Medical Hostages: Detention of Women and Babies in Hospitals

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A disturbing but common practice in many developing countries is the detainment of women who have recently given birth and who cannot afford their hospital charges. Contrary to policies aimed at encouraging women to deliver in health facilities, this practice is an abuse of their rights and has implications for wider maternal and neonatal health.

Detention of women is a surprisingly common problem, with current and recent examples of this practice found in Burundi, Cameroon, the Democratic Republic of Congo, Ghana, Kenya, Nigeria, the Philippines and Zimbabwe.[1] It is, however, very difficult to estimate the extent of the problem as there are no prevalence studies and in many situations these detentions are illegal with no official figures. Most of the information concerning this practice therefore comes from assessments of single hospitals or anecdotal reports.

A typical example involves a woman being admitted to hospital, often with a complication of pregnancy that requires an emergency intervention. She is treated with no upfront charges but is then required to pay before being allowed to leave. If she doesn't have the money to pay on departure, she may be detained, often with her baby, for weeks or months while her family raises the necessary funds. A Caesarean section, for example, can cost a woman more than the average annual wage in her country. In effect, she is held hostage until the debt is paid. A report from Cameroon described a case where an infant spent nearly an entire year with her mother in hospital.[2]

For their part, hospitals stress that women are not denied treatment and point to the need for co-payments for services to be delivered. This practice is not limited to maternal health; it also happens with patients who have had surgical or other costly procedures. Generally law enforcement agencies are not involved in detaining patients, but hospitals employ private security guards, who check and stop patients on exit. Some are "just" detained, while others are forced to work to earn money. Women who need emergency obstetric care are therefore faced with a ghastly dilemma: do they risk giving birth at home without access to medical care, or do they face an uncertain period of detention in hospital until someone pays their bill?

Detention is detrimental to maternal and child health with short and long-term implications for the infant. Pregnancy and childbirth are precarious times for both mother and baby and institutional deliveries are considered best practice in global health. The threat of being detained discourages women from going to hospital in the first place, reducing antenatal care and increasing the risk of maternal and infant death around childbirth. Globally, 290,000 women die from pregnancy-related causes each year.[3] Usually the causes are preventable and, in a clinical setting, relatively simple to treat. In addition to this unacceptable

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maternal death toll, 2.9 million newborns die and a further 2.6 million are stillborn.[4] Being detained, often in unsanitary conditions, is also clearly detrimental to a woman's physical and mental health, with both mother and baby at greater risk of nosocomial infection. The infant's social and emotional development may be affected by not being with his or her wider family. The threat of detention may also encourage women to use traditional healers who generally cost less and accept non-financial payments.[5]

Detention is an abuse of women's and children's rights and contravenes national and international laws. Most countries have ratified the International Covenant on Civil and Political Rights (Article 11), which states that arbitrary detention, especially for non-payment of a debt, is prohibited.[6] Detention also contravenes the United Nations Convention on the Rights of the Child (for example, Articles 3, 24 and 37).[7]

Why does this practice persist?

There appear to be two main reasons this illegal practice persists: a persistent shortage of government funding to public hospitals; and poor governance within the hospitals. Detention of women tends to occur in low- and middle-income countries where private expenditure as a proportion of total expenditure on health is high. Structural adjustment programs, recommended by the World Bank in the 1980s, introduced user fees for healthcare into many low- and middle-income countries. This resulted in reduced demand for health services and greater inequity.[8] Direct out-of-pocket payments, both formal and informal, for healthcare during pregnancy are commonplace throughout the world. These can vary from small bribes or "tips" for community health workers, to much larger official charges especially for emergency obstetric care. In Cameroon and Nigeria out-of-pocket expenditure makes up 68% and 67% of total health expenditure respectively, while the median for Africa is 49%.[9] These payments, combined with the reduced ability to earn money during pregnancy and periods of illness, can lead to catastrophic financial burdens, especially for the poorest members of society. The effects of user charges are worst in poor, rural populations who often lack health insurance and have difficulty accessing remote health services.[10]

Despite ratification of binding universal human rights treaties, the detention of patients continues due to a lack of effective governance structures. Countries with poor legal systems have limited capacity to stop hospitals from executing these illegal practices.

Ways to eliminate detention

Given the complex nature of hospital detentions, reflecting failings in health systems governance and financing, eliminating this practice is not always straightforward. It requires concerted action across various agencies including political leaders, health, justice and finance ministries, local government, law enforcement agencies, and local community groups. The exact policy and systems reforms required will depend on the context of each country as there is no 'one-size-fits-all' strategy to address this problem. In most cases though, in addition to announcing and enforcing a ban on detentions, it is also necessary to implement simultaneous health systems reforms (notably finance reforms) to remove the incentive to treat vulnerable patients as sources of income. One way to do this is to introduce free health care for pregnant women and children and replace the income from user fees with higher levels of public financing from domestic sources, augmented by development assistance where necessary.

In order to eliminate medical detentions, some countries have introduced specific legislation, for example the Hospital Detention Law in the Philippines, and others, like Kenya, have used case law.[11] In Turkey, a political decision to ban medical detention launched the country's successful universal health coverage reforms.[12] Initiatives such as this require active and functioning institutions that assist implementation and evaluation, and protect against the encroachment of informal fees.

Free health care for pregnant women and children was implemented in a number of sub-Saharan countries to promote access to health services and accelerate progress towards the child and mater-

nal health millennium development goals.[13] For the mother and child, the benefits are obvious both in financial and health terms, resulting in reduced mortality and morbidity by encouraging delivery in a facility. There is evidence from Ghana for example, that universal free care for pregnant women increased health facility utilization and reduced inequalities, with a greater increase in the proportion of facility-based deliveries amongst the poorest groups.[14] Increasing health coverage leads to improved population health and better maternal healthcare which can lead to healthier offspring decades later.[15] Removing user fees for pregnant women and increasing public financing can be a first step towards universal health coverage.

While benefits are clear, the costs of financing free health services from already stretched state budgets, with many competing priorities, is a major hurdle. Public hospitals in sub-Saharan Africa are typically severely under-resourced, and healthcare workers are poorly paid. There is now a consensus amongst the leading health agencies that the majority of health funding should be sourced from compulsory public mechanisms (taxation and social insurance) rather than private voluntary mechanisms (user fees and private insurance). Furthermore, it is essential that public financing is allocated efficiently and equitably to meet the healthcare needs of vulnerable groups including pregnant women and young children.[16] However at present many developing countries are not meeting their public health financing commitments—for example, allocating at least 15% of their annual budget to improve the health sector, agreed by African Governments in the Abuja declaration.[17]

International donors could play an important role both in helping states cover the initial cost of extending health care and in adding political pressure to do so. Free health services have long-term cost benefits through the reduction of costs related to maternal and neonatal morbidity and mortality, and improvements in health and economic productivity. There are also cost savings when user fees are no longer collected, relating to reduced administration, and elimination of debt collection and detention.[18]

Other aspects of the health system are also affected by elimination of user fees. The increased demand for maternal and child healthcare will require increases in the health workforce, medication, equipment supplies and health facilities. Removal of user fees for pregnant women must be a carefully planned and executed strategy, as seen in Ghana, Sierra Leone and South Africa.[19] Targeting a vulnerable group, such as pregnant women, can be considered an example of progressive universalism whereby countries move towards universal health coverage by prioritizing coverage of high need groups first.[20] However, removing user fees only addresses the financial accessibility of health services. Whether services are available in the first place and whether they are fit for purpose in terms of quality and social and cultural acceptability to patients also needs to be addressed. Stopping the detention of patients does not prevent other substandard or inhumane practices from occurring. It is, however, an obvious extreme that should not be tolerated.

Burundi changed detention policy and increased health service use

Burundi is a poor country of approximately 10.5 million people in east Africa. It spends 14% of government expenditure on health, though its GDP-per-capita is ranked the second lowest in the world.[21] Although improving, mortality for both mothers and infants is high (maternal mortality ratio is 740 per 100,000 live births; neonatal mortality rate is 36 per 1000 live births).[22]

Before 2006, healthcare in Burundi was limited and access had worsened from 2002 when the government introduced user fees. Detention of patients was commonplace throughout the country and also extended to not releasing dead bodies to families. For example, in the Prince Régent Charles Hospital 621 patients were detained in 2005. A study by *Human Rights Watch* found that approximately a third of the detainees were women who had undergone Caesarean sections. At the time, the annual gross national income per capita was $90, and the cost of a Caesarean section was about $100. Surgical patients, and both adult medical and

paediatric patients, made up the other two thirds of detainees. Patients were detained in nine of the 11 hospitals studied by *Human Rights Watch* and most were detained for several weeks.[23]

Following the release of the *Human Rights Watch* report in 2006, the President of Burundi, Pierre Nkurunziza, visited many public hospitals. On seeing the situation, he declared that all women and children should be released from public health units.[24] This was followed later in the year by a new policy providing free healthcare services to all pregnant women and children under six years of age.[25] It was a popular policy that led to an increase in health care usage. It also helped the government secure additional aid funding, and by increasing his popularity, contributed towards the President being re-elected. International aid was sufficient to make up for the revenue lost from user fees as well as increasing health workers' pay to cover the additional workload. The change in user fees policy combined with other government funded health reforms contributed to an increase in the proportion of babies born in hospital from 34% in 2005 to 60% in 2010.[26]

The Burundian case study illustrates how a high profile advocacy campaign targeting the issue of medical detentions helped catalyze broader health systems reforms that have clearly benefited pregnant women and children.

However, the Burundi example also highlights some of the problems when policy changes quickly. While the decision to remove user fees was admirable, it did not cover other patients who were detained, and in practice it was implemented rapidly without strategies about how the system would function. Baseline data was not collected nor targets set for success in banning detentions. Soon after the Presidential announcement, thousands of women and children attended hospitals and health services could not cope with the surge in demand. The additional workload for health professionals and the cost of the increased demand for services led to shortages of drugs and initially reduced the quality of services.[27]

Conclusion

Banning the detention of mothers and infants in hospitals and providing free health services for them should be a top priority for governments and development agencies. These policy changes can also be seen as a first step towards Universal Health Coverage.[28] Ending the practice of medical detention has an important role in advancing women's rights and respecting their dignity, improving both their health and the health of their children.

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