AIDS, POVERTY AND REPRESENTATIVE DEMOCRACY IN TANZANIA

Introduction

The United Republic of Tanzania comprises the Mainland Tanzania (Tanganyika) and Zanzibar. The Mainland attained its independence from Britain under the leadership of the Tanganyika African National Union (TANU) on 9th December, 1961. In Zanzibar the Afro-Shirazi Party (ASP) staged a revolution on 12th January, 1964 ousting an Arab-dominated coalition after an election late 1963. A Union between Zanzibar and Tanganyika came into being on 26th April 1964. By the operation of law, TANU was the sole political party on the Mainland from 1965 while ASP remained the only political organization in Zanzibar. On the 5th February, 1977 TANU and ASP merged to form *Chama cha Mapinduzi* (CCM) and the two governments came under a single political party, CCM. Constitutionally there have always been two governments: the Union Government and the Revolutionary Government of Zanzibar. The Government of the United Republic has jurisdiction over all Union matters throughout the United Republic and over Non-Union Matters on the Mainland. The Revolutionary Government of Zanzibar (RGoZ) has jurisdiction over all Non-Union matters in Zanzibar.

The population of Tanzania stands at around 34 million as per the 2002 population census. The population includes some 120 ethnic groups and each has its vernacular. But Tanzania has a lingua franca in Kiswahili which most of the 120 ethnic groups can speak. There are still some hunter-gatherers in Tanzania in the Sandawe and Hadzabe. But their livelihoods are in danger because of the encroachment of farming activities into their areas, as well as 'modern' ways of doing things. About 24% of Tanzanians live in urban areas. It is widely held that 50% of Tanzanians live below a locally defined poverty line while 36% of them live in abject poverty (DFID, 1999: 1; URT, 1999: 7; Assey, 1999: 129). Studies indicate that poverty is likely to persist for the foreseeable future. GDP per capita income is around 700 US$. Population growth is at 2.9 per cent, while the economy has been growing at around 6% in the past four to five years. Of the rural population which account for about 75% of the total population, around 60% live below the poverty line. In comparison, only 39% of the urban population living in urban areas other than Dar es Salaam, live below the poverty line. Women who comprise 51% of the population constitute 54% of the economically active population. Women – and especially rural women - are known to bear the brunt of the poverty. Of the economically active rural women, 98% are engaged in agriculture, producing between 60 – 80% of all domestic food supplies (URT, 1998: 5). They also contribute substantially to cash crop production. Despite these statistics, they are severally disadvantaged (Assey, op. cit.: 135 – 137; DFID, 1999: 2). Firstly, they do not have equal chance as men in accessing education. Secondly, there are outdated traditions that work against them. Thirdly, while they carry a heavy burden in production and reproduction in rural areas, their access to wage employment is very limited. Fourthly, they have been, for a very long time, underrepresented in decision making bodies like parliament, cabinet, different committees, although efforts are underway to rectify this. For instance, since 2005 women representation in parliament is 30% through both constituency and special seats. Lastly, many of them are ignorant of their rights.

Tanzania has had some respectable social development indicators when compared to other countries despite her weak economy and her position in the world economic rankings. At some point in the 1980s she had over 90 per cent school enrollment for primary schools, over 80 per cent literacy rates, and every Tanzanian could access a health facility at a distance of only up to 10 kilometers, 90% of whom could access such facilities at 5 kilometers (Munishi, 1997). This was part of the successes of the ***ujamaa*** project when the government was providing free health and education to all. Now that the government has rolled back and user

fees are part of the matrix, these percentages have gone down. Life expectancy has gone down from around 55 years in 1990 to 46 mainly due to HIV and AIDS related deaths (World Health Organization). HIV prevalence is at 8% on the mainland and just below 1% in Zanzibar. Infant mortality rate is at 96 per 1,000 live births (IndexMundi, 2006).

Tanzania's economy depends heavily on agriculture. It accounts for almost half of the GDP and provides for 85% of exports and employing some 80% of the labour force of about 19.5 million. 2004 estimates show that the breakdown of the contribution to GDP is: agriculture 42.2%, industry 17.2% and services at 39.6% (IndexMundi: 2006). But recently the mining sector has attracted investors from abroad and it has started to substantially contribute to the GDP. Due to increased extraction of minerals – mainly gold, diamond and the unique Tanzanian gem called Tanzanite, the mining sector has moved to the third foreign exchange earner for the government. At the moment, tourism is the second foreign exchange earner at around US$ 700 million a year. Efforts are underway to increase its share in the economy. Tanzania is also endowed with many tourist attractions including national parks like the famous Serengeti and Selous, Mount Kilimanjaro, a long beach along the Indian Ocean, as well as some historical sites like Olduvai Gorge.

Industries are mainly for agricultural products processing – sugar, beer, cigarettes, sisal twine, wood products. But there are also other industries like those for cement, oil refining, shoes, and fertilizer. The main trade partners (imports) include South Africa (12.7%), China (7.8%), India (6.4%), Kenya (5.4%), USA (4.8%), UK (4.6%) and a few others (ibid.). Most of the imports comprise consumer goods, machinery, transportation equipment, medicines, crude oil and industrial materials. Estimates put the import value at US$ 2.4 billion f.o.b. for the year 2005. When it comes to exports, the main partners include India, Netherlands, Japan, UK, China, Kenya and Spain. Exports amounted to US$ 1.6 billion f.o.b. for the year 2005 (ibid.).

Unreliable sources of power have been a problem to industry, investors and domestic consumers as well. Electricity has been a problem of late because the country is dependent on hydropower and when there are droughty conditions there have been falling water levels at the production dams. The government has been investing in natural gas plants to generate power as an alternative given that Tanzania has some 22.65 billion cubic meters of proved natural gas in the southern parts of the country. Tanzania is yet to discover oil in its territory although efforts are being made by local and external prospectors (ibid.).

The national budget stood at US$ 2.7 billion including capital expenditure. The revenue collected stand at around US$ 2.2 billion (ibid.). The deficit is financed by development partners and borrowing from banks. By 2005, the external debt stood at around US$ 7.95 billion. Public debt is estimated at 5% of GDP. Inflation has been at respectable 4% on comparison to countries in similar economic conditions (Mwase, 2006: 7). The strength of the local currency – the Tanzanian shilling – has been shaky in the past few years and it has been sliding against the major currencies in the foreign exchange market. In 2001 it was 880 to the US$; 970 in 2002; 1,040 in 2003; 1,090 in 2004; 1,130 in 2005 and 1,210 in May 2008.

HIV/AIDS: The Extent of the Problem

HIV & AIDS is a serious health and socio-economic problem in Tanzania. It is rather considered to be among the major development impediments that affect all sectors of the economy and thus a threat to the country's social and economic development. Thus the government in collaboration with different stakeholders have responded strongly to the pandemic by committing resources on several interventions, policy and strategy formulation, and by forming specific institutions to coordinate the response. According to the Tanzania HIV & AIDS Indicator Survey2003/04, the average national HIV prevalence rate is 7 percent. However, prevalence rates range from 2 percent to 14 percent when data are disaggregated by region (URT, 2005a). There are 21 regions on the Mainland and 5 on the Isles.

The first cases of AIDS in the country were reported in 1983 in Kagera region in the North West of the country. Since then, the number of cases has continued to rise and by 1986 just three years later, all the regions of Tanzania Mainland had reported AIDS cases. By the end of 1999 (only a decade later), there were 118,713 reported cases of AIDS and a similar number of orphans. By 2004 there were cumulative 192,532 reported cases of AIDS in Tanzania (URT, 2005b). In the period 1983-1986 few cases were reported to National AIDS Control Program (NACP) and these were not characterized in terms of age group. Overall there has been a gradual increase in the number of reported cases from 1983 to 2004. There was a significant increase in the number of reported cases between 1990 and 1993. This peak just reflects aggressive data collection during this period and does not represent a peak in AIDS morbidity in the country.

The infection rate among pregnant mothers attending Ante-Natal Clinics (ANC) has been declining based on two rounds of data collected by NACP in 2001 and 2004. When the HIV results of 2003/04 surveillance are compared with those of the first Ante-natal Clinic (ANC) survey conducted in 2001/02, we notice a decrease in prevalence in Dar es Salaam and Mtwara regions, with the other regions having no significant change. The HIV prevalence among women attending border clinics fell from 17.3 percent to 15.3 percent. However, these changes are rather small and are probably a result of random variation in the different regions and sites.

The fact that HIV & AIDS is sensitive to the social context also makes its prevalence vary strongly across residence and regions in Tanzania. Tanzania HIV/AIDS indicator Survey (THIS) 2005, a population based survey, (contrast with NACP figures which are based on blood donors and women attending antenatal clinics), shows that HIV & AIDS prevalence is higher in urban areas (12 percent for women and 9.6 percent for men) compared to rural area where it was 5.8 percent for women and 4.8 percent for men. The study further indicates that overall, the regions with highest HIV prevalence rates are Mbeya (14 percent), followed by Iringa (13 percent) and Dar es Salaam (11 percent). Regions with lowest HIV prevalence levels are Manyara and Kigoma, at 2 percent each. Overall, seven regions showed HIV prevalence levels below 5 percent (URT, 2005a). Again, in many regions women have higher levels of prevalence of HIV infection than men. In Pwani region, the prevalence of HIV infection among women is almost three times that of men, and prevalence among women is twice as that of men for Tanga, Singida and Tabora.

The predominant mode of HIV transmission has remained heterosexual constituting up to 78.1 percent of all reported AIDS cases in 2004. Mother to child transmission constituted 4.6 percent and blood transfusion 0.5 percent. In about 17 percent of the cases, the mode of acquisition of infection was not stated (URT, 2005b). The study shows that females generally females have higher case rates than males in the 15 – 39 years group. But males have higher case rates when it comes to the 40 – 49 years cohort.

Zanzibar Islands

The trends of HIV infections in Zanzibar are increasing albeit for some population sub-groups. The total number of cases diagnosed has increased from 3 in 1986 to 3,926 in 2004. The population of Zanzibar is approaching 1 million. Newly reported HIV positive patients among specific groups also support the upward trend of HIV epidemic.

Research has shown that the HIV epidemic in Zanzibar is a concentrated epidemic in high-risk groups that affects three populations, Substance Users, in particular Injecting Drug Users; sex workers (both male and female) and their clients; and men who have homosexual males. Studies carried out in 2005 showed that the HIV prevalence was 13 percent among substance users, and 26 percent among Injecting Drug Users (Dahoma et al., 2005). The Vulnerable Groups in the population are equally affected given the fact that due to some reasons, they

may engage in unsafe sex. Infection rates among Voluntary Counseling and Testing (VCT) attendees also increased sharply from 0.6 percent in 2002 to 5.6 percent in 2003, but declined to 4.3 percent in 2004. Additionally, HIV screening of donated blood doubled in a 3 years period, from 0.7 percent in 1996 to 1.5 percent in 1998. It declined to 0.5 in 2004. A much higher proportion of HIV positive patients have been recorded among patients with Sexuality Transmitted Infections (STI) and Tuberculosis (TB) patients at 5.6 percent and 25.5 percent respectively.

HIV & AIDS among pregnant women at antenatal clinics has doubled from 0.3 percent in mid 1980s to 0.6 percent in 1997 to 1 percent in 2002. In general, women show infection rates that are five times higher than that of their male counterparts (0.9 percent and 0.2 percent respectively) (RGoZ, 2002). Accordingly, despite low infection on the general population, infection among subgroups is significantly high.

In Zanzibar HIV has affected all age categories. Disregarding the age categories with small sample, we may conclude that overall HIV prevalence is high in age category >45 in general and for males, but it is high in age category 35-44 for women. It is pointed out in the Zanzibar AIDS Control Programme's reports that infection rate has increased among the youth (age group 15-24) compared to last year, but all other age categories indicate a declining trend.

Factors Contributing to the Spread of HIV

HIV & AIDS in Tanzania is predominantly transmitted through heterosexual contacts (78 percent). This is greatly related to ignorance and social behaviors that are influenced by cultural factors and augmented by alcoholism, infidelity, and carelessness (Kessy *et. al*., 2004). There are a number of cultural factors that contribute greatly to the spread of HIV & AIDS. Unavailability of protective gear and stigma associated with requesting for condom from health facilities or vending shops contribute greatly to the spread of HIV & AIDS. The silence surrounding HIV & AIDS pandemic is another factor contributing to the spread of HIV & AIDS. Rape and domestic violence have also been reported as a consequence of drug abuse. Thus, drug abuse has been documented as one among the risk factors fuelling the epidemic. Gender imbalance is another well documented factor in both Tanzania Mainland and Zanzibar that influences the high HIV & AIDS prevalence among women. Gender related constraints caused by patriarchal ideology and culture give men disproportionate power and ownership over things of value and major decisions. Some of the social, cultural norms and values, policies and laws on which sexual and reproductive health perceptions and practices are engraved lead to unattainable dowry, early and forced marriage, multiple partners, and early sexual engagement among girls, high teenage pregnancies and induced abortions and subsequently to high STD, HIV and AIDS.

On the economic front, poverty has been documented as one of the contributory factors to the spread of HIV & AIDS. As a result of poverty, women are engaged in high-risk sexual affairs as a means of earning a living for lack of alternative means of survival. Their inability to negotiate for safer sex due to gender imbalances puts them at even a higher risk. The so-called "mobile populations" which consist of those who work and stay away from home for varied lengths of time during a year are on one hand also highly exposed to infections, but on the other hand, they simultaneously contribute in spreading the virus.

The General Impact of HIV/AIDS

HIV & AIDS is a big problem in the public sector in Tanzania. Young, trained and energetic human resource is being wasted through this scourge. All sectors have been affected – banking, insurance, education, health, police, and the army. Where there are many employees like health, education, and the police force, it has been easy to notice that many public

servants have been affected by the virus. For smaller employers it has not been so conspicuous that many people are dying of the diseases related to HIV & AIDS. However, statistically it could be proven that the threat to smaller employers is just as big.

A study by the Economic and Social Research Foundation (ESRF) in 2003 identified the following economic and social variables through which the HIV & AIDS pandemic impacts on affected and infected households, sectoral economic performance, as well as important macro-economic variables. First, the pandemic has resulted in decreased labor supply at household and the sectors studied through HIV & AIDS related mortalities and morbidities. The study revealed that the majority of People Living with HIV and AIDS (PLHAs) and individuals dying of HIV & AIDS related illness were in the economic and social productive years (age group 30-40 years). Secondly, there is the loss of productivity as measured by three proxy variables which are the rate of absenteeism, total number of years of experience lost, and paid sick leave. AIDS has resulted in increased rate of absenteeism (and hence a loss of labor time), and loss of skills and experiences. About 26 percent of the sick employees in the surveyed health facilities were granted a paid sick leave in the survey period. The average duration of sick leave was 3.6 months with a range of 1-9 months.

Thirdly, HIV & AIDS was found to have affected the time allocation of infected and affected households. About 8 per cent of the individuals interviewed at the household level indicated that they had attended a HIV & AIDS patient in or outside the household in the past 14 days prior to the survey. More than 43 percent of women respondents spent more than 20 hours in two weeks time prior to the survey caring for HIV & AIDS patients compared to men (36 per cent). The majority of the respondents reported to have had spent at least 3 hours in visiting HIV & AIDS sick person in the past 14 days prior to the survey.

Fourthly, from the financial point of view, the obvious impact of HIV & AIDS is the increased expenditure that arises from medical treatment of opportunistic infections affecting people living with HIV & AIDS. The costs are borne by PLHAs themselves, household members, extended family members and friends, employers, private sector, local politicians, donor community and the government. The range of medical support needed include facilitation of testing, drugs to cure AIDS related opportunistic infections, drugs to cure sexually transmitted infections related to HIV & AIDS, outpatient care, and inpatient care. HIV & AIDS indicated to be an expensive illness, and on average, it costs the individual more than other health problems that were reported by the respondents to be affecting people at the household level. An average household reported to have had spent more on a funeral than what their members contributed for the funeral implying that households received assistance from relatives, friends, employers, neighbours and other sources to finance the funerals.

Fifthly, AIDS is also affecting delivery of social services especially in education and health sector. The impact on service delivery can be observed in at least three ways: the supply of experienced personnel is reduced by AIDS related illness and death; there is decreased productivity due to illness and absenteeism; and depletion of resources due to increased HIV & AIDS related expenses such as those on medical treatment, transport and burial of workers who die and training costs. For one, teachers dying of AIDS related illnesses constitute a significant proportion of the total number of teachers dying. The education system is also experiencing the problem of increased teacher absenteeism due to HIV & AIDS related illnesses. The health sector is found to be facing a double whammy. First there is the resultant situation of having an overburdened health sector as it offers its services to the sick, but also in terms of the extra resources needed to such as funds for buying specialized equipment, drugs and so on.

Implications of HIV and AIDS for Democratic Governance

Elections and the Epidemic

The cost of operating electoral systems in Tanzania is envisioned to rise as a result of the HIV & AIDS epidemic. Unless the government takes practical steps to prioritize the management of the disease, increasing number of deaths at a leadership level and among the electorate will seriously undermine the value of elections as one of the pillars of democratic governance. There are also ramifications for the stability of the political system**.** At the moment**,** however, there is very little empirical evidence to demonstrate the exact nature of the impact of HIV & AIDS on the fundamental forms of participation in political life and to inform interventions to counter it.

The broad objective of this section is to look at how HIV/AIDS impacts or is likely to impact on the democratic practice of electioneering in Tanzania, specifically looking at four aspects of the process:

(a) Elected Representatives.
(b) Electoral Administration.
(c) Voter/Citizen participation.
(d) Electoral System.

The following five main areas are of concern to us;

(a) Representative institutions tend to suffer at leadership level through loss of expertise and experience, with implications for appeal to the electorate, effective policy formulation, and quality of debate due to absenteeism.
(b) The country's number of by-elections increases substantially in the era of HIV and AIDS with rising economic costs.
(c) Political parties, especially those with a younger membership base feel the brunt as their support base is consistently eroded thus compromising their electoral chances as well as future leadership pool.
(d) HIV and AIDS complicate the management and administration of the voters' register as the disease tends to increase the number of "dead voters" on the register.
(e) In absence of voter friendly methods, PLHAs and the care takers of the sick are marginalized from the electoral process due to the debilitating nature of the disease, stigma and discrimination, and the time needed to take care of the infected persons and orphans.

Electoral Systems and Vulnerability

Preliminary evidence confirms the claim that countries using the First Past The Post (FPTP) system are particularly vulnerable in terms of impact of HIV and AIDS because FPTP requires the staging of by-elections to replace members who die, resign or for some other reasons have decided to quit. A pilot study by IDASA in Zambia, for example, revealed that the country's number of by-elections has substantially increased in the era of HIV & AIDS (1984-2003) compared to the "AIDS free era" (1964-1984). The study indicates that the total number of by-elections as a result of death increased to 59 in the period 1984-2003 compared to 14 during the 1964-1984. Thirty nine of the 59 deaths occurred between 1993 and 2003, incidentally the period of high HIV & AIDS prevalence. Only four were listed as having died from road accidents while the rest were more accurately infected and eventually died of the disease. Although it cannot conclusively be said the 39 deaths were influenced by AIDS, an examination of the age ranges does help to extrapolate some useful conclusions. Fifteen Members of Parliament fell in the age-group of 15-49 years, which is most vulnerable to the disease. In the Proportional Representation (PR) system people vote for a party rather than an individual member and when a vacancy occurs it is filled from the party list (Strand et al., 2005).

Electoral systems determine the rules according to which voters or the electorates express their political preferences and according to which it is possible to convert votes into parliamentary seats or government. Electoral systems further influence voting behavior and election results. In essence they shape political representation and party systems. There are several factors, which exert influence on the electoral systems. These are: (a) size of the constituency/district, (b) the candidates, (c) the voting process, and (d) conversion of votes into seats.

There are basically two common electoral systems that shape and influence voting behavior and election results in liberal democracies and Africa in particular. First, is the plurality or majority system, which is also referred to as the first-past-the-post electoral system. This can either be (a) absolute or (b) relative. At the present this system is applied in many former British territories in Africa. The second type of electoral system is the proportional representation (PR) system.

The First Past The Post System in Tanzania

The results of constituency elections in Tanzania are determined by the Westminster principle of *first-past-the-post* electoral system. This system has been part of the country's political life since independence. The 1977 Constitution does not expressly stipulate that the system shall apply to Tanzania. However, the Constitution provides for the country to be divided into a certain number of electoral districts (constituencies) each to be represented by one representative (single-member constituency). Election candidates are nominated by the political party participating in the election in a constituency. In each constituency the candidate with the most votes is regarded as the winner (relative majority). Thus, most Members of Parliament and Local Councilors are elected through a single district plurality system (URT, 1979). The whole country has been demarcated into constituencies and each constituency elects one Member of Parliament. There are 231 constituencies.

The Proportional Representation System

In parliament and local councils there are special seats for women. In both sets of elections, every contesting political party is required to provide list containing a given number of names. In the 2000 elections, the special seats were allocated to the political parties in proportion to the share of plurality seats they obtained. In the 2005 elections, the seats were allocated in proportion to the valid votes obtained by a political party. This is according to the 14th Amendment of the constitution of February 2005.

Voters Registers

Rigging is an endemic problem in many African democracies. The likelihood of manipulating the voters register using "dead voters" names on the registers may open up the system to electoral fraud (or provoke perceptions of fraud) through the use of "ghost voting". People dying in unusually big numbers will have implications for political legitimacy and institutional integrity of elections. Young people of voting age are particularly affected by HIV & AIDS and an investigation of how this will affect elections is important**.** Women, who form more than half of the voting population, are likely to spend more time taking care of ill family and community members that will make it difficult for them to register as voters, to vote and to participate in other activities which are associated with the election process.

Political Institutions: Parties and Parliament

On the hypotheses that representative institutions may suffer at leadership level through loss of expertise and experience, with implications for appeal to the electorate, effective policy formulation, and quality of debate due to absenteeism. Political parties, especially those with

a younger membership base will likely feel the brunt as their support base is consistently eroded thus compromising their electoral chances as well as losing the pool from which future leaders can be picked from.

Electoral Administration and Management
The efficacy of the Electoral Commission as a result of the pandemic is also an issue that we have to address. Tanzania's National Electoral Commission (NEC) depends heavily on civil servants especially teachers and health workers to serve as election officers and monitors at the sub-national levels. It could be that the skills and knowledge of election conduct acquired in the relatively brief period of multiparty democracy will be lost. The principal purpose of an Electoral Commission should be to protect and strengthen multiparty democracy in order to cultivate a truly pluralistic, open and tolerant political culture. The level of responsibility that rests with the Electoral Commission and its staff is, therefore considerable.

The Economic Electoral Costs of the Epidemic

Pre Election and Polling Phase
Data from the sectors that provide temporary employees whom the Commission hires during election periods show that these sectors have been hard hit by the virus. The two sectors that supply employees to the NEC during election periods are the education sector (teachers) and the health sector (nurses and health officers). There are others also depending on the constituency; in some areas veterinary and agricultural officers are used. In the former two sectors many have been infected with the virus.
A study by ESRF (2003) has clearly shown that a larger proportion of teachers who died during the period 1999 to 2002 died from AIDS related illnesses. Data collected at school level show that the proportion of teachers dying from AIDS related illnesses as a percentage of the total number of teachers who died ranged between 66 to 100 percent. District level data generally depict a similar picture to that emerged from school level data, with the teachers dead due to AIDS constituting a larger proportion of the total dead. The fact that the sectors that provide part time employees to the NEC have been affected does not affect the NEC operations as such. This is because the NEC employs these personnel on a short period of time. For instance the registration period took three weeks in each zone. The many part time employees will be hired again for a period of about one week or so when the polling day approaches. And there are plenty of teachers and nurses as well as other government employees to pick from. It would not affect the NEC operations where two or three people died during the short period they are hired. Replacement would be instant, and, in fact, the NEC trains some reserve people in case. We can therefore, say for sure that the NEC has not suffered a significant, if at all, pecuniary loss through losing people they train to participate in election activities.

Post Election Occurrences
Economic cost incurred as the results of the loss of elected representatives include those related to holding of by-elections, illness (treatment and other service provisions) and those linked to death, including direct and indirect funeral costs. As the number of deaths increases, the number of by-elections and costs to the treasury will subsequently rise. This has many implications in terms of resources required to deal with First-Past-The-Post system. By and large by-elections in Tanzania have been a result of MPs dying or being moved to other posts, say to the Tanzanian embassies abroad. However, with the advent of the multiparty system, there have been by-elections that are a result of petitions on grounds of some winners not playing according to the rules. And, of recent, there have been by-elections

resulting from mismanaged elections as was the case in Pemba (Zanzibar) where 17 constituencies had their 2000 election outcomes cancelled because of gross irregularities. As a result of these discrepancies, the 2000-05 Parliament witnessed many by-elections. Apart from the 17 Pemba by-elections (held due to irregularities), there were about 6 others arising from the deaths of MPs.

In Mainland Tanzania a by-election typical used to cost around TZS 500,000,000 (approximately USD 416,000) before the Permanent Voters Register (PVR) was introduced. This figure is likely to change as a new registration format has since been instituted. Registration used to be done manually as there was no PVR. In Zanzibar, a by-election to get a representative for one constituency and respective nine councillors cost TZS 54,000,000 (approximately USD 45,000). The rather significant difference in the cost of by-elections between the Mainland and Zanzibar can be explained by the disparities in the sizes of the constituencies. While in Zanzibar there are constituencies with some 2000 voters, in the Mainland there are electoral zones with more than 100,000 eligible voters.

Indicative evidence suggests that personal costs to MPs arising from the death of members of their constituencies have also been reported. The MPs are being asked to donate to multiple funerals, and increasingly attend burials as a result of AIDS related deaths amongst members of their constituencies. Interview with MPs in November 2006 revealed that each of the MPs in the group had incurred costs due to HIV and AIDS. The range was between TZS 200,000 to TZS 1,000,000 per year. Further, each MP had lost a close relative due to HIV & AIDS and one had a clinic to treat people living with HIV and AIDS. Some people follow their MPs to Dodoma (where the parliament meets) during parliamentary sessions to get assistance, mostly on areas such as treatment, care, funeral, orphans and widows support. In general, however, we can say that there have been more by-elections after the reintroduction of multiparty politics, than it was before because of inter-party competition. Before that the single party controlled the contestants and issues were sometimes settled within party caucuses rather than the courts.

The number of MPs is not that high when compared to that of Councillors, of which Tanzania has 2,552 that are elected (NEC, 2005: 75). There are some 988 special seats councilors meant for women; but these ones are allocated through the PR system so it does not involve any substantial financial costs. When a councillor dies there is also a by-election. With this much greater number one can imagine that it is likely that some Councillors will also die, and probably from the epidemic as well thereby making it necessary to have by-elections. This is economically costly too.

The Politico-Electoral Costs of the Pandemic

The Parliament

In Tanzania Mainland, 6 constituencies had no MPs at the time of December 2005 general elections as they died in the course of the 2000 - 2005 parliament. Politically, it means that the views and needs of citizens from these electorates have not been represented for a period of time. Further, when an MP dies, everything comes to halt at least in the short run in respect of the constituency's development. This vacuum is a result of the time it takes before a by election is called. Even after by election, the constituency may be governed by a new MP who does not honor the development efforts of the former MP due to differences in political ideology. Politically, the parliament might also suffer by loss of expertise and experience of the deceased, with implications for effective policy formulation, and quality of debate in the House. Further, illness resulted from opportunistic infections results to intermittent attendance

of sick members of the House and thus decreased opportunity to engage in Parliament debates.

Deaths whether HIV and AIDS related or not affect the electoral process financially and politically. Financial costs include the costs of by elections, and MPs personal costs. Political costs include under-representation of the views and needs of citizens from electorates which have lost an MP, halting of development processes in the constituency (at least in the short run), and loss of expertise of the deceased in parliamentary and other development debates. Thus, the 6 constituencies that did not have MPs at the time of 2005 general elections had suffered some of these political costs. Given the debilitating nature of HIV and AIDS, psychological torture, stigma, and illnesses resulted from opportunistic infections that result to intermittent attendance of the sick member of the House, efforts geared towards reducing infections among the members of the House are imperative.

Parliament as an institution and Parliamentarians as individual leaders can play a significant role in contributing to the improvement of the quality of good governance in Tanzania through their function at the national and local levels. As an institution, the Parliament forms one of the three arms of government with legislative powers over the whole country. As individuals, Members of Parliament are among the most highly respected people in the country and are therefore able to provide leadership and influence development at community and personal levels.

The capacity of Parliament and parliamentarians to perform their duties can be impaired by HIV and AIDS if issues pertaining to the epidemic are not addressed. As explained earlier, this impact may inhibit the exercise of powers of parliament to legislate and enact policies and programs to run the government. MPs' illness and death rob the parliament of the contribution of the affected MP and the constituency of its representation. On the supply part, HIV and AIDS may cause a rise of government expenditure through by-election of new members of parliament to replace those who may have passed away due to HIV and AIDS within the tenure of Parliament. This scenario can be avoided if proper course of action by Parliament is taken to prevent the spread of HIV & AIDS among its members.

Since 1991 to date a total number of 31 MPs have died. Four of them died of motor accident and shooting incident while the rest died of either short or long illnesses which were undisclosed. Mortality rates at the House of Representatives in Zanzibar are quite low. During the 1990 – 1995 parliament there were two deaths (both women), and in 1995 – 2000 parliament there was one death (a woman). In the 2000 – 2005 parliament there were two deaths, (both men). Contrary to mainland Tanzania, where HIV prevalence is high, the prevalence in Zanzibar is low and the likelihood that these deaths were related to HIV and AIDS is relatively low. In the post HIV and AIDS era, increasing number of deaths and consequently the increase in number of by-elections is envisioned (URT, 2005c).

With regard to parliament losing expertise, experience and vibrancy in the House due to HIV & AIDS, MPs were of the opinion that this has not happened. The House is as active as ever and after all, none of the deceased has been officially declared a casualty of the disease. They noted that it was hard to say that one died of the disease due to lack of evidence. The MPs admitted that sometimes members have been suspicious – but there is no way one can use it officially!

The new and young MPs have changed the melody of the debates in the Parliament, and to a larger extent they have made it more active as ever. However, having a more active house does not mean that the house has not lost experiences and expertise through the MPs who have past away.

Political Parties

Political parties are a critical player in a democratic system and they should play a role in making sure that democratic norms and processes are enforced in the rules of competition, more so when it comes to elections. This is to say that there has to be, among other things, a level playing field. We do not expect elections to be a hundred percent problem free in a young democracy, but the fact is that political competition has always been tough – at least for some if not for every competitor. However, there are things that contribute to the playing field not being level and these would include people left out of the electoral process through exclusionary measure or what one can call unintended exclusion. If a constituency of say, AIDS sufferers is left out because they have failed to speak for themselves, we can say this is an unintended exclusion. But there can be also measures intentionally put in place to make sure that some people do not participate in an election. In between political parties, when the rules of the game are clear, fair and agreed upon by the players, we can say there is inter-party democracy.

Overall, the feeling is that the current level of prevalence of HIV and AIDS did not affect the results of the 2005 elections. However, each of the political parties on both sides of the Union believes that at some point in time, this phenomenon will be a big issue when it comes to elections and other political processes.

PVR and Voter Turnout

Tanzania started to use a PVR in the 2005 General Elections. This was a decision taken in an earlier constitutional amendment in the year 2000, as a measure to reduce costs of registering voters every time an election or by-election is due, as well as reducing complaints with regard to voter registration. Registration into the PVR is continuous as there are people who qualify every day and there are others who lose qualifications as voters on a daily basis. The work of updating the PVR is yet to be experienced as it has just been introduced. But as the law has it, the PVR will be updated from time to time.

The way the NEC is going to purge the dead from the PVR is by decentralizing the registration process whereby each constituency will have a chance to update its list of voters, and thereafter the lists of each hamlet, village/street and ward will be displayed for stakeholders to verify. It will be at this point that the dead and those who have migrated to other areas will be identified. Political parties through their agents will be key players in this aspect. But as mentioned earlier, the problems or difficulties that will be associated with this exercise are yet to be experienced.

Theoretically, HIV and AIDS is envisaged to have a direct bearing in terms of the voting population. Firstly it will decrease the size of the electorate, which could have a bearing in terms of support for political parties especially in communities with a high prevalence and high mortality rates. The poor health status of the electorate could also have a bearing in terms of the number of voters.

Conclusion

There are several political social and economic consequences from the epidemic on the representation of the people in parliament. These have got to be borne in mind as Tanzania and other countries in similar situation attempt at more democratic systems of government, otherwise the efforts can be derailed or they can take a much longer time to be realized. Not only the political aspects but also economic cost of running democratic politics will be impacted upon. Firstly, the cost of by elections under the FPTP system will be unbearable to the poor economies and there should be the readiness to change the electoral system to a more accommodating one – such as PR. Secondly, there is considerable loss of talent and experience. Some MPs have been key contributors to the law-making exercise and they may not be there in the future because of the epidemic. Electoral officials at the sub-national whom

we have seen are teachers and health workers are among the most affected by the epidemic. Their experience and commitment will be lost once they die because of AIDS.
Thirdly, there will be costs in terms of absenteeism of MPs in their constituencies because of the hassle they get from the electorate related to HIV/AIDS. MPs are seeing as people who should help their electorate once in problems. This has made some MPs to absent themselves from their constituencies as a way to avoid costs related to such demands on them, including financial contribution to families which lose their loved ones to the epidemic. This absence has a negative impact on the people represented by the MPs in that the people would not have a chance to express their wishes and demands to an "absent" MP. Fourthly, legitimacy of the PVR in an economy that can hardy support simple infrastructure as that of Tanzania will be in question. Can Tanzania maintain a clean PVR given the rates of deaths from other as well as HIV/AIDS related deaths? Does she have the money and expertise to do it? Fifthly and lastly, are we heading for a situation in which election services for the sick due to HIV/AIDS have got to be designed – like following voters in their homes or providing mobile services for such processes as registration and the actual voting? Are we starting to see the forming of a new constituency as has been the case with the people with disability? And all this at what cost to a poor economy like that of Tanzania?

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BIBLIOGRAPHY

Assey, P. (19990 "Poverty Alleviation Initiatives in Tanzania" in V.S. Vyas and Pradeep Bhargava (eds.), Poverty Reduction in Developing Countries: Experiences from Asia and Africa (New Delhi, Rawat Publications): 125-151.

CCM. (2005). "CCM Electoral Manifesto for 2005 General Elections." National Executive Committee of CCM, Dodoma, Tanzania.

CUF. (2005). "Party Elections Manifesto." Dar es Salaam: CUF.

CUF. (2001). "Report on HIV & AIDS Testing for Senior Leaders of Civic United Front" as reported by different media.

Dahoma M., A. A. Salim, R. Abdool, A. A. Othman, A. Abdullah, and A. S. (2005). "Prevalence of HIV, Hepatitis B and C and Syphilis Infection in Substance Users in Zanzibar, Tanzania."

Department for International Development (DFID, UK) (1999), Tanzania: Country Strategy Paper (DFID, East Africa).

ESRF (2003). "The Social and Economic Impacts of HIV in Tanzania." Research Report Submitted to SIDA, Dare ss Salaam.

IndexMundi, at http://www.indexmundi,com/Tanzania

Kessy, F., S. Tax and R. Aiko. (2004). "The Impact of HIV & AIDS on Agriculture: The Case of Kilombero and Ulanga Districts." Final Draft Submitted to Eastern Zone Client Oriented Research and Extension Program (EZCORE), October 2004.

Munishi, G. K. (1997) *Private Health Care in Tanzania: Private Health Sector Growth Following Liberalization in Tanzania* Washington DC: International Health Policy Program.

Mwase, Nkunde (2006), "An Empirical Investigation of the Exchange Rate Pass-Through to Inflation in Tanzania", IMF Working Paper No 06/150.

National Electoral Commission (NEC) (2006), The Report of the National Electoral Commission on the 2005 Presidential, Parliamentary and Councillors' Elections (Dar es Salaam: National Electoral Commission).

NCCR. (2005). "The Electoral Manifesto of NCCR-Mageuzi for 2005 General Elections." Dar es Salaam: NCCR.

Nyalali Commission. (1991). "*Taarifa ya Mapendekezo ya Tume Kuhusu Mfumo wa Siasa Nchini Tanzania*" (Dar es Salaam: The Nyalali Report)

Revolutionary Government of Zanzibar [RGoZ]. (2002). "Zanzibar HIV Validation Study." Zanzibar: Zanzibar AIDS Control Program.

RGoZ. (2005). "Report on Implementation of Planned Activities by the Zanzibar AIDS Control Program for the Year 2004-2005." Zanzibar: Zanzibar AIDS Control Program.

Strand, P., K. Matlosa, A. Strode and K. Chirambo. (2005). ***HIV & AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Process***. IDASA Publication.

URT (1977). ***The Constitution of The United Republic of Tanzania.*** Dar es Salaam: Government Printer.

URT (1998), *The National Poverty Eradication Strategy* (Dar es Salaam, Vice President's Office).

URT (1999), *Poverty and Welfare Monitoring Indicators* (Dar es Salaam, Vice President's Office).

URT. (2003). "HIV/AIDs/STIs Surveillance Report—Report Number 17." Dar es Salaam: NACP.

URT. (2005a). "Tanzania HIV & AIDS Indicator Survey 2003-04." Dar es Salaam: TACAIDS, National Bureau of Statistics; and Calverton, Maryland: ORC Macro.

URT. (2005b). "HIV/AIDS/STIs Surveillance Report—Report Number 19." Dar es Salaam: NACP.

URT. (2005c). "Assessment of the HIV & AIDS Impact on the National Assembly of the Untied Republic of Tanzania." Dar es Salaam: Parliament Secretariat.