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**When Doctors Become Creditors:
The Detainment of Impoverished Patients in Uganda**

A Thesis Submitted to the
Yale University School of Medicine
In Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by

Michael Otremba

2012

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NOTE FROM THE AUTHOR

This written portion of my thesis represents only one half of a larger body of work, which also includes a documentary film entitled, “Twero: The Road to Health.” The documentary was made over the course of 2 years, including 6 months of filming on location in Uganda. Like this essay, the film explores the many challenges faced by patients and physicians within the East African nation’s health care system. In particular, the documentary follows a journalist who uses his radio station as a means to expose what is happening to patients, like Esther Ayugi, who find themselves unable to pay their medical bills. A DVD copy of “Twero: The Road to Health” has been submitted along with this written portion in fulfillment of my thesis requirements, and a transcript of the film has been included as an appendix to this essay.

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Abstract:

This essay explores the practice of imprisoning patients in private health care facilities. Despite the Ugandan government's promise to provide free basic medical services to all as a fundamental human right, the nation's inadequate health infrastructure is forcing many patients to seek assistance in a private sector, which most cannot afford. Underpaid by the government, many Ugandan physicians open private clinics, where they also struggle to recover the costs accrued by the many impoverished patients they treat. Employing an age-old strategy akin to debtor's prisons, these physicians then choose to detain patients who fail to pay their bills immediately with the hope that their family and friends will bail them out. In this essay, I will examine the historical, cultural, and political origins of this practice. I will first demonstrate how the provision of health care in Uganda has become both a commodity and a right. I will show how physicians in Uganda's private health sector feel an obligation provide patients with services, but which is at odds with their socio-economic survival. I will argue that Uganda's private physicians today have developed a role similar to that of creditors during the colonial period in Africa. These creditors were particularly essential to native peoples during times of famine, and employed two indigenous forms of debt bondage, pawnship and panyarring, as the predominate means of recovering loans from a destitute population. In connecting the practice of patient detainment to these historical practices, I will illustrate how a lack of alternative, legal methods to regain costs has contributed to its persistence today. I will end

the essay by describing how Uganda is not alone in wrestling with the issue of detainment for medical debt.

Methods:

This paper uses the following methods: a review of medical, public health, human rights, and African studies literature; analysis of Uganda health care policy; interviews with Ugandan health care professionals, patients, and government officials; and consultation with human rights, public health and health policy experts.

Esther Ayugi's Story

In 2010, I returned to Uganda for a third time to make a documentary film that would follow a complaint filed with the Uganda Human Rights Commission regarding the government's failure to provide basic health necessities guaranteed to all Ugandans. When I arrived at the commission's regional office in Gulu, however, none of their cases categorized under the right to health were what I had expected to record. Instead, the staff presented me with a "right to health" issue that I had never come across in all my prior research and clinical work in Uganda and elsewhere. It was an issue that I would discover was well known in the region, but not well documented. This is how I learned the story of Ms. Esther Ayugi. The following information comes from multiple interviews with Ms. Ayugi, members of her family, staff from the human rights commission office, Ms. Ayugi's physician, and a journalist involved in her case.

Almost exactly one year before I had arrived in the country, Ms. Ayugi had had a hysterectomy for an infected prolapsed uterus, which was performed at a private clinic in the town of Lira in northern Uganda. She was 40 years old and a single mother with 4 children. After the civil war in the north had ended 5 years prior, she and her children returned to a hut, constructed of mud and cow dung. Her family grew just enough beans, cassava, and ground nuts to feed themselves.

Ms. Ayugi had struggled for years with a prolapsed uterus, which had

prevented her from working in the fields. In the months leading up to her operation, her uterus had become infected and the pain from it unbearable. One of her sons, Joseph, who was 16 at the time, had ferried her on his bicycle to every nearby health center. After being turned down by multiple government health facilities because of either lack of resources or skilled medical personnel, Joseph brought his mother to Dr. Patrick Odongo's clinic, located in a town three hours away from their village [1].

At the clinic, Ms. Ayugi made an arrangement with Dr. Odongo for her care [1-3]. She agreed to pay a deposit of 100,000 schillings (about \$40) up front that would cover the expenses of her ultrasound scan, and the antibiotics required to treat her infection. After the operation, her other son, Alfred, a Ugandan soldier working with peace keeping forces in Juba, was supposed to send the rest of the money to cover the cost of the procedure, which was 350,000 schillings (about \$150) [3-5]. The operation took place inside Dr. Odongo's clinic (Figure 1).

After recovering for a week in the clinic's inpatient dormitory, Alfred could only send half the money necessary to pay off his mother's medical expenses. At this point, the doctor decided to detain Ms. Ayugi within his clinic until the rest of her bill was paid. Joseph, who was acting as his mother's caretaker while she was recovering, was required to do manual labor for the doctor as well as assigned to be a guard at the clinic's gates [1, 2, 6]. He was supervised by the nursing staff, and held responsible for not allowing other patients who couldn't meet their bills from escaping the

premises [6]. For his work, the doctor paid him 700 schillings (about 30 cents) a day, far lower than the average daily wage of a manual laborer in Uganda [1]. According to Ms. Ayugi and her son, if a patient escaped under his watch, the money owed by those patients would be deducted from his wages. Ms. Ayugi meanwhile was allowed to remain in her hospital bed, unless the clinic was overflowing with patients, at which time she would have to sleep in the kitchen. She received no medical treatment from the staff, and occasionally given food [1, 2, 5]. Often times, she and Joseph would beg for food and money from the family and friends of other patients.

Ms. Ayugi and her son remained in Dr. Odongo's clinic for two and a half months, because no other family member could raise the funds to pay her medical bill. She was released from the facility after a local radio news reporter had visited the clinic and learned about her story from other patients. When the journalist, Joe Orech, broadcast Ms. Ayugi's story on the radio, the doctor became furious with her, and ushered her out of his clinic immediately while withholding her medical records. Fortunately, a staff member of the Ugandan Human Rights Commission also heard the radio program, which is how its regional office took up her case.

Health care as a Commodity

Uganda's health system performance currently ranks 186th out of 191 countries according to the World Health Organization [7]. The country's life expectancy is still one of the lowest in the world at 52 years with nearly 1 in

7 children dying before the age of 5 and 1 out of every 35 women dying in childbirth [8, 9]. But this was not always the case, for Uganda's health care system was once recognized as one of the best in Africa during its early years of independence. Nearly all of the medical services in the country were provided in government facilities, and free of charge to patients [10-12]. Decades of civil and economic turmoil, however, had left Uganda's public health care system severely crippled by the end of the 1980s [11, 13-15]. A disintegrated state, scant resources and massive inflation forced Uganda's physicians to look for new sources of income beyond a government salary [14]. Many doctors chose to leave the country entirely. In 1991, there were an estimated 811 registered physicians working within Uganda, while 660 were practicing abroad where it was speculated they could earn salaries 20 times what the government paid [15]. Those who chose to work within the country were left to trade their practice of healing as a commodity either through informally charging patients for services that should be free in a government facility or by opening their own private clinics.

Shortly after coming to power in 1986, President Yoweri Museveni and his government's top two priorities for reforming the country's health care system were to rehabilitate medical facilities and to decentralize the way government health services were provided with an emphasis on primary health care [15]. This new decentralized system was modeled after the country's political structure, with an expected level of facility and number of staff to care for each tier of Ugandan society: village, parish, sub-county,

county, district, and country [16]. From 1980 to 1992, the number of Ugandans living within 5 km of a government health unit had increased from 27% to 49% [17]. Yet, despite this dramatic expansion in the population's physical access to health facilities, the quality of health services offered to them were still very poor as a result of inadequate government funding, especially towards staff salaries. From the 1987-1992, the government's health expenditure had increased from 4.3% of the national budget to 8.5% [18], yet the total health expenditures in Uganda was still only at \$7.73 per capita (\$2.82 of which came only from the government health expenditure) as compared with \$11-19 per capita in most other sub-Saharan African countries [19]. At the time, a government physician was only being paid a salary of \$52 per month, and with minimal economic incentives for health workers to operate lower level facilities, over 40% of their staff were unskilled laborers, such as ward maids or nursing aides [13]. In order to curb the low morale of underpaid health workers, and improve the services offered at its health facilities, the government began charging patients a fee to receive care at them starting in 1993 [15].

A large percentage of these new user fees at government health centers did in fact go towards supplementing staff salaries, but it had little impact on service improvements or on the need for staff to supplement their income from the government [17]. The continuation of low pay was also exacerbated by severely irregular intervals of payment, with instances of health care workers going years without receiving their government salaries

[13]. This led health workers to continue developing coping strategies for “social-economic survival.” [20, 21]. One strategy was to work in private clinics or drugs shops, where they could earn nearly double their salary [11, 14]. Susan Whyte describes the privatization of Uganda’s health service delivery as “explosive” and cites one example of a rural county in Eastern Uganda, which had no private facilities in 1971 but 20 years later had 11 private clinics. All government health workers became virtually part-time employees, spending a large part of their working hours in the private sector where their services had much more of a cash value [13].

In 2001, during campaigns for Uganda’s national elections, President Museveni decided to abolish all user fees at government health facilities, citing that they were creating a barrier to the general public’s access to care [22]. At this time, however, the government was still grossly underfunding the health sector, allotting only half the expected minimum percentage of its national budget that had it promised the year before to allocate as a signatory of the Abuja Declaration [23]. Even within the health care budget itself, wages and allowances for staff only made up 15% of expenditures while medical services and goods represented the largest portion at 50% [23]. Throughout the 1990s, health care workers held strikes, or threatened to strike, over poor pay frequently at hospitals throughout Uganda and continued even throughout the next decade [15, 24-26]. While their efforts led to modest increases in salaries, it had little impact on the health workers’

need to work in the private sector to earn a living wage or in the public's reliance on private facilities to get basic care.

Today, private for-profit facilities are estimated to be 46% of all health facilities in Uganda [27]. As of 2007, 51% of health expenditures in the country are paid out of pocket with only 26% coming from the government [8]. 54% of doctors who work in the public sector also work in private facilities [28]. The starting salary for a Ugandan physician in a government hospital is \$220 per month, while the lowest salary of any of its neighboring countries is \$560 per month and in South Africa salaries begin at \$2,400 [29]. Ugandan physicians continue to leave the country, with less than 60% staying to care for the local population [30]. Those who remain in the country prefer to work where they can receive a living wage for their services, which is in the private sector. In this way, Ugandan doctors continue to rely on their practice as a tradable commodity for their socio-economic survival.

Health Care as a Right

Above I have described how the provision of health care has become a precious commodity in Uganda, I will now describe how the nation also deems access to medical services to be a human right. In Uganda, access to essential medical care is established as a right legally, socially, and professionally. The Ugandan government has ratified an extensive list of international and regional human rights treaties affirming the right to health,

which has been broadly defined as a right to the provision of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health [31]. This right requires that health services, goods and facilities be available, accessible, acceptable and of appropriate quality [31]. The list of treaties ratified include the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All forms of Discrimination against Women, the Convention on the Rights of the Child and the African Charter on Human and Peoples' Rights. While the right to health is not stated among the operational articles of the Ugandan constitution, it is provided for within the constitution's National Objectives and Directive Principles of State Policy, which the government is still legally obliged to uphold [32]. There are also a variety of mechanisms in place to enforce the right to health. Most notably, the Uganda Human Rights Commission (UHRC), which in 2007 established a special unit for the purpose of monitoring and promoting the right. This unit offers a unique mechanism for individuals to directly bring complaints against the government for any failures to receive the basic medical necessities granted to them.

In Uganda, the right to access health services has also been instilled socially through the work of non-governmental organizations (NGOs) that have proliferated in the country since achieving its relative peace and stability. Internationally, the idea of using human rights to promote access to medical care became popularized in late 1980s through the work of Jonathan

Mann, the former head of the World Health Organization's (WHO) Global AIDS program [33]. In particular, he emphasized the need for a human rights approach, based on the principles of non-discrimination and equitable access to health care, as essential for stemming the HIV/AIDS epidemic in Africa [33]. In Uganda, the epicenter of the continent's epidemic, Mann's vision was adopted by local NGOs working to improve the country's health care system. According to Rosette Mutambi, executive director of The Coalition for Health Promotion and Social Development in Uganda (HEPS-Uganda), "We started off with the debate around access to medicines by people living with HIV/AIDS. By then we did not think that anybody would ever get them because they were too expensive even for the richest Ugandan...but from the time I joined this health movement to now, people are receiving ARVs free of charge and it was [from] using the human rights perspective" [34].

Over the past decade, numerous NGOs incorporating health and human rights have been established in Uganda. Of the 83 health NGOs registered on the Uganda National NGO website, 35 of them are also dedicated to joint human rights work [35]. Along with this increase in volume, NGOs have also broadened the scope of their work from applying human rights to securing more equitable access to HIV medications to general health services at large. The majority of the work carried out by these NGOs tends to be education and advocacy. For example, the organization HEPS-Uganda has as one of its core programs a community outreach service, through which they disseminate information regarding the population's right

to access health services. HEPS hosts educational sessions for all levels of the general public as well as with health care workers (Figure 2). Several NGOs have also formed broad coalitions to carry out nationwide campaigns for advertising the right to health, with some of Uganda's most popular celebrities even taking part. Since 2006, a group of NGOs, lead by the Uganda National Health Consumers Organization, have also been successful in creating a national Health Rights Day, which falls on December 7th. As a result of all these efforts, advertisements promoting health care as a right have become part of the visual culture within Uganda. It can be found on office posters (Figure 3), advertised on the street (Figure 4), and even promoted on clothing worn by government health workers (Figure 5).

Within the Ugandan medical profession itself, equitable access to health care is also reaffirmed as a right. The Ministry of Health has an office specifically assigned to monitoring the right to health, and the Uganda Medical Association even has a committee dedicated to it, which is chaired by a physician-lead NGO, The Action Group for Health, Human Rights and HIV/AIDS. In its code of ethics, the Uganda Medical and Dental Practitioners Council not only recognizes access to health care as a human right but even mandates physicians to uphold it. The council is authorized by the government to regulate and monitor medical practice within the country. All Ugandan physicians are required to register with the council. In Section 4 of its code of ethics, it clearly states that physicians are to respect all human rights, and section 8 explicitly states that no practitioner shall deny health

care to a patient or emergency treatment [36].

Doctors As Creditors

Now that I have shown how health care has come to be regarded as both a right and a commodity within Uganda, I will describe how the country's physicians have been placed in the role of compulsory creditors as a result of this duality in the setting of having to provide care for an impoverished population. As shown above, Uganda's physicians are unable to support themselves from a government salary and rely on payments for their services in the private sector in order to earn a living wage. Ugandan physicians working in the private sector do not receive any support from the government to subsidize the care they provide. While a national public health insurance scheme has been debated in parliament, currently only 3% of the population has health insurance [37]. 80% of private-for-profit facilities in Uganda are also owned individually by a health care provider [27]. In this way, physicians are not only independently in charge of the care they provide within their clinics, but are also solely responsible for maintaining their clinic's financial livelihood.

With two thirds of Ugandans living on less than \$2 per day, much of the population cannot afford the basic costs of services at private facilities. For example, a consultation fee to see a physician in the town of Lira costs the equivalent of \$1.30 and medication for malaria, the most common cause of all clinical visits in Uganda, costs roughly \$3.50 [38]. One private physician

described the impact of treating one patient with malaria for free in his clinic. “Look at the cost now you have incurred. You have lost medical reagents. You have lost the drugs. You have lost the drug envelope they use for putting the drugs in. You have even lost a pen because you used the thing for writing. So you have lost a lot of things by treating this lady free... And since you don’t have any support, any funding, you have to struggle for a few weeks more to recover whatever you have lost so that you can get more drugs to give to the incoming patients” [39]. Several private physicians estimated the amount of patients unable to afford their medical services were between 40 and 75% [4, 39, 40]. Put in this position of having to treat so many patients unable to meet the costs of their services, however, these physicians are still obliged to treat patients first and then worry about retrieving the payment afterwards. As one private physician explains, “It is unethical... if a patient comes to your facility, sick, needs an operation, needs resuscitation, then you start think of money first before you help the patient, that is the part that is unethical. But treat the patient first, and if the patient has recovered, then definitely you demand for payment” [40].

It is in this way that the doctors become compulsory creditors. Ugandan physicians are obliged to offer their patients treatment as a right, “a legal, moral and ethical entitlement.” They are compelled to provide their services and goods to patients up-front but saddled with the duty of recovering the costs from them afterwards. The ways in which costs can be recovered from insolvent patients are severely limited. In Uganda, there is no

public credit registry and private credit bureau coverage recently began in 2008 with currently only 3% of the population registered [41]. Therefore, doctors cannot rely on a credit agency to recoup their costs. The official procedure that physicians are supposed to use in reclaiming debts from patients is through the Ugandan civil court system. This measure, however, is thought to be impractical for physicians as it can take up to years for civil cases to be heard in court, and as one private physician also notes, “sometimes the legal fee is much more expensive than the, maybe 800,000 Ugandan shillings, you are trying to recover from them” [40]. Without any financial support from the government, and no functional mechanism for reclaiming money owed to them, private physicians in Uganda have adopted an age-old strategy for recovering debts from their patients, detainment.

Detention of Patients

As in the story of Ms. Ayugi at the beginning of this essay, private physicians detain insolvent patients at the time of discharge with the expectation that family or friends will raise the money to bail them out. Patients do not receive any extra care during the time that they are forced to remain within the clinic. Visiting family members or attendants who have accompanied patients to the facility are also still responsible for feeding the patients. The doctors, however, typically continue to provide the detained patients with a bed, and allow them to use the facility’s water and electricity [40]. As also described in Ms. Ayugi’s story above, nursing staff or guards at a

clinic's gates are responsible for making sure that patients do not escape before medical bills are cleared. Family members of insolvent patients, like Ms. Ayugi's son Joseph, have also been detained and required to perform duties for private physicians to help pay off medical bills [40, 42, 43].

The practice of detainment has been described as "rampant" and "occurring everywhere" in Uganda, but no research has been done on the subject [40, 44]. Reference made to the practice, however, can be found in numerous newspaper articles [43, 45-47]. The Uganda Human Rights Commission has even ruled on a case against a major private hospital in Kampala for having detained a patient who was unable to pay a \$45 bill for cataract surgery, with the hopes that it would decrease the incidence of other private facilities from carrying out the practice [44, 47]. According to one private physician, the types of patients who most often get detained are emergencies, in particular obstetric surgical emergencies [40].

The amount of time that patients are detained in private facilities also appears to be variable. According to the same private physician above, patients at his facility are usually only detained for about a week, because beyond that point he feels that he is losing more money by keeping patients around since they use his utilities and occupy a bed [40]. Ms. Ayugi, on the other hand, was detained for several months, and others have been reported to be held for weeks at a time [47].

How or when this practice of detainment for medical bills began in Uganda is still unclear, but it has been noted to take place as early as 1997

[43]. Detainment for debt occurs in other areas of Ugandan society as well. In particular, civil debtors can be sent to jail for failure to clear bills, and there has even been a recent report of a private school detaining a student whose parents failed to pay her school fees [48]. Debt bondage, however, has had a long history in East Africa in the form of “pawnship,” a system by which “a person was held as collateral for a loan”[49]. Pawnship has existed amongst Bantu and Nilotic tribes prior to colonialism and was particularly prevalent in communities during times of famine [50]. This system was distinguished from slavery in that a pawn was not the property of a creditor, while a slave was the property of a master. In pawnship, creditors have control over the labor and activities of a person who pawns himself. Creditors, however, merely own the contract by which a person has agreed to become a pawn and not the pawn himself. Within this system, those who chose to pawn themselves would work for their creditors to pay for the interest being accrued on a loan while relatives would assist to pay off the original debt [49]. Pawnship was a common the means of survival for destitute populations. For example, during the 19th century the Maasai people of North Eastern Tanzania would pawn themselves or their children to Spiritan missionaries for food and protection during times of great famine [51].

In contrast to pawnship, another system of debt bondage, “panyarring,” was especially popular with indigenous societies in West Africa. Unlike in pawnship, where there was a contractual agreement in advance of a loan, panyarring “involved the seizure of goods or people to

force payment or their sale to compensate the creditor” [52]. In other words, panyarring was the practice of holding a debtor or his property hostage until bills could be cleared. Panyarring as a system of reclaiming debts particularly thrived in times of civil conflict and instability, when the promises of pawnship or credit security could not be assured [53, 54]. Despite their differences, it is of note that panyarring and pawnship share the same ideological basis. Both have been justified based on kinship, the idea that relatives or next of kin are responsible for coming to aid of each other [53]. By the beginning of the 20th century, pawnship and panyarring had become outlawed throughout most of Africa as a result of colonial repugnance to them, yet the practices did not completely die out [55, 56].

The detention of patients in private health facilities in Uganda shares a large number of similarities with the practices of pawnship and panyarring. Firstly, a unique African appreciation of kinship, the ideological basis for the two historical practices of debt bondage, has also been suggested as the rationale for why the practice of detaining patients has become so common place in Uganda. In an interview with the Dean of Gulu University Faculty of Medicine, the doctor explained:

In our African culture, and individual's health problems are the community's health problems. An individual's successes are the community's successes. And an individual's riches are the community's riches. We share everything... When a patient is unable to pay and if a clinic is compassionate, they forgo the

charges, and grudgingly they release the patients to go. But those that are not compassionate hold the patient and the patient's relatives have to come to the aid of the patient. Again, going back to what I said earlier on, we share our health problems with relatives and community. So quite often relatives and communities come in to rescue the patients [57].

This understanding that relatives are expected to bail patients out was also echoed by both private physicians who detained patients in their defense of the practice [4, 38]. The physicians agree to treat insolvent patients because they assume that the next of kin will eventually come to rescue them by clearing the bill.

In the same way that African creditors historically relied on pawnship as a tool for collecting debt from destitute families in times of famine, private physicians in Uganda today are also relying on detainment as a means of recovering costs accrued by impoverished patients who are in the direst of situations. As noted earlier, the types of patients who are most commonly detained are those who present with an emergency and who have not had the chance to raise funds in advance. With so much of the population living on less than \$2 per day, many patients who need emergency treatment possess little more than themselves to offer as collateral for the services they receive. In Ms. Ayugi's case, which was not an emergency, she had sold a number of her primary assets, a chicken and some beans, in advance of going to Dr. Odongo's clinic. Even with the money she had received from her son in

the military, she was unable to raise half the funds that would be required for her procedure. It is in these types of circumstances, where patients have so little means of revenue, that the doctors are choosing to use the patients themselves as collateral for debts. Unlike in pawnship, however, there is not a contractual agreement between the doctor and the patient stating either that detainment will result for defaulting on a bill or that a patient will be required to work to pay it off.

In this way, the practice of detaining patients is more similar to panyarring. As noted above, panyarring was particularly prevalent in times of instability or civil conflict, when there was little ability to enforce that debts would be repaid other than by holding property or persons hostage. While although Uganda has achieved relative stability and peace over the past few decades, the structures for civil redress in the country are still dramatically deficient. As of 2007, nearly 40% of civil court cases in Uganda were over 2 years old [58]. Local bailiffs are also unreliable to carry out their jobs as they lack adequate training [59]. As mentioned earlier, credit agencies are in their infancy in Uganda too. In the setting of having no assured mechanism to enforce contracts, private physicians are resorting to the “hostage system” of economics by imprisoning their patients as opposed to gambling that, if discharged, they will return to pay their bills.

Uganda is Not Alone

Detention of insolvent patients in health care facilities occurs in numerous countries throughout the world. Stories about detained patients can easily be found in newspapers from Ghana, Kenya, India, and Nigeria [60-63]. In May 2011, the Philippine government tried to put an end to the practice in its country by passing the “Patient’s Illegal Detention Act.” Despite all the news reports and the evidence of its prevalence on a global scale, to date there has been only one official study investigating the practice. The study was conducted in 2006 by researchers from Human Rights Watch and examined the detention of insolvent patients in government hospitals in Burundi. The study found that 9 out of 11 hospitals were routinely detaining patients for failing to pay their bills. It also reported that two-thirds of all patients who were detained had been admitted for surgery, and a majority of them were women who required cesarean deliveries [64].

The demographics and experiences of patients were not the only similarities found between the practice of detention in Burundi and Uganda. The sentiments and rationale of the physicians were also resonant. In an interview with Joe Amon, the lead researcher for the study in Burundi, he noted that “the doctors that we interviewed and the hospital directors said that they had no choice but to detain patients... they didn’t like the idea of detaining patients, but they often justified it as being what was required, and they often minimized it, saying that they weren’t really detaining patients,

they were holding them for a small period of time while their families got their financial house in order” [65].

Conclusion

In Uganda, access to health care is regarded as right, which the government is legally obliged to protect. In the decades since Uganda has achieved relative peace and stability, the government health sector has remained significantly underfunded and physicians continue to work in a private sector for ‘socio-economic’ survival. Despite working outside of government facilities, these physicians still attempt to live up to their obligation to provide all Ugandans with access to medical services while trying to make ends meet. Struggling to recover the costs accrued by the overwhelming number of impoverished patients in need of medical care, doctors have become creditors and adopted age-old strategy akin to debtor’s prisons within their clinic walls. These physicians choose to detain patients who fail to pay their bills at the time of discharge with the hope that their family and friends will bail them out. This contemporary form of debt bondage has many similarities two historical indigenous practices of credit security on the African continent, pawnship and panyarring. Despite the hopes that these sort of practices would have been eradicated by now, a lack of effective measures for civil redress and financial assistance from the government have left Ugandan physicians choosing to violate one set of human rights for sake of providing another.

Figure 1:



Figure 2:



Figure 3:

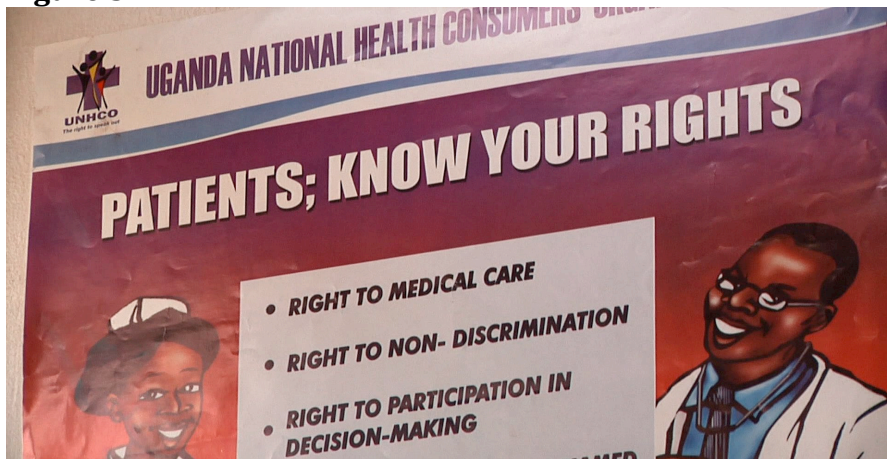
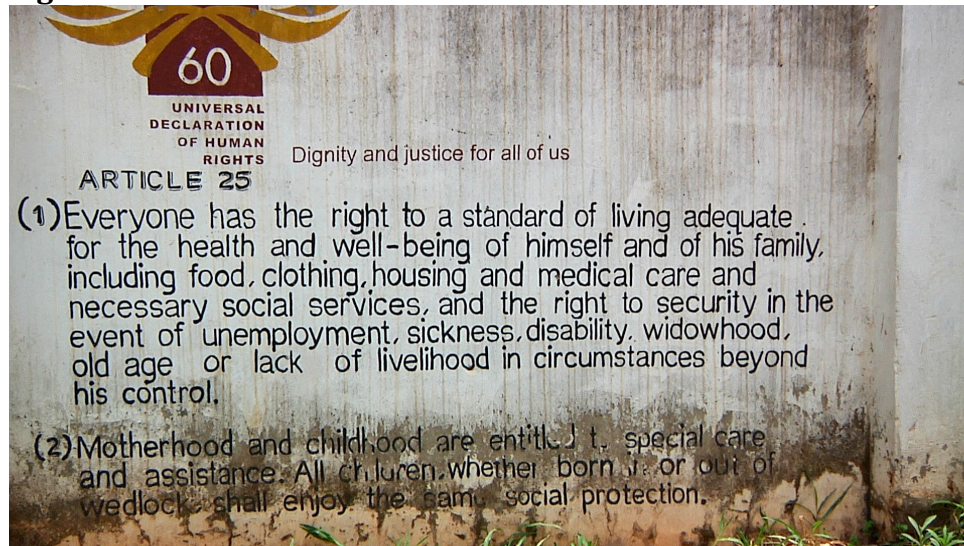


Figure 4:**Figure 5:**

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Appendix

Transcript for “TWERO: The Road to Health”

Total Running Time: 31:28

Director: Michael Otremba

Yale University

3/30/2012

[SUPER TITLE: Lira, Uganda]

JOE ORECH, Radio Reporter – Voice of Lango: When I was a child, I dreamed about becoming a radio presenter. In my village, I would always see people gather around one radio set and they are listening to issues coming over the radio. My role as a journalist is that I am a watchdog. I report and present on issues that impact on people’s life, especially health.

[SHOW TITLE: TWERO The Road to Health]

JOE ORECH [voiceover]: In Uganda, we are struggling to bring drugs and health services for free to all our citizens. And we are also helping people understand that they have a human right to good health.

[While riding his motorcycle through Lira town, Joe Orech passes a billboard with an advertisement by President Yoweri Museveni and his political party, the National Resistance Movement, promoting their success in expanding health facilities throughout the country. Following the billboard ad is a shot of a public notice from a government hospital: “The general public is reminded that all hospital services / treatment are free.”]

JOE ORECH: I visited Aduku health center to find out the problems that the patients were facing.

[Joe Orech arrives at Aduku Health Center, a government run facility. While interviewing patients, he encounters a family, who he decides to follow throughout their visit to the health center.]

JOE ORECH [voiceover]: When I was visiting Aduku health center, I met this father, Yeko, with his two daughters. Yeko is a poor farmer who earns less than a dollar a day. His two daughters have both been sick.

ADUKU CLINICAL OFFICER [subtitles]: We found that the blood smear is positive, there is malaria parasite in the blood. And now I've diagnosed the condition being malaria. And I've prescribed some treatment here, the Coartem, which each child has to take for three days and Panadol for fever. This is still uncomplicated malaria but it can become complicated if it's not treated, because a child has to get treatment within 24 hours of this diagnosis.

[SUPER TITLES: Malaria is the leading cause of death in Uganda. Over 70,000 children die from malaria each year.]

[Joe Orech accompanies Yeko and his two daughters to Aduku Health Center's drug dispensary, where the family hopes to receive the antimalarial medication, Coartem.]

ADUKU NURSE [subtitles]: It's for Coartem

JOE ORECH [subtitles]: Is Coartem there?

ADUKU NURSE [subtitles]: But they are not there.

JOE ORECH [subtitles]: So what do you advise them to do?

ADUKU NURSE [subtitles]: Now what I can tell him, maybe if he has some money, he can maybe go and buy in some clinic. There they can help him.

JOE ORECH [subtitles]: But in the mean time you don't have Coartem?

ADUKU NURSE [subtitles]: For the mean time, I'm not seeing it here.

JOE ORECH [voiceover]: Forty key medicines in this country that treat the most common diseases are available in government medical facilities only half the time.

CELESTINO OJOK, Clinical Officer – Cwero Health Center: In Uganda, there is a drug shortage at the facilities. Drugs come every two months but in not in the quantity that can serve our population.

[While boxes of drugs are delivered to Cwero health center, a government facility, Celestino Ojok and the rest of his clinic staff review the delivery paperwork. Flipping through the inventory pages, Celestino notes that Septrim, an essential prophylactic medication for HIV patients, was not included with the delivery.]

CELESTINO OJOK [voiceover]: As I talk now we're lacking oral antibiotics. It's not very nice when you see a patient you have diagnosed and you have nothing to give that patient

BERNARD ODONG, Clinical Officer – Kal Ali Health Center: I look at my patients, I know what I have to do for them, but I cannot do it. I push their issues up. Nothing is done about it. Then, what do I get just sitting and talking to them? I know it's a kind of psychological treatment to the patients. "At least our doctor is here talking to us. He is a good person." I get that. But what does it mean to them? My smiles will not heal them of their ailments, no.

CELESTINO OJOK: You lose morale of working. That is the dilemma we are in.

MOSES MULAMBA, Human Rights Lawyer: In the history of Uganda, there is a strong understanding that we can use human rights to prevent, for instance, torture. But this is not the case when it comes to people appreciating the fact that they have the right to access health care.

ROSETTE MUTAMBI, Executive Director – HEPS Uganda: Because people were more aware about women’s rights, children’s rights, but health was not among those ones. So, I think that the communities would be surprised to know that actually health is a human right. So, we train leaders who in turn also train the communities on their health rights and their responsibilities.

[Near a rural trading outpost, a crowd of villagers gathers under a tree to listen to an instructor from HEPS Uganda talk about the community’s right to access medical care in government facilities.]

HEPS Community Instructor [translated subtitles]: As human beings we have human rights, and under human rights we have a right to health. Our government has committed to provide free health services in public facilities.

CELESTINO OJOK: The right to health can be translated as *twero me yotkom*. In other words, the community have the right to access quality health care services and the government has the obligation to render such services.

[A poster sponsored by the Uganda Health Consumers Organization reminds all patients to “Know Your Rights.” Flanked by a cartoon drawing of a Ugandan physician and nurse, individual rights related to health are listed in the middle of the poster. At the top of list is the right to medical care.]

ROSELYN SEGAWA, Uganda Human Rights Commission: It's prescribed in our Constitution the patient is entitled to certain things. They're entitled to drugs being available, services being available, the Health care Services have to be accessible; they have to be of a certain quality.

[A tall billboard in the middle of Lira town tells the community to "Honor Your Vote... It's Your Life! Vote A Leader Who Will Promote Health Care In Our Area." Beside the billboard's headline is a large photograph of two men holding a placard promoting the right to health in the local language, "twero miyo kwo me yotkom."]

[SUPER TITLE: During recent elections the ruling NRM Party advertised the success of Uganda's health care system.]

[Images of president Yoweri Museveni are prominently featured on billboards that market his political party's success in expanding the country's number of public health facilities. It states, "Every county and sub-county in Uganda now has a Health Unit. Now 74% of Ugandans live within 5kms of a dispensary. In the next 5 years, we will focus on provision of medicine, modernizing medical facilities and health workers' welfare. Vote NRM. Vote Yoweri K. Museveni."]

[Interwoven with gloomy music and grainy, archaic video footage of Ugandan patients looking dejected and sad, a television commercial begins with the text, "there was a time, when good health care wasn't for everyone." Then suddenly the commercial's music rapidly increases its tempo and energy while a bright yellow screen flashes the headline "And Now with the NRM." This is followed by sequence of images depicting modern looking health facilities, new laboratory microscopes, well-equipped operating rooms with surgeons busy at work, and children receiving immunizations. The images are accompanied with messages such as "Every County in Uganda, Has a Medium Sized Hospital" and "Immunization of Children Now at 85%"]

BERNARD ODONG: For sure the politicians can get out there and make it very loud to people, "We are providing this. We are providing this." And when it comes to the implementers, you find that those things are not there.

PETER KUSOLO, District Health Officer – Lira District: This country says there are free health services but according to World Health Organization recommendation, this country is supposed to have at least \$40 per person per year to give the expected minimum standard of health care. However, if I talk about the budget, the national budget that we are running now, it is only \$9 that are available, less than a quarter. So right from the beginning, we can't have enough supplies.

DR. EMILIO OVUGA, Dean Faculty of Medicine-Gulu

University: I don't think the government lacks the resources to provide for drugs. The drug supply system is rather complex and the bureaucratic system itself is complex. So while drugs may be available, getting them out may be difficult because of the process involved. As a result, we often read in the papers of drugs being burned by National Drug Authority because they have expired.

[A newspaper headline states "AIDS drugs worth billions expire in stores" above a photo of Members of Parliament touring the warehouse of Uganda's National Medical Stores.]

ROSETTE MUTAMBI: Also there are people taking advantage of the limited resources to make them seem like the resources are not even there. So then corruption also enters. So limited resources gives a gap to corruption because people with responsibility can hide behind the limited resources. So even the little that is being released is not reaching the people who need it.

CELESTINO OJOK: When one is sick and the facility does not have drugs of course the only option is to tell them to go and buy drugs from the private practitioners.

JOE ORECH: There are two different health sectors in Uganda, we have the private and public sector. When you go to the public health sector, there is this problem of drugs not enough for the patients that visit the health center everyday. But when you go to the private sector, there is this problem of overcharging the patient.

[Having received no medicine from the dispensary, Yeko and his two daughters leave Aduku Health Center on their bicycle. Joe Orech accompanies them to their village home.]

JOE ORECH [voiceover]: Yeko must raise money for medicine before approaching the private drug dispensaries. He must buy medicine for his daughters, medicine that should be free.

JOE ORECH: As they come home, there's nothing to pick immediately. There's no money in the bank, there's no money at home.

JOE ORECH [voiceover]: He must sell one of his family's primary assets.

[Yeko and his two daughters chase down a chicken in the bushes around their village home.]

JOE ORECH [voiceover]: Yeko hopes to get 10,000 shillings for his chicken in the nearby town.

[Joe Orech accompanies Yeko while he tries to sell his chicken to two men in an alleyway alongside a restaurant in Aduku town.]

JOE ORECH: The Owner of the chicken wants 10,000 but the buyer wants to give him 8,000 So he has reduced to 9,000 but still the buyer is saying it should go to for eight. Eight is better.

JOE ORECH [voiceover]: The chicken only raised 8,000 shillings.

[Joe Orech goes with Yeko into a private drug shop where the farmer purchases medicine.]

JOE ORECH: So treatment of malaria for the average child of about 13, 12 years is going to be 8,200. That is for one child. Now since he has two

children, that means he has to part with 16,400 for the two of them, or something relatively that. But for now, he is only going to buy one. Now that was meant for one child, but they are going to share between them, the two of them. And tomorrow again when he gets money, then he'll buy another drug. Then they will keep treating themselves like that.

JOE ORECH: To see that Yeko was not going to treat this child because of lack of drugs in the public health center, it was so sad and so sorry for me because any time I would imagine this child is going to lose her life.

MOSES MULAMBA, Human Rights Lawyer: The clear fact that families are dividing medicines shows that there is failure on the part of the government, shows that the community is left with nothing but to go with the ways like the division of drugs which is...shows a sense of hopelessness within the community. And we think that that is inhuman.

[Large crowds of patients, many of them women with young children, gather outside of government health facilities as they wait to be seen.]

[SUPER TITLES: In the United States there is 1 doctor for every 390 patients. In Uganda there is 1 for every 15,000 patients.]

DR. DRAKE ADUPA, Obstetrician Gynecologist: It's unfortunate that doctors in Uganda, they work almost 24 hours, because you find there are some districts which we only have one doctor in the whole district. And like, if you see, like in the whole of Lango sub-region, I am the only senior consultant. That is one of the problems. However efficient you are, even a machine has to get a time to rest.

DR. RICHARD NAM, Private Physician: With these huge African populations especially in Uganda we have more than 30 million. With all these problems, we go to public sector, we're too many, funding for health is too low, we don't get enough of what we're supposed to get. So what do we do? The population overflows to private sector where they can get better services.

DR. DRAKE ADUPA: Most of us, who now work in Northern Uganda, would prefer to work in private sector. Some work both in government and also in private sector. The main reason is because of the pay. A senior consultant or consultant doctor in Uganda earns equivalent of seven hundred dollars take home per month seven hundred dollars which is something very meager considering the level. So if you want to make ends meet, you have to work in the private.

[Radios of all different shapes and size are sold in the local market. In shops throughout Lira town, staff listen programs on the radio as they work.]

JOE ORECH [presenting on radio - translated subtitles]: In the Studio, I am Joe Orech. In our news bulletin this morning we have learned that some patients who go to private clinics end up being detained due to huge medical bills that they cannot pay. We are hearing that in some health facilities you are simply detained until the bill is cleared!

ROSELYN SEGAWA: We learned about the case of Esther Ayugi from Voice of Lango radio station. We moved in to investigate. Found out the facts were true. Esther Ayugi is from Lira and she was detained for failure to pay her medical bills.

[In front of her rural home, a hut made of mud with a grass roof, Esther Ayugi uses a walking stick to stand up. Esther's son, Joseph Opio, can be seen behind her as he cleans his bicycle.]

[SUPER TITLES: Esther Ayugi suffered from a debilitating gynecological problem that required surgery. For years, she sought help from government clinics that were unable to treat her.]

ESTHER AYUGI [translated subtitles]: I had to send my son to sell beans and a chicken to raise money to go to another clinic. My son then used a bicycle to bring me to Dr. Odongo's clinic.

[Esther Ayugi rides on the back of her son Joseph Opiio's bicycle as he peddles it through the rural countryside.]

[SUPER TITLES: In Uganda, hospitalized patients are accompanied by family members who feed and care for them. While in Dr. Odongo's clinic, Esther's teenage son Joseph looked after her.]

[Esther Ayugi tells her story to Joe Orech under a tree at her village home.]

ESTHER AYUGI [translated subtitles]: To see the nurse we paid 1,000 shillings, then to see the doctor 2,000 shillings, and again 100,000 shillings for the doctor to do a scan. That's how the doctor diagnosed my infection. I was told to stay at the clinic for 2 days while being treated with some drugs. Then I underwent my operation on the third day.

[SUPER TITLES: Dr. Odongo charged Esther the equivalent of \$200. Her family was able to raise \$135.]

DR. DRAKE ADUPA, Private Physician: Northern Uganda is a poor area, abject poverty. The biggest challenge we usually get in the private sector is one, patients are not able to meet the cost. They are not able to afford it. If a patient comes to your facility, sick, needs operation, then you start think of money first before you have the patient, that is the part that is unethical. But treat the patient first, and if the patient has recovered, then definitely you demand for payment. The ones who we tend to detain are those who come as emergency. Sometimes we prolong their stay up to around three or five days thinking that maybe they will go and get some money from some other place.

DR. EMILIO OVUGA: Where a patient is unable to pay and if a clinic is compassionate, they forgo the charges and gradually release the patients to go. But those that are not compassionate hold the patients, and the patient's relatives have to come to the aid of the patient.

[Megwa clinic is a single story cinder block building. Behind its tall, metal barbed gate, the clinic's sign is clearly labeled in pastel blue paint and bordered with two Greek

crosses, universal symbols for health care. A chain-linked fence, capped with barbwire, stretches around the clinic.]

[SUPER TITLE: Esther's Doctor agreed to an interview but refused to appear on camera.]

DR. PATRICK ODONGO [voiceover, subtitles]: This business of detaining patients, actually it's not detention as such. Because, when we give you the services you get here, we work out our bill, then we wait for you to bring the money. So, not that we are detaining you, no; we assume the relatives, they are out there looking for the money to come and bail you out

JOE ORECH: By the time we heard about Esther's story, treatment had ended long ago, two to three months. Now, keeping Esther up to this time, three months, would mean Esther is a prisoner.

ROSELYN SEGAWA: We also learned during investigations that Esther's son had been forced to do manual labor and he was also working as a guard at the, at the doctor's clinic.

[Joe Orech interviews Esther Ayugi's son, Joseph Opiio, in front of the family's village home.]

JOSEPH OPIO [translated subtitles]: In November, the doctor was able to do surgery on my mother, that was fine with me. Then in the month of December, the doctor had me become a guard, which made me really sad.

ESTHER AYUGI [translated subtitles]: Whenever a patient would escape the doctor would punish my boy. My boy was given food once a day and 700 schillings to pay for our necessities. But when any patient escaped from the clinic without payment then they would refuse to pay him.

JOSEPH OPIO [translated subtitles]: In there I can say that your life is no better than that of a prisoner.

JOE ORECH [translated subtitles]: How? In what way?

JOSEPH OPIO [translated subtitles]: When you are in the clinic as either a patient or an attendant you are not allowed to leave its gates freely. You must ask permission to leave the clinic and a nurse can give it or not.

DR. PATRICK ODONGO [voiceover, subtitles]: And yet he knows it's not true. Everybody knows that it's not true. How was he being detained? Was he under lock and key?

JOSEPH OPIO [translated subtitles]: The doctor instructed a nurse at the front counter to keep watch over me, because he was worried if I escaped, my mother would also try to leave.

ESTHER AYUGI [translated subtitles]: There reached a time when the doctor further restricted our movement and my boy was no longer paid. That was in February and March when we suffered a lot and no one came to visit us.

DR. DRAKE ADUPA: Detention of patients who have not paid happens everywhere, in big cities and even smaller clinics. Currently even I have a patient I was supposed to have discharged two days ago, but she's always saying, "ok, tomorrow they will bring the money. Tomorrow, the next day they will bring the money." So we keep detaining according to the time she is saying the money is coming. But some can stay up to five days or one week. Then you know exactly they are not going to bring the money. When we consider using all utilities, the bed, accommodations and so on, that's when we prefer, I'd rather discharge them rather than keeping them here.

ROSELYN SEGAWA: If you can't get paid for your services, you can sue in a civil court, of course it's a long process but it's the proper process.

DR. DRAKE ADUPA: Claiming the money from the courts can be even more costly than the money you are trying, ah, you are trying to claim. And it is time consuming, sometimes it can drag up to for one year claiming that amount. And also, most of these patients will abscond or run away, are themselves very poor. So you go to the court, then you say the person is supposed to pay, but where is he going to get the money?

ESTHER AYUGI [translated subtitles]: Our plight only got attention when some people came to visit another patient and helped us with some food. While coming to visit the other patient, these people learned that I had been without food for one week. I was so weak. I couldn't even walk or go to bathe because I had nothing to eat.

DR. EMILIO OVUGA: Patients need to be protected. But beyond that people need to be aware of expectations. You see private clinics must survive. They pay for their staff, they pay rent, they must purchase drugs and equipment, they pay tax. And so patients who opt to go for care in private clinics need to be aware that they must meet the costs.

ROSETTE MUTAMBI: Why she went to the private sector when she knew she could not afford it? Most likely the reason is that she had tried out the government hospital and she couldn't get a service. Many cases like that happen. So people who are not as brave, I think she is a brave woman, people who are not as brave, once they go to the government and the services are not available, they go home, and maybe die.

JOE ORECH: Esther was finally released when the story came out. The doctor felt ashamed and really wanted the story not to continue so his clinic would continue making more money.

ESTHER AYUGI [translated subtitles]: I am very glad that my name went on the radio. Because had it not been that way, I would still be stuck in there. But now that I'm out, I'm able to take care of my children again.

[Esther Ayugi, her children and relatives sit together outside the family's village home.]

[SUPER TITLE: After her release Esther chose not to sue for unlawful detention.]

ROSELYN SEGAWA: Doctors are untouchable because they are very few and you will need a service sooner or later so if you sue them, that could spoil relations between you and them, and at the end of the day, you need the service more, so people kind of take the horrible treatment. I mean, I would take it because I know the situation.

[SUPER TITLE: Instead, the Human Rights Commission has taken up Esther's case.]

ROSELYN SEGAWA: With Esther's case investigations are now complete what's going to happen next is that it's going to be presented before the Tribunal and a decision will be made.

[On the cover of the Uganda Human Rights Commission's file for Esther Ayugi's case, the commission is listed as the complainant and Megwa Clinic as the respondent. In the middle of the file, written in marker with large lettering is "Illegal arrest and Detention. (Liberty)"]

ROSELYN SEGAWA: If it's found in Esther's favor could be an order for the doctor to pay money to her for having detained her unnecessarily and hopefully the decision will also deter other doctors or other medical professionals who detain their patients for failure to pay.

[SUPER TITLE: Even though Doctor Odongo released Esther he kept her medical form]

ESTHER AYUGI [translated subtitles]: When I went to another health center for the first time they asked for my medical form. I told

them that it was still at the clinic. They asked, "Which clinic?" I told them Megwa Clinic, Dr. Odongo's clinic.

JOE ORECH: A medical form in Uganda is very important because it gives history to the sickness of a patient. If you want to go to another clinic, the medical personnel or the doctor of that clinic will want to follow the history of that sickness. That's when you can take another step. So, to me, a medical form is like life. Because without the medical form, you may not be admitted or given any medical assistance in other clinics or health centers.

ESTHER AYUGI [translated subtitles]: I was never given any medication that day instead I was sent back to Dr. Odongo.

[Clinical staff and patients enter Gulu referral hospital, a government facility. Outdoors, the hospital grounds are littered with discarded operating tables and dilapidated ambulances.]

BERNARD ODONG: If government facilities were well equipped, the doctors are there, everything is in place, such situations wouldn't arise. And also...a kind of subsidy should be given to these private clinics. So that they reduce the charges levied to private patients. I think this is a way that we can avoid people getting stuck with bills they cannot pay.

ROSELYN SEGAWA: Health as a human right is not abstract. Maybe it's because people have been looking at it as an abstract idea that the health care system is failing, but if you know that there are people out there who are demanding, and rightfully so, access to the service of good-quality, availability of drugs, then the government will work towards making this a reality and that's where the human rights angle comes in.

MOSES MULAMBA: The state keeps quiet if its population is not demanding. It keeps quiet and it takes advantage of the ignorance of the people. So part of our work is to bring out these voices to the people through the courts of law, through raising more awareness on the radio, through the journalists such that people begin to appreciate and that the voices of the people are brought to the government.

[Joe Orech interviews Esther Ayugi under a tree at her village home.]

ESTHER AYUGI [translated subtitles]: I only hope to get my medical form back so I can go to a health center again. Because as you can see, I'm not yet well.

JOE ORECH [translated subtitles]: Besides getting your medical form back, do you think Dr. Odongo should be punished?

ESTHER AYUGI [translated subtitles]: You should only ask him to return my medical form. Look. I tried so many health units but it was him who helped me out. Five other clinics refused to treat me, but he had the courage to operate on me and now I'm alive. I just need him to give back my medical form.

[SUPER TITLES: Yeko was unable to buy more malaria medicine for his daughters. Joe Orech and the filmmaker paid to complete their treatment. 2 years after Esther's release her case is still pending.]

[END CREDITS]

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