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Abbreviations

AGYW	adolescent girls and young women
ANC	antenatal care
ART	antiretroviral therapy
BPG	benzathine penicillin G
CHAI	Clinton Health Access Initiative
CHW	community health worker
EID	early infant diagnosis
EVT	elimination of vertical transmission
GC8	Global Fund Grant Cycle 8
HBsAg	hepatitis B surface antigen
HBV	hepatitis B virus
HBV-BD	hepatitis B birth-dose vaccination
HIV	human immunodeficiency virus
IPTp	intermittent preventive treatment in pregnancy
LLIN	long-lasting insecticidal net
MNCAH	maternal, newborn, child, and adolescent health
PBFW	pregnant and breastfeeding women
PHC	primary health care
PNC	postnatal care
PrEP	pre-exposure prophylaxis
RAPID	Readiness Assessment and Prioritization for Integration Decisions
RDT	rapid diagnostic test
RSSH	resilient and sustainable systems for health
SRH	sexual and reproductive health
STI	sexually transmitted infection
TDF	tenofovir disoproxil fumarate
WHO	World Health Organization

About this resource

This practical resource is intended to support country teams in preparing Global Fund Grant Cycle 8 (GC8) funding requests. Complementing tools developed by the Clinton Health Access Initiative (CHAI) and Evidence Action (Annex I), this guide emphasizes strategic prioritization, integrated service delivery, readiness assessment, and practical implementation planning to advance elimination of vertical transmission (EVT) of HIV, syphilis, and hepatitis B (HBV).

This implementation guide is designed for ministries of health, Country Coordinating Mechanisms (CCMs), Principal Recipients, civil society organizations, and technical partners engaged in country dialogue, proposal development, budgeting, and implementation planning.

It is intended to be practical, modular, and complementary to existing disease-specific technical resources. EVT is used as the primary term throughout, while recognizing established elimination of mother-to-child transmission (EMTCT) and triple elimination frameworks, where relevant.

This is a living resource and may be updated as GC8 guidance evolves and additional resources become available.

I. A strategic investment: Why EVT matters for GC8

GC8 presents an important opportunity for countries to accelerate progress toward EVT while advancing more integrated, sustainable health systems.

The Global Fund grant architecture recognized EVT in prior cycles, and GC8 continues this recognition through a dedicated HIV module for the **elimination of vertical transmission of HIV, syphilis, and HBV**. In a cycle marked by constrained resources and a greater emphasis on efficiency, sustainability, and measurable impact, this creates an important pathway for countries to prioritize high-impact maternal and child health investments.

Across many low- and middle-income countries, vertical transmission remains a preventable cause of infant infection, stillbirth, neonatal mortality, chronic disease, and long-term economic burden. Each year, an estimated 120,000 children acquire HIV through vertical transmission pathways, 700,000 congenital syphilis cases occur, and 100,000 children acquire hepatitis B, many through perinatal or early childhood transmission. EVT is therefore not only an infectious disease priority but also central to improving maternal health, child survival, and long-term development outcomes.

HIV, syphilis, and HBV affect overlapping populations, share common service-delivery platforms, and can often be addressed through coordinated interventions during pregnancy, childbirth, breastfeeding, and infancy. Integrated programming can improve service uptake, reduce missed opportunities for diagnosis and treatment, and increase efficiency by leveraging shared workforce and systems for laboratory, commodity management, and data.

Why EVT is a strong investment case for GC8

Global Fund GC8 is being launched in a context of tighter financing and stronger expectations that countries optimize available resources through strategic prioritization, sustainability planning, and integrated service delivery. Within this environment, countries are encouraged to focus on interventions that are high-impact, cost-effective, feasible to implement, and capable of strengthening broader health systems. EVT is strongly aligned with these objectives.

The Global Fund's *GC8 Strategic Shifts* emphasize prioritizing allocations toward settings where disease burden remains high and domestic resources are limited; establishing clearer transition pathways; and optimizing resources through prioritization, market shaping, integration, and community systems financing. EVT directly supports these priorities through proven interventions delivered via routine antenatal care (ANC), maternity, postnatal care (PNC), and maternal, newborn, child, and adolescent health (MNCAH) touchpoints within broader primary health care (PHC) platforms.

EVT is also closely aligned with the Global Fund's *Enabling Guidance on Advancing Integration*, which identifies integration as a key enabler of impact through more people-centered, efficient, and resilient service-delivery systems. The guidance highlights country ownership, differentiated approaches based on local context, measurable results, broader access for underserved populations, strong partnerships, and meaningful community engagement through codesign and co-leadership with affected communities. EVT provides a practical example of these principles in action by integrating services for HIV, syphilis, HBV, MNCAH, malaria in pregnancy, and immunization across the continuum of care. These service-delivery models can be strengthened through aligned laboratory networks, supply chains, data systems, financing, workforce capacity, including government-led polyvalent community health workers (CHWs), and broader community systems. When designed with women, families, and communities at the center, EVT

investments can improve access, strengthen continuity of care, and help ensure that integrated platforms respond to the needs of those most affected.

For many countries, EVT offers a timely opportunity to translate GC8 strategic priorities into visible, measurable, and equitable gains for women, newborns, and children. Several core GC8 priorities are particularly relevant to integrated EVT programming, including:

- **Strategic prioritization and value for money.** Investments in antenatal screening, timely maternal treatment, infant prophylaxis, hepatitis B birth-dose vaccination (HBV-BD), early infant diagnosis (EID), and follow-up of mother-infant pairs are among the most cost-effective public health interventions available. Delivered through integrated ANC, maternity, PNC, MNCAH, and PHC platforms, these interventions can rapidly reduce new pediatric infections, stillbirths, neonatal deaths, and future treatment costs.
- **Integration and efficiency.** GC8 emphasizes stronger integration across both service delivery and health systems, in alignment with national EVT and MNCAH acceleration plans. Integrated delivery of EVT interventions can reduce duplication, simplify client pathways, and improve efficiency by linking HIV, syphilis, and hepatitis B into broader MNCAH platforms such as ANC, maternity, PNC, child health, immunization, adolescent health, and sexual and reproductive health (SRH) services. Opportunities in ANC may also include strengthening tuberculosis (TB) screening and case management for pregnant and breastfeeding women (PBFW) or malaria in pregnancy services (i.e., intermittent preventive treatment in pregnancy [IPTp] and long-lasting insecticidal net [LLIN] distribution). These gains are reinforced by stronger laboratory systems, coordinated supply chains, interoperable data systems, and community platforms that support continuity and follow-up.
- **Sustainability and health systems strengthening.** EVT investments can strengthen routine systems rather than create standalone vertical programs, supporting long-term sustainability and transition planning and broader PHC reforms. Benefits may include stronger workforce capacity, better routine data systems, improved laboratory systems, more reliable supply chains, stronger community engagement and retention mechanisms, and improved referral pathways across levels of care supported by multiprofessional PHC teams, including government-led polyvalent CHWs.
- **Equity and people-centered impact.** Women and infants often experience missed opportunities for diagnosis, treatment, and follow-up when services are fragmented. EVT helps reorient systems around the client journey—from pregnancy through childbirth, breastfeeding, and infant follow-up. Prioritizing EVT can therefore improve access for underserved women and newborns, strengthen continuity of care, and contribute to more equitable health outcomes across geographies and populations.
- **Innovation and future readiness.** GC8 also encourages the adoption of innovations that can improve impact, efficiency, and sustainability. For EVT programs, relevant innovations may include triplex rapid diagnostic tests (RDTs) that detect HIV, syphilis, and HBV from a single sample, digital follow-up systems, and redesigned integrated service-delivery models. Countries may wish to assess readiness, market availability, and budget implications as part of phased GC8 planning. Additional planning tools for triplex tests are referenced in companion resources (Annex I).

Minimum core EVT package

The package below reflects a pragmatic set of high-impact EVT interventions that may be integrated into the broader World Health Organization (WHO) essential package of interventions on ANC for a positive pregnancy experience. Countries may consider prioritizing these interventions within GC8 funding

requests and broader national planning processes (see Section II), recognizing that financing feasibility, module placement, and complementary funding sources may vary across contexts:

Maternal screening and prevention

- HIV, syphilis, and HBV testing at least once, and as early as possible, during pregnancy.
- Prevention of incident HIV infection during pregnancy and breastfeeding, including access to HIV pre-exposure prophylaxis (PrEP).
- Immediate (same-day) linkage to treatment and prophylaxis according to national policy, including:
 - Antiretroviral therapy (ART) for HIV;
 - Treatment of syphilis infection with benzathine penicillin G (BPG); and
 - Prophylaxis for hepatitis B with tenofovir disoproxil fumarate (TDF).
- Retesting during pregnancy, where indicated.
- Sexually transmitted infection (STI) screening and management.
- Partner testing and family-centered linkage services.
- Linkage to adolescent-friendly SRH, HIV prevention, and gender-based violence (GBV) first-line support services, where appropriate.

Infant prevention and follow-up

- Infant HIV prophylaxis, where indicated.
- EID and follow-up HIV testing for HIV-exposed infants.
- Integrated support for timely HBV-BD delivery and follow-up within maternity and immunization platforms, according to national guidelines.
- Timely treatment with procaine penicillin among newborns whose mothers were not effectively treated for syphilis.
- Linkage to immunization and PNC services.

Retention and continuity of care

- Retention support for PBFW through facility and community platforms, including by CHWs.
- Follow-up of HIV-exposed infants (HEI) and mother-infant pairs through the breastfeeding period.
- Postnatal care follow-up for mothers and babies, including community-based follow-up for missed visits, where appropriate.
- Linkage to postpartum family planning and broader sexual and reproductive health (SRH) services during the postnatal period.

Positioning EVT across GC8 modules

While GC8 includes a dedicated EVT module within the HIV component, successful implementation will require complementary programming and budgeting through other modules, including HIV Treatment, Care, and Support (for treatment costs, specifically); HIV Prevention (for SRH services to support HIV

prevention); and Resilient and Sustainable Systems for Health (RSSH) (for cross-cutting systems strengthening and support). For example:

EVT need	Module placement
HIV module	
Provision of integrated HIV/syphilis/HBV testing and retesting for pregnant and breastfeeding women	Prevention of Vertical Transmission
Integrated ANC testing commodities (including dual HIV/syphilis and HBsAg tests; triplex if applicable)	Prevention of Vertical Transmission
Linkage to ART, BPG, or TDF for treatment or prophylaxis	Prevention of Vertical Transmission
Infant testing and prophylaxis, including EID, ART, and integrated management of infants exposed to syphilis and hepatitis B	Prevention of Vertical Transmission
Integrated service delivery for the provision of HBV-BD (not vaccine cost)	Prevention of Vertical Transmission
HIV prevention among pregnant and breastfeeding women (including PrEP)	Prevention of Vertical Transmission
Retention support for pregnant and breastfeeding women, including partner services	Prevention of Vertical Transmission
Integrated management of coinfections and comorbidities, including ART, BPG, and TDF, for pregnant and breastfeeding women	HIV Treatment, Care, and Support
Treatment commodities (ART, BPG, TDF)	HIV Treatment, Care, and Support
Sexual and reproductive health services to support HIV prevention for key and vulnerable populations (including AGYW, PBFW, and FSW)	HIV Prevention
RSSH module	
Community engagement and demand generation	Community Systems
Community health workers: in-service training, integrated supportive supervision	Human Resources for Health and Quality of Care
Health workers (excluding CHWs): continuous professional development, integrated supportive supervision, quality improvement	Human Resources for Health and Quality of Care
Laboratory quality assurance and sample transport	Laboratory Systems
Integrated registers and reporting, data quality, and training	Monitoring and Evaluation Systems
Forecasting, procurement, and supply chain	Health Products Management Systems
Regulatory support to facilitate market access for new diagnostics (i.e., triplex tests)	Health Products Management Systems
Integrated PHC planning, readiness assessments, redesign, and coordinated services (EVT, malaria, SRH) through ANC/maternity/PNC platform strengthening	Health Sector Governance and Integrated People-Centered Services
Gender-based violence interventions, including first-line support and care, as well as prevention	Reducing Gender-related Vulnerabilities and Barriers

Abbreviations: AGYW, adolescent girls and young women; ANC, antenatal care; ART, antiretroviral therapy; BPG, benzathine penicillin G; CHW, community health worker; EID, early infant diagnosis; EVT, elimination of vertical transmission; FSW, female sex worker; HBV, hepatitis B virus; HBV-BD, hepatitis B birth-dose vaccination; HBsAg, hepatitis B surface antigen; HIV, human immunodeficiency virus; PBFW, pregnant and breastfeeding women; PHC, primary health care; PNC, postnatal care; PrEP, pre-exposure prophylaxis; RSSH, resilient and sustainable systems for health; SRH, sexual and reproductive health; TDF, tenofovir disoproxil fumarate.

Broader returns on EVT investments

Well-prioritized EVT investments can generate benefits beyond elimination targets, including:

- Improved quality and continuity of ANC, perinatal, and PNC.
- Increased access for underserved women, adolescent girls and young women (AGYW), and infants.
- Stronger surveillance and routine data systems.
- More integrated service-delivery models.
- Improved ANC platforms that also deliver malaria in pregnancy services.
- Stronger perinatal, PNC, and adolescent platforms integrated with broader SRH and family planning services.
- Progress toward universal health coverage and resilient health systems.

GC8 provides a timely opportunity to build on prior grant cycle investments in EVT and translate national triple elimination commitments into stronger, more integrated, and more sustainable programming. By strategically aligning EVT priorities across HIV and RSSH funding streams, countries can better position maternal and infant interventions within constrained funding environments.

II. Prioritizing EVT investments under constrained GC8 funding envelopes

A practical framework for strategic decision-making

Global Fund GC8 is being launched in a tighter financing environment, with a stronger emphasis on strategic prioritization, value for money, sustainability, and optimized use of all available resources. In many countries, available funding may not be sufficient to support every desired intervention at once. Country teams will therefore need to make deliberate choices about which investments are essential to protect, which should be expanded to improve performance, and which innovations may be phased in over time. Tough decisions will also need to be made about which interventions to deprioritize or modify in GC8 or which other funding sources may be leveraged to support them.

For EVT, prioritization will often be most effective when it begins with lifesaving, high-impact interventions that directly reduce maternal infection, infant transmission, stillbirth, neonatal mortality, and long-term disease burden. Countries can then consider additional investments that strengthen delivery systems, improve efficiency, or accelerate future gains.

Core prioritization considerations

When reviewing potential EVT investments, countries may find it helpful to consider several practical questions to guide prioritization:

1. **Which core EVT services are currently underfunded or at risk?** Ensure core EVT activities are adequately funded to have maximum impact.
2. **Does the intervention prevent transmission, reduce mortality, or improve outcomes in the near term?** Activities with immediate impact on women and infants will often merit strong consideration.
3. **Is this intervention supported by WHO guidance or a strong evidence base?** Proven, high-value interventions will often deliver greater returns than more complex or lower-yield activities.
4. **Does this strengthen multiple programs or platforms at once?** Interventions that support HIV, syphilis, HBV, MNCAH, PHC, or community systems simultaneously may offer greater efficiency.
5. **What can be sustained domestically or with other funding after GC8?** Countries may wish to consider recurrent costs, commodity dependence, and prospects for domestic financing.
6. **Which innovations are realistic now, and which should be phased in later?** Readiness considerations may include workforce capacity, supply chain performance, policy alignment, and data systems.

Under constrained funding envelopes, countries may achieve the greatest impact by first protecting the minimum lifesaving EVT package, then investing in system improvements that increase coverage, quality, and efficiency, and finally phasing in catalytic innovations where readiness and resources allow.

The framework below is intended to support both narrative prioritization and budget decision-making. Countries may use this framework to:

- Protect high-impact core EVT services during budget reductions.
- Prioritize integrated investments that strengthen multiple programs.

- Identify catalytic activities that may be considered for above-allocation requests, reprogramming, or phased financing.
- Support country dialogue and consensus-building on difficult trade-offs.
- Align narratives and budgets around strategic prioritization.

Final prioritization should be informed by country epidemiology, program performance, available financing, implementation readiness, and national strategies. Countries may also review lower-impact or duplicative activities that could be modified, integrated, or deprioritized to protect higher-impact core services.

Three-tier prioritization approach

Countries can apply the following tiers as a practical approach to prioritize interventions:

Tier 1: Protect core lifesaving services. In most settings, the priority will be protecting a minimum package of high-impact EVT services. These are interventions that save lives now and are foundational for triple elimination, including:

- Routine ANC testing for HIV, syphilis, and hepatitis B.
- Linkage to treatment and prevention.
- Treatment and prophylaxis, including ART, BPG, and TDF.
- Integrated maternity and immunization support for timely HBV-BD delivery and follow-up.
- EID and infant prophylaxis for HIV, syphilis, and hepatitis B.
- Integrated retention support for broader MNCAH priorities.
- Reliable commodity availability.

Tier 2: Strengthen performance and efficiency. Once core services are protected, countries may consider investments that improve quality, coverage, and efficiency. These may include:

- Integrated workflows.
- Stronger linkages between ANC/maternity/PNC and immunization services.
- Enhanced data systems, including integrated digital platforms.
- Mentorship and supportive supervision, including for CHWs.
- Quality improvement.
- Community follow-up, increasingly supported by CHWs.

In practice, core lifesaving services depend on a minimum set of functional systems and integrated delivery platforms. Tier 2 investments may be essential enablers for the successful delivery and scale-up of Tier 1 services; where GC8 funding allows, these may be appropriate for financing through broader RSSH modules.

Tier 3: Catalytic or future investments (phase strategically). Some investments may be valuable but should be introduced or scaled as readiness and resources allow. Examples may include:

- Triplex RDTs.

- Digital maternal-infant tracking tools.
- Service redesign pilots.
- Operational research.

Where GC8 funding is constrained, countries may consider these activities as pilot investments, phased implementation in selected geographies, above-allocation requests, or opportunities for mid-cycle reprioritization. This approach can allow countries to pursue innovation while protecting core services.

Spotlight: Triplex RDTs as a potential Tier 3 strategic investment

Triplex RDTs detect HIV, syphilis, and hepatitis B from a single sample at the point of care. Building on the scale-up of dual HIV/syphilis tests, triplex products may help countries strengthen integrated ANC screening while simplifying workflows and reducing missed opportunities for diagnosis and treatment. Potential benefits may include:

- One visit, one sample, three results.
- Streamlined ANC workflows.
- Improved client experience.
- Reduced provider burden.
- Earlier linkage to treatment or prophylaxis.
- Stronger integration of EVT services.

The triplex product market is still emerging. There is currently one World Health Organization (WHO)-prequalified triplex test available for procurement, with additional products in development and expected to receive WHO prequalification during the GC8 implementation period. Countries may therefore wish to consider triplex testing as a strategically phased option rather than an immediate universal shift. For further details about the triplex test product landscape, please refer to CHAI's **GC8 Toolkit: Triple Test Considerations** (Annex I).

Illustrative readiness pathways. Countries may broadly fall into three readiness groups:

- **Early adopters:** Countries with strong enabling environments that may be ready to introduce triplex tests during early GC8 implementation.
- **Planned adopters:** Countries that may maintain current dual and standalone approaches initially while preparing for transition during reprioritization, reprogramming, or later GC8 years.
- **Maintain current approaches:** Countries that may prioritize strengthening existing dual and single-test workflows and defer transition until a later cycle.

Planning considerations for GC8. Countries considering triplex introduction during GC8 may wish to review:

- National HIV testing algorithms.
- ANC screening policies.
- Confirmatory pathways and linkage protocols.
- Quality assurance protocols.
- Training and workforce readiness.
- Procurement timelines and market availability.
- Commodity quantification and budgets.

Complementary tools, such as CHAI's *GC8 Toolkit: Triple Test Considerations* and Evidence Action's *Quantification and Budgeting Tool* (Annex I), can support country planning by clarifying the evolving triplex product landscape and informing forecasting and budgeting for dual tests, triplex tests, BPG, TDF, and related commodities.

III. Practical guidance for integrating EVT across ANC, MNCAH, and PHC platforms

Women and infants interact with the health system across a continuum of care, from pre-pregnancy through antenatal, delivery, and postnatal services. However, services are often delivered through parallel, disease-specific programs. This fragmentation results in missed opportunities for early diagnosis, timely treatment, and effective prevention of vertical transmission.

To advance the goals of EVT, strengthened PHC, and national self-reliance, countries must intentionally strengthen integration across this continuum, improving maternal and newborn outcomes while optimizing limited resources under evolving financing constraints. Anchoring EVT within MNCAH and PHC platforms enables more efficient, person-centered service delivery and helps ensure that critical interventions are delivered at the right time, in the right settings. When these entry points function in a coordinated way, countries can reduce missed opportunities, improve continuity of care, and increase the return on existing investments.

This section provides practical guidance for integrating EVT within routine systems while aligning with Global Fund priorities on efficiency, sustainability, quality of care, and resilient health systems. It is aligned with the Global Fund GC8 [HIV Prioritization Guidance](#), [RSSH Prioritization Guidance](#), [Enabling Impact Guidance on Advancing Integration](#), and PATH's [Integration Primer](#).

A five-step integration approach

Strengthening integration of EVT at the PHC level requires a structured, stepwise process that connects national leadership with subnational and frontline service delivery. Countries begin by establishing integrated EVT as a priority within broader PHC platforms, followed by readiness assessments to identify practical opportunities and constraints for integration. These insights inform an actionable, time-bound roadmap for implementation, supported by routine monitoring of service delivery, health outcomes, and systems-level integration improvements.

This is not a linear or one-time effort. The following five steps provide a practical framework to help countries move from national prioritization to implementation, monitoring, and iterative scale-up of integrated EVT services.

1. **National prioritization.** Effective integration begins with clear national leadership and alignment across programs. EVT should be explicitly positioned within broader PHC strategies, ensuring coordinated planning across HIV, SRH, MNCAH, hepatitis, malaria, immunization, and community health platforms. This creates an enabling environment for integration at the service-delivery and health system levels. Community representatives, women living with HIV (including PBFW), AGYW, civil society organizations, and affected communities should be engaged in codesign, implementation, and monitoring.

Key actions may include:

- Establishing or strengthening multiprogram integrated technical working groups.
- Aligning policies and guidelines to support integrated service delivery along the continuum of MNCAH care, including ANC testing algorithms, use of dual/triplex RDTs, integrated treatment and prophylaxis protocols, the essential package of MNCAH services, and availability of HBV-BD in maternity wards.

- Adapting ministry of health structures and coordination mechanisms to reduce vertical silos.

Implications for GC8 funding applications: Ensure integrated EVT is explicitly included as a cross-cutting priority within HIV, MNCAH, and PHC platforms and community systems strengthening investments.

2. **Readiness assessment.** A structured readiness assessment can help countries move from policy intent to practical implementation by identifying what is already working and where gaps need to be addressed. Assessments can be conducted at the national level but can also be effective at the subnational or even facility level, where small changes are likely to have more immediate impact.

Assessments should be conducted early to inform planning and repeated periodically (i.e., every six months or annually) to track progress. Tools such as the [PATH Readiness Assessment and Prioritization for Integration Decisions \(RAPID\)](#) can be adapted to reflect EVT priorities within ANC, PNC, and PHC contexts.

Key domains to assess include:

- **Service delivery:** Are ANC, PNC, SRH, MNCAH, HIV, STI, and immunization services coordinated or co-located?
- **Diagnostics and commodities:** Are HIV, syphilis, and HBV tests (including dual/triplex RDTs) and treatment consistently available at the point of care?
- **Health workforce:** Are health workers and CHWs trained, mentored, and authorized to deliver integrated EVT counseling, testing, and treatment services (including task shifting)?
- **Capacity strengthening:** Are integrated training and mentorship services reinforced through ongoing quality improvement, supportive supervision, and competency-based learning approaches?
- **Data systems:** Can systems track integrated indicators across diseases and longitudinal care for mother-infant pairs? Can systems track integrated indicators between facilities and community-level follow-up? Does the system capture whether care was provided in an integrated way?
- **Supply chains:** Are procurement and distribution systems aligned across program areas? Are procurement and distribution systems aligned across facilities and community-based service delivery?
- **Community systems:** Are there strong channels for community engagement to support demand generation, feedback, and follow-up? Are these linked with a broader community health strategy?
- **Demand generation:** What systems are in place for raising awareness and knowledge about EVT services during ANC/PNC? How are polyvalent community health workers (CHWs) supporting demand generation?
- **Linkage and service continuity:** What systems are available to support identification of and referral for missed EVT screening, treatment, or vaccination (e.g., HBV-BD)? How are government-led polyvalent CHWs supporting linkage and follow-up?

Implications for GC8 funding applications: Plan and budget for adaptation and implementation of an EVT-focused integration readiness tool to identify strengths and bottlenecks.

3. **Implementation roadmap.** Findings from the readiness assessment should be used to create a prioritized, costed, time-bound roadmap to strengthen integration of services and systems. This roadmap should guide resource allocation and serve as a practical bridge between assessment and implementation.

A strong roadmap will:

- Prioritize integration of high-impact, feasible interventions across life stages (see the next section).
- Identify actions across multiple service-delivery and system domains.
- Include clear timelines, responsibilities, and costs.
- Incorporate a monitoring framework with integration and outcome indicators (see Annex II).
- Support phased implementation and scale-up.

Implications for GC8 funding applications: If EVT integration priorities are already known, plan and budget for these in GC8 funding applications. If they are unknown, incorporate plans to develop and implement a roadmap during the GC8 period.

4. Monitoring outcomes and benchmarks. A strong EVT response requires monitoring systems that measure not only disease-specific outcomes but also the performance of integrated MNCAH and PHC platforms through which services are delivered.

PATH's [Integration Primer](#) includes a measurement framework that can be adapted for integrated EVT/MNCAH to support monitoring across service coverage, quality, continuity of care, efficiency, health outcomes, and system functionality.

Where possible, countries may wish to prioritize harmonized indicators drawn from existing ANC, maternity, PNC, SRH, MNCAH, HIV, immunization, laboratory, and health management information systems rather than creating parallel reporting tools. This can reduce reporting burden while strengthening routine use of data for decision-making. Data should be reviewed regularly at the facility, district, and national levels to identify bottlenecks, inform course correction, and guide continuous improvement.

Illustrative domains for monitoring integrated EVT programs include:

- Coverage of integrated maternal screening (HIV, syphilis, HBV).
- Timely maternal treatment and prevention services during the continuum of care (ANC, maternity, PNC).
- Infant interventions and follow-up.
- Retention of mother-infant pairs across the breastfeeding period.
- Quality and efficiency of integrated service delivery.
- Commodity availability, workforce readiness, and data system performance.
- Equity of access across populations and geographies.

A suggested menu of indicators—drawing from Global Fund GC8 modular framework measures, WHO triple elimination priorities, and PATH integration measurement approaches—is provided in Annex II.

Implications for GC8 funding applications: Ensure core EVT indicators are captured and tracked throughout the grant period. Consider planning and budgeting for activities to strengthen integrated data tools and systems to track outcomes and impact of EVT programs and use data to guide continuous improvement.

5. Iterative improvement and scale-up. Integration is a dynamic process that evolves over time. Countries should use monitoring data, implementation experience, and emerging evidence to refine their approach, address bottlenecks, and expand successful models. This may include:

- Adjusting service-delivery models and workflows based on performance.
- Incorporating new tools (e.g., diagnostics, digital tools).
- Expanding integration from pilot sites to a broader scale.
- Strengthening system enablers as capacity grows.
- Leveraging the community health workforce to support EVT educational messaging, identification of missed services, and referral linkages.

Implications for GC8 funding applications: Embed continuous learning and adaptation into funding applications to ensure integration efforts remain responsive, sustainable, and aligned with country priorities.

Priority interventions across the life course

As countries increasingly shift toward more integrated, person-centered PHC approaches, EVT programming should also move beyond isolated pregnancy-focused interventions toward a broader life-course framework that links prevention, screening, treatment, and follow-up across adolescence, pregnancy, childbirth, breastfeeding, and early childhood. Integrated EVT services can be delivered through multiple entry points across the continuum of care, helping strengthen continuity, reduce missed opportunities, and improve long-term MNCAH outcomes. The examples below illustrate how EVT interventions may be operationalized across key service-delivery platforms and stages of care. These examples are illustrative and should be adapted to country epidemiology, service-delivery models, workforce capacity, and available financing.

Pre-pregnancy care for adolescent girls and young women of reproductive age. Integration begins before pregnancy through SRH and community health platforms, with a focus on primary prevention and early detection. Priority actions may include:

- Delivering HIV, syphilis, and hepatitis services within family planning and SRH platforms, adolescent- and youth-friendly spaces and clinics, and through general outpatient touchpoints for acute care.
- Expanding community-based and self-care approaches, where feasible.
- Strengthening linkage pathways from community to facility services.
- Delivering high-impact prevention services (e.g., PrEP, including long-acting methods such as long-acting injectable cabotegravir and lenacapavir).
- Partner testing and linkage for prevention or treatment services, as indicated.
- Providing comprehensive counseling for HIV, STI, and hepatitis prevention and screening alongside contraceptive counseling and provision.

ANC for pregnant women and their families. ANC is a high-impact entry point for EVT. Early integrated testing and same-day linkage to treatment are critical at this stage for detection and immediate intervention during pregnancy. Priority actions in ANC may include:

- Educational counseling on HIV, syphilis, and HBV.

- Testing at least once and as early as possible during pregnancy for HIV, syphilis, and HBV.
- Using dual or triplex RDTs to streamline service delivery and result return, where appropriate.
- Enabling same-day results and treatment initiation for HIV, syphilis, and HBV.
- Implementing task shifting to support integrated care.
- Partner and family testing and linkage.
- Aligning ANC workflows to reduce missed opportunities (i.e., one-stop service delivery), including integrating malaria in pregnancy interventions (e.g., IPTp, LLINs).

Implementation will require updates to national algorithms, training materials, standard operating procedures (SOPs), and job aids, alongside strong coordination to ensure commodity availability and quality assurance at the point of care.

Labor and delivery. Labor and delivery provide a critical, time-sensitive opportunity to offer integrated care for preventing transmission at birth. Priority actions may include:

- Ensuring HBV-BD vaccination is available in maternity wards and that nurses and immunization officers coordinate on vaccine administration, including coverage during nights and weekends.
- Administering HBV-BD vaccination within 24 hours of birth, per guidelines, and monitoring and tracking timeliness within routine data systems.
- Maintaining continuity of maternal and infant HIV care, treatment, and prophylaxis.
- Strengthening linkages between maternity and immunization services.
- Addressing gaps in facility delivery and cold chain systems (i.e., for HBV-BD vaccine).
- Integrating EVT into maternal and newborn care protocols.

PNC and mother-infant follow-up. Sustained, integrated engagement during PNC is essential for reducing interruptions in treatment and prophylaxis and achieving EVT outcomes. Priority actions may include:

- Providing EID for HIV-exposed infants.
- Ensuring infant prophylaxis and vaccination, including HBV-BD within 24 hours (per guidelines) and the full HBV series at 1–2 months (dose 2) and 6 months (dose 3 or 4, depending on weight).
- Timely treatment with procaine penicillin for newborns whose mothers were not effectively treated for syphilis or where treatment failed.
- Strengthening longitudinal follow-up of mother-infant pairs, leveraging polyvalent community platforms.
- Integrating PNC visits with immunization and child health services.
- Postpartum family planning and SRH services.
- Equipping CHWs with integrated digital tools to support follow-up and retention.

To maximize impact within GC8 funding applications, countries should position EVT as a core component of integrated PHC. Priority should first be given to protecting high-impact, lifesaving interventions delivered through ANC, maternity, and PNC platforms, particularly integrated testing and same-day treatment, prophylaxis, and PrEP. At the same time, countries should consider strengthening the critical

system enablers needed to sustain and scale integrated EVT services, including the health workforce, data systems, supply chains, laboratories, and community platforms that support demand generation, linkage, follow-up, and retention.

A readiness-based, phased approach allows countries to prioritize feasible actions while progressively building toward more comprehensive integration over time. Clear costing, measurable results, and routine monitoring should underpin all proposed activities, helping ensure that investments are actionable, accountable, and aligned with sustained progress toward EVT goals.

Annex I. Companion partner resources

Tool name	Description	Source
Strategic/proposal support		
GC8 Integration Toolkit for Hepatitis, Harm Reduction, and Triple Elimination within HIV programming	Summary of GC8 updates, plus guidance, templates, and planning tools for hepatitis, harm reduction, and triple elimination.	CHAI
Evidence Action briefs	Evidence briefs on congenital syphilis, dual HIV/syphilis testing, and BPG treatment.	Evidence Action
Quantification and budgeting		
Quantification Budget Integrated Calculator	Excel-based tool for forecasting and budgeting dual HIV/syphilis tests, triplex RDTs, HBsAg tests, BPG, and TDF.	Evidence Action
Costing and Budgeting Guide	Practical costing framework aligned with GC8 Program Essentials.	CHAI
Diagnostics		
Triple Test Considerations	Product landscape and planning considerations for triplex test introduction.	CHAI
Market Memo: Integrated screening for triple elimination of HIV, syphilis, and hepatitis (2026)	Reviews integrated ANC screening and market potential for triplex HIV/syphilis/HBV tests.	CHAI
Dual HIV/Syphilis Rapid Tests: Lessons from Scale Up Across Six Countries (2025)	Summarizes 10 years of dual RDT scale-up experience across countries.	CHAI
Integration		
Integration Primer	Pragmatic guidance to strengthen integrated systems and services for PHC.	PATH
Readiness Assessment and Prioritization for Integrated Decisions (RAPID) Tool	Helps managers assess current integration status and identify priority actions at the PHC level.	PATH

Abbreviations: ANC, antenatal care; BPG, benzathine penicillin G; CHAI, Clinton Health Access Initiative; EVT, elimination of vertical transmission; GC8, Grant Cycle 8; HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus; HIV, human immunodeficiency virus; PHC, primary health care; RAPID, Readiness Assessment and Prioritization for Integrated Decisions; RDT, rapid diagnostic test; TDF, tenofovir disoproxil fumarate.

Annex II. Suggested indicators

Coverage of integrated ANC screening (HIV, syphilis, HBV)
1. % of pregnant women attending ANC who know their HIV status (positive, negative, or unknown)
2. % of women accessing ANC services who were tested for syphilis (positive, negative, or unknown)
3. % of women accessing ANC services who were screened for hepatitis B (positive, negative, or unknown)
4. % of pregnant women receiving at least four ANC visits during pregnancy
Maternal treatment and prevention
1. % of pregnant women diagnosed with HIV who initiated or continued ART during pregnancy
2. % of pregnant women testing positive for syphilis who received adequate treatment during pregnancy
3. % of HBsAg-positive pregnant women who were assessed and linked to prophylaxis or treatment according to national policy
4. % of eligible pregnant or breastfeeding women initiated on PrEP (disaggregated by PrEP type)
5. Median time from diagnosis to treatment initiation
6. % of women with documented repeat testing in the third trimester or during the breastfeeding period, where indicated
7. % of women who give birth with a skilled health worker present
Infant intervention and follow-up
1. % of women and their babies who receive postnatal care within two days of birth
2. % of HIV-exposed infants receiving a virological test for HIV within two months of birth (positive, negative, or unknown)
3. % of HIV-exposed infants receiving prophylaxis according to national guidelines
4. % of newborns receiving timely hepatitis B birth-dose (HBV-BD) vaccination (i.e., within 24 hours, where nationally recommended)
5. % of infants completing routine immunization milestones by 12 months
6. % of newborns whose mothers were not effectively treated for syphilis and who received treatment with procaine penicillin
7. % of exposed infants enrolled in follow-up care within six weeks of birth
Retention and continuity of mother-infant care
1. % of mother-infant pairs retained in care at six months postpartum
2. % of mother-infant pairs retained in care at the end of the breastfeeding period
3. % of postpartum women linked to family planning and SRH services within six months of delivery
Quality and efficiency of integrated service delivery
1. % of ANC sites offering integrated HIV, syphilis, and hepatitis B screening during routine visits
2. % of eligible sites implementing dual or triplex RDT workflows (where introduced)
3. % of clients receiving same-day treatment or referral after positive screening
Health system enablers
1. % of facilities without stockouts of HIV, syphilis, or HBV tests in the last quarter
2. % of facilities without stockouts of ART, benzathine penicillin, or relevant prophylaxis commodities
3. % of facilities with at least one provider trained in integrated EVT services in the last 12 months
4. Laboratory turnaround time for EID or confirmatory tests
5. Reporting completeness and timeliness for priority EVT indicators
6. % of facilities conducting routine data review or quality improvement meetings
7. % of districts that have sick and small newborn care units and emergency obstetric care accessible to at least half of the population

Abbreviations: ANC, antenatal care; ART, antiretroviral therapy; EID, early infant diagnosis; EVT, elimination of vertical transmission; HBV, hepatitis B virus; HBV-BD, hepatitis B birth-dose vaccination; HBsAg, hepatitis B surface antigen; HIV, human immunodeficiency virus; PrEP, pre-exposure prophylaxis; RDT, rapid diagnostic test; SRH, sexual and reproductive health.