Resource Toolkit

Strengthening HIV Outcomes through integration with Hepatitis, Harm Reduction, and Triple Elimination within Global Fund's Grant Cycle 8

CLINTON HEALTH ACCESS INITIATIVE

Version: April 2026

This toolkit is considered a "living" document and will be updated as needed

Table of contents

Cover page photo credit: Sujata Khanna / WJCF

Acronyms and abbreviations

AGYW	Adolescent Girls and Young Women	**AIDS**	Acquired Immunodeficiency Syndrome	**ANC**	Antenatal Care
ART	Antiretroviral Therapy	**BD**	Birth Dose (HBV vaccine)	**BPG**	Benzathine Penicillin G (syphilis treatment)
CCM	Country Coordinating Mechanism	**CDC**	Centers for Disease Control	**CHAI**	Clinton Health Access Initiative
CHW	Community Health Worker	**CLM**	Community-Led Monitoring	**CSO**	Civil Society Organization
DAA	Direct-Acting Antiviral (HCV treatment)	**DALY**	Disability-Adjusted Life Year	**DHIS2**	District Health Information Software 2
DNA	Deoxyribonucleic Acid (DNA PCR testing)	**EIA**	Enzyme Immunoassay	**EID**	Early Infant Diagnosis
EMTCT	Elimination of Mother-to-Child Transmission	**EPI**	Expanded Program on Immunization	**EVT**	Elimination of Vertical Transmission
FCDO	Foreign, Commonwealth & Development Office (UK)	**Gavi**	Gavi, the Vaccine Alliance	**GBV**	Gender-Based Violence
GC	Grant Cycle (Global Fund)	**GF/GFATM**	Global Fund to Fight AIDS, Tuberculosis and Malaria	**GHSS**	Global Health Sector Strategies (WHO)
HBeAg	Hepatitis B e Antigen	**HBIG**	Hepatitis B Immunoglobulin	**HBsAg**	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus	**HCV**	Hepatitis C Virus	**HIV**	Human Immunodeficiency Virus
HMIS	Health Management Information System	**HR**	Harm Reduction	**HRH**	Human Resources for Health
ICER	Incremental Cost-Effectiveness Ratio	**IEC**	Information, Education and Communication	**KVP**	Key and Vulnerable Population(s)
LIS	Laboratory Information System	**LMIC**	Low- and Middle-Income Country	**MNCH**	Maternal, Newborn and Child Health
MoH	Ministry of Health	**MSM**	Men who have Sex with Men	**MTCT**	Mother-to-Child Transmission
NASCP	National HIV/AIDS,Viral Hepatitis and STIs Control Program (Nigeria)	**NAT**	Nucleic Acid Test	**NCHADS**	National Center for HIV/AIDS, Dermatology and STD (Cambodia)

NPHCDA	National Primary Health Care Development Agency (Nigeria)	**NSP**	Needle and Syringe Program (context-dependent)	**NSP**	National Strategic Plan (context-dependent)
OAMT	Opioid Agonist Maintenance Therapy	**OD**	Operational District	**PAAR**	Prioritized Above Allocation Request
PCR	Polymerase Chain Reaction	**PE**	Program Essential (Global Fund)	**PEP**	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief	**PFM**	Public Financial Management	**PHC**	Primary Health Care
PLHIV	People Living with HIV	**PMTCT**	Prevention of Mother-to-Child Transmission	**POC**	Point of Care
PPM	Pooled Procurement Mechanism (Global Fund)	**PQ**	Prequalification (WHO)	**PrEP**	Pre-Exposure Prophylaxis
PSCM	Procurement and Supply Chain Management	**PSM**	Procurement and Supply Management	**PUD**	People Who Use Drugs
PWID	People Who Inject Drugs	**PUD**	People who Use Drugs	**QA**	Quality Assurance
QALY	Quality-Adjusted Life Year	**QI**	Quality Improvement	**RDT**	Rapid Diagnostic Test
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health	**RNA**	Ribonucleic Acid (HCV RNA viral load testing)	**RSSH**	Resilient and Sustainable Systems for Health
SOF/DCV	Sofosbuvir/Daclatasvir (HCV treatment regimen)	**SRH**	Sexual and Reproductive Health	**STD**	Sexually Transmitted Disease
STI	Sexually Transmitted Infection	**TB**	Tuberculosis	**TCS**	Treatment, Care and Support (HIV module)
TDF	Tenofovir Disoproxil Fumarate	**TE**	Triple Elimination (of MTCT of HIV, syphilis and hepatitis B)	**TG**	Transgender
TRP	Technical Review Panel (Global Fund)	**TWG**	Technical Working Group	**UNAIDS**	Joint United Nations Programme on HIV/AIDS
UQD	Unfunded Quality Demand	**USD**	United States Dollar	**USG**	United States Government
VfM	Value for Money	**VL**	Viral Load	**WHO**	World Health Organization

Overview

Introduction

Integrating viral hepatitis, harm reduction, and triple elimination into HIV programs strengthens outcomes, advances equity, and improves efficiency — and is supported by Global Fund policy. Hepatitis B (HBV) and C (HCV) co-infections drive higher morbidity and mortality among people living with HIV. Harm reduction prevents HIV and HCV transmission among people who inject drugs, with the Global Fund as the largest international donor in LMICs. Triple elimination of vertical transmission of HIV, syphilis, and HBV is a proven, delivery-ready package built on antenatal care.

Grant Cycle 7 (GC7) demonstrated strong uptake. Approximately USD 60 million was approved for hepatitis-related integration within HIV programs - a threefold increase from prior cycles. Of 104 countries with GC7 HIV grants, at least 69 selected and budgeted for the Elimination of Vertical Transmission (EVT) / Triple Elimination (TE) module. Strong applications aligned early with Global Fund priorities, integrated into existing platforms, and demonstrated value for money. However, mid-cycle budget cuts exposed vulnerabilities where investments were broadly scoped or framed as standalone additions to HIV programs.

Grant Cycle 8 (GC8) offers stronger policy for integration but operates under tighter financial constraints. HIV Program Essentials (PEs) cover these areas through four PEs: PE3 (harm reduction), PE16 (coinfection management), and new PEs — PE5 (SRH, STI and hepatitis screening for key and vulnerable populations) and PE11 (integrated testing for HIV, syphilis, and HBsAg in pregnancy). At the same time, most countries face flat or reduced allocations, greater value-for-money scrutiny, and a shift toward integration, transition planning, and larger co-financing. Success will depend on tightly scoped, policy-aligned investments integrated into primary health care platforms and strong delivery systems.

Purpose

This Toolkit helps users understand what is eligible for support under GC8, translate policy into actionable investment asks, and navigate the GC8 application process from country dialogue to submission. The Toolkit is complemented by practical templates, quick reference guides, and planning resources to support countries at each stage.

Scope

This Toolkit focuses on three population groupings where viral hepatitis, harm reduction, and triple elimination integration priorities are most aligned with GC8 priorities.

Population I: people living with HIV (PLHIV), reached through ART clinics and other HIV care platforms

Population II: people who use drugs (PUD) and other key and vulnerable populations (KVP), reached through harm reduction services and sexual and reproductive health (SRH) platforms

Population III: pregnant women, breastfeeding women and infants, reached through antenatal care (ANC) and maternal and child health services.

This Toolkit covers hepatitis-relevant interventions for Populations I and II, while covering the full triple elimination scope across HIV, syphilis, and HBV for Population III. For Population II, this also includes harm reduction services (needle and syringe programs, opioid agonist maintenance therapy, and overdose prevention), given these are key interventions for the prevention of HCV and HCV among people who inject drugs (PWID). For brevity, this Toolkit refers

collectively to HBV and HCV, harm reduction, and triple elimination services as 'hepatitis, HR and TE investments' throughout.

Users

Application leaders: Principal Recipients, Sub-Recipients, and Country Coordinating Mechanism (CCM) members, consultants or technical partners supporting GC8 Funding Request development.

Advocates for viral hepatitis, harm reduction and triple elimination programming that engage with or seek to influence the application process ('advocates'):

- Ministry of Health focal points (e.g., hepatitis, HIV, EVT, harm reduction)
- Civil society and community organizations representing people living with HBV and/or C (HBV / HCV), people living with HIV, key and vulnerable populations, or pregnant women
- Technical partners supporting governments on hepatitis, harm reduction or triple elimination programs

1. Background

1.1 Why Viral Hepatitis, Harm Reduction, and Triple Elimination Matter for GC8

i) Clinically justified and supported by GC8 policies

Viral hepatitis and harm reduction[1] interventions directly improve outcomes for people living with HIV and other key and vulnerable populations. Triple elimination[2]; people who use drugs and other key and vulnerable populations; and pregnant and breastfeeding women and infants. For viral hepatitis programming, Global Fund support is intended for integrated service delivery, not standalone national programs.

Four Program Essentials (PEs) anchor these investments in GC8: PE16 (coinfection management), PE3 (harm reduction), PE5 (SRH and hepatitis screening for key and vulnerable populations), and PE11 (integrated testing for HIV, syphilis, and HBsAg in pregnancy). PE designation — set out in the HIV Prioritization Guidance — is the strongest policy basis available for HIV programming, giving advocates firmer footing in country dialogue than investments framed only as eligible interventions within the broader Modular Framework. In a constrained allocation environment, PE-anchored investments are more resilient to budget pressures and reprioritization. Section 2 provides detailed guidance on eligible interventions, PEs, and prioritization tiers.

HBV (HBV) and C (HCV) coinfections are common people living with HIV (PLHIV). Globally, ~254 million people live with chronic HBV infection and 50 million with chronic HCV[3]. An estimated 5-25% of PLHIV are coinfected with HBV — highest rates in Africa and Southeast Asia[4] — and about 2.3 million PLHIV (6%) have HCV[5]. Coinfection is especially concentrated among people who inject drugs (PWID) and men who have sex with men (MSM), with HCV rates exceeding 80% in some PWID populations[5]. Left unaddressed, viral hepatitis coinfections accelerate progression to cirrhosis, liver

[1]Harm reduction refers to a comprehensive package of evidence-based interventions to prevent HIV and HCV transmission among people who inject drugs, including needle and syringe programs (NSP), opioid agonist maintenance therapy (OAMT), and naloxone distribution for overdose prevention. See WHO 2022 Consolidated Guidelines on Key Populations.

[2]Triple elimination (TE) refers to the WHO-endorsed initiative to eliminate mother-to-child transmission (MTCT) of HIV, syphilis and hepatitis B virus. Also referred to as 'elimination of vertical transmission' or EMTCT. See WHO 2023 Triple Elimination Framework.

[3] WHO. *WHO sounds alarm on viral hepatitis infections claiming 3500 lives each day*. 2024.

[4] Platt et al.. *Prevalence and burden of HBV co-infection among people living with HIV: A global systematic review and meta-analysis*. Journal of Viral Hepatitis, 2019.

[5] Platt et al., *Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis*. National Library of Medicine, 2025

cancer, and death — even with effective antiretroviral therapy. HBV impairs immune recovery, while HCV-related liver disease remains a leading cause of mortality among PLHIV. Addressing hepatitis within HIV care is critical to improving outcomes.

Harm reduction — including needle and syringe programs (NSP), opioid agonist maintenance therapy (OAMT), and overdose prevention — remains the most effective strategy for preventing both HIV and HCV transmission among people who use drugs (PUD). Without sustained harm reduction, HIV prevention gains among key and vulnerable populations are fragile and reversible. The Global Fund is the largest international donor for harm reduction in low- and middle-income countries, accounting for 73% of all donor harm reduction funding in 2022[6].

Triple elimination (TE) brings together HIV, syphilis, and HBV services into a single, integrated package delivered through antenatal care to prevent transmission of infections from pregnant women to their babies. The interventions required — integrated testing, treatment, and prophylaxis for pregnant women (ART for HIV, benzathine penicillin G for syphilis, tenofovir prophylaxis for high-viral-load HBV), infant vaccination, and partner services — are proven, affordable, and deliverable within existing ANC care. Since 2015, 17 countries have reached one or more WHO targets for elimination of mother-to-child transmission[7], signaling rapid uptake and strong outcomes are achievable.

ii) Aligned to GC8 integration priorities

Viral hepatitis, harm reduction, and triple elimination services can be delivered through existing HIV platforms: ART clinics for PLHIV, community-based harm reduction and sexual health services for PUD and other KVP, and ANC services for pregnant women. Integrating these services within HIV platforms reduces program duplication, lowers marginal delivery costs, and maximizes patient contact with the health system. Shared laboratory infrastructure, coordinated clinical workflows, and bundled commodity procurement yield further efficiency gains.

Well-designed integrated packages deliver more health impact per dollar than parallel, disease-specific programs. Peer-reviewed modelling evidence supports this across all three areas: integrated antenatal triple-screening for HIV, syphilis, and HBV is highly cost-effective relative to dual HIV/syphilis screening (incremental cost-effectiveness ratio of US$114 per DALY averted in Nepal modelling)[8]. HBV and HCV testing and treatment scaled to WHO guideline levels in 67 LMICs is cost-effective in all regions (US$532/DALY for HBV; US$613/DALY for HCV — both below the average GDP per capita of modelled countries).[9] Integrated HCV testing within harm reduction, SRH, and HIV platforms consistently outperforms universal population-based approaches in LMIC settings, with cost-effectiveness mainly driven by HCV prevalence in target groups.[10]

iii) Reaching populations at highest risk

The Global Fund's mandate centers on equity — reaching the people most affected by HIV, TB, and malaria and removing structural barriers that prevent access to services. Key and vulnerable populations and pregnant women are central to this commitment.

PWIDs can experience the highest burden of HCV globally and encounter compounding risks from criminalization, stigma, and exclusion from mainstream health services. Harm reduction platforms are often the only way to reach this population with integrated hepatitis and HIV services. For pregnant women in high HBV-burden settings, the ANC contact is often the single opportunity to prevent vertical transmission of three infections.

[6] Harm Reduction International. *The Cost of Complacency: A Harm Reduction Funding Crisis*. 2024
[7] WHO. Policy Brief Introducing a framework for implementing triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus, 2023
[8] Shrestha et al. *Cost-effectiveness of integrated maternal HIV, syphilis, and hepatitis B screening opt-out strategies in Nepal*. Lancet Reg Health SE Asia, 2024
[9] Tordrup et al. *Cost-Effectiveness of Testing and Treatment for Hepatitis B Virus and Hepatitis C Virus Infections*. Value in Health, 2020
[10] Tordrup et al. *Economic evaluation of HCV testing approaches in LMICs*. BMC Infect Dis, 2017

1.2 GC7: What We Learned

Grant Cycle 7 (2023–2025) (GC7) marked a significant expansion of hepatitis financing within Global Fund HIV grants, building on policy developments in prior cycles. The Global Fund approved approximately USD 60 million for viral hepatitis, a threefold increase from previous cycles[11]. Of the 104 countries the Global Fund funded HIV programs in under GC7, at least 69 selected and budgeted for the Elimination of Vertical Transmission (EVT) / Triple Elimination module — a strong signal of country demand for integrated EMTCT. The CHAI GC7 Hepatitis Toolkit was disseminated to 21 countries, and where requested, CHAI provided tailored technical assistance. Twenty countries included hepatitis-related funding requests. Sixteen countries included triple elimination. Requests varied in scope and population focus, reflecting country-driven priorities.

Figure 1. Growth in Global Fund allocations for hepatitis from GC6 to GC7 (left), and the 21 CHAI footprint countries that included hepatitis-related funding in their GC7 application (right). Source: Global Fund data; CHAI analysis.

What worked

- **Early advocate engagement with focused, context-driven asks.** Countries were most successful where advocates coordinated early across populations and platforms and prioritized a focused, country-specific ask — not a catalogue of everything eligible. Alignment on which interventions to prioritize prevented dilution and strengthened defensibility. The CHAI GC7 Hepatitis Toolkit and similar tools provided frameworks for advocacy and proposal design.
- **Alignment with Global Fund priorities.** Countries that framed hepatitis within established GF priorities — triple elimination, harm reduction for PUD, and coinfection management for PLHIV — secured funding more effectively than those proposing standalone activities.
- **In-country partner coordination.** Alignment between government, civil society, and technical partners strengthened proposals, prevented duplication, and enhanced efficiency during proposal development and Country Coordinating Mechanism (CCM) review.
- **Leveraging the Global Fund's procurement role.** Countries that integrated commodities into GF pooled procurement achieved better pricing and supply security.
- **Clarity and ambition in the application itself.** The strongest applications articulated a clear strategic rationale for hepatitis investments anchored in epidemiological evidence and strong technical justification; defined implementation approaches that leveraged existing HIV platforms rather than creating parallel structures; specific target populations and service volumes that demonstrated realistic ambition; and costed plans aligned with national priorities and co-financing realities.

[11] WHA. *Opportunities and Risks for Hepatitis in Global Fund Programmes*. 2025

Hurdles and challenges

Overall, GC7 saw growing interest in prioritizing viral hepatitis, harm reduction, and triple elimination, but the opportunity has not been maximized.

- **Insufficient ambition.** The Technical Review Panel (TRP) observed that many applications showed limited ambition in hepatitis coinfection and comorbidity management. Hepatitis testing and treatment investments specifically constituted less than 1% of the USD 6.5 billion in GC7 HIV allocation funding[21]. One contributor to limited visibility on hepatitis coverage has been measurement: the GC7 Modular Framework did not include any hepatitis-specific routine indicators, so country programs had no GF-tracked measure of HCV or HBV testing, treatment, or linkage. GC8 introduces the first — TCS-11 (Proportion of people starting ART who were tested for HCV) — but comparable indicators for HBV among PLHIV, HCV/HBV among key and vulnerable populations, and HBV screening in ANC remain absent from the GF core set. Available data from GF Windows 1 and 2 show that only 13 of approximately 60 HIV applications included HCV treatment and just 11 planned viral hepatitis point-of-care diagnostics.
- **Reprioritization risk.** In June 2025, mid-cycle for GC7, the Global Fund confirmed reduced country budgets, triggering a reprioritization process. The guidance explicitly placed HBV screening for pregnant women and new HBV screening for PLHIV in the "de-prioritize" category while retaining HCV diagnosis/treatment and existing HBV treatment as priorities.
- **Fragmented framing.** The broader lesson from the reprioritization experience is about structural vulnerability: hepatitis investments framed as standalone additions rather than integrated into HIV program performance were the most exposed when budgets contracted. This pattern showed up during both country dialogue and TRP review.

The GC7 Country Illustrations in the Toolkit Resources examine how country-led advocacy for hepatitis integration translated into inclusion in GC7 funding requests across selected countries, with lessons that could inform the approach for GC8.

1.3 GC8 Context: What Changed and Why it Matters

A changing external aid landscape. GC8 operates in a rapidly changing aid environment. USG programs including PEPFAR are scaling back and reshaping — including through new bilateral MOUs with individual countries — and overall external resources for HIV programs are contracting. The Global Fund frames GC8 around two strategic pillars: **sustainable program design** and **effective transitions**. Allocation letters to each country now communicate transition timelines where applicable. For hepatitis, harm reduction, and triple elimination advocates, this means planning the investment ask deliberately across available resources — Global Fund, USG and other bilateral agreements, and domestic co-financing — rather than treating GF as the sole or default source.

Constrained allocations and structural changes. Most countries will receive flat or reduced allocations under GC8, requiring sharper prioritization. GC8 introduces the option to submit a single, consolidated Funding Request bringing together HIV, TB, malaria, and Resilient and Sustainable Systems for Health (RSSH) — a shift from previous cycles where disease program applications were often developed separately. Countries on a transition pathway will submit a shorter Transition/Focused Application with a higher bar for inclusion.

GC8 retains Program Essentials from GC7 and adds **Rigorous Prioritization considerations** categorizing activities as *Areas prioritized for GF investment*, *Opportunities to increase optimization and efficiency*, and *Activities of lower priority (context dependent)*. The Global Fund has set out five strategic shifts for GC8: (1) Supporting effective, predictable transitions from GF financing; (2) Rigorous prioritization of GF investments; (3) Integrate systems for health and service delivery; (4) Community health systems and sustainable financing; (5) Optimize domestic resources and effective co-financing.

Priorities for GC8. GC8 offers a stronger policy foundation for viral hepatitis, harm reduction, and triple elimination than GC7 — but the financial environment is more constrained. The lessons from GC7 point to the following priorities for countries entering the GC8 application cycle:

1. **Anchor investments to Program Essentials from the outset.** With four PEs directly relevant in GC8 (see 1.1), anchoring investment advocacy in PEs provides the strongest available policy basis and makes investments more resilient to budget pressures and reprioritization.
2. **Engage early, coordinate broadly.** The GC7 experience confirmed that early engagement with CCMs, technical partners, and civil society is decisive. Countries that waited until the proposal-writing stage to introduce viral hepatitis, harm reduction, or triple elimination struggled to secure space.
3. **Bring absorption evidence into the conversation where it helps.** Countries and advocates reviewing GC8 investment priorities pay close attention to how well previous grant resources were absorbed — high absorption signals delivery capacity, low absorption signals delivery bottlenecks. Where GC7 hepatitis, harm reduction, or triple elimination activities have strong absorption records, this is useful evidence to surface early in country dialogue and CCM discussions to support the case for retention or expansion in GC8.
4. **Design for reprioritization resilience.** GC7's mid-cycle cuts demonstrated that investments are vulnerable when broadly scoped. Tightly scope investments to what is integrated, measurable, and clearly linked to HIV outcomes — and identify in advance which elements are protected and which can be deferred.
5. **Build on GC7, not start from scratch.** Countries that included viral hepatitis, harm reduction, or triple elimination in GC7 have program data, delivery experience, and procurement infrastructure to leverage. GC8 applications should reference GC7 results - what was delivered, what was learned, what needs to scale - to demonstrate feasibility and build the case for continued or expanded investment.

What the TRP will focus on. Based on the GC8 Prioritization Guidance and Strategic Shifts, TRP scrutiny in GC8 is likely to sharpen around:

- **Prioritization grounded in country epi and program data**. Applicants will need to justify which interventions they prioritized and deprioritized based on country epidemiology and current program coverage.
- **Integration within primary health care**. Standalone or parallel delivery structures will face higher scrutiny; applications should demonstrate how services are integrated within PHC where appropriate.
- **Alignment with transition timelines**. For countries receiving transition timelines in their allocation letters, how the GC8 ask positions the program toward effective, predictable transition.
- **Community systems integration and social contracting**. How community-led services are structured, financed, and integrated into national systems, including plans for social contracting mechanisms.
- **Quality and differentiation of co-financing commitments.** Credibility of domestic co-financing, with focus on quality programmatic commitments, not just headline numbers.

2. Summary of GC8 Guidance for Hepatitis, HR, and TE

Overview

How GC8 guidance is structured. The Global Fund's GC8 investment guidance operates through three complementary documents:

- The Modular Framework Handbook sets out the full scope of interventions eligible for Global Fund financing, organized into modules, interventions, and activity descriptions
- The HIV Prioritization Guidance layers on top of the Modular Framework, guiding applicants on where to prioritize within the eligible scope. It sets out **28 Program Essentials (PEs)** for HIV which are evidence-based interventions that applicants are expected to address in their applications – these were introduced in GC7 and

the list has been expanded for GC8. In addition, Global Fund has introduced **Rigorous Prioritization considerations** in GC8 that categorize activities as *Areas prioritized for GF investment ('priority')*, *Opportunities to increase optimization and efficiency*, or *Activities of lower priority*.

- Cross-cutting Enabling Impact guidance covers five themes: (1) Adapting investments to mitigate the impact of climate on HIV, TB, and malaria service delivery, (2) Advancing integration, (3) Maximizing Value for Money, (4) Strengthening Sustainability and (5) Tackling human rights and gender barriers to accessing services.

Hepatitis, harm reduction, and triple elimination activities do not have standalone guidance — they sit within the **HIV Prioritization Guidance** and the *HIV areas* of the **Modular Framework**. This Toolkit section brings together the relevant content from across these documents in one place.

Program Essentials relevant to this Toolkit. As introduced in Section 1, four PEs anchor hepatitis, harm reduction, and triple elimination investments in GC8, mapped to the three population groupings below:

Mapping of Population I / II / III to HIV Module and Primary HIV Program Essential			
Mapping to GC8 Priorities	**Population I** People living with HIV (PLHIV)	**Population II** PUD and other key and vulnerable populations[12]	**Population III** Pregnant women, breastfeeding women and infants
Primary 'Program Essential' (PE)	**16 (formerly a component of PE 14 in GC7):** Screening and testing for relevant co-infections and co-morbidities.	**3 (Continuing from GC7):** Harm reduction services for people who use drugs. **5 (New for GC8):** Sexually transmitted infections (STIs) screening and treatment for people at increased risk of HIV infection.	**11 (New for GC8**): Testing for HIV, syphilis and hepatitis B surface antigen (HBsAg) at least once and as early as possible in pregnancy
Module	HIV Treatment, Care and Support	HIV Prevention	Elimination of Vertical Transmission of HIV, Syphilis and HBV

Each population draws on multiple PEs across the full HIV application. Population III (pregnant women, breastfeeding women and infants) also draws on PEs 1, 2, 12, and 18 reflecting the full triple elimination scope across prevention, testing, infant care, and retention support. Some activities, particularly treatment costs and systems strengthening, sit under different modules than the primary one shown.

How the tables are organized. The tables within sections 2.1 to 2.3 take a different lens for each population. For Populations I and II, they focus on hepatitis-relevant interventions, with Population II also including harm reduction services (NSP, OAMT, and overdose prevention), given these are the primary entry points for HCV prevention among PUD. The full HIV prevention, testing, and treatment scope for Populations I and II is not captured here. For Population III, the tables cover the full triple elimination package across HIV, syphilis, and HBV, reflecting the integrated nature of the TE ask. Interventions are organized by care cascade step — Prevention, Screening & Testing, Treatment, and

[12] Global Fund definitions: Key Populations are defined by UNAIDS as those particularly vulnerable to HIV and frequently lack adequate access to services. These five groups are gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs (PWID) and prisoners and other incarcerated people. Key and Vulnerable Populations (KVP) include Key populations, adolescent girls and young women (AGYW) and other vulnerable populations at risk

Follow-up & monitoring — to aid navigation. This framing is specific to this Toolkit; the GF guidance organizes interventions by module and intervention structure.

2.1 People Living with HIV (PLHIV)

i) Where PLHIV access services

PLHIV primarily access HIV-related services (including any hepatitis services integrated within them), primarily through HIV and ART clinics, primary health care settings, decentralized community services, and pharmacy-based models. Hepatitis investments should be designed to integrate within these existing touchpoints rather than require separate visits or parallel systems.

** These entry points are illustrative. Specific platforms will vary by country context.*

ii) How this population is positioned within GC8

The primary GC8 anchor for this population is **Program Essential 16** (continuing from GC7, formerly a component of PE 14[13]), which covers integrated management of common coinfections and comorbidities within HIV care. While the primary module is 'Treatment, Care and Support' for HIV, note that systems strengthening activities — including laboratory capacity, data systems, and quality assurance — sit under the relevant RSSH modules.

In the table below, interventions are grouped by care cascade step to aid navigation:

[13] In GC7, PE 14 was "CD4 and viral load testing, and diagnosis of common comorbidity and co-infections are available for management of HIV" which include diagnosis of comorbidities and coinfections for PLHIV.

Table 1: GC8 intervention table — what GF supports for People Living with HIV (PLHIV)				
●= in scope ◐ = partially in scope, context-dependent, or GF financing limited ○= inferred based on GC8 guidance				
Care cascade step	**GF Intervention** *(corresponding PE)*	**What GF supports** *(per Modular Framework)*	**GF prioritization tier** *(per HIV Prioritization Guidance)*	**Financing notes**
Screening & Testing	Integrated management of common coinfections and comorbidities — HCV *(PE16)*	● HCV diagnosis among at-risk populations who are accessing HIV service delivery platforms	**Priority:** Integrated as part of HIV care — focus on countries with high HCV burden, including among PWID, and where HIV/HCV coinfection is prevalent **Optimization:** Delivered through integrated low-cost delivery models	Standalone or high-cost delivery models unlikely to be defensible under GC8
	Integrated management of common coinfections and comorbidities — HBV *(PE16)*	● HBV diagnosis among at-risk populations who are accessing HIV service delivery platforms	**Priority:** Among those most at risk and within triple elimination programs	—
Treatment	Integrated management of common coinfections and comorbidities — HCV treatment *(PE16)*	● HCV treatment for PLHIV accessing HIV service delivery platforms	**Priority:** Integrated as part of HIV care — focus on countries with high HCV burden, including among PWID, and where HIV/HCV coinfection is prevalent **Optimization:** Delivered through integrated low-cost delivery models	Standalone or high-cost delivery models unlikely to be defensible under GC8
	Integrated management of common coinfections and comorbidities — HBV management *(PE16)*	● HBV management for PLHIV accessing HIV service delivery platforms	**Priority:** Among those most at risk and within triple elimination programs	—

What changed from GC7 → GC8 (Screening/Testing & Treatment)

GC7: PE14 broadly addressed diagnosis and treatment of co-infections including HBV and HCV.

GC8:

- PE16 explicitly prioritizes integrated HCV testing and management as part of HIV care, with clear focus on geographies with higher HCV burden and HCV/HIV prevalence, with a focus on 'efficiency' (one of the three GC8 VfM dimensions).
- PE16 also separately identifies HBV identification and management among those most at risk and within TE programs as a priority.

***Overall**: HCV programming now entails stronger VfM lens via integration, with prioritization guidance based on burden and population (PWID and PLHIV with HCV coinfection). HBV programming now has its own prioritization line within PE16, with TE linkage providing additional policy basis for PLHIV who are also pregnant or in TE-relevant settings.*

Follow-up & monitoring	Integrated management of common coinfections and comorbidities — monitoring *(PE16)*	○ HCV and HBV monitoring and follow-up within HIV care, leveraging shared laboratory infrastructure and integrated data systems	**Optimization:** Inferred from a broader PE16 coinfection management scope.	Consider budgeting under RSSH modules rather than Treatment, Care and Support.

What changed from GC7 → GC8 (Follow-up & monitoring)

GC7: No explicit follow-up/monitoring framing for hepatitis within HIV care. CD4 and viral load testing were the focus of PE14.

GC8: Inclusion of comorbidity/coinfection management implies inclusion of monitoring activities for HBV/HCV.

***Overall**: Hepatitis monitoring for PLHIV now inferred within PE16 scope.*

***Note**: GC7 PE14 ("CD4 and viral load testing, and diagnosis of common comorbidity and co-infections are available for management of HIV") refined and renumbered to GC8 PE16 ("Screening and testing for relevant co-infections and co-morbidities."). Broader in scope and more specific prioritization.*

iii) Key implementation considerations

The primary risk for this population under GC8 is scope creep and cost. Hepatitis investments framed broadly or built on expensive standalone delivery models are likely to be cut during reprioritization. Applications should frame viral hepatitis as tightly integrated into HIV care, specific to populations already accessing HIV services, delivered through existing clinical touchpoints, and measured through shared indicators where possible.

For HCV treatment, the GF promotes low-cost, pan-genotypic treatment regimens within its HIV Prioritization Guidance's Product List.

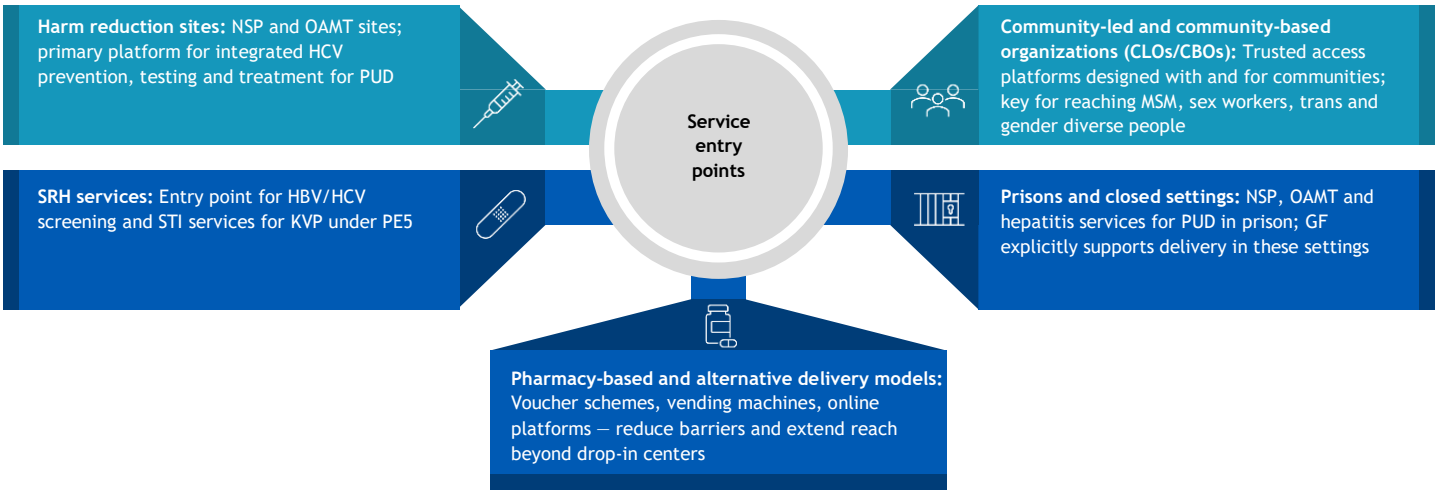
For HBV vaccination and referral, the GF did not mention these as part of the scope for PLHIV under GC8; However, for PLHIV who overlap with PUD and other key and vulnerable populations, HBV vaccination referral is in scope under PE3 (harm reduction) and PE5 (SRH services for KVP) — see **Section 2.2**. Countries are urged to finance HBV vaccination referral for the remaining PLHIV population — as well as vaccine commodity costs for all PLHIV populations — through alternative pathways (note: Gavi's HBV vaccine support covers infant immunization and does not extend to adult PLHIV).

Finally, untargeted screening or services outside HIV care platforms are explicitly lower priority under GC8 and should be funded through domestic or other sources.

2.2 PUD and other key and vulnerable populations

i) Where PUD and other key and vulnerable populations access services

PUD and other key and vulnerable populations (KVP) access services through differentiated, community-led platforms that are designed to be low-threshold and non-judgmental. Hepatitis investments must be embedded within these existing platforms. Services that require separate visits, identity documents, or police-facing environments will not reach this population effectively.



** These entry points are illustrative. Specific platforms will vary by country context.*

ii) How this population is positioned within GC8

The primary GC8 anchors for this population are **Program Essential 3 (continuing from GC7)**, which covers harm reduction services for PUD, **and Program Essential 5 (New for GC8)**, which covers SRH screening and treatment for people at increased risk of HIV infection (or 'KVP'). While the primary module is HIV Prevention, systems strengthening activities — including community systems, laboratory, and M&E — sit under the relevant RSSH modules.

GC8 guidance makes clear that hepatitis services for PUD and other KVP should be embedded within existing low-threshold, community-based platforms. At the same time, it acknowledges that integrated models—while beneficial—may unintentionally exclude marginalized populations and therefore should not replace specialized harm reduction platforms, which must be maintained.

In the table below, interventions are grouped by care cascade step to aid navigation:

Table 2: GC8 intervention table — what GF supports for PUD and other KVP

●= in scope ◐ = partially in scope, context-dependent, or GF financing limited ○= inferred based on GC8 guidance

Care cascade step	GF Intervention *(corresponding PE)*	What GF supports *(per Modular Framework)*	GF prioritization tier *(per HIV Prioritization Guidance)*	Financing notes
Prevention	Harm reduction (HR) services — NSP, OAMT, overdose prevention **(PE3)**	●**Needle Syringe Program (NSP) for PWID:** Procurement and distribution (direct/secondary) including in prison settings; safe collection and disposal; peer-based information and support on safe practices; basic healthcare and first-aid. ●**OAMT for PUD:** Protocol and policies development, procurement and distribution, including for pregnant women and	**Priority:** NSP — sterile needles/syringes and safe injecting equipment; wound care; safe disposal. OAMT — procurement and distribution; continuous supply. Naloxone (Overdose) — procurement and distribution in community settings **Optimization:**	—

		in prison settings; peer-based support. ●**Overdose prevention for PUD:** Naloxone procurement, distribution and administration, including in community settings and prisons; peer-based support	NSP – Limit add-on services; minimize non-essential staff; extending outreach. OAMT – service integration; take-home OAMT dosing and low threshold pharmacy/vending models; long-acting depot buprenorphine; regionally manufactured HR commodities	
	HBV vaccination	◐ Vaccine service delivery and referral only	—	HBV vaccine cost not supported by GF. Domestic or partner financing required.

What changed from GC7 → GC8 (Prevention)

GC7: PE3 defined as "Harm reduction services are available for people who use drugs." Scope included NSP, opioid substitution therapy (OST), overdose prevention and response including naloxone and gender-sensitive services and linkages to SRH for women and transgenders who are PWID, as well as interventions for prisons and closed settings PWID.

GC8: PE3 refined to "Harm reduction services for people who use drugs." Significantly more granular: NSP now explicitly includes low dead space syringes, wound care, and safe disposal as separate priority activities. OAMT rebranded from OST, with take-home dosing and long-acting depot buprenorphine added as efficiency/optimization activities. Naloxone distribution in community settings elevated to priority.

Overall:

- *Harm reduction: Substantial upgrade in specificity and ambition. Clearer prioritization across activities.*
- *HBV vaccination: No change since GC7. GF does not pay for vaccine doses but can cover service delivery investments needed to reach high-risk groups.*

Screening & Testing	Harm reduction services (PE3), SRH services including hepatitis (PE5)	●HBV and HCV screening and testing integrated within harm reduction services and SRH/KVP platforms	**Priority:** HCV testing in harm reduction services in countries with high HIV/HCV coinfection (PE5) **Optimization:** HBV testing for high-risk groups accessing HIV prevention platforms (PE5) **Lower-priority/context-dependent:** Deprioritize untargeted adult HBV screening (PE5)	Services related to prevention, screening and testing for HBV/HCV, when part of NSP should be included under that intervention.
Treatment	Harm reduction services (PE3), SRH services including hepatitis (PE5)	●HBV and HCV treatment within harm reduction platforms and SRH/KVP platforms	**Priority:** HCV treatment in harm reduction services and SRH/KVP platforms (PE5) **Optimization:** Low-cost, low-threshold HCV integrated delivery models; HBV management within existing HIV prevention platforms (PE5)	—

What changed from GC7 → GC8 (Screening/testing and Treatment) **GC7:** HCV diagnosis and treatment were prioritized for harm reduction settings (PE3) as well as for SRH, while HBV diagnosis and treatment were only prioritized as part of SRH service delivery. **GC8:** HCV diagnosis and treatment are priorities in both SRH and HR context (PE3). HBV diagnosis and treatment are indicative for both SRH and HR context and should be optimized as part of SRH service delivery. Untargeted adult screening is explicitly deprioritized. ***Overall**: HCV programming remains a priority in both SHR and HR contexts, while HBV programming is included in both but framed under 'optimization & efficiency' consideration in SRH and suggested in HR context.*				
Follow-up & monitoring	Harm reduction services (PE3), SRH services including hepatitis (PE5)	○ HCV and HBV follow-up and monitoring leveraging shared laboratory infrastructure and integrated data systems	**Optimization:** This activity is inferred from the broader PE5 SRH and PE3 HR services scope.	Consider budgeting under relevant RSSH modules.
What changed from GC7 → GC8 (Follow-up & monitoring) **GC7:** No explicit follow-up/monitoring framing for hepatitis SHR nor HR contexts. **GC8:** Inclusion of HCV/HBV management in SRH and HR contexts implies inclusion of additional follow-up and monitoring activities for PUD and other KVP health. ***Overall**: Hepatitis monitoring in SRH and HR contexts now inferred within PE3 and PE5 scope.*				

Note: Program Essential 16 in GC8 "Integrated management of common coinfections and comorbidities" under HIV Treatment focuses on PLHIV and touches on HBV and HCV diagnosis and management for PWID and those most at risk. However only interventions and activities listed in PE3 and PE5 have been listed here due to their direct relevance to PUD and other KVP.

iii) Key implementation considerations

The primary risk for this population is harm reduction, and hepatitis services being scaled back or redesigned in ways that undermine low-threshold access. Applications should protect the core harm reduction platform (NSP, OAMT, and overdose prevention) and frame hepatitis integration as an enhancement of these services, not a reorganization of them.

GF explicitly supports delivery of hepatitis services for PUD and people in prisons regardless of HIV status, provided services are part of comprehensive HIV programming for prevention, and strong epidemiological care is provided.

For HCV treatment, GF promotes low-cost, pan-genotypic treatment regimens within its HIV Prioritization Guidance's Product List.

2.3 Pregnant women, breastfeeding women and infants (TE)

i) Where pregnant women and breastfeeding women access services

Pregnant and breastfeeding women access HIV, syphilis and HBV services primarily through antenatal and postnatal care platforms. These are the main touchpoints through which TE services reach this population. Investments should be designed to work within these existing structures. *

** These entry points are illustrative and reflect common models. Specific entry points will vary by country context.*

ii) How this population is positioned within GC8

Integrated testing for HIV, syphilis, and HBsAg in pregnancy has been designated as a Program Essential for the first time in GC8 as **Program Essential 11**. While the primary module is Elimination of Vertical Transmission of HIV, Syphilis and HBV some activities sit under different modules in the GC8 application: treatment costs (ART, syphilis treatment, HBV prophylaxis) sit under the Treatment, Care and Support module; health system strengthening activities including staffing, training, mentoring, and quality assurance sit under the relevant RSSH modules; and integrated HRH capacity building sits under RSSH/PP: Human Resources for Health and Quality of Care.

In the table below, interventions are grouped by care cascade step to aid navigation:

Table 3: GC8 intervention table — what GF supports for Pregnant women, breastfeeding women and infants

●= in scope ◐ = partially in scope, context-dependent, or GF financing limited ○= inferred based on GC8 guidance

Care cascade step	GF Intervention *(corresponding PE)*	What GF supports *(per Modular Framework)*	GF prioritization tier *(per HIV Prioritization Guidance)*	Financing notes
Prevention	Prevention of incident HIV among pregnant and breastfeeding women (including STI) *(PE1, PE2)*	● Condom & lubricants provision and information on safer sex, condom use; Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); intimate partner response; STI prevention, screening, testing and management; partner testing and engagement	**Priority:** Condoms; lowest-cost oral and injectable PrEP in settings with either >3% incidence, or 1-3% incidence and high-risk behavior; continued PrEP access for those currently using PrEP; screen for gender-based violence (GBV) and ensure referral per WHO guidance **Lower-priority:** Limit one-month PrEP ring for new user; deprioritize PrEP diagnostics and service not in WHO minimum service package **Optimization:** RDTs and HIV self-tests for PrEP initiation and follow-up; task shifting for PrEP; GBV referral networks	Use the lowest-cost oral and injectable PrEP options

	Maternal HBV vaccination	◐Vaccine referral and linkage for pregnant women	—	Maternal HBV vaccine cost not supported by GF and requires alternative financing. Referral for HBV vaccination falls under scope for SRH and harm reduction platforms and therefore only interpreted as inferred for pregnant women
What changed from GC7 → GC8 (Prevention) **GC7:** Broader framing for HIV and STI prevention including condoms, PrEP, PEP, GBV prevention, STI services, HIV self-testing. HBV prevention included vaccination delivery supported within HIV platforms for PLHIV and KVP (vaccine cost excluded). **GC8:** For HIV prevention, GF prioritizes lowest-cost oral and injectable PrEP in high-incidence settings (>3% or 1–3% and high-risk behavior), and deprioritizes PrEP diagnostics and services not in WHO minimum service package and one-month PrEP ring for new users. STI prevention still included though not explicitly prioritized. Maternal HBV vaccination not explicitly named. HBV vaccination referral for HBsAg-negative pregnant women is inferred from PE5 screening for KVP and SRH/HR platform scope. ***Overall**: For HIV prevention, tighter PrEP targeting by incidence, with new cost-efficiency and deprioritization guidance. For HBV vaccination for pregnant women, explicit GC7 scope for PLHIV/KVP replaced by inferred scope within triple elimination under GC8. Minimal change in STI prevention prioritization.*				
Screening & Testing	Integrated testing of pregnant women for HIV, syphilis and HBV *(PE11 — new for GC8)*	● Integrated testing for HIV, syphilis and HBsAg (including re-testing during pregnancy and breastfeeding); linkage to treatment; test commodities (dual HIV/syphilis kits, HBsAg tests); community mobilization, demand creation, peer navigation	**Priority:** HIV testing as part of antenatal care in high-burden settings; HIV testing for women in KVP groups or at high risk; integrated HIV, syphilis and HBsAg testing (dual HIV/syphilis test as first test encouraged) **Optimization:** Leverage innovations including dual HIV/syphilis RDTs and self-tests, and forthcoming WHO-prequalified Triple test (HIV/syphilis/HBsAg); optimize service delivery to ensure rapid linkage to treatment for mothers and timely interventions for infants	Treatment costs for HIV, syphilis and HBV sit under 'Treatment, Care and Support' module. HRH/training under RSSH.
Treatment	Antiretroviral treatment (ART) for pregnant and breastfeeding women *(PE10)*	● ART drugs; ART initiation and viral suppression management for pregnant and breastfeeding women living with HIV; adherence support; differentiated service delivery models	**Priority:** ARTs procurement and optimized service delivery; adherence for patients with viral non-suppression and re-engagement support **Optimization:** resource-saving dispensing models; multi-month dispensing; regimen switching; health products cost efficiency including transition from protease inhibitors, retention of tenofovir, tenofovir alafenamide and abacavir, transition to combined paediatric regimen	Sits under Treatment, Care and Support module

	Integrated management of common coinfections — Syphilis treatment for syphilis-positive pregnant women *(PE16)*	● Treatment for syphilis-positive pregnant women identified through antenatal screening	**Priority:** Syndromic management of STIs	Sits under Treatment, Care and Support module
	Integrated management of common coinfections — HBV prophylaxis for HBsAg-positive pregnant women *(PE16)*	● Tenofovir prophylaxis for eligible HBsAg-positive pregnant	**Priority:** Identify and manage HBV among those most at risk and within triple elimination programs	Sits under Treatment, Care and Support module; long-term HBV care supported for PLHIV
	Postnatal infant prophylaxis *(PE12)*	●Tools and job aids for post-natal prophylaxis for HIV-exposed infants (including management of infants exposed to syphilis and HBV); ARTs for routine and enhanced infant prophylaxis; ◐ Integrated service delivery investments to support scaling HBV birth dose vaccination (not vaccine cost)	**Priority:** Infant prophylaxis for all children exposed to HIV	Infant HBV birth dose vaccine cost not supported by GF. Gavi or domestic financing required. GF can support programmatic delivery activities.

What changed from GC7 → GC8 (Screening/Testing and Prophylaxis/Treatment)

GC7:

- Maternal Screening/Testing: Integrated HIV/syphilis/HBV testing at first ANC visit was supported but not a standalone PE.
- Maternal Prophylaxis/Treatment: ART for pregnant and breastfeeding women living with HIV prioritized as a PE (PE8). Syphilis treatment and HBV prophylaxis for pregnant women supported under the *Elimination of Vertical Transmission* module but not named as a PE nor priority.
- Infant prophylaxis: Supported activity within the *Elimination of Vertical Transmission* module — not a standalone PE.

GC8:

- Maternal Screening/Testing: Integrated HIV/syphilis/HBV testing elevated to PE11 — prioritizing testing at least once, early in pregnancy. Triple test introduction pathway named as optimization opportunity.
- Maternal Prophylaxis/Treatment: ART for pregnant and breastfeeding women living with HIV remained a priority and renumbered from PE8 to PE10. Syndromic management of syphilis and HBV prophylaxis prioritized under PE16 and related treatment costs sit under *HIV Treatment, Care and Support* module.
- Infant prophylaxis: Consolidated under PE12 — provision of care for all HIV-exposed infants and postnatal prophylaxis. Now explicitly references integrated management for infants exposed to syphilis and HBV.

Overall:

- *Triple elimination testing now a Program Essential — strongest policy signal available for ANC testing investments.*
- *ART for pregnant women scope remains largely the same, with new optimization guidance on regimen transitions and dispensing for cost efficiency. Syphilis treatment and HBV prophylaxis elevated to priority investments. Framing shifted for syphilis from 'treatment' to 'syndromic management'.*
- *Infant prophylaxis now anchored in a Program Essential, with scope extended to syphilis- and HBV-exposed infants.*

Follow-up & monitoring	Early infant diagnosis (EID) and follow-up HIV testing for exposed infants *(PE12)*	●Point of care (POC) devices and near POC multiplex devices for DNA PCR testing; conventional and near POC instruments in line with laboratory networks; HIV testing of exposed infants per national protocols	**Priority:** Infant diagnosis and follow-up testing and prophylaxis for all children exposed to HIV **Optimization:** Optimize existing diagnostic networks **Lower-priority:** Investment in new POC equipment for EID/viral load	Activities to support broader postnatal care should be included under respective RSSH modules
	Retention support for pregnant and breastfeeding women (facility and community) *(PE18)*	● Mother-to-mother and peer-led mentoring; adherence support using facility and community-based models, and HIV stigma reduction; electronic reminder systems; community mobilization for male involvement in ANC and provision of partner services	**Priority:** Retention support to continue ART including community-based strategies **Optimization:** Efficiencies in peer support/mentor mother models based on HIV burden; stigma and discrimination reduction to improve patient retention	Activities to support broader postnatal care should be included under respective RSSH modules

What changed from GC7 → GC8 (Follow-up & monitoring)
GC7: HIV testing including EID available for all HIV-exposed infants as a priority (standalone PE9). Retention support was positioned across all population under PE13 under *HIV Treatment and Care* module.
GC8: EID consolidated from a standalone PE into PE12 (scope unchanged) with new lower-priority language against investment in new POC equipment for EID/viral load. Retention support for pregnant/breastfeeding women explicitly named as a priority activity under PE18, including community-based strategies under *HIV Treatment and Care* module.
***Overall**: EID scope unchanged but new deprioritization of new POC equipment investment. Retention support of pregnant and breastfeeding women now a priority investment.*

iii) Key implementation considerations

GAVI-GF complementarity on HBV birth dose: Maternal HBV vaccination is not explicitly listed for pregnant women within the Modular Framework Handbook or HIV Prioritization Guidance, however referral to vaccination is covered within Sexual and Reproductive Health services under Program Essential 5. For infant vaccinations, GC8 supported integration-enabling and service delivery costs of HBV birth dose. However, Global Fund will not cover vaccine commodity costs. Global Fund has messaged that countries should consider financing this through Gavi (if eligible) or domestic sources.

Triple test introduction: Forthcoming WHO prequalified triple tests for HIV, syphilis and HBsAg could offer an opportunity for cost-effective, integrated testing at ANC, and could be introduced during GC8. Guidance content on planning for triple test introduction and implications for GC8 applications is available in the Triple Tests Considerations within the Toolkit Resources.

Lenacapavir introduction: In 2025, WHO released new guidelines on lenacapavir for PrEP, with a strong recommendation. The PURPOSE 1 study, one of the two efficacy trials that provided the foundation for lenacapavir regulatory approvals and WHO's recommendation, included pregnant and breastfeeding women in the study population. Pregnancy data published separately (see Bekker et al, 2025) showed that lenacapavir was safe and well-tolerated during pregnancy and breastfeeding. Based on this data, early lenacapavir adopters, including Eswatini, Kenya, Mozambique, Zambia, and Zimbabwe, are delivering lenacapavir to pregnant and breastfeeding women through integrated delivery with ANC services. Injectable PrEP is included under the Global Fund intervention of "prevention of incident HIV among pregnant and breastfeeding women." With generic market entry expected by early 2027, countries can plan for introduction of lenacapavir, a six-monthly injectable PrEP option, early in GC8. Generic lenacapavir is expected to enter the market at USD$20 per dose (USD$40 per person-year) for injections and $17 for the oral loading

dose. The oral loading dose is required for anyone initiating, re-initiating, or switching from another PrEP product to lenacapavir.

2.4 RSSH Investments

Resilient and Sustainable Systems for Health (RSSH) investments are Global Fund resources dedicated to strengthening the cross-cutting building blocks of a health system—rather than focusing on a single disease in isolation. The Global Fund acknowledges that integration and specialized care are not mutually exclusive. The upfront RSSH investment is intended to create the "foundations and governance" that make integration possible, ensuring that when a patient walks into a PHC clinic or an ANC visit, the system—the workers, the tests, the drugs, and the data—is already unified to meet all their needs in a single encounter

For hepatitis, HR, and TE advocates, RSSH is not a separate ask—it is what determines whether population-level investments succeed or fail.

RSSH matters for hepatitis, HR, and TE for four reasons:

- **Sustainability and integration.** RSSH is the primary vehicle for moving away from siloed, vertical programs. It provides the framework to integrate hepatitis and TE services into existing PHC, ANC, and HR platforms—the delivery models that GC8 demands.
- **Clinical safety and quality.** Strengthening laboratory systems is critical for diagnosing HBV and HCV and monitoring treatment outcomes. Without functional diagnostic networks—including multi-disease platforms like GeneXpert for HCV RNA and HBV DNA testing—population-level screening and treatment targets cannot be met.
- **Workforce efficiency**. RSSH funds the transition to a polyvalent workforce: training health workers to provide a bundle of services (e.g., HIV, syphilis, and HBV screening) during a single patient encounter. WHO guidance on HCV and TE emphasizes task-sharing to non-specialist providers as essential for delivering treatment at scale.
- **Removing barriers.** By consolidating human rights and gender modules under RSSH, GC8 enables a systemic approach to addressing the stigma, criminalization, and legal barriers that prevent marginalized KVP from accessing HR and hepatitis services.

i) What changed from GC7 to GC8

The transition from GC7 to GC8 reflects a major strategic evolution toward “horizontal convergence” and self-reliance. Five shifts are directly relevant to hepatitis, HR, and TE:

Table 5: Key RSSH shifts from GC7 to GC8: implications for hepatitis, HR, and TE

Strategic shift	GC7	GC8
A. Mandating Primary Health Care Integration	Integration was encouraged but often resulted in fragmented, disease-specific system support.	Integration into Primary Health Care is now an imperative for sustainability. *Note: For instance, it can be interpreted that TE is no longer a standalone "HBV" or "HIV" activity but an "imperative for sustainability" through PHC integration. Similarly, merging HBV/HCV screening into HR platforms for PUD and ANC settings for TE.*
B. Workforce transformation toward	Although a shift from disease-specific support to integrated HRH strategic planning—and from	Prioritize converging HRH investments to enable more integrated service delivery (polyvalent cadre). Discourage disease-specific

integrated polyvalent cadres	piecemeal, standalone CHW investments to scaled-up, integrated community health programs—was encouraged, workforce investments could still be implemented separately under HIV, TB, or malaria modules.	health workforce investments when an integrated approach is more cost-efficient. *Note: This is critical for TE - supporting training of midwives and nurses to provide integrated HIV, syphilis, and HBV care rather than relying on specialist-led models.*
C. Data-Driven Maturity Prioritization	Prioritization was often based on "data-driven discussion on the priorities and gaps" identified during country dialogues.	Prioritize cost-effective systems investments that directly improve the sustainability of interventions, based on context-specific data, including systems maturity assessments. *Note: Hepatitis and TE are more likely to be prioritized when integrated into mature, cost-effective systems with clear impact, while harm reduction—often reliant on enabling policies, community systems, and strong data—may be deprioritized where these conditions are weak.*
D. Institutionalizing social contracting for community financing	Focused on institutional capacity strengthening—building the governance and financial management of CSOs so they could deliver services at scale	The priority has shifted to "social contracting". The highly emphasized goal is to incentivize community systems integration and financing by enabling CSOs and CBOs to receive direct government funding. *Note: Hepatitis, TE, and especially harm reduction benefit from government funding of community-delivered services, but impact depends on supportive policies and governments' capacity to contract CSOs.*
E. Innovation of the systemic delivery model.	The approach largely focused on increasing inputs—such as salaries, equipment, trainings, and other commodities—to improve program outcomes. Investments in tools and hardware were often treated as standalone inputs.	A shift is proposed toward strategic, country-led prioritization and market shaping to support the introduction and scale-up of innovations. This includes mandating approaches like all-inclusive pricing (AIP), where procurement bundles equipment with service, maintenance, and training. The goal is to move from simply purchasing commodities to ensuring their sustained functionality, effective deployment, and long-term system integration—thereby supporting scalable and sustainable innovation.

Specifically, GC8 RSSH investments for viral hepatitis, HR and TE can be included across nine of the eleven RSSH modules. Rather than treating all nine equally, this section identifies the modules most directly relevant to each population grouping, followed by a full module reference table for applicants who need the complete picture.

Table 6: RSSH modules most relevant to viral hepatitis, harm reduction and triple elimination in GC8

RSSH Module	How the Module Supports Viral Hepatitis and Triple Elimination Programming
Health Sector Governance and Integrated People-Centered Services	Supports policy development, strategic planning, and coordination for integrated hepatitis and Triple Elimination services, including decentralization to primary health care and engagement with private sector providers.
Community Systems Strengthening	Builds capacity of community-led organizations to support outreach, peer navigation, community-led monitoring, advocacy, and linkage to hepatitis and TE services.

Health Financing Systems	Strengthens sustainability by integrating hepatitis services into national insurance and benefit packages, supporting domestic financing and transition planning, social contracting for community services, and innovative financing approaches.
Health Products Management Systems	Ensures reliable access to viral hepatitis medicines and diagnostics through all-inclusive pricing, strengthened procurement, supply chain management, regulatory systems, and inclusion in national essential medicines and diagnostics lists.
Human Resources for Health and Quality of Care	Expands workforce capacity through training, task-sharing policies, supportive supervision, and integration of hepatitis and Triple Elimination competencies into health worker and community health worker programs.
Laboratory Systems	Strengthens integrated diagnostic networks by optimizing multi-disease testing platforms, specimen referral systems, laboratory supply chains, and data systems to support hepatitis testing and monitoring.
Monitoring and Evaluation Systems	Improves data availability and use by integrating hepatitis indicators into national health information systems, strengthening surveillance, supporting program reviews, and generating operational research.
Reducing Human Rights-Related Barriers	Promotes equitable access through stigma reduction, legal literacy, access to justice, law enforcement sensitization, and policy reforms supporting key and vulnerable populations.
Reducing Gender-Related Vulnerabilities	Addresses gender-related barriers by strengthening women's decision-making power, integrating hepatitis services into gender-based violence services, and improving equitable access to care.

ii) Key framing principles for RSSH investments

When building your RSSH ask, three principles determine whether it will withstand CCM and TRP scrutiny:

1. *Integration, not parallel systems.* RSSH investments should converge hepatitis and TE services into existing HIV, MNCH, and primary health care platforms. Investments that create standalone hepatitis infrastructure are unlikely to be defensible under GC8.
2. *System strengthening, not cost substitution.* GC8 guidance is explicit that RSSH investments should build system capacity, not substitute for recurrent costs — including health worker salaries, commodity procurement, and program management costs — that governments are expected to absorb domestically. Draw a clear line in your application between what GF finances and what domestic or partner financing covers.
3. *Anchor to the TRP's distinction between health system support and health system strengthening.* The TRP distinguishes between investments that support a specific disease program (health system support, less defensible as RSSH) and investments that strengthen systems more broadly (health system strengthening, more defensible). Laboratory systems strengthening that explicitly names HBV and HCV as target conditions is a stronger RSSH anchor than a request for laboratory support framed around a single disease program.

3. Navigating the GC8 Process

3.1 Summary of GC8 Process and Key Considerations

As outlined in Section 1.3, most countries face flat or reduced allocations in GC8 compared to GC7. GC8 emphasizes rigorous prioritization, integration within primary health care, and pathways to self-reliance — reflecting the Global Fund's six strategic shifts for this cycle (see 1.3). For hepatitis, HR, and TE advocates, this context demands sharper positioning, tighter integration, and stronger value-for-money (VfM) framing than in any prior cycle.

i) Where viral hepatitis, harm reduction and Triple Elimination investments sit in the GC8 application

Investments are categorized under four primary components: HIV, TB, Malaria, and Resilient and Sustainable Systems for Health (RSSH). Hepatitis, HR, and TE activities sit primarily within the HIV component, with systems-level investments under RSSH. Countries should refer to the three complementary documents that together structure GC8 guidance (see Section 2): the Modular Framework Handbook (eligible modules, interventions, and activity descriptions); the HIV Prioritization Guidance (the 28 Program Essentials and Rigorous Prioritization considerations — Areas prioritized for GF investment, Opportunities to increase optimization and efficiency, and Activities of lower priority (context dependent)); and the Enabling Impact guidance [pending publication] (cross-cutting themes including VfM, integration, sustainability, human rights and gender barriers, and climate).

To build a funding request for GC8, countries must organize programmatic activities into standardized modules and interventions (defined in the Modular Framework Handbook). Below are the key components of the GC8 applications:

- **Main allocation - module narratives** — the primary location for articulating the rationale, scope, and Program Essential alignment for each proposed intervention.
- **Prioritized Above Allocation Request (PAAR)** - countries can include additional priorities in the PAAR, which identifies investments that could be funded if resources become available during implementation. Interventions not funded at grant start may be categorized as Unfunded Quality Demand (UQD – a formal GF mechanism for documenting unfunded priorities for potential future inclusion) and considered for future funding through grant efficiencies or portfolio optimization. For hepatitis, HR and TE investments that cannot be accommodated in the main allocation, the PAAR is a strategic place to document and protect them.
- **Detailed budget** — all activities and associated costs must be linked to specific modules and interventions.
- **Performance Framework** — indicators and targets must be selected and linked to the modules included in the application. GF core indicator coverage for hepatitis, triple elimination, and harm reduction investments is limited — GC8 introduces TCS-11 (Proportion of people starting ART who were tested for HCV) as the first hepatitis-specific routine indicator, but comparable indicators for HBV among PLHIV, HCV/HBV among KVP, and HBV screening in ANC remain absent. Countries are likely to need country-specific indicators to adequately track these investments.
- **Funding Priorities from Civil Society and Communities annex** — introduced in GC7, this mandatory annex for Full Review Funding Requests formally captures the key funding priorities (typically the top ~20 asks) identified by communities and civil society during Country Dialogue. It provides a strategic opportunity for advocates to ensure hepatitis; HR and TE priorities are on record, even where they may not be fully reflected in the main allocation. During the TRP review, the main funding request is assessed to ensure annex priorities are reflected. This annex is mandatory for countries with High Impact and Core portfolios and applying using the

Full Review funding request— GC8 portfolio categorizations[14] and associated application approaches were communicated in country allocation letters in March 2026.

ii) What CCMs and the TRP will focus on

Building on the TRP focus areas outlined in Section 1.3, reviewers will assess hepatitis, harm reduction, and triple elimination investments through the following operational lenses at the application review stage:

- **Integration with PHC. Applications should demonstrate how services are integrated within PHC platforms rather than delivered through standalone or parallel structures.** The GC8 guidance acknowledges that specialized services must be maintained where necessary to avoid quality loss from poorly planned integration - so the messaging is appropriate integration, not integration at any cost.
- **Rigorous prioritization grounded in epi and program data.** CCMs must demonstrate data-driven prioritization, using country epidemiology and program coverage data to determine the optimal mix and scale of interventions that maximize impact. Applications that include hepatitis without a clear prioritization rationale risk being flagged or deprioritized.
- **Value for money.** The TRP assesses VfM across three core dimensions: effectiveness (does the intervention work?), efficiency (does it reduce duplication and cost?), and equity (does it reach those most at-risk?). Peer-reviewed cost-effectiveness evidence across all three areas — triple elimination, HBV/HCV testing and treatment, and integrated HCV testing within harm reduction platforms — is summarized in Section 1.1(ii).
- **Pathways to self-reliance.** Allocation letters now explicitly communicate transition pathways and timelines, alongside funding conditional on meeting co-financing targets. CCMs must focus on increasing domestic financing and progressive take-up of key costs, such as first-line treatments and HRH remuneration. Hepatitis investments must be mapped to clear domestic or partner financing pathways for items outside GF scope.
- **Integrated systems planning (RSSH).** For RSSH, countries are encouraged to use maturity assessments (e.g., for community health workers, laboratories, and supply chain) to identify gaps and prioritize foundational system investments. This is especially relevant for hepatitis laboratory and data system investments.
- **Accelerating innovation.** The TRP looks for rapid and equitable deployment of new tools—such as triple RDTs (HIV/syphilis/HBV), low dead space syringes, long-acting injectables and digital technologies—integrated into people-centered services.

Investments framed as integrated, targeted, and catalytic—rather than standalone additions—are most likely to withstand CCM and TRP scrutiny.

iii) Common pitfalls

The following pitfalls have been consistently flagged by the TRP and GF Secretariat. Each is directly relevant to hepatitis, HR, and TE positioning:

- **Siloed country dialogue.** CCMs often fail to move beyond disease-specific silos. GC8 requires an integrated, holistic dialogue on how to maximize the total country allocation alongside domestic and other partner funding. Hepatitis, HR, and TE advocates must be at the table during this dialogue, not brought in late as an addition.
- **Vertical workforce investments.** The Global Fund discourages funding for new, single-disease health worker cadres or CHWs. Instead, it prioritizes a polyvalent workforce integrated into the national PHC strategy. Frame hepatitis training as competency-building within existing cadres.
- **Inefficient training models.** Short-term, off-site, or hotel-based refresher trainings are considered lower-priority. Budget instead for integrated supportive supervision, clinical mentoring, and blended learning.

[14] The Global Fund determines each country's portfolio categorization at the start of each grant cycle based on country allocations and disease burden. See: https://resources.theglobalfund.org/en/policies-requirements/portfolio-categorization/

- **Parallel data systems.** Investing in disease-specific or parallel community-led monitoring (CLM) that is not linked to national quality assurance or program improvement cycles is discouraged. Hepatitis indicators should be integrated into existing national HMIS and M&E systems.
- **Incomplete or overlapping investments.** Reduced donor support and an intent to scale-up domestic contributions can create gaps or duplication across funding sources. Ensure a comprehensive set of services across funding sources (e.g. commodities through one source and programmatic implementation through another) with no gaps or overlap in asks.
- **Ignoring transition realities.** Failing to plan for progressive take-up of operating costs, particularly in upper-middle-income countries, leads to negative TRP assessments on sustainability. Show a clear domestic absorption pathway.

iv) Key principles for defensibility

Applications that secure and protect hepatitis, HR, and TE funding in GC8 share these features:

- **PE-anchored**. Investments are anchored to one or more of the four directly relevant Program Essentials (PE3, PE5, PE11, PE16 — see Section 1.1).
- **Integrated multicomponent request.** The Global Fund strongly recommends submitting a single multicomponent funding request to demonstrate a unified model for maximizing impact. Hepatitis, HR, and TE investments should be woven throughout—not siloed in a separate annex.
- **Catalytic rationale.** Clearly explain how GF resources complement domestic budgets and other donor funding to catalyze progress—not merely replace existing funds. Show how each investment unlocks broader HIV program performance or system capacity.
- **Evidence-based prioritization.** Defend selected interventions by demonstrating they are superior to alternatives based on the latest epidemiological data, program gaps, and cost-effectiveness analysis. The strongest applications make trade-offs visible.
- **Disaggregated data use.** Resource allocation must be based on data disaggregated by age, sex, KVP status, and geography to prove that investments explicitly aim to close health access and outcome gaps for those at highest risk.
- **Rights-based design.** Funding requests must meet minimum human rights standards: non-discriminatory care, informed consent, data privacy, and access for criminalized populations.
- **Community leadership.** Demonstrate that programs were designed with and for affected communities, and that community-led organizations are meaningfully engaged in service delivery and oversight.
- **Grant Ready readiness.** CCMs can strengthen defensibility by nominating well-performing, continuing Principal Recipients (PRs) early, enabling granular, grant-level performance frameworks and budgets alongside the funding request.[15]

The bar for defensibility in GC8 is higher. But hepatitis, HR, and TE investments that are PE-anchored, integrated, VfM-driven, and equity-focused are among the most defensible in the HIV portfolio.

3.2 How to Get Your "Ask" into the GC8 Application

The steps below are not rigid phases with fixed timelines—country processes vary significantly, and many of these activities will overlap or run in parallel. They are organized to reflect the logical sequence from evidence-building through to submission.

[15]The Grant Ready pathway allows CCMs that nominate a continuing, well-performing Principal Recipient (PR) early to develop granular, grant-level performance frameworks and budgets alongside the funding request, enabling faster grant-making.

Step 1: Build the evidence base

Before formal country dialogue begins, proponents of hepatitis, HR, and TE investments should assemble the evidence that will justify inclusion:

- **Maturity assessments.** Where possible, leverage GF-validated maturity assessments for laboratory systems, supply chain, and CHWs to identify foundational gaps that your investment can help address. This is especially relevant for hepatitis diagnostic networks and commodity supply chains.
- **National documentation.** Review your country's National Strategic Plans (NSPs) and costed operational plans. The GC8 Full Review application requires referencing these documents (section and page) rather than re-writing context.
- **Gap analysis.** Use the Programmatic Gap Table and Funding Landscape Table[16] to demonstrate that the intervention is not currently covered by domestic or other donor funding. This establishes the financing gap that GF resources are intended to fill.
- **Cost-effectiveness evidence.** Peer-reviewed cost-effectiveness evidence supporting hepatitis, harm reduction, and triple elimination investments is summarized in Section 1.1(ii). Reference this evidence in VfM narrative and in CCM discussions.

Toolkit Resources*:* Use the Readiness Scorecard within the *Toolkit Resources* to determine your level of ambition before engaging in country dialogue. Review the GC7 Country Illustrations within the *Resources section* for precedents from comparable countries.

Step 2: Engage in the integrated country dialogue

GC8 mandates that country dialogues move away from disease-specific silos. Hepatitis, HR, and TE advocates must participate in the combined dialogue and not present their ask separately:

- **Holistic discussion.** Proponents must participate in a combined dialogue where HIV, TB, malaria, and RSSH stakeholders discuss the total country allocation together. Hepatitis framed as an isolated "add-on" will not survive this process—it must be positioned as strengthening HIV program performance.
- **Community leadership.** Ensure that representatives from KVP, PLHIV, and affected communities are involved in the design of the request. The TRP looks for evidence that programs are designed with and for affected communities. The Civil Society and Communities annex is where this is formally captured.
- **Integration task forces.** In many countries, an integration task force oversees how disease-specific services come together into PHC platforms, with some countries creating new intervention working groups for this GC8 planning cycle. Engage with these mechanisms early where they exist.
- **Program split awareness.** During country dialogue, track the program split discussion — the CCM's decision on how to divide the total allocation between disease components and RSSH. Hepatitis, harm reduction, and triple elimination investments can sit in both HIV and RSSH modules (e.g., laboratory strengthening, data systems, workforce). Position investments to benefit from both disease and systems allocations where appropriate.

Step 3: Map the ask to the Modular Framework and PEs

Once the priority is agreed upon, it must be correctly coded into the GC8 Modular Framework to ensure it is budgeted and monitored properly. Refer to Section 2 for mapping of Program Essentials and activities by population groups. Additionally, ensure that relevant new health products prioritized for scaling in GC8 HIV Prioritization Guidance, HIV

[16] The Programmatic Gap Table and Funding Landscape Table are mandatory annexes in the GC8 Full Review application package. See GC8 Applicant Guidance.

Products —including triple RDTs, pan-genotypic DAAs, and low dead space syringes are considered and, where appropriate, included.

Toolkit Resources: The Module and Activity Mapping resource within the *Toolkit Resources* provides detailed module and activity mapping. Use the Country Assessment Template to build a defensible, integrated package.

Step 4: Articulate the VfM defense

The TRP will rigorously assess every investment against VfM criteria. For hepatitis, HR, and TE, three dimensions are most critical:

- **Allocative efficiency.** Use modelling tools where available to show that your investment maximizes impact of available resources. Target investments to the populations and geographies with the highest burden and greatest unmet need.
- **Technical efficiency.** Demonstrate how integration into existing platforms reduces duplication. Examples: multi-disease molecular platforms (GeneXpert) for both TB and HCV testing; affordable triple test enabling simultaneous screening for HIV, syphilis, HBV by one healthcare worker; shared commodity procurement through the Pooled Procurement Mechanism.
- **Equity rationale.** Defend the ask by showing it explicitly aims to close health access and outcome gaps for marginalized or hard-to-reach populations—PUD, KVP, pregnant women in high-HBV-burden settings. Use disaggregated data by age, sex, KVP status, and geography.

Toolkit Resources: Use the Sample Advocacy Language within the *Toolkit Resources* for CCM justification and TRP narrative framing. Use the Costing and Budgeting Guide for credible, VfM-aligned budgets.

Step 5: Address the PAAR

Because allocations are lower, many technically sound interventions will not fit in the initial budget. The PAAR is a critical safeguard:

- **Protect unfunded priorities.** If your hepatitis, HR, or TE investment is prioritized but cannot be accommodated in the main allocation, place it in the PAAR. This has been a critical mechanism in prior cycles for bringing in hepatitis investments mid-grant when underspend or additional resources become available.
- **Unfunded Quality Demand (UQD) register.** Interventions not funded at grant start can be placed on the UQD register and considered for future funding through grant efficiencies or portfolio optimization.

Step 6: Choose the submission route

The CCM must decide how to present the request:

- **Single multicomponent request.** The Global Fund strongly recommends a single, integrated funding request for all eligible disease components and RSSH. Hepatitis, HR, and TE investments should be woven throughout this integrated application—not submitted as a standalone package.
- **Grant Ready option.** If the CCM nominates a continuing, well-performing Principal Recipient early, they can develop granular performance frameworks and detailed budgets alongside the funding request. This strengthens defensibility by demonstrating immediate implementation readiness.
- **Transition/Focused pathway.** Countries on a transition pathway submit a shorter application. In this context, hepatitis, HR, and TE investments must be framed around continuity and domestic financing—not scale-up.

The process is not linear and timelines vary by country. But the logic is consistent: build the evidence, engage early, map correctly, defend on VfM, protect the unfunded, and submit as part of an integrated package.

3.3 CHAI's Toolkit Resources

Ready-to-use Templates and Reference Materials

CHAI has developed seven resources to support countries to build a defensible GC8 application for hepatitis, harm reduction, and triple elimination. Each resource can be used independently — go directly to the resource that matches your current need. **'Step'** references correspond to Section 3.2 of the Toolkit.

Resource	Description	Primary audience	Relevant step(s)
Ready-to-use templates			
Readiness Scorecard	Scoring tool to determine the appropriate level of ambition and primary PE anchor(s) — applied separately per population group (PE11, PE16, PE3/PE5). Produces a recommended GC8 positioning.	CCM leads, technical working groups, technical assistance partners	**Step 1:** Build the evidence base
Country Assessment Template	Structured working template to translate GC8 positioning into a defensible investment case — covering PE anchor selection, current financing map, risk and reprioritization analysis, and PAAR planning. Complete once per population group.	Technical working groups, CCM secretariats, principal recipients	**Step 2:** Engage in integrated country dialogue **Step 3:** Map to the Modular Framework **Step 4:** Articulate the Vfm defense **Step 5:** Address the PAAR
Sample Advocacy Language	Ready-to-adapt narrative language for the GC8 HIV funding request. Part A covers cross-cutting rationale (integration, VfM, equity). Part B provides population-specific module narrative by PE.	Country advocates, civil society representatives, CCM members, technical writers	**Step 2:** Engage in integrated country dialogue **Step 4:** Articulate the VfM defense
Costing and Budgeting Guide	Practical costing framework aligned to GC8 Program Essentials — with illustrative unit costs, clear GF-financed vs domestic/partner cost boundaries, commodity guidance, and VfM framing by population group.	Finance staff, principal recipients, technical advisors supporting budget development	**Step 4:** Articulate the VfM defense **Step 6:** Choose the submission route
Reference materials			
GC7 Country Illustrations	Country-level evidence of how hepatitis, HR, and TE were included in GC7 across Africa and Asia — covering context, challenges, what worked, and key implications for GC8.	CCM leads, country teams, national hepatitis advocates	**Step 1:** Build the evidence base
Triple Test Considerations	Guidance on triple combination test (HIV/syphilis/HBsAg) planning within GC8 — product landscape, anticipated WHO prequalification timelines, country readiness pathways, and a decision framework for introduction planning.	Technical advisors, laboratory teams, hepatitis advocates in countries planning triple test introduction under PE11	**Step 1:** Build the evidence base **Step 3:** Map to the Modular Framework and PEs
Module and Activity Mapping	Detailed tables of GC8 modules, interventions, and illustrative activities per population group, drawn from the GC8 HIV Prioritization Guidance and Modular Framework. Includes prioritization status and GF financing boundaries.	Technical advisors, program officers, principal recipients	**Step 3:** Map to the Modular Framework and PEs