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Heroes on Strike: Trends in Global Health Worker Protests During COVID-19

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Summary

This *Accountability Note* describes global trends in health worker protests between March 11, 2020 and March 10, 2021.¹ We argue that the frequent characterization of health workers as heroes of the pandemic obscures the fact that health workers themselves describe the challenges they face during this time as violations of their *rights as workers*, highlighting the obligations of their employers to provide working conditions and remuneration that justify the risk they assume.

Using data from the Armed Conflict Location & Event Data (ACLED) Project, we first provide a global overview of the growth in health worker protest activity in the March 2020–2021 period as compared to the March 2019–2020 period. Health workers engaged in protest activity with greater frequency during the first year of the pandemic than during the prior year. The eighty-five countries included in the ACLED data set in both the March 2019–2020 period and the March 2020–2021 period experienced a sixty-two percent increase in health worker protest activity (from 2416 protests to 3913 protests). We then provide an overview of the content of the 6589 health worker protests in the ACLED dataset between March 2020 and March 2021, describing protests in 149 countries in terms of five categories: working conditions and remuneration, resources, health system delivery issues, public policy, and other. By far, the largest category of protests during this period are those related to working conditions and remuneration. Approximately sixty-six percent (N=4358) of global protests in the 2020–2021 period expressed health worker dissatisfaction about issues such as: occupational hazards, unpaid wages, risk allowances and job security. Surprisingly, personal protective equipment (PPE) concerns—an issue covered frequently in the media—motivated a relatively low percentage of the protests (less than nine percent). We note this not to downplay the gravity of global PPE shortages, but to situate PPE shortages as one among many health worker concerns during the pandemic. Protests initiated by health workers about health system delivery issues provide an important reminder that even in the middle of a pandemic, not everything was about COVID-19. Sixty-two percent of the health system-related protests during the 2020–2021 period were about issues that were not coded as directly related to the COVID-19 pandemic. Similarly, the vast majority of health workers’ protests around public policy were not about pandemic-related government policy, but about social issues like climate change, immigration, police brutality, and elections.

The aim of this analysis is to understand what health workers advocated for during a time of immense pressure, and to identify some broad areas of concern for health sector accountability. Through this analysis, we prepare the groundwork for future research and action, and share preliminary guidance regarding how health sector stakeholders—including government, health worker associations, unions, and civil society—might develop improved systems of accountability.

Introduction

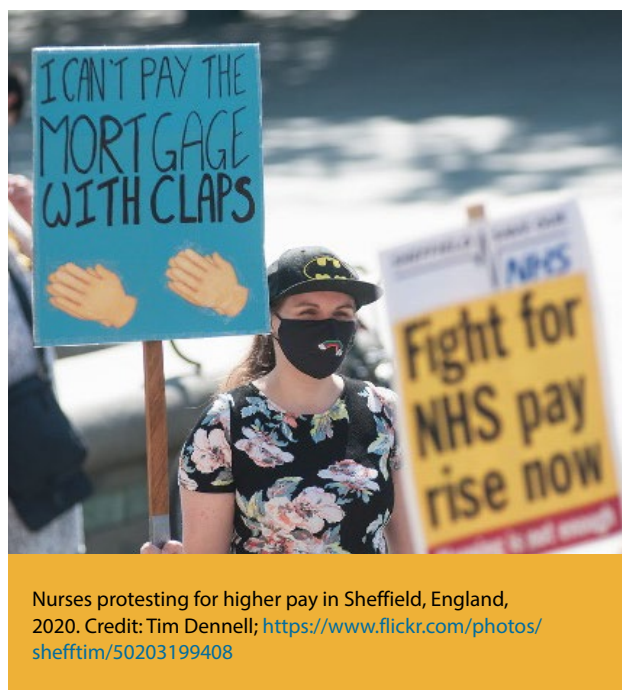
The COVID-19 pandemic has placed extraordinary levels of pressure on health workers at the forefront of the response (Khanal et al. 2020; Mukherjee and Parashar 2020). They have faced myriad challenges, including high workloads, resource constraints, evolving treatment guidelines, the lack of personal and workplace protections, burnout, and violence (Ballard et al. 2020; Devi 2020; Shoja et al. 2020). Their endurance in the face of these enormous challenges has resulted in them being widely referred to by terms such as ‘heroes’ and ‘warriors.’

However, health workers need more than to be acknowledged for their heroics. Throughout the pandemic, health workers around the world have been vocal about their frustrations regarding inadequate resourcing and the underlying system conditions that negatively impact their ability to do their job. These concerns have been expressed through a variety of platforms—such as news coverage and social media—but one of the most powerful tools has been the use of protests. Analysts have noted a large number of protests in 2020 around the world (Johnson 2020). The [Health Worker Protests and Proposals Project](#) from the Accountability Research Center at American University collected over 830 reports of health worker protests and proposals from 96 countries between May 2020 and October 2020. The Partnership for Evidence-Based Response to COVID-19 (PERC) reported nearly 300 health worker protests on the African continent between March and August 2020. These figures suggest a mounting sense of discontent from health workers globally about both their immediate work context and macro-level policy decisions. The frustrations felt by health workers point to serious challenges in health policy and systems globally that have implications not only for COVID-19 and future health emergencies, but health service delivery and access to care more broadly. Health worker discontent is likely to be exacerbated by—and presumably will exacerbate—the projected shortfall of 18 million health workers by 2030 (World Health Organization 2016).

In May 2021, a team of researchers from the University of British Columbia, Columbia University, and the University of Chicago began a systematic examination of health worker protests globally. Using data from the Armed Conflict Location & Event Data (ACLED) Project, we set out to answer the following questions:

1. Between March 2020 and March 2021, what were the total number of health worker protests, and how were those protests distributed temporally and geographically?
2. For countries with data from March 2019 to March 2021, how did the frequency and distribution of protests change?
3. Between March 2020 and March 2021, what policy demands did health workers express through protest?

The goal of this brief is to present a picture of global health worker protests from March 11, 2020 (the date that the WHO declared COVID-19 a global pandemic) to March 10, 2021. We focus on the number of events, their



locations, and the policy demands that formed the basis of the protests. The broader aim of this analysis is to understand what health workers advocated for during a time of immense pressure, and to also shed light on the failures in accountability in health sector governance leading to or exacerbating these issues. Through this analysis, we seek to prepare the groundwork for future research and action, and to share preliminary guidance regarding how stakeholders—government, associations, unions and civil society—might develop improved systems of accountability in the health sector.

What do we know about health worker protests?

The term *protest* captures an array of actions wherein social groups express disapproval. Protests may range from actions taken by individuals to large gatherings (i.e., rallies, sit-ins, marches, etc.) to actions organized by unions or other bodies, such as strikes or boycotts (Lofland 2017).

In the last decade, media reports and some published research suggest a growing frequency in the number of health worker protests (Hardy et al. 2015; Koon 2021; Khan 2011; Polak, Wagner, and Świątkiewicz-Mośny 2020). One study investigating health worker strikes in low-income countries between 2009 and 2019 found that strikes in these contexts have become more frequent in recent years (Russo et al. 2019). It is unclear if the uptick in reports reflect a measurable increase of protests, or if researchers and the media are paying more attention to these issues. Nevertheless, it is likely that health workers are more publicly vocalizing their demands. The driving factors behind a *potential* increase in protests could include persistent human resource challenges (i.e., salary delays, etc.) and poor working conditions, pay gaps within and between occupational groups and cadres, limited systemic options for mediation and arbitration of health workers' concerns, innovations in organizing technologies (i.e., instant messaging and social media), and vocal involvement of health worker groups in contemporary political and social issues. However, there has yet to be a systematic assessment that tracks health worker protests globally. This is a major gap in our understanding of health workforce policy processes, of accountability structures in national and subnational health policy, and in the interactions between health workers, social movements and public policy.

COVID-19 has seemingly accelerated the frequency of health worker protests. In a recent analysis of unrest in the United States from February 2020 to February 2021, ACLED researchers noted a sizable spread of health worker protests in the United States to thirty-eight states and the District of Columbia (ACLED 2021). These events appear to be correlated with COVID-19 transmission spikes or infection waves, as health workers voiced concerns about issues such as inadequate personal protective equipment (PPE) and burnout caused by understaffing. The Health Worker Protests and Proposals Project from the Accountability Research Center provided a global lens on the issue through their analysis of health worker protests from eighty-four countries (Johnson 2020). This analysis noted that health workers in many countries face additional threats of arrest or assault for carrying out protests, in addition to harassment and sometimes violence. Media reports of protests by health workers closest to communities—largely women of low socioeconomic status—indicate a growing frustration from members of these occupational groups with the immense workload during the pandemic without adequate remuneration and decent working conditions.

As the pandemic evolves globally, anecdotal evidence suggests diversifying reasons for protests reflecting particular health and social contexts, including vaccinations (both demands *for* vaccines and *against* vaccine mandates) and for social and political reasons, such as anti-coup protests in Myanmar and #WhiteCoats4BlackLives in the United States.

Methodology

The analysis presented here draws on the ACLED Project. ACLED collects data about reported political violence and protest events in 149 countries.² We made use of the curated data file “Disorder Involving Health Workers,” and then further delimited this data to only include protest events in the year following March 11, 2020—the date that the World Health Organization declared a global pandemic. ACLED defines health workers as “all civilians who engage in actions with the primary goal of providing health services to a community” (doctors, nurses, community health workers, vaccinators, etc.)³ and protests as “non-violent demonstrations, involving typically unorganized action by members of society.” We do note that our analysis suggests that protest activity captured by ACLED includes examples of both organized and unorganized protest action.

In order to investigate whether there was an increase in protests in the 2020–2021 period, we first compared the eighty-five countries that were included in the ACLED data set in both the 2020–2021 period and the year prior (March 11, 2019–March 10, 2020). We then proceeded to investigate the content of health worker protests in the 2020–2021 period. The ACLED Disorder Involving Health Workers file includes detailed information about the locations and actors involved in protests but does not provide variables specifying the reasons for protests. For this, we made use of the qualitative component of the data—the ‘notes’ provided by data set coders for each protest, which provided a short summary of the protest events. Our research team used these notes to isolate the issues that health workers were protesting in each of these events and then, through an iterative process, refined the reasons into first nine and then five different categorical variables for analysis (described in Figure 4 below).



Nurse in Niger after screening patients for COVID, 2020. Credit: Anna Psiaki; [Wikimedia Commons](#).

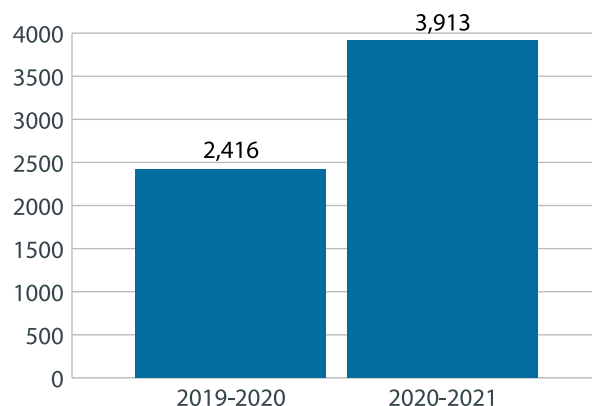
Analysis

GLOBAL OVERVIEW

The COVID-19 pandemic has increased protest activity of health workers around the globe. In sum, the 85 countries included in the ACLED data set in both the 2019–2020 period and the 2020–2021 period experienced a sixty-two percent increase in health worker protest activity (from 2416 protests to 3913 protests).

At the country level, the percent increase was considerable. Below, we show the percent change in protests for the countries with the highest number of protests in 2019. All but a very few countries experienced a large increase in total number of protests, with some countries—such as Mexico, Argentina, Peru, Algeria, and Kazakhstan—experiencing a particularly steep increase.

Figure 1. Total number of protests in 2019–2020 and 2020–2021



Source: Authors' analysis of ACLED data (<https://acleddata.com/#/dashboard>)

Figure 2. Country rankings for number of protests, 2019–2021

RANKING (#)	2019–2020	2020–2021	RANKING (#)	% CHANGE
#1 (479)	India	India	#1 (431)	-10.02%
#2 (281)	Pakistan	Pakistan	#2 (392)	39.50%
#3 (133)	Venezuela	Mexico	#3 (391)	344.32%
#4 (133)	Chile	Argentina	#4 (300)	368.75%
#5 (109)	South Korea	Venezuela	#5 (165)	24.06%
#6 (105)	Brazil	Peru	#6 (163)	56.73%
#7 (99)	Honduras	Brazil	#7 (163)	918.75%
#8 (88)	Mexico	Morocco	#8 (154)	123.19%
#9 (69)	Morocco	Tunisia	#9 (148)	169.09%
#10 (64)	Argentina	South Korea	#10 (137)	25.69%
#11 (55)	Tunisia	Honduras	#11 (56)	-43.43%
#12 (16)	Peru	Chile	#12 (54)	-52.21%

Source: Authors' analysis of ACLED data (<https://acleddata.com/#/dashboard>)

Figure 3. Percent change of the number of protests

Country	2019–2020	2020–2021	Percent change
India	479	431	-10.0%
Pakistan	281	392	39.5%
Mexico	88	391	344.3%
Argentina	64	300	368.8%
Venezuela	133	165	24.1%
Peru	16	163	918.8%
Brazil	104	163	56.7%
Morocco	69	154	123.2%
Tunisia	55	148	169.1%
South Korea	109	137	25.7%
Algeria	24	124	416.7%
Turkey	57	116	103.5%
Iran	43	84	95.3%
Paraguay	19	73	284.2%
Iraq	28	69	146.4%
South Africa	18	67	272.2%
Honduras	99	56	-43.4%
Bolivia	35	56	60.0%
Chile	113	54	-52.2%
Kazakhstan	5	51	920.0%
Romania	13	49	276.9%
Colombia	15	44	193.3%
Greece	24	43	79.2%
Ecuador	10	43	330.0%
Panama	7	40	471.4%
Yemen	13	38	192.3%
Ukraine	16	34	112.5%
Japan	12	31	158.3%

Source: Authors' analysis of ACLED data (<https://acleddata.com/#/dashboard>)

Though there were considerable overall increases in the number of protests globally, it is important to attend to differences in the percentage change of protests in different countries during the pandemic. For instance, as indicated by looking at the countries with the greatest number of protests in 2019–2020 and 2020–2021, there are both countries where there were relatively few protests in 2019–2020 but a large number in 2020–2021 (such as Peru and Kazakhstan), as well as countries where there were a large number of protests in both the 2019–2020 and 2020–2021 periods (such as India and Pakistan).

One significant limitation of this data is the lack of comparability across all countries between the 2019–2020 and 2020–2021 period. The ACLED dataset considerably increased its country coverage in January 2020. This means that while we were able to include 149 countries in our assessment for 2020–2021 (6589 protests), we only have comparable data for 2019–2020 for eighty-five countries (See [here](#) for a list of ACLED country and time period coverage for the data used in this accountability note). Several of the countries that we hypothesize might have had the greatest percentage increase in protest activity between the 2019–2020 and 2020–2021 period (for instance, the United States) were not included in the ACLED dataset until 2020. Still, even without the evidence of these countries, it is clear that:

1. Health workers engaged in protest activity with greater frequency during the pandemic than during the prior year.
2. There is considerable variation in the percentage change of health worker protests at the country level during the pandemic.

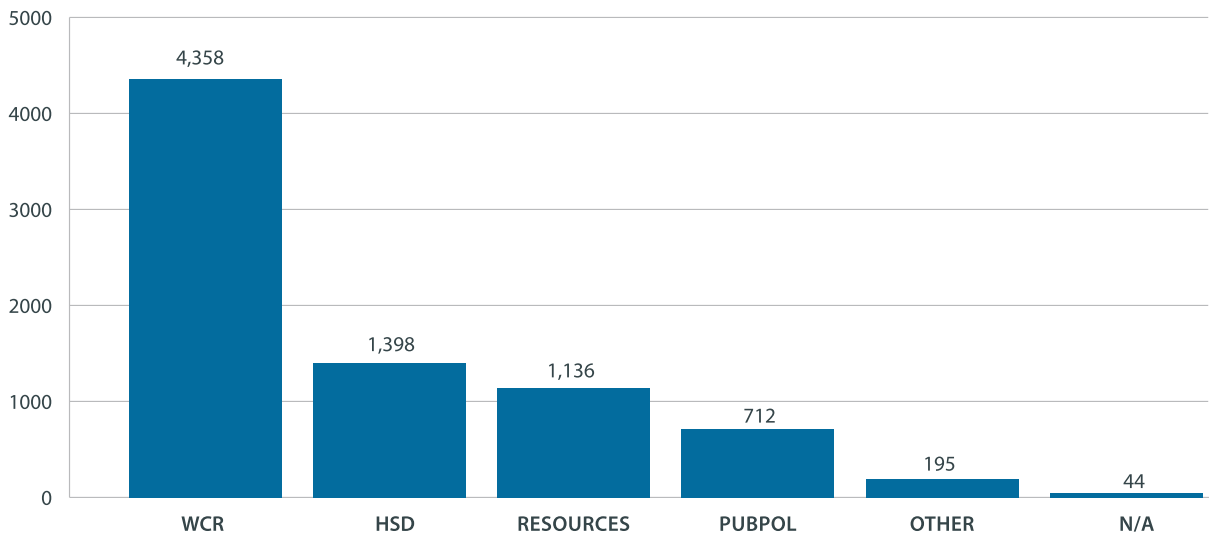
This indicates how important it is not to tell a monolithic story about the relationship between the pandemic and health worker protest activity. The differences in the protest levels between 2019–2020 and 2020–2021 indicate a number of different questions that might be pursued in future research. For countries that have a considerable increase in protests between these two periods, we might consider whether the pandemic served to catalyze a shift in how health workers articulate dissatisfaction. To what extent is protest consonant with how health workers in a given country have historically articulated dissatisfaction? Is this a trend we can expect to continue? Under what conditions? What conclusions might we draw about how factors such as: existing social movement strategies, protest culture, health worker status, and health system infrastructure influence how health workers articulate discontent?

POLICY DEMANDS

The 6589 health worker protests between March 11, 2020 and March 10, 2021 can be broken down into protests about the following topics: working conditions & remuneration (4358), health system delivery (1398), resources (1136), public policy (712), and other (195).⁴

Figure 4: Number of protests by protest reasons

Of the 6589 protests between 2020–2021, about half (3213) are explicitly COVID-19 related.⁵ Health worker protests in each of the five categories include both pandemic-specific concerns as well as issues that pre-date the pandemic (for instance, health system infrastructure problems, contract negotiations, etc.).



WORKING CONDITIONS & REMUNERATION (WCR)

Protests regarding worker protections, worker safety, job security, contract disputes, understaffing, living supports, supervision, discrimination against workers, remuneration (delayed, insufficient and reduced pay, risk allowances), and benefits.

HEALTH SYSTEM DELIVERY (HSD)

Protests about health services and system problems, including finance allocation (spending and investment in the health system); access and quality of services for the public (availability of care, services in rural or marginalized areas, health disparities, etc.), and health system organization (planning and management).

RESOURCES

Protests regarding material supplies, such as personal protective equipment (PPE), medical supplies, water, gasoline, beds, etc.

BROADER PUBLIC POLICY

Protests about government policies that do not meet the above definition of health systems delivery issues (including pandemic-related border closures, mandatory quarantines, etc.), public behavior, and social issues (climate change, police brutality, elections, immigration, etc.). This category highlights the multiple self-identifications of health workers (for example, as both “professionals” and “citizens”).

OTHER

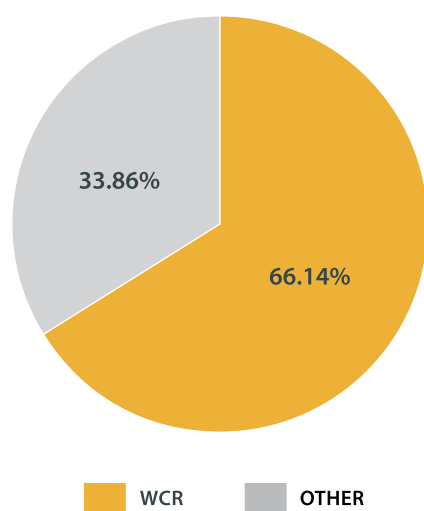
Protests held in solidarity with other health workers, or protests demanding respect or recognition from employers, government or the public.

Source: Authors’ analysis of ACLED data (<https://acleddata.com/#/dashboard>)

Working Conditions & Remuneration

Working Conditions and Remuneration is by far the largest category of protests during this period, with approximately sixty-six percent (N=4358) of global protests in the 2020–2021 period expressing health worker dissatisfaction about issues such as: occupational hazards, unpaid wages, risk allowances and job security.

Figure 5: Proportion of protests about WCR



Source: Authors' analysis of ACLED data (<https://acleddata.com/#/dashboard>)

This finding is significant in part because it diverges from the most publicized hardships of the pandemic for health workers. International news outlets have given considerable [attention to the plight of health workers during the pandemic](#), and have [advanced a narrative about them being 'heroes'](#), describing their tireless work to fight the pandemic in spite of often inadequate resources. Our data indicates that health workers themselves primarily articulate frustrations about hardships during the pandemic in terms of their rights as workers, and in terms of the obligations of their employers to provide working conditions and remuneration that justify the risk they assume. This is an important corrective to the hero narrative because a focus on health workers' presumed character/altruism can disguise the financial obligations and workplace protections that health workers themselves see as connected to the risk and hardship of their jobs.

The concerns articulated by health workers about working conditions and remuneration during this period include both concerns that are explicitly related to the pandemic (such as risk allowances for exposure to COVID-19), as well as those that are not identified as specifically related to the pandemic (such as unpaid salaries). Approximately fifty-three percent of the protests about working conditions and remuneration during this period were COVID-related.

Given the size of this category, there is considerable diversity regarding the working conditions and remuneration concerns of health workers. We initially intended to disaggregate working conditions from remuneration issues in order to provide more detail about these subcategories. However, we have presented them together here because it became apparent while coding the dataset that health workers perceived these concerns as interrelated and it was often difficult to differentiate between the two. For instance, one common protest demand was that of risk pay. In these protests, health workers pointed out dangerous working conditions while also claiming that these conditions should result in additional remuneration. Several other issues—particularly those related to benefits—also fell in the gray area between working conditions and remuneration. Another issue that we do not explore here, but intend to pursue in future research is the differences in the degree of precarity of the workers engaged in protest. For instance, there are considerable differences between demands for additional pay and demands for unpaid wages. There are also considerable differences in the salaries, benefits, and statuses of workers who are protesting.

Resources

News outlets around the world have brought attention to the exposure risks of health workers due to [inadequate protective equipment](#). The lack of proper protective gear has proven a hazard for health workers in [both high and low-income countries](#). However, surprisingly, PPE concerns motivated a relatively low percentage of the protests in our data set—less than nine percent. We note this not to downplay the gravity of global PPE shortages, but to situate PPE shortages as one among many health worker concerns during the pandemic.

While there were 561 protests about PPE during the 2020–2021 period, it is also important to highlight that protective gear is not the only resource shortage about which health workers protested. Approximately fifty three percent of resource-based protests were about resources other than PPE, including gasoline, water and medication. This is an important reminder about the ways that the pandemic created additional strain for already under resourced health systems.

Health System Delivery

Protests initiated by health workers about health system delivery issues provide an important reminder that even in the middle of a pandemic, not everything was about COVID-19. Sixty-two percent of the health system-related protests during the 2020–2021 period were about issues that were not coded as directly related to the COVID-19 pandemic. Even as health systems canceled many non-COVID-19 related procedures and appointments, health workers engaged in public protest to highlight broken aspects of health system infrastructure. These protests provide opportunities to investigate the relationship between the system shock of the pandemic and existing health infrastructure problems.

Broader Public Policy

Over the last two years, news outlets have chronicled the [participation of health workers in protests about social issues](#). In total, the health workers in this data set engaged in 712 protests about public policy issues. However, the vast majority of health workers' protests around public policy were not about pandemic-related government policy, but about social issues like climate change, immigration, police brutality and elections. Future studies might contrast health workers' attempts to impact public policy through protest with their already-documented work to influence public policy through other strategies (for instance, through professional association lobbying). How might these strategies differ based on the type of health worker articulating discontent? Under what conditions are health workers most likely to use protest as a means of impacting public policy?



Health workers in support of Black Lives Matter, Ohio, USA, 2020. Credit: Paul Becker; <https://www.flickr.com/photos/becker271/50094550253>

Future research directions

The findings presented in this Accountability Note lay the groundwork for several avenues of future research and analysis. Building an interdisciplinary, global knowledge base about health worker protests will aid in the identification, adoption, and implementation of policies to improve accountability.

There is a clear need for longitudinal data on the quantity and distribution of health worker protests. Future analyses should attempt to comprehensively identify health worker protests globally from previous years, and examine trends in temporal and geographic distribution. Analyzing the frequency of protest by different economic levels longitudinally could yield insights into the relationship between economic development and health worker discontent, and the ways in which COVID-19 has influenced those dynamics. Researchers might also identify particular contexts in which to examine additional sources of evidence beyond media reports, such as social media posts, professional association and union newsletters and primary accounts from health workers. Finally, longitudinal assessments might also examine diversity in forms of protest, such as those including self-harm (i.e., hunger strikes), protests resulting in intervention from authorities that do not cause injury or fatality, and protests involving excessive force from authorities that do cause injury or fatality.

The categories used in our analysis of protest demands consolidate sub-categories that could exist as independent categories. For example, the category on working conditions and remuneration consists of issues that range from poor living conditions to unpaid wages to demands for increased wages. Further, sub-categories such as remuneration might have disparate motivations underlying the protests. For example, a protest demanding unpaid wages in low- and middle-income countries is arguably a different type of demand from one that calls for increased wages in a high-income setting. Further research papers from our team will address these questions in greater depth.

Delving into the relationship between political systems, quantity of protests and policy demands will also yield important findings. Future research might analyze the relationship between health system characteristics, level of health system development, political environment and protest. How do protest demands differ by these dimensions? And what personal risks do health workers assume when vocalizing discontent in jurisdictions strongly opposed to protest? We also find that health workers engage in protests pertaining to issues of relevance outside the health sector, such as political, social or cultural issues. Investigating how health workers engage in public policy protest will be important for understanding how health workers are positioned in major political debates such as democratic movements and racial injustice, and also how they wield their power to influence policy on these issues. Specifically, understanding the ways in which health worker protests engage in 'boundary-spanning,' connecting their concerns to other labor and social movements will be an important area of future work.⁶

Researchers also need to account for the types of health workers conducting protests, to explain how these health workers are organized, and to assess variation in their policy demands and the type of protests undertaken. Do health workers in the public sector engage in protest activity more frequently than those employed in the private sector? Do physicians protest for shorter durations (due to their access to high-level decision makers) than, say, community health workers (who arguably have less access to decision makers and therefore fewer venues for mediation)? How do protests differ when unions and/or associations are involved? How do these groups work in coalition? What is the impact of protest on service delivery? It will also be important to examine the intersection of profession/occupation, gender, religion, caste, ethnicity and other factors in understanding the internal dynamics of protest organization and the response of state authorities to particular protests. In particular, recognizing that women comprise seventy percent of the health workforce, and describing the intersection of gender and protest by health workers will be an important future area of work.

Finally, a deeper investigation of specific protest events is also urgently required; few scholars have investigated the outcomes of policy processes involving health worker protests (see Polak et al. 2020; Koon 2021, Mishra, Sriram, and Elias 2021). In-depth, qualitative or mixed method analysis of individual or select protests are required to understand the ‘anatomy’ of protests—the social, political and historical context in which protests occur, how protests interact with other advocacy strategies from health worker groups, the nature of coalitions within and outside the health sector, the institutions in which policy processes unfold, and finally the factors influencing policy outcomes.



A health worker receives her first dose of Sinovac Biotech's Coronavac vaccine at the Ospital ng Malabon (Hospital of Malabon) in Metro Manila, 5 March 2021. Picture credit: International Monetary Fund/ Lisa Marie David. Used under CC BY-NC-ND 2.0 license.

Conclusions and Policy Recommendations

Our study on health worker protests between March 2020 and March 2021 led to the following findings:

- Health workers engaged in protest activity with greater frequency during the pandemic than during the prior year. The eighty-five countries included in the ACLED data set in both the March 2019–2020 period and the March 2020–2021 period experienced a sixty-two percent increase in health worker protest activity (from 2416 protests to 3913 protests).
- There is considerable variation in the percent change of health worker protests at the country level, with some countries experiencing steep increases in protests during this time period.
- By far, the largest category of protests during this period are protests related to working conditions and remuneration. Approximately sixty-six percent (N=4358) of global protests in the 2020–2021 period expressed health worker dissatisfaction about issues such as: occupational hazards, unpaid wages, risk allowances and job security.
- Surprisingly, PPE concerns motivated a relatively low percentage of the protests—less than nine percent. This finding helps situate the considerable public attention to PPE shortages in a wider context of health worker concerns.
- The vast majority of health workers' protests around public policy issues were *not* about pandemic-related government policy, but about social issues like climate change, immigration, police brutality and elections.
- The onset of a global pandemic has exacerbated persistent challenges and presented new concerns, while also energizing health workers to call attention to their demands. Our study has implications for policy, specifically that health workers need more than public expressions of solidarity—they require adequate and timely remuneration and benefits, decent working conditions, workplace protections, safety, and adequate resources to perform their roles. Decision-makers at local, provincial, national and global levels—and those working across sectors—should redouble their efforts to provide resources and protections to health workers at all times, including health emergencies such as COVID-19. Decision makers and other stakeholders must also consider improved accountability mechanisms for health workers to voice their policy demands, particularly for those cadres closest to communities that are overwhelmingly women, and often poorly remunerated. These efforts will help strengthen the health workforce, health sector governance, and health systems—during this current pandemic, and well beyond.

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Notes

1 Hereafter March 2020–March 2021.

2 ACLED uses four sources of event data: 1) traditional media at the subnational, national, regional and international level that are verified; 2) reports from international institutions, non-governmental organizations and on occasion, from actors involved in conflict; 3) local data from partner conflict observatories; 4) Targeted and verified new media sources (Twitter, Telegram, WhatsApp). ACLED also utilized several mechanisms to ensure continued monitoring of data sources and data quality. Details on ACLED's process are available [here](#).

3 The World Health Organization defines health workers as “all people engaged in actions whose primary intent is to enhance health” ([World Health Report, 2006](#))—[this definition overlaps significantly with the ACLED definition, and we anticipate that few occupational groups in the health sector would be excluded from the ACLED dataset as a result.](#)

4 Many protests concerned more than one topic, so topics do not sum to the total number of protests.

5 We define protests as “COVID-19 related” where the word ‘*coronavirus*’ is included in the ‘Notes’ column of the ACLED dataset. ACLED Researchers include this tag [only when an incident report explicitly states that the coronavirus motivated the event. This means that our “COVID-19 related” designation is conservative, as many of the incidents we describe are indirectly motivated by the pandemic.](#)

6 See Wang, Dan, Alessandro Piazza, and Sarah A. Soule. 2018. “Boundary-Spanning in Social Movements: Antecedents and Outcomes.” *Annual Review of Sociology* 44:167-187.

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