Performance-Based Funding Management Framework for CBOs in China's Response to HIV

China-Gates Foundation HIV Prevention Cooperation Program

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BMGF	Bill & Melinda Gates Foundation
CASAPC	China Association for STD/AIDS Prevention and Control
CBO	Community–Based Organization
CD4	CD4 helper T–cell count
CDC	Chinese Center for Disease Control and Prevention
CPMA	China Preventive Medicine Association
FSW	Female Sex Worker
GONGO	Government–Organized Non–Governmental Organization
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIV+	HIV positive (infected with HIV)
IDU	Injecting Drug User
MARP	Most–at–Risk Population
MSM	Men who have Sex with Men
NCAIDS	National Center for AIDS/STD Control and Prevention
NHFPC	National Health and Family Planning Commission of China
NGO	Non–Governmental Organization
NPMO	National Program Management Office
PBFM	Performance–Based Funding Management
PLHA	People Living with HIV and AIDS
RMB	Renminbi or Chinese Yuan (USD 1 = RMB 6.24yuan as of 23 Feb 2013)

Executive Summary

The five year China-Gates HIV Prevention Cooperation Program (China-Gates HIV Program), started in 2007, aimed at scaling up prevention of HIV in key urban centers of China among population groups that were most-at-risk of HIV infection and those infected with HIV. The program was based on the premise that early detection leading to early treatment would decrease HIV transmission within the target population. The program emphasized collaboration between Center for Disease Control and Prevention (CDC), health care providers (hospitals and clinicians) and community-based organizations (CBOs) in the delivery of its program objectives. A unique feature of the program was that it leveraged China's two large national government-organized non-government organizations (GONGOs) - China Association for STD/AIDS Prevention and Control (CASAPC) and China Preventive Medicine Association (CPMA) – to manage and channel funds to CBOs. The program allocated two-fifths of its total budget of USD 50 million to supporting CBO involvement in HIV services. Most of the CBOs supported by the China-Gates HIV Program were serving the MSM and PLHA communities.

This paper focuses on MSM CBOs to illustrate a performance-based funding management (PBFM) framework the program used to manage its funds to support CBOs in its program. By 2012, the program had supported 141 CBOs serving the MSM community across its 15 program sites. The key components of the PBFM framework were organized along three mutually supporting steps of the program cycle: (1) CBO program planning; (2) CBO program implementation quality control; and (3) CBO fund flow.

In addition to providing a summary of how this framework was implemented within the China-Gates HIV Program, this paper also describes some of the challenges and lessons learned during the implementation of this framework. Based on a successful implementation by the China-Gates HIV Program, it is hoped this framework will be considered by government policy makers as a plausible CBO funding management model to increase CBO involvement in the national response to HIV.

1 Introduction

The China-Gates HIV Prevention Cooperation Program (China-Gates HIV Program), started in 2007, aimed to scale up prevention of HIV in key urban centers[01] of China with a two-pronged strategy:

- Prevention for groups most at risk - ensure the reach and effectiveness of interventions for injecting drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSM) – to reduce risky behavior and increase HIV testing.
- Prevention with positives - accelerate the provision of adequate counseling and support for people living with HIV and AIDS (PLHA) including intensified interventions to reduce HIV transmission.

The program was based on the premise that early detection leading to early treatment would decrease HIV transmission within the target population. The program emphasized collaboration between Center for Disease Control and Prevention (CDC), health care providers (hospitals and clinicians) and community-based organizations (CBOs) in the delivery of this two-pronged strategy. A unique feature of the program was that it leveraged China's two large national government-organized non-government organizations (GONGOs) - China Association for STD/AIDS Prevention and Control (CASAPC) and China Preventive Medicine Association (CPMA) – to manage and channel funds to CBOs. The program allocated two-fifths of its total budget of USD 50 million to supporting CBO involvement in HIV services. Most of the CBOs supported by the China-Gates HIV Program were serving the MSM and PLHA communities. This paper focuses on the framework the program used to manage funds to support MSM CBOs. By 2012, the program had supported 141 CBOs serving the MSM community across its 15 program sites.

[01] Fourteen cities - Beijing, Tianjin, Shanghai, Chongqing, Harbin, Shenyang, Qingdao, Xi'an, Nanjing, Wuhan, Hangzhou, Changsha, Kunming, Guangzhou - and the province of Hainan.

1.1 Background

Men who have Sex with Men in China's key urban centers have an HIV prevalence of about five percent with many unaware of their HIV status. While having sex without condoms was widespread, MSM were largely hidden from the public health system. This was related MSM mistrust of government services for fear of being exposed to family about their sexual orientation and HIV status.

Civil society was a relatively new phenomenon in China at the time when the China-Gates HIV Program was launched. To guide its work with CBOs, the China-Gates HIV Program conducted a baseline study of CBOs in 2007. The study found there were on average three to fourCBOs serving the MSM community in each of its program sites. The same study also found many of the CBO staff lacked skills, capacity and experience in working on HIV/AIDS.

1.2 Principles

The China-Gates HIV Program put strong emphasis on program cost-effectiveness via a performance-based funding management (PBFM) framework. This innovative funding and management approach was designed to foster accountability and genuine achievements by all program implementers – CBOs, hospitals, CONGOs and CDCs. Performance-based funding management is a standard practice in the private sector and is increasingly being adopted by international development donors, governments and NGOs. The China-Gates HIV Program adopted this approach to ensure a prudent use of resources and to maximize the public health value of its program. The core of the PBFM adopted by the China-Gates HIV Program was linking fund disbursements for an operating period to achievements of targets in the previous operating period to ensure program implementers improve their performance throughout the contract and to manage underperformance before contracts finished. The China-Gates HIV Program also set annual ceilings for the management fees for each program site's management office (Bureau of Health, Center for Disease Control and Prevention, GONGOs) and linked it to the program outputs under its responsibility. At community level, the funding allocated to participating CBOs was closely linked to specified program outputs measured by core program indicators. This paper focuses on how this framework was applied to the management of funds to CBOs.

1.3 Structure

The key components of the PBFM framework the China-Gates HIV Program adopted to manage funds to CBOs were organized along three mutually supporting steps of program cycle: (1) CBO program planning; (2) CBO program implementation quality control; and (3) CBO fund flow:

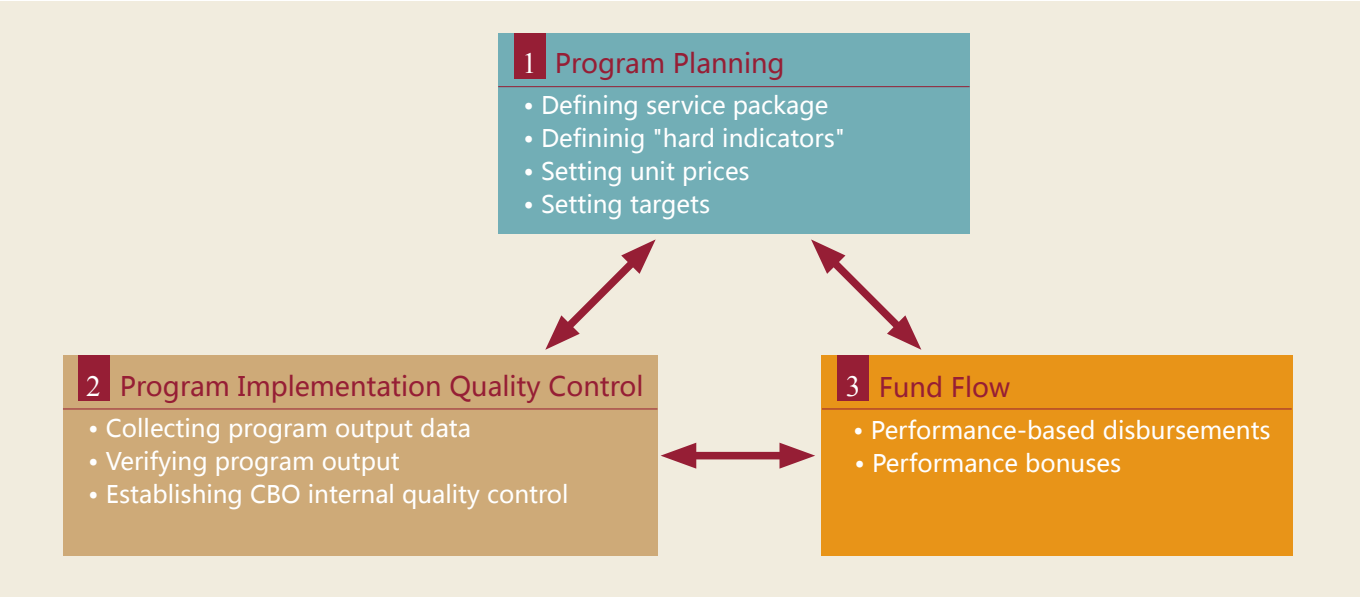

Figure 1 CBOs Performance-based Funding Management Framework Structure

2 The Framework Details

2.1 CBO Program Planning

2.1.1 Defining the service package

At the beginning of the China-Gates HIV Program, the program first determined a set of specific service packages to be delivered to meet the overall objectives of the program. Then clear, measurable program output indicators for each service package were defined. This initial step, done in consultation with stakeholders (CDCs, GONGOs, hospitals, CBOs), divided the overall outputs of program supported services into relatively independent service packages that could be easily measured. Agreed principles for defining each service package included:

- Each service package had to have a clear role in the overall HIV service chain and demonstrate potential contributions to the achievement of program objectives.
- Service packages selected must be relatively independent in their delivery to ensure clear accountability of output to be delivered by individual stakeholders (i.e., roles and responsibilities of each stakeholder – CDCs, hospitals, CBOs – for each component within the HIV service chain were clearly spelt out).
- Each service package must be clear and measurable.

Each service package definition was clearly linked to objectives that would contribute to the overall program goal of developing a large scale model of integrated HIV prevention. Prevention was defined as the reduction of new HIV infections. Service packages were also linked to each other, with outputs that flowed across the whole HIV service chain beginning with mobilization for testing and outreach to ongoing care and treatment of PLHA. More specifically, the China-Gates HIV Program, service packages included:

- Mobilization for HIV testing
- Identification of HIV+ cases HIV/AIDS
- Care and support
- Treatment

In defining each service package program stakeholders agreed on the detailed descriptions, explanations and requirements. For example, requirements for HIV/AIDS care and support by CBOs included five key types of activities: (1) education; (2) home-based care; (3) assistance in medical support; (4) social support; and (5) provision of CD4 test (see Figure 2).[02]

2.1.2 Defining "hard" indicators

After the service packages were defined, a series of measurable "hard" indicators were carefully developed. The combination of service quality, process and output requirements described for the service package could not be easily captured using a single indicator. Thus the program focused on devising a limited number of indicators for the "core components" of each service package that were most representative of the package.

"Hard" indictors were used as the output measure of achievement for each service package and also as important information for the program's service quality control mechanism. Like indicators used by other international cooperation programs, these "hard" indicators also focused on output. But "hard" indicators in the China-Gates HIV Program differed in that they consisted of information collected further down the HIV service chain beyond activities. Previous international cooperation programs usually used program implementers' self-reported activities output (e.g. condoms distributed, outreach sessions conducted, target individuals reached). But the China-Gates HIV Program used the number of HIV tests conducted, HIV positive cases found and CD4 tests done. Therefore, when program implementers self-reported on these indicators, program management offices in program site could verify these data against national infectious disease database and local CDC records. This solved the problem of double reporting and moved the HIV program forward along the HIV service chain from just activities (material distribution) to output (testing and case finding). Thus the notion of "hard" indicators of the China-Gates HIV Program stemmed from the program's focus on measuring output (instead of just activities) and having a strict verification mechanism in place.

Following development of service packages and corresponding "hard" indicators, unit prices

[02] CD4 test as a hard indicator was added after the midterm adjustment in 2010 to further improve quality assurance of the service package.

China–Gates HIV Program: Performance Based Funding
Examples of Service Packages, Unit Prices and Indicators for Program Implementers

Prior to Midterm Adjustment (2008–2010)

Service package	Unit price	Hard indicators
Mobilizing MSM/FSW/IDU & HIV screening , + Syphilis and HCV diagnostics	62 RMB: per MSM/FSW/IDU screened for HIV to CBOs	# MARP screened for HIV
	13 RMB: @ per HIV screening & syphilis and HCV tested for CDC	# IDU HCV test # MARP tested for HIVs # MARP for syphilis
	35 RMB: per positive blood samples sent for screening hospitals	# HIV + blood samples
Case confirmation	53 RMB: per HIV confirmatory test performed for CDCs	# of confirmatory test conducted
	300 RMB: per MSM &IDU confirmed HIV+ for CDC 1000 RMB: per FSW confirmed HIV+ for CDC 300 RMB: per MARP confirmed positive for CBOs; 300 RMB: per HIV positive found for STD clinic.	# of those who screened positive confirmed
Follow up and care	180 RMB: per PLHA joined epidemic survey for CDC	# of PLHA doing epidemic survey
	200 RMB: per PLHA followed (50 per time) for CBOs 300 RMB: per patient followed for CBOs 60 RMB: per person per time CD4 test for CBOs	# PLHA followed; # of AIDS patients followed
ART	800 RMB: per person treated for hospitals	# of person treated

Changes After Midterm Adjustment (2011–2012)

Service package	Unit price	Hard indicators
Mobilizing MSM and HIV screening and confirmation	62 RMB per MARP screened HIV (CBOs). 500 RMB per HIV+ case found for CBOs 100 RMB per HIV+ case found for hospitals 200 RMB per HIV+ case found (300 RMB for each case above previous years total) for CDCs.	# of MSM screened for HIV # of HIV positive confirmed
HIV Care and Support	300/500 RMB per PLHA case managed for CDC	# of PLHA tested 1 time CD4 per year
	300 RMB per patients cared for CBOs	# PLHA cases completed (1 time follow-up,+ 1 time CD4 test +1 time syphilis test)
ART	1000 RMB per person treated more than number treated previous year for hospitals	# of persons treated

Figure 2 Examples of service packages, unit prices and indicators

were developed that would be paid by the program for each service package implemented as measured by the achievement of the hard indicators. Through this process, the China-Gates HIV Program was able to assign and agree on service packages, and hard output indicators (see Figure 2).

2.1.3 Setting unit prices

In developing appropriate and acceptable unit prices for service packages as measured by agreed output indicators, program stakeholders took into account the responsibilities of each organization involved in the delivery of the service packages, and a appropriate costs for their services. The unit price for a specific service package delivered by one or more program implementers (CDC, hospitals, CBOs) was set in such a way as to foster collaboration and avoid competition between partners. The price points for services also took into account the overall program budget, organizational resources of the stakeholders and amounts that would be reasonably motivational to each organization. Calculation of unit prices for each service package also took into account the reasonable cost of delivering the whole service package, not just buying the specific service used as the output indicator. For example the amount paid to a CBO or CDC for each person who underwent a screening test for HIV was set to cover all the activities in the service package by the organization. For the CBO this included pre- and post-test counseling, transportation, labor costs, condom distribution, etc. The unit prices also factored in an incentive for positive performance. For example, the unit costs for CBOs were set at: RMB 62 (USD 10) for screening, and RMB 500 (US$80) as incentive for each HIV positive person confirmed (see Figure 2).

2.1.4 Setting targets

In several cases, city program management offices found that some CBOs set annual goals on mobilization for testing that overestimated their capacity. To manage this problem most of the city level program management offices set overall targets for the entire city and allocated a proportion of the city's overall target to each CBO. Good planning, a review of the CBO's previous year application and achievements, and some negotiation were required to assure a balance among resource allocation, appropriate motivation of CBOs, problems of incompletion of targeted achievements, and efforts to improve service quality. Target setting in different program sites varied depending on the number of local CBOs, previous achievements, CBO capacity and professionalization and program budget. For example, Harbin CDC used an evidence-based approach to set overall targets for individual CBOs.

CASE

Harbin's CDC

An expert team was responsible for calculating the CBO targets in Harbin city. Four factors with different weights were utilized in the calculation. The CBOs' previous HIV test rate was weighted at 45%, the CBOs previous syphilis positive rate for 15%, and the CBOs' previous target completion rate was assigned a 20% weight. The remaining 20% of the total score was assigned to a subjective indicator based on overall expert opinion. The score calculated for each CBO was compared with those of other participating CBOs and to annual targets, and then allocated proportionately. All CBOs could participate and the process was transparent.

These procedures helped guide CBOs toward making a good estimate of their capacity and developing realistic annual plans. In practice, the CBOs in Harbin were encouraged to achieve as much as possible without being constrained by the assigned target. If they achieved more than their target, their funding amount could be raised accordingly. However, if CBOs reported achievement exceeded the allocated target by more than 10%, data quality and service quality were reviewed. If a CBO did not achieve their allocated target, their following year's application was reviewed accordingly.

2.2 CBO Program Implementation Quality Control

To be effective the PBFM framework included systematic quality control for services. The "hard" indicators for the service packages were used not only to measure and link services performed to fund disbursements but the data were also analyzed to monitor service quality. For example, in addition to being an output indicator, the number of tests mobilized also served as a quality control measure when it was compared to the average number of confirmed cases previously found in the program site. If a significant difference from the estimate of HIV+ prevalence within the target group was found, this would indicate a potential problem. Generally, the China-Gates HIV Program found there were three kinds of potential problems: (1) the number of tests reported was exaggerated, (2) a different target group was being tested, and (3) multiple tests on the same persons were being performed. The data from other output indicators were similarly used to compare achievements with information from alternative sources including various records maintained by the CBOs, hospitals and CDCs.

2.2.1 Collecting program output data

Effective implementation of the China-Gates HIV Program PBFM framework relied on a well-designed and managed information system. Although the details of information system management varied in different program sites, the core components of information system were shared. These included:

- Patient information collection and tracking
- Program information collection and analysis
- CBO reporting and verification
- Information on the performance of CBOs

During the first three years (2007-2010) of the program, information was periodically collected using standard data collection forms and a paper-based system that moved from implementing organizations and units to municipal program management offices for verification and aggregation. Aggregated information from each city was sent to the national program management office and the national GONGOs for final review.

Following the program mid-term adjustment in 2010 a web-based data reporting system was developed and implemented throughout the program. All program sites, to the level of the CBO, were required to enter program data into this system. The information collected was periodically analyzed by national and city levels to monitor key program indicators used as evidence for making necessary modifications to program implementation.

2.2.2 Verifying program output

Respective output indicators reported by program implementers measured the quantity of each service package delivered. The degree to which the program target was achieved was directly linked to the level of funds given to that program implementer. To ensure appropriate funding allocations to CBOs, the quantities reported for each output indicator were verified by both the local CDC where the CBO operated and by the GONGO that served as the CBOs funding management organization. The China-Gates HIV Program required three sources of documentation to validate the CBO's reported output. These included records kept by the CBOs who mobilized MSM for testing, records maintained by the local CDC that performed confirmatory tests, and a sheet kept by tested clients. Data triangulation was also performed

among CDC, the GONGOs and the CBOs at all the program sites prior to finalizing the output numbers for each CBO.

The program did not pay for testing or confirmation of cases already identified as HIV+ in the national infectious diseases database. Such cases were identified by periodic checks of the national identification numbers of those tested (included in CBO files) with the identification numbers of known HIV+ persons in the national infectious diseases database. Duplicated HIV positive cases were removed from the total number HIV+ cases reported as reported by CBOs. Through this process the program ensured that HIV+ cases found through program supported mobilization activities were newly identified HIV+ persons.

2.2.3 Establishing CBO internal quality control

The China-Gates HIV Program also encouraged and supported CBOs in establishing internal quality control systems. Additionally, some CBOs developed specific internal quality control systems.

CASE

Harbin's "Tongkang"

In Harbin, the CBO "Tongkang" strengthened their internal quality control of services in four areas: (1) capacity building, (2) compliance with standard operation procedures, (3) quality-control focused service delivery information management system, and (4) performance based salary.

"Tongkang" held periodic internal seminars and capacity building events to further improve staff service delivery capacity. The CBO leader actively encouraged and supported staff participation in national and, provincial training and their efforts to earn certificates in counseling and testing. All staff members were required to follow a standard operation procedure and use a rapid test flowchart that ensured the quality of counseling and testing service. The CBO also designed a comprehensive information collection system on testing and clients that was used for data analysis and reporting to the local CDC. Staff improvement and provision of high quality services was encouraged by CBOs through an internal performance-based salary mechanism that rewarded staff who provided high quality counseling and testing service and were able to attract more clients.

2.3 CBO Funding Flow Mechanisms

2.3.1 Performance-based disbursements

The funding flow to program implementers in the China-Gates HIV Program involved separate disbursement channels for CBOs and government departments. Funds for CBOs went through GONGOs, and funding to government institutions went through government channels. The national management program office allocated and managed funding to provincial and municipal government health departments participating in the program. The provincial branches of the two GONGOs - CPMA and CASAPC - allocated and managed funding designed for CBOs. This funding disbursement and management mechanism took full advantage of the GONGOs financial systems to allocate and transfer funds to CBOs and to monitor CBOs use of funds according to program priorities and regulations. The funding management fees to these GONGOs at national and provincial levels were set up to be linked closely and proportionate to program outputs.

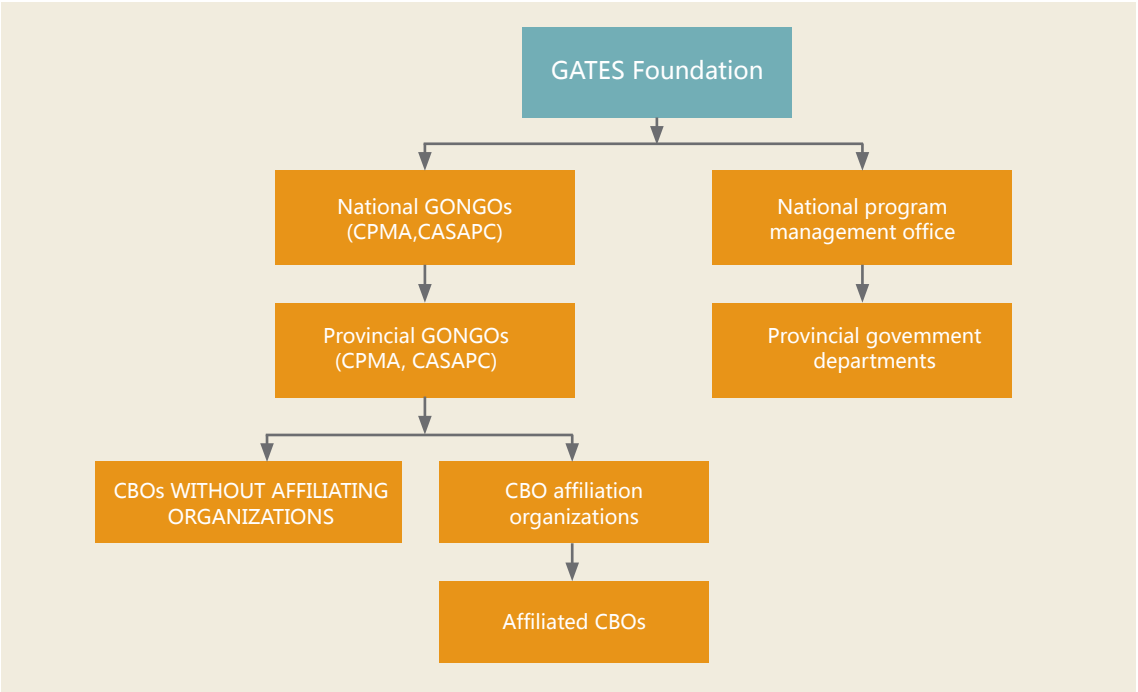

Figure 3 Funding flow in the China-Gates HIV Program

At implementation level, participating CBOs received direct funding through the city or provincial CPMA or CASAPC depending on local management structures. Although most participating CBOs were not legally registered in China, they could be supported through an affiliation with the GONGOs or with established NGOs that had full legal status and independent bank accounts (See Figure 3). The GONGOs would only disburse program funds to CBOs for an operating period (typically one to three months) when agreed program targets for the previous operating period were actually met or steps taken by CBOs to mitigate underperformance were considered satisfactory.

2.3.2 Performance bonuses

To encourage better performance among CBOs, some city-level branches of the GONGOs, which serve as the funding management organizations for CBOs, established systems of rewards and penalties.

CASE

Wuhan's Hubei Preventive Medicine Association

In Wuhan, a scoring system linked to key program indicators was set up by the GONGO in charge of CBOs, Hubei Preventive Medicine Association. The CBOs that were found to have higher performance scores than the program site average in key implementation areas were awarded at the end of each year with small financial bonuses as symbolic recognition of their superior achievements. The performance score was calculated based on the CBO's reported rate of completion of its targets:

- Number of MSM mobilized for testing
- Number of MSM screened to be HIV positive
- Number of positive MSM screened positive and confirmed by CDC
- Number of CD4 tests positive MSM received
- Completeness of case information collection and storage

3 Fine-Tuning the Framework

The PBFM framework of the China-Gates HIV Program was adjusted throughout the entire program implementation. For example, the mid-term review in 2010 led to adjustments to this framework. Both program priorities and service packages were adjusted with new indicators and the unit prices to ensure the best possible public health outcome the program sought to achieve. Before the program mid-term adjustment, more than ten service packages were used. Analysis of program data and monitoring information reviewed in preparation for the mid-term adjustment showed that the costs to mobilize IDUs and FSWs were much higher MSM. The review also found the definition of output indicators for the "care" services for PLHA were not precise enough, leading to overpayment to program implementers.

Adjustments to the PBFM framework during the mid-term adjustment included; (1) removing the supported service packages related to IDU and FSW thereby narrowing the program's focus to MSM populations and PLHA in order to increase program cost-effectiveness; (2) linking fees for the city program management office to program outputs in order to improve cost efficiency in program management for both government program implementers and GONGOs managing CBOs; (3) increasing the incentives for a confirmed positive person from RMB 300 (USD 50) to RMB 500 (USD 85); (4) simplification of the overall service from ten to seven packages; And (5) an annual CD4 test was added as a "hard" indicator for quality of care service.

In addition to the adjustment of service packages and "hard" indicators, the China-Gates HIV Program developed a comprehensive implementing agency scoring system based on the PBFM framework, which was used as an incentive to improve program effectiveness and efficacy across all program sites. Two types of indicators were included into the scoring system with a total score of 100:

- Program effectiveness indicators (scoring 70) - indicators reflecting effective identification of HIV+ and AIDS case management that were derived from the "hard" indicators.
- Program management indicators (scoring 30) - indicators reflecting quality of reporting, implementation management, planning and financial management, program information management, and improvement of supportive environment.

Starting from July 2011 the China-Gates HIV Program ranked all of its 15 program sites annually based on the overall scores calculated using the scoring system. A site would be regarded as a failed program site if the management score was lower than 18 or the total score was lowers than 60. These failed sites would face a delay in disbursement of their management fees until rectification steps taken were considered satisfactory by the program.

4 Lessons Learned

The PBFM framework can significantly reduce program management and monitoring workload and complexity by basing disbursements on regular reporting of easily quantifiable outputs and a simplified program budget.

The framework fosters accountability of implementing agencies, especially CBOs. During participation in the China-Gates HIV Program, CBOs learned how to follow program requirements and to complete required tasks before receiving funds. Some CBOs used the tenets of .the program to establish their own internal performance-based management systems to improve their program service and staff/volunteer performance. The PBFM framework also increased CBOs sense of responsibility and helped the competent CBOs to further develop into a more sustainable, long-term organization.

In most cases, the framework worked in favor of those competent CBOs to obtain more funding support than less effective or less committed CBOs. These additional funds were often used to further develop these CBOs. Therefore, the framework tends to support the "the survival of the fittest." This factor may help in national level selection of the competent CBOs.

Because disbursements were closely linked with program outputs and they were made only after the reported achievements were confirmed, the framework improved funding security and minimized risk for misuse of program funds. This strong linkage between funding and program outputs resulted in value for money and increased cost-effectiveness of the program.

The framework also helped promote positive collaboration among health departments (CDCs), CBOs and hospitals. All three are critical to a successful delivery of high quality HIV/AIDS services.

Effective participation of CBOs and related partners in using a PBFM framework requires orientation and initial capacity building resources that cover performance issues. Understanding and acceptance of PBFM by partners is important to avoid misunderstanding and improve effectiveness. During PBFM introduction in the China-Gates HIV program some program sites objected that the "hard" indicators were difficult to meet. During program implementation, CBOs capacity to achieve the output indicators increased.

Any program using PBFM should clearly and carefully link prices for services to measureable "hard" indicators. When "hard" indicators are used to represent a service package, participants need to know that the unit price is not simply for delivering the "hard" indicator but rather the whole service package that the hard indictor represents. This explanation needs continual reinforcement to ensure that all components of the service package are delivered. For example, the RMB 62 (USD 8) paid for each HIV test was expected to fund not only achievement of the indicators, but the cost of delivering the whole service package including counseling, costs of organizing outreach or other mobilization activities, motivating volunteers, etc.

Unit prices covered the full delivery of a service package, including human resources, transportation, etc. However, economic situations vary substantially in different cities and this affects what can be done from the funding provided through the PBFM framework. A more flexible strategy model for calculating unit prices, such as their linkage with the local consumer price index or local economic situation, should be considered.

A well-developed and implemented quality control mechanism is extremely important for an effective PBFM framework. Both service quality and information systems for supporting quality control need to be well designed and implemented. Although "hard" indicators were an important component of the PBFM framework in the China-Gates HIV Program, inclusion of key process indicators and quality-focus indicators also were important to ensure service quality. As the China-Gates HIV Program was implemented additional quality control systems were put in place. The CBOs that were purely money driven, or delivered poor quality service and/or lacked efforts toward internal development, dropped out or were eliminated from participation when more stringent quality control measures were put in place after the program mid-term review in 2010.

A reward and penalty mechanism that is clear, strict, transparent, fair and consistently applied can help ensure service quality and distinguish between the best performing CBOs and those that were abusing the system. If fraudulent behaviors were not identified and rigorously penalized, the enthusiasm and initiatives of competent CBOs can be dampened.

5 Summary

The use of the PBFM framework by the large and complex China-Gates HIV Program proved to be quite successful in providing a mechanism to maximize the possibility of achieving program objectives. The program budget was calculated based on transparent service packages and unit prices. Indicators and targets provided the basis for monitoring the performance of program implementation and corresponding adjustment to redress shortcomings before the entire program was finished. It is important to note the China-Gates HIV Program did face substantial challenges when initially implementing the PBFM framework, when its principles were not fully understood by program implementers. Despite these initial problems, the experience of the China-Gates HIV Program showed the effectiveness of the PBFM framework has substantial potential for China's future HIV/AIDS work, particularly in the area of managing the funding mechanism to facilitate CBO involvement in HIV services.