

# Public Health Assistance to Sub-Saharan Africa

## An Exploratory Introduction to the Topic

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### Introduction

After a number of close votes, an “Africa” topic has finally been chosen as the debate topic. The 2007-8 resolution is Resolved: The United States federal government should substantially increase its public health assistance to Sub-Saharan Africa.” This resolution accesses a very interesting literature base that will sustain a variety of strong affirmatives as well as many interesting negative disadvantages, counterplans, and kritiks (“critiques” – proper spelling).

The resolution focuses the debate on two specific issues – a type of assistance to be provided (public health assistance) and the place to which it should be provided (Sub-Saharan Africa). Since most of the literature on health problems in developing countries focuses on the needs of Sub-Saharan Africa (SSA), this resolution is well-designed to access some great debates.

In fact, there is probably no better area to access a debate on public health care than SSA. In the 1960s and 70s many African countries had effective public health systems and the life expectancy was 62 years. Today, the average life expectancy has plummeted to 47 years and the public health infrastructure has collapsed. SSA suffers the highest child mortality<sup>1</sup> rate in the world. Out of every 1,000 children born, 118 do not make it to their first birthday (Rotberg, 2007).

### Focusing on Key Terms

The only real weakness to the wording of the resolution is that the term “public health assistance” is not a foreign assistance budget category<sup>2</sup> and the topic is obviously designed to focus debates on foreign assistance. The term, however, does appear in other related uses.

In the Code of Federal Regulations,<sup>3</sup> “public health assistance refer” to “health services” that “(1) that are generally available to needy individuals residing in a State; (2) that receive funding from units of State or local government; and, (3) that are provided for the primary purpose of protecting the health of the general public, including, but not limited to, immunizations for immunizable diseases, testing and treatment for tuberculosis and sexually-transmitted diseases, and family planning services.”<sup>4</sup> These services are defined in a similar manner under Medicaid,<sup>5</sup> a federal health insurance program for the poor.

Although these narrow definitions are available, and will most likely be the ones accepted for the purposes of establishing a more limited topic, there are other broader definitions available which may actually better capture the idea providing foreign assistance to improve public health abroad. Note that the definition referenced above is discussing *domestic* public health services.

The World Bank Institute (2004) explains that, “Public health as a field of action and knowledge, is concerned with col-

lective or social actions aimed at ensuring conditions in which people can be healthy. It is the sum total of all of the activities that are undertaken to protect, promote, and restore the health of a community or population” (p. 4). Roland Labonte & Ted Schrecker, writing in *FATAL INDIFFERENCE: THE G8, AFRICA AND GLOBAL HEALTH* (2004), discusses the importance of actions such as forgiving third world debt as a measure to deal with public health problems.

Despite the difficulty of finding definitions of public health assistance that are specific to the foreign policy context, and broader uses of the term in context, I think that negatives will be able to win topicality debates based on the more narrow definitions.

Sub-Saharan Africa (SSA) refers to the mainland area of Africa south of the Sahara desert. Forty-two countries are considered to be a part of SSA.<sup>6</sup> Affirmatives can certainly topically increase assistance to the entire region. There will be few topicality debates as to what constitutes this region because most definitions list these 42 countries.

There will be topicality debates about whether or not affirmatives can topically increase assistance to individual countries within the region, with negative teams arguing that if the affirmative can increase assistance to any country in the region then there are 42 affirmatives for every health problem in Africa. Affirmatives will respond

<sup>1</sup>“Mortality” refers to “death.”

<sup>2</sup>McGugh (2001) notes that the U.S. Agency for International Development (USAID) allocates money to “health programs” in many parts of its budget, including its Child Survival and Disease account. Population programs, which everyone will consider topical, are allocated in a different part of the USAID account, and the Center for Disease Control (CDC) and the Department of Health & Human Services (HHS) also provide overseas assistance for public health. Finally, U.S. contributions to the World Health Organization (WHO) are provided through the State Department budget.

<sup>3</sup>Document that codifies all rules of the executive departments and agencies of the federal government. It is divided into fifty volumes, known as titles. Title 40 of the CFR (referenced as 40 CFR) lists all environmental regulations. [www.nema.org/lamprecycle/support\\_files/glossary1.html](http://www.nema.org/lamprecycle/support_files/glossary1.html)

<sup>4</sup>Title 45, Vol. 2, 10-1, [http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr\\_2004/octqtr/45cfr402.2.htm](http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/45cfr402.2.htm)

<sup>5</sup>Claudia Schlosberg. National Health Law Program, 1-12, <http://www.healthlaw.org/library.cfm?fa=download&resourceID=67503&print>

<sup>6</sup>Wikipedia. “Sub-Saharan Africa.” [http://en.wikipedia.org/wiki/Sub-Saharan\\_Africa](http://en.wikipedia.org/wiki/Sub-Saharan_Africa). A full list of the countries is provided at the end of this essay.

by arguing that if they have to increase assistance to the entire region negatives will simply counterplan to exclude specific countries, meaning that each individual country will have to be researched anyway.

There will also be topicality debates about whether or not the affirmative has to provide the public health assistance through the governments of SSA countries. Normally, foreign assistance is delivered through foreign governments, but since public health assistance does not refer to a budget category, affirmatives may argue that they can simply deliver the aid without going through host country governments. This will be discussed further in the counterplan section

## Affirmative Advantage Areas

*Death.* Millions of people die every year from a variety of causes due to a lack of public health care in SSA. There is even good evidence that projects how many people will die absent action to address a specific health issue. The statistics are quite sobering and this basic harm will be difficult for the negative to refute.

*State collapse, civil conflict, and terrorism.* Many diseases have taken such a toll in SSA that they threaten the stability of many governments. The lack of care puts substantial political pressure on governments; the death from the disease often targets many middle-aged individuals, leaving the government without a productive population and only a younger, radicalized population; a lack of care pits ethnic and political groups against one another in fights for limited resources, and the extreme deprivation and lack of security provides a fertile recruiting ground for terrorist organizations. For a full explanation of the harms of state collapse see Rice (2006) and Kaplan (1996).

*Development.* Like state collapses, this advantage stems directly from the death toll that various health problems have created. A lack of health care has killed so

many people in Africa that businesses lack an adequate work force, governments lack adequate tax revenues, and foreigners are afraid to invest.

*Racism.* There is some good evidence that indicates that many of SSA's problems are due to problems that were created by colonialism, and that it is racism that is driving the West's<sup>7</sup> indifference to SSA's plight. Affirmatives will claim that action is needed to confront this racism and may argue that this is a unique justification for U.S. action. Although this evidence is easy to find, answers are relatively sparse. Calderisi (2006) argues that the West has done a lot to help Africa and that the problems in Africa are not due to colonialism. Vasquez (2005) argues that Africa has already received the equivalent of five Marshall plans.<sup>8</sup>

*Morality.* This is somewhat similar to the racism claim; affirmatives will argue that we have a moral obligation to act to improve the health situation in SSA.

*U.S. leadership.* Joseph Nye, the chair of the JFK School of Government at Harvard, argues that there are three types of power in the world – economic power, military power, and soft power.<sup>9</sup> “Soft power” refers to how well other countries like us. Nye argues that soft power boosts our economic power by building trade ties and facilitating investment and that it boosts our military power by enhancing allied relationships. Affirmatives will claim that by public health assistance to SSA to address a high profile health issues, particularly HIV/AIDS, will boost U.S. soft power.

One weakness of this advantage is that it is difficult to quantify the threshold at which the U.S. becomes a global leader in the provision of health services, particularly AIDS prevention. The affirmative's advantage cards are rarely, if ever, unique to the plan and U.S. leadership has already been expanded under President's Emergency

Plan For AIDS (PEPFAR). The U.S. also provides half of the resources to the Global Fund to Fight Aids (GAO (2006); USAID (2006)).

## Affirmative Plans

All affirmative plans will increase a form of public health assistance to SSA and will likely claim one or more of the previous advantages that have been discussed. In this next section I will address some of the particular plans the affirmative will likely advocate.

*Public health capacity building.* One recurrent theme in all of the literature on public health in SSA is that countries in this region lack a basic and effective public health infrastructure to deliver public health care (Danyo (2003); Garrett (2007); HealthGap.org (2005); Woods (2004)).

There are a number of reasons for this lack of capacity. First, most of the health care systems in these countries even suffer from a massive brain drain where health care professionals – primarily doctors, but also nurses – leave SSA to work in the Western world. Second, structural adjustment programs that require governments to cut government spending in exchange for low interest loans have resulted in reductions in spending on public health. Third, a focus on spending to fight certain high-profile diseases such as HIV/AIDS, have reduced foreign assistance spending on the development of basic health infrastructure. Fourth, the scale of many of the health problems that will be discussed in this section has simply overwhelmed the existing health infrastructure.

A collapsing public health infrastructure not only undermines the ability to care for sick patients, resulting in death, but also undermines the ability to monitor and prevent the outbreaks of more deadly

<sup>7</sup> The “West” is a general reference to the wealthy countries of the world, including the U.S., the U.K., Canada, Germany. Countries that are not literally in the West, but are wealthy, such as Japan and South Korea, are also included in this list.

<sup>8</sup> The “Marshall Plan” was a large “Economic aid from the United States used to rebuild Europe after World War II. Named after United States Secretary of State George Marshall.” regentsprep.org/Regents/global/vocab/topic.cfm

<sup>9</sup> SOFT POWER (2004).

pandemics<sup>10</sup> such as the avian flu<sup>11</sup> (Rice, 2006).

Garrett (2007) argues that foreign donors should act to strengthen the public health sectors of developing countries:

Donors and those working on the ground must figure out how to build not only effective local health infrastructures but also local industries, franchises, and other profit centers that can sustain and thrive from increased health-related spending. For the day will come in every country when the charity eases off and programs collapse, and unless workable local institutions have already been established, little will remain to show for all of the current frenzied activity.

*HIV/AIDS.*<sup>12</sup> More than 20 million people have died from AIDS since 1981. About 2/3 of the estimated 40 million people living with HIV/AIDS are in SSA (GAO, 2006). The overall rate of infection in Africa is 7.2% of the population, versus 1.1% world-wide. AIDS has surpassed malaria as the leading cause of death in Africa (Rotberg, 2007). An additional 20 million Africans are likely to die of AIDS by 2020. Six hundred thousand infants are infected yearly (Cook, 2006).

In addition to the enormous human death toll, AIDS in particular is a disease that is threatening the development of the entire continent by depriving the area of individuals in the most productive years of their lives. According to the GAO (2004), “The disease has decimated the ranks of parents, health-care workers, teachers, and other productive members of society in the region, severely straining economies and contributing to political instability.” Rotberg (2007) explains that “AIDS has killed 7 million agricultural workers in 25 African countries since 1985, contributing to severe food shortages” (p. 22).

There are a number of different ap-

proaches that the affirmative can take to deal with the AIDS crisis in Africa.

**Funding.** According to Cook (2006), “UN AIDS maintains that significant AIDS funding gaps remain.” Cook references a recent study that indicates that while \$14.9 billion was needed to fight HIV/AIDS in 2006, only \$8.9 billion was provided. The funding could be used to focus both on prevention and treatment.

**Prevention focus.** Increasing support for prevention programs involves things like education and condom distribution. Prevention programs have proven effective in a number of SSA countries, including Kenya, Uganda, and Senegal. Thailand is often pointed to as a country that demonstrates the effectiveness of condom distribution (USAID, 2006).

**ARVs.** ARVs are antiretroviral drug therapies that prevent (or at least substantially slow) the process that transforms HIV into full-blown AIDS. ARVs are used in combinations – a regime called Antiretroviral Therapy (ART). These therapies have been very effective at arresting AIDS development in the West, but in Africa more than 85% of those with HIV/AIDS do not have access to these drugs (Cook, 2006). ARVs are particularly effective at stopping mother-to-child transmission of the virus when the fetus is in utero (Rotberg, 2007).

One big issue related to ARVs is the protection of intellectual property. Large drug companies that make the ARV drugs have patents on the drugs that prevent copying and making them into less expensive generic drugs. As a result, the U.S. limits the number of generic drugs available under PEPFAR to 15 (USAID, 2006). One strong affirmative would be to increase the number of generic drugs available under PEPFAR, reducing the cost of buying the drugs to developing countries.

Remove the abstinence focus. In

January of 2003, President Bush announced the Emergency Plan for Aids Relief (PEPFAR). PEPFAR focuses on prevention, treatment and care of HIV/AIDS patients. PEPFAR was authorized by the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (GAO, 2006). Fifteen SSA countries are eligible for PEPFAR assistance.<sup>13</sup> PEPFAR is implemented by the Department of State, USAID, and the Department of Health and Human Services (HHS). The U.S. also has a Global Aids Coordinator who was appointed in October 2003.

At the center of the prevention program element of PEPFAR is an endorsement of the “ABC Model” (Abstain, be Faithful, or use Condoms). Cook (2006) argues that the abstinence focus has reduced condom distribution because two-thirds of prevention funds must be spent on abstinence & “be faithful” programs. This undermines the ability of providers to adapt the program to local conditions and limits funding on other parts of the program since two-thirds of the spending total must be on abstinence (GAO, 2006). Affirmatives could increase public health assistance by removing this requirement.

*Malaria.* Malaria is caused by a “microscopic single-celled parasite” that is carried by the Anopheles mosquito... It attacks the red blood cells of the body (which carry oxygen)...Once inside the human body the malaria causing protozoa travel to the liver and reproduce within the red blood cells. Malarial attacks occur when the rapidly reproducing parasites become so numerous that they cause the cells to rupture, releasing more parasites into the bloodstream to attack more red blood cells. Each time the red cells rupture, the victim suffers from a high fever...Most victims will die from the infection if not treated” (Rotberg, 2007, pp. 46-7).

<sup>10</sup>A “pandemic” is “An epidemic occurring over a very large area.” [www.nbc.com/nbc/Medical\\_Investigation/medical\\_terms/](http://www.nbc.com/nbc/Medical_Investigation/medical_terms/). An “epidemic” is “a widespread outbreak of an infectious disease; many people are infected at the same time” [wordnet.princeton.edu/perl/webwn](http://wordnet.princeton.edu/perl/webwn)

<sup>11</sup>For more information on the avian flu, see [http://en.wikipedia.org/wiki/Avian\\_flu](http://en.wikipedia.org/wiki/Avian_flu)

<sup>12</sup>HIV is the human immunodeficiency virus. HIV weakens the body’s immune system so that it cannot fight off infections. AIDS is acquired immune deficiency syndrome, which can develop in an HIV positive individual. There are two main types of HIV – HIV-1 and HIV-2. The HIV-1 strain has three subtypes – A, B, C, and E. The most common killers in Africa are HIV-1C and HIV-2.

<sup>13</sup>Botswana, Ethiopia, Ivory Coast, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia (GAO, 2006).

Up to three million people die from malaria each year. Almost 90% of those deaths occur in Africa, and 71% of the victims are under five (Rotberg, 2007). Between 10 percent and 13 percent of maternal mortality is due to malaria (McGugh, 2001).

There are a few different ways to treat malaria. First, malaria anti-drug regiments can be used. These are expensive and difficult to administer to at-risk populations. Second, malaria can be prevented by eliminating the mosquito population with chemicals such as DDT. Third, chemically-treated bed nets can be used, but the \$2-\$5 nets are economically out of reach for most SSA households (Rotberg, 2007).

*Diarrheal Disease.* Diarrhea diseases are mainly spread through contaminated food or water. These diseases infect the intestinal tract, causing diarrhea. Death results because the children's bodies are weakened by a rapid loss of fluid and undernourishment (McGugh, 2001).

Common diarrheal diseases include cholera, dysentery, trachoma, schistosomiasis, typhoid fever, and rotavirus. In SSA, 30% of those with cholera died. Worldwide, approximately two million children under the age of five die from these diseases each year.

Dysentery outbreaks kill almost a million a year, with many of the deaths occurring in SSA. 600,000 children out of about 125 million die each year as a result of rotavirus. For a more detailed examination of all of the diarrheal diseases see Rotberg (2007).

*Insect-born diseases.* Rotberg (2007) identifies all of the following insect-born diseases: dengue fever, sleeping sickness, leishmaniasis, yellow fever, plague, river blindness, relapsing fever, lymphatic filariasis, and rift valley fever. Rotberg says that the best way to control these diseases is through education/prevention and insect eradication.

*Tuberculosis (TB).* TB is a disease caused by the tubercle bacillus bacterium that attacks and grows in the lungs and throat. TB is spread easily through coughing or sneezing.

About eight million people contract TB each year and about two million die from

it. The number of cases has been increasing in Africa, growing from 200,000 in 1990 to 539,000 in 2003 (Rotberg, 2007).

The spread of HIV has compounded the TB problem because weakened immune systems are unable to fight off TB. Over a half a million cases were observed in Africa in 2005 (Rotberg, 2007).

The most common and effective program for dealing with TB is DOTS (Directly Observed Treatment, Short Course), which has been about 80 percent effective in Africa. It costs about \$11 per patient for a six month treatment (McGugh (2001)).

It takes about six months of continual regiment to fight TB, which is obviously difficult in an area that has a limited to non-existent health infrastructure. Some African TB strands have also grown resistant to common TB drugs.

*Infectious Diseases.* Infectious disease refers to the diseases that have already been mentioned as a collective. Ninety percent of all infectious diseases deaths, which account for half of all deaths in developing countries, are caused by six diseases: TB, malaria, HIV/AIDS, pneumonia, diarrheal disease, and measles McGugh (2001). The collapsing public health infrastructure in SSA has made it difficult to control the spread. Rotberg (2007) explains:

The economies of many low-income African nations have declined significantly since the 1980s, depriving governments of financial resources that could be used to provide much-needed health care services or to fund education programs to slow the spread of diseases such as HIV/AIDS. Limited public health budgets have also taken a toll on the basic infrastructure to control disease: training of medical workers and volunteers, immunization programs, and medical facilities. In some cases, the lack of public health funds has forced governments that previously offered free health care to charge for such services. As a result, the extremely poor have lost access to health care entirely.

The spread of infectious diseases can occur so rapidly and have such a dramatic impact on countries that the spread of such disease are likely to trigger state collapse and civil conflict (Cheek, 2004). Travel means that these diseases could spread

very quickly (Rice, 2006). Danyo (2003) argues that there has been a resurgence of these diseases in Africa.

Garrett (2007) argues that donors "should strive to integrate their infectious-disease programs into general public health programs." One particular plan that has been popular in the past has been to have the CDC support disease surveillance in developing countries in order to monitor and prevent the outbreak of diseases (World Bank, 2004, p. 8).

*Viral hemorrhagic fevers.* Viral hemorrhagic fevers have not killed many individuals in Africa compared to those deaths caused by communicable diseases such as AIDS and TB, but they attract a lot of attention because they are highly contagious and result in a relatively quick death through high rates of excessive internal bleeding. The best known of these fevers are Ebola, Marburg, and Lassa (Rotberg, 2007). Rotberg argues that since there is no cure, the best potential solution is containment and preventative education. For a fascinating account of an Ebola outbreak, read Robert Preston's *THE HOT ZONE: A TERRIFYING STORY* (2005).

*Vaccine preventable diseases.* There are a number of diseases in Africa that are easily preventable through vaccines. These include the measles, HIV diseases, neonatal tetanus, whooping cough, diphtheria, poliomyelitis (polio), meningococcal disease, and pneumococcus diseases. There are not just economic limits to expanded vaccinations. A lack of a public health infrastructure, nomadic families, and civil unrest often make distribution difficult. Only about 35 percent of SSA children are immunized against common diseases (Rotberg 2007).

*Prenatal health care.* Garrett (2007) argues that the focus on HIV/AIDS prevention has undermined a resource focus on providing mothers with and children with basic prenatal (before birth) and postnatal (after birth) care. She explains that "HIV-positive mothers are given drugs to hold their infection at bay and prevent passage of the virus to their babies but still cannot obtain even the most rudimentary of obstetric and gynecological care or infant immunizations." HealthGap.org (2005)

explains that as a result “in sub-Saharan Africa, a woman’s lifetime risk of maternal death is 1 in 16, compared to 1 in 2,800 in rich countries.”

A lack of pre-natal care threatens child survival, and Garrett (2007) argues that a lack of such a provision of services is the leading causes of a reversal in life expectancy throughout the continent.

A basic affirmative would simply expand the provision of prenatal health care, and may even focus on expanding immunizations (McGugh (2001)). Immunization programs are usually implemented through the CDC.

### *Family Planning/Reproductive Health*

Reproductive health care encompasses everything from family planning and birth control, including the provision of abortion services, to ensuring the health of the mother and child during the pregnancy and the early life of the child. Under the Bush administration, the U.S. has eliminated financial support for health providers that offer abortion services in places like SSA. The affirmative could generally increase the availability of reproductive health services or reverse the abortion-provision constraints. The World Bank explains in 2004:

Because problems affecting maternal and child health and reproductive health are interconnected, failure to provide integrated services at the primary health care level is a major concern. In many countries family planning, maternal health, and child health programs are still provided as vertical programs. There is a need to integrate these services and to integrate reproductive health policies and strategies with social policies (p. 19).

### **Advantage Answers**

It will be difficult for the negative to refute most of the basic disease harms that affirmatives will claim. It is simply factually correct that these diseases are spreading in SSA and will likely trigger a large death toll. Negatives can attempt to minimize these harm claims by arguing that the affir-

mative statistics are exaggerated, that many different international actors are moving to address the problem, and that the terminal impact (most teams will claim total human extinction) are unlikely.

### **Solvency Answers**

Large problems are very difficult to solve. Given the size of the harms, it will come as no surprise that there are a number of reasons that solving these problems will be incredibly difficult.

Ayodele (2005), Garrett (2007), and CATO (2004), argue that corruption means that the assistance is never distributed. Garrett (2007) argues that an injection of foreign funds can undermine the development of local, self-supporting health care infrastructures and that individuals working for foreign aids groups often make salaries that are substantially higher than those of the locals, driving up the price of goods so far that it places them out of reach for the poorest individuals. Easterly (2005) argues that many people do not even take advantage of available public health services, relying on folk remedies. He also claims that as many as 30% of the drugs destined for African countries simply disappear. He notes that, “According to a survey in one district in Zimbabwe, pregnant women were reluctant to use public health clinics to give birth because nurses ridiculed them for not having better baby clothes, forced them to wash bed linens soon after delivery or even hit them during delivery.” Easterly (2006) argues that one fundamental problem with foreign aid programs is that they are designed by utopian “Planners” who try to devise grand solutions to problems without local input. Garrett (2007) argues that this is true in the provision of public health assistance where “(v)irtually no provisions exist to allow the world’s poor to say what they want, decide which projects serve their needs, or adopt local innovations. And nearly all programs lack exit strategies or safeguards against the dependency of local governments.”

Garrett (2007) argues that focusing on AIDS prevention trades-off with the

provision of basic health services necessary to fight disease, and that “normal means”<sup>14</sup> implementation will focus on abstinence rather than more effective condom distribution and needle exchange programs. HealthGap (2005) and others cited in the affirmative plan section argue that SSA lacks the public health infrastructure necessary to deliver more public health services. Affirmatives that seek to deliver more services but do not develop more health infrastructure will have limited solvency. The GAO (2004) argues that U.S. programs tend to simply crowd-out the programs of other donors such as WHO, the World Bank, and UNICEF. Highly-visible HIV/ADS programs also tend to crowd-out the provision of basic health services (McGugh, 2001). Cook (2006) notes “there are multiple social barriers to a more effective AIDS response in Africa, such as cultural norms that make it difficult for many government, religious, and community leaders to acknowledge or discuss sexual matters, including sex practices, prostitution, and the use of condoms.”

Wynn (2004) argues that the provision of bed nets may actually reduce immunity of younger children, increasing the susceptibility of older children and that no studies confirm that DOTS programs are effective. Abdullah (2001) also criticizes the bed nets approach.

As strong as all of these solvency arguments seem, there are good answers to them. Nancy Birdsall, the President of the Center for Global development, argues in her 2004 book, *MILLIONS SAVED: PROVEN SUCCESSES IN GLOBAL HEALTH*, that public health assistance is effective. Jeffrey Sachs (2005) argues that corruption is not inevitable and that governance can be improved.

### **Disadvantages**

*Spending.* It is costly to solve large problems. HealthGap.org (2005) argues that improving the health infrastructures of developing countries will cost \$2 billion annually. Garrett (2007) argues that HIV/AIDS

<sup>14</sup> Most affirmative plans give little thought to implementation, claiming that it will simply occur through “normal means.”

prevention in SSA will cost \$20 billion and that providing ARVs will cost \$50 billion.

Spending disadvantages come in two basic forms. One, teams can argue that the plan will undermine principals of fiscal restraint, threatening compromises necessary to reduce the budget deficit. Large deficits could scare investors or generally threaten the economy. Two, teams may argue that the plan trades-off with spending on other foreign aid programs and that these programs are good.

*Structural Adjustment Good.* Structural Adjustment Programs (SAPs) are designed to facilitate free market reforms in developing countries by reducing the role and size of the public, governmental sector. Vazquez (2005) argues that expanding the public health sector undermines these reforms.

Negative teams that wish to run this disadvantage should be forewarned that this will be a hard argument to win. Most of the evidence indicates that pushing these free market reforms is what has left little money available to tackle the health crisis in Africa.

*Politics.* While the Bush administration clearly supports the provision of public health assistance to Africa (Bush even had a short line in the State of the Union address about it), most plans that would substantially scale-up the provision of funds and resources would be politically unpopular in this new era of fiscal restraint. More “liberal” programs that remove things such as the abstinence requirement for HIV/AIDS prevention programs will be particularly unpopular.

Unlike most of the affirmatives on this year’s national service topic, affirmatives on the SSA topic will have very large impacts, many of which can outweigh disadvantages or access their impacts (such as economic downturn). The strategic upside for the negative is that most disadvantage impacts will also trigger the affirmative advantage impacts and make solvency for public health nearly impossible. McGugh (2001) explains:

Developing countries are doubly handicapped in addressing infectious dis-

ease outbreaks. Many infectious diseases are endemic to the tropical areas where most developing countries are located. Because of poverty, the health and sanitation infrastructure is poorly equipped to address local health needs. WHO studies indicate that infectious disease is spreading most rapidly in areas of conflict or political crisis.

*China.* A lot of recent evidence indicates that China is building ties with African states to secure resources and prestige (Brookes, 2006). There are at least two different impact scenarios that the negative could read. First, the negative could argue that if China loses influence in Africa due to increased U.S. influence that China will no longer think they can stop Taiwanese independence because they use Africa ties to fight-off Chinese moves for independence (Brookes, 2006). A perception of Taiwanese independence could trigger a Chinese invasion of Taiwan. Second, an increase in U.S. “soft power” could undermine China’s soft power. If China loses its soft power, it could resort to more “hard,” military forms of power.

*Malthus.* The Malthus disadvantage, named after biologist Thomas Malthus, who warned that population growth would outstrip food supply, argues that saving lives is bad because a “death check” is needed to avoid an overshoot of the earth’s carrying capacity – the number of people that the earth’s environment can support. To begin your research, see Abernathy (1993, Brown (2006), Hardin (1991), Tobias (1998).

## Counterplans

Affirmatives will have to defend having the U.S. increase its “public health” assistance to SSA. This sets-up a number of strong negative counterplans.

*Foreign actors.* Instead of having the U.S. increase its public health assistance to SSA, the negative can argue that another foreign actor such as the EU (European Union),<sup>15</sup> Japan, the World Bank, or the WHO should do it. For example, HealthGap.org (2005) argues that the World Health Organization (WHO) should take ef-

forts to improve SSA’s health infrastructure.

There is very limited evidence that articulates strong reasons why U.S. action is uniquely necessary to avoid the harms. Much of the literature that I have cited in the bibliography simply speaks for the need for “donors” to act, and it often lists actors other than the United States. The negative will likely be able to win that the counterplan solves an overwhelming amount of most of the affirmative advantages.

*Country exclusion.* If the negative can win that the affirmative has to provide the assistance through foreign country governments, they can counterplan to deliver the aid directly. Easterly (2006) advocates this approach. Negatives can claim corruption net-benefits and argue that that approach is more politically popular.

*NGOs.* NGOs are non-governmental organizations. They are also “foreign actors,” but are not governmental entities, so they are considered in a separate category. These private actors mobilized efforts to raise funds and provide services to countries in need. Garrett (2007) claims that there are now more than 60,000 AIDS-related NGOs alone.

One problem with relying on NGOs alone is that NGOs lack necessary coordination. Garrett (2007) explains:

Thanks to their efforts, there are now billions of dollars being made available for health spending — and thousands of nongovernmental organizations (NGOs) and humanitarian groups vying to spend it. But much more than money is required. It takes states, health-care systems.

*SSA PICS.* If the affirmative argues that assistance should be provided to the entire region of SSA, the negative could counterplan to exclude a particular country that may have a widespread corruption problem or that is politically unpopular to aid. Given that there are 42 countries in SSA, it will be difficult for the affirmative to be prepared to debate all of these country PICS, particularly at the beginning of the year.

<sup>15</sup> See European Health Alliance. <http://www.eph.org/a/2252>

*Conditional funding.* The plan's funding could be conditioned on program implementation and progress in meeting targets. This is advocated by Wynn (2004).

*Consultation.* The U.S. may want to consult other actors, particularly the EU and China, before it begins a large public health campaign. Consultation counterplans have been very popular on international topics and are likely to be popular on the Africa topic.

*Term exclusion counterplans.* It may be possible for the negative to generate kritiks of the terms "public health assistance" and "Sub-Saharan Africa." If so, the negative could counterplan not to use either one of those terms, simply calling what is provided "assistance" or individually listing all of the countries in SSA.

*Other process counterplans* Counterplan competition standards, particularly at the national circuit level of high school debate, have become incredibly lax. I think the negative can easily get away with counterplanning to change the "normal" means process of foreign aid implementation. If they negative does, as I suspect they will, then all the literature about how to improve foreign aid generally becomes fair game for the negative.

## Kritiks

*Biopower/Foucault.* This critique is popular on every topic, but it links particularly well on a topic that expands the role of public health services! For a specific focus on public health and biopower see Beaglehole (1997), Lupton (1995), and Porter (1994).

*Compassion Fatigue.* Compassion Fatigue is based on a book by Susan Montague (1995). In the book she argues that the continual display of suffering creates a "compassion fatigue" that reduces the willingness of people and their governments to aid other countries.

*Disaster Porn.* The disaster pornography critique argues that it is bad to constantly display images of suffering.

*Population Health.* The provision of public health assistance generally fo-

cuses on improving the health of an individual through direct medical interventions such as ARVs. Critics, however, argue that such solutions ignore the environmental factors that contributed to the decline in the person's health in the first place. And, similar to the Malthus argument, ignores the environmental impact that a given individual will have as a result of a longer lifespan. Rainham (2005) explains:

The attractiveness of population health is that it shifted the discourse away from individual health toward examining health as an ecological characteristic of populations; it helped us to identify, promote, and intervene with forces that operate beyond the level of the individual. Ultimately, population health concepts help to complete the causal picture of the full range of factors that influence health. However, as has been shown here, the discourse of population health must also recognize and integrate an assessment of its sustainability. Our analysis reveals that current trends in improvements to prosperity and population health are associated with the unsustainable appropriation of resources and declines in global biodiversity. It has also demonstrated strong associations among the ecological footprint, wealth, and health-adjusted life expectancy. For example, each unit increase in 10 per capita GDP corresponds to another 20.2 years of health-adjusted life expectancy. However, the logarithmic relation shows this to be a relationship of diminishing returns, while the growing GDP consumes ever more ecological resources. The ecological footprint (as well as declines in planetary biodiversity) is also strongly related to improvements in life expectancy and with declines in infant mortality. So we have a dilemma: growing wealth supports improved health (on average), but implies exponentially greater con-

sumption of resources. It is uncertain as to how much of the relation between wealth and health is predicated on the unsustainable appropriation of Earth's biological capacity. Our analysis addresses important questions concerning the articulation of population health determinants, including the following issues. First, many countries with the best population health are the most dependent on external resources and the least sustainable. The shape of the curve indicates a slight decline in health status associated with extension along the flat of the curve. Countries such as the United States, Singapore, and the United Arab Emirates, for example, have lower life expectancies than countries like Japan or Iceland which require only half the amount of per capita bioproductive land to maintain their standard of living. Perhaps this reflects the development of diseases of over-consumption—diabetes, obesity, and cardiovascular disease.

*Disease Kritiks.* There are a variety of kritiks of the concept of "disease." One argument is that the construction of disease as a random event that attacks individuals masks socio-economic power differentials that are actually responsible for differences in health. Specifically, the Western medical "germ" theory of disease has historically been used to legitimize oppression of the poor. The public health focus on reducing exposure to dangerous microbes masks the contribution of social inequalities to health problems. Another argument is that the term "disease" is discursively objectionable.

Some have argued that the term has historically been applied to disfavored groups - being "Jewish" was constructed as a disease. The Nazis in particular embraced disease rhetoric to justify the extermination of Jews. To begin your research, see Barrett (1998), Bury (1998), Farmer (1996), Gilman (1995), Hays (1998), Herzlich

(1997), Hudson (1983), and Levinson (1998).

*Development.* This kritik argues that the whole idea of “development” is based on Western notions of the values of a modernized life. These critics argue that imposing this development model on others is racist and that development produces many problems. See Center For Global Development (2006) for a further elaboration of the argument.

*Globalization.* There are many different definitions of the term “globalization,” but it generally refers to the growing interconnectedness of the planet through economic integration. Negative teams can argue that by providing foreign assistance the affirmative supports such a trend, but that such trends have a negative impact on the developing world’s health. Labonte & Schrocker explain in 2004:

NEPAD (New Partnership for Africa’s Development) was created largely for G8 and other industrialized world audience and despite its ‘made in Africa’ branding, critics argue that it exemplifies the problems of shaping development policy around external expectations of how poorer nations should ‘develop’ with an increasingly globalized market. NEPAD therefore reflects the tensions between neoliberal economic policy assumptions and health and human development identified in earlier chapters (p. xxi)

For a defense of Globalization, see Bhagwati (2004).

*Statism.* Increasing the size of the public health sector obviously expands the role of the state. Bok (2004) argues that defining “health” broadly to include all aspects of “well-being” further expands the intervention and role of the state.

*Imperialism.* Expanding any form of Western intervention into Africa is arguably imperialist. This kritik was run extensively on the peacekeeping topic, and it has been run frequently against Peace Corps affirmatives on the national service

topic.

*Terminology.* As mentioned, it may be possible to find kritiks of popular terms such as “public health assistance” and “Sub-Saharan Africa.” Garrett (2000) argues that the use of the term pandemic is bad because it breeds fear which makes it even more difficult to control disease outbreaks.

## Being Affirmative

There are a number of things that you need to consider when choosing an affirmative and preparing for your first debates.

*The harm is not the issue.* It will be easy for you to find harm evidence, particularly if you choose to focus on a problem like HIV/AIDS or general disease surveillance. It will be difficult if not impossible for the negative to win any substantial harm reduction. No matter what affirmative you pick, you will be able to prove a substantial harm.

*You have to defend U.S. action in light of all of the disadvantages to the U.S. acting.* This will be the most difficult hurdle for the affirmative to handle. If I were debating next year, I’d find a problem where I could prove that the U.S. had a substantially unique capability and build the affirmative around that.

Carefully choose your rhetoric and presentation. You cannot get out of all kritik links. You can, however, minimize the links and debate the kritiks you want by minimizing links to kritiks like disaster porn by avoiding particularly troubling descriptions of the problem and Africa. You can also avoid kritiks of “development” by not claiming those advantages. You need to be careful about your claims and be prepared to defend them.

## Being Negative

*Counterplan.* At best you will be able to minimally reduce the harms. In order to outweigh these big impacts, you should counterplan to solve them through other means. Since the counterplans are strong, I think you should be able to win many debates with them.

*Attack the solvency.* There is good literature cited throughout this essay that identifies substantial solvency problems with many of these affirmatives. In areas

of the country where counterplans are less well-received, you can probably win a lot of debates with these solvency attacks.

*Develop Disadvantages.* I’d develop a few disadvantages that are unique to U.S. action, such as spending, politics, and China. You can either extend these as net-benefits to an agent counterplan or use them in combination with your solvency arguments to outweigh the affirmative case.

*Develop a kritik.* Even if you do not want to run kritiks, you need to learn how to debate them. And, many of the kritiks are strong.

*Strategically employ topicality arguments.* In order to focus the debate on what you are prepared to engage in, limit the affirmative to the provision of medical services and to providing assistance to/through governments in SSA.

## Conclusion

I think that this is one of the better high school debate topics in recent years. The resolution is well-worded and it accesses a very interesting debate about public health care in SSA. Affirmatives have the strategic advantage of claiming big impacts, but are will struggle to defend U.S. action against other potential actors and to present their case in a less-kritikable manner. We should have some interesting debates in 2007-08.

## Reading Highlights

It may be the case that you will not have time to read all of the items listed in this bibliography. If your time and resources are limited, I do suggest a few key volumes. First, Rothbert’s AFRICA: PROGRESS & PROBLEMS—AIDS AND HEALTH ISSUES (2007) outlines all of the major health problems facing Africa and is full of well-written, recent evidence. Cook’s (2006) Congressional Research Service report outlines many of the programs that the U.S. has in place to deal with the health problems in Sub-Saharan Africa, and Garrett’s (2007) article in FOREIGN AFFAIRS outlines many of the issues that governments wishing to increase public health assistance to the developing world must encounter. Even if you have time to read everything referenced in the bibliography, I’d start with those.

## Countries that Make Up Sub-Saharan Africa

Angola  
 Benin  
 Botswana  
 Burkina Faso  
 Burundi  
 Cameroon  
 Cape Verde  
 Central African Republic  
 Chad  
 Cote d' Ivoire (Ivory Coast)  
 Democratic Republic of Congo  
 Djibouti  
 Equatorial Guinea  
 Eritrea  
 Ethiopia  
 Gabon  
 Gambia  
 Ghana  
 Guinea  
 Guinea-Bissau  
 Cape Verde  
 Comoros  
 Kenya  
 Lesotho  
 Liberia  
 Madagascar  
 Malawai  
 Mali  
 Mauritania  
 Mauritius  
 Mayotte (France)  
 Mozambique  
 Namibia  
 Niger  
 Nigeria  
 Republic of Congo  
 Reunion (France)  
 Rwanda  
 Sao Tome and Principe  
 Senegal  
 Sevechelles  
 Sierra Leone  
 Somalia (including Somiland)  
 South Africa  
 Togo  
 Uganda  
 Tanzania  
 Zambia  
 Zimbabwe

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## Scholarly Journals

- African Health Sciences  
African Journal of AIDS Research  
African Journal of Reproductive Health  
AIDS  
AIDS Education & Prevention  
Bulletin of the World Health Organization  
European Journal of Public Health  
Family Planning Perspectives  
Globalization & Health — <http://www.globalizationandhealth.com/>  
Health Policy & Planning  
International Journal of Tuberculosis and Lung Disease  
Population Bulletin

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