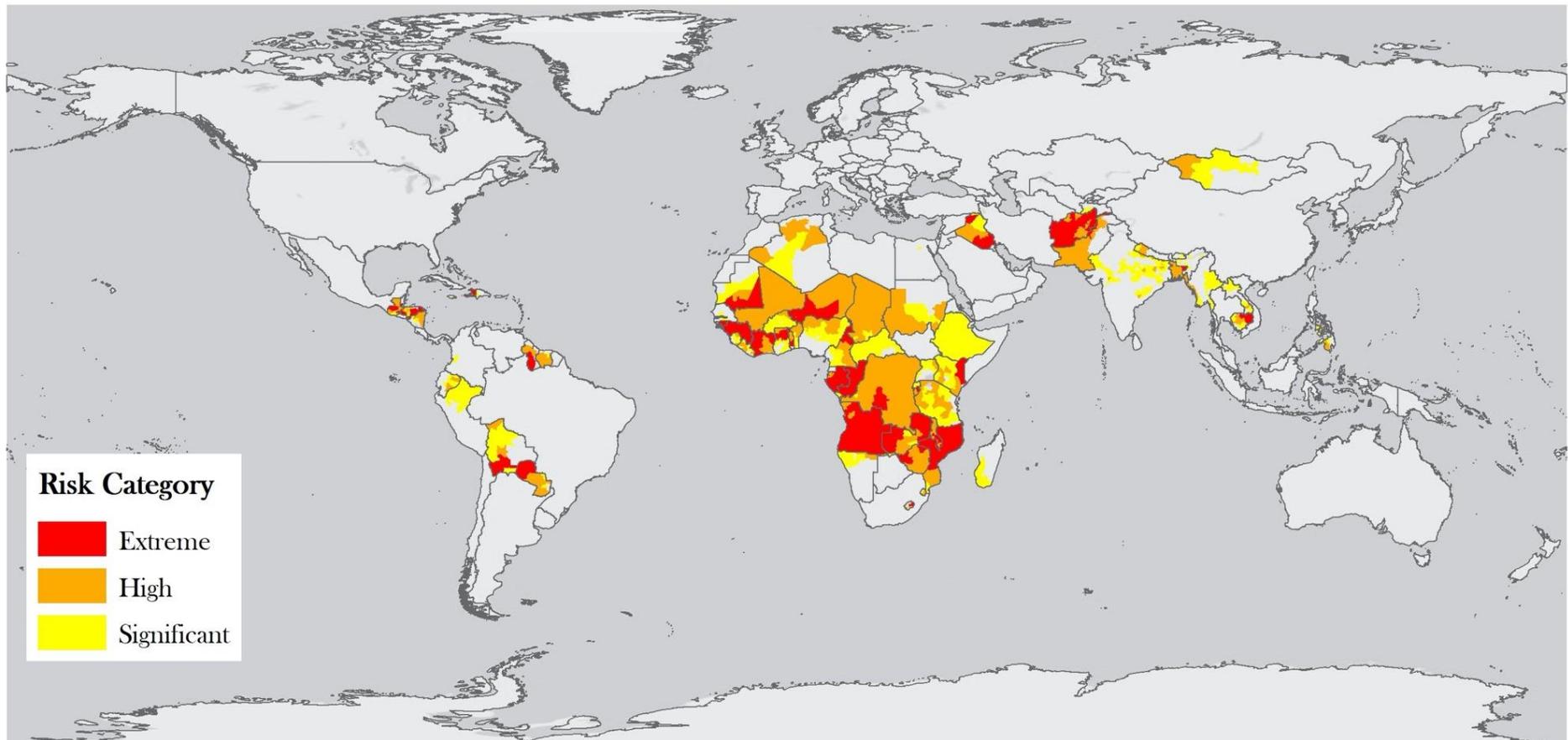# TMPSYSTEMS

Inequality, COVID-19 and Conflict:

Recommendations for people trying to design or implement public health interventions in developing countries

See and use our risk model (for free) at

www.tmpsystems.net/coronavirus

or contact us at

coronavirus@tmpsystems.net

These are the 224 districts that TMP Systems believes are more likely to see outbreaks of violent local resistance to COVID-19 interventions, organized by level of risk. Currently, data is incomplete or unreliable for some developing countries, including Argentina, Libya, Somalia, South Africa, South Sudan, Thailand, Venezuela and numerous island states. See www.tmpsystems.net/coronavirus for an interactive version.

TMPSYSTEMS

Introduction

In our paper "Inequality, COVID-19 and Conflict", we[1] asserted that 754 million marginalized people across Africa, Asia and Latin America may resist restrictions on movement, controls on trade and business and other health measures intended to fight COVID-19. We also asserted that, as the virus' death toll and economic impact mount, this resistance may tip into widespread violence across many countries.

This was a high-level analysis that did not address a very important ground-level concern: if our model indicates that risk is a particular location is high, what actions should be taken to reduce, manage or otherwise account for it?

Nowhere is this question more pressing than in public health, and the purpose of this paper is to fill that gap by offering four suggestions to improve the chances for success of ground-level interventions for preventing or treating COVID-19.[2]

We are not health professionals. Instead, these concepts stem from our company's own field experience from working on something called "social license to operate" with companies and investors in developing countries, as well as our various experiences from public and private organizations dealing with major health crises. We explain below why we believe the former is relevant for COVID-19.

Our advice is specific, in that we have adapted general social license principles to the unique challenges that COVID-19 poses, as well as frank, in that our objective is to help you make the best out of what is a very bad situation. We hope that you find it informative and useful.

The first sections describe some definitions and the dynamics of resistance, after which we offer four pieces of advice. We welcome any questions you might have, which should be directed to coronavirus@tmpsystems.net.

---

[1] TMP Systems is a consultancy. For more than a decade, our mission has been to measure, analyze and manage the risks (or opportunities) created by social and environmental changes. We work with both private and public clients, and have ground-level experience in 19 countries, much of it relevant to the risks described in this analysis. See Appendix One for more about our company or contact us at coronavirus@tmpsystems.net.

[2] Since restrictions on freedom of movement, business and trade are quite different, we are still considering ground-level recommendations for how to deal with their inevitable impacts. Contact us at coronavirus@tmpsystems.net for details.

TMP SYSTEMS

A few important definitions

We first need to define a few terms used frequently in the following pages, starting with the word "intervention". This means any health program that is designed to reduce the impact of COVID-19 in a developing country.

It can be a national program covering tens of millions, or a village-level intervention covering hundreds. It can include programs being implemented right now, such as attempts to emphasize hand washing, testing for the virus or enforcement of social distancing. It can also include programs that will be designed and implemented in the future, such as large-scale care for those with advanced pneumonia, systematic protocols for handling of corpses, or, more hopefully, vaccination programs (if and when a vaccine is found).

The next term to define is you. "You" are someone who is in a position to design, implement or monitor these interventions. What institution you work for does not much matter, nor is it meaningful whether that institution is public, private, philanthropic or for-profit. What matters is that you are either trying to come up with an intervention that reduces the impact of COVID-19, or implementing an existing intervention that someone else has designed.

Finally, the word "marginalized" is crucial and sits at the core of our analysis. "Marginalized" does not mean people who are poor. Rather, it means those who are poorly treated. It covers a broad category of communities whose dignity has been eroded by economic inequality, political exclusion, or religious, racial and ethnic disrespect, such that they feel themselves foreigners in their own countries. Our model was designed to identify areas with a high percentage of these groups, and so, we refer to those areas as "risky" in the following pages.

From media reports and our own sources, we know that many risky areas have already been startled by the sudden appearance of unfamiliar government officials imposing restrictive new rules on trade, assembly or religious practice, or by the arrival of unknown clinicians trying to perform invasive COVID-19 tests. If explained at all, the presence of these outsiders has likely been justified in a language many of local people do not speak well, often in breach of cultural norms.

Maladroit as communications may be, we are not saying that interventions are unnecessary. The only known way to control COVID-19 is for national and local authorities to impose social and/or economic controls on an unprecedented scale. But, if you will excuse the ham-handed metaphor: like any necessary and strong medication, they have side effects. Where marginalized people are concerned, those side effects are often both predictable and consequential.

Although quite different in some obvious ways, this aspect of COVID-19 interventions reminds us of what we have seen when consulting companies, investors and governments who trying to advance investment projects in developing countries.

Our company has analyzed more than 600 case studies of (often violent) local opposition to these projects in emerging markets and we have used that data to work with numerous organizations to reduce these risks.

The following outlines the dynamics that we usually see in play and explains why they are applicable to COVID-19. This provides important context for the recommendations that come later in this paper.

What causes the problem

Very often, new investment or economic development projects in the developing world are based on a false assumption. Their proponents arrive assured by the national government, local authorities and/or various lawyers and consultants that they have the legal right to begin digging, building or cordoning off land (or other resources).

In a similar way, your intervention (whether you are in government or not) may well arrive with the same reassurances that you can begin testing, treatment or prevention. It is important to understand that it does not really matter that your actions are more ethically-driven than an investment in a new copper mine. Marginalized people will often not trust you or your agenda. Indeed, they will think that both the mine and your intervention have been granted an entitlement by an outside power generally does not serve or protect their interests.

Typically, we see problems either when no one has thought to include the local population in the allocation of an entitlement, or when they have been deliberately excluded from the process. It is therefore crucial to understand answer some questions before implementing an intervention, such as: is your intervention being implemented near such a marginalized population? Is this population likely to be impacted negatively by the intervention? And, have these people been well informed about the intervention or appropriately included in its design.

We are sorry to report that if your intervention involves preventing COVID-19's spread, you may face a major challenge to work with marginalize populations. Time is of the essence in imposing restrictions on movement and business but this urgency is hard to understand for most normal people (whether marginalized or not). Since health officials do not have time to conduct proper consultations, we expect many local populations to initially resist these rapid attempts to protect them from the virus.

They will do so for the same reasons that they often oppose a new factory, wind farm or mine: they do not trust those implementing the intervention to change their life for the better.

Even more regrettably, we must report that local opposition is likely to be an even greater problem if you are trying to treat COVID-19 cases and/or consequences, or

implement vaccination programs. If you are not already active in the field, then this is a difficult time to get started.

Marginalized people will perceive your intervention, not as a standalone program, but as one of a series of changes to their lives. These changes will be almost entirely negative, particularly so wherever governments lack the financial means to soften the blow of what may now shaping up to be the biggest global economic program since the Great Depression.

By the time your intervention arrives, it is more likely to be perceived as malevolent subjugation than benevolent protection. Many will already be struggling with urgent problems like food security, which they may connect to other interventions. Some will feel compelled to resist, and if nothing is done to understand and address that resistance, it will likely target healthcare workers and the programs supporting them.

Social license to operate

This kind of problem calls for obtaining what experts refer to as "social license to operate" (hereafter, "social license"). Social license will be familiar to anyone with ground-level experience operating real assets – mines, plantations, power plants and the like – whose ongoing operation requires the cooperation and goodwill of the people living next to them over time. In these situations, social license is achieved when a local community consents with the asset being built or operated in a certain fashion, and maintained as construction or operation fulfill those expectations.

Social license is primarily a local issue. However, it is important to understand that the level of risk will depend significantly whether the national government itself has a kind of social license for its own functions. This was evident in the different reactions to health interventions between Sierra Leone and Guinea during the Ebola crisis in West Africa:

> *Sierra Leone and Guinea share broadly similar cultural worlds […] There was, however, a notable difference in their reactions to the Ebola epidemic. As the epidemic spread in Guinea, acts of violent or everyday resistance to outbreak control measures repeatedly followed, undermining public health attempts to contain the crisis. In Sierra Leone, defiant resistance was rarer. [A] comparison between Sierra Leone and Guinea suggests that explanations lie in divergent political practice and lived experiences of the state.*[3]

Equally important is understanding that social license needs to be constantly maintained. Indeed, as we have become more familiar with these issues in our own work over the past decade, we have found the term "license" a bit misleading.

---

[3] Wilkinson, A., & Fairhead, J. (2017). Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture. Critical Public Health, 27(1), 14-27.

Gaining social license is not, typically, a one-off affair. Nor is it a binary state of "yes" or "no".

It is rather a continuum born of an ongoing process of speaking with local communities, gauging their apprehensions about the actions you might want to take, and either modifying the intervention or negotiating ways to address their concerns and resolve their objections.

Social license in health: Lessons from Ebola

We do not mean to say that these challenges are unfamiliar to all health professionals. Quite the opposite: in recent years, some public health experts have paid increasing attention to earning the social license required to make safe and successful interventions, particularly in areas where community acceptance and tolerance of these interventions has been frayed or withdrawn.

This has been especially true in the wake of some high-profile issues with Ebola interventions in Africa over the last decade. Useful work has been done in the health sector to understand where interventions like the ones that failed in Guinea, Liberia or DRC went wrong, and what approaches might work better.

We have reviewed many of these studies in composing this brief[4], and the best summary of what can go wrong comes from a review of violence against Ebola treatment centers in 2019:

> The isolation of cases during the early stages of infection is critical to curtailing Ebola transmission. However, the heavy security around disease control teams has raised suspicions that the response to the outbreak is politically motivated. Mistrust of government and the public health response among civilians compounded hostility and fueled reluctance of sick people to seek treatment. Integrating humanitarian work with the response as well as community engagement is needed to improve trust among the residents[5].

There is also useful advice on steps to be taken in integrating that humanitarian work and community engagement. For example, the Ebola Gbalo Research Group is a group of experts who have studied the outbreak in Sierra Leone and found that it "showed the need to work closely with front-line health responders and other authorities perceived locally to be legitimate." That Group has offered four key pieces of advice, paraphrased here:

---

[4] Only some are cited here due to limited space, but we provide a complete list of these in Appendix Two and we recommend them to anyone interested in learning from past experiences of these issues.

[5] Wells, C. R., Pandey, A., Mbah, M. L. N., Gaüzère, B. A., Malvy, D., Singer, B. H., & Galvani, A. P. (2019). The exacerbation of Ebola outbreaks by conflict in the Democratic Republic of the Congo. Proceedings of the National Academy of Sciences, 116(48), 24366-24372.

- o Work through local authorities even if they lack great capacity
- o Rely on front-line health workers, even if they lack expertise
- o Get the right protective equipment to those who need it, not just to health centers (which are often far from demand); and
- o Recognize that using the military or security forces is highly problematic[6]

But these and similar recommendations have their limits, if only because these experts (quite understandably) did not envision having to implement these recommendations in a situation like the one we face with COVID-19. The scale and urgency is completely different. Here, we think that experience from the business world might be of some use.

Businesses sometimes face social license situations in which their productive asset needs to reestablish operations as quickly as possible, and therefore, time is of the essence. This, and real resource constraint, force them to adapt social license principles that were designed for less urgent situations. In that spirit, we offer the following pieces of practical advice.

1. The approach we have seen in China and now Europe and North America will not work in developing countries. Rapid, sustained lockdown without resistance is not realistic. You should certainly attempt it, but also plan for it to fail.

China's experience suggests that COVID-19 can be pushed back if communities can maintain a months-long commitment to having their lives and livelihoods massively disrupted. This approach has now been adopted, almost uniformly, by developed countries grappling with the pandemic, as well as in countries like India, Kenya or Honduras.

We cannot emphasize enough that no such restriction will be feasible in many risky areas. One major reason is that many cultures in these areas are highly communal, poorly resourced and not subject to national control. At the same time, the state does not have the material or organizational capacity to provide the bailouts and stimulus support that even citizens of rich countries have needed in this crisis. A combination of custom and necessity will therefore compel many to resist.

---

[6] This is a paraphrase of the following quote from Ebola Gbalo Research Group. (2019). Responding to the Ebola virus disease outbreak in DR Congo: when will we learn from Sierra Leone?. Lancet.

"These lessons are: (1) to work closely with the different forms of local authority, including recognising heterogeneity and different capacities among those authorities, with a commitment to allowing local authorities to shape the response; (2) to allow local front- line health workers to advise international responders on the best means to reach, and encourage cooperation from, affected communities; (3) to disperse resources and basic life-saving equipment (including gloves, boots, and chlorine) to communities, particularly in remote locations beyond formal health systems (front-line health workers and distant community leaders should also be provided with communication tools to expand the surveillance area beyond those reached by formal health systems); and (4) to recognise that in the highly politicised context of the Ebola virus disease outbreak in DR Congo, securitisation of response is problematic and will require reflection.

Regrettable as this may be, those intervening will have to settle for the proverbial half-a-loaf, something we assume will lead to significantly more deaths than the desirable level of restrictions would allow. Nevertheless, the toll will still be much lower than that which the community would experience if the intervention could not take place because social license had not been secured.

So when we say "plan for it to fail", we mean that your intervention should assume that lockdowns and/or social distancing will not work, and that therefore, more people will die as a result. You should design your interventions accordingly.

For example, one implication of this is that there must be a plan to anticipate that death toll and persuade – not educate, as one often reads in public health interventions, but *persuade* – local populations that an outbreak of COVID-19 is not being caused by the very interventions intended to protect them from sickness.

Another implication is the need for high awareness of and respect for local beliefs (especially things like burial practices or vigils for those gravely ill). This tolerance is a tricky business, in that it may have to be taken to the point where some risk of ongoing risk of infection caused by these beliefs is accepted in order to maintain cooperation. But it is a requirement for success.

Here, it is especially important to avoid the problem we saw during Ebola outbreaks, where there was a complete misunderstanding of burial practices by the media and medical professionals. In particular, interventions "focused on a few key practices identified by biomedical professionals as most likely to spread the disease, rather than those aspects of funerals which might be most meaningful to the populations involved."[7]

In other words, try to understand burials from the perspective of the bereaved as an emotional reaction, in addition to thinking about it as a source of ongoing risk and infection (which it certainly is)[8] – and adjust your interventions to match that understanding.

---

[7] Moran, M.H. (2017). Missing Bodies and Secret Funerals: The Production of "Safe and Dignified Burials" in the Liberian Ebola Crisis. Anthropological Quarterly 90(2), 399-421.

[8] Recognize also that cultural traditions are not the only factors in play. As one research paper explained from experience in Sierra Leone: "In addition to concerns about breaking cultural traditions, barriers to safe burial acceptance included concerns by family members about being able to view the burial, perceptions that bodies were improperly handled, and fear that stigma may occur if a family member receives a safe, dignified medical burial. Participants suggested that providing opportunities for community members to participate in safe and dignified burials would improve community acceptance." For details, see Lee-Kwan S.H., DeLuca N., Bunnell R., Clayton H.B., Turay A.S., and Mansaray Y. (2017) Facilitators and Barriers to Community Acceptance of Safe, Dignified Medical Burials in the Context of an Ebola Epidemic, Sierra Leone, 2014, Journal of Health Communication, 22:sup1, 24-30.

2. Do not rely on officials from government for communication and education. Work as much as possible through local organizations, community health workers and local leaders.

By emphasizing the need to persuade, we are not saying that education does not have a role to play. It does but in any developing country, this poses no small challenge. As Ethiopian health expert Sosena Kebede puts it, one must:

> …massively disseminate basic but science-based facts about this virus, how to prevent its transmission and address false narratives about the virus. Epidemics are anxiety provoking and can be rife with dangerous and false information. In populations where the literacy level may not be high, every effort should be made to reach people where they are at, speak to them in a language of their preference and give them the opportunity to ask questions. This requires large human resources commitment, but the effort made early in giving enough education to the public will save lives, improve public health efforts and avert chaos.[9]

But if you are in an area with marginalized communities, the challenge is greater still. Bluntly: if the national government says they have communicated something to the local community, you should not imagine that it has been done effectively or that the message has been accepted without question. In most cases, it has either been poorly communicated, or not accepted because marginalized communities usually have a history of seeing government officials either lie or break promises.

There are three classes of people who can help you get past these barriers, starting with local non-governmental organizations (NGOs) and anthropological experts. In our experience, these people are particularly useful in identifying reliable intermediaries who are trusted by communities and, even more helpfully, the specific ways in which information needs to be disseminated. As an expert review of Ebola in West Africa put it:

> A critical step is to begin with a more realistic account of local social relationships. Including anthropologists with specialist knowledge of people and contexts in policy formation and implementation can assist this process. A 'one size fits all' approach and public meetings with supposed key stakeholders is not enough[10].

The second group is community health workers (CHWs), by which we mean "any health worker carrying out functions related to healthcare delivery, trained in some

---

[9] https://addisstandard.com/covid%e3%83%bc19-lessons-of-past-present-and-the-future-on-interventions-that-are-cost-effective-can-be-done-locally-and-done-now/

[10] Wilkinson, A., & Fairhead, J. (2017). Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture. Critical Public Health, 27(1), 14-27.

way in the context of the intervention, and having no formal professional or paraprofessional certificate or tertiary education degree[11]."

Evidence from health interventions suggests that wherever CHWs are present, their opinions carry far more weight than those of outside (even if well-qualified) professionals[12]. Again, being frank, we do recognize that CHWs can be challenging to work with because they are untrained or less educated – this has parallels in our own work with local agronomic "experts", among others. But evidence suggests that the benefits of local support outweigh the costs in most circumstances. The exigencies of COVID-19 should make their superior ability to gain trust even more valuable.

To these two groups, we add a more problematic category: local leaders. It is practically impossible to imagine successful initiation of any COVID-19 countermeasures in risky areas without the cooperation of local leaders, and it is not an exaggeration to say that their decisions will determine the fate of their communities, and collectively, the overall success of national COVID-19 programs.

They must therefore be engaged with a degree of respect and regard commensurate with that power. If basic principles of communication common to any public health intervention have been applied, the collaboration of local leaders should be enough to get things started. However, you should also be aware that in not a few cases their interests oppose those of their communities, and they sometimes represent corrupt authorities that a marginalized community resists.

For that reason, engaging with all three categories – NGOs, CHWs and leaders – is likely to yield the best results.

3. The old are particularly vulnerable to COVID-19, and particularly important for marginalized communities. Develop a plan that takes account of these facts.

Overwhelming evidence suggests that mortality rates for COVID-19 are most severe among the old. We are not experts in projecting health outcomes, but because most marginalized communities in developing countries will lack access to ventilators or trained staff to operate them, we logically assume that older people in those communities will die in significant numbers.

We have operated in a number of risky locations across Africa, Asia and Latin America, and although their communities are quite diverse, we can report almost all of them use some form of age-based traditional authorities to settle disputes and maintain order. These traditional authorities are often much more influential in daily

---

[11] Lewin, S., Munabi-Babigumira, S., Glenton, C., Daniels, K., Bosch-Capblanch, X., van Wyk, B. E., Odgaard-Jensen, J., Johansen, M., Aja, G. N., Zwarenstein, M., & Scheel, I. B. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. The Cochrane database of systematic reviews, 2010(3), CD004015.

[12] Mishra, A. (2014). 'Trust and teamwork matter': Community health workers' experiences in integrated service delivery in India, Global Public Health, 9:8, 960-974.

life than state or local legal authorities. Additionally, as in most of the world, these elders are deeply beloved and important parts of their families even when they have no authoritative standing beyond their relatives.

When those elders die, it will be highly destabilizing. In fact, your interventions may well be blamed for it. It is therefore imperative that these communities understand the likely impact of COVID-19 on their elders; that they not be given false hope about outcomes if key elders fall ill and equipment is lacking. Similarly, It is vital that outside interventions work closely with well-respected local intermediaries to plan for whatever disorder, despair or discontent may result from the passing of elders.

Pay particular attention to vigils and burial practices, as mentioned above. Respecting local customs may significantly increase transmission of the virus, but show them disrespect runs the risk your intervention being shut down completely. If you plan to navigate the trade-offs between those two scenarios, we reckon that you should tend towards respect of custom, putting you in the regrettable but necessary position of having to deal with the consequences of higher infection rates.

4. Provide ready access to grievance mechanisms alongside immediate material support.

As mentioned several times, widely-accepted social license *processes* are not well-suited to this rather unique situation. This is because they assume a far greater period of time in which to obtain social license than will be permissible under the vital constraints COVID-19 will impose on health and security authorities. Instead, it will be more helpful to implement their *principles*.

One seems particularly important: so-called "grievance mechanisms". This term is a kind of catch-all meant to describe an outlet through which communities to vent their inevitable frustrations and concerns, as well as some kind of clear, tangible benefit that they receive for their cooperation.

The specific kind of grievance mechanism you will want to implement is called an "operational-level grievance mechanism". There are a few well-understood characteristics[13] that define these, but they do not fit COVID-19 particularly well for some of the reasons explained above. We have therefore defined and adapted them in ways our experience suggests might be useful:

1. **Legitimacy and equity.** Basically, "legitimate" means that the grievance mechanism cannot be coopted or rigged in favor of any one actor. The best way to do this in a short period of time is to make sure the people involved come from different backgrounds. "Equity" is also quite important. Essentially, try as best you can to ensure that disadvantaged people can offer

[13] For a more complete list and discussion of experiences, see the Harvard Kennedy School's "Piloting Principles for Effective Company-Stakeholder Grievance Mechanisms: A Report of Lessons Learned" at http://www.thecahngroup.com/uploads/6/4/2/1/64212261/company-stakeholder-grieveance-mechanisms.pdf

complaints and you are able to help see them through. NGOs will be particularly adept at offering advice and manpower for this.

2. **Accessibility.** This means that people have to know that the mechanism exists and how to bring their complaints to it without fear of being punished, ostracized or killed. It also means the process is not too complex or difficult for marginalized people to use easily. Here again, working with NGOs and CHWs to get the word out will help. There are also steps that can be taken (anonymous complaints via SMS) that can make it easier, if technology and time allow.

3. **Predictability.** This is the requirement that the mechanism have a well-organized and systematic process for handling complaints. To be candid, our experience is that this attribute appears on every grievance mechanism list but does not work in practice if the mechanism is at an operational level because it clashes with how local populations are used to organizing resolution of their disputes. In particular, it leads to a slow process. Instead, we suggest working with the aforementioned local experts to design a relatively rapid process that fits local needs.

4. **Rights-compatible.** This means "ensuring that its outcomes and remedies accord with internationally recognized human rights standards". We imagine it will be quite difficult to do this while also dealing with the challenges of designing, overseeing or implementing a successful COVID-19 intervention, so we suggest prioritizing 1-3 above.

The mining sector has decades of experience with these mechanisms and is a good resource of knowledge. Not all of their experience is positive, but we suggest you look in this footnote for additional guidance if you need more specific ideas about how these mechanisms work in practice[14].

Conclusion: Defining risky areas

Throughout this document, we have made reference to marginalized peoples and risky areas. Since the view of both is informed by our risk modeling, we thought it useful to wrap up this paper with a quick guide on how you can interpret the results of data we offer at www.tmpsystems.net/coronavirus.

When you access the tool, you will see a map with three levels of data: community, district and national. Each uses a similar classification of risk levels which should be intuitive. From most risky to least, these are: Extreme, High, Significant and Moderate.

If you are designing or implementing an intervention that stretches across countries, the national data will inform you about whether we think a given country has a

---

[14] https://www.icmm.com/grievance-mechanism; https://guidance.miningwithprinciples.com/community-development-toolkit/tool-5-grievance-mechanism/

TMPSYSTEMS

widespread number of marginalized peoples in combination with a deficient health system. You should pay particular attention to the advice under number 2 in any country designated as Extreme or High and plan to allocate more manpower to that place, no matter where in the country your intervention is operating.

In most other cases, we think it is either the community or district data that will be the most informative. The community data is expressed in 20x20 kilometer squares, which will encompass a lot of villages in rural areas and a mid-sized city in urban ones. It will give you a sense of whether the population in that zone is marginalized. These 20x20 scores are then aggregated into district scores, which convey similar information across an entire administrative area (similar to an American state or English county, depending on the country).

Communities or districts scored as Extreme Risks are places where you should plan to encounter a lot of difficulties and where it may be challenging to get good results, even if your intervention is well-executed. Communities or districts marked High Risk will also be challenging but you can have more hope for success. Finally, it should be significantly less difficult to implement successful interventions in communities or districts marked Significant or Moderate Risks.

In all cases, we of course think you will fare better if you apply the advice offered above. We hope you have found this informative and helpful. If there is anything we can do to make it more so, or if you have any questions, please do not hesitate to contact us at coronavirus@tmpsystems.net.

TMPSYSTEMS

APPENDIX ONE: TMP SYSTEMS AND SOCIAL LICENSE

TMP Systems has worked on community engagement, social license and associated disputes across the world for almost a decade. As the map below shows, we have conducted in-depth analysis in 51 countries, with fieldwork and significant on-the-ground engagement in 19 of these countries.

■ Analysis
■ Fieldwork
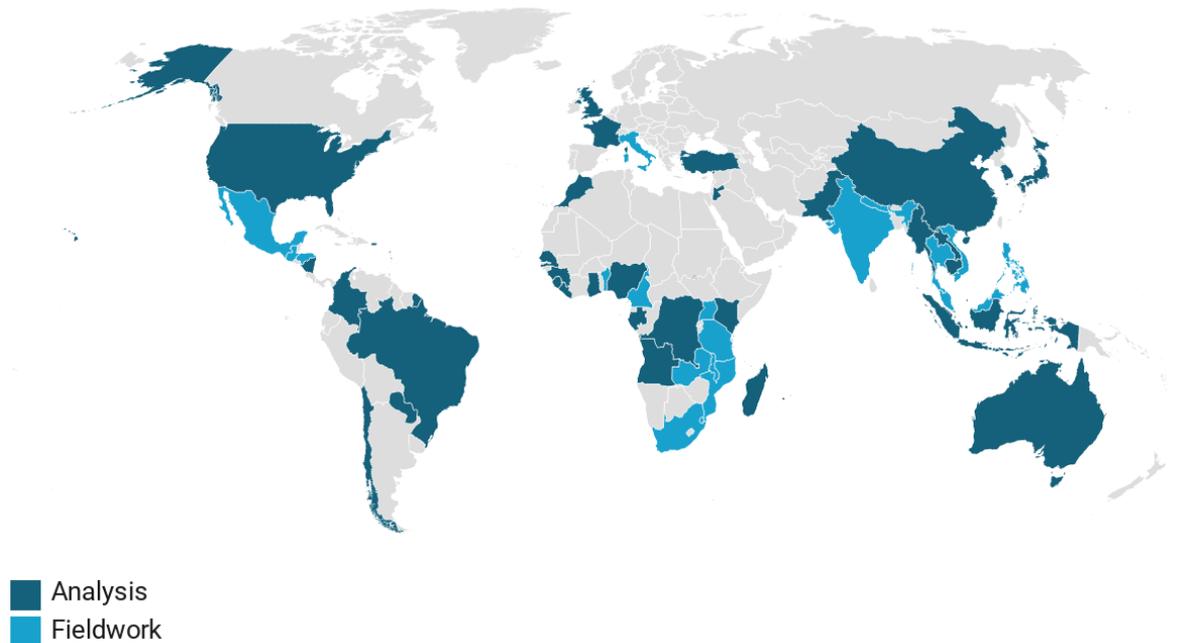
The nature of this work varies, so we provide examples of three projects where we have worked on developing and maintaining social license to operate. If you would like any further information about any of these projects, or our broader work in this area, please contact ben.bowie@tmpsystems.net.

Landscope (2019-present)

Landscope[15] is a geospatial system that helps companies and investors to assess "tenure risk", a term that describes the financial risk associated with local opposition to industrial projects (e.g. mines, wind farms, plantations, and infrastructure).

This kind of opposition is very common across Africa, Asia and Latin America, often causing significant financial losses and operational headaches for businesses involved. Landscope is being used by hundreds of companies and investors in sectors like agriculture, infrastructure, forestry and mining.

Bonsucro (2018-2019)

Over an 18-month period, TMP worked with Bonsucro – the leading sugarcane sustainability certifier – to develop more efficient and powerful ways to support

---

[15] https://landscope.info/

small farmers in the African sugar sector to report on sustainability improvements and drive towards certification. This initiative included the largest buyers, traders, refiners and producers of African sugar and was deployed across Malawi, Tanzania, Zambia, Mozambique, South Africa and Eswatini. It worked to improve relationships and communications between different parts of the supply chain, particularly farmers and millers.

Dryad (2016-present)

Since 2016, our Dryad financial system has been delivering monetary and technical support to 29 different community forest enterprises (CFEs) in the Congo Basin, as part of a £5.8 million, DFID-funded experiment to determine whether economic development and environmental outcomes are truly linked. Dryad works by encouraging bottom-up responses to large-scale problems. One unique feature of the system is that some reporting indicators are selected by the CFE, which encourages local buy-in.

TMPSYSTEMS

APPENDIX TWO: RELEVANT RESEARCH

In preparing this report, TMP Systems reviewed a wide range of documents on health systems, social license in health and lessons from the 2014-2020 Ebola outbreaks in Africa. These are listed below.

Abramowitz, S. A., Bardosh, K. L., Leach, M., Hewlett, B., Nichter, M., & Nguyen, V. K. (2015). Social science intelligence in the global Ebola response. The Lancet, 385(9965), 330.

Abramowitz, S. A., Hipgrave, D. B., Witchard, A., & Heymann, D. L. (2018). Lessons from the west Africa Ebola epidemic: a systematic review of epidemiological and social and behavioral science research priorities. The Journal of infectious diseases, 218(11), 1730-1738.

Abramowitz, S. A., McLean, K. E., McKune, S. L., Bardosh, K. L., Fallah, M., Monger, J., ... & Omidian, P. A. (2015). Community-centered responses to Ebola in urban Liberia: the view from below. PLoS neglected tropical diseases, 9(4).

Achoki, T., & Lesego, A. (2016). Implementing health financing reforms in Africa: Perspectives of health system stewards. Annals of global health, 82(5), 903-911.

Agyepong, I.E. et al (2017). The path to longer and healthier lives for all Africans by 2030: the Lancet Commission on the future of health in sub-Saharan Africa. The Lancet, 390: 2830-59.

Akinlo, A. E., & Sulola, A. O. (2019). Health care expenditure and infant mortality in sub-Saharan Africa. Journal of Policy Modeling, 41(1), 168-178.

Baseler, L., Chertow, D. S., Johnson, K. M., Feldmann, H., & Morens, D. M. (2017). The pathogenesis of Ebola virus disease. Annual Review of Pathology: Mechanisms of Disease, 12, 387-418.

Bervell, B., & Al-Samarraie, H. (2019). A comparative review of mobile health and electronic health utilization in sub-Saharan African countries. Social Science & Medicine.

Büyüktahtakın, İ. E., des-Bordes, E., & Kıbış, E. Y. (2018). A new epidemics–logistics model: Insights into controlling the Ebola virus disease in West Africa. European Journal of Operational Research, 265(3), 1046-1063.

Claude, K. M., Underschultz, J., & Hawkes, M. T. (2019). Social resistance drives persistent transmission of Ebola virus disease in Eastern Democratic Republic of Congo: A mixed-methods study. PloS one, 14(9).

Cohn, S., & Kutalek, R. (2016). Historical parallels, Ebola virus disease and cholera: understanding community distrust and social violence with epidemics. PLoS currents, 8.

Coltart, C. E., Lindsey, B., Ghinai, I., Johnson, A. M., & Heymann, D. L. (2017). The Ebola outbreak, 2013–2016: old lessons for new epidemics. Philosophical Transactions of the Royal Society B: Biological Sciences, 372(1721), 20160297.

Confraria, H., & Wang, L. (2020). Medical research versus disease burden in Africa. Research Policy, 49(3), 103916.

Cori, A., Donnelly, C. A., Dorigatti, I., Ferguson, N. M., Fraser, C., Garske, T., ... & Van Kerkhove, M. D. (2017). Key data for outbreak evaluation: building on the Ebola experience. Philosophical Transactions of the Royal Society B: Biological Sciences, 372(1721), 20160371.

Dhillon, R. S., & Kelly, J. D. (2015). Community trust and the Ebola endgame. New England Journal of Medicine, 373(9), 787-789.

Ebola Gbalo Research Group. (2019). Responding to the Ebola virus disease outbreak in DR Congo: when will we learn from Sierra Leone?. Lancet.

Fairhead, J. (2016). Understanding social resistance to the Ebola response in the Forest Region of the Republic of Guinea: an anthropological perspective. African Studies Review, 59(3), 7-31.

Fast, S. M., Mekaru, S., Brownstein, J. S., Postlethwaite, T. A., & Markuzon, N. (2015). The role of social mobilization in controlling Ebola virus in Lofa County, Liberia. PLoS currents, 7.

Fullman, N. et al (2018). Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. The Lancet, 391(10136), 2236-2271.

Gostin, L. O., & Friedman, E. A. (2015). A retrospective and prospective analysis of the west African Ebola virus disease epidemic: robust national health systems at the foundation and an empowered WHO at the apex. The Lancet, 385(9980), 1902-1909.

Grant, M., Wilford, A., Haskins, L., Phakathi, S., Mntambo, N., & Horwood, C. M. (2017). Trust of community health workers influences the acceptance of community-based maternal and child health services. African journal of primary health care & family medicine, 9(1), 1-8.

Hollard, G., & Sene, O. (2016). Social capital and access to primary health care in developing countries: Evidence from Sub-Saharan Africa. Journal of health economics, 45, 1-11.

Horton, R., & Lo, S. (2017). Africa and health: a Commission to accelerate success. The Lancet, 390(10114), 2745-2747.

Huber, C., Finelli, L., & Stevens, W. (2018). The economic and social burden of the 2014 Ebola outbreak in West Africa. The Journal of infectious diseases, 218(suppl_5), S698-S704.

Jombart, T. et al (2020). The cost of insecurity: from flare-up to control of a major Ebola virus disease hotspot during the outbreak in the Democratic Republic of the Congo, 2019. Eurosurveillance, 25(2), 1900735.

Kamradt-Scott, A. (2016). WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa. Third World Quarterly, 37(3), 401-418.

Kankeu, H. T., & Ventelou, B. (2016). Socioeconomic inequalities in informal payments for health care: An assessment of the 'Robin Hood' hypothesis in 33 African countries. Social Science & Medicine, 151, 173-186.

Kruk, M. E., Leslie, H. H., Verguet, S., Mbaruku, G. M., Adanu, R. M., & Langer, A. (2016). Quality of basic maternal care functions in health facilities of five African countries: an analysis of national health system surveys. The lancet global health, 4(11), e845-e855.

Leuenberger, A. et al (2019). Health impact assessment and health equity in sub-Saharan Africa: A scoping review. Environmental impact assessment review, 79, 106288.

Li, L., Sy, M., & McMurray, A. (2017). A comparative study of IMF bailouts on African recipient country health systems. Journal of Policy Modeling, 39(3), 568-589.

MacIntyre, L. M., Waters, C. M., Rankin, S. H., Schell, E., Laviwa, J., & Luhanga, M. R. (2013). How community trust was gained by an NGO in Malawi, Central Africa, to mitigate the impact of HIV/AIDS. Journal of transcultural nursing, 24(3), 263-270.

McCord, G. C., Liu, A., & Singh, P. (2013). Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions. Bulletin of the World Health Organization, 91, 244-253b.

TMPSYSTEMS

McLean, K. E., Abramowitz, S. A., Ball, J. D., Monger, J., Tehoungue, K., McKune, S. L., ... & Omidian, P. A. (2018). Community-based reports of morbidity, mortality, and health-seeking behaviours in four Monrovia communities during the West African Ebola epidemic. Global public health, 13(5), 528-544.

Moon, S., Sridhar, D., Pate, M. A., Jha, A. K., Clinton, C., Delaunay, S., ... & Goosby, E. (2015). Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola. The Lancet, 386(10009), 2204-2221.

Mostert, S., Njuguna, F., Olbara, G., Sindano, S., Sitaresmi, M. N., Supriyadi, E., & Kaspers, G. (2015). Corruption in health-care systems and its effect on cancer care in Africa. The Lancet Oncology, 16(8), e394-e404.

Mwai, G. W., Mburu, G., Torpey, K., Frost, P., Ford, N., & Seeley, J. (2013). Role and outcomes of community health workers in HIV care in sub-Saharan Africa: a systematic review. Journal of the International AIDS Society, 16(1), 18586.

Negev, M., Teschner, N. A., Rosenthal, A., Levine, H., Lew-Levy, C., & Davidovitch, N. (2019). Adaptation of health systems to climate-related migration in Sub-Saharan Africa: Closing the gap. International journal of hygiene and environmental health, 222(2), 311-314.

Nelson, R. (2014). Tackling violence against health-care workers. The Lancet, 383(9926), 1373-1374.

Nuzzo, J. B., & Inglesby, T. V. (2018). Ramping up the response to Ebola. New England Journal of Medicine, 379(26), 2490-2491.

Nxumalo, N., Goudge, J., & Manderson, L. (2016). Community health workers, recipients' experiences and constraints to care in South Africa−a pathway to trust. AIDS care, 28(sup4), 61-71.

Ogundari, K., & Awokuse, T. (2018). Human capital contribution to economic growth in Sub-Saharan Africa: does health status matter more than education?. Economic Analysis and Policy, 58, 131-140.

Otu, A., Ameh, S., Osifo-Dawodu, E., Alade, E., Ekuri, S., & Idris, J. (2018). An account of the Ebola virus disease outbreak in Nigeria: implications and lessons learnt. BMC public health, 18(1), 3.

Patel, P., Gibson-Fall, F., Sullivan, R., & Irwin, R. (2017). Documenting attacks on health workers and facilities in armed conflicts. Bulletin of the World Health Organization, 95(1), 79.

Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annual review of public health, 35, 399-421.

Petherick, A. (2015). Ebola in west Africa: learning the lessons. The Lancet, 385(9968), 591-592.

Regmi, K., Gilbert, R., & Thunhurst, C. (2015). How can health systems be strengthened to control and prevent an Ebola outbreak? A narrative review. Infection ecology & epidemiology, 5(1), 28877.

Shears, P., & Garavan, C. (2020). THE 2018/19 EBOLA EPIDEMIC IN THE DEMOCRATIC REPUBLIC OF CONGO (DRC): EPIDEMIOLOGY, OUTBREAK CONTROL, AND CONFLICT. Infection Prevention in Practice, 100038.

Shobande, O. A. (2020). The effects of energy use on infant mortality rates in Africa. Environmental and Sustainability Indicators, 5, 100015.

Shoman, H., Karafillakis, E., & Rawaf, S. (2017). The link between the West African Ebola outbreak and health systems in Guinea, Liberia and Sierra Leone: a systematic review. Globalization and health, 13(1), 1.

TMPSYSTEMS

Siekmans, K., Sohani, S., Boima, T., Koffa, F., Basil, L., & Laaziz, S. (2017). Community-based health care is an essential component of a resilient health system: evidence from Ebola outbreak in Liberia. BMC public health, 17(1), 84.

Singh, P., & Sachs, J. D. (2013). 1 million community health workers in sub-Saharan Africa by 2015. The Lancet, 382(9889), 363-365.

Southall, H. G., DeYoung, S. E., & Harris, C. A. (2017). Lack of cultural competency in international aid responses: the Ebola outbreak in Liberia. Frontiers in public health, 5, 5.

Wells, C. R., Pandey, A., Mbah, M. L. N., Gaüzère, B. A., Malvy, D., Singer, B. H., & Galvani, A. P. (2019). The exacerbation of Ebola outbreaks by conflict in the Democratic Republic of the Congo. Proceedings of the National Academy of Sciences, 116(48), 24366-24372.

WHO Ebola Response Team. (2016). After Ebola in West Africa—unpredictable risks, preventable epidemics. New England Journal of Medicine, 375(6), 587-596.

Wilkinson, A., & Fairhead, J. (2017). Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture. Critical Public Health, 27(1), 14-27.

Wilkinson, A., Parker, M., Martineau, F., & Leach, M. (2017). Engaging 'communities': anthropological insights from the West African Ebola epidemic. Philosophical Transactions of the Royal Society B: Biological Sciences, 372(1721), 20160305.

World Health Organization. (2016). Report on attacks on health care in emergencies based on consolidated secondary date 2014 and 2015 (No. WHO/OHE/ERM/PPE/2016.2). World Health Organization.