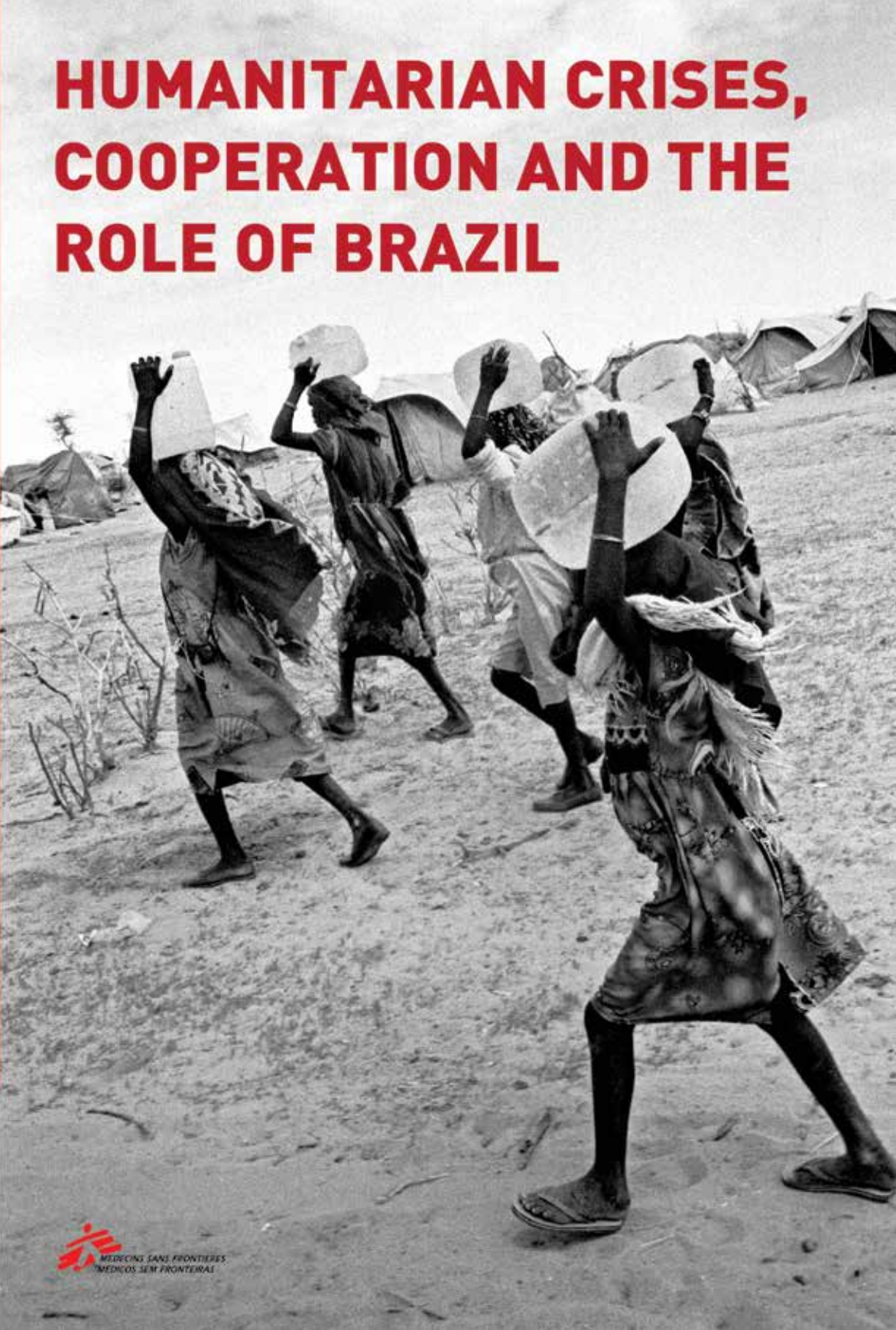
HUMANITARIAN CRISES, COOPERATION AND THE ROLE OF BRAZIL



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SUMMARY

Ebola exposed the failure of state-building programmes

Deisy Ventura

Deisy Ventura is a professor at the Institute of International Relations and the School of Public Health at the University of São Paulo (USP). She dedicates her work to the study of what people have been referring to as "global health" since the 1990s – that is, the idea that any health event could be a potential threat to the world population and the national security of the richest countries. She focuses on the securitization of international responses to health emergencies and the impacts of this approach. In this interview, Deisy Ventura discusses her research on the United Nations' response to the Ebola epidemic in West Africa in 2014 and compares it to the reaction to the Zika outbreak in Brazil. One of the differences is the absence of healthcare systems with a minimum of structure in Africa, despite the presence of multilateral organizations dedicated to "state-building" in post-conflict or catastrophe periods in the region.

In the first article of this publication, MSF expresses two concerns: one with the intersection between development aid and humanitarian aid, and the other, with the impact anti-terror laws may have on humanitarian organizations' access to populations in need. In your research on Ebola, have you noted any influence of these factors?

In relation to Ebola, it is worth noting that the one who was capable of identifying the extent of what was happening in West Africa, had the largest team in the region and actually succeeded in responding to the crisis was MSF.

The United Nations already had special missions in Sierra Leone and Liberia. It is incredible that the UN Integrated Peacebuilding Office in Sierra Leone (UNIPSIL) closed its doors on March 31st 2014, a few months before the onset of the epidemic, whereas the UN Mission in Liberia (UNMIL) that has existed since 2003 remains active until today. How does one explain that in a territory where United Nations missions were underway, the health conditions, the organizational capacity and the capacity to respond to a health crisis were as precarious as they were there?

What I mean by this is that the current international response that is supposed to strengthen state and their structural elements in that region is a total failure. In the case of emergencies such as the Ebola crisis, the UN missions in the region have been incapable of stopping them from reaching such large proportions and of formulating adequate responses given the seriousness of the situation. In the case of Ebola, once it was recognized that there was an emergency, it was decided that a new mission had to be created. Announced on September 18th 2014, the UN Mission for Ebola Emergency Response (UNMEER) was the first United Nations mission created for health reasons. It was presented as a *sui generis* mission and concentrated the whole international response to the Ebola crisis under the United Nations Secretary General in the form of a special envoy that coordinated fundraising and the provision of aid on site.

It is not that the UN Security Council had never dealt with health issues or emergencies before. The HIV/AIDS issue, for example, has appeared several times in Security Council resolutions. However, according to the UN Secretary-General himself, it was the first time that the UN had created a health mission to respond to an emergency. What was the significance of this? First, it relegated the World Health Organization (WHO) to a secondary role, when the WHO is the only international

organization whose raison d'être and logic are rooted in public health. The mandate of the Security Council is to maintain international peace and security. This was, then, a very important shift. It is important to note that it was not the Security Council that created this mission; it was the Secretary-General, but with the approval of both this organ and the UN General Assembly.

With this, a new phenomenon in international relations emerged. An international health crisis triggered a response from the United Nations Secretary General and a UN mission was created with the blessing of the Security Council, which began to provide this kind of international response. Contrary to previous international health emergencies, such as the H1N1 flu in 2009 and 2010 and the resurgence of polio since 2014, this time, it was not the WHO that guided the response based on International Health Regulations (IHR). This is one aspect that seems extremely important to me.

What was done essentially? When this mission began to operate in West Africa, it was announced that 3,000 US marines would be sent to the region. Thus, the response was one of militarization and contention. I am not saying that this was not necessary at the time. What happened later is that when the end of this mission was announced in August 2015, we went back to square one. We do not know what was left by this experience. What was the significance of this first international health mission?

There is currently one development that I find enormously unsettling. The responses to international health crises have begun to be coordinated by UN missions that are accumulating a history of extraordinary failure in relation to the objectives of development and state-building. And the best example of this is the missions set up in the Ebola-affected regions in West Africa that were incapable of preventing what happened.

And why were they incapable of this? When we talk about epidemics, what I consider an emergency is quite different from what the international community considers an emergency. For example, when the International Health Regulations were adopted in 2005 (but came into effect in 2007), a legal category called "a public health emergency of international concern" was created. This category has been used four times up until now: for the H1N1 flue; the return of the poliovirus, especially in regions with armed conflicts because it becomes impossible to vaccinate people; Ebola; and the association between the Zika virus and microcephaly and/or alterations to the central nervous system.

And what are the specificities of this category?

One very revealing detail of the process of implementing the Health Regulations in relation to public health emergencies of international concern is that the emergency related to the Zika virus fever was decreed not because of the disease itself, but because of its association with microcephaly and/or alterations to the central nervous system. If someone asks me what the current public health emergencies are here in Latin America, I would say, for example, dengue, chikungunya or Zika. For me, the fact is that some endemic diseases – the so-called neglected diseases – constitute enormous health emergencies. They are diseases that appear where poverty exists, but that also keep people in poverty, as they limit the ability to work and to enjoy life of those who contract them.

However, the criteria the international community developed for identifying public health emergencies of international concern are quite different from those used in the field of public health and by independent NGOs such as MSF or academics. Therefore, different criteria and different responses mix to form a broth in which health acts as a pivot in the unravelling of the security

ideology that has prevailed mainly since the September 11 attacks in New York. Based on my research, it is obvious that this security-focused vision can be applied to absolutely everything, including public health.

If we analyze recent literature on Ebola, we will note that there has been a change of course since late 2014 and that there is now a specific sub-area in health studies on "global health security". There is a set of dossiers, articles, proposals of reforms for institutions, namely the World Health Organization, and an agenda on this. But if we ask MSF how the organization sees global health security, its response will certainly be different from the one from the United States, which is driving the global health security agenda.

From my point of view, the major difference between these views resides in what I call a "totalitarian utopia": the idea that the developed world is capable of keeping these diseases in places that they should never have left. The global health security ideology establishes the capacity to detect an emergency or risks as the main element of the global health security approach and this leads to the focus being on surveillance systems. It appears to me, however, that real security can only be guaranteed by focusing on national health systems and universal and free access to healthcare. To contest this idea of surveillance-based security, we need to defend systems with free access in which health is treated as a right.

Currently, we are seeing the exact opposite. Systems that were once considered references, such as the British or Brazilian systems, are in the process of being destroyed. These are truly difficult times. If we compare the response to Ebola with the one to Zika, we see that in the latter, neither the World Health Organization nor the Brazilian state was removed from their functions. 3,000 marines were not sent to Brazil on a UN health mission.

Why was the response here different? Obviously, the country's level of development is different from that of the countries hit the hardest by the Ebola epidemic, even though Brazil is not a developed country. But the main difference is the existence of a healthcare system with facilities set up all over the country and universal access. Thus, the radical difference between the response to Ebola and the one to Zika is not only the number of cases or deaths. If we did not have the Unified Health System (SUS, for its acronym in Portuguese), it would be impossible to predict what the statistical results would have been. But we did have the SUS, the Olympics...

We also had research institutions, such as Fiocruz...

In Brazil, there is a scientific community that can prove the relation between the Zika virus and microcephaly and the alterations to infants' central nervous systems, but the ones who detected the virus were "bedside" doctors. In her recent book *Zika: do Sertão Nordestino à Ameaça Global* (Zika: from the Northeastern Interior to a Global Threat), Debora Diniz shows how the first cases were discovered. She overturns the idea of the medical community in the Southeast being the protagonist and demonstrates that it was the bedside doctors in the universal healthcare system that made this association. And Brazil had the capacity to manage this response.

There was another important factor. In November 2015, Brazil declared a national health emergency. Later, in February, the WHO declared an emergency of international concern. But the fact that we had a public healthcare system is the element that separates what is humanitarianism – that is, emergency responses to guarantee people's survival – from what is structural. If national healthcare systems with adequate operational conditions exist, we can put humanitarian workers where they really aim to be, which is responding to emergencies, the unpredictable. I

imagine that this is where humanitarianism dreams of being, and not responding to needs that are structural.

You said that development aid projects did not enable the countries affected by Ebola the most – Sierra Leone, Liberia, Guinea – to establish a health system that is at least capable of taking the first steps to control the epidemic, even if help will be needed later on. Why is this?

While the international community was proclaiming that development aid would be able to establish the rule of law, generalize democracy and strengthen the economies and the political and social organization of these territories, it must be recognized that international financial institutions were promoting the dismantlement of sectors of the state through their famous recipes for reform and good governance. There is a common idea that these countries have never had a public health structure, but that is not true. Healthcare systems did exist, even if conditions were precarious. Recent studies show that the structural adjustment policies of the International Monetary Fund (IMF) played a decisive role in the lack of personnel and unpreparedness in the healthcare systems in West Africa. In Sierra Leone in the 1990s, for example, World Bank consultants succeeded in having more than 5,000 hospital employees fired and reducing the Ministry of Health payroll by two thirds in three years. According to the WHO, the result of this was that prior to the epidemic, Sierra Leone only had 0.2 doctors for every 10,000 inhabitants, whereas Liberia had 0.1.

Therefore, the Ebola epidemic clearly reveals not only the failure of international development cooperation, but also the contradiction between what was being promoted in the development arena and the demands being made in the area of financial aid. It seems to me that we must find ways to hold the international organizations that contributed not to the

strengthening, but to the weakening of these healthcare systems accountable.

The idea that there can be health security without universal national healthcare systems is false. Yet, we can observe today the alignment of pressures to implement an efficient surveillance system, universal health coverage rooted essentially in the private health insurance market and the internationalization of the health market. I believe that the developed world imagines that with this, diseases will be restricted to the poor and the rich will be protected. What is more, they will gain access to a market with an incredible scope. The problem is that this does not and will not work.

Did the Brazilian government play an active role in the response to Ebola?

Brazil did not exercise leadership in this crisis, even though it sent donations. There was essentially one international response led by the United States and the UN. The resolution on UNMEER was unanimously approved in the UN Security Council. At the time, it would have been hard for someone not to agree. I think Cuba was the state that stood out the most for its individual response. Often perceived negatively in international relations, it was one of the only countries that had the capacity to immediately send health professionals to West Africa and it was successful in doing this.

Can you explain how the International Health Regulations work?

The regulations exist since 1951 and until 2005, they gave priority to international cooperation efforts to fight specific diseases. In 2005, mainly due to the influence of September 11th, the envelopes sent with anthrax and the fear of attacks with biological

weapons or bioterrorism, the category that I mentioned – public health emergency of international concern – was created. Instead of fighting a specific disease, the combat targets something the WHO defines as a threat. The moment this kind of emergency is declared, a series of practical recommendations is released for different actors to follow, particularly governments and the transportation sector. With this approach, more than 1 million cases of dengue in six months are not considered an emergency. An intervention is urgent if its motive is to preserve security in the developed world.

Based on your research on the international reaction to the Ebola epidemic, what suggestions can you make for a Brazilian humanitarian aid policy?

Right now, it is difficult to discuss Brazilian foreign policy and the possibility of Brazil playing a role on international issues, including humanitarian ones. Since late 2015, we have been seeing the government coalition at the federal level fall apart. Once a confrontation between interests and proposals, even antagonistic ones, erupted within the federal government, it became difficult to imagine that any policy would be consolidated, including foreign policy.

During both of Dilma Rousseff's mandates, we saw international issues losing ground and Brazil's lack of commitment to its contributions to the budgets of international organizations. Thus, it was hard to believe that Brazil would adopt a strong foreign policy, or even maintain the Lula administration's foreign policy direction. In relation to this direction, while there were inconsistencies between Brazil's discourse and some of its actual practices, it is important to note that there was clearly an ideology and an agenda to follow. With Dilma, then, we could at least demand coherency in relation to the so-called political spectrum to which she belonged. Now, I do not see any interlo-

cutor in the government with whom we could debate the issues that MSF is raising. It appears as if alignment with the developed world is a value in itself. Brazil will probably stop appearing on the international stage as an actor that questions global governance.