ICLD
Learning Case

Equitable Health: a far-away dream for young girls and women in Uganda?

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Overview

This case reveals the reproductive health challenges young people face in Uganda that predispose them to maternal mortality, and invites to discussion of the responsibilities and opportunities for local leaders. It references concerns of teenage pregnancy reported in Jinja District during the COVID-19 pandemic. According to the 2020 District Health Office report, 17% of women who attended Antenatal care were teenage girls 10–19 years old (Office of the PM, 2021). The scenario further shows the difficulty many women experience in accessing reproductive health information and services.

1. Learning Objectives

Learners are encouraged while examining the scenario to reflect on the inequities within the framework of the right to health, identify the deep seated social, political and economic influences that underpin the highlighted social injustices.

By the end of this scenario participants/learners will be able to:

- Identify health inequities associated with maternal health,
- Appreciate the underlying social determinants of the inequities within their localities,
- Examine the system and leadership failure or weakness underlying the burden of maternal mortality to women within their localities,
- Articulate the most feasible strategies leaders and communities can do to address the maternal health inequities within their localities, and
- Take agency in implementing the identified strategies.

2. Case Description

Dilemma description

Nabirye, a 16-year-old girl in Mawoyito Village in Buwenge Sub-county's Jinja District had not attended school for two years due to school closures. She moved to Jinja Town to support her Auntie and found work in Jinja Central Market. While at the market she was seduced by Kasada, a 45-year-old married man from Mafubira. She soon realized she was pregnant and told her Auntie. Her Auntie was extremely unhappy; she had warned Nabirye about having relations with men. Because of their living situation—six people living in a two-room rented house in Walukuba—Nabirye couldn't stay with them and had to return to her village.

At 8-months pregnant, she has no idea what to do with the coming baby. She has not been attending Antenatal care, since her nearest health centre of Bugembe Health Centre III is about 15km away from her parents' home. She has no support from the baby's father and her parents are peasant farmers who don't have any money to help. She's terrified she will not have transportation to deliver the baby at the Health Centre III. Recently, one of the girls in her village who delivered with a Traditional Birth Attendant passed away and left behind a premature baby who was brought to the girl's grandparents. Nabirye feared for her life—and her baby's future—as labor and delivery drew near.

Background

In 2020, Uganda's Maternal Mortality Rate (MMR) was 336 maternal deaths per 100,000 live births; on average, 19 mothers died every day (MOH, 2020/2021). According to the World Health Organization, in 2018, Uganda contributed 2% to the entire global MMR, yet had a population of only 0.59% of the world's population. The 2016 Uganda Demographic Health Survey (UDHS) report noted that the main causes of death among women were the following: haemorrhage 27%; malaria, HIV and other indirect cause 27%; hypertension 14%; sepsis 11%; and direct causes (obstructed labour) 10%. (UDHS, 2016).

Further analysis by the UDHS revealed that the causes of deaths were related to three major delays, namely, those delays in seeking care, connecting to health facilities and receiving adequate healthcare. The delays were associated with women's social-cultural and economic conditions and the general state of affairs of the society, including women's rights and welfare. The 2016 UDHS report noted urban versus rural disparities, though both figures were worrying: 64% of women in rural areas and 44% in urban areas reported enormous challenges in the access to and quality of healthcare.

Photo 1 Teenage mothers waiting for Post-natal care services at Karambi Health Center, Uganda. Photo credit: Danny Gotto, Innovations for Development

3. Discussion

Discussion questions

1. What are the key human rights violations that Nabirye and her peers are experiencing?
2. As a local leader, what are the health inequities that you see Nabirye is experiencing?
3. How has the leadership and health system failed Nabirye?
4. What role can local leaders play to ensure that young women like Nabirye do not find themselves in such a predicament?

Discussion key: facts about the right to health

Meaning of the Right to Health

As specified in the General Comment No. 14 on the highest attainable standard of health by the Committee on Economic, Social and Cultural Rights, the right to health is a fundamental human right and is an inclusive right which extends not only to timely and appropriate health care but also to the underlying determinants of health, such as;

- The right to a clean and healthy environment.
- Access to shelter.
- Access to safe water.
- Safe food and nutrition.
- Healthy occupational and environmental conditions and health related education and information.

In the human rights discourse and practice in Uganda, the right to health has been—and continues to be—contentious. Primarily located within legal frameworks that focus on civil and political rights, the right to health is more frequently being used to challenge abuses of health by invoking social and economic rights, even though this places the right to health on slippery terrain that is not as internationally accepted as civil and political rights. (Mulumba M, et al, 2010)

Is access to healthcare the same as right to health?

practice, the right to health is often favored, as the right to health care is seen as too narrow in focus. At the same time, the right to health is also seen as too demanding, because for some it implies a right to be perpetually healthy, which is an impossible standard. In turn, the right to health care is too narrow to include important factors like safe environmental conditions or adequate sanitation. Thus, the right to health is an umbrella term that implies a variety of practical requirements.

Other human rights and the right to health

The right to health is closely related to — and depends upon — the realisation of other human rights. The right to health intersects, for example, with HIV/AIDS, disability, and climate change. Protecting the right to health means upholding other human rights such as:

- The right to social security: A comprehensive social protection system helps to address the multiple dimensions of deprivation and hardship often linked to poor health, and ensures an adequate standard of living through illness.

- The right to food: A healthy diet helps to build resilience, while poor or inadequate nutrition has significant negative health effects.
- The right to education: Access to accurate information and health education allows us to make healthy choices about how we eat, how we protect ourselves from poor health and how we choose health care and services.

This calls for a whole-of-government, whole-of-society approach to setting effective health policies that leave no one behind.

It is linked with principles of equity and non-discrimination and highlights the needs of poor and vulnerable groups. The right to health is linked with the realization of all other human rights and forms the basis for enjoyment of other rights.

Essential elements of the right to health that the State must ensure

1. Availability: Adequate healthcare infrastructure including hospitals, community health facilities, trained healthcare professionals, drugs, equipment and health services must be available in all geographic areas and to all communities.

2. Accessibility: Access to health care must be universal and guaranteed for all on an equitable basis. Healthcare must be affordable and comprehensive for everyone and physically accessible where and when needed.

3. Acceptability: Health care providers must respect dignity, provide culturally appropriate care, be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. They must respect medical ethics and protect confidentiality.

4. Quality: All health care must be medically appropriate and of good quality, provided in a timely, safe, and patient centered manner and have quality standards.

What other human rights values pertain to the right to health? (Leaders can ensure that the right to health promotes these values).

- Non Discrimination: Health care must be accessible and provided without discrimination on account of health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status.
- Equality and Equity: In the provision of health services, everyone should have equal opportunity. Equity requires resources and services to be distributed according to people's needs.
- Transparency: Institutions that organize, finance or deliver health care must operate transparently and health information should be easily accessible.
- Participation: Individuals and communities must be able to actively participate in decisions that affect their health, including in the planning, organization and implementation of health care.
- Accountability: There must be enforceable standards put in place to monitor and hold agencies accountable for realizing the right to health.

Role of the State (duty bearers) in protecting the Right to Health

The right to health, like all human rights, imposes obligations on States parties: the obligations to respect, protect and fulfil.

- Respect: The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health.
- Protect: The obligation to protect requires States to take measures that prevent third parties from interfering with the right to health.
- Fulfill: Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health.

Reflecting on the causes of Health Inequities in your country

There are numerous causes of health inequities in any country and the reality and context varying from country to country. These can be seen from the perspective of social, economic and political hindrances that perpetuate the imbalance in access to resources and opportunities.

Social:

- Demographics (age, sex, gender, sexual orientation, tribe/cultural identity, religion, etc.)
- Geography (rural vs urban; highlands vs lowlands, etc.)
- Education (literate vs illiterate, level of completions)
- Historical
- Economic:
- Access to jobs/opportunity
- Access to land/natural resources like water, etc.
- Poverty

Political:

- Policies
- International law/frameworks (international relations)
- Aid/Debt
- Trade systems
- Resource allocation (budgeting/taxation)
- Political ideology/orientation (democratic, dictatorship/autocracy, meritocracy)

Photo 2 The burden of Teenage pregnancy in Uganda: Expectant young girls seeking assistance from the District Probation Office. Photo credit: Danny Gotto, Innovations for Development.

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