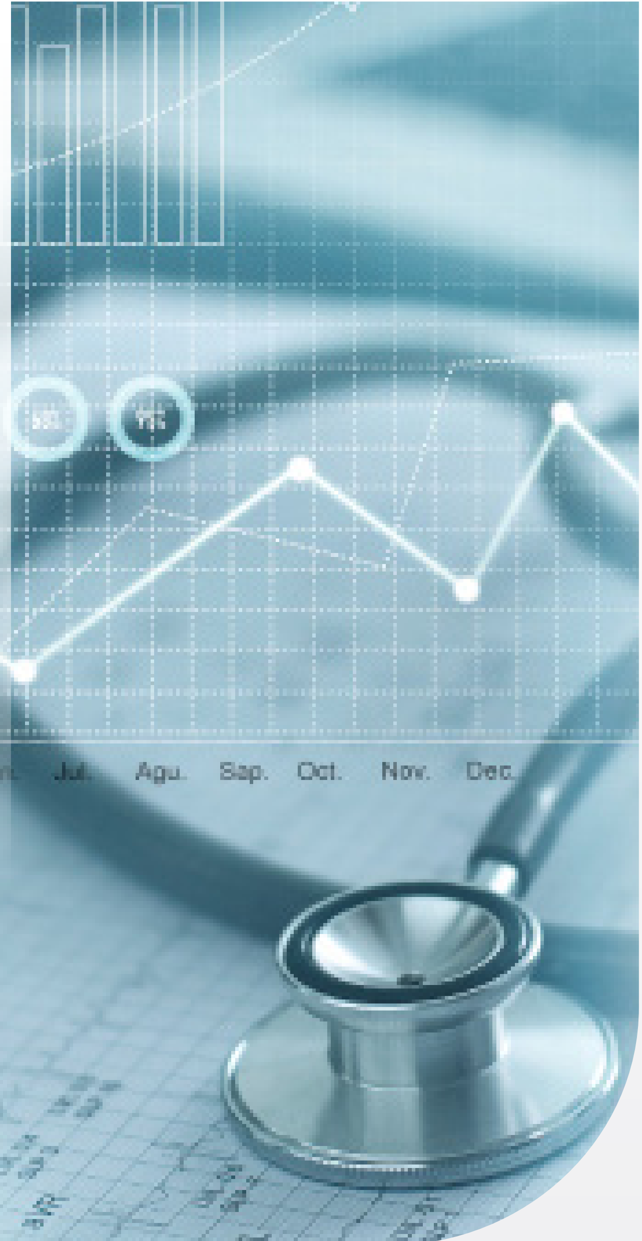
THE CASE OF
UGANDA



Enhancing the value of short term volunteer missions in health from host country perspectives

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i

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ii LIST OF ACRONYMS

CAP	Common Africa Position
CBPR	Community-Based Participatory Research
DHT	District Health Team
GNI	Gross National Product
GoU	Government of Uganda
HSDP	Health Sector Development Plan
LMIC	Low Middle Income Countries
MAKSS REC	Makerere University School of Social Sciences Research Ethics Committee
MoH	Ministry of Health
NGOs	Non-Governmental Organisations
SDG	Sustainable Development Goals
STMMS	Short Term Medical Missions
TNR	Total Number of Responses
UBOS	Uganda Bureau of Statistics
UK	United Kingdom
UNCST	Uganda National Council for Science and Technology
UNDP	United Nations Development Program
UNHS	Uganda National Health Survey
USA	United States of America

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iv EXECUTIVE SUMMARY

Short-term medical missions (STMMs), estimated to involve 1.6 million volunteers and US$2-3 billion annually, can be very valuable, but there is a growing critique of practices. Serious concerns have arisen around possible harms to host countries and patients, including medical errors, non-alignment with local systems and priorities, cultural insensitivity, and the high cost compared to benefits. Scholars and practitioners across diverse sectors involved-faith-based, corporate, NGO, and educational-have questioned the value of STMMs and proposed strategies for improving them.

Missing from this assessment are voices of host communities and research on host country efforts to control the quality of visiting programs. In this study, we investigated host perspectives on STMMs. The study was driven by the need to examine the regulatory and policy environment as well as to establish the perspectives of all country stakeholders on STMMs with the view of enhancing their value. This research is a collaborative effort between researchers at Uganda Christian University in Mukono, Uganda and Lehigh University, PA, United States of America.

A qualitative methodology was adopted, with in-depth interviews as the main tool. A total of 46 interviews with policy makers, Non-Governmental Organisations and those who have engaged with volunteers in the communities were conducted in Uganda. The analysis was computer-assisted and thematic.

The study revealed that the health needs of the country are many, and STMMs contribute to closing some of the gaps, although this may be limited given the scope of needs. Some of these health needs include limited infrastructure and budget support for health, low levels of staffing and inadequate resources such as equipment in the facilities.

It was further revealed that the contributions made are bi-directional, with host communities claiming that they contribute towards pre-visit preparations, accommodation, local expertise on tropical diseases, and social support while volunteers contribute skills, treatment, equipment, awareness and research.

Nevertheless, from the perspective of stakeholders interviewed, STMM volunteers face challenges such as cultural shock, inadequate resources to work with, manpower to support them, high expectations from the communities and delay in clearance for practice.

Despite their contributions, the study established that host communities expressed concerns about the nature of STMMs involving lack of experience, hidden interests, misalignment with community needs, security risks, code of conduct and sustainability of support.

A review of Ugandan laws reveals many that are related to the regulation of health services, but none that specifically mentions short-term mission trips. Most stakeholders interviewed were unaware of any regulatory oversight of visiting health teams, although some were aware of the need for clearance of visitors' credentials.

It is therefore recommended that in order to enhance the value of STMMs in Uganda, concrete actions be taken involving improving and making known the conditions for licensing and oversight, improving communication, enhancing collaboration and supporting capacity building for local experts.

INTRODUCTION 1

Background to the study

There has been growing attention in scholarly and popular literature in recent years to the problems with short-term global health experiences, focused on the ethics of students practicing beyond their training, volunteers lacking preparation or skills for the needs of host communities, lack of continuity or sustainability of programs, and lack of cultural humility on the part of volunteers (Ackerman, 2010; DeCamp, 2011; Crump & Sugarman, 2010; Lasker, 2016; Rozier et al., 2017). In response to these problems, scholars, practitioners, and organizations have created guidelines identifying what they consider best practices for short-term programs.

These critiques and guidelines are produced almost entirely by people in the sending countries. Additionally, they rarely incorporate the views of host community members and leaders (Lough et al., 2018; Lasker et al. 2018). Yet experts in the field often write or speak about the central importance of involving host partners in a more powerful way (Catholic Health Association, 2015; Melby et al., 2016).

Major actors in the field are also starting to pay attention to the problems and to discuss solutions. These include major faith-based organizations (e.g. Catholic and Evangelical), educational associations such as the Consortium of Universities for Global Health, hospital organizations such as the International Hospital Federation, and NGOs such as Americares.

Further, there has been significant call to action within the movement of service-learning and civic engagement research to critically examine and move away from transactional, technocratic models to more collaborative and democratic partnerships (Saltmarsh et al., 2009; Clayton et al., 2010). The results of these changes are anticipated to be more ethical, transformative, and effective engagement that places community voice at the forefront.

The virtual absence of host country voices in the debate over the advantages and disadvantages of what are often called short-term medical missions (STMMs) calls for a new direction in research, one based on the principles of Community-Based Participatory Research (CBPR). This now widely accepted approach requires that the research questions and procedures be driven by members of the community of interest. This approach is not only ethically responsible, but it produces more valid results. (Wallerstein and Duran, 2010; Hardy et al., 2016). There is logically little likelihood of outside researchers obtaining totally frank responses when asking Ugandans what they think about outside health volunteers. Norms of politeness and the operation of the social desirability principle in interviewing make the risks to validity very serious.

This study addresses that problem by being designed and conducted by a Ugandan Principal Investigator (PI) focused on two key research questions:

1. *What are the specific concerns of host community members and leaders with regard to their experiences with volunteers? And*

2. *What efforts have been made by host countries to ameliorate these concerns, and what are the barriers to those efforts being more effective?*

Researchers in Uganda conducted in-depth interviews with key individuals from the major in-country stakeholders, including government entities, host organizations involved with medical missions, regional and community medical facilities, healthcare NGOs, church and service organizations. The design and conduct of the study by Ugandans most likely allowed for a franker expression of views about outsiders than can be gathered by outsiders themselves, and it assessed the capacity of the country and the various stakeholders to control the quality and purpose of STMMs.

Study Objectives

The objectives of this study were:

a. *To examine the overall health needs of Uganda which relate to medical missions*

b. *To investigate the views of all in-country stakeholders of STMMs regarding their benefits and problems*

c. *To assess the extent to which sending organizations can better collaborate and align with host organizations and in-country stakeholders to support the local healthcare system and improve overall health.*

d. *To examine the regulatory and policy environment for short-term medical missions in Uganda*

Literature and study significance

In Uganda, literature on Mission Trips is presented in an isolated, scattered manner, only accessible from websites of NGOs. There is no government owned database for these activities or any after treatment reports from patients. The lack of evidence is particularly concerning when one considers the vulnerable nature of patients living in LMICs. It is not easy to justify the visit of the medical volunteers if government cannot measure the value of their services with facts and proper statistics, neither can the government come up with guiding regulations with such scarce information.

The few studies, none carried out in Uganda, that consider host country views emphasize the need for greater respect for local staff (Arye & Nouvet, 2018; Green et al. 2009; McLellan, 2014; Lasker et al., 2018; Sullivan, 2017). Partner organizations express a desire for a far more significant role in the partnership beyond providing logistical support, and they ask that their feedback be taken seriously by volunteers and volunteer organizations (Catholic Health Association, 2015).

Loiseau et al. (2016) surveyed staff and community members in the Dominican Republic and reported a "misalignment of the desired and actual skill sets of volunteers; duplicate and uncoordinated volunteer efforts; and the perpetuation of stereotypes suggesting that international volunteers possess superior knowledge or skills". Smaldino et al. (2017) analyzed how perceived power differentials between host organizations and international visitors can make a true partnership difficult to achieve. These power differentials are reflective of much broader historical and current international inequalities and the dynamics of relationships between high and lower income countries in the field of global health (Crane, 2013; Eichbaum et al., 2020; Sullivan, 2017).

To our knowledge, practically none of this research has been carried out by scholars in the host countries, a crucial step to greatly increase the validity of the findings (Wallerstein and Duran, 2010; Hardy, 2016). And no study has examined the existing laws and regulations in place in host countries (e.g. licensing of visiting health professionals, controls over importing of medications) to analyze their effectiveness or to consider what additional regulations might be imposed by host countries to improve adherence to best practices. In fact, it is very hard to find out what those policies are, as many lower and middle income countries do not publish their policies online or make them otherwise readily available to researchers. For example, Tanzania's effort to crack down on improper volunteer behavior by specifying proper procedures were communicated to volunteers in Swahili (personal communication).

This study, one of three country projects funded by a grant from Lehigh University in Bethlehem PA, USA, aimed to address these two gaps by identifying ethical, practical, and policy issues surrounding the planning and execution of STMMs, as seen from the perspectives of various host country stakeholders. This is crucial because the potential for improvement of STMMS partly relies on successful enforcement of host country regulations. Some host countries have made efforts to control the entry of volunteers, but so far with mixed results (Kuo, 2016; Kwamboka, 2016). A similar study conducted in Ghana was recently published (Mantey et al., 2021).

The results of this project are expected to be valuable to the governments of host countries as they attempt to reduce the disadvantages of short-term missions. Another important benefit of the results will be in helping sending organizations in the Global North better prepare volunteers in ways that are consistent with the goals of in-country stakeholders.

Policies and programs recommended are more likely to be deemed credible and taken up by the community, and are thereby more sustainable, than studies and programs developed and carried out by external groups *(Mosavel et al., 2005; Minkler et al., 2006; Schatz et al., 2015).*

METHODOLODY 2

The research team

The Principal Investigator has expertise in development policy, communication and qualitative research. The Co-authors are Lehigh University Scholars from sociology and public health, who have experience studying short-term medical missions. Research assistants were selected and trained by the PI, each assistant going to a region. These Research Assistants were graduate students at Uganda Christian University. They were provided with introductory letters, interview guides, ethical forms and contacts of potential respondents. They conducted the interviews and transcribed each. These were selected for the specific tasks, and supported by three other research assistants (Statistician, Journalist and Lawyer) who have worked with PI in the past on similar research programmes. The four students for data collection were selected based on their knowledge of the areas and local languages. The research sites were selected before the choice of research assistants was made. A two-day team meeting to discuss the findings was convened in August 2019.

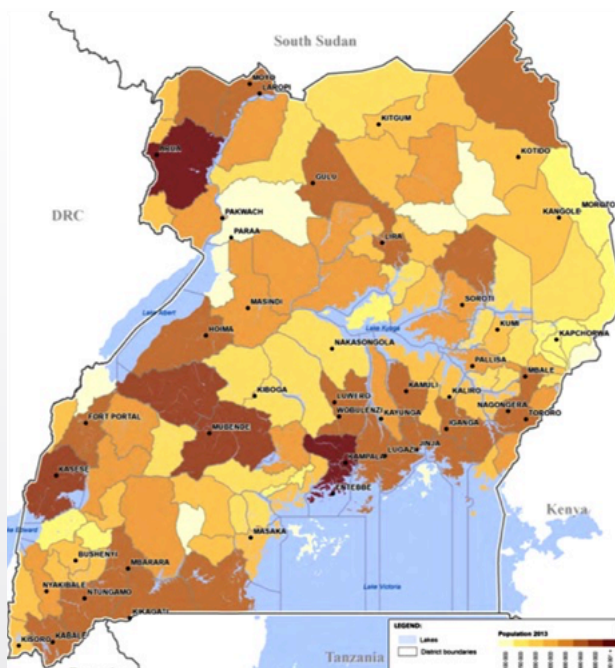
Study design

The research focused on the specific case of Uganda through interaction with districts and national level institutions. A qualitative case study design was adopted. We examined the regulatory and policy environments, actors and their interests and motivations for medical missions, and the overall socio-cultural context of medical missions in Uganda.

A qualitative approach, using multiple methods of document review of policies and laws, in-depth interviews, and a media monitoring was employed. A systematic document analysis of the legal and policy framework was conducted by a lawyer and the PI, giving meaning to some of the provisions. In addition, stories on medical missions appearing in the major dailies, New Vision and Daily Monitor were monitored for stories of interest throughout the year, 2019 although very few seen.

The research was approached from the perspective of the host communities who are actors at various levels. This implies that policy makers, other state actors and host communities were all considered important participants in the study.

Figure 1: Map of Uganda showing population density.



Population and Sample

Uganda borders to the south with Tanzania and Rwanda, to the east with Kenya, to the West with the Democratic Republic of Congo (DRC), and to the north with South Sudan. The Ugandan population as already noted stands at 37.7 million people, according to the 2017 estimates of National Bureau of Statistics (UBOS). There are four main regions, namely Central, Northern, Eastern and Western. Each region has a regional referral hospital.

The selection of participants was based on administrative units distributed through the four regions. Uganda (by the time of data collection) had 139 districts across the four regions, and the 10 districts identified were purposively selected to cover all the regions based on perceived high level of engagement with STMMs, ensuring rural based and urban geographies.

The central region was represented by Kampala and Mukono; Northern region including West Nile represented by Arua, Nebbi, Gulu and Lira; Eastern Region by Mbale and Bududa; while Western Region was represented by Mbarara and Kasese. A total of 46 respondents were interviewed by the Principal Investigator and four Research Assistants.

The study respondents formed three broad categories: 1. policy makers who are people working in the medical environment with administrative roles or in government institutions that plan for health services like Ministry of Health; 2. other health actors like Non-Governmental Organizations, academics, media (health reporters) and local organizing committees, and 3. host communities, comprising of those who have directly engage with short term medical missions in their communities or hospital setting. This wide range of actors enabled collection of diverse perspectives.

Data collection procedure

The two year grant period involved the collection and analysis of two types of data in Uganda, which is a popular destination for short-term volunteers from the Global North. The Study was conducted using desk reviews and Key Informant Interviews as detailed below:

- **Desk reviews:** Desk reviews of relevant health laws, regulatory frameworks and policy documents were conducted by a legal and policy expert and the PI. The reviews of the laws were aimed at ascertaining the legal, regulatory and institutional provisions for STMMs, the gaps there in and recommendations. The policy reviews explored the state of health services and the gaps that justify the need for STMMs. This is reported in the section on legal and policy framework. Also review of media was done.
- **Key Informant Interviews:** A total of 46 Key Informant Interviews were conducted by 5 Interviewers during the period of April to September 2019. These were purposively selected and interviews conducted face to face and recorded by research assistants who travelled to their location. There were 17 policy makers (Ministry of Health, District Health Services, Chief Administrators at Local Government, and Private Health Providers), 19 administrators and staff of host institutions (NGOS and media), and 10 host communities who were purposively chosen as participants in a medical camp. Each category was included to provide a unique perspective on the as summarized in the table below. All interviews were done in 2019.

Table 1: Category of key informants interviewed by purpose and number.

Category	Perspective	Number
Policy makers (Ministry of Health, District Health Services and Chief Administrators at Local Government, Private Health Providers).	Provided insights on policies, laws and regulatory frameworks on STMMs.	17
Non-Government Organization, local organizing committees (Coordinators of NGOs, Journalists and medical workers)	Provided perspective based on their experience of inviting, clearing, hosting, and working with volunteers.	19
Host communities (Local Council representatives at village level, participants (patients) in programs supported by STMMs)	Provided perspective based on their experience of hosting the volunteers in their communities, interactions and program participation	10

Most of the volunteers are hosted in the upcountry facilities, where there is more demand for their services. Also getting policy makers for interviews proved a big challenge despite repeated attempts.

Data processing and analysis.

Interview transcripts and field notes were entered into MS Word. A workshop by the lead researcher for interviewers and data analysis was conducted to debrief on the field work and clean up the transcripts. The emerging themes, based on the study objectives, were identified, discussed, and consensus reached on the final themes with the research team. The cleaned transcripts were imported to NVIVO for further review, coding (based on agreed themes) and analysis. Analysis was conducted using text search queries and visualization functions of NVIVO, then transported into tables. Coding was done on different nodes based on a predetermined report structure. The study findings can be divided into three main aspects, the perspectives of Ugandan interviewees, how to enhance STMMs and the legal, policy and institutional framework.

Analysis and dissemination plans

A political economy analysis examines the interactions between the political and economic forces in any given context, and how these interactions affect decision-making and resource allocation (Acosta & Pettit, 2013; Duncan & Williams, 2012). Given that medical missions remain very complex and involve different actors and different settings, a political economy analytical approach was useful to establish potential issues that can enhance or inhibit medical mission activities in the future.

The dissemination of the research report includes the publications, conference presentations, workshops and invited talks based on findings from the project. The findings will inform policies in host countries as well as in sponsoring countries and international agencies, in a way that current research has not been able to accomplish.

Ethical considerations

Ethical clearance was obtained from Makerere University School of Social Sciences Research Ethics Committee (MAKSS REC) and registered at the Uganda National Council for Science and Technology (UNCST). Administrative clearance and permission to conduct interviews was sought from relevant organizations where we seek to study. Another study clearance was also obtained from the IRB at Lehigh University in United States of America.

The study team in Uganda has relevant training in human subjects' protection for research, and all research assistants were trained. There was minimal risk to the participants. All study procedures followed the recommended, conventional guidelines to ensure the welfare and protection of human subjects including seeking informed consent, ensuring confidentiality, privacy and voluntariness. Participants provided signed written consent to the study and did not object to use of their names.

3 OVERVIEW OF THE HEALTH SECTOR: THE GAINS AND GAPS

One of the specific objectives of study was to examine the overall needs of Uganda which relate to medical missions. This section provides an overview of the health sector in Uganda for context and highlights the gains and gaps.

Uganda has a growing population that is increasingly youthful. The population that in 2006 was 27.2 million people stood at 37.7 million people in 2017, with females more than males as figure one below presents.

Table 2: Population size (Millions) by gender and year

Gender	2005/2006	2009/2010	2012/2013	2016/2017
Male	13.2	15.0	16.5	18.2
Female	14	15.7	17.6	19.5
Total	**27.2**	**30.7**	**34.1**	**37.7**

Source: Compiled from UNHS, UBOS 2017[1]

Over 75 per cent of the population is located in rural areas, where access to services such as health and education remain a huge challenge as figure three below presents.

Table 3: Population distribution by residence (Percentage)

Residence	2005/2006	2009/2010	2012/2013	2016/2017
Rural	84.6	85	76.5	75.5
Urban	15.4	15	23.5	24.5
Total	100	100	100	100

Source: Compiled from UNHS, UBOS 2017

The steady increase in the proportion of the urban population is attributed to the creation of new urban centers, and rural-urban migration. The other key characteristics are poverty and unemployment, which are critical challenges for development in Uganda. According to the Uganda National Health Survey (UNHS) 2017 report, the youth (18-30 years) constituted 21% of the population; an equivalent to 7.9 million. In terms of gender distribution of this youth population, 44.2% and 55.8% are male and female respectively. This rapid population growth has implications for health service delivery.

Gains in health service delivery over the years

Whereas many of the health indicators remain at low levels of achievement, there are some gains that have been made in the last few years through investments by the government of Uganda or public private partnerships. These include in the areas of child mortality, maternal mortality, HIV/AIDs prevention and general improvement in the life expectancy of Ugandans.

Child mortality: The general trends in childhood mortality show an improvement over the years. For instance, according to the Uganda Demographic Health Survey (UDHS, 2016), infant mortality reduced by more than half from 98 deaths per 1000 children in 1989 to 43 deaths per 1000 children in 2016. Similarly, under -5 mortality[2] reduced over the same from 177 to 64 deaths per 1000 children respectively.

1. All population figures are forecast based on population census reports by Uganda National Bureau of Statistics.

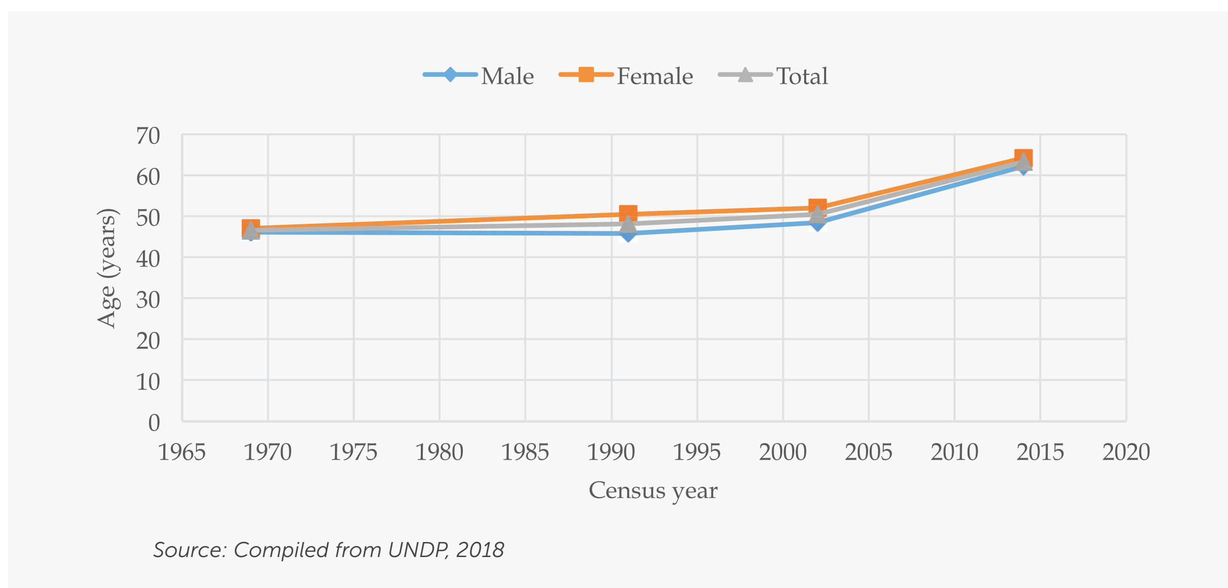
2. Under-5 mortality is defined as the probability of dying between birth and the fifth birthday

Maternal mortality rate: Uganda has continued to reduce pregnancy-related death over the years. The maternal mortality ratio declined from 524 deaths per 100,000 live births (UDHS, 2000/01) to 368 deaths per 100,000 live births (UDHS, 2016). According to the UDHS 2011 report, the major causes of maternal mortality include hemorrhage (42 percent), obstructed or prolonged labour (22 percent) and complications from abortion (11 percent), compounded with high adolescent pregnancy rate at 24 percent. By contrast, it's worth noting that the situation is likely to be worse for the rural, less educated and poor women who are the large part of the population in the country.

HIV / AIDS: The burden of the HIV/AIDS epidemic remains unacceptably high in Uganda but declining. According to the UNAIDS, there are 1.4 million people who were living with the HIV/AIDS in 2020. (UNAIDS 2020). The adult HIV prevalence (ages 15-49) was at 5.9%, with women disproportionately affected at 8.8% of adult women living with HIV compared to 4.3% of men (United Nations Program on HIV/AIDS, 2018). The report further estimated annual new HIV infections at 50,000 people and AIDS-related deaths of 26,000 people. Nonetheless, there have been marked improvements.

Life expectancy: The life expectancy of Ugandans has been on a steady progress since the first census in 1969. Specifically, the report indicates that life expectancy at birth in 2017 stands at 60.2 Years, up from 45.5 in 1990. This can be attributed to many compounding factors but the recent improvements in the childhood mortality rates play a critical role (UNDP 2018). Figure two below shows that increase:

Figure 2: Life expectancy in years (1969 -2014)



Source: Compiled from UNDP, 2018

Additionally, expected years of schooling increased from 5.7 to 11.6 and the Gross National Income (GNI) per capita from US$755 to US$1,658 between 1990 and 2017 respectively. Improvements in the health sector have implications for volunteer missions when they translate to needs that should be filled and beyond the government to fulfil.

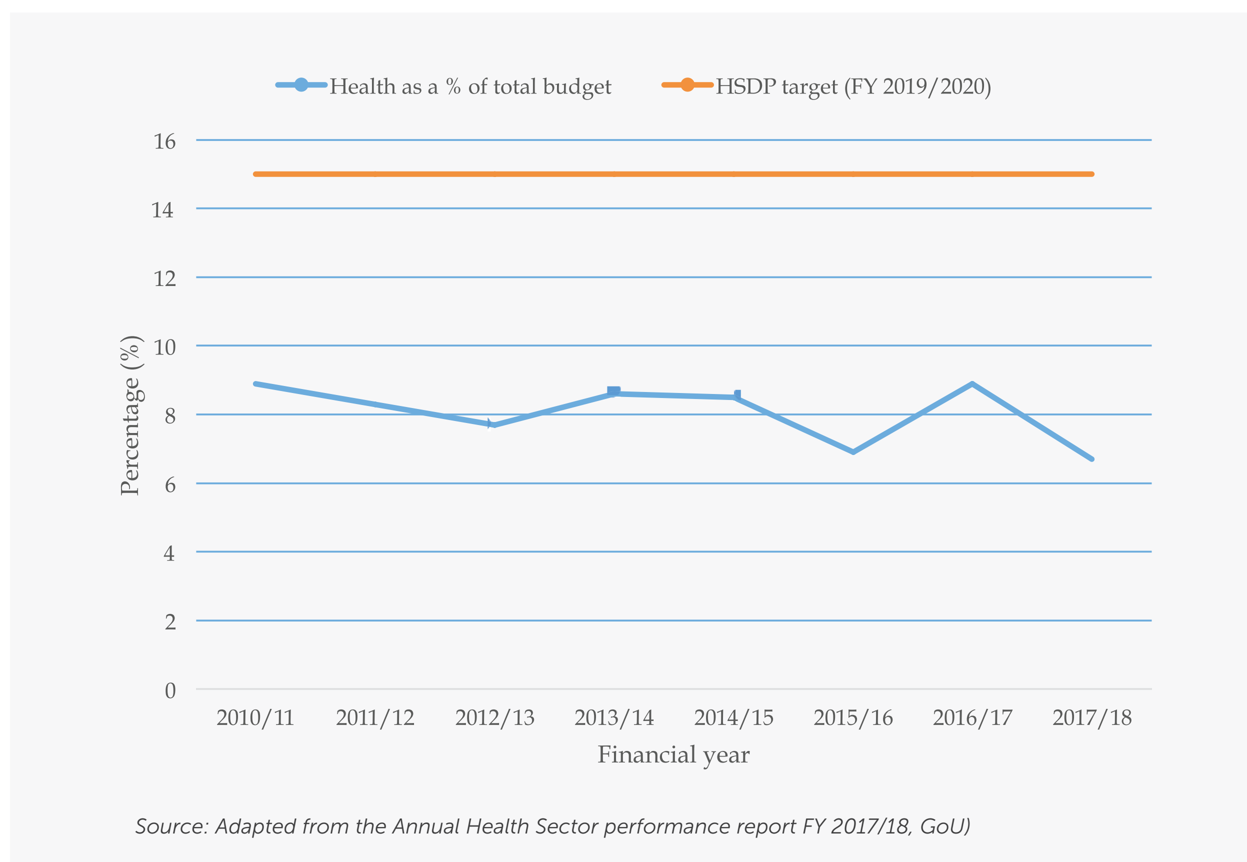
Despite these improvements, iIn terms of human development, Uganda is ranked at 162 out of 189 with a Human Development Index (HDI) of 0.516 – putting it in the low human development category (UNDP, 2018).

Gaps in the health sector

Having identified the gains, there are three major gaps in the health sector, namely: financing health, human resource-staffing and health infrastructure.

Health financing gaps: For the last eight financial years (2010/11 – 2017/2018), Uganda had been allocating an average of only eight percent of the total budget to the health sector. As shown in figure five below, this is about half the recommended amount according to the Abuja declaration and the country's Health Sector Development Plan (HSDP) target of 15 percent. Additionally, the health sector budget is heavily reliant on donors. For instance, between FY 2010/11 and FY 2014/15, the proportion of donor resources contributing to the total health sector budget increased from 14% to 42% (MoH, 2018). This situation makes the country vulnerable and unable to attain her key priorities.

Figure 3: Health sector budget as a proportion of total budget (Actual Vs HSDP target)



Source: Adapted from the Annual Health Sector performance report FY 2017/18, GoU)

This gap in health sector financing is a huge problem because most Ugandans live in poverty. The 2016/2016 UNHS estimated that 21.4 percent of Ugandans were poor, corresponding to nearly eight million people. The incidence[3] of poverty remains higher in rural areas (7.1million) than in urban areas (0.9 million). The Eastern region is the poorest, with 3.6 million people living in poverty, followed by Northern Uganda (2.3 million), Western (1.1million) and Central Uganda at 0.9 million people in poverty. (Uganda Bureau of Statistics (UBOS), 2018). In the absence of comprehensive universal health coverage, this presents a critical need.

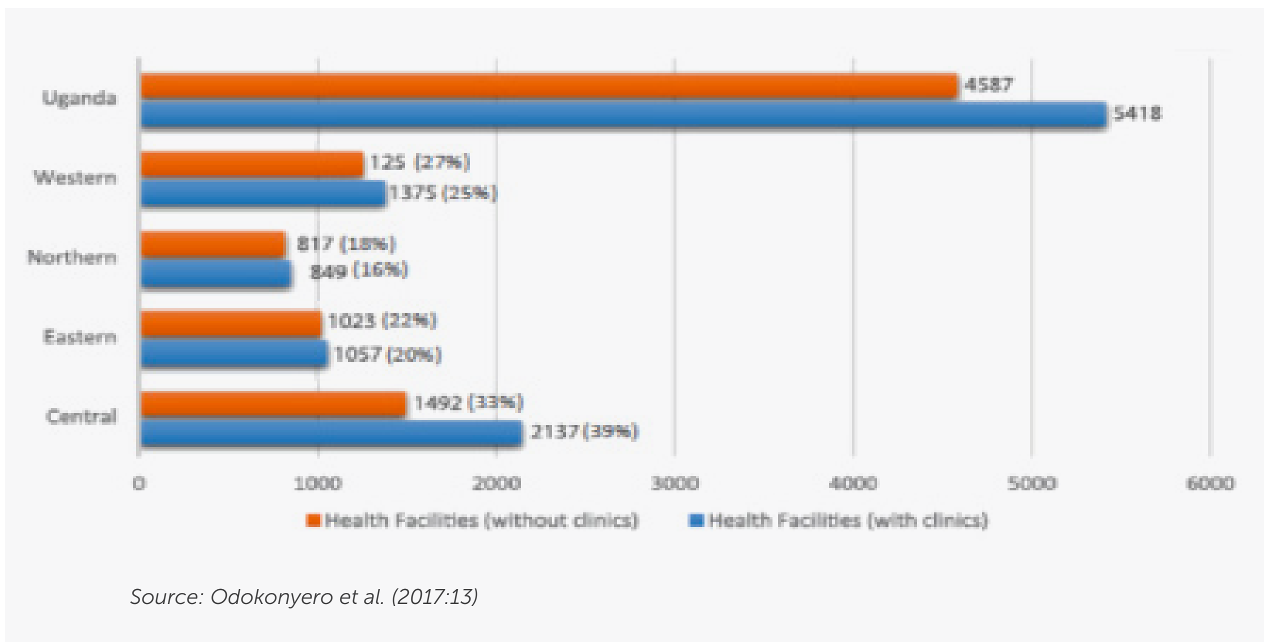
However, with the current concerns over the coronavirus pandemic, financing for health is set to improve, including human resources. The coronavirus exposed the poor state of health infrastructure and the need to prevent the spread of coronavirus depended on improving health service delivery. It should be noted that the increment was largely directed to efforts to fight the Covid-19 pandemic, which leaves the actual funding gap as a matter of grave concern since the outbreak of the coronavirus disease. More importantly, government was forced to reconsider its priorities as well as ask for more donations.

Health infrastructure gaps: Healthcare infrastructure is a central facet of the health system and a requisite for health service delivery as well as an ultimate driver of progress towards universal coverage and access

3. Poverty was computed based on three poverty indicators; head count, poverty gap and squared poverty gap.

(Odokonyero, Mwesigye, Adong, Mbowa, 2017). According to Odokonyero et al. (2017), Uganda had a total of 5,418 health facilities in 2015. The majority of the facilities were in Central Uganda (39%), followed by Western (25%), Eastern (20%) and lastly Northern Uganda (16%). There is marginal private sector investment in health facilities in the North and Eastern regions as Private for Profits (PFP), account for only 3.2% and 3.7% of all health facilities in the regions respectively. Those facilities with clinics means they offer HIV-related services while those without do not offer them. These inequalities match the regional incidences of poverty distribution.

Figure 4: Distribution of health facilities across regions with HIV clinics



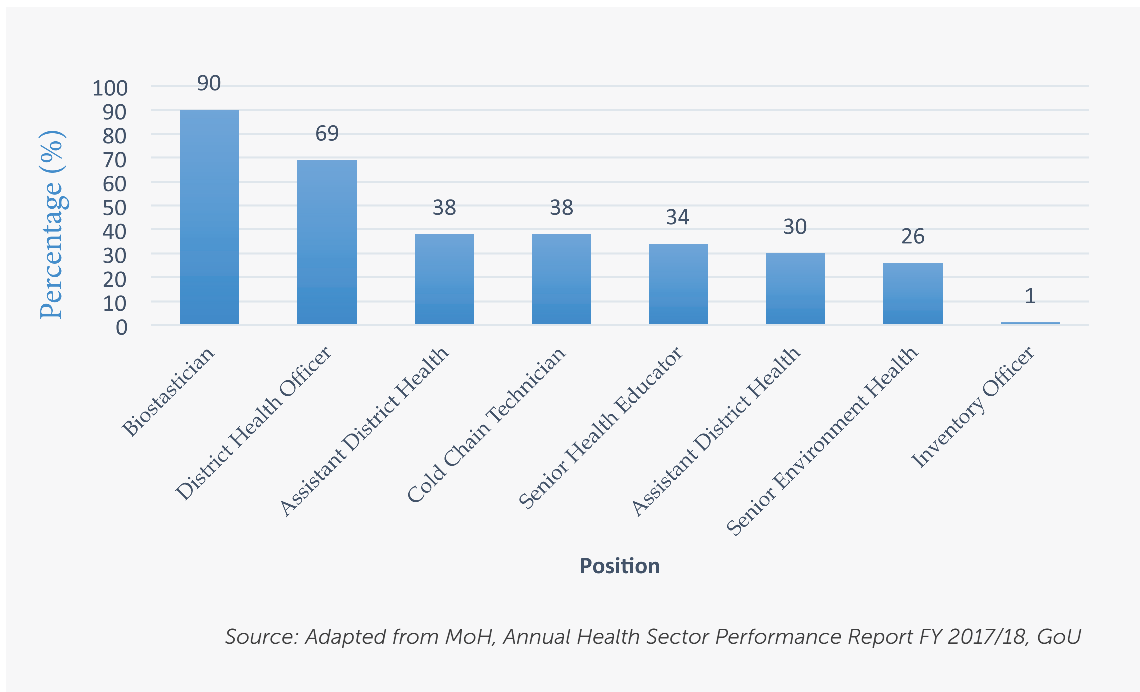
Source: Odokonyero et al. (2017:13)

In terms of access, the UNHS 2017 report shows that 86 percent of the total population live within a 5 km radius from a health facility; an increase from 83 percent in 2012/13. Whereas the percent of people who live within the 5km radius is high, the fraction of individuals[4] who access health care within a distance of 5km is generally low across the country (Odokonyero et al. 2017). Moreover, they argue that living near a facility does not necessarily guarantee access to needed medical care or treatment for reasons like lack or inadequacy in equipment, unavailability /or stock out of drugs and unavailability of health workers. More investments are needed to put in rehabilitating old infrastructure and building and equipping new facilities if the sector's aspiration of Universal Health Coverage for a healthy and productive population in Uganda should be attained. The implication of this gap is that it presents a fertile ground for the invitation of short term medical missions to Uganda.

Health staffing gaps: In Uganda, the health worker-population ratio was 0.4 in 2017 (MoH, 2018). By March 2018, the MoH reported that the staffing level at health facilities was at 74% up from 69% in 2014. This is still below the Health Sector Development Plan (HSDP) target of 80% by 2019/2020. Critical to note is that many central MoH institutions have over 98% of the approved leadership positions substantively filled as compared to only 45% of the District Health Teams (DHTs) that have substantive appointments (MoH, 2018). The irony is that much of health service delivery is at the districts. This is shown below:

4. *Defined by Odokonyero et al.2017 as individuals who fall sick and seek the required medical care.*

Figure 5: Positions in the District Health Teams that are filled (June 2018)



Source: Adapted from MoH, Annual Health Sector Performance Report FY 2017/18, GoU

Moreover, not only does the country face shortage in the number of health workers but also high rates of attrition and absenteeism among the personnel, especially at the lower health units. For instance, the 2017/18 sector performance report recognizes that competitive employment opportunities, low capacity to plan for the human resource requirements especially in the new districts, inadequate supervision at all levels, high cost of medical education, low supply of some critical cadres, low salaries and incentives make it unattractive to work in remote regions of the country with poor/inadequate infrastructure. Many doctors use the hard to reach areas as stepping stones to go for training abroad. Many of these do not return to their work stations.

Some of the gains and gaps identified and discussed above are critical drivers of the demand for STMMs in Uganda. It also has bearing on host country perspectives regarding STMMs. This section, which focused on evaluation of various reports and documents, will further be reinforced next by what participants consider concerns and contributions of short term medical missions. The background information is drawn from general health reports and literature on the health sector.

4 THE NEED FOR SHORT TERM MEDICAL MISSIONS IN UGANDA

Drivers of the need for STMMs in the health sector

This section looks at the problems in the health sector according to respondents. In addition to the gaps identified in the overview section from relevant documents, general gaps were identified by the respondents that drive the demand for short term medical missions and define the appreciation for it. Respondents were asked to name what they perceived as the major gaps that STMMs often fill. As summarized in Table 4 below, human resources[5] was the most cited gap), followed by equipment, medicine, weak primary health care that make prevention of diseases weak. Funding, administrative supplies and means of transport were also cited by some few respondents.

Table 4: Gaps in the health Sector

Gaps in the health sector	Count	Percentage of responses	Percentage of respondents (N=46)
Human resources	22	22%	48%
Equipment	19	19%	41%
Medicine	18	18%	39%
Weak primary health care	15	15%	33%
Infrastructure	11	11%	24%
Funding	7	7%	15%
Administrative supplies	5	5%	11%
Transport	4	4%	9%
Total responses	101	100%	

Source: Survey data.

A member of one local organizing committee[6] , also a Doctor in a private hospital answered the question on the urgent health needs, captured well the range of needs from equipment, medicine administrative supply to funding:

> ***Majorly in education, continuous professional development. Secondly, support like the donation of reagents. You know as a private not-for-profit hospital sometimes the funding is not enough. Most of these Church-funded organizations are like that, may be apart from those in the city. Ideally we are supposed to charge people small fee and give them quality services. You know there is discrepancy in quality when money for maintaining standards is not there, money for drugs is not there, that is the discrepancy the volunteers meet. Before Kuluva was being run by the Bazungu (Whites) and would get drugs, equipment from their countries (P[7] 3, Interview).***

Similarly, another respondent, added that the weak medical care system that cannot meet the needs of the community is another driving factor creating a need for volunteers.

5. Human resource gaps in health is mostly medical staff but also includes administrative and non-medical staff who may also be in short supply

6. NGOs form committees to organize medical camps, although not all STMMs are organized this way

7. P represents first category of respondents who are policy makers while N represents the second category of Non-governmental organizations. HC represents host community member.

...maternal and child health is one of the health needs in this community. Also Malaria and HIV are also among health needs in this community. (P2, Interview).

These health needs may not all be addressed by STMMs because each medical mission tends to be specific, addressing particular health challenges.

Human resources was the most frequently cited gap. The respondents (48 %) mention gaps in the number of specialized medical workers at the community, lower local facilities and the regional and national specialized hospitals. For instance, the respondent P2 cites a case of gap at the community level:

For us in the rural area when they come it is basically the lack of human resource in health in a place like this basically because Kagando may not have enough funds to pay (P2, Interview).

Similarly," Another respondent iterated that

There are so many sicknesses in Uganda but when you look at the patient and doctor ratio, it is very low. So they come to try to bridge the staff gap in the health sector (N3, Interview)

...our maternal mortality rate is still very high and we need more experts to help address the problem. There is also need to have volunteer health workers in health facilities to cover the staffing gap like in health center IV's that lack specialists (P11, Interview).

The human resources gap also exists at the training institutions. For instance, one respondent noted that:

We also lack manpower. We still have very few trained tutors compared to the number of students that we are teaching (N1, Interview).

Others are lack of funding, inadequate medical supplies and transport in rural areas. Many of these gaps in the health sector account for some of the need for volunteer missions. They support our understanding of the contributions that STMMs make from the perspective of respondents.

Activities of the STMMs

In light of the gaps in the sector, the respondents were also asked to mention the activities that are being undertaken by the STMMs. This is summarized in table 5 below.

Table 5: Activities undertaken by volunteers

Activities undertaken by the STMMs	Count	Percentage of responses	Percentage of respondents (N=46)
Treatment and care	31	37%	67%
Training	20	24%	43%
Resource mobilization	19	23%	41%
Sensitization	9	11%	20%
Preparation prior to coming	4	5%	9%
Total responses	83	100%	

Source: Survey data

Treatment and care followed by training and resource mobilization and sensitization were mentioned. Resource mobilization has to do with finding the money and human resources to work with while sensitization involves creating awareness in the community about specific activities like health risks or pending medical camps. These activities were emphasized by some respondents as;

> ***So when they come they are offering free care which is not paid for and in that way they are helping to reduce on the burden in the human resource (P2, Interview).***
>
> ***Provision of medicines and drugs, availability of equipment, the expertise of volunteers and free health services (HC13, Interview).***

Interestingly, the activities they do as part of preparations prior to coming were mentioned by some few respondents. This includes working with local contacts to make various arrangements and application for travel permits among others.

Expectedly, the gaps in the health sector, the activities being undertaken by the STTMS and the existing knowledge in the state of the health service delivery in Uganda seem linked.

5 HOST COUNTRY PERSPECTIVES ON STMMS PRACTICES

The perspectives of host communities on STMMs in this section is presented in the form of their characteristics, contributions, challenges and concerns. Characteristics relate to their duration of stay and country of origin, contributions are what the volunteers and host communities bring to the table, challenges are those faced by the volunteers in Uganda from the perspective of respondents, while concerns are those specific issues that the host communities find troubling about the nature of STMMs and wish to be addressed in order to enhance the value of STMMs.

Characteristics of STMMs (Duration and place of origin)

Out of the 34 total responses from the stakeholders[8] asked about the duration of stay, the majority of the participants indicate that volunteers come for a period of less than one month, followed by 3-6 monthsand then 2-3 months. Whereas the respondents also treated 3-6 months as short medical missions, the study focused on a duration of only up to three months, leaving out the data outside this period.

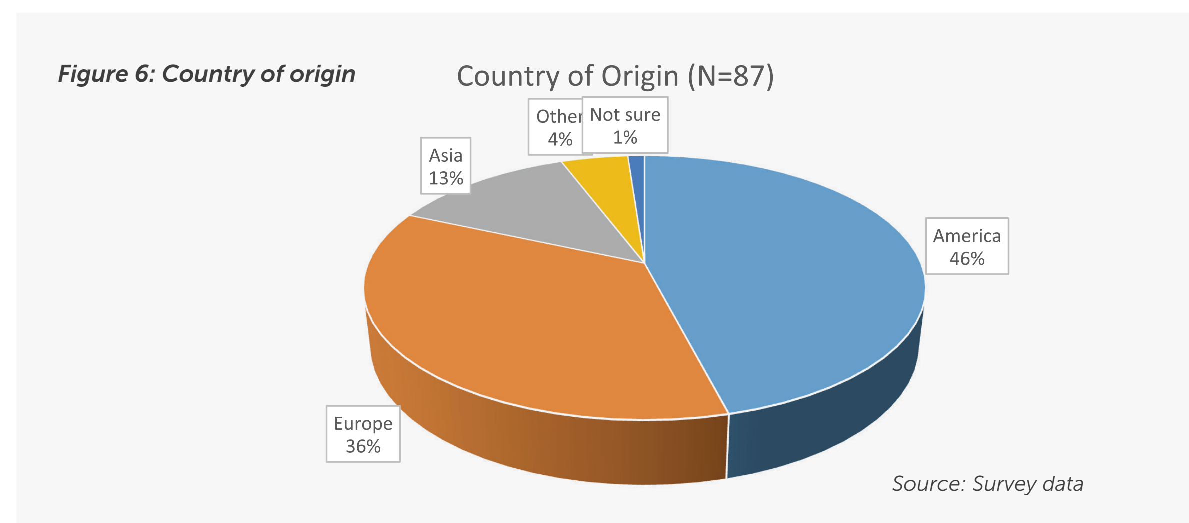
Table 6: Duration of Stay

Duration of the stay	Count	Percentage of responses	Percentage of respondents (N=36)
Less than a month	19	56%	53%
3 to 6 months	10	29%	28%
Between 2 to 3 months	5	15%	14%
Total responses	34	100%	94%

Source: Survey data

As shown in figure 8 below, out of the 87 mentions of countries as origins for the STMMS, the United States of Americawas the highest, followed by Europe, Asia and remaining was others / not sure. The country of origin had to do with participating NGOs and who their partners are. It was clear that there are established relations with some of the partners that are consistent, say with annual visits.

Figure 6: Country of origin



Source: Survey data

8. *This question was asked to the policy makers and NGOs only*

Contributions of STMMs to and by the host communities

The level of contribution was twofold, seen from the perspective of what the host communities bring to the table and what volunteers bring. Contrary to popular belief that STMMs are one way benefits for host communities, the majority of respondents pointed to bidirectional benefit. It was revealed that the host communities are instrumental in helping STMMs to perform their duties and also those who come teach the personnel some things. One experience demonstrates this two levels of contribution:

> ***My experience is that they are often very helpful and of course being in a very rural place like this where we have very few health workers. They offer a helping hand and help us with our work load. So usually when they come in for those who are qualified what we want to do is try and get them used to the conditions that we have as fast as we can because they may not see most of the things in their countries. For the new conditions, we try to teach them as much as we can how to manage them in our setting. So basically they form a team, they join the team that they found on ground. (P2, Interview).***

What the above contribution suggests is that it is not just the host communities that benefit from STMMs but also those who come to provide services. The discussion of these contributions are therefore segmented as contributions by the host communities towards STMMs and contribution of STMMs to host communities. This shows the two-way nature of contributions.

Contributions by the host communities towards STMMS

The host communities made significant contributions in the form of pre-visit support, sharing of experiences, supporting welfare of volunteers and security as shown below.

Table 7: The contribution of Host Communities to the STMMs

Contribution of host country	Count	Percentage of responses	Percentage of respondents (N=46)
Pre visit support	24	59%	52%
Experience	13	32%	28%
Welfare	3	7%	7%
Security	1	2%	2%
Total responses	41	100%	89%

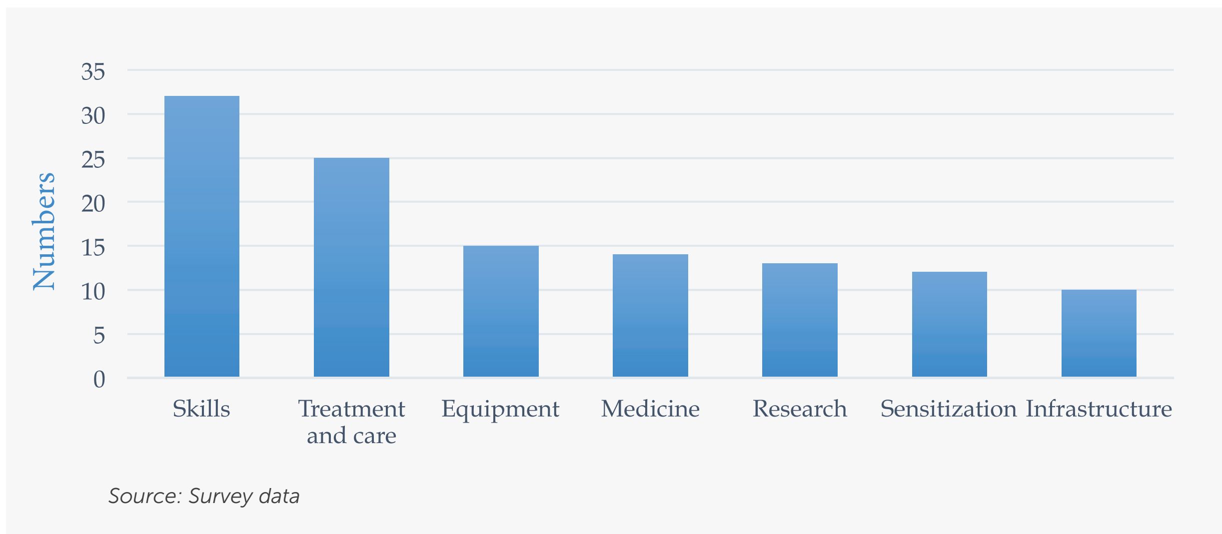
Source: Survey data

The pre-visit support involves getting the necessary clearance per the law, arranging for pick up at the airport, accommodation and all forms of clearance, as well as informing them of what needs to be done and avoided.

Contributions of STMMs to host communities

The contribution to the host communities is seen as what volunteers bring or the value they add. These include treatment and care, skills that those from the local communities get from volunteers, equipment, medicines, and research opportunities when they collaborate with host community experts, sensitization and contributing to infrastructure development when they fundraise. These are captured as follows:

Figure 7: Contributions of volunteers (N=121)



Source: Survey data

The respondents stated a total of 121 comments of contribution by the STMMs to the host communities that include skills, treatment and care, equipment, donation of medicine, research -through funding and actual research, creation of awareness within communities on specific diseases and sometimes also development of infrastructure such as building of health facilities. The respondents narrated on skill and sensitization of community need respectively below:

> ***They contribute to the different expertise with which they come; for example, if you have somebody experienced in radiology or anesthesia so they are bringing to you that expertise and they are able to train your local people into gaining more skill in that (P2, Interview).***

> ***Yes, we have HOSPICE Africa- UK, HOSPICE Africa-USA, and HOSPICE Africa-France. They come together and when the go back, they tell people how we need money and they send it to us (N9, Interview).***

Going to the hard to reach communities is an important contribution to host communities. The host communities believe that they too contribute immensely to the growth and development, and knowledge creation for those who visit them. Indirectly, these contributions create more opportunities. For instance:

> ***It is another way of creating new and better relationships with these countries where they come from. It will also create sharing of professional experience and ideas, not only that but also exchange of health programmes. It opens doors for our health workers to study in those countries and later on volunteer too (HC13, Interview.***

At the same time, they are not shy to admit that given the dire need of the health system in Uganda, these volunteers have also contributed towards research. A case in point is the experience in Kasese district as narrated by a respondent:

The experience with them, we have been able to have short research studies which end up opening our minds. You realize that some things have been happening in the community without your knowledge and when they come you end up identifying a problem and you set intervention according to the findings. A case in point is the gut perforation in Kagando, we were able to conduct a study and able to know the cause. P3, Interview).

Research and knowledge sharing are thus important areas of contribution to host communities. This was corroborated by other experiences. For instance, one medical doctor shared similar experiences which relate to contribution to the skills gap as such:

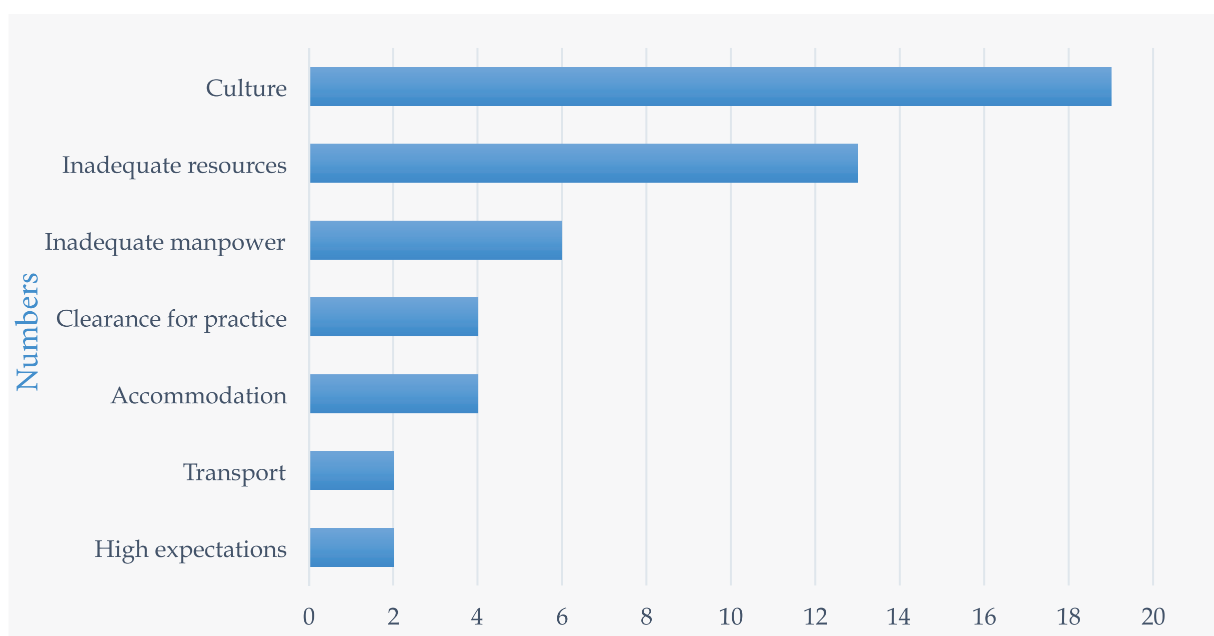
Because when these people are there, they help to build the capacity of our staff first of all and also fill the staff gap. You know when they are there, they help us at the facility to handle many patients and they go back when they are happy. This also reduces the work load of staff at the facility. (N19, Interview).

These contributions vary from community to community depending on the scale of volunteer mission. What is clearly the case, is that there are some positive contributions from STMMs to host communities as some of the experiences show. There are also benefits to the visitors.

Challenges of volunteers on STMMs to Uganda

Despite the acknowledgement that STMMs contribute significantly to improving health service delivery, they also face some specific challenges that require reform from the perspective of the hosts in order to enhance the value of STMMs. These included volunteers dealing with a foreign culture, having inadequate resources to work with when they have been trained in systems that have everything to work with, inadequate staffing to support their work, high expectations from the host communities, challenges with accommodation, transport to and from facilities as some of these are in remote places, and difficulties in clearing for practice. Figure 8 below shows the frequency of the challenges as cited by the respondents.

Figure 8: Challenges faced by Volunteers (N=50)



Source: Survey data

As far as culture is concerned, some cases of cultural shock and community belief system and practices around some illnesses become disturbing for volunteers. Besides the shock, there is also the challenge of language in some communities since most volunteers cannot speak local languages, yet the people in rural communities they work on may not speak English. Some volunteers also struggle dealing with many deaths. This was narrated by one medical doctor:

> ***Some of them have had very many challenges with dealing with death from the initial time when they come. It takes time for them to get used to losing people and moving on with losing someone for they don't commonly see it that side. (P2, Interview).***

Also key is the issue of inadequate resources. Volunteers arrive and find that they have to work with very little resources that they are not used to. They are urged to come with what is not available, and even then, they find that local health practitioners may be used to working with little or no personal protective gear

> ***..They come with the perception that they will find everything up to date, yes. Sometimes they find we are doing certain procedures in rudimentary way and they are shocked. And, many are not in position to handle many patients so sometimes, because they stand for long, some of them faint (N 13, Interview).***

In some cases, volunteers face very high expectations, including meeting community needs outside of their medical duty. For instance:

> ***Given the fact that we are looking forward constructing a hospital in Kasese, so we may need volunteers coming to offer medical support given that it will be addressing a larger population. It is of interest to have medical volunteers coming in to reduce on spending of human resource. (N20, Interview).***
>
> ***The only problem with our clients, sometimes because of the nature of where we are, our patients expect a little more than just health care because sometime they expect monetary benefits from them which they are not able to offer but on the whole when it comes to the basic care of the people, they are very good (P2, Interview).***

While the community is planning to build a hospital in the above case, they are hoping that spending on human resources will be reduced by engaging volunteers. More so, there is mention of hope for volunteers to stay much longer than three to six months, to over a year or contribute to infrastructure projects.

Concerns of the community with STMMs

The findings revealed great concern around the relationship between the host communities and the volunteers. As detailed in table 7 below, there was a total of 47 mentions of concerns, ranging from lack of experience as the biggest (21 percent), other interests (19 percent), misalignment with community needs (17 percent). Code of conduct and security risks each had 15 percent and 13% of comments referred to the unsustainable nature of their work. It is noted that the concerns were also far fewer than the contributions which had 121 mentions in total in comparison to 47 of concerns. This is significant in what perspectives of host communities are about the STMMs.

Table 8: Concerns of host communities about STMMs

Concerns of host communities	Count	Percentage of responses	Percentage of respondents (N=46)
Lack of experience and respect	10	21%	22%
Other interests	9	19%	20%
Misalignment with community needs	8	17%	17%
Code of conduct	7	15%	15%
Security risk	7	15%	15%
Sustainability	6	13%	13%
Total responses	47	100%	102%

Source: Survey data

Most frequently mentioned is the issue of lack of experience, where volunteers who come sometimes are far less experienced than the host community doctors or may not have any adequate knowledge of tropical diseases. Some doctors felt that although they are experts in their own right, sometimes they are looked down on when working with volunteer experts in highly specialized fields. These volunteer experts often lack experience in tropical diseases. This is a concern for them.

Volunteers, it was argued, carried several other interests. Sometimes they were researchers pretending to volunteer, or promoting medical equipment and drugs, or tourists who spend most of the time travelling to different tourist sites, while others may simply have another hidden agenda that remains unknown to the hosts. Although tourism may be part of the visitors' plan, it is not explicit to communities. There was therefore an issue of trust by the communities. This was well captured as a concern:

> ***Volunteering per say, as much as they say it is voluntary, but it is a cost to somebody and sometimes if somebody comes to volunteer in your home, you need to be very careful because this person could be stealing information, could have come as a spy. All those are associated risks but as institutions we usually factor into the positive side, what has somebody done, what they are doing, whatever the person does or what could be behind, that one becomes a hidden agenda (P6, Interview).***

There is a misalignment with the communities where volunteers do not really understand the local context and yet have to supervise those that they may find on the ground. This was elaborated by a policy maker:

> ***We have seen people who come, I must be honest and not only in the health fields but we have in other fields. Somebody is actually below you in terms of their academics, in terms of their skills and the person comes and is structurally put above you. (P1, Interview)***

This practice, based on the assumption that because someone is coming from a high income country, they ought to be above those from the host communities, breeds unfairness and unequal power relations. The communities also fail to understand the volunteers, expecting them to conform to their community values and traditions.

> ***In most cases the locals look at the foreigners as superior and there's that bias but along the way as they interact, they begin blending. But I want to emphasize that personality matters. When the volunteer is outward, open, you find the blending becomes very fast and easy. But some of them can be so strict, you find they limit their level of exposure, decision of knowledge and understanding of the local people. (P3, Interview)***

Other concerns are that occasionally, they become a security risk when people assume that foreign nationals come with a lot of money. Their lifestyle, going to clubs and entertainment places without caring about their security, becomes a big concern for the communities, who worry about their safety.

There are behaviors which host communities say appear scandalous sometimes, especially dressing. In many of the rural areas, the society is conservative and people do not understand the dress code of female volunteers, who may wear revealing clothes. Issues of code of conduct are largely due to difference in value systems.

Finally, the question of sustainability is also of concern. While donation of equipment is seen as a good thing, but sometimes seen as draining the health facilities, as one doctor explained:

> ***I don't know if it's a policy but if those people come in good faith and bring for us say equipment, you may find that this equipment becomes a burden to the health facility because it has consumable parts and the parts are not easily available here, they are quite costly. Sometimes they send things from their country and this ends up being a dumping ground for technology. (P1, Interview).***

In addition to the problems of sustainability, there are issues around sustained treatment.

> ***When they go back, our community members who will be referred for further treatment expect to get the same kind of treatment but end up being disappointed and failing to get the treatment as expected (HC8, Interview)***

Many volunteers come for less than one month and conduct serious surgeries. There were cases of deaths reported in the media which, when investigated, turned out were due to mismanagement of post operation, and the specialists had already left. The specific case of American doctors who operated on patients in Mengo Hospital, which resulted in deaths in 2017, is a good example (observer.ug/news/headlines/56376-mengo-surgery-deaths-put-us-doctors-in-spotlight).

The issues raised in this section, covering the characteristic of STMMS, contributions of the missions and host communities, challenges faced by volunteers and concerns raised by these communities lead us to the discussion on how to enhance the value of STMMs. It is clear from the study that there is value added through STMMs, but also that these could be enhanced to ensure the host communities own and gain from this process. The following section therefore discusses the ways through which the value of STMMs can be enhanced in Uganda.

6 ENHANCING THE VALUE OF STMMS IN UGANDA

In order to enhance the value of STMMs in Uganda, four specific things are needed, based on current findings. The question was, 'what do you think would help enhance the best use of volunteers for improving health in Uganda?' A thematic analysis of this question led to four categories of issues that cover setting up the legal and policy Conditions to ensure quality, improving Communication between actors, effective Collaboration framework, and Capacity building for host communities.

The first is that there is a need to set conditions specifically for STMMs by way of setting up appropriate legal, policy, regulatory, institutional and ethical code of conduct. These should form an effective guideline for the country that then is popularized and adopted by all actors. The second is to communicate these guidelines and also develop key communication practices around STMM practice. Third, adequate promotion of genuine collaboration between host countries and sending countries in the spirit of true partnership that is a win-win for actors. Lastly, a formal capacity building process, highlighting some of the contributions on both sides, should be encouraged.

CONDITIONS: Legal, policy, regulations, institutions and code of conduct

There is need to set up some conditions, it was revealed. Some respondents saw the enhancement of STMMS value as an issue of legal and policy regime. They proposed that there should be specific legislation on STMMs, effective licensing and accreditation, code of conduct and improved awareness on laws and policies that the study found to be low.

Table 9: Summary of issues under conditions

Enhancing STMMS - Conditions	Count	Percentage of responses	Percentage of respondents (N=36)
Legislation on STMMs	10	36%	28%
Licensing and accreditation	9	32%	25%
Code of conduct	3	11%	8%
Awareness on laws and policies	2	7%	6%
Total responses	28	100%	

Source: Survey data

The analysis of the legal and policy instruments revealed that Uganda has a piecemeal approach to licensing and accreditation of STMMs, leaving several institutions such as the National Drug Authority, the Medical and Dental Practitioners' Council, the Ministry of Health itself, among others, to clear different aspects of volunteer activities. The systems are in place for these groups to follow as the following experience suggests:

> ***For us in the medical field, we've always encouraged them to must have been registered with the Uganda Medical and Dental Practitioners' Council and that they can do online while still that side so they usually apply to the council and then present their papers, vetted and then allowed to come and practice. Some of them have needed to get a work permit from I think the ministry of internal affairs. (P2, Interview).***

While these forms can be accessed online before volunteers visit, some do the clearance on arrival. The challenge is that this takes time. Suggestions were made as conditions for practice, falling within the areas of legal, policy and regulatory framework as well as institutional reforms and code of conduct. For instance, it was suggested:

I think one of the key things is proper vetting such that it is clear what the terms and conditions of a volunteer are, such that one is able to know whether it really benefits institution or not and then that helps in proper allocation/ positioning of the volunteer and where they could best be needed. It would be good when they have people choose their working areas, they should be able to pick on what exactly the skills and knowledge they are trying to impart or otherwise technically being able to adapt and transmit those skills and knowledge for local consumption. (P6, Interview).

Mostly, there is suggestion that any reforms in regulation should allow for a quick process and a one stop center. It may be beneficial if volunteer missions had standard practices in law and policy that are easy to enforce. In order to enhance the value of STMMs as already identified and address the challenges they face or present to host communities, there must be certain conditions codified in law, policy, regulations, institutional practice and ethical code of conduct. While it is acknowledged that several of these conditions already exist in various frameworks, they are too many within various legal frameworks and present a challenge rather than enabling environment. Perhaps more importantly, most study participants were not aware of the existence of such rules and procedures. That means that the possibility of holding STMM volunteers accountable is a challenge.

COMMUNICATION: Practice, intercultural communication and expectations

Developing the communication around STMMs is going to be crucial in terms of enhancing the value of this practice. Many of the challenges are issues of communication and understanding cultural values of both groups, volunteers and host communities. Building on the first issue of conditions, these have to be communicated. Creating awareness around the conditions and processes would be very important in order to ensure the laws and policies are well known by those they affect.

I think they have been very good and helpful to us and as long as they are willing to quickly learn what we are managing and have good interpersonal and communication relations and respectful to the rest of the colleagues, we have always worked together and very well with them. (P2, Interview).

The value of having these conditions and greater communication among partners lies in the knowledge that volunteers may also impart a value system. For instance, it was noted that their commitment and work ethic, that is often different from that of host communities, may rub onto the local community workers.

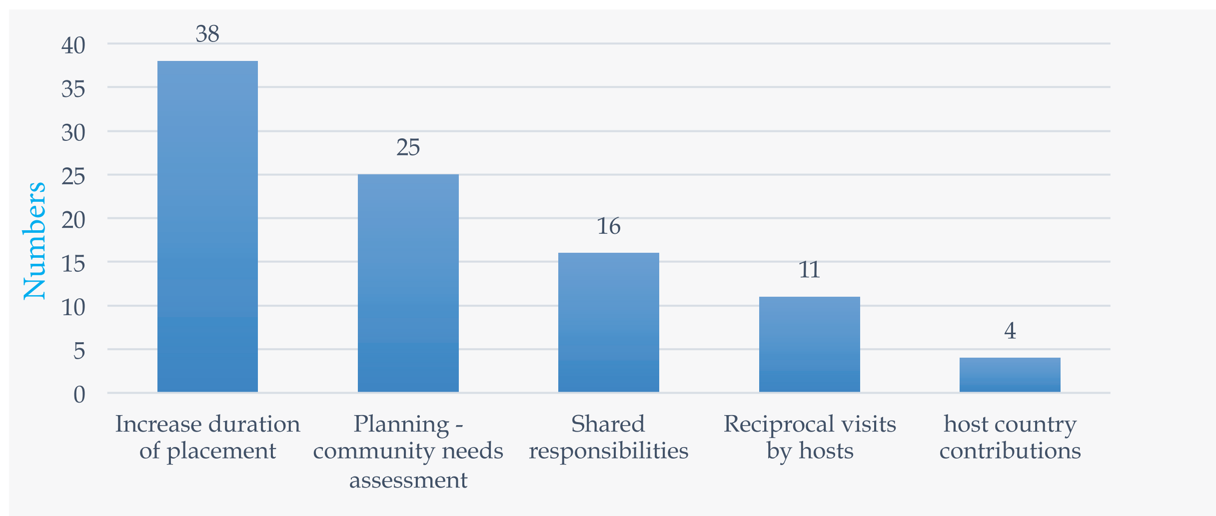
The attitude to work, volunteers tend to be more committed and to us as managers we pick a lesson from the kind of commitment they have in terms of time keeping, doing assignments. So in that area you find when you have a volunteer, you give them something to do with computer activity, they will work on it. (P6, Interview).

Communication moves beyond just informing to also shaping the value system, ensuring adequate preparation between STMMs and host communities, and authorities in the receiving countries.

COLLABORATION: Establishing institutional partnerships

Specific issues around collaboration were raised. Better collaboration is an important step in enhancing the value of STMMs. As shown in figure 8 below, collaboration should be in the form of negotiating for a long duration of placement, planning, decision on the roles and responsibilities, possibilities of reciprocal visits and host country contributions as shown in Figure 9.

Figure 9: Collaborations to enhance STMMs (N=94)



Source: Survey data

In order to improve trust and also ensure the value of STMMs is enhanced, there is need for guidelines to cover how to collaborate and with who as well as the role of different actors. It was revealed that the whole STMMs engagement is one of stakeholder collaboration, down to practice. For instance, respondent N 14 noted:

> ***Let services go where it is most required. Let them dialogue with the government, get the deficiencies and bridge the gap (N14, Interview)***

It was also clear that collaboration enables the smooth running of STMMs and is a best practice that will enhance the value of STMMs. For instance, it was noted that:

> ***When they come to us here, we just need to take them through what it means to work in a rural place like this, some of the cultural things that they need to take care of as they work here and then of course we share with them the other guidelines that we use here as we take care of our patients. (P2, Interview).***

For the case of reciprocal visits, the respondents argue that if medical workers in the host communities visit and get trained from countries sending the volunteers, collaboration will be greatly enhanced

> ***We are trying to work on some partnership with Sweden where they send us their young doctors and then we also do an exchange and send our doctors the other side but the limiting factor is sometimes they are not able to do as much as they do in the advanced way so you find that in our case when our doctors go they only benefit from those short term kinds of training but I think if well trained, it would be good for us to also volunteer and get to know how they manage different things that side. (P.2, Interview).***

Even when volunteers come as experts, the role of collaboration on the ground is crucial.

CAPACITY BUILDING: Ensuring Mentorship, Research and Training

The study also suggests that capacity building of both the host health workers and the volunteers is important in enhancing the value of the STMMs. As noted in table 10 below, capacity building can be done through mentorship and internship, training and research. For mentorship, it is suggested that the experts who come for short visits could work with local experts as mentors, in research as peer researchers of collaborators, and in training during visits to train local experts in specific procedure.

Table 10: Enhancing the value of STMMs through capacity building

Enhancing STMMS-Capacity Building	Count	Percentage of responses	Percentage of respondents (N=46)
Mentorship and internship	5	42%	11%
Training	4	33%	9%
Research	3	25%	7%
Total responses	**12**	**100%**	**26%**

Source: Survey data

Because STMMS are in very short periods, it is very difficult to meaningfully cultivate capacity building. It was therefore suggested by the respondents above that capacity building can be enhanced by inviting host country medical personnel to work with these experts who normally come to volunteer in their own contexts or environment, or for collaboration to continue through research activities.

To conclude, it was revealed that host communities find the STMMs beneficial to them in the various ways discussed. However, the value of STMMs and their contributions may be further enhanced through setting up appropriate conditions, cultivating effective and strategic communication, continuous collaboration between actors on both sides and capacity building of experts in host communities even after STMMs are concluded. We now look at the legal, policy and institutional framework for STMMs in Uganda.

7 LEGAL, POLICY AND INSTUTIONAL FRAMEWORK FOR STMMs

This section contributes to the objective that sought to understand the nature of legal and policy frameworks for STMMs. Aware of the need they fulfil, both in terms of legal and moral justification, how can the activities of STMMs be regulated and enhanced? In order to do this, the researchers reviewed and examined the regulatory instruments (laws, policies, plans, rules and regulations, and institutional frameworks) that govern health in general and STMMs in particular, from both an international and national perspective. This method of content review of instruments was supplemented by interviews with stakeholders and a media review. The examination looks at both provision for regulation and gaps in regulatory instruments to facilitate smooth operations of STMMs.

The practice of medicine and health service delivery in most countries is governed by strict codes of ethics and practical regulatory measures to ensure that the rights of patients are protected and promoted.

Uganda's health care system is planned around various laws, policies and regulations to which medical practitioners and service providers are expected to adhere. The questions asked was, 'Can we please discuss the procedure for volunteers coming-any laws, codes or policies in Uganda regarding appropriate or ethical practices?'

The majority of interviewees (75%) as in Figure 12, were not aware of any specific laws relating to STMMs, and indeed there is no single law for them in the first place as per the legal and policy analysis presented.

The health sector is both a local and an international concern, because some Public Health events endanger international health, thereby hindering international trade. Recent such events in Uganda were Ebola pandemic and polio, including most recently coronavirus. Due to the fact that low income countries sometimes lack resources such as proper infrastructure and equipment coupled with scarcity of required skill sets (Scheffer, Liu, Kinfu & Dal Poz, 2018), the international community tends to step in as an act of moral good faith but also to fulfil their obligation under certain International instruments such as the United Nations Declaration of Human Rights (1948) and the Helsinki Declaration of 1964. Some of such international intervention is offered through STMMs to Low- and middle-income countries.

This section therefore analyses both international and local-legal justification for the promotion of health and health care, considering their relevance to STMMs; and the local legal capacity to manage any liabilities arising as a result of STMMs.

International regulations and policies

The review found that a number of international regulations and institutions exist to govern health provision, and some goals and targets are set at an international level. These appear to be relevant as they bind countries at all levels. The following are relevant in creating a regulatory and policy environment for health in Uganda.

Figure 10: Summary of international regulatory and policy framework

International Regulation/policy		Year
1.	United Nations' Universal Declaration of Human Rights	1948
2.	The Helsinki Declaration	1964
3.	The Alma Ata Declaration	1978
4.	The Bamako Initiative	1987
5.	The UNESCO Declaration	2005
6.	International Health Regulations; Procedures concerning public health emergencies of international concern (PHEIC)	2005
7.	Millennium Development Goals	2000
8.	The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa	
9.	The Common African Position (CAP) of the African Union on SDGs	
10.	Sustainable Development Goals	2008

Source: Various regulatory frameworks

These international declarations relate to standards that countries should follow in the delivery of health services and the making of policies and laws to govern their implementation. Current health policy goals are now guided by the Sustainable Development Goals (SDGs). In 2015, United Nations member states challenged themselves to "Ensure healthy lives and promote wellbeing for all at all ages" in the SDGs-Goal 3.

Other goals related to health are Goal 1. End poverty in all its forms everywhere; Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture; Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; Goal 5. Achieve gender equality and empower all women and girls; Goal 6. Ensure availability and sustainable management of water and sanitation for all, and Goal 13. Sustainable Climate.

National regulations and policies

Uganda has enacted several laws, regulations, professional codes of conduct and national policies pertaining to health. The challenge is that most of these laws do not directly address STMMs. These include:

Figure 11: Summary of national regulations and policies

Regulation/Policies		Relevance to STMMs
1.	The Constitution of the Republic of Uganda, 1995	General
2.	The Health Service Commission Act, 2001	General
3.	The Uganda Medical and Dental Practitioners Act Cap 272, 1998.	General
4.	The Uganda National Council for Science and Technology Act, 2001	General
5.	The Uganda Medical and Dental Practitioners Code of Professional Ethics, 2013	General
6	The Allied Health Professionals Act. Cap 268, 1996	General
7	The Uganda National Health Research Organisation Act, 2011	Specific
8	The Nurses and Midwifes Act Cap 274, 1996	General
9	The HIV and AIDs Prevention and Control Act, 2014,	General
10	Uganda National Policy Guidelines for HIV Counselling and Testing, 2005	General
11	The Local Government Act 2007 (Amended 2015)	General
12	Public health management Act CAP 281	Specific
13	National Drug Policy and Authority Act 206	General
14	The National Drug Policy and Authority (Importation and Exportation of Drugs) Regulations, 2014	General
15	The National Drug Policy and Authority (Registration) Regulations, 2014	General
16	The Second National Health Policy 2010	General
17	National Policy on Public Private Partnership in Health, 2005	Specific
18	National Medical Stores Act Cap 207, 1993	General
19	Non-Governmental Organisations Act 2016	Specific
20	Health Sector Development Plan 2015/16 - 2019/20	General

Source: Various legislation

The regulatory environment for the health sector in Uganda adopts a piecemeal approach, with the Health Sector Development Plan being the most comprehensive of all, covering several aspects of health, and the Local Government Act, which provides for subnational health service provision, decentralising health care provision to districts. The rest of the legislation seeks to regulate specific aspects of health care provision such as HIV/AIDS, registration of drugs, importation and exportation of drugs among others, while some are more general. They do not mention STMMs but generally provide for regulation of medical service provision regardless of source. Some are worth singling out:

Health Service Commission Act, 2001.
Section 8 (1c) stipulates that one of the functions of the commission is to review the terms and conditions of service, standing orders, training and qualifications of members of the health service like doctors, nurses, dentists

and other health providers, and any other matters connected with their management and welfare and make recommendations on them to government. In essence, visiting short-term mission practitioners should be checked for qualification under this provision.

The Uganda Medical and Dental Practitioners Act Cap 272.
This is the main law providing for health practitioners in Uganda. Section 2 of the Act establishes the Uganda Medical and Dental Practitioners' Council whose functions include (i) to monitor and exercise general supervision and control over and maintenance of professional medical and dental educational standards, including continuing education; and (ii) to promote and review the terms and conditions of service, standing orders, training and qualifications of members of the health service and any other matters connected with their management and welfare and make recommendations on them to government; and the maintenance and enforcement of professional medical and dental ethics.

Other functions include to exercise general supervision of medical and dental practice at all levels; to exercise disciplinary control over medical and dental practitioners; to protect society from abuse of medical and dental care and research on human beings; to advise and make recommendations to the Government on matters relating to the medical and dental professions; to exercise any power and perform any duty authorised or required by this Act or any other law; to disseminate to the medical and dental practitioners and the public, ethics relating to doctor-patient rights and obligations; and for the purposes of discharging its functions under this.

Section 24 allows only registered practitioners to practice;

- *A person registered or provisionally registered as a medical practitioner under this Act may engage in medical practice.*
- *A person registered or provisionally registered as dental practitioner under this Act may engage in dental practice.*

Section 25 mandates the Council to handle disciplinary cases of registered practitioners while 18 recognises qualifications from other jurisdictions outside Uganda. It states that:

The council may, taking into account the entrance requirements, the curriculum followed and, where possible, the professional standards exhibited by persons holding qualifications of the medical or dental school awarding the qualification under consideration, recognise qualifications other than qualifications awarded by a university established in Uganda by law, for purposes of registration under this Act.

The recognition under Section 18 of foreign qualifications can be invoked by Health Commission to check the qualification of volunteers on medical mission before they are allowed access to patients. It is, however, not clear owing to the general lack of data for the STMMs how many volunteers, especially those hosted by CBOs, are checked for qualification since these CBOs operate in communities with less supervision. The interviews could not verify this.

Public Health Management Act CAP 281
Section 11 deals with cases of infectious diseases, which usually attract STMM volunteers to Uganda. The Minister's powers in section 11(1)(d) extends to missions or missionary institutions. This is the only regulation which might directly affect STMMs. The other powers of the Minister under this Act include oversight of:

- *the duties of medical practitioners called in to visit or in any manner becoming aware of any notifiable disease;*
- *the duties of heads of families, parents or other persons having the care of or in attendance on any sick person;*
- *the duties of owners or occupiers of land, the owners or managers of mines, employers of labour, and all chiefs or headmen or others;*
- *the duties of the person in charge of any school, mission or missionary institution, orphanage or similar institution in regard to the reporting of such diseases or any other disease specified in the rules*

It is not clear how practical this law has been in regulating volunteer health missions in Uganda, as they are largely organised by those already having other types of activities, such as Non-Governmental Organisations. This was not confirmed in data.

National Drug Policy and Authority Act 206 with the regulations made thereunder

Section 3 of the Act establishes a National Drug Authority as a body corporate with its functions. Section 5 stipulates functions of the authority to include;

- *5(d) to control the importation, exportation and sale of pharmaceuticals;*
- *5(e) to control the quality of drugs;*

Sections 12 and 13 restrict the dispensation of restricted drugs to only registered medical practitioners. This applies to all medical practitioners including STMMs although it does not mention STMMs specifically, which is a gap identified.

However, it is difficult to verify how many STMM personnel submit their drugs to National drug authority for inspection of the quality of drugs being brought into Uganda. However, new practices suggest that there is more vigilance at the airport and occasionally, at health facilities.

The National Drug Policy and Authority (Importation and Exportation of Drugs) Regulations, 2014
Regulation 3(1) requires a license for any drugs entering Uganda; thus, "a person shall not import drugs into Uganda, without an import license issued by the Authority."

According to 3(5) The Authority shall, prior to issuing an import license, ascertain that the facility from which the drugs to be imported, are manufactured, complies with the internationally accepted Good Manufacturing Practice Guidelines adopted by the Authority. This regulation is silent on whether the drugs imported under this regulation extend to donor drugs brought in by STMM to be dispensed while offering services during their stay in the country. The regulations only restrict the resale of donor drugs.

The National Drug Policy and Authority (Registration) Regulations, 2014
Regulation 4(2) directs a person who intends to manufacture, import or export a product to apply to the Authority for registration of the product prior to the manufacture, importation or exportation of the product. Regulation 5 enjoins the Uganda National Drug Authority to maintain a register of the drugs. Like the prior Regulations, this one too is silent on drugs brought in by STMM practitioners since it is directed at importation and exportation with intent to sell.

National Policy on Public Private Partnership in Health
This policy is relevant to this chapter because STMM are hosted by some private health providers and Missionary Institutions or Non-Governmental Organizations. This policy enjoins the private practitioners to offer high quality services. Its focus is largely on training and how the private sector can contribute to infrastructure and human resource development with the aim of improving service delivery. By working in partnership with government, the mixed system of public and private services thus created is stronger and can compensate for short-comings in either provider.

Non-Governmental Organisations Act 2016
This is an Act to strengthen and promote the capacity of Non -Governmental Organisations (NGOs) and their mutual partnership with Government; to make provision for the corporate status of the National Bureau for NGOs and provide for its capacity to register, regulate, coordinate and monitor NGO activities; to provide for the board of directors; to provide for the establishment of branch offices of the Bureau, District NGO Monitoring Committees, Sub county NGO Monitoring Committees, to make provision for special obligations of NGOs and to provide for other related matters.

The NGO Act is important while deliberating on matters of STMM because some STMM are hosted by NGOs; therefore, it is important to understand the governing body of NGOs. While the law is clear on objectives to maintain standards, there are limited ways of monitoring these from the perspective of the NGOs that might organise STMMs. Critics argue that the NGO Act only targets some types of NGOs deemed political, thus neglecting the less political ones like health, who appear to come into the country hoping to help. As such, some serious cases of lapse endangering lives of Ugandans have been reported in the past. In 2017, it was reported in the Observer Newspaper that:

Several people have died inexplicably after undergoing brain surgery at Mengo hospital performed by American doctors between October 23 and 29. Now, the Uganda Medical and Dental Practitioners Council and the ministry of Health want to know what went wrong (https://observer.ug/news/headlines/56376-mengo-surgery-deaths-put-us-doctors-in-spotlight).

This was as a result of a short medical mission that Ministry of Health clarified had been cleared and operated legally.

Health Sector Development Plan 2015/16 - 2019/20

The plan sets Uganda's mid-term strategic direction, development priorities and implementation strategies. With the theme; "Strengthening Uganda's Competitiveness for Sustainable Wealth Creation, Employment and Inclusive Growth," the Plan mainly focuses on how to customize the International Health Regulations to suit the needs of Uganda. It expired at the end of the year 2020. The overview of the Health Sector Development Plan is the implementation strategy of the Laws already discussed above, the most helpful of its strategies with regard to STMM being paragraph 1.6 vi) and vii) which require a development of laws and regulations to better manage the health sector, and to ensure adequate and appropriate human resources for the health sector.

Actor Analysis: The Institutional Framework for health service delivery

Several institutions are involved in health service delivery that are both at the central and local levels. Some are also private or non-governmental.

Ministry of Health (MoH)

The overall institution for health services in Uganda is the Ministry of Health. Its mandate is to plan for, budget and implement activities in health. However, the ministry is supported by a number of other government Departments and Agencies such as (i) the National Medical Stores; (ii) the Uganda Medical Association; (iii) Uganda AIDS Commission (iv) the Pharmaceutical Society of Uganda; (v) the Uganda Veterinary Association; (vi) the Head of the School of Pharmacy, Makerere University; (vii) the Uganda herbalists; (viii) the Uganda Dental Association; (ix) Uganda Virus Research Institute; and (x) the Joint Medical Stores among others. These are part of the value chain in health service provision. It should be noted that National Media Stores is a government institution mandated to procure, store and distribute human medication and health related consumable items to government owned health units to all districts of Uganda. Joint Medical Stores is a private not for profit joint venture between Uganda Catholic Medical Bureau and Protestant Medical Bureau. Their mandate is the same but JMS deals with non-government health services

District Local Government

Under the decentralisation system in Uganda, service delivery, including that of health, is devolved to subnational levels, including that of health with support from the central government. These administrative units in the health sector are headed by the District Medical Officer.

Non-Governmental Organisations (NGOs)

The Catholic and Protestant Medical Bureaus[9] run several health facilities in the country. These are independent of the government health system but comply with national legal and policy framework. There are also other NGOs that support medical services like Hospice.

The national regulatory and policy environment: Opportunities and gaps

As has already been noted, there are several international and national institutions relevant for health service provision. The problem though, is that very little of it directly provides for the regulation of STMMs. Despite this, there are opportunities and also some gaps.

The legal justification for STMMs

The first opportunity is that the Universal Declaration of Human Rights provides the foundation for adequate health care for all. Its universality remains impractical for most nations where resources are scarce and infrastructure for health services are inadequate. This places a burden on the whole of human race to ensure that humans live in a healthy environment, and have access to necessary medical care.

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9. These operate as the governing bodies for health facilities that are founded by catholic or protestant missionaries operating across the country.

According to the World Health Organization, the highest proportions of the global burden of disease fall on the regions that also suffer significantly from physician shortages (Scheffler et al., 2018) A growing group from High Income Countries aims to address both. Other infectious diseases that have attracted STMM to Uganda are Cholera, Tuberculosis and polio among others.

Other professionals who believe they can make a difference in such situations have visited Uganda and offered their services individually under the guidance of NGOs such as Project Helping Hand, Empower a Child, among others. Uganda cooperates with international and regional organisations that stand for the well-being of humanity. In the STMM field, these organizations include; International Volunteer Headquarters, (Volunteer for Ever), and Samaritan's Purse that have in the past sought and coordinated STMM workers to visit Uganda (Hotchicks, 2016).

The moral justification

While STMMs can be very beneficial to patients in LICs, it is worth noting that most mission trips are taken by the volunteers for their own benefit in furthering their career. One student had this to say after a medical mission trip to Africa;

All the doctors and nurses I observed were all so open to teaching me about what I was seeing," Candice said as a testimonial for love volunteers. "They often would tell me to come closer and proceeded to explain exactly what was going on. The people there were so approachable and patient, allowing me to gain so much more knowledge from this experience (volunteersforever.com).

Generally, under the best circumstances, STMMs address an unmet medical need with high-quality care. Under the worst circumstances, they serve as an opportunity for physicians to practice techniques for the treatment of conditions that are less common in the developed world (Smith, Keen & Edwards, 1991). This example is extreme and is unlikely to play a role in the justification for most contemporary STMMs, but the possibility is concerning. One report in the faith-based literature (of an evangelical short-term mission trip in this case) suggested that some trips may benefit the volunteer as much as or more than the recipient of aid as well as potentially costing the hosts valuable time and resources (Ver Beek, 2006).

Despite their relevance, there is discomfort about the work of STMMs, especially within the context of limited regulation. What this analysis has found is that there is not enough provision for the regulation of the STMMs, with general references in the multiple laws and policies, either general in nature or specific to something else. What is even less clear, is how the very limited provisions are brought to bear in terms of implementation.

Implications of this regulatory and policy environment for STMMs in Uganda

The examination of these laws and policies reveal that there are no specific laws or provisions for STMMs. Although some provisions may apply generally, it is not clear to what extent they are applied to STMMs or enforced. Unfortunately, most of the respondents were not sure of this either. It therefore raises the question of: what are the implications of the current regulatory and policy environment in Uganda for STMMs and for Ugandans who are exposed to their activities?

General lack of proper information about effectiveness of STMMs

Reporting inputs rather than outcomes appears to be the default approach for quantifying the value added to the communities and individuals served by STMMs. This criterion, however, falls short of the measures used to identify high-quality evidence-based medicine. The assessment of process output data, without assessing the short-term or long-term impacts of STMM (Langowski & Iltis, 2011), precludes the ability to measure efficacy of interventions performed. A successful treatment is one which ends with the patient feeling better and stronger than when they first sought treatment. It has been persuasively argued that the success of treatment should be judged by direct reports from patients (Barley, Grunkemeire, & Lansky, 1995).

Professional liability arising from activities of STMMs

While Ugandan legislation is ripe with regulations to discipline misbehaving medical practitioners, that in general appear to be applied as the Medical and Dental Practitioners' Council remains active, there is an absence of the same related to STMM Volunteers. While the same can apply, failure to explicitly discuss how to handle STMMs in the laws can easily be exploited.

The concept of STMMs poses a serious legal paradox, in the event of liability arising from professional negligence. The nature of STMMs is short visits which mostly lasts for eight days, although cases of longer stay were common. In the event that the patient's condition is worsened due to negligence on the part of the STMMs worker, who takes responsibility? Certain guidelines have to be formulated to hold the hosting NGOs, health units or churches responsible for such eventualities.

Although Ugandan laws allow for a civil suit to be instituted against foreigners in both commonwealth and non-commonwealth countries, it is a long, time-consuming procedure with costs that the destitute patients may not afford to pursue should they realise professional malpractice after the volunteers have left. Under the Civil Procedure Rules Order 5rule 22 (c) a person may serve a defendant outside Uganda if the person is domiciled permanently in that jurisdiction.

The service in the foreign country itself is an elaborate process which requires the notice to be served to first be sealed with the seal of the High Court for use out of the jurisdiction, and should be forwarded by the registrar to the Minister of foreign affairs together with a copy of it translated into the language of the country in which service is to be effected, and with a request for the further transmission of the notice through the proper channels to the government of the country in which leave to serve notice of the summons has been given; and the request should be in a certain Form 10 of Appendix A to the Rules with such variations as circumstances may require.

As shown by the tedious procedure above, cases of professional negligence or misrepresentation by STMMs volunteers should be prevented by enacting regulating laws which weed out the unserious practitioners before any damage is done to patients. The legislation of the country is also ambiguous with regard to STMMs; this, with good reason because a good legislation is one which is passed with proper background information on the matter to be regulated.

Registration of STMMs volunteers is a function that the Uganda Health Commission should embrace and treat with utmost importance; otherwise the lives of sick Ugandans are exposed to non-qualifying volunteers who are not regulated in any way. Any un-licensed medical practitioners on missions should face disciplinary action if caught. This can only be achieved if Health Commission, in conjunction with Local Government, becomes more vigilant with regard to STMMs.

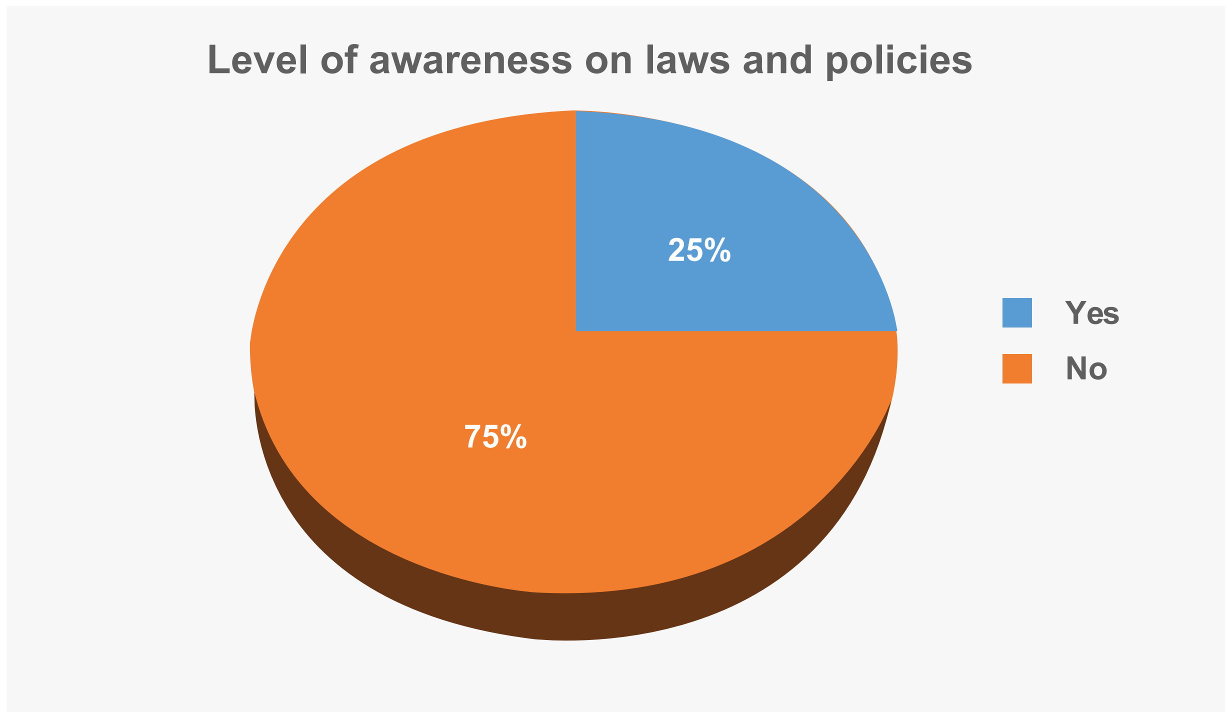
Perspectives of host country respondents on the legal and policy framework

Whereas the legal analysis presented important aspects of opportunities and gaps in the laws and policies, there were various perspectives on the legal and policy framework seen in the interviews. There was clear sense of the need for a more appropriate legal and policy framework that both enables but also disenables the wrong elements. Many practices, as it is, slip through the cracks in laws and policies. One policy maker in health made the point that:

> *There is need for reforms in policy, government should look at their period of stay. The volunteers should be scrutinized and sent to areas of operation according to their areas of expertise and need of particular areas to operate from (P17, Interview).*

There is at the moment limited choice for host communities. They receive whoever is interested in working with them. Many of the participants had limited awareness of the laws and policies to substantially contribute to the conversation on whether existing laws and policies are adequate and which aspects needed to be worked on. Out of the 36 participants who were asked the question, 'Can we please discuss the procedure for volunteers coming-any laws, codes or policies in Uganda regarding appropriate or ethical practices?' only 25 per cent knew something specific, and these were all in the category of policy makers. This is shown below:

Figure 12: Level of awareness for laws and policies



Even of the 25 per cent who said they were aware that the policies and laws were there, the majority (6/9) could not name specific laws. The respondents asked this question were policy makers (17) and NGOs and organizers (19), excluding patients (36 respondents). This in itself represents a huge problem in terms of compliance, since the two groups are actively involved in the organization of STMMs. Besides awareness, the problem of weak enforcement of regulation was envisaged despite existence of the laws.

8 CONCLUSION AND RECOMMENDATIONS

If STMMs are justified and warrant a regulatory framework, a balance between the value of the STMM services and rules regulating them must be upheld. Too much restriction could deter helpful groups from visiting completely, while too little restriction could put sick Ugandans in harmful fates as dire as death.

The first conclusion is that there are several health needs at a general level which in turn drive the demand for STMMs. Second, there is an existing legal and policy framework found in multiple laws and policies. These laws and policies have also created adequate institutional frameworks, although they do not explicitly provide for STMMs, and they regulate in a piecemeal manner (various aspects regulated by different laws). Third, host perspectives on STMMs is that contributions are made both by volunteers and host communities, but duration is too short, there is a need to rethink the period especially for specialized interventions that require serious post treatment follow-up. Fourth, numerous challenges are faced by volunteers such as cultural shock, inadequate resources, limited manpower, cost of accommodation, high expectations from communities, poor transport and delays in clearance. Fifth, host country members interviewed have some concerns involving the relationships with volunteers which include lack of experience, misalignment with community needs, security risks, lack of code of conduct, having other interests and sustainability of interventions.

It is important to note, however, that the type of contributions made by visiting teams were mentioned 121 times, or almost three times per participant, while there were 47 mentions of concerns, an average of one per participant. This suggests a relatively favorable view of STMMs overall, but that the participants saw ways in which they could be improved.

Consequently, it is recommended that some actions can be taken to enhance the value of STMMs. This can be achieved by setting conditions for practice through legal, policy, regulatory, institutional and ethical codes of conduct; improving communication at practice level, intercultural communication and setting up of expectations on both sides; instituting mechanisms for collaboration between countries of origin and host countries at institutional level of partnership with stakeholders; and building capacity of local experts though mentorship, research and training.

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APPENDICES

APPENDIX 1: INTERVIEW GUIDE FOR HOST COMMUNITIES

1.	Please describe any experience you have had with volunteers coming from other countries for short visits (3 months or less) and your perception of them.
2.	How long their stay in your community (Uganda)?
3.	Which countries were they come from?
4.	What are some of the things they did while in your community?
5.	What benefits did the volunteers bring to you and your community?
6.	What do you think are the most urgent health needs in your community that the volunteers fill?
7.	Can volunteers help meet those needs? If yes, how? If no, why not?
8.	Do volunteer groups ask about your community's needs before they arrive? Who decides what they will do while they are here?
9.	How do you know if volunteers make a difference (benefits) for your organization/patients/the community?
10.	What kinds of evidence exist to document their impact?
11.	What are some of the challenges about having volunteers come from other countries to your community/country?
12.	What problems does hosting volunteers bring to you or the community/country?
13.	How can the benefit of volunteers be improved to support the health sector?
14.	Is there an ideal amount of time that a volunteer should stay in the community/country? If yes, what is it?
15.	If a group wanted to volunteer in your community, what would you recommend as the most important things for them to consider?

APPENDIX 2: INTERVIEW GUIDE FOR MEDICAL PROFESSIONALS AND HEALTH POLICY MAKERS

1.	Please describe your experience with volunteers coming from other countries for short visits (3 months or less) and your perception of them.
2.	Can we please discuss the procedure for volunteers coming-any laws, codes or policies in Uganda regarding appropriate or ethical practices?
3.	In your experience, which countries do volunteers come from the most?
4.	What do you think volunteers contribute to Uganda?
5.	What do you think are the most urgent health needs in Uganda that volunteers help meet? If yes, how? If no, why not?
6.	Do volunteer groups ask about the community's needs before arrival?
7.	What are the challenges with having volunteers from other countries?
8.	Do you believe that volunteers usually have the skills needed to work here?
9.	Do you believe that volunteers have a good understanding of what the country needs to enhance health delivery?
10.	What do you think of the way volunteers relate to a) the people who work here? b) Patients c) others in the community (if relevant)?
11.	What do you think would help enhance the best use of volunteers for improving health in Uganda?
12.	Is there an ideal amount of time that a volunteer should stay in the country? If yes, what is it?
13.	If it were completely up to you, would you want to have volunteers in Uganda? Explain.
14.	Would you be interested in volunteering in other countries in Africa? Or in higher income countries, e.g. Europe or North America?
15.	If a group wanted to volunteer in your community, what would you recommend as the most important things for them to consider?
16.	Do you think there are any reforms in policy needed to get the most from volunteers in health?

APPENDIX 3: INTERVIEW GUIDE FOR NGOS, ACADEMICS, MEDIA AND LOCAL ORGANIZING GROUPS

1.	Please describe the work you do here.
2.	Please describe your experience with volunteers coming from other countries for short visits (3 months or less) and your perception of them.
3.	How long do they usually stay in Uganda?
4.	Which countries do they come from?
5.	What are some of the things they do or projects they typically work on?
6.	Why do you think most volunteers come here?
7.	What do you think volunteers contribute (benefits) to your country or to your program specifically?
8.	What do you think are the most urgent health needs in the place where you work?
9.	Can volunteers help meet those needs? If yes, how? If no, why not?
10.	Do volunteer groups ask about your organization's or community's needs before they arrive? Who decides what they will do while they are here?
11.	What problems does hosting health volunteers bring to you or the community/country?
12.	How well do volunteers relate to a) the people who work here? b) patients c) others in the community (if relevant)?
13.	What do you think would be the best use of volunteers for improving health in your country?
14.	Is there an ideal amount of time that a volunteer should stay in the country? If yes, what is it?
15.	If it were completely up to you, would you want to continue having volunteers in your facility? Explain.
16.	Do you know if there are any laws, codes or policies in Uganda that apply to volunteers regarding appropriate or ethical practices when it comes to health programs? Please name some
17.	If a group wanted to volunteer in your community, what would you recommend as the most important things for them to consider?

Appendix 4: Informed Consent-NGOs

KEY INFORMANT INTERVIEW CONSENT FORM

Study Title: ENHANCING THE VALUE OF SHORT-TERM VOLUNTEER MISSIONS IN HEALTH FROM HOST COUNTRY PERSPECTIVES:

A CASE OF UGANDA

Principal Investigator: Dr. Emilly Comfort Maractho

Address: Uganda Christian University

P.O Box 4, Mukono-Uganda

Telephone: +256752008664

E-Mail: emillycm@gmail.com

Version 1, September 2018

I am ...., working as a research assistant on a collaborative Study between Uganda (scholars Emilly Comfort Maractho, PhD., Uganda Christian University and United States of America (scholars at Lehigh University, PA). We are aiming to identify ethical practical policy issues surrounding planning and execution of STMMs as seen from the perspectives of various host country stakeholders for improvement. We would like to ask you some questions. We are doing research on "Enhancing the values of short term volunteer missions in Health from Host Country perspectives"

You are being asked to participate in a research study because you are a Key informant/well experienced in your job/role. This consent form explains the research and the role of participants in the study. Please consider this information and take as much time as you need. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

There may be some words that you do not understand. Please ask me to stop as we go through the information and I will explain them to you. If you have questions at a later time, you can ask them of me or other members of the research team.

Purpose of the Research

We are conducting this research that seeks to understand more clearly, the dynamics of short-term medical mission practices in Uganda and the barriers to those efforts being more effective by improving short-term global health efforts into the country in the future. Specifically research will examine the overall health needs of Uganda which relate to medical missions, identify any gaps which could be appropriately addressed by short-term health efforts, find out the policies and health plans of Uganda government regarding short-term efforts, investigate the roles and responsibilities of all in-country stakeholders of short-term medical missions and assess ways in which sending organizations can better collaborate and align with host organizations and in-country stakeholders to support the local healthcare system and improve overall health.

Participation in the study

We have purposively sampled you to participate in this study to have face-to-face interviews with you to provide in-depth information you have on the topic. This interview will last for approximately 45 minutes, will be audio-recorded with your permission and we shall take notes. However, we will not note names, simply your comments and thoughts. The information will be treated as confidential and will be used to improve short term global health in the country in the future (overall health). If at any point in the interview you do not want your views to be recorded, you can request that we turn off the recorders. To protect your anonymity, pseudonyms would be used to report the findings so that you remain anonymous. Personal information shared will also remain confidential. Recordings from the interview will only be accessed by the members of the project and stored properly to prevent others from gaining access to it.

Voluntary Participation

Your participation in this study is entirely voluntary. It is your choice whether to participate or not. You may stop participating in the interview at any time that you wish or withdraw from the study at any time and this will not affect your job or service provision. If you choose not to participate, your tasks that you routinely provide at the health facility will not be affected.

Duration

The study will take place over a period of one year in total.

Benefits/Risks in being in the study

There is no direct benefit for you participating in this study. Therefore, the study does not have a program to pay you for participation in the study. By participating in this study, it is possible that you may be at a very minimal risk, such as feeling discomforted by some questions. But this may cause no harm. However, we do not wish this to happen and you may refuse to answer any questions or not take part in a portion of the interview if you do not wish to. You may as well stop the interview at any time.

Compensation/Reimbursement

You will receive refreshments during the interview and will be reimbursed with a token of transport should you be invited to the interview. We will give you 10,000 UGX (Ten thousand Uganda shillings) at the point of interview as a round figure to cover your refreshment and transport.

Confidentiality

The records of this study will be kept private. There may be a risk of exposure if sensitive personal information is disclosed. We will not include your name on any study documents or any information that will make it possible to identify you. We will not be sharing the identity of those participating in the research with the community or any institutions related to your job. Information about you that will be collected during the research will be put away under lock and key as well as on password protected computers and no one except the researchers will have access to the records.

Privacy

You will be interviewed from a private place where no one can hear what you are answering. This would be a place, which is convenient for you to avoid any disturbances and to avoid disclosing personal information publically.

Sharing Results

We will share the results through publication in program reports to the sponsors, peer reviewed journals, presentations at national and international scientific conferences, policy briefs that will be distributed to relevant policy makers and a cross section of stakeholders, presentations to participant groups and/or to staff at the field sites where research was conducted, participation in a dissemination workshop at the Ministry of Health to be conducted with relevant stakeholders following completion and approval of the study reports in order that other interested people may learn from our research. However, confidential information will not be shared.

The knowledge that we get from doing this research will also be shared with you through presentations to participant groups and/or to staff at the field sites where research was conducted, before it is made widely available to the public. We will inform you of the presentations to participant groups and/or to staff at the field sites where research was conducted through telephone SMS messages or radio announcements.

Right to Refuse or Withdrawal

You do not have to take part in this research if you do not wish to do so. You may also stop participating in the research at any time you choose. It is your choice and all of your rights will still be respected. Refusing to participate in this study will not affect your routine tasks, job, or care at this facility in any way.

Conflict of Interest

There is no conflict of interest while carrying out this study.

Contact Information

The researchers involved in this study are led by Dr. Emilly Comfort Maractho. If you have any questions, you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact the following person(s):

Principal Investigator:	Dr. Emilly Comfort Maractho
Address:	Uganda Christian University
	P.O Box 4, Mukono-Uganda
Telephone:	+256752008664
E-Mail:	emillycm@gmail.com

This research study has been reviewed and approved by the Makerere University School of Social Sciences Research Ethics Committee, which is a committee whose task it is to make sure that research participants are protected from harm. Therefore, if you would like to talk to someone other than the researcher(s) about; (1) concerns regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects' issues, please contact:

Dr. Stella Neema

The Chair, Makerere University School of Social Sciences Research Ethics Committee

Makerere University

Telephone: + 256-772457575

E-mail: sheisim@yahoo.com

OR

The Executive Secretary

Uganda National Council for Science and Technology

Plot 6 Kimera Road, Ntinda, P.O. Box 6884, Kampala Uganda

Telephone: +256 414 705500, +256 312 314800

Fax: +256 414 234576

Questions

You may ask me any questions you may have about any part of the research study and I will take time to answer them. Do you have any questions?

Part II: Certificate of Consent

Statement by Participant

I have read the above information or had the above information read to me. I have had the opportunity to ask questions about it and have received answers to the questions to my satisfaction. I consent voluntarily to serve as a participant in this research.

Printed name of Participant:

____

Signature or thumbprint of participant: ___________________________________ Date: ________________

Statement by the Person Taking Consent

I have accurately read out the information sheet to the potential participant and ensured that the participant understands the information within to the best of my ability. I confirm that the participant was given the opportunity to ask questions about the study and all the questions asked by the participant have been answered correctly based on my knowledge. I confirm that the individual has not been coerced into giving consent and that consent has been given freely and voluntarily. A copy of this informed consent form has been provided to the participant.

Printed Name: ____

Signature or Thumb print: _______________________________________ Date: _______________________