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Special Edition
Why has Brazil surpassed 100 thousand deaths?

Covid-19: Public Policies and Society's Responses

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Policy Briefing Note 20

Lacking a strategy, the Federal Government foments the country's fragmentation and fails to coordinate the fight against COVID-19. The demobilization of the Ministry of Health, alongside disorganized testing and social distancing policies, dramatically exposes the Government's failure for tackling the pandemic and Brazil's tragic lead in the number of new deaths-per-million inhabitants, overtaking the United States.

Main Conclusions

- Contrary to WHO guidelines, which recommend mass testing, identification, isolation, and tracing of infected people and suspected cases, the Federal Government has ceased to develop and coordinate public policies to protect the population and save lives.
- Pandemic control measures focused on primary care were only enacted in June 2020, with the creation of Reference Centers for Coping with COVID-19. Furthermore, pre-existing primary health capabilities and resources are used on a limited basis. The demobilization of the family health network, structured over the years by the Ministry of Health (MH) and the Unified Health System (UHS), undermines the population's resistance to the virus, especially the most vulnerable segments.
- In the absence of vaccines and drugs to cure infected persons, the WHO recommended increasing social distancing measures and the adoption of economic and social policies to assist the population in surviving and staying at home amidst the crisis. Since March, the Federal Government has adopted orchestrated measures to undermine state and municipal social distancing policies.
- The President of the Republic has ignored or redesigned technical recommendations, discontinued the work of the Ministry of Health by replacing two ministers, relaxed social distancing measures by expanding services that are considered essential, and even reduced the state-mandated mask regulations in July.

- By equating health performance with economic performance, the Federal Government caused the country to confuse its priorities. It ignored evidence suggesting that economic losses would be smaller insofar as the virus is contained. In health, the measures employed by the Federal Government were targeted primarily at increasing highly specialized care capacities, such as increasing ICU beds. Federal spending on economic and social assistance was practically three times higher than in health.
- As a result, the country is now at high risk. Brazil registers 468 total deaths per million inhabitants (total accumulated up to August 8) surpassed only by the USA, with 487 deaths per million inhabitants.
- However, when we look at the number of new deaths per million inhabitants, Brazil emerges in first place with 33 new deaths, ahead of the USA, which registered 24 new deaths between 08/02 and 08/08.

Introduction

At a time when Brazil, USA, and Mexico seem to dispute the leading position in the number of COVID-19 deaths, we seek to promote a debate on the quality of the public policies adopted by the Brazilian Federal Government. The Government's feeble reaction to the pandemic is rooted in its lack of strategy and uncoordinated response, which gave rise to a succession of errors and misjudgments that have defined the Federal Government's performance over the last six months. The result was a sequence of mismatches and poor decisions, which demobilized the Ministry of Health, disoriented the government's technical and scientific staff, and hindered the response capacity of the UHS, even though this component structurally differentiates Brazil from those without universal health coverage. By politicizing the reaction to COVID-19, the Government signaled contradictory stances to society, stirred conflicts with governors, and spread inconsistent information.

Brazil, United States, and Mexico lead the global death toll. Other federations such as Germany, Argentina, and Canada are performing better and have managed to reduce the COVID-19 incidence rate, even with relatively large territories and heterogeneous population profiles. Brazil and the United States stand out negatively with limited initiatives or coordinated efforts at the national level to respond to the pandemic. Comparatively, Germany, Argentina, and Canada exhibit relatively higher levels of coordination between regions, as reflected in the policies adopted at the subnational levels.

Since the beginning of the pandemic, the Solidarity Research Network has emphasized how the Federal Government has failed to provide a clear and articulated strategy to contain COVID-19. This negligence revealed itself in the lack of mass testing programs, the limited distribution of more reliable tests for diagnosing the disease, such as RT-PCR, the lack of actions to identify and isolate suspected cases, and by challenging state-mandated social distancing policies. The absence of guidelines and underuse of the UHS, a universal constitutional system, the lack of transparency, and the increasing disparities between various government levels left the population helpless and unattended amidst the gravity of the pandemic, with a direct negative impact on their prevention capacity against the virus.

To evaluate the performance of the Federal Government, the Solidarity Research Network analyzed each act of the Executive and the MH since the beginning of their activities against COVID-19, and identified the sequence of decisions allegedly aimed for steering the country's reaction against the pandemic. As we show in this policy brief, the advantages that Brazil had in terms of organizational structure, experience against epidemics, and even the swift measures taken as soon as the virus arrived were either lost or neutralized. Delays, inaccuracies, and ambiguities began to shape the response to a major crisis.

The WHO and the Responses in Germany, Argentina, Brazil, Canada, and the USA

Following the initial descriptions of an outbreak in Wuhan, China, disclosed by the World Health Organization (WHO) on January 5, 2020, the organization published on January 12, 2020 a wide-ranging package of documents with guidelines for tackling COVID-19. The WHO guidelines were reinforced by the Pan American Health Organization (PAHO) on January 16, with suggestions for public policies to combat the outbreak of the new virus[1], including recommendations for the use of protocols for infectious diseases and a monitoring system for people arriving from Wuhan.

On January 30, the WHO declared an international public health emergency and several countries, including Brazil, endorsed the announcement. As the WHO issues alerts regarding the gravity of the symptoms caused by the new virus in February, the Federal Government delegated to the Ministry of Health the task of leading the response to the pandemic[2]. On February 3, Brazil's Ministry of Health declared a National Public Health Emergency, with Ordinance No. 188, and three days later, the National Congress admitted the possibility of enacting social distancing measures, quarantine, and the mandatory application of medical tests (Law 13.979). When the WHO warned that SARS-CoV-2 seemed closer to a severe acute respiratory syndrome (SARS)[3] disease than a flu, the first infection in São Paulo was confirmed on February 26.

On March 11, while the WHO confirmed the situation had reached a pandemic, Brazil registered 53 confirmed cases in 8 states, a milder scenario compared to the 1,296 cases in Germany, 19 in Argentina, 93 in Canada, and 1,025 in the USA on the same date. At that time, the pandemic in South America was in an earlier stage and there were a high number of cases in Europe and North America. On the same date, the Ministry of Health issued Ordinance 356, which established measures to quarantine suspected cases.

Shortly after, a significant change occurred in the Federal Government. On March 20, President Jair Bolsonaro enacted Provisional Measure No. 926 and amended law 13.979, determining that measures would be managed at the subnational level, which weakened previous ordinances issued by the Ministry of Health.

The decision to decentralize the strategies for coping with the pandemic in Brazil contrasts with the decision of most countries hereby analyzed. Apart from the United States, the other federations organized coordinated responses through their national leaders, motivated by the need for cohesion in the responses to convince the population to act together against the pandemic. In the case of Canada[4] and Argentina[5], for example, political polarization and partisan rivalry did not thwart the responses for tackling the pandemic. The German federation was highly coordinated[6] with convergent strategies for controlling the spread of the virus despite significant differences in politics and partisan control of regions, and even considering that most measures were enacted by subnational governments and not imposed by the Federal Government.

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1 For the documents issued by WHO, see https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline. For documents issued by the PAHO, see https://www.paho.org/hq/index.php?option=com_docman&view=list&slug=coronavirus-epidemiological-alerts-and-updates&Itemid=270&layout=default&lang=en.

2 See Law Nº 13.979 of February 6, 2020. Avaliable at: https://www.in.gov.br/en/web/dou/-/lei-n-13.979-de-6-de-fevereiro-de-2020-242078735.

3 See www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf.

4 Merkley, E., Bridgman, A., Loewen, P., Owen, T., Ruths, D., & Zhilin, O. (2020). "A Rare Moment of Cross-Partisan Consensus: Elite and Public Response to the COVID-19 Pandemic in Canada." *Canadian Journal of Political Science*, 1-8. doi:10.1017/S0008423920000311 e Webster, Paul. "Canada and COVID-19: Learning from SARS." *The Lancet* 395: 10228, P936-937 (2020).

5 Blofield, M., Hoffmann, B., & Llanos, M. (2020). Assessing the Political and Social Impact of the COVID-19 Crisis in Latin America. (GIGA Focus Lateinamerika, 3). Hamburg: GIGA German Institute of Global and Area Studies - Leibniz-Institut für Globale und Regionale Studien, Institut für Lateinamerika-Studien. https://nbn-resolving.org/ urn:nbn:de:0168-ssoar-67260-7.

6 Siewert, Markus, et al. "A German Miracle? Crisis Management during the COVID-19 Pandemic in a Multi-Level System." *PEX Special Report: Coronavirus Outbreak, Presidents' Responses, and Institutional Consequences* (2020).

In addition to delegating responsibilities to states and municipalities, none of these other federations changed the leadership of the authority heading the health portfolio during the pandemic. Brazil performed two ministerial changes in the Ministry of Health, and the person currently responsible, General Eduardo Pazuello, has been in office for circa 90 days as an interim Minister.

Table 1 - Initial Conditions and Crisis Governance on COVID-19: Germany, Argentina, Brazil, Canada, and the USA

	Germany	Argentina	Brazil	Canada	USA
Health Ministers during the pandemic	Jens Spahn	Ginés González García	- Luiz Henrique Mandetta (1/2019-04/16/2020) - Nelson Teich (04/17-05/15) - Eduardo Pazuello (interim, 05/16-present)	Patty Hajdu	Alex Azar
Degree of Policy Coordination	High	High	Low	High	Low
Health System	Statutory System (contribution from the payroll of employees and employers)	Public, Private System + Statutory System (contribution from the payroll of employees and employers)	Universal Health System and Private Health System	Universal Health System and Private Health System	Statutory System (contribution from the payroll of employees and employers) and Private System
Expenditures on Public Health or Compulsory Systems[1] (GDP per capita) 2017	9.6	2.7	4.0	7.6	14.4
Expenditures on Private Health[1] (GDP per capita) 2017)	0.3	2.1	2.9	1.6	0.8

Source: World Health Organization (2020)

Note. 1. Health expenditure data was retrieved from the WHO. For further estimates, see: https://stats.oecd.org/Index.aspx?DataSetCode=SHA.

The WHO and medical experts stand in consensus that laboratory testing for COVID-19 is an essential component for containment and mitigation strategies, allowing for adequate clinical management and public health interventions. Compared to other federative nations, Brazil took considerably longer to initiate testing. Chinese scientists released information about the viral genome on January 11, 2020 on the *Global Initiative on Sharing All Influenza Data – GISAID* portal while the WHO sent the first RT-PCR laboratory diagnostic kits to its regional offices on February 2, 2020.

In most countries – including those that rapidly developed testing capacity such as USA and Germany, as well as developing countries with more limited resources such as Malaysia – technology acquisition and the protocols governing testing were coordinated by national health authorities since the first weeks of January 2020.[7] As shown in Table 2, the testing policy in Brazil was fragmented,

7 Oliveira, Beatriz Araújo; Oliveira, Lea Campos de; Sabino, Ester Cerdeira and Okay, Thelma Suely. "SARS-CoV-2 and the COVID-19 disease: a mini review on diagnostic methods." *Revista Instituto de Medicina Tropical São Paulo*. 2020, vol.62: e44.

initially concentrated only in the states of São Paulo and Rio de Janeiro. This resulted in a delayed expansion for the number of tests performed in each state. Despite the low capacity to carry out mass testing in state laboratories, Fiocruz qualified and enabled laboratories throughout Brazil in early March.[8]

Table 2 - Responses in Germany, Argentina, Brazil, Canada and, USA

	Germany	Argentina	Brazil	Canada	USA
Date of the first RT-PCR test performed1[1]	January 17	–	February 15	January 24	January 28
Tests per Day (average in the last week of March)	51,678	387	The federal government does not disclose this information[9]	15,378	79,170
Confirmed cases (per million) (accumulated up to 8/8)	2,570	5,049	13,937	3,152	14,929
Confirmed cases (per million) (new cases from 8/2 to 8/8)	67	947	1,411	70	1,147
Deaths (per million) (accumulated up to 8/8)	109	94	468	237	487
Deaths (per million) (new cases from 8/2 to 8/8)	0.6	18	33	1	24
Tests Performed (per 1000) (accumulated up to 8/2)	102	14	12.9	109	171
Positivity Rate (7-day moving average on 8/1)	0.8%	43.7%	33.2%	0.8%	8.2%

Sources: European Centre for Disease Prevention and Control (ECDC) and Cota (2020)

Note. 1. In Brazil, the first laboratories with testing capacity were the Adolfo Lutz Institute, Albert Einstein Hospital, and Fiocruz. For an analysis of the progress in the state of São Paulo, see: https://jornal.usp.br/ciencias/ciencias-da-saude/tecnologia-que-sequenciou-coronavirus-em-48-horas-permitira-monitorar-epidemia-em-tempo-real/. Fiocruz began producing tests on March 4. For further information, see https://portal.fiocruz.br/sites/portal.fiocruz.br/files/documentos/fioempauta_202_1_coronavirus.pdf. In Canada, the date was confirmed by Jason Blakely from the Nova Scotia Health Authority (NSHA). For the USA, see https://www.cdc.gov/coronavirus/2019-ncov/lab/testing.html.

The WHO recommends a positivity test rate (equivalent to the percentage of positive tests among all tests performed) that is 5% or lower. When analyzing the period from the beginning of the pandemic until August 2, we find that the USA and Canada have the highest number of total tests performed per 1,000 inhabitants, 171 and 109, respectively. Considering the countries with the highest positivity rate within the same period, Argentina (43.7%), Brazil (33.2%), and USA (8.2%) stand out. In contrast to the USA and Argentina, and somewhat surprisingly, this result is not found on the official website of the MH where pandemic statistics are reported. On this webpage, even today, 5 months since the outset of the pandemic, no data exists on the volume and types of tests performed, notified, or processed.

8 In Brazil, the first laboratories with testing capacity were the Adolfo Lutz Institute, Albert Einstein Hospital, and Fiocruz. For an analysis of the progress in the state of São Paulo, see: https://jornal.usp.br/ciencias/ciencias-da-saude/tecnologia-que-sequenciou-coronavirus-em-48-horas-permitira-monitorar-epidemia-em-tempo-real/. Fiocruz began producing tests on March 4. For further information, see https://portal.fiocruz.br/sites/portal.fiocruz.br/files/documentos/fioempauta_202_1_coronavirus.pdf. In Canada, the date was confirmed by Jason Blakely from the Nova Scotia Health Authority (NSHA). For the USA, see https://www.cdc.gov/coronavirus/2019-ncov/lab/testing.html.

9 https://noticias.uol.com.br/saude/ultimas-noticias/redacao/2020/04/28/governo-federal-nao-sabe-quantos-testes-de-covid-19-sao-feitos-no-brasil.htm

We may only estimate Brazil's positivity rate by using data disclosed by each state health secretariat and consolidated by academic researchers. In other words, Brazil not only underperforms in testing, but also fails to report the data transparently to society. The only reason the situation is not worse is that states and private laboratories have invested significantly to increase testing capacity.[10]

In terms of new cases and total accumulated cases, the USA and Brazil currently lead with the highest numbers per million inhabitants. Since the beginning of the pandemic until the present date, the USA has registered 14,929 total cases per million inhabitants (total accumulated up to August 8) and 1,147 new cases per million inhabitants (new cases from 8/2 to 8/8/2020). Brazil, in turn, registered 13,937 total cases per million inhabitants (total accumulated up to August 8) and 1,441 new cases per million inhabitants (new cases from 8/2 to 8/8/2020). Brazil and the USA are also the countries in our sample with the highest number of deaths per million inhabitants. Since the beginning of the pandemic, the USA has reported 487 deaths per million inhabitants due to the new coronavirus (total accumulated up to August 8) and 24 new deaths per million inhabitants (data from 8/2 to 8/8/2020). At the same time, Brazil registered 468 total deaths per million inhabitants (total accumulated up to August 8) and 33 new deaths per million inhabitants (new deaths from 8/2 to 8/8/2020).

The Absence of a National Public Health Policy

For managing a pandemic, a country needs to activate an emergency system with clearly-defined rules and responsibilities. In Brazil, the Federal Government laid out clear strategies in the fight against recent pandemics, guiding the UHS and coordinating the policies of states and municipalities. Such was the case for AIDS, H1N1, and SARS, which led to international recognition of Brazil's efforts. The same did not happen with COVID-19.

Structured in the early 1990s, the UHS established and organized a federated assistance network for the promotion and strengthening of primary care. Primary care structures have been responsible for health prevention policies, dedicated to implementing local programs planned by the Ministry of Health. Thus, the Brazilian health system, although decentralized in implementation, remains centralized in planning and proposing health programs, policies, and actions. This spatial and hierarchical dimension of the UHS becomes especially important when trying to understanding the MH's response to the pandemic, as it attributes competences across different government levels.

In addition to the most common health interventions, such as the creation of field hospitals, the qualification of ICU beds for COVID-19, and the maintenance of basic health units, the federal level is also responsible for other attributions in health emergencies, as listed in Table 3 which presents the main programs and actions that were proposed by the Ministry of Health in response to COVID-19.

10 In the case of the Albert Einstein Hospital, these investments mean that its laboratories are now able to process 3,500 to 4,000 samples per day. The Adolfo Lutz Institute reports currently processing 1,400 tests per day.

Table 3 - Health Policy Dimensions and Responses to Pandemic

Responsibilities of the Federal Government	Policies and Regulatory Measures proposed by the Ministry of Health
Specialized Care	Enabling and disabling COVID-19 ICU beds throughout the period. As of March, authorized small hospitals to provide long-term care beds and, in June, defined criteria for the creation of field hospitals.
Primary Care	In April, financial support for primary care units to expand their opening hours. In June, a proposal to create the Community Reference and Service Centers for Tackling Covid-19.
Science and Technology	The only policy identified was a legal provision issued in April on submitting clinical trials for validating medical devices in response to the pandemic.
COVID-19 Diagnoses and Laboratories	The first policies were implemented in April destined to the Federal Agricultural Defense Laboratories for diagnosing COVID-19; Import regulation of products for diagnosing and authorizing "rapid tests" for COVID-19 in drugstores. In May, policies regarding tests for the laboratory diagnosis of SARS-CoV-2 infection in the Table of Procedures of the Unified Health System (UHS) were introduced and, in July, the allocation of resources for state laboratories (LACEN) was authorized.
Human Resources	The only identified policy took place in March and referred to the Strategic Action "Brazil Against the Enemy" for students in health courses.
Surveillance	In April, mandatory registration procedures for hospitalizations of suspected and confirmed cases of COVID-19 were outlined and, in July, the mandatory notification to the MH of COVID-19 tests performed in the country were mandated.
Health of Indigenous Populations	The only policy identified was in early April with the creation of the Crisis Committee for planning, coordinating, implementing, supervising, and monitoring the Impacts of COVID-19 in the Health of Indigenous Peoples, and the Rapid Response Team within the scope of the Special Indigenous Health Districts.
Health in the Prison System	No policy was identified.
Health Education	No policy was identified.
Private Health Coverage	In March, May, and June regulations were enacted making it mandatory for private health plans to cover the costs of serological tests. However, a regulation guideline issued, in June 2020 removed this obligation from private health plans.

Source: HM Guidelines issued until the end of July

Regarding the policies and regulatory measures proposed by the Federal Government between March and August, roughly half of the regulations issued by the Ministry of Health, 131 from a total of 267, were targeted at enabling and deactivating ICU beds for COVID-19 and, as of May 21, authorizing the use of beds in small-scale hospitals (HPP in the Portuguese acronym) for long-term care of COVID-19 patients. In addition to the availability of beds for specialized care, the criteria for the creation of COVID-19 field hospitals were defined in June; even though many field hospitals have been operating since March 2020, some even reaching maximum occupancy in states such as Amazonas.

On the other hand, as shown in Table 3, there was no pandemic control policy measures for areas under the responsibility of the Federal Government, such as ensuring the health of people in the prison system and health education. Other issues were addressed through ordinances in April, but were discontinued. One example is the health policies concerning the indigenous population. A Crisis Committee created to plan, coordinate, implement, supervise, and monitor the impacts of COVID-19 within the scope of the Health of Indigenous Peoples was only created on April 2nd. After this date, we did not identify any policy or measure in the Ministry of Health addressed at protecting this population group.

We only found references to contact tracing and early diagnosis of infected individuals in the ordinances issued by the Ministry of Health in June, with the creation of the Community Reference and Service Centers for Tackling COVID-19. According to the guidelines, the role of these centers includes: (i) the "early identification of flu-like syndromes and severe acute respiratory syndromes, as well as individuals suspected of being infected with SARS-CoV-2"; (ii) assisting "patients who seek care with symptoms resembling the flu or COVID-19"; and (iii) carrying out "in-person assistance for cases that require triage assistance in Primary Care."

Thus, although Brazil had a structured primary care assistance network with approximately 280 thousand trained community health workers before the pandemic, the first policies to guide the use of primary care occurred as late as June, with the creation of these aforementioned centers. Moreover, the ordinances issued in June specified that all municipalities that adhere to the creation of the Community Reference and Service Centers for Tackling COVID-19 would no longer receive pandemic-fighting resources directed at basic health units.

The glaring flaws when managing the institutional health crisis, particularly the inconsistencies in mass testing, social distancing measures, and identifying infected or potentially infected individuals, were followed by a series of economic measures subsidizing companies, favoring employment, and creating emergency assistance programs. Measures that required an immense fiscal effort from an already underperforming economy struggling to overcome a recession that began in 2014.

Testing and Contact Tracing: Federal Policies

At the beginning of the pandemic, Brazil's COVID-19 testing capacity was limited and highly concentrated in the state of São Paulo and Fiocruz laboratories. Data from the Adolfo Lutz Institute indicate that its laboratories processed 400 tests/day in March, while the laboratory of the Albert Einstein Hospital processed 300 tests/day.[11] As a reference comparison, within the same period, the USA performed an average of 80 thousand tests per day and Germany over 50 thousand.

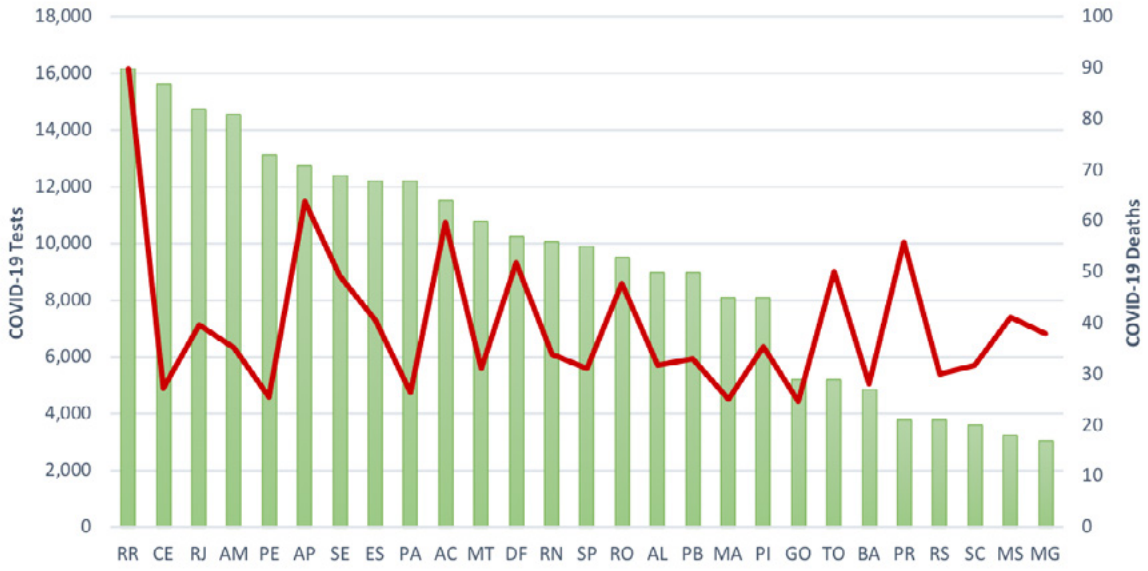
According to data reported on the "Testing Dashboard" platform, updated by the Ministry of Health, the Federal Government had provided 13,206,188 tests across the country up until 08/07, which were distributed in 5,348,948 RT-PCR (40.5%) and 7,857,240 rapid serological tests (59.5%). Although we did not identify any action plan for COVID-19 testing, as shown in Table 3, the Federal Government has favored the use of rapid tests over RT-PCR testing, considered a gold standard for COVID-19 diagnosis both by the WHO and the United States Center for Disease Control (CDC).

Upon analyzing the low priority of RT-PCR testing, we did not identify the criteria adopted for the distribution of tests among states. As shown in Figure 1, the states that received the highest number of tests per 100 thousand inhabitants were not necessarily those with a more severe level of severity in the pandemic. One example of this lack of criteria is the states of Amazonas and Ceará, which had the highest number of COVID-19 deaths per 100 thousand inhabitants and did not appear among the states that received a higher number of tests from the Federal Government. On the other hand, the southern states were among those that received a higher number of tests per 100 thousand

11 The testing data from the Albert Einstein Hospital was confirmed by Cristóvão Luis P. Mangueira. For a report on the beginning of the pandemic, see http://www.ial.sp.gov.br/resources/insituto-adolfo-lutz/publicacoes/atuacao_ial_covid-19.pdf.pdf.

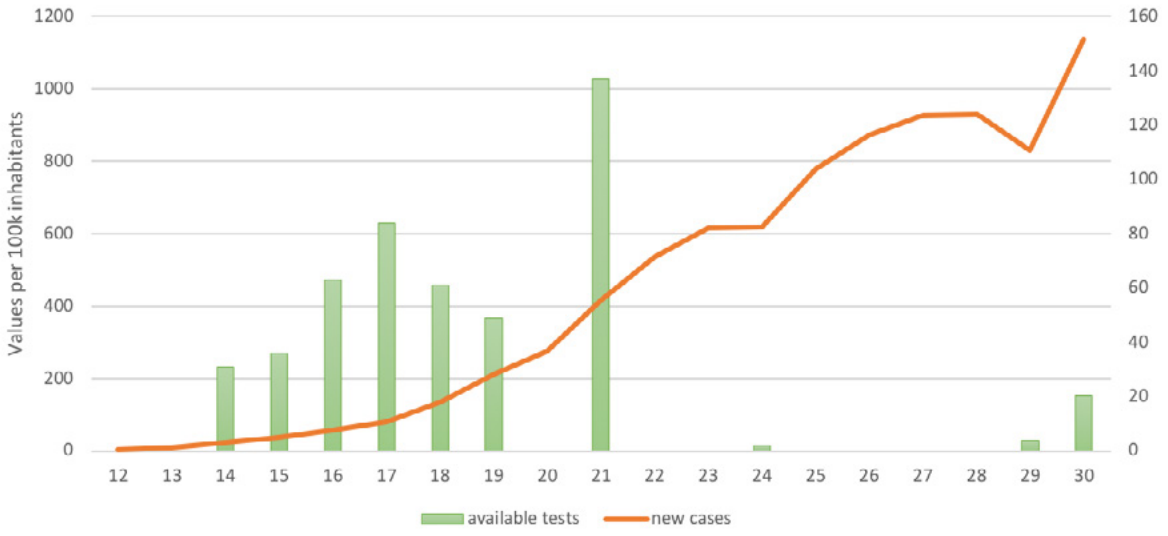
inhabitants, even though they registered a lower death rate per 100 thousand inhabitants. An analysis of the distribution of COVID-19 tests over time also allows us to confirm that tests were not provided according to the evolution of the pandemic, since the majority of tests were provided between epidemiological weeks 14 and 21, even though the number of cases has increased since that week (Figure 2).

Figure 1 - Provision of RT-PCR and Rapid Tests by the Federal Government to states and the number of deaths per 100 thousand inhabitants.



Source: https://viz.saude.gov.br/extensions/DEMAS_C19Insumos_TESTES/DEMAS_C19Insumos_TESTES.html, inquired on 08/09/2020.

Figure 2 - Amount of COVID-19 tests provided by the Federal Government and positivity rate per 100 thousand inhabitants between epidemiological weeks 11 and 30.



Source: https://viz.saude.gov.br/extensions/DEMAS_C19Insumos_TESTES/DEMAS_C19Insumos_TESTES.html, inquired on 08/09/2020.

There is a vast disparity between the expansion of the pandemic and the provision of tests. The Federal Government has not implemented any structured policy for controlling the pandemic through mass testing nor for identifying and quarantining infected individuals and tracing their contacts. Furthermore, the positivity rate of tests performed in Brazil, 33% (Table 2), associated with the preference for rapid tests over RT-PCR tests (Figure 1), represents one of the main bottlenecks in controlling the pandemic, and further distances Brazil from the successful experiences of countries such as South Korea, Taiwan, and Germany.

The Federal Government Strived to Weaken Social Distancing Measures in States and Municipalities

After the President delegated the responsibility to states and municipalities for defining which measures would be implemented to intensify social distancing in their territories (March 20), the Federal Government interfered at several levels to weaken the stringency levels of such measures, considered essential by the WHO for fighting the pandemic. Several previously published policy briefs issued by the Solidarity Research Network have shown that the Federal Government has systematically strived to limit the states' capacity to close commercial and service businesses and has undermined efforts to avoid crowding and, more recently, the mandatory use of masks.

Table 4 presents a comparison of the services and sectors deemed essential by the WHO and some of the services and sectors deemed essential in the three guidelines issued by the Federal Government during the pandemic.

Table 4 - Services deemed essential by the WHO, and Federal Measures to Expand Essential Services

WHO Essential Services	Essential Services in Decree 10282, dated March 20	New Essential Services in Decree 10292, dated March 25	New Essential Services of Decree 10329, dated April 28	New Essential Services in Decree 10344, dated May 8
Health professionals (e.g. doctors, nurses, social workers, etc.)	Health services	Generation, transmission and distribution of electricity,	Sale and maintenance of new and used parts and pieces, and new and refurbished tires;	Civil construction activities, obeying the determinations of the Ministry of Health;
Frontline professionals (e.g. police, law enforcement officers, ambulance drivers and crew, firefighters, etc.)	Social assistance and assistance to vulnerable people;	Labor inspection;	Radio and sound and image broadcasting services;	Industrial activities, obeying the determinations of the Ministry of Health;
Food Provision and Preparation	Public and private security activities	Pandemic-related research activities	Product and service development activities;	Beauty salons and barber shops, obeying the determinations of the Ministry of Health; and
Funeral Services	Intercity, interstate, and international passenger transport	Judicial and extrajudicial representation activities	Trade activities in goods and services;	Sports gyms of all kinds, obeying the determinations of the Ministry of Health.
Pharmacists	Telecommunications and internet;	Religious activities of any kind	Benefit processing activities;	
Government and public service agents	Call center services;	Lottery houses.	Vehicle rental activities;	
Sanitary Services	Collection and treatment of water, sewage, and waste;		Maintenance of escalators and elevators;	

WHO Essential Services	Essential Services in Decree 10282, dated March 20	New Essential Services in Decree 10292, dated March 25	New Essential Services of Decree 10329, dated April 28	New Essential Services in Decree 10344, dated May 8
Supervisors or managers of professional and/or volunteer teams	Generation, transmission and distribution of electricity and gas;		Chemical and petrochemical industries;	
Support of loved ones and vulnerable people in the community	Production, distribution, sale, and delivery of health, hygiene, food, and beverage products;		Steel process activities that cannot be interrupted;	
	Funeral services;		Activities involving mineral goods;	
	Bank services;		In-person customer service at bank branches.	
	Postal services;			
	Transport and delivery of general cargo;			
	Production, distribution, and sale of fuels and derivatives;			
	Capital and insurance markets.			

Source: Barberia, et al, 2020[12]

The Federal Government defined which commercial and industrial establishments could continue to operate and did not issue a decree to interrupt commercial activities. In March, while it delegated the definition of social distancing measures to states, the Government prepared a list of services considered essential (Decree 10.282). Contrary to the legislation enacted in the states, aligned with WHO priorities, the first federal guidelines ensured the continuity of lottery houses, telemarketing, and other sectors far from what can be considered essential (Decree #10.282 and Decree #10.292 March 25).

To further relax social distancing measures in these states, the Government also considered religious activities of any nature to be essential (Decree #10.292 on March 25). At the end of April, the President signed a new decree (#10.329 on April 28) and included vehicle rentals, maintenance of escalators and elevators, in-person services at bank branches, and the operation of general commercial and service businesses among essential activities. On May 8, the pandemic had already spread across the entire country as the nation registered 145,328 cases and 9,897 deaths. Nevertheless, the Federal Government authorized activities such as beauty salons, barbershops, and sports gyms (Decree # 10.344).

The political and social cost of this competition was high, particularly in the issuing of inconsistent guidelines and the generation of widespread confusion among the population. These actions by the Federal Government created a conflicting atmosphere with state governors, who adopted stricter measures to suspend non-essential activities, as in Rio de Janeiro and São Paulo.

The presidency's strife against elementary strategies to combat the virus went as far as his questioning of the mandatory use of masks, internationally acknowledged as a basic protection equipment. Figure 3 confirms that since April, governors have followed the recommendations of global health authorities

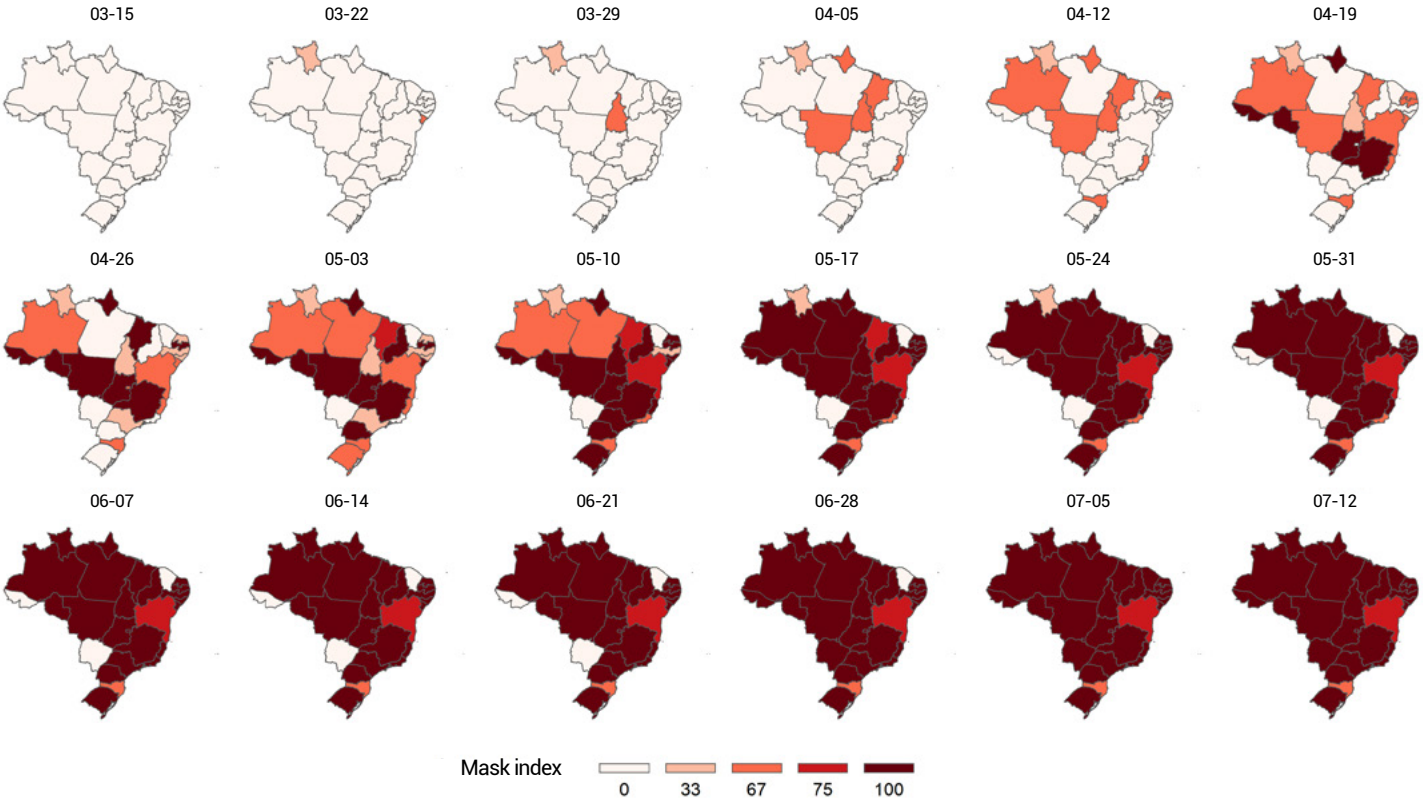
12 Barberia, Lorena G. , Natália de Paula Moreira, Anna Paula Ferrari Matos, Luiz Cantarelli, Maria Leticia Claro, Isabel Seelaender Costa Rosa, Pedro de Santana Schmalz, Marcela Zamudio, Paulo Agabo & Dara Aparecida (2020). COVID-19 Government Response Tracker for the Brazilian Federation (CGRT-BRFED). SP, USP.

and adopted measures to make mask use mandatory. In July, the confusion became blatant within the Government itself upon enacting Law No. 14019, which requires the use of masks "for moving in public spaces as well as private spaces accessible to the public, on public roads, and public transport." However, the Law received numerous presidential vetoes, among which the removal of restrictions on the mandatory use of masks in "commercial and industrial establishments, religious temples, educational establishments, and other closed environments with gatherings of people."

The President also disputed the mandatory use and distribution of masks by establishments that continued to operate during the pandemic and prohibited the expelling or barring of customers without a mask.[13] Finally, the President also vetoed the Federal Government's obligation to run "public interest ad campaigns to inform the need for the use of individual protection masks, as well as instructing on their correct use and disposal in compliance with the recommendation by the Ministry of Health".

The presidential vetoes represented a decisive attack on one of the most fundamental and provenly effective policies adopted by countries afflicted by the pandemic. One of the President's vetoes was eventually overturned by the Supreme Federal Court Minister, Gilmar Mendes[14], who ruled in favor of the mandatory use of masks in prison units.

Figure 3 - Stringency Index for Mandatory Use of Masks in Public Settings



Source: CGRT-BRFED

14 "STF - MC ADPF: 714 DF - DISTRITO FEDERAL 0097644-53.2020.1.00.0000, Relator: Min. GILMAR MENDES, Data de Julgamento: 03/08/2020, Data de Publicação: DJe-194 05/08/2020".

The President's actions during the pandemic were disjointed and sought to reverse social distancing measures for containing the COVID-19 crisis. The Government's track record has been guided by the lack of legislation on fundamental issues, an adversarial attitude towards governors, and the trivialization of the population's protection. The President pitted the economy against health, while ignoring the preserving of lives as a public policy priority and that the only path for saving the economy is by controlling the pandemic.

Lack of Coordination as a Political Strategy

Statements by the President, the Minister of Economy, and leading Health authorities have unequivocally distanced themselves from the WHO since the outset of the pandemic. From 113 quotes that the Solidarity Research Network extracted from major national press outlets, 88 are from the President, 13 from former Minister Luiz Henrique Mandetta, 2 from former Minister Nelson Teich, 5 from the interim Minister of Health, Eduardo Pazuello, and 5 from the Minister in charge of the economy, Paulo Guedes.

Practically all statements reveal a lack of allusions to a combat strategy against COVID-19, opposition to social distancing policies, and neglect or downplay of the gravity of the pandemic.

On April 15, just over a month after the WHO raised COVID-19 to pandemic status, the Supreme Federal Court (STF) endorsed Minister Marco Aurélio's injunction addressing the jurisdiction of states and municipalities for taking actions to contain the pandemic[15].

The Federal Court's unanimous understanding was that all federal entities could decide upon measures such as isolation, quarantine, and the definition of essential activities, and the Federal Union must respect the measures decreed by states and municipalities. This decision, like others that followed[16], reiterated the constitutional responsibility of the Union in health-related matters and emphasized its role in coordinating actions.

Despite being abundantly clear, the President exhaustively repeated that the STF removed from the Union the responsibility for combating the pandemic, delegating it to states and municipalities.

A coordinated action between the Union, states, and municipalities is the only way to ensure the effectiveness of public health policies – whether in vaccination campaigns, control of chronic diseases, or the expansion of viral contamination. Over the past few decades, both the control of communicable diseases (pertussis, diphtheria, polio, measles, and neonatal tetanus and H1N1) were successful precisely due to the universalization and decentralization of the UHS activities, especially in health care, by way of coordinated efforts.

15 Amends Law No. 13.979, dated February 6, 2020, which "Provides for measures to address the public health emergency, of international importance, resulting from the coronavirus responsible for the 2019 outbreak". "Provides [among other determinations], on an exceptional and temporary basis, restrictions by highways, ports, or airports for entering and leaving the country and interstate and intercity transportation. Attributes to the President of the Republic the competence to define, by decree, about essential public services".

16 Namely: Direct Action of Unconstitutionality (ADI in the Portuguese Acronym) 6341 and 6343, in addition to the Statement of Noncompliance with Fundamental Precept (ADPF in the Portuguese acronym) 672 (not yet concluded).

There is still time to control the pandemic and prevent further unnecessary deaths

The first step, albeit difficult, is a shift by the Federal Government to coordinate efforts for combating the pandemic effectively. The country would gain further cohesion, quality of information would increase, and more precise guidelines would facilitate awareness-raising, and even financial costs would tend to decrease.

Signs that the situation with the coronavirus may be stabilizing in some regions should not result in relaxed protective measures, as the level of the pandemic remains exceptionally high. As shown in our previous policy briefs by the Solidary Research Network, when we associate infection cases to severe acute respiratory failure (SRAG) there is no clearly defined downward trend. Hence, public managers and authorities must remain attentive and ready to:

- Effectively conduct mass testing, primarily because of the debate on reopening schools.
- Increase the Federal Government allocated resources for RT-PCR testing, especially in states lacking the necessary structure and equipment to perform this type of testing.
- Invest in surveillance strategies, such as tracing, identifying, and quarantining infected individuals and their contacts. Community health agents are an excellent support point for actions of this nature.
- Launch awareness-raising campaigns clarifying the need for protective measures, such as the use of masks and social distancing.
- Cease declarations by public authorities minimizing the seriousness of the COVID-19 pandemic and which try, artificially, to induce the population that the worst is over. The erroneous perception that the country is undergoing a declining moment in the epidemic masks the reality of the numbers, which suggest an increase in deaths if the same isolation levels continue, which currently ranges from 40% to 50%.
- Legislation changes to match the list of essential services and mandatory use of masks with the guidelines of the WHO and the Pan American Health Organization.
- Establish a dialogue with the academic community and civil society entities on how to monitor the pandemic in vulnerable populations, such as indigenous communities and the prison system population. Special measures are necessary to reduce exposure to the virus, ensure mass testing, isolation, and medical treatment of suspected and confirmed cases.
- Special attention must be given to indigenous peoples, who endure the tragedy of infection with the increased invasion of their lands by loggers, miners, and land grabbers. The Government's negligence has reached a point where the infection has spread to native communities through infected health workers. The critical situation calls for urgent measures to prevent extermination by neglect.
- Provide transparency and disclose data on the evolution of the pandemic in real-time, including the incidence of the moving average of new daily cases separately identified by RT-PCR and serological tests at the national level.

With this policy brief, the Solidarity Research Network takes another step forward in building an effective interdisciplinarity research program. We wish to thank the participation of all researchers involved in this research.

ABOUT

We are over 70 researchers, actively engaged in the task of improving the quality of public policies within federal, state, and municipal governments as they seek to act amidst the Covid-19 crisis to save lives. We dedicate our energies towards rigorous data collection, devising substantial information, formulating indicators, and elaborating models and analyses to monitor and identify pathways for public policies and review the responses presented by the population.

The Solidary Research Network has researchers from all scientific fields (Humanities as well as Exact and Biological Sciences) in Brazil and overseas. For us, the combination of skills and techniques is vital as we face the current pandemic. The challenge ahead is enormous, but it is particularly invigorating. And it would never have come to fruition if it weren't for the generous contribution of private institutions and donors who swiftly answered our calls. We are profoundly grateful to all those who support us.

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