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DESDE 1902

**Universidade Nova de Lisboa**  
**Instituto de Higiene e Medicina Tropical**

Desenvolvimento e impacto do movimento grevista de médicos:  
estudo de caso da greve dos médicos moçambicanos de 2013

**Alexandre Lourenço Jaime Manguela**

**TESE PARA A OBTENÇÃO DO GRAU DE DOUTOR EM SAÚDE INTERNACIONAL**  
**ESPECIALIDADE EM POLÍTICAS DE SAÚDE E DESENVOLVIMENTO**

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moçambicanos de 2013**

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## ELEMENTOS BIBLIOGRÁFICOS

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## RESUMO

**Introdução:** Greve é uma paralisação individual ou coletiva, temporária, parcial ou total da atividade laboral pelos trabalhadores. A ocorrência de greves no sector da saúde têm sido uma preocupação frequente em todo mundo, dado seu impacto negativo na prestação de serviços e cuidados aos pacientes. A greve dos médicos e profissionais de saúde moçambicanos em 2013 é considerada por muitos o maior movimento grevista da história no país, que deixou marcas que até a data são razão de debate e controvérsia.

**Objetivo:** A presente tese tem como objetivo compreender as causas, estratégias e impacto percebido da greve dos médicos moçambicanos em 2013 na perspectiva dos principais atores envolvidos, fazendo uma retrospectiva de tudo o que aconteceu, incluindo os bastidores e momentos de tensão durante as negociações. Estes detalhes foram pouco abordados em estudos semelhantes e são importantes para um melhor entendimento e gestão deste tipo de movimento.

**Métodos:** Realizou-se um estudo de caso, de abordagem qualitativa fenomenológica, com base em entrevistas semiestruturadas dirigidas aos principais atores envolvidos no movimento grevista dos médicos moçambicanos em 2013 e análise de documentos (como correspondências, atas de reuniões, despachos, jornais) produzidos no âmbito deste movimento. A amostragem não probabilística em bola de neve foi utilizada para selecionar os participantes até atingir a saturação dos dados. As entrevistas foram transcritas e importadas para o Nvivo versão 12, e os dados foram analisados através de análise de conteúdo para identificar temas relacionados com as questões de investigação.

**Resultados:** O principal motivo das reivindicações foram salários considerados baixos e más condições de trabalho. Com a greve, o governo adotou uma série de medidas para manter os serviços mínimos de saúde, restringindo-os para casos urgentes, cancelando as consultas e cirurgias eletiva, e readaptou as funções do pessoal disponível. Para pôr fim à greve, o governo recorreu a mecanismo intimidatórios e punitivos, o que gerou muita tensão e revolta, com troca de acusações nas médias. Enquanto isso, os grevistas marchavam e exibiam cartazes nas ruas, e pediam intervenção de embaixadores e outras entidades influentes no país. Os pacientes viam seus cuidados adiados, o tempo nas filas de espera pelos cuidados de saúde aumentava, as farmácias ficavam sem medicamentos, e com os médicos não grevistas sobrecarregados (e em alguns casos, descontentes), os cuidados de saúde perdiam certa qualidade. A pós-graduação ficou suspensa e alguns grevistas foram suspensos, transferidos e aposentados à semelhança do que aconteceu em alguns países da África subsaariana.

**Conclusão:** A greve foi motivada por aspetos associados aos salários e às condições de trabalho. Algumas das abordagens adotadas distanciaram ainda mais as partes e atrasaram o consenso. A greve teve consequências negativas para todos, sobretudo para os doentes. Há necessidade de reflexão sobre o custo-benefício da greve no sector da saúde e nas formas de fazer greve num sector tão sensível quanto o da saúde. Este estudo fornece lições importantes para melhorar as estratégias de prevenção e gestão de greves no sector da saúde.

**Palavras chave:** médicos, trabalhadores de saúde, greve, Moçambique

## ABSTRACT

**Introduction:** A strike is an individual or collective, temporary, partial or total stoppage of labour activity by workers. The occurrence of strikes in the health sector has been a frequent concern around the world, given their negative impact on the provision of services and care to patients. The Mozambican doctors' strike of 2013 is considered by many to be the largest strike movement in the country's history, which left its mark and is still the subject of debate and controversy today.

**Objective:** This thesis aims to understand the causes, strategies and perceived impact of the 2013 Mozambican doctors' strike from the perspective of the main actors involved, looking back at everything that happened, including behind the scenes and moments of tension during the negotiations. These details have been little covered in similar studies and are important for a better understanding and management of this type of movement.

**Methods:** A case study with a qualitative phenomenological approach was carried out based on semi-structured interviews with the main actors involved in the Mozambican doctors' strike movement of 2013 and analysis of documents (such as correspondence, meeting minutes, orders, newspapers) produced in the context of this movement. Non-probabilistic snowball sampling was used to select participants until data saturation was reached. The interviews were transcribed and imported into Nvivo version 12, and the data was analysed using content analysis to identify themes related to the research questions.

**Results:** The main reason for the demands were wages considered low and poor working conditions. As a result of the strike, the government adopted a series of measures to maintain minimum health services, restricting them to emergency cases, cancelling elective consultations and surgeries, and readjusting the tasks of the available staff. To end the strike, the government resorted to intimidating and punitive mechanisms, which generated a lot of tension and revolt, with accusations being exchanged in the media. Meanwhile, the strikers marched and displayed placards in the streets, and called for the intervention of ambassadors and other influential organisations in the country. Patients saw their care postponed, queues for healthcare increased, pharmacies ran out of medicines, and with non-striking doctors overworked (and in some cases, disgruntled), healthcare lost some quality. Postgraduate studies were suspended and some strikers were suspended, transferred and retired, as happened in some sub-Saharan African countries.

**Conclusion:** The strike was motivated by issues related to salaries and working conditions. Some of the approaches adopted further distanced the parties and delayed consensus. The strike had negative consequences for everyone, especially patients. There is a need for reflection on the cost-benefit of strike action in the health sector and on ways to strike in a sector as sensitive as health. This study provides important lessons for improving strike prevention and management strategies in the health sector.

**Key words:** doctors, healthcare workers, strike, Mozambique

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## **LISTA DE ABREVIATURAS, SIGLAS E ACRÓNIMOS**

OMS - Organização Mundial da Saúde

MISAU - Ministério da Saúde

AMM - Associação Médica de Moçambique

PSU - Profissionais de Saúde Unidos

ANEMO - Associação Nacional de Enfermeiros de Moçambique

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# **1. INTRODUÇÃO**

## 1.1 Sistema de saúde e suas componentes

Segundo a Organização Mundial da Saúde, um sistema de saúde consiste em todas as organizações, instituições, recursos e pessoas, cujo principal interesse é promover, restaurar ou manter a saúde das pessoas (1, 2).

Um sistema de saúde que funcione bem rege-se por políticas e ações que de forma equilibrada buscam: (1) melhorar o estado de saúde dos indivíduos, família e comunidades, (2) controlar os determinantes de saúde, bem como intervir diretamente para a melhoria da saúde das pessoas, (3) proteger as pessoas contra as consequências financeiras dos problemas de saúde, (4) proporcionar um acesso equitativo a cuidados centrados nas pessoas (controlando os determinantes sociais e financeiros), (5) utilizar os recursos disponíveis de forma justa e racional, e (6) possibilita que as pessoas participem nas decisões que afetam sua saúde e o sistema de saúde que lhes serve (2, 3).

Existem seis componentes estruturantes de um sistema de saúde, nomeadamente (i) *Liderança e Governança* - estruturas políticas e de planificação de saúde, gestão do setor de saúde, prestação de contas e transparência; (ii) *Financiamento dos cuidados e serviços de saúde* – provisão do investimento e gastos públicos e uso eficiente de ajudas; (iii) *Força de trabalho (recursos humanos)* – garantir uma força de trabalho motivada, em número e com qualidade, distribuída de forma equitativa e equipada adequadamente para a prestação dos serviços de saúde, (iv) *Produtos e tecnologias médicas* – aquisição racional, armazenamento, abastecimento e uso adequado dos produtos e tecnologias de saúde, (v) *sistema de informação em saúde* – garantir sistemas de investigação e de informação e uso apropriado da tecnologia de informação e comunicação que contribuam com as evidências necessárias para desenvolver políticas, especificar estratégias e promover uma gestão com base nessas evidências, (vi) *Prestação dos serviços* – definição do modelo apropriado de prestação de serviços, dando ênfase aos cuidados primários de saúde, prestação de serviços integrados e provisão de pacotes tendo em conta a realidade socioeconómica, segurança e infraestrutura (1, 3, 4).

As seis componentes são interdependentes e contribuem de diferentes formas para o fortalecimento dos sistemas de saúde. Algumas componentes assumem um caráter transversal, como é o caso da *liderança e governação* e o *sistema de informação em saúde*, que constituem a base para a formulação de política e operacionalização das outras componentes do sistema de saúde. O *financiamento* e a *força de trabalho da saúde* constituem as principais componentes do sistema de saúde. Enquanto, *os produtos e tecnologias médicas e prestação de serviços* refletem os resultados imediatos do sistema de saúde, ou seja, a disponibilidade e distribuição de cuidados (1). Estes elementos são importantes para garantir o acesso aos serviços de saúde para a população.

O acesso universal aos serviços de saúde é uma das metas que as nações do mundo definiram quando adotaram os Objetivos de Desenvolvimento Sustentável (ODS) de 2030 em 2015, e entende-se que a saúde seja uma pré-condição e um resultado e indicador das dimensões social, econômica e ambiental do desenvolvimento sustentável. Portanto, o acesso universal aos serviços de saúde é garantir que todas as pessoas tenham acesso a todo o tipo de serviços de saúde de qualidade de que precisa, quando e onde precisa, sem dificuldades financeiras (5).

## **1.2 Acessibilidade aos serviços de saúde**

O acesso aos serviços de saúde pode ser visto como a oportunidade de alcançar e obter cuidados de saúde adequados em situações de necessidade percebida pelos pacientes, isto é, corresponde a todo processo desde a percepção de necessidade de cuidados de saúde à procura pelos serviços de saúde, alcance dos recursos de saúde, utilização dos serviços de saúde e de receção dos cuidados adequados às suas necessidades. O acesso resulta de uma combinação de fatores como características pessoais, sociodemográficas, culturais, económicas, ambientes, físicos e as características dos sistemas, das organizações e dos prestadores de cuidados de saúde (6).

Portanto, segundo Levesque et al. este acesso aos serviços de saúde depende das cinco (05) características dos provedores dos serviços de saúde (sistema de saúde), assim como das cinco (05) habilidades dos usuários desses serviços (6, 7).

As cinco características dos provedores dos serviços de saúde (sistema de saúde) a considerar são: (1) abordagem (approachability), (2) aceitabilidade (acceptability), (3) disponibilidade e acomodação (availability and accommodation), (4) acessibilidade financeira (affordability) e adequação (appropriateness) (6-8).

As cinco habilidades atribuídas aos usuários dos serviços de saúde (famílias e comunidades) são: (1) habilidade para perceber (ability to perceive), (2) habilidade de procurar (ability to seek), (3) habilidade de alcançar (ability to reach), (4) habilidade de pagar (ability to pay) e (5) habilidade de se envolver (ability to engage) (6-8).

A abordagem está associada a capacidade das pessoas com necessidade de cuidados de saúde de identificar os serviços existentes e que pode alcançar, o que pode depender de vários elementos, como a transparência, divulgação e informação sobre os tratamentos e serviços disponíveis e as atividades de sensibilização nas comunidades. Contudo, a abordagem é interdependente da habilidade do usuário de perceber a necessidade de cuidados de saúde, que por sua vez pode ser determinada por fatores como a literacia em saúde, o conhecimento sobre saúde e as crenças relacionadas com a saúde e a doença (6, 8).

A aceitabilidade dos serviços de saúde está associada ao quão confortável está o utente com as características do provedor do serviço, que pode estar aliado a aspetos culturais e psicossociais (como género, idade, grupo social, crenças, credibilidade ou confiança no sistema). Portanto, para que o utente aceda aos serviços de saúde, ele precisa aceitar, sentir-se cómodo e acreditar nos serviços (6, 9).

A habilidade de procurar por cuidados de saúde está relacionada a autonomia pessoal e a intenção de procurar por cuidados de saúde, conhecimento sobre as opções de cuidados de saúde e direitos individuais que determinariam a expressão da intenção de obter cuidados de saúde (6).

A disponibilidade dos serviços de saúde está condicionada pela disponibilidade de recursos necessários (humanos e tecnológicos), para satisfazer as necessidades do utente. Enquanto a acomodação está associada a oferta do serviço adequado tendo em conta as restrições e preferências do utente (como por exemplo: horário de funcionamento, a forma como as

comunicações telefónicas são tratadas e a capacidade do utente de receber cuidados sem marcação prévia). Os serviços devem ser alcançados tanto fisicamente como em tempo útil (10).

A habilidade de alcançar os cuidados de saúde está associada a capacidade de mobilidade pessoal e disponibilidade de transportes, flexibilidade ocupacional e informações sobre os serviços de saúde. Por exemplo, a mobilidade restrita dos idosos ou deficientes, bem como a impossibilidade de alguns trabalhadores ocasionais se ausentarem do trabalho para aceder às consultas (6).

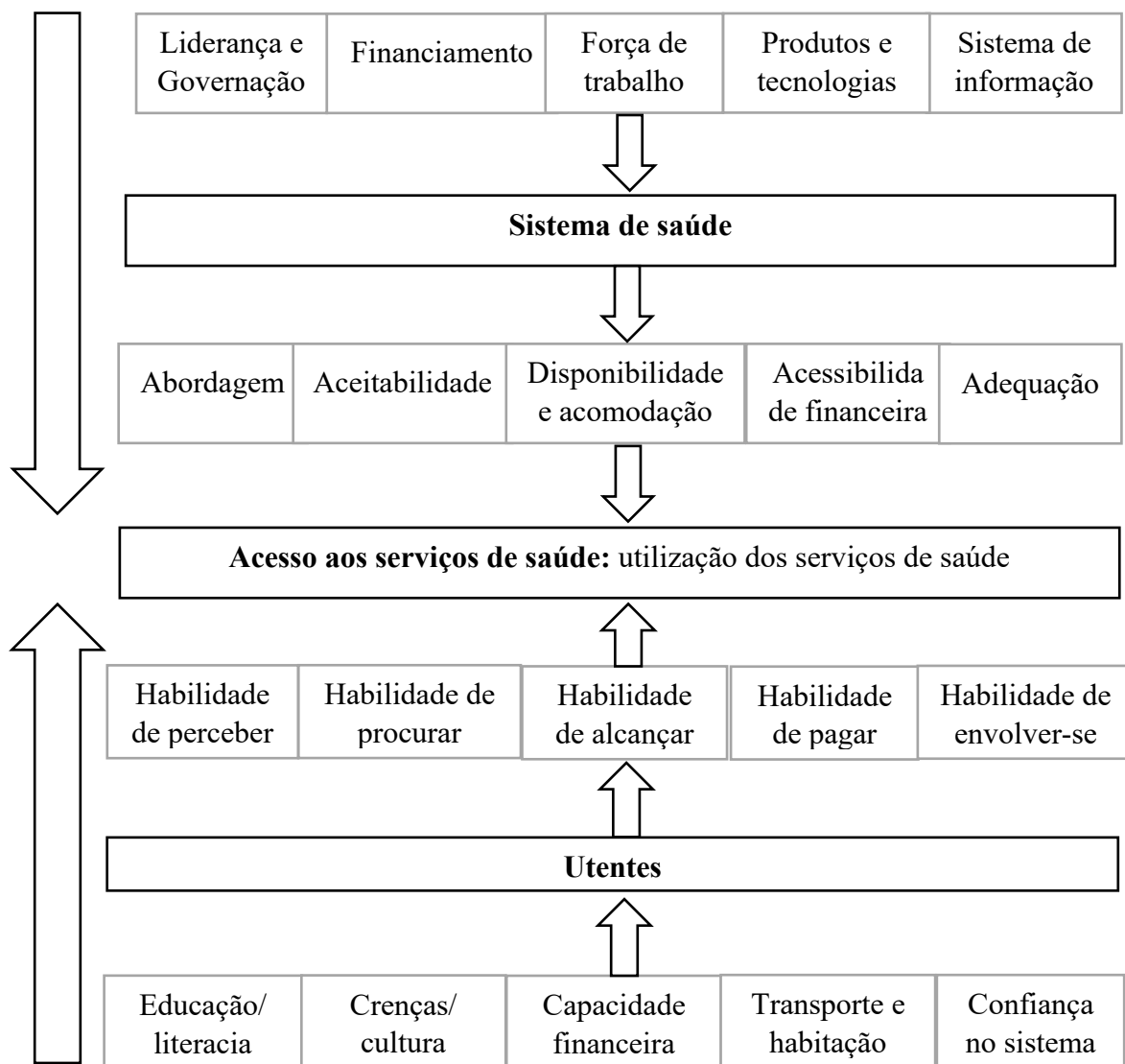
A acessibilidade financeira resume-se à capacidade económica dos utentes para gastar recursos e tempo para utilizar os serviços de saúde, o que resulta da relação direta entre a capacidade de gerar receita (renda pessoal ou familiar) e os custos dos serviços e outras despesas relacionadas com os cuidados de saúde (6, 10).

A habilidade de pagar os cuidados de saúde é a capacidade de gerar recursos económicos através de rendimentos, poupanças ou empréstimos para pagar os serviços de saúde sem gastos catastróficos de recursos necessários para as necessidades básicas (por exemplo, venda de casa). Alguns fatores como a pobreza, o isolamento social ou o endividamento podem limitar a habilidade do utente de pagar os cuidados de saúde necessários (6).

Adequação dos serviços de saúde implica seu ajuste às necessidades dos utentes, isto é, deve ser oportuno e com qualidade necessária para suprir as necessidades dos utentes de forma efetiva. Os cuidados de saúde devem ser seguros, eficazes, centrados no doente, atempados, eficientes (custo-eficácia) e equitativos. Neste âmbito, a oportunidade de utilizar apenas serviços de má qualidade é vista como uma restrição do acesso aos cuidados de saúde. O acesso abrange a possibilidade de escolher serviços aceitáveis e eficazes. Por exemplo, a oportunidade de uma pessoa com maior poder aquisitivo utilizar serviços altamente especializados e eficientes, supostamente, não pode ser comparada à outra pessoa menos favorecida, e isto é uma barreira para o acesso aos serviços (6, 11).

A capacidade de se envolver nos cuidados de saúde estaria relacionada com a participação e envolvimento do utente na tomada de decisões sobre o tratamento para o problema que o

apoquentas, que pode depender da capacidade e motivação para participar e comprometer-se, como também da capacidade de comunicar, da literacia em saúde, autoeficácia e autogestão e, não menos importante, adequação dos cuidados à pessoa, seus recursos e necessidades (6).



**Figura 1:** Conjuntura de fatores que determinam o acesso aos serviços de saúde.

### 1.3 Força de trabalho da saúde

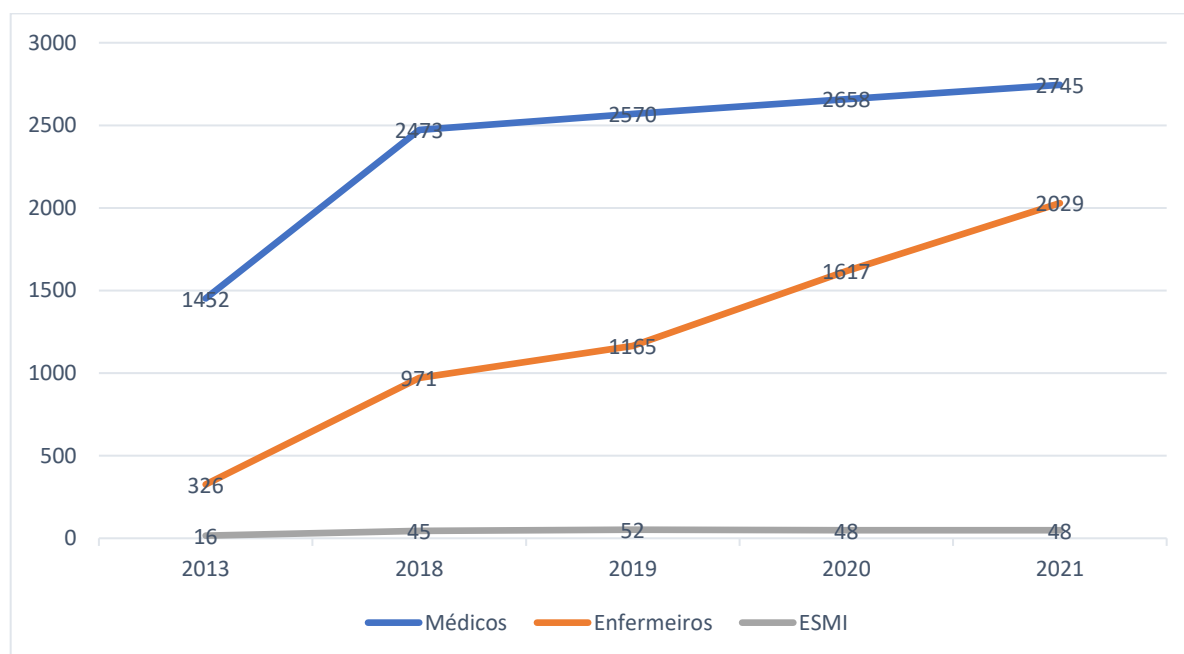
A força de trabalho da saúde é composta pelos diferentes tipos de pessoal clínico e não clínico que tornam possível cada intervenção, individual e de saúde pública. Os profissionais de saúde são reconhecidos como uma componente importante entre todos os contribuintes dos sistemas de saúde, pelo que, é uma prioridade máxima na agenda global (4, 12). O desempenho dos sistemas de saúde depende, em última instância, do conhecimento, das competências e da motivação dos profissionais envolvidos na prestação dos serviços de saúde (4).

Profissionais de saúde qualificados, equitativamente distribuídos, motivados e produtivos são fundamentais para garantir os cuidados de saúde da população, bem como para o alcance da cobertura universal de saúde e dos Objetivos de Desenvolvimento Sustentável (ODS). A Estratégia Global sobre Recursos Humanos para a Saúde (GSHRH) enfatiza que os sistemas de saúde só poderão funcionar adequadamente quando esta premissa se cumpra (12).

Vários países enfrentam uma escassez de profissionais de saúde, sobretudo países com poucos recursos, que inclui um grande número de países africanos. Até 2015, apenas 11 países africanos tinham atingido o rácio mínimo recomendado (de 22,8 profissionais de saúde por 10.000 habitantes ou 2.28 por 1000 habitantes: médicos, enfermeiros e parteiras) pela Organização Mundial da Saúde (OMS) (12-14).

Entre 2018 e 2019, os países da Região Africana da OMS contavam com cerca de 3.6 milhões de profissionais de saúde, dos quais 0.24 milhões eram médicos de clínica geral, 0.09 milhões de médicos especialistas, 1.31 milhões de enfermeiros/parteiras, 0.06 milhões de médicos dentistas, 0.09 milhões de farmacêuticos, 0.37 técnicos de laboratório, 0.49 milhões de trabalhadores de saúde comunitários, 0.42 milhões de profissionais de saúde gestores e pessoal de apoio, e 0.5 milhões de outros profissionais de saúde. Dos 3,6 milhões de profissionais de saúde em África, a Nigéria tinha 26% (0.94 milhões), a África do Sul tinha 13% (0.45 milhões), Argélia com 9% (0.32 milhões), Etiópia com 7% (0.25 milhões), República Democrática do Congo com 6% (0.22 milhões) e Quénia com 5% (0.16 milhões). Enquanto Moçambique contava com 0.016% (0.06 milhões) de profissionais de saúde (12).

A densidade de médicos, enfermeiros e parteiras na Região Africana da OMS, entre 2018 e 2019, era de 1.55 por 1.000 habitantes, sendo que as Seicheles, a Namíbia, as Maurícias e a África do Sul apresentavam limiares superiores a 4.45 médicos, enfermeiros e parteiras por 1.000 habitantes. E Moçambique estava entre os 24 países com o rácio abaixo de um (01) médico, enfermeiro e parteira por 1.000 habitantes (12). Em Moçambique, embora tenha-se notado um aumento significativo de médicos e enfermeiros de nível superior entre 2013 (com 1450 médicos, 326 enfermeiros gerais e 16 enfermeiros de saúde materna infantil-ESMI) e 2021 (com 2745 médicos, 2029 enfermeiros e 48 ESMI), os números ainda estão aquém do esperado (figura 1) (15-19).



**Figura 2:** Número de médicos, enfermeiros e enfermeiros de saúde materno-infantil (ESMI) de nível superior entre 2013 a 2021.

Portanto, esta lacuna não só prejudica a prestação de serviços de saúde essenciais para o cumprimento dos ODS relacionados com a saúde, como também representa um entrave para o alcance da cobertura universal dos cuidados de saúde (5, 7, 12).

O desafio dos sistemas de saúde na África Subsariana não é apenas a insuficiente quantidade de recursos humanos, há aspetos qualitativos que trazem implicações para a prestação de cuidados de saúde (20).

A crise nos recursos humanos para a saúde precisa ser abordada numa perspetiva mais ampla, que não só envolve a disponibilidade dos profissionais de saúde, mas também o desempenho destes profissionais associado a produtividade e qualidade dos serviços prestados aos que necessitam e os resultados obtidos (12, 21).

A motivação é um aspeto preponderante no desempenho de qualquer trabalhador, e esta tem sido definida como a disponibilidade do trabalhador de exercer e manter o esforço necessário para atingir as metas estabelecidas pela organização ou empresa. A satisfação no trabalho está intrinsecamente relacionada com a motivação, isto é, é o resultado direto de processos motivacionais (20).

Estudos têm demonstrado que nos países de baixo rendimento, as características intrínsecas do trabalho, como o desafio, o reconhecimento, a autonomia e o próprio trabalho, estavam menos associadas à satisfação profissional, enquanto as características extrínsecas, como o salário, a segurança no emprego e as condições de trabalho, estavam fortemente associadas à satisfação profissional (20).

A baixa remuneração, as más condições de trabalho e, conseqüentemente, a baixa satisfação no trabalho têm sido reconhecidas como alguns dos fatores responsáveis pela escassez de profissionais de saúde na África Subsariana, e a insatisfação no trabalho tem sido descrita como estando no centro da crise de recursos humanos e de prestação de serviços de saúde nesta região (22).

A insatisfação de profissionais de saúde tem custado bilhões de dólares ao sector de saúde como consequência da exaustão, desânimo, perda de produtividade, erros, absentismo e dispendiosas disputas laborais. Esta insatisfação dos profissionais de saúde também se reflete na perda de capacidade de demonstrar empatia por si mesmo, pelos colegas e pacientes. A compaixão é uma habilidade essencial dos profissionais de saúde porque lidam com a vida, interagindo constantemente com pacientes e seus familiares. Portanto, quando estes

profissionais se encontram desmotivados para o exercício de suas atividades, eles são menos capazes de ter empatia com aqueles que necessitam de seus cuidados, e sua capacidade de demonstrar compaixão diminui, trazendo falhas de comunicação, perda de empatia entre profissionais de saúde e pacientes, e baixa qualidade dos serviços de saúde (20, 23, 24).

#### **1.4 As greves no sector de saúde**

Greve é uma paralisação individual ou coletiva, temporária, parcial ou total, da prestação de serviço ao utilizador (utente), independentemente da relação de trabalho existente (25). É um dos principais mecanismos utilizados pelo trabalhador, sindicato ou associação para pressionar o empregador (26).

O primeiro movimento grevista registado na humanidade ocorreu durante o reinado de Ramsés III no Século XII AC e as greves de médicos foram pouco frequentes até à segunda metade do Século XX (27).

Inicialmente, a greve era vista como revolta e desobediência dos trabalhadores para com o patronato, mas com o passar do tempo passou a ser compreendida como sinónimo de luta pelos direitos e melhores condições de trabalho (25). Estas greves podem ser de natureza propositiva (quando anseiam por novas conquistas) ou defensiva (quando reivindicam a manutenção e/ou o cumprimento das condições vigentes). As greves podem igualmente ser classificadas como políticas ou económicas, gerais, setoriais ou locais (25, 26).

Existem uma relação direta entre o poder ou força do grupo trabalhista, dimensão da greve e a capacidade de impor suas exigências. Com o crescimento das empresas, a força de trabalho e o reconhecimento legal dos sindicatos crescem, e assim, as greves tem maior dimensão, os trabalhadores conseguem paralisar maior parte da empresa e impor as suas reivindicações com maior sucesso (28, 29).

A qualidade de vida do trabalhador associada ao direito à habitação condigna, alimentação, saúde, educação, segurança, conforto e bem-estar tem sido vista como uma necessidade e direito de todo trabalhador nas relações sociais e de trabalho contemporâneas (25). Portanto,

os trabalhadores costumam recorrer a greve como forma de protesto quando as negociações (para salvaguardar os seus direitos) com empregador entram em impasse (30).

Se por um lado os trabalhadores instrumentalizam a greve para afetar a produção e pressionar o patronato a ceder às suas exigências, por outro, o patronato tende a buscar mecanismos punitivos, como por exemplo a substituir os trabalhadores grevistas e intensificar a exploração como forma de combater as greves (29).

O grande desafio para os trabalhadores é adotar estratégias e ferramentas de protesto adequadas para o contexto em que se encontram. A literatura descreve dois tipos de estratégias: as estratégias contidas, que são pacíficas e relativamente institucionalizadas; e estratégias de confronto, que visam perturbar a rotina da população ou das autoridades, afastando-se da legalidade e, por vezes, tornando-se violentas (29, 31). As estratégias contidas são divididas em duas categorias: convencionais e culturais. A primeira categoria é a mais utilizada pelos movimentos grevistas e inclui marchas, manifestações, declarações públicas, bem como recolha de assinaturas e dinheiro, enquanto as culturais reforçam a solidariedade interna dos grupos e a identidade dos manifestantes (29).

As estratégias de confronto podem ser disruptivas e violentas. As disruptivas interferem com a rotina do quotidiano, incluindo greves com tiros, tomadas de posse e bloqueios de estradas, e ao interromper a rotina, chamam a atenção para as causas da greve e evidenciam a determinação do movimento, enquanto as estratégias violentas incluem queima de veículos ou edifícios, destruição de propriedades públicas ou privadas, saques e confronto agressivo entre grevistas ou forças policiais (29, 32, 33).

Contudo, embora as greves sejam direcionadas aos empregadores, estas podem causar danos a terceiros, e quando ocorre no sector público, os danos e pressões são direcionados principalmente à população que se beneficia do serviço prestado por aquele setor e indiretamente aos empregadores (30).

Médicos em greve geralmente têm um dilema moral entre a adesão aos princípios hipocráticos da profissão médica e a obrigação fiduciária aos pacientes. Em tais circunstâncias, os princípios éticos de respeito a autonomia, justiça e beneficência entram em

conflito, pelo que os médicos lutam com o seu papel como funcionários que têm direito a um salário justo pelo seu trabalho versus as suas obrigações morais para com os pacientes e a sociedade (34, 35).

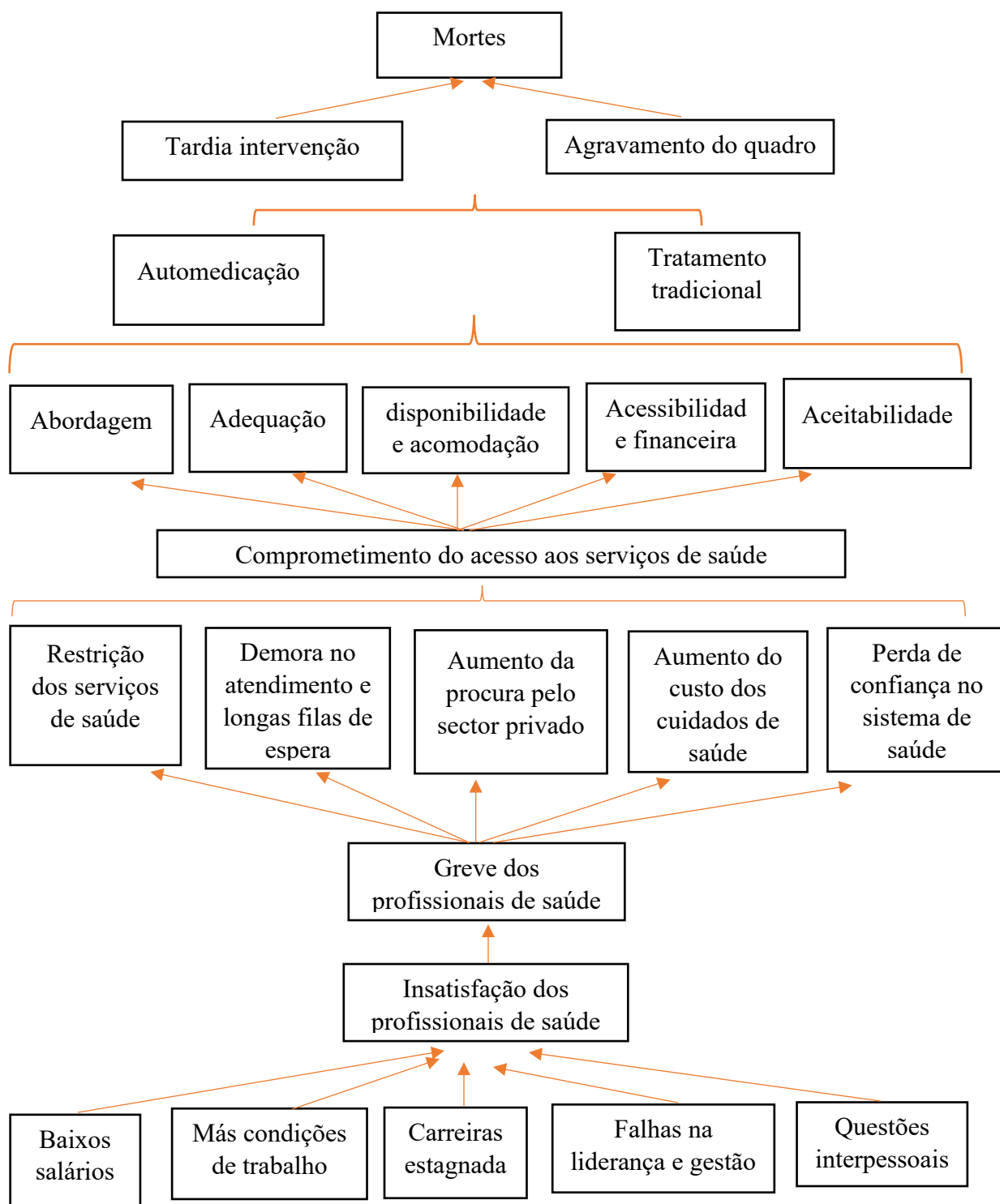
Alguns autores defendem que as greves só são justificáveis se forem direcionadas para a melhoria das condições de trabalho para a prestação de cuidados e serviços de saúde aos pacientes. E estas poderiam ser aceitáveis se fossem adequadamente comunicadas (36).

Portanto, as greves em unidades de saúde levantam questionamentos morais e éticos complexos por acarretarem prejuízos para os pacientes, o que levou ao desenvolvimento de orientações para o recurso à greve pelos profissionais de saúde e estudos diversos para compreender as razões e o impacto destas greves (35, 37).

Embora, geralmente, motivadas por razões laborais legítimas, relacionadas com progressão nas carreiras, melhoria de salários e de condições de trabalho, muitas dessas greves têm causado danos duradouros, dos quais os sistemas de saúde têm lutado para superar. É também reconhecido na literatura que, por vezes, o recurso à greve reflete falhas na liderança, gestão e questões interpessoais (34, 35, 38-41).

Os efeitos da greve dependem da sua duração, sectores envolvidos, das ações específicas de greve adotadas, das respostas dos órgãos de gestão e da capacidade das populações afetadas para aceder a cuidados alternativos (42). Os efeitos da greve no sector de saúde têm sido piores nos países de baixo e médio rendimento devido às limitações em termos de infraestruturas e recursos, códigos e práticas de ética organizacional menos eficientes e falta de alternativas de cuidados de saúde disponíveis e acessíveis (42, 43). As restrições para o acesso aos cuidados de saúde são maiores para pessoas pobres e desfavorecidas, e África Subsariana é uma das regiões mais pobres do mundo (de acordo com o Índice de Desenvolvimento Humano), pelo que, o impacto da greve é significativo nesta região (44, 45). As greves no sector de saúde tem trago várias implicações para os serviços e que incidem diretamente sobre o bem-estar do paciente, como é o caso da interrupção de alguns serviços de saúde, redução do número de cirurgias, hospitalização prolongada, perda de seguimento dos doentes, agravamento do estado de saúde dos doentes, procura de serviços de saúde

alternativos, elevadas taxas de encaminhamento para hospitais privados, elevados custos hospitalares privados, perda de confiança no sistema de saúde público, automedicação, busca por tratamento tradicional, aumento da morbidade e mortalidade (figura 3)(42, 46-48).



**Figura 3:** Causas e consequências da greve no sector da saúde (fonte: elaborado pelo autor)

Os conflitos e disputas laborais são inevitáveis em sociedades democráticas, mas nem sempre assumem um carácter destrutivo. Os conflitos podem ser construtivos dependendo da forma como são geridos, o que por sua vez depende da cultura organizacional de conflitos adotada. Existem três tipos de culturas de conflito: I) culturas de conflito colaborativo, que têm sua ênfase no diálogo coletivo construtivo, através da negociação e resolução conjunta de problemas; II) culturas de conflito dominante, nas quais os membros da organização procuram coletivamente a competição e a vitória, e tentam enganar-se uns aos outros, e III) culturas de conflito evitativa, nas quais os membros da organização oprimem coletivamente e se mantêm afastados do problema (49).

A greve em qualquer contexto é influenciada por fatores que incidem sobre a utilização de serviços de saúde. A pobreza é um dos fatores mais preponderantes e que afeta, inclusive, a forma como as pessoas priorizam a saúde. Por exemplo, em países em desenvolvimento, a maioria das pessoas não é coberta por um seguro saúde. Portanto, em caso de greve no sector público de saúde, estas pessoas podem não ter condições de pagar por cuidados de saúde em unidades de saúde privadas (44).

Portanto, a greve no sector de saúde é atualmente um fenómeno global com incidência crescente e potencial para impactar negativamente na qualidade dos serviços de saúde oferecidos, nas relações interprofissionais e médico-paciente (35, 39). Contudo, a baixa qualidade dos serviços prestados durante a greve nem sempre se traduziu em mortes e aumento da taxa de mortalidade, visto que alguns estudos não reportam mudanças significativas na mortalidade durante a greve, outros apontam até mesmo para sua redução durante a greve, o que foi atribuído em grande parte à prestação contínua de cuidados de emergência e apoio de outros quadros (40, 50, 51).

### **1.5 Sistema de Saúde moçambicano**

A constituição moçambicana no seu Artigo 89 afirma que toda a pessoa tem direito ao mais alto padrão de cuidados e serviços de saúde. Afirma também que a nenhum indivíduo, em nenhuma circunstância podem ser negados os cuidados e serviços médicos. A constituição

da República de Moçambique também consagra o direito à greve ou manifestação e o Setor da saúde não é exceção (52).

Moçambique, oficialmente designado República de Moçambique, é um país localizado no Sudeste do Continente Africano, banhado pelo Oceano Índico a Leste e faz fronteira com a Tanzânia ao Norte; Maláui e Zâmbia a Noroeste; Zimbabué a Oeste e Reino de Essuatíni e África do Sul a Sudoeste (figura 4). Na sua estrutura governamental, o país conta com vários ministérios, incluindo o Ministério da Saúde (MISAU) que é responsável por garantir o acesso aos serviços e cuidados de saúde a toda a população, independentemente da raça, etnia, religião, grupo social ou filiação política.



**Figura 4:** Mapa de África, países da África subsaariana destacados e Moçambique (disponível em: <https://www.todamateria.com.br/africa-subsaariana/>)

O MISAU é responsável pela implementação da política de saúde do Estado em todo o território de Moçambique (53, 54). Tem por missão salvaguardar a saúde dos cidadãos

moçambicanos, implementando ações coordenadas de prevenção de doenças, promoção de saúde e tratamento de doentes. Para alcançar este objetivo, implementa diferentes atividades operacionalizando os principais Planos Estratégicos Nacionais, nomeadamente: Plano de Desenvolvimento de Recursos Humanos para a Saúde (PDRHS 2016-2025) (53).

Moçambique é um dos países onde a cobertura do Serviço Nacional de Saúde não chega aos níveis considerados satisfatórios. Existe um défice absoluto de profissionais de saúde e um défice relativo do pessoal assistencial, que se encontra mal distribuído entre níveis de cuidados, entre províncias e, nas províncias, entre distritos e municípios (55, 56). A produtividade, a par do problema da qualidade, não está adequadamente aferida, mas os poucos estudos feitos sugerem uma produtividade que fica aquém do possível e desejado (56). Transparece grande insatisfação dos trabalhadores da saúde e falta de confiança na capacidade de a entidade empregadora corrigir os problemas do sistema de serviços de saúde (57, 58).

De entre estes problemas os trabalhadores e gestores destacam as deficientes condições de trabalho, a falta de biossegurança, a não implementação das carreiras, uma política de incentivos inadequada às diversas realidades do país, a não execução da política de incentivos vigente, o défice de pessoal, a falta de acesso à formação contínua, a morosidade na tramitação dos documentos do pessoal, a inexistência de uma liderança forte no sector, a falta de acesso à atividade privada fora dos grandes centros urbanos e as desigualdades entre províncias e distritos (58-63).

Alguns estudos feitos em Moçambique sobre a satisfação dos utentes com os cuidados e serviços oferecidos, em particular para as mulheres, em relação aos serviços de Planeamento Familiar, indicaram um longo tempo de espera até o atendimento e deficiente interação entre as utentes e os provedores dos cuidados e serviços de saúde (62, 64). Um estudo feito por Wagenaar et al. (2016) também indica que os utentes atendidos no sector público ficam muito tempo a espera para serem atendidos e em contrapartida ficam muito pouco tempo na consulta com o provedor dos serviços de saúde, o que determina para a sua insatisfação com os cuidados e serviços oferecidos (65).

Portanto, dos utentes, as maiores queixas referem-se a tempos de espera, à falta de biossegurança, às más condições das infraestruturas de saúde, à falta e/ou custos dos medicamentos e à falta de transporte para as unidades de saúde (66). Estes fatores condicionam o acesso aos serviços de saúde, e quando este acesso é limitado, as pessoas tendem a recorrer à automedicação ou tratamento tradicional, que por sua vez pode retardar a administração de uma terapêutica realmente eficaz, aumentar o risco de intoxicação, além de contribuir para a resistência microbiana e potenciais infeções, podendo agravar o quadro clínico do paciente e levar a óbito (48, 67).

A prestação de serviços de saúde depende da combinação eficiente de recursos financeiros, recursos humanos e suprimentos, bem como da prestação de serviços e cuidados em tempo útil, distribuídos espacialmente por todo o território nacional ou país. Isto requer um sistema que mobilize e distribua de forma eficiente os recursos e motive o comportamento apropriado dos provedores e administradores. Neste ato, a boa governação torna-se um fator crítico e decisivo (68-71). No sector de saúde, a boa governação implica que os sistemas de saúde funcionem com eficiência, o que engloba a capacidade dos governos de formular políticas sólidas, gerir recursos e fornecer serviços com eficiência, permitindo aos cidadãos escolher, responsabilizar, monitorar e substituir o governo e o respeito do governo e dos cidadãos pelas instituições que governam, e a interação económica e social (68, 69, 71). Quando tal fenómeno não se observa, então instala-se o fenómeno designado corrupção, onde se observa a utilização de cargo público para ganhos privados ou venda por funcionários do governo de propriedades do governo para ganho pessoal (68, 69, 71). Vários estudos feitos entre 1985 e 1997, evidenciam que a corrupção interfere negativamente no sector de saúde e traduz-se em forma de aumento da mortalidade infantil, baixo peso ao nascimento e baixas coberturas de alguns serviços de saúde (68, 71).

A situação do sistema nacional de saúde é agravada pela escassez de outros serviços de saúde, nomeadamente os serviços de saúde do setor privado, que noutros países constituem alternativas robustas para os que podem pagar um pouco mais pelos serviços de saúde oferecidos e constituem também fontes para o incremento dos rendimentos dos clínicos (59). Para os clínicos que trabalham exclusivamente no setor de saúde privado ou lucrativo, as

motivações para optarem por este setor, são ganhos financeiros maiores, autonomia e flexibilidade no horário de trabalho. Com relação aos clínicos que trabalham nos dois sistemas, público e privado, as suas principais motivações estão relacionadas com oportunidades de aumentar a renda, consolidar a reputação profissional e aproveitar as complementaridades que os dois sistemas oferecem (59, 61). Tem sido observado um padrão onde os clínicos mais experientes e formados há mais tempo, são os que mais frequentemente exercem a sua prática clínica no setor público e privado em simultâneo e com maiores possibilidades de terem maiores rendimentos comparativamente aos menos experientes e mais novos na carreira, determinando diferenças consideráveis nos rendimentos e reputação profissional entre profissionais da mesma área de formação (59).

Como corolário do fraco desenvolvimento socioeconómico do país e da fraca capacidade do governo responder as necessidades básicas da população no seu todo e dos profissionais da saúde em particular, em 2013, registou-se um movimento de greve dos médicos, cujas motivações e consequências nunca foram estudadas de forma sistematizada e técnico-cientificamente, sendo uma das razões que justificam esta pesquisa, cujos resultados poderão contribuir para prevenir futuras situações e retirar lições para o país e outros países da região.

O movimento da greve teve duas fases, uma primeira, que ocorreu entre 05 a 15 de janeiro de 2013, envolvendo apenas médicos e a segunda, entre 20 de maio e 20 de junho do mesmo ano, onde os médicos mobilizaram outros grupos profissionais de saúde, com a finalidade de aumentar a pressão junto do patronato e granjear mais simpatias e maior impacto na sociedade e na esfera do sistema governamental.

Durante a greve, os médicos estiveram representados pela Associação Médica de Moçambique (AMM), enquanto outros profissionais de saúde (como enfermeiros, técnicos de farmácia, técnicos de laboratório, agentes de serviço e outros técnicos de saúde) foram representados pela Profissionais de Saúde Unidos (PSU), ambos atualmente registados como sindicatos.

No início da greve, o PSU, ao contrário da AMM, era uma associação não oficial, ou seja, não tinham sido seguidos todos os procedimentos legais para a sua criação (72). A PSU foi

criada em resposta à não adesão à greve da Associação Nacional de Enfermeiros de Moçambique (ANEMO) e da Associação dos Técnicos de Laboratório e Análises Clínicas (ATLAC) (73), tendo a ANEMO sido acusada de agir de forma clandestina e passiva, descurando a defesa da classe (72).

## **1.6 Perguntas da investigação**

Com o presente estudo, pretende-se responder as perguntas e objetivos como a seguir se apresentam.

- ✓ Como decorreu a greve dos médicos moçambicanos em 2013?
  - O que terá determinado a ocorrência desta greve?
  - Que estratégias foram adotadas pelo governo para mitigar o seu efeito ou pará-la?
  - Que estratégias foram adotadas pelos grevistas para alcançar suas pretensões?
- ✓ Quais foram as consequências da greve dos médicos moçambicanos de 2013 para a sociedade, médicos (grevistas e não grevistas) e serviços de saúde no geral?
- ✓ Que estratégias podem ser adotadas das lições apreendidas desta greve para evitar situações similares no país e em outros países com contextos socioeconómicos e do sector de saúde similares?

## **1.7 Justificativa**

A greve é um direito constitucionalmente consagrado em vários países, porém quando ocorre no sector da saúde a preocupação é sempre acrescida por se tratar de um sector essencial para o bem-estar da população. Embora nem sempre as greves resultam em aumento da taxa de mortalidade, mas é certo que tem impactado negativamente na qualidade dos serviços de saúde oferecidos, nas relações interprofissionais e médico-paciente. Portanto, este é um fenómeno global com incidência crescente e potencial para impactar negativamente na

qualidade dos serviços de saúde oferecidos e representam um retrocesso para quaisquer sistemas de saúde.

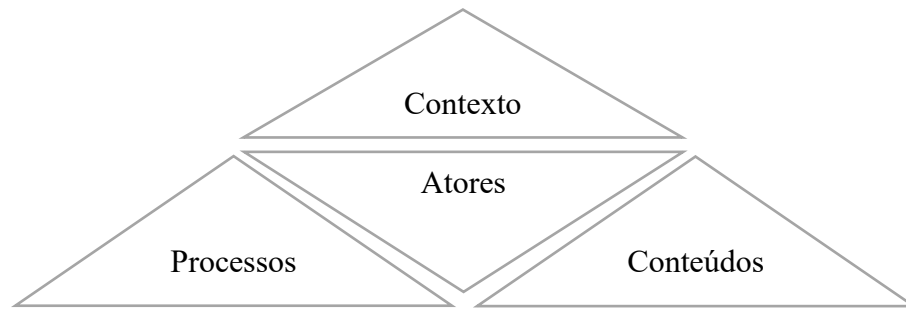
Em 2013 registou-se o primeiro grande movimento grevista dos médicos e outros profissionais de saúde, no sector público de saúde, em Moçambique, cujas motivações, estratégias, contornos e consequências nunca foram sistematicamente e técnico-cientificamente estudadas.

Estudos mostram que as greves no sector público de saúde têm limitado o acesso aos serviços de saúde e geralmente, os mais afetados são as camadas sociais menos favorecidas, com incapacidade financeira para aceder aos serviços privados de saúde, acabando alguns por buscar alternativas como tratamento tradicional ou automedicação que, por vezes complica o seu quadro clínico, podendo levar mesmo à óbito. Portanto, as greves dos profissionais de saúde, embora legítimas, sempre levantam questionamentos morais e éticos complexos, pelo que, há necessidade de compreender este fenómeno nas diferentes perspetivas, para melhor orientar as estratégias e políticas de gestão e manejo de conflitos laborais no sector da saúde.

Os resultados irão permitir identificar as razões associadas ao desenvolvimento do movimento grevista dos médicos. Este conhecimento irá permitir a sensibilização dos dirigentes políticos e de todas as forças vivas da sociedade para a prevenção de situações similares no país em particular e noutros países em geral.

### **1.8 Quadro conceptual**

O quadro conceptual para analisar o movimento grevista de 2013 em Moçambique foi adaptado do triângulo para análise de políticas de saúde proposto por Walt e Gilson (1994) (Figura 1) (74).



**Figura 5:** Triângulo de análise do processo grevista em Moçambique (74, 75)

Neste triângulo, no caso do movimento grevista em estudo:

1. O contexto refere-se:
  - a. Ao enquadramento da greve dos médicos moçambicanos no contexto dos movimentos grevistas na África Subsaariana
  - b. Ao que determinou a greve dos médicos moçambicanos em 2013;
  - c. As estratégias adotadas e seus contornos durante a greve dos médicos moçambicanos em 2013 e
  - d. Ao impacto da greve dos médicos moçambicanos em 2013 nos serviços e saúde e usuários, e para os médicos e outros trabalhadores de saúde grevistas e não grevistas.
2. O conteúdo diz respeito:
  - a. Ao caderno de reivindicações dos médicos grevistas e
  - b. Às propostas do Governo para a resolução ou mitigação dos pontos apresentados no caderno de reivindicações.
3. Os atores são:
  - a. Os grevistas,
  - b. Os agentes estatais envolvidos nas negociações e
  - c. Outros *stakeholders*, incluindo os que estiveram envolvidos nas negociações.
4. Os processos incluem:
  - a. As estratégias de reivindicação adotadas e/ou rejeitadas pelos médicos ou seus representantes,
  - b. As estratégias de negociação adotadas ou rejeitadas por parte do MISAU e dos médicos envolvidos no movimento grevista e

- c. As estratégias de mobilização de apoios encetadas pelos grevistas e pelo MISAU junto de stakeholders e da opinião pública.

A estrutura conceptual destaca a necessidade de considerar as dimensões micro e macro das greves do setor de saúde, por exemplo, as condições económicas e jurídicas pré-existentes, incluindo o crescimento económico, salários e níveis de desemprego, bem como a existência de mecanismos para a resolução de disputas. Atores como sindicatos, governo, partidos políticos e associações profissionais, desempenham um papel importante no desenvolvimento e resolução de greves ou disputas.

## **1.9 Objetivos**

### ***1.9.1 Objetivo Geral***

Compreender o movimento da greve dos médicos e outros profissionais de saúde de 2013 em Moçambique (antecedentes, motivações, reivindicações, estratégias usadas pelos grevistas, estratégias adotadas pelo governo para negociações e sua resolução, consequências para a sociedade e para o setor de saúde no geral e para os recursos humanos em particular).

### ***1.9.2 Objetivos Específicos***

1. Compreender o movimento grevista dos médicos e outros profissionais de saúde no contexto da África subsaariana entre 2000 a 2020.
2. Identificar as razões apresentadas pelos diferentes atores envolvidos para a génese do movimento da greve de médicos de 2013 em Moçambique;
3. Interpretar os efeitos e consequências da greve de médicos de 2013 em Moçambique;
4. Descrever as estratégias adotadas e os contornos das negociações para a resolução da greve dos médicos de 2013 em Moçambique.

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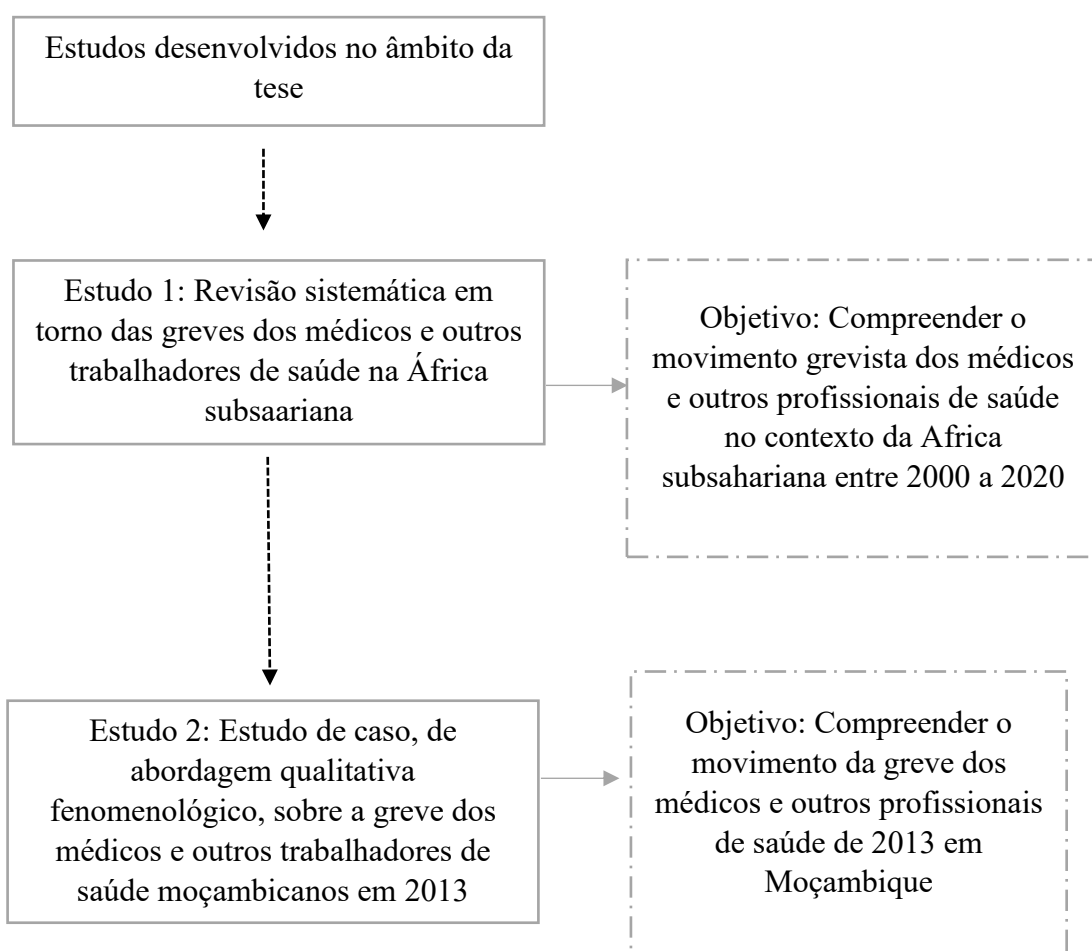
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## **2. Resultados**

## 2.1 Apresentação dos estudos publicados no âmbito da tese

Para responder aos objetivos da presente tese foram desenvolvidos sequencialmente dois estudos (figura 6). Portanto, neste capítulo serão apresentados os artigos compilados que sustentam esta tese e as respetivas referências:



**Figura 6:** Ordem dos estudos desenvolvidos no âmbito da tese

## **2.1 Estudo 1: Strikes of physicians and other health care workers in sub-Saharan African countries: a systematic review**

**Referência bibliográfica:** Manguela ALJ, Sidat M, Ferrinho P, Cabral AJR, Craveiro I. Strikes of physicians and other health care workers in sub-Saharan African countries: a systematic review. *Front Public Health*. 2024;12. DOI: 10.3389/fpubh.2024.1209201



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# Strikes of physicians and other health care workers in sub-Saharan African countries: a systematic review

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**Introduction:** Strikes in the health sector have been of growing concern, given their disruptive nature, negatively impacting the provision of health care and jeopardizing the well-being of patients. This study aims to identify the main actors, the reasons behind industrial actions protests, strikes and lockouts (IAPSL) in sub-Saharan African countries and their impact on health care workers (specifically doctors) and health services, as well as to identify the main strategies adopted to reduce their impact on healthcare services.

**Methods:** Studies published between January 2000 and December 2021 and archived in MEDLINE, Google Scholar, Scopus, ProQuest, and Science Direct were included. Quantitative, observational (i.e., cohort, case-control, cross-sectional, and ecological) and experimental studies, as well as mixed methods, quasi-experimental, and qualitative studies were eligible

**Results:** A total of 5521 studies were identified and after eliminating duplicates, applying the inclusion criteria, and assessing the risk of bias, a total of 11 studies were included in the review. Nurses and doctors are the actors most commonly involved in strikes. The main causes of strikes were salary claims and poor working conditions. The main strategies adopted to mitigate the strike consequences were to restrict services and prioritize emergency and chronic care, greater cooperation with the private sector and rearrange tasks of the available staff. The strikes led to a reduction in hospitalizations and in the number of women giving birth in health units, an increase in maternal and child morbidities and delays in the immunization process. Increased mortality was only reported in faith-based hospitals.

**Discussion:** This evidence can assist decision-makers in developing strategies and interventions to address IAPSL by health care workers, contributing to strengthen the health system. Strikes in the health sector disrupt healthcare services provision and compromise the well-being of patients, especially the most disadvantaged, with consequences that may be difficult to overcome ever. The potential health impacts of strikes highlights the importance of their prevention or timely resolution through regulation and negotiations to balance the rights of health care workers and the rights of patients.

**Systematic review registration:** [https://www.crd.york.ac.uk/PROSPERO/display\\_record.php?RecordID=334173](https://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=334173), identifier CRD42022334173.

## KEYWORDS

strikes, industrial actions, health care workers, physicians, nurses, sub-Saharan Africa, systematic review

## 1 Introduction

A strike is defined as a temporary stoppage of work by a group of employees to express a complaint or enforce a demand (1). Strikes can range from a simple interruption of the workday (for a few hours) or the reduction of non-critical services, to the complete stoppage of work as a last resort (2).

Strikes in the health sector have been of growing concern, given their disruptive nature, negatively impacting the provision of health care and jeopardizing the well-being of patients (1, 3). The effects of the outage of health services can vary based on the organization of health systems in that environment, demand for health services, patterns of morbidity and the number of health care workers (HCWs) on strike, as well as the level of participation (4).

Although strikes in the health sector have been reported on almost every continent, varying with respect to duration, demands and impact, their effects have been worse in low- and middle-income countries (LMIC) due to infrastructure and resource challenges, weak institutional arrangements, less efficient organizational ethics codes and practices, and lack of alternative available and affordable health care (1, 2). Poor and disadvantaged people report greater unmet health care needs when there are strikes (4). According to the Human Development Index (HDI), sub-Saharan Africa (SSA) is one of the poorest regions in the world, and today, with international poverty line at \$1.90 per person per day, SSA accommodates the largest number of poor people in the world (5).

Various factors have been reported as the cause of strikes in several studies, ranging from wage delays, housing and risk allowances, career advancement, continuing education, deterioration of academic facilities, low numbers of doctors in training, working conditions, shortages of essential medicines as well as political oppositions related to leadership and management in health, and government economics for health (2, 6–8).

These factors lead to dissatisfaction among HCWs which in turn leads to migration, strikes and low quality of health services (9, 10). The already inadequate health systems of SSA, have been severely hampered by the shortage of human resources and the “brain drain” from Africa to Europe, the Middle East and North America: strikes further compound this problem (11, 12).

SSA countries have the most severe shortage of human resources for health (HRH) in the world, with more than 60% of countries with extreme HRH shortages found in the African region. Studies show that 47 countries in SSA have a critical shortage of HCWs, with an approximate deficit of 2.4 million doctors and nurses. These data denote a crisis in the health sector and strikes are an aggravating factor and a barrier to achieving universal health coverage, thus compromising the 2030 Agenda for Sustainable Development with respect to health (13–15).

Therefore, studies that aim to understand the causes and consequences of strikes in the health system are essential to better target actions to minimize the potential for new strikes, reduce the negative effects of strikes, if they occur, and nurture the robustness, resilience and anti-fragility of the health systems (2).

This study aims to identify the main actors, the reasons behind the industrial actions, protests, strikes and lockouts (IAPSL) in SSA countries

and their impact on HCWs (specifically doctors) and health services, as well as to identify the main strategies adopted to tackle them.

## 2 Methods

### 2.1 Study design

This is a systematic review (SR) performed in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) checklist (16–18). The study protocol for this systematic review was registered in the PROSPERO International Prospective Registry of Systematic Reviews (registration number CRD42022334173). The study was carried out between September 2022 and April 2023.

### 2.2 Inclusion and exclusion criteria

The type of publications considered were quantitative, observational (i.e., cohort, case-control, cross-sectional and ecological) and experimental studies, as well as quasi-experimental, mixed-methods and qualitative studies published between January 2000 and December 2021 in the official languages of the Member States of the World Health Organization African Region, namely: English, French, Portuguese and Spanish. Gray literature was not included.

Eligibility criteria were developed using the PICOC criteria (19).

#### 2.2.1 Population/participants

The review included studies on HCWs and other actors involved in strikes in the health sector, such as health managers, NGOs, representatives of associations and civil society.

#### 2.2.2 Intervention(s) and exposure(s)

Only studies addressing IAPSL by HCWs were included, and studies on IAPSL by non-health care workers were not considered.

#### 2.2.3 Comparator(s)/control

We included studies that report changes in indicators (related to services, morbidity, mortality, well-being, working conditions or socio-political context) comparing the period during the IAPSL with the period before and after the IAPSL. Exclusion criteria are not applicable for this component.

#### 2.2.4 Outcome(s)

Studies that report consequences of IAPSL by HCWs for services, morbidity, mortality, well-being, working conditions, and socio-political aspects were included. Exclusion criteria are not applicable for this component.

#### 2.2.5 Context

All studies on IAPSL by HCWs in SSA were included, and studies on IAPSL by health care workers from countries outside SSA were excluded.

## 2.3 Information sources and search strategy

For this review, we used the following databases: MEDLINE, Google Scholar, Scopus, ProQuest, and Science Direct for a period between January 2000 and December 2021.

For the search algorithm, MESH terms, free text words and related terms were considered, taking into account the PICOC criteria components (19).

The search equations varied according to the operational specificities of each database, for example, ProQuest and Scopus have a location filter, so it was not necessary to include the terms *Africa south of the Sahara* or *sub-Saharan Africa* in the equation (as can be seen in Table 1).

## 2.4 Data management

The electronic search was performed by the first reviewer (A.L.J.M) and the search results in each database (MEDLINE, Scopus, ProQuest and Science Direct) were directly exported to Rayyan web-tool (20), except Google Scholar, since this does not

include a mechanism for exporting all results simultaneously. With the Rayyan web tool, duplicates were eliminated, and then the screening and selection of studies was performed. For results obtained through Google Scholar, screening and selection were done manually.

## 2.5 Selection of studies

The document selection process was conducted independently by two reviewers (A.L.J.M. and I.C.). In case of disagreement, a third reviewer (M.S) was consulted. First, the eligibility criteria were applied to the titles and abstracts of the identified articles, followed by the retrieval of the selected articles, and subsequently the eligibility criteria were applied for the full text screening of the retrieved articles.

## 2.6 Assessment of risk of bias

Joanna Briggs Institute (JBI) critical appraisal tools were used to assess the risk of bias of the included studies. A checklist adapted by

TABLE 1 Search algorithm in different databases.

Electronic databases	Search algorithm	Filters applied	Date	Result
MEDLINE	"Africa South of the Sahara" [MeSH Terms] AND "Health personnel"[MeSH Terms] OR "healthcare workers" OR "health care worker" OR "health professionals" OR "health workforce" OR "doctor" OR "physicians"[MeSH Terms] AND "Strikes, Employee"[MeSH Terms] OR "industrial action" OR "Strikes, Employee"[MeSH Terms] OR "protest"	<ul style="list-style-type: none"> <li>Time limit: January 2000–December 2021</li> <li>Language: English, French, Portuguese and Spanish.</li> </ul>	2022-08-18	1,499
ProQuest	("healthcare workers" OR "health care worker" OR "health professionals" OR "doctor" OR "physicians") AND ("Strikes" OR "industrial action" OR "grievances" OR "protest")	<ul style="list-style-type: none"> <li>Time limit: January 2000–December 2021</li> <li>Document type: articles</li> <li>Location: Africa, Nigeria, Liberia, Kenya, Ethiopia, Ghana, Uganda, Zimbabwe and West Africa</li> <li>Source type: Scholarly Journals.</li> </ul>	2022-08-18	899
Google scholar	"Sub-Saharan Africa" AND "Health personnel" OR "healthcare workers" OR "health care worker" OR "health professionals" OR "health workforce" OR "doctor" OR "physicians" AND "Strikes" OR "industrial action" OR "grievances" OR "protest"	<ul style="list-style-type: none"> <li>Time limit: January 2000–December 2021</li> <li>Language: English, French, Portuguese and Spanish.</li> </ul>	2022-08-18	2,900
Scopus	"Health personnel" OR "healthcare workers" OR "health care worker" OR "health professionals" OR "health workforce" OR "doctor" OR "physicians" AND "Strikes" OR "industrial action" OR "grievances" OR "protest"	<ul style="list-style-type: none"> <li>Time limit: January 2000–December 2021</li> <li>Language: English, French, Portuguese and Spanish.</li> <li>Document type: article</li> <li>Source type: Journal</li> <li>Country/territory: South Africa, Nigeria, Kenya, Ethiopia, Tanzania, Cameroon, Congo, Cote d'Ivoire, Malawi, Botswana, Mozambique, Guinea-Bissau, Senegal, Uganda</li> </ul>	2022-08-18	70
Science direct	"Sub-Saharan Africa" AND ("Health personnel" OR "healthcare workers" OR "health professionals" OR "doctor" OR "physicians") AND ("Strikes" OR "industrial action")	<ul style="list-style-type: none"> <li>Time limit: January 2000–December 2021</li> <li>Article type: Research articles</li> <li>Language: English, French, Portuguese, and Spanish.</li> <li>Content type: Journal article</li> </ul>	2022-08-18	153

Betran et al. was used to evaluate ecological studies (21, 22). The researchers agreed on a minimum percentage of 70% of the total items in the assessment tools to include studies in the review (21). This process was conducted independently by two reviewers (A.L.J.M. and I.C.), and in case of disagreement the third reviewer (M.S) was consulted.

## 2.7 Evidence quality assessment

The overall quality of each evidence was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach (23), considering the limitations, inconsistency, indirectness and imprecision of the studies, and were classified as high, moderate, low or very low quality. Two reviewers (A.L.J.M. and I.C.) independently assessed the quality of evidence using GRADE, and possible discrepancies were decided through discussion or consultation with a third author (M.S).

## 2.8 Data extraction

Documents for data extraction were randomly divided between the two reviewers (A.L.J.M. and I.C.). Data were extracted using a RedCap (24) electronic data collection spreadsheet prepared according to the design of the studies involved. The extracted data comprised: characteristics of the studies (authors, year of publication, place of study, type of study and data source), population (all actors involved in the IAPSL, their profession), intervention (duration of IAPSL, causes and strategies adopted to address or mitigate its effects), comparison (comparative aspects between the period before, during and after IAPSL) and outcomes (consequences of IAPSL for services, health care workers and users). The reviewers collaborated in case of doubts or questions. The third reviewer (M.S) was consulted to resolve any discrepancies.

## 2.9 Synthesis of data

The narrative synthesis was used to review and synthesize the data extracted from the papers included in this study. It was carried out by two reviewers (A.L.J.M. and I.C.), at first individually (until the preliminary synthesis of the data) and then jointly to ensure alignment between them. The final synthesis was shared with the other authors (M.S, P.F, and A.J.R.C) for critical evaluation and identification of eventual biased interpretations. Tables and figures are used, as appropriate, to present the information, disaggregating it according to the PICOC criteria (19) to answer the research questions. Due to the nature of the questions and the objectives of the research (which aims to identify the actors involved in strike movements, all the possible causes and implications), heterogeneity and sensitivity analyses were not carried out, so meta-analysis was not performed.

## 2.10 Level of agreement among reviewers

The agreement between reviewers (A.L.J.M. and I.C.) was evaluated using the Kappa statistic, and for kappa values between

0.0–0.20 it was considered none agreement, 0.21–0.39 minimal, 0.40–0.59 weak, 0.60–0.79 moderate, 0.80–0.90 strong and above 0.90 almost perfect (25).

## 3 Results

Through the MEDLINE, Scopus, ProQuest and Science Direct databases, 2,621 studies were identified and directly exported to the Rayaan web-tool. Duplicates were eliminated ( $n=92$ ) and 2,529 studies were submitted to the screening process based on title and abstract, of which 29 studies were selected for full text retrieval (Figure 1). Only 28 studies were retrieved, of which only 13 studies met the inclusion criteria and therefore underwent risk of bias assessment (as can be seen in Supplementary Table S1 for additional details). A parallel process was carried out in Google Scholar, where a total of 2,900 articles were identified and 6 studies were manually selected and retrieved, of which 3 studies met the inclusion criteria and were submitted to risk of bias assessment. Therefore, a total of 16 studies were submitted to risk of bias assessment, of which 5 did not reach the minimum points and were excluded. However, 11 studies were included for review (Figure 1). Most of the research questions were addressed by the studies included. However, the strategies or interventions adopted to mitigate the effect of the strike and comparison of health indicators between the period before, during and after the strike were addressed by less than 50% of the studies (Figure 1).

Among the studies included, two were classified by the authors as ecological, two as case reports, three as qualitative, two as cross-sectional and two as quasi-experimental studies (Table 2).

Overall, the quality of the evidence is “low” according to the GRADE assessment (Table 2). The studies had important limitations that presupposed a risk of bias. Some studies were hospital-based and did not include regional data, so the effect of the strike may be underestimated. The retrospective and longitudinal nature of some studies led to data loss or incomplete follow-up. Some studies based on interviews did not describe the characteristics of the strike (intervention) and took place later, after the strike, with a risk of memory bias.

The level of agreement between reviewers (A.L.J.M. and I.C.) during the selection of studies (Kappa = 0.87 and  $p < 0.001$ ) was strong, while for risk of bias (Kappa = 0.652 and  $p < 0.001$ ) and evidence quality assessment (Kappa = 0.647 and  $p < 0.001$ ) it was moderate.

## 3.1 Study location and health care workers on strike

All studies referred to strikes with no reference to other forms of IAPSL. Most of the included studies address strikes that took place in Kenya (with 7 studies) (2, 4, 26, 27, 29, 32, 33), followed by Nigeria (with 3 studies) (6, 30, 31) and finally Malawi (with 1 study) (28), as can be seen in Table 3.

### 3.1.1 Kenya

Of the 7 studies, 6 addressed the HCWs' strike in Kenya in 2017 (2, 4, 27, 29, 32, 33), and one study addressed the HCWs' strikes that occurred in Kenya between 2011 and 2013 (26). In 2017, 4 episodes

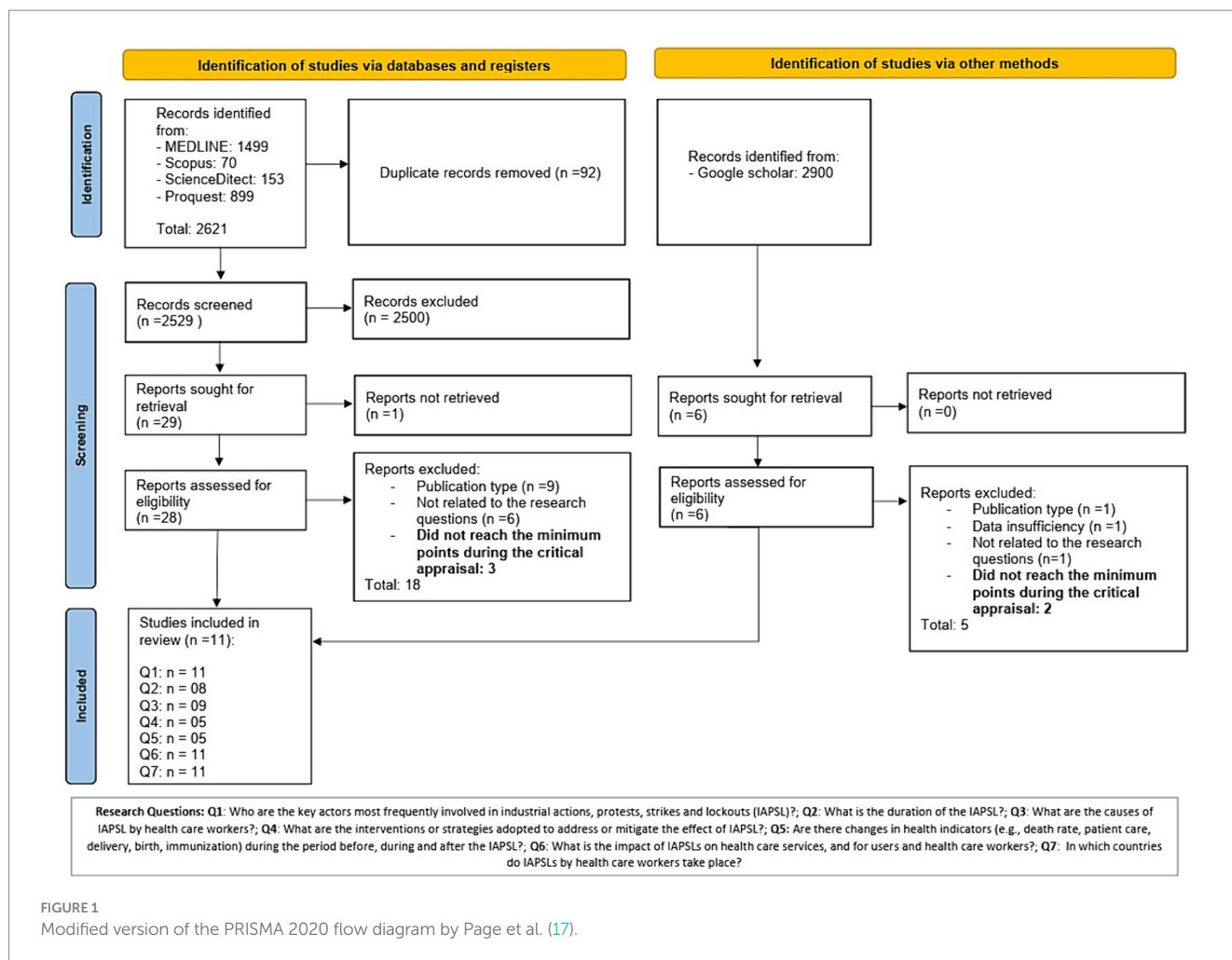


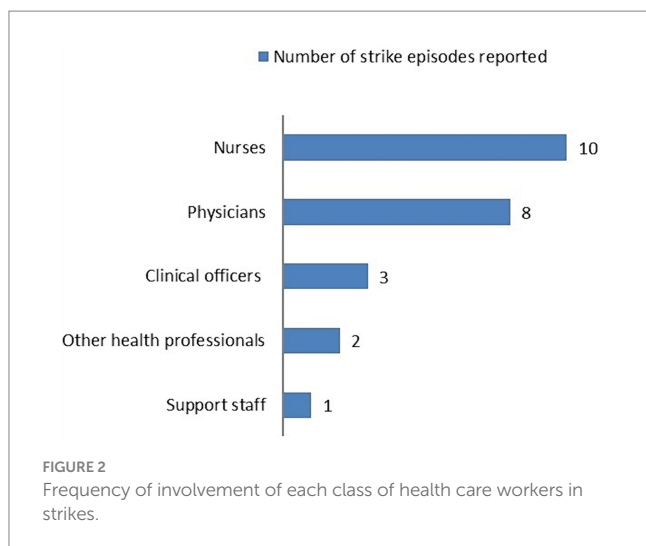
TABLE 2 characteristics of studies and quality of evidence.

Authors	Study design	JBI checklist (%)	Betran et al checklist (%)	GRADE Rating
Kaguthi et al. (4)	Ecological study	-	71.4	Low
Ong'ayo et al. (26)	Ecological study	-	85.7	Low
Adam et al. (27)	Case reports	87.5	-	Very low
Muula et al. (28)	Case reports	75.0	-	Very low
Oleribe et al. (6)	Qualitative study	80.0	-	Low
Scanlon et al. (29)	Qualitative study	90.0	-	Low
Waithaka et al. (2)	Qualitative study	90.0	-	Low
Aturak et al. (30)	Cross-sectional study	77.8	-	Very low
Oleribe et al. (31)	Cross-sectional study	77.8	-	Low
Shikuku et al. (32)	Quasi-experimental study	88.8	-	Low
Scanlon et al. (33)	Quasi-experimental study	88.8	-	Moderate

of strikes were reported: national doctors strike, national nurses strike, Trans Nzoia nurses strike and national clinical officers' strike. Between 2011 and 2013, six national strikes episodes were reported: two doctors' strikes, three nurses' strikes, and one doctors' and nurses' strike.

### 3.1.2 Nigeria

The three studies address the strike of HCWs (6, 30, 31), and only one specified the period of occurrence of the strikes under study (2013–2015) (31). There was no description of the number of strike episodes, much less of their duration.



### 3.1.3 Malawi

An episode of strike by all HCWs and support staff at Malawi's main referral hospital, Queen Elizabeth Central Hospital, which occurred in 2001, was reported (28).

In general, nurses and doctors are the ones most commonly involved in strike episodes (Figure 2).

## 3.2 Duration of strikes

The duration of strikes ranged from 9 to 150 days, with an average of 41.5 days. Nurses' strikes, on average, last longer (55.4 days) than doctors' strikes (43.6 days).

## 3.3 Causes of strikes

The most commonly cited causes of HCWs' strikes were disagreements regarding the salary and allowances earned by HCWs when compared to some other public servants and also poor working conditions (2, 4, 6, 27–29, 31–33). Other causes mentioned were linked to relationship with the leadership and management, interprofessional relations and dissatisfaction with political aspects (Table 3) (6, 31).

## 3.4 Strategies adopted to mitigate the effects of the strikes

To mitigate the effect of HCWs' strikes, several measures were adopted. These vary depending on the context and the HCWs involved.

### 3.4.1 Services provision

The most commonly adopted strategy to mitigate the effects of strikes was to restrict services and give priority to emergency conditions and chronic care, in some cases with a screening system to establish priority access/admissions (2, 4, 26, 27). Greater cooperation with the private sector was also sought (waiver of fees and hiring more

staff at private facilities, provision of supplies and referral of cases for hospitalization) (2, 4, 29).

### 3.4.2 Collaboration of non-strike actors

Other strategies adopted were the readaptation of the tasks of the available staff, such as: doctors in management positions and doctors from the military forces provided clinical support in the health care units of the striking HCWs; clinical staffs who often act as a filter took over operations; nursing and medical students and teachers provided clinical nursing and support services (2, 4, 27, 28).

## 3.5 Consequences of strikes (outcomes)

Among the studies, the most commented consequences of the strikes by HCWs were: disruption in the provision of services (with a reduction in hospitalizations and outpatient services), delays in care, higher rate of referrals to private hospitals, increase in the out of pocket costs with private services and the loss of confidence in the public health system within the community (2, 4, 6, 26–31).

The effects of the strikes on maternal and child services were the most commonly addressed, with a decrease in the use of prenatal care—pregnant women had fewer prenatal consultations—and a reduction in the proportion of women giving birth in public health care units. Peaks of mother-to-child HIV transmission, maternal complications and deaths, new-born deaths and delays in the immunization process were also reported (2, 4, 6, 27, 29, 31–33).

With regard to mortality, the majority of hospital-based studies reported a reduction in mortality (4, 28), and only one study reported an increase (27), but in the latter, a religious hospital, its employees were not on strike, with a greater inflow of patients and overload of services, which may have caused the increase in mortality. Two population-based studies that assessed mortality during the strike period did not find significant changes (26, 32).

For non-striking HCWs, there was a greater workload, weariness, and lack of motivation (2, 30). Training programs were disrupted during the strike and care workers in training (specialization) were unable to finish their training programs on time (6, 28).

For HCWs on strike, loss of dignity, respect and prestige before society were reported (6). There were reports of cases of suspension or transfer of HCWs on strike (28).

## 4 Discussion

Over the past century, strikes have been a common occurrence, across the world and among HCWs (34). The contours and consequences of the strikes includes a multitude of factors, among them: the causes, the subjects involved, the strategies adopted to solve it and the place where it occurs.

This study aimed to identify the HCWs most frequently involved in strikes, the main motivations for strikes (causes), the consequences of strikes for HCWs (strikers and non-strikers), for services and users, and the measures or strategies adopted to mitigate the effects of the strike, always in the context of SSA.

Strikes by HCWs have been a global phenomenon that affects various countries and social groups regardless of their socio-economic

TABLE 3 Description of studies included in the review.

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Kaguthi et al. (4)	2020	Kenya	Database of Kenyatta National Referral Hospital, AIC Kijabe Hospital, Mbagathi Hospital and Siaya Hospital	Ecological study	Physicians, nurses and clinical officers	100-day strike of doctors (December 2016 to March 2017); 150-day strike by nurses (June 2017 to November 2017); and 20-day strike of clinical officers (September 2017 to October 2017)	The government has not fulfilled the agreement reached with the classes (doctors and nurses) to improve remuneration (salaries and allowances), human resources and equipment in health facilities, as well as funding for research.	Senior physicians (consultants) and military physicians were stationed at the national referral and teaching hospital. Services were restricted to emergencies. Elective procedures were postponed or referred to private hospitals. In peripheral government hospitals, clinical staffs who often act as a filter took over operations and cases they could not manage were possibly abandoned, especially if they could not afford transport and management in private facilities.	Period without strike and with strike	There was a reduction in the number of patients treated during the strike period. During the doctors' strike mortality reduced considerably.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Waithaka et al. (2)	2020	Kilifi, Kenya	Interviews with frontline health managers and community representatives, review of documents and the Health Information System database.	Qualitative study	Physicians and nurses	100-day strike of doctors (December 2016 to March 2017); and 150-day strike by nurses (June 2017 to November 2017).	Failure of the government to implement the agreements signed with doctors and nurses (which established an increase in subsidies). Dissatisfaction with human resource processes and poor working conditions. Differences and injustices among health care workers. Political aspects associated with nurses and other government actors focused on national and municipal elections. Poor coordination between national and local governments affected the handling of the strike.	Prioritization of specific services (emergency and chronic care), minimizing and managing conflicts between striking and non-striking nurses, NGO staff continuing to offer services in supportive areas (such as TB/HIV), changing tasks for students and others non-strike cadres. In some facilities, support staff would have dispensed medication for minor ailments. Increased cooperation with the private sector (adoption of a system of transferring patients for post-operative care in private facilities), increased number of supervisory visits to private facilities and provision of supplies to these facilities. The community launched protest messages against the continuation of the strike.		Interruptions in service delivery (reduced hospitalizations and outpatient services), delay in accessing care, maternal complications and deaths, new-born deaths and long-term complications from delayed treatment, search for other care alternatives (private sector and traditional treatment) and increased costs of care (some families had to borrow or sell assets to pay for private services), overload and demotivation of non-striking health care workers, slower service delivery, loss of confidence in the public health sector among the community.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Scanlon et al. (29)	2021	Trans Nzoia, Kenya	Interviews with women who were pregnant during strikes in 2017, community health volunteers (CHVs) and health facility managers.	Qualitative study	Physicians, nurses and clinical officers	100-day national Physicians' strike (December 2016 to March 2017); 44-day Trans Nzoia nurses' strike (February 2017 to March 2017); 150-day national nurses' strike (June 2017 to November 2017); 20-day clinical officers' strike (September 2017 to October 2017).	Non-compliance by the government with the agreement reached with the classes (physicians and nurses) to improve remuneration (salaries and subsidies), better working conditions, delays in salaries and promotions.	Waiver of fees and hiring more staff at private (mainly religious) facilities, coordination of services, referrals and supplies between public and private facilities, and provision of services in public facilities in secret or off-premises.		Peaks in maternal and child deaths and mother-to-child HIV transmission due to decreased use of antenatal care. Limited access to maternal and child services. Pregnant women were less likely to give birth in public health facilities. Those without resources have no access to health care. Several community health volunteers described stories of using their own money to help pregnant women and mothers access care during the strike. Tension and loss of trust between the community and the health system.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Scanlon et al. (33)	2021	Trans Nzoia, Kenya	Questionnaires on women were pregnant in 2017 (year of strike) and 2018 (year without strikes)	quasi-experimental study.	Physicians, nurses and clinical officers	100-day national Physicians' strike (December 2016 to March 2017); 44-day Trans Nzoia nurses' strike (February 2017 to March 2017); 150-day national nurses' strike (June 2017 to November 2017); 20-day clinical officers' strike (September 2017 to October 2017).	Non-compliance by the government with the agreement reached with the classes (physicians and nurses) to improve remuneration (salaries and subsidies), better working conditions, delays in salaries and promotions.		Period with strike and without strike	Pregnant women attended fewer antenatal consultations during the strike period compared to the non-strike period. Lower proportion of women gives birth in health facilities during the strike period. New-borns in the strike period received their first OPV 0 vaccine significantly later compared to the non-strike period.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Adam et al. (27)	2017	Rift Valley, Kenya	Africa Inland Church-Kijabe Hospital (AICKH) database	case report study	Public sector physicians (national level), including trainees	100 days (December 2016–March 2017)	Low wages and poor working conditions	Increase beds for sick new-borns. A tracking system to establish priority admissions. The medical staff, including specialized interns, at the AICKH remained working during the strike, with the exception of government-sponsored official medical interns ( $n = 10$ ). Clinical Officers (CO) functioning as mid-level medical outreach workers, working closely with AICKH doctors, nurses and auxiliary staff to care for as many sick children and pregnant women as possible, straining the already limited resources of the hospital infrastructure. Doctors from the Kenyan military were sent to the Kenyatta National Hospital. Physicians in management positions provided support at the referral facilities.	Before, during and after strike	Excessive demand for services, refusal of referral admissions, overload and inability to care for the sickest new-borns, women in premature labour or with high-risk pregnancies. Obstetric admissions closed intermittently. The monthly death rate has increased. In the neonatal and paediatric medical services, there was an approximate four-fold increase in deaths during the strike and an almost eight-fold increase in the paediatric surgical service. In obstetrics, there was an approximately three-fold increase in monthly maternal deaths.
Aturak, Chiegil, Ademola et al. (30)	2018	Cross River, Nigéria	Questionnaire applied to patients treated at secondary health facilities	cross-sectional study (prevalence)	Health care workers					Poor quality of health care, rising costs of health care, poor adherence to medication, high rate of referrals to private hospitals, wasted time and loss of confidence in health services, and low staff morale

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Shikuku et al. (32)	2020	Busia County, Kenya	Kenya Ministry of Health reports.	quasi-experimental study	Physicians, nurses and midwives	100-day national Physicians' strike (December 2016 to March 2017); and 150-day national nurses/ midwives' strike (June 2017 to November 2017)	Disagreements over terms of service		Physicians strike period, non-strike period and nurses and midwives strike period.	The number of patients seen in maternal and newborn care at health facilities dropped slightly during the doctors' strike and was much lower during the nurses' strike. During the nurses' strike, the number of patients cared for by community midwives was higher than in health units. There was a non-significant decline in macerated stillbirths and neonatal during the nurses' and midwives' strike.
Oleribe et al. (31)	2016 (2015)	Abuja, Nigéria	Questionnaire applied to health care workers	cross-sectional study (prevalence)	Strikes by health care workers between 2013–2015		Poor healthcare leadership and management, demand for higher wages and salaries, infrastructure and interpersonal issues.			Disruption of patient care, high referral rates to private hospitals, loss of patient follow-up, mismanagement by alternative healers, and high private hospital costs.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Muula and Phiri (28)	2003	Blantire, Malawi		case report study	Health care workers and support staff at Malawi's main referral hospital, Queen Elizabeth Central Hospital	14 days of strike (5 October and 19 October 2001) at hospital level.	Lack of risk subsidies, poor professional subsidies, low wages, and low housing subsidies. Comparisons were made with the judicial service, where officials are better paid.	The Council of Nurses and Midwives of Malawi and the Medical Council of Malawi threatened to take disciplinary action if their members were absent from their workplace without informing their patients or making alternative arrangements to safeguard their patients' care. Volunteers (68 from the Red Cross and 36 nursing and medical students and teachers from the University of Malawi) provided clinical nursing and support services at QECH. The government sent armed police to guard the hospital premises. Intimidation of health care workers by community and political leaders. Negotiations between representatives of health care workers and the Ministry of Health, mediated by the Malawi Human Rights Commission. The Government has promised to meet some of the requests. Workers' representatives demanded that suspended employees be immediately reinstated and that those transferred be returned to the QECH.		The strike resulted in the closure of nearly all of the hospital's 1,500 beds, with the exception of the burn and orthopaedic wards. The government suspended 20 officials. Some health care workers on strike were transferred from QECH to other hospitals. There was a reduction in the number of deaths in the QECH. Education for medical students, clinical officers and nursing interns was disrupted during the strike. There was a greater demand for health care in private hospitals.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Ong'ayo et al. (26)	2019	Kilifi, Kenya	Health and Demographic Surveillance System	Population-based cohort	Nurses and physicians strike	Six nationwide health care workers' strikes (between 2011 and 2013: total of 128 strike days). 9-day physicians' strike (Dec 5 to 13, 2011); 15-day nurses' strike (March 1 to 15, 2012) 22-day physicians' strike (Sept 13 to Oct 4, 2012) 42-day nurses' strike (Dec 3, 2012, to Jan 13, 2013) 26-day nurses' strike (Jan 16 to Feb 11, 2013) 14-day physicians and nurses' strike (Dec 10 to 23, 2013)			Period with strike and without strike	Service delivery was stopped, hospitalization rates reduced (paediatric hospitalization services were limited), admissions were restricted to the most critical cases. There were no significant changes in mortality between the non-strike and strike periods.

(Continued)

TABLE 3 (Continued)

Author	Year	Study location	Data source	Study type	Care workers on strike	Strike duration	Causes of the strike	Strategies adopted to mitigate or solve	Comparison	Outcomes
Oleribe et al. (6)	2018 (April and June 2017)	Nigéria	Questionnaire for physicians who attended the recently completed West African College of Physicians (WACP)/Royal College of Physicians (RCP) Millennium Development Goal 6 Partnership for African Clinical Training (M-PACT) course.	Qualitative study	Health care workers		The lack of well-being of care workers, salary issues, leadership and management, precarious hospital infrastructure, poor guidance and services, and disputes between care workers			Interruption in the provision of key health services, including immunization services and prevention of mother-to-child transmission of HIV, poor patient care, increased morbidity and mortality, reduced revenue generation by hospitals, loss of confidence in the health system, conflicts between staff and management, loss of dignity and respect for the profession, poor public perception of medical staff, reduced efficiency of services, distortions of patient care indicators (clinical and patient satisfaction), resident physicians are unable to timely fulfil demands for their training, poor performance in postgraduate exams with huge financial losses, Interruption of research activities.

level (35). Dissatisfaction with salaries, allowances and working conditions have been the main reasons for strikes by HCWs around the world, and studies have shown a direct relationship between these factors and the satisfaction, motivation and productivity of HCWs and, consequently, the quality of healthcare services and the satisfaction of patients themselves (36, 37). The results show that failure to reach timely common understanding between the government and HCWs or lack of compliance on agreements achieved by the government (regarding salaries, allowances and working conditions) have been the triggers for strikes in the health sector, coinciding with the findings of Chima (in 2020), in which failed negotiations over remuneration and failure to address poor working conditions were the main cause of HCWs strikes in developed countries (such as the UK, USA, Norway, Israel and Portugal), as well as in less developed countries (such as Haiti, Uganda, Sudan, and Zimbabwe) (38).

The strikes reported in the studies included in this review occurred exclusively in the public sector. In fact, during strikes private health care units (for-profit and not-for-profit) remain in operation and maintain the healthcare services helping to overcome the service-deficit caused by the strikes. During the strikes, some interventions, such as restricting services to bare essential and prioritizing emergency cases, were the most highlighted as a way of mitigating the effects of the strike, and could even reduce including hospital mortality in the public sector, as reported in some studies (4, 28). Private for-profit health care units are less accessible to a large part of the population, since they impose costs on users which are an important barrier to healthcare services access, particularly in SSA countries where poverty is prevalent in many countries (5, 39). The demand for private non-profit health services (such as religious ones) ends up being greater due to better accessibility (low cost). Therefore, it is understandable that the impact of the strikes in these health units was associated with work overload, exhaustion and demotivation of the available staff, causing a reduction in the quality of services provided and a worsening of health indicators, such as an increase in the mortality rate (2, 27, 30).

Another strategy used to mitigate the effects of strikes was to readapt the tasks of the available staff, mainly doctors in management positions and military doctors, so that they could provide clinical support in the health care units affected by the strike (2, 30, 32), showing a low tendency for these groups to get involved in strike movements. The International Labour Organisation considers the right to strike to be restrictive or prohibitable in the case of public servants exercising authority on the state's behalf (such as doctors in management positions) or workers in essential services whose interruption could endanger the life or safety of all or part of the population (31, 40). Military doctors belong to the defence forces, so their services are considered essential for the security of the population, and the services provided by HCWs are considered essential because they deal with life and the patient's health is held in the highest esteem. The essence of medical practice is to save and preserve life, to promote and administer health, so it is always expected that the HCWs' actions will always seek to preserve the patient's health. Therefore, their rights are limited by their responsibility to save lives and promote health, according to the code of conduct for medical practice (7). On the other hand, there are those who argue that, in a democratic state, strike action is a fundamental right of workers during collective bargaining and in

labour relations. It is the right of every human being to defend a fairer salary for themselves and to fight for the satisfaction of their needs, so much so that denying this right to anyone would be an act in favour of slavery (35). Some voices in the literature argue that HCWs are as essential as those who collect garbage or waste, and that uncollected garbage or unprocessed sewage is just as dangerous and has many more side effects on health than untreated pneumonia or appendicitis, and that those who advocate a strike ban must demonstrate that healthcare is as important as they say. It is understood that health care results from a joint effort and shared responsibility between HCWs, the government and society. It takes everyone's commitment to keep the health system functional. Government and society have a responsibility to provide the necessary means for HCWs to care for patients (34). Some argue that threats to patient safety are safeguarded by providing minimum services during the strike, so HCWs should enjoy the same labor rights as other workers. Therefore, only urgent and emergency cases would be attended to, all other procedures (such as non-urgent surgeries, investigations, outpatient consultations, routine general practice consultations and documentation) would be postponed (41). However, the urgent nature of a clinical condition sometimes carries a certain subjectivity, and the fact is that if the patient comes to the health unit it is because they have concerns, so there is a need to understand how patient feels and understand the postponement of his care. Therefore, studies that assess patients' perceptions of the HCWs' strike and its implications are important to understand the problem from different perspectives.

However, strikes tend to undermine interprofessional relationships and those between managers and other HCWs, bringing mistrust and conflict within work teams. In turn, labour conflicts can affect the productivity and motivation of HCWs, limiting their contributions, altering the dynamics and communication in work teams, affecting the efficiency of the services provided to patients (42, 43). Strikes also lead to a loss of trust in the healthcare system and doctors in society, which can be associated with a decrease in hospital adherence, a worsening of patients' health status, a decrease in adherence to medication and medical recommendations, and low overall satisfaction with healthcare on the among patients (39, 44).

As a result of strikes, there are also interruptions in medical training (undergraduate and postgraduate), some doctors were suspended and others transferred, meaning a setback for the national health system, further aggravating the human resources for health (HRH) crisis in this region (SSA), which had a shortage of approximately 2.4 million doctors and nurses (13–15). Another aggravating factor for this (HRH) crisis is the brain drain (emigration) from LMIC to high-income countries due to the exhaustion, demotivation and disillusionment generated by the strikes in the health sector (45, 46).

During strikes, there are reductions in prenatal consultations and births in public health units, as well as delays in the immunization process, which represent a setback in the fight against neonatal and maternal mortality and in the prevention of vertical infections of the human immunodeficiency virus (HIV), which has been on the rise in this region (47–49), and a setback in achieving the Sustainable Development Goals (specifically the third) defined by the United Nations, which have maternal and child health indicators as a priority (50).

## 4.1 Study limitations

The study was limited in time (2000–2021) and in space (SSA) and intended to approach this phenomenon within a current and particular context which, although endowed with a certain cultural, socio-political and economic diversity, as is the case of SSA, may share needs and challenges in this part of African continent (51).

This review included peer-reviewed studies and excluded grey literature and additionally excluded a total of five studies for not achieving the minimum quality required for the review which, somehow, restricted its results to strikes in Kenya, Nigeria and Malawi. Therefore, these results cannot be fully extrapolated across SSA because there was not much diversity with respect to the study location (countries).

Among SSA countries, Kenya is one of best ranked in terms of income (in the list of Lower-Middle Income Economies Countries) (52) and HDI (0.575, in position 152) (53). Therefore, the consequences of strikes may be worse in other SSA countries, due to greater scarcity of resources, lack of available and accessible health care alternatives and unmet health needs (1, 2, 4).

According to the systematic review carried out by Russo et al. (9), there have been many strike episodes among SSA countries in the last two decades, but few studies have been published in peer-reviewed journals, and unlike this study, the review by Russo et al. (9) included grey literature (and countries beyond SSA). The inclusion of grey literature in the systematic review is a challenge given the difficulty in analysing the credibility and quality of the information, since the sources of information are not always referenced, which jeopardizes the quality of the review (54). Although, on the other hand, its inclusion may reduce the risk of publication bias and provide more balanced results, since many studies are not published in peer-reviewed journals for reasons such as the complexity of the submission process, long waiting time until publication, high rejection rates or even when the results are null or negative (55).

On the other hand, the studies included are lacking in terms of quality (in general, they have low quality according to GRADE) and lacked a detailed description of the strike and its contours, such as, for example, the strategies adopted to stop the strike, the proportion of non-striking HCWs and the socio-political or epidemiological context in which they occur.

However, the reality of private for-profit health units during the strike period was little known, and this information should be on the agenda since, according to Yoong et al. (56), the participation of the private sector in SSA is positively associated with better functioning of the health system in terms of access and equity. It is suggestive to think that the effect of the HCWs' strikes in the public sector might be worse without the active participation of the private sector in providing substitution services. Another fact to consider is the role that the traditional medicine has played in health care, especially in SSA, where, for example, in countries like South Africa, 80% of the population seek health care from traditional healers (57). Despite this reality, the demand for services provided by traditional healers was not discussed in these studies. Therefore, future studies that address the impact of strikes by HCWs should consider not only the private sector but also the traditional health services.

Most of the included studies do not address the resolution of the strike, what happened to stop the strike and consequences or overall outcomes after the strike. The resolution of strikes is not always peaceful and pleasant for parties involved, as was the case with the strike in Malawi (in 2001), where as a result, HCWs were transferred, suspended, dismissed and the government's promises were not kept (28). These actions are probably not the most appropriate way to resolve the strike problem, as they could lead to legal action and disputes between the parties, causing discomfort, mistrust, resentment and further distancing between employees and employers, producing an effect contrary to the desired one (35). These conflicts, if unresolved, set precedents with an impact on the future, subsidising future strikes and leaving historical marks that are difficult to overcome.

## 5 Conclusion

Among HCWs, nurses and doctors are the most involved in strike movements, and aspects associated with salaries and working conditions have dominated the grievances' agendas and have stood out as the main causes of strikes in the healthcare sector in SSA. Strikes occurred in the public health sector and, to mitigate their impact, the most prominent strategy was to restrict health services and prioritize emergency cases, causing greater demand for private services and worsening healthcare costs. To make up for the shortage of human resources, the tasks of the available staff have been readapted, such as military doctors and those with management positions who have been helping in the health units, but there has been overload, tiredness, and demotivation among the available staff. The strikes compromise access to health care systems and the well-being of patients, especially the most disadvantaged. They may represent a setback for a country's development, with implications for everyone involved in the health system. Therefore, there is a need to adopt strategies to prevent this phenomenon or timely resolution through regulation and negotiation to balance the rights of HCWs and the rights of patients.

## Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

## Author contributions

AM, IC, and PF worked on designing the study protocol. AM, IC, and MS conducted the systematic literature review. AM worked on the conceptualization and writing of the original draft. IC, PF, AC, and MS reviewed and edited the manuscript. All authors contributed to the article and approved the submitted version.

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## Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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## Supplementary material

The Supplementary material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fpubh.2024.1209201/full#supplementary-material>

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## **2.2 Estudo 2: A look back at the strike by Mozambican doctors in 2013: What can we learn?**

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RESEARCH

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# A look back at the strike by Mozambican doctors in 2013: what can we learn?

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## Abstract

**Background** The occurrence of strikes in the health sector has been an increasing concern around the world, given their negative impact on the provision of services and care to patients. The Mozambican doctors' strike in 2013 is considered by many to be the largest of a kind in the country's history, and marked the changes which are still a matter of debate. The aim of this study is to understand the causes, strategies and perceived impact of this strike from the perspective of the main actors involved, taking a look back at everything that happened, including the back-stage and tense moments during the negotiations. These details have been little covered in similar studies and are important for a better understanding and management of this type of movement.

**Methods** This is a qualitative study with a phenomenological approach that consisted of semi-structured interviews with the main players involved in the strike movement, and analysis of documents produced around this movement. Non-probabilistic snowball sampling was used to select participants until data saturation was reached. The interviews were transcribed and imported into Nvivo version 12, and the data was analysed using content analysis to identify themes related to the research questions.

**Results** The doctors were demanding better salaries, career prospects and working conditions. Failure to fulfil agreements, threats from the government and a lack of communication are believed to have precipitated the strike. Faced with staff shortages, the government restricted services, prioritised urgent cases, and patients saw services slowed down, their care delayed, a lack of medicines in health units and a loss of confidence in the healthcare system. Although the strike contributed to the approval of the Doctors' Statute, it led to the interruption of postgraduate studies, transfers and suspensions of professionals.

**Conclusion** The strike was motivated by aspects associated with salaries and working conditions. Some of the approaches adopted further distanced the parties and delayed consensus. The strike had negative consequences for everyone, especially patients. This study provides important lessons for improving strike prevention and management strategies in the health sector.

**Keywords** Doctors, Healthcare workers, Strike, Protests, Health services, Mozambique

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**Background**

Strikes are mechanisms adopted by employees to force specific demands or claims when the possibilities of reaching an agreement with the employer through negotiated means have been exhausted. Strikes imply interrupting, partially or completely, the provision of services for a few hours, several days or longer [1–3].

The occurrence of strikes by doctors and other healthcare workers (HCW) has been a frequent concern around the world, given their negative impact on the provision of healthcare to patients, and the political, organizational and financial implications they bring [2, 4].

Wage arrears, non-payment of allowances, lack of opportunities for professional development and career progression, poor working conditions, shortages of essential medicines, as well as aspects related to political opposition and leadership have all been reported as triggers for HCW’s strikes [1, 5–7].

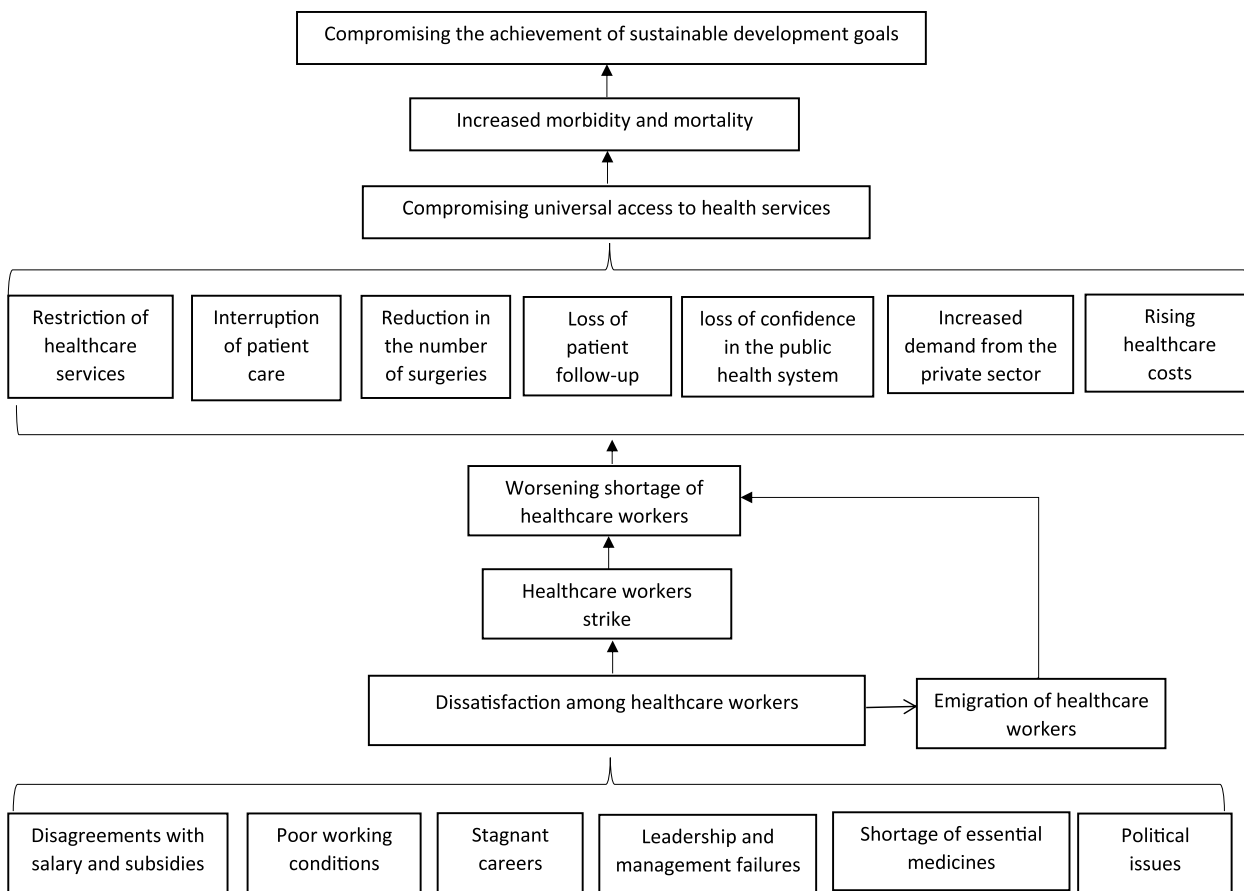
Several implications of HCW’s strikes for health services and patients have been reported in published studies, including interruption of patient care, reduction in the number of surgeries, prolonged hospitalization,

loss of patient follow-up, worsening of patients’ state of health, increased morbidity and mortality, search for alternative health services, high rates of referral to private hospitals, high private hospital costs, loss of confidence in the public health system and emigration of qualified HCW (as can be seen in Fig. 1) [1, 8, 9].

The effects of HCW’s strikes seem to be worse in low- and middle-income countries due to already underlying limitations regarding infrastructure and resources, weak institutional arrangements and a lack of affordable alternative healthcare outlets [1, 10].

Strikes aggravate pre-existing human resources for health crisis in sub-Saharan African (SSA) countries. This compromises the achievement of universal health coverage, as well as of the Sustainable Development Goals [11, 12].

In 2013, there was a doctors’ strike in Mozambique, the motivations and consequences of which have never been systematically studied, and there are no published studies on this topic in Mozambique. This strike took place in two periods, the first from the 5th to the 15th of January 2013, involving only doctors, and the second from the 20th of May to the 20th of June of the same year, when



**Fig. 1** Conceptual diagram of the causes and consequences of the strike

the doctors mobilized other HCW groups to support their fight.

During the strike, the doctors were represented by the Mozambique Medical Association (AMM, acronym in Portuguese), while other HCW (such as nurses, pharmacy technicians, laboratory technicians, service agents and other health technicians) were represented by the United Health Professionals (PSU, acronym in Portuguese), both currently registered as trade unions.

At the beginning of the strike, the PSU, unlike the AMM, was an unofficial association, that is, all legal procedures for its creation had not been followed [13]. The PSU was created in response to the non-adherence to the strike by the National Association of Nurses of Mozambique (ANEMO, acronym in Portuguese) and the Association of Laboratory Technicians and Clinical Analysis (ATLAC, acronym in Portuguese) [14], and ANEMO was accused of acting clandestinely and passively, neglecting the defence of the class [13].

Therefore, this study aims to understand the process of the 2013 doctors' strikes in Mozambique, including the contextual factors that contributed to the strikes, motivations and demands of HCW, tactics used by public health authorities and the government to mitigate its effects and/or stop it, and its consequences for the public, HCW and the public health system. In addition to documenting the findings and to contributing for the analysis of the topic in a scholarly manner, the study also aims to be an evidence base for health sector policy and decision makers to guide strategies and policies to manage and control strikes, as well as anticipate and prevent their occurrence in Mozambique and other countries with similar socio-economic conditions.

## Methods

### Study location

Mozambique is a country in south-east Africa, bathed by the Indian Ocean to the east and bordered by Tanzania to the north; Malawi and Zambia to the north-west; Zimbabwe to the west and the Kingdom of Eswatini and South Africa to the south-west. In its government structure, the country has several ministries, including the Ministry of Health (MISAU, acronym in Portuguese), which is responsible for guaranteeing access to health services and care for the entire population. The governance of the health system is being progressively decentralized to provinces, municipalities and district health authorities [15].

In 2013, Mozambique had a total of 1,452 doctors (one per 17,235 inhabitants) and 6,395 nurses (one per 3,913 inhabitants). This number increased to 2,745 doctors (one per 11,232 inhabitants) and 10,268 nurses (one per 3,003 inhabitants), in 2021 [16, 17].

### Study design

This is a qualitative study with a phenomenological approach that consisted of semi-structured interviews with the key actors involved in the Mozambican doctors' strike movement in 2013 (government leaders, civil society and HCW organizations) and analysis of official and media documents issued in the context of the doctors and HCW's strikes [18–21].

### Data collection procedures and tools

#### *Semi-structured interviews*

Data were collected between March 2022 and May 2023. Semi-structured in-depth interviews were carried out based on an interview guide prepared, pre-tested and revised with the help of a panel of experts with extensive experience in qualitative research. The pre-test helped to ensure better adequacy and focus of the questions to the research objectives, as some questions were a little vague, so they were reformulated. Some questions were very similar, with a certain redundancy, so they were eliminated or combined.

The interview guide comprised open questions to better understand the determinants and contours of the Mozambican doctors' strike in 2013 and included questions about: 1) the purpose of the strike; 2) the main actors involved; 3) the implications; 4) the tactics adopted; 5) the repercussions and the resolution of the strike (as can be seen in the supplementary material 1). During the interviews, the interviewers were allowed to add questions, while the interviewee was allowed to delve deeper into issues that they considered pertinent to a better understanding of the strike movement. The interviews lasted an average of 45 min.

Initially, the most prominent actors in the media during the strike were intentionally selected (the leaders of the strikers' group, government representatives and civil society actors), who made up an initial sample of eight (08) interviewees (including the first author A.L.J.M., as minister of health on the date of the facts).

This study began with the application of an episodic interview exclusively to the first author (A.L.J.M., as minister of health at the time of the strike) to minimize a potential risk of bias, since the first author also lived through the episode to be investigated, as a preponderant figure, so the use of his information is complex and requires a different methodology [22]. Therefore, the episodic interview was carried out separately in October 2021 (by I.C.), to gather information from the former health minister before the interviews with the other participants began, and even before the process of re-reading and analyzing the documents written by him at the time of the strike, in order to minimize influences on the way he experienced the phenomenon under study, as described by Flick [22].

The other interviews were conducted by a trained researcher (Celso Soares Give, trained by I.C.). Celso Soares Give is a senior lecturer and researcher affiliated to the community health department of the Eduardo Mondlane University in Mozambique, with a Master’s degree in Public Health, who has dedicated himself to carrying out qualitative research, so he is familiar with the application of interviews in this field, while I.C. (who conducted only the episode interview) is a sociologist, teacher and researcher with mastery and experience of interview techniques in different contexts. None of the interviewers was involved in the strike movement in any capacity.

It was important that the interviews (with the exception of the episodic interview) were carried out by a researcher external to the study, as a strategy to control any kind of influence (personal, interpersonal or political) that the study might suffer (described in the research team’s reflexivity in supplementary material 2).

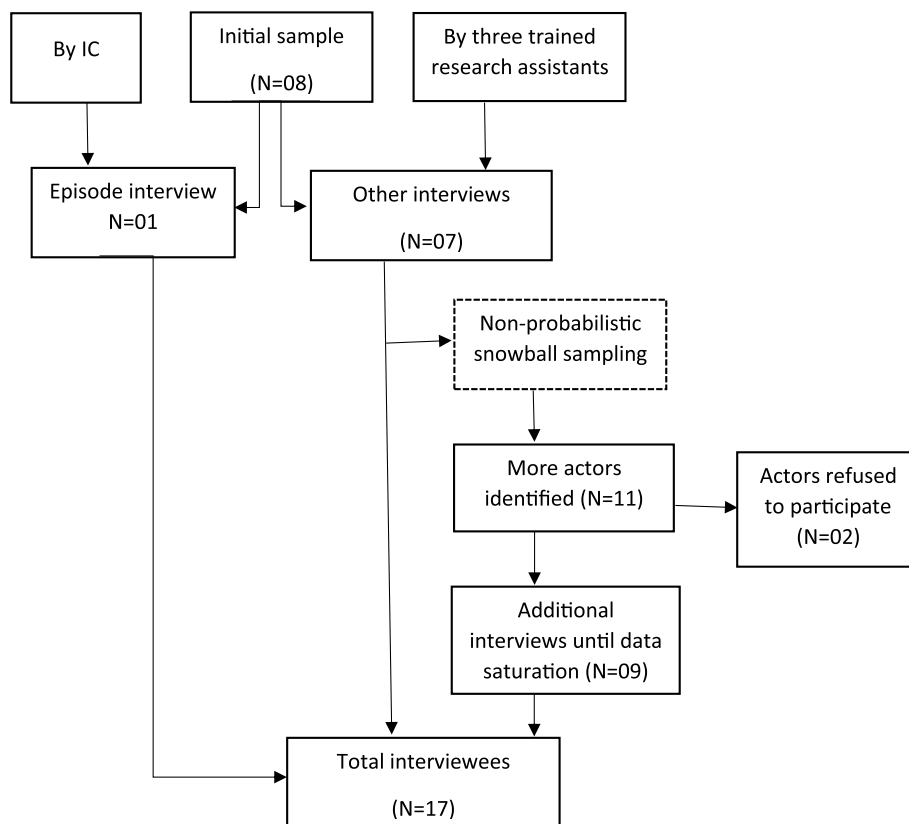
During these interviews, more actors ( $n=11$ ) were identified through a non-probabilistic snowball sampling conducted until data saturation. No new data emerged from the 13th interview onwards, and the subsequent three interviews confirmed the achievement of data saturation [23–26]. Of a total of 19 actors identified, only two

actors, one from the striking group and the other from the government, refused (without justification) to participate in the study, giving a refusal rate of 10.5%. Therefore, a total of 17 interviews were carried out, including the episodic interview (as can be seen in Fig. 2).

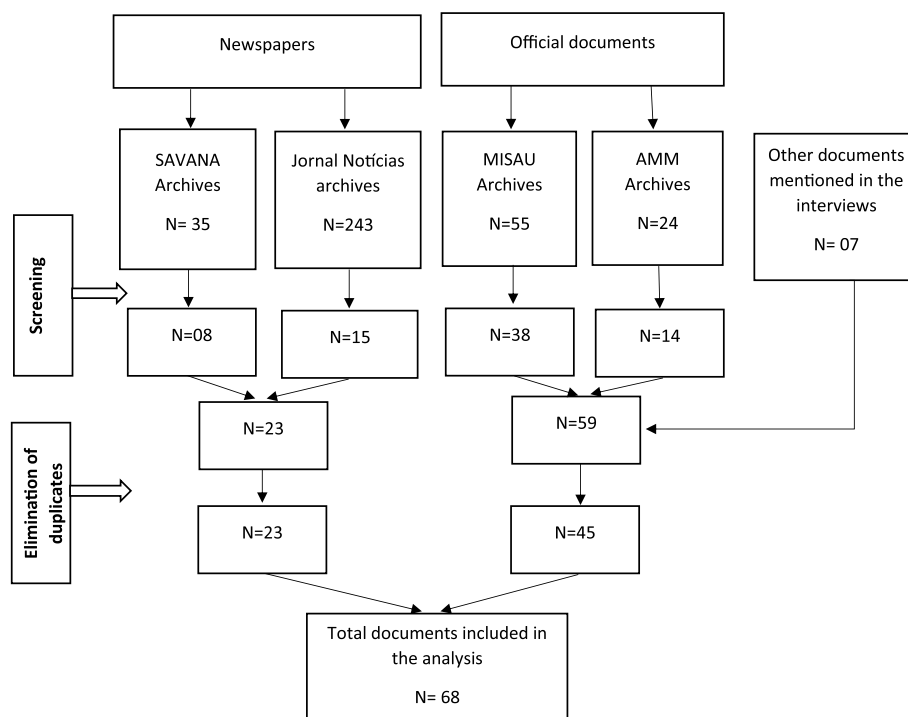
All interviews were conducted in Portuguese and recorded with the prior written consent of the interviewees. The interviews were conducted mostly in person, but in four cases virtually (via Zoom), depending on interviewees’ availability.

**Document analysis**

The archives of the MISAU, the AMM and two prominent printed media in Mozambique were manually searched (by Arménia Leia Sofar Mucavele, Dalmázia Helena Mariza de Castanheira e Cossa, Maria Luísa Miguel Falcão and Rosa Langa) to identify relevant documents and publications from December 2012 to July 2013. A total of 357 documents were identified and submitted to the selection process. Documents whose title or subtitle addressed the strike in the health sector were selected. To these were added documents cited by the interviewees or related to their comments (as can be seen in Fig. 3).



**Fig. 2** Summary of the interview process



**Fig. 3** Flowchart of the document selection process

Therefore, a total of 68 documents were selected and analyzed, which included: media publications (two newspapers), Annual Health Human Resources Report, Pre Notice and Strike Guidelines for doctors and HCW and the respective demand books, General Report on the paralysis of activities in the National Health Service, Memorandum of Understanding (MoU) between the MISAU and AMM, Regulation and Statute of Doctors in Public Administration, AMM Regulation, Dispatches from the Minister of Health, book of minutes of meetings between MISAU and AMM, book of minutes of meetings of the MISAU Management Collective, Report of Disciplinary Processes raised in the context of the work stoppage, Constitution of the Republic of Mozambique of 2004, Regulation of the General Statute of State Employees and Agents, and Statute of the Mozambican Doctors Council (OrMM, acronym in Portuguese) and Code of Ethics (as can be seen in the supplementary material 3: Supplementary Table 1).

### Data analysis

The interviews were transcribed verbatim by a researcher external to the study (Sofia Arminda Roberto) and then checked (by I.C.). In the end, the preliminary transcripts were shared with the interviewees for checking, and after four weeks, the interviewees were telephoned for additional comments (with the exception of the

episode interview), which were recorded, transcribed and included for analysis [27]. All interviewees were involved in this process, but only three interviewees (18.8%) made additional comments.

The final (anonymised) transcripts were shared with the researchers (A.L.J.M., D.B.S. and M.S.) so that they could proceed with the analysis, first independently and then together to ensure better alignment between them [28]. All analyses were carried out using the Nvivo programme (version 12).

The content analysis technique was used to analyse the documents and the interviews' transcriptions, identifying the emerging core in each text, through the process of coding (categorisation) and interpretation of the information contained, to uncover its manifest and latent content, according to the procedure described by Bengtsson [29]. Initially, through a quick review of the literature, a set of themes and subthemes were predefined, and others were added during the analysis of the transcripts and documents (Table 1).

The researchers then read and re-read the transcripts as a whole to familiarise themselves with the data. The transcripts were broken down into smaller meaning units. These units are constellations of sentences or paragraphs containing aspects related to the causes, tactics adopted and impact of the strike. Each meaning unit was labelled with a code according to the pre-defined list (deductive) and others that emerged from the data (inductive). This

**Table 1** Summary of themes defined during analysis

Themes	Subthemes
Causes	Income and living conditions
	Working conditions
	Socio-political conditions
	Government’s approaches
Approaches adopted during the strike	Strikers’ approaches
	Mediators’ approaches
Impact of the strike	For the National Health System, services and for users
	For doctors and other healthcare workers
	Changes achieved with the strike

process was repeated twice, starting from a different page each time to increase stability and reliability. Subsequently, the transcripts were read again together with the final list of meaning units and each meaning unit was marked on the original transcript. The unmarked text was re-evaluated to see if any important aspects had been missed. Then, the number of meaning units was reduced by condensing them. The meaning units were grouped into causes, tactics (strategy) and the impact of the strike, taking into account the research questions, so the meaning units were transformed into sub-themes, and their groupings into themes. After this phase, the researchers (A.L.J.M., D.B.S. and M.S) met to analyse the categorisation made by each of them and eliminate discrepancies. The data was compiled and analysed in manifest and latent form, and in each theme and sub-theme, meaning units were chosen that best represented the manifest or latent content and presented in quotations [29].

The recording of the episode interview (with A.L.J.M.) was shared at the end [22], after the analysis of the other interviews had finished, so it was transcribed verbatim (by Sofia Arminda Roberto) and analysed (by A.L.J.M., D.B.S. and M.S.), serving as a complement for a better understanding of the facts.

**Ethical considerations**

This study was approved by the Institutional Bioethics Committee of the Instituto Superior de Ciências de Saúde (on 21 August 2020, ref. 02/CIBS-ISCISA/2020) and by the Ethics Committee of the Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa (on 06 April 2021, ref. 2.21). All the interviewees were previously informed about the nature of the study and participated by signing an informed consent form. They were also informed that their participation was voluntary and that they were free to withdraw their consent to participate in the study at any time, without conditions or reprisals. The

anonymity of the participants was guaranteed by coding their names (E1, E2... E17) in the interviews, transcripts and manuscript. The interviews took place in a private environment of each participant’s choice and only in the presence of the interviewer and the interviewee. Twelve months after the end of the study, the interview recordings and informed consent forms will be destroyed by the principal investigator. The study data, which will be protected by the principal investigator in electronic files, may not be used for any other type of study or for any purpose other than that inherent to this study. In these terms, this study followed the principles of the Declaration of Helsinki [30].

**Results**

The interviewees were all based in the capital city, Maputo, aged between 36 and 93, with an average of 58.6 years (SD:12.8), and the predominant gender was male (70.6%). The majority were surgeons (23.5%), specialist public health doctor (23.5%) and general practitioners (17.6%), as shown in Table 2.

**Antecedents of the doctors’ and HCW’s strike in Mozambique**

On 7 December 2012, the AMM sent a nationwide strike notice to the MISAU, which would begin on 17 December 2012 [31], since then a cascade of key events have taken place (Table 3).

**Table 2** Socio-demographic characteristics of the interviewees

Variables	N	%
<b>Age</b> (average: 58.6 years)		
31–40	2	11.8
41–50	2	11.8
51–60	6	35.3
> 60	7	41.2
<b>Gender</b>		
Male	12	70.6
Female	5	29.4
<b>Group belonging during the strike</b>		
Striking healthcare workers	6	35.3
Mediators (civil society)	5	29.4
Employers (Government)	6	35.3
<b>Occupation</b>		
Surgeon	4	23.5
General practitioner	3	17.6
Internist doctor	1	5.9
Specialist public health doctor	3	23.5
Nurse	1	5.9
Religious leaders	2	11.8
Manager	1	5.9
Lawyer	1	5.9

**Table 3** Summary of the main events

Chronology of events	Date	
1	Approval of the Doctor Statute by the 22nd Ordinary Session of the Council of Ministers	07/21/2012
2	Pre-strike notice by AMM in representation of doctors	12/07/2012
3	Talks begin between MISAU and AMM	12/07/2012
4	Postponement of strike after reaching some points of consensus	12/14/2012
5	Creation of the Statute Revision Committee and the Salary Technical Committee	12/17/2012
6	Mozambique doctors' strike begins	01/05/2013
7	Negotiations resume	01/09/2013
8	MoU signed between the MISAU and AMM	01/15/2013
9	Mozambique doctors' strike ends	01/15/2013
10	Approval of the revised Doctor Statute by the 4th Ordinary Session of the Council of Ministers	02/26/2013
11	Pre-notice of strike for doctors and other HCW	05/13/2013
12	Start of talks between MISAU and AMM and PSU	05/16/2013
13	Start of strike by doctors and other HCW	05/20/2013
14	Suspension of postgraduate studies (specialization)	06/05/2013
15	Doctors' and other HCW's strike ends	06/20/2013
16	Approval by the Assembly of the Republic of the Medical Statute	11/01/2013
17	Approval of the Regulations for the Statute of Doctors in Public Administration	08/29/2014

AMM Mozambique Medical Association, HCW Healthcare workers, MISAU Ministry of Health, PSU United Health Professionals

The strike consisted of doctors paralyzing their activities in all sectors, except for emergency services at central and provincial hospitals, pediatric, gynecological and obstetric emergency services, emergency operating theatres and emergency services at health centers. The doctors were demanding better salaries and a revision of the Statute of Doctors in Public Administration (approved by the Council of Ministers on 7/21/2012, without either the AMM's or the OrMM's opinion). They wanted some rights safeguarded in the Statute [31, 32].

Following the strike notice, talks began immediately between the Mozambican government (represented by MISAU) and the AMM, and two independent working committees were formed: The Statute Review Committee and the Technical Salaries Committee [33]. While these negotiations were ongoing the starting date of the strike was suspended. Nevertheless, the lack of consensus on salary issues triggered the beginning of the strike on 5 January 2013. This only ended with the signing of a MoU between the parties [33].

The MoU agreed to renounce threats, intimidation and future reprisals against doctors and trainee doctors as a result of the work stoppage, and the approval (by Decree and Ministerial Diplomas) of the Statute of Doctors in Public Administration and the respective revised salary scale by April 2013 [34]. The Doctors' Statute guaranteed doctors the right to housing, allowances (risk and seniority) and a different career regime within the civil service [35, 36].

On 20 May 2013, the doctors, this time accompanied by other HCW, represented by the AMM and PSU,

respectively, began a national strike (under the slogan: caring for those who care), motivated by the government's failure to comply with the terms of the MoU signed in January 2013, namely: no reprisals against doctors and trainees, approval of the Doctor's Statute in the first session of the Assembly of the Republic and permanent dialogue [13, 37].

According to the strike guidelines announced by the AMM [37], the strike consisted of paralyzing the activities of doctors in all sectors, i.e. all doctors from general practitioners, academics, researchers, dentists, specialists and those with non-clinical activities in public institutions, such as the MISAU or other sectors, with minimum services being the responsibility of military doctors, foreign doctors and doctors in management positions. In districts where there were no foreign doctors, it would be up to the government to allocate the available foreign and military doctors.

According to the guidelines announced by the PSU, the strike consisted of paralyzing the activities of HCW in all sectors, that is, all service agents, security guards, drivers, nurses, technicians, administrators, lecturers and others; they should not attend their workplace. The minimum services were ensured by foreign HCW, military personnel and those in management positions [13].

#### The different actors involved in the strike movement

##### Strikers

The first strike (from 5th to the 15th of January 2013) was exclusively for doctors and, according to the interviewees,

the non-involvement of other HCW was a preference of the doctors themselves. This changed in the second strike (from the 20th of May to the 20th of June 2013), which involved other classes of HCW.

E01 (Doctor, government representative): *"The first strike was by doctors and when they saw that it wasn't having the desired effect, they tried to mobilize nurses and other classes to get as many people on strike as possible and they called it a strike by health professionals."*

The leaders of the strike movement were young doctors with some professional experience who had already been exposed to the reality of medical practice in Mozambique, and some were even in the process of specialization.

E10 (Doctor, government representative): *"The forces that appeared most engaged were young people, but not recent graduates, they were young people with some experience, they had already experienced some of these difficulties on a day-to-day basis. It's interesting that many of these young people were doctors in postgraduate training (specialization). There were also some older adults, eh!, I wouldn't say in leadership, but in encouragement to strike"*

But among the strikers, not all worked in the public health sector, some worked in Non-Governmental Organizations (NGOs).

E12 (doctor, strike leader): *"I and the president of the AMM put our interests aside to the benefit of the collective, although many thought it was for financial reasons, but no, the president (of the AMM) for example, was in an NGO, to say that in 2013 he earned [a significant amount in USD], that amount is still something today, so he was well paid"*

E17 (episode interview, government representative): *"We heard that many of the strikers were NGO workers, they even took vacations from work to come here to guide the strike, this was the case with their leader"*

The first strike was also attended by trainee doctors (in their final year of medical school), as they could be effective members of the AMM [38].

E11 (Doctor, government representative): *"They [trainee doctors] were being pressurized to go on strike, I heard that they were even being threatened if they attend the internship"*

#### **Employers (the Mozambican government)**

On the government side was the MISAU, represented by the Minister of Health, the Permanent Secretary, the Inspector General of Health and the respective National Directors, the Director General of Maputo Central Hospital, representatives of the Ministry of Public Service, the Ministry of Finance and the Ministry of Justice [33].

E17 (episode interview, government representative): *"A priori, the government thought that it was the*

*responsibility of the Ministry of Health to resolve this issue, but then realized, due to the course of events, that some issues addressed were not within the responsibility of MISAU, therefore, they should be assessed by other sectors, therefore, it required greater intervention and involvement from other governmental sectors"*.

#### **Mediators**

The mediators' mission was to bring the two parties (government and HCW) together. Some mediators acted directly, even accompanying the negotiating teams, such as the Mozambican Doctors' Council (OrMM), the Mozambican Workers' Organization—Central Trade Union (OTM-CS) and the Human Rights League [39], and later, as part of the government's tactic to sensitize the strikers, religious leaders were included. Some civil society organizations such as the League of Non-Governmental Organizations in Mozambique (Joint, acronym in Portuguese), ANEMO, ATLAC and the Mozambican Lawyers Council intervened in the negotiations in order to bring the parties together and resolve impasses in negotiations.

E01 (doctor, government representative): *"The government negotiated in good faith and there came a time when we saw that we weren't getting the results we wanted, so we included religious leaders, civil society, and other people who could help in the negotiation."*

E15 (doctor, OrMM, mediator): *"The OrMM was there (at the negotiating table) but as an attempt to bring the parties together, these parties, in this specific case, were the Government and on the other side were the doctors."*

E07 (doctor, striking group): *"The president of the Human Rights League supported us a lot, yeah!, then some entities appeared, some personalities tried to talk to us to try to get us to stop the strike and continue the dialogue: that is the case of the President of the Lawyers' Council"*

E17 (episode interview, government representative): *"When I realized that the Human Rights League was on the strikers' side, on the day I had to meet with the striking doctors I also asked for the Human Rights League to be present"*

#### **Causes of the doctors' and other HCW' strike**

From the strikers' perspective there were three types of causes underlying the strike: those associated with living conditions, working conditions and socio-political conditions (Table 4).

#### **Income and living conditions**

Aspects associated with the living conditions of doctors and other HCW were cited as the main triggers for the strike by comparison with the salaries of other

**Table 4** Summary of the main causes of the strike

Themes	Subthemes	
Causes	Income and living conditions	<ul style="list-style-type: none"> <li>• Lack of right to housing</li> <li>• Salary gap (compared to other sectors)</li> <li>• Low salary</li> <li>• Non-payment of allowances;</li> <li>• No career progression</li> </ul>
	Working conditions	<ul style="list-style-type: none"> <li>• Insufficient biosafety equipment</li> <li>• High workload</li> <li>• Lack of medicines and supplies</li> <li>• Inadequate infrastructure</li> </ul>
	Socio-political conditions	<ul style="list-style-type: none"> <li>• Regulation of the Doctor's Statute</li> <li>• Lack of communication with healthcare workers</li> <li>• Lack of transparency in public fund management</li> <li>• Lack of investment in the healthcare sector</li> <li>• Lack of trust in government</li> <li>• Negative influences of foreign policy stakeholders</li> </ul>

professional classes such as judges, prosecutors and fiscal technicians, so doctors and other HCW were demanding better salaries, including risk and seniority allowances, as well as the right to housing (especially for HCW who worked far from their usual place of residence).

E07 (doctor, strike group): *"We demanded a salary similar to that of magistrates and a risk allowance different from the one stipulated at the time, which I think was 7.5 or 10 per cent of the monthly salary; so we wanted it to be between 25 and 30 per cent, taking into account the risks, the exposure we are subject to; another thing was to be given the right to have a furnished house with expenses paid for by the state, with water, electricity bills all paid for by the state; and the approval of our statute."*

Another aspect cited by the interviewees that motivated the strike was the lack of progression in their professional careers.

E14 (nurse, strike group): *"The problem of career progression was a major factor for us, we made little progress, so it made the nurses angry too and they supported the strike"*

#### **Working conditions**

HCW complained of a lack of infrastructure, medicines, diagnostic and protective equipment to carry out their activities, as well as a high workload.

E04 (doctor, strike group): *"I'm talking about the day-to-day of being a doctor, arriving at a Health Unit and seeing patients without the right conditions for the patient and for us too, from infrastructure to working resources and diagnostics"*

E12 (doctor, strike group): *"We had a heavy workload, in other words, for example, I was in a sector where I did 24-h emergencies, then went to the operating theatre, and*

*after operating, I had to see the patients on the ward and then go home, so that the next day I could be there at 8am to work"*

#### **Socio-political conditions**

The first strike ended with the signing of a MoU between the AMM and the MISAU (on 15 January 2013), with some terms and deadlines for compliance, but some of these terms were not met by the agreed deadlines, and the government's openness to dialogue decreased, showing a certain insensitivity towards the HCW' problem, which led to the second strike.

Doctors wanted to be treated with distinction within the civil service, as a way of valuing the profession and giving it prestige in society, and they had the doctors' statute as a guarantee, which is why they demanded that it become law (being approved by the Assembly of the Republic) and within the established deadlines [34, 36].

In the strike guidelines (dated 14 May 2013), the AMM refers to three unfulfilled points: 1) No reprisals against doctors and trainee doctors; 2) Approval of the Doctors' Statute in the first session of the Republic Assembly; and 3) Permanent dialogue and joint action to achieve the established goals [37].

According to the strikers, dialogue between the parties had become even less fluid since the initial strike. Despite continuous insistence on the need for dialogue on the part of AMM, silence was always the response from the competent entities (government) [37].

E07 (doctor, striking group): *"There was a violation of the MoU by the government and the deadlines were not met, which is why we went on a second strike."*

Another aspect cited by the interviewees was the lack of transparency in the management of public funds,

with no clarity in the criteria for allocating funds, clearly disadvantaging the health sector.

E04 (doctor, striking group): *"We saw that the application of funds wasn't judicious and transparent, with an imbalance that affected the health area and didn't allow it to develop, so we saw that health wasn't a priority"*.

However, it was also believed that there was external influence, that the strike movement was inspired by similar movements abroad.

E17 (episode interview, government representative): *"This movement had a greater dimension because there were already a good number of Mozambican general practitioners and specialists, and it was organised in detail. I think it was organised based on experiences of what we see happening in other countries"*.

Among members of the government, there were those who believed that the strikers had external support and that the movement was linked to the fulfilment of a foreign and domestic political agenda, precisely because of the timing of the strikes (in the run-up to the 2014 general elections), which was denied by the strikers.

E01 (doctor, government representative): *"The strike was more of a political movement because there were clearly signs of subversion on the part of some countries, ambassadors and NGOs that openly supported the strike's mentors, and used embassies for meetings and there was political exploitation of others. It was expected that services would be paralyzed at a national level and this would provoke disproportionate discontent among the population against the government and this would create a fury among the population with very negative consequences, such as deaths and more"*.

E05 (doctor, government representative): *"If we increased salaries in the health sector, then there would come a strike by the teachers and police, who were already organized, that was the scenario and we were a year away from the elections, the elections were for 2014, do you realize the implications?"*

E12 (doctor, leader of the strikers): *"There was miscommunication and the basis of the miscommunication was the misinterpretation of the causes of the strike as political or personal. There were never any political aspects, there were always social aspects, the issue of doctors' and HCW' salaries and the working conditions that were deteriorating, these were the two reasons, I repeat there were never any political reasons, so much so that we had a meeting with leaders of the ruling party to explain that 'look, nobody here has anything against the party, what we want is salary and working conditions and we're not against the leadership, what happens is that now the pot has burst, that's all"*.

One aspect cited by the strikers as a catalyst for the strike was the feeling of insensitivity on the part of the team representing the government towards their concerns during the negotiations.

E04 (doctor, striking group): *"The treatment we received there, from the leaders, was something that really impacted me, they said 'we were a bunch of kids,' so they didn't look at us as serious people, and many of the things that were said in those meetings were too insensitive, and we wondered how people who head the Ministry of Health would say things like that to us, wow!"*

#### **Approaches adopted during the strike**

During the strike, the main mechanism adopted to reach consensus was dialogue (negotiations) between government representatives and HCW, however, this was not always possible, and additionally each group adopted different strategies to achieve their objectives (Table 5).

At the beginning of the second strike (from the 20th of May to the 20th of June 2013), there was resistance on the part of the government to include other HCW at the negotiating table with the doctors, allegedly because their association was not regulated, contrary to the wishes of the AMM, which in turn refused to negotiate.

According to the general report on the paralysation of activities in the health sector: *"The PSU, however representative it may be, as far as we know, is an entity without legal recognition in the Mozambican legal landscape, which makes it illegitimate to celebrate any agreement on behalf of all HCW in Mozambique, some of whom are already organized in associations, such as nurses, pharmacists and laboratory professionals"* [33].

Savana newspaper (edition 06–28–2013): *"At the first meeting, scheduled for May 16, the AMM Management was accompanied by other HCW who were not part of this Association, with whom the dialogue would have to take place in another moment, but AMM imposed that the dialogue could only restart in the presence of these professionals. At this meeting, when the government expressed its position of talking only with AMM, within the scope of the MoU signed in January 2013, the AMM left the meeting room and never returned, and on the 20th the second work stoppage of 2013 began"* [40].

However, the parties continued the dialogue on May 28. The government retreated, showing openness to dialogue also with the PSU, but as mere workers of the State Apparatus and not representatives of other HCW [33].

#### **Tactics adopted by the government**

Faced with the doctors' wage demands, the government claimed that there were insufficient funds and that the budget plan for that year had already been approved, and that its fulfilment even depended on external aid,

**Table 5** Approaches adopted during the strike by doctors and other HCW

Approaches adopted during the strike	Government's approaches	strikers' approaches	Mediators' approaches
	<ul style="list-style-type: none"> <li>• Ask former health ministers for advice</li> <li>• Presentation of a Doctor's Statute with compensation allowances</li> <li>• The use of police force</li> <li>• Readjusting the tasks of available staff</li> <li>• Request support from the Mozambican Red Cross and doctors from the defense forces</li> <li>• Restricting services and prioritizing the most critical sectors</li> <li>• Interrupting pre-scheduled appointments and surgeries</li> <li>• Raising awareness among students and guardians by invoking the pedagogical regulations</li> <li>• Threat of disciplinary proceedings</li> <li>• Inclusion of religious leaders and civil society organizations in the negotiations</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement of other entities (such as embassies)</li> <li>• Pressurizing final-year medical students (trainee doctors)</li> <li>• Marches and demonstrations in the streets</li> <li>• Control/spy on the Ministry and Hospitals (entrances and exits)</li> <li>• Prevent other HCW from working</li> <li>• Advocate the right to strike and invoke the Constitution (legislation)</li> <li>• Use the media to pressure the government</li> </ul>	<ul style="list-style-type: none"> <li>• Educating and sensitizing based on ethics and religion</li> <li>• Listening to the parties, promoting rapprochement and dialogue</li> <li>• Recruit believers and people from the community to help with activities in the health units</li> </ul>

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a somewhat paradoxical argument in the eyes of the strikers.

The President of the Republic says that doctors are pressurising the government to give them money that the state doesn't have: "HCW chose to strike to force the government to give them more money, at a time when the state budget still depends on contributions from external partners, in the order of 30 per cent. The pay issue is a general problem and not just for the medical profession" (SAVANA newspaper, 05–31–2013 edition) [41].

For the AMM press office, a poor country doesn't import luxury cars for its leaders, it doesn't provide luxury pensions or high-level perks for its leaders. For the doctors, it's a paradox to say that the country is poor while it spends rivers of money on useless perks (SAVANA newspaper, 05–31–2013 edition) [41].

The government planned a gradual increase in the salaries of HCW in order to reach the salary required by them within a few years, which was not understood by the strikers.

General report on the paralysation of activities in the health sector: "In April 2013, the Council of Ministers approved the general guidelines for salary readjustment in the public service for 2013. This document differentiates the readjustment in the health sector, and aims to bring the salary scale for doctors closer to that of the judiciary in a phased process. The increase approved for this year

[2013] will be 15 per cent on the basic salary for doctors and 9 per cent for other HCW" [33].

According to the guidelines for the second doctors' strike: "The 15 per cent salary increase, which translates into an increase in the doctor's basic salary of around two thousand meticaais, demonstrates the appreciation that the Mozambican government has for us—a total contempt" [37].

E06 (religious leader, mediator): "We really all agreed that conditions should be improved, but there were no material conditions to realise this desire. So, the point of contention starts here, because the doctors, especially the younger ones, wanted to solve the problem immediately, but the country doesn't solve problems immediately, but with medium and long-term programmes".

In an attempt to stop the strike, the government presented a proposal for a Doctor's Statute with some compensation allowances included, as a discreet way of increasing doctors' salaries.

There was a certain fear on the part of the government that the increase in doctors' salaries would have a domino effect and provoke strikes by other classes such as police officers, teachers and other public sector employees.

E17 (episode interview, government representative): "I showed them the Doctor's Statute because the Ministry had no way of increasing the salary itself, so the Doctor's

*Statute was created as an alternative, which was a big step forward for their lives."*

*Savana newspaper (05–17–2013 edition): "On 19 December 2012, another meeting was held to discuss the issue of salaries where the AMM expressed its desire to see an increase in salary from the approximately 20,000 meticals that the younger doctors earned to 50,000 according to the table of private clinics and NGOs, with the MISAU informing that there were no conditions for the increase desired by the medical profession, the best way out being to increase the subsidies" [42].*

E01 (doctor, government representative): *"We thought there might emerge an Arab Spring and a general strike. So, when negotiating, the government also thought about the possible broader consequences of giving in".*

On the other hand, the MISAU met with Mozambique's former health ministers to seek advice on how best to manage this conflict, given their experience in governance.

E17 (episode interview, government representative): *"Well, I had the idea of calling former government officials to talk to them about their experience of these issues and ask for recommendations, advice... which helped a lot because they advised us on how we should approach this issue, in a cordial way and knowing that they are strikers, yes, but we are responsible for them, we exist because of them, and then understanding their cause and engaging in dialogue whenever possible, reducing confrontational attitudes as much as possible".*

On the ground, however, in the face of difficulties, the tactics adopted by the government were not always peaceful. At some point, the government resorted to intimidating mechanisms to achieve its objectives.

Through the Faculty of Medicine, the government pressurized trainee doctors (final year medical students) to return to their internships in hospitals by invoking article 37 of the Pedagogical Regulations of the Eduardo Mondlane University, which stipulates that the requirement for admission to a certain subject is not to have missed the equivalent of 20 per cent or more of the workload of the respective subject [43].

E11 (doctor, government representative): *"We decided to give the students an ultimatum and told them that if they came back by that day, we would ignore everything, there would be no penalization and they would resume their internships as if nothing had happened, ok, otherwise we would penalize them by failing their internship. Some of the trainees' parents came to see us and we explained that the measure was even the mildest, we shared a copy of the pedagogical regulations, and explained that if we were strict all these kids would be expelled, but that's not what we want, we want it to be educational, but also within the rules, and the mildest measure is to fail a person who has 20% absences in a subject, repeats the subject".*

E17 (episode interview, government representative): *"The students felt pressurized because they wanted to finish the course, and failing the internship meant a delay in their lives".*

Nevertheless, after the first strike ended (on 15 January 2013), the Faculty of Medicine at Eduardo Mondlane University failed the (final year) medical students who participated in the strike, ignoring the terms of the MoU signed between the AMM and the MISAU, which provoked a revolt from the AMM, which saw the Faculty of Medicine as an extension of the MISAU.

SAVANA newspaper (edition 02–01–2013): *"On January 30, 2013, the medical faculty of the Eduardo Mondlane University informed, in a statement, the failure of all 6th year medical students who joined the strike called by the AMM, and also determined to award certificates of recognition for selflessness and sacrifice in their academic obligations to students who did not join the strike, establishing an armistice between AMM, MISAU and the Faculty of Medicine, at Eduardo Mondlane University" [44].*

SAVANA (edition 02–08–2013): *"Under the Pedagogical Regulations of the Eduardo Mondlane University, 6th year students, for the 10 weeks (7 days × 10 weeks = 70 days) of internship in the health units of the National Health Service, and due to the absence of 9 days at no time do they exceed the 25% stipulated in these regulations, which by arithmetic calculations are (9 days/70 days) 12.9% of the time after the end of the strike, the trainee doctors made up to 2 weeks' compensation for the 9 days of work stoppage" [45].*

SAVANA newspaper (02–08–2013): *"The spokesperson for the Ministry of Health says that her institution has no powers to intervene in this imbroglio, given that it involves the AMM and the Faculty of Medicine. she recalled that the MISAU is doing everything it can to comply with the MoU signed on 15 January between the MISAU and AMM, to avoid persecution and reprisals against doctors, but with regard to trainee doctors it can do nothing" [45].*

Consequently, in the second doctors' strike (from May to June 2013), 6th year medical students did not join the strike, they were even assigned to provide minimum services together with foreign doctors [33].

During the strike, the available healthcare workforce was very limited, which led the government to restrict services (prioritizing the most critical sectors), interrupt pre-scheduled consultations and surgeries, readjust the tasks of the available staff, and request support from the Mozambican Red Cross and defence forces (military doctors).

Savana newspaper (07.06.2013 edition): *"Given this crisis situation, Mavalane General Hospital has been forced to interrupt treatment in some wards in order to prioritize the most critical sectors. At Maputo Central Hospital, surgeries are only being carried out on emergency patients.*

All pre-scheduled surgeries and consultations have been canceled" [14].

E02 (doctor, government representative): "We had to recruit military doctors and doctors with management positions to work in Central Hospitals".

E017 (episode interview, government representative): "We took the students from ISCISA (acronym in Portuguese for the Health Sciences Institute for Higher Education), because a good number of them were already health professionals, nurses, technicians (basic and secondary level), and we sent them to the units to provide support".

The government threatened the striking HCW with disciplinary proceedings on the basis of Article 95 of the Regulation of the General Statute of State Employees and Agents [46], generating some pressure on the striking group, which later contributed to end the strike.

E17 (episode interview, government representative): "I told them: look, you're on strike, but I'll keep marking absences every day, when you reach 30 absences you will have a disciplinary process."

E12 (doctor, strike group): "The financial part started to weigh on us, because we weren't working, right? And clearly, the government had said that the salaries wouldn't come in and many depended a lot on this salary. So, during the negotiations, we were aware that we didn't have much time."

At some point the government resorted to the use of police force to contain the strikers, prevent vandalism and control crowds, culminating in arrests, causing tension between the government, the strikers and some supporters (the population).

SAVANA newspaper (05–24–2013 edition): "At the Beluluane Health Center, Boane district, Maputo province, patients broke down the door and removed a number of medicines. Information from Magude, also in Maputo province, indicates that the police chased away and arrested the HCW involved in the strike. The population protested against the measure, invaded the district police command and released the detainees" [47].

SAVANA newspaper (05–24–2013 edition): "Despite several members of the executive reiterating that there is openness to dialogue, the same government used police force to prevent the doctors' meeting scheduled for this Wednesday in the Nangade garden in Maputo city center. Early in the morning, a contingent of armed police surrounded the garden and prevented the strikers from accessing the site. The strikers moved to the Costa do Sol beach where they met to outline new strategies" [47].

#### **Tactics adopted by the strikers**

One of the tactics adopted by the strikers was to establish contact with other entities that could intervene in their favor because they believed that the negotiating team

representing the government did not have any decision-making power and that negotiations with them would not have the desired effect.

E04 (doctor, strike group): "We involved other people who had influence or who could reach the leaders, like ambassadors, to go behind the scenes to unblock this, because the people we had been talking to on a day-to-day basis weren't working.". This contributed to the government considering the existence of an external political influence on this movement.

During the negotiation process, while some were in dialogue with the government, others were marching and protesting in the streets.

E12 (doctor, strike group): "This negotiation process was about sitting down and talking and sometimes they gave in, but then they [government negotiators] didn't comply, so we had to sit down and negotiate again, and in the meanwhile our colleagues were protesting and marching in the streets."

There were also threats and attempts to prevent other non-striking HCW from entering the hospitals to work.

E01 (doctor, government representative): "There was a day when they wouldn't let any workers in and threatened to remove everyone who was working there, it seemed that the aim was for patients to be left without care."

On the other hand, they pressurized trainee students (in their final year of medical school) to join the strike by invoking the AMM Statute, which in its sixth article includes them as effective members, calling them trainee doctors [38].

E11 (doctor, government representative): "There was some opportunism on the part of the AMM because in the Statute, final year students were called trainee doctors and, if they wanted to, they could be members of the Association."

Due to the pressure exerted by the Faculty of Medicine during and after the first strike, the final year medical students didn't join the second strike, they were present at the internship (in the hospitals) and at some point, they had to take care of patients without proper supervision, which was opportunely denounced and criticized by the strikers.

E17 (episode interview, government representative): "They used to call the students 'trainee doctors' to encourage them to join the strike, but when they saw that the students were helping to care for the sick, the discourse changed, the criticism became 'they left the sick in the hands of the trainee students,' they were no longer trainee doctors, they were students".

SAVANA newspaper (06–07–2013 edition): "Every day there are reports of deaths in maternity wards and other wards due to lack of care or poor care by inexperienced medical students" [14].

Jornal Notícias (06–08–2013 edition): *“The strike by doctors and other health professionals enters its third week today. To alleviate the absence of these professionals in caring for patients, the management of the Maputo Central Hospital (HCM) decided to use, among other resources, final year students, something that is deserving criticism from different sectors of society, with some even going so far as to consider the attitude as criminal”* [48].

E017 (episode interview, government representative): *“We’ve reached the point of such desperation that we’ve got final year medical students doing things that only doctors can do, you see? But if we didn’t do that, mortality would be higher”*.

SAVANA newspaper (edition 05–24–2013): *“A group of nursing students from the Maputo Institute of Health Sciences helped a 22-year-old patient bring her baby into the world at 11:30 pm this Tuesday. The labor pains began at 2pm and two hours later, the patient was already at Mavalane General Hospital. Until 10 pm she had not been visited by any health professional. An hour and a half later, she gave birth with the help of the students”* [47].

#### **Tactics adopted by mediators**

The mediators assumed a pedagogical role, raising awareness and promoting dialogue between the parties.

E06 (religious leader, mediator): *“We started educating the believing doctors in our churches, sensitizing them and showing them the value and role that God has given them, and so we gradually managed to bring the medical and auxiliary staff back.”*

On the other hand, the mediators recruited people (from the communities, religious groups) to provide support in the health units (in administrative and cleaning activities) as a way of relieving the workload of the available professionals.

E06 (religious leader, mediator): *“We had to bring in a lot of people, believers from the churches, to do auxiliary service in the hospitals, because the auxiliary staff also went on strike.”*

Other civil society organizations—intervened in the media (through interviews and press releases) criticizing the way the strike was being managed, trying to raise awareness and bring the parties closer together, so that they would reconsider their positions to safeguard patients’ rights.

*“This is no longer the time to discuss the legality or otherwise of the strike, but the seriousness of the situation leads us to seek only solutions. This requires humility on both sides in order to facilitate dialogue,”* said the civil society representative (Joint) as reported in Jornal Notícias newspaper (06–13–2013) [49].

Jornal Notícias (06–10–2013 edition): According to OrMM, the *“Guidelines for the second general strike by*

*doctors in Mozambique contravene the profession’s Code of Ethics and Deontology, which is why it called on doctors to provide minimum essential services (with ward rotations, permanent work in emergency services and the maternity ward)”* [50].

Jornal Notícias (06–08–2023 edition): *“The executive secretary of the Forum of Non-Governmental Organizations of Gaza (FONGA) stands in solidarity with the medical profession and all staff for their demands for better salaries and working conditions, however, at this time, it is imperative to look at the precious value of human life, returning to work to make your contribution, while steps are being taken for an eventual solution to the dispute”* [48].

#### **Perceived impact of the strike**

##### **For the National Health System, services and users**

With the strike, many services were limited in the public health sector, compromising even laboratory and pharmaceutical services and the follow-up of patients with chronic diseases. Many other impacts have been referred to in the previous quotations (Table 6).

E15 (doctor, OrMM, mediator): *“In this strike, the health services were practically closed. In any strike, from the outset, the services that will continue to operate must be defined, I’m talking about emergency rooms, pharmacies, laboratories, because health is not just about doctors, health is a set of activities, if the laboratory doesn’t work, if the pharmacy doesn’t have medicines, the presence of the doctor is almost nil, so I think these aspects were not taken care of”*.

Savana newspaper (06–07–2013 edition): *“In the pharmacies of Maputo’s central hospital, Mavalane and Jose Macamo general hospitals, as well as in some health centers on the outskirts, there is a shortage of almost all kinds of medicines, even simple painkillers like paracetamol. The situation is much more dramatic for chronic patients such as those suffering from tuberculosis, high blood pressure and HIV/AIDS. At Mavalane General Hospital, thousands of people suffering from tuberculosis come to the hospital looking for medication, but to no avail. The answer is almost the same: either the health workers aren’t there or there are no medicines”* [14].

Patients had their healthcare postponed due to the strike and were forced to live with their health problems until the situation normalized.

SAVANA newspaper (05–24–2013 edition): *“A 55-year-old patient had surgery scheduled at Maputo’s Central Hospital for Monday, May 20. The treatment didn’t take place and he will have to endure the pain of the wounds on his face caused by skin cancer for as long as the strike lasts. It hurts so much, it’s burning, I don’t know what to do, the wounds bleed and I spend sleepless nights. I can’t take any medication because nothing has been prescribed.*

**Table 6** Perceived impact of the strike by doctors and other HCW

Impact of the strike	For the National Health System, in services and for users	<ul style="list-style-type: none"> <li>• Delays in hospital care</li> <li>• Poor service /Low quality of services</li> <li>• Postponement of care</li> <li>• Lack of care and deaths</li> <li>• Fear of using public health services</li> <li>• Lack of medicines in health units' pharmacies</li> <li>• Exhaustion of morgue capacity</li> <li>• Loss of trust between doctors and the government</li> <li>• Loss of credibility of the National Health System</li> <li>• Limited operation of health units</li> </ul>
	For doctors and HCW	<ul style="list-style-type: none"> <li>• Physical and psychological exhaustion of non-striking HCW</li> <li>• Interruption of the postgraduate program</li> <li>• Mistrust among HCW</li> <li>• Loss of empathy towards HCW</li> </ul>
	Changes achieved with the strike	<ul style="list-style-type: none"> <li>• Expulsion, disciplinary process, transfers, compulsory retirements and arrests</li> <li>• Approval and (partial) implementation of the Doctors' Statute</li> <li>• Salary increase for doctors (through subsidies)</li> <li>• Career progression and postgraduate restructuring (specialisation)</li> </ul>

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*I live on painkillers to try to alleviate the pain' she complained in a conversation with our newspaper" [47].*

The strike affected the provision of health services, since it caused a greater shortage of human resources, leading to delays in care, including a lack of care for the sick and deaths.

E09 (religious leader, mediator): *"It was the people suffering, regardless of whether the doctors were right or wrong, the people were suffering, and there were images of people lying on the ground, unattended and in a state of neglect".*

*"The nurses only call people in every 20 or 30 min, and when the person comes in, they stay for a long time. I don't know what's going on, but it's not normal. We're suffering,"* said one user interviewed by Savana newspaper (06–07–2013) [14].

On the other hand, users complained about the impatience and arrogance of the doctors on duty, as a way of expressing their disagreement with salaries and other aspects claimed by the strikers. Some HCW adopted a kind of silent strike.

*"She (the patient) went to that health unit to have a gynecology consultation, but the health professional who attended her told her to go back and violently closed the office door..."*, as reported by a user of the Chimoio Provincial Hospital in *Jornal Notícias* newspaper (06–19–2013) [51].

Savana newspaper (06–07–2013 edition): *"Although some HCW stay at their posts to guarantee minimum services, the few patients who gain courage and go to the health units told SAVANA that the staff are there just to be present and avoid absences" [14].*

Patients had a certain fear of seeking health services, and only did so in a serious condition, which made treatment and prognosis difficult.

*"The number of patients, especially children, who arrive at the hospital at an advanced stage of illness, which makes medical treatment difficult, and ends in death, is on the rise. This shows that people, even if they are ill, prefer to stay at home"*, said a non-striking doctor to Savana newspaper (06–07–2013 edition) [14].

The strike by doctors and other HCW has also affected funeral services in some hospitals.

SAVANA newspaper (05–24–2013 edition): *"Bodies left the mortuary adjacent to the HCM due to the lack of doctors to sign death certificates and allow autopsies to be carried out. By Wednesday afternoon, more than 50 bodies were waiting for autopsies to be carried out and then handed over to their relatives. SAVANA sources say that the HCM morgue is running out of capacity to hold more bodies" [47].*

The strike created a climate of distrust between HCW and the government, and added to this, the National Health System was discredited by the people.

E01 (doctor, government representative): *"Patients lost faith in the health services, there was a great discrediting of the Health System, and they were afraid to even visit the health units."*

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As part of the strike, postgraduate programs (specialization) were interrupted due to a shortage of human, material and financial resources [52]. As a result of the work stoppage, disciplinary proceedings were initiated because

of unauthorized absenteeism, which resulted in fines, demotions, dismissals, transfers, arrests and compulsory retirement [53].

E02 (doctor, government representative): "All (of the strikers) were instructed in disciplinary proceedings, and according to the outcome of each case, decisions were taken".

E04 (doctor, strike group): "There were many threats and reprisals, and the president of the association was arrested, and some colleagues were dismissed and lost their management positions".

On June 5, 2013, the MISAU decreed the suspension of post-graduate training in the National Health System due to a shortage of human, material and financial resources, and doctors undergoing post-graduate training would be reallocated to health units throughout the country [52].

This decision represented a setback in the lives of the strikers, most of whom were in postgraduate studies, which provoked revolt and created a moment of tension between MISAU, OrMM and AMM. The colleges of obstetricians and gynecologists, and dermatologists issued statements expressing their displeasure with the decision and demanding the reinstatement of the program (SAVANA edition 06–14–2013) [54].

According to the AMM representative (SAVANA edition 06–21–2013): "some doctors were disappointed with the decision, some thought they would return, but many of those who wanted to return to work before the end of the strike were not received, because the specialty colleges did not agree with the MISAU's action to stop postgraduate studies. This measure taken by the MISAU is illegal, because the issue of postgraduate studies should not be dealt with unilaterally by the Ministry, it needs a joint commission with the OrMM" [55].

The oldest doctors and founders of the National Health System (85 specialists, including former ministers of health, previously advisors to the minister of health) wrote and made public a letter addressed to the president of the republic expressing support for the striking doctors and their indignation and revolt regarding the working and living conditions of HCW, especially young doctors and postgraduates. They also condemned the acts of coercion, intimidation, dismissal and repression exercised against striking HCW and the use of students, rescuers and volunteers to meet the demand for services, classifying this act as an illegal practice of medicine (Jornal Notícias, edition 06–08–2013) [48].

On the other hand, civil society felt that HCW had lost their professionalism and patriotism, which contributed to part of the community losing empathy and trust in them.

E06 (religious leader, mediator): "A social situation of mistrust towards health professionals has been created, there have been serious consequences in relation to patient care that have greatly undermined the ethical recognition of HCW".

For the non-striking doctors and HCW, there was an overload of work that resulted in exhaustion and demotivation.

One of the students from the Maputo Institute of Health Sciences assigned to provide support at Mavalane General Hospital told SAVANA that people are working overtime and some of her colleagues are already complaining of tiredness: "My roommate came in at 10am on Monday and didn't leave until 12 pm on Tuesday. She's going to rest all afternoon and evening, because she has to return at 7am tomorrow (Wednesday). I have many colleagues in this situation. It's very complicated. I think that even people who have been doing these routines for years wouldn't be able to deal with it" (SAVANA newspaper, 05–24–2013 edition) [47].

Savana newspaper (06–07–2013 edition): "Doctors who guarantee care in hospitals are exhausted and are threatening with a public letter denouncing the chaos in health units" [14].

### Changes after the strike

After the strike, the Doctors' Statute was approved and implemented with the corresponding allowances, which in a way led to an improvement in doctors' salaries. Career issues and the right to housing were also supposedly safeguarded by the Statute, once approved.

E07 (doctor, strike group): "Looking at it with a cool head, we had a different salary increase, because that year the salary increase for all public services was 7.0 or 7.5% and we had a 15% increase, and the following year the same. We had our Statute approved in 2013, some aspects of the Statute began to be implemented in 2016, so three years later, others had to go to the Administrative Court, so they were only implemented in 2021".

## Discussion

### Contextualisation

The strike by public sector HCW in Mozambique in 2013 was an unprecedented protest movement, which initially involved only doctors (10-day strike in January), but took on a greater dimension as agreements were not reached with government, culminating in the involvement of other HCW groups in month-long strike in May and June, thus becoming a generalized strike in the public health sector.

Within the framework of the strike, agreements were reached, but many of these pacts are still subject for

debate and disagreement factors for perpetuating dissatisfaction and maintaining mood of revolt. These factors contributed for a more recent strikes, especially because of deficient implementation of the Statute of Doctors in Public Administration. Since the end of 2022, the country has been facing successive strikes (by doctors and other HCW) in the public health sector including dissatisfaction over the salary reforms implemented by the government in 2022, which clashed with the terms agreed in the Statute of Doctors in Public Administration following the 2013 strike, which in turn, according to the doctors, was never fully implemented [56]. This close look at the 2013 strike in terms of its causes, contours and consequences from the perspective of the main actors involved, may help to shed light on how to improve the means to address the issues that persist and help to prevent further strikes in the future.

This strike in Mozambique, follows a previous undocumented strike by doctors in 1989. It took place at a time when there were strike movements by HCW in neighboring countries (such as Tanzania and Madagascar in 2012) and all over Africa (such as Niger, the Democratic Republic of Congo, Liberia, Kenya, and Burkina Faso in 2013) [4, 57], and there may have been some cross-country influence among all these movements in different SSA countries. In Mozambique, as in other countries [4], the strike movement was led by a trade union or medical association and assumed contours that were not always supported by the Medical Councils.

### Causes of the strike

The main factors motivating the strike of doctors and other HCW in Mozambique were related with salaries and working conditions. The lack of communication and trust between the parties, and the failure of health authorities as employers to fulfil previously signed agreements, precipitated the subsequent strikes.

These results corroborate the findings of studies carried out in other countries [1, 5, 8, 58–63], and in Kenya in particular, that reflects government's failure to fulfil agreements reached with the HCW (doctors and nurses) to improve remuneration (salaries and allowances), enhance human resources capacity and equipment availability in health facilities; these triggered a sequence of strikes by doctors, nurses and clinical officers during 2017 [1, 59, 60, 62].

Salary demands sometimes arise by comparison with the private sector or other public sectors but with different privileges. The salary levels of these other privileged civil servants were, according to the present study, taken as a reference by strikers-leadership to advocate for better remuneration for HCW, as shown also in a study carried

out in Malawi (in 2001), where doctors used the salaries of the judiciary as a reference, while in Niger (2017), junior doctors used the salaries of specialists doctors to demand better salaries [4, 6]. Hence salary reforms in the public sector needs to consider the overall public servant salary structure and minimize unreasonable disparities.

### Approaches adopted during the strike, its contours and impact

The government of Mozambique, represented by MISAU, as a way of stopping the strike, created a mixed team to negotiate with AMM. Initially, a consensus was reached regarding the need to increase doctors' salaries, but there was disagreement regarding how this could be done. The government was worried that its decisions would trigger a generalised strike (involving the police, teachers, and other professional classes), so they opted for a discreet salary increase mechanism, by means of allowances. These were specified in the Statute of Doctors in Public Administration, which would be regularised and implemented in stages. However, factors such as lack of communication, political interference and questionable criteria for managing public funds were pointed out by the string workers as contributing to a climate of mistrust and intolerance between the parties, which made the negotiation process challenging. On the one hand, the government was asking for more time to regulate and implement the Doctors' Statute (including allowances), while on the other the doctors were intolerant and inflexible with the proposed deadlines that were relatively long, hence, the strike continued, and access to health services remained compromised.

The National Health System was facing a critical shortage of human resources, with a ratio of one doctor per 17,235 inhabitants, far from that recommended by the World Health Organization [16, 64], and with the strike, the situation became worse, causing overload and exhaustion of available HCW, leading to critical challenges in health services, compromising the availability and the quality of the health care provided. However, in order to mitigate the effects of the strike, the government opted to call for an alternative workforce (such as military doctors, health managers, medical students and students from other health courses) and ask for help from the Mozambican Red Cross, communities and religious groups to provide support in health units with shortage of HCW. This approach has been adopted by other governments in similar situations, as shown by studies carried out in Kenya and Malawi [1, 61–63], which brings some relief to the workload of non-striking HCW.

The inclusion of religious leaders as mediators in the dialogue between the parties was a tactic of the

government, which sought, through them, to sensitise the striking doctors who, as well as being HCW, were also believers, calling on them to think about the patients suffering in hospital queues and to look at the purpose of their profession. This tactic seeks to exploit the influence that religion has on well-being and social behaviour, promoting a set of self-regulatory behaviours, as explained by McCullough and Willoughby [65], thus taking advantage of the fact that the strikers profess these religions and would eventually be more sensitive to appeals from religious leaders.

However, religious leaders were also trying to recover the apparent loss of sensitivity that doctors had suffered in the eyes of civil society. The trust and empathy that society had for doctors and other HCW was shaken, and the National Health System, in turn, was discredited, as was also reported in studies carried out in Nigeria [8, 9] and Kenya [1].

The striking group included were doctors in post-graduate training (medical specialisation) who were affected as their programmes were interrupted, and as an aggravating factor, disciplinary proceedings were launched, resulting in fines, demotions, dismissals, transfers, arrests and compulsory retirements, corroborating the results of studies carried out in Nigeria and Kenya [5, 61].

Therefore, although there were changes after the strike, with the regulation and implementation of the Statute of Doctors in Public Administration (with risk and seniority allowances, as well as the right to housing included), all parties involved lost with the strike, especially the patient. It should be taken into account that a large part of the Mozambican population is poor and reside in rural areas and cannot afford to access private healthcare services, mostly prevalent in urban areas (in 2009 the incidence of poverty was 54.7 per cent). The public sector is the only option for accessing healthcare for many [66, 67]. Therefore, when the public health sector goes on strike, a large part of the Mozambican population is prevented from accessing formal healthcare. This is also well described from other strike movements in Africa [68].

#### **Reflections around the strike in the healthcare sector and recommendations**

The legitimacy of the strike has always been a controversial issue, although it is allowed by law as a fundamental right of workers, according to article 87 (1) of the Constitution of the Republic of Mozambique of 2004. However, the provisions of article 87( 2) limits the exercise of the right of strike by essential services and activities, by workers from the unavoidable needs of society and national security [69]. The same law, in its articles 40 and 89 guarantees citizens the right to life

and physical and moral integrity, free from torture or cruel and inhuman treatment, and the right to medical and health care, respectively. Not forgetting the Code of Ethics of the Medical Council [70], Article 6 (1) which states that "doctors must exercise their profession with the utmost respect for the right to health of patients and communities", and Article 10 which states that "in the event of a doctors' strike, and whatever the circumstances, doctors must ensure the continuity of therapeutic care for their patients, as well as assistance to urgent and seriously ill patients".

However, during the second strike of doctors and other HCW in 2013 in Mozambique, according to the strike guidelines released by AMM, minimum services were the responsibility of foreign and military doctors and of doctors with management positions who, due to the inherent nature of their functions and contractual aspects, could not join the strike. Therefore, the exercise of the strike is a constitutionally guaranteed right, but it is conditional on the provision of minimum services, so the strike guidelines clash with this last precept, since the strikers delegated the minimum services to others [13, 37].

There are several reported strategies used around the world for similar strikes to minimize harm to patients and protect their rights. The "urgent and emergency care" industrial action model adopted by the British Medical Association has been an example to follow as it ensures that patients receive care in a real emergency situation [71]. This model advises that doctors, although on strike, should be at their usual place of work providing care in emergency or urgent cases, and since it is not always clear how serious the case is, in case of doubt, it is recommended that care be provided. Therefore, the strike is limited to non-urgent cases only. This model has also been implemented in Tanzania, Australia and Israel, where an alternative "fee for service" system was also created to ensure that patients had healthcare options [71]. Another strategy that has been adopted by governments in similar situations is to seek greater cooperation with the private sector, including relieving fees, providing supplies and referring cases for hospitalization, thus relieving the burden on public health units and preserving the well-being of patients [1, 62, 68, 72].

No matter how just the struggle or the demand for our rights may be, "life" must be considered as the most precious asset. The motto of the MISAU says it all: "Our greatest value is life". There is a need for deep reflection at all levels on how this class can claim its rights when its services and activities are essential to the well-being of the citizens.

On the other hand, it is understood that each profession has its specificities and requirements. Doctors are

required to have good character, integrity, compassion, altruism, continuous improvement, excellence, teamwork and selflessness for the benefit of humanity, with patient care being above all else, including their own wants [73]. A lot is demanded from doctors because they deal with human life. It is understandable that these HCW deserve better remuneration, so that they feel motivated. The motivation of HCW is directly linked to the quality of the services they provide. Therefore, motivating HCW means ensuring better care for the population. Studies have shown that remuneration is a determining factor for the satisfaction of HCW, and in turn for the quality of services [74, 75]. The adoption of sustainable, fair, and transparent remuneration models in the public service is crucial to overcoming the ghosts of strikes and retaining staff.

Disputes or conflicts in the workplace are inevitable and are not always destructive. They can be constructive depending on how they are managed, which depends on the organizational conflict culture adopted. There are three types of conflict culture: I) collaborative conflict cultures, in which collective constructive dialogue, negotiation and joint problem solving prevail; II) dominant conflict cultures, in which the members of the organization collectively seek competition and victory, and try to outwit each other, and III) avoidant conflict cultures, in which the members of the organization collectively oppress and stay away from the problem [76].

The intimidating or punitive actions taken by the government, together with the lack of fluidity in the dialog between the parties, caused the conflict to reach undesirable proportions, with accusations, mistrust, distancing between the parties, and a climate of tension established. This may not be the most appropriate way to resolve this type of conflict, as it could have the opposite effect to that desired [3], generating judicial actions, disputes, mistrust, distance and resentment between the parties, and historical marks that are difficult to overcome. As seen, years have passed since this strike occurred, but it is still the result of debate, controversy and disagreements, being identified by many as the genesis of strikes in the National Health System in Mozambique [77].

It was evident that the strike has damaged the relationship between all stakeholders (managers, striking HCW, non-striking HCW, patients, and civil society), creating distrust in the health sector. Distrust undermines interpersonal relationships and teamwork and is a strong catalyst for more labour conflicts and repulsion towards public health services on the part of the community [78]. It is essential to adopt a culture of collaborative conflict within the workplace and permanent dialogue between the parties is the key, not only to resolving the strike, but also to maintaining a healthy, productive and innovative working environment.

It is important to restore trust and adopt a mechanism to preserve it. A more participatory leadership model, involving different stakeholders in decision-making, such as governments, universities, civil society, the private sector, the media and voluntary groups (including religious organisations and patient groups), in addition to the communities themselves, ensures that groups share concerns and responsibilities, which can generate better understanding and sensitivity to difficulties, and manage expectations, directly impacting on group satisfaction, motivation and behaviour [79, 80].

There is also a need to strengthen leadership in human resource management and labour conflicts in health, so it would be opportune to introduce a master's level course in human resource management and leadership for health, aimed primarily at public health service managers. Studies that identify the countries with the least occurrence of strikes in the health sector and analyse the factors that contribute to this fact and the management tactics adopted in these countries would be of vital importance.

With regard to working conditions, it is important to note that health care is the result of a joint effort and shared responsibility between HCW, the government and society, and that everyone's commitment to its provision is essential. The government and society have a responsibility to provide the necessary means for HCW to operationalize health services [2].

Therefore, future intervention studies aimed at promoting humanisation in the health sector are fundamental, as are studies evaluating and monitoring the satisfaction and motivation of HCW in the workplace and mechanisms to ensure an ongoing constructive dialogue with HCW. Any information that allows the government to act in advance to address issues that may result in HCW's strike situations is useful.

### Study limitations

However, this study had some limitations: the phenomenon under study (strike) took place 10 years ago (2013), so there is a risk of memory bias. However, the inclusion of document analysis and member checking may have minimized the likelihood of its occurrence, thus giving the data greater reliability. On the other hand, the non-inclusion of private health sector stakeholders limits the understanding of the implications of the strike, since according to Yoong et al. [81], private sector participation is positively associated with better functioning of the health system in terms of access and equity and may provide overflow flow care for patients not received in the public sector. Therefore, future studies that address the HCW' strike from the perspective of private sector managers would be important, as well as studies with a quantitative approach aiming to

analyze the impact of the strike considering health indicators such as mortality, number of patients treated, hospitalizations and surgeries performed.

## Conclusions

This study represents an opportunity to reflect on the causes and consequences of strikes in the health sector, as well as on the ways to strike in a sector that is so crucial to the well-being of society. It also represents a starting point for drawing up effective strategies and policies for managing and preventing labor conflicts in the health sector. The strike by doctors and other HCW in Mozambique in 2013 was the first major strike movement in the history of the public health sector in Mozambique, due to its duration and impact. The main causes of this strike were issues related to salaries and working conditions. The end of the strike was not entirely peaceful and the contours were marked by a lot of tension between the parties. Disagreements regarding wages and working conditions were not completely resolved maintaining grievances even after resuming of work by doctors and other HCW. All approaches apparently were for short term gain, but weak on reflection to deepen understandings necessary to ground sustainable strategies for the future.

## Abbreviations

HCW	Healthcare Workers
MISAU	Ministry of Health
AMM	Mozambique Medical Association
OrMM	Mozambican Doctors' Council
HCM	Maputo Central Hospital
FONGA	Forum of Non-Governmental Organizations of Gaza
MoU	Memorandum of Understanding
ANEMO	National Association of Nurses of Mozambique
ATLAC	Association of Laboratory Technicians and Clinical Analysis
PSU	United Health Professionals
OTM-CS	Mozambican Workers' Organization Central Trade Union
NGO	Non-Governmental Organizations

## Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12913-024-11998-7>.

Supplementary Material 1. Interview Guide  
 Supplementary Material 2. Supplementary Table 1  
 Supplementary Material 3.

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## Authors' contributions

A.L.J.M., P.F. and I.C. Conceptualization, A.L.J.M., P.F., I.C. and M.S. methodology, A.L.J.M., M.S. and D.B.S. formal analysis, I.C. data curation, A.L.J.M. writing—original draft preparation, P.F., I.C., M.S., D.B.S. and A.J.R.C. writing—review and editing, P.F., I.C., M.S. and A.J.R.C. supervision, A.L.J.M. project administration, A.L.J.M. and P.F. funding acquisition. All authors reviewed the manuscript.

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## Data availability

The datasets used and analyzed during the current study are not publicly available due identifiable information but are available from the corresponding authors upon request.

## Declarations

### Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Bioethics Committee of the Instituto Superior de Ciências de Saúde (ref. 02/CIBS-ISCISA/2020, on 21 August 2020) and by the Ethics Committee of the Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa (ref. 2.21, on 06 April 2021). Informed consent was obtained from all subjects involved in the study.

### Consent for publication

Not applicable.

### Competing interests

A.L.J.M. was the Minister of Health at the time of the strike. M.S. was the Director of the Faculty of Medicine of the Universidade Eduardo Mondlane. The other authors declare no conflicts of interest.

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### **3. DISCUSSÃO, CONCLUSÕES E RECOMENDAÇÕES**

### 3.1 Discussão geral

Moçambique é um país em vias de desenvolvimento, cujo em 2014 tinha uma taxa de pobreza situada em 48,4%, que aumentou para 62,8% em 2020 (1). O país contém um índice de capital humano extremamente baixo (0.36), representando um desafio para o seu crescimento inclusivo e sustentável (1). Os cuidados básicos de saúde são prestados de forma assimétrica em todo país, com notáveis desigualdades espaciais na distribuição dos recursos de saúde (1, 2). Moçambique faz parte do grupo de países em que a maior parte dos cuidados de saúde são providos pelo sector público de saúde, portanto, grande parte da população depende destes serviços.

A greve no sector de saúde tem sido uma preocupação mundial crescente pela natureza disruptivo e impacto negativo na prestação de cuidados de saúde aos pacientes, e em países de baixa renda, como Moçambique, a preocupação é acrescida. Um estudo feito por Russo et al (3), indica que, entre 2009 e 2018, houve ocorrência de greve de profissionais de saúde em 23 países de baixa renda, e só não houve relato de greves em 8 países. E ao todo foram 70 episódios de greve de profissionais de saúde, com tendência crescente quanto em número de episódios como em duração (dias).

A greve dos médicos e outros trabalhadores de saúde moçambicanos de 2013 é considerada a primeira grande greve no sector de saúde, e suas motivações, contornos e consequências tem sido razão de debate e controversas entre as partes, e tem-se agudizado com a reforma salarial implementada pelo Governo em 2022, que colide com alguns acordos alcançados em 2013, o que contribuiu para que os fantasmas da greve de 2013 voltassem a assolar o sector público de saúde, com sucessivas greves, desde finais de 2022 (4, 5). Contudo, a presente tese busca trazer uma retrospectiva sobre esta greve na perspetiva dos principais intervenientes, com vista a entender as motivações, estratégias adotadas por ambas partes, os contornos e consequências, incluindo os bastidores e momentos de tensão durante as negociações. Estes detalhes foram pouco abordados em estudos semelhantes e são importantes para um melhor entendimento e gestão deste tipo de movimento.

### ***3.1.1 Antecedentes***

Em anos antecedentes a esta greve, estudos feitos em Moçambique já reportavam insatisfação dos profissionais de saúde com as condições de trabalho, os salários, falta de incentivos, difícil acesso a formação contínua e não implementação das carreiras (6-8). O governo, ciente disso, avançou com elaboração e aprovação de um Estatuto do Médico na Função Pública, porém sem a auscultação dos médicos, isto é, sem o parecer da Associação Médica de Moçambique (AMM) e da Ordem dos Médicos de Moçambique (OrMM), o que despoletou descontentamento da classe. Embora, a iniciativa do governo fosse bem-intencionada, os médicos queriam que certos direitos fossem assegurados por via do estatuto, sobretudo com respeito ao direito à habitação e a um nível salarial diferenciado na função pública. Contudo, a falta de acordo entre as partes em relação aos salários precipitou o início da primeira greve (que decorreu entre 05 a 15 de janeiro), que foi exclusivamente da classe médica. Esta greve só terminou com a assinatura de um Memorando de Entendimento entre as partes, com alguns termos e metas por alcançar nos respetivos prazos. Porém, o não cumprimento de alguns termos por parte do governo culminou com a ocorrência da segunda greve em menos de 6 meses (que decorreu entre 20 de maio e 20 de junho de 2013). Dessa vez, a greve seria maior e mais duradoura que a primeira. Os médicos estariam acompanhados de outras classes de trabalhadores de saúde. Contudo, tanto na primeira, como na segunda greve, a falta de fluidez na comunicação precipitou a ocorrência da greve. Não houve participação ativa da classe médica na conceção do Estatuto do Médico na Função Pública, sendo que o envolvimento da classe médica neste processo era decisiva, visto que estes estão em melhor posição para avaliar os aspetos mais preponderantes para a classe. Percebe-se assim que a exclusão destes no processo provocou insatisfação e rejeição do próprio Estatuto (9). A comunicação proactiva no contexto dos conflitos laborais é vital para resguardar a confiança e empatia entre as partes, do mesmo modo que, para resolver ou mitigar o efeito de qualquer conflito laboral (10).

### ***3.1.2 Causas da greve***

Os médicos e outros trabalhadores de saúde reivindicavam por melhores salários, tendo em conta os salários auferidos pelos juízes, procuradores e técnicos tributários. Além de outros aspetos, os médicos queriam que o Estatuto do Médico na Função Pública lhes garantisse um subsídio de riscos maior, o subsídio de antiguidade e o direito à habitação (especialmente para os profissionais que trabalhavam longe do seu local de residência habitual). Os médicos e outros trabalhadores de saúde pediam também melhoria das condições de trabalho, através de maior investimento e pacote orçamental para o sector de saúde. Eles sentiam que o sector de saúde por vezes não era priorizado pelos governantes.

Portanto, os desacordos com respeito aos salários e subsídios recebidos pelos trabalhadores de saúde, quando comparados com alguns funcionários públicos, e as más condições de trabalho têm sido as principais causas de greve não só em Moçambique, como em outros países da África Subsaariana (11-19). Estes aspetos, por coincidência, já tinham sido reportados em estudos feitos em Moçambique como causadores da insatisfação dos trabalhadores de saúde (6-8, 20-22). Portanto, um sector de trabalho em que prevalece a insatisfação dos colaboradores é mais propenso a ocorrência de conflitos laborais, rotação de trabalhadores e queixas (23).

### ***3.1.3 Abordagens adotadas pelas partes***

O principal mecanismo usado pelas partes para alcance dos acordos foi o diálogo entre representantes do governo e dos trabalhadores de saúde com ajuda dos mediadores. Segundo a Organização Internacional do Trabalho, o diálogo é uma ferramenta forte e viável para resolver conflitos laborais e queixas entre trabalhadores e gestores, portanto, é sempre o mais recomendado nestas situações (24).

Enquanto decorriam as negociações, a greve continuava e o sistema público de saúde enfrentava uma limitada capacidade de oferta de serviços de saúde, visto que os recursos humanos disponíveis eram escassos para atender a procura, pelo que, o governo optou por restringir os serviços e priorizar os sectores mais críticos, readaptar as funções dos profissionais disponíveis (como os médicos militares, gestores de saúde, estudantes de medicina e estudantes de outros cursos de saúde para prestarem apoio nas unidades de saúde).

Esta abordagem tem sido utilizada também por outros países da África subsaariana como forma de aliviar a carga de trabalho dos trabalhadores de saúde não grevistas e manter a oferta dos serviços mínimos de saúde (25).

Por outro lado, os grevistas, enquanto decorriam as negociações entre seus representantes e o governo, marchavam e protestavam nas ruas para pressionar o governo a ceder e buscar comoção popular. Houve igualmente relato de ameaças e tentativas de impedir que outros trabalhadores de saúde não-grevistas entrassem nos hospitais para trabalhar. Pelo que, o governo, a dado momento, se viu obrigado a recorrer ao uso de força policial para conter os grevistas, prevenir vandalismo e controlar multidões, o que terá culminado em detenções, aumentando a tensão entre as partes.

A abordagem predominantemente que foi adotada pelos grevistas foi contida e convencional, visto que incluiu marchas, manifestação e declarações públicas, porém em certo momento foram de confronto e disruptivas porque interferiam com a rotina normal dos hospitais, impedindo que os profissionais de saúde não grevistas exercessem suas atividades (26-28). Enquanto isso, o governo pressionava para que os grevistas desistissem da greve e voltassem ao trabalho mediante intimidações e ameaças com processos disciplinares com base no artigo 95 do Regulamento do Estatuto Geral dos Funcionários e Agentes do Estado (29), que diz que “a falta injustificada implicará, para além do procedimento disciplinar que possa caber, a perda do vencimento correspondente e de 3 dias na antiguidade”.

Os grevistas sentiram-se pressionados porque não teriam o salário do respetivo mês e perfaziam quase três semanas em greve, sem trabalhar, e dependiam deste salário para sobreviver. Esta pressão terá contribuído, de certa forma, para o fim da greve.

Segundo Velásquez Orellana, Pérez e Link (2022), esta é uma tendência natural das greves, os trabalhadores buscam afetar a produção e pressionar o patronato a ceder às suas exigências, enquanto o patronato tende a buscar mecanismos punitivos, como por exemplo substituir trabalhadores grevistas e intensificar a exploração como forma de combater as greves (26).

Os trabalhadores organizam-se, fazem greve e assumem os riscos, tentam resistir através do capital acumulado e, pressionados, adotam diferentes estratégias buscando sempre acordos para que a greve termine o mais rápido possível, visto que, com o passar do tempo, o poder do trabalhador fica enfraquecido devido ao esgotamento de recursos, que são mais limitados que do empregador, portanto, a chance de alcançar o que pretende reduz (26).

Por outro lado, os mediadores tentavam aproximar as partes e promover o diálogo, como também desenvolver ações de educação e sensibilização, com base na ética e religião, buscando convencer os médicos e outros trabalhadores de saúde a retornar ao trabalho. E dado a insuficiência de trabalhadores de saúde para atender a demanda pelos serviços de saúde, houve recrutamento de crentes e pessoas nas comunidades para prestar apoio (em atividades administrativas e de limpeza) nas unidades de saúde.

A inclusão de líderes religiosos como mediadores no diálogo entre as partes foi uma tática do governo, para sensibilizar os médicos em greve que, para além de trabalhadores de saúde, eram crentes, chamando-os a reflexão com relação ao seu propósito como profissional de saúde e seu dever para com a saúde dos pacientes, tentando recuperar a sensibilidade que os médicos haviam perdido aos olhos da sociedade. Essa tática busca explorar a influência que a religião tem sobre o comportamento social, através da promoção de um conjunto de comportamentos autorregulatórios que afetam a tomada de decisões, assim como comportamento moral (30, 31).

No sentido tradicional, a mediação compreende intervenção de um terceiro elemento num determinado litígio. Este é um mecanismo determinante na resolução de conflitos desta natureza. E nos moldes relatados, esta foi uma mediação tática, visto que seu envolvimento foi durante a greve. Embora, a contribuição global da mediação tática fosse limitada, esta pode reduzir irracionalidades, ajudar a explorar soluções e encorajar a cedência entre as partes (32).

### ***3.1.4 Consequências da greve***

Os pacientes viram os seus cuidados de saúde adiados, sendo dada prioridade a emergências médicas. Havia lentidão nos serviços, longas filas de espera, unidades de saúde sem medicamentos essenciais e perda de acompanhamento de pacientes com doenças crônicas.

Os trabalhadores de saúde não grevistas queixavam-se de sobrecarga e exaustão no trabalho, inclusive alguns tornavam-se coniventes com os grevistas, portanto, havia um descontentamento generalizado.

A sociedade perdia a confiança e empatia pelos médicos e outros trabalhadores de saúde e, o sistema nacional de saúde, por sua vez, era descredibilizado, provocando certo receio por parte dos utentes em usar os serviços públicos de saúde, o que por sua vez, atrasava a terapêutica e complicava o prognóstico.

Embora, fosse reportado ocorrência de mortes no âmbito da greve, a mortalidade como indicador de saúde não foi objeto de estudo na presente pesquisa. Contudo, a maioria dos estudos de base hospitalar na África Subsaariana reportou redução da mortalidade (17, 18, 25), e apenas um estudo num hospital religioso sem fins lucrativos, cujo os funcionários não aderiram a greve, reportou aumento da mesma (19), o que foi associado a maior afluência de pacientes neste hospital, sobrecarga dos serviços e esgotamento dos profissionais de saúde, que terá reduzido a qualidade dos serviços nesta unidade. A afluência dos pacientes a este hospital deve-se ao facto de este representar a única opção de cuidados de saúde acessível para grande parte da população durante a greve no sector público, ditada pela limitada capacidade de pagamento pelos serviços privados de saúde. Por outro lado, dois estudos de base populacional, que avaliaram a mortalidade durante o período de greve, não encontraram alterações significativas (12, 33).

Após a greve, em Moçambique, assim como em alguns países da África Subsaariana, os médicos e outros trabalhadores de saúde sofreram represálias por parte do ministério da saúde, com instauração de processos disciplinares, expulsões, transferências e reformas compulsivas. Houve inclusive interrupção do programa de pós-graduação ou residência médica, o que terá provocado revolta e indignação no seio da classe médica porque

representava um grande retrocesso para a classe e na vida profissional de boa parte dos grevistas, que estavam em processo de especialização (pós-graduação) (25).

Contudo, a greve trouxe também alguns aspetos positivos como aprovação do Estatuto do Médico na Função Pública. Este estatuto garantia à classe médica uma remuneração diferenciada na função pública, com alguns subsídios e direitos assegurados (como o subsídio de risco e diuturnidade, e o direito a habitação). Enquanto, para os outros trabalhadores de saúde a organização e reconhecimento do seu sindicato foi um grande avanço para a classe na luta pelos seus direitos.

### ***3.1.5 Análise da greve no âmbito do modelo proposto por Walt e Gilson (1994)***

O modelo de Walt e Gilson (1994) nos permite uma análise mais estruturada e sintética dos resultados segundo seus quatro componentes centrais (conteúdo, contexto, processo e atores)(34).

#### *Conteúdo*

No caso da greve dos médicos moçambicanos em 2013, o conteúdo principal está relacionado com as reivindicações por melhorias salariais e condições de trabalho, reformas na carreira médica, melhoria na gestão dos recursos humanos no setor da saúde.

Portanto, as exigências da classe médica eram claras, mas a resposta do governo foi pouco transparente e, por vezes, repressiva, com ameaças de sanções e substituições por médicos militares ou estrangeiros, o que afetou diretamente o conteúdo prático da gestão deste movimento.

#### *Contexto*

O contexto moçambicano em 2013 era marcado por fragilidade institucional e limitada capacidade de negociação do Estado, desigualdades socioeconómicas profundas e desníveis salariais no setor público (o sector de saúde com salários baixos com relação a outros sectores), uma sociedade civil pouco organizada, limitada participação dos profissionais na formulação de políticas públicas e um sistema de saúde com carências estruturais. Este

contexto condicionou fortemente a forma como a greve foi tratada, revelando uma fraqueza do ministério da saúde em gerir conflitos laborais complexos no setor da saúde.

#### *Processo*

Os resultados deste estudo transparecem uma política de gestão pouco inclusiva, com escassa participação dos profissionais de saúde nas decisões, o que refletiu também no processo de gestão da greve, marcado por confronto, em vez de diálogo social construtivo, abordagens táticas buscando suprimir ou adiar a greve por meios coercitivos ou transacionais, com medidas reativas, como ameaças de despedimento e judicialização do protesto, em vez de soluções estruturais que trouxessem ganhos a longo prazo.

Este tipo de abordagem comprometeu a eficácia da resposta e agravou a relação entre os médicos e o governo, resultando em desconfiança institucional.

#### *Atores*

Este movimento teve vários intervenientes, dos quais no primeiro plano destacam-se os médicos representados pela AMM (como principais reivindicadores de mudanças), os outros trabalhadores de saúde representados pela PSU (como coadjuvantes), o governo e Ministério da Saúde (MISAU) representados por uma equipe mista de gestores (vários sectores) e a população afetada diretamente pela greve, especialmente os mais pobres. E em segundo plano, estavam as distintas forças que, embora com influência limitada, tentaram intermediar o conflito, como os líderes religiosos, Organizações da Sociedade Civil e internacionais.

#### ***3.1.6 Reflexão em torno ao movimento grevista***

O conflito industrial é um fenómeno frequente e inevitável numa sociedade democrática, e tem sido determinante para o alcance de certos objetivos sociais e solução de controvérsias, conflitos intergrupais e no equilíbrio de poder entre o patronato e o trabalhador (32).

As relações antagónicas entre o empregador e trabalhador permitem greves e, estas surgem quando os trabalhadores têm capacidades organizacionais e recursos suficientes para se mobilizarem (35). E evidências mostram que a maior parte das greves dos profissionais de saúde nos países de baixa renda (3), assim como no contexto particular dos países da Africa

subsaariana (25), tem sido encabeçada pelo sindicato, mostrando a valência da organização e mobilização desta classe.

A greve de 2013 no sector público de saúde em Moçambique ocorreu numa altura em que outros países vizinhos (como a Tanzânia e Madagáscar em 2012) e um pouco por toda a África (como o Níger, a República Democrática do Congo, a Libéria, o Quênia e o Burkina Faso em 2013) enfrentavam movimentos similares (3, 36), mostrando que, até certo ponto, pode ter havido alguma influência entre grupos.

O exercício da greve é um direito constitucionalmente consagrado, considerado fundamental para o bom exercício da negociação coletiva entre empregador e trabalhadores nas sociedades democráticas (37). Porém, no sector da saúde, sempre foi controverso porque entende-se que, de alguma forma, o direito a greve colide com os direitos do cidadão, igualmente plasmados na Constituição da República, nomeadamente: o direito à vida, integridade física e moral, livre de tortura ou de tratamentos cruéis e desumanos, e o direito à assistência médica e de saúde. Entretanto, é compreensível que a mesma lei limite o exercício à greve aos prestadores de serviços e atividades essenciais, consideradas necessidades inevitáveis para a sociedade e segurança nacional (38). Portanto, limitar o exercício à greve não implica proibição, isto é, é factível sob certas condições. O Código Deontológico da Ordem dos Médicos de Moçambique diz que os médicos devem exercer a sua profissão com o máximo respeito pelo direito à saúde dos doentes e das comunidades e que, caso entrem em greve, em quaisquer que sejam as circunstâncias, devem assegurar a continuidade dos cuidados terapêuticos aos seus doentes, bem como a assistência aos doentes urgentes e graves (39).

Contudo, durante a segunda greve de médicos e outros trabalhadores de saúde em 2013 em Moçambique, segundo as diretrizes de greve divulgadas pela AMM (40, 41), os grevistas delegaram os serviços mínimos aos médicos estrangeiros, militares e aos médicos com cargo de chefia que, pela natureza de suas funções e aspetos contratuais, não podem aderir à greve, contrariando todo pressuposto ético e deontológico que rege a profissão. Era suposto que os próprios grevistas proovessem serviços mínimos e não os delegassem a outrem, conotando uma aparente falta de zelo para com os pacientes. Portanto, embora o sector privado não estivesse em greve, a greve representou uma privação aos cuidados de saúde para maioria da

população, visto que o acesso aos serviços privados acarreta custos e a capacidade de pagar para boa parte da população moçambicana é limitada, associada com a pobreza que, segundo dados publicados, assolava cerca de 54,7% da população (2, 42). Portanto, nestas condições, quando o sector público de saúde entra em greve, grande parte da população fica desprovida de cuidados de saúde. O sistema de saúde deixa de cumprir com um dos seus maiores preceitos que é proteger as pessoas contra as consequências financeiras dos problemas de saúde, bem como proporcionar um acesso equitativo a cuidados centrados nas pessoas (controlando os determinantes sociais e financeiros) (43, 44).

Contudo, as greves no sector da saúde exigem uma abordagem ética de todos os intervenientes, assumindo-se que todas as partes têm obrigações morais para com a sociedade (37). As responsabilidades precisam ser repartidas, os cuidados de saúde precisam ser vistos de forma mais ampla e não centralizados. Aos médicos é exigido bom carácter, integridade, compaixão, melhoria contínua, excelência, trabalho em equipa e altruísmo para o benefício da humanidade, estando os cuidados aos doentes acima de tudo, incluindo dos próprios anseios (45). Porém, os cuidados de saúde são resultado de um esforço conjunto entre os profissionais de saúde, o governo e a sociedade. O governo e a sociedade têm a responsabilidade de fornecer os meios necessários para que os profissionais de saúde operacionalizem os ditos serviços (46). E os meios necessários, seriam não só as condições de trabalho em si, mas também condições para a subsistência e bem-estar dos próprios médicos. Recentemente, durante o fórum “Universalidade e Sustentabilidade dos Serviços de Saúde Nacionais na Europa”, o Papa Francisco defendia que os profissionais de saúde precisavam tanto de apoio quanto os doentes que estes tratam, e que havia necessidade de cuidar primeiro de quem cuida (47), curiosamente fazendo menção ao lema da greve dos médicos moçambicanos em 2013 (cuidar de quem cuida), num claro chamado à valorização dos profissionais de saúde e partilha de responsabilidades.

Os médicos são humanos, antes mesmo de médicos, e é necessário que assim sejam vistos para serem mais bem compreendidos, e como qualquer ser humano tem necessidades que precisam ser satisfeitas, caso não, estes profissionais não terão como exercer suas atividades de forma plena, e muito menos terão motivação para tal.

A motivação dos profissionais de saúde é fundamental para a qualidade dos serviços prestados à população (48). A desmotivação pode comprometer a capacidade de sentir empatia com aqueles que necessitam de seus cuidados, a compaixão pelo outro reduz, a comunicação falha e perde-se a empatia entre profissionais de saúde e pacientes (48-50).

A falta de comunicação associada a ações intimidatórias e punitivas terão contribuído significativamente para maior distanciamento e falta de consenso entre as partes. As transferências, suspensões e reformas obrigatórias em massa de profissionais de saúde grevistas tem se mostrado inadequadas nestas situações (37), visto que não resolvem o problema, pelo contrário, elevam os ânimos, geram disputas, desconfianças e ressentimento entre as partes. Houve um clima de tensão, com acusações de ambas as partes que repercutiam na média e dividiam opiniões, aumentando mais pressão sobre os intervenientes. Todos estes aspetos tornavam os consensos difíceis, a greve continuava e o direito dos pacientes continuava restrito.

O desfecho desta greve não foi amigável e tão pouco consensual. A greve terminou, porém, as desconfianças e distanciamento entre os médicos e o executivo perduram. Tem havido muito debate e divergências em torno aos acordos e desacordos nesta greve. Alguns acordos não foram ao todo cumpridos pelo executivo, e outros colidem com a recente reforma salarial implementada pelo executivo moçambicano, o que tem provocado uma onda de greves no sector público de saúde, sendo a greve de 2013 apontada como a génese destas (4).

### ***3.1.7 Limitações do estudo***

O fenómeno em estudo (greve) ocorreu há 10 anos (2013), pelo que existia um considerável risco de viés de memória. Contudo, a inclusão da análise documental e da verificação dos membros pode ter minimizado a probabilidade de sua ocorrência, conferindo maior fiabilidade aos dados.

A não inclusão dos intervenientes do sector privado de saúde limita a compreensão das implicações da greve, uma vez que segundo Yoong et al (51), a participação do sector privado está positivamente associada ao melhor funcionamento do sistema de saúde em termos de acesso e equidade, servindo de alternativa para os doentes que não podem ser recebidos no

setor público, embora, dada as limitações financeiras, esta não é tão acessível à grande parte da população moçambicana.

Este estudo não aborda o impacto da greve de forma quantitativo, não faz uma apreciação objetiva do comportamento dos indicadores de saúde como o número de atendimentos perdidos e mortes durante a greve. Em vez disso, o estudo traz uma abordagem qualitativa, descritiva e reflexiva do impacto percebido da greve na perspetiva dos principais intervenientes. Tendo em conta as disparidades sociais, económicas e culturais ao longo do território moçambicano é muito provável que este movimento não tenha sido homogéneo em todo país, com um impacto diferenciado de região em região. Portanto, uma análise da greve que não se limitasse aos intervenientes de nível central, mas envolvesse também os atores a nível provincial e distrital, bem como a população, forneceria uma visão mais abrangente e realista deste movimento. Portanto, futuros estudos que abordem a greve dos profissionais de saúde na perspetiva dos gestores provinciais, distritais e do setor privado, bem como estudos de abordagem quantitativa que visem analisar o impacto da greve com base nos indicadores de saúde como a mortalidade, o número de doentes atendidos, os internamentos e as cirurgias realizadas, seriam relevantes.

### **3.2. Conclusões e recomendações**

A presente tese representa uma oportunidade única para refletir em torno às causas, consequências e estratégias adotadas em torno a este tipo de movimento. As principais causas desta greve foram as questões relacionadas com os salários e as condições de trabalho. Aos profissionais de saúde muito é exigido porque prestam serviços essenciais para o bem-estar da população. Portanto, é compreensível pensar que estes profissionais mereçam boa remuneração e melhores condições de trabalho. A remuneração e as condições adequadas de trabalho são aspetos decisivos para a motivação destes, e conseqüentemente, para garantir qualidade dos serviços prestados à população. A desmotivação pode ter como consequência o esgotamento, diminuição da produtividade e má qualidade dos cuidados de saúde (52-54). Portanto, é imperioso que, na função pública, a política de remuneração seja justa,

transparente e sustentável, e que as disparidades salariais sejam justificadas com base em critérios claros e justos.

Por outro lado, os profissionais de saúde devem pautar pelo bom senso durante as reivindicações, fazendo exigências salariais realistas, tendo em conta a situação socioeconómica do país, para não remeter o Estado a situação de falência ou dificuldades para prestar outros serviços sociais igualmente importantes à população (37).

Em relação às abordagens, a restrição dos serviços e priorização de casos urgentes, igualmente com o reajuste das funções do pessoal disponível, foram importantes para mitigar o efeito da greve.

A tensão vivida no sector público de saúde gerava incertezas e dúvidas no seio da população com relação à idoneidade do sector público para cuidar, razão pela qual havia receio de uso destes serviços pelos utentes.

As greves no sector da saúde são legais, porém é imperioso que alguns preceitos sejam cumpridos. Os serviços mínimos devem ser respeitados e prestados pelos grevistas para preservar o direito do paciente à assistência médica, que é a quem recaem as piores consequências da greve. Os pacientes enfrentavam longas filas de espera pelos cuidados de saúde e outros viram os seus cuidados adiados.

Há necessidade de adoção de abordagens mais incisivas para minimizar os danos aos pacientes e salvaguardar os seus direitos. O modelo de “atendimento de urgência e emergência” adotado pela Associação Médica Britânica é um exemplo a seguir. Segundo este modelo, os médicos em greve ficam em prontidão no local de trabalho habitual e prestam cuidados em casos de emergência ou urgência. Este modelo foi bem-sucedido na Tanzânia, na Austrália e em Israel, onde foi igualmente instalado um sistema alternativo de taxa de serviços para permitir que os doentes tivessem mais alternativas de cuidados de saúde (55). Outra abordagem adotada por outros governos em situações similares tem sido cooperar e reforçar o sector privado com redução de taxas, fornecimento de suplementos e encaminhamento de casos para internamento (11, 13, 18, 25). Contudo, seria oportuno a realização de estudos que identifiquem países com menor ocorrência de greves no sector da

saúde e analisem as políticas de gestão de recursos humanos para a saúde e as estratégias por estes adotadas para prevenir este fenómeno neste sector, que é tão vital para a sociedade.

A greve afetou a relação entre todos intervenientes (gestores, profissionais de saúde em greve, profissionais de saúde não grevistas, doentes e sociedade civil), criando desconfiança e mal-estar no seio do sector público de saúde. A desconfiança interfere nas relações interpessoais, na comunicação e trabalho em equipa. No trabalho em equipa, é imperioso que os membros da equipa, incluindo os doentes, comuniquem uns com os outros, de forma livre, trocando impressões e conhecimento, fundindo suas observações e ideias, para que as responsabilidades sejam repartidas e os cuidados ao doente otimizados (56). Assim sendo, é essencial a adoção de uma cultura de resolução de conflitos laborais colaborativa (57), e o diálogo permanente entre as partes é a chave, não só em momentos de conflito, para manter um ambiente de trabalho saudável, produtivo e inovador.

Portanto, restaurar a confiança entre todos intervenientes e adoção de mecanismo para preservação da mesma é crucial. A adoção de modelos de liderança mais participativos, com envolvimento dos diferentes atores, nos diferentes níveis, na tomada de decisões, tais como governos, universidades, sociedade civil, sector privado, meios de comunicação social e grupos voluntários (incluindo organizações religiosas e utentes), para além das próprias comunidades, pode garantir partilha de preocupações e responsabilidades, gerando melhor compreensão e sensibilidade às dificuldades enfrentadas pelo Sistema de Saúde, o que pode ajudar na gestão de expectativas e impactar positivamente na satisfação, motivação e comportamento do grupo (58, 59). Há igualmente necessidade de fortificar a liderança em matérias de gestão de recursos humanos e conflitos laborais na saúde, que pode ser por via de um curso de mestrado em gestão de recursos humanos e liderança para a saúde, destinado principalmente aos gestores de serviços públicos de saúde.

Há necessidade de reflexão profunda sobre a vital importância da saúde e bem-estar para o desenvolvimento sustentável das comunidades. As problemáticas associadas aos salários e condições de trabalho dos trabalhadores de saúde evidentemente minam os sistemas de saúde e comprometem a sua resiliência. Os sistemas de saúde precisam estar fortalecidos e prontos para os tempos que se avizinham, sendo capazes de prevenir, se preparar, detetar, se adaptar,

responder e se recuperar de ameaças à saúde pública (60). Recentemente, o mundo foi assolado pela pandemia da COVID-19, que evidenciou fragilidades em todas componentes dos sistemas de saúde, sobretudo a força de trabalho (recursos humanos) e tecnologias médicas (condições de trabalho) (61). Durante períodos de pandemia, perante o desgaste psicológico, stress e esgotamento gerado por razão do alto risco de contaminação e alta carga de trabalho, as queixas e reivindicações dos trabalhadores de saúde tendem a agudizar-se, resultando em mais greves no sector de saúde (62-65). Esta pandemia trouxe consigo importantes lições para o presente e futuro, que os governos e tomadores de decisão precisam considerar, visto que, segundo as previsões da Plataforma Intergovernamental sobre Biodiversidade e Serviços de Ecossistemas, com a degradação do meio ambiente, as pandemias surgirão com mais frequência, se espalhando mais rapidamente e causarão mais danos (66).

Futuros estudos de intervenção para a promoção da humanização no sector público de saúde são fundamentais, assim como estudos de avaliação e monitoria da satisfação e motivação dos profissionais de saúde no local de trabalho.

Qualquer informação que permita o governo agir antecipadamente para resolver questões que possam resultar em situações de greve dos profissionais de saúde é útil. Percebe-se que houve muito tacticismo (táticas) e pouca estratégia na gestão deste movimento em Moçambique, bem como em outros países da África Subsaariana. Grande parte da abordagem adotada nesta greve era oportunista, temporária e muito orientada para ganhos imediatos, para calar os trabalhadores e tentar fazê-los regressar ao trabalho, com pouca reflexão crítica sobre os fatores causantes. Portanto, é imperioso a adoção de abordagens mais estratégicas, sustentáveis e prósperas, baseadas em evidências, que tragam benefícios a longo prazo, como por exemplo:

- Institucionalização e cobertura legal dos mecanismos de diálogo social, com criação de estruturas formais, permanentes e reconhecidas legalmente para este diálogo, como por exemplo criação de comissões bipartidas ou tripartidas de saúde (governo, empregadores e trabalhadores), tribunais trabalhistas da saúde, política de incentivo a organização e reconhecimento jurídico dos sindicatos, participação dos sindicatos em conselhos nacionais

de saúde, mesas de negociação coletiva setorial, formalização de mecanismos de mediação e arbitragem, existência de protocolos claros de negociações prévias às greves, resguardar o direito à greve, porém estabelecer requisitos prévios (como esgotamento do diálogo e cláusulas de serviços mínimos em caso de greve) (67-69);

- O Planeamento dos recursos humanos para saúde deve ser baseado em evidências científica buscando alinhar a oferta, distribuição e retenção da força de trabalho com as metas nacionais de saúde (70, 71);

- Inclusão obrigatória de representantes sindicais no planeamento dos recursos humanos em saúde;

- Promoção de negociações colaborativas por meio de formações e workshops com gestores governamentais e representantes sindicais (72);

- Adoção de sistemas transparentes de resolução de queixas que antecipem e neutralizem o descontentamento antes da escalada.

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## **4. APÊNDICE**

## 4.1 Apêndice 1: Guião de entrevista

<b>Guião de entrevistas</b>
-----------------------------

### I. Dados Sociodemográficos

1.1 Idade \_\_\_\_\_

1.2 Género \_\_\_\_\_

1.3 Grupo pertencente:

a) Representante do governo \_\_\_\_\_ b) Grevista \_\_\_\_\_ c) Mediador \_\_\_\_\_

1.4 Ocupação: \_\_\_\_\_

### 2. Aspetos gerais

2.1 Quando pensa na greve dos médicos e outros profissionais de saúde de 2013 em Moçambique, o que é que lhe vem em mente?

2.2 Quais foram os momentos mais delicados que terá vivenciado durante a greve? O que mais o marcou?

2.3 Quais os atores você destacaria como chaves na gestão do movimento grevistas?

2.4 Que lições se pode tirar daquele movimento grevista?

### 3. Causas

3.1 Quais aspetos considera que foram as motivações do movimento grevista dos médicos de 2013?

3.2 Haverá algum aspeto político ou social, na sua opinião, que terá contribuído para que aquela greve ocorresse?

3.3 Qual é sua opinião com respeito ao caderno reivindicativo, os pontos apresentados eram justos naquele momento?

3.4 Que aspetos terão contribuído para a eclosão da greve?

### 4. Estratégias

4.1 Que estratégias ou intervenções foram adotadas pelas partes para evitar que a greve começasse?

4.2 O que acha que deveria ter sido feito e não foi feito (pelos partidos) para evitar o início da greve?

4.2 Que intervenções foram feitas para mitigar o efeito da greve? Que implicações tiveram?

4.3 Que intervenções foram feitas para parar a greve? Que implicações tiveram?

4.5 Que estratégias foram adotadas pelos grevistas para alcançar seus objetivos?

4.6 O que terá contribuído efetivamente para o fim do movimento grevista?

## **5. Consequências**

5.1 Que avaliação faz das consequências do movimento grevista para os pacientes, o sector de saúde e governo no geral?

5.2 Que consequências a greve teve para os médicos e outros profissionais de saúde (grevistas e não grevistas)?

5.3 Considera que todos os aspetos constantes no caderno reivindicativo foram satisfeitos pelo governo?

5.4 Avaliação faz das condições de vida e de trabalho dos médicos e outros profissionais antes e depois da greve?

5.5 Como foi noticiada esta greve nos meios de comunicação social e qual foi a opinião pública em relação ao movimento?

## 4.2 Apêndice 2: Relação dos documentos incluídos na análise

Tabela 1: Lista de documentos incluídos na análise documental.

Ord	Lista de documentos incluídos na análise	N
1	Jornal Notícia (diário)	15
2	SAVANA (semanal)	08
3	Relatório Anual de Recursos Humanos em Saúde 2013	1
4	Relatório Anual de Recursos Humanos em Saúde 2021	1
5	Pré-aviso de greve geral dos médicos (2012)	1
6	Pré-aviso de greve geral dos médicos e profissionais de saúde (2013)	1
7	Caderno reivindicativo dos médicos (2012)	1
8	Caderno reivindicativo dos médicos (2013)	1
9	Caderno reivindicativo dos profissionais de saúde unidos (2013)	1
10	Relatório geral sobre a paralisação das atividades do Serviço Nacional de Saúde por parte dos médicos e outros profissionais de saúde (2013)	1
11	Memorando de Entendimento entre o Ministério da Saúde e a Associação Médica de Moçambique (2013)	1
12	Regulamento do Estatuto do Médico na Administração Pública (2014)	1
13	Estatuto do Médico na Administração Pública (2013)	1
14	Diretrizes da Greve Geral dos profissionais de Saúde em Moçambique (2013)	1
15	Diretrizes da Segunda Greve Geral dos Médicos em Moçambique: cuidar de quem cuida (2013)	1
16	Regulamento da Associação Médica de Moçambique (2015)	1
17	Despachos emitidos pelo Ministro da Saúde entre 12/2012 e 07/2013	06
18	Atas das reuniões entre o MISAU e a AMM	12
19	Atas das reuniões da Direção Executiva do Ministério da Saúde	8
20	Relatório dos processos disciplinares levantados no âmbito da paralisação laboral (2013)	1
21	Constituição da República de Moçambique de 2004	1
22	Regulamento do Estatuto Geral dos Funcionários e Agentes do Estado (2009)	1
23	Estatuto da Ordem dos Médicos de Moçambique e Código Deontológico (2011)	1
24	Regulamento Pedagógico da Universidade Eduardo Mondlane (2010)	1
	Total	68

## **5. ANEXOS**

## **5.1 Anexo 1: Material e Métodos**

Neste subcapítulo apresenta-se um resumo da metodologia aplicada para alcançar os objetivos da tese. Esta informação está descrita com mais detalhe nos artigos apresentados no capítulo 2 (resultados).

### ***5.1.1 Greve dos médicos e outros trabalhadores de saúde na África subsaariana entre 2000 a 2020***

Foi realizada uma revisão sistemática com o objetivo de identificar os principais atores, as razões por detrás das greves nos países da África subsaariana e o seu impacto nos profissionais de saúde (especificamente médicos) e nos serviços de saúde, bem como identificar as principais estratégias adotadas para mitigar ou pará-las.

#### *5.1.1.1. Estratégia de busca*

Foi feita uma busca de estudos publicados entre janeiro de 2000 e dezembro de 2021 nas seguintes bases de dados: MEDLINE, Google Scholar, Scopus, ProQuest e Science Direct.

Para o algoritmo de pesquisa foram considerados termos MESH, palavras de texto livre e termos relacionados com a força de trabalho de saúde (trabalhadores de saúde, profissionais de saúde, profissionais de saúde, pessoal de saúde, força de trabalho de saúde) e greves (ação industrial, queixas, protestos), tendo em conta os componentes dos critérios PICOC (População, Intervenção, Comparação, Resultado e Contexto) (1).

#### *5.1.1.2. Tipos de estudo incluídos na revisão*

Para esta revisão sistemática foram considerados estudos quantitativos, observacionais (i.e., de coorte, caso-controlo, transversais e ecológicos) e experimentais, bem como estudos quase experimentais, de métodos mistos e qualitativos publicados entre janeiro de 2000 e dezembro de 2021, nas línguas oficiais dos Estados-Membros da Região Africana da Organização Mundial de Saúde, nomeadamente: inglês, francês, português e espanhol. A literatura cinzenta não foi incluída.

#### *5.1.1.3. Avaliação da qualidade e síntese da evidência*

Os instrumentos de avaliação crítica do Joanna Briggs Institute (JBI) foram utilizados para avaliar o risco de viés dos estudos incluídos. Um instrumento adaptado por Betran et al. foi utilizado para avaliar estudos ecológicos (2, 3). Foram incluídos na revisão estudos que tivessem uma percentagem total mínima de 70% (2). A qualidade global de cada evidência foi avaliada mediante o Grading of Recommendations Assessment, Development and Evaluation (GRADE) (4). A síntese narrativa foi utilizada para rever e sintetizar os dados extraídos dos artigos incluídos neste estudo.

Todo processo de seleção, avaliação da qualidade da evidência encontrada e extração de dados foi conduzido por dois revisores (A.L.J.M. e I.C.), e em caso de discrepâncias, o terceiro revisor foi consultado (M.S).

#### ***5.1.2 Greve dos médicos e outros trabalhadores de saúde moçambicanos em 2013***

Com o objetivo de identificar as causas, estratégias adotadas e o impacto do movimento da greve de médicos de 2013 em Moçambique foi feito um estudo qualitativo com uma abordagem fenomenológica que consistiu em entrevistas semiestruturadas (com base no guião, anexo 1) com os principais atores envolvidos no movimento de greve dos médicos moçambicanos em 2013 (líderes governamentais, sociedade civil e organizações de profissionais de saúde) e análise de documentos emitidos no contexto da mesma.

##### *5.1.2.1. Entrevistas*

Inicialmente, foram intencionalmente selecionados os atores mais destacados na média durante a greve (os líderes do grupo grevista, representantes do governo e atores da sociedade civil), o que terá constituído uma amostra inicial de oito (08) entrevistados (incluindo o primeiro autor A.L.J.M., como ministro da saúde à data dos factos).

Foi feita uma entrevista de episódio exclusiva ao primeiro autor (A.L.J.M., enquanto ministro da saúde no momento da greve) para minimizar um potencial risco de viés, uma vez que este viveu o episódio a investigar, como figura preponderante, pelo que a utilização da sua

informação é complexa e requer uma metodologia diferenciada (5). A entrevista de episódica foi realizada separadamente, antes que as outras entrevistas iniciassem, e antes que releitura e análise dos documentos fosse feita. As restantes entrevistas foram realizadas por um investigador externo ao estudo previamente treinado.

Durante estas entrevistas, foram identificados mais atores (n=11) através de uma amostragem não probabilística tipo bola de neve conduzida até à saturação dos dados. Não surgiram dados novos a partir da 13ª entrevista, e as três entrevistas subsequentes confirmaram a obtenção da saturação dos dados (6-9). E assim, um total de 17 entrevistas foram realizadas, incluindo a entrevista episódica.

#### *5.1.2.2. Análise documental*

Foi feito uma busca de forma manual nos arquivos do MISAU, da AMM e em dois proeminentes meios de comunicação impressos em Moçambique (SAVANA e Jornal Notícias) com ajuda de quatro (04) auxiliares de pesquisa. Foram selecionados documentos cujo título ou subtítulo estivesse relacionada com a greve no setor da saúde, publicados entre dezembro de 2012 a julho de 2013. A estes foram acrescentados documentos citados pelos entrevistados ou relacionados com os seus comentários. Um total de 68 documentos foram selecionados e incluídos para análise (anexo 2).

#### *5.1.2.3. Análise de dados*

As entrevistas foram transcritas literalmente por uma investigadora externa ao estudo e, posteriormente, conferidas (por I.C.). No final, as transcrições preliminares foram partilhadas com os entrevistados para verificação (com exceção da entrevista episódica) e os comentários adicionais foram gravados, transcritos e incluídos para análise (10). As transcrições finais foram analisadas por três investigadores análise, primeiro de forma independente e depois em conjunto para garantir um melhor alinhamento entre eles (11). Todas as análises foram realizadas no programa Nvivo (versão 12).

A técnica de análise de conteúdo foi utilizada para analisar os documentos e as transcrições das entrevistas, identificando o núcleo emergente em cada texto, através do processo de codificação (categorização) e interpretação da informação contida, para desvendar o seu

conteúdo manifesto e latente (12). Inicialmente, através de uma rápida revisão da literatura, foi pré-definido um conjunto de temas e subtemas (método dedutivo), tendo sido acrescentados outros durante a análise das transcrições e dos documentos (método indutivo).

A gravação da entrevista do episódio (com A.L.J.M.) foi partilhada no final (5), depois de terminada a análise das restantes entrevistas, pelo que foi transcrita na íntegra (por um investigador externo ao estudo) e analisada (por A.L.J.M., D.B.S. e M.S.), servindo de complemento para uma melhor compreensão dos factos.

### **5.1.3 Referências**

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## **5.2 Anexo 2: Parecer da Comissão de Ética do Instituto de Higiene e Medicina Tropical da Universidade Nova de Lisboa**



INSTITUTO DE HIGIENE E  
MEDICINA TROPICAL  
DESDE 1902

## COMISSÃO DE ÉTICA

### PARECER 2.21

**Título do estudo:**

Desenvolvimento e impacto do movimento grevista de médicos: estudo de caso da greve dos médicos moçambicanos de 2013

**Investigador(a) principal:**

Alexandre Manguela

**Outr@s Investigador@s / Orientador@s:**

Paulo Ferrinho, Isabel Craveiro

**Entidade Promotora:**

Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa

**Resumo do estudo:**

O estudo tem como objetivo compreender o movimento da greve dos médicos de 2013 em Moçambique (antecedentes, motivações, reivindicações, estratégias usadas pelos grevistas, estratégias adotadas pelo governo para negociações e sua resolução, consequências para a sociedade e para o setor de saúde no geral e para os recursos humanos em particular), contextualizando-o na evolução das greves médicas no mundo e na evolução da força de trabalho médica desde a independência de Moçambique em 1975.

O estudo compreende uma revisão de literatura, análise documental, entrevistas semiestruturadas e grupos focais.

**Conflito de interesses:**

Existem conflitos de interesses que são claramente declarados. Igualmente são apresentadas as formas previstas para minimizar estes conflitos no desenho do estudo, na sua operacionalização e análise de dados: será conduzida uma “Entrevista de episódio” ao investigador principal (IP) previamente ao início da restante investigação; os demais investigadores não estarão na dependência hierárquica do IP; as entrevistas, grupos focais, convites à participação e recolha de assinaturas dos Consentimentos informados não serão realizados pelo IP; os entrevistados com dependência hierárquica / profissional com o IP não serão convidados a



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participar no estudo (critério de exclusão); a análise de conteúdo será feita pelo IP e por outro investigador, o orientador ou coorientadora.

**Informação ao participante, Consentimento informado e confidencialidade:**

Informação ao participante completa. São descritas as ações previstas para garantir a confidencialidade dos dados fornecidos pelos participantes, assim como as suas identidades.

**Conclusão:**

Parecer favorável

**Observações:**

1. Em relação ao Termo de consentimento informado deve ser feito em duplicado, ficando uma cópia com o participante na investigação;
2. Em relação à Folha de Informação ao Participante, não há necessidade de ter uma assinatura da entidade promotora no final;
3. Aconselhamos vivamente repensar o tempo até à destruição dos formulários de consentimento informado, gravações e guiões de entrevistas preenchidos pelos entrevistados em papel. Aconselhamos que o prazo seja alargado até alguns anos após a publicação do trabalho;
4. Solicitamos que a destruição referida seja realizada com testemunhas do projeto e externas a este. Dessa destruição deve ler lavrado um Auto (Auto de destruição) a detalhar que material foi destruído e ser datado e assinado pelas testemunhas. Deve ser enviado para esta Comissão.
5. Solicitamos igualmente que no final do trabalho de investigação nos seja enviado relatório ou publicação do mesmo.

**Documentos analisados:**

Protocolo (versão de 6 de abril 2021); Guiões de entrevistas e grupos focais; Formulário de informação ao participante e consentimento informado; CV dos investigadores.

MARIA CLÁUDIA GOMES  
DOS SANTOS RODRIGUES  
DA CONCEIÇÃO

Assinado de forma digital por  
MARIA CLÁUDIA GOMES DOS  
SANTOS RODRIGUES DA  
CONCEIÇÃO  
Dados: 2021.04.14 16:31:05 +01'00'

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Professora Doutora Cláudia Conceição  
Presidente da Comissão de Ética

### **5.3 Anexo 3: Parecer do Comit  Institucional de Bio tica para Sa de do Instituto Superior de Ci ncias de Sa de**



**INSTITUTO SUPERIOR DE CIÊNCIAS DE SAÚDE  
(ISCISA)  
COMITÉ INSTITUCIONAL DE BIOÉTICA PARA SAÚDE - CIBS**

Exmo Senhor

**Presidente do Comité Nacional de Bioética para Saúde (CNBS)**

MAPUTO

Nossa Ref<sup>o</sup> nr 02/CIBS-ISCISA/2020

Assunto: Envio do protocolo de investigação científica com o título “Desenvolvimento e impacto do movimento grevista de médicos: estudo de caso de greve dos médicos moçambicanos de 2013”.

Exmo Senhor;

Depois do Protocolo de Investigação Científica em referência ter sido avaliado pelo CIBS – ISCISA, o mesmo chegou a seguinte conclusão:

- É de parecer favorável à sua aprovação.

Com os nossos melhores cumprimentos

Maputo, 21 de Agosto de 2020



Eng. Freireira Aires Raposo