When Hospitals Become Prisons:
Debt Detention of Insolvent Mothers, Children, and Families in Clinical Spaces

A mother who expected to birth at home, and who doesn't have birth funds, is awaiting examination after experiencing abnormal bleeding and fever in the 9th month. Saint Marc Hospital. Photo by Alissa Jordan.

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Abstract

The following is a research update for a collaborative investigation into the hospital detention of mothers and infants in hospitals in Haiti, developed in partnership between Dr. Alissa Jordan, Associate Director of the Center for Experimental Ethnography at the University of Pennsylvania (CEE), Jean-Denis Aureleus, President and Founder of Asosasyon De Dwa Enfant ak Fanm (ADDEF) and Carmelle Moise, Midwife and Board Member of MamaBaby Haiti (MBH). This project comes out of a mutual desire to craft a policy-influencing platform for Haitian mothers and families to voice their experiences of hospital detention, and for them to inform more equitable and just strategies for healthcare allocation. The central aim of this research is to produce a national report on the frequency and extent of hospital detention practices in Haiti, the impact of hospital detention on maternal and infant wellbeing and healthcare decision making, the status of patients rights in healthcare facilities, the legal frameworks pertinent to debt, extra-judicial arrest, and extrajudicial detention in Haiti, and the financial impact of patient insolvency on healthcare institutions. The report will be published in digital and physical form, including recommendations, and will be circulated to a broad range of stakeholders and policymakers in Haitian government, Haitian healthcare systems, and global public health. It is expected to be of interest to a broad range of audiences and institutions, especially those invested in maternal health, reproductive justice, public health and public health financing, patients rights, and universal health coverage in Haiti and beyond. As the first study to 1) explore hospital detention in Haiti and 2) to compare hospital detention experiences internationally, it will provide critical information for understanding the practice and its impact on maternal decision-making globally.

1. Introduction

While investigating the growth of hospital detention across the world, Maria Cheng (2018), Robert Yates and Eloise Whittaker (2017), and Kakudji Yumba Pascal (2018) concluded that the rise in the practice was related to public health restructuring initiatives in the late 80's, such as the 1989 Bamako Accords in Africa. These accords shifted the onus of healthcare costs onto patients themselves in the form of pay-to-play user fees. The intense pressure hospitals experience to settle debts is related to broader international public health initiatives to prioritize funding and support for those health systems that are most "sustainable." One central measure of sustainability is whether hospitals can successfully recoup hospital costs, largely in the form of user fees. Over the past thirty years, anthropological, legal, and public health research has argued that the pressures created by user-fee based systems have dire consequences on the healthcare outcomes of the poorest and most vulnerable users of health systems. These consequences can be particularly intense during life-threatening emergencies, such as complex obstetric deliveries.

Obstetrics, Economics, and Imprisonment

There is a paucity of field research on the widespread practice of hospital detention, but the few journalists, reviewers, and organizations that work on the issue agree that the most frequent prisoners held by hospitals across the globe are economically marginalized birthing people,

specifically black birthing people and birthing people of [1]color and their babies.[2] [3] [4] [5] Hospital detention notwithstanding, reproductive justice scholars like Dorothy Robets, Julia Chinyere Oparah, and Black Women Birthing Justice have long researched and explored the dual identity of hospitals for communities of color---as places of care and places of unfreedom.[6] Obstetrics and gynecology are a field whose existence comes out of this duality, the beginnings of the field can be traced back to experimentation on enslaved black women, and reproductive interventions on birthing people's bodies were critical wings of eugenics science.[7]

Not unrelatedly, few subjects have been as targeted by development interventions as mother/infant dyads or pregnant people. In development metrics, maternal mortality stands as a prime indicator of the health of the population. In Haiti's case, these metrics have been bleak for some time---the nation is often cited as having the highest maternal and infant mortality rates in the Americas. In a maternal health survey I conducted in rural Arcahaie in 2014, families reported that nearly one out of four children died before reaching the age of 5. In one out of 150 births, the mothers died as well. Nationally in Haiti, over 63% of births occur outside of clinical facilities. As in many locations with similarly dire statistics, ideals of development have aimed at changing Haiti's maternal mortality rates by shifting birth and prenatal care into western medical settings.[8]

Along with providing regular prenatal care and nutrition, access to safe Cesarean sections is one of the most important tools that Western medicine has for reducing maternal mortality. Cesarean sections are life-saving interventions for infants and mothers in as many as 1 out of 10 births.[9] Given these statistics, it isn't surprising that the Cesarean section is the most common major surgery in the entire world.[10]It is also the most costly common surgery. It requires resources, skilled labor, specific education and tools, and carries significant risks.

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[1] *Roberts, Dorothy E. Killing the black body: Race, reproduction, and the meaning of liberty. Vintage, 1999.*

[2] *Handayani, Krisna, et al. "Global problem of hospital detention practices." International Journal of Health Policy and Management 9.8 (2020): 319.*

[3] *Yates, Robert, Tom Brookes, and Eloise Whitaker. "Hospital detentions for non-payment of fees: a denial of rights and dignity." (2017).*

[4] *Cheng, Maria. "AP Investigation: Hospital patients held hostage for cash" Associated Press, October 25 2018.*

[5] *Cowgill, Karen D., and Abel Mukengeshayi Ntambue. "Hospital detention of mothers and their infants at a large provincial hospital: a mixed-methods descriptive case study, Lubumbashi, Democratic Republic of the Congo." Reproductive health 16.1 (2019): 1-15.*

[6] *Oparah, Julia Chinyere, and Alicia D. Bonaparte, eds. Birthing justice: Black women, pregnancy, and childbirth. Routledge, 2015.*

[7] *Owens, Deirdre Cooper. Medical bondage: Race, gender, and the origins of American gynecology. University of Georgia Press, 2017.*

[8] *Raymondville M, Rodriguez CA, Richterman A, et al. Barriers and facilitators influencing facility-based childbirth in rural Haiti: a mixed method study with a convergent design BMJ Global Health 2020;5:e002526.*

[9] *Yaya, S., Uthman, O.A., Amouzou, A. et al. Disparities in caesarean section prevalence and determinants across sub-Saharan Africa countries. glob health res policy 3, 19 (2018). https://doi.org/10.1186/s41256-018-0074-y*

[10] *Jauniaux, E., & Grobman, W. (2016-04). Cesarean section: Introduction to the 'World's No. 1' Surgical Procedure. In Textbook of Cesarean Section. Oxford, UK: Oxford University Press. Retrieved 6 Nov. 2021, from https://oxfordmedicine.com/view/10.1093/med/9780198758563.001.000/med-9780198758563-chapter-1.*

In user-fee based systems, such as those that dominate Haiti's health sector, administrators set about the task of recouping the cost of Cesarean sections from patients themselves, as they do with other major surgeries. The fact that the procedure is common, necessary, costly, and need for the procedure seems to increase with higher maternal economic and social stresses, insolvent mothers who have had Cesarean sections appear to be the most common patients imprisoned within hospital spaces around the world. This also means that birthing people who undergo Cesarean sections are the most crucially important and consistent debtors that hospitals can extract funds from.

In Haiti, obstetrically-capable NGO and mission hospitals that institute user fees are sites where insolvent birthing mothers are sent to undergo Cesarean sections, and where they are subsequently imprisoned as corporeal collateral for the debt. In spite of rhetoric which situates the patient as the debtor, the practice is in all actuality used to extract funds from families and communities and not from patients themselves, who are of course imprisoned and thus unable to work or otherwise collect funds. This is why their condition is more akin to that of a hostage, held to extract funds from outsiders, rather than that of a prisoner, who is held to "pay" for their debt through serving time.

By instituting this dual edged process of medical care, debt assignment, and captive collateral, growing organizations and mission hospitals are better able to meet a number of development needs: demonstrating improved sustainability at the financial level, at the same time that the medical care they provided (for which they took patients prisoner) improves maternal and infant survival, increases their number of patients treated, and allows them to more effectively lobby for funding and support.

By taking this approach, they put the freedom of mothers and infants in the hands of communities and families. For those women without families or for those whose bills are particularly high, patients who are unable to escape can remain stuck for months or even years. Locked inside maternity wards, hallways, patios, and storage closets, unskilled male laborers are hired as guards are paid and paid to keep watch. Often coming from similarly precarious economic predicaments as patients themselves, guards are the frontline of the hospital prison, while also being prime suspects when patients escape, and being those held financially accountable for their escapes.

In the event of patients who are able to find a means to escape, hospital administrators brand them as thieves, and guards are under strict orders to apprehend them if they set foot in hospital spaces again. Escape is rarely successful with mothers, but it is attempted[11]. Mothers I spoke to were unwilling to leave babies behind and unable to scale fences with them in tow, presenting them with a double bind. This formulation of patients as potential thieves of their own babies and bodies is telling, indicating that at least in common rhetoric if not through institutional practice, the breathing lungs, beating hearts, sutured abdomens, and hungry babies are spoken of as assets of the hospital, both as embodied collateral, and as an embodied debt. Their actual surviving body, when they survive, is evidence of the credit that was granted and that now demands repayment.

The impact of this approach to medical care is not limited to birthing families, who have understandably hesitated to use hospitals unless emergencies are readily apparent. Such practices

[11] *Jordan, Alissa and Tolliver, China. 2020. Podcast: "Birthing Resistance: Stories of Hospital Prison" Spotify, Apple Podcast*

affect other patients, they affect decisions about care, and they shape expectations of medical treatment [12]. If you were to speak to Noutchie and Naomi's neighbors and friends, you would see how this shapes the sort of medical futures that many Haitians are willing to imagine for themselves. During the production of the podcast, a close neighbor of Naomi refused to go to the Milot hospital during a particularly difficult labor. She was terrified of being seperated. Unfortunately her infant did not survive.

Hospitals often claim that they depend on the practice for survival. They have to choose, in their words, between letting insolvent patients die in spite of having the resources to treat them, or treating insolvent patients with resources that will not be easy to recoup. Hospital detention is a solution that many hospitals employ, striking a bargain (even if it is an illegal one) between the patient's right to life and the patient's rights to freedom.

1.2 Link Between Obstetric Medicine and Detention

Practices of in-hospital incarceration span all areas of medical practice where surgeries are common. Globally, they are used particularly intensely during the delivery of western obstetric care, a pattern seen in countries from South America to the Eastern Europe (Klippenberg 2008[13]; Cowgill & Ntambue 2019[14]; Cheng 2018[15]; Cheng 2018[16]; Cheng 2018[17]; Yates ak Whittaker 2017[18]; Pascal 2018[19]). In a press-based literature review released in 2020, Handayani et al identify 42 countries where hospital detention is not only instituted regularly, but where it has received published attention in media outlets. Today, there are only a handful academic publications on hospital detention that derive from primary research on the matter, making the proposed research a critical intervention into the problem.

Although comprehensive figures are lacking, Yates and Whittaker (2017)[20] indicate that the vast majority of detained patients worldwide are women who have undergone cesarean sections and other emergency obstetric procedures. Looking at this trend, Bowser and Hill 2010[21], explored it as one of the major forms of disrespect that mothers face in facility-based childbirth, and epidemiologists Karen Cowgill and Abel

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[12] Castro, Arachu. "In and out: user fees and other unfortunate events during hospital admission and discharge." Cadernos de Saúde Pública [online]. 2008, v. 24, n. 5 [Accessed 17 November 2021] , pp. 1174-1178. Available from: <https://doi.org/10.1590/S0102-311X2008000500026>. Epub 29 Apr 2008. ISSN 1678-4464. https://doi.org/10.1590/S0102-311X2008000500026

[13] Kippenberg, Juliane. A high price to pay: Detention of poor patients in Burundian hospitals. Vol. 18. No. 8. Human Rights Watch, 2006.

[14] Cowgill, Karen D., and Abel Mukengeshayi Ntambue. "Hospital detention of mothers and their infants at a large provincial hospital: a mixed-methods descriptive case study, Lubumbashi, Democratic Republic of the Congo." Reproductive health 16.1 (2019): 1-15.

[15] Cheng, Maria. "AP Investigation: Congo hospitals openly jail poor patients" Associated Press, October 26 2018.

[16] Cheng, Maria. "Slovak hospitals hold new Roma mothers against their will" Associated Press, December 10, 2018.

[17] Cheng, Maria. "AP Investigation: Hospital patients held hostage for cash" Associated Press, October 25 2018.

[18] Yates, Robert, Tom Brookes, and Eloise Whitaker. "Hospital detentions for non-payment of fees: a denial of rights and dignity." (2017).

[19] Yumba, Pascal Kakudji. "De la séquestration des mamans insolvables et leurs enfants dans les maternités des établissements de santé de Lubumbashi: Cas de l'hôpital général Jason Sendwe." RiA Recht in Afrika| Law in Africa| Droit en Afrique 18.1 (2016): 78-96.

[20] Yates, Robert, Tom Brookes, and Eloise Whitaker. "Hospital detentions for non-payment of fees: a denial of rights and dignity." (2017).

[21] Bowser, Diana, and Kathleen Hill. "Exploring evidence for disrespect and abuse in facility-based childbirth." Boston: USAID-TRAction Project, Harvard School of Public Health (2010).

Ntambue name it definitively as a "gendered violence" in their study of hospital detentions in the Democratic Republic of Congo (2019).[22]

Like these other parts of the world where prolonged clinical incarceration is a routine method of debt recuperation, mothers and newborn infants in Haiti are the single most likely targets of debt detention. Given that Haiti is the country with the highest maternal and infant mortality rates in the Americas, the gendered violence of hospital-prisons further frays relationships between birthing women and the medical sector. Furthermore, a majority of humanitarian funds headed to Haiti bypass national actors altogether, and the healthcare sector in Haiti is managed by predominantly non-Haitian NGOs that are notoriously unregulated. This means that hospital-prison can not only be considered a gendered violence in Haiti, as Cowgill and Ntambue argue, but a gendered violence that is colored by geopolitical, racial, and religio-moral inequities.

1.3 Maternal Health and Detention in Haiti

Like much of the globe where debt detention constitutes a normative public health practice, there is virtually no systematic research on detention or its impacts in Haiti despite plentiful research questions on barriers to institutional birth. Nationally, over 67% of births occur outside of clinical facilities, and public health research identifies a lack of access to medical care and obstetric intervention as a leading factor in poor birth outcomes for Haitian families (Cayemittes et al 2013[23]). In a maternal health survey conducted by Alissa Jordan in Arcahaie and Montrouis region in 2014, families reported that nearly one out of four children died before reaching the age of 3, (24.7%, n=72). In one out of 150 births, the mothers died as well (Jordan 2016[24]). In order to understand these remarkably poor outcomes, researchers have explored the specific barriers to hospital access that pregnant women face in Haiti (eg. Ambitor 2013; Cianelli et al 2014[25]; Gage 2018[26]; Jacobs 2016[27]; White et al 2006[28]; MacDonald 2018[29]; Barnes-Josiah 1998[30]; Raymonville 2019[31]; Shaffer 2007[32]; Gage &

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[22] *Cowgill, Karen D., and Abel Mukengeshayi Ntambue. "Hospital detention of mothers and their infants at a large provincial hospital: a mixed-methods descriptive case study, Lubumbashi, Democratic Republic of the Congo." Reproductive health 16.1 (2019): 1-15.*

[23] *Cayemittes, Michel, et al. "Enquête mortalité, morbidité et utilisation des services (EMMUS-V): Haïti 2012." Calverton, MD: Measure DHS, ICF Macro (2013).*

[24] *Jordan, Alissa. 2016. "Atlas of Skins: Becoming Persons, Becoming Werewomen, Becoming Zonbi in a Haitian Vodou Courtyard." University of Florida Dissertation. Department of Anthropology.*

[25] *Cianelli, Rosina, et al. "Maternal–child health needs assessment in Haiti." International journal of applied science and technology 4.5 (2014): 30.*

[26] *Gage, Anna D., et al. "Does quality influence utilization of primary health care? Evidence from Haiti." Globalization and health 14.1 (2018): 1-9.*

[27] *Jacobs, Lee D., Thomas M. Judd, and Zulfiqar A. Bhutta. "Addressing the child and maternal mortality crisis in Haiti through a central referral hospital providing countrywide care." The Permanente Journal 20.2 (2016): 59.*

[28] *White, Kari, et al. "Health seeking behavior among pregnant women in rural Haiti." Health care for women international 27.9 (2006): 822-838.*

[29] *MacDonald, Tonya, et al. "The fourth delay and community-driven solutions to reduce maternal mortality in rural Haiti: a community-based action research study." BMC pregnancy and childbirth 18.1 (2018): 1-12.*

[30] *Barnes-Josiah, Debora, Cynthia Myntti, and Antoine Augustin. "The "three delays" as a framework for examining maternal mortality in Haiti." Social science & medicine 46.8 (1998): 981-993.*

[31] *Raymonville, Maxi. Barriers and Facilitators Influencing Facility-Based Delivery in Rural Haiti: A Mixed Method Study With a Convergent Design. Diss. Harvard University, 2019.*

[32] *Shaffer, Stan, et al. "Improving Maternal Healthcare Access and Neonatal Survival through a Birthing Home Model in Rural Haiti." Social Medicine 2.4 (2007): 177-185.*

Calixte 2006[33]; Babalola 2014[34]). Along with distance to healthcare facilities, "poverty" (e.g. "neighborhood poverty" in Gage & Calixte 2006[35]; "household poverty" in Babalola 2014[36]) is held up as a critical barrier that prevents families from seeking adequate prenatal care or emergency interventions.

Although many Haitian mothers report that they cannot go to hospitals to deliver babies because it "costs too much", our past interviews with detained mothers (as well as those who chose home-birth) clarified that the "cost" of hospitals is not merely countable in gourdes or kòb, but also in days and weeks spent away from support networks (see also Shaffer 2007[37]), in the insecurity of unresolvable hunger, in newborn infants exposed to disease, and the mental violence of forced post-partum isolation. In short, persons who cannot produce large sums of cash to compensate hospitals for care are held prisoner just at the moment when their intimate familial ties are of unparalleled importance to their wellbeing and survival (Jordan 2016[38]).

While in hospital detention patients must survive through relying on the charity of other patients who share food, most often prisoners themselves (Jordan 2020), or arranging with their family members and friends to bring food for them. These family members are not reliable sources of food in spite of what is often an intense pressure and desire to help (Jordan 2020). They are frequently left unable to help, given that they live at a great distance from the hospital and the most committed family members are often already thinly stretched between caring for their own dependents as well as those of the imprisoned person's household, all while attempting to secure the freedom of the prisoner through acquiring loans. This is because the burden for repaying debt falls firmly upon the shoulders of family members and communities rather than patients themselves, whom--- being in detention---cannot carry out economic activities, leave to collect funds for hospital care, and often have very few liquidatable assets. Critiquing the dynamic of this system that puts kin-pressure on families to "save" family members from rights violations and abuses, many colloquially refer to this coercive dynamic as a 'kidnapin', or a kidnapping in Haitian Creole. [39]

Much as they try to avoid it, postpartum imprisonment has become a common outcome of hospital birth for Haitian mothers who need emergency cesarean sections and do not have the cash in hand to pay for them. In the course of our research, one mother, N, poignantly spoke of her time in detention as a period in her life during which she ceased to be recognized as a "moun" [person] and instead became an "esklav" [slave] or "bèt" [animals], who had lost all rights to her own body in the eyes of the hospital. Drawing from insights gathered from prior oral histories with detained mothers, this new report will hone in on the connection between forcible confinement and women's health and wellbeing, their relationship with their infants, and their self-esteem. Given the rich, varied, comfort-centered maternity practices that traditionally exist in Haiti, the profound contrast offered with the trauma and insecurity of post-birth hospital-imprisonment seems

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[33] Gage, Anastasia J., and Marie Guirlène Calixte. "Effects of the physical accessibility of maternal health services on their use in rural Haiti." Population studies 60.3 (2006): 271-288.

[34] Babalola, Stella O. "Factors associated with use of maternal health services in Haiti: a multilevel analysis." Revista Panamericana de Salud Pública 36 (2014): 1-09.

[35] Gage, Anastasia J., and Marie Guirlène Calixte. "Effects of the physical accessibility of maternal health services on their use in rural Haiti." Population studies 60.3 (2006): 271-288.

[36] Babalola, Stella O. "Factors associated with use of maternal health services in Haiti: a multilevel analysis." Revista Panamericana de Salud Pública 36 (2014): 1-09.

[37] Shaffer, Stan, et al. "Improving Maternal Healthcare Access and Neonatal Survival through a Birthing Home Model in Rural Haiti." Social Medicine 2.4 (2007): 177-185.

[38] Jordan, Alissa. 2016. "Atlas of Skins: Becoming Persons, Becoming Werewomen, Becoming Zonbi in a Haitian Vodou Courtyard." University of Florida Dissertation. Department of Anthropology.

[39] Jordan, Alissa 2020. Akouchman ak Rezistans. Spotify.

dramatic enough to dissuade mothers from hospital birth if problematic symptoms are not explicit, noticeable, and persistent.

In spite of its ubiquity as a practice, and in spite of mounting pressure from reports such as Cheng (2018) and Yates and Whittaker (2017), leading global health organizations remained largely silent on the practice until quite recently.[40] This institutional silence persists in Haiti as well. Far from being a problem limited to "corruption / kowonpi" at only a few sites in a nation with a decentralized healthcare system, our research makes it clear that hospital imprisonment is an endemic and institutionalized form of debt recuperation in some of the most well-funded, foreign-operated, fee-based private NGO hospitals, as well as private fee-based hospitals and clinics. The practice is also used in precarious public hospitals that routinely close because they don't have enough funds to function, to pay doctors, or to keep lights on. Yet there has been no official response to the problem from the Haitian government, and foreign NGOs who dominate the health sector have remained largely silent with very few exceptions (e.g. MamaBabyHaiti).

The practice of detention challenges the numerous constitutional guarantees. It is ostensibly illegal to imprison patients for debt in Haiti, just as it is in most other nations where it occurs. As a practice whereby corporate entities independently deprive citizens of fundamental rights without juridical authority, the practice offers a sustained challenge to State sovereignty. In spite of this, many nations where hospital detention occurs have been slow to enforce these rights in healthcare delivery systems. In order to fill the gap between constitutional rights, written laws, and enforcement, certain nations have taken direct steps to explicitly name, define, and forbid hospital detention. This was the case in Burundi, where President Pierre Nkurunziza issued an explicit prohibition of the practice on May 1 2006, declaring that the Burundi government would provide for free healthcare services for women and children under the age of five[41].

Likewise, the practice is explicitly prohibited in the Philippines in Republic Act (RA) 9439, titled "the Act Prohibiting the Detention of Patients in Hospitals and Medical Clinics on Grounds of Nonpayment of Hospital Bills or Medical Expenses"[42]. This act penalizes hospital administrators and personnel with imprisonment of 1-6 months, and significant fines, should they be found guilty of detaining patients for financial reasons. In lieu of withholding patients as collateral, medical institutions are allowed to withhold medical records until patients or family members present a mortgage-secured promissory note to the hospital for the record release. In the case of deceased patients whose bodies are impounded by hospitals, withholding documentation related to death can mean that patients cannot be buried. [43]

In Haiti, the use of hospital detention not only violates the Universal Declaration of Human Rights, which Haiti signed into law as Article 19 of the Haitian Constitution in 1987, but also goes against other guaranteed rights in the Haitian constitution (see Aurelus 2021). To name but a few, Article 24-1 of the Haitian Constitution promises citizens that "No one may be prosecuted, arrested or detained except in the cases determined by law and in the manner it prescribes" (Article 24-1), and Article 24-2 and 24-3 guarantees that citizens can only be arrested after a written order of the court is issued. In the event that a "perpetrator of a

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[40] *Following years of pressure, in December 2020, the WHO published a document on hospital detention officially for the first time, confirming that the problem is global in scope several years after Maria Cheng's groundbreaking investigative reports on the practice (Clarke et al 2020).*

[41] *This prohibition was issued immediately after the publication and circulation of the report on hospital detention devised by Julie Klippenberg (Klippenberg 2008#). During 2006-2011, Burundi restructured international and national funding to support maternal and child healthcare in the nation.*

[42] *Republic Act No. 9439. Republic of the Philippines. Passed Monday 2007.*

[43] *It is also important to note that this law does not apply to patients held in private rooms with toilets and private beds, but only those held in common areas of the hospital.*

crime is caught in the act," and this written order is not available, or citizens other than police arrest the accused, it is explicitly forbidden for the accused to be held for more than 48 hours without appearing before a judge who will rule on the legality of the arrest (Article 26). Given that State authorities are not involved or informed about the process of detention, and that patients do not appear before a judge (where their fundamental rights would likely be affirmed, and the hospital held liable for violations), the use of hospital detention is highly suspect under Haitian law.

1.5 Conclusion

In such a complex field of costs, emergencies, debts, and threats, how do Haitian mothers decide to caretake their lives and those of their unborn children? How do they navigate healthcare programs that take away their supposedly inviolable right to liberty in order to ensure their equally inviolable right to life? How do care structures in Haiti explain the use of hospital detention, and what alternatives exist? What impact does maternal insolvency have on healthcare institutions in Haiti, and what alternatives to detention exist? And finally, but not least of all, what does "justice" look like to mothers and what does it look like to the institutions that serve them?

When imprisoning mothers within hospitals, or impounding the bodies of those who die, hospitals treat medical care for insolvent patients as something that is only possible through violations of patients rights to freedom. In spite of the apparent fact that these practices are a violation of constitutional guarantees and legal doctrine, hospital administrators argue that few if any alternatives exist. There is a clear need to better understand the extent of these practices across Haiti's health sector, to clarify the alternatives that are already in use, to identify the personal and health impacts, to pinpoint the juridical frameworks that it relates to, and to understand hospital detention in Haiti in an international context. This study offers one of the first concerted attempts to shed light on these vital concerns on a national scale, in the hopes of jointly attending to the personal impacts of detention, its practical solutions, and considering the future of patients rights in Haitian clinics and hospital facilities.

2. Concrete Project Aims:

1) describe Haitian experiences of hospital detention using oral historical research with ex-detained mothers, family members, and participating hospital personnel

2) identify regional and institutional patterns in detention practices in clinics and hospitals in Haiti

3) identify and assesses existing responses to hospital detention at institutional levels

4) calculate the financial impact of insolvent patients on healthcare institutions

5) identify and assesses alternative institutional strategies for managing insolvent debtors in Haiti

6) clarify the relevant juridical frameworks pertaining to debt, bankruptcy, detention, and patient rights in Haiti

7) compare hospital detention in Haiti to hospital detention internationally, using research literature

8) make recommendations to relevant bodies regarding hospital detention, including bodies within the Haitian state and healthcare providers.