CHAPTER 6

# Confronting Africa's Health Challenges

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Are sick people as big a threat to the stability and security of Sub-Saharan Africa as arms proliferation and civil conflict? Health and disease have emerged as major themes in analyzing the state of politics and security in Sub-Saharan Africa in recent years. While there appears to be a growing consensus on the importance of health and disease for African politics and security, understandings and interpretations of that importance vary widely. We find ourselves in a situation where most people agree that health matters, but large disagreements exist over *how* and *why* it matters. Resolving, or at least understanding, the nature of these differences has important implications for both academic analysis and policymaking.

This chapter seeks to offer an understanding of the current state of the debate over the relationship between health and security in Africa. To do this, I will examine how the role of health in security politics has changed, how scholars and policymakers have assessed the nature of this relationship, and the consequences they have foretold.

## State of Disease in Sub-Saharan Africa

Infectious diseases pose a particular threat to Sub-Saharan Africa. Strikingly, Africa is the only region in the world where infectious and communicable diseases are responsible for the majority of deaths. In 2004, Africa experienced 11.3 million deaths. Of these, 7.7 million—68 percent of all deaths on the continent—were attributable to communicable diseases, maternal conditions, and nutritional deficiencies. Infectious diseases, like

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AIDS, tuberculosis, and malaria, collectively caused 4.85 million deaths—63 percent of deaths from communicable diseases, and 43 percent of all deaths. AIDS was the leading killer among infectious diseases, causing 1.65 million deaths, followed by diarrheal diseases (1.00 million), malaria (806,000), and tuberculosis (405,000). Noncommunicable conditions, such as cancer, stroke, heart disease, and diabetes, took 2.80 million lives in Africa in 2004 (25 percent of all deaths).[1]

To put Africa's disease burden into a global context, no other region of the world had a majority of its deaths come from communicable illnesses. Globally, communicable diseases were responsible for 17.97 million out of 58.77 million deaths worldwide in 2004—just over 30 percent. Noncommunicable conditions, on the other hand, caused 35.01 million deaths, or nearly 60 percent of the worldwide total. These stark figures hammer home the reality that Africa's communicable disease burden more than twice as high as the world average and far exceeds all other regions in the world. The World Health Organization (WHO) has compiled the ten leading causes of disease burden, using a measure of DALYs (disability-adjusted life years). Each DALY is the equivalent of one year of full health, and is the sum of years of life lost due to premature mortality and years lost due to disability due to a health condition. As of 2004, the top three causes of DALYs were HIV/AIDS (12.4 percent), lower respiratory infections (11.2 percent), and diaherreal diseases (8.6 percent). These three were responsible for nearly one-third of Sub-Saharan Africa's DALYs.

### *HIV/AIDS*

Twenty-two million people in Sub-Saharan Africa are HIV-positive. This is approximately two-thirds of all the cases of the disease worldwide. During 2007, UNAIDS estimates that 1.9 million more Africans contracted the virus, while 1.5 million died of AIDS.[2] Infection rates vary widely throughout Sub-Saharan Africa; three countries—Botswana, Lesotho, and Swaziland—have adult HIV infection rates of over 20 percent. The vast majority of cases in Sub-Saharan Africa are transmitted via heterosexual intercourse. As a consequence, Sub-Saharan Africa has high rates of mother-to-child HIV transmission. Reports estimate that 90 percent of the world's 2 million HIV-positive children live in Sub-Saharan Africa.[3]

The demographic breakdown of HIV cases in Sub-Saharan Africa reveals three fascinating patterns. First, the epidemic is concentrated overwhelmingly among women. Sixty-one percent of all infections in the region are among women.[4] This is a significant deviation from the epidemic as a whole, which

has a nearly even split between males and females. Second, there exist age disparities within infection rates. Women 15–24 are the most vulnerable to HIV infection, with twice the infection rates than men of the same age.[5] Third, deaths due to AIDS have had a dramatic effect on life expectancy rates in many parts of Sub-Saharan Africa. Demographers estimate that Sub-Saharan Africa as a whole would have an average life expectancy of 61 years today without AIDS. Instead, average life expectancy has dropped to 47.[6] In many countries, this means that life expectancy rates today are lower than at independence.

### *Lower Respiratory Infections*

Lower respiratory infections (LRIs) include pneumonia, emphysema, and acute bronchitis. These diseases target the trachea, bronchi, and lungs and are generally more serious than upper respiratory infections. In 2004, LRIs caused 1.417 million deaths in Sub-Saharan Africa, more than any other region. Further, they are the leading cause of mortality in children under the age of five, and the number of deaths from LRIs increased between 2002 and 2004. Though access to antibiotics has increased in recent years, many children in Africa lack access to health care facilities to receive treatment in a timely manner. Further, the overuse and abuse of antibiotics has led to an increase in antibiotic-resistant LRIs.[7] Treating these cases puts an even greater burden on already stretched health care resources.

### *Diarrheal Diseases*

Diarrheal diseases include diarrhea, cholera, and dysentery. Diarrheal diseases caused more than 1 million deaths in Sub-Saharan Africa in 2004, accounting for nearly half of all such deaths worldwide. While these illnesses can be viral, bacterial, or parasitic in origin, they are primarily transmitted via contaminated water. Water may be contaminated with human or animal feces in areas with inadequate sanitation systems. The recent cholera epidemic in Zimbabwe, for example, is a direct result of the collapse of the country's sanitation infrastructure due to its dire economic situation. NGOs working on diarrheal diseases note that, despite the heavy disease burden caused by these illnesses, they receive far less funding than other infectious diseases. Governments spent $1.5 billion on sanitation between 2004 and 2006—one-tenth the amount devoted to HIV/AIDS and one-third spent on malaria, even though neither disease kills as many children as diarrhea, cholera, and dysentery.[8]

### *Malaria*

Malaria is a vector-borne disease caused by parasites transmitted by infected mosquitoes. Once infected, the parasites colonize the liver and infect red blood cells. Fever, vomiting, and headache appear 10–15 days after exposure. Malaria can become fatal if it interrupts the supply of blood to vital organs. Each year, between 300 and 500 million cases of malaria occur worldwide, causing between 1.5 and 2.7 million deaths annually. Ninety percent of these cases occur in Sub-Saharan Africa.[9] In 2004 alone, malaria caused 806,000 deaths in Sub-Saharan Africa—90.7 percent of all deaths worldwide from the disease.

During the 1950s and 1960s, the World Health Organization led an international effort to eradicate malaria, primarily through vector control strategies relying heavily on DDT and other insecticides. While this strategy initially showed some promise, mosquitoes quickly developed resistance to the insecticides and common treatment methods. As a result, the number of cases of malaria in Sub-Saharan Africa between 1982 and 1995 was four times as high as those between 1962 and 1981.[10] Today, malaria is responsible for 20 percent of all mortality in children under five, and every African country (except for Libya) is endemic for the disease. WHO figures cite malaria as causing up to 40 percent of public health expenditures, 30–50 percent of hospital admissions, and up to 60 percent of outpatient visits in the region.[11] Among the 35 Sub-Saharan African countries with the highest malaria rates, economic analysis suggests that malaria depressed economic growth by 1.3 percent annually. Cutting the rate of malaria by 10 percent, on the other hand, could allow these states to grow by 0.3 percent.[12]

### *Tuberculosis*

Approximately one-third of the world's population is infected with the bacilli that cause tuberculosis. In most cases, the immune systems keep the bacteria in check and people feel no ill effects. Approximately 10 percent of these latent infections become active, characterized by chronic coughs, weight loss, chest pain, fever, and night sweats. Without treatment, tuberculosis can kill more than 50 percent of its victims. The treatment regimen entails a six-month course of antibiotics, taken on a consistent basis. Tuberculosis killed 405,000 people in Sub-Saharan Africa in 2004, with more than 2 million additional people falling ill.[13]

As with malaria, tuberculosis rates in Sub-Saharan Africa have increased dramatically in recent years. Between 1990 and 2003, the rate of infection in the region more than doubled, from 149 cases per 100,000 population to 343 cases. During this time, nearly every other region in the world experienced

a decrease in tuberculosis rates. Much of the blame for startling increase in tuberculosis in Sub-Saharan Africa belongs to HIV. Tuberculosis is the most common coinfection among HIV-positive persons, as their immune systems cannot keep tuberculosis bacilli walled off any longer. As a result, 30–40 percent of HIV-positive adults die of tuberculosis.[14] Rising infection rates also put the general population at greater exposure to the disease; each untreated infected person can infect 10–15 others.[15] Failure to diagnose an active infection early or inconsistent access to drugs has led to forms of tuberculosis increasingly resistant to treatment. These new strains, multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) are far more difficult and expensive to treat.[16]

## Health and Security

With the demise of the Cold War, security studies scholars grappled with questions of the nature of security in the new international environment. Traditional understandings of security focused exclusively on military and physical threats within a state-centric framework.[17] In a now-seminal article, Deudney explicitly argued against the expansion of security into new realms, such as environmental degradation.[18] While not denying the challenges posed by environmental changes, including it and other "new" security threats led to inappropriate policy suggestions and engendered us-versus-them thinking that directly contradicted the international cooperation necessary to address these problems. A number of researchers questioned the applicability of this paradigm in the post-Cold War era. While the military-focused, state-centric model may have been appropriate in a bipolar world, they challenged the model's usefulness in a world facing numerous serious nonmilitary threats (such as environmental degradation, refugee flows, illicit drugs, crime, and food scarcity) with only one superpower.[19] Incorporating nontraditional threats under the rubric of "security" also called for greater attention paid to the threats faced by individuals rather than states.

While this debate emerged in the pages of international relations journals, the AIDS epidemic entered the public consciousness. International organizations began to create programs dedicated to preventing the disease's spread, offering treatment (though such options were almost nonexistent in the late 1980s and early 1990s), and raising public awareness of the disease. The emergence of AIDS and the potential threats it posed coincided with the emergence of the human security paradigm. With the end of the superpower rivalry of the Cold War, a movement developed to redefine conceptualizations of security away from its traditional state-centric focus on military and physical concerns and toward a more individual-level conception of security.

The United Nations Development Program, in particular, embraced this redefinition of security. In its 1994 *Human Development Report*, the authors defined human security: "It means, first, safety from such chronic threats as hunger, disease, and repression. And second, it means protection from sudden and hurtful disruptions in the patterns of daily life—whether in homes, in jobs, or in communities."[20] UNDP then went on to disaggregate security into seven distinct realms: economic, food, health, environmental, personal, community, and political security. By so doing, UNDP hoped to change the conversation within the international community, shift the referent of security away from the state and toward the individual, and develop an all-encompassing, integrative redefinition of security. As this broadened definition of security took hold, health gradually became incorporated into the realm of security issues.[21] Advocates of human security emphasized its relevance to the real challenges threatening most people in their daily lives.

## Security Implications of Disease in Africa

With growing debates over the nature of security, a growing number of scholars and policymakers have wondered about the ethical considerations of expanding or restricting the definition of security. Securitization theory, popularized by the Copenhagen School, can play a particularly important role here. It focuses on *how* and *why* certain issues become security concerns in the first place. A wide range of nonmilitary issues, like HIV/AIDS, environmental degradation, poverty, hunger, and global warming, could conceivably be security issues, but not all will successfully make it to the national security agenda.

What determines which issues succeed? Securitization theory focuses on the performative nature of speech acts. Calling something a security issue or security threat constitutes a performative speech act, in which the words used to describe something themselves function as an activity. Describing an issue as a security issue gives that issue a special social quality for policymakers. The designation itself brings with it certain connotations, and implies a certain sort of response. It also affects how other parties view the issue and its place on the political agenda. Waever notes that the security label "does not merely reflect whether a problem *is* a security problem, it is also a political choice."[22] Choosing to designate something as a security issue is thus a political tool to advance particular goals and aims.

The discussions of securitizing health and disease in Africa have focused almost exclusively on HIV/AIDS. Though recent analyses have broadened this focus to include diseases like malaria and tuberculosis, the analytical gaze (and, consequently, most of the evidence offered in this section) pays the vast majority of attention to HIV/AIDS.

Concerns about the security implications of disease in Africa tend to fall in one of thee categories: economic, political, and military. These three channels, according to the causal mechanisms of health security, could exacerbate economic deprivation, foster the breakdown of social institutions, and erode the legitimacy and authority of democratic political institutions and bureaucracies.[23] From an economic perspective, the effects of disease have the potential to be dire. Nguyen and Stovel make the connection between disease and economics explicit. They write, "There is widespread agreement that HIV/AIDS causes or exacerbates economic vulnerability."[24] This is particularly problematic, as significant erosion in socioeconomic conditions in highly afflicted states poses the leading threat to development in Africa.[25] Reports by the United Nations Development Program note that AIDS causes household incomes to decline by up to 80 percent. In addition, AIDS-afflicted households can see a 15–30 percent decline in food consumption.[26] Another United Nations organization, the Food and Agricultural Organization, estimated in 2001 that AIDS killed 26 percent of the agricultural workforce in the ten most afflicted Sub-Saharan African states.[27] The education sector also faces severe effects from HIV/AIDS. Teachers form the foundation of the education system, and a well-functioning education system is crucially important for political and economic development. Unfortunately, teachers appear to be particularly vulnerable to HIV infection. A 2001 report estimated HIV infection rates among teachers in southern Africa and found prevalence rates of 33 percent (South Africa), 40 percent (Zambia), 40 percent (Malawi), and 70 percent (Swaziland).[28]

Politically, HIV/AIDS can introduce greater uncertain into the realm of governance. Butler notes that the HIV/AIDS epidemic could threaten to undermine the institutional and bureaucratic framework necessary for a functioning democracy. The loss of skilled civil service personnel and the basic organs of political competition could work against the tide of democratization that swept across Sub-Saharan Africa in the 1990s.[29] A government's failure to adequately address the epidemic could also weaken its legitimacy among the public, though recent public opinion analysis suggests that evaluations of a government's AIDS policies are not significantly weakening support for governments in Sub-Saharan Africa.[30] Strand and others found that Zambia has experienced a significant increase in the number of parliamentary by-elections due to MP death since AIDS emerged in the country. Between 1990 and 2003, the years when Zambia's AIDS prevalence rates were at their highest, the country held 38 such by-elections. By comparison, the country only had 14 by-elections due to death between 1964 and 1984. More strikingly, the deaths between 1990 and 2003 were disproportionately among younger members. Fifteen of the 38 were between 40 and 49, while only two such deaths occurred among MPs over the age of 70. While not all of these deaths

are due to AIDS, Strand et al. highlight that "70 percent of the MPs who died between 1990 and 2003 would have been in their most sexually active phase during parts of that time period" and hence at risk of contracting the virus.[31] In 2000, Zimbabwean President Robert Mugabe announced that AIDS had killed at least three cabinet ministers and numerous traditional chiefs. Kenyan civil service officials declared that AIDS caused 86 percent of employee deaths in 1998 and 75 percent of police deaths between 1996 and 1998.[32] A 2003 report asserted that at least one-quarter of the South African police personnel were HIV-positive.[33]

The military is of particular interest to discussion of security and particularly problematic for the spread of HIV in Sub-Saharan Africa. AIDS, not war, is the leading cause of death among southern African militaries, accounting for over 50 percent of all in-service and post-service mortality.[34] Reports suggest that between 40 and 80 percent of military members in the region are HIV-positive.[35] AIDS challenges for the military in four key ways. First, it compromises military performance and effectiveness. If a large number of your people are sick, you cannot be as effective a force. The South African National Defense Force has had to curtail its involvement in international peacekeeping and joint military exercises because they have not been able to field large enough contingents of HIV-free soldiers.[36] Second, high rates of AIDS within society decrease the pool of potential recruits. There are fewer healthy people available to replace those already in the military who fall victim to AIDS. Third, militaries suffer from a loss of leadership. The upper ranks of any military are crucially important for instilling a sense of discipline in new recruits and for ensuring operational effectiveness. As AIDS kills these people, the military not only loses their experience, but also faces a smaller pool of available replacements.[37] Finally, AIDS itself is becoming a weapon of war. HIV-positive soldiers have reportedly raped women and girls as they have retreated to cause a "slow genocide."[38] Not only does this further burden already weakened health systems in conflict zones and spread the disease to new areas, but it also serves to weaken the social fabric—which itself contributes to the disease's spread.[39]

## Is Security the Right Framework for Promoting Health in Africa?

It is undeniable that Africa's infectious disease burden places enormous strains on governments and societies throughout the continent. The losses associated with premature death dampen the abilities of governments throughout the continent to build stronger, more robust polities and economies. Reducing the disease burden would increase gross domestic products throughout

the continent, allow for the reallocation of government funds, and create an environment more hospitable to foreign investment. Infectious disease and health are undoubtedly important humanitarian issues for Sub-Saharan Africa. The question arises, though, as to whether they are also security issues.

While it may be tempting to categorize infectious diseases in Africa as security issues or threats, it appears increasingly unlikely that such a strategy will be effective over the long term. The contentiousness over the meaning of health security and the nature of the health challenges faced by Sub-Saharan African states suggest that human rights or humanitarianism may be more appropriate frameworks for promoting health and the development of a strong health care infrastructure throughout Africa.

How could this happen? Four big concerns emerge for securitizing health within Sub-Saharan Africa. First, a security framework focuses on a state protecting itself against threats rather than a broader, more holistic sense of global well-being. The irony in such a juxtaposition is that promoting global well-being and paying attention to the underlying determinants of health and disease would ultimately provide greater levels of protection. A security and threat posture frequently ignores the diseases and illnesses that cause the highest levels of mortality and privileges those diseases that most concern Western states. Diarrheal diseases rarely, if ever, are conceptualized as security threats, even though they are one of the most common killers in Sub-Saharan Africa. Avian influenza, on the other hand, receives disproportionate attention, despite the fact that Africa as a whole has recorded only 83 cases—all but two of which were in Egypt.[40]

Second, securitizing health narrows the range of diseases that receive attention and tends to focus on specific diseases themselves rather than the broader public health infrastructure. Most of the diseases that animate discussions of health security pose the greatest potential threat to Western states—SARS, avian influenza, and swine flu. These diseases certainly have the potential to exact heavy costs on the international community, and taking precautionary measures to avoid negative consequences is certainly advised. However, focusing on these theoretical threats instead of the very real and already apparent infectious diseases threats facing Sub-Saharan Africa distracts attention and finite resources. A focus on discrete diseases leads to stovepiping—creating programs and systems that address one illness or concern but do little to address broader measures of health. It is a focus on *disease* rather than a focus on *health*, yet health is more than the absence of disease. Because measles, mosquito-borne diseases, and diarrheal diseases are largely absent from industrialized countries, they receive little if any attention from the security framework. The benefits Elbe associates with the securitization of AIDS have not translated to health more broadly, nor are they likely to do

so. Thus, the illnesses with the greatest mortality and morbidity burdens in Sub-Saharan Africa are largely left out.

Third, despite efforts otherwise, the security framework still largely casts its analytical gaze at national, rather than human, security.[41] Policymakers and academics tend to think about security in terms of what could threaten the state. The language of security studies emphasizes direct threats—those that are readily apparent and provide a linear causal relationship to safety. It focuses on direct risks to state structures (particularly the military), potential epidemic diseases, and bioterrorism, though these are not the problems that dominate the African health agenda.[42] The nature of infectious disease, as described above, is better understood as an indirect, nonlinear threat. An infectious disease outbreak in and of itself is highly unlikely to bring a state to its knees or lead to armed conflict between two states. However, if state structures are already weakened or atrophied, and if a government lacks the governance capabilities to deal with an additional stressor, then it is possible that infectious disease could pose a serious risk to a state. It is this latter scenario that most challenges African states. If they are already weakened, then they may lack the reserve capacity and capability to handle an additional stressor.

Fourth and finally, the direct security effects envisioned by advocates of AIDS securitization (and health securitization more broadly) are largely speculative and overstated. While it is indeed true that high rates of infectious disease can have a deleterious effect on a state's social, political, and economic institutions, there is little empirical evidence of direct military effects or civil conflict.[43] Barnett and Prins argue that much of the discussion about disease's security effects rests on "factoids" and anecdotes that do not provide robust, reliable information.[44] McInnes concurs, asserting that making blanket statements about the security implications of infectious disease across the entire African continent overstates and overgeneralizes the risk.[45] Further, the statistical evidence for the relationship between poor health and internal instability remains ambiguous at best. The Central Intelligence Agency's State Failure Task Force found that high infant mortality rates are a sign of poor quality of life, which is in turn a causal factor for internal instability. This finding suggests that infectious disease and poor health has an *indirect* effect on state security, not the direct effect commonly ascribed within the securitization literature.[46] These findings do not diminish the fact that poor health and infectious disease have severe effects on life within a state, nor do they suggest that infectious disease is not a problem with which African government need to grapple. They do suggest, though, that focusing on the direct security effects goes too far. By overstating the case, securitizers risk provoking a backlash when the hypothesized effects fail to materialize.

Along these same lines, a security framework begs two important questions: security *for whom* and security *from what*? The health security discourse that has developed over the last 10–15 years has generally answered the first question by focusing on Western states. "Health security risks" or "new security risks" are those diseases that Western states fear could emerge from Africa and potentially come to their shores.[47] It is not a discourse about health in general, nor is it even a discourse about helping Africa. It is instead a discourse that envisions Africa largely as an emitter of disease. What happens within African states with health concerns is irrelevant *unless* it could emerge and spread to industrialized states. This skews the international agenda, focusing attention away from those health issues that most directly affect African states and publics. The broader determinants of health, such as poverty and access to clean water and proper sanitation, receive less attention.

Africa itself receives short shrift, too. Africa is not important in this construction because of the suffering from infectious disease or the disproportionate child mortality burden it experiences; it is only important insofar as it could potentially be the source of diseases that could threaten wealthy industrialized states. Africa is more of a signifier than a participant in the larger conversation about international health policy.

If the above is true and the security framework has largely come to dominate the discussion of African health, why is this the case? McInnes and Lee, while approving of the increased attention health has received within the international agenda, highlight "the apparently successful attempt to move health beyond the social policy and development agenda, into the realms of foreign and security policy."[48] One answer might be "forum-shifting." Health is a cross-cutting issue that fits within many different policy arenas. By shifting health away from the realms of social and development policy and toward foreign and security policy, advocates seek to operate within the diplomatic arenas with more attention, more resources, and more favorable outcomes.[49] Security, for better or worse, commands far more attention and far more resources than social policy or international development. Policymakers pay attention to security issues, particularly security *threats*, with an urgency not present for development issues.

While this strategy may have led Western states to pay more attention to Africa and health issues, it does not appear to be a useful long-term strategy. Aldis documents a growing suspicion of health securitization. Developing state governments are increasingly uncomfortable with the framework because of the associated loss of control and policy autonomy. Since the health security discourse largely focuses on those diseases that could threaten developed states, developing states like those in Africa find their health policies increasingly dominated by responding to developed state

concerns. It also undermines state sovereignty and autonomy, as health programs in African states become increasingly dependent upon donor requests and conditionalities.[50] As a result, governments in Sub-Saharan Africa are increasingly reluctant to accept the categorization of health as a security concern.[51]

Furthermore, conceptualizing health as a security issue frequently leads to a crisis-oriented mentality. New and novel diseases receive disproportionate attention, and attention focuses on epidemic diseases that threaten to spread beyond borders.[52] Endemic diseases, which are responsible for the majority of Africa's disease mortality and morbidity burden, receive less attention because they are assumed to be part of the fabric of the country. A short-term crisis mentality may lead to rapid, immediate responses, but addressing the underlying determinants of health requires long-term, sustained commitments. A crisis-based response emphasizes defensive measures, but pays less attention to long-term processes like prevention, strengthening the public health infrastructure, and building surveillance capabilities in developing countries.[53] While praising the President's Emergency Plan for AIDS Relief (PEPFAR), Patterson notes that its relatively quick passage demonstrated a belief among policymakers that AIDS was less a long-term development issue and more of a short-term fix. "Emergencies require quick attention, but the implication is that an emergency can be fixed relatively rapidly."[54]

Fixing a country's health care infrastructure or ensuring that children have access to life-saving vaccinations will not emerge from a crisis mentality. That sort of sustained attention will likely only emerge from a framework that recognizes the value of addressing health concerns in Africa as human rights or humanitarian issues. As Feldbaum notes, "Addressing most global health issues cannot be justified by national security considerations . . . some serious global health issues will likely never be linked credibly to US national security interests. Such issues will have to rely on moral, humanitarian, or other frameworks to win US funding and political support."[55] Instead of focusing on security-based concerns, foreign governments that want to promote improved health in Africa should base their assistance and commitment on generosity, compassion, and creating the preconditions for economic development and global prosperity.[56]

Finally, and perhaps most importantly, attempting to create a direct, linear relationship between health and security may actually work against its advocates' desires. Barnett and Dutta find no conclusive evidence for a direct link between HIV prevalence and state fragility,[57] while Sato uncovers no statistically significant relationship between AIDS and state fragility among low-income countries under stress.[58] Peterson describes the paradox

thusly: "By overdrawing the link between infectious disease and security, however, public health and human security advocates sabotage their own attempts to motivate developed nations to fights AIDS in Africa and elsewhere . . . . Linking an urgent issue to security may raise awareness, but it likely will also hinder much of the cooperation that human security and public health advocates seek and that the disastrous humanitarian and development effects of infectious diseases demand."[59]

Addressing health in Africa requires international cooperation and a willingness to share among states. Security encourages governments to think narrowly about their own interests and how they can gain or preserve their advantages over others. Humanitarian health objectives are largely at odds with this state-centric model of security because the former offers a far more inclusive vision and responsibility than the latter.[60]

## Suggestions and Conclusions

In this paper, I have argued that security is not the most appropriate framework for encouraging national and international action on infectious disease in Sub-Saharan Africa. Infectious diseases cause a disproportionate share of the region's morbidity and mortality, and the international community clearly has an interest in reducing the spread of AIDS, malaria, tuberculosis, diarrheal diseases, and lower respiratory infections. Calling these diseases security threats or issues, while potentially attention-grabbing, distracts attention from the nature of the threat posed by these diseases and skews funding.

If security is inappropriate, what is a better framework for encouraging action and attention? I propose conceptualizing infectious disease as a human rights or development issue instead of a security issue. Such a framework would emphasize the connections between human rights as written in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the African Charter of Human and Peoples' Rights, among others, and good health. People need to be healthy in order to take advantage of and realize their inherent human rights, and numerous human rights charters explicitly recognize a right to health. Some, like the African Charter of Human and Peoples' Rights and the South African Bill of Rights, go even further and specify a positive obligation for the government to ensure the good health of their citizenry.

Using a human rights or development framework for addressing infectious disease in Africa instead of security has four distinct advantages. First, it emphasizes the long-term nature of these issues. Neither human rights

nor development can be realized in a few short years. They are an ongoing project, requiring constant attention and vigilance. Doing so requires the active attention of both local governments and the international community in a collaborative manner.

Second, this framework encourages paying attention to a wider range of infectious diseases and health threats in Sub-Saharan Africa. Some of the leading causes of death in the region, like malaria, lower respiratory infections, and diarrheal diseases, overwhelmingly affect children. As such, they are highly unlikely to receive attention within a security framework. Few would argue that the deaths of children under the age of five is likely to destabilize a country, provoke international aggression, or lead to the collapse of a national government. The security framework encourages this selective attention, emphasizing those diseases that may have military implications rather than those that have the greatest effects on the population as a whole. This has helped to distort health spending, with AIDS receiving a disproportionate share of health-related aid from international sources.[61] A human rights or development framework pays attention to a wider range of infectious diseases because it has a more holistic approach. Children may not militarily relevant, but their survival and prosperity can lead to greater economic prosperity and political development over time.

Third, a human rights or development framework resonates with existent narratives, Over the past 20, AIDS activists have come to situate their claims for treatment and prevention programs in human rights terms.[62] Universal access to antiretroviral drugs has gained currency as an international norm, altering existing paradigms about pharmaceutical access.[63] Tapping into this emerging consensus will allow for greater long-term success.

Finally, a human rights framework allows for greater participation from nonstate actors. Security is widely seen as the sole domain of the state. Given the challenges ill health poses to Sub-Saharan Africa, though, it is highly unlikely that state governments on their own can adequately address them. A human rights and development framework, on the other hand, recognizes the value of reaching out to and incorporating voices from nongovernmental organizations, philanthropic organizations, and private business. Incorporating all of these difference groups along with governments and finding mechanisms for coordination heightens the chance that the full spectrum of health issues will be addressed.

Calling health in Sub-Saharan Africa may initially appear attractive, and its discourse has been dominant in recent years. However, its shortcomings limit its efficacy. The infectious disease threat in Sub-Saharan Africa is real and significant, but a security framework has not and will not produce the sort of long-term attention necessary to adequately address the issue.

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