


### Paradoxes and contradictions in health under the effect of global pressures: the case of the Portugal-Brazil-Africa geopolitical space

Paradojas y contradicciones en la salud bajo la influencia de las presiones globales: el caso del espacio geopolítico Portugal-Brasil-África

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The Brazilian National Health System, known as SUS, is a social and development project in Brazil. For the first time, in 1988, the Brazilian Constitution recognised the right to health as a social right and a state duty (Article 196), via economic and social policies that were supposed to guarantee free, universal access. As Brazil is so much larger than Portugal, the decentralisation of SUS enabled municipal, state and federal-level management, in order to protect the country's economic, social and health diversities. It is the municipalities, above all, that make the most important decisions on the management of people's health. This brief description shows a health system that faces very complex, very different realities. But what I wanted to show you is that it is at the national level that Portugal and Brazil face governance and regulation challenges under the effects of supranational and transnational determinants.

Let's look at this aspect. With fragmented and dispersed prior experiences, since the 1940s and 1950s the globalisation of health has gained strength and become divided between north and south on the basis of global management guidelines, recommendations and directives from international bodies in America and Europe (WHO, UNO, WB, WTO, IMF, ILO,

to name only the most important). They have been the dominant players in defining and implementing global health strategies that involve ways of organising the health of populations in regions of the world that are extremely different from each other, not only in geographical terms but especially in terms of their structural position in the globalisation processes.

The so-called north-south cooperation in health has abided by the dominant forms of hegemonic globalisation that are linked to capitalism and global governance. They contain social processes through which the borders of sovereign states are weakened when exposed to global impacts on social and cultural processes of local health governance<sup>1</sup> (p. 9). This has forced the decline or erosion of the sovereignty of national states, compressed space and time and intensified the interdependence and interconnections of social health relations at the global level<sup>2</sup> (p. 51). The distinction between global and local is getting more complex and problematic, because the domination of global over local does not work without possibilities of more or less organised resistance or stronger or weaker resilience of local over global, so that different forms of localised globalisms emerge<sup>3</sup> (p. 297). This is the case of Portugal and Brazil, where, as we have seen, we recognise the influences of central, northern-hemisphere countries in the similarity of their national health projects but see a mixture of aspects of their differences from semi-peripheral countries, in the northern hemisphere in Portugal's case and in the southern hemisphere in the case of Brazil. What aspects express these differences?

As hegemonic globalisation is not homogeneous, it contains other forms of globalisation that may increase the pressures and tensions caused by the effects of global health (for Portugal, this is the case of supranational determinants for health coming from the European Union, and for Brazil, they come from Mercosur). It can also have effects that are presented as potentially emancipating and counter-hegemonic (i.e. with proposed alternative agendas to north-south globalisation) but eventually reproduce the processes and mechanisms of global powers. This is the case of BRIC (Brazil, Russia, India and China), whose countries want to be partners with more powerful countries and continue to follow the global capitalism model, based no longer on the United States, but on the development logic of countries considered emerging powers (which explains, for example, the idea of the creation of Banco do Sul in Brazil, which was to be an alternative to the World Bank).

This framework is important in making a more precise determination of Portugal's and Brazil's position in the political context of global health governance, not only in vertical north-south cooperation, but, more important to this analysis, also in horizontal south-south cooperation. This means extending the Portugal-Brazil axis to Africa so that we can move from a central axis of the global economy to a peripheral or excluded axis of this economy, where health disparities explode in all directions. Such disparities are not limited to the "old health problems" of AIDS, malaria or tuberculosis, but bear the so-called "double burden of disease": epidemics that emerge and re-emerge (such as Ebola), cardiovascular diseases, diabetes, obesity, cancer and mental illness, as well as diseases resulting from climate change in contexts of poverty, hunger and malnutrition, infant and maternal mortality, low life expectancy at birth, without the ability to respond to health needs because the health services are fragile

and human resources are scarce and badly paid, with huge gaps in scientific and technical training.

Let us look at the machine that makes these geopolitical strategies operate. The south that we are talking about is not the geographical south. It is a geopolitical south, an epistemic south that includes health territories governed by players and institutions that coincide politically and ideologically with those that have engraved their traditional globalising logic of development on multilateral cooperation for health. But there are also other global players that reproduce this logic in the south, either from Brazil, in the cooperation established with the countries of South America (UNASUL Saúde) and the Pan American Health Organisation (OPAS), or from Brazil's and Portugal's joint cooperation, organised by CPLP (Community of Portuguese-speaking Countries), with the creation of the Strategic Plan for Cooperation in Health, in 1996, involving Brazil in the Americas, Portugal in Europe, East Timor in Asia, and five countries in Africa (Angola, Mozambique, Guinea-Bissau, Cape Verde and São Tomé and Príncipe).

Drawing the political and administrative contours of these two cooperations would mean describing tangled networks of international bodies that would involve not only regions and countries in the south but also regions and countries in the north, in a tight web of interests tied up in their relations of global and local interdependence between political plans, technical goals and forms of action in the field. This would involve an endless production of reports, full of nomenclatures and abstract models that make it difficult to understand what has been done and what targets have been achieved - targets set and reset in agreements, consensuses and treaties, during interminable meetings held all over the world between international political leaders and their technical entourages... Above all, this would be far away from the knowledge of the territories involved, their local populations, their living conditions, their representations of the world and nature, their cultures and knowledge of healing. This detachment and aloofness is so outrageous for anyone accepting a political health-related position that:

A former Minister of Health of Mozambique, while examining the cooperation processes in his country, once said: When I was appointed minister, I thought I was the Minister of Health and, therefore, responsible for the health of the country. Instead, I found I was the minister for health projects run by foreigners<sup>4</sup>. (p. 87)

But what ideas move this cooperation machine?

There are many intertwined concepts in the field of health cooperation that are used to justify the forms of cooperation introduced. The most common are “international health”, “diplomacy in health”<sup>5,6</sup> and “global health”.

The concept of “international health” was coined in 1913 by the Rockefeller Foundation, though its roots date back to the 19th century and the first attempts at international cooperation for the control and prevention of infectious diseases, especially those spread by maritime travel, for the protection of the interests of health and trade. This programme continued in the 20th century and measures extended to the fight against malnutrition, maternal and infant mortality and technical assistance,

mainly in the so-called underdeveloped countries<sup>7</sup>, based on medical and biological theories and assistance relationships<sup>8</sup>. Therefore, it is also a 20th century concept that contains naturalised visions of the differential power between rich and poor countries and unequal development, which legitimise the ranking of the countries that help and the countries that are helped, according to the most common terms of “international aid”:

most initiatives in international health are not shared between ‘equivalent’ nations; they reflect the international political and economic order, in which international ‘assistance’ is ‘provided’ by rich and industrialized nations and ‘received’ by poor and underdeveloped countries. [...] The international assistance reflects geopolitical relations and replicates inequalities in power and resources<sup>9</sup>. (p. 62-3)

“Diplomacy of health” reflects the idea that the factors of health that go beyond national borders and are more subject to global influences could be better coordinated if health matters were linked to diplomatic relations. This is the proposal of a protectionist, condescending vision that is based on the reproduction of the unequal model of relationships of force that only protects those who are already protected and does not protect the most vulnerable.

The concepts and ideas underlying health cooperation carry historical and ideological baggage that the idea of global health cannot overcome; for one thing, because there is no consensus on what global health is. There is not a single definition that describes it and there will never be, because its field of action has fuzzy limits that are sometimes highly unlimited. We are not on the merely technical and diplomatic planes of aid-based practice for the poor, but in a giant arena of power that has converted the purposes of cooperation into the purposes of economic, political, cognitive and ethical domination, in which there is no place for local choices of resources, knowledge or health policies and systems that adapt to variable cultural standards in the territories receiving aid.

On this subject, the case of the Brazilian technical health cooperation with Mozambique (2000 to 2014) is paradigmatic as an instrument for analysing south-south cooperation. Mozambique is Brazil’s largest partner in numbers of projects and resources. This cooperation used the typical model of a developing country, and, with Mozambique, Brazil reversed its historical role, from a recipient of cooperation to a provider, along the lines of development of global governance to improve health systems, by means of a triangulation with WHO and its inter-American agency (Pan American Health Organization).

The official Brazilian line to justify technical cooperation for Africa focuses not only on its “historical debt” because of slavery and solidarity as a principle of Brazil’s foreign policy, but also on a supposed “common past” fostering historical and cultural affinities and “common problems”. Indeed, there are similarities and affinities between the Brazilians and many Africans, and the Mozambicans were aware of it. Nonetheless, we cannot ignore the cultural differences between African countries and between them and Brazil. The



discourse of Africa as a monolithic unit is criticised, as it does not correspond to the continent's absolutely plural political and socio-cultural reality<sup>10</sup>. (p. 2272)

In an analysis of the perceived obstacles and difficulties of this cooperation, most discourses vary between the accountability of African countries, Africans and their political instability, and the excessive centralisation of decisions by the national government that runs the cooperation. But a critical assessment is still being made of the interests in a cooperation process like this. It is hard to work in a network with people who have different training and knowledge. Implementers of projects are not comfortable when coming up against unfamiliar cultures. The management of information is difficult and full of shortcomings and most communication is by virtual channels, which prevents the participation of the few local experts. There are countless geopolitical disputes between traditional donors of resources and China, which is seeking geo-economic and political space in Africa, but the actual traditional donors engage in disputes among themselves when it comes to transfers of costly technology, such as AIDS medication in Mozambique, which has all been donated by international aid from the north and has been coveted by private governments and private companies for more than 10 years of the project. There have been attempts to sabotage the factory that makes it, the country's only factory of antiretroviral medicines and generic drugs.

In an interpretation from the inside out, Africans demand autonomy in decision-making to find national solutions for their social and citizenship challenges. They are growingly aware that 21st century African peoples and nations, especially their elites, must look towards the construction of the future.

The most important initiative, a perfect example of the self-confidence that is growing within political intelligence in the continent, was the launch of the New Partnership for African Development (Nepad) in 2001. By demanding the capacity to build their own future, African leaders are seeking a more active, less secondary role in asymmetric, hegemonic globalisation and want the responsibility for overcoming the marginal degree of inclusion that the continent had to tolerate in the 1990s.

Are we looking at the emergence of new ethical configurations of African contexts in which more participation boosts inventive empowerment and enables local strategies of convergence imbued with forms of knowledge that have been devalued by the hegemonic knowledge of biomedicine? We don't know yet.

What we know is that Brazil and Portugal seem to be "countries duplicated" by two concepts of positioning in relation to the political strategies of global health. One, from the outside in, is acceptance of and complacency towards global governance and regulation of their national health systems, where liberalisation, deregulation and privatisation prevails as neoliberal policies of capitalism. The other, from the inside out, is the imposition of north-south cooperation in health (Portugal-Brazil) and south-south cooperation (Brazil-Africa), reproducing global inequalities in non-existent or unfinished health systems in other continents (Africa in this case), where neocolonialism policies dominate in the form of "humanitarian health", "international health" and "diplomacy in health".

I would like to leave two particularly stimulating proposals in the field of spatial justice theory. In his work "Seeking Spatial Justice", Soja<sup>11</sup> comes up with the idea

of “unfair geographies” and considers that they are produced not only at a meso-geographical level (supranational scale), but also at “exogenous” and “endogenous” levels. The other proposal refers to the work of Göran Therborn<sup>12</sup> – *Inequalities of the World, New Theoretical Frameworks, Multiple Empirical Approaches* -, who points out the analytical pertinence of inequality mechanisms, such as “distancing”, “exclusion”, “hierarchy” and “exploitation”.

These perspectives fit in well with the processes that we have been analysing.

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