RESEARCH GUIDANCE MANUAL

Mobility & Health

An International Networked Research Programme

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HOW TO USE THIS MANUAL

This Manual provides background information, guidelines and instructions for designing, planning, undertaking and writing up the fieldwork and case study research associated with the Project: ***MOBILITY AND HEALTH: AN INTERNATIONAL NETWORKED RESEARCH PROGRAMME***. In addition it will outline the milestones, information on the web site and list serv and overall reporting information relevant to the Project.

This Manual is a direct outcome of three participatory regional workshops: Uganda (8-10th of August), Indonesia (15-17th of August) and Mexico (12-14th of September). During these workshops researchers developed the contents of this manual as a way to plan and execute their field work and research. Each section will have brief instructions on how it needs to be used. Please read these carefully since some instructions are very specific and need to be strictly adhered to. Others are more flexible.

Contractually this Manual serves as an Addendum to the Letters of Agreement for each research.

1. INTRODUCTION TO THE PROJECT

The two-year project, titled Mobility and Health, an International Networked Research Programme has the following objectives:

(1) To increase the understanding of the impacts of mobility constraints on the health, well-being and issues of poor people in different developing country contexts;

(2) To develop tools that will enable transport professionals to include holistic health impact assessments and mitigation measures in the planning, design and implementation of transport interventions; and

(3) To develop an advocacy programme to sensitise the health sector to mobility and health issues.

Using a Networked Research methodology, the programme on Mobility and Health will carry out 24 case studies in Asia, Latin America and Africa. These case studies will demonstrate the existing and potential links between mobility and health, especially in rural areas. The researchers will initially come together in regional workshops to finalise the methodology and framework the case studies will take. Once finished, an international symposium will be organised to present the issues flowing out of the case studies and to develop outlines for a 'toolkit' and an advocacy programme. Part of this advocacy programme will take the form of setting-up an electronic network which will host a discussion or E-mail group to share experiences and knowledge, supported with advice offered by the core group. The project also intends to reach out to the health sector and their listservs and Community of Practitioners in order to sensitise and engage them more in the mobility debate. For more background information please visit www.mobilityandhealth.org

2. WHAT ARE WE TRYING TO FIND OUT?

For the purposes of the Mobility and Health programme, Kate Molesworth from the Swiss Tropical Institute has been commissioned by the Swiss Development Corporation to develop a literature review. This literature review is available through http://www.ifrtd.gn.apc.org/h_mob/about/Kate%20Molesworth%20Mobility%20and%20Health%20Paper%20final.pdf and demonstrated that there are major knowledge gaps in the limited existing research. The 24 research case studies aim to demonstrate and fill these knowledge gaps in the multi-complex relationship between rural mobility and health.

Obviously it is not the programme's intention for each case study to answer all questions and fill all knowledge gaps, some examples of which are listed below. Rather the questions are meant as an introductory guide to help the researchers review the issues and their case study from different perspectives and offer some useful insights into potential recommendations. The researchers will be addressing the following gaps, set out in the following questions:

Examples of Knowledge Gap Themes	**Who will/may address**
1 .What are the key barriers to poor people's use of existing transport facilities to access health services?	Mulu Muleta (ETHIOPIA) PK Tarsi Hurmali/Charlotte Kakebeeke (INDONESIA) Binjwala Shrestha (NEPAL) Alfonso Balbuena and Fernanda Briones (MEXICO) Eduardo Neira and Diógenes Ampam (PERU) Andrea Gutiérrez and Diego Minuto (ARGENTINA)
2. How might female access to health services, and that of disadvantaged groups, be improved with mobility interventions?	Taye Berhanu (ETHIOPIA), Kenneth Odero (KENYA) Rose Mlay (TANZANIA) PK Tarsi Hurmali/Charlotte Kakebeeke (INDONESIA) Binjwala Shrestha (NEPAL) Juan Contreras and CarolinaTarqui (PERU) Julio César Sánchez and Miriam Sánchez (BOLIVIA)
3. What are the most cost-effective means of enabling the optimal use of transport for the most disadvantaged to access and/or be accessed by health services?	Christel Jost (BURKINA FASO)
4. What are the mechanisms by which increased mobility is associated with raised awareness and demand for health services?	
5. How do transport interventions impact upon different social groups and on their access to health services (and	Ashoke Sarkar (INDIA) Shamim Hasan (BANGLADESH)

their contact with outreach services)?	Ansu Tumbahangfe (NEPAL) Julio César Sánchez and Mirian Sánchez (BOLIVIA)
6. How does enhanced mobility impact upon health views and requirements, where strong indigenous health paradigms prevail? In what circumstances is bio-medicine rejected? Why? How can mobility interventions be used to enable integration of healing approaches to best meet the needs of different communities?	Ansu Tumbahangfe (NEPAL)
7. In different settings, over what distances can people access health resources by foot or using IMTs? How does this differ by age, gender, state of health, pregnancy etc.	Aziza Benegusenga (RWANDA), Frank Aechampong (GHANA) Shamim Hasan (BANGLADESH) Germán Delgadillo and Cecilia Bellido (BOLIVIA)
8. What innovative schemes might be devised to optimise use of existing (private and commercial) transport infrastructure, to enable the most economically, geographically and socially marginalised to access resources (including referrals), impacting on their health?	Marco Aurelio Colindres and Rebeca Orellana (GUATEMALA)
9. How might revolving funds for fuel, vehicle and IMTs be established, managed and sustained in different low-income settings?	Susan Nanduddu, Patrick Kayemba (UGANDA)
10. How might IMTs be developed in different settings to improve access to health outlets and provide means of transport in cases of medical emergencies?	Jun Hada (NEPAL)
11. How might health outreach workers' travel and transport be improved in different settings to enable them to work more efficiently? How might transport interventions improve human resources for health in poorly-served and difficult access areas?	Paul Kwamusi and Alice Nganwa (UGANDA) Mac Mashiri (SOUTH AFRICA)
12. Do mobility interventions measurably improve the uptake of different types of health care (e.g. primary, secondary, tertiary)?	
13. What best (and worst) practices have been experienced by different projects and programmes in various LIC settings? What lessons can be drawn from these to inform health and mobility strategies?	Abdul Shakoor Sindhu (PAKISTAN) Juan Contreras and Carolina Tarqui (PERÚ)
14. How infrastructure affects quality of health services? (addition from Asia workshop)	
15. What other factors influence access to health services, e.g. local beliefs, gender, local emergency planning? (addition from Asia workshop)	
16. What are the key barriers to poor people's, female, marginalised communities and community based health workers use of existing transport facilities to access health service and community based services? (addition from Asia workshop)	

17. How does transportation affect the health of persons with disabilities in rural areas? (addition from Asia workshop)	Shivram Deshpande (INDIA)
18. How do mobility and health services reduce the vulnerability of different groups in a community/area to man-made and natural disasters? How does vulnerability to various kinds of disaster impact on the mobility and health services of a community? (addition from Asia workshop)	Abdul Shakoor Sindhu (PAKISTAN)
19. What are the other barriers to enhanced health, besides improving transport facilities?	

A full description of each project and the contact details of each researcher will be available through www.mobilityandhealth.org This way each researcher will be able to contact those researchers that try and address a similar issue and knowledge gaps.

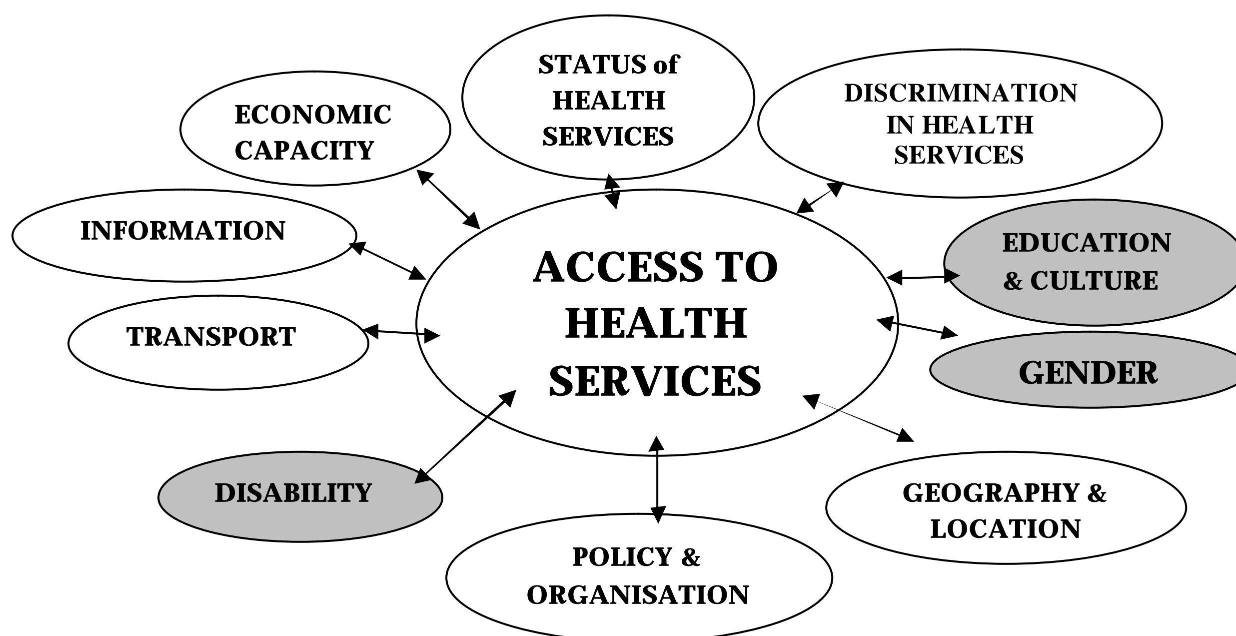
3. THE RESEARCH APPROACH AND METHODOLOGY

This section is crucial for the design and execution of the research and field work and will focus on the approach and methodology each study will adopt. The section is divided in seven: 3.1. Building a Conceptual Framework, 3.2. Disaggregating data to provide meaningful analysis, 3.3. Diversity of data and informants, 3.4. Balance between field and desk work, 3.5. Policy dimensions, 3.6. Principles of working successfully with communities, and 3.7. Sound practices on gender and research. Each section has been developed through participatory exercises throughout the workshop, such as the World Café, skits and small group discussion and work. Under each section it lists what data, principles and information needs to be included in developing the methodology and approach of the research. These lists are not meant to be exhaustive and will still need to be adapted to the specifics of each case study. Other sections focus on the principles of conducting research; these principles need to be adopted by each researcher while carrying out the field work.

3.1. Building a Conceptual Framework

The researchers in Latin America thought it useful to develop an overall conceptual framework for their own research and to help the researchers in the other regions. The visual below is the result of this discussion. This framework serves as a “map” to help each researcher identify, clarify and/or measure all links and interactions relating to access to health services in general and their project in particular. It was agreed that Access to Health Services was the common objective hence its position in the centre of the circle. The other circles surrounding the centre include issues that are somehow related to Access to Health Services and therefore need to be researched in more detail. However some issues such as gender, disability and culture (indicated in lighter grey circles) were cross-cutting and needed to be addressed in every research. Unfortunately there was not enough time to finish a detailed framework but the visual below should help the researchers in finalising their project proposals.

Visual 1: Building a conceptual framework



**Note: Circles coloured in with light grey indicate cross-cutting issue that needs to be included in every research.*

3.2. Disaggregating data to fully represent all groups in a research community

Researchers from all regions agreed that all collected data needs to be disaggregated (in some cases in great detail) and there was consensus that **gender, disability** and **poverty** would be the basic disaggregating factor. **Therefore gender, disability and poverty are the minimum standards of disaggregation that every one needs to include in their research**. This will help develop a meaningful analysis to include all groups in a research community. Other disaggregations will need to be added, according to the objective of the research.

***Examples of other categories of disaggregation*:**

- Gender (compulsory)
- Persons with disabilities and their family members
- Mothers and children (their female friends and sisters)
- Women of reproductive age
- Pregnant women
- Tribes/ ethnicity/culture
- Harmful practices
- Age (children, youth, elderly)
- Literacy/level of education
- Social status
- Opinion leaders
- Economic status (household income/access to cash)
- Employed/unemployed
- Occupation/profession
- Geographical location
- Vehicle/IMT ownership/control
- Access to information regarding local health services
- Proximity to transport infrastructure and services
- Availability and cost of fuel

- Fodder and water availability for animal transport
- Climatic conditions (seasonality)
- Permanent/ temporary transport means

In addition to considering collecting and disaggregating a body of research data to provide meaningful analysis, the researchers also recommended considering weighting information from different sources. Taking the primary informant group of "mothers and children" as an example, the researchers explored how a study might further disaggregate this informant category. It also considered other informants that might add pertinent data to issues relating to mothers and children:

Example of additional disaggregation:

Disaggregating "Mothers"

- Mothers married, unmarried, widowed, separated, divorced
- Number of pregnancies (first, versus second, third etc)
- Literacy/education status of mothers
- Degree and types of disabilities
- Socio-cultural and economic status
- Caste/ethnicity, religion

Other key informants relating to maternal and child issues

- Mothers' female friends and sisters
- Fathers
- Mothers-in-law
- Transport user groups

Traditional healers, TBAs, female community health volunteers & health workers Overall collecting PRIMARY DATA are the key objective for this research since we are filling the knowledge gaps. Secondary data may only be used to complement primary data set out above. Examples of secondary data sources are:

- Community leaders (at all levels)
- Extension workers
- NGOs
- Government officers
- Local security services

Agreed Guidelines for Disaggregating Data

1. Primary information needs to be obtained "raw" from those providing and using transport and health services. The interrelation between supply and demand is crucial.
2. Besides gender and poverty, culture and vulnerability are important aspects to disaggregate.
3. It is crucial to seek information from all possible perspectives to have as complete a picture as possible, in order to obtain the broadest possible objectivity.
4. Each researcher needs to be familiar with mobility and access patterns.
5. The most important techniques for collecting the information are structured or semi-structured interviews, focus groups and life stories.
6. It is important to define disaggregated groups clearly, e.g. it needs to be stated that the term "minors" refers to young people aged between 15 and 19.
7. With regard to HIV status, it is recommended that strict anonymity be observed, as this is a highly sensitive piece of information; particularly so in small groups. It was agreed to only disaggregate data by HIV status if appropriate for the study. It needs to be kept in mind that in the majority of locations where testing is low, the level of confidence in figures for sero-negative people will be low. In addition labelling the people as HIV positive may aggravate stigma so caution and discretion needs to be of utmost importance.
8. Disaggregation of data should be carried through up to the recommendations section in the report.

3.3. Diversity of Data and Informants

The following lists are examples of different people who may be interviewed. **Each research needs to include an as wide range of key informants as possible. Key in the study are your primary data informants and a lot of examples of these are listed below**. Again this list is not exhaustive and each researcher needs to customise this list according to the objectives of their case study. The discussions under this header focused on just one question: *Whose opinions matter most in your study?* The collected responses are gathered according to the different levels of stakeholders.

At the Community/Local level
(THESE ARE CRITICAL SOURCES AND NEED TO BE INCLUDED):

- Household (gender sensitive, elderly men and women, decision makers at home)
- Patients including in hospitals, rural health clinics and home-based care patients
- Youth including:
    - children in upper primary and above
    - youth (range age to be determined and mentioned)
    - teenagers (specific what age)
- Women including:
    - child bearing age

    - elderly women
    - female-headed households
    - single women
    - pregnant women
    - organised groups, including mothers' groups
- Women, men and children living with disabilities
- Future eligible beneficiaries, (they are very sensitive stakeholders, and we should avoid results biases from them)
- Local business proprietors
- Environmental health technicians
- Local authorities including
    - communities leaders/elders (religious, council and traditional)
    - police
    - councillors responsible for health and transport
- Community members/individuals including
    - senior citizens
    - organisations
    - NGOs and associations including support staff
- Health service providers/workers including
    - doctors
    - nurses
    - hospital staff (including technicians and support staff)
    - private medical practitioner
    - female and male community health volunteers
    - health extension worker
    - specialists on maternal health
    - traditional birth attendants
    - traditional medicine practitioners
    - home-based care givers/practitioners
    - health insurers
    - medicine manufacturer and representatives
    - medical stores and pharmacies (including informal)
- Transport service providers/operators including:
    - boat operators and makers (for water studies)
    - IMT-users committees
    - operators of motorised and non-motorised modes of transport
    - commercial head porters
    - taxi owners
    - transport staff and regulators

District and regional level:
- Road authorities
- Civil society members (NGO, associations, etc.)
- Health service providers/workers

- Transport planners and District head of transport
- Health motivators (the ones supported by district authorities)
- Local administrators/politicians
- District planners
- Public works officers

National level:

- Transport and health ministries (planners and researchers)
- Members of Parliament
- Politicians

3.4. Balance between Field and Desk Work

Since the Mobility and Health research is meant to fill existing knowledge gaps it was agreed that the onus of the research should be spent on field work. Added to this is the fact that the literature review has already been carried out and is available in all three languages through the web site www.mobilityandhealth.org Furthermore, the research's aim being quite different from more "traditional" research every one conducted in the past – meaning influencing people from local to policy level – the field work share would even be higher than usual as the data (results) have not only to come from the field, but have also to "go back to the field".

AGREED DEFINITION OF FIELD AND DESK WORK

Desk work (office work):

- Local literature review (even though the extensive literature review done by Kate Molesworth exists, some review of more topic and context specific literature is generally needed). These sources need to be added to the web site.
- Development / finalisation of the research framework (research question, research objectives and the indicators, methodology, etc.)
- Development of the tools (questionnaires, data collection aides, etc.)
- Report writing
- Designing information and dissemination strategy and system
- Overall (quality) management and administration of the research project
- Organising the process
- Preparing technical instruments
- Consolidation, systematisation and analysis of the information
- Final report

Field work:

- Everything that isn't spelled out above, but including specifically:
    - Training of the field workers / data collectors
    - Pre-test and finalisation of data collection tools
    - Travelling
    - Collecting primary information to fill information gaps
    - Data collection, compilation and control
    - Dissemination of findings, networking and policy dialogue with beneficiaries

All researchers emphasised the importance of designing the research and its methodology (including questionnaires) properly before starting data collection hereby avoiding problems in case of poorly designed tools. Therefore an appropriate amount of desk work is needed as the initial preparatory work in the office is crucial for the subsequent success of the research.

After a lot of discussion the researchers across all regions reached a consensus on the ideal balance between the two types of work. The majority of the researchers came to the conclusion that the research should begin with an initial desk phase of approximately 10% of the total time. They thought 10% and not more, because the majority of the literature review has already been done and is available. Then, approximately 65% to 70% of the total time would be spent in the field stage and it was said that this was because the main objective of the project is to collect primary information. It was also emphasised that this time should include dissemination and policy dialogue. The researchers recognised the necessity of a final phase of approximately 20% to 25% of desk work to analyse the information and write up the report. After the report is finished a new phase of dissemination and policy dialogue should be developed.

3.5. Relevant Policy Dimensions

One of the objectives of the programme is to disseminate the results in an effort to influence change at the policy and practical level. Therefore the researchers brainstormed about strategies how to do this and came up with the following ideas. These ideas are meant as inspiration for each researcher from which a specific dissemination and advocacy strategy needs to be developed. ***Please keep in mind that policy influencing and dissemination should start right from the beginning of the research*****; experience has learned that after the study is done is too late.** One great idea that came up was to appoint a local core or steering group (mirroring the international steering group to the local level) consisting of several stakeholders in order to influence them as the research is progressing.

Other ideas are:

- To identify interfaces between transport policy interventions and health outcomes
- To link research to policy through sustained dialogue
- To demonstrate and promote innovative and successful models
- To identify and promote best practice
- To carry out a policy audit to identify policy gaps
- To analyse the disconnection between transport and other sectoral policies
- To provide scientific evidence on links between health and access issues
- To promote acceptability of intermediate means of transport to policy makers and other stakeholders
- To engage with ongoing policy and institutional reforms, such as Poverty Reduction Strategies [PRSPs] and Sector Wide Approach [SWAPS]
- To examine how local level policies and institutions interact with those at the national level
- To combine national level dissemination with local level dissemination and advocacy

- To challenge policies that do not work and advocate for more appropriate and implementable approaches.
- To empower and raise awareness at the local target community through strengthening its knowledge in order to improve its management skills
- To identify and initiate a relationship with opinion leaders who make decisions on health and transport
- To take into account the “type” of information which the decision-makers usually access
- To disseminate the question of mobility in discussion slots devoted to public health, education and transport. If these slots do not already exist, they need to be created
- To involve, inform and influence international bodies (donors) to influence local governments
- To legitimise the research process by involving all social actors - public, private and institutional at local, regional and national level

Other observations:
- There is need to use the language that policy makers understand
- International symposium offers an opportunity for international influence

3.6. Principles of Working Successfully with Communities

Since a lot of the researcher’s time will be spend in the field while working with communities and the quality and outcomes of the research depend on our behaviour and rapport with those communities, the researchers developed some practical tips of Do’s and Don’ts. During the workshops participants worked in small groups to act out short skits (‘theatre plays’) to illustrate some of the principles of working successfully with communities.

Some are obvious, others are not. Overall the table below gives each researcher instructions on how to plan, prepare and behave while interviewing and working with communities.

In addition each researcher needs to be mindful of the visual aspects and behaviour all of us display while working with people. We need to be aware of our body language and the image it may create (*crossing one’s arms may be considered defensive in some cultures*).
Other considerations are:
- Ensure being at the same eye level as the person you are interviewing.
- Include a proper introduction and be mindful of who does this.
- Be open to the people
- Trust the interviewee and his/her opinions
- Use gender-neutral language
- Respect hierarchies in the particular environment or institution
- Please ensure a private environment to avoid others interrupting/ contributing
- Intimidating attitude of the interviewer

Examples of Do's	**Some Don'ts**
Plan properly	
Introduce yourself and the project – set the scene	Appear without appointment
Ask permission to ask questions	Raise expectations
Carefully selected communication channels	Take too long
Build trust, confidence	Just ask yes/no questions
Sensitivity to languages	Ask provocative questions
Build a dialogue – not one way conversation	Fail to differentiate or deal with issues without taking into account aspects of gender and disability
Be mindful of body language	Lead responses/questions
Be sensitive to gender	Be harsh, insensitive, authoritarian
Plan the timing of the interview according to interviewee's schedule and NOT YOURS	Be irrelevant
Be kind	Be critical
Ensure environment is relaxed and conducive	Be judgmental
Ensure anonymity	Accuse or undermine
Make prior appointments	Force your programme on them
Be sensitive to his/her culture	
Be sensitive to his/her disability	Be condescending
Write brief introductory letter in advance	
Be brief and informed	Forceful replies to fit our own programme
Be constructive in interviews	Prompt responses
Propose visible solutions	Take up too much of the interviewee's time
Dress appropriately	Be a nuisance
Arrange suitable meeting place	Offer money
Be interested in their responses	Invade privacy
Be passionate	Be authoritarian
State the facts	
State your objectives clearly	
Make no promises	
Ensure voluntary participation	
Be respectful, respect their points of view	
Ask open-ended questions	
Listen to their views	
Use appropriate and simple language	
Master information-gathering techniques.	
Minimal set of structured questions	

Use graphic format options	
Discuss female issues in women-only settings	
In mixed groups ensure that both women and men reply in the interview.	
Be impartial	
Have a feedback process	
Ask permission when using tape recorder, taking photographs, filming or writing.	

3.7. Sound practices for gender and research

All regional workshop devoted time to discuss sound practices to be gender sensitive as all case studies will not only need to collect gender-disaggregated data but also overall be linked to the reduction of maternal mortality. The groups thought it was important to define gender balance in general, and in regard to mobility and health in particular.

Definition of gender balance in general:

- Equitable consideration for men and women focusing on the marginalised, especially women and children
- Addressing social limitations imposed especially on women

Gender considerations in respect to Mobility and Health:

- Design and provision of transport infrastructure and services is male dominated. Women and children bear the consequences. Therefore transport infrastructure and modes and health facilities need to be assessed from the perspective of gender and marginalised groups.
- The effectiveness of women as health care providers at household and community levels is constrained by gender conditioning

Each researcher needs to include the gender aspects relating to Mobility and Health in their own research. More specifically each researcher should include the following instructions on gender in order to make this research meaningful to both women, men and children.

For gender inclusion, each researcher should:

- Create a gender representative team
- Be clear on the concepts of gender and empowerment
- Have an integrated (holistic) vision of gender so that there isn't a bias towards sexual or quantitative issues
- Use different techniques and tools that allow collecting data by sex and gender with different perspectives
- Take into account cultural aspects (gender is a social 'concept' in time and space)

- Include a woman to especially address qualitative in depth questions for which only women can elicit answers from other women
- Consider the sex of the facilitator in Focus Group Discussions and separate the sessions for men and women
- Ensure information captured is disaggregated by mode
- Separate men and women according to:
    - Research topic
    - What you need to know
- Separate sessions for different sub-sections in communities/marginalised groups
- Continue to involve women in the process of the full research
- Assess planning process of transport and health services: who influences and decides
- Gender sensitisation of data collection staff/field staff (gender disaggregated data)
- While doing baseline studies get representative samples
- PRA/PPA methods can also allow better participation of women
- Collecting of data (during literature reviews) with particular focus on issues related to women, children and marginalised groups (get data at the national, district and community level)
- Recording of caste/ethnicity in service utilisation registers maintained at the health centres (in Nepal) not done. So getting the figures may be difficult but do what you can. PRIMARY DATA ALL NEED TO BE DISAGGREGATED ACCORDING TO GENDER
- Target group of respondents, female headed households (especially in conflict and disaster prone areas.)
- Separate data on maternal health and transport
- Factors to be aware of whilst collecting data:
    - Women with disability are more vulnerable to sexual harassment by male transport service providers
    - Local culture and social practices that affects women's mobility
    - Design of rural transport facilities to fit women's needs
    - Different transport modes for various people (elderly, women and children)
    - Cultural barriers for using transport modes – unsafe modes of transport and systems
    - Special seats for women in public transport
    - Cultural and social restrictions that hinder women from using transport
    - High rate of discrimination for women and the disabled women and children
    - Denial of services (education, health) to for the disabled
    - No planning for health and infrastructure for the disabled persons
    - Beneficiary mothers
    - The impacts of disasters on women and children
    - Frequent elections effect the women and children

Key gender research questions would include:

- What makes it more difficult for women to travel?
- What has been the response to tackle issues of gender at the local level?

- Where is the disconnection between policy and practice?
- Are there any particular gender related trauma arising out of use of various transport modes?

4. CHECK LIST OF INFORMATION TO SEEK

The following section is a check list of information and data that needs to be collected for each case study. Please keep in mind that all case studies are cross-sectoral so you need to include this cross-sectoral approach throughout the research. In addition all data need to be at the minimum gender- and poverty- disaggregated (but most probably each study will disaggregate data according to its objectives). **This list is intended to be a document for use in the field to ensure that the researchers collect data under each header.** The sub-headers are not exhaustive but give guidance on what data may be considered. **Each sub-header check list needs to be customised to the study**. Based on the information listed in these sections, qualitative or quantitative tools such as focus group discussions and/or questionnaires have to be developed to collect the data.

4.1. Demographic Data

- Census report (will include much information – e.g. number of households, families, population forecast, growth rate, people with disabilities)
- History of place
- Name of place
- Hierarchy of settlement
- Distance for main settlements
- Distance for link roads
- Population pyramid
- Religion/ethnicity/caste/culture
- Disease (common and acute)
- Available facilities (schools, etc)
- Mobility mapping
- Livelihood sources
- Crop patterns
- Mobility modes
- Income level
- Ownership patterns
- Assets (physical, social, political, economic, material)
- Governance
- Village/local level planning/funding
- Gender relation/gender roles
- Social, economic and political barriers
- Education status (literacy profile)
- Migration patterns (in and out)
- National and man-made disasters, conflicts, displacements and coping patterns

4.2. Geographical Data

- Road condition/surface
- Distance form community to health facility
- Time (by walking, vehicle, bicycle)
- Means of transport
- Hill or plane area
- Village settlement patterns (hill and plane)
- Health care practices (hill and plane)
- Health services (hill and plane)
- Seasonal mobility changes
- Water/sanitation source
- Waste management/environmental health
- Referral system (communication with referral centre, availability of means of transport, emergency fund)
- Emergency service availability

4.3. Data on Health Issues

- Number of health services
- Availability of health services (both centres and outreach)
- Quality of health services (both centre and outreach)
    - Availability of medicine
    - Affordability of medicine (health insurance)
    - Considerations for the poor
    - Knowledge and skills of health staff
    - Service time/waiting time
    - Acceptability of community (gender, social status, disabled)
    - Satisfaction by community of services
    - Satisfaction of staff in relation to what they can offer
    - Support (financial, supplies, capacity, resources) from government, communities, society, NGOs
    - Cost effectiveness (optimal use of resources)
    - Monitoring, supervision, evaluation systems
    - Human resources (high turnover of staff)
- Health issues
    - MMR and IMR
    - Most common diseases and disability
    - Socio-economic status
    - Seasonal diseases
    - Immunisations
    - Environmental risks (epidemics, natural disasters)
    - Utilisation of health facilities for safe mothers

4.4. Data on Health & Transport (Services & Infrastructure)

- Availability of health services/infrastructure
- Distance from community to health facility
- Modes of transport available
- Suitability of mode of transport used
- Availability and condition of infrastructure [road/paths/trails] for the use by modes used
- Condition of terrain and suitability/compatibility of the equipment
- Potential for upgrading/changing mode of transport in use
- Maintenance of health facilities
- Management system of the health service
- Operation of equipment
- Efficiency of mode in use
- Durability of the equipment
- Suitability and acceptability of equipment in respect of gender
- Safety of mode of transport and infrastructure
- Sustainability [costs, cost-recovery, maintenance etc]
- Storage of the transport mode.

4.5. Data on Access Issues (Relating to Health and Transport)

- Location of health services for target population
    - Rural Typology
    - Proximity
    - Distances
    - Weather patterns
- Common diseases
- Modes of Transport
    - Types
    - Suitability
    - Gender and disabled sensitive modes of transport
    - Availability
    - Affordability
    - Safety and Security
    - Transport infrastructure
- Health Services
    - Availability
        - Quality Standards staffing
        - Hours of work
        - Equipment and drug supplies
        - Skills
- Services offered
    - Types of services
    - Dispensary\Out-patient

  - Caesarean
  - Child screening
  - Ante natal care
  - Acceptability
  - Willingness of community to improve acceptability

4.6. Data on Social Issues

- How is mutual support organized? [community responses to health and transport]
- Acceptability of different health systems
- Community perception of health workers [professionally and personally]
- Medical workers
- Perception and interpretation of various ailments
- Local knowledge on health and transport
- Social dynamics in ownership and control of various transport modes
- Attitudes towards use of various modes
- Social attitudes towards the sick, ill, indisposed, poor, marginalized etc
- Traditional beliefs
- Knowledge and skills of traditional healers
- Availability and affordability of traditional healers
- Community initiatives, funds and strategies

4.7. Financial Issues

- Local financial structures
  - Types of Sources
    - Micro-finance/credit/NGO support
    - Bank
    - Merry go round
    - Remittances
  - Where relevant – Management of financial sources
- Local options to access cash
  [e.g., selling clothes, jewellery, animals, sex labour, illegal activities, remittances etc]
- Costs of means of transport
  - Purchase/hiring
  - Manufacturing [project specific]
  - Maintenance
  - Profitability and return on investments
- Affordability
  - Differences in users fees [members, non-members fee]
  - Costs of alternative means [in kind and human costs]
  - Total costs of service, divided in
  - Transport fares
  - User charges

NB: need to look at gender issues at all levels

4.8. Data on Local Solutions (Successes & Failures)

Local Solutions that were observed during field trips. Please include the examples you find in your own research as part of the findings and recommendations section in your report:

- Regular outreach to isolated areas
- Mobile health units facilitated by health centres
- Mobilisation of local volunteers
- Capacity building of community health volunteers, traditional healers and birth attendants
- Financial mechanism/initiatives which encourage income generation and group membership
- Local Government funds
- Setting up revolving funds
- Contributions to construction of health facility
- Self-help road construction/improvement government schemes
- Good quality affordable public transport (through community support, government, private sector)
- Express need for public transport for specific times/routes – e.g. school hours, hospital opening times to relevant authority
- Transport facilities or reimbursement for medical staff/volunteer travel
- Using locally available resources and technologies
- Flexibility in users fees
- Health insurance schemes
- Free health insurance for health workers
- Involvement of NGOs in health programmes
- Working with community-based organisations
- Community forms health and mobility pressure/lobby groups
- Sharing best practice, knowledge exchange, within district and beyond
- Health institutions giving information on preventative health to communities
- Hiring as a sustainable response to bike-ambulance maintenance
- Provision of ambulance service
- Relatives of patients asked to operate bicycle ambulance to health centres
- Transport solutions
    - Use of animals
    - NMTs
    - IMTs
- Community responses to emergencies
    - Men carrying sick people
    - Burial group
    - community trust funds
- Network with local transport service providers
- Sale of household items
- Traditional healers
- Traditional birth attendants

- Giving birth with attendance of health staff
- Community Safety networks
- Cohesive community – willing to help each other
- Over the counter drugs
- Temporary migration

5. CRUCIAL PROJECT INFORMATION & RESPONSIBILITIES

In this section some critical information about the research logistics and technical review is described. In addition to a timeline and milestones it also includes information about the final proposal and budget, and the format of the final report. Each researcher needs to strictly adhere to these guidelines as they will help to facilitate the process and support process. This section also contains practical information about the list serv, technical review and web site instructions.

5.1. SHARING INFORMATION

As we now know information sharing and networking is key to the success of Networked Research. You are in the process of establishing a Community of Practice working on issues relating to Mobility and Health. In order to facilitate this process we have set up a virtual D-group called Mobility and Health. If you have not done so we would like to ask you to please register through http://www.dgroups.org/groups/mobilityandhealth/ . Once you are registered you will receive a Welcome E-mail which explains how to use it. Let us know if you encounter difficulties and we will see how we can assist you. This Virtual Forum will be run in Spanish, French and English and IFRTD is committed to make sure the information is translated when relevant. Contractually every researcher is obliged to report at least once a month on the Virtual Forum to report on progress, successes, but more interesting for every one's learning purposes challenges. IFRTD will be developing a reporting format for every one to use. Obviously we hope that you will be using it more than once a month in order to help strengthen each other's work, cross-pollinate, and build synergies.

In addition you will have a responsibility to share and disseminate the case study and other relevant information (including pictures, new literature, links etc) through the web site www.mobilityandhealth.org and other sources that will help materialise the objectives of the programme. In the instructions it will explain how to do this.

Finally information sharing should not only be done at the international level. Local information sharing is even more important if we want this research to be taken forward to lead to policy changes and practices.

5.2. TIMELINE

The core group wishes to propose the following timeline:

a. AUGUST 15-17 — Asia regional researchers workshop
b. SEPTEMBER 12-14 — Latin America regional researchers workshop
c. OCTOBER 1 — Final Research Guidance Manual

d. OCTOBER 1, 2006 Final deadline for revised proposals and budgets, where necessary
e. JUNE 1, 2007 First draft submitted to IFRTD and Virtual Forum
f. SEPTEMBER 1, 2007 Feedback on first draft from core group
g. NOVEMBER 2007 International Symposium (looking at options, suggestions welcome!)
h. JANUARY 31, 2008 Submission of final draft
i. AUGUST 2008 Launch of book
j. MONTHLY REPORTING ON PROGRESS and SHARE INFORMATION ON WEB SITE AND LIST SERV

5.3. TECHNICAL REVIEW AND SUPPORT

In every research project you will encounter challenges; this is nothing to be afraid of or be intimated by, it WILL simply happen as it is the nature of the job. In order to build your confidence and capacity we urge all researchers to use the Virtual Forum ('D-group listserv') as your first point of call. After all there are other researchers working on similar issues as you now know and they will be able to help and support you as a member of this Community of Practice. Just keep in mind that giving and receiving this feedback and support should be done in a respectful and constructive manner as you have learned from the peer assist process.

Members of the core group will also be able to help you wherever they can. They are also members of the Virtual Forum so they will see the information flowing on the listserv. In case you get seriously stuck on a technical level, Kate Molesworth will be available on a limited basis. She will share with us the days during which she will be available for so-called 'Walk-In Hours'.

5.4. FINAL REPORT FORMAT

The final report will be between 30-40 pages long (excluding annexes) and will be submitted in a Word document format. The first and final draft will include the following sections:

- Table of Contents
- Executive Summary (mainly focusing on findings)
- Introduction
- Methods
- Findings (Outcome and Analysis)
- Conclusion
- Recommendations
- References (in the same format as the current literature review)

The font used will be Times New Roman size 12 and single space.

5.5. COPYRIGHT ISSUES

IFRTD will hold the rights to whatever material is produced under the provisions of this programme. As IFRTD is committed to placing information in the public domain, there will

be no constraints on the researchers' ability to share the information generated under this programme, provided the researchers clearly acknowledge the authors, IFRTD and the project, including its technical partners the Swiss Tropical Institute, the Swiss Resource Centre and Consultancies for Development (Skat) and its funding partners: Swiss Agency for Development and Cooperation.

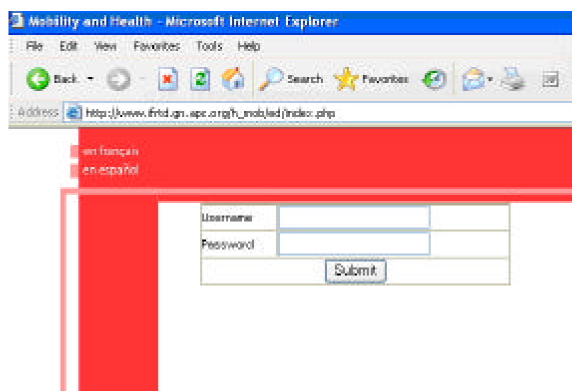
5.6. WEBSITE INSTRUCTIONS

The Mobility and Health Website has been designed so that everyone in the research team can add News items, photographs, links and publication references to the website www.mobilityandhealth.org. This is a step by step guide to entering and editing resources on the website:

1) Go to http://www.ifrtd.gn.apc.org/h_mob/ed/index.php

2) Logging in

Enter your user name and password and press *'submit'*.



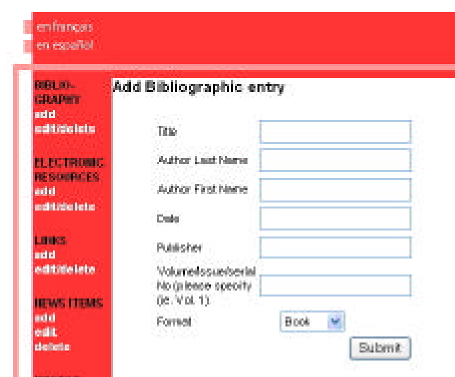
Your user name and password will be chosen by you at the 1st researcher workshop. If you have any problems logging in please email marinke@ifrtd.org

You will get a welcome message which you should click on to continue.

You will then see the adding and editing links listed down the left hand navigation bar.

3) Entering Publication References

The website hosts two bibliographies – one called BIBLIOGRAPHY for paper references, i.e. publications that are not available online, and the second for electronic references i.e. publications that can be opened or downloaded online. This is called ELECTRONIC RESOURCES



The first item on the editing list is the **paper bibliography** (items NOT available online).

Enter your text according to the prompts: Title, Author Last Name, Author First Name, etc.

Use the drop down menu to submit the format e.g... book, paper or journal.

If you have made an error or want to change something click on '*edit/delete*' in the left hand navigation bar. You will see a list of the items you have permission to edit or delete. Click on either the edit or delete button and make your changes or delete the item.

The **electronic bibliography** can be added to and edited in a similar way. However there is the additional section (shown to right) for either adding the web url to the publication online, or to upload the file directly.

If you are uploading a file please ensure that you have permission from the author or publisher to share it publicly on the internet.

4) Adding web links

This section enables you to add links to interesting websites or web pages relating to mobility and health.

NOTE – This section is for websites and pages, if you have a web link to a specific document or publication that can be opened or downloaded online then this should be placed in the ELECTRONIC RESOURCES section.

Follow the instructions to input your text. **When you input the url DO NOT enter the http:// this is already entered for you. You DO need to enter www. if it is part of the url.**

Links can be edited or deleted if necessary. Click on '*edit/delete*' to see the list of items that you have permission to amend.

5) Adding News Items

Click on '*add'* under NEWS ITEMS on the left hand navigation bar.

Use the drop down list to enter the language you will be writing the piece in. You can write it in English, French or Spanish.

Enter the title & enter a brief summary – these appear on the homepage of the site.

The summary should be 20 WORDS MAXIMUM

The date is generated automatically and enables the website to list the news items in chronological order – **please do not change this.**

Use the large box to enter the text of your news item. You can use the icons at the bottom of the box to format your text. If you enter web urls or email addresses they will be created as links automatically. When you have finished press 'submit' then check your entry on the homepage.

To edit or delete a news item click on 'edit' or 'delete' under NEWS ITEMS in the left hand navigation bar. Follow the instructions as before to make your changes. Press 'submit'

6) Adding photographs

To add a photograph **RELEVANT TO THE PROGRAMME AND YOUR STUDY** please click on 'add' under PHOTOS in the left hand navigation bar

Title (en):
Title (es):
Title (fr):
Location: choose location
Keywords: Please select from the list below: affordable transport, Animal Ambulance, Child health, Cycle Ambulance, HIV/AIDS, Maternal Mortality, Positioning, Stretcher
If you ABSOLUTELY NEED TO ADD A KEYWORD put it below
Pic: Browse...
Don't forget that the longest side of the pic should be 300 pixles max, and the resolution of the pic should only be 72 dpi. ONLY UPLOAD jpeg files... no GIF files please
Pic Alt Text
Input by
Input / Modify Date: 2006-08-03 yyyy-mm-dd

Enter the **title** in the language of your choice – if you are able to enter the language in 2 or all three languages then please do!

Select the **location** where the photo WAS TAKEN from the drop down list.

Tick the boxes of applicable **keywords**. If you do not feel that any of the keywords are appropriate please add one in the box as directed. This will trigger emails to the IFRTD Secretariat to add this keyword in the other two languages. Please think carefully about keywords and do not add unnecessary or duplicating words.

Use the browse button to select the photo from your computer hard drive or disc. The longest side of the photo should be 300 pixels maximum and the resolution should be no more than 72dpi. If we all upload huge pictures we will quickly exhaust the space available on the website.
ONLY UPLOAD JPEGS - NO GIFS PLEASE.

Please use the 'pic alt text' box to enter the caption for the photograph and to include a **CREDIT TO THE PHOTOGRAPHER**.

PLEASE DO NOT UPLOAD PHOTOGRAPHS THAT ARE NOT YOUR OWN OR THAT YOU DO NOT HAVE PERMISSION TO SHARE ONLINE.

To edit or delete a photo entry, please click on '*edit/delete'* under the PHOTOS section on the left hand navigation bar. This will bring up a visual list of all the photos that you have permission to amend or delete. Follow the instructions.

General Notes:

- You will only be able to edit or delete items that you yourself have added to the site.
- Marinke van Riet, Simon Chouffot & Kate Czuczman in the IFRTD office are the administrators and are very happy to help you if you get stuck.
- Items can be added in English, French or Spanish. All 3 language sites will display the same lists of references, links and photos.
- Please try not to use more text than necessary so that we do not overwhelm users of the site.
- **You cannot add anything to the site that cannot be amended or changed by you or the administrators at a later date - so don't be shy, get started and help us to develop a great online resource that will help us to raise awareness of the issues!**

6. ACKNOWLEDGEMENTS

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Core Team:
Kate Molesworth, Swiss Tropical Institute

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IFRTD Secretariat

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For more information contact: ifrtd@ifrtd.org or visit www.mobilityandhealth.org