

Global Fund to fight AIDS, TB and Malaria

Updated support for viral hepatitis



Global Fund to fight AIDS, TB and Malaria (GFATM) policies have evolved to increasingly enable countries to request resources to support viral hepatitis, harm reduction & triple elimination services, with the latest GFATM funding cycle allowing countries to prioritise requests for hepatitis services among people living with HIV (PLHIV), key populations and pregnant women.

GFATM defines key populations as men who have sex with men, sex workers, people in prisons and other closed settings, people who inject drugs (PWID), trans and gender diverse people and sexual partners of key population groups.

What support can countries request for viral hepatitis?

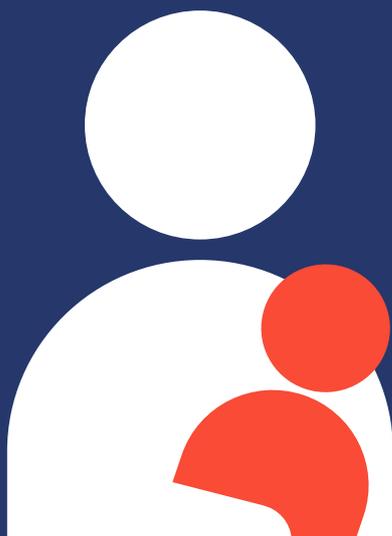
For PLHIV and key populations:

- ▶ Screening, testing and treatment for hepatitis B and hepatitis C, and vaccination for hepatitis B within HIV prevention and treatment services, sexual reproductive health services, and harm reduction services.
- ▶ For PWID and people in prisons and closed settings, hepatitis B and hepatitis C services to be delivered as part of harm reduction services, regardless of HIV status.

For pregnant and breastfeeding women:

- ▶ HIV, syphilis and hepatitis B testing during antenatal care (ANC) visit.
- ▶ Confirmatory testing and prophylaxis treatment.

Note: Hepatitis B birth dose vaccine for newborns is not covered by GFATM, but a case for resources to support programmatic delivery can be made. Other funding sources for hepatitis B birth dose vaccine will need to be identified.





For harm reduction services:

Harm reduction is now a “program essential” for applicants, meaning all applicants must describe status of progress.

Harm reduction interventions include support for hepatitis B vaccination and hepatitis B and hepatitis C testing and treatment.

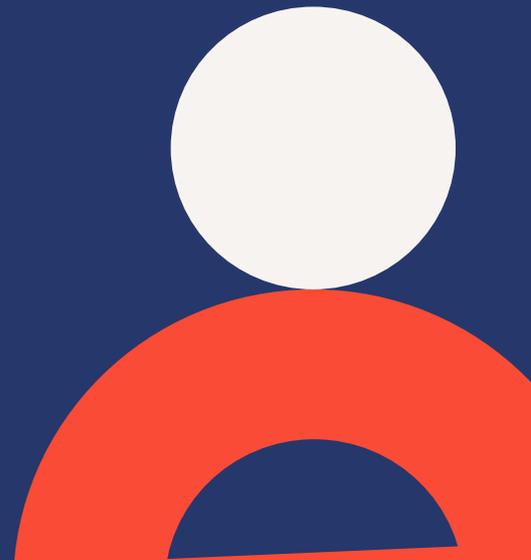
Other interventions include opioid substitution treatment (OST), needle and syringe programmes (NSP), naloxone and other elements of the WHO comprehensive package of harm reduction interventions for people who inject drugs.

Delivery within harm reduction settings including prison/ closed settings.

Resilient and Sustainable Systems for Health (RSSH)

GFATM also fund RSSH and this is another opportunity to include support for hepatitis programmes. Funding for RSSH could support hepatitis programmes through:

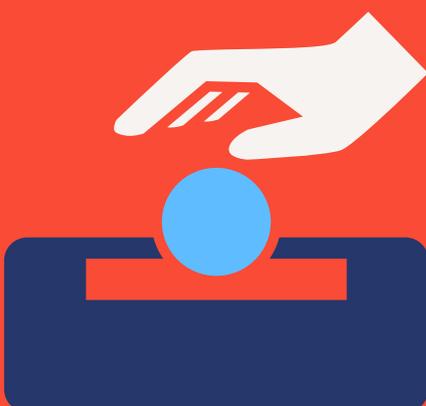
- ▶ Strengthening governance, policy, and programming towards UHC, potentially including viral hepatitis.
- ▶ Health product management systems which may support supply chain management for hepatitis commodities.
- ▶ Human resources for health strengthening.
- ▶ Monitoring & evaluation activities.
- ▶ Laboratory systems strengthening which could include and enable hepatitis testing.



Why is this important?

The latest funding round is a critical opportunity for countries to request funding to introduce and/or strengthen hepatitis programmes.

Although GFATM cannot fund comprehensive national hepatitis programmes, funding can be mobilised to deliver hepatitis services among the specified target populations and leverage HIV, ANC, and harm reduction platforms, and human resources to strengthen hepatitis programming.

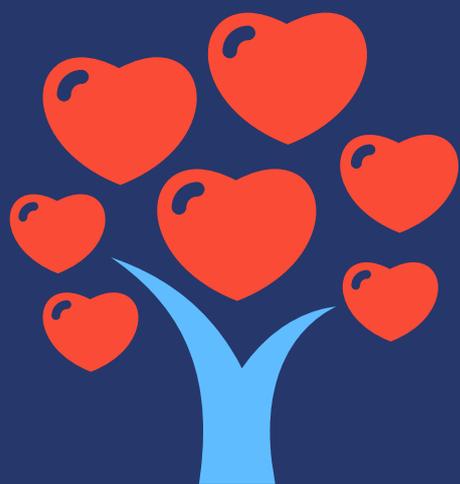


Countries interested in leveraging GFATM funding for hepatitis programming, must evaluate and define a funding ask appropriate for their context. Understanding the context of the HIV program performance and priorities, can help stakeholders identify opportunities to integrate hepatitis services.

To access GFATM financing for hepatitis services for the target populations, countries will need to formulate a strong investment case informed by:

- ▶ Epidemiology
- ▶ Programmatic needs and priorities
- ▶ Potential impact and rationale, including targets and costs at national and subnational levels

The investment case will need to explain how these investments can help improve outcomes for PLHIV, articulate programme readiness, and plan for integration and implementation.



Making the case for hepatitis integration in numbers

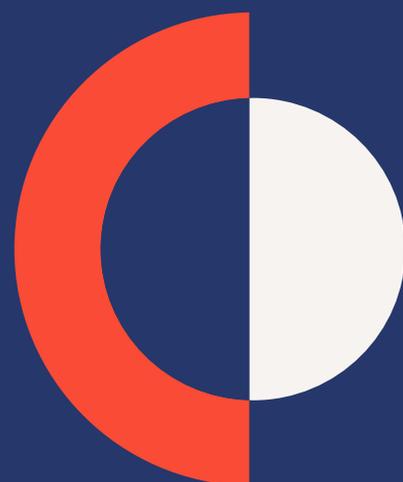
Integrating hepatitis services with other services can improve patient outcomes and make health systems stronger, more efficient and effective.

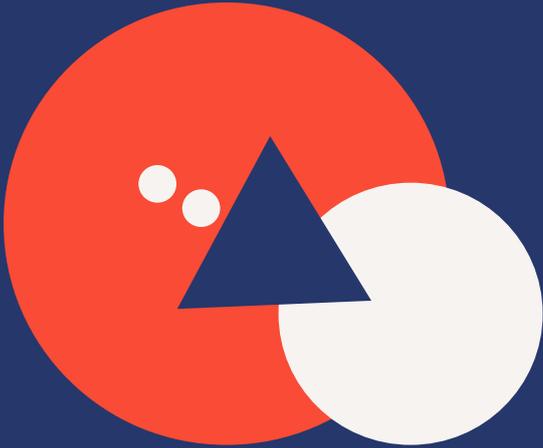
People co-infected with HIV/HCV or HIV/HBV suffer from greater liver-related morbidity and mortality, non-hepatic organ dysfunction, and overall mortality than hepatitis mono-infected patients.

Research shows that HIV/HCV co-infected populations progress to cirrhosis on average 12-16 years earlier than mono-infected patients and in some cases experience ultra-rapid progression in 2-8 years from hepatitis C infection and cirrhosis.

What's more globally 25% of liver cancer cases are thought to be attributable to HCV, and HBV is responsible for at least half of all liver cancer cases worldwide.

The inclusion of hepatitis services will therefore stop PLHIV from dying from hepatitis.





Over 50% of PWID globally are estimated to be living with hepatitis C, 10% with hepatitis B and 17.8% with HIV.

Vertical transmission is driving new hepatitis B infections and is a major contributor to the HIV pandemic, thus there is a critical need and opportunity to interrupt this transmission route and potential life-long consequences of chronic infection.

HIV/HCV coinfection among pregnant mothers can increase the risk of HIV vertical transmission.

For more details on GFATM funding and the process through which countries must apply please:

- ▶ See the '[Resource Toolkit on GFATM 2023-2025 Funding Opportunities for Hepatitis](#)' which has been developed by the Clinton Health Access Initiative (CHAI).
- ▶ Refer to the [Global Fund website](#)
- ▶ Contact us at contact@worldhepatitisalliance.org