The Challenges and Facilitating Factors for International Cooperation on HIV/AIDS Prevention and Control in China

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Abstract

In a world of globalisation and massive health inequalities, international cooperation is a powerful tool for the management of global health. Moreover, because of the need for global health security, international cooperation for health can be seen as an important aspect of foreign policy. A major threat to global health security is infectious diseases, such as HIV/AIDS, which have become significant threats to the development and the economic and social stability of developing countries. These diseases need global partnerships for international cooperation.

The response to the challenges such as HIV/AIDS depends on partnerships that lead to effective cooperation of various sectors – international organisations, government, non-government organisations, and business enterprises. No single sector has either the resources or the capacity to work effectively to address complex health problems. Partnerships have many benefits, such as providing opportunities to share workloads and resources, building the capability of the members and creating the motivation for people to pull together. Successful cross-sector partnerships in health are fundamentally inclusive; they are actively involved in bridging government, academic, business, and nongovernmental organisation communities. At a time when public health depends more and more on partnerships, effective partnerships are needed to advance international cooperation. This is particularly the case in China.

China has faced a number of challenges since AIDS was first recognised in the 1980s, as it has striven to contain a large and growing HIV/AIDS crisis. In recent years, the Chinese government has cooperated extensively with the international community on HIV/AIDS prevention and control, and has called on all sectors to become involved. Such cooperation has played an important role in China’s response to HIV/AIDS. In order for China to effectively utilise international resources, it is very important to ensure that resource mobilisation is well coordinated to avoid duplication and confusion among key donor groups. This can be done through effective project management.

Project management is an essential tool in facilitating effective partnerships. Understanding the critical factors that influence project success enhances the ability of
donors and implementing agencies to ensure desired outcomes. Developing strategic management to remove barriers and successfully implement the complex international HIV/AIDS programs is desperately needed in China.

Despite improvements in living standards and GDP, vast areas of China are still underdeveloped, so that the country still needs international sources to support health development. However international resources for HIV/AIDS response in China have dramatically diminished recently. Knowing how best to manage the challenges posed by international cooperation on HIV/AIDS, and developing a strategic mechanism to cope with funding changes and changes in the programs themselves has become even more important. There is a need for research into ways to improve management of these issues.

This research aims to identify the challenges of, and facilitating factors for international cooperation on HIV/AIDS prevention and control in China. It provides information and evidence to HIV/AIDS program planners and providers of how to achieve sustainable outcomes, and form the foundation for developing policy actions. Apart from reviewing the literature, this study utilises the China Global Fund AIDS Program as a case study to explore the challenges and facilitating factors associated with international cooperation on the HIV/AIDS program in China. Data was collected from: a literature review, participant observation, in-depth interviews, focus groups, and documents review, as well as secondary data review. This research drew its conclusion from a synthesis of the results.

The key findings of this research are as follows:

- currently, the situation of China health cooperation has changed. China has become less dependent on foreign funds and other foreign resources and plays dual role as both a recipient and a donor country. The role and impact of the international community on China has also changed;
- Civil Society Organisations/Community Based Organisations have played an increasingly important role in the China’s HIV/AIDS response. However they are currently facing multiple challenges, such as registration difficulties, the lack of funding and organisational development;
the factors that facilitate partnerships in international health cooperation in China are clarity of roles and responsibilities of partners, better communication, and improved mechanisms for multi-sectoral collaboration;

the integration of international and national HIV/AIDS programs in China brings benefits of improved information sharing and minimisation of duplication. However, at this early stage of the integration, the research has identified some problems such as dependence on unpredictable foreign sources, the expanded scope of the program, and invisibility of single projects in the larger integrated program;

problems of consistent staffing and capacity of the local organisations arose. These are related to issues arising from the nature of management of international projects – clashes of donor and recipient policies, and local cultural attitudes or customs.

Based on these major findings, the research provides a number of recommendations regarding China’s future international health cooperation, partnership improvement, HIV/AIDS response, and project management. They will assist Chinese government agencies, international communities and relevant organisations in developing policies and strategic plans for international cooperation on HIV/AIDS prevention, care, support and treatment in China. The research also provides deeper understanding and suggestions to improve international cooperation to address other emerging global threats such as climate change and food security.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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                        Yan Wang                   Date
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<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>AWCOs</td>
<td>AIDS Working Committee Offices</td>
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<td>AWG</td>
<td>AIDS Working Group</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CDC</td>
<td>Centre for Disease Prevention and Control</td>
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<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CPs</td>
<td>Conditions Precedents</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>DFID</td>
<td>UK Department for International Development</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment, Short-course</td>
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<td>FAO</td>
<td>Food and Agriculture Organisation for the United Nations</td>
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<tr>
<td>FPM</td>
<td>Fund Portfolio Manager</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GONGO</td>
<td>Government Organised Non-Governmental Organisation</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
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<td>IHR</td>
<td>International Health Regulation</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<tr>
<td>LFA</td>
<td>Local Fund Agent</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MMT</td>
<td>Methadone Maintenance Therapy</td>
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<tr>
<td>MOCA</td>
<td>Ministry of Civil Affairs</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MSM</td>
<td>Men Who have Sex with Men</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NBS</td>
<td>National Bureau of Statistics</td>
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<td>NCAIDS</td>
<td>National Centre for HIV/AIDS Prevention and Control</td>
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<td>NDRC</td>
<td>National Development and Reform Commission</td>
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<tr>
<td>NGO</td>
<td>Non-government Organisation</td>
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<td>National Program Office</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<tr>
<td>OIG</td>
<td>Office of the Inspector General (Global Fund Secretariat)</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-child Transmission (of HIV)</td>
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<tr>
<td>PR</td>
<td>Principal Recipient</td>
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<td>PU/DR</td>
<td>Progress Update/Disbursement Request</td>
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<td>RCC</td>
<td>Rolling Continuation Channel</td>
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<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<tr>
<td>SCAWCO</td>
<td>State Council AIDS Working Committee Office</td>
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<td>SIDA</td>
<td>Swedish International Development Cooperation</td>
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<tr>
<td>SR</td>
<td>Sub-Recipient</td>
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<tr>
<td>SS(S)R</td>
<td>Sub-Sub (-Sub) -Recipient</td>
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<tr>
<td>STCs</td>
<td>Special Terms and Conditions</td>
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<td>STD</td>
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<td>UN</td>
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<td>UNDP</td>
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<td>United Nations Environment Programme</td>
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<td>United Nations Population Fund</td>
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<td>UNICEF</td>
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<td>UNIFEM</td>
<td>UN Entity for Gender Equality and the Empowerment of Women</td>
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<td>United States Agency for International Development</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WTO</td>
<td>World Trade Organisation</td>
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Acknowledgement

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Chapter One

Introduction

1.1. Introduction

In our globalised world international cooperation plays a crucial role in public health. With rapid economic development and more and more players involved, some issues, such as overlapping mandates by donors and lack of coordination are of concern when the requirement is to build effective partnerships.

Partnership is an important approach in public health as no single sector has either the resources or the capacity to work alone effectively to address complex health problems. Partnerships can afford a scale and integration of services that is impossible for any actor operating alone. At a time when public health success depends more and more on partnerships, an effective partnership in a complex multi-sectoral issue, such HIV/AIDS becomes very important.

HIV/AIDS has devastating impacts on individuals, families, communities and nations, and it also has a significant security dimension. China, the world’s most populous country, faces a number of challenges as it strives to contain a large and growing HIV/AIDS crisis. In recent years the Chinese government has cooperated extensively with the international community, and it calls to all sectors to become involved, on HIV/AIDS prevention and control. Such cooperation has played an important role in China’s response to HIV/AIDS. Developing strategic management to remove barriers and successfully implement complex international HIV/AIDS programs is desperately needed in China.

There is no doubt that project management in general, and project management tools and techniques, in particular, play an important role in project success (Munns & Bjeirmi, 1996). In China many challenges raised by international HIV/AIDS cooperation projects have been of concern to international communities and Chinese agencies. Understanding the critical factors that influence project success enhances the ability of donors and implementing agencies to ensure desired outcomes.
With its rapid economic development, China is now in a transitional period of international health cooperation, moving from a role as a recipient to a donor. However, relatively little is known about the effectiveness of multi-sectoral cooperation regarding the international HIV/AIDS program in China. The aim of this research is to identify the challenges and facilitating factors for international cooperation on HIV/AIDS prevention and control in China. It further aims to provide information, evidence, and recommendations to HIV/AIDS project planners and providers on how to achieve sustainable outcomes, and form the foundation for developing policy actions.

This chapter provides an overview of the thesis. It discusses the background and rationale of the research, explains its aims and purpose, outlines its nature and scope, and describes the methodology used. Finally, it presents the structure and topics of the thesis.

1.2. Research Background and Rationale

1.2.1. Research Background

*International Health Cooperation*

International health cooperation plays a crucial role in our globalised world. As the world is increasingly becoming smaller, health can be seen as global public goods which are outcomes or intermediate products that trend towards universality in the sense that they benefit all countries, population groups, and generations (L. C. Chen, Evans, & Cash, 1999; McKee, Stott, & Garner, 2001). No individual or country can fully guarantee its own health. Health problems transcend national boundaries, as they can affect and are influenced by circumstances or experiences in other countries. They are best addressed by cooperative actions and solutions.

International cooperation on health has a long history and the development cooperation on health has rapidly changed since the final quarter of the 20th century. In the context of organisation, health inequality, foreign policy, and global health security, such collaboration is more vital than ever, bringing benefits to both developed and developing countries. At the same time, however, the rise in the number of international health players has created a challenging environment for harmonisation and alignment.
efforts (OECD, 2007b). Discussing the past and present trends of international health cooperation, understanding its influencing factors and benefits, identifying the roles and limitation of the main players in international health cooperation, and analysing the issues which are raised by the complex situation of international cooperation for health, can help international communities and their partner countries to make sounder decisions and achieve more sustainable development strategies.

Nowadays there are lots of international cooperative programs that have been implemented in China and the trends of international cooperation on health are increasing. As a developing country, international cooperation on health is needed to achieve equitable national development and growth, as well as to assist China to adopt international norms, meet global standards and contribute to critical areas for international cooperation (WHO, 2008b). Though the current political environment and commitment to address health has created unprecedented opportunities for international health cooperation, many challenges have emerged with the rapid changes in China. Furthermore, as China has become an increasingly important part of the global health over the past several decades, interest in China’s international health cooperation has increased among both international and China’s public health professionals. Thus, a review and analysis of international cooperation in China is timely and necessary for removing barriers and successful implementation of projects.

**Partnership in Public Health**

Partnership is an important approach in public health. Our rapidly transforming global health environments have created unique health challenges that demand cross-sector solutions. HIV/AIDS is a prominent example. No single sector has either the resources or the capacity alone to work effectively to address complex health problems. With hundreds of new health actors having emerged, the traditional system of global health governance, which relied on governments, and intergovernmental organisations alone, has moved toward a system in which multiple actors, both state and non-state, are playing an increasingly active role. The idea that partnerships represent a superior way of cooperation marks a departure from traditional public health approaches.

Partnerships have many benefits. They can provide opportunities to share workloads
and resources, build the capacity of their members and creating the motivation for people to pull together. Successful cross-sector partnerships in health are fundamentally inclusive and actively involved in bridging government, academic, business, and nongovernmental organisation communities. At a time when public health success depends more and more on partnerships, effective partnerships are needed to advance international cooperation.

**HIV/AIDS Prevention and Control in China**

Since AIDS was first recognised in 1980s, HIV/AIDS has emerged as one of the greatest threats to development and the economic and social stability of China. HIV/AIDS is more than a health issue. It has shown a dramatic impact on many different sectors, such as education, transport, health, the economy. China, the world’s most populous country, faces a number of challenges as it strives to contain a large and growing HIV/AIDS crisis. In recent years the Chinese government has cooperated extensively with the international community and it calls to all sectors to become involved on HIV/AIDS prevention and control. Such cooperation has played an important role in China’s response to HIV/AIDS. Developing strategic management to remove barriers and successfully implement the complex international HIV/AIDS programs is desperately needed in China.

**International Development Project Management**

International cooperation provides aid to developing countries every year. Most international assistance is provided via international development projects (Diallo & Thuillier, 2004). These projects are different from other types of projects for a number of reasons and the approach to implementation must also be different. Understanding the critical factors that influence project success enhances the ability of donors and implementing agencies to ensure desired outcomes. In addition it helps them forecast the status of projects, diagnose problem areas, and prioritise their attention and scarce resources to ensure successful completion of their projects (Khang & Moe, 2008).

Unlike general industrial or commercial projects international development projects are characterised by less tangible objectives, a large number of heterogeneous stakeholders, divergent perspectives among these stakeholders, the need for compromise, and the
profound cultural and geographical gaps between project designers and their beneficiaries (Crawford & Bryce, 2003; Diallo & Thuillier, 2004, 2005; Khang & Moe, 2008). These characteristics make project management in the international development sector unique and especially challenging. To improve these project management characteristics requires specific approaches.

Project management can be a powerful tool to improve the ability of organisations to plan, implement, and control their activities. For the past several decades, the use of project management methods has been well established in the health field. However, each project is unique and consequently there is no one formula for success. In China, many challenges raised during international HIV/AIDS cooperation projects have been the concern of international communities and Chinese agencies.

1.2.2. Research Rationale

Despite the growing recognition of the importance of international cooperation for health in our interdependent world, there is insufficient current research on international cooperation for health in China. The literature does provide recommendations for management concerning donor support projects and partnership effectiveness but there is, however, limited research on the effective implementation of international health projects in China. So there are few published articles to guide health professionals on the effective implementation of international health projects in China.

The situation for Chinese international health cooperation has changed. In particular, since 2011, China has entered the ranks of the upper middle-income countries as defined by the World Bank and is no longer seen by the international community as needing international aid and assistance. However as a developing country with a large population and imbalanced development, China still needs help from the international community. With a dramatic reduction in international resources, China is also moving towards the role of donor and is contributing more to international development. It lacks, however, a systematic analysis of the current complex situation. Research regarding the current and future direction of international health cooperation is now desirable.
While experience and analysis of health partnerships has generated significant learning and consensus building over the past years, there is still some considerable uncertainty, misunderstanding and divergence of opinion among stakeholders about partnership. More research is needed to provide the conceptual clarity, basic ground rules and institutional innovations necessary to make partnership more effective and strategic, especially for complex health issues like HIV/AIDS. Much research about public health partnerships has been conducted in some countries, while there is very little in China.

HIV/AIDS is a major threat to China. The Chinese government has increased investment in the HIV/AIDS response and has called on all sectors to be involved. Meanwhile international communities have also prioritised HIV/AIDS as a cooperative area with China. Recently, as China’s economy has rapidly developed, China has been classified as an upper-middle income country, so foreign funding for its HIV/AIDS program has declined dramatically and the scenario for international cooperation on HIV/AIDS has changed. Thus there is a critical need to reconsider the situation of HIV/AIDS cooperation regarding the different stakeholders’ involvement, increased efficiency and effectiveness of HIV/AIDS programs, reduction in duplication of effort, and better identification of gaps, needs and complementary functions to achieve sustainable outcomes.

This research addresses these gaps and explores influencing factors and issues from multiple angles. It analyses and discusses them through an empirical case study of the Chinese international HIV/AIDS project, the Global Fund AIDS Program, and provides suggestions to Chinese government agencies, international communities, and public health professionals to overcome challenges. The findings of this research can also be used as a model and their implications will benefit other developing countries.

1.3. Nature, Scope and Aim of Research

This research focuses on international health cooperation and public health partnership approach in China, particularly in the HIV/AIDS prevention and control area, by means of an international HIV/AIDS program. It identifies factors that impact on and
challenges for multi-partner involvement related issues, and explores their future development.

This research asks the question: What are the key challenges and facilitating factors of international cooperation on HIV/AIDS prevention and control in China?

This research aims to identify the challenges and facilitating factors for international cooperation on HIV/AIDS prevention and control in China, provide information, evidence, and recommendations to health policy makers and HIV/AIDS project planners and providers to achieve sustainable outcomes, and form the foundation for developing public health policy actions.

The objectives of this research are:

1. to analyse the roles, functions and key challenges facing international health cooperation globally and in particular in China, and explore the future direction of China’s international health cooperation;
2. to explore how different kinds of partners/organisations can work together more effectively to produce better partnerships in China HIV/AIDS response;
3. to identify challenges and facilitating factors of the international HIV/AIDS projects in China;
4. to develop strategic project management to address challenges hampering the implementation of international HIV/AIDS projects in China and so help stakeholders to inform and improve future implementation through international support;
5. to provide recommendations to assist the Chinese government agencies, international communities and relevant organisations in developing policies and strategic plans for international cooperation on HIV/AIDS prevention, care, support and treatment in China.

1.4. Methodology

This research used a mixed-methods approach which combined qualitative and quantitative approaches. The research process included three stages: literature review, data collection and data analysis. In the first stage, a large number of data sources
including books, journal articles, government documents, policy reports and conference papers covering the research’s contextual fields were reviewed. The literature review established the background of the study and the context for the analysis, helping the researcher to understand the knowledge, share the results of other studies, and provided a framework for establishing the importance of the research.

The second stage of this research, fieldwork, involved three phases: a preliminary study, case study and follow-up interviews. The preliminary study carried out an in-depth exploration through various methods, including reviews of documents and program reports, and a series of key informant interviews. The analysis of the data led to the conceptualisation of the research and contributed to the construction of the research question. Phase two, fieldwork, was a case study. In the case study research, the researcher used multiple sources of evidence to address the research question. These sources included documentary review, participant observation, in-depth interviews, focus group interviews and existing and secondary data analysis. All the data was analysed and interpreted to provide the evidence for the findings. In phase three, a follow-up study, in-depth interviews with key informants were conducted to collect supplementary data.

The third stage was the data analysis stage. Both qualitative and quantitative data were analysed to inform the findings and recommendations for the research.

1.5. Structure of the Thesis
This thesis includes three parts, in a total of eleven chapters. Part I, the literature review, sets the background for this research; it provides a review of the literature of four contextual fields. The first contextual field pertains to the fast changing global situation of international health cooperation, generally and also in the specific context of China. The second contextual concerns the partnership approach in public health, as a response to the challenges of international health cooperation. The third contextual field is China’s HIV/AIDS response, which draws heavily on international cooperation for support and relies on partnerships both internal and external. The fourth contextual field explores international development project management as an important tool. Part II, the research methodology and results and key findings, starts
with the research design and methodology of this study, followed by the results, and highlights the major findings of the research. Part III the discussion, recommendations and conclusion, develops a discussion based on the major findings, draws some conclusions about international health cooperation projects, makes some recommendations and ends with a summary of the thesis.

Chapter One, the introductory chapter sets the scene of research in the context of the thesis, develops the background and rationale, scope, nature and aim of the research, and the study methodology, then describes the structure of the thesis.

Part I, the Literature Review, includes Chapters Two to Six. Chapter Two and Chapter Three focus on international health cooperation that provide an overall picture of global international health cooperation and examine it in relation to China. Chapter Two reviews the global international health cooperation history, describes its current status and future trends, emphasises the importance and necessity of international health cooperation, analyses its influencing factors (globalisation, global health inequality and the Millennium Development Goals (MDGs), foreign policy and global health security) and explains its benefits for both developed and developing countries. Four main players, with their roles, functions of and limitations, are identified. At the end of this chapter, key challenges and some possible solutions in international cooperation on health are highlighted.

Chapter Three examines international health cooperation in China. The chapter first introduces the Chinese political environment for international health cooperation, including China’s health administration structure and management, and then gives national guidelines for international cooperation on health. Finally it analyses the benefits and needs of, and opportunities for, international cooperation on health in China. This chapter lists the main international players and outlines their activities in China, as well as discussing major challenges of current and future international health cooperation in China.

Based on the challenges of international health cooperation since more and more actors have been actively involved, Chapter Four addresses an important public health approach, partnership. The chapter begins by introducing the concept of partnership,
including several definitions, its benefits and values for public health, and its classifications. Building an effective and successful partnership is emphasised, then the barriers and main challenges are discussed.

Chapter Five focuses on the HIV/AIDS response in the setting of China, which requires international cooperation and partnerships. The first part of Chapter Five reviews the current global HIV/AIDS epidemic and responses to it, and then gives a brief overview of China’s HIV/AIDS epidemic and the progress of, and issues in, the response to HIV/AIDS in China. International cooperation and partnerships within the HIV/AIDS response in China are also discussed in this chapter.

Chapter Six critically reviews a tool of international health cooperation, the international development project and its management. The chapter provides an explanation of the concept of the international development project, its life cycle, environment, stakeholders, success criteria and critical success factors, and then presents the unique characteristics and specific problems of international development projects. Finally it discusses some required approaches in international development project management.

Part II, Chapters Seven to Nine, includes the methodology, key results and findings of this research. Chapter Seven is concerned with the research design, methodology and the details of the research processes. This chapter first describes the research background and its rationale, aims and specific objectives. Then, based on the conceptual framework, the chapter develops the research design and explains how the methodological approach for this research was chosen. Three stages of data collection methods are detailed. The methods of data analysis and issues of rigour, and ethics are also discussed.

Chapter Eight describes the case study, the China Global Fund AIDS Program. This chapter provides critical features of the Global Fund program and how these are applied in China. It then presents the key findings from the case study.
Chapter Nine focuses on the results and major findings of the research. It presents the main results from various data collection methods, and then highlights the key findings from the case study – the China Global Fund AIDS Program.

Part III, the last two chapters of the thesis, Chapters Ten and Eleven, carries on a discussion of the research and provides a summary of the thesis. Chapter Ten draws from the main findings of the case study and discusses them by linking these to current Chinese realities and the literature. The features are discussed and relevant facilitating factors, challenges, and recommendations for international HIV/AIDS cooperation in China, are provided.

The concluding chapter, Chapter Eleven, gives a brief summary and critique of the research findings. It includes a discussion of the limitations of this research and implications of the findings for future research into this area.

1.6. Conclusion

This chapter has set the scene of this research, and then provided background and rationale, nature, scope and purpose, and methods of this research. The structure of the thesis has been outlined in this chapter. The following chapters of Part I contain the literature review of the contextual fields of this research.
Chapter Two

Global Overview of International Health Cooperation

2.1. Introduction

In a world with globalisation and massive health inequalities, international cooperation on health is inarguably a powerful tool for the management of global health. According to Chen et al (1999) health can be seen as a global public goods, which is defined as outcomes or intermediate products that trend towards universality in the sense that they benefit all countries, population groups and generations. Thus health problems can be best addressed by cooperative actions and solutions. This chapter reviews the history of international cooperation on health. It analyses the current situation and future trends, and examines some of the concepts and issues that are relevant to the consideration of international cooperation on health. It does this by discussing globalisation and its impact on international health cooperation, global health inequality and the Millennium Development Goals (MDGs), foreign policy and global health security, and benefits both developed and developing countries can gain from the cooperation. The four main players and key challenges and some possible solutions in the international cooperation on health are also explored.

2.2. History, Current Trends, and Future Directions

International cooperation on health has a long history, dating from as early as the 14th century, and its forms have changed with the development of the globalised, modern world. Discussion of the past, the current situation, future trends of international cooperation and identifying the importance of their influencing factors enable international communities and countries to make sounder decisions on strategies within the cooperation.

2.2.1. History

The cooperation between countries on health issues has a long history. According to Banta (2001), the pandemic of the bubonic plague in the 14th century can be cited as the beginning of international action on health. The plague forced countries to engage in diplomatic dialogue and make agreements to protect their public health and contain the pandemic of infectious disease. “The impetus was contagion control and the approach was global” (Banta, 2001, p. 74). For several centuries, as ocean shipping and travel continued as the major vehicle for the
spread of infectious diseases and epidemics, the policy of quarantine was an effective means for controlling the spread of infection.

The scope of international health cooperation has expanded greatly since the mid-nineteenth century as a strategy to contain infectious diseases, notably cholera, while maintaining the benefits of increasing international movement of goods and people through trade and migration (Borowy, 2011). By the middle of the 19th century, quarantine confronted two major challenges: the speed of trade due to the introduction of the railway and the steamship and the appearance in Europe of cholera, a disease that the existing arrangements seemed unable to control (McKee et al., 2001). With the aim to reconcile international commerce and public health, a series of international sanitary conferences were convened. The first conference in Paris on August 5, 1851 was attended by government representatives of 12 countries. The subsequent sequence of events provided the first of many examples of the difficulties in agreeing on action on international health (McKee et al., 2001). In 1907 the Office International d'Hygiène Publique was established in Rome. It was international in scope, and its principal functions were to gather and share epidemiological information (Banta, 2001). Although most of these conferences were ad hoc and largely limited to epidemic intelligence gathering between scientists or professionals, they led to international agreements on common approaches for the control and treatment of disease (Walt, 2001). The most common pattern for international action in this period began with no-state actors that engaged in scientific exchanges on such things as health statistics, cholera, temperance, and tuberculosis (Savedoff, 2012).

International health cooperation had begun to change after World War II. The international concern for epidemiological surveillance was interrupted by World War I and II. After the war ended in 1945, a truly international health establishment came into being with the founding of the World Health Organisation (WHO), which was internationally ratified in 1948. The inception of a new era for international health cooperation was identified with the enunciation by President Harry S. Truman, in his 1949 inaugural address, when he proposed that the United States embark on a program of foreign aid and technical assistance for the improvement and socioeconomic development of the underdeveloped world (Howard, 1989), which included health programs. Many other countries have joined the task of providing aid and technical assistance to the developing world, such as the Australian Agency for International Development (AusAID), UK Department for international Development (DFID), and Swedish International Development Cooperation (SIDA).
2.2.2. Current Trends

The final quarter of the 20th century saw a profound change in international health cooperation. Global health today is no longer the province of only public health professionals and governments. The ever-changing roster of global health actors have expanded to involve collaborative relationships of government and non-government stakeholders that share common global health objectives. New global partners have entered the scene and become major funding agencies. Beyond officially recognised NGOs, unofficial NGOs, transnational corporations, individuals, philanthropies, as well as hybrid alliances that arise around specific issues (for example human rights) have emerged as viable stakeholders and governance parties who can act and interact through advocacy, fund raising and communications in the global context (Borowy, 2011).

The situation of international health cooperation has changed from vertically organised formal institution to horizontally linked coalitions; from being a merely bilateral effort together with a few multilateral organisations and many NGOs involvement. Walt (2001) described the vertical representation as a relationship between the states and international organisations that make up the United Nations (UN) system, representing the interests of all states and promoting cooperation between them. The various fragmented and ‘verticalised’ global health program (often disease-based) that emerged since the late 1990s have had direct and real benefits for many, many people, but they are often unsustainable and inefficient, and, at times, harmful to the broader needs and responsibilities of health systems (Borowy, 2011).

By the end of the last decade of the 20th century, UN agencies made serious effort to work in partnership with each other, and the private sector, including Non-government Organisations (NGOs). Many donor governments which are the main contributors to international health programs through UN organisations also expanded their activities to the country level by channeling funds through NGOs in the health field. And the entry of others, such as Public-Private Partnership (PPP) and private industry, into health is changing the landscape of health cooperation. Therefore, the health cooperation has changed to horizontal participation. Today, broad-ranging partnerships are increasingly being set up to target specific health problems. For example, to achieve polio eradication, a global partnership was formed with, among others, ministries of health in polio-endemic countries, Rotary International, United
Nations Children's Fund (UNICEF), the Governments of Australia, Canada, Denmark, Japan, the United Kingdom and the United States, as well as NGOs (WHO, 1998).

The constitutions of UN agencies encourage interaction, consultation and cooperation with donor government agencies and NGOs, thus enhancing collaboration (World Bank, 1989). For example, as a UN agency, the WHO is financed through the UN system by contributions from member states. In recent years, the WHO's work has involved more collaboration with NGOs and the pharmaceutical industry, as well as with foundations such as the Bill and Melinda Gates Foundation and the Rockefeller Foundation. Some of these collaborations may be considered global public-private partnerships (GPPPs); half the WHO budget is financed by private foundations. The donor governments support international health project through multilateral organisations, either through their own contributions to the regular budget, or through voluntary contributions, known as extra budgetary funds (Walt, 2001). They also provide funds to NGOs and various special partnerships established to tackle particular problems, such as the AIDS Vaccine Initiative (Walt, 2001). NGOs are also actively increasing their involvement with the UN agencies (Walt, 1998), and work very closely with the donor government agencies. For the Public-private partnerships, they are funded by donor governments, civil society, and the private sector, working in close collaboration with other bilateral and multilateral organisations. Global public health strategies have expanded from governments to incorporate civil society organisations, private and philanthropic efforts and public – private partnerships.

2.2.3. Future Directions

International health cooperation in the future is dependent on a better appreciation of the meaning of modernisation, as interpreted by the country, and recognition that it is (Howard, 1989). Chen, Evans, & R.A. (1999) pointed out that future international health cooperation will be influenced by at least three factors--resource mobilisation (as public expenditures to promote global health are strong on economic, moral and practical grounds), systems of global governance (gaps and challenges may not be fatal if the systems are adaptive, flexible and responsive to changing demands), and the creation of institutional space for organisational renovation and innovation (the interactions between diverse international health agencies are conflictual and harmonious, they need to change the times and reshape their institutional instruments to meet the new challenges).
Walt (2005) presents both a pessimistic and an optimistic view for international health cooperation in the future. The pessimistic vision is that multilateralism will have diminished and unilateralism increased. The UN will have focused only on coordination in wars, conflicts and natural disasters (Walt, 2005). Most of its agencies will have disappeared, and many of its policy functions will have been overtaken by global partnerships or other agencies, which will convene expert panels and develop international norms and standards (Walt, 2005). Emerging countries like China and India may follow the example of the other developed countries, providing aid unilaterally in a self-serving manner. The optimistic view is that multilateralism will still be a force, but the UN will be smaller. There will be no bilateral aid (government to government), all aid will be channelled through public-private partnerships, regional organisations or intergovernmental mechanisms (L. C. Chen et al., 1999; Walt, 2005). NGOs will be actively involved in policy discourse and in dispensing and delivering aid. In this optimistic scenario, countries will still have to demonstrate good governance to receive assistance. There will be no large amounts of aid to address specific issues including building up systems for health care delivery or capacity building. Those countries with weak of failed governments will receive much lower levels of aid, channelled through NGOs.

The need for health cooperation will not have disappeared. In an increasingly inter-dependent world, where the effects of poverty and ill-health are not confined within country borders, the international cooperation will be as important in the future as it is today.

2.3. Globalisation and International Health Cooperation

Globalisation has highlighted the need for strengthened international cooperation. The process of globalisation is now advancing rapidly and leads to growing interdependence between different people, regions and countries in the world. It impacts on a wide range of social spheres including the economic, political, cultural and technological. Globalisation also affects health, bringing benefits and posing risks to human health. At a time when challenges are posed by globalisation, closer cooperation is required more than ever. Thus international cooperation on health becomes a powerful tool for the management of global health.

2.3.1. Context of Globalisation

There is no consensus on the precise definition of the term “globalisation”. The concept of “globalisation” has generally been used to both describe as well as prescribe the transnational
economic, social and political relations that prevail in the world today; and often prescribed with an air of inevitability, moral superiority, and overwhelming conviction (UNDP, 1997). More often than not the concept is used to focus on the increasing flow across national boundaries of capital, labour, technology, products, services, information, values, and cultural practices (Harris & Seid, 2004). As a result, the concept of globalisation is used frequently to describe the increasing global “interconnectedness” or global interdependence of humanity in nearly all spheres of human endeavour, including health (Harris & Seid, 2004). In short, most concepts of globalisation concern the involvement of costs, risks, challenges, tensions, and conflict as well as many potential benefits of the global transformation process.

Globalisation has a complex influence on health (Cornia, 2001), both in a negative and a positive manner. As the WHO report on “Macroeconomics and Health” (2001, p. 1) claims, “the benefits of globalisation are potentially enormous, as a result of increased sharing of ideas, culture, lifesaving technologies, and efficient production processes”, but also emphasizes that “globalisation is under trial, partly because these benefits are not yet reaching hundreds of millions of the world’s poor, and partly because globalisation introduces new kinds of international challenges”. Yach and Bettcher (1998) depicted the transnationalisation of health risks and disease caused by globalisation in Table 1. However, many risks could be turned into opportunities for improving health. For instance, if modern information technologies are accessible and affordable to developing countries, the potential benefits are extensive: the uses of modern information technology in health include telemedicine, interactive health networks, communication services between health workers, human resources development and continuing education, and distance learning (Yach & Bettcher, 1998).
Table 1: Health and Global Change

<table>
<thead>
<tr>
<th>Global Transnational Factor</th>
<th>Consequences and Probable Impact in Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Macroeconomic prescriptions</strong></td>
<td>Marginalization, poverty, inadequate decreased social safety nets(^a) ^{b}</td>
</tr>
<tr>
<td>Structural adjustment policies and downsizing</td>
<td>Higher morbidity and mortality rates(^a)</td>
</tr>
<tr>
<td>Structural and chronic unemployment</td>
<td></td>
</tr>
<tr>
<td><strong>Trade</strong></td>
<td>Increased marketing, availability, and use(^b)</td>
</tr>
<tr>
<td>Tobacco, alcohol, and psychoactive drugs</td>
<td>Ineffective or harmful therapy(^b)</td>
</tr>
<tr>
<td>Dumping of unsafe or ineffective pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td>Trade of contaminated foodstuffs/feed</td>
<td>Spread of infectious diseases across borders(^b)</td>
</tr>
<tr>
<td><strong>Travel</strong></td>
<td></td>
</tr>
<tr>
<td>More than 1 million persons crossing borders/day</td>
<td>Infectious disease transmission and export of harmful lifestyles (e.g., high-risk sexual behaviour)(^c)</td>
</tr>
<tr>
<td><strong>Migration and demographic</strong></td>
<td></td>
</tr>
<tr>
<td>Increased refugee populations and rapid population growth</td>
<td>Ethnic and civil conflict and environmental degradation(^c)</td>
</tr>
<tr>
<td><strong>Food security</strong></td>
<td></td>
</tr>
<tr>
<td>Increased demand for food in rapidly growing economies, for example, countries in Asia</td>
<td>Structural food shortages as less food aid is available and the poorest countries of the world are unable to pay hard currency(^b)</td>
</tr>
<tr>
<td>Increased in global food trade continuing to outstrip increases in food production, and food aid continuing to decline</td>
<td>Food shortages in marginalised areas of the world; increased migration and civil unrest(^a)</td>
</tr>
<tr>
<td><strong>Environmental degradation and unsustainable consumption patterns</strong></td>
<td></td>
</tr>
<tr>
<td>Resource depletion, especially access to fresh water</td>
<td>Global and local environmental health impact(^b)</td>
</tr>
<tr>
<td>Water and air pollution</td>
<td>Epidermis and potential violence within and between countries (water wars)</td>
</tr>
<tr>
<td>Ozone depletion and increases in ultraviolet radiation</td>
<td>Introduction of toxins into human food chain and respiratory disorders</td>
</tr>
<tr>
<td>Accumulation of greenhouse gases and global warming</td>
<td>Immunosuppression, skin cancers, and cataracts</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>Major shifts in infectious disease patterns and vector distribution (e.g., malaria), death from heat waves, increased trauma due to floods and storms, and worsening food shortages and malnutrition in many regions of the world</td>
</tr>
<tr>
<td>Patent protection of new technologies under the trade-related aspects of intellectual property rights agreement</td>
<td>Benefits of new technologies developed in the global market are unaffordable to the poor(^c)</td>
</tr>
<tr>
<td><strong>Communications and media</strong></td>
<td></td>
</tr>
<tr>
<td>Global marketing of harmful commodities such as tobacco</td>
<td>Active promotion of health-damaging practices(^b)</td>
</tr>
<tr>
<td>Foreign policies based on national self-interest, xenophobia, and protectionism</td>
<td>Threat to multilateralism and global cooperation required to address shared transnational health concerns(^a)</td>
</tr>
</tbody>
</table>

\(^a\) Possible short-term problem that could reverse in time
\(^b\) Long-term negative impact
\(^c\) Great uncertainty

Source: Yach, D, Bettcher, D (1998, p. 737)
Globalisation is a double-edged sword. It brings both opportunities and challenges to the international health cooperation. The impact of globalisation on international health cooperation is further discussed in the next section.

2.3.2. Impacts of Globalisation on International Health Cooperation

In the wake of globalisation, development cooperation is increasingly occupied with helping to shape regulatory policy framework conditions and global structure as they shift and evolve. As the factors accounting for globalisation, such as information technology, trade and the flow of capital, undermine the state's control over what happens in its territory, it forces individual states to cooperate with each other and build partnerships with non-state actors, such as multinational corporations and nongovernmental organisations, in order to develop global governance (Fidler, 2001). International cooperation is becoming ever more significant.

Globalisation offers great opportunities for international health cooperation. The process of globalisation improves technological development and increases global interconnections. The new technologies, particularly information and telecommunication technologies have cut the distance between people in different parts of the world, and have also accelerated social interaction. Improvement in communication and informational technologies has enabled international responses to catastrophic events that threaten health to be organised more rapidly and facilitated the coordination of emergency situations. Technological innovation reduces costs of transportation and communication, intensifies the interconnections between states and societies in economic, political, social, and culture relations. Thus, as Hurrell (1995) discussed, globalisation has dismantled barriers and generated interconnections between the states and societies to bring about greater sharing of information and increasing international interactions and collaboration.

Implementation of international agreements has become important. Globalisation requires increasing cooperation among countries to ensure the stability and security of the global system. For instance, industrial development creates new environmental threats, such as water and air pollution, that can transcend boundaries and impact on all human society in the global village. These issues have raised the need for international cooperation and global agreements. The implementation of these agreements has primarily been a decentralised process, undertaken separately by each country, based on its own policy decisions, and often, according to its
specific conditions and at its own speed (Inge Kaul, Grunberg, & Stern, 1999). Values, policies and rules are shaped in today’s more interdependent world by international cooperation, which involves the interaction of countries, international organisations, and non-government actors (Inge Kaul et al., 1999).

International aid becomes more important. As globalisation widens the gap between rich and poor nations, interest in foreign assistance has grown in importance. Countries which lack the most basic foundations of development and requisite national development management capacities cannot effectively share the provision of Global Public Goods, for example, to infectious disease control, or to the alleviation of poverty and all its negative consequences (Inge Kaul et al., 1999). In a world of interconnected threats and opportunities, international aid is one of the most effective weapons (UNDP, 2005). It is an investment in shared prosperity, collective security and a common future (UNDP, 2005).

In short, the process of globalisation has particular impacts on health where there is a clear need to better understand and more effectively respond to these impacts. The widespread influence of globalisation has increased the need of international cooperation to address emerging opportunities for and threats to global health and improved the health status of poor states that have not benefited from globalisation. As a consequence of globalisation, national governments should turn increasingly to international cooperation to attain national public health objectives and achieve some control over the transboundary forces that affect their populations. More importantly, international health cooperation should be designed to fit the realities of a globalising world.

2.4. Other Important Factors in International Health Cooperation

Globalisation has an important influence on international health cooperation, bringing both opportunities and challenges to international cooperation for health. In a world with massive health inequalities, achieving Millennium Development Goals (MDGs) needs effort by the entire world. Moreover, international cooperation for health can be seen as one important plank of foreign policy, and cannot be separated from global health security.
2.4.1. Global Health Inequality and the Millennium Development Goals

Inequities in health conditions and in the access to healthcare are found both between counties and within countries. There is no doubt that the world has massive inequalities in the opportunities to live a free, healthy, and fulfilled life.

The Millennium Development Goals (MDGs) have been a fundamental framework for global development. The targets of the MDGs provide a focal point for international concern, putting development and the fight against poverty on the international agenda (UNDP, 2005). MDGs have played a role in increasing aid, provided a framework within which the international community can work towards a common end. To close the health gap between the developed and developing countries and achieve the MDGs requires international communities, rich and poor countries, and all the partners to be involved.

There is a disparity in health between rich and poor countries. Children have dramatically different life chances depending on where they are born. In Japan or Sweden children can expect to live more than 80 years; however, in several African countries, children can expect to live less than 50 years (WHO, 2012). More than two thirds of all cancer deaths occur in low- and middle-income countries, with lung, breast, colorectal, stomach and liver cancers causing the majority of such deaths. Deaths associated with diarrhea and respiratory infection are rare in developed countries but are the major killers of children in developing countries; diseases that do not occur in developed countries, e.g. malaria and schistosomiasis, or ones that are comparatively rare in these countries, e.g. tuberculosis and HIV/AIDS, impose a heavy burden on both adults and children in developing countries (WHO, 2012). However, richer countries with lower disease burden use more health resources than poorer countries with higher disease burden, for example, money spent on health is US$ 11 per person per year in Eritrea while US$ 8262 per person in Luxembourg (WHO, 2012). A major result of this is both poor environmental health and the lack of access to information, technology and quality basic care, which threatens to leave the global poor even further behind (McCracken & Phillips, 2012).

The Millennium Development Goals (MDGs), identified and agreed by the some 190 United Nations member states and at least 23 international organisations at the Millennium Summit of the United Nations in September 2000, called for a dramatic reduction in poverty and marked improvements in the health of the poor. MDGs were effectively new, quantifiable – and
ambitious – international development targets, most to be achieved by 2015. They included fundamental goals with targets, such as reducing extreme poverty, child and other mortality levels, and fighting many forms of epidemic disease. Three of the MDG targets specify health objectives (MDG 4 on reducing child mortality, MDG 5 on improving maternal health and MDG 6 on combating HIV/AIDS, malaria and other diseases), and four others attempt to improve social determinants of health, namely poverty and hunger, education, gender equality, and environmental protection (Box 1).

**Box 1: The Millennium Development Goals**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eradicate extreme hunger and poverty. Halving the proportion of people living on less than $1 a day and halving malnutrition.</td>
</tr>
<tr>
<td>2</td>
<td>Achieve universal primary education. Ensuring that all children are able to complete primary education.</td>
</tr>
<tr>
<td>4</td>
<td>Reduce child mortality. Cutting the under-five death rate by two-thirds.</td>
</tr>
<tr>
<td>5</td>
<td>Improve maternal health. Reducing the maternal mortality rate by three-quarters.</td>
</tr>
<tr>
<td>6</td>
<td>Combat HIV/AIDS, malaria and other diseases. Halting and beginning to reverse HIV/AIDS and other diseases.</td>
</tr>
<tr>
<td>7</td>
<td>Ensure environmental stability. Cutting by half the proportion of people without sustainable access to safe drinking water and sanitation.</td>
</tr>
<tr>
<td>8</td>
<td>Develop a global partnership for development. Reforming aid and trade with special treatment for the poorest countries.</td>
</tr>
</tbody>
</table>

http://www.un.org/millenniumgoals/
UNDP (2005) stated that the health gap between developed and developing countries was widening. If current trends continue, there will be large gaps between MDG target and outcomes. Reducing inequality in health is a public priority. It would also be instrumental in accelerating progress towards the MDGs.

Both developed and developing countries have the responsibility of facing the challenges of health inequality and achieving of the MDGs. Success in achieving the MDGs will require a seriousness of purpose, a political resolve, and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis (WHO, 2001).

2.4.2. Global Health Security and Foreign Policy

The interdependence that globalisation brings results in a common vulnerability, including a vulnerability in public health, that requires a collective response. This interdependence has transformed the foreign policy-health linkage. With the onset of globalisation and threats arising from public health security, public health is increasingly recognised as important for foreign policy. Governments at all income levels are increasingly prepared to cooperate to prevent the emergence and spread of infectious disease and provide public health security.

As health is closely linked to issues such as poverty, employment, education, trade, environmental protection, climate change and intellectual property, it is today a growing concern in foreign policy. Historically, public health has predominantly been a domestic policy concern (Cheek, 2004). However, globalisation and developments over the last decade have forced public health experts and diplomats to think of health as foreign policy, namely public health as important to states’ pursuit of their interests and values in international relations (Fidler, 2006). In 2006, the Ministers of Foreign Affairs from Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand issued a joint statement in Oslo highlighting the need to apply a health lens to foreign policy:

We believe that health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time. ... We believe that health as a foreign policy issue needs a stronger strategic focus on the international agenda. We have therefore agreed to make ‘impact on health’ a point of departure and a defining lens that each of our countries will use to examine key elements of foreign policy and development strategies, and to engage in a dialogue on how to deal with policy options from this perspective (Amorim et al., 2007).
The statement emphasises that health is one of the most important, long-term foreign policy issues of our time.

Horion (2006) described the advantages of using health as an instrument of foreign policy, such as protecting nations against health threats, social cohesion, strengthened national infrastructure, improving bilateral relations, and encouraging trust across global multilateral agencies. Public health today features in all foreign policy’s basic function: achieving national and international security; contributing to state’s economic power and prosperity; supporting the development of political and economic order and stability in other countries; promoting and protecting human dignity (Fidler, 2006). The public health examples with respect to each function are listed in Table 2.
Table 2: Public Health Examples with Respect to Each Foreign Policy Governance Function

<table>
<thead>
<tr>
<th>Foreign policy governance function</th>
<th>Examples of importance of public health to each function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security</td>
<td>• Fears about the state proliferation of biological weapons</td>
</tr>
<tr>
<td></td>
<td>• Concerns about the use of biological weapons by terrorists</td>
</tr>
<tr>
<td></td>
<td>• Acknowledgment that emerging communicable diseases, such as SARS and avian influenza, can pose direct threats to the security of states, peoples and individuals</td>
</tr>
<tr>
<td></td>
<td>• Recognition that the political, economic and social devastation caused by HIV/AIDS can threaten the security of states, peoples and individuals</td>
</tr>
<tr>
<td></td>
<td>• Development by WHO of the concept of ‘global health security’ with respect to communicable disease threats</td>
</tr>
<tr>
<td>Economic well-being</td>
<td>• Understanding of the economic damage communicable disease epidemics and pandemics can cause to national economies integrated through globalisation</td>
</tr>
<tr>
<td></td>
<td>• Tensions between states that export products harmful to human health (e.g. tobacco products) and states that import such products and try to mitigate the health effects of the products</td>
</tr>
<tr>
<td></td>
<td>• Controversies over the effect of trade liberalisation strategies on national health regulatory powers and capabilities</td>
</tr>
<tr>
<td>Development</td>
<td>• Advocacy to put public health at the centre of economic development strategies</td>
</tr>
<tr>
<td></td>
<td>• Centrality of health to the achievement of the UN’s MDGs</td>
</tr>
<tr>
<td></td>
<td>• Research and analysis that highlights the contributions health makes to macroeconomic and microeconomic development</td>
</tr>
<tr>
<td></td>
<td>• Linking debt-forgiveness and future international assistance to increased attention on, and investments in, health</td>
</tr>
<tr>
<td>Human dignity</td>
<td>• Focus on a human-rights-based approach to HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>• Human-rights-cantered arguments in favour of increasing access to essential medicines subject to patent rights under TRIPS</td>
</tr>
<tr>
<td></td>
<td>• Appointment by the UN of a Special Rapporteur on the Right to Health</td>
</tr>
<tr>
<td></td>
<td>• Challenge of balancing enjoyment of civil and political rights and addressing dangerous communicable disease outbreaks effectively</td>
</tr>
</tbody>
</table>

Source: Fidler (2006, p. 55)
The concept of health security has also become increasingly important in foreign policy. Over the past 15 to 20 years, disease has increasingly come to be seen as a security issue, posing potential threats to peace and stability both within countries and internationally (McCracken & Phillips, 2012). Emerging infectious diseases such as severe acute respiratory syndrome (SARS), avian influenza and H1N1 influenza have occurred one after another, indicating that no one can ever relax vigilance against health security threats. In a world of growing interdependence, no country can be immune from another’s problems. Protecting national and global health security requires collective and coordinated action.

While national security focuses on the defence of the state from external attack, national health security relates to defence against internal and external public-health risks and threats. Beyond traditional concerns with direct trans-boundary threats (for example communicable diseases and cross-border pollution), the challenges now encompass additional communicable and non-communicable health harms, health infrastructure problems (such as water and sanitation, surveillance and response capacities, health care systems), and deteriorating social determinants of health (Fidler, 2010). Ideas about human security are increasing cooperation in public health. Building bilateral, regional and multilateral cooperation for global health security is a priority in foreign policy in an Agenda for Action to all national governments.

In summary, public health has been an important tool of foreign policy, and it is an important concern for human security. A high degree of international cooperation is required. All the stakeholders, including international communities and all counties, need to work together, to develop a broader base for international relations and collaborative strategies to strengthen global public health security. Apart from addressing the threats to health security, cooperation on health also brings many other benefits for both developed and developing countries.

2.5. Benefits for Developing and Developed Countries

As a global public good, health towards universality and benefits all countries, population groups and generations (I. Kaul, Grungberg, & Stern, 1999). Thus health problems are best addressed by cooperative actions and solutions. International cooperation for health has benefited both poor and rich countries.
2.5.1. Benefits for Developing Countries

Developing countries are facing enormous health problems, notably from infectious diseases such as HIV/AIDS, malaria, and tuberculosis, and lack of access to basic health care, clean water, adequate sanitation, and food. The health systems of most developing countries are unable to address the needs of their populations, their prevalent diseases, their main risk factors and bad life conditions, which make them very dependent on international aid, which, in turn, is crucial for development as a whole and the life and health conditions of their populations.

Because of their limited resources, the implementation of effective measures to control disease in most developing countries requires external assistance. Development aid, for example, aims to build and strengthen capacity in low-income countries, through technical assistance, grant, or loans (Walt & Buse, 2006). The aid to the developing countries can be of crucial importance.

For developing countries, as Kaul et al (1999) argued, improving international cooperation would strengthen the capacity of national governments to achieve their national policy objectives. Also, the international health organisations are a major source of expert technical advice and training for local health professionals. Research and pilot programs can generate many of the best ideas for improving health in developing countries (I. Kaul et al., 1999).

2.5.2. Benefits for Developed Countries

Getting involved in international health projects is also beneficial for the developed countries. With their combined human and financial resources, and their experience in health sciences, they can have a key role in providing solutions for the increasingly complex and widespread health difficulties that the world now faces.

Developed countries can play a vital part in helping solve global health problems, and it is in their own interests as well as those of developing countries to do so (WHO, 1998). The importance of international engagement in a globalised world has been emphasised in many developed countries. The American Institute of Medicine (1997) in its report “America’s Vital Interest in Global Health” argues three key interests of the United State (U.S.) extensive engagement in world health: protecting America’s population, enhancing the economy, and advancing America’s international interests. The report notes that in partnership with other countries and international organisations, the United States can lend a great deal in the areas of
research and development, surveillance, education and training, and coordination and leadership. A recent report in *Hartford Courant* (Johnson, 2012) also stressed that “foreign health aid is a vital U.S. interest” and “U.S.’s commitment to global health programs must be strengthened”. Donaldson & Banatvala (2007) also pointed out that engagement with the global health agenda can improve global security and health protection, enhance sustainable development, improve trade by promoting health as a commodity, maximise the potential of global public goods, and encourage a human rights approach to health. Rekart et al (2003) presented the five reasons why Canada should get involved in international health projects in Box 2.

**Box 2: Five Reasons Why Canadians Should Get Involved in International Health Projects**

1. Global health affects the health of Canadians, Canadians cannot safeguard their health by closing borders or ignoring the health concerns of those less fortunate.
2. Global health affects the security of Canadians. Canadians can contribute to improved global security by helping poor nations focus on the major avoidable causes of death and disability: HIV/AIDS, malaria, TB, childhood infections, maternal and prenatal conditions, micro-nutrient deficiencies and tobacco-related illness.
3. International projects give Canadians opportunities to make new discoveries, use their knowledge in new ways and gain experience with interventions and diseases currently uncommon in Canada.
4. Successful international projects enhance Canadian credibility and promote excellence for Canadian agencies and individuals.
5. Empowering people in developing countries to deal more effectively with their problems can generate personal satisfaction for individual Canadians.


It is believed that international cooperation for health is so important to the health and well-being of people in both developing and developed countries that it should involve both of them. In a world without borders, international cooperation for health is the appropriate avenue.
2.6. Main Actors in International Health Cooperation

Actors in international health cooperation have increased. In the middle of the twentieth century, there were few actors in health. By the end of the century, the development of international health cooperation had increased the quantity and diversity of actors. Four kinds of main actors are identified within international health cooperation. They are the multilateral organisations (such as WHO, UNDP, UNICEF, and others), the governments of developed countries (USA, Canada, European Union, among others) or emerging countries (such as Brazil, China, India), the non-government organisations (NGO), and public–private partnerships (PPPs) which incorporate various actors that work in the international sphere (such as Global Fund or GAVI).

2.6.1. Multilateral Organisations

Multilateral organisations are organisations whose members include at least three countries, that have activities in several countries, and whose members are held together by a formal intergovernmental agreement (Karns & Mingst, 2004, p. 7). Multilateral organisations have a critical role to play in international health. They help set the rules, influence the development agenda, set international objectives like the Millennium Development Goals (MDGs), and help catalyse funding. Multilateral organisations remain central actors and have a critical role to play in international health. They have become more prominent as venues for analysing problems, designing solutions, and facilitating negotiations, while the current environment for them is more complicated, competitive, and difficult (Fidler, 2010).

Multilateral organisations include United Nations agencies, multilateral development banks (for example World Bank, regional development banks), and regional groupings (for example certain European Community and Arab agencies). Within the UN agencies, the leading role of the WHO, established in 1948, in international health is unquestioned (McKee et al., 2001); many sister UN organisations also have prominent roles in health, including, among others, United Nations Children’s Fund (UNICEF), the United Nations Development Programme (UNDP) and the United Nations Population Fund (UNPF). Other agencies essentially have international status representation at government levels, such as the World Bank which has been involved in health from time to time, especially after the publication of its landmark 1993 World Development Report – *Investing in health* (World Bank, 1993). Moreover, some organisations such as the World Trade Organisation (WTO), may not have initially participated
in the development of health but now are seen as important actors with regard to many of the tradable determinants of health (McKee et al., 2001). For others, such as the Organisation for Economic Co-operation and Development (OECD) and the Regional Development Bank, health may be a side issue but their overall importance on the international scene makes them significant actors (McKee et al., 2001).

There is no doubt that multilateral agencies play a vital role in international health cooperation, but there are many issues of concern. With many sovereign member states, the focus of much of their work, therefore, is communication. For example, within the UN agencies, discussions are conducted in many languages and documentation is available in six official languages. Thus it is not surprising that progress is slow and painstaking (Kelley Lee, 2005). Multilateral organisations include many different bodies, agencies, and programs. Balancing power within these bodies and sharing financial responsibility for their work are continuing challenges (Kelley Lee, 2005). Additional they may face inherent difficulties by trying to manage a technical scientific enterprise with bureaucratic procedures that are essentially diplomatic (Savedoff, 2012). Other issues, such as lack of sufficient authority and resources to implement its policies and plans effectively, lack of coordination, poor leadership, petty (and sometimes not so petty) corruption, bureaucratic tangles, and waste of resources have also been evident (United States Institute of Peace, 2005).

Cooperation in health, however, has not been limited to collaboration through the multilateral organisations. National development agencies or bilateral organisations, such as the United Kingdom’s Department for International Development (DFID), the Swedish International Development Agency (SIDA), or the US Agency for International Development (USAID), among many others, have played important roles at international and regional levels and in many countries. These agencies are often the main contributors to international health programs through UN organisations, but they also provide assistance to lower-income countries through government-to-government agreements know as bilateral aid.

2.6.2. National Development Agencies

National development agencies (bilateral agencies) are government agencies in a single country, which provide aid to developing countries. Most of them are members of the Development Assistance Committee (DAC), the organisation from Economic Co-operation
and Development (OECD). The OECD reformed from the Organisation for European Economic Co-operation (OEEC) in 1961, is an international organisation helping governments tackle the economic, and social challenges of a globalise economy. For them, health may be a side issue but their overall importance on the international scene makes them significant actors (McKee et al., 2001). National development agencies have increased development assistance for health but have done so in a variety of ways, such as by bilateral aid, traditional institutions (for example WHO and World Bank), or by new mechanisms (that is, Global Fund to Fight AIDS, Tuberculosis and Malaria).

Official development assistance (ODA) to developing countries for health has increased steadily since 1975 (WHO, 2001). According to OECD (2009b), after stagnating in the 1980s and 1990s, aid to health has risen sharply in recent years, average annual growth over the period 1980-2007 was 10 per cent but this accelerated more recently (17 per cent annually from 2000 to 2007). It notes the prioritisation of the health sector in donors’ aid programs with 18 per cent of total DAC countries’ bilateral sector-allocable aid dedicated to health in 2006-2007, compared with 12 per cent in 2001-2002 (OECD, 2009b).

The sharp growth in ODA to the health and basic education sectors has contributed to some notable results, for example the number of children dying before their fifth birthday has fallen below 10 million per year for the first time and deaths from measles in Africa have fallen by 91 per cent since 2000 (Manning, 2008). In Egypt a national diarrhea control program supported by the USAID and WHO helped reduce infant deaths by 82 per cent in five years, preventing 300,000 child deaths (UNDP, 2005). The DAC member countries and the names of their aid agencies are listed in Table 3.
Table 3: The DAC Member Countries and the Name of Their Aid Agencies

<table>
<thead>
<tr>
<th>Country</th>
<th>Aid Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Australian Agency for International Development (AusAID)</td>
</tr>
<tr>
<td>Austria</td>
<td>Austrian Development Agency (ADA)</td>
</tr>
<tr>
<td>Belgium</td>
<td>Development Cooperation (DGDC)</td>
</tr>
<tr>
<td></td>
<td>Technical Cooperation (BTC)</td>
</tr>
<tr>
<td>Canada</td>
<td>Canadian International Development Agency (CIDA)</td>
</tr>
<tr>
<td>Denmark</td>
<td>Danish Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>Finland</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>France</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td></td>
<td>Le Groupe de l’Agence française de Développement (AfD)</td>
</tr>
<tr>
<td>Germany</td>
<td>Ministry for Economic Cooperation and Development</td>
</tr>
<tr>
<td></td>
<td>(Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklungs, BMZ)</td>
</tr>
<tr>
<td></td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)</td>
</tr>
<tr>
<td></td>
<td>Development Cooperation (KfW)</td>
</tr>
<tr>
<td>Greece</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>Ireland</td>
<td>Irish Aid</td>
</tr>
<tr>
<td>Italy</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td>Japan</td>
<td>Ministry of Foreign Affairs (MOFA)</td>
</tr>
<tr>
<td></td>
<td>Japan International Cooperation Agency (JICA)</td>
</tr>
<tr>
<td></td>
<td>Japan Bank for International Cooperation (JBIC)</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Ministry of Foreign Affairs</td>
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<tr>
<td></td>
<td>Lux-Development</td>
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<tr>
<td>Netherlands</td>
<td>Ministry of Foreign Affairs</td>
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<td>New Zealand</td>
<td>NZAid</td>
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<tr>
<td>Norway</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td></td>
<td>Norwegian Agency for Development Cooperation (NORAD)</td>
</tr>
<tr>
<td>Portugal</td>
<td>Ministry of Foreign Affairs</td>
</tr>
<tr>
<td></td>
<td>Portuguese Institute for Development Support (IPAD)</td>
</tr>
<tr>
<td>Spain</td>
<td>Spanish Agency for International Cooperation (AECI)</td>
</tr>
<tr>
<td>Sweden</td>
<td>Swedish International Development Authority (SIDA)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Swiss Agency for Development and Cooperation (SDC)</td>
</tr>
<tr>
<td></td>
<td>State Secretariat for Economic Affairs (SECO)</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Department for International Development (DFID)</td>
</tr>
<tr>
<td>United States</td>
<td>United States Agency for International Development (USAID)</td>
</tr>
<tr>
<td></td>
<td>Millennium Challenge Corporation (MCC)</td>
</tr>
</tbody>
</table>

Source: revised from OECD, Development Co-operation Directorate www.oecd.org/dac/memberswebsites
The practice of international development aid has moved away from the traditional donor-recipient model to more multilateral, cooperative models (Walt, 2005). Donor government allocations to development assistance for health (DAH) are channelled in variety of ways: directly to partner governments; through the UN system; through NGOs working at country, regional, and global levels; and through various global initiatives involving several stakeholders. Some sources of assistance are more or less continuous, while other assistance is given in response to specific appeals or following events such as natural disasters or disease outbreaks. Development assistance for health by channel of assistance from 1990 to 2010 is shown in Figure 1, with dollars assigned to the institution that channels resources directly to the final recipient.

**Figure 1: DAH by Channel of Assistance, 1990-2010**

![Graph showing DAH by Channel of Assistance]

Source: Institute for Health Metrics and Evaluation (2010, p. 17)

Whether the general maintenance of health aid will continue is not clear. Major donors’ aid to developing countries fell by nearly three per cent in 2011, breaking a long trend of annual increases (OECD, 2012a). Disregarding years of exceptional debt relief, this was the first drop since 1997. The WHO (2010) believes the effects of economic downturn (especially after 2008) on development assistance are unclear. However, many bilateral donor countries in the richer groups (such as Greece, Ireland, Portugal and others in the EU) were beset by exceptional financial challenges and budgetary debt crises around 2010-12, with the result that future assistance is uncertain.
With the rapid increase in flows of development assistance to health, national development agencies face many challenges. One of the problems is that the budget targets set by donors may not be achieved (Manning, 2008; UNDP, 2005). Many donors find their geographic and sector aid allocations frequently driven by domestic political leadership or legislative initiatives (Manning, 2008). Even where donors establish clear allocation priorities, it may be difficult to convince domestic decision makers of the importance of maintaining such a disciplined and longer-term approach. Another issue of bilateral aid is that it lacks transparency. Commitments are funds that are set aside to cover costs for a project, which most often span several years. Disbursements are funds actually expended. Most agencies routinely report commitments made each year, but only a few report disbursement (Manning, 2008; WHO, 2001).

Health sector assistance may be focused on popular or high-profile health initiatives or ‘high-profile’ diseases, while other more basic, ongoing, essential requirements are neglected (see, for example, Graph 1). Given the criticism that aid leads to dependency and undermines the fostering of local talent, some technical assistance has often focused on in-country capacity building, skills training and facility improvement (McCracken & Phillips, 2012).
2.6.3. Non-government Organisations and Private Sectors

Many international NGOs have been important since health cooperation began and now enjoy more influence on global health than ever before. They focus on particular aspects of health, or groups requiring services.

Non-governmental organisations (NGOs) have increased in number, size and scope and established themselves in pivotal positions in social, economic and political landscapes across the globe. They have made critical contributions to health development at both the international and domestic level. NGOs make up a broad group of agencies of considerable complexity. They include church missions providing health care to isolated rural communities; agencies such as Oxfam, which may be involved in advocacy on behalf of lower-income countries (for example on debt relief) or may be working with local groups (AIDS support groups, for example); and private foundations, such as the Rockefeller, Ford, and the Bill and Melinda Gates Foundations.
The non-government organisations, or NGOs, are largely a post-World War II phenomenon. They are private voluntary organisations whose members are individuals or associations that come together to achieve a common purpose (Karns & Mingst, 2004). The World Bank defines a NGO as a group or an institution that is entirely or largely independent of government, which has primarily humanitarian or cooperative rather than commercial objectives (World Bank, 1989). At a national level NGOs are often called interest or pressure groups, and many of them are now linked to counterpart groups in other countries through transnational networks or federations. International NGOs may draw their numbers from one region or several regions, and they may have very specific functions or be multifunctional (Karns & Mingst, 2004). Their roles may be generalised as three overlapping spheres: advocacy, lobbying and vigilance (policy and rights); provision of services on specific areas of research, counselling and technical support (knowledge and resources); providing global ‘poverty’ services in terms of relief, welfare and service provision in health care and population policies (services and charity) (Koivusalo & Ollila, 1997, p. 98). Some large international bodies are actually international NGOs, often working closely with the intergovernmental agencies (McKee et al., 2001).

The numbers of NGOs and private foundations have grown rapidly in recent years, helped along by access to money and communication technology (Anheier, Glasius, & Kaldor, 2001). Activities of NGOs in developing countries’ health include: providing health care to specific populations, both in urban and rural areas teaching specific preventive and promotive measures, educating about preventive services such as safe drinking water and sanitary latrines; engaging in the control of many diseases such as diarrhoea, TB, or HIV/AIDS; working exclusively for family planning, or experimenting in health delivery systems; assistance to national governments, providing funds to national governments to carry out selected health programs, providing funds for training to develop national capacities for health development, creating public awareness about particular health problems, such as over population, through the dissemination of information (M. Reich & Marui, 1989).

Comparing other actors in the international health cooperation, NGOs have many advantages. They can mobilise more resources, or mobilise untapped human and financial resources and bringing them to bear on the task; they can be the mediator, acting as liaison among social groups, between fields, and across political boundaries, thus reducing the divisions that often impede effective action (Jamali, 2009). The vast number of NGOs neither have bureaucracies of their own nor work according to bureaucratic rules. They are flexible and in most situations
able to respond rapidly to needs as they arise (Basch, 1999). Much of the public on both donor and recipient sides have more faith in NGOs than in official agencies, which are frequently viewed as corrupt, inefficient, or at least suspect (Basch, 1999). NGO workers are seen to have higher standards, a greater sense of mission, and to be less self-serving than government officials and bureaucrats (Basch, 1999).

Despite the increasing role of the NGOs in the international field which has been enhanced by expectations of their greater effectiveness in health cooperation, NGOs confront problems and constraints that can undermine their contributions. The most commonly identified weaknesses of the sector relate to objectives that are sometimes vague, management problems, limited institutional capacity, lack of financial sustainability, and low project replicability coupled with isolation or lack of coordination with other NGOs (Jamali, 2009). Other negatives include: the fact that these NGOs are responsible to their organisations and must meet their goals and objectives that may not reflect local or national priorities of host nations (Akukwe, 1998); uncertain funding sources which contribute to shaky NGO projects and which are of short duration, locally disruptive and often unsustainable. Moreover, as Koivusalo & Ollial (1997) argued, increasing funding possibilities may also create private interests to be channelled into nongovernmental action where lines between for-profit firms and non-profit organisations may be blurring, or private interests in terms of income of social status may lead to increasing hollowness of non-profit claims from NGOs.

In short, NGOs, as voluntary non-profit organisations, make a substantial contribution to international cooperation for health. They have been engaged in different types of activities. The growing influence of NGOs in international health cooperation presents important challenges and opportunities. In view of changed circumstances and new understandings of their roles, it is believed that NGOs need to change their strategies in order to respond to larger and long-term needs of health.

2.6.4. Public-Private Partnerships

As we move into the 21st century, Public-Private Partnerships (PPPs) have had widespread impact, and are becoming a popular mode of tackling large, complicated, and expensive public health problems (Buse & Walt, 2000a; M. R. Reich, 2000). PPPs use the comparative advantages of the participating actors, pooling resources, and sharing risks and benefits in
order to address issues that could not be solved by a single actor alone. Examples of PPPs that have already been successful are numerous. While partnerships between public and private organisations on the one hand can contribute to innovative and effective solutions to certain problems, they are on the other hand associated with considerable challenges.

Definitions of PPPs tend to vary based on the objectives, ideology, scope, composition, funding mechanism and structure of the partnership (Thomason & Rodney, 2009). The most commonly used definition in the health arena is that proposed by Kent Buse and Gill Walt (2000a, p. 500), they defined a global PPP for health as: “A collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organisation, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour”. Whatever their form, the fundamental assumption that is made by public and private actors in the field is that by coordinating their actions, the PPP can achieve added value in the form of cost savings, greater efficiency, or more innovative results (Edelenbos & Klijn, 2009).

Many kinds of PPPs for health emerged in recent years. For example, the Medicines for Malaria Venture is a partnership of academic and public research institutes, as well as the pharmaceutical industry, to develop necessary but not commercially viable new treatments for malaria. The Global Alliance for TB Drug Development, a collaboration of private foundations, commercial enterprises, governments, multilateral donors and individuals, seeks to develop new, second-line drugs for resistant TB. The International AIDS Vaccine Initiative involves academic, commercial and government institutions in mounting clinical trials for promising HIV vaccine candidates. Some global-health partnerships, notably The Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), with their focus on a country-driven approach, accountability, and results, have shown that substantial finance can be absorbed and the delivery of better health is apparent in poor countries (Lob-Levyt & Affolder, 2006).

Buse et al (2007) identified seven impressive contributions and seven unhealthy habits of Global public–private health partnerships (GHPs). Details of these are in the Table 4.
Table 4: Seven Impressive Contributions and Seven Unhealthy Habits of Global Public-private health Partnerships

<table>
<thead>
<tr>
<th>Impressive Contributions</th>
<th>Unhealthy Habits</th>
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<tbody>
<tr>
<td>• Getting specific health issues onto national and international agendas;</td>
<td>• Skewing national priorities by imposing external ones;</td>
</tr>
<tr>
<td>• Mobilising additional funds for these issues;</td>
<td>• Depriving specific stakeholders a voice in decision-making;</td>
</tr>
<tr>
<td>• Stimulating research and development;</td>
<td>• Inadequate governance practices;</td>
</tr>
<tr>
<td>• Improving access to cost-effective health-care interventions among populations with limited ability to pay;</td>
<td>• Misguided assumptions of the efficiency of the public and private sectors;</td>
</tr>
<tr>
<td>• Strengthening national health policy processes and content;</td>
<td>• Insufficient resources to implement partnership activities and pay for alliance costs;</td>
</tr>
<tr>
<td>• Augmenting health service delivery capacity;</td>
<td>• Wasting resources through inadequate use of recipient country systems and poor harmonisation; and</td>
</tr>
<tr>
<td>• Establishing international norms and standards.</td>
<td>• Inappropriate incentives for staff engaging in partnerships.</td>
</tr>
</tbody>
</table>

Source: modified from Buse et al (2007)

Public-private partnerships are at the top of many agendas in international public health these days (M. Reich, 2002). They are seen as an innovative method with a good chance of producing the desired outcomes (M. Reich, 2002). For PPPs, ideally, the actors expect the benefits of the cooperation to outweigh the costs. However, the reality is that PPPs also lead to greater complexity because the number of actors, problem definitions, and preferred solutions often increases dramatically (Edelenbos & Klijn, 2009). The strategies of the multiple actors may conflict, and their institutional backgrounds (private and public) often bring about serious differences in objectives and opinions.
Firstly, public and private partners have strong differences in their cultures, governance structures, and financial resources. These differences create challenges in the partners’ efforts to collaborate effectively and achieve their objectives (M. Reich, 2002). Also, differences in public and private ethos may create tensions or conflicts of interest for those involved. For example, sharing information may be difficult: private industry or researcher groups may want to protect product leads or early data from trials (Ruair Brugha et al., 2004). There may be debates on risks, such as public to private subsidies; or on setting norms and standards; or on agreement between prices and profitability (Walt, 2001).

The governance issues are in the realm of representation, accountability and transparency (Ruair Brugha et al., 2004; Ruairi Brugha & Walt, 2001; Buse & Walt, 2000b; M. Reich, 2002). The representation issue raises the question of whose interests should be represented in the partnership and whose should not. The universality of multilateral institutions is diluted by partnerships, since some partners may represent a wide constituency of members, while others, such as the private sector or NGOs may not (Buse & Walt, 2000b). Accountability, which is broadly concerned with being held responsible for one’s actions, may also be interpreted in different ways by different partners. Both the public and private sectors have well-established mechanisms of accountability. However accountability within public-private partnerships may be less straightforward. Furthermore, since partnerships can involve a range of partners with different rights and responsibilities, achieving the governance goal of transparency may also raise difficulties. Thus it is important for public-private partnerships to specify what accountability means and how accountability can be implemented and assured with adequate transparency (M. Reich, 2002).

Additionally, such partnerships focus on much narrower programs of disease control, and neglect other important issues in health, such as developing good quality and accessible health systems, in which outcomes and impact are more difficulty to measure (Walt, 2001). Partnerships may also raise issues around equity, by choosing to
work in some countries with a particular disease rather than all countries (Buse & Walt, 2000b; Kichbusch & Buse, 2001; Walt, 2001).

Partnership effectiveness is very important to PPPs. As Buse & Walt (2000b) suggested future research would need to learn more about what makes a partnership “effective” and what factors contribute to partnership effectiveness on the ground, using these findings to develop appropriate guidelines, procedures and safeguards.

2.7. Key Challenges for International Health Cooperation and Possible Responses

2.7.1. Key Challenges in International Health Cooperation

International cooperation of health is crucial and there is little question that development assistance has yielded some major improvements in public health. With just a few years to go to the 2015 target date for achieving the MDGs, the rapid increase in the flow of development assistance to health, and the large number of donors active in the sector, have created a challenging environment for harmonisation and alignment efforts (Manning, 2008). The challenges in planning future levels and forms of international cooperation for health are enormous.

The first issue in international cooperation for health is overlapping mandates (either with the same purpose or in the same geographical area) (Buss & Ferreira, 2010; Walt & Buse, 2006). Although each organisation has its own comparative advantage, it is not clear that in practice these always coincide or are complementary. For example, just in the field of children’s vaccines and immunisation programs, there are overlapping interests among several existing organisations: WHO, the partners of the Task Force on Child Survival, and the newly established Children’s Vaccine Program of the Melinda and Bill Gates Foundation, among others (Walt & Buse, 2006). The danger of overlapping continues to exist, at both global and country levels (WHO, 2001).
Secondly the foreign fund project tends to reflect the interests and concerns of the donors, not the recipients. Donors influence priority-setting. Many governments and activists complain that the US government, in particular, already exerts too much control over the design and emphasis of local HIV/AIDS programs (Garrett, 2007). Donor-driven projects have generated problems at the country level, such as poor communication, coordination and duplication among partners (lacking clearly defined roles and responsibilities), high transaction costs, variable degrees of country ownership (government lacking control over outside donors’ decisions), and lack of alignment with local health systems (Wang, 2012). Problems arise because donors do not adapt their approach to differing circumstances on the ground in recipient countries, in effect relying on a one-sized-fits-all approach for all recipient countries (Radelet, 2004).

Thirdly the swelling numbers of actors in the health sector has resulted in a proliferation of projects. This increase in projects has led to fragmentation and duplication of effort, and placed a burden on health departments. As each donor wants its own project presentations, evaluations, accounting systems, and meetings, officials in health departments have to spend “most of their working hours entertaining visiting delegations, meeting donors, and preparing project documents” (Cliff, 1993, p. 239). For example, in 2005, the Tianshan District in Urumqi City, China, had five HIV/AIDS projects separately funded by China CARES, The World Bank, AusAID, DFID and US. Local AIDS authorities became inundated with project-related work, especially report writing. Staff coordinating multiple projects or projects which required separate reports for every activity funded were left with limited time to actually carry out the project activities (Zunyou Wu et al., 2011). According to OECD (2006a) government authorities in Vietnam in 2005 received 791 missions from donors, which means more than two missions a day, including weekends and holidays. The proliferation of channels of funds may also have increased the accompanying administrative costs (Manning, 2008; WHO, 2001). Some have estimated that 30-40
per cent of the resources expended may be the result of unnecessary transaction costs, duplicated efforts or missed opportunities for effective partnerships (Atwood, 2011).

Fourthly as there are so many different actors in the international health cooperation field, one of the main concerns is the extent of the lack of coordination between donors, governments, and other key public and private partners. There are many reasons for the problems faced in coordination both among and between governments and donors, including different interests, agendas, and cultures between the different actors. Poor coordination between organisations in health has been a problem long recognised at both the international and country levels (Walt & Buse, 2006). At the global level, the specialised agencies, funds, and financial institutions act as independent authorities, and tend to act on their own (Walt & Buse, 2006). At the country level, assistance to the health sector may come from many different donors, and although the coordination of these donors is agreed by all to be the responsibility of the government, many studies attest to the difficulties governments in this instance, MOHs -- have in coordinating this sometime “unruly melange” (Buse & Walt, 1997, p. 449). Additionally, the growth of global initiatives such as the Global Fund for AIDS, Tuberculosis, and Malaria has further complicated national coordination efforts (Walt & Buse, 2006).

Finally international health projects lack predictability, stability and sustainability. The predictability of finance is critical to the longer-term stability and sustainability of health plans (WHO, 2008a). Many health interventions require a long-term perspective, notably: health systems strengthening, particularly training and deployment of skilled doctors and nurses; the development and introduction of new drugs for treating diseases in low income countries; the treatment of chronic illnesses with drugs that are at present too costly for low-income countries, particularly for HIV/AIDS; and the eradication of diseases such as polio and malaria. Funding is influenced by global financial crisis, donor political considerations and relationship with and capacity of the recipient government. The relationship with the recipient government, in particular around issues of trust and accountability, also affects donor
decisions to provide multi-year commitments (OECD Working Party on Aid Effectiveness Task Team on Health as a Tracer Sector, 2011). Funding is uncertain and subject to macroeconomic and political changes, and lacks long-term focus. This makes it difficult for international health cooperation to support the sustainable development goals of the host countries.

2.7.2. Possible Responses

In view of the current situation in the area of international cooperation in health and dissatisfaction with the results obtained in development and health, many researchers engaged in global health began seeding solutions, a few of which are discussed below. These possible solutions for international communities and countries to improve the effectiveness of international cooperation on health are based on comprehensive literature reviews.

2.7.2.1. Aid Effectiveness

Background

The question of how to ensure development and improve aid and development effectiveness has long been debated, especially after the 1980s (Martini et al., 2012). Since then, new modalities of aid have been promoted such as sector-wide approaches and budget support, and several commitments have been taken by donors and governments to enhance aid effectiveness. At the beginning of the 21st century, it became clear that increasing aid resources had to be managed better. Donors and partner countries had been gathering in a series of High Level Forum on Aid Effectiveness during the last decade: firstly in Rome in 2003, then in Paris in 2005, and in Accra, Ghana in 2008; more recently from the 29th of November to the 1st of December 2011 in Bussan, South Korea. Since the first forum, significant steps towards improving aid quality and fostering development have been achieved.
Improving aid effectiveness is defined by the five principles of the "Paris Declaration". The Paris Declaration on Aid Effectiveness issued in 2005 committed both donors and recipients to principles (ownership, alignment, harmonisation, results, and mutual accountability) for multilateral and bilateral aid, and set 2010 as a timeline for improvement of practice (Figure 2). This was followed in 2008 by the Accra Agenda for Action (promoting predictability and use of country systems, and reductions in conditionality and relaxing of tied aid). The Accra Agenda for Action reaffirmed commitment to the original Paris Declaration principles, while also redefining the relationship between different parties working on aid and development calling for greater partnership between donors, recipients, governments, and civil society organisations (Accra Agenda for Action, 2008). More recently, the 4th High Level Forum on Aid Effectiveness, in its final declaration, established an agreed framework for development cooperation that embraces traditional donors, South-South co-operators, developing countries, civil society organisations and private funders (Busan Partnership for Effective Development Co-operation, 2011). The Busan Forum marked a turning point in international consideration of development cooperation as it moved from a focus that had been purely on aid effectiveness to a more holistic approach, looking at the contribution that effective development cooperation can make to overall development effectiveness (United Nations, 2012).
Country Ownership

Country ownership is central to better aid effectiveness (The Paris Declaration, 2005). It means that developing countries determine and implement their own development policies to achieve their economic, social and environmental goals. All development actors -- parliaments, central and local governments, CSOs, research institutes, media and the private sector -- should actively participate, and donors should respect country decisions and support efforts to increase local capacity (The Paris Declaration, 2005).

Alignment

Alignment means that donors base their overall support on partner countries’ national development strategies, institutions and procedures (The Paris Declaration, 2005). In
return, developing countries will improve the quality and transparency of their public financial management system.

**Harmonisation**

Harmonisation requires that donors make their actions more coordinated, transparent and agile. They should make common arrangements at country level to simplify and unify procedures to avoid overburdening developing countries. Harmonisation can drastically reduce transaction costs and facilitates the coherent implementation of development (The Paris Declaration, 2005).

**Managing for Results**

Managing for results means managing and implementing aid in a way that focuses on desired results and uses information to improve decision-making (The Paris Declaration, 2005). Developing countries should strengthen linkages between national development strategies and budget processes. Focusing on results avoids aid being lost in processes rather than directed towards outcomes.

**Mutual Accountability**

Accountability and transparency are excellent ways to ensure implementation of agreed commitments (The Paris Declaration, 2005). Donors should make aid predictable by providing timely, transparent and comprehensive information; and developing countries should strengthen parliament and civil society’s role in overseeing the development process (The Paris Declaration, 2005). All development partners need to undertake mutual assessments of progress in implementing agreed commitments.

Aid Effectiveness is crucial to international cooperation and is able to provide guidance -- especially by means of its harmonisation and alignment strategies to future cooperation processes. The ultimate aim of aid effectiveness efforts today is to help
developing countries build well-functioning local structures and systems so that they are able to manage their own development and reduce their dependency on aid.

2.7.2.2. Political and Administrative Commitment

Past experience shows definitively that political and administrative commitment is the key to success (WHO, 2001). Both donors and their partner countries should fulfill their political and administrative commitments. The political environment has strongly influenced the evolution of international health cooperation (Scriven & Speller, 2007). The international donor community should commit adequate grant resources for low income countries to ensure universal coverage of essential health interventions. The countries should enforce their political commitment. All partners need to fulfill their commitments, with a focus on practical and collective action within the agreed frameworks that build on the comparative advantages of each partner (Manning, 2008). The commitments also need to emphasise the long-term instead of focusing exclusively on short-term needs. This means strengthening key institutions to acquire true leadership in national processes; in the development of a future-oriented agenda; and in balancing specific actions destined to solve immediate problems with the generation of knowledge and the development of sustainable national institutional capacities (Buss & Ferreira, 2010).

2.7.2.3. An Alternative Response: South-South Cooperation

Today’s aid architecture has moved far from the traditional “North-South” donor-recipient paradigm to an increasingly complex picture involving actors at different stages of development, new sources of financing, and knowledge-sharing. Due to the proliferation of discriminatory commercial barriers, the decrease in aid for development (caused by the economic/financial crisis), the increase in foreign debt and the decline in prices for raw materials, South-South cooperation has grown in importance (Buss & Ferreira, 2010).
South-South cooperation refers to the sharing of knowledge and resources between middle-income countries with the aim of identifying effective practices (Task Team on South-South Co-operation 2010). Southern countries that have been witnessed quick growth and development, such as India, China and Brazil, have become aid providers and international investors. Brazil has been very active in providing aid for development to other countries in the fields of public administration, health, education, agriculture, the environment, energy and small companies; China and India have important technical training programs for citizens of developing countries, which in turn improves the institutional capacity of these countries (Buss & Ferreira, 2010). South-South cooperation is an excellent example of the way developing countries can help each other to accomplish much more than they can individually achieve and is an innovative, cost-effective and results oriented modality for transfer or exchange among developing countries of relevant knowledge and experience in the field of health (Buss & Ferreira, 2010).

2.8. Conclusion

The profile of international cooperation in health has changed considerably. The development of international health cooperation has been accompanied by a growing number of actors and increasingly complex governance and aid management arrangements. This chapter has reviewed the situation of international health cooperation and its influencing factors, set the context of four main players within international health cooperation and explored the key challenges and possible solutions.

In China, the current political environment and the commitment to redressing health have created unprecedented opportunities for international health cooperation. It will still be one of the strategic choices of the government in the foreseeable future. In light of the many and rapid changes in China, the review and analysis of international health
cooperation in China are timely and necessary. The next chapter will address the international health cooperation in China.
Chapter Three

International Health Cooperation in China

3.1. Introduction

Since the reform and the opening up of China the Chinese government has conducted extensive cooperation with the international community in health development. Various international institutions together with China’s health agencies at all levels have made a collaborative effort to carry out a series of activities related to health. Such cooperation has played an important role in health development. The contribution of international health cooperation for health development is unquestioned. As the world’s most populous country and a leading economic power China is also becoming a central player in the provision of assistance to developing countries.

To attempt to critically examine and describe the development of international health cooperation in China, this chapter describes China international health cooperation management mechanisms, policy strategies, and relevant national guidelines including a description of critical features of the Chinese health system; explores the benefits and needs of and the opportunities for international cooperation on health in China; and discusses the main international agencies and their activities. Finally, this chapter identifies the major challenges of current situation and future implication of the international health cooperation in China.

3.2. International Health Cooperation Management in China

The Chinese healthcare system has a complex division of authority and technical implementation that does not directly translate to components of other foreign health systems. This fact has the potential to complicate collaboration among the various stakeholders in global health. It is crucial for international organisations to have a sufficient understanding of this system in order to support effective collaborations at the national, provincial, or county levels.
3.2.1. Health Administrative Structure in China

There are many ministries or agencies that have health-related responsibilities in China. The Ministry of Health (MOH)* is the principal authority to set policy and supervise the different components of the public health system and affiliated institutions. It oversees health care in the country and addresses core public health issues. The other main organisations involved in health responsibilities are the National Development and Reform Commission; the ministries of Agriculture, Construction, Finance, Health, Labor and Social Security, Science and Technology, Civil Affairs; the State Food and Drug Administration; the State Administration of Traditional Chinese Medicine, and the National Population and Family Planning Commission. The Chinese Centre for Disease Control and Prevention (CDC) is an important agency that has policy and supervision provided by the MOH.

China’s health administrative system is a multiple tier structure headed by the MOH which reports to the State Council. Health authorities are established within governments at every level in China. They take instructions from the local government but also receive technical guidance from higher level health authorities. Based on China’s administrative hierarchy, there are four tiers of health authorities: central level (Ministry of Health), provincial level (provincial health offices/bureaus, including those of autonomous regions and municipalities directly under the central government), municipal/prefectural level (municipal/prefectural health bureaus) and county level (county health bureaus) (Figure 3). Each tier of the system has a Department of Public Health.

With authority and purview over the disease control component of the national health system, the MOH supervises the CDC, the technical implementing agency for disease control and prevention at the national level. The CDC then has its own counterpart

* The Ministry has changed its name to National Health and Family Planning Commission since March 2013. It is currently still under restructure.
CDC entities at the various provincial, prefecture, and county levels. This network of authority, supervision and implementation, results in an enormous system of MOH and CDC entities with more than 2200 provincial and county CDCs creating a national network of public health agencies.

Figure 3: China's Health Administration System Structure

3.2.2. Department of International Cooperation, Ministry of Health

The MOH brings together different sectors, international organisations, and NGOs to manage international cooperation on health in China. The Department of International Cooperation in MOH is in charge of cooperation between the MOH and international organisations, foreign government agencies and foreign institutions. The Department is
also responsible for assisting other departments to promote major international cooperative projects and carry out studies on world health. The duties and functions of the Department of International Cooperation are showed in Box 3. According to the “Administrative Rules for international health cooperation projects (For Trial Implementation)” issued by MOH (China Ministry of Health, 2007a), the international health cooperation program is under centralised management of the department of foreign affairs within the health administration departments and medical institutions at all levels. These departments are responsible for the administration and coordination of international cooperation programs.

Box 3: Duties and Functions of Department of International Cooperation, MOH

<table>
<thead>
<tr>
<th>Department of International Cooperation, MOH</th>
<th>Duties and Functions</th>
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<tbody>
<tr>
<td>o To draft relevant regulations and agreements of multilateral and bilateral cooperation with government and civil society.</td>
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<tr>
<td>o To organise the international cooperation of foreign governments, international organisations such as WHO, WTO and etc.</td>
<td></td>
</tr>
<tr>
<td>o To formulate cooperation strategies, plan projects, organise the implementation of projects, draft bilateral cooperation agreements, and organise the implementation of cooperation agreements.</td>
<td></td>
</tr>
<tr>
<td>o To manage, coordinate and supervise medical and health exchanges between China and WHO and other international organisations.</td>
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<tr>
<td>o To manage health aiding programmes offered by other countries to China as well as health aid programmes provided to other countries by China.</td>
<td></td>
</tr>
<tr>
<td>o To examine, approve and administrate institutions and programs engaged in health cooperation and exchanges.</td>
<td></td>
</tr>
<tr>
<td>o To manage health cooperation and exchange with international non-government organisation and affiliated institutions.</td>
<td></td>
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<tr>
<td>o To manage the Hong Kong, Macau and Taiwan affairs.</td>
<td></td>
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<tr>
<td>o To examine report and approve international health conferences conducted in China.</td>
<td></td>
</tr>
<tr>
<td>o To be responsible for assisting other departments within the Ministry to promote major international cooperative projects and day-to-day foreign affairs of the Ministry.</td>
<td></td>
</tr>
<tr>
<td>o To participate in the nomination and selection of employees to international organisations and Chinese embassies and consulates abroad.</td>
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3.2.3. National Guideline of International Health Cooperation

“Outline of the 11th Five-Year National Plan for the Development of Health Undertaking” (China Ministry of Health, 2007c) provides the guide for international health cooperation: international health cooperation should adhere to the principle of supporting and servicing for national health reform and national foreign affairs, tighten up the health cooperation with all other countries, further strengthen relation with international organisations such as WHO and Global Fund; through the bilateral, multilateral channels and non-governmental channels, it should actively strive for international cooperation program and funding, enhance the medical technology and health management; it should strengthen supervision and management of cooperative program and increasing efficiency of fund utilisation; meanwhile, it should actively carry out foreign medical assistance, support developing countries with HIV/AIDS, malaria and other infectious disease prevention and control, and help to train health workers; explore new ways and new channels of foreign medical assistant, improve its effectiveness, and serve the national diplomacy.

In 2007 the China MOH issued a paper “Administrative Rules for International Health Cooperation Programs (For Trial Implementation)”. The document clearly states that the principles of international health cooperation are equality and reciprocal benefits, results sharing, and observance of international norms. International health cooperation program should be in accordance with the requirements of local health development and with the overall deployment of national health development strategies (China Ministry of Health, 2007a).

In 2008, in accordance with the Administrative Rules for International Health Cooperation Programs (For Trial Implementation), MOH formulated another two relevant papers: “Financial Administrative Measures for Foreign Fund International Health Cooperation Program” and “Detailed Regulations on Management for National International Health Cooperation Program”. The first paper aims to tighten the control
of the foreign funds and improve their utilisation benefits. The second paper addresses the whole process of management with regard to initiating and approving programs, signing documents, use of funds, implementing, auditing, and overseeing projects and other matters. Currently, these three papers are the guide for international health cooperation management.

Understanding the network of compartmentalised chains of authority and guidelines is very important for a foreign entity wishing to collaborate with an identified Chinese counterpart. Lacking the understanding of the Chinese health system structures and these guidelines may create bureaucratic barriers to potential collaboration efforts from foreign entities.

3.3. Benefits of the International Health Cooperation in China

International health cooperation supports health development in China in a number of ways. The main contributions have been:

- increases in the overall investment in the health and development program
- improvements in the health outcomes in the project areas
- rich development experiences through introductions, tests and deployments of multiple methods
- improvement of project management
- contributions to capacity building and human resource development
- promotion of international exchanges and cooperation in health

3.3.1. Increases in the Overall Investment in the Health and Development Program

Overseas development assistance to China provided the funds that helped to fill the gaps left by the government. In China the rapid economic growth of the past two decades has not been reflected in increasing public investment in health. The fund investment on health makes up for insufficient funds in poor areas. Up until 2008 the
loans from the World Bank to the Chinese health and development program have totalled US$ 972.60 million (World Bank, 2008). This has been for 30 provinces, autonomous regions and municipalities (World Bank, 2008). In 2007 the total official development assistance to Chinese health sector from all the multilateral and bilateral donors was US$109.1 million (OECD, 2009a). International support has not only been provided to governmental agencies, but also to Chinese domestic NGOs, civil society organisation or grass-root organisations. From 2005 to 2008, in HIV/AIDS areas, US$ 11.8 million was provided for their activities, including training and prevention interventions (J. Sun et al., 2010).

3.3.2. Improvements in the Health Outcomes in the Project Areas

Health outcomes have improved considerably. The Implementation Completion Report of World Bank Disease Prevention Project shows that over the life of the project (1996-2004) both the infant mortality rate and under-five mortality rate dropped for all project provinces (World Bank, 2005). Also the incidences of measles, pertussis, cerebrospinal meningitis, Japanese B encephalitis, and hepatitis B have all declined, and the immunisation coverage has been largely increased (World Bank, 2005).

3.3.3. Rich Development Experiences through Introductions, Tests and Deployments of Multiple Methods

International cooperation projects bring not only funding to China but also introduce advanced theories and strategies. Some concepts such as disease intervention, community health, medical insurance, DOTS (Directly Observed Treatment, Short-course) have been widely used within the country. Some of these concepts have been incorporated into national health policy. Other strategies have been employed in several areas, such as using surveillance to promote testing and early diagnosis of HIV infection, and increasing universal access to AIDS care and treatment and preventing second-generation HIV transmission. These activities have significantly accelerated the
improvement of China’s HIV/AIDS surveillance strategy from passive to active case surveillance and combined the surveillance with case management (J. Sun et al., 2010).

3.3.4. Improvement of Project Management

Foreign-funded programs have a longer period of preparation than domestic projects. Because specific plans and targets are identified in the annual plan the projects are more efficiently implemented. Strict scientific management standards were applied to make the projects more transparent. Moreover monitoring and assessment systems were established to ensure successful achievement of pre-set objectives. The management process has been constantly adjusted and improved so it can be replicated in various regions and applied in domestic projects. The international cooperation projects allow valuable experiences and models conforming to China’s national conditions to be documented thus playing a significant role for improving the management of projects (Ooi, 2005). An example of this is the piloting of projects in their design, implementation, monitoring and management stages.

3.3.5. Contributions to Capacity Building and Human Resource Development

The international health cooperative projects have improved the varying competencies and capabilities of the different communities in China to operationalise health programs (Ooi, 2005). This is specifically applicable to staff training. A large number of administrative, management and professional staff have been trained who, through the experiences gained working in the projects, have become a strong force in their field (Ooi, 2005). Constant training is very important for building a qualified taskforce and for improving management and institutional innovation as well.

3.3.6. Promotion of International Exchanges and Cooperation in Health

International cooperation in health promotes Chinese exchange with other countries and increases friendship and mutual understanding with international communities. The implementation of international cooperation projects has established a platform of
communication and cooperation between China and other countries. For example, through the support of international cooperation projects, China’s National AIDS Reference Laboratory (NARL) has been strengthened (J. Sun et al., 2010). The reference laboratory passed the international quality control and quality assurance certification tests relating to HIV/AIDS in 2008. In a rapidly changing and populous middle-income country like China, international experience and technical expertise can assist China to attain more equitable health outcomes. It also supports progress towards the achievement of global health norms and standards as well as the Millennium Development Goals (WHO, 2008b).

3.4. Needs and Opportunities for International Health Cooperation in China

As a developing country with a huge population China still needs resources and help from international donors. The current political environment provides great opportunities for international cooperation.

3.4.1. Needs for International Health Cooperation in China

Because China accounts for over a fifth of the world’s population and is a major contributor in the control and spread of global health risks, what happens in China is important for the health of others around the world. Emergence of new infectious diseases, such as severe acute respiratory syndrome, and persistence of old pathogens (for example tuberculosis) illustrate why China’s health situation has global importance. Moreover China is a substantial part of virtually all global health challenges: the prevalence of chronic cardiovascular diseases and cancers; re-emergence of infectious threats such as avian influenza; nutritional transitions due to changing food, diet, and physical activity, and new environmental and behavioural threats.
In China there is still a range of public health challenges such as tuberculosis, HIV/AIDS, infectious diseases, and the growing problem of non-communicable diseases. The emerging infectious diseases (such as Severe Acute Respiratory Disease Syndrome or SARS, and avian influenza) are also increasingly important. Further there are health-related issues such as food safety, inequities in access to quality health services and huge disparities in health outcomes (United Nations System in China, 2004). There are also geographic public health challenges in China. Many of the rural areas are limited access to public health infrastructures. International collaboration is necessary to prevent and control infectious diseases, address environmental health issues, and regulate food, product and drug safety, and other health related issues (WHO, 2008b).

China remains a developing country with a low per-capita income and a large poverty-stricken population (State Council Information Office, 2011). While increasing public investment in health has contributed to improved health outcomes in China, health spending has not risen as rapidly as overall budget spending (UNDP China, 2008). The government health budget as a share in China’s GDP has remained quite low (China Ministry of Health, 2007b). Furthermore the national system faces heavy constraints at the provincial and local levels. Local governments bear heavy public expenditures that are not covered by central funding and weak financial controls sometimes impact on the flow of funds and their intended use (China Ministry of Health, 2007b). Moreover there are great disparities in the distribution of health resources, including health care practitioners, between cities and rural areas, coastal regions and inland regions in China, and this gap continues to grow (UNDP China, 2008). Seeking foreign capital from international financial organisations and bilateral governments for supporting health development in China is one of the strategic choices of the government (UNDP China, 2008).

China is ahead of schedule in achieving most of the Millennium Development Goals (MDGs), benefiting from the positive effects of both rapid economic growth and
targeted Government programs. But achieving all the MDGs, especially child and maternal mortality, HIV/AIDS and tuberculosis, and ensuring access to basic water and sanitation, is challenging (United Nations System in China, 2004). It is apparent that the Government alone cannot solve the problem.

The Government of China has made global commitments to improve health. Recently China has signed a number of important health related international agreements. The International Health Regulations or IHR (2005) and the WHO Framework Convention on Tobacco Control (FCTC) were signed respectively in 2003 and 2006. China has also ratified two other important frameworks: the Convention on the Elimination of All Forms of Discrimination against Women in 1980 and the Convention on the Rights of the Child in 1992. China has become an increasingly important part of global health over the past several decades strengthening international health cooperation, improving its health development, and making contribution to global health.

The shortage of trained personnel and insufficient institutional capacity within health care remains a serious challenge in China, particular in rural areas. Government agencies continue to request international technical support and contribution to health human resource development. The existing national human resources strategy for the health sector in China needs to be revised based on health reform plans, and needs to address the gaps in capacity and deployment for rural and remote regions, as well as at the peripheral levels of the health system (United Nations System in China, 2004). In a vast, diverse and populous country such as China, technical assistance and contribution of trained health professionals are still needed to achieve equitable national development and growth, as well as to assist China to adopt international norms, meet global standards and contribute to critical areas for health.

International cooperation in health development constitutes an important part of China’s policies of health diplomacy (Zhu Chen, 2012). On one hand China’s contributions to international public health are essential for cross-border issues such as
the prevention and control of infectious diseases, food and drug safety, and environmental health. On the other hand its considerable technical knowledge and an increasingly wide range of good public health experiences, lessons and practices should be shared with other countries in developing their health (Zhu Chen, 2012).

3.4.2. Opportunities for International Health Cooperation in China

Achieving international health cooperation requires immense political resolve. The current political environment and commitment to redressing health has created unprecedented opportunities for international health cooperation. It will still be one of the strategic choices of the government in the foreseeable future.

Since 2003 the Government of China has shown commitment to expand its investment in health. In the aftermath of the SARS epidemic public health has been placed higher on the national agenda. As a result a national consensus has emerged that the Government needs to re-assume greater responsibility for public health functions and services, including health surveillance, reporting, regulation, and prevention and control of infectious diseases (WHO China & Social Development Department of China State Council Development Research Centre, 2006).

International and regional cooperation is laid out as an important strategy in the State Council note and the 12th Five Year Action Plan (2011-2015). China has already established its international and south-south cooperation in a wide range of areas such as health, poverty and sustainable development, trade and investment, and technology transfer. As the world’s most populous country and a leading economic power China has a natural place at the heart of global dialogue and cooperation, and has become a major investor in many of the poorest developing countries.

The Government has made many international commitments to a wide range of health targets best exemplified by its acceptance of the MDGs. Supporting China's
achievement of the MDGs provides an important organisational framework for donor coordination in the country, and the majority of donors have reflected this in their country assistance plans (such as Australia, UK, and the US). China is ahead of schedule in achieving most of its MDGs as it has benefitted from the positive effects of both rapid economic growth and targeted government programs (WHO, 2011a). It may be an appropriate time to develop indicators that reflect the current health challenges, including for the control of non-communicable diseases, and stronger health policies and systems that could address inequalities in health outcomes (WHO, 2011a).

China’s domestic success in improving health care with limited resources provides it with a strong comparative advantage in giving technical assistance to other developing countries. Its experience in addressing its own domestic health challenges can serve as examples of best practice in global health projects in Africa and other parts of the world (Freeman & Lu Boynton, 2010).

3.5. International Agencies in China

Many international agencies are actively involved in health programs in China and they have contributed greatly to China’s health development. Main agencies of multilateral organisations, bilateral organisations, international NGOs and international public-private partnerships and their activities are discussed as bellows.

3.5.1. Multilateral Organisations

China has enjoyed increasingly active multilateral health cooperation. The Xiaokang (meaning “moderate prosperity”) development vision provides an unprecedented opportunity for cooperation between China, the UN and other multilateral organisations. In recent years links between the intergovernmental organisations and the Chinese Government have become even stronger (United Nations System in China, 2006). The cooperation with WHO, World Bank and other key organisations has pushed the development of health in China.
**World Health Organisation (WHO)**

As a core group of the UN health theme WHO plays an extremely important role in international health cooperation in China. The cooperation began in October 1978 in Beijing when the Minister of Health and the WHO Director-General signed a “Memorandum of Understanding on Health Technology Cooperation” in Beijing. In 1981 the WHO set up its office in Beijing thereby increasing and strengthening its friendly cooperative relations. In 2004 the Chinese Ministry of Health and the WHO Director-General signed a Memorandum of Understanding (MOU) to strengthen health cooperation and exchange, identifying key areas of cooperation (WHO, 2008b):

- public health priorities (rural health, prevention and treatment of major diseases, mechanisms for public health emergency response);
- control of major communicable diseases (HIV/AIDS, TB, Hepatitis B, Schistosomiasis, Malaria and other emerging diseases);
- non-communicable diseases (including health determinants such as environment, tobacco control, food safety);
- traditional medicine (including standard setting, quality control and safe use of Traditional Chinese medicine in accordance with World Health Assembly policies); and
- human resources for health.

During the period of 2002-2007 expenditures under the program budget totalled US$61.421 million. The country planning figure for the regular budget was US$7.08 million for the 2008-2009 biennium (WHO, 2008b).

**World Bank (WB)**

Another important multilateral organisation in China health sector is the World Bank. In early 1982 China submitted the Rural Health and Medical Education project proposal to the World Bank. This formally started the collaboration with the World Bank in the health sector (Foreign Load Office, Ministry of Health changed its name to
“Centre for Project Supervision and Management” in July, 2008). The World Bank loan projects have covered 30 provinces, autonomous regions and municipalities, except Tibet, Hong Kong Special Administrative Region (SAR), Macao SAR and Taiwan province.

There are many other multilateral organisations which are actively involved in China health area. Some multilateral organisations in China health sector and main areas of their support are showed in Box 4.

**Box 4: Key Multilateral Organisations in China Health Sector and Main Areas of Support (since 2004)**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Main Areas of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Development Bank (ADB)</td>
<td>Nutrition, surveillance, food safety, CSR, HIV/AIDS</td>
</tr>
<tr>
<td>Food and Agriculture Organisation for the United Nations (FAO)</td>
<td>Avian influenza, food safety</td>
</tr>
<tr>
<td>International Labour Organisation (ILO)</td>
<td>Occupational health and insurance</td>
</tr>
<tr>
<td>UN Foundation</td>
<td>Measles elimination</td>
</tr>
<tr>
<td>Joint United Nation Programme on HINV/ADIS (UNAIDS)</td>
<td>HIV/AIDS coordination</td>
</tr>
<tr>
<td>United Nations Development Programme (UNDP)</td>
<td>Environmental health, health sector reform, occupational health, food safety</td>
</tr>
<tr>
<td>United Nations Environment Programme (UNEP)</td>
<td>Environmental health</td>
</tr>
<tr>
<td>United Nations Industrial Development Organisation (UNIDO)</td>
<td>Health and trade issues, food safety</td>
</tr>
</tbody>
</table>

Source: modified from WHO (2008b)
3.5.2. Bilateral Agencies

Official development assistance is an extremely small proportion of the resources available to China. Donor countries provide assistance in the health sector through various channels. In recognition of the country’s consistent economic growth since 1995 a number of donors are redefining their aid programs to China. Some main bilateral agencies and their activities are presented below.

**Australian Embassy/ Australian Agency for International Development (AusAID)**

Australia became a western donor to China in 1981. It is one of China’s largest bilateral donors by volume of bilateral grant-based assistance. The shape and direction of AusAID’s China Program over the last decade has responded to the country’s rapid economic growth. In 2011 Australia remained one of China’s largest donors with projects focused on health, environment and governance (AusAID, 2012b). The total estimated Australian Official Development Assistance (ODA) to China in 2011–12 was AU$35.7 million (AusAID, 2012a). Health-related activities support the ongoing development of China’s capacity to halt and reverse the spread of HIV/AIDS, protect its population against emerging infectious diseases and strengthen its health systems. Australia is also providing expertise in community health, health planning, surveillance, food safety, disease control strategies and emergency response planning systems. These are all helping China to implement its national health reform plan (AusAID, 2012a).

**UK Department for international Development (DFID)**

DFID’s Country Assistance Plan for 2006-11 for China (2006) contains two priorities: to continue to support China’s efforts to achieve the MDGs on basic education, health, HIV & AIDS and water supply and sanitation; and to support the development of a global partnership for development. In the health sector DFID focuses on western provinces, working on child and maternal health, HIV/AIDS and TB, improving health services and reforms to the health system. According to the UK Foreign & Commonwealth Office, DFID had committed over £55 million to HIV and AIDS work
in China since 2000, £27 million to a World Bank project on TB control which covered 16 provinces, and over £31 million to strengthen China's health system so that more poor people could benefit from basic health services. DFID's program in 2007/08 was £33.16 million, provided entirely on grant terms (DFID, 2008). In March 2011 DFID closed its bilateral aid program to China. The relationship with China now identifies ways in which both countries can work together as partners on shared global development objectives on global public goods and poverty reduction.

**Japan International Cooperation Agency (JICA)**

JICA’s support for China focused on the three priority areas: cooperation to tackle environmental and other global issues including measures against environmental problems and infectious diseases; assistance for the opening and reforming policy, promotion of sound social development and the transition to a market economy, and promotion of mutual understanding (JICA, 2011). In the health sector, the cooperative areas included: polio control, expanded program on immunisation (EPI), tuberculosis control, serious infectious disease control and HIV/AIDS (JICA, 2005). With the rapid economic development and changes in China's economic structure Japan stopped providing new ODA loans for China in the 2008 fiscal year.

**Swedish International Development Cooperation Agency (SIDA)**

Sweden is a small donor in China. Development cooperation between China and SIDA started in 1979. In recent years the volume of this co-operation has been SEK 50-60 million per year (Government Offices of Sweden, 2010). Health is one of the cooperation areas where China and Sweden have signed an MOU on cooperation. One issue of considerable mutual interest in this area is infectious disease control (Government Offices of Sweden, 2010).
United States Agency for International Development (USAID)

USAID's bilateral health assistance programs in China focus on the threat of HIV/AIDS and other pandemic diseases (Biswal, 2011). Since 2007 the United States has supported programs to address HIV/AIDS problems in regions of high incidence in China. They have aimed to enhance the ability of Chinese local and provincial governments to respond to the disease in the areas of prevention, care, and treatment. US assistance also focuses on the development of health systems or models including monitoring and research that can be replicated or adopted by provincial governments (Lum, 2012).

3.5.3. International Non-government Organisations

International NGOs, such as the Ford Foundation have been coming to China since the start of the reform and opening period in the 1980s. They have been building partnerships and collaboration among different stakeholders and playing a significant role in promoting development in China. According to the Directory of International NGOs (China Development Brief (English)) there are over 200 International NGOs operating in China. In recent years the number of international NGOs involved with China’s health sectors has grown, the organisations themselves have begun to mature, and key partners including the Chinese government now increasingly recognise the importance of NGO participation. More recently a number of donors have increased funding levels for health development. For example, the Gates Foundation has committed US$50 million for HIV/AIDS and US$25 million for TB in 2007 (WHO, 2008b). Save the Children also increased health resources to China (WHO, 2008b). Some international NGOs which are involved in health related activities and their activities are listed in Table 5.
Table 5: Selected International NGOs Which Performance Health Project in China

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Start to work in China</th>
<th>Main actives</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Relief Fund for China</td>
<td>Established in 2003; in China since: 2003</td>
<td>This US-based organisation makes small grants to grassroots AIDS service and education organisations in China. They hope to foster grassroots leaders and organisations in China, providing start-up assistance to new groups, promoting innovative pilot projects, encouraging exchange, communication and partnerships among Chinese AIDS-related NGOs and, where appropriate, helping Chinese organisations to access larger grants. Current grantees are in Sichuan, Beijing, Nanjing and Shanghai.</td>
</tr>
<tr>
<td>Australian Red Cross</td>
<td>In China since: 1994</td>
<td>The Australian Red Cross (ARC) delivers programs through the provision of technical assistance and some financial support to Provincial Red Cross branches.</td>
</tr>
<tr>
<td>Bill and Melinda Gates Foundation</td>
<td>The foundation created in 2000; in China since: 2000</td>
<td>The foundation works with a range of partners—including the government, nongovernmental organisations, and other groups—to implement our HIV prevention efforts in China. Funding for HIV prevention in China supports both governmental and nongovernmental programs that are focused on: prevention services for high-risk groups; HIV testing; prevention and support for people living with HIV; stigma reduction.</td>
</tr>
<tr>
<td>Clinton Foundation</td>
<td>Founded in 1997; in China since: 2004</td>
<td>Since 2004, the foundation has supported ARV treatment for HIV-positive children in Henan Province. It has also developed laboratory capacity building programs to improve laboratory testing and procedures; provided training and mentoring for health workers and technicians, and developed training manuals and protocol guidelines in collaboration with the Ministry of Health and Centre for Disease Control. Other initiatives include work to increase procurement of ARVs, to expand paediatric care, to integrate testing into TB clinics and to support community health education.</td>
</tr>
<tr>
<td>Damien Foundation</td>
<td>Established in 1964; in China since: 1998</td>
<td>The foundation continues to work with people affected by leprosy in Tibet and Guangxi. And also overseen tuberculosis control programs in Tibet, Inner Mongolia and Qinghai. It supports physical rehabilitation programs, and works to prevent disability among people who, although cured of leprosy, are prone to injuring themselves because they have lost sensation in their hands and feet. Work includes training of health care professionals and development of IEC materials, along with the supply of equipment and medicines.</td>
</tr>
<tr>
<td>Family Health International 360</td>
<td>Established in 1971; in China</td>
<td>FHI 360 is working to prevent the spread of HIV, especially among and from high risk groups and also to improve access</td>
</tr>
<tr>
<td>Organization</td>
<td>Since</td>
<td>Programs</td>
</tr>
<tr>
<td>--------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>(FHI 360)</td>
<td>2003</td>
<td>Implements the USAID-funded HIV/AIDS Prevention, Care and Treatment program in Yunnan and Guangxi Provinces (2007-2012); provides technical assistance for DFID-GFATM China HIV/AIDS Program in the areas of antiretroviral therapy, injecting drug users, and voluntary counselling and testing; conducted a longitudinal enhanced evaluation of ART patients in Guangxi from May 2007 through April 2010; provided program and administrative support to the Gates Foundation's HIV and TB program development in 2010.</td>
</tr>
<tr>
<td>Netherlands Red Cross</td>
<td>1996</td>
<td>In 1996 the Netherlands Red Cross began working in the Tibet Autonomous Region on disaster relief and preparedness and primary health care in rural needs. It is now providing funding support for China Red Cross Society branches in Changchun, Shenyang, and Beijing, along with training in program management skills, resource mobilization, English language, leadership and dissemination of the Red Cross/Red Crescent principles.</td>
</tr>
<tr>
<td>PATH</td>
<td>1979</td>
<td>Since 1979, PATH has collaborated with Chinese government agencies, NGOs, research institutes, and manufacturers to improve health, particularly reproductive, maternal, and child health. PATH opened its representative office in Beijing in 2003. Currently, they are implementing programs to empower and enhance the health of young girls in rural China, increasing access to Japanese encephalitis vaccine through work with both private- and public-sector partners, working with research partners to develop new screening tests that detect human papillomavirus (a precursor of cervical cancer) and are safe, accurate, reliable, and acceptable to women and health care providers, supporting development of a malaria vaccine candidate through partnerships that include a Chinese biotechnology enterprise and the World Health Organisation.</td>
</tr>
<tr>
<td>Project HOPE</td>
<td>1983</td>
<td>Project HOPE has partnered with Chinese leadership and Ministers of Health since 1983 to address some of the country’s most pressing health issues including children’s heart defects, diabetes, HIV/AIDS and nurse education. Significant programs include: helped in the development of the facility of the Shanghai Children's Medical Centre, and supported with ongoing health care professional training; the China Diabetes Education Program - a health education initiative that has trained and educated more than 200,000 health professionals and patients since its beginnings in 1998; HIV/AIDS Health Professional Education Program - this program, developed in 2003 decreased mortality of HIV/AIDS patients in Hubei Province by 72 percent.</td>
</tr>
<tr>
<td>Save the Children</td>
<td>1919</td>
<td>Since 1995, Save the Children’s became one of the largest...</td>
</tr>
</tbody>
</table>
(UK) | in China since: 1920 | international NGO programs in China. In all program areas the organisation works closely with government partners, introducing its distinctive approach through Child Rights Training for agencies and individuals that work directly with children or on related research and policy. HIV/AIDS has been an important area of work, starting in 1996. Save the Children has also provided technical support for several local NGOs, and supported empirical research into issues such as bilingual education, children and migration and inter-generational poverty.

The Ford Foundation | Established in 1936; in China since: 1988 | In 1988, under a special agreement with the State Council, it became the first international non-government organisation to establish an office in Beijing, with the Chinese Academy of Social Sciences acting as a local counterpart. From that time, grant-making was concentrated in four main fields: legal system reform; reproductive health; environment and development, and economic reform and its social impacts. In addition, the foundation has ongoing, subsidiary programs in international relations, civil society, and economics and development finance.

The International HIV/AIDS Alliance | Set up in 1993; in China since: 2001 | Alliance China, works with 45 partner organisations in ten cities across three provinces in the South West of China: Yunnan, Sichuan and Guangxi. The Alliance supports local organisations working on prevention projects with people who inject drugs and men who have sex with men. It also supports community organisations providing care and support for people living with HIV.


### 3.5.4. International Public-Private Partnerships

Public-Private Partnerships (PPPs) have been increasingly recognised as an effective and appropriate mechanism to manage the complexity of the development challenges and the attainment of the MDGs. Two public-private partnerships, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI) have played an important role in influencing the national health agenda in China. China is also a donor to the GFATM, and has been a board member representing the Western Pacific Region since its foundation. Additionally there are many other public-private partnerships such as the China Health Alliance which addresses TB and AIDS in China and is active in the health sector.
GFATM

The GFATM grants greatly exceed funding provided by multilateral and bilateral agencies and play an increasingly important role in influencing the national health agenda. Since 2003 China has applied for and been awarded nearly $1 billion in grants, becoming the fourth-largest recipient of funds behind Ethiopia, India, and Tanzania. GFATM funding for HIV/AIDS has helped to support HIV treatment, care and prevention, reduce transmission, and mobilise civil society to scale up HIV/AIDS efforts. GFATM assistance for TB control has focused on expanding DOTS, improving health promotion, capacity building and addressing major threats to TB control (for example drug resistant TB, TB in internal migrants, TB/HIV co-infection). GFATM efforts to control malaria focus on addressing high transmission regions and rolling back re-emerging malaria.

GAVI

GAVI is a global health partnership launched in 2000 and is dedicated to saving children’s lives and protecting people’s health through increased access to vaccines and improved health systems. The partnership comprises partners, including UNICEF, WHO, the Gates Foundation, the World Bank, developing country governments, donor country governments, the vaccine industry, civil society groups, and research and technical health institutes (GAVI, 2010). Since 2002 GAVI has supported expansion of Hepatitis B immunisation to all Chinese newborn infants, providing US$38 million of co-funding for the US$76 million China GAVI project on Hepatitis B vaccination and immunisation injection safety (WHO, 2008c).

3.6. Major Challenges of International Health Cooperation in China

Though China is still a developing nation it no longer receives funding from many bilateral and multilateral agencies. International aid to China is declining, bilateral ODA flows to China for health & population are anticipated to decrease (OECD, 2012b) (Figure 4). In recognition of consistent economic growth since 1995, a number of donors have re-defined their aid programs to China. For instance, Germany’s international cooperation agency GIZ ceased bilateral aid to China in 2009, the United Kingdom ended bilateral aid in 2011, and Canada will phase out bilateral aid by 2014.
Figure 4: Total ODA Net and Bilateral Official Development Assistance Commitments for Health & Population to China (2006-2010)

With respect to declining ODA levels, a large part of the country with highly complex and layered administrative structure may not have enough time for the entire government structure at all levels to re-allocate resources to ensure international programs’ sustainability. In a vast, diverse and populous country such as China, major economic, legal and social challenges remain. International aid and technical assistance is still needed in China. Over the next 20 years China will need to deepen reforms to reduce the risk of a hard landing from its economic boom and to manage an ageing population, rising inequality, environmental stresses, and external imbalances (World Bank & Development Research Center of the State Council of the People’s Republic of China, 2012).

There are many ministries or agencies which have health related responsibilities in China however the communication and collaboration among them is weak. The implementation of China’s health policies does not rely solely on the MOH and its counterparts at lower levels. There are no clear responsibilities, power and resource allocation of some key sectors and lack of accountability for implementation of international health cooperation programs (UNAIDS,
While the MOH remains the primary focal point of the international health cooperation several key areas of work are the responsibility of other ministries or require a coordinated effort by several ministries. The limited communication between agencies results in poor implementation of programs (UNAIDS, 2008). In a modern China it is recognised that collaboration beyond the health sector is necessary to address complex public health issues (WHO, 2008b).

In addition to poor communication between Chinese health authorities, the cooperation among international donors is also limited. This is due to the fact that donors and Chinese government have not put a priority on harmonisation and donor coordination (DFID, 2006; Ooi, 2005; SIDA, 2007). Cooperation among donors is limited, partly due to the lack of the usual coordination mechanisms, and also from the donors’ point of view there is a limited interest in concrete coordination. Different cooperation modalities constitute a technical barrier. In order to improve efficiency and to avoid duplication and waste, the efforts of the various actors in the international health cooperation should be coordinated to improve the exchange of information.

China is an unusual recipient country because it is itself a large donor that has been giving and providing aids for decades to a large number of countries. The development of China’s role as a donor, boosted by the African Summit in 2006, has gradually added other components to the donors’ agenda for cooperation with China (WHO, 2008b). Several multilateral and bilateral donors have made efforts to cooperate with China on development cooperation with Africa (AusAID, 2006; DFID, 2006; WHO, 2008b). The World Bank currently classifies China as a middle-income country. Therefore how to develop cooperation and stress transparency, governance, ownership and sustainability is a consideration for donor communities.

3.7. Conclusion

This chapter has discussed China’s management structure and policy related to international cooperation in health, and summarised benefits and achievements from the cooperation. It also has analysed the needs and opportunities of Chinese international health cooperation and examined the main international agencies and their activities and working areas in China. Finally it has argued that although much progress has been made China has additional and
future challenges to face and overcome with continued support from the international community.

The global picture and China’s profile of international health cooperation have been described. With hundreds of new health actors emerging, the traditional system of global health governance which relied on governments and intergovernmental organisations alone has decreased and a new system is emerging in which multiple actors, both state and non-state, are playing an increasingly active role. The idea that partnerships represent a superior way of cooperation marks a departure from traditional public health approaches. The next chapter will focus on an important public health approach, partnership.
Chapter Four

Partnerships in Public Health

4.1. Introduction

The changing global environment and its demands for new and innovative ways of working signal the need for different kinds of partnerships. Partnership remains an evolving concept and practice. Partnership can afford a scale and integration of services that is impossible for any actor operating alone. In the case of major public health issues such as HIV/AIDS, TB and malaria, the multisectoral nature of the epidemics and the resulting impact on the national social fabric cannot be ignored. All the pandemics require responses which are, in many cases, in partnership with parties both within and outside of the health sector.

This chapter explores the notion of partnerships and their public health context a little further – what they mean, what types exist, the key factors contributing to the success of partnerships. Then the main challenges and barriers in building effective are discussed.

4.2. Concepts of Partnership

This section briefly addresses some core conceptual issues of partnership before discussing the practice of partnership. These core conceptual issues include notion of partnership, the importance of partnership in public health, and types of partnership.

4.2.1. Notion of Partnership

The notion of partnerships for development cooperation is not new. Numerous definitions have been proposed to characterise what partnership means, focusing on objectives, responsibilities and gains (Buse & Walt, 2000a). Reviewing the literature reveals that there is little common understanding regarding the meaning of partnership. Generally partnership is an umbrella term and is often used interchangeably with words such as interagency, cooperation, joint working or inter-professional all of which can have more specific meanings. Brinkerhoff (2002, p. 21) defined the ideal type of partnership as follows:

Partnership is a dynamic relationship among diverse actors, based on mutually agreed objectives, pursued through a shared understanding of the most rational division of labour based on the respective comparative advantages of each partner. Partnership encompasses mutual influence, with a careful balance between synergy
and respective autonomy, which incorporates mutual respect, equal participation in decision making, mutual accountability and transparency.

However, as Brinkerhoff (2002) argued, there are three obvious problems with these ideal-type definitions: 1) the extent to which they can be operationalised is unclear; 2) they may not be universally appropriate; and 3) their justification is subjective and values-based. As a result, ideal types tend to hinder understanding of how partnerships can be helpful in the real world. It may be more appropriate to map partnership practice onto some scalar dimensions.

In the health sector, Kickbusch and Quick (2007, p. 69) described partnership as a means to "bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles". In this definition, agreement on key principles is thought to be crucial, as well as the maintenance of a balance of power between the parties, to enable each to retain its core values and identities (Buse & Walt, 2000a).

For the purposes of the research, the researcher adopts the Audit Commission’s (1998, p. 8) definition of partnership as:

A joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint program, as well as sharing relevant information, risks and rewards.

This definition is compatible with a wider range of terms than “partnership”, including similar terms such as “cooperation” and “collaboration”. Therefore what the above definitions implies is that a partnership is a shared commitment, where all partners have a right and an obligation to participate and will be affected equally by the benefits and disadvantages arising from the partnership.

4.2.2. The Benefits and Values of Partnership in Public Health

Effectively addressing the determinants of health and achieving health equity requires actions and partnerships that extend beyond the health sector to implement forms of collaboration, cooperation and integration between sectors (WHO, 2009a). Collaboration in partnership with a wide range of groups from many sectors has been the central feature of public health practice since the mid-19th century, and it is even more crucial now. A definition of public health by Beaglehole et al. (2004, p. 2084) “Collective action for sustained population-wide health improvement” emphasises that public health practice needs collective or collaborative action.
Peckham (2007) argued that the partnership or collaboration is an essential aspect of public health in four key ways: requiring action by a range of international, national and local agencies to tackle the key determinants of health (as conceptualised in the social model of health); seeing public health as a shared responsibility; needing to avoid overlap and duplication; and recognising the important role individuals and communities play in promoting their own health.

Working in partnership with other organisations has many benefits. The Audit Commission (1998, p. 9) identified five main reasons why agencies form partnerships: 1) to deliver co-ordinated packages of services to individuals; 2) to tackle so-called ‘wicked issues’, that is, cross-cutting, complex problems where we do not really know the best way of responding to the issue at stake; 3) to reduce the impact of organisational fragmentation and minimise the impact of any perverse incentives that arise from it; 4) to bid for, or gain access to, new resources, and 5) to meet a statutory requirement. A partnership practice guide (Victorian Council of Social Service, n.d., p. 3) concluded the benefits of partnering as “partnerships can allow for diverse thinking and values to lead to better outcomes; provide opportunity to share a workload and resources; build capacity of their members; create the environment for taking risks in developing new service models; and create the motivation for people to pull together, which in turn drives and sustains the partnership”.

Partnership approaches are also important for the health promotion. Health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (WHO, 1986, p. 1). Since the first global conference in health promotion sponsored by WHO in Ottawa in 1986, partnership has been emphasised as an important approach in health promotion.

Partnership has been linked with health promotion in each global health promotion conference. The first global conference in health promotion declared that health promotion is a multi-disciplinary pursuit in the advancement of health, equity and sustainable human development (Chu, 2009). In the 2nd International Health Promotion Conference held in Adelaide in 1988, where the theme was healthy public policy, Mahler, the Director-General of the WHO stressed that community participation and collaboration between all sectors of government were crucial aspects of healthy public policy. The 3rd International Conference held in Sundsvall, 1991, focused on environmental issues, and emphasised that human health
promotion was explicitly linked with the health of the physical environment. Expanding and consolidating partnerships for health is one of the priorities identified in the 4th International Conference on Health Promotion. One of the objectives of the 5th Global Health Promotion Conference was to stimulate partnerships for health between different sectors and at all levels of society. The Bangkok Charter (WHO, 2005, p. 3) for Health Promotion in a Globalise World from the 6th Conference also requires all sectors and settings to “partner and build alliances with public, private, nongovernmental and international organisations and civil society to create sustainable actions”. The theme of “Partnerships and intersectoral action” in the 7th Conference in 2009 discussed how meaningful partnerships can be struck across sectors and which are based on common objectives and joint ownership.

4.2.3. Types of Partnership

In addition to contributing to conceptual clarity, distinguishing different types of partnership is considered important for operational purposes. Partnerships vary enormously in terms of their purpose, scope, complexity, level of engagement (local to global), size and diversity of partners. Different types of partnerships are motivated by diverse factors, have varying governance requirements and face distinct operational challenges.

According to the literature partnership can have be classified into different types (Table 6). Powell and Glendinning (2002) categorised partnerships according to which sectors are involved as in public-private, public-public, public-voluntary and public-community partnerships. Pratt, Gordon and Plamping (1999) divided partnership into four types of behaviour, competition, co-operation, co-ordination and co-evolution, with true partnerships including parts from each and movement between them.
In addition, as Peckham (2007) argued, a categorisation of being strategic (or co-ordinating), facilitative or implementing partnerships is useful as it highlights different function of the partnership. Based on the different functions, WHO (1999) provided a typology to classify partnership. These are: research and development partnerships; technical assistance/service support partnerships; advocacy partnerships; and financing partnerships. In the context of public health Peckham (2007) stated that in practice partnership occurs at a number of levels. These include: the international level (between governments and international agencies, as in the WHO); the national level (for example in China between devolved areas/regions within national government); the local level (between key local agencies such as local government, health bureau, voluntary agencies); the community level (locality or area based such as community partnerships), and the individual level (between individuals working jointly).
Partnerships also can be differentiated by the type of commitment they undertake. The commitments are Project Partnerships (time-limited for the duration of a particular project), Problem-oriented Partnerships (arise in response to a publicly identified problem and will remain as long as the problem persists), Ideological Partnerships (possess a certain viewpoint that they are convinced is the correct way of seeing things), and Ethical Partnerships (have a sense of ‘mission’ and have an overtly ethical agenda, which seeks to promote a particular way of life) (Carnwell & Carson, 2005).

Partnerships in the health sector can be for various purposes. These purposes have been categorised by the Initiative on Public-Private Partnerships for Health which are summarised in Table 7. The table outlines the possible roles and benefits for different partners in PPPs for health, education and poverty alleviation.
### Table 7: Roles in Multi-stakeholder Public-private Partnership

<table>
<thead>
<tr>
<th>Partner</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global private sector</td>
<td>• Core business competency</td>
</tr>
<tr>
<td></td>
<td>• Strategic philanthropy</td>
</tr>
<tr>
<td></td>
<td>• Policy advocacy</td>
</tr>
<tr>
<td></td>
<td>• Program leadership</td>
</tr>
<tr>
<td>International donors</td>
<td>• Resources</td>
</tr>
<tr>
<td></td>
<td>• Development expertise</td>
</tr>
<tr>
<td>International NGOs</td>
<td>• Global networks</td>
</tr>
<tr>
<td></td>
<td>• Implementation experience</td>
</tr>
<tr>
<td></td>
<td>• Development expertise</td>
</tr>
<tr>
<td>Academic institutions</td>
<td>• Education expertise</td>
</tr>
<tr>
<td></td>
<td>• Technical expertise</td>
</tr>
<tr>
<td></td>
<td>• Monitoring and evaluation capability</td>
</tr>
<tr>
<td>Local private sector</td>
<td>• Resources</td>
</tr>
<tr>
<td></td>
<td>• Local leadership</td>
</tr>
<tr>
<td></td>
<td>• Entrepreneurship</td>
</tr>
<tr>
<td></td>
<td>• Execution on the ground</td>
</tr>
<tr>
<td>Local government</td>
<td>• Stewardship</td>
</tr>
<tr>
<td></td>
<td>• Openness to innovation</td>
</tr>
<tr>
<td>Local technical agencies (private and NGOs)</td>
<td>• Development expertise</td>
</tr>
<tr>
<td></td>
<td>• Implementation expertise</td>
</tr>
<tr>
<td></td>
<td>• Technical expertise</td>
</tr>
<tr>
<td></td>
<td>• Partnership brokering</td>
</tr>
</tbody>
</table>

Source: amended from *Public-private partnership for health—what does the evidence say?* (Thomason & Rodney, 2009, p. 169)

### 4.3. Effective and Successful Partnerships

In understanding partnership it is important to identify what a successful partnership will require. It is clear that there are no one-size-fits-all rules for successful partnerships. This section identifies and discusses some basic principles for effective and successful partnership.
The purpose is to provide a starting point for a discussion about potential solutions for dealing with core operational challenges.

Three factors have been reported that govern an effective partnership: a partnership that is clear about its goals and objectives; partners who are aware of their roles and responsibilities; and a partnership that has a clear strategic overview of how it is performing through robust monitoring and evaluation (D. Hunter & Perkins, 2012).

Peckham (2007) concluded that successful partnerships have two dimensions – process success and outcome success. Successful processes require the commitment and engagement of partners; agreement about purpose; high levels of trust, reciprocity and respect; favourable political and social conditions (finance, institutional arrangements, and legal structures); satisfactory accountability arrangements and adequate leadership and management. Successful outcomes of health and social care partnerships require improved service delivery to users and the public; greater equity; improvements in efficiency and effectiveness; improved experiences for staff and informal workers and overall improvements in health status (Dowling, Powell, & Glendinning, 2004; Peckham, 2007). Measurement of partnership success requires, therefore, some attention to identifying relevant criteria along these two dimensions.

Markwell (2003) identified six key elements of good practice for partnerships to work successfully: 1) leadership (including shared vision, ownership and commitment, and recognition of key external relationship); 2) organisation (including public participation, flexible working arrangements, transparent management and communication); 3) strategy (including strategic development, information and evaluation and action and review); 4) learning (including valuing people, developing knowledge and skills and supporting innovation); 5) resources (including building social capital, pooling financial resources and using information and technology appropriately); and 6) programs (developing coordinated programs and integrated services through joint planning, focused delivery and monitoring and review).

There are many factors associated with partnership success. Mattessich, Murray-Close, & Monsey (2001, p. 8) identified 20 critical success factors, grouped into six categories. These 20 factors have been extrapolated through an extensive review of the literature and are quoted in Table 8. However as Hunter et al (2011) argued how these various factors get played out in
actual practice, their respective weighting, and the balance between them, will vary according to the particular partnership in question, its purpose and the context in which it is located.

**Table 8: Factors Associated with Partnership Success**

<table>
<thead>
<tr>
<th>Environment</th>
<th>History of collaboration or co-operation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Collaborative group seen as a legitimate leader</td>
</tr>
<tr>
<td></td>
<td>Favourable political and social climate</td>
</tr>
<tr>
<td>Membership</td>
<td>Mutual respect, understanding and trust</td>
</tr>
<tr>
<td></td>
<td>Appropriate cross section of members</td>
</tr>
<tr>
<td></td>
<td>Members see collaboration as in their self-interest</td>
</tr>
<tr>
<td></td>
<td>Ability to compromise</td>
</tr>
<tr>
<td>Process and structure</td>
<td>Members share a stake</td>
</tr>
<tr>
<td></td>
<td>Multiple layers of participation</td>
</tr>
<tr>
<td></td>
<td>Flexibility</td>
</tr>
<tr>
<td></td>
<td>Clear roles and policy guidelines</td>
</tr>
<tr>
<td></td>
<td>Adaptability</td>
</tr>
<tr>
<td></td>
<td>Appropriate pace of development</td>
</tr>
<tr>
<td>Communication</td>
<td>Open and frequent</td>
</tr>
<tr>
<td></td>
<td>Informal relationships and communication links</td>
</tr>
<tr>
<td>Purpose</td>
<td>Concrete, attainable goals and objectives</td>
</tr>
<tr>
<td></td>
<td>Shared vision</td>
</tr>
<tr>
<td></td>
<td>Unique purpose</td>
</tr>
<tr>
<td>Resources</td>
<td>Sufficient funds, staff, materials and time</td>
</tr>
<tr>
<td></td>
<td>Skilled leadership</td>
</tr>
</tbody>
</table>

**4.4. Barriers and Main Challenges in Building Effective Partnerships**

Despite mature arrangements for partnerships to work in many areas, and much support for joint working in principle, many barriers still exist. These include cultural issues such as a lack of shared values and language, the inherent complexity of intersectoral collaboration for public health, and macro issues including political and resource constraints (Taylor-Robinson et al., 2012).

Partnership building can be challenging because there are so many complex dimensions involved. These challenges result from the inherent difficulties of getting a range of agencies with differing purposes, structures and ways of doing things to work together.
Based on the literature, the following key operational challenges relating to building effective partnerships have been identified:

- **partnership inclusion.** A first key operational challenge of effective partnership is getting the right actors around the table. The identification of relevant stakeholders and an “optimal” level of inclusion must, however, derive directly from the specific purpose and goals of the partnership (Malena, 2004).

- **lack of clarity of roles and responsibilities** (Audit Commission, 1998; D. J. Hunter et al., 2011; Malena, 2004; Rowitz, 2009). A second important operational challenge is ensuring that the purpose and expected results of the partnership as well as the respective roles and responsibilities of each partner are clearly defined and commonly agreed. Though this may seem obvious it is described by practitioners as a classic example of “more easily said than done” and, in reality, many partnerships fail to explicitly specify goals, expectations and clear roles (Malena, 2004).

- **authority/power sharing.** All partners engage as equals in the decision-making process. Lack of authority slows up decision making and frustrates progress (Audit Commission, 1998; Foodvision, 2009). Moreover, as Malena (2004) argued, the ways in which stakeholders interact, deliberate and make decisions within partnerships have important implications not only for the outcomes of the partnership but also for the evolution of multi-lateral governance more generally.

- **competition between organisations.** Although some competition between organisations can be motivating, excessive competition can result in an unwillingness to co-operate and potential duplication (Foodvision, 2009).

- **conflict.** When different organisations work together it can be difficult to adapt to each other’s style of working. Also each organisation’s expectations of partnership working may be different, which can lead to conflict when attempting to establish priorities and goals (Foodvision, 2009). Conflict can associate with difference in perspective, priorities, assumptions, values, beliefs, language, and emphases on task and process (Foodvision, 2009; Israel, Schulz, Parker, & Becker, 1998). Frequently conflict also arises over funding (Israel et al., 1998).

- **communication.** Too much and too little communication can lead to problems. Too many meetings can put partners off attending; too little communication can result in duplication of effort, lack of understanding and mistrust amongst partners.
time. The partnership working approach often takes longer to produce results than most organisations anticipate. For example, it takes time to develop trust between partners which can slow up the process of making decisions.

- expensive. Many of the costs involved, particularly senior and middle managers’ time, are not routinely recorded and few partnerships have precise information about the costs of their activities (Audit Commission, 1998).

- monitoring and evaluating the partnerships’ effectiveness (Audit Commission, 1998; Perkins, Smith, Hunter, Bambra, & Joyce, 2010). It is difficult to monitor and evaluate for various reasons such as the long timescales for achieving impact, different perspectives on what success means, the complexity and variability of partnership interventions, and the different contexts within which partnerships work.

4.5. Conclusion

This chapter has explored the concept of partnership, the value and impact of partnerships in public health, effective and successful partnerships, and potential challenges and barriers. As this chapter has sought to highlight partnerships are notable for their considerable complexity and diversity which, in turn, impact on their development and effectiveness.

Many public health issues, especially for the HIV/AIDS response, require a partnership approach, the mobilisation of collective strengths and resources, mutual accountability and a sense of common purpose. Strong partnerships have been and will remain the core of national HIV/AIDS responses. The next chapter will concentrate on HIV/AIDS prevention and control in China.
Chapter Five
HIV/AIDS Prevention and Control in China

5.1. Introduction

HIV/AIDS has posed an increasingly serious issue in China. In recent years the Chinese government has taken further intensified efforts to combat HIV/AIDS. The efforts have included high-level political commitment, supportive policy development, increased financial allocation, large-scale initiatives, expanded international cooperation and greater involvement of non-governmental organisations. Meanwhile gaps and challenges coexist impacting on the implementation and the results of national HIV/AIDS programs. Thus further government efforts are needed to improve and tailor the actions to meet the requirement of HIV/AIDS control in China.

This chapter first reviews the current global HIV/AIDS epidemic and response, and then gives a brief overview of China’s HIV/AIDS epidemic and of the progress and issues in the response to HIV/AIDS in China. International cooperation and partnerships in HIV/AIDS in China, as well as the main challenges to cooperation and partnerships, are discussed in this chapter.

5.2. Global HIV/AIDS Epidemic and Response

Human immunodeficiency virus (HIV), the virus that causes AIDS, “acquired immunodeficiency syndrome,” has become one of the world’s most serious health and development challenges. It not only affects the health of individuals, it impacts on households, communities, and the development and economic growth of nations. HIV prevention remains one of the world’s development priorities.

5.2.1. Global HIV/AIDS Epidemic

The first cases of AIDS were reported in 1981. According to UNAIDS/WHO (2009) almost 60 million people have been infected with HIV and 25 million people have died of HIV-related causes since the beginning of the epidemic. AIDS-related illnesses remain one of the leading causes of death globally and are projected to continue as a significant global cause of premature mortality in the coming decades (WHO, 2008c).

Globally in 2011, 34.0 million [31.4 million–35.9 million] people were living with HIV, and 1.7 million [1.5 million–1.9 million] people died from AIDS-related causes (UNAIDS, 2012).
Worldwide, the number of people newly infected continues to fall. The number of people (adults and children) acquiring HIV infection in 2011 (2.5 million [2.2 million–2.8 million]) was 20 per cent lower than in 2001 (UNAIDS, 2012). Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9 per cent) living with HIV and accounting for 69% of the people living with HIV worldwide (UNAIDS, 2012). The epidemic’s future is still uncertain underscoring the need for intensified action to move towards universal access to HIV prevention, treatment, care and support (UNAIDS, 2012).

5.2.2. Global Response to HIV/AIDS

The global response to HIV/AIDS epidemic has changed radically over the years. National and international policymakers were initially slow to respond to AIDS as a public health issue. From 1981-1985 researchers only focused on gathering vital clinical, information on the disease (K. Lee & Zwi, 1996). It was not until 1985 that the first International AIDS Conference was held after which there occurred a mobilisation of expertise and other resources with unprecedented speed (K. Lee & Zwi, 1996). Soon afterwards the international community began to discuss AIDS as a serious global issue. In 1987 AIDS became the first disease to be discussed at the United Nations (UN) General Assembly which mobilised the entire UN system in a worldwide campaign to control the disease. In 1996 the UN created a separate agency to rally support for HIV/AIDS efforts, coordinate UN activities around the disease, collect data on the epidemic, and assist governments in the development of national AIDS strategies. The Joint United Nations Programme on HIV/AIDS (UNAIDS), previously under the purview of WHO, morphed into the first UN agency dedicated solely to a single disease.

International mobilisation to combat HIV has increased substantially since the Millennium Development Goals were established in 2000, which included the target to halt and reverse the spread of HIV/AIDS by 2015. The year 2001 saw a remarkable convergence of political, scientific and economic forces, creating major new opportunities for a more intensive global response to the AIDS pandemic (Piot & Coll Seck, 2001). In June 2001 the UN General Assembly convened a Special Session (UNGASS) to address the security implications and long-term financing efforts of HIV/AIDS. This marked the first time in the history of the UN that a disease had been the focus of a General Assembly. International commitment was emphasised within the UNGASS. The United Nations 2001 Declaration of Commitment on HIV/AIDS marked the beginning of a sea change in the response to AIDS (UNAIDS, 2002).
In the political sphere there has been more concerted and higher-level action than ever before including increased financial commitment.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was established in 2001. It was created to function as a financial instrument, rather than an implementing agency, with the goal of attracting, managing, and disbursing resources to fight AIDS, TB and malaria. Governments are the primary donors to the Global Fund (95 per cent), but some contributions also come from corporations, foundations, and individual donations. It has been remarkably successful in raising and mobilising resources to support country-driven strategies.

A new and forward-looking Political Declaration on HIV/AIDS was adopted unanimously by the UN Member States on 2 June 2006 at the close of the United Nations General Assembly (2006 High Level Meeting on AIDS). The 2006 Declaration provided a strong mandate that helped move the AIDS response forward, particularly with regards to scaling up towards universal access to HIV prevention, treatment, care and support. ‘Universal access’ means establishing an environment in which HIV prevention, treatment, care and support interventions are available, accessible and affordable to all who need them (WHO, 2009b). It covers a wide range of interventions that are aimed at individuals, households, communities and countries (WHO, 2009b). So far, 111 countries have set targets for achieving universal access (UNAIDS, 2009b). The global partners’ continuing reaffirmation of their commitment to the universal access goal highlights the need for an accelerated scale-up of a comprehensive package of HIV prevention, treatment and care, and for a more rapid strengthening of health-care systems (WHO, 2009b).

In 2011, 30 years into the AIDS epidemic, and 10 years since the landmark UN General Assembly Special Session on HIV/AIDS, leaders came together at the 2011 UN General Assembly High Level Meeting on AIDS in New York (8–10 June 2011). They reviewed progress and adopted a new Political Declaration that includes new commitments and new targets which would create momentum in the AIDS response.

The responses over the past 25 years and the broad social mobilisation of stakeholders have spearheaded remarkable action and results. A rapid expansion in HIV services and dedicated AIDS financing with commitments rising from US$1600 million in 2001 to US$ 15 900 million in 2009, including substantial financing from the United States President’s
Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other bilateral, multilateral and domestic sources (WHO, 2011b). Even though many countries have increased their domestic investments they will still require international investments. According to UNAIDS (2012) programs to reach key populations receive only four per cent of investments globally, but for an optimised HIV response in 2015, this share will need to be about 14 per cent. The gap between required and available resources will probably still be substantial and could impede progress.

5.3. HIV/AIDS Epidemic in China

While overall HIV prevalence in China remains low at less than 0.1 per cent of the total population, the epidemic continues to grow in all regions of China, particularly among certain key populations at higher risk and in certain regions. The number of reported HIV and AIDS cases have increased each year, as has the number of newly diagnosed cases and deaths also increase (China Ministry of Health, 2012).

The first case of AIDS was reported in 1985 and since then the number has increased rapidly. According to Sheng and Cao (2008), China’s HIV/AIDS epidemic can be divided into four phases. The first phase, in 1985-8, involved a small number of imported cases in coastal cities—mostly foreigners and overseas Chinese (Sheng & Cao, 2008; Zhang & Ma, 2002). The second phase, from 1989 to 1993, began with finding HIV infection in 146 drug users among minority communities in Yunnan province in the south west, adjacent to the “Golden Triangle” bordering Myanmar, Laos and Vietnam. The third phase began in 1994, when a number of infections were reported among drug users and commercial plasma donors (Sheng & Cao, 2008; Zhang & Ma, 2002). By 1998 HIV infection had been reported in all 31 provinces, autonomous regions, and municipalities under control of the central government (State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China, 2007). The fourth phase of the HIV/AIDS epidemic in China started in 2001 (Sheng & Cao, 2008). It was at this stage that the silence surrounding HIV in China began to end.

According to the China Ministry of Health (2012) by the end of 2011 the estimated number of alive People Living with HIV/AIDS in China was 780000; women accounted for 28.6 per cent of these cases; prevalence among the population as a whole was 0.058 per cent; of the total
number of people living with HIV 154,000 were cases of alive AIDS; it is estimated that 48000 people were newly infected with HIV in 2011, and the estimated number of deaths 28000.

Although the HIV/AIDS epidemic covers a broad range of populations, it remains concentrated in certain areas and in certain groups. The six provinces with the highest number of reported HIV cases (from highest to lowest: Yunnan, Guangxi, Sichuan, Henan, Xinjiang, Guangdong) accounted for 75.5 per cent of the total number of reported cases nationwide. The seven provinces with the fewest reported cases of HIV (Tibet, Qinghai, Ningxia, Inner Mongolia, Gansu, Tianjin, Hainan) accounted for 1.2 per cent of the total number of reported cases nationwide (China Ministry of Health, 2012). HIV prevalence also varies significantly between different population groups, with prevalence greatest among drug users (China Ministry of Health, 2012).

Of the 780000 people estimated to be living with HIV in 2011, 46.5 per cent were infected through heterosexual transmission, 17.4 per cent through homosexual transmission, 28.4 per cent through injecting drug use, 6.6 per cent were former blood donors or transfusion recipients, and 1.1 per cent were infected through mother-to-child transmission (China Ministry of Health, 2012). This is illustrated in Graph 2. Among the transmission modes, sexual transmission is now the main mode. The ratio of sexual transmission is increasing each year.
Overall China is still experiencing a low-prevalence epidemic in HIV with only 0.058 per cent (0.046-0.070 per cent) of the Chinese population living with HIV. However the epidemic has already started to spread from high-risk populations to the general population. China’s HIV epidemic exhibits five major characteristics: 1) National prevalence remains low but the epidemic is severe in some areas; 2) the number of PLHIV continues to increase but new infections have been contained at a low level; 3) gradual progression of HIV to AIDS resulting in an increase of the AIDS-related deaths; 4) sexual transmission is the primary mode of transmission, and continues to increase; 5) China’s epidemics are diverse and evolving (China Ministry of Health, 2012). There is a potential risk that the epidemic will spread further. The situation is a confluence of multiple epidemics that require specific strategic response strategies.
5.4. China’s Response to HIV/AIDS

Since the first AIDS case was identified in 1985 China has experienced dramatic changes in the course of its HIV/AIDS epidemic and the government’s response to it. The overall course of the government’s response to the epidemic could be summarised as: moving from denial to taking positive action; from policy advocacy to policy implementation; from a purely health-oriented response to a multi-government response, with greater involvement from non-governmental organisations; and from small demonstration projects/programs to a countrywide scale-up (Z. Wu, Sullivan, Wang, Rotheram-Borus, & Detels, 2007).

China has made significant progress in its HIV response over the past decade. China now has each of the ‘Three Ones’ (One agreed AIDS action framework, One national AIDS coordinating authority and One agreed country-level monitoring and evaluation system) recommended by the United Nations Program on HIV/AIDS (UNAIDS) as key elements supporting a results-based HIV response. Table 9 summarises this coordination effort.

Table 9: The "Three ones" Coordination of National AIDS Responses in China

<table>
<thead>
<tr>
<th>UNAIDS ‘Three ones’</th>
<th>‘Three ones’ in China</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>One</strong> agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.</td>
<td>China’s HIV/AIDS action framework is its 5-year action plan for the containment and control of HIV/AIDS. Three 5-year action plans have already been completed (2001–05, 2006–10, and 2011-15).</td>
</tr>
<tr>
<td><strong>One</strong> National AIDS Coordinating Authority, with a broad-based multisectoral mandate.</td>
<td>China’s National AIDS Coordinating Authority is the State Council AIDS Working Committee Office (SCAWCO) which was established in 2004.</td>
</tr>
</tbody>
</table>

Source: modified from Sun et al (2010, p. ii5)
5.4.1. Government Leadership, Commitment and Management

Leadership and commitment by high-level government leaders are important contributors to controlling HIV/AIDS epidemics in countries. Political and financial commitment underlies the implementation of all effective HIV/AIDS programs in China. Recent years have seen strengthened government leadership in China’s HIV response. In 2008 Vice Premier of the State Council Li Keqiang was made Chair of the State Council AIDS Working Committee, which brings together heads of 30 departments and seven provinces to coordinate China’s HIV/AIDS response. Nationally all 31 provinces and 88 per cent of local governments have established HIV/AIDS response leadership bodies.

Both President Hu Jintao and Premier Wen Jiabao have publicly demonstrated their commitment to HIV/AIDS efforts. Speaking at the 2010 Millennium Development Goals (MDG) Summit in New York Premier Wen Jiabao reaffirmed China’s promise to meet the MDGs, including MDG 6, by 2015.

The government role has been mainly played by China’s Center for Disease Control and Prevention’s National Center for AIDS Prevention and Control (NCAIDS). The national CDC operates under the leadership of China’s MOH. At the provincial and local levels the provincial health bureaus and their affiliated CDCs have led the AIDS response and HIV prevention activities (with substantial financial support from GFATM and other international donor programs), and are the main government counterparts for most international AIDS funding programs.

5.4.2. HIV/AIDS Policy Development

In the past twenty years, the Chinese government has gradually shifted from an attitude of denial to a more pragmatic and positive attitude toward the HIV/AIDS epidemic. This is illustrated in the Figure 5. The government of China was initially slow to respond to the epidemic. Passive surveillance was initiated in 1985 but active surveillance was not initiated until 1995. In 1995 China sets up its HIV/AIDS sentinel surveillance system. However, the fight against HIV/AIDS has received serious attention from the Chinese government which formulated and started implementing the AIDS strategy in 1998. In 1998, the Chinese State Council issued *China’s Medium- and Long-Term Plan for the Prevention and Control of AIDS (1998-2010)*, which has served as the blueprint for the HIV/AIDS prevention and control
strategy in China until the present. From that time China has taken increasingly aggressive action to slow the epidemic.

**Figure 5: China HIV/AIDS Policy Development**

In 1999 a comprehensive bi-annual surveillance was initiated which included eliciting of epidemiologic, serologic and behavioural information. In 2001 with increasing pressure from the growing HIV/AIDS epidemic, *the China HIV/AIDS Containment, Prevention and Control Action Plan (2001-2005)* was issued by the State Council (the highest government body in China). The document signified the government’s strong commitment to fight the epidemic and for the first time it highlighted effective strategies for the control of HIV. Along with the policy shift increasing funding through central government and international organisations was apportioned.

The challenge of managing the severe acute respiratory syndrome (SARS) epidemic in 2003 is often credited with further motivating the government to take aggressive policy action on HIV-related issues. Since the SARS epidemic in 2003 a considerable increase in funding and a sincere commitment on the part of policymakers resulted in a change in China’s HIV/AIDS response.

Source: modified from Z. Wu et al (2007, p. 679)
In September 2003 the “Four Frees and One Care” policy was implemented which provided 1) free antiretroviral drugs to AIDS patients in rural areas and those with financial difficulties living in urban areas; 2) free voluntary counselling and testing for HIV, free drugs for HIV-infected pregnant women to reduce mother to child transmission, HIV testing of newborn babies; 3) free schooling for children orphaned by AIDS; and 4) care and economic assistance to the households of people living with HIV/AIDS. In February 2004 the State Council established “The State Council HIV/AIDS Working Committee”, with the Vice-Premier and the Minister of Health as directors. The committee includes vice ministers from 23 key ministries and vice-governors from the seven most affected provinces. In March 2004 the “State Council Notice on Strengthening HIV/AIDS Prevention and Control” was issued.

In 2006 the State Council of the People’s Republic of China officially announced the first legislation directly aimed at controlling HIV/AIDS, AIDS Prevention and Control Regulations (Decree No. 457). These regulations provide a legal framework for AIDS initiatives, emphasising the accountability of governments and Ministries at different levels. They also set out the rights and responsibilities of people living with HIV ensuring the funding of AIDS measures and providing the legal foundations for AIDS policy formulation and its effective implementation. These regulations, together with the “Five-Year Action Plan to Control HIV/AIDS (2006–2010)”, are an important step in the development of government policy related to the care and prevention of HIV/AIDS (He & Detels, 2005).

At the end of 2010 the State Council issued the “Notice Regarding Further Strengthening AIDS Prevention and Control” describing the current situation and providing actions for the next stage. The Notice sets out new policies and measures in the form of the “Five Expands, Six Strengthen”. The “Five Expands” covers expanding information, education and communication (IEC) activities, surveillance and testing, preventing mother to child transmission (PMTCT), comprehensive interventions, and coverage of antiretroviral therapy (ART). The “Six Strengthens” covers to strengthening blood safety management, health insurance, care and support, rights protections, organisational leadership and response teams. The “Five Expands, Six Strengthen” approach is resulting in important achievements.

In January 2012 the State Council issued “China’s 12th Five-Year Action Plan for Containment and Control of HIV/AIDS” setting out targets for the end of 2015 to reduce new infections by 25 per cent and reduce mortality from AIDS by 30 per cent (State Council of P.R. China, 2012).
China’s current national policies are responsive to changes in the epidemic. However, new policies are still needed to achieve the goals of universal access and to respond to the changing dynamics of China’s HIV/AIDS epidemic (X. Sun et al., 2010). Along with policy shifts, there is increased funding through central government and international organisations, and a number of programs were initiated and gradually scaled-up.

5.4.3. Financial Investment in HIV/AIDS

Government funding for the HIV response has significantly increased annually. While funding for HIV/AIDS used to come primarily from international organisations and foreign agencies, the Chinese government now funds over 80 per cent of China’s total HIV/AIDS budget (J. Sun et al., 2010). The national budget for HIV/AIDS prevention and care has risen from 390 million RMB in 2003 to 2.2 billion Yuan RMB in 2011. This increase is illustrated in Figure 6. While the central level of government has increased its AIDS budget allocations, it has also broadened fund raising channels, both domestic and international.

**Figure 6: China Central Government Funding for AIDS Response (2002-2011)**

![Graph showing China Central Government Funding for AIDS Response (2002-2011)]


The AIDS budget contributions by provincial governments have also increased. According to the China Ministry of Health (2008) incomplete data, the AIDS budget contributions by provincial governments increased from 98 million Yuan RMB in 2003 to 342 million Yuan RMB in 2006. In 2010 and 2012, 31 provinces (including autonomous regions and
municipalities) invested total funding of two billion Yuan RMB (China Ministry of Health, 2012). The central government developed protocols and regulations on budget use and management. The annual central earmarked transfers for HIV/AIDS projects are based on the workload and unit cost planned activities at the local level, which are then incorporated into the central implementation plan. At the same time central and local governments audit the utilisation of their HIV/AIDS funds.

While the domestic investments have increased dramatically the international investments have decreased. The total international funding in 2008 was 610 million Yuan RMB which fell to only 388 million Yuan RMB in 2011 (China Ministry of Health, 2008, 2012). The majority of major international donors ceased providing development assistance to China in 2011. With the completion of the Global Fund grant in 2012 virtually all international supports for HIV programming in China have ended. China currently invests more than 80 per cent domestically for HIV/AIDS and the country has announced it will fully fund its response from 2013.

China’s Medium and Long-Term Plan for HIV/AIDS Prevention and Control (1998-2010) (State Council of P.R. China, 1998) explicitly requires that HIV/AIDS prevention and control follow the principle that funds for HIV/AIDS prevention and control in China are mainly input by the governments at different levels from various sources. The regulations explicitly define the scope of HIV/AIDS prevention and control efforts that necessitate government funding, as well as the specific roles and responsibilities of the government at various levels in funding the responses to HIV/AIDS. The central finance department of the national government provides subsidies to high prevalence areas and key projects implemented in economically underdeveloped areas. The local governments identify HIV/AIDS prevention and control projects and ensure funding for implementation in accordance with the prevalence of the HIV/AIDS epidemic, and the trends and needs within their administrative regions. The international funds have been a very important supplement. To ensure efficient resource integration, the central government takes into account all national, local and international resources and their adequacy to address the key needs of and issues for different populations and geographical area.
5.5. International Cooperation on HIV/AIDS in China

China is a large developing country that has received considerable international support for its HIV/AIDS program. Until 2003 China’s HIV/AIDS programs were mainly supported by international donors (Zunyou Wu et al., 2011). In response to the spread of HIV/AIDS the Chinese government has received large funds to combat the HIV/AIDS epidemic from several UN agencies, government aid (for example UK, US and Australian government), many international non-government organisations, and the public-private partnerships such as the Global Fund, and the Global AIDS Program. According to the Ministry of Health (China Ministry of Health, 2009) up until 2009 China has implemented over 276 HIV/AIDS international cooperation projects. This has involved over 40 major multilateral international organisations, bilateral governments, international non-governmental organisations and foundations. The project total funding has been approximately 3.58 billion Yuan RMB. According to incomplete statistics more than 100 international cooperation projects were implemented in China in 2008-2009 involving more than 30 international development partners. Funding support for the two years amounted to 610 million Yuan RMB and 580 million Yuan RMB respectively (a combined total of approximately US$174 million) (China Ministry of Health, 2010).

5.5.1. Achievements

The implementation of international cooperation projects not only makes up for shortages in funding for China’s AIDS response, it more importantly introduces successful and advanced concepts, strategies, techniques and experiences from the international response (China Ministry of Health, 2010). The areas being supported by international cooperation include all aspects of the HIV/AIDS response (China Ministry of Health, 2010). The role of international cooperation is no longer limited to technical inputs but also applies international ‘best practice’ experience in order to define effective AIDS prevention and control measures in China and facilitates the achievement of the Five-Year Action Plan objectives (China State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China, 2007).

HIV/AIDS programs have been integration. As the foreign HIV/AIDS projects were mainly determined by the donors when many HIV/AIDS projects were simultaneously implemented in the same locations problems emerged such as inconsistency and overlap in data collection.
China has thus coordinated and integrated all large international and domestic HIV/AIDS projects into one national program.

In addition China has also played an increasing role in providing international assistance in the field of HIV/AIDS to developing countries. It has conducted training courses for HIV/AIDS professionals from African countries, cooperated in the development of pilot HIV/AIDS projects in cross-border areas of China, Myanmar, Laos and Vietnam, donated US$10 million to the Global Fund, demonstrated best practice in China through hosting delegations from countries to undertake study tours of HIV/AIDS interventions in China, and actively participated in sharing information at international conferences (China State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China, 2007). China is also a donor to the Global Fund to Fight AIDS, TB and Malaria and has been a board member representing the Western Pacific region since its foundation.

5.5.2. Main Players and Their Projects

*Multilateral Organisations*

The Joint United Nations Program on HIV/AIDS coordinates and facilitates the work of UN agencies working in the field of HIV/AIDS (UNAIDS, 2007a). Strategically the joint UN country program is guided by one of UNAIDS’ key policy recommendations, the ‘Three Ones’ principle, namely: one agreed AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority with a broad-based multi-sector mandate; one agreed country level monitoring and evaluation system (UNAIDS, 2007b). China has followed the ‘Three Ones’ in its response to the AIDS epidemic: a five-year plan action plan provides the agreed action framework; the State Council AIDS Working Committee Office (SCAWCO) is the national coordinating authority; and the protocols for a national M&E system were adopted in 2007 (UNAIDS, 2007b).

Besides UNAIDS, nine other UN agencies are actively involved in the UN Joint Program on AIDS in China. They are UNICEF, UNFPA, ILO, WHO, UNESCO, World Bank, UNIFEM, UNDP, and UNODC. The UN agencies focus on three areas in the field of HIV/AIDS: an enabling environment and multi-sector response; increased awareness and intensified prevention interventions; and improved treatment, care and support of people living with or
affected by HIV (UNAIDS, 2007a). Table 10 shows the list of UN agencies that have activities in 2007-08 under each of the focus areas.

### Table 10: List of UN Agencies under Each of the Focus Areas in China

<table>
<thead>
<tr>
<th>UN Agencies</th>
<th>An enabling environment and multi-sector response</th>
<th>Increased awareness and intensified prevention interventions</th>
<th>Improved treatment, care and support of people living with or affected by HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>√</td>
<td>√ *</td>
<td>√</td>
</tr>
<tr>
<td>UNFPA</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>ILO</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>√</td>
<td>√ *</td>
<td></td>
</tr>
<tr>
<td>UNESCO</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>World Bank</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNIFEM</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>UNDP</td>
<td>√ *</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>UNODC</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>UNAIDS</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

* Convening agency of that focus area.

Source: UNAIDS (2007a, p. 4)

In the joint program the UNAIDS China office is in charge of coordination within the UN system in China. It works with the State Council AIDS Working Committee Office (SCAWCO) to coordinate the program development, planning, monitoring, and integration of the financial resources (UNAIDS, 2007a). A lead agency coordinates the work of the UN agencies in each of the three focus areas. The UN agencies are responsible for the direction and supervision of the program in their respective areas and providing technical assistance where needed. The national counterparts are responsible for the project implementation under the overall coordination of UNAIDS and SCAWCO, while SCAWCO is responsible for the coordination of program progression, development planning and resource prioritization (UNAIDS, 2007a). The UN agencies communicate at the working level with their national implementation counterparts. With the support of SCAWCO they set up working
relationships with AIDS working committees at provincial level and with locally responsible bureaus.

**National Development Agencies (Bilateral Agencies)**

Most bilateral agencies put their working priority in the HIV/AIDS area. They support HIV/AIDS through multiple channels. AusAID's new China Program Strategy 2006-2010 identifies HIV/AIDS as a priority for cooperation. Engagement focuses on high risk groups such as injecting drug use (IDU), commercial sex workers and (as an emerging area for policy engagement) men who have sex with men (AusAID, 2006). The Department for International Development (DFID) supports the implementation of China’s National Medium-Long Term HIV and AIDS Plan. It supports efforts to create a more effective role for civil society organisations in China’s response to HIV and AIDS; increases access to harm education services by vulnerable groups, such as drug users and sex workers; improves surveillance and strategic information systems; increases the effectiveness of UN agencies in supporting the Government; and supports the Global Fund to fight AIDS, TB and Malaria (DFID, 2006). The majority work of Swedish International Development Cooperation Agency (SIDA) with HIV/AIDS is carried out within the framework of a partnership with the WHO. Other potential areas of cooperation include regional HIV/AIDS programs and measures against trafficking in women and children (SIDA, 2006).

**International Non-government Organisations**

Compared with other international actors, the total financial and human resources of the international NGOs looks slim, however they play a unique role in HIV/AIDS prevention in China. They have provided considerable technical and financial support to Chinese health institutions, schools and other related organisations; new information on HIV/AIDS policies and treatment; and crucial support to Chinese grassroots, and/or voluntary social groups to further AIDS prevention goals (F. S. Wu, 2005). More generally the environment for international NGOs engagement in the response to HIV/AIDS is improving.

The number of international non-governmental organisations working in AIDS related issue areas in China has grown steadily and substantially. A considerable increase in NGO numbers due to the positive changes in governmental policies was seen in 2003 (F. S. Wu, 2005). Even though NGOs are constrained by financial and other factors when compared with multilateral
and bilateral official assistance agencies they have still played a unique role in the fight against AIDS in China.

The international NGOs are very diverse in terms of their organisational structures, personnel composition, financial resources, and working philosophies. According to Wu (2005) a majority of them share three characteristics: first that they came to China on independent missions; second that they have established networks and a working base inside China, localised their practices by recruiting Chinese staff members and implementing the projects directly with Chinese citizens; and third that they mostly are not AIDS exclusive organisations.

**Public-Private Partnerships (PPPs)**

In HIV/AIDS prevention and control, the experiences of private and public sector stakeholders sketch a picture of mutual appreciation. The collaborations of both can enhance the role each of them plays in the health system (UNAIDS, 2009a). PPPs also enjoy a good reputation among multilateral and bilateral donors and support agencies.

**Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund)**

Since 2003 the Global Fund has supported China to carry out multiple rounds of cooperative HIV/AIDS response projects which have achieved highly positive results. The upper limit for total funding supported by the Global Fund is US$510 million (China Ministry of Health, 2010). Details regarding the Global Fund are given in the Chapter Eight.

**5.6. Partnership in HIV/AIDS Prevention and Control in China**

Governments, particularly ministries of health, take overall responsibility for responses to HIV. Many government departments and agencies outside the health sector (such as those with responsibilities in finance, justice, education, planning labour, agriculture, transport, tourism, corrective services, defence and foreign affairs) also have an important role to play in responding to HIV/AIDS. Generating such broad government participation in the fight against HIV/AIDS will be necessary if national efforts to combat the pandemic are to be optimized. Furthermore, an effective and comprehensive response demands the active involvement of the international organisations, private sector and civil society, as well as non-governmental, faith-based and academic organisations. Civil society organisations (CSOs) complement and
supplement formal health services by playing key roles in HIV education and prevention, especially in reaching most-at-risk populations. The CSOs also assist in creating demand for HIV services; ensuring that HIV/AIDS services are acceptable and of good quality; preparing people for treatment through information and education; supporting adherence to treatment; and providing other forms of prevention, care and support (WHO, 2009b). Academic institutions have an important role in capacity-building, adapting guidelines and tools for local use, supporting operational research, and providing technical assistance (WHO, 2009b). It is also important to include faith-based organisations and private businesses in any key mechanisms or processes for planning, coordinating, financing, monitoring and evaluating the overall response to HIV/AIDS.

In China the central government encourages and supports relevant organisations and individuals to participate in HIV/AIDS prevention and treatment. Over the past several years more and more mass organisations, civil society organisations and enterprises and businesses are actively involved in the national response to HIV/AIDS. Their range of involvement has become broader in its scope and depth and they have become an important player and indispensable force in the national response to the epidemic (China Ministry of Health, 2012).

5.6.1. Cross-sectoral Collaboration

In accordance with the “Regulation on AIDS Prevention and Treatment” the national government encourages and supports organisations (including Trade Unions, Youth Leagues, Women’s Federations and Red Cross societies) to undertake cooperative activities in HIV/AIDS prevention and treatment with various levels of government. There has been significant advancement in the coordination and cooperation across sectors. Various large-scale initiatives were jointly conducted, which are summarised in Table 11.
### Table 11: Summary of Key Cross-sector Initiatives

<table>
<thead>
<tr>
<th>Activities</th>
<th>Sectors involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention to Women, Against AIDS</td>
<td>Central Department of Publicity, MOH, State Population &amp; Family Planning Commission and All China Women’s Federation</td>
</tr>
<tr>
<td>Women” Face to Face” Education Campaign in China CARES Areas</td>
<td>All China Women’s Federation and MOH</td>
</tr>
<tr>
<td>Youth Red Ribbon Action – Youth Volunteer Face to Face Education Campaign</td>
<td>Central Youth League and MOH</td>
</tr>
<tr>
<td>Employee Red Ribbon Health Action</td>
<td>All China Trade Union, Ministry of Labour &amp; Social Security, MOH, China Enterprises Confederation/China Association of Entrepreneurs</td>
</tr>
<tr>
<td>The Chinese Campaign on HIV Prevention among Children and Youth</td>
<td>SCAWCO, MOH, Ministry of Education, Ministry of Civil Affairs, State Population &amp; Family Planning Commission, Central Youth League, All China Women’s Federation and Chinese National Committee for the Care of Children</td>
</tr>
<tr>
<td>Support and Care activities to PLHIV and their families</td>
<td>SCAWCO, MOH, Ministry of Civil Affairs, State Population &amp; Family Planning Commission, All China Women’s Federation and Red Cross Society of China</td>
</tr>
<tr>
<td>Attention to Orphans and 10,000 Home of Love Welfare activities</td>
<td>All China Women’s Federation, MOH and SCAWCO</td>
</tr>
<tr>
<td>Awareness Campaign on HIV Knowledge among University Students</td>
<td>SCAWCO, MOH, Ministry of Education and Central Youth League</td>
</tr>
<tr>
<td>Support to HIV Prevention and Control Work in Yunnan Province</td>
<td>More than 30 national ministries and agencies, including Central Department of Publicity, State Commission for Public Sector Reform, Ministry of Foreign Affairs, National Development &amp; Reform Committee, Ministry of Finance, Ministry of Science &amp; Technology and State Ethnic Affairs Commission</td>
</tr>
<tr>
<td>Working Protocol on Opium Abusers Community Drug Maintenance Treatment</td>
<td>MOH, Ministry of Public Security and State Food &amp; Drug Administration</td>
</tr>
</tbody>
</table>

5.6.2. Whole of Society Involvement

Civil society in China is becoming increasingly organised, and several organisations and networks representing various populations have been established in recent years. At present, there are around 1500 Civil Society Organisations (CSOs) and Community-Based Organisations (CBOs) that are active in HIV work (China Ministry of Health, 2012). Chinese civil society is increasingly playing an important role in the AIDS response in China, especially in advocacy and provision of prevention services amongst high-risk behaviour populations and with treatment adherence education and counselling. The faith-based organisations, such as Buddhist, Islamic and Christian groups, also participated in the HIV awareness campaigns and supported activities in Xinjiang, Yunnan, Ningxia, Shaanxi, Hunan, Liaoning and other areas (China State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China, 2007).

The central government has established special funds for social mobilisation for HIV/AIDS while utilising international cooperation funds, especially the Global Fund, to support the involvement of mass organisations and civil society groups. In the four years from 2002 to 2006 some 287 social mobilisation projects from across China were approved with funding amounting to 26.9 million Yuan RMB (China State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China, 2007). In 2010 the Global Fund provided 44.32 million Yuan RMB to support 1245 CSOs and community-based organisations in carrying out HIV work, principally among most at risk populations and PLHIV (China Ministry of Health, 2012).

5.6.3. Enterprise and Business Involvement

In 2007 the Chinese government issued the “Notification Regarding Mobilisation of the Business Sector for Broad Participation in the AIDS Response”. The Ministry of Finance and the State Administration of Taxation issued a taxpayer deduction policy for donations to HIV prevention and AIDS care activities. In 2008 the All-China Federation of Industry and Commerce became a member organisation of the State Council AIDS Working Committee, and called on businesses to participate actively in the AIDS response (China Ministry of Health, 2010).
Workplace programs are the most common private sector HIV/AIDS projects. Many enterprises increased their efforts in workplace HIV/AIDS education programs to promote knowledge and awareness and developed workplace HIV/AIDS policies to reduce stigmatisation and discrimination. Prevention activities and HIV/AIDS education for workers supplement national prevention efforts. Businesses also provided financial and in-kind donations through various channels. According to the report of UNAIDS (2008), pharmaceutical enterprises were actively involved in the development and production of Antiretroviral drug, giving strong support to the ongoing development of ART. Some enterprises cooperated with the government to undertake comprehensive campaigns on HIV/AIDS prevention and control. During 2010-2011 the All-China Federation of Industry and Commerce mobilised the participation of private companies in the AIDS response, not only managing to raise over 49.7 million Yuan RMB, but also motivating a large number of workers to take part in HIV/AIDS work as volunteers (China Ministry of Health, 2012).

5.7. Main Challenges of HIV/AIDS Response in China

While there have been impressive achievements in the national response to HIV/AIDS significant challenges remain in reversing the spread of HIV/AIDS in the country. Under China's AIDS Action Plan for the 12th Five-Year Program period (2011-2015) published in February 2012 by the State Council, the country is aiming to decrease HIV/AIDS fatalities by 30 per cent by 2015, and new cases by 25 per cent. According to the China Ministry of Health (2010) the primary challenges currently being faced are as follows: 1) the AIDS epidemic is becoming increasingly complex with serious epidemics in some regions and among some populations. It has also not been possible to effectively bring new infections under control; 2) some people living with HIV remain undiagnosed and the risk factors promoting the spread of the AIDS epidemic still exist; 3) interventions directed at high-risk groups, particularly Men Who have Sex with Men (MSM) groups, still lack effectiveness, making this work very challenging; 4) implementation of the “Four Frees, One Care” policy is uneven. Coverage of Prevention of Mother-to-child Transmission (PMTCT) and antiretroviral treatment is insufficient; 5) social stigma still exists to a considerable degree. On the 2012 World AIDS Day the health minister, Chen Zhu, emphasised the four new challenges in fighting HIV/AIDS. These are increasing difficulties for HIV/AIDS interventions, increasing risks of transmission, growing demand for treatment funds, and inadequate capabilities among social organisations (Xinhua, 2012).
5.8. Conclusion

This chapter has reviewed the global and Chinese HIV/AIDS epidemics and responses. The details of China’s HIV/AIDS response have been provided based on the epidemic in China, and linked with approaches in international cooperation and partnership. The main challenges of the HIV/AIDS response have been discussed. International cooperation programs were seen as a very important part in the China’s national HIV/AIDS response. The next chapter will analyse the management of international development projects.
Chapter Six

International Development Project Management

6.1. Introduction

Developing countries, like China, because of their limited resources, require external assistance for the implementation of effective measures to control disease. International cooperation provides aid to developing countries every year. Most international assistance is provided via international development projects (Diallo & Thuillier, 2004). These international development projects are delivered by donor countries under diverse forms of funding and collaboration, for example using bilateral agreements with recipient governments or through a “middlemen”, frequently a non-governmental organisation (NGO) (Crawford & Bryce, 2003). These projects are different to other types of projects for a number of reasons and the approach to their implementation must also be different. Understanding the critical factors that influence project success enhances the ability of donors and implementing agencies to ensure the desired outcomes. In addition understanding of these factors helps donors and agencies to forecast the status of the project, diagnose the problem areas, and prioritise their attention and provide scarce resources to ensure successful completion of the projects (Khang & Moe, 2008).

This chapter provides a review of the project management literature. It discusses the concept of international project development, life cycle, environment, stakeholders, success criteria and critical success factors. The chapter then presents the unique characteristics and specific problems of international development projects and discusses some required approaches to international development project management.

6.2. Concept of International Development Projects

6.2.1. Definition

In order to understand international development project management, we need to know first what constitutes a “project”. A common definition is one given by the Project Management Institute (Project Management Institute, 2008, p. 5) which is “A temporary endeavour undertaken to create a unique product (either a component of another item or an end item in itself), service (for example a capability to perform a business function that supports production or distribution), or result (such as an outcome or document)”. Dwyer et al (2004)
focus on the process within an international development project and defines a project as “an organised, time-limited, one-off effort towards a defined goal, which requires resources, and it traditionally has three objectives--to meet specifications, to finish on time and to do it within budget”. Longest (2004) defined projects as groups of people and other resources formally associated with each other through intentionally designed patterns of relationships in order to pursue desired results. The projects pertain to any of the determinants of health are health projects (Longest, 2004).

International development projects are special projects and they are the most common instrument used by policy makers to deliver international aid (Hermano, López-Paredes, Martín-Cruz, & Pajares, 2013). These international development projects aim to improve living conditions in emerging countries by, for instance, enhancing agricultural, health, or educational systems (Landoni & Corti, 2011). The majority of funding for international development projects is from the official development assistance provided by multilateral or bilateral aid agencies and usually takes the form of concessionary loans, grants, or technical assistance implemented through the governments of the recipient countries. Other sources of funding come from private philanthropic organisations and NGOs. The projects generally last from three to five years but there is a trend to fund up to ten years programs which can be prolonged depending upon the findings of the end of project evaluation (Diallo & Thuillier, 2004).

6.2.2. International Development Project Life Cycle

Most projects go through similar stages on the path from conception to completion. These stages are defined as the project life cycle (Meredith & Mantel, 2009). The project life cycle provides the basic framework for managing the project regardless of the specific work involved. It is typically described as three to five distinct stages in the life of the project, usually along the pattern of initiation, execution or implementation, and project termination (Pinto & Prescott, 1988). Projects vary in size and complexity, however according to “Project Management Body of Knowledge (PMBOK) Guide” (Project Management Institute, 2008), all projects can be mapped to the following life cycle structure: starting the project, organising and preparing, carrying out the project work, and closing the project. For example, for a health promotion project, starting the project includes rationale, community needs analysis, literature review, action research, organising and preparing-developing the plan, setting goals and objectives,
defining tasks, timelines, resources, responsibilities and outcomes; carrying out the project includes work-hiring of new staff, training existing staff, procurement of equipment, preparing material, organising and conducting workshops, seminars and project activities; closing the project includes an evaluation and review which often involves making a decision about whether to sustain the outcomes of the project as an ongoing part of the organisation’s services or products (Dwyer et al., 2004).

Working from the literature many development organisations have developed models that reflect their interpretation of the life cycle of their projects. These project life cycle diagrams, although similar in terms of their phases and intended purpose, generally differ in terms of design and terminology. The “Project Management in Development” (PM4NGOs, 2010) generic project life cycle model includes six phases: project identification and design, project initiation, project planning, project implementation, project monitoring, evaluation and control, and end of project transition. This research uses the model developed by Khang and Moe (2008), which identifies four stages: conceptualising, planning, implementing, and closing/completing.

6.2.3. International Development Project Environment

All projects are planned and implemented in a social, economic, and environmental context, and have intended and unintended, and positive and/or negative impacts. These impacts include those on the cultural and social environment, the international and political environment, and the physical environmental contexts (Project Management Institute, 2008). Project management requires an understanding of aspects of the economic, demographic, educational, ethical, ethnic, religious, and other characteristics of the people whom the project affects or who may have an interest in the project (Project Management Institute, 2008). For international development projects consideration of all the factors identified is very important as they can all significantly affect the project.

6.2.4. International Development Project Stakeholders

Projects involve a wide array of stakeholders whose interests and demands need to be considered in the management decision-making in order to ensure the success of the project (Diallo & Thuillier, 2005). International development projects face a variety of pressures from their different stakeholders. A lack of understanding of the various stakeholders, the drivers of
their actions and their potential to influence, has been identified as a major challenge for international development projects (Youker, 1999).

There are several definitions of project stakeholders. The *PMBOK Guide* (2008) defines project stakeholders as individuals and organisations that are actively involved in the project, or whose interests may be affected as a result of project execution or project completion. Their roles and responsibilities can overlap and influence over the project’s objectives and outcomes. The key stakeholders on every project include: project manager, customer/user, performing organisation, project team members, project management team, influencer, and project management office (Project Management Institute, 2008). A typical division of group stakeholders is into direct stakeholders and indirect stakeholders. Direct stakeholders are the people of the organisations directly associated or involved in all or some of the various phases of the projects, these include the client, project sponsor, project manager, members of the project team, technical and financial services providers, internal or external consultants, material and equipment suppliers, site personnel, and contractors. Indirect stakeholders cover all those people indirectly associated with the project such as internal managers of the organisation and support staff not directly involved in the project but who may affect or be affected by the project.

The number of stakeholders interested in the project can dramatically increase the complexity of the project. Each of these stakeholders usually has their own interest in the project and this may result in different priorities and may cause conflicts. In order to ensure a successful project it is very important to identify the stakeholders, determine their requirements and expectations, and manage their influence in relation to the requirements (Project Management Institute, 2008). The process of listing, classifying and assessing the influence of these stakeholders is termed the stakeholder analysis. Once stakeholders are identified, it is useful to consider the impact that a particular stakeholder group may have on the project, and how they will be managed (Dwyer et al., 2004). Stakeholder management means working with stakeholders as the project unfolds, shoring up their commitment, responding to their concerns and monitoring any shifting alliances (Dwyer et al., 2004).

Stakeholders may have a positive or negative influence on a project. Positive stakeholders are those who would normally benefit from a successful outcome from the project, while negative stakeholders are those who see negative outcomes from the project’s success. In the case of
positive stakeholders, their interests are best served by helping the project succeed. Negative stakeholders are often overlooked by the project team at the risk of failing to bring their projects to a successful end.

Many stakeholders are involved carrying out the physical implementation of components and activities of the international development projects. The stakeholders include donor agencies (often more than one), government organisations at several levels of the host country, a project management unit, local beneficiaries including local organisations, consultants, a multitude of contractors, trainers, evaluators, researchers, and firms and individuals (Youker, 2003). Project management is often managed through a complex array of stakeholder relationships (partner agencies, government ministries, community-based organisations, contractors, global consortia).

6.3. Criteria for Success and Critical Success Factors for International Development Projects

The success of international development projects determines the socioeconomic progress in the recipient countries but also the effectiveness of the contribution of the donor countries and agencies. Measuring the success of international development projects commonly involves a high degree of subjective judgments, due to the intangibility of their objectives (Khang & Moe, 2008).

6.3.1. Project Success

The concept of success in projects has been widely discussed in management literature and has been central to the literature of project management. Kerzner (2006, p. 7) offered a definition of project success that is “within the allocated time period, within the budget cost, at the proper performance or specification level, with acceptance by the customer/user, with minimum or mutually agreed upon scope changes, without disturbing the main work flow of the organisation, and without changing the corporate culture”. The literature proposes that project success consists of two components, project success and project management success. Project success deals with goals and purpose, as well as the satisfaction of the users and key stakeholders’ needs where they relate to the project’s final product. Project management success deals with outputs and inputs. It is process oriented and involves the satisfaction of the
Delivering project success is necessarily more difficult than delivering project management success because it inevitably involves “both goals and methods liable to change”, whereas the latter involves only “hold goals constant, and change practices to meet pre-determined goals” (Cooke-Davies, 2002, p. 187). However project management success is also important. It is the difference between success criteria (the measures by which success or failure of a project or business will be judged) and success factors (those inputs to the management system that lead directly or indirectly to the success of the project or business) (Cooke-Davies, 2002).

There is consensus that project success entails both efficiency and effectiveness, that it is a matter of perspective, that there are project success criteria, a set of principles or standards used to determine project success, and critical success factors that refer more specifically to conditions, events and circumstances contributing to project success (Ika, 2009; Müller & Turner, 2007). It is very important for project managers to identify the relevant success criteria, and from them determine appropriate success factors in order to increase the chance of achieving those success criteria, and then select a project management methodology that delivers those success factors.

### 6.3.2. Success Criteria

Whether international development projects are successful or not can give rise to ambiguity. However there is agreement that international development project success criteria include relevance, efficiency, effectiveness, impact, and sustainability (Ika, Diallo, & Thuillier, 2012). Relevance refers to the extent to which the project suits the priorities of the target group, the recipient and the donor; efficiency refers to the extent to which the project uses the least costly resources possible to achieve the desired results; effectiveness refers to the extent to which the project meets its objectives; impact refers to the positive and negative changes produced by the project, directly or indirectly, intentionally or not; and sustainability refers to whether the benefits of the project are likely to continue after donor funding has been withdrawn (Ika et al., 2012).

Diallo and Thuillier (2004) outlined ten comprehensive set of evaluation criteria and grouped into three broader categories: project management success (objectives, time, and budget), project success or impact (satisfaction of beneficiaries with goods and services delivered,
impact on beneficiaries, and institutional capacity for the country), and profile (conformity of the goods and services delivered to the project plan, national visibility of the project, project reputation among donors, and probability of additional funding, if necessary). Building on the work of Diallo and Thuillier (2004), Khang and Moe (2008) added some further success criteria for international development projects including relevance of project needs, choice of the project implementing agency, and an alignment between key stakeholder priorities and interests.

6.3.3. Critical Success Factors

Understanding the critical factors that influence project success enhances the ability of donors and implementing agencies to ensure desired outcomes. In addition, it helps them forecast the status of the project, diagnose the problem areas, and prioritise their attention and scarce resources to ensure successful completion of the projects (Khang & Moe, 2008). Many researchers argue that it is unlikely that critical success factors be suitable for all projects (Diallo & Thuillier, 2004, 2005; Ika, Diallo, & Thuillier, 2010; Ika et al., 2012; Khang & Moe, 2008).

The most well-known list of critical success factors is one that was developed by Pinto and Prescott (1988) which includes items such as project mission, top-management support, project schedule, client consultation, personnel, technical tasks, client-acceptance, monitoring and feedback, communication, and troubleshooting. Pinto and Prescott integrated these critical success factors into the most accepted project life cycle (Conceptualisation, Planning, Execution and Termination) because they argued that the concept of the project life cycles helps to clarify the reasons why different factors may be more important to project success at different times. Their reasoning is more clearly illustrated in Table 12.
Currently many researchers suggest using life-cycle approaches to assess the critical success factors of international development projects (Hermano et al., 2013; Khang & Moe, 2008). Khang and Moe (2008) developed a list of 16 success factors linked to the different phases of the life cycle. Table 13 summarises the criteria and factors in these four life cycle phases and the overall project success.
Table 13: Success Criteria and Factors for International Development Projects

<table>
<thead>
<tr>
<th>Life-Cycle</th>
<th>Phases Success Criteria</th>
<th>Success Factors</th>
</tr>
</thead>
</table>
| Conceptualising | • Addressing relevant needs of the right target group of beneficiaries  
• Identifying the right implementing agency capable and willing to deliver  
• Matching policy priorities and raising the interests of key stakeholders | • Clear understanding of project environment by funding and implementing agencies and consultants  
• Competencies of project designers  
• Effective consultations with primary stakeholders |
| Planning | • Approval of, and commitment to, the project by the key parties  
• Sufficient resources committed and ready to be disbursed  
• Core organisational capacity established for project management | • Compatibility of development priorities of the key stakeholders  
• Adequate resources and competencies available to support the project plan  
• Competencies of project planners  
• Effective consultation with key stakeholders |
| Implementing | • Resources mobilised and used as planned  
• Activities carried out as scheduled  
• Outputs produced meet the planned specifications and quality  
• Good accountability of resources utilisation  
• Key stakeholders informed of and satisfied with project progress | • Compatible rules and procedures for PM  
• Continuing supports of stakeholders  
• Commitment to project goals and objectives  
• Competencies of project management team  
• Effective consultation with all stakeholders |
| Closing/Completing | • Project assets transferred, financial settlements completed, and team dissolved to the satisfaction of key stakeholders  
• Project end outputs are accepted and used by target beneficiaries  
• Project completion report accepted by the key stakeholders | • Adequate provisions for project closing in the project plan  
• Competencies of project manager  
• Effective consultation with key stakeholders |
| Overall Project Success | • Project has a visible impact on the beneficiaries  
• Project has built institutional capacity within the country  
• Project has good reputation.  
• Project has good chance of being extended as result of success  
• Project’s outcomes are likely to be sustained | • Donors and recipient government have clear policies to sustain project’s activities and results  
• Adequate local capacities are available  
• There is strong local ownership of the project |

Source: Khang & Moe (2008, p. 78)
6.4. Characteristics of International Development Projects

International development projects form a specific category of projects that provide socioeconomic assistance to developing countries or to some specially designated group of target beneficiaries. Unlike general industrial or commercial projects, international development projects are characterised by the less tangible, a large number of heterogeneous stakeholders, divergent perspectives among these stakeholders, the need for compromise, and the profound cultural and geographical gaps between project designers and their beneficiaries (Crawford & Bryce, 2003; Diallo & Thuillier, 2004, 2005; Khang & Moe, 2008). These characteristics make project management in the international development sector unique and challenging. Therefore it is vital that the international development project manager understands and analyses the characteristics identified above and develops a project management strategy to enhance the probability of project success.

International development projects differ from industrial or commercial projects in several important ways. Firstly, most international development projects are not concerned with profitability and do not have a business focus. The objectives of the international development projects concern issues where the usual profit motive is often missing such as poverty alleviation and living standards improvement, environmental protection, basic human rights protection, assistance for victims of natural or people-caused disasters, capacity building and development of basic physical and social infrastructures (Ika & Lytvynov, 2011; Youker, 2003). International development projects are responsible for delivering outcomes and not just for delivering outputs. Outcomes such as promoting social change and behaviour change that lead to improvements in the well-being of the project’s target populations (PM4NGOs, 2010) are critical. Compared with general industrial and commercial projects, these humanitarian and social objectives are usually much less tangible, with deliverables less visible and measurable. This vagueness in objective formulation raises a special challenge in managing and evaluating development projects and requires adopting new tools and concepts to define, monitor and measure the extent that the development projects achieve these objectives (Ika & Lytvynov, 2011).
Another important characteristic of most international development projects is the complex web of the many stakeholders involved (Youker, 1999). Industrial and commercial projects usually have two kinds of key stakeholders, the client, who pays for the project and as a result benefits from its deliverables, and the contractor or implementing unit, who is paid for managing the project to achieve the desired results. International development projects, in contrast, commonly involve three separate kinds of key stakeholders, namely the funding agency that pays for but does not directly use project output, the implementing unit, and the target beneficiaries who benefit from project output but usually do not pay for the project. The role separation of these three key stakeholders has several important implications.

Youker (1999) identified some issues in connection with multiple stakeholders: first that financial accountability by the project management team is often considered as the important feature because it is its responsibility to complete the projects within the time, cost and quality; second that there are many common developmental, cultural and knowledge gaps between donors and the target recipients and this makes for a mismatch between the real needs and capacity of the target groups and the understanding and development policies of the funding agencies which may result in poor project design (a precursor of failure in the implementation); and third that complicating the requirements for financial accountability are the efforts by the funding agencies and the governments of the recipient countries to establish rules and procedures to regulate the disbursement and utilisation of the development funds. Set with similar intention, but by different institutions with different organisational cultures and traditions, these various rules and procedures often contradict each other, raising special and unnecessary difficulties during project implementation (Youker, 1999).

Moreover international development projects are very particular and very specific because of their unique environments. The project environment for international development is far more complex than domestic projects in industrialised countries. There are many internal and external, visible, and invisible factors that influence the environment that create high risk in accomplishing project objectives (Kwak & Dewan, 2001; Landoni & Corti, 2011; Youker, 2003). These factors include influence of various stakeholders such as international development financial institutions (IDFIs), citizen groups, NGOs, media, the political ruling class, and bureaucrats (Kwak & Dewan,
poor infrastructure and a lack of resources (Kwak & Dewan, 2001; Landoni & Corti, 2011; Youker, 2003); cultural, socio-economical, technological, and political environment (Kwak & Dewan, 2001); lack of managerial and technological capabilities in the recipient countries; and external driving forces such as inflation, currency exchange, and international politics (Kwak & Dewan, 2001). All of these factors should be taken into consideration during the project initiation and project planning phases to enhance project success.

6.5. Specific Problems and Required Approaches in Management of International Development Projects

Youker (1999) listed a number of problems for international development projects. Some of the problems are:

- the lack of shared perception and agreement on the objectives of the projects by staff and stakeholders;
- the lack of commitment by the team, management and stakeholders;
- the lack of detailed, realistic, and current project plans within organisations not structured for project management;
- unclear lines of authority and responsibility;
- the lack of adequate resources;
- poor feedback and control mechanisms for early detection of problems;
- poor or no analysis of major risk factors;
- delays caused by bureaucratic administration systems.

Given the special features of international development projects and the common problems encountered in developing and implementing them there are specific approaches that have been identified from the literature, which can improve management. These approaches are listed as follows:

- as the traditional project management standards cannot be applied to international development projects without a proper adaption (Khang & Moe, 2008), instead of trying to adapt to already existing bodies of knowledge, a completely new framework specifically created to manage international development projects could be developed (Landoni & Corti, 2011);
locate the project in developing countries, ensure full participation of locals in the entire process of the project life cycle and endeavour to develop complete local ownership of the project by both the various levels of government involved as well as all stakeholders (Ahsan & Gunawan, 2010; Kwak & Dewan, 2001; PM4NGOs, 2010; Youker, 2003);

as project management deals with people the international development project manager must understand and appreciate the importance of cross-cultural differences (Youker, 2003).

6.6. Conclusion

As the final chapter of Part I, Literature Review, this chapter has discussed international development projects and their characteristics and identified their required approach to management. All these features will be examined in the case study of this research. The next part, Part II Research Methodology and Key Results and Findings, will identify and discuss the details of the research design and methodology.
Chapter Seven
Research Conceptual Framework and Methodology

7.1. Introduction

Part I provided background information about this research drawn from literature the review. It critically reviewed the contextual fields of this research, namely global international health cooperation and its situation in China, the public health partnership approach, HIV/AIDS prevention and control, and project management and techniques in international development projects.

This chapter, the first chapter of Part II, shows how the research question was developed based on the research background and rationale, presents a conceptual framework, and provides an overall picture of the study design and the rationale for the particular methodologies used. The chapter then describes the implementation of fieldwork and the data analysis process, and ends with a discussion about issues of rigour and ethics.

7.2. Research Conceptual Framework

7.2.1. Background and Rationale

The research background and rationale provide the justification for the research, including its overall goal. It describes how the research helps fill gaps in existing knowledge or solve a particular problem.

International cooperation plays a crucial role in health care. Compared with other components of development, health improvement should easily foster international cooperation. International cooperation on health is varied, complex, and changing. In the context of globalisation, health inequality, foreign policy and global health security, such collaboration is more vital than ever, bringing benefits to both developed and developing countries. Although there have been positive developments in international health cooperation recently, with the rapid change in our globalised world, issues regarding cooperation and effectiveness have become high profile among international communities and their partner countries. In particular, since the rise in the number of
actively involved international health players, ensuring the coherence and collaboration necessary to develop effective partnerships among them are major challenges.

The contribution of international health cooperation for Chinese health development is unquestioned. As the world’s most populous country and a leading economic power, China is also becoming a central player in the provision of assistance to developing countries. With playing both roles as a recipient country and a donor country, China has additional and future challenges to face and overcome with continued support from the international community.

Partnership is an important approach in public health. The twenty-first century is a world of cooperation and collaboration. Central to this view of the world will be partnerships. As public health problems in the developing world grow more complex and resources to address them remain limited, health partnerships become increasingly important. No organisation working alone could hope to control or make a significant improvement in health issues. Although partnerships can bring many benefits, making them work and optimising their efficiency and effectiveness can be a tough challenge.

International health projects, as was noted previously, can involve many different kinds of agencies and organisations, so effective partnerships are desperately needed. While growing experience and analysis of partnership has generated significant learning and consensus building over the past few years, there is still some considerable uncertainty, misunderstanding and divergence of opinion among stakeholders about partnerships. More research is needed to provide the conceptual clarity, basic ground rules and institutional innovations necessary to make partnerships more effective and strategic, especially for the complex health issues like HIV/AIDS response. A lot of research about public health partnerships has been conducted in some countries, but little in China.

HIV/AIDS is more than a health issue. It is a complex multi-sectoral issue with devastating impacts on individuals, families, communities and nations, and has a profound security dimension. Since the first case was identified in 1985, China has experienced dramatic changes in the course of its HIV/AIDS epidemic and the government’s response to it. In recent years, Central Government funding for
HIV/AIDS prevention and care has been significantly increased. Additionally, an increasing number of large public organisations, civil society organisations and enterprises and businesses have become actively involved in the national response to HIV/AIDS over the past several years. The current political environment and commitment to address HIV/AIDS has created unprecedented opportunities for international cooperation on HIV/AIDS. However, despite the progress made in national responses to HIV/AIDS in China, delivery of effective programs is hampered by multiple challenges. Particularly, as China has recently been classified an upper-middle income country, foreign funding for HIV/AIDS programs have declined dramatically, and the scenario of international cooperation has changed. Thus, there is a critical need to reconsider the situation of HIV/AIDS cooperation, regarding different stakeholder’s involvement, increased efficiency and effectiveness of HIV/AIDS programs, reduction in duplication of effort, and better identification of gaps, needs and complementary functions.

Projects remain important instruments and vehicles for international development assistance (Ika et al., 2010). There is no doubt that project management in general and project management tools and techniques, in particular, play an important role in project success (Munns & Bjeirmi, 1996). As discussed before, international development projects have their unique characteristics and environment, project managers or coordinators have to deal with complexity, resistance to change, competing agendas of a large number of stakeholders, and diverse and even contradictory expectations that render compromises very difficult to reach (Diallo & Thuillier, 2004, 2005; Khang & Moe, 2008).

From 2011, China entered the ranks of the upper middle-income countries according to the World Bank and is no longer seen by the international community as needing international aid and assistance. However, as a developing country with a large population and imbalanced development, China still needs help from the international community. With a dramatic reduction in international resources, China is also moving toward the role of donor and is contributing more to international development. The situation of China’s international health cooperation has changed. There is an urgent need for the Chinese government and international communities to deal with the challenges raised during this period.
It lacks, however, a systematic analysis about the current complex situation. Regarding the international health programs, particularly the HIV/AIDS program, there is little known about the effectiveness of cooperation of multi-stakeholder involvement on it and little attention has been paid to international HIV/AIDS projects as far as project management literature is concerned in China. There is little literature to guide health professionals on collaborative strategic management, especially where implementation and outcomes are concerned. Furthermore, with the development of the global economy and the emergence of China, the situation of China’s international health cooperation has changed and become more complex. Exploring an appropriate way to achieve sustainable outcomes for international projects, especially for the HIV/AIDS response in China is desired.

This research addresses these gaps, explores influencing factors and issues from multiple angles, analysing and discussing them through an empirical Chinese international HIV/AIDS project, the Global Fund AIDS Program. It provides suggestions to Chinese government agencies, international communities, and public health professionals to overcome the challenges. This research can also be a model and its implications will benefit other developing countries.

7.2.2. Research Question, Aim, and Objectives

This research asks the question: What are the key challenges and facilitating factors of international cooperation on HIV/AIDS prevention and control in China?

This research aims to identify the challenges and facilitating factors for international cooperation on HIV/AIDS prevention and control in China, provide information, evidence, and recommendations to health policy makers and HIV/AIDS project planners and providers to achieve sustainable outcomes, and thus form the foundation for developing public health policy actions.

The objectives of this research are:

1. to analyse the roles, functions and key challenges regarding international health cooperation globally, particularly in China, and explore the future direction of Chinese international health cooperation;
2. to identify challenges and facilitating factors of the international HIV/AIDS projects in China;
3. to explore how different kinds of partners/organisations can work together more effectively to produce better partnerships;
4. to develop strategic project management to address challenges hampering the implementation of international HIV/AIDS projects in China, to help stakeholders to be informed and improve future implementation through international support;
5. to provide recommendations to assist the Chinese government, international communities and relevant organisations in developing policies and strategic plans for international cooperation on HIV/AIDS prevention, care, support and treatment in China.

7.2.3. Contextual Fields and Conceptual Framework

Contextual fields
This research draws upon four contextual fields – namely, international health cooperation, partnerships in public health, HIV/AIDS prevention and control in China, and international development project management. International health cooperation is the background of the global situation; partnership is the essential approach in public health; HIV/AIDS prevention and control is one of the important tasks both globally and in China; and international development project management can be a useful tool to solve cooperation and partnership issues in international cooperation for HIV/AIDS prevention and control in China. These contextual fields are theoretically and practically linked and they guide and inform the research.

Conceptual Framework
The conceptual framework for this study was developed through the research rationale. It presents the contextual fields for consideration, the relationships among them, and which information is linked to answer the research question. The details of the conceptual framework are illustrated in Figure 7.
Figure 7: Research Conceptual Framework

**Global**
- Globalisation
- Global health inequality
- MDGs
- Global health security
- Foreign policy
- Benefit for developing and developed countries

**China**
- Current management
- Needs
- Opportunities
- Challenges

**Global:**
- Global epidemic
- Global response
- Challenges
- Strategies

**China:**
- China epidemic
- Response
- International cooperation on HIV/AIDS
- Partnership in HIV/AIDS
- Challenges

**International Health Cooperation**
- Many players

**Partnership in Public Health**
- Conceptions
- Partnership in public health
- Effective and successful partnership
- Challenges

**HIV/AIDS Prevention and Control in China**

**Challenges**
- Overlapping mandates
- Donor-driven
- Proliferation
- Collaboration
- Stability and sustainability

**International Development Project Management**
- Characteristics of ID project
- Specific problems and required approaches
International cooperation on health plays a crucial role in public health. In the context of organisation, health inequality, foreign policy and global health security, such collaboration is more vital than ever, bringing benefits to both developed and developing countries. There are many international cooperative programs that have been implemented in China, and the trend of international cooperation on health is increasing. Though the current political environment and commitment to address health has created unprecedented opportunities for international health cooperation, many challenges have emerged with the rapid changes in China.

Our globalised world is varied, complex, and changing. Since an increasing number of players are actively involved, issues regarding cooperation and effectiveness of partnerships have become high profile among international communities and their partner countries. Partnership is a very important approach for the health field. Although partnerships can bring many benefits, making them work more efficiently and effectively can be a tough challenge.

As a global crisis, HIV/AIDS requires a concerted response through global action and cross-sectoral collaboration. The global response to the HIV/AIDS epidemic has been radically transformed over the past years. Developing countries like China need to encourage international cooperation to support country-driven HIV/AIDS response strategies. In developing the country strategies consideration should be given to the challenges rising from the international cooperation and partnership approach.

HIV/AIDS is a major threat to China. As a country with a huge population, China faces special difficulties in HIV/AIDS prevention and control and would like to cooperate with other countries and international agencies concerned in such areas. Recently the Chinese government increased funding for HIV/AIDS prevention and control and has called for all sectors to be involved. While the government increased its HIV/AIDS budget, it also broadened fund-raising channels and utilised resources from international resources. Correspondingly, HIV/AIDS prevention and control is the focus working area for the international community. Given this complex situation, many challenges and issues related to international cooperation and partnerships have emerged. These issues are related with overlapping mandates, donor-driven,
proliferation, collaboration, and stability and sustainability. Solving these problems can be through project management.

All international health cooperation operates via projects. When considering the complex situation of the China HIV/AIDS project, project management is a powerful tool that can be used to achieve project success. The main purpose of the study is to using project management to solve the problems and then provide recommendations and future directions at the national level, to help the central government in developing policies and strategic planning for HIV/AIDS prevention, care, support and treatment, and to explore the strategies for international health cooperation in China. The contextual framework identifies the relationships among the stages of the study.

7.3. Research Design and Methodology

Research design is the argument for the logical steps which will be taken to link the research question and issues to data collection, analysis and interpretation in a coherent way (Hartley, 2004). Yin (2009, p. 26) stated that a research design is a “logical plan” for getting the “initial set of questions to be answered” to “some set of conclusions (answers) about these questions”. Between the “questions” and “answers”, there are a number of major steps, including the collection and analysis of relevant data. A research design guides the investigator in the process of collecting, analysing, and interpreting observations (Frankfort-Nachmiñas & Nachmias, 2008).

The aim of this section, and an important starting point for all research, is to develop a research method for this study. This section describes the processes of the research design and discusses the theory and rationale of methods chosen in this research. The research design details the stages of the study, including qualitative techniques, data collection methods in each phase of fieldwork, and data analysis techniques. The research methodology explains why and how the methods in this research were chosen.

7.3.1. Research Design

Figure 8 illustrates the methodology framework of the research. It includes three stages: literature review, data collection and data analysis. Each stage represented on the left side of the flowchart is supported by further details (on the right side of the chart). In the
first stage, the literature review provides an understanding of the four contextual fields of the research. In the second stage, the research uses a triangulation approach, combining qualitative and quantitative methods to collect data. A case study was conducted. Data collection methods included participant observations, key informants interviews (in-depth and focus group interviews), and documents and secondary data analysis. The analysis of the qualitative and quantitative data in the third stage provides further discussion and recommendations.
Figure 8: Research Design

Research Question: What are the key challenges and facilitating factors for international cooperation on HIV/AIDS prevention and control in China?

Stage One
- Literature Review

Stage Two
- Literature Review
- Phase I: (Preliminary Study)
- Phase II: Case Study (Data Collection)

Field work
- Phase III: Follow-up Data Collection

Stage Three
- Data Analysis
- Results and Findings
- Discussion and Recommendations

Documents Analysis
- International Health Cooperation (Background)
- Partnership in Public Health (Approach)
- HIV/AIDS Prevention and Control in China (Particular area)
- International Development Project Management (Tool)

In-depth Interviews

Case Study
- Documentation Review
- Participant Observation
- In-depth Interviews
- Focus Group
- Secondary data review

Follow-up In-depth Interviews

Qualitative Data Analysis

Quantitative Data Analysis

Results and Findings
7.3.2. Research Methodology

Social scientific research involves qualitative data (non-numerical) and quantitative data (data in the form of numbers) (Neuman, 2011). Qualitative and quantitative approaches share core scientific principles, but also differ in significant ways (Table 14). Both approaches use multiple research techniques (for example survey, interview, ethnography) to gather and analyse empirical data (Neuman, 2011). Each approach has its strengths and limitations, and should be used in complementary ways.

Table 14: Qualitative versus Quantitative Approaches

<table>
<thead>
<tr>
<th>QUALITATIVE APPROACH</th>
<th>QUANTITATIVE APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct social reality, cultural meaning</td>
<td>Measure objective factors</td>
</tr>
<tr>
<td>Focus on interactive processes, events</td>
<td>Focus on variables</td>
</tr>
<tr>
<td>Authenticity the key factor</td>
<td>Reliability the key factor</td>
</tr>
<tr>
<td>Values present and explicit</td>
<td>Value free</td>
</tr>
<tr>
<td>Theory and data fused</td>
<td>Separate theory and data</td>
</tr>
<tr>
<td>Situationally constrained</td>
<td>Independent of context</td>
</tr>
<tr>
<td>Few cases, subjects</td>
<td>Many cases, subjects</td>
</tr>
<tr>
<td>Thematic analysis</td>
<td>Statistical analysis</td>
</tr>
<tr>
<td>Researcher involved</td>
<td>Researcher detached</td>
</tr>
</tbody>
</table>

Sources: Neuman (2011, p. 17)

Mixed Methods

Mixed methods is a fairly recent addition to the research lexicon, which was formerly referred to as “multi-method”, “multi-strategy”, or “triangulation by method” (Tashakkori & Teddlie, 2010). Because all methods have strengths and weaknesses, a single research method cannot tap all dimensions of a complex problem; and therefore combinations of multiple methods are particularly valuable. Similar results from more methods could increase the credibility of the findings, whereas dissimilar results might raise new questions about alternative interpretations (Ulin, Robinson, & Tolley, 2005). There are three reasons for carrying out mixed methods studies, which include triangulation (refers to comparisons for purposes of corroboration), complementarity (refers to enhancement or clarification) and expansion (refer to presenting “side-by-side” or juxtaposed findings to keep them intact) (Caracelli & Greene, 1997; Padgett, 2012). Many researchers have demonstrated that combining qualitative and
quantitative strategies in a single study can result in a more powerful design than either used alone.

According to Silverman (2006), there are three main ways to combine quantitative and qualitative research: 1) using qualitative research to explore a particular topic in order to set up a quantitative study; 2) beginning with a quantitative study in order to establish a sample of respondents and to establish the broad contours of the field, then using qualitative research to look in depth at a key issue using some of the earlier sample; 3) engaging in a qualitative study which uses quantitative data to locate the results in a broader context.

This research utilised mixed methods in order to gain complementary views about the same phenomenon. The research mainly used qualitative methods, while engaging quantitative methods to complement and enlarge the qualitative methods (Figure 9). The researcher started by exploring the key influencing factors and challenges in international cooperation in China by using a qualitative approach such as document review and analysis and in-depth interviews. Then, based on the qualitative exploration, a case study was conducted. Both qualitative and quantitative data were collected and analysed in parallel and then merged together to develop a more complete understanding, or to compare the different results.

**Figure 9: Quantitative Methods to Enlarge Qualitative Study**

![Diagram of Quantitative Methods to Enlarge Qualitative Study]

**Case Study**

This research conducted a case study to help the researcher to understand a real-life phenomenon in depth. The case study method has a long and honourable history in social research. Gillham (2000, p. 1) defined a case study as “one which investigates the
cases (can be an individual, an institution, a large-scale community, or multiple cases) to answer specific research questions (that may be fairly loose to begin with) and which seeks a range of different kinds of evidence, evidence which is there in the case setting, and which has to be abstracted and collated to get the best possible answers.” The case study addresses either a descriptive question (What is happening or has happened?) or an explanatory question (How or why did something happen?) (Yin, 2012, p. 5). The reason for using the case study method is to understand a real-life phenomenon in depth (Yin, 2009).

Regardless of its subject matter, the case study draws on multiple perspectives and data sources to produce contextually rich and meaningful interpretation (Padgett, 2012). The major strength of the case study is its ability to deal with a wide range of evidence. It is not only a collection technique but a comprehensive research strategy that takes into account the many variables affecting one result, allows triangulation, and is guided by theoretical propositions (Yin, 2009). Yin (2009, p. 19) suggested that the case study method is “not just a form of qualitative research, it can include quantitative evidence”. Some case study research goes beyond being a type of qualitative research, by using a mix of qualitative and quantitative evidence. Using multiple sources of evidence, each with its strengths and weaknesses, is a key characteristic of case study research (Gillham, 2000).

Six sources of evidence are the ones most commonly used in doing case studies: documentation, archival records, interviews, direct observations, participant observation, and physical artefacts (Yin, 2009). Yin (2009) highlighted their comparative strengths and weakness. These strengths and weakness are shown in Table 15. As the various sources are highly complementary, a good case study should therefore use as many sources as possible.
Table 15: Case Study Six Sources of Evidence: Strengths and Weaknesses

<table>
<thead>
<tr>
<th>Source of evidence</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
</table>
| Documentation      | • Stable—can be reviewed repeatedly  
                      • Unobtrusive—not created as a result of the case study  
                      • Exact—contains exact names, references, and details of an event  
                      • Broad coverage—long span of time, many events, and many settings  | • Retrievability—can be difficult to find  
                      • Biased selectivity, if collection is incomplete  
                      • Reporting bias—reflects (unknown) bias of author  
                      • Access—may be deliberately withheld  |
| Archival records   | • [Same as those for documentation]  
                      • Precise and usually quantitative  | • [Same as those for documentation]  
                      • Accessibility due to privacy reasons  |
| Interviews         | • Targeted—focuses directly on case study topics  
                      • Insightful—provides perceived causal inferences and explanations  | • Bias due to poorly articulated questions  
                      • Response bias  
                      • Inaccuracies due to poor recall  
                      • Reflexivity—interviewee gives what interviewer wants to hear  |
| Direct observations | • Reality—covers events in real time  
                      • Contextual—covers context of “case”  | • Time—consuming  
                      • Selectivity—broad coverage difficult without a team of observers  
                      • Reflexivity—event may proceed differently because it is being observed  
                      • Cost—hours needed by human observers  |
| Participant-observation | • [Same as above for direct observation]  
                      • Insightful into interpersonal behaviour and motives  | • [Same as above for direct observation]  
                      • Bias due to participant-observer’s manipulation of events  |
| Physical artifacts  | • Insightful into cultural features  
                      • Insightful into technical operations  | • Selectivity  
                      • Availability  |

Source: Yin (2009, p. 102)
This research uses a single-case study. The single-case study is an appropriate design under several circumstances. Yin (2009) gave five rationales for single-case designs (Box 5).

**Box 5: Five Rationales for Single-Case Designs**

1. A critical case in testing a well-formulated theory. The theory has specified a clear set of propositions as well as the circumstances within which the propositions are believed to be true. A single case, meeting all of the conditions for testing the theory, can confirm, challenge, or extend the theory. The single case can then be used to determine whether a theory’s propositions are correct or whether some alternative set of explanations might be more relevant.

2. An extreme case or a unique case. Either of these situations commonly occurs in clinical psychology, where a specific injury or disorder may be so rare that any single case is worth documenting and analysing.

3. Representative or typical case. The case study may represent a typical “project” among many different projects, a manufacturing firm believed to be typical of many other manufacturing firms in the same industry, a typical urban neighbourhood, or a representative school, as example. The lessons learned from these cases are assumed to be informative about the experiences of the average person or institution.

4. Revelatory case. This situation exists when an investigator has an opportunity to observe and analyse a phenomenon previously inaccessible to social science inquiry.

5. Longitudinal case. Studying the same single case at two or more different points in time. The theory of interest would likely specify how certain conditions change over time, and the desired time intervals would presumably reflect the anticipated stages at which the changes should reveal themselves.

Source: modified from Yin (2009, pp. 47-49)

This research aims to identify the facilitating factors and challenges of international HIV/AIDS project in China (research question refers to “what” and “how and why” in depth) from a real-world context and needs to collect data in natural settings. Thus, conducting a case study is necessary. The research selected the China Global Fund AIDS Program as the case study.
The China Global Fund AIDS program is a representative and typical international AIDS program in China. The Global Fund is a signatory member to a number of international initiatives that aim to improve aid effectiveness. Principles include support to country-owned and aligned programs, through a partnership model that is committed to delivering accountable results (The Global Fund, 2011). To effectively avoid duplication and to maximise existing capacity at the national level, a multitude of stakeholders have been involved in program design and implementation. The Global Fund Program is the largest international health program in China. The China Global Fund AIDS Program is a Consolidated Rolling Continuation Channel (RCC) Program. The Program consolidated all China Global Fund AIDS program grants (grant 3/4/5/6/8), and all the resources on HIV/AIDS prevention and control in China, including centrally transferred funds, local funds from provincial, city and county levels and other international cooperation funds. The RCC program was formally initiated on 1st January 2010, and will be ending in December 2013.

In this case study research, the researcher used multiple sources of evidence to address the research question. These sources include documentary review, participant observation, in-depth interviews, focus group interviews and existing and secondary data analysis. All the data were analysed and interpreted for findings.

**Data collection methods**

Kumar (2005) described methods of data collection which are shown in Figure 10. In this research, the researcher formulated sampling approaches for both the quantitative and qualitative data collection to ensure some degree of representation and to reflect a broad range of stakeholder perspectives.
Qualitative Methods

*Literature and documentary review*

A literature review can be an effective way of defining a problem, and finding the current thinking on a subject (Dwyer et al., 2004). A literature review establishes the background of the study and the context for the analysis, helping the researcher to understand knowledge, share the results of other studies, and provide a framework for establishing the importance of the research.

This research began from a comprehensive literature review. The literature review went through the whole research. In the field work, the researcher reviewed lots of project documents, reports, meeting minutes etc. and collected relevant data to analyse.

*Participant observation*

Participant observation is especially appropriate for exploratory studies, descriptive studies, and studies aimed at generating theoretical interpretations (Jorgensen, 1989). It
is generally practiced as a form of case study that concentrates on in-depth descriptions and analysis of some phenomenon or set of phenomena (Jorgensen, 1989). From observation, a researcher can have a first-hand experience with participant and record information as it occurs (Creswell, 2009), describe what goes on, who or what is involved, when and where things happen, how they occur, and why, at least from the standpoint of participants, things happen as they do, in particular situations (Jorgensen, 1989).

Since this is an exploratory and descriptive research and single-case study, participant observation is useful for forming new theories as well as testing existing ones. In this research, the researcher worked as a project officer in the National Global Fund AIDS Program Office for nine months (April to December, 2011). During this period, the researcher was directly or indirectly involved in all the important events which happened in that period. Direct observation and experience are primary forms and methods of data collection, but the researcher also needed to conduct interviews, collect documents, and use other methods of gathering information.

**In-depth interview**

An in-depth interview is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation (Boyce & Neale, 2006). The aim of in-depth interviews, as Liamputtong (2009, p. 43) suggested, is ‘to elicit rich information from the perspective of a particular individual and on a selected topic under investigation.’ In-depth interviews are typically an exchange between a researcher and a participant. Walliman (2006) identified the three types of interview which are often mentioned: structured interview -- standardised questions read out by the interviewer according to an interview schedule; unstructured interview -- a flexible format, usually based on a question guide, but where the format remains the choice of the interviewer, who can allow the interview to “ramble” in order to get insights into the attitudes of the interviewee; and a semi-structured interview -- one that contains structured and unstructured sections with standardised and open-format questions. Table 16 shows the three different interview types.
Table 16: Interview Structure Continuum of Formality

<table>
<thead>
<tr>
<th>Structured interviews</th>
<th>Semi-structured interviews</th>
<th>Unstructured interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Most formally structured.</td>
<td>■ More or less structured.</td>
<td>■ Completely unstructured.</td>
</tr>
<tr>
<td>■ No deviations from question order.</td>
<td>■ Questions may be reordered during the interview.</td>
<td>■ No set order to any questions.</td>
</tr>
<tr>
<td>■ Wording of each question asked exactly as written.</td>
<td>■ Wording of questions flexible.</td>
<td>■ No set wording to any questions.</td>
</tr>
<tr>
<td>■ No adjusting of level of language.</td>
<td>■ Level of language may be adjusted.</td>
<td>■ Level of language may be adjusted.</td>
</tr>
<tr>
<td>■ No clarifications or answering of questions about the interview.</td>
<td>■ Interviewer may answer questions and make clarifications.</td>
<td>■ Interviewer may answer questions and make clarifications.</td>
</tr>
<tr>
<td>■ No additional questions may be added.</td>
<td>■ Interviewer may add or delete probes to interview between subsequent subjects.</td>
<td>■ Interviewer may add or delete questions between interviews.</td>
</tr>
<tr>
<td>■ Similar in format to a pencil-and-paper survey.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: modified from Berg (2009, p. 105)

In this research, semi-structured in-depth interviews were conducted with key informants (both international staff and Chinese staff) who were associated with the international project management from various organisations, such as government officials at national and sub-national levels, experts/heads of health programs, NGOs, bilateral organisations, multilateral organisations, and private sector informants. Certain key informants were interviewed more than once to obtain updates on the status of implementation of Global Fund activities. Interview guides were adapted to reflect the knowledge and experience of different sub-groups of key informants. Informed consent was obtained from all respondents. The Informed Consent Form and Indicative Questions for In-Depth Interview and Focus Group are presented in Appendix A and B. The interviews lasted between 50 and 90 minutes each and they were tape recorded and transcribed.
Focus group

Focus groups are relatively homogeneous. They are composed of people who are similar with respect to characteristics related to the topic and have become a more commonly used method of data collection in health research in recent years (Liamputtong, 2009). The only difference between a focus group interview and an in-depth interview is that the former is undertaken with a group and the latter with an individual (Walliman & Ebooks Corporation., 2006). The focus groups are commonly used in the areas of exploratory studies in health issues, testing ideas about and acceptances of new programs, solving specific program problems and evaluating health programs (Liamputtong, 2009). In a focus group, the researcher explores the perceptions, experiences and understandings of a group of people who have some experience in common with regard to a situation or event. It can be quite difficult to organise focus groups due to the difficulty of getting a group of people together for a discussion session (Walliman & Ebooks Corporation., 2006).

In this research, the focus group discussions were conducted in order to explore key emergent themes from the individual interviews and to address some of the discrepancies and gaps in the interview data. Two focus groups were undertaken to investigate the views of Chinese project officers in the implementation of international HIV/AIDS projects (particularly for the Global Fund Program). For each focus group, six and eight participants were recruited. The participants were the project officers at national and provincial level.

Quantitative Methods

Existing statistics/documents and secondary data analysis

Secondary analysis entails the analysis of data that others have collected. The existing and secondary data are normally high-quality data (Bryman, 2012). In the field work, the researcher was involved in the project management, and collected and reviewed a large range of documents and existing data. These documents and data included existing regulations and manuals, program management letters, meeting minutes, periodic review reports, operational research reports, auditing reports, self-correction reports.
From 1 to 15 June 2011, the program self-check and self-correction were conducted, covering financial management, program management and materials verification. A questionnaire survey was sent to all program offices. As the questionnaires were sent to the program officers officially, the response rate was 100 per cent. For the questionnaire details see Appendix C. As a member of staff in the national program office, the researcher was involved in questionnaire collection, analysis and report.

7.4. Research Progress

7.4.1. Stage one: Literature review

This research began by reviewing relevant literature and documents of the research contextual fields. The review drew on a large data source including books, journal articles, government documents, policy reports and conference papers. Searches were varied and came from different sources. Most books were searched for in the library catalogue. Journal article searches were made from the library catalogue, and reference lists of retrieved articles and textbooks, and electronic literature databases, such as: ScienceDirect, John Wiley and Sons, Medline, Health and Medical Complete (ProQuest). All sources were searched for over the period covered by the databases up to the present. Publications in all languages were sought, although for non-English-language publications, only abstracts in English and Chinese were evaluated. Google Scholar was used to search for sources from the Internet. The Internet web sites of international organisations and governments, as well as any of their relevant documents were accessed. Websites in English and Chinese were accessed. Documents and reports regarding China were of particular interest. Google was also used to search Chinese web sites and documents. Publications and documents both in English and Chinese were sought. The unpublished papers of oral reports and presentations, which come from Chinese formal and informal academic conferences and government meetings, have also been reviewed. The key search words varied depending on the topics of the different contextual fields.

The initial search produced hundreds of sources related in some way to the research. All the sources were first screened for relevance from their titles and abstracts. The relevant articles were then evaluated for their content from the introductions and conclusion
sections to decide whether they were worth selecting for further study. Only sources that addressed some aspects of this research were included.

Based on the literature, the researcher developed the research question and designed the research plan. The literature review went through every part of the research.

7.4.2. Stage two: Fieldwork and data collection

This stage involved three phases: preliminary study, case study and follow-up interviews.

*Phase One -- Preliminary study: September to December, 2010*

From September to December, 2010, the researcher conducted a preliminary study in Beijing, China. The major task in this phase was fieldwork preparation and carrying out an in-depth exploration through various methods, including review of documents and program reports, and a series of key informant interviews. There are a total of 22 in-depth interviews that were conducted in this stage. The details of the key informants are listed in Table 17.
Table 17: Details of the Key Informants

<table>
<thead>
<tr>
<th>Organisation of Key informants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese Government Agency</td>
<td></td>
</tr>
<tr>
<td>MOH</td>
<td></td>
</tr>
<tr>
<td>● Department of Disease Control (1)</td>
<td></td>
</tr>
<tr>
<td>● Department in International Cooperation (2)</td>
<td>3</td>
</tr>
<tr>
<td>China CDC</td>
<td></td>
</tr>
<tr>
<td>● National Center for AIDS/STD Prevention and Control (3)</td>
<td></td>
</tr>
<tr>
<td>● National Center for Chronic and Non communicable Disease Control and Prevention (2)</td>
<td>7</td>
</tr>
<tr>
<td>● National Center for Tuberculosis Control and Prevention (1)</td>
<td></td>
</tr>
<tr>
<td>● Office for Disease Control and Emergence Response (1)</td>
<td></td>
</tr>
<tr>
<td>International Organisation</td>
<td></td>
</tr>
<tr>
<td>Multilateral Organisation</td>
<td></td>
</tr>
<tr>
<td>● WHO (3)</td>
<td></td>
</tr>
<tr>
<td>● International Labour Organisation (1)</td>
<td></td>
</tr>
<tr>
<td>● UNAIDS (1)</td>
<td>5</td>
</tr>
<tr>
<td>Bilateral Organisation</td>
<td></td>
</tr>
<tr>
<td>USCDC (1)</td>
<td></td>
</tr>
<tr>
<td>Australian Embassy (1)</td>
<td>2</td>
</tr>
<tr>
<td>Chinese NGOs</td>
<td></td>
</tr>
<tr>
<td>● Chinese Association of STD/AIDS Prevention and Control (2)</td>
<td>2</td>
</tr>
<tr>
<td>Research institute</td>
<td></td>
</tr>
<tr>
<td>● School of Public Health, Peking University</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>
conceptualisation of the research and contributed to the construction of the research question. The indicative questions of the in-depth interview are listed in Appendix B.

**Phase Two -- Fieldwork -- Case Study: April to December, 2011**

Field research is often a case study, but choosing a field is not identical to focusing on a case for study (Neuman, 2011, p. 429). During the field period, the researcher worked as a program officer in the National Global Fund AIDS Program Office, involved in the day-to-day work of program management. During this period, the researcher experienced “grant freeze”, “program self-check and self-correction”, “lifting of grant freeze”, diagnostic review conducted by Global Fund Office of the Inspector General (OIG), and the notice of grant early termination (details of which are in Chapter Eight). The main responsibilities of the researcher included: providing assistance to collect, certify and analyse various data and information; to assist in reviewing budgets, financial reports and conducting correction reports; assisting with daily office routines and performing other duties as required. The researcher worked closely with the project manager (and duty manager), other project officers, directly contacted local project officers (especially with provincial level officers), counterpart officers from other organisations (including international organisations and NGOs) and members of the Global Fund.

For the qualitative component of the study, 32 in-depth semi-structured interviews were conducted from May 2011 with key actors in Global Fund implementation and the health sector more broadly. Key informants details are in Table 18. In the Global Fund level, members were from CCM and LFA. The public sector, included interviews at the national level with senior Ministry of Health officials and the directors of the national programs for AIDS and TB; and at the sub-national level, with departmental and district health representatives and a provider involved in Global Fund service delivery. Outside the public sector, interviews were conducted with representatives of bilateral development agencies, domestic and international NGOs, the private for-profit sector, and other international organisations (for example WHO). Certain key informants were interviewed twice in order to get the latest information on Global Fund activities.
Table 18: Phase Two In-Depth Interview Key Informants Details

<table>
<thead>
<tr>
<th>Organisation of Key informants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global Fund</strong></td>
<td></td>
</tr>
<tr>
<td>- China Global Fund CCM</td>
<td></td>
</tr>
<tr>
<td>• Government agency (1)</td>
<td></td>
</tr>
<tr>
<td>• International organisations (1)</td>
<td>3</td>
</tr>
<tr>
<td>• LFA staff (1)</td>
<td></td>
</tr>
<tr>
<td><strong>China PR</strong></td>
<td></td>
</tr>
<tr>
<td>- Finical officer (1)</td>
<td></td>
</tr>
<tr>
<td>- M&amp;E officer (1)</td>
<td>2</td>
</tr>
<tr>
<td><strong>National AIDS Program Office</strong></td>
<td></td>
</tr>
<tr>
<td>- Managers and deputy manager (2)</td>
<td></td>
</tr>
<tr>
<td>- Program officer (6)</td>
<td>8</td>
</tr>
<tr>
<td><strong>National TB Program Office</strong></td>
<td></td>
</tr>
<tr>
<td>- Program officer (1)</td>
<td>1</td>
</tr>
<tr>
<td><strong>SR (SSR)</strong></td>
<td></td>
</tr>
<tr>
<td>- Beijing Municipal program officer (2)</td>
<td></td>
</tr>
<tr>
<td>- Guang Dong Provincial program officer (1)</td>
<td></td>
</tr>
<tr>
<td>- CSO/CBO SR (Chinese Association of STD/AIDS Prevention and Control (1)</td>
<td>4</td>
</tr>
<tr>
<td><strong>Other member involved in Global Fund program management</strong></td>
<td></td>
</tr>
<tr>
<td>- MOH (2)</td>
<td></td>
</tr>
<tr>
<td>- China CDC (3)</td>
<td></td>
</tr>
<tr>
<td>- UN organisation</td>
<td></td>
</tr>
<tr>
<td>• WHO (2)</td>
<td></td>
</tr>
<tr>
<td>- Bilateral Development Agencies</td>
<td></td>
</tr>
<tr>
<td>• DFID (1)</td>
<td></td>
</tr>
<tr>
<td>- International NGOs</td>
<td></td>
</tr>
<tr>
<td>• Family Health International 360 (1)</td>
<td></td>
</tr>
<tr>
<td>• Bill &amp; Melinda Gates Foundation (1)</td>
<td></td>
</tr>
<tr>
<td>- Private For-Profit Sectors</td>
<td></td>
</tr>
<tr>
<td>• Merck Corporate, China (1)</td>
<td>11</td>
</tr>
<tr>
<td><strong>Other international project officer</strong></td>
<td></td>
</tr>
<tr>
<td>- CHARTS project officer (1)</td>
<td>2</td>
</tr>
<tr>
<td>- GAP project officer (1)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32</td>
</tr>
</tbody>
</table>

The interview items included descriptive information concerning the project, its organisation and proceedings, project management practices, people’s experiences and expectations related to the project, the thoughts they had concerning project operations, processes, and outcomes, and about any changes they perceived in themselves as a result of their involvement in the projects. The objective was to gain knowledge especially about the management contexts of the projects.
Using the opportunities of a workshop and progress report meeting, the researcher also conducted two focus group discussions. The participants were program officers at national and sub-national level (Table 19). The first focus group discussion included six participants and the second include eight. The researcher, as a moderator, introduced the topic and assisted the participants to discuss it, encouraging interaction and guiding the conversation. The main issues of program management were discussed in the meetings (indicated questions of the focus group are listed in Appendix B). Each focus group discussion lasted around one hour.

**Table 19: Participants of Focus Group Discussion**

<table>
<thead>
<tr>
<th>Number of participants</th>
<th>Focus group discussion 1</th>
<th>Focus group discussion 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>National level</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sub-national level</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

The data collected also were from a mix of formal one-to-one conversations (not interviews), informal conversations, the views of the management team support staff present at the meetings and the researcher’s own observations. In addition, project documentation such as project plans, progress reports, financial reports and lessons learned reports complemented the interview data in the case analysed.

Besides collecting the qualitative data, the researcher also collected the quantitative data. During the field work, the researcher reviewed all the relevant project management documents reports (including financial and audit reports) and recorded the important data. During the Global Fund funding freeze, the program started to implement self-check and self-correction (June 1 to 15, 2011) across the country and received field monitoring from the Ministry of Health and PR (each monitoring 15 provinces), covering financial management, program management and materials verification. A comprehensive questionnaire was sent to the project officers at each level (Appendix C). The researcher was involved in this questionnaire survey process and data analysis.
Phase Three -- Follow-up interviews: September to October, 2012

As so many changes occurred, the researcher proceeded with follow-up in-depth interviews. The researcher visited National Global Fund AIDS Program Office again, and had in-depth discussions with program managers and officers. Government officials, staff from international organisation and international and domestic NGOs were also interviewed. Nine key informants were interviewed. These discussions focused on the current Global Fund Program implementation and future HIV/AIDS programs. The interview questions are listed in the Appendix D. Organisations of key informants are listed in the following Table 20.

Table 20: Phase Three In-Depth Interview Key Informants Details

<table>
<thead>
<tr>
<th>Organisation of Key Informants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government agency</td>
<td>1</td>
</tr>
<tr>
<td>China CCM</td>
<td>1</td>
</tr>
<tr>
<td>National AIDS Program Office</td>
<td>4</td>
</tr>
<tr>
<td>National TB Program Office</td>
<td>1</td>
</tr>
<tr>
<td>Domestic NGO</td>
<td>1</td>
</tr>
<tr>
<td>International NGO</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9</td>
</tr>
</tbody>
</table>

7.4.3. Stage Three: Data Analysis

In general, data analysis means a search for patterns in data—recurrent behaviours, objects, phases, or ideas. Data analysis involves examining, sorting, categorising, evaluating, comparing, synthesizing, and contemplating the coded data as well as reviewing the raw and recorded data (Neuman, 2011, p. 517). The similarities and differences between qualitative and quantitative data analysis are listed in Table 21.
Table 21: Comparing Quantitative and Qualitative Data Analysis

<table>
<thead>
<tr>
<th>SIMILARITIES</th>
<th>DIFFERENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both infer from the empirical data to abstract ideas</td>
<td>Quantitative uses a few shared, standardised techniques. Qualitative uses may diverse, nonstandard techniques.</td>
</tr>
<tr>
<td>Both use a public process and described in detail</td>
<td>Quantitative analyses after all data have been collected. Qualitative begins data analysis while still collecting data.</td>
</tr>
<tr>
<td>Both make comparisons</td>
<td>Quantitative tests pre-existing theories and hypotheses. Qualitative conceptualizes and builds a new theory.</td>
</tr>
<tr>
<td>Both avoid errors and false conclusions</td>
<td>Quantitative uses precise and compact abstract data. Qualitative uses imprecise, diffuse, relatively concrete data.</td>
</tr>
</tbody>
</table>

Source: Neuman (2011, p. 509)

**Qualitative Data**

Despite these analytical differences, depending on the type of strategy used, Creswell (2009) developed a general procedure and proposed the steps for data analysis (Figure 11). In this research, the researcher analysed qualitative data in the following steps: 1) transcribing interviews, optically scanning material, typing up field notes; 2) reading through all the data and coding to generate a small number of themes or categories. These themes are the ones that appear as major findings and are used to create headings in the findings sections of the research. 3) using a narrative passage to convey the findings of the analysis; 4) making of an interpretation or meaning from the data.
Recording the data

**Writing field notes**

Field notes are the qualitative research equivalent to quantitative researchers’ “raw data.” During the field work, the researcher chose the important data to record and saved it to the hard drive and external drive.

**Transcription**

It is important to transcribe everything that is said during the interviews, including the interviewer’s own questions and probes, because these shape the respondent’s answers (Warren & Karner, 2010). It is also important to transcribe everything the respondent says, including things that do not seem important or relevant to the topic, because what seems irrelevant at one stage of interviewing might seem much more relevant at a later time during the analysis phase (Warren & Karner, 2010).
In this research, all interviews and the focus group discussions were recorded by using a digital recorder and then relayed through a USB port to the computer. The in-depth interviews and group discussions were transcribed and downloaded electronically into the researcher’s personal laptop. The transcription includes everything that was said during the interviews and focus groups discussions, including the researcher’s own questions and probes, and everything the respondents said. Key themes were identified in the interview transcripts.

Coding
This research follows the general processes to code qualitative data: Open Coding which examines the data to condense them into preliminary analytic categories or codes; Axial Coding which organises the codes, links them, and discovers key analytic categories; and Selective Coding which that examines previous codes to identify and select data that will support the conceptual coding categories that were developed (Neuman, 2011).

The open coding focused on the actual data and on assigning code labels for themes. It then organised ideas or themes and identified the axis of key concepts in analysis. Finally it reorganised specific themes identified in earlier coding during the selective coding. Based on the coding, the case descriptions were formulated.

The computer software program QSR NVivo (version 8) was used to speed up the analysis and facilitate the coding process. The researcher first imported all the data, including interview transcripts, field notes, memos into the software program, then created nodes as storage devices for ideas, coding, and the results of searches.

Almost all information and data were managed and analysed during the fieldwork. The translation of the information from Chinese to English, and the final analysis, were completed in Australia.

Quantitative Data
According to Neuman (2011), researchers do several things to the quantitative raw data: reorganise them into a form suitable for computers, present them in charts or graphs to
summarise their features, and interpret or give theoretical meaning to the results. In this study, the researcher analysed some secondary data. For these quantitative data, the researcher first coded the raw data. Then using software SPSS 19 analysed the data and described the numerical data with a frequency distribution.

7.5. Issues of Rigour and Ethics

7.5.1. Issues of Rigour

Rigour refers to the issues that are raised by reliability and validity (Liampoutong, 2009; Liampoutong & Ezzy, 2005). Reliability refers to the ‘stability of findings’ and validity the ‘truthfulness of findings’ (Neuman, 2011). Neuman (2011) concludes that reliability means dependability or consistency; it suggests that the same thing is repeated or recurs under the identical or very similar conditions. Validity suggests truthfulness and refers to the match between a construct, or the way a researcher conceptualises the idea in a conceptual definition, and a measure. It refers to how well an idea about reality “fits” with actual reality. Reliability and validity are the central issues in all measurement.

Reliability and Validity in Qualitative Methods

Reliability

Reliability in qualitative methods is concerned with the question of whether the results of the study are repeatable, whether the measures that are devised for concepts are consistent (Bryman, 2012). Reliability in qualitative research includes external reliability (by which is meant the degree to which a study can be replicated) and internal reliability (by which is meant whether, when there is more than one observer, members of the research team agree about what they see and hear) (Bryman, 2012). In this research, the researcher interviewed all the key informants by using the semi-structured interview which focused on same topics. The observer is the researcher, she coded and analysed all the data. Also, the researcher kept all the detailed transcriptions of interviews and notes of participant observation to assist readers to evaluate the research.
Validity

Validity is concerned with the integrity of the conclusions that are generated from a piece of research (Bryman, 2012). The core of the concept is truthfulness. It refers to the bridge between a construct and the data (Neuman, 2011). Two types of validity in qualitative research are identified: internal validity (by which they mean whether there is a good match between the researchers’ observations and the theoretical ideas they develop) and external validity (the degree to which findings can be generalised across social settings) (Bryman, 2012; Neuman, 2011). Neuman (2011) argued that qualitative researchers try to create a tight fit between their understanding, ideas, and a statement about the social world and what is actually occurring in it. This research adopts a triangulation approach to address the issue of validity. In this research, the key informants come from varied organisations with different backgrounds. The researcher used a variety of data collection techniques--document reviews, participant observation, focus groups, and in-depth interviews to ensure validity. All the information came from real cases.

Reliability and Validity in Quantitative Method

Reliability

Reliability in the quantitative method is concerned with issues of consistency of measures (Bryman, 2012). It involves three prominent factors: stability (whether a measure is stable over time), internal reliability (whether the indicators that make up the scale or index are consistent), and inter-observer consistency (whether the recording of observations or the translation of data into categories are consistent when there are more than one observer) (Bryman, 2012). According to Neuman (2011), there are four ways to increase the reliability of measures in quantitative methods: 1) clearly conceptualise constructs; 2) use a precise level of measurement; 3) use multiple indicators; and 4) use pilot tests. In this research, the questionnaire survey was conducted for the China Global Fund AIDS Program self-check, self-correction and rectification. The indicators cover all the aspects of the program implementation. The questions were pretested before the survey was conducted.
Validity

Validity in quantitative research refers to whether the means of measurement are accurate and whether they are actually measuring what they are intended to measure (Bryman, 2012; Golafshani, 2003). In order to improve the validity, the quantitative data were collected after the qualitative data. The questionnaire which was used in this research was designed based on the findings of focus groups and in-depth interviews of project staff and developed by experienced project officers. Before the survey was applied, the questionnaire was also reviewed by several senior program officers and relevant experts and was pretested.

7.5.2. Ethical Issues

Ethics is a set of moral principles that aim to prevent research participants from being harmed by the researcher and the research process (Neuman, 2011). Ethics defines “what is or is not legitimate to do, or what ‘moral’ research procedure involves” (Neuman, 2011, p. 143). Ethical issues arise from the kinds of problems social scientists investigate and the methods used to obtain valid and reliable data. These may emanate from the research problem itself (for example genetic engineering, determinants of intelligence, program evaluation), the setting in which the research takes place (hospitals, prisons, public schools, government agencies), the procedures required by the research design (exposure of research participants to conditions that may have negative effects on them), the method of data collection (covert participant observation), the kinds of persons serving as subjects (the poor, children, people with AIDS, politicians), and the type of data collected (personal information, recruitment practices in public agencies) (Frankfort-Nachmias & Nachmias, 2008).

There are a few ethical absolutes. Firstly, participation must be voluntary. In this research, before the interviews, all the key informants read and signed a written agreement statement -- informed consent -- after they had learned something about the research procedure. To ensure that interviewers were able to give full informed consent, the researcher provided a full disclosure of the nature of the research. For the survey, the researcher stated clearly the purpose at the outset and let people know that they had the right to refuse to participate and could withdraw from the research at any
time. The informed consent of in-depth interviews and focus groups are attached in *Appendix A*.

Secondly this research also involved anonymity and confidentiality to address the ethical issues. According to Neuman (2011), anonymity means that subjects remain anonymous or nameless; confidentiality means that information may have names attached to it, but the researcher holds it in confidence or keeps it secret from the public. In this research, the data which was collected through individual interviews and focus group sessions is rendered anonymous, so that no individual can be identified in any related reports, presentations, or publication.

Finally, the research design, the research methods, the interview and questionnaire guidelines were approved by the Griffith University Human Research Ethics Committee (HREC) on Human Research Ethics (Protocol Number ENV/11/10/HREC) (*Appendix E*).

### 7.6. Conclusion

This chapter has presented the research’s study design and methodology through explanations of the research’s rationale, question, and objectives, which led to the conceptual framework for the research. The description of the three research processes and details of the data analysis then followed. At the end of this chapter, issues of rigour and ethics have been discussed. The following chapter will focus on the case study, and the features of the program.
Chapter Eight

Case Study – China Global Fund AIDS Program

8.1. Introduction

This thesis examines the four contextual fields namely international health cooperation, partnership approach in public health, HIV/AIDS prevention and control in China, and international development project management using the China Global Fund AIDS Program as a case study. The previous chapters have reviewed these four contextual fields. The China Global Fund AIDS Program includes all the above components. A study of its implementation can serve to identify successful models and methods of engagement for international organisations. The China Global Fund AIDS Program offers insights that will be helpful for multilateral and bilateral organisations, the Chinese government and non-governmental, and private sectors to help them provide better health-related services, protection, or health promotion in China.

This chapter focuses on analysis of China Global Fund Program, particularly the AIDS Program. There are three sections in this chapter. Firstly, this chapter describes the critical features of the Global Fund Program, and then presents how these features apply to China in the second section. The third section of the chapter focuses on the China Global Fund AIDS Program, especially on the China Global Fund HIV/AIDS Rolling Continuation Channel Program (RCC Program), analysing its organisational structure and management system, describing the actors and partnerships of the program, and presenting important events in the RCC Program.

8.2. Global Fund Program

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a major source of international funding for programs to fight these three diseases since its establishment in January 2002, following the commitment by the United Nations General Assembly Special Session on AIDS in June 2001. By the end of 2011, the Global Fund to Fight AIDS, Tuberculosis and Malaria had direct investments in 151 countries, with approved funding of US$ 22.9 billion for more than 1,000 programs (The Global Fund, 2012c).
The Global Fund to Fight AIDS, Tuberculosis and Malaria is a unique program. It is as unique as its partnership model, providing different groups of stakeholders with equal rights of decision-making at the global and at the country levels. It operates as a partnership among governments, civil society, the private sector and affected communities. This represents a new approach to international health financing (The Global Fund, 2008b). Further, the Global Fund’s model is based on the concepts of country ownership and performance-based funding. That is, people in countries implement their own programs based on their priorities and the Global Fund provides financing on the condition that verifiable results are achieved (The Global Fund, 2012c).

The funding period allows long-range planning for a minimum of five years, with possible continuations for further six years (Figure 12). The initial proposals of the Global Fund usually cover a five-year period. Global Fund grants have usually been disbursed in two phases: in Phase I, countries qualify for two years of initial funding; in Phase II they can apply for an additional three years of funding as part of a renewal if the program is performing well. Strongly-performing programs that are reaching the end of their five year funding term will be assessed, and, if they meet certain criteria, will be invited apply for continued funding to cover a maximum of six years. The Global Fund program lifecycle includes country-owned proposal development, grant, and implementation, grant renewal, and grant closure.

Figure 12: Global Fund Program Period

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>RCC – 1st Term</th>
<th>RCC – 2nd Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years</td>
<td>3 years</td>
<td>3 years Mid-term Review</td>
<td>3 years</td>
</tr>
</tbody>
</table>

8.2.1. Core Structures and Main Actors

The core structures of the Global Fund is divided into these parts which are the Global Fund level, country level, and partners level. Each level has different actors. Figure 13 shows main actors at each level of the Global Fund, and Table 22 shows the main actors and their responsibilities during the program life cycle.

Figure 13: The Global Fund Core Structure and Main Actors

### Table 22: Global Fund Structures and Main Actors in the Program Lifecycle

<table>
<thead>
<tr>
<th>LIFECYCLE</th>
<th>THE GLOBAL FUND</th>
<th>RECIPIENT COUNTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Board</td>
<td>Secretariat</td>
</tr>
<tr>
<td><strong>Proposals</strong></td>
<td>funding decision</td>
<td>proposal screening</td>
</tr>
<tr>
<td><strong>Grant negotiation</strong></td>
<td>grant signing; disbursement decision</td>
<td>disbursement decision</td>
</tr>
<tr>
<td><strong>Implementation</strong></td>
<td>funding decision; negotiation to amend grant agreement</td>
<td>recommendatio n to board on continued funding / additional financial commitment</td>
</tr>
<tr>
<td><strong>Grant renewal</strong></td>
<td>initiates closeout with letter; approves plan and budget, decides continuity of services</td>
<td></td>
</tr>
<tr>
<td><strong>Grant closure</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Global Fund Level

Board
The Board oversees the work of the Global Fund and its committees engage at a deeper level in the operational details of the Global Fund’s work (The Global Fund, n.d.-b). The members of the Board consist of representatives of donor and recipient governments, NGOs, private sector and affected communities. It is responsible for overall governance of the organisation, and determines policies, objectives and strategies of the Global Fund. The Board approves or rejects proposals for funding based on Technical Review Panel (TRP) review and available funds; decides whether or not to continue funding a grant, and decides on the annual Local Fund Agent (LFA) budget. The Board also receives reports from the Office of the Inspector General (OIG) and provides strategic direction on risk management.

Secretariat
The Secretariat, located in Geneva, Switzerland, is responsible for carrying out day-to-day operations of the Global Fund. Its responsibilities include resource mobilisation, managing the proposal applications process, overseeing grant implementation, providing financial, legal and administrative support and reporting information on Global Fund activities to the Board and the public (The Global Fund, n.d.-b).

Technical Review Panel (TRP)
The TRP is an independent, impartial team of disease-specific and interdisciplinary health and development experts, appointed by the Global Fund Board to guarantee the integrity and consistency of an open and transparent proposal review process. Its main roles include: reviewing grant proposals for technical merit; assessing proposed interventions to ensure they reflect current knowledge and best practice; recommending proposals for funding to the Board; reviewing requests for continued funding that entail material reprogramming of the original proposal (The Global Fund, n.d.-b).
Office of the Inspector General (OIG)

The OIG operates as an independent unit of the Global Fund, providing the Board with independent and objective oversight to ensure that the Secretariat and recipients of Global Fund grants comply with Fund policies and procedures. More specifically, the OIG has an important role to play in providing assurance and advice on risk management. The scope of work of the OIG encompasses all aspects of the Global Fund’s activities including those carried out on its behalf by recipients, partners and suppliers. Activities of the office include audits, and inspections, investigations of country-fraud activities (The Global Fund, n.d.-b).

Trustee


Country Level

The Global Fund does not maintain country offices and, therefore, has no formal presence in individual countries. Nevertheless, the following structures operate in each implementing country and form part of what is known as “the Global Fund architecture”.

Country Coordinating Mechanism (CCM)

The CCM is a country-level multi-stakeholder partnership that has overall ownership of and responsibility for proposal development and grant oversight (The Global Fund, n.d.-b). The CCM is a cornerstone of the Global Fund’s architecture, where innovative public/private partnerships are built to rapidly disburse funds in the battle against AIDS, TB, and malaria. It is central to the Global Fund's commitment to local ownership and participatory decision-making. At country level, CCM comprises all key stakeholders in a country’s response to the three diseases. The main responsibilities of CCM include: developing funding applications for Global Fund financing based on country needs and financing gaps, and submitting these to the Global Fund; nominating the principal recipient(s) to implement Global Fund grants;
overseeing of PR performance in program implementation; requesting continued funding for existing grants (The Global Fund, n.d.-b).

Principal Recipient (PR)

PR is the recipient of the grant from the Global Fund, nominated by CCM, responsible for program implementation. The PR should be a national entity from the governmental or nongovernmental sector. It has ultimate accountability for the use of grant funds and has an obligation to operate internal control systems to ensure that funds are efficiently and effectively directed to achieving programmatic results and reaching people in need, and to ensure that programmatic and financial data are accurate and complete (The Global Fund, n.d.-b).

Sub-recipients (SR)

Sub-recipients are selected by the PR to assist in implementing the grant. These are entities (government or nongovernment, big or small) receiving Global Fund financing through a principal recipient for the implementation of program activities. They are responsible for: implementing activities of the grant, based on a contractual arrangement with the PR that largely obligates the sub-recipient to comply with the obligations contained in the grant agreement between Global Fund and PR; providing the PR with periodic progress updates; and contracting with sub-sub-recipients (if applicable) to implement grant activities (The Global Fund, n.d.-b).

Local Fund Agent (LFA)

The LFA is an entity contracted by the Global Fund in countries with active grants to provide independent information, advice and recommendations to the Global Fund. LFA is responsible for assessing grant recipients, verifying the programmatic and financial deliverables under the grant and providing recommendations to the Global Fund (The Global Fund, n.d.-b). To effectively perform its functions, LFA needs to communicate on a regular basis with PR, CCM and other in-country stakeholders to access information relating to the grant, grant recipients, the health sector and other country-specific issues that may affect the grant (The Global Fund, 2011). As the Global Fund does not have offices in recipient countries, it engages LFAs to assess the
capacity of grant recipients (principal recipients), and monitor and verify grant implementation at the country-level.

**Partners**

The Global Fund relies on a wide range of partners to carry out key activities necessary for its functioning and success (The Global Fund, n.d.-b). Partners can be drawn upon throughout the grant process to help develop proposals, implement programs and evaluate program performance. Partners include development partners; multilateral and bilateral agencies, nongovernmental organisations, civil society organisations, private sector entities, and other development organisations that address AIDS, TB and malaria (The Global Fund, n.d.-a). These partners, united by a common stake in public health, are involved at all levels of the Global Fund model, from membership of the Board through to country coordination and implementation of programs in communities (The Global Fund, n.d.-a).

Friends of the Global Fund are another partner group. Their organisations are entirely independent entities and have diverse operational models. They are either national or regional and are governed by their own boards and represent donors, implementing partners of the Global Fund or both of them. They receive no financial support from the Global Fund. Friends’ organisations are dedicated to raising awareness about the three diseases, to advocating the vision, mission and work of the Global Fund and to lobbying decision-makers and private sector entities to lend their political and financial support to the Global Fund. Some Friends are involved in research and in fostering policy debates (The Global Fund, 2009).
8.3. China Global Fund Program

The Global Fund Program is the largest international health program in China. It is an effective supplement to the national funding for AIDS, Tuberculosis and Malaria, and has greatly promoted prevention and control for these three diseases. Since 2003, China has applied for and been awarded nearly US$1 billion in grants, becoming the fourth-largest recipient of funds behind Ethiopia, India, and Tanzania (The Global Fund China Country Coordinating Mechanism Secretariat, 2009).

Currently, the Global Fund (GF) has approved 18 programs, among which 15 Round-Based grants and 3 Rolling Continuation Channels (RCCs). The total amount of budget approved by the GF is USD 1.814 billion (The Global Fund, 2012b). The total disbursements from 2003 to 2012 are shown in Figure 14. The Round based grants for HIV was consolidated under Rolling Continuation Channel (RCC) as of 1st January 2010. Similarly, the Round based grant for TB and Malaria (except Round 6) were consolidated under Single Stream Funding (SSF) and National Strategy Application (NSA), respectively, as of 1st July 2010.

Figure 14: Disbursed Funds to China

Source: The Global Fund (2012b)
According to the Global Fund Twenty-Fifth Board Meeting decision, as a country which has above average income, and the burden of disease are not extremely serious, China is not eligible for Phase II funding under the consolidated grants. Global Fund Grants to China would end after completion of Phase I. At the time of this thesis, China had already begun transitioning Global Fund grants toward closing its portfolio by the end of 2013, after ten years of highly successful partnerships.

8.3.1. China Global Fund Program Organisational Structure and Management System

Figure 15 shows the organisation and management mechanism of China Global Fund Program. At the national level, the China Country Coordinating Mechanism for the Global Fund Programs (China CCM) and China Ministry of Health are the guiding and coordination departments of the China Global Fund Program, responsible for guiding and coordinating the implementation work of the Global Fund in China. China CDC serving as the PR is responsible for the program implementation. The leadership system at provincial, city and county level is similar to the national level. Each local health department guides the implementation of Global Fund Program projects, solves any critical issues during project implementation, and coordinates with the local department of finance to ensure the investment of HIV/AIDS prevention funds.
8.3.2. China CCM

China Country Coordinating Mechanism (China CCM) for the Global Fund Programs was established in 2002, according to the requirements of the Global Fund and has been functioning well (The Global Fund, 2012a). It is responsible for evaluating and approving the work plans and process reports of the China Global Fund Program before submitting them to the Global Fund, and overseeing the implementation of projects. The China CCM has four working groups: HIV/AIDS, TB, Malaria, and Drug and Health Product Working Groups. Membership of the working groups is open to all China CCM members and all members of sector groups. The groups meet regularly; seek the advice of multi-sector organisations; and assist in drafting the program proposals, providing suggestions on work plans and progress reports, and monitoring and evaluating the program implementation of the principal recipient and sub-recipients.
Within the country context, the China CCM is a unique and critical platform for encouraging partnership among all stakeholders and developing a complementary and coordinated approach with existing national policies and priorities. The current China CCM is composed of 26 members (6 convenors and 20 sector group representatives). The six convenors are the chair, the vice chair, the chair of the AIDS special working group, the chair of the TB special working group, the chair of the malaria special working group and the chair of the drug and health product working group; among the 20 sector group representatives, five are from the government sector, eight are from the non-governmental organisations, two are from People Living with HIV/AIDS, TB, Malaria sector group, one is from the private sector owned enterprises and four are from international organisations. Table 23 shows the details of the China CCM members.
<table>
<thead>
<tr>
<th>China CCM Members and Sector Groups</th>
<th>Sector Group Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Convenors (6)</strong></td>
<td>1) Chair</td>
</tr>
<tr>
<td>(Non-voting)</td>
<td>2) Vice Chair</td>
</tr>
<tr>
<td></td>
<td>3) Chair of AIDS Special Working Group</td>
</tr>
<tr>
<td></td>
<td>4) Chair of TB Special Working Group</td>
</tr>
<tr>
<td></td>
<td>5) Chair of Malaria Special Working Group</td>
</tr>
<tr>
<td></td>
<td>6) Chair of Drug and Health Product Working Group</td>
</tr>
<tr>
<td><strong>Government Sectors (5)</strong></td>
<td>7) Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>8-11) Others: Ministry of Education, Ministry of Justice, State Food and Drug Administration, Ministry of Finance</td>
</tr>
<tr>
<td><strong>Non-Government Sectors (8)</strong></td>
<td>12) China Centre for Disease Prevention and Control (Non-voting)</td>
</tr>
<tr>
<td></td>
<td>13) Chinese Academic/Educational Institutions</td>
</tr>
<tr>
<td></td>
<td>14) Chinese Mass organisations</td>
</tr>
<tr>
<td></td>
<td>15) Chinese associations or societies</td>
</tr>
<tr>
<td></td>
<td>16-18) Community Based Organisations or other NGOs (including one women’s organisation)</td>
</tr>
<tr>
<td></td>
<td>19) International Non-governmental Organisation: Family Health International 360</td>
</tr>
<tr>
<td><strong>Private/State Owned Enterprises (1)</strong></td>
<td>20) Private Enterprise: North-East Pharmaceutical Group</td>
</tr>
<tr>
<td><strong>People Living with HIV/AIDS, TB and /or Malaria (2)</strong></td>
<td>21-22) People Living with HIV/AIDS, TB and /or Malaria</td>
</tr>
<tr>
<td><strong>International Organisations (4)</strong></td>
<td>23-24) Multi-lateral Organisation</td>
</tr>
<tr>
<td></td>
<td>25-26) Bilateral Organisation</td>
</tr>
</tbody>
</table>
8.3.3. The Principal Recipient of China Global Fund Programs (China PR)

There is only one PR in China. The Chinese Centre for Disease Control and Prevention (China CDC) is designated by China CCM as the PR of Global Fund programs which have been approved by the Global Fund. China CDC is a non-profit institution established for disease control and prevention, public health management and provision of health service under the leadership of the Ministry of Health of the People's Republic of China. It is responsible for the implementation of national strategies and providing technical guidance and training nationwide through its network of provincial and county-level CDCs.

China PR is responsible for implementation of the program. It implements the grants through three National Program Offices (NPOs): National Centre for Tuberculosis Control and Prevention (NCTB), National Centre for AIDS (NCAIDS) and National Institute of Parasitic Diseases (NIPD) and their Sub-Recipients (SRs), Sub-Sub-Recipients (SSRs) and Sub-Sub-Sub-Recipients (SSSRs) at Province, Prefecture and County levels. Key functions and responsibilities of the China PR are as follows: to implement and manage the China Global Fund Program; to periodically submit progress updates to MOH and the CCM; and to coordinate with the CCM on program implementation. The director of the Chinese Centre for Disease Control and Prevention (CDC) works as the director of PR. The PR is composed of following departments: General office, National Program Offices (located in the National Centre for STD and AIDS NCAIDS office), Financial Department, Auditing Department, M&E Department, and Procurement Department.

8.3.4. Local Fund Agent (LFA)

The current Local Fund Agent for China, the United Nations Office for Project Services (UNOPS), has been providing a service as LFA since the first Global Fund grant was signed in 2003. During the re-tendering process in 2008 and in 2011, UNOPS was selected for an additional period.

8.3.5. Development Partners

Development partners in China were actively engaged in Global Fund programs through their involvement in the China CCM. For Global Fund grant program in
China, the international organisations provided considerable support in: proposal writing; monitoring and evaluation of grant implementation; and technical support to the implementing entities when needed. Key development partners such as UNAIDS, US-CDC, WHO, DFID and UNICEF, are represented in the China CCM. The working groups for the three diseases were either chaired or vice-chaired by representatives of development partners. In addition to their involvement in China CCM, development partners also provide other support such as UNDP manages China CCM funds, UNAIDS houses China CCM secretarial function, and CBO/SR review was being jointly sponsored by UNAIDS and Gates Foundation.

8.4. China Global Fund AIDS Program

Since 2003, the Global Fund has supported China to carry out multiple rounds of cooperative HIV/AIDS response projects, achieving positive results. Global Fund Round 3 mainly addresses the provision of comprehensive prevention, treatment and care to HIV-infected former plasma donors in seven central provinces. Global Fund Round 4 focuses on reducing the spread of HIV/AIDS among IDU and CSW in seven provinces in the south and west. Global Fund Round 5 aims to contain the continuing spread of HIV/AIDS among high-risk, vulnerable populations, particularly sexual transmission of HIV, in seven provinces in north and north eastern China. Round 6 focuses on civil society involvement and overlaps with 11 provinces of other rounds. Round 8, targets the rapidly expanding sub-population of internal rural-to-urban migrants, who tend to be young and sexually active, and in some provinces already account for the majority of reported cases of HIV. The details of the AIDS programs are illustrated in Table 24.
<table>
<thead>
<tr>
<th>Round</th>
<th>Title</th>
<th>Principal Recipient</th>
<th>Total Funding Requested</th>
<th>Program Duration</th>
<th>Program Goal</th>
<th>Program Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 3</td>
<td>China CARES (China Comprehensive AIDS Response) - A Community-Based HIV Treatment, Care and Prevention Program in Central China</td>
<td>China CDC</td>
<td>USD 97,888,170</td>
<td>2004—2009</td>
<td>To mitigate the impact and reduce the spread of HIV/AIDS in and from 58 highly-affected resource-poor counties in seven provinces</td>
<td>Henan, Hebei, Hubei, Shandong, Shaanxi, Shanxi and An hui</td>
</tr>
<tr>
<td>Round 4</td>
<td>Reducing HIV Transmission among and from Vulnerable Groups and Alleviating Its Impact in Seven Provinces in China</td>
<td>China CDC</td>
<td>USD 63,742,277</td>
<td>2005—2010</td>
<td>To reduce the spread of HIV/AIDS among Injecting Drug Users (IDUs) and Sex Workers (SWs) and to mitigate its impact in 37 highly-affected prefectures in seven provinces and autonomous regions</td>
<td>Guangxi, Yunnan, Sichuan, Xinjiang, Guizhou, Hunan, Jiangxi</td>
</tr>
<tr>
<td>Round 5</td>
<td>Preventing A New Wave of HIV Infections in China</td>
<td>China CDC</td>
<td>USD 28,902,073</td>
<td>2006—2011</td>
<td>To restrain the continuous HIV spread among high risk and vulnerable population in seven provinces in China through comprehensive intervention on controlling sexually transmitted HIV</td>
<td>Chongqing, Liaoning, Heilongjiang, Jilin, Inner Mongolia, Ningxia and Gansu</td>
</tr>
<tr>
<td>Round 6</td>
<td>Mobilising Civil Society to Scale Up HIV/AIDS Control Efforts in China</td>
<td>China CDC (first two years)</td>
<td>USD 14,395,715</td>
<td>2007—2012</td>
<td>To utilise the unique strengths of NGOs and civil society to strengthen and fill gaps in existing AIDS control programs and will fill gaps in prevention efforts aimed at key vulnerable populations that are either not reached or underserved by existing interventions</td>
<td>Beijing, Tianjin, Shanghai, Chongqing, Yunnan, Sichuan, Guizhou, Guangxi, Guangdong, Hunan, Hubei, Anhui, Henan, Xinjiang and Gansu</td>
</tr>
<tr>
<td>Round 8</td>
<td>Reaching Vulnerable Migrants with HIV/AIDS Prevention and Care Services in Seven Provinces in China</td>
<td>China CDC</td>
<td>Euro 40,003,425</td>
<td>2009—2014</td>
<td>To prevent HIV transmission and mitigate the impact of HIV on vulnerable migrants in seven provinces of China</td>
<td>Beijing, Tianjin, Shanghai, Jiangsu, Zhejiang, Fujian and Guangdong</td>
</tr>
</tbody>
</table>

In 2009, with the support of international cooperation partners, and based on the Global Fund’s rolling principle, China successfully applied for the Global Fund HIV/AIDS Rolling Continuation Channel Program (RCC Program). The Program consolidates the existing China Global Fund AIDS program grants (Rounds 3, 4, 5, 6 and 8), and integrates all the resources on HIV/AIDS prevention, treatment and control in China (including transferred payment funds from the central government, local provincial funds, city and county level funds and the Global Fund together with other international cooperation funds) into one national HIV/AIDS prevention and treatment strategy and action plan. The RCC program was formally initiated on 1st January 2010. Originally, the duration of the RCC program was six years (2010-2015), and covered 31 provinces (and municipalities, and autonomous regions). However, according to the a decision of the Global Fund Twenty-Fifth Board Meeting, as one of the G20 countries with upper-middle income and without serious disease burden, China is not eligible for the application for Phase II funds. Thus the originally planned Phase II (2013-2015) will not be implemented, and the RCC program should be closed by the end of December 2012. Currently, the program is under the “No-cost extension” until 30 June 2013. The timeline of the RCC program is in Figure 16.
Figure 16: Timeline of RCC Program

China Global Fund AIDS Program

- Time

China Global Fund AIDS Program
• Time
Jan '10 Jan '13
2003                   2004                    2005         ...    '06
Jun '10
Jun   '11Jan   '08 Jul    '08
phase 1     phase 2    
R6
RCC 
Jun   
'13
No 
cost 
exten
sion
The RCC program is the largest and one of the most influential international cooperation HIV/AIDS projects in China (J. Sun et al., 2010). It covers 31 provinces, autonomous regions or municipalities, and provides management funding for 291 prefectures or cities and 1,133 counties or districts. The program consolidates all the HIV/AIDS prevention resources in the country. This includes the funds of the central government, provincial, municipal and county (district) levels, as well as the funds from other international cooperation programs.

8.4.1. RCC Program Organisational Structure and Management

National Level

At the national level, China CCM, State Council AIDS Working Committee Office (SCAWCO) and the China MOH are the guiding and coordination departments of the China Global Fund Program, responsible for guiding and coordinating the implementation work of Global Fund in China. The leadership system at provincial, city and county level is similar to the national level. Each local AIDS Working Committee Office guides the implementation of Global Fund Program projects, solves any critical issues during project implementation, and coordinates with the local department of finance to ensure the investment of HIV/AIDS prevention funds.

The National Centre for AIDS/STD Prevention and Control (NCAIDS) of CDC undertakes the key functions and responsibilities of the China Global Fund AIDS Program. A program Office is for the concrete management work of the Program. The director of NCAIDS is appointed National Global Fund AIDS Program Director and is responsible for: drafting project proposals, providing necessary logistical support, supervising and evaluating, supporting social organisations, and providing technical guidance and training to provincial project implementation agencies. The National Global Fund AIDS Program Office is directly under NCAIDS. The Program Manager reports to the National Director. The Deputy Program Manager and Program Officers are directly under the Program Manager. The Program Office currently includes four groups: Global Fund Group (Planning, Budget Management), PR Group (Office Management and Program Implementation), SR Group (Provincial Coordination and Management), and Community-based Organisation (CBO) group (CBO Management).
Local Implementing Agencies and Partnerships

The RCC program covers 31 provinces, autonomous regions or municipalities, and provides management funding for 291 prefectures or cities and 1,133 counties or districts. Each level has its implementation agency. Provincial CDCs are the provincial implementation agencies, responsible for provincial project work, the corresponding supervision and evaluation work, and consolidation of the local HIV/AIDS prevention and control resources. CDCs in cities and counties are the county-level implementation agencies of China Global Fund Program, responsible for county project work and consolidating routine HIV/AIDS prevention and control work. Government departments, social organisations, academic institutions, medical institutions, international organisations and enterprises at all levels actively participate in China Global Fund projects.

8.4.2. Important Events in RCC Program

Since the RCC program started, some important events occurred and impacted the program implementation. These events are shown in Figure 17.

Figure 17: Important Events in RCC Program

On 11th March 2009, the China RCC AIDS program funding has been approved. The Program funding was based on the aggregation of China’s Round 3 HIV grant (the primary grant) and the additional HIV grants approved under Rounds 4, 5 and 6. The target groups included sex workers and their clients, injecting drug users, men who have sex with men,
people living with HIV/AIDS (including children) and pregnant women. On the 1 January, 2010, the program formally started.

In November 2010 the Global Fund halted disbursement for 2010 Quarter Four for the AIDS RCC grant. The 2011-2012 HIV grant contract was not signed. The key issue leading to the RCC grant freeze concerned civil society participation. The CDC failed to allocate 20 per cent of program budgets to CSO implementers, as had been agreed (The 20 per cent figure applies to the first year of the grant; the agreement was that the allocation would gradually increase in subsequent years until it reached 35 per cent). Other issues included poor financial performance with expenditure rates at all levels and delayed reports with insufficient information.

In May 2011 the Global Fund extended the freeze to grants for malaria and TB. The reasons cited for the freeze were insufficient participation of civil society organisations in program implementation, inadequate financial management and possible misuse of grant fund.

From 1 to 15 June 2011 China PR conducted program self-check and self-correction, covering financial management, program management and materials verification. The Ministry of Health and PR conducted joint monitoring for 16 provinces from June 20 to July 3, including Yunnan, Guangxi and Sichuan. In each province, monitoring was conducted for two county implementing agencies. The monitoring mainly focused on the verification of self-check and self-correction and the spot check of financial, materials and program management. By June 15 program implementing agencies at all levels submitted self-check and self-correction reports and performance commitments.

On 2 September 2011, the Global Fund lifted the temporary freeze on disbursements for its grants to China, but said that discussions were continuing on some unresolved issues. Appendix F is the management letter from the Global Fund.

From 14 November to 18 December, 2011, the Global Fund Office of the Inspector General (OIG) conducted a diagnostic review of all previous rounds and ongoing consolidated programs in three diseases in China in a bid to evaluate program implementation mechanisms and risk control strategies. During the five-week process, OIG conducted comprehensive
review on financial management, materials management, program management and health service delivery related to the AIDS program at national, provincial, city and county levels. The OIG also made several rounds of face-to-face meetings. In addition OIG conducted field reviews for six provinces, four prefectures and six counties.

On 26 November, 2011 Global Fund Twenty-Fifth Board Meeting made a decision excluding G20 countries with upper-middle incomes and without a serious disease burden from the application for Phase II funds. Thus, RCC would be concluded by the end of December 2012. The originally planned Phase II (2013-2015) will not be implemented.

In October 2012 the Global Fund approved the No-cost Extension to extend the duration the RCC program from 1 January 2013 until 31 December 2013. Appendix G is the relevant management letter from the Global Fund.

8.5. Conclusion

This chapter has described innovation features of Global Fund Program and explained how these features applied in China, especially for the China AIDS program. As the case study of this research, its related systematic management issues have been also discussed. A number of important results and key findings from the fieldwork of the Program will be identified and analysed in the next chapter.
Chapter Nine

Results and Key Findings

9.1. Introduction

The case study of this research is Global Fund AIDS Program—Consolidated Rolling Continuation Channel (RCC) Program, which is a good representative of international programs in China. It is the largest international health program in China. The Program consolidates all China Global Fund AIDS program grants (grant 3/4/5/6/8), and all the resources on HIV/AIDS prevention and control in China, including centrally transferred funds, local funds from provincial, city and county levels and other international cooperation funds. The management structure for the China Global Fund AIDS Program (RCC Program) is based on the principles and specialties of Global Fund program design and implementation. The description and analysis of the management structure have been detailed in Chapter Eight.

This chapter presents results of the case study and highlights important findings of the RCC Program. The data are derived from various data collection methods, including participant observation, review of documents, in-depth and focus group interviews, and a questionnaire survey*. The key findings are highlighted and further analysis is carried out to identify issues. These results and key findings are of two types: those that are confirmed by the literature and those that are unique to the China Global Fund AIDS Program. They have been identified in this chapter and will be discussed in the next chapter.

9.2. Results

This section presents the key results of the research that were collected from various data collection methods. These key results are closely related to the research themes and form the basis for the discussion that follows in Chapter Ten.

9.2.1. Results of Participant Observation

From April to December 2011, the researcher worked as a project officer in the National Global Fund AIDS Program Office. During this period, the researcher was directly or indirectly

*The raw data are presented in a limited form to prevent the disclosure of information source and identity of informants.
involved in all the important events which happened in that period, and was thus able to gain inside knowledge of how the Program operated. Observation enabled the researcher to gain a deeper understanding of how the Program is organised and of the complexities of the management structure.

**Organisation and Management Structure of China Global Fund AIDS Program**

To enhance understanding of complexities and impact factors of the management, the organisation and management structure of RCC Program is mapped in Figure 18. At the national level, the China Country Coordinating Mechanism for the Global Fund Programs (China CCM), State Council AIDS Working Committee Office (SCAWCO) and Ministry of Health (MOH) are the guiding and coordination departments of the China Global Fund Program, responsible for guiding and coordinating the implementation of the Global Fund Program in China. The CCM is responsible for evaluating and approving the work plans and process reports of the China Global Fund Program before submitting them to the Global Fund, and for oversight of the implementation of the program. As part of China's HIV/AIDS prevention and control work, the Program is also incorporated into the unified coordination and management work of SCAWCO and MOH, the government bodies that are responsible for the design and implementation of the China HIV/AIDS national plan. At the local level, each local AIDS Working Committee Office and health department guides the implementation of Global Fund Program projects, resolves any critical issues during project implementation, and coordinates with the local department of finance to ensure the proper administration of HIV/AIDS prevention funds.

The China CDC as the Principal Recipient (PR) is responsible for implementation of the program. The Director of the Chinese Centre for Disease Control and Prevention (CDC) works as the Director of PR, and below him there is an Executive Director. The PR is composed of the following departments: General office (PR office), National Program Offices (located in the National Centre for STD and AIDS NCAIDS office), Finance Department, Auditing Department, Monitoring and Evaluation (M & E) Department, and Procurement Department.
Provincial CDCs are the provincial implementation agencies, serving as Sub-Recipients (SRs) responsible for provincial program implementation, the corresponding supervision and evaluation, and consolidation of the region’s HIV/AIDS prevention and control resources. Under the provincial level, local CDCs in cities and counties are the Sub-Sub-Recipient (SSRs) and Sub-Sub-Sub-Recipients (SSSRs), responsible for management of each level’s program and for consolidating routine HIV/AIDS prevention and control.

Thus it is evident that the structure of the Program is quite comprehensive, but also complex, operating at many levels and depending on the cooperation of many stakeholders. Mostly the system worked smoothly, but inevitably the complexity raised issues. These issues arising will be analysed and discussed in the following section and in Chapter Ten.
National Global Fund AIDS Program Office

The researcher worked only in the National Global Fund AIDS Program Office. The National Global Fund AIDS Program Office is one of the departments directly under the National Centre for AIDS/STD Prevention and Control (NCAIDS) of China CDC. It is responsible for the concrete implementation of the Program. Its routine work mainly consists of drafting the national program working plan, guiding, supervising, monitoring and evaluating local program implementation, providing technical support to the local implementing agencies, summarising and reporting program progress, facilitating coordination with other departments of PR, and so on.

Including the manager and deputy manager, there were a total of twelve staff during the period while the researcher was working. The director of the Office (Program Manager) reports to the National Program Director. The Deputy Program Manager and Program Officers are directly under the Program Manager. The Program Office at that time included four groups: Global Fund Group (Planning, Budget Management), Principal Recipient Group (Office Management and Program Implementation), Sub-Recipients Group (Provincial Coordination and Management), and Community-based Organisation group (CBO Management).

The researcher noticed that the workload was heavy in the Office, and that the staff worked overtime most days. In addition, as the disbursement of funds was delayed and the grant was frozen, the staff felt that the program was not stable. Some staff left the office for other jobs. The office suffered serious staff morale problems, and faced strong working pressure.

9.2.2 Results of Document Review

In the field work, the researcher reviewed many project documents, reports, meeting minutes and other related documents. The review deepened the researcher’s understanding of the program and formed the basis of the issues identification. Most of these documents fall into one of the following two categories:

Official Global Fund Documents and Management Letters

The official Global Fund documents include Global Fund program manuals, operational policies, guidelines and tools; agreements between Global Fund and China; Progress
Update/Disbursement Request (PUDR) Forms, working plans, progress and annual reports, financial and auditing reports submitted by China PR. At a lower level, management, implementing and financial handbooks which were developed by China PR for implementing units were also reviewed. In addition, management letters, the formal communication between Global Fund and China PR, as far as the researcher could access them, were reviewed. These manuals, guidelines and handbooks offer guidance to project officers on implementation of the project, and can reduce risks of misappropriation of funds. In addition, the official management letters provide a record of formal communication and negotiation between the Global Fund and China PR. These documents enabled the researcher to understand the policy framework in which the Program operated and the expectations of how it should be implemented.

**Meeting Minutes and Reports of the Program**

The researcher also reviewed all the Global Fund meeting minutes including CCM, PR, Oversight Committee, the AIDS Working Group, financial meetings, and other related meetings (Appendix H as an example). Reports of the program related training workshops, working plans, progress reports, annual reports from all level implementing agencies, and internal and external auditing reports were also reviewed. Additionally, during the period of field work, the researcher was involved in a national level internal auditing process. With other colleagues, she had the opportunity to check and review the archived original invoices and receipts of program related expenditures. These documents identified issues such as communication and financial performance. The minutes all clearly showed the participants of the meeting, the procedure of meeting and the problems that needed to be addressed. Most reports are comprehensive, and include budget expenditures, serving as the evidence for monitoring and evaluation. These documents enabled the researcher to understand what was going on ‘on the ground’.

**9.2.3. Results of In-depth Interviews and Focus Groups**

The data of the in-depth interviews and focus groups are very important for determining key issues and developing discussion for this research. The data were gathered from the informants with different kinds of organisational backgrounds. From the data the following main themes were extracted:
• the need for international cooperation in response to AIDS,
• the importance of partnerships in response to AIDS,
• the challenges of project management in international AIDS projects.

The first two themes are completely confirmed in the literature while the third theme—the challenges of project management in international AIDS projects such as financial problems and personnel—is specific to the Chinese context and is not addressed in the literature. The key data are classified under these main themes in the following paragraphs.

**Theme 1: The need for international cooperation in response to AIDS in China**

The need for international cooperation in response to AIDS in China has been confirmed in the literature. The informants expressed a common view regarding China’s AIDS response in the future that China still needs international fund to support AIDS response. A informant who is from international organisation commented:

> As a public good, HIV/AIDS prevention and control depends mainly on government inputs. Although the government has increased its input into this service, there is still a shortfall between the needs and the input.

A senior Chinese official said:

> Funding for health comes from central, provincial, municipal and county government. However, due to uneven economic development, some rich areas can fully provide funding, while some poor areas cannot afford.

The Chinese project officers and researchers believed that the international cooperation projects serve the overall national strategy as an important supplement to national projects. Therefore, making the international cooperation projects play a complementary role in the resources and technology of the national projects is a challenge. The analysis shows that the international funding and national funding have obvious inconsistencies.

> Chinese officials and researchers need to build a systematic understanding of their experience with the management of change and rapid development.

The national funding, based on the policy of “four free one care”, is used in the areas of treatment, caring, mother-child transmission, and monitoring, while the international funding is used in education, intervention, training, and project management, as it is more focused on capacity building, advanced techniques and theories, motivation, and seed funding.
There is a common view that international funds have made a great contribution to China’s AIDS response. However, at the same time, the international community has expressed a desire that China should share its experiences and lessons with other developing countries and should contribute more to global health efforts as a donor rather than as a recipient of international assistance.

They [Chinese officials and researchers] also need to build their capacity to communicate the lessons from this experience to counterparts in other countries.

China now is an upper-middle income country, and should act as a donor country not a recipient country any more.

**Theme 2: The importance of partnerships in response to AIDS**

All informants agreed that the AIDS response relies on multi-sectoral collaboration. This finding agrees with most authorities mentioned in the literature review. Although the health sector is central to the AIDS response, it must collaborate with other sectors in order to tackle the social, economic, cultural and environmental issues that shape the epidemic and provide access to health services. Some experts think that successful AIDS program management is

A pattern of multi-sectoral cooperation is supported by incentive mechanisms, an effective information system and a comprehensive evaluation system.

Most informants agreed the multi-sectoral cooperation has improved in China, and the leadership of the State Council HIV/AIDS Working Committee is very important.

Involvement of the State Council AIDS Working Committee promotes multi-sectoral cooperation. Chinese ministries’ vertical management system (central level-provincial level-city and county level) also facilitates the multi-sectoral cooperation.

However, some Chinese project officers expressed their concerns related to current Chinese governmental system. One of the obstacles of in this model is, as a local project officer said:

Higher level did not say, lower level did nothing.

Clarity of roles and responsibilities of partners is important for effective partnership. The interview results show that the partners are quite clear about their roles and responsibilities.
The partners communicate to each other by following a communication mechanism. For instance, an informant from an international NGO organisation clearly expressed:

As a technical support organisation, we mainly just do what the donors and implementing agencies require us to do.

As the program already has a communication mechanism, whether the communication is smooth depends on the communicators.

The biggest concern of partnership issue is the participation of the Civil Society Organisations/Community Based Organisations (CSOs/CBOs). Currently, the CSOs/CBOs are facing many problems.

We are deeply concerned that the civil society participation in HIV/AIDS program implementation is inadequate.

A project staff member in the Yunnan office of a local NGO, said

Fundraising is hard for NGOs even though the government has pumped huge amounts of investment into AIDS prevention programs.

The flow of the investment is not transparent enough and the money left for us is sometimes very little.

**Theme 3: The challenges of project management in international AIDS projects**

The challenges of international AIDS project management are specific to the Chinese context. Financial management is the most important aspect for management of the international project. As a Chinese financial project officer said:

Financial management pervades the implementation of the entire project. From management of our international AIDS programs in recent years, we found that the management of the projects is based on the management of funds. Particularly for the Global Fund Program, the main content of the program operation is its fund management. In order to ensure that the program was implemented smoothly, a precondition of the 3rd round China Global Fund AIDS Program was that all the financial staff of all programs in the provinces and counties needed to be trained. After they had been trained, the agreement could be signed.

However, project officers from different levels complained about the difficulty of the fund’s procedures:
As the Global Fund Program has too many rules and regulations, money circulates very slowly.

Money is hard to use [i.e. The procedures for using money are cumbersome].

Financial administration is inefficient. There are too many intermediate links. This means that the funds cannot be in place on time, seriously affecting the progress of project implementation.

Additionally, as an international project, conflicts between the donor and local organisations arose in the management of the Global Fund Program. A national level project officer complained:

Global Fund management is inflexible. The management skills of their staff are not good. They lack the capability for controlling big country programs. It is the truth.

At the local level, these kinds of issues are more serious. For example, problems related to bank accounts and top-up salaries were outstanding:

The Global Fund require a specific independant bank account. However, we cannot have our own bank account, because the higher-level department does not allow it.

All the staff work in the same office, and have the same workloads. If the staff who work for Global Fund Program have a higher salary, it is unfair to the others.

9.2.4. Results of Questionnaire Survey

The results of quantitative data come from Chinese government agency official “self-check and self-correct” questionnaire survey. The target informants were national and sub-national project officers from government agencies (most of them are CDC staff at various levels). The data related to their attitude to international program management, how the program actually operated and problems with management, particularly with financial performance. The questionnaire is contained in Appendix C.

The complete results of the questionnaire are not disclosed in this thesis. The purposes of this questionnaire survey were deep investigation of management behaviours and searching for problems, so that management could forestall the consequences of any problems. The results of the survey are only for government agencies internal use. In order to avoid ethical conflicts,
this thesis only lists some important results related to the present research. Table 25 identifies specific problems encountered.

### Table 25: Main Problems of RCC Program from Self-check

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description of Main Problems</th>
<th>Number of local project Units involved</th>
<th>Percentage of Units involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds Payments &amp; Accounting</td>
<td>Vehicle Log-books (including: start time, return time, odometer reading at start and at the time of finishing should be recorded and the purpose for which the vehicle was used) are not provided when reimbursing petrol costs.</td>
<td>333</td>
<td>15</td>
</tr>
<tr>
<td>Bank Account</td>
<td>Did not open a separate GF program bank account</td>
<td>303</td>
<td>13.7</td>
</tr>
<tr>
<td>Counterpart Funding</td>
<td>No evidence of actual counterpart funding provision has been made available for verification.</td>
<td>284</td>
<td>12.8</td>
</tr>
<tr>
<td>Assets Management</td>
<td>Program assets are not tagged and labelled for identification</td>
<td>240</td>
<td>10.8</td>
</tr>
<tr>
<td>Other Finds</td>
<td>Other deviations from the financial management manual, procurement and fixed assets management manual and other guidelines</td>
<td>240</td>
<td>10.8</td>
</tr>
<tr>
<td>Other Finds</td>
<td>Findings that were not listed in the National Program Officer's notice</td>
<td>239</td>
<td>10.8</td>
</tr>
</tbody>
</table>

Source: AIDS NPO reports

This section has listed facts which are categorised by different data collect methods. They form the basis for analysis and discussion of the important key findings, which will be identified in the next section.

### 9.3. Key Findings from the RCC Program

Though the RCC program has mostly achieved its target indicators, from the beginning the program activities have not been implemented smoothly. The activities were affected by various factors. Based on the results presented above, triangulated against all the data from
participant observation, document review, interviews, and questionnaire survey, and especially the personal understanding and experiences of the researcher who was working as a project officer, this section highlights and analyses some key findings related to program consolidation, involvement of civil society organisations, communication, financial performance, and personnel issues. Some of key findings such as problems of communication confirm the literature. Some of them (i.e., program consolidation, involvement of civil society organisations) are new discoveries, unique to the Program, that are not reflected in the existing literature. These findings are described as follows.

9.3.1. Impact of Program Consolidation

The RCC Program has been fully integrated with the national HIV/AIDS response. Under the direction of the State, between June 2008 and December 2010, China consolidated five HIV grants into one consolidated grant and fully integrated the grant into the National HIV/AIDS response. The “integration” includes integration of management, planning, funding and targets.

This consolidation is a new concept for the implementation of China Global Fund AIDS program. With the consolidation of the National Transfer Payment and local funds along with the funding from the Global Fund, the project activities were implemented smoothly and most indicators related to consolidation of the Global Fund have met their targets. However the program consolidation faced several changes and negative impacts including fund suspension, funding freeze and exclusion from application for Phase II. These changes have increased the complexity of program implementation and uncertainty of the program outcomes.

The Global Fund China AIDS Program and China’s AIDS Response work-plan and budget are influenced by each other. The integration significantly expanded the scope and scale of the RCC Program. The enhanced scope and scale of the new Global Fund program has raised difficult strategic, policy, regulatory and programmatic issues, such as the definition, nature and role of civil society participation, the registration of new lines of drugs and the necessary regulatory processes (Zhongdan Chen, Wei, & Godwin, 2011). Moreover as the RCC program has been integrated with the national program, the system constraints and the
difficulties arising from either system can disrupt not only the RCC program but also the overall national program. For instance, the delays in RCC disbursements have affected the overall national program performance.

9.3.2. Inadequate Involvement of CSOs/CBOs

Promoting greater participation of social organisations is one of the priorities of the China Global Fund AIDS Program. The CSO representatives on the CCM play a crucial role in determining priorities and preparing proposals for funding. The Chinese Association of STD and AIDS Prevention and Control serves as a sub-recipient which oversees program implementation by CSOs. The National CSO/ CBO Advisory Group was set up in December 2010 with the mission of promoting CBOs’ broad participation in program planning, implementation and oversight and to represent the CBO’s voices and interests.

Currently the Global Fund and stakeholders within the Global Fund China structure, including CBOs, the RCC and UNAIDS among others, are dissatisfied with the implementation of the CBO component in the program. The suspension of funding to the China Global Fund RCC AIDS Project by the Global Fund in 2010 was mostly due to the inadequate involvement of CSOs/CBOs. The following analysis focuses on the definition of CSOs, funding allocation for CSOs, cooperation between CSOs and government departments, and some issues highlighted in the interviews with key informants.

Lack of an agreed definition of CSOs between the Global Fund and China PR

For the purposes of the Global Fund, a definition is required that specifies the key groups. It seeks to have represented in its processes people working not only in HIV/AIDS, but also in TB and malaria as well. The Global Fund (2008b) has therefore adopted the United Nations (2004) definition of civil society:

The associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies. The term does not include profit-making activity (the private sector) or governing (the public sector). Of particular relevance to the United Nations are mass organisations (such as organisations of peasants, women or retired people), trade unions, professional associations, social movements, indigenous people’s organisations, religious and spiritual organisations and academic and public benefit nongovernmental organisations.
The Global Fund and China PR hold different interpretations of the definitions of civil society and the entitlements of civil society organisation to RCC resources particularly in the first year of the program implementation. The Global Fund were interpreting the definitions from a Western European perspective, while the China PR interpreted the definition from a specifically Chinese perspective. Lack of an agreed definition represented a major barrier to smooth and effective grant implementation. Under the terms of the agreement with the Global Fund, in the first year of the RCC Program 20 per cent of funding was to be allocated to CSOs. However the RCC National Project Office disagreed about how to define “CSOs” and argued that their expense accounting was unclear. A lack of clear-cut definitions meant that the RCC Program working plan did not allocate 20 per cent of funding and did not provide sufficient technical support to CSOs in the first year.

In response to the above arguments, the China CCM requested the AIDS Working Group to facilitate consultation between PR, RCC Office, civil society and other stakeholders, and make an operational definition of CSOs to guide the allocation of RCC resources to CSOs for year 2-3 of the RCC. The new definition is currently used for the program implementation. For the China Global Fund Program, the China CCM (AIDS Working Group of the Global Fund China CCM, 2011) defines the CSOs to include five types of organisations:

- academic/educational institutions;
- mass organisations (for example Red Cross, Women’s Federation, Youth League, Trade Unions, etc.);
- associations or societies such as the Chinese Association of STD and AIDS Prevention and Control, Preventive Medicine Association.
- CBO and other NGOs (includes organisation of MSM, IDU, sex workers, migrants, women, youth, etc., plus faith based or community-based organisations); and
- organisations representing people living with HIV/AIDS.

This more specific list allowed the GF and the China PR to operate with less disagreement about what constituted a CSO or CBO.

**Incomplete allocation of funding targets for CSOs/CBOs**

The China CCM pledged to the Global Fund that at least 35 per cent of project activity funds would be allocated to CSOs (20 per cent in the first year, to increase progressively thereafter).
The RCC developed funding targets to increase the civil society (CBO/NGO) share of the RCC budget. The following Table 26 shows the funding targets for civil society and allocations:

Table 26: Funding Targets for Civil Society and Allocations in RCC Program

<table>
<thead>
<tr>
<th>Allocation by Sector</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBO/NGO and PLWH organisations</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Academia, mass org, associations, societies</td>
<td>-</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

The China PR failed to allocate 20 per cent of Global Fund finding to CSOs in 2010. The suspension of fund disbursement in the fourth quarter of 2010 and the subsequent delay in the signing of an agreement further resulted in the failure to disburse the remaining sum of funds to the bid-winning/commissioned social organisations in 2010. This seriously affected the progress of program activities carried out by the social organisations and provincial level program implementing agencies.

CSOs/CBOs funding was allocated to national or local organisations through national or local CDCs respectively. The Chinese Association of STD and AIDS Prevention and Control at National level is the CBO-SR while the Provincial Association as the COB-SSRs is responsible for CBO management work with the China Global Fund AIDS program. The Associations are affiliated with the relevant level CDCs, and they do not have independent financial functions. This means that the funds of the CBOs are allocated by the CDC. The centralised system through which the financial and programmatic components of the RCC program are enabled is entirely fitting with the logic of China’s tiered health system. However, this funding allocation to CSOs/CBOs through the CDC structure means that CSOs/CBOs cannot have full control over the funds allocated to them and are dependent on the willingness of their local CDCs to eventually disburse the grants to them. This often creates additional strains for the relationship between both sides. An independent assessment (McKinsey & Company, 2011) showed that there was also a lack of trust among many CSOs/CBOs. The current mechanism which allocates CSOs/CBOs funding through the CDC structure implies a serious risk of conflicts of interest which run counter to the objectives of the entire program.
Weak cooperation between CSOs/CBOs and government departments

Interviews and surveys of the staff of CSOs/CBOs and CDCs showed that poor communication, little collaboration and mutual suspicion are common between CBOs and the CDC offices. Some consequences are that the CSOs/CBOs may disconnect from the CDC and operate independently, or that they behave in a confrontational manner. The CBOs see the CDCs as a “controller”, which is often “non-responsive”. Some CBOs reported that they do not feel welcome to go to their local CDC offices, or if they try to make contact they are rejected, or ignored (Non-Profit Incubator (NPI), The International HIV/AIDS Alliance, & The Technical Support Facility for Southeast Asia and the Pacific, 2011). The CDCs think the CBOs are “troublesome” and unwilling to contact them. A failure to develop more constructive ways for the CBOs and government to cooperate not only has a negative impact on the effectiveness of CBO activities, but also makes it unlikely that many of the CBOs which have emerged through the funding support of the Global Fund China program would be able to survive after 2013. To successfully achieve the aim of enabling a capable, strong, and healthy civil society to strengthen and complement government action in the fight against HIV/AIDS in China, CBOs and relevant government departments should be aware of each other’s strengths and jointly develop complementary win-win collaborations (Non-Profit Incubator (NPI) et al., 2011).

Other challenges and issues highlighted in the interviews with key stakeholders related to the participation of CSOs/CBOs in the Program

Selection of CSO/CBOs

Many respondents from NGOs and international organisations expressed concern that the China CCM is dominated by government, and that the selection process is highly bureaucratic and politicised. Furthermore there was a general lack of transparency in the election process. For example a report from China Global Fund Watch (2011) pointed out that at the provincial level and below, there are no definite mechanisms to guarantee transparency, openness, and efficiency in the process of provincial level CSO/CBO project selection and agreement drafting. Thus there was disagreement about how effectively the Chinese government included CBS/CSOs in the partnership.
Lack of monitoring and evaluation

There was no evidence to show how monitoring of CSO/CBO projects is carried out at the provincial level and below, including ordinary monitoring (apart from ordinary data collecting) and quality control. The definition of “activity expenses” and “CSOs” was unclear and there was no evidence regarding how efficiency and outcomes of this part of the budget are measured (China Global Fund Watch, 2011). Thus there is a need to have a monitoring and evaluation system for CSO/CBO projects.

9.3.3. Communication Analysis—Strengths and Weaknesses

Managing relationships and good communication is important in maintaining certainty, assuaging threats, easing difficulties and sustaining communication. Effective communication between CCM, PR, LFA and other in-country stakeholders is crucial to ensuring the accountability and effectiveness of Global Fund grants. According to the Global Fund (2008a) each actor has certain responsibilities to provide information. As implementers of Global Fund grants, PR channel their progress reports and disbursement requests (generally referred to as “progress updates and disbursement requests” (PUDRs)) to the Global Fund through the LFA. PRs must also keep the CCM informed by providing the CCM with periodic narrative and financial progress reports (2008a). PRs also need to communicate with sub-recipients on grant-related issues, collect data and information to include in their PUDRs and provide technical support (2008a). The LFA should keep the CCM apprised of progress in general and share any significant concerns regarding grant implementation so that the CCM can perform its oversight function and provide technical support for improved implementation; in the interest of transparency and accuracy of information, LFA should also debrief the PRs on the key findings before they are submitted to the Global Fund (2008a). China Global Fund program communications are shown in Figure 19.
There were some strengths in China Global Fund AIDS program communication. The program communications were through various channels. Overall, meetings have emerged as the dominant communication mechanism between the CCM and PR. Progress reports serve a similar function for communication between the LFA and PR. Field visits are used by both the CCM and LFA to review progress in the field. Networks and workshops have been effective forums for sharing experiences and learning. Other communication platforms such as an ad hoc CCM retreat (15 June, 2011), and websites have provided an opportunity to facilitate information sharing and consensus building on setting priorities, and enabling lessons to be learned across the CCM membership. The training exchange was found to be useful in terms of networking, sharing experiences and ideas and strengthening capacity. The researcher’s observations and the interviews with key personnel suggest that these communication channels were effective.

In addition China has established the China Global Fund Programs Principal Recipient website (http://www.chinaglobalfund.org/en/index.html) and China Global Fund Country Coordinating Mechanism (http://www.chinaccm.org.cn/) website as channels for communication. These websites are available both in Chinese and English versions and post
all key documents and provide all the relevant information in a timely manner. From the researcher’s observations and from the key personnel interviews, it appears that these websites have been effective as paths of communication.

Based on the management structure of Chinese health system, communication between the PR and SR/SSR was functioning well. The PR communicated with sub-recipients on grant-related issues, collecting data and information to include in their PUDRs, and providing technical support. The communications functioned so well because the National Program Office of the PR used a variety of channels, including regular field visits to the Local Program Office and formal training workshops, progress report meetings, informal telephone calls, emails, and online chat.

Furthermore, communication between the CCM and the PR was described as “frequent, open, transparent, supportive and based on mutual trust”. It takes place primarily through CCM meetings, reports and presentations made to the CCM by the PR. The PR attends the CCM meetings as observers and contributes to the discussions and deliberations.

Nevertheless, certain weaknesses became apparent. The communication at program management level could be improved. China Global Fund program formal communication at grant/program management level regarding grant management is primarily managed under the current system through the PR’s PUDR and GF Management Letters. These formal communications appear to be supplemented by informal email communication and country visits by Global Fund staff. An assessment by CCM AIDS Working Group and Oversight Committee (2011) found that formal communication between the PR and GF on Conditions Precedents (CPs)/Special Terms and Conditions (STCs) had been weak. Documentation and formal submissions made by PR have been of variable quality (a mixture of letters and informal emails) and GF responses have also been delayed and often lack specific advice on CP status and what needs to be done to resolve the issues raised.

In addition, PR communications with CSOs/CBOs and other development partners were weak. Those communications were mostly through the CCM meetings. In the interviews with key stakeholders, the communication was described as “limited and unsystematic”.

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The communication between the LFA and PR was also unsatisfactory. The LFA kept communication with the CCM and PR/SRs. The LFA attended all CCM meetings as an observer. Communication between PR and LFA includes PR reports to the LFA, site visits by the LFA, and participation by the LFA in CCM or PR meetings. At times LFA interacted with the PR to clarify certain aspects of the program. However, the PR was dissatisfied with the LFA communication especially in relation to special financial management verification exercise and external audit arrangements at the PR level. Further the PR also stated that they were not adequately briefed about the LFA assessments.

Thus, it is clear that there were both strengths and weaknesses in program communication. The strengths facilitated the cooperation among the partners, and the weaknesses became problems in the project management. Further analysis of communication is in the discussion chapter (Chapter Ten).

9.3.4. Problems of Financial Performance

Although most project targets were achieved during the reporting period and all funds were expended, financial control was poor at all levels. Reports from the self-check and self-correction activity (details of the questionnaire in the Appendix C) and the OIG review found a general weakness in the financial controls at the PR, SR and SSR levels. At the time of the review, the significant outstanding issues include inadequate accounting, insufficient documentation of expenditure, fixed asset management and unauthorised expenditures.

Delays in allocation of funds were frequent. Funds were sometimes delayed in their disbursal from central to county level, and this delay affected the project’s effectiveness. Delays were caused by complex bureaucratic administrative systems (approvals, procurement, personnel, and release of funds).

The Global Fund guidelines require that the grant funds should be maintained in separate bank accounts. However many implementation units, especially at county level, have no separate bank accounts for the Global Fund Grants and it is difficult for them to open separate accounts in the near future. This is because according to the Ministry of Finance regulations one organisation is not allowed to open multiple bank accounts. This issue has not been solved so far and will continue in the rest of the program implementation.
9.3.5. Personnel Issues

Capacity building of management teams needs to be strengthened. The China Global Fund AIDS Program has a wide geographical coverage. Most program areas have no previous experience in managing and implementing HIV/AIDS programs. Capacity gaps were observable at each level—central, provincial, and county.

The Global Fund excludes all CDC staff from subsidies (“top-up” payments) for outreach interventions, which posed a great challenge to program implementers at all levels. The Global Fund has not established a policy to define what is acceptable as payment. The "top-up" salaries and allowances being paid from Global Fund grants were considered excessive when compared to those that were being paid by other development partners. The absence of a defined basis for charging the salary cost of employees working on multiple projects, the absence of documentation of monthly payroll reconciliation, and the mismatch between budgeted and hired positions are examples of the personnel issues that had to be dealt with. Some staff felt that the disparities in payment were not fair, and this affected staff morale.

Additionally the frequent change of project staff such as project manager and other officers, particularly after funding was frozen in May 2011, seriously affected the program implementation. For example two thirds of the staff have left the national program office since May 2011. Staff losses also happened in the local project offices. This high staff turnover is often caused by job instability and unsatisfactory pay levels.

9.4. China Global Fund AIDS Program Early Termination and Potential Impacts

China Global Fund Program was terminated early in 2012. On 22 November, 2011, the 25th Global Fund Board Meeting held in Ghana made the following resolution: “those countries in the G-20 which have above average income, and whose burden of disease are not extremely serious, do not meet the qualifications to apply for the second phase of project funds of any existing approved projects.” As a country having above average income China would no longer meet the qualifications to apply for the second phase of project funds of any existing projects and would also lose the opportunity to apply for any Global Fund projects after 2013.
Termination of Global Fund support for the China HIV/AIDS response has significant implications for the implementation and sustainability of the national HIV/AIDS response. Firstly, the integration of the Global Fund AIDS Program impacted on more than 2000 counties. The decision by the Global Fund to hugely reduce funding meant that the national response plan and budget allocations needed to be completely revised. Some areas of the response have had to be suspended and CSOs, in particular CBOs, are completely unable to continue participating in AIDS response work (China Ministry of Health, 2012). As the Global Fund program is closed in 2013 the limited timeframe and considerable effort associated with the transition means that there may not be enough time for the entire government structure at all levels to re-allocate resources to ensure continuity of the program implementation.

Secondly, a large number of staff will be lost. Loss of the staff will impact on the ability to sustain capacity building and provide services. Thus it will further influence the China HIV/AIDS response.

Thirdly, as China still has no strong and sustainable national funding mechanism and quality support for CSOs/CBOs, their contribution to HIV/AIDS response will be affected. Furthermore, the various advanced international concepts that the Global Fund has been actively promoting, such as the participation of marginalised groups and communities, partnership building among various stakeholders, human rights protection of marginalised groups, policies sensitive to gender and women, creation of cross-sectoral collaboration, transparent decision-making mechanisms to democratise the public health system, a supervision system with the National Coordination Committee as a core governance and conflict resolution mechanism (CCM Oversight), are all valuable concepts for China to adopt and learn from (Jia, 2011). With the loss of the Global Fund as a major external driving force, China will face challenges in learning from international management experiences.

9.5. Conclusion

This chapter has focused on results from the case study of this research. A number of important findings from the fieldwork have been also identified and analysed in this chapter. Some of these findings will be discussed in the next chapter.
Chapter Ten

Discussion and Recommendations

10.1. Introduction

The previous chapter presented key results and identified main findings from the implementation of the current China Global Fund AIDS Program. Although the program has not been finally completed yet, the current findings show it has brought both benefits and challenges to the HIV/AIDS response in China. The experiences and lessons have great implications for the future of Chinese international health cooperation.

Based on literature and findings from the case study, this chapter develops a discussion of the key findings. Some points of the discussion are confirmed by the literature, such as the changes in international programs themselves; changes in China's role in international health cooperation (from being a receiver of aid to also being a donor); the importance of multi-sectoral cooperation; and conflict issues in the international project management. Other points of discussion such as CSO/CBO involvement, integration of HIV/AIDS program are based on new findings from the research. The recommendations provided in this chapter are also based on the literature and the new findings.

This chapter first highlights the main findings from the case study, and then discusses them by linking these to current Chinese realities and to the literature. The discussion looks at the key facilitating factors and the challenges in the five main areas of the findings, finishing with some recommendations for each. The five areas are: an analysis of current international health cooperation in China and the implications for future cooperation; the role of civil society organisations (CSOs) including the expanding demand for their services and the implications of the reduction of funding from the international community; the challenges of partnerships in the area of HIV/AIDS, especially clarity of roles, effectiveness of communication and issues of multi-sectoral collaboration; the integration of the international and national programs, including the achievements and difficulties; and the lessons learned about management of a large international program such as the China Global Fund Program. It finishes with a table summarising this discussion and the recommendations.
10.2. The Main Findings from China Global Fund AIDS Program

The following important findings are identified from the case study:

- the Global Fund Program makes a large contribution to the health development of China. As an influential international health project, its early termination has significant implications for the implementation and sustainability of the national program;
- involvement of CSO/CBO is an important feature of the Global Fund Program. In the specific environment of China participation of CSOs/CBOs is still facing many challenges. Further their future in the HIV/AIDS response in China is unpredictable particularly after the termination of the Global Fund Program in China;
- the Global Fund was designed to reflect at every level the principle and practice of public/private partnerships. This approach recognised the inherent necessity for all key stakeholders at each level to work together in a coordinated and collective way. It also underscores the comparative advantage of each entity. Issues such as accountability, communication, and multi-sector cooperation have a strong impact on program implementation;
- the China Global Fund AIDS Program has been integrated with the national program. There have been some successful results in the initial progress of the integration. However there are still some challenges;
- as an international health program, the implementation of the Global Fund Program faced many project management problems. These problems are raised from the different standards and understandings between the international providers and local implementers especially in areas such as the financial operating system, staff salaries and allowances, and high staff turnover.

These major findings are linked with the literature in the discussion that follows. Relevant recommendations are provided as they flow from the discussion.

10.3. Findings about the Current Situation and Implications for Future International Health Cooperation in China

Over the last few years, with Chinese GDP and living standards continue to rise and the international funding to China gradually decreased, the role of China in global health has
changed. As a developing country, China plays dual role as both a recipient and donor country. At the same time, the international community has expressed concern about whether China should contribute more to global health efforts as a donor rather than as a recipient of international assistance. China is moving toward the role of donor and is contributing more to international development.

Since 2011 China has entering the ranks of the upper middle-income countries as identified by the World Bank and is no longer seen by the international community as needing international aid and assistance. Government aid from other richer nations has also been steadily shrinking. This is evident with countries such as the UK and Australia, who have been the major source for international health operations in China. Currently China is becoming less dependent on foreign funds and other foreign resources. For instance, with the completion of the Global Fund grant in 2012, virtually all international supports for HIV/AIDS programs in China have ended. China currently invests more than 80 per cent of its domestic budget on HIV/AIDS and the country has announced it will fully fund its response from 2013. The reduction of international funding will have impacts on China’s HIV/AIDS response and the public health sector.

International communities are finding that their role, leverage and impact in China are declining. The impact and leverage of international partnerships are decline. China is becoming less dependent on foreign funds and other foreign resources. It is now more of an equal partner on the global scale and no longer solely a recipient of foreign aid. Many international communities have changed their roles from simply providing source funding to China to co-funding projects of mutual interest with China. For example, when international NGOs first began operations in China, China’s development needs were substantial and a small amount of foreign funding went a long way to meeting those needs, so international NGOs were welcomed by the Chinese. As international aid is gradually withdrawn from China, rather than simply providing China resources for domestic development, international NGOs are now shifting their focus to transferring their international development technologies, know-how and experiences to their Chinese partners to shape the way in which they carry out development aid to other less developed countries, particularly in Africa. This shift is changing the international NGO/Chinese partner relationship from a donor-recipient one to a strategic one in which both sides regard each other as equals.
China continues to pursue and expand its global health engagement and will play a bigger role in global health. The international community has expressed concern about whether China should contribute more to global health efforts as a donor of international assistance to other countries. China has been a player in health related development assistance since the 1950 and its foreign aid has emerged as a model with its own characteristics (State Council Information Office, 2011). However its aid efforts are still in the early stages. China has a long way to go in providing foreign aid. Developing a long-term aid strategy and cooperation with other international partnerships is under discussion. In keeping with the transition from a donor-recipient relationship with China, foreign donors are also exploring ways to work with China as a donor nation.

**Recommendations for Chinese Agencies and International Community**

In order to effectively utilise international resources, at the national level, based on their targets, the Chinese government agencies should:

- develop a transition plan including the commitment of funds to bridge the funding gap;
- help and direct international agencies to choose appropriate project areas and reasonable project activities to avoid the uneven nature of international aid;
- develop communication mechanisms to ensure that resource mobilisation is well coordinated to avoid duplication and confusion among key donor groups. Given the large number of partnerships and actors involved, a strategic approach is needed to ensure that messages are clear and consistent and actions taken under different partnerships are mutually reinforcing. Communicate to all levels about budget responsibility is imperative;
- explore other innovative oversight mechanisms based on the country context.

The International community need to:

- set the right directives for their staff to commit long-term aid, coordinate with other agencies and encourage the move towards program-based approaches under the leadership of China;
• work towards joint missions and joint annual sector reviews as a critical opportunity to review shared objectives, agree on process and policy conditions and encourage further alignment with country plans, under country leadership;
• make full use of existing Chinese mechanisms and flexibilities to provide a greater portion of Chinese health aid over the longer-term. They also need to eliminate conditions on the use of technical cooperation in health;
• support efforts to improve the dialogue and coordination between health ministers and other central ministers (finance, economy and planning). This will help ensure that health plans and budgets are properly reflected in the long-term country strategy, and activities are appropriately funded, particularly those that require long-term commitments such as human resources and drugs.

10.4. Implications for the Involvement of CSOs /CBOs in HIV/AIDS Response in China

In recent years civil society organisations (CSOs) have played an increasingly important role in global health governance. They are seen as key partners in recently established global health initiatives (GHIs) such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (Global Fund), The Global Alliance for Vaccines and Immunisation (GAVI) and the World Bank’s Multi-Country HIV/AIDS Program (Doyle & Patel, 2011). They are also increasingly seen as crucial agents in delivering health interventions on the ground. CSOs have an advantage in delivering health interventions. Many donors, therefore, prefer to channel funds through the CSOs in developing countries rather than through perceived to be corrupt or inefficient government agencies (Doyle & Patel, 2011). Since the beginning of the HIV/AIDS epidemic, CSOs have played an essential role in reaching out to communities with prevention and education messages as well as in the provision of care and support.

The need for greater local CSOs involvement in China’s HIV/AIDS response is clear, especially to reach groups that avoid government scrutiny. Over the past 20 years CSOs in China have significantly increased their involvement in the HIV/AIDS response. The number of CSOs specifically working on HIV/AIDS increased from none before 1988 to over 400 in 2009 (Li et al., 2010). They are now widely involved in nearly all aspects of HIV/AIDS related prevention, treatment and care efforts, and have had a positive impact. Funding to HIV/AIDS
CSOs in China has increased during the past decade with a large proportion coming from international sources. There are various international organisations, including the United Nations system, and various foundations (Ford, Clinton, Bill and Melinda Gates) and bilateral programs, providing support to AIDS CSOs in China (F. S. Wu, 2005). Moreover increasing numbers of CSOs have received funding from international programs (for example Global Fund).

However in China there is still a lack of effective civil society engagements in implementing international health projects. The lack of participation of Chinese CSOs in health aid further narrows the space of cooperation between China and other donors. Successful implementing of international projects often hinges upon the support of civil society entities.

Civil society participation is a key part of the Global Fund Program’s identity. It actively improves CSOs participation in HIV/AIDS responses in China. The benefits, problems and challenges emerged from its implementation should be focused and analysed, and its experiences have implication for the future CSO involvement in the Chinese HIV/AIDS response as well as in the public health sphere. The following points need to be considered in this discussion.

10.4.1. Issues of Definition of CSO

The civil society sector is emerging as a clear societal actor in many parts of the world. However it is also quite varied in its nature and composition. For this reason definitions of civil society vary considerably based on differing conceptual paradigms, historic origins, and country context. The World Bank defines the civil society as:

The term civil society to refer to the wide array of non-governmental and not-for-profit organisations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. Civil Society Organisations (CSOs) therefore refer to a wide of array of organisations: community groups, non-governmental organisations (NGOs), labour unions, indigenous groups, charitable organisations, faith-based organisations, professional associations, and foundations” (World Bank).

Civil Society Organisations are defined by the OECD (2006b) as the multitude of associations around which society voluntarily organises itself and which represent a wide range of interests
and ties. These can include community-based organisations, indigenous peoples’ organisations and non-government organisations.

China and the West have different understandings of what a CSO is, as well as different social and cultural systems. It has come to the point where this problem must be addressed. In the case study of this research, the Global Fund requires that a part of the program funding be given to CSOs for implementation, but what exactly is a CSO? The difference between the Global Fund and the Chinese government in defining what constitutes a “CSO” is one of the reasons that have brought about the temporary freezing of funds. To support the participation and development of China’s grassroots CSOs it is very important to make clear what it means to be a civil society organisation with no government backing and how to differentiate between these different types of organisations.

10.4.2. Major Obstacles to Development of CSOs

China’s civil society has grown rapidly over the past ten years but it is still in an early stage of development. Because most grassroots CSOs are unable to legally register, limited sources of funding, and because most founders have little to no prior CSOs or management experience, they face numerous challenges in the effort to professionalise operations while providing needed services and conducting policy advocacy.

Difficulty in Registration

CSOs, particular CBOs face registration difficulty in China. There have been strong political statements from senior government as well as HIV/AIDS-specific policies and regulations in support of CSOs in China. However beyond the HIV/AIDS field the legal environment for CSOs still remains rather restrictive. The main route for CSOs to operate legally in China is to register with the Ministry of Civil Affairs (MOCA). Financial and political sponsorship are necessary and the required registration is often difficult (Joan Kaufman, 2012; Li et al., 2010). A “dual management system” was instituted that required a sponsoring organisation and yearly re-registration. Interviews with CSOs’ staff showed that the dual management system often acts as a hindrance to CSOs’ operations, as some good organisations are unable to find sponsors willing to manage and take responsibility for them. Apart from the constraint of China’s civil registration law for NGO, AIDS related CSO find it even more difficult to be affiliated to

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bigger organisations because of the sensitivity around HIV/AIDS. Without legal status it is hard for CSO to apply for large-scale funds and this restricts their growth.

**Lack of Funding**

The lack of adequate funding for CSOs, particularly at the grassroots level in poorer parts of China, is a major problem (Gill, Morrison, & Lu, 2007; J. Kaufman, 2009). In China many Chinese CSOs rely heavily on international funding. In some cases international funding of grassroots CSOs is not so apparent because international foundations may disburse funds first to government organised non-governmental organisation (GONGO) or a university or research institute which serves as an intermediary platform for getting money to small CSOs or community-based organisations (CBOs). Such is the case with the Global Fund Program which funds HIV/AIDS CBOs for AIDS prevention work through the CDC and national-level GONGOs such as the Chinese Association of STD & AIDS Prevention and Control. As a result local CSOs are unable to effectively design programs to fulfill their missions. In addition strict registration requirements have led to many unregistered groups. Due to their illegal status and lack of bank accounts these groups face difficulties in receiving funding, finding technical support, and accessing information and other resources.

**Difficulty in Organisational Development**

Grassroots Chinese CSOs lack sufficient management and technical experience, influence and resources to operate large-scale and long-term programs. Most CBOs were staffed with a mixture of full-time staff, half-time staff, and volunteers. Many organisations cited high staff and volunteer turnover as significant obstacles to their work. In addition the short funding period makes it hard to develop a long-term plan. However most funds (such as Global Fund) are for HIV/AIDS programs rather than the institutional development of CSOs such things as the payment and welfare of staff, effective capability programs and capacity building is often not covered by the funding grants (McKinsey & Company, 2011).

**10.4.3. The Future of CSO/CBO Participation in AIDS Response**

The Chinese government has begun to acknowledge the need for CSOs. This is because it recognises the severity of the AIDS problem facing China and of the important role that civil
society groups can play combating the epidemic. However participation of CSOs, particular CBOs, is still facing the challenges of registration and sustainable funding.

For the near future, most CSOs, particular CBOs will still face the challenges of registration and sustainable funding. Chinese CSO registration laws will continue to limit the growth and activity of local CSOs. Despite increased investment by the government, these funds are still provided on an ad hoc basis and, as yet, there is no institutionalised funding for CSOs from the government. In addition as most CSOs receive funding primarily through international sources such as the Global Fund, the Bill and Melinda Gates Foundation programs and other international organisations, funding sustainability may become an issue in the future as more donors start to withdraw their bilateral aid for China.

Early termination of Global Fund program will impact the CSOs involvement. Nevertheless, the Global Fund Program served as a door opener for CSO/CBO participation in the HIV/AIDS response in China (Joan Kaufman, 2012). It also helped to bring on board central government leaders who accepted the Global Fund requirements, and established a mechanism for a voice for and input by CSOs into China’s HIV/AIDS response. The grant termination has hurt CBOs the most and may also jeopardise years of cooperation between the China CDC and CBOs. The China government recently announced that it would use domestic resources to substitute for cancelled Global Fund moneys and has accelerated a process to contract directly with CSOs and CBOs for program implementation. Questions such as “What will the future fundraising situation for CSOs be like once the Global Fund has gone?”, and “If the Global Fund leaves, will the government have to supplement its investment in the CSO sector?” are still under consideration by public health professionals.

10.4.4. Recommendations for Strengthening CSOs/CBOs to Effectively Contribute to Response HIV/AIDS in China

Active and effective civil society participation requires commitment by leadership; integration into all structures, polices and processes; adequate resources to facilitate participation; and transparency in decision-making. Based on the findings and discussion of this research described above, the following recommendations are provided for strengthening CSOs/CBOs capacity and enabling them to effectively contribute to the fight against HIV/AIDS in China.
**Investment in Building the Capacity of CSOs**

A national system of standards and financial and technical assistance can be established to ensure CSOs are increasingly capable of providing effective services to meet growing public health needs, especially among vulnerable and at risk populations. Such a system could be operated by a GONGO with strong support from a network of Chinese universities and international donors.

Domestic and foreign donors need to do far more to ensure adequate and sustained funding is reaching successful grantees, which can make a positive contribution to meet China’s burgeoning health needs. CBOs need enhanced skills in information technology networking, communication, negotiation, fundraising, accounting, human resource management, and in establishing more collaborative relationships with government agencies and with other CSOs both inside and outside of their respective communities. A part of this effort should be to encourage greater CSO engagement with cross-border and other international counterparts to share experiences, lessons learned, and best practices.

**Developing a New Management System for CSOs and Supportive Collaborations between Government and CSOs**

Government support is vital to ensure financial sustainability of CSOs in the long run as well as providing legal status for these organisations. In order to enable them to make long-lasting contributions in the fight against HIV/AIDS in China the government should first clear the uncertain legal status of independent grassroots organisations and give them a recognised position in society; and introduce more favourable policies to encourage their development. The government should also consider encouraging the registered CSOs to help the unregistered grassroots organisations and encourage the sharing of experience in financial and program management. As a result the registered CSOs are able to act as intermediaries between the independent CSOs and the government. Registered and experienced CSOs can better communicate with the government and advocate for those with HIV/AIDS because these people often have a mutual aim with the independent CSOs. It is even possible to use those registered CSOs as a monitoring system in the future.
10.5. Partnership in International HIV/AIDS Cooperation

For Chinese international health cooperation, building effective partnerships is a key to program success such as the HIV/AIDS response projects. As projects move from planning to implementation conflicts are likely to emerge along the way. When considering the challenges of building partnership and the key findings from the case study, the main components which make partnership successful are discussed below.

10.5.1. Clarity of Roles and Responsibilities of Partners

Clarity of Roles and Responsibilities of partners is important for effective partnerships. In order to make partnerships work all the partners must share the same goals, have mutual respect for one another, and have a common understanding of how to achieve the project’s objectives. Lack of clarity of roles and responsibilities of partners is the big challenge in building effective partnerships. The role of development partners is cleared in the China Global Fund Program. Key development partners such as UNAIDS, US-CDC, WHO, DFID & UNICEF were represented in the China CCM. The working groups for the three diseases are either chaired or vice-chaired by representatives of the development partners. The international organisations provided considerable support in proposal writing, monitoring and evaluating grant implementation and providing technical support to the implementing entities when needed. In addition to their involvement in the China CCM development partners provided additional support. For instance UNDP manages China CCM funds, UNAIDS houses the China CCM Secretariat function, and CBO/SR review is jointly sponsored by UNAIDS and the Gates Foundation.

10.5.2. Communication

Effective communication is a fundamental component of any partnerships. Open and effective communications are particularly critical to create trust in dispersed organisational forms. A frequent observation during the study concerned communication. A key lesson to come out of China Global Fund AIDS Program experience has been the vital importance of managing the various relationships well, and maintaining good communication, and how easily lack of good relationship management and poor communication can create problems. In general a key lesson was the importance of clear communication and definition of roles among all stakeholders from the start of the process, to ensure general understanding of the
responsibilities, milestones and expectations. The Global Fund has very clear communication protocols (The Global Fund, 2006, 2011). However the partners of China Global Fund AIDS Program did not follow the guidelines. Thus it is very important to sign a memorandum of understanding between partners that details each actor’s roles and responsibilities in promoting communication and coordination between them. Formulating a communication strategy ensures all the partners communicate in a frank, open respectful and diplomatic manner.

Communication is the most important aspect in a project. It should cover every aspect of the project from the initial approval of the project to the final closure providing the right information to the right people at the right time (William Dow & Taylor, 2010). Communication can be enriched by bringing diverse views together and by sharing programmatic progress across all stakeholders involved in project implementation. Communication between project actors can influence the effectiveness of project implementation.

Effective communication platforms influence project implementation. Meetings have generally been a good communication platform. Meetings are effective forums for direct communication when they are held regularly and participation is good. Conversely they are tedious and dull when poorly planned and executed. Another platform is reports. Reports provide a good channel for information exchange, but only when reporting requirements are not excessively demanding. Over reporting is a burden for the project officers while analysis of the reports for decision making is a challenge. Networks and workshops have also been effective platforms for sharing experiences and learning. Training exchange is useful in terms of networking, sharing experiences and ideas and strengthening capacity. Technology (for example via videoconference and teleconference or using voice on internet phone) has the potential to facilitate communication and ensure greater transparency. Other communication platforms, for example, an ad hoc China Global Fund Program CCM retreat, also can provide an opportunity to facilitate information sharing and consensus building on setting priorities and enable lessons to be learned across the partnerships.

10.5.3. Multi-sector Collaboration

Although the health sector is central to disease control particularly for HIV/AIDS response, it must collaborate with other sectors in order to tackle the social, economic, cultural and
environmental issues that shape the epidemic and provide access to health services. Conflicts of interest between government agencies, such as those responsible for health and public security, need to be moderated so that they can coordinate services to reach high-risk groups that engage in illegal behaviour. In addition the Ministry of Health relates also to other government agencies; this is typically required as part of the cross-governmental process of management in relating to ministries such as finance, social affairs, and labour. In China the central government has called for greater cooperation between relevant departments.

In February 2004, the State Council established the State Council HIV/AIDS Working Committee, with the Vice-Premier and the Minister of Health as director to strengthen the AIDS coordinating mechanism. The Committee now includes vice-ministers from 29 key ministries and organisations, as well as the vice-governors of the seven provinces most affected by HIV/AIDS (Guangdong, Guangxi, Henan, Hubei, Sichuan, Xinjiang, and Yunnan). AIDS Working Committees (or AIDS Prevention and Control Leading Groups) have been established in all provinces, autonomous regions and municipalities to coordinate HIV/AIDS responses across sectors. The important function of the Committee is to organise and coordinate cross-sector efforts for HIV/AIDS responses and ensure the participation of the whole society. This work is undertaken by the China Ministry of Health.

During the past decade, the multi-sectoral cooperation is improved in China. The mobilisation of multiple sectors occurred through a series of educational workshops, conferences, collaborative projects, and networking between members in a number of levels of the government and administrative structural hierarchies. At local, national, and international forums, officials from many sectors were able to meet one another, share information to form a common knowledge base, and debate the appropriateness of different interventions. Personal relationships were also formed.

However there are many challenges that make the multi-sectoral cooperation difficult. Multi-sectoral cooperation has always been a weak link in HIV/AIDS prevention and control. Chinese government services are traditionally hierarchical and departmentalised and have not directly cultivated cooperation and collaboration across sectors. This tradition made the organisation of multifaceted responses appropriate for HIV/AIDS control difficult. Additionally although the health sectors at all levels are the primary sectors responsible for
HIV/AIDS control it is very difficult for the health sector to coordinate the sectors which have more powerful (for example the State Development and Reform Commission).

A second challenge is that there are no clear responsibilities, authority or resource allocations in some key sectors leading to a lack of accountability for the implementation of HIV/AIDS programs. A large problem is the lack of communication between sectors and a sharing mechanism. The limited communication between agencies results in poor implementation of HIV/AIDS programs.

A third challenges is that AIDS Working Committee offices at each level lack sufficient full-time staff and trained personnel. Staff retention and recruitment of inexperienced personnel have major impacts on the project implementation.

To overcome these problems following suggestions are provided to the Chinese government:

- increase commitment to and accountability for the implementation of HIV/AIDS programs by key sectors and local governments and engage various sectors to strengthen the multisectoral response;
- further strengthen advocacy and training of leaders, especially those who have recently been appointed and the leaders of other key agencies;
- promote the strengthening of cross-sectoral communication and coordination. Relevant sectors need to prepare joint strategic plans that tackle priority responses with clear lines of responsibility.

10.5.4. Other Recommendations for Partnership Management

The following recommendations can be taken into account by the Chinese government after considering the characteristics and demographics of China, the termination of the Global Fund Program, and the integration of all the HIV/AIDS programs.

The management system that supports the day-to-day work of collaborating among different partners should be considered when developing management and process structures for further joint international health cooperation. This complex and extensive system does have significant advantages for coordination, including utilisation of a centralised health information system with real time electronic disease reporting from nearly every health
institution in the county that can significantly improve disease surveillance and reporting (Brown, Mackey, & Liang, 2012). The system has been utilised in some other countries. For example, in Tanzania, the government replaced the Global Fund CCM with the Tanzania National Coordinating Mechanism (TNCM), which coordinates all international resources for HIV, TB and malaria. The TNCM now provides a unified forum for sharing information amongst all stakeholders, enabling development partners to minimise duplication and reinforce synergies with improved information sharing (UNAIDS, 2013).

Strong and clear management procedures are critical. By having articulated management procedures and annual activity plans approved by all partners a joint activity based monitoring system that meets all the partners’ requirements can be put in place which will ensure a smooth working relationship and implementation process (Hill, Dodd, Brown, & Haffeld, 2012). For example in the China Global Fund Program, the PR had developed a Finance Management Manual to strengthen the funds management processes and improve the efficiency in the use of program funds. All sub-recipients use this Finance Manual. Moreover joint monitoring and communication procedures were established to guide and measure the collaboration’s progress over time.

**10.6. Integration of International and National AIDS Programs**

The integration of AIDS program in China has brought many benefits for both the Chinese government and for external project funders. The diversity and multitude of resources in Chinese HIV/AIDS programs presented significant challenges for the capacity, implementation, coordination, data collection, and potential for programmatic overlap and waste of resources (Zunyou Wu et al., 2011). In order to ensure appropriate allocation of limited resources, prevent duplication of investments and to ensure effective use of funding the Ministry of Health integrated funding from the HIV/AIDS response from various levels of government and from international sources, creating a united, comprehensive national HIV/AIDS response plan. The “integration,” includes integration of management, planning, funding and targets. The international program strategies, resources and targets have been integrated into the national system and the international resources have become part of the national budget.
An online comprehensive HIV/AIDS data system was developed and became operational on 1st January 2008. Data is entered into this system from all HIV/AIDS projects operating in China and is provided as needed to those programs for monitoring of implementation and assessment of project impact (Mao et al., 2010). This process has significantly reduced the workload of project staff in project sites, as well as permitting a much clearer picture of the country’s progress in its HIV/AIDS response (Zunyou Wu et al., 2011).

Integration has greatly facilitated implementation of the national HIV/AIDS program (Liu et al., 2010; Mao et al., 2010). The integration is now complete and encompasses the processes of project planning, budgeting, implementation, monitoring and evaluation (Zunyou Wu et al., 2011). The preliminary results have been positive leading to reduced workload for local public health agencies, reduction and standardisation of reporting, increased identification of cases in certain at-risk population groups, and greater leveraging of resources for other forms of public health testing/screening in local communities (Zunyou Wu et al., 2011). The integration now provides a unified forum for sharing information among all stakeholders enabling development partners to minimise duplication and reinforce synergies with improved information sharing (Liu et al., 2010).

Integration is a new concept for the implementation of China HIV/AIDS Program. The process of integrating all HIV/AIDS projects into one national HIV/AIDS program in China is a prime example of the “Three Ones” principles advocated by UNAIDS:

- one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners—*China’s 12th Five-Year Action Plan for Containment and Control of HIV/AIDS*;
- one National AIDS Coordinating Authority, with a broad based multi-sector mandate—*State Council AIDS Working Committee*;
- one agreed country level Monitoring and Evaluation System.

Although the integration has greatly facilitated implementation of the national HIV/AIDS program (Liu et al., 2010; Mao et al., 2010), in the early stage of the integration, some problems were encountered and needed to be considerate. First the changes in policies of international programs impacted not only the implementation of the programs themselves but also China’s overall HIV/AIDS response plan. In the case of the China Global Fund AIDS
program, the Global Fund suddenly suspended fund disbursement in May 2011, which had a negative impact on China’s HIV/AIDS response work. In terms of funding, the 2010 program budget amounted to USD $595 million, but as a result of the Global Fund’s suspension of fourth quarter funding, the actual amount received was USD $48.5 million (China Ministry of Health, 2012). On 22nd November 2011, at the 25th Global Fund Board Meeting, a resolution was made that the already approved Phase II China Global Fund program (2013-2015) could no longer be funded (upper ceiling for funding was set at USD $268 million). Because of the integration of the Global Fund Program and national response work the decision to hugely reduce the funding meant that the national response plan and budget allocations needed to be completely revised. Some areas of the response had to be suspended. In particular CSOs/CBOs were totally unable to continue participating in HIV/AIDS response work (China Ministry of Health, 2012). Therefore adequate project planning is crucial for the successful integration of foreign projects into one national program. Ensuring the budget integration of funding sources is also crucial for adequate funding so planned activities can be fully implemented and are complementary to the national program.

Secondly, the scope and scale of the integrated programs were significantly expanded. All programs were integrated within a giant national program with corresponding complexities of financial disbursement, fiduciary oversight, technical quality assurance and control, and program and financial reporting (Zhongdan Chen et al., 2011; Zunyou Wu et al., 2011). Simple (even though large) project grants do not usually involve such issues -- or where they do, on a scale that can usually be relatively easily negotiated in a manner that is far more difficult on a national scale.

Thirdly, integration may make the impact of a single project “invisible” if it does not have specific features (Zunyou Wu et al., 2011). Most international projects have particular focus areas for HIV/AIDS control (for example the Gates Foundation has focused on projects for men who have sex with men). Once these projects have completely integrated their work into the national HIV/AIDS program their impacts are difficult to disentangle from the overall HIV/AIDS program.
Finally, the integration process increased workload to staff. During the integration of the programs, additional time and effort is required for coordinating planning, budgeting, implementation and evaluation of multiple projects (Zunyou Wu et al., 2011).

When considering the above challenges some experts have suggested (Zunyou Wu et al., 2011) that adequate project planning is crucial for the successful integration of foreign projects into one national program. Further ensuring budget integration of funding sources is also crucial to ensure adequate funding so planned activities can be fully implemented and are complementary to the national program.

To be concluded, the integration has brought many benefits for the Chinese government. The model of integration recounted here may serve as a useful model for other countries.

10.7. International Project Management Issues

10.7.1. Country Contexts and Alignment

Country contexts and political realities have a major influence on international health projects. The transfer and adoption of internationally accepted norms and approaches sometimes is in conflict with cultural attitudes and political positions. All too often generic donor’s sector structures are used at country level which are not useful in terms of either the countries’ own sectoral or administrative structures.

The findings of the case study in this research indicated that the Global Fund Program created many problems for the local implementing units when its policies did not align with local policy and regulation. For example the Global Fund guidelines required that the grant funds should be maintained in separate bank accounts. However the field investigation found that many SR’s disease dedicated bank accounts were not maintained for the Global Fund Grants. The reason is that in China, according to the regulations of the Ministry of Finance, an organisation was not allowed to open multiple bank accounts. Thus many local implementing units, especially in county level or under, have no separate bank accounts maintained for the Global Fund Grants. Other examples from the case study include different definitions of CSOs between the Chinese agency and the Global Fund and also salary and compensation for program staffing issues.
Therefore the program design and implementation process should respect country contexts and political realities. The international fund-financing should be coordinated and harmonised. For example donor fund-financed salaries should be coordinated with existing in-country salary frameworks and international stakeholders should engage in donor coordination efforts to avoid gaps or overlaps in implementation and to allow for synergies in country planning.

10.7.2. Personnel Issues

Most staff are employed as sessional staff in the international health projects. There is a high staff turnover usually due to unmet expectations, job uncurtailed, and unsatisfying pay. This occurs at every level. High staff turnover affects the functioning of the project. Although there is constant and repeated training every year it is difficult for new staff, especially in management and technical posts, to quickly reach functioning level. Further frequent changes in staff within the respective organisations can weaken communication flow.

Hence the government agencies should develop long-term personnel mechanisms to deal with the issues. Firstly a long term job perspective is important. Employers should try to offer long term job contracts instead of short term contracts to increase the commitment from the employee. Secondly career development opportunities are necessary. Employers should aim, encourage and expect employees to engage in constant learning and try to provide space for personal development. Job training should become part of the employment policy. Finally, improving retention strategies can be achieved by: improving organisational structure; identifying a clear job description; improving communication among the staff and the managers; employing workers on long term contracts and encouraging career goals; and establishing and improving the human resources department within the organisation.

10.8. Summary of Main Facilitating Factors, Challenges and Recommendations

This research can serve as a tool in supporting countries to understand the challenges and the facilitation factors involved in international health cooperation. Its findings and recommendations are useful and can be used by decision makers and leaders from government,
academia, the NGOs and private sector to further improve the effectiveness of development cooperation. The facilitating factors, challenges and relating recommendation are summarised in Table 27.
Table 27: Conclusions of Findings and Recommendations

<table>
<thead>
<tr>
<th>Area</th>
<th>Facilitating Factors</th>
<th>Challenges</th>
<th>Recommendations China government agencies</th>
<th>Recommendations International community</th>
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<tbody>
<tr>
<td><strong>International Health Cooperation in China</strong></td>
<td>• strongly political commitment</td>
<td>• reduction of international resource roles as recipient and donor</td>
<td>• develop a transition plan including the commitment of funds to bridge the funding gap</td>
<td>• set the right directives for their staff to commit long-term aid, coordinate with other agencies and encourage the move towards program-based approaches under the leadership of China</td>
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<td></td>
<td>• continue to pursue and expand global health engagement</td>
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<td>• help and direct international agencies to choose appropriate project areas and reasonable project activities, avoid the uneven nature of international aid</td>
<td>• work towards joint missions and joint annual sector reviews as a critical opportunity to review shared objectives, agree on process and policy conditions, and encourage further alignment within country plans, under country leadership</td>
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<td>• develop communication mechanism to ensure that resource mobilisation is well coordinated to avoid duplication and confusion among key donor groups</td>
<td>• make full use of existing mechanisms and flexibilities to provide a greater portion of their health aid over the longer-term</td>
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<td></td>
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<td>• explore other innovative oversight mechanisms based on the country context</td>
<td>• support efforts to improve the dialogue and coordination between health ministers and other central ministers</td>
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<td><strong>CSOs/CBOs Involvement in HIV/AIDS Response</strong></td>
<td>• CSOs in China have significantly increased their involvement in the HIV/AIDS response</td>
<td>• registration difficulty, lack of funding, organisational development</td>
<td>• invest far greater resources in building the capacity of CSOs</td>
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<td>• build a new management system for CSOs and develop mutual supportive collaborations between</td>
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<td>Partner in International HIV/AIDS Cooperation</td>
<td>government and CSOs</td>
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<td>• clear roles and responsibilities of partners</td>
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<td>• network built through workshops, conferences, and projects</td>
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<td>• poor communication among the partners</td>
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<td>• weak multi-sector collaboration</td>
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<td>• define roles among all stakeholders from the start of the process, sign MOU and formulate a communication strategy</td>
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<td>• use effective communication platforms</td>
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<td>• develop a partnership collaboration management system</td>
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<td>• strengthen and clear management procedures</td>
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<td>• increase commitment to and accountability for the implementation of HIV/AIDS programs by key sectors and local governments</td>
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<td>• engage various sectors to strengthen the multi-sectoral response</td>
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<td>• further strengthen advocacy and training of leaders</td>
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<td>• promote strengthening of cross-sector communication and coordination to strengthen their involvement</td>
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<td>• relevant sectors need to prepare joint strategic plans</td>
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<th>HIV/AIDS Program Integration</th>
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<tr>
<td>• “Three Ones”</td>
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<td>• unique online comprehensive HIV/AIDS data system</td>
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<td>• influenced by the changes and uncertainty of policies of international programs</td>
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<tr>
<td>• the scope and scale of the integrated programs is significantly</td>
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<td>• adequate project planning</td>
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<td>• ensure budget integration of funding sources</td>
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</table>
| **International Project Management** | • county contexts and alignment  
• capacity building  
• high staff turnover | • develop long-term personnel mechanism to deal with the personnel issues  
• improvement of organisational structure | • the program design and implementation process should respect country contexts and political realities  
• the international fund-financing should be coordinated and harmonised |
10.9. Conclusion

The chapter has first outlined the main findings from the previous chapter and then developed a discussion about the “current situation and implication for future international health cooperation in China”, “CSOs/CBOs involvement in HIV/AIDS response in China”, “partnerships in international HIV/AIDS cooperation”, “the integration of international and national HIV/AIDS program in China”, and “international project management” by linking with the literature review in Part I of this thesis. Finally, based on the discussion, the chapter has concluded with the facilitating factors, challenges, and recommendations for the future international cooperation on HIV/AIDS responses in China. This discussion allows for the research conclusions to be accurately documented in the next chapter.
Chapter Eleven

Conclusion

11.1. Introduction

This thesis examines international health cooperation in China through a case study of an international HIV/AIDS project – known as China Global Fund AIDS Program. The program reflects China’s changing international health cooperation environment and highlights some impact factors and challenges that the Chinese government and their international country partners need to seriously address. The recommendations provided in the previous chapter have significant implications for the future of the China HIV/AIDS program, and also for future direction in public health programming in China.

This final chapter summarises the purpose and overall findings of the research, emphasises the findings of each chapters, and draws attention to the major contribution and significance of the research. Limitations of the research and suggestions about possible directions of further research on China’s international health cooperation are discussed.

11.2. Conclusions from the Research

11.2.1. Overall Purpose and Main Findings of the Research

The overall purpose of this research is to identify challenges and facilitating factors for international cooperation on HIV/AIDS prevention and control in China, provide information, evidence, and recommendations to both Chinese and international community health policy makers, HIV/AIDS project planners and providers to achieve sustainable outcomes, and form the foundation for developing policy actions. There is growing recognition that international health cooperation plays a crucial role in our globalised world. Health issues such as HIV/AIDS demand international cooperation and effective partnership. China, as a developing country with rapid growing economy, is facing a transitional period of international cooperation on HIV/AIDS prevention and control. This research addressed the international cooperation for HIV/AIDS response in China by utilised a mixed method through a
signal case study, the China Global Fund AIDS Program. The main findings and discussion of this research are summarised as follows:

- currently the situation of China health cooperation has changed. China has become less dependent on foreign funds and other foreign resources and played dual role as both a recipient and a donor country. The role and impact of the international community on China has changed;
- CSOs/CBOs have played an increasingly important role in the China’s HIV/AIDS response. However they are currently facing the multiple challenges, such as registration difficulties, the lack of funding and organisational development;
- to facilitate partnerships in international health cooperation certain factors have been identified as very important in China. They are clarity of roles and responsibilities of partners, better communication, and improved mechanisms for multi-sectoral collaboration;
- the international and national HIV/AIDS programs have been integrated in China. The integration brings benefits such as improved information sharing and minimisation of duplication. However, at this early stage of the integration, the research has identified many problems such as stemming from unpredictable foreign sources, the expanded scope of the program, and single project invisibility in the larger integrated program;
- problems of consistent staffing and capacity of the local organisations arose. These are related to issues arising from the nature of management of international projects – clashes of donor and recipient policies, and local cultural attitudes or customs.

Based on the discussion above, this research formulated the following key recommendations:

**Future Directions for International Health Cooperation in China**

Chinese government agencies should:

- develop a transition plan including the commitment of funds to bridge the funding gap;
• help and direct international agencies to choose appropriate project areas and reasonable project activities, and avoid the uneven nature of international aid;
• develop communication mechanisms to ensure that resource mobilisation is well coordinated to avoid duplication and confusion among key donor groups;
• explore other innovative oversight mechanisms based on country context.

The international community should:
• set the right incentives for their staff to commit long-term aid, develop coordination with other agencies and encourage the move towards program-based approaches under the leadership of China;
• work towards joint missions and joint annual sector reviews as a critical opportunity to review shared objectives, agree on process and policy conditions and encourage further alignment with country plans, under country leadership;
• make full use of existing Chinese mechanisms and flexibilities to provide a greater portion of Chinese health aid over the longer-term;
• support efforts to improve the dialogue and coordination between health ministers and central ministers (finance, economy and planning).

Involvement of CSOs/CBOs in HIV/AIDS Response in China

The Chinese government agencies and international community should:
• invest far greater resources in building the capacity of CSOs.

The Chinese government agencies should:
• build a new management system for CSOs and develop mutual supportive collaborations between government and CSOs.

Partnerships in International Health Cooperation

The Chinese government agencies and the international community should:
• clarify roles and responsibilities of partners;
• use effective communication platforms;
• develop a management system that supports the day-to-day work of collaborations among different partners;
• develop strong and clear management procedures.

The Chinese government agencies should improve multi-sectoral collaboration by:
• increasing commitment to and accountability for the implementation of HIV/AIDS programs by key sectors and local governments;
• engaging various sectors to strengthen the multisectoral response;
• further strengthening advocacy and training of leaders, especially those who have recently been appointed and the leaders of key agencies;
• promoting strengthening of cross-sector communication and coordination to strengthen their involvement;
• preparing joint strategic plans with relevant sectors that tackle priority responses with clear lines of responsibility.

The Integration of International and National AIDS Programs
The Chinese government agencies should:
• ensure adequate project planning for the successful integration of foreign projects into one national program;
• ensure budget integration of funding sources to ensure adequate funding so planned activities can be fully implemented and are complementary to the national program.

International Project Management
The international community should:
• respect country contexts and political realities in program design and the implementation process;
• coordinate and harmonise international fund-financing.

The Chinese government agencies should:
• develop long-term personnel mechanism to deal with the personnel issues;
improve organisational structure, having clearly identified job description, improving communication among the staff and the managers, working towards long term employment and career planning, establishing and improving the human resources department within the organisation to play a role to reduce unwanted turnover.

11.2.2. Findings from Each Chapter of the Thesis

Focusing on the research topic, this thesis is developed in three parts: first, a literature review, then the methodology and findings, and finally the discussion and conclusion. Chapter One provided the fundamentals of this research. It focused on the research background and rationale, nature, scope and aim, significance, and described the research methodology and provided the structure of this thesis.

Part I, the Literature Review, included Chapters Two to Six, and summarised the literature of the contextual fields of this research, global and Chinese international health cooperation, the partnership approach in public health, the China HIV/AIDS response, and important components in international development project management.

Chapter Two described why and how international cooperation plays a crucial role in health development, analysed the functions and limitations of the main players, and identified major issues such as overlapping mandates, donor-driven policy, proliferation of projects and lack of coordination, and predictability, stability and sustainability. This chapter also provided current responses to aid effectiveness, political and administrative commitments, long-term rather than short-term needs, and South-South Cooperation.

Chapter Three analysed international health cooperation in China. This chapter pointed out that China was now facing the challenges of decreasing international resources, weak communication and collaboration among sectors, and China’s unclear role as both a donor and a recipient country.
Chapter Four addressed the partnership approach, emphasising the importance of building an effective and successful partnership. The chapter highlighted the barriers and main challenges of the partnership approach. These barriers and challenges covered areas such as inclusion, clarity of roles and responsibilities, authority/power sharing, competition between organisations, conflict, communication, time, expense, and monitoring and evaluating the partnerships’ effectiveness.

Chapter Five linked international cooperation and the partnership approach and provided a description of the China HIV/AIDS response. This chapter reviewed Chinese policy development for the HIV/AIDS response, highlighted that HIV/AIDS response was a priority area in China, and that future actions are needed to address cooperation with international communities and multi-sector collaboration.

Chapter Six identified characteristics of international development projects. These characteristics are intangible, with deliverables less visible and measurable, and involve a complex web of many stakeholders in unique environments. The chapter concluded that the development of a completely new framework that emphasised full participation of locals and complete local ownership, and an understanding of cultural difference was required to manage international development projects.

Part II, Research Methodology and Results and Key Findings has three chapters. Chapter Seven, based on the literature reviewed in Part I, explained the research design, presented the research question, the conceptual framework and the methodological approach (including the combination of qualitative and quantitative methods applied in this research), and provided the details of the fieldwork processes, the data collection, and the analysis.

Chapter Eight described the features of the Global Fund program and how these apply in the China Global Fund AIDS Program, the case study of this research. These specific features of the China Global Fund AIDS Program are closely linked to the results and discussion in the later chapters.
Chapter Nine listed the results from the observation, document review, in-depth and focus group interviews, and a questionnaire survey from the case study. These results centred on the research question, aim and objectives, providing evidence to the later discussion. It then highlighted and analysed the main findings relating to program consolidation, CSO/CBOs’ involvement, communication, and financial performance and personnel.

Part III, Discussion, Recommendations and Conclusion, includes Chapter Ten and Eleven. Chapter Ten developed a discussion based on the key results and main findings identified in Chapter Nine. The discussion covered future international health cooperation in China, CSOs/CBOs involvement in HIV/AIDS response, partnership in Chinese international health cooperation, integration of the HIV/AIDS program, and international project management issues. Recommendations were provided for each area discussed.

Chapter Eleven, this chapter, concludes the whole thesis and indicates the significance and limitations of the research. It suggests a cross-national study is needed for future research.

11.2.3. Significance of the Research

This research can serve as a model to support health leaders and project managers in other countries in understanding the challenges and facilitation factors involved in international health cooperation. The investigation regarding partnerships not only confirms key findings in literature, but also provides an illustrative example from China. It thus enhances understanding regarding partnership facilitation for international cooperation in China. Its findings and recommendations are useful and should be used by decision makers, and other officials and scholars from government, academia, and NGOs, or the private sector to further improve the effectiveness of development cooperation.

The lessons learned from the case study presented in this research are useful in formulating strategies and programs that can facilitate successful health protection, promotion and service delivery for a changing Chinese health demographic with its
own multiplicity of risks and opportunities. China is the largest emerging country in the world with a massive and complex health system. It presents challenges that can create barriers to successful international health project management. Integrating and adapting into the existing Chinese health infrastructure is imperative for collective success in global health efforts. To foster successful engagement critical for shared public health goals these efforts require sensitivity to the culture, an understanding of its formal hierarchies, and developing joint results based on governance and management structures. This study can help inform other international health cooperation projects between China and the international community as well as provide lessons for supporting international health cooperation in other middle income countries.

The research findings can help other countries in HIV/AIDS response. After a slow start and a reluctance to recognise the existence of risk activities in its population and of the rise of the HIV/AIDS epidemic China has responded to international influences, media coverage, and scientific evidence to take bold steps to control the epidemic using scientifically validated strategies. The country now faces the challenge of scaling up HIV/AIDS prevention and control programs and of convincing all levels of government to implement these innovative strategies and policies. This dynamic response by incorporating the research findings of this research into policy formulation can be informative to other countries that face similar challenges in responding to the HIV/AIDS epidemic.

The knowledge gained from this case study about the health sector can also be used to inform and promote broader public sector. International cooperation in the health sector is significant, complex and subject to rapid change and has more global initiatives and donors than most other sectors. Important lessons from this study and the health system more generally can also inform global efforts to tackle issues such as climate change and food security. Both these areas would benefit from following a similar path to the HIV/AIDS Program, including strong political commitment, significant needs analysis, and the launch of new initiatives and funding channels, and similar aid architecture challenges.
11.3. Limitations of the Research and Future Research Implications

11.3.1. Limitations of the Research

There are a number of limitations of the research. Firstly this research used a single case study. Much of the data focused on the Global Fund Program which was the core of this research. Caution is needed when generalising about the applicability of this research on other international health programs.

Secondly the fieldwork of the research was conducted in a limited period. Participant observation for the research was for a short period (around nine months), and only conducted in the program implementation period. The observation focused on the program implementation rather than the program preparation and evaluation. Additionally as the Global Fund Program was terminated early the program implementation progress was accompanied by many changes. These changes may impact on the case’s representation of the international health cooperative program.

Also this research did not use a specifically formulated questionnaire survey from the researcher. In the original research design there was a proposed questionnaire survey to collect quantitative data from national and sub-national project officers. During the process of the fieldwork an official questionnaire survey (self-check of China Global Fund Program) was conducted by a Chinese government agency which had many of the same content items as the researcher’s proposed questionnaire. In order to avoid repetition the researcher canceled her proposed questionnaire survey and used the data from the government survey. The data collected from the official survey may be less specific and lack validity and may not truly reflect the project officer’s position.

11.3.2. Future Research Implications

Further studies on the current topic are recommended because there are still several knowledge gaps remaining as rapid changes and unknown future developments in international health cooperation in China occur. Follow-up research should focus on future development of China’s international health cooperation which would be especially valuable in helping policy makers to better understand the roles and responsibilities of China in global health governance. Further studies can go hand in
hand with learning by doing as strategic options that exist in international health cooperation domain need testing.

Finally researchers in China also need to build their capacity to communicate the lessons from their experience to counterparts in other countries. What is needed is a cross-national study involving other emerging countries (for example BRIC countries) and developing countries such as Vietnam. This cross-national study will contribute to international debates on effective strategies for development and poverty reduction.
References


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WHO. (1999). Health21 - the health for all policy framework for the WHO European Region *European Health for All Series* Denmark: Regional Office for Europe Copenhagen.


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Appendices

Appendix A: Informed Consent Form for In-Depth Interview and Focus Group

Information Sheet

Project Title
The Challenges and Facilitating Factors for International Cooperation on HIV/AIDS Prevention and Control in China

Investigators
Chief Investigator:
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Contact Email: c.chu@griffith.edu.au

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PhD candidate
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Contact Email: yan.wang@griffith.edu.au

Background
International cooperation plays a crucial role on health. It is varied, complex, and changing. Partnership is an important approach in public health. In recent years the Chinese Central Government has increased financial input and received large international funds to HIV/AIDS projects. At same time, more and more different kinds of agencies are actively involved in the national response to HIV/AIDS.
Therefore project management becomes more important to deal with these complicated projects.

**Purpose**

This study aims to identify challenges and facilitating factors for international cooperation on HIV/AIDS in China, provide information and evidence to planners and providers of HIV/AIDS prevention and control in order to achieve sustainable outcomes.

**Inclusion criteria**

You are eligible for inclusion in the research because you are involved in China international health projects.

**Procedures**

You will be asked some questions about your experiences participating in the China international health projects, difficulties in implementing the project, and your expectations and suggestions regarding international health programs. The session will last 45 minutes to one hour and will be tape recorded. I will transcribe the tape recordings, removing any identifying information such as individual names and keep the tapes secure.

**Expected benefits of the research**

There is no direct benefit to you. However, some people find it beneficial to discuss work affairs because they face some issues on a day-to-day basis and often do not discuss these issues with others at work. Also, we hope the results of the research may be helpful in developing policies and strategic plan of international cooperation in HIV/AIDS prevention, care, support and treatment in China.

**Risks**

There is no risk involved in this research except loss of your valuable time.
Voluntary Participation

You are free to choose to participate in the research. You may refuse to participate without any loss of benefit which you are otherwise entitled to. You may also refuse to answer some or all the questions if you do not feel comfortable with those questions.

Confidentiality

The information provided by you will remain confidential. Nobody except the principal investigator will have an access to it. Your name and identity will also not be disclosed at any time. However the data may be seen by the Ethical Review Committee of Griffith University and the data may be published in journals and elsewhere without giving your name or disclosing your identity. All records will be stored in a locked filing cabinet with restricted access for a minimum of five years in a private office. All computer records will be password protected.

Feedback

The investigator will send you the summary of interview by email after data analysis.

Contacting the investigators

I am happy to answer any questions you may have at this time. If you have any further questions you may contact the investigators. The contact information of the investigators is provided at the top of the sheet.

Complaints Mechanism

Griffith University conducts research in accordance with the National statement on Ethical Conduct in Human Research (2007). If you have any concerns or complaints about the ethical conduct of the research project you should contact the Manager, Research Ethics on 0061 7 3735 5585 or research-ethics@griffith.edu.au).
Privacy statement

The conduct of this research involves the collection, access and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet Australian government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However your anonymity will at all times be safeguarded. For further information consult the University’s Privacy Plan at www.gu.ed.au/ua/aa/vc/pp or telephone 0061 7 3735 5585.
INFORMED CONSENT FORM

- I have read and understand this consent form, and I have been given the opportunity to ask questions about the study.
- I understand that taking part in the study will include being interviewed and audio recorded.
- I volunteer to participate in this research. I understand that I will receive a copy of this form.
- I understand that my personal details such as name and employer address will not be revealed to people outside the study.
- I understand that my words may be quoted in publications, reports, web pages and other research outputs but my name will not be used.
- I voluntarily choose to participate, but I understand that I am free to withdraw at any time without comment or penalty.
- I further understand that if I have any additional questions I can contact the investigators, and if I have any concerns about the ethical conduct of the project, I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 5585 (or research-ethics@griffith.edu.au).

___________________        ____________________           ______________
(Participant)                 (Participant’s signature)            (Date)

___________________        ____________________           ______________
(Investigator)                (Investigator’s signature)           (Date)
Appendix B: Indicative Questions for In-Depth Interview and Focus Group
(English and Chinese)

Semi-structured in-depth interviews and focus group are developed base on these questions:

General questions
✓ Roles and main responsibilities
✓ How long have you work in the area

Part 1 Questions regarding international health cooperation
✓ Current situation of international health cooperation in China
✓ Current situation of international organisations involvement in HIV/AIDS programs
✓ Roles and responsibilities of the different international organisations and the current cooperation among them in fighting AIDS in China
✓ The communication and collaboration mechanisms between different organisations (international—international organisation, international—China organisation)

Part 2 Questions regarding China HIV epidemic and response
✓ How would you describe the current HIV epidemic in China?
✓ In your opinion, what are achievements of China response to HIV/AIDS?
✓ What are some of facilitating factors and the key challenges in responding to the issues of HIV/AIDS?
✓ Describe the current situation of international AIDS programs
✓ What are the facilitating factors and challenges of international HIV/AIDS programs?
Part 3 Questions regarding partnership collaboration

- How would you describe the current situation of multiple organisations involvement in HIV/AIDS programs (both domestic and international organisation)?
- How would you describe the roles and responsibilities of the different organisations and the current cooperation among them in fighting HIV/AIDS in China?
- The communication and collaboration mechanisms between different organisations
- What are the key factors for making different organisation work together efficient and effectively?
- Suggestions and recommendations

Part 4 Questions regarding project implementation

- What is your role in the implementation of international HIV project?
- What are the mechanisms of the project planning, monitoring and evaluation?
- What are the communication and collaboration mechanisms?
- What are the particular challenges you face in your work?
- Do you have any suggestions to improve project implementation?
访谈的问题

访谈，小组访谈及问卷调查的问题将以下的问题为基础。

基本问题

- 您的职位及主要工作职责
- 您在此领域工作的时间

第一部分：中国卫生国际合作

- 目前卫生国际合作的状况
- 当前国际组织在艾滋病领域的参与情况
- 国际组织在艾滋病防控领域中的作用及他们之间的合作沟通情况
- 不同机构间的沟通和合作机制（国际组织间，国际组织与中国机构之间）

第二部分：中国艾滋病流行与应对

- 您认为当前在中国艾滋病的流行情况是什么？
- 您认为中国在应对艾滋病方面取得了哪些成绩？
- 您认为当前中国在应对艾滋病的促进因素及面临的主要挑战是什么？
- 目前艾滋病国际合作项目的情况
- 当前国际合作在艾滋病防控领域的有利因素及困难是什么？

第三部分：中国艾滋病应对的多部门合作

- 您能描述一下中国艾滋病多部门合作的现状吗？（包括国内机构之间及国内机构与国际机构之间）
- 您能描述一下不同的部门在中国艾滋病防治中的作用？
- 各个不同部门的作用和职责是什么，他们是如何进行合作的？
- 各部门间的沟通和合作机制？
- 如何促进多部门合作的有效性？
- 建议

第四部分：项目管理

- 在艾滋病国际合作项目中您的主要职责是什么？
- 项目规划，监督及评估的机制是什么？
- 项目实施中的交流和合作机制是什么？
- 您在工作中面临的重要困难是什么？
- 您对如何提高项目管理有什么建议吗？
### Appendix C: Details of Problems from the Self-Check and Responses of Implementing Units (Implementing Unit Reporting) - English and Chinese

#### Details of problems from the self-check and responses of implementing units (Implementing Unit Reporting)

Implementing Unit:

Disease:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Code</th>
<th>Description of Main Problems</th>
<th>Problems Found</th>
<th>Amount (Yuan)</th>
<th>Correction and rectification (including the measures)</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Budget Management</td>
<td>1.1</td>
<td>Inconsistencies between the budget that SR actually followed and the budget submitted to PR</td>
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<td></td>
<td>1.2</td>
<td>Inconsistencies between the budget that SSR actually followed and the budget submitted to SR</td>
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<td></td>
<td>1.3</td>
<td>Program expenditures did not strictly follow the program budget</td>
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<td></td>
<td>1.4</td>
<td>Did not follow the program procedure to submit notifications regarding changes of the budget</td>
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<tr>
<td>2.Bank Account</td>
<td>2.1</td>
<td>Did not open a separate GF program bank account</td>
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<td></td>
<td>2.2</td>
<td>Global Fund funds are co-mingled with other funds</td>
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<td></td>
<td>2.3</td>
<td>Transfer program funds into personal account</td>
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<td>3.Internal Control</td>
<td>3.1</td>
<td>Did not establish financial reimbursement authorisation system</td>
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<td></td>
<td>3.2</td>
<td>Did not establish asset management system</td>
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<td></td>
<td>3.3</td>
<td>Did not establish TORs for program positions</td>
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<td></td>
<td>3.4</td>
<td>Program staff did not sign employment contracts</td>
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<td></td>
<td>3.5</td>
<td>The contract did not specify job TOR responsibilities and payments</td>
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<td>3.6</td>
<td>Did not allocate additional staff for incompatible positions</td>
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<td>3.7</td>
<td>Did not follow the procedure to handover for the sake of changes of staff</td>
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<td></td>
<td>Financial staff did not have accountant certificates</td>
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<td>3.8</td>
<td>Financial staff did not have accountant certificates</td>
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<td><strong>4. Disbursement of Fund</strong></td>
<td><strong>5. Funds Payments &amp; Accounting</strong></td>
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<td>4.1</td>
<td>Inconsistencies between disbursed funds and budget</td>
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<td>4.2</td>
<td>Did not transfer funds to SR within 10 working days</td>
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<td><strong>5.1</strong></td>
<td>Recording non-existent expenditures</td>
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<td><strong>5.2</strong></td>
<td>Reimburse with fake invoice</td>
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<td><strong>5.3</strong></td>
<td>Transfer funds to other bank account within the same organisation</td>
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<td><strong>5.4</strong></td>
<td>Funds were expended in non-program activities</td>
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<td><strong>5.5</strong></td>
<td>Allocation of salaries and allowance for a second time (inconsistencies between staff shown on salary charts and actual staff receiving payments)</td>
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<td><strong>5.6</strong></td>
<td>Inconsistencies between number of staff received salaries and number of budgeted positions</td>
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<td><strong>5.7</strong></td>
<td>Non-program staff received salaries</td>
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<td><strong>5.8</strong></td>
<td>Overtime payment was not attached with overtime record (including staff names, time and work content)</td>
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<td><strong>5.9</strong></td>
<td>Selection of hotels for meetings and trainings did not comply local government procurement regulations</td>
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<td><strong>5.10</strong></td>
<td>Lack of meeting/training notice when reimbursing meeting and training fees</td>
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<td><strong>5.11</strong></td>
<td>Meeting/training hotel invoices do not provide sufficient details and no detailed statement (meeting/training date, topic, number of participants) is provided</td>
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<td><strong>5.12</strong></td>
<td>Discrepancy of meeting/training date and the date of invoice</td>
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<td><strong>5.13</strong></td>
<td>Some participants sign as proxies for others in attendance sheets</td>
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<td><strong>5.14</strong></td>
<td>Some staff who receive full time salary or part-time allowance from GF also receive expert fee</td>
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<td><strong>5.15</strong></td>
<td>Overtime payments were fixed monthly payments</td>
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<td><strong>5.16</strong></td>
<td>No detailed list is provided when purchasing office supplies</td>
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<td><strong>5.17</strong></td>
<td>Log-books (including: start time, return time, meter reading at start and at the time of finishing should be recorded and the purpose for which the vehicle was used) are not provided when reimburse petrol fee</td>
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<td><strong>5.18</strong></td>
<td>Discrepancy of the date of supervision between the date on taxi ticket</td>
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<td><strong>5.19</strong></td>
<td>No monitoring report or statement is provided when reimburse</td>
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<td>5.20</td>
<td>Problems identified during monitoring are not updated with follow up actions.</td>
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<td>5.21</td>
<td>Travel charge and supervision allowance are paid over budget</td>
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<td>5.22</td>
<td>Water, electricity and other office expenses not accompanied by reasonable basis for cost allocation</td>
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<td>5.23</td>
<td>No printing contract was signed even for the printing fee is over 10,000</td>
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<td>5.24</td>
<td>No detailed record maintained for distributing of publicity materials, gifts, etc.</td>
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<td>5.25</td>
<td>Payment of subsidies to doctors or patients are not in line with budget</td>
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<td>5.26</td>
<td>Hospitals do not maintain separate records for tests done on patients treated under the Global Fund grants</td>
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<td>5.27</td>
<td>Mismatching of the number of patient detected and the amount of allowance paid to staff</td>
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<td>5.28</td>
<td>The living support payments is often insufficient in relation to details of patients’ ID number, case number and other supporting documentation</td>
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<td>5.29</td>
<td>No activity object is filled on the reimbursement sheet</td>
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<td>5.30</td>
<td>Fail to adjust accounts accordingly</td>
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<td>5.31</td>
<td>Fail to set up accounting codes accordingly</td>
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<td>5.32</td>
<td>Incorrectly recorded financial reports</td>
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<td><strong>6. Indicator Data</strong></td>
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<td>6.1</td>
<td>Discrepancy of submitted indicator data between the budgeted objective</td>
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<td>6.2</td>
<td>Discrepancy of submitted indicator data and recorded indicator data</td>
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<td>6.3</td>
<td>Discrepancy of recorded indicator data and actual indicator data</td>
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<td><strong>7. Assets Management</strong></td>
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<td>7.1</td>
<td>The procurement procedure does not meet the standard procurement guideline.</td>
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<td>7.2</td>
<td>The procurement budget is modified without approval.</td>
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<td>7.3</td>
<td>Fixed asset registers are not being maintained and updated regularly.</td>
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<td>7.4</td>
<td>The financial account does not match with the fixed asset account.</td>
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<td>7.5</td>
<td>Program vehicles are not insured.</td>
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<td>7.6</td>
<td>Program assets are not tagged and labelled for identification.</td>
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<td>7.7</td>
<td>Program assets are used for non-program related activities.</td>
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<td>Section</td>
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<td>7.8</td>
<td>Fixed asset loss exists.</td>
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<td>Unserviceable assets are not processed according to the guidelines.</td>
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<td>7.10</td>
<td>Lack of effective asset monitoring and supervision.</td>
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<td>7.11</td>
<td>Self-purchased fixed assets are not recorded.</td>
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<td>7.12</td>
<td>Cash in treasury exceeds the prescriptive amount.</td>
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<td>7.13</td>
<td>Large amount of cash payment exists.</td>
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<td>7.14</td>
<td>Bank account interest income is not recorded.</td>
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<td>7.15</td>
<td>No fixed assets reconciliation has been made regularly.</td>
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<td>8.Counterpart</td>
<td>No evidence of actual counterpart funding expenditure has been made</td>
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<td>Funding</td>
<td>available for verification.</td>
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<td>9.CSO/CBO</td>
<td>CSOs/CBOs are not selected by bidding.</td>
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<td></td>
<td>Some CSOs/CBOs staff are actually CDC staff.</td>
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<td></td>
<td>CSO/CBOs pay expert fee to CDC staff.</td>
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<td></td>
<td>The entrusted outlay is fully disbursed to CSO/CBO at one time.</td>
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<td>10.Financial</td>
<td>The financial reports submitted are not consistent with the account.</td>
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<td>Reports</td>
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<td>11.Annual Audit</td>
<td>No annual audit.</td>
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<td></td>
<td>Findings in external audit are not addressed.</td>
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<td></td>
<td>Internal audit findings are not addressed.</td>
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<td></td>
<td>Auditors were not selected using a fair and transparent process.</td>
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<td></td>
<td>The Audit Reports did not comply with the audit TOR.</td>
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<td></td>
<td>Audit reports are of uniformly poor quality. They did not identify</td>
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<td></td>
<td>the inconsistencies reported in other sections of this report.</td>
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<td>12.Other Finds</td>
<td>Self-examination findings in accordance with the financial management</td>
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<td></td>
<td>manual, procurement and fixed assets management manual and other</td>
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<td>Self-examination findings in accordance with the financial management</td>
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<td>manual, procurement and fixed assets management manual and other</td>
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<td>Self-examination findings in accordance with the financial management</td>
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<td>manual, procurement and fixed assets management manual and other</td>
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<td>12.4</td>
<td>Self-examination findings in accordance with the financial management manual, procurement and fixed assets management manual and other guidelines.</td>
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<td>12.7</td>
<td>Findings that were not listed in the NPO's notice.</td>
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<td>自查内容</td>
<td>编号</td>
<td>主要问题列举描述</td>
<td>对照检查发现的问题</td>
<td>金额（元）</td>
<td>纠正及整改情况（含采取的措施）</td>
<td>备注</td>
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<tr>
<td>1. 预算管理</td>
<td>1.1</td>
<td>省级项目办实际执行的预算与上报给 PR 的预算不一致</td>
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<td>1.3</td>
<td>项目支出未严格按照项目预算执行</td>
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<td>预算变更未按规定程序报批</td>
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<td>2. 银行账户</td>
<td>2.1</td>
<td>未单独开设全球基金项目银行账户</td>
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<td>将其他项目经费放在全球基金银行账户核算</td>
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<td>将项目资金转入个人账户使用</td>
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<td>3. 内控制度</td>
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<td>未建立财务报销审批制度</td>
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<td>未建立项目人员岗位职责</td>
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<td>财务人员无会计上岗证</td>
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<td>4. 拨付资金</td>
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<td>5. 资金支付</td>
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<td>用假发票报销</td>
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<td>5.3</td>
<td>将资金转入单位其他账户使用</td>
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<td>将项目经费用于非项目活动支出</td>
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<td>5.5</td>
<td>二次分配工资及补助（发放表列示的人员与实际领取的人员不一致）</td>
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<td>5.6</td>
<td>领取工资的人数与预算人数不符</td>
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<td>非项目人员领取项目工资</td>
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<td>支付加班费未附加班记录（人员、时间、加班内容）</td>
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<td>5.9</td>
<td>会议、培训的宾馆选择不符合当地政府采购规定</td>
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<td>会议、培训费报销未附培训、会议通知</td>
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<td>5.11</td>
<td>会议、培训费报销发票内容不详，且未附酒店出具的财务盖章的结算明细单（标明时间、内容、人数等）</td>
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<td>会议、培训签到人员不真实</td>
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<td>领取固定工资或补助的人员又领取专家费等</td>
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<td>加班费以每月固定数额发放</td>
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<td>购置办公用品未附明细清单</td>
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<td>报销汽油费未附行程记录表（时间、事项、公里数）</td>
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<td>报销督导费未附督导报告或督导情况说明</td>
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<td>5.20</td>
<td>督导发现的问题没有进行整改追踪</td>
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<td>5.21</td>
<td>超标准报销差旅费或督导补助</td>
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<td>金额在1万元以上的印刷，未签定印刷合同</td>
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<td>宣传材料、礼品等的发放无明细记录</td>
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Appendix D: Phase Three—Follow-up Study Semi-Structure In-Depth Interview Questions

✓ Current implementation of Global Fund program
✓ Main tasks in the Global Fund Program final stage, when the program complete
✓ Impacts of Global Fund Program termination
✓ National response for HIV/AIDS after Global Fund Program termination
✓ Challenges of HIV/AIDS response in China in the future
✓ Challenges of international cooperation in China in the future
✓ The situation and challenges for CSO/CBO in the future, government attitude and coping strategies
✓ Recommendations for future HIV/AIDS response and international health cooperation
Appendix E: Letter of Approval ENV 11 10 HREC

Griffith University Human Research Ethics Application – ENV/11/10/HREC

This is to confirm that Human Research Ethics Application ENV/11/10/HREC titled ‘The Challenges and Facilitating Factors for International Cooperation on HIV/AIDS Prevention and Control in China’ conducted by Cordia Chu and Yan Wang was approved by the Griffith University Human Research Ethics Committee (HREC) on 12 July 2010. The authorisation for this research was issued from 27 September 2010 to 30 June 2011.

The HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research (2007).

Please do not hesitate to contact me if you have any further queries about this matter.

Regards

Gary Allen
Senior Manager, Research Ethics and Integrity
Office for Research
Appendix F: Global Fund Management of “Lift the Freeze”

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Our Ref: MEF/PA6/18.08.2011

19 August 2011

Dr. Wang Yu
Director General
Chinese Center for Disease Control and Prevention
27 Nan Wei Road
Beijing 100056
People’s Republic of China

Dear Dr. Wang Yu,

Thank you for hosting our mission this week in Beijing. This letter is to follow up on our productive discussions in how to take forward the Global Fund investments in China.

As you are aware, on 13 May 2011 the Global Fund temporarily froze disbursements to China following the findings from the Financial Management Verification (FMV). We recognize that China has made considerable efforts to address the issues identified in the FMV report, and while not all issues have been completely addressed, we believe there has been sufficient progress to lift the freeze on expenditure and disbursements as of August 31.

Our Country Team will be in communication with your staff at the PRs to continue working with them on fully addressing the issues in the FMV report and other issues needed to reduce risk and improve how Global Fund investments contribute to helping China in its fight against the three diseases.

As discussed, I and/or the Country Team remain ready to travel back to China at the end of August or later to continue our progress on these issues together.

With best personal regards.

Yours sincerely,

Mark Eldon-Edington
Director
Country Programs Cluster

cc: Dr. Ren Minghui, Chairperson of CCM, Director General, Dept of International Cooperation
Appendix G: Global Fund Management of “Approval of No-Cost Extension”

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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F +41 58 791 1661
Chemin de Blandonnat 87
1216 Verrières, Geneva
Switzerland

Our ref: CCM/12/06

24 October 2012

Dr Ren Minghui
Chair, China Country Coordinating Mechanism
Director-General
Department of International Cooperation
Ministry of Health
2-8-2, Teyuan Diplomatic Office Building
14 Liangmahe Naniu, Chaoyang District
Beijing, 100600
People’s Republic of China

Dear Dr Ren Minghui

I am pleased to inform you that the Global Fund has approved the No-Cost Extension (NCE) submitted by the Country Coordinating Mechanism (CCM) of China on 12 October 2012 to extend the duration of the HIV program until 31 December 2013.

I understand a team from the Chinese Center for Disease Control and Prevention (CDC) will visit Geneva next week to negotiate the details of the NCE with the Secretariat and ideally sign the extension prior to my visit to China and November 2012.

This timely agreement would send a very strong positive signal to civil society organisations and will sustain a key source of predictable funding throughout 2013 to reach Most-at-Risk Populations. We have also recently agreed with CDC to reprogram a significant share of funds to support the transition of a large number of patients to Tenofovir which is, for the Secretariat, a clear sign of increased impact in the fight against HIV in China.

Year 2013, as you rightfully pointed out, will continue to be a year of transition during which we will work closely with CDC to ensure that no programmatic and financial gaps are created. In that respect, I was particularly reassured that fruitful discussions along these lines have taken place in China between the Principal Recipient and the Secretariat.
Appendix H: Meeting Minutes for the 36th China CCM Plenary

Meeting minutes for the 36th China CCM Plenary

China CCM held the 36th Plenary in Beijing Debao Hotel on May 20th, 2011. The meeting was chaired by Dr. Michael O’Leary, China CCM Vice Chair and WHO representative to China. Attending the Plenary were 19 China CCM members, meeting the quorum for the event. Also present was a Global Fund (GF) mission headed by Deputy Executive Director Dr. Debwerk Zewdie as well as LFA representative and UNOPS team leader Ms. Sabrina Ambrosino. (See attached attendance list).

Dr. O’Leary welcomed Dr. Zewdie and her China mission, followed by self-introduction by mission team members. Next Dr. O’Leary briefed the meeting on new members joining CCM working groups since the 35th CCM Plenary (PATH joining AIDS working group and IFRC joining TB working group). Then Dr. O’Leary introduced the meeting agenda and, confirming there was no conflict of interests among the members given the items on the agenda, declared the meeting to proceed.

1. **Report of Principal Recipient (PR)**

1. PR Executive Director Dr. Han Mengjie gave a presentation on overall GF programs progress including current status, bottlenecks and challenges, and PR action plan.

2. Dr. Han Mengjie believed problems identified in GF financial management verifications (FMV) were similar or the same with those found in PR internal audit. PR already took corrective measures and would take further actions to address those problems. PRC Ministry of Health (MoH) also took importance of the issue and a meeting of senior leadership of nationwide health system would study the GF programs issue. PR would continue to work towards resolution of current problems.

3. Plenary decisions:
   a) CCM takes note of the PR work report.
II. Global Fund briefing

1. Dr. Zewdie gave a brief on global fund stance on related issues. She thanked China CCM, and especially UNAIDS, WHO, and civil society representation, for their efforts in helping GF programs in China.

2. Dr. Zewdie said the GF China team Fund Portfolio Manager (FPM) Dr. Enkhjin Bavuu was rotating to another country. Thanking Dr. Bavuu for his contributions in the past two years and a half, Dr. Zewdie introduced to China CCM Dr. Olivier Cavey, new FPM on GF China team.

3. Dr. Zewdie then responded to Dr. Han Mengjie’s report. National programs consolidation is a cornerstone of GF work. China should be congratulated as one of the first countries to consolidate programs and should not be discouraged at current difficulties. Lack of clarity results in long time of disbursement. GF must protect fund safety. GF donors are not necessarily rich. We must not allow misuse of funds. Lack of clarity in proving adherence to grant agreements can only result in long process of disbursement.

4. Dr. Zewdie stressed the need to enhance civil society capacity. It is time to stop using low capacity of civil society organizations as an excuse; rather we need to see it as a challenge. In terms of financial management, we need an empowered Sub-Recipient (SR) to deal with civil society funding, and the final objective is to establish a dual-track funding mechanism.

5. Dr. Zewdie stressed that GF was not imposing on China. Rather, through consultation with the Health Minister and PR, GF had good results and reached agreements on key issues. In terms of civil society, PR would select through transparent process a major non-government organization as SR to deal with civil society funding. Such SR should build up its capacity and is expected to be an independent PR by June, 2012. In terms of financial management, the 24 counties with problems exposed should take corrective measures, and other counties should take necessary measures to prevent such problems.
China Country Coordinating Mechanism for Global Fund Programs

On behalf of China CCM, Dr. O’Leary thanked Dr. Zewdie for her important briefing.

Plenary decisions:
   a) CCM takes note of the GF briefing.

III. Q&A with Global Fund

1. Dr. O’Leary announced the start of the Q&A session with GF mission. He raised the first question: to avoid back and forth, what are the specific requirements to resolve current difficulties? Dr. Zewdie responded that GF mission had close discussions with PR on the issues of civil society and financial management. GF would provide all necessary support for problems resolution.

2. Academic sector group representative Mr. Hou Yuangao of West Development Research Center, Minzu University put forward two questions: 1) Can PR share audit information with CCM members? 2) Would CCM consider setting up an expert panel for oversight and consultative services for the empowered SR dealing with civil society funding?

3. Dr. Han Mengjie informed that PR had reported its internal audit results to the ad-hoc Oversight Committee meeting before the CCM Plenary and promised to regularly brief the CCM Oversight Committee on auditing results. He also added that PR agreed to set up a SR for civil society funding. Such arrangement was already in planning and budget. PR agreed in principle that the SR would become a new PR through capacity building and assessment. Such process would require time and PR cannot promise a deadline.

4. CBO/NGO sector group representative Mr. Meng Lin thanked GF, China CCM, and PR for their joint efforts. He agreed with Mr. Hou Yuangao on the idea of setting up an expert panel. Meng Lin said CBOs would continue to be committed to GF programs and would particularly like to strengthen their role in programs oversight so as to better voice community concerns. He said CBOs had the confidence and capacity to address current challenges.

5. UNAIDS Coordinator and Chair of AIDS Working Group Dr. Mark Stirling said
today’s meeting indicated a positive way forward. RCC funding was suspended in the fourth quarter last year, which affected RCC program implementation, particularly civil society participation. Also, the relationship between China and GF was damaged. He hoped GF and PR could agree specific milestones or deadlines to resolve current challenges and get funds moving again. He reminded the CCM that GF set the date of May 15th to conclude the new RCC grant agreement, was concerned that this deadline has not been met, and suggested that a new deadline needs to be agreed to guide PR and partner’s work.

6. Dr. Zewdie responded that it was not GF intention to halt disbursement. However, GF cannot make grants when conditions were not met. Recent news exposed misuse of funds in several countries, and such news made GF vulnerable. GF must protect safety of funds and cannot give specific dates. Stopping disbursement shall not affect procurement of life-saving drugs.

7. TB Working Group Chair Dr. Fabio Scano hoped to expedite the process of clarification on CPs/STCs and to ensure the supply of drugs, especially TB-MDR drugs.

8. MoH Disease Control Department Director and Chair of Malaria Working Group Ms. Wang Liying expressed her appreciation for GF helping China to improve programs. She said PR was making great efforts. Malaria Working Group would provide all necessary support. The Chinese side would fulfill all of GF’s reasonable requirements. She pointed out that it was the malaria epidemic season between May and October, and suspending programs at this time would affect whole year’s work. She hoped to see normal operation of programs as soon as possible.

9. Ms. Pai Yalin from DFID said that so far the Global Fund Program is China’s largest international program in terms of finance. From her experience of DFID supported HIV/AIDS program harmonized with Global Fund Round 4 over the past 4 years, she witnessed commitment and dedication of PR and AIDS RCC Office at central, provincial and county level. She understood the complexity of national consolidated
programs and the time needed for rectification after FMV. Regarding the audit in August, she asked if the August audit will give a recommendation/conclusion on whether China's Global Fund program could be continued or have to be terminated.

10. Dr. Zewdie responded that Global Fund was aware of the large amount of work done by China PR. The OIG mission to China in August would be independent of the GF Secretariat. The OIG’s major responsibility was to check if resources were used according to grant agreements. An example could be whether 25% of funding allocated to CBOs was met. Non-fulfillment could result in OIG recommendation to the GF Secretariat to suspend funding. The recent FMV was to help PR identify problems, rectify immediately, and smoothly go through OIG audit in August.

11. Dr. O’Leary voiced his concern about the challenge of OIG audit in August and the potential for negative impacts beyond those areas where problems might be found. Dr. Zewdie suggested China check out information on GF website concerning OIG missions in other countries. She reaffirmed that OIG mission was to help implementers do the right things.

12. USAID representative Ms. Virginia Bourassa inquired whether OIG had a threshold of passing or failure. She suggested OIG mission include Chinese speaking staff. Dr. Zewdie responded that OIG mission would include native speaking staff when going to a non-English speaking country. As for threshold of passing or failure, Global Fund had zero tolerance for fraud and required adherence to grant agreements.

13. GF Officer Mr. Elmar Vinh-Thomas added that past experience showed the worst case scenario resulting from a failed OIG mission was OIG reporting the non-suitability of PR to continue its work and requesting CCM to name a new PR. He stressed that GF had no intention of terminating programs but would like to make sure adherence to agreements.

14. Dr. O’Leary inquired how the FMV letter dated 13th May may be shared and Dr. Zewdie replied that it was up to PR to decide. Dr. Zewdie added that the FMV letter
was copied to OIG and OIG would expect problems exposed would be corrected by August. She said it was helpful that LFA financial verification exposed problems before OIG mission, and hoped China could see the urgency and resolve problems by August.

15. Dr. O’Leary concluded the Q&A session by reaffirming CCM commitment to actions in helping programs back on track given current difficulties. He thanked Dr. Zewdie and her mission for coming to China at this crucial time. After the Q&A session, GF team, PR, RCC, and some of the Working Group members left the Plenary for detailed panel discussion. The Plenary then continued with remaining agenda items.

16. Plenary decisions:
   a) CCM acknowledges the difficulties faced by China GF programs and remains committed to helping programs back on track.

IV. CCM Retreat

1. CCM Secretariat Executive Secretary Mr. Li Dafei gave a report on Secretariat preparation work for the coming CCM Retreat. Based on decision made on the 35th CCM Plenary and through consultation with CCM members, the CCM Secretariat proposed the CCM Retreat take place on 15th June and the two topics include civil society participation and GF programs consolidation. The CCM Retreat would be open to CCM members and alternates.

2. Mr. Li Dafei explained that CCM planned to hold quarterly plenary meetings. Today’s 36th Plenary was convened for Dr. Zewdie’s China mission. The CCM Retreat would take place in June. Therefore by that time CCM would have held two large events in the second quarter. The CCM Secretariat would request CCM members to consider holding the next CCM Plenary in the third quarter.

3. PLWATM representative Mr. Li Hu suggested CCM Retreat facilitator consult with civil society representation before the Retreat to better prepare the topic on civil society participation. Mr. Li Dafei offered further background that civil society
discussion at the Retreat would be based on previous UNAIDS papers on CBO definition and capacity building study, while programs consolidation would be based on independent expert review paper on the same issue commissioned by UNAIDS. The CCM Retreat facilitator would combine previous research and adapt to serve the needs of the Retreat.

4. Mr. Hou Yuangao opined that though there were already many AIDS-related CBOs, a comprehensive view of Chinese civil society and future policy development may still be lacking. It would help if a leading expert could deliver a presentation on the overall picture of Chinese civil society. Dr. O’Leary suggested Mr. Hou contact CCM Secretariat after the CCM Plenary for detailed arrangement.

5. Mr. Etienne Poiriot of UNICEF raised the question who should select an empowered SR to deal with civil society funding, i.e., should CCM or PR select such SR? Mr. Hou Yuangao said CCM should select such SR. Mr. Poiriot wondered whether current rules allowed CCM to make the selection decision.

6. Dr. O’Leary said the capacity of the empowered SR should be reviewed by LFA. He suggested CCM Secretariat talk with PR and confirm the way how such SR should be selected. Also, Dr. O’Leary confirmed with CCM members that the next CCM Plenary should take place in the third quarter of 2011.

7. USAID representative Ms. Virginia Bourassa again raised the serious challenge given the OIG audit in August. Mr. Poiriot suggested the CCM Oversight Committee collect online information about OIG auditing cases in other countries.

8. Plenary decisions:
   a) CCM decides to hold CCM Retreat on 15th June, 2011.
   b) CCM decides to hold the next Plenary (37th CCM Plenary) in the third quarter of 2011.
   c) CCM requests the Oversight Committee to collect online information about OIG auditing cases in other countries and share such information with CCM members.

V. TB R11 application consideration
1. TB Working Group (TWG) Chair Dr. Fabio Scano gave a report on TWG recent consideration on R11 TB application based on a request by the stop TB partnership to China for the purpose to organize proper technical assistance. TWG made an e-voting through email on whether to apply for R11 TB programs for the purpose of the request from the stop TB partnership. Among 14 TWG members, 10 voted. Among the 10 members who voted, 9 voted no, and one voted yes. A more in depth discussion on the needs to apply to R11 will be conducted at the next TB Working Group meeting.

2. Dr. O’Leary requested CCM members to consider whether to apply R11 TB programs given current circumstances.

3. Mr. Hou Yuangao admitted to the unfavorable conditions at present but offered his personal view that China should apply for R11. He suggested CCM talk about the issue at the next Plenary.

4. Mr. Marc Bulterys opined that now the international community would not support China’s new applications.

5. Dr. O’Leary said the Plenary cannot make a decision at the moment as some members left for the small meeting with GF mission. Mr. Poiret suggested CCM members make a decision through e-voting.

6. Plenary decisions:
   a) CCM takes note of TWG consideration on R11 TB application based on the request form the stop TB partnership.
   b) CCM requests CCM Secretariat to organize an e-voting process to invite CCM members to vote on the application to R11 TB programs.

Now CCM concluded all items on the agenda. Dr. O’Leary declared the end of the 36th CCM Plenary.