CATÓLICA LISBON
BUSINESS & ECONOMICS

RIDERS FOR HEALTH

Healthcare Delivery Solution in Lesotho

The Need for Reliable Transport in African Health Systems

Simão Silveira Botelho

Advisor: Susana Frazão Pinheiro

Dissertation submitted in partial fulfilment of requirements for the Degree of MSc in Business Administration, at Universidade Católica Portuguesa

February, 2012

ABSTRACT

Title: *Riders for Health* – ***Healthcare Delivery Solution in Lesotho***
Sub-title: The Need for Reliable Transport in African Health Systems

Author: Simão Silveira Botelho

The present dissertation, written in the form of a case study, aims to present Riders for Health, a British social enterprise whose mission is to create and manage transport systems in rural Africa. In December 2011, Riders for Health (Riders), was operating in seven African countries - the Gambia, Zimbabwe, Nigeria, Kenya, Zambia, Tanzania and Lesotho - employing more than 300 Africans, managing more than 1.600 vehicles and providing better access to healthcare services for up to 12 million Africans. We chose Riders' Lesotho programme to present an overview of the enterprise's innovative and sustainable business model.

In the following pages we introduce the dissertation outline, then we provide the reader with an overview of the main literature about the development state of the African continent, health determinants, foreign aid effectiveness and social entrepreneurship. Afterwards, the case study focuses on Riders as a social enterprise, providing an overview of its general operations and business model. The country profile of Lesotho is also addressed in order to better understand Riders' approach which is extensively presented along the financing of its programme. Later, Riders' goals for 2015 are outlined and the case study finishes with a wrap-up of Riders' main drivers of success. Finally we provide teaching notes for in-class discussion about the case study, and conclude with final remarks and future research guidelines.

RESUMO

Título: *Riders for Health* – ***Solução para a Distribuição de Cuidados de Saúde no Lesoto***
Sub-título: A Necessidade de Transportes Confiáveis nos Sistemas de Saúde Africanos

Autor: Simão Silveira Botelho

A presente dissertação, escrita sob a forma de um caso-de-estudo, tem como principal objectivo apresentar os Riders for Health, uma empresa social Britânica, cuja missão é criar e gerir infraestruturas de transporte para a África rural. Em Dezembro de 2011, os Riders for Health (Riders) tinham operações em sete países Africanos - a Gâmbia, Zimbabué, Nigéria, Quénia, Zâmbia, Tanzânia e o Lesoto - empregando mais de 300 Africanos, gerindo mais de 1.600 veículos e alcançando mais de 12 millhões de Africanos. Escolhemos o programa dos Riders no Lesoto para apresentar uma visão geral acerca da sustentabilidade e inovação do modelo de negócio desta empresa.

Nas páginas que se seguem, apresentamos o esquema da dissertação, em seguida oferecemos ao leitor uma revisão sobre a literatura mais importante relativa ao desenvolvimento do continente Africano, bem como os condicionantes da prestação de cuidados de saúde, a eficácia da ajuda externa e a importância do empreendedorismo social. Seguidamente, o caso-de-estudo apresenta os Riders como um empresa social focando-se nas operações da empresa e no seu modelo de negócio. O perfil do Lesoto é apresentado para melhor compreendermos a abordagem dos Riders, a qual é extensivamente apresentada conjuntamente com o financiamento dos programas. Adiante, são traçados os objectivos dos Riders para 2015 e o caso termina com uma breve conclusão sobre os factores que conduziram ao seu sucesso. Finalmente, oferecemos algumas notas explicativas para a discussão do caso, apresentamos as nossas observações finais e clarificamos as nossas directrizes para futuras pesquisas.

TABLE OF CONTENTS

PREFACE

The reader is holding my final academic project, which reflects my strong belief in entrepreneurship as part of the solution for a better world. While deciding on the topic for the present dissertation I felt it was the perfect moment to dig deeper into the world of *Entrepreneurship and Development*; I have always been intrigued by business' potential to provide tools for societies' development. Hence, instead of writing about the strategy of a successful company or presenting an important social issue, I have decided to combine both and work on the field of *Social Entrepreneurship*.

Once I had the main topic in mind, all I needed was a successful story through which I could raise the awareness for the importance of social entrepreneurship in our times. Thanks to the suggestion of my advisor, Professor Susana Frazão Pinheiro - to whom I am deeply grateful for all the help and orientation during this dissertation preparation - I came to know the work of a British social enterprise that has been saving millions of lives in Africa for the past twenty years.

With this dissertation I would like to introduce you to ***Riders for Health – Healthcare Delivery Solution in Lesotho***, a case study that aims to present a social enterprise operating in Africa and striving to help Ministries of Health and other health partners to overcome one of the biggest barriers to African health systems: the tyranny of distance that exiles the sick from health structures and the lack of managed transportation for healthcare delivery.

The following pages provide for the reader a case study on Riders' programme in Lesotho, a small southern-African country also called the *Mountain Kingdom of Lesotho*. The usefulness of this dissertation is linked to the fact that it helps Riders to increase awareness of people from all around the world to the importance of managed transportation and its contribution to preventing people from dying due to easily preventable and curable diseases. The case study describes operations in Lesotho and addresses many of the important factors behind the success of this award-winning enterprise.

I want to tell the story of Riders, a story of hope for all of us, as it shows how *people* can be at the centre of businesses' goals. Thus, I would honestly say that this case study was made not only for devoted students and professors but also for companies, families and friends and all the citizens committed to making this world a better place for us and for future generations.

I would like to thank Riders for the opportunity to write about its story, and especially to Danny O'Farrel for the countless e-mails that we have exchanged in the past four months and for all the conference calls, information and clarifications provided. I would also like to thank my editor and dear friend Eva Marie Haine for the rigorous and professional English revision and to all those who supported me during this intense but rewarding period, especially my always understanding family and girlfriend. To all of you I dedicate this dissertation, hoping that Riders' example may motivate you to become *changing agents* in your environments.

LIST OF ACRONYMS

ACT	Active Community Transport
ARV	antiretroviral
CBOs	Community Based Organizations
CEO	Chief Executive Officer
CHAI	Clinton Health Access Initiative
CHAL	Christian Health Association of Lesotho
COO	Chief Operating Officer
Cowater	Cowater International
CPK	cost per kilometre
DAC	development assistance committee
ED	Executive Director
EJAF	Elton John AIDS Foundation
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHPPP's	global health public-private partnerships
HDI	Human Development Index
HIV/AID	human immunodeficiency virus/acquired immunodeficiency syndrome
IAVM	International Academy of Vehicle Management
LDC	Least Developed Country
LHWP	Lesotho Highlands Water Project
M2M	Mother 2 Mothers
M&E	Monitoring and Evaluation
MDR-TB	multi-drug resistant tuberculosis
MoH	Ministries of Health
MoHSW	Ministry of Health and Social Welfare
NGO	non-governmental organization
ODA	official development assistance
OECD	Organization for Economic Co-operation and Development
OHW	Outreach Health Worker
OHWM	Outreach Health Worker Mobilization programme
PIH	Partners in Health
Riders	Riders for Health
RfH	Riders for Health
SCF	Save the Children Fund
SE	Social Entrepreneurship
SSA	sub-Saharan Africa
ST	Sample Transport programme
TAM	Transport Asset Management
TB	tuberculosis
TQs	Teaching Questions
TRM	Transport Resource Management
UK	United Kingdom
UNDP	United Nations Development Programme
UN-OHRLLS	United Nations office of the high representative for the least developed countries landlocked developing countries and small island developing states
WHO	World Health Organization
WTO	World Trade Organization

LIST OF ANNEXES AND EXHIBITS

Chapter 1: INTRODUCTION

The present dissertation was developed in the scope of an Entrepreneurship and Development seminar. The main purpose is to raise awareness to the importance of managed transportation for African health systems by providing the elucidative example of Riders and its programme in Lesotho. Commonly business is known for having profit as its ultimate goal, however, as Aristotle once said, *"wealth is evidently not the good we are seeking, for it is merely useful and for the sake of something else"*[1], we also agree and are deeply persuaded that business should serve societies and not the other way around.

To address this topic, we adopted a straight forward structure so that the reader can find and follow all of the expected elements of the case study. Initially, we present a summary of the main literature in order to provide a solid basis from which one can build an understanding of Riders in Africa and its impact in this *poor* continent. Later, we introduce Riders and the Lesotho programme followed by clear teaching notes on the case study. Finally we present concluding remarks and a list of the used bibliography.

For Chapter 2 - *Literature Review* - we had access to a comprehensive number of articles and other publications which proved to be useful for our case study. We start by presenting *Africa: a Developing Continent* and use the Human Development Index to depict the development status of most of the African countries. In the second sub-chapter we carefully analyse *Healthcare in Africa*, its determinants and also the existing barriers to more efficient health systems. Afterwards, we provide a sub-chapter devoted to the *Effectiveness of Foreign Aid* - an important topic for discussion - and finally the theory of *Social Entrepreneurship* is briefly explained.

Chapter 3 - the *Case Study* - presents Riders' solution for healthcare distribution in African health systems. Instead of telling Riders' story for it, we wanted to allow the enterprise's own words and ideas to speak for itself, so we have collected information from conference calls with Ms. Mahali Hlasa (Lesotho's Programme Director), Ms. Kameko Nichols (Partnership Director) and Mr. Danny O'Farrel (Partnership Office). In addition, we used the Annual Report from 2010, Lesotho Programme Impact Report and the Strategic Overview Report from 2011, and much of the information available on Riders' website and TV channel, including transcribed statements from Riders' co-founders and relevant films about its several African programmes. Moreover, the case study is enriched by elucidative exhibits that are meant to help the reader better assimilate the provided information.

These sources largely contributed to elaborate this chapter, which starts with an *Introduction* to address the problem of managed transportation in Africa and Riders' solution. Then we present *Riders as a Social Enterprise*

[1] Aristotle, *Nicomachean Ethics* (325 BC)

with a summary of its story, vision and mission, followed by a sub-chapter on *Riders the Perfect Partner in Transportation*, in which managed transportation solutions and its operational models are displayed. Afterwards, we aim to illustrate the *Country Context* of the *Mountain Kingdom of Lesotho* and provide a review over its main characteristics, which include the topics of *Geography and People, History, Politics and Economy*. The country introduction finishes with a single sub-chapter devoted to *Healthcare Delivery and Health Transport in Lesotho*. *Riders*' *Approach in Lesotho* forms the largest portion of our case study where we present the programme overview, Riders' Lesotho organizational structure, the importance of partnerships and the programme striking impact. The next sub-chapter is devoted to the *Financing of Riders*' *Lesotho Programme*, which underscores the importance of its sustainable models and self-sufficiency. Later, Riders' *Future Plans for Africa* and its goals for 2015 are outlined, and the case study concludes by enumerating the *Drivers of Riders*' *Success*, which are meant to inspire others to use Riders' business model and place people at the centre of business decisions.

Chapter 4 - *the Teaching Notes* - was prepared to assist professors on the preparation of an in-class discussion. We first lay out the *Case Summary* and the underlying *Learning Objectives*, lately posing relevant *Teaching Questions* and the *Suggested Teaching Methods*. This chapter is completed by a comprehensive *Analysis and Discussion* of the questions as we provide guidelines for complete answers. Again, this chapter is supported with several exhibits meant to illustrate the questions and respective answers.

Finally we present our dissertation's *Conclusion and Future Research* recommendations as well as the *Bibliography* that includes all of the sources of information that are at the reader's disposal for consultation.

Chapter 2: LITERATURE REVIEW

2.1. Africa: a Developing Continent

"The poor you will always have with you." (Matthew 26, 11)

For over two thousand years ago the existence of people in need has been a reality. Albeit this being an undeniable truth, in this first sub-chapter, we aim not just to demonstrate that poverty exists and affects millions of people but also that it has a particular predominance in certain developing regions of the world.

In fact, when considering the *poorest* nations in the world our eyes turn immediately to the African continent and especially to sub-Saharan Africa (SSA). However, in order to name a nation as *poor* one has to use indicators that evidence that qualification and, even more important, one has to understand them. Laderchi et al (2003) presents four different approaches to poverty in an attempt to better define this concept: *"the monetary approach, the capabilities approach, the social exclusion as poverty and the participatory approach"*. Nevertheless, it is not in the scope of this dissertation to deeply think about the topic of measuring the determinants of poverty, and in that sense we will use the worldwide known indicator for country development that is the Human Development Index (HDI)[2].

2.1.1. Measuring Development - the HDI

In 1991, the Human Development Report 1990[3] (UNDP, 1990), firstly introduced the HDI with the purpose of creating a composite index capable of capturing the complex reality of human development, establishing the link between it and economic growth. The HDI is based on the idea that *"people are the real wealth of a nation"* (UNDP 1990) and that income alone is not an appropriate proxy for human development.

Canning (2010) identifies health as a key component of the HDI, following the idea presented by the World Bank (World Bank 2000/2001) that human development is dependent on social elements like health and education. The need for these was commonly accepted by many authors (see Stiglitz et al, 2009), however the choice of the indicator that best measures the health of a given population was not subject to general agreement (see Mathers et al, 2003). Life expectancy thus seemed the most appropriate measure, as Canning (2010) showed how *"population mortality and illness measures tend to move closely together, allowing us to use life expectancy as a reasonable proxy for population's health"*.

[2] World Bank's Poverty Line measurement could also be a valid choice, however HDI appeared to be more complete

[3] The project director was *Dr. Mahbub ul Haq* a Pakistani economist and one of the pioneers of the human development theory

Hence, more than twenty years ago the UNDP created a new index composed of three equally weighted components[4]. Nevertheless, in UNDP (1990), the authors admit that all these measures of development have a common shortfall as they are global averages hiding inequalities in the overall population. Despite these indicators' choice considerations[5] we consider that the HDI is assumed to be a reasonably well composed index and a reliable development indicator.

2.1.2. The Least Developed Countries (LDC's)

"They (LDC's) comprise more than 880 million people (about 12 per cent of the world population), but account for less than 2 percent of world GDP and about 1 percent of global trade in goods".[6]

In 2011, from a group of 187 countries, the world HDI was 0.682 and the *poorest* region was considered to be the SSA with 0.463 (more HDI information in Annex 1). In fact, the use of this index enables the division of countries in different groups according to their state of development, and currently the African countries are seen as the most lagging. Moreover the use of HDI enables identification of the current LDC's as being the ones with an HDI lower or equal to 0.439.

The LDC's group was first determined in 1971 by the UN General Assembly and *"represent the poorest of the international community"* (UN-OHRLLS 2011). The UN-OHRLLS[7] has already organized four United Nations Conferences on the LDC's[8], and in the last conference, the Istanbul Programme of Action (IPoA) for 2011 to 2020 was adopted reflecting the UN support to surpass LDC's structural handicaps, to eradicate poverty and achieve international development goals.

In Annex 2 we can see the current LDC list comprising 48 countries, from which 33 belong to the SSA, 14 to Asia and 1 to Latin America and the Caribbean. The fact that almost 70% of LDC's belong to the SSA is evidence that this is the *poorest* region in the world and the one that needs the most urgent attention from the international community.

2.1.3. The Problem Over-stating Negative Stereotypes

Having thus demonstrated the real development problems in SSA, it is nonetheless important to separate these claims from Africa's extremely negative stereotypes. The same concern is presented by Easterly (2009), who helped to clarify facts versus emphatic extrapolations. One cannot say that Africa lives in the *"fourteenth*

[4] Longevity (to which the best indicator is *life expectancy*), Knowledge (measured by the *literacy* rates) and the "*Basic Income for a decent living standard*" (reflected in the *gross national income* per capita in PPP$)
[5] Note: see Ranis et al (2006) and Wolff et al (2011)
[6] *Source: http://www.unohrlls.org/en/ldc/25*
[7] *Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States*
[8] UN Conferences on LDC's - Paris 1981 and 1990; Brussels 2001 and Istanbul 2011 (http://www.unohrlls.org)

century", like Collier (2007) or that *"War, Famine, Plague & Death are the Four Horsemen of the Apocalypse"* haunting Africa, like the celebrity activist Bob Geldof[9]. Easterly, in the already cited paper, clearly showed that the SSA is the *poorest* region in the world, but also that its reality contradicts such extremely negative portraits.

The reasons behind such problems are many and not easy to fully comprehend. One might be linked to the fact that when dealing with Africa, some NGOs, journalists and other organizations and/or individuals tend to exaggerate Africa's negative aspects in order to favour fundraising campaigns. The argument for advocacy is plausible, however it is unfortunately leading Africa into a *trap* of self-fulfilling prophecies and foreign aid dependency.

2.2. Healthcare in Africa

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services. Motherhood and childhood are entitled to special care and assistance".[10]

More than sixty years ago the UN General Assembly adopted the Declaration of Human Rights, elucidating the rights of any human being anywhere in the world. In the cited article, it is clear how healthcare is crucial for any individual – one could even say that this is one of the most important pillars of the world's development. In this section we seek to present Africa's key determinants of health in order to better understand the barriers that its healthcare system's face. In addition, we also strive to briefly demonstrate the importance of transportation to healthcare and the need of global healthcare partnerships for Africa's development.

2.2.1. Key Determinants of Health

Before addressing the barriers to healthcare, first let us review the key determinants of health, in order to better understand the continent's health status and what its health strategies should be. In accordance with WHO Africa (2011), nine critical variables are used (see data in Annex 3):

- ***Demography*** (we find a young population growing every year, with almost 70% living in rural areas);
- ***Poverty & income inequality*** (with more than half of the population living in *absolute poverty*);
- ***Resources & infrastructure*** (with the lowest ratio of physicians and nursing personnel, the lowest per capita expenditure in health, and also a low electrification rate and kilometres of roads paved);
- ***Gender inequity*** (with a low participation of women in political and public life);

[9] Source: http://www.brookings.edu/opinions/2007/0706globaleconomics_easterly.aspx
[10] UN, *The Declaration of Human Rights*, part of Article 25th (1948)

- ***Education*** (albeit adult literacy rates are growing, half of African women do not know how to read and write);
- ***Environment*** (with almost 40% of the population not using improved drinking water sources, and almost 70% not using improved sanitation facilities);
- ***Global partnerships*** (with the existence of many forms of external aid, discussed further in section 2.3.);
- ***Science and technology*** (with low rates of telephone and internet usage);
- ***Emergencies and disasters*** (that foster a great number of refugees from this region).

In Annex 4 we can also find a summary of some health indicators that demonstrate how in, the past decade, SSA countries had bad health results, in comparison to all the other WHO regions in the World.

2.2.2. Barriers in the Healthcare System

We will now focus on the barriers that have been influencing the health status just described, only mentioning the most relevant to this reflexion.

Firstly, we have to consider the existence of great ***shortages of health personnel*** that undermine the health system's functioning. These shortages, seen in Annex 4, are shocking when compared with the global and European averages (14 physicians and 28 nurses; 33 physicians and 68 nurses, respectively, per 10.000 population)[11]. Human resources are, in fact, a vital piece in any health system, and that is why the migratory trend of physicians, nurses and other medical staff is hampering the already fragile African health system. Connell et al (2007) presents this situation as a major *"health workforce crisis"*, with health professionals often migrating to developed countries[12] outside the African continent. These migratory flows also happen inside the continent, from less developed countries to more developed ones, and also inside the same country from the rural areas to the urban centres and from the public to the private sector. The reasons behind these shortages are many[13] and the implications of such *crisis* pose great questions to the African Ministries of Health (MoHs).

Connell et al (2007), as well as Gerein et al (2006) and Eastwood et al (2005) present some of the consequences for the African countries: adequate healthcare provision is affected, especially for rural populations; populations look for overseas treatment; existence of non-neglectible economic costs (sunk education costs, the need of importing foreign health expertise); skill loss with existence of a *"brain drain"*; and for the remaining workforce, emotional exhaustion and low morale are also expected.

Secondly, we have to account for the ***supply shortages of medicines and treatments*** that also hamper the

[11] Data relative to 2000-2009, from *WHO Africa* (2011) p. 22

[12] The author mentions a list that includes Portugal, Canada, UK, Australia, France and also USA

[13] Reasons: low wages and other economic reasons; health careers; poor working conditions; heavy workloads; security conditions and also a globalized world where a free movement of goods and services exists

provision of adequate healthcare. The lack of access to medicines (e.g. drugs and vaccines) is contributing to millions of deaths in Africa, with HIV/AIDS, TB and Malaria - diseases that are treatable with proper medication and care - accounting for millions of deaths every year (WHO Africa 2011). This barrier raises a serious number of controversial debates, including whether access to medication should be a global concern (Ngoasong 2009). In regards to the latter, issues with the pricing of the medicines (discussion around generics, TRIPs[14] and Patents[15]) its necessary quality and also the almost inexistent integrated and efficient supply chain of medicines[16]. Dionisio et al (2006) also refers to these barriers and the need of ARV drugs for an effective control of the HIV epidemic in developing countries. In addition, this paper presents the ethical responsibility that the international community has in providing access to these medicines, as well as the imperative necessity of developing countries' governments to pay greater attention to the *"persistently unaffordable drug prices, inadequate financing for health, poor priority setting, inappropriate dug selection and prescription, and weak health and supply systems."*

Thirdly, the ***lack of health resources and infrastructures*** is a major barrier. African health systems need more and modern health centres, hospitals and laboratories (Petti et al, 2005), and there is also the need of more medical equipment (e.g. microscopes and other medical utilities needed for quality diagnosis and treatment). Also noteworthy is the necessity of viable healthcare vehicles and of their consumables (e.g. fuel, spare parts and other). These constraints might be overcome with the help of international organizations and other external agents, nevertheless the building of a long lasting and independent national health infrastructure is essential.

Finally, it is necessary to refer to the hard ***geographic conditions*** for many African countries that make it almost impossible to provide healthcare to the entire population. This specific barrier changes from country to country, but in the worst cases, a great distance separates the ill-people from the medical infrastructures, and also the harsh terrains (e.g. hills, valleys and loose soils) and/or climate that these fragile individuals often face in order to receive proper medical care are added risks. These long distances are worsened by the lack of paved roads (also in Annex 3) where healthcare vehicles, and others, can drive in order to link the people in need to the established health infrastructure.[17]

2.2.3. Transportation at the Centre of Healthcare

As we have seen, geographic conditions are natural barriers undermining health care provision especially to the rural populations. These conditions make health related transportation issues even more crucial, like Dr.

[14] TRIPs (i.e. Trade-Related Aspects of Intellectual Property Rights) are a WTO agreement (1994) to the safeguard of Intellectual Property Rights (IPRs) in the world, protecting companies by stopping anyone from copying their products for twenty years at least (Dionisio et al, 2006)

[15] A twenty-year warranty securing inventor exclusive rights on drug production and marketing aspects. When countries signed up to WTO they accepted to protect the patent rights of corporations selling drugs within their boundaries (Dionisio et al, 2006)

[16] Note: see more in Lufesi (2007)

[17] Note: Murman and Sullivan (2008)

Mamady Chad, Director of the Gambian Health Services Ministry of Health in 2011, simply explained: *"transport is an essential element in any healthcare delivery. Without transport a lot of service cannot be delivered."*[18]

While there are several means of transportation, this study will focus on road transport (motorized and non-motorized, namely bicycles and wheelbarrows)[19], which is the most commonly used for healthcare services in SSA. In regards to road transport, Queiroz and Gautam (1992) states the importance of it especially in developing countries, as it plays an essential role in providing access to products (e.g. agricultural and others) and services (e.g. health and education). The authors also underscore the significance of road transport while referring to rural populations' mobility needs.

The importance of roads to African development is also a common actual idea[20]. In a more recent paper, Abuhamoud et al (2011) stresses the need for high investments to build or improve road conditions and to ensure its safety. Moreover, Porter (2007) emphatically explains that roads are necessary but not sufficient in end of themselves; appropriate vehicles to deliver the basic services to the populations are needed too.

Transport is a vital piece for an effective health system. Lord Mark Marloch-Brown (former UN Deputy Secretary General) convincingly states: *"(Transport) is not a kind of nice luxury addition. It's at the core of the development model of health delivery, and without it, the doctors, the medicines, the clinics risk being a wasted investment, because that key linkage in the middle, getting the health worker to the patient, becomes impossible."*[21]

2.2.4. Global Partnerships in Healthcare

African Governments alone cannot overcome the barriers just discussed in sub-chapter 2.2.2. – a reality that point to another of Africa's key health determinants: *Global partnerships.*

Global partnerships can take many forms; in this study, the term *global health public-private partnerships* (GHPPPs) is used to describe *"relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision-making"* (Buse and Harmer 2006). The GHPPPs have an important role in health governance, with seven major contributions (see in Annex 5), including *augmenting health service delivery* and the *mobilization of funding for health policies*.

[18] Riders for Health (RfH) TV: *"Uncommon Heroes"* (http://www.youtube.com/user/RidersForHealthTV#p/u/0/KM80QCaVtr0)
[19] Note: Murman and Sullivan (2008)
[20] Note: see Bryceson et al (2008)
[21] RfH TV: *"Uncommon Heroes"* (http://www.youtube.com/user/RidersForHealthTV#p/u/0/KM80QCaVtr0)

Regarding the contribution to healthcare delivery, Ngoasong (2009) discusses how two GHPPPs (*Roll Back Malaria partnership (RBM)* and the *Accelerating Access Initiative (AAI)* for HIV/AIDS treatment) facilitated populations' access to medication. He also explains how, in the 1990's, GHPPPs were emerging to bring together different health-agents[22] creating a highly effective force for African health systems.

The mobilization of funds for healthcare is a corner stone of Africa's development strategies, hence it is not surprising that these GHPPPs are also active in the financing of global health issues. McCoy et al (2009) addresses the GHPPPs' contribution to global health by clarifying the players and their functions, that are not only to *manage and pool* global health funds and channel those for the adequate recipients, but also to *spend* the given funds on health-related consumption.

It is clear that GHPPPs' work is contributing to SSA's development, however a closer look at the effects that this form of aid might have in the long run is necessary. The next section devoted to aid effectiveness will do serve that purpose.

2.3. The Effectiveness of Foreign Aid

"If all the aid to Zambia had gone into productive investment, it would be a rich country today".[23]

World Bank (1998), coordinated by Joseph E. Stiglitz, produced a seminal World Bank policy research report that carefully analyzed the foreign aid reality and strived to answer the questions: *"What Works, What Doesn't, and Why?".* This report contributed to the *"rethinking of aid that the international community (was) engaged in"*, by presenting what should be the role of assistance under a changing development paradigm. In fact, with the surge of capital markets and private inflows to the developing countries, aid also became more dependent on *knowledge* and not just on *money disbursements* (World Bank 1998).

At this point, it is important to state that aid is timeless, and so its main objective has always been to promote long-term growth and foster poverty reduction. Nonetheless, in the literature, there is little consensus on the impact of aid on growth outcomes. On the one hand we have authors, like Easterly et al (2004), arguing that foreign aid is hampering African development, and on the other hand authors, like Arndt et al (2009) that envision a much worse situation in SSA without any form of aid. The vast and complex reality of aid in developing countries it is in itself a relevant and important topic for an entire thesis, hence this study can only briefly present the main positions regarding these matters.

[22] The term "health-agents" define governments, development agencies (WHO, UNICEF, IMF or the World Bank), private corporations (e.g. pharmaceutical and others) and also society organizations (e.g. NGOs and philanthropic donors)
[23] Note: World Bank (1998), p.10

2.3.1. Foreign Aid Definition

Foreign aid is a post World War II concept, commonly used to describe the assistance that rich countries give to the poorest nations. Moreover, foreign aid signifies the Official Development Assistance (ODA) given to the poorest nations and which can be of two types (Ram 2003 and also World Bank 1998): *bilateral* (i.e. managed by agencies of donor governments, like the U.S. Agency for International Development) or *multilateral* (i.e. dependent of the funds of wealthy donor countries and managed by agencies such as the UN or the World Bank), with the latter being the most effective (Radelet et al, 2005).

2.3.2. Foreign Aid: Facts and Numbers

It is curious how Africa can be a continent full of natural resources and at the same time have the greatest necessity of foreign aid. In Annex 6 and 7, the current numbers for the total ODA (net disbursements), collected by OECD and given by the DAC (Development Assistance Committee)[24] countries are shown. These data suggests a greater weight of bilateral forms of aid and evidences that, from the list of developing countries, the Africans account for the greatest share of ODA.

2.3.3. Donors, Agencies and Recipients

One cannot understand the impact of foreign aid on growth without distinguishing the three major players: the donor countries, the development agencies and the recipient countries. More specifically, the effectiveness of aid is dependent on the motivation of the donors, the development agencies' decisions and on the recipient's response and usage of that aid.

Bourguignon and Sundberg (2007) go further and define a causality chain for the assistance process (in Annex 8) demonstrating that growth outcomes are dependent on the policies chosen, which in turn depend on the policymakers that can be influenced by the donors and/or the international agencies. The linkage between donors/agencies and the policymakers enable not just the flow of *financial resources* and *technical assistance* but also a certain influence on policy debate and in the decision-making process within the recipient country (this is *aid conditionality*). Another link is the way in which policymakers choose the policies that best fit their country's development needs (this as to do with *governance* and is related to the country's *institutional capacity*). The final and critical link relates to the policies put in place and the resultant growth outcomes (classified as *knowledge*). These three different linkages describe the causality chain between aid and growth. Yet, despite its simplicity, this problematic draws upon a very complex development puzzle, as many different variables act to influence the major participants in the process.

[24] DAC is a forum for aid discussion for OECD member states composed by 24 countries: Australia, Austria, Belgium, Canada, Denmark, European Union, Finland, France, Germany, Greece, Ireland, Japan, Italy, Luxembourg, Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, United Kingdom, the United States and having as observers the World Bank, the IMF and the UNDP

As Ram (2003) explained, multilateral and bilateral aid have different characteristics that are important when considering the *donor motives*, the *conditions of aid* and the *donor/recipient relations*. The *donor motives* (i.e. their strategic and economic interests) are more important in the presence of bilateral forms of aid: there is evidence that *"donors support countries with which they have strong cultural, economic, political or strategic ties"* (also defended in Burnside and Dollar 2000). In fact, we have to recognize that for a donor, a long-standing relationship with a specific country will ease the process of aid. Important variables like the colonial past or the linguistic and cultural affinities might facilitate communication and consequently assistance. Finally, in multilateral forms of aid the *conditions of aid* are another criteria for allocation as the aid packages and programmes presented by the development agencies are dependent on the fulfilment of certain criteria.

Furthermore, in the literature there is a general concern about how recipient's *good policies* influence a donor's decisions and then growth outcomes. Bourguignon and Sundberg (2007), Ram (2003), Burnside and Dollar (2000) and the authors of World Bank (1998), agree that the recipients with better economic, political and social policies have favourable conditions for success in the development process and hence have a higher probability of being assisted with more aid. Alesina and Dollar (2000) focuses on the political dimension and shows that there is a trend for democratized recipients *"to get a substantial increase in assistance (50 percent on average)"* given the reform of political institutions.

However, this debate is not closed and Easterly et al (2004) argue that there are some limitations of these findings and remains sceptical about the implications of foreign aid on the recipient country's development. Seeking a middle ground, one should recognize the importance of *sound policies* on the part of the recipients, as the use of that aid is dependent on the policies' efficiency, while acknowledging the great challenges posed by poor data quality and the difficulty in controlling the multidimensionality of all the development variables.

2.3.4. Negative Effects of Foreign Aid

The scepticism about foreign aid and its effectiveness is related, in part, to what Lensink and White (2001) described as the existence of negative returns to aid. This is not a new concern, as in World Bank (1998) the institution had also assumed that initial aid inflows have a positive impact but after a certain level the aid benefits start to decline and might become harmful to the recipient country.

Furthermore, the same theory, developed by Lensink and White (2001), was presented in the form of a *Laffer* curve (Annex 9) applied to aid. This curve is useful in understanding the variety of negative impacts, for different levels, that foreign aid might have in low-income countries, especially in SSA (Moss et al, 2006). First, Lensink and White present that a higher level of aid inflows will lead to the surge of aid dependent nations and will not *"lay the basis for self-reliant development as aid is intended to"*. Second, the authors explain that foreign aid has

the effect of crowding out local savings[25] and reducing the productivity of investment in the recipient country. Third, the same authors explain that recipient countries often have limited *absorvative* capacity to successfully implement the development projects, as there is an inverse relation between aid and its productivity. And fourth, large inflow of aid can affect the real exchange rates of the recipients, thus undermining the competitiveness of its export sector, a well-known problem called the *Dutch disease* (Moss et al, 2006).

Moreover, Moss et al (2006) explains a series of negative impacts in the recipient country's institutions. First, the existence of *donor proliferation* leads to a situation where *"aid dynamics simply dominate local development efforts"* and pleasing donors can become more important than focusing on the people's needs. The author also suggests *"that large sustained aid flows fundamentally alter the relationship between government elites and local citizens"*. Second, following the conclusions of Alesina (2002) that found a positive correlation between aid flows and high levels of corruption, we have to account for the possibility, in these low-income countries, of existing government resources being used by *political elites* that strive to maintain themselves in power and satisfy their needs, rather than promote their country's development. In addition, donors do not denounce government incompetence and corruption, delaying institutional development. Third, there is the risk of aid being seen as a natural resource fully available at any moment in time. This will reduce a government's necessity and ability to generate revenues, by tax collection and also by appropriate budgeting. There is also an uncertainty risk linked to the dependence on external aid that leads to even greater difficulties in long-term policy planning. And fourth, some African governments have blamed donors for unpopular policies and poor economic and social outcomes, excusing themselves for any responsibility.

These effects are alarming and demand a greater attention to what has been called the *"aid curse"* (Lensink and White 2001). This striking conclusion however needs a clarification, as many of these negative effects are only experienced when there are large inflows of aid. Then, the question that results is: *How much is too much?* One cannot easily answer this question, nevertheless we have to pay greater attention to the majority of SSA countries that are facing aid's anti-developmental outcomes. Thus there is an urgent need to revise the characteristics and effects of the current foreign aid practices and social entrepreneurship presents an important path that will be considered in the next sub-chapter.

[25] Note: also in Burnside and Dollar (2000)

2.4. Social Entrepreneurship

"The job of a social entrepreneur is to recognize when a part of society is stuck and to provide new ways to get it unstuck. He or she finds what is not working and solves the problem by changing the system, spreading the solution and persuading entire societies to take new leaps. Social entrepreneurs are not content just to give a fish or teach how to fish. They will not rest until they have revolutionized the fishing industry." (Bill Drayton, Founder of Ashoka - in Leviner et al, 2006)

Entrepreneurship[26], commonly associated with the action of starting a business, is not a new phenomenon and it has always been one of the most important motors that enabled mankind to move forward in its long development process. But what is social entrepreneurship (SE)? Why is there no agreement on its definition? What characterises and influences SE? And what is the role that this form of entrepreneurship takes in the current development phase we live in? These are some questions to approach in this final sub-chapter of the present literature review, though one do not claim to expose the whole debate and in many cases can only point to the need for future research.

2.4.1. SE Definition

In the 1970s, Milton Friedman argued that *"there is one and only one social responsibility of business: to use its resources and engage in activities designed to increase its profits"*, claiming that social responsibility was a *"fundamentally subversive doctrine"* (Friedman 1970). However, forty years were enough to outdate Friedman's idea, as a growing concern with social matters lead ultimately to the surge of social entrepreneurship, that links business thinking with social development.

In 1998, Prof. J. Gregory Dees was already defining this concept by stating that SE *"combines the passion of a social mission with an image of business-like discipline, innovation and determination"* (Dees et al, 1998). Dees underlines two important characteristics of SE: a *social mission* and the *business discipline*. *Entrepreneurs with a social mission*, can still mean different things for different people, as some might indentify SE with organizations of the non-profit sector that start for-profit ventures. Others use it to describe an individual who only starts a non-profit organization, yet some might even use it to indicate business people who integrate social responsibility into their operations.

It is also valuable to remember the contribution of John Elkington and Pamela Hartigan (in Elkington and Hartigan 2008), which helped to identify the different organizational models that social entrepreneurs might adopt while accomplishing their mission. The authors present three different models for social enterprises: the

[26] The term *"entrepreneur"* was originated in France in the 17th and 18th centuries (Dees et al, 1998)

"leveraged non-profit" model, the *"hybrid non-profit"* model and the *"social business"* model, which one can see in more detail in Annex 10.

Hence, in the following sub-chapters, the concept SE will always refer to an *"innovative, social value creating activity that can occur within or across the non-profit, business, or government sectors"* (Austin et al, 2006).

2.4.2. The Dynamics of SE

In this field of study the distinction between common entrepreneurship and a social oriented one is key to correctly grasp this concept.

On one hand, Austin et al (2006) show that there are common variables to both types of entrepreneurship: *People*, *Context*, *Deal* and *Opportunity;* and the success of any entrepreneurial activity will depend on the interaction of these components. Nevertheless, the author also presents four main areas of distinction:

- ***Market failure***, where "a problem for the commercial entrepreneur is an opportunity for the social entrepreneur" (e.g. when those in need cannot pay for a good or service);
- ***Mission***, the underlying goal of any social entrepreneur is to create social value for the common good and not to create profitable operations that would result in private gains;
- ***Resource mobilization***, the values and characteristics of social entrepreneurs have restricted their access to human resources and capital markets, as they are less competitive than their commercial peers;
- ***Performance measurement***, a social mission poses a challenge in what matters to measure performance, whereas commercial entrepreneurs make use of relatively more tangible measures of performance.

In contrast, Boschee and McClurg (2003) states that there are only two main differences: social entrepreneurs apply earn income strategies directly linked to their mission or sell products and services that have a direct impact on a specific social problem; and also that these entrepreneurs have a double bottom line of financial and social returns, specifying that *"profitability is still a goal, but it is not the only goal, and profits are re-invested in the mission rather than being distributed to shareholders".*

There is a general consensus on the fact that social mission is the corner stone of SE (Dees et al 1998, Boschee 2003, Austin et al 2006 and Haugh 2007) however, while Dees et al (1998) presents wealth creation as being a means to an end, Boschee and McClurg (2003) focuses on the need of a social enterprise to be self-sufficient. In the same article, Boschee states that *"unless a non-profit organization is generating earned revenue from its activities, it is not acting in an entrepreneurial manner"*, clearly distinguishing the implementation of a valuable social project and the necessary capacity of sustaining it without depending on philanthropy or public subsidies.

This appears to be a relevant dimension as the non-profit sector is traditionally seen as dependent on charity and voluntarism. However, as Boschee and McClurg (2003) defends, there is a growing trend for social entrepreneurs to be sustainable and/or self-sufficient, meaning different things. In the non-profit sector, "sustainability" defines the ability to sustain a business with philanthropy, government subsidies and earned revenue, while *self-sufficiency* describes a business that relies solely on earned income. The same authors explain that the two forms of independency will enable social entrepreneurs *"to do more mission"*.

2.4.3. The Reality of SE

This brief overview of its main characteristics and dynamics has prepared one to assess how SE is important in the current development phase in which we are living. Nowadays more than ever, social entrepreneurs are proving themselves to be more than just innovators and professional managers, they are, in the words of Bill Drayton, *"the most powerful force for change in the world"*[27].

It would not be an easy task to know how many social entrepreneurs exist in the world, and the best guess would be that there are as many as all the social challenges we can find. However, through the Venture Organizations that support SE one can gain more insight into its global scale. In Annex 11, we can see a list of these organizations, three of which merit special attention here (also see Annex 12): *Ashoka*, founded in 1980 by Bill Drayton, that has more than 2.000 fellows in over 60 countries in the world and strives to invest *"in new solutions for our world's toughest problems"*[28]; the *Schwab Foundation for Social Entrepreneurship*, founded in 1998 by Professor Klaus Schwab (after having developed the World Economic Forum since 1971), with more than 190 social entrepreneurs[29]; and the *Skoll Foundation*, founded in 1999 by Jeff Skoll (who also founded Ebay) currently supporting more than 70 social entrepreneurs[30].

All these organizations support thousands of social entrepreneurs all over the world and in many different fields of work, including economic & social development, environment sustainability, health, peace & security and also human rights. They contribute to the worlds' development in many ways: by identifying leading social entrepreneurs and giving awards for best practices; by advocating for social causes and driving public awareness; with all sort of investments that enable social entrepreneurs to achieve maximum social impact; by creating a network that links social entrepreneurs generating solutions in partnerships, which helps to spread the social impact; and also by bridging business and academic sectors, involving social entrepreneurs and top universities in the world.

[27] Full quote: *"Drayton founded Ashoka because he believes that the most powerful force for change in the world is a new idea in the hands of a leading social entrepreneur"* (Ashoka wesbite: http://www.ashoka.org)
[28] Website: http://www.ashoka.org
[29] Website: http://www.schwabfound.org
[30] Website: http://www.skollfoundation.org

One can easily look at these social entrepreneurs as *"society's change agents who create innovation that disrupt the status quo and transform our world for the better".*[31] Bearing in mind what has been discussed in this chapter, we can imagine how essential these *change agents* are in a continent such as Africa, where poverty and underdevelopment are a common reality (sub-chapter 2.1.), where health systems are inefficient allowing people to die of easily preventable and curable diseases (sub-chapter 2.2.) and where the current forms of foreign aid have negative consequences (sub-chapter 2.3.).

In the next chapter, the application of social entrepreneurial solution to the health problems of SSA will be investigated more closely through a case study of a British social enterprise named "Riders for Health" (Riders). Riders has been working since the mid-1980s to provide feasible solutions for the health transportation problems in Africa. Hence, one will present their organizational models and way of conducting business, analyse its operations and extract valuable conclusions that might help other social entrepreneurs in different parts of the world.

[31] Website: http://www.skollfoundation.org/about

2.5. Annexes

Annex 1: Human Developmet Index 2011				
COUNTRY	HDI (value)	Life expectancy at birth (years)	Expected years of schooling (years)	GNI per capita (constant 2005 PPP$)
1st - Norway	0.943	81.1	17.3	47,557
2nd - Australia	0.929	81.9	18.0	34,431
186th - Niger	0.295	54.7	4.9	641
187th - Congo (Dem. Rep.)	0.286	48.4	8.2	280
HUMAN DEVELOPMENT INDEX GROUPS				
Very high HD	0.889	81.1	17.3	47,557
High HD	0.741	81.2	17.4	48,557
Medium HD	0.630	81.3	17.5	49,557
Low HD	0.456	81.4	17.6	50,557
HDI BY REGIONS				
Arab Sates	0.641	70.5	10.2	8,554
East Asia & Pacific	0.671	72.4	11.7	6,466
Europe & Central Asia	0.751	71.3	13.4	12,004
Latin America & the Caribbean	0.731	74.4	13.6	10,119
South Asia	0.548	65.9	9.8	3,435
Sub-Saharan Africa	0.463	54.4	9.2	1,966
Least Developed Countries	0.439	59.1	8.3	1,327
WORLD	0.682	69.8	11.3	10,082

Source: Author, adapted from UNDP (2011)

Annex 2: The Current Least Developed Countries			
AFRICA (sub-Sharan)			
1	Angola	18	Madagascar
2	Benim	19	Malawi
3	Burkina Faso	20	Mali
4	Burundi	21	Mauritania
5	Central African Rep.	22	Mozambique
6	Chad	23	Niger
7	Comoros	24	Rwanda
8	Dem. Rep. of Congo	25	São Tomé
9	Djibouti	26	Senegal
10	Equatorial Guinea	27	Sierra Leon
11	Eritreia	28	Somalia
12	Ethiopia	29	Sudan
13	Gambia	30	Togo
14	Guinea	31	Uganda
15	Guinea-Bissau	32	United Rep. of Tanzania
16	Lesotho	33	Zambia
17	Liberia		
ASIA			
1	Afghanistan	8	Nepal
2	Bangladesh	9	Samoa
3	Bhutan	10	Solomon Islands
4	Cambodia	11	Timor-Leste
5	Kiribati	12	Tuvalu
6	Lao People's Dem. Rep.	13	Vanuatu
7	Myanmar	14	Yemen
LATIN AMERICA & THE CARIBBEAN			
1	Haiti		

Source: Author, adapted from (http://www.unohrlls.org/en/ldc/25)

Annex 3: Key Determinants of Health in SSA				
INDICATOR	**Year**	**Data**		
1 - DEMOGRAPHY				
Population	2008	804.865.000	Rural	63%
			Urban	37%
Annual growth rate	1998 - 2008	2,5%		
Age distribution of population	2008	**0 - 15** (42%)	**15-59** (53%)	**>60** (5%)
2 - POVERTY & INCOME INEQUALITY				
% of pop. living under $1 a day[1]	2000 - 2007	53%		
3 - RESOURCES & INFRASTRUCTURE				
Gov. Expenditure on Health[2]	2007	**SSA** - 9,6%	**Global Region** - 15,4%	
Ratio of physicians	2000-2009	***per 10.000 population***	11	
Ratio of nurses and midwifes	2000-2009		2	
Hospital beds	2000-2009		9	
Elerctrification rate	2000 - 2005	31%		
Total road density[3]	2010	***per 1.000 km²***	137	
Paved road density[3]			31	
4 - GENDER INEQUITY				
% of seats held by women in national parliaments	2009	53%		
5 - EDUCATION				
Adult literacy rate (age >15)	1995 - 2005	**Male**	67	
		Female	49	
6 - ENVIRONMENT				
% of pop. using improved driking water sources	2008	**SSA** - 61%	**Global Region** - 87%	
% of pop. using improved sanitation facilities	2008	**SSA** - 34%	**European Region** - 94%	
7 - GLOBAL PARTNERSHIPS				
ODA received as % of total GDP	2005	13%		
8 - SCIENCE & TECHNOLOGY				
% of pop. with telephone	2005	3,3%		
% of pop. who are internet users	2005	5,5%		
9 - EMERGENCIES & DISASTERS				
Total number of refugees	2006	1.738.000		

Notes:

Source: Author, adapted from WHO Africa (2011)

[1] In PPP int. $

[2] As % of total Government Expenditure

[3] Source: African Development Indicators 2010, The World Bbank

Annex 4: Health Status in SSA Region and in the World				
INDICATOR		**Year**	**SSA region**	**Global**
Life expectancy	Pop.	*2008*	**53**	68
	Male		**52**	66
	Female		**54**	70
Adult mortality rate (age 15 -60) per 1.000 population	Pop.	*2008*	**392**	180
	Male		**412**	NA
	Female		**374**	NA
Mother mortality ratio per 100.000 live births		*2008*	**620**	260
Under-5 mortality rate per 1.000 live births		*2009*	**127**	60
Infant mortality rate per 1.000 live births		*2009*	**80**	42
Prevalence of HIV per 100.000 pop.		*2007*	**5700**	644
HIV/AIDS mortality rate per 100.000 pop.		*2007*	**174**	NA
Prevalence of TB per 100.000 pop.		*2008*	**480**	NA
TB death rate per 100.000 pop.		*2007*	**90**	NA

Source: Author, adapted from WHO Africa (2011)

Annex 5: GHPPPs Contributions to SSA Health System
• Getting specific health issues onto national and international agendas
• Mobilising additional funds for these issues
• Stimulating research and development (R&D)
• Improving access t cost-effective health-care interventions among populations with limited ability to pay
• Strengthening national health policy process and content
• Augmenting health service delivery capacity
• Establising international norms and standards

Source: Buse and Harmer (2006), p. 261

Annex 6: ODA by Donor							
Donor	*DAC countries, Total*						
Flow Type	*Net Disbursements*						
Amount Type	*Constant Prices (in 2009 USD millions)*						
YEAR	2004	2005	2006	2007	2008	2009	2010
Bilateral	63.333,05	93.590,93	85.131,03	75.301,50	84.823,94	83.502,48	90.248,45
Multilateral	29.571,37	28.684,92	30.810,99	31.286,95	33.770,45	36.278,46	37.269,71
TOTAL ODA	**92.904,35**	**122.275,87**	**115.942,03**	**106.588,39**	**118.594,38**	**119.780,95**	**127.518,17**

Source: Author, adapted from OECD.Stat (http://stats.oecd.org/Index.aspx)

Annex 7: ODA by Recipient								
Donor	*DAC Countries, Total*							
Aid type	*ODA Total, Net disbursements*							
Amount type	*Constant Prices (in 2009 USD millions)*							
YEAR		2004	2005	2006	2007	2008	2009	2010
Total ODA to LDCs		18.582,51	17.984,64	18.822,22	20.029,47	22.669,55	24.328,60	NA
Developing Countries	Europe	2.291,70	2.724,48	3.501,86	2.244,07	2.931,98	2.970,50	NA
	Africa	**22.624,19**	**27.946,01**	**34.626,33**	**25.133,37**	**26.493,33**	**28.155,79**	NA
	America	6.064,00	5.577,54	5.891,51	5.133,87	6.851,94	6.572,72	NA
	Asia	17.811,35	42.804,29	24.838,80	25.341,37	28.582,84	23.523,79	NA
	Oceania	1.027,25	1.124,36	1.215,48	1.187,63	1.267,51	1.351,60	NA
	Unspecified	13.514,79	13.413,92	15.057,31	16.260,78	18.697,08	20.928,45	NA
	TOTAL ODA	**63.333,28**	**93.590,60**	**85.131,29**	**75.301,09**	**84.824,68**	**83.502,85**	**NA**

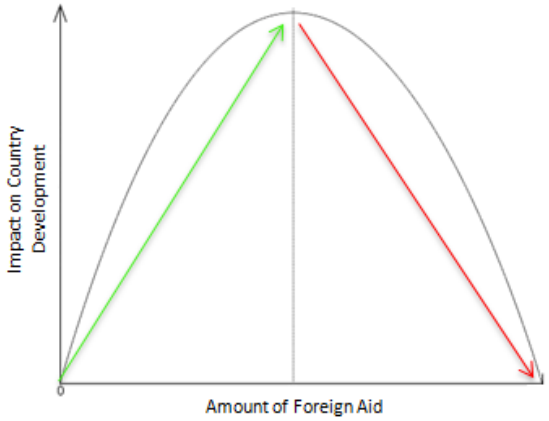
Source: Author, adapted from OECD.Stat (http://stats.oecd.org/Index.aspx)

Annex 8: *The Causality Chain* for the Assistance Process

Notes:
IFI's = International Financial Institutions

Source: Bourguignon and Sundberg (2007), p. 317

Annex 9: Laffer Curve Applied to Foreign Aid



The concept of a Laffer Curve, originally applied to taxes and Governemnt revenues, was developped in the 1970s by the American Jude Wanniski. Here, the concavity of the curve shows positive impacts of smaller amounts of aid, and after a certain amount of aid negative effects start appearing.

Source: Author, adapted from (http://upload.wikimedia.org/wikipedia/commons/thumb/3/36/Laffer-Curve)

Annex 10: Three Models for Social Enterprises

MODEL 1 - *Leveraged Nonprofit Ventures*	
●	*A public good is being delivered to the most economically vulnerable, who do not have access to the service rendered.*
●	*Both the entrepreneur and the organization are change catalysts, with a central goal of enabling direct beneficiaries to assume ownership of the initiative, enhancing its longer-term sustainability.*
●	*Multiple external partners are actively involved in supporting the venture financially,*
●	*The founding entrepreneur morphs into a figurehead, in some cases for the wider movement, as others assume responsibility and leadership.*
MODEL 2 - *Hybrid Nonprofit Ventures*	
●	*Goods and services are delivered to populations that have been excluded or underserved by mainstream markets.*
●	*Sooner or later, the founding entrepreneur typically develops a marketing plan to ensure that the disadvantaged can access the product or service being provided.*
●	*The enterprise is able to recover a portion of its costs through the sale of goods and services, in the process of identifying new markets.*
●	*To sustain activities and address the unmet needs of poor the entrepreneurs mobilizes funds from public, private and/or philantropic organizations, commonly, in the form of grants or loans.*
●	*As mainstream investors and business enter the picture, they tend to push these ventures to become model 3 social businesses, to ensure access to new sources of funding, particularly, capital markets. This might be beneficial, but risks refocusing activities to the point where the poor will no longer be served*
MODEL 3 - *Social Business Ventures*	
●	*The entrepreneur sets up the venture as a business with the specific mission to drive transformational social and/or environmental change.*
●	*Profits are generated, but the main aim is not to maximize financial returns for shareholders but instead to financially benefit low-income groups and to grow the social venture by reinvestment, enabling it to reach and serve more people.*
●	*The entrepreneur seeks out investors interested in combining financial and social returns.*
●	*The enterprise's financing—and scaling—opportunities can be significantly greater because social businesses can more easily take on debt and equity.*

Source: Author, adapted from Elkington and Hartigan (2008), p. 5; 10 and 15

Annex 11: Venture Organizations Supporting SE	
ORGANIZATIONS	***Year Founded***
Ashoka	*1980*
Echoing Green	*1987*
Avina Foundation	*1994*
Robert Enterprise Development Fund	*1997*
Social Venture Partners (Seattle)	*1997*
New Profit, Inc.	*1998*
New Schools Venture Fund	*1998*
Omidyar Network	*1998*
Schwab Foundation for Social Entrepreneurship	*1998*
Skoll Foundation	*1999*
Venture Philntropy Partners	*2000*

Source: Leviner et al (2006), p. 91

Annex 12: Selected Venture's Vision & Mission Statements	
ASHOKA	
ASHOKA	*MISSION: Ashoka strives to shape a global, entrepreneurial, competitive citizen sector: one that allows social entrepreneurs to thrive and enables the world's citizens to think and act as changemakers.*
	VISION: Ashoka envisions an Everyone A Changemaker™ world. A world that responds quickly and effectively to social challenges, and where each individual has the freedom, confidence and societal support to address any social problem and drive change.
SCHWAB FOUNDATION FOR SOCIAL ENTREPRENEURSHIP	
SCHWAB FOUNDATION FOR SOCIAL ENTREPRENEURSHIP	*MISSION: The Schwab Foundation for Social Entrepreneurship provides unparalleled platforms at the regional and global level to highlight and advance leading models of sustainable social innovation. It identifies a select community of social entrepreneurs and engages it in shaping global, regional and industry agendas that improve the state of the world in close collaboration with the other stakeholders of the World Economic Forum.*
SKOLL FOUNDATION	
skoll FOUNDATION	*MISSION: The Skoll Foundation drives large scale change by investing in, connecting and celebrating social entrepreneurs and the innovators who help them solve the world's most pressing problems.*
	VISION: Our vision is to live in a sustainable world of peace and prosperity.

Source: Author, adapted from Venture Organizations' websites

Chapter 3: CASE STUDY

3.1. Introduction

"Tsepo Kotelo has been an Heath Assistant at the Likalaneng Health Centre, in Lesotho, for three years. Tsepo's job is to monitor HIV and TB patients whose treatment involves taking a complicated cocktail of drugs for long periods of time. He also conducts inspections on food, water and sanitation in the surrounding areas to prevent the spread of diseases. Before Riders for Health helped to mobilize him with a motorcycle, Tsepo had to visit his patients in rural villages by foot. In mountainous Lesotho it can take hours to travel between remote villages and the roads are often no more than rocky tracks. This made it impossible for Tsepo to reach the more isolated communities in his catchment area.

In 2008, Tsepo received a motorcycle and Riders for Health trained him to ride it safely and carry out daily checks on things like oil and petrol so that it did not breakdown unexpectedly. Once he was mobilized, Tsepo was able to visit a village 80 kilometres away called Ha Thaba-Bosiu for the first time. When Tsepo arrived he found out that he was the first healthcare worker ever to visit the isolated village. No health professional had been able to follow up on vulnerable HIV or TB patients, to make sure that they had the right course of medication and they understood how to take it properly. And no one had been there to educate the community on how to avoid spreading easily preventable, but devastating, diseases like cholera. Tsepo recognizes that without his motorcycle, hundreds of men, women and children in this village might still have no healthcare visits."[32]

Tsepo is one of the many riders that Riders for Health (Riders) manages transport for in sub-Saharan Africa (SSA). This United Kingdom (UK) based social enterprise has developed a simple but innovative approach to address the question on how to improve Africa's healthcare delivery systems. Since the beginning, Riders' co-founders, Andrea and Barry Coleman (in Exhibit 1), understood the importance of having consistently reliable transportation for an effective delivery of healthcare to the people. This was particularly crucial in rural areas where remote villages suffered even more with the lack of transportation, the distance to health centres and the harsh conditions of the terrains.

Millions of *Euros* are committed every year to fight killer diseases in Africa; however, Riders know that *"all the donated drugs in the world won't do any good without an infrastructure for their delivery"*[33], so they have been developing an important system to ensure that vehicles used in healthcare delivery can be prevented from breaking down. Hence, in order to allow millions of people across Africa to receive healthcare treatments Riders focused on this crucial and often missing link in the health delivery supply chain: the necessity of well-maintained vehicles.

Riders' vision has been implemented in several African countries. Riders also works in the "*Mountain Kingdom*" of Lesotho in Southern Africa, and there it has been applying the concept of preventive maintenance for healthcare vehicles since the 1990s. The first programme started in 1991 with a partnership between Riders and the Ministry of Health and Social Welfare (MoHSW). However in 1998, when the motorcycles had to be

[32] Riders for Health (RfH) website: *"Impact story of the month"*, 25th February 2011 (http://www.riders.org/n_details.aspx?nwId=293)
[33] Dr. Margaret Chan, Director-General of the World Health Organization, in RfH website (http://www.riders.org/the_need.aspx)

replaced, the programme ended due to the lack of funding from the Lesotho government. More recently in 2008, Riders decided to implement a national scale programme based on two different operating models to address specific needs identified in this country. These programmes are the Outreach Health Worker Mobilization (OHWM) programme, providing access to reliable transportation so that outreach health workers are better resourced to do their work, and the Sample Transport (ST) programme for the transport of patients' medical samples from the health centres and clinics to district laboratories and the results back to the health centres.

This case study aims to examine Riders' work in Africa, its models and success factors, with a focus on their operations in Lesotho, a small country with noticeable health issues that was a perfect candidate for Riders' intervention. In the end we aspire to demonstrate the need that Africa has of managed transportation and to show how good and sustainable Riders' solution is.

3.2. Riders for Health: the Social Enterprise

Riders for Health is an awarding winning social enterprise, meaning that it is an *"organization that applies business models and strategies to achieve philanthropic goals"*[34] and does it in a very effective way. Riders was able to correctly identify the issue of reliable transportation in developing Africa and focused all its energies in finding a solution for this problem. In fact, Barry and Andrea Coleman, with many enthusiastic collaborators, have been leading the Riders to effectively pursue its goal of *"reaching everyone, no matter where they are"*[35].

3.2.1. Riders' Story[36]

The story of Riders dates back to the year of 1986 when Andrea Coleman, a motorcycle team manager, decided to help Randy Mamola, an American Grand Prix motorcycle racer, to fundraise for the development programmes of a UK non-profit organization called Save the Children Fund (SCF).

A couple of years later, Mamola and Andrea were invited by SCF to go to Somalia and observe how the funds were being used for the immunization of children. Andrea had her own young children at that time and she could not travel to Somalia; instead her husband, Barry Coleman, a journalist for the *Guardian*, went in her place with the intention of writing a story on it. During their visit, Barry and Mamola were shocked to see that some of the most needy and remote villages were not getting any health assistance due to insufficient transportation. Moreover, they noticed that many motorcycles and other vehicles were considered irreparably damaged because they had broken down, sometimes after only 800 kilometres of usage. The vehicles' short operational

[34] Website: Social Enterprise definition (http://en.wikipedia.org/wiki/Social_enterprise)
[35] RfH TV: *"Introducing Mahali Hlasa - Lesotho Programme Director"* (http://www.youtube.com/user/RidersForHealthTV#p/u/46/ViRkzDX24oY)
[36] RfH website: http://www.riders.org/history.aspx

lives were blamed on the hard conditions of the terrains; the health official with whom they spoke explained that the dust and hot conditions were *deadly*. However, after further investigation, Barry and Mamola found that these premature breakdowns were also due to the lack of training on how to perform basic maintenance.

In 1989, SCF and World Health Organization (WHO) invited Barry Coleman to be a part of a consulting team hired to assess its fleet of 86 motorcycles in the Gambia. As he travelled throughout the country he found out that only 12 of the donated motorcycles were still in operation, while the remainder was not roadworthy due to mechanical problems or because they had been sold. These 12 motorcycles were operable because of the regular and basic maintenance conducted by Ali Ceesay, a driver, who, with few tools and no formal and technical expertise, was keeping the bikes running. The example of Ceesay motivated Barry and helped him to understand *"that a little goes a long way"*[37].

Through his experience in the Gambia, Barry and Andrea had the idea to design and develop a motorcycle preventive maintenance outreach programme that would help organizations in Africa to better use their health vehicles with cost-effective measures. The programme, labelled Riders for Health, started in the Gambia as a consulting project with immediate replications in Uganda (1990), Lesotho (1991) and Zimbabwe (1994).

While Barry was working on Riders' first maintenance programmes, his wife Andrea was focusing on setting up Riders as an independent entity with the required administrative, legal and funding platforms. Thus, in 1996 Riders was registered as an independent charity in the UK, with a special mission of managing health transport in rural Africa. Since then, Riders has been offering its maintenance programmes and services to several African MoHs and to other NGOs and non-profit organizations working in Africa (see Exhibit 2 for more on Riders' story).

3.2.2. Vision, Mission and Organizational Structure

Nowadays, Riders is a successful international social enterprise that has continued expanding since its foundation. For this to be a reality, Riders' ***vision*** has always been *"of a world in which no one will die of an easily preventable or curable disease because barriers of distance, terrain or poverty prevent them from being reached"*.[38] This vision is far from accomplished, yet the organization is not attempting to achieve it alone; instead Riders' defined its ***mission*** *"to strengthen health systems by addressing one of the most neglected, yet vital, aspects of development for the health of Africa - transport and logistics. We achieve this by managing vehicles on a reliable, predictable and cost-effective basis, to support the work of our partners whose remit is to reach rural communities with healthcare and other vital services."*[39]

[37] Barry Coleman, in Rammohan, Sonali (2010), p. 12
[38] RfH A (2011), p. 8
[39] Ibidem, p. 8

From its headquarters in the UK, Riders assists country programmes in the Gambia, Nigeria, Zimbabwe, Lesotho, Malawi, Zambia, Kenya and also provides support in areas like fundraising, training, global health, technical developments, procurement, accounting and others. Moreover there are fundraising branches in Italy, Spain, Netherlands and in the United States, which help Riders to have a consistent source of funds both from the European and American motorcycling community.

Riders management team is composed of a chief executive officer (CEO) and an executive director (ED) that together with the chief operating officer (COO), a fundraising director and communications director, the partnership director, the operations director, a programme management team and the Country directors from each African programme decide on the developments of the operational strategy[40]. There is also a board of trustees whose responsibility is to review and approve Riders' decisions (elements of Riders' team in Exhibit 3).

3.2.3. Awards[41]

The quality of Riders programmes employed in the field have been recognized by the international community throughout the years. Since 1998, Riders were recognized with several awards: the Worldaware for Innovation (in 1998), the UK Charity of the Year (2001), the Global Health Council award for best practices in Global Health (2005), the Skoll Award for Social Entrepreneurship (2006), the Third Sector Awards (2009) and more recently in 2011, the International Health Promotion Awards, due to its innovative vehicle leasing programme in the Gambia (see the list of all the awards in Exhibit 4).

3.3. Riders for Health: The Perfect Partner in Transportation

Riders wants to provide regular and reliable access to healthcare for all the communities in Africa, no matter how remote they are, and that is why it ensures that African health partners (e.g. MoHs, WHO and others) have access to well-managed vehicle fleets, allowing them to allocate time and resources in order to achieve their health goals.[42] For more than 20 years Riders has gained experience in managing health vehicle fleets using four distinct management models, adequate for different kinds of scale and partnerships.

3.3.1. Riders' System

Barry Coleman states, in an interview, that *"people imagine that somehow there is a great network of vehicles operating perfectly like they are in developed countries delivering healthcare to people, and that's not true. There is no such network, vehicles that come here routinely fail".*[43]

[40] OC&C (2005), p. 9
[41] RfH website: http://www.riders.org/awards.aspx
[42] RfH (2010), p. 8
[43] RfH TV: *"An introduction to Riders for Health"* (http://www.youtube.com/user/RidersForHealthTV#p/u/1/hrhjKTWyIfs)

Africa needs urgent transport logistics and infrastructure development, however this cannot be done either by the governments nor by the health partners working in the continent. To the lack of roads, vehicle dealerships, systems for delivering parts, services and/or training for maintenance practices, Riders responded with well designed transport management models and rigorous implementation and execution.

The frequent and reliable access with which health personnel can now visit rural villages is a natural consequence of a well-designed strategy grounded on one key principle: the need of preventive maintenance. As Riders explains, *"all our work is underpinned by a focus on high-quality training in safe riding/driving, preventive maintenance and fleet management."*[44] Moreover, the five key elements of Riders' preventive maintenance are explained in Exhibit 5.

3.3.2. Operational Models

The different programmes in each country are established with contracts between Riders and the several partners from the MoHs and UN agencies to other local humanitarian organizations. The structure of these contracts changes from country to country depending on the needs of each partner and of each location.

Currently, Riders offers two main service delivery models, TAM and TRM, which are based on a simple idea: *"there is no technical reason why any correctly-maintained vehicle would breakdown".*[45] In fact, breakdowns are unpredictable and can be very costly, hindering healthcare delivery. To solve this, Riders' designed TRM and TAM that use a zero-breakdown approach with the preventive maintenance strategy.

In Exhibit 6 we present a resume of Riders' transport models, as of December 2011, nonetheless a more detailed description of each transport model follows[46]:

Transport Resource Management **(TRM)** - This was the first of Riders' models for managing healthcare transportation in Africa. TRM focuses on management of a partner's existing fleet. Riders provides preventive maintenance by outreach where possible, including replacement parts when needed according to a maintenance schedule, as well as training for the riders to drive safely and to perform daily preventive maintenance. The partners own the vehicles and pay all the set up and running costs through a Cost per Kilometre (CPK) fee, which covers the cost for refresher training for vehicle users, lubricants, maintenance, replacement parts and programme management among others. Riders' CPK is customizable and it can also include the fuel cost, vehicle replacement, insurance and drivers, if the required (for more details section 3.7.).

[44] RfH (2010), p. 11
[45] RfH website: http://www.riders.org/resource.aspx
[46] RfH website: http://www.riders.org/systems.aspx

Transport Asset Management **(TAM)** - This is a vehicle leasing model particularly useful for large-scale partnerships. TAM works like TRM in regards to vehicle management, training and CPK fees; however, with TAM Riders - rather than the partner - owns the health vehicles. This is a form of complete outsourcing, as Riders buys and leases the vehicles to the partner, and hence avoids the frequent need of often large initial investments. By managing the entire fleet, Riders can thus better ensure that healthcare treatment reaches every community. TAM provides secure and long-term sustainable solutions for fleet management.

Sample Transport **(ST)** - The ST, that can either be based on TRM or TAM, utilises reliable sample couriers on motorcycles that collect the samples in health centres, deliver them to the laboratories, and also return the results of the tests to the centres. The structure of an ST programme is mainly depending on how it is set up.

Active Community Transport **(ACT)** - This is not one of Riders main models, but it does offer a suitable service for NGOs and other smaller Community-Based Organizations (CBOs). With ACT the vehicles are owned, managed and operated by the small-scale partner that chooses a senior member to work as a Riders' agent, overseeing the execution of Riders' preventive maintenance system. This model is valuable in two ways, in that it helps the CBOs to have reliable transportation and enables Riders to raise awareness about the importance of managed transportation in other countries.

Once a transport management platform is put in place any health intervention can be developed: *"specimen referral, mobilization of community health workers, vaccinations logistics, medical store logistics, health waste management, clinical outreach services, emergency referral services, etc".*[47] This is Riders' strong belief and we will now present these models' application in Africa, where it helps to save millions of lives.

In addition, Riders also provides servicing for organizations on a regular basis (Interval Servicing) or *on-demand* basis (Demand Servicing), and has developed the International Academy of Vehicle Management (IAVM) a specialist training school for vehicle maintenance and management, working in Zimbabwe and more recently in Kenya.

3.3.3. Riders in Africa

Riders' experience is made of more than 20 years of operations in SSA, from western to eastern and southern Africa (see Riders' map of operations in Exhibit 7). Riders' models of managed transportation have been evolving through time enabling its partners to respond effectively to a host of healthcare needs. The numbers speak for itself: in December 2011, Riders was operating in seven African countries - the Gambia, Zimbabwe, Nigeria,

[47] RfH B (2011), p. 10

Kenya, Zambia, Tanzania and Lesotho - employing more than 300 people, managing 1.600 vehicles and providing better access to healthcare services for up to 12 million Africans.[48]

Over the years Riders' strategy has been the same: develop initial local systems and replicate them on a national scale; understand the needs of each partner and scale-up the programmes; establish long-term contracts with its partners in Africa; developing innovative and sustainable financial models (e.g. the TAM model); and also to successfully replicate the models from one country to another (e.g. the replication of ST in Zimbabwe and Zambia after scaling it nationwide in Lesotho). [49]

It is very important to notice that all Riders' *"programmes are managed by wholly-African, wholly-professional teams, and not by volunteers or expatriates"*[50]. Therefore, all the managerial, administrative and technical staff members are nationals of these countries. Such a practice has benefited the local economies (e.g. creating skilled employment) and has built a sustainable base of local knowledge.
Moreover, an extensive resume of Riders' presence in Africa is available in Exhibit 8.

3.4. About Lesotho: Country Context

In this section we identify Lesotho's main country characteristics regarding its *Geography and People*, *History*, *Politics* and *Economy*. Our goal is to briefly describe each of these topics in order to better understand the country's severe health issues and the solution Riders has been implementing to overcome it.

3.4.1. Geography and People[51]

The Kingdom of Lesotho is one of the smallest countries in Africa, being completely encircled, within its 909km boundaries by the Republic of South Africa. Its surface area extends for only 30,335 km^2 with a total population of 2.067.000 inhabitants in 2009, 74% of which lived in rural areas. One of its most noteworthy characteristics is its mountainous terrain - with more than 80% of its territory placed 1.800 m above sea level - which is why Lesotho is often called the *Mountain Kingdom*. When people living in its many rural villages seek healthcare, they often have to walk for several hours over rough mountain tracks in order to get to the nearest health centre. In 2003, of the 7.091 km of roads only approximately 19% were paved[52], which makes healthcare delivery a big challenge. The weather is also a critical consideration with cold dry winters and hot wet summers. Administratively, the country is divided in ten districts (see map of Lesotho in Exhibit 9) and its capital is Maseru,

[48] RfH website: http://www.riders.org/us/media.aspx
[49] RfH B (2011), p. 19
[50] RfH website: http://www.riders.org/us/media.aspx
[51] All data from: WHO, Global Health Observatory (http://www.who.int/countries/lso/en) and CIA World Fact Book (https://www.cia.gov/library/publications/the-world-factbook/geos/lt.html)
[52] Note: However this number has increased since then with significant infrastructure development since 2003

a city in the west of the country, with less than 500.000 inhabitants.[53] In terms of population, the largest ethnical group is the Basotho, with 99,7% of the population, while the remaining 0,3% are Europeans and Asians. The main official languages are Sesotho and English, and regarding religion, almost 90% are Christians and 45% Roman Catholic, while 10% practice according to indigenous beliefs.

3.4.2. History[54]

The Basotholand was given the name the *"Kingdom of Lesotho"* after the independence from the United Kingdom in the 4th day of October in 1966. The Basotho National Party was in power for the first two decades and King Moshoeshoe was exiled in 1990. A couple of years later the King returned and was reinstated as the head of state, then he was succeeded by his son King Letsie III, in 1996. Lesotho's Constitution was signed in 1993 and the country's motto is *"Lesotho fatse la bo ntat'a rona"* (i.e. *Lesotho land of our fathers*), which signifies the patriotism of the people.

3.4.3. Politics[55]

Lesotho is a politically stable country based on a parliamentary constitutional monarchy. Prime Minister Mosisili is the head of government and has the executive authority. His Majesty King Letsie III is the head of state, however he has only ceremonial functions and no executive power. Since 2007, Dr. Mphu Ramatlapeng has been the Minister of Health and Social Welfare of Lesotho. Moreover, there are two chambers in Lesotho's political system: the democratically elected National Assembly with 120 members, controlled by the party Lesotho Congress for Democracy (62 seats), and the Senate, which is composed of 22 principal chiefs whose membership is hereditary plus 11 members chosen directly by the King. The Constitution provides an independent judicial system and also defends the freedom of speech and freedom of religion among others.

3.4.4. Economy

In Exhibit 10 one can see important information on Lesotho's development indicators. Moreover, its unique geography provides scarce resources, thus, in 2010, imports accounted for about 60% of the GDP[56], with the most imported goods including food, building materials, vehicles, machinery, medicines and petroleum products. Lesotho's economy is highly dependent on subsistence farming, in which 86% of population is engaged, despite the fact that only one quarter of the land is suitable for cultivation.[57] Manufacturing and the inflow of remittances from workers labouring in South African mines account for the rest of its economy. Almost 35% of active male labour force works in the mines of South Africa for most of the year.[58] The working and living

[53] Website: http://en.wikipedia.org/wiki/Maseru_District
[54] Website: http://en.wikipedia.org/wiki/Lesotho
[55] Ibidem
[56] In 2010, Imports were *$ 1.885 billion*, exports *$ 823.2 million* and GDP PPP at 2010 US *$ 3.303 billion* (in CIA World Fact Book)
[57] Note: Murman and Sullivan (2008) p.3
[58] PIH website: http://www.pih.org/pages/lesotho-background

conditions in the mines are very low with the miners living in crowded barracks where TB and other infectious diseases spread easily. Moreover, miners are also exposed to high risk for HIV and other sexually transmitted diseases. Additionally, South African labour laws require that migrant workers return to their countries of origin two weeks per year, often bringing HIV and TB with them to the remote villages of Lesotho.[59]

Nevertheless, water is a significant natural resource and in 1986, the Lesotho Highlands Water Project (LHWP) was started (see Exhibit 11), with the intent of capturing water from the Orange River and then storing and transferring it to South Africa in order to serve that country's population, industry and agriculture. Despite being self-sufficient in electricity production in 2008 only 7% of the Lesotho population had access to electricity.[60]
In response to the country's contemporary challenges, the government, helped by the UN, formulated the *Lesotho Vision 2020* and the *Poverty Reduction Strategy 2010/2011* to guide its own actions towards improving living conditions and overall welfare for its people.

3.5. Health Delivery and Health Transport in Lesotho

"Medical care in Lesotho is largely framed by the nation's challenges with HIV/AIDS, TB, poverty and topography".[61]

No introductory statement could be more adequate to define Lesotho's main health challenges. In fact, the WHO health statistics reveal that the country faces currently a *"double-burden of disease*[62]*"* and it had the third highest HIV infection rate in the world in 2009[63], with almost 25% of the population estimated to be living with HIV/AIDS[64], *"of whom less than one quarter is aware of the infection".*[65] Such a high prevalence of HIV, which weakens people's immune systems, fuels a rise in tuberculosis (TB), and in 2009 there were 405 cases per 100.000 people.[66] Experts in these diseases explain that the problem it is even more severe, with *"the majority of people infected with TB being also HIV-positive and nearly 1.000 new people per year contract multi-drug resistant TB (MDR-TB)".*[67]

[59] Note: Murman and Sullivan (2008) p.3
[60] PIH website: http://www.pih.org/pages/lesotho-background
[61] Note: Murman and Sullivan (2008) p.3
[62] *"Double Burden"* refers to infectious diseases plus chronic diseases
[63] CIA World Fact Book website: *(https://www.cia.gov/library/publications/the-world-factbook/geos/lt.html)*
[64] WHO (2011), p.1
[65] PIH website: http://www.pih.org/pages/lesotho-background
[66] WHO (2011), p.1
[67] PIH website: http://www.pih.org/pages/lesotho-background

In 2011, these health challenges have lowered the life expectancy at birth to 48,2 years[68], while *"without HIV/AIDS epidemic, life expectancy would be an estimated 75 years".*[69] In Exhibit 12 we can find more data on Lesotho health status that help us to conclude how great is the country need for more and better health service delivery.

In addition, in 2009, 8,2% of the total government expenditures were health related, and similarly, the total expenditure on health was 8,2% of GDP (of which 68,2% was public and 31,8% was private expenditure).[70] Lesotho's health system is comprised with 192 health centres at a primary level, but also 17 hospitals and 17 high-level laboratories (see more in Exhibit 13). In the same exhibit we can see a crucial shortage of health-personnel - namely physicians, nurses and midwives - in contrast to 8 physicians and 41 nursing personnel per 10.000 population in South Africa.[71] In addition, Lesotho has almost no formal medical education[72], and the Basotho who attend medical school abroad (i.e. South Africa) rarely return to their home country. Many of the physicians working in Lesotho live in urban areas and come from South Africa and the remainder from other African countries, however, the majority stay for short periods of time. The lack of qualified health-personnel is limiting the access to healthcare treatments leading to situations where only 48% of the HIV positive patients have access to ARV medication.[73]

Despite the fact that Lesotho's hospitals have ambulances for emergency transport of patients, normally these do not have qualified and trained medical staff on board, and many of the ambulances lack fuel to run on.[74] Besides this, only the patients who have phones can call for an ambulance, and then they will also be required to pay for the service. Hence, the most common modes of health transport are minibuses, wheelbarrows pulled by work animals, and even walking long distances - options that could greatly worsen the health condition of the patient.

Lesotho had recently started a decentralization process regarding its health system by giving more autonomy to the individual districts but still conserving the health policies and planning decisions for the central government. This strategic decision will effectively help to reach more of the country's population, especially in rural areas. Nevertheless, this decentralization, while necessary to foster the access to primary healthcare services, does not necessarily apply to diagnostics that are often performed at a laboratory in a higher level of the system, due to issues regarding laboratory equipment needs.[75] Therefore, it is especially critical that there be reliable and

[68] UNDP (2011), p. 128
[69] Murman and Sullivan (2008) p.3
[70] WHO Website: Global Health Observatory (http://www.who.int/countries/lso/en)
[71] WHO Africa (2011), p.24
[72] Murman and Sullivan (2008) p.3
[73] RfH A (2011), p. 11
[74] Murman and Sullivan (2008) p.3
[75] RfH A (2011), p. 11

regular linkage between the primary healthcare centres and higher-level laboratories. The lack of reliable transport for sample collection and delivery is one of the largest barriers to starting treatments and to monitor patients. Even where there is a sample transportation intervention in place, if it is unreliable and fails, it causes an *"erosion of the trust in the laboratory by clinics and patients, which can result in a reduction in testing volumes".*[76]

In order to better understand how the Basotho government views the situation of its own country we present in Exhibit 14 a resume of the Lesotho health priorities of the Ministry of Health and Social Welfare (MoHSW), by doing so we are prepared to explore Riders' approach in Lesotho and assess its key success factors.

3.6. Riders' Approach in Lesotho

Lesotho's health crises with serious HIV and TB epidemics are being triggered by many factors including poverty, the lack of health-personnel and also the insufficiency of reliable and accessible health transportation. The mountainous terrains and extremely harsh tracks have made the provision of healthcare services especially difficult. Lesotho's MoHSW stated that one of the biggest problems faced is that the vast majority of the country is in difficult to access areas[77], and that is how Riders became the perfect *last-mile partner*, enabling healthcare to reach the most vulnerable people living in rural areas.

3.6.1. Programme Overview

With these challenges in mind, in 2008, Riders started two different nationwide programmes in Lesotho: the Outreach Health Worker Mobilization (OHWM) and the Sample Transport (ST) programme.

3.6.1.1 Outreach Health Worker Mobilization

In January 2008 Riders initiated a national motorcycle fleet management programme in Lesotho, financially supported by the Elton John AIDS Foundation (EJAF). It was meant to directly assist the outreach healthcare workers of Lesotho's MoHSW, and also to support the health activities of other smaller partners like Partners In Health (PIH) or the Christian Health Association of Lesotho (CHAL). In 2009 this programme trained 130 health workers[78] across all the 10 districts, however the number of rider can fluctuate accordingly with each districts' demand[79], while currently there are 59 health workers mobilized (see more information in Exhibit 15).

[76] RfH A (2011), p. 11
[77] WHO (May 2009), p. 1
[78] RfH A (2011), p. 12
[79] RfH: Interview with Ms. Mahali Hlasa (16.11.2011)

The outreach health workers can perform a multitude of health-related activities. The majority are *health assistants*, meaning that they do follow ups on HIV and TB patients, educational talks and might also be responsible for water and sanitation inspections as well as food or business inspections. In Lesotho, from the group of mobilized health workers[80] we know that *"90% have roles which include work around HIV; 82% linked with TB prevention and treatment; 89% are involved in preventive health care; 86% include health education as part of their work; 73% are involved in disease surveillance".*[81]

3.6.1.2. Sample Transport

"In many African countries testing rates are low and the average wait in some countries is four months".[82]

Riders understood this essential service was missing and, in October 2008, in partnership with the Laboratory Services Directorate and Family Health Division of the MoHSW and CHAI, initiated the first ever sample transport programme in Lesotho. Funded by EJAF and the MoHSW, and grants managed by CHAI and WHO, the ST programme was able to start in the district of Qacha's Nek, which was chosen due to its remote nature and difficulty to access, and then was replicated to all the other districts over a year. The focus of the ST programme is to *"transport patient medical samples in a professional and quality-controlled manner to bring consistency and reliability to the collection and delivery of samples".*[83] So far, the programme has linked the rural health centres and the laboratories via 26 samples' couriers, plus 4 back-up couriers to ensure that the service is never interrupted, serving 166 health centres in all the districts, affecting a total of 2 million people (more on ST in Exhibit 15).[84]

Both the OHWM and ST models are based on the same transportation management platform, which we have already presented: the TRM (see again section 3.3.2.). The TRM model was Riders' first model and has proven for the last decade to provide a reliable service even within the toughest conditions and in locations where there is simply no infrastructure. That is why the vehicle's choice was for 120 motorcycles type *Honda CTX200* which was considered to be suitable for riders in Lesotho.[85]

3.6.2. Riders' Lesotho Structure

Ms. Mahali Hlasa said in an interview: *"For me, I would really hope that every health worker that needs to go to the community is provided with a bike and is able to do so."*[86]

[80] Which include *health assistants*, *community counsellors, TB officers, nurse assistants*, *nursing sisters*, *M2M mentors, HTC counsellors*. Riders also mobilized a *district health information* and a *district social welfare officer* as well as a *PMTCT co-ordinator (i.e. Prevention Mother To Child Transmission)*
[81] RfH website: http://www.riders.org/impact_of_our_work.aspx
[82] RfH website: http://riders.org/sample_courier_transport.aspx
[83] RfH A (2011), p. 12
[84] Ibidem, p. 17
[85] RfH: Interview with Ms. Mahali Hlasa (16.11.2011)
[86] RfH TV: "Introducing Mahali Hlasa - Lesotho Programme Director (http://www.youtube.com/user/RidersForHealthTV#p/u/46/ViRkzDX24oY)

Ms. Hlasa, who was appointed in 2008 to be Riders' Country director in Lesotho, started out as a qualified motorcycle rider in 1991 at the time of Riders' first programme in the country.[87] She is based in Maseru, where Riders' has its only workshop, and from where she oversees the execution of both Riders' programmes. Ms. Hlasa is assisted by the programme manager, the financial manager and the data clerk. In Exhibit 15 we present more information on the logistics behind Riders' programmes. For instance, in Maseru there is a Riders' workshop where the 2 technicians are based and where replacement parts are kept and other consumables.

3.6.3. Partnerships in Lesotho

"Partnerships and collaboration are essential to Riders' model. Our aim is to underpin the work of health-related organizations that serve rural communities in Africa, giving them predictable and reliable access to their beneficiaries."[88]

From this statement it is clear Riders does not work alone, on the contrary, Riders was specifically created to work in partnerships[89]: with African MoHs, UN agencies, NGOs, at a local or international level, and also CBOs.[90] In its turn, Riders focuses on ensuring its partners' mobilization so they can explore their core competences and deliver healthcare services to the people. Therefore the relationships with its several partners have always been of great importance to Riders, which views itself as the providers of *"the critical missing link in the healthcare delivery chain"*.[91]

When working with governments and other partners, Riders strives to get partners to understand that effective transport systems should be a priority. The existence of predictable transportation provided by Riders enables the partners to better plan their work, manage finance resources and budget with more precision. In addition, because health workers are mobilized, they can visit more communities and spend more time with patients, and, do all this more regularly and reliably. In Lesotho, Riders works with several in-country partners[92]:

- Ministry of Health and Social Welfare **(MoHSW)**
- World Health Organization **(WHO)**
- Elton John AIDS Foundation **(EJAF)**
- Christian Health Association of Lesotho **(CHAL)**
- Global Fund to Fight AIDS, Tuberculosis and Malaria **(GFATM)**
- Clinton Health Access Initiative **(CHAI)**
- Partners In Health **(PIH)**
- Cowater International **(Cowater)**
- mothers2mothers **(m2m)**

[87] Note: Ms. Hlasa was also the first female rider in Lesotho
[88] RfH A (2011), p. 9
[89] RfH B (2011), p. 16
[90] Note: Community Base Organizations
[91] RfH A (2011), p. 8
[92] RfH: Interview Ms. Kameko Nichols (22.11.2011)

Riders' way of developing its business models is based on a trust-building process with their partners. In fact, Riders' success is always directly linked with the success of their partners, meaning that good relationships are crucial for effective healthcare delivery. The quality of the partnerships established in Lesotho reveals Riders' strong capabilities of engaging and developing contracts with the MoHs and other agencies and through which they are able to sensitize the government's health officials about the great need of managed health transportation.

Yet, the utilization of these public-private partnerships brought some difficulties, mainly related to *"resistance from our partners to outsource their transport logistics and paying for the service".*[93] This is a problem that Riders faces systematically as it not only has to motivate its partners to recognize the importance of managed transportation but also to effectively demonstrate how its not-for-profit cost recovery model works. At first glance, some of the partners might view Riders as a fixed cost rather than as a *"cost-saving"*[94], due to the fact that Riders programmes require significant initial investment, and because of that Riders always strives to show the impact of their work.

In response to these challenges, Riders developed a considerable network of robust partnerships not just in Lesotho, but in all the countries where it operates. These relationships are giving Riders' programmes significant credibility among other institutions in Africa which is also an important form of promoting their entry in new locations.

3.6.4. Riders' Impact in Lesotho

Ms. Mahali Hlasa knows of the importance of Riders' work in the country and so she said: *"I would like to see this programme continue forever. I think we have no choice, otherwise we would go back to the same problems that we had, and we would still lose people when they could have been helped."*[95]

In fact, Riders know that when participating in *social business* it is extremely important to provide evidence of their work in Africa. Hence, in 2005, OC&C Strategy Consultants carried out a pro-bono due diligence process on the entire organization, with special attention to the programmes in the Gambia and in Zimbabwe. Although this report is outdated, it shows that Riders' programmes had great impact in Africa in terms of health and socio-economic benefits (see some examples in Exhibit 16).

Fortunately, there is another more frequent way of evaluating its work over time, as all Riders' programmes have a Monitoring and Evaluation (M&E) team in the field that helps to assess the baseline situation before the

[93] RfH B (2011), p. 19
[94] Ibidem
[95] RfH TV: "Introducing Mahali Hlasa - Lesotho P. Director" (http://www.youtube.com/user/RidersForHealthTV#p/u/46/ViRkzDX24oY)

operations start and conduct follow up studies with results every six months.[96] Until July 2011, the M&E team in Lesotho, was managed by Ms. Malehlonolo Kuleile, formulated the Lesotho Programme Impact Report of June 2011 that help us to assess Riders' impact in the country health system.[97] Let us now show the impact of Riders presence in Lesotho by presenting simple but significant data.

3.6.4.1. Outreach Health Worker Mobilization

Baseline[98]: When Riders arrived to Lesotho they found that 82% of the health centres had no transport for outreach work, that more than 30% did not perform any outreach work and 34% of outreach health workers conducted it by foot. The lack of transportation was preventing entire communities from being reached, as 64% of the communities had no outreach services and more than 35% had no form of healthcare support in their village or community. These communities would have to go to the nearest health centre, sometimes 200 km away. Their distance, which was psychological as well as geographical, from health treatments resulted in a dearth of knowledge about health problems and of confidence in the health system.

Impact[99]: In 2009, Riders provided motorcycles for a total of 130 health workers for their outreach work. Through several interviews, Riders were able to demonstrate that 94% of the health workers said that the number of people they were able to visit had *"increased dramatically"*, 2% said they had seen a slight increase and 4% affirmed it had stayed the same.

Health workers say that with a motorcycle they can visit more villages and see more people (see in Exhibit 17). Motorcycles have also allowed health workers to do follow up visits for individual patients because of increasing the frequency of visits to whole communities. Moreover, they can now spend more time with the patients and better monitor and assist the ones who default on their treatments (in Exhibit 18). The motorcycles also enable an increase in the health workers' pride and satisfaction as they feel more useful and see their help being more effective. The OHWs were also asked to qualitatively rate Riders' service considering the reliability of the motorcycles and the maintenance service provided.[100] Riders OHWM programme led to an increase in healthcare delivery to the people, example of this impact is the story of the rider Tsepo Kotelo (in section 3.1.).

[96] RfH A (2011), p. 13
[97] To perform Riders' follow up study, M&E team used riders' daily log sheets, health centres referral logs, patient attendance figures and laboratories testing volumes. They also interviewed (from August 2010 to April 2011) 56 health centres, all the laboratories served by ST programme, all ST riders and 85% of OHWM riders and other partners that gave their feedback on the programmes (RfH A 2011, p. 13 and 14)
[98] RfH A (2011), p. 26
[99] Ibidem, p. 27-32
[100] RfH A (2011), p. 32

3.6.4.2. Sample Transport

Baseline[101]***:*** Before Riders ST programme almost 50% of health centres were using public means of transportation to deliver the patients' samples for testing in the laboratories and also 17% of them simply did not take any samples but referred the patients to the hospitals. Riders also understood that 61% of health centres sometimes did not collect samples and deliver them to the laboratories due to lack of transportation. There were also delays in the returning of the results, with 61% of health centres receiving them within 1-2 weeks and 11% receiving the results 3-4 weeks later.

Another problem was that of sample rejection on the part of the laboratories, due to the inappropriate sample transportation and sample handling, in addition to old samples that had stayed too long at the health centres deteriorating in condition. This setback would require the patients to be called again to redraw more blood, leading to a decrease in trust in the health system.

Impact[102]***:*** It is the Basotho Minister of Health and Social Welfare that says: *"Patients are able to get their results on time and that means we start treatment quite early; so it (Riders' ST) has been one of the biggest resources we have ever had. It's saving lives definitely."*[103]

In fact, Riders was able, with 26 sample couriers, to provide a sample transport service that adequately and permanently responded to the challenges faced upon their arrival to Lesotho. In Exhibit 19 is presented the number of samples and results transported by ST riders, which means that, on average, all of the couriers in Lesotho transport more than 2.800 samples and over 2.000 results combined every week, the difference is justified by the fact that some tests require more than 1 test (e.g. *"TB testing requires three different samples"*[104]). In addition, almost 70% of health centres noticed a rise in the number of patients coming to the health centres. The frequency of sample collection increased while the time taken for results to be returned decreased (see in Exhibit 20).

Health centres were asked about their level of satisfaction regarding the ST programme and 75% answered they were "very satisfied", 20% were "satisfied" and only 1 health centre was neither satisfied nor dissatisfied. Laboratories were also interviewed and asked about Riders' reliability, professionalism and effectiveness and almost all qualified their level of satisfaction as "very satisfied" (see example of laboratory feedback in Exhibit 21). Riders'ST programme has been producing great results and one example could be the story of Setsabi Tikisi presented in Exhibit 22.

[101] Ibidem, p. 15
[102] Ibidem, p. 16-24
[103] RfH TV: "Riders for Health in Lesotho" (http://www.youtube.com/user/RidersForHealthTV#p/u/9/AtcclFE2LgM)
[104] Ibidem, p. 17

3.7. The Financing of Riders' Lesotho Programmes

Financing has always been at the centre of Riders' strategy and that is why Lakshmi Karan (former Director of Impact Assessment of the Skoll Foundation) said that *"what really attracted us to Riders was the sustainability aspect of it, the earn revenue aspect of it. It's not just a handout that they get from their donors, but they are starting to build a model that can tap into different revenue opportunities, even in developing countries, even with cash-strapped governments that may not have a lot of funding"*.[105]

Since its beginning, Riders has been concerned with finding an operationally and financially sustainable solution for its African health partners. In fact, Riders has always understood the value of money, especially in these *"cash-strapped"* African economies, designing programmes that should be financially self-sustaining in the long run.[106] In order to accomplish this goal Riders started charging a CPK to pay for the logistics of the programmes. Therefore, it is important to clarify that as a not-for-profit social enterprise, Riders can charge for its services and products as long as it will not make profit from such fees.

The CPK fees raise important challenges such as the unwillingness of health partners to outsource management transportation services, because they might judge Riders as a fixed cost and not solely as an efficient transportation partner. Moreover, the fees necessitate that Riders convince the MoHs as well as other partners that its managed transportation programmes ultimately reduce their fleet maintenance costs. In Exhibit 23 we can see how, in the first years of implementation, the cost of running the vehicles is the same under Riders' system versus an unmanaged system. However, either after the first year of an unmanaged system or when its vehicles start having some problems (e.g. breaking down and being subject to lengthy un-operational times) its cost rises dramatically. While under Riders' system, there is the *zero-breakdown* goal due to its reliance on preventive maintenance (see again Exhibit 5).[107] Now let us review in more detail the CPK model and understand why its success is directly linked to preventive maintenance.

3.7.1. Riders' CPK Model

One of Riders' key elements of preventive maintenance is *cost prediction*, which means that Riders is fully committed to an accurate and transparent costing model. This model is underpinned by Riders' belief that vehicles can be predictable if they are well maintained in accordance to the manufacturer's instructions - an essential assumption for the CPK's sustainability and for the system's stability. As Barry Coleman explains, *"If you have a breakdown it is a catastrophe. Logistically is a catastrophe, from the cost point of view, and certainly*

[105] RfH TV: *"Interview with Lakshmi Karan "* (http://www.youtube.com/user/RidersForHealthTV#p/u/39/2l93G7dD7pU)
[106] RfH website: http://www.riders.org/social_enterprise.aspx
[107] RfH B (2011), p. 6

from the point view of delivery of public healthcare. You can't afford not to get to a clinic when fifty women have turned up there with their children."[108]

The CPK calculator provides an accurate cost for each kilometre travelled by a motorcycle or four-wheeled vehicle. The regular components of the CPK are: replacement parts, technical staff costs, management costs, workshop costs, outreach maintenance costs, logistics & support costs, protective clothing. Nonetheless, CPK might also include fuel costs, insurance and replacement motorcycles cost. Then, the CPK is calculated as *"the total cost of running the fleet divided by the distance travelled (kms) by the fleet over its useful life"*[109], which in turn is invoiced monthly, assisted by Riders' technicians using the vehicle's odometers. Thus, the monthly fee is based on vehicle mileage rather than on specific labour and parts.

Lesotho two programmes are distinct and require different contracts. One of the biggest differences is that ST riders are directly employed by Riders while OHWs are employed by other health partners. Hence the CPK will be different for both programmes, see in Exhibit 24 the CPK composition for the OHWM in December 2009.

There are five main reasons that justify the use of the CPK model:[110]

- **Payment for performance** - Riders only receives payments if the vehicles run. Therefore if Riders fails to provide reliable vehicles, it does not get paid.
- **Enables reliable budgeting** - The CPK gives full transparency and visibility to the actual costs of running a fleet of vehicles. Moreover, the *"direct link between distances travelled and the cost regulates the normally unpredictable costs of vehicle maintenance, and allows health partners to budget expenditures".*[111]
- **Assists outreach journey planning** - Knowing the total distances of each journey enables health partners to better monitor and plan its health workers' activities.
- **Increases the level of control** to ensure that each vehicle is used most effectively - The CPK's implied control on a riders' work disincentivizes the misuse of the motorcycles that generates additional costs for the partners.
- **Riders' programmes replicability** - The CPK model can be applied to any partner in Africa.

The CPK cost for each partner depends on the service that Riders' provides and it is established in a contract signed by both parties. These contracts, and also the CPK, can be changed by both parties by making addendums, otherwise the terms will be valid until the end of the contract. [112]

[108] RfH TV: *"An introduction to Riders for Health"* (http://www.youtube.com/user/RidersForHealthTV#p/u/1/hrhjKTWyIfs)
[109] RfH (2009), p. 1
[110] Ibidem, p.2
[111] RfH website: http://www.riders.org/resource.aspx
[112] RfH: Interview Ms. Kameko Nichols (22.11.2011)

3.7.2. Other Sources of Financing

"In 2010, Riders had an income of $8 million, $3 million of which was earned through our operational contracts. There is a 32% year-over-year growth on our overall income compared to 2009."[113]

As a matter of fact, in addition to its earned income Riders' programmes still utilise outside funding, with operational earned income being less than 50% of the 2010 income. The other forms of funding include *Events and other Fundraising Activities* (e.g. the event *Day of Champions* and other motorcycling events), *Donations* (e.g. from UK, US and other fundraising branches that can be from individuals, groups and corporations) and also *Grants Receivables* (e.g. grants given by foundations like Bill and Melinda Gates Foundation or Skoll Foundation, which are a form of ongoing support). In Exhibit 25 we can find information on 2010 Riders' I&E statement.
While examining Riders accounts, we have to pay closer attention to an important detail: Riders' expenditure in the logistics for charitable activities (i.e. on running the programmes in Africa) were more than $5 million while the incoming resources from operations were only $3 million. This disparity points to the current necessity of Riders having other sources of funding for covering its expenditures.

The *buffer* that Riders manages to have can be crucial, as it was in the beginning of Riders' operations in Lesotho. In fact, the first two years of Riders' programme were entirely financed by EJAF[114], which in 2007 had given a grant to the MoHSW to start Riders operations in Lesotho.[115] However, since 2010, Lesotho's MoHSW has begun to take over the running costs of Riders' programmes.

3.8. Future Plans for Riders

In 2011 Riders' achievements in supporting partners to provide better access to healthcare services for over 12 million people in Africa were notable and praiseworthy. Nevertheless, the entire continent of Africa needs help and as Barry Coleman said, *"there is actually no country in Africa where this (managed health transportation) won't be profoundly beneficial".*[116] We can easily see that Africa needs predictable, reliable and cost-effective transportation that mobilizes its health workers. There are still many isolated, rural communities that do not receive healthcare treatments because the health providers cannot reach them.

That is why Riders wants to expand its operations in both its existing programmes and in other African countries, and that is why their models are designed to be scalable and replicable in different locations. Riders' ability to grow from local operations into a nationwide programme and to establish its models in new countries is possible

[113] RfH B (2011), p. 5
[114] Note: the grant served to purchase 120 motorcycles, set Riders' infrastructure, training and protective clothing for 120 health workers, full running for 2008, 2009 and partial costs of 2010 (RfH 2009, p. 1)
[115] RfH: Interview with Ms. Mahali Hlasa (16.11.2011)
[116] RfH TV: *"An introduction to Riders for Health" (http://www.youtube.com/user/RidersForHealthTV#p/u/1/hrhjKTWyIfs)*

due its creation of a Replication Department, managed by Mr. Alfred Gonga.[117] In order to further boost its expansion strategy, Riders also established the positions of Global Strategy director and a Partnership director, which are now held by Ms. Lakshmi Karan, and Ms. Kameko Nichols, respectively.[118]

The expansion strategy developed by these directors is part of Riders overall strategy, which foresees not only an expansion of Riders' work to new territories but also the increase in depth of the pre-existing programmes. In this sense, Riders is planning on starting in 2012 their operations in Malawi, and meanwhile, it intends to expand TRM in Lesotho with four-wheeled vehicles.[119] In order to make informed and appropriate decisions regarding new African locations, Riders has determined specific criteria, which are outlined in Exhibit 26.
To sum up we present in Exhibit 27 the enterprise's six strategic goals for 2015.

3.9. Drivers of Riders' Success

Andrea deeply believes in Riders' ability of developing African health systems, and so she says in an interview: *"Riders for Health has been working in Africa now for 20 years. We know that what we do has the potential to transform healthcare across Africa, but in order to do that we need support, and any investment and support that anybody can give us we are going to make that go a long way".*[120]

In the present case study, it has been demonstrated that Riders has been mobilizing health workers across Africa in order to improve that population's access to healthcare services. Riders' Lesotho ST and OHWM programmes are an example of the impact that managed transportation can have in a country where proper healthcare was often impossible to provide to its 2 million inhabitants. Riders knows what is needed for a health system to be more effective, and these variables are Riders' main drivers of success, synthesized below:

1st - **Focus on transportation management and the existence of strategic partnerships**, as Riders' central goal has always been to develop the transport infrastructure needed for more efficient health systems. This enabled Riders' to develop innovative transport models (e.g. TRM, TAM and ST) that better serve its partners' needs. And in this sense **Preventive maintenance** has been a core value underpinning Riders' strategy, as health workers are trained to drive safely and to conduct daily maintenance, and Riders' technicians work towards a zero-breakdown standard to ensure that healthcare services are reliably and effectively delivered.

[117] Note: The replications team (including Mr. Gonga) moves around based on need. Mr. Gonga has been working in Zambia, Malawi, and Zimbabwe. (RfH website)
[118] RfH website: http://www.riders.org/future_plans.aspx
[119] RfH: Interview with Ms. Mahali Hlasa (16.11.2011)
[120] RfH TV: *"An introduction to Riders for Health"* (http://www.youtube.com/user/RidersForHealthTV#p/u/1/hrhjKTWyIfs)

2nd - **Strong organizational structure**, with a well coordinated relationship that balances independence of the in-country offices with a certain degree of dependency on the UK centre, where Andrea and Barry Coleman, with Riders' UK team, assist all the programmes. The **Colemans' charisma and entrepreneurial sense** also guided Riders to its current successful structure.

3rd - **Financial sustainability** based on the innovative CPK costing model and on transparency and rigorous accounting methods. Riders is a not-for-profit enterprise that charges fair fees for its valuable services.

4th - **Advocacy for health transportation issues**, with an impressive marketing strategy that uses the media (e.g. Riders' website or Riders TV channel on *YouTube*) to clarify the urgent infrastructure needs of African health systems for the international community. Thus, Riders' has received considerable **Awards and Prizes** which expose and commend Riders' work throughout the world. And also the **Support of private Foundations and Universities** (e.g. Skoll Foundation, Bill and Melinda Gates Foundation or EJAF, and also the protocols with Stanford University Graduate School of Business) that gives Riders more credibility and helps its sustainability.

5th - And last but not least, the existence of a **Monitoring and Evaluation team** in each country, which shows Riders' commitment to frequently evaluate its programmes in order to identify improvements and assess changes when needed. In this sense, **Riders' publications**, which include Annual Reports, specific Impact Reports for the different locations, Strategy Reports and also reports like the *OC&C 2005 Due Diligence Report*, are critical for evaluation and transparency. These demonstrate Riders' concern for knowing and carefully describing the African reality and clearly presenting it to its partners, donors and every individual that might be interested. Finally, those reports present a fantastic resume of its *modus operandi*.

Along with these specific drivers of success, Riders' effectiveness can be summed up in what Andrea Coleman simply explains: *"It is certainly not rocket science, it is just putting an appropriate infrastructure where there is no transport infrastructure."*[121] As a matter of fact, this couple had a simple, practical idea that is helping to save millions of lives; if only these drivers could motivate others and ideas like this were implemented by such selfless entrepreneurs, great progress could be made all over the world. Nonetheless, we should be able to depict in Riders' example not only the drivers of its success but also the areas where it could have improvements and in that sense we present the next chapter that provides enlightening questions formulated as teaching notes.

[121] RfH TV: *"Skoll World Forum on Social Entrepreneurship"* (http://www.riders.org/the_need.aspx)

3.10. Exhibits

Exhibit 1: Andrea and Barry Coleman, Riders' Co-founders

Source: http://www.skollfoundation.org/entrepreneur/andrea-and-barry-coleman

Exhibit 2: Timeline of Events in Riders' history

1986 - 1996	Andrea Coleman, Barry Coleman and Randy Mamola, supported by Jeanette Wragg and a large number of volunteers, raise money in motorcycle sport for Save the Children Fund.
1988	Barry Coleman and Randy Mamola see motorcycles intended for use by the ministry of health in Mogadishu, Somalia, terminally damaged after very short operational lives.
1989	Barry Coleman, acting as consultant to SCF and WHO, examines motorcycle use/maintenance arrangements in the Gambia and the basis of a new training/management system is laid down.
1990	Andrea Coleman organises the first Day of Champions at Brands Hatch, which has grown into an annual event attached to MotoGP (the motorcycle racing equivalent of Formula 1).
1991	Riders opens its first national programme, managed by Mohale Moshoeshoe, in Lesotho. Riders start operating in Uganda.
1993	Riders started to manage motorcycles in Ghana.
1994	First large-scale national programme begins in Zimbabwe.
1996	Riders for Health registered as an independent charity in the UK focusing its attention solely on managing transport for outreach in rural Africa.
1997	HRH Princess Royal becomes Riders' patron. Beginning of revolutionary 'transport resource management' programme in Zimbabwe.
1999	Nigeria logistics programme begins. Fundraising begins in Holland.
2000	Democratic Republic of Congo logistics begins. Riders USA incorporated. Riders recieves UK National Lottery funding for building academy of transport management in Zimbabwe.
2001	New programme of work begins in the Gambia with the government outsourcing its transport management to Riders.
2002	International Academy of Vehicle Management (IAVM) opens in Zimbabwe. Riders initiated operation in Kenya. Ducati commit one dollar to Riders for every motorcycle sold.
2004	Launch of Motos Solidarias (Spanish branch of Riders) and Riders Germany. Andrea and Barry are invited to join the elite Schwab Foundation for Social Entrepreneurship.
2005	Riders is featured in a global health campaign to concentrate the world's attention on global health issues (New York). Andrea and Barry are named 'Heroes of Global Health' by Time magazine.
2006	Riders again attends the World Economic Forum in Davos. Riders is featured in a CNN documentary by Christiane Amanpour.
2008	Riders launched a new programme in Lesotho in January, returning to the country after a break of 12 years. Working with the ministry of health and other partners Riders is mobilising 120 health workers in this mountainous country.
2009	In February Riders launched its new Transport Asset Management programme in the Gambia. Riders began operating in Zambia.

Source: RfH website (http://www.riders.org/history.aspx)

Exhibit 3: Riders' Team	
Mrs Andrea Coleman CEO and Joint Founder	Andrea is chief executive officer of Riders and has guided the financial/funding and advocacy development of Riders from its inception, including establishing the entrepreneurial income streams and innovative fundraising initiatives.
Mr Barry Coleman ED and Joint Founder	Barry is the executive director, the designer of the TRM and TAM systems and the Riders cost-per-kilometre calculator. He has nearly 20 years' experience in developing sustainable systems for managing transport in hostile conditions.
Mr Randy Mamola Joint Founder	Widely regarded as the most exciting and most charismatic grand prix motorcycle racer of his generation, Mamola was a consistent challenger for the 500cc world championship title throughout the 1980s and early 1990s.
Ms Mahali Hlasa Lesotho Programme Director	Mahali qualified as a motorcycle rider under Riders' first nationwide motorcycle fleet programme in Lesotho in 1991. She is now programme director for Lesotho.
Mr Ngwarati Mashonga Operations Director	Ngwarati was programme director for the programme in Zimbabwe before transferring to the UK resource centre in January 2008. He is now overseeing all of our programmes and working with our teams to replicate them.
Mr Alfred Gonga Replications Director	Alfred first became involved with Riders for Health in 1996. He is now in charge of replicating our programmes in new countries and overseeing the Zambia programme.
Mr Lloyd Chipere Replications Manager	As part of the replications team, Lloyd works with Alfred Gonga to establish Riders' programmes in new countries.
Ms Kameko Nichols Partnership Director	Kameko's focus is on the continued devolpment of Riders' relationships with ministries of health and NGO's in African countries.
Ms Lakshmi Karan Global Strategy Director	Lakshmi, former Skoll Foundation Impact Assessment Director, is responsible to build relationships with potential large-scale investors in America.

Source: RfH website (http://www.riders.org/our_team.aspx)

Exhibit 4: Awards received by Riders	
2011 International Health Promotion Awards	Riders for Health's work was recognized with 3rd place. The URAC and the Care Continuum Alliance have partnered to present these 2011 awards, an opportunity to recognise, honour and share best practices that improve health care quality in a significant and lasting way.
2009 Third Sector Awards Social Enterprise	Riders won in the social enterprise category at the 2009 Third Sector Excellence Awards in recognition of Riders for Health's innovative vehicle leasing programme in the Gambia.
2006 Skoll Award for Social Entrepreneurship	In 2005 Riders was awarded $765,000 to help strengthen our existing programmes and replicate our programme in a new country.
2006 The Tech Museum Award	The Tech Museum, based in California, named 25 Laureates from among 951 entries for the prestigious Tech Museum Awards Programme, which celebrates those who leverage new and existing technologies to benefit humanity.
2006 Ernst & Young Entrepreneur Of The Year Award	Riders won the Social Enterprise Entrepreneur Of The Year. An award category for people who have deployed entrepreneurial skill and leadership in organisations that delivers positive social change.
2006 Paul Harris Fellowship	Andrea Coleman awarded the Paul Harris Fellowship. Given to Rotarians to reward distinguished service.
2005 Global Health Council Award	Award for Best Practices in Global Health. The award is given annually to highlight and celebrate successful and innovative efforts on the ground dedicated to improving the health of disadvantaged populations.
2004 Sage/Daily Telegraph	Riders were rcognized as the Best Business Leader of the year.

(Continues on the next page)

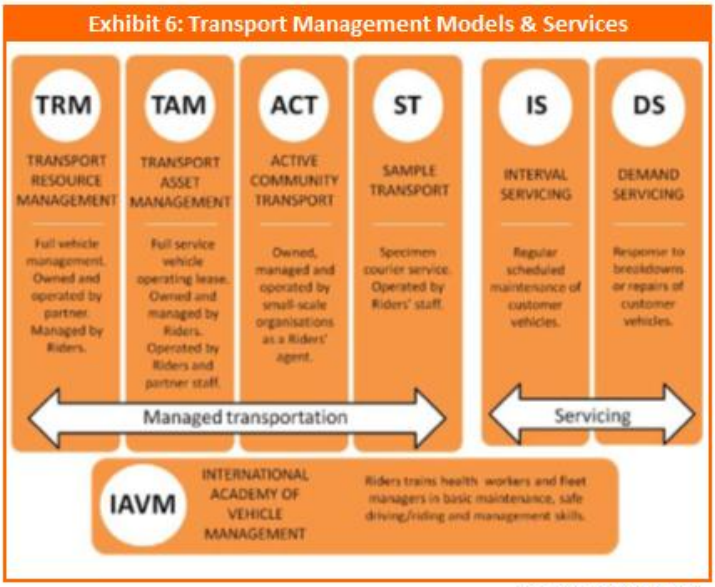
2004 Schwab Foundation	Riders were invited to join the elite Schwab Foundation for Social Entrepreneurship.
2002 National Lottery	Riders won the National Lottery funding for building International Academy of Vehicle Management in Zimbabwe.
2002 Nedlloyd/Worldaware Award	This award is given to a company or organization which has assisted economic and social development through the provision of appropriate, sustainable and environmentally complementary transport systems or other infrastructure.
2002 World Bank Award	The Development Marketplace Award administered to the projects that better succees on: innovation, potential for growth,visible benefits, realism and sustainability.
2002 HSBC Award	Riders were awarded with "Community Business of the Year" nomination.
2001 UK Charity of the Year	The UK Charity Awards are annual awards for outstanding achievements within the UK not-for-profit sector.
2001 Price Michael International Road	This award recognise achievements and innovations which improve road safety.
1998 Worldaware Award	A prestigious public recognition of the ways in which business and other organisations contribute in a responsible way to the development of poorer countries.

Source: RfH website (http://www.riders.org/awards.aspx)

Exhibit 5: Key Elements of Preventive Maintenance	
Training	The quality of driving and maintenance practices are crucial for the longevity of any vehicle. Hence, riders and drivers are trained to drive safely and to carry out daily maintenance, identifying potential damages before they happen.
Outreach Maintenance	The technicians provide monthly service to the vehicles where they are based, avoiding unnecessary down-time and fuel wastes. This maintenance with high technical standards is performed by very well prepared technicians.
Parts' Supply Chain	From its UK headquarters, Riders' staff assist in procuring the parts that must be available for needed replacements and ship them directly to the countries.
Cost Control	Riders relies on the fact tht, under rigorous maintenance systems, vehicles are "extremely predictable". Riders' developed an accurate and transparent pricing measured on a cost per-kilometer basis (CPK), meaning that the partners only pay for the real service provided.
Appropriate Vehicles	Riders also provides consulting advices on the best transport solutions for its partners; in order for it to effectively provide valuable service, the choice of cost-effective vehicles that are appropriate for the terrains and health-programmes is crucial.

Source: Author, adapted from RfH website

Exhibit 6: Transport Management Models & Services



Source: RfH (2010), p.11

Exhibit 7: Map "Where Riders work"

Source: RfH website (http://www.riders.org/where_we_work.aspx)

Exhibit 8: Fact Sheet of Riders' Operations in SSA

	COUNTRY	HEALTH INDICATORS (2009)					PROGRAMME DETAILS			
		Population	HIV[1]	TB[2]	Life Expectancy	Child Mortality[3]	When	Programme	Staff[4]	Vehicles[4]
PRESENT OPERATIONS	Lesotho	2.067.000	23,60%	0,41%	46 (m), 50 (w)	84	1991- 1998 2008 - Present	TRM TRM and ST	89	120
	The Gambia	1.663.000	2,00%	0,43%	58 (m), 61 (w)	114	1989 - 2001 2002 - 2005 2005 - 2009 2009 - Present	Servicing IS and DS TRM TAM	181	404
	Zimbabwe	13.228.000	14,30%	0,43%	47 (m), 50 (w)	90	1998 - 2006 2002 2010 - Present	TRM IAVM ST and TRM	33	708
	Zambia	12.935.000	13,50%	0,31%	46 (m), 50 (w)	470	2009 - Present	TRM and ST	15	30
	Nigeria	144.720.000	3,60%	0,50%	53 (m), 54 (w)	191	1999 - 2005 2005 - Present	TRM IS and DS	39	262
	Kenya	36.553.000	6,30%	0,28%	58 (m), 62 (w)	121	2002 - Present 2011	TRM IAMV	8	90
	United Republic of Tanzania	43.739.000	5,60%	0,17%	53 (m), 58 (w)	108	2003 - Present	TRM	0	8
PAST Operations	Ghana	22.113.000	1,80%	0,33%	57 (m), 64 (w)	112	1993-1994	Training	NA	600
	Uganda	28.816.000	6,50%	0,28%	48 (m),57 (w)	136	1990 - 1991	Training	NA	NA
	Democratic Republic of Congo	47.549.000	NA	0,65%	47 (m), 51 (w)	205	2000 - 2006	TRM	NA	40
	TOTALS[5]	**254.905.000**			**51 (m), 55 (w)**				**365**	**1.622**

Notes:

Source: Author, adapted from WHO - Global Health Observatory and RfH website

[1] Prevalence of HIV among adults (15-49) per country

[2] Prevalence of TB per country

[3] Under 5 Child Mortality per 1000 live births

[4] Current Programme Numbers (riders/staff and vehicles managed)

[5] Total values without considering past operations

NA = "Not Available"

Exhibit 9: Map of Lesotho

Source: FAO's website

Exhibit 10: Lesotho Development Indicators

Least Developed Countries (LDC's)	2011	Lesotho is considered by the UN to be one of the LCD's in world, having a Human Development Index (HDI) of 0,45 and listed as the 160th least developed country from a list of 187.			
Poverty (World Bank Poverty Line)	2011	A great percentage of the population is poor with about 43,4% living with less than PPP $ 1,25 a day.			
Corruption Perceived Index (CPI)	2010	Corruption is not perceived to be high, as Lesotho is placed at 78th with a CPI from a group of 180 countries.[1]			
Unemployment	2009	Unemployment rate was over 40%.[2]			
Adult Literacy Rate (+ 15 years old)	2009	Literacy rate was 87%, one of the highest in the Africa.			
GDP per Capita in 2009 (PPP in int. $)	2009	**Lesotho**	**South Africa**	**UK**	**USA**
		1.700	10.400	34.600	46.400
Currencies		Lesotho Loti and South African Rand.			
Inflation	2010	Infaltion rate (consumer prices) was only 3,6% and has been kept relatively low.			
International Organizations		As a former British colony, Lesotho is a part of the Commonwealth of Nations, and also participates in WTO (World Trade Organization), SACU (Southern Africa Customs Union) and SADC (Southern Africa Development Community).			

Notes: *Source: Author, adapted from UNDP (2011) and CIA World Factbook website*

[1] Extracted from (http://en.wikipedia.org/wiki/Corruption_Perceptions_Index)

[2] Extracted from WHO Lesotho 2009

Exhibit 11: Mohale Dam, part of the LHWP

Source: Government of Lesotho (2007), p. 15

Exhibit 12: Lesotho Health Context

Leading Causes of Institutional Deaths (2008)	
Tuberculosis	31%
Pneumonia	29%
Diarrheal Diseases	14%
HIV/AIDS	9%[1]
Other Indicators (2009)	
Life Expectancy	46 (m), 50 (w)
Under-5 mortality	84 per 1000 live births
Maternal Mortality	530 per 100.000 live births
% Population with access to Improved Sanitation	80%
% Population with access to Improved Water Source	< 30%

Notes: *Source: Murman and Sullivan (2008) and WHO (2011)*

[1] Nevertheless contributing to all the illnesses listed above

Exhibit 13: Lesotho Health Resources & Infrastructure

Infrastructure (2011)				
DISTRICT	**Hospitals**	**Health Centres**[2]		**Laboratories**
Berea	2	16	*16*	2
Butha-Buthe	2	12	*10*	2
Leribe	2	27	*27*	2
Mafeteng	1	20	*20*	1
Maseru (Capital)[1]	3	48	*40*	3
Mohale's Hoek	1	15	*11*	1
Mokhotlong	1	12	*8*	1
Qacha's Nek	2	14	*12*	2
Quthing	1	9	*8*	1
Thaba-Tseka	2	19	*14*	2
TOTAL	**17**	**192**	***166***	**17**
Resources (2000-2009)				
Physicians	**1**	*per 10.00 people*		
Nursing Personnel	**6**			
Hospital Beds	**13**			

Source: RfH Interview with Ms. Mahali Hlasa (16.11.2011) and WHO Africa (2011)

Notes:

[1] In Maseru there are also 1 private hospital and 4 specialized hospitals that have their own specimen collection services.

[2] In the second column are presented the number of health centres serviced by Riders.

Exhibit 14: Lesotho's Government Health Sector Priorities

Lesotho National Vision 2020	Poverty Reduction Strategy 2010/2011
Good quality and affordable health for all.	Promoting acess to quality and essential health care by developing clear policies.
Adequate incentives to retain health professionals.	Good quality and improved capacity in health management systems.
Traditional and modern medicines will be well integrated.	Good quality and strengthening disease prevention programmes.
All Basotho will have access to safe drinking water and basic sanitation.	Improving health infrastructure, equipment maintenance and supplies.
There shall be no new HIV and AIDS infections and there will be care and support for orphans.	Communicable disease control, including universal access to HIV/AIDS and TB treatment and prevention.

Source: WHO (2008), p. 10

Exhibit 15: Current Logistics of Riders' Lesotho

DISTRICT	# ST Couriers[1]	# Riders OHW	# Riders Technicians	# Fuel Stations[3]
Berea	2	10		1
Butha-Buthe	2	6		1
Leribe	4	8		1
Mafeteng	2	4		1
Maseru (Capital)	7	9	2	1
Mohale's Hoek	2	4		1
Mokhotlong[2]	3	10	1	1
Qacha's Nek[2]	3	6	1	1
Quthing	2	2		1
Thaba-Tseka[2]	3		1	1
TOTAL	**30**	**59**	**5**	**10**

Source: Interview with Ms. Mahali Hlasa (16.11.2011)

Notes:

[1] One ST courier is based in Maseru as relief, and 2 injured ST couriers are still in their districts.

[2] Three extra ST couriers, included in Mokhotlong, Qacha's Nek and Thaba Tseka, also work as junior technicians. They are employed as STs but with technical background so that they can help with bike maintenace in those areas as well.

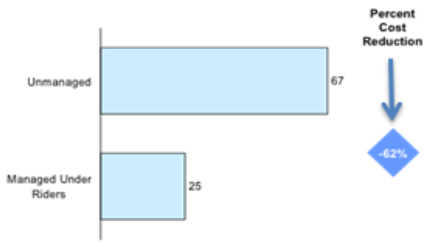
[3] All fuel stations used by Riders are governemnt owned.

Exhibit 16: OC&C Report on Riders' Zimbabwe (2005)

ECONOMIC Benefits

Riders has dramatically reduced maintenance costs associated with health worker outreach

Estimated Annual Motorcycle Fleet Maintenace Cost per Thousand Population Reached by Health Worker in Zimbabwe[1] (in £ per annum)



[1]Includes replacement costs; assumes motorcycles reach 20k peopleper month (interviews); motorcycles assumed to last 20k km unmanaged, 80k km managed (interviews).

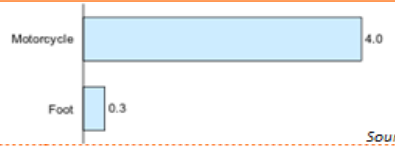
Source: RfH, Interviews, OC&C analysis

HEALTH Benefits

Creating 'mobile health workers' dramatically improves access

Population Covered by Health Worker in Zimbabwe, by Mode of Transport (per 1.000 Population)

Frequency of Visit by Health Worker in Zimbabwe, by Mode of Transport (Visits per Month)



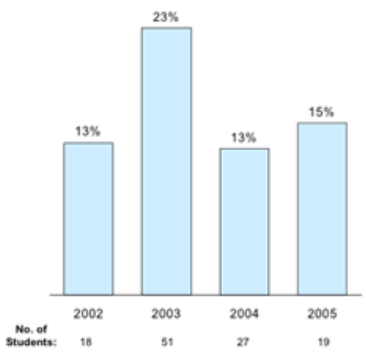
Source: Interviews, OC&C analysis

(Continues on the next page)

SOCIAL Benefits

Riders has empowered women in Zimbabwe

Female IAVM Students, 2002–05 (% of Total)



Riders trains substantial numbers of professional women health workers to ride motorcycles.

"We have a culture where men do some things and women do other things. Now here we have a program for children. The men will not work with children and the women can't got to the children. The training puts the women on the bikes and gets them there."

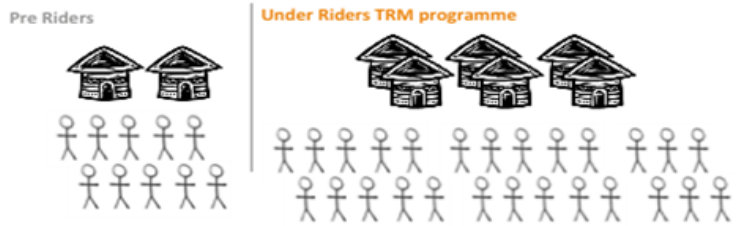
- Deputy Director, FCTZ

Source: IAVM, Interviews, OC&C analysis

Source: Author, adapted from OC&C (2005), p. 30, 18 and 39

Exhibit 17: Average Number of Villages and People Visited by OHW

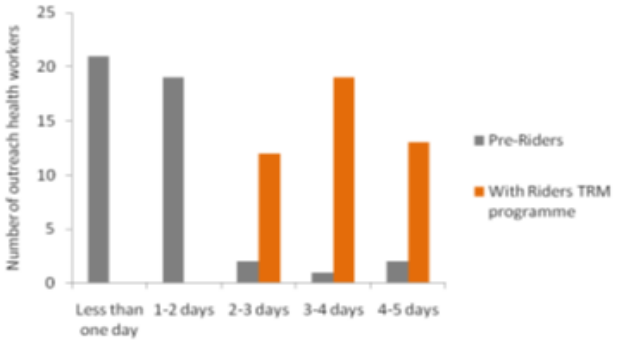
(per week, before and after mobilisation)



Source: RfH A (2011), p. 27

Exhibit 18: Length of Time OHW Spend in the Communities

(per week, before and after mobilisation)



Source: RfH A (2011), p. 29

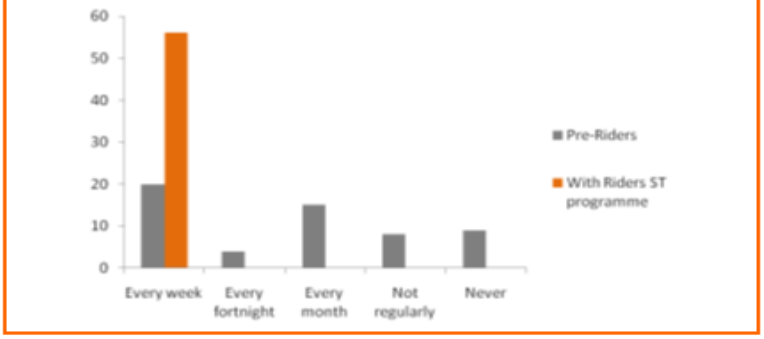
Exhibit 19: Average Number of Samples and Results Transported

(per Riders' sample courier, per week)

Note: Each picture represents 10 samples or 10 results.

Source: RfH A (2011), p. 17

Exhibit 20: Time Taken for Results to be Returned to Health Centres
(before and after Riders' ST programme)



Source: RfH A (2011), p. 19

Exhibit 21: Laboratory Feedback

Khotso Kalake the Laboratory Technician at St. Joseph's Laboratory said that, *"the rejections that we used to have from the clinics are no longer there, and also a lot of patients are now seeking services in the health centres because they know that when there are tests to be done, they will get results and be treated immediately."*
He went on to say that *"our sample courier is very efficient, and he knows how to handle the samples very well."*

Source: RfH A (2011), p. 25

Exhibit 22: Sample Courier Profile

Name:	Setsabi Tikisi
Job role:	Sample courier
Laboratory:	St. Joseph's
District:	Maseru
Health centres served:	6
Distance travelled:	19,661 kilometres
Samples transported:	over 6,500
Results delivered:	nearly 5,000
Been with Riders since:	March 2009
Motorcycle:	Honda CTX 200

Setsabi Tikisi is one of the 30 sample couriers working in Lesotho for Riders for Health in support of MoHSW. He is based at St. Joseph's Laboratory in Maseru and visits six health centres each week to collect their patients' samples and return test results from the lab. Setsabi was trained to ride a motorcycle and given specific sample handling training in March 2009.

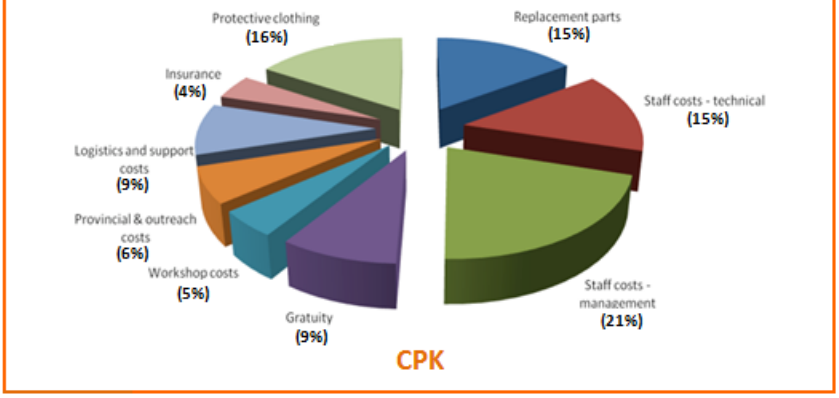
Setsabi collects samples from Fatima Health Centre, which serves 60 villages, meaning laboratory services are available at the primary health care level for these communities. He went on to rate Riders 5/5 "very satisfied" with the Sample Transport programme, explaining: *"we are very satisfied, our patients are receiving their results after testing within a week, and also the sample courier knows how to handle the samples so we don't have rejections because of them."*

Source: RfH A (2011), p. 25

Exhibit 23: Cumulative cost for managed and unmanaged systems (per vehicle)

Source: RfH B (2011), p.7

Exhibit 24: CPK Components for OHWM Programme (as a % of total cost)[1]



Notes:

[1]Refers to December 2009

Source: RfH (2009), p.5

Exhibit 25: Riders 2010 I&E Statement (in USD)

	Unrestricted funds USD	Restricted funds USD	2010 Total funds USD	2009 USD
Income and expenditure				
Incoming resources				
Incoming resources from generated funds				
. Events and similar activities	517,591	0	517,591	664,741
. Donations	554,647	62,639	617,287	763,700
. Grants receivable	577,769	2,978,852	3,556,621	1,938,825
. Interest receivable	48,390	26,800	75,190	54,522
Incoming resources from charitable activities				
. Logistics	2,786,685	299,110	3,085,795	2,265,519
. Advocacy and Education				
Other incoming resources	74,889	83	74,972	67,619
FX gains	52,059	37,688	89,746	292,428
Total incoming resources	4,612,029	3,405,171	8,017,201	6,047,354
Resources expended				
Cost of generating funds				
.Events and similar activities	449,990	4	449,994	549,297
.Fundraising	426,010	49,166	475,177	564,789
Charitable activities				0
.Logistics	2,206,804	2,808,540	5,015,343	4,324,132
.Advocacy and Education	281,711	592,953	874,664	757,882
Governance	168,578	28,740	197,318	145,251

(Continues on the next page)

Total resources expended	3,533,092	3,479,403	7,012,496	6,341,351
Net movement in funds before gains (losses)	1,078,937	(74,232)	1,004,705	(293,997)
Other recognised gains (losses)				
Exchange rate gains/(losses)	31,983		31,983	(26,647)
Gain/loss on assets	(15,407)		(15,407)	0
Net movement in funds	1,095,513	(74,232)	1,021,281	(320,644)
Funds brought forward at 1 January 2010	1,436,494	672,995	2,109,490	2,430,134
Transfers between funds	95,739	(95,739)	0	0
Funds carried forward at 31 December 2010	2,627,747	503,024	3,130,771	2,109,490

Note, these figures are subject to Riders consolidated audit.

Source: RfH B (2011), p.22

Exhibit 26: Criteria for Expansion
Government commitment to health care and level of MoH resources, and willingness to engage in Public Private Partnerships (Priority).
Presence of complementary NGO's.
Likelihood of funding support/donor interest and presence of key and influential partners.
Health indicators.
Political/economic stability.
Proximity to established Riders programmes to allow for most effective management of expansion and ease for replication teams.
Languages (Anglophone preferred at this stage while engaging in advocacy and in-depth monitoring, which require strong communication).
Availability of promising staff.
National scalability potential.

Source: RfH B (2011), p. 20

Exhibit 27: Riders' Goals for 2015	
1st	Establish new and larger-scale partnerships with health-providing organizations. Expand our operations into at least two additional counties in sub-Saharan Africa.
2nd	Enable local health workers to provide health care access to 25 million people living in the poorest rural African communities.
3rd	Manage 4,000 vehicles for our health care delivery partners.
4th	Build the capacity of Riders' existing programmes, implementing in-depth evaluation and monitoring to demonstrate the value and impact of our work.
5th	Strengthen the core of Riders for Health to provide a strong platform for growth and sustainability.
6th	Raise awareness of the importance of transportation in global health initiatives and create the expectation that vehicles should run for years without breaking down.

Source: RfH website (http://riders.org/future_plans.aspx)

Chapter 4: TEACHING NOTES

4.1. Case Summary

The case study ***Riders for Health – Healthcare Delivery Solution in Lesotho*** presents Riders a British social enterprise that has been working in sub-Saharan Africa (SSA) since the 1980s with the special mission of managing health transportation in rural areas. Since the beginning, Riders' co-founders, Barry and Andrea Coleman, understood the importance of developing an innovative and practical approach to one of the biggest challenges of African health systems: the lack of health resources and proper infrastructure exacerbated by difficult hard geographic conditions.

In fact, Riders' ultimate goal is to enable African Ministries of Health (MoHs), and other health partners, to have uninterrupted access to appropriate and reliable transportation. Thus, Riders has been developing an innovative and sustainable strategy underpinned by a simple but crucial concept: *Preventive Maintenance*. In the past twenty years of operations Riders has employed its efforts to create and develop previously inexistent health infrastructures; these are shown in Exhibit 28, which demonstrates the importance of access to health delivery and the components of Riders' services.

In December 2011, Riders was a mature and successful organization with its headquarters in the UK and operations in seven African countries: Zimbabwe, the Gambia, Kenya, Tanzania, Zambia, Nigeria and Lesotho. It manages about 1,600 vehicles and employs 300 workers in SSA, that enable partners to provide better access to healthcare services for up to 12 million Africans.[122] This case study presents in detail Riders' operations in the *Mountain Kingdom of Lesotho*, a country entirely encircled by South Africa, with 2 million inhabitants and the 3rd highest HIV infection rate in the world. In 2008, Riders initiated two nation-wide programmes in Lesotho, a challenging location due to its mountainous topography and the inexistence of significant paved roads.

Despite such problems, for the past three years the Outreach Health Worker Mobilization (OHWM) and the Sample Transport (ST) programmes have been helping to provide healthcare services to Lesotho's entire population. These programmes are both based on TRM and enable almost 60 health workers to visit more villages more frequently (OHWM) and to increase the quality and quantity of diagnosis, with more samples and results transported from the health centres to the laboratories, a service performed by 30 sample couriers (ST).

Riders' Lesotho programme illustrates the importance of strategic partnerships, as Riders is only the *last-mile partner*, and it also addresses the necessity of measuring the impact of its programmes. At the same time, it

[122] Note: Riders at a glance in 2011 (http://www.riders.org/media.aspx)

proves how its innovative and accurate pricing model enables Riders to be a sustainable social enterprise less dependent on external donors and philanthropy. The case also presents Riders' future plans and objectives for 2015 and concludes with a summary of the main drivers for Riders' success.

Finally, we hope that the reader understands Riders' simple but effective approach and is inspired to reproduce it, not just in African countries but in every location where the sick need medical care but distance and transport are barriers to it.

4.2. Learning Objectives

The case study was prepared for students interested in the fields of social entrepreneurship (SE) and development. It could be also a valid example for a management course related to strategy, as the students will have the opportunity to learn important strategy lessons and to encounter an award-winning social enterprise. Let us more specifically enumerate the learning objectives to be found in the present case:

- To give students an increased awareness of Africa and one of its health system's most challenging barriers: the inexistence of appropriate infrastructures - especially health transportation resources. As Riders' solution helps provide better access to healthcare services to millions of Africans, and illustrates how crucial managed transportation is.
- Students will deeply understand the organization and expansion strategy behind a successful social enterprise, and how the developed world can utilise SE to help Africa. Riders' long-term experience in Africa has the power to influence the way the developed world is *assisting* Africa.
- The example of Andrea and Barry Coleman will help students to comprehend what social entrepreneurs *are made of*. They are, as Bill Drayton explains, society changing agents: *"the most powerful force for change in the world"*[123].
- This case also underscores the importance of strategic partnerships while working in Africa and in healthcare. Riders understands that if each *agent* specializes in a specific area of action, the impact of a conjoint effort will be greater.
- To demonstrate the importance of monitoring the impact of operations, especially when dealing with socio-entrepreneurial activities, as Riders' operations evidence how important it is to conquer partners and donors' trust.
- To highlight how crucial clear and transparent financing models are in social business, as Riders' not-for-profit innovative costing model presents an important example of how a social enterprise can be sustainable and effective.

[123] Full quote: *"Drayton founded Ashoka because he believes that the most powerful force for change in the world is a new idea in the hands of a leading social entrepreneur"* (Ashoka website: http://www.ashoka.org)

4.3. Teaching Questions (TQs)

Riders' work is exciting and its success might dazzle anyone who discovers its operations; however, we would like to propose a closer look at some important questions that the case raises. The TQs are as follows:

TQ1 - Riders presents a specific set of criteria for expansion and focuses its operations in the health sector. Could these be restricting Riders' entrance in other countries and in other areas of action?

TQ2 - What are Riders main challenges and what can be done to minimize them?

TQ3 - After reading the chapter devoted to social entrepreneurship can we say that Riders is truly a Social Enterprise? If yes, of what kind?

TQ4 - How can we measure Riders' success? Do operational statistics (e.g. number of kilometres and visits) reflect real improvements in the African health systems?

4.4. Suggested Teaching Methods

As a teaching method, it could be interesting for the professor to present the case to a group of students and ask them to play the role of independent advisory consultants hired by Riders. The students can imagine that the TQs were formulated by an international board of judges analysing Riders' application for an important award (e.g. the *Social Enterprise of the Year* award).

The TQs could be divided between four groups of students who would be asked to prepare Riders' answer to the board of judges. Students would have access to Riders' website where they could find all of the important information for their research (e.g. Annual Reports, Strategic Reports and also Impact Reports) and through which they could contact Riders for extra information and clarification.

For the final class, the professor could invite a representative of Riders, for example its CEO Andrea Coleman, to come address the class. Andrea could start by presenting her experience as Riders' CEO for the past 20 years, and afterwards, the groups would present a case summary in light of each question and also their answer to it. After each presentation, the rest of the class would be asked to comment on the group's defence and discuss its practical impact for Riders. This discussion could be even more interesting and constructive if the class could be divided in two, with one half supporting the group's solution and the other elucidating its disadvantages.

The students should be told that these are real questions with which Riders has to deal, thus a well elaborated answer could be very useful to help Riders save millions of lives. At the end of the class Andrea and the professor would comment on all of the answers and choose the most complete one, suggesting an opportunity for the group to implement it in the field.

4.5. Analysis and Discussion

In this sub-chapter we do not aim to extensively answer the four TQs but rather to provide guidelines for students' answers. In this sense, we will only present ground concepts that will help students to develop their own ideas to which there are no limits.

TQ1 - Riders presents a specific set of criteria for expansion and focuses its operations in the health sector. Could these be restricting Riders' entrance in other countries and in other areas of action?

Students could frame TQ1 using the Ansoff model, in Exhibit 29, where expansion and diversification decisions are considered in regards to the conditions of the market and services provided.

To answer to the first part of TQ1, we must review Riders' vision and mission statement (in sub-chapter 3.2.2.) in order to better understand the enterprise's nature and future aspirations. These are the factors that influence the mentioned criteria for expansion, present in Exhibit 26. Moreover, an attentive student will be able to divide the nine criteria into two groups: in the exhibit, the *orange group* includes core elements that are strategic to Riders and directly linked to the enterprise's vision; and the *black group* is constituted by the criteria that are subjective to modifications.

In fact, as it is mentioned in the case study, Riders considers the possibility of partnerships with MoHs, the existence of *complementary NGOs* and the presence of other key influential partners to be essential for its operations' success (in sub-chapter 3.6.3.). At the same time, it is only natural that health indicators and country stability are crucial for Riders' decision to start its programmes. Moreover, "*the availability of promising staff*" is an important criterion because Riders has its own programmes for training riders, but its managers and technical directors should have highly skilled technical backgrounds.

Nevertheless, the remaining criteria should be critically analyzed. Indeed, the preference for Anglophone countries, with the purpose of easing communication between Riders' headquarters and the country programme offices, sets aside other African countries (e.g. Lusophone and/or Francophone). Hence, this criterion might be seen as restrictive for Riders expansion. However, with some research students will find that almost half of the African countries speak English, which shows that there is room for Riders' expansion. The importance of "*potential national scalability*", which determines Riders' market potential, and the "*proximity to established Riders' programmes*" can also be misleading and can be considered secondary criteria. Yet, students can be certain that Riders does not disregard these insights and that careful analysis is made when deciding the expansion strategy.

Still, it could be interesting for the students to present locations where *orange indicators* reveal that Riders' operations could succeed. For this, an environmental analysis would be suggested in order to describe the country's macro and micro environment (Exhibit 30). The choice could relapse on a country with a very low HDI (e.g. the Lusophone Mozambique with 0.322, seen in chapter 2.1.) and students could recommend that new associates (e.g. a Portuguese-speaking talented student) could be hired in order to overcome existing barriers.

In addition, students could suggest Riders' expansion to different continents (e.g. Asia or South America) and if so, plot out how Riders' operations and way of conducting the programmes would change. The students have to bear in mind that the standardization of Riders' transport models might not be the perfect solution and that local adaptation would be needed for such a decision. Again a cost/risk-benefit analysis would be needed, balancing the advantages and disadvantages (e.g. cultural differences and distance from Riders' headquarters) of such expansion.

TQ1 also raises the question of diversification by applying Riders' business model to other social areas of action. For the following analysis we suggest a matrix similar to Exhibit 31.

First, students have to suggest different areas and demonstrate the relevance of the specific mission: like education (e.g. mobilizing professors so they can teach in more schools, and also to use managed transportation to distribute books and other materials) and famine reduction (e.g. transportation could be used to distribute basic food in locations where famine is decimating entire populations). Second, students would have to enumerate the changes in Riders' operational structure in order to adapt its models to correctly grasp these new social missions. Third, a projection of these operations would have to be made considering the location's choice, the potential for strategic alliances, the existence of *competitors* (i.e. partners with similar activities) and the forecast of entry and running costs. And finally a risk-benefit analysis would be necessary.

TQ1 poses interesting questions for Riders, which strives to have the maximum social impact it can. However, when discussing expansion and diversification strategies students should remember Riders' drivers of success (in sub-chapter 3.9) and notice the importance of focusing on *health-transportation logistics*. In the end, students will have to assess Riders' core competencies and strengths and balance those with the changes implied by these new strategies. Students will also understand Riders' position of setting the example and leading the way for others to do the same in different locations and in areas of action.

TQ2 - What are Riders main challenges/risks and what can be done to minimize them?

The case study does not summarize the Riders' challenges, thus TQ2 seems to be the perfect opportunity to encourage students to find the areas of Riders' business model which involve certain risks. This answer can be

very useful to Riders, since it is always more than willing to change in order to improve its operations' impact on the field.

First, we suggest students to begin with a New SWOT analysis in order to understand Riders' strengths and weaknesses. Yet, this *new* analysis replaces *Threats* by *Time* as we believe that strategically *Threats* should be seen as opportunities in the appropriate timing (see in Exhibit 32). The summary of Riders' core competencies, discussed in sub-chapter 3.9., will help students to think of how Riders can take advantage of these windows of opportunity.

Nonetheless, these challenges (i.e. strategic opportunities) exist and we recommend students to elaborate a comprehensive list, similar to the one presented in Exhibit 33. It is important to define the area where it happens, the challenge description, the suggested solution to overcome it and also the timing of such opportunity.

While going carefully through the case, students will be able to observe challenges in the Lesotho programme and extrapolate from those to Riders' challenges as a whole. Students could identify some among the following:

- The possibility of **riders misusing the vehicles** is something that Riders cannot fully control, and might imply higher costs for its partners. Nevertheless, this is only a real problem when riders are directly hired by Riders (e.g. the 30 ST riders mobilized in Lesotho), otherwise it is the partners' responsibility.
- **Inexistence of accurate and actual health data** might hamper Riders' work in what matters with resources' allocation.
- The **country's political and/or economic instability** (e.g. potential civil wars) can create problems for Riders, such as difficulties in entering and moving around the country.
- The potential **inability of partners to pay** monthly CPK is a great challenge as Riders is a not-for-profit enterprise charging the minimum for its services. If Riders does not has the capacity to pay its suppliers, it might encounter difficulties in running the programmes (see how this situation was surpassed in Lesotho, in sub-chapter 3.7).
- At first glance, African health partners might think of **Riders as free service provider**, or a traditional donor.
- The **exchange rate risk** while doing fuel procurement and other financial transactions in different African, European and American currencies (e.g. the problem of Zimbabwe hyperinflation in 2008 and 2009, when the price of $1 USD cost $Z 2,621,984,228).[124]

[124] Source: http://en.wikipedia.org/wiki/Hyperinflation_in_Zimbabwe

Students will have to analyze these challenges and understand how controllable they are and what Riders can do to minimize them. While suggesting solutions the topic of vertical integration might arise, as Riders could extend its functions in the operational chain (e.g. Riders directly hiring and controlling all the riders or having a finance expert doing risk management). Still, students cannot forget how important partnerships are, enabling Riders to spread the risk among several agents. Again, a careful cost-benefit analysis would have to be made and students should be encouraged to recommend improvements for these and other challenges.

TQ3 - After reading the chapter devoted to SE can we say that Riders is truly a Social Enterprise? If yes, of what kind?

Throughout the case study, Riders is frequently presented as a *social enterprise*. In its website Riders announces that it *"is proud to be a part of the global community of social entrepreneurs"*[125], and also mentions that it is a member of both Skoll and Schwab Foundations, presented in chapter 2.4. In addition, in Exhibit 4 students can easily find that Riders has been awarded many times as a social enterprise. Albeit, the first part of TQ3 seems almost answered the question goes deeper and tries to comprehend the concept of social entrepreneurship in light of Riders' work and strives to identify its co-founders as genuine social entrepreneurs.

The first logical thing to do is to understand what these concepts mean:

Social Entrepreneurship - an *"innovative, social value creating activity that can occur within or across the non-profit, business, or government sectors"* (Austin et al 2006).

Social Entrepreneurs - "*combine the passion of a social mission with an image of business-like discipline"* (Dees et al, 1998).

While going through Riders' operations, and particularly while revising its mission and vision statements (in sub-chapter 3.2.2.), students will realize that Riders' *modus operandi* was the first ever being implemented in Africa (*"innovative"*), that its focus in health delivery systems to provide better access to healthcare for up to 12 million people in 2011[126] (*"social value creating activity"*), by working with MoHs and other public/private health partners (*"within or across the business or government sectors"*).

When considering Riders' history and also while viewing most of the interviews and videos on Riders TV[127], students will easily look at Riders co-founders, Andrea and Barry Coleman, and understand why Bill Drayton says that social entrepreneurs are *"the most powerful force for change in the world"*[128]. As a matter of fact, the Colemans perfectly grasped a barrier in the African health systems and had a simple idea to overcome it by

[125] Note: http://www.riders.org/social_enterprise.aspx
[126] RfH website: http://www.riders.org/media.aspx
[127] RfH TV: http://www.youtube.com/user/RidersForHealthTV
[128] Ashoka website: http://www.ashoka.org

putting in place the principle of preventive maintenance. Moreover, these entrepreneurs did not rest until their vision was set in Africa, and they still do not rest as many more countries can benefit from Riders' managed transportation solution.

To answer the second part of TQ3 the students may use the three different models for social enterprises presented by Elkington and Hartigan (2008) and summarized in Annex 10. Students will find three distinct definitions: the *"leveraged non-profit"* (1), the *"hybrid non-profit"* (2) and the *"social business"* (3) model.

A closer first look at the three models will lead the students to realize that Riders does not fit model 3 because it is a not-for-profit enterprise and is not actively seeking for *"investors interested in combining financial and social returns"*. While considering model 1, students might agree with many of the propositions, however, one cannot say that Riders enables the *"direct beneficiaries to assume ownership of the initiative"* and also that it is dependent on external funding. Riders has headquarters in the UK from which Riders' central team (CEO, ED and COO, among others) coordinate and define the strategy for the enterprise as a whole.

By following this reasoning, students will come to the point where a *"hybrid non-profit"* model seems the best fit for Riders' enterprise. As a matter of fact, in order for a public good to be rendered to the unserved, a marketing plan has been developed to enable Riders to reach more people, and cover its costs by charging for its services and also by mobilizing financial resources from other public and private sources. The last proposition suggest that Riders would have the desire to be a model 3 social enterprise, but this would imply that Riders would have no longer have non-profit status, which is in fact not a part of Riders' strategy for the near future.

In order to complement this analysis, students should read Elkington and Hartigan (2008)[129] and visit the Schwab Foundation website to understand more about what distinguishes social enterprises[130]. By doing so, they will find that the international community points Riders to be an "*hybrid non-profit*" social enterprise, perfectly aligning a not-for-profit sustainable strategy with business discipline and a social mission.

TQ4 - How can we measure Riders' success? Do operational statistics (e.g. kilometres and visits) reflect real improvements in the African health systems?

Health impact on African systems poses a tricky question for any health-focused organization, not just Riders. This concern is carefully underscored in the case study (especially in sub-chapter 3.6.4.), as monitoring the evaluation of Riders' programmes has always been a pillar of Riders' work in Africa. Since the beginning, Riders

[129] Note: Specially the chapter one: "Creating Successful Business Models", p. 9-14
[130] Source: http://www.schwabfound.org/sf/SocialEntrepreneurs/Profiles/Abouttheorganizationalmodels/index.htm

has strived to link operational success to health outcomes and ultimately to real health impacts as its final goal is and always will be to save lives.

In order to understand the links on this *impact chain* students are encouraged to use Michael Porter Value Chain[131] (in Exhibit 34) that summarizes the enterprise's main activities and helps illustrate to what extent Riders controls each step of the operational chain:

- **In-bound logistics** refers to the relation that Riders establishes with its suppliers. In this sense, while receiving and storing motorcycles, fuel, replacement parts or protecting riding equipment, Riders has total control on the decisions it makes.
- **Operations** include the activities through which the inputs are transformed into outputs. In Riders' case, this step of the value chain would include its services like drivers' training.
- **Outbound logistics** involve activities required to collect and distribute the output. Riders has its own network for delivering services and necessary equipment.
- **Marketing and sales** include the activities to induce and facilitate clients' purchases. In this sense, Riders has control of this step, conducting the meetings and conversations with health partners, potential donors and other strategic agents.
- **Services** normally refer to post-purchase activities, and for an enterprise like Riders, this relates to the Outreach Maintenance and the Sample Transport services.

Porter also considered the existence of secondary activities as important in understanding the value chain: procurement, human resources management, technological development and infrastructure. All of these also take place in Riders' operational organisation.

Nevertheless, while applying Porter's Value Chain to the case study, students will find that Riders control almost every step of the chain but not completely. Despite the fact that Riders is an important piece of the system, we cannot forget that it is also only a partner for the MoHs and other health institutions which means that the final health impact is still dependent on its partners' effective completion of jobs. This notion is key in making sense of Riders' work in SSA.

In fact, while enumerating Riders' challenges in TQ2, one is faced with the inability to control exactly how riders use their motorcycles. Riders can make sure that the motorcycles will not break-down, but it cannot make sure

[131] Source: http://www.ifm.eng.cam.ac.uk/dstools/paradigm/valuch.html

that the rider is using it for the given health purpose. This relates to human resource management activity, and Riders has difficulties in controlling the riders, especially those hired by its partners.

At this point students have to make a clear distinction between the ST and OHWM programmes. Regarding the first, Riders controls every step of the service provided: it has hired the 30 riders and trained them to perform the requested service, controls their work through scheduling and verifies daily log sheets. Also, while considering ST programme in Lesotho, students should remember that there was no previous system and there were only *un-orthodox* methods for transporting samples; this past reality implies that the programme has had a clear impact because now there is an organised and reliable network that enables quality diagnosis and treatments to be initiated earlier preventing needless deaths due to delays in diagnosis.

Regarding the OHWM the story is different, as Riders only has access to operational numbers. Riders knows how many km each rider in different districts travels during a specific month, but currently it has no way of controlling the work these riders conduct on the field. However, this was a well known situation before Riders' solution and Riders only claims to be the best in mobilizing health workers and assuring their vehicles do not break. If students recall Exhibit 29 they understand that Riders only controls 1/3 of the healthcare delivery determinants, and if Riders cannot control the entire value chain, it cannot easily measure efficiency improvements.

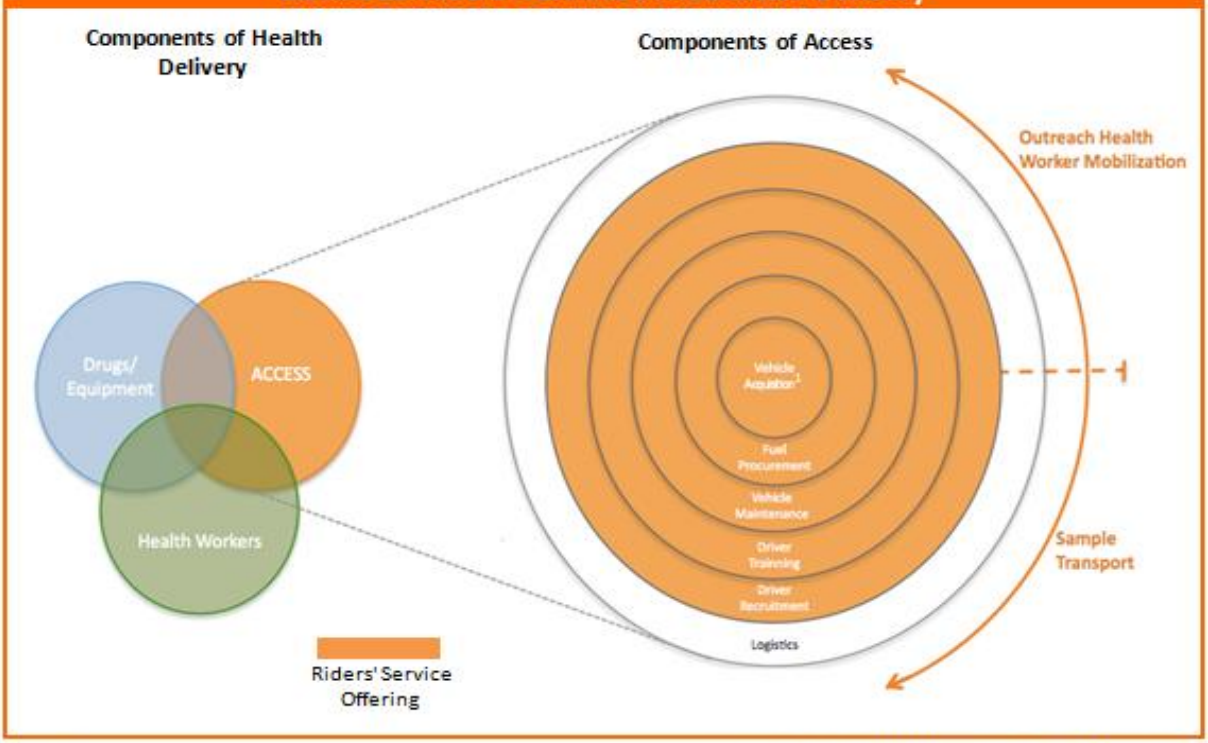
Riders is concerned with these matters and that is why it has one M&E team in every country and has also decided to partner with universities, such like Stanford University in California[132], and private consultants[133]. In order to correctly answer TQ4 students should acknowledge the existence of such implications in the *impact chain* and suggest alternative measures for an improved control over Riders' programmes.

[132] *"As part of a grant from the Bill & Melinda Gates Foundation, Riders has been partnering with Stanford University in California since November 2008 to produce an external evaluation on the impact of Riders work on health care coverage. The Stanford research team's study in Southern Province, Zambia is monitoring four districts in which Riders for Health will be running a programme and four districts where we won't work"* (http://www.riders.org/impact_of_our_work.aspx)

[133] Note: *OC&C Strategy Consultants in 2005*

4.6. Exhibits

Exhibit 28: Riders' Services in Healthcare Delivery



Note:

[1] Service offered through TAM model

Source: Author, adapted from OC&C (2005), p. 10

Exhibit 29: Ansoff Model (TQ1)

		Riders' Services	
		Present	**New**
Market	**Present**	**Market Penetration** Increase current services in current location	**Service Diversification** Create new services in current locations
	New	**Market Expansion** Cover new locations with the same services	**Complete Diversification** Create new services in new locations

Source: Author, adapted from original Ansoff Model

Exhibit 30: Environmental Analysis for Expansion Strategy (TQ1)		
LOCATION:		
MACRO Environment	Political-Legal	
	Economic	
	Socio-cultural	
	Health	
	Geographic	
MICRO Environment	Clients	
	Suppliers	
	Community	
	Competitors	

Source: Author

Exhibit 31: Diversification Strategy Matrix (TQ1)			
AREA of ACTION:			
Mission Relevance			
Changes in Riders' Op. Structure	1-	3-	5-
	2-	4-	6-
Projection of Operations	Strategic alliances		
	Competitors		
	Financial forecasts		
Risks	1-	2-	3-
Other			

Source: Author

Exhibit 32: New SWOT Analysis (TQ2)		
	Opportunities & Time	
	Short/Medium	Medium/long term
Strenghts		
Weaknesses		

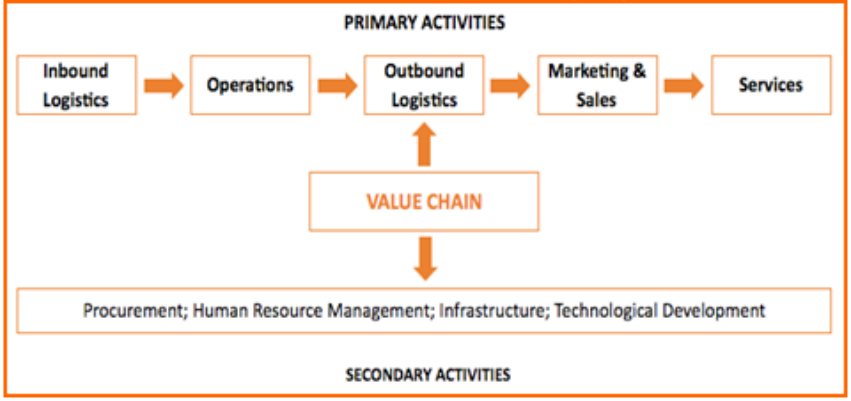
Source: Author

Exhibit 33: Challenge Matrix (TQ2)

Area	Description	Solution	Time

Source: Author

Exhibit 34: Porter's Value Chain (TQ4)



Source: Author, adapted from (http://www.ifm.eng.cam.ac.uk/dstools/paradigm/valuch.html)

Chapter 5: CONCLUSION AND FUTURE RESEARCH

By the end of the present dissertation we hope that the reader found it interesting and worthy of his or her time. Should the case study provide a clear understanding of how social entrepreneurship has a fundamental role in helping Africa to escape the *poverty trap* in which it has been captured for the last decade, then our goals have been attained.

Sub-Saharan Africa was particularly presented as the world region most lagging in terms of human development, but also where the presence of social entrepreneurs with innovative and sustainable *ideas* might be seen as essential for its welfare. Moreover, we have provided evidence on how crucial efficient health systems are for countries to be *healthier* and we certainly conclude that healthcare is an essential pillar of Africa's development strategy. While considering Riders' operations in Lesotho we were also able to ascertain Africa's necessity of a well-designed strategy and rigorously executed business plan. In fact, Riders' programmes show that the continent needs more than just the foreign aid developed countries provide in the form of ODA. Riders is a perfect example of a credible and well successful social enterprise, as it managed to revolutionize the transportation paradigm in rural Africa.

The case study also raises the question of how important enterprises' sustainability is and Riders long-term existence proves that a not-for-profit enterprise can exist and subsist in a *cash-strapped* continent like Africa. As a matter of fact, by charging fees for its services, Riders is assuring MoHs and other partners that the funds for running the programmes will never fail. It is also interesting to assess the importance of strategic partnerships for Riders' success as well as the relevance of constantly monitoring programmes' evolution. With all of these aspects attributed to Riders' success, we must underscore how significant the contribution of Riders co-founders - and now CEO and ED - Andrea and Barry Coleman has been. The Colemans represent a sign of hope and pose an inspirational example to social entrepreneurs all around the world, as they prove that simple ideas and a portion of resilience may save millions of lives.

Nonetheless, while writing the case study we felt limitations that sometimes prevented us from going deeper into some of the sub-chapter topics. Firstly, we have to point out the inexistence of actual, accurate and reliable data on African countries including Lesotho[134]. This impeded us from inferring what the actual healthcare state of the *Mountain Kingdom* was, as we only had access to reports provided by WHO Africa, dated 2011 but only showing information from 2004 till 2009. More up-to-date health-data would have enabled us to better assess

[134] *Note: this limitation is also clear to WHO that, through the Human Metrics Network, state that "Lesotho is performing poorly on data management [measured by data collection, data storage, data analysis and data distribution] with a score of 39%. Currently, a set of procedures for data management are present but not adequate." (http://www.who.int/healthmetrics/library/countries/lso/en/index.html)*

Riders' impact after 3 years of operations in Lesotho and we would have been able to answer TQ4 regarding the real health impact (i.e. the evolution of HIV and TB prevalence rates and mortality rates). It became clear how urgent it is to invest on Africa's information systems and data management. Reliable statistics provide the essential knowledge for decision-makers to correctly decide on policies for the continent's development. Riders faced the same limitations while trying to assess its impact in the different locations. Secondly, we dwelt with a more practical limitation of the lack of space and time to elaborate all aspects of this dissertation. More time would have allowed us to have a closer contact with Riders and its Lesotho programme; perhaps an organized trip to Northampton (Riders' headquarters) or to Lesotho would have deepened the study in many respects. Nevertheless, we believe that this dissertation has been completed with the quality that Riders merits.

As we mentioned in the beginning of this dissertation we did not aim to exhaustively cover this topic, and moreover we know that healthcare issues, especially in Africa, will still constitute an important and interesting theme for future dissertations and other researchers. We would suggest a research on the implementation of information systems and data management tools in African countries, maybe an investigation done in partnership with WHO Africa. Another interesting topic could be a research on Riders' programmes in Zimbabwe, or some other location where the programme is not a nation-wide one, in order to help Riders design a strategy for its scalability. An investigation on how Riders' example could be expanded into other continents and an assessment of challenges that one would experience of its adaptability would also be interesting. Moreover, Riders' business model could be applied to other critical areas like education and food transportation, which are also relevant in aiding Africa's development. As one can see, while dealing with Africa and human life, the topics are never exhausted.

I also would like to state how grateful I am to have met Riders and its Lesotho programme. I have been inspired by this extraordinary social enterprise that has proved to the world that, when our goal is to help our *brothers in life*, no barriers are insurmountable. Finally, if it is undeniable that *"the poor you will always have with you"*[135], each one of us should never forget that *"you shall love your neighbour as yourself"*[136], and only by doing so can we reciprocate the greatest gift that has been given to us: *life*.

[135] from Matthew 26, 11
[136] from Mark 12, 31

BIBLIOGRAPHY

Articles and Books

Abuhamoud, M. A. A.; Rahmat, R. A. O. K. and Ismail, A. (2011*) "Transportation and its Concerns in Africa: A Review"*, The Social Sciences, 6 (1): 51–63.

Alesina, A. and Dollar, D. (2000), *"Who Gives Foreign Aid to Whom and Why?"*, Journal of Economic Growth, 5: 33–63.

Alesina, A. and Weder, B. (2002), *"Do Corrupt Governments Receive less Foreign Aid?"*, American Economic Review 92 (4): 1126–1137.

Ardndt, C.; Jones, S. and Tarp, F. (2009), *"Aid and Growth: Have We Come Full Circle?"*, United Nations University - World Institute for Development Economics Research, Discussion Paper No. 2009/05.

Austin, J.; Stevenson, H. and Wei-Skillern, J. (2006), *"Social and Commercial Entrepreneurship: Same, Different or Both?"*, Entrepreneurship Theory and Practice.

Bryceson, D. F.; Bradbury, A. and Bradbury, T. (2008), *"Roads to Poverty Reduction? Exploring Rural Roads' Impact on Mobility in Africa and Asia"*, Development Policy Review, 26 (4): 459–482.

Bourguignon, F. and Sundberg, M. (2007), *"Is Foreign Aid Helping: Aid Effectiveness - Opening the Black Box"*, The American Economic Review, Vol. 97, No. 2: 316–321.

Boschee, J. and McClurg, J. (2003), *"Toward a better understanding of social entrepreneurship: Some important distinctions"*, Chief Executive: 1–5.

Burnside, C. and Dollar, D. (2000), *"Aid, Policies, and Growth"*, The American Economic Review, Vol. 90, No. 4: 847–868.

Buse, K. and Harmer, A. M. (2006), *"Seven habits of highly effective global public–private health partnerships: Practice and potential"*, Social Science & Medicine, 64: 259–271.

Canning, D. (2010), *"Human Development Research Paper: progress in Health around the World"*, UNDP Research Paper 2010/43.

Collier, P. (2007), *"The Bottom Billion: Why the Poorest Countries are falling and What Can Be Done About It"*, Oxford University Press: 3.

Connell, J.; Zurn, P.; Stilwell, B.; Awases, M. and Braichet, J. (2007), *"Sub-Saharan Africa: Beyond the health worker migration crisis?"*, Social Science & Medicine, 64: 1876–1891.

Dees, J. G.; Haas, M. and Haas, P. (1998), *"The Meaning of Social Entrepreneurship"*, Working Paper, Kauffman Center for Entrepreneurial Leadership.

Dionisio, D.; Cao, Y.; Hongzhou, L.; Kraisintu, K. and Messeri, D. (2006), *"Affordable Antiretroviral Drugs for the Under-Served Markets: How to Expand Equitable Access Against the Backdrop of Challenging Scenarios?"*, Bentham Science Publishers Ltd., Current HIV Research, Vol. 4, No. 1: 3–20.

Easterly, W.; Levine, R. and Roodman, D. (2004), *"Aid, Policies, and Growth: Comment"*, The American Economic Review, Vol. 94, No. 3: 774–780.

Easterly, W. (2009), *"Can the West Save Africa?"*, Journal of Economic Literature, 47(2): 373–447.

Eastwood, J. B.; Conroy, R. E.; Naicker, S.; West, P. A.; Tutt, R. C. and Plange-Rhule, J. (2005), *"Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK"*, Lancet, 365: 1893–900.

Elkington, J. and Hartigan P. (2008), *"The Power of Unreasonable People: How Social Entrepreneurs Create Markets That Change the World in Creating Successful Business Models"*, Lessons from Social Entrepreneurship, Harvard Business Press: 1–26.

Friedman, M. (1970), *"The Social Responsibility of Business is to Increase its Profits"*, The New York Times Magazine, September 13.

Gerein, N; Green, A. and Pearson, S. (2006), *"The Implications of Shortages of Health Professionals for Maternal Health in Sub-Saharan Africa"*, Reproductive Health Matters, 14(27): 40–50.

Government of Lesotho (2007), *"Poverty Reduction Strategy 2004/2005 - 2006/2007"*, Kingdom of Lesotho.

Haugh, H. (2007), *"Review Article: New Strategies for a Sustainable Society: The Growing Contribution of Social Entrepreneurship"*, Business Ethics Quarterly, Vol. 17, Issue 4: 743–749.

Laderchi, C. R.; Saith, R. and Stewart, F. (2003), *"Does it matter that we don't agree in the definition of poverty? A comparison of four approaches"*, Queen Elizabeth House Working Paper Series, University of Oxford.

Lensink, R. and White, H. (2001), *"Are There Negative Returns to Aid?"*, Journal of Development Studies, Vol. 37 Issue 6: 42–65.

Leviner, N.; Crutchfield, L. R. and Wells, D. (2006), *"Understanding the Impact of Social Entrepreneurs: Ashoka's Answer to the Challenge of Measuring Effectiveness"*, Published in Research on Social Entrepreneurship: Understanding and Contributing to an Emerging Field, edited by Rachel Mosher-Williams.

Lufesi, N. N.; Andrew, M. and Aursnes, I. (2007), *"Deficient supplies of drugs for life threatening diseases in an African community - Review Article"*, BMC Health Services Research, 7:86.

Mathers, C. D.; Salomon, J. A.; Murray, C. J. L. and Lopez, A. D. (2003), *"Health Systems Performance Assessment: Debathes, Methods and Empiricism"*, Chapter: "Alternative summary measures of average population health, World Health Organization": 319–334.

McCoy, D.; Chand, S. and Sridhar, D. (2009), *"Global health funding: how much, where it comes from and where it goes"*, Health Policy and Planning, 24: 407–417.

Moss, T.; Petterson, G. and Van de Walle, N. (2006), *"An Aid-Institutions Paradox? A Review Essay on Aid Dependency and State Building in Sub-Saharan Africa"*, Centre for Global Development, Working Paper Number 74.

Murman, D. and Sullivan, A (2008), *"Emergency Medicine in Lesotho"*, American Academy of Emergency Medicine: 3, 9.

Ngoasong, M. Z. (2009), *"The emergence of global health partnerships as facilitators of access to medication in Africa: A narrative policy analysis"*, Social Science & Medicine, 68: 949–956.

OC&C (2005), *"OC&C due diligence report on Riders' operations in Africa - Report Digest",* OC&C Strategy Consultants.

Petti, C. A.; Polage, C. R.; Quinn, T. C.; Ronald, A. R. and Sande, M. A. (2005*), "Laboratory Medicine in Africa: A Barrier to Effective Health Care"*, Laboratory Medicine in Africa CID, 42: 377–382.

Porter, G. (2007), *"Transport planning in sub-Saharan Africa: Progress Report"*, Progress in Development Studies, 7(3): 251–57.

Queiroz, C. and Gautam, S. (1992), *"Road Infrastructure and Economic Development: Some Diagnostic Indicators"*, World Bank Policy Research WORKING PAPERS, Transport Western Africa Department and Infrastructure and Urban Development Department, WSP 921.

Radelet, S.; Clemens, M. and Bhavnani, R. (2005), *"Aid and Growth"*, Finance&Development - IMF, Vol. 42, No 3.

Ram, R. (2003), *"Roles of Bilateral and Multilateral Aid in Economic Growth of Developing Countries"*, KYKLOS, Vol. 56, Fasc. 1: 95–110.

Rammohan, S. (2010), "Riders for Health – A fleet leasing model in the Gambia", Stanford University Global Supply Chain Management Forum, Socially and Environmentally Responsible Supply Chains Program.

Ranis, G.; Stewart, F. and Samman, E. (2006), *"Human Development: Beyond the Human Development Index"*, Journal of Human Development, Vol. 7, No. 3.

RfH (2009), *"Proposal for Continuance of Kingdom of Lesotho's Healthcare Mobility Programme"*, Riders for Health publication.

RfH (2010), *"Annual Report and Accounts - 2010"*, Riders for Health publication.

RfH A (2011), *"Lesotho Programme - Impact Report June 2011"*, Riders for Health publication.

RfH B (2011), *"Strategic Overview - May 2011"*, Riders for Health publication.

Stiglitz, J. E.; Sen, A. and Fitoussi, J.P. (2009), *"Report by The Commission on the Measurement of Economic Performance and Social Progress"*, Working Papers and Reports CMEPSP.

UNDP (1990), *"Human Development Report 1990: Concept and Measurement of Human Development"* Overview and Chapter 1: 1–16.

UNDP (2011), *"Human Development Report 2011: Sustainability and Equity: A Better Future for All"*, Chapter: Statistical Annex: 121–165

UN-OHRLLS (2011), *"World Statistic Pocketbook 2010: Least Developed Countries"*, Series V, No. 35/LDC.

WHO (2008), *"Cooperation Strategy - Lesotho 2008 /2013",* WHO - Regional Office for Africa, NLM Classification**:** WA 540 HU5.

WHO (2009), *"Country Cooperation Strategy, at a glance - Lesotho"*, (available online at http://www.who.int/countryfocus

WHO (2011), *"Lesotho Health profile"*, WHO - Regional Office for Africa, last update 4 April 2011.

WHO Africa (2011), *"Health Situation Analysis in the African Region - Atlas of Health Statistics, 2011"*, WHO - Regional Office for Africa.

Wolff, H.; Chong, H. and Auffhammer, M. (2011), *"Classification, Detection and Consequences of Data Error: Evidence from the Human Development Index"*, The Economic Journal: 843–870.

World Bank (1998), *"Assessing Aid: What Works, What Doesn't, and Why"*, A World Bank policy research report, Oxford University Press.

World Bank (2000/2001), *"World Development Report - Attacking Poverty: Opportunity, Empowerment and Security"*, A World Bank policy research report, Oxford University Press: 1–12.

Conference Calls:

1 - Mr. Danny O'Farrel, Riders' contact for this case study preparation- in 2.11.2011

2 - Ms. Mahali Hlasa, Riders' Lesotho Programme Director - in 16.11.2011

3 - Ms. Kameko Nichols, Riders' Partnership Director - in 22.11.2011

Websites:

Ashoka Foundation - *http://www.ashoka.org*
Accessed on 5.01.2012

CIA World Fact Book - *https://www.cia.gov/library/publications/the-world-factbook*
Accessed from November to December 2011

OECD Statistics - *http://stats.oecd.org/Index.aspx*
Accessed on the 13.12.2011

Partners in Health - *http://www.pih.org*
Accessed on November 2011

Riders for Health - *http://www.riders.org*
Accessed from October 2011 to February 2012

Riders for Health TV - *http://www.youtube.com/user/RidersForHealthTV*
Accessed in 13.11.2011

Schwab Foundation for Social Entrepreneurship - *http://www.schwabfound.org*
Accessed on 5.01.2012

Skoll Foundation - *http://www.skollfoundation.org*
Accessed on 5.01.2012

UN-OHRLLS - *http://www.unohrlls.org*
Accessed on 2.01.2012

Wikipedia - *http://wikipedia.org*
Accessed from November 2011 to February 2012

WHO Global Health Observatory - *http://www.who.int/countries*
Accessed on December 2011