

**BACKGROUND INFORMATION ON GOALS AND TARGETS
FOR THE GLOBAL FUND STRATEGY 2012-2016**

1. INTRODUCTION

1.1 For the first time, the Global Fund Strategy 2012-2016 sets explicit health impact goals and targets. This background paper provides further information on the definitions and methodologies used to define these goals and targets.

1.2 “Leading targets” for specific services and indicators for other selected services have been chosen in consultation with partners and have been set to align with their plans and priorities.

1.3 Two health impact goals were set for the duration of the Strategy. The expected numbers of lives-saved from Global Fund programs have been derived from the leading targets set for the diseases. The anticipated number of new infections averted has also been calculated.

2. PROCESS TO DEVELOP GOALS AND TARGETS

2.1 Goals and targets were developed starting from an initial **package** of services with indicative target levels for each service as proposed at the May 2011 Board meeting (GF/B23/15).

2.2 A **technical consultation** was held in Montreux on 7-8 July to align on an approach for setting goals and targets, and a methodology for calculating these and lives saved. Participants included UN and GHI partners, academics and technical experts. During this meeting, it was agreed to align the Strategy's target services with global partner plans, and to set Strategy target numbers at ambitious but achievable levels, in relation to resources available. The discussions also agreed on changes to the Global Fund's lives-saved estimation methodologies, which were re-aligned to be in line with updates made by WHO and UNAIDS [1].

2.3 During the PSC meeting on 24-26 October 2011, the approach to goals and targets was refined. The list of services was maintained, with one service per disease selected as a leading target, and the remainder included as other selected services.

2.4 An **ongoing dialogue** is being maintained with the partners, including WHO, UNAIDS, Stop TB Partnership and Roll Back Malaria Partnership, and experts, including a seminar that was held with WHO and UNAIDS in Geneva on 15 September. In addition, further discussions with partners were held following the PSC meeting, focusing on clarification and data validation. Further refinements are expected based on feedback and dialogue with partners, especially with respect to setting targets for other selected services.

3. LEADING TARGETS AND INDICATORS FOR OTHER SELECTED SERVICES

3.1 “Leading targets” have been set for a service selected for each disease. These services were chosen on the basis that the Global Fund currently invests substantially in them and will continue to do so. These services are in-line with results currently tracked and published by the Global Fund from its programs.

3.2 Consistent with the Global Fund's approach to reporting grant results, these numbers represent targets for programs supported by the Global Fund – to which domestic resources and other donors are also assumed to contribute.

3.3 The level of the leading targets has been set based on the 2016 partner plans, according to the principle of allowing the Global Fund to maintain its current share of contributions to global results for these targets. Rounding was applied to tuberculosis and malaria leading targets to simplify communication; however they are not rounded in the explanations for their derivation.

HIV/AIDS	7.3 million people alive on ARTs
Tuberculosis	4.6 million DOTS treatments in 2016 21 million DOTS treatments over 2012-2016 (5-year total)
Malaria	90 million LLINs distributed in 2016 390 million LLINs distributed over 2012-2016 (5-year total)

3.4 Partner targets are ambitious compared to current levels of service provision achieved by countries. A joint effort alongside partners and other international and domestic funders will be required to fill current gaps and further scale-up to ensure these targets are met.

3.5 Table 1 shows the assumptions used to derive the strategy targets for 2016, based on the currently reported Global Fund and worldwide results, and the targets set for 2016 communicated by partners.

Table 1: Derivation of 2016 targets based on current shares applied to partner plans for low- and middle-income countries (M= millions)

	Current share based on end-2010 results			Targets in 2016	
	Global results (national and international)	Global Fund-supported programmes	Global Fund programme share	Global Partner Plans	Global Fund-target Supported
People alive on ART	6.6M [2]	3.0M	45%	16M [3]	7.3M
Number of all forms of TB treated under DOTS	5.6M [4]	3.9M	68%	6.7M [5]	4.6M
Number of LLINs distributed	145M [6]	89M [7]	62%	150M [8]	92M

3.6 For setting the LLIN distribution leading target, a slightly different approach was taken, which reflects the Roll Back Malaria partnership's focus on nets in Africa over the coming years. The share of bednets delivered to countries in Africa was used as the basis for the current share. The 2016 target is based on the Roll Back Malaria Partnership's estimate of the steady-state net replacement need for Africa.

3.7 In addition to the leading targets, **other selected services** have been chosen to reflect their integral role in a comprehensive response in the strategies against the diseases. These interventions are often currently underutilized compared to their effectiveness against the diseases. The level of services delivered will be monitored and reported, as indicators for the Global Fund's contribution in the fight against each disease. This list is indicative rather than exhaustive, and signals the commitment to work with partners to fund a coordinated set of interventions appropriate to the disease contexts.

HIV/AIDS	<ul style="list-style-type: none"> • PMTCT: HIV-infected pregnant women to receive ARV prophylaxis and/or treatment • HIV testing and counseling • Prevention intervention services delivered for most-at-risk-populations • Male circumcision
Tuberculosis	<ul style="list-style-type: none"> • HIV co-infected TB patients enrolled on ART • Treatments of multi-drug-resistant-TB
Malaria	<ul style="list-style-type: none"> • Houses sprayed through IRS • Parasitological diagnoses of suspected cases with RDTs • Courses of ACT administered to confirmed malaria cases

3.8 It is intended that targets eventually be set for these other selected services, as appropriate, in collaboration with partners.

3.9 The choice of services to be leading targets and other selected services is based on the consultations and discussions with partners to date, as well as the targets and services set in the global plans and investment frameworks of the Global Fund's partners [5,9,10], notably the:

- UNAIDS 2011-2015 Strategy, UNAIDS 2011 *Investment Framework* and UNGASS Declaration, June 2011
- *Global Plan to Stop TB 2011-2015*
- Roll Back Malaria *Global Malaria Action Plan 2008*, and updated targets of May 2011.

Setting these leading targets and other selected services reaffirms the Global Fund's commitment to align and coordinate with the disease-control priorities set by partners, building on evidence-based demand articulated by countries.

3.10 This is *not* an exhaustive list of services that the Global Fund will support, which covers a broader sets of recommended interventions and activities contributing to comprehensive disease responses.

3.11 There is no intention to abandon the founding principle of national ownership; rather, it is expected that through a dialogue-based, coordinated approach with partners and countries, country demand for funding of these services will be expanded.

3.12 The level of leading targets, and the composition of indicator services may be updated during the course of the Strategy period for good reason, for example due to changes in evidence of effectiveness of interventions, partner priorities and global plans, country demands and resource availability.

4. SCALE-UP OF LEADING TARGET SERVICES

4.1 Table 2 shows the expected scale-up of the leading target services.

Table 2: Global Fund leading target service levels (in millions, annual and cumulative) for 2012-2016

Leading target	2012	2013	2014	2015	2016	2012-2016
Patients on ART	4.3	5.0	5.8	6.5	7.3	
DOTS treatments	3.7	3.9	4.1	4.4	4.6	20.7
LLINs distributed	62	70	77	85	92	387

4.2 2012 services are based on targets from approved proposals, Phase 2 and RCC renewals from Round 1-10 grants.

4.3 A linear scale-up to 2016 target levels is assumed from 2012, which will require substantial reprogramming from late-2011 in order to enhance targets of grants from Rounds 1-10 with effect from 2013, especially for DOTS where current approved program targets fall off dramatically past 2012.

5. GOALS – LIVES SAVED AND INFECTIONS AVERTED

5.1 Lives saved were estimated for the leading services: ART, DOTS and LLINs. Estimations built on existing Global Fund models, which updated to re-align with the latest methods and estimates used by WHO and UNAIDS, as agreed at the July 2011 technical partner consultation [1].

5.2 The revision of model assumptions for DOTS, more specifically the change in counterfactual from ‘no treatment’ to ‘pre-DOTS (1995) standard of care’ caused the revised baseline estimate to be lower than to the published result of 6.5 million[11], at a new estimate 4.0 million lives saved cumulatively between 2003 and end-2010.

5.3 The lives saved for each of the three leading target services each year are shown in Table 3. The total number of lives saved is 9.7 million over 2012 to 2016. The ongoing increase in lives saved over the period of the strategy will depend most critically on grant achievements against targets for LLINs and DOTS, the two largest contributors to total lives saved. For further information on the assumptions used, please see Appendix A.

Table 3: Estimated lives saved by Global Fund-supported services (in millions), for the three leading target services

Lives saved	Service	2002-2010	2011	2012	2013	2014	2015	2016	2012-2016
Annual	ART	1.6	0.6	0.7	0.8	1.0	1.1	1.2	4.8
	DOTS	1.9	0.2	0.4	0.4	0.5	0.5	0.5	4.4
	LLINs	0.6	0.4	0.5	0.5	0.5	0.5	0.6	2.6
	Total – leading services	4.0	1.2	1.6	1.8	1.9	2.1	2.3	9.7
Cumulative (since inception)	Total – leading services	4.0	5.2	6.8	8.5	10.4	12.5	14.8	

5.4 Other services will also contribute to lives saved and their impact will be included in future revisions of the Strategy goals, and in the reporting of results achieved.

5.5 A target for infections averted was set to signal the Global Fund's commitment to disease prevention.

5.6 There is no simple partner-agreed model to convert Global Fund-supported service deliveries into infections averted, so instead an estimate was made based on WHO and UNAIDS country estimates of HIV infection incidence, TB case incidence and malaria case incidence. The target corresponds to the sum of HIV infections and TB + malaria cases averted. Assuming Global Fund programs contributes to gains which at least continue the current rate of decline of

incidence (2005-2009) across the low- and middle-income countries, and which could as much as double the current rate of decline starting from 2014, against the counterfactual that the global incidence rate would have stayed constant at its 2009 level, then a high-level estimate of 140-180 million infection averted is appropriate for the period of 2012-2016.

APPENDIX A. METHODS OF ESTIMATING LIVES SAVED BY GLOBAL FUND CO-SUPPORTED SERVICE DELIVERIES

<i>Service</i>	<i>Unit of service delivery</i>	<i>Assumptions</i>
ART	Patient alive on ART	Lives saved based on patients of preceding year, adults and children combined, <i>Spectrum</i> model using UNAIDS assumptions of July 2011[12].
DOTS	TB patient treated, all forms	Counterfactual: pre-DOTS 1995 standard of care[13,14]; from WHO-STB model, use global average of 0.11 lives saved per DOTS treatment (any form) [14]
ITNs	LLINs distributed	Each LLIN distributed results in 0.73*1.5 years of protection for a child under-5 (up to 2009; reflecting effective lifespan 1.5 years for conventional ITNs [15] and ratio of ITN usage by children to household ownership of 0.73[16]; or 0.73*3 years from 2010 for LLINs, reflecting 3-year lifespan[17]. 80 percent of Global Fund-supported LLINs are in SSA and PNG. For SSA and PNG (but not in other countries), apply 17 percent reduction in all-cause under-5 mortality [18] relative to national mortality rates of 2010. Lives saved distributed equally between year of distribution and following two years.

Notes: Approximations based on global average lives saved per service delivery unit, derived from cross-country aggregated outputs of WHO/UNAIDS models – as agreed at July 2011 partner consultation [1], thus ignoring variations among countries in quality of services, effective population coverage reached, and actual health outcomes measured locally. Estimations cover deaths prevented before end-2016, within each target group of service beneficiaries only.

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