idasa

Aids and Electoral Democracy

Insights into impacts on Africa's democratic institutions

Presentation to the World Conference of Democracy Promoting Foundations, Stockholm 28–30 August, 2005

Kondwani Chirambo
Manager, Governance and AIDS Programme (GAP),
Institute for Democracy in South Africa (IDASA)

idasa

Published by the Governance & AIDS Programme (GAP), of the Institute for Democracy in South Africa (IDASA), Kutlwanong Centre, 357 Visagie St, cnr Prinsloo St, Pretoria, South Africa 0001

© Idasa

ISBN 1-920118-04-7

First published 2005

Editing by Paul Wise
Design by Jenny Wheeldon
Cover design by Mandy Darling

All rights reserved. No part of this publication may be reproduced or transmitted, in any form or by any means, without prior permission from the publishers.

Bound and printed by Megadigital, Cape Town

Contact IDASA at
Tel: +27-12-3920500/556
Fax: +27-12-3292415
E-mail: Kondwani@idasa.org.za

Contents

ABBREVIATIONS 5

ABOUT THE AUTHOR 6

OVERVIEW 7

1. BACKGROUND 8
   1.1 IDASA's Involvement in HIV/AIDS Work 8
   1.2 Partnerships: State, Civil Society and Private Sector 8
   1.3 Changing the Policy Discourse 9

2. THE AIDS AND ELECTIONS PROJECT 11
   2.1 The Electoral Process as an Entry Point 11
   2.2 Hypothesis: Africa Study 11

3. AIDS, ELECTIONS AND ELECTORAL SYSTEMS 12
   3.1 Understanding the relationship 12
   3.2 Types of Electoral System in SADC 13
      3.2.1 Single Member Plurality (SMP) 13
      3.2.2 Single Member Majority (SMM) 13
      3.2.3 Proportional Representation (PR) 13
      3.2.4 Mixed Member Proportional (MMP) 13
   3.3 Linking HIV/AIDS to Electoral Systems in the SADC Region 13

4. KEY FINDINGS: IMPACT ON ELECTORAL SYSTEMS 15
   4.1 Strain on electoral models 15
   4.2 Power shifts 16
   4.3 Electoral Management and Administration 16
   4.4 Political Parties 17
   4.5 Voter Participation 17
      4.5.1 Voter Mortality 17
      4.5.2 Public Opinion 17
      4.5.3 Stigma and Discrimination 17
      4.5.4 Special Votes 18

5. KEY RECOMMENDATIONS 18
   5.1 Institutional or Structural Reform 18
   5.2 Public Opinion and Participation 19
   5.3 Strategic Interventions 19

6. GENERAL COMMENT: TREATMENT VS WORST-CASE SCENARIOS 20

REFERENCES 22

Abbreviations

ARVs	antiretrovirals
EMB	electoral management body
FPTP	first past the post (electoral system)
GNP	Gross National Product
HSRC	Human Sciences Research Council (South Africa)
IEC	Independent Electoral Commission (South Africa)
MMP	mixed member proportional (electoral system)
MP	Member of Parliament
NEPAD	New Partnership for Africa's Development
PLWHAs	people living with HIV/AIDS
PR	proportional representation (electoral system)
SADC	Southern African Development Community
SADC-ECF	Electoral Commissions Forum of SADC Countries
SMM	single member majority (electoral system)
SMP	single member plurality (electoral system)
TAPAC	Tanzania Parliamentarians AIDS Coalition
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

About the author

Kondwani Chirambo is the Manager of the Governance and AIDS Programme (GAP) of the Institute for Democracy in South Africa (IDASA). He holds a Master of Arts Degree in Mass Communications from the University of Leicester, United Kingdom. Chirambo has extensive experience of election observation and evaluation in southern Africa and has published numerous articles on the subject. The AIDS and Elections project, which he initiated, now covers seven African countries.

Previously, Chirambo was Head of the Democracy and Governance Programme of the Southern African Research and Documentation Centre (SARDC) and before that he held several editorial portfolios with the Times Newspapers (Zambia) Limited, including the post of Political Editor. He also served as a part-time correspondent for the United States-based world news agency, Associated Press (AP).

Overview

This paper is intended to share some key findings about the impact of HIV/AIDS on electoral processes, based on the work of IDASA's Governance and AIDS Programme (GAP). It briefly explains why IDASA – an institute promoting democracy – is involved in the field of HIV/AIDS, and elucidates the nexus between HIV/AIDS and the electoral process, a core component of democratic practice and order.

The principal objectives are to:

- *Set out the implications of the HIV/AIDS epidemic for sustaining democracy in Africa, with specific focus on the electoral process;*
- *Clarify the implications of HIV/AIDS for electoral systems; and*
- *Demonstrate that electoral engineering in Africa may be inadequate if critical political and economic issues around the replacement of elected representatives are not taken into account.*

Although research by IDASA-GAP is multifaceted within the general realm of governance, the programme has undertaken to investigate the impact of HIV/AIDS on electoral processes because the institution of elections is central to a democracy.

The electoral process serves as a point of entry into a much larger policy discourse on how best to manage national resources in an emergency, taking into account the economic, political and social costs of the HIV/AIDS pandemic. The robust nature of this debate also indicates the need to broaden national strategies to encompass accountability and participation.

Investigating the impact of HIV/AIDS on components of the electoral process brings other related issues to light: the need for legal and electoral reform to absorb the shocks of the pandemic; the participation of marginalised groups in policy processes; the integrity of the electoral process; the institutionalisation of political parties; management and administrative regimes; the prudent use of national resources; and the effectiveness of national responses to HIV/AIDS. In many ways, this is a broader discussion on human development.

In the final analysis, IDASA-GAP's findings on the subject, upon which this discussion Is largely based, indicate the need for a more critical interrogation of mainstream approaches, such as HIV/AIDS education and information for communities in which traditional practices appear to constrain attempts to deal with the pandemic. The programme's work also confirms the importance of closer engagement between state and civil society in developing a deeper understanding of the ramifications of this disease in the short and long term, as Africa inches towards more focused treatment, care and support strategies.

1. Background

1.1 IDASA's Involvement in HIV/AIDS Work

What does an institute promoting democracy seek to achieve in the field of HIV/AIDS?

Obviously our primary aim is to deliver on IDASA'S mission of "building democratic institutions, educating citizens and advocating social justice". In the case of HIV/AIDS, we have been galvanised by the catastrophic effects of the pandemic on citizens and institutions, and hence seek to fathom to what extent, if at all, the pandemic poses a threat to our nascent political systems.

Indeed, if democracy is dependent upon strong political institutions, vibrant economies and robust political cultures, how might its consolidation be affected by a pandemic that seems to whittle away the very capacities essential to strengthening political systems?

In a number of ways, and with gradual success, we have engaged our various audiences on the possible implications of the HIV/AIDS pandemic for democracy. Initially, such engagements did little more than stimulate curiosity. Over time, however, the new knowledge engendered by our exploratory research seemed to evoke a new level of awareness, primarily amongst political elites.

Without doubt, advocates for a "governance approach" to HIV/AIDS have been few. Information on the matter has been limited. The United Nations Development Programme (UNDP), through its body of literature, perhaps lends the most authority to governance as a concept that is relevant to framing approaches to development, and consequently to HIV/AIDS.

In the past four years, the realisation that HIV/AIDS would pose serious challenges to the developmental agenda of the United Nations (UN) has taken shape in sensitisation programmes that have generated a growing consensus that the disease is more than just a health crisis: many now concede that its profound effects on the social and economic fabric of society elevate the disease to the status of a crisis affecting governance.

1.2 Partnerships: State, Civil Society and Private Sector

Governance, as a concept and a process, asserts a strategic developmental interaction between state and non-state actors in the management of a country's political, economic and social affairs.[1] Confronting a challenge of the enormity of the AIDS pandemic demands multisectoral capacities developed through partnerships involving the state, civil society and the private sector. Such capacities, it is argued, enhance the implementation, monitoring and evaluation of all interventions.

Based on cross-sectoral collaboration, good governance is meant to deliver on many developmental fronts, including education and employment, thus providing the conditions in which citizens can live long and healthy lives. However, the illness, stigma and discrimination associated with HIV/AIDS evidently compromise the capacity of citizens to engage with these sectors. Governments continue to experience a loss of skills and institutional memory through premature deaths, with productive capacity reduced and output in key areas affected as a result. Even on this rather casual level, the relationship between the process of governance and HIV/AIDS appears profound.

1 Cheema (2000) defines governance as a "set of values, policies and institutions by which a society manages economic, political and social processes at all levels through interaction among the government, civil society and private sector".

More recently, the UNDP has attached a normative value to the concept of good governance, equating it to democratic governance: that is, embracing such facets as freedom of expression and association, a vibrant civil society, gender equity and equality, the rule of law, fundamental human rights, media freedom, and free and fair elections. These elements, among several others, are essential to the fulfilment of the principles of accountability and participation, which, in turn, are relevant to the practice of democracy and the notion of effective governance (UNDP, 1997; UNDP, 2002a).

The re-evaluation of governance as a concept by the UNDP has also more categorically endorsed democracy as the ideal system to provide the right environment for constructing responses that place citizens at the centre of all activity and nurture a viable alliance between state and non-state actors. This means, among other things, that:

- People's human rights and fundamental freedoms are respected, allowing them to live in dignity (with a balance between individual and group rights);
- Inclusive and fair rules, institutions and practices govern social interactions (including interaction with the infected and affected);
- People are free from discrimination based on race, ethnicity, class, gender and any other attribute (including HIV/AIDS status);
- The needs of future generations are catered for in current practices (care for orphans and the sustainability of society beyond the current generation);
- People can hold decision-makers accountable (through various institutional arrangements, democratic elections being one); and
- People have a say in decisions that affect their lives (expressing a choice of policy on HIV/AIDS, for instance, through procedures such as elections) (IDASA, 2005).

1.3 Changing the Policy Discourse

Although a fairly sound body of information exists concerning the prevention, mitigation and socioeconomic impacts of HIV/AIDS, and the care and support of those infected and affected, research on links between the pandemic and democratic governance was virtually non-existent until recently.

Commitment by political leaders, financing agencies and AIDS activists to new approaches taking these links into account has been slow in coming, especially in the absence of supporting evidence. IDASA and its partners therefore embarked on an exploratory quest, in an attempt to make the impact of the pandemic a factor in the democratisation discourse, given the dominance of health-focused strategies on HIV/AIDS.

Indeed, we "hypothesised with little knowledge", to borrow a phrase, mainly because there was little knowledge available to inform our propositions! It was, if anything, the allure of exploring uncharted territory that egged us on as debate raged within the institution as to how we could contribute to changing the strategic vision for dealing with the pandemic.

Health systems were clearly overburdened, national budgets were under strain;[2] local needs and international commitments all contended for the same level of attention. We needed to ask:

- *Could the impact of HIV/AIDS ultimately make citizens lose confidence in the state and possibly result in democratic reversals?*

2 Mattes (2004) reports:
In Zambia, government AIDS spending rose from US$1.7 million in 1990 to US$12.9 by 1995, and is expected to rise to US$21 million by 2005. Zimbabwe spends almost half of its health budget on treating AIDS patients. This is expected to rise to almost two-thirds by 2005. In Malawi, senior government health officials have publicly expressed their concern that half of their health budget will soon have to be devoted to treating AIDS patients.

The wealth of research in the economic and social domains has brought to light some worrying developments. African governments, in their New Partnership for Africa's Development (NEPAD) – a shared strategy to eradicate poverty and foster sustainable economic growth and development – have acknowledged that HIV/AIDS poses a severe challenge to the continent's ambitions. Life expectancy has declined from 60 years to 43 years in the worst-affected countries since the advent of the disease in the 1980s. HIV prevalence ranges from 1% in parts of north Africa to over 30% in southern Africa, rendering the continent the most affected region in the world (NEPAD, 2003). (Explaining how and why that came to be is not the purpose of this brief.)

The United Nations Commission on HIV/AIDS and Governance in Africa (CHGA) says that the pandemic has claimed 19.2 million African lives since the early 1980s and that 25 million are currently living with the disease (CHGA, 2004).

NEPAD estimates that economic growth has been slowed by 2.6% in southern Africa, with rising numbers of orphans illustrating the social effects of the pandemic.

Malaria, the other prominent killer, causes one million deaths each year and is estimated to have slowed economic growth by 1.3% per annum, at an economic cost of US$12 million. But while the effects of malaria and tuberculosis (which claims 600 000 lives annually) are severe, it is often argued that HIV/AIDS is unique firstly, because it poses a silent threat that can lurk unnoticed for ten years or more before killing the infected person; secondly, because it generates denialism and ignorance, as most of its victims appear to be in good health for several years; and finally, because it is sexually transmitted in the main, therefore having a bias towards the sexually active population – that is, the productive section of society.

Responses by governments may be slow, because states seem naturally programmed to respond more expeditiously to immediate threats. A response to an outbreak of cholera, for instance, sees a total mobilisation of cross-sectoral actors, including the military.

Over time, the worst-case scenarios posited by most studies on HIV/AIDS irresistibly lead to further questions on the governance implications of the pandemic:

- *With the current alarmingly high levels of infection, will citizens retain enough enthusiasm to participate in political processes, given that HIV/AIDS marginalises people through stigma, discrimination and incapacity?*
- *Could the demands of HIV/AIDS on national fiscal resources be so overwhelming as to compromise the ability of governments to deliver in other areas?*

IDASA responded in 2002 by establishing the Governance and AIDS Programme (GAP), which was mandated to investigate some of the complex linkages between HIV/AIDS and democratic governance. Supported by the Ford Foundation, GAP initiated a new intellectual discourse among top political leaders, activists, intergovernmental agencies and supranational bodies, among others, and began the process of developing relevant strategies.

In 2003, IDASA-GAP held a landmark intervention in collaboration with the UNDP's HIV and Development Project for Sub-Saharan Africa. The Governance and AIDS Forum for Southern Africa, as it was called, was hosted in Cape Town and brought together senior representatives from 12 Southern African Development Community (SADC) countries. The Forum was funded by the Swedish International Cooperation Agency (SIDA), the European Union (EU) and the UNDP. Delegates came from UNAIDS (the Joint United Nations Programme on HIV/AIDS), the UNDP, the SADC Health Sector Coordinating Unit, the SADC Parliamentary Forum, the Electoral Commissions Forum of SADC Countries (SADC-ECF), finance ministries and research institutions to discuss, analyse and seek

solutions to the impact of HIV/AIDS on governance processes in Africa. One of the key concerns raised by the electoral management bodies (EMBs) and research institutions was the possible impact of HIV/AIDS on key areas of the electoral process in the absence of coping mechanisms in most African countries.

At the forum, it was argued strongly by social scientists that *political institutions*, *sound economics* and the *attitudes of rulers and citizens* were three critical pillars for the sustenance of democracy, and that democratic practice leading to institutionalisation required a professional civil service and strong, viable and autonomous courts, legislatures, executives and electoral systems at national and local levels. It was further argued that it was the very skills required to enable efficient public service delivery that were being depleted by the HIV/AIDS pandemic, possibly undermining the capacity to strengthen political systems (Mattes, 2004).

Mattes posits, for instance, that while wealthier countries are far more likely to maintain democratic rule, poor countries' prospects of democratic endurance are increased if their economies grow steadily and inequalities are reduced. The negative effects of HIV/AIDS on economic growth and the skills base – theoretically, at least – militate against consolidation (Mattes, 2004).[3]

Perhaps one of the most significant challenges raised at the IDASA/UNDP Governance and AIDS Forum, put forward by the SADC-ECF, concerned AIDS increasing the number of dead voters' names appearing on election registers. There was a strong likelihood that rising deaths among qualifying voters would outstrip the capacity of EMBs to purge those names from the rolls, and a register bloated with the names of dead electors was open to fraud. A classic example was Malawi, where suspicions of such malpractice were partly responsible for post-election conflict.

2. The AIDS and Elections Project

2.1 The Electoral Process as an Entry Point

The development of the AIDS and Elections Project by IDASA-GAP was directly motivated by recommendations from the IDASA/UNDP forum.

With the support of the Rockefeller Brothers Fund (RBF), IDASA-GAP initiated the first ground-breaking study in South Africa with snapshot surveys of Lesotho, Zambia and Zimbabwe.

2.2 Hypothesis: Africa Study

Our main aim was to test a hypothesis developed by IDASA and its associates that interrogated the extent to which the AIDS pandemic would destabilise political processes – if at all.

We sought to determine the validity of several key statements:

- AIDS affects electoral systems differently;

3 Mattes (2004) goes on:
Ever since the pioneering work of Seymour Martin Lipset, social scientists have been aware of the strong correlation between national wealth and democracy. The most recent work by Adam Przeworski and his colleagues has given clear specification of the linkages between economic development and democratic endurance. Wealthy democracies do not die. The wealthiest democracy to revert to authoritarian rule was Argentina, in 1974, with a Gross National Product (GNP) per capita of US$6,055. Under that threshold, the death rate of democratic systems increases as national wealth declines. While those with a GNP per capita between US$6,001 and US$7,000 have a probability of reversion in any single year of 0.008 (or an average life expectancy of 125 years), those with a GNP per capita of US$1,000 or less have a probability of reversion of 0.122 (or an average life expectancy of approximately eight years).
Given these findings, in theory none of southern Africa's multiparty systems has a very long life expectancy. Botswana and South Africa are the region's wealthiest countries, yet all other things being equal, their GNP per capita suggests a democratic life expectancy of just 36 years. And democracies with Namibia's level of wealth have lasted, on average, just 18 years. Given their levels of national wealth, the rest of the region's multiparty systems have an average calculated life expectancy of eight years.

- The loss of skilled personnel in EMBs impacts on the efficiency with which elections are conducted;
- HIV/AIDS is likely to shape public opinion, with political and social ramifications;
- People living with HIV/AIDS (PLWHAs) and care-givers are marginalised in the electoral process (through stigma, discrimination and structural factors);
- HIV/AIDS is reducing the pool of voters available to participate in elections, which might have implications for political outcomes.

Our intention was to help EMBs and state systems take an informed approach to their future interventions in the area of electoral democracy. The information gathered was intended ultimately to support mechanisms responding to the HIV/AIDS pandemic.

The first study entailed a comprehensive mapping exercise of South Africa with respect to the mortality of registered voter populations in the past five years and comparative analyses of the electoral systems in selected southern African countries. The HIV/AIDS policies of South Africa's Independent Electoral Commission (IEC), leading political parties and the government were analysed in this context. In addition, key interviews were undertaken with political parties and registered voters infected and affected by HIV/AIDS.

A second and much larger study launched in 2005, and supported by SIDA, will involve selected countries in southern, east and west Africa. The four focus areas are:
- Electoral systems;
- Political parties;
- Electoral management and administration; and
- Voter participation.

3. Aids, Elections and Electoral Systems

3.1 Understanding the relationship

It is well understood that elections in themselves do not denote democracy – after all, even authoritarian regimes often hold them – but there is a normative value attached to *democratic* elections.

Matlosa (2005) elucidates the relationship between elections and democracy:
"Democracy denotes a political system that, among other things, allows citizens to freely choose their government over time through credible, legitimate and acceptable elections; a system which accords them adequate participation in national affairs; a system in which the national affairs are run in a transparent and accountable manner; and, above all, a system in which there is a fair distribution of the national wealth."

He goes on to indicate that democracy requires the political leaders in a country to be chosen through an election governed by fair rules under which social groups and political forces may compete on equal terms.

There is an important distinction between elections and electoral systems. An *election* is a process of selecting local and national leaders on a periodic basis, defined in a national constitution and relevant electoral laws. An *electoral system*, on the other hand, is a method of selecting leaders and translating votes into parliamentary seats. The electoral system, defined by a country's constitution and electoral laws, gives authenticity to citizens' votes through the configuration of parliament and ultimately the government (Matlosa, 2005).

Andrew Reynolds (1999:89) informs us that an electoral system is a critical institution that shapes and influences the rules for political competition over state power, in that it determines "what parties look like, who is represented in parliament, and ultimately who governs".

3.2 Types of Electoral System in the SADC

Electoral systems vary from country to country. In much of Africa, they are a colonial legacy. There are key variables, such as the electoral formula used (whether the system is majoritarian or proportional, and what mathematical formula is used to calculate the seat allocation) and the district magnitude (how many members of parliament a district elects). There are four main types of electoral system employed in southern Africa, as defined by the Electoral Institute of Southern Africa (EISA, 2003).

3.2.1 Single Member Plurality (SMP)

Popularly referred to as "first past the post" (FPTP), this system is considered the simplest. The country is divided into electoral zones or constituencies, and one candidate is chosen to represent each zone. The victor is the candidate who receives more votes than any of the other contestants, even if these are fewer than the opponents' votes combined. *One of the key elements of this system is the requirement for a by-election or supplementary election to fill vacancies in the event that the elected representative dies, resigns or crosses the floor.* There are seven SADC countries that operate the FPTP electoral system, most of which are former British colonies: Botswana, Malawi, Seychelles, Swaziland, Tanzania, Zambia and Zimbabwe.

3.2.2 Single Member Majority (SMM)

This is similar to the SMP system, in that the country is divided into electoral constituencies. However, a candidate needs an absolute majority of votes (50% + 1) in the constituency to be declared winner. Sometimes, where candidates fail to achieve an absolute majority, a run-off is called. The SMM has been used for presidential elections in some countries in the SADC region.

3.2.3 Proportional Representation (PR)

Various types of PR are used around the world, but the most common variant is the closed party list system. Under this system, the entire country is treated as a single constituency. Political parties are allocated seats according to the proportion of votes they garner nationally. The PR system therefore favours broader representation. The parties use the closed lists submitted to the EMB to assign members of parliament (MPs) to seats in hierarchical order. *There is no requirement for a by-election when a vacancy occurs. Parties are allowed to fill the void with the next person on the party list.* A few SADC member states use PR, namely Angola, Mozambique, Namibia and South Africa.

3.2.4 Mixed Member Proportional (MMP)

This system is a combination of SMP (or FPTP) and PR. It facilitates the election of one stream of MPs through FPTP and the other through PR. The only two SADC countries to have adopted the MMP system are Lesotho and Mauritius.

3.3 Linking HIV/AIDS to Electoral Systems in the SADC Region

As we examine these electoral systems in the context of HIV/AIDS, we begin to appreciate how sensitive such systems can be to the pandemic. The HIV/AIDS prevalence levels in the SADC region concretise the argument and rationale for this examination.

Table 1: *HIV/AIDS Prevalence and Effects in the SADC Region*

Country	Estimated number of people living with HIV/AIDS	% of total population	% adults with HIV/ AIDS	HIV/AIDS adult prevalence (%, age 15–49)	Women (15–49)	Children (0–14)
Botswana	330 000	21.24	38.6	36.13	170 000	28 000
Swaziland	150 000	15.99	33.4	25.00	89 000	14 000
Zimbabwe	2 500 000	19.45	33.7	24.26	1 200 000	240 000
Lesotho	360 000	17.50	31.0	14.05	180 000	27 000
Zambia	1 200 000	11.27	21.5	20.06	590 000	150 000
South Africa	5 000 000	11.42	20.1	19.87	2 700 000	250 000
Namibia	230 000	12.86	22.5	18.99	110 000	30 000
Malawi	850 000	7.35	15.0	16.06	440 000	65 000
Mozambique	1 100 000	5.90	13.0	12.78	630 000	80 000
Tanzania	1 500 000	4.17	7.8	7.96	750 000	170 000
Congo DR	1 300 000	2.48	4.9	5.10	670 000	170 000
Angola	350 000	2.59	5.5	2.78	190 000	37 000
Mauritius	..	..	0.1	0.08	..	..
Seychelles	..	..	..	..	..	..
SADC	14 870 000	7.18	13.7	12.76	7 719 000	1 261 000
Sub-Saharan Africa	28 500 000	4.50	..	8.56	15 000 000	3 000 000
World	40 300 000	0.66	..	1.07	18 000 000	2 600 000

Source: UNAIDS Reports on the Global HIV/AIDS Epidemic, June 2000 & July 2002

Table 1 indicates that the pattern of the HIV/AIDS epidemic, in absolute numerical terms of people living with the disease, is more pronounced and profound in South Africa (5 million), Zimbabwe (2.5 million), Tanzania (1.5 million), Zambia (1.2 million) and the Democratic Republic of Congo (1.3 million). All these countries have large populations.

However, considered as a percentage of the total population, the pattern of HIV/AIDS infections is different. The five SADC states with the highest rates of people living with HIV/AIDS as a percentage of the total population are Botswana (21%), Zimbabwe (19%), Lesotho (18%), Swaziland (16%) and Namibia (13%). It is worth noting that all five bar one, Zimbabwe, have smaller populations.

The five countries hit hardest by the epidemic in terms of the percentage of the adult population affected are Botswana (39%), Zimbabwe (34%), Swaziland (33%), Lesotho (31%) and Namibia (23%). In South Africa, 20% of the adult population lives with HIV/AIDS.

A household survey on HIV/AIDS prevalence in South Africa conducted by the Human Sciences Research Council (HSRC) in 2002 calculated the provincial distribution of the epidemic on the basis of a national population sample of 8 428.

Table 2: *HIV/AIDS Prevalence in South Africa*

Province	Number	HIV-positive
Western Cape	1 267	10.7
Eastern Cape	1 221	6.6
Northern Cape	694	8.4
Free State	540	14.9
KwaZulu-Natal	1 579	11.7
North West	626	10.3
Gauteng	1 272	14.7
Mpumalanga	550	14.1
Limpopo	679	9.8
Total	8 428	11.4

Source: Nelson Mandela/HSRC Study on HIV/AIDS, 2002:46

The five provinces in South Africa hardest hit by HIV/AIDS are the Free State (15%), Gauteng (15%), Mpumalanga (14%), KwaZulu-Natal (12%) and the Western Cape (11%).

4. Key Findings: Impact on Electoral Systems

"It is now an acknowledged fact that political parties, which are an essential part of any multiparty democracy, are affected by HIV/AIDS. Almost all political parties in this country have been losing leaders at various levels due to HIV/AIDS-related illness and deaths."
Hon. K. Simbao, Zambian Deputy Minister of Health, in his opening speech at the IDASA/FODEP/INESOR policy forum on AIDS and elections, 2005.

4.1 Strain on electoral models

Our research demonstrates that countries with FPTP systems are coming under immense political and economic pressure from the high HIV/AIDS prevalence rates shown in the tables above. The higher levels of mortality among MPs and local councillors in constituency-based systems are increasing the number of by-elections and hence multiplying many times over the economic and political consequences for the countries concerned. Apart from the economic tensions generated by the cost of replacing MPs, the rising number of by-elections may increase government sensitivity to shifts in public opinion and impact on levels of voter participation in the form of electoral fatigue (Chirambo & Caesar, 2004).

We surmise that PR is cost-effective in this regard, and probably the best option in an HIV/AIDS-ridden environment. Of course, the FPTP system can be modified to withstand the shocks of HIV/AIDS; for instance, Senegal employs substitute MPs. MMP, on the other hand, offers only minimal insulation, unless the requirement for by-elections is waived (IDASA, 2005).

Preliminary evidence on by-elections generated by increased deaths and the cost of holding them comes from three southern African countries. While South Africa uses PR at national level, it operates a hybrid of FPTP and PR at local level and might yet suffer the effects of the disease. Our analysis of

the effect of AIDS on the PR list at national level and on the hybrid local government system failed to point to any specific conclusions on the impact of the disease, owing to the lack of key information on the causes of deaths of MPs and councillors or any clearly discernible pattern of mortality.

In 2003, IDASA undertook a pilot study in Zambia, which uses the FPTP electoral method. This indicated that between 1964 and 1984 (the 20-year period before the advent of HIV/AIDS), 46 by-elections were held, 14 of them the result of illness and accidents combined, while over the 18 years from 1985 (the year in which the first case of AIDS was documented in Zambia) to February 2003, 102 by-elections were held, 59 of them due to death by disease. Of these 59 by-elections, 39 were held between 1992 and February 2003, which happen to be the years in which the HIV/AIDS pandemic peaked in Zambia. While there may be no specific information on the nature of the illnesses that led to the deaths of representatives, trend analyses can be indicative of the influence of the pandemic. By-elections in large constituencies can cost up to K1 billion (approximately US$200 000 at the time of publishing).[4]

Despite altering its electoral system from FPTP to MMP, Lesotho held six by-elections between 2002 and 2004. A by-election costs approximately R1 million (US$160 000). Three of the by-elections were held as a result of deaths of MPs caused by undisclosed illnesses.

4.2 Power shifts

We note that disease in general, and HIV/AIDS in particular, will contribute to power shifts in countries operating the FPTP electoral model. The effects of illness, combined with vacancies generated by expulsion, resignation and floor-crossing, have compelled Zimbabwe to hold 14 by-elections since the 2000 polls, eight of them from death through illness. The opposition parties have lost the majority of the by-elections – partly, perhaps, owing to their inability to compete consistently with a well-resourced ruling party.

South Africa has been debating electoral reform, and it is imperative that these implications be examined critically, given the experience of neighbouring countries.

4.3 Electoral Management and Administration

Our analyses of the internal policy of the IEC of South Africa, and of existing studies on the impact of HIV/AIDS on parastatal or state institutional skills bases, suggest that the IEC is vulnerable to the pandemic's effects, which could compromise its institutional capacity. This vulnerability is aggravated by the fact that most temporary staff are from the public service, particularly the teaching profession, which is one of the sectors hardest hit by the HIV/AIDS pandemic. As conducting elections requires experienced staff, the vulnerability of support personnel to the disease is likely to reduce the IEC's ability to rely on them to bring a fund of accumulated experience and skills to bear on future elections. As for the commission's permanent staff, at the time of writing its age structure – four members from 18 to 24 years, 178 from 25 to 49 years and 28 from 50 to 60 years – renders the IEC vulnerable to the much higher prevalence of HIV and AIDS among young and middle-aged adults.

4 According to Priscilla Isaacs, Deputy Director of the Electoral Commission of Zambia (telephone interview, 2004).

4.4 Political Parties

The leading political parties in South Africa, including the African National Congress (ANC), the Democratic Alliance (DA) and the Inkatha Freedom Party (IFP), acknowledge that HIV/AIDS could, or does, put strain on party structures, by increasing the rate at which cadres succumb to illness and need to be replaced. Although no discernible functional defects have arisen in party structures, the loss of seniority and experience is reported, in some cases, to have reduced parties' capacity and intellectual memory somewhat. A more direct impact acknowledged by religiously based parties, such as the African Christian Democratic Party (ACDP), is the time that HIV/AIDS-related deaths cost those political leaders who officiate at the funerals of their cadres. This might have effects on their organisational capacity.

4.5 Voter Participation

4.5.1 Voter Mortality

Our South African study established that 1 488 242 of the country's registered voters died between 1999 and 2003, out of a total of 20 674 926 on the voters' roll for the 2004 general elections. The concentration of mortality was higher in the 20–49 and 60–79 age cohorts. We argue that the sharp increase in mortality among registered voters between the ages of 20 and 49, and particularly women in the 30–39 age group – up to 200%, in some cases –- can be attributed to a large extent, if not wholly, to AIDS. We base our argument on the strong correspondence between the profiles that our analysis generated and those described by expert demographers in the field of HIV/AIDS. It is fortunate that South Africa's population and voter registration systems are fully compatible, allowing the voters' roll to be updated promptly. In this regard, the IEC gave the assurance that all dead voters had been purged from the voter's roll before the 2004 elections, thus allaying fears of "ghost voting".

4.5.2 Public Opinion

While detailed analysis of Afrobarometer public opinion data from southern African countries suggests an increase in public awareness of HIV/AIDS as a political and social problem, there is no basis on which to argue that HIV/AIDS is shaping public opinion in a consistent fashion across the region. South Africa is an exception, though, because statistical patterns indicate that people who suffer personal loss are more likely to prioritise HIV/AIDS in their demands on government. At this point, however, there is nothing to suggest that those affected by HIV/AIDS would change their choice of political party as a result of the affliction.

4.5.3 Stigma and Discrimination

These are the dominant determinants for lack of participation in elections by PLWHAs and care-givers. Focus group discussions held in urban and rural areas of KwaZulu-Natal with PLWHAs and care-givers, all of them voters registered for the 2004 elections, revealed apparently well-founded fears that communities would ostracise or marginalise those infected and affected further if they exposed themselves to major public events.

These opinions correlate with the findings of studies on stigma and discrimination, particularly the 2002 study by South Africa's Department of Health, indicating that HIV/AIDS remains a taboo amongst some South African communities, especially in rural enclaves. The sense of stigma, it seems, is strongest amongst people who are symptomatic: respondents claimed that most members of their communities would not stand in the same queue as someone showing visible signs of disease, such as rashes and sores.

From these discussions, we have drawn the conclusion that persons who bear visible signs of HIV/AIDS or have publicly declared their status are more likely to refrain from public voting, particularly

if they reside in a rural area. There is nothing to suggest, however, that PLWHAS have substantially lost the will to participate in political life. Quite the contrary: the majority of respondents expressed a desire to participate, but were constrained by attitudinal and structural factors.

These results do not represent the opinions of all PLWHAs, as only 68 people participated in the focus groups, but are indicative of their attitudes and may have external validity.

4.5.4 Special Votes

South Africa operates a special voting mechanism that allows the disabled, business people and travellers who are not able to present themselves on election day to vote from home or by post. The special vote is a very useful institutional arrangement, in that it sets out to ensure, as far as possible, that people are not disenfranchised through disability, pregnancy, or business or educational commitments abroad.

The mere fact that the mechanism exists and was used by more than 650 000 voters in the last election is a powerful indication of the commitment by the South African authorities to making democratic participation through the vote as inclusive as possible. However, the public needs to be informed, clearly and categorically, whether people suffering from debilitating or chronic illnesses qualify for this facility, as some PLWHAs who might wish to cast a special vote do not know whether they are eligible or not. This is likely to have implications for the participation of people infected by diseases such as HIV/AIDS, which are accompanied by stigma and discrimination.

5. Key Recommendations

5.1 Institutional or Structural Reform

1. Given that an electoral system is the main instrument for translating votes cast in an election into seats for elected representatives, the impact of HIV/AIDS on the system has a direct bearing on the functioning of the two most important representative institutions, parliament and local government. Therefore one of the most important ways in which the political ramifications of HIV/AIDS in elections can be demonstrated by the academic and policy communities is through the elucidation of the direct and/or indirect impacts of the epidemic on electoral systems as part of the broader agenda of electoral reform.

2. As SADC countries embark upon electoral reforms, they need to take issues around HIV/AIDS into account when determining which electoral systems are appropriate to their needs. All indications are that the costs of the HIV/AIDS pandemic, both financial and political, are more onerous in countries that operate the FPTP electoral system than in those with PR. From this point of view, South Africa would be better off retaining its PR model at national level.

3. Currently, legislation in South Africa does not provide for special votes for people unable to travel to polling stations during local government elections. This is a significant omission that may effectively disenfranchise many people infected or affected by HIV who wish to vote in local government elections. We submit that the IEC should recommend to Parliament's Portfolio Committee on Justice that the Local Government: Municipal Electoral Act, Act 27 of 2000 be amended to create a right to a special vote in local government elections.

4. The IEC should revise its skills succession plan to ensure that it has sufficient skilled staff in strategic positions. HIV/AIDS focal point people should be appointed in all offices, or specific staff members should take responsibility for HIV/AIDS activities. These tasks should be included in formal job descriptions.

5. Political parties should consider institutionalising strong responses to the epidemic within their own party structures and membership. The need for democratic governance on HIV/AIDS applies not only to governments and states, but also to political parties, which, through their actions, set the norms for what should be effective government policy and humane and tolerant social attitudes.

5.2 Public Opinion and Participation

6. The urgency with which HIV/AIDS is addressed through policy by governments and the emphasis it is given by international agencies is not reflected in the most recent (2002) and comprehensive opinion surveys from sub-Saharan Africa. It is not yet clear how this should be understood, and more research is needed. The fact that no obvious political momentum is being generated among the electorates in the region by issues relating to HIV/AIDS does not, however, necessarily imply a lack of concern. Politicians should engage with communities to mobilise a political awareness that can be channelled constructively as part of an overall response to the epidemic.

7. When we tested the problematic hypothesis that those directly infected or affected by the epidemic are more likely not to participate in the electoral process, our results were confirmed, with two exceptions. The lack of data at appropriate levels of analysis, however, means that these results are inherently unstable and thus offer no solid base for political action. Governments and electoral commissions in southern Africa are urged to assist in providing the data required for research with a regional scope that can produce more authoritative results.

8. Our analysis of mortality profiles among the South African electorate, on the basis of data from the voters' roll, has uncovered information that amounts to a veritable "smoking gun" of AIDS-related mortality. These results should add energy to the political response to the epidemic at the local, provincial and national levels of government. The information needs to be discussed intensively by local communities and local authorities, in order to stem an increase in death rates that, in some places, are already alarmingly high.

5.3 Strategic Interventions

9. It is recommended that political leaders – MPs and local councillors in particular – become more intensely involved in public education campaigns to reduce stigma and discrimination, the factors with the most profound potential impact on voter turn-out and registration. This might require the establishment of a strategic bipartisan extraparliamentary body involving all elected national representatives.

   Tanzania, for instance, has established the Tanzania Parliamentarians AIDS Coalition (TAPAC), whose membership is open to former and serving MPs from all parties. As TAPAC is a non-governmental organisation, and therefore not formally part of the parliamentary system, it has empowered MPs and enabled them to interact with constituencies and AIDS bodies. It enhances their advocacy role, enabling strong leadership at parliamentary level, while keeping HIV/AIDS on the agenda in parliamentary committees. As nearly all MPs are members of TAPAC, the structure is a good example of a practical way of depoliticising HIV/AIDS while dealing with issues such as stigma and discrimination.

10. It is further recommended that state and non-state actors in the area of HIV/AIDS put greater emphasis on empowering traditional leaders to address stigma and discrimination in rural enclaves, and thus allow PLWHAs greater participation in political, social and economic life. The potential of traditional governance systems to enhance service delivery and ensure that rural populations are not marginalised in development activities was acknowledged and underlined at the Fourth

African Development Forum (ADF IV) hosted by the UN's Economic Commission for Africa, the African Union and the African Development Bank in Addis Ababa, Ethiopia, in October 2004. Respondents in this study also confirmed the critical role played by traditional leaders in sensitising communities on various issues. The involvement of kings, councillors and religious leaders, through community radio networks and public forums, is strongly recommended, as they clearly command a high level of esteem, especially in rural contexts.

11. It is imperative that South Africa's IEC build HIV/AIDS awareness into its voter education programmes to reduce the level of stigma and discrimination prevalent in communities. Establishing links with HIV/AIDS service providers and civic education groups should help the commission develop context-specific responses to misconceptions about HIV/AIDS and improve, or at least sustain, voter participation levels. Public communication programmes should cover all aspects of HIV/AIDS, including prevention, treatment and nutrition, while emphasising the human and political rights of all individuals (IDASA, 2005).

6. General Comment: Treatment vs Worst-Case Scenarios

South Africa has launched what might be the largest treatment programme in the world. Although the mechanics are yet to be lubricated, we see in this programme a potential to contribute significantly to efforts to reduce HIV/AIDS-related stigma and discrimination. The sooner the communities that ostracise PLWHAs for fear of contagion come to see the pandemic as a chronic illness, rather than a death sentence, the better for them.

Treatment on its own, however, does not guarantee a reversal of the multifaceted impact of the pandemic. The operational efficiency and capacity of health systems over the next 20 years, in combination with food security and nutrition strategies, will ultimately determine how effectively the pandemic is dealt with. A sobering fact, amidst all the hype about treatment, is that of the 3.8 million people in sub-Saharan Africa in dire need of it, only 150 000 – less than 4% – were on antiretrovirals (ARVs) in June 2004.[5]

AIDS, it must be remembered, is depleting skills in the health sector too. In addition, Africa loses 23 000 health professionals annually to the better remuneration packages and working conditions in the West (NEPAD, 2003).

Worryingly, a third of sub-Saharan Africans, about 200 million people, are reported to be chronically malnourished. Experts say that malnutrition is linked to poverty, disease and mortality. More than half of deaths of children under the age of five and almost 60% of malaria deaths are attributed to malnutrition.
For the 25 million people in Africa living with HIV/AIDS, malnutrition and disease lock in a vicious negative cycle. HIV compromises nutritional status and increases susceptibility to infection while malnutrition weakens immunity, worsens the severity of infections and hastens the onset of disease. (NEPAD, 2005)

5 http://www.plusnews.org/webspecials/ARV/default.asp

The underlying causes of inadequate diet and disease, NEPAD elaborates, are food insecurity; inadequate care and feeding practices; limited access to health services, potable water and sanitation; and other environmental factors.

NEPAD experts assert that these causes can be traced back to the so-called political and economic superstructure issues of *governance*, *peace* and *security*. There are global factors involved in the dire state of things on the continent, including global agricultural policies that disadvantage African producers (NEPAD, 2005).

It is now well documented by medical professionals that ARV therapy needs a substantially good diet to accompany the drugs. It is clear, then, that even where the dominant strategy is medical treatment, Africa needs to focus on nutrition and food security, and this means higher investment in the food and agriculture, health and human development sectors.

The optimum use of resources, driven by good governance practices, will play a critical role in addressing the multiple problems confronting countries in the context of these scenarios. Expenditure on institutions such as expensive electoral models and exclusive health care for political elites will surely come under increasingly critical scrutiny from opposition and civil society forces as states grapple with contending priorities.

See www.idasa.org.za for an extended report on the impact of HIV/AIDS on electoral processes in South Africa (2005); co-authors: Strand P., Matlosa K., Strode A., & Chirambo K. IDASA.

References

Literature

Cheema, G.S. 2000. "Good Governance: A Path to Poverty Eradication", *Choices* (UNDP), March.

Chirambo, K., and Caesar, M. (eds.) 2004. *AIDS and Governance in Southern Africa: Emerging Theories and Perspectives*. Cape Town: IDASA.

Matlosa, K. 2005. "Elections and Democracy in Southern Africa, Progress, Problems and Prospects for Electoral Systems Reform: Electoral Systems and Reform in Representation", Electoral Institute of Southern Africa (EISA) conference paper, 29 June – 1 July.

Mattes, R. 2004. "Healthy Democracies? The Potential Impact of AIDS on Democracy in Southern Africa", in Chirambo, K. and Caesar, M. (eds.) *AIDS and Governance in Southern Africa: Emerging Theories and Perspectives*. Cape Town: IDASA.

Olowu, D. and Sako, S. (eds.). 2002. *Better Governance and Public Policy: Capacity Building and Democratic Renewal in Africa*. Bloomfield: Kumarian Press

Reynolds, A. (ed.). 1994. *Election '94 South Africa: The Campaigns, Results and Future Prospects*. Cape Town: David Philip

Reynolds, A. (ed.). 1999. *Election '99 South Africa: From Mandela to Mbeki*. Cape Town: David Philip

Reynolds, A. and Reilly, B. 2002. *The International Idea Handbook of Electoral System Design*. Stockholm

Strand, P., Matlosa, K., Strode, A. and Chirambo. K. 2005. *HIV/AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Processes*. Cape Town: IDASA.

Institutional Sources

CHGA. 2004. *Paper: Q&A*. Gaborone, Botswana: United Nations Commission on HIV/AIDS and Governance in Africa.

EISA. 2003. *Principles for Election Management, Monitoring and Observation in the SADC Region*. Johannesburg: Electoral Institute of Southern Africa.

HSRC. 2002. *Nelson Mandela/HSRC Study of HIV/AIDS: South African national HIV prevalence, behavioural risks and mass media*. Pretoria: Human Sciences Research Council/Nexus.

IDASA. 2004. *HIV/AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Processes*. Cape Town: IDASA.

NEPAD. 2003. *Health Strategy*.

NEPAD. 2005. "NEPAD Food and Nutrition Programme", *Focus on Africa*, Issue 104, 19 August.

UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic*, June.

UNAIDS. 2002. *Report on the Global HIV/AIDS Epidemic*, July.

UNAIDS. 2003. *Epidemiological Update*. Geneva: UNAIDS.

UNAIDS. 2004. *Report on the Global AIDS Epidemic*. Geneva: UNAIDS

UNDP. 1997. *Reconceptualising Governance: Discussion Paper 2*. UNDP Management Development and Governance Division. New York: UNDP. Available at http://magnet.undp.org/Docs/!UN98-21.PDF/Recon.htm.

UNDP. 2002a. *Assessment of UNDP Assistance for a Multi-Sectoral National Response to HIV/AIDS in Tanzania*. Pretoria: UNDP

UNDP. 2002b. *Deepening Democracy in a Fragmented World*. UNDP Human Development Report 2002. New York: Oxford University Press. Available at http://www.undp.org/hdr2002/complete.pdf

UNDP. 2002c. *Human Development Report*. Oxford: Oxford University Press.

UNDP. 2003. *South Africa Human Development Report 2003: The Challenge of Sustainable Development in South Africa: Unlocking People's Creativity*. Geneva: UNDP.