The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the Standard Concept Note Instructions to complete this template.**

SUMMARY INFORMATION			
Applicant Information			
Country	**Republic of Azerbaijan**	**Component**	**HIV**
Funding Request Start Date	**01 January 2016**	**Funding Request End Date**	**30 June 2018**
Principal Recipient(s)	**Ministry of Health of Azerbaijan**		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints.

The Republic of Azerbaijan gained independence after the break-up of the Soviet Union in 1991. The period of transition to the democratic society and market economy was complicated by severe economic downturn, war with Armenia in 1991-1994 and resulting crisis of refugees and internally displaced population, worsened living conditions, breakdown of the social safety net and profound disintegration of the health system. The economic recovery began in late 1990s and today, Azerbaijan has a total population of 9.5 million, out of them 22.7% are under the age of 15 years. The Gross National Income (GNI) is USD 7,350 per capita.[1] The World Bank defines Azerbaijan as upper-middle income country. Administratively, the country comprises of 59 rural districts, 10 towns, an autonomous republic (Nakhchivan) and the capital city of Baku, where one-third of the total country population is concentrated.

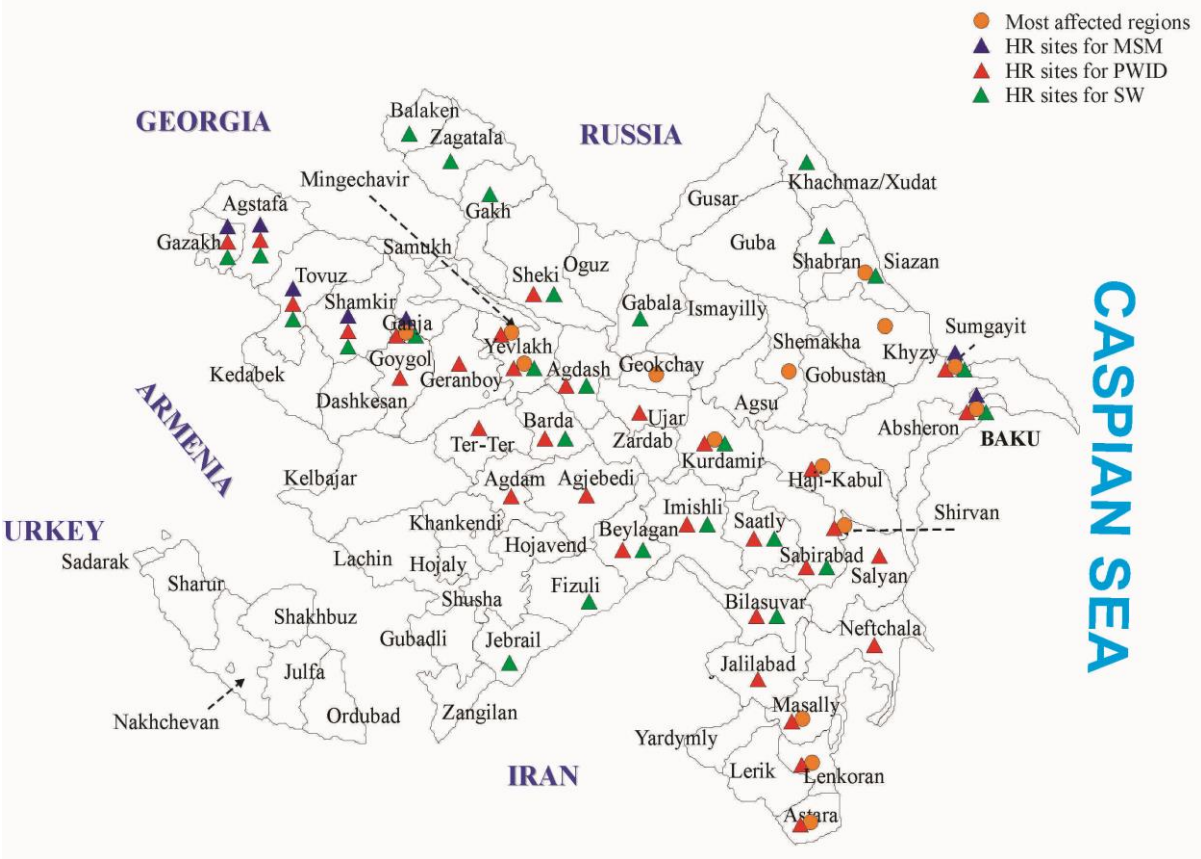
The epidemic and key affected populations in Azerbaijan. Azerbaijan has a concentrated HIV epidemic, with an estimated HIV prevalence in adults of 0.2% (Source: UNAIDS, 2013 Report on the Global AIDS Epidemic). Although the burden of HIV in Azerbaijan has been comparatively low, it is probably underestimated, in particular due to difficulties in accessing key affected populations (KAP), i.e. people who inject drugs (PWID), sex workers (SW) and their clients, men who have sex with men (MSM) and prisoners. The estimated number of people living with HIV (PLHIV) in Azerbaijan is 10,402 (UNAIDS estimates for 2015 based on SPECTRUM).

According to national statistics, by January 1, 2014, a total of 4,444 HIV cases were officially registered in the Republic of Azerbaijan. Of them, 1,319 persons developed AIDS and 368 of them died. The annual number of people newly diagnosed with HIV has been increased from 40 in 2000 to 548 in 2011. There are signs of amelioration: the number of newly registered HIV cases stabilized during past years and counted 517 in 2012 and 514 in 2013. Cases of HIV-infection have been registered in all administrative-territorial regions and towns. The highest HIV cumulative number of cases are registered in the following cities and districts: the city of Baku – 1,031 cases (28%), the city of Sumgayit – 433 cases (10.4%), the town of Shirvan – 348 cases (10.4%), Lankaran district - 323 cases (7.8%), Astara district – 181 cases (4.4%), Hajigabul district – 175 cases (4.2%) and the city

[1] World Bank development indicators, http://data.worldbank.org/country/azerbaijan, accessed on 28.12.2014

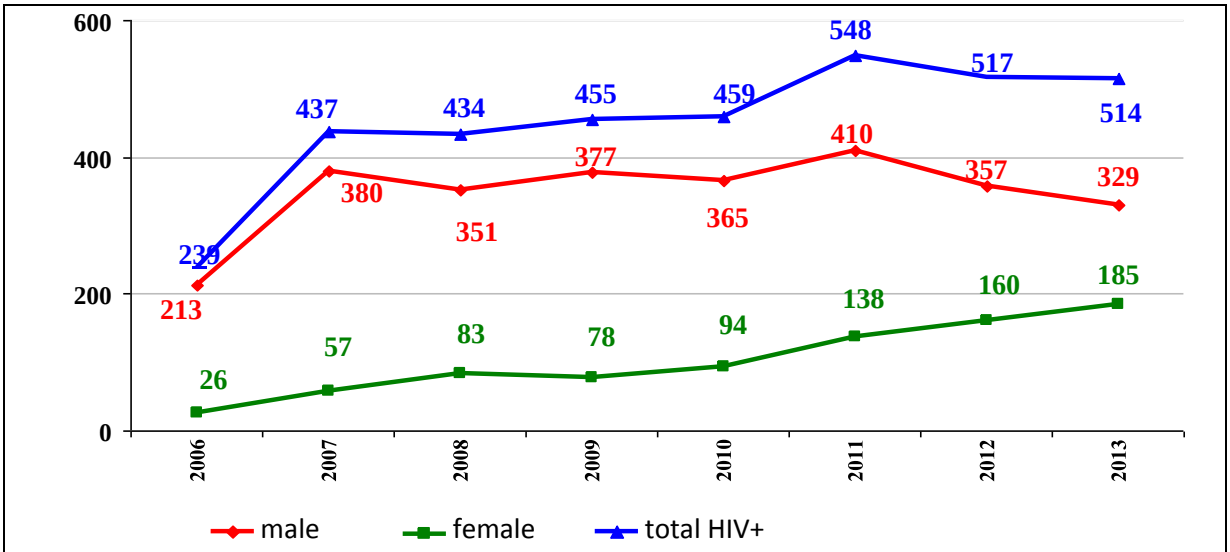
of Ganja - 145 cases (3.5%). However, when calculated per 100,000 population, the highest HIV prevalence is recorded in Shirvan - 44.2, Hajigabul district - 26.0, Astara region - 18.4, Lankaran region - 15.4, Sumgait city - 13.8, Yevlakh region - 9.9, Masalli region - 7.6 and Mingachevir - 7.3. Figure 1 below shows the geographical location of the regions with high HIV prevalence in Azerbaijan and the availability of HIV preventive services.

Figure 1. Most affected regions and distribution of preventive services



Out of the total number of the PLHIV 77.4% are men, 22.4% - women. Among newly diagnosed HIV cases, men still are predominant; however during recent years an increase in number of HIV infected women is observed (see Figure 2). A difference in main mode of transmission is observed between men and women: men report mainly through injecting drugs (71.5%), while for women through sexual intercourse (84.4%). The predominant mode of HIV transmission is sharing of injecting equipment among people who inject drugs (56.8%), however transmission through heterosexual sex is increasing and currently accounts for 32.4% of cases; majority of PLHIV are in the age group 25-39 years. In 2011, the Republican AIDS Center together with technical partners conducted the first size estimation, which indicated a population of 71,283 PWID, 25,054 SW and 6,572 MSM in Azerbaijan.

Figure 2. New HIV cases, total and disaggregated by gender, 2006-2013



People who inject drugs. Besides the 9.5% prevalence of HIV, PWID have also the highest prevalence of HCV (62.8%), HBV (10.1%) and syphilis (7.0%) compared to other key affected populations. Based on 2011 IBBS conducted in seven cities (Baku, Lankaran, Ganja, Hajigabul, Sumgayit, Shirvan and Masalli), only 46.3 % of people who inject drugs report using sterile injecting equipment the last time they injected; only 7.7% report the use of a condom at last sexual intercourse. In the previous 12 months, 36.3% of PWID reported having commercial sex and every third participant did not use a condom at last sexual intercourse with a commercial sex partner. At the same time, only 19.2% of PWID reported participating in prevention programs in the previous year: this figure was higher in Baku than for any of the other 6 cities surveyed.

Men having sex with men. HIV prevalence among MSM doubled from 1% to 2% between 2007 and 2011. The condom use during last anal sex with a male partner is 28.5%. The IBBS indicated a high proportion of MSM (26%) engaged in commercial sex in the previous six months, which suggests that the sample included a sizeable proportion of male sex workers. Despite some knowledge about risks and prevention methods, the condom use at last sexual intercourse with a regular partner is 3.4%, while with commercial partners it was only slightly higher at 4.9%. Only 26.5% reported having receiving HIV prevention services in the previous year and only 24.5% had HIV test in the past 12 months. The prevalence of HCV is 6.5%, HBV - 5.0% and syphilis - 8.0%. More than 40% of MSM surveyed had sex with both men and women.

Sex workers. The prevalence of HIV in SW is 0.7%, whereas prevalence of HCV is 11.7%, HBV - 5.3% and syphilis is 6.0%. The 2011 IBBS showed that condom use with clients at last sex was only 53.7% while the median number of clients reported by SW in the previous week was 15. Condom use with non-commercial sex partner at last sex was much lower (16.3%). Slightly more than a half of SW (56.7%) reported participation in preventive programs. Only 65.7% of sex workers were aware that using condoms protects them against HIV, while 82.3% knew that sharing needles and syringes may lead to HIV transmission. The high HCV prevalence suggests that a proportion of about 10%-11% female sex workers are also PWID.

Prisoners. The 2011 IBBS indicated high percentage of needles sharing (42.3%) among a small proportion (2.5%) of prisoners who reported injecting drug use in the past month. The high prevalence of HIV (5.8%) and HCV (57.8%) among prisoners may indicate that the injection drug issue is higher than reported by participants. Prevalence of HBV and syphilis were 5.8% and 5.3% respectively. Awareness about prevention programs and use of condoms is still low in this group.

Two rounds of second-generation sentinel surveillance in key affected populations have been conducted based on same methodology. Comparative results are presented in the Table 2 below.

Table 2. HIV prevalence among key affected populations, IBBS 2007 and 2011, Azerbaijan

	PWID		SW		MSM		Prisoners	
	2007	2011	2007	2011	2007	2011	2007	2011

HIV prevalence	10.3 [1.3-33.0]	9.5 [2.0-16.5]	1.7 [0-2.5]	0.7 [0-4.0]	1.0	2.0	2.9	5.8

Based on the above-mentioned, the current Concept Note to the Global Fund is focused primarily to people who inject drugs, men having sex with men, sex workers and prisoners as the most affected populations in Azerbaijan.

Health and community systems in Azerbaijan. The Government has made substantial progress in rationalizing public health facilities and health care staff, developing treatment protocols, training personnel, and introducing family doctors and a licensing system for health professionals. Improvements are also being made to health care facilities through the construction of new regional hospitals and the upgrading of rural health centers with a focus on strengthening primary health care.

The health system structure in Azerbaijan is highly centralized and hierarchical, and most decisions about key health policy initiatives are made at the state level. The Ministry of Health has ultimate responsibility for the management of the health system, but it has limited means to influence health care providers at the local level, as they are financially dependent on the local district health authorities. Although efforts have been undertaken to shift the focus from hospital provision to primary care, progress has been slow. The main goal of the health system - to provide universal access to health services for all citizens - is hampered by severe lack of funding and high out of pocket payments, resulting in limited access to services for large parts of the population.

The Ministry of Health has authority over the central institutions and the tertiary level (Republican) hospitals, research institutes and the Sanitary-Epidemiological Service, while the funding for these facilities comes from the Ministry of Finance. The Ministry of Health coordinates the district health authorities and from 2006 it is responsible for direct management and financing of health services in Baku. District health authorities are subordinated to the Ministry of Health in matters of health policy, while the funding comes from the local governments. The Ministry of Finance defines the annual health budget (in collaboration with the President and National Assembly) and then allocates funds to the Ministry of Health for services under its control and to local governments for services provided at the district level.

While there are notable improvements in the health system, such as increasing investments in the health sector infrastructure and the expansion of the package of free services, Azerbaijan public health care system continues to face challenges in contracting and increasing government funding for non-governmental sector involved in HIV/AIDS prevention, and care for KAP and PLHIV. This is a key weakness of the health system that affects the performance and outcome of HIV control efforts. HIV/AIDS issue in the Republic of Azerbaijan remains as one of the highest priority. Policy in this field is entirely formed. It is based on multi-sectoral approach, implying cooperation between governmental and non-governmental sectors as well as the interaction between various organizations within a nationwide response.

Traditionally, in the Central and Eastern European region and Newly Independent States (CEE/NIS) the health and social systems were heavily centralized with little participation of community in service provision and human rights advocacy. The Republic of Azerbaijan is not an exception. Only after getting independence from the USSR in 1991 some elements of the Community Systems Strengthening (CSS) started to be implemented in the country with participation of international organizations. All initiatives were focused on provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities (home care services to vulnerable populations including mental disable people, elderly and others, and lately HIV/AIDS communities).

The major partners working in these areas are local NGOs that comprise and/or provide services to people living with HIV/AIDS (PLHIV), tuberculosis, members of vulnerable populations, and individuals who otherwise have sub-standard access to vital health services. However, these initiatives are still under development in Azerbaijan. The local NGOs are concentrated more around the capital city, the capacity of NGOs needs major attention and the public and civil society

partnership needs further development. The community based and non-governmental organizations as a whole need to participate more in program planning, design, implementation and monitoring. Also, there are no program-based initiatives on human rights, including the right to health and non-discrimination.

At the same time, there is a commitment in the country to increase accessibility, uptake and effective use of services to improve health and well being of communities. As example, the National HIV/AIDS National Program for 2016-2020 mentions the provision of harm reduction HIV prevention activities as basic activities provided by community-based organizations in strong collaboration with the Republican AIDS Center. However, the non-government civil society organizations do not participate in promoting general accountability to communities, including government accountability to its citizens and donors to the communities they aim to serve.

These systemic weaknesses impact upon HIV control and to a greater extent they define and shape the specific challenges for the National HIV/AIDS Program. It is anticipated that further strengthening of community participation will contribute to improved outcomes of disease specific interventions. The Global Fund programs started to address the issues by development of the role of key affected populations and of non-governmental organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV. The current proposal to the Global Fund will further boost the CSS activities, including involving national mechanisms created in previous programs (ex. National Harm Reduction Network) and ensure their full sustainability by 2018.

Barriers to access health services. Access to high quality diagnosis, prevention, treatment and care services for the most at risk for HIV people has been limited by the lack of availability of these services in areas outside the capital city and by the very limited reach of targeted programs into key affected populations. Stigma, discrimination and the fact that the main risk behaviors are illegal (injecting drug use, commercial sex) have kept these people from coming forward for asking services in large numbers. There is neither a coordinated referral system, nor designated responsibility at the local level to channel people diagnosed with HIV into ongoing prevention, treatment and care services.

The main barrier to service delivery for key affected populations in Azerbaijan is the stigmatization of drug use, sex work and sex between men. Health services, especially TB and HIV services are those who receive a significant proportion of people who are most at risk. Similarly, services dealing with drug users, sex work and the criminal justice system encounter a significant proportion of people who have become infected with HIV and/or TB. The need to attend multiple services acts as a barrier in providing adequate treatment to people who are most in need in the country. Currently TB and HIV services and services for key affected populations in Azerbaijan are functioning separately and are not integrated as they should be.

The many social and health service barriers in accessing prevention and care services in Azerbaijan result in lengthy delays in seeking health care. The care provision is further complicated by lower levels of adherence to prescribed treatments. Daily drug use, alcohol dependence and depression are associated factors that complicate care and treatment. Stigma against people who inject drugs, sex workers and MSM among health workers, law enforcement personnel and social service workers also contributes to poor outcomes, such as the forced registration of people who inject drugs within mandatory drug treatment programs in Azerbaijan. Women who inject drugs are much more likely to delay approaching health facilities than men who inject; further studies are needed to indicate that female who inject drugs may have lower and suboptimal access to HIV care and may be less likely to receive antiretroviral therapy than male populations.

Despite the concentration of HIV cases among PWID, there is uneven geographic distribution of needle-syringe programs and other harm reduction activities, with low coverage in many parts of the country. Even in areas with a high concentration of PWID, needle-syringe programs and opioid substitution treatment (OST) programs are not sufficiently available.

In relation to the legal framework, there were many changes in political environment and legal

context in regard to HIV that created enabling supportive environment for National HIV/AIDS Program implementation. In 2010, a new law on HIV/AIDS adopted by the Milli Mejlis (Parliament of Republic of Azerbaijan) has been entered into force. The Law has been followed by a number of changes in current legislation, regulations and normative acts: the Order No. 62 from Cabinet of Ministers to ensure HIV Law implementation, Action Plan for Preventing and combating HIV/AIDS in the Republic of Azerbaijan and Strategic Plan of the Ministry of Health of the Republic of Azerbaijan for 2011–2015, the National HIV/AIDS Program for 2016-2020 are among other main documents on HIV that along with major fundamental country's documents and decrees/laws ensure an achievement of national targets for universal access.

The Global Fund NFM Concept Note took into consideration all the country epidemic specifics and existing barriers. The Concept Note has been developed under comprehensive country dialog in strict accordance to the above-mentioned legal documents and it is an integral part of the National HIV/AIDS Program for 2016-2020.

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

e. For standard HIV or TB funding requests[2], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

The legal framework and health policies demonstrate country's political commitment in responding to the HIV epidemic, including those related to general health policy and HIV/AIDS issues. HIV control is an integral part of the Strategic Plan of the Ministry of Health of the Republic of Azerbaijan for 2011-2015, which foreseen for the control of HIV epidemic. HIV control is also part of the "Azerbaijan 2020: Look into the future" concept of development, which foreseen state responsibility to carry out work to fight the diseases and implement preventive measures, health-educational work, and various programs against drug addiction. The legislative tools include a set of laws which have been adopted to ensure sustainability of actions: Law on Health Protection (July 26, 1997), Law on epidemiological welfare of the population (November 10, 1992), Law on HIV/AIDS (June 10, 2010), Law on Gender equality (October 10, 2006), Law on Narcological service and drug use control (July 29, 2011), National Action Plan for Protection of Human Rights (December 28, 2006), Criminal Code of Republic of Azerbaijan (art. 142. Failure of medical workers

[2] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

to provide aid to a patient), Civil Code (chapter 60. Compensation for damage caused to life and health of an individual), Administrative Code (art. 38.2. Recovery of physical or moral damage caused by administrative offence), Labor Code (art. 16. Prevention of discrimination in labor relations).

The Program evaluation implemented by the World Health Organization in 2014 has shown achievement and positive results for all areas of intervention, including funding for HIV prevention; improving policies, creation of legal and social supportive environment; reducing the risk of HIV infection among key affected populations, prevention of transmission through blood transfusion; counseling and testing for HIV; post exposure prophylaxis; prevention of HIV transmission from mother to child; treatment, care and support; TB/HIV; better M&E system etc. It also identified a list of shortfalls, which have been taken into consideration by the new National HIV/AIDS Program for 2016 – 2020 developed during a comprehensive and inclusive country dialog process (Annex 1. WHO 2014 Review of the HIV Programme in Azerbaijan, preliminary report).

The National HIV multi-sector coordination has improved over past several years after establishment of the Country Coordination Mechanism (CCM) in 2005. In 2011 CCM bylaws have been revised, its operational procedures upgraded, members trained in program monitoring and evaluation, and most importantly civil sector membership was expanded. The enhanced CCM, together with well-equipped M&E framework and necessary funding will further play key role in improving and scaling up national response to HIV/AIDS.

Harm reduction programs are the most important prevention interventions in Azerbaijan and are embedded into the HIV Law. Harm reduction has been initiated and piloted by OSI-AF until 2006 in Baku. Since then, with the launch of the Global Fund project, harm reduction interventions entered a new phase of development, the services have been expanded to 34 sites, the quality of services strengthened and the package of services standardized to the maximum extent across regions. Still, the coverage remains low to date (See Table 3). The package of services made available by non-government organizations and government services to key populations are suitable for each specific key population. NGOs have proven to be the key link to HIV prevention, testing, treatment, care and support for key populations. However, even more can be done through closer collaboration between the NGOs and government services.

Table 3. Coverage by preventive services

As of March 2014	Reached	Target	*PSE*	% reached
PWID	13,372	14000	71,283	18.8
FSW	6189	6075	25,054	24.7
MSM	2517	1750	6,572	38.3
Prisoners	12,698	10,200	17,500	72.56%

The package of services for people who inject drugs includes distribution of needles and syringes, information and education materials, condoms, water for injection, post-injection plaster, alcohol swabs and containers for used syringes. Free legal, medical and psychosocial counselling is also available as well as linkages to VCT services and the OST programme. This package of services is similar to the comprehensive package recommended by WHO for addressing HIV among PWID. During October 2013 - March 2014 the program sharply increased PWID coverage by HIV prevention services through NGOs. The coverage increase is attributed to the introduction of mobile VCT units and expansion of services in new geographical areas. In addition, the number of client workload per outreach worker has been increased, and outreach workers were trained in appropriate techniques.

The package of services for men who have sex with men includes free STI treatment drugs and linkage to VCT centres and mobile units. Distribution of condoms and lubricants is ensured along with information and education materials. Psychosocial, medical and legal consultations are also provided free of charge. The package of services for SW includes distribution of condoms and linkages to VCT services, STI and HIV treatment and care, distribution of information and education materials and referral to medical, legal and psychosocial counseling services. Similarly to PWID, the

significant increase in the number of MSM and SW reached during last year was due to expansion of services to new geographical areas, recruitment of new outreach workers, and expansion of mobile VCT units.

Psychological services for prisoners are provided in twenty-four prisons and correctional settings. Hygienic packages and IEC materials are distributed (including condoms) and information sessions are regularly held. VCT services are continuously available in all prisons and correctional facilities. Recently, the number of psychologists available for provision of services to prisoners was increased from 5 to 9. All of these psychologists are recruited externally by NGOs and are under the Ministry of Justice supervision. In parallel, a total of 5,304 prisoners have been provided with HIV testing. Diagnostic and treatment services for prisoners is under the responsibility of Ministry of Justice and its Medical Commission is in charge of ARV selection and treatment regimens. The Republican AIDS Center performs confirmation tests and provides technical expertise for HIV treatment.

HIV testing and counseling is provided based on updated guide to voluntary HIV counselling and testing (VCT). At the moment, 39 centres are providing VCT services for target populations in Azerbaijan. As mentioned above, testing for key populations has increased dramatically since the introduction of rapid testing through mobile units, a measure that has proven to be effective intervention in increasing the numbers of key population reached with these services. The number of mobile units has been increased to 12; however, the coverage still remains low (see Table 4).

Table 4. HIV testing for key affected populations, 2013, Azerbaijan.

2013	HIV Test	HIV+	% of PSE Tested	% Tested of Reached
PWID	5,484	38	7.7	41
SW	880	0	3.5	14.2
MSM	606	2	10	34.6

Opioid substitution treatment (OST) started in 2006 triggered by the Law on narcological service and control[3] and the Law on circulation of narcotic substances, psychotropic drugs and precursors.[4] The first OST site was opened at the Republican Narcological Dispensary and later on the branch office was opened in the Republican AIDS Center to cater for HIV positive opiate users. The collocation OST service within the Republican AIDS Center is a good example of service integration and orientation to clients. Total number of patients involved in OST is only 137 and this number remains low compare to the estimated need. There are still certain statements remaining of concern in the Crime Code that serve as legal and structural barriers for accessing preventive and treatment services and these will be primarily targeted under the new National HIV/AIDS Program.

In 2013, 81.2% pregnant women and 84.9% children received antiretroviral therapy to reduce the risk of mother to child transmission. While there is a progress compare to 2007 when 38.5% pregnant women and 7.1% children received antiretroviral therapy, PMTCT program needs further improvement that has to be addressed by the health system. The coverage with ARV prophylaxis of HIV-positive pregnant women is hampered by delays in seeking antenatal care by pregnant women.

Blood safety has received significant attention from the government and donated blood throughout the country is being tested for: HIV, hepatitis B & C and for syphilis. Azerbaijan reached 100% blood testing, which has been possible with the help of the Central Blood Bank established at the Scientific Research Institute of Haematology and Transfusiology and two regional blood banks in the cities of Ganja and Sheki. Based on the last five-year data HIV prevalence among blood donors is only 0.01%. While achievements with safe blood supply are obvious, the situation regarding infection prevention within clinical setting receives attention under the new National HIV/AIDS Program. Also, both PMTCT and blood safety programs will be fully supported by

[3] Law on narcological service and control, Law No.161-IQ (29 June 2001).
[4] Law on circulation of narcotic substances, psychotropic drugs and precursors, Law No.959-IIQ (28 June 2005).

domestic resources starting 2016 and no Global Fund resources are requested.

Since 2006, Azerbaijan has made bold steps in establishing and delivering curative services for PLHIV through the Republican AIDS Center outpatient and inpatient and regional outpatient ART centers and through the medical service in penitentiary system. Of 1,252 patients who are receiving ART in the country, 217 are being treated in the regional ART centres outside Baku. The regional centres were established in September 2012, and currently there are 6 regional centers around the country. According to Republican AIDS Center data, 1,771 people have been started ART by January 01, 2014; only 1,252 continued treatment. From the total 1,771 PLHIV ever enrolled in ART, 25.7% (455) received it in the penitentiary system. Out of 1,252 PLHIV that continue treatment, 892 have achieved viral load level <5000 copies/ml, 650 patients - <1000 copies/ml and 461 patients achieved undetectable levels of <150 copies/ml. This comprises only 26% of all patients started on ART, or 36.8% of all patients who continued on ART.

The enrolment in ART almost doubled over last years, 470 patients were enrolled in 2013 compare to 257 in 2010. Although substantial scale-up of ART, and no waiting lists, by the end of 2013 only 22% of PLHIV in need of ART received treatment (see Table 5; based on SPECTRUM estimations). The Government of Azerbaijan is gradually taking over the ART costs: it is expected that in 2016 the ART costs will be covered entirely through MOH budget.

Table 5. Coverage by ART, 2013, Azerbaijan

	2013
Estimated # of HIV positive people (based on SPECTRUM)	9195
Total in need of ART (based on SPECTRUM)	5767
Total in ART	1250
ART with coverage (%)	22%

While more people are able to access ART, there is need for improvement of the treatment outcomes, close coordination and collaboration between curative facilities and NGOs delivering outreach or care & support services in order to increase number of those seeking care and improve adherence to ART. Also, ART is provided based on the national protocol based on WHO old guidelines. Treatment initiation is recommended when CD4 count falls below 350, in children and in pregnancy, in patients with stage III-IV disease, hepatitis B co-infection, and among discordant couples. Patients are monitored every 6 months if they are not on ART, but every 3-4 months if they receive ART. The Ministry of Health is considering updating the protocol to increase the CD4 count to 500 for treatment initiation under new National HIV/AIDS Program and address treatment outcomes issue.

TB/HIV co-infection continues to be the most important cause of death among PLHIV: 34% of HIV positive people died of TB. TB/HIV co-infection is estimated at 2%. Based on the national statistics, 13% of newly detected HIV cases had TB. HIV testing among TB patients in 2013 was 97%, and only 69% of HIV-positive incident TB cases were put on ART that further emphasizes importance of strengthening TB/HIV collaborative activities. The management of TB/HIV within prison settings is well organized and functional. Initiation of ARV treatment in TB patient and any modifications of current treatment in HIV patients are done by a special professional commission, which closely collaborates with the Republican AIDS Center. There are specific guidelines for treatment of TB/HIV co-infected patients.

Every prisoner is screened for TB with a chest x-ray every 6 months. Courses of INH prophylaxis are administered to prisoners every 5 years (if they stay in prison). After discharge from prison, two NGOs are notified to ensure follow-up, both for completion of TB treatment and ARV treatment at Republican AIDS center. There are well-established linkages between the NGOs and the health and prison systems, and this has led to successful community follow-up of prisoners being treated for HIV and/or TB while in prison.

Taking into account the specifics of the epidemic, response analysis and lessons learned from the implementation of the previous and current HIV/AIDS programs (described above), the Government of Azerbaijan lead the process of designing a complex framework to guide the

national HIV response for next 5 years. During the country dialog process, the Ministry of Health in collaboration with the Ministry of Justice, medical department involved all local and international technical partners, non-governmental organizations and people living with diseases to develop next cycle of the National HIV/AIDS Program for 2016 – 2020.

The aim of the National HIV/AIDS Program for 2016-2020 is to prevent the spread of HIV infection primarily within the key affected populations and reduce HIV associated mortality while providing prevention, treatment, care and support services, reducing stigma and discrimination and developing program capacities (See Annex 2). It has the following four objectives: (1) Implement evidence-based preventive activities focused primarily on key affected populations; (2) Ensure access to quality diagnosis of HIV infection; (3) Provide universal treatment, care and support to people living with HIV; (4) Create enabling environment and develop program capacities. The impact targets for 2020 are as following: HIV prevalence among PWID is contained under 9%, among SW - under 1%, among MSM - under 2%, among prisoners - under 5%, among pregnant women - under 0.05%, and AIDS-related mortality is reduced by 50%. The expected results per each objective are presented below.

Objective 1. Implement evidence-based preventive activities focused primarily on key affected populations. The objective is focused on preventing further transmission of HIV within key population (PWID, SW, MSM, prisoners) through providing access to harm reduction programs, which will cover at least 60% of the estimated number of beneficiaries, and also on preventing transmission of infection from these populations to the general population. Furthermore preventing mother-to-child transmission, blood safety and prevention of HIV within health care setting also receives attention under this strategic objective. The outcomes targets are the following: percentage of PWID reporting the use of sterile injecting equipment the last they injected - not lower than 95%; percentage of PWID reporting the use of a condom the last time they had sexual intercourse - not lower than 80%; percentage of sex workers reporting the use of a condom with their most recent client - not lower than 90%; percentage of men reporting the use of a condom the last time they had anal sex with a male partner - not lower than 70%; percentage of infants born to HIV infected mother who are HIV infected - not higher than 1%. The following are the outputs per the objective:

- Output 1. By 2020, at least 60% of PWID reached with HIV prevention services through harm reduction programs (baseline 18.8%) within 34 administrative units (baseline 32).
- Output 1.1.2. By 2020, substitution treatment will be provided in sites with the highest rate of drug use to at least 444 people, cumulative (baseline 137).
- Output 3. By 2020, at least 80% of individuals that initiated OST treatment will receive treatment for at least 6 months (baseline 70.8%).
- Output 4. By 2020, at least 70% of SW will be covered by HIV prevention services (baseline 24.7%) and services to prevent HIV will be available for sex workers in 26 administrative territories (baseline 26).
- Output 5. By 2020, at least 60% of MSM will be covered by HIV prevention services (baseline 38.3%) and services will be available for MSM in 8 administrative territories (baseline 8).
- Output 6. By 2020, at least 95% of HIV positive pregnant women will be covered by antiretroviral treatment to reduce the risk of mother-to-child-transmission (baseline 81.2%).
- Output 7. By 2020, all infants born to HIV-positive women receiving HIV test (baseline 84.9%).
- Output 8. By 2020, all of infants born to HIV-positive women receiving antiretroviral prophylaxis (baseline 84.9%).
- Output 9. By 2020, at least 90% of prisoners (are covered with HIV prevention programs in 24 penitentiaries (baseline 74%).
- Output 10. Maintain blood safety by ensuring 100% of donated blood units screened for HIV in a quality-assured manner (baseline 100%).

- Output 11. By 2020, all persons exposed to occupational HIV risk receive post-exposure prophylaxis (baseline 100%).

Objective 2. Ensure access to quality diagnosis of HIV infection. The objective is focused on ensuring routine HIV testing among key populations (PWID, SW, MSM, prisoners). HIV testing of TB patients, other patients in prison settings and vulnerable young people also receives attention under this strategic area. The outcome targets: percentage of key affected populations (PWID, SW, MSM, prisoners) tested on HIV and know the results - not lower than 60%. The following are the outputs per the objective:

- Output 1. By 2020, at least 60% of PWID have been tested for HIV and know their results (baseline 7.7%).
- Output 2. By 2020, at least 70% of SW have been tested for HIV and know their results (baseline 3.5%).
- Output 3. By 2020, at least 60% of MSM have been tested for HIV and know their results (baseline 9.2%).
- Output 4. By 2020, at least 90% for prisoners have been tested for HIV and know their results (baseline 30.3%).
- Output 5. By 2020, 100% of TB patients have an HIV test result recorded at the time of TB diagnoses (baseline 97%).
- Output 6. By 2020, 100% of HIV diagnosis laboratories provide high quality tests (baseline 100%).

Objective 3. Provide universal treatment, care and support to PLHIV. The objective is focused on reducing the negative impact of the HIV/AIDS epidemic, particularly by providing antiretroviral treatment for PLHIV, treatment of opportunistic infections, a wide range of care and support services targeted at increasing enrolment in care and adherence to ART, including home based care for people living with HIV. The outcomes targets: percentage of adults and children with HIV known to be on treatment for 12 months after initiation of antiretroviral therapy - not lower than 90% (baseline 75.6%), for 24 months – not lower than 85% (baseline 65.2%) and for 36 months – not lower than 80%. The following are the outputs per the objective:

- Output 1. By 2020, 60% of estimated adults and children living with HIV in need of ART (based on SPECTRUM) are provided with antiretroviral therapy (baseline 22%).
- Output 2. By 2020, not more than 10% of PLHIV that initiate ART have a CD4 count of <200 cells/mm3 (baseline 33.4%).
- Output 3. By 2020, 90% of people living with HIV that initiated ART have an undetectable viral load at 12 months (<50 copies/ml) (baseline 40.5%).
- Output 4. BY 2020, at least 90% of new individuals who test positive for HIV are enrolled in care (pre-ART or ART) services (baseline 66.5%).
- Output 5. By 2020, not more than 5% of patients primarily diagnosed with HIV have a CD4 count less than <350 cells/mm3 at the moment of diagnosis (baseline 18%).
- Output 6. By 2020, at least 90% of HIV-positive incident TB cases received treatment for both TB and HIV (baseline 69%).
- Output 7. By 2020, at least 90% of people living with HIV that require prophylaxis with cotrimoxazole receive it (baseline 19.3%).
- Output 8. By 2020, at least 85% of people living with HIV receive care and support services to increase enrolment in care services and adherence to ART (baseline 65%).
- Output 9. By 2020, psychosocial support will be provided to people living with HIV in 7 administrative territories (baseline 5).

Objective 4. Create enabling environment and develop program capacities. The objective is focused on promoting evidence-based intervention in prison settings, reducing stigma and discrimination for better access of PLHIV and KAP to preventive, health care and support services by combating stigma among health care providers, increasing awareness about the disease and reduce stigma in the society and improve legislative framework. It addresses data generation and management of

strategic information through special studies and effective monitoring and evaluation systems. In addition, the objective ensures effective and efficient coordination and management of the program through capacity building for service providers from a wide range of stakeholders and implementing partners, including government agencies, civil society organizations and people living with HIV. The success of this objective will be measured by the extent to which objectives 1, 2 and 3 of the program are achieved through the mid-term and end-of-program evaluation. The outcomes targets: reduced stigma and discrimination against people living with HIV and key affected population and effective coordination, implementation and monitoring and evaluation. The following are the outputs per the objective:

- Output 1. By 2020, key decision makers and service providers from penitentiary system are acknowledge with evidence-based HIV preventive interventions in prisons.
- Output 2. By 2020, medical personnel that provide services to PLHIV and KAP have non-stigmatizing and non-discriminatory attitudes.
- Output 3. Strong and effective monitoring and evaluation systems.
- Output 4. Surveillance studies of second generation conducted every three years focused on key affected population.
- Output 5. Skilled service providers with high level of knowledge in priority issues of HIV prevention, treatment and care.

The development of the new National HIV/AIDS Program for 2016-2020 started in 2014, during the Country Dialog initiated under the New Funding Model of the Global Fund. The Concept Note to the Global Fund is embedded into the Program; budgeting exercise covered both Government and the Global Fund support in unison. The process implied large-scale consultations with all local stakeholders, the Global Fund, WHO and other international technical partners. The CCM of Azerbaijan extensively involved both public and non-state actors (active NGOs), through the use of technical working groups. It is expected that the elaborated document will pass through the formal Governmental approval process by mid 2015. The entire National HIV/AIDS Program development was documented during the country dialog process; the country dialog documentation is enclosed to this Concept Note as requested by the Global Fund.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

Despite significant increases in public health expenditure in recent years, Azerbaijan is still characterized by relatively low levels of public health expenditure both in absolute terms and as a share of GDP. According to the latest WHO estimates (source: Health For All Database,

WHO/EURO, update April 2014), public expenditures on health in the Republic of Azerbaijan in 2012 constituted 1,24% of GDP which is lower that Commonwealth of Independent States (CIS) average (3.51%) and munch lower that EU average (7.32%). In absolute terms public health expenditure remained as low as 130.24 $PPP per capita in 2012 (CIS - 571.64; EU - 2,567). The burden of financing health care is on the health care users, with OOP expenditure reaching almost 69% of total health spending in 2012. The share of health spending in the total government expenditure is 3.88%, 2.6 times lower than the CIS average (10.21%) and almost four fold lower than the European Union countries (EU average: 15.17%).

Public health funding comes primarily from general government revenues, which includes money from the State Oil Fund. Much of the public funding for health is under the control of district authorities, which finance the network of primary and secondary health facilities in their jurisdictions. The central budget is implemented by the Ministry of Health, which funds procurement of drugs and equipment for certain health conditions such as diabetes, hereditary blood diseases, cancer and others), as well as the Sanitary-Epidemiological Service. Since 2007, all Baku city health facilities are also funded through the Ministry of Health (source: Ibrahimov F, Ibrahimova A, Kehler J, Richardson E. Azerbaijan: Health system review. Health Systems in Transition, 2010, 12(3):1–117).

Government funding for the National HIV Program in Azerbaijan is carried out through central budget funds to the Republican AIDS Centre as well as local (district level) financing of related services (e.g. STI services, PMTCT, Blood transfusion and Narcological services). Major part of Government funding of National HIV/AIDS Program is carried out through the budget of the Ministry of Health. Other Ministries and agencies, such as Ministry of Justice have their own budget for interventions directed to HIV control.

The government of Azerbaijan is committed to fighting the HIV epidemic and allocated over past years increasing amounts of financial, human and infrastructural resources for this purpose, particularly to cover the substantial costs of staff, medical interventions and facility expenses. At the same time the government has made serious steps in overtaking funding for essential services as are HIV diagnostic, ARV drugs, examination of immune status and treatment monitoring, diagnosis of opportunistic infections and treatment, STIs diagnostic, etc. for which TGF contribution is currently about 20%. Almost all priority areas of the National HIV/AIDS Program are significantly or entirely financed by the Government, except of HIV preventive interventions in KAP (PWID, SW, MSM, prisoners), community-based care and support for PLHIV including home-based care, that are currently financed by the Global Fund.

Understanding the importance of sustainability and continuation of consistent, evidence-based and impact oriented national HIV response, the Government of Azerbaijan is committed to further increase the level of domestic funding in order to bridge the gaps and take over the funding of all priority HIV control interventions included in the National HIV/AIDS Program for 2016 - 2020. Starting 2016, the Government is committed to fully finance ARV treatment, treatment monitoring and prevention of vertical HIV transmission, blood safety, post-exposure prophylaxis, management of opportunistic infections, STIs testing and treatment, laboratory operation. During first three years of the National HIV/AIDS Program for 2016 – 2020, the Government plans gradual transition from external to domestic funding for HIV preventive interventions among KAP, community based care and support to KAP and PLHIV for retention in care, targeted HIV counseling and testing and retention in ART including home-based care and other enabling interventions as provided in the Financial Sustainability Plan for the National HIV response (part of the National HIV/AIDS Program for 2016 – 2020).

The National HIV/AIDS Program investment framework, is streamlined with the Global Fund investment guidance for EECA and plans for a well-defined, time bound transfer of key interventions from external to domestic funding as following:

- Prevention among key affected populations (PWID, SW, MSM, prisoners): gradual transition over 2016-2018 from 7%, 31% and 68%, followed by 100% takeover in 2019.
- Preventing mother-to-child transmission: 100% takeover since 2016.

- Prevention program for general population: 100% takeover since 2016.
- HIV testing and counseling: gradual transition over 2016-2018 with 73%, 74% and 94% domestic support followed by 100% takeover in 2019.
- Quality HIV diagnosis: 100% takeover since 2016.
- ARV treatment and monitoring: gradual transition over 2016-2018 with 90%, 92% and 97% domestic support followed by 100% takeover in 2019.
- Care and support to PLHIV: 85% in year 2018 followed by 100% takeover in 2019.
- Development of necessary practices for targeted HIV/AIDS interventions: 56% in year 2018 followed by 100% takeover in 2019.
- Monitoring and evaluation and integration of HIV/AIDS into health information system: 41% in year 2018 followed by 100% takeover in 2019.
- Capacity building activities and training: 43% in year 2018 followed by 100% takeover in 2019.
- Program management: gradual transition over 2016-2018 from 77%, 79% and 95%, followed by 100% takeover in 2019.

The Concept Note to the Global Fund and respective funding request aims at filling the gaps and assisting the National HIV/AIDS Program in transition towards Government funding for major intervention such as:

- Uphold and scale-up needle and syringe programs (NSP) as part of programs for PWID and their partners
- Uphold and scale-up behavioral change as part of programs for sex workers and their clients
- Promotion of behavioral change as part of programs for MSM
- Uphold and scale-up behavioral change as part of prevention programs for prisoners
- Scale-up HIV testing and counseling for key affected populations
- Support of clinical examination of inmate PLHIV
- Scale-up counseling and psycho-social support, including home-based care, as part of care and support programs for PLHIV
- Support of behavioral change interventions to create enabling environment for targeted evidence-base interventions among health care workers and prison staff
- Operationalization of routine reporting including second generation surveillance
- Strengthening capacity of HIV medical service providers in both civil and penitentiary sectors.

The Table 6 below presents the detailed interaction of the Global Fund financed activities and the Government supported activities under the current Concept Note.

Table 6. The Global Fund and Government supported joint interventions

Interventions	TGF	GOV
Prevention in PWID	Scale up NSP to reach 50% coverage (expand to two additional sites), new intervention (PDI, overdose management). Provide HR mobile services in areas with high concentration of KAP through 12 units. Develop capacities of OST staff in sites.	Scale up NSP through NGOs to reach 50% coverage – gradual take over of financing: 0.5 grant out of seven in year one, two in second year and 6 grants in year three including procurement of basic HR supplies. Similar for mobile units support: 1 in year one, 4 in year two and 12 in year three. Scale up OST in sites with high drug use. Opioid substitution treatment entirely covered by Government including methadone procurement.
Prevention in SW	Scale up preventive programs through NGOs to reach 60% coverage, new interventions (PDI).	Scale up preventive program through NGOs to reach 60% coverage – gradual take over of financing: 0.5 grant out of five in year one, 2

		in year two and 4 grants in year three including procurement of condoms.
Prevention in MSM	Expand services to reach 50% coverage, new interventions (PDI).	Not financed by the Government at this moment.
Prevention in prisoners	Scale-up preventive services among prisoners in 24 prisons to reach 75% coverage.	Not financed by the Government at this moment.
PMTCT	Not financed by the Global Fund in the current application.	Fully financed by the Government. Testing pregnant women, including rapid tests, and prophylactic ART and milk formula for children.
Blood safety	Not financed by the Global Fund in the current application.	Fully financed by the Government.
Post exposure prophylactic	Not financed by the Global Fund in the current application.	Fully financed by the Government.
HIV testing and counseling	Rapid tests (saliva based) for key affected populations to be used by NGOs through mobile units and NSP. HIV tests for patients in prison setting including TB patients.	VCT country network is fully covered. HIV diagnostic test including ELISA and immunobloting for key affected populations. Rapid tests for KAP starting with year three. Lab equipment, maintenance, quality control.
ART treatment and monitoring	Regular laboratory and clinical examination penitentiary sector.	ART treatment. ART facility and staff. Regular laboratory and clinical examination (excluding penitentiary). Laboratory and equipment (PCR, CD4/CD8, etc.).
Opportunistic infections	Not financed by the Global Fund in the current application.	Fully financed by the Government.
Care and support for PLHIV	Community support to PWID and SW, community support to PLHIV including home-based care, counseling and psycho-social support for prisoners for continuation of care upon release.	Community support to PLHIV including home-based care starting with year three.
Stigma reduction	Awareness increase on evidence based intervention in prisons, Information campaigns to build awareness, capacity building for health care providers on stigma.	Not financed by the Government at this moment.
M&E	AIDS software integration into HMIS, monitoring visits in civil and penitentiary sectors; IBBS, KAP size estimation survey and specific operational researches.	Partially financed (routine statistics, salaries of personnel, infrastructure). Support for integration of AIDS software into HMIS starting with year three.
Development of health and community workforce capacity	Capacity building for health and community HIV service providers from civil and prison sectors, on HIV prevention, ART and other priority topics.	Not financed by the Government at this moment.

Other donor's contribution to the National HIV/AIDS Program is insignificant compare to the Global Fund. Besides technical support and contribution of UN agencies (ex. WHO), no other

external funding for HIV/AIDS control is anticipated for the coming years. WHO orients their support primarily to technical assistance for development and adjustment on national guidelines/regulations and normative framework and do not duplicates the Global Fund support through this funding request.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☒Yes ☐ No	n/a
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☒Yes ☐ No	n/a
iii. Increasing government contribution to disease program	☒Yes ☐ No	n/a

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

This proposal has been developed in line with the counterpart financing requirements of the Global Fund, which are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization. The Government of Azerbaijan is committed to uphold financial sustainability of priority public health interventions, as it is key to ensuring continuity of impact. Over the last years, the Government has substantially increased financial allocations to HIV control interventions, while the contributions of external partners in this area have been decreasing substantially during this period of time. At the moment, the Global Fund is the main external

source of support to HIV control in the country.

The Financial Gap Analysis and Counterpart Financing Table have been completed (see Table 1 enclosed). The counterpart financing requirements have been met. As seen from Line N (and P) in the 'Financial Gap Analysis and Counterpart Financing' table, the government contribution share is higher than a minimum threshold set for upper-middle income countries (63%). There is an increasing government contribution to national disease program over the next implementation period (figures in Line B of the 'Financial Gap Analysis and Counterpart Financing' table increase over time) of about 20% annually. Also, there is an increasing government contribution to the overall health sector over the next implementation period (figures in Line J of the 'Financial Gap Analysis and Counterpart Financing' table increase over time).

Over the last years government investments for the HIV/AIDS control interventions were oriented to procurement an important share of HIV tests, management of opportunistic infections, STIs testing and treatment, VCT, ART and treatment monitoring, etc. Compared to previous years, over the next period the Government contribution increased for essential services reaching full coverage of ART and treatment monitoring (CD4, PCR), except for prisoners, full coverage of opportunistic infections, PMTCT, blood security and PEP, and gradual transfer to domestic funding of preventing services for key affected populations with overtake of projects for needle and syringes exchange for PWID, mobile harm reduction units, preventive services for SW from year one, including procurement of HR basic supplies starting from Year two. Detailed Government contribution is presented in the p.2.1 above.

The information used to complete the financial gap analysis and counterpart financing table was obtained from the National HIV/AIDS Program for 2016 - 2020 draft document (budgeted amounts for 2016-2018), 2014 Country UNGASS report (expenditure incurred in 2013) – for domestic resources and for external - UN team contribution to HIV; TGF grant agreement (resources disbursed in previous period of implementation and disbursements planned for 2015) for Global Fund contribution. Taking into account the National HIV/AIDS Program for 2016 - 2020 and to ensure data comparability, only financial data related to national HIV response priority interventions, as provided by the National HIV/AIDS Program document have been extracted from the UNAIDS National AIDS Spending Matrix (as part of the UNGASS Country Report for Monitoring the Declaration of Commitment on HIV/AIDS) and used to calculate previous and current domestic and non-Global Fund external resources.

Estimates for UN agencies' contributions are based on previous allocations for the same priority areas as those planned in the National HIV/AIDS Program for 2016-2020 and provided in the Concept Note to the Global Fund. Calculations of financial needs for the HIV response are based on the National HIV/AIDS Program for 2016-2014.

The estimate of funding for HIV control was made taking into account centralized procurement, MOH budget expenditures and estimated HIV control portion spent from the decentralized local budgets. The further projections of the national financing of HIV control were made taking into account the actual public expenditures for 2012-2013 and forecasted annual increase for the following years. It is expected an increase in public health budget allocations of about 20% annually during 2016 - 2020. No other public funding such as loans or debt relief are foreseen in the near future; private contributions (domestic or foreign) in the field of HIV control are not significant at the moment and difficult to predict for the future and therefore are not accounted for this Concept Note.

The financial data presented are considered to be largely complete and reliable; the needs are estimated based on previous experience and the contributions have been calculated only for the priority interventions of the National HIV/AIDS Program, therefore this was taken into account when assessing the overall reliability.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

The programmatic gap tables are attached in Excel format (see Table 2 enclosed). The coverage levels for the priority modules selected are consistent with the coverage targets in the modular template. The following priority interventions have been identified in this section:

1. Prevention programs for PWID and their partners
2. Prevention programs for SW and their clients
3. Prevention programs for MSM
4. Prevention programs for prisoners

These interventions are considered of high priority and represent a major focus of the current funding request and are described in details in the Programmatic gap tables. Also, the Project addresses additional priority interventions such as treatment, care and support, health information system and M&E and health and community workforce. The identified gaps of the treatment, care and support are related to clinical examination of PLHIV & treatment monitoring in penitentiary sector and psychosocial support to PLHIV and KAP. The gap under health information system and M&E are related to routine M&E supervision and reporting, and Bio-behavioral surveillance in KAP. The gaps at health and community workforce level are related to the need to strengthen HIV service provider's capacity, increase awareness on evidence-based interventions for KAP and reduce stigma.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

The Republic of Azerbaijan was invited by the Global Fund to submit HIV proposal for the New Funding Model. The CCM considers that the Global Fund decision took account of the disease burden and, at the same time, was based on the recognition of the progress in HIV/AIDS control in the country. The recent national efforts are still not sufficient to fully address the needs and

drivers of the epidemic, therefore the Government is committed to follow the international recommendations, apply evidence-based interventions and target the Global Fund support based on national priorities for effective fight against the disease.

The overall **Goal of the Effective HIV Control Project is to reduce HIV prevalence among key affected populations and AIDS related mortality in Azerbaijan** through improving access of key affected populations to essential HIV prevention, diagnostic, treatment, care and support services. The project principles and priorities are consistent with the international policies and guidance and it is integrated into the National HIV Program for 2016-2020. It is aligned with the Global Fund HIV and TB Strategy and Investment Framework for EECA 2014-2017.

The project is build on lessons learned during implementation of previous Global Fund grants (described in Section 1.2. above) as well as on the existing capacity to fully address programmatic and financial gaps. The Effective HIV Control Project is an integral element to the National HIV/AIDS Program and involves Governmental and non-governmental organizations (NGOs). The project is constructed around three main Objectives, listed below with the 8 key Modules as following:

Objective 1. To implement evidence-based preventive activities focused on key affected populations

Module 1.1. Prevention programs for people who inject drugs (PWID) and their partners

Module 1.2. Prevention programs for sex workers and their clients

Module 1.3. Prevention programs for MSM

Module 1.4. Prevention programs for prisoners

Objective 2: To ensure universal access to comprehensive HIV treatment, care and support

Module 2.1. Treatment, care and support

Objective 3. To create enabling environment and ensure program sustainability

Module 3.1. HSS: Policy and governance

Module 3.2. HSS: Health Information System and M&E

Module 3.3. HSS: Health and community workforce

The proposal requests to uphold and scale-up the existing interventions that have been supported by the Global Fund, such as needle and syringe exchange programs for PWID, preventive programs for SW and MSM, preventive programs for prisoners, HIV testing and counseling for key affected populations, quality ARV monitoring for prisoners, key NAP interventions in terms of targeted capacity building and stigma reduction among health care workers, M&E, etc. The proposal targets health system strengthening, by intensifying case finding and improving case management using multi-disciplinary teams, support to improving quality and performance, and strengthening patient-centered approaches in HIV/AIDS care delivery.

The Project duration is thirty months starting 01 January 2016, the timeline has been aligned with the country financial cycle and it frames a logical continuation of existing grants supported by the Global Fund. The ongoing HIV grant will come to an end in December 2015, therefore there is no duplication or overlap of the activities between the previous round-based grants and the resources allocated by the Government to HIV control. The needs in procurement of ARV drugs, opioid substitution therapy, PMTCT blood safety and post-exposure prophylactics are fully covered by domestic sources, as well as the substantial human resources and ART facility costs. Government largely supports the need in HIV diagnostic tests for KAP, pre-ART and ART monitoring; preventive programs for KAP are partially covered from domestic sources with gradual increase of share during the project life.

The project will be implemented through the Ministry of Health as Principal Recipient from the

government sector and two sub-recipients: Republican AIDS Center and Prisons Medical Department of the Ministry of Justice. The implementation structure has been discussed during CCM meeting and the Principal Recipient has been nominated by the CCM in accordance with the Global Fund recommendations (see enclosed CCM Eligibility Requirements).

A brief description of proposed Interventions by each Objective is given below.

Objective 1. To implement evidence-based preventive activities focused on key affected populations

The design of current prevention program is largely consistent with the needs of the key affected populations, but requires scale up in coverage and quality improvements. Still, the HIV prevention services do not fully reach those most hidden and vulnerable populations and do not effectively address the high-risk behaviors of populations (as described in Sections 1.1. and 1.2. from above). The activities under this objective are focused on the needs of the key affected populations from civilian and penitentiary sectors. The Project uses outreach workers to target the most vulnerable PWID who cannot afford syringes and condoms, street sex workers who are the most vulnerable and MSM engaged in unsafe sex in cruising areas. The Project will provide low-threshold range of harm reduction services, including community access to rapid voluntary counseling and testing for HIV, and will support prevention programs for prisoners.

Module 1.1. Prevention programs for people who inject drugs (PWID) and their partners

Intervention 1.1.1. Needle and Syringe programs as part of programs for PWID and their partners.

Sterile syringe use has not yet become consistent, and safer sexual behaviors have been adopted only by a small portion of PWID in Azerbaijan. At this stage, harm reduction services supported by the Global Fund offer a package of services for PWID close to the comprehensive package recommended by WHO for addressing HIV among PWID which include distribution of needles and syringes, information-education-communication (IEC) materials, condoms, water for injection, post-injection plaster, alcohol swabs and containers for used syringes. Free legal, medical and psychosocial counseling is also available as well as linkages to VCT services and the OST program and linkage to HIV care for positive PWID (See Annex 1. WHO 2014 Review of the HIV Programme in Azerbaijan, preliminary report).

To increase the coverage and make these measures more effective, the Project activities are centered on service provision of the comprehensive package (needle exchange, condom programming, IEC, VCT, Hepatitis, STI, ARV, OST) in areas with highest concentration and put additional emphasis on those at greatest HIV risk: female PWID/ SW in all geographical areas where PWID or female SW NGOs work, overdose prevention, peer-driven interventions, linkage to HIV treatment and care and integration of services for PWID. The intervention includes also mobile harm reduction services provided by multidisciplinary teams that proven to be extremely effective especially in increasing uptake with HIV counseling and testing of key populations in Azerbaijan.

Through specific grants to NGOs managed by the Republican AIDS Center, the Project will scale up the coverage, expand the range and support quality of harm reduction services provided by NSP in 34 sites and ensure access for PWID to needle exchange, condom distribution, targeted behavior change communication for PWID and their sexual partners, counseling and referral to VCT, STI prevention, linkage to care, ART, OST, legal advice and provision of on-site integrated services. The Global Fund is requested to support a total of 6 grants to NGOs in year one, 5 in year two and 1 in year 3; the Government is committed to gradually overtake HR services for PWID starting year one by supporting one project, two projects in year two and 6 projects in year three with complete take over in mid 2018.

To boost preventive activities the project will expand to two uncovered geographic sites

with high concentration of PWID. Also, to increase the coverage of PWID with harm reduction services, the Project will introduce a new approach in boosting coverage of key affected populations through peer-driven interventions in three areas with height concentration of PWID in Azerbaijan (Baku, Ganja and Sumgait). It is estimated that the PDI seeds will recruit additional 1,500 new beneficiaries by providing them peer-to-peer educational session and link them to NSP sites to access services.

To address the perpetuation of unsafe injection and unsafe sexual behaviors in PWID, the project will conduct communication for behavior change activities to increase sterile syringes use and condom acceptability and promote safer injection and safe sex behaviors. Activities will include production of new informational materials to be used in motivational activities and will focus on developing new skills in service providers and outreach work in counseling for behavior change in key affected populations. Community-based overdose prevention has proven to be effective in saving lives but also engaging PWID with harm reduction programs and outreach workers, thus the project provides that harm reduction organizations will add informational and educational activities regarding overdose prevention to their current range of activities and will promote Naloxone use. Also, the NSPs will cover, as part of their comprehensive approach to behavior change communication additional issues regarding the STIs, HCV, HBV and will build additional links to these services.

Additionally the project will provide mobile harm reduction services through 12 units with multidisciplinary teams that will provide HIV preventive services for PWID, including NSP, and most important encourage and provide HIV counseling and testing. The harm reduction sites and mobile units will improve links with specialized TB and HIV health departments to improve crosscutting links and TB/HIV collaborative interventions.

The detailed activities of this intervention are described further in the Modular Template attached to the Concept Note (Table 3 enclosed) as well as in the Workplan and Budget (Annex 3).

Intervention 1.1.2. HIV testing and counseling as part of programs for PWID and their partners. The testing for key populations has increased dramatically since the introduction of mobile rapid testing, which has proven to be effective intervention in increasing the numbers of KAP reached with these services. The number of mobile units has recently been increased to 12 under the previous Global Fund grants allowing for a better coverage with HIV testing as part of integrated HIV preventive services for PWID, including NSP. While there have been improvements in reaching and testing key populations, these efforts will be further scaled-up to double the coverage of PWID with HIV testing in Azerbaijan.

During year one and year two of the Project, the Global Fund will support procurement of rapid tests to increase community-based rapid HIV testing and counseling in PWID through mobile units and in service delivery points and improve enrolment in care (pre-ART and ART) for PWID who test positive for HIV. Mobile units will continue to provide testing in cities with high concentrations of key populations and few or no prevention projects working with KAP. To support the targets mentioned above, behavior change communication key messages will be enhanced so that all PWID are encouraged to test for HIV at least once per year.

At the same time, the Government will procure and support necessary HIV ELISA testing from the year one of the project and till take over full procurement for rapid tests in year three of the project implementation.

Intervention 1.1.3. Opioid substitution therapy and other drug dependence treatment as part of programs for PWID and their partners. OST started in 2006 and is currently provided in

two sites opened in the Republican Narcological Dispensary and in the Republican AIDS Center to cater for HIV positive opiate users. For 2016-2018, opioid substitution treatment will be entirely covered by Government including methadone procurement, which is a rare example in the region. The National HIV/AIDS Program provides for scale up OST in existing locations, increase enrolment and retention in treatment.

The Global Fund will further support training of service providers from OST sites to ensure quality service provision and minimal standards of services. To improve sectoral coordination, monitoring and evaluation to boost OST activities and increase coverage the Project will support necessary technical assistance. The Ministry of Health as Principal Recipient will implement the intervention in closed collaboration with the Republican Narcological Center.

Taking into account performance and developments under previous Global Fund grants implementation, the Project will double the coverage of PWID with prevention services (from 18.8% in 2013 to 50% in 2018) and will reach up to 35,641 PWID with preventive as well as HIV testing services. The targets are in accordance with the National HIV/AIDS Program for 2016-2020 M&E Plan (See Annex 4. NAP M&E Plan for 2016-2020).

The activities under this module will be implemented by the Ministry of Health (principal recipient) and the Republican AIDS Center (sub-recipient). The Republican AIDS Center will sub-contract the existing and new NGOs to perform the requested tasks.

Module 1.2. Prevention programs for sex workers and their clients

Intervention 1.2.1. Behavioral change as part of programs for sex workers and their clients. The project will continue support of service provision to SW in 26 sites through 5 projects. The Global Fund is requested to support a total of 4 grants to NGOs in year one, 3 in year two and 1 in year 3 of the project; the Government is committed to gradually overtake HR services for SW by supporting one project in year one, two projects in year two and four projects in year three with complete take over in mid 2018.

A comprehensive range of well-coordinated and flexible services will be provided to SW, using peer and community outreach and based on lessons learnt in the previous period. HIV prevention in sex work settings will be directed to ensure: increased condom use and safer sex; reduced STI burden. A complex approach to be able to respond to various needs (SW who are PWID) will be strengthened. The following approaches will be used: easy access to condoms; easy access to information, communication, and education; risk reduction counseling; peer education; referral system for health care, including HIV testing and counseling, STIs and HIV treatment and care as well as referral to legal and psycho-social counseling services. HIV preventive services will also be provided by mobile units multidisciplinary teams in site with little or not services for SW.

To increase the coverage of SW with preventive services, the Project will introduce a new approach in boosting access of key affected populations through peer-driven interventions (PDI) in three cities with high concentration of Azerbaijan (Baku, Ganja and Sumgait). PDI seeds will recruit other new clients, by providing them peer-to-peer educational session and link them to sites to access preventive services. Around 1,500 new beneficiaries will be reached with prevention services in the first year in the above-mentioned territories, which will achieve coverage of 60% in year 3 of the project. The target is in accordance with the National HIV/AIDS Program for 2016-2020 M&E Plan (See Annex 4. NAP M&E Plan for 2016-2020).

While, there have been improvements in reaching and testing sex workers, these efforts will be scaled-up through mobile units described above as well as in service delivery points, including rapid tests procured under the intervention 1.1.2 from above. The Government will procure and support necessary HIV ELISA testing for key affected populations, including SW from the year one

of the project and will take over full procurement for rapid tests in year three of the project implementation.

The activities under this module will be implemented by the Ministry of Health (principal recipient) and the Republican AIDS Center (sub-recipient). The Republican AIDS Center will sub-contract the existing and new NGOs to perform the requested tasks.

Module 1.3. Prevention programs for MSM

Intervention 1.3.1. Behavioral change as part of programs for MSM. The project will support continuation of service provision to MSM in 8 sites through 1 national project implemented by NGO. Service provision includes outreach work in cruising areas, provision of IEC, condoms and lubricants, counseling services and peer support, STI management and linkage to VCT centers and mobile units, medical and legal consultations. Condoms with increased resistance and lubricant will be procured and distributed by outreach workers. A complex approach to be able to respond to various needs (MSM who are sex workers) will be strengthened. To increase the coverage of MSM with preventive services, the Project will introduce a new approach in boosting access of key affected populations through peer-driven interventions in Baku, Ganja and Sumgait. PDI seeds will recruit other new clients, by providing them peer-to-peer educational session and link them to sites to access preventive services. About 1,500 new beneficiaries will be reached with prevention services in the first year in view of reaching 50% coverage. The target is in accordance with the National HIV/AIDS Program for 2016-2020 M&E Plan (See Annex 4. NAP M&E Plan for 2016-2020). Similarly to PWID and SW, the increase in the number of MSM reached with HIV testing and counseling is due to expansion of mobile VCT units described under intervention 1.1.2 above. The Government will procure and support necessary HIV ELISA testing for MSM from the year one of the project.

The activities under this module will be implemented by the Ministry of Health (principal recipient) and the Republican AIDS Center (sub-recipient). The Republican AIDS Center will sub-contract the existing and new NGOs to perform the requested tasks.

Module 1.4. Prevention programs for prisoners

Intervention 1.4.1. Behavioral change as part of programs for prisoners. Preventive and psychological services for prisoners expanded under current grant and are provided in twenty-one prisons and correctional facilities. The number of prisoners covered with HIV preventive activities has doubled over the past two years reaching 12,968. The Project will expand HIV preventive service to prisoners to all twenty-four penitentiary institutions in country and ensure access of prisoners to a standard package of services that include psychosocial support, safe behavior promotion, hygienic packages, condom and IEC materials distribution, peer-to-peer education, health clubs, etc. A series of information sessions on HIV prevention and health promotion will be provided, including social theater activities. The preventive and psychological support activities are provided by partner NGOs proved to be very effective in collaboration with Prison Medical Department of the Ministry of Justice. The Project is led by programmatic achievements of 80% coverage of prisoners (estimated population 17,500) with prevention services by 2018 and will cover up to 14,000 prisoners.

Intervention 1.4.2. HIV testing and counseling as part of programs for prisoner. The project will increase rapid HIV testing and counseling in prisoners and support HIV testing for patients in prison settings including TB patients. HIV testing in prisoners will be scaled up to reach 80% of prisoners with testing. The established targets are in accordance with the National HIV/AIDS Program for 2016-2020 M&E Plan (See Annex 4. NAP M&E Plan for 2016-2020).

The activities under this module will be implemented by the Ministry of Health (principal

recipient) and the Prison Medical Department of the Ministry of Justice (sub-recipient). The Medical Department will sub-contract existing NGOs to perform the requested tasks.

Objective 2: To ensure universal access to treatment, care and support to PLHIV

The project will support government efforts to ensure universal access to ARV treatment of patients in need, including treatment monitoring, psychosocial support and home-based care to improve the quality of life of people in need. The Government committed to fully support ARV treatment for civil and penitentiary sectors and regular laboratory and clinical examination to PLHIV. At the same time, treatment monitoring in prison sector will be covered by the Global Fund support during the project life with taking over by the Government in mid 2018.

Module 2.1. Treatment, care and support

Intervention 2.1.1. Treatment monitoring. The project will cover the needs related to regular laboratory and clinical examination to PLHIV through Prison Medical Department: determining the viral load for patients, PCR and CD4 testing for HIV positive prisoners. Calculations for tests are based on national protocols provisions based on WHO recommendations. Funds provided by the Government will cover fully the regular laboratory and clinical examinations through the Republican AIDS Center in the civilian sector: the Global Fund will support treatment of PLHIV in prisons only. The table below illustrates the gradual Governmental commitment regarding sustainability monitoring of PLHIV in care (pre-ART and in ART).

	2016		2017		2018	
	GOV	TGF	GOV	TGF	GOV	TGF
# Patients on treatment	2,051	400	2534	450	3077	500
# PLHIV in care	734	615	997	565	1293	515

In addition, the Government will support substantial costs such as staff remuneration, facility costs, opportunistic infections diagnosis and treatment for the entire National HIV/AIDS Program for 2016-2020 (See Annex 5. National HIV/AIDS Program Budget for 2016-2020).

Intervention 2.1.2. Counseling and psychosocial support. Peer support and community-based self-support programs have proven successful in providing enhanced wraparound services to PLHIV, while other project activities work on improving quality of public services and non-discriminatory attitudes. The project will continue to provide support community-based organizations to outreach to PLHIV and KAP with a comprehensive support package, including psychosocial support, mentoring and case-management, support for enrolment and retention in care and linking them to other services (including OST, TB/HIV collaborative). One grant per year will be awarded during project implementation to support two community centers: one for PLHIV and another to support PWIDs and SW.

Care and support, including home based care increase the quality of life for many PLHIV through all disease stages. Under current Global Fund grant, home based care services have been extended outside Baku and provided in 4 additional cities (Sumgayit, Shirvan, Lankaran, Gadjigabul) through community-based organizations. The project will continue to support three NGOs grants to provide home based care and support to those living with HIV/AIDS from hospices.

In parallel, the project will further support a non-governmental organization to provide a standard package of services for people who are released from detention, especially PLHIV and key affected populations. A comprehensive post-release program for prisoners has been established under current grant, which led to successful community follow-up of prisoners and good linkage to HIV care. In order to ensure continuation of the same services, information on contact details for VCT points, NGOs/projects working with key

affected populations, treatment sites, legal advisers, psychologists and other will be distributed.

The activities under this module will be implemented by the Ministry of Health (principal recipient) together with the Republican AIDS Center and Prison Medical Department (sub-recipients). The sub-recipients will sub-contract currently active and new NGOs to perform requested tasks.

Objective 3. To create enabling environment and ensure program sustainability

Module 3.1. HSS: Policy and governance

Intervention 3.1.1. Other: Increase high-level awareness on evidence-based HIV prevention in prison. The prison system is very active in the field of TB and HIV control and registered substantial results. However, it is still reluctant to introduce needle exchange and opioid substitution treatment as part of harm reduction package. The Project will support activities to build awareness and advocate for full harm reduction package implementation in prison. For this purpose, four information and advocacy meetings per year will be conducted with participation of high decision makers during year one and year two. In addition, a study tour to a country were harm reduction and OST interventions are provided in prisons will be organized. It is expected that the relevant measures will be taken to prepare environment for needle exchange and OST in prisons by the end of the Project life.

Intervention 3.1.2. Other: Combat stigma and discrimination. In order to address barriers to health services, the Project will support a series of training to multidisciplinary teams linked to decentralized ART centers on stigma related topics and non-discrimination. In parallel, training will be provided to managers of ART health units to better design management strategies related to reducing stigma and discrimination. In addition, the Project will support targeted communication campaigns in the eve of notable days (World AIDS Day, Candlelight) to build public awareness and promote non-discrimination and non-stigmatization of PLHIV and key affected populations.

The activities under this module will be implemented by the Ministry of Health (principal recipient) together with the Republican AIDS Center and Prison Medical Department (sub-recipients).

Module 3.2. Health Information System and M&E

Intervention 3.2.1. Routine reporting. The Project activities are directed to integrate AIDS software into the health information system. The developed software for monitoring and evaluation of the national program will be integrated at national level to cover laboratory diagnosis, treatment monitoring and management of ARV drugs. In addition, the project will cover routine M&E supervision visits in both civilian and penitentiary sector from central (Republican AIDS Center and Prison Medical Department) to regional level to oversee HIV/AIDS control program implementation.

Intervention 3.2.2. Surveys. Activities under this intervention are oriented to support the costs for second-generation surveillance study in key population groups (PWID, SW, MSM and prisoners). Data from 2011 IBBS have been used as baseline for the current Concept Note and development of the National HIV/AIDS Program for 2016-2020. There is ongoing IBBS exercise in 2014 with the final report to be produced by the mid of 2015. The next round is proposed for the years 2017 based on the methodology used in 2011 and 2014 to ensure data comparability, consistency and monitoring relevant progress and trends. In parallel, a KAP size estimation survey will be initiated in 2017 to verify data provided by the first survey conducted in 2011 and provide reliable data for NAP interventions planning and targets revision. The PSE has been mentioned by WHO NAP Evaluation

report (See Annex 1. HIV Program evaluation preliminary report, draft, WHO). Additionally, specific operational research on key issues to provide evidence for decision-making and improvement of national HIV response will be conducted (ex. HIV and labor migrants in Azerbaijan, etc.).

The activities under this module will be implemented by the Ministry of Health (principal recipient) and the Republican AIDS Center (sub-recipient).

Module 3.3. HSS: Health and community workforce

Intervention 3.3.1. Health and community workforce. Activities under this intervention are oriented to further develop and strengthen capacity of the National HIV/AIDS Program, governmental and NGOs stakeholders and create enabling environment for evidence-based targeted HIV interventions. The project will support quality of HIV services in civilian and penitentiary sectors through a series of capacity building events planned for personnel who administer ART, and for medical and non-medical staff that provide HIV prevention activities in prison settings. Attendance of international events abroad for NAP staff and NGOs in priority issues of HIV/AIDS will be also supported to overtake evidence based interventions, efficient approaches to service provision, innovations and successful experience.

The activities under this module will be implemented by the Ministry of Health (principal recipient) together with the Republican AIDS Center and Prison Medical Department (sub-recipients).

4. Program management

The program management component includes staffing, office management, communication and other relevant activities and costs of the Principal Recipient – Ministry of Health implementation unit and two identified sub-recipients: Republican AIDS Center and Prison Medical Department of the Ministry of Justice.

* * *

Detailed description of the proposed project activities are further presented in the Work plan and Budget files (Annex 3. TGF Workplan and budget) and in Modular Template (Table 3).

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

This request for funding has been designed taking into account the epidemiological profile (described in details in p.1.1. and p.1.2. above) and the most important targets to be addressed in the next period: need to increase coverage of the key affected populations and increase effectiveness of prevention of sexual transmission from key populations to their sexual partners through consistent use of condoms, especially sex workers and MSM. This will be addressed through new strategies: peer-driven interventions, strengthening behavioral change communication for each specific group, diversification of condoms and strengthening of

counseling to reduce risk sexual behaviors, including of the sexual partners.

To address the need to decrease mortality, improve adherence to ART, and improve clinical management of HIV cases, the strategy will involve enhanced focus on improving capacities of multidisciplinary teams in civilian and penitentiary sectors and to increase clinical competencies in regional AIDS centers. A particular focus emphasizes the role of NGOs in community-based outreach with rapid HIV testing, timely clinical follow-up and start of ART and adherence and psychosocial support to PLHIV including home based care. It also takes into account the need for further work on increasing medical workers and public awareness towards stigma reduction and strengthening M&E system as part of the process of service institutionalization and sustainability.

To address the need to improve TB/HIV collaborative activities, the HIV grant will provide support to harm reduction sites that will improve links with specialized TB and HIV health departments to improve crosscutting links and TB/HIV collaborative interventions. The community-based sites establish their services on 'one stop shopping' approach and provide additional services to improve cost-efficiency, quality of services and coverage, e.g. outreach work, HIV testing and counseling, harm reduction, linking with other services (including TB/HIV collaborative), peer-to-peer consultation, psychological consultations, self support and social support. The collaborative activities of that aim for health system changes and collaboration of public medical institutions are being addressed in the TB proposal to the Global Fund. Taking all this into consideration, the following modules have been prioritized:

- Prevention programs for people who inject drugs (PWID) and their partners
- Prevention programs for sex workers and their clients
- Prevention programs for MSM
- Prevention programs for prisoners
- Treatment, care and support
- HSS: Policy and governance
- HSS: Health Information System and M&E
- HSS: Health and community workforce

The Modular Template has been completed and attached to the application in Table 3 enclosed. The performance indicators and budget figures, presented in the Modular Template, are based on detailed estimates of programmatic and financial needs.

3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is <u>not</u> applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.

b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

Republic of Azerbaijan is an upper-middle-income country; this is why the Project focuses 100 percent of the budget on underserved and key affected populations and highest-impact interventions. It is oriented to the needs of the key affected populations: PWID, SW, MSM and prisoners. Although PWID, SW and MSM are the main drivers of the epidemic, they are those who most often experience barriers to prevention measures, treatment and care. These populations

are perceived as lower social classes, are especially vulnerable economically and often hesitate to seek treatment for fear of discrimination and potential legal ramifications. The focus will be made on increasing their access to health care services, promoting harm reduction, condom use and other safe behaviors to prevent the spread of HIV as well as to improve health care services and making them user-friendlier to KAP.

The project aim at increasing coverage and targeting enhanced access to essential comprehensive packages of services for the most vulnerable marginalized and discriminated sub-populations of KAP. Outreach workers will target the most vulnerable PWID who cannot afford syringes and condoms, SW projects will target mostly street SW, which are the most vulnerable socially and simultaneously at highest risk of HIV transmission, as will MSM outreach work target MSM engaging in unsafe sex in cruising areas. The project will provide low-threshold range of harm reduction services, including community access to rapid HIV testing and counseling. The project will provide preventive services to prisoners in all penitentiary institution, including, follow up at release and linkage to civil sector services, and also promote HR service for prisoners.

The project aims to improve the quality of services and increasing equal access of KAP to the same services regardless of location. The project will prioritize KAP access to services through free HIV prevention programs, improving quality of care of PLHIV and PWID and meeting their non-medical needs through psychosocial and peer support through the continuum of care.

In conclusion, the Project interventions target key populations who are at the most risk for HIV and include prevention, diagnosis, treatment, care, support and capacity building activities. Budget-wise (excluding project management), the interventions above consume 100% of the requested project funds, meeting the Global Fund requirements. The project focus on institutionalization and gradual financing of prevention and psychosocial support activities so that by the end of the grant the government in partnership with the civil society can take over all activities.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).

b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.

d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.

e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

The Country Coordination Mechanism oversees the overall implementation of the project and ensures proper coordination between different sectors as well as different programs implemented by other external partners. The CCM will monitor the project progress to ensure that the activities are carried out according to the work plan and indicators of programmatic and financial performance are accomplished. It will make the key financial and programmatic decisions and will have the responsibility to address the main problems and challenges related to

the project.

The CCM meetings will be convened quarterly or more frequently as necessary. Technical working group for HIV/AIDS will work with the stakeholders between the CCM meetings and prepare the documentation to be endorsed by the CCM. The CCM and the Ministry of Health will carry out the role of coordination with other programs and development initiatives. The CCM will ensure practical coordination and collaboration with all local partners involved.

On an annual basis (or more frequently as requested by the CCM), the Principal Recipient will prepare the project progress reports for review by the CCM. These reports will present the current state of the epidemic, project implementation progress, financial expenditures and implementation challenges and problems. The CCM will use this information to approve the changes in the program setup and resource allocation when necessary. The CCM will negotiate the recommended changes with the Global Fund through the country's Fund Portfolio Manager (FPM) and the Country Team.

The Principal Recipient will execute its functions and apply procedures in accordance to the Global Fund requirements and in compliance with the national legislation. The grant funds will be transferred to the special accounts of the PR. The PR will be responsible for all practical issues related to the project implementation including oversight of the Sub-recipients (SRs). The PR will undertake the functions of procurement (of health and non-health products, equipment and services), financial management, project-related monitoring and evaluation and reporting to the Global Fund.

The PR will develop work plans for project implementation and will present project performance reports to the CCM. Financial and activity progress reports will be forwarded to the CCM members for review. On an annual basis, the CCM will review the project performance and proposed work plans for the upcoming year. The following SRs have been identified for this Project:

- Republican AIDS Center – to implement prevention programs for PWID and their partners, SW and their clients, MSM, HIV testing and counseling for key affected populations, counseling and psycho-social support to PLHIV and KAP, capacity building for medical and non-medical service providers, M&E system strengthening and stigma reduction activities.

- Prison Medical Department of Ministry of Justice – to implement prevention programs for prisoners, HIV testing and counseling, regular examinations to PLHIV and treatment monitoring, counseling and psycho-social support for prisoners.

Before signing the SR agreements, the PR will carry out assessments of prospective SRs in terms of their correspondence to the Global Fund requirements vis-a-vis capacities for financial management, procurement, M&E and other aspects. The activities of SRs will be continuously monitored on the basis of verification of programmatic and financial indicators towards project implementation progress, including visits to SRs project sites. The CCM Secretariat and the PR will communicate with the Global Fund on the project progress. Progress Updates and Disbursement Requests will be forwarded to TGF FPM on a semi-annual basis or as otherwise agreed; other documentation will be provided as requested by TGF.

The Republican AIDS Center is also the main technical partner of the project. It will ensure practical coordination and collaboration with all other partners involved. The Local Fund Agent (currently United Nations Office for Project Services, Azerbaijan) will act within the Terms of Reference agreed upon with the Global Fund, including on-site verifications (OSV) of project performance. External audits evaluating the project performance and financial management are an integral part of the proposed management arrangements.

4.2 Ensuring Implementation Efficiencies
Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.
Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM. In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.
Currently there is one Global Funds HIV grant under implementation, valid until the end of 2015, namely: Grant AZE-910-G05-H (PR: Ministry of Health of Azerbaijan). The application has been built to uphold the goal, scope and key directions of the ongoing TGF-financed HIV program through supporting the key priorities of the National HIV/AIDS Program for 2016-2020, namely prevention in key affected populations, care and support for PLHIV and communities and consolidating health service's capacities for successful HIV service provision, with special focus on groups at high risk. Implementation of the National HIV/AIDS Program, as well as development of external funding applications in support of the National HIV/AIDS Program implementation, are coordinated by the Country Coordination Mechanism, an interministerial and intersectorial decision-making body that has under its auspices 4 functional working groups enhancing coordination and capitalizing upon the value added of joint efforts of all key stakeholders from different sectors. Any type of new or additional intervention in HIV are discussed through the CCM structures to avoid overlapping. Interventions proposed under current Concept Note have been designed following a thorough analysis of program needs for 2016-2018 and their coverage under planned funding from both governmental and external sources and are integer part of the National HIV/AIDS Program for 2016-2020 developed in parallel. The process has been carried in a transparent, cooperative and participatory manner, through a country dialogue involving relevant governmental entities, international agencies, and civil society, with the aim to avoid any overlapping of activities, as well as to ensure that all priority interventions are covered, from either local, or external resources.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	Ministry of Health	**Sector**	**GOV**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☒Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and	The Project Implementation Unit (PIU) for the Global Fund projects was established in 2005. PIU have separate teams per each disease. Up to now, HIV PIU has had an experience of management of two HIV Grants (Round 4 and 9). The Program's performance was rated within the grade "A" for the last periods. Current HIV grant is		

planning	implemented together with 13 Sub- recipients (3 governmental and 10 non-governmental organizations). All Grant SRs have enough strong management capacity for the implementation of their projects.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	HIV PIU has extensive experience and capacity to effectively manage and coordinate sub-recipients. PIU has skilled staff and appropriate systems and tools (standard operating procedures, manuals, guidelines) to manage and oversee Sub-recipients project-related M&E, finance and procurement.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	At all levels the PR ensures transparency of all project-related activities – programmatic decisions are made within CCM HIV working group, represented by stakeholders from the various sectors; procurement decisions are made through the Tender Committee composed from independent experts; all financial transactions are done through wire transfers, cash use per small projects is strictly minimized. On-site monitoring of project-related activities (services, events, etc.) are carried out by PIU and SRs' teams on routine basis.
4. The financial management system of the Principal Recipient is effective and accurate	The objective of the PIU financial management is to comply with the Grant Agreement covenant that the Principal Recipient shall maintain a financial management system and prepare financial statements in a format acceptable to the Global Fund and requirements of the Azerbaijan Republic. According to TGF requirement of grants to be used economically, efficiently and only for the purposes described in the Grant Agreement and adequately reflecting the resources and expenditures of the project implementation, PIU is legally responsible for: • ensuring that accounting systems are adequate to generate timely and reliable financial information; • requires & reviews periodic financial reports relevant to each disbursement; and • requires verification of financial reports through regular audits. PIU developed the Program Operations Manual designed with aim to assist the PIU in the financial management system including: budgeting requirements, PIU transaction procedures (special project account, disbursements of funds, bank operations, method of payments), accounting procedures (accounting system, accounting records, foreign currency transactions, fixed assets, petty cash, advances, payroll etc.), financial aspects of contracts administration, financial reporting and audit, financial reporting of SRs, audit of SRs and other financial management's issues. Based on the detailed principles described in the above listed matters PIU ensures the effectiveness and accurateness of financial management system.

5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The Central and regional warehouses of RAC have capacity and are aligned with good storage practice to ensure adequate condition, integrity and security of health products. Those were confirmed during several spot checks visits held by LFA experts, external consultants and indicated in their reports. The personal have passed through "Medicines procurement forecasting and warehouse management" training.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	Drugs and other health products distribution and transportation are made based on normative framework. In order to establish efficient, continuous distribution and transportation of health products to end user 6 pieces 4x4 vehicles were procured and hand over to RAC. These cars are used by 6 regional ART centers.
7. Data-collection capacity and tools are in place to monitor program performance	National M&E Plan on HIV for 2012-2016 years, M&E unit established in 2012 year on the basis of the RAC, M&E team of PIU, unified electronic database for NGOs at the PIU, National HIV M&E software is under development, trained and experienced project management and M&E staff at both PIU and major SRs' levels.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Information data flow and frequency of reporting is reflected in National M&E Plan, All program related information is gathered and analyzed at the level of the RAC and PR (Health Information and Statistics Department). SRs report to the PR on quarterly basis. Quarterly press-releases for the public, semiannual newsletters with detailed information, annual reports (RAC) and semiannual progress updates reports (PIU) are submitted to the PR. In addition to in-country data reporting, the PR provides timely reporting to UN agencies (UNGASS, TESSY, etc.).
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	Assurance and quality monitoring is based on normative acts that provides for the quality assurance requirements across all stages of product movement, including storage and transportation conditions. Storage of medicines has to comply with the Instructions on transportation, storage of medicines, health products endorsed through the MOH.

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance
a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues.

b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.
No major external risks are anticipated that may negatively affect the implementation of the proposed interventions. Still, there are some issues that have to be raised as factors to contribute to risk appearance. It is linked to latest updates to the normative framework regarding funding of NGOs from external sources and the development of the contracting mechanism. The issue has been discussed by CCM, nominated PR and SRs that will sub-contract HIV preventive and psychosocial support service from NGOs and appropriate measures will be applied to ensure timely service provision to KAP and PLHIV. The transition to full government financing of HIV preventive services for key affected populations in 2018 also might be a factor to contribute to risk appearance. The transition to domestic funding is provided in the National HIV/AIDS Program for 2016-2020 and CCM will oversee the implementation of the sustainability plan to ensure there is no interruption or delay in service provision to KAP.