Eastern African Journal of Humanities and Social Sciences
Vol. 4 No. 2 (2025): ISSN (Online): 2958-4558
DOI: https://doi.org/10.58721/eajhss.v4i2.1255
Psychosocial effects of Medical Detention for Unpaid Bills in South Kivu, DRC: Implications for Medical Social Work and Ubuntu-Centred Care

Psychosocial Effects of Medical Detention for Unpaid Bills in South Kivu, DRC: Implications for Medical Social Work and Ubuntu-Centred Care

Ntinu Mutama Kabesha[1,3], Gloire Murhula Kapalata[1,3]
Juvenal Bazilashe Mukungu Balegamire[1,3] & Mulumeoderhwa Philippe Kaganda[1,2]
[1]Université Evangélique en Afrique, DR Congo
[2]Université Officielle de Bukavu, DR Congo
[3]Centre de Recherches et des Consultations Psychologiques (CERCOP-UEA)

Article History
Received: 2025-04-02
Revised: 2025-08-20
Accepted: 2025-08-26
Published: 2025-08-31

Keywords
Mental health
Medical detention
Psychosocial effects
Ubuntu care

How to cite:
Kabesha, N. M., Chiribagula, M., Kapalata, G. M., Balegamire, J. B. M., & Kaganda, P. M. (2025). Psychosocial effects of Medical Detention for Unpaid Bills in South Kivu, DRC: Implications for Medical Social Work and Ubuntu-Centred Care. *Eastern African Journal of Humanities and Social Sciences*, *4*(2), 113-122.

Abstract
Various patterns and contexts of wartime, poverty, and lack of health insurance raise mental health and social issues for inpatients, especially for Recovered Patients Detained (RPDs). This study examines the psychological and social implications of detaining patients for unpaid medical bills in healthcare facilities in South Kivu, DRC. It applies the qualitative approach and Ubuntu theory with an exploratory, cross-sectional research design. Using the Kessler Psychological Distress Scale (K10) of mental health and an in-depth interview guide on 30 participants, the research explores the experiences of RPDs, healthcare providers, and family members. Findings revealed that RPDs present psychological effects, translating into moderate depressive and anxiety symptoms. These symptoms are often expressed in sadness, sleep and eating disorders, remarkable anxiety, fatigue, agitation, etc. Social consequences were equally profound, with patients experiencing stigma, loss of dignity, family conflicts, and children dropping out of school, especially if the patient is the main breadwinner in the family. Factors exacerbating these effects include prior trauma, poor detention conditions, strained relationships with healthcare staff, and socio-economic vulnerabilities. Drawing from the Ubuntu philosophy, the study highlights the urgent need for psychosocial interventions, such as counselling services, payment instalment systems, and improved patient-staff communication.

Introduction
Wars and conflicts majorly impact social service delivery, particularly in healthcare settings. Conflict-affected environments are particularly challenging situations where biopsychosocial approaches to health treatment are crucial, given the complexity of the physical and mental health problems caused by armed conflict, loss, poverty and forced displacement (Kasherwa et al., 2023). In this context, recovered patients are detained after treatment due to a lack of financial resources. The detention of patients over unpaid hospital bills has become a common phenomenon that raises important questions about the psychosocial consequences, including distress and stigma (WHO, 2018; Karuti, 2021).

In sub-Saharan Africa, mainly in Kenya, Burundi, Ethiopia, Uganda, Nigeria and the DRC, 100 million people are pushed into poverty because of healthcare costs, including 40 million detained because of unpaid bills (Melariri et al., 2024). The practice of detaining patients appears to have harmful effects on patients' mental health. Medical detention is associated with an increased risk of depressive and anxiety disorders, influenced by the length of detention and social support (Human Rights Watch, 2006; Mekonnen & Bekele, 2019).

In the Democratic Republic of Congo (DRC), access to healthcare for disadvantaged is a major raising significant challenges (WHO, 2018). They are often unable to pay bills, so they are placed in medical detention. This practice leads to psychosocial effects, including stigma, loss of dignity, social isolation, stress, etc. (Mbugua & Molyneux, 2021). Yates et al. (2017 found that over six weeks in 2016, 46 of the 85 women (54 %) who had given birth in one health facility eligible for discharge were detained for unpaid bills. Furthermore, in Kinshasa City, 15% of patients were detained, with an average detention period of 3 days to a year (Brouwere & Criel, 2014).

In Bukavu Town (South Kivu province), public and private hospitals face the problem of medical detention of patients for unpaid bills (MSF, 2020). In 2020, medical detention for unpaid bills was higher in public hospitals (12%) than in private hospitals (8%), and medical detention was associated with poverty, lack of housing, and lack of social support (Mutambala, 2020). It is linked to negative consequences, including mental health conditions, complications, and prolonged hospital stay (Mutambala, 2020; Ngamaba et al.,2024). Despite humanitarian missions, the hospitals are not subsidised, and there is a total absence of health insurance in the context of war and extreme poverty. Hospitals operate in the context of the commercialisation of healthcare, and supply is a function of patient resources. As observed, some recovered patients are detained due to the insolvency of bills. Even in the absence of a finding, indigent patients are separated from others and often kept in a room where doctors can rarely attend. This issue raises challenges about psychosocial support and mental health programmes to help RPDs cope with mental health issues.

GRHs have no mental health programmes or professional social workers to help patients cope with social problems, especially the RPDs. Similarly, Mental Health and Psychosocial Support programmes are underdeveloped (Kasherwa et al., 2023; Ngamaba et al.,2024. Hospitals are private institutions in business, entitled to pursue recovery of the costs incurred by patients for services rendered to them. Living in hospital detention after receiving treatment constitutes an economic, social, and psychological burden for patients (Asahngwa et al., 2023). The lack of empirical knowledge and effective medical social work interventions suggests that health quality may be subject to significant limitations, especially for RPDs. This article addresses the expertise and practical gaps.

Theoretical framework

Ubuntu is an emergent theory of decolonising social work practices and knowledge. Ubuntu questions the existence and survival of Africans, as human beings in their environments (Muwanga-Zake, 2024). It is a call to humanity toward others, community, and unification. Ubuntu refers to togetherness within humanity, whereby every individual has an impact on the next person's life (Makhetha, 2024). It challenges individualistic perspectives (e.g., Maslow's hierarchy of needs) and encourages a more holistic approach to human relationships (Mugumbate & Chereni, 2019; Tusasiirwe, 2022, 2023; Makhetha, 2024). Khan and Ntakana (2023) summarise the conceptual framework of Ubuntu in five key principles, including the principles of survival, solidarity, compassion, respect, and dignity. All the values and principles of Ubuntu are translated into "I am because you're", expressing belongingness, interconnectedness, communalism and humanism. This theory is developed to promote African values in problem-solving. In their works, Mugumbate & Chereni (2019), Mugumbate & Nyanguru (2013), and Tusasiirwe (2023) demonstrate that promoting

Ubuntu is the way to indigenising and decolonising social work research and practices. Ubuntu perspective advocates for policies that prioritise patient dignity over financial considerations and mobilise the community. Additionally, developing interventions that address not only the financial aspects of healthcare but also the psychosocial needs of patients.

Methods and materials

The study used a qualitative approach (Flick, 1998) with an exploratory research design, a hypothetico-deductive (Mills & Birks, 2014; Casula et al., 2020). The study was done in General Referral Hospitals, Bukavu town, South Kivu, DRC. The study population involved RPDs (male and female), physicians, nurses, and family members. The sample size consisted of 30 respondents, including 15 patients, five physicians, five nurses, and five family members of patients. To select the participants, we were guided by two nurses. For detainees, we used the Kessler Psychological Distress Scale (K10) (Kessler et al., 2003) and semi-structured interviews for in-depth interviews. In-depth interviews were used to collect data from doctors, nurses and patients' relatives. For in-depth interviews, the questions were divided into four themes. Each interview took approximately 45 to 60 minutes.

Data analysis and interpretation

The K10 is a tool used to measure the level of psychological distress, including symptoms of anxiety and depression. It was developed by Kessler and colleagues (Kessler et al., 2003) and has become a widely used tool in mental health surveys and clinical research (Ongeri et al., 2022). The K10 scale is a screening tool used to measure non-specific psychological distress in adults. The 10-item version of this psychological distress scale measures the level of distress or psychological effects over the past four weeks. Each item is rated on a scale of 0 to 4, indicating the frequency of the symptom. To interpret the K10, these criteria were applied (Kessler et al., 2002; Andrews & Slade, 2001): a score of 0 to 9: likely to be well; 10 to 19: mild level of psychological distress; 20 to 29: moderate level of psychological distress; 30 to 50: severe psychological distress (likely to have severe mental disorder). For the data collected using interviews, content analysis was applied for data analysis. Thus, starting by translating (if needed), coding, grouping, identifying core categories, constant comparative analysis, and finally interpreting by comparing with the K10 score and analysing and discussing.

Ethical considerations

The Université Evangélique en Afrique provided institutional approvals for this project. Research approval was given under the condition of adhering to the do no harm principle. Voluntary participation and informed consent were required from participants. All participants (patients and medical staff) agreed on respect for confidentiality and anonymity in reporting data. Thus, the names of the respondents have been replaced by pseudonyms.

Results

Socio-demographic characteristics

Data on socio-demographic characteristics include sex, age, level of education, duration, occupation and length of detention. 56.6% were male and 43.4% female. This includes 15 detainees, among them eight men (53.3%) and seven women (46.6%). The medical staff (doctors and nurses) were six men (60%) and four women (40%). Regarding age, only RPDs were considered among them, 63,3% were young and aged between 19-33 years, and 23.3% were aged 34–38 years. A few numbers, 17 % of patients were aged over 45 years. In terms of education, the majority, 40% attained secondary school and 33.3% university level (33.3), the remaining 26.7% dropped out of primary school. That means unemployment and poverty due to war conflict impact the power to pay the bills. Regarding the length of detention, 33.4% had been detained for 1 to 5 months, while 66.6% had been detained for 6

or 10 months. Long-term detention of patients for non-payment of medical fees has psychosocial effects on inmates.

Psychological effects developed by RPDs in hospitals

K10 test indicate 8/15 patients have a moderate level of psychological distress at a high score, representing 53.3%; followed by patients with a mild level of psychological distress, representing 33.3%; and only 13.3% patients have a severe level of psychological distress as a result of detention. To explain these results, in-depth interviews were conducted and interpreted on two levels, namely the development of anxiety and depressive symptoms.

The results obtained from in-depth interviews indicate that recovered patients experience depressive symptoms of higher intensity expressed in sadness, sleep and eating disorders, low self-esteem, and thoughts linked to fear and suicide. This is further explained in the testimony reported below:

"Since I've been here, I don't smile anymore." I often think about my family and my home. I feel alone and abandoned. I don't feel like doing anything, even eating. I spend my days watching other sick people go out, thinking about my debts. "I wonder if I'll ever get out of this hospital" (Pascaline [pseudonym])

This testimony shows a deep and persistent feeling of sadness, reflecting depressive effects in recovered patients detained. Other interviews have evoked the psychological effects of depression linked to sleep and eating disorders, as reported below:

> I'm not hungry anymore. When food is brought to me, I look at my plate without touching it, and I can't sleep either. I think about all the money owed to the hospital. I feel guilty and useless. At night, I often wake up hungry, but unfortunately, I can't eat (Albert [Pseudonym])

Medical detention is linked to sleep and eating disorders, translated into frequent awakenings and exhaustion. Furthermore, this study has taken into consideration the testimonies of some of the nurses and doctors. Some of the nurses and doctors working for several years observed signs of depression linked to sadness, as illustrated in a quote from the following testimonial:

> As a doctor, I am confronted with the physical suffering of these patients." But psychological suffering is just as real and can worsen overall health. […] Some even develop suicidal thoughts (Paul [Pseudonym])

Recovered patients detained often suffer from depressive symptoms such as sadness, anxiety, sleep disorders, and appetite disorders. As a result, psychological suffering is an integral part of the illness, which can worsen the physical state of health and delay recovery in detained patients. Nevertheless, the need for comprehensive, psychologically inclusive care for patients detained in hospitals may be an asset in reducing mental problems among patients.

Anxiety symptoms are expressed in a state of nervousness, tension, remarkable worry, fatigue, agitation, and difficulty remaining calm. Some of the testimonies gathered through interviews help to understand the problems of the recovered patients detained, as follows:

> I don't know what to do anymore. I'm going around in circles, overwhelmed by negative thoughts. I feel constantly tense as if a weight were crushing my chest. The idea of not being able to get out of here overwhelmed me (Alain [Pseudonym]). A medical doctor reported the following statement:

> It's tough to live with. You can see the distress in their [detained patient] eyes; they're constantly on edge. Arguments break out easily, even over trifles. They need psychological support, that's obvious (Innocent [Pseudonym])

The above extracts highlight the physical and psychological manifestations of anxiety among recovered and detained patients, underlining the importance of a holistic approach to care. Nevertheless, it is essential to note that each individual uniquely experiences anxiety and that symptoms may vary from one person to another. A thorough psychological assessment is necessary to establish a precise diagnosis and propose a treatment adapted to each RPD.

Social effects related to the detention for unpaid medical bills

Patients' detention for unpaid bills has consequences for family ties, the development of family conflict, and children's education. Explicitly, detainees believe that they are neglected by other people and some family members, not because of the current situation. Detention has long-lasting and far-reaching consequences for patients directly concerned and their families or dependents, as the following extract of testimonies relates:

> I am the mother of five children. My youngest fell seriously ill, and I had no choice but to take him to the hospital. The care was excellent, but the bills quickly escalated. I couldn't pay. My in-laws and I—we don't speak anymore; they have means but don't want to pay for my child—took advantage of this situation to chase us out of their home. They say I have "dishonoured the family by not being able to pay for my child's care.

A father whose wife is detained and who had come for his visit from the village said:

> I'm a farmer. My harvest failed this year, and I couldn't pay my wife's medical bills. My children, who are already angry with me for not paying their mother's bill, have completely broken up with me. They no longer want to see me. "I'll do anything to find the money." During that week, I put my field up for sale.

Detention can exacerbate pre-existing tensions or conflicts between family members, particularly when it involves issues of honour and social status. Detention for non-payment can become a pretext for family members to shirk their responsibilities. The loss of dignity associated with detention and the inability to provide for one's family lead to deep depression and feelings of failure among RDPs.

These testimonies illustrate both the short—term and long-term consequences of medical detention. Children end up dropping out of school due to the high cost of health care, compromising their futures and perpetuating the cycle of poverty. The long-term consequences of dropping out of school due to detention can negatively impact a family's social mobility. It reinforces the cycle of poverty by preventing families from generating income and forcing them to spend money on medical care rather than on children's education.

Factors contributing to the development of the psychosocial effects of RPDs in hospitals

These factors are psychiatric background, lack of perspective for the discharge, relationship with healthcare staff, social precariousness, and feelings of guilt. The psychiatric background is linked to the previous traumatic experiences of certain patients before their detention in hospitals. The lack of prospects of release and the conditions of detention. Findings from interviews show that RPDs with psychiatric histories are particularly vulnerable to the effects of detention. None of the respondents in this study reported having a traumatic background, but the experience of detention was linked to the context of war or extreme vulnerability and post-traumatic memories. The traumatic nature of being detained is exacerbated by comparisons with prison, evoking feelings of confinement, loss of control,

loneliness, and anguish, leading some RPDs to develop symptoms such as nightmares, fear, and feelings of abandonment, reflecting post-traumatic stress disorder (PTSD). A patient interviewed said:

> Before I became ill, I was already suffering from anxiety following the death of my husband and the conflict in the war. The hospital forced me to confront my fears again. Yet I couldn't bear the idea of being away from home and not being able to control my situation. The nights are hell here; I have panic attacks and feel like I'm going crazy".
>
> Another adds:
>
> I've always been strong; I've faced many difficulties in life." But now, I confess, I'm starting to weaken. Detention is eating me up inside. I feel powerless and useless. "I no longer recognise the man I used to be.

The inability to control the situation and the fear of the unknown trigger panic attacks, revealing a heightened vulnerability to stress. From this, other surveys put forward the idea of a feeling of powerlessness and despair in the context of medical detention. For patients, detention undermines their self-esteem and leads them to question their identity and existence. RPDs attributed the reason contributing to his increased psychological effects following detention to the total absence of the prospect of discharge.

Social system factors contributing to Psychosocial effects among RPDs

These environmental factors are detention conditions, relationships, social precariousness, guilt and social stigma. Findings show that some RPDs complained of the humiliating behaviour, insults, and mistrust shown towards them by the staff, as well as the poor condition linked to the lack of beds or beds without covers, as illustrated in the following statements:

> Last time, I had asked a nurse for a service, but she only distrusted me, saying that if I didn't have to call on family members and contribute to pay my bill, she hadn't even waited for me to ask for it.' 'Now I'm in pain.' 'I didn't sleep at night; I was thinking about it.

Another RPD added to this, saying:

> The medical staff are overworked; they see us as a loss of earnings.' When we're in pain... we don't have to be looked after anymore. We feel abandoned.

The relationship between healthcare staff and detained patients is a trigger for the psychosocial state of RPDs. Unfortunately, this side is overloaded and underestimated. The feeling of abandonment and the failure to respond to RPDs' needs increase their suffering and psychological distress. This lack of human consideration also exacerbates the adverse effects of detention and hinders the recovery process. Nevertheless, specific training and policy can enable healthcare staff to adopt a more empathetic and caring attitude towards RPDs.

Social precariousness, guilt and social stigma

Apart from individual and environmental factors, socio-economic factors such as social insecurity, level of vulnerability, guilt, and stigma are also reported in this study. Interviewers believe that the socio-economic factor also contributes negatively to psychological and social distress among RPDs. The following testimonies from RPDs illustrate this point:

> Being here, it's like my life is on pause. Illness has already exhausted me, but being detained for financial reasons is breaking me down even more. I feel powerless, ashamed, and abandoned. I can't stop thinking about my family, my children who need me. A

psychologist could help me understand what I'm going through and find the inner strength to cope with this situation.

Detention leads to family dependency, feelings of guilt or shame, loss of income, job or financial resources, especially if the patient is working in the informal sector, and loss of autonomy, increasing stigma and psychological distress. Illness, combined with an inability to pay for treatment, has plunged RPDs into a spiral of financial and personal difficulties. The sense of failure and uncertainty about the future are compounding psychosocial distress.

Discussion

The findings of this study show that RPDs for medical bills face psychological and social effects characterised by depressive and anxiety symptoms. The K10 test indicated that 53.3% of RPDs have a moderate level of psychological distress. In comparison, 33.3% have a mild level of psychological distress, and only 13.3% have a severe level of psychological distress as a result of the practice of detention. Young people were likely to have fewer relationships than older people, which may impact problem-solving skills. These results differ from those obtained as part of the Canadian Community Health Survey (CCHS, 2010), which showed a higher score associated with greater psychological distress, ranging from 0 to 40. Ongeri et al. (2022) identified a low level of psychological distress among outpatients. The moderate level of psychological distress among RPDs in this study was due to the social support system, especially family and significant others. Generally, hospital environments with complex social relationships impact the psychological well-being of RPDs expressing Ubuntu principles. Despite being detained and other challenges faced, RPDs were not likely to develop very severe mental health disorders because of social support from family members and significant others. Negative emotions make RPDs more vulnerable to financial and other health problems (Katz and Jones, 2017).

Furthermore, RPDs often present fragile socio-economic profiles, characterised by low levels of education, a lack of social support, poverty, loss of income, limited access to healthcare, and strained family relationships and friendships (Cowgill & Ntambue, 2019; Mutambala, 2020). This vulnerability makes them susceptible to harmful effects such as anxiety, depression, feelings of injustice, and stigma, creating a vicious circle of poverty and dependency. Mental Health and Psychosocial Support providers in complex humanitarian settings adopt a principle-based approach (Adams, 2009; Hugman et al., 2021; Kasherwa et al., 2023).

RPDs are consumed by the total absence of any prospect of release in this situation. When they see other patients being discharged, their psychological state worsens. Individuals already weakened by previous traumatic experiences appear to be the most likely to develop depressive and anxious symptoms linked to deprivation of liberty and uncertainty about the future of their lives. The consequences can be long-lasting, with significant repercussions on RPDs' quality of life. Smith and Johnson (2015) showed that medical detention leads to tensions within the family, affecting relations between members, stigma, social isolation and creating conflicts linked to debt management or family conflicts. These mental health issues have a lasting impact on their quality of life and the ability to reintegrate into society.

The lack of any prospect of discharge increases psychological and social effects. Detention is a highly stressful life event that can exacerbate pre-existing mental disorders and induce new ones (Aubard, 2022). Psychiatric history and the absence of a clear time horizon for release are individual factors that are particularly significant in aggravating the psychological suffering of RPDs. There is a need to develop psychological interventions tailored to the specific needs of detainees. The specific context of

hospitals, with humanitarian missions and the challenges associated with medical bills, provides fertile ground for enhancing interpersonal relationships and psychosocial support.

Conclusion

Despite its role, the Medical Social Work Department often remains in the shadows and is a victim of a chronic lack of recognition. This research identified the presence of a social work department in two hospitals among three, but the absence of activities and patient-oriented interventions. Attention should be paid to the factors such as social change, social legislation, the range of facilities on offer, the hospital environment, and the patient's status. It should vary considerably in its day-to-day operation from one hospital to another, but also from one department to another within the same hospital, or even the same department. This study represents a significant initial effort to evaluate and screen the mental health outcomes of RPDs (Recovered Patients Detained) within the Democratic Republic of the Congo context. However, it is subject to several limitations. It does not account for the indirect effects of detention on detainees' relatives, families, and children. Methodologically, the study is exploratory in nature, which constitutes a limitation in itself, as it provides a snapshot of a situation that may evolve considerably over time. A longitudinal study is necessary to assess the long-term impacts. The absence of comprehensive statistics of RPDs over a period of at least five years prevented the findings from being situated within a broader context and hindered an accurate assessment of the scale of the problem.

Actionable solutions from the perspective of a Medical Social worker in Bukavu Town

There is a need for psychological support systems, enhancing Ubuntu as a resilience mechanism, advocating for instalment payments, and counselling services. Hospital administration should maintain patients in good condition to avoid serious consequences for their mental health and social well-being, even though they were detained for non-payment of medical fees. Dealing with RPDs in the context of extreme vulnerability (lack of social services and resources, war conflict, unemployment, extreme poverty) requires integrating solutions grounded in the local context. Bukuvu's inhabitants believe in Ubuntu as a mechanism of solidarity, belongingness and togetherness.

Acknowledgements

The authors acknowledge the Université Evangelique en Afrique for its manifold support to this work, which was graciously funded through the project A-COD 2023-0035 on improving research and teaching quality, funded by Bro für die Welt.

References

Adams, L. (2009). Mental health and psychosocial support in emergency settings. *OMS*. **https://apps.who.int/iris/handle/10665/44278**

Andrews, G., & Slade, T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health*, *25*(6), 494–497. **https://doi.org/10.1111/j.1467-842x.2001.tb00310.x**

Asahngwa, C. (2023). *Poverty and health in conflict-affected regions*. Non publié.

Aubard, L. (2022). *Psychological impact of detention on vulnerable populations*. Éditions Santé Mentale.

Bans-Akutey, A., & Tiimub, B. M. (2021). Triangulation in research. *Journal of Applied Research*, *5*(2), 45–52. https://doi.org/10.20935/al3392.

Casula, M., Rangarajan, N., & Shields, P. (2020). The potential of working hypotheses for deductive exploratory research. *Quality & Quantity*, *55*(5), 1703–1725. https://doi.org/10.1007/s11135-020-01072-9.

Cowgill, K. D., & Ntambue, A. M. (2019). 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). https://doi.org/10.1186/s12978-019-0777-7

Hugman R., Pawar M., Anscombe A. W. B., Wheeler A. (2021). *Virtue Ethics in Social Work Practice*. Routledge & CRC Press.

Human Rights Watch. (2006). *Detention and abuse in healthcare settings*. HRW Reports.

WHO. (2018). *Detention of patients for non-payment of bills: A global review*. World Health Organisation. **https://www.who.int/publications/i/item/9789241514390**

Jones, B., Brown, C., & Smith, A. (2019). L'impact de la détention pour dette médicale sur les relations familiales : une étude qualitative. *Relations familiales, 30*(4), 456-468.

Kasherwa, A. C., Alexandre, A. B., Mugisho, G. M., Foussiakda, A. C., & Balegamire, J. B. (2023). The roles and ethics of psychosocial support workers in integrated health services for sexual and gender-based violence survivors. *Journal of Social Work*, *23*(3), 586–607. **https://doi.org/10.1177/14680173221147218**

Katz, D., Garcia, E., & Jones, F. (2017). Le stress financier et la santé mentale : une revue de la littérature. *Journal de psychologie financière, 20*(2), 189-201.

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M. J., Normand, S. L. T., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*, *60*(2), 184–189 **https://doi.org/10.1001/archpsyc.60.2.184**

Kluender, R., Mahoney, N., & Wong, F. (2024). *Medical debt and poverty in the U.S*. National Bureau of Economic Research. **https://www.nber.org/papers/w32153**

Makhetha, T. (2024). Ubuntu Ethics: A framework for rehumanising social research with young people. *African Journal of Social Work, 14*(6), 382-391. *https://dx.doi.org/10.4314/ajsw.v14i6.9*

Mbugua, W., & Molyneux, S. (2021). Je me sentais comme un animal : Les effets néfastes de la détention médicale sur le bien-être mental des patients au Kenya. *Global Mental Health*, 8(e23), 1-10.

Melariri, H., Freercks, R., Van Der Merwe, E., Ham-Baloyi, W. T., Oyedele, O., Murphy, R. A., Claasen, C., Etusim, P. E., Achebe, M. O., Offiah, S., & Melariri, P. E. (2024). The burden of hospital-acquired infections (HAI) in sub-Saharan Africa: a systematic review and meta-analysis. *EClinicalMedicine*, *71*, 102571. https://doi.org/10.1016/j.eclinm.2024.102571

Mills, J., & Birks, M. (2014). *Qualitative Methodology: A Practical Guide*. Sage Publications. https://doi.org/10.4135/9781473920163.

Mugisha, J. (2022). Stratégies d'intervention pour les patients détenus pour défaut de paiement des frais médicaux. *African Journal of Social Work*, 8(2), 1-12.

Mugumbate, J., & Chereni, A. (2019). Now, the theory of Ubuntu has its place in social work. *African Journal of Social Work*, 10(1), v–xvii

Mugumbate, J. R., & Chereni, A. (2020). Now, the theory of Ubuntu has its place in social work. *African Journal of Social Work* 10 (1), v-xv.

Mutambala, P. (2020). Medical detention in Bukavu: A public health issue. South Kivu Health, Report.

Muwanga-Zake, J. W. F. (2024). Using Ubuntu-Bulamu in research. Inaugural Ubuntu Lecture delivered on 25 November 2022. *African Journal of Social Work, 14(3)*, 166-173. https://dx.doi.org/10.4314/ajsw.v14i3.9

Ndoye, M. (2023). *Human rights violations in healthcare settings*. Human Rights Watch Africa**: https://www.hrw.org/africa**

Ngamaba, K. H., Lombo, L. S., Makopa, I. K., Webber, M., Liuta, J. M., Madinga, J. N., Mampunza, S. M. M., & Heap, C. (2024). Mental health outcomes, literacy and service provision in low- and

middle-income settings: a systematic review of the Democratic Republic of the Congo. *Npj Mental Health Research*, *3*(1). https://doi.org/10.1038/s44184-023-00051-w.

Ongeri, L., Mwangi, P., & Atwoli, L. (2022). Psychological distress among outpatients in Kenya. *Journal of Affective Disorders*. https://doi.org/10.1016/j.jad.2022.02.012.

Smith, J., Brown, A. & Johnson, M. (2015). Les effets psychologiques de la détention pour non-paiement de frais médicaux. *Journal de psychologie de la santé*, 28(3), 341-356.

Tusasiirwe, S. (2023). Disrupting colonisation in the social work classroom: using the Obuntu/Ubuntu framework to decolonise the curriculum. *Social Work Education*, 1–15. https://doi.org/10.1080/02615479.2023.2246499.

WHO (2018). *Detention of patients for non-payment of bills: A global review*. World Health Organisation. **https://www.who.int/publications/i/item/9789241514390**

WHO (2019). *Mental Health Atlas 2019*. World Health Organisation. **https://www.who.int/publications/i/item/9789240036703**

Yates, R., Brookes, T., & Whitaker, E. (2017). *Detention of women and newborns in Kenyan hospitals*. BMJ Global Health. **https://doi.org/10.1136/bmjgh-2017-000350**