7. QUESTIONNAIRE ANALYSIS

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In order to achieve the objectives of the Project, it was decided that the main resource for empirical research would be a Questionnaire, made available through the UCILeR online platform, addressed to a significant number of interested parties (health institutions, NGOs for the defence of patients' rights, civil servants, academics) to collect the necessary data. It was important for the Team to present a Project that not only reflected the very relevant theoretical and conceptual analysis of available bibliographic and technical resources, such as updated Legislation and Literature, but that went further and allowed for empirical research, incorporating recently collected data and its analysis, that would allow the Team to prepare proposals for public policy solutions, enabling the construction of ethically adequate systems, and to respond to the difficulties brought about by pandemic situations.

The Questionnaire includes 44 questions: most of them imply yes/no answers, although some of them require the respondent to provide a more detailed answer, including his opinion, thus combining both an objective perspective of the proposed ethical questions, as well as a subjective assessment of the identified problems.

Dozens of questionnaires were sent out, in the different countries and regions, to selected entities. The Team ended up with 41 Questionnaires, from respondents with different occupations and from the 5 Legal Systems involved in the Project. The population of respondents follows the following profile:

Table 1 – Number of Respondents by Legal System

Number of Respondents by Legal System				
Angola	Brazil	Mozambique	Portugal	Macao, S.A.R.
8	15	5	7	6
Without Submission of Information: 0				

Table 2 – Number of Respondents by Occupation

Number of Respondents by Occupation			
Law	Health	Administration	Other
15	12	3	4
Without Submission of Information: 7			

Table 3 – Number of Respondents by Response Language

Number of Respondents by Response Language	
Portuguese	English
39	2

Among the range of topics this Project aims to cover are the issues related to Responsibility in Public Health in the Lusophone World. Therefore the Questionnaire prepared by the Team could not fail to start by trying to understand the importance of public health in each legal system.

Taking into account the example provided by **Angola**, the respondents stated that public health becomes of particular importance, especially when there is a need for direct State intervention in health, given the circumstances of this country, with "very limited health infrastructures, with few professionals and insufficient training.". The respondents believe in the importance of the public health sector in education, as it provides basic information on health and hygiene to the most vulnerable segments of the population. In addition, one respondent mentions that "The lack of sanitation, basic hygiene conditions and the fact that Angola is an endemic area for the transmission of infectious diseases, makes public health fundamental". In this country, the Framework Law of the National Health System - Law No. 21-B / 92, of August 28th, is in force, establishing the promotion and guarantee of public health as part of the State's activity (article 1/2).

Presidential Decree no. 11/95, of December 29th, which establishes the powers of the Ministry of Health in **Mozambique**, discusses the responsibility of this body in the context of epidemiological research and surveillance (article 3/3), and is also concerned with the status of individuals who may compromise public health (Article 3/6/d)). Also in this country, the role of the National Health Institute (*Instituto Nacional de Saúde*) stands out, as it exercises competences in terms of prevention and control of epidemic diseases in the context of Public Health (as stipulated in article 4/e) of Resolution no. 17/2018, of June 1st, which approves the Statute of the National Institute of Health). This body also includes the direction of the Public Health Laboratories (Article 19). Respondents, while considering this sector fundamental, point out the lack of funding as a reason for not having a more prominent role in Health in Mozambique.

In **Brazil**, Law No. 8.080, of September 19th, 1990, establishes as a competence of the national management of the Unified Health System (SUS – *Sistema Único de Saúde*) defining and coordinating the systems of the network of public health laboratories (article 16/III/b)). The same diploma approaches the topic of determinants of health (article 3), establishing as one of the priorities of SUS the identification and dissemination of these determinants (article 5/I). The importance of this area of health is further demonstrated by the abundance of public health schools, among which is the *Escola Nacional de Saúde Pública Sérgio Arouca*, which, in addition to dedicating itself to research, plays an important role in terms of health education, providing masters and doctorate programmes in Public Health.

One respondent considers that: "If it weren't for the SUS, it would be impossible to provide assistance to the existing 5570 Brazilian municipalities. In addition, in a scenario of scarcity of resources, with an important impact on employment and income (which are a product of social isolation measures), without public health we can imagine what the lack of healthcare would imply. Moreover, by observing the expansion of the public health network, it is clear that all efforts were made to cope with the pressure on the system, whereas the private network did not make a comparable effort. " [Translated].

Another respondent says that: "the SUS was the result of the health reform movement, which started in the 1970s, and which, following its guidelines of universality, decentralization and community

participation, found an echo in the Federal Constitution of 1988, based on management and financing of all federal entities, currently characterized as the largest social policy in the country. The SUS serves the entire population of the Brazilian territory, with approximately 25% (considered the national average) having a private health plan/ insurance to cover outpatient and hospital treatments. However, whilst other healthcare systems in the world are fighting for improvements (Canada, United Kingdom, Portugal), the SUS still struggles for survival, a scenario that has been aggravated in recent years, considering the lack of investments and the increasing costs to provide care during the Covid-19 pandemic." [Translated].

In **Portugal**, Public Health is of relative importance in the Portuguese Medicine curriculum, with the specialty of Public Health Physician[1] (MSP - *Médico Especialista em Saúde Pública*), a professional who can intervene on different sections of the National Health System (SNS – *Sistema Nacional de Saúde*), as well as perform research with Universities, the Pharmaceutical Industry or Private Entities. MSP's are represented by an Association, the National Association of Public Health Doctors (*Associação Nacional de Médicos de Saúde Pública*), founded in 1987, which offers training opportunities, namely a Postgraduate course in Public Health. Postgraduate training in the subject (masters and doctorate degree's and other specializations) is also offered by the National School of Public Health at the Universidade Nova de Lisboa (ENSP-NOVA), so different opportunities for training in the area are identified in Portugal, which attests to its relevance. In this country, respondents understand that the importance, before the Pandemic, of this sector, was practically nonexistent. From another perspective, some respondents clarify that that importance was never questioned, but was not recognized ("[...] degradation, in means and resources, of public health units" [Translated]) and Public Health was not valued. Half of the Portuguese respondents believe that Public Health is a fundamental pillar of the organization of the Portuguese SNS

A Portuguese respondent reveals that: "Under the tutelage of the Regional Health Administrations and Health Center Groups, the Public Health units, before the COVID-19 pandemic, were not valued in terms of medical, technical and human resources (doctors, nurses and

[1] According to Portaria no. 141/2014, July 8th.

administrative staff). The public health medical career has never been considered attractive and the conditions for exercising the profession have always been insufficient. In Portugal, there are only 350 doctors specialized in Public Health. There are areas of the country where each doctor is in charge of 12, 13 or 14 counties. It is a situation that is already being reviewed, but much too slowly. " [Translated].

With regard to the inclusion of Public Health in the Legislation, the Preliminary Draft of the Framework Law on Healthcare (Lei de Bases da Saúde) elaborated in 2018 by a Team led by Professor Maria de Belém Roseira, PhD, placed, almost in a premonitory way, a great emphasis on Public Health issues, fully dedicating Chapter III of the Proposal[2] (eight articles – "*Bases*"), of great development) to this topic, dealing with the centrality of health policy in public health and also, in particular, addressing the need to assess the impacts of different policies (employment, environmental, public works, among others) on public health. Base XV was specifically dedicated to public health emergency situations, setting out the possibility of civil requisitions of health professionals and establishments, as well as the need for the Health Authority to act in harmony with international entities, allowing "[. ..] preparing for and responding to threats, early detection, risk assessment and communication." (Base XV/4) [Translated].

As this Law Proposal was set aside, few references to Public Health are identified in the diploma currently in force, Law No. 95/2019, of September 4th (which revoked the previous Framework Law, which dates from 1990). Base IV states that one of the foundations of the Health Policy is the improvement of the health of the population, through, inter alia, a public health approach. Base X is dedicated specifically to this matter, setting out, under the heading "Public Health":

1. It is the responsibility of the State to monitor the evolution of the health of the population, the general well-being of people and the community, through the development and implementation of health observation instruments.
2. The member of the Government responsible for the health must identify specific areas of intervention, programs and actions to promote health and prevent disease throughout life,

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[2] Which can be found at: Cadernos da Lex Medicinae - n.º 3 | Lei de Bases da Saúde - Materiais e razões de um projeto, 2018, pp. 41 ff.

> bearing in mind the health problems with the greatest impact on morbidity and mortality, sociodemographic challenges and the existence of non-modifiable determinants, as well as social, economic, commercial, environmental, lifestyle elements and access to services.

Other references to Public Health appear in the *scope of genomics and its relevance to Public Health* (Base XI, 1st paragraph), as well as the *need for the presence of health literacy in decisions on Public Health* (Base XI / 2). Greater emphasis is given to this matter in the list of competences of the Health Authority (Base XXXIV), whose duties were particular relevant in mitigating the SARS-CoV-2 Pandemic. The need to assess the impact of programs, plans or projects (public or private) that may affect public health is established in Base XXXVII.

Unlike other jurisdictions, the **Macao, S.A.R.** already had a legal basis to support the necessary measures to control Pandemic: Law No. 2/2004 (updated by Law No. 1/2016), for the prevention, control and treatment of communicable diseases, published in the wake of the health crisis caused by the 2001-2003 SARS epidemic, which deeply affected Macao. Based on this law, even before the first cases arrived in Macao, the New Coronavirus Contingency Coordination Center was created, with the aim of monitoring the evolution of the pandemic and implementing any measures deemed necessary. Another fact that makes it possible to explain the relevance of public health in Macau is the inclusion, in the organic-functional structure of the Macau Health Services (SSM) (Decree-Law no. 81/99/M, of November 15th), of a Laboratory of Public Health (article 23), integrated in a subsystem of generalized health care (article 18), in whose attributions we emphasize the programing and execution of "the necessary actions that allow for the best knowledge of risk factors for health, epidemiological situations, the most relevant diseases of the population and evaluate the results of those actions"(23/1 /a)).

Regarding the **Administrative Region**, one respondent affirms that a strong public health policy is needed in the territory, given the fact that it is a tourist destination with millions of annual visitors and with hundreds of workers crossing the border with China and Hong Kong every day. In addition, it was reported that this subject received increased attention after the SARS Pandemic of 2002. All respondents understand that Public Health is essential in Macao.

Taking this overall picture into consideration, it is noticeable that in the universe of the Countries/Administrative Region studied, SARS-CoV-2 emphasized the importance of public health. In **Angola**, the highlight again is in the country's economic and political situation: the population's fragile economic situation demanded that the State policies adopted to mitigate the Pandemic reinforce the protection afforded to citizens. In **Portugal**, Public Health started to emerge as a daily protagonist of political discussions, conditioning the decisions made by the Government. Experts in the field began to be systematically asked about the impact of the policies adopted in the development of the number of cases and in the advancement of the "waves" of contagion of the virus. Respondents were sensitive to this accentuated relevance, mentioning an "exponential increase in the importance attributed" to Public Health and mentioning that "Portugal 'woke up' to the importance of these services, which are the first line of defense against epidemics and the first response to people's health problems " [Translated].

Regarding legislation, the options of the **Portuguese** legislator were conditioned by the emergence of the conditioning of Public Health concerns, at levels as distinct as in the State's Non-Contractual Responsibility, whose regime is stipulated by Law 67/2007, of December 31st, which enshrines a general *indemnity clause for sacrifice*, which aims to compensate for *abnormal* and *special* damages: "[...] losses or expenses that affect a person or a group of people, providing that they do not affect the majority of people, are considered special; and abnormal losses or expenses are those which, exceeding the costs of living in society, for their gravity, deserve the protection of the law."(article 2). With sectors to be disproportionately affected by the State of constitutional emergency and its regulation by the Government, there is a clear "sacrifice" in the current context of the Pandemic. As a derogation from this right to compensation, Decree-Law 19-A/2020, of April 30th (which establishes an exceptional and temporary regime for the financial rebalancing of long-term contracts, within the scope of the COVID-19 disease pandemic), whose Article 8 removes this compensation during the Covid-19 pandemic, stating that: "Losses resulting from acts legally practiced by the State or another public entity, in the exercise of the powers conferred by public health and civil protection legislation, or in the context of a state of emergency, for the purposes of prevention and combating the COVID-19 pandemic, are considered product of a

force majeure event for this purpose and do not warrant compensation for sacrifice.". This rule appears problematic, of dubious constitutional conformity, especially considering the economic impact of the measures adopted to combat SARS-CoV-2. Transposing the content of the rule to the scope of Health, it is undeniable that there is a sacrifice when a citizen is vaccinated in order to protect the population in general and who, due to his decision, may suffer damage. Likewise, it is known that non-covid patients have been particularly affected by the right of access to treatment and the right to treatment in a timely manner, guaranteed by the legislation that sets maximum waiting times for consultations and surgical interventions[3].

Of the 37 respondents who answered this question, 38% revealed that the Pandemic highlighted the weaknesses of national health systems; 60% believe that Covid brought with it an exponential increase in the relevance of Public Health, allowing the population to understand the need to adopt universal hygiene and health policies, valuing the figure of the health professional and the provision of health care, in general.

The public health career in the field of Medicine appears, as we have already had the opportunity to clarify, regulated in **Portugal**. Firstly, in this country, Decree-Law no. 177/2009, of August 4th, establishes the regime of special medical careers, as well as the respective professional qualification requirements, and sets out in article 7/1, safeguarding the possibility of integrating other areas of professional practice, that there are different medical specializations: "[...] the hospital, general and family medicine, public health, legal medicine and occupational medicine areas [...]" (emphasis added). The training program for the Public Health specialization area is regulated by Ordinance No. 141/2014, of July 8th. This plan includes internships in fields as diverse as community health, epidemiological research in public health, or public health auditing. Among the skills to be acquired, it is intended that interns are knowledgeable, among other areas, in the issues of epidemiology and control of communicable diseases as well as generally aware of the demographic, social, biological and environmental factors that influence health. One respondent clarifies that "in the past, there were, in fact, 3 medical careers: general practice, hospital and public health",

[3] Portaria no. 153/2017, May 4th.

Currently, however, "Being integrated into the medical career and being a medical specialty, Public Health, is like all other specialties, regulated by the Order of Doctors (*Ordem dos Médicos*), having its own specialty college. At the international level, Public Health in Portugal is a member of the board of Public Health Medicine of the European Union of Medical Specialists (UEMS). " [Translated].

Likewise, in the **Macao S.A.R.**, the public health medical career is set out by Law no. 10/2010 (article 8/1/3)). One respondent clarifies that the medical career in Macau includes hospital medicine, general medicine, public health medicine, dental medicine and traditional Chinese medicine. Thus, there is a branch of public health in the complementary internship that enables the doctor to practice the public health specialty (Decree-Law no. 8/99/M, of March 15th).

In **Brazil**, in addition to the *public health professional's career* (Ordinance No. 256, of March 11th, 2013, Article 5 that defines him as a "[...] professional with a university degree in health and with a postgrad in public or collective health, or with a degree in one of these fields"), there is, in addition, the *collective health professional*[4], whose role implies a broader view of public health, which goes beyond epidemiological issues and which takes into account other areas of knowledge that affect health, namely the social determinants of health (housing, education, etc.). These professionals are not doctors, they usually have a Bachelor's degree in Collective Health. They work in health institutions, assuming administrative functions, alerting, now with the Pandemic, to the variants that are affecting the response of these institutions to Covid, recommending an articulated action from different areas of practice. Having these professionals has had very positive results in **Brazil** and, in our view, could be replicated in other countries. Thus, one of the recommendations for the countries and S.A.R. involved is the implementation of a career path comparable to the collective health professional, to be assumed by people who have received specialized training (for example, with basic training in nursing or who have graduated from a specific degree made available in higher education institutions). These professionals may support public health doctors in situations of pandemic crisis', namely exercising screening functions and coming up

[4] Fernando CUPERTINO. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

with action plans to organize the administration of vaccines (determining priorities, for example). Developing a specific occupation in this area aims to alleviate the diversion of specialized health professionals to screening functions carried out, for example, as in Portugal, by telephone (SNS 24).

In **Angola** and **Mozambique**, respondents do not seem very sure as to whether or not such regulation exists. In the first country, only 3 respondents answered affirmatively. In the second, the only respondent who answered the question believes that this career is regulated.

Within Health Law, the subject of Public Health is not always studied. In **Angola**, there are no law degree programmes that include studying Health Law, there are only postgraduate courses that occasionally mean that theses and dissertations in the area of Health Law are produced. If one looks at the **Portuguese** case, it is necessary to take into account that, from the outset, Health Law itself is not an area of Law that receives a lot of attention in the legal universe, notwithstanding a recent growing interest in its research and legal practice, with law firms having Health Law as an exclusive practice area or incorporating this subject in the range of more classic legal fields. Given that the subject of Public Health is very specific, few training opportunities for lawyers are available. In the last years, two Postgraduate courses were organized by the Center for Biomedical Law of the Faculty of Law of the University of Coimbra (CDB): the first edition, in 2016, and the second, more recently, in 2019, bringing together Health and Law specialists. Publications on the subject include the Portuguese Journal of Public Health, previously titled *Revista Portuguesa de Direito da Saúde*, published by ENSP-NOVA.

In **Brazil**, respondents report that Health Law is a subject offered by some institutions that teach law (the 12 respondents who answered the question answered it affirmatively). However, it more often appears in specialization or postgraduate courses or as a non-mandatory subject in postgraduate training.

We shall dedicate the following pages to the analysis of the Health Systems of the territories involved in the Study. As for the characterization, per se, of these Systems, comparing those that assume a Bismarckian character (mandatory insurance) to those structured in a Beveridgian format (financed by taxes), we can say that the Portuguese System is undoubtedly a *blended* system, combining the SNS, financed by the

State, with private insurance contracted by citizens. In the Report on the Evolution of Insurance Activity for the 3rd Quarter of 2020, published by the Insurance and Pension Funds Supervisory Authority (ASF - *Autoridade de Supervisão de Seguros e Fundos de Pensões*), there was an increase of 8.9% in the acquisition of health insurance compared to 2019 (within the realm of non-life insurance)[5]. It is estimated that more than 3.15 million Portuguese resort health insurance. The SNS, on the other hand, is rooted in the Constitution of the Portuguese Republic, specifically in its article 64, which establishes the right to health protection. Number two, paragraph a) of this article sets out that this right is exercised namely "Through a universal national health service which takes into account the economic and social situation of citizens, and tends to be free" [Translated]. The word "*tends*" included in this article authorizes fees being charged to citizens[6], in compliance with the limits and guidelines set out in the Health Framework Law, specifically Base 24. Of the total expenditure on health, the OECD estimates that 66% of the expenditure is borne by the State[7], through direct government funding ("government schemes") and social security insurance. In Portugal, between 2009 and 2017, the same entity reported a 3% increase in the amount of health expenses borne out-of-pocket by citizens. In the acquisition of medication, the OECD reports that 55% of expenses are borne by the State, 1% by insurance companies and 44% by citizens[8]. Thus, the presence of health insurance in the Portuguese system has been growing and has been increasing in step with the evolution of the Pandemic. The interest in insurance was consolidated after it became clear that most insurers (Multicare, Advancecare, Allianz, Médis, Montepio, Future Healthcare, Generali ...) were going to cover the costs of Covid-19 testing, providing that

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[5] Report Available at: https://www.asf.com.pt/NR/rdonlyres/8BD33AE3-9A-2D-4D8F-92D0-1EF3039A877E/0/REAS_3T2020_3.pdf (last access: 10/02/2021)

[6] From January 1st, 2021, there has been a progressive exemption of these Fees: in addition to the exemptions that were put in place prior to this year, these fees are now waived in primary health care appointments and also in supplementary diagnostic and therapeutic testing prescribed within the provision of primary and equivalent health care.

[7] Data from 2017, available at: https://www.oecd-ilibrary.org/sites/7f66369c-en/index.html?itemId=/content/component/7f66369c-en (last access: 10/02/2021)

[8] Data from 2017, available at: https://www.oecd-ilibrary.org/sites/3b2d8ac-1-en/index.html?itemId=/content/component/3b2d8ac1-en (last access: 10/02/2021)

the insured citizen had obtained a medical prescription for these tests. Other costs, namely Medical Protection Kits (PPE), are reimbursed by some insurers, although hospitalization costs related to SARS-Cov-2, as a general rule, are not covered by the policies, since epidemics are usually excluded from health insurance policies. Of the 7 Portuguese respondents, 3 consider the system "combined" and 4 "Beveridgian".

The **Angolan** system follows the same *mixed/combined/blended* model, despite the prevalence of the Beveridgian segment. There are few public institutions that use the Bismarckian system, in contrast, in the private sector are the large companies that use the Bismarckian system. According to Cristóvão Simões, Dean of the José Eduardo dos Santos University, guest speaker at the Workshop organized by the Team, the Angolan health system is a fragile and insufficient health system, characterized by the reduced number of health units, with few professionals, with limited specialization[9].

There is a State funded Public Health System in **Portugal**. The SNS Statute was approved by Decree-Law no. 11/93, of January 15th (currently updated by Law no. 82-B/2014, of December 31st), which is, notwithstanding its national scope, divided into five health regions, subdivided into sub-regions, in turn divided into health areas (articles 3, 4 and 5 of the diploma). The financing of the SNS is regulated by articles 23 and following of the Decree: the State appears as responsible for the funding of the SNS, alongside, namely, the users who not beneficiaries of the SNS. Article 24 explicitly enshrines the possibility of acquiring health insurance. Recently, the role of Municipalities in the management of the SNS has received the changes contained in Decree Law No. 23/2019, of January 30th, 2019, which transfers to the Municipality, competences for maintenance and equipment conservation of the facilities of primary health care services. However, only a low percentage of Municipalities agreed to immediately assume these responsibilities in the field of health, benefiting from the regime that allows this transfer to be carried out by 2021 (article 20/2).

Also State funded, but with financial support through donations from international organizations, such as WHO and the EU, is the National Health System (SNS) of **Angola**. The Framework Law of the

[9] Cristóvão SIMÕES. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

National Health System contemplates the possibility of the State contracting with private entities to provide health care to the population (article 11/3). The SNS provides health care universally and *tends* to be free of charge (Article 22, since fees may be charged, under the terms of Article 28), financed by the State Budget (Article 27), but allowed to collect its own revenue and able to receive donations.

The **Angolan** SNS includes both a Central (State) and Local (Provincial and Municipal) component - Article 17. Three levels of hierarchy are identified in the Angolan SNS (Article 12): the basic level is represented by Primary Health Care, provided by health clinics and centers, nursing clinics and doctors' offices and Municipal hospitals. At an intermediate (secondary) level, there are General Hospitals and the top of the pyramid is occupied by reference hospitals[10].

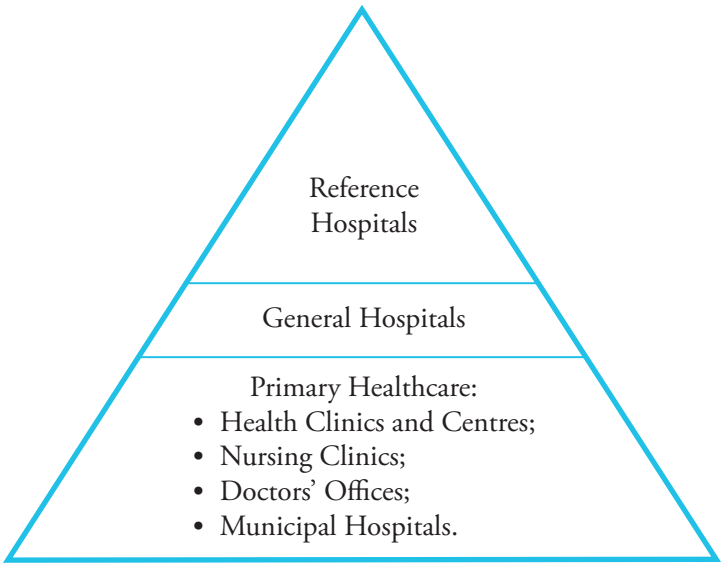

Figure 1 – SNS hierarchy in Angola

In **Brazil**, the framework diploma in this matter is Law 8.080, of September 19th, 1990, which establishes the Unified Health System (SUS), which establishes that "The private sector may participate in the Unified Health System (SUS), in supplementary function" (article

[10] Cristóvão SIMÕES. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

4/§2) and having a Title (Title II) setting out the possibility of health care being provided through private initiative, as well as the possibility of articulation between the SUS and private individuals, namely by inability of the SUS to respond. The SUS is financed by the social security budget (article 31), and also has revenues, for example, from donations and fees and emoluments charged for its services. One respondent explained that, despite the universal coverage of SUS, "about 25% of the population has a private health plan/insurance for outpatient and hospital actions", a value with some expression, so he considers that the system is mixed.

In **Mozambique**, the public health system was established by Law No. 25/91 of December 31st, and the articulation with private entities is provided for by Law No. 26/91 of December 31st (amended by Law No. 24/2009 of September 28th). Respondents reveal the lack of structure of the public health system alongside the increase in the expressiveness of private insurance.

The public health sector in **Macao** is covered by the Macao Health Services (SSM), with administrative, financial and patrimonial autonomy (article 1 of Decree-Law no. 81/99/M, of November 15th). According to article 52 of the Decree, SSM resources come from the General Budget, contributions from Public Administration workers for medical and medication assistance, but also, among other resources, the amounts charged for the services provided. It was clarified by a respondent that, in Macao, the system is of Beveridgian origin, presenting an increasingly mixed character, due to the contracting of private health insurance at the business level, when, after 1999, there was a decrease in the quality of these services, hence another respondent even classified the mixed system. We were also informed that according to article 123 of the Basic Law, the Government of the Macao Special Administrative Region defines, on its own, the policy regarding medical and health services.

In **Portugal** the role of the third sector (social sector, cooperative, houses of mercy and charitable foundations) in health care is an important one but needs to be reinforced. The third sector plays an essential role, for example, at the level of integrated long-term care units. The presence of "[...] private institutions of social solidarity and others of recognized public interest without a profit character" is set out in article 63/5 of the CRP, which are awarded the support and supervision of the

State, "[...] with a view to pursuing social solidarity objectives [...]". **Angola** faces the similar issues: in a country in which the third sector is almost non-existent, boiling down to religious institutions (Catholic Church and Evangelical Congregational Church) that have hospitals in their Missions that are providing some service in the provision of health care. Cristóvão Simões also pointed out a very important social support program called "Kwenda", which means in many of Angola's national languages "to travel", "to walk", "to go", "to come" ... This program has *agents for sanitary and community development* (ADECOS) whose mission is to register areas and people with severe levels of poverty and to catalog areas at risk of contamination by covid-19. They are also dedicated to educating people on implementing personal and community measures to prevent covid-19[11]. In **Brazil**, the response capacity of the third sector was enhanced through Law No. 13.995, of May 5th, 2020, which provides for the provision of financial assistance by the Union to non-profit houses of mercy and philanthropic hospitals which participate in the fight against SARS-CoV-2.

In **Macao**, a respondent highlights the role of the third sector, especially among the most vulnerable citizens and migrant workers.

Of the 30 respondents who answered this question, 65% believe that the third sector works in a supplementary way to national health systems. In **Brazil**, respondents underline that this sector allows for the burden on public systems to be eased. In the **Macao, S.A.R.** and **Angola**, there are those who say that the sector is almost non-existent, very limited, but despite it not being appreciated, it nonetheless plays a predominant role among the most vulnerable population groups. This is a tendency of response common to other systems: 30% of the total respondents recognize the importance of the social sectors with specific population groups. A respondent from Angola says, in this regard, that "[…] there are private clinics with limited access by the majority of the population due to the high costs. On the other hand, there are charitable institutions and houses of mercy mainly associated to religious institutions that provide services without payment or at a much lower price when compared to services provided by private clinics. ".

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[11] Cristóvão SIMÕES. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

Then assessing the degree of preparedness for emergency situations, it is noted that, in most of the institutions surveyed, prior to the SARS-CoV-2 pandemic, there were no emergency preparedness and response mechanisms (for example: teleworking), use of personal protective equipment, telemedicine, distance learning, limited visits, etc.). In **Angola**, only two of the respondents answered this question positively: there was, in general, no implementation of these mechanisms in the institutions. Only one case of preparedness was identified in **Mozambique** and again in **Macao**. The same situation of lack of preparation was identified in **Portugal**: if we look at the case of the University of Coimbra, the institution to which a relevant number of researchers of the Team is affiliated, these mechanisms did not exist. In **Brazil**, eleven cases were reported of institutions that already provided for the possibility of adopting remote work in case of need (such as allowing employees to provide support to their families and which will be extended soon to protect motherhood - pregnant women and mothers of children up to two years old - and for those with disability family members at their charge). In **Mozambique**, one of the respondents referred that the institution where he works had long invested in the implementation and improvement of telemedicine, and welcomed the mandatory imposition of these mechanisms, as they streamlined and made health care more flexible.

Now considering the respondents' opinion, regarding imposing that these mechanisms in health-related institutions are made mandatory, almost all were in favour of imposing them. From the Team's perspective, it was clear that at least the maintenance of PPE stocks would be beneficial, namely surgical masks and alcohol-gel and temperature measurement equipment, *at the very least* in institutions linked to healthcare provision. The organization of drills, similar to those that are mandatory for earthquakes and fires was also deemed useful: organizing a situation in which, in two weeks, in a School, distance learning is adopted, complying with prepared protocols for this purpose could be essential as a preventative measure. Only one respondent spoke out against mandatory measures, as he understands that a legal requirement will not meet the particular context of each health institution.

Regarding **Portugal**, one respondent clarifies that "public health contingency planning (national in scope and local implementation) has been carried out since 2004 and that in 2007 the national contingency

plan for the flu pandemic (ie, two years before the emergence of the so-called "influenza A" virus)" [Translated].

The question on whether there is in each country a National Institution that issues recommendations on how to act in the event of a pandemic, in **Angola** this function falls on the National Health Directorate (*Direção Nacional de Saúde*), an organ within the organic structure of the Ministry of Health. There is also an Interministerial Commission to Combat Covid-19.

In **Brazil**, we were told that: "[...] historically, national coordination for pandemics (like AIDS, H1N1) has been under the guardianship of the National Health Surveillance Secretariat (*Secretaria Nacional de Vigilância em Saúde*), subordinated to the Ministry of Health, based on commands debated and agreed upon in Intergovernmental Commissions, while taking into account the specific powers of the National Health Surveillance Agency (Anvisa - *Agência Nacional de Vigilância Sanitária*). In 2020, during the Covid-19 pandemic, in the face of difficulties with creating a unanimous speech in favour of the pandemic prevention, control and mitigation measures, the Supreme Federal Court (Constitutional Court of Brazil) recognized the competing competence of the state, district and municipal entities for the purposes of issuing recommendations in their respective territories, therefore, the authority issuing the recommendations belongs to the public sector, in any sphere. " [Translated].

In **Portugal**, this institution is the Directorate-General for Health (DGS – *Direção Geral da Saúde*), which depends on the Government. Regulatory Decree No. 14/2012, of January 26th, approves the structure of the DGS as a central service of the Ministry of Health (which not only has revenues from the State Budget but also its own revenues - article 6 - and is integrated in the direct administration of the State, endowed with administrative autonomy - article 1). Among the duties of the DGS is the epidemiological surveillance of health determinants and communicable diseases, as well as the coordination of alert systems and preparing appropriate response to public health emergencies (article 2/2/b)). The issuance of rules and guidelines and collaboration in the definition of policies and priorities of the Public Prosecution Service are also part of the mission of the DGS (2/2/a) and e)). In 2017, the *Saúde 24* telephone hotline (Contact Center of the National Health Service – CCSNS - *Centro de Contacto do Serviço Nacional de Saúde*),

which assumed a relevant role during the Pandemic subject to a new configuration, came out of the DGS' competence for the SPMS (the Shared Services of the Ministry of Health, in Portuguese the *Serviços Partilhados do Ministério da Saúde, E. P. E.*), through Decree-Law No. 69/2017, of 16 June. One respondent stresses the INFARMED's (*National Authority for Medicament and Health Products*) competence to issue recommendations.

In **Macao**, through Chief Executive Order No. 23/2020, of January 21st, the New Coronavirus Contingency Coordination Center was created (whose financial, administrative and logistical support falls upon the SSM - article 6 - and under the direct dependence of the Chief Executive - article 3) responsible for the overall planning, guidance and coordination of the actions of public and private entities, within the scope of prevention, control and treatment of infections by a new type of coronavirus. One respondent also stresses the role of the Secretariat for Health and Social Affairs and Culture and the Directorate of Health Services (SSM), as well as the Center for Disease Prevention and Control in Health Services.

In **Mozambique**, the role of Presidential Decree No. 41/2020 of December 28th was highlighted, through which "the competences, organization and functioning of the Coordinating Entity for Disaster Risk Management and Reduction (*Entidade Coordenadora de Gestão e Redução do Risco de Desastres*), created by Law no. 10/2020, of August 24th, with the designation of the National Institute for Disaster Risk Management and Reduction (*Instituto Nacional de Gestão e Redução do Risco de Desastres*), were defined. Among the respective bodies we have the Technical Council for Disaster Risk Management and Reduction (*Conselho Técnico de Gestão e Redução do Risco de Desastres*), a multisectoral technical advisory body to the Coordinating Council for Disaster Risk Management and Reduction (*Conselho Técnico de Gestão e Redução do Risco de Desastres*) on matters of management and disaster risk reduction, chaired by the President of the Institute (it also includes directors and representatives from different areas, including health). In pursuit of its objectives, it is incumbent upon the Technical Council for Disaster Risk Management and Reduction, among other functions: to coordinate sectorial systems for early warning and warning of phenomena of meteorological, hydrological, geological origin, epidemics, pandemics and impacts on food security and nutritional; as well as to propose to

the Coordinating Council for Management and Disaster Risk Reduction the declaration of the Situation of Public or Emergency Disasters." [Translated].

Evaluating the response to the SARS-CoV-2 public health emergency, specifically with regard to the allocation of public resources (for the prevention, treatment and rehabilitation of COVID patients) the data currently available for **Portugal** was published by *Jornal Público*[12]. According to this publication, the biggest expense of the State was the purchase of PPE, amounting to 212,743,342 euros. In addition to this equipment, which aims to prevent the spread of the virus, testing also assumed a substantial part of the State's expenditure, almost 60 million euros. One of the most significant contracts was the acquisition of 243 ventilators from a Guangdong company, in the amount of more than 10 million euros (out of a total of almost 40 million spent on the purchase of ventilators, which does not include the 4 million spent with the necessary accessories for this equipment). Other treatment expenses include the purchase of medication (about 11 million). Despite the high costs of prevention against SARS-CoV-2, it is understandable that people are increasingly investing in this sector. The high cost of maintaining patients in intensive care units is substantial when patients have to be transferred to private institutions: the admission of a Covid patient for treatment using a ventilator can cost the State 8431 euros[13], which private hospitals consider to be much lower than the real cost of the service.

In **Angola**, opinions on this matter were relatively divided: on the one hand, some respondents considered that this allocation has been made according to the availability of the State Budget and, in that sense, it has been positive. On the other hand, it is considered that the response was too centralised, not reaching the entire territory and that prevention did not receive sufficient resources.

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[12] Data available at: https://www.publico.pt/interactivo/gastos-covid-19#/ (last access: 13/02/2021).

[13] See, for reference, Annex I of the Contract Template between the Health Regional Administrations (ARS - *Administração Regional de Saúde*) and private healthcare institutions, available at: http://www.acss.min-saude.pt/wp-content/uploads/2020/11/Clausulado-Tipo-Convencao-Hospitais-Privados_V_Nov-2020.pdf (last access: 13/02/2021).

In **Brazil**, of the 8 respondents who answered the question, 6 negatively evaluate the allocation that was made (reasonable and positive allocation, respectively, received one vote). The respondents consider that more resources were needed and improving their management should be a priority. The participants also condemned the embezzlement of public funds, the delay in the distribution of materials and the investment in treatments had been proved to be ineffective from a scientific point of view.

In **Mozambique**, the allocation of resources was rated by one respondent as "terrible". Another considers that what was possible was done, arguing that the allocation was thus reasonable.

In the **Macao S.A.R.**, instead of a mitigation strategy, measures were adopted to prevent the virus from entering the territory, as well as preventing its transmission within the community. The allocation of resources thus focuses on the prevention of spread (organized distribution of masks to residents, installation of body temperature measurement equipment in public places, etc.). Of the 5 respondents who answered the question, all were satisfied with the allocation implemented in the territory.

One respondent testified that "The Macao S.A.R. has adopted an epidemic suppression/ elimination strategy. The prevention, treatment and rehabilitation of COVID-19 patients has been an objective with a high degree of priority in the allocation of public resources (especially prevention)" [Translated].

In view of these values and data, the Team understands that prevention must assume the main priority in the allocation of health public resources in the management of this pandemic. The costs with PPE, information and clarification campaigns, although significant, allow the control of the development of the phases of the Pandemic, to prevent infections and deaths. Among participants' responses, prevention was also deemed essential: increasing testing capacity, providing information to citizens, increasing the number of hospital beds and, in general, investing in the health sector (hospital facilities, equipment, etc.).

In view of the data collected, it was clear to the Team that the transmission of information related to the public health emergency response COVID-19, by the official authorities, has been *slow and unclear* in **Portugal**. The authorities were slow to advise the use of masks to the population, denied that air transport was a rapid source

of the spread of the virus, although, in an apparently opposite sense, they mentioned the need to ventilate the houses. Throughout the first wave of the virus, in relation to public transport - one of the places with the highest concentration of people and prone to quickly spreading the virus - no practical measures of social distancing were initially implemented and, at a certain point in time, the frequency of buses and trains was actually reduced. More recently, after many European countries have abandoned the use of the so-called "social masks" (as they apparently do not offer the necessary protection against the new strains of SARS-CoV-2) and the United States of America recommends the use of two masks simultaneously, authorities have struggled to quickly and effectively enlighten the population on this topic. As the idea that the correct use of masks could be more advantageous than the adoption of the options advocated by other countries, there is no information campaign via television, for example, explaining with clear and accessible language and imagery, the necessary caution that is needed to select, use, handle and dispose of masks. 5 of the 7 respondents point out contradictory information, excessive information, fearmongering, misinformation, etc. Only 1 considers that it was positive. Another labels the transmission of information as "quick, but not clear" [Translated].

Furthermore, while in **Mozambique**, for example, it was reported to the Team (in the sharing sessions held with specialists), that there was a massive mobilization of the media, **Portugal** lacked information that could be clearly interpreted, which resulted in the population being the target of many numerical and statistical data, which the general public fails to easily grasp, becoming particularly susceptible to disinformation. Of the 4 **Mozambican** respondents, 3 believe that the transmission was positive, praising the fact that it was a major political priority, stressing that "the media maintained their normal functioning even during the state of emergency" [Translated].

In **Angola**, participants believe that the information has been transmitted clearly and quickly. Of the 8 respondents, only one is dissatisfied with information dissemination. Evaluated as reasonable by 2 respondents, they warned that the media, such as radio and television, do not reach the entire population. There was also one respondent who considers that there are some doubts about the reliability of the number of infections publicly advertised.

In **Brazil**, one of the difficulties inherent to combating SARS-CoV-2 identified by Professor Fernando Cupertino[14], PhD is, precisely, the inexistence of an effective information network through the media, able to provide educational information to the population. Respondents point the finger at the Government, which has been inefficient in disclosing information in a clear way, and has advocated for the adoption of scientifically condemnable behaviours, as well as generally underestimated the SARS-CoV-2 pandemic, which has hampered the adoption of effective prevention measures, such as social distancing. There is talk of the lack of a "nationally coordinated communication plan that can reflect the unanimous thinking of health authorities.". The respondents' opinion reflects this position: 11 out of 15 Brazilians who answered this question believe that contradictory information was disseminated, in a non-timely manner, aggravated by being difficult to apprehend and often lacking the necessary scientific basis.

In **Macao**, there was a great mobilization of the media to transmit institutional advertisements, alerting the population to the need of adopting the essential respiratory etiquette practices. Bulletins included guidelines on the correct use of masks, hand washing, space hygiene, as well as explaining how digital tracking media (to track contacts and alert the authorities to potentially positive Covid cases) should be used. In October 2020, a study by the Macao Polling Research Association[15], which surveyed half a thousand residents, found that 95% of the population was generally satisfied with the Government's performance during the Pandemic and, in particular, with the way how the authorities communicated with the population, transmitting the necessary recommendations. 5 of the 6 respondents evaluate the dissemination of information in a positive way, with clear, complete and updated information, with one participant inclusively labelling the information policy as "excessively zealous".

To alleviate the problems related to the dissemination of information, it was reported, in March 2021, that the **Portuguese** Government

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[14] Fernando CUPERTINO. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

[15] Juliana Qi Xuan YUNCG, *et al.*, *Towards a Dialogic Approach: Crisis Communications and Public Reactions in the World's Most Densely Populated City to Tackle COVID-19*, Asian Journal for Public Opinion Research, Volume 8, Issue 3, 2020, pp. 265-296

was committed to this issue, having created a Task Force of scientists to improve communication about the Pandemic. Of the general population of respondents who answered the question (38), criticisms of contradictory information (26%), untimely (13%) and difficult to understand (18%) information, were prevalent, so the Team recommends that efforts be made to improve these vectors.

Instituting the career of the peer mediator (or similar) can be a fundamental vector for overcoming similar situations in the future, according to respondents and experts interviewed by the Team. As they are close to the communities, the mediators provide citizens with information adjusted to their individual and social reality, and may even be in charge of conducting epidemiological surveys and could play a fundamental role in supporting vulnerable population groups, contributing to the effective dissemination of more personalized information.

Regarding the priorities set in health care during the first wave of the pandemic, it is noted that, in **Portugal**, the SNS favoured the fight[16] against Covid[17], which meant the drop in the number of appointments, surgeries and general visits to hospital urgent care. In the second wave, efforts were made to keep the healthcare system functioning as best as possible. Nevertheless, non-urgent surgeries, for example, continue to be postponed, putting pressure on the already fragile SNS[18].

In **Brazil**, the allocation of resources to combat Covid were a priority (increase in the number of hospital beds, designating certain health institutions for exclusive treatment of Covid patients, installation of field hospitals, acquisition of PPE and other essential equipment, hiring professionals and suspension of non-essential activities). In the second wave, in this country, respondents indicate that the effort centred

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[16] These policies had a substantial impact on vulnerable populations, in particular on those who suffer with chronic respiratory illnesses, an impact which was evaluated by the Team with the contribution of Professor Isabel Saraiva, PhD, who represents the *Respira* Association in Portugal, and who was a guest speaker at the Workshop organised by the Team.

[17] According to data from the *Movimento Saúde em Dia*, 57% of the Portuguese consider that the Pandemic has limited the access to health care. Also, 7.8 million less doctors' appointments happened in health centres. On the other hand, not in person appointments doubled from 2019 to 2020, from 9.1 million to 18.5 million. For more data, please refer to: https://www.saudeemdia.pt/?p=home (last access: 26/02/2021).

[18] André DIAS PEREIRA and Ana Elisabete FERREIRA. *Vítimas Colaterais da Covid-19*, Revista Gestão Hospitalar, N.º 20, jan./fev./mar. 2020, pp. 42-47

on the implementation of the vaccination plan and the achievement of the objective of increasing hospital beds.

In **Angola**, the objectives coincide with those established in **Brazil**. Respondents also mention the effort that was made to train professionals (which included hiring doctors, particularly from Cuba) and strengthening laboratory capacity. In **Mozambique** a similar reality is portrayed: the mitigation of SARS-CoV-2 received priority attention. In **both territories**, in the second wave, efforts were made to strengthen the means of response to the virus. In the **Macao S.A.R.**, respondents did not indicate that any priorities were established, other than informing the population and adopting measures to prevent Covid's transmission within the community.

As for changes in the provision of health care, some situations were detected by respondents. In **Mozambique**, a participant reveals, among the measures adopted: "The timely creation of a transit infirmary for patients with covid-19; the opening of isolated temporary wards for infected patients in some hospital services; mandatory use of a mask and visor by health professionals; mandatory use of protective equipment in traffic wards; mandatory hand washing at all hospital entrances and respective services, as well as temperature measuring at the hospital entrances; reduction in the number of visits to the wards per day; cancellation of external consultations and other non-urgent medical procedures " [Translated].

In **Angola**, the cancellation of medical appointments and the suspension of non-urgent surgical activity were also reported. In **Portugal**, the reprogramming of hospital activity, in terms similar to those described above, as well as changes in the level of decision-making in health institutions were reported by respondents.

In **Brazil**, one respondent describes that efforts have been made to implement telemedicine, reinforcing non-face-to-face service channels and training professionals to adapt to these digital media.

Regarding the question of whether it is desirable that changes remain after the pandemic situation, respondents are in favour of some of them remaining in force, namely the reinforcement of human and material resources and the use of PPE.

In **Macao**, no changes were identified at this level.

In **Portugal**, there are situations in which COVID-19 tests are free of charge for the citizen, which correspond to the cases in which testing

is recommended by the SNS, when there is a suspected case of infection with SARS-CoV-2 (clinical, epidemiological, imaging or testing criteria are used to approve such a recommendation). We have already had the opportunity to clarify that health insurance covers some forms of testing (the TRAg and serological testing types are not always covered), when the SNS determines that testing is required. Tests required for travel purposes or carried out on a private initiative, as a general rule, are not covered by insurers. The prices of private tests (of the TAAN type) are fixed at around 100 euros, serological tests at 80 euros and TRAg around 25 euros. These values are considered by respondents to be too high and not accessible to the average citizen.

Hospitalised patients have access to free of charge testing in **Angola**. If the test is carried out by private initiative, it has to be paid. It is understood that the cost is not accessible to the general population, costing between 6000 to 75000 kwanzas, according to one respondent.

In **Macao**, the TAAN test is available from the Government and from 3 private entities (University Hospital, Kiang Wu Hospital, Namyue Group Macao Federation of Trade Unions). The tests are free once, when performed by the SSM for residents. After that, they cost around 180 mop. They are always free for students, citizens under 18 and over 65 and holders of disability certificates. The test costs 90 mop when carried out in private institutions, a cost which is accessible to the population. Respondents consider the values of paid tests to be perfectly accessible to the population of the territory.

In **Brazil**, respondents reveal that, although there are instances in which the test can be performed free of charge under the SUS, when they are paid individually by citizens, they are on the market at very high prices, inaccessible to the population, around R $ 270.00. The same reality is portrayed in **Mozambique**: there are situations in which tests are free, but when they have to be paid out-of-pocket, all respondents report that they are not accessible to the general population.

As for digital traceability mechanisms, the StayAway COVID digital application was implemented in **Portugal**, to be downloaded voluntarily by citizens. Although the Government made efforts in October 2020 to make enforcement mandatory[19], voting on the Proposal was

[19] Law Proposal no. 62/XIV, Presidency of the Council of Ministers, October 18th, 2020, available at: https://app.parlamento.pt/webutils/docs/doc.

abandoned. The application had no geolocation system and its effectiveness was considered very low: the registration of a Covid case in the application had to be done by a doctor and only 2708 contagion alerts were sent. After about three million users were initially identified, in January 2021 it was reported that the Application had been deleted by 60% of users[20].

In **Macao**, the "Macao Health Code" was implemented, an online declaration through which data on health status must be provided upon entering the territory[21] (numbers 1 and 2 of article 10 of Law no. 2/2004), or, voluntarily, within the Macao S.A.R. territory, to access certain public (Post Offices, Banks, Public Services, etc.) or private establishments. The use of the declaration requires the digital submission of identifying personal data (name, date of birth, and, more recently, user's address, etc.), which may be disclosed between government departments and which can be processed to track patients and their contacts. After entering the data, it is processed and the citizen is assigned a green (entry permit), red (prohibition) or yellow (health self-management measures are to be adopted) code. If the person concerned does not have a mobile device, there is a possibility that the digital code may be replaced by a paper declaration. In March 2021, it was announced that the Health Code would start presenting the vaccination record of residents to whom the two doses of the vaccine had already been administered. In addition to this novelty, the digital system now allows for area management, creating records of areas affected by a possible pandemic outbreak and signalling residents with the "red" colour, when their addresses coincide with the affected area.

In **Brazil**, on the other hand, the options for digital tracking mechanisms available are more abundant. Among those identified by the Team, the following stand out: *Coronavirus SUS*, launched by the Ministry of Health of Brazil (digital mobile application that, in addition to

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77634777324d693159535659755a47396a&fich=ppl62-XIV.doc&Inline=true (last access:13/02/2021)

[20] Data from Jornal Público, January 15th, 2021

[21] See, as an example, the Chief Executive Order no. 120/2020, of May 11th which establishes that presenting a Green Code is a prerequisite for entry in the territory by non-resident workers (who are resident in mainland China) - article 1/3.

providing contact alerts, discloses official information about Pandemic, accessing the geolocation of mobile equipment); *Guardiões da Saúde* (digital mobile application, developed by the Association of Field Epidemiology Professionals - *Associação de Profissionais de Epidemiologia de Campo* - associated with the University of Brasília, which aims to organize a database for notification of mild cases suspected of being infected with SARS-CoV-2, using geolocation). The use of these mechanisms is voluntary. The first application has about 10 million downloads (the third most used in the world), and the second about 19 thousand[22].

In **Angola** and **Mozambique** these mechanisms have not been implemented. It is important to highlight, however, and safeguarding the fact that it is not a screening mechanism, the mobilization, in **Mozambique**, of a digital Coronavirus Risk Self-Assessment Tool, made available online, in which citizens they can submit certain data, such as age and sex and identify the presence of virus symptoms, as well as any risk factors (such as travel to heavily affected areas).

Assessing the effectiveness of these mechanisms, when adopted, the respondents (6 of 12 participants who answered the question) understand that the effectiveness is "very low", pointing out the lack of adherence by both health professionals and citizens as the main reason for the failure of these applications. Fears were also raised regarding the processing of personal data. A Portuguese respondent argues that "In addition to being reduced, its effectiveness is questionable and may even disturb the response by public health services" [Translated].

In accessing treatment, there are action protocols, seeking, in the Portuguese case, to avoid the "first come, first served" criteria and favouring the diagnosis criteria, without discrimination based on gender, age or financial situation. In **all the territories evaluated**, it seems clear that the criteria of age, diagnosis (namely, the intensity of respiratory symptoms, says a Brazilian respondent) and risk (presence of comorbidities) have been mobilized.

Regarding the question of whether health professionals have priority access to diagnosis and treatment against SARS-CoV-2, the existence of these priorities was pointed out by almost all respondents (of the 32 respondents who answered this question, 81% identify the existence

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[22] Data available at: https://www.poder360.com.br/coronavirus/conheca-os-aplicativos-de-rastreamento-da-covid-19-usados-pelos-paises/ (last access: 04/03/2020).

of at least one form of priority given to professionals), and it is emphasized that they are, in particular, privileged in accessing vaccination against Covid **in all the territories evaluated**.

Of the universe of 37 respondents who answered this question, about 78% considered the possibility of another Pandemic happening with an equally destructive magnitude to be real, although some participants did not state any particular reasons to justify this opinion, arguing their lack of scientific knowledge on the subject. Among the reasons stated to justify their opinion were the recent history of Pandemics in the global context, globalization (and associated phenomena, such as the frequency of international travel), climate change (and their aggravating factors, such as destruction of ecosystems), the increase in the frequency of transmission of viral chains between animals and humans (with emphasis, by **Brazilian** respondents, on the practice of intensive farming and meat consumption in large proportions), consumerism, laboratory manipulation of viruses and bacteria (and frequent use of antibacterial agents) and the possibility of biological warfare. In **Angola**, respondent believe that the lack of basic sanitation will have implications on the frequency of the spread of infectious and contagious diseases.

As for the declaration of the State of Calamity/Emergency/Exception, we refer the explanation of this reality to the article by Professor Ana Raquel Moniz, PhD. In **all the territories evaluated**, the right to move within and outside the administrative country/region was suspended. In **Portugal**, both in the first and in the second wave, a home confinement policy – lockdown – (duty to remain at home) was adopted. In **Angola**, this partial confinement lasted for about 30 days. The rights of private, social and cooperative initiative were also suspended in **both countries** and civil requisition, although it has not yet materialized in **Portugal**, it remains a possibility at the disposal of the Government, according to the Decree-Law no. 637/74, of November 20th (under article 62/2 of the CRP) or by invoking Base 34, number 2, paragraph d) of the Framework Law on Health (which sets out the possibility of "Requesting services, establishments and health professionals in cases of serious epidemics and other similar situations", or requesting the "[...] intervention by private entities, the social sector and other services and entities of the State" - number 3), in the case of public health emergencies. In **Angola**, it was not necessary to resort to

civil requisition. In **Macao**, the possibility of requisitioning goods and services is also contemplated in Law no. 2/2014 (article 25/1/10)). In this territory, it should be noted that respondents consider that there was a *suspension* of fundamental rights (right to association and right to demonstration, for example), although there was no declaration of a state of exception. Others speak of a *restriction* (but not suspension) of fundamental rights, such as freedom of movement.

In **Mozambique**, a lockdown, per se, was not adopted. Authorities opted to impose reduced access to public spaces, suspend face-to-face teaching, impose curfews (namely in Maputo), introduce mandatory rotation of employees, closing restaurants, among other measures that also limit private events (Decree no. 12/2020, of April 2nd). The Presidential Decree no. 11/2020, of March 30th, which immediately declared the State of Emergency, for reasons of public calamity, was extended several times and Decree No. 79/2020, of September 4th, which Declares the Situation of Public Disaster and Activates the Red Alert.

In **Macao**, access to public spaces (namely casinos, theatres, gyms, cinemas, etc.) was limited through Chief Executive Order no. 27/2020, of February 4th. Access to casinos was resumed on February 20, 2020 and to other public spaces on March 2nd of the same year. Restrictions were imposed on entry into the territory (for example, see Chief Executive Order no. 40/2020, which entered into force on February 20th, including establishing mandatory medical observation periods before entering the territory). Through Chief Executive Order no. 72/2020 (which entered into force on March 18th), all non-residents were prohibited from entering the territory and Chief Executive Order no. 80/2020 suspended all transfer services from the Macau International Airport (article 1/2)). Circulation limitations are derived from articles 10, 14 and 15 of Law no. 2/2014. It should also be stressed the imposition of a mandatory 21-day quarantine, upon arrival at the territory, in a place designated by the Authorities and the inherent expenses to be borne by the interested party.

The **Portuguese** Armed Forces played an important role in the screening of infections, having set up Field Hospitals in their facilities, receiving patients in their Hospitals (in January 2021, more than a thousand infected by SARS-CoV-2 had already been housed there), with a highlight to the contribution of the military laboratory in the processing of Covid tests. In March 2021, Decree No. 4/2021 (which

regulates the extension of the state of emergency) stipulated, specifically, in its article 14 that the armed forces would conduct epidemiological inquiries and track contacts of patients with COVID-19. Respondents mentioned the development and implementation of the vaccination plan as one of the tasks performed by the armed forces, although not all agree with the Armed Forces assuming these tasks. It was suggested that they should play a more active role in the practical logistical organization of combating Covid (equipment management, support in administering and organizing vaccination centres, which is currently carried out, inter alia, by police forces). In addition, criticism was made to the underutilization of the armed forces' human resource potential, as well as the delayed decision of incorporating them in the response to the Pandemic.

In **Angola**, the role played by the military stands out not only in their effort to strengthen defence and security (border control), but also, specifically, in the area of Health, with relevant tasks in the area of testing and treatment of patients. In **Mozambique**, respondents understand that the main tasks assumed by the armed forces were the supervision of the compliance to restrictive measures imposed over the past year.

In this context, it is important to refer to the screening procedures which, according to the experts heard in the sharing opportunities carried out within the scope of the Project, have been of great relevance in the fight against Pandemic. In **Brazil**, screening is an important role of *community family agents* (*agentes comunitários de família*), who are part of the Family Health teams[23]. They are the link between communities and primary health care, and their competences also include tracking illnesses and monitoring chronic conditions. In **Mozambique**, the figure of the *community health agent* stands out: these professionals took care of the Covid screening during the year 2020, as they are particularly close to the populations.

In **Brazil**, the armed forces, in addition to the tasks of tracking and controlling contacts and, in general, supporting the provision of health care, some respondents identify the important role of installing and preparing field hospitals, distributing hospital equipment and, to a lesser extent, producing the controversial hydroxychloroquine.

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[23] Fernando Cupertino. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

In **Portugal**, there were significant changes to religious rituals. In 2020, Decree No. 14-A/2020, of March 18th, stated that the exercise of some rights was "partially suspended", among them "freedom of worship, in its collective dimension" (article 4/f)). Throughout the same year, places of worship imposed limits on the number of people who could be present for celebrations. In 2021, the President's Decree no. 6-B/2021 did not set out the same partial suspension of freedom of worship (article 35/1/a) - religious ceremonies were an exception to the ban on events). The option to suspend the celebration, namely, of public Mass services, was taken by the Portuguese Episcopal Conference and has been in force since January 23rd, 2021. With the imposition of national lockdown, participating in religious ceremonies remained authorized (article 4/2/k) of Decree no. 3-C / 2021, of January 22nd).

Changes were reported in **Angola**. In **Mozambique**, places of worship, conference and religious meetings were shut (article 15, Decree no. 12/2020, of April 2nd). In **Macao**, religious celebrations were also suspended, a measure taken under article 25/1/1) of Law no. 2/2014.

In **Brazil**, the issue has to be assessed concretely in each federal state and has generated some controversy. For example, the decision of the Court of Justice of the State of São Paulo, of March 2020[24], produced by Judge Randolfo Ferraz de Campos, establishes the prohibition "of carrying out masses, services or any religious acts" under "[...] penalty of a daily fine in the amount of R $ 10,000.00 for each defendant.". Days later, the decision of the First Instance, which had given rise to this appeal, was revoked by the President of the Court of Justice of the State of São Paulo. Other judicial decisions to suspend the right to worship were determined in the courts of Rio de Janeiro and Porto Alegre. On March 25th, 2020, Decree 10.292/20 defined religious activities as essential activities, susceptible of being celebrated respecting the limits and guidelines established by the Ministry of Health. Respondents report, above all, the establishment of a maximum capacity occupation of places of worship.

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[24] Court of Justice of the State of São Paulo, *Ação Civil Pública Cível*, Digital Process no. 1015344-44.2020.8.26.0053, by Randolfo Ferraz de Campos, 20/03/2020, available at: https://www.defensoria.sp.def.br/dpesp/Repositorio/31/Documentos/Decisao%20Liminar%20do%20TJSP%20para%20suspensao%20de%20cultos%20e%20missas%20pdf.pdf

As for funeral rituals, in **Portugal**, after the difficulties in determining the criteria for participation in these rituals (non-discrimination of criteria in the cases of funerals of people infected with Covid or not, fixing maximum numbers of people, in what is considered a "dehumanization of death"), Decree no. 3-A/2021 leaves it up to municipalities to define organizational measures that guarantee social distancing, allowing them to fix maximum numbers of attendees (safeguarding the presence of a spouse or de facto partner, ascendants, descendants and relatives - article 29). It was detected in the universe of Portuguese respondents that this aspect is the target of many criticisms: depriving family members of saying goodbye to hospitalized patients and having funeral rituals performed with many limitations are labelled a great "violence" to family members of the deceased.

Changes were reported in **Angola**. Although Law no. 2/14, through its article 22, sets out specific measures for the treatment of bodies in the context of epidemics and infectious diseases, as there were no deaths from SARS-CoV-19 in **Macao**, there was no need to implement these additional measures. In March 2020, the Ching Ming Festival (cult of the ancestors) motivated the SSM to publish recommendations aimed at residents, in order to prevent the spread of the virus in cemeteries and graves[25].

In **Mozambique**, article 16 of Decree no. 12/2020, of April 2nd determined that the number of participants in funeral ceremonies must not exceed 20 people, still ensuring compliance with social distancing and mandatory use of mask. A different regime applies to funeral ceremonies for people suffering from COVID-19, in which the number of participants must not exceed 10 people.

The impact of changes in religious and funeral rituals in **Portugal**, **Angola**, **Mozambique** and **Brazil** is profound. In these countries, all respondents who answered the question found substantial changes in this regard.

There was also a limitation on the right to visit hospitalised patients, with restrictions and suspension of this right covering both Covid and non-Covid patients, in the two phases of Pandemic, in

[25] *Prevention of pneumonia caused by the novel coronavirus (COVID-19) – Recommendations on paying homage to ancestors*, SSM, 23/12/2020, document available at: https://www.ssm.gov.mo/docs/17723/17723_6c70c78a49c241d492540bcf0828c6ae_000.pdf (Last Access: 03/03/2021).

Portugal. According to respondents, restrictions meant that blind patients and patients with reduced mobility were deprived of being accompanied in doctor's appointments and, occasionally, urgent care triage. The ban on visits, respondents report, particularly affected long-term inpatients in intensive care and institutionalized patients. One respondent reported that this limitation applied "[…] to all patients. Exceptional standards and measures have been adapted by the boards of directors of hospitals, hospital centres and local health units. However, digital technology equipment was provided, in several hospitals, so that the contact with family members could be made through videoconference. In some cases, it even brought the patients closer to their relatives. ".

In **Brazil**, it was pointed out by respondents that pregnant women could not be accompanied during labour and birth. The option of the **Angolan** authorities was different, opting to exclude the right to visit Covid patients, maintaining, although with restrictions, the right to visit non-Covid patients. In **Mozambique**, Decree 12/2020, of April 2nd, through its article 4, prohibited visits to Covid patients, reducing the frequency of visits to other patients (maximum of two people per day, per patient). In **Macao**, changes were detected, although it was not clear to respondents at what level they were introduced and who they affected.

With regard to education, at the level of child and youth education (up to 18 years old), in **Portugal**, there was a change in educational practices, suspending all classroom activities. No level of education has been maintained in person, either in the first wave or in the second - since February 5th, 2021 (article 3/2 of Decree no. 3-D/2021, of January 29th). In **Angola**, throughout the State of Emergency, all educational institutions were shut (Executive Decree no. 124/20 of March 30th, from the Ministry of Education). Subsequently, throughout the State of Calamity, a modified in-person regime was introduced in higher and secondary education.

In **Brazil**, in-person learning was suspended (Ordinance no. 343, of March 17th, 2020). In general, it is clear from the questionnaire responses that terrible damage has been done to the education system. One respondent testifies that: "In terms of child and youth education (up to 18 years old) there was a change in educational practices. In-person learning was prohibited for primary and elementary education. The

public school system has not been adapted for distance learning and there is no foreseeable date to return to face-to-face classes. In private education, there was a period where in-person classes were resumed, but were again suspended during the second wave. High school education was severely penalized, with no in-person classes for more than 11 months now, which are not expected to resume, in both the public and private sector, any time soon. University education is also not expected to return to an in-person format more than 11 months after the start of the pandemic. ".

In **Mozambique**, substantial changes were also identified (Decree No. 12/2020, April 2nd), with on-site teaching suspended. Professor Orquídea Massarongo[26], speaker at the Workshop organised as part of the Project, reports that online classes, especially in public schools, did not have the conditions to be successful: even university students have limited access to computers and the internet, especially outside urban areas. As in-person education resumed, in September 2020, it was clear that public schools were not prepared to function in the Pandemic scenario. This conjuncture requires, among other things, regular cleaning: in many of the educational institutions access water was not a reality, and water is the most basic guarantee for hygiene.

In the **Macao S.A.R.**, establishments at all levels of education were closed in the first months of 2020 and online classes were introduced. In-person learning was resumed in stages: the classes from the 4th to the 6th grades restarted onsite on May 25th and on the 1st of June for those between the 1st to the 3rd grades. Kindergartens as well as special, secondary and higher education resumed their normal format afterwards.

Thus, **in all the territories studied**, it is reported that, at least at a certain point in the fight against Pandemic, there was a suspension of in-person education at all levels of education.

To support the education system, the Team proposes that measures are implemented to enhance the access of the educational community to computers and the internet. It is also proposed that proximity schools in areas of the territory where there may be a small number of children per class/school are reopened, taking into account, when suspending in-person learning, a case-by-case assessment of the number of

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[26] Orquídea Massarongo. Content from the Project's Workshop, on the subject of: *The Covid-19 Pandemic in the Lusophone World,* approved by the Speaker.

students and the size of the school. The SARS-CoV-2 Pandemic also revealed the urgency to reassess the current dimension of schools in **Portugal**, which, although they have not been identified in this specific Pandemic as a source of virus spread (because this virus, in particular, does not seem to profoundly affect children, it is known that other epidemic viruses such as the H1N1 strain of 2009-2010 can victimize mostly young people) they could prove to be, in the future, a potentially worrying source of infections.

Among the measures proposed by respondents, there was a clear priority on making equipment and affordable internet plans available to students, with other participants defending the adoption of combined teaching models (with an on-site and off-site system), organizing psychological, social and financial support for families, not suspending sports activities, training teachers on the use of technological equipment, broadcasting classes on an open channel on television (proposed by respondents from **Mozambique** and **Brazil**). The overall need to restructure education systems to cover preparation for pandemic and similar situations was also mentioned.

In **Portugal**, studies on the mental health of children and young people gained particular relevance in 2021, as the effects of the Pandemic worsened and studies began to assess the impact of a new suspension of in-person learning on the mental health of this population group. The Team highlights the research carried out by the *Centro de Estudos e Sondagens de Opinião* (Cesop) of the Catholic University (which was divulged by the television news broadcaster RTP and Jornal Público newspaper[27]); by *Mind* (the Institute of Clinical and Forensic Psychology - *Instituto de Psicologia Clínica e Forense*); and the study "Economic Crisis, Poverty and Inequalities - Report on Socioeconomic Impact and Mental Health", published by the Portuguese Psychologists Order (*Ordem dos Psicólogos Portugueses*). Very recently, a Study entitled "The Impact of Lockdown in the Academy of Coimbra", promoted by the Academic Association of Coimbra (AAC – *Associação Académica de Coimbra*), in which the shortcomings of distance learning and the impact on mental health brought about by the restrictions imposed as a

[27] Jornal Público, 12/02/2021, https://www.publico.pt/2021/02/12/p3/noticia/confinados-74-alunos-universidade-coimbra-pensaram-desistir-estudar-1950408 (Last Access: 18/02/2021).

result of the Pandemic were evaluated. In **Angola**, **Mozambique** and in **Macao**, respondents are generally unaware of any study on the matter.

In **Brazil**, there are 3 studies organized by the Institute for Applied Economic Research (Ipea) and the International Labour Organization (ILO), focused on researching the impact of the Pandemic on the youth labour market, which highlights the increase in inactivity, non-integration of the youth in the country's workforce and decreased professional training[28].

Regarding the elderly population, in **Portugal**, few or no measures have been institutionally adopted to support them. In **Angola**, there is no record of measures adopted in this matter, with the exception of promoting the isolation of this population group and supplying PPE to elderly care homes. The main support, in **Portugal**, was the product of the effort of the social and private sector and, occasionally, by municipal authorities. Situations of abandonment and isolation are reported. Among the realities that most affected this population were, in particular, the closure of Elderly Daycare Centres (*Centros de Dia*) - which, in addition to depriving the elderly of the necessary stimulation and social interaction, has put more pressure on caregivers and families, with the added burden of the prohibition of visits to nursing homes and hospitals. It should be noted that, in **Portugal**, the population residing in elderly homes contributed to the large number of infections and deaths: in addition to their age, they were a risk group due to the frequent presence of associated comorbidities and the fact that they were residents in closed spaces. The not unusual isolation of the elderly has worsened with the suspension of visits to elderly care homes and hospitals and the mortality rate in homes remains high due to the resistance to adopt testing systems and not imposing exclusivity regimes for the employees of these institutions (who could reside in the homes and work in teams on a rotation basis, an option that has been useful in other European countries[29]). However, one respondent reveals some measures that have been adopted in retirement and nursing homes, which have helped to alleviate the impact of SARS-CoV-2 on this

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[28] Cfr. Diene M. Carlos *et al.*, A saúde do adolescente em tempos da COVID-19: scoping review, Cadernos de Saúde Pública, 36 (8) 28 agosto 2020

[29] André Dias Pereira and Heloísa Santos. Reflexões Éticas e Normativas a Propósito do Artigo: "Direitos Humanos e Mortes Evitáveis", Revista Gestão Hospitalar, N.º 21, abril/maio/junho, 2020, pp. 70-76

population: strengthening contacts of the elderly with families (resorting to technology) and reinforcing other visitation systems, without direct contact, namely through transparent structures (such as permitting contact through closed windows).

In **Mozambique**, a respondent reveals that Article 6 of Decree no. 26/2020, of May 8th was particularly useful, granting citizens over the age of 60 a "special protection". This involves a "priority in dismissal from on-site work" (number 2 of the same article) when the citizen's employment would require him to work in person during the state of emergency.

Priority vaccination for the elderly is considered by most respondents to be the main (and sometimes only) measure implemented to support this age group.

The main Study taking place in **Portugal** regarding the impact assessment of SARS-CoV-2 on the mental health of the elderly is the one being carried out by specialists from the Center for Research in Neuropsychology and Cognitive-Behavioural Intervention at the University of Coimbra, by the *CuidadosaMente* group[30].

With regard to Access to Medication and Clinical Trials of Medicines and Vaccines, in **Portugal**, specifically regarding the existence of clinical trials of vaccines or medicines for COVID-19, it is worth mentioning an experimental drug based on stem cells produced by *Crioestaminal*, a company from Coimbra, as well as the participation of Portuguese research centres in the clinical trials of the WHO "Solidarity" project, aimed at collecting scientific data on some treatment options for SARS-CoV-2. As for vaccines, two Portuguese teams are reported to have proposed to proceed with pre-clinical trials in the beginning of 2021 and to conduct clinical trials with humans throughout the current year[31]. The Team is sensitive to the importance of genetics in this area[32], allowing the preparation, in record time, of vaccines and treatments, as well as the identification and characterization of new variants

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[30] Project details available at: https://www.cuidaidosamente.pt/ (Last Access: 14/02/2021).

[31] Jornal Público, 3/02/2021: https://www.publico.pt/2021/02/03/ciencia/noticia/vacinas-portuguesas-covid19-procuram-dinheiro-testes-humanos-1949013 (Last Access: 14/02/2021).

[32] Heloísa Santos, *A evolução no campo da genética tem sido essencial no combate à pandemia*, interview to *Gradiva Publicações*.

of the virus. In addition, with the strengthened interaction between genetics and public health, it is expected that the law will increasingly assume a prominent role in these matters, so it is recommended that special attention be given to cases of transfer and sale of genomic information by research agencies.

In **Brazil**, about 20 vaccines are currently in a preliminary phase, which should not be available in 2021. Some of these scientific projects are financed by the Government. There are no records in **Angola**, **Mozambique** and the **Macao, S.A.R.** of clinical trials of vaccines or drugs.

Regarding incentives to participate in clinical studies related to COVID-19 in the institutions where the respondents exercise their professional activity, in the universe of respondents, there is only a record of 5 cases in which this participation was fostered (2 in **Brazil**, 2 in **Angola** and 1 in **Portugal**).

The off-label use (outside the therapeutic indication provided for in the AIM – *authorization of introduction in the market*) of drugs in the treatment of COVID-19 is accepted in **Portugal**: cases of use of steroids such as dexamethasone have been reported, as well as antiviral drugs used in the treatment of HIV, and the DGS specifically authorized the use of prescription drugs commonly used to treat malaria and ebola. One respondent stated: "There was no solid scientific evidence to support its use. There were trials, but they were inconclusive and demonstrated that there are no advantages. " [Translated].

In **Brazil**, the surveyed population explains that the off-label use was a political option of the Government, often without scientific evidence to support this implementation. Although it tends not to be positively viewed by respondents, the Ministry of Health Guidelines for Medication Use in the Treatment of COVID 19 allows such a use. For respondents in the **remaining territories**, the answer to this question is not very clear.

In **all the territories that were part of this research project**, there is a national plan for vaccinating the population against Sars-Cov-2. There are priority groups established in these plans. Access to the vaccine will be free for all nationals/residents of those countries/region.

Figure 2 – Comparative Table of Vaccination Plans

	Angola	Brazil	Mozambique	Portugal	Macao, S.A.R.
Legal Basis		**Provisory Measure no. 1.026, January 6th, 2021**		**Ordinance no. 298-B/2020**	**Chief Executive Order no. 27/2021**
First Inoculation Date	02/03/2021	17/01/2021	08/03/2021	27/12/2020	09/02/2021
1st Phase	02/2021 - 06/2021 Health professionals, social services and public order and security workers; • People with risk comorbidities; • People aged 40 years and over (among these, giving priority to those over 65 and those most likely to be exposed to the virus).	01/2021 - *4 Subphases* FIRST: • Health care professionals; • People over 65 years of age; • People who are over 60 years of age and are institutionalized; • Indigenous Population; • Traditional riverside communities; SECOND: • People between 60 and 74 years of age (organized by age); THIRD: • People over 18 years of age which carry a comorbidity; FOURTH: • Teachers of higher and elementary education; • Security forces; • Prison facilities' workers.	• Health care professionals; • Elderly who live in care homes and care home workers; • Security and Safety workers; • Diabetes patients.	*3 Subphases* FIRST: 12/2020 - • Health care professionals; • Professionals of the armed forces, security forces and critical services; • Professionals and residents of elderly care homes; • Professionals e users of the National Network of Continued and Integrated Care. SECOND: 02/2021 - • People who are over 80 years of age; • Public office workers and Sovereign Bodies title holders (2000 doses). THIRD: • People of ≥50 years of age, who carry one of the comorbidities indicated in the Plan.	• Health care professionals; • Border control officers; • Other individuals involved in the first line of the response to the Pandemic; • Social Services first line workers; • Teaching and other staff of education facilities; • Public Transport Staff; • Flight crew; • Workers who are in contact with the refrigeration chain and fresh food products; • Inter border travel drivers; • Naval crew; • Fishing industry workers; • Betting and Hotel industry workers; • Citizens who are required to urgently travel to endemic areas.

(to be continued)

(continuation)

	Angola	Brazil	Mozambique	Portugal	Macao, S.A.R.
Legal Basis		**Provisory Measure no. 1.026, January 6th, 2021**		**Ordinance no. 298-B/2020**	**Chief Executive Order no. 27/2021**
First Innoculation Date	02/03/2021	17/01/2021	08/03/2021	27/12/2020	09/02/2021
2nd Phase	06/2021 – • People between 16 and 39 years of age		• Other diabetes patients (who were not vaccinated on the first phase); • Inmates and Prison workers; • People who are institutionalized; • People who are over 50 and reside in urban areas.	04/2021 – • People of ≥65 years of age who have not been previously vaccinated; • People between 50 and 64 who carry one of the comorbidities identified in the plan.	
3rd Phase	2022 • People under 16 years of age		• The remainder of people who are institutionalized; • People who are over 80 and reside in rural areas.	• All other citizens.	
4th Phase			• All other citizens, except under 15s and pregnant women.		

In **Portugal**, **Angola** and **Macao**, vaccination is voluntary. As for the possibility of imposing vaccination as a requirement for entry into **Portugal**, the presentation by the European Commission, on March 17th, of a Regulation with aimed at instituting a European Green Certificate will be a novelty in this matter[33]. In **Brazil**, the Supreme Federal Court's judgment in the joint judgment of processes no. ADI 6586, 6587 and no. 1267879, affirms the possibility of compulsory vaccination of citizens, in the best interest of public health. Still regarding this aspect, some respondents detect, **in the different territories**, the

[33] Available at: https://ec.europa.eu/info/files/proposal-regulation-interoperable-certificates-vaccination-testing-and-recovery-digital-green-certificate_en (Last Access: 19/03/2021)

possibility of this vaccination being mandatory for certain professions or to be set as a requirement for entering the respective country/administrative region is being studied.

With regard to vaccination, the Team did not overlook the importance of the impact of the *shortage of vaccines*, which could affect, to a large extent, above all, **Angola** and **Mozambique**, countries that host particularly vulnerable populations and **Brazil**, a country that has suffered from the high number infections and deaths.

In the same sense as what was defended in the UNESCO *Redbioética Declaration*[34] of February 2021, the Team emphasizes that vaccines are a common good of all Humanity, and that, in general, the technologies mobilized in the mitigation of SARS-CoV-2 are global public goods. Understanding the urgency in the breach of vaccine patents, it is useful, however, to underline that this breach is not a guarantee of easy access and universalization of vaccine administration and could even result in being counterproductive.

Evaluating the concrete adoption of practical and institutional measures, the Team can offer, in **Portugal**, the example of the University of Coimbra (and the University of Lisboa), which adopted measures for the protection of users, but also workers, instituting teleworking when compatible with the exercise of professional activities, suspending, in accordance with the Government's guidelines, on-site education and, among other measures, implementing projects to consistently test the educational community[35]. In **Angola**, among the measures for the protection of workers that were identified by participants, we point out: making disinfectants available in the workplace (as well as water and detergent for hand washing), implementing social distancing, and constant measurement of body temperature. An **Angolan** respondent who works in the healthcare industry, reports that: "One of the greatest difficulties is the lack of PPE (mask, alcohol, gloves, gowns, etc.), forcing professionals to reuse items repeatedly and often for longer than recommended. " [Translated].

Of the 37 respondents who answered these two questions, all identified measures that were adopted to protect users and employees. Re-

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[34] *Declaración de la Redbioética UNESCO*, February 2021

[35] A detailed list of adopted measures is available at: https://www.uc.pt/covid19 (Last Access: 11/02/2021).

garding the latter, teleworking (70%), alternating workers (37%), mandatory use of PPE (76%) and availability of alcohol disinfectants (51%) stand out among the most common measures. Other measures include the implementation of random testing of workers, making technological equipment available to them, providing internet and telephone services, offering psychological support, ensuring a frequent measurement of body temperature, exemption from on-site work for employees who carry risk factors (age, comorbidities, pregnant women and mothers of children aged 12 years or less).

Finally, regarding the Experience acquired in the Public Health Emergency Response brought by Covid-19, respondents, in the face of a possible future pandemic, presented some suggestions for improving the situation in their countries and institutions: preparing contingency plans, carrying out pandemic simulations, organizing PPE stocks, among other preventive solutions, such as investing in the health sector, combating misinformation, valuing health professionals, adopting sustainability policies, improving primary health care, implementing effective mechanisms of international diplomacy for pandemic situations, decentralizing decision-making, etc.

Regarding the role played by the Ethics Committees, in **Portugal**, the National Ethics Council for Life Sciences (*Conselho Nacional de Ética para as Ciências da Vida*), has produced several Communications with Statements on different ethical aspects associated with Pandemic, including a Position on the use of Mobile Digital Applications for the Control of Transmission of Covid-19 and also a Position, of a more general character, on the "Public health emergency situation by the Covid-19 pandemic: Relevant ethical aspects". One respondent also mentioned a series of Recommendations issued by the *Ordem dos Médicos* (OM - Portuguese Medical Association), which identify problems faced by the SNS during the Pandemic, namely, the lack of response given to priority non-Covid patients. The respondent said: "The Medical Association created a Crisis Office to monitor the Pandemic. The National Council of Ethics and Medical Deontology (Advisory Body of the National Council of the OM) issued a set of ethical recommendations related to situations caused by Covid-19. Two documents were produced on ethical issues: one produced by the OM on the admission of patients in intensive medical services in the context of lack of beds and another produced by the Ethics Committee of the Hospital I work

at on the delivery of SARS-CoV-2 test results to non-medical health professionals." [Translated].

In **Brazil**, the contributions of the National Research Ethics Commission (Conep - *Comissão Nacional de Ética em Pesquisa*), associated with the National Health Council (CNS – *Conselho Nacional de Saúde*) stand out as important documents that set out an urgent procedure for research protocols on SARS-CoV-2 (January 31st, 2020), transforming its scope of activity and providing information to those who participate in Covid vaccine trials and are part of placebo groups (January 27th, 2021).

According to one respondent: "several Councils took a stand on issues related to the COVID-19 pandemic, including the Federal Psychological Council that regulated the provision of psychological services through Information and Communication Technology. In fact, in one way and another, ethics councils have positioned themselves to guide professionals during these times. The National Research Ethics Commission (Conep) instructed the Ministry of Health to adopt certain measures in order to minimize the potential health risks and the integrity of research participants, researchers and members of the Research Ethics Committees during the pandemic caused by the SARS-CoV-2 coronavirus (Covid-19)." [Translated].

In **Macao**, there is the Ethics Committee for Life Sciences (article 11 of Law no. 2/96/M, of June 3rd), whose composition and powers are defined by Decree-Law no. 7/99/M, of February 19th. No contributions from this Organ were recorded in the context of the Pandemic.

Despite being able to identify some recommendations, some respondents consider the contribution of these Commissions to be manifestly insufficient, and participants deem it desirable that they assume a more central role in the future.

Regarding the performance in accordance with the WHO recommendations, it is reported that, although the countries/Macao, S.A.R. have acted in accordance with these recommendations, the timing of this action varied from country to country. Experts in **Angola** and **Mozambique** reported that border closure, for example, immediately after alerts on SARS-CoV-2 were received, was instrumental in mitigating Pandemic in its initial phase. In the opinion of some respondents, the *décalage* of time between the issuance of guidelines by the WHO and the adoption of measures in the territories studied is objection-

able. Some respondents understand that the WHO recommendations to strengthen the involvement of all political actors in the response to SARS-CoV-2 were not taken into account **Portugal**, a country in which the DGS centralized the competence of managing and disseminating information about the Pandemic, relegating important figures such as Associations, Hospitals' administration bodies and citizens to the background of the decision-making process, entities who have fundamental contributions to develop and implement Covid's mitigation strategies.