WHITE BOOK

RESPONSIBILITY FOR PUBLIC HEALTH IN THE LUSOPHONE WORLD

DOING JUSTICE IN AND BEYOND THE COVID EMERGENCY

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WHITE BOOK

The Ethics of Public Health Emergency Preparedness and Response

RESPONSIBILITY FOR PUBLIC HEALTH IN THE LUSOPHONE WORLD

DOING JUSTICE IN AND BEYOND THE COVID EMERGENCY

Project Sponsored by the World Health Organization
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LIST OF ABBREVIATIONS

Art. – Article
CDB – Centre for Biomedical Law (*Centro de Direito Biomédico*)
CRP – Constitution of the Portuguese Republic (*Constituição da República Portuguesa*)
EU – European Union
Macao, S.A.R. – Macao Special Administrative Region
PPE – Personal Protection Equipment
WHO – World Health Organization

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INITIAL REMARKS

João Carlos Loureiro

The White Book now being presented to the public, academic or otherwise, is first and foremost an act of accountability for the results of a research project that responded to a challenge issued by the World Health Organization (WHO) in a pandemic context. The proposed motto for the research was a broad "The Ethics of Public Health Emergency Preparedness and Response", capable of accommodating bridges with Law. The University of Coimbra Institute of Legal Research (UCILeR) has certainly some experience in this field, namely through the work in Health Law of its researchers in the area of Vulnerability and Law, but also of colleagues from other areas. As a matter of fact, faithful to its strategic project, based in the trilogy - Vulnerability/ Plurality/ Undecidability - the Institute promoted, in April and May 2020, a series of talks with the theme "Pandemic(s), Uncertainty and Law", with four meetings: I. State of Emergency in Democracy; II. Health Policies in Times of Pandemic; III. Freedoms and Rights in Times of Confinement (Part 1); IV. Freedoms and Rights in Times of Confinement (Part 2). Besides articles by its researchers, published in Portugal or abroad, a volume dedicated to Pandemic and Law has appeared in the collection Societal Challenges and Research in Law.

One should not be surprised, then, by the positive response to the challenge that materialized in the project, funded by the World Health Organization, entitled Responsibility for Public Health in the Lusophone World: doing justice in and beyond the covid emergency. However, it did not do this by shutting itself off, turning the University Tower into an ivory tower, but rather by strengthening the networks that build bridges into the Lusophone world, united by a language that

is plural in its incarnations and re-appropriations. In Africa, we invited representatives from Angola (Armindo Jelembi, also an UCILeR researcher) and Mozambique (Carlos Serra); in Latin America, we invited a solid partner, the Oswaldo Cruz Foundation (Sandra Alves); in Asia, we went to the *Portas do Cerco* to see, through the hand of Vera Raposo, the experience of the Macao Special Administrative Region. Four continents, all ravaged, to a greater or lesser degree, by the pandemic and with disparate means to respond to the public health crisis. In a time of neo-globalization, but in which glocalization is taken seriously, this pandemic proved the differences and inequalities of the world, also in this field. If in the 19th century (the first international sanitary conference took place in 1851) the risks of epidemics significantly drove an International Health Law, in more recent years the development of post-Westphalia governance mechanisms must be underlined. Despite introversion trends in some countries, where an old conception of sovereignty is waved as a flag, revealing excesses of "globalism" (the reduction of globalization to its economic sphere, as Ulrich Beck said), it is becoming clear to many that health, besides being a personal and communitarian good, is also a global public good. It is a matter of responding to the pandemic, and responsibility should not be said in a disjunctive way - either/or - but rather requires an "and", which brings together state and civil society, national and international and supranational instances. This period of health emergency has proven that, except for a hermit-like retreat into the desert, no one can be saved alone. To guarantee *immunitas*, we need more *communitas*, a common action, because the pandemic laughs at human borders and does not need a passport to advance.

The openness of the project was also expressed in the multiplicity of knowledge. *Ab initio*, the project had the precious collaboration of a renowned bioethics specialist, Maria do Céu Patrão Neves, Professor at the University of the Azores. Thanks to the network that had been established, jurists and health professionals, academics and practitioners, people from the Health Administration, and representatives of patients' associations participated. The openness was materialized trough the communication, by the hands of Fernando Vannier Borges.

In this "risk society" (Ulrich Beck), the (bio)ethic convoked, without forgetting the differences of national realities, should not lose the global note. In fact, it should be global as to space, speaking of a

"macro-ethics" of responsibility (Karl-Otto Apel), without this being synonymous with the erosion of national states as communities (also of sociality); yet global as to the object, keeping in mind the interaction between men and animals and, in general, the environment, in the time of the Anthropocene.

The project, in the straitjacket of the temporal constraints, did not shy away from some efforts. Not giving in to the temptation of limiting itself to a more or less commented inventory of mobilized norms, a questionnaire was launched, which was based on a platform, taking empirical data seriously. In this way, not only academics, but public servants, as well as health institutions and Non-Governmental Organizations defending patients' rights and interests, were able to participate in the discussion. Without unveiling the meaning of the results and concretizing the list, it should be said that the answers allowed us to unite on the map all the territories involved - Angola, Brazil, Macau and Mozambique, and Portugal.

In the proposed roadmap, we find the following steps: Maria do Céu Patrão Neves addresses the "Ethical principles and the limitations imposed by States in times of pandemic"; Ana Gaudêncio analyzes the pandemic from the perspective of human rights; Luís Meneses do Vale bridges the gap between Constitutional Law and pandemic; Ana Raquel Moniz addresses the connection between Public Law and pandemic; Inês Godinho focuses on the relationship between Criminal and Sanctions Law and pandemic; André Dias Pereira, Ana Elisabete Ferreira and Carla Barbosa address the theme Patients' Rights and pandemic. In the final chapter, André Pereira and Catarina de Almeida analyze the questionnaires.

In the genesis of the World Health Organization, in 1948, some perceived utopia in the comprehensive pledged notion of health, which does not confine it to a medical reading, but takes its assumptions seriously. Now, in the context of the pandemic, in circumstances where there is also talk of environmental emergency and catastrophe scenarios are outlined, the theme of apocalypticism receives additional impetus. «Apocalypse», a word with a Hellenic flavor, means, etymologically, to remove the veil, to unveil, and is associated with images of destruction. Despite the pandemic and the millions of lives that have been taken, the sick who experience after-effects, and the people who have seen their daily lives and ways of existence destroyed, we are certain that this

is not the time of the end for humanity, nor will this be the last epidemic. Amidst the pain and suffering, we are witnessing an unveiling: the thesis of the insularity of some societies, particularly those of the Euro-Atlantic axis, does not stand the test of reality.

We began this century with the terror of 9/11 in New York. We experienced in the streets of Paris and London, among many other cities, the fragility of collective security; environmental catastrophe scenarios are being drawn now that, after Hiroshima and Nagasaki, the possibility of unprecedented destruction hovers over humanity. The pandemic helped many, but not all, to think about the fragility of the human condition and the limits of technological capabilities.

Researchers in the fields of Ethics and Law are not expected to discover a drug. Their contribution, illustrated in this work, involves thinking about normative frameworks, identifying rights and duties, assessing the adequacy of norms (material, formal, procedural and organizational) and looking at inter-normativities. The issue of justice, which appears in the title, also deserves special attention when we reach the 50th anniversary of the publication of John Rawls' magnum opus *(A theory of justice)*, even if we privilege, as Amartya Sen does, "a realization-focused understanding".

At the time of writing – March 2021 – uncertainty is still high, with a number of differences in access to vaccines; new waves and confinements; economic and social disorder that varies greatly from country to country, given the great disparity of means and possibilities, the weight of the informal sector, social networks, etc. However, having followed the project from the beginning, in the role of UCILeR's Research Area Coordinator, but with the advantage of not having been a participant, in view of the results achieved so far, which are not exhausted in this work, we are already certain that something has been accomplished. Finally, a word of thanks is due to the participants: to those who elaborated the project, to André Dias Pereira who was also responsible for its coordination, and to those who were willing to participate, either by presenting papers or by answering the questionnaire.

It is up to the reader(s), as usual, to evaluate the work and, if they wish, to continue the dialogue. Furthermore, health, as the Constitution of the Portuguese Republic reminds us, in art. 64/1, is not just a matter of rights, since "everyone has (...) the duty to defend and promote it".

1. CHALLENGES OF THE SARS-COV-2 PANDEMIC TO BIOETHICS

Maria do Céu Patrão Neves

A pandemic is always a rare and extreme situation. A pandemic in a globalized, borderless world, such as the one we live in, is an unprecedented situation that becomes even more extreme, calling into question the usual standards of action that then seem inexorably and frustratingly inadequate to the reality.

The first questions that need to be addressed regarding the most appropriate course of action are technical, that is, of an operational nature, concerning the procedures due in the various exceptional situations that are occurring, mobilizing the existing human, equipment, financial and legislative resources. However, all of the available resources tend to run out quickly, given the exponential increase of needs to be met in a short period of time and under a *tremendous urgency*. In such a context of severe scarcity of resources, technical issues quickly become ethical in nature, since it is the balancing of specifically human factors, and in particular the values involved in the various actions available, that become crucial in the decisions to be taken. Subsequently, the intervention of Law also becomes indispensable, in the legal regulation of the aforementioned technical and ethical considerations. This was the most extraordinary reality of the SARS-CoV-2 pandemic, which has now become our own daily reality.

Bioethics, as Ethics applied to Biomedical Sciences from the perspective of society, that is, as Civic Ethics, was therefore called upon to intervene as a decisive factor in the resolution of unprecedented and dramatic human problems, thus recovering and reinforcing the original spirit that had once unleashed it, in the last century, as a transdiscipli-

nary knowledge, and a concrete and effective practice. The intervention of Bioethics, faithful to its identity, was as intense in this pandemic as it was wide in the diversity of issues it envisaged, as well as in the number of bioethicists that it mobilized.

Whilst trying to provide a wide, albeit synoptic, view of this broad action of Bioethics, it is important to systematize it in two major fundamental plans: one at a micro level, centred on the individual, and the other at a macro level, focusing on the shared problems of individuals, on the community. Both unfold into a panoply of issues that we will also seek to systematize in their most relevant impacts.

1. Intervention at a micro level: care for the individual

We have characterized the micro action plan of Bioethics as focusing on the individual. At this level, Bioethics has developed a particularly relevant intervention, both (1) in the definition of criteria for *patient prioritization* for access to health goods and services, and (2) in the legitimization of restrictions to individual civil rights, in favour of public health protection.

It was precisely at this micro level that, in the chronology of the pandemic, severe problems requiring bioethical reflection were first experienced. We refer specifically to access to intensive care and to invasive ventilation, during the first wave of the pandemics in Europe, in March and April 2020, when there were not enough ventilators for all patients. In fact, in the previous weeks, the lack of facial masks, latex gloves, hand *sanitizer gel*, and alcohol for the general population, was already a reality, as well as the lack of *personal protective equipment* for health professionals. Later, with the outbreak of new strains or variants of the virus and the worsening of the health situation worldwide, there was a dramatic shortage of oxygen supplies for critically ill patients, particularly in Brazil, and also a severe scarcity of hospital beds and even of health professionals to provide proper treatment for all patients. More recently, due the urgent need to vaccinate the country, and also the entire world population, the need to define criteria to establish priorities for vaccination has arisen, while not only the insufficiency of the current levels of vaccine production, but also the inevitability of its rationing, have become increasingly evident.

The *prioritization* of citizens for access to health goods requires thoughtful consideration of the criteria to be applied. Although, these should be based on objective analysis of the real public health situation, they do not ignore consideration of factors of a personal nature. This is a huge challenge to the obligation to respect the principle of human dignity, which sets out the absolute and unconditional value of each and every person. At this level, we can consider, as an example, the specific criteria of "age" particularly interesting due to the discrepancy in its valorization in different situations and also to the severity of its consequences in some circumstances. Indeed, "age" has been used to exclude patients from intensive care, even when it is vital for them, when there has been limited capacity remaining; at the same time, age has been used to give priority to vaccination, most particularly when supplies are scarce. In the first case, the justification is that the elderly have a shorter life expectancy (it is important to "save years of life"), applying the principle of utility, or maximum utility for the greatest number of people. However, this principle is valid for the distribution of goods, but not for the exclusion of people, because it would entail their objectification, that is, their consideration as simply objects, as if their worth erodes with time. In the second case, the justification is that the senior's life is at greater risk (it is important to "save lives"), thus respecting the principle of vulnerability, which implies that care should be directly proportional to the vulnerability of the patient. The inconsistency is evident and the ethical reflection is urgent: if all lives are worth the same, that is, if each life's worth is viewed in absolute terms, to consider the number of life years as criteria to gain access to healthcare, as criteria to determine whether there should be an attempt to save it or not, stands out as a gross violation of human dignity.

At this micro level, Bioethics has also been committed to the evaluation of public health measures which have had a strong impact on citizens' individual rights (first generation), particularly on their individual freedoms, the ability of individuals to decide by themselves for themselves, or autonomy, and also on their privacy, or the right to protect personal life. We refer, for example, to the imposition of quarantines and prophylactic isolation, to the identification of all contagion risks, to *mandatory* body *temperature measurements*, or to the *presentation of* a *negative* PCR *test* for access to circumscribed spaces. The fundamental

question that arises is one of ethical legitimacy and legal authority for the limitation of individual rights.

Ethical legitimacy has been argued by the protection and promotion of the common well-being, which can be broadly defined by a set of conditions (tangible and intangible) of shared life that support the development and the fulfilment of the person, singularly and communally considered. Therefore, each citizen is called upon to accept the suspension of some of their rights as an individual contribution to the promotion of the general well-being of the community to which they belong and from which they also benefit. After all, autonomy cannot be seen as an abstract and uprooted concept; it is built and matures in a specific space, time and circumstance, which confirms its inseparability from social responsibility, from the obligation to respond to society's needs and expectations, according to the power each one holds. In fact, nobody lives alone and we all find ourselves embedded in countless networks of dependencies, in an intertwining of rights and duties.

Stretching the same line of reasoning, it could be argued that the entitlement of individual rights could be deeply compromised without the provisional suspension of them and without each one assuming its duties as a contribution to the common good: if infection chains are not contained, all citizens, individually considered, will have an increased risk of infection with unforeseeable consequences. In this context, the authority to impose restrictions on individual rights can only belong to representatives of the common well-being, of the social well-being, that is, public institutions and the government itself.

2. Intervention at the macro level: attention to the community

We have already characterized the macro action plan of Bioethics as focusing on communities and on the problems shared by their members, the citizens. At this level, Bioethics has developed a particularly relevant intervention both (1) in legitimizing restrictions on social rights for the protection of public health, and (2) in the request for international cooperation and solidarity.

Similarly, to what we have pointed out at the micro level as restrictions on individual rights, at the macro level we are also faced with limitations to the entitlement of human rights as the first ethical problem

in the chronology of the pandemic. We refer to the general confinement of the population and the imposition of sanitary fences, the lockdown of almost all economic activities and the imposition of teleworking. Unlike that which occurred at the micro level, in which the negative obligations of the State were reduced in its obligation of non-interference in the private sphere of the citizen, at the macro level the State has positive obligations, that is, it has a duty to build conditions for the social and economic development of the population, which have been severely compromised by the socioeconomic impact of public health measures. Considering that these are second generation rights, which demand for active or positive obligations, States have a duty to implement compensations to mitigate the negative impacts of the pandemic, which should contribute to the legitimization of the imposed measures.

At the same time, it is important to consider that public health measures do not have the same impact on the entire population: for example, there are workers in full-time employment (e.g. health professionals), those who are teleworking (e.g. teachers), those affected by lay-offs (e.g. retail store employees) and inactive workers without recourse to any compensation (e.g. artists). These different social realities show the urgency of implementing the principle of justice as equity, i.e., an equal or balanced distribution of the burdens caused by the pandemic and the compensations attributed by the State. There is yet another important additional problem to consider regarding new ways of discrimination, as has happened with the elderly, locked up in retirement homes and isolated from all family contact, and with the stigmatization of certain groups, as has happened in neighbourhoods with a higher population density, and potentially greater spread levels of the disease, enclosed within a sanitary fence. Equity, non-discrimination and non-stigmatization are rules of the principle of justice, as an obligation to "treat equals equally, and unequals unequally, to the extent of that inequality", following the principle's so-called "golden rule", as formal and abstract as it is broad and consensual.

Also at this macro level, the fundamental question that arises is that of the ethical legitimacy for the reduction of some socioeconomic rights (such as the right to work) in favour of other rights, such as the right to public health. The fundamental ethical principle to be considered is that of proportionality, which requires that State intervention be limited to the minimum necessary and indispensable (in the extension

of the measures and in their length) to guarantee the common well-being; the restrictions and interdictions must be scientifically justified and presented with objectivity and transparency (the way of the intervention must be subordinate and limited to its defined purpose); and the measures adopted must gain the consensus of the population.

Still, at this macro level, Bioethics has also been committed to act within the international relations realm, in the global context, focusing on the third generation of rights, those that concern collective interests, stressing the principles of solidarity and cooperation, among all countries worldwide, and particularly toward developing countries, and sharing benefits from advances in scientific research and for global health. In this context, we can mention realities that seem to be quite different, such as: in the first wave of the pandemic in Europe, the frequent diversion of primary health care goods purchased in China, either breaching sale contracts by being beaten by backstage auctions, or even by the holding of cargo planes and the subsequent theft of the transported goods (State's piracy), where the cargo made stopovers; more recently, and in a much broader dimension, the struggle for the purchase of available vaccines for large sums of money, raising the market price to values that are unaffordable for most countries, as well as their pre-acquisition in volumes that exceed the needs of the national population, leaving other countries with no realistic prospect of being able to vaccinate their own population in the near future. These procedures take place within a rationale based on power, competition and hoarding, which is directly contrary to the logic of ethical action, cooperation and sharing.

3. Overcoming conflicts through conciliation

The enunciation of ethical principles that, at the micro and macro levels, seek to justify and legitimize a wide range of public health and social measures in this pandemic, are not yet sufficient to validate an ethically sound and sustainable course of action. Indeed, the identification and definition of core ethical principles can lead to moral dilemmas, that is, to the conflict between two equally strong obligations that cannot be both fulfilled, at the same time. The choice of a single one, no matter which, will always entail the failure of the other, which, nevertheless, is also an obligation that has to be complied with. We could

point out, as an example, the conflict between individual autonomy and social responsibility, at the micro level, and, at the macro level, the conflict between the right to health, to its protection, and the right to work, to have effective conditions in order to reach a standard of living that ensures the individual and family well-being. Therefore, we also need an adequate methodology to ***weigh*** the relative importance of the ethical principles in their application to the concrete reality, one that follows a logic of inclusivity, which, at every moment, balances the principles involved, maximizing the values that are in conflict, namely free will, or autonomy, and the protection of public health.

Therefore, the ethical imperative at stake, is not only to identify the structural ethical principles, but also the methodology for their articulation; and the ethical criteria to be established are not essentially of selection, but also of ***conflict*** resolution, harmonization or conciliation – the latter being obviously a greater challenge than the first. At this level, it is important to:

(1) objectively and rigorously consider the reality in which it is urgent to intervene (e.g. pandemic);
(2) evaluate the goodness of the aims of human actions, their goals or purposes (e.g., tendency to eliminate contagions / infections);
(3) identify the obligations expressed by the ethical principles to be respected (e.g. individual autonomy and common or social well-being) and the potential conflict between some of them (e.g. freedom and confinement);
(4) consider the moral weight of each of the conflicting obligations (e.g. freedom is compromised in the absence of health) and propose intermediate ways of action that seek to respect both (e.g. more restrictive confinement measures, such as the sanitary fence, for those who represent greater risk of contagion); and
(5) maintain the commitment in relation to the unfulfilled obligations, reducing the period of non-compliance, mitigating the negative consequences, compensating the burdens, etc. (e.g. lay-off regime or moratoria issuing).

Ethical deliberation will therefore have to be inclusive, requiring consideration of the totality of the values involved, conciliatory, centred on its possible articulation, and comprehensive, keeping the

commitment towards all values and carrying them out to the widest possible extent. This will contribute to building the broadest social consensus, which Ethics requires to ensure its authenticity as a non-violent relationship.

These are the most basic ethical requirements for any and all limitations to be imposed on human rights, to the civil and political, socioeconomic and collective rights.

4. From ethical consensus to legal regulation, to political implementation

Bioethics, in its action at both the micro and macro levels, through the enunciation of the fundamental principles that have to be respected and the imperative of its continuous harmonization, establishes the minimum conditions of ethical legitimacy for the provisional and proportional restriction of human rights, in a time of public health emergency, as well as the authority of the State for the respective legislative initiatives and political implementation.

Ethical reflection must, therefore, be at the base and ground the process of adopting public health measures that, involuntarily but consequently, restrain the rights of citizens and communities. In turn, it is essential that the broad social consensus for which Bioethics contributes, be reinforced by the power of Law. This means that it is important to go further than the recommendations addressed to the individual goodwill, in an inconsequential way, to the establishment of mandatory practices whose contravention is penalized. For example, taking into account the broad consensus regarding the high prophylactic value of wearing facial masks, this measure cannot be just a voluntary undertaking, which would undermine its efficacy; there is a need for it to be made compulsory by a legal power to ensure a real protection of the population.

The sequence from Ethics to Law ensures that the Law cannot be imposed upon the individual and on the community, from top to bottom, in a dynamic of power, which is overbearing and aggressive, but rather that it is claimed by the people, as a desired protection measure, in a process that goes from the bottom to the top. Exceptional legislation in times of pandemic thus responds to the needs, expectations and aspirations of society, with an indelible ethical legitimacy.

In turn, political implementation presents itself as an indispensable and urgent sequence, showing that restrictive measures are not random or potentially easily discriminatory, but are rather an integrated part of a justified, coherent and consistent strategy for the pursuit of a higher and commonly desired social value, in this case, individual and public health.

The ethical process described and its development within the legal and political levels, establish the boundary of legitimacy for the severity of public health measures. As long as these remain within the parameters set out for their proportionality, and their commitment to the speediest and broadest compliance to the universal common moral of Human Rights, they can be considered ethically justifiable.

2. HUMAN RIGHTS AND PANDEMIC

Ana Margarida Gaudêncio

1. Pluralisms, pandemic and rights

The pandemic crisis that has been surprising and plaguing the world for more than a year now, has re-exposed and sharpened, in multiple ways, the signalling of weaknesses and limitations in today's plural-*pluralistic*, heterogeneous, and complex societies… *Pluralism* – of demands, convictions, ideologies, identities, vulnerabilities... –, as contemporarily affirmed – and, thus, prior to and independent of the current pandemic –, mirrors the growing pulverization of the material foundations of social interaction, progressively widening the individualistic affirmation of rights and freedoms in intersubjective relations, in an increasingly complex web of options and meanings which, potentially, may peacefully coexist as long as they are procedurally made possible with a minimal degree of delimitation. This may imply the impoverishment, if not the annihilation, of the specifically normative dimension that is attributed to the law as a crucial historical-cultural dimension, selectively valuing and regulating intersubjective *praxis*. Gradually fading the dimensions of the *absolute* in pluralist cultures, multiple diverse cultural options battle with each other in different societies[1].

The word *pandemic*, now as a metaphor for *reality*, has been crossing the planet and humanity as a storm: a tiny, invisible, *virus*,

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[1] See Hans-Jörg Sandkühler, "*Pluralism, Cultures of Knowledge, Transculturality, and Fundamental Rights*", *in* Hans-Jörg Sandkühler/Hong-Bin Lim (Ed.), *Transculturality: Epistemology, Ethics and Politics*, Peter Lang, Frankurt, 2004, p. 79-100, p. 93.

unknown and unexpected, like an event-*Ereignis*, to say it with Heidegger[2]... quickly installed, together with the astonishment, the (un)understanding, the fear, and the plurality of speeches ... and forcing the fastening of multiple *masks*... and these, after all, do not always, and not necessarily, make the human *persona*, but increasingly show, at least, as a *means*, of physical protection, or not, or of discretion, or of isolation...

The urgency of juridical and political regulation of the exceptional situation caused by the COVID-19 pandemic generated multiple doubts within the juridical systems, on the one hand, and multiple criticisms, on the other, which manifest themselves, after all, as other pandemics, able to hinder, if not to block, the understanding of the seriousness of the situation and the adequate mobilization of means for the respective confrontation. It must be mentioned, before any other, and still only in an exemplary way, the *pandemic of disinformation*. The constitutionally enshrined freedom of expression and of information, a human and fundamental principle and right, as the right to inform as well as the right to be informed, has spread the circulation of (dis) information content on an unprecedented scale, both officially and unofficially, directly challenging the also constitutionally enshrined security, also a fundamental principle and right, directly as such, and still as workers, consumers, users of public services, including those of health... In addition, it must also be considered the *pandemic of exceptionality*, still only in an exemplary way. At the intersection between pandemic and law, threatening to become tenuous, if not diffuse, the *limitations* to the *limitations*, it will be necessary to reinforce that, within the framework of a Democratic Rule of Law, the discussion on the delimitation of rights and duties is sustained in and through the assumption that restrictions on citizens' rights and freedoms, even if they put the right(s) in an exceptional situation, will not constitute a situation of exception to the right(s).

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[2] See Martin Heidegger, *Beiträge zur Philosophie. Vom Ereignis* (1936-1938), *in* Friedrich-Wilhelm von Herrmann (Hrsg.) *Gesamtaugabe*, *III. Abteilung: Unveröffentlichte Abhandlungen*, Band 65, Vittorio Klostermann, Frankfurt am Main, 1989, 1994, 2003, p. 7, 23-35, 73-78, 80-83, 84-87.

2. *Human rights* in *pandemic*

At the centre of such vicissitudes, the COVID-19 pandemic introduced, in the multiple strands in which it developed, the questioning of the very cultural assumptions of intersubjectivity. As a consequence, the reflexive plasticity assumed by the legal regulation in face of the demand for speed and efficiency regarding the progression of the pandemic is projected in the questioning of the very foundations, meanings and limits of the juridical referencing of the *idea of law* and *human rights*, and, thus, subjectively, of *juridical person* – as *holder* of *rights* and *duties* –, and, objectively, of *juridical normativity* – as the practical and substantially autonomous rationalization of a specific domain and sense of intersubjectivity. In this context, in light of a re-perspectivation of the substantially densifying determinations of so-called *human rights* in the current circumstances, the traditionally called perspectives on the *nature* of the so said *human rights* are effectively at stake – starting from the distinction between *naturalist* and *political* perspectives, and, essentially intermingled in that, the distinction between human rights as moral, political and legal rights – and from the respective sphere of relevance – based on the distinction between *universalism(s)* and *relativism(s)*, and therefore exposing the problem of the *culturality* or *aculturality* of human rights.[3]

Between an *extreme relativism* and an *irreducible universalism*, the attempts to discern a common core and a differentiated ramification of human rights, in view of the difficulties of presenting universalizable densifications, aim nowadays to assimilate the material concretization of the *sense* of *humanity*, within the innumerable synchronic and diachronic perspectives in presence. Which is to say that, around a *core* of *common humanity* – despite the necessary and absolutely variable evolution and content, and without reduction to a *common* defined by any *cosmopolitanism* –, multiple *peripheries* of particularized densification, hardly decontextualizable, of *positive* affirmations

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[3] Rowan Cruft, S. Matthew Liao, Massimo Renzo, The Philosophical Foundations of Human Rights: An Overview, *in* Rowan Cruft, S. Matthew Liao, Massimo Renzo (Ed.), *Philosophical Foundations of Human Rights*, Oxford, Oxford University Press, 2015, p. 1-41.

of rights – but also, in its verse, and still *positively*, of *duties* – will develop[4]. And, still, affirmed as *rights*, and *human*, as the representation of the highest reference to *humanity* and to its *dignity*, which the institutionalization of the 1948 *Universal Declaration of Human Rights*[5] *– later complemented by the International Covenant on Civil and Political Rights*[6] *and the International Covenant on Economic, Social and Cultural Rights*[7]*, both from 1966 –, came to restate and emphasize in the issue of human rights*, replacing the modern *Déclaration des Droits de l'Homme et du Citoyen*, in the light of the World War II events, and therefore opening their *new generations*[8]*, whilst establishing the notions of humanity* and *dignity* as a fundamental pillar – as stated in its article 1/1: «All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood».

In the current pandemic situation, focusing the human rights *issues* and *discourses* in public health, nationally and internationally, it is the very notion of health as a *human right* that is called into question, decisively emphasizing the relevance, in its content and in its structure, of international public health law[9]. The basis for supporting the relevance of health as a human right can be found in the Universal Declaration

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[4] *Vide* José Carlos Vieira de Andrade, *Os direitos fundamentais na Constituição Portuguesa de 1976*, Coimbra, 1987, 6.ª Ed., Coimbra, Almedina, 2019, p. 31-37; Guy Haarscher, *Philosophie des droits de l'homme*, Bruxelles, Éditions de l'Université de Bruxelles, 1987 (Ed. revisée 1993), especially p. 41-45 and 119-124; Patrícia Jerónimo, *Os Direitos do Homem à escala das Civilizações*, Coimbra, Almedina, 2001, p. 259-260.

[5] *Universal Declaration of Human Rights* (https://www.un.org/en/about-us/universal-declaration-of-human-rights; http://undocs.org/A/RES/217(III)).

[6] *International Covenant on Civil and Political Rights* (https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx).

[7] *International Covenant on Economic, Social and Cultural Rights* (https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx).

[8] See Mário Reis Marques, *Introdução ao Direito I* (Figueira da Foz, 1992), 2nd. Ed., Almedina, Coimbra, 2007, p. 217-224; Mário Reis Marques, *"Direitos fundamentais e afirmação de identidades", in Economia e Sociologia*, n. 80, Évora, 2005, p. 157-169, p. 163-166. *Vide* ainda Ghislain Waterlot, *"Human Rights and the Fate of Tolerance", in* Paul Ricoeur (Ed.), *Tolerance Between Intolerance and the Intolerable*, Providence, Oxford, Berghahn Books, 1996, p. 53-70, p. 60-65.

[9] Brigit Toebes, "International Health Law: An Emerging Field of Public International Law", *in Indian Journal of International Law*, 55(3), 2015, p. 299-328 [DOI 10.1007/s40901-016-0020-9].

of Human Rights, in its article 25/1, as a starting point: «Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control». In turn, the International Covenant on Civil and Political Rights states, on its article 6/1: «1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life». And, additionally, the article 12/1 and 2 c) and d) of the International Covenant on Economic, Social and Cultural Rights establishes: «1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (…) (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness».

Assuming the right to health as a *human right* the understanding of the meaning(s) of "human right" that underlies it, it will be emphasized here, specifically, Brigit Toebes' proposal concerning this notion – in the assumption of the notion of human rights presented by Charles C. Beitz –, considering human rights as *norms* that reflect "urgent individual interests", that is, interests whose protection is sufficiently relevant to the point that the absence of such protection is an issue of international relevance[10]. In this sense, it is the very notion of "health", or "good health", that is discussed, assumed as an *urgent individual interest*, and whose protection is of decisive relevance both for individuals and the international community[11]. This is confirmed by the fundamental role played by the World Health Organization in global health management, and has been particularly highlighted

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[10] Brigit Toebes, "International Health Law: An Emerging Field of Public International Law", p. 302-303, referring to Charles C Beitz, *The Idea of Human Rights*, Oxford, OUP, p. 137.

[11] Brigit Toebes, "International Health Law: An Emerging Field of Public International Law", p. 303, referring Brigit Toebes, "Introduction", in Brigit Toebes et al., *Health and Human Rights in Europe*, Antwerp, Intersentia, 2012, 13, 15-16.

since the declaration of COVID-19 as a pandemic, on March 11, 2020[12].

Gradually and arguably accentuating the relevance of public health as a global problem – in terms of access to health facilities, treatment and vaccination – the COVID-19 pandemic involves multiple other consequences in terms of the protection of human rights, in many other dimensions and with very different repercussions in different locations around the globe. Naturally, the polysemy of the word *health*, and thus the reach of the notion of *health*, as a point of reference, will require, from the point of view of human rights, an inevitable multilevel structural consideration and a specific treatment of each issue, in its social and cultural relevance, which is differently understood and realized, depending on the cultural matrices[13].

More than a discussion on the value and relevance of human rights, what will now be at stake is the reflection on the existence of formal and material conditions to assure the maintenance of the objectives civilizationally assumed as the concretization of human rights in very diverse cultural and political environments. There is now a profound review of human habits, both individually and in social relations, in projection of political discourses, also on human rights, and of the effectiveness of public policies related to the pandemic, far beyond the direct implications of the contagion, the treatment and the vaccination.

In a systematic critical-reflective (re)positioning of problems related to human rights, the following problematic cores will be mainly involved, and crucially under scrutiny: on the one hand, the right to health[14] – physical and mental –, and, consequently, the right to education[15] – from the access to education to the (im)possibility of distance learning – and to social protection[16] – concerning work, abandonment, isolation, criminality... –; and, on the other hand, and decisively, the

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[12] *Vide* https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. See also, exemplarily, the Human Rights Watch reports on the pandemic situation: https://www.hrw.org/world-report/2021.

[13] James R. May/Erin Daly, "Dignity Rights for a pandemic", *in Law, Culture and the Humanities*, 2020, 1-20 (DOI: 10.1177/1743872120944515).

[14] Article 25/1 of the *Universal Declaration of Human Rights*.

[15] Article 26 of the *Universal Declaration of Human Rights*.

[16] Articles 23 and 25 of the *Universal Declaration of Human Rights*.

rights to freedom[17] – concerning politics, information, expression, movement... – and security[18] – *of* the law and *before* the law.

2.1 Health

In fact, it is, first of all, a health problem, that is at issue, as an essential reference and conditioning point of the other matters in the current circumstance. In addition to the multiple direct effects caused by the contagion with the SarsCov-2 virus, it is the health, physical and mental, individual and global, of human beings that is at stake. Although the World Health Organization defines "health" as "complete physical, mental and social well-being" [19], the concept of "health" is multifaceted and complex – "having health" and "being healthy" constitute references with multiple and contextually very different meanings.

Exemplarily, starting from the affirmation of a "capability to be healthy", within the "capabilities" approach proposed by Martha Nussbaum and Amartya Sen, and due to the influence of the specification introduced by Sridhar Venkatapuram, Brigit Toebes emphasizes the meaning of health as a vital need, decisively requiring protection under international law. Differently, then, from the definition of "health" proposed by the World Health Organization, for aiming at a broader sense, Brigit Toebes emphasizes that guaranteeing access to health services is not enough, it is be necessary to establish basic conditions conducive to health – such as access to drinking water and sanitation, health-related information and education, safe and healthy working conditions, and healthy living environments[20]. Making such *capacity-capability* a

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[17] Articles 2, 3, 18 and 21, 26, 28 to 30 of the *Universal Declaration of Human Rights*.

[18] Articles 3, 22, 25 of the *Universal Declaration of Human Rights*.

[19] Preamble to the Constitution of the World Health Organization, 22 July 1946 (entry into force 7 April 1948).

[20] «All in all, health is a vital need that requires strong protection under international law. For international health law, it would be important to focus on the individual's capacity to function adequately in society and to pursue one's life plans. Moving away from the absolute WHO definition prevents persons with chronic diseases or disabilities from being labeled as 'unhealthy'. It also implies that emphasis needs to be placed not only on ensuring access to healthcare services, but also on creating conditions for being healthy, including access to safe drinking water and sanitation, health-related information and education, safe and healthy working conditions, and

"right" will therefore involve international institutions in its structuring and consolidation: if the "right to be healthy" is a *human right* as an urgent individual interest – the right "to the highest standard of health possible", or the "right to health" – it is no less an urgent collective need, and at the same time inseparable from the circumstantial social and economic development. It is also this the broad sense of *health* which is fundamentally at issue in the pandemic crisis of COVID-19[21], accentuating the weaknesses in promoting and protecting human rights on all continents.

2.2 Freedom and security

Critically reflecting on freedom and security in these circumstances, from the juridical point of view, there shall be clarified the axiological-normative meanings of the principles of freedom and security as foundations of current juridicity, and their constitutively pertinent dialectical tension, primarily as foundations of current juridicity , and, therefore, as effective *normative principles*[22].

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healthy living environments». – Brigit Toebes, "International Health Law: An Emerging Field of Public International Law", p. 304 (*vide* p. 303-304), referring to Amartya Sen, *Development as Freedom*, Oxford, OUP, 1999; Martha Nussbaum, *Creating Capabilities: The Human Development Approach*, Cambridge, Harvard University Press, 2011; Sridhar Venkatapuram, *Health Justice: An Argument for the Capabilities Approach* Cambridge/Malden, Polity Press, 2011.

[21] Brigit Toebes, "International Health Law: An Emerging Field of Public International Law", p. 304.

[22] See, especiallly, António Castanheira Neves, "A unidade do sistema jurídico: o seu problema e o seu sentido", *in Digesta – Escritos acerca do Direito, do pensamento jurídico, da sua metodologia e outros*, vol. II, Coimbra, Coimbra Editora, 1995, p. 95-180, 172-175; Fernando José Bronze, *Lições de Introdução ao Direito*, Coimbra Editora, Coimbra, 2002, 3rd. Ed., 2019, Coimbra, Gestlegal, p. 627-650; José Manuel Aroso Linhares, "Na 'coroa de fumo' da teoria dos princípios: poderá um tratamento dos princípios como normas servir-nos de guia?", *in* Fernando Alves Correia, Jónatas E. M. Machado, João Carlos Loureiro, *Estudos em Homenagem ao Professor Doutor José Joaquim Gomes Canotilho*, *STVDIA IVRIDICA*, 106, *Ad Honorem* – 6, *Volume III – Direitos e interconstitucionalidade: entre dignidade e cosmopolitismo*, Coimbra, Coimbra Editora, 2012, 395-421, 413-421; José Manuel Aroso Linhares, *"Validade comunitária e contextos de realização. Anotações em espelho sobre a concepção jurisprudencialista do sistema"*, 2009, *in Revista da Faculdade de Direito da Universidade Lusófona do Porto*, 1/1, 2012, 30-35 (https://revistas.ulusofona.pt/index.php/rfdulp/article/view/2966).

The reciprocal delimitation of fundamental principles and rights, namely freedom and responsibility, in question here, thus poses a problem of practical-normative adequacy, specifically of practical agreement[23]. Between *ethical virtues*, on the one hand, and *legal rights* and *duties*, on the other, far from unanimity, the dialectic between freedom and responsibility implies that the boundary between *self* and *other*, and thus between freedom and responsibility, which are specific qualities of law – as the reciprocal enforceability, to the *Other* and to the *I*... –, assume contradictory contours, depending on the contexts, from the most individual responsible to the most collectively repressive.

Freedom, as a manifestation of autonomy, a socially coined category, constitutes a rational referencing of action, which corresponds, within the concept of the bilateral character of law, to a respectively intrinsic dimension of responsibility[24]… Next to this, security constitutes also a fundamental value, conjoining a materially densifying understanding of law with a materialized, contextualized, meaning of justice. Whilst assumed, then, upstream, as components of the set of founding principles of law, freedom and security will not be less, downstream, effects of the juridicity in force, as practical consequences of the character and effectiveness of the law. And they both produce effects sustained in those fundamental assumptions – built and revealed as *positive* and *negative* freedom, on the one hand, and as security *of* the law, *through* the law, and *before* the law, on the other[25].

In the current pandemic situation, divergences around the tension between the need of confinement and of freedom of movements have led to discussions about the (un)equilibria of intersubjectivity, namely in terms of the relationship between freedom and responsibility, and, more than that, the sense of *co-responsibility*. It is, exemplarily, a matter

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[23] *Vide* José Joaquim Gomes Canotilho, *Direito Constitucional e Teoria da Constituição*, 7th. Ed., Coimbra, Almedina, 2003, p. 1161-1162, 1225.

[24] Please refer to the reflexion presented in Ana Margarida Gaudêncio, "Responsabilidade como princípio e limite(s) da(s) intersubjectividade(s) jurídica(s): reflexões em torno da proposta de Castanheira Neves", Revista de Direito da Responsabilidade, Ano 2, 2020, p. 771-790 (https://revistadireitoresponsabilidade.pt/2020/responsabilidade-como-principio-e-limites-das-intersubjectividades-juridicas-reflexoes-em-torno-da-proposta-de-castanheira-neves-ana-gaudencio/).

[25] António Castanheira Neves, *"Justiça e Direito", in Digesta – Escritos acerca do Direito, do pensamento jurídico, da sua metodologia e outros*, vol. I, Coimbra, Coimbra Editora, 1995, p. 241-286.

of understanding the character, the foundations and the criteria for determining confinement in the face of freedom of movement, on the one hand, and the confrontation between the demand for information and the needs to supply goods and services in view of the demands presented within the protection of privacy rights and of personal data, on the other[26]. As if there was an insurmountable gap between self--accountability *models* and hetero-accountability *models*, between consideration and inconsideration of the capacity for self-discipline and autonomy, and, therefore, of self-discretion and self-control… and, as far as it concerns to law, between (in)capacity for self-definition and self-imposition of limits.

3. Consubstantiation of human rights *in/as* law, beyond the *pandemic crisis*

The mobilization of the *human rights* "*discourse*" as the definition of an ideal human condition, determined as *universal*, within the context of the current pandemic crisis, plays a crucial role in the raising of the awareness of different cultural and juridical approaches to the relationships between human living conditions and strategies for political and economic expansion[27]. Which, being increasingly evident in the face of this global health and humanitarian crisis, is associated with multiple other crises, which, meanwhile, have not dissipated, and have even become more acute – exposing, in one way or another, more or less serious vulnerabilities, on all continents, associated with social, political and economic crises, and consequently, humanitarian crises, far beyond the confrontation of the COVID-19 pandemic[28].

Projecting, within and beyond this framework, the realization of *human rights* as *rights*, as effectively *juridical*, turning the axiological--normative presuppositions that they contain into normative effectiveness, will imply more than seeing them as demands for the protection of citizens before the States, and even as differentiated levels of protection

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[26] Mart Susi (Ed.), *Human Rights, Digital Society and the Law. A Research Companion*, Routledge 2019; Council of Europe (Ed.), *Human Rights Challenges in the Digital Age: Judicial Perspectives*, 2020.

[27] James R. May/Erin Daly, "Dignity Rights for a pandemic", p. 6-7.

[28] Equally essential at this point are the continuous updates provided by Human Rights Watch reports (https://www.hrw.org/).

and/or of intervention by the States, in a potentially universalizable movement. It will imply determining them historically and culturally, and viewing them from the specific contextualization of legal intersubjectivity. This is proposed here essentially on the basis of the proposal presented by Castanheira Neves, when affirming the juridicity of human rights beyond the constructions that project them as pretensions, essentially justified by political demands, and exactly through the accentuation of what this character of *juridicity* decisively introduces to them as a differentiating factor: the fact that, assuming a juridical character, they imply, in the consideration of the *other*, the counterpoise of *duty*, and, thus, both the affirmation of *rights* and of (*corresponding*) *duties*, in a *communally* assimilated dialectic between *autonomy* and *responsibility*[29] – *with which the mentioned cultural contextualization of juridical intersubjectivity will lead to different balances, assuming the dialogical basis of the construction of juridicity. In an opening of the meaning of law, in the dialectical conjugation between the suum* of each one and an integrative *commune*, simultaneously as a condition of reciprocal delimitation of action and of convergence of human realization[30].

Proposing a reflection on the meaning of law which admits a material basis for the juridicity of human rights and the recognition of a *minimum* core, or threshold, of common values – at this point referring to the proposal presented by Mário Reis Marques[31] –, it is pointed out the possibility, beyond a first threshold, a *minimum*, as a common

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[29] See António Castanheira Neves, *"Uma reconstituição do sentido do direito – na sua autonomia, nos seus limites, nas suas alternativas"*, 2009, *in Revista da Faculdade de Direito da Universidade Lusófona do Porto*, vol. 1, n. 1, 2012 (http://revistas.ulusofona.pt/index.php/rfdulp/issue/current/showToc, p. 20-21); António Castanheira Neves, *"O direito interrogado pelo tempo presente na perspectiva do futuro"*, *in* António Avelãs Nunes/Jacinto de Miranda Coutinho (Coord.), *O Direito e o Futuro. O Futuro do Direito*, Coimbra, Almedina, 2008, p. 9-82, p. 42-51.

[30] António Castanheira Neves, *Curso de Introdução ao Estudo do Direito: lições proferidas a um curso do 1.º ano da Faculdade de Direito de Coimbra, no ano lectivo de 1971-72*, Coimbra, 1971-1972, p. 125-130; António Castanheira Neves, "O princípio da legalidade criminal. O seu problema jurídico e o seu critério dogmático", *in Digesta – Escritos acerca do Direito, do pensamento jurídico, da sua metodologia e outros*, vol. I, Coimbra, Coimbra Editora, 1995, p. 349-473, p. 416. See the reflection proposed in Ana Margarida Gaudêncio, "Responsabilidade como princípio e limite(s) da(s) intersubjectividade(s) jurídica(s): reflexões em torno da proposta de Castanheira Neves", p. 4 ff.

[31] Mário Reis Marques, *Introdução ao Direito I*, p. 227. *Vide idem*, p. 227-242.

minimum of universalizable subjectivity, of a peripheral multiplicity of substantializations, non-coincident, rather of variable density, depending on the contexts and goods-rights-*pretensions* in question, and thus enhancing protection in differentiated levels. There is, therefore, essentially a specific intersubjectivity culturally underlying the perception of *human rights*, as concerned here, and, above all, paying attention to the *otherness of the Other*, which, now with inspiration in Douzinas – and, therefore, in Levinas[32] –, may provide an *inter*-subjective confrontation, rationally erected from a responsibility dimension (in this sense, *ethical*), able to convoke contents of specific cultural determination for its underpinnings[33].

Even if *human dignity* is a signifier with as many meanings(-contents) as the civilizational experiences considered – since the generic category *human dignity* will only make sense if it is substantially densified, in concrete[34] –, only the *reciprocal recognition* of that dignity – understood as a constitutive element of juridical *subjectivity* and *intersubjectivity*, and of their respective realization – may constitute, considering Castanheira Neves, the support of a *materially autonomous meaning of law[35], which, without resigning to affirm a validity* – and not

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[32] See Emmanuel Levinas, "*Interdit de la représentation et 'droits de l'homme'*", *in* Emmanuel Levinas, *Altérité et transcendance*, Montpellier, Fata Morgana, 1995 (Le Livre de Poche, 2010), p. 127-135; Emmanuel Levinas, *"Les droits de l'autre homme"*, *ibidem*, 149-153; Emmanuel Levinas, *"Droits de l'homme et bonne volonté"*, *in* Emmanuel Levinas, *Entre nous. Essais sur le penser à l'autre*, Paris, Grasset, 1991 (Le Livre de Poche, 2010), p. 215-219.

[33] See Costas Douzinas, *The End of Human Rights*, Oxford, Portland, Hart, 2000, especially 13. «*The Human Rights of the Other*», p. 343-369, especially p. 348-351, and 14. «*The End of Human Rights*», p. 371-380. See also the developments proposed in Costas Douzinas/Ronnie Warrington, *Justice miscarried. Ethics and Aesthetics in Law*, Hemel Hempstead, Harvester Wheatsheaf, 1994, mostly p. 80, and *ibidem* n. 183, p. 84, n. 200, p. 85, and *ibidem*, n. 201.

[34] Mário Reis Marques, "A dignidade humana como prius axiomático", *in* Manuel da Costa Andrade/Maria João Antunes/Susana Aires de Sousa (Org.), *Estudos em Homenagem ao Prof. Doutor Jorge de Figueiredo Dias,* vol. IV, Coimbra, Coimbra Editora, 2009, 541-566

[35] See António Castanheira Neves, "Coordenadas de uma reflexão sobre o problema universal do Direito – ou as condições da emergência do Direito como Direito", *in* R. M. Moura Ramos, C. Ferreira de Almeida, A. Marques dos Santos, P. Pais de Vasconcelos, L. Lima Pinheiro, M. Helena Brito, D. Moura Vicente (Org.), *Estudos em homenagem à Professora Doutora Isabel de Magalhães Collaço*, vol. II, Coimbra, Almedina, 2002, p. 837-871, p. 869-870.

forgetting the contributions of other normatively relevant practical dimensions – confers to law the role of an indispensable instance, at the same time normatively regulating and reflexively critical of social *praxis*.

Beyond the exceptional situation we are experiencing, will there be a post-pandemic society – will the so-called *new normal* remain? What role will freedom and security, and, consequently, responsibility and justice, play in the so-said *new normal*? Scientific means promise a *return*... In such a prophesied *return*, what *mask* will be buckled? A *mask* that, as for now, appears more and more also as a manifestation of responsibility and solidarity – or, even more, of *care*... – for oneself and for the other(s)… Or a mask as a means of affirming a protective *individualism*, of isolation and social sectorization, as others, already known, in a reduction, if not actually a substitution, of convivence, admitting an aseptic coexistence, the same still in the name of a selective protection of certain meanings of freedom and security…

Among the *pandemics of facts*, of *speeches*, of *fear*, and juridical normativity, there are decisive challenges, of an eventual reconstruction of the contents and the boundaries of intersubjectivity. And, consequently, of the reflections on the meaning and on the realization of *human rights as right(s).*

3. CONSTITUTIONAL LAW AND PANDEMICS: RESPONSIBILITY FOR SOCIAL JUSTICE AND PUBLIC HEALTH NEED(S)

Luís Meneses do Vale

Introduction

After being exposed to the values highlighted by the specifically bioethical prospection of the pandemic, but also to human rights (in whose discourse many of today's most pressing axiological problems of political, legal and moral nature tend to converge and intersect), it now seems proper lay eyes on the *constitutional normativity* responsible for assuming and reflecting those references – in a critical, constitutive and fundamental-regulatory manner - *on* (but also *from*…) the *global social project* by which political communities self-transcend themselves, according to the specific intentionality of that quest for a certain *nomos* - of, by and for – the common.

Now, as the present investigation directly questions the value and service capacity displayed and promised by law and politics in responding to the challenge posed by the current pandemic and the strong likelihood of similar emergencies in the near future, it is necessary to assert, right at the head, the place and fundamental role of constitutions in our common responsibility for justice - social, legal, public health, and health care justice: both in the quality of *Grundnorm* of the legally positive order, as in that of a broader *cultural project of ordering and socio-political coexistence*.

If one is not mistaken, a thorough legal analysis of the state (and regime) of necessity, dictated by the pandemic, would seriously risk diverting us from the main purpose of the research: less aimed at the self-reflection and self-regulation of the law and the constitution,

whenever disturbed by emergencies of the kind, than pointed to a critical reflection of the social functions by which they try to prevent, precate and combat them. Indeed, the secondary warrants of the system's self-subsistence constitute only part of the legal and constitutional response demanded by the circumstances, which now should yield to its primary function and material meaning in the relationship with society. Nothing that would blunt the relationship with secondary, tertiary (or even quaternary) norms, especially if densified by a phenomenological understanding of both law and constitutional normativity (as a principle of 'structure-action') *modus essendi*: vg., in what concerns the sociological-material moment of its sources, the reality within the system, the efficacy and effectiveness on which the respective validity depends, and above all, the specific rationality and method of its practice of realization. In fact, also indirectly - as basic or supreme law, law of laws and political source of sources, occupying the apex of the normative pyramid - it ends up being challenged in the above-mentioned task of fundamental and structuring normative-material conformation of society (with all its plurality) interests, powers and values, and the societal practices, institutions and subsystems that they engender and sustain).

Omitting explanations otherwise due, but impertinent here, it is worth saying that constitutionality is intended, in this regard, as an almost ecological or eco-systemic dimension of our social dwelling in the world, as a sense of value underlying the design, architecture and dynamics of fair institutions - mediating between good and right - through which, we actively seek and cultivate, in a context of plurality, the possibilities of the common; which amounts to say that through this elusive *justice* they aim at *peace*, seek the *stabilizing self-correction of the basic social structure* or aspire to *co-move* us to the *promotion* of the democratic and normative sociality indispensable to social integration. Hence, in spite of the previously protested scruples, it is legitimate to wonder whether, and to what extent, such nomos will be able to avoid the understandable diatribes and warnings against the temptations of social technology, of bio-political inspiration, whose techniques of governmentality and disciplinarity, the current emergency, the state of exception and the right of necessity, far from disturbing or surprising, only seem to intensify[36].

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[36] Günther Frankenberg, *Staatstechnik: Perspektiven auf Rechtsstaat und Ausnahmezustand*, Berlin: Suhrkamp Verlag, 2010. Regarding the current pandemic - Ming-Sung

Thus, along the following pages (I), the discourse will proceed from *Ethos* and *Nomos*, and dialectically between both, with respect to *responsibility* and to the reciprocal correlation between *justice* and *health*, as intentionally sanctioned by constitutional law; (II) this constitutionality, socially responsible for justice and health, will then be confronted with the *limits* and *limitations* imposed and revealed by the pandemic *ananké* and the tragically dilemmatic fracture between *salus populi* and *suprema lex* it makes us suffer, while offering a pretext to illuminate the theoretical and dogmatic (international and national) frameworks relevant for the matter. In this light, a chronic summary of the Portuguese response to the crisis will be sketched, mentioning its protagonists, main chapters, crucial episodes and recurring issues. To conclude (IV), very modestly, some lessons about the past and the present and, perhaps, some suggestions for the future will be drawn, animated by the constitutional synthesis of responsibility and hope (P. Häberle).

One last set of explanations should be put forward, regarding our starting point and the false evidence with which it can easily betray us. From the outset, and in the immediate follow-up to the above, the very cautious expectation in relation to the list of lessons possibly collected at the end of this journey, arises not only from historical and philosophical prudence concerning the vaunted magistracy of the past, but also from a concrete doubt about the nature of the experience provided by the difficult period we are going through; namely, with regard to the value of proof and trial that has been hastily signed to him, as an alleged *moment of truth*, plenty of *moralizing or propaedeutic* (if not *therapeutic*) *punishment* and *sacrifice*. After all, does it not reveal himself, also (or above all ...) liable to manipulation and diffusion of falsehoods, to illusory imagery, to perceptive deceptions and distortions and even to perverse sublimations segregated by our individual and colective unconscious? It seems far from safe, in any case, to believe it could emerge an unmistakable factor of sharpness (instead of adumbration), in terms of our self-representation and self-determination as *beings-there*, *in-the-world* and *with-others*.

Kuo, "From Institutional Sovereignty to Constitutional Mindset: Rethinking the Domestication of the State of Exception in the Age of Normalization", in Richard Albert/Yaniv Roznai (Eds.), *Constitutionalism under Extreme Conditions: Law, Emergency, Exception*, Springer, 2020, pp. 21-39; and Pedro A. Villarreal, "Public Health Emergencies and Constitutionalism Before COVID-19: Between the National and the International", Ibidem, pp. 217-238.

These ambiguities are prolonged, etymologically, in the conceptual oscillation between *exception*, *emergency* and *necessity*, even if we alleviate such terms from their heavy historical and legal-dogmatic burdens: (i) the first exposes the insufficiencies of the *logical reference to the rule*, suggesting the liberating potential of *escape*, while admitting the negative connotation of *expulsion* or *extraction* of a set [put shortly: leaving from *norm-ality* or *norm-ativity* - and in what sense (*emancipation*, *exclusion* or *abandonment*)?]; (ii) the aletic category, translated by the second, undermining the conditions of empirical or transcendental freedom and the deontic *sollen* built on them, opens the never totally sutured wound of all monistic (or, if less, dialectical) normativizations of social needs; (iii) the third one seemingly dilutes itself in the generic flow of contingent events or in the long-term process of vital emergency (from phylogenesis, ontogenesis and noogenesis) and the cultural patterns generated by social complexification .

Finally, between light and shadow, rule and exception, what is necessary and what is due, it would have to be clarified, if there were time, the *specific difference* of the times we're going through, therefore analogically comparing the *old* with the *new*, while reflexively reconstructing the *tertium* implied (FJ Bronze) in that exercise of historical rationalization, crucial in order to gain a clear understanding of the peculiar temporality of constitutions as ongoing collective *responses – from*, *to*, *by* and *before something* and *someone*.

Refusing any uncritical fascination with the *new*, as well as the relativism of a *nihil novum sub sole* attitude (which absorbs all the surprise in indifference), one must consider (i) the accumulated knowledge generated by the *general intellect* in matters of pandemics, (ii) the historical and reflective patrimony of constitutional law, in relation to situations of emergency, necessity or exception - without thereby undermining the *kairós* for social critique and the subsequent invention/discovery of transformative criteria of organization and action, provided by the current crisis.

As for the first (but also contributing to the substantiation of the second), suffice is to recall the succession of crises that we have been facing for some time - from the eruption of new forms of terrorism (after 9/11), going through the economic and financial debacle (of 2007), till the multiplication of natural disasters (typhoons, fires, floods) and the accumulation of pandemic episodes (SARS, Avian Flu, Ebola, Zika)

and the acuity they confer to the national and international *preparation and response agenda* [37].

With regard to the second, it would be foremost advisable not to neglect the changes prompted by relatively similar phenomena in the past[38], and the way many aspirations and desires born from those events or fed by the slow and pervasive accretion of injustices – suddenly uncovered in outbreaks of indignation - act as pressing redeemable promises.

I. Responsibility and Constitutionality: between Ethos and Nomos

1. Responsibility

Despite its seminal role in the universe of our normative references, responsibility can be said to have emerged relatively late in the philo-

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[37] It should be noted that the WHO dedicated its 2007 annual report to health security. In addition, it was proposed to devote 2019 to the theme of preparation and response, within the framework of a five-year plan initiated in 2018 - v. WHO, The World Health Report 2007: Global Public Health Security in the 21st Century, WHO, Geneva, 2007 and the Director General's Report, Public health emergencies: preparedness and response, Annual report on the implementation of the International Health Regulations (2005) : Progress in the implementation of the five-year global strategic plan to improve public health preparedness and response (2018–2023), WHO, 2019. Notwithstanding, attention should be drawn to the observations made in 2017 by Andrew LAKOFF, in the essentially theoretical analysis he developed in his *Unprepared. Global Emergency in a Time of Emergency*, University of California Press, 2017; a work where two distinct models of emergency response are envisaged and outlined: one based on risk calculation and a precautionary imperative and the other based on the idea of preparedness or potential preparation (preparedness). In addition to the allusions made in the application for the current project, see, especially for terminological explanations, Bruce JENNINGS / John D. ARRAS / Drue H. BARRETT / Barbara A. ELLIS (Eds.), Emergency Ethics. Public Health Preparedness and Response, Oxford University Press, Oxford, 2016; Chloe SELLWOOD / Andy WAPLING (Eds.), Health Emergency Preparedness and Response, Cabi, Wallingford, Boston, 2016; Rebecca KATZ / James BANASKI (Eds.), Essentials of Public Health Preparedness and Emergency Management, 2nd Edition, Jones & Bartlett, Wall Street, 2019.

[38] Walter Scheidel, *The Great Leveler: Violence and the History of Inequality from the Stone Age to the Twenty-First Century*, Princeton University Press, Princeton, 2017; Jared Diamond, *Collapse: How Societies Choose to Fail or Survive*, Penguin Books, London, 2005.

sophical *field* and - even more so - in its peculiar political and social endings. Moreover, the long-lasting centrality it has secured in the legal world (and in moral discourse), threatens to cloud the renewed meaning (eminently prospective and positive, institutional and structural)[39] recently achieved on those first domains.

Indeed, the asseveration of a *responsibility for social justice*, in general, and *for health*, in particular, relies on a radical rethinking of the *Mit-Sein* and an appeal to the *objective solidarity* brought about by natural and technical interdependencies as well as cultural aspects of sociality; it breaks with the exclusive and reducing circumscription of the category to the medullary (and indispensable) notion of moral and individualistic

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[39] In addition to Hans Jonas and Karl Otto-Apel - outstanding precursors of this shift *in* (or *to*) responsibility (whose works were deeply echoed within the walls of portuguese constitutional law, thanks to João Loureiro) - we have in view the *structural responsibility* (*for the social connection*) conceived and proposed by Iris Marion Young or the *positive institutional responsibility* suggested by Yasha Monk, or even the scheme of *responsibility for harm*, based on negative duties, delineated by Thomas Pogge - v. Iris Marion YOUNG, *Responsibility for Justice*, Oxford University Press, Oxford, New York, 2011; Yasha MONK, *The Age of Responsibility. Luck, Choice, and the Welfare State*, Harvard University Press, Cambridge (Ma), London, 2017; Thomas POGGE, *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms*, 2nd ed., Polity Press, Cambridge, 2008. Praising Young's contribution (put into dialogue with others – by Derek Parfit, Christopher Kutz, Judith Lichtemberg, Mary Gray, Melissa Lane or Barbara Fried), Vafa GHAZAVI, "Ethics at a distance", in The Politics of Care. From Covid 19 to Black Lifes Matter, *Review & Verso Books*, Boston, 2020; Kathryn SIKKINK, "Rights and responsibilities in the pandemic Coronavirus", *Open Global Rights*, 30 March 2020 (text also explicitly influenced by Max Weber's *Verantwortungsethik*). The severe difficulties posed by these transfigurations of responsibility don't go unnoticed, nor the differences that separate them from the traditional configuration of legal responsibility are ignored, especially on account of the strict delimitation (*quoad modum* and *quoad substantiatiam*) that the latter's intersubjective matrix ensures. However, it would now be dislocated to dive deeper into the remarkable efforts made in order to consolidate the potential detected and already released by this *Oberbegriff*'s *eidos-ousia* of practical reason - see, in the expectation of further developments on later and more propitious occasion - Kurt BAYERTZ / Birgit BECK, "Soziale Verantwortung Zur Entwicklung des Begriffs im 19. und frühen 20. Jahrhundert". *Preprints and Working Papers of the Center for Advanced Study in Bioethics Münster*, 81, Westfälische Wilhelms-Universitäts, Münster, 2015; exploring the numerous possible declensions of responsibility, Ludger HEIDBRINK / Claus LANGBEHN / Janina LOH (Hrsg.), *Handbuch Verantwortung*, Springer, Wiesbaden, 2017; Jan Henrik KLEMENT, *Verantwortung. Funktion und Legitimation e Begriffs im Öffentlichen Recht*, Mohr Siebeck, Tübingen, 2006; Joseph RAZ, *From Normativity to Responsibility*, Oxford University Press, Oxford, 2012.

imputation, ultimately grounded on the reason and freedom of the transcendental subject, underlying the empirical and phenomenal self.

Such responsibility… also holds us responsible for an adequate *constitutionality*, (capable of honouring it) and for the right law (able to do it justice), thereby performing the task values and embodying the core convictions that animate it, throughout the institutions of a culture-environment favourable to the corresponding ethos and the micro, meso and macro responsiveness, that signals its permanent openness to otherness and strangeness. Thus, a chain of responsibilities[40] becomes apparent, linking a complex set of goods, both factually and normatively or ontically and axiologically, in the practical dynamics of the respective realization.

In fact, social justice (even with a global ambition) - as a requirement for the *structurally integrated realization of personal equality*, through all the societal spheres engendered around the access to the main collective goods - is doubly correlated, as a factor and an effect, with the fair provision of health care and the promotion and protection of public health, thence considered as their constitutive or expressive dimensions[41].There is no social justice without health, nor health without health care and fair public health policies, the same way these, and the former, also benefit from social justice and its demands and repercussions in other sectors.

The infrastructural responsibility for the creation, maintenance and increase of practical institutions of care and attention regains legitimacy,

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[40] Neil Levy, "Taking Responsibility for Responsibility", in *Public Health Ethics*, Volume 12, Number 2, 2019, pp. 103-113; John Coggon, "Legal, Moral and Political Determinants within the Social Determinants of Health: Approaching Transdisciplinary Challenges through Intradisciplinary Reflection", *Public Health Ethics*, Volume 13, Issue 1, 2020, pp. 41-47.

[41] Karien Stronks/Brigit Toebes/Aart Hendriks/Umar Ikram/Sridhar Venkatapuran, *Social justice and human rights as a framework for addressing social determinants of health*. Final report of the Task group on Equity, Equality and Human Rights. Review of social determinants of health and the health divide in the WHO European Region, WHO Copenhagen, 2016; Richard Wilkinson/Michael Marmot (Eds.) *Social Determinantes of Health: The Solid Facts*, 2nd edition, WHO, Copenhagen, 2003. Sudhir Anand/Fabienne Peter/Amartya Sen (Eds.), *Public Health, Ethics, and Equity*, OUP, Oxford, 2004; CSDH, *Closing the gap in a generation: health equity through action on the social determinants of health* (Final Report of the Commission on Social Determinants of Health), World Health Organization, Geneva, 2008; Daniel S. Goldberg, *Public Health Ethics and the Social Determinantes of Health*, Springer, Cham, 2017.

in a spiral of inter-influential correlations, since they are trained for permanent attentiveness, service and responsiveness, both to immediate requests and to people's deep needs (as well as to the multiple levels of factual and normative expectations they nurture), in relation to any occurrences at a personal level or of a collective and even international magnitude[42].

2. Constitutionality

In both a broader and a stricter sense - to which the wide range of *constitutional studies* and the notions of *political morality* (as well those of *political jurisprudence*, *political law* or *constitutional culture and software*) seem to refer us – the *nomos* of constitutionality is hereby surprised at the heart of a triple crossroads: (i) between national and international axis, (ii) normality and normativity; (iii) law, politics and social arenas.

In the first case, by way of an interconstitutionality built as an aspiration of inter and transculturality, based on subjectivities, practices, institutions, systems, and trans-state intentions; in the second, as a socio-cultural response to the classic problem of integration and to the risk of *Zerfall,* against the fatalism of the *böckenfordian* oracle and to the detriment of the normative-formal (kelsenian), decisionist and concrete order (schmittian) and scientific-spiritual (smendian) models; finally, in the guise of a meta-medial *trans-structuring-a(c)tion* or *trans-institutionaliz-a(c)tion* that integrates pluralism and societal differentiation, in a scalar molecularity (from regional or local to global level), around the *chronotopic* incorporation or carnal root of man and the statutory modules (and corresponding ecosystems) of their equal freedom of realization.

In that first instance, it bears in mind the pandemic phenomenon, and in the second it opens up to the provocations caused by the pandemic disruption of daily life and its normative framework[43], in

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[42] Luís Meneses do Vale, "Responsividade nos sistemas públicos de saúde: o exemplo da OMS", in *Estudos de Homenagem ao Professor Doutor Figueiredo Dias*, Volume IV, Coimbra Editora, Coimbra, 2010, pp. 1049-1106.

[43] Since the normative assimilation of social needs, combining empirical well-being with recognized values/ goods, and individual happiness with a *eudemonistic* idea of fulfilment, demolishes the counterfactual resistance to the emergence of situations

the third, resuming the previous ones, it outlines the specific normative-constitutional and multilevel integration in context of global societal differentiation (by over-structuring the social sectors, from within, on the grounds of rights and their supporting institutions[44]). The extent to which it waits and responds, resists and confronts the ingredients of the tragedy (Jack Balkin), from its central core, is what will matter, in the case of health.

3. Constitutional responsibility for justice and public health

Taking for granted the adduced evidence as to the virtuous circle that justice and health tend to engender (at least whenever mutually reinforced through correct and just regulatory and sanctioning mediations), the corresponding constitutional (legal and political) responsibility for its guarantee appears as justified, deserving our strong commitment and advocacy[45].

In a broad interpretation of the *constitutional blocs* and the *transnational networks* to which the Portuguese-speaking countries belong, several international responsibilities stemming from the universal and regional, generic and sectoral systems of rights[46] call for special attention,

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of need, re-enacting - for the umpteenth time - one of the greatest problems of post-Kantian practical philosophy and contemporary legal and political theory and methodology. *Procedural* or *conflictual* solutions (discursive or systemically-functionally autopoietic) do not manage to overcome this difficulty in a totally convincing way; and even material jurisprudentialism has a hard time struggling with it in the macro or mesoscopic contexts, better intended by a political social normativity of teleological modeling of complex actions and institutions, namely, through the system of attributions and competences of public entities finalized to the satisfaction of collective interests.

[44] Drawing our attention - with another depth, scope and environment - to the trans- or supra-state dimensions of the issues in question, João LOUREIRO, "Goods, Males and (E) (E) states (In) constitutional: Sociality and Freedom (s): Notes on a Pandemic", in *Revista Estudos Institucional*, v. 6, n. 3, Sept. / Dec. 2020, pp. 787-832.

[45] On public health law, v. for instance, Lawrence Gostin (Ed.), *Public Health Law and Ethics. A Reader*, University of California Press, Berkeley, Los Angeles, London, 2002 e John Coggon/Keith Syrett/A.M. Viens, *Public Health Law: Ethics, Governance and Regulation*, Routledge, London and New York, 2017.

[46] See the articles from the *International Convention on the Elimination of All Forms of Racial Discrimination* (12th and 11th, no.1) the *Convention on the Rights of the Child* (24th), the *Convention on the Rights of Persons with Disabilities* (25th), the *European Social Charter* (11th and 13th), the *EU Charter of Fundamental Rights* (35th); the *Oviedo Convention* (3th), the *African Charter on Human and Peoples' Rights*

with emphasis on the *obligations* stipulated in the ICESCR[47] and further developed by the *doctrinal jurisprudence* of the Social Rights Committee - whether in terms of their *applicability*, *effectiveness*, *intensity*, *pace* and *scope*, or through the material distinction between *duties of respect*, *protection* and *fulfilment* (*facilitation*, *promotion* and *provision*) and a thorough specification of the main requirements concerning the social determinants of well-being, public health and health systems [*availability*, (geographic, financial, cognitive and timely) *accessibility* and *acceptability*]. An important array of demands that the Optional Protocol has made more pregnant, and the High Commissioners and Special Rapporteurs, on their side, have densified and determined with enormous courage and straightforwardness in recent years.

Internally[48], what juts out is the adoption of a *developmentalist*

(16th); the *African Charter on Welfare of the Child* (14th); the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (Protocol of San Salvador) (10th), among others ...

[47] See art. 12.º and Luís Meneses do Vale, "Sobre o sentido jurídico do acesso aos bens sociais fundamentais: a 'jurisprudência doutrinal' da ONU em matéria de saúde", *e-cadernos CES*, 15, 2012: 70-97; already during the pandemic - Pedro A. Villarreal, "Can They Really do That? States' Obligations Under the International health regulations in Light of Covid 19" (Part I e II), in Barrie Sander/Jason Rudall (eds.), *COVID-19 and International Law, Opinio Juris Symposium*, March 30, 2020; Tim Fish Hodgson & Ian Seiderman "COVID-19 Responses and State Obligations Concerning the Right to Health", Part I and II, Ibidem.

[48] See: *Constitution of the Portuguese Republic* (64th), *Constitution of the Brazilian Republic* (196 to 199, in addition to art. 6); *Constitution of the Republic of Angola* (77th, but also 21st); *Constitution of the Mozambican Republic* (89 and 116). In turn, according to Article 123 of the Basic Law of the Macao Special Administrative Region, *the Regional Government defines, on its own, the policy regarding the promotion of medical and health services and the development of Chinese and Western medicine and pharmacology. Social associations and individuals may, under the law, provide medical and health services of any kind*. The Public Health Services of the SAR are dependent on the Secretariat for Social Affairs and Culture and are concerned both with the *provision of differentiated and primary health care, as well as with the implementation of the actions necessary for the prevention of disease and the promotion of health (including surveillance epidemiology, health education, food hygiene, control of environmental hygiene vectors, occupational health and community health surveillance).* Finally, it should be said that the actions of the authorities, during the pandemic, were governed, in this field, by the provisions contained in Law No. 2/2004 (law for the prevention, control and treatment of infectious diseases), drawn up and approved following the SARS epidemic in the early years of the current millennium. As for the constitution of China, among the *General Principles* is stipulated, in art. 21, ia, that *the State, in order to protect people's health, must develop medical and health care, as well as modern and traditional*

paradigm, that relates social rights to public policies[49], somehow along the lines of the so called *common transformational constitutionalism*, theorized by A. Von Bogdandy about From Latin America. Characteristics that some tend to deride, namely a certain romanticism and aspirational idealism – regarded, in the global north, as needless *legal complication*, *utopian ingenuity* or *pure symbolic compensation* (although shared with other Mediterranean countries) – make an important presence in these constitutions, inspiring their fundamental and structuring principles, the tasks of the State, the guarantee of the various sectors of production, the political subordination of the economy, the concern for interaction and social cohesion, and of course, the umbilical relationship established between social rights and their institutional guarantees of achievement, through democratically socializing infrastructures such as those *beveridgian* health systems.

The distance between norm and reality, text and action, performance and impact, perception, appreciation and public satisfaction varies significantly between Portugal, Brazil and the African countries[50], without belittlement to the (intrinsic and consequential) value of the constitutional option for a democratic-social model of equalization (*from all to all*), aligned or tuned - whether in terms of health care access and financing, or in relation to these and other determinants of collective health, through well-being - with the *millennium development goals*, the *ecological* or *environmental-social revolution* regarding the *determinants of health*, the *best standards of practice*, the agendas for *universalization*, *new public* and *common services*, *integrated systems*, *global health*, *equality-oriented policies*, etc.

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medicine, encourage and support the management of various medical and health infrastructures by collective rural economic organizations, public companies, public institutions and neighbourhood organizations, and to promote public health activities. And in art. 45, §1, it is added that *citizens of the republic must have the right to material assistance from the State and Society* when they are elderly, sick or lose the ability to work. *The State must, therefore, develop social security, social assistance and the medical and health services necessary for citizens to enjoy this right.*

[49] In Portugal and Angola along the various numbers of one and the same article (although the affirmation of a right is clear only in the first case).

[50] Leaving aside, for the moment, the extreme case of Macau. Consider, as an example - indeed emblematic of the two cultures in question - the contrast between the scarce use of the judicial system, patent in Angola, and the accentuated judicialization registered in Brazil.

In short, the preparation and responsiveness to health emergencies will stand out and increase in a society: (i) solidary, egalitarian and cohesive, where social peace and the possibilities of realization are works of justice (which consolidates interpersonal and institutional trust, contributing to individual and collective resilience); (ii) with public health policies transversal to the various social sectors and a fair public health system (both legitimate and effective); (iii) endowed with the capacity to act in an integrated manner, with the support and confidence of citizens, combining global public policies with sectoral ones, reflecting health in all of them and combining the various response systems.

II. Under the Sign of *Ananké: health needs*

1. Overview[51]

Whoever does not settle for the *formalist escapism* of an *ideal normativism* and refuses to yield to the *pre-juridical sovereignty* of a more or less theologized power, or surrender to the normatization of a purely contingent facticity - bringing, instead, the constitutive tension between axiological-normative demands of ideal validity and practical-material performative instantiations of its efficacy or effectiveness, into the culturally intelligible and experienced normativity - is faced, with regard to the *law* or state of *need*, *emergency* or *exception*, in an

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[51] As a *locus classicus* on the subject, on the 20th century, please refer to the works of Carl Schmitt, especially from the 20s, namely, from the beginning of the 20s, *Die Diktatur. Von den Anfängen des modernen Souveränitätsgedankens bis zum proletarischen Klassenkampf*, 1921 e Idem, *Politische Theologie. Vier Kapitel zur Lehre von der Souveränität*, 1922. An easily understandable overview is available at Elliot Bulmer, *Emergency Powers*, International IDEA Constitution-Building Primer 18, IDEA, Stockholm, 2018. On a predominantly sociological perspective, cf. Matthias Lemke, "What does state of exception mean? A definitional and analytical approach", *Zeitschrift für Politikwissenschaft*, 28, 2018, pp. 373-383; Idem (Hrsg.), *Ausnahmezustand. Theoriegeschichte – Anwendungen – Perspektiven*, Springer, Wiesbaden, 2017. As a testimony to the variety of opinions on the subject, see the most recent collections: Gary Garstle & Joel Isaac (Eds.), *States of Exception in American History*, University of Chicago Press, Chicago, 2020; Cosmin Cercel, Gian Giacomo Fusco, Simon Lavis (Eds.), *States of Exception: Law, History, Theory*, London: Routledge, 2020; Richard Albert/Yaniv Roznai (Eds.), *Constitutionalism under Extreme Conditions: Law, Emergency, Exception*, Springer, 2020.

extreme situation, suspended on the Radbruchian bridge between *being* and *value*, streaked between the lines of the *Schranken* and *Grenzen* of law, and forced to problematize these complex *folds* of human existence, knowledge and evaluation, which we would rationally like to deem medially-dialectically productive and superiorly synthesizing. As announced, the problem becomes even more sensitive if a *jurisprudentialist* perspective, which overcomes this difficulty through a finalizing decision at the end of a spiral of correspondences (all mutually tuned, between both the system and the legal controversy and the intentional problematicity of the norm and the problematic of the case[52]) gives way to a critically reconstitutive relationship between normativity and social reality – like the one implied in the domain of constitutionality (according to its intentional conscience of the correspondent phenomenon).

The abovementioned figure dates back to the beginnings of legal-political reflection, namely in the context of the Roman republic (where the dictator, appointed by the superior magistrates, was temporarily invested with the powers and symbols of *Imperium*), having been rethought by Machiavelli in the transition to modern age, or by Locke (theorizing the *prerogative power*) and then by Rousseau and Harrington, at the dawn of contemporaneity. Ultimately, this flow led to the explosive drama nurtured by the cultural, political, economic and social conditions in which the German Republic of Weimar was immersed. Owing to the contribution of (above all) Giorgio Agamben, the theme was somewhat reinvented by the continental philosophy of the late 20th and early 21st centuries (inspired by Foucault's archeology and Walter Benjamin's theory of violence[53]),

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[52] Here, the negotiation between fact and law is resolved through a progressive concentration in the *normative programme* and the *material scope of the norm* (Müller), or the confluence of the *pre-comprehensive decision of a case* with the *legally set out normative hypothesis* (Esser), or even the *hypothetically constructed norms to solve the case* with the *legally inscribed rules* (Kriele).

[53] Giorgio Agamben, *Stato di eccezioni, Homo sacer, II, I*, Bollati Boringhieri, Torino, 2003. See, also, the monumental edition of the series dedicated to the homo sacer: *Homo sacer (1995-2015). Ediz. Integrale*, Quodlibet, Macerata, 2018; possibly *less convincing* are the last considerations by the author, especially the *polemic* set of thoughts published on his editor's site and which were compiled in: Idem, *A che punto siamo? L'epidemia come politica*, Quodlibet, Macerata, 2020.

whereas the USA's[54] constitutional theory would also revisit it, with great diligence, in the aftermath of the 9/11 attacks and against the subsequent international neo-belligerent and homeland security paradigm, soon established in America - and progressively, extended to all over the world. Subsequently, the economic and financial crisis generated yet another penultimate wave of reconsiderations, which extended and stretched its borders and the significant potential for the domains of the action against the normalization of the forms of oppression and patriarchal, neocolonial and economic-social control, which have a supranational scope[55].

2. The Legal Framework

2.1. Theory

The constitutionally relevant situations of *abnormality* lend themselves to diverse possibilities of analysis, allowing for the organization of very heterogeneous typologies, according to the chosen criteria or along different axes of systematization: times, subjects, powers, measures, effects, objects, etc. Thus, it is possible to speak of *monist* and *dualist* models and modalities of *authorization* or

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[54] Cf. Bruce Ackerman, "The Emergency Constitution", *The Yale Law Journal*, Vol. 113, 2004, pp. 1029-1091: and the discussion sparked by the Yale Professor v.g., David Cole, The Priority of Morality. The Emergency Constitutions Blind Spot", The Yale Law Journal, 113, 2004, 1753 e ss; Kim Lane Scheppele, "Law in a Time of Emergency: States of Exception and the Temptations of 9/11", *Journal of Constitutional Law*, Vol. 6, 5, May, 2004, pp. 1001-1083; Laurence H. Tribe and Patrick O. Gudridge, "The Anti-Emergency Constitution", *Yale Law Journal*, 113, 2004, pp. 1801 e ss; Martha Minow, "The Constitution as Black Box During National Emergencies: Comment on Bruce Ackerman's Before the Next Attack: Preserving Civil Liberties in an Age of Terrorism", *Fordham Law Review*, 75, pp. 593 (2006).

[55] See, for example, Lorenzo Cotula, "The state of exception and the law of the global economy: a conceptual and empirico-legal inquiry", *Transnational Legal Theory*, 8:4, 2017, pp. 424-454; José Atiles-Osoria, and D. Whyte, "State of Exception, Law and Economy: A socio-legal approach to the economy of exception in an era of crisis", in *Oñati Socio-legal Series*, 8 (6), 2018, pp. 808-818. Environmental disasters – with more or less broad impact (such as hurricane Katrina) and the epidemics that mainly emerged in the orient and Africa, added to these.

ratification[56], involving *implicit powers*[57] or *explicit enabling clauses*[58], contemplating *strictly bound*, *discretionary*, free and even irresponsible, *ordinary* or *extra-ordinary*, *legal* or *non-legal*, *constitutional* or *legislative*, *political* or *administrative*, *suspensive* or *restrictive* regimes. Darning some of the most advanced and best achieved taxonomies, it may be possible to elaborate further on the gap between models of legal *provision*, *accommodation* (or of internalization and normative domestication of a clearly differentiated facticity), *irrelevance* and extralegal *reaction*[59].

2.2. Dogmatic

a) National: In view of the subject which will be addressed on the next chapter of this White Book, there is no need for further considerations on the topic at this point: we shall only underline that the Portuguese constitutional *corpus* allows for a distinction between an *external* (of *war* or *military emergency*) and *internal state of need*. Flanked by situations of *serious threat or disturbance to the democratic constitutional order*, - under the latter hypothesis - the occurrence of pandemics, together with other natural or human disasters and serious accidents should be interpreted, in a normative manner, as an example of *public calamitiy*[60]. Once

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[56] As are the British Indemnity Bills, for example.

[57] As it happens, to a large extent, in the USA.

[58] See the notorious article 48 of the German Weimar Constitution and article 16 of the 1958's French Constitution.

[59] Oren Gross/Fionnuala Ní Aolaín, *Law in Times of Crisis. Emergency Powers in Theory and Practice*, CUP, Cambridge, 2006; David Dyzenhaus, *The Constitution of Law. Legality in Time of Emergency*, Cambridge University Press, Cambridge, New York et al, 2006; John Ferejohn/Pasquale Pasquino, "The law of the exception: A typology of emergency powers", *International Journal of Constitutional Law*, Volume 2, Issue 2, April 2004, pp. 210–239; based on these authors, Miguel Nogueira de Brito, "Modelos de Emergência no Direito Constitucional", *e-Pública*, Volume 7, N.º 1, Abril, 2020, pp. 6-26; cfr. Jorge Bacelar Gouveia, *O Estado de Excepção no Direito Constitucional: Entre a Eficiência e a Normatividade das Estruturas de Defesa Extraordinária da Constituição*, vol. II, Almedina, Coimbra, 1998; Idem, *Estado de Exceção no Direito Constitucional: Uma Perspetiva do Constitucionalismo Democrático – Teoria Geral e Direito Português*, Almedina, Coimbra, 2020.

[60] J.J. Gomes Canotilho, *Direito Constitucional e Teoria da Constituição*, 7.ª edição, Almedina, Coimbra, pp. 1083 and ff.

the respective material preconditions are verified, the Constitution provides for the possibility of instituting a legal regime or discipline of the state of need, which essentially consists of a collective suspension of rights that the President can declare – whilst opting between the *state of siege* or *emergency* (separated by tenuous lines…), depending on the severity of the case at hand - by decree presented to the AR (*Assembleia da República*, which corresponds to the Parliament), after consulting the government, and subject to a governmental referendum if, and when, the declaration has been previously authorized (or later confirmed) by the AR[61]. In addition to these formal, procedural and organic limits, addressing the substance of this institute (i) certain constitutional rights and principles are excluded from the potential scope of suspension[62], (ii) the specification of the affected rights is required, (iii) a limited time frame for its effects to be produced is defined, and (iv) special caution is requested in observing the principles of prohibition of excess, as well as, of course, equality and non-discrimination. The main legal regime continues to act as a parameter for the declaration of state of siege or emergency and for the measures adopted in its execution, guaranteeing the possibility of judicial review, beyond parliamentary political control.

b) International: regarding the derogation of rights, it is also worth highlighting, albeit briefly, the protection granted by the OHCHR (art. 4), supported by the Syracusa Convention and, specifically, General Comment no. 29, as well as the International Health Regulations, *maxime* in its article 43. So widely ignored during the national and international management of the pandemic, they led Lawrence Gostin and other experts, as early as February 2020[63], to call for international compliance with this normative complex. With the intention of elucidation collimated without a doubt to a greater

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[61] See articles 19, 134/1/d), 138, 140/1, 161/l) and 197/1/f) of the CRP.

[62] In harmony with what is set out in article 4 of the International Covenant on Civil and Political Rights (OHCHR), article 27 of the American Convention on Human Rights or in article 15 of the European Convention on Human Rights (ECHR).

[63] "Do not violate the International Health Regulations during the COVID-19 outbreak", *The Lancet*, 20 February, 2020

dissemination, transmission and inculcation in the collective conscience and to the modeling of the agency of the responsible public entities, beginning by the States, as well as by the populations, a consensus was reached and established not long ago by the the *Stellenbosch Consensus on Legal National Responses to Public Health Risks*[64]. Although it is not possible to analyze its content in this short space, it is an instrument which invites a devoted study of the legal nexus with which, in the future, state responsibilities in matters of health in general and public health in particular must be entangled, in addition to other requirements, of global solidarity, international trade and protection of rights of which real well-being and personal fulfillment (essential to the mutual support of individual and collective health) are dependent.

III. The National Narrative: from *Pathos* to *Logos*

If history only records accidents seismographically, forgetting, among the harsh peaks of change, the flat valleys of lukewarm happiness, we should not be surprised by the fascination and attraction of its privileged writers to epidemic phenomena. The metaphorical propensity and allegorical helpfulness will not weigh less in this calculation/underbudgeted/lesser amount, to which are added the dramaturgical form they tend to assume (Charles Rosenberg) and the social choreography they exhibit as they unfold in time and space[65].

In Lusophone countries history is told at various speeds and rhythms, impossible to track at length, therefore we shall only describe (and in a non-detailed way) the intricacies of the Portuguese novel. It contains two episodes of lockdown that began in March 2020 and January 2021, interspersed with a period where lockdown was lifted, from May to September; it includes three states of emergency decreed in March and November (2020,) and January (2021), which were followed by successive renewals each time; and it extends, as in a *Leitmotiv*, by a lasting and rarely relieved administrative management of

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[64] Available at: *International Organizations Law Review*, 2020, 1-68.

[65] Jeremy A. Greene & Dóra Vargha, "How Epidemics End", June 30, 2020, in *Thinking in a Pandemic: The Crisis of Science and Policy in the Age of COVID-19*, op. cit.

the calamity, throughout almost all of this period. The cast includes first-class institutional actors, such as the PR, the AR, the Government, the Autonomous Regions, the Municipal Councils, the Health Administration, the Courts and the Ombudswoman, but also the citizens and many of their civic and professional associations (orders, unions, leagues, employers' confederations, etc.), in addition to the media and social networks – the face to the world –, a plethora of specialists (promoted from the rear to the antenna) and social movements, more or less inorganic. Among many other topics and, most of all, in the midst of an immense list of non-trivial details, three major legal issues would perhaps deserve a more extended look: the opportunity and content of the declaration of state of emergency and the respective execution by the government; administration in a state of calamity; the holding of elections during the pandemic, all in the meantime leading to proposals of *iure condendo* and *lege ferenda*, regarding the constitution and current legislation.

Essentially, the deeds can be narrated as follows: in view of the international scenario and despite the absence of cases in Portugal, on March 2nd, the Government began to adopt restrictive measures, set out in the civil protection law, the Framework Law on Health, and the health surveillance law. Strong social pressure, especially by health professionals, led the PR to declare the first state of emergency, even though, in principle, it was possible for the executive to restrict the affected rights, which are subject, according to Reis Novais, to a "*reserva imanente de ponderação*" (theory which proposes that a right is inherently "born" with limits)[66]. In addition, the President's decree did not suspend the *right to personal freedom*, which was instead primarily affected by the core of government intervention (and which

[66] Jorge Reis Novais, "Estado de Emergência – Quatro notas jurídico-constitucionais sobre o Decreto Presidencial", *Observatório Almedina*, 19 de Março de 2020; Idem, "Direitos Fundamentais e inconstitucionalidade em situação de crise – a propósito da epidemia COVID 19", in *e-Pública*, Vol. 7., N.º 1 Abril, 2020, pp. 78-117; Pedro Costa Gonçalves, "Abdicação parlamentar na emergência e continuação da abdicação na calamidade", *Observatório Almedina*, 21 de Maio de 2020. Similar proposals were presented internationally, by authors such as Martin Scheinin. In Germany, inversely, the lack of constitutional measures that could expressly be invoked was resented. For a comparative analysis of the response, see: Joelle Grogan, "Power and the COVID-19 Pandemic – Introduction & List of Country Reports", *VerfassungsBlog*, 2021/2/22.

constituted the main argument for resorting to its suspension, if we are not mistaken), who also delegated powers to delimit the suspended rights, a measure with questionable constitutional conformity. It could hardly be said, in any case, that the Government's measures were a mere execution of the presidential decree: they had, in fact, a constitutive role, in material terms, in the restriction of rights, which is why they should have assumed the legal format, and not just a regulatory nature, like it ended up happening. In any case, after two renovations, without significant changes in these problematic points, the state of emergency expired on May 2nd, and gave way to an *administrative state of calamity* (in turn renewed until June 28th), framed by the above mentioned legislation, confident in the citizens' civic conscience, as the restrictions were gradually being lifted. However, the summer sun did not last long and in September the infection rates rose again, at the same time as new strategies (such as compulsory use of masks and the evaluating the possibility of implementing a mobile digital application to track contacts) were entered on the agenda. Although the first measure was definitively incorporated on the agenda with no hesitation, the second entered the agenda hesitantly, and ended up completely failed. The worsening of the situation resulted in the declaration of another state of emergency on November 6th and in the implementation of more severe constraints during the month of December (night curfews during the week, and from 1 pm, at the weekends). The failure of restraint during the festive period (perhaps due to the regulatory complexity of the measures), combined with the early appearance of new virus strains in the country, resulted in the blackest period of the pandemic, in January, inducing the implementation of another lockdown, from the middle of the month, in the face of the alarming numbers of deaths and infections, the congestion of hospitals and the imminent rupture of the system. Measures were not adopted to guarantee that the presidential election was conducted with more safety and it was held on the scheduled date. The arguments put forward in favor of a possible postponement (notwithstanding the constitutional deadlines admitting a relative delay) were not convincing, and the concern over maintaining a healthy democratic regularity outweighs them. From this experience, however, it was learned that there is need to calmly consider a reform of the system, although without embarking on an occasional and polemic electronic alternative, which lacks research and debate; and this because

the logistical lack of preparation, particularly with regard to early voting, was very much noticeable[67].

In addition to the aspects emphasized above, and many other points of uncontroversial interest, there were other subjects of permanent discussion, including: (i) the lack of professionals (and the ways of supplying them, with immediate importation, expansion of the network of institutions that provide training, relaxing corporate constraints, etc.); (ii) the authorities' communication protocols; (iii) testing and, later, vaccination programs and plans; (iv) remote attendance and monitoring systems (by telephone); (v) the strategy of articulation between economic sectors included in the broad concept of health care system; (vi) the possible definition of rules for prioritizing or rationing access to care; (vii) the financial support provided and the economic and social support solutions for business expenses with personnel; or (viii) privacy hindered by rapid telematization and the imminence of recourse to digital patient tracking systems. These can be understood as tips to strengthen the response capacity of the population as a whole, of cities, regions and countries, of the various economic sectors and above all, of the national health service to situations of emergency and adversity.

IV. Elements for a *Paideia*

From the impact caused by the pandemic, in particular, on our self-understanding as inhabitants of one Earth and members of a common Humanity, we will certainly draw conclusions - hopefully interconnected, and profound - regarding human values and rights, constitutions and the law, the social structures that guarantee and instantiate them and the subjects, praxis and institutions who carry this structuring responsibility.

We present a handful of pointers, somewhat unstructured, since they are systematically reflected in the recommendations advanced by the team responsible for the project, which are organized later on in this Book.

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[67] Early voting was not available to citizens who were under surveillance (to detect a possible infection) after January 14th. Also, queues to vote were long and citizens waited for significant lengths of time to vote, not always following the recommended sanitary measures.

- With regard to **health**, *per se*: (i) telemedicine and the rapidly growing electronic health, call for thoughtful planning, which does not undermine the importance of human contact; (ii) public health must be significantly revalued in all its aspects, taking into account the *impact pyramid* and *circles of determinants of health;* (iii) the health care response lacks integration at various levels (since hospitals remain essential) and requires the involvement from the community, through which citizens participate responsibly in its organization and functioning; (iv) after years of disarray the agendas of *communization, integration, universality, intersectionality and transversality* gain particular importance.
- From a **scientific-cultural and communicative-informational point of view**, (i) science must be collaborative and prestigious, subject to financial and social support and recognition; (ii) access to the internet emerged as a fundamental right and its provision cannot be left to operators controlled solely by weak regulators (focused on guaranteeing substantial results through economic competition); (iii) schools and health establishments are primary investment areas, starting from the quality of common spaces, which should be open to society and are essential to guarantee the maintenance of in-person social relationships in times of crisis; (iv) the creative industry and cultural habits and media play an irreplaceable role (including in the field of mental and family health) in the face of social unrest and the existential void; (vii) the media carry increased responsibilities during crises such as the one we live in, whether in terms of informing the public, or as guarantors of criticism and plurality of opinions, or even in the exercise of primary educational and pedagogical functions.
- Regarding the **economy**, in general, (i) as in many other aspects, the crisis does not affect everyone equally; (ii) the advantage of a coexistence between the economic sectors is evident, as their differences stand out and can result in a more fruitful relationship; (iii) planning is crucial; (iv) international cooperation calls for urgent improvements; (v) logistics chains cannot escape the scrutiny and control of the authorities; (vi) development is not, in fact, to be confused with growth;
- In the **urban and housing** dimensions, (i) human corporeality and the consequent need for *common luxury* became evident, as

important investment sectors on what belongs to everyone, as a place of quality, safety, hygiene, well-being and sociability (therefore resistant privatization and complete idiotization of our existence); (ii) in parallel, however, the quality of housing remains a major problem, as well as (iii) the articulation of one and the other, in urban models designed for man, which guarantee an interface between private and public life, and private and community living.

From somewhere comes to us the parallel between pandemic cities and the surreal landscapes of *De Chirico*, empty of men. Fundamental nodes of a networked constitutionalism in a global world of cities, in an unstoppable expansion, they rediscover themselves, however, as the ideal place of the reinvented (e) utopia - classic and medieval, modern and contemporary - of man's realization and flourishing. We must, therefore, engage ourselves to the public imagination that transforms them, committed to honoring the hopes we have been dreaming in these times of isolated dispersion for them and us. If so (and we are worthy of such), as someone has also suggested, evoking Neruda's noble speech, sooner rather than later the day will come when, at last,

"*A l'aurore, armés d'une ardente patience, nous entrerons aux splendides Villes*."

(Rimbaud)

4. PUBLIC LAW AND THE PANDEMIC

Ana Raquel Gonçalves Moniz

1. Introduction

Protecting *public health* as a legal-constitutional asset, embodied in an objective health right, proves its transversality. This cross-cutting bundle of rights traverses all normative-social dimensions and all the legal dogma domains that are encountered during the pandemic. Therefore, it is conceivable that no other subject matter has experienced the influxes caused by the pandemic crisis with increasing intensity that are the hallmark of pandemic applications of Public Law. During the pandemic, public authorities gave paramount importance to achieving the right to health protection (addressing the impact on health services). Additionally, and of co-equal importance, public health measures to prevent and combat COVID-19 inevitably affect the ability to guarantee several fundamental rights.

In the context of pandemic response, invoking different kinds of states of exception presents problems that cross several legal and constitutional components of the infrastructure in public law systems. Many countries have experienced difficulty because emergency measures were often the product of legal-administrative actions. As the pandemic wore on from weeks to months to over a year, the grew increased negative reactions from citizens, who brought judicial actions against the various measures adopted under the declared State(s) of exception.

2. Exceptionalism applied to the Emergency and how it Impacts Rights

The reamrkably sudden emergence of COVID-19 forced legal systems to react through the mechanism(s) of the state(s) of exception.

In Portugal, the 2020 pandemic caused mobilization of the figure of the state of emergency within the framework of the 1976 Constitution for the first time since its entry into force (even though emergency powers have been in the CRP from the outset). Unlike many countries[1], western systems (including Lusophone legal systems) were faced with the legal projection of the effects of a pandemic in terms of fundamental rights, a crisis framed by a normative framework that is easily blurred. The admixture of these components gives rise to three questions: the distinction between situations of normality and situations of exception (2.1.); the central role played by the Executive, in the context of the response to the crisis (2.2.); the subordination of exceptional measures to juridicity, underlying that crisis measures do not operate beyond the rule of law.

2.1. Fundamental rights: between normality and exception

Current circumstances confront pre-existing distinctions between situations of normality and situations of exception; the divide between the "law of normality" and the "law of crisis"[2]. In Portugal, fighting against the pandemic led to the mobilizating legal instruments of exception: both a constitutional state of exception (as happened with the

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[1] Necessary attention is due to the affected Eastern States, right at the dawn of the 21st century, by the SARS outbreak, and whose reactions are seen as exemplary, since, after that epidemic, the response instruments were developed and improved, creating public health plans and, as such, giving public authorities a *preparedness*, which extended to the context of political and administrative planning and organization, which, in turn, resulted in faster and more efficient reaction mechanisms: this is what happened, for example, with Singapore or Taiwan. See SHAABAN/PELETEIRO/MARTINS, «COVID-19: What Is Next for Portugal?», In: *Frontiers in Public Health*, vol. 8, 2020, 392 (doi: 10.3389 / fpubh.2020.00392). Also in the Macao Special Administrative Region, the SARS epidemic between 2001 and 2003 was an educational experience, which resulted in the approval of Law No. 2/2004 (law for the prevention, control and treatment of infectious diseases), the mechanisms of which were, immediately activated to face the pandemic - v. Vera RAPOSO / Man Teng IONG, «The Struggle Against CoViD-19 Pandemic in Macao», in: *BioLaw Journal | Rivista di BioDiritto*, special no. 1, 2020, pp. 747 and following.

[2] Bacelar Gouveia, «Portugal e a COVID-19: Balanço e Perspetivas de uma Ordem Jurídica da Crise», in: *Revista do Ministério Público*, número especial COVID-19, ano 41, junho 2020, p. 94.

state of emergency) and (special) "administrative states of exception"[3] which are set out in the Civil Protection Framework Law (LBPC - *Lei de Bases da Proteção Civil*[4]), the Framework Law on Health (LBS – *Lei de Bases da Saúde*[5]), as well as the Public Health Surveillance System Law (LVSP - *Lei do sistema de vigilância em saúde pública*[6]). In general, and when perceived as forms of "states of emergency", these mechanisms embody a way of legalizing actions which, had they happened under other circumstances, would be invalid, but, in scenarios of imminent and/or existing danger to interests superior to those being sacrificed, a danger that is not imputable to the perpetrator of the injury.

Clearly, adopting each of the states of exception require verificating each of their own prerequisites and each has a (partly) different duration. Yet, from the perspective of how each of them affects fundamental rights, the respective effects differ. Under the Portuguese legal construct, if states of constitutional exception lead to the possibility of *suspending* the exercise of fundamental rights, the remaining mechanisms only result in their *restriction* - in line (at least, tendentially) with the seriousness of the underlying situations.

2.1.1. Thus, in the most serious situations - in which a state of siege or a state of emergency is decreed - article 19 of the Portuguese Constitution sets forth the possibility of suspending fundamental rights. Such a suspension is allowed only if it conforms to a set of limits outlined in the Constitution itself ; among those limits, we will underline two: one a structural-formal level; secondly, of a material nature.

On one hand, declarating a state of siege or a state of emergency presupposes a significant articulation between the sovereignty bodies: in Portugal, the President of the Republic, the Government and the Parliament embody a system of checks and balances as it arises from

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[3] See also: Pedro Gonçalves, *Manual de Direito Administrativo*, vol. 1, Almedina, Coimbra, 2019, pp. 391 and 392, distinguishing between the state of administrative need (as a general rule contained in the CPA – Code of Administrative Procedure) and the "special rules of *emergency law*" (italics in the original), which embody a different specific regime.

[4] Law no. 27/2006, of July 3rd, amended by Organic Law (*Lei Orgânica*) no. 1/2011, November 30th and Law no. 80/2015, of August 3rd.

[5] Approved by Law No. 95/2019, of September 4th.

[6] Law No. 81/2009, of August 21st.

an adequate understanding of the principle of separation and interdependence between powers. Prior to a presidential declaration of state of emergency, there must be a hearing within the Government, and requires authorization by the Assembly of the Republic (according to articles 138, 161/l), and 197/1/f), of the Portuguese Constitution[7]], as well as parliamentary control of its specific execution (*see* article 162/b] of the CRP[8]). Additionally, the declaration of a state of siege or a state of emergency maintains the constitutional scheme for organizing political power (including the self-governing bodies of the autonomous regions) thus untouched (*see* article 19/7), from CRP).

On the other hand, it must be emphasized that the constitutional state of exception regime has material limits. From the outset, and without interfering on the essential observance of the requirements of the principle of proportionality (cf., in particular, article 19, sections 4 and 8, of the Portuguese Constitution) and the principle of exceptionality and limits on suspension[9], the number 6 of article 19 of the Portuguese Constitution prevents the suspension of the rights to life, personal integrity, personal identity, civil capacity and citizenship, non-retroactivity of criminal law, the right of defence of defendants and the freedom of conscience and religion.

The Portuguese influence in Lusophone countries is noticeable, many of them opting for a constitutional state of exception system, which, also with the aim of restoring constitutional order, provide for the possibility of suspension (and, in certain cases, of limitation) of fundamental rights, temporarily (cf. table 1).

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[7] See also article 10 of the State of siege and State of emergency regime (*Regime do estado de sítio e do estado de emergência*, RESEE - Law no. 44/86, of September 30th, amended by Framework Laws (*Leis Orgânicas*) no. 1/2011, of November 30th, and no. 1/2012, of May 11th). The steps involved in the process are contemplated in articles 23 and following of this same act.

The decree of the President of the Republic declaring a state of siege or a state of emergency [cf. article 134/1/d) of the Portuguese Constitutionl] is subject to ministerial referendum, in accordance with the provisions of paragraph 1 of article 140 of the Constitution. See also article 11 of the RESEE).

[8] See also article 28 of the RESEE.

[9] Cf. Jorge Miranda, «Artigo 19.º», in: Jorge Miranda/Rui Medeiros (dir.), *Constituição Portuguesa Anotada*, tomo I, 2.ª ed., Coimbra Editora, Coimbra, 2010, p. 410.

Articles 282 to 284 of the Constitution of Mozambique thus enshrines the concepts of state of siege and the state of emergency, declared in the event of an agression (or imminent aggression), serious threat, disturbance of the constitutional order or situations of public calamity (reserving the state of emergency for cases in which these preconditions are verified but are less severe). Declaration of the state of emergency allows suspension and limitation of rights, not exceeding 30 days, (although it may be extended for equal periods of 30 days, up to three times, if so justified). Article 58 of the Angolan Constitution includes the mechanisms of the state of war, state of siege and state of emergency, to be mobilized in situations of effective or imminent aggression by foreign forces, of serious threat or disturbance of the democratic constitutional order or situations of public calamity. These states of exception produce the suspension and limitation of rights (without the possibility of affecting the right to life, personal integrity and personal identity, civil capacity and citizenship, as well as the non-retroactivity of criminal law, the right of defence and freedom of conscience and religion).

The Brazilian Constitution establishes a more significant material duality between the emergency State of defense and the State of siege, which projects on the design of the applicable legal regimes (cf. articles 136 and 137 of the Federal Constitution, respectively): the former is dedicated to the preservation or the prompt restoration of public order or social peace (threatened by serious and imminent institutional instability or affected by calamities of great proportions) and exclusively allows the restriction of rights in limited and determined areas (with a duration not exceeding 30 days, without prejudice to the possibility of one prorrogation, for an equal period). The latter option is designed to address serious commotions with national repercussions, or is pin the aftermath facts that prove the ineffectiveness of the measures adopted during the state of defense, declaration of state of war or as a response to foreign armed aggression. This state of siege involves the suspension of rights (for a period not exceeding 30 days - successive extensions for equal periods are allowed – or, when applicable, for the duration of the war or armed aggression).

2.1.2. In parallel but independent from this very specific regime, the Portuguese system sets out regulations that allow the adoption of exceptional measures in very different circumstances (not all associated

- *rectius*, regardless of their association - to the protection of public health). This can occur using instruments resulting from the LBPC: the declarations of a situation of alert, contingency or calamity consist of mechanisms generally intended for mitigating collective risks by limiting their effects in the event of a serious accident or catastrophe (cf. article 1 of the LBPC). These declarations presume increasing severity of the situation which in turn is projected in the intensity of the measures to be adopted and in the body vested with powers to issue them (cf. articles 8, 9. 13 and following of the LBPC). In particular, legal actions and material operations carried out under the declaration of a calamity situation and for the purpose of executing this declaration are presumed to be carried out in a state of need (cf. Article 23, number 2 of the LBPC) and may involve limitations on fundamental rights, such as private property or free private economic initiative (cf. Articles 23/1, and 24 of the LBPC).

In the context of public health crises, Article 17 of the public LVSP gives extensive powers to the member of the Government responsible for the area of health. Contrary to the implied power in its title ("exceptional regulatory power"), this rule includes exceptional measures that are not restricted to merely issuing regulations. Instead, this norm provides generic authorization for the practice of administrative acts that imply restriction, suspension or closure of activities, and separation of people who are not sick, means of transport or goods that have been exposed to infection or contamination, in order to contain pandemic spread. Therefore, under this precept, the Government can adopt (primary?) measures that restrict fundamental rights, limiting, for example, the freedom of movement, the right of assembly or the right to private economic initiative.

2.2. The centrality of the Executive

Operationalization of the "law of the crisis" signifies, as a rule, a rebalancing of the various powers, determining the centrality of the executive power, in general, and the Government, in particular. Thus, the situations of exception and the responses that are designed to react to them inevitably lead to a stronger Executive, even when (as in Portugal) competence for the declaration (of the state of emergency) is entrusted to the Head of State endowed with direct democratic legitimacy.

2.2.1. From the outset, the national execution of the declaration of the state of emergency is entrusted to the Government (cf. article 17 of the RESEE), as the highest organ of Public Administration. It should also be noted that the CRP uses the expression "authorities" (cf. article 19/8 which is repeated by article 19 of the RESEE) to designate the entities which have the competence of adopting the appropriate and necessary measures for the prompt restoration of the constitutional order - which, in turn, refers to the Administration[10] [naturally, under the direction (*hoc sensu*) of the Government] a determinative role, not only shaping the measures that are adopted, but also forming their execution. Although the law imposes a duty to inform the President of the Republic and the Assembly of the Republic regarding the measures that enforce the state of emergency, this does not exclude the government's role, but emphasizes the importance of this organ's political accountability to others.

The importance of the administrative regulation is significant: in fact, the rules contained in the various government decrees that have implemented the declaration of the state of emergency issued by the President of the Republic assume the nature of administrative regulations[11]. This form of administrative action has an enforcement function here, as a normative instrument that is essential to define the legal policies that result from the declaration of the constitutional state of exception.

2.2.2. The declaration of the calamity situation, based on the LBPC, also reinforces centrality of the Government. In situations of serious public health emergencies, particularly in the event of a calamity or catastrophe, the member of the Government who are responsible for health must institute all necessary exceptional measures that are indispensable to the situation, coordinating the contribution of the

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[10] On the specific context of the state of siege/state of emergency, cf. Bacelar GOUVEIA, Estado…, cit., P. 190.

[11] See Decrees No. 2-A/2020, of March 20th, 2-B/2020, of April 2nd, 2-C/2020, of April 17th, 2-D/2020, of April 30th, 8/2020, of November 8th, 9/2020, of November 21st , 11/2020, of December 6th, 11-A/2020, of December 21st, 2-A/2021, of January 7th, 3 -A/2021, of January 14th, 3-B/2021, of January 19th, 3-C/2021, of January 22nd, 3-D/2021, of January 29th, 3-E/2021, of February 12th, 3-F/2021, of February 26th, and Decree No. 4/2021, of March 13th.

central services of the Ministry with the institutions and services of the National Healthcare System and health authorities at national, regional and municipal levels (cf. article 5, no. 4, of Decree-Law no. 82/2009). Consistent with these precepts, the aforementioned Law no. 81/2009, which establishes that, in the event of a public health emergency, there are exceptional administrative powers granted to the member of the Government responsible for the health area (cf. article 17). In this normative scope, the practical problems that arose can be traced back to the circumstance that, during the firste wave, some of the measures adopted under the declaration of the state of emergency were extended beyond it and also adopted under the declaration of calamity or under the health surveillance system.

2.3. Jurisdictional means of defending fundamental rights

Prerequisites and preconditions to declare the states of exception set out in the Constitution and the Law clearly indicate that the legislator is not acting outside the principle of legality, but, on the contrary, that public authorities are still acting within the framework of the rule of law.

Safeguarding (possible) violation of the right to freedom (and, therefore, litigation for example in reaction against an illegal detention), the remedies used to control the legality of actions performed by public authorities (when they affect fundamental rights) are primarily derived from Administrative Justice and/or Constitutional Justice. Among us (but similarly to what happens in other legal systems), there are already some (although not many) cases that, having reached the Constitutional Court[12] or the Supreme Administrative Court[13], dealt with the

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[12] See Judgments no. 424/2020, of July 31st, and no. 687/2020, of November 26th. In the meanwhile, a request for the general review of constitutionality of rules that deal with property right and free private economic initiative, has already been submitted by the Ombudsman to the Constitutional Court on November 23rd, 2020, but, due to the absence of deadline associated with this process, has not yet been decided upon.

[13] See Judgments of 10.09.2020 (P. 088 / 20.8BALSB), 31.10.2020 (P. 01958 / 20.9BELSB) and 31.10.2020 (P. 0211 / 20.1BALSB), Orders of 20.11.2020 (P. 2090 /20.0BELSB) and of 23.12.2020 (P. 143 / 20.4BALSB), and Judgment of 05.02.2021 (P. 012 / 21.0BALSB).

constitutionality/legality of the measures adopted in the context of the pandemic that contend with fundamental rights (see table 3).

A preliminary analysis of the jurisprudence available in Portugal allows us to anticipate three possible outcomes:

a) As far as administrative jurisdiction is concerned, despite not having data regarding the courts of first instance, in comparative terms (to, for example, German and French cases), there are relatively few cases that are aimed at defending fundamental rights. It does not seem to us, however, that it is possible to infer from this fact that the measures adopted do not raise questions regarding their constitutional or legal conformity (on the contrary: these questions are clear in the Judges' voting results of two of the decisions);

b) There have been two Constitutional Court's judgements in appeals within the judicial review process, but most court proceedings aimed at protecting fundamental rights were directed to the Administrative Justice, in particular through the writ for the protection of rights, freedoms and guarantees (*intimação para a proteção de direitos, liberdades e garantias*). These decisions, as they are qualified as an urgent court proceeding, were rendered quickly, which translates the fulfillment of the right of effective judicial protection and consolidates the role of the Courts as guardians of fundamental rights and the rule of law;

c) Assessing the legal conformity of the measures lead to the mobilization of fundamental normative principles, as happened, paradigmically, with the principle of proportionality or with the principle of equality. However, summoning such principles also ended up revealing some of the perplexities underlying the valuation judgments they presuppose and the weaknesses emerging from their traditional understandings.

3. Final Reflections

In light of the exceptional circumstances under the pandemic of 2020 and its attendant emergency orders, the legal projections of the pandemic turn out, to be a "stress test" of the rule of law itself, whose defence takes on special relevance in times of crisis. The current expe-

rience opens the way for further reflection, both in terms of Constitutional Law and in terms of Administrative Law.

The lack of legal instruments for responding to the pandemic has generated some uncertainty regarding the form and degree of how rights are affected – a concept which is one of the pillars of the Rule of Law. In terms of right(s), this crisis confirms that preparedness represents a fundamental aspect for the evolution of legal regimes, imposing an *a posteriori* reflection and improvement on the matter[14]. In this context, it stands out, in Europe (and, therefore, in a legal-cultural horizon closer than the Asian experiences), the German *Infektionsschutzgesetz* which, having entered into force in 2001, established a relatively solid legal framework for similar situations (although without the dimension of COVID-19), but which, nevertheless, had to undergo significant changes during the pandemic, including the introduction of a State of "epidemiological situation of national importance".

In any legal system, if a government wishes to design a heightened preparedness strategy for pandemics based on epidemiology to protect people during a public health emergency, it will require more than a mere adequate articulation with the existence of a constitutional state of exception based on public calamity (or equivalent institute), as well as a reflection and consideration on the subject of conformation / limitation / restriction of fundamental rights (especially rights, freedoms and guarantees) and the possibility and degree of normative intervention of the Administration. Drafting new laws about this subject will enjoy the advantage of lessons learned, to be better equipped to respond to a pandemic situation. In addition to specific problems related to the legitimacy of the interference of the law in the practice of

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[14] The Portuguese legal system was *almost* due to achieve a leading position in this matter: in fact, Base XIII of the Draft Framwork Law on Health (cf. *Lei de Bases da Saúde: Materiais e Razões de um Projeto*, Cadernos da Lex Medicinae n.º 3, Instituto Jurídico | Faculdade de Direito da Universidade de Coimbra, Coimbra, 2018, pp. 47 e s.) provided for the development and implementation of health observation instruments, namely for epidemiological monitoring and surveillance, as well as the development of a public health system that would make it possible to identify, assess, manage and communicate risk situations in relation to communicable diseases and other threats to public health, and the systematic preparation and updating of contingency plans in the face of emergency or public calamity situations, determining the temporary measures necessary to protect public health. Unfortunately, none of these aspects would end up being set out in Base 10 of the new LBS ...

medicine (for example, when testing patients), there are also problems regarding the scope of protection for fundamental rights (and, concommitantly, determining how those rights may lawfully be restricted). For example, the right to privacy data confidentiality (and the very different questions that arise either from the possible mandatory use of location tracking mechanisms and contact tracking through mobile digital applications, registration of vaccinated persons and having their data publicized namely through the issuance of "COVID-19 immunity passports" or "health certificates", or the control of body temperature) can be addressed in a transparent and accessible manner when writing new laws for pandemic preparedness. So too, rights to physical integrity (underlying issues related to mandatory vaccination), or economic freedom, and managing traffic within communication networks, all can be discussed in an open manner with input form stakeholders. Lastly, this approach can embrace material dimensions related to the principle of proportionality, or the formal dimensions related to the principle of the determinability of norms or the heightened normative density that characterises all the provisions that are related to rights, freedoms and guarantees.

Considering that the pandemic brings both health and economic consequences that constitute a normatively relevant social challenge, these aspects of the pandemic require reflection in order to determine which significant changes in the development of public law are acceptable without undermining cornerstone structural principles of the rule of law, democracy and sociality.

Country/Legal System	Constitutional State(s) of Exception	Preconditions and Effects		(Special) Administrative States of Exception	Preconditions and Effects	
Angola	State of War | State of Siege | State of Emergency (article 58 of the Constitution of Angola)	Effective or imminent aggression by foreign forces, serious threat or disturbance of the democratic constitutional order or public calamity	Suspension and limitation of rights (but impossibility to affect the right to life, personal integrity and personal identity, civil capacity and citizenship; non-retroactivity of criminal law; the right to defence by defendants; and freedom of conscience and of religion)	Declaration of public calamity (Law No. 28/03, of November 7th, Civil Protection Law and National Health Regulations, approved by Law No. 5/87, February 23rd)	Occurrence or danger of serious accident, catastrophe or public calamity	Restriction of rights (measures necessary to prevent the spread of the consequences of a major accident, catastrophe or public calamity, in order to restore normality, and measures that are essential for safeguarding the health and safety of the population, including the right to property, the right to assembly, freedom of worship, freedom of artistic expression, of movement, freedom of private economic initiative)
Brazil	State of Defense (article 136 of the Federal Constitution)	Preservation or prompt restoration, in restricted and determined places, of public order or social peace threatened by serious and imminent institutional instability or affected by major calamities	Restriction of rights | duration not exceeding 30 days, without prejudice to the possibility of one extension, for an equal period of time	Public Health Emergency Declaration of National Importance (Federal Decree No. 7616, of November 17, 2011) Public health emergency of international importance resulting from the coronavirus responsible for the 2019 outbreak (Federal Law No. 13.979, of February 6th, 2020) State level public health emergency	Situations that demand the urgent use of measures for the prevention, control and containment of risks, damages and aggravations to public health (including epidemiological situations, disasters or lack of assistance to the population)	Restriction of rights (including freedom of private economic initiative) | Temporal effects of the public health emergency declaration of national importance
	State of Siege (article 137 of the Federal Constitution)	Serious commotion of national repercussion or occurrence of facts that prove the ineffectiveness of a measure taken during the state of defence or declaration of a state of war or response to foreign armed aggression	Suspension of rights | duration not exceeding 30 days, without prejudice to successive extensions for equal periods (or, in the second case, for the duration of war or armed aggression)		Coping with a public health emergency of international importance caused by the coronavirus responsible for the 2019 outbreak	Restriction of rights (including freedom, right of movement, property)
Mozambique	State of Siege | State of Emergency (articles 282-284 of the Constitution of Mozambique)	Effective or imminent aggression, serious threat or disturbance of the constitutional order or public calamity (the state of emergency is declared when the preconditions are verified with less severity)	Suspension and limitation of rights | duration not exceeding 30 days, extendable for equal periods of time, up to three times, if the reasons that determined its declaration persist	State of calamity (Legal Regime for Disaster Risk Management and Reduction, approved by Law No. 10/2020, of August 24th)	Occurrence or danger of occurrence of a serious accident, catastrophe, public calamity or an abnormal event caused by a major catastrophe, which causes damages and losses that result in the substantial compromise of the responsiveness of public powers	Restriction of rights (including property rights, freedom of education, right of assembly, freedom of worship, freedom of artistic expression, freedom of movement, freedom of private economic initiative)
Macao, S.A.R.	N/A	N/A	N/A	(Law No. 2/2004, Law for the prevention, control and treatment of communicable diseases)	Epidemiological surveillance and control of communicable diseases	Restriction of rights (including freedom, the right of movemet, freedom to practice a profession, freedom of private economic initiative)

Court	Date of Entry	Date of Decision	Process/Decision Number	Type of Court Proceeding	Party who Filed Legal Action	Measures Questioned/ Affected Rights	Need to Adjudicate on the Case	Decision	Mention of Comparative Law	Statements of Vote
Constitutional Court	29/05/2020	31/07/2020	Judgement no. 424/2020 (Proc. 403/2020)	Concrete Review of Constitutionality (appeal to the TC)	Appel from the Public Prosecutor's Office	Articles 9 to 12 of DLR no. 26/2019/A, of November 22nd, paragraphs 3/e), and 11 of the Resolution of the Government Council no. 123/2020, paragraphs no. 1 to 4, and 7, of Government Council Resolution No. 77/2020 (mandatory confinement, for 14 days, of passengers landing in the Autonomous Region of the Azores; deprivation of liberty)	Yes (but not for articles 9 to 12 of DLR No. 26/2019/A, of November 22nd, whose application was not refused by the *a quo* court)	Unconstitutionality, for breach of article 165/1/b), by reference to article 27, both of the CRP [matters that must exclusively be regulated by the Assembly of the Republic]	No	No
Constitutional Court	22/09/2020	26/11/2020	Judgement no. 687/2020 (Proc. 726/20)	Concrete Review of Constitutionality (appeal to the TC)	Appel from the Public Prosecutor's Office	No. 6 of the Government Council Resolution No. 207/2020 (judicial validation of the mandatory quarantine decree or prophylactic isolation decree by the regional health authority, regarding passengers disembarking at airports in the Autonomous Region of the Azores; deprivation of liberty)	Yes	Unconstitutionality, for breach of article 165/1/b), by reference to article 27/p), both of the CRP [matters that must exclusively be regulated by the Assembly of the Republic]	No	No
Constitutional Court	23/11/2020	No Decision Yet	N/A	Declaration of unconstitutionality with general mandatory force	Ombudswoman's Office	Article 168-A, no. 5, of Law no. 2/2020, of March 31st, which approved the State Budget for 2020, as amended by Law no. 27-A/2020, of July 24th, which approved the Supplementary State Budget (exemption from rent in shopping centers stores; property rights and freedom of private economic initiative)	N/A	N/A	N/A	N/A
Supreme Administrative Court	12/08/2020	10/09/2020	Proc. 088/20.8BALSB	Subpoena for the protection of rights, freedoms and guarantees	Citizen	Resolution of the Council of Ministers no. 55-A/2020, paragraphs 1, 2 and 8, and article 14 of the Alert and Contingency Situation Regime, approved as an annex to the aforementioned Resolution (amended by Resolutions no. 63-A/2020 and 68-A/2020) (right of assembly)	Yes	Rejection of the request (sufficiency of the enabling legislative base and observance of the requirements of the principles of proportionality and equality)	Yes	No
Supreme Administrative Court	29/10/2020	31/10/2020	Proc. 01958/20.9BELSB	Subpoena for the protection of rights, freedoms and guarantees	Political Party	Resolution of the Council of Ministers no. 89-A/2020 (right to travel, freedom of worship, right to family, right to moral and physical integrity)	No: procedural active illegitimacy			Yes (same as the decision, but with different grounds)
Supreme Administrative Court	29/10/2020	31/10/2020	Proc. 0122/20.1BALSB	Subpoena for the protection of rights, freedoms and guarantees	Citizen	Resolution of the Council of Ministers no. 89-A/2020 (right to travel, freedom of worship)	Yes	Rejection of the Request (existence of legal basis, compliance with the requirements of the principles of proportionality and equality)	No	Yes (dissenting vote regarding the decision)
Supreme Administrative Court	17/11/2020	20-11-2020 (preliminary order)	Proc. 2090/20.0BELSB	Subpoena for the protection of rights, freedoms and guarantees	Political Party	Resolution of the Council of Ministers no. 92-A/2020, amended by Resolution of the Council of Ministers no. 96-B/2020 (private economic initiative, right to work)	No: procedural active illegitimacy	Preliminary Rejection	N/A	N/A
Supreme Administrative Court		23-12-2020 (preliminary order)	Proc. 143/20.4BALSB	Subpoena for the protection of rights, freedoms and guarantees	Citizen Action (*Ação Popular*)	N/A	No: unintelligible request	Preliminary Rejection	N/A	N/A
Supreme Administrative Court	24/01/2021	05/02/2021	Proc. 012/21.0BALSB	Subpoena for the protection of rights, freedoms and guarantees	Citizen	Decree no. 3-C/2021, of January 22nd (suspension of teaching and non-teaching activities and social support and suspension of in-person teaching and non-teaching activities in higher education institutions; freedom to learn and teach)	No: the proceedings regarding the dispute were considered useless (for revocation of the rules and consequent cessation of the alleged offense of rights)	Dismissal of the proceedings	N/A	N/A
Supreme Administrative Court	20/11/2020	18/02/2021	Proc. 136/20.1BALSB	Protective Order: provisional arbitration of payment of amount on account of legally due installment or indemnity to be arbitrated in the main action	Private Legal Person	N / A (Protective Order initiated as a preliminary to the main proceedings in which it requests the recognition of the unconstitutionality of rules combined with an indemnity claim based on material unconstitutionality of the rules, for violation of article 61/1 of the CRP)	Yes	Rejection of the Protective Order: the damage suffered does not have the character of an abnormality presupposed by article 16 of the RRCEE, so the *fumus boni turis* precondition is not verified	No	No

Type I	Type II	Legal Basis	Preconditions	Duration	How Fundamental Rights are Affected	Utilized during the Pandemic?
Constitutional States of Exception	State of Siege	CRP (article 19)	Actual or Imminent Agression by foreign forces, serious threat or disturbance to the democratic constitutional order or public calamity	Up to 15 days, which may be extended	Suspension of rights (but impossibility of suspending the rights to life, physical integrity, personal identity, civil capacity and citizenship, non-retroactivity of criminal law, the right to defence by defendants and freedom of conscience and religion)	No
	State of Emergency		*Idem* , but when the above mentioned preconditions are of less severity			Yes
(Special) Administrative States of Exception	Situation of Calamity*	Framework Law on Civil Protection (articles 8 and ff, 19 and ff.)	Mitigating collective risks and limiting their effects in the event of a major accident or catastrophe	Unspecified	**Restriction** of Rights (namely private property, private economic iniciative, right of movement, right of assembly)	Yes
	(The adoption of the measures provided for in these diplomas does not depend on a specific declaration of the state of exception, and they can be issued under the legislative qualifications they offer, provided the respective preconditions are verified).	Framework Law on Health (Base 34)	Protecting Public Health	Unspecified	**Restriction** of Rights (namely freedom e and private economic initiative)	
		Public Health Surveillance System (article 17)	Public Health Emergency (which can potentially be articulated with declaring the situation of calamity, cf. article 18)	Unspecified	**Restriction** of Rights (namely freedom, right of movement and assembly and private economic initiative)	

* The LBPC sets out two other levels (situation of alert and contingency), but only the situation of calamity is set out as a type of state of "need" (article 23/2).

5. PUNITIVE LAWS DURING PANDEMICS

Inês Fernandes Godinho

Introduction

Punitive law is one of the instruments used by governments during pandemics as both a deterrent and a tool to repress behaviours that may jeopardize the public health. These new laws may be justified during the emergency, even if the same measures would be illegal or ultra vires if the government imposed the same measures at another time. This topic is presented following the path that illuminates the law previously written and currently in force, in addition to rules created in response to the pandemic in order to thereby identify and outline some trends in the use of punitive Law. We will primarily focus on Criminal Law, but also mention the Law applicable to Administrative Offences.

1. Criminal Law

1.1. In force

- For Public Health protection

In terms of existing Criminal legislation, articles 282 (Corruption of food or medicinal substances) and 283 (Propagation of disease and tampering of tests or prescriptions) of the Portuguese Criminal Code (hereinafter, CP, *Código Penal*, in Portuguese) can be mentioned. There may be doctrinal debate whether the legal interests protected by these

criminal provisions are directly associated with public health (concept necessarily interpreted in the context of the pandemic[1]), being commonly understood that these laws aim to protect life and physical integrity[2]. Nonetheless these criminal provisions have acquired front and center importance during in the pandemic emergency context[3], and are inserted in the CP under the Title of *crimes against life in society*, in the Chapter which refers to crimes of common danger.

According to art. 282 of the CP:

> **1.** Whoever
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> a) takes part in the use, production, confection, manufacture, packaging, transport, treatment, or otherwise engages in another activity that involves substances intended for the consumption (swallowed, chewed or drunk) by others for medical or surgical purposes, or engages in corrupting, falsifying, altering, reducing their nutritional or therapeutic value or adding ingredients to those substances; or
>
> b) imports, conceals, sells, exhibits for sale, stocks for sale or, in any way, delivers for anothers' consumption, the substances subjected to any activity referred to in the previous subparagraph or that are used after the expiration date or are damaged, corrupted or altered by the course of time or other agents and to whose action they are exposed;
>
> and thus creates danger to the life or physical integrity of another shall be punished by a term of imprisonment from one to eight years.
>
> **2.** If the danger referred to in the previous paragraph is created by negligence, the agent shall be punished by a term of imprisonment up to five years.
>
> **3.** If the conduct referred to in paragraph 1 is perpetrated with negligence, the agent is punishable shall be punished by a term of imprisonment of up to three years or a fine.

Article 282 of the CP sets forth penalties for corrupting medicinal or surgical substances, (so-called "Medicrime" of trafficking counterfeit

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[1] In Decree-Law no. 28/84, of January 20th, on anti-economic and public health violations, the only crime clearly oriented towards the protection of public health is clandestine slaughter (art. 22 of Decree-Law no. 28/84), which is clearly not adequate to the pandemic problem that serves as guidance for this work.

[2] Cfr. J. M. Damião da Cunha, Anotação ao Art. 282º, in: Jorge de Figueiredo Dias (Dir.), *Comentário Conimbricense do Código Penal*, Tomo II, Coimbra: Coimbra Editora, 1999, p. 998 e s., p. 999; J. M. Damião da Cunha, Anotação ao Art. 283º, in: Jorge de Figueiredo Dias (Dir.), *Comentário Conimbricense do Código Penal*, Tomo II, Coimbra: Coimbra Editora, 1999, p. 1006 e s., p. 1007-1008.

[3] These provisions are also included in other legal orders hereinafter analysed.

or deliberately altered medicines) and may be especially important in light of its text as a roadmap for safely and fairly distributing vaccines for COVID-19.

Additionally: The Council of Europe Convention on Preventing Counterfeit Medicine and similar offenses involving threats to public health ("Medicrime Convention"[4]), opened to signature in October 2011, was ratified by Portugal in 2018. The Convention entered into force in the Portuguese legal system on April 1st, 2019. Articles 5 to 9 of the Convention establish several obligations for ratifiying countries to criminalize the falsification and adulteration of medical products. Citing that a global problem of counterfeit or "fake" medicines and the reports of denatured malaria vaccines in Africa, the role of preventing counterfeit medicines clearly is a public health concern. It is noteworthy therefore first, the Convention has a broader range of application, when compared to article 282 of the CP: while the latter considers only medicinal substances for medical or surgical purposes - "substances that have diagnostic, prophylactic, therapeutic or anaesthetic virtues with scientific properties, in relation to human health"[5] - the Convention's script includes both medical devices and accessories of such devices, which cannot be included in art. 282 of the CP[6]. The "counterfeiting" of a drug, when unrelated to a specific danger, has no criminal consequences, and only constitutes an administrative offence, within the scope of the Statute of Medication (in Portuguese, *Estatuto do Medicamento*, Decree-Law nr. 176/2006, of August 30th), which, despite a recent change in 2019, has not been altered regarding this subject. As the Handbook for Parliamentarians for Ratification of the Convention points out, counterfeit medicine is a global threat to public health requiring a global response[7].

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[4] Ilise Feitshans, "Handbook for the Ratification of the Convention Preventing Counterfeit Medicines (Medicrime)" for the Council of Europe, presented at OECD Paris, France November 2015 published by the Secretariat of the Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly, the European Directorate for the Quality of Medicines and Health Care Council of Europe. 2015.

[5] J. M. Damião da Cunha, Anotação ao Art. 282º, p. 1000.

[6] Susana Aires de Sousa, A Convenção Medicrime do Conselho da Europa, *Cadernos da Lex Medicinae* n.º 4, Vol. II (2019), p. 465 e s., p. 469.

[7] Council of Europe Press Release launching the report about the convention, held in OECD headquarters Paris November 2015: "The Convention against Medi-

According to Article 283 of the CP,

1. Whoever:
   a) Spreads contagious diseases;
   b) As a doctor or his employee, nurse or laboratory employee, or person legally authorized to prepare an auxiliary examination or record of medical or surgical diagnosis or treatment, provides inaccurate data or results; or
   c) As a pharmacist or pharmacy employee, supplies medicinal substances that do not comply with the prescription;

   and thus creates danger to life or serious danger to the physical integrity of another person is punishable by imprisonment from one to eight years.

2. If the danger referred to in the preceding paragraph is created by negligence, the criminal agent shall be punished by a term of imprisonment of up to five years.

3. If the conduct referred to in paragraph 1 is perpetrated with negligence, the criminal agent shall be punished by a term of imprisonment of up to three years or a fine.

As for article 283 of the CP, it has deserved greater attention in view of the current pandemic situation[8].

Indeed, contagious disease referred to in subparagraph a), must involve "serious" danger, cannot be applicable the myriad of every contagious disease that is not particularly serious. Nevertheless, "the article covers all types of diseases (regardless of whether their mandatory declaration is necessary, whether they are of known or unknown origin) that can be considered to be contagious"[9]. In turn, the agent shall take steps to prevent propagation of the disease, whether this spread occurs through transmission (in which the agent is himself a carrier of the

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crime presents the rare opportunity for corporate pharmaceuticals, scientific researchers international law enforcement and human rights activists to work together to defend civil society against organized crime." stated Mme Claude Chirac of the Fondation Chirac, Paris, France. "Fake medicines not only hurt the unsuspecting patients who are victims of fake medicine and undermine public confidence in the integrity of healthcare delivery systems, but medicrimes also make profits that fuel efforts against governments and civil society by funding terrorism".

[8] Maria Fernanda Palma immediately defended, in April 2020, that public health should be a legal good worthy of protection under the crime of disease propagation. Cfr. Maria Fernanda Palma, Propagação de doença contagiosa, disponível em: https://cidpcc.wordpress.com/2020/04/10/propagacao-de-doenca-contagiosa-por-maria-fernanda-palma/.

[9] Quoted from Cunha (1999), p. 1008 (Translated).

disease), or by infection (in which the agent "contaminates" food/water or objects, etc). All human diseases and diseases common to humans and animals are under the scope of application of this article.

The Macau Special Administrative Region (Macao, S.A.R.), in its Criminal Code (hereinafter, CPM), also includes the criminalization of corrupted food or medicinal substances (art. 269 CPM), spreading disease, as well altering tests or prescriptions (art. 270 CPM); the latter two use identical wording as articles 282º and 283º of the CP (and inserted in the respective criminal codes following a similar order).

After the SARS health crisis of 2001-2003 however, Law no. 2/2004 (Law on prevention, control and treatment of infectious diseases) was approved in Macao[10]. This Law, aimed at guaranteeing public health and the effective prevention, control and treatment of infectious diseases (through the principles of priority prevention and appropriate treatment - art. 1/1), contains several measures that may be applicable in outbreaks, situations of rapidly increased numbers of infectious disease cases ("incidence") or in situations where there is a risk of outbreaks or risk of propagation of infectious disease (arts. 14, and 23 to 25). It establishes the crime of breach of preventive health measures as a tool to punish the violation of any imposed restrictive measures and for the violation of the filling in any required declarations (art. 10).

According to art. 30 of Law n. 2/2004:

> Infringement of preventive health measure
> The following penalties are applicable to (unless a more serious penalty is applicable under other legal provisions):
> 1) Whoever refuses to complete the declarations mentioned in subparagraph 1) of number 2 of article 10 or provides false data on those declarations to avoid the measures set out in this Law or otherwise refuse to undergo the medical examination referred to in subparagraph 3) of the same number, may be imprisoned for up to 6 months or punishable with a fine of up to 60 days;
> 2) Anyone who fails to comply with the measures mentioned in subparagraph 1) of number 1 of article 14, shall be punished by a term of imprisonment of up to 6 months or with a fine of up to 60 days;

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[10] For all see: Vera Lúcia Raposo, Macau, a Luta contra a COVID-19 no Olho do Furação, *Cadernos Ibero-Americanos de Direito Sanitário* 2020; 9(2): p. 12 e s.

3) Whoever fails to comply with the measures mentioned in subparagraphs 2) or 3) of number 1 of article 14 shall be punished by a term of imprisonment of up to a year or with a fine of up to 120 days; and
4) Whoever fails to comply with the measures mentioned in paragraphs 1), 2) or 5) to 9) of number 1 of article 25, shall be punished by a term of imprisonment of up to 2 years or with a fine of up to 240 days.

In the new Criminal Code of Angola[11] (hereinafter CPA) the crimes of adulteration of food and medicinal substances (art. 286)[12] and the criminalization of the propagation of contagious disease (art. 287) are treated in a significantly different manner: although both crimes are included in the Title of *crimes against collective security* (specifically, in the Chapter dedicated to *crimes of common danger*), the crime set out in art. 287º CPA addresses only the propagation of disease, that is, the article does not mention, within the same crime, the alteration of tests or prescriptions. Another important difference is that the CPA specifically includes the crime of transmission of serious illness (art. 206) in the Chapter of *placing people in danger*, under the Title of *crimes against people*.

According to art. 206 of CPA:

1. Whoever, with the intention of transmitting a serious illness from which he / she suffers performs an act which is susceptible of infecting another person shall be punished by a term of imprisonment of up to 3 years or a fine of up to 360 days.
2. If the disease is transmitted, the penalty of imprisonment applicable is from 6 to 10 years.

The situation in Brazil is even more specific. Indeed, within the Brazilian Criminal Code (hereinafter, CPB), we can find a Chapter related to *crimes against public health* within the scope of the Title of *crimes against public safety* (arts. 267 and ff). Yet, although the Code sets forth the crime of counterfeiting, corrupting, adulterating or altering a product intended for therapeutic or medicinal purposes (art. 273 CPB), this law is part of the specific Chapter related to *crimes against public health*, crimes directly related to epidemic situations, which are the crime of epidemic (art. 267º CPB), the crime of infraction of

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[11] Approved by Law no. 38/20, November 11th, 2020.
[12] In the Mozambican Penal Code, the equivalent crime only refers to food items.

preventive sanitary measure (art. 268º CPB) and the crime of omission of disease notification (art. 269º CPB).

> Epidemic
> Art. 267 - To cause an epidemic, through the spread of pathogenic germs:
> Penalty - imprisonment, from ten to fifteen years.
> § 1 - If death results from the crime, the penalty is applied in double
> § 2 - In the case of guilt, the penalty is imprisonment from one to two years, or, in the event that the death of the victim results from the crime, from two to four years.
>
> Infringement of preventive health measure
> Art. 268 - Infringing a decision from the public authorities, aimed at preventing the introduction or propagation of a contagious disease:
> Penalty - imprisonment, from one month to one year, and fine.
> The penalty is increased by one third, if the criminal is a public health worker or is a doctor, pharmacist, dentist or nurse.
>
> Omission of disease notification
> Art. 269 - The doctor who does not report to the public authority a disease whose notification is mandatory:
> Penalty – imprisonment, from six months to two years, and a fine.

The crime of infringement of a preventive sanitary measure, as it results from its typical wording ("infringing a decision from the public authority"), is a blank criminal rule, and requires further specifications[13].

- Other crimes

One of the crimes which also is problematic and widely manifest during pandemics is the crime of disobedience, set out in art. 348 of the CP and again in art. 7 of Law no. 44/86, of September 30th (State of Siege and State of Emergency Regime, hereinafter RESEE, in Portuguese: *Regime do estado de sítio e do estado de emergência*).

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[13] Which followed suit through Law 13.979/2020, regarding isolation and quarantine, and Decree (*Portaria*) no. 356/2020, by the Ministry of Health, as well as the Interministerial Decree (*Portaria Interministerial*) no. 5/2020, by the Ministries of Justice, Public Safety and Health.

At the beginning of the state of emergency in Portugal, Decree No. 2-A/2020, of March 20th [14], established a specific crime of disobedience applicable to cases of violation of the obligation of mandatory confinement (art. 3). Additionally punishable with this crime of disobedience (art. 348 CP) was a set of other situations, such as failure to close facilities and establishments or suspend retail commerce or service provision (art. 32/1/b) of the Decree). This model was maintained by Decree no. 2-B/2020, of 2 April (arts. 3 and 43/1/d)); and Decree no. 2-C / 2020, of 17 April (arts. 3 and 46/1/d)). Decree no. 2-D/2020, of April 20th set out the crime of simple disobedience, applicable to citizens for the violation of prohibition of circulation between May 1st and 3rd, 2020, a period in which Portugal had already decreed the state of calamity (art. 3). Subsequently, the new state of emergency declaration, in Portugal on November 6th 2020, the crime of specific disobedience (set out in the above mentioned Decrees no. 2-A, 2-B and 2-C) was substituted by the crime of disobedience (art.12/1/b) of Decree no. 8/2020, of 8 November), a measure that would be maintained in the following state of emergency decrees enacted by the President of the Republic (Decree no. 9/2020, November 21st [art. 50] and Decree no. 11/2020, of 6 December [art. 58]). Under this construct, the crime of disobedience is fundamentally linked to the violation of mandatory confinement, to the violation of the ban on driving on public roads and to the violation of the limitation of the activities of commercial establishments and services.

The crime of disobedience is also found in art. 312 CPM, art. 330 CPB, art. 340 CPA or in art. 353 of the Penal Code of Mozambique.

By contrast to a specific regime in the Macao Special Administrative Region, resorting to the crime of disobedience, following the options adopted in the Portuguese legal system is not necessary. In countries where there is nothing similar to Law No. 2/2004 in force in Macao. S.A.R, the use of this repressive approach - even when there are clearly articulated specific crimes for the protection of public health - has been the path followed as a way of sanctioning the violation of sanitary measures imposed in the control and fight against COVID-19.

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[14] Which regulated the first declaration of the state of emergency (decreed by the President of the Republic's Decree no. 14-A/2020, March 18th).

- Crimes applicable to vaccination fraud (violation of the vaccination plan)

Since the vaccination process is already underway, benefiting oneself or a third party may result in the perpetrator being charged for the crime of abuse of power or the crime of undue receipt of an advantage, if the perpetrator adopts fraudulent conduct, designed to anticipate the inoculation and violate the adopted Vaccination Plan.

1.2. Special

As stated above, most legal systems already had crimes related to public health or the crime of disobedience.

However, it is possible to point out the case of the specific crime of disobedience for the violation of mandatory confinement (initially introduced by art. 3 of Decree no. 2-A/2020, of March 20th), which has been removed and integrated in the crime of disobedience set out in art. 348 of the CP[15].

2. Other punitive legislation

2.1. Administrative infractions

The administrative offense regime for calamity, contingency and alert situations[16] is established by Decree-Law no. 28-B/2020, of 26 June[17], aimed at "the creation of a sanctioning regime that ensures scrupulous compliance by the population with the measures that are indispensable to contain the infection".

In structural terms, the law establishes a set of duties - from mandatory use of the mask, to the rules of maximum occupancy in venues and rules for physical distancing - in its art. 2, providing, later, in art. 3, the fines for non-compliance with the duties listed in art. 2.

Currently, violating most duties is sanctioned with a fine of 100 to 500 euros for natural persons and 1000 to 10000 euros for legal

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[15] And in the RESEE, regarding its scope of application.

[16] Declared by Law no. 27/2006, of July 3rd (Framework Law for Civil Protection).

[17] Which has been altered five times, the last of which by Decree-Law no. 8-A/2021, January 22nd.

persons, being the fine amount doubled during the state of emergency (art. 3-A). The amount of the fine is increased in the event of non-compliance with rules applicable to air traffic and airports.

3. Tendencies

There are two key trends regarding sanctions:

1. use of the crime of disobedience as the main criminal repressive tool for the cases of violation of sanitary measures, especially in countries that have resorted to exceptional regimes.

2. imposition of compliance with the sanitary measures has been achieved through the non-criminal path of applying administrative and civil sanctions. In Portugal, for example, recourse to the crime of disobedience continues to exist, but the prolonged health crisis led to approval of a specific administrative regime to ensure that the population observed the imposed measures (Decree-Law no. 28- B / 2020, of 26 June).

4. Application

In terms of relevance, the crime of disobedience has been, in criminal terms, the criminal law format that has been most widely applied from the outset as a a basis for arresting disobedient people. As an illustration, note that between the beginning of the pandemic, in March 2020, and January 2021, Portuguese Public Security Police made 438 arrests for disobedience, when carrying out the inspection of the restrictive measures imposed by the Government in the fight against COVID-19[18].

The crime of specific disobedience created at the beginning of the pandemic by Decree No. 2-A/2020, of 20 March – was quickly criticized[19] . It was declared unconstitutional (organic unconstitutionality) by the Court of Appeal of Guimarães, in a judgment from November

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[18] As it was reported by RTP: https://www.rtp.pt/noticias/pais/psp-fez-438-detencoes-em-portugal-desde-marco-por-violacao-de-regras-de-confinamento_n1290209.

[19] Alexandre Au-Yong Oliveira *et al.*, Jurisdição Penal e Processual Penal, in: CEJ (Org.), *Estado de Emergência – COVID-19 – Implicações na Justiça*, Lisboa, 2020, p. 429 e s., p. 432 e s.

9th, 2020[20]. The decision states that because creating crimes is a matter of relative reserve of competence of the Assembly of the Republic, under article 165/1/c), of the Constitution of the Portuguese Republic, the aforementioned Decree no. 2-A/2020, of March 20th, "when defining a new type of crime, invades the legislative competence that does not belong to it, which determines that no. 2 of art. 3 of the aforementioned Decree is damaged by organic unconstitutionality". Thus, a criminal rule - such as is the crime of disobedience in question in the Decree - must take the form of a law[21]. Furthermore, RESEE makes it clear, in its art. 19, no. 7, that the state of emergency cannot call into question the constitutional rules regarding the competence and functioning of the sovereign bodies. Thus, the Decree No. 2-A/2020, of March 20th, could not, as it did, have created a specific crime of disobedience. Reason, moreover, why the Government ceased to set out the specific disobedience crime in the subsequent Decrees.

This issue is illustrative of a more repressive initial trend, which has since then subsided, following the creation of the administrative regime of Decree-Law no. 28-B/2020, of June 26th.

5. Main conclusions

Concerning the criminal law currently in force, such as the Criminal Code, there exists a striking similarity between the different countries and the Macao, S.A.R. regarding the crimes of corruption of medicinal substances and the spread of disease. In addition, these crimes are generally classified as crimes of common danger, not specifically threatening public health. CPB's situation is different, because it has a chapter dedicated to crimes against public health, that lists types of crime specifically geared to epidemic and pandemic situations. It should

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[20] Disponível em: http://www.dgsi.pt/jtrg.nsf/86c25a698e4e7cb7802579ec004d3832/4bf68cafb74dfa02802-58639005815e9?OpenDocument.

[21] Restriction applicable to both Laws enacted by the *Assembleia da República* (Parliament) or authorized Decree-Laws enacted by the Government (article 165º/1/c) of the Constitution of the Republic of Portugal). Cfr. José de Faria Costa, *Direito Penal*, Lisboa: Imprensa Nacional casa da Moeda, 2017, p. 138º e s.; Specifically regarding this Decree, see: Alexandra Vilela, COVID-19 e o Direito Penal, in: Inês Fernandes Godinho/Miguel Osório de Castro (Eds.), *COVID 19 e o Direito*, Lisboa: Edições Universitárias Lusófonas, 2020, p. 127 e s., p. 134.

also be noted the crime contained in art. 30 of Law no. 2/2004 in force in Macao specifically addresses these situations.

Another very interesting point, in terms of criminal law, is the use, by default, of the crime of disobedience, as a way of repressing disrespect to measures adopted to prevent and combat the pandemic. In fact, in countries not equipped with a law like Macao's Law No. 2/2004, states of exception – for example, states of emergency - have been used and the crime of disobedience is a commonly used tool to sanction the different violations of duties imposed on citizens, significantly increasing the relevance and impact of this form of criminalization in a pandemic context.

Despite its insertion in the CP having been originally contested[22], it is nevertheless clear that the repressive path initially accentuated in Portugal - with the creation of a specific crime of disobedience - raises the veil over the dangers of resorting to states of exception[23].

Using the Macao S.A.R. regime as a point of reference, the advantages over the use of other regulations and the necessity of adopting a better punitive framework for public health crises caused by epidemics or health pandemics should be emphasized, as heightened preparedness for pandemics is increasingly important in the future.

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[22] Cfr. Cristina Líbano Monteiro, Anotação ao Art. 348º, in: Jorge de Figueiredo Dias (Dir.), *Comentário Conimbricense do Código Penal*, Tomo III, Coimbra: Coimbra Editora, 2001, p. 349 e s., p. 350; Alexandra Vilela (2020), p. 133.

[23] Even though it is clear that in the context of the RESEE the principle of Separation of Powers may never be jeopardized.

6. PATIENT'S RIGHTS IN THE CONTEXT OF A PANDEMIC – ANALYSIS OF THE SITUATION IN PORTUGAL

André Dias Pereira, Ana Elisabete Ferreira and Carla Barbosa

Introduction

At the beginning of 2020, it was unimaginable that we would be faced with the challenges brought by the emergence and evolution of the Covid19 pandemic. Attempting to react to the most urgent needs first, government entities relied on legally established instruments that allow the government to adopt exceptional emergency measures that would otherwise be beyond limits of the law. The Constitution of the Portuguese Republic allows a state of emergency to be declared in cases of effective or imminent aggression by foreign forces; serious threats or disturbances to the democratic constitutional order; or situations of public calamity. Without question, Covid19 is a public calamity justifying emergency measures.

Decrees pertaining to the state of emergency are nonetheless limited because the emergency laws must not negatively impact the right to life, personal integrity, personal identity, civil capacity, and citizenship. Emergency new criminal law cannot be retroactive, and previous guarantees of defence for defendants and freedom of conscience and religion remain in place. At the same time, the Portuguese Constitution of 1976 proclaimed the right of citizens to health protection through "the creation of a universal and free National Health Service" (art. 64) and, in 1979, Law no. 56/79, of September 15th, creates the National

Health Service (in Portuguese, SNS, *Sistema Nacional de Saúde*) as a universal and general health system, free of charge.

Therefore, it is important to examine how lawful measures adopted in response to the pandemic impact the rights of patients, whose rights are in principle, part of a rubric that cannot be undermined during the pandemic emergency.

a) Statistics About the Portuguese Health Care System

It is empirically proven that Portugal has a high standard of healthcare. In 2018, the Portuguese health system ranked in 13th place, in the Euro Health Consumer Index (EHCI), rising seven positions in comparison to 2015 (and definitively improved from 25th place, its previous position in 2012). For the first time, Portugal ranked above the United Kingdom and Spain. Portugal performed particularly well in quality-price ratings. In the World Health Report, organized by the World Health Organization, published in 2020, with data from 2019, Portugal ranks 12th worldwide[1]. According to data from the Statistics Database *Pordata* Portugal spends about 9.5% of its GDP on health care in 2019. In 2019, according to the European Observatory of Health Systems and Policies, Portugal spent EUR 2029 per capita on health care, which corresponds to 9% of GDP and represents a third less than the EU average (EUR 2884) despite an increase in health expenditures compared to the period of economic crisis in 2017. Direct payments have grown to become the second largest source of revenue, reaching 27.5% of total health expenditures. Capacity building primary care, required the Government to adopt measures to increase the number of general practitioners for the National Health Service, thus increasing the number of users with access to general practitioners and family doctors. Municipalities were thereby granted a more relevant and interventional role in the management of primary health care[2]. According to 2019 data from the OECD Observatory, Portugal`s health profile demonstrates effectiveness in the treatment of chronic

[1] Full Report and Statistic Tables available at: https://www.who.int/data/gho/publications/world-health-statistics

[2] Report available at: https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_pt_english.pdf

pathologies by primary and outpatient care, with avoidable admission rates well below the European average, and has a high performance in the treatment of certain diseases, such as cancer, registering survival rates above the other member states. Unfortunately, the greatest weaknesses within the Portuguese system represent constant unmet needs in key areas in the last five years: the country must reduce socioeconomic and gender disparities in order to: ameliorate the health profile of its citizens; lessen the impact of risk factors such as obesity and behavioural factors (such as excessive alcohol and tobacco consumption); e reduce the time for waiting lists for scheduled appointments and surgery; and this in turn will offer better and more intense allocation of human resources.

Design of the health policy in the late 1980s reshaped health care in Portugal by introducing neoliberalism and applying it by opening up the health care infrastructure to the market economy. A revision of the Constitution, in 1989, eliminated total gratuitousness, admitting an SNS which "tends to be free". The *Lei de Bases da Saúde* (Framework Law on Healthcare) was reformulated in 1990[3] providing greater openness to the private health market. Yet, the fundamental structure of the SNS, the system based on publicly provided health care remained in force, complemented by an increase in the access to consultations in private offices and out-of-pocket payments.

Since 2000, there has been a marked emergence of strong private health corporations that base their billing largely on private insurance (health plans) purchased by companies and families, in *ADSE* (public health plan limited to workers in public functions) and other health subsystems and services of the *SIGIC* system (an integrated management system for surgery candidates - *Sistema Integrado de Gestão de Inscritos para Cirurgia*, in Portuguese), designed to shorten waiting lists for surgery. Many of these companies are foreign. The combined system incorporates different payment models: (1). the National Health Service (SNS) financed through the annual State Budget; (2) social insurance, financed by professionally funded health funds; and (3) individually funded voluntary insurance and a model based on direct

[3] Version repealed by Law no. 95/2019, of 4 September which approves the Basic Law of Health and repeals Law no. 48/90, of 24 August, and Decree-Law no. 185/2002 , of August 20.

payments[4]. This hybrid character of the Portuguese health system reflects a strong presence of the public system (SNS), even though more than 20% of the population pays for private and social systems. The Portuguese health system is therefore characterized by three coexisting and overlapping systems: (1) universal SNS; (2) special health insurance schemes for certain professions or sectors (such as civil servants, banks and insurance companies' employees), known as health subsystems; and (3) private voluntary health insurance. The Portuguese health system therefore mixes public, private and social providers.

The universal nature of the SNS makes it especially important. A policy goal to improve efficiency and effectiveness of the SNS is the underpinning for a wide range of measures and reforms, implemented in recent years. The Ministry of Health, responsible for allocating resources to the SNS, ensures that the overall budget for the SNS is distributed among various institutions, based on past expenses. More recently, payment methods have been introduced to cover the general costs of some pathologies. Oncology has its own model of care, consisting of three highly specialized centers (*Institutos Portugueses de Oncologia Francisco Gentil*, known as IPO), located in the cities of Lisbon, Porto and Coimbra, which cover the whole territory, complemented by care provided in general hospitals.

Continuous Care and Palliative Care providers are also organized in specific networks, articulated between the Ministries of Health and Social Security, and with a very important impetus from the social sector of health, in particular from the IPSS's (private institutions for social solidarity, in Portuguese, *Instituições Particulares de Solidariedade Social*) and of the *Misericórdias* (Houses of Mercy).

b) *Health Democracy*: Patient Participation in Health Decisions

Unlike other European countries, Portuguese patients do not usually hold a seat on the board of directors or management of hospitals, usually comprised of health professionals and management professionals. Health democracy and the relaxation of the doctor-patient relationship

[4] On the Portuguese Healthcare System see Jorge Simões/António Correia de Campo, O Percurso da Saúde: Portugal na Europa, Almedina, 2011.

are thus impaired, a reality only diminished by the fact that patients form private associations that promote dialogue with health entities.

There is vast international evidence supporting the importance of democratic operability and representation in health management. Several international organizations and entities, including the European Patients 'Forum (EPF), the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD) advocate public participation in the field of health. Since 2002, reform laws in France have effectively operationalized a response to these challenges for stakeholders, by placing emphasis from the standpoint of d*émocratie sanitaire*, by giving high priority to the collective powers of patients. Indeed, article L1114-1 of the French Public Health Code has come to provide, *inter alia*, that associations, when regularly constituted, with an activity in the field of health quality and patient care, can be approved by the competent administrative authority at the regional or national levels to represent users, concerning decisions about the direction or administration of health units, or public health authorities. Patient representatives are entitled to training, in order to facilitate the exercise of this mandate. Note that this goes beyond a purely consultative role: in reality, this role involves actively participating (on an equal footing to managers directors and administrators) when defining the system. This approach ensures effective participation of patients in health management, by empowering them.

Associations and non -governmental informal groups of stakeholders that seek to represent and participate in health policy decisions are entitled to broad support across our legal system. The *Lei de Bases da Saúde (Law no. 95/2019)*, in accordance with the Constitution, expressly sets out the right of citizens to intervene in health decision-making and the participatory management of the SNS institutions. Yet, in Portugal, there has not been a specific and concrete concern within the legal system regarding this issue. Until recently, there was not a clear role for patients in the management and administration of health services, nor in the institutional framework for training health professionals. The Charter for Public Participation in Health (*Carta para a Participação Pública em Saúde*), approved by Law no. 108/2019, of September 9th, intended to change situation. Adopted with objectives of encouraging: participation by people, ill or not, and their representatives regarding decision making affecting the health of the

population; decision making in health based on broad public participation; consolidation of public participation at the policymaking level and within different organs and entities of the State, the law mandates deepening the existing participation processes and the creation of new spaces and participatory mechanisms[5] in Portugal.

It remains to be verified and established whether existing mechanisms for enhancing participation by patients and their representatives are aligned with the international norms for health democracy, and to identify their impacts on health policies. According to the Charter, public participation of people with or without disease and their representatives covers, *inter alia*, the following areas: National Health plan and health programs; SNS management (including human, material and financial resources, and the organization of health care provision, through the grouping of health centres and hospitals); state budget for health; health technology assessment; health quality assessment; standards and guidelines; health ethics and research; rights of people with or without disease and their representatives.

When balancing the structural features of health democracy (which provide support to individual decision-making and empower patients, by ensuring veritable respect for the right to information and for the right of access and control of individual patient health information), once the collective dimension is reinforced, then there must be a

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[5] The Charter for Public Participation in Health contributes to: promoting and defending the rights of people with or without disease, especially with regard to the protection of health, information and participation; inform public authorities about the priorities, needs and concerns of people with or without disease and their representatives; make health policies more effective and, consequently, achieve better health outcomes; promote the transparency of decisions and accountability by those who decide; bring the State and civil society closer together, deepening the dialogue and regular interaction between the two; legitimize decisions about cost-effectiveness assessment and ethical dilemmas posed by technological innovations.

Public participation in health must be based on the following principles: recognition of public participation as a right of people with or without disease and their representatives; recognition of people with or without disease and their representatives as partners in decision-making processes; recognition of the importance of the specific knowledge and experience of the person with or without illness; autonomy and independence of people with or without disease and their representatives in the proceedings; transparency and public disclosure of participatory processes; creation of the necessary conditions for participation; complementarity and integration between institutions and mechanisms of representative democracy and participatory democracy.

structural counterweight in order to preserve effective patients' rights. This can be achieved by creating and legitimizing patient associations and NGOs, in the hope of strengthening civil society.

c) Global Pandemic: Gamechanger for systemic solutions and omissions

Two key dimensions of the Portuguese health system were severely impoverished by the pandemic. - 1) the quality of health care delivery and 2) promotion of patient participation in health policies and decisions.

The SNS has significantly increased its capacity to provide health care, increasing and continuing to increase, by the hundreds, the number of beds, health professionals, supplementary means of diagnosis, therapy and medical devices, in an unparalleled growth. The response offered by the SNS proved to be quite robust - in speed, adequacy, quality and quantity. We believe that the public response was robust compared to any possible private response in the same context, given the demands for rapid decision making and coordination that were necessary during pandemic peaks. Yet, weaknesses in the system were accentuated due to the lack of available resources (human or equipment resources,) which become scarce while demand continued to rise.

Testing

Regarding testing, the Ministry of Health organized and monitored the implementation of a system of tests, free of charge for each user, within the framework of indications of the General Directorate of Health (*Direção Geral da Saúde*, DGS). Tests were available for anyone who developed a clinical presentation suggesting the diagnosis of an acute respiratory infection with at least one of the following symptoms: persistent coughing, worsening of the usual coughing symptoms or coughing associated with headache or myalgia; or fever (temperature ≥ 38.0ºC without another attributable cause), or breathing difficulty/dyspnoea, without another attributable cause total; or partial loss of smell (anosmia), weakened taste (ageusia) and sudden onset or decreased taste (dysgeusia). All these categories of symptoms were considered suspected cases of infection by COVID-19, and were indicated for testing (free), in reference centres.

A majority of this monitoring is carried out by *Linha Saúde 24* (a telephone hotline, known as SNS24), through which all citizens can obtain information on the proper way to handle their situation. The laboratory test for SARS-CoV-2 may be ordered by the family health unit (USF) team doctor / personalized health care unit (UCSP) for patients with indication for clinical surveillance and isolation at home (process which guarantees that the test is performed free of charge). It may also be requested remotely through the *Exames Sem Papel* online platform, by the doctor of the ADR-C teams (areas dedicated to respiratory patients in primary health care) or ADR-SU (areas dedicated to respiratory patients in hospital units) or by any doctor who, during the clinical evaluation, suspects a COVID-19 infection. SNS24 health professionals who perform clinical screening, may, **exceptionally** and **automatically**, also generate a test request, by applying an algorithm approved by the DGS.

The reference test for the diagnosis of COVID-19 is the Molecular Nucleic Acid Amplification Test (TAAN). During an outbreak however, rapid antigen tests are used to reduce the time needed for results in order to implement the necessary measures. The tests used in Portugal are those recommended by international health authorities, either by the European Centre for Disease Control (ECDC) or by the World Health Organization (WHO).

Patients without symptoms of COVID-19 do not, in principle, have an express indication to take the free test, according to the protocol issued by the DGS. They may be tested by their own initiative or within the institutions where they usually provide their professional activity, if those promote screening. Within the private health sector, there is a wide offering of testing, with different available procedures and prices[6].

Treatment

Within the SNS, the treatment for COVID-19 is free. Hospitalization, supplementary diagnosis testing and therapy in hospitals are universal and free. When there is no need for hospitalization, medication acquired at a community pharmacy respect the general and special regimes of participation by the State in the price of medicines.

[6] Please note only that these guidelines are subject to recurring updates.

Considering the scarcity of SNS resources, the treatment of some patients which, in a normal situation, would be monitored within the scope of the SNS was contracted with private hospital units.

Vaccination

Regarding vaccination, there is legal decision to vaccinate the entire Portuguese population completely free of charge, as long as they are eligible according to the clinical indications approved for each vaccine in the European Union. Priority groups were defined, in order to reach more vulnerable populations who are prone to COVID-19 infection. According to the established vaccination plan, which may change due to the evolution of scientific knowledge and the indications and contraindications that may be approved by the European Medicines Agency, the vaccination strategy will be as follows:[7]

Phase 1, from December 2020:

- Health professionals involved in providing care to patients
- Professionals in the armed forces, security forces and critical services
- Professionals and residents in Elderly Residential Homes (ERPI, *Estruturas Residenciais para Pessoas Idosas*) and similar institutions
- Professionals and users of the National Integrated Continuing Care Network (RNCCI, *Rede Nacional de Cuidados Continuados*)

From February 2021:

- Individuals over 80.[8]
- Aged 50 or above, diagnosed with one of the following pathologies:
  - Cardiac Insufficiency;
  - Coronary Disease;

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[7] See: https://covid19.min-saude.pt/vacinacao/. However, new groups of people were added as priorities and, therefore, were included in Phase 1 of the vaccination..

[8] On this matter, the active participation of citizens (including Professor André Dias Pereira) defending the widening the established priorities to include individuals over 80 years old was decisive: *Carta Aberta sobre os critérios para vacinação prioritária no Plano de Vacinação contra a covid-1, in Público, 26 de janeiro de 2021:* https://www.publico.pt/2021/01/26/sociedade/opiniao/carta-aberta-criterios-vacinacao-prioritaria-plano-vacinacao-covid19-1947843

  - Renal insufficiency;
  - Chronic respiratory disease with ventilator support and/or long-term oxygen therapy.

Phase 2, from April 2021:

- People 65 years and older (who have not been previously vaccinated)
- People between 50 and 64 years of age, with at least one of the following pathologies:
  - Diabetes;
  - Active malignant neoplasm;
  - Chronic kidney disease;
  - Liver failure;
  - Arterial hypertension;
  - Obesity;
  - Other pathologies with less prevalence that may be later defined, depending on scientific knowledge.

Phase 3, date to be determined, following conclusion of Phase 2:

- All other eligible population, within which priorities may equally be determined.

d) Articulation between the Health System and the Social Security System

The pandemic crisis has serious socio-economic consequences, decreasing household productivity and income, and increasing unemployment and daily expenses. Portugal created a set of «ad hoc» support to minimize these effects.

For employers:

Through Social Security, the following employment support measures were created for employers:

- Simplified Layoff (Extraordinary Measure to Support the Maintenance of Employment Contracts)
- Support to Progressively Resume Activity (Extraordinary Support to Progressively Resume Activity)

In the first quarter of 2021, employers benefit from the suspension of foreclosures for social security debts and the suspension of ongoing benefit plans. They also benefit from the deferral of contributory obligations for the months of November and December 2020.

Salaried Employees

Through Social Security, employees, (including members of statutory bodies and domestic service workers, maintain access to extraordinary social protection measures:

- Disease Allowance for Prophylactic Isolation
- Covid-19 sickness benefit
- Covid-19 sickness allowance for Health Sector workers
- Assistance to child or grandchild by Prophylactic Isolation

The measure for Child or Grandchild Assistance for Prophylactic Isolation is applicable to workers who cannot perform their activity, when they are assisting children or other dependents, under 12 years of age, or disabled and chronic illness sufferers regardless of age, in situation of prophylactic isolation (certified by the Health Delegate) or when they are infected by COVID-19. Citizens are entitled to childcare allowance, in an amount corresponding to 100% of the net reference remuneration, with a minimum limit of 65% of the gross remuneration. This value has been in effect since April 1, 2020.

For people seeking assistance for a grandchild, the amount of the subsidy corresponds to 65% of the reference remuneration. The net reference remuneration value is obtained by deducting the contributory rate applicable to the beneficiary and the personal income tax (IRS) retention rate from the gross amount of the reference remuneration.

Large-scale communication work was also carried out to inform workers about their social rights.

Self-employed Workers

Self-employed workers, including individual entrepreneurs (who were subject to suspended activities or closure of facilities and establishments during the emergency by legislative or administrative determination), were supported by several measures:

- Extraordinary support to reduce the economic activity of self-employed workers

- Extraordinary Measure of Incentive to Professional Activity
- Support for Social Disprotection

Social and Health Institutions

Through the IEFP - Institute of Employment and Professional Training, *Instituto do Emprego e da Formação Profissional* - the Support Program for the Emergency Reinforcement of Social and Health Equipment (*Programa de Apoio ao Reforço de Emergência de Equipamentos Sociais e de Saúde*) was created, with the Emergency Reinforcement of Social and Health Equipment (MAREES - *Reforço de Emergência de Equipamentos Sociais e de Saúde*), a temporary and exceptional measure, which consists of supporting the performance of socially necessary work, to ensure the responsiveness of public institutions and the solidarity sector with activity in the social and health area, during the COVID-19 disease pandemic.

This measure aimed to contribute to ensuring the responsiveness of public institutions and the solidarity sector with activity in the social and health area, namely health services, hospitals, homes or residential homes for the elderly and people with disabilities; promote the employment, by preserving and improving the socio-professional skills of the unemployed (through maintaining contact with the labour market and striving to improve the earnings of the unemployed or of workers with a suspended employment contract, working reduced hours or employed part-time).

The measure is aimed at unemployed people with or without unemployment benefits), workers with a suspended work contract, workers who had reduced hours, or were employed part-time. It also covers students, in higher education, and trainees, aged no less than 18 years.

e) Impacts on Patients' Rights

During the pandemic, the Government, through the Ministry of Health, issued Guidelines to suspend scheduled and non-priority activity. The last of these decrees, Order no. 574-A/2021, currently in force, determines that hospital establishments of SNS must up their Contingency Plans to the maximum level and suspend the programmed non-urgent assistance activity that can revert in reinforcing care for

critically ill patients. This measure is justified by the emergence and spread of the SARS-CoV-2 virus in Portugal, which determined the need to ensure the prevention, containment, mitigation and treatment of COVID-19, through the adoption of a set of exceptional and temporary response measures to the pandemic.

In January 2021, the date of publication of the referred decree, Portugal registered a rate of over 900 cases per 100 000 inhabitants and an average number of secondary cases resulting from an infected case, measured as a function of time, R (t), greater than 1 (the rate refers to the accumulated infections of the previous 14 days).

These factors put the health system and the SNS in particular, under extreme pressure, especially considering hospitalization rates (hospitalization in infirmary and hospitalization in intensive care, both with occupancy rates, in January, which are situated between 85% and 96%). In January 2021, the number of hospitalizations for COVID-19 in SNS institutions peaked. Imposing a strict lockdown in February and March may control the pandemic and thereby safeguard public health.

Health resources allocation guidelines were published, considering the current epidemiological circumstances, high occupancy rates for infirmary and intensive care beds and the need to guarantee a response to a demand that was exponential (in January and February 2021), by ensuring the mobilization of all health professionals and providing a response aligned with the demand for resources.

According to these guidelines, hospital establishments of the SNS must ensure prompt response to COVID-19 and guarantee the best possible balance of the various care responses, especially at the level of Intensive Care. To achieve this prioritization, health establishments:

a) *upped their Contingency Plans to the maximum level and proceeded to their review and expansion, in order to maximize the response of the hospital capacity to the local, regional and national epidemiological situation, in articulation with the National Response Monitoring Committee in Intensive Care Medicine* (CARNMI, Comissão de Acompanhamento da Resposta Nacional em Medicina Intensiva) *and the respective Regional Health Administrations;*
b) *suspended the programmed non-urgent assistance activity that can be rerouted to reinforcing care to the critically ill patients, provided*

that such suspension, due to its nature or clinical priority, does not signify risk placing the patients' lives at risk, severely limiting their prognosis and/or limiting access to periodic or monitoring treatments (namely in the context of monitoring pregnancy), or worsening chronic or other diseases;

c) *proceeded with the deferral of (normal or priority) scheduled surgical activity;*
d) *promoted the allocation of human resources for Intensive Care Medicine, in order to maximize the response capacity in this area, in accordance with the suspension and deferral of care activity carried out (subject to proposal by CARNMI and always in articulation with the clinical management of each unit).*

Considering all of the above, regarding the terms of resource allocation, the Portuguese Government has given total priority to combating the pandemic, relegating to the background all other pathologies that need hospital follow-up. This fact has resulted in a high increase in mortality rates in Portugal (with cause of death established as pathologies other than infection by the SARS-CoV-2 virus).

In the accounting made by the National Statistics Institute (INE, *Instituto Nacional de Estatística*), between March 2nd and December 27th, 2020, 99356 deaths were recorded in Portugal, which represents an additional 12852 (compared to the average of the last five years) . Of these, only 52% - (6677) - were caused by covid-19.

Monitoring of the remaining pathologies remains ongoing. The Portuguese Ministry of Health clarified that the Dispatch sent to hospitals does not order urgent or very priority surgery to be suspended and does not apply to hospitals such as the Portuguese Institute of Oncology (dedicated, exclusively, to the treatment of cancer patients). The Ministry of Health ensures that "the deferral of surgical activity will always be done through clinical evaluation and with the guarantee that there is no limitation of the patients' prognosis". The Ministry adds that the priority oncologic surgeries must occur up to 45 days after the indication for surgery, stressing that the order is in force until January 31st. According to this entity, "the dispatch does not apply to hospitals such as the IPO that, according to the healthcare network, are available to receive patients who require priority surgery during the period of application of the order". In addition, this pandemic had a special impact on some consolidated rights of patients, namely, on the maximum

guaranteed response times, on free access and circulation in the SNS and on visiting rights.

Maximum Guaranteed Response Times

The Charter of Access Rights to Health Care (*Carta dos Direitos de Acesso aos Cuidados de Saúde*), applicable to patients of the SNS, determines that the user of the SNS is entitled not only to the provision of care in a time considered clinically acceptable for his health condition, but also the fulfilment of the maximum guaranteed response times (TMRG, in Portuguese, which are defined annually by ordinance of the Ministry of Health) for all types of care provided without urgency as well as the right to complain to the Health Regulatory Entity if the TMRGs are not met.

In Portugal, maximum guaranteed response times are defined by law. Law no. 15/2014, of March 21st, consolidated the legislation on the rights and duties of the user of health services, and was complemented by Ordinance no. 153/2017, of May 4th, which defines the maximum guaranteed response times in the SNS, depending on the clinical priority. However, according to information released by the Government, during the first wave of the pandemic, in May 2020, there was a very significant drop in the activity of the SNS due to the COVID-19 pandemic, which resulted in a decrease of primary health care responses, with a 3.9% drop in overall appointments (which corresponds to 300,000 consultations) and a decrease of 5.7% in hospital appointments (minus 180,000 consultations).

Concerning SNS scheduled surgeries, in the same period, there was a decrease of 5.3% (minus 9,000) and a general drop in emergency services amounted to a 11.5% reduction. Additionally, supplementary diagnosis tests had a decrease of 25% in some specialties (such as gastroenterology). Oncological surgery was reduced by 15% and the demand for emergency services dropped, on some of the registered days, by 50%. SPO - *Sociedade Portuguesa de Oncologia,* the Portuguese association for Oncology - estimates an 80% reduction in cancer diagnoses (data from: Jornal Expresso, 11-05-2020).

The situation rapidly deteriorated in January 2021. On the 13th of January, Order no. 574-A/2021, determined, as we have already mentioned, that SNS hospital establishments up their Contingency Plans to

the maximum level and suspend the programmed non-urgent activity. With this decision, and in accordance with the objective of maximizing the available capacity, it was necessary to suspend the programmed assistance activity (*as long as it does not place the patient in a life threatening situation or serious damage, given his clinical priority*).

At the end of December, more than 5000 patients were enrolled for cancer surgery. The Ministry of Health has been requested to and has since announced plans to reduce waiting lists, resorting to the private and social sectors, but it is too early to assess the practical reality and the eventual success of these plans[9].

What is unquestionable at this point, according to the permanent updates of the National School of Public Health, is that between February 2020 and February 2021, the mortality in Portugal (not including deaths attributable to a SARS-COV-2 infection) was the highest of the last ten years.

Free Access and Circulation Within the SNS

In Portugal, the system of Free Access and Circulation of Users within the SNS, approved by Order no. 5911-B/2016, of May 3rd, allows the patient, together with the family doctor responsible for referral, to opt for any of the SNS hospital units where there is availability for the specialty consultation the patient requires. Referencing is done according to the patient's interest, according to geographical proximity criteria and considering the average response times in the institutions.

The right to free access and circulation was compromised with as the maximum level of Contingency Plans was instated. Currently, the health care offer receives almost daily updates, due to the need to open new wards and hospitals, which seek to support an excessive health care need. At the same time, many health professionals with specific training were allocated to other medical specialties, namely, in support platforms for intensive care and pulmonology. This reality has drastically altered the reality of the basic referral networks.

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[9] https://www.publico.pt/2021/02/10/sociedade/noticia/ministerio-saude-prepara-plano-recuperar-cirurgia-oncologica-ficou-1950159

Right to accompany a Patient and Visitation Rights

In accordance with the Portuguese law on the rights and duties of the user of health services (Chapter III of Law no. 15/2014, of 21 March), the patient is entitled to be accompanied by a person of his/her choice, and this information must be provided upon admission by the service. Pregnant women admitted to a health facility are also awarded the right to be accompanied, during all stages of labour, by any person chosen by them.

This right is extended to hospitalized children, the disabled, people in a situation of dependency and people with an incurable disease in an advanced stage and in a final stage of life.

In cases where the clinical situation of the patient does not allow for him/her to freely choose a companion, the hospital must promote the right to be accompanied, and for this purpose may request the demonstration of family relationship between the patient and the companion.

Point 13 from The Charter for the Rights of Hospitalized Patients (DGS) states that the hospitalized patient has the right of visitation by his family and friends whenever he wishes (within the approved schedule), and provided that there is no contraindication. Institutions and professionals must facilitate and even encourage affective support that family members can provide to the patient. The most complicated family situations where there are conflicts between different family members and/or friends have to be discreetly and subtly considered by the professionals. Patients who do not have visits and feel isolated should have greater support from both health and volunteer staff who are properly prepared and trained. Inpatients who are unable to understand or make themselves understood are entitled to be accompanied by the person who usually cares for them and for whom there must be minimal conditions.

When the hospitalized person is not accompanied, the management of the health establishment must take care to provide any necessary personalized assistance, appropriate to the situation.

A patient is not allowed company to attend surgical interventions and other exams or treatments which, for their nature, may see their effectiveness and quality hindered by the presence of the companion, unless express authorization by the responsible clinician is given in these instances. In general, the right to be accompanied cannot compromise

the technical conditions and requirements that medical care must comply with.

Health institutions, both public and private, define their visit regulations according to the dynamics of the services, providing that, as a rule, patients can always receive visits, fulfilling the requirements generically defined in those regulations.

In specific situations, such as end-of-life, the law itself clearly affirms the right to receive visitors as a transversal principle with reinforced value. This right to be accompanied and the right to receive visitors were both trimmed back dramatically during the pandemic. Some of these limitations were directly and objectively based on the needs for sanitary care provision and were carried out with strict respect for the recommendations of the General Directorate of Health. But limitations due to failures in the organization of services and the arbitrariness of the adopted measures, resulted in situations of profound loneliness and isolation, especially for vulnerable people.

Also concerning visitation rights, the pandemic imposed a set of extraordinary measures for residential homes for the elderly (ERPI), Integrated Continuous Care Units (UCCI) of the National Network of Integrated Continuous Care (RNCCI) and Social Assistance Establishments for the Support of Children, Youth, the Elderly or People with Disabilities. Initially, visits were unequivocally prohibited in such places, because health authorities believed that the measure was essential for containing spread of the infection. In May 2020, however, the DGS suspended this measure, setting forth the number and frequency of visits and stating the environmental conditions in which they should take place, thus providing a partial return to fundamental family and social interaction. During the very strong pandemic wave of January 2021, these limits on the right to visit returned. Although less stringent[10], the new restrictions were also tempered by a concurrent national vaccination campaign for users and employees in residential services.

[10] For example, visits to elderly residential homes and elderly daycare activities were authorized during the state of emergency declared in January 15th.

Conclusion

As stated at the outset: the state of emergency resulting from the pandemic, cannot legally create negative impacts on rights to life, personal integrity, personal identity, civil capacity and citizenship, the non-retroactivity of criminal law, the defence guarantees of the defendants and freedom of conscience and religion, although tempered by reasonable emergency restrictive measures. Considering all of the above, regarding the terms of resource allocation, the Portuguese Government has given total priority to combating the pandemic, relegating to the background all other pathologies that need hospital follow-up. Confronted with an inelastic supply of scarce health resources, guidelines have been implemented that, necessarily, entail restrictions impacting patient access to health care and exercise of their rights as patients, as a consequence of emergency pandemic measures. Nonetheless, such "restrictions" cannot legally jeopardize patients' life nor health.

7. QUESTIONNAIRE ANALYSIS

André Dias Pereira and Catarina Zamith de Almeida

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].

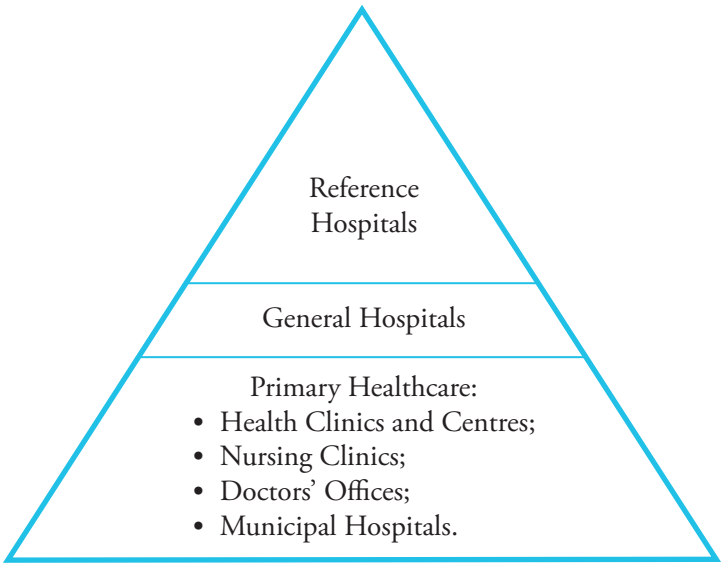

Figure 1 – SNS hierarchy in Angola

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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6c756157357059326c6864476c3259584d7657456c574c33526c65485276637939
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.

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9. THE TEAM

WHO ERC number - (CERC.0079/ HEG 70)

André Dias Pereira
[Lead Researcher]

Academic Education:

- PhD in Legal-Civil Sciences from the University of Coimbra (2014);
- Master in Legal-Civil Sciences from the University of Coimbra (2003);
- Law degree from the University of Coimbra (1998).

Profession:

- Assistant professor at the Faculty of Law, University of Coimbra;
- Chairman of the Board of the Center for Biomedical Law;
- Counsellor, General Council - University of Coimbra;
- Researcher at the Institute for Legal Research – FDUC.

Ethics Committees:

- Member of the National Ethics Council for Life Sciences (*Conselho Nacional de Ética para as Ciências da Vida*) (2015-2021 2 2021-2026);
- President of the Ethics Committee of the AIBILI (Association for Innovation and Biomedical Research on Light);

- Member of the Ethics Committee of the Polytechnic Institute of Coimbra;
- Member of the Ethics Committee of the National Institute of Legal Medicine and Forensic Sciences, I.P (*Comissão de Ética do Instituto Nacional de Medicina Legal e Ciências Forenses, I.P.*);
- Member of the Medical-Legal Council of the National Institute of Legal Medicine and Forensic Sciences, I.P (*Conselho Médico--Legal do Instituto Nacional de Medicina Legal e Ciências Forenses, I.P.*).

International Scientific Organisations:

- Fellow of the European Centre of Tort and Insurance Law;
- International member of the Brazilian Institute of Civil Liability Studies (*Instituto Brasileiro de Estudos de Responsabilidade Civil* - IBERC);
- Member of the European Association on Health Law;
- Member of the World Association for Medical Law;
- Member of the Luso-Brazilian Comparative Law Institute (*Instituto de Direito Comparado Luso-Brasileiro*);
- Member of the *Association internationale de droit comparé*/ International Association of Comparative Law.

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Maria do Céu Patrão Neves
[Bioethics Consultant]

Maria do Céu Patrão Neves studied philosophy at Lisbon University, Portugal, and Louvain-la-Neuve, Belgium (PhD 1991), and bioethics at The Kennedy Center, Georgetown University, Washington DC, where she was a Visiting Scholar. She is currently Full Professor of Ethics at the University of the Azores, Portugal. She has been teaching Applied Ethics and Biomedical Ethics in several Portuguese Universities. She was consultant on Ethics of Life for the President of the Portuguese Republic, and a Member of the National Ethics Committee, and of the Board of Directors of the International Association of Bioethics. She is a Member of several Ethics Committees, and Advisory Boards, a Member of the "Global Ethics Observatory", UNESCO, and an expert on Ethics for the European Commission. She authored/edited 33 books (the latest books are: The Brave World of Bioethics, The Origin of Bioethics in Portugal, through its pioneers (2016); a 12-volume series on Applied Ethics (2017-2018), Ethics, Science, and Society: Challenges for BioPolitics (2019), and Dictionairy of Global Bioethics (2021). She is coordinator of the project "Biomedical Ethics and Regulatory Capacity Building Partnership for Portuguese Speaking African Countries (BERC-Luso)", financed by the European Development Clinical Trials Partnership/ European Commission (2018-2021).

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Ana Raquel Gonçalves Moniz

Associate Professor at the Faculty of Law of the University of Coimbra, where she completed her Bachelor's, Master's and Doctorate in Law. She is also a Researcher at the Institute for Legal Research of the Faculty of Law of the University of Coimbra. Research subjects are centered on Administrative Law, Constitutional Law and the History of Public Law - areas where her scientific production is centered, consisting of monographs and studies included in collective works and periodical publications. Among published books, the following stand out: Introduction to Constitutional Justice (2021); Fundamental Rights and their Circumstances: Crisis and Axiological Link between the State, Society and the Global Community (2017); Studies on Administrative Regulations (2013; 2016); Administration's Refusal to Apply Regulations on the grounds of Invalidity: Contribution to the Theory of Regulations (2012); The Public Domain: The Criterion and the Legal Regime of Dominance (2005); Non-contractual Civil Liability for Damages Resulting from the Provision of Health Care in Public Establishments: Access to Administrative Justice (2003). She was a member of the Scientific Council (2013-2019) and is Subdirector (since 2013) and member of the Pedagogical Council (since 2009) of the Faculty of Law, and also integrates the Quality Council of the University of Coimbra (since 2013).

Ana Margarida Simões Gaudêncio

Assistant Professor at the Faculty of Law of the University of Coimbra (Portugal), and a founding member of the Portuguese Association for Theory and Philosophy of Law and for Social Philosophy (the Portuguese section of the International Association for Legal and Social Philosophy, IVR). Her main research areas are Philosophy of Law, Theory of Law, and Methodology of Law, mostly on Critical Legal Studies, Tolerance and Law, Multiculturalism and Law, and Jurisprudentialism, with two monographies (Entre o centro e periferia: a perspectivação ideológico-política da dogmática jurídica e da decisão judicial no Critical Legal Studies Movement, Rio de Janeiro, Lumen Juris, 2013; O intervalo da tolerância nas fronteiras da juridicidade: fundamentos e condições de possibilidade da projecção jurídica de uma (re)construção normativamente substancial da exigência de tolerância, Coimbra, Instituto Jurídico, 2019), and several articles in portuguese and international publications (https://apps.uc.pt/mypage/faculty/anagaude).

Inês Fernandes Godinho

Inês Fernandes Godinho is an Associate Professor at the Universidade Lusófona do Porto. She holds a PhD in Legal-Criminal Sciences from the University of Coimbra in May 2013 and is a researcher at the University of Coimbra Institute for Legal Research (UC), in which she belongs to the Coordinating Council. She is also an associate of the Centre for Biomedical Law, the Portuguese Ass. of Law Theory, Philosophy of Law and Social Philosophy and the International Foundation for Criminal Sciences. In 2016 she won an award from the Max-Planck Institut (Freiburg) and in 2017 she was an Invited Professor at the Martin-Luther Universität Halle-Wittenberg, Germany. She was also a DAAD Fellow in a research project with the University of Bonn (Germany) and a PhD FCT Fellow. As a researcher she did several research stays in Germany (Bonn and Freiburg) and in England (Oxford). Currently the Editor in Chief of ULP Law Review, she is the author of several legal titles, published in Portugal and abroad.

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Luís Meneses do Vale

Graduation, Master and Doctorate Studies in Law (juridical and political sciences) at the Faculty of Law of the University of Coimbra, under the supervision of J. J. Gomes Canotilho, with additional studies in Bologna and Gallway. Professor at the Faculty of Law of the University of Coimbra, where he held previous positions as Monitor and Assistant, but also as Member of the Board, of the Pedagogical Council, and of the Assembly. Founding Member of the *ALUMNI Association* of his Faculty, of the P*ortuguese Association of Theory of Law, Philosophy of Law and Social Philosophy*, as well as of the *Portuguese Chapter of I-CON*, he stands as member of the *Portuguese Association of Constitutional Law,* of the *Centre for Biomedical Law of the Faculty of Law of the University of Coimbra* and of the *Luso-German Association of Jurists.*

Carla Barbosa

Law degree; postgraduate degree in Medical Law; Master in Law and Bioethics. Lawyer practicing in the area of health law; Off-counsel in the health area; Data Protection Officer in health-related companies; Researcher and associate at the Center for Biomedical Law of the Faculty of Law of the University of Coimbra; Member of the Editorial Board of Lex Medicinae - Portuguese Journal of Health Law (*Revista Portuguesa de Direito da Saúde*); Researcher at the Institute for Legal Research of the Faculty of Law of the University of Coimbra, Member of the Ethics Committee for Health at ARSCentro; Member of the UICISA Ethics Committee; Member of the advisory committee for the drafting of the DGS Informed Consent standard, Member of the task force group for the drafting of the National Plan for Patient Safety 2021-2026; Member of the 1st edition of Health Parliament Portugal (Universidade Nova; Grupo Impresa; Jansen; Microsoft); Lecturer in several undergraduate and graduate courses, master's and doctoral courses on topics related to medical law; Participated in several colloquia and conference cycles (national and international) on topics of medicine and pharmacy and medicine law; Participates in projects financed by national and EU institutions both as a researcher and in the monitoring of the preparation of applications and the execution/closure of projects; External expertise in health projects financed by the European Commission; Author and co-author of several articles (in national and international publications) on health law; coordinator of several books and magazines on health law.

Ana Elisabete Ferreira

Degree and master's in law by the Faculty of Law of the University of Coimbra

PhD in Bioethics by the Portuguese Catholic University

Lawyer. Specializations in Biomedical Law and in Pharmacy Law by the Centre for Biomedical Law | Portugal

Assistant Professor at the School of Technology and Management of Leiria

Invited Professor of Bioethics at the Pontifical Catholic University of Paraná

Collaborating researcher at the UCILER, University of Coimbra

Responsible for the Medical Civil Law Section of the Iberoamerican Law Institute

Adviser to ORBEA (responsible for animal welfare) and Vivarium by the Faculty of Medicine of the University of Porto

Published 3 books on the field of Bioethics and Medical Law; has 38 "peer reviewed" publications and has participated in 51 national and international events, as keynote speaker. Received 3 academic awards

Fernando Vannier Borges

Fernando Vannier Borges holds a PhD in Communication Studies from Université Panthéon-Assas (Paris II), a Master Degree in Communication and Journalism from University of Coimbra and a Degree in Comunication and Journalism from Universidade Federal do Rio de Janeiro. Currently, he is a full-time researcher at University of Coimbra and a Professor at Lusófona University. Previous experience includes a science manager position and teaching in Cape Verde.

His current interests are Science Communication and the social outreach of research projects. With publications on the nexus of Communication and Sport, his work has deepened into the economical and symbolical elements of the media-sport spectacle, namely by the creation of football club's own media channels.

CV: https://www.cienciavitae.pt/E617-6159-27F9

Vera Lúcia Raposo

Vera Lúcia Raposo has a law degree, a postgraduate degree in medical law, a master's in legal-political sciences and a doctorate in legal-political sciences, granted by the Faculty of Law of Coimbra University, Portugal (FDUC).

Currently she holds a dual position: Associate Professor at the Faculty of Law of the University of Macau, China and Assistant Professor at FDUC. She is a researcher at the Centre for Human Rights-Ius Gentium and the Centre for Biomedical Law, both from FDUC. Among many other things, she was lecturer at the Faculty of Law of the Agostinho Neto University, in Angola, and of counsel at the Vieira de Almeida e Associados office, in Lisbon, in the area of health law.

She is the author of several studies in Portuguese, English and Spanish (some translated into Chinese), in particular on biomedical law and new technologies.

Armindo Gideão Kunjiquisse Jelembi

A)

- Law degree from the Faculty of Law of UAN (2003)
- Master in Civil Law from the Faculty of Law of the UAN (scientific collaboration with the Faculty of Law of the UC; 2008)
- PhD in Civil Law from the University of Coimbra (2018-07-30)
- Postgraduate degree in pedagogical aggregation
- Post-graduate degree in banking law
- Course on corruption
- Course on international judicial cooperation in criminal matters Licenciado em Direito pela Faculdade de Direito da UAN (2003)

B)

- Assistant Professor at the Faculty of Law of the José Eduardo dos Santos University
- Head Professor of the Law of Obligations Subject
- Lawyer

C)

- Assistant coordinator of the UAN Law Faculty in Huambo 2005-2009
- Pro-rector for cooperation at the José Eduardo dos Santos University 2009 - 2014
- Vice-rector for extension and cooperation at the José Eduardo dos Santos University 2015 -2021

Sandra Mara Campos Alves

PhD in Public Health (UnB), Master in Social Policy (UnB), Specialist in Health Law (Fiocruz), Graduated in Law (UFC). Researcher and Coordinator of the Health Law Programme at the Oswaldo Cruz Foundation, Brasília. Professor of the Postgraduate Programmme in Public Health Policies at the Oswaldo Cruz Foundation. Chief editor of the journal *Cadernos Ibero-Americanos de Direito Sanitário*. Member of Aldis (Lusophone Association for Health Law, *Associação Lusófona do Direito da Saúde*) and Red Iberoamericana de Derecho Sanitario. Author of books, chapters and articles in the area of Health Law.

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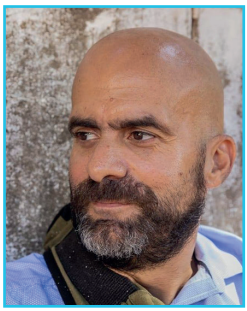

Carlos Manuel dos Santos Serra

Academic training:

- Doctorate in Public Law, by the Institute of Sciences and Technology of Mozambique (ISCTEM) and Universidade Nova de Lisboa, 2013;
- Postgraduate in Law of Planning, Urbanism and Environment, Center for the Study of Land Law, Urban Planning and Environment, Faculty of Law of the University of Coimbra, 1998;
- Degree in Law, in the legal-forensic area, Faculty of Law of the University of Coimbra, 1997.

Occupations / positions and activism:

- Coordinator of the Center for Environmental, Biodiversity and Quality of Life Law at the Faculty of Law of the University Eduardo Mondlane
- Founding member and General Director of the Cooperativa de Educação Ambiental Repensar. (Environmental Education Cooperative Repensar, aimed at carrying out environmental education and awareness raising activities for children and young people;
- National Coordinator of Let's Do It Mozambique (which organizes World Cleaning Day);
- Jurist in the National Fund for Sustainable Development (FNDS) - Ministry of Land, Environment and Rural Development (MITADER), between June 2017 and November 2019;
- Trainer and researcher of the Juridical and Judicial Training Center (CFJJ) from 2000 to 2020; as well as in the invited Trainer of the National Institute of Judicial Studies - Angola, between 2009 and 2014;
- Lecturer at the Eduardo Mondlane University and at the Higher Institute of Science and Technology, in the courses of Law, Architecture and Environmental Engineering from 2002 to the present moment.

Catarina Zamith de Almeida
[Junior Researcher]

Law Degree from the University of Coimbra's Faculty of Law, currently Master of Laws candidate (Specializing in Public International Law and European Union Law).

10. ANNEXES

The Covid-19 Pandemic in the Lusophone World - Workshop

February 2nd, 2021 – 14:00 PM to 17:30 PM GMT
Institute for Legal Research, University of Coimbra
Portugal

Moderator: Professor André Dias Pereira, PhD

Guest Speakers

Angola - "Managing the SARS-CoV-2 Pandemic in Angola"

Professor Cristóvão Simões, PhD
Rector at the Universidade José Eduardo dos Santos and Doctor

Brazil – "Sanitary Aspects on the SARS-CoV-2 pandemic in Brazil"

Professor Fernando Cupertino, PhD
Professor at the Faculty of Medicine of the Federal University of Goiás. He is a technical advisor to the National Council of Health Secretaries (Conass), which he presided over twice. Coordinates the Thematic Commission on Health, Food and Nutritional Security of the Community of Portuguese Speaking Countries, since 2015.

Mozambique – "Human Rights Perspective: Mozambican Law"

Professor Orquídea Massarongo, PhD
Professor at the Faculty of Law of Eduardo Mondlane University and consultant in the areas of Health Law and Human Rights.

Portugal) – "The Perspective of Patients with Respiratory Illnesses"

Isabel Saraiva, Doctor
Chairman of the Board of *Respira* - Portuguese Association of People with COPD [Chronic Obstructive Pulmonary Disease] and Other Chronic Respiratory Diseases. She was a member of the Board of the EFA - European Federation of Allergies and Airways Diseases Patients' Associations (Brussels), and an expert of the EMA - European Medicines Agency (London). Between 2017 and 2020 she was Chair of the European Lung Foundation (ELF).

Portugal – "The Legal and Administrative Framework in Portugal"

Professor Ana Raquel Moniz, PhD
Assistant Professor at the Faculty of Law of the University of Coimbra and Researcher at the Institute for Legal Research, University of Coimbra.

Final Seminar

RESPONSIBILITY FOR PUBLIC HEALTH IN THE LUSOPHONE WORLD: DOING JUSTICE IN AND BEYOND THE COVID EMERGENCY

WHO ERC number - (CERC.0079/ HEG 70)

March 25th, 2021

Roundtable 1 - 9:00 am – 10:00 am – Opening Roundtable:

- Vice-Rector of the UC for External Relations and Alumni - Prof. João Nuno Calvão da Silva, PhD
- UCILeR's President – Professor José Manuel Aroso Linhares, PhD
- Coordenator of the Vulnerabilities and Law Programme at the UCILeR – Professor João Loureiro, PhD
- Head of CPLP (Community of Portuguese Speaking Countries) Executive Secretariat Cooperation Directorate – Manuel Clarote Lapão

Roundtable 2 - 10:15 am - 13:00 pm – Interdisciplinary Analysis of the COVID-19 Pandemic Issues:

- Professor Maria do Céu Patrão Neves, PhD (Azores University) – "*Combating Covid from a Bioethics Perspective*";
- Professor Vera Lúcia Raposo, PhD and Professor Man Teng Iong (Macao University) – "*The Macao Experience Against Covid: the good and the bad*";
- Professor Luís Meneses do Vale, PhD (University of Coimbra's Faculty of Law/ UCILeR) – "*The Constitutional Experience in a «State of Need»*";
- Ricardo Mexia, MD (Public Health Doctors' Association - ANMSP - *Associação Nacional de Médicos Saúde Pública*) – "*The Challenges of the Pandemic to Public Health Medicine*";
- Vítor Rodrigues, PhD, MD (University of Coimbra's Faculty of Medicine/Portuguese Against Cancer League) – "*The Issue of Non-Covid Patients, Especially Cancer Patients*";
- Alexandre Lourenço (Portuguese Association of Hospital Administrators - APAH - *Associação Portuguesa de Administradores Hospitalares*) – "*Challenges to Hospital Administration*";

Roundtable 3 - 14:30pm – 15:30pm – The Southern Hemisphere Experience:

- Professor Sandra Mara Alves, PhD – Oswaldo Cruz Foundation (Fiocruz), Brazil– "*The Performance of the Brazilian National Congress in Response to Covid*";
- Professor Armindo Gideão Jelembi, PhD – José Eduardo dos Santos University, Angola – "*The Influence of the Covid-19 Pandemic on the Functioning of academic institutions – the Angolan experience*";
- Professor Carlos Serra, PhD – Eduardo Mondlane University, Mozambique – "*Environmental Law and Sanitary Law: the Pandemic as an Intersection Line*";

Roundtable 4 - 15:45pm – 16:30pm – Project Outcomes:

- Professor Ana Gaudêncio, PhD – University of Coimbra's Faculty of Law/UCILeR – "*Human Rights, Lusophone Countries and the Covid Pandemic*";
- Professor André Dias Pereira, PhD – University of Coimbra's Faculty of Law/UCILeR – Project Outcomes

Closure

RECOMMENDATIONS

The WHO ERC (CERC.0079/ HEG 70) Project Team, whereas:

(1) The States' political responsibility for the structuring, organisation and implementation of just health care systems within just societies;

(2) The predicted intensification of the emergence of infectious communicable diseases, which, although appearing in a specific area, are quickly spread throughout the current globalized world, with devastating effects on public health, as well as the overall human interactions and activities;

(3) The need to adopt prevention and surveillance measures, which allow for quick, adequate and proportional action, combined with measures destined to monitor these situations;

(4) The professional and civic duty to contribute to the States' preparedness and response to public health emergency situations;

(5) The importance of social, economic and environmental determinants on individual and collective health, as well as their impact on health care systems;

(6) The relevance of intersectionality and flexibility of the health care systems, as well as of integrating these aspects in all policies;

(7) The requirement that the allocation of health resources – human, technical and financial –, as well as the priority protocols established to organise the population's access to these vital goods, observe the respect for Human Rights, upholding the ethical structuring principles of human dignity and social justice, respectively, on an individual and social level;

(8) The geographical, socioeconomic, political, legal and cultural differences in the countries involved in this Project;

(9) The different realities that were identified in the legal systems that took part in the Project, and the need to respect their heterogeneity;

(10) The United Nations *2030 Agenda for Sustainable Development*, especially considering the objectives listed in Goal 16: "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels";

Presents the following proposals for a public policy approach, aiming to contribute to the implementation of adequate, robust and resilient systems, prepared to respond to challenges that arise in pandemic situations:

1) Drafting a Sanitary Surveillance Law

- This Law must maintain parliamentary control over the adoption of restrictive measures concerning fundamental rights (in particular, rights, freedoms and guarantees). At the same time, the diploma should endow the Government with agile and responsive mechanisms that can be activated in situations of pandemic crisis, whilst guaranteeing full respect for human dignity and promoting a preventive rather than a punitive approach, in the adoption of an eminently pedagogical policy;
- The role of the President of the Republic should be evaluated and determined depending on the nature of the system (presidential or parliamentary) in force in each country;
- The restriction or suspension of fundamental rights and freedoms must uphold the principle of proportionality. To observe this principle, State intervention must be limited to the minimum necessary and indispensable (both in the breadth of the adopted measures and in the time frame in which they are to be in force) to guarantee the common good; restrictions and interdictions must be scientifically justified and presented with objectivity and transparency (the type and content of the intervention must be subordinate and limited to the established purpose).

2) Reinforcing the creation of Public Health Teams and investing in their qualification

- In Brazil, collective health professionals do not have a degree in Medicine, going instead through a different academic training that provides them with a Bachelor's Degree in Collective Health. These *collective health professionals* work in health institutions, carrying out administrative tasks and recommending articulated action in different areas;
- In Portugal, these teams have Doctors specializing in Public Health, as well as Community Health Nurses, Environmental Health Technicians and, at other levels, Clinical Analysis and Public Health Technicians. Increasing the number of professionals and investing in their training should be promoted;
- It is recommended that both the Portuguese and Brazilian examples are studied to possibly transpose, with the necessary adaptations, a solution to be implemented in Angola and Mozambique.

3) Preparing institutions, especially health care institutions (but notwithstanding elderly care homes) for epidemiological/ pandemic emergencies

- Ensuring that PPE stocks are maintained at all times, namely surgical masks, alcohol disinfectants and body temperature measurement equipment, at least in institutions that provide health care;
- Promoting the national capacity of PPE production, including the identification of companies capable of rapid conversion from their essential activity to PPE production, according to possible needs that might arise during a pandemic crisis;
- Medium and large companies must keep a constantly updated contingency plan for pandemic situations (organization of telework, teams that work on rotation, preparing methods to guarantee physical distance between workers, cleaning the workplace, etc.).

4) Creating and reinforcing the national pharmaceutical industry, meeting the highest standards of product safety and efficacy and protection of health data and genetic data of people and communities (applicable to all countries studied)

- In Portugal and especially in Brazil, there are relevant activities in the field of the creation of medication and clinical trials of medicines and vaccines. In Brazil, about 20 new vaccines are currently in a preliminary phase;
- The Lusophone relationship in this area should be strengthened. Technical and scientific capacities should be extended to African countries;
- Genetics and artificial intelligence have revealed their importance in this field, allowing for the formulation, in record time, of vaccines and treatments, as well as the identification and characterization of new variants of the virus. In addition, with the strengthened interaction between genetics, Public Health and the global digital connection, it is expected that the Law will increasingly assume a more prominent role in these issues. Therefore, it is recommended that special attention be given to cases of sale of genomic information by research agencies, as well as the protection of personal data;
- A clear and reinforced commitment to academic training and long-term scientific research (namely in virology) and the strengthening of public funding for research is imperative;
- Each State should provide a model of civil liability rules to deal with the risk of vaccination.

5) Organise the health system so that, in an epidemic/pandemic situation, the ability to care for non-infected patients is maintained

- Prepare the system for epidemic and pandemic situations, in order to guarantee the least possible disruption of treatments in outpatient appointments, scheduled surgical operations and emergency care for non-infected patients;
- The large increase in the mortality rate, in several countries, is mostly due to the increase in lethality attributed to non-COVID causes, than from SARS-CoV-2 infection. Discrimination against non-infectious patients is ethically unsustainable;

- The flexibility of the systems and the development of integrated care are crucial for coping with pandemic crises;
- The digitalization of the health system must be reinforced, together with adequate training of health professionals, in order to maximize their benefits, translated into improvements to the health of people and communities.

6) Improve the accuracy of information, the quality of communication, and the level of health literacy, including public health

- Improve the capacity to transmit information regarding the public health emergency response to COVID-19;
- Official authorities should come up with an information plan (which takes into account the psychology that underlies each organisation and addresses the contribution of communication professionals) which reaches the various sectors of society (the elderly, adolescents, minorities and migrants);
- Promote health literacy, with campaigns and practical actions aimed at promoting hygiene, healthy lifestyles, with the involvement of the social sector and local authorities.

7) Establishing, by Law, the role of the Armed Forces and security forces in situations of epidemiological/pandemic emergencies

- The Armed Forces may have an important interventional role in public health emergency situations, namely in the screening of infections, organising field hospitals in their facilities, receiving patients in their hospitals, having military laboratories process tests, conducting epidemiological surveys, tracking contacts of patients with COVID-19 and in the development and implementation of the vaccination plan;
- A more active involvement of the Armed Forces in the practical logistical organization during pandemic outbreaks (equipment management, support to the administration and organization of vaccination centres) should be established;
- Defining the role of the security forces in preventing infections and inspecting compliance with health standards in a pandemic situation.

8) Reinforce the protection of the people most vulnerable to the particular infectious agent, namely the elderly (in their homes, institutions and public spaces)

- Promote the contribution of both social and private sectors, as well as of municipal authorities and parish councils in supporting the most vulnerable people (namely the elderly), advocating healthy living habits, social and intergenerational interactions, and combatting situations of abandonment or isolation;
- Avoid the closure of Day Care Centres and institutions that support people with disabilities, which, in addition to depriving the elderly and people with disabilities of the necessary stimulation and social interaction, put additional pressure on caregivers and families;
- Avoid a (complete) ban on visits to nursing homes and hospitals. Reinforce connections which can be made without direct contact, namely through transparent structures (such as windows);
- Adopt frequent testing systems in institutions (Day Care Centres, Institutions that care for people with disabilities and similar institutions);
- Amend labour legislation to have more robust work provisions to provide assistance to members of the household, other than just children (namely assistance to the elderly or dependent people with disabilities);
- Amend labour legislation to foster exclusivity regimes for employees in residential institutions and to enable rotational internment by teams.

9) Preserve the affective and spiritual experience of people and communities, namely with regard to visits to hospitals and residential care homes, as well as religious and specifically funeral rituals

- These are two different subjects, but of great ethical, anthropological and social density. The constraints imposed on these dimensions lead to a destruction of the essence of families, with disruptive effects on individuals, communities and the ethical and spiritual framework of the population;

- Strictly upholding the principles of legality and of proportionality must prevail in this area, not allowing de facto powers (of health professionals and struggling companies) to override the rule of law and the primacy of fundamental rights.

10) Prepare educational establishments, teachers, students and families, for teaching regimes adapted to epidemic/pandemic situations, namely distance learning

- Educational institutions, and at the beginning of each school year, should be incentivized to identify whether the requisite pre-conditions exist, in the school community, to conduct teaching activities at a distance, and prepare solutions to overcome any difficulties that are encountered;
- Schools shall be organized for pandemic situations, preparing solutions for different circumstances, such as establishing that students should spend less time in school, classrooms hold fewer students at a time, and implementing more intense and regular hygiene, and training families with digital skills for families;
- It is also proposed that schools are reopened gradually, taking into account the fact that there are some areas of the territory where there may be a small number of children per class/school. Also, the closing of schools should be decided on the basis of a case by case assessment of the number of students and size of each school;
- The SARS-CoV-2 Pandemic also demonstrated the urgency of re-evaluating the current dimension of schools, which, although they have not been identified in this specific Pandemic as a main source for the spread of the virus (as this strain, in particular, does not seem to particularly affect children), it is known that other epidemic viruses such as the H1N1 strain of 2009-2010, can mainly target young people;
- There is a need for equipment and social internet plans to be available to students, and for the adoption of a combined system of both in-person and distance teaching methods, implementing psychological, social and financial support for families, maintaining sports activities, investing in the training of teachers in the use of technological equipment, and transmitting school classes on an open channel on television.

11) Investing in territorial planning and urban planning, as well as building housing for the protection of health and disease prevention

- Home confinement, besides being highly disparate and harmful to people with co-morbidities, given the housing conditions in several countries, induces other serious pathologies, so it is necessary to mitigate it through the organization of cities that offer facilities for people to spend time outdoors, with the necessary social distancing;
- States must assume the responsibility of guaranteeing that people (1) live in healthier homes and (2) live in cities with greater environmental sustainability and which allow for better living conditions, including the practice of sport, thus avoiding the creation of overcrowded suburbs that lead to large flows of public transport and commercial areas with large population concentrations.

12) Defend the importance of international collaboration on (global) health and respect for international standards regarding states of emergency

- A final objective, which must be adopted in the short term, is to reinforce the importance of international cooperation in health matters, through a revaluation of the role of the WHO and promoting the respect for international regulations;
- There is an urgent need to revalue international rules that aim to promote the protection of human rights in situations of health emergencies, namely Article 43 of the International Health Regulations (IHR) and Article 4 of the International Covenant on Civil and Political Rights, which was subject to the detailed General Comment No. 29, by the Human Rights Committee, and specified through the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, as well as at continental level, Article 15 of the European Convention on Human Rights and Article 27 of the American Convention on Human Rights.

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