government did not have a designated share of the money devoted to the CBOs/NGOs. In so doing, the Global Fund failed to pay adequate attention to the ability of Chinese CSOs to meaningfully participate in its projects and programs. In view of the nascent Chinese civil society, China's AIDS CSOs, for example, lack the skills, experience, and capacities to connect with the Global Fund as effectively as their more seasoned counterparts in other countries. Another NGO leader estimated that 99 per-

cent of Chinese CBOs were unable to communicate in English, and the OIG Diagnostic Review found that most grassroots NGOs did not have computers or internet connections. A large number of the CBOs/NGOs emerged to pick the low-hanging fruits delivered by the Fund, but few were adequately prepared to manage international funding for local projects or even serious about reaching the MARP and socially marginalized populations. As a senior Chinese health official noted, many NGOs aspired to be funded, but ultimately proved less interested in actually distributing condoms or reaching sex workers and MSM.[36]

The proliferation of CBOs/NGOs financed by the Global Fund also did not lead to effective coordination and cooperation among them, which is essential for the expansion of their activities beyond the community level. In March 2007, the grassroots HIV/AIDS NGOs formed an NGO Work Committee (*fei gong wei*), consisting of representatives from across the country, to improve the representatives' communication and promote civil society's participation in the Global Fund's affairs. Over time, regional NGO alliances on HIV/AIDS were also built across the country. Unfortunately, even though these CSOs worked on the same or similar issue areas, they had difficulty working together. As Amy Gadsden observed, "AIDS activists have been quick to accuse each other of malfeasance or other bad dealings, weakening their capacity for advocacy or joint action."[37] The NGO Work Committee and the regional alliances were plagued by cliquishness and shady decision-making. Some NGOs with more funding—but with poor accountability—gained disproportionately more power than others and used that power in a way that jeopardized the development of Chinese civil society. Competition over limited resources led to infighting among the groups, which only gave the government more opportunities to manipulate and suppress them. It is no surprise that even today most of China's health-promoting NGOs remain small and weak. The Fund's Round Six HIV grant program initially required an NGO to serve as the PR, but because China did not have a truly competent national-level NGO or NGO alliance to implement the grant, the China Association of STD and AIDS Prevention and Control (CASAPC)—a government-organized NGO, or GONGO—became the PR in 2006. A January 2007 review conducted by the Fund's local funding agents nevertheless found that CASAPC had many gaps in staffing, management, procurement, monitoring, and assessment. Based on the Fund's advice, the China CCM changed the PR back to China CDC, a government organization. In 2009, efforts to push for the inclusion of CASAPC as a parallel PR failed again with the unexpected pullout of the GONGO. As a result, China was the only country among the Fund-recipient countries that saw the domination of government health authorities at CCM, PR, and SR levels.

THE SUSTAINABILITY PROBLEM

China has benefited from the involvement of the Global Fund, but sustaining the existing level of achievement could be a daunting challenge as the Global Fund withdraws from China. In response to the Fund's decision to terminate its grants to China, Premier Wen Jiabao made it clear that China would rely on its own efforts. It even opted to forego the Fund's transitional funding of $250 million in HIV and malaria grants. All it asked was for a twelve-month extension to complete the funded projects. Few observers seemed concerned that China would repeat Russian missteps in its post-Fund transition. In 2009, Russia decided not to apply for Global Fund grants, although Russian NGOs continued to receive funding from the Global Fund despite government opposition. Even with the

transitional fund, the government's refusal to fund harm-reduction approaches accounted for a surging HIV/AIDS epidemic that runs counter to the global trend.[38]

Compared to Russia, China's more robust economic growth and lower disease burden in HIV/AIDS would place it in a better position to assume greater funding responsibilities for its HIV/AIDS, TB, and malaria programs. But, on the other hand, China was more dependent on external funding for financing the three disease programs than Russia was. Between 2006 and 2011, external funding accounted for more than 19 percent of the total TB funding in China, compared with 1.2 percent in Russia.[39] Moreover, the Global Fund underwrote 100 percent of the external funding for China's malaria program at the time. Therefore, it was clear that China would need to respond decisively to avoid underfunding disease prevention and treatment as the Global Fund money tapered.

Similar to its withdrawal from Russia, the Global Fund has yet to come up with a clearly defined, coherent exit strategy to guide China's transition out of receiving support from the Fund. The Fund's executive leaders seem to be more interested in negotiating with China on how the two could work together in Africa than on solidifying and sustaining the Fund's legacy in China. As one senior Global Fund official joked, in the near future, China might finance NGOs in Africa, but not NGOs in China. The earlier-than-expected withdrawal and soured relationship between China and the Fund over NGO funding and fiduciary controls meant that both China and the Global Fund did not have the time or understanding to map out a workable plan to build on what was achieved. On the one hand, the existing institutions and processes would lose their raisons d'être and would likely not last long. On the other hand, it takes time for the programs supported by these institutions and processes to take effect. Project planning and management, for example, had been considered an important legacy of the Global Fund. If China were funded for another three to five years, government departments would become accustomed to budget management. The early withdrawal of the Fund made sustaining this legacy less likely. Indeed, a recent OIG diagnostic report suggests that the grant assets might be lost due to "un-reconciled differences between fixed asset financial records, fixed asset register and the physical count records."[40] China might continue to tap into the Global Fund's technologies, experiences, and ideas, but the effectiveness of the programs was jeopardized when the institutional bases were removed. One official of the Joint United Nations Program on HIV and AIDS (UNAIDS) even predicted that as much as 40 to 50 percent of the gains made through the Fund-supported interventions could be negated with Global Fund's withdrawal from China.

Also at stake is the survival and development of many Chinese NGOs working on Fund-related projects. In the absence of effective government financial commitment or strong support from indigenous philanthropic entities, the Global Fund money had the unintended result of exacerbating these NGOs' dependence on international support. A survey of more than two hundred HIV/AIDS CBOs conducted in May 2011 found that 74 percent received financial support from the Fund, and nearly one hundred CBOs had half of their project funding covered by the Fund.[41] In provinces such as Heilongjiang, the Fund support accounts for 80 percent of the NGO funding. Unsurprisingly, when the Global Fund withheld disbursement to protest the government's lack of support of CSOs, the immediate victims were not the government or GONGOs, but CBOs/NGOs whose only major funding source was the Global Fund. Half of the projects operated by Chengdu Tongle, for example, were immediately paralyzed. Indeed, many of the CBOs were already dissolved by the end of 2011, after the Fund lifted a freeze on grants to China. In the same survey of CBOs, 83 percent expressed concern about their future.

The concerns of NGOs led the then premier-to-be Li Keqiang to reiterate the government commitment to funding health CSOs in China. The government pledge to continue funding NGOs was encouraging, but hardly reassuring. First, since most Chinese CBOs/NGOs do not have legal status, they are not eligible for funding through government purchasing services, not to mention that such services may not reflect the community's actual needs and interests. Second, there is no strong and sustainable national funding mechanism and service quality support put in place to support CBOs/NGOs. Local government officials do not have strong incentives to finance health-related NGOs. Some NGO leaders working on HIV/AIDS have already been warned by local CDC officials that their organizations should not look to local governments for financial support once international projects left.

Buck-passing in China's bureaucracy also creates hurdles for adequately funding the CSOs. As a senior MOH official indicated, though the government could cover capacity-building and pharmaceuticals for NGO operations, the MOH had to obtain the cooperation of the Ministry of Finance to use government funding to cover organizational overhead of NGOs. Previously, the Global Fund had covered this overhead in the form of subsidies as part of the government budget.[42] Third, it is likely that the existing mechanisms and institutions built to channel civil society demands to the health authorities in implementing Global Fund grants (e.g., CCM, advisory groups) will no longer exist. According to a prominent HIV/AIDS advocate in China, the idea of CCM has never been internalized by the Chinese government, and like Russia, China prefers to act on its own after the Fund's departure. A leader of an HIV/AIDS NGO based in Henan complained that the discussion on how to fill in the gap left by the Global Fund was confined to government agencies and NGOs were not invited to participate. Sensing this regression, most of the NGO leaders the authors interviewed in the summer of 2013 were not optimistic about their NGOs' future in the post-Fund era. Finally, since the government has not undertaken any concrete steps to fill in the gap thus far, it is unrealistic to anticipate the availability of government money after the Fund money dried up. One NGO leader predicted that at least half the NGOs would cease to be active after the Global Fund's departure.

Today, there are signs that the government is moving to create more space for Chinese civil society. In July 2013, the Ministry of Civil Affairs announced measures that, if implemented, would relax registration and approval requirements for the NGOs. It is possible that after the Fund money is gone, the government will identify a smaller but more manageable number of CSOs for long-term funding and capacity-building. It appears that individual health officials, especially those from the China CDC, increasingly see the value of involving CSOs in their work. But the overwhelming concern about social-political stability and intense pressure from other quarters of the government may sustain government efforts to suppress CSOs that are not directly under its control. In January 2014, China sentenced Xu Zhiyong, the founder of the New Citizens Movement, to four years in prison for "disturbing order in a public place." With the withdrawal of the Global Fund, the government not only becomes the only major source of funding for existing NGOs, but also regains its autonomy in dealing with the NGO sector. This increasing leverage and lessening constraint will place the government in a more favorable position in state-society relations, and it is not difficult to imagine that overly accommodating organizations will be supported and promoted while independent NGOs, or potential "troublemakers," will be unfunded and suppressed.

Policy Recommendations

The Fund's experience in China over the past decade has important implications for global health governance. By tying a recipient country's international reputation and resource needs to external commitments, global health institutions can indeed make a difference in the target country's public health status and domestic health governance. To make the interventions effective, however, an integrated, system-wide approach is essential. Vertical, disease-specific interventions should be pursued only if such interventions have clear spillover effects or strong potential to be scaled up. Single-minded, straightforward efforts to foster improvements to conform to the global paradigm (e.g., civil society–building) may lead to unintended, undesirable outcomes that only undermine the long-term program effectiveness. In seeking the diffusion of global health norms and practices, outside actors should also strike a delicate balance, permitting some flexibility in national implementation without endangering important principles and values. A cookie-cutter approach will not recognize differences between countries but overemphasis on national ownership could make room for forces that defeat the very purpose of international intervention. A politically savvy and productive strategy would entail improved communication between the target governments and global health institutions. To that end international health institutions should learn to conduct effective health diplomacy and to negotiate with their counterparts in a manner that is simultaneously candid, nuanced, and practical.

The Global Fund's experience in China serves a reference point for the work of the relatively young institution in other countries. As indicated by its new funding model, the old approach of "raising the money, spending it, proving the money's worth, and raising more money" not only incurs significant opportunity costs. With its emphasis on quantifiable indicators, it can also create all kinds of moral hazards. The Global Fund should place more emphasis on responding to the actual disease burden, ensuring program quality, and creating effective co-funding mechanisms. When dealing with recipient countries in the implementation stage, the Fund should take a more long-term view in applying its standards, values, and processes, particularly when the recipient nation confronts serious capacity building challenges. Since the absence of country offices restricts its direct control of in-house monitoring and evaluation systems, the Fund should also train its portfolio managers not as bankers pulling the strings thousands of miles away, but as global health diplomats who have a keen understanding of each country's internal dynamics and are skilled at cutting deals efficiently. It is imperative that the Global Fund work closely with countries transitioning out of Fund projects to develop a coherent, flexible and gap-free exit strategy. This would enable these countries to sustain and scale up what has been achieved, while encouraging them to serve as partners and donors in Global Fund investments in other countries. Finally, it is time for the Global Fund to consider taking a broader mandate that goes beyond the three diseases in order to stay relevant in the context of shifting global burden of disease and growing momentum for universal health coverage.

The departure of the Global Fund signals China's transition from a recipient of foreign aid to full donor status. Rather than resist the calls to assume more international responsibilities, it is time for China to come up with a timetable for partnering with other emerging economies and multilateral aid agencies and investing in the improvement of health status in other countries. Meanwhile, China

should develop a comprehensive strategy to transition seamlessly from Fund-supported programs. The government will need to mobilize more domestic resources to fill the financing gap left by the Fund's departure, to establish a mechanism to sustain procurement and provision of pharmaceuticals, therapies and other services, and to undertake measures to integrate the disease-specific interventions into the government's package of universal health coverage. In this process, the principles and concepts of the CCM should still be honored. They include participation by marginalized groups and affected communities, the protection of human rights for vulnerable groups, gender equity (especially for women), and multisectoral decision-making mechanisms to enhance democratization of public health services. Indeed, the government should seriously consider building a quasi-CCM mechanism in the post-Fund era to advise policy makers, monitor the implementation of ongoing health projects, and find solutions to conflicts of interests among CSOs. Civil society groups should be included in the discussion and development of such a strategy. Instead of being viewed as dispensable actors or trouble-makers, they should be treated as partners and catalysts for positive change in China's health governance. As the first step, the government should change its laws and regulations to give NGOs legal status and enable them to participate in public fundraising, advocacy, and service provision, as well as program monitoring and evaluation. In considering CSOs to be funded for service purchasing, China could borrow the Global Fund's TRP model, and make the review process more professional, independent, and transparent.

Conclusion

"The Global Fund acts more like a banker than a partner," a UN official once complained during an interview in Geneva. The Fund is indeed different from most of the multilateral health organizations, in that it relies primarily on its performance-based funding mechanism to seek change in recipient countries like China. The presence of a major emerging power with a murky Leninist regime has not prevented the Fund from playing a vital role in boosting resources available to fight HIV/AIDS, TB, and malaria. It has contributed to reduced growth in new HIV infections, increased survival rates of those living with the disease, and significant drops in TB and malaria infections. But as a values-based initiative, the Fund has contributed more to China's domestic health governance than to its fighting of the three diseases themselves. The Global Fund has helped bridge the normative gap between China and the global community in disease prevention and control. It has introduced important norms and innovations to China's domestic health governance, including transparency, accountability, and inclusiveness. It has also fostered policy dynamics that have profound implications for state-society relations. Through China CCM and other institutional arrangements, China's civil society groups for the first time formally participated in health policymaking.

That said, it is not time to celebrate a decade of a successful partnership between the Fund and China. After all, the overall performance of the consolidated Global Fund grants in China was not as strong as anticipated. The low-value-for-money problem has made it difficult to justify some of the Fund's grants, especially those for malaria control. The vertical, disease-specific interventions are hardly scalable or conducive to national health system strengthening. Equally important, Global Fund programs have at times produced unintended and undesirable outcomes for efforts to build China's civil society. The termination of Global Fund grants and the absence of a timely and workable exit strategy have posed serious challenges to sustaining what has already been achieved. In short, the Global Fund's China legacy is mixed at best, which highlights the complexities in global health governance.

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