COMEBACK OF MEASLES THROUGH THE BORDER WITH VENEZUELA: CONTROVERSIES BETWEEN RESISTANCE AND ACCEPTABILITY

Sílvia Deeke Cachoeira de Oliveira[1]
Phelipe dos Santos Souza[2]
Théo Nicolacópulos[3]
Wagner Eduardo Estácio de Paula[4]
Rita de Cássia Gabrielli Souza Lima[5]

ABSTRACT:

The comeback of measles in Brazil through the border with Venezuela has become a social issue. This article makes interdisciplinary reflections about the respective health systems and the polynomial vulnerability/violation/resistance/acceptability within the context of the border region in question. Among the considerations, it is highlighted the success of the Immunization National Program to eradicate measles in Brazil and the fragility of the political and health systems from both countries under analysis regarding border regions mainly in crisis situations. Finally, it is argued that education is the coherent way for the construction of a nation aware of its individual rights and collective duties and that appreciates social policies as they must be respected and valued by the government itself. Thus, herein is an alert on how anti-vaccination movements contribute adversely in the eradication of diseases that can be controlled through more efficacy of vaccination campaigns.

Key words: vaccination; measles; public health policy; social policy.

Vaccination coverage against measles is a tragedy, says the substitute coordinator
[of the National Immunization Program].
Lígia Formenti. *O Estado de São Paulo* 3/06/2018.

[1] Advogada, pós-graduada em Direito Empresarial e dos Negócios.
[2] Médico, mestrando no Programa de Mestrado em Saúde e Gestão do Trabalho da Universidade do Vale do Itajaí, docente do Curso de Graduação em Medicina na Universidade do Vale do Itajaí, SC.
[3] Médico, mestrando no Programa de Mestrado em Saúde e Gestão do Trabalho da Universidade do Vale do Itajaí, docente do Curso de Graduação em Medicina da Universidade do Vale do Itajaí, SC.
[4] Educador físico, mestrando no Programa de Mestrado em Saúde e Gestão do Trabalho da Universidade do Vale do Itajaí, SC, docente do Centro Universitário de Brusque, SC.
[5] Cirurgiã-dentista, doutora em Saúde Coletiva pela Universidade Federal de Santa Catarina, SC, docente e pesquisadora da Universidade do Vale do Itajaí, SC.

On March 6, 2018, the newspaper *O Estado de São Paulo* reported news about the vaccination coverage against measles in Brazil and emphasized the concern of the Brazilian government with the cases recently registered in Roraima.

Upon conceptualizing the vaccination coverage against this disease as "a tragedy", the substitute coordinator of the National Immunization Program (NIP) of the Health Ministry (HM) supported her assertion on two arguments, one of historical nature and another of contextual nature, that is, the need of improving the coverage in the Country and the presence of the Venezuelan newcomers. She highlighted that until March 6, six cases have been confirmed in Roraima, after three years without any record in the national territory. These cases occurred among Venezuelan children and Venezuela already faces an epidemic outbreak of measles.

With this background, the HM decided for a vaccine blockade and sent a group of professionals to work on the prevention of the disease in the region.

The coordinator emphasized that in general the vaccination coverage is low in Brazil. She introduced four explanatory hypotheses: a) the vaccination became less relevant for the families and health professionals from the moment when there was a reduction of the contingent of people affected with diseases targeted for vaccination; b) the primary health centers are open at the same time when people are working; c) the eventual lack of vaccines in the health centers; and, d) opposition to vaccination

Yet, according to the coordinator, to face this scenario, the Health Ministry "*wants to launch a program towards enhancing immunization*", based on strategies such as to create mobile health posts and to foster the municipalities to open the vaccination posts in a time schedule alternate to the regular working hours.

The first outbreak of measles, that is taking place in the State of Roraima, on the border with Venezuela, had been identified in the previous month. The case was imported from Venezuela, where an outbreak of the disease occurred in July 2017 mainly in the State of Bolívar, on the border with Roraima. This episode was due to the absence of cross-border health barrier, what allowed the comeback of the disease from Venezuelan immigrants who have low vaccination coverage and hold the measles outbreak (Brazil, 2018).

It is estimated that at present there are more than 50,000 Venezuelans in the city of Boa Vista, capital of Roraima, a number that surpasses 10% of the total population. However, this figure may increase even more since almost 700 people cross the border daily. This strong migratory movement has affected the State of Roraima directly in such a way that it does not manage to facilitate the proper humanitarian support to these migrants, since it is undergoing difficulties with the increase in the demand of public services as a collateral effect (Campos, 2018). The sanitary issue has given reasons for a big concern. The World Health Organization (WHO) warned about the spread of the measles outbreak in the region and it is making a follow-up together with the Pan-American Health Organization (PAHO) and giving its contribution to minimize this hazard (PAHO, 2018).

In order to respond to the hazard, the HM started a campaign of selective vaccination against measles for approximately 400 thousand people, 300 thousand out which are Brazilians not covered by the vaccine and 100 thousand are Venezuelans already in the country, in the six months-49 age group in all

municipalities of Roraima. This selective campaign was initially carried out in the period from March 10 to April 10 with vaccination block-up of their contacts too within 72 hours and monitoring them for 21 days (Brazil, 2018).

On April 9, 2018, the Health Secretariat of Roraima reported that 79 cases of measles have already been confirmed in Roraima, and two cases of death have been registered since the beginning of 2018, correspondent to two Venezuelan children. Recent data point to 316 suspected cases, being 213 in Roraima and 103 in the state of Amazonas, what configures a situation of Measles Epidemic, with the virus coming from the neighbor country (Brazil, 2018).

In this article, we make a few considerations on the binomial health/social health public policy and the polynomial vulnerability/violation/resistance/acceptability as categories from the field of applied ethics that interpenetrate in the development of the specific scenario of measles comeback in Roraima. The objective here is to identify probable controversies that apply on our daily lives regarding people, foreigners or not, through actions that impact the life of an entire society. There is no intent to reflect on international relations, national laws and immigration policies but rather to promote a discussion addressed to the complex question in a moment of political and economic crisis in both countries although of different orders.

The text is an interdisciplinary product, generated in the development of the discipline "Ethics, Dialectics and Politics" of the Master´s Program on Health and Labor Management of *Universidade do Itajaí*, SC, in the first semester of 2018. It is organized in three topics. In the first topic, the authors introduce a national scene of the vaccination phenomena and of vaccination against measles in Brazil. Next, they describe a perspective of the relation between health public policy and social health by contextualizing the health public systems from Brazil and Venezuela. Finally, they outline a few reflections on vulnerability, violation, resistance and acceptability within the context of the border situation under discussion.

Vaccination in Brazil and Measles

Brazil has several policies and public programs to guarantee the health of the population. The Immunization National Program (INP) of the Health Ministry is certainly a highlight within this context, with worldwide recognition. It was instituted by means of Law no. 6.259 of October 30, 1975 that disposes about the organization of Epidemic Vigilance actions and establishes the standards regarding compulsory notice of diseases and vaccination all over the national territory (Brasil, 1975). This Program completed 45 years, but its history goes back to more than two centuries of conquests.

One hundred years after the introduction of the vaccine in the national territory and in view of a smallpox epidemic plaguing Rio de Janeiro, the law concerning obligation of vaccination was approved in 1904, through government enforcement on the part of hygienists, driven by the great number of existing morbidities. The measure of authoritarian nature and guided by Oswaldo Cruz was not accepted by the population who denied receiving the vaccine for fear and suspicion as to the efficacy what generated policy confrontation towards the population. The outcome was a violent week when the armed forces conflicted with the population who did not understand the objective of the government with the body invasive procedure of vaccination. Known as the Vaccine Rebellion, the episode was a milestone that marked the

beginning of government policies to control epidemic diseases. The obligation to vaccinate by the Health Council at that time exhibited an important issue: the certainty of the vaccination rational grounds and the connection between social and scientific relationship (Moulin, 2003).

The mechanism whereby vaccination acts in the human body reproduces a contact with a fragment of a pathogenic microorganism (antigen) or with the attenuated antigen itself, by searching an adaptive immune response and stimulating the production of antibodies, preparing and immunizing the subject to reduce a possible pathological response upon a second contact with this same antigen. Thus, it minimizes the reproduction and circulation of such pathogenic microorganisms among human beings of a certain population.

Within this context, it has been observed a valuable potential to prevent infectious and contagious diseases within populations, so that vaccination began to be understood as a health policy. Nowadays, Brazil is one of the countries that offers for free the highest number of vaccines to its population. Estimates calculate that over 300 million doses are yearly distributed among vaccines, sera and immunoglobulins (Brazil, 2014)

Vaccination has enabled the dissemination control, the combat and elimination of several infectious diseases. This is due to the fact that the procedure not only protects those who receive the vaccine, but also the community as a whole. To summarize, the higher the number the people protected by the vaccine, the smaller will be the odds that any subject in a community – vaccinated or not – be contaminated.

The NIP establishment has consolidated vaccination as an important intervention of public health of universal approach that strengthened the role of the Health Ministry in the coordination of immunization actions thereby contributing in a significant way for the reduction of morbidity and mortality due to communicable diseases in the country. The NIP program has been continuously updated in the search to develop actions that are feasible economically and to implement strategies that can guarantee and expand the population access to the recommended vaccines, especially for the people that are more vulnerable (Silva Júnior, 2013).

One of the greatest conquests regarding the NIP is the control of measles, an acute infectious disease of viral nature, severe and extremely contagious, quite common in childhood, whose vaccine is composed of an attenuated live virus and is conjugated with rubella and mumps. Measles has universal distribution and presents a seasonal variation, being its endemic behavior directly related between the immunization degree and the population susceptibility besides the circulation of the virus in the area. Although it has been eliminated in Brazil since 2001, measles persists endemic in other countries of Latin America and Europe (Brasil, 2017).

The vaccine against measles was introduced in Brazil in the 1960 decade but only in the years 1973 and 1974 the first vaccination campaigns were carried out in urban areas from several states. In 1976, a decree determined the national compulsory notice of measles cases what marked the start of more reliable records of this disease. In the beginning of the 1980´s, vaccination campaigns were made in places of low vaccinal coverage, and in the years 1987 and 1988, the states of São Paulo, Paraná and Mato Grosso do Sul held mass vaccination campaigns. However, only in the beginning of the 1990´s, plans to eradicate measles started in the country (Santos, 1998).

In Brazil, thanks to the performed control over successive vaccination campaigns and to epidemiologic vigilance programs, the lethality rate has not reached 0.5% in spite of the fact that the virus is highly contagious and presents high mortality rate with indexes that vary from 5 to 10% in peoples from the third world. The first great national vaccination campaign against measles took place in 1992 when approximately 42 million children and adolescents under 15 were immunized, covering a vaccinal coverage of 95%, what was the starting point for the creation of the Measles Control and Elimination Program (Brasil, 2011)

Since 2001, there is no record of the disease cases with origin inside the country itself. Between the years 2013 and 2015, in the states of Pernambuco and Ceará, there were outbreaks related to the importation of the virus and, after the implementation of prevention and control measures like intensification of vaccinal campaigns, vaccinal blockades, screening and quick monitoring of vaccinal coverage, the transmission was interrupted. Due to the commitment with the control of this morbidity, in the second semester of 2016, Brazil received the certification of measles elimination from PAHO for its intense vaccinal vigilance and coverage (Brasil, 2017).

Health Policies and Social Health: historical-conceptual and conjunctural aspects

In recent years, the WHO has advocated the importance of the global community to join forces to reach the eight Millennium Development Goals (MDGs) launched by the United Nations Millennium Declaration, signed in 2000, with the approval of 191 Member States. The goals are: to eradicate extreme poverty and hunger; to achieve universal primary education; to promote gender equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria, and other diseases; to ensure environmental sustainability; and to develop a global partnership for development (World Health Organization, 2018).

Even based on a preliminary reading of these goals, we understand that the great challenge lies in the absolute necessity that the health sector of each nation compromise with the social health of its people, aiming to overcome the health condition as a privilege by the health condition as a right so that from such overcoming it makes efforts to strengthen its health systems and programs. It is a provocation for the global community, since the devastating "unfair, avoidable and remedial inequalities" (Berlinguer, 2012, p. 224) of conditions, opportunities and results (Whitehead, 1992), historically imposed to peoples by economical choices (Berlinguer, 2012), define different starting points for each nation. The venture requires political willingness to carry out the 8th MDG, the most challenging of all – to establish a world partnership for the development -, whereby developed and illuminated countries would give technical support to countries with less place in the sun, that long for the creation and/or organization of health systems within the due specificities of human and financial resources. Far from easy in times of seduction for walls and barriers to protect borders.

In the its Interim Report with the title "Global strategy on people-centered and integrated health services", published in 2015, the WHO introduced to global community a position about the health of the population: "an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways" (World Health Organization, 2015, p. 7).

Upon observing that WHO began to consider the global need of health systems to respond to the needs of individuals, families and communities, and considering that the health needs are not limited to biological demands (Breilh, 1991), we refer to the Welfare State model, disseminated from the XIX century on within most of the developed countries. According to this model, the creation of any health system should foresee the overlapping of three S *sanità-salubrità-sicurezza*[1] to the three M of the Hippocratic triangle *malato-medico-malattia*[6] (Canguilhem, 1998). S*anità* corresponded to the set of provisions and initiatives, both individual and collective, that allowed to resist to an eventual disease. *Salubrità* pointed to the absence of disease in a given environment. *Sicurezza* was equivalent to the elimination of several pathologies and proclaimed the possibility of not knowing the disease in fact in the future (Fantini 2012 apud Berlinguer, 2012).

However, health policies change. Nowadays, a progressive displacement in the conceptual and practical dimensions of the three S can be noted. The health sector of a State becomes the task of health professionals within health structures aiming at the cure and prevention of diseases. Salubrity has taken over a global target in a displacement from the medical domain into the biopolitical one by defending the intervention in life and labor environments. Maximum safety becomes an imperative of investment even though breaking individual freedoms might be needed.

The populations from Brazil and Venezuela have not enjoyed the *Welfare State* yet.

In the case of republican Brazil, after a long historical period marked by movements of democratization, dictatorships and re-democratization, the Federal Constitution of 1988 foresaw a Chapter for the groundings of the right to health as everyone´s right and duty of the State. This constitutional framework gave support to the creation of the Brazilian Unique Health System (SUS). The System has been conceived to integrate health actions and services within a regional and hierarchic network from levels of growing complexity, that is: primary healthcare, mean complexity and high complexity. Since then, the SUS has been a process of social construction fed by governmental choices, democratic ups and downs and ruled by a wide and complex regulatory framework. At the current historical moment, many challenges – a few persistent ones, other emerging – menace its sustainability, such as: the recent contingency and rationalization reforms; the Brazilian political system; the federalism controversial model; the historical lack of precision in the health concept; the management of supply and demand for the primary care; the failure of its regionalization; the opening of its operationalization to health social organizations; the

[1] Health sector of a national service of health-salubrity-safety.

[2] Sick - medical doctor - disease.

growing judicialization of health; the education of workers for the System; and, above all, its (under) financing and respective logic of incentives.

In the scope of financing, the actions and public services of health that compose the SUS are guaranteed mainly by the product of collection of taxes and funds transferred by the State. Upon analyzing the percentage of participation of the tax revenue in the total revenue of Boa Vista capital vis-à-vis the percentage of participation of São Paulo capital, for example, based in the System of Information about Public Budget in Health (SIOPS), taking as reference the second bimester of 2017, one can notice that while the participation of Boa Vista was of 9.07%, the participation of the tax revenue in the total revenue of São Paulo was of 57.44%. The total expenditure with health, in R$/inhab, under the responsibility of Boa Vista was of R$139,37 while that one of São Paulo was of R$246,91, in the same period (Brasil, 2018). These data exhibit a portrait of the geographic heterogeneity *per capita* of the expenditure with health: for the citizens of Boa Vista, the expenditure corresponds almost to 50% of the expenditure for the citizens from São Paulo. Yet, the SUS survives and it is an immaterial patrimony of its society.

In the case of Venezuela, the Bolivarian Republic with its area organized in 23 states, a capital district and 335 municipalities, the health system was the product of the Bolivarian movement and likewise it happened in Brazil, it was conquered via Constitution. The Bolivarian Constitution of Venezuela, of 1999, recognized the National Public Health System (SPNS), in its Art. 84, based on the principles of gratuity, universality, integrality, equity, social integration and solidarity (Venezuela, 2000). The SPNS was organized through the addition of existing physical structures financed by the State and it was operationalized by means of health networks anchored by a conception integral health, capacity of resolution and technological of social territories. The primary health care was fostered starting from the Misión Barrio Adentro I, that took over the role of central axis of the SPNS (Organización Panamericana De La Salud, 2006).

However, this Misión ended up performing like a parallel health system since the constitutional conquest of the Public System had not been the object of subsequent specific legislation. The fifteen years that followed without regulation of the System finally led it to a "silent process of privatization" (Roa, 2018, p. 12).

In 2011, with a total population of almost 30 million inhabitants, Venezuela showed good demographic indexes, as well as of mortality, coverage and social and economic ones, among which it is worth telling: birth rate of 20.2 births per thousand inhabitants, life expectancy of 74.5% at birth; infantile mortality rate of 15.8 per a thousand of live births; measles coverage of 79%; 95% of the population under 15 years old or more was literate; and, 93.6% of the population was organized in urban areas (Organización Panamericana De La Salud, 2011).

The deep economic crisis that ravaged the Country and undermined the Rule of Law intensified the tacit privatization of the health system that was taking place in the last years. The population has been submitted to the highest inflation rate in the world: according to the International Monetary Fund, the inflation shall reach 13,000% still this year (Organización Panamericana De La Salud, 2018).

The effects have not been few: increase of poverty levels, social fracture, increase of social conflicts, expressive lack of food and degradation of the nutrition condition of society, high rate of homicides, among

others. Within the health system, the collapse seems a reality: The State no longer gave priority to the fiscal budget of the health sector; consequently, its funding was privatized, while half of the Venezuelan population depends exclusively on the public system. Health professionals are migrating due to the deterioration of the working conditions: medical doctors are lacking; waiting lists for surgeries are endless; hospital beds per inhabitant are diminishing fast; medicines lack in the public and private networks; diagnosis services are not operating; maternal and infantile mortality is increasing; and, there is regression in the coverage of vaccination (Roa, 2018).

Vulnerability, violation, resistance and acceptability: reflections of the applied ethics

The comeback of measles to the Brazilian territory through the border of Venezuela, after years of eradication of the disease places us before a complex situation. They are neighboring countries whose populations are mutually submitted to increasing vulnerability and/or violation and inserted in a hidden or explicit way into two extremes of the same logic, present in dialogues about health: vulnerability/violation and resistance/acceptability. For this reason, it is opportune to question this issue.

Vulnerability in its semantic meaning refers to the possibility of being hurt considering that the word derivates from Latin – *Vulnus* (wound). That is, an individual is vulnerable when susceptible to danger, to wound. Vulnerability is a possibility of life, since all of us are susceptible to accidents, diseases or evils. However, some ways of living, social classes and population experience higher degree of vulnerability (Sotero, 2011). This higher degree of vulnerability can reach such a point that besides the possibility of risk, the individual or social group that previously had potential condition to suffer, becomes subject to the concrete condition of such risk. At this stage, there is no longer vulnerability but, instead, violation as a social product generated in the displacement of risk as a possibility for the risk as a "virtual reality", in the words of Beck (2011, p. 328).

From the context of above understanding, it is possible to infer that the population of Roraima, resident on the border with Venezuela, was vulnerable to a measles episode since there is an epidemic in the neighbor country and measles is of quick infection, there is potential condition for the occurrence of this disease in Roraima. With the imminence of the risk of outbreak/epidemic of measles, mainly the inhabitants of the state of Roraima transit from a state of vulnerability related to measles to a state of violation. This condition raises enquiries from the field of individual liberties, collective well-being and resistance. Within a context where individual liberties are respected, what would be the role of the State in a region of violation? Within a larger context, with the perspective of measles coming back to entire Brazil, how far can one define individual right and collective well-being? The individuals who are resistant to vaccination, upon facing the condition of being vulnerable, do they pass to the condition of acceptability?

Schramm (2008, p.1537) defends that "the protection of Public Health legitimates some kind of restriction to the exercise of individual autonomy" and it also expresses that is the managing sanitary agent is responsible to take over the actions to be met for the well-being of the Public Health. One collides then with a quite complex issue for our Country, mainly in the current times: in uncertain times, with tiny public funding in health and education and with the SUS suffering from decree to decree, where is democracy, regarding this issue, to mediate individual rights aiming at the collective well-being?

The vaccination strategy, widely spread in Brazil, with campaigns and results considered a success even worldwide, is undergoing a delicate moment, already mentioned by the coordinator of the National Immunization Program: the discredit of the population regarding the efficacy and the importance of the vaccine. Moved by the most varied feelings, it is common to find groups of parents, elderly and youngsters, including in the social networks, in common thinking regarding movements in opposition to vaccination. In this historical moment, when information is shared instantly from all parts of the world, reaching a countless number of persons, the search for the veracity of information is not always the main concern. Rumors and fake news supported by a language that seems to contain a scientific bias lead these movements to grow worldwide exponentially.

The interlocution between the category resistance and vaccination contains several temporalities. Long before the episode of the Vaccine Rebellion in Brazil for example, Prussia created the medical police in the beginning of the XVIII century with the intention of improving the health level of the population through the obligatory intervention of the State (Schramm, 2008).

Among other world populations, cases of resistance against vaccination procedures have been also observed. In Italy, for instance, it has been observed a reduction of the vaccinal coverage in 2015 of children born in 2013 in almost all Regions and Autonomous Provinces. In the case of vaccine against measles, which is considered non-obligatory by the Italian Health Ministry, though recommended, the coverage signaled a fall of 90.4% to 85.3%, between 2013 and 2015. This reality, besides being nationally worrisome, resulted also by "deteriorating the international credibility" of the Country that had invested in 2003 in a global Plan to eliminate measles before the European Regional Office of the OMS (Italy, 2018). New efforts have been endeavored in the Sanitarian Plan of Vaccinal Prevention 2017-2019 (Italy, 2017).

According to the Italian Health Ministry, contextualized studies are needed to exploit the motivations for the low adhesion of vaccination in general. However, the Ministry itself signals a few actions that could stop this trend to the reduction of adhesion: increased initiatives of communication between State, Regions and Provinces to defend the vaccination; the progressive development of computerized regional vaccination centers; and, confrontation against resistance movements based on scientific disinformation (Italy, 2018).

This scenario where information and disinformation are still an issue of the agenda from the health system of a Country far from ours regarding the cultural capital (Lima et al, 2009) revives the Brazilian historical debate about the quality of information. In so far as society began to access information more easily, either by means of vaccination campaigns widely divulged or by larger access of the citizen to data and facts related to diseases that have been fought by means of this practice, it was expected that the polarization resistance/acceptability would be object of reflections and/or discussions by the common sense. After all, the efficacy of the national vaccination programs reached results more and more higher, so that it became one of the best in the world. However, according to own words of the PNI coordinator, that opened this text, resistance is still a reality in Brazil.

The categories resistance and acceptability can be determined by many factors that change according to the society model, historical moment, economy, access to social rights, culture of a certain region. In our perspective, the efforts to overcome the resistance to vaccination must consider the

peculiarities of the cyclic movements resistance/acceptability/resistance visited by countries with national health systems. Thus, the transit from one category (resistance) to the other (acceptability) does not go straight ahead neither one-way. Each new procedure, plan, program, campaign or disease that reaches the population goes through a path that is cyclically offered as an opportunity by the conditions of the historical moment and travelled by means of consensuses, dissents, tensions and détentes.

Through information, yes, it is possible to outline a common social target once the individualities have been respected. This is why terms like "medical police" sound somewhat strange to the standards of contemporaneous societies. However, in the age of data velocity and instantaneous communication, in times of easy access to means of communication and internet in a country where the culture of reading has not been established yet and one headline only summarizes a whole complex context, what kind of information are we talking about? There is resistance to a certain practice when it is founded by its architects without the help from a strategy of information of quality capable to go into the people´s homes and question them about "common well-being", based on an accessible pedagogy. It is worth pointing out that when we refer to the vaccine, it can be thought in an individual ambit – in the sense of not contracting a determined pathology and, in a collective ambit, in the sense of eradication of a certain disease.

Resistance, from the individual point of view, regarding a biomedical intervention, is according with the UNESCO Universal Declaration on Bioethics and Human Rights which in its Art. 3rd disposes that: "The interests and welfare of the individual should have priority over the sole interest of science or society" (UNESCO, 2005, p.06). Herein, another issue is raised: the individual denial to vaccination may lead to outbreaks or epidemics of lethal diseases that have already been eradicated. Therefore, would the vaccination (or its denial) be an individual right or a collective duty?

From other perspective, it would also be possible to inquire: who are the vulnerable ones and/or the violated ones at this moment? Are the Brazilians from the borderline with Venezuela who suffer? Or are the sick Venezuelans who run away from their national reality?

Such different ways of inquiring the situation are possible because the appointed phenomenon navigates in a very subtle manner through other two situations that are quite one-off, by making a coordinated movement between them, but not definitive, depending on the point of view of whom analyses the situation. Also, in this line of reasoning, the movement goes through vulnerability, resistance and acceptability but in this exact order and not necessarily from one side only, i.e. Brazilian or Venezuelan. And why?

From the Brazilian point of view, there is the vulnerability of a needy border people, living in one of the regions of the country that suffer the most with the deprivation of fundamental means for social life, work, food, health, housing and who are faced with the situation of sick immigrants entering their country to share the little of the almost nothing they have.

In 2010, when the population of Roraima comprised 450,479 inhabitants, the percentage of the vulnerable ones to poverty, that is, of individuals living in permanent private domiciles in the state, with per capita income equal or less than R$255,00 was of 45.72% while the percentage of people being 18 years old or more without complete elementary school and on informal occupation was of 35.56%. Yet, about 2010, the Brazilian Human Development Atlas unveils that 65.84% of the children between 0 and 5

years old were out of school and that the percentage of mothers who are household heads without elementary school and with minor child, out of the total of mother household heads was of 22.84% (Brazil, 2018).

Now, it is understandable why, as Brazilian citizens, the people from Roraima experience the phenomenon of resistance in its higher connotation, by rejecting any possibility of receiving these immigrants and in addition bearing the costs of the situation. But, also as Brazilians, it is probable that they do not resist and with the heart moved by humanity, they slide onto acceptability and welcome these immigrants by allowing them to share the few that the locals still own and to share the few of almost nothing that they still have.

Yes, this movement reflects a Brazil that we do not see every day, maybe a constitutional Brazil outlined in the Preamble of the Federal Constitution of 1988 where it is beautifully provided that: "We, the representatives of the Brazilian People, convened in the National Constituent Assembly to institute a democratic state for the purpose of ensuring the exercise of social and individual rights, liberty, security, well-being, development, equality and justice as supreme values of a fraternal, pluralist and unprejudiced society, founded on social harmony and committed, in the internal and international orders, to the peaceful settlement of disputes, promulgate, under the protection of God, this CONSTITUTION OF THE FEDERATIVE REPUBLIC OF BRAZIL."

Many Brazilians do not even know about the existence of such a dense, serious and deep text, but, specifically within this situation of Venezuelan immigration, it is clearly seen the commitment of the Brazilian people to maintain social harmony and order.

In addition, we can affirm that the introduced issue of vulnerability finds a democratic consciousness in Melkevik´s words (2017, p. 657), that reflects the outlined situation exactly: "Democracy consists in the capacity that different consciousnesses have to develop in reciprocity through adequate processes and to select in cooperation, as we have noticed, the rules, rights, institutions, worth of them. Every democratic cooperation is therefore dependent on the individuals` vulnerability."

In the light of this, it is possible to see the movement of reciprocal cooperation between national and foreign peoples before this tragic health situation that also detects the vulnerability of the local system that has deep difficulties to help the people who live there and nowadays find themselves obliged to give support to sick people quite beyond from the forecasts or from their limits.

The situation of inequality reflects the position that each subject takes before what comes ahead of him/her, by considering that each one has the same freedom but who is also susceptible to see himself/herself contaminated by a disease already eradicated in Brazil and that comes back to trigger the vaccinal movements aiming at to diminish its proliferation.

The reflection of this movement of vulnerability, resistance and acceptability as a continuous chain also reflects directly in the issues of public policies because the border city with Venezuela needs to take a position as to the frequent exodus of the immigrants. Considering that there are cooperation policies among Latin American countries, it becomes difficult to adopt attitudes that do not have xenophobic connotation, but that, at the same time, expose Brazilian citizens to situations like a measles comeback that obliges the Country to act vigorously.

A few considerations

Although it can be conceived as a tragedy, the National Immunization Program of Brazil is one of the major social and health policies of the country, that has been instituted even before the Objectives of the Millennium. It has been a great ally for the control of diseases and infantile mortality in the last decades being configured as an international example of strategies and conquests like the case of measles eradication. Even though it has been conceived as something imposed to the population, nowadays the National Immunization Program recommends and organizes the vaccination calendar and it is available through the public health system, the SUS.

The comeback of Measles to Brazil through the border of Venezuela evidences the fragilities of the political and health systems of both countries, from one side Brazil that is not totally prepared to deal with the arrival of foreign people under critical situations and, on the other side, that of Venezuela that is undermined by an intense political and social crisis. Both nations revealed populations vulnerable to measles thereby exhibiting not only the danger due to the limitations of the vaccination coverage but also the risks that the resistance and the low adhesion to vaccination that is increasing worldwide, may expose to the populations.

It is undeniable to think on the resistance to vaccination as the exercise of autonomy for an individual right but upon the acceptability and adhesion to vaccination there is also the conception and the exercise of the duty to protect the collective. Such dichotomy is the reflection of the fast movements where the news circulates, of the paradigm between defending the right and the individual merit and the thought of collective duties and conquests, and of forces and weaknesses that the State has before its political and social relations, either the domestic ones or the international ones.

Education and access to coherent information combined is the way for the construction of a nation aware of its individual rights, that respect the collective rights and appreciate social policies, just as they must be respected and valued by the government itself. A self-conscious nation and a present government are able to elaborate together the strategies to keep themselves strong and to cooperate with those who need help.

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