INTERVIEW WITH DR. MIRTA ROSES PERIAGO, WORLD HEALTH ORGANIZATION

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December 3rd marked the Pan American Day of Medicine in honor of Carlos Finlay, the Cuban doctor who identified the transmission of Yellow Fever through a mosquito. Also on December 3rd, a century after Finlay's death, Dr. Mirta Roses Periago sat down with the *Diplomatic Courier* to discuss her experience as the first female Regional Director of the World Health Organization, the Ebola crisis, and the Millennium Development Goals. Finlay's discovery allowed for the possibility to control yellow fever and to build the Panama Canal. His contribution is demonstrative of the intersection of health and politics, a connection that Dr. Periago herself has embodied for more than three decades.

DC: Could you please give us a bit of personal background about yourself as a medical health professional?

I specialize in infectious diseases and public health. In 1984 I entered the Pan American Health Organization (PAHO), the regional office of the Americas of the World Health Organization (WHO). First I went to the Caribbean, based in Trinidad and Tobago, but I worked with all of the Caribbean as an epidemiologist and an expert in infectious diseases. Then I moved to the Dominican Republic, to Bolivia, and finally, in 1995, I went to Washington, DC as the Assistant Director of PAHO. Then in 2003, I was elected Director of PAHO for two terms. My second term ended in 2013 and I retired and came back to Buenos Aires.

DC: Since 2013, when your second term as Director of PAHO came to an end, what have you been doing?

I came back to Argentina with two or three international commitments. I am representing the region of Latin American and the Caribbean to the Board of the Global Fund for HIV, Malaria, and Tuberculosis, a big funding mechanism that was created in 2002 to fund programs on these three diseases. The Board has 20 seats: 10 for donors and 10 for implementers, as they are called. Each region has a board member. I was selected by the Ministries of Health to represent the Latin American and the Caribbean region. So I am a member of the Board.

I am also a special envoy for the Global Network for Neglected Tropic Diseases. This is a big coalition of many organizations working for the elimination of Neglected Tropical Diseases in the world by 2020. We call the movement "N7." These are mostly parasitic diseases that have been accompanying humanity for thousands of years. Today, we have all the tools and knowledge to eliminate them. But they are still so related to poverty, to vulnerable people, and to excluded communities that we call them "neglected." I am an advocate [for these groups], together with some relevant political leaders such as the former President of Ghana, Kufuor, and the former President of Chile, Lagos,

and the former President of Guatemala, Arzú. I am the only medical [professional], and the only woman, in the group of ambassadors for these diseases.

I am also on the Board of the Gulbenkian Foundation, which is a very important and large foundation in Portugal that deals with mental health. In particular, the Gulbenkian Foundation addresses the discrimination and the stigma of mental health, defending the human rights of people affected by mental health issues. [Special emphasis is placed on] children that are institutionalized, deprived of rights and proper care and attention. Basically I am an advocate of diseases that affect those that are discriminated against or isolated.

Here in Argentina I am in the National Academy of Medicine. I am a member and I am responsible for Humanitarian Medicine. So again, I work in the areas that are not served by many. Now we are discussing the problems of foreign medical teams—like the ones being mobilized for Ebola but that are usually put to work after emergencies and disasters—because we want to improve certification and standards for these foreign medical teams that go to help countries. The teams can sometimes become a problem if they are not properly managed.

DC: Speaking of Ebola: where are we now and why can't we stop it?

I think that we will stop it. But there are very few tools that we have in terms of therapeutics to treat the patient and to stop the transmission beyond the usual safety and infection control measures and good practices to deal with patients affected by the viruses. We have known about Ebola since the 70s. The only Hemorrhagic Fever that has a successful vaccine developed is the Argentinean one. These types of viruses used to effect people living in very concrete and reduced geographic areas. Where they have the conditions for the transmission between animals—most of the time wild life or sylvatic animals—and humans.

The situation definitely changed last year because of demographic, social, and economic changes. So what we have seen in Liberia and the affected countries is the urbanization of the disease—just as we saw with Yellow Fever when the virus became urban. These [changes] are mostly related to changes in society. These countries underwent civil war, people were displaced, and people altered their agricultural practices because of changes in the proprietorship of land with extensive agriculture. So people either move to sylvatic areas to make a living from small production, or they have their families migrate to urban areas.

But it's important to note that people who are very sick don't move. While infected, a person has around 7-20 days with no symptoms where they can continue to move around. They are not infectious. But when they get sick, they are so sick that their families care for them. That's when the people get infected.

This was a new situation that took everyone by surprise. In fact the response of experts, and the world came late. They were not equipped to deal with a lot of cultural practices in the affected countries, not only to care for the sick, but also to care for the dead and to dispose of bodies. People were not aware of the tremendous infectivity of this virus. So we are paying the cost of lack of awareness and lack of early response.

What is going to happen now is that we will see things recede little by little, but it is estimated—at least in Sierra Leone where Ebola is still very active today—that it will take more than six months to really see an end to the

epidemic. The interior of the poorer countries where there were no health systems—like Liberia, where there were only 60 doctors for the whole country—are the most affected.

There are also many lessons learned, particularly the fact that we need to strengthen health systems where the people are. If the people don't have tools for every day problems, including the delivery of babies, accidents, and so on, no one will be looking at the problem and no one will be able to respond to the problem.

DC: You mentioned that this type of urbanization was something we weren't expecting, so we didn't know how this particular bout with Ebola would turn out. But why were the existing response systems so late to the game?

There were several situations. First of all, there was no reporting. People started to die, and the international system of alert and response that was established in 2001 didn't really respond.

The system's first test was the Avian Flu when it started in 2008 on the border of Mexico and the U.S. After that, there weren't really any emergencies. There was a lot of criticism regarding suspicion of corruption during the Avian Flu crisis. People wondered if the alert was given too early, if the alert was given in order to mobilize the resources and to buy medicines. Because there was a lot of criticism, the pendulum went too far. Political people and the system in general became too cautious about putting out alerts. So I think that it was a combination of the lack of capacity in these countries, awareness, and reporting. These things create a ripple effect. At the beginning, the waves are very small and you don't notice, and then they become larger and larger, and finally it explodes. The people working there, like Médecins Sans Frontières (MSF), NGOs, and other humanitarian teams, were putting up field hospitals to care for people where there are no doctors or health systems. They were the first to see what was going on.

Then when the alert became international, people reacted by putting up barriers. This has become an immediate problem: where people try close countries and impede flights and immigrants coming in. But once we start to analyze the situation, we understand that unless people are being evacuated—particularly sick people, mostly health workers—the people that travel are healthy when they travel. They are not a danger with this particular disease. With influenza and other diseases it is different. But with Ebola, if you travel, it is because you are not having hemorrhages, vomiting, or diarrhea. Because the symptoms haven't appeared, the person is not contagious. But once the people arrive, they may develop these symptoms.

I think that countries, in the beginning, wanted to close the doors without noticing that what they had to do was to establish and strengthen the system to detect if someone in the country developed the disease, to isolate the person, and to treat the person adequately. I think that now the international situation is clearer, but there is still a lot to do in the countries affected. There are countries that reacted very well, like Nigeria or Senegal. They had people coming in from neighboring countries, and they were still able to handle these cases and contain the outbreak.

DC: There are some people in the U.S.—particularly on social media—that think we have overacted to the Ebola outbreak. Do you think it's valid to say we overacted? Do you think there are myths or misperceptions associated with this particular epidemic?

This epidemic, as any epidemic in the history of the world, has unveiled a lot of other issues. For instance, there are people on social media [that have always] advocated for better access to medicine. They are concerned with intellectual property rights and how this affects or facilitates access to medicines and vaccines. Ebola brings this issue to the forefront, because we don't have a vaccine, we don't have a treatment, and it brings to the table all the discussion about why we don't have treatment and vaccines. Is it because it is affecting the poor and the Africans, groups we have never invested in. So all of these groups that advocate for intellectual property rights and access to medicine are concerned, and they are pounding the table because of Ebola.

Then you have the people who are concerned about corruption and the behavior of politicians, and if they are really there to care for the people or if they are looking at other issues. You also have people who are concerned about the behavior of international organizations, if they are properly managed and properly funded. So you also have those groups coming to the table.

Any epidemic, in this case Ebola, brings people to the discussion that come from different walks of life or have different flags or advocate for different issues, including human rights, including poverty, and respect for the culture. Any epidemic in the history of the world has served to shake up society and look at different components. Social media is a market place, the central square where you have all the different concerns coming together. So it seems that we are overreacting, but I don't think it's an overreaction. It's just the reaction of people with different interests looking at complex issues. Epidemics are complex issues.

DC: There are many parties trying to contribute to combating the Ebola outbreak. Where does all of the international aid go?

In any disaster or emergency, we need to mobilize resources that we should have invested in prevention and in strengthening the system before the catastrophe. But that's the reality of life. You usually pour money in after the disaster has hit. Epidemics awaken a feeling of fear, and people tend to be defensive. The fear is like a retraction, a protection. After fear comes solidarity. Then you really go to a higher level of engagement and involvement.

Right now international aid is going through different channels. Some is going bilaterally to the countries affected and, of course, to those who are caring for patients—the MSF, churches, and so on. But there is also international aid coming through organizations like the World Health Organization and others, to support international response and to mobilize external teams of experts to help in these countries. There is also a stream of funding from the developed countries and big foundations to support the private sector, the pharmaceutical industry, to develop therapeutic and vaccines necessary. That is the future. If we want to control these diseases, we will need those tools.

DC: You mentioned that in many cases throughout your career, you are the only woman involved in projects. And you were the first female regional leader in the World Health Organization (WHO). Could you speak to the topic of women in the medical health profession?

In my time at medical school, women were the minority. It's not like today. The majority of students today—in many different careers, but particularly in medicine—are female. But that was not the situation in my time. Of 300 students, maybe 6 or 10 were female. And of course, almost all of the professors were male. Also in the hospital environment—with the exception of nurses, who were all female—the doctors were all male. That was the gender division of labor.

But I think that my generation was the generation of change. We started occupying some of the positions that had never been occupied by women before.

This, of course, required a lot of changes in society. But particularly important was the possibility of male bosses or mentors or professors to open the doors. Otherwise we never would have been able to do that. In my case, for instance, in the Argentine Ministry of Health, I got to the highest position in the career—National Director of Institutes and Research in Public Health—before going to PAHO and international work. Again, I was working for four years as an epidemiologist and then they asked me to become Representative, or chief of the country office, which is already a high position. Then the Director of PAHO invited me to be the Assistant Director. So I think that this has also been the reality—that there were men that were ready to make those changes, to open the doors, and to recognize the value of having women on the team.

So I became the first Regional Director of the WHO. I am very proud because sometimes you think, ok, what happens after me? Is this an exception, or is this a trend? Is this only for me, or is this really an advance for women? And today, we can say that we have a Regional Director in the Euro-region, also the first woman. The first female Regional Director in Southeast Asia, and the first female Regional Director for Africa was just elected in November. We also have a female Regional Director that succeeded me in the Americas. So now there are four female Regional Directors—and that's a majority, because there are six regions—and we have a female Director General, Dr. Margaret Chan. Now there is a majority of women in a very short period of time: only 10 or 11 years.

DC: Piggy-backing off of that, because the advancement of women and children is one of the Millennium Development Goals (MDG): The MDG target date is fast approaching (2015). Do you believe the MDGs have been successful? Why?

I think that they were successful because for the first time ever, they were able to set a common agenda for all of the countries of the world. They created a movement not only for the governments—the ones who endorsed the MDGs—but also for the non-governmental area, the philanthropic area, and the development banks, to concentrate on a short but powerful list of commitments on a common agenda. I think that was very important.

It was the first time there were Development Goals—in 2000 approved for 2015. And I think that as a first experience, there were many things that became very challenging, particularly all the framework for assessing, monitoring, and evaluating success. One of the things that we would say, particularly for the Region of the Americas, is that because the poorest countries in the world heavily influenced the Development Goals, sometimes other regions felt that it was not for them. So it took us three or four years to put all the advocacy in place to make the more developed areas in the world aware that this was a call for everybody. Everyone is aware that poor people live in all countries, not only in poor countries.

The issue of inequities was not central to the MDGs. Instead, it was much more focused on the poorest of the poor in the poorest countries. Now I think there is an awareness that we should focus on poor people and not just on the poorest countries, because the majority of the poor people are living in non-poor countries. Even in the U.S., or in Spain, or in England, there are poor people that are being left behind. So the call should be for equity, not only for poverty. The national averages, most of the time, are hiding the differences among geographic areas and differences among population groups.

The MDGs were a fantastic flag to focus the attention of the world, to make commitments, and to hold countries accountable. I think that in these 15 years we have made tremendous progress. The Region of the Americas did the best in terms of reduction of infant mortality, one of the best in terms of water, hunger, and malaria, TB, and HIV achievement. But on the over hand, we made little progress in sanitation, in maternal mortality, and in some other aspects within the goals. But I would say the fact that the highest levels have taken this up—like at Summits of heads of state—every year to report to see if they are making progress [shows that this] has been a tremendous success. [The MDGs have also] made countries aware that they can compare themselves with others of similar economic development, but who are not doing well in social development.

DC: What will the post-2015 UN global development agenda look like?

The world is discussing the post-2015 agenda based on those lessons learned. There has been a tremendous movement of consultation; the Secretary General created a panel of eminent people, and different groups and working groups have been contributing to the thinking. There have been major international conferences like the Second Rio Conference on sustainable development and environmental issues. There was the Agenda 21 from the First Rio Conference, and then there was the Second Rio Conference at the end of 2014. There was also the Second International Conference on Nutrition.

I think that the struggle is, again, to find a short list that will focus the attention of all countries on what the world requires to become more peaceful, more equitable, safer, and more sustainable. I think that the concern about the environment is now right at the top. I think that the environment, along with peace, security, and human rights, will become [more important] than they were in the MDGs.

By June of 2015 we will have the final list. There is an open working group that is focused on just that. [They are] shortening the list and trying to integrate the issues in a more coherent way. But there is also a struggle to define what the specific indicators will be, because that is one of the key issues that we saw with the MDGs. Most of the indicators [for the MDGs] were not appropriate, were done by a small group without consulting all countries, and were not feasible or applicable for the countries to report. For the civil society, the non-governmental area, and for the advocates, it is very important to keep accountability and to have good indicators.

DC: What is the role of the private sector and private industry in global health?

The private sector came a little late to the agenda of the MDGs. The eighth Development Goal is about partnerships and speaks to the involvement of the public sector, the private sector, alliances, partnerships, financing, and mobilization of resources. It was a latecomer to the agenda of the MDGs.

But in these 15 years there has been a tremendous movement in that sense, including [the idea of] social responsibility for the private sector. This includes the private sector's responsibility for their own workers and for the communities where they develop their businesses. There's quite [a movement for] social responsibility now and for contribution back to society.

So the process has had much more involvement from the private sector, and there have been many conferences for its inclusion as a basic component of society and of future Development Goals.

DC: Could you elaborate on the global health community's relationship with political entities like the OAS? As Regional Director, I am sure you had to deal with a lot of politics when trying to implement any kind of initiative. That juncture where health meets politics is very relevant, especially now.

Definitely. I can tell you about a very successful experience in the region when the "3 by 5" initiative was launched by the World Health Organization. The goal was to have three million people treated for HIV/AIDS by 2005. We really didn't get to that target globally, but there was a tremendous push. But in the Region of the Americas, we took it to the OAS and to the Summit of the Americas working group, and the member countries committed. In 2005 when the Summit of the Americas was in Mar del Plata, Argentina, we had reached the target. The target for the Americas was 600,000 people treated by 2005, and we had reached 680,000 people.

So it is important to get to that political level, because the leverage and the potential of having all of society really commit to these goals is tremendous. To get political backing, it requires that all of the right arguments be put in place: the evidence, the impact on other sectors…you cannot only speak about health. You have to speak about the economic impact, the impact on education, the impact on women, the impact on children, the impact on nutrition. You have to look at all the other sectors of society to make them see the advantage of investing in health.