Substitution, Complementarity, or Transformation?

China's Engagement After Traditional Donor Retrenchment

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Abstract

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Global development assistance for health declined by 21% between 2024 and 2025, led by sharp reductions among traditional Western donors. As traditional financing contracts, China has become an increasingly prominent participant in global health, raising the question of whether it substitutes for, complements, or transforms the prevailing donor model. Existing scholarship rarely examines how Chinese actors themselves interpret this retrenchment.

This qualitative study used semi-structured interviews with 11 global health stakeholders from academia, government, research and philanthropic institutions, spanning Chinese and non-Chinese communities, analyzed through iterative thematic coding.

Thematic analysis showed that participants framed China's engagement as driven by its own developmental logic rather than as a reactive response to Western withdrawal, while candidly acknowledging concerns over transparency and evaluation.

These findings suggest China's role is best understood not as wholesale substitution or simple complementarity, but as an emerging and still-contested paradigm: selective complementarity at the multilateral level coexists with a more transformative, development-integrated model at the bilateral level. The future of global health cooperation may depend less on whether China replaces traditional donors than on whether multiple models can coexist and remain accountable.

Introduction

Over the past decade, global health assistance has operated within an increasingly unstable political and financial environment. Development assistance for health (DAH) refers to the financial and in-kind resources transferred through major development agencies to low- and middle-income countries to maintain or improve health, and is tracked annually by the Institute for Health Metrics and Evaluation (IHME) by source, channel, recipient region, and health focus area. Global DAH declined by 21% between 2024 and 2025, falling from $49.6 billion to $39.1 billion, with forecasts suggesting further reductions over the next five years. These cuts have been led by traditional donors: the United States reduced its DAH by an estimated 67%, followed by the United Kingdom (39%), France (33%), and Germany (12%) (IHME, 2025). The consequences are particularly acute for low- and middle-income countries (LMICs) that rely heavily on external financing for disease control, health system strengthening, and emergency preparedness.

Abrupt funding cuts and donor retrenchment disrupt coordination mechanisms, weaken multilateral institutions, freeze ongoing projects, scale down future programs, and force recipient countries and implementing partners to rapidly adapt to new financing landscapes. Concurrently, China has emerged as a more prominent participant in global health, expanding its engagement through bilateral assistance, technical cooperation, and selective multilateral involvement. China's growing role coincides with a period of strain on traditional health financing, driven by funding cuts and policy changes among traditional donors, including Western bilateral donors such as the United States and the United Kingdom as well as major multilateral institutions such as the WHO, the Global Fund, and Gavi. This raises important questions about how emerging actors understand their responsibilities and positioning within the global health system. While China is frequently cited as a potential alternative or complement to these traditional donors, it remains unclear how Chinese actors themselves interpret global aid contraction, and how such interpretations shape their approaches to global health governance.

China's assistance programs also remain subject to significant debate. Critics have questioned the efficiency and measurable impact of Chinese-funded health initiatives, raising concerns about financial management, auditing practices, and limited application of standardized monitoring and evaluation frameworks. However, existing discussions rarely examine how Chinese global health policymakers and practitioners themselves perceive and respond to these critiques, or how such debates may influence the future evolution of China's programs. Examining these perspectives is therefore essential for understanding both the challenges facing China's global health engagement and the pathways through

which its approaches to accountability and governance may evolve.

The convergence of global aid retrenchment and China's expanding engagement raises a central question for contemporary global health governance: when traditional donors reduce or withdraw health assistance, does China fill the resulting gaps, and if so, through what mechanisms and strategic approaches? Rather than assuming China either substitutes for or complements traditional donors, this study examines how global health stakeholders interpret China's role under conditions of donor retrenchment, exploring whether its engagement is better understood as gap-filling, selective complementarity, or a broader transformation in global health governance.

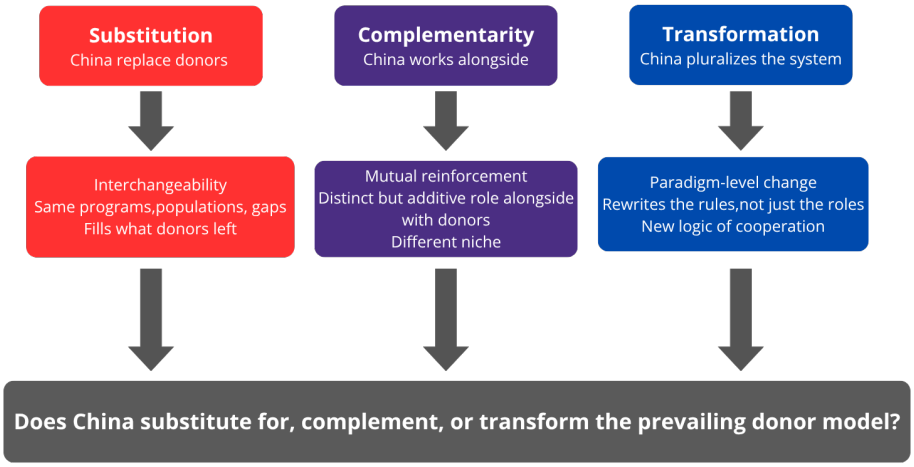

Figure 1. Conceptual framework

Literature Review and Research Gap

The question of whether China works within or fundamentally reshapes global health governance has a longer intellectual lineage. In the first book-length study of China's participation in global health governance, Chan (2011) framed the central puzzle as whether China acts as a "responsible stakeholder" or a "system-transformer", concluding that while China actively engages multilateral health institutions, it does so on terms anchored in national sovereignty and non-intervention, and does not seek a radical transformation of the prevailing order. This study builds on Chan's framing by asking how that tension plays out under conditions of acute donor retrenchment, and extends it with a third possibility, which is the transformation not of the system's norms but of the operational model of cooperation itself.

Existing scholarship on China's role in global health governance has documented the rapid expansion of China's engagement through bilateral assistance, technical cooperation, and

selective multilateral involvement. Liu et al. (2014) characterize China's approach as "distinctive," shaped by South–South cooperation principles, domestic development experience, and pragmatic problem-solving. South–South cooperation here denotes a specific political and aid paradigm rather than mere geographic shorthand: a partnership among equals grounded in solidarity, sovereign equality, non-interference, non-conditionality, and mutual benefit, in deliberate contrast to the conditionality associated with traditional North–South assistance (UNOSSC, 2019). Husain and Bloom (2020) and Guo et al. (2024) further trace how China's engagement has evolved institutionally, noting that responsibility is fragmented across multiple ministries and that its health activities are shaped by a mix of developmental, diplomatic, and commercial motivations alongside public health aims.

A significant strand of this literature focuses on the Belt and Road Initiative (BRI) and its Health Silk Road (HSR) component as the primary strategic vehicle for China's global health engagement. Formally integrated into the BRI in 2015, the HSR encompasses hospital construction, disease control cooperation, medical personnel dispatch, pharmaceutical partnerships, and traditional Chinese medicine promotion (Tambo et al., 2019; Wang et al., 2025). Tang et al. (2017), in an early quantitative analysis, document that China's development assistance is structurally distinct from that of traditional donors: of China's overseas development assistance in 2010–2013, nearly four-fifths (78%) was directed toward infrastructure and about a fifth (21%) toward medical supplies and drugs, in contrast to the disease-specific and multilateral focus of Western donors. A further conceptual distinction underlies this divergence. China's overseas health engagement is situated within its broader framework of overseas development assistance (ODA), oriented toward infrastructure and state-to-state development cooperation, whereas US and other Western health funding is conceived as development assistance for health (DAH), a dedicated, disease-focused, and largely multilateral financing stream. The two operate through different concepts, accounting systems, and logics of legitimacy. China is therefore not simply a smaller or alternative DAH donor; its engagement is framed within a different paradigm altogether, a distinction central to understanding why its role may be transformative rather than substitutive or complementary. Habibi and Zhu (2021) further document how the HSR has evolved in Africa toward service-oriented cooperation with growing private sector involvement, while Rudolf (2021) demonstrates that China's health diplomacy operates simultaneously at bilateral and multilateral levels, enabling rapid deployment of aid in contexts where traditional donors were absent. Zoubir and Tran (2022), drawing on role theory, argue that China's health diplomacy reflects a composite strategic identity combining material interests, realist power objectives, and constructivist aspirations to position Beijing as a "responsible great power" and moral leader of the Global South.

Crucially, despite China's expanding engagement, existing analyses consistently challenge

the assumption that China can or will substitute for traditional donors at scale. Tang et al. (2017) conclude that it is unlikely China would simply fill large financing gaps vacated by other donors, given both structural capacity constraints and China's preference for establishing its own multilateral mechanisms like the Asian Infrastructure Investment Bank (AIIB) rather than reinforcing existing Western-led frameworks. Wang et al. (2025), in a decade-long HSR policy review, identify persistent governance limitations including regulatory fragmentation, weak dispute-resolution mechanisms, and insufficient integration of non-state actors. Tambo et al. (2019) similarly note that China's assistance is heavily bilateral and poorly coordinated with multilateral bodies. Concerns about transparency, sustainability, and accountability recur across multiple studies, though existing analyses rarely examine how Chinese actors themselves perceive and respond to these critiques.

A separate and expanding body of literature examines the retrenchment of traditional donor funding. Recent analyses warn that cuts to bilateral and multilateral health assistance, particularly in HIV/AIDS, tuberculosis, malaria, maternal and child health, and pandemic preparedness, risk substantial health setbacks and place severe strain on already fragile health systems in LMICs. These studies emphasize that aid cuts constitute structural shocks rather than mere budgetary adjustments, reshaping governance dynamics, coordination mechanisms, and long-term preparedness capacity across the global health system. Rudolf (2021) observes that during COVID-19, China stepped into spaces vacated by traditional donors by supplying medical materials and deploying health teams across Africa, the Middle East, and Latin America. Most recently, Bloom, Husain, and Ren (2025) argue that the US withdrawal from global health signals a need for fundamentally new governance arrangements, and raise a critical open question: whether China and other BRICS (Brazil, Russia, India, China, and South Africa) countries will prioritize genuine South-South cooperation and the interests of other LMICs, or whether short-term economic and geopolitical considerations will dominate their responses. Wang et al. (2025) further note that the US withdrawal from the WHO has added complexity to the HSR's positioning within the existing multilateral health system, creating both new challenges and potential openings for China's engagement.

Despite these two well-developed strands of scholarship, a notable gap exists at their intersection. While Tang et al. (2017) raised early questions about China's gap-filling capacity, Rudolf (2021) observed China's partial role during COVID-19, and Bloom et al. (2025) highlighted the governance transition challenge, none systematically examines how Chinese global health actors themselves interpret conditions of sustained donor retrenchment, nor how these perceptions shape strategic choices and governance practices beyond emergency contexts.

Existing scholarship has thoroughly documented what China does in global health, including mapping projects, analyzing BRI frameworks, and comparing allocation patterns with Western

donors. What remains absent is evidence of how global health actors interpret the current moment of Western retrenchment. This study fills that gap not by adding another structural account of China's engagement, but by examining the framings that global health stakeholders bring to a question the literature has so far treated as hypothetical. The objective of the study is to answer a question on whether China substitutes for, complements, or transforms the prevailing donor model under conditions of financial crisis.

Methods

Study Design

This study employed a qualitative design using semi-structured in-depth interviews to examine how key global health stakeholders understand China's role in the context of traditional donor retrenchment. Whether China's engagement is best understood as substitution, complementarity, or transformation. A qualitative approach was selected because the study seeks to understand meanings, interpretations, and competing policy narratives surrounding donor withdrawal and China's evolving global health engagement. Interviews, rather than document analysis or program data only, were essential because the study's central concern is not what China does but how key actors interpret donor retrenchment and rationalize China's role. This discursive, sense-making dimension is relatively hard to capture through official documents or disbursement figures alone. Semi-structured interviewing provided sufficient consistency across participants while allowing flexibility to probe differences in professional experience, institutional perspective, and geopolitical framing.

Study Population and Recruitment

Participants were purposively selected to capture diverse perspectives on China's evolving global health role under conditions of donor retrenchment. The study population included government policy advisors, global health program managers, Chinese and non-Chinese scholars with China-related expertise, and representatives from research and philanthropic institutions. A total of 11 participants were interviewed: 5 from academia, 4 from government or Ministry of Health–related institutions, and 2 from research and philanthropic institutions. This diversity enabled comparative analysis across Chinese and non-Chinese epistemic communities and across implementation, governance, and research perspectives.

Recruitment combined purposive and snowball sampling. Initial participants were identified through academic mentors, committee referrals, and professional networks relevant to global health policy and China's development cooperation. Following each interview, participants

were invited to recommend additional experts, allowing strategic expansion of the sample. Recruitment continued until thematic sufficiency was reached, defined as the point at which additional interviews no longer substantially expanded the conceptual range of emergent themes. This judgment was informed by ongoing memo review and faculty mentor discussions.

Participant	Role	Nationality	Institutional Affiliation	Interview Duration
P1	Academic	Chinese	Chinese	58 mins
P2	Government	Chinese	Chinese	72 mins
P3	Government	Chinese	Chinese	70 mins
P4	Research Institutions	Non-Chinese	Non-Chinese	55 mins
P5	Academic	Chinese	Chinese	50 mins
P6	Academic	Chinese	Non-Chinese	51 mins
P7	Government	Chinese	Chinese	125 mins
P8	Government	Chinese	Non-Chinese	67 mins
P9	Academic	Chinese	Non-Chinese	106 mins
P10	Philanthropic Institutions	Chinese	Non-Chinese	66 mins
P11	Academic	Non-Chinese	Non-Chinese	45 mins

Table 1. Characteristics of Participants

Data Collection

Primary data were collected through semi-structured in-depth interviews guided by an interview guide developed from the research questions and relevant literature on donor transition and global health governance. Core topics included participants' perceptions of recent donor funding reductions, impacts on institutions and programs, interpretations of China's capacity and willingness to respond, institutional pathways of Chinese engagement, and comparisons with traditional donor approaches. The guide was iteratively refined throughout data collection: following each interview, field notes and memos were reviewed to identify emerging conceptual gaps, and subsequent interviews incorporated targeted probes

based on these themes. In several subsequent interviews, perspectives raised by one participant were intentionally introduced as probes to engage in a cross-interview dialogical strategy. This approach facilitated a deeper exploration of institutional tensions and contrasting geopolitical perspectives.

Interviews were conducted in Mandarin Chinese or English according to participant preference; six were conducted in English and five in Chinese. Duration ranged from 45 to 125 minutes, with a median of 61 minutes. With consent, interviews were audio-recorded, transcripts manually cleaned and verified, and analytic memos written immediately after each session.

Data Analysis

Data were analyzed using an iterative thematic analysis approach combining deductive and inductive coding in ATLAS.ti. Deductive coding applies a predefined, theory-derived codebook, whereas inductive coding lets codes emerge from the data. Analysis began with repeated close reading of transcripts alongside the development of methodological, reflexive, and thematic memos to document analytic decisions and capture emerging patterns. An initial deductive codebook, drawn from the interview guide and the study's core conceptual interests (donor retrenchment, institutional response, China's engagement logic, and comparative framing with traditional donors), was then refined inductively as new codes emerged from the data.

This inductive refinement followed a '3+8' coding strategy: three especially information-rich transcripts were selected for intensive close coding, during which emergent codes were generated, merged, and sharpened alongside the existing deductive codebook. The revised codebook was then applied to the remaining seven interviews. This approach allowed early immersion in dense data to drive code development before broader application, balancing theoretical grounding with openness to unanticipated themes. Code definitions and inclusion and exclusion criteria were continuously updated to ensure internal consistency, and themes were reviewed against the full dataset to ensure coherence, conceptual distinctiveness, and adequate representation of both dominant and divergent perspectives.

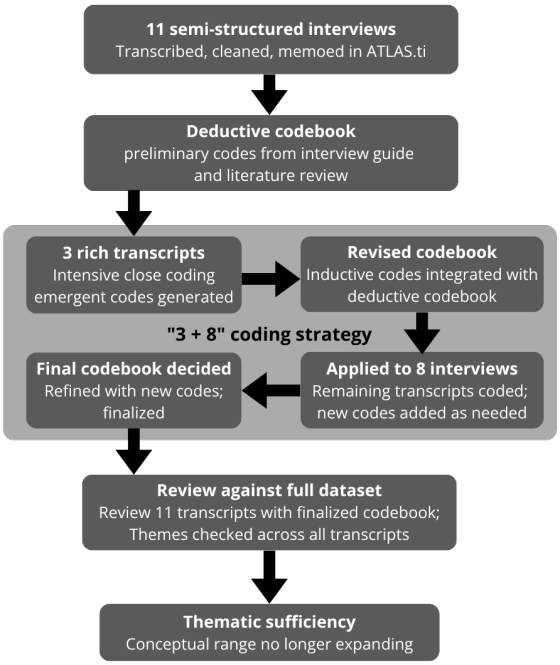

Figure 2. Study design: the iterative qualitative coding process, from deductive codebook to thematic sufficiency.

Ethical Consideration

This study received ethical approval from the University of Washington Institutional Review Board, and verbal informed consent was obtained from all participants prior to each interview. To protect confidentiality, participant identifiers were removed during analysis and reporting, and quotations were minimally edited for clarity while preserving original meaning.

Positionality and reflection

The study was conducted by a Master of Public Health candidate in Global Health at the University of Washington, serving as the sole interviewer, coder, and primary analyst. As a Chinese researcher with prior exposure to China-related global health policy, the researcher brought contextual familiarity to the topic while remaining attentive to how this positionality might shape data collection and interpretation. An initial assumption—that participants might frame China as a natural gap-filler for declining Western aid—was repeatedly challenged during interviews and coding, as many participants emphasized China's distinct strategic and institutional logic. Reflexive memos were maintained throughout to document how interpretations evolved and minimize unexamined bias.

Results

Aid Disruption Contributed to Structural Shocks in Global Health Financing and Governance

The retrenchment of traditional donor support has precipitated a period of profound structural instability across the global health system. Participants consistently described disruptions that extend well beyond direct budgetary shortfalls, manifesting instead as cascading shocks across financing chains, institutional capacity, and the coordination mechanisms that link donors, intermediaries, and recipients.

A recurring theme was the indirect nature of funding erosion. Because major international intermediaries (such as the WHO, UNAIDS, and private foundations) rely on government-backed contributions to sustain their grant-making capacity, cuts by traditional donors ripple far beyond their direct recipients. Several participants described how their own institutions, though not directly funded by western governments, experienced significant resource constraints as these intermediary pipelines contracted. Others noted the tangible consequences for ongoing research collaborations: joint projects suspended, field programs quietly wound down, and access to international funding channels progressively narrowing.
These financial shocks have been translated directly into workforce and institutional continuity crises. Global health projects depend on pre-committed funding to maintain field operations, supply chains, and personnel salaries; without guaranteed disbursement, projects stall immediately. Participants described significant staffing uncertainty within major international agencies and characterized the attrition of disease-control personnel in African countries as reaching a critical level. Beyond workforce disruption, several participants highlighted the collapse of what they described as the "innovation ecosystem", synergy between government-funded infrastructure and private philanthropic investment. As one participant from a private foundation explained, "we have always described our work as catalytic ... we pioneer a methodology or an innovative tool, hoping the government will scale it up. Once the infrastructure for that scale-up no longer exists, the value of new tools becomes far less certain" (P10). Once the foundational layer of government support recedes, catalytic private investments lose their operational platform and can no longer be effectively deployed.

Taken together, these disruptions signal a potentially irreversible shift in how global health is coordinated and governed. Participants emphasized that the institutional damage caused by donor withdrawal cannot be quickly rebuilt even if funding eventually returns.

"While establishing such an organization [USAID] requires a long-term process of institutional

accumulation, its dissolution can be abrupt. Re-establishing lost connections and rebuilding decades of expertise requires an extensive recovery period. Even with the return of funding, the restart remains a protracted challenge." (P9)

The Logic of China's Global Health Engagement: Beyond Gap-Filling

A fundamental finding across interviews was the explicit rejection of the "gap-filler" narrative, both strategically and linguistically. Participants argued that China has neither the obligation nor the intention to mitigate the consequences of donor retrenchment by others. This rejection is rooted in a specific accountability logic: problems created by the withdrawal of certain powers should be addressed by those powers themselves, not transferred to emerging partners as a moral or financial burden. Several participants also noted that the term "gap-filling" is fundamentally inconsistent with China's official discourse system, and that China's resource allocation follows its own internal developmental logic, centered on sustaining existing bilateral commitments rather than reactively covering vacancies left by Western donors.

Beyond discursive rejection, participants consistently pointed to objective capacity constraints that make large-scale substitution structurally unachievable in the short term. China's total financial volume, professional global health workforce, and established presence in multilateral agenda-setting still lag considerably behind the long-standing dominance of Western donors. Even if political will existed to fill the gap, the institutional infrastructure required to deploy resources at a comparable scale and depth is not yet in place.

Underpinning both the rhetorical and structural limits is a deeper divergence in strategic motivation. Participants described China's engagement logic as having evolved over decades, from Maoist-era ideological solidarity and free aid, toward a pragmatic focus on mutual economic development and regional stability under the BRI framework. While longstanding humanitarian programs such as the dispatch of Chinese medical teams retain a charitable, solidarity-based character, participants emphasized that China's contemporary engagement is increasingly embedded in a broader strategy of development cooperation, in which health interventions align with commercial interests, infrastructure projects, and long-term diplomatic partnerships, rather than following the charity logic of traditional donor–recipient models.

This strategic divergence also manifests in operational paradigms. Participants contrasted the research-oriented, disease-specific focus of traditional donors with China's implementation-driven approach, delivering integrated packages of personnel, funding, and technology aimed at tangible outcomes rather than scholarly documentation. This 'small but beautiful' model, exemplified by targeted, high-visibility interventions such as the "Brightness Action" cataract surgery program (Husain & Bloom, 2020), emphasizes bilateral ownership and recipient-

defined needs, though participants acknowledged significant trade-offs: tight project timelines, limited standardized evaluation, and insufficient long-term community engagement.

“We don't permit to fill the Gap. Of course, we understand their financial crisis in the African countries in many countries. If we, if we can't have a solution globally and collectively, China will suffer as well because we understand the health is cross border issues, very clear. So we are, so that's why we're working on this, but we have to say very clearly, we are coming Not just fill the gap, that's not our purpose.” (P2)

"Why would China do that? You have to understand their motivation. In the Maoist age, they provided a lot of aid for free—for solidarity and political influence. Then they moved to an economic focus, and they have been doing that for the last 40 years. Why would China change now?" (P4)

China’s Global Health Engagement Through Bilateral Pathways Within the Belt and Road Framework

A defining characteristic of China's global health practice is its strategic prioritization of bilateral channels. Participants were careful to note that this does not represent a wholesale rejection of multilateralism: China actively embraces the UN framework and has recently increased its support for the WHO, pledging USD 500 million over five years (Reuters, 2025). Participants framed this not as passive gap-filling prompted by the US withdrawal, but as a deliberate and selective expansion of engagement at the multilateral level, consistent with China's allocating resources according to its own logic rather than reacting to others' cuts. This distinction between rejecting "gap-filling" as a framing and selectively deepening multilateral commitments as an activity illustrates the layered character of China's role: selective complementarity at the multilateral level coexists with a more transformative, development-integrated model in its bilateral work. By contrast, China remains considerably less engaged with major non-UN global health initiatives such as Gavi and the Global Fund, a pattern participants attributed to its limited involvement during the founding of these organizations, which produced a persistently low sense of participation and institutional ownership. Bilateral cooperation, meanwhile, is favored for its speed and directness: it bypasses the procedural complexity of multilateral bodies and leverages China's robust domestic network of CDCs, provincial health centers, and universities to execute state-to-state projects with an efficiency that multilateral channels cannot match.

Underpinning this bilateral engagement is the Belt and Road Initiative (BRI), which is China's flagship foreign policy and economic connectivity strategy launched in 2013, along with its

Health Silk Road (HSR) component, formally integrated into the BRI framework in 2015 to promote international health cooperation across partner countries. Participants described the BRI and HSR as an essential political umbrella granting China's global health work its legitimacy, financing, and domestic policy priority. Several participants emphasized that without the BRI framework, global health initiatives would struggle to secure a foothold on the government's agenda; by integrating into this overarching structure, projects gain immediate political and moral legitimacy at both the state and institutional level. Universities can apply for funding; scholars can secure buy-in; and bilateral health commitments can be elevated into strategic diplomatic deliverables. Importantly, participants noted that the substantive content of many BRI health projects, including hospital construction, malaria control, health workforce development, remains largely continuous with China's pre-BRI medical aid tradition; what has changed is their framing and political embeddedness.

At the operational level, China's bilateral engagement follows a demand-driven logic that stands in deliberate contrast to the supply-side model of traditional donors. Rather than pre-designing programs based on global agendas, China responds to requests from host governments, treating recipient ownership as a foundational principle. Projects are characterized by what participants call a "small but beautiful" philosophy: precise, manageable, high-visibility interventions delivered through integrated packages of personnel, funding, and technology. Recent initiatives have further emphasized mutual investment from both parties, reframing cooperation as a shared endeavor rather than a unidirectional aid relationship.

"It is not purely an aid model, but a philosophy of cooperation where both sides have ownership. It requires both sides to contribute with what they have, whether it is money or effort. Everyone has a greater say in the project, and priorities and intellectual property rights are clearly defined from the start. At least from our perspective, it is a fairer way to promote cooperation rather than the traditional aid model." (P5)

Transformative Alternatives to Donor Paradigms

Participants consistently identified structural limitations in the traditional donor model that China's approach seeks to address. The dominant critique centered on the "vertical" nature of established aid, in which funding is tied to specific diseases that, while achieving narrow short-term targets, neglects underlying health systems and imposes externally defined priorities disconnected from recipient governments' developmental needs. Several participants argued that this donor-driven agenda-setting creates cycles of dependency rather than sustainable health capacity.

China's alternative is rooted in what participants described as a development-oriented logic,

drawing on China's own historical experience of achieving public health gains through multisectoral social mobilization rather than isolated clinical intervention. Instead of targeting single diseases, China integrates health cooperation into broader infrastructure and economic development frameworks, as in its schistosomiasis and malaria work, where technical control measures were combined with water-system improvements, sanitation, and multisectoral mobilization rather than delivered as standalone clinical interventions. Participants framed this integration not as a choice but as an "inevitable" feature of China's engagement model: health indicators cannot advance sustainably in isolation from broader development progress. This approach also reflects a deeper philosophical reframing: from charity and donor responsibility toward bilateral partnership, sovereign equality, and mutual investment, where both parties contribute resources and share ownership of outcomes.

Crucially, participants did not characterize China's model as a replacement for traditional donors, but rather as a contribution to the pluralization of the global health landscape. China introduces a different set of rules and mechanisms, giving recipient countries additional options between the research-based vertical multilateralism of established donors and the implementation-focused, system-integrated bilateralism of emerging partners. This coexistence of paradigms fosters a more diverse, if also more fragmented, global health system.

Yet China's model was not viewed as an uncontested alternative. Several participants raised persistent concerns about transparency, limited monitoring and evaluation, and weak integration with international reporting systems. Chinese bilateral projects were seen as fulfilling high-level diplomatic commitments without generating sufficient evidence of long-term health impact.

"The Ministry of Commerce might say they don't want evaluation—all they need to do is fulfill the promise, and their job is done. They don't necessarily care what happens after. This model does not produce the same level of efficiency or measurable impact as traditional donors." (P4)

"Our projects do not have funds for evaluation, which is an embarrassing situation. Our national aid projects do not include a budget line for evaluation. We really want to have evaluations—to have a third party tell us where we need to strengthen, where our weaknesses are, or which parts of the project could be cut. We also hope for such an evaluation to improve effectiveness." (P7)

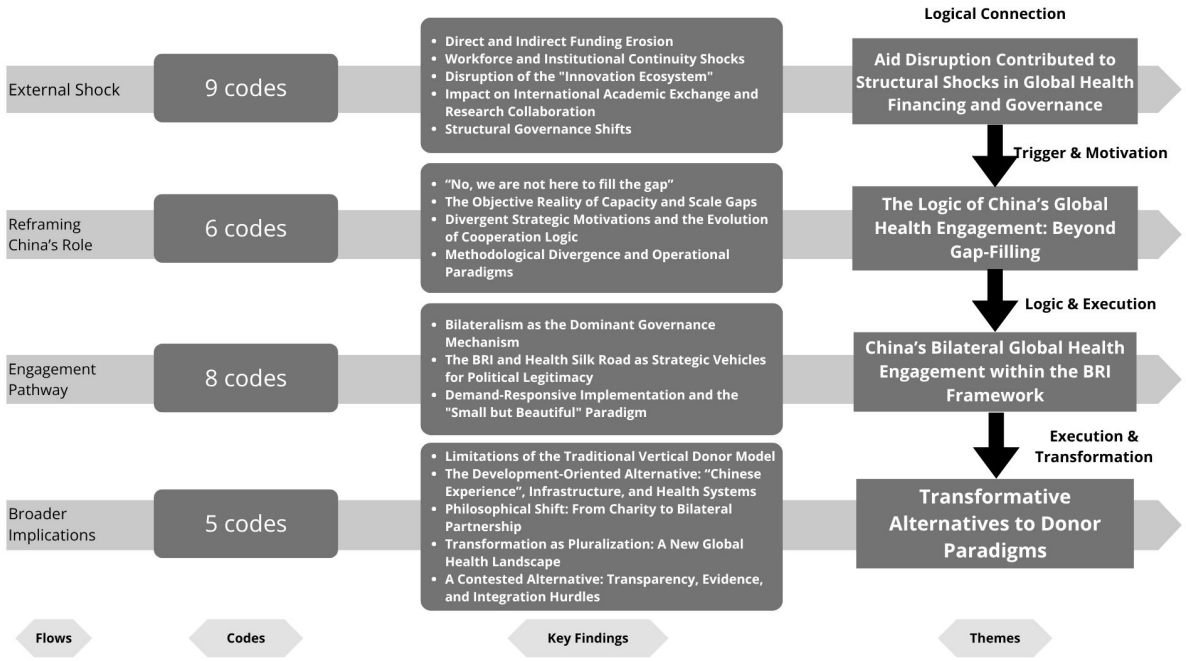

Figure 3. Thematic framework: major themes, subthemes, and analytic flow.

Discussion

China's Project-Based Model: Resilient but Pressured

China's project-based model offers a degree of structural resilience under conditions of donor retrenchment. Because Chinese global health projects are funded through bilateral aid channels and embedded within BRI cooperation agreements, they are less immediately exposed to cuts by Western donors. This partly explains why participants described Chinese projects as relatively insulated from recent aid disruption. However, resilience should not be mistaken for sustainability. Chinese projects are typically organized around fixed implementation cycles, predefined targets, and short-to-medium timelines, creating substantial pressure on implementers when projects simultaneously require community mobilization, surveillance, treatment, and capacity building. The key question is whether pressure to deliver visible outputs within tight cycles may compromise the depth and durability of public health outcomes.

State-Led Bilateralism: Efficiency, Authority, and Bureaucratic Constraints

State-to-state agreements under the BRI framework can facilitate political buy-in, accelerate project approval, and mobilize Chinese technical institutions with a speed that multilateral channels cannot match. Yet when health projects are coordinated primarily through agencies whose mandates center on commerce, diplomacy, or development cooperation, critical public health considerations, including monitoring and evaluation, ethical review, long-term disease

surveillance, and integration into local health systems, risk being subordinated to diplomatic deliverables. This tension is not unique to China: PEPFAR is managed by the US Department of State rather than health agencies, and UK aid has similarly shifted toward foreign policy institutions. What distinguishes the Chinese context is the degree to which upward accountability to funders and government agencies may crowd out outward accountability to local communities and health system outcomes, with project design prioritizing visible completion over long-term public health impact.

Bilateral Demand-Driven Cooperation and the Limits of Local Agenda-Setting

China's demand-responsive model is framed as more respectful of recipient sovereignty than donor-driven vertical programs, in theory giving partner governments greater ownership over project selection. In practice, however, its effectiveness depends heavily on a partner government's capacity to identify priorities, translate them into implementable proposals, and coordinate them across ministries within project cycles.

Furthermore, bilateral priorities shift with China's diplomatic calendars and leadership changes, creating vulnerability for programs requiring long intervention cycles; disease elimination, workforce strengthening, and surveillance system development all demand time horizons that typical project cycles cannot accommodate. This reveals a tension within China's own model: cooperation is presented as demand-driven and grounded in recipient ownership, yet its priorities remain tied to the donor's diplomatic and political cycles. Recipient ownership therefore operates within boundaries set by China's political agenda rather than fully displacing it. The central challenge is thus whether bilateral projects can transition from externally supported initiatives into locally owned systems that persist after Chinese funding and political attention recede.

Learning, Adaptation, and the Emergence of "Small but Beautiful" Projects

China's global health engagement is better understood as an evolving model than a fixed paradigm. Participants acknowledged shortcomings of earlier Chinese projects, including weak evaluation, limited documentation, insufficient post-completion sustainability, while emphasizing that Chinese institutions are increasingly reflecting on these failures. The growing emphasis on "small but beautiful" projects can be partly understood in this context: smaller, targeted interventions reduce exposure to large-scale financial criticism, avoid debt concerns, and produce more visible outcomes aligned with current economic constraints. This study also identified an unexpected effect of aid disruption: in some contexts, the withdrawal of traditional donor projects reduced field-site competition, allowing Chinese initiatives to roll out more smoothly. This illustrates how fragmented aid landscapes can reshape implementation conditions in unintended ways, though it should not be interpreted as evidence of substitution.

Toward a Contested New Paradigm of Global Health Cooperation

Taken together, these findings suggest that China's global health engagement represents neither direct substitution nor simple complementarity, but rather an emerging paradigm whose legitimacy and long-term impact remain contested, one that Tang et al. (2017) anticipated when they concluded that China was unlikely to simply fill gaps vacated by other donors, and that Bloom et al. (2025) more recently framed as a governance transition requiring new leadership and new partnerships. This study provides empirical grounding for that observation: China's model emphasizes bilateral cooperation, state-led implementation, infrastructure, technical transfer, and recipient government demand, differing structurally from the vertical disease programs, multilateral financing mechanisms, and standardized evaluation frameworks of traditional donors. Yet as Wang et al. (2025) caution, the legitimacy of any emerging paradigm depends on its ability to demonstrate impact, improve transparency, and integrate with existing governance systems, challenges that participants in this study candidly acknowledged. The broader implication is that global health governance is moving toward a more pluralized but also more fragmented landscape. China is not filling the space left by traditional donors; it is advancing a different model whose strengths and weaknesses are still being tested. The future of global health cooperation may therefore depend less on whether China replaces traditional donors, and more on whether multiple models can coexist, coordinate, and remain accountable to the health needs of partner countries and communities.

Limitations

This study has several limitations.

First, it does not address China's response to the 2014–2016 West African Ebola epidemic, an episode directly relevant to its central question. The Ebola response illustrates a mode of engagement in which China cooperated with established actors rather than building parallel mechanisms: it provided five rounds of assistance, mostly in-kind, totaling USD 123 million across 13 West African countries, and the epidemic prompted a formal memorandum of understanding with the United States so that the two countries' CDCs could jointly support the establishment of an Africa CDC, even amid strained China–US relations (Tang et al., 2017). Although modest in financial scale relative to broader Belt and Road engagement (compared with USD 213.5 billion in total BRI engagement in 2025; Nedopil, 2026), this case complicates a purely transformative reading of China's role and merits dedicated future analysis.

Second, the study relied solely on interviews and did not incorporate document analysis or program-level disbursement data. Triangulating stakeholder accounts against official

documents and quantitative aid-flow data would strengthen validity and allow subjective narratives to be tested against observable resource allocation.

Third, the sample was small (n = 11) and recruited through purposive and snowball sampling, which may introduce selection bias and limits generalizability; the findings are analytically rather than statistically generalizable.

Fourth, participants were drawn predominantly from Chinese institutions and actors directly involved in China's global health engagement. Perspectives from recipient countries, frontline implementers, and traditional Western donors were underrepresented, which may have shaped how China's role was characterized.

Finally, the study captures a particular moment of acute donor retrenchment, and these interpretations may shift as the funding landscape and China's own priorities continue to evolve.

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