

Research Paper

Robert Yates, Tom Brookes and Eloise Whitaker
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Hospital Detentions for Non-payment of Fees

A Denial of Rights and Dignity



Summary

- In some parts of the world it is common practice for patients to be detained in hospital for non-payment of healthcare bills.
- Such detentions occur in public as well as private medical facilities, and there appears to be wide societal acceptance in certain countries of the assumed right of health providers to imprison vulnerable people in this way.
- The true scale of these hospital detention practices, or ‘medical detentions’, is unknown, but the limited academic research to date suggests that hundreds of thousands of people are likely to be affected every year, in several sub-Saharan African countries and parts of Asia. Women requiring life-saving emergency caesarean sections, and their babies, are particularly vulnerable to detention in medical facilities.
- Victims of medical detention tend to be the poorest members of society who have been admitted to hospital for emergency treatment, and detention can push them and their families further into poverty. They may also be subject to verbal and/or physical abuse while being detained in health facilities.
- The practice of detaining people in hospital for non-payment of medical bills deters healthcare use, increases medical impoverishment, and is a denial of international human rights standards, including the right not to be imprisoned as a debtor, and the right to access to medical care.
- At the root of this problem are the persistence of health financing systems that require people to make high out-of-pocket payments when they need healthcare, and inadequate governance systems that allow facilities to detain patients.
- Universal health coverage (UHC) cannot be achieved while people are experiencing financial hardship through their inability to pay for healthcare, so by definition any country that allows medical detention is failing to achieve UHC.
- Health financing systems should be reformed by moving towards publicly financed UHC, based on compulsory progressive pre-payment mechanisms. This would enable hospitals to become financially sustainable without the need to charge significant user fees.

Introduction

The detention of patients in hospital for having insufficient means to pay their medical bills is common practice in some parts of the world (Otremba et al., 2015). In some instances, vulnerable people are detained for long periods in health facilities and are subjected to abuse from health workers, including the denial of vital services. These detentions result in patients being forcibly separated from their families and becoming unable to maintain their livelihoods. This is not only deeply psychologically distressing, but is potentially economically disastrous, and can result in some of the poorest people sliding further into poverty.

The practice of detaining people in hospital for non-payment of medical bills deters healthcare use, increases medical impoverishment, and is an infringement of human rights (Mostert et al., 2014; Mostert et al., 2015).

In many countries, however, the population is unaware of their rights, or that detention in health facilities for non-payment of fees may be both proscribed under domestic law and constitute an interference with rights enshrined in international treaties to which their country is a party. For instance, one recent newspaper report from Uganda suggests that detention of patients there for non-payment of medical bills is so commonplace that many citizens wrongly believe that hospitals have the right to detain them (Wesaka, 2016).

This research paper summarizes the findings of a review of available evidence on hospitals detaining patients against their will for non-payment of healthcare bills. The purpose of the research was to assess the prevalence of medical detentions worldwide; discuss the health implications of this practice; and outline some policy options that could reduce, and potentially eradicate, this problem.

Methodology

The review was based on published research, grey literature and media articles identified through internet searches for English-language material related to hospital detentions. More than 60 articles produced between 2003 and 2017 outlining specific detention cases in 14 different countries were identified. The overwhelming majority of these articles were reports in local newspapers. Strikingly, only nine short academic articles were identified on the subject through searches on PubMed, the Directory of Open Access Journals, the Public Library of Science (PLOS) and Bielefeld Academic Search Engine (BASE).

Terms used in the search, which had no date restrictions but were limited to English-language media, included 'fees and detained', 'hospital fees and detained', 'non-payment of user fees' and 'fees and retention'.

The scale of detention

Given the lack of academic research on this issue, it is difficult to put precise figures on the number of people actually being detained, and there is likely to be significant under-reporting of detention cases outside well-connected urban areas. It is also probable that the problem is even more widespread than demonstrated in this research, and that a search of media including languages other than English would reveal many additional cases. Nevertheless, the research for this paper strongly suggests that detention of patients who cannot afford to pay hospital fees occurs across much of sub-Saharan Africa, including in Nigeria (Sahara Reporters, 2015), Kenya (Mohamed, 2014), Ghana

(Ghana News Agency, 2014), Zimbabwe (Jakes, 2015), Liberia (Kanneh, 2013), Uganda (Lancet TV, 2015), Cameroon (Ngwa Niba, 2012) and the Democratic Republic of the Congo (DRC) (Castro, 2008); and that the practice also occurs at a significant level in India (*The Hindu*, 2015) and Indonesia (Ruffins, 2011). The reviewed articles collectively identified in excess of 950 detention cases over the period 2003–17. This includes a report of as many as 400 patients being detained in a single hospital in Kenya (*Guardian*, 2009).¹ An Agence France-Presse news report from the DRC estimated that at least 20 per cent of new mothers were forced to stay on until they settled their bills (AFP, 2010).

A study in the DRC found that over a six-week period in 2016, 46 of the 85 women (i.e. 54 per cent) who had given birth in one health facility and were eligible for discharge were detained for the non-payment of user fees.

More recently, a study in the DRC found that over a six-week period in 2016, 46 of the 85 women (i.e. 54 per cent) who had given birth in one health facility and were eligible for discharge were detained for the non-payment of user fees. Analysis of data for recorded discharges from another DRC facility for 2014–15 revealed that 16 per cent of women had been detained for the same reason (Cowgill and Ntambue, 2017). According to a qualitative study of 13 Kenyan health facilities, 52 of 641 women surveyed (8.1 per cent) reported having been detained for failing to pay their medical bills, and of those included in the research six women (1 per cent) reported having been asked to pay a bribe for service provision (Abuya et al., 2015).

These reports and studies suggest that the annual global number of detained patients is in the hundreds of thousands, and could plausibly be even greater if the practice is widespread and unreported in some parts of the world. There is no doubt that more research would enable a better understanding of the true scale of the problem.

The victims of detention

Unsurprisingly, hospital detention practices disproportionately affect the poorest members of society. Many reported cases are the result of unavoidable emergency care, which tends to cost far more than many patients can afford to pay (Kippenburg et al., 2008; Akinola, 2017; James, 2016). These cases often involve women who have suffered complications in childbirth and who require caesarean sections or other emergency treatment (Akolisa, 2015). Other detainees are victims of car accidents who require trauma services, including surgery, followed by long and expensive inpatient care. Cancer patients may also be significantly affected: one survey of a Kenyan hospital found that 53 per cent of uninsured families with children undergoing cancer treatment cited detention as a reason for abandoning treatment (Mostert et al., 2014).

In most maternity cases, both mother and baby are detained until payment is received, although in Indonesia it appears more common for the baby to be detained after its mother leaves hospital (Ruffins, 2011).

The often emergency nature of these patients' needs means that the situation arises whereby hospitals treat poor patients who would otherwise be turned away and who subsequently amass unaffordable

¹ The article, which also identified 150 further detention cases in other Kenyan hospitals, exemplifies the high degree of uncertainty about overall numbers, as well as highlighting the likelihood that the global scale of the problem is underestimated even in the research for this paper.

medical bills. In an attempt to recoup their costs, hospitals then detain patients, sometimes for many months after treatment has finished, until their families pay their bills. Some countries, such as Ghana and Kenya, that ostensibly have free public maternity services still have high rates of detention because the service provision does not include costly emergency surgery (Opondo, 2015; MyJoyOnline, 2014). Although a slight majority of named hospitals in the reported cases are private, it is important to note that the absolute numbers of patients detained in public hospitals are often far higher (*Guardian*, 2009). Hospital detention is therefore a practice that extends far beyond the private healthcare system.

It is clear that the most vulnerable groups within societies are the most likely to become victims of hospital detention. In South Africa, for instance, detention in state hospitals of undocumented foreign women from countries such as Zimbabwe has been reported, even though all women have the legal right to free maternity services in state-funded facilities (*Chronicle*, 2015). In another example, a human rights lawyer explained that in Kenya police tend to view detention cases as a private dispute, and the impoverished victims are unlikely to be aware of their rights (Saunders, 2009). It is notable that a non-trivial number of cases involve mothers who have been abandoned by their families, for instance in situations where they become pregnant outside marriage (SDE, 2015). In cases where abandoned mothers are detained, the care and wellbeing of any children at home during a period of detention must be considered. One report into the violation of women's rights in health facilities in Kenya noted that the practice of detaining women until hospital bills are paid 'provides abusive spouses with an added weapon against their wives' (Center for Reproductive Rights and the Federation of Women Lawyers – Kenya, 2007).

Abusive practices during detention

Although hospitals tend to present detention of patients as a practical, short-term expedient while families raise money, in reality the practice is often highly degrading and abusive, with reports revealing serious social and gender discrimination by hospital authorities (Saunders, 2009; Wesaka, 2016). In many affected countries the majority of women give birth at home, and hospital detention forms part of a wider range of discriminatory practices affecting poor women, including abusive and degrading treatment by hospital staff. In one case, 60 women were held next to an overflowing toilet in a Kenyan hospital; and one victim reported being told by nurses that she was 'stupid' for not having known she was pregnant after being raped (Migiro, 2015). In another, a Nigerian woman was chained to a urinal pipe during her detention (Sahara Reporters, 2015). A Kenyan woman who was forced to leave her bed and lie on the floor a day after her caesarean operation spoke of being berated by staff who asked her: 'Why do you open your legs and give birth every time?' (Carmon, 2012).

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Some of the allegations made by Kenyan detainees were even more serious. Patients at Kenyatta National Hospital claimed in 2015 that they had been pressured into having sex with hospital staff in exchange for cash to help pay their bills (Kenya Digest, 2015). Another article reported an interview with two women who believed that baby-trafficking had been taking place at Kenya's Pumwani Maternity Hospital (another public facility), citing evidence of nurses offering single mothers money in exchange for

their babies, and reports of women being told their child had died before being shown a baby who had clearly been dead for days (Carmon, 2012).

Many women fear the risk of sterilization or even baby-trafficking as a result of hospital treatment (Carmon, 2012). These concerns make them less likely to use hospital services for childbirth if they fear abuse as the result of detention, and mean that they are more likely to rely on traditional birth attendants who lack medical training (Abuya et al., 2015; Devakumar and Yates, 2016). One article cited research showing that the distrust arising from these types of experiences makes women also less likely to seek out other types of services such as family planning and antiretroviral treatment (White Ribbon Alliance, 2014).

Hospital detention practices are often very heavy-handed, with medical staff or guards employed to watch over the detainees, and sometimes authorized to beat patients who attempt to escape. In 2005 the then Kenyan health minister, Charity Ngilu, acknowledged in a public meeting that women were throwing their babies to relatives from hospital windows in order to facilitate their escape (TIME Global Health Summit, 2005).

In some cases, security guards are supplied by outsourced companies that are paid a commission by the hospital for their ability to prevent escapes (Ngwa Niba, 2012), while in at least one hospital in Nigeria individual nurses and doctors had the medical bills of patients who escaped while under their care deducted from their salaries (BIGLAWNewsLine, 2014). Such practices may incentivize a very tough approach towards detainees, and are likely to have increased the extent of abuses.

Advocacy campaigns

The issue of the unethical and inhumane practice of hospital detention for non-payment of medical fees has attracted the attention of human rights groups, medical practitioners and the media. Notably, the position statement of an international taskforce of paediatric oncologists, published in 2015, underscores that detention of patients in hospital for lack of payment of medical bills violates international human rights standards, including the right not to be imprisoned as debtors and the right to access to medical care (Mostert et al., 2015).²

There does, meanwhile, appear to be a significant public backlash against the routine practice of hospital detention, particularly in Nigeria and Kenya. In 2009, for example, Kenyatta National Hospital was pressured into releasing 44 detained patients after a TV station used a hidden camera to show them being held in a padlocked room (Saunders, 2009).

Advocacy groups have challenged some detention cases in the courts. Two Kenyan women were awarded large financial settlements against Pumwani Maternity Hospital in 2015. The court judgment declared that the hospital had illegally detained the two women, and recognized that this abuse was based on social and gender discrimination by the hospital authorities (Migiro, 2015). Additionally, following advocacy pressure, the governments of Burundi and the Philippines have taken action to end hospital detention (Otremba et al., 2015). Such cases suggest that the practice is less tolerated in a number of affected countries.

² The stated objectives of the taskforce are to augment critical awareness of the practice of hospital detentions; to introduce a consistent terminology used in academic literature and by human rights organizations and the media to describe the practice of medical detentions; to help reliably map the global scale of the issue; to recognize and report on the adverse consequences of hospital detention practices; to address the root causes of medical detentions; and to identify and support the implementation of effective solutions to stop hospital detention practices.

In Nigeria in 2013, an advocacy group recorded undercover footage of hospital detention before handing the evidence over to state officials; seven women and seven babies were rescued as a result (Yisa, 2013). Detention and wider issues regarding the treatment of women have also prompted strong reaction in Nigeria. In December 2015, for example, female activists stormed the Lagos assembly to protest about the deaths of women in the city's hospitals (Olokede, 2015).

Despite such political pressure, recent media articles indicate that hospital detentions persist in many countries. In 2016 the federal government of Nigeria announced that hospitals did not have the right to detain patients for the non-payment of hospital bills, although no mention was made of any sanctions for continuing the offence (Daniel, 2016).

The recent case of a 17-year-old burn victim being detained and refused transfer to another hospital for further care because of outstanding medical bills indicates that medical detention has continued in Nigeria (Kayode-Adedeji, 2017).

The underlying causes of detention

Societal discrimination against poor citizens is clearly a contributing factor in cases of detention, yet it would be simplistic to blame the problem entirely on prejudice by hospitals. Often, vague government definitions of poverty place hospitals in the difficult position of having to determine which patients are poor enough to be exempt from fees. Hospitals in Kenya, for example, are supposed to waive treatment costs for the poorest patients, but there is a strong financial incentive to 'squeeze' patients in an attempt to procure payment, and the hospital boards (which hear patient appeals regarding exemption status) are often bureaucratic and slow to make decisions (Center for Reproductive Rights and the Federation of Women Lawyers – Kenya, 2007). Equally, hospitals point out that there would be little incentive for patients to find the money to cover treatment costs if they knew that they could easily avoid payment by claiming poverty, which would put further pressure on already stretched hospital finances (Kanneh, 2013).

Clearly, it is important for governments to state unequivocally that detention in medical facilities for non-payment of bills is illegal, but this in itself is unlikely to end the practice if governments do not also provide the necessary finance to allow hospitals to cover their costs. Detentions in public hospitals in Zimbabwe for non-payment of maternity fees, in the context of deteriorating health services in the country, were found to have continued despite an official directive against detention of patients (Mambo, 2014). In Kenya, too, legislation establishing free maternity care was adopted in 2013, but inadequate financing has made this difficult to implement and the post-natal detention of mothers has continued (Opondo, 2015).

Burundi, one of the poorest countries in the world, mandated free maternity services and healthcare for children under 5 in May 2006, partly in response to growing pressure to tackle the problem of medical detentions of women and children (Kippenberg et al., 2008). In December 2005, in an ad hoc 'charitable' initiative, President Pierre Nkurunziza had ordered the release of detained patients and instructed the Ministry of National Solidarity to pay their hospital bills. However, a Human Rights Watch report published in 2006 noted that hospitals had again begun filling up with poor people unable to pay their bills (Human Rights Watch, 2006). This extensive study found, inter alia, that nine of 11 public hospitals visited were detaining patients. In May of that year President Nkurunziza declared that healthcare user fees for all maternity patients and children under five years of age would henceforth be abolished, but, in the absence of additional compensatory funding, services were initially overwhelmed

(UNICEF, 2006; Human Rights Watch, 2006). When the government subsequently allocated additional domestic and international aid funding directly to health units, they were able to meet rising demand for free health services from these patient groups (Falisse et al., 2015; World Bank, 2012). As a result, in the five years following Burundi's introduction of free, publicly financed healthcare for pregnant women and children, deliveries in health units trebled and the country recorded a 43 per cent reduction in infant and child mortality (ISTEEBU, 2012). This suggests that the provision of free, publicly financed healthcare led to an uptake in services as the fear of detention and debt was reduced.

Many hospitals are undoubtedly grappling with a genuine financing problem, and often find it hard to collect debts from poor patients through normal legal channels. One Zimbabwean hospital official argued that many patients gave fictitious addresses, and that it was very difficult and expensive to employ debt collectors to recover costs later (New Zimbabwe, 2014). Moreover, some hospitals even frame detention as a benevolent practice. One, in Liberia, justified its policy on the grounds that many of its patients had previously been turned away from other hospitals for failing to make an initial payment prior to treatment. The hospital made the case that in detaining patients it was at least providing the treatment that the patients needed (Kanneh, 2013).

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Hospitals clearly regard detention as a strong motivator for patients to rally wider family networks to assist with payment, and assume that the families of detained patients will pool their resources to help with this (Otreмба et al., 2015). However, as noted above, research indicates that a non-trivial number of detained women have been abandoned by their families or partners.

Families that do publicize detention cases often seem to be motivated less by a desire to highlight the abusive or degrading behaviour endured by the victims than by the hope that publicity may persuade a philanthropist, politician or NGO to come to their aid in meeting their payment obligations (Jet, 2012). In some reported cases, the local church or mosque is responsible for making a public fundraising appeal on behalf of a victim of medical detention (Mohamed, 2014).

There have also been high-profile instances of politicians securing the release of disadvantaged patients. Such demonstrations of apparent philanthropy have been institutionalized in Kenya, where politicians receive a specific allowance for paying these types of costs. In 2016, for example, one politician in Kenya was reported to have entered several hospitals and handed over cash to pay for the release of a number of patients – including an 89-year-old woman who had been detained for three months (James, 2016).

This practice is also apparently widespread in Ghana and Nigeria (Straziuso, 2012; Ghana News Agency, 2014; Carmon, 2012). In one revealing case, a Ghanaian hospital appeared almost in denial about its own role in detaining patients, and instead bemoaned the fact that bill payments had stopped after the previous member of parliament had died – an event it said had ‘unfortunately’ led to prolonged detention of women in the hospital (Ghana News Agency, 2014). In Nigeria in 2016, also in 2016, the wife of the governor of Abia State paid the hospital bills of eight detained patients. The local newspaper publicized her generosity under the headline ‘Ikpeazu’s wife rescues nursing mothers detained over hospital bills’ (Udokwu, 2016), but made no comment on the fact of this ‘rescue’ having being undertaken from a hospital in the state governed by the benefactor’s spouse.

While governance factors contribute to the detention of vulnerable people, the main underlying cause relates to shortcomings in the health financing systems in the countries concerned. In particular, hospital detention for non-payment is a direct result of the heavy reliance on charging user fees for services when people require healthcare. As noted above, it is not surprising that this is more likely to lead to detention for the poorer and more disadvantaged members of society who cannot afford to pay.

The charging of healthcare user fees in developing countries has been a highly contentious topic in global health for many years. It was initially a policy promoted by development agencies, in particular the World Bank in the 1980s (Kim, 2000). The rationale for charging patients was that it would be an effective way to raise revenue for services and could contribute towards improved efficiency in the health system, while poor people could be protected from financial hardship by being exempted from payments (Akin, Birdsall and de Ferranti, 1987).

However, research conducted in developing countries over the last three decades has provided overwhelming evidence that none of these objectives was ever realized at scale. Instead, user fees have tended to raise little revenue, have incurred high administration costs (increasing inefficiency), and have represented a major barrier to poor people's access to essential healthcare (Yates, 2009). Exemption schemes designed to protect the poor have tended to be ineffective (Bitrán and Giedion, 2003), with only 1–3.5 per cent of the poorest people benefiting in Burundi, Sierra Leone, the DRC, Chad, Haiti and Mali (Ponsar, 2011).

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Mounting evidence of the damaging effects of user fees has led the World Bank to reverse its policy, to the extent that its current president has called these fees 'unjust and unnecessary' (Kim, 2013). Furthermore, there have been calls for those responsible for imposing their implementation and not changing policy sooner to be held to international account (Rowden, 2013).

The practice of hospital detention affects a person's right to health and impedes their ability to work. Detention in hospital for non-payment of user fees prevents people when well enough from returning to work, and can in turn push families into poverty or deepen their pre-existing poverty. Where families sell land or cattle in order to pay user fees, this may remove their source of livelihood and impede their right to earn a living (Human Rights Watch, 2006; Leive and Xu, 2008; Udokwu, 2016).

Recommendations for governments

Since medical detentions are caused by failures in governance and health financing systems, the solution appears to lie in remedial actions in these areas. Relying on philanthropists, NGOs, politicians and publicity campaigns to rescue vulnerable debtors from health facilities on an ad hoc basis will not tackle this problem effectively. There are two main policy interventions that could have an immediate impact in tackling this problem.

Legal ban

One action that national leaders should take immediately is to explicitly proscribe this practice in domestic law. There is no legal or moral justification for health facilities to detain people on their premises, in effect holding them hostage until their families settle their bills. It is striking that there appears to be wide societal acceptance in some countries of the assumed right of health providers to imprison vulnerable people in this way, when there would be outrage if a café or shop, for instance, were to detain a customer who was unable to pay their bill. In order to encourage a shift in societal attitudes, an outright ban on medical detentions should be imposed on all public and private providers. This could be enacted through a decree by the head of state, where constitutionally permitted, and/or the adoption of specific legislation. To ensure effective implementation of such a policy, it may be necessary to invest in improved governance mechanisms, for example by strengthening accountability systems so that civil society organizations and members of the public can alert authorities if detentions continue. Additional investment may be required in enforcement mechanisms. In particular, strengthening legal systems, including improved access to courts, would be critical in facilitating the enforcement of any prohibition and help facilitate the prosecution of perpetrators.

However, in implementing measures to ban medical detentions, it is important that health authorities maintain and fund access to emergency services and do not allow hospitals to turn people away because of a suspicion that they will be unable to settle their bills.

Universal health coverage

In many respects, the most effective way to tackle this problem is not through legal and governance reforms but through reforming health financing systems so that people are not presented with unaffordable medical bills. This would require reducing the use of direct charges to pay for health services, and instead moving towards pre-paid financing mechanisms that also pool contributions from across society.

There has been a tendency for health financing systems across the world to evolve in this way: compulsory public financing mechanisms (general taxation and mandatory social insurance) are replacing private voluntary mechanisms (patient fees and private non-mandatory insurance) (Savedoff et al., 2012). Indeed, this broad health financing strategy was explicitly recommended by the World Health Organization in its seminal *World Health Report 2010: Health Systems Financing – the Path to Universal Coverage* (Evans et al., 2010).

Universal health coverage (UHC) is achieved when everybody in society receives the health services they need without suffering financial hardship. It has been shown to deliver considerable benefits to societies in terms of improved health outcomes, fewer inequalities, accelerated economic growth and lower levels of impoverishment (Nicholson et al., 2015). For these reasons (and also because extending health coverage is a highly popular policy), achieving UHC was incorporated as a target within Goal 3 – to ensure healthy lives and promote wellbeing for all at all ages – of the UN’s Sustainable Development Goals in 2015 (United Nations, 2015).

UHC cannot be achieved while people are experiencing financial hardship owing to their inability to pay for healthcare, so by definition any country in which medical detention is practised is failing to achieve UHC. However, this problem can be effectively eliminated when countries adopt the most effective policies to achieve UHC, specifically by moving towards pre-paid public financing mechanisms that pool

resources from across society and increase coverage. Achieving UHC and ending medical detentions thus go hand in hand – as is evident from health systems associated with high health coverage rates (in most OECD countries as well as in countries including Thailand, Sri Lanka and Malaysia, and widely in Latin America) that do not experience the problem of medical detentions. Conversely, countries with low coverage rates and high levels of out-of-pocket health spending in sub-Saharan Africa and Asia tend to report most detentions.

Moving towards publicly financed UHC would enable hospitals to become financially sustainable without needing to charge significant user fees. It would also provide countries with the opportunity to meet the aspirations of the Universal Declaration of Human Rights (United Nations, 1948) and subsequent human rights treaties on the right to health. The attainment of UHC would therefore not only obviate the need for large out-of-pocket payments that push families into poverty, but also stop the unlawful practice of detaining patients in healthcare facilities.

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About the authors

Robert Yates is a senior fellow and head of the UHC Policy Forum at the Centre on Global Health Security, Chatham House.

Tom Brookes is a programme officer at The Elders. This paper does not represent the views of The Elders.

Eloise Whitaker is a previous fellow of the Improving Global Health through Leadership Development programme at the Thames Valley and Wessex NHS Leadership Academy.

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Cover image: Women admitted to the maternity ward at Roi Baudoin hospital in Kinshasa, Democratic Republic of the Congo, are counselled by a staff member on 3 March 2010, after having been detained at the hospital for non-payment of medical fees.

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The Royal Institute of International Affairs
Chatham House
10 St James's Square, London SW1Y 4LE
T +44 (0)20 7957 5700 F +44 (0)20 7957 5710
contact@chathamhouse.org www.chathamhouse.org

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