

GC7 Country Illustrations

What is this: 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.

Who it's for: CCM leads, country teams, national hepatitis advocates

How to use: Review before engaging in country dialogue to benchmark ambition and anticipate challenges based on comparable country experience. Use alongside the GC7 lessons in [Section 1.2 of the Toolkit](#), which synthesizes the strategic implications at the global level.

The section below examines the context, key challenges, and opportunities faced by selected countries across Africa and Asia during the GC7 application process. It explores how country-led advocacy for hepatitis integration translated into tangible inclusion in funding requests.

Cambodia Country Case Study



Lessons learnt from the GC7 application process

Hepatitis Landscape: Disease Burden, Policy and Financing

1Mn

Since 2023, USD 1 million in annual domestic funding has been secured for HCV and HBV screening, testing, and treatment, led by the Ministry of Health–CDC and implemented across 15 rural operational districts (ODs), mainly targeting the general population for program roll-out in 2024.

HBV

4.39%

Among nearly 270,000 pregnancies annually, an estimated HBsAg prevalence of 4.39% was recorded in mothers. Since 2024, HBV PMTCT services – HBsAg and HBeAg testing, TDF prophylaxis – are available in all public facilities in Phnom Penh, the nation’s capital. Commodities for service provision in Phnom Penh are covered by the GC6 RSSH grant.

In 2025, Cambodia simplified HBV PMTCT clinical guidelines. This enabled public health facilities outside of Phnom Penh (within 15 ODs that have HBV services) to provide HBsAg testing and TDF to eligible pregnant women (without HBeAg confirmatory tests). However, no additional budget was made available for PMTCT service provision.

HCV

9.4%



Among 77,000 PLHIV in Cambodia, around 9.4% also live with HCV.

Under GC6, HCV services for PLHIV were led by the National Center for HIV/AIDS, Dermatology and STD (NCHADS) and included PLHIV’s partners and key populations registered for PrEP.

Key Opportunities and Challenges



GFATM RSSH grant supported TE efforts and initial success of antennal screening and prophylaxis in Phnom Penh in 2021 built the case and foundation for further scale up. In 2025, the national HBV guidelines were updated and simplified, enabling faster scale-up of services.

Despite annual domestic financing of USD 500,000 for HBV programming, funding is limited to the general population, with no dedicated allocation for integrated TE efforts.

Initial results from the HIV/HCV co-infection program funded by GFATM from 2017-2019 informed national strategic plans and guidelines, setting up the foundation for nationwide elimination targets.

However, limited annual domestic financing of USD 500,000 for HCV restricted intervention scale-up beyond already defined geographies.

Approach to GC7 application



Prioritized HBV screening and treatment for pregnant women in Phnom Penh and rural ODs where hepatitis service is already provided.



Defined comprehensive hepatitis scope within the GC7 application, covering HCV coinfection among PLHIV and HCV mono-infection among partners of PLHIV, PrEP clients, and PWID, including commodities procurement and core programmatic activities (training and supervision);



• Anchored hepatitis integration in existing national HIV and maternal health platforms, ensuring alignment with national strategies and feasibility within GFATM grant structures.



• Built broad stakeholder alignment through engagement with NGOs serving key populations, CCC members, and national programs to articulate the value, scope, and feasibility of hepatitis interventions under GFATM.



• Used national planning and review processes (e.g., HIV NSP Midterm Review) to embed hepatitis priorities, including TE and continued HCV screening and treatment for PLHIV and expanded prevention and care for PWID and pregnant women.



• Targeted technical assistance, provided by CHAI, helped convert advocacy into concrete, costed hepatitis components.

GC7 Application Outcome



Prior to 2025 Reprioritization

HBV: Screening and prophylaxis for pregnant women in for Phnom Penh. HBeAg testing to pregnant women in Phnom Penh and rural ODs where hepatitis service is already provided.

HCV: Screening and treatment for PLHIV co-infected with HCV and their partners who are co- or mono-infected, as well as mono-infection in PrEP eligible clients and key populations (MSM, TG, FEW, PUD).

RSSH: Coordinated assessment across disease programs for monitoring and evaluation of data and strategy shaping.

Post 2025 Reprioritization

Limited additional procurement of certain commodities (e.g., HCV RDT, SOF/DCV) especially when stocks remain. Any potential shortfall in commodities to be covered by domestic budget.

Programmatic Impact



For the period from January 2024 to September 2025, over 26,000 pregnant women were screened for HBsAg.

For the same period, nearly 10,000 PLHIV were screened for HCV, over 600 screened positive (~6% prevalence), and over 300 initiated treatment (Note: Data on people with chronic HCV not captured).

Key Learnings



• Clear policy eligibility is necessary but not sufficient without early and sustained advocacy (across multiple platforms such as NSP reviews/revision, CCM discussions, NGO coordination, and workplan development).



• Costed, implementation-ready proposals to drive inclusion (defining target populations, service delivery settings, and fully costed activities made hepatitis components feasible within GFATM applications).



• Integration works best when anchored in existing platforms (embedding hepatitis services within established HIV, PrEP, harm reduction, and maternal health programs for increased acceptability and alignment with national priorities), though sustainability may be constrained if limited budgets hinder the long-term integration of newly added services.



• Stakeholder breadth strengthens proposals (e.g., national programs, civil society, and NGOs serving key populations helped legitimize hepatitis needs and broaden ownership).

Uganda Country Case Study



Lessons learnt from the GC7 application process

Hepatitis Landscape: Disease Burden, Policy and Financing



4.1%

National HBV prevalence in Uganda is 4.1% in the general population. Among Uganda's ~2,000,000 pregnant women annually, the prevalence was estimated at between 1-2%.

<1%

HCV prevalence in Uganda is generally low at <1%, and among ~1.4 million PLHIV, a prevalence of 0.24% was estimated. Given the low HCV prevalence in the country, there is limited program scope.

1.5 Mn

Overall, more than 1.5 million people in Uganda live with viral hepatitis. Uganda's hepatitis response is guided by four key documents which are strategically aligned and supported by investment cases: Viral Hepatitis NSP; Triple Elimination NSP; HIV/ AIDS NSP; and Syphilis NSP. Hepatitis interventions in Uganda are funded by a mix of resources from the Government of Uganda (~\$3 Mn annually), PEPFAR (>\$300 Mn annually) and GFATM (~530 Mn under GC6).

Key Opportunities and Challenges



- Uganda expanded HIV PMTCT programming to include Syphilis (2017) and HBV (2019). However, by 2023, progress on HBV PMTCT still lagged behind HIV and syphilis—highlighting the need for greater integration and coordination across programs. Challenges included:



Low awareness among communities and HCWs



Frequent stock-outs affected screening capabilities, with HepB-BD relying on adult vials.



Absent patient-level data and limited coordination between EPI and maternal/child health & PMTCT programs resulted in weak linkages for maternal long-term care and inconsistent HepB-BD delivery.

- Domestic funding for hepatitis programs has stagnated around USD 3 Mn, despite increased program scope, particularly HBV service coverage. This limits overall achievable impact.

Approach to GC7 application



- MoH engaged with PEPFAR/CDC and CSOs on alignment of HBV PMTCT commodities to be included in the GC7 application.
- This engagement enabled \$500,000 to be allocated to purchasing hepatitis B commodities including RDTs and viral load assays.
- The CCM team effectively articulated the hepatitis component under the PMTCT module, specifically outlining costing as well as the complete cascade of hepatitis care from screening to diagnosis and prophylaxis in alignment with GF funding priorities to maximize funding opportunities.

GC7 Application Outcome



Approved components included the following.



Procurement of HIV, syphilis, and HBV screening commodities (RDTs)



Procurement of HBV VL commodities and consumables



ART for HIV and TDF for HBV prophylaxis and treatment

Programmatic Impact



- GF funding contributed to national progress towards triple elimination, with hepatitis services integrated into existing HIV and maternal-health platforms through updated policies.
- Procurement of commodities, e.g., HBV test kits was also supported under GC7.
- CSOs received support to address structural barriers to service access, focusing on HBV prevention, testing, and stigma/discrimination reduction.
 - GF investments into lab networks, procurement systems and the healthcare workforce bolstered the country's overall health infrastructure.

Key Learnings



Clear articulation of the burden, and early identification of the key areas that require funding ensures effective planning and allocation.



Having hepatitis champions who actively advocate for hepatitis prioritization beyond just developing supportive guidelines, enhances the chances of integration of hepatitis in allocations.



Developing and clearly articulating high-impact interventions strengthens the case for investment.

Nigeria Country Case Study

Lessons learnt from the GC7 application process

Hepatitis Landscape: Disease Burden, Policy and Financing

10Mn

- Overall more than 15 million people lived with hepatitis B, C, or both; yet more than 80% of the people infected are unaware of their status, according to some estimates.
- The viral hepatitis policy landscape is guided by National Strategic Framework for on Viral Hepatitis Control in Nigeria 2022–202630; the Nigeria Immunization Policy / NPHCDA guidance on Hepatitis B birth-dose; and the NASCP / Federal MoH technical briefs and TWG outputs.
- Hepatitis interventions in Nigeria are funded through resources from multiple sources including the National Government, State Governments, GFATM, FCDO and Unitaaid.

HBV

5.4%

While HBV prevalence in the general population was estimated at 5.4% in 2022, among ~7.5 million pregnant women, 6.49% were estimated to have HBV.

HCV

1.1%

The national HCV prevalence was low at 1.1%. However, among 1.8 million PLHIV, an estimated prevalence of 4.7% was recorded.

Key Opportunities and Challenges

14%

Despite Nigeria's high burden of vertical transmission of HBV, large HBV testing and prophylaxis gaps exist amongst pregnant women, with 14% ANC testing coverage

With a high HCV burden, opportunities exist for targeted intervention. Local fundraising efforts have been driven by senior officials across different states.

Approach to GC7 application



Potential opportunities for Viral hepatitis investment areas were identified and costed through stakeholder consensus in-country.



Data analysis was undertaken by partners to support costing and determine volume, scope, and areas of focus.



Robust stakeholder engagement was conducted to advocate for inclusion of viral hepatitis, building on data generated through the analysis.



The GC7 HIV Information Note, particularly the provisions for hepatitis, was used to guide stakeholder engagements.

GC7 Application Outcome

For triple elimination, services among pregnant women that were approved included HBV rapid tests, HBV VL tests and consumables, TDF for HBV prophylaxis.

Approved components for key populations included HCV and HBV screening, viral load testing and treatment.

Programmatic Impact



GF support expanded access to \$60 DAA treatment and HBV and HCV testing and diagnosis in Nasarawa State and other states providing HCV services through the public health model.



Procurement of HBV testing and treatment commodities was funded under GC7.



GF investments supported health systems readiness assessments across 55 sites in 9 states, and is currently supporting triple elimination operational research across 9 states, assessing the feasibility of integrated testing and treatment at ANC including "test-and-treat" HBV integration to inform scale-up.



GF investments shaped the triple elimination policy landscape through support for the development of national policy documents and implementation guidance.



Work done under GC7 is also supporting development of a decentralized, simplified HBV PMTCT and HCV pathways to expand access.

Key Learnings



Early alignment and coordination with stakeholders across the hepatitis landscape was critical to avoid duplication and present a unified front.



Stakeholders' collaboration and buy-in is necessary in driving inclusion of focus areas. Given the political nature of the process, it is important to understand and accommodate for the perspectives of different stakeholders.



Comprehensive/robust data is essential to the process and can aid in prioritization of focus areas.



There is a need to clearly articulate areas of integration and sustainability, particularly linking investments to health systems strengthening efforts/outcomes.