Youth Voices in Development Report 3

Sustainable Development Goal (SDG) Three: Ensure healthy lives and promote well-being for all at all ages

My experience of healthcare in Uganda has been generally positive, with a few exceptions and serious issues. I will draw from an event on April 27th that focused on adolescent healthcare in Uganda and a handful of my experiences and those told to me by friends.

Observations

Uganda's government created an adolescent health policy to address the needs of Uganda's exploding adolescent (11-19 years old) population, and that policy is being either reviewed or renewed this year. Thirty-four percent of Uganda's population is between 10 and 24 years old, which is apparently the highest in Africa. I found out about that at an event on April 27th. Organized by an organization called Reach a Hand, the event included a panel of persons ranging from ministers and executive directors to peer educators and a private sector CEO.

The policy indirectly covers many of the Goal Three targets: reducing infant mortality by reducing the incidence of youth pregnancy while also ensuring better antenatal and neonatal care, reducing AIDS infections, treating substance abuse, and improving access to sexual and reproductive health education and healthcare.

Part of the conversation at the event revolved around one of the targets, increasing "...health financing and the recruitment, development, training and retention of the health workforce". One activist at the event stated that there ought to be a department within the ministry of health specifically addressing adolescent health. At this time there is only a division. I don't know the size or funding of said division, but the activist's suggestion makes sense, given the population of adolescent Ugandans and rural nature of the country.

Both at the adolescent health policy event and in my experience at Kibuye village it has become clear that healthcare service quality varies wildly. Panelists explained that they had found rural clinics frequently understaffed, open few days of the week, and sometimes staffed by biased providers who may refuse service or provide very negative service to vulnerable persons such as adolescents. I know Kibuye's clinic is staffed by three individuals, though a doctor/nurse is only there one day each week, and a panelist noted the same in other regions of Uganda. One NGO staff member at Reach a Hand's event stated that he heard from many adolescent Ugandans that they are treated like sexual deviants or idiots by healthcare providers when accessing medical facilities to deal with their reproductive, sexual, mental, and general health issues.

Bias also exists in urban areas. For example, a female friend of mine went to a clinic in Jinja because of stomach pains, and the first suggestion from the doctor was "you're probably pregnant". She was not asked if she was sexually active, nor had the doctor run any laboratory tests. Obviously upset by that suggestion, I think my friend is unlikely to go to that clinic again and is developing a negative opinion of doctors and healthcare providers, meaning she is less likely to seek medical help.

Funding reproductive and sexual health services has a very direct relationship to Goal 3 targets about reducing maternal and infant mortality, and addressing the AIDS epidemic. It seems that "...universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines" is part of Uganda's adolescent health policy. I believe, based on what

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I heard at the Reach a Hand event, that many sexual and reproductive health services are free. However it was stated that access can be extremely difficult in rural areas – one person on the panel quoted an instance where a family was 20km from the nearest facility and did not have a means to use motorized transportation. Were a pregnant family member to begin labour, it is unlikely they would be able to access the hospital.

Relationship to Sustainable Development Goals Four and Five

I think Goal Three has a very direct relationship to Goals Four (quality education) and Five (gender equality). Quality education and gender equality are essential elements in good health and wellbeing.

There is a link between quality education and understanding the challenges one may face at any period in their life, especially those of a medical nature and ensuring one's own wellbeing. At Reach and Hand's event it seemed that the Ministry of Health panelist believed that adolescents cannot conceive solutions to their healthcare issues, and I would argue that is an education gap. A person cannot conceive what they do not know or understand.

Quality education is also essential for healthcare providers. Bias against young Ugandans and poor bedside manner I mentioned earlier could be mitigated in medical education. I will address that in **Recommendations**.

Gender equality is essential to healthcare. Women seem to be frequently discriminated against by some healthcare providers (see earlier example of doctor assuming stomach pains are pregnancy), and they also bear the brunt of risk in reproduction, evidenced by a target in Goal Three to reduce maternal mortality and the fact that women bear children.

Recommendations

- Inform as many Ugandans as possible about government policies that directly relate to their life (i.e. healthcare policies).
- Implement a comprehensive sexual and reproductive health and rights, and health/wellbeing education program (this is reportedly underway, but I include it anyway).
- Introduce a reporting mechanism for persons served incorrectly or poorly by healthcare professionals, including when they fail to meet standard set by government policy.
- Introduce youth-sensitization and bedside manner training to all healthcare providers and government officials in Uganda, focusing on polite and friendly provision and design of services to persons of different education levels, ages, and cultural/religious backgrounds.
- Decentralize medical services provision in rural areas from physical clinic locations, using them instead as a home base for mobile health teams that go where health services are needed.
- Introduce financial incentives, education subsidies, or other perks for healthcare professionals who sign contracts to join rural health teams.