The impact of HIV/AIDS on the electoral process in Namibia

Graham Hopwood Justine Hunter Doris Kellner

idasa

ISBN: 978-1-920118-62-4
First published 2007

Edited by Kondwani Chirambo, Idasa-GAP
Design and layout by Jenny Wheeldon
Cover design by Magenta Media

Sida

Konrad Adenauer Stiftung

NID
NAMIBIA INSTITUTE FOR DEMOCRACY

GAP staff

Programme Manager: Kondwani Chirambo
Regional Coordinator (Communications): Marietjie Myburg
Regional Coordinator (AIDS Budget Unit): Vailet Mukotsanjera
Coordinator (Policy Dialogue Unit): Josina Machel
Researcher/Trainer (AIDS Budget Unit): Rabelani Daswa
Project Administrator: Jennifer Dreyer
Intern: Christele Diwouta

Contact GAP at

Idasa Kutlwanong Centre
P O Box 56950
Arcadia
South Africa 0007
Tel: 27-21-392 0500
Fax: 27-21-320 2414

NID staff

Executive Director: Dr J Hunter
Financial Manager: Mrs E Benz
Receptionist: Mrs I Kariazu
Programme Managers: Ms N Hishoono
Mr G Hopwood
Project Officers: Mrs N Kisting
Ms CM Ngqula
NID Consultant: Mr T Keulder
Former NID Programme Manager and now NID Consultant: Mrs D Kellner

Contact NID at

PO Box 11956
Klein Windhoek
Windhoek.
Namibia
Tel: 264-61-229117
Fax: 264-61-229119

Background and acknowledgments

The Impact of HIV/AIDS on the Electoral Process in Namibia is one in a series of publications initiated by Idasa, an institute committed to promoting democracy in Africa, working with a network of partners in seven African countries. The Namibia Institute for Democracy (NID) was commissioned to conduct the research and compile the report on Namibia.

Idasa's Governance and AIDS Programme (GAP) was formed to unravel the governance consequences of the AIDS epidemic to help political institutions understand the implications and respond appropriately. The project, which began in 2002 with **Ford Foundation** support, started with a pilot study in Zambia, which was released in 2003. This was followed by a comprehensive study of South Africa in 2004/5 with the support of the **Rockefeller Brothers Fund (RBF).**

This study on Namibia forms part of a seven-country investigation also covering Botswana, Malawi, Tanzania, Senegal, South Africa and Zambia. The multi-country study was financed by the **Swedish International Development Agency (SIDA)'s HIV/AIDS Team for Africa,** based in Lusaka, Zambia. A book comprising the research on all the countries, which draws out the comparative aspects of this extensive study, has also been published.

Publication of the Namibia study as a separate report is funded by the **Konrad Adenauer Stiftung (KAS).** We take this opportunity to sincerely extend our thanks to SIDA for the invaluable level of support rendered to this project and to KAS for enabling us to extend the publication and distribution of the outcomes specific to Namibia.

This work would not have been possible without the participation of parliamentarians, political parties, the Electoral Commission of Namibia, civil society groups including People Living With HIV/AIDS and the NID researchers who have dedicated the past two years to exploring a field that is fast generating academic and policy interest.

The commitment of the staff of Idasa-GAP and of Idasa's publishing department to delivering a product that was as close to our original vision as possible is highly commendable, given the many challenges that go with a project of this nature.

If we have failed to acknowledge others whose valuable input we benefited from, we do so with sincere apologies.

Kondwani Chirambo, Manager Idasa-GAP

Contributors

Graham Hopwood

Graham Hopwood is the Manager of the Public Dialogue Centre at the Namibia Institute for Democracy (NID) in Windhoek, Namibia. He is also a co-editor of *Insight Namibia*, Namibia's only current affairs magazine. He holds a BA Hons degree in English Language and Literature from the University of Liverpool, UK. Hopwood was a journalist and sub-editor at *The Namibian* newspaper, based in Windhoek, from 1992 to 2004. Prior to that he was the co-ordinator of Church Action on Namibia (CAN) in London, from 1989 to 1991. From 1985 to 1988, Hopwood worked as an outreach worker for a community centre in the East End of London. His published work includes *Tackling Corruption: Opinions on the Way Forward In Namibia* (editor), published by NID (2007); the *Guide to Namibian Politics* published by NID (2004 and 2006); *Regional Councils: At the Crossroads,* an occasional paper published by NID (2005); *The Swapo Extraordinary Congress: Uncharted Territory*, a research paper published by IPPR (2004); *The Men Who Would Be President*, a research paper published by IPPR (2004); *Walvis Bay: South Africa's Hostage*, published by the Catholic Institute for International Relations (1991).
email – graham@nid.org.na

Justine Hunter

Justine Hunter is the Executive Director of the NID. She has a Masters degree in Political Science, History and Anthropology from the Rheinische-Friedrich Wilhelm University, Bonn, Germany and a PhD in Political Science from the Albert-Ludwigs-University, Freiburg i.Br./Germany. Her thesis, *The Politics of Memory and Forgetting in Independent Namibia: Dealing with Gross Human Rights Abuses Committed during the Era of Armed Liberation Struggle, 1966-1989,* is due to be published. Her other publications include *Who Should Own the Land? Analyses* and *Views on Land Reform and the Land Question in Namibia and Southern Africa*, published by NID (2004).
email – hunter@nid.org.na

Doris Kellner

Doris Kellner is a freelance consultant working with NID. Until 2006, she was the Programme Manager: Civic Education Programme of the NID, responsible for the conceptualisation and execution of numerous traditional and interactive civic and voter education programmes including multimedia campaigns, publications, national competitions, national and regional workshops and conferences. She has a B.A Honours degree in Communication Science from the Rand Afrikaans University, Johannesburg and a Masters degree in Business Leadership from the University of South Africa.

Contents

Acronyms

ACN	Action Christian National
ANC	antenatal clinic
CA	Constituent Assembly
CAA	Catholic AIDS Action
Cafo	Church Alliance for Orphans
CCN	Council of Churches in Namibia
CoD	Congress of Democrats
DCN	Democratic Convention of Namibia
DTA	Democratic Turnhalle Alliance
ECN	Electoral Commission of Namibia
FCN	Federal Convention of Namibia
FGD	focus group discussions
FPTP	first-past-the-post
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HDI	Human Development Index
HPI	Human Poverty Index
IDASA	Institute for Democracy in South Africa
IPPR	Institute for Public Policy Research
Lac	Legal Assistance Centre
Mag	Monitor Action Group
M&E	monitoring and evaluation
MoE	Ministry of Education
MoHSS	Ministry of Health and Social Services
MMP	mixed member proportional
MP	Member of Parliament
MTPI	first medium-term plan
MTPII	second medium-term plan
MTPIII	third medium-term plan
MWACW	Ministry of Women's Affairs and Child Welfare
NA	National Assembly
Nabcoa	Namibian Business Coalition on AIDS
Nac	National AIDS Committee
Nacop	National AIDS Coordination Programme
NACP	National AIDS Control Programme
NAEC	National AIDS Executive Committee
Namacoc	National Multisectoral AIDS Coordination Committee
Namcol	Namibian College of Open Learning
Nanaso	Namibia Network of AIDS Service Organisations
Nappa	Namibia Planned Parenthood Organisation
Nasoma	National Social Marketing Programme
NC	National Council
NCCI	Namibian Chamber of Commerce and Industry

NDP II	second national development plan
Nepru	Namibian Economic Policy Research Unit
NGO	non-governmental organisation
Nid	Namibia Institute for Democracy
NNF	Namibia National Front
NP	National Party
NPF	National Patriotic Front
Nudo	National Unity Democratic Organisation
O&L	Ohlthaver and List
OVC	orphans and vulnerable children
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother–to–child transmission
PR	proportional representation
Racoc	Regional AIDS Coordinating Committees
RP	Republican Party
Sadc	Southern African Development Community
SMA	Social Marketing Association
SMM	single-member majority
SMP	single-member plurality
STI	sexually transmitted infection
Swapo	South West Africa People's Organisation
TB	tuberculosis
UDF	United Democratic Front
UN	United Nations
Unam	University of Namibia
UNDP	United Nations Development Programme
VCT	voluntary counselling and testing
WHO	World Health Organisation

1. Introduction

In 1990, Namibia gained independence, experiencing a successful transition from authoritarian to democratic rule. The young democracy is among the countries worst hit by the HIV/AIDS pandemic. The United Nations (UN) recognises that the pandemic challenges both social and economic development in Namibia. The pandemic constitutes the key obstacle to Namibia achieving its Millennium Development Goals (RoN, 2004a), which, as such, might undermine the realisation of Vision 2030, the Namibian long-term development framework (UN, n.d.).

The most relevant demographic statistics and epidemiological data are used to analyse how the pandemic affects the electoral processes in Namibia. A causality analysis leads into exploring the effects of the pandemic. The chapter ends with a comprehensive discussion of the multisectoral response to HIV/AIDS in Namibia.

2. Methodology

The research carried out in Namibia involved five different key methodological approaches to collecting information:

1. The *comprehensive overview of available literature* included an analysis of the legal and constitutional framework; the status of the voters' roll with regard to deceased voters; key documents on HIV/AIDS in Namibia; records of parliamentary debates and on deceased Members of Parliament (MPs) and regional councillors; party manifestos; research papers; newspaper articles; information on the administration and management capacities of the Electoral Commission of Namibia (ECN); and election results and voter turnouts.
2. Largely structured *in-depth interviews* with key informants have been conducted with the ECN; the Ministry of Health and Social Services (MoHSS); political party representatives; public servants; and civil society activists.
3. *Focus group discussions* (FGDs) with people living with HIV/AIDS (PLWHA) have been used to enrich the qualitative analysis of citizens' perceptions and their ability to participate in elections and civil society.

To determine the impact that HIV/AIDS has on civic participation and to correlate public perception with government actions, a detailed analysis of *public opinion survey data* from the Afrobarometer has been carried out.

A *post-research stakeholder meeting* was held to help with reviewing the preliminary findings and to ensure that the information presented is relevant, appropriate and accurate, allowing it to be used for policy design to mitigate the effects of HIV/AIDS on the electoral process.

Owing to the stigma and secrecy that surrounds HIV/AIDS and the absence of precise illness-related information, determining whether a person has died of an AIDS-related illness is difficult.

Ascertaining how many by-elections have resulted from AIDS is just as difficult. Proxy-indicators, like age at death, might indicate whether deaths might be AIDS-related. The study does not imply that any civil servant, parliamentarian or councillor died from AIDS. Questions that are proxy-indicators are used in the Afrobarometer survey data.

3. The HIV/AIDS pandemic in Namibia

3.1 Demographic and epidemiological data

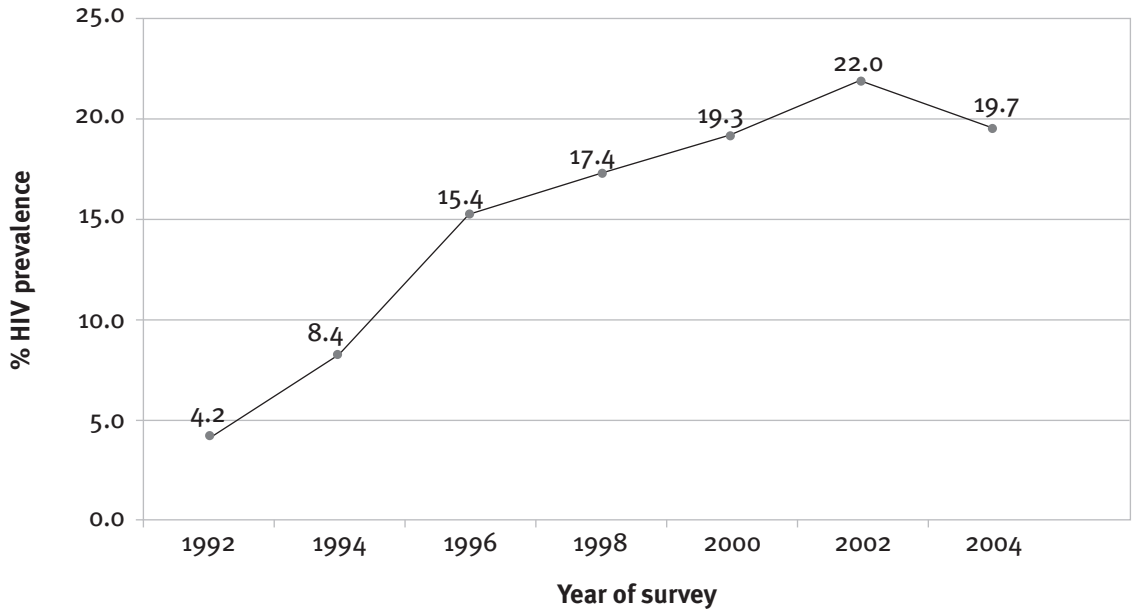
According to the *2001 Population and Housing Census* (Central Bureau of Statistics, 2003), Namibia had a total population of 1 830 330 people in 2001, with the 2005 estimate for the total population being 2 030 000 people. With one of the lowest population density ratios in the world at 2.1 people a square kilometre, most Namibians live in the five north–central regions. HIV/AIDS has profoundly affected Namibian demography, reducing the population growth rate (3.1% a year) in the decade before independence to 2.6% a year. Because of the pandemic, Namibia's life expectancy declined from 61 to 49 between 1991 and 2001 (RoN/UN System in Namibia, 2004: 6). Since the mid-1990s AIDS has been the leading cause of death. The high percentage of mortality due to AIDS seems to be underestimated, since by far most deaths blamed on tuberculosis (TB) and other infectious and parasitic diseases were most probably caused or complicated by HIV (El Obeid, Mendelsohn, Lejars, Forster and Brulé, 2001: 35–36).

Women face a greater risk of HIV infection due to their biological vulnerability and their generally lower societal status (Phororo, 2002: 5). Namibia also has more than 120 000 orphans, which is likely to increase to more than 250 000 (AIDSBRIEF, 2004b: 8; UNICEF, 2005: 4).

Vision 2030 aims to transform the country from a lower-middle income country to a more highly developed nation by 2030 by means of a series of seven five-year development plans. The solid progress made towards meeting several Millennium Development Goals and Targets, such as achieving universal primary education and promoting gender equality, is undermined by the deteriorating HIV/AIDS situation (RoN/UN Systems in Namibia, 2004: 3).

The MoHSS (RoN/MoHSS, 2005: 1) identifies those most at risk: the mobile populations; young women and girls along transport routes; sexually active youth; uniformed service members; and commercial sex workers, noting that all who have unprotected sex with a partner of unknown HIV status are at risk. Risk factors include high unemployment; poverty; cultural norms; alcohol abuse; gender discrimination; and stigma. According to its 2001 impact projections, the MoHSS estimates that the rapid growth in HIV prevalence which occurred in the last few years of the previous century will soon be reflected in increased morbidity and mortality, with 38% of boys and 48% of girls who are assumed to be HIV negative on their 15th birthday dying before their 40th (MoHSS, 2001: 40). The long incubation period of the pandemic means that its full-scale impact will manifest itself only within the next decade or so.[1]

Figure 3.1: HIV prevalence among pregnant women, biennual surveys, 1992–2004, Namibia

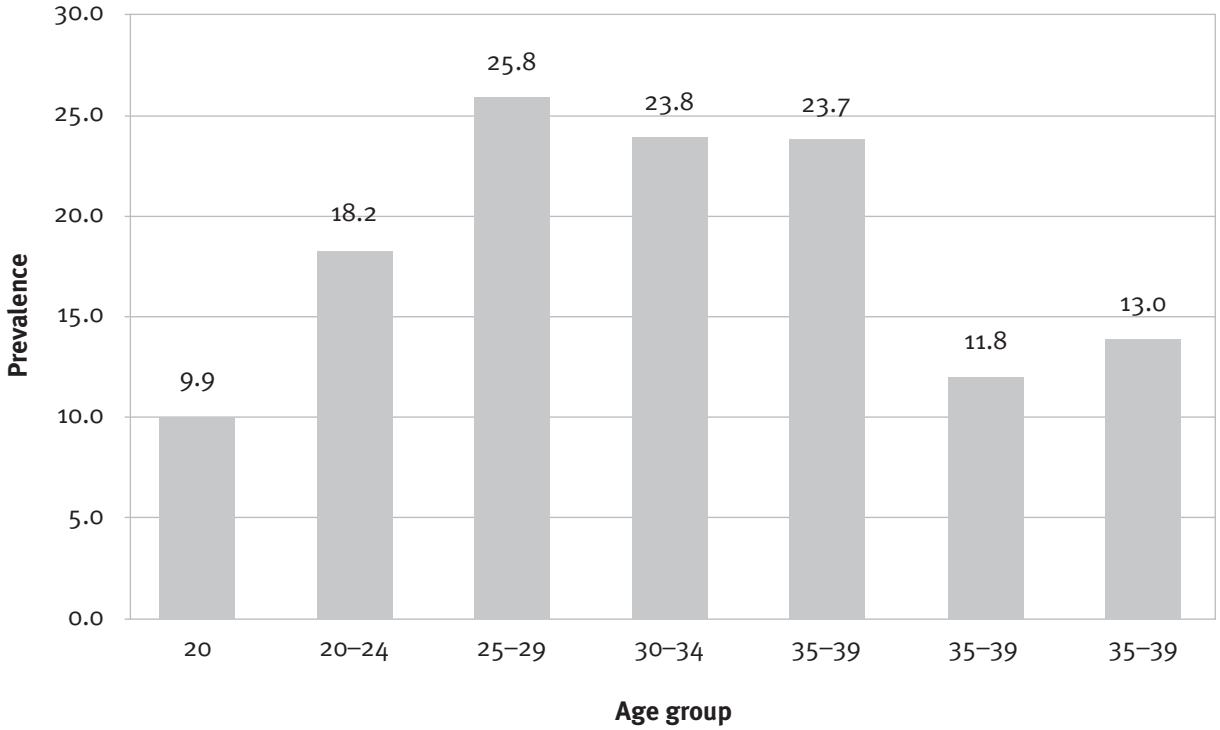


Source: MoHSS, 2005: 10.

The National HIV Sentinel Survey, which is conducted among pregnant women, has so far given the most reliable information on the pandemic in Namibia, due to its early detection of changes or trends and its ability to discern meaningful differences in disease rates and trends between sentinel sites.[2] Namibia has followed internationally accepted guidelines developed by the World Health Organisation (WHO). The weakness of the system lies in its incapacity to produce national prevalence rates, as it is biased against gender and age factors coupled with the geographical accessibility of sites.

The first AIDS cases in Namibia were reported in 1986. Since 1992, the MoHSS has biennially conducted a sero surveillance survey of all women visiting a participating antenatal clinic (ANC) for the first time during the current pregnancy during the sampling periods. Namibia was found to have experienced a steep rise from its 1992 level of 4.2%,[3] followed by a levelling of the pandemic, which does not clearly indicate whether the country's pandemic has stabilised. In 2004, the prevalence of HIV was estimated at 19.7%, compared with 22.0% in 2002 (see Figure 3.1). Accordingly, the 2004 sero-sentinel survey represents the first clear decrease in HIV prevalence since the start of ANC surveillance by the MoHSS in 1992. Apart from monitoring trends in HIV prevalence over the past 12 years, the MoHSS seeks to improve overall representativeness by including additional sites, bringing the total number of participating sites to 24 in 2004 (RoN and MoHSS, 2005).

Figure 3.2: HIV prevalence among ANC attendees by age group, 2004



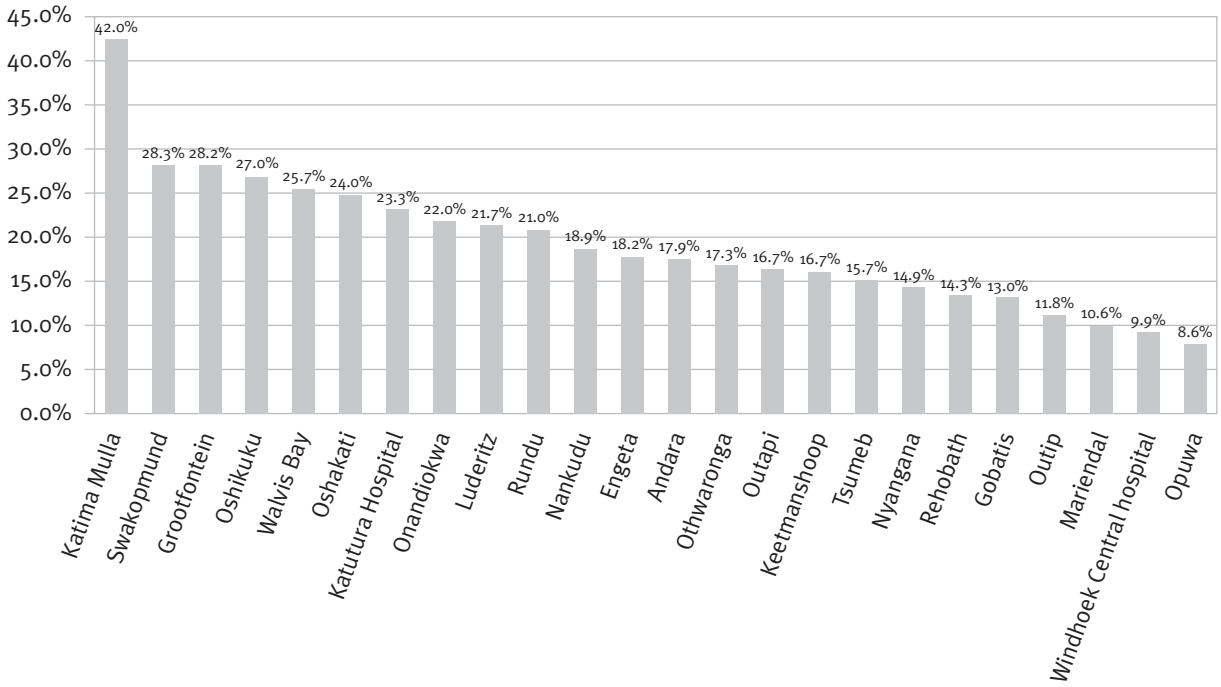
Source: MoHSS, 2005: 9.

Both site-specific longitudinal data and HIV trends by age group, including the sexually active age groups (15–34 years), show a slight decline of the HIV prevalence rate in Namibia. Positive behavioural patterns learned while young are increasingly being upheld, thereby favourably affecting the prevalence rates among the older age groups (Nanaso, 2005b: 7).

According to the *Namibia Demographic and Health Survey 2000,* awareness of AIDS is almost universal in Namibia, with 98% of women and over 99% of men saying they had heard of it (MoHSS, 2003). Nevertheless, according to the MoHSS (RoN and UN System in Namibia 2005: 17), trends in HIV prevalence must be examined carefully, as they might not be influenced only by policies and prevention efforts, but also by the survival time of PLWHAs[4] and risk behaviour change.[5]

Though the rate of infection might be slowing, Namibia is experiencing increasing numbers of PLWHAs, who, by falling severely ill or dying, result in an increase in the number of orphans and vulnerable children (OVC) (Nanaso, 2005a: 9; RoN and UN System in Namibia, 2004: 20).

Figure 3.3: HIV prevalence among ANC attendees by site, 2004



Source: Nanaso, 2005b: 6.

Site-specific prevalence, ranging from a high of 42.4% in Katima Mulilo in the Northeast (a transit area bordering Zambia, Botswana and Zimbabwe, countries that all have high infection rates) to 8.5% in Opuwo in the isolated Northwest, provides clear evidence of the need to translate the findings of the sero-sentinel survey into regionally comparative data (see Figure 3.3).

While a decreasing or levelling trend was observed in 16 of the 21 sites compared in 2002, an additional five sites, including Swakopmund and Walvis Bay (Keulder and LeBeau, 2006), have increased in prevalence. Particular prevention interventions are necessary in those areas where the pandemic is still expanding or only slowly stabilising (Nanaso, 2005b: 7; RoN and MoHSS, 2005: 17).

To approximate the number of PLWHAs in a region, the prevalence data is used with the regional census data, adjusted for population growth since the census in 2001 and for the proportion of the population that is sexually active. The number of those likely to have developed AIDS has been estimated on the basis that 15% of PLWHAs are likely to have developed the terminal condition (Nanaso, 2005b: 9).

Though costly population-based surveys can more accurately assess the levels of HIV prevalence in a country than can ANC surveillance systems, as they use a representative sample of both men and women in reproductive ages, no such population-based survey has yet been undertaken. The lack of such a survey has been described as "the single largest obstacle to progressive and coordinated research in Namibia" (Van Zyl, 2003: 17).

Apart from the sentinel survey, the MoHSS publishes yearly epidemiological reports which include AIDS-related hospitalisation and deaths (like MoHSS, 2000).[6] The *Namibia Demographic*

and Health Survey conducted by the MoHSS in 1992 and 2000 offers a representative sample of people and households across Namibia. Though the behavioural surveillance survey provides valuable health-related data relating to HIV/AIDS awareness, the level of stigma associated with the pandemic and the frequency of testing, it implies nothing about the HIV status of the respondents (MoHSS, 2003).

Similar survey instruments to the Afrobarometer do not directly question the interviewees' HIV/AIDS status or the status of those in their care (Strand and Chirambo, 2005: 122). Moreover, the voluntary counselling and testing (VCT) service centres managed by the Council of Churches in Namibia (CCN) and Catholic Aids Action (CAA) cannot serve as surveillance centres, due to their unsystematic approach. The *Human Development Report, 2000/2001* argues that under-reporting of HIV/AIDS deaths is generally widespread and that the total number of infections can, therefore, only be estimated (UNDP and UN Country Team, 2000: 11).

3.2 Causality analysis

High rates of unprotected sex with an infected person and mother–to–child transmission are the main causes of Namibia's high HIV prevalence (RoN, 2004a: 25–26; RoN and UN System in Namibia, 2004: 20–23). Many Namibians have multiple sexual partners and seldom know their own HIV status or that of their partners. The high prevalence of sexually transmitted infections (STIs) increases the risk of transmission, as does the sexual exploitation of women, including intergenerational sex.

Widespread alcohol abuse decreases self-control, increasing risky sexual behaviour. Many lack accurate HIV/AIDS-related information, so that stigma and discrimination are common. The low status of women, unemployment and connected high mobility have added to the spread of HIV/AIDS.

3.3 The effects of the pandemic

AIDS-weakened capacities of families, communities and institutions are likely to lead to decreased household income and agricultural productivity, worsening poverty. Households face stigma and discrimination, expensive health care and funerals, and having to care for orphans (Phororo, 2002: 9). Though first felt at household level, the effect of the pandemic is then experienced by the community and, ultimately, the economy. Reduced productivity, increased health care expenditures, reduced savings and human capital investments in term of skill loss will occur (UNDP and UN Country Team, 2000: 12).

Increased mortality rates will result in a decreased population rate and changed age structures (UNDP and UN Country Team, 2000: 12), with AIDS-related morbidity and mortality eroding the capacity of governance institutions to function effectively (RoN and UN System in Namibia, 2004: 54–55). Key areas of democratic governance that have been influenced by AIDS include: the electoral system; electoral administration and management; political parties; voter participation; and the accuracy of voters' rolls.

3.4 The multisectoral[7] response to HIV/AIDS in Namibia

3.4.1 Government policies and strategic efforts

The National AIDS Control Programme (NACP), based within the MoHSS, coordinates and manages HIV/AIDS patient care and preventive activities (Nanaso, 2005b: 9). Post independence, the government introduced both a short-term plan and the first medium-term plan (MTPI) of action aimed at raising awareness, articulating political commitment and implementing management structures (Nanaso, 2005b: 9). Through the launch of its second medium-term plan (MTPII) at the turn of the century, the government sought to create a broad national response by including all stakeholders in a nationwide multisectoral exercise (UNDP and UN Country Team, 2000: 13).

Figure 3.4: The MTPII structure

NATIONAL AIDS CO-ORDINATION PROGRAMME (NACOP)

National AIDS Committee (NAC)
Cabinet ministers/Governors/General Secretaries of CNN and NANAWO

National Multi-sectoral AIDS Co-ordination Committee (NAMACOC)
Technical operations committee responsible for implementation

National AIDS Executive Committee (NAEC)
NAEC is part of MOHSS and is responsible for advising and supervising the implementation of NAC and NAMACOC decisions

MOHSS
Directorate of Primary Health Care, Division Communicable Diseases, Section STI/HIV AIDS Control and NACOP Secretariat

Source: Caesar-Katsenga and Chirambo, 2005: 12.

MTPII set up the National AIDS Coordination Programme (Nacop) to replace NACP. Nacop aimed to strengthen preventive efforts; ensuring that HIV-positive Namibians have access to services which are responsive to their needs; teaching prevention, home-based care and self-protection; setting up national and regional programme management structures; and ensuring continuous support by both national and international communities in addressing the socioeconomic effect of the pandemic (RoN, 1999).[8] The highest policy-level body is the National AIDS Committee (Nac),

which is tasked with setting major policy and strategic directions. The National Multisectoral AIDS Coordination Committee (Namacoc) is the technical operations committee, responsible for intersectoral coordination and central implementation. Under the leadership of Namacoc, the Take Control Namibia HIV/AIDS Campaign uses television, billboards, radio and print media to create awareness.

The National AIDS Executive Committee (NAEC) advises and supervises the implementation of Nac and Namacoc decisions, monitoring all HIV/AIDS-related activities throughout the country (Caesar-Katsenga and Chirambo, 2005: 9–10). The second national development plan (NDP II) complemented the strategies laid out in MTPII, bringing the targets in line with the indicators developed for the Namibian application to the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM)[9] (Nanaso, 2005b: 10).

To campaign for support among the private sector in the fight against HIV/AIDS, a *Menu of Partnership Options* was compiled in 2002. Addressing HIV/AIDS as a crosscutting issue, the overarching development framework *Vision 2030* highlights the need for leadership at all levels, a multisectoral approach, the promotion of policies to combat stigma and discrimination, the inclusion of HIV/AIDS in all development plans, and greater understanding of the effect of the pandemic on different sectors.

In 2003, the review of MTPII concluded that, though much progress has been made, the capacity to plan, coordinate, and monitor the national and local responses, in particular the multisectoral response, needed strengthening (Nanaso, 2005b: 11). HIV/AIDS is not yet systematically mainstreamed in the relatively underdeveloped multisectoral response.

The review guided the formulation of the current third medium-term plan (MTPIII). MTPIII aims to broaden the response to HIV/AIDS, as well as focusing on areas previously neglected (RoN, 2004b). The five-year plan set for 2004 to 2009 has ambitious goals, ranging from providing treatment for HIV/AIDS patients and pregnant women to drastically reduce the number of HIV infections (AIDSBRIEF, 2004a: 8–10). With a mid-term review planned for 2007, the Nac and Nacop will be responsible for monitoring and evaluation (M&E) of the process at all levels.[10]

The Namibian HIV Charter of Rights (Lac, n.d.); an HIV/AIDS Policy for the Education Sector;[11] a National Code of HIV/AIDS in Employment, which was compiled in cooperation with the AIDS Law Unit at the Legal Assistance Centre (Lac) and the National Policy on OVC, are in place. Policies and guidelines have been developed for a wide range of health interventions, such as prevention of mother–to–child transmission (PMTCT), post-exposure prophylaxis, access to antiretroviral therapy and VCT. The percentage of HIV-infected pregnant women receiving treatment for reducing the risk of mother–to–child transmission increased from 7% in 2003 to 25% in 2005.

By late 2005, 35% of PLWHAs in an advanced stage of the illness were receiving antiretroviral combination therapy, while 71% were receiving antiretrovirals.[12] Cabinet recently approved plans for the production of generic HIV/AIDS drugs within Namibia to boost affordable public treatment, as articulated by the Treatment Action Forum at the AIDS Law Unit/Lac (Caesar-Katsenga and Chirambo, 2005: 6–7).

Through Nacop, the government distributed 11.2 million condoms in 2000 and 2001 by way of family planning services, health services, government sectors, non-governmental organisations (NGOs) and private companies (UNAIDS, n.d.). Free female condoms have also been made widely available throughout the country. The Ministry of Women's Affairs and Child Welfare (MWACW) has set up a trust fund for OVC, who do not receive any other kind of help (AIDSBRIEF, 2004b: 9;

RoN and UN System in Namibia 2004: 12; UNICEF, 2005: 10). However, the Orphans Law needs to be restructured to facilitate access to funding (NDI and Sadc PF, 2004: 18). Throughout the country, regional AIDS coordinating committees (Racocs) have been tasked with the synchronisation and monitoring of HIV/AIDS-related activities (Caesar-Katsenga and Chirambo, 2005: 14).

Local and regional governments coordinate well with NGOs where councils show commitment to addressing the problem of HIV/AIDS. However, regional councils require more resources to fulfil their mandate (Caesar-Katsenga and Chirambo, 2005: 18, 21, 30–31; NDI and Sadc PF, 2004: 34). Joint programmes, including multipurpose centres, OVC interventions and youth skills training, have been coordinated by local authorities and their umbrella bodies (Caesar-Katsenga and Chirambo, 2005: 21–22, 30).

The response to HIV/AIDS requires more leadership and commitment at all levels and among all stakeholders (RoN and UN System in Namibia, 2004: 22), as well as the multisectoral coordination of HIV/AIDS prevention, care and support. An environment must be created in which PLWHAs are more open to declare their status (RoN and UN System in Namibia, 2004: 22). The issue of HIV/AIDS tends to be regarded as less important than economic challenges, such as poverty and unemployment.

Key decision-makers seem to lack knowledge of the illness, which can be seen in the way in which MPs debate and deal with issues such as the confidentiality of PLWHA (AIDSBRIEF, 2004a: 10). Public awareness needs to be raised to overcome stigma (Caesar-Katsenga and Chirambo, 2005: 16; NDI and Sadc PF, 2004: 22–23). Parliament lacks a standing committee on health (NDI and Sadc PF, 2004: 22–23),so that, despite the public sector being the largest single employer in Namibia, the affect of HIV/AIDS on government institutions remains under-researched (Van Zyl, 2003: 14).

Though the government has not developed multisectoral workplace policies for the public sector, the office of the Prime Minister is in the process of developing a Charter of Rights on HIV/AIDS for the public service sector, in cooperation with the AIDS Law Unit/Lac. Only some individual ministries have developed workplace HIV/AIDS-related programmes for both their target group and their own staff (Caesar-Katsenga and Chirambo 2005: 20). In 2003, the government launched national guidelines and training programmes for antiretroviral therapy and introduced access to antiretroviral therapy in the public sector. The government covers the cost of antiretroviral medicines for members of the Public Service Employees Medical Aid Scheme and their dependants, so that many HIV-positive public servants are taking life-prolonging drugs. However, membership in the medical aid scheme is not compulsory.[13] Public servants with medical aid and people with private medical aid are able to access treatment, thereby dividing the Namibian society into those who can afford to live with AIDS and those who cannot (Caesar-Katsenga and Chirambo, 2005: 16).

To harmonise and systematically mainstream the approaches, the HIV/AIDS Unit at the Office in the Prime Minister called a *Workshop on Workplace Programmes for the Public Service Sector* at the end of April 2006.[14]

3.4.2 Civil society activities

The umbrella organisation Namibia Network of AIDS Service Organisations (Nanaso) records that 240 organisations employ 840 full-time staff, 300 part-time staff and nearly 15 000 volunteers (Nanaso, 2005b: 12). However, about 35% of the organisations involved in fighting the pandemic are very small and have no full-time staff at all. Many agencies work only in one or two regions (Nanaso, 2005b: 17). Of the organisations actively seeking to create an enabling environment, 69% are engaged in prevention and 58% are focused on mitigating the effect of AIDS. While 42% focus on providing access to treatment, care and support, 17% are involved in integrated and coordinated programme management (Nanaso, 2005b: 18).

The umbrella body CCN and its member churches have set up HIV/AIDS committees and VCT centres throughout Namibia, as well as trained pastors in counselling (UNAIDS, n.d.). The Church Alliance for Orphans (Cafo) is an interfaith organisation, representing a wide network of faith-based organisations and congregations, all active in the care of OVC (AIDSBRIEF, 2004b: 10).

Namibia's largest civil society AIDS service organisation CAA records 84 full-time staff and 1 600 volunteers. The AIDS Law Unit/Lac has helped to set up a human rights approach to the pandemic and to develop workplace policies (Caesar-Katsenga and Chirambo, 2005: 19). The Namibia Planned Parenthood Organisation (Nappa) advocates for the rights and access of young people to information, education and counselling services on sexual and reproductive health (UNAIDS, n.d.). The National Social Marketing Programme (Nasoma) uses commercial marketing techniques to promote condoms; while the Social Marketing Association (SMA) provides information and education on HIV/AIDS through radio shows and health awareness events at village level (UNAIDS, n.d.). Based in northern Namibia, Hope Namibia reaches people with general information, education and condoms. The Johanniter Hilfswerk organisation conducts courses in home-based care, manages several clinics and schools and offers support to OVC (AIDSBRIEF, 2004b: 5). Furthermore, the Namibian network of PLWHA Lironga Eparu ("Learn to Survive"), launched in 2001, mobilises communities. Apart from civil society activists, traditional leaders are involved in HIV/AIDS activities, where they strongly influence societal attitudes and behaviour (Caesar-Katsenga and Chirambo, 2005: 19; NDI and Sadc PF, 2004: 28).[15] In civil society, the print media also forms a "powerful agenda-setting agent" (Keulder, 2006: 10).

The Tenor Institute for Media Analysis concludes, "looking at the media coverage on HIV/AIDS … one might be forgiven for thinking that there is no pandemic at all" (Keulder, 2006: 10). The only media attention paid to the pandemic is in the form of media campaigns, such as the Take Control Campaign.

3.4.3 The private sector as latecomer

Though the private sector organises HIV/AIDS-directed funds and develops relevant workplace programmes, the former has still to gain momentum (RoN and UN System in Namibia, 2004: 24). The umbrella body Namibian Chamber of Commerce and Industry (NCCI) has set up an HIV/AIDS desk to spearhead several initiatives. The Namibian Business Coalition on AIDS (Nabcoa) undertakes the coordination and facilitation of business activity to best address the pandemic, as well as devising a strategy for small and medium-sized enterprises (Phororo, 2003: 11).[16]

The Hanns Seidel Foundation concludes that "the private sector still continues to believe that HIV/AIDS is not their responsibility" (Phororo, 2003: 10). Concern has been expressed about the inactivity of the business community in this regard (AIDSBRIEF, 2004a: 12).

Smaller companies lack the resources to set up HIV/AIDS programmes (Phororo, 2003: 12–14), while some of the larger companies, such as the Ohlthaver & List (O&L) Group, are implementing HIV/AIDS workplace programmes. Only a few of the Namibian parastatals with written policies or guidelines run specific campaigns for their employees and participate in HIV/AIDS campaigns. Tertiary education institutions, such as the University of Namibia (Unam), the Polytechnic of Namibia and the Namibian College of Open Learning (Namcol), reach out to young, sexually active adults on HIV/AIDS issues (AIDSBRIEF, 2004b: 12–13).

With a growing number of development partners[17] joining the fight against HIV/AIDS, coordination will become one of the key priorities for the government. The duplication of efforts and loss of resources at the expense of the beneficiaries must be avoided.

4. Impact of HIV/AIDS on the Namibian electoral systems

Since the UN-supervised election of 1989, which paved the way for Namibia's independence, Namibia has held regular presidential, National Assembly (NA), regional and local elections. Despite occasional administrative problems and reports of intimidation, the elections have largely been regarded as free and fair by international observers.

4.1 Elections and electoral systems in Namibia

Four types of elections and three different electoral systems are used in Namibia (see Table 4.1).

Table 4.1: Electoral systems and frequency of Namibian elections

Type	Frequency (last election)	System
Presidential election	Every five years (November 2004)	Majority (50%+1)
National Assembly election	Every five years (November 2004)	PR (list)
Local authority election	Every five years (May 2004)	PR (list)
Regional council election	Every six years (November 2004)	FPTP

The electoral system is inherited from Namibia's pre-independence history. UN Security Council Resolution 435 of 1978 was instrumental in attaining Namibia's independence as it set out a plan for UN-supervised elections for the Constituent Assembly (CA) that heralded independence.

The *Constitutional Principles* brokered by the Western Contact Group (consisting of Canada, France, West Germany, the UK and the US) in 1982 set out the post-independence dispensation, including regular multiparty elections and respect for human rights. Though neither Resolution 435 nor the *Constitutional Principles* specified the system for the CA election, the UN secretary-general's office confirmed in 1985, after talks between South Africa and the Contact Group, that the proportional representation (PR) system would be used. Resolution 435 was eventually implemented in 1989 and Namibia's first genuinely democratic elections were judged free and fair by the UN (Hopwood, 2006: 33).

Due to the success of the UN-supervised 1989 elections, the CA opted to continue using the PR system. The South West Africa People's Organisation (Swapo) abandoned its preference for a single-member constituency system and a unicameral Parliament in exchange for concessions on other issues, including an executive presidency. With the adoption of the Constitution on 9 February 1990, article 49 enshrined the party list and PR system for the NA elections. As the Constitution did not prescribe an electoral system for local authority elections, the proposed ward system was abandoned in 2002 in favour of a party list system.

In the presidential elections, a single-member majority (SMM) of 50%, plus one vote, is used. According to article 28 of the Constitution, if there is no clear majority, then further ballots will be held, until a candidate gains over 50% of the vote. The Constitution further states that elections for regional councillors should follow a single-member plurality system (SMP) (article 106), or the first-past-the-post system (FPTP), meaning that the candidate with the most votes in a constituency wins the seat. The National Council (NC) comprises two members elected by each regional council (article 69).

Voters (meeting the criteria of citizenship, voting age and a minimum period of one-year residence in their constituency for the local elections) are eligible to vote on voting day only upon presenting their voter's card and must vote within their constituency for both regional and local elections.

4.1.1 The proportional representation system

Set up according to article 44 of the Constitution, the NA is the highest law-making body of Namibia. The 72 seats of the NA are filled in accordance with the PR system, with the president being empowered to appoint an additional six individuals, who lack voting rights, based on their expertise in an advisory capacity. Parties are required to submit their party list, containing a minimum 24 and maximum 72 names of candidates, to the ECN on a predetermined date before the election. As there is no legislative provision for selection of such candidates for both the NA and local authority elections, the selection process has sometimes been controversial (Hopwood, 2006: 37).

4.1.2 The first-past-the-post system

Regional council elections are administered on the FPTP system. As with the local authorities, such councils are decentralised institutions formed to bring democracy closer to the people they serve and to whom they are directly accountable within their jurisdiction. Each region in Namibia has its own council, consisting of between six and twelve councillors, with one councillor being elected for each constituency, which is responsible for its development and administration. During the first sitting of the regional council, a governor is elected directly by the members, as are two councillors to represent the region in the NC. Table 4.2 shows the parties which have held parliamentary seats since independence.

Table 4.2: Parties holding parliamentary seats since independence

Abbreviation	Full name	Period
ACN*	Action Christian National	1990–95
NNF	Namibia National Front	1990–95
DCN	Democratic Convention of Namibia	1995–2000
DTA	Democratic Turnhalle Alliance	1990–2010
Mag*	Monitor Action Group	1995–2010
FCN	Federal Convention of Namibia	1990–95
NPF	National Patriotic Front	1990–95
UDF	United Democratic Front	1990–2010
Swapo	South West Africa People's Organisation	1990–2010
COD	Congress of Democrats	2000–10
RP	Republican Party	2005–10
Nudo	National Unity Democratic Organisation	2005–10

**The ACN was renamed the Monitor Action Group (Mag) in 1995.*

Source: *Guide to Parliament*, 2005.

4.1.3 The accessibility of suffrage

Held concurrently with presidential elections over two days, the first day of the elections has been declared a public holiday to facilitate voting. With women representing 52% of the electorate, the issue of gender balance in Parliament has received increasing attention over the years, gaining in momentum with the 50/50 Campaign in 2004. Implemented by the Namibian Women's Manifesto Network, the campaign lobbied for gender balance in Parliament, specifically through the implementation of the "zebra list" system (the alternation of male and female candidates on party lists) and the implementation of the National Gender Policy. The campaign also addressed other related issues, including the representation of people living with disabilities, and the securing of a living wage for domestic workers and adequate pensions. In the campaign, the electorate was

encouraged to vote for parties that would work towards gender equality and the empowerment of women in the regions[18] by:

- Developing the gender policies of regional councils in consultation with the community to ensure that development and service delivery strategies are gender- sensitive and supportive of gender equality;
- The setting up of regional gender desks or committees to administer the implementation of gender policy; and
- Gender budgeting in regional councils to ensure the equitable distribution of resources.

The campaign further challenged political parties to elucidate on their position regarding:

- Programmes to eliminate poverty;
- The promotion of the economic independence of women;
- The accessibility of affordable housing, land and water;
- The provision of affordable and safe childcare facilities;
- The combating of violence against women and children;
- The provision of support for prevention programmes;
- The provision of treatment and care for PLWHAs;
- The promotion of reproductive and sexual health and the rights of girls and women;
- The promotion of accessible education and lifelong learning; and
- The promotion of the sharing of domestic responsibilities between men and women.
- The 50/50 Campaign has thus spearheaded a holistic approach to the relationship between development and inclusive politics, focusing particularly on issues affecting women.

Table 4.3: Gender representation in the National Council

Party	1992–	98	1998–	2004	2004–	10
	Female	Male	Female	Male	Female	Male
Swapo	1	–17	2	22	6	18
DTA	0	8	0	1	1	0
UDF	0	0	0	1	0	1
Total	1	25	2	24	7	19

Source: *Guide to Parliament*, 2005.

Table 4.4: Gender representation in the Constituent/National Assembly

Party	1989–	90	1990–	95	1995–	2000	2000–	05	2005–	2010
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
CAN/Mag	0	3	0	3	0	1	0	1	0	1
CoD	0	0	0	0	0	0	3	4	2	3
DCN	0	0	0	0	0	1	0	0	0	0
DTA	1	20	1	20	2	13	2	5	0	4
FCN	0	1	0	1	0	0	0	0	0	0
NNF	0	1	0	1	0	0	0	0	0	0
NPF	0	1	0	1	0	0	0	0	0	0
Nudo	0	0	0	0	0	0	0	0	0	3
RP	0	0	0	0	0	0	0	0	0	1
Swapo	4	37	4	43	12	47	16	45	18	43
UDF	0	4	0	4	0	2	1	1	1	2
Total	5	67	5	73	14	64	22	56	21	57

Source: *Guide to Parliament*, 2005

4.2 Economic and political costs

The total budget provision of N$60.5 million for the 2004 presidential, NA and regional council elections was allocated as follows: N$30 million to the ECN; N$20 million to the Namibian Police Force; N$8 million to the Namibian Defence Force; and N$2.5 million to the Namibian Broadcasting Corporation. While the PR list system is not as expensive as the FPTP system, under which by-elections must be held whenever members die or resign, both systems are contentious in their response to HIV/AIDS. The costs associated with the effect of HIV/AIDS on electoral systems are either tangible quantitative (financial) costs or intangible qualitative costs.

4.2.1 Costs associated with by-elections

The effect of HIV/AIDS on the electoral system is difficult to gauge, primarily due to the policy of non-disclosure, in which no MPs have apparently died of HIV/AIDS-related illness. The ECN has also not kept official records of Namibian by-elections.

No statistical comparison is possible of the mortality rate of MPs pre- and post-Independence. Table 4.5 shows that the post-1999 records of regional council by-elections indicate that 32 by-elections have been held. Specified illness (illnesses generally unrelated to HIV/AIDS) is distinguished from unspecified illness (where reference is made to only a "long" or "short illness", which might serve as euphemisms for AIDS).

The results indicate one specified case of illness and eight unspecified cases of illness. Furthermore, there was one resignation due to incapacity ("illness"), one case in the pursuit of other business and seven cases involving political ventures.

The high incidence in 2004 of resignation to embark upon other ventures is due to the splintering of the National Unity Democratic Organisation (Nudo) from the Democratic Turnhalle Alliance (DTA) to form an independent political party. Political posting, where the incumbent was promoted to an ambassadorial position, accounted for three by-elections. The causes of the other by-elections are unknown. Of the total of 32 by-elections, eight (25%) might thus be blamed on AIDS. Since 1989, one NC member died from a heart attack, while another died, as reported in the media, due to a "short illness".

Table 4.5: Regional council by-elections held since 1999

Year	Total number of by-elections	Venue	Death: Specified/ unspecified illness	Resignation: Incapacity/ Other ventures	Other	Unknown	Political party of previous councilllor	Political party of successor
1993	5	Kabe K'hoop Rural Arandis Aroab Olukonda	Unspecified	 1		 1 1 1	Unknown Unknown Unknown Unknown Unknown	Swapo DTA Unknown Unknown Unknown
1994	1	Ompundja				1	Unknown	Unknown
1995	2	Gobabis Okongo					Unknown Unknown	Swapo Unknown
1996	1	Katima Mulilo			Councillor expelled		DTA	Swapo
1997	1	Ompundja				1	Unknown	Unknown
1998	2	Kapako Rundu Urban	Unspecified			1	Unknown	Swapo
1999	2	Wanaheda Walvis Bay Urban			Political posting Political posting		Swapo Swapo	Swapo Unknown
2000	2	Gobabis Rundu Urban	Unspecified		Nullified		DTA Swapo	SWAPO Swapo

Year.	Total number of by-elections	Venue	Death: Specified/ unspecified illness	Resignation: Incapacity/ Other ventures	Other	Unknown	Political party of previous councilllor	Political party of successor
2001	5	Rehoboth Kapako Oshikango Karibib Rundu Urban	 Unspecified Unspecified Unspecified	 Incapacity	All removed		 Swapo Swapo Swapo Unknown	 Swapo Swapo Swapo Unknown
2002	0							
2003	4	Windhoek West Kapako Oshikango Reho Urban West	 Unspecified Unspecified Specified	Other			DTA Swapo Swapo DTA	Swapo Swapo Swapo DTA
2004	7	Otjinene Tsumkwe Omatako Aminius Okakarara Grootfontein Tsumeb		Other Other Other Other Other Other	 Political posting		DTA DTA DTA DTA DTA Swapo Swapo	* Swapo Swapo Nudo Nudo Swapo Swapo

** Note: The Otjinene by-election voting process was suspended midway, as ballot papers ran out. Due to the regional council elections scheduled for four months later, an extra by-election was not held.*

Source: Electoral Commission of Namibia, *The Namibian* 19 July 2004

Table 4.6 depicts the deaths of CA/NA MPs since 1989, with the one case of specified illness being distinguished from one unspecified. Of the total five deaths, one might thus be AIDS-related. The death rate is relatively low, with deaths unrelated to HIV/AIDS, such as vehicle accidents, accounting for three of the five deaths.

Table 4.6: Deaths of Constituent/National Assembly MPs

	Total	Vehicle accident	Illness: Specified	Illness: Unspecified
1989–90	1	1		
1990–95	0			
1995–2000	2	1	1	
2000–05	2	1		1

MPs, due to their high incomes, have access to life-prolonging medication, about which they know considerably more now than before 2003, when treatment first became more readily available.

4.2.2 Political costs

Political costs incurred can, at this point, largely not be quantified, as such costs include:

- The loss of institutional knowledge and capacity at political party level;
- A decrease in the potential future leadership base of political parties;
- The loss of members of the electorate;
- A potential shift of power from opposition to ruling parties or vice versa, because of losing by-elections (in this study, such shifts are largely attributable to factors other than HIV/AIDS, including shifts in the political environment); and
- The potential political cost of a stagnation of constituency issues and "loss of representation" in a constituency during the first declaration of a vacancy and the filling of that seat by way of a by-election within three months, in terms of the Regional Councils Act, Act No. 22 of 1992.

4.2.3 Economic costs

While comparatively easy to quantify, the costs of individual elections in Namibia are, however, sometimes difficult to ascertain due to more than one election being held simultaneously to cut costs.

*Table 4.7: Budget: Presidential and National Assembly elections, 2004**

Description	Expenditure US$
Remuneration: Coordinators; area managers; returning offices; polling/counting officials	3 503 142
Electronic voters' register operators, including materials and supplies	393 692
Transport of personnel and materials	1 270 642
Other services: Printing of ballot papers, advertisements, maps and manuals; venue rental; equipment and installation of equipment	1 488 786
Voter education	571 831
Total US$	7 228 093

**Forex rate of 6.5*

Savings for presidential by-election are possible on only pro rata voter education and ballot paper printing. Regional council by-elections cost an average of US$77 000, at a forex rate of 6.5.

Table 4.8: Budget: Local authority elections, 2004

Description	Expenditure US$
Remuneration: coordinators; area managers; returning offices; polling/counting officials	843 881
Materials and supplies	67 253
Ballot papers	22 559
Voter education	77 841
Total US$	1 011 534

4.3 Electoral system reform debate

Electoral system reform might result in the adoption of the mixed member proportional (MMP) electoral system, due to difficulties with the PR system, which have been debated since the mid-1990s (Hopwood, 2006). Though benefiting the smaller parties, the latter system is criticised for its lack of accountability, because of a party list system in which:

- The selection and sorting of names on party lists is highly centralised;
- MP representation of regions in the NA is undefined;
- NA MPs are more likely to be accountable to their party than to the electorate;
- MPs are likely to tow the party line to ensure their political careers; and
- The prevalence of MPs in the Executive limits the availability of MPs for service on committees.

As any electoral system reform would entail substantial constitutional amendment, it would therefore need to be addressed sensitively and considerately. Any such reform should be contextualised within Africa and incorporate the experiences of other countries on the continent.

Legislative reform stems from a Cabinet decision in 2002 which called for the complete redrafting of electoral legislation in Namibia. Proposals forwarded to the National Planning Commission were approved in March 2006. In 1999, the tendered ballot was extended to absentee voters in foreign countries and continuous registration gave rise to the Electoral Amendment Act of 1994. The Act further stipulated that all future ballot papers used in the list system were to contain photographs of nominated candidates or of party leaders.

Though HIV/AIDS has not emerged as an electoral reform issue, further considerations include a postal voting system and the Namibian equivalent of South Africa's special vote facility.

5. HIV/AIDS and electoral administration and management

5.1 Structures, staff and legal framework of the Electoral Commission of Namibia

In Namibia, the responsibility for the administration of elections is divided between two bodies: while the ECN directs and supervises the electoral process, the Directorate of Elections administers registration, polling and related activities on behalf of the Commission and works under its authority. In elaborating the implications HIV/AIDS might have on electoral management, this chapter will investigate the potential impact on the core functions of the ECN.

5.1.1 Structures and staff

The ECN is headed by five commissioners appointed by the president. As part of the voter registration process, the commission appoints a supervisor of registration and registration officers in each constituency and each local authority area. Furthermore, the ECN might employ additional staff to help the supervisors and registration officers. To conduct elections, the ECN appoints returning officers,[19] counting officers and presiding officers,[20] mostly through public advertisement (EISA, 1999: 35).

The head of the Directorate of Elections is appointed on the commissioners interviewing five candidates, of whom they recommend at least two candidates to the president. In 2003 President Sam Nujoma confirmed Philemon Kanime, the Chief Executive Officer of the ECN, as Director of Elections. The director is responsible for the administrative and clerical work of the commission. Between elections, the directorate employs core administrative staff, including a deputy director and chief control officer, chief clerks, secretaries and typists. During elections, temporary staff, including "unemployed literate people" reflecting "the social composition of the population", are employed (EISA, 1999: 15). Accordingly, the directorate commits itself to affirmative action and gender awareness (Tötemeyer, 1996: 19). During elections, the directorate is subdivided into sections that appoint their own support team. The vast distances in Namibia necessitate the use of regional coordinators. Besides, political parties may appoint their representatives as election agents to observe and monitor polling stations and as counting agents (EISA, 1999: 36).

5.1.2 Legislative framework

Through the promulgation of the Electoral Act (Act No. 24 of 1992) the ECN was set up to direct, supervise and control national, regional and local elections in a fair and impartial manner.[21] According to the Act, the ECN's duties include: the supervision and control of the registration of voters; the supervision of the preparation, publication and updating of a national voters' register and a local authority voters' register; the supervision and control of the registration of political parties; and the supervision, direction and control of the conduct of elections.

Though not specifically included as part of its mandate in the Electoral Act (Hopwood, 2006: 36), the commission also oversees voter education in cooperation with NGOs, such as Lac and the Namibia Institute for Democracy (Nid). Until 2000, the commission was located within the office of the prime minister, after which it was set up in its own right and given its own budget. Electoral commissioners became more transparently selected. On candidates' application in response to the posts advertised in two daily newspapers, a selection committee recommends eight short-listed applicants to the president, who chooses five (Hopwood, 2006: 36).

The setting up of the Directorate of Elections as the administrative arm of the ECN has been determined by a government notice of 19 November 1992 (Tötemeyer, 1996: 16).

5.2 The internal impact of HIV/AIDS

5.2.1 The internal impact of HIV/AIDS on the ECN

IDASA's *HIV/AIDS and Democratic Governance in South Africa* reviews literature on the impact of HIV/AIDS on the internal functioning of workplaces (Strand and Chirambo, 2005: 85–88), indicating what the impact on electoral commissions will be like.

The taking of additional sick leave by HIV-positive employees is likely to affect both productivity and costs. Accordingly, the increased levels of morbidity might pose a threat to the effective administration of elections. High rates of mortality or early retirement have also been identified as potential threats to the effectiveness and competence of electoral commissions.

With the loss of skilled, experienced employees, staff will need to be trained at extra cost. Increased absenteeism due to AIDS-related illnesses, the attendance of funerals and having to take care of sick family members might also hinder the internal functioning of commissions. The effective administration of elections is also likely to be seriously affected by lower staff morale, making for a negative impact on the employment equity profile. On the basis of the literature review carried out by IDASA, this section will investigate to what extent the ECN has already been negatively affected by the pandemic, and, if so, whether the Namibian electoral body has developed a strategic plan for effectively countering such effects.

Getting AIDS-related mortality information tends to be difficult, as PLWHAs have, according to the National Code on HIV/AIDS in Employment, the legal right to confidentiality regarding their HIV status in the workplace, with disclosure of such status possible only with the employee's written consent (MoL, 1998). As most of their personnel are employed only temporarily during voter registration and elections, the ECN staffs only 25 permanent employees, of whom most (15) are women, who suffer most from the pandemic. As 21 of its permanent staff are between the ages of 25 and 49, the ECN is likely to be vulnerable to the effects of HIV/AIDS among young and middle-age adults.[22] With some permanent staff being part-time students, only 20% are highly skilled.[23]

During the past five years, two permanent staff died due to illness while employed by the ECN, with absolutely no indication of either having died from an AIDS-related illness. Therefore, AIDS seems to have had little effect, as yet, on the permanent staff. Neither has increased absenteeism, due to illness, caring for sick family members and attending funerals, been observed.[24] Nonetheless, anecdotal evidence in the regard was provided by the former Director of Elections, Joram Rukambe. Though unaware of any AIDS-related mortality during his tenure at the ECN from 1998 to 2003, he recalls that absenteeism increased due to more frequent attendance of funerals.[25]

As the temporary staff noticeably outnumbers the permanent staff, the composition of the short-term workforce employed by the ECN during the 2004 local authority elections and the 2004 presidential and NA elections is now reviewed. The ECN report on the local authority elections states that, for the supplementary registration process before the elections, 1 245 officials (57.5% females and 41.9% males) were appointed, of whom 161 were government officials and 1 084 were unemployed at the time of appointment. The polling staff for the local authority elections comprised 40.4% males and 59.6% females, of whom 319 were government officials and 1 215 were unemployed at the time of appointment (see Table 5.1).

Table 5.1: Supplementary registration and polling staff, 2004 local authorities elections

	Government officials	Unemployed citizens	Female staff (%)	Male staff (%)
Supplementary registration staff	161	1 084	57.5	41.9
Polling staff	319	1 215	59.6	40.4

Source: ECN, 2004: v.

Before the 2004 presidential and NA elections, 13 regional coordinators were recruited for supplementary registration purposes, with most being females and/or unemployed at time of appointment (see Table 5.2).

Table 5.2: Supplementary registration staff, 2004 presidential and National Assembly elections

	Total	Government officials	Unemployed citizens	Female staff	Male staff
Regional coordinators	13	12	1	4	9
Area managers	26	21	5	5	21
Constituency supervisors	10826	81	77	37	71
Supplementary registration officers	2 906	453	2 453	1 724	1 181

Source: ECN, 2005: 46.

The election and polling officials recruited included 13 regional coordinators, 26 area managers, 108 returning officers, 1 368 presiding officers and 6 066 polling officials, who were largely recruited in response to vacancies advertised in local newspapers. In 2004, about 7 000 (44% male and 56% female) were appointed from more than 30 000 applicants, with the minimum requirement being a grade 12 secondary school qualification or grade 10 with experience (see Table 5.3) (ECN, 2005: 47).

Table 5.3: Presiding and polling officials, 2004 presidential and National Assembly elections

	Female staff (%)	Male staff (%)
Presiding and polling officials	56	44

Source: ECN, 2005:47.

As most temporary staff come from the highest HIV prevalence age cohorts,[27],[28] the pandemic is likely to reduce their numbers. With public jobs being advertised before every election, previously employed candidates still have to reapply for temporary positions, despite the ECN preferring to appoint those with experience of electoral procedures. Proving increased levels or mortality or morbidity among temporary staff is very difficult.[29] However, as the ECN encourages returning officers, one for each constituency, to reapply for their positions in writing, increased levels of morbidity and mortality among the returning officers might be more apparent. Some returning officers were unable to reapply due to their employers not giving their consent.[30] As most temporary staff have no experience of elections, the cost of training has to be factored in, regardless of the probable increased loss of skilled, experienced staff due to HIV/AIDS. The ECN learned from the 2004 presidential and NA elections to limit the appointment of the unemployed youth, in favour of "experienced and active retired officials who have done management and administration before" (ECN, 2005: 63).

5.2.2 The Electoral Commission of Namibia's response to the internal impact of HIV/AIDS

HIV-positive employees are protected by the National Code on HIV/AIDS in Employment (MoL, 1998). Though the ECN has no formal workplace policy on HIV/AIDS, apart from that which applies to the public service in general, awareness has been created on an *ad hoc* basis. Rukambe,[31] Director of Elections from 1998 to 2004, increased HIV/AIDS awareness during staff meetings and has also spoken privately with employees in this regard.

5.3 The external impact of HIV/AIDS

IDASA's literature review (Strand and Chirambo, 2005: 85–88) shows that the administration of elections might not be negatively affected only by increased levels of morbidity, mortality and absenteeism, but also by an increased demand for service delivery.

5.3.1 Pre-election phase

IDASA argues that the sharp increase in mortality due to the pandemic will pose considerable problems for the accurate and timely compilation and maintenance of the voters' register (Strand and Chirambo, 2005: 91–93). If the ECN does not manage this process as well as it should, inaccuracies on the register could facilitate electoral fraud. Protecting the integrity of the voters' register against unrecorded deaths and other problems is possible only with regular reregistration (Keulder and Wiese, 2003: 5).

General voter registration, which should take place at least once every ten years, occurred in 1992 and 2003. A supplementary registration of voters was also instituted a month before the 2004 National Elections (ECN, 2005: 7). Before the elections, and after supplementary registration, the ECN continued to update the register. According to the ECN, more than 200 temporary employees were recruited to update the voters' roll, during which exercise the names of 4 833 deceased were removed from the register to tally with the names available from the Ministry of Home Affairs and Immigration deceased persons' register (ECN, 2005: 14).

Continuous registration, in which post offices were used as fixed registration points, was abandoned in 2001,[32] due to serious errors having occurred on the voters' roll (Hopwood 2006: 37).[33] However, electoral law reformers are considering reviving continuous registration on a regional level.[34]

The high final figure of 878 869 on the voters' register for the 1999 elections aroused suspicion, as it meant that over 90% of the eligible population registered. Yet, the registration figure for the 2004 presidential and NA elections, based mainly on the 2003 general registration, was 978 036 – again, a very high proportion of the voting age population (ECN, 2005: 60).

The high figures are surprising, as Namibians are not obliged to register as voters. Though Namibian citizens are required to have two cards, one proving their status as a registered voter and another proving that they are Namibian citizens, voters can use any one of a variety of identity documents to register or, if such documents are not available, they can use sworn statements verifying the voter's identity. More than 30% of those registering for the 1999 NA elections, especially among young and rural voters, used sworn statements (Keulder, Van Zyl and Wiese, 2003: 5). Such heavy reliance on sworn statements might facilitate fraud (Hopwood, 2006: 37).

Both the 2003 reregistration and the 2004 voting processes introduced a number of technical innovations. To get more information about registered voters, a registration form, using additional data entry fields and photographs, was introduced (Keulder and Wiese, 2004: 10–11).

Legislative reforms were proposed to restrict the use of sworn statements to those potential voters with valid birth certificates (Keulder and Wiese, 2004: 15). To speed up both the registration and the voting process, the ECN provided the polling stations with a computerised voters' register in place of manual paper-based voters' registers (ECN, 2005: 13).[35]

Since 2000, Namibia's electoral administration has been provided with two registers: one for local authority elections and the other for regional, NA and presidential elections. The Electoral Act (Act No. 24 of 1992) prescribes that the Ministry of Home Affairs and Immigration must supply the ECN with monthly death returns, enabling it to update its registers accordingly. However, staff shortages have led to delays in processing death returns, making it difficult to keep the registers up to date.

In a 2006 stakeholder meeting convened by Nid and IDASA, ECN representatives indicated that the deletion of the names of dead voters took so long because about 25 people had to deal with a large volume of death certificates from Home Affairs. Even if the death rate among registered voters was high, the data could not be computed on time.

A voter is also required to tell the ECN of any change of residence. The supervisor of registration appointed for each local authority area or constituency must submit a voters' list to the director of the ECN on the 15th of each month. Updated lists are then made available for inspection at the ECN or any other place specified in the *Government Gazette* during the first seven days of each month (Keulder *et al*., 2003: 7), during which time the names of those not found eligible to vote can be removed from the list. By law, the ECN is required to make the register public ahead of elections. According to the ECN, before the 2004 National Elections took place, the national

voters' register was finalised and certified and copies made available for inspection by the public at specific places in every constituency.

The call for public inspection has been made to ascertain that the names of all qualifying individuals have been included and to allow for final objections to be made against the inclusion of those names that should not be on the voters' list (ECN, 2005: 7–11). The cumbersome task of going through the long printed lists raises concern about the effectiveness of this process (Keulder and Wiese, 2004: 1).

The ECN is also required by law to allow political parties enough time to inspect the final voters' roll. However, before the 2004 presidential and NA elections, the ECN granted political parties too little time to inspect the final voters' roll, which had been provided in hard copy of the computerised voters' register.[36]

Published by the Institute for Public Policy Research (IPPR), a research report on the 1999 voters' roll and a research paper on the 2003 Windhoek West by-election voters' registration roll has helped to identify problems recurring within the datasets (Keulder *et al.*, 2003; Keulder and Wiese, 2004). According to the findings, both voters' registration rolls contain double entries and dubious cases, stemming mainly from the data-recording process at the different registration points (Keulder and Wiese, 2004: 7). The 1999 voters' registration roll was replaced by the ECN's reregistration of all eligible voters in 2003.

The substantial number of inaccuracies caused by technical shortcomings identified in the 1999 voters' roll might indicate how accurately the 2003 voters' register was compiled and has been maintained. Analysis of the 1999 voters' registration roll highlighted the most common mistakes in the database (Keulder *et al.*, 2003: 12–14): duplicate or multiple entries; inadequate biographical information; incomplete entries; inaccurate data entry; and ghost voters.

The problem of ghost voters, which has been identified as one of the most serious shortcomings of the voters' roll (Keulder *et al.*, 2003: 14), is likely to have increased with the rise in the number of HIV/AIDS-related deaths. However, Keulder and others acknowledge that the extent of the problem is unknown. To solve the problem, the ECN depends on the help of the Ministry of Home Affairs and Immigration.

According to Keulder *et al.* (2003: 16–18), the accuracy of the voters' roll could be improved by extending the network to include alternative sources of information about deaths. Ideally, legislation that makes it compulsory to tell the ECN of all deaths should be drafted (Keulder *et al.*, 2003: 17). The problem of a large percentage of individuals declaring themselves eligible to vote by means of sworn statements remains, given the slow rate at which the Ministry of Home Affairs and Immigration issues identity documents.

The Ministry of Home Affairs and Immigration failed to supply the ECN continuously with monthly death returns from 1998 to 2003.[37] The Ministry also provides the ECN with individual documents and files instead of a database, thereby overloading the ECN's limited permanent staff with work.

The ECN gave computers to the Ministry of Home Affairs and Immigration so that the latter could process information on the dead more quickly. Even if the Ministry of Home Affairs and Immigration were to supply the ECN with regular updates, the lists might be incomplete, since deaths are not always reported in the rural areas (Keulder *et al.*, 2003: 14; UNDP and UN Country Team, 2000: 21). Children and young adults under the age of 18, as well as those not registered, who died of AIDS-related illnesses are also excluded from the ECN's death statistics.

The ECN has finalised the statistics, drawn from the Death Register of the Ministry of Home Affairs and Immigration (see Table 5.4), of all the registered deceased whose names have been removed from the voters' register for the period July 2003 to August 2005. As the aim of such statistics is only to identify registered voters who have died, to enable the removal of their names from the register, the statistics do not indicate the cause of death. The death statistics, which are translated into regionally comparative data, indicate the gender of the deceased, but not the age ranges involved. As it could not be established whether deaths were disproportionately high among young adults, no strong indication is given that AIDS was primarily responsible.

Table 5.4: Death statistics: Total number of names of the deceased removed from the voters' register, July 2003 to August 2005

Region	Population by region (2001)	HIV prevalence by region (%)	Female deceased registered voters	Male deceased registered voters	Total: Deceased registered voters in each region	Death rate registered voters in each region (%)
Caprivi	79 826	42.6	545	561	1 106	1.39
Erongo	107 663	27	275	393	668	0.62
Hardap	68 249	14.9	408	494	902	1.32
Karas	69 329	18.7	255	364	619	0.89
Kavango	202 694	18.2	629	662	1 291	0.64
Khomas	250 262	16.7	626	911	1 537	0.61
Kunene	68 735	9.5	104	118	222	0.32
Ohangwena	228 384	18.2	1 335	1 429	2 764	1.21
Omaheke	68 039	13.8	229	220	449	0.66
Omusati	228 842	20.8	1 225	1 360	2 585	1.13
Oshana	161 916	24.9	919	955	1 874	1.16
Oshikoto	161 007	19.7	837	900	1 737	1.08
Otjozondjupa	135 384	22.8	297	340	637	0.47
Total	1 830 330		7 684	8 707	16 391	

Source: Electoral Commission of Namibia. Death Statistics; Hopwood, 2006: 3; Nanaso, 2005b: 8 .

The total number of registered deaths among eligible voters is, inevitably, higher in densely populated regions, such as Kavango, Khomas, Ohangwena, Omusati, Oshikoto and Otjozondjupa, requiring a comparison of the regional death rate of registered voters. According to the death statistics, the Caprivi region has the highest death rate. At 42.6%, the Caprivi region also has the highest HIV prevalence rate. According to the United Nations Development Programme (UNDP and UN

Country Team 2000: 23–28), Caprivi also has the lowest life expectancy (32.6 years), the lowest Human Development Index (HDI), and the highest Human Poverty Index (HPI). In 2001, according to the *2001 Population and Housing Census* (Central Bureau of Statistics, 2003), more than 50% of all deceased Caprivians died between the ages of 15 and 49, which is the age group with the highest HIV prevalence. According to the ECN's death statistics, the Hardap region has the second highest death rate among registered voters, though the HIV prevalence rate is much lower than that of Caprivi.

5.3.2 Polling phase

The Electoral Act (No. 24 of 1992) and the subsequent Amendment Act govern issues relating to the organisation of polling stations, such as the distribution of voters, the availability of suitable locations, access to polling stations, and distances to be travelled to such locations. The Act also provides for both permanent and mobile polling stations, of which the latter are especially important in sparsely populated rural areas (Tötemeyer, 1996: 49). The average polling station is expected to serve about 1 000 voters and should be within two hours walking distance (EISA, 1999: 43).[38] Being situated in schools or community halls, the permanent voting stations are equipped with toilets and seating.[39]

The tendered vote system, due to much internal migration and inadequate rural road and railway networks, provides for those who cannot vote at a polling station in the voting district in which they are registered.[40] In the system, which is used in the NA and presidential elections, people can cast their votes anywhere in the country or at diplomatic posts abroad. As tendered votes are counted in the constituency where they were cast, confusion arose in 2004 when tendered and ordinary ballots were combined and declared votes of the constituency where they were cast (Hopwood, 2006: 37).[41]

The current electoral law reform debate is considering whether the tendered vote system might be replaced by a postal voting system,[42] meaning that those who cannot go to the polls will not miss out on their right to vote. Though such a system could make democratic participation in voting as inclusive as possible, it needs to be carefully scrutinised, as it might facilitate electoral fraud. To ensure that the postal voting system will not be abused by those who do not qualify for it, the applicants for such a vote should clearly explain why they are asking to vote in this way.

A postal voting system requires formal identification of the voters, so that relying on sworn statements challenges the Ministry of Home Affairs and Immigration's ability to deliver formal identification to the voting age population. "Special vote" facilities, as already implemented in South Africa, would enable people to ask to register and vote at home in the presence of a visiting electoral officer.

5.3.3 The Electoral Commission of Namibia's response to the external impact of HIV/AIDS

The Electoral Act (Act No. 24 of 1992) provides for the ECN to make arrangements for disabled voters, who may either get help from the presiding officer or an adult family relative or friend (Tötemeyer, 1996: 49). In such a situation, the voter's decision might not be entirely secret.[43] Presiding officers may encourage disabled, pregnant or sick voters to skip the queue, or to queue separately.[44] In June 2004, the ECN set up a steering committee to plan and implement a project on the treatment of people with disabilities during elections.

From 2003 to 2005, an Election Support Consortium, consisting of the ECN, Lac and Nid, has been responsible for a voter education programme, in which each implementation partner participated according to its core competence. The initiative, apart from encouraging everyone eligible to vote to access this right, also included civic education material for people with disabilities. Strategies targeting HIV/AIDS-affected or -infected voters have not yet been implemented.

As the Act does not provide for bedridden patients who are unable to register or to visit the polls on election day, home-based care AIDS patients find it very difficult to register for elections[45] and to cast their votes (Strand, 2005: 4). Mobile polling stations have visited hospitals, prisons and old-age homes, allowing hospitalised AIDS patients to vote, but excluding patients in home-based care.[46] More flexible registration and voting times, improved access for those with special needs at polling stations, or home visits by electoral officials might help. However, such solutions are expensive.

6. Impact on parliamentary configuration

Namibia's bicameral parliamentary system was set up based on the country's Constitution in 1990. The lower house – the NA – has the power both to make and repeal laws. It comprises 72 members elected every five years, using a PR system based on closed party lists. The president also appoints six extra non-voting members for their special expertise, status, skill or experience. The upper house – the NC – has the power to review all legislation and reports passed on to it by the NA, as well as to initiate legislation on matters of regional concern.

The NC comprises 26 members who, unlike NA MPs, represent territorial constituencies. NC members are regional councillors nominated by their regional councils. Each of Namibia's 13 regions selects two representatives for the NC. Regional council elections have been held every five or six years since 1992. Since Namibia became independent on March 21 1990, Swapo has dominated both houses of Parliament (see Tables 6.1 and 6.2).

The CA, elected in November 1989 after UN-supervised elections, was transformed into the first NA (1990–1995) on independence. Swapo gained a majority of seats, but not the two-thirds majority which would have enabled the party to write the Constitution on its own. However, after subsequent elections in 1994, 1999 and 2004 Swapo gained more than two-thirds of the NA's 72 seats. Swapo has been even more dominant in the NC, set up in 1993, after Namibia's first regional elections at the end of 1992. The ruling party's share of seats increased from 19 to 24 (out of 26) in 2004.

The closed party list system used in the NA elections has been criticised for producing candidates who feel accountable to their parties ahead of the electorate. The fact that NA MPs are not rooted in constituencies influences the manner in which they contribute to debates and their accessibility to the public and civil society organisations.

Since 2000, more than 40 out of 55 Swapo MPs in the NA have formed part of the executive, either as ministers or deputy ministers, which has negatively affected the quality of debates, the functioning of the committee system (which depends on a small number of opposition MPs and Swapo backbenchers), and public perceptions of the effectiveness of MPs who are not on the executive. Though national councillors are the only MPs who directly represent the local constituents, their powers in the chamber of review are limited. They are often viewed as the "poor cousins" of the NA, and so their political influence is seen as secondary to that of the lower house.

Table 6.1: Share of seats in the National Assembly since 1990

	Swapo	DTA	UDF	ACN/Mag	FCN	NNF	NPF/DCN	CoD	Nudo	RP
1990	41	21	4	3	1	1	1	–	–	–
1995	53	15	2	1	0	–	1	–	–	–
2000	55	7	2	1	0	–	0	7	–	–
2005	55	4	3	1	–	–	–	5	3	1

Table 6.2: Share of seats in the National Council since 1993

Year	Swapo	DTA	UDF
1993	19	7	0
1999	22	3	1
2004	24	1	1

Table 6.3: National Assembly and National Council MPs by age in 2000 and 2005

Age group	National Assembly, 2000	National Assembly, 2005	National Council, 2000	National Council, 2005
20–29	0	3	0	0
30–39	8	5	9	5
40–49	27	23	11	17
50–59	27	25	5	4
60–69	9	15	1	0
Over 70	1	1	0	0
Average age	51	51	44	45

6.1 Parliament and HIV/AIDS

The potential role of Parliament as an institution and parliamentarians as individuals in raising awareness about HIV/AIDS and creating leadership role models has largely been overlooked in official policy. Parliament as an institution has also been slow to wake up to the challenges posed by the pandemic. The government has acknowledged the need to involve all public institutions in efforts to reduce the level of HIV infections. In the preface to MTPIII, Health Minister Dr Amathila wrote: "Effective management and control of the HIV/AIDS pandemic call for a multi-sectoral approach" (RoN, 2004b: ii). However, in MTPI and MTPII the role of Parliament was not prominent. Only when MTPIII, outlining plans for the 2004–2009 period, was issued in 2004 were the obligations and commitments of the Legislative Sector included. In MTPIII, MPs are urged to do everything within their sphere of influence to:

- Influence public opinion and lead their constituents towards attitudes supportive of an effective national response to the pandemic, by increasing public knowledge and understanding of relevant issues;
- Ensure that legislation that they vote into being protects human rights and advances effective HIV/AIDS prevention, treatment, support and care programmes;
- Ensure political commitment and better governance essential for a rights-based response to HIV/AIDS;
- Mobilise the involvement of the government, private sector and civil society in discharging their societal responsibilities by responding appropriately to the pandemic; and
- Ensure that adequate and consistent financial resources are allocated to support and enhance effective HIV/AIDS national programmes that are consistent with human rights principles. (RoN, 2004b)

MTPIII then outlines a series of commitments, including:

- legislative committees "providing an ongoing forum for parliamentarians to deepen their understanding of the pandemic";
- MPs "ensuring that HIV/AIDS is kept on the political agenda";
- parliamentarians "combining intellect, tolerance, compassion and resolve to address the most important issues that cause suffering among communities and PLWHAs"; and
- parliamentarians "demonstrating strong personal commitments" on the issue of HIV/AIDS (RoN, 2004b).

6.1.1 Death rates

Between 1990 and 2006 four sitting MPs from the NA and two from the NC died, though none died from HIV/AIDS-related illnesses, according to the causes of death announcements issued to the media. Press reports at the time of the MPs' deaths gave the causes shown in Tables 6.4 and 6.5.

Table 6.4: Cause of death, Members of Parliament, National Assembly

Year	Cause of death	Sex	Age	Political party
1997	Complications from diabetes	Male	55	Swapo
1999	Vehicle accident	Male	71	Swapo
2002	Vehicle accident	Female	65	Swapo
2005	Long illness	Female	44	Swapo

Table 6.5: Cause of death, Members of Parliament, National Council

Year	Cause of death	Sex	Age	Political party
2000	Short illness	Male	43	Swapo
2001	Heart attack	Male	47	Swapo

The death rates among the 98 elected members of both houses have remained low. Death certificates rarely give AIDS as a cause of death, instead listing the secondary infection, such as TB or pneumonia, partly because of the stigma and partly because some life insurance schemes are likely to pay out less if AIDS is cited as the cause of death.

The average age of MPs across both houses was 49 in 2000 and 50 in 2005. In the first NA (1990–1995), no deaths of sitting MPs occurred, while in both the second and the third NAs two members (2.7%) died. While no members died during the first term of the first NC (1993–1998), two (7.7%) died during the second NC (1999–2004). All sitting MPs who have died were members of Swapo, with only one being a cabinet minister.

The party list system used in the NA does not require a by-election when an MP dies. Instead, the party of the MP simply selects the next person from the party list used at the last election to take up the vacant seat. As a result, the cost of replacing an MP in the NA is minimal. However, the two deaths in the NC necessitated the holding of by-elections in the regional council constituencies represented by the late politicians. Since 1990, only one MP appears to have resigned his parliamentary seat citing ill health as a reason. The Swapo MP, who resigned in mid-2004, gave complications arising from diabetes as the reason for his withdrawal as one of the six non-voting MPs in the NA. HIV/AIDS seems to have caused minimal disruption to the working of Parliament in terms of the illness or deaths of MPs.

Though the issue of attendance, particularly in the NA, has been raised since the latter part of President Nujoma's final term in office, HIV/AIDS or more general ill health has not been used to explain the failure to achieve quorums. Instead, claims that MPs were attending to their private business and making too many foreign trips were suggested as the cause in press reports. However, this cannot be taken as an indicator of the actual HIV prevalence rate among MPs. MPs receive such high incomes that they were able to access medical treatment long before antiretroviral drugs became widely available in Namibia in 2003. The fact that no death has publicly been linked to HIV/AIDS might also indicate the degree of stigma associated with the virus and the generally impersonal way in which MPs talk about the pandemic.

6.2 Parliamentary debates

Since the late 1990s several significant, if not always well-informed, debates have taken place in the NA on the issues of testing, notification, discrimination and the availability of antiretroviral drugs.

6.2.1 Testing for HIV/AIDS

The debate over whether MPs should go public about the results of their HIV tests has been heavily influenced, if not undermined, by the consequences of a political controversy that occurred in 1996. Swapo MP Ben Ulenga, who was at the time Deputy Minister of Local Government, said, during a debate on the MoHSS's budget, that he had undergone testing for HIV/AIDS and would shortly announce the result in the NA.

During the ensuing heckling and questioning, Ulenga suggested that 50% of MPs in the NA could be PLWHAs. Ulenga also spoke about members of his own family being HIV positive. Due to the furore after Ulenga's comments, he did not return to the house to announce his test result, but left Swapo in 1999 to start an opposition party, the Congress of Democrats (CoD), which won seven seats in the 2000 to 2005 NA.

In November 2000, Home Affairs Minister Jerry Ekandjo, recalling Ulenga's announcement of four years earlier, called on the latter to reveal his status. On the next day, Ulenga distributed a letter to all MPs, to which he had attached a copy of his negative HIV test result, urging other MPs to declare their HIV status. Though several Swapo MPs were dismissive of Ulenga's challenge to publicly declare their test results, the remaining CoD MPs in the NA stated their intention to disclose their test results. However, this did not happen and the party later decided not to make a partisan point out of public testing, for fear of making other parties even more reticent on the issue.[47]

Emma Tuahepa, the National Coordinator of Lironga Eparu, the national association for PLWHAs, has called on public figures to be more open about their HIV status:

> *It is unfortunate the HIV/AIDS has a face of poverty … We have our ministers, top officials and business people who are also HIV [positive]. Because they have good medical schemes their lives are prolonged. I call on them to come out in public to help fight the disease.*[48]

Despite such a call, no public figures had acknowledged their HIV-positive status by April 2006. Staff and members of the NC, which, as an institution, has shown more commitment on the HIV/AIDS issue than did the NA, decided collectively to go for HIV testing on December 1 2005, World AIDS Day, to show the importance of being aware of one's HIV status.[49] However, logistical problems meant that the testing did not take place on December 1. By April 2006, another date for the tests had not yet been arranged, while talks with the NA were being held to see if the whole of Parliament could be involved in the exercise.[50]

In the light of previous reticence and hostility over the issue, and due to, apart from Ulenga, no MP having acknowledged being tested, the plan seemed unlikely to succeed in the short term. However, in March 2005, Richard Kamwi was appointed Minister of Health, since when he has more enthusiastically propounded VCT than have previous holders of the post. In May 2006, he told an HIV/AIDS awareness campaign launch, held at the Namibian Polytechnic, that he was prepared to undergo VCT, saying:

> *Voluntary counselling and testing generates optimism, as large numbers of persons test HIV-negative. It reduces stigma and discrimination and enhances the development of care and support services. Counselling and testing also reduces transmission and enables access to preventive prophylaxis and to antiretroviral treatment.*[51]

However, whether Kamwi would undergo public testing was unclear.

6.2.2 Notification of disease

In 1999, Health Minister Dr Amathila declared a directive on HIV/AIDS. Trying to end the "secrecy" surrounding the disease, Amathila said Southern African Development Community (Sadc) health ministers had decided that HIV/AIDS should be regarded as a "public health concern" and that the disease would be "notifiable", meaning that medical practitioners could disregard the usual strictures about confidentiality concerning a patient's status. Though Dr Amathila included the policy in a ministerial statement to the NA, no debate occurred on the issue.

The notification policy, however, was alluded to in Swapo's 1999 election manifesto (Swapo, 1999). Though MPs did not question the notification policy, civil society groups immediately advised against the move, consulted among themselves and sought audiences with Dr Amathila. At no point, however, did they try to lobby MPs. The AIDS Law Unit/Lac drew up an alternative policy on the issue of notification, which was accepted by Cabinet in 2002. Though there were many positive aspects to the way in which the notification controversy was handled, apart from the Minister's statement, Parliament was completely bypassed.

6.2.3 Discrimination against people living with HIV/AIDS

In 1997, Deputy Labour Minister John Shaetonhodi tabled in the NA a National Code on HIV/AIDS and Employment, which stated that there should be no pre-employment testing and that PLWHAs should be protected from discrimination in the workplace.

The code was approved by Parliament, despite some objections from MPs, particularly Minister of Defence Malima, who said that pre-employment testing was crucial for potential recruits to the Namibian Defence Force. In 2000, the labour court ruled in favour of a prospective recruit, Haindongo Nanditume, who had been rejected by the army because he was HIV-positive. The labour court ruled that the army could still carry out pre-employment HIV tests, but the decision as to whether an HIV-positive recruit could join the army should be based on CD4 counts and a viral load test, rather than allowing for a blanket rejection.

In 2001, the NA amended the Labour, Defence and Security Acts that would enable the security forces to continue pre-employment testing for HIV as part of their medical tests for potential recruits. The CoD was the only party to vote against the amendments, on the grounds that they were discriminatory. The NC's Standing Committee on Foreign Affairs, Defence and Security later held public hearings on the amendments, at which it recommended that the Ministry of Defence revisit the criteria for army recruitment and introduce a panel of experts to advise on medical issues regarding who should be considered fit to serve in the army. However, the committee's recommendations appear not to have been taken up by the Ministry of Defence.

The handling of pre-employment testing and the security services issue indicates the strength of the executive in the face of a weak opposition in Parliament. Concerns expressed by the CoD and parts of civil society could not stop the executive proceeding with plans to exempt the security forces from the National Code's provisions. Ultimately, only the court system was able to limit government policy.

6.2.4 Antiretroviral treatment

The provision of antiretroviral treatment provides a rare example of the government changing policy direction, after pressure from a political party, civil society and Swapo. The government had undertaken to provide antiretrovirals in specific cases, such in PMTCT, from the late 1990s. However, a general rollout of antiretroviral drugs had then been ruled out as too expensive.

The climate on antiretroviral drug provision changed in 2002, when the Swapo-dominated Congress urged that treatment be extended to all PLWHAs. In early 2003, CoD MP in the NA, Rosa Namises, tabled a motion calling on the government to provide antiretroviral treatment at major hospitals. The motion coincided with several civil society candlelit vigils on the issue, organised by

the Treatment Action Forum at Lac. While criticising CoD for using HIV/AIDS as a political issue, Dr Amathila told the NA that antiretroviral treatment would be made available to all who needed it. Though the process was still slow, at least the rollout would be general, rather than targeting specific groups.

6.3 Institutional response

Parliament as an institution has become increasingly required to do much more to raise awareness about HIV/AIDS, encouraging and supporting MPs to make a serious contribution on the issue, and providing internal resources and support for affected and infected staff. However, parliamentary response over the past 16 years has been tardy.

Three parliamentary clerks are assigned to the NA's HIV/AIDS desk, with HIV/AIDS-related issues taking up 10% of their time.[52] In the NC, which has made more progress on the issue than the NA, efforts have been spearheaded by one personally committed official, senior parliamentary clerk Samuel Kaxuxuena, who also spends about 10% of his working time dealing with HIV/AIDS-related matters.[53] As a former pastor, he also offers unofficial counselling sessions to NC staff affected and infected by the disease. However, his position as clerk is not enough to ensure that policy change takes place without the support of more senior personnel.

The NA lacks a standing committee dedicated to dealing with the issue of HIV/AIDS. Instead, the issue is only one of the many responsibilities of the Standing Committee on Human Resources, Social and Community Development, which also has to deal with education, health, housing, rural development, gender equality and child welfare. The standing committee has to set up an HIV/AIDS subcommittee. Internally, the NA has a staff committee (set up in 2003) that deals with HIV/AIDS, disseminating information about testing, health matters and condom usage among staff members.

NA staff declared that they were aware of one HIV/AIDS-related death of a colleague in the past three years. Detecting the influence of HIV/AIDS on the turnover of staff was difficult to do, as many NA employees left for other public service jobs after relatively short periods spent working for Parliament.[54] A workplace policy on HIV/AIDS is only in the planning stages. The NA has organised several training workshops for MPs, principally for members of the standing committee, and is sending MPs to the different regions to raise HIV/AIDS awareness. The programme started with the planned visit of six MPs to the Northeast of the country in May 2006. Members of the standing committee, including MPs from Swapo, the DTA, CoD, the United Democratic Front (UDF), the Monitor Action Group (Mag), and Nudo are expected to provide leadership on HIV/AIDS and to "represent the National Assembly in the fight" against the disease.[55]

The NC deals with HIV/AIDS through its Standing Committee on Habitat, which is setting up a subcommittee dedicated to dealing with HIV/AIDS. According to Kaxuxuena,[56] a longer-term plan exists to form a joint parliamentary committee on HIV/AIDS, which would include members of both houses.

Mag chairperson Kosie Pretorius has pointed to the weaknesses of the present parliamentary system:

> *The first mistake made after independence was to appoint a Cabinet that is more than half of the National Assembly members. Actually the backbenchers must be in a position to influence government, but we cannot do that. For an ordinary member, it is impossible to make a difference. You have to rubberstamp against your will because you cannot even do research.*[57]

Swapo Chief Whip Ben Amathila said the main problem for backbenchers was that they lacked "assistants and researchers" to help them to make informed contributions. As a result, "everyone has to do his own little research" (*Insight Namibia*, 2004: 18–19). Some contributions by MPs have been ill-informed, while many have been defensive on the issue, failing to acknowledge that the disease has personally affected them (as it has everyone in Namibia). Only CoD leader Ulenga has formally declared his HIV status and, unfortunately, this was not done in an open and voluntary manner, but after political baiting from Home Affairs Minister Ekandjo.

7. Impact on political parties and policy proposals

With an estimated one in five of Namibian adults HIV-positive, almost 200 000 registered voters could be infected. If voters living with HIV/AIDS were to vote in one bloc, they would, consequently, significantly influence national election outcomes.

However, in the 1999 and 2004 NA elections, several of the parties avoided taking a confrontational stance on the issue. The parties' 2004 manifestos mostly offer similar policies on HIV/AIDS, phrased in language similar to that of the government. In theory, an opposition "AIDS party" would be most likely to focus on the thorny issue of the availability of antiretroviral drugs. However, since the issue was first "party politicised" by a CoD motion brought in the NA in 2003, opposition parties have not dedicated themselves to raising the issue, despite clear evidence that the antiretroviral rollout was delayed.

CoD has been the most outspoken on access to treatment and testing, though its stance has stirred minimal debate. AIDS activists operating in civil society have largely avoided using opposition parties to raise their concerns. Tending to bypass Parliament and the opposition parties, they have directly lobbied the executive instead, a route they see as more likely to produce effective and quicker responses. Though civil society groups working on HIV/AIDS rarely clash openly with the government, in 2003 one such incident made headlines. HIV-positive demonstrators (part of the national campaign group Lironga Eparu) publicly urged the then Deputy Minister of Health Kamwi to speed up the process of making antiretrovirals available at a candlelit vigil in Windhoek.

Later, Lironga Eparu National Coordinator Tuahepa said the demonstration "was really effective" in ensuring that the antiretroviral rollout was implemented with more urgency:

> *Perhaps it was not the proper way to go about things according to the Minister, but for us people living with HIV/AIDS it worked really effectively. Immediately, people were treated.*[58]

This section examines how the pandemic has affected the seven political parties that won seats in the 2004 NA elections, in their views of the electoral process, their capacity to campaign, their internal

party practices, and the development of their policies. The findings are based on manifestos and policy statements produced since 2004 and interviews carried out with representatives of the CoD, the DTA, Mag and the UDF. Requests for interviews with senior officials from the remaining parties represented in the legislature were unsuccessful. Several parties have clearly spent little time and resources on devising HIV/AIDS-related policies or on how they might be able to reduce the negative affect of the pandemic on their ability to function as a political party, despite several politicians providing anecdotal evidence of how HIV/AIDS had eroded their ability to perform effectively.

7.1 Political parties regarding HIV/AIDS and elections

The history of the liberation struggle, personalities and tribal identity appear to have been primary factors in determining the way in which voters cast their ballots (Hopwood, 2006). In the words of DTA Secretary-General Alois Gende:

> *You can write a very good manifesto, but people don't read manifestos – they ask who is the leader, where does he come from, is he respectable, is he a strong leader, is he from my region? (cited in Hopwood, 2005)*

7.1.1 Integrity of the electoral process

After the 2004 NA election, several opposition parties complained that the polling had been unfair. Concerns about possible irregularities affecting the count prompted the CoD and the Republican Party (RP) to launch a court case seeking a recount of NA votes, which they won in March 2005. The high court found that, while there had been no conspiracy to subvert the election outcome, ECN officials had committed many errors, which could have undermined the integrity of the election. However, opposition parties also claimed that the recount, which produced a similar result to the first count, was riddled with errors.

A legal challenge of the result, emanating from the RP, was still pending at the time of writing. Despite complaints from several opposition parties about the competence levels and training of election officials, none of the parties interviewed for this chapter had considered that HIV/AIDS might have influenced the way in which the election was organised. The possible high turnover of ECN staff and the failure to build on staff experience gained in previous elections due to illness and/or death had not been considered by most party representatives as a possible reason for the ECN's reduced effectiveness. The DTA, Mag and UDF representatives felt that HIV/AIDS had not obviously affected the administration of the 2004 election.[59] However, the CoD's Secretary-General, Reinhard Gertze, said that the organisation of the 2004 ballot had been affected, because: "HIV/AIDS has its impact on everything and elections are no exception … Looking at that given the percentage of people infected, certainly HIV/AIDS has a huge impact in that we are losing people who could play their role effectively not only as voters but in the administration – they could help in the ECN."[60]

Gertze was also concerned that the voters roll would quickly become out of date due to the high death rates caused by HIV/AIDS. He wanted the ECN to undertake "immediate and consistent" updating of the roll, rather than "waiting to the last minute" before an election.[61] The problem of clearing ghost voters (those who had died since the last election) off the roll would become a major problem if it was left for five years. Both the UDF and CoD felt that HIV/AIDS was negatively

affecting voter turnout, because many voters were bedridden at home or in hospital, preventing them from visiting polling stations.

Both the CoD's Gertze[62] and the UDF's Michael Goreseb[63] have said that the depression caused by being in an advanced stage of such a serious illness would deter some HIV-positive people from voting. Goreseb has said that some voters were "so disillusioned that they no longer care about life". Swapo has the most to lose from high mortality rates, as it is the dominant party in regions such as Caprivi, which have the highest prevalence rate.

However, smaller parties whose support is concentrated in certain geographical areas, such as the UDF in the Northwest or Nudo in the East, could find their limited support bases eroded through high mortality rates in the future. Such an erosion might be particularly evident in regional council elections, in which relatively small swings in voting patterns can determine the winning candidate under the FPTP system. As a result, for example, the few constituencies held by the DTA and UDF in the Northeast could be lost to Swapo. Smaller parties are also often dependent on charismatic leaders and their support bases are vulnerable to erosion if such a leader is no longer able to be the party's dominant figure. In Namibia's case, several smaller parties are headed by tribal chiefs, including the UDF and Nudo.

7.1.2 Party capacity to campaign

With the possible exception of Swapo and Mag, the internal organisation of most parties is poor. Mag neither actively recruits members, nor does it hold formal campaign meetings before elections. Instead, Mag views itself as a pressure group, for which people will vote if they share the party's principles. Though Swapo has released no official membership figures, the party has invested in developing its membership and recording payment of membership fees.

Delegates to important congresses and meetings may be barred if they are not fully paid up Swapo members. The 1997 and 2002 Swapo congresses both passed resolutions urging the party to set up a functioning membership database. In contrast, however, most opposition parties have no meaningful membership records and only have *ad hoc* scattered structures, apart from their head office. In 2005, the CoD's Gertze conceded that the official opposition had fewer than 50 paid-up members (Hopwood, 2005). The DTA, after 29 years, still has no membership records.

The parties blame their absence of membership systems on a lack of financial and other resources. They also find the task of recruiting members highly time- and energy-consuming, when compared with the small income that they believe a paid-up membership could produce. The RP, for example, complains that many of its prospective members lack the income to pay even a minimal annual membership fee. As a result, the party distributed 10 000 free party membership cards before the 2004 elections (Hopwood, 2005).

While the political will to develop administrative capacity among opposition parties appears to be lacking, Swapo clearly receives most state funding for political parties. In the 2005/06 budget year, Swapo was due to receive N$11.7 million in state funds, while the other six parties in Parliament were expecting to receive only N$3.5 in total (Hopwood, 2006). As most parties hold scant membership data, assessing to what extent HIV/AIDS might have affected their campaigning capacity is difficult for them.

However, nearly all the party spokespeople interviewed acknowledged that HIV/AIDS has robbed them of key activists and degraded their campaign abilities, with several referring to specific party

organisers or candidates who had died. DTA Secretary-General Gende[64] said the party's administration had been "dysfunctional", since "highly skilled officials who had been trained through NGOs and the party throughout the years had passed away or were sick in bed and cannot perform."

The UDF's Goreseb[65] indicated that "even the death of one party activist is a notable loss", which causes stress within the organisation, especially as small parties are financially strapped. Gertze of the CoD said that a candidate for the 2004 regional council elections had died, though it was not clear whether the death was HIV/AIDS-related. He also stated that the prevalence of HIV/AIDS made it difficult to organise meetings:

> *I will call for an executive meeting and a lot of time I get people saying my brother or sister has died and I cannot attend. I suspect in many instances it is HIV/AIDS. In the leadership you can feel that the impact is there.*[66]

Only the Mag MP in the NA, Jurie Viljoen, said his party's campaigning had been unaffected by HIV/AIDS. Mag, the party which emerged from the ashes of the National Party (NP) in Namibia in the early 1990s, has repeatedly stated that "the best way of fighting HIV/AIDS is moral values" (Mag, 2004b).

Since most parties have yet to develop the institutional capacity to recruit and maintain paid-up memberships, the only accurate measure of their support bases is the most recent election results. Swapo has maintained its share of over 75% of the vote at the last two NA elections, while the other parties are of negligible importance. Even the official opposition CoD only attracted 7% of the vote in 2004.

Only the ruling Swapo has a significant youth league, which accepts members up to the age of 35. Despite this being the hardest hit of age groups in terms of HIV prevalence, little evidence exists of a high death rate among Swapo Youth League leaders. Several are paid for completing their party duties or have other paid roles, providing them with the necessary resources to access antiretroviral treatment even before the 2003 rollout started.

7.1.3 Party practice

Parties have not institutionalised their response to HIV/AIDS by creating support structures or educational programmes for their members who are infected and affected. Most party representatives spoke of "informal", "*ad hoc*" or even "random" attempts to address the issue of HIV/AIDS within their organisation. None of the parties interviewed have openly HIV-positive people working in the party structures. The UDF representative said the party's management level had led by example by undergoing VCT,[67] even though this had not been done publicly. The DTA also said that its party leaders had been tested, though the results were not declared. Though the CoD stated in 2000 that the party's MPs would publicly set an example by undergoing testing, they did not do so.

The response to Ulenga's declaration that he would disclose his HIV status in 1996 and 2000 indicated the "political stigma" attached to any politician known to be HIV-positive. Because of such potential stigma, politicians are less likely to undergo public HIV testing and to lead the public campaign for VCT. Gertze said that the party had realised that making testing a party political issue could be counterproductive, as other parties would see such a move as a political challenge and could become defensive on the issue. He urged that public testing should be undergone as parliamentarians rather

than as party political leaders: "One should not be very political about this thing. If we exclusively do this [go for testing] we would be challenging Swapo and other political leaders."[68]

Viljoen said that his party had not developed internal written policies on HIV/AIDS, due to its members' belief in high moral standards, implying that such policies were unnecessary for Mag.[69] None of the parties have workplace HIV/AIDS programmes for their staff, and while several said they would like to have such a policy, they pointed to the perennial lack of resources as the reason for their not making progress on the issue.

7.2 Policy proposals

In 1994, only Swapo made reference to HIV/AIDS in its manifesto for the NA elections. Five years later, three parties addressed the issue in their manifestos. The most controversial aspect of Swapo's 1999 manifesto was the proposal that HIV/AIDS be made a "notifiable" disease (Swapo, 1999). However, plans to identify PLWHAs were later dropped, after consultation with civil society. The CoD, in its manifesto, said that HIV/AIDS should be declared a national emergency and that coordination of the government's programmes should be transferred to the office of the president (CoD, 1999).

The UDF was the only party to call for subsidised drugs to be made available to PLWHAs (UDF, 1999). In the five years after Swapo's re-election in 1999, it countered opposition criticism by hastening antiretroviral rollout from 2003 onwards. In 2004 most parties included sections on HIV/AIDS in their manifestos. Swapo's 2004 manifesto stretched to 75 pages, which was much longer and more detailed than the other parties, which mostly produced mere pamphlets on the issue (Swapo, 2004). Nudo's manifesto came in second longest, at 23 pages (Nudo, 2004). Swapo policies are largely drawn from NDP II, *Vision 2030* documents, and the party's resolutions at its 2002 congress. In contrast, most of the opposition parties' proposals are limited to a few paragraphs. In heading the government, Swapo is able to set out more detailed policies and, in some areas, state specific targets.

Swapo aimed to have at least one hospital in each region providing a comprehensive HIV/AIDS service by the end of 2004 and said at the time that all 35 public-sector hospitals would provide such services by the end of the 2006/07 financial year. Concerning the rollout of antiretroviral drugs, Swapo pledged that 18 000 PLWHAs would receive treatment by the end of 2007 and 25 000 by the end of 2009. Swapo also wants civil society, including PLWHAs, to take part in the planning and implementation of HIV/AIDS (Swapo, 2004).

The CoD said that it wanted all senior public officials to undergo VCT and to make their results public. The party repeated its calls for HIV/AIDS to be made a national emergency and for the campaign against the disease to be relocated to the president's office (CoD, 2004). The DTA stated that treatment for PLWHAs should be a national priority, and proposed that special care centres be set up to look after the infected (DTA, 2004). Nudo said that it would approach the HIV/AIDS pandemic on the basis of medical science rather than ideology. Though emphasising that it would promote cultural and family values, it said that it also wanted more effective sex education programmes (Nudo, 2004). The RP (2004) also adopted a moralistic approach, denouncing the government for confusing Namibian citizens about sexual behaviour, and urging the adoption of programmes based on Christian values.

Mag, a Christian rightwing party, did not refer to HIV/AIDS in its election material. However, the judgmental approach of the party was clearly portrayed in the budget debate speech of its MP in the NA, Viljoen, when he said: "A person with AIDS doesn't care and will infect as many people as possible." He also said that the government's provision of antiretroviral drugs should be regarded as "a sin tax" (Mag, 2006).

Those parties (Swapo, CoD, DTA) that take a human rights-centred approach, in which treatment features prominently, and those (RP, Mag) that focus on the perceived rights and wrongs of sexual behaviour and what are seen as family values are clearly split as regards their manifestos and policy statements. The UDF and Nudo, which gain much of their support from traditional communities, feature elements of both approaches in their manifestos. Most of the opposition parties feel that they are unable to devise detailed or innovative HIV/AIDS policies, due to their lack of resources, especially any research capacity.

Several parties have said that they are still in the process of developing and revising their positions before entrenching them in policy statements. Such procrastination might be a tacit acknowledgement that their previous statements and manifestos were limited in scope and thin on detail. DTA's Gende said that his party was still busy "redefining the policy to cope with the situation".[70] Only the UDF was able to provide a short policy statement and a manifesto (UDF, 2005), while Mag provided its sole MP's speech on the 2006/7 budget, which referred to the HIV/AIDS issue (Mag, 2006).

In a 2005 policy statement, the UDF stated that MPs "must be champions in the fight against HIV/AIDS by using their status to raise awareness and commitment" (UDF, 2005). Both the DTA and the UDF have said that all party leaders should deal with HIV/AIDS when addressing community meetings. However, politicians seem generally to have failed to provide the required leadership in this regard in both their communities and the nation. The main progress made within the last six years concerns the move away from simply regarding HIV/AIDS as a contagious disease to viewing the pandemic in the context of human rights.

As a result, the issue of making HIV/AIDS a notifiable disease, raised by Minister of Health Dr Amathila in the late 1990s, has receded in importance. From a situation where only the UDF was mooting the possibility of providing antiretroviral drugs in 1999, a concerted rollout started in 2003. Though no attempt has yet been made to make a joint party statement on HIV/AIDS, there is scope for crossparty agreement and action on the issue.

8. Political opinion and civic participation in the context of the pandemic

How Namibians prioritise HIV/AIDS-related issues and are affected in their participation in civil society activities is explored in this section. The Afrobarometer reports the results of national sample surveys on the attitudes of citizens in selected African countries towards democracy, markets and other aspects of development. In Namibia, the first round of the Afrobarometer survey was conducted in 1999 (round 1), while the next two rounds were conducted during 2002 (round 1.5) and 2003 (round 2), with the most recent round (round 3) being conducted in 2005.[71]

8.1 Political opinion and HIV/AIDS

Table 8.1 shows the percentages of Namibians who thought AIDS was one of the serious policy issues that should receive attention from the government rather than other development-related issues such as poverty, unemployment and education.

Table 8.1: Percentage of Namibians considering HIV/AIDS the most important problem

	2003 (%)	2002 (%)	1999 (%)
AIDS most important problem	28	35	1472

Source: Keulder and Wiese, 2003: 14; Strand and Chirambo, 2005: 119.

The number of Namibians who regard the pandemic as one of the most important problems[73] first increased significantly between 1999 and 2002 by 21%, but then declined slightly by 7%. Overall, the pandemic was regarded as a more serious problem by larger sections of the population in 2002 and 2003 than at the end of the 1990s. Public consciousness regarding the HIV/AIDS issue has risen significantly over time in Namibia, though it declined slightly between 2002 and 2003. Unemployment remains by far the most dominant problem, with 72% regarding it as an important policy issue in 2003 (Keulder and Wiese, 2003: 13–14).

With the approval of more than two-thirds of Namibians, combating HIV/AIDS is among those policy areas where the government is perceived to be doing either fairly or very well. However, such approval of the government's performance is believed to have decreased from 2002 to 2003 by 12%, though it increased by 6% between 2003 and 2005 (see Table 8.2). Table 8.3 shows the similarity between rural respondents and their urban counterparts, as well as between how male and female Namibians view government performance.

Table 8.2: Positive ratings of government performance in combating HIV/AIDS, 2002-05

Ratings	2005 (%)	2003 (%)	2002 (%)
"Fairly well" and "very well"	72	66	78

Source: IDASA, 2006; Keulder and Wiese, 2003: 15.

Table 8.3: Positive ratings of government performance in combating HIV/AIDS, 2005

Ratings	Urban (%)	Rural (%)	Male (%)	Female (%)	Total (%)
"Fairly well" and "very well"	71	71	72	72	72

Source: IDASA, 2006.

Nevertheless, Namibians are split on whether they would support allocating extra resources to combating the pandemic, even if it meant diverting resources from other key developmental issues. In 2005, when asked to choose between two contrasting statements, 41% agreed or agreed very strongly on (A) "The government should devote many more resources to combating AIDS, even if this means that less money is spent on things like education", while 54% agreed or very strongly agreed on the alternative, (B): "There are many other problems facing this country besides AIDS; even if people are dying in larger numbers, the government needs to keep its focus on solving other problems". Thus, clearly there is less support for prioritising anti-AIDS spending (IDASA, 2006). Again, Table 8.4 shows no real distinction between urban and rural respondents, and no significant difference between male and female Namibians.

Table 8.4: Statement closest to respondent's view, 2005

Statement closest to respondent's view	Urban (%)	Rural (%)	Male (%)	Female (%)	Total (%)
"Agree very strongly with A" and "Agree with A"	41	40	41	40	41
"Agree very strongly with B" and "Agree with B"	52	54	53	54	54

Source: IDASA, 2006.

The Afrobarometer data further suggest that, between 1999 and 2005, many more Namibians proportionally have experienced personal loss in having lost a friend or a relative to AIDS-related illness, with a drastic increase of 31% between 1999 and 2003, and a significant decline by 11% between 2003 and 2005 (see Table 8.5).

Table 8.5: Percentage of people who have lost a friend or relative to AIDS74

	2005 (%)	2003 (%)	2002 (%)	1999 (%)
Personal loss from AIDS	60	71	57	40

Source: IDASA, 2004: 2; IDASA, 2006.

Table 8.6 shows the results of when, in 2005, respondents were asked, "How many close friends or relatives do you know who have died of AIDS?". Overall, Namibians recognise that the increasing numbers of death that they see are the result of AIDS-related illness, and they are becoming willing to talk about it more openly.[75]

Table 8.6: Number of friends or relatives known to have died of AIDS, 2005

Number of friends or relatives	Percentage
1–5	44
6–10	10
11–20	1
More than 20	0
Refused to answer	0
Do not know 76	3
Not applicable	41

Source: IDASA, 2006.

Rather than asking respondents about their own HIV status, approximate levels of public health have been estimated by asking Namibians about their physical and mental well-being, with two sets of questions being used as proxy-indicators. Table 8.7 shows the results of when the respondents were asked, as a measure of their physical health, "In the last month, how much of the time has your physical health reduced the amount of work you normally do inside or outside your home?". As the levels of stress and depression associated with people knowing or suspecting that they are ill from HIV/AIDS-related causes tend to be high, respondents were asked "In the last month, how much of the time have you been so worried or anxious that you have felt tired, worn out or exhausted?" as a measure of their mental health. Table 8.8 shows the results in this regard.

Table 8.7: Amount of time normally worked inside/outside the home reduced due to physical ill health

Amount of time	2003 (%)	2005 (%)
Never	69	45
Just once or twice	17	29
Many times	11	22
Always	3	4
Do not know	0	1

Source: Bratton *et al.*, 2004: 27; IDASA, 2006.

Table 8.8: Amount of time worry or anxiety resulting in feeling tired, worn out or exhausted

Amount of time	2003 (%)	2005 (%)
Never	67	38
Just once or twice	17	27
Many times	12	28
Always	4	7
Do not know	0	1

Source: Bratton *et al.*, 2004: 27; IDASA, 2006.

According to the 2003 results, Namibians appear by far to be the healthiest people of the many nations included in the Afrobarometer survey (Bratton, Logan, Cho and Bauer, 2004: 27). The relatively low levels of severe illness compared with those of other countries might be due to HIV/AIDS only relatively recently reaching pandemic proportions in Namibia, with the number of respondents feeling often or always physically ill rising significantly by 12% between 2003 and 2005. During the same period, the number of people who felt often or always tired, worn out and exhausted increased drastically by 19%.

Table 8.9: Amount of time health reduced

	Amount of time normally worked inside/outside the home reduced due to physical ill health		Amount of time worry or anxiety resulting in feeling tired, worn out or exhausted	
Amount of time	Urban (%)	Rural (%)	Urban (%)	Rural (%)
Never	55	38	44	34
Just once or twice	25	31	27	27
Many times	16	25	22	31
Always	3	4	6	7
Do not know	1	1	1	1

Source: IDASA, 2006.

In 2005, respondents in rural areas reported feeling significantly more often physically ill, tired, worn out and exhausted than their urban counterparts (see Table 8.9).

8.2 Civic participation and HIV/AIDS

Whether the endemic remobilised civic activism or whether people are demobilised by HIV/AIDS because they have to spend time looking after sick household members[77] or orphaned children is a concern for debate.[78] People were asked whether they provided home-based care for sick family or household members as well as orphans, and, if they did, how many hours a day they spent doing so. In 2003, only 1% of Namibian respondents said that they spent more than five hours a day caring for the sick (IDASA, 2004: 3). Despite Namibia having more than 120 000 orphans (AIDSBRIEF, 2004b: 8; UNICEF, 2005: 4), the same pattern could be observed with respect to their care (IDASA, 2004: 4). Orphans are regarded as biological children within the extended family support system. Namibians have only recently entered the phase where increasing numbers of people need care due to AIDS-related illnesses. The Namibian health care system is better than average (Strand and Chirambo, 2005: 123). The communities contain inadequate caring networks, so that other networks, like private or church orphanages, relieve families of some of the burden (IDASA, 2004: 4). In conclusion, the burden of home-based care for sick family members or orphaned children seems to have been relatively insignificant in Namibia up till now, resulting in little or no impact on people's ability or willingness to participate in civil society.[79] Therefore, people might be "more concerned with getting a chance to earn an income, feed their families, protect themselves from crime and insecurity, and obtain basic health care, than with being saved from a largely invisible killer" (Whiteside, Mattes, Willan and Manning, 2002: v).

9. Exploring the impact of HIV/AIDS on levels of voter turnout

The electoral statistics for the 2004 NA elections showed a significant increase in voter participation. As no major policy issues dominated the campaign, it appears that voters have been energised by the succession of the presidential candidate taking place in the ruling party, Swapo. President Nujoma, having completed three terms in office, had to make way for the presidential candidate Hifikepunye Pohamba (Hopwood, 2006: 41). Both Nudo and the RP broke away from the DTA in 2003 and registered with the Directorate of Elections as separate parties, thus perhaps increasing voter participation.

9.1 HIV prevalence and voter turnout

The 2004 presidential and NA elections produced a turnout of nearly 85% – the highest since the watershed 1989 founding elections. At the end of the last supplementary registration of voters, the total number of registered voters was 978 036. As the 2005 estimate for the total population was 2 030 000 people,[80] serious doubts have been raised about the close to one million who registered as eligible voters. The total number of votes cast in the 2004 NA elections was 829 269, representing an 84.8% voter turnout. According to the ECN (2005: 54), such a turnout was "a milestone in voter motivation", in comparison with the turnout for the two preceding NA elections. Table 9.1 shows the numbers of registered voters, the total number of votes cast and the percentage of voter turnout at national level for NA elections in 2004, 1999 and 1994.

Table 9.1: National Assembly elections, 2004, 1999 and 1994

Year	2004	1999	1994
Registered voters	978 036	878 869	654 189
Total votes cast	829 269	540 790	497 508
Voter turnout	84.8%	61.5%	76.05%

Source: ECN, 2005: 60.

Table 9.2 shows the voter turnout in the 2004 NA elections and the 2004 regional council elections in each region.

Table 9.2: Voter turnout in the 2004 National Assembly elections and the 2004 regional council elections in each region

Region	Voter turnout: 2004 National Assembly elections (%)	Voter turnout: 2004 regional council elections (%)
Omusati	88.12	74.2
Khomas	87.91	37.92
Ohangwena	88.03	72.32
Oshana	88.42	61.06
Kavango	79.85	56.13
Caprivi	79.7	56.64
Oshikoto	89.44	68.32
Otjozondjupa	79.59	47.24
Erongo	87.92	44.09
Karas	84.15	38.57
Hardap	72.18	50.83
Omaheke	78.16	61.81
Kunene	76.44	59.99

Source: ECN, 2005: 58–59; Hopwood, 2006: 336–340.

To consider HIV prevalence by region, the translation of the sero-sentinel survey into regionally comparative data gives the spread shown in Table 9.3.

Table 9.3: Likely HIV prevalence in each region, 2004

Region	Prevalence (%)
Omusati	20.8
Khomas	16.7
Ohangwena	18.2
Oshana	24.9
Kavango	18.2
Caprivi	42.6
Oshikoto	19.7
Otjozondjupa	22.8
Erongo	27.0
Karas	18.7
Hardap	14.9
Omaheke	13.8
Kunene	9.5

Source: Nanaso, 2005b: 8.

To examine whether the voter turnout in 2004 was lower in regions with a higher HIV prevalence than in regions with a lower HIV prevalence, the voter turnout for the 2004 NA elections is compared with the prevalence rates found among pregnant women in selected regions. Table 9.4 shows the percentages of registered voters among the adult population (18<) in each region.

Table 9.4: HIV prevalence/voter turnout in each selected region

Region	HIV prevalence (%)	Registered voters/ adult population: National Assembly elections, 2004* (%)	Voter turnout: National Assembly elections, 2004 (%)	Registered voters/ adult population: regional council elections, 2004* (%)	Voter turnout: regional council elections, 2004 (%)
Caprivi	42.6	75.6	79.7	75.6	56,64
Erongo	27.0	97.3	87.92	97.3	44.09
Oshana	24.9	81.6	88.42	81.6	61.06
Kunene	9.5	92.4	76.44	92.4	59.99
Omaheke	13.8	89.3	78.16	89.4	61.81
Hardap	14.9	98.3	72.18	98.1	50.83

Source: Central Bureau of Statistics, 2003; ECN, 2005: 58–59; Hopwood, 2006: 336–340; Nanaso, 2005b: 8.
*Registered voters in each region provided by the ECN for 2004. Regional population projections (Central Bureau of Statistics, 2006). Number of eligible voters (18<) in each region is based on proxy-indicators, as the Population and Housing Census distributes age groups as follows: 0–4; 5–9; 10–14; 15–19; 20–24; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65<.

The HIV prevalence rate in the Caprivi region is significantly higher than that of any of the remaining regions around the country. In the 2004 NA elections, the Caprivi had an HIV prevalence ratio of 42.6% for a total voter turnout of 79.7%. The Erongo region, with an HIV prevalence ratio of 27%, had a total voter turnout of 87.92%. The Oshana region, with an HIV prevalence ratio of 24.9%, had a voter turnout of 88.42%. The Kunene region, with a prevalence rate of 9.5%, had a total voter turnout of 76.44%. The Omaheke region, with a prevalence rate of 13.8%, had a voter turnout of 78.16%. Finally, the Hardap region, with a prevalence rate of 14.9%, had a total voter turnout of 72.18%. In conclusion, the three regions recording the highest prevalence rates had an average voter turnout of 85.3%, while the three regions recording the lowest prevalence rates had an average voter turnout of 75.6%. The average turnout in the regions recording high prevalence rates was clearly significantly higher than in those with low prevalence rates. A possible explanation for the high voter turnout in regions with high prevalence rates is that PLWHAs participated in the 2004 NA elections if their state of health allowed them to. However, this argument needs to be qualified by emphasising that, for instance, the percentage of registered voters among the adult population in the Caprivi region was significantly lower than that of other selected regions.

With a countrywide voter turnout of 53.65%, participation in the 2004 regional council elections was significantly lower than in the NA elections that took place later in the same year.[81] The three regions recording the highest prevalence rates had an average voter turnout of 53.9% while the three regions recording low prevalence rates had an average turnout of 57.5%. Accordingly, the average voter turnouts in regions with high prevalence rates was slightly lower than in those with low prevalence rates, possibly resulting from people attaching greater importance to NA elections and therefore being more willing to exert the effort to participate.

10. Focus groups: The role of stigma and discrimination

The design of the FGDs was structured in three phases, namely: the preparatory phase; the FGD phase; and the evaluation phase. In preparation for the FGDs, the preparatory phase sought the input of various stakeholder organisations to ensure a process that would attain optimal results. Organisations sourced included those active in the field of HIV/AIDS, namely the Namibian Red Cross Society, Lironga Eparu and PharmAccess. Participant selection criteria were set up to include the status of registered voter; as well as his/her HIV status; gender; age; level of education; employment status (income); and ethnicity. To ascertain whether there are marked qualitative differences between rural and urban participants, FGDs were held both in Windhoek (Khomas region) and Ondangwa (Oshana region). On short notice, the northern FGDs had to be cancelled due to logistical problems, with their being held in Otjiwarongo (Otjozondjupa region) instead.

Due to the effects of non-disclosure in Namibia and the stigma associated with disclosure, participants were sourced from among members of Lironga Eparu, a local NGO providing various support functions for PLWHAs. While the members of Lironga Eparu might inherently be more informed about, and less inhibited by, their HIV status and the effects of stigmatisation than PLWHAs who are not affiliated to a support group, such arguments are negated by the overriding consideration of status. FGDs were conducted in English and/or Afrikaans and/or the vernacular.

A translator was present at all seven FGDs to ensure that participants were able to participate in their language of choice, thus ensuring optimal qualitative results. Translators were selected according to their credibility within the relevant community, thus ensuring that participants

would be comfortable and as unrestricted as possible in their participation, due to the presence of a respected community member sanctioning the FGD. To maximise group dynamics for optimal participation, FGDs were restricted to between eight and ten participants and differentiated on grounds of gender and age. A total of 64 participants, all registered voters and all PLWHAs, participated in the FGDs. Of the participants, the ratio of male to female was 1:2. FGDs were structured to solicit responses on the following themes:

- Baseline understanding of democracy and democratic systems;
- Perception of elections;
- Reasons for and (non-)participation in the 2004 elections;
- Perception of change agents; and
- Perception of election management bodies.

While pre-employment screening is not permissible in Namibia, and while HIV is not transmitted in most workplace settings, employers have been known to terminate the employment of, or to refuse employment to, PLWHAs. Fear of stigmatisation and discrimination by colleagues might also make employees reluctant to reveal their infection status. Discrimination might become more subtle and less explicit, with, for example, rather than having their employment terminated outright when their HIV-positive status becomes known, employees might now find themselves laid off for other reasons, or they might be harassed and pressured to the point where they would rather resign.[82] "AIDS denialism" entrenches the stigma and prejudice surrounding the virus, compounding people's fear of AIDS, resulting in a continued battle with the government (Haywood, 2004: 99).

10.1 The Namibian situation

According to the 2000 *Namibia Demographic and Health Survey* (MoHSS, 2003):

- The level of education and an urban setting encourage HIV/AIDS-related awareness and knowledge;
- 98% of women and over 99% of men have heard of AIDS;
- 54% of women and 53% of men know someone who has AIDS or who has died of AIDS;
- 83% of women and 87% of men are aware that a healthy-looking person can be a PWLHA;
- 26% of women and 32% of men believe that PLWHAs should be allowed to keep their status private;
- 91% of women and 92% of men would be willing to care for a relative with AIDS (due more to social obligation than to altruism);
- 67% of women and 55% of men believe that an HIV-positive teacher should keep on working;
- 45% of women and 46% of men would buy food from a vendor with HIV/AIDS;
- 81% of women and 80% of men believe that children aged between 12 and 14 should be taught how to use condoms;
- 95% of women and 97% of men think it acceptable to discuss HIV/AIDS on the radio and in the print media;
- 94% of women and 96% of men think it acceptable to discuss HIV/AIDS on television;

- 24% of women and 25% of men have undergone VCT, while younger participants and the more educated are more likely to opt for testing;
- 67% of women and 66% of men would like to undergo testing;
- 73% of women and 67% of men know of a place where they can go to be tested;
- 43% of women and 67% of men report the use of a condom with a non-cohabiting partner; and
- 28% of women and 45% of men report the use of a condom with all partners.

According to the same survey (MoHSS, 2003), men's attitudes to condoms and contraception were found to be:

- 35% believe a condom reduces a man's pleasure;
- 25% believe a condom is inconvenient to use;
- 3% believe a condom can be reused;
- 96% believe a condom protects against disease;
- 24% believe a woman has no right to tell her sexual partner to use a condom;
- 24% believe that a woman is responsible for contraception and that it is not the concern of a man;
- 38% believe that a sterilised woman might become promiscuous;
- 52% believe that male sterilisation equals castration; and
- 47% believe that, as the woman is the one who falls pregnant, she should be the one to be sterilised.

10.2 Findings

Though the sample size is indicative rather than conclusive, it does provide a sound basis for future quantitative research into the suffrage of PLWHAs.

Table 10.1: Details of participants included in the sample

	Participants		PLWHAs	Age group	Employment	
	Male	Female			Employed	Unemployed
FGD 1	0	9	9	30–45	1	8
FGD 2	0	9	9	18–29	2	7
FGD 3	9	1	10	30–45	2	8
FGD 4	7	1	8	18–29	1	7
FGD 5	0	9	9	20–45	5	4
FGD 6	4	5	9	30–45	2	7
FGD 7	2	8	10	18–29	1	9
Total	22	42	64		14	50

In designing the FGDs and selecting the participants (for an enumeration of which, see Table 10.1), more women than men use the services provided by Lironga Eparu, so that women, in their role of child-bearer, are more likely to be tested (according to sero-surveys conducted among pregnant women who attend ANCs and in hospital during childbirth). They are, therefore, more likely to seek counselling and support than are men. Male engagement in extramarital relations and possession of multiple partners tends to be culturally acceptable, as is a woman's subjection to her partner.

What is the level of knowledge of democratic processes, particularly elections?

The impact of HIV/AIDS on the electoral process can only be gauged as meaningful within the context of democracy and democratic processes and individual understanding of these concepts. Participants' perceptions of democracy included associations with peace; unity; independence; liberty; equal rights for all; majority rule; and a government for, of and by the people. Participants furthermore stated a belief in the holding of elections as conducive to stabilising and peaceful change which facilitate the translation of rights into action.

Only four focus groups could identify all four types of elections held in Namibia, with the others having particular difficulty with identifying the regional council elections. Regional councils, therefore, do not seem key to decentralisation, accounting for the relatively low voter turnout in such elections. The choice of FPTP is questionable, especially due to the expense of by-elections. All participants thought that registering as a voter is essential, as doing so empowers all citizens to exercise their rights and responsibilities, to support their party of choice and to achieve a better life.

Which attitudinal and/or structural factors impede the participation of PLWHAs?

Only three female and one male participant did not vote during the 2004 elections, as one was abroad, one bedridden and two were registered in another constituency. The latter indicates a lack of voter education and knowledge among the electorate regarding their eligibility to vote in elections outside their registered constituency. In terms of structural factors and participation, the following perceptions were recorded:

- *Queuing*: Most participants noted the very long queues, especially in the rural areas, resulting in their queueing for between four and six hours, with a maximum time of 11 hours recorded by one participant. Three participants, in an effort to avoid excessively long queues, tried two or more polling stations before casting their vote.
- *Distance to the polling station*: While peri-urban and rural participants said that travelling distances were far, the urban-based participants found the distance reasonable, given the large number of stations in towns and cities.
- *Ablution facilities*: Only 24 participants were aware of the ablution facilities available at the polling station where they cast their votes. However, most were reluctant to make use of the facilities, in case they lost their place in the queue. Peri-urban and rural participants were seldom aware of ablution facilities or the availability of potable water at the stations.

Shade and seating are largely unavailable at polling stations. Urban residents were aware of Namibian Red Cross Society volunteers providing help and first aid to voters in need, while others noted the help given by sympathetic election officials, especially to pregnant women, women with babies and the infirm (though such help was not the norm).

- *Child care*: While no participants were unable to exercise their right to vote due to having to care for children or the ill, polling stations were regarded as inappropriate for children, due to

the lack of basic services. Women with babies, however, indicated that they had had to take their babies with them when they went to vote, while leaving toddlers and older children with neighbours or relatives.

- *Political party campaigning on HIV/AIDS*: Only one participant was aware of an HIV/AIDS campaign message before the 2004 elections, stating that the CoD had promised to provide for improved service delivery and living standards for PLWHAs.
- *Government response to the HIV/AIDS pandemic*: Peri-urban and rural participants compared the prioritisation of urban HIV/AIDS initiatives with the scant attention paid to such initiatives in the rural areas.

PLWHAs tend to regard their HIV status as secondary to that of their being citizens with the fundamental human right to choose their own representatives.

What is the effect of status on political involvement?

The effect was regarded in terms of two aspects:

- *Attendance at rallies*: Only seven participants did not attend rallies to hear the latest on plans and proposed developments and to lobby for specific issues.
- *Political party membership*: Only three male participants said that they did not belong to a political party, noting their disillusionment with unfulfilled election promises.

All participants stated that they believed in their right to vote, irrespective of HIV status and degree of faith in political structures.

To what extent does the electoral structure reach the electorate on the issue of HIV/AIDS?

Peri-urban and rural participants were unaware of any voter education conducted by the ECN. PLWHAs were regarded as being excluded from both ECN administration, as well as from observation, as they were not encouraged to participate and lacked access to the correct channels. Only five participants thought that the ECN was handling the issue of HIV/AIDS satisfactorily. The participants were generally unaware of any ECN-directed HIV/AIDS specific intervention. The ECN was criticised for the long queues at polling stations; the poor communication between voters and election officials, who tended to be ill-trained; the lack of access to first aid facilities; and the excessively long voter process, especially where the ill, disabled, pregnant and mothers with small children were concerned.

What motivates PLWHAs to participate?

More discrimination seemed to occur among peri-urban and rural populations, leading to the migration of many participants to the cities. All participants had suffered stigma and discrimination, whether in personal relationships, employment, social benefits or health care provision.

Participants blamed stigmatisation and discrimination on a lack of education and information All participants disparaged traditional leaders as agents of social change, due to their apparent perpetuation of HIV/AIDS-related myths and misinformation, resulting in financial loss and delays in treatment, counselling and the need for lifestyle change. Participants regarded them as helping only OVCs.

In contrast, community leaders, religious leaders and politicians rank highly as social change agents, as they are perceived to provide support, counselling and a voice for PLWHAs. While no participants were aware of any politician declaring their HIV-positive status, they had noted their support for VCT. Overall, their involvement of PLWHAs in elections was regarded as encouraging.

Participants were unaware of any PLWHAs or HIV/AIDS advocates among athletes and television and film stars, though they expressed a belief in the vital role played by sport in maintaining a healthy lifestyle, so that they regarded athletes as potential role models, as were television and film stars, who could help with civic education, dispelling HIV/AIDS-related myths and discrimination.

What structural changes would accommodate PLWHAs in the electoral process?

The participants argued against campaign messages targeting PLWHAs, as such messages might be interpreted as discriminatory. However, all stated that they felt that structural change would encourage the participation of PLWHAs in the electoral process. All participants, bar one,[83] supported a Namibian equivalent of South Africa's special vote facility. Participants urged an increase in the number of polling stations, suggesting that use be made of staffed support organisations, which would facilitate the participation of PLWHAs. Officials should be well-trained communicators. Scanners should be used to check names against the voters' roll. PLWHAs should be encouraged to use existing structures and networks, such as support groups, for voter education.

What is the effect of the conceptualisation of HIV/AIDS on voting behaviour?

HIV/AIDS was regarded as an issue of national concern by all participants, due to the non-discriminatory nature of HIV and its far-reaching effects. Politicians are thought of as vital in ensuring the provision of antiretrovirals.

What is the importance of politics and political participation?

The participants reported participating in:

- Community/local authority forums, to learn of development issues and to lobby for concerns;
- Volunteer services, including counselling, soup kitchens, providing treatment support in hospitals and positive speaking;[84]
- Political rallies and meetings, to show their support for their party and learn about tabled developments and issues; and
- Civic activities, such as the promotion of HIV/AIDS awareness via the electronic media and support groups.

All participants are members of a support group, their motivation to join being attributed to:

- Their desire to learn to live positively;
- Find acceptance among others like them;
- Receive and disseminate HIV/AIDS-related information;
- Help fight stigma and discrimination; and
- Be proactive.

All but five participants expressed a belief that political participation can enhance one's quality of life, by being able to choose one's own leaders, so that one can feel represented and accounted for. Political actors were, however, encouraged to leave apartheid politics behind and to focus on securing a better future for all.

11. Conclusion and recommendations

Electoral systems

HIV/AIDS-related concerns need increasingly to be factored into analyses of the viability of electoral systems and included in associated reform.

Electoral management and administration

As the ECN lacks formal workplace policies, it should develop policies and strategies to educate its staff about HIV/AIDS. Such awareness-raising activities should aim to reduce stigma and discrimination against PLWHAs. Accordingly, campaign information and material should be designed to inform and motivate PLWHAs. Inclusive messages should reduce HIV/AIDS stigma and discrimination among communities. Enough polling stations and transport facilities should be strategically situated to minimise the distance that people have to travel. Permanent and mobile polling stations should be equipped with functional ablution facilities and resting places, with the guarantee that those who make use of such facilities will not lose their place in the queue. Voter registration should be computerised and regularly checked against the population register and monthly death returns of the Ministry of Home Affairs and Immigration. Special votes should, if financially viable, accommodate bedridden PLWHAs at home.

Mobile polling stations for hospitalised patients should be continued and incorporated in the envisaged redrafting of electoral legislation. The envisaged postal voting system could make voting more inclusive, though it must be carefully implemented. The voter registration system is a serious challenge to both the ECN and the Ministry of Home Affairs and Immigration, as up to 30% of voters are still allowed to register and vote on the basis of sworn statements as to their identity.

Parliamentary configuration and political parties

Parliament should expedite plans to set up a Joint Committee on HIV/AIDS for members of both the NA and NC. Staff and members of both houses of Parliament should also become more active in public education campaigns within their own parties and through partisan platforms. Parliamentarians should undergo public VCT, as, if found positive they could show that HIV does not hinder their performance, thereby promoting greater acceptance of PLWHAs.

Political parties should consider institutionalising a strong internal response to HIV/AIDS and pledge part of their official state funding to creating an HIV/AIDS desk within their party headquarters. As well as coordinating the party's internal institutional response to HIV/AIDS (in creating workplace policies and strategies), it could also develop the party's policies on the issue. Parties should adopt bipartisan approaches to the issue, in the light of the significant amount of ground shared between several of the parties on the HIV/AIDS issue.

Electoral participation has not been as badly affected as some other countries have by the HIV/AIDS pandemic. Namibia is still among the countries with the highest voter turnouts worldwide.

References

AIDSBRIEF, 2004a. Quarters 1 and 2, Windhoek: Institute for Public Policy Research (IPPR), Namibia Business Coalition on AIDS (Nabcoa).

AIDSBRIEF, 2004b. Quarters 3 and 4. Windhoek: Institute for Public Policy Research (IPPR), Namibia Business Coalition on AIDS (Nabcoa).

Boer, M., 2005. "Taking a Stand: Comparing Namibia's Political Party Platforms" in Hunter, J. (ed.), *Spot the Difference: Namibia's Political Parties Compared*, Windhoek: Nid.

Bollinger, L. and Stover, J., 1999. *The Economic Impact of AIDS in Namibia*. Washington: Futures Group International, Research Triangle Institute, Centre for Development and Population Activities.

Bratton, M. and Cho, W., 2006. *Where is Africa Going? Views From Below: A Compendium of Trends in Public Opinion in 12 African Countries, 1999–2006*, Pretoria: IDASA.

Bratton, M., Logan, C., Cho, W. and Bauer, P., 2004. *Afrobarometer Round 2: Compendium of Comparative Results from a 15-Country Survey*, Pretoria: IDASA.

Caesar-Katsenga, M. and Chirambo, K., (eds) 2005. *Understanding the Institutional Dynamics of Namibia's Response to the HIV/AIDS Pandemic*, Pretoria: IDASA.

Central Bureau of Statistics, 2003. *2001 Population and Housing Census National Report: Basic Analysis with Highlights*, Windhoek: National Planning Commission.

Central Bureau of Statistics, 2006. *Population Projections, 2001–2031: National and Regional Figures*, Windhoek: National Planning Commission.

CoD, 1999. *Political Declaration and Principles of the Congress of Democrats*, Windhoek: CoD.

CoD, 2004. *CoD's Programme for a Better Namibia*, Windhoek: CoD.

Directorate of Elections and Namibia Institute for Democracy, 1997. *Glossary of Electoral Terms and Related Concepts*, Windhoek: Directorate of Elections and Nid.

DTA of Namibia, 2004. *Election Manifesto of the DTA of Namibia*, Windhoek: DTA of Namibia.

ECN, 2004. *Local Authority Elections 14 May 2004 – Report*, Windhoek: ECN.

ECN, 2005. *Presidential and National Assembly Elections Report, 2004*, Windhoek: ECN.

ECN. [n.d.] *Death Statistics. Total number of deceased persons removed from the Voters' Register on the basis of the Ministry of Home Affairs and Immigration since beginning of July 2003 until end of August 2005.*

Electoral Act (Act No. 24 of 1992).

Electoral Amendment Act (Act No. 23 of 1994).

Electoral Amendment Act (Act No. 30 of 1998).

Electoral Amendment Act (Act No. 11 of 1999).

Electoral Institute of Southern Africa for the Directorate of Elections of the Republic of Namibia (EISA). 1999. *A Handbook on Namibian Electoral Laws and Regulations, 1999*, Johannesburg: EISA.

El Obeid, S., Mendelsohn, J., Lejars, M., Forster, N. and Brulé, G. 2001. *Health in Namibia: Progress and Challenges*, Windhoek: MoHSS, French Embassy in Namibia.

Haywood, M., 2004. "The Price of Denial", in Haywood, M. (ed.), *From Disaster to Development? HIV and AIDS in Southern Africa*, Johannesburg: INTERFUND.

Hopwood, G., 2005. "Trapped in the Past: The State of the Opposition", in Hunter, J. (ed.) *Spot the Difference: Namibia's Political Parties Compared*, Windhoek: Nid.

Hopwood, G., 2006. *Guide to Namibian Politics*, Windhoek: Nid.

Hunter, J., 2005. "Political Parties on the Record: Party Representatives Challenged" in Hunter, J. (ed.) *Spot the Difference: Namibia's Political Parties Compared*, Windhoek: Nid.

Hunter, J., 2005. *Spot the Difference: Namibia's Political Parties Compared*, Windhoek: Nid.

IDASA, 2004. *Public Opinion and HIV/AIDS: Facing Up to the Future?* Afrobarometer Briefing Paper No. 12, April.

IDASA, 2006. *Afrobarometer Data Namibia Round 3*, February.

Insight Namibia, 2004. *Bench Warfare*, October.

Keulder, C., 2002. *Public Opinion and the Consolidation of Democracy in Namibia*, Windhoek: IPPR.

Keulder, C., 2006. "HIV: A Forgotten Issue", *Insight Namibia*, March.

Keulder, C. and LeBeau, D., 2006. *Ships, Trucks and Clubs: The Dynamics of HIV Risk Behaviour in Walvis Bay*, Windhoek: IPPR.

Keulder, C. and Wiese, T., 2003. *Democracy without Democrats? Results from the 2003 Afrobarometer Survey in Namibia*, Windhoek: IPPR.

Keulder, C. and Wiese, T., 2004. *The 2003 Windhoek West Voter's Registration Roll*, Windhoek: IPPR.

Keulder, C., Van Zyl, D. and Wiese, T., 2003. *Report on the 1999 Voters' Registration Roll: Analysis and Recommendations*, Windhoek: Institute for Public Policy Research (IPPR).

Lac, [n.d.]. *Namibian HIV/AIDS Charter on Rights*, Windhoek: Lac.

Mag, 2004a. *Ons Saak, Ons Man*, Windhoek: MAG.

Mag, 2004b. *Programme of Principles and Constitution*, Windhoek: Mag.

Mag, 2006. *Comment on the Budget, 2006/7,* Jurie Viljoen Monitor Action Group, 30 March.

Mattes, R., 2003. *Healthy Democracies? The Potential Impact of AIDS on Democracy in Southern Africa*, ISS Occasional Paper No. 71, Pretoria: ISS, April.

Ministry of Regional and Local Government and Housing and Namibia Institute for Democracy, 2002. *The Constitution of Namibia*, Windhoek: Ministry of Regional and Local Government and Housing (MRLGH) and Nid.

MoHSS, 2000. *Epidemiological Report on HIV/AIDS for the Year 2000*, Windhoek: MoHSS.

MoHSS, 2001. *First Report of the Working Group on HIV/AIDS Impact Projections for Namibia (Year 2000 Projection Base)*. Windhoek: MoHSS.

MoHSS, 2003. *Namibia Demographic and Health Survey*, Windhoek: MoHSS.

MoL, 1998. *Guidelines for Implementation of National Code on HIV/AIDS in Employment*, Windhoek: MoL.

Namibian Women's Manifesto Network, 2004. *5% to 50% – Women and men in Regional Government – Get the Balance Right!* Windhoek: Sister Namibia, October.

Nanaso, 2005a. *Annual Report, January–December 2004*, Windhoek: Nanaso.

Nanaso, 2005b. *Monitoring and Evaluation of the Civil Society Contribution to Tackling HIV/AIDS in Namibia*, Windhoek: Nanaso.

National Council, 2004. *Workplace HIV and AIDS Policy*, Windhoek: National Council.

National Democratic Institute for International Affairs (NDI) and The Southern African Development Community Parliamentary Forum (Sadc PF), 2004. *Survey of Legislative Efforts to Combat HIV/AIDS in the Southern Africa Development Community (Sadc) Region*, [n.p.]: NDI, Sadc PF.

Nid/Parliament of Namibia, 2005. *Guide to Parliament*, Windhoek: Nid, Parliament of Namibia.

Nudo, 2004. *Nudo of Namibia: Our Mission*, Windhoek: Nudo.

Otaala, B., [n.d.]. *Impact of HIV/AIDS on the University of Namibia and the University's Response*, Windhoek: Unam.

Phororo, H., 2000. *Why the Private Sector Should Be Concerned About HIV/AIDS*, Windhoek: Hanns Seidel Foundation.
Phororo, H., 2002. *HIV/AIDS: Who Suffers in Namibia?*, Windhoek: Namibian Economic Policy Research Unit (Nepru).
Phororo, H., 2003. *HIV/AIDS and the Private Sector in Namibia: Getting the Small Business on Board*, Windhoek: Hanns Seidel Foundation.
RoN, 1999. *The National Strategic Plan on HIV/AIDS*: *Second Medium Plan (MTPII)*, Windhoek: RoN.
RoN, 2004a. *Namibia 2004*: *Millennium Development Goals*, Windhoek: Office of the President, National Planning Commission.
RoN, 2004b. *The National Strategic Plan on HIV/AIDS*: *Third Medium Plan (MTPIII)*, *2004–2009*, Windhoek: RoN.
RoN. *Debates of the National Assembly, Third Parliament, 2000–2005*.
RoN and MoHSS, 2005. *Report on the 2004 National Sentinel Survey*, Windhoek: RoN, MoHSS.
RoN and UN System in Namibia, 2004. *Common Country Assessment, 2004, Namibia*, Windhoek: RoN and United Nations System in Namibia.
RP, 2004. *Vote RP: Henk Mudge, President*, Windhoek: RP.
Sacks, A. 2005. *The Other Side of HIV/AIDS: The Impact of the Epidemic on Voting Participation and Electoral Trends in Six Sub-Saharan African Countries*. Department of Sociology, University of Washington, Proposal for PAA 2006.
Strand, P., 2005. *AIDS and Elections in Southern Africa: Is the Epidemic Undermining its Democratic Remedy?* ISS Occasional Paper No. 110, Pretoria: ISS, July.
Strand, P. and Chirambo, K., (eds.) 2005. *HIV/AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Processes*, Pretoria: IDASA.
Swapo, 1999. *Election Manifesto, 1999*, Windhoek: Swapo.
Swapo, 2004. *Swapo Party Election Manifesto, 2004*, Windhoek: Swapo.
Tötemeyer, G.K.H., 1996. 'The Legal Framework and Organisational Requirements', in Tötemeyer, G.K.H., Wehmhörner, A. and Weiland, H. (eds) *Elections in Namibia*, Windhoek: FES.
Tötemeyer, G.K.H., Wehmhörner, A. and Weiland, H., 1996. *Elections in Namibia*, Windhoek: Friedrich-Ebert-Stiftung (FES).
UDF, 1999. .*Manifesto*, Windhoek: UDF of Namibia.
UDF, 2004. *Society Back to the People – People Back to the Society*, Windhoek: UDF of Namibia.
UDF, 2005. *UDF's Policies Relating to HIV/AIDS*, Windhoek: UDF of Namibia.
UN, [n.d.]. *Declaration of Commitment to Accelerating and Scaling Up the Fight Against HIV/AIDS in Namibia*, Windhoek: UN.
UNAIDS, [n.d.]. *Join the Fight Against AIDS in Namibia*, Windhoek: UNAIDS.
UNAIDS, 2002. *Namibia: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections – 2002 Update*, Windhoek: UNAIDS.
UNDP and UN Country Team, 2000. *Namibia: Human Development Report 2000/2001*, Windhoek: UNDP Namibia.
UNICEF, 2005. *Childhood under Threat in Namibia: A Supplement to the State of the World's Children Report, 2005*, Windhoek: UNICEF.
Van Zyl, D., 2003. *An Overview of HIV-related Research in Namibia since Independence*, Windhoek: IPPR.
Whiteside, A., Mattes, R., Willan, S. and Manning, R., 2002. *Examining HIV/AIDS in Southern Africa through the Eyes of Ordinary Southern Africans*, Afrobarometer Paper No. 21, Pretoria: IDASA.

Endnotes

1 The MoHSS (2001: 15) concedes the limitations of its impact projections, since the discovery of a cure for AIDS, or the development of cost-effective drugs, could "radically transform the situation".

2 The sample data on women attending ANCs has several disadvantages: First, the subjects are all women and, therefore, the data is only directly representative of infection rates among women. Second, the data is not representative of all women, as the results only include those of childbearing age who have become pregnant. Third, they are not representative of all pregnant women, as they only include those that attend state or public clinics. As Namibia has a relatively well-developed private health care system, middle-class women are under-represented. Fourth, younger women who are more sexually active are likely to be over-represented, while HIV-positive women are likely to be under-represented, as the HIV infection reduces fertility. Fifth, the sampled ANCs are not necessarily randomly selected and are, therefore, not necessarily representative (Whiteside *et al*., 2002: 3–4).

3 *Prevalence* refers to the absolute number of people infected, while the *prevalence rate* is the proportion of the population that exhibits the disease at a particular time. *Incidence* is the number of new infections over a given period of time (Whiteside *et al*., 2002).

4 The prevalence will increase at the same rate if the survival time increases due to the availability of antiretroviral medications and better living conditions, while the prevalence will decline if the survival time decreases, due to an increased death rate among those who are HIV infected.

5 Resulting from social or psychological trends unrelated to prevention efforts.

6 The Joint United Nations Programme on HIV/AIDS (UNAIDS) also summarises data collected by the MoHSS in yearly publications.

7 *Multisectoral* refers to the different sectoral activities of the government and civil society, such as education and health (Caesar-Katsenga and Kondwani, 2005: 9). Please add this reference to your list of references.

8 Critics argue that Nacop's coordination of responses has been ineffective, due to understaffing of the programme (NDI and Sadc PF, 2004: 37).

9 The government's first proposal to the GFATM was rejected, due to civil society not being involved; with NGOs collaboration on the application, it was approved (NDI and Sadc PF, 2004: 48).

10 The M&E component is especially important, as government recording of budgets and expenditure on MTPII was inadequate (AIDSBRIEF, 2004a: 8–10).

11 The HIV and AIDS Management Unit at the MoE has developed a workplace policy for HIV-positive teachers (MoE: 46) and introduced a new life skill programme for schools ("Window of Hope"), aimed at teaching primary school children how to protect themselves from HIV (AIDSBRIEF, 2004a: 3).

12 Source: *The Namibian*, 2 June 2006.

13 Source: Interview with Ella Shihepo, Special Programmes (TB, Malaria, HIV/AIDS), MoHSS, Windhoek, on 25 April 2006.

14 Source: Interview with Kapenda Marenga, Policy Analyst: Public Service Commission, HIV/AIDS Unit: Office of the Prime Minister, Windhoek, on 21 April 2006.

15 For instance, in July 2004 the Evangelical Lutheran Church in Namibia AIDS Action, the Western Diocese and King Taapopi of Uukwaluudhi hosted an HIV/AIDS conference for traditional leaders and their communities in Tsandi in the Omusati region (AIDSBRIEF, 2004b: 3).

16 Moreover, the AIDS Care Trust of Namibia has led HIV/AIDS workplace intervention programmes with a number of private businesses and parastatals.

17 According to the *Common Country Assessment 2004 Namibia*, the international community also plays a key role in researching and providing technical know-how and global perspectives, as well as being vigilant and dynamic in coordinating efforts directed at prevention and treatment (RoN and UN System in Namibia, 2004: 23). For instance, the UN Theme Group on HIV/AIDS in Namibia has facilitated the setting up of a "Partnership Forum" to share information and support the national response.

18 Source: *Sister Namibia*, 16(4): 9. Please obtain the title of the article and the name(s) of the author(s) and transfer this reference to your list of references.

19 The main function of returning officers is to administer the candidate nomination procedures in the case of Regional Council and Local Authority elections (EISA, 1999: 36). Tötemeyer (1996: 54) regards

returning officers "as the kingpins in the electoral process and as the most highly-ranked election official in the field".

20 Presiding officers are appointed for each polling district and ward (EISA, 1999: 36).

21 In 1989, the first National Assembly was elected under the legislative terms of the Constituent Assembly. National elections in 1994 were conducted using the 1992 Electoral Act (Act No. 24 of 1992). Since then, the Act has been amended several times by: the Electoral Amendment Act (Act No. 23 of 1994), the Electoral Amendment Act (Act No. 30 of 1998), and the Electoral Amendment Act (Act No.11 of 1999).

22 Sources: Interviews with Bock, Senior Personal Officer, ECN, Windhoek; Ushi Nauvala, Control Officer, ECN, Windhoek; and Gustaf Tomanga, Information Officer, ECN, Windhoek, on 24 April 2006.

23 *Ibid*,

24 *Ibid*.

25 Source: Email interview with Joram K. Rukambe. International IDEA, Africa Programme, Former Director of Elections (1998–2003), on 12 April 2006.

26 Total obtained from ECN (2005: 46).

27 Teachers who are form the "high-risk group" with respect to HIV/AIDS are usually not temporary staff. Exceptionally, they are employed if elections take place during school holidays or on public holidays (Source: Interview with Gerhard K.H. Tötemeyer, former director of elections, 1992–1998, Windhoek, on 11 April 2006).

28 Sources: Interviews with Bock, Nauvala and Tomanga on 24 April 2006 and with Tötemeyer on 11 April 2006.

29 Sources: Interviews with Bock, Nauvala and Tomanga on 24 April 2006.

30 *Ibid*.

31 Source: Interview with Rukambe on 12 June 2006.

32 The Electoral Amendment Act (Act No. 23 of 1994) provides for the continuous registration of voters, aiming to accommodate those previously unregistered or who have turned eighteen since the last national registration process (Tötemeyer, 1996: 23–24).

33 "Errors on a voters' list are possible: they include double registration, incorrect spelling of names, and voters registered in the wrong constituency." (Tötemeyer, 1996: 29).

34 Source: Interview with Tötemeyer on 11 April 2006.

35 The average amount of time for finding a voter's particulars was reduced from an average of 12 minutes to a mere 30 seconds due to the computerisation (ECN, 2005: 14).

36 The paper-based voters' register provided too little information, as some pages were unreadable, with an incomplete dataset. After the elections, the request for a computerised voters' register has been rejected several times (Source: Telephonic interview with Carola Engelbrecht, civil society activist, former secretary-general of the RP, on 13 April 2006).

37 Source: Interview with Rukambe on 12 April 2006.

38 Additional source: Interview with Tötemeyer on 11 April 2006.

39 Source: *Ibid*.

40 Source: *Ibid*.

41 The tendered vote system is not applicable to local authority elections.

42 Source: Interview with Tötemeyer on 11 April 2006.

43 Due to the publicity surrounding polling stations, the personal help provided to sick voters might also increase stigmatisation.

44 Source: Interview with Tötemeyer on 11 October 2006.

45 The Electoral Act (Act No. 24 of 1992) prescribes that voters must be present in person.

46 Source: Interview with Tötemeyer on 11 April 2006.

47 Source: Interview with Reinhard Gertze, secretary-general of the CoD, Windhoek, on 27 March 2006.

48 Source: *The Namibian*, 27 February 2002.

49 Source: Interview with Samuel Kaxuxuena, Senior Parliamentary Clerk in the NC, on 21 April 2006.

50 Source: *Ibid*.

51 Source: *New Era*, 18 May 2006.

52 Source: Interview with Chippa Tjirera, principal parliamentary clerk in the NA, Windhoek, on 20 April 2006.

53 Source: Interview with Kaxuxuena on 21 April 2001.

54 Source: Interview with Tjirera on 20 April 2006.
55 Source: *Ibid*.
56 Source: Interview with Kaxuxuena on 21 April 2001.
57 Source: *Insight*, November 2004.
58 Source: *Ibid*.
59 Sources: Interviews with Alois Gende, secretary-general of the DTA, Windhoek, on 13 April 2006; Michael Goreseb, Spokesperson on Health for the UDF, Windhoek, on 29 April 2006; and an email interview with Jurie Viljoen, Mag Member of Parliament, on 7 April 2006.
60 Source: Interview with Gertze on 27 March 2006.
61 Source: *Ibid*.
62 Source: Interview on 27 March 2006.
63 Source: Interview on 20 April 2006.
64 Source: Interview on 13 April 2006.
65 Source: Interview on 20 April 2006.
66 Source: Interview with Gertze on 27 March 2006.
67 Source: Interview with Goreseb on 20 April 2006.
68 Source: Interview with Gertze on 27 March 2006.
69 Source: Interview with Viljoen on 7 April 2006.
70 Source: Interview on 13 April 2006.
71 The sample was nationally representative, multistage and stratified, including 1 200 Namibians. All 13 regions were included and interviews were held according to each region's contribution to the country's rural and urban population (Keulder, 2002: 4).
72 HIV/AIDS was identified as the most important problem by more urban than rural respondents (Keulder, 2002: 30).
73 The participants were encouraged to state up to three issues (IDASA, 2004: 4).
74 The question is regarded as "an admittedly imperfect proxy for actual contact with the AIDS epidemic". Whiteside *et al*. (2002: 10) name several restrictions, such as refusal to admit knowledge, misinterpretation of the reasons for death, or a multiple reporting of the same death.
75 "One factor that probably facilitated more candid responses was that we did not ask for specific names, but merely whether or not they knew of some friend or relative who had died of AIDS." (Whiteside *et al*., 2002: 12).
76 The answer "Do not know" could mean that responses are unsure if they know anyone who died, know victims but do not know how many, do not know what caused the death, or do not wish to reveal the truth (Bratton *et al*., 2004: 26–27).
77 This question also captured home-based care for patients who are not PLWHAs (Strand and Chirambo, 2005: 122).
78 Uncertainty exists as to whether the children were orphaned due to AIDS-related diseases (IDASA, 2004: 3).
79 Within the scope of the 1999 Afrobarometer survey, civic participation has been measured by means of a set of questions determining the frequency with which participants attend the meetings held by public institutions. The frequency of attendance varies substantially. While meetings of groups concerned with local matters, such as schools and housing, are most frequently attended, attendance of the meetings of local commercial organisations, self-help associations, and trade unions, is quite low. Overall, a low rate of participation has been stated (Keulder, 2002: 43).
80 The percentage of people under 15 years was 39% (Hopwood, 2006: 3).
81 The low voter turnout at regional council elections might be due to several reasons. First, it could mean that national elections are regarded as more important. Second, Regional Council elections are constituency-based, so that no tendered votes are included. Third, people might prefer to support political parties, rather than to vote for individual candidates.
82 Source: www.aidslaw.co, accessed 6 February 2006.
83 The one exception noted that she would be too embarrassed to make use of the special vote.
84 By means of a formal organisation of PLWHAs, who make themselves available to share their experiences in public forums.