



Research Agenda



Economic Commission for Africa



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About CHGA

Under the Chairmanship of the Executive Secretary of the Economic Commission for Africa (ECA), K. Y. Amoako, the Commission on HIV/AIDS and Governance in Africa represents the first occasion on which the continent most affected by HIV/AIDS will lead an effort to examine the epidemic in all its aspects and likely future implications. The challenge for CHGA is to provide the data, clarify the nature of the choices facing African governments today, and help consolidate the design and implementation of policies and programmes that can help contain the pandemic in order to support development and foster good governance.

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Preface

In February 2003, United Nations (UN) Secretary-General Kofi Annan announced his intention to establish the **Commission on HIV/AIDS and Governance in Africa (CHGA)**. The strategic aims of CHGA are: (i) to assess the complex and long-term implications of the HIV/AIDS epidemic on government capacity and economic development in Africa, and to make African governments, their citizens, and their international partners fully aware of the scale, gravity and nature of this threat; (b) to mobilise political will amongst African governments, regional and international organisations, civil society, business and other stakeholders in support of adopting the necessary policy and programme measures in the fields of human resource capacity planning and scaling up treatment.

Under the Chairmanship of the Executive Secretary of the Economic Commission for Africa (ECA), Mr. K.Y. Amoako, CHGA represents the first occasion on which the continent most affected by HIV/AIDS will lead an effort to examine the epidemic in all its aspects and likely future implications. The work of the Commission will last for two years and be guided by twenty-one Commissioners who bring considerable experience and expertise to the issue from diverse perspectives. The specific mandate of the Commission is to complement the vital work on transmission and prevention being done by UN and other agencies, with a rigorous agenda that charts the way forward on HIV/AIDS and governance in Africa in three crucially interrelated areas:

- (a) the implications of sustained human capacity losses for the maintenance of state structures and economic development;
- (b) the viability (technical, fiscal and structural) of utilizing anti-retroviral (ARV) medication as an instrument of mitigation; and
- (c) in partnership with UN and other agencies, synthesizing best practices in HIV/AIDS and governance in key development areas with a view to formulating policy recommendations.

In all three areas, the challenge for CHGA is not only to detail the choices that confront African governments, but also to assist them in delineating the policy options needed to begin the formidable task of maintaining development and good governance in the era of AIDS. The Commission will address essential gaps in responses to HIV/AIDS and its wider impacts. It will focus on the challenges of governance –

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Given the urgency of the task, CHGA is an activist Commission. It will not wait for its Final Report (scheduled for June 2005) to make its key findings known and to energetically advocate their adoption.

including maintaining essential public services, keeping economic development on track, maintaining rural livelihoods, tackling the gender dimension of the epidemic, and ensuring national security – despite the fact that large numbers of adults are living with HIV/AIDS.

Given the urgency of the task, CHGA is an activist Commission. It will not wait for its Final Report (scheduled for June 2005) to make its key findings known and to energetically advocate their adoption. In their first meeting on 16 -17 September 2003, the Commissioners have placed great emphasis on the exceptional nature of the HIV/AIDS epidemic and the need for Ministers of Finance and their international development partners, including the global financial institutions, to begin the process of adjusting their fiscal and macro-economic frameworks to address effectively the HIV/AIDS challenge.

Background

By all accounts, the African continent has been the most severely ravaged by the HIV/AIDS pandemic. The statistics on the toll that the pandemic has already exacted are grim enough, but grimmer still are forecasts of the consequences which are still expected to flow over the medium to long term. With increasing tempo HIV/AIDS is reducing the living standards of communities on the continent; diminishing their capacities for personal and social achievement as well as making it difficult for them to maintain what has been secured over past decades in terms of social and economic development. Not surprisingly, a true process of immiseration is now observable in many parts of the continent – particularly in the hardest hit countries in southern Africa.

A distinctive characteristic of the pandemic is that it appears both as a **crisis** and a **systemic condition**. The crisis nature of the pandemic is evidenced by the speed with which HIV has spread across the continent. In some communities, infection rates have increased from 4 to 20 per cent or more in adult populations in less than a decade. In Cameroon, for example, the levels of infection have doubled in just the last six years. Thus, before societies are even aware of the structural threat of the pandemic, their communities have been deeply penetrated.

The systemic dynamics of the pandemic is revealed in its associated morbidity and mortality. Increasing numbers of people, mostly healthy, productive young women and men, are falling ill and dying. A 2000 survey in Bobo-Dioulasso, Burkina Faso, showed that infection rates among young girls aged 13 to 24 were 5-8 times higher than those among boys of the same age (UNDP, 2001). In lower prevalence situations, young men usually have higher infection rates than young women; as the pandemic progresses, an increasing number of women are infected. Crucially, in both groups, males and females, HIV/AIDS impacts most heavily on the most productive sectors of African economies, namely prime-aged adults, thus robbing these economies of scarce skills, depriving children of their parents and the continent of a generation in the prime of their working lives.

Policy responses over the past two decades have concentrated on the pandemic's first characteristic: namely, the need to decrease the level of prevalence among communities on the continent. This has imposed the imperative of targeting interventions aimed at modifying individual and community behaviour through Information and Education Campaigns (IEC). The process, however, necessitates changes in society's sexual

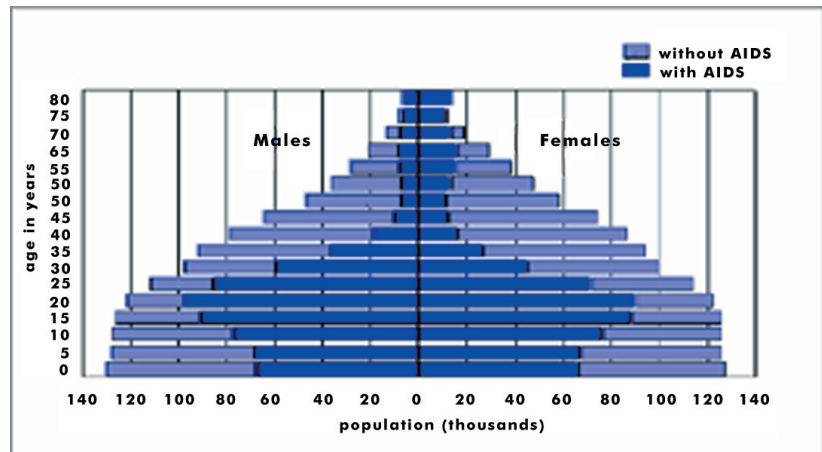
A distinctive characteristic of the pandemic is that it appears both as a crisis and a systemic condition.

An estimated 20 million African lives have been lost to the pandemic and a further 30 million are presently thought to be living with the virus.

norms, values and the creation of an environment which promotes the possibility of open and honest discussion of sexuality and dying. As such, it is evolutionary rather than revolutionary. Hence, whilst being effective, behavioral modification strategies have had little impact on curbing the pace and intensity of HIV prevalence across the wider African continent over the past two decades.

In ten countries on the continent, HIV prevalence among adults has exceeded 20 percent and it has risen above 10 percent in an additional eleven countries. An estimated 20 million African lives have been lost to the pandemic and a further 30 million are presently thought to be living with the virus. As a result, life expectancy at birth has fallen dramatically. In Malawi, Botswana, Mozambique and Swaziland, life expectancy is now less than 40 years, while for the continent as a whole it is 47 years – a figure not dissimilar to the continental average at the time of independence. Progress made in life expectancy over four decades is being wiped out. Against this background of declining life expectancy and increasing mortality, the overall population growth rate of the worst affected countries is expected to decline by 3 percent by 2010. As a consequence, the age pyramids of the most affected societies are expected to change dramatically, with a narrowing of the distribution in the working-age population and a consequent problem with respect to age dependency, resulting from larger numbers of youthful and elderly dependents (see Figure 1).

Figure 1: Projected population structure with and without the AIDS epidemic, Botswana, 2020



The Challenge for CHGA

The ability of African governments to respond to this systemic challenge will largely depend on three interrelated factors:

- their understanding of the long-term development threats posed by HIV/AIDS and the related costs –both social and economic – of inactivity;
- their capacity to devise and cost appropriate policies and programmes for mitigating the development impacts of HIV/AIDS and;
- their ability to marshal adequate and sustained resources to support these policies and programmes.

Three core challenges confront the Commission on HIV/AIDS and Governance in Africa: the **first** is to help African policy makers to fully grasp the nature of the long term development challenges posed by HIV/AIDS to the constitution of their societies; and the ability of these societies to continue functioning normally. This means helping them to understand the impact of HIV/AIDS from three inter-related levels: the micro level (family, households and communities), the level of structures both public and private - i.e. education, military, health, business sector – (the sector level), and finally the likely implications of these impacts for the ability of state and society structures to continue functioning normally (the macro level).

The **second** challenge for CHGA is to assist African policymakers in devising appropriate policies and programmes to help treat the millions of Africans already living with HIV/AIDS. This has three components: first, enabling African governments to fully understand the extent of recent advances in the biomedical field in relation to the efficacy of HIV medication in extending the productive lives of people living with the virus. Second and relatedly, to help them to devise appropriate strategies that would take full advantage of recent changes in global trading rules and the related drop in the price of HIV related medication for resource limited countries. Finally, to assist policymakers in understanding both fiscal and structural implications of up scaling HIV related medication in resource limited settings.

To compliment these two core research activities, CHGA will also actively seek to engage a wide range of stakeholders – including civil society organisations, development practitioners, research institutions,

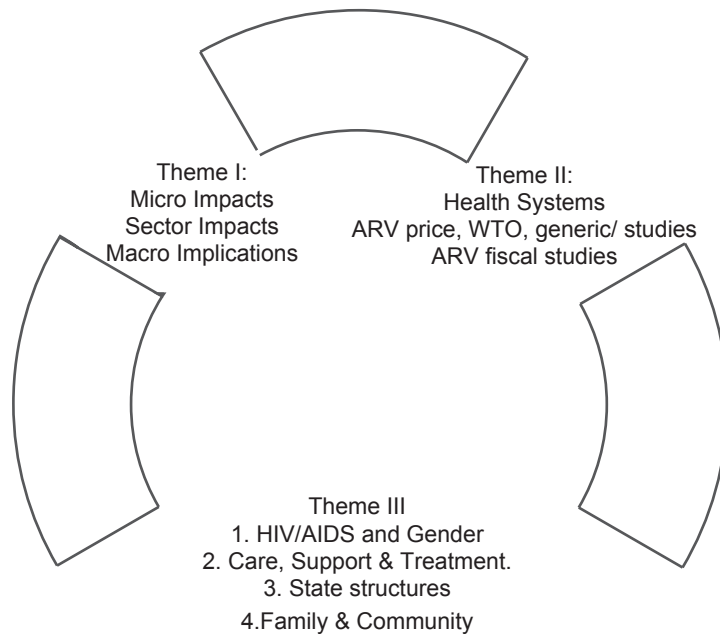
The ability of African governments to respond to this systemic challenge will largely depend on three inter-related factors.

In specific instances this research may provide African governments with policy tools, but in general it will serve the purpose of directing policymakers to existing best practices and best analyses of engaging with HIV/AIDS in resource limited settings.

specialist UN agencies and People Living with HIV/AIDS (PLWHA) - in delineating the most effective mitigations strategies drawn from their experiences of confronting HIV/AIDS. In specific instances this research may provide African governments with policy tools, but in general it will serve the purpose of directing policymakers to existing best practices and best analyses of engaging with HIV/AIDS in resource limited settings.

The three challenges discussed above, neatly lend themselves to three forms of inter-related research components for CHGA – see Figure 2:

Figure 2: CHGA's three core research themes



Research Components

Theme I: Human Capacity Losses and Development implications

African policymakers are at a very early stage of understanding how the structural impacts of human capacity losses (micro, sector and macro) will affect their long term development capacity. Thus far, the projected development implications, as measured by anticipated reduction in the growth rate of GDP, range between 0.3 and 1.5 per cent annually. The cumulative implications of this impact will prove to be a considerable challenge for countries with limited resources. It is also increasingly clear that the existing models, and the development impacts they project, either conceal or fail to adequately capture the extent of the long term development challenges posed by HIV/AIDS for the most affected states and societies on the African continent.

The problem lies at the high level of abstraction. The advantage of GDP is that it is an effective indicator of macro movements as it relies almost exclusively on aggregate data. Unfortunately the HIV/AIDS pandemic is unfolding at the micro level – with significant psychosocial impacts on family members, particularly children, which are difficult to capture in aggregate terms. Moreover, the majority of HIV infections at any one time are asymptomatic and the full effects of the HIV epidemic on mortality and orphanhood will take decades to unfold. These factors are central to understanding the difficulties of mapping the long-term development implications of the pandemic. The time delay compromises the ability of analysts to monitor and fully capture the true nature of the threat posed by the pandemic. In turn, this also acts to slow down the nature of the response needed to effectively safeguard societies and communities against the effects of the pandemic – thus delaying the rewards of action.

Across Africa, HIV/AIDS is significantly reshaping the demographic structure of families. This is diminishing the capacity of communities for sustainable development whilst simultaneously reducing their ability to maintain what has been secured over past decades in terms of social and economic growth. The pandemic brings three processes together in a particularly devastating combination: **First**, HIV/AIDS is killing people in the prime of their working lives. This has the effect of sharply

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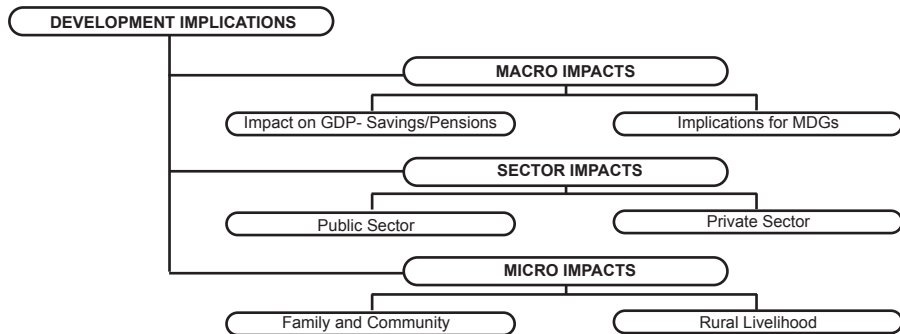
The pandemic brings three processes together in a particularly devastating combination

reducing life expectancy, changes labor force demographics and destroys intergenerational human capital formation. **Second** and relatedly, by destroying intergenerational human capital formation, HIV/AIDS is also weakening the ability of succeeding generations to maintain the development achievements of the past. **Third**, the net effect of the preceding two processes is the systematic erosion of society’s ability to replenish the stock and flow of vital human capital needed to maintain and ensure socio-economic development. The net effect of these losses is that households rarely recover even their initial level of living, since their capacity is eroded. As a result, a true process of structural economic decline quickly sets in. The process is thus insidious, since the effects are felt only over the long-term, as increasing mortality among the most economically active members of African societies translate into low adult productivity a generation or two later.

As such, the erosion of vital human resources by HIV/AIDS has not only personal costs for those affected, but also deep implications for the structure of families, the survival of communities, constitution of economies and to the extreme, the very viability of certain aspects of state structures.

The Commissions work will seek to map the implications of human capacity losses from HIV/AIDS for the maintenance of state structures and economic development at three complimentary levels– micro, sector and macro, see **Figure 3**. To ensure that the work has a high degree of

Figure 3: CHGA's three core research themes



relevance and is consistent with sufficient depth and scope, the mapping exercise will converge on five **case study countries**: *Ethiopia, Kenya, Senegal, Zambia and the Democratic Republic of Congo*. Collectively, these case study countries reflect: (a) the diversity of the continent – economic, political and socio cultural; (b) countries with different HIV prevalence – both in terms of current and anticipated levels; and (c) variations in strategies pursued by central government in terms of prevention and care. In all five countries, the research activities will be identical in both methodology and scope – that is, as much as possible the same components under each of the three levels will be investigated in each country.

By approaching Africa's HIV/AIDS crisis from this multi-dimensional perspective, CHGA's work will enable policymakers to have a much fuller grasp of the way HIV/AIDS undermines inter-generational development capacity and the likely implications for: the family, communities, the public/private sector and ultimately state capabilities – both fiscal and structural. In the absence of such a broad appreciation of the structural threats posed by HIV/AIDS, policymakers run the risk of drawing conclusions from existing literature – which as we have seen, fails to fully capture the true nature of the pandemic's threats to the fabric of African societies in the decades to come.

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Table 1: Sectoral Studies

Country Studies	Partner Institutions	Case Country	Synthesis
Macro/ Fiscal Studies	World Bank/ International Monetary Fund and African Development Bank	All	
Private Sector	Boston University: Center for International Health and Development – support from ILO	All	CHGA
Public Sector	University of Natal: Health Economics & HIV/AIDS Research Division (HEARD) – support from ILO	All	CHGA
Military Sector	University of Pretoria – support of UNAIDS	All	CHGA
Family and Community	Lead Consultant with Institutional support from UNICEF and UNAIDS	All	
Rural Livelihood	University of Makerere., with support from the Food and Agriculture Organization of the UN (FAO) and the World Food Programme (WFP), UN Regional Inter-Agency Coordination and Support Office (RIACSO)	All	CHGA
Health Sector	Unité de Recherche Prise en Charge de SIDA en Afrique, IRD, Sénégal University of Southampton: Centre for AIDS Research, UK	All	CHGA

Theme II: Treatment and Access to Care

The implications for the care and treatment of people living with HIV/AIDS extends from the immediate family to the extended family and eventually stretches to the community, finally to the state. Providing health care, for whatever disease, is essential if the quality of life for the majority of people living in any given place is to be improved. By restoring health and prolonging life, treatment for AIDS benefits not only those who are ill, but also their families, community and the nation in which they live. As individual nations benefit, so does the rest of the continent, from the goods they produce to the services they offer and the cultural contribution they make to humanity. But, access to treatment is not simply an abstract question of logistics and economics. Each individual denied treatment is denied his or her right to life (under the UN Human Rights Convention), hope and a focus on the future. For the individual, denial of life-giving drugs leads to fear, anxiety and bewilderment and, for the many who are parents, uncertainty as to what will happen to their children after they, the parents, die.

Yet, until recently, the option of treatment for the majority of people living with HIV/AIDS in Africa had seemed impossible: high costs, demanding treatment regimes and the lack of even basic health infrastructure in many heavily affected countries were all cited as potential insurmountable barriers. Today, however, despair over unmitigated mass human suffering is giving way to hope over the possibility of feasible AIDS care. A number of recent developments are responsible for this dramatic change in perception:

1. the emergence of simpler treatment regime in the form of a single pill in the morning and the evening;
2. the dramatic drop in the cost of Anti-Retroviral Medication (ARV's);
3. the success of a number of pilot treatment programmes in low income countries leading to agreement on a medical treatment protocol for resource-limited settings
4. increased international funding for Anti-Retroviral Treatment (ART) for low-income countries.

As a consequence, the international climate of opinion has now shifted in favor of sharply expanding HIV/AIDS treatment in low-income countries. In June 2001, for example, the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS unanimously adopted a Declaration of Commitment recognizing the need for implementing: 'national strategies,

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supported by regional and international strategies [...], to address factors affecting the provision of HIV-related drugs, including antiretroviral drugs.’ As a direct follow up to UNGASS, the Global Fund to fight AIDS, Tuberculosis and Malaria has been put in place and along with the World Health Organization (WHO), has pledged to expand ART to 3 million people in the developing world by 2005. Similarly, the Economic Community of West African States (ECOWAS) has committed itself to providing treatment access to 400,000 patients, representing at least one-third of the people in need of HIV treatment in the region by the end of 2005.

What is clear, however, is that progress in scaling up has not kept pace with rising demands.

What is clear, however, is that progress in scaling up has not kept pace with rising demands. It is estimated that ART was initiated for only an additional 70,000 patients during 2002, leading to only 300,000 HIV-infected persons in the developing countries currently receiving ARV’s of any kind – nearly half of them in Brazil alone. The WHO estimates that there are currently 50,000 people on antiretroviral therapy (ART) in Sub-Saharan Africa, coverage of only 1%, whilst over 4 million people remain in need of immediate treatment on the continent. The first funding commitments by the Global Fund made in 2002 will allow a two-fold increase in the total number of individuals receiving ART in developing countries, and a six-fold increase in Africa. In addition, the commitment by the WHO to provide ARV to an additional three million people (3by5) across the developing world – the majority in Africa - by the end of 2005 will also contribute enormously in helping Africa to meet the challenge of scaling-up treatment.

A large gap clearly exists between international commitments for ART provision and the level required to meet the unmet demands of Africa’s HIV population. Given the reality that HIV prevalence is showing scant signs of slowing down anywhere on the continent, and the related fact that the full impact of the pandemic is still to come, the need to fill the treatment gap is a necessity. If this is to happen, then the cost of both providing affordable drugs and of creating the necessary infrastructure for their delivery will need to be carefully understood by African policymakers. With the help of core partners – see Table 2 - the challenge for CHGA is to assist African governments in understanding the choices they confront in bridging this treatment gap. In particular, they need to understand the long-term benefits, not only to the families concerned, but to maintaining the critical state structures and economic development of sustaining the lives of the millions of their population affected by the pandemic.

Crucially, their ability to bridge the treatment gap will also largely depend on their capacity to devise and cost appropriate policies and programmes in support of systems of health care targeting HIV/AIDS. Clearly this is the domain of the WHO and as such CHGA will seek to work very closely with them in devising recommendations for African governments. Beyond this, the activities of CHGA on this important issue of treatment will focus on helping African governments to understand:

- the fiscal implications of scaling up ARV treatment - including procurement and sustainability - in resource limited-settings;
- the capacity of existing health infrastructure and human resources to guarantee efficient delivery of ARV's (including the assessment of voluntary counseling and testing (VCT) for HIV infections systems);

In partnership with the World Bank's Treatment Acceleration Programme (TAP), CHGA will explore the feasibility of decentralising access to ART treatment in Africa. The TAP initiative offers CHGA a unique insight into two core areas: regulation and decentralization of ARV treatment. In many countries access to ART has been fragmented and uneven, with states in some cases having little control over the distribution or administration of the therapies. Further, there are many areas, especially rural areas, where there is little infrastructure for delivering ART. The question, then, is how to decentralize access to these treatments, away from the major cities and large hospitals in order to widen the access base. The benefits of decentralization would be firstly to widen access to ART and secondly to ease the burden on hospital infrastructures, so freeing them to undertake other tasks and preventing 'crowding out' of other forms of treatment. To answer this question it will be necessary to study programmes that have been introduced to provide access to ART, and to see the different roles of state institutions and infrastructures, NGOs, and local and community organizations in this process. How can all of these organizations be coordinated to ensure widespread and decentralized access to treatment?

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Table 2: Key partners in health systems and ARV studies

Sector Studies	Partner Institutions	Case Country
ARV Fiscal Studies	The Futures Group -	Not applicable
Health Systems Capacity Studies	WHO	Not applicable
Decentralization studies	World Bank / TAP Secretariat UNECA	Burkina Faso, Ghana, Tanzania
ARV experience studies	Unité de Recherche Prise en Charge de SIDA en Afrique, IRD, Sénégal	Senegal
Background Papers on HIV/AIDS and Health Systems	Centre for AIDS Research,	Zambia, Kenya and Democratic Republic of Congo
Synthesis of final work	CHGA Secretaries and Futures Group	All

The overall activities under this component of CHGA's work will seek to complement the vital work being conducted by UNAIDS and other agencies.

Theme III: Best Practice

As an 'activist commission' CHGA does not intend to have distinct 'research' and 'implementation' phases, but rather that advocacy and policy engagement are mounted in parallel with research. It will seek stakeholder buy-in to the CHGA process and outcomes during its two-year lifetime, so that when the Final Report is launched, it falls on fertile ground. Through a combination of web-based discussion strategy, conferences and workshops, the best practice component of CHGA's activities will engage with civil society organizations, including associations of people living with HIV/AIDS, service delivery organizations, and those involved in research as well as specific policy response units – both within the UN system and beyond.

The overall activities under this component of CHGA's work will seek to complement the vital work on best practices in areas such as education, prevention, home-based care, etc., being conducted by UNAIDS and other agencies. Specifically, it will concentrate on the how: how do we translate the knowledge we have accumulated from the past two decades of confronting HIV/AIDS into effective policies and programmes of mitigation. This will be achieved through a review of cutting edge research undertaken by partner institutions both within and outside the UN system, and a synthesis of experience with policies and programmes concerned with mitigating the impact of HIV/AIDS. Two broad outcomes are expected: first, to provide best practice policy tools in the area of HIV/AIDS and governance; and second, to serve the purpose of directing policymakers towards existing best practices and best analyses.

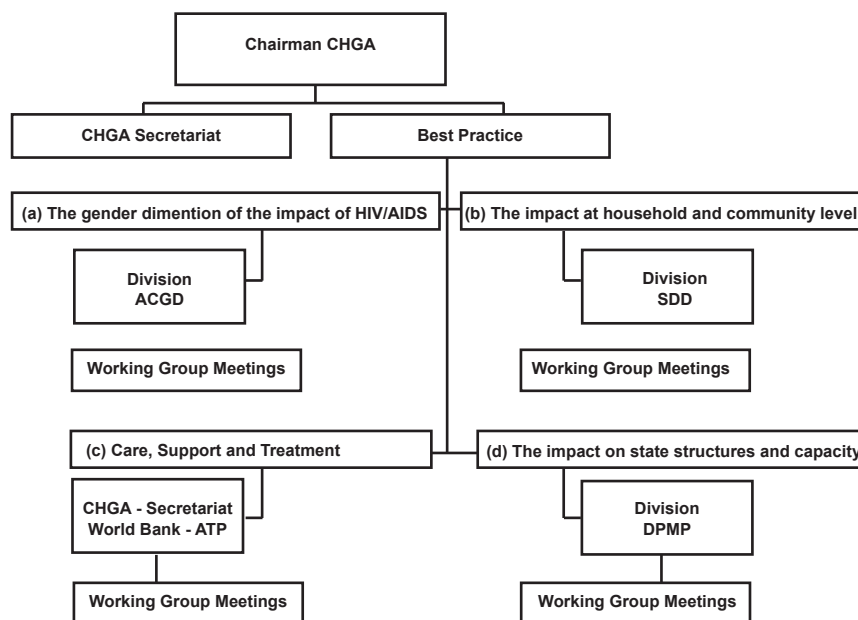
To facilitate this process four Working Groups will be established and organized around the following broad headings:

- (a) The impact at household and community level.
- (b) The gender dimension of the impact of HIV/AIDS.
- (c) The impact on state structures and capacity.
- (d) Care, Support and Treatment

Under the direct supervision of CHGA Chairman, each Working Group will be located in a division of the Economic Commission for Africa (ECA) – see Figure 4. Supported by CHGA Secretariat (through the appointment of a leading expert in each field (Friend of the Commission)) each Working Group will hold at least two meetings over the lifetime of the Commissions work. These meetings will provide CHGA Commissioners with an opportunity to interact with Civil Society Organisations (CSOs) – in particular, People Living with HIV/AIDS (PLWHA) - with the aim of promoting CSO reflection on the issue of Best Practice in AIDS and governance. Crucially, these meetings will inform civil society of the work of CHGA, while obtaining civil society inputs into CHGA’s own deliberations and recommendations.

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Figure 4: Best Practice Orginigram



POLICY ADVOCACY

UN agencies and international development partners have significant influence with governments and, therefore, must be fully engaged as well.

CHGA's policy engagement and advocacy agenda aims to garner political commitment among African governments to adopt the social and economic policies necessary to sustain state functions despite the impacts of HIV/AIDS. This will include communicating key messages to a wide variety of stakeholders, advocating for political commitment and mobilizing the necessary constituencies in order to help make this a reality. At the country level, critical audiences include Ministries of Finance and Planning; Ministries of Health and relevant institutions like National AIDS Councils, the legislature, and the media. At the regional level, the African Union and sub-regional organizations are vital constituents.

UN agencies and international development partners have significant influence with governments and, therefore, must be fully engaged as well. A key role for CHGA Commissioners in this regard is to explore all potential avenues to make it possible for affordable drugs to be available in sufficient numbers to meet the needs of HIV/AIDS patients in Africa. At all levels, dialogue with CSOs will be paramount, including associations of people living with HIV and AIDS, service delivery organizations, and those involved in governance and democracy activities. In each of these categories, CHGA will work with leading organizations and networks as focal points for mobilizing a wide constituency around the issues, with the aim of informing civil society of the work of CHGA, obtaining their inputs into CHGA's own deliberations and recommendations, and promoting CSO reflection on the issues of AIDS and governance.

Policy advocacy will be organized proactively around significant events and the release of research findings. For example, focus groups will be convened, national dialogues held, key interim findings released on all studies, and the Final Report of the Commission issued after two years of work. A conferencing strategy aims to place the key issues on the agendas of national, regional and international conferences, and obtain appropriate resolutions. This includes ECA's own conferences, such as the annual Joint Conference of Ministers of Finance, Development and Economic Planning, the Big Table and the African Development Forum; other UN fora; and the African Union Summits and ministerial conferences, plus those of sub-regional organizations.

PARTNERSHIPS

CHGA is a UN system-wide initiative, involving partnerships with a number of UN agencies, as well as leading institutions in Africa and internationally, on aspects of research, policy engagement and implementation. UNAIDS is a key partner in formulating CHGA's strategic vision, and also has specific interests related to elements of the research programme (*see below*). It will also play a central role in ensuring UN system-wide follow-up by assigning an expert dedicated to work exclusively with CHGA.

The African Development Bank (ADB) is a key partner in the macroeconomic research pillar. A senior ADB staff member will provide CHGA with intellectual guidance in this area. The World Bank is collaborating with CHGA on the macroeconomic components as well as the ARV scaling-up research activities. In fact, ECA will be hosting the Secretariat for the Bank's Treatment Acceleration Program, enabling CHGA to address the issues of the decentralization of ARV provision through civil society and the private sector. The Institute for Development Research's Management of AIDS in Africa Research Centre in Senegal (*L'Institut de recherche pour le développement, Unité de Recherche Prise en charge de SIDA en Afrique*) is also contributing to the studies on ARV. WHO is a leading contributor on macroeconomic and health systems research. In addition, CHGA is seeking suitable partners within each case study country to undertake substantial parts of the research work required by the Commission. Most importantly, the technical and economic feasibility of making the requisite supply of affordable ARV medication available to African countries in the short, medium and long term, will need to be carefully studied by the appropriate partner institutions.

In terms of thematic areas, the work on gender will be done in consultation with ECA's African Centre for Gender and Development, the UN Development Fund for Women (UNIFEM), and the World Bank, among others. On human resource planning, CHGA will draw upon work undertaken by the International Labour Organization (ILO), the United States Agency for International Development (USAID) and the Health Economics and HIV/AIDS Research Division (HEARD) at the University of Natal, South Africa. The United States-based Boston University Centre for International Health will contribute on the effects of HIV on the private sector. The UN

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Children's Fund (UNICEF) will be an excellent resource for input on studies on family, orphans, community safety nets, and food security.

Both the Food and Agriculture Organization of the UN (FAO) and the World Food Programme (WFP), in part through their role in the UN Regional Inter-Agency Coordination and Support Office (RIACSO) in Southern Africa, will support CHGA's work on HIV/AIDS and food security, along with the Southern African Development Community (SADC) Vulnerability Assessment Committee. Finally, the UN Department of Peacekeeping Operations (DPKO) and the UNAIDS Office for AIDS, Security and Humanitarian Response can contribute on issues related to peace and security.

CHGA SECRETARIAT

CHGA will be serviced by a small secretariat, which will provide backup to the Chairman and carry out the day-to-day activities associated with the Commission. The Secretariat will undertake the key research work and policy advocacy outreach, as well as write up interim and final results, organize events, liaise with partner institutions, and coordinate the work of the Commissioners. The substantive work of the Commission will be guided by a Steering Committee. This Committee will comprise of a cross ECA divisional team including: CHGA Chairman, Principle Advisor to the Executive Secretary, Senior Advisor to the Executive Secretary, Advisor to CHGA Chairman and the Research Director. The principle task of this Committee is to provide strategic guidance to the Research Director in operationalising the research activities of the Commission. In addition, the Steering Committee will call upon the advice and expertise of leading researchers in the field and partner institutions, who will constitute an ad-hoc experts group to assist with peer review of the Commissions reports.

The ECA Communications Team will support the Secretariat. Communication Team members will ensure that the Commissioners have the research information, policy strategies, advocacy materials and logistical support they need to be effective in their outreach. The outreach campaign involves creating and sustaining visibility for the Commission through large-scale, targeted media outreach and events, including video and radio spots; maintaining a CHGA web presence; and producing and widely disseminating CHGA publications. A knowledge-sharing strategy will ensure that the Commission achieves greater impact by instituting the appropriate systems and tools to facilitate the conception, sharing and use of knowledge in meeting its objectives.

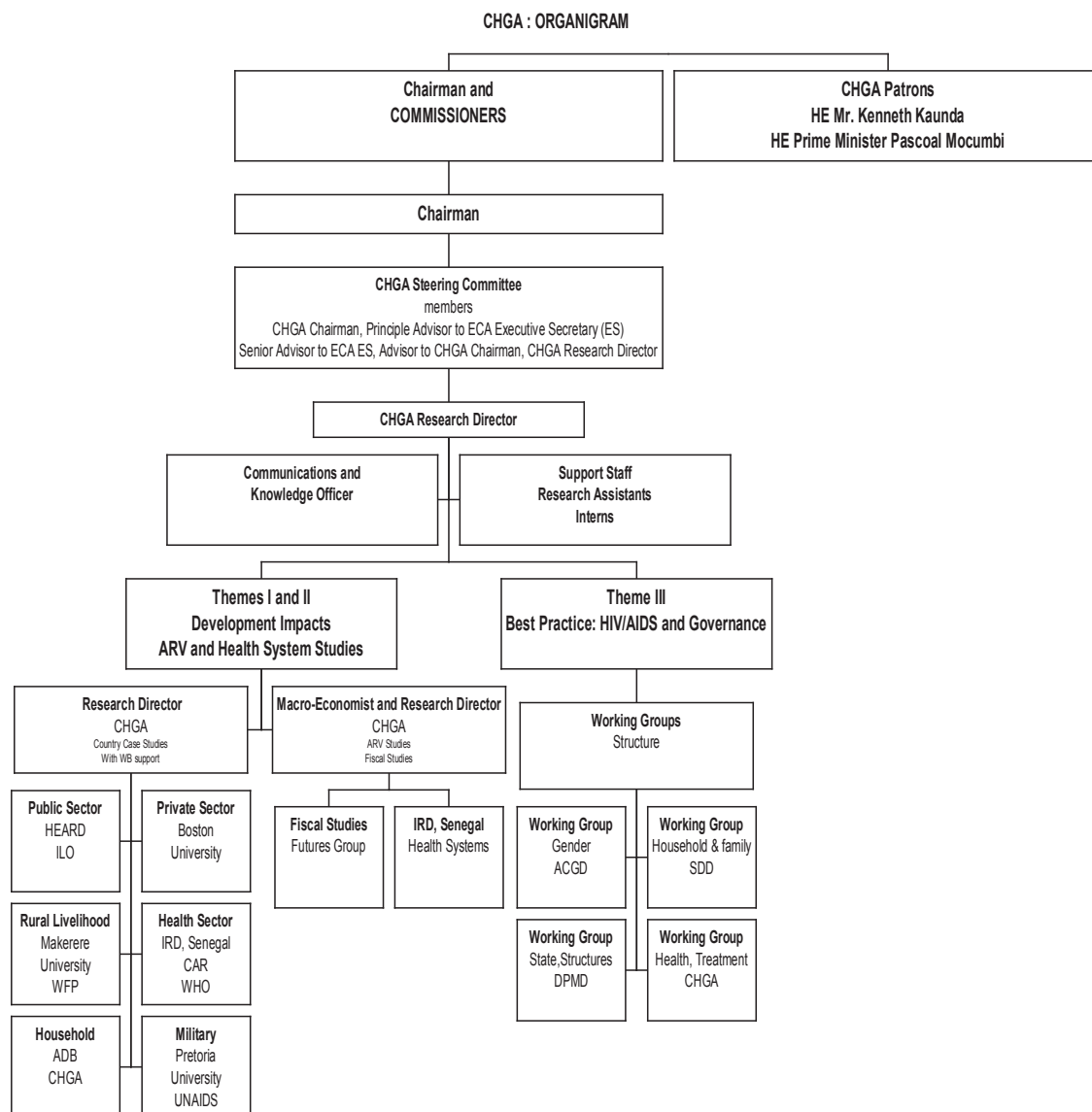
The Secretariat will undertake the key research work and policy advocacy outreach, as well as write up interim and final results, organize events, liaise with partner institutions, and coordinate the work of the Commissioners.

FINAL OUTPUT

The culmination of CHGA's work will be the Commissioner's Final Report, which will be presented to the UN Secretary-General. This will be an authoritative overview of the issues concerning HIV/AIDS and governance covered in the research agenda, both painting a broad picture of the complex ways in which HIV/AIDS impacts upon governance and development, and producing detailed analysis and recommendations for macroeconomic policies and scaling up ARV medications. This report will be launched in June 2005, in time for it to be presented to the Joint Conference of Ministers of Finance, Planning and Economic Development, the African Union Conference of Ministers of Health, the African Union Summit and the G-8 Summit.

APPENDIX

Appendix A - CHGA Organigram



Appendix B - List of CHGA Commissioners

1	K.Y. Amoako	Chairman Executive Secretary	Economic Commission for Africa	Addis Ababa, Ethiopia
2	Seyyid Abdulai	Director-General	OPEC Fund	Vienna, Austria
3	Abdoulaye Bathily	Professeur, Député, Vice- Président	Assemblée Nationale du Sénégal	Dakar, Sénégal
4	Mary Chinery-Hesse	Vice- Chairperson	National Development Planning Commission	Accra, Ghana
5	Awa Coll-Seck	Ministre de la santé, de l'hygiène et de la prévention	Ministère de la santé, de l'hygiène et de la Prévention	Dakar, Senegal
6	Haile Debas	Professor of Surgery	School of Medicine University of California	San Francisco, U.S.A.
7	Richard G.A. Feachem	Executive Director	The Global Fund to Fight AIDS, TB and Malaria	Geneva, Switzerland
8	Marc Gentilini	Président	Croix Rouge Française	Paris, France
9	Eveline Herfkens	The Secretary- General's Executive Coordinator for the MDGs Campaign	United Nations	New York, USA
10	Omar Kabbaj	President	African Development Bank (ADB)	Tunis, Tunisia
11	Milly Katana	Lobbying and Advocacy Officer	Health Rights Action Group	Kampala, Uganda
12	Madeleine Mukamabano	Journaliste	Radio France Internationale	Paris, France

13	Benjamin Nzimbi	Archbishop of Kenya and Bishop of all Saints	Anglican Diocese of Kenya	Nairobi, Kenya
14	Joy Phumaphi	Assistant Director-General (Family and Community Health)	World Health Organization	Geneva, Switzerland
15	Peter Piot	Executive Director	Joint United Nations Programme on HIV/AIDS (UNAIDS)	Geneva, Switzerland
16	Mamphela Ramphela	Managing Director	World Bank	Washington, DC, USA
17	Ismail Serageldin	Director of Bibliotheca	Library of Alexandria	Alexandria, Egypt
18	Bassary Toure	Ministre de l'économie et des finances	Ministère de l'économie et des finances	Bamako, Mali
19	Paulo Teixeira	Director in Charge of HIV/AIDS	HIV/AIDS, TB and Malaria cluster World Health Organization	Geneva, Switzerland
20	Alan Whiteside	Professor and Director of the Health Economics and HIV/AIDS Research Division (HEARD)	University of Natal	Durban, South Africa