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OFFICE OF THE PERMANENT SECRETARY

The Executive Director
Global Fund to Fight AIDS, Tuberculosis and Malaria
Centre Casaï
53 Avenue Louis Casaï
1216 Cointrin-Geneva
Switzerland
Attention: Dr. Richard Feachem

Dear Sir

Re: Namibia's Round 6 Country Coordinated Proposal on HIV/AIDS and Malaria

Introduction

1. It is with great pleasure that the Namibian Co-ordination Committee for HIV/AIDS, Tuberculosis and Malaria (NaCCATuM), our Country Coordinating Mechanism, presents you with Namibia's Round 6 Country Coordinated Proposal on HIV/AIDS and Malaria.

2. In this letter I would like to present a number of aspects related to the compilation process and contents of our Round 6 CCP as well as to our particular context. While the proposal form did not provide any specific space for these, we believe them to be of significant relevance to our application.

3. Firstly, I would like to refer to your letters of 7 October 2005 (your ref.: Proposals/kcm/AFR/17), according to which our Round 5 HIV/AIDS and Malaria CCPs had been classified in Category 3 by your Technical Review Panel (TRP) and were subsequently not approved for funding by the GF Board. In accordance with the TRP Review Forms for the two disapproved proposals, Namibia was strongly encouraged to resubmit in Round 6 following major revision.

Taking on board Round 5 TRP comments

4. As you are aware, Namibia's CCM had written to your esteemed institution during December 2005 in response to the Category 3 classification of our Round 5 HIV/AIDS and Malaria CCPs. Our CCM had specifically referred to the list of weaknesses identified by the TRP and had provided specific explanations in this regard. We would like to point out that our current submission has taken full cognisance of all Round 5 TRP comments.

5. In this regard we would like to share the following with you: a) Based on our annual monitoring reporting, Namibia has evidently surpassed our initial targets on a number of indicators contained in our Third Medium Term Plan on HIV/AIDS. This success was realised with the commitment of the Government of Namibia, and the technical and financial support of the donor community. It became clear therefore that new programme targets needed to be set. Consequently, a comprehensive Universal Access (UA) target setting exercise for Namibia's response was done through technical working groups composed of a wide range of stakeholders during the first half of this year. This exercise was based on the relevant contents of respective global and continental (African Union) Universal Access declarations, including the Political Declaration of the UNGASS+5 high level meeting of the UN General Assembly of 2 June 2006. It was further informed by considerations of feasibility and disbursement capacity, which were based on the track record established by our Namibian sub recipients of Global Fund, PEPFAR and other funding support. b) In addition, a detailed coverage and financial gap analysis was executed. Our coverage gap analysis was largely informed by and further expanded on a global coverage study undertaken by the Futures Group through a USAID/PEPFAR contract. Our financial gap analysis is premised on a comprehensive costing exercise executed during the past four months. The latter took into account the revised Universal Access targets as well as the most current Namibian unit costs for respective basic service packages obtained from our experience with the implementation of Phase 1 of our Global Fund Round 2 grant, the PEPFAR 2006 Country Operational Plan (COP), and projects implemented by civil society organisations financed by various bilateral and UN agencies in Namibia. The results of this exercise therefore obviously override the costs contained in Namibia's Third Medium Term Plan on HIV/AIDS, which was compiled more than two years ago.

6. We believe that Namibia, being a country with a relatively small population and with the current increasing trend to strengthen capacity to deliver, may be one of the few countries in Africa where the universal access and MDG targets can be met. Evidently, this can only be done if there is sustained financial and technical assistance commitment for the next eight to ten years. Namibia also needs adequate time to build up its human resource capacity and to further decentralise the national response to constituency/district level in order to effectively reach the most vulnerable groups.

Growing role for civil society and private sector

7. As a result of the country's history, the civil society needs to be strengthened and the private sector needs to be more engaged to enhance our service delivery mechanisms. Our current submission envisages a growing role for civil society in Namibia's response to both HIV/AIDS as well as malaria. Consequently, the proportion of funds allocated to civil society organisations, including vulnerable groups, academic institutions and the private sector is significantly higher than in our Round 5 submissions. The fund allocation to government makes for only around 50%, but is in fact less, since a significant proportion of antiretroviral and malaria medicines, which are procured centrally through government, are distributed on no-cost basis to hospitals which are operated by faith based NGOs. The latter cater for around 20% of all ART and malaria clients in the not-for-profit sector. Significant funds in the proposal are allocated to institutional and human resource capacity building of civil society entities and umbrella organisations.

The current Round 6 Proposal

8. We would like to emphasise that the CCP being submitted now (which contains both the HIV/AIDS and Malaria components in one proposal in line with the requirements of the Round 6 guidelines) is a substantially revised resubmission of our Round 5 CCPs for HIV/AIDS and Malaria.

9. The substantial revision of our Round 6 CCP as compared to last year's submission is evidenced by the following: a) A considerably more focused proposal and b) a significantly reduced budget.

10. Enhanced focus was obtained through the implementation of a comprehensive gap analysis exercise and a review and revision process that largely benefited from concurrent and very integrated planning/programming exercises for this Round 6 CCP, as well as for our Round 2 Phase 2 proposal (which is also due for submission during the first week of August 2006) and the US Government/PEPFAR 2007 Country Operational Plan (COP) and funding estimates for subsequent years. In addition, we closely worked with all development partners and took into account the following, a) the United Nations Development Assistance Framework (UNDAF) for Namibia for 2006 to 2010, b) major programmes implemented by the European Community and respective bilateral partners, as well as c) other ongoing and envisaged development partner support.

Budget

11. Our Round 6 proposal includes a significantly reduced budget. The HIV/AIDS component - budgeted at USD 49 Million - is 45 percent less than that of our Round 5 proposal, while the malaria component budget - at USD 16 Million - has been reduced by 25 percent.

HIV/AIDS Component

12. Our proposal focuses especially on those service delivery areas, which experience inadequate coverage and considerable funding gaps into the next five years.

13. For HIV/AIDS these are: 1) Orphans and vulnerable children (USD 9 Million); 2) Case management, essentially antiretroviral drugs, including paediatric formulations (USD 9 Million); 3) Community-based prevention, care and support, including advocacy and BCC outreach, home-based care and psychosocial support (USD 7,5 Million); 4) Capacity building and support for enhancement of the coordination and partnership functions of civil society and the private sector (USD 7,1 Million); 5) Health systems strengthening (USD 6,5 Million); 6) Condom marketing and distribution as an important component of prevention (USD 4,7 Million); 7) M&E and operational research (USD 3 Million) and 8) mainstreaming and workplace programmes (USD 1.6 Million).

14. The plan we have outlined in our proposal presents an ambitious but practical approach to respond to the HIV/AIDS epidemic in Namibia. We firmly believe that should the Global Fund finance these efforts in their entirety, we will be able to accelerate the response to the HIV/AIDS epidemic and during the next five years substantively turn the tide of the epidemic. All efforts have been made to ascertain that the funding requested in this proposal does not replace any resources provided through our own Namibian sources or duplicate activities supported by partners. In fact, complementarity and mutual cohesiveness have been important considerations, especially while specifying detailed activities and compiling the relevant budgets.

15. We are confident that our proposal provides for a very well crafted approach to Namibia's current HIV/AIDS situation in that it addresses key priority areas as outlined above, which include focused interventions for vulnerable groups and address environments and stakeholders that drive the epidemic, but have to date been inadequately resourced. In addition, it goes further than our previous proposal in that it highlights strategic intervention areas that are aimed at building the determinants of sustainability, namely institutional capacity building for all major players, very strong human resource development efforts, and health systems strengthening geared towards integration of services. This proposal therefore lays solid foundations for the "long haul", which we believe to be very important in our national response to the HIV/AIDS epidemic.

16. Further more, the advantage of Namibia being a small country of 2.2 Million inhabitants is that every effort detailed in our proposal reaches, in one way or another, each of our citizens. We therefore view our proposal as an opportunity for the Global Fund to comprehensively fill specific resource gaps in our expanded national response, and to have the unusual opportunity to reach every member of one of the most HIV/AIDS impacted populations on the planet. Namibia, situated in the very epicentre of the pandemic in Southern Africa, has around 280,000 citizens infected with HIV.

Malaria Component

17. I should also like to emphasise that our CCM regards the Malaria component of our proposal as very important indeed. This component includes the following: 1) Malaria treatment (arthemeter combination therapy - ACT)(USD 5,5 Million); 2) Insecticide treated nets (USD 4,5 Million); 3) M&E and operational research (USD 2,5 Million); 4) In-door residual house spraying (USD 1,2 Million); 5) Human resource development (USD 1 Million) and 6) Behaviour change communication (USD 0,7 Million).

18. We believe that our Malaria component contains an ambitious but practical approach to combating Malaria in Namibia. It will contribute to a rapid roll-out of interventions that are all proven in Namibia, but that have lacked the necessary resources for comprehensive scale-up towards universal access. Approximately 1, 5 million citizens live in Malaria endemic areas, an average of 400, 000 Namibians are annually treated for Malaria and about 1 000 deaths occur every year. The strong interaction of the Malaria epidemic with HIV/AIDS poses a serious threat, which needs a much stronger response. Malaria still causes the largest number of patients annually. It contributes significantly to maternal mortality (especially in conjunction with HIV/AIDS) and is the first cause of death of children under 5 years of age. Addressing Malaria comprehensively and effectively requires broad health systems support and especially a rapid scale-up of the human resources and various technologies required for the implementation of our five year Roll Back Malaria strategy. This proposal makes an important contribution in this regard.

Additionality of funding

19. Also, and very importantly, we would like to highlight that the results of our funding gap exercise demonstrate very clearly that despite foreseen funding from a number of sources, including Phase 2 of our Global Fund Round 2 grant, USG/PEPFAR and other partners, and in spite of increasing funding from Namibia's Government over the medium term, the funding gap for Namibia's response is very considerable. In fact, even if our current submission for Round 6 funding would be approved – which we strongly trust – a very significant funding gap still remains. In addition, Namibia will also elaborate on basket funding and budget support for drugs and medical supplies in order to proceed towards more enhanced and sustainable financing mechanisms.

Processes followed

20. With regard to the process followed in compiling our current submission, I should like to emphasise that Namibia has made considerable efforts to implement a very broadly based process which remained open to participation by all stake holders and consciously and at a number of occasions extended invitations in that respect. We started our process of revision of the Round 5 CCP a considerable time before the GF Board called for Round 6 proposals. We involved a very significant number of stakeholders directly through the establishment of multi-sectoral technical working groups on the specific intervention / service delivery areas. These working groups were provided with technical assistance, which thereby became available to all represented stakeholders, including civil society. We ensured that minority and

vulnerable groups were well represented and could actively participate. In addition, a series of dedicated meetings with specific organisations and/or interest groups were held, e.g. the Partnership Forum (which essentially represents all UN, EC and bilateral development partners working in Namibia), the various organisations representing the USG/PEPFAR in Namibia, PLWHAs, NANASO, the umbrella for AIDS service organisations, and NABCOA, the business umbrella organisation. A considerably more active role was played by the latter two organisations, whose coordination of civil society/private sector stakeholders was pivotal. We believe that this augurs well for these organisations becoming increasingly capacitated to potentially take on principal recipient functions in future.

Role of the CCM

21. Further more, we would like to inform your good office that throughout the process we took very close cognisance of the contents of the Country Summary Report for Namibia on the assessment of our Round 5 CCP development process. This evaluation had been commissioned by your institution and was executed by the Euro Health Group in our country - amongst only very few others - during November/December 2005. We have actively and closely engaged the CCM and specific CCM members on various occasions and at important milestones throughout the process and beyond the formal CCM meetings. This included a full day session for the purpose of finally reviewing our proposal with a number of CCM members. We would also like to point out that both the last two meetings of the CCM, which deliberated on the details of our proposal and finally endorsed it, were chaired by the vice-chair, who represents the private sector on the CCM.

Namibia's socio economic status

22. Finally, we are of course not privy to the process in which you are engaged. But we are hopeful that a cursive assessment of the macroeconomic status of our country will not work against us. From afar, it might seem that Namibia is relatively wealthy - our per capita income was recently just over U$D 1,000. This completely shadows our reality. Only 15% of our population have access to private medical insurance, while 80% rely on the public and not for profit private sectors for their medical care. Over 40% of our inhabitants live in abject poverty – subsisting on only about USD 1 per day. At the same time, factor costs in Namibia remain relatively high and are in most instances higher than those in South Africa, from where many items are imported. Also, Namibia's Gini co-efficient is amongst the highest in the world, which indicates the severe income disparities that exist between the wealthy and the poor. Thus, while our government expenditure on health is close to 10 %, we continue to fall short of the funds required to comprehensively address HIV/AIDS and Malaria in our country.

23. As part of a 2004 UN supported Common Country Assessment, the following Triple Threat to Namibia's people was identified: 1) the HIV/AIDS epidemic; 2) high levels of income poverty concomitant with high and rising levels of food insecurity; and 3) severely compromised governance and delivery of social sector services. Root causes for persistent high levels of income poverty are low economic growth, high

levels of unemployment and income inequality, pervasive gender inequality, incapacity and loss of life due to HIV/AIDS, Malaria and other diseases, inadequate access to and quality of education, and widespread environmental degradation. Natural resources are the main source of livelihood and survival for the vast majority of Namibians, yet processes of impoverishment and environmental degradation interact in ways that reinforce each other.

Resume

24. We strongly believe that the vicious cycle created by the Triple Threat described above must and can be broken. The approval of our Round 6 proposal to combat HIV/AIDS and Malaria in Namibia can make an enormous contribution to that important endeavour.

Yours sincerely,

Dr. Kalumbi Shangula
Chairperson: NaCCATuM
Permanent Secretary