Sample Advocacy Language and Justification

What is this: Ready-to-adapt narrative language for the GC8 HIV funding request, organized in two parts: Part A covers cross-cutting rationale for use across multiple application sections; Part B provides population-specific module narrative by PE.

Who it's for: Country advocates, civil society representatives, CCM members, technical writers

How to use: Select the blocks relevant to your country context and intervention package. Replace all bracketed text with country-specific data, targets, and financing details. The language is designed to be adapted and inserted directly into the relevant section of your application — it is not intended to be submitted as a standalone document.

Part A: Cross-cutting language

For use in GC8 Funding Request Form: Section 1.2 (Integration priorities), Section 2.1A (Strategic priorities of the funding request), Section 2.1D (Prioritization approach), Section 2.1E (Building upon existing investments), Section 3.1 (Sustainability)

Overall rationale for hepatitis and triple elimination integration

HBV and C and triple elimination represent high-value, clinically grounded integration opportunities within HIV programming. HIV/HCV coinfection accelerates progression to cirrhosis and liver cancer among PLHIV; HBV coinfection increases morbidity and mortality; vertical transmission of HBV remains the leading cause of chronic HBV infection globally; and HCV is highly prevalent among PUD and key and vulnerable populations due to shared injecting equipment and structural barriers to care. Integrating hepatitis and triple elimination services within HIV platforms — including ART clinics, ANC and PMTCT services, and harm reduction sites — addresses shared disease burdens across all three populations, directly supports HIV prevention and treatment outcomes, and aligns with GC8's emphasis on value for money through integrated service delivery.

In [country], the case for integration is supported by [describe epidemiological evidence — e.g., HBsAg prevalence among pregnant women, HCV burden among PUD, HIV/HCV coinfection rates among PLHIV]. Existing HIV platforms provide established entry points for reaching populations with hepatitis services at marginal additional cost.

GC8 strategic fit

Under GC8, the Global Fund has explicitly elevated hepatitis and triple elimination through two new Program Essentials: PE11 (integrated testing for HIV, syphilis, and HBsAg in pregnancy) and PE5 (SRH services to support HIV prevention for key and vulnerable populations). Under PE5, HCV testing and treatment in harm reduction settings is a Priority activity; HBV testing and management for individuals at high risk accessing HIV prevention platforms is an Optimization activity. Harm reduction (PE3) and coinfection management in HIV care (PE16) continue as Program Essentials from GC7. Together, these four PEs provide a strong policy foundation for the investments proposed in this funding request.

The proposed investments are scoped to interventions directly integrated into HIV platforms, targeted to populations with documented need, and structured around service delivery and commodity costs. Activities outside GF scope — including vaccine commodity costs and long-term HBV treatment beyond pregnancy — are mapped to [Gavi / domestic financing / partner resources], consistent with GC8 sustainability expectations.

Prioritization rationale

Hepatitis and triple elimination investments were prioritized based on [describe process — e.g., epidemiological data, country dialogue outcomes, stakeholder consensus, GC7 lessons]. The proposed package represents the minimum viable scope that can be sustained and measured within GC8 constraints, assessed against GF Program Essential alignment, integration feasibility, delivery platform readiness, and co-financing availability. Items outside GF scope or identified

for progressive domestic absorption are mapped to alternative financing sources and transition timelines, as detailed in Section 3 of the Funding Request.

[If GC7 included hepatitis investments]: Building on GC7 experience, [describe what was included, what was learned, and what changes are being made for GC8].

[If new in GC8]: This is the first GC8 funding request to include hepatitis and triple elimination investments. Scope has been calibrated to what is feasible within existing platforms and available financing.

Sustainability and financing

GF financing is targeted to incremental service delivery costs, commodities, and integration-enabling systems investments. [Describe domestic co-financing commitments — e.g., government financing of HBV vaccine procurement through Gavi, domestic budget for HBV treatment post-delivery, PEPFAR contributions to harm reduction]. RSSH investments included in this request support the sustainability of hepatitis services by [describe — e.g., integrating hepatitis indicators into national HMIS, strengthening laboratory networks, building CHW capacity].

This funding request includes targeted RSSH investments that address the system-level enablers required to sustain hepatitis, harm reduction, and triple elimination services at scale. These investments are designed around integration into existing HIV, MNCH, and primary health care platforms rather than standalone infrastructure; deliver value for money by leveraging shared diagnostic networks, multi-disease supply chains, and polyvalent health workforces to reduce unit costs across disease areas; and support sustainability by building domestic system capacity in [describe — e.g., national procurement systems, HMIS, laboratory networks, community health workforce] that will outlast GF financing. RSSH priorities have been informed by GC8 maturity model assessments in [describe areas assessed — e.g., laboratory systems, community systems, supply chain, digital health], which identified [describe key bottlenecks] as the binding constraints to integrated service delivery. In line with GC8 RSSH prioritization guidance, RSSH investments in this request are scoped to system-strengthening activities — not health worker remuneration, program management, or recurrent operational costs — which are mapped to domestic financing as part of the country's transition pathway.

Note: Please refer to the *Toolkit Section 2 and* Module and Activity Mapping *resource* for example of RSSH activities.

Part B: Population-specific module narrative language

For use in: Section 2.1B (Module narratives) and Performance Framework

Each population section focuses on the primary hepatitis and TE-relevant Program Essentials. Paragraphs are labelled to indicate when they apply — select those relevant to your intervention package and omit the rest.

Pregnant women, breastfeeding women and infants *Module: Elimination of Vertical Transmission of HIV, Syphilis and HBV. Primary PE anchor: PE11 (new for GC8)*

- **Epidemiological rationale** (include in all packages): In [country], HBsAg prevalence among pregnant women is estimated at [X%], with [describe gaps in testing coverage, linkage to care, and prophylaxis]. Vertical transmission of HBV remains a significant contributor to preventable chronic liver disease, yet integration of HBsAg testing into routine ANC has [describe current state].
- **Intervention scope and PE alignment** (include in all packages): This module strengthens implementation of the triple elimination agenda by integrating systematic HBsAg testing into routine ANC alongside existing HIV and syphilis screening, anchored in Program Essential 11. Syphilis testing for pregnant women is a Priority activity under PE11, with syphilis treatment for syphilis-seropositive women supported under the Treatment, Care and Support module — test kit costs are GF-eligible where not already covered by other financing sources. Services are delivered through established ANC and PMTCT platforms, with targeted provider training, supervision, and clearly defined referral and linkage pathways for HBsAg- and syphilis-positive women in line with national protocols and WHO guidance.

- **HBV prophylaxis and postnatal care** (include if HBV prophylaxis is in scope): For women identified as HBsAg-positive, tenofovir prophylaxis is included where WHO eligibility criteria are met. Postnatal prophylaxis for HBV-exposed infants is included, with infant HBV birth dose vaccination service delivery supported — vaccine commodity costs are financed through [Gavi / domestic]. Long-term HBV treatment for mothers beyond pregnancy is mapped to [domestic / partner] financing.
- **Scope and value for money** (including in all packages): The scope is limited to integration-enabling activities and core service delivery within routine ANC and postnatal care, avoiding parallel delivery structures. GF financing covers [testing commodities, service delivery, training, quality assurance]. This package leverages existing ANC contacts, counselling workflows, and supply chains, adding incremental delivery costs while improving early detection and prevention of mother-to-child transmission of HBV. Integration with existing PE11 HIV and syphilis activities avoids duplication and maximizes the efficiency of each ANC visit.
    - Integrating HBV screening, vaccination, and maternal antiviral prophylaxis into existing antenatal care and PMTCT platforms is among the most cost-effective health interventions available. In Burkina Faso, adding a HBV birth dose to the existing vaccination schedule — preceded by antenatal HBsAg screening — cost just US$18 per DALY averted (Gosset et al., Vaccine, 2021), and in Ethiopia, universal tenofovir prophylaxis for all HBsAg-positive pregnant women cost US$220 per DALY averted with a 97% probability of being cost-effective (Negasa et al., BMC Public Health, 2025).
- **Expected impact:** [Describe expected outcomes — e.g., increase HBsAg testing coverage among pregnant women from X% to Y%; increase percentage of HBsAg-positive pregnant women receiving prophylaxis from X% to Y%. Adapt to reflect interventions included.]
- **Suggested indicators**
    - Number and percentage of pregnant women tested for HBsAg at least once in pregnancy
    - Number and percentage of HBsAg-positive pregnant women receiving recommended prophylaxis per protocol (include if prophylaxis is in scope)
    - Availability of HBsAg testing commodities at ANC sites

  Data sources: [DHIS2, ANC registers, LIS]. GF core indicator coverage for HBsAg testing is limited — country-specific indicators are likely needed.

Bonus: The table below outlines the core indicators for the triple elimination of mother-to-child transmission (EMTCT) of HIV, syphilis, and HBV virus (HBV), identifying which are currently included in the Global Fund (GF) Grant Cycle 8 (GC8) core indicator list and those recommended by global guidelines which Countries can consider including.

	HIV	Syphilis	HBV (HBV)
IMPACT			
Global Fund Indicators (Modular Framework)	• Indicator: HIV I-6 Module: All modules Description: Estimated percentage of children newly infected with HIV from MTCT among women living with HIV delivering in the past 12 months. Disaggregation: None listed.	None included in the core impact indicator list.	None included in the core impact indicator list.
Global guidelines (WHO)[1]	• New pediatric HIV infections due to MTCT of <= 50 cases per 100,000 live births.	• Congenital Syphilis (CS) case rate of <=50 per 100,000 live births.	• Prevalence of HBsAg in children <=5 years old of <=5 0.1%.

[1] https://www.who.int/publications/i/item/9789240086784

	• MTCT rate of <2% in non-breastfeeding populations OR <5% in breastfeeding populations.		• MTCT rate of <=5 2% (for countries using targeted timely birth dose).
PROCESS/OUTCOME			
Global Fund Indicators	• Indicator: VT-1 Module: Elimination of Vertical Transmission Description: Percentage of pregnant women who know their HIV status. Disaggregation: HIV status (positive, negative, unknown). • Indicator: TCS-10 Module: Treatment, Care and Support Description: Percentage of pregnant women living with HIV who received ART to reduce risk of vertical transmission. Disaggregation: None listed.	•Indicator: VT-3 Module: Elimination of Vertical Transmission Description: Percentage of women accessing antenatal care (ANC) services who were tested for syphilis. Disaggregation: None listed.	None included as a standalone coverage indicator in the core list.
	Integrated RSSH Indicators: GF includes an integrated outcome indicator (RSSH O-1.1) to measure the percentage of facilities providing integrated RMNCH, HIV, TB, and malaria services to pregnant women, which supports the "triple elimination" delivery platform.		
Global guidelines (WHO)	• ANC coverage (at least one visit) of <= 95%. • HIV testing coverage of pregnant women of <= 95%. • ART coverage of pregnant women living with HIV of <= 95%.	• ANC coverage (at least one visit) of <= 95%. • Syphilis testing coverage of <= 95% among those attending ANC. • Adequate syphilis treatment of syphilis-sero-positive pregnant women of <= 95%.	• HepB3 vaccine coverage of <= 90%. • Timely HepB birth dose coverage of <= 90%. • Maternal HBsAg testing coverage of <= 90%. • Antiviral coverage for eligible HBsAg-positive pregnant women of <= 90%.

People Living with HIV (PLHIV) *Module: HIV Treatment, Care and Support. Primary PE anchor: PE16 (continuing from GC7)*

- **Epidemiological rationale** (include in all packages): Among PLHIV in [country], HIV/HCV coinfection prevalence is [X%] and HBV coinfection is [X%]. Hepatitis co-infection accelerates progression to liver disease and increases mortality among PLHIV, with direct implications for HIV treatment outcomes. Addressing hepatitis within HIV care is both clinically indicated and consistent with GC8's emphasis on value for money through integrated service delivery.
- **HCV screening and management** (include if HCV is in scope): This module integrates targeted HCV screening and management into routine HIV treatment services under Program Essential 16, focused on populations with documented need in settings with high HIV/HCV coinfection burden. Services use existing ART clinic workflows and shared laboratory platforms. Untargeted HCV screening and standalone hepatitis services outside HIV care

platforms are excluded, consistent with GC8 lower-priority guidance. HCV services are delivered through integrated, low-cost delivery models in line with GC8 Optimization guidance.

- **HBV screening and management** (include if HBV is in scope; note this is context-dependent and lower-priority under GC8): HBV screening and management is included for populations most at risk already accessing HIV services, where HBV identification directly informs HIV clinical management. Where confirmatory testing or clinical staging is required, referral pathways, turnaround time targets, and responsible entities are clearly defined.
- **Scope and value for money** (include in all packages): Efficiency gains are achieved through shared laboratory infrastructure, integrated data systems, and coordinated clinical follow-up within existing ART clinic structures. This investment avoids duplication and reduces the marginal cost of hepatitis service delivery by leveraging platforms, workflows, and staff already in place for HIV care.
    - Integrating hepatitis screening and treatment into existing ART platforms is one of the most efficient uses of Global Fund investment, because the infrastructure, workforce, and even the drugs are already in place — tenofovir-based ART regimens treat both HIV and HBV simultaneously, meaning the only additional cost for HBV is a rapid screening test. For HCV, a real-world DAA program embedded in MSF's HIV clinic in Myanmar achieved a 96% cure rate among 122 co-infected patients, and when modeled as a simplified government-led protocol using existing ART staff and facilities, cost just US$316 per DALY averted PubMed Central — with 100% of simulations falling below the cost-effectiveness threshold (Marquez et al., BMJ Global Health, 2021). Critically, this figure is based on 2017 DAA prices; with current generic costs now as low as US$60 per treatment course, the intervention would approach cost-saving territory by averting expensive downstream liver disease management.
- **Expected impact:** [Describe expected outcomes — e.g., increase percentage of PLHIV screened for HCV at ART initiation from X% to Y%; initiate X people on HCV treatment. Adapt to reflect interventions included.]
- **Suggested indicators**
    - Percentage of eligible PLHIV screened for HCV per national protocol (include if HCV is in scope)
    - Percentage of eligible PLHIV screened for HBV per national protocol (include if HBV is in scope)
    - Number of PLHIV linked to hepatitis clinical management where indicated
    - Turnaround time for confirmatory HCV or HBV testing

  Data sources: [HIV clinic registers, LIS, DHIS2. TCS-11 (proportion of people starting ART tested for HCV) is a GF core indicator and should be included where applicable. Additional country-specific indicators are likely needed.

PUD and other key and vulnerable populations. *Module: HIV Prevention. Primary PE anchors: PE3 (continuing from GC7) and PE5 (new for GC8)*

- **Epidemiological rationale** (include in all packages): In [country], HIV/HCV coinfection is [X%] prevalent among PUD, and key and vulnerable populations face disproportionate HBV exposure where vaccination coverage is low. Harm reduction platforms — including NSP and OAMT sites — are the primary entry points through which this population can be reached with integrated hepatitis services. Failure to address hepatitis within these platforms undermines HIV prevention outcomes and perpetuates avoidable morbidity among a population already facing significant structural barriers to care.
- **Core harm reduction package under PE3** (include if NSP, OAMT, or overdose prevention is in scope): This module maintains and strengthens the core harm reduction package under Program Essential 3, including NSP (with low dead space syringes), OAMT, and overdose prevention with naloxone. Services are delivered through low-threshold, community-based platforms. GF explicitly supports hepatitis services for PUD regardless of HIV status where a strong epidemiological case is provided, as documented for [country] through [cite evidence].
- **HCV services integrated within harm reduction** (include if HCV testing and treatment within harm reduction is in scope): HCV testing and treatment is integrated within harm reduction services under Program Essential 3, in settings with high HIV/HCV coinfection. Services are delivered through the same low-threshold platforms as

the core harm reduction package, avoiding separate service visits and reducing loss to follow-up. HCV services are structured around integrated, low-cost delivery models in line with GC8 Optimization guidance.

- **HBV and HCV screening within SRH and KVP platforms under PE5** (include if PE5 is a primary or secondary anchor): Under Program Essential 5, new for GC8, hepatitis services are integrated within SRH services for key and vulnerable populations. HCV testing and treatment in harm reduction settings is a Priority activity under PE5. HBV testing and management for individuals at high risk accessing HIV prevention platforms is an Optimization activity, targeted to populations with documented elevated risk, with untargeted adult HBV screening explicitly deprioritized. Together, these create an explicit GC8 pathway for hepatitis services within HIV prevention platforms that did not exist as a formal Program Essential in GC7.
- **Scope and value for money** (include in all packages): The proposed package builds on existing high-utilization harm reduction and SRH platforms, applying differentiated, low-threshold delivery models to minimize incremental costs and maximize reach. The inclusion of low dead space syringes and take-home OAMT dosing for stable patients further improves efficiency, consistent with GC8 Optimization guidance. HBV vaccine commodity costs are mapped to [domestic / Gavi / partner] financing.
    - HBV screening and treatment into harm reduction services for PUD is highly cost-effective, with costs falling further as generic DAA prices decline. In Kenya, HCV test-and-treat at harm reduction drop-in centers cost US$975 per DALY averted — below GDP per capita — and could fall to as low as $2 per DALY averted at current generic drug prices (Mafirakureva et al., Addiction, 2022), while in Tanzania, integrating simplified point-of-care HCV screening and DAA treatment into existing OAT-based harm reduction services cost US$633 per QALY gained (Mohamed et al., International Journal of Drug Policy, 2022).
- **Expected impact:** [Describe expected outcomes — e.g., reach X PUD with NSP and HCV testing; initiate Y people on HCV treatment; maintain naloxone coverage at Z%. Adapt to reflect interventions included.]
- **Suggested indicators**
    - Number of PUD reached through NSP (include if NSP is in scope)
    - Number of PUD and key vulnerable populations tested for HCV within harm reduction services (include if HCV testing is in scope)
    - Number and percentage of HCV-positive clients initiated on or linked to treatment (include if HCV treatment is in scope)
    - Number of high-risk individuals screened for HBV within SRH and HIV prevention platforms (include if PE5 HBV screening is in scope)
    - Coverage of overdose prevention interventions (include if naloxone is in scope)

  Data sources: [program registers, LIS, community-led monitoring]. GF core indicator coverage for harm reduction and HCV is limited — community-led monitoring and program-specific indicators are likely needed.

Note on scope and positioning

Across all three population groupings, hepatitis, triple elimination, and harm reduction activities are framed as integrated, targeted, and measurable. GF-financed costs are clearly bounded and separated from domestic or partner-financed costs. This positioning reflects GC8 expectations on prioritization under constrained allocations and is intended to support applications that are resilient to reprioritization during CCM and TRP review.