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MSD for mothers
Committed to Saving Lives

MSD for Ugandan Mothers Programme

FINAL PROGRAMMATIC REPORT

Improving the availability of affordable transport as a means to overcoming the constraints to accessing maternal health services

September 2015

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1. Acknowledgement

On behalf of Transaid, the project team wishes to express its appreciation to the following groups for their invaluable contributions towards the successful execution of this assignment:

- The staff at PACE headquarters in Kampala for their advice and support throughout.
- The Northern, Central and Western Regional PACE Teams for being very generous with their local knowledge and their incredible interpretation skills.
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2. Abbreviations/Acronyms

ANC	Ante-natal Care
Boda boda	Motorcycle Taxi
EmONC	Emergency Obstetric Neonatal Care
ETS	Emergency Transport Scheme
IMT	Intermediate Means of Transport
MAHEFA	Malagasy Healthy Families
MAMaZ	Mobilising Access to Maternal Health Services in Zambia
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MUM	MSD for Ugandan Mothers
NGO	Non-Governmental Organisation
NURTW	National Union of Road Transport Workers
PACE	Program for Accessible Health, Communication & Education
PSI	Population Services International
TBA	Traditional Birth Attendant
UGX	Ugandan Shillings

3. Executive Summary

The MSD for Ugandan Mothers Programme aimed to 'strengthen private health providers' ability to offer affordable and quality maternal health services. As well improving service delivery the programme aimed to address the transport related constraints to accessing obstetric care. Transaid's role was to improve the understanding around these constraints as well as to design and implement an intervention to improve access for pregnant women.

To contextualise this, Uganda's estimated maternal mortality ratio is presently 440 maternal deaths to every 100,000 live births. Whilst there have been substantial improvements since 1990, Uganda looks unlikely to achieve its target as part of the Millennium Development Goals. Uganda's underfunded health sector is becoming increasingly reliant on private sector health provision to fill the gaps, with up to 50% of clinics now privately run. Most rural areas lack reliable transport services, especially those communities deemed to be 'hard to reach'. Whilst bicycles are common as a means of transport, they are considered inappropriate for use by pregnant women, in part due to cultural constraints but also due to unsuitable terrain. Motorcycle taxis (boda bodas) are prolific and for most are the only accessible means of motorised transport.

Transaid's 5 target districts or operation were Mubende, Hoima, Ibanda, Lira and Alebtong. These districts provide the variation needed to pilot interventions with the potential to be replicated and scaled up to additional districts in the future. The project commenced with a formative assessment comprising a mix of semi-structured interviews and focus group discussions involving all stakeholders, whereby quantitative and qualitative data was recorded and contributed to project design. A number of factors influencing access to maternal health services was discussed and included but was not limited to transport availability, affordability, access to credit, terrain, journey distance and communication.

Based on the findings from the formative assessment, a project intervention was designed. An emergency transport scheme appropriate to context was proposed working with boda boda riders in each of the five target districts. The ETS would involve targeting strategically located boda boda stages to recruit boda boda riders on a voluntary basis. Riders would be asked to pledge to reduce the cost of journeys for pregnant women wishing to access maternal health services. In return, the 'ETS riders' would be promoted to the wider community as the preferential providers of emergency transport in their respective areas which in turn would lead to an increase in status for them within their own communities as well as an increase in their client base and therefore their income levels. Transaid decided that due to the relative isolation of two clinics from secondary health provision that the installation of a boda boda ambulance trailer was appropriate to assist with referrals. An emphasis was placed on safety carrying out sensitisation activities and procuring motivational items such as high visibility jackets to enhance the safe passage of pregnant women.

From January to July 2015 Transaid carried out extensive monitoring of the intervention which included, the review of project activities and the collection of data relevant to the project's objectives. Ongoing meetings were arranged with ETS riders and every effort was made to maximise their participation. Prior to the handover of monitoring responsibilities to PACE in August, a system of data collection was put in place whereby 'focal riders' would collect data from their fellow riders.

This made the collection of data by PACE less time consuming, and provided a relatively easy means of establishing whether or not ETS riders remained active participants of the project.

Analysis of the data collected was carried out to establish the impact of the project.

ETS rider retention rates

Transaid suggested guidelines on the optimal number of ETS riders serving each ProFam Clinic which are important to consider when considering whether or not there is a need to recruit new riders. Whilst there have been riders that have dropped out of the project during the 7 month monitoring period, from January to July there has been a net increase in 6 riders, with 330 ETS riders in total.

Number of women transported

3720 women were transported during this period for ante-natal check ups, delivery or illness. Transaid is careful not to say that this total represents women that would otherwise have not accessed maternal health services without affordable transport. However, by installing as system that offers an affordable means of transport it is safe to say that the transport related barriers to accessing maternal health services have reduced.

Uptake of maternal healthcare services by sector

Despite a general perception that service delivery at private health clinics is better than at government-run clinics, given the choice, mothers overwhelmingly chose to travel to government run health centres. There evidently exists an issue of affordability at the point of service delivery at private clinics. The majority of those that do utilise the private sector do so to attend relatively low cost ante-natal check-ups before travelling to government run facilities to deliver.

Level of cost reduction

The journey cost for pregnant women has reduced by up to 41.6% in places. All areas where project implementation has taken place shows a substantial decrease in the cost when compared to the data that the project team collected during the formative assessment. In addition, this level of reduction has stayed consistent throughout the 7 month monitoring period with no signs of changing. This reduction is strengthened by the fact that many of the ETS riders are now beginning to see their level of business rise and therefore their household income.

Through cross referencing the data to establish whether or not the information received was realistic, as well as carrying out rural assessments with service users and non-users evidence points to this intervention achieving its objective in improving access to affordable transport by pregnant women.

4. Introduction

In 2013, the WHO estimated that maternal deaths were more than 14 times higher in developing countries than in developed countries. In fact, 99% of global maternal deaths occur in developing countries (WHO, 2014). Global health inequities are directly linked to the distribution of wealth and power which in turn influence the resources to hand at a national and local level. Poverty is a direct social determinant of maternal mortality. From poor nutrition, lack of access to clean water and adequate housing, and gender discrimination at a household level, to poorly developed health and education infrastructure, which is understaffed and/or inadequately trained are major obstacles to reducing the number of maternal deaths in developing countries.

In September 2000 world nations gathered to adopt the United Nations Millennium Declaration committing them to achieving a series of time-bound targets which became known as the Millennium Development Goals (MDGs). MDG 5 calls for a 75% reduction in maternal mortality from 1990 to 2015 as well as universal access to reproductive health. The maternal mortality ratio is the measurement that gauges whether this target is to be achieved or not. The maternal mortality ratio (MMR) determines the number of deaths of women while pregnant or within 42 days of the termination of the pregnancy for every 100,000 live births.

Whilst the global average maternal mortality ratio has declined by almost 50% since 1990, from 400 maternal deaths per 100,000 live births in 1990 to 210 in 2010 (United Nations, 2013) it is forecast that a 75% reduction will not be achieved. This global average masks the fact that in many countries, most notably within sub-Saharan Africa, maternal mortality remains unacceptably high with an MMR of 510 (WHO, 2014). Whilst countries like Equatorial Guinea, Eritrea and Rwanda represent countries in the sub-continent that will achieve the MDG 5 target the 16 countries with the worst MMR are in sub-Saharan Africa. Sierra Leone has the highest estimated MMR at 1100 maternal deaths for every 100,000 live births.

The vast majority of maternal deaths are preventable. With haemorrhage and hypertension being the primary cause in the majority of maternal deaths, access to skilled care during pregnancy and at birth is critical. The delay in achieving this access to the appropriate care is a key determinant in maternal mortality. Thaddeus and Maine introduced the three delays model which has been hugely influential in defining approaches to address the numbers of maternal deaths and in analysis of the barriers to accessing maternal healthcare services (1994). They stated that delays in accessing maternal health services can occur at 3 levels:

1. *Delay in the decision to seek care*: This is influenced by late recognition of symptoms, a reluctance to travel to health facilities possibly due to cultural norms, or the absence of a decision maker highlighting gender inequity at the household level.

2. *Delay in reaching the appropriate health facility:* Usually due to the lack of an appropriate means of transport or an inadequate network of health facilities resulting in low coverage.

3. *Delay in receiving adequate care once at the health facility:* Often caused by a lack of equipment or essential supplies such as blood for transfusions and medicines, or a shortage of staff.

The second delay recognises that transport plays an integral role in influencing the level of access a woman has to maternal healthcare services. In many isolated rural areas where there is low demand and inadequate infrastructure, the lack of available and affordable transport services is a major contributing factor to reducing the uptake of essential services, in turn exacerbating rural poverty. Therefore failure to integrate transport into programmes designed to address the constraints to accessing essential services, in this case maternal healthcare, will reduce the effectiveness of community-based efforts that aim to improve maternal health through increasing uptake of institutional deliveries. Murray and Pearson (2006) state that transport strategies implemented alongside other interventions could contribute to as much as an 80% reduction in maternal deaths. Barriers to access such as transport can increase the clinical severity of cases particularly where complications exist. Recent research by Transaid (2013) in partnership with the Ghana National Ambulance service and the State Ministry of Health in Katsina State, Nigeria found that women with access to motorised means of transport for referral arrived at a referral facility in significantly better health than those without such means.

4.1 The MUM Programme

This programme was developed and is being implemented in collaboration with MSD for Mothers, MSD's 10-year, $500 million initiative to help create a world where no woman dies giving life. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, N.J., U.S.A.

The MUM Programme aims to improve the quality of service delivery by private sector health providers, whilst addressing issues around the accessibility and affordability of maternal healthcare services in some of the poorest and hardest to reach areas of Uganda. The programme was officially launched in March 2013 and aims to have an impact in up to 30 districts in Uganda, reaching more than 150,000 women over 3 years.

The programme links to Population Services International's (PSI) global social franchising programme where in Uganda specifically, PSI, the NGO PACE (Program for Accessible health, Communication and Education), a PSI network member, has set up a network of franchised private primary healthcare providers called ProFam Clinics with whom PACE has carried out an extensive programme developing the capacity of these providers. It is through leveraging the private health sector that PACE aims to "strengthen the health system's ability to offer affordable, quality maternal health services" (MSD for Mothers, 2015) to address unacceptable levels of maternal mortality in Uganda.

This picture shows the majority of the ProFam Clinics that Transaid have engaged with during this project in all five of the targeted districts.

The MUM Programme in Uganda will:

- Expand PACE's private franchise clinic network and provide technical and business training for health providers
- Enhance the role of local pharmacies in providing information on safe motherhood and linkages to care
- Explore a community-based emergency transport system to connect women to care
- Test innovative methods of making maternal health services more affordable, including a community health insurance model.

4.2 Transaid

Transaid is an international development NGO dedicated to reducing poverty and improving lives across the developing world, improving access to essential services through implementing appropriate, safe, and affordable transport interventions. Transaid has a team of transport and

logistics specialists with extensive experience of implementing appropriate and sustainable emergency transport schemes with a view to facilitating access to essential services.

In Nigeria, Transaid has been working to improve the availability of low cost emergency transport to reduce the delay between the onset of an obstetric emergency and the patient receiving appropriate care by working with the National Union of Road Transport Workers (NURTW). Through extensive training and sensitisation, and the development of a team of in situ master trainers, taxicab drivers have been recruited to provide transport to women wishing to access maternal health services at an affordable price which equates to the cost of fuel used. A priority loading system incentivises drivers to participate in the project whereby on providing evidence of having transported a pregnant woman, drivers can move to the front of the queue to accept new business at their respective taxi parks. Between March 2010 and July 2011 1735 emergency cases were transported by ETS drivers. The project ownership lies with the NURTW to facilitate a sustainable transition as part of Transaid's exit strategy.

Improving access to maternal health services in Northern Nigeria.

The Mobilising Access to Maternal Health Services in Zambia (MAMaZ) was a hugely successful programme where Transaid and partners tested innovative approaches to addressing the barriers at a household and community level preventing the timely access to Emergency Obstetric Neonatal Care (EmONC) services and the utilisation of other essential Maternal, Newborn and Child Health (MNCH) services. A total of 123 bicycle ambulances, 28 oxcarts, 9 motorcycle ambulances, one boat and one donkey cart were introduced across the six programme districts. Except for the facility-based motorcycle ambulances, all modes of transport were community managed and comprehensive training in vehicle maintenance, the safe-handling of pregnant women and record keeping was carried out. Between July 2011 and December 2012 1225 women were beneficiaries of the project. This programme led to More MAMaZ which is successfully replicating the programme's previous successes expanding its coverage in Zambia.

Emergency Transport Schemes in Zambia

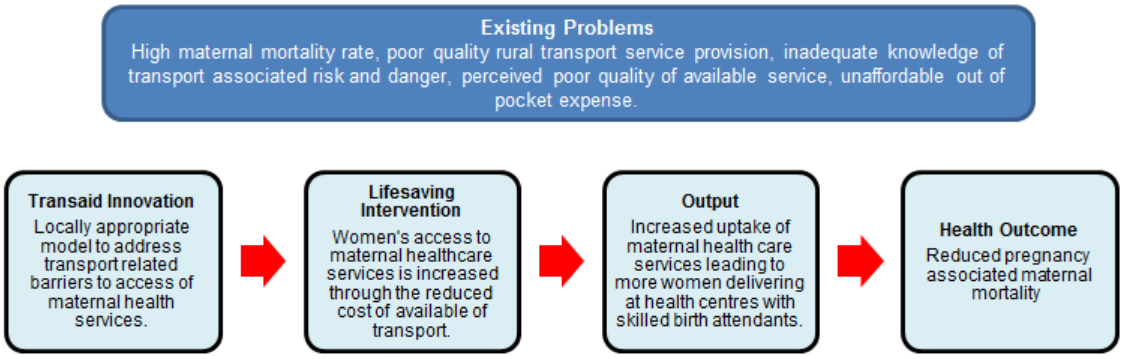
As part of the MAHEFA programme in Madagascar, Transaid is working towards ensuring the availability of reliable emergency transport for pregnant women, children under 5s and newborns, improving Community Health Worker mobility and strengthening supply-chains at community level through increased availability of essential health commodities for people in hard to reach areas. In terms of emergency transport Transaid's strategy is based on the implementation of community-managed intermediate means transport (IMT) initially in three districts with a link to community health insurance schemes.

Intermediate Modes of Transport and Community Healthworker Mobility in Madagascar

It is with this experience and more, that Transaid were invited to participate in the MUM Programme.

4.3 Terms of Reference

In 2012, Transaid were contracted by PSI to assess and implement a project as part of the MSD for Ugandan Mothers (MUM) Programme, which is also the donor. Transaid's role was to increase understanding around the transport-related constraints experienced by women in accessing maternal healthcare services.



As part of the wider MUM Programme, Transaid was contracted to "…understand the role that Uganda's transport unions might play in reducing the cost and time for pregnant women in labour or distress to reach a health facility…Transaid will establish an Emergency Transport System[1] (ETS) from the community to the facility level…this approach will utilise existing infrastructure and ensure that local communities are able to take ownership of their transport needs."

[1] ETS more often refers to an Emergency Transport Scheme in this report.

Transaid will also "…work closely with the community engagement specialists within the partnership team to ensure that birth preparedness and behaviour change interventions incorporate important elements regarding the transport of women to facilities including discussions regarding the cost of transport, means of communication, and potential barriers such as flooded rivers and poor roads. It is expected that through this combination of activities poor and vulnerable women in the ProFam Clinic catchment areas will have both the understanding of the referral process and the access to transport to enable it to happen."

4.4 Background/Context

In 2012, Uganda's estimated maternal mortality rate (MMR) was 440 maternal deaths for every 100,000 live births, down from 780 maternal deaths in 1990 and in 2014 the WHO estimated that despite substantial progress against the MDGs, there are still approximately

5900 maternal deaths each year. Uganda has therefore been classified as 'making progress', by the WHO but is almost certain to miss out on achieving its MDG target. The 2012/13 Annual Health Sector Performance Report (MoH, 2013) states that for this year 39% of pregnant women underwent a facility-based delivery with 30% of women having attended the recommended 4 ANCs.

Naturally the delivery of maternal health services is affected by the general organisation and functioning of the current health systems. With restrictive funding available to the health sector, an emerging private sector health industry is increasingly expected to fill the gaps left by government run health facilities. Current health sector infrastructure constitutes a tiered system of service delivery points, provided from the community level to the national referral hospitals and is structured as follows in Uganda:

- *Health Centre II*: Located at Parish level to provide preventive, promotive and curative services. Not all health centre IIs are equipped to provide maternal healthcare services, although most run ANCs.

- *Health Centre III*: Located at the Sub-County to offer preventive, promotive, curative, maternity and in-patient services. Delivery services are usually available.

- *Health Centre IV*: Located at the county or health sub-district headquarters to provide preventive, promotive, out-patient, curative and in-patient services, emergency surgery and blood transfusions.

- *Regional Referral Hospital*: In addition to the services offered at the HC IV, it offers laboratory and X-Ray facilities. In-service training, consultation and outreach to community.

- *National Referral Hospital:* In addition to the services offered at the regional referral hospital, they provide comprehensive specialist services and are involved in teaching and health research.

An estimated 50% of health services in Uganda are provided through the private sector and with this in mind, the MUM Programme intends to strengthen the capacity of private providers to contribute to the achievement of reducing maternal mortality in Uganda. As part of improving access to health services, the provision of affordable transport plays an important role directly impacting on what Thaddeus and Maine (1994) refer to as the 2nd delay, which relates to the delay in reaching the appropriate health facility.

The challenges for transport provision in rural areas in Uganda are no different to many countries in sub-Saharan Africa. The first challenge is the operating environment where issues such as infrastructure, the low density of demand and socio-economic status are factors. Secondly, the high vehicle operating costs, which combined, have a significant impact on the level of competition, the diversity of vehicles, service frequency and cost.

The majority of rural communities are served by community access roads, which amounts to an estimated 55,000km, by far the largest category of road in Uganda, all of which is unpaved. It is unknown what proportion of the total amount of community access roads is accessible to motor vehicles; however seasonal factors such as rainfall do have an impact on whether or not these roads are passable. Bicycles are inevitably an important means of transportation, particularly for agricultural and other commodities. Their use is common in Eastern and Northern Uganda, although in Western and Central parts of Uganda bicycle use is more limited due to the terrain and cultural beliefs. Whilst the situation is changing, cultural taboos do still exist that inhibit the use of bicycles by women relating to the sitting position and bodily contact with the rider.

Since the lifting of trade restrictions in the 1990s which led to an increase in the import of motorcycle spare parts, motorcycle boda bodas have emerged as the dominant means of transport in both low and high demand settings. They play an important role in allowing men, women and children to access vital services such as healthcare, markets and education, and are able to meet the demands of door to door travel that other services cannot do.

Studies have already been carried out in Uganda examining the issue of transport as a constraint to accessing maternal health services (Pariyo, 2011), specifically examining the potential that the proliferation of boda bodas presents in functioning as a means of emergency transport. Whilst this

project does not use transportation vouchers due to issues around sustainability, Pariyo's research (2011) examined their use as an incentive for riders and the reduction of transport cost to the user led to a marked increase in the attendance of ante-natal classes and delivery care services. Interestingly this project also resulted in economic benefits for the transport providers themselves through an increase in business. Pariyo highlights the potential innovative use of boda bodas in reducing the challenges presented by a poor public transport network in harder to reach communities.

5. Methodology

The following key activities were undertaken in order to achieve the objectives of the project:

- Execution of formative research to inform project implementation and to obtain rudimentary baseline data in the absence of a baseline study.
- Project design based on the findings of the formative research.
- Project implementation of Emergency Transport Schemes (ETS) appropriate to each of the 5 target districts.
- A series of monitoring visits to collect relevant data, and to cross-check data with users of the service.

These activities included:

- In depth focus group discussions with communities relating to the transport related constraints to accessing maternal health services.
- In depth interviews with ProFam Clinic service providers to understand the wider context to transport and problems relating to access.
- The implementation of ETS in 5 districts including the recruitment of 324 ETS riders.
- Related sensitisation activities for all stakeholders.
- Procurement and distribution of motivational items for all recruited riders.
- Procurement and distribution of stretcher trailers for boda bodas where appropriate.
- A dataset over 7 months to assess project impact.
- A series of rural assessments consisting of in depth interviews to cross-check data.

5.1 Target Areas

The 5 districts that Transaid's project team was to target for project implementation were decided by PACE as Mubende, Hoima, Ibanda, Lira and Alebtong Districts. The national average for facility-based deliveries is 52% (UDHS, 2011) with attendance of the recommended 4 ANC classes during pregnancy being far lower than this. The table below shows that all 5 of the target districts have a figure lower than the national average for facility-based deliveries and all have low levels of ANC attendance. With plans for PACE to scale up the emergency transport to

additional districts, it is presumed that the 5 chosen target districts are representative of the variety of different terrains and distances in the districts where this intervention will be replicated.

Amongst the target districts there are substantial differences in terms of land area (size of the district) as well as population density, the larger and sparser of which could reflect longer journey distances to and from health facilities with a coverage based on demand. Where private health sector providers are expected to go some way to filling the gaps where coverage by the government run system is low, there is a challenge in that there is little incentive for profit making health centres to locate themselves in harder to reach areas where demand is low which could lead to reduced coverage in harder to reach areas. Likewise, profit making transport services are less likely to exist in such areas where there is little demand and possibly poor quality roads with reduced access.

Relevant data for each of the 5 target districts (2012/2013 Annual Health Sector Performance Report, MoH)

District	Location	Area (km2)	Population	Population Density (km2)	Admin Units	Facility Deliveries	4 ANC visits
MUBENDE	Central Region (150km from Kampala)	4625	633,400	132	15 sub-counties 91 parishes	30.8%	28.6%
HOIMA	Western Region (230km from Kampala)	3683	575,100	149	13 sub-counties 62 parishes	46.8%	27.2%
IBANDA	Western Region (315km from Kampala)	964	261,900	265	8 sub-counties 36 parishes	36.3%	22.6%
LIRA	Northern Region (339km from Kampala)	1330	416,100	303	28 sub-counties 192 parishes	44.2%	29.7%
ALEBTONG	Northern Region (366km from Kampala)	1527	233,400	148	5 sub-counties 35 parishes	18.1%	17.0%

5.2 Formative Assessment

The formative research served two purposes. Firstly, it improved the project team's understanding of the day to day challenges in accessing essential services and the transport seeking behaviour. Secondly, in the absence of a baseline study, the research provided some rudimentary data with which the project team could use for a baseline.

The in situ assessment itself was divided into 2 strands matching quantitative data at each of the ProFam Clinics with qualitative data obtained at community level. In depth semi structured interviews were carried out with staff at each of the ProFam Clinics (including ProFam Ambassadors) using pre-determined questions to guide the discussion. In addition, a series of focus group discussions took place with communities randomly located within the 'presumed' catchment areas of each of the clinics in all five target districts (see *Table 2*).

The research commenced in May 2013 and was completed in February 2014 due to delays relating to the selection of target districts as well as the lack of availability of local staff. In the project's early stages it was agreed between PACE and Transaid that regional PACE staff should accompany the project team to assist with local knowledge, and also to familiarise themselves with the transport element of the MUM Programme. ProFam Ambassadors and where relevant, CBO staff were also asked to accompany the project team during visits to communities for the same reason.

5.2.1 Facility-Based Interviews

A data collection tool (see Annex 1) was developed with a view to obtain a greater understanding of the following factors:

- Details of services offered and take up of these services
- The clinic's referral practice
- Its capacity to provide support and outreach to the wider community, and its reach
- The clinician's perspective on the primary challenges to women accessing maternal healthcare services.

Interviews were carried out with the clinic's 'in-charge' member of staff, which in all cases was the Clinical Officer, the Senior Midwife or the resident Doctor. The same questions were put to the ProFam Ambassadors which are community-based volunteers that carry out sensitisation activities in communities and are associated with one or other of the ProFam Clinics. In all cases, whilst the 'in-charge' carried out one of the aforementioned roles, they also managed and owned the clinic itself. The interviews lasted between 45 minutes and 1 hour and were carried out at each of the following ProFam Clinics.

ProFam Clinics in each of the 5 target districts. The highlighted clinics are ones where a project intervention was deemed unnecessary based on a number of factors.

District	ProFam Clinic
MUBENDE	St Balikudembe Health Centre
	Kitokolo Health Centre

	Bangi Maternity Home
	Matia Mulumba Health Centre
	Mirembe Maria Health Centre
	Mutungo Nursing Home
HOIMA	Bugambe Tea Clinic
	Gloria Health Care
	Kabalega Medical Centre
	Mary Maternity
	Peric Maternity Home
	Shalome Medical Centre
	Tusabe Medical Centre
IBANDA	Busingye Clinic
	Mary's Domiciliary Clinic
	Igorora Health Clinic
	Ibanda Central
	Ibanda Medical Clinic
	St Joseph's Clinic
LIRA	Aduku Road Maternity Clinic
	Ayira Health Services
	Charis Health Centre
	Downtown Medical Centre
	Lira Medical Centre
ALEBTONG	Ocan Community Clinic

During the facility-based interviews, in an attempt to establish a realistic catchment area for a particular clinic, the interviewees were asked for a list of the most commonly recorded villages from which mothers travel to access the ProFam's services. The distance between the village and the clinic gave the project team a realistic idea of how far one would expect people to travel to take up

the services of the ProFam Clinic and thus, the catchment area. This information guided the community-based focus group discussions in that in part, they were carried out in the villages listed.

5.2.2 Community-Based Focus Group Discussions

The project team chose to travel no further than 20km from a ProFam Clinic to sample community opinion based on information suggesting that this would be the furthest point from which someone would choose to travel to the ProFam Clinic. On the whole the project team targeted a selection of the villages in which women were known to have used ProFam Clinic services. This information was made available by the ProFam Clinic itself. In the minority of cases where the listed villages were clustered in one direction from the clinic, the project team randomly chose additional villages which the team deemed were located in strategically important places. As much as possible, a mix of villages close to and far from primary roads was chosen as were those in areas of differing topographies. Every effort was made to maximise the number of participants, which in many cases led to the project teams taking advantage of the fact that groups were meeting (e.g. savings groups) or locations where many people were grouped together (such as rural markets).

A data collection tool (see Annex 2) was developed with a view to establishing a number of factors including:

- Transport availability and affordability
- Issues around payment and communication with available transport providers
- Take up of facility-based services for ante-natal classes and delivery
- Other factors influencing transport related access to maternal health services.

Focus Group Discussions

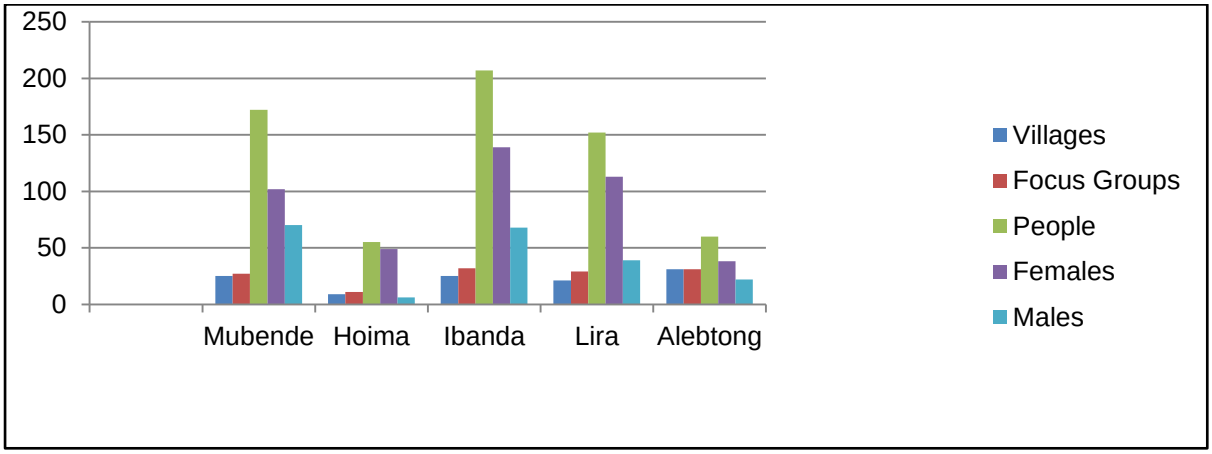
Whilst the tool contains a number of prescribed questions, every effort was made to ensure that the discussion was free-flowing to ensure that appropriate additional information could be recorded.

Both women and men were invited to participate in the focus group discussions although efforts were made to ensure that women were in the majority, and that all voices were heard. The size of the groups varied from 1 to 30 participants. Where groups consisted of more than 2 participants, a consensus was reached on the group's answers to each key question. It naturally took time to reach a consensus however every effort was made to ensure that focus group discussions did not last longer than 90 minutes. Where possible, community-based boda boda riders were also included in the discussion to ensure an unbiased discussion where matters relating to the service they provide were talked about.

The number of participants during the formative assessment

Districts	Focus Group Participation					Proportion of Women
	Villages	Focus Grps	People	Female	Male	
MUBENDE	25	27	172	102	70	59%
HOIMA	9	11	55	49	6	89%
IBANDA	25	32	207	139	68	67%
LIRA	21	29	152	113	39	74%
ALEBTONG	31	31	60	38	22	63%
TOTAL	111	130	646	441	205	68%

The composition and number of focus groups carried out during the formative assessment.



5.2.3 Findings

The findings from the study provided a solid justification for a timely and accessible emergency transport system to be put in place with transport identified as a principal constraint to accessing maternal health services.

5.2.3.1 Transport Availability

The types of transport most commonly used are influenced by the area's terrain as well as people's ability to pay amongst other factors. Bicycles are widely available but are considered unsuitable for emergency transport. For some communities where road infrastructure is acceptable, one can travel in a motorcar taxi by walking to the nearest all weather road but for most this is an unaffordable option and the infrequency at which motorcars materialise is not usually conducive to emergency scenarios. The network of minibus taxis is reduced in harder to reach areas and cannot be relied upon as a means of emergency transport where the arrival of transport in a timely manner is critical. In an emergency, the boda boda is the preferred option. At least one boda boda rider resides in the

vast majority of the villages that the project team visited. However, boda boda operators generally station themselves elsewhere during the day at busier locations where they can get more business, usually in trading centres or closer to all-weather roads

Boda boda transport services are in fact originally a Ugandan innovation that grew from small beginnings in the 1960s in the border region with Kenya (Malmberg-Calvo, 1994). The term boda boda is a corruption of the English 'border border'. The findings support the fact that in Uganda, as well as in towns and cities, boda bodas are the only means of transport that operate where it is not possible for conventional services to exist. This fact however comes at a cost to one's own safety where there is a concern held by many that boda boda riders can be reckless at times.

5.2.3.2 Transport Affordability

The findings established that transport (primarily boda bodas) is generally available (either based in the village or a phone call away), but not necessarily affordable. As well as factors beyond people's control, such as the price of fuel, there are a number of factors which can lead to a variation in the cost of a journey. These factors include time of travel (day or night), seasonality, terrain and the reason for travel.

Many of the riders that the project team spoke to expressed concern at travelling during the night time fearing theft or in the worst possible scenario, being fatally attacked. In addition the influence that the rainy season has in some places is a factor as the surface of community access roads becomes slippery and in some cases waterlogged. These two factors result in the rider increasing his or her price to passengers, at times by more than 100%. This strategy is also employed in cases where riders are expected to act as emergency transport for people with illnesses, pregnant women etc. The view from members of the community is that this strategy is an exploitative one in which the riders are taking advantage of a person in need. The riders claim that an increase in the use of fuel due to carrying the patient and carer or baggage, and the liability that they perceive that the community puts on them is the reason.

5.2.3.3 Access to Credit

As well as a lack of readily available cash, an integral link to people's ability to pay for transport is their access to credit. Savings groups exist in many of the villages that were visited and many of the focus group attendees (principally women) were members of these groups. People seemed generally positive about the presence of savings groups and where they do not exist, some requests have been made to set them up. In a minority of areas there was low confidence in savings groups due to a lack of trust, possibly based on previous misappropriation of funds. In some cases it was implied that there was rarely any money in the pot for members to borrow because previous borrowers had not paid the money back.

Saving within the household was common although any savings were not ring-fenced for specific things. This means that families often find themselves without any savings in the pot having spent the money on some unforeseen expense earlier. Money earned from carrying out 'piece work' (short term work) or selling produce is sometimes added to savings at home.

Whether or not women had direct access to cash or whether they needed permission from men before receiving money varied hugely although traditionally it is the man's role to make transport related payment and therefore the latter situation it is assumed would generally be the case. However, most women stated that whether or not they had direct access to money was reliant on i) there being money in the pot at home in the first place and ii) what relations were like with their husbands at any given moment in time. Though many women stated they usually did need permission from their husbands, it is important to consider this issue on a case by case basis rather than using generalisations. In one case, this generalisation was substantiated by a savings group where the rules dictated that a woman's husband is required to sign a document to enable his wife to withdraw her savings. Boda boda riders on the whole require payment up front for each journey although this varied depending on the relationship between rider and passenger and between rural and urban areas.

5.2.3.4 Boda Boda Regulation and Organisation

Regulation of the boda boda industry has long been a challenge and it is only recently that tentative steps are being taken by the Ministry of Works and Transport to do so. Officially, boda boda riders must be registered at a specific boda boda stage, although in rural areas, there is a high level of non-compliance and rides are generally available from anybody with a motorcycle. Howe (2001) implies that associations are widespread and that a responsibility to enforce and ensure compliance with laws lies with them.

Loose associations do exist in some places although their jurisdiction is limited and their role seems linked more to the needs of local government rather than the riders themselves. A degree of organisation was found to exist at stage level with many of them having an elected chairperson each of which serves a term of one year. The chairperson's role is limited to but does not always include the collection of registration fees, the distribution of welfare payments where riders are unable to work and a remit to ensure discipline amongst his or her fellow riders.

5.2.3.5 Terrain

The community access roads which generally link villages to all-weather roads were of varying quality. These roads were generally compacted earth and therefore subject to periodic rain damage. However, generally, people claimed that while the journey times and costs were affected (both of these increase) by seasonal factors such as the rainy season, it is rare for villages to be completely isolated by flooding with roads remaining passable. The terrain is generally undulating, often hilly, although in the northern districts (Lira and Alebtong) the terrain is generally flat. The landscape certainly has an influence on the modes of transport used to travel to and from villages. In hillier terrain, people favour motorised transport (most commonly the boda boda) despite the high costs and adjust the frequency of their trips to and from the villages accordingly. Pedestrian transport is a more common option for people who cannot afford motorised transport. In flatter terrain where bicycles are far more common, their main use is for the carriage of heavy loads and generally deemed unsuitable for the carriage of pregnant women to and from health centres.

5.2.3.6 Communication

Improved connectivity as a result of the spread of mobile phones results in efficiency advantages with regards to accessing rural transport services especially in under-served areas where demand is low (Porter, 2013).

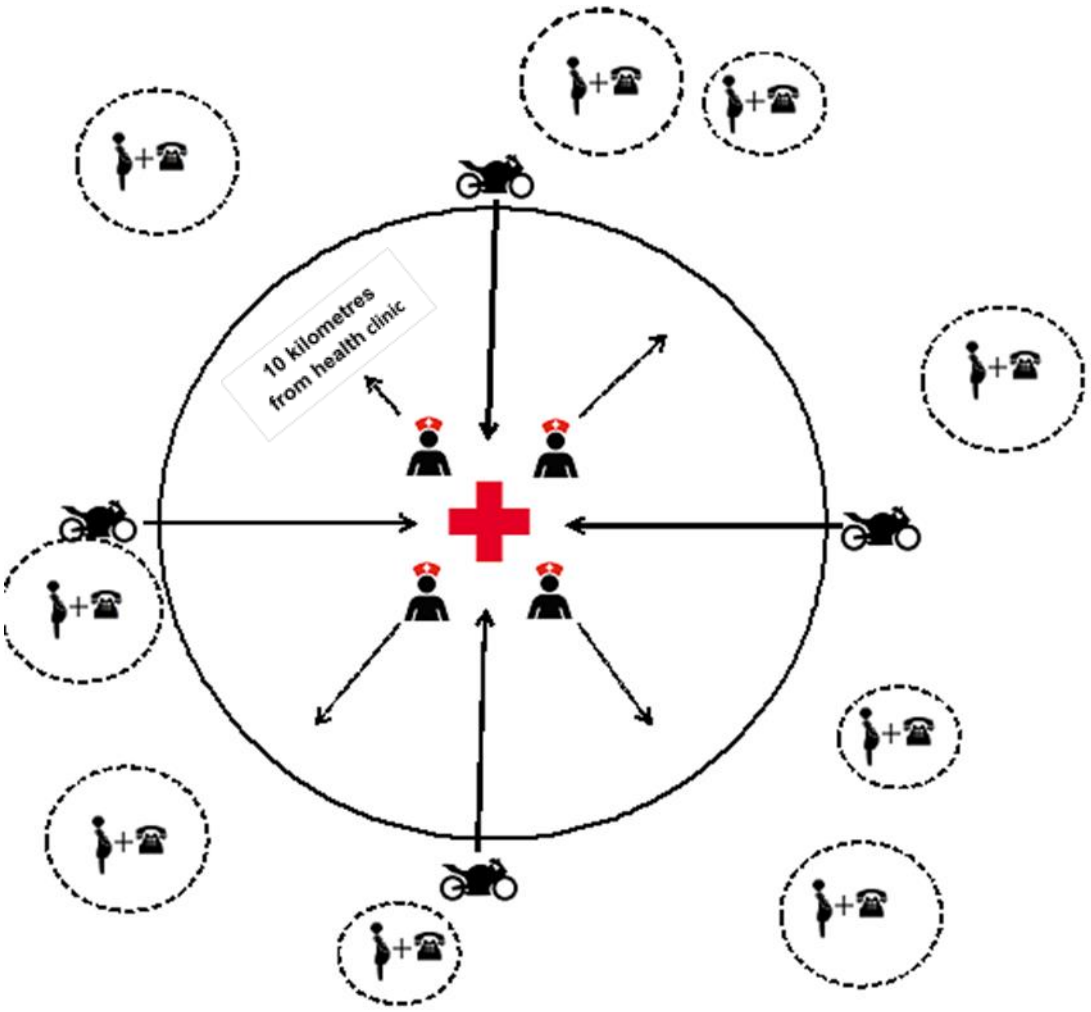
Mobile phone network coverage is generally good and everybody spoke to in the focus groups claimed to have either direct access to mobile phones or knew someone whose phone they could borrow, in some cases for a small fee. In fact, when asked how people arranged transport in an emergency people's most common first response was that they telephone the boda boda operators to arrange their journey. Another common response was to walk to the nearest boda boda stage which is generally found at the nearest village trading centre or further afield. These responses reinforce the above mentioned discovery that while boda boda operators live in the villages, they are often absent during the day.

5.2.3.7 Proximity to Health Centres

The rural areas surveyed are generally served by a reasonable network of health centres, most commonly government run health centres. However the quality of service at government-run health centres was often brought into question by focus group participants. There is an obvious preference for ProFam and other privately run clinics due to a perception that they provide a better service and that there is less waiting time required. However, the cost of using these services is prohibitive to most people and, many of the profit making clinics are naturally located in more densely populated areas, a fact that does not favour harder to reach communities.

5.3 Project Design

The findings of the formative assessment in all districts pointed to widespread overpricing by boda boda operators actively exploiting emergency situations for their own personal gain. One such emergency situation where this strategy is commonly employed is when pregnant women enter the early stages of labour. This and other findings influenced the design of the project for implementation which is illustrated below.



This illustration shows the health clinic at the centre of a circle which is at a distance of 10km from the heath centre. ProFam Ambassadors travel outwards from the clinic to distribute ETS riders contact telephone numbers. Pregnant women requiring the service calls the rider based closest to them directly and is then transported to the clinic.

5.3.1 Emergency Transport Scheme

The introduction of an Emergency[2] Transport Scheme (ETS) creates a situation where the burden of not being able to pay for transport is reduced and the availability of transport is increased. As was evident from the interviews conducted, cost and availability of transport are the biggest issues in accessing government-run healthcare at the appropriate time[3]. For the purpose of this project intervention it was proposed that the introduction of an emergency transport solution linked to local 'boda boda' riders was the most appropriate and sensible solution. It was evident that boda bodas were common as a mode of transport but it was the high cost (applied in emergency situations) that was the main barrier to women utilising them more frequently.

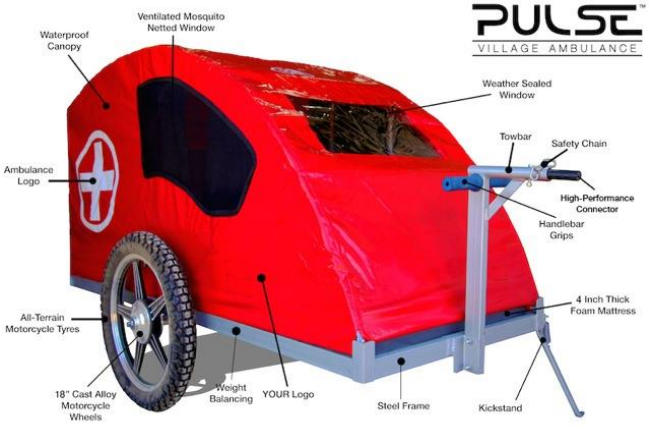
[2] In this context, the use of the word 'emergency' could be said to be a little misleading as the project is about increasing access to health services in the broader sense for pregnant women generally.

[3] With privately run clinics, the cost of the service is another major factor in accessing healthcare.

It was therefore proposed that a simple emergency transport solution be introduced to serve pregnant women in the target areas. The following key actions were to take place:

- Chose strategically important boda boda stages within clinic catchment areas from which to recruit boda boda riders
- Recruit a proportion of the total boda boda riders on a voluntary basis to act as *ETS riders*
- Sensitise ETS riders to matters relating to:
    - The objectives of the project
    - This issues around maternal health in Uganda
    - The importance of giving birth in the presence of a skilled attendant
    - Transport as a constraint to accessing maternal health services
    - The importance of safe carriage of passengers
- Gain buy-in from the clinics and their associated ProFam Ambassadors to ensure that ongoing sensitisation occurs

The outcome would be the provision of a safer and affordable means of transport for pregnant women in order to access health centres, either to attend ante-natal classes, delivery services or to receive treatment for illness during pregnancy.



In areas where the cost of transport for the referral of patients from primary to secondary health clinics/referral hospitals was prohibitive, due to the distance from the referral hospital and/or the need for motorised transport the project team sought the donor's approval to procure locally manufactured stretcher trailers that could be attached to boda bodas. Two clinics were deemed to require trailers; St Joseph's Clinic in Ibanda, and Ocan Community Clinic in Alebtong.

The trailer's ownership lies with the clinic that it is associated with. When not in use the trailer is stored at the clinic, and responsibility for maintenance and repairs lies with the centre manager.

5.3.2 Participant Motivation

Whilst voucher schemes (Pariyo, 2011) have proved effective in isolating transport as a key constraint to accessing essential services as well has having been a powerful incentive for transport providers to participate, these schemes do present challenges in delivering a sustainable solution to this problem. The project team therefore proposed that the incentive to the ETS rider should focus on the potential economic benefits to the rider in being part of the project in terms of an increase in business. By positioning the recruited riders as 'preferential' providers of emergency transport and with the support of clinics and ProFam Ambassadors in distributing their contact details to the wider community, it was anticipated that demand for their services would increase to a level that would more than compensate for the reduction in their overpricing.

The correct number of recruits matched with the expected demand for their services from pregnant women was crucial to this. As a guide on average the transportation of 2 to 4 pregnant women by each rider every month would be feasible bearing in mind the requirement that the rider absorb the reduced cost in the initial stages prior to the anticipated growth in the demand for his or her services. Using this as an indicator, the project team can assess the required number of recruits for each clinic. An average of less than 2 women transported each month would perhaps be indicative of too many having been recruited (this would point to there being less urgency in recruiting new riders should some drop out). An average of more than 4 women would be indicative of too few.

5.3.3 Project Promotion

A key factor in achieving this outcome, whereby demand increases for the services of ETS riders, is the promotion of the project itself to the wider community. The project team proposed that the clinics and the ProFam Ambassadors were to be agents through whom the project was to be promoted. Obviously, the ProFam Clinics have an incentive to promote their services in order to increase take up of their services. ProFam Ambassadors perform this role at present through carrying out sensitisation activities in their given 'patch' and through referring pregnant women to the clinic during home visits. Therefore the promotion of this project demanded no alteration to the role that is expected of them in the first place, only requiring knowledge of the project itself. In this way, clinics and PAs could be agents through which the project was promoted and the contact telephone numbers of the ETS riders could be distributed.

In addition, and in some ways linked to the motivation of the ETS riders themselves, the project team proposed the distribution of waterproof high visibility jackets with text (in local languages) on the rear of the jacket informing people about the project. This item would serve the project in a number of ways:

- Act as a motivational item for each of the riders
- Increase the visibility of the rider day or night and therefore contribute to improving safety
- Promote the project to the wider community

5.4 Implementation

In the absence of unions or high level boda boda associations, it was envisaged that the ProFam Clinics and PACE regional offices would contribute to the monitoring and evaluation of the project. In order for the project to be successful, a carefully planned and systematic implementation was vital. All stakeholders that would be part of the ETS needed to be sensitised to the project, its aims and objectives, and how the entire system is proposed to operate on the ground. A systematic approach of sensitising the ProFam clinics, the ProFam Ambassadors and the boda boda riders was adapted to ensure this happened. Transaid adapted an approach which has been successful in other African countries such as Nigeria to conduct this activity. The approach included engaging each level of stakeholder involved in order to maximise buy-in and participation from all levels thereby increasing the impact and success of the intervention.

The primary stakeholders were the ProFam Clinics themselves, the ProFam Ambassadors and the boda boda riders. The schedule (see Annex 3) shows the content and the schedule of the sensitisation activity. It was critical that all stakeholders understood their individual role in the intervention and each other's roles to avoid any misinterpretation of the scheme by community members and potential beneficiaries. Also important was the stakeholder's involvement in solidifying the intervention and its appropriateness in the context of the areas it was being implemented.

The following is a reflection of discussions and the topics that were discussed during the sensitisation activities in each district.

5.4.1 ProFam Ambassador Sensitisation

This activity was conducted over the period of one day of sensitisation and with a participatory approach to discussions with ProFam Ambassadors. It took place at various central locations in the districts where the project is operating.

5.4.1.1 Discussion Topics

The PAs were very forthright, engaged and willing to discuss and debate the topics. The following subjects relating to the project were discussed during the sensitisation activity and were helpful in building the understanding of the project team about the constraints to women being able to access maternal health services.

- Poverty and the high prices charged at health facilities stop women going to health facilities
- Lack of respect by midwives stops women going to health facilities
- Ambassadors find their roles challenging because of:
    - The cost of or lack of transport trying to get around to do their role
    - Drunk husbands
    - Women go to ProFams for ANC but they deliver at government facilities
    - Different ethnic groups and languages cause issues
    - Lack of ambulances at ProFams means that, particularly at night due to security concerns, referral to the next level of health facility is difficult

It was clear from the initial research conducted in the districts that finance, or lack thereof, was a key factor in creating a barrier to accessing health facilities. This topic was discussed in detail with the ProFam Ambassadors to get a clear understanding on the feasibility of such solutions as saving schemes.

The PAs were quite clear in their opinions on such schemes run by or through ProFam clinics or run by or through the PAs themselves. They were of the opinion that community members would not trust the ProFams or Ambassadors to collect and hold their money for the following reasons:

- Bad past experiences with saving schemes (money being stolen, misused)
- Cost of ProFams (ProFams, in some cases, are too expensive and they feel they would be restricted to go there if they were saving with them and so may not go to a health facility at all, even when needed)
- Communities think ambassadors are being paid well and if they gave them their money they would just keep it for themselves
- Community members may need quick and easy access to the money saved for other non-health related emergencies in the household and if it was being held at the ProFam or by the ambassadors they would not be able to have that access
- Although most ambassadors agreed most community members would be able to gather small amounts of money on a monthly basis to be saved they almost all agreed this extra money would only be trusted with a close friend or family member to hold/save and not a "stranger" no matter the structure or sensitization.

In conclusion a clinic based saving scheme would not work in the form suggested and considered by the team.

5.4.2 Boda Boda Rider Sensitisation

This activity was conducted in communities through participatory discussions with boda boda riders and community members.

5.4.2.1 Stage Selection and Rider Recruitment

The criteria for boda boda rider selection was set based on previous experience and a logical approach to what would be realistic and achievable on the ground.

Selection of boda boda stages was carried out according to their location within each of the clinic catchment areas. The information gained from ProFam staff members during the formative assessment was key to providing a logical approach to choosing which stages to target. During the interviews, staff were asked to identify the clinic's catchment area estimating the realistic distance in kilometres from which people travel to the clinic. The records kept at each of the clinics enabled the project team to identify specific villages

and communities from which patients travel from. This process was repeated for each clinic in all five target districts.

Based on this information the selection of the boda boda stages could be done. In order to select a boda boda stage, initially as a guide, certain criteria were discussed. These criteria required that:

- The stage was centrally located in the area to enable maximum coverage
- There were a minimum of approximately 10 riders at the stage when visited in order to have a larger pool of volunteers to choose from
- There was a clear structured hierarchy in place with a chairperson who was in charge

Whilst conditions are different from location to location Transaid maintained a flexible approach to ensure the best suited solution to selection was used. For example, at some stages there was no chairperson. This applied in particular to stages in more remote locations. Therefore this criterion was applied where possible and appropriate. As the reader will note later in the report, systems for monitoring and evaluation, including the use of 'focal riders' were in part an attempt by the project team to encourage leadership amongst the riders. Each stage was visited to confirm that it adhered to the criteria as well as to ensure that it was located strategically, to maximise coverage.

To take Lira district as an example, initially discussions established that the approximate catchment area of one the clinics, was up to 12km from the clinic. On concluding discussions with ProFam Ambassadors the stages between 3 and 12km from the clinic were investigated for potential involvement in the project.

During the implementation exercise the following number of stages in each district was targeted, each of which adhered to the necessary criteria to participate in the project:

District	Number of Stages
Mubende	19
Hoima	18
Ibanda	24
Lira	24
Alebtong	07

The number of stages varies according to the number of clinics in each of the districts and the size of the catchment areas.

In locations where it was decided there was a need for a boda boda trailer ambulance for referral purposes, as ownership of the trailer lay with the ProFam Clinic, this required that a stage was selected close to the clinic whose riders could learn to operate the trailer competently.

For each of the stages selected, the number of riders participating from each stage was capped at between 4 and 5 riders. The reasoning behind this was threefold. Firstly, whilst many more riders

were interested in joining the project, capping the number was key to achieving the anticipated increase in income as they became the preferred means of transport for pregnant women. Secondly the project team exercised quality assurance during recruitment to ensure that only the riders who were committed to the ideals of the project would be recruited. Lastly there were criteria set by the project team for boda boda rider recruitment which only a proportion of the riders met. As the project progressed in some places additional riders were selected to accommodate a larger than expected geographical area.

The selection criteria for selecting boda boda riders were as follows:

- The must be willing to work voluntarily (i.e. not be paid by the project of ProFams)
- The stage chairperson is judged to be a reliable person, supportive of the projects objectives
- The riders must be willing to reduce their rates during times of emergency and/or at night. Their pledge is to keep the prices fair and as close to the normal rate as possible
- The riders must be willing to be contacted for information about the women they transport during the monitoring phase of this project
- Riders should preferably own their own motorcycle, otherwise get permission from the owner to use the motorcycle at night when needed.
- The riders must show willingness to travel at night, when safe to do so.

The number of riders that were initially selected for sensitisation in each of the five districts was:

District	Number of ETS riders
Mubende	75
Hoima	20
Ibanda	85
Lira	85
Alebtong	10

The number of riders varies according to the number of clinics and in Hoima's case, whether or not clinics were clustered together.

5.4.2.2 Planning to Maximise Participation

Initial planning for this activity was to conduct a two day sensitisation workshop with boda boda riders in each of the selected areas. This method of sensitisation had been thoroughly thought out, planned and discussed before implementation. However, upon further discussions with all of the PAs and interaction with boda boda riders in their communities at the start of implementation, it was thought that this approach needed to be adapted to suit individual time constraints.

Although initially boda boda riders and ProFam Ambassadors both agreed on the workshop approach when it came to actual implementation several issues arose that dictated a new approach.

- Nearly all boda boda riders were unhappy at the thought of losing business by attending the workshop and either would not participate or wanted substantial compensation from the project for lack of earnings
- As boda boda riders are reasonably fluid in when and where they work it was quite difficult to locate and communicate with all of the boda boda riders in each area selected
- The PAs felt it would be difficult to differentiate between boda boda riders who were genuine and wanted to participate and those who saw the sensitisation workshop as a way of getting free food and money

Based on these issues a new approach was accepted and resulted in the project team carrying out the sensitisation activities by travelling to the key boda boda stages and conducting the sessions in situ. It was felt that this approach would:

- Reach a wider group of boda boda riders as they would be approached in their communities at their stages and therefore would not need to travel to reach the workshop
- Be more acceptable to boda boda riders as if and when business arose they could make the choice whether to take it and leave. This meant they could participate in the discussions without fear of losing business or income and not have to choose one or the other
- Provide a more comfortable and relaxed environment as opposed to a classroom-based workshop
- Be a means to establishing which boda boda riders were genuinely interested in participating in this project through removing any monitory incentive to take part in the sensitisation.

As was mentioned, adaptability was key to the implementation of the activities conducted. Although each activity was carefully planned and structured the actual implementation of said activities evolved and changed as they were conducted. This type of approach was utilised in all districts to ensure optimum impact.

5.4.2.3 Discussion Topics

Participatory discussion was a key part of improving the project team's understanding about the challenges faced by transport providers as well as a key means of disseminating the key messages pertinent to this project.

During the discussions with the boda boda riders several interesting topics were raised:

- Riders said they charge more for pregnant women due to the fact that if anything goes wrong they are blamed
- They have to ride slower and therefore believe that they use more fuel as a result
- At night they cannot coast (ride the motorcycle downhill out of gear or with the engine turned off as they do during the day as they have to keep their lights on) and so use more fuel
- Several riders stated they would happily transport women for free or a reduced rate but only if the project subsidised them.

- Not knowing the client and fear of robbery are both the major reasons why riders are reluctant to travel at night. It was envisioned that the distribution of their contact telephone numbers to women living in their respective communities would reduce their fear of travelling at night.
- Some riders feel that they would be perceived to be responsible should anything go wrong during transportation, largely due to their reputation within communities.

The reasons as to why riders would be motivated to participate in the project and therefore reduce their prices for pregnant women, was discussed and accepted with the following incentives proposed:

- An increased amount of business for those operators willing to charge less exploitative prices through being part of a preferential contact list of transport providers
- An improved status/reputation within the village/parish as a result of being part of this initiative
- Increased confidence in terms of caring for pregnant women during transportation

5.4.2 Placement of Boda Boda Ambulance Trailers

The 2 trailers that were installed were procured from a local manufacturer based in Kampala. Despite all efforts to source alternative solutions, without sourcing a product outside of Uganda, this was undoubtedly the best option. On assessing the integrity of the equipment, the project team deemed it to be strong and robust, with available replacement parts if needed.

A stage located near to the clinic which owned the trailer was identified and recruited from. Each of the riders recruited required a fitting to be attached to the rear of their motorcycles so that the trailer could easily be attached to the motorcycle when called upon to do so. The manufacturer provided a trainer who facilitated a day's training, whereby the riders and ProFam staff were taught about:

- The workings of the trailer,
- The attachment of the trailers to the motorcycles
- The safe use of the trailer
- Basic maintenance.

5.5 Data Collection/Monitoring

It is clear from the academic literature that monitoring and evaluating of emergency referral and particularly, the impact of integrating transport within efforts to improve referral is a challenge. Improved monitoring of the referral chain as well as more robust evaluation of transport interventions is definitely necessary. The project's monitoring and evaluation related activities aimed to achieve the following:

- Monitor the achievements of the activity's intervention
- Collect and analyse performance information to track progress toward planned results
- Use performance information and evaluations to present recommendations
- Use performance information to act as guidance for the potential scale up of this intervention

Although the level of planned scale up of this project to additional districts is unclear, through rigorous monitoring the project team's aim was also to analyse the findings from monthly data collection to inform the potential for replicating this intervention in other districts.

5.5.1 Monthly Data Collection

The monitoring of this project presented a number of challenges, not least the absence of a baseline study. Another challenge was the distribution of roles and responsibilities, whereby with guidance from Transaid, PACE Regional Staff Teams were given the responsibility of carrying out the monthly collection of data. Unfortunately where the data was collected, the datasets were incomplete and therefore not usable in terms of establishing the impact of this intervention. Transaid took back this responsibility in January 2015 to ensure that there existed a full dataset for the final 7 months of the project. A data collection tool was developed (see Annex 4) to capture the necessary information from the ETS riders on a monthly basis. From January to July 2015, Transaid took on this responsibility during bimonthly monitoring visits. Riders were mobilised in advance, and asked to attend a meeting at the respective ProFam Clinics that each group was associated with. ETS riders were compensated for the transport costs incurred in travelling to the meetings. The agreed amount was 5000 UGX each. The following objectives were carried out during monitoring visits:

- To confirm the number of active participants.
- To correct and confirm contact details of participants.
- To reinforce the key messages associated with ETS provision.
- To identify, discuss and provide a solution to any problems or concerns arising since implementation.
- To distribute motivational items to all ETS riders.

5.5.2 Data Collection via 'Focal Riders'

In May 2015, PACE communicated the fact that data collection would continue until December 2015, despite Transaid's involvement ending in August. To facilitate the effective capture of data by PACE staff, Transaid installed a new system of capturing data based on the principle of utilising nominated 'focal riders' who would effectively take on the responsibility of collecting the necessary data from their fellow ETS riders and then pass this information to PACE staff at the end of each month.

Focal riders were put in place at stages where there was more than one ETS rider recruited (Annex 5). Each focal rider was trained to collect the relevant information from his or her fellow riders and a trial run was carried out under the supervision of Transaid's project team. Where necessary, additional guidance was provided. This system of data collection was trialled during June and July at which point the project team reviewed the process to establish its effectiveness. Please note that this system was not deemed applicable in Hoima District due to the dispersed nature of the majority of ETS riders.

5.5.3 Rural Assessments to Evaluate the Effectiveness of the Scheme

In order to cross reference the data received from the ETS riders, Transaid carried out a comprehensive series of rural assessments whereby visits were made to women who had used the ETS service as well as those that had not.

The additional objectives of the rural assessments were to establish:

- The level of awareness in communities about the project
- The uptake of the ETS rider service
- That the correct messages in target areas were communicated and that there was no misinterpretation
- The validity of the data collected from ETS riders by cross checking it with women in the community

These objectives were to be achieved by means of carrying out semi-structured interviews and targeting a mix of villages where there has been take-up and villages where there has been no reported take-up.

A data collection tool (Annex 6) was created in advance of the assessments themselves and constituted an expanded version of the tool used during the formative assessments. It was designed to extract the following information:

- Confirmation of the key data gathered as part of the formative assessment
- A means of establishing how the project is being promoted with information to be included as recommendations as part of the final report
- For those that are aware of the project, to find out if the changes are noticeable and if things have changed for the better, and in what way, would they use it again
- Measuring the opinions of people in villages where there were expectations about the project

- Clarification of any misunderstandings or misinterpretations relating to the key messages about the project

6. Findings

The findings are based on the data collected during the project teams monitoring visits, for the period January to July 2015. Ideally the team would have favoured a longer period over which to gather data however due to various factors beyond its control this was not possible. The findings are a mix of qualitative and quantitative data obtained primarily via the following sources:

- Desk-based research
- Group discussions with ETS riders
- Transcribing data from ETS rider logbooks
- Semi-structured interviews with users and non-users of the service
- Semi-structured interviews with ProFam Clinic staff

Sections 6.1 and 6.2 below show the findings based on the data obtained from ETS riders during the monitoring period. This is data that has been collected primarily during frequent meetings with the riders which took place on each of the project team's visits. Section 6.3 presents a means of cross referencing this data through obtaining information from different sources, namely the pregnant women who have used the service, and through examining data provided by the Uganda Bureau of Statistics to establish an estimate of the actual birth rate at parish level in each of the five districts so that the project team could confirm that the data received from the ETS riders was realistic.

6.1 Feedback from ETS Riders

As well as providing a means to collect relevant data, monitoring visits provided an opportunity to review the project at regular intervals, and to respond to any concerns or problems that the ETS riders were experiencing in carrying out their roles. Without exception, these concerns/suggestions were recorded in monitoring reports subsequent to each visit throughout the monitoring period. Annex 7 shows all of the recorded concerns and suggestions raised for each clinic in each of the districts throughout the monitoring period (January-July 2015). Many of the same issues were raised amongst different groups of riders in different districts, and the project team were able to act upon the majority of points raised. Indicative of this fact is the high level of retention of riders throughout the period.

A story from one of the ETS riders that stands out was told by a rider in Mubende.

Adamu Mulinde, and ETS rider associated with Matia Mulumba Clinic in Mubende, told the project team that he had recently transported a woman in the late stages of labour. The labour was so advanced that Adamu had to stop on the way to their destination. He made his passenger comfortable at the side of the road and ran off to find the nearest traditional birth attendant. Adamu returned with a TBA and stayed with his passenger until she had given birth to a baby boy.

This and other stories points to a behavioural change amongst some riders, who as a result of the growing awareness they have around pregnancy, have gone above and beyond to ensure that their passengers give birth safely.

6.2 Monthly Monitoring

Transaid set out to address the transport-related barriers to accessing maternal health services through the implementation of an appropriate emergency transport scheme whereby pregnant women have access to an affordable means of transport. In the absence of a baseline, data obtained by Transaid during the formative research is being used where possible to establish the impact of Transaid's intervention.

Emergency transport schemes appropriate to context were implemented in 5 districts in Uganda and initially 275 boda boda riders were recruited to serve as voluntary ETS riders during the sensitisation activity.

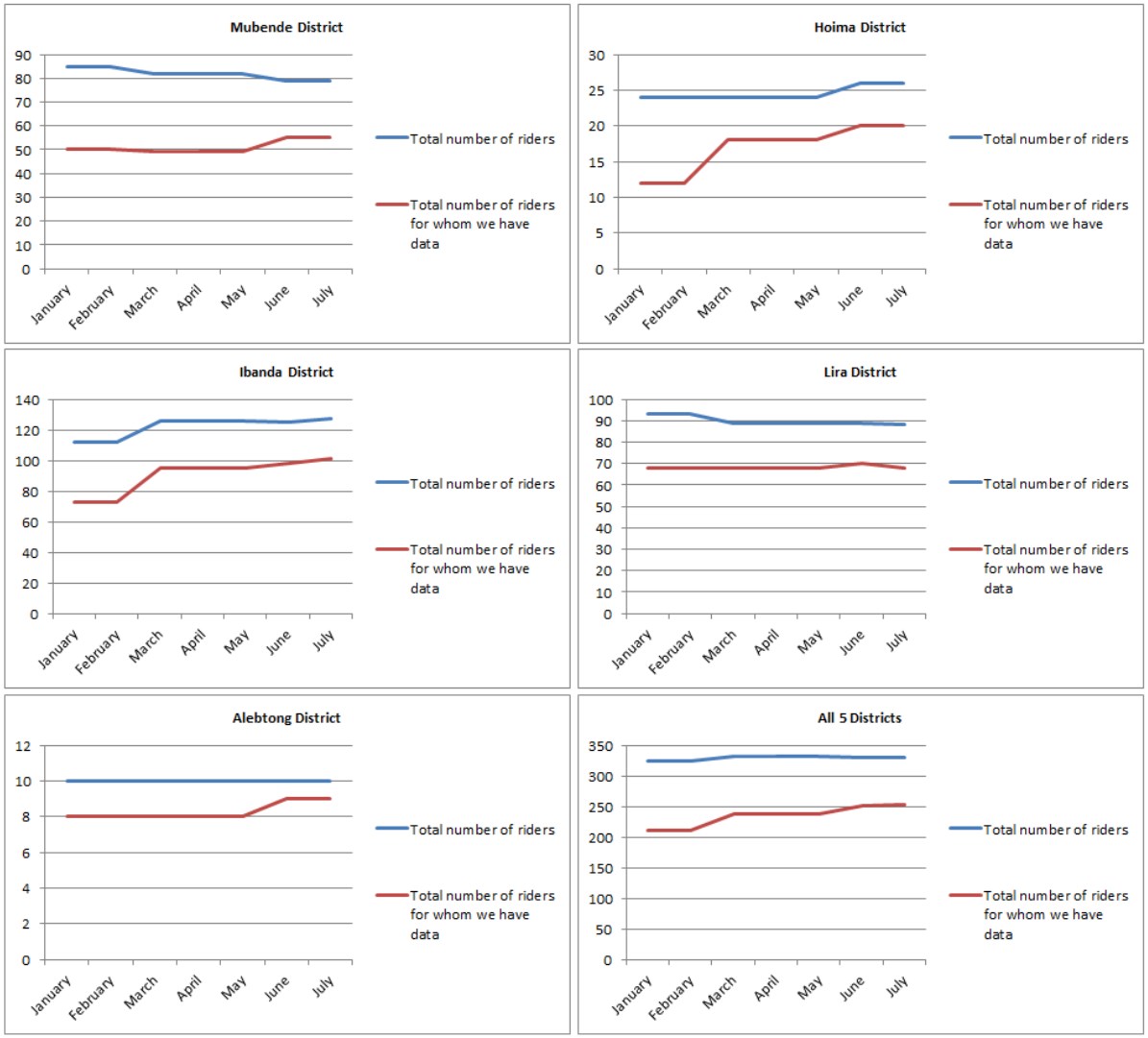
6.2.1 ETS Rider Retention

The number of recruits for each district varied hugely, largely according to location of ProFam clinics. For example, where clinics were clustered in more urban settings, a fewer number of stages were recruited from. The opposite occurred where clinics were sparsely located in harder to reach places. Through carefully adjusting the numbers of ETS riders, to ensure an optimal number, the number of ETS riders recruited at the start of the monitoring period had risen to a total of 324.

The retention of ETS riders is critical to the continued functioning of the emergency transport scheme. Inevitably riders have and will continue to drop out of the scheme and the challenge will be to ensure that the total numbers of riders in each of the five districts remains relatively consistent. In a context where there is little evidence of organisation amongst boda boda riders, installing a mechanism whereby replacement riders are recruited and sensitised presents a challenge. Organisation at the stage[4] level however, does seem to present an opportunity in terms of the recruitment of replacement riders especially for stages where there is a chairperson who is chosen by the other riders to serve a term of usually one year. Where there was no chairperson, the project team worked towards installing a level of leadership at the boda boda stages whereby 'focal riders' were nominated by their peers. Their primary role would be to lead on the collection of project data. In the longer term, the 'focal rider' will take on the responsibility for recruiting replacement riders from his or her stage should another rider drop out of the project.

[4] A boda boda stage is the equivalent of a taxi stand and constitutes a group of boda boda riders registered as members of that particular stage.

ETS Rider retention rates by district.



The above graphs represent the ETS rider retention rates between January and July 2015 for each of the 5 target districts, as well as the number of riders that the project team are reaching during monitoring visits. *The last of the graphs above* shows the retention rates consolidated from all 5 districts as well as consolidated data regarding the number of riders that the project team engaged with during monitoring visits. For all 5 districts, the amount of riders providing data has either remained constant or increased as a proportion of the total riders.

ETS Rider retention rates, number of riders engaged during monitoring, proportion of riders from whom data was obtained against the total number of riders.

DISTRICT	ETS RIDERS	MONTHS 2015							LOSS/GAIN (NO. OF RIDERS)
		January	February	March	April	May	June	July	
MUBENDE	Total Riders	85	85	82	82	82	79	79	-6
	Total data obtained	50	50	49	49	49	55	55	N/A

	from								
	Proportion of Total	59%	59%	60%	60%	60%	70%	70%	N/A
HOIMA	Total Riders	24	24	24	24	24	26	26	+2
	Total data obtained from	12	12	18	18	18	20	20	N/A
	Proportion of Total	50%	50%	75%	75%	75%	77%	77%	N/A
IBANDA	Total Riders	112	112	126	126	126	125	127	+15
	Total data obtained from	73	73	95	95	95	98	101	N/A
	Proportion of Total	65%	65%	75%	75%	75%	78%	80%	N/A
LIRA	Total Riders	93	93	89	89	89	89	88	-5
	Total data obtained from	68	68	68	68	68	70	68	N/A
	Proportion of Total	73%	73%	76%	76%	76%	79%	77%	N/A
ALEBTONG	Total Riders	10	10	10	10	10	10	10	0
	Total data obtained from	8	8	8	8	8	9	9	N/A
	Proportion of Total	80%	80%	80%	80%	80%	90%	90%	N/A
TOTALS	Total Riders	324	324	331	331	331	329	330	+6
	Total data obtained from	211	211	238	238	238	252	253	N/A
	Proportion of Total	65%	65%	72%	72%	72%	77%	77%	N/A

Overall there has been a net gain of 6 riders in total over the five districts. At the time of writing this report there are now 330 operational ETS riders working with the project. This is an impressive retention rate over this period and bodes well for the long term sustainability of the project. In fact, a cap on any future recruitment was enforced by the project team despite widespread interest from other boda boda riders in joining the project. As PACE takes over the monitoring responsibility from August 2015, it will be its responsibility to monitor numbers based on the guidance provided in this report.

As illustrated in the table above, data was received from only a proportion of riders at each meeting. This proportion remained high throughout indicating a highly motivated team of riders. In fact the proportion of riders generally increased throughout the monitoring period to between 70 and 90%.

There are always expected to be some absentees at the meetings due to over commitments etc. Whilst the riders that were present were always asked whether or not individual absentees were still active in their role as ETS riders, it was difficult to verify this fact. However, the introduction of the 'focal rider' monitoring system in June and July 2015 resulted in an increase in the number of riders that the project team were able to collect data from, as even the data for riders that were absent was recorded in the focal rider's logbook. This is illustrated in the above table by an increase in all except one district of the proportion for whom the team received data for. Over time, this will give PACE a more accurate picture of which ETS riders are active and which are not.

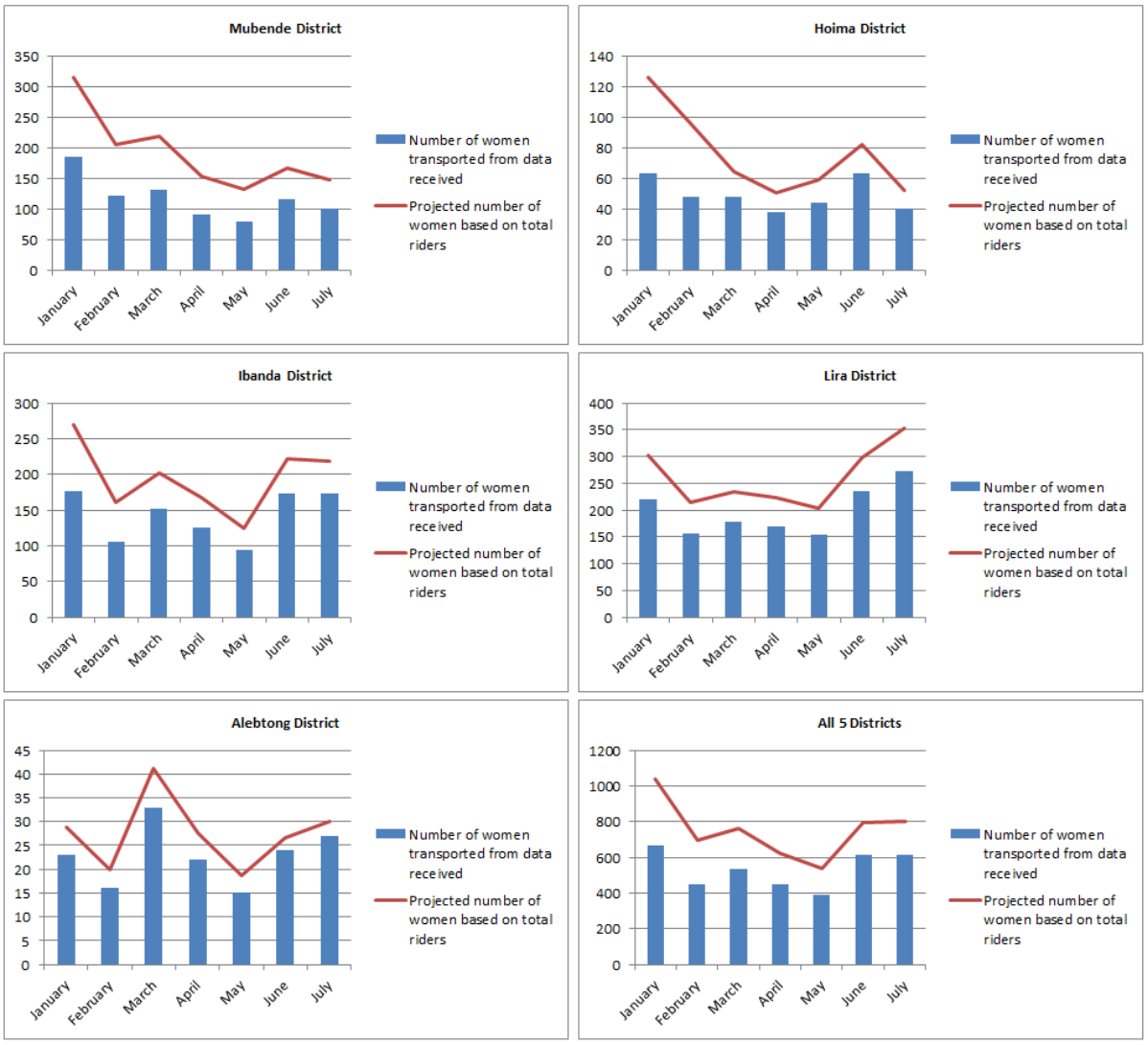
6.2.2 Number of Women Transported

The number of women transported by the ETS riders is recorded by the focal rider at each stage in his or her logbook at the end of each month and is indicative of the level of uptake of the service provided by the ETS riders but not necessarily of an increase in uptake of formal health services by the women using the service. Whilst data can be obtained regarding the numbers of women transported, it is not possible to establish whether or not these women would have travelled to health centres in the absence of an affordable means of transport without an extensive study. The data regarding take up of maternal health services at ProFam Clinics is available, however, the number of women travelling to ProFam Clinics represents a small proportion of the total number of women that are using the service provided by the ETS riders. Data from government-run and other private health providers was not available and for this reason, the project team has not sought to demonstrate an increase in the monthly uptake of maternal healthcare services over the lifetime of this project.

The 'number of women transported' represents those travelling to ProFam and 'other' clinics to attend ante-natal classes, to deliver their babies, and pregnant women travelling to treat illness. 'Other' clinics represent on the whole government run facilities, but also in the minority of cases, other private health sector providers.

The graphs below show the number of women transported based on the data received from ETS riders in blue, matched with the projected, or potential number of women transported taking into account the riders absent from the monitoring meetings based on applying the average number of women being transported by each present rider, to the absentee riders.

Number of women transported for each district.



The graphs above show obvious peaks and troughs relating to the numbers of women using the ETS rider service. These variations could simply be the result of fertility trends in Uganda during the year, or could be influenced by external factors. For example, one explanation might be that with the maize crop being harvested in June and July, there is likely to be little available household income in the months leading up to harvest influencing a woman's decision about whether or not to travel to a health clinic. As seen in most of graphs this could explain the 'trough' seen between March and May and the subsequent increase in users in June and July, after the maize has been harvested. A more definitive explanation to this would perhaps be possible with a dataset that covers more than a year.

A breakdown showing the number of women transporte; why they were being transported and their choice of destination (health facility).

MONITORING MONTH	District	No. of Women Transported	REASON FOR TRANSPORTATION			HEALTH FACILITY TYPE	
			ANC	Delivery	Illness	ProFam	Other
January	M	185	97	88	0	76	109
	H	63	23	40	0	27	36
	I	176	75	101	0	17	159
	L	221	121	98	2	34	187
	A	23	16	7	0	5	18
TOTAL		**668**	**332**	**334**	**2**	**159**	**509**
February	M	121	52	69	0	39	82
	H	48	31	17	0	11	37
	I	105	48	57	0	14	91
	L	157	95	61	1	29	128
	A	16	5	11	0	7	9
TOTAL		**447**	**231**	**215**	**1**	**100**	**347**
March	M	131	65	58	8	45	86
	H	48	27	13	8	18	30
	I	152	74	72	6	17	135
	L	179	103	60	16	32	147
	A	33	13	7	13	15	18
TOTAL		**543**	**282**	**210**	**51**	**127**	**416**
April	M	91	50	37	4	35	56
	H	38	16	11	11	17	21
	I	126	57	55	14	23	103
	L	170	94	57	19	30	140
	A	22	9	6	7	7	15

TOTAL		**447**	**226**	**166**	**55**	**112**	**335**
May	**M**	79	42	33	4	28	51
	H	44	12	13	19	19	25
	I	94	34	48	12	19	75
	L	155	78	45	32	52	103
	A	15	2	4	9	6	9
TOTAL		**387**	**168**	**143**	**76**	**124**	**263**
June	**M**	116	52	56	8	27	89
	H	63	41	22	0	24	39
	I	174	109	48	17	45	129
	L	235	116	70	49	32	203
	A	24	6	10	8	6	18
TOTAL		**612**	**324**	**206**	**82**	**134**	**478**
July	**M**	101	55	41	5	20	81
	H	41	33	7	0	13	28
	I	174	106	38	30	47	127
	L	273	135	79	59	56	217
	A	27	7	4	16	3	24
TOTAL		**616**	**336**	**169**	**110**	**139**	**477**

GRAND TOTAL		**3720**	**1900**	**1443**	**377**	**895**	**2825**

M Mubende
H Hoima
I Ibanda
L Lira
A Alebtong

However, what is clear is that expectations have been exceeded in terms of the take up of the ETS rider service. From January to July 2015 alone, there have been 3720 women transported by ETS riders over the five districts. Whilst this does not necessarily indicate an increase in the uptake of maternal health services, it is evidence that the availability of a means of affordable transport has been embraced by communities. The ETS riders remain motivated despite the lack of financial incentives, and riders are now stating that as providers of transport, their levels of income are beginning to increase. Undoubtedly there is important work to do in continuing to promote the project, to further increase their income levels.

6.2.3 Ante-Natal, Delivery or Illness

It is recommended that women attend 4 ANCs before delivery so that the pregnancy can be monitored at regular intervals by skilled attendants reducing the chance of unexpected complications during delivery. Whilst the project team were unable to record whether or not individuals were attending a minimum of 4 ANCs, the number of women using the ETS riders to attend one ANC class was recorded. As expected, the majority of journeys carried out each month were with a view to women attending ANCs, more so than for delivery and illness.

The number of women transported for delivery, ANC or illness for each district.

Whilst there is no discernible pattern from the graphs above the most striking observation is the rise in the number of women using the ETS service to travel due to illness. To clarify, this is illness occurring during pregnancy but not pregnancy related, such as malaria. The rise is therefore thought to represent a seasonal surge in malarial transmission and could relate to the March-May rainy season in Uganda, although increased reporting could also be a contributing factor.

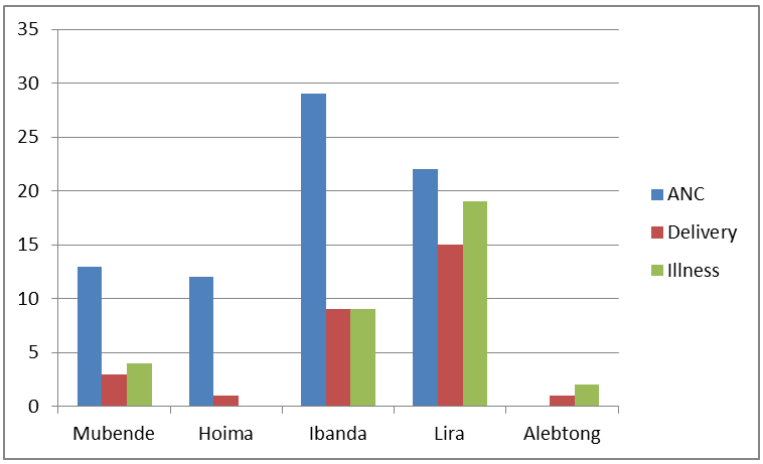
6.2.4 Uptake of Maternal Health Services by Type

Whilst the MUM Programme focuses on developing the capacity and quality of service at PSI's franchised clinics (ProFam Clinics), for the transport element to the MUM Programme, the choice of which clinic to travel to remains the decision of the women travelling. The formative research found that whilst many women knew about the ProFam Clinics, and were of the opinion that the clinics provided a better quality of service than alternative clinics, the cost of the service is a barrier. This is reflected in the data collected during monitoring visits which shows the majority of women choose to travel to government run health centres where they receive a service which is in theory free of charge. For those that do choose to use the ProFam Clinics, a large proportion of these women use them only to attend ANCs which at some clinics are affordable, whilst attending 'other' more affordable government-run clinics for delivery.

Uptake of ProFam Clinic services as compared with government run clinics in each district

The cost of the service at ProFam Clinics is undoubtedly the primary reason for women choosing to deliver at government-run health services. However, these graphs hide the differences in approaches that individual clinics are taking in terms of their role in this project, and the potential this can have on increasing the uptake of their services. Some clinics have evidently embraced the role of the ETS riders and have made efforts to get to know their riders, to record data and to collectively discuss approaches with them. Other clinics have taken a very hands-off approach and have had little contact with the riders. The graph below shows the difference in take up between clinics in the five target districts.

Proportional uptake of different ProFam maternal health services July 2015

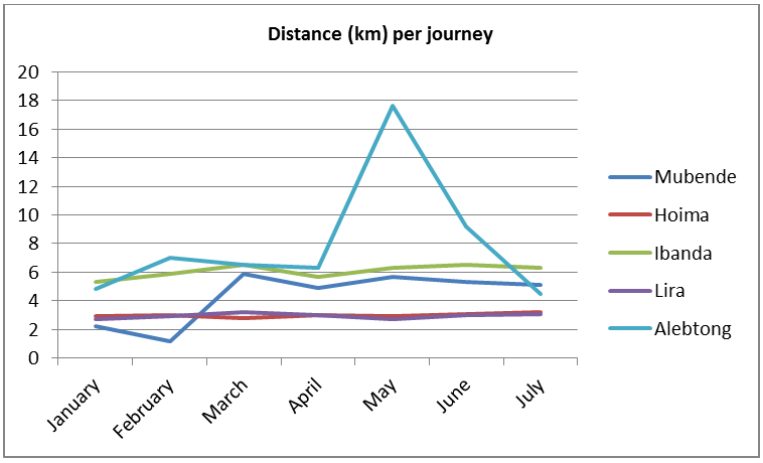


As expected in most cases the proportion of users going to ProFams for ANCs is much higher than take up for other maternal services. The exceptions are both districts in the north of Uganda. In Lira, the reason for this might be that many of the ProFam clinics are based in Lira Town itself, where there is more wealth and therefore more women able to afford ProFam services. In Alebtong the numbers are low due to the fact that there is only one clinic in this district.

6.2.5 Length of Journey by ETS

As mentioned above, based on information from the formative assessment, ETS riders would in most cases not carry women more than approximately 10-12kms. This was based on the information that ProFam clinics gave the project team when attempting to establish the size of their catchment area. The graph below shows this to be the case, with one exception, Alebtong District. Alebtong District does not have a regional referral hospital and therefore many patients experiencing complications must go to Lira Regional Referral Hospital which is more than 40km away. For this very reason, a boda boda ambulance trailer was purchased to deal with cases where complications arise.

Excluding Alebtong, the average journey length is from 1.2 to 6.5km. On the whole these figures appear to remain consistent throughout the 7 month data collection period.



The average journey distance when transporting women for each district

Whilst the journey lengths mentioned above are averages and therefore obscure periodic long journeys at all locations, this finding however, could indicate one of two things.

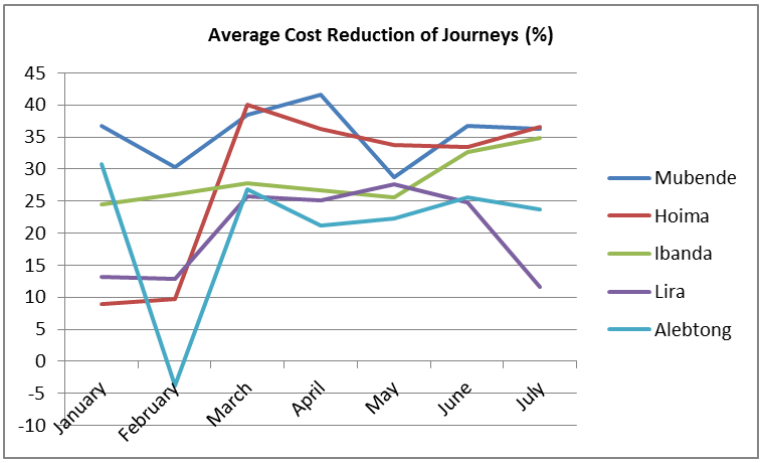
Firstly it could point to the ETS riders operating in regular patches perhaps those which are familiar to them and/or those that are within reasonable distance from village and/or their boda boda stage. This makes complete sense, as they know the geography of the area, and therefore are less likely to receive a call from a woman in an unknown location. It also gives them an advantage in terms of promoting themselves as a preferred means of emergency transport.

Alternatively it could be an indication of how far pregnant women are willing to travel by boda boda, bearing in mind comfort and other factors. By no means are boda bodas the ideal means of emergency transport, especially over longer distances, and also for women in the later stages of labour. However, bearing in mind the lack of alternative transport services and the fact that bicycle is deemed unfit for purpose, the use of boda bodas as a means of emergency transport is an incremental improvement by virtue of the fact that it is reducing the delay in helping women access maternal health services.

6.2.7 Cost Reduction per Journey

It is important for this intervention to demonstrate a reduction in the cost of each journey for pregnant women who use the service provided by the ETS riders. Therefore, during the 7 month data collection period the distance and the cost of each journey were recorded by the ETS riders. In addition, the price that the rider would usually have charged prior to joining the project was also recorded.

The average reduction in cost as a percentage over the 5 target districts



This graph shows a reasonably consistent reduction in price over time although the size of the reduction does vary between districts. Reductions in price generally seem to increase as a proportion of the total cost, the longer the journey is. **With the exception of Hoima it is evident that Mubende and Ibanda Districts seem to offer the largest reductions, up to a 41.6% reduction in Mubende and 34.8% in Ibanda**. These two districts differ from the others in 3 important respects related to the fact that the ProFam Clinics are largely rural-based.

As a result of being largely rural-based more stages have been targeted during implementation which means collectively, the ETS riders cover a greater part of the district in terms of land area. Therefore based on these factors journeys could be expected to longer than in other areas. If journeys are longer, then as mentioned above, this would lead to greater reductions in the total charge for each journey.

Alternatively it could also be the result of more people having heard about the scheme. This in turn could lead to an increased level of business for each of the riders making it within their means to make larger reductions.

The third possibility is that if the riders are operating in the area close to the communities within which they live, then the passengers are more likely to know the riders on a personal level. This might lead to riders giving people they know larger reductions than they would if the person was unknown to them. As this study will show below, there does indeed seem to be an increased likelihood that credit is given by the rider if he or she is familiar with their passenger.

The one dip in the graph above is in Alebtong where the boda boda trailer is in operation for journeys of up to and around 40km. Whilst the cost of these long distance journeys remains less expensive than the few other options available, it is expected to cost more due to the trailer.

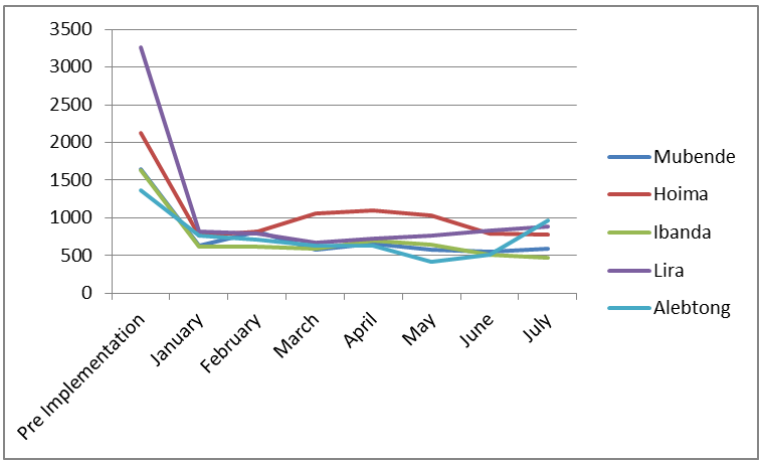
The project team understands that there is scope here to misinform the data collector as well as a difficulty in judging distances on occasion. In this instance data was collected from communities estimating the cost per kilometre of each journey. In addition spot checks were carried out. In such cases, the information that the rider submitted was cross checked with the woman that had used his or her service. In all cases, the information that the project obtained from the women reflected the information received from the ETS rider.

6.2.8 Costs Before and After Project Intervention

This graph shows the reduction in prices based on data collected during the formative assessment, whereby the cost per kilometre was estimated. This shows evidence of a substantial decrease in prices for journeys offered by the ETS riders.

The decrease is variable in terms of the proportion of the total cost, for each districts, however, the reduction is consistent throughout the 7 month data collection period. The largest reduction is in Lira District although the starting point (pre-implementation) is abnormally high at more than 2 times what was then classed as the usual price.

Cost per kilometre (UGX) before the project was implemented compared to July 2015



6.3 Cross Referencing Data

Whilst data was forthcoming from the ETS riders, the project team felt it necessary to be able to cross reference the data to ensure that the numbers of women being transported was accurately reported and realistic. Transaid decided to carry this out in two ways. Firstly, a series of rural assessments were carried out whereby women who had used one of the ETS riders were interviewed and their views corroborated with the data that the associated ETS rider had provided. Secondly, through desk based research, an estimate of the expected birth rate in each of the parishes where the project is operating was calculated and cross referenced with the data from the ETS riders. In this way the project team could verify whether or not the data was realistic, and were able to calculate the proportion of pregnant women from each parish that had benefited from the project.

6.3.1 Rural Assessments

Rural assessments were carried out on two separate occasions, in March 2015 and June 2015. As well as giving the project team the means to cross reference data with service users, it also gave the team the opportunity to assess perceptions of the project in communities both with previous users and with those that had not yet used the service.

This study targeted communities that fall into two categories:

- Communities where women have utilised the ETS riders
- Communities where women have not utilised the ETS riders

In total, 53 interviews took place involving 77 people over the 5 districts. The table below shows a breakdown according to district. The villages that fall into the second category were chosen at random and acted as a control.

District	Number of Interviews	Number of Participants
Mubende	10	20
Hoima	9	21

Ibanda	15	17
Lira	15	15
Alebtong	4	4

Some of the key facts to emerge from the rural assessments.

S/N	Question/Information Required	Response
1	Have you heard about the project? If yes, what is your understanding of the project?	Women in 38 out of 53 interviews carried out had heard about the project before. The vast majority had a similar understanding of the project to the interviewer. In one case (Mubende) only the woman's husband knew about the project and one other woman knew about the ETS riders but not about the project itself.
2	How did you hear about the project?	In Mubende, most women are learning about the project from the ETS riders themselves or simply from reading the text on the back of the jackets that the riders wear. In one case it was claimed that the Village Health Team had mentioned the project in a village meeting. In Hoima all those who responded said that they had heard about the project and that they were told by ProFam Ambassadors. One stated they had heard about it on the radio. In Ibanda, almost everyone had heard about the project from the riders themselves. One respondent said they had heard about it from a ProFam Ambassador, one from other women in the community and one other had read the text on the rider's jacket. Women in Lira knew about the project from the riders, 2 respondents had heard information about it on the radio and 1 had heard about it from another woman at Lira Hospital. In Alebtong 2 out of 3 women had heard about the project from the ProFam clinic. The third heard about it on the radio.

3	Have you used one of the ETS riders to travel to the health centre? If yes, was it for delivery or to attend ANC? (numbers of each)	In 37 out of the 53 interviews there was at least one woman who had used one of the ETS riders. ANC x27 Delivery x26
4	How did you get the ETS riders contact numbers?	All mothers that had used the service got the contact details from the riders directly in Mubende. In Hoima most received the numbers from the ProFam Ambassadors, the one exception was from the Mary Maternity ProFam clinic. In Ibanda all the women who had the riders contact numbers received them from the riders themselves. The same was the case in Lira. In Alebtong the contact details came from the ProFam in 2 cases and from the rider in the third case.
5	Do you receive visits from Community Health Workers? Are they ProFam Ambassadors (PAs) of Village Health Team (VHTs)? Are they distributing the ETS contact numbers to women?	15 out of 53 interviews answered yes to this question. VHTs (Not sure understanding is there to differentiate between MAs and VHTs) Yes answered by one of the interviewees in Mubende and one in Ibanda. Not at all in Lira or Alebtong.
6	Do you use the SAME ETS rider for all pregnancy related visits to the health centre? Are you able to tell riders' names?	Of those that have used the riders, almost all do tend to use the same rider. Almost all respondents were able to name the riders that they use and these were cross referenced with our data.
7	Do any of the riders live in the village?	In Mubende, 2 out of 10 interviews said that there is at least one ETS rider that lives in their village. In Hoima, all respondents said that there was an ETS rider living in their village. The same for Ibanda and Lira. In Alebtong 2 out of 3 women stated that at least one ETS rider lived in their village.

	How far do they have to come when you contact them? How long does it take for them to reach you?	Mubende: between 0.5 and 4km Hoima: between 1 and 1.5km Ibanda: between 0 and 2km Lira: between 0 and 2km Alebtong: between 0.5 and 1km Mubende: between 10 and 20 minutes Hoima: between 3 and 30 minutes Ibanda: between 0 and 20 minutes Lira: between 2 and 15 minutes Alebtong: between 5 and 10 minutes
8	Does the rider demand payment up front or can you pay with credit?	In Mubende, many of the women answered that the riders seem to show some flexibility in terms of getting paid, with most accepting payment later. In Hoima it seems the riders are less flexible and demand payment upfront according to the majority of respondents. In Ibanda there was an even mix amongst respondents between riders who demanded cash up front and those that would accept payment later. The ETS riders in Lira on the whole seem to offer credit to the women that use their service to travel to the health centre. Most of them demand cash up front in Alebtong.
9	Rate your experience of using the ETS riders (bad, average or good). What improvements could be made to the project?	All respondents rated the service that ETS riders provide as good, with some emphasising that they also ride safely. Some pointed out (Ibanda & Lira) that they have recommended the riders to other women. One respondent also said that the riders are 'not too fast and careless like these other ones'. Only one suggestion, that riders be supplied with boots and raincoats as sometimes they refuse to take people when it's raining.
10	Any other comments or information?	Mama kits are too expensive. Women in Ibanda wanted more visits from health workers.

In terms of cross referencing information about payment each woman who had previously been transported by one of the ETS riders was asked the prices that the rider charges now, compared with those that he or she charged before project implementation. From this information the following calculation in reductions was made for each district.

Price reductions according to service users

District	Number of Interviews
Mubende	54% reduction
Hoima	14% reduction
Ibanda	28% reduction
Lira	38% reduction
Alebtong	34% reduction

Whilst the reductions vary hugely and may not represent a high level of accuracy, it is positive to learn that the perception is that prices have genuinely reduced. Whilst a 54% reduction in Mubende might not be realistic it represents a huge difference in affordability in many of the women that the project team spoke to. The following further positive comments were made during the collection of information from users of the service:

"Other riders who are not in the project would charge you 3 times and would not even wait for you at the clinic; we are benefiting a lot as women from this project."

"The Rider is very good he picked me up twice in the night without even a complaint."

"Very happy with the programme, the riders are safe and can be contacted at any time. They are not too fast and careless like these other ones."

6.3.2 Estimated 'Actual' Birth Rates

With a view to verifying the number of women transported as reported by the ETS riders, and to ensure that the totals were realistic, the project team calculated the expected number of births at a parish level, in order to estimate what proportion of pregnant women in a particular parish are benefiting from the ETS riders. This would allow the team to confirm that the data being collected is realistic.

Due to a lack of recent data, calculations were based on information from 2012, and then with the use of a projection tool, the information was adapted to reflect estimated populations for 2015. At the parish level, the project team were able to obtain 2012 population figures although there was no breakdown of this data. Therefore the data available at national level was applied at parish level in order to generate the number of estimated births in 2015. For example the proportion of women of childbearing age at a national level was 43.9%. In the absence of additional data this figure had to be applied at parish level to establish the number of women of childbearing age in each parish. In the same way, the proportion of women of childbearing age likely to give birth in 2015 (22%) again required applying the national average at a parish level.

In the table below, each of the parishes where the stages of ETS riders are based is listed. An assumption has been made that most if not all of the women transported are made within the parish in which the ETS rider is based.

Estimated number of births at Parish level.

District/Parishes	Female Population	Women of Child-bearing Age	No. of Births
MUBENDE DISTRICT			
Kabbo	7,703	3,381	1,009
Kasambya	5,942	2,609	778
Muyinayina	7,703	3,381	1,009
Kizibawo	5,282	2,319	692
Kitongo	6,052	2,657	793
Lwantale-Namiringa	5,392	2,367	706
Namabaale	5,832	2,560	764
Kawungera	7,263	3,188	951
Kayunga	4,181	1,836	548
Nsozinga	2,751	1,208	360
HOIMA DISTRICT			
Central Ward	10,894	4,782	1,052
Northern Ward	8,913	3,913	861
Western Ward	6,382	2,802	616
Karongo	3,851	1,691	372
Bulindi	5,612	2,464	542

IBANDA DISTRICT			
Nyakatokye	4,181	1,836	404
Kabaare	3,301	1,449	319
Bufunda	10, 234	4,493	988
Kagongo	6,382	2,802	616
Birongo	4,402	1,932	425
Kashozi	5,392	2,367	521
Nyantsimbo	6,602	2,898	638
Keihangara	5,832	2,560	563
Kihani	5,062	2,222	489
Rugaaga	5,832	2,560	563
Rwengwe	5,942	2,609	574
Kayenje	3,411	1,498	329
Nyamirima	4,732	2,077	457
Bwahwa	1,761	773	170
Bihanga	4,512	1,981	436
Kyengando	5,172	2,270	499
Rushango	4,181	1,836	404
LIRA DISTRICT			
Anyomerem	5,832	2,560	563
Ober	3,741	1,642	361
Bar Apwo	3,301	1,449	319

Anai	3,741	1,642	361
Kirombe	1,761	773	170
Lango Central	2,641	1,159	255
Omito	6,932	3,043	670
Ireda West	6,162	2,705	595
Senior Quarters	1,430	628	138
Ireda East	2,311	1,014	223
Ojwina Ward	7,263	,3,188	701
Kakoge	6,162	2,705	595
Railway Headquarters	660	290	64
Omito	1,981	870	191
Atang-Gwata	1,761	773	170
ALEBTONG DISTRICT			
Acede	4,402	1,932	425
Owalo	3,521	1,546	340
Olyet	2,751	1,208	266
Alal	5,172	2,270	499

Estimated project coverage

Districts (Active Parishes)	Total Estimated Births (One year)	Total Estimated Births (6 months)	Total Deliveries reported by ETS (6 months)	Coverage
Mubende	7,610	3,805	341	9%
Hoima	35,652	17,826	116	0.7%

Ibanda	8,375	4,187.5	381	9%
Lira	5,376	2,688	391	15%
Alebtong	1,530	765	45	6%

The table shows the proportion of pregnant women benefiting from the use of the ETS riders to travel for delivery in parishes where the project is active. Note that there are caveats to consider in making this calculation:

- It is assumed that the number of estimated births in 6 months is half of the total of estimated annual births, and therefore does not take into account any seasonal fluctuations.
- The project team have only included recorded data on women in labour using the ETS riders and not ANC.

As an estimate, the project is therefore currently reaching between 6 and 15% of women in the areas where riders are active. The one anomaly is Hoima district where coverage appears to be 0.7%. This is likely to be due to the fact that all but one of the ProFam Clinics are located within Hoima Town Municipality. Therefore the population is likely to be more concentrated, there is less need for transport as a greater proportion resides within easy reach of a health centre, and there is more wealth within the community and better access to other types of motor vehicles.

7. Conclusion

Affordability and availability constitute 2 dimensions relating to the accessibility to maternal healthcare services particularly pertinent to the issue of transport provision. The poor often either do not seek the use of maternal health services, or only do so when they can afford it. However, the reduction in out of pocket expenses through the provision of affordable transport has the potential to improve access to maternal health services.

Evidence points to the fact that the introduction of an emergency transport scheme using boda boda riders in five districts in Uganda is achieving its objective in providing affordable transport. The uptake of this service as exceeded expectations and the sustainable approach taken appears to be bearing fruit as boda boda riders start to see an increase in their earnings. This is reinforced by the positive perception of this project by pregnant women who have used the service and corroboration with ETS rider data that journey prices have reduced significantly and, as a by-product access to credit has increased.

The approach to this intervention has been one which maximises sustainability and promotes longevity through avoiding the dangerous precedents set by offering financial incentive to participants. By addressing transport providers as effectively people with their own businesses, the focus has been to grow their business over time, an approach which will result in an increase in their household income level, with benefits also being passed to pregnant women.

The challenges remain the role that the clinics and the ProFam Ambassadors play in supporting and promoting the project. At present, feedback demonstrates that the majority of users of the service know about the project through having been told about it by the riders themselves. With buy in from ProFam Ambassadors and the ProFam Clinics that they are associated with, there is a huge potential to increase both the clinics and the riders' client base.

Boda boda safety is quite rightly an increasing cause for concern in countries where boda bodas are widespread. Legislation to safeguard the riders and their passengers needs to be balanced with the absolute need that there is for this form of transport particularly in rural hard to reach communities. Training provision for boda boda riders needs to be more readily available at an affordable cost otherwise many of the more isolated communities face losing an essential means of transport.

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9. Annexes

9.1 Annex 1: ProFam Clinic assessment tool for Facility-based interviews

Date of Interview	
Name & Address of Clinic	
Location (Incl. distance & direction from main town)	Km:

Centre Manager & Contact Details	**Interviewee Name & Contact Details (if different)**
Name	Name
Telephone	Telephone
Email	Email

Clinic's Catchment Area	
Approx. Number of Villages	**Number and Names of Parishes**
Hardest to Reach Villages	

Clinic Details			
Average number of deliveries per month	**Delivery Charge**	**Average number of ante-natal class participants per month**	**Ante-natal charge**
	USH		USH
Stage that women present themselves to the clinic when in labour?		**Average number of classes that pregnant women attend**	
1st stage ☐			

2nd stage ☐	**Number of women who attend who then go on to deliver at the clinic?**	
	Do women have Birth Preparedness plans?	**Y / N**
	Does the plan mention Transport?	**Y / N**

Referral Practice

Referral Destination	**Referrals per month**	**Clinic's Transport Assets** Confirm whether the clinic has the means to transport patients, what type of transport they have and what it would cost the patient.	
		Bicycle ☐	Cost USH
Distance From Clinic to Referral Destination	Km	Boda Boda ☐	USH
Transport Means of Referral	**Cost to Patient** USH	Motorcar ☐	USH
		Other or None?	USH

Support and Outreach

No. of Maama Ambassadors →		**Maama Ambassador's Means of Travel**	**CBO Support** **Y / N**
Female	Male	None ☐	**CBO Name**
Names & Contact details		Walking ☐	
		Bicycle ☐	**CBO Representatives**
		Boda Boda ☐	Name Telephone
		Other	Name Telephone

Any other comments of useful information?

9.2 Annex 2: Community-based assessment tool for focus group discussions

Date of Interview	
Location (Incl. distance from town)	Km:

Number of people spoken to?		**Nearest ProFam?**		**Nearest Clinic?**		**Most frequently used clinic?**	
F	M	Name	Km	Name	Km	Name	Km (if different)
Distance from house to village hub/centre?		**Road Type: ProFam to village? % of each.**		**Road Type: Nearest clinic to village? % of each.**		**Road Type: Most frequently used clinic to village? % of each.**	
Km		Hilly	Poor	Hilly	Poor	Hilly	Poor
Birth preparedness plans?	**Does it mention transport?**	Undulating	Fair	Undulating	Fair	Undulating	Fair
Y / N	Y / N	Flat	Good	Flat	Good	Flat	Good
		Road Surface i.e. compacted earth, mud, sand, gravel, tarmac etc.		**Road Surface** i.e. compacted earth, mud, sand, gravel, tarmac etc.		**Road Surface** i.e. compacted earth, mud, sand, gravel, tarmac etc.	

What proportion of women in the village, deliver their children at home instead of travelling to the nearest health clinic?

What would most women's preference be?

If travelling to the clinic at what stage of labour do you consider arranging transport?

Early/late/1st, 2nd or 3rd phase?

At what stage of labour would you expect to arrive at the health clinic? Why?

This question tries to establish what the delay is, whether its transport related, or whether it's a delay that occurs prior to travel.

What types of transport are there available to you locally and how many of each?

i.e. Ox carts/bicycles/boda bodas/taxis/private car etc.

In the village:	Passing by (and how frequently does it pass?)

What type of transport would households use in an emergency?

i.e. if someone needed to reach the health facility.

How long does the journey take to get to the health clinic for different modes of transport?

How would you contact the available emergency transport to make the journey

i.e. would you have to walk far to arrange it/can you telephone/is it something your husband has to do?

Do you have a telephone? If not can you/do you borrow one if you need to?

Is there a charge for borrowing someone's telephone?

How much would a single journey cost?

And how does it vary in price according to different factors?

Emergency USH	Non-Emergency USH
Day USH	Night USH
Dry weather USH	Wet weather USH

How would you pay and WHO pays?

i.e. payment up front/in kind/by borrowing money/savings? Does the husband have to pay for the journey?

Are there savings groups within the village and are you a member?

Details on membership and what the money is used for that is saved.

If not a member do you save within the household?

Do women have access to this money?

Is the journey to the Health Clinic influenced by seasonal factors? If so in what way?

e.g. Cost, availability, road accessibility, journey time etc.

Who owns the different types of available transport?

Are transport operators organised into groups and/or unions?

Are there skills in the village and spare parts available needed to repair each transport mode. If not how close can skills and spare parts be found?

Any other comments or useful information?

9.3 Annex 3: ETS Riders

9.3.1 Mubende District

9.3.1.1 Mirembe Maria and Bangi Clinics

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Kassanda (Mirembe)	Kitongo	Ssebulime	Gerard	0703 495048	0703 495049
Kassanda (Mirembe)	Kitongo	Ssebbaarle	Charles	0775 352043	
Kassanda (Mirembe)	Kitongo	Musinguzi	Willy	0755 462441	
Kassanda (Mirembe)	Kitongo	Sokonwagi	Robert	0750 606184	0777 139186
Kassanda (Mirembe)	Kitongo	Kaliisa	Noah	0783 073556	
Kassanda (Mirembe)	Kitongo	Semugera	Gerard	0754 927569	0754 927509
Kassanda (Bangi)	Kitongo	Sekate	Akim	0756 866828	0789 116924
Kassanda (Bangi)	Kitongo	Ssekikubu	Matta	0705 668139	
Kassanda (Bangi)	Kitongo	Kasangwa	Steven	0755 894797	0775 394797
Kassanda (Bangi)	Kitongo	Masembe	John	0757 257797	
Kassanda (Bangi)	Kitongo	Muyanja	Livingstone	0788 308813	0751 868531
Kassanda (Bangi)	Kitongo	Kizza	Akileo	0770 170002	0774 170002
Kassanda (Bangi)	Kitongo	Baguma	Haruna	0757 503878	
Kassanda (Bangi)	Kitongo	Sempala	John	0756 012805	0756 438533
Kassanda (Bangi)	Kitongo	Sevume	Frank	0754 359903	0784 349981
Kassanda (Bangi)	Kitongo	Ssemango	Jackson	0754 516220	
Kassanda (Bangi)	Kitongo	Kagere	Evaristo	0752 938269	
Namabaale (Mirembe	Namabaale	Owinji	James	0755 733346	
Namabaale (Mirembe	Namabaale	Tusenge	Emmanuel	0753 773509	
Namabaale (Mirembe	Namabaale	Kato	Mutumba	0753 121642	
Namabaale (Mirembe	Namabaale	Semande	Muhamoni	0755 364845	
Nanula (Mirembe)	Lwantale/Namirin	Sempi	Dan	0755 158342	
Nanula (Mirembe)	Lwantale/Namirin	Sekteme		0749 090491	
Mirembe (Mirembe)	Lwantale/Namirin	Anonymous		0780 249253	
Seeta (Bangi)		Ssebuma	Jackson	0773 220338	
Seeta (Bangi)		Semuyaba	Francis	0772 057693	

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Seeta (Bangi)		Lubowa	Ivan	0754 649498	
Makonzi (Bangi)		Semiko	Musa	0756 655752	0771 871701
Masooli (Bangi)		Lukandwa Katend	Assan	0753 871960	
Masooli (Bangi)		Senabulya			
Masooli (Bangi)		Sematiko			

	Rider has left the project since our last visit
	Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)
	Chair's of their stages (possible mobilisation role)
	New ETS rider

9.3.1.2 Matia Mulumba Health Centre

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Katwe	Muyinayina/Kirolero	Byaruhanga	Francis	0703 216053	0775 304578
Katwe	Muyinayina/Kirolero	Kamanzi	Fraim	0752 519403	
Katwe	Muyinayina/Kirolero	Nsabimaana	Pius	0757 146572	
Katwe	Muyinayina/Kirolero	Maniraguha	Nesta	0705 038281	0784 437927
Katwe	Muyinayina/Kirolero	Kajongobe	Ramanzani	0788 412332	
Nkuruma	Kabbo	Segawa	Ibrahim	0774 572891	
Nkuruma	Kabbo	Bagalazimbye	Hassan	0757 611713	
Nkuruma	Kabbo	Kiruta	Ismail	0776 237321	0781 963942
Nkuruma	Kabbo	Kakande	Kasimu	0787 635150	0754 171517
Nkuruma	Kabbo	Kirumira	Hamuza	0779 075149	
Nkuruma	Kabbo	Kalute	Sukulu	0752 547494	
Nkuruma	Kabbo	Kamulegeya	Sulaiman	0785 099960	0777 624333
Nkuruma	Kabbo	Mwesige	Adam	0789 401341	
Kasambya	Kasambya	Musisi	Wilberforce	0774 118799	0756 130246
Kasambya	Kasambya	Mwejje	David	0750 150846	
Kasambya	Kasambya	Kiseka	Perez	0785 852007	
Kasambya	Kasambya	Amiri	Ssentongo	0779 862535	
Lyembogo	Muyinayina/Kirolero	Kamazi	Fulayimo	0755 463586	
Lusana	Kabbo	Ronard		0788 179841	
Lusana	Kabbo	Mugabe	Robert	0783 438447	

	Rider has left the project since our last visit
	Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)
	Chair's of their stages (possible mobilisation role)
	New ETS rider

9.3.1.3 Kitokolo Health Centre

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Kitokolo	Kizibawo	Lubega	Gerard	0788 367150	
Kitokolo	Kizibawo	Kazibwe	John	0783 106260	
Kitokolo	Kizibawo	Nkaka	Ssentongo	0759 206523	0775 206523
Kitokolo	Kizibawo	Kadugu		0784 236414	
Kassanda	Kitongo	Kasujja	James	0759 718448	
Kassanda	Kitongo	Kiwanuka	Nathan	0789 633071	0784 630671
Kassanda	Kitongo	Kilyowa	Godfrey	0757 488909	
Namiryango	Namiryango	Kyemwa	Gonzaga	0785 866169	
Namiryango	Namiryango	Ssebuufu	Gerard	0774 642968	0785 790805
Buyambe	Kizibawo	Kamugisha	Edward		
Kilyanongo		Mweside	Julius	0755 97081?	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.1.4 Mutungo Nursing Home

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Katwe	Muyinayina/Kirolero	Byaruhanga	Francis	0703 216053	0775 304578
Katwe	Muyinayina/Kirolero	Kamanzi	Fraim	0752 519403	
Katwe	Muyinayina/Kirolero	Nsabimaana	Pius	0757 146572	
Katwe	Muyinayina/Kirolero	Maniraguha	Nesta	0705 038281	0784 437927
Katwe	Muyinayina/Kirolero	Kajongobe	Ramanzani	0788 412332	
Nkuruma	Kabbo	Segawa	Ibrahim	0774 572891	
Nkuruma	Kabbo	Bagalazimbye	Hassan	0757 611713	
Nkuruma	Kabbo	Kiruta	Ismail	0776 237321	0781 963942
Nkuruma	Kabbo	Kakande	Kasimu	0787 635150	0754 171517
Nkuruma	Kabbo	Kirumira	Hamuza	0779 075149	
Nkuruma	Kabbo	Kalute	Sukulu	0752 547494	
Nkuruma	Kabbo	Kamulegeya	Sulaiman	0785 099960	0777 624333
Nkuruma	Kabbo	Mwesige	Adam	0789 401341	
Kasambya	Kasambya	Musisi	Wilberforce	0774 118799	0756 130246
Kasambya	Kasambya	Mwejje	David	0750 150846	
Kasambya	Kasambya	Kiseka	Perez	0785 852007	
Kasambya	Kasambya	Amiri	Ssentongo	0779 862535	
Lyembogo	Muyinayina/Kirolero	Kamazi	Fulayimo	0755 463586	
Lusana	Kabbo	Ronard		0788 179841	
Lusana	Kabbo	Mugabe	Robert	0783 438447	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.3 Ibanda District

9.3.3.1 Mary's Domiciliary Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Nyabuhikye	Kayenje	Abimanya	Timothy	0750 655024	0752 877275
Nyabuhikye	Kayenje	Barigye	Pius	0775 250621	
Nyabuhikye	Kayenje	Nuwagira	Francis	0773 948139	0751 720917
Nyabuhikye	Kayenje	Bainomugisha	Herbert	0781 883144	0700 961135
Nyabuhikye	Kayenje	Ssebata	Hadadi	0781 223306	
Nyabuhikye	Kayenje	Katungye	Christopha	0783 386840	0778 462749
Nyabuhikye	Kayenje	Bwengye	Samson	0758 737619	
Nyabuhikye	Kayenje	Agaba	Jevunali	0751 720917	0752 877275
Katongore	Rwengwe	Tushabirane	Felex	0752 612471	0784 612471
Katongore	Rwengwe	Twizukye	Edimoni	0777 681957	
Katongore	Rwengwe	Nahwera	Robinson	0756 351068	0778 290365
Katongore	Rwengwe	Barikitenda	Bright	0775 661598	
Katongore	Rwengwe	Abenaitwe	Steven	0751 761100	
Katongore	Rwengwe	Katorogo	Posiano	0753 555574	
Katongore	Rwengwe	Musunguzi	Edson	0703 595449	0716 944985
Rwomuhoro	Rwengwe	Twekiyerizi	Innocent	0781 073729	0782 881253
Rwomuhoro	Rwengwe	Karuhaga	Debonanto	0757 140865	
Rwomuhoro	Rwengwe	Atwijukyire	Wise	0778 400795	
Rwomuhoro	Rwengwe	Nuwagaba	Innocent	0789 966960	0782 853875
Rwomuhoro	Rwengwe	Nigye	John Bosco	0754 677670	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.3.2 Igorora Health Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Kajwamusana	Rugaaga	Ahabwe	Moses	0783 715650	0758 049729
Kajwamusana	Rugaaga	Beinomugisha	Albert	0785 058118	
Kajwamusana	Rugaaga	Amutuhauri	Deo	0754 733301	
Keihangara	Keihangara	Atukunda	Godfrey	0787 397770	
Keihangara	Keihangara	Mucunguzi	Robert	0757 607753	
Keihangara	Keihangara	Atuhaire	Lopez (F)	0777 116900	
Keihangara	Keihangara	Kitengye	Geoffrey	0703 969410	
Embaho	Keihangara	Amutuhaire	Godfrey	0750 028479	
Omukagyera	Nyamirima	Ndyabahika	Innocent	0782 271858	0754 271858
Omukagyera	Nyamirima	Kiiza	Milliton	0772 393473	
Omukagyera	Nyamirima	Amanya	Vanpersie	0776 327518	
Omukagyera	Nyamirima	Twinomugisha	Julius	0774 537330	
Nyamnyobwa	Rugaaga	Tayebwa	Medard	0783 758080	
Katunguru	Kihani	Mpumwire	Ronard	0752 256559	

Rider has left the project

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.3.3 St Joseph's Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Rushango	Rushango	Tukwatsibwe	Aloni	0756 014150	
Rushango	Rushango	Kiiza	Robert	0757 110397	
Rushango	Rushango	Asiimwe	John	0750 750918	
Rushango	Rushango	Twebaze	Joseph (Byara)	0756 932002	
Rushango	Rushango	Barugahare	Elias	0756 930507	
Rushango	Rushango	Gumisiriza	Gerard	0758 084475	
Rushango	Rushango	Hakorimaana	Edward	0755 425645	0773 936963
Rushango	Rushango	Sunday	Fred	0755 598227	
Rushango	Rushango	Turyahabwe	Amuza	0755 716093	
Rushango	Rushango	Kishua	Felix	0756 313978	0754 625334
Rushango	Rushango	Nsheija	Patrick	0757 340691	0772 908002
Rushango	Rushango	Bunani	Evaristo	0754 286513	
Kanyarugiri	Bihanga	Niyonzima	Apollo	0756 311000	
Kanyarugiri	Bihanga	Munanura	Amon	0755 160412	
Kanyarugiri	Bihanga	Tumuranye	Bright	0744 928766	
Kanyarugiri	Bihanga	Mujuni	Sainioni	0753 100837	
Kanyarugiri	Bihanga	Kamugisha	Kenneth	0757 733179	
Kanyarugiri	Bihanga	Gumisiriza	R	0753 558892	
Kanyarugiri	Bihanga	Tukamuhebwa	Innocent	0757 690102	0771 690102
Kanyarugiri	Bihanga	Ndinawe	Emmanuel	0771 814480	
Kanyarugiri	Bihanga	Mutembuzi	Hassan	0783 928520	
Kanyarugiri	Bihanga	Kyomukama	Silva	0787 571957	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.3.4 Ibanda Central

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Kigarama	Bufunda	Katurebe	Frank	0784 826603	
Kigarama	Bufunda	Atwebe	Alex	0773 450368	
Kigarama	Bufunda	Twehayo	Pius	0783 516556	
Kigarama	Bufunda	Sunday	Wilfred	0777 020410	
Omukatoma	Bwahwa	Mukasa	Gerald	0757 701252	
Omukatoma	Bwahwa	Musinguzi	Robert	0787 083785	0787 083385
Omukatoma	Bwahwa	Bogere	Bernard	0771 648633	
Kagongo	Kagongo	Tumuhaise	Jackson	0784 340043	
Kagongo	Kagongo	Sunday	Innocent	0773 079794	0778 131508
Kagongo	Kagongo	Turyahabwe	Denis	0777 356596	
Kagongo	Kagongo	Mugume	Leonard	0787 546478	
Kagongo	Kagongo	Mwesigye	Francis	0771 835351	0756 980326
Kagongo	Kagongo	Twaha	Kayima	0777 528949	
Kagongo	Kagongo	Ndahula	Vincent	0755 327371	0752 34179?
Kagongo	Kagongo	Muchunguzi	Julius	0786 444543	
Kagongo	Kagongo	Kazahura	Naboth	0788 530408	

Rider has left the project

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.3.5 Ibanda Medical Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Kagongo	Kagongo	Guma	Robert	0772 936749	
Kagongo	Kagongo	Murisa	Coruman	0788 260010	
Kagongo	Kagongo	Mucunguzi	Nicholas	0777 289613	
Kagongo	Kagongo	Turyahabwe	Denis	0777 356596	
Kagongo	Kagongo	Bakesiima	Ambrose	0789 306015	
Kagongo	Kagongo	Gumisiriza	Sadam	0784 555668	
Omukagano	Kagongo	Kazara	Robert	0752 601645	
Omukagano	Kagongo	Bagarukayo	Robert	0787 531285	
Omukagano	Kagongo	Kazahura	Maboti	0778 761484	
Omukagano	Kagongo	Rugarwana	George	0753 883402	
Bunya	Nyakatokye	Mbuza	Edison	0775 746796	

	Rider has left the project
	Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)
	Chair's of their stages (possible mobilisation role)
	New ETS rider

9.3.3.6 Busingye Clinic

Stage Location		ETS Rider		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Kyenkanga	Birongo	Tumwine	Job	0750 400462	0776 373771
Kyenkanga	Birongo	Musasizi	Edson	0756 320663	
Kyenkanga	Birongo	Mucunguzi	Caleb	0786 810016	
Kyenkanga	Birongo	Muganzi	Roman	0750 023472	0754 792144
Kyenkanga	Birongo	Mwebembezi	E	0757 532526	0753 940003
Kyenkanga	Birongo	Nuwagaba	Godfrey	0783 512743	
Kyenkanga	Birongo	Nsubuga	Emmanuel	0756 403345	0777 858289
Kyenkanga	Birongo	Arinaitwe	Jamson	0752 158262	
Kyenkanga	Birongo	Akatwijuka	Gaston	0789 088355	
Kyenkanga	Birongo	Nimbimusiimira	Justus	0775 948402	0788 062668
Kyenkanga	Birongo	Bagarukayo	Apollo	0785 236771	
Kyenkanga	Birongo	Mujuni	Gilivazio	0752 981428	
Kyenkanga	Birongo	Byamukama	Geoffrey	0777 338598	
Kambendyaho	Nyantsimbo	Karugaba	Johnson	0759 991200	0779 991200
Kambendyaho	Nyantsimbo	Twinomugisha	Godfrey	0776 689913	0754 689913
Kambendyaho	Nyantsimbo	Byarugaba	Wilson	0783 034404	0788 420250
Kambendyaho	Nyantsimbo	Balikudembe	Mukasa	0778 719012	0758 211991
Kambendyaho	Nyantsimbo	Nuwagaba	Samson	0787 867162	0777 576819
Kambendyaho	Nyantsimbo	Bansigara	Edson	0777 925440	
Kambendyaho	Nyantsimbo	Ngabirano	Matthew	0757 395465	
Kambendyaho	Nyantsimbo	Twesigye	Denis	0786 789611	0786 941780
Kabaare	Kabaare	Musiime	Abias	0783 917755	
Kabaare	Kabaare	Niwabiine	Alex	0783 063437	
Kabaare	Kabaare	Tindyebwa	Osbert	0779 836010	0779 836110
Kabaare	Kabaare	Muhereza	Rodgers	0756 911380	
Kabaare	Kabaare	Mwzoora	Elias	0784 555191	
Kabaare	Kabaare	Nyangirwe	Asumani	0789 391179	
Katengyeto	Kashozi	Shaban	Ganshanga	0754 499281	

Stage Location		ETS Rider		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Katengyeto	Kashozi	Muwagaba	Alex	0778 946215	
Katengyeto	Kashozi	Tumusiime	Michael	0775 813972	
Katengyeto	Kashozi	Twinomugisha	Rodson	0750 798338	0777 878967
Katengyeto	Kashozi	Singura	Abroze	0784 018313	
Katengyeto	Kashozi	Twinamatsiko	Amon	0753 746010	0777 844845
Katengyeto	Kashozi	Kanusime	Jamson	0781 221971	
Katengyeto	Kashozi	Ahimbsibwe	Gerard	0753 986076	
Katengyeto	Kashozi	Kajungu	Wilburforce	0782 490544	
Katengyeto	Kashozi	Tweheyo	Benson	0755 495856	
Katengyeto	Kashozi	Tumuhise	Felix	0758 519894	0758 590894
Katengyeto	Kashozi	Baran	Esau	0755 911071	
Katengyeto	Kashozi	Musunguzi	G	0787 151330	
Katengyeto	Kashozi	Niwagaba	Gardinho	0779 242560	
Katengyeto	Kashozi	Tumwekwase	Rashid	0789 292830	
Kiburara	Nyantsimbo	Nuwajika	Samuel	0777 880729	
Kiburara	Nyantsimbo	Nshija	Johnson	0754 107381	
Kiburara	Nyantsimbo	Kamugisha	Albert	0752 558691	
Kiburara	Nyantsimbo	Mugisha	Hillary	0779 926955	
Kiburara	Nyantsimbo	Biyaruhanga	Edson	0776 747402	
Kiburara	Nyantsimbo	Akeddi	Kenneth	0750 028454	
Kiburara	Nyantsimbo	Mpakaniye	Crispus	0758 204183	
Kiburara	Nyantsimbo	Kobushashe	Naftari	0758 774243	
Atanamunana		Kaiwarire	Moses	0758 663413	
Nyakabungo	Kyengando	Kajungu	Mohammed	0782 970617	

Rider has left the project

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.4 Lira District

9.3.4.1 Lira Medical Centre

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Labour Line	Railway Quarters	Acuma	Charles	0752 697536	
Labour Line	Railway Quarters	Okullo	Sam	0785 091852	
Labour Line	Railway Quarters	Ekam	Bosco	0783 199891	
Labour Line	Railway Quarters	Odongo	Peter	0777 036726	
Labour Line	Senior Quarters	Ogwang	Alex	0773 659181	
Municipal Stage	Kirombe	Opio	Leonard	0751 651687	
Municipal Stage	Kirombe	Ogolo	Moses	0787 974829	
Municipal Stage	Kirombe	Ojok	Isaac	0773 881151	
Municipal Stage	Kirombe	Omara	Emmanuel	0785 96311	
Municipal Stage	Kirombe	Omudo	Ronald	0776 119408	
Te-olam	Ireda East	Ogom	Jasper	0777 805190	
Te-olam	Ireda East	Ogwal	Solomon	0788 719584	
Te-olam	Ireda East	Okoo	Peter	0777 569734	
Te-olam	Ireda East	Ogwang	Ronald	0787 686271	
Te-olam	Ireda East	Otira	Kenneth	0778 440203	0756 020544
Corner Kamdini	Lango Central	Ocen	George	0788 240888	
Corner Kamdini	Lango Central	Odongo	Francis	0772 714362	
Corner Kamdini	Lango Central	Opio	Felix	0787 357553	0778 699579
Corner Kamdini	Lango Central	Opio	Lameck	0773 896812	
Corner Kamdini	Lango Central	Bua	Tonny	0788 732421	
Lira Medical Centre	Ireda East	Otim	Sam	0782 374802	0774 464849
Lira Medical Centre	Ireda East	Okullo	Moses	0774 138849	0754 138849

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.4.2 Downtown Medical Centre

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Odokomit	Omito	Ayoo	Moses	0786 664763	
Odokomit	Omito	Okello	Kenneth	0772 714646	
Odokomit	Omito	Ocen	Jimmy	0785 905532	0786 627301
Odokomit	Omito	Adonyo	Emma	0778 109128	0753 332322
Odokomit	Omito	Oguta	Walter	0775 667656	
Te-cwao	Kirombe	Opaka	Geoffrey	0784 246229	
Te-cwao	Kirombe	Ocen	Obote	0789 018084	
Te-cwao	Kirombe	Atepo	Sam	0774 602626	
Te-cwao	Kirombe	Oyaka	Alex	0789 025211	
Te-cwao	Omito	Okullo	Sam	0773 119810	
Te-cwao	Omito	Omara	Bernard	0776 708460	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.4.3 Ayira Health Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Akwoyo	Kirombe	Moro	Charles	0776 902442	
Akwoyo	Kirombe	Bapa	Sam	0779 474263	
Akwoyo	Kirombe	Ogwok	Denis	0775 652225	
Akwoyo	Kirombe	Ojok	Luka	0775 487603	
Akwoyo	Kirombe	Okello	Jimmy	0784 003974	
Alir	Omito (Adyei)	Ogwal	Emmanuel	0782 481941	0759 494157
Alir	Omito (Adyei)	Obong	David	0774 189472	0774 189470
Alir	Omito (Adyei)	Adupa	Richard	0771 084997	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.4.4 Aduku Road Maternity Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Anai Pida	Anai	Emwony	Patrick	0782 314790	
Anai Pida	Anai	Okuma	Sunday	0774 199602	
Anai Pida	Anai	Ekwaro	Andrew	0771 642784	
Anai Pida	Anai	Ewai	Kenneth	0779 611184	
Anai Pida	Anai	Ogwang	Ivan	0774 213041	0752 790175
Central Park	Ireda East	Oleke	Walter	0789 780662	
Corner Kagoge	Kakoge	Okidi	Sam	0775 711150	
Corner Kagoge	Kakoge	Adyel	Moses	0773 808431	
Corner Kagoge	Kakoge	Ogwal	Alfred	0774 019350	
Corner Kagoge	Kakoge	Omung	Thomas	0789 282296	
Corner Kagoge	Kakoge	Malinga	Patrick	0777 111865	
Corner Kagoge	Kakoge	Okello	Geoffrey	0775 985062	
Corner Kagoge	Kakoge	Onguu	Kenneth	0783 437499	
Lumumba	Ireda East	Akora	Sam	0775 887197	
Lumumba	Ireda East	Elem	Patrick	0787 714824	
Lumumba	Ireda East	Omara	Walter	0779 343033	
Lumumba	Ireda East	Onyanga	Ronald	0773 593719	
Lumumba	Ireda East	Opio	Tonny	0773 659063	
Obanga Pe Wany	Ireda West	Agea	Jasper	0778 204922	
Obanga Pe Wany	Ireda West	Ongom	Leo	0774 751947	
Obanga Pe Wany	Ireda West	Okello	Felix	0784 803251	
Obanga Pe Wany	Ireda West	Ali	Ousman	0772 875356	
Okot Ogona	Ireda West	Ogwang	Alex	0787 567806	
Okot Ogona	Ireda West	Edonga	Thomas	0778 926060	
Okot Ogona	Ireda West	Okabo	Shaban	0783 191369	
Okot Ogona	Ireda West	Odongo	Nixon	0788 839904	
Rainbow	Kakoge	Olung	Geoffrey	0773 943699	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.4.4 Charis Health Centre

Stage Location		ETS Rider		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Omodo	Anai	Ogwang	Bonny	0772 001900	
Omodo	Anai	Obong	Musa	0773 806683	
K.C.B	Bar Apwo	Oloya	Felix	0772 720074	
K.C.B.	Bar Apwo	Eding	Isaac	0775 874443	
K.C.B.	Bar Apwo	Aluka	Isaac	0773 394631	
K.C.B.	Bar Apwo	Miromi	David	0751 688683	
K.C.B.	Bar Apwo	Ogwang	Denis	0782 489344	
K.C.B.	Bar Apwo	Ojok	Isaac	0785 577240	
K.C.B.	Bar Apwo	Otuo	Diken	0783 648700	
Kakoge	Kagoge	Obote	James	0775 459594	
Ober	Anyomerem	Ocen	Dickens	0777 614031	
Ober	Anyomerem	Ogwul	George	0774 304786	
Ober	Anyomerem	Omara	Alex	0778 850646	
Ober Kampala	Ober	Olubi	Nelson	0782 590075	
Te-cuk	Atang-gwata	Obala	Moses	0771 675348	
Te-cuk	Atang-gwata	Bampiga	Francis	0774 717999	
Te-cuk	Atang-gwata	Odero	Ronald	0778 399620	
Te-cuk	Atang-gwata	Odero	Mark	0777 778053	
Gombola Lira	Ojwina Ward	Okwir	Moses	0771 674440	
Gombola Lira	Ojwina Ward	Okello	Secondo	0782 788208	
Gombola Lira	Ojwina Ward	Odea	James	0786 856507	
Gombola Lira	Ojwina Ward	Apita	Patrick	0772 361869	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.3.5 Alebtong District

9.3.5.1 Ocan Community Clinic

Stage Location		ETS Riders		Contact Details	
Stage	**Parish**	**Name 1**	**Name 2**	**Tel. Number 1**	**Tel. Number 2**
Amukaola	Owalo	Apet	James	0773 624104	
Acede	Acede	Ofim	Robert	0781 878477	
Adagani B	Olyet	Agetta	Sam	0773 222329	
Anino	Alal	Awan	Walter	0781 144066	
Anino	Alal	Awany	C.P.	0786 438718	
Ogengo	Alal	Okello	Gilbert	0782 275900	0788 697555
Dargo	Alal	Opio	Geoffrey	0783 419540	
Anyoi A	Alal	Opio	Geoffrey	0786 950549	
Anyoi A	Alal	Okello	Bonny	0787 964892	
Anyoi A	Alal	Odongo	Jasper	0779 615631	

Rider has left the project since our last visit

Nominated Focal ETS Riders - 1 per stage (Monthly data collection responsibility)

Chair's of their stages (possible mobilisation role)

New ETS rider

9.4 Annex 4: ProFam Ambassador Sensitisation

Workshop Agenda	
Welcome	Sign in and update contact details sheet
Presentation	Introduction to the project ▪ Introduction to Transaid ▪ Aims & objectives of this project ▪ What is ETS? ▪ Questions and answer session
Discussion	Roles & responsibilities ▪ Mama Ambassadors present role ▪ CBOs responsibility for Mama Ambassadors ▪ Mama Ambassador's role for this activity ▪ ProFam Clinic's role for this project ▪ Questions and answer session
LUNCH	
Presentation & Discussion	Sensitisation of boda bodas ▪ Introduction to the ETS. ▪ What is expected of boda boda riders. ▪ Their role in their communities. ▪ The importance of quick, safe and affordable transport. ▪ Safety while riding and riding with a pregnant woman. ▪ Basic understanding of care of pregnant women (non-medical, basics)
Practical and Discussion	▪ Monitoring and support
Discussion	▪ Recap on today's training with questions and answers.

9.5 Annex 5: ETS Rider Data Collection Tool

Location	ETS Riders		Contact Details		Month/Year						
Stage	Name 1	Name 2	Tel. Number 1	Tel. Number 2	No. of Women Transported	ANC/Delivery/ Illness	To Which Clinic	From Which Village	Distance (km)	Cost of Trip (USH)	Usual Cost (USH)

Totals				

9.6 Annex 6: Nominated 'Focal Riders'

9.6.1 Mubende District

9.6.1.1 Mirembe Maria & Bangi Clinics

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Masembe	John	Kassanda	0757 257797	Sokonwagi	Robert
				Kasangwa	Steven
				Sekate	Akim
				Ssebulime	Gerard
				Ssebbaarle	Charles
				Sempala	John
				Musinguzi	Willy
				Masembe	John
Baguma	Haruna	Kassanda	0757 503878	Kizza	Akilendo
				Muyanja	Livingstone
				Semugera	Gerard
				Sevume	Frank
				Kaliisa	Noah
				Baguma	Haruna
Owinji	James	Namabaale	0755 733346	Tusenge	Emmanuel
				Semanda	Muhamoni
				Owinji	James

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Sempi	Dan	Nanula	0755 158342	
Sekteme		Nanula	0750 090491	
Ssebuma	Jackson	Seeta	0773 220338	
Semuyaba	Francis	Seeta	0772 057693	
Lubowa	Ivan	Seeta	0754 649498	
Kagere	Evaristo	Makonzi	0752 938269	
Semiko	Musa	Makonzi	0756 655752	0771 871701
Ssemango	Jackson	Makonzi	0754 516220	
Lukandwa	Assan	Masooli	0753 871960	

9.6.1.2 Matia Mulumba Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Nsibuka	Rashid	Kiganda	0702 985355	Mutyaba	Sula
				Matovu	Hamidu
				Byekwaso	Deo
				Musaazi	Zedde
				Sebanja	Joseph
				Nsibuka	Rashid
Mulinde	Adamu	Nakiganda	0756 959788 0782 959788	Jingo	Joseph
				Ssemwogerere	Edward
				Jeselo	Robert
				Keeya	John
				Mulinde	Adamu
Mayanja	Fred	Kalamba	0704 885454	Ssenabulya	Christopher
				Semakula	Godfrey
				Ssembule	Peter
				Kagwa	Andrew
				Nyenge	Isima
				Mayanja	Fred
Kalasi	Sazili	Nsozinga	0702 291714	Kiddu	Sulayetu
				Kafeelo	Paul
				Kalumba	Akamada
				Kalasi	Sazili
Golden	Msimbe	Kalagi	0705 054025	Msimbe	Golden

9.6.1.3 Kitokolo Health Centre

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Kasujja	James	Kassanda	0759 718448	Lubega	Gerard
				Kiwanuka	Nathan
				Kilyowa	Godfrey
				Kasujja	James
Nkaka	Ssentongo	Kitokolo	0759 206523 0775 206523	Kazibwe	John
				Kyemwa	Gonzaga
				Sebufu	Gerard
				Nkaka	Ssentongo

9.6.1.4 Mutungo Nursing Home

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Segawa	Ibrahim	Nkuruma	0774 572891	Kamulegeya	Sulaymani
				Kiruta	Ismail
				Kirumira	Hamuza
				Bagalazimbye	Hassane
				Kakande	Kasimu
				Kalute	Sukulu
				Segawa	Ibrahim
Maniragulia	Nesta	Katwe	0705 038281 0784 437927	Kamanzi	Fraim
				Kajongobe	Ramanzani
				Byaluhanga	Francis
				Maniragulia	Nesta

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Mugabe	Robert	Lusana	0783 438447	
Kamazi	Fulayimo	Lyembogo	0755 463586	
Musisi	Wilberforce	Kasambya	0774 118799	0756 130246
Mwejje	David	Kasambya	0750 150846	
Kiseeka	Perez	Kasambya	0785 852007	

9.6.2 Ibanda District

9.6.2.1 St Marys Domiciliary Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	**Name 2**	**Stage**	**Telephone No.**	**Name 1**	**Name 2**
Nuwagira	Francis	Nyabuhikye	0773 948139 0751 720917	Abimanya	Timothy
				Barigye	Pius
				Bainomugisha	Herbert
				Ssebata	Hadadi
				Katungye	Christopha
				Bwengye	Samson
				Agaba	Jevunali
				Nuwagira	Francis
Tushabirane	Felex	Katongore	0752 612471 0784 612471	Twizukye	Edimoni
				Nahwera	Robinson
				Barikitenda	Bright
				Abenaitwe	Steven
				Katorogo	Posiano
				Musunguzi	Edson
				Tushabirane	Felex
Nuwagabe	Innocent	Rwomuhoro	0789 966960	Twekiyerizi	Innocent
				Karuhaga	Debonanto
				Atwijukyire	Wise
				Nigye	John Bosco
				Nuwagabe	Innocent

9.6.2.2 Igorora Health Centre

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Mucunguzi	Robert	Keihangara	0757 607753	Ahabwe	Moses
				Beinomugisha	Albert
				Amutuhauri	Deo
				Mucunguzi	Robert
Atuhaire	Lopez (F)	Keihangara	0777 116900	Kitengye	Geoffrey
				Mpumwire	Ronard
				Amutuhaire	Godfrey
				Atuhaire	Lopez
Ndyabahika	Innocent	Omukagyera	0782 271858 0754 271858	Kiiza	Milliton
				Tayebwa	Medard
				Twinomugisha	Julius
				Ndyabahika	Innocent

9.6.2.3 Ibanda Medical Centre

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Guma	Robert	Kagongo	0772 936749	Gumisiriza	Sadam
				Turyahabwe	Denis
				Bakesiima	Ambrose
				Guma	Robert
Kazara	Robert	Kagano	0752 601645	Bagarukayo	Robert
				Rugarwana	George
				Kazara	Robert

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Mbuza	Edison	Bunya	0775 746796	

9.6.2.4 St Joseph's Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	**Name 2**	**Stage**	**Telephone No.**	**Name 1**	**Name 2**
Hakorimaana	Edward	Rushango	0755 425645 0773 936963	Kiiza	Robert
				Asiimwe	John
				Twebaze	Joseph
				Barugahare	Elias
				Gumisiriza	Gerard
				Sunday	Fred
				Turyahabwe	Amuza
				Kishua	Felix
				Nsheija	Patrick
				Bunani	Evaristo
				Hakorimaana	Edward
Kamugisha	Kenneth	Kanyarugiri	0757 733179	Niyonzima	Apollo
				Munanura	Amon
				Tumuranye	Bright
				Mujuni	Sainioni
				Gumisiriza	R
				Tukamuhebwa	Innocent
				Ndinawe	Emmanuel
				Mutembuzi	Hassan
				Kyomukama	Silva
				Kamugisha	Kenneth

9.6.2.5 Busingye Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Nuwagaba	Godfrey	Kyenkanga	0783 512743	Tumwine	Job
				Musasizi	Edson
				Mucunguzi	Caleb
				Muganzi	Roman
				Mwembembezi	E
				Nsubuga	Emmanuel
				Arinaitwe	Jamson
				Akatwijuka	Gaston
				Nimbimusiimira	Justus
				Bagarukayo	Apollo
				Mujuni	Gilivazio
				Byamukama	Geoffrey
				Nuwagaba	Godfrey
Karugaba	Johnson	Kambendyah	0759 991200 0779 991200	Twinomugisha	Godfrey
				Byarugaba	Wilson
				Balikudembe	Mukasa
				Nuwagaba	Samson
				Bansigarra	Edison
				Ngabirano	Matayo
				Twesigye	Denis
				Karugaba	Johnson
Tindyebwa	Osbert	Kabaare	0779 836010 0779 836110	Musiime	Abias
				Niwabiine	Alex
				Muhereza	Rodgers
				Mwzoora	Elias
				Nyangirwe	Asumani
				Tindyebwa	Osbert

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Twinamatsiko	Amon	Katengyeto	0777 844845	Tumwekwase	Rashid
				Muwagaba	Alex
				Tumusiime	Michael
				Twinomugisha	Rodson
				Singura	Amburozi
				Kanusime	Jamson
				Ahimbsibwe	Gerard
				Kajungu	Wilburforce
				Tweheyo	Benson
				Tumuhise	Felix
				Baran	Esau
				Niwagaba	Gardinho
				Musinguzi	G
				Twinamatsiko	Amon
Mpakaniye	Crispus	Kiburara	0758 204183	Nuwajika	Samuel
				Nshija	Johnson
				Akeddi	Kenneth
				Kamugisha	Albert
				Mugisha	Hillary
				Byanhanga	Edson
				Kobushashe	Nafhtari
				Mpakaniye	Crispus

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Kaiwarire	Moses	Atanamunan	0758 663413	
Kajungu	Mohammed	Nyakabungo	0782 970617	

9.6.2.6 Ibanda Central Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	**Name 2**	**Stage**	**Telephone No.**	**Name 1**	**Name 2**
Katurebe	Frank	Kigarama	0784 826603	Atwebe	Alex
				Twehayo	Pius
				Sunday	Wilfred
				Katurebe	Frank
Tumuhaise	Jackson	Kagongo	0784 340043	Sunday	Innocent
				Turyahabwe	Denis
				Mugume	Leonard
				Mwesigye	Francis
				Twaha	Kayima
				Ndahula	Vincent
				Mucunguzi	Julius
				Kazahura	Naboth
				Tumuhaise	Jackson

Riders at Stages with No Focal Person				
Name 1	**Name 2**	**Stage**	**Contact 1**	**Contact 2**
Mukasa	Gerald	Omukatoma	0757 701252	
Musinguzi	Robert	Omukatoma	0787 083785	0787 083385
Bogere	Benard	Omukatoma	0771 648633	

9.6.3 Lira District

9.6.3.1 Lira Medical Centre

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Acuma	Charles	Labour Line	0752 697536	Okullo	Sam
				Odongo	Peter
				Ogwang	Alex
				Ekam	Bosco
				Otim	Sam
				Acuma	Charles
Opio	Leonard	Municipal Stage	0751 651687	Ogolo	Moses
				Ojok	Isaac
				Omara	Emmanuel
				Omudo	Ronald
				Opio	Leonard
Ogom	Jasper	Tee-olam	0777 805190	Ogwal	Solomon
				Okoo	Peter
				Ogwang	Ronald
				Otira	Kenneth
				Ogom	Jasper
Odongo	Francis	Corner Kamdini	0772 714362	Ocen	George
				Opio	Felix
				Opio	Lameck
				Bua	Tonny
				Okullo	Moses
				Odongo	Francis

9.6.3.2 Downtown Medical Centre

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Ayo	Moses	Odokomit	0784 703215	Okello	Keneth
				Ocen	Jimmy
				Adonyo	Emma
				Oguta	Walter
				Ayo	Moses

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Opaka	Geoffrey	Te-cwao	0784 246229	0756 714404
Ocen	Obote	Te-cwao	0789 018084	
Atepo	Sam	Te-cwao	0774 602626	
Oyaka	Alex	Te-cwao	0789 025211	0755 600866
Okullo	Sam	Te-cwao	0773 119810	
Omara	Bernard	Te-cwao	0776 708460	

9.6.3.3 Ayira Health Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Bapa	Sam	Akwoyo	0779 474263 0741 194433	Moro	Charles
				Ogwok	Denis
				Ojok	Luka
				Okello	Jimmy
				Bapa	Sam

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Ogwal	Emmanuel	Alir	0782 481941	0759 494157
Obong	David	Alir	0774 189470	
Adupa	Richard	Alir	0771 084997	

9.6.3.3 Aduku Road Maternity Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Emwony	Patrick	Anai Pida	0782 314790 0751 429200	Okuma	Sunday
				Ekwaro	Andrew
				Ewai	Kenneth
				Ogwang	Ivan
				Emwony	Patrick
Ogwal	Alfred	Corner Kagoge	0752 019350	Okidi	Sam
				Adyel	Moses
				Omong	Thomas
				Malinga	Patrick
				Okello	Geoffrey
				Ongu	Kenneth
				Ogwal	Alfred
Akora	Sam	Lumumba	0751 887197	Elem	Patrick
				Omara	Walter
				Onyanga	Ronald
				Opio	Tonny
				Akora	Sam

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Oleke	Walter	Central Park	0789 780662	
Agea	Jasper	Obanga Pe Wany	0778 204922	
Ongom	Leo	Obanga Pe Wany	0774 751947	
Okello	Felix	Obanga Pe Wany	0784 803251	
Ali	Gusman	Obanga Pe Wany	0772 875356	
Ogwana	Alex	Okot Ogona	0787 567806	
Edonga	Thomas	Okot Ogona	0778 926060	
Okabo	Shaban	Okot Ogona	0783 191369	
Odongo	Nixon	Okot Ogona	0788 839904	
Olung	Geoffrey	Rainbow	0773 943699	

9.6.3.4 Charis Health Centre

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Ogwang	Bonny	Omodo	0772 001900	Obong	Musa
				Oludi	Nelson
				Ogwang	Bonny
Ogwang	Denis	K.C.B.	0754 489344	Ojok	Isaac
				Otuo	Diken
				Ocen	Dickens
				Ogwang	Denis
Apita	Patrick	Gombola Lira	0772 361869	Okwir	Moses
				Okello	Sekodo
				Odea	James
				Apita	Patrick
Aluka	Isaac	K.C.B.	0773 394631	Miromi	David
				Aluka	Isaac
Bampiga	Francis	Te-cuk	0774 717999 0758 717999	Odero	Ronald
				Odero	Mark
				Obala	Moses
				Bampiga	Francis

Riders at Stages with No Focal Person				
Name 1	Name 2	Stage	Contact 1	Contact 2
Obote	James	Kakoge	0775 459594	
Ogwang	George	Ober	0774 304786	0755 304786
Omara	Alex	Ober	0778 850646	0774 206670

9.6.4 Alebtong District

9.6.4.1 Ocan Community Clinic

Focal Person		Location	Contact	Responsible For…	
Name 1	Name 2	Stage	Telephone No.	Name 1	Name 2
Apet	James	Amukaola	0773 624104	Agetta	Sam
				Opio	Geoffrey
				Apet	James
Awany	CP	Anino	0786 438718	Awan	Walter
				Ofim	Robert
				Okello	Gilbert
				Opio	Geoffrey
				Okello	Bonny
				Odongo	Jasper
				Awany	CP

9.7 Annex 7: Rural Assessment Tool

Date of Interview	
Location (Village & PARISH)	

Number of people spoken to		Nearest ProFam	
Female	Male	Name	Km

Nearest health centre		Most frequently used health centre	
Female	Male	Name	Km

Did you have a birth preparedness plan?	Did it mention transport?
Y / N	Y / N

Present summary of the project (when presenting a summary key points to include: the drivers are volunteers and are not paid by the project; they have voluntarily agreed to offer a fair price to pregnant women travelling to health centres; they are working to improve access to health centres for pregnant women in the district)

1. Have they heard about the project?
If yes, continue with questions 2-4 then go to section one. If no, go to section two.

2. Is what they've just been told in the summary above, what they understand in terms of how the project works?

3. If not ask them to explain their understanding and correct where necessary.

4. How did they hear about it?
(e.g. from the riders, the clinic, seeing the text on the hi viz jackets, from the Maama Ambassadors, or somewhere else)

SECTION ONE A:
(refers to most recent pregnancy)

5A. Did you use the ETS rider for delivery or for ANC? (specify how many of each)

6A. Do you receive visits from Community Health Workers? (to mothers only)

SECTION ONE B:
(refers to a previous pregnancy)

5B. Did you go to the health facility to deliver your last child?

6B. Did you receive visits from Community Health Workers? (to mothers only)

7A. Are they Maama Ambassadors or Village Health Teams (VHTs)?	**7B.** Were they Maama Ambassadors or Village Health Teams (VHTs)?
8. If Maama Ambassadors do they distribute the riders phone numbers to mothers?	▼
9. If no, how did they get the phone numbers of the riders?	▼
10. (If there is more than one woman who has used the project present) Do you use the same riders?	▼
11. What is/are the rider's names?	▼
12. Do you use the same rider for other non-medical related journeys?	
13A. Do any of the project's riders live in the village?	**13B.** Did any boda boda riders live in the village?
14A. How far do they have to come when you contact them?	**14B.** How far did they have to come if you contacted them?
15A. How long does it take for them to reach you?	**15B.** How long did it take for them to reach you?
16A. Do the riders demand payment up front or can you pay later?	**16B.** Did the rider demand payment up front or can you pay later?

17A. How much does a single journey cost to the health centre for pregnant women?	
Before Project	**After Project**
Emergency (USH)	**Emergency (USH)**

17B. How much did a single journey cost to the health centre?	
Normal Cost	
Cost during labour	

Non-Emergency (USH)	**Non-Emergency (USH)**

Cost at night	

18A. What is your experience of using these riders to travel to the health centre?

Rate your experience of using the riders.

□ Bad □ Average □ Good

(Ask them to explain their reasoning behind whatever rating they give the project)

18B. What was your experience of using boda bodas to travel to the health centre?

Rate your experience of using the riders.

□ Bad □ Average □ Good

(Ask them to explain their reasons behind whatever rating they give the project)

19. What improvements could be made to the project?

▼

20A. Any other comments or useful information?

20B. Any other comments or useful information?

SECTION TWO:

21. What proportion of women in the village, deliver their children at home instead of travelling to the nearest health clinic?

22. What would most women's preference be?

23. If travelling to the clinic at what stage of labour do you consider arranging transport?
Early/late/1st, 2nd or 3rd phase?

24. At what stage of labour would you expect to arrive at the health clinic? Why?
This question tries to establish what the delay is, whether its transport related, or whether it's a delay that occurs prior to travel.

25. What types of transport are there available to you locally and how many of each?
i.e. Ox carts/bicycles/boda bodas/taxis/private car etc.

In the village:	Passing by (and how frequently does it pass?)

26. What type of transport would households use in an emergency?

i.e. if someone needed to reach the health facility.

27. How long does the journey take to get to the health clinic for different modes of transport?

28. How would you contact the available emergency transport to make the journey

i.e. would you have to walk far to arrange it/can you telephone/is it something your husband has to do?

29. Do you have a telephone? If not can you/do you borrow one if you need to?

Is there a charge for borrowing someone's telephone?

30. How much would a single journey cost?

And how does it vary in price according to different factors?

Emergency USH	Non-Emergency (in labour) USH
Day USH	Night USH
Dry weather USH	Wet weather USH

31. How would you pay and WHO pays?

i.e. payment up front/in kind/by borrowing money/savings? Does the husband have to pay for the journey?

32. Are there savings groups within the village and are you a member?

Details on membership and what the money is used for that is saved.

33. If not a member do you save within the household?

Do women have access to this money?

34. Is the journey to the Health Clinic influenced by seasonal factors? If so in what way?

e.g. Cost, availability, road accessibility, journey time etc.

35. Who owns the different types of available transport?

36. Are transport operators organised into groups and/or unions?

37. Are there skills in the village and spare parts available needed to repair each transport mode. If not how close can skills and spare parts be found?

38. Any other comments of useful information?

9.8 Annex 8: ETS Rider Feedback during monitoring

Location	Comment	Response
MUBENDE DISTRICT	The introduction of high visibility jackets (distributed in June 2014) has helped bring attention to the project. More people know about the project now.	This is a positive start. One of the key challenges is promoting this project in the community and it is good to hear that the jackets are making a positive contribution to this.
	Some riders state that women in communities believe that the ETS riders are being paid to participate in the project and therefore expect to be transported for free. In some cases this perception extends to the owners of the boda bodas (where the motorcycles are not owned by the riders themselves).	Transaid is now collecting a list of villages where this perception of the project persists. In March, Transaid will bring a rural specialist to commence community based monitoring. Where possible the villages on this list will be prioritised for further sensitisation. Approval will be sought for identification cards for all riders with text that clarifies that the riders are working voluntarily.
	Riders say that more efforts could be made to distribute their numbers to the wider community. They say that the ones who call them now have their number because they gave it to them. They can't see any progress in terms of ProFam Ambassadors distributing	This is an important factor that needs to be addressed. Whilst riders are pointing to an increased level of business as a result of being part of the project, this is yet to translate into an increase in income. Further sensitisation by ProFam Ambassadors

	numbers. However, they do say that the high visibility vests have improved their visibility.	is required as is visiting the idea of engaging with VHTs[5] based in communities.
	ETS riders commented that most of their journeys with pregnant women take place during the night, and that the women were often in the late stage of labour.	This apparent link between late stage labour and travelling at night points to women waiting until the last minute before deciding to travel. This could be due to a number of factors, including access to money, cultural issues, lack of transport availability etc. Either way, there is obviously progress to be made in helping women identify early signs of labour to facilitate the early arrangement of transport (preferably during daylight hours).
	The issue of whether or not the ETS riders were providing free transport was raised again, and was linked to people's interpretation of the text on their high visibility jackets. Riders stated that 'esoboka' means 'it is possible' which some think means there is no charge.	For future reference, the English text needs to be altered slightly to minimise the chances of misinterpretation. The project message also needs to be reinforced as part of sensitisation activities carried out by the PAs. The message must be that the ETS riders are volunteers and that they are offering 'more affordable' transport as opposed to 'free' transport.
	ETS riders say that on the whole, women do not want to travel to ProFam Clinics for delivery due to the cost. Instead they generally choose government-run clinics.	The information gained in the formative assessment pointed to this very fact. By implementing a community-based ETS the choice of where women want to travel to remains in their hands. Under no circumstances should women be refused transport because they don't want to travel to the ProFam clinics.
	Some riders are finding it difficult to extract payment for the journeys they carry out to clinics. Many are being flexible and are allowing payment after the journey or in some cases at a later stage. However, this presents problems when the riders try to	It would be preferred if journey's were not refused on the basis that the life of a woman and child is worth far more than a few thousand shillings. Ultimately though the decision lies with the ETS rider. If a degree of flexibility can be exercised in terms of

[5] Village Health Teams are a community's initial point of contact for health related matters and are village-based volunteer teams.

	recoup their costs. Riders ask if they can refuse to take someone if payment is not forthcoming.	payment then all the better.
	ETS riders say that women contact them either by telephone, they knock at their doors, or they come to the boda boda stage. They often live in the same locality. Riders are generally happy that the clinic is giving out their telephone numbers, as are the ProFam ambassadors. However, when asked if business had increased, many of them said that yes it had, although this hadn't yet been matched with an increase in profit.	Despite the fact that everyone is happy that their telephone numbers are being distributed this should theoretically be translating into increased profit for the riders which currently it is not. A concerted effort is needed to continue distributing numbers.
	Riders requested gum boots and raincoats as motivational items.	The approach adopted by the project is one where no financial incentives are provided to volunteers. This includes the purchase of items for riders. If the project functions correctly, the riders should in the long term start to earn a higher level of income, at which point the riders can purchase gum boots and raincoats themselves. However, for those that haven't already got them, waterproof high visibility jackets will be distributed.
	One rider mentioned the fact that his wife was suspicious of him receiving calls from women sometimes during the night. This is inevitably having a strain on their relationship.	Transaid suggested that Adamu and anyone else, bring their wives to the next meeting in March where they can be told about the project. Also, the potential introduction of ID cards may help to persuade others about their role as part of the project.
	Some riders are being stopped by Traffic Police which leads to a delay for them when transporting a pregnant woman to one of the clinics. The riders suggest identification cards to overcome this	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	When questioned whether ETS riders were reducing the journey cost all participants confirmed they were as	ETS riders were informed that as part of the project they were not expected to sacrifice profit when it came to

	evidenced in their notebooks. However, all ETS riders claimed to be charging for the cost of fuel only for each journey. So while many of the riders have seen an increase in the number of clients, they are not benefitting from this by only charging for fuel.	transporting pregnant women. In fact, in the interest of keeping their continued support, the project wanted to see their profits increase as more customers start to use the service that they offer.
	Participants claimed that they were being taken for granted by pregnant women in the community. They are perceived to be employees of the ProFam Clinics and to be benefiting from the project personally.	This is the type of message that needs to be dealt with by ProFam Ambassadors during their sensitisation activities. It is important for the PAs to reinforce the fact that ETS riders are volunteers, that they receive no payment from the project or ProFam, and that they continue to rely on charging fares for journeys to be able to earn an income for their own families.
	Some of the ETS riders believe that the ProFam Ambassadors have not done enough to promote the scheme to women in the villages.	The idea behind this meeting is to ensure that all stakeholders have a good understanding of the project including an understanding of what messages must be passed to communities in order to promote the project. It is hoped that by the time of the next monitoring visit, the benefits of improved messaging will be felt.
	The clinic staff that attended here said that the ProFam clinic itself is not benefiting much from the scheme.	The responsibility of boosting the clinic's business lies with the clinic itself. Transport is one of many variables affecting the clinic's success, not least the cost of the services, and its reputation within the area it serves.
	Riders ask whether by being part of the project, they can receive treatment from the clinic at a reduced price if they should fall sick.	This is an idea that could be mentioned to the clinics, although at the time it was suggested that this should be their responsibility to negotiate.
Location	**Comment**	**Response**
HOIMA DISTRICT	Sometimes the patient does not have enough money to make payment for the journey.	The riders should discuss with the client before they are transported the cost and ability to pay. The clinics were

		also encouraged to tell the PAs to tell communities to try and save for transport along with other maternity costs. Although it is understood this situation cannot always be avoided and the riders are not being asked to transport clients for free they should use common sense while dealing with pregnant women who are experiencing a dangerous complication.
	Riders ask whether by being part of the project, they can receive treatment from the clinic at a reduced price if they should fall ill.	This is an idea that could be mentioned to the clinics, although at the time it was suggested that this should be their responsibility to negotiate.
	Some riders state that women in communities believe that the ETS riders are being paid to participate in the project and therefore expected to be transported for free.	In March, Transaid is bringing a rural specialist to commence community based monitoring. Villages will be further sensitized and ProFam Ambassadors will be invited to accompany Transaid. Approval will be sought for providing identification cards for all riders with text that clarifies that the riders are working voluntarily.
	Misinterpretation of the text on the back of their high visibility jackets remains and is said to be one of the reasons why women expect the service to be free of charge. Many people perceive the word 'affordable' as meaning that it is a free service.	Transaid will revisit the text, simplify it and seek translations from PACE staff for the future procurement of hi viz jackets.
	Some riders are being stopped by Traffic Police which leads to a delay for them when transporting a pregnant woman to a clinic and also they are sometimes asked for bribes to let them pass. The riders suggest identification cards to overcome these issues.	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	Riders say that more efforts could be made to distribute their numbers to the wider community. They can't see	This is an important factor that needs to be addressed. Whilst riders are pointing to an increased level of

	any progress in terms of ProFam Ambassadors distributing numbers. However, they do say that the high visibility vests have improved their visibility.	business as a result of being part of the project, this is yet to translate into an increase in income. Further sensitization by ProFam Ambassadors is required as is visiting the idea of engaging with VHTs based in communities.

Location	Comment	Response
IBANDA DISTRICT	One rider pointed to a similar nearby project where, as a way of monitoring progress, PAs distribute cards to pregnant women. The women then give these cards to the ETS Riders who then leave the cards with the facilities once they have transported the pregnant woman successfully.	Unfortunately this idea is not under consideration as it is obvious from the data that is being collected that more than 90% of women are not travelling to ProFam clinics to give birth. They would therefore be missed in the data when establishing the effectiveness of this ETS.
	There is a mix of journeys carried out during the day and at night. While all ETS Riders are reducing their prices for pregnant women, there is still an increase in price for night time journeys depending on the time the rider's service is required. For example a journey at 1am is more expensive than a journey at 10pm.	This is a difficult problem to overcome completely. However, from the fares charged that were quoted by ETS Riders travelling at night, the team remains happy that prices overall have reduced.
	Women are contacting ETS riders both by telephone and through making arrangements face to face. The women contacting them by telephone seem to be getting their contact numbers from friends rather than the details being distributed by PAs as is supposed to happen.	This message will be reinforced both to the CBO supervising the PAs and the PAs themselves that they should be kept up to date with the correct contact details and that during sensitisation they should be distributing numbers. Contact details can also be given to the CBO, to the ProFam Clinics, and the drug shops.
	All riders were very keen to be given their high visibility jackets, and were confident that with greater visibility, there would be more customers forthcoming.	Apologies were made for the late distribution of the jackets. The team was informed that the jackets will be ready week commencing 29/09/14 and therefore ready for distribution in the coming weeks.
	For some riders the waiting time has	It was suggested that the driver

	been a problem from when they drop pregnant women at the clinic for a check-up, and when they need to be transported back. There is the uncertainty that they will be needed for the return journey and the associated loss of business.	negotiate a time at which to return for the woman during the first journey.
	One ETS rider pointed to a slight increase in the business he was getting as a result of being part of this project.	This is a key incentive to ensure the participation of all ETS Riders and greater efforts will be made to ensure that their contact details are distributed to the wider community.
	Women are contacting ETS riders both by telephone and through making arrangements face to face. The women contacting them by telephone seem to be getting their contact numbers from friends rather than the details being distributed by PAs as is supposed to happen.	This message will be reinforced both to the CBO supervising the PAs and the PAs themselves that they should be kept up to date with the correct contact details and that during sensitization they should be distributing numbers. Contact details can also be given to the CBO, to the ProFam Clinics, and the drug shops.
	Riders are concerned about night travel and refer specifically to the possibility of getting injuries. They asked whether as part of the project, there is any support for them available should they be injured.	ETS riders were informed that unfortunately there is no financial support for riders in the case of injuries. However, it is hoped with improved sensitisation amongst women by the ProFam Ambassadors, that women will be better able to identify early signs of delivery so that the need to travel at night is reduced.
	ETS riders expressed a wish to have some form of identification as participants of the project. ID will add to their credibility within communities and help ensure smooth passage with traffic police in emergencies.	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	One rider was concerned about his income if he reduced the journey price for women travelling to clinics.	The main theory of the project was explained in that the more the riders contacts are distributed in the communities, the more income/business they are expected to get which should more than compensate for reducing prices. It

		should be noted here that riders are being asked not to overcharge expectant mothers, but to charge them a fair price.
	There is a misconception in the villages that this boda boda service is a free service. This is due to a misinterpretation of the text on the back of the riders' Hi Viz vests and a belief that riders are getting paid as participants of the project.	The text will be reviewed and simplified for all future Hi Viz vests to avoid confusion. Also the ProFam Ambassadors have been instructed to reinforce local awareness about the project to ensure there is no confusion.
	Some riders are being stopped by Traffic Police which leads to a delay for them when transporting a pregnant woman to one of the clinics. The riders suggest identification cards to overcome this.	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	There are concerns that the ProFam Ambassadors only carry out sensitisation activities within the town council area due to the cost of travelling to more isolated areas. However, the geographical spread of ETS riders is far wider than the town council area. This means that there is little hope that the PAs can assist in distributing their contact details to rural areas.	There are two suggestions as to how to deal with this. (1) when future PAs are recruited, it is up to the clinic to ensure that their home villages are evenly spread throughout the clinic's catchment area. (2) Can we make use of the village based Village Health Teams of which there are at least 2 per village, to build awareness.
	Some riders have claimed that they have been told by PACE staff that they would receive top up airtime on their mobile phone as part of the project.	Transaid clarified that this is not the case and that it would speak to PACE to ensure that this is not happening.
	The group suggested that riders were needed from other areas. PAs and Clinic Staff came up with the following list of Parishes: Bwahwa (10km away), Nyaminyobwa (12km away), Kibingo (15km away), Kyenyena (20km away).	While there was no time to carry out the recruitment during this monitoring visit, time will be factored into the plan for the next trip. Riders agreed that they would invite a maximum of 2 boda boda riders from each of these stages to the next meeting although it is expected to be unrealistic for the ETS riders based 15-20km away to participate fully.
	One rider asked whether they should only take women to ProFam Clinics.	It was explained that the choice of destination should always lie with the

		pregnant women. She should always have the choice where she wants to deliver here child.

Location	Comment	Response
LIRA DISTRICT	Riders are saying Lira Referral Hospital is charging them to park inside the hospital grounds. The riders fear leaving their motorcycles outside in case of theft but are losing money by having to pay every time they go to the hospital.	Transaid will ask PACE to discuss this with the hospital administration. Also as a group the riders could have a discussion with the hospital to see if they could get a reduced rate once they have ID so they know they are ETS riders.
	ETS riders expressed a wish to have some form of identification as participants of the project. ID will add to their credibility within communities and help ensure smooth passage with traffic police in emergencies.	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	Some riders are being stopped by Traffic Police which leads to a delay for them when transporting a pregnant woman to one of the clinics. The riders suggest identification cards to overcome this problem.	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	Riders asked if they were still to receive high visibility vests. They felt it would help promote the project and identify them as ETS riders to their communities and the general public.	Transaid confirmed that the riders would be receiving high visibility jackets.
	One rider stated that he often has a problem running out of fuel when called out during the night. At this time there is nowhere to buy additional fuel	It was explained that the riders should always have some fuel in their motorcycles at night. They could get calls from anyone, not just project related calls, or even need the motorcycle themselves for an emergency so they should be prepared.
	Riders are concerned about night travel and refer specifically to the possibility thieves.	The riders were told that of course their own safety was vitally important. If they are truly concerned about an area or time of the year for travelling then they must consider this carefully and not put themselves or their clients at risk. It was suggested that in other

		areas some riders ride at night in pairs. This of course would incur an additional cost for the client and this must be discussed beforehand.

Location	Comment	Response
ALEBTONG DISTRICT	The riders indicated that due to there being no stage at the clinic and that if in the future there was a need for boda riders to be stationed at the clinic they would happily set up a temporary stage. They agreed they could set up a rota and try to man it 24/7 or be nearby and easily and quickly accessible 24/7.	The team were very happy to hear this commitment and suggestion from the riders. They were told that if in the future there is a need it can be discussed in more detail and arranged. They were thanked by the PACE team and ProFam staff for their commitment to the project and helping their community.
	ETS riders expressed a wish to have some form of identification as participants of the project. ID will add to their credibility within communities and help ensure smooth passage with traffic police in emergencies.	Transaid agreed to seek approval from PACE for ID cards. There is little chance that ID cards will have photos and signatures due to the number of riders. Therefore Transaid would propose a generic identification card.
	There was a suggestion that indicator lights and break lights should be fitted to the trailer.	It is understood that this is a valid concern however having lights on the trailer requires power and wiring from the motorcycle. This would mean the modification of all 10 motorcycles for their wiring and controls such as the break and indicators.